

Approved



Dominican Republic
Country Operational Plan
FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



Operating Unit Overview

OU Executive Summary

i. Country Context

Epidemiology

The Dominican Republic (DR) has a population of approximately 10.3 million persons (2013 estimates) and shares the Island of Hispaniola with Haiti. HIV seroprevalence in the general population was 1.0% in 2002 and 0.8% in 2007 and 2013 (DHS, 2002, 2007, 2013). DHS 2013 data showed higher prevalence among those with no formal education (4.3%), compared to those with higher education (0.1%). The data also showed higher prevalence among those in the lowest wealth quintile (1.8%) compared to those in the highest (0.2%). In 2013, HIV prevalence among pregnant women was 1.96% (1,136/57,928) in 15 high-volume maternity units. Teenage pregnancy is high with 21% of teenage girls currently or previously being pregnant (UNFPA 2013). In 2013, the Early Infant Diagnosis Program tested 1,259 infants, of whom 73 (6%) were HIV positive.

HIV seroprevalence among Key Populations (KP) in 2012 (2012 BSS) was higher than the general population: (range by province) MSM 3.9%-6.9%, CSW 1.7%-6.3%, drug users 1.3%-4.8%. These findings are similar to the 2008 BSS. However, among MSM, prevalence of active syphilis was twice as in 2012 compared to 2007 (8.7% vs. 19%) in the most affected province. The 2012 BSS found that the percentage of persons who had an HIV test in the last 12 months was (range by province): MSM 11%-28%, CSW 52%-21%, Drug Users 6.8%-31.4%. In the same study, nearly 100% of persons who tested HIV positive knew their sero-status.

Approximately 7% of the population is Haitian or of Haitian decent (UNFPA 2013); a secondary analysis of the 2007 DHS revealed HIV seroprevalence among Haitians resident in the DR to be 6.5%.

Community testing data among mobile populations (largely Haitian) provide preliminary approximations of HIV prevalence: farm workers 5% (n=1,685), construction workers 2.6% (n=1,055), street vendors 2.1% (n=1,607), and market vendors 1.4% (n=2,451). Population-based survey data from a BSS among Haitian construction workers and Haitian CSW will be available in July 2014. Seroprevalence among residents of Bateys (areas by sugar cane plantations, historically populated by low-income Haitians) was estimated at 3.2% in 2007 and 2.5% in 2013 (DHS 2007, 2013). DHS 2013 data for Batey residents showed higher prevalence among young women than young men (3.3% vs. 1.5% for ages 20-24). Prevalence was higher among older men (7.2% for men age 40-44, vs. 3.7% for women in the same age group).

In 2009 an Armed Forces study of sexual risk behavior among military personnel stationed along the Haitian border showed that military personnel in these areas exhibited significantly high risk sexual behaviors, including multiple sexual partners, inconsistent condom usage, sexual coercion, high rates of alcohol use, and high risk sexual behaviors.

The 2013 Spectrum model estimates approximately 43,700 persons living with HIV. Of persons newly



diagnosed with HIV, approximately 50% of men and 35% of women have an AIDS defining condition (MOH, 2013). As of January 2014, there were 25,232 (45.6% male, median age=41) persons receiving clinical follow-up in one of 77 treatment facilities, of which 18,539 (73.5%) were on ART. In 2013, there were 26,060 CD4 tests conducted (1.0 per patient) and 20,766 viral load tests (0.8 per patient). A small cohort study (N=359) estimated transmitted resistance to first line ARVs to be 8% (Taylor 2011). DR has the fifth highest prevalence of tuberculosis (65 per 100,000 persons) in the Americas, with 3,529 cases diagnosed in 2013. Sixty seven percent of TB patients received an HIV test, of whom 21% were HIV positive; 70% of patients with HIV/TB coinfection received Co-trimoxazole.

The National Response (NR) and the USG role

The NR is led by the MOH and the National AIDS Council (CONAVIHSIDA), and is supported largely by the Global Fund for AIDS, TB and Malaria (GF) and PEPFAR. An HIV/AIDS program costing study (MEGAS 2008, UNAIDS) indicated that external sources provided approximately 49% of the funding of the NR, while the GODR contribution was about 16%. The balance of national resources came from out-of-pocket payments, according to the National Health Accounts study. An updated MEGAS study is underway, the results of which should be available late in 2014.

