

**HAITI Country Operational Plan
(COP/ROP) 2016
Strategic Direction Summary**

July 8, 2016

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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 leading to a reduction in new infections and AIDS-related mortality. This goal will be achieved through a focus on program performance and the scale-up of HIV clinical and community services and strategies that have demonstrated the most impact based on the latest epidemiologic and programmatic data. These services and strategies will lead to achievement of 80% ART coverage in the 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.

COP 15 pivots geographically refocused on 20 priority “arrondissements” (districts) out of a total of 42 districts and this prioritization will be maintained in COP16. Program pivots were informed by program data analysis that demonstrated that the 20 districts (10 saturation and 10 aggressive) represent 90% of individuals receiving HIV testing and counseling (HTC) services, 90% of patients in the cumulative national ART cohort, and 75% of the overall HIV-infected population (58% in the 10 saturation districts). Successful implementation of these pivots will result in the delivery of more impactful, cost-efficient, and streamlined interventions with reductions in per-patient spending for enhanced efficiency.

A key change for COP16, in alignment with the UNAIDS 90-90-90 goals, is the introduction of the new World Health Organization (WHO) guidelines recommending the Test and Start approach to HIV treatment. The National AIDS Control Program (PNLS, French acronym) of the Ministry of Health (MOH) announced its plan to adopt these recommendations in May 2016, and has already started the process of revising the national guidelines to adopt the WHO recommendations. The revisions are expected to be completed by July 2016 and the implementation to begin in October 2016. The PEPFAR Haiti team will closely collaborate with MOH and PNLS in this process.

As the Test and Start strategy is implemented, the PEPFAR program will continue to target high HIV burden areas and high risk groups to improve and maximize the HTC yield. This will be achieved through a mixed approach based on facility and community/mobile testing, prioritizing high-yield service delivery points such as TB clinics, STI clinics, prisons, and targeting key populations. Using the best available data, the team has set ambitious targets for COP16 that will result in a significant increase in ART coverage. The elimination of CD4 to determine eligibility will fast track ART initiation.

A major challenge for the PEPFAR program is patient linkage to and retention in care. The team and our Implementing Partners have identified and piloted a package of interventions aimed at addressing this challenge. These interventions include: implementation of the improved linkage and retention (ILR) program, unique patient identifier using biometric codes, multi-month scripting and community drug distribution for stable patients, task shifting to community health

workers (CHWs), use of mobile health technology and positive peer navigators to improve linkage and retention in care amongst priority populations.

With effective national roll-out of these interventions, significant progress towards the second of the UNAIDS 90-90-90 goals will be made by end of fiscal year 2017 (FY17). Furthermore, in FY16 the program initiated the roll out of viral load (VL) testing. By the end of FY17, the program plans to have VL for 100% of patients with at least 6 months on ART and report on the proportion of ART patients who have achieved viral suppression.

To support our COP16 programming, PEPFAR Haiti is focusing on addressing stigma-related barriers through our Civil Society dialogue and a focus on the Human Rights Agenda within our team and with our Implementing Partners. Also, PEPFAR Haiti is sensitive to the role of gender in our programming and the team completed a Gender Analysis in preparation of COP16 and this document will continue to evolve as the conversation continues in country.

Finally, to ensure sustainability of these programs and investments, the PEPFAR Haiti Team continues to engage and advocate with the Government of Haiti (GOH), through the MOH and PNLS, for increased funding for the national HIV/AIDS program.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Haiti is a low-income country with GNI of \$810 per capita (World Bank 2013) and a GDP of \$771 per capita (2012), which makes it the poorest country in the Western Hemisphere. 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 141,269 people living with HIV (PLHIV) (Small Area Estimates, OGAC 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. However, the last Integrated Bio-Behavioral Survey (IBBS, 2015) has shown that there are other drivers of new infections such as unprotected transactional and commercial sexual activities as well as unsafe sexual practices among men who have sex with men (MSM). 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.

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

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, destroying and damaging much of the previously existing physical infrastructure (including 30,000 commercial 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 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). Lastly, the country is currently in transition following the political turmoil surrounding the presidential election which is yet to be completed. With no set timeline for the elections, this situation has further weakened the economy. The national currency (Gourde) has lost nearly one third of its value during the last year only; 62 gourdes are now needed for 1USD compared to 47 gourdes in 2015.

Nonetheless the DHS data from 2006 and 2012 indicate that HIV prevalence among adults (15-49 years old) 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 2015, over 66,528 individuals were receiving antiretroviral treatment (ART), representing 53% of the estimated number of people eligible for ART under the current guidelines, and nearly 14,000 individuals were receiving pre-ART care services. Over 80% of all pregnant women were tested for HIV, and of those identified as HIV-infected 89% 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.

The major geographic shifts and technical pivots, undertaken since 2014 and during FY15, in the PEPFAR Haiti portfolio have allowed for a better response to the unevenly distributed HIV disease burden among the different subnational units in the country. Three departments (Ouest, Artibonite and Nord) account for 62% of all PLHIV and for 8 of the 10 saturation districts. The district of Port-au-Prince alone accounts for 26% of all PLHIV. The prioritization exercise guided PEPFAR investment in COP 15 to accelerate impact towards achieving epidemic control despite the constrained budget environment.

During recent years - concomitant to an overall decrease in external funding (end of title II, reduction of World Food Program activities, and end of Canadian support to free obstetric care) - the program has experienced a significant attrition among people receiving antiretroviral therapy (ART). As retention in care and adherence to treatment are key determinants of the treatment outcome, such a level of attrition may hamper program capacity to reach saturation and to contribute to the UNAIDS 90-90-90 goals by 2020. To reduce loss to follow up (LTFU), PEPFAR

Haiti has identified successful approaches, namely the patient linkage and retention (PLR) program, use of mobile health technology, implementation of unique identifier using biometric codes, and use of PLHIV peers, that will be rolled out in COP16 in addition to other ongoing support and community activities described in sections below (program activities).

Table 1.1.1 Key National Demographic and Epidemiological Data

	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	10,749,925	100%	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 IHSI/ UEP estimations
HIV Prevalence (%)		1.41		0.34		0.35		2.25		1.59	Avenir Health, 2014
AIDS Deaths (per year)	4,449		196		196		1,857		2,200		Small Area Estimates, OGAC 2015
# PLHIV	141,269		4,164		4,203		78,691		54,211		Small Area Estimates, OGAC 2015
Incidence Rate (Yr)		0.07									Avenir Health, 2014
New Infections (Yr)	5,257		138		144		2,852		2,123		Small Area Estimates, OGAC 2015
Annual births											
% of Pregnant Women with at least one ANC visit											
Pregnant women needing ARVs	6,164										Avenir Health, 2014
Orphans (maternal, paternal, double)	93,057										Avenir Health, 2014
Notified TB cases (Yr)	15,963		591		335		7,335		7,702		PNTL, 2014
% of TB cases that are HIV infected	2,588	19%	64	10.8%	65	19.4%	1,254	17.1%	1,205	15.6%	PNTL, 2014: MESI
% of Males Circumcised											
Estimated Population Size of MSM*											
MSM HIV Prevalence											

Estimated Population Size of FSW											
FSW HIV Prevalence											
Estimated Population Size of PWID											
PWID HIV Prevalence											
Estimated Size of Priority Populations (specify)											
Estimated Size of Priority Populations Prevalence (specify)											

**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months), FY15.

				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	141,269	80,045	66,528	48,662	N/A	*1,135,628	*22,118	*17,866
Population less than 15 years	3,591,528	0.35	8,367	4,142	3,319	N/A	N/A	77,731	908	927
Pregnant Women	436,879		5,426	4,872	4,872		N/A	228,039	4,956	4,387

*Includes PMTCT numbers, that are also reported in the last row

1.2 National Investment Profile

Haiti is currently in a transition period after the contested presidential election and is experiencing significant political turmoil. Such conditions have further weakened the economy and further reduced the tax base and revenue streams that were already low. In a country with such limited resources and competing social needs, public spending on health is likely to remain low, especially because the new budget is yet to be voted on by the parliament. Only an estimated 5% of the national budget is allocated to the health sector. Of these limited funds, more than 90% supports personnel costs of the Ministry of Health (MOH) staff. This leaves almost no room for the Haitian government to earmark specific resources for health system development and for the HIV program outside its in-kind contribution in the form of salaries for personnel and the availability of public facilities to carry out the program. Funding for the HIV program comes from PEPFAR (90%) and the Global Fund (GF) (9%), and the in-kind contribution of the MOH is estimated at 1%. PEPFAR Haiti continues to work closely with the Country Coordinating Mechanism (CCM) and PSI, the primary recipients of the GF joint HIV/TB grant, to avoid duplication and to leverage GF resources for strategic alignment with PEPFAR goals. GF will address epidemic control in specific geographic areas in harmony with PEPFAR prioritization and among key populations and youth, and will focus its efforts on integrating TB and HIV services. GF will also partially take over blood safety support through the end of its current grant.

Program Area	Total Expenditure ⁽¹⁾	PEPFAR FY16 Budget allocation	% PEPFAR	GF CY16 Budget allocation	% GF
Clinical care, treatment and support	\$63,650,128	\$49,118,079	77%	\$14,532,049 ⁽²⁾	23%
Community-based care, treatment, and support	\$5,000,000	\$5,000,000	100%		0%
PMTCT	\$3,446,103	\$3,329,941	97%	\$116,162	3%
HTS	\$7,321,879	\$7,321,879	100%		0%
VMMC	\$-				
Priority population prevention ⁽³⁾	\$4,063,871	\$3,509,860	86%	\$554,011	14%
Key population prevention	\$1,708,542		0%	\$1,708,542	100%
OVC	\$9,073,877	\$9,073,877	100%		0%
Blood Safety	\$4,099,361	\$2,200,000	54%	\$1,899,361	46%
Laboratory	\$4,768,526	\$4,768,526	100%		0%
SI, Surveys and Surveillance	\$6,052,536	\$4,854,936	80%	\$1,197,600 ⁽⁴⁾	20%
HSS	\$3,426,659	\$3,426,659	100%		0%
Total	\$112,611,482	\$92,603,757	82%	\$20,007,725	18%

- (1) This represents the FY16 budget for these program areas
(2) This amount includes community support, HTS and lab
(3) Priority population prevention for PEPFAR also include Key populations
(4) This amount also includes HSS

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	6,281,991	34.63%*	65.37%	0.00%	
Rapid test kits	3,034,762	81.89%	18.11%	0.00%	
Other drugs	1,858,553	66.62%	33.38%	0.00%	
Lab reagents	5,440,139	58.56%	41.44%	0.00%	
Condoms **	1,118,980	100.00%	0.00%	0.00%	
Viral Load commodities	1,509,949	100.00%	0.00%	0.00%	
VMMC kits					
MAT					
Other commodities	25,975	0.00%	100.00%	0.00%	
Total	\$19,270,348	61%	39%		

* Expenditure in FY2016 by PEPFAR for ARVs is lower than historical trends and future projections due to draw down of additional stock originally procured to cover the transition to GHSC/PSM. The historical procurement profile has been closer to 65% PEPFAR and 35% Global Fund and is anticipated to be similar through the current Global Fund grant period.

**Condoms are purchased for PEPFAR Program only

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	14,000,000	8,000,000	5	\$11,290,020	There are 5 USAID IMs that receive PEPFAR &MCH. USAID works in an integrated way to deliver health care—meaning these projects deliver a variety of different services—MCH, FP, HIV—at one sites. This integrated service delivery allows clients to access multiple health services in one site.
Family Planning	9,000,000	5,000,000	5	0*	
HHS Post Earthquake Supplemental Funding	\$5,600,000	\$5,600,000	3	\$20,230,752	The purpose was to support the provision of high-quality integrated TB/HIV services and operation of critical disease surveillance systems.
Total	28,600,000	18,600,000			

* There are 5 IMs receiving both MCH and FP funding

1.3 National Sustainability Profile

The process to complete the Sustainability Index and Dashboard (SID) was very participatory this year. Contrary to last year, when we had separate meetings with key stakeholders on distinct domains or elements, this year, the PEPFAR team held a one-day workshop with the support of UNAIDS and under the leadership of the National AIDS Control Program (PNLS). UNAIDS and PNLS were very active, reviewed the tool and helped identify key stakeholders for the workshop including different entities of the Ministry of Health (MOH), Ministry of Finance, Global Fund, UNFPA, Civil Society, Implementing Partners, etc. During the workshop, attendees were divided into five groups, one for each domain except for the services delivery domain for which there were two groups given the number of elements and the number of questions. We had two group sessions: one to answer the questions and a second to identify strengths of and threats to the sustainability as well as the main priorities that the program should focus on over the next few years.

Sustainability Strengths

Quality Management

One of the greatest sustainability strengths of the program is its Quality Management component. Quality management is well integrated at different levels including national, regional and site level with a national coordination entity chaired by the General Director of the MOH. In a collaborative effort, health facilities develop continuous quality improvement activities to address weaknesses and improve health services while key stakeholders including sanitary departments (regional level) and other partners provide technical assistance. Bi-annual national and regional forums represent opportunities, not only to share best practices, but also to publicly recognize sites and departments with best quality improvement projects. The MOH will continue to work with all involved entities to maintain this level and even further strengthen this element through the inclusion of health service consumers.

Planning and Coordination

Over the last ten years, the MOH through the National AIDS control Program (PNLS, French acronym) has made significant progress in its capacity to plan and coordinate the HIV response in Haiti. The multi-year multi sectoral national strategic plan for HIV is timely revised to address the new challenges and reflect new evidence in the fight against the epidemic. National guidelines for HIV care and treatment and for PMTCT are written by and periodically updated by PNLS. These are participatory processes with strong leadership from the MOH and minimal assistance from external stakeholders. However, PNLS will need to make the necessary effort to reach the private sector and foster their involvement in the planning and coordination of the response and advocate for their financial contribution.

Public Access to Information

The government of Haiti has improved its capacity to collect data and generate reports that are publically available; for example, the periodically published “epidemiologic bulletin”. PNLIS publishes data on service delivery and overall performance of the HIV program. One limitation, however, is “procurement transparency.” The Haitian government does not fund the procurement of HIV/AIDS commodities and therefore is not able to publish detailed data on procurement activities (tenders, awards, etc) exclusively supported by PEPFAR and GF.

Sustainability Vulnerabilities

Domestic resources mobilization

One of the greatest threats to sustainability of the HIV response in the country is the lack of capacity to mobilize domestic financial resources. Despite the work of advocacy groups over the last few years, HIV services are funded almost exclusively through international support, namely PEPFAR (90%) and GF (9%). The Haitian government allocates very limited funding to the health sector and almost the entire budget supports salaries. Last year a budget line was added to the MOH budget to specifically support HIV/AIDS activities. However, the political turmoil, leading to the dysfunction of the parliament for an extended period of time, has prevented a vote on the new budget.

Commodity Security and Supply Chain

The government of Haiti does not provide any funding for the procurement of HIV commodities including antiretroviral medicines and rapid test kits which are essential to reach the UNAIDS goals for 2020. However, the MOH participates actively in national quantification exercises, to plan for the future needs of drugs and test kits.