The DR is a middle-income country and thus must provide higher counterpart to the GF program. The National Treatment Program (NTP) is comprised of 77 HIV treatment services, of which 58 are public facilities and 19 are NGO facilities. All ARVs and HIV test kits are coordinated through the national supply chain management system for medicines and supplies, SUGEMI, which PEPFAR was instrumental in developing. For 2014, the cost of the NTP is US\$10.9 million, of which US\$7,627,036 million is spent on ARVs, US\$ 344,210 on PMTCT consumables, and US\$2,940,039 on HIV test kits (rapid tests, CD4, viral load, DNA-PCR). In 2014, the GF will contribute US\$4,863,437 and the Government of the Dominican Republic (GoDR) US\$ 6,047,850 towards the NTP. PEPFAR/DR does not provide funds to procure ARVs in the DR, but does provide TA support on forecasting, procurement and logistics.

With increasing funding for treatment coming from the host country, the PEPFAR contribution is focused on combination prevention, especially for KP; health systems strengthening, including laboratory capacity, strategic information, supply chain, and HRH, and NGO strengthening.

Coordinating with Other Donors

Although the GF is the second largest financial contributor to the NR, its annual contribution has been gradually reducing. The current GF program in HIV/AIDS totals \$ 42.2 million, for five years, through May 2015. PEPFAR coordinates with GF activities through the CCM, directly with GF delegations when they visit the DR, and through individual meetings and consultations with Principal Recipients (PR) and with CONAVIHSIDA, which is both a PR and the governmental entity tasked with leading GODR AIDS policy and strategic planning.

Other donor agencies provide limited and targeted assistance to the NR. UNAIDS is the lead UN agency in HIV/AIDS; it is a member of the CCM, supports policy dialogue and is the lead agency in assisting the



NR to prepare GF proposals. The Pan American Health Organization is also a member of the CCM and provides support for labs and information systems. UNICEF supports the Ministry of Education (MOE) sexual education program in public schools. PEPFAR continually communicates with these agencies and sits on working groups with them.

The private for-profit sector is a member of the CCM, but it contributes limited resource to the NR.

Pipeline and/or other HIV/AIDS funding sources

PEPFAR/DR has worked diligently to spend down our pipeline. According to the Report on Obligations and Outlays (March 2014), PEPFAR/DR's pipeline totals approximately \$ 25 million, down from over \$ 27.4 million only three months earlier. As part of the portfolio review, the team discussed existing and future activities, current needs, available funding and potential new directions. The prudent management of pipeline continues to be an important issue as the DR team planned its 2014-2015 program.

PEPFAR/DR has offered \$2.9 million of pipeline as part of the 2014 budget of \$ 15.5 million.

To ensure continuity of services and improve programmatic and fiscal planning, PEPFAR/CDC developed a strategy to realign the budget periods of its PEPFAR-funded activities. Implementing mechanisms will be realigned in 2014, by extending those which are ending for another six months until March 2015, when new IMs will be funded. This will avoid potential delays in funding and/ implementation of critical activities.

II. PEPFAR Focus in FY 2014

The PEPFAR program has adapted the GHI results framework to achieve the goal of saving lives and reducing the number of new HIV infections in the DR. Three priority areas identified by the PEPFAR/DR team to achieve this goal are: 1) Strengthen health systems, 2) Greater implementation of quality improvement strategies, and 3) Improved use of information for action [See Document Library, Dominican Republic Results Framework].

The PEPFAR team has discussed our priorities and taken the decision to focus our program on the continuum of response, with emphasis on KP and other vulnerable populations (OVP). In the DR the continuum of response prioritizes the need to improve identification of vulnerable populations; reach those populations with primary prevention education; demand creation for and provision of counseling/testing and STI services; enrollment in care/treatment programs of those who test positive; retention in treatment; and ARV treatment leading to suppressed viral load. A cross-cutting issue throughout the continuum is reduced stigma and discrimination, which enables those who are HIV positive and/or members of key populations to seek clinical services free of the social barriers which in the past have been obstacles to access to and retention in those services.

PEPFAR will increase its focus on KP and OVP; strengthen the linkages across the continuum of response, with access to clinical services being a key goal; geographic and population targeting, to "locate" KP and OVP more efficiently; and reducing S&D at health facilities. Activity focus implies a reconsideration of current activities supported by the PEPFAR program: reducing support to PMTCT clinical services, focusing interventions for health systems strengthening to those which support the continuum of care; ending blood safety programs; and improved interagency collaboration and



articulation.