Technical and Allocative Efficiency

Since the government does not fund any HIV/AIDS commodities and currently only has an in-kind contribution to the HIV program (infrastructure and some cross-cutting personnel), there is no system in place to ensure the maximum efficiency from HIV spending or to reprogram unused funds. On the other hand, expenditure data is available in Haiti and has been recently used to estimate cost for HIV programming.

Overall threats to sustainability of the program are closely linked to one underlying issue: the quasi-absence of funding from the government of Haiti to support the HIV program in general.

Priorities Identified

- Stakeholders have identified the following priorities for the program:
- Strengthen the capacity of the MOH to advocate for and allocate domestic government resources to support the fight against HIV

- Evaluate and implement innovative integrated service delivery models to reduce cost and expand the HIV response despite limited resources
- Make available and use good epidemiologic HIV data at the arrondissement and commune levels including data on key populations as well as services delivery (viral load) to support programmatic decisions and advocacy for domestic funding
- Advocacy to increase private sector involvement in the response to the epidemic and foster their financial contribution
- Advocacy with Parliament to pass the bill on HIV and approve the new penal code
 - While there are no specific laws criminalizing homosexuality or prostitution, there is no National HIV/AIDS Policy or set of policies and laws fostering non-discriminatory and safe access to HIV/AIDS services.

During COP16, PEPFAR will focus on supporting the implementation of innovative integrated service delivery models to reduce cost. The program will also support the Government of Haiti in increasing the availability of epidemiologic HIV data at the arrondissement (district) level.

All priority points outlined above receive some level of support from one or multiple development partners. However, in many instances this support is scarce and intermittent

- Several partners of the Haitian Government including USG, GF, WHO, UNICEF, and other local groups (SEROVIE, FOSREF, GIPA, ASON, POZ) are working with the MOH to develop policies. This work has contributed to improving the environment. The PNLs has held a meeting on key populations and plans to integrate a module on key populations into the HIV care and treatment guidelines, soon to be revised. The penal code has been revised and awaiting approval by parliament.
- The USG, through its implementing partners, is the main donor supporting activities aiming at increasing availability of good epidemiologic HIV data (ANC, DHS, HIA, IBBS, PLACE, etc.). Other donors including Global Fund, UNFPA, also contribute to support the demographic health survey (DHS). However, in addition to its leadership in coordinating the core surveillance activities, the MOH should continue to advocate for an increase in health expenditures in the national budget and use the domestic resources to support these activities. Good epidemiologic HIV data also depends on the availability of good census and vital registry data. The last census was conducted in 2003 and vital statistics are greatly under-reported.
- One area that needs greater focus is the engagement of the Haitian private sector in the HIV response in Haiti. So far the private sector has not been engaged beyond very limited contribution to institutions like GHESKIO. Donors need to support the MOH in its advocacy efforts to engage the Haitian private sector in the national HIV response.

1.4 Alignment of PEPFAR investments geographically to disease burden

During COP15, 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 arrondissements (districts) and led to divestment from low-burden arrondissements (districts). In COP15, the prioritization of arrondissements (districts) was based on PLHIV burden and testing yield. For COP16, the same prioritization of arrondissements (districts) was kept, with 10 arrondissements (districts) selected for Scale-up to Saturation; 10 others categorized as Scale-up Aggressive, and 16 labeled “Sustained”. Four arrondissements (districts) are no longer supported by PEPFAR. These 10 Scale-up to Saturation arrondissements (districts) represent the absolute priority for PEPFAR in Haiti during the COP16 implementation period, as all but one of them will achieve saturation (80% ART coverage) by September 2017, contributing substantially to the UNAIDS 90-90-90 goals set for 2020. In COP16, we used the PLHIV estimates provided by OGAC, which are slightly different from the Spectrum estimates used for COP15. Although the PLHIV burden changed for most arrondissements (districts), the composition of the top 10 did not change. These 10 arrondissements (districts) account for 58% of the estimated total PLHIV burden.

Among the list of the top 10 is Port-au-Prince, the arrondissement (district) with the highest burden of PLHIV. Although, with the new estimates Port-au-Prince appears saturated (over 80% of estimated PLHIV on ART), programmatic data and geographic proximity with other Scale-up to Saturation Districts with lower coverage, support the need to scale-up treatment in this arrondissement. Analysis of FY15 EA data by SNU, compared to the share of PLHIV, indicates inadequate investments in five Scale-up to Saturation arrondissements: Croix-des-Bouquets, Dessalines, Leogane, Mole St-Nicolas, and Saint-Marc (see figure 1.4.1 a-d). Substantial investments and efforts will be needed to achieve 80% coverage in those areas. Shifting of investments has started this year and will continue in COP16, to ensure adequate funding to support the objectives. However, given the limited existing health infrastructure and capacity in Mole Saint-Nicolas, in particular, saturation of this arrondissement (district) is programmed for the end of FY18, instead of FY17.

PEPFAR will remain present in the 16 sustained arrondissements (districts) where the focus will be on maintaining existing patients on ART, and enrolling identified patients on ART.

Figure 1.4.1.a 2015 PEPFAR Expenditure Per PLHIV and Percent of PLHIV by Arrondissement (District)

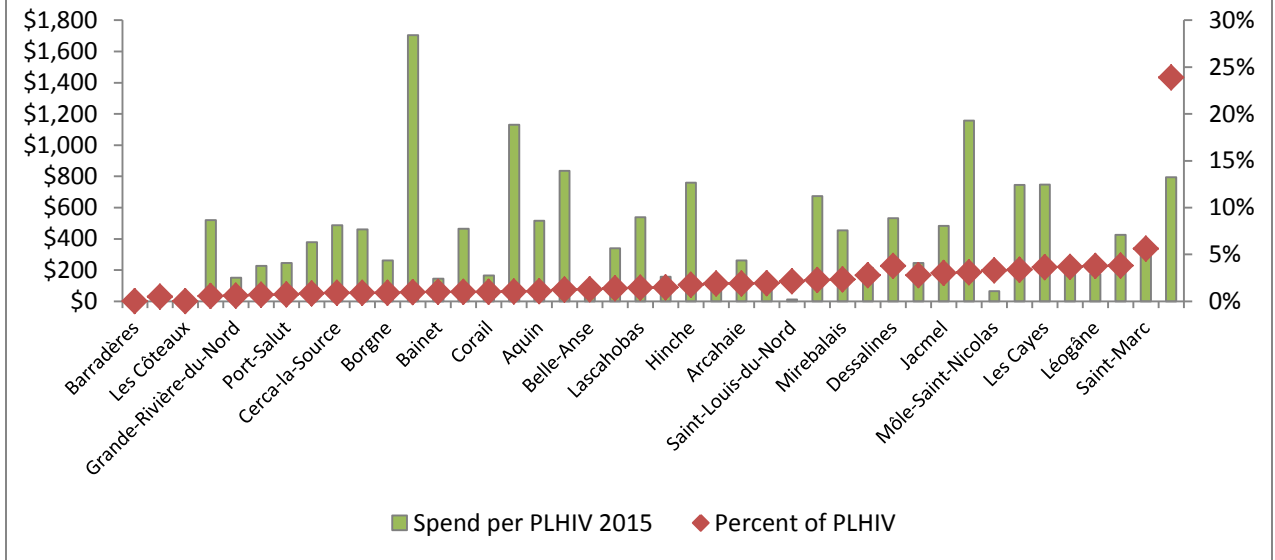


Figure 1.4.1.b 2015 PEPFAR Percent of Expenditure Per PLHIV and Percent of PLHIV by Arrondissement (District)

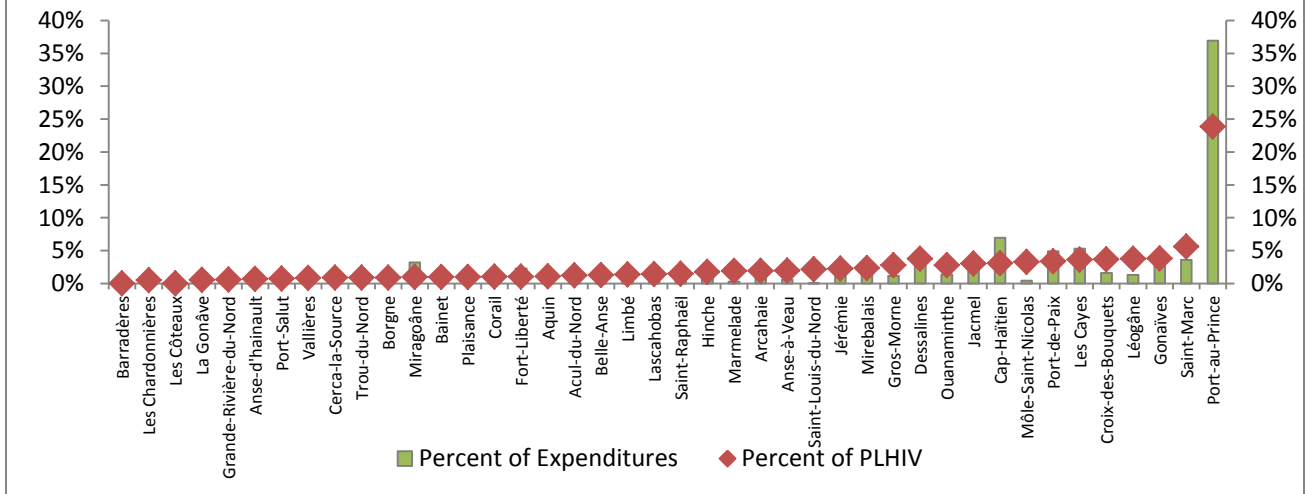


Figure 1.4.1.c 2015 PEPFAR Percent of expenditures & percent of PLHIV, 10 Saturation Arrondissements (Districts) (68% of total expenditures)

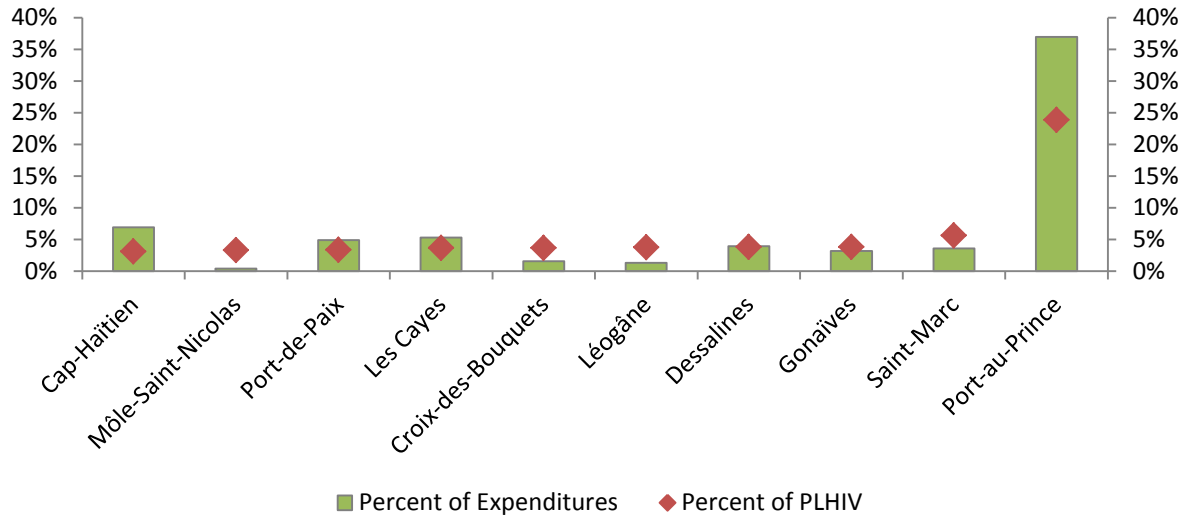


Figure 1.4.1.d _ 2015 PEPFAR Care and Treatment Expenditure, Total PLHIV, and Number in CARE by Arrondissement (District)

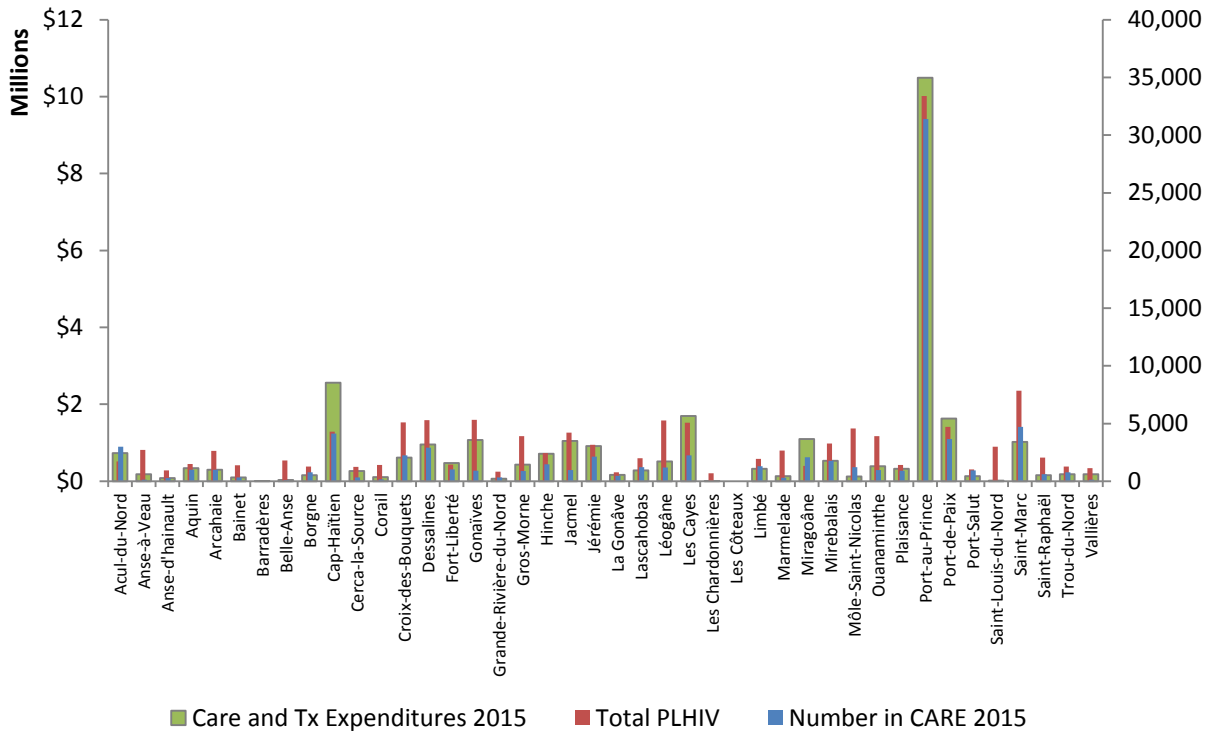
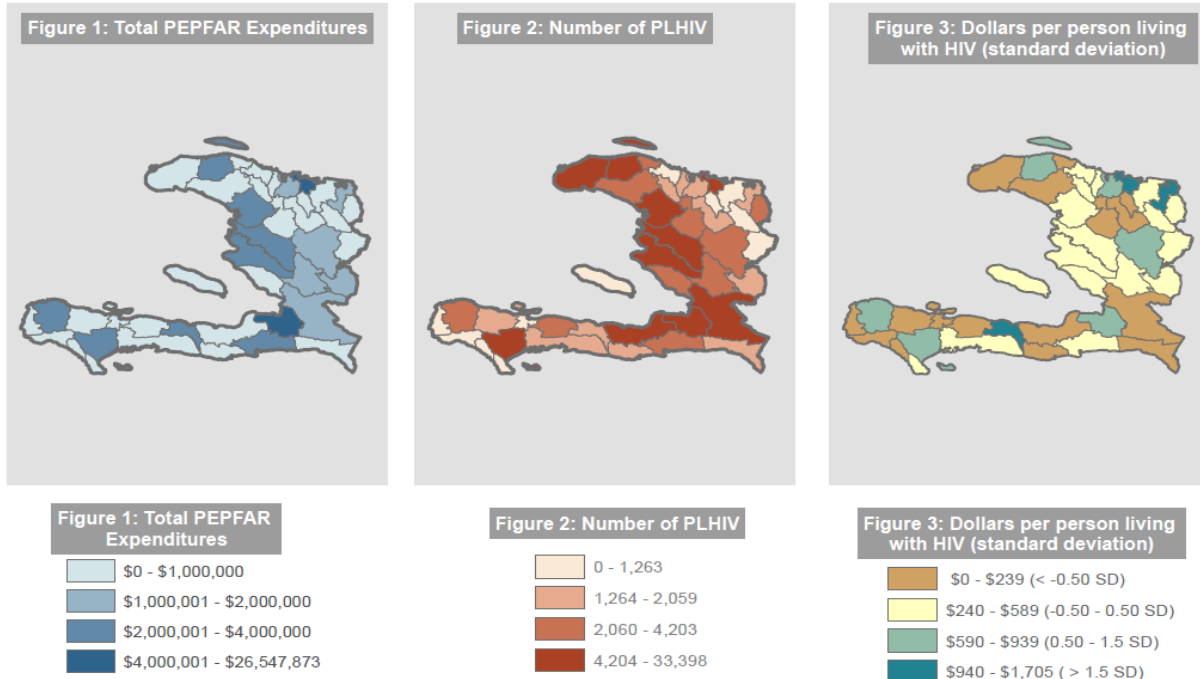


Figure 1.4.2

Total PEPFAR Expenditures, Number of People Living with HIV (PLHIV) and Expenditure per PLHIV in Haiti in FY 2015



Data Sources: Expenditure Analysis of the PEPFAR Haiti program and COP process

Spatial Data: IHSL, CNIGS
Created: 19 April 2016

1.5 Stakeholder Engagement

The PEPFAR Haiti team has continued strengthening its engagements with the Government of Haiti, through the MoH and PNLs. The PEPFAR team maintains regular meetings and communications with MoH and PNLs. The most recent meeting was held on April 6, 2016 at PNLs to share the outcomes of the D.C. management meeting, discuss the strategic direction and receive input from the PNLs to inform the development of the SDS and discuss MoH/PNLs' participation in the June COP16 review. During the meeting PNLs has confirmed its intent to revise the national HIV care and treatment guidelines to adopt Test and Start and proposed a timeline for implementation by end of 2016.

The PEPFAR Team also continues to develop and reinforce its relationships and coordination with the GF through both its in-country and Geneva Teams. Both PEPFAR and the GF are committed to sharing programmatic data and investment portfolios, especially in the areas of support for commodities to maximize investments, limit duplication and wastages, and achieve savings to sustain the expansion of HIV services to achieve epidemic control.

During FY16, the PEPFAR Haiti team increased its collaboration and engagement with Civil Society Organizations (CSOs) and has committed to regular meetings with both Implementing Partners and CSOs. The Civil Society meetings are co-led by PNLs and UNAIDS with PEPFAR and the Global Fund as participants providing updates. This format has been a success, increasing multilateral collaboration and providing a forum for enhanced engagement with the civil society. The last meeting with the CSOs was held on February 2, 2016 and was followed-up with development and distribution of a questionnaire in French to collect written feedback from members of the CSOs. The written feedback received from the CSOs was used in the COP development. Selected, translated inputs are included below.

“PEPFAR’s geographic prioritization puts emphasis on the areas with the most people on treatment and also where there is the largest number of new infections. It is an excellent strategy that ensures the maximum number of people infected with HIV are on treatment.”

“Recommendation to write out the PEPFAR objectives for providers because they are not aware of what is being talked about at PEPFAR meetings (they don’t even know what is 90-90-90). MSPP should get together with donors to pass the information along.”

“Going on social media or other means of communication (like radio, TV) to disseminate messages. Will target especially youth. Sensitizing on subjects like testing.”

“It is good that PEPFAR has begun to be open to suggestions from civil society and especially with government and multi-lateral partners.”

“It is necessary to include and work directly with the LGBT community because it is also necessary to prioritize foundational community organizations.”

Additional feedback was that since some members of our Civil Society group are also Implementing Partners, we should have joint meetings and as a result the team is planning a joint meeting after COP approval. One area where the program needs to improve is its support to the MOH to better engage the private sector in health activities. The GOH should increase engagement with the private sector and the team is committed to provide appropriate technical assistance to this end.

2.0 Core, Near-Core and Non-Core Activities

The program is committed to achieving epidemic control despite a steady decrease in budget and a difficult political and economic environment in the country. As such, the program will continue in COP16 to concentrate its efforts on essential activities. PEPFAR Haiti's programmatic core activities (Appendix A) will be a combination of prevention activities including ART, PMTCT, HTC services in prioritized arrondissements (districts) and targeting key populations with a particular emphasis on improving retention in care and adherence to treatment. The program continues to consider OVC, support for commodities, essential lab support, and high-impact strategic information strategies as core activities. Blood safety activities have been phased out; no COP16 funding is being allocated to this budget code. GF will support 100% of activities related to blood transfusion in Haiti in fiscal year 2017 (FY17). Through this prioritization process the program expects to move closer to its goal of controlling the HIV epidemic in the country, and achieving saturation in the prioritized districts, with the exception of Mole St Nicolas, by the end of COP16 implementation period (FY17).

3.0 Geographic and Population Prioritization

In COP16, PEPFAR Haiti will continue to focus its investments in the 20 prioritized districts identified through the geographic prioritization exercise and program pivots undertaken during COP15. The selection of the districts was based on the estimated disease burden and the HTC yield. Indeed, the 20 districts (10 saturation and 10 aggressive) represent 90% of individuals receiving HIV testing and counseling (HTC) services, 90% of patients in the cumulative national ART cohort, and 75% of the overall HIV-infected population (58% in the 10 saturation districts). The program will also focus on expanding HIV clinical and prevention services to key populations as the recent IBBS (2015) found much higher HIV prevalence among CSW (8.7%) and MSM (12.9%) than the general population. Included in the key populations are the prisoners who present high HIV positivity rate and TB infection. Through this prioritization exercise, the program pivots and the implementation of new HIV treatment guidelines and new services delivery models, the program expects to reach saturation in the vast majority of the saturation districts.

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

4.1 Targets for priority locations and populations

PEPFAR Haiti foresees that the program will reach saturation in all saturation districts by the end of COP16, except for Mole Saint Nicolas given the disease burden and the very limited infrastructure, which will bring the country closer to the 90-90-90 goals. Using available epidemiologic data and the result of the COP 15 prioritization exercise, the team identified coverage gaps in the clinical cascade and determined program activities and targets accordingly. The program projects to enroll 26,311 patients in COP16 of which 19,348 (~74%) will come from the 10 Saturation districts and the rest from Aggressive and Sustained districts. The program will capitalize on an overall retention rate of 84% and expects to have a net gain of 13,819 patients.

The National AIDS control program (PNLS, French acronym) has confirmed that the national HIV Care and Treatment guidelines will be revised to adopt the Test and Start approach to HIV treatment to align with the 2015 WHO recommendations. The full implementation of these guidelines is expected before the end of FY16. As a result all individual receiving pre-ART care will be immediately eligible for ART in addition to all HTC clients newly diagnosed with HIV. Taking into account the strategies, described elsewhere, to reduce LTFU and enhance linkage to care, pre-ART and newly diagnosed patients will represent the majority of the target for new ART patients (program summary sections and data pack). The remaining will derive from: (1) investments in prevention of mother to child transmission as nearly 95% of pregnant women newly diagnosed with HIV will receive ART; (2) improvement in treatment of TB/HIV co-infected patients to ensure 100% ART coverage; (3) expansion of HIV clinical care and treatment to key populations including MSM, commercial sex workers (CSW) and prisoners.

To reach the ambitious targets in a declining budget environment, the program envisions modifying its service delivery models (section 6) to maintain and decrease cost where possible while expanding HIV services. These modifications (e.g., multi-month scripting of ARV, bi-annual clinical appointments, community drug distribution, implementation of the PLR and the use of biometric codes to reduce duplication, and reduction in laboratory test including elimination of CD4 testing) will generate savings to allow the national rollout of viral load diagnosis and implementation of the Test and Start approach to HIV treatment.

Over a two year period (FY16 and FY17), the program proposes to support the MOH in improving the availability of epidemiologic data at the SNU levels. A number of surveys including DHS, HIV/AIDS impact assessment (HIA), and ANC sentinel sero-survey will be completed by the end of FY17. These data will inform key programmatic decisions in subsequent years particularly in light of potential further budget decline beyond FY17.

District	Total PLHIV	Expected current on ART (APR FY16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) <i>TX_CURR</i>	Newly initiated (APR FY17) <i>TX_NEW</i>	ART Coverage (APR 17)
Port-au-Prince	33,398	30,616	0	32,117	5,787	97%
Saint-Marc	7,838	5,335	0	6,270	1,629	80%
Môle-Saint-Nicolas	4,580	1,790	1,145	2,519	1,051	55%
Dessalines	5,284	3,675	0	4,227	1,287	80%
Léogâne	5,274	2,194	0	4,219	2,574	80%
Croix-des-Bouquets	5,103	3,173	0	4,083	1,481	80%
Port-de-Paix	4,715	2,983	0	3,772	1,326	80%
Les Cayes	5,082	3,533	0	4,065	1,027	80%
Cap-Haïtien	4,294	3,231	0	3,864	1,215	90%
Gonaïves	5,311	2,450	84	4,055	1,973	80%
TOTAL	80,879	58,980	1,229	69,191	19,350	Avg: 80%

Entry Streams for ART Enrollment	Tested for HIV (in FY17)	Identified Positive (in FY17)	Newly initiated (APR FY17) TX_NEW
Adults			
Clinical care patients not on ART			3,950
HIV+ TB Patients not on ART	9,506		1,430
HIV-positive Pregnant Women	161,062	3,262	1,845
Other priority and key populations	15,016	1,057	1,369
Pediatrics	67,721		829
Clinical care pediatrics not on ART			
HIV Exposed Infants	3,099	154	139
Total			9,562

Districts	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY17)	KP_PREV FY17 Target
Acul-du-Nord	N/A	N/A	88
Aquin	N/A	N/A	262
Arcahaie	N/A	N/A	193
Cap-Haitien	N/A	N/A	3619
Cayes	N/A	N/A	1909
Croix-des-Bouquets	N/A	N/A	702
Dessalines	N/A	N/A	2,139
Fort-Liberte	N/A	N/A	2,631
Gonaives	N/A	N/A	2,248
Jacmel	N/A	N/A	0
Leogane	N/A	N/A	1,250
Limbe	N/A	N/A	114
Miragoane	N/A	N/A	0
Ouanaminthe	N/A	N/A	1,189
Port-au-Prince	N/A	N/A	22,994
Port-de-Paix	N/A	N/A	1,250
Port-Salut	N/A	N/A	158
Saint-Marc	N/A	N/A	5528
Trou-du-Nord	N/A	N/A	158
Total			46,632

4.2 Priority and Key Population Prevention

Recent surveys conducted in Haiti (the Integrated Biological and Behavioral Survey, 2014) have shown that Men Who Have Sex with Men (MSM) and Female Sex Workers (FSW) contribute significantly to the burden of HIV with prevalence rates higher than the general population; respectively 12.9% and 8.7%. Furthermore, the growing incidence rates of HIV and TB in the prisons urge the PEPFAR Haiti program to include prisoners among the priority populations.

PEPFAR Haiti will support high-impact core interventions for key populations in COP16 including: targeted education and HTC for priority populations, combination prevention services extended to clients of FSW, condom/lubricant promotion and distribution, implementation of “Test and Start,” STI testing and treatment services, linkage to clinical care, as well community drug distribution. The program will build capacity of local organizations to provide KP services; hot spots validation will be conducted and validated by sub-partners to ultimately link targeted high-risk individuals to HTC services.

The results of the last IBBS conclude that stigmatization and violence are consistently reported by a majority of MSM and FSW. To help address this issue a PEPFAR-supported organization has been using mystery clients to assess facilities to ensure KP friendly services are provided. PEPFAR Haiti will continue to collaborate with the National AIDS Control Program (PNLS) to ensure that the different HIV-related guidelines incorporate segments about key populations. Furthermore, the program through its implementing partners will encourage the sensitization trainings for the healthcare workers in order to improve the quality and the appropriateness of services offered to key populations.

Since the reporting gaps are greater for key populations, the PEPFAR Haiti program will strengthen the accurate reporting of indicators that inform the HIV cascade of care for the patients living with HIV and particularly the priority populations. SIMS visits targeting key populations have revealed gaps in the referral and counter-referral systems between community and clinical partners, and also in the development of a work plan for peer educator outreach. During COP16, the PEPFAR team will continue to assist selected implementing partners and their supported KP sites in the elaboration of a detailed peer educator outreach system.

To foster sustainability and continuity, services for KP should be integrated within existing services where possible. PEPFAR Haiti will continue to support activities that are strategically designed to involve host government and community level structures, including civil society. National and sub-national entities will be involved in the evaluation, dissemination and sharing of best practices, with attempts to obtaining community involvement and notable changes.

4.3 Voluntary Medical Male Circumcision (VMMC)

Not applicable in the Haiti program.