To achieve the health priorities, the PEPFAR/DR team has undergone a programmatic realignment in COP 2014, which reflects the items outlined in the FY 2014 funding level letter. Broadly, CDC will focus on improved quality of HIV and TB treatment services, especially for KPs, STI clinical services, strengthened strategic information (epidemiology, M&E, and health information systems), laboratory capacity building, and some HIV prevention interventions among mobile populations (many of which are Haitian), with MSM prevention interventions being transitioned to USAID in FY15. DoD will continue to work with the Armed Forces on combination prevention and systems strengthening. USAID will focus on community-based HIV prevention, linkage to treatment, and care and support for key populations and to a lesser extent other vulnerable populations, such as Batey residents; NGO strengthening and sustainability; reducing stigma and discrimination and improving the response to violence against KP, and strengthening the health system to support HIV care and treatment, through improving supply chain and HR management. CDC and USAID will reduce the number of IMs in COP14.

According to the 2013 DHS adolescent girls and boys (15-19) have the lowest HIV prevalence (0.1 and 0.2% respectively), while older male Batey residents (40-44) are estimated to have higher HIV prevalence of 4.5%-11.1%. Given this reality, Peace Corps/DR will slowly phase out its youth-centered PEPFAR-funded prevention activities and increase activities to ensure that the higher-risk Batey populations have increased access to testing and services. PC/DR will work closely with CDC and USAID to link activities and relevant populations with testing services. PC/DR will support the MOH and local NGOs to provide testing and counseling services to the poorest and hardest to reach populations. In the past year USG interagency TWG teams examined the PEPFAR program in SI, PMTCT and KPs, and provided recommendations on strengthening interventions. The PEPFAR team has incorporated a number of their recommendations into COP 14.

Priority Area 1: Strengthened Health System

The DR has an extensive infrastructure of primary (1,100 facilities), secondary and tertiary level healthcare facilities (148 hospitals), covering even the most remote areas of the country. The health workforce includes over 14,000 physicians, 2,000 nurses, 370 lab technicians and 43,000 other health and administrative staff. However, the deficient quality of services—especially primary health care—mitigates the benefit of such an infrastructure.

A major challenge for improving HIV/AIDS services involves strengthening the quality of and linkages to the continuum of care, including reaching (identification) of persons at risk, testing, enrolling into care those who are found to be HIV positive, providing ARVs, retention in the program, and monitoring the effectiveness of ARV treatment. PEPFAR supported improvements in the efficiency of national expenditures on commodities and staff enables the NR to achieve improved health outcomes, whether by ensuring the procurement of the most effective medications at the best prices, or eliminating payroll duplications, or improving the distribution and performance of service delivery staff, which enables the workforce to better serve the needs of HIV/AIDS patients.



Improved planning and decision making for the healthcare system also requires robust collection, analysis, and use of data. A 2006 USG assessment of surveillance for STI and HIV/AIDS in the DR reported multiple opportunities. Since the 2006 assessment, PEPFAR resources have substantially strengthened surveillance, M&E, and information systems for HIV/AIDS programming and decision making. PEPFAR continues to be committed to those focused SI interventions which support the effective monitoring of identification, referral to treatment and retention in clinical HIV, TB, STI, and PMTCT services, including laboratory services. These include procurement and logistics/supply chain management system and TA in Human Resources (HR) management, for the appropriate staffing of HIV clinical services and linked TB services, and performance management of staff to reduce absenteeism and improve productivity.

Improving health sector performance requires a strong partnership between the public, private, and non-governmental (NGO) sectors. GODR recognizes the important role that civil society plays in health promotion. Furthermore, civil society groups and non-profits also provide critical services not covered by the public and private sectors. KPs depend on these groups for HIV prevention, care and treatment services. PEPFAR funds and provides TA to selected NGOs and works to expand access for KPs, ensure quality, and promote the integration of the NGOs with public sector programs. The Local Capacity Initiative will contribute to building the sustainability of these NGOs, in order to support their continued contribution to the NR.

PEPFAR support is aligned with the HIV/AIDS National Strategic Plan (NSP) and is coordinated with the GF. Many PEPFAR-supported activities are designed and implemented directly by the MoH, such as the PMTCT program, HIV service provision, TB Control Program, and Epidemiology functions, and Technical Working Groups, such as HIV clinical care, PMTCT, HIV laboratories, TB laboratories, HIV/TB co-infection, Blood Safety, FETP training, and supply chain management.

Priority Area 2: Greater implementation of quality improvement strategies

Improving the quality of clinical services for target populations – MSM/TG, CSW, mobile populations, residents of Bateyes, military, youth who by their risky sexual behavior include them as KP -- is a major focus for the PEPFAR/DR team. Specifically, in the context of a program focused on the continuum of care, activities will include the organization of two MSM-friendly clinics in the two largest cities of the country, with a third to be established under COP 2015, in collaboration with the MOH. They also include clinics which accommodate the unique work schedules of migrant populations, by remaining open during hours that these groups could access services. In August 2014, the Vice Ministry of Quality Assurance published a national framework for quality improvement of health services. It is expected that this framework will address several quality-related structural issues within the MoH, including the provision of focused clinical care and treatment services to vulnerable populations.