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

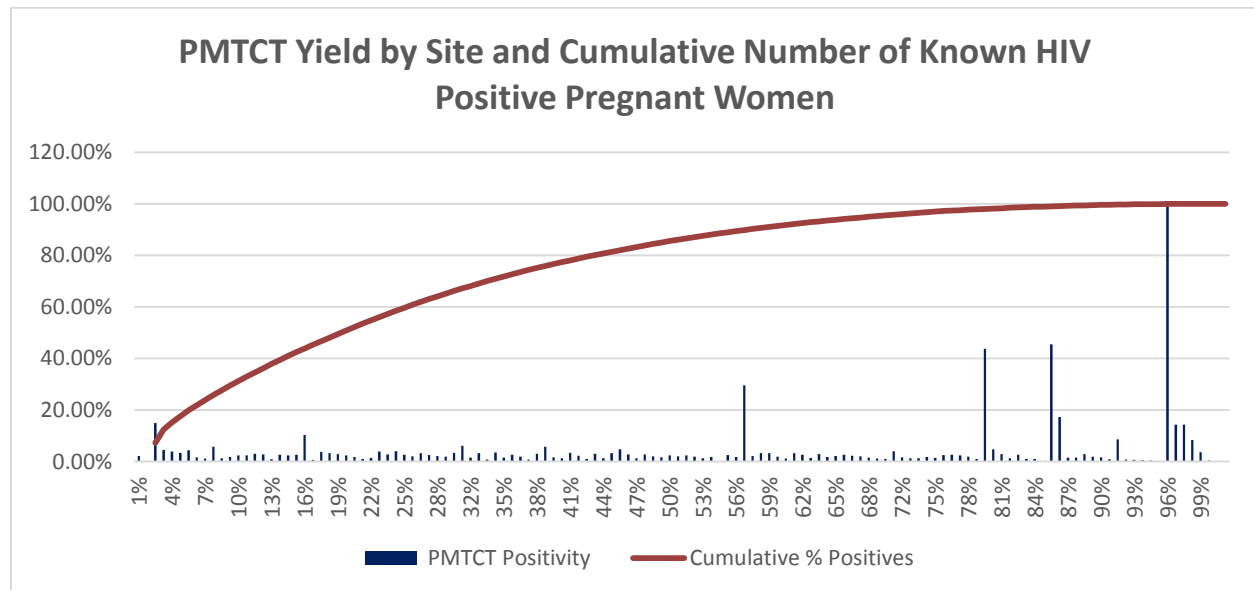
Over the last five years, Haiti has significantly expanded access to prevention of mother to child transmission of HIV (PMTCT). During this period, in which the country adopted and implemented Option B+, the program has seen an increase of PMTCT coverage to reach 89% (HIV-infected pregnant women identified and received ART) in FY15. Last year, 4.7% of HIV-exposed infants who had a PCR within 12 months of birth were positive compared to 5.6 the previous year and 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 (MTCT), particularly in terms of retention of pregnant women enrolled on ART.

PEPFAR Haiti will support the provision of HTC services to at least 90% of pregnant women attending ANC clinics at supported health facilities. In FY17 the program is expected to help 237,462 pregnant women know their HIV status; 90% of this number will come from priority districts. Although a steady decline in positivity rate has been observed during the past years, the program will continue its efforts to identify more infected pregnant women by improving its targeted testing strategy by intensifying testing in areas with high prevalence and thus increasing testing yield. An estimated 4,797 infected pregnant women will be identified in FY17 and 88% are expected to come from scale-up districts. Based on WHO guidelines, the program will support retesting of HIV positive pregnant women before initiating ARV. The program will provide ART to 95% of those who are HIV-positive and 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, IAS 2015). PEPFAR partners will expand the Improved Linkage and Retention (ILR) program that has shown quite promising results. In a pilot, sites implementing this program have seen nearly 50% of patients LTFU brought back to care. Providers will continue to 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 pair (HIV-exposed infant and mother).

In COP16, the program will continue to expand EID coverage within existing PEPFAR sites. In order to improve monitoring of HIV-exposed infants, PEPFAR will continue to support BEST for EID DBS specimen transportation for PCR testing and to implement longitudinal birth cohort reporting to follow HIV-exposed infants through the end of the breastfeeding period. The turnaround time between EID specimen collection and return of results to clinics has been between four to six weeks.

Efficiency Analysis

In Haiti, 42% of PMTCT sites (n=55) identified 80% of HIV-infected pregnant women in 2015 (see figure below). Most of these sites were in the 20 priority districts. In COP16, PEPFAR Haiti will support 106 sites to deliver PMTCT services and cover 79% of the estimated 300,000 expected pregnancies. Close to 80% of those sites are located in priority districts. 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 to reduce unwanted pregnancies and further enhance efficiencies.



4.5 HIV Testing and Counseling (HTC)

HIV testing and counseling (HTC) has been shown to reduce the incidence of new HIV infections and has many benefits including linkages to HIV care and treatment services. In order to ensure that implementation of HIV testing is targeted, non-repetitive and efficient, Haiti's national HTC guidelines will be updated to align with the 2015 WHO recommendations. Prior to the full implementation of Test and Start strategy in FY17, the USG team in Haiti will provide financial and technical support to the National AIDS Control Program (PNLS) for the revision of counseling messages and training of counselors, peer navigators and community health workers involved in HIV testing.

In order to maximize yield, PEPFAR Haiti and its partners are currently targeting high HIV burden areas and high risk groups as defined during our prioritization exercise. This is a mixed approach using both facility-based and community /mobile testing in the areas highly affected by the epidemic. It also includes mobile testing in remote underserved areas. PEPFAR Haiti will ensure that HTC services are provided to high-yield service delivery points such as TB clinics, prisons and to patients with sexually transmitted infections and key populations.

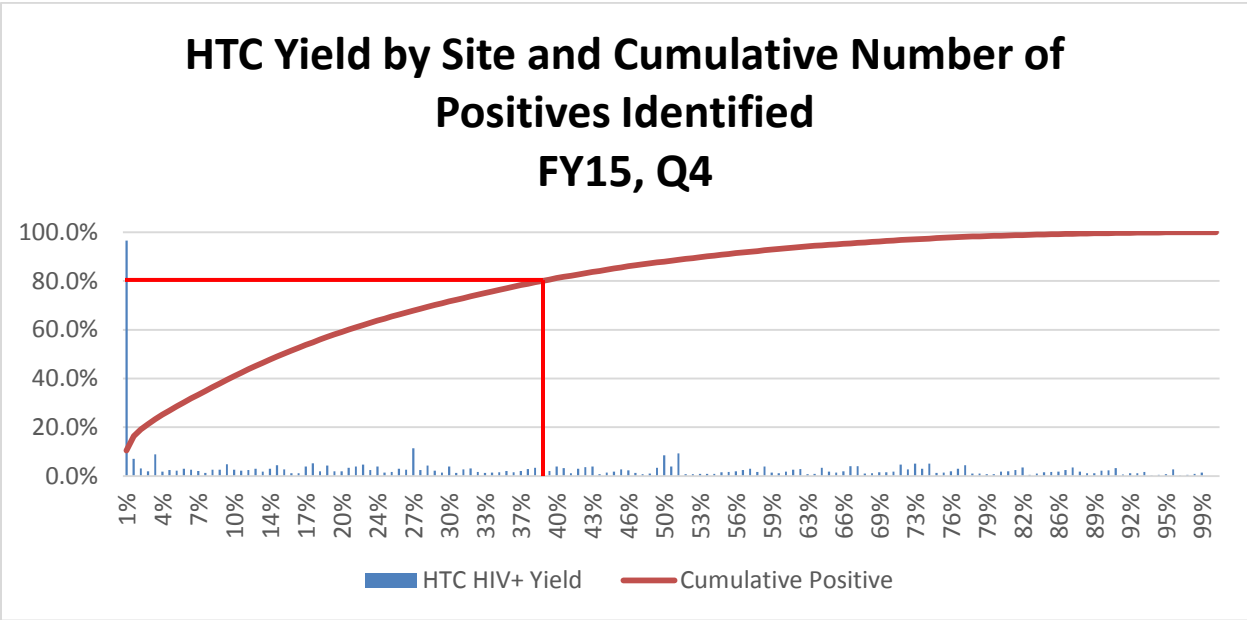
PEPFAR Haiti's gender analysis showed that Haiti has made significant progress on ability to access testing services, though coverage levels still need to be increased. Based upon this analysis, males are not being tested at the same proportion as women and PEPFAR Haiti will refocus efforts towards testing more men.

The last integrated HIV bio-behavioral survey has shown higher prevalence among key populations (primarily FSW and MSM). The program has since invested in outreach activities using peer navigators to expand access to HTC services and foster reductions in new HIV infections among key populations. Discussions have already started with PNLS on a pilot/demonstration project with USAID and CDC implementing partners to support oral fluid-based HIV testing conducted by lay counselors/peer navigators for key and priority populations. This program will expand the HIV testing models through free and confidential counseling and rapid HIV diagnosis to priority and key populations in stigma-free and discrimination-free environments in alternative venues. Additionally, trained peer navigators are facilitating the interaction and linkage of HIV-infected persons with HIV care and treatment services.

Quality of HIV testing is an integral part of HTC and is accompanied with regular training and information for teams involved in testing. While nearly all HTC facilities are already participating in an External Quality Assessment (EQA) program, continuous supportive supervision to improve providers' competences is lacking. Therefore, USG team in Haiti will be taking a more prominent role in training and oversight of HIV rapid diagnostic tests (RDTs). The USG team will do re-training of trainers, develop a more comprehensive RDT standard operating procedure (SOP) and have regular monitoring of staff/technicians that have received formal training. This is even more important as limited number of personnel were adequately trained on HTC particularly in remote underserved areas. Furthermore, for the quality of record keeping and duplication of patient counting, the PEPFAR team is moving forward with the implementation of a unique identifier using biometric code.

Efficiency Analysis

PEPFAR Haiti supported 263 HTC sites in FY14 and the prioritization exercise showed that 26% (n=69) of HTC sites were responsible for 80% of the total number of HIV-positive patients identified during this fiscal year. In FY15, 39% (n=60) of HTC sites were responsible for 80% of the total number of HIV-positive patients identified. Of these sites, 42 were located in the scale-up saturation districts, 11 in the scale-up aggressive districts, and 7 in the sustained districts; which confirmed PEPFAR Haiti's team prioritization process. In FY17, PEPFAR Haiti will be supporting 275 HTC sites including 40 community testing sites which will be providing services as described in the community-based approaches package. More than half of HIV testing (52.72%; n=145) will happen in scale-up saturation districts during this fiscal year. PEPFAR Haiti is expecting an overall program yield of 2.8% at the end of FY17. This includes PMTCT, pediatric testing and additional adjustment in testing targets mainly at the sustained districts. In addition, 76% and 14% of the positives will be identified in the scale-up saturation and scale-up aggressive districts respectively.



4.6 Facility and Community-Based Care and Treatment

During COP16 PEPFAR Haiti will continue to provide comprehensive clinical care and support services to PLWHA. The program will continue to improve linkages between HTC and clinical services and will expand strategies to reduce loss to follow-up (LTFU). As mentioned elsewhere, PNLS is supportive of the adoption of the Test and Start approach to HIV treatment recommended by WHO and has initiated the revision of the national guidelines. As a result the program expects a decrease in the proportion of pre-ART patients and a reduction in the incidence of opportunistic infections as ART is initiated sooner. Nonetheless the program will continue active prevention of OI among ART patients. The PEPFAR facility-based package of core services includes clinical assessment and staging, monitoring, routine provision of CTX prophylaxis, TB screening, PHDP services, and support groups for PLWHA including children and adolescents. This package of services will be the same in sites in all PEPFAR-supported districts.

To fulfill the objective of maintaining a standard quality HIV clinical care, the program will continue its effort to ensure that all supported sites use continuous quality improvement methodology (HealthQual). Furthermore, 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 and identify weaknesses to be addressed through HealthQual activities. SIMS data will be used to facilitate improvement of the quality of both facility and community-based services offered within the PEPFAR-supported sites.

The program will also support its partners in implementing strategies to ensure continuum of care and services for all PLWHA in order to foster retention and adherence. In COP16 the program proposes to rollout strategies nationally which will result in better coordination between facility and community staff, facilitate deduplication and improve community tracking. With the addition of appropriate tools and technology support, proactive reminder phone calls/SMS and customized support group activities to prevent stigmatization and discrimination, the team expects significant improvement in patient linkage to and retention in care.

PEPFAR Haiti will continue to provide technical support to MOH in updating and developing guidelines, adapting training materials for health providers and care givers 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.

Finally, given the steady decrease of resources, the program is placing an emphasis on improving program efficiency and reducing cost. The program will conduct ongoing human resource optimization assessments which will assist in understanding the quantity and quality of time spent with patients by each cadre, while determining administrative and reporting demands.

4.7 TB/HIV

Tuberculosis remains the leading cause of death for patients living with HIV/AIDS in Haiti and the prevalence is 249 per 100,000 (WHO country report, 2014) with approximately 19% of TB patients co-infected with HIV. The recent FY15 annual progress report estimated that more than 95% of TB patients in PEPFAR-supported sites were tested for HIV and simultaneously 98% of HIV-positive patients are screened for tuberculosis. Additionally, around 65% of the co-infected TB/HIV patients were put on ART which will be improved since the guidelines require 100% ART initiation for all TB/HIV co-infected patients.

While PEPFAR TB/HIV activities in FY 17 will continue to be focused in the priority scale-up districts for epidemic control, screening and prevention of TB will remain part of a national basic package of services across all PEPFAR-supported sites in Haiti.

The majority of TB funding in Haiti is provided by Global Fund. However, at an implementation level PEPFAR will provide additional TB/HIV support focused primarily on laboratory diagnostic capacity and surveillance. There are currently a total of 23 GeneXpert machines available in PEPFAR-supported scale-up sites to ensure that HIV-positive TB suspects systematically undergo appropriate evaluation for TB in addition to the fluorescence microscopy and culture. A referral GeneXpert network, already established in the West department, will expand to cover all HIV treatment sites countrywide.

PEPFAR Haiti will continue to support the integration of TB/HIV collaborative activities to ensure linkage and retention through expansion of TB/HIV clinical service delivery model. For COP16, the USG team will continue to encourage the partners to increase the ART uptake among the

TB/HIV population through improved linkages between TB and ART sites, training of the healthcare workers and supporting monitoring activities such as SIMS and HealthQual. Consequently, in scale-up districts, PEPFAR Haiti will continue to provide a core package to increase ART coverage of TB/HIV co-infected patients: human resources to accelerate planning and implementation of collaborative TB/HIV activities; enhanced TB/HIV case finding to ensure that 100% of all HIV patients are screened for TB, all TB patients and their contacts are screened for HIV, and a greater number of TB/HIV patients initiating ART as recommended by the national guidelines

The overall SIMS results show that there are still many challenges related to TB/HIV activities, with low marks for ART initiation for all TB/HIV co-infected patients and TB infection control. Appropriate recommendations were sent to implementing partners and during COP16 we expect that the sites will be supported to implement corrective measures to address these challenges.

PEPFAR will continue to support the national TB program in the implementation, expansion of MDR-TB detection, and continued support to the national reference laboratory network for improved diagnostic capacity. Finally, we plan to support integration of M&E for TB and HIV, and continue our efforts on aligning PEPFAR and Global Fund-financed TB-HIV activities to leverage and best utilize both investments.

4.8 Adult Treatment

PEPFAR Haiti, working in close collaboration with the government, has successfully expanded HIV treatment over the years, and is currently supporting services in 36 out of 42 arrondissements, with about 66,500 patients current on ART at the end of FY15, which represents over 53% of patients eligible for ART in Haiti, and 47% of total PLHIV (141,269) in the country.

Last year, PEPFAR-Haiti has made strategic pivots in the program by prioritizing geographic areas, health facilities, and services, for a more efficient and impactful approach, that will effectively contribute to the UNAIDS 90/90/90 goals, adopted by the country. In COP15, PEPFAR Haiti underwent a thorough review of available programmatic and epidemiologic data, which led to the prioritization of 10 Scale-up to Saturation arrondissements (districts) and 10 Scale-up Aggressive arrondissements. The goal is to achieve saturation (at least 80% ART coverage) by the end of FY17 in 9 Scale-up to Saturation arrondissements, and by FY18 in the remaining one. At the same time, the team is planning to scale-up treatment in the 10 Scale-up Aggressive arrondissements, in order to reach saturation between FY18 and FY20, depending on current coverage status of the arrondissements.

After assessing ART demand/gap estimates and cohort retention for each district, the team determined the necessary net gains in ART patients that will enable the targeted coverage in FY17. To reach these ambitious goals, over 24,000 patients need to be initiated on ART during FY17 within the Scale-up to Saturation and Scale-up Aggressive arrondissements only, in addition to the FY16 expected results. By APR17, the team aims to enroll 26,311 new patients on ART, out of which 74% will come from Scale-up to saturation arrondissements, and 18% from the Scale-up

Aggressive, and to support 93,591 patients on ART (74% in scale-up to saturation arrondissements). This represents an overall 41% increase compared to FY15 results, with 47% and 40% growth in the Scale-up to Saturation and in Scale-up arrondissements, respectively, compared to 10% growth in Sustained districts. PEPFAR Haiti anticipates that these projections will be influenced by the planned updates in National Guidelines to adopt “Test and Start” by the end of FY16, and by an increased alignment of GF and PEPFAR programming. The government has already begun the revision process of the guidelines to embrace “Test and Start”, as recommended by WHO. The revisions should be completed in July 2016 and full roll out of “Test and Start” is expected before October 2016. The effective implementation of these policies will greatly contribute to the attainment of the COP16 ART coverage targets.

In COP16, in addition to the shift towards high burden/high yield areas, and the expected adoption of Test and Start, several strategies will be emphasized to boost gain of patients in order to reach FY17 treatment targets, including: 1) emphasis on diagnostic and treatment of TB/HIV patients, and priority populations; and 2) fast-tracking ART enrollment via testing-based triage. PEPFAR Haiti is also implementing new delivery models for treatment services with a mix of facility- and community-based services allowing multi-month scripting (up to 6 months) with community-drug delivery for stable patients, and task-sharing/task-shifting, when appropriate, to cover the growing needs in human resources and increase efficiency.

Review of programmatic data, and analysis from the Haiti longitudinal HIV/AIDS case-based Surveillance System (HASS) highlighted two important issues: low rates of early linkage to care after HIV diagnosis, and large attrition within the overall ART cohort during the past years, impeding optimal net gain. Attrition 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. To reach the ambitious COP16 targets, PEPFAR Haiti has recently developed the Improved Linkage and Retention program (ILR), in order to improve retention, and, with the potential to also impact linkage to care and treatment.

The ILR, which was presented as PEPFAR Haiti Team’s game changer intervention, uses mobile technology to allow active tracking of patients lost to follow-up (LTFU) by community health agents. The PLR is already implemented in 40 sites, with the very promising results of about 50% of LTFU patients reached coming back to treatment. Pregnant women and OVC are also followed-up by community health agents using mobile technology. Although not yet used for these purposes, the perspective is to use the PLR in order to facilitate linkage to care for newly diagnosed patients, and to assess the need for alternative service delivery models, when distance and/or costs of transportation are causing missed appointments. The plan is to expand the PLR project to all PEPFAR treatment facilities. In addition, the preventive approach to avoid LTFU will be maintained, by promoting regular contact with all patients, and not only defaulters, via calls or text messages, and by increasing linkages between communities and facilities. Review of SIMS data indicated a need for improvement in documenting adherence support to patients, which will be addressed at the IM and the site-level.

Concurrently, the PEPFAR Haiti team started piloting a biometric code, using digital fingerprint as a unique health identifier. This initiative, while responding to the absence of reliable national unique identifier, will strengthen the program capacity to detect “duplicates” by determining which patients are enrolled at more than one treatment location, even if they did not provide the same name. This project is the second game changer of the PEPFAR-Haiti team, and is expected to have a major impact on the program, once fully implemented.

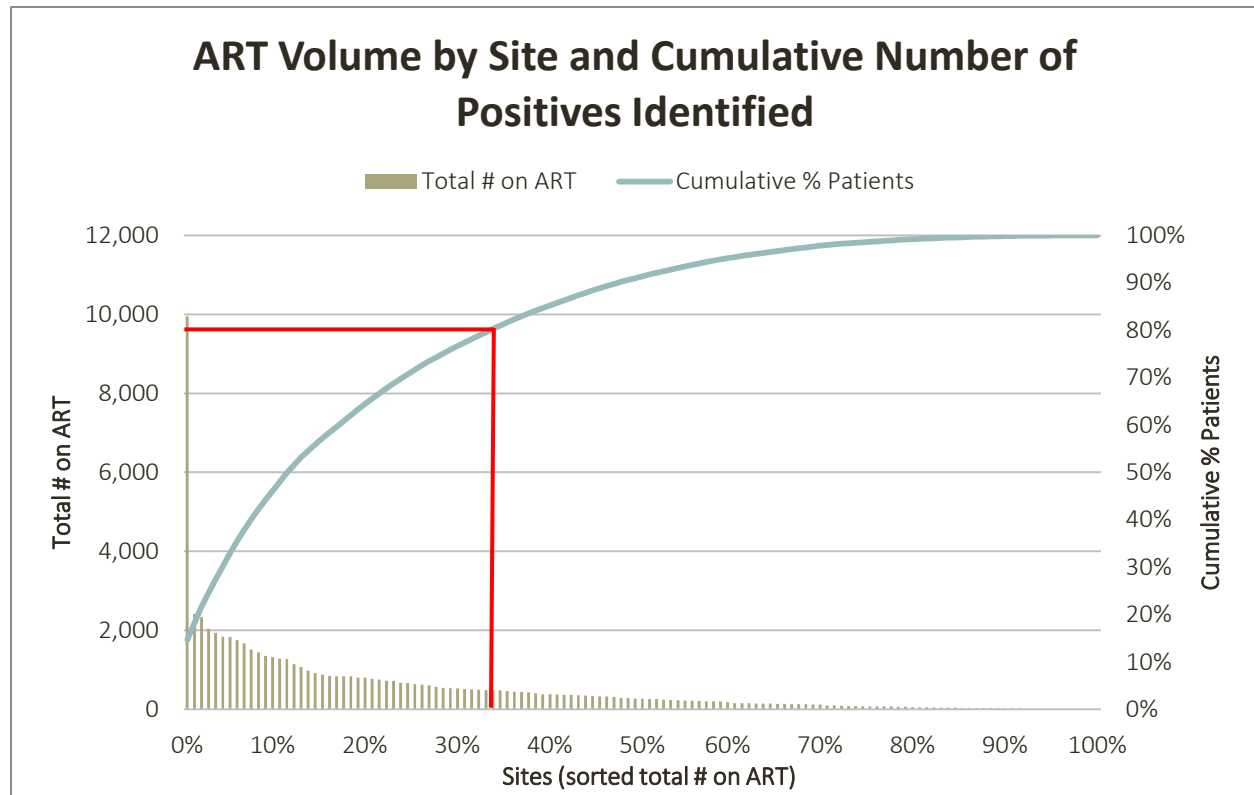
Building on the FY15 cost-band analysis of the clinical service packages provided by sites, which was proactively requested by PEPFAR Haiti, the team detailed and streamlined the standard package of services to be supported for COP15, based on WHO recommendations and the core, near-core, non-core analysis. Major changes in last COP included important reductions in the frequency of lab tests and spacing of visits, while remaining in compliance with national guidelines. In COP16, this package of services is further streamlined, with notably: (i) the elimination of support for CD4 testing, in order to generate funds for viral load expansion at the national level; (ii) spacing frequency of clinical visits to up to 6 months, which will require modification of reporting definitions and processes. The new treatment package will continue to support provision of salaries and training of essential healthcare providers, quality improvement, and ARV commodities. Currently, ART patients receive ARV drugs through both PEPFAR and GF procurement with a ~65/35 split (see table 1.2.2).

Analysis of HASS data, as well as the Gender Analysis, demonstrated that males are less likely to be diagnosed, and are diagnosed at a later stage than females. They also bear a higher proportion of mortality, in each step of the HIV clinical cascade. The PEPFAR Haiti program will look for technical assistance from other countries that have been successful in reaching men with HIV clinical services.

Efficiency Analysis

In FY15, PEPFAR Haiti supported ART services in 129 sites, a reduction from the 142 sites supported in FY14. Across all arrondissements, 27 ART sites were identified for transition in COP15, based on low volume, low HTC yield, relative location to other sites, and expenditure analysis results; 13 of these were completed before the beginning of FY15. Out of the 129 ART sites that reported in FY15, 34% (n=44) accounted for 80% of ART patients, while the remaining 85 sites (66%) accounted for only 20% of ART patients, with a volume range between 1 and 473 patients and with 39 sites supporting <100 patients. As in APR14, in terms of ART services, APR15 results align with the new geographic focus: 57,893 (87%) ART patients are already coming from Scale-up Saturation and Scale-up Aggressive arrondissements. Furthermore, the 10 scale-up to saturation arrondissements alone, already accounted for 47,058 (71%) ART patients in FY15. During FY15, 16 low volume sites (under 30 persons on ART) were identified; out of which 9 completed transition between September and December 2015, and an additional one is expected by the end of FY16. As in COP15, the funding used to support sites that have transitioned will be redirected to scale-up sites. The six remaining sites that will be funded in COP16, including a prison and a key-pop site, are all located within Scale-Up Saturation and Scale-Up Aggressive

arrondissements. PEPFAR-Haiti will further evaluate sites with low performance in Scale-Up arrondissements to identify individual issues. Only four sites reported <4 ART patients, out of which 3 will no longer be supported in FY17.



4.9 Pediatric Treatment

As of September 2015, there were 3,319 patients (<15 years) on ART. This represents 55 % of the 5,996 pediatric patients needed to reach 90% coverage (UNAIDS 2013 Global Report). PEPFAR has put emphasis in reaching more pediatric patients despite the constraints of a lack of trained human resources and the dependency on caregivers who often have themselves a retention issue. During COP 15, the Ministry of Health (MOH) with support from PEPFAR, issued recommendations on the revised pediatric guidelines to treat all HIV positive children <5 years. These updates emphasize the need for scale-up testing in inpatient wards and for malnourished children.

Early Infant Diagnosis (EID) testing with PCR continues to increase as more sites are added. Additionally, PEPFAR and UNICEF have begun working together to create a larger network of sites located in hard-to-reach regions that are not part of the PMTCT program yet. The goal is to have a center/main site with satellites to more efficiently collect specimens and transport them to the two national labs equipped for PCR testing.

Dried Blood Spot (DBS) PCR has been now used in Haiti since 2009 and DBS is being used as the platform for viral load testing. Viral load testing will be expanded in FY 17 to reach national coverage. The MOH has taken the lead with PEPFAR support to improve infrastructure in order to improve viral load specimen transport to ensure the sustainability of this intervention. CARIS/BEST will continue to transport EID specimens for PEPFAR supported DBS PCR testing.

During FY 17, scale up in saturation and aggressive districts will improve coverage in high prevalence and very populated districts. The Metropolitan area of Port-au-Prince, the Artibonite (second most populated department), and the North, Northwest and Northeast departments will be the focus for expanding pediatric ART coverage. Additionally, PEPFAR in partnership with UNICEF is looking to create a cadre of trained nurses for the delivery of ART to children. PEPFAR has already been engaged in discussions with MOH/PNLS and UNICEF regarding the training curricula on Pediatric HIV. The training is important to ensure adequate task shifting from doctors to nurses. This is critical in order to achieve the goal of increasing the number of children on ART. PEPFAR Haiti will continue to emphasize retention through the community network within implementing partner organizations.

Furthermore, the testing of siblings has increased recently, but the yield is still low, under 2%. PEPFAR will scale-up targeting of more vulnerable populations like street children in coordination with the OVC program. Children and youth living in and around identified Key Population (KP) hotspots will also be targeted in an effort to increase the proportion of children with known HIV status and the pediatric ART coverage. OVC programs will continue to ensure children and adolescents adhere to their medication and provide adequate support through peer support groups to improve retention in treatment.

4.10 Orphans and Vulnerable Children (OVC)

PEPFAR remains the main contributor to OVC activities in Haiti and has been working closely with the National HIV /AIDS Program (PNLS) as well with IBESR (Institut du Bien Etre Social et de la Recherche), which is responsible for OVC under the Ministry of Social Affairs (MAST).

Discussions between all parties including UNAIDS, UNICEF, Global Fund, implementing partners, PNLS, IBESR and MAST (MOH/GOH) are ongoing to mitigate the negative impact of the PEPFAR OVC programs phase out in certain geographical areas. As a transition plan for OVCs in sustained and centrally supported districts, the PEPFAR Haiti is expanding the Savings Group (MUSO, French acronym) program in these areas to ensure families are able to address their basic needs. Implementing partners are also encouraged to link vulnerable families to other USG or non-USG supported programs in those areas.

Household economic strengthening (HES) will also facilitate the transition for many families and will reduce dependency on OVC education programs. Access to education has been an important element of our OVC program so adolescent girls can be less vulnerable. The ratio of girls: boys is currently 51:49 among the OVC supported for school fees by the larger implementers. The dropout rate for girls was below 1%. The Savings Group program aims to empowering young

women and their families by social and economic strengthening and consequently help to reduce gender base violence and decrease HIV risk. Those interventions include referrals to condom promotion and access to comprehensive ASRH services, including HIV prevention, family planning, as well as linkages to HTS for a strengthened continuum of care particularly focused and scaled up in areas of high HIV prevalence.

Challenges still remain as 1.5 million Haitians are severely food insecure and about 3.6 million persons country-wide (700,000 households) are food insecure. Furthermore, Haiti is currently experiencing one of the worst droughts in recent decades due the ongoing El Nino phenomenon. (*Haiti Emergency Food Security Assessment, CNSA/WFP Feb.2016*). Drought has caused severe loss in agricultural yields and very poor households will exhaust their food stocks, relying on market purchase to meet their food needs. The economy is down as inflation has reached double digits in March 2016 (14%) compared to 6% in the same month last year. Finally, the Haitian gourde is devaluating at an accelerated rate from about 47 gourdes in February 2015 to 61 gourdes/1USD this month, reflecting on increased cost of living.