PEPFAR will support stronger linkages among community prevention activities, treatment, and care services. A KP unit within the MOH will further facilitate coordination between NGO and MoH activities; PEPFAR has met with this unit and with the Directors of the NR, for the purpose of articulating those



interventions which focus on KPs and which are supported by PEPFAR, the GF, and other donors. Building on operational research, PEPFAR will support an evidence-based intervention for positive health, dignity and prevention for HIV positive CSW, MSM and TG, using multiple approaches.

PEPFAR is supporting the application of stigma measurement tools at health facilities, stigma reduction activities with clinical staff, the development of facility policies and codes of conduct, and the documentation and response to incidents of discrimination. Over time, PEPFAR support will reduce stigma and discrimination associated with HIV and KP. In the short term, there is an urgent need to provide clinical services that are accessible to MSM and TG.

With PEPFAR support and TA, an HIV Patient Information System will provide monitoring data at the programmatic level. A Site Supervision Program covering 76 treatment service sites will be developed with the MoH, to assess treatment quality indicators and conduct regular patient reviews (for example, in case of treatment failure).

Since 2010, USG has provided technical support to the MOH to implement a unified pharmaceutical management system, known as SUGEMI. The PEPFAR team considers that this is a vital component of a strong national response and supports its continuation. Accordingly, this assistance will continue in 2014. This system has increased access to ARVs at service delivery level, with 94% availability of ARVs at treatment sites (up from 64% in 2012). PEPFAR support has been integral to a 25% increase in the number of ARVs procured from 2012 to 2013, a reduction in the cost of treatment per patient from \$371 in 2011 to \$164 in 2014, and the mobilization of national funding for treatment.

Since 2010, PEPFAR support has enabled the MOH to develop standard operating procedures for selection, estimation, distribution, storage, dispensing, and supervision of medicines and commodities, train MOH staff in pharmaceutical management, and conduct national level estimation and programming exercises for the public health sector. The next period will focus on consolidation of the national supply chain management (SCM) system at the central, regional, and site levels of the health system, as well as continued focused TA to improve SCM for HIV and TB. PEPFAR will provide less support for the core operations of the national SCM system from 2016, under the expectation that the MOH will have the capability to assume greater technical responsibility for the national SCM system. PEPFAR will continue to address the SCM needs of an expanding national treatment program after this point.

A laboratory quality management system (QMS) has been adapted and implemented in the DR with PEPFAR support. Twenty high-volume laboratories, including the National Reference Laboratory, have enrolled in the Strengthening Laboratory Management toward Accreditation (SLMTA) program and have achieved an average 20% increase in the checklist score. Development of a National Strategic Plan is included in COP14. Between 2011-2013, PEPFAR-support has enabled the MoH to develop National Laboratory Quality Norms; a National Guide to Biosafety; a National Blood Bank Strategy; guidelines for RDT, CD4, and viral load testing, and manuals for clinical laboratories, among other normative documents.

PEPFAR has supported the MOH to build human resource (HR) leadership and management capacity in



the health sector through HR policy, regulatory and governance interventions, workforce planning and performance management. PEPFAR has supported the enactment of the Health Career Law and the General Salary Law. These laws govern the contracting, supervision and evaluation of personnel; ensure stability of skilled human resources in the health sector, with the purpose of reducing the turnover that occurs after presidential elections. PEPFAR TA has helped the MOH to save \$6.2 million per year, through eliminating much of the duplication and “ghost workers” in the payroll and retirement system. Future support will include TA for effective workforce distribution and improving site-level performance management to reduce absenteeism and improve productivity for staff delivering HIV and TB services..

Priority Area 3: Improved Use of Information for Action

Improved Strategic Information (SI) continues to be a priority for PEPFAR, as part of our work in health systems strengthening and to enable the NR to monitor its treatment and retention services for persons living with HIV and TB, and for the PMTCT program. A challenge of the health sector reform has been that SI functions were spread over several operating units of the MoH. PEPFAR-supported activities have assisted the MOH to rationalize SI functions and avoid duplicate or parallel data reporting systems. Although a National SI strategy does not currently exist, PEPFAR support for surveillance has been developed within the second generation HIV surveillance framework. At the end of 2012 the MoH established a Directorate for Technology and Informatics, providing a counterpart with which to undertake and coordinate HMIS projects.