This background provides a general sense of the challenges ahead for the OVC program in Haiti. Additionally, the Global Fund (GF) has ended contribution to the OVC program for those infected or affected by HIV. Although there has been an increase in the number of OVC served in the sustained districts compared to last Fiscal Year (FY), a significant decrease (26%) is expected to happen during the next FY. MUSO's expansion that started this year in the sustained areas will be fully expanded by then and able to contribute to the resilience of those vulnerable families as they transition out of the program.

Home gardens will also be expanded. One hundred (100) families have received training to date and have access to home gardens in the area of Grande Rivière du Nord and they are expected to transition out of the program by September 16. Eighty (80) OVC families have integrated MUSO activities and some of them will also be close to graduation by that time. These examples highlight the plan to meet the goal of at least 1,000 families expected to graduate in FY17 with about 500 additional families in the process of graduation but in need of relocation to other supportive organizations. It is not realistic, based on the current country socio-economic situation, the lack of other donors, and limited MOH/GOH capability, to absorb the needs of the remaining OVC families living in sustained districts by September 2017. An additional 18 to 24 months may be necessary to complete this transition and to ensure effective coordination with other stakeholders and fully implemented mechanisms are in place (savings groups, home gardens, whenever feasible, or other linkages).

As the link between the OVC and the Pediatric AIDS program continues to strengthen, implementing partners will ensure referral access to basic pediatric services not only related to child survival such as immunization, deworming, Vitamin A supplementation and nutrition care, but also for identification of HIV-infected children and initiation on ART. These efforts will be scaled-up in priority districts. Furthermore, access to adolescent-friendly care activities and sexual reproductive health education, counseling and support for young teenage girls will be

enhanced 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.

In summary, the majority of implementers are using case management to assess the child and family improvement within their programs. This is of utmost importance as the OVC program phase out begins in the sustained districts. PEPFAR will keep working with the USAID Office of Democracy and Governance for the roll out of the response to the Violence Against Children Survey (VACS). We will leverage with other partners involved in child protection to address issues raised by the VACS survey including settings for post rape care and networking with GOH , UNICEF and other key stakeholders.

The previous Health Policy Project (HPP) is closed and soon to be replaced by another project that will be looking at issues related to human rights, child abuse and trafficking. The project will also look at strengthening the capability of Institut du Bien être Social et de la Recherche (IBERS) which is the main GOH structure under the Ministry of Social Affairs for Orphans and Vulnerable Children.

Table 4.1.5 Targets for OVC and Linkages to HIV Services

Arrondissement (Districts)	Target # of active OVC (FY17 Target) OVC_SERV
Acul-du-Nord	2285
Anse-à-Veau	301
Anse-d'hainault	91
Aquin	1269
Arcahaie	720
Bainet	160
Barradères	
Belle-Anse	131
Borgne	498
Cap-Haïtien	4023
Cerca-la-Source	518
Corail	36
Croix-des-Bouquets	1320
Dessalines	6151
Fort-Liberté	877
Gonaïves	2619
Grande-Rivière-du-Nord	773
Gros-Morne	316
Hinche	3203
Jacmel	645
Jérémie	2358
La Gonâve	27

Lascahobas	2349
Léogâne	720
Les Cayes	2809
Les Chardonnières	128
Les Côteaux	
Limbé	386
Marmelade	898
Miragoâne	1148
Mirebalais	4405
Môle-Saint-Nicolas	780
Ouanaminthe	2787
Plaisance	642
Port-au-Prince	18863
Port-de-Paix	6348
Port-Salut	245
Saint-Louis-du-Nord	170
Saint-Marc	5460
Saint-Raphaël	366
Trou-du-Nord	1132
Vallières	200

TOTAL

78,157

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

The program completed the geographic prioritization exercise and is currently supporting 36 of the 42 districts, of which 16 are sustained. Transition plans and alternative models were worked out with implementing partners in order to avoid disruption of care and treatment to patients previously receiving HIV services at PEPFAR supported sites.

The package of HIV care and treatment services to be delivered at the sustained sites in COP16 will be the same as in the previous period - the minimum package sufficient to provide appropriate care consistent with national and/or international standards. In general the package includes: passive enrolment of PLHIV in ART, TB screening for all PLHIV, routine viral load monitoring, CTX prophylaxis for all PLHIV, post-rape care, and provision of condoms. PMTCT services will be available at 24 health facilities and will include: routine HTC at first presentation in ANC (repeat testing for negative clients if evidence of high risk), ART for all HIV-positive pregnant women, EID for HIV-exposed infants, and support for retention of pregnant women initiated on ART. 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 for those children already at school, case management, HTC for OVC, and household economic strengthening.

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. For COP16 the volume of beneficiaries of PMTCT services is expected to have an increase of 17% compared to the previous period. The program expects an increase (9%) in the number of patients currently on ART as passive ART enrollment will continue mainly from pre-ART, TB/HIV co-infection, and PMTCT. Also, the number of OVC served will decrease by 26%.

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	27,674	32,392	17%
HTS (only maintenance ART sites in FY 17)	55,547	71,500	29%
Current on ART	8,480	9,251	9%
OVC	10,541	7,754	(26%)

5.2 OVC Transition

The OVC program is working with implementing partners in order to phase out from the centrally supported and sustained districts. The package of care is being reduced as provision to education support is limited only to children already at school and savings group are being extended so vulnerable families are better prepared to face external shock (death in family, urgent medical care.) and to respond to some basic needs including improved access to food and increased capacity of spending on educational fees. This intervention has been proven with evidence based data to be efficient in reducing the vulnerability of families and to be sustainable after projects end. In addition, PEPFAR will be relying on other strategies like home gardens and linkages to other USG or non USG interventions to help support those families in the sustained districts.

It is planned that an estimated number of one thousand five hundred families (1500) will graduate and achieve a degree of self-sufficiency by September 2017. Over five thousand five hundred (5500) estimated families will not achieve a degree of self-sufficiency at that time and will need to be transitioned to other local support.

This is a great challenge for the program that will need and additional eighteen to twenty four months beyond September 2017 before that may happen. PEPFAR is the sole contributor to the care for Orphans and Vulnerable Children in the context of HIV as Global Funds is no more engaged in that intervention. The key stakeholders (MOH/PNLS, GF, UNICEF, UNAIDS,

MAST/IBESR) have been informed of PEPFAR transitioning out of the sustained districts but the lack of funding from other Agencies/Donors as well as the limited capacity of GOH/MOH are serious constraints for a complete phase out by September 2017.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

In assessing its capacity to achieve epidemic control and contributing to the ambitious global UNAIDS goals of reaching 90-90-90 in Haiti, the program has identified three main programmatic gaps.

1. *Programmatic Gap #1: Low number of patients on ART nationally and in some specific arrondissements (districts) in particular (Mole St Nicolas, Jacmel, et.c) given recent estimates of people living with HIV (PLHIV).* On average less than 50% of PLHIV are currently on ART and it is much lower in some historically underserved *arrondissements (districts)*. The goal of COP16 (to be implemented in FY17) to achieve saturation in the 10 priority districts will not be reached if coverage of patients active on ART do not significantly increase. To reach the second 90 of the UNAIDS ambitious goals for 2020, the program will need to increase the proportion of PLHIV actively receiving ART both through an increase in ART initiation and an increase in retention rates.

As detailed in table 6.1.1, starting in the second half of COP 15 and in COP16 the program will implement activities to address the following systems barriers that are key determinants of this programmatic gap.

- a) High level of attrition among patients initiating ART on average with additional achievement levels in some subgroups
 - b) Absence of a unique patient's identifier system to facilitate patient follow up across the program
 - c) High staff turnover and limited number of staff trained on HIV care and treatment, and HIV information systems, particularly in some saturation districts
 - d) Limited availability of population level epidemiologic data down to the district level and low national analytic capacity
2. *Programmatic gap #2: Unknown (very limited) number/proportion of people enrolled and active on ART who have achieved viral suppression.*

To be able to at least report on the third 90 of the UNAIDS 2020 goals the program needs to assess Viral Load (VL) for the entire cohort of active ART patients. Currently less than 10% of active ART patients had VL monitoring with an objective of 50% by the end FY16. Given the implementation of the Test and Start approach to HIV treatment, it is critically important to have an objective method to monitor treatment outcome.

As detailed in table 6.1.2, the following systems barriers have been identified as key determinants of this programmatic gap.

- a) Limited viral load diagnosis capacity centralized at the National Public Health Laboratory (LNSP) and GHESKIO
 - b) Currently there are two parallel specimen referral/ transport networks (SRN), one for EID which is fully supported by PEPFAR (specimen from all sites to IMIS and LNSP) and the second one for CD4, VL, TB and surveillance supported in the past by post-earthquake supplemental funding.
 - c) Limited number of qualified trained personnel for VL and EID services at both lab and clinical services for ART programs and Lacking of monitoring DBS VL PT program globally to ensure quality-assured VL services
 - d) Limited knowledge on primary and secondary HIV drug resistance prevalence in the country to inform Haitian public health guidelines on quality of HIV care and treatment
 - e) Limited laboratory information system capability for specimen tracking, data collection, analysis and report for timely and accurate results dissemination.
3. *Weak environment for policy development, governance and regulation is a hindrance to the implementation of new policy such as Test and Start as well as the adoption and scale up of new service delivery models.*

The attainment of epidemic control within our defined timeline hinges on : (i) the rapid adoption by the country of Test and Start so that the program can immediately initiate treatment for the 20,000 pre-ART patients and the additional 20,000 patients identified as positive on a yearly basis (ii) the timely roll out of a new community-based service delivery model free of the current medical and psychosocial requirements that delay initiation, multiply unnecessary medical visits that overcrowd facilities and increase unit cost. Achievement of these intended goals requires:

- Policy actions that fall within the purview of MOH, and that go beyond the execution of routine duties to take on new challenges such as: speedy realignment and dissemination of treatment guidelines and other policy documents; consensus among program implementers; and sequencing and coordination of the multiple steps involved in the process that touch on lab, drug supply system, qualification and certification of personnel.
- Physical presence by MOH's regional representatives at targeted arrondissements(districts) to support the adoption of new service delivery practices, enforce implementation of revised patient flow, overcome staff's natural resistance to change, reinforce integration of HIV to other related services such as TB and reproductive health, mobilize communities for elimination of stigma and discrimination and establishment of supportive environments for a new service model.

As detailed in table 6.1.3, the following systems barriers have been identified as key determinants of this programmatic gap.

- a) Lack of MOH means (resources and staff) to drive the policy agenda

- b) Limited capacity at MOH departmental directorate level to coordinate and monitor field interventions, slows down scale up and does not foster harmonization and quality of services
- c) History of fragmented, vertical systems of planning and organization of services. Does not facilitate integration of HIV with TB and MCH
- d) Lack of national laboratory policy that includes requirements for licensure/certification for labs and certification for technicians performing HIV RDTs

Section 6.1 Addressing Challenges to a Sustainable National HIV Program for Epidemic Control

• Table 6.1.1 Key Programmatic Gap #1: Low number of patients on ART nationally and in some specific <i>arrondissements</i> (districts) in particular (Mole St Nicolas, Jacmel, etc...) given recent estimates of people living with HIV						
Key Systems Barrier	Outcomes expected after 3 years of investment*	Proposed COP 16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
High level of attrition among patients initiating ART on average with excess level in some subgroups	1. Community health tracking system expanded nationally 2. New service delivery model using community distribution of ARVs implemented at 100% of ART sites 3. Modification/adjustments of EMRs to accommodate the new services delivery model completed by the end of Q1 of COP 16 4. 50% reduction in Attrition among patients initiated on ART 12 months prior	Activity 1: <u>Through specialized TA</u> provide training and mentoring to field data personnel; develop related policy guidance and procedures; and support the use of related data	HVSI, OHSS, HVCT, HTXS	500,000	NASTAD	(7) Human Resources for Health
		Activity 2: <u>Reinforce the PLR platform</u> through : improvement of the PLR interface; expansion of the use of mobile devices; greater interoperability between PLR and EMR; integration of module to support new community-based service delivery model	HVSI, OHSS, HVCT, HTXS	500,000	UGP	(6) Service Delivery
		Activity 3: <u>Adjust EMRs</u> to exchange full range of treatment data with data repository(HASS), provide critical service alerts, support multi-scripting and community-based service delivery	HVSI, OHSS, HVCT, HTXS	800,000	ITECH GHEKIO PIH	(6) Service Delivery
		Activity 4: <u>Network establish supporting mechanisms</u> for home and community-based services including fixed points for drug distributions, transportation systems for CHWs	OHSS, HVCT, HBHC, PDCS	1,800,000	All Networks	(6) Service Delivery
Absence of a unique patient's identifier system to facilitate patient follow up across the program	1. Development and implementation of a unique patient's identifier system using biometrics and integrated to the EMR is completed 2. 100% of facilities providing HIV treatment services use the unique patient's identifier system 3. 50% reduction in the proportion of silent transfers reduced by the end of COP 16	Activity 1: <u>Collection and processing of biometric data</u> , including: installation of readers, training of field personnel, maintenance of Master Patient Index	HIVSI, OHSS	200,000	UGP	(15) Performance Data
		Activity 2: <u>Reinforce Data Repository (HAAS) and develop policies</u> across the board for data security, data deduplication, sharing and use	HVSI	400,000	NASTAD	(15) Performance Data
		Activity 3: MOH Establish a formal nationwide HIV referral system	OHSS	50,000	All Networks	6. Service Delivery
High staff turnover and limited number of staff trained on HIV care and treatment, and HIV	1. Task sharing policy developed and validated by the MOH 2. Training of 50 nurse practitioners and pediatric nurse practitioners to cover the	Finalize the task sharing policy and complete the process for MOH validation	OHSS	10,000	UGP, I-TECH	(7) Human Resources for Health
		Conduct training for nurse practitioners	OHSS	100,000	TBD	(7) Human Resources for Health

• Table 6.1.1 Key Programmatic Gap #1: Low number of patients on ART nationally and in some specific <i>arrondissements</i> (districts) in particular (Mole St Nicolas, Jacmel, etc...) given recent estimates of people living with HIV						
Key Systems Barrier	Outcomes expected after 3 years of investment*	Proposed COP 16 activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Information system particularly in some saturation <i>arrondissements</i> (districts)	needs particularly in remote and underserved areas 3. HIV care and treatment training/refresher training on revised guidelines for providers at 100% of ART sites	Conduct training for pediatric nurse	OHSS	100,000	TBD	(7) Human Resources for Health
		Conduct training/refresher training on new HIV care and treatment guidelines	OHSS	90,000	I-TECH, UGP	(7) Human Resources for Health
Limited availability of population level epidemiologic data down to the district level and low national analytic capacity	1. DHS conducted 2. ANC survey conducted 3. HIA conducted 4. HASS analysis completed 5. KP PLACE and size estimation completed 6. MOH staff analytics capacity built	Conduct DHS	HVSI	90,000	ICF MACRO	(13) Epidemiological and health Data
		Conduct ANC survey	HVSI	400,000	UGP, NASTAD	(13) Epidemiological and health Data
		Conduct HIA	HVSI		HQ funded	(13) Epidemiological and health Data
		Complete HASS analysis and prepare the dashboard	HVSI	100,000	NASTAD	(13) Epidemiological and health Data
		Conduct the PLACE study and estimate the size of the key populations	HVSI			(13) Epidemiological and health Data
		Provide training to MOH staff to increase their analytic skills	HVSI	200,000	UGP, NASTAD, Palladium	(7) Human Resources for Health
TOTAL				5,340,000		

* All outcomes will be monitored annually unless otherwise specified

• Table 6.1.2 Key Programmatic Gap #2: Unknown (very limited) number/proportion of people enrolled and active on ART who have achieved viral suppression

Key Systems Barrier	Outcomes expected after 3 years of investment*	Proposed COP 16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)	
Limited viral load diagnosis capacity centralized at the national public health laboratory and GHESKIO	<ol style="list-style-type: none"> All patients on ART have <u>at least one viral load monitoring per year</u> and 100% of patients newly initiated on ART have viral load monitoring at <u>6 and 12 months</u>. A confirmatory viral load test for patients who had virologic failure at the first viral load after intensive adherence counseling within 3 months after the 1st VL test Decentralization of VL testing for hard to reach sites using existing in country equipment for near POC VL completed (assuming validation of technology completed) 	Perform 40,000 HIV VL tests and 9,000 EID test for FY16 and to target at least 80,000 patients receiving VL tests and 9,000 EID test for FY17	HLAB HBHC	1,000,000	UGP, GHESKIO	(10) Laboratory	
		Evaluation of DBS for VL testing using the high output Abbott m2000 VL testing platform				(7) Human Resources for Health	
		Evaluation and validation of GeneXpert for VL testing at strategically selected high burden ART sites					
		Train technicians if the evaluation meet the pre-determined standards for VL testing					
Currently there are two parallel specimen referral/ transport networks (SRN), one for EID which is fully supported by PEPFAR (specimen from all sites to IMIS and LNSP) and the second one for CD4, VL, TB and surveillance supported in the past by USG non-PEPFAR fund	<ol style="list-style-type: none"> Integrated specimen referral system implemented to achieve <ol style="list-style-type: none"> 50% Reduction in cost over 3 years 30% reduction in turnaround time 50% reduction in the proportion of specimen rejected Single specimen tracking system developed and implemented at LNSP. 	Mapping how the specimen referral network to evaluate distance and shorter route from peripheral labs to LNSP and IMIS	HBHC PDCS HTXS	300,000	UGP	(10) Laboratory	
		Cost analysis of the different strategies to transport specimen across the country based on existing model					
		Work with all stakeholders to improve specimen quality and tracking.					

• Table 6.1.2 Key Programmatic Gap #2: Unknown (very limited) number/proportion of people enrolled and active on ART who have achieved viral suppression						
Key Systems Barrier	Outcomes expected after 3 years of investment*	Proposed COP 16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Limited number of qualified personnel for VL and EID services at both lab and clinical services for ART programs and Lack of monitoring DBS VL PT program globally to ensure quality-assured VL services	<ol style="list-style-type: none"> 100% of providers (clinician and nurse practitioners) at ART facilities receive training on VL testing policy based on national VL testing algorithm. 100% training for lab techs on specimen collection, packaging and transport, specimen quality for VL testing. Continuous quality improvement and certification for lab techs performing VL testing at LNSP and IMIS DBS VL PT program established at LNSP. 	Train 100% of the clinical and laboratory personnel at the PEPFAR supported HTC for viral load testing Perform regular assessment and onsite technical assistance to support HTC on viral load specimen collection packaging and shipping Prepare and distribute quarterly DBS proficiency testing panels to LNSP and IMIS for quality assessment.	HLAB HTXS	300,000	UGP	(7) Human Resources for Health (10) Laboratory
Limited knowledge on primary and secondary HIV drug resistance prevalence in the country to inform Haitian public health guidelines on quality of HIV care and treatment	<ol style="list-style-type: none"> Survey on HIV drug resistance prevalence and mutations patterns completed 	Provide HIV Drug resistance testing for a subset of patients with 2 consecutive VL >1000 copies/mL	HVSI, HLAB	100,000	UGP	(10) Laboratory
		Conduct regular cross-sectional survey on the prevalence of primary drug resistance in Haiti				(13) Epidemiological and health Data
Limited Laboratory information System capability for specimen tracking, data collection, analysis and reporting for timely and accurate results dissemination	<ol style="list-style-type: none"> Decrease the turnaround time for VL and EID results to 1 week Improve data quality and specimen tracking Decrease data entry error rates by 100% by interfacing the LIS with Abbott and open MRS Generate quarterly reports on number of patients tested and level of virologic suppression 	Install the SCC LIS at LNSP, IMIS and PIH	HLAB, HVSI	100,000	UGP	(10) Laboratory
		Train lab technicians at these 3 institutions to effectively use the system				(7) Human Resources for Health
		Regular monitoring of data quality and generating reports for program evaluation				(13) Epidemiological and health Data
TOTAL				1,500,000		

* All outcomes will be monitored annually unless otherwise specified

• Table 6.1.3 Key Programmatic Gap #3: Weak environment for policy development, governance and regulation is a hindrance to the implementation of new policy such as Test and start as well as the adoption and scale up of new service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
MOH central's <u>lack of wherewithal</u> (resources and Staff) <u>to drive a sound policy agenda</u> that supports changes without compromising quality.	<ol style="list-style-type: none"> Guidelines updated and Policy Memo released by July 2016 to embrace Test and Start and accompany changes in service models National consensus reached on new service model operationalization and related service models and implemented at all ART sites Standardized HIV indicators and tools validated by MOH used at 100% of ART sites (both PEPFAR and GF sites) 	Activity 1: Create through MOH central <u>a policy package for Test and Treat</u> including revision and dissemination of testing and treatment guidelines, partner consensus meetings, revision of indicators and information tools to support multi-scripting, new definition of loss to follow up	OHSS, HVSI	400,000	UGP, I-TECH	(2) Policy and Governance
		Activity 2: MOH <u>ensures standardization of information system that support shift in service</u> by editing, printing and distributing revised information tools (Forms, log and registers)	HVSI	450,000	UGP	(13) Epidemiological and health Data
		Activity 3: <u>Incorporate new indicators and benchmarks related to Test and Start into Quality assurance and Quality Improvement (QA/QI) program.</u> Continue to support: (i) MOH's leadership in the activity (ii) expansion to all sites (iii) training of regional coaching teams and local quality circles	HVSI	600,000	UGP, I-TECH	(9) Quality Management (13) Epidemiological and health Data (7) Human Resources for Health
		Activity 4: <u>Support the hiring of senior contractuals to fill key positions at critical MOH units involved in the planning and implementation of the HIV program such as PNLS, DSF, UPE</u>	OHSS	350,000	UGP	(2) Policy and Governance (2) Planning and Coordination
MOH departmental (DD) level's <u>lack of capacity to coordinate</u>	<ol style="list-style-type: none"> Test and Treat policy is implemented at 100% of ART sites New Models of services rolled out at 100% of priority districts 	Activity 1: <u>Sustain the hands-on support provided by selected Departmental Directorates to the scale up services, and the shift toward new models of services</u>	OHSS	600,000	UGP	(6) Service Delivery

• Table 6.1.3 Key Programmatic Gap #3: Weak environment for policy development, governance and regulation is a hindrance to the implementation of new policy such as Test and start as well as the adoption and scale up of new service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP ¹⁶	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
and oversee field interventions, slows down scale up, and does not foster harmonization and quality of services	3. Program and Service quality objectives (as evidenced by MER indicators and 50% reduction in red (SIMS)) are met as a result of DD staff participating in SIMS and HealthQual coaching	by enabling them to perform regional partner forum, regular site supervision, and community mobilization.				(2) Planning and Coordination
		Activity 2: Support Desk and Field Data Validation through Regional M&E officers. Site validation serves both PEPFAR and National needs by ensuring quality of data posted both on MESI and DATIM	HVSI	300,000	UGP. I-TECH, NASTAD	(13) Epidemiological and health Data (15) Performance Data
Lack of national laboratory policy that includes requirements for licensure/certification for labs and certification for technicians performing HIV RDTs	Policy document finalized and adopted by MOH	Finalize Laboratory policy document Conduct stakeholders meeting with all laboratory stakeholders to discuss the policy document and have feedback Submit the policy to parliament to turn it into law allowing MOH to regulate lab activities in the country	OHSS	65,000	UGP	(10) Laboratory
TOTAL				2,765,000		

* All outcomes will be monitored annually unless otherwise specified

Section 6.2. Aligning System Investments with PEPFAR Epidemic Control Priorities

6.2 Critical Systems Investments for Achieving Priority Policies

The overarching goal of the program is to achieve epidemic control of HIV in Haiti in a context of very limited availability of domestic resources and steady decrease of external funding. It is thus critical to implement policies and efficient strategies that will facilitate the provision of ART to all individuals diagnosed with HIV soon after diagnosis while maintaining quality of care. In that sense, the program has initiated discussion with the leadership of the MOH on the new WHO guidelines. PNLs has confirmed its intent to revise the national HIV care and treatment guidelines to adopt the Test and Start policy and new models of service delivery with full implementation before the end of 2016. The HTC guidelines will also be revised concomitantly. As detailed in tables 6.2.1 and 6.2.2, the following systems investments have been identified as determinant to a successful implementation of the aforementioned policies:

Test and Start

- a) Revision of current national HIV care and treatment guidelines recommending ART initiation at $CD4 \leq 500$ for adults and adolescents to adopt Test and Start
- b) National rollout of viral load diagnosis capacity through the National Public Health Laboratory and GHESKIO
- c) Improve the quality of HIV diagnostic testing through implementation of the HIV Rapid Test Quality Improvement Initiative (RTQII)
- d) Support the External Quality Assessment program for HIV RDT EID/VL testing

New and Efficient Service Delivery Models

- a) Improve supply chain management capacity at the site level
- b) Revision of current national policies to adopt new models for services delivery (bi-annual clinical appointments for stable patients, VL for every patients, limited lab work at initiation and based on need; and reporting tools modelled accordingly)
- c) Redefining the role of the selection committee to reduce the impact of non-medical criteria on ART enrollment
- d) National rollout of the Patient Linkage and Retention (PLR) and patients unique identifier

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes Expected after 3 year of investment *	Proposed COP 16 activities	Budget code	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Current national HIV care and treatment guidelines recommend <u>ART initiation at CD4 ≤ 500</u> for adults and adolescents	<ol style="list-style-type: none"> <u>The revision National HIV care and treatment guidelines</u> for adolescents and adults is completed and recommend TEST and START for all patients diagnosed HIV positive regardless of WHO stages or CD4 count <u>100% of ART providers have attended HIV care and treatment refresher trainings</u> on the then newly revised guidelines 	Provide technical and financial assistance to National AIDS control program for the revision of the national HIV care and treatment guidelines according to the new TEST and START WHO guidelines	HTXS	See table 6.1.3	UGP	(2) Policies and Governance
		Provide technical and financial assistance to National AIDS control program for the revision of the national HTS guidelines according to the WHO HTS guidelines	HTXS	See table 6.1.3	UGP	(2) Policies and Governance
		Provide refresher training for health providers on the new guidelines (Care and treatment and HTS guidelines)	HTXS	See table 6.1.1	UGP, I-TECH	(7) Human Resources for Health
<u>Limited viral load diagnosis capacity</u> centralized at the national public health laboratory and GHESKIO	<ol style="list-style-type: none"> Viral Load test capacity is expanded nationally. All patients on ART have <u>at least one viral load monitoring per year</u> and 100% of patients newly initiated on ART have viral load monitoring at <u>6 and 12 months</u>. A confirmatory viral load test for patients who had virologic failure at the first viral load after intensive adherence counseling within 3 months after the 1st VL test Decentralization of VL testing for hard to reach sites using existing in country equipment for near POC VL completed 	<p>Perform 40,000 HIV VL tests and 9000 EID test for FY16 and to target at least 80,000 patients receiving VL tests and 9000 EID test for FY17</p> <p>Evaluation of DBS for VL testing using the high output Abbott m2000 VL testing platform</p> <p>Evaluation and validation of GeneXpert for VL testing at strategically selected high burden ART sites</p> <p>Train technicians if the evaluation meet the pre-determined standards for VL testing</p>	See Table 6.1.2	See Table 6.1.2	See Table 6.1.2	See Table 6.1.2
Improve the quality of HIV diagnostic testing through implementation of the HIV Rapid Test Quality Improvement Initiative (RTQII)	<ol style="list-style-type: none"> Revision of The national HTS guidelines to adopt the new WHO standards completed and validated 100% of technical staff within HTC sites proficient in HIV RDT using RTQII guidelines 100% of HTC sites recording results in standardized RTQII HIV RDT log books 	Develop new HIV RDT algorithm based on WHO recommendations with 3 rapid tests	HLAB HTXS	500,000	All Networks	(10) Laboratory
		Train technical staff (Implementing partners' lab specialists, laboratory technicians, nurses) at HTC on the new HIV algorithm and quality assurance	(7) Human Resources for Health			
		Work with the National HIV/AIDS program to update the national guidelines with the new HIV RDT algorithm, print and share revised guidelines with all stakeholders	(10) Laboratory			
		Retest all positive patient before treatment	(10) Laboratory			

Support the External Quality Assessment program for HIV RDT EID/VL testing	1. 100% of PEPFAR HTC sites enrolled in the HIV RDT EQA program	Preparation of Proficiency Testing (PT) panels for HIV RDT to support quarterly EQA for all HTC. Preparation of PT panels for DBS HIV VL for NPHL and IMIS	HLAB	300,000	UGP	(10) Laboratory
	2. 100% of PEPFAR HTC sites with a score of 100% on HIV proficiency testing	Onsite technical assistance and refresher training for HTCs that performed poorly on EQA				(10) Laboratory
	3. 30% reduction in turn-around-time of EQA results and subsequent follow-up of mentoring/training at low-performing HTC sites	Certification of laboratories that perform well on HIV RDT EQA and follow-up onsite assessments, certification of laboratory technicians on HIV RDT.				(10) Laboratory
4. Establish a DBS VL PT program to ensure the quality of VL testing for patient care						
Total				800,000		

* All outcomes will be monitored annually unless otherwise specified

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 16 Activities	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Limited supply chain management capacity at the site	<ol style="list-style-type: none"> Storage capacity assessed at 100% of PEPFAR ART facilities; and storage capacity improvements made at ART sites as per assessment recommendations. Supply chain data collection and reporting tools modified to reflect the need of the new approach to ARV drugs dispensation 	In collaboration with PNLAs and MOH, conduct a site assessment for all ART facilities, to define a site profile that captures storage capacities, drug dispensing pharmacies/points capacities, LMIS capacities, weaknesses and recommendations for improvement.	HTXD, PDTX	\$68,365	Global Health Supply Chain – Procurement Supply Management (GHSC)	(8) Commodity Security and Supply chain