PEPFAR's work in SI includes the following areas:

Epidemiology

Routine Surveillance Systems with PEPFAR support have included the MOH reportable disease surveillance system (SINAVE), which reached 20% coverage by the end of 2013 to capture new diagnoses of HIV, recording 598 new HIV infections in 2013. Support to HIV/TB case reporting found that in 2013, 67% of TB patients received an HIV test; however, the system still does not accurately capture the number of HIV patients who are screened or treated for TB.

To gain better knowledge of STI etiology, PEPFAR is supporting the creation of a six-clinic STI sentinel surveillance system. The HIV Patient Information System (HPIS), created with PEPFAR TA in 2013, has been implemented in 76 HIV treatment sites (includes MOH and NGO providers), and collects data on 100% of the patients receiving clinical follow-up or who are on ART.

In partnership with the MOH, PEPFAR has supported a number of studies, which have strengthened the in-country capacity in this SI area. These include General Population Prevalence, as part of the DHS in 2013 (with results due in summer 2014) and prevalence among KP. A BSS among Haitian construction workers and CSW and a PLACE study have concluded and preliminary data are now being reviewed.

Monitoring and Evaluation

In 2013 PEPFAR supported the development of a Diploma program in M&E, now completed by 198 MOH participants, and a mentorship program for 12 senior MOH officials.

Health Information Systems



Since 2012, PEPFAR has supported the development and progressive implementation of an electronic TB register. In 2013 PEPFAR supported the development of an HIV Patient Information System (PIS), now implemented in 100% of treatment services facilities and the SINAVE disease reporting system. Both of these systems have been co-funded with Global Fund and PEPFAR resources. For 2014 PEPFAR will support the development of a Laboratory Information System at the National Reference Laboratory (NRL) and an electronic reporting tool for the PMTCT program. These activities are consistent with PEPFAR's commitment to support systems which monitor treatment and retention in clinical services among persons who are living with HIV, TB or an STI.

III. Progress and Future

As mentioned above, the PEPFAR team has taken the decision to focus our program on those activities which save lives (i.e., identifying persons who are HIV positive and linking them to ARV treatment and care) and/or prevent new infections (i.e., prevention interventions), along the continuum of response, with emphasis on KP and OVP. In the DR this implies the need to improve the identification of vulnerable populations; reach those populations with primary prevention education and testing; enroll and retain those who test positive in care/treatment programs; ensure an adequate national supply of ARVs; and monitor the effects of ARV treatment in terms of suppressed viral load. A cross-cutting issue throughout the continuum is reduced stigma and discrimination, which would enable those who are HIV positive and/or members of KP and OVP to seek clinical services free of the social barriers which in the past have been obstacles in accessing those services. Additionally, PEPFAR will seek ways to measure the extent of these changes.

PEPFAR plans to increase its focus on KP and OVP; strengthen the linkages across the continuum of response, with access to clinical services being a key goal; and geographic and population targeting, to identify KP and OVP more efficiently. This focus implies a reconsideration of current activities supported by the PEPFAR program, and indeed PEPFAR/DR acknowledges that there will be major shifts. For example: support to PMTCT clinical services will be reduced; health systems interventions which support the continuum of care will be enhanced, but others will be reduced and ended; blood safety programs will be discontinued; youth who exhibit risky sexual behaviors will be targeted, but general youth prevention programs will be reduced; renewed efforts to refer KPs and OVP living in Bateyes to testing, counseling and clinical treatment services; drug users will no longer be a target group.

To achieve the health priorities, the PEPFAR/DR team has agreed to a programmatic realignment in COP 2014. Broadly, CDC will focus on improved quality of HIV and TB clinical services, especially for KPs, STI clinical services, strengthened strategic information (epidemiology, M&E, and health information systems), laboratory capacity building, and some HIV prevention interventions among mobile populations (many of which are Haitian). MSM prevention interventions will be transitioned to USAID in FY15. DoD will continue to work with the Armed Forces on combination prevention and systems strengthening. Peace Corps will work at the community level in Bateyes on HIV prevention, referral for testing, and education. USAID will focus on community-based HIV prevention, linkage to treatment, and



care and support for KP and to a lesser extent OVP (such as Batey residents), SCM and HR management. NGO strengthening and sustainability will continue to receive PEPFAR support. Regarding Country Ownership, in 2013 and 2014 the GODR invested more of its own resources in the NR. Responding to GF counterpart requirements, the GODR budgeted nearly \$ 2 million in 2013, approximately \$ 6 million in 2014, and a projected \$8 million in 2015, for ARV procurement. It is expected that PEPFAR's work to strengthen health systems and build local capacity will fortify the management capabilities of the GODR. For example, with the skills obtained in the TB information system project, the MoH has the capacity to manage other health information projects, such as SINAVE and the HIV Patient Monitoring Information. The NR now procures through the Partners for Supply Chain Management (PfSCM) mechanism, which has lowered costs considerably. The NRL is participating in and has obtained excellent results in the External Quality Assurance (EQA) Proficiency Testing Program for HIV and Hepatitis B (with the College of American Pathologists), for HIV CD4 and viral load, DNA/PCR, and syphilis. In 2014, PEPFAR support will enable an EQA Program for HIV serology to be developed at the NRL.

The NR is in the process of reviewing and updating the National HIV/AIDS Strategic Plan (NSP). The review will focus on progress and current gaps in the NR, consider new priority areas, and plan for future management and financing.

USG continues to have a strong partnership with the GODR and has carried out a consultation meeting with Civil Society partners, GODR and other donor agencies prior to finalizing COP 2014, which has helped inform and more closely aligned the PEPFAR program to national priorities.

USG programs have supported local NGOs and Civil Society organizations (CSOs) to strengthen their organizational capacity. These organizations have been the bedrock of the response to HIV among KP since the onset of the HIV epidemic. Several long-term USG-supported NGOs now receive and successfully manage funds from non-USG sources. Five members of Civil Society are voting members of the CCM, and this block is now more active in providing input into NR policies and programs.

IV. Program Overview

Key Populations

Targeted interventions for KP and OVP are funded by international resources (mainly PEPFAR and the GF), and implemented by national NGOs. There is a major need to increase the sustainability and national ownership of these programs. PEPFAR will work with the NR to increase the quality, coverage, enabling environment and sustainability of prevention programs addressing the needs of groups most affected by the epidemic.

The PEPFAR/DR team will continue its work with KPs, as underscored by the TWG visit in December 2012, specifically with CSW and MSM/TG. In COP 2014 there is a strengthened emphasis on the continuum of care for KPs. The KP TWG report put major emphasis in the team's focus on identifying and then assisting with the provision of a minimum package of services for KPs, which includes peer



education and outreach (including risk reduction counseling), access to condoms and lubricants, HIV testing, stigma reduction, referrals for care and treatment, and STI screening and treatment, in targeted geographic areas. PEPFAR has supported condom social marketing for several years. This program will continue for the next two years, funded by income generated through sale of socially marketed condoms. As well as marketing condoms at “hotspots” and motels, the program will ensure continued supply of free condoms and lubricants for KPs. It will also provide TA for NGO-implemented community-level demand creation for condom use and HIV/STI clinical services, including testing, care and treatment.

The PEPFAR team will implement an evidence-based comprehensive HIV/STI prevention model for MSM and TG. The program will complement and significantly expand community initiatives and clinical services in Santo Domingo, Santiago and Barahona. It will establish a self-sustainable model for the delivery of user-friendly health services, responsive to the culture and characteristics of this population in collaboration with the MOH, other government institutions and civil society.

PEPFAR interventions will help reach MSM/TG with testing, referrals of HIV positive individuals to clinical services, help establish two MSM/TG-friendly clinical services, and cover clinic infrastructure and administration costs (a third clinic will be part of COP 2015). The PEPFAR program will promote adherence and retention through peer educators, process navigators and home visitors, and assist with access to other health or legal services, as appropriate. Clinical staff, ARVs, test kits and other consumables will be provided by the MoH.

PEPFAR will continue to work with at-risk youth, that is, those who exhibit sexual behaviors which render them vulnerable to acquiring HIV and which place them in the category of KP. Peace Corps (PC) supports a number of programs, including Escojo mi Vida (I Choose my Life), GLOW (Girls Leading our World), Chicas Brillantes (Brilliant Girls), Superman (for boys), Deportes para la Vida (Sports for Life), and Hogares Saludables (Healthy Homes), which deliver HIV prevention messages through peer educators. PC Volunteers working in Bateyes will provide a continued focus on primary prevention and will seek opportunities to connect high risk and HIV positive persons with testing and clinical care, treatment and retention services. Positive gender norms and behaviors are emphasized in the PC programs.

Improvements in Quality of Services

PEPFAR supports the DR to provide a comprehensive, accessible and sustainable package of effective care and support services, for all PLHIV and with a focus on KP and OVP. The goals include improving linkages across the continuum of care, improving the enabling environment for KP, and expanding the evidence base and using information for program planning. PEPFAR will support and monitor linkages from counseling and testing to prevention, care, treatment, retention and adherence services for target populations. PEPFAR-supported NGOs will provide counseling and testing services through mobile units and/or at their own facilities and community outreach. Individuals who test positive will be referred to clinical sites, and peer health navigators will accompany/follow up patients to support their retention/engagement in the system.