	3. 280 facility staff managing and dispensing ARV Stock trained on LMIS	Assist the MOH in designing a logistics management information system (LMIS) for the unified national supply chain system. The LMIS will capture stock availability at facility level and distribution through facilities and CHWs, using existing innovating strategies with smartphones (with a logistics module).	HSVI	\$140,000	Global Health Supply Chain – Procurement Supply Management (GHSC)	
	4. Adequate Forecasted quantity of Drugs delivered to the sites to match the twice a year ARV dispensation					
	5. SCMS delivery schedule adapted (Number of distribution sessions modified as needed) to ensure cost efficiency					
		Assist the MOH and partners to develop an implementation plan for the MMS strategy, including: a) revised/adapted LMIS reporting tools to better capture community based distributions and facility based drug dispensation, b) implementing partners and sites (PNLAs, Pharmacists, CHW etc.) training plan on revised LMIS tools, c) supplies procurement plan (back packs, and cool boxes for CHW to transport the medication), d) data quality audit plan to validate stock and consumption data at site level, e) monitoring plan of the country stock levels, the resupply frequency and	HSVI	\$136,000	Global Health Supply Chain – Procurement Supply Management (GHSC)	
		Assist the MOH to review the national STGs to reflect the Test & Offer and Multi-Month Scripting (MMS) strategies. Assist the MOH to review the quantification process to better adjust the ARV forecasts and supply plans before the	HTXD, PDTX,		Global Health Supply Chain – Procurement Supply Management (GHSC)	
Current national policies recommend clinical appointments at least every 3	1. The National HIV Care and Treatment guidelines revision to include the new service delivery model is completed and validated 2. EMR and reporting tools modified to	Provide technical and financial assistance to National AIDS control program for the revision of the national guidelines allowing multi-month scripting	See table 6.1.3	See table 6.1.3	See table 6.1.3	(2)Policies and Governance

months, lab work at initiation; and reporting tools are modelled accordingly	accommodate the changes in the service delivery model 3. Training for CHW completed	Revise EMRs and other electronic tools to accommodate the changes in the service delivery model including biannual appointment, etc...	See table 6.1.1	See table 6.1.1	See table 6.1.1	(15) Performance Data
		Develop/adapt curriculum for CHW on new service delivery model and the use of monitoring tools	See table 6.1.1	See table 6.1.1	See table 6.1.1	(2) Policies and Governance
		Train CHW on new services delivery model	See table 6.1.1	See table 6.1.1	See table 6.1.1	7) Human Resources for Health
The weight of non-medical criteria in the selection committee process	1. Role of selection committee revised to focus more on strengthening adherence 2. Providers trained on the new services delivery model reinforcing the importance of adherence counseling post ART initiation and the notion that each patient encounter with a provider (CHW, nurse, pharmacist, etc...) is an opportunity to strengthen patient adherence	Revise the scope of work of the selection committee to focus on patient adherence to treatment	HTXS	10,000	I-TECH	(6) Service Delivery
		Conduct training/refresher training on new HIV care and treatment guidelines	See table 6.1.1	See table 6.1.1	See table 6.1.1	7) Human Resources for Health
TOTAL				344,365		

* All outcomes will be monitored annually unless otherwise specified

Table 6.3 Other Proposed Systems Investments

Systems Category* (only complete for categories relevant to country context)	Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment / deliverables (Outcomes) expected after 1- 3 years of investment/ Milestones	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance							
	Provide support for the implementation of a Health Financing Strategy and build the capacity of the MSPP in resource mobilization	1) First 90; 2) Second 90; 3) Third 90; and 4) Sustained Epi Control.	Improved financing for priority health services development of a health financing strategy Long term 1-3 year	\$214,903	OHSS	HFG	(1) Domestic Resource Mobilisation
	Provide assistance to MSPP in resource strategic planning and costing of the Plan Directeur (2012-2022)	1) First 90; 2) Second 90; 3) Third 90; and 4) Sustained Epi Control.	Increased efficiency of health sector resource allocation Costing of the plan directeur 1 year	\$89,755	OHSS	HFG	
Governance							
	Improve the communication capacity of the CCM to inform the public and to engage the private business sector	4) Sustained Epi Control	Accessible CCM website, Quarterly CCM communication plan CCM communication plan developed , 12 month Quarterly bulletins published on the CCM's website CCM bulletins Quarterly report reporting on grants' progress and engagement of various sectors in the country responses to the diseases	\$58,000	OHSS	LMG	(2) Policies and Governance

Inst & Org Development							
	Develop the UCP coordination manual that defines the coordination mechanism between the UCP and national priority health programs and provide funding to print and disseminate the manual	4) Sustained Epi Control	150 copies of the coordination mechanism manual for the three national priority programs developed and disseminated " Draft coordination mechanism manual for the UCP and three national priority programs 6 months	\$73,839	OHSS	LMG	(2) Policies and Governance
Laboratory							
	Technical Assistance to the MOH to enhance laboratory equipment management and quality of lab services by providing training and mentorship on maintenance and repair services to the National Lab Technicians.	1) First 90; 2) Second 90; 3) Third 90; and 4) Sustained Epi Control.	1. Responsibility for the maintenance and repair services of the PEPFAR laboratory equipment transferred to National Lab Technicians of the MOH2. Laboratory asset management strategy developed and approved by MOH National Lab. (Strategy includes protocol for instrument deployment, storage, maintenance, repair, disposal of nonfunctional instruments, etc)	\$458,005	HTXS, PDTX, HLAB	Global Health Supply Chain – Procurement Supply Management (GHSC)	8. Commodity Security and Supply Chain
Strategic Information							
Lack of a unified Data warehouse capturing all health data elements	Technical Assistance to the MOH to fast track the implementation of the National Unified Information System (SISNU) by financing/embedding consultants at the MOH/UEP unit. Revise and standardize all primary care registers and reporting forms	1) First 90; 2) Second 90; 3) Third 90; and 4) Sustained Epi Control.	Integrated health information system based on the DHIS2 platform(SISNU) deployed and available at all health facilities Revised and standardized all primary care registers and reporting forms used by all health facilities	200,000	HVSI OHSS,	Palladium	(13) Epidemiological and health Data
Systems Development							
	Technical Assistance to the MOH to implement its	1) First 90; 2) Second 90; 3) Third 90; and 4) Sustained	Availability of a technical unit within the MOH officially	\$200,000	OHSS	Global Health Supply Chain –	8. Commodity Security and

	plan for the creation of the National Unified Supply Chain System by financing/embedding consultants to a newly created coordination unit. At central and departmental level.	Epi Control.	mandated to oversee and coordinate the supply chain operations and ensure constant availability and accessibility of health commodities in service delivery points throughout the country.		Procurement Supply Management (GHSC)	Supply Chain
TOTAL				1,991,751		

7.0 Staffing Plan

Summarize your approach to reviewing and analyzing your staffing footprint and organizational structure for COP16

The PEPFAR Haiti team reviewed individual position descriptions, OGAC reporting requirements and the specific needs of each agency to minimize duplication and ensure complementarity of efforts. The current staff footprint organizational structure will allow both agencies to work collaboratively, analyze progress and respond to requirements.

The team also looked at the current approach to interagency collaboration in an effort to identify areas to consolidate activities and improve efficiency. We reviewed areas such as technical assistance to MSPP and other stake holders, and the work currently been conducted by the global fund.

Summarize overall changes to OU footprint and organization to facilitate pivot achievement

To strengthen the pivot process, the team has requested for one new position, a change from a Global Fund Liaison position in the Coordinator's office to an additional position in the PEPFAR Coordination Office.

Position fill rate (FTE and Individual) increased from 85% to 90%. Increase in staff reflects field monitors to conduct SIMS visits.

A CDC PEPFAR Director was hired and came on board on December 2015, the CDC Country Director was removed from the PEPFAR budget, and CDC will repurpose a position to assist with CDC's communications with the PEPFAR coordinator.

USAID has accounted for existing staff that had been working on PEPFAR but not listed in the past, especially in support offices.

Greater LOE allocations were made for partners site visits and TA.

Spotlight overall challenges, hindrances in conducting review for 16 (consider highlighting specific challenges in your opening session overview) and specific staffing needs

New PEPFAR requirements (SBOR, POART) have been excellent initiatives pushing us to proactively review our data and actively consider potential changes; however, at the same time they reduce the amount of time available to provide hands on TA, conduct SIMS visits and prepare required documentation.

The State Department hiring process continues to be a strong hurdle for CDC to get people hired with the move to DOS regional HR office.

Identify what, if any, staffing-related Plans you have for CY 2016, e.g. Position Description review

Reviewing the PDs of multiple positions to ensure job descriptions clearly outlines new PEPFAR requirements.

APPENDIX

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

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"> HTC 	<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 STI Prevention, treatment and counselling 	<ul style="list-style-type: none"> Condom provision PEP Maintain existing STI Screening Maintain KP friendly health services

	<ul style="list-style-type: none"> ○ STI Prevention, treatment and counselling ○ Condoms and lubricants ○ ART ○ Peer education and community based outreach ○ HCW trainings 	<ul style="list-style-type: none"> ○ Condoms and lubricants ○ ART ○ Peer education and community based outreach ○ HCW trainings 	
Clinical Care and Adult and Pediatric ART	<ul style="list-style-type: none"> ● ART for all HIV positive patients (Test and Start) and ● Support to improve retention of current PLHIV on ART ● Routine clinic visits and regimen pick-ups (Multi-month scripting and community drug distribution) ● Pharmaco-vigilance ● 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 ● CTX prophylaxis for all PLHIV ● Hepatitis B Screening (when already available at the facility) ● IPT as per guidelines ● Quality Management; DQAs ● Orientation, standard training (annual), and quarterly mentorship for service providers 	<ul style="list-style-type: none"> ● ART for all HIV positive patients (Test and Start) and support to improve retention of current PLHIV on ART ● Routine clinic visits and regimen pick-ups (Multi-month scripting and community drug distribution) ● Pharmaco-vigilance ● Quality Management; DQAs ● 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) ● CTX prophylaxis for all PLHIV ● IPT as per guidelines ● Orientation, standard training (biennial), and quarterly mentorship for service providers 	<ul style="list-style-type: none"> ● ART for all HIV positive patients (Test and Start) and support to improve retention of current PLHIV on ART ● Routine clinic visits and regimen pick-ups (Multi-month scripting and community drug distribution) ● 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) ● CTX prophylaxis for all PLHIV ● IPT as per guidelines <hr/> <ul style="list-style-type: none"> ● Routine clinic visits (with CHW-supported regimen delivery where appropriate) ● 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 	<ul style="list-style-type: none"> ● Routine HTC at first presentation in ANC (Repeat testing if evidence of increased 	<ul style="list-style-type: none"> ● Routine HTC at first presentation in ANC (Repeat testing if evidence of

	<p>exposure) or in L&D (for women with unknown status admitted for delivery)</p> <ul style="list-style-type: none"> • 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) 	<p>exposure) or in L&D (for women with unknown status admitted for delivery)</p> <ul style="list-style-type: none"> • Lifelong ART for all HIV+ pregnant women • EID for exposed infants • PMTCT case-manager • Support for retention of Pregnant women initiated on ART 	<p>increased exposure) or in L&D (for women with unknown status admitted for delivery)</p> <ul style="list-style-type: none"> • 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; • 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"> • 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; • 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"> • 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 • 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) 	<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 	<ul style="list-style-type: none"> • Maintain current numbers of people in community health teams (including CHWs) • Improved referral and defaulter

	<ul style="list-style-type: none"> 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 	<p>services</p> <ul style="list-style-type: none"> Transport fees to attend appointments Improved patient monitoring platforms; Increased involvement of civil society and community based organizations and networks. 	<p>tracking services</p> <ul style="list-style-type: none"> 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 Patient Linkage and Retention using mobile technologies and unique patient identifier and biometric codes Support Groups (increase as needed, and linked to health facilities) 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"> Enhanced facility-based counselling and support (with presence of psychologist where already supported) Additional adherence counselling by polyvalent CHWs Patient Linkage and Retention using mobile technologies and unique patient identifier and biometric codes Support Groups (maintain existing); Empower CHWs on adherence monitoring (training, capacity building, logistics) 	<ul style="list-style-type: none"> Facility-based counselling and support (no support for psychologist) Additional adherence counselling by polyvalent CHWs Patient Linkage and Retention using mobile technologies and unique patient identifier and biometric codes Support Groups (maintain existing) 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

Support for Essential Laboratory Services	<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) • 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) • 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) • 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

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP16

Prevention	Core Activities	Near-core Activities	Non-core Activities
Key Populations	Ensuring HTC, condom, and treatment services to key populations		
	-Condoms and lubricants to be available	Psychological support	
	-Adapted ART services	Treatment of other STDs	
	-Retention specifically for key pops.	Surveys to better understand needs: 1) Formative research, 2) Hot spotting/mapping, 3) Population size estimation	
	Maintain key population friendly sites with highest yield		
	Condom procurement		
	Essential Survey: IBBSS/with Bio marker		
	Training of provider		
	Target mobile HTC based on pop size estimate data (FSW)		
General Populations	N/A	Condom procurement with transition to non-core as other funding sources identified	
HTC	Conduct targeted HTC based on surveillance epidemiology data	Provision of HTC at facilities should be aligned with ART/PMTCT sites strategy (scale-up, maintenance)	
	Increase HTC for key populations		
	HTC on the Haiti/DR border		
	EQA		
PMTCT	Core Activities	Near-core Activities	
Primary prevention of HIV			
Prevention of unwanted pregnancies among HIV+ women		Integration of FP into PMTCT	
		Training of providers on FP	
Treatment of HIV Infected pregnant women to prevent	HTC services	Mobile clinic for pregnant women at moderate burden areas	

HIV transmission	Providing ARVs to HIV+ pregnant women		
	Innovative, evidence based tracking system		
	Improvement of patient flow and adherence support mechanism - peer groups	Support Groups for adherence support	
	Case manager at high yield sites		
Providing care and treatment services to HIV+ Pregnant women and their families	EID testing	Transport system for EID	
	Testing for children and partners		
Cross-Cutting	Core Activities	Near-core Activities	
HSS	Direct support for central directorates: PNLs, PNLT (TB/HIV), DSF (PMTCT) -- support to supervision, training, clinical mentoring, quality management, guidelines revision, technical working groups, development of and implementation of policy guidelines and tools and HIV related healthcare staff	TA to the CCM	
	NHA support	TA for UCP for cohesive planning and evaluation	
	HR Support for UPE embedded staff (2)		
	HR Support for embedded advisors at PNLs (2)		
Supply Chain	Quantification and procurement of HIV/AIDS commodities	TA to local organizations/transition of distributions activities to local organizations	
	Integrated warehousing of HIV/AIDS and FP commodities	TA to MOH DPM for elaboration for national Supply Chain System	
	Distribution to Service Delivery points	TA to MOH DSF for integrated management of HIV and FP commodities at sites	

Strategic Information	Support