Within the positive health, dignity and prevention framework, PEPFAR will work to keep PLHIV



physically healthy (through focusing on access to treatment, retention, and adherence, nutrition, including supporting peer health navigators), mentally healthy (psychosocial support through counselors at treatment sites, peer counselors and support groups), prevent transmission to others (through ensuring HIV positive individuals reach and maintain a suppressed viral load and promoting partner testing and counseling, STI screening and treatment, condoms and lubricants and prevention education, and linkage to family planning and PMTCT services), increase participation of people living with HIV (through supporting PLHIV groups, and PLHIV role in care and support delivery, planning, monitoring and advocacy). PEPFAR-funded community support will be provided through NGOs and CBOs linked to major treatment sites in urban areas.

PEPFAR will continue to develop and roll out tailored models for care and support for KP, through the Abriendo Puertas (opening doors) model for HIV positive MSM, TG, and CSW, a research-to-practice intervention developed with Johns Hopkins University.

PEPFAR interventions will help reduce stigma and discrimination against PLHIV and KP at clinical service delivery sites. This will be accomplished through assessment of stigma and discrimination, training of staff at clinical sites, development of facility-level policies and protocols, and monitoring of cases of discrimination. PEPFAR will apply stigma indicators developed for health facilities and will continue and expand support for S&D reduction training for healthcare providers, using the technical expertise of the Health Policy Project and applying the same models and in conjunction with the same technical specialists supporting the CHART program.

Strategic Information

PEPFAR will maintain its focus on those SI interventions which measure HIV, TB and STI care services. These include strengthened routine surveillance systems, such as HIV Case reporting (the MoH reportable disease surveillance system [SINAVE]), HIV/TB case reporting, STI Surveillance (including continuous support to the creation of a six-clinic STI sentinel surveillance system) and an HIV Patient Monitoring System (HPMS) in 67 HIV treatment sites in the country (which includes MoH and NGO providers).

During FY2014 the PEPFAR Team supported the completion of a BSS among Haitian construction workers and CSWs and a PLACE study. The PLACE study covered five regions, helped map target populations and interventions sites, and will inform the implementation of PEPFAR and Global Fund prevention activities at selected "hotspots", as well as estimates of numbers of KP who can be covered through outreach programs.

As part of our focus on building M&E capacity within the MOH, PEPFAR will continue to support the Diploma course in M&E involving the 38 Health Provinces, through a strengthen mentorship program to develop an evaluation capacity for 12 senior M&E professionals in the MoH

PMTCT

The DR now has a National Strategy for the Elimination of Mother- to- Child Transmission of HIV and congenital syphilis. The current system of hand-counting PMTCT counseling and testing encounters that



are recorded in physical registers will be replaced through COP 2014 with an electronic system. This will enable the NR to identify how many pregnant women are HIV positive, ensure they are enrolled into treatment, and ensure their infants are tested. This activity will contribute to the continuum of response. PEPFAR will reduce its support to PMTCT clinical services.

Systems Strengthening

The PEPFAR program will continue to provide targeted support to systems strengthening: MOH information systems, supply chain management, Human Resources (HR) management, as it impacts on the appropriate staffing distribution and performance management for the workforce at care and treatment services, and laboratory system strengthening. All of these interventions contribute to strengthened performance and sustainability of the continuum of care services.

In 2011 PEPFAR completed an HR assessment of MOH staff. Findings included a high risk of corruption in parallel payroll systems at central and hospital level (30% of payroll going to ghost workers), inequitable distribution of staff – not linked to service delivery needs, and lack of performance management, resulting in absenteeism and poor quality services. The MOH has used this assessment to clean the payroll, saving \$6.2 million per year. With PEPFAR support, the MOH is enhancing its personnel performance management practices and will apply the WHO Workload Indicators of Staffing Need tool to systematically identify the appropriate kinds and numbers of trained staff needed to support HIV clinical treatment and care services in the different health facilities.

PEPFAR reaffirms its commitment to support a strong supply chain management (SCM) system. Our program will continue to provide TA on SCM to the MOH to support the consolidation of the National Pharmaceutical Management System, SUGEMI. This TA has resulted in cost savings, and efficient SCM has reduced stockouts of essential medicines and supplies for the HIV and TB programs.

Further PEPFAR support to SCM will focus on consolidation of the national SCM system, at the central, regional, and site levels. As the MOH develops the capability to assume greater technical responsibility for the national system, PEPFAR will reduce its support for these core operations for 2016. a reduction of funding is projected for FY 2016. At this point TA will continue to address the SCM needs of an expanding national treatment program.

PEPFAR's ample work in SI is described above.

COP 2014 reflects PEPFAR's continued support to the WHO/CDC laboratory systems strengthening program "Strengthening Laboratory Management towards Accreditation (SLMTA)." This program provides the MOH with the tools and processes to build its own laboratory systems strengthening program. SLMTA includes developing a strategic plan for laboratory equipment maintenance, training of maintenance engineers, external and internal quality assurance, and a laboratory information system. Once the SLMTA program is completed, the MOH can apply for international accreditation for its best performing laboratories, under the ISO framework. PEPFAR has budgeted to procure point-of-care CD4 and GeneXpert machines to improve the NR's testing capacity. PEPFAR has worked with the MOH to determine the best mix and placement of these machines, but as of August 2014, the MOH has not made



a decision. PEPFAR also supports the MOH to develop a national laboratory sample referral network for HIV and TB.

V. GHI, Program Integration, Central Initiatives, Other Considerations

COP 2014 and GHI

The COP process supports GHI strategy concepts, documented in the Results Framework [see Document Library]. The PEPFAR mission of reducing the number of new HIV infections and providing assistance to the treatment of PLHIV clearly supports the GHI goal of improving the health of women, children, youth, and high risk populations. The GHI objectives of equitable access to integrated services and promoting health-seeking behaviors are directly supported by PEPFAR program activities. At the intermediate results level, PEPFAR supports activities which directly strengthen the three GHI focus areas of 1) strengthened health systems, 2) expanded access to quality evidence-based interventions, and 3) improved use of information for action.

The GHI principle of “focus on women, girls and gender equality” is supported in the PF and COP by a policy dialogue agenda on gender equality and by the revised AIDS Law. The principle of “encourage country ownership and invest in country-led plans” finds its counterpart in the PF and COP principles of GODR responsibility for the HIV/AIDS NSP and the NR, and PEPFAR support to strengthen GODR systems and its management capacity.

The GHI principle of “health systems strengthening” is supported by PEPFAR’s focus on strengthening the information, supply chain management, laboratories, and HR systems. PEPFAR supports the principle of improved health for Dominicans through our strong alignment with the NR and by utilizing the comparative strengths of the participating USG agencies in the PEPFAR portfolio. The GHI principle of “improve use of information” is supported by the TA provided to the MOH surveillance, M&E, and information systems, and our focus on evidence-based interventions.

Engaging with other donors

USG continues to interact with the GF, through its membership on the CCM, dialogue with GF Portfolio Manager and short-term TA to the CCM and PRs by Grant Management Solutions (GMS). The TA includes assessment and strengthening of the CCM on governance and strategic oversight, to improve GF operations and meet GF eligibility requirements, and support in preparing and submitting a Concept Note to the GF, which will request \$17 million of additional funding for the NR. Core-funded TA was also provided to one of the PRs pilot the new grant management dashboard for data-based decision making and improved management of sub-recipients. The CCM, PRs, and GF have been pleased with the quality of TA provided by GMS and have requested additional core-funded GMS support to continue the process for strengthened CCM governance and strategic oversight. PEPFAR will support the PR working with NGO sub-recipients delivering services to KP, to introduce the new grant management dashboard, at the request of the PR itself and the GF.

PEPFAR is working with GF principal recipients to map geographical coverage and technical content of interventions for KPs and PLHIV. Harmonizing minimum packages of services, developing national quality



standards, scaling up effective interventions, and conducting joint analysis and planning based on program and survey data will be hallmarks of the strategy for the next period.

UNAIDS has an important presence in the NR, mostly at the policy level. PEPFAR collaborates closely with UNAIDS; for example, PEPFAR sent a delegation of high level GODR officials to the PEPFAR/UNAIDS workshop on the Investment Framework, in Jamaica in May 2013. A working group has been formed and continues to promote the implementation of the Investment Framework principles. UNAIDS is a member of the CCM. The Pan American Health Organization is also a member of the CCM and provides some assistance to the NR. PEPFAR converses regularly with PAHO, to ensure synergies between the two programs.

Central Initiatives: Local Capacity Initiative (LCI)

PEPFAR supported a Sustainability Forum in 2012, focused on the sustainability of NGO programs contributing to the NR. The event brought together the NGO, public and private sectors. There are continuing concerns about sustainability for the activities of the NGOs which are at the heart of service provision for the most marginalized groups, including KP. Through PEPFAR's successful application to LCI, a national sustainability strategy will be developed and TA provided to NGOs to increase the sustainability of their programs, based on the priorities and opportunities identified at the Sustainability Forum. As PEPFAR's primary vehicle for funding NGO sustainability development, the LCI investment will enable PEPFAR country funds to be directed to activities primarily related to the clinical cascade for KP, OVP, and PLHIV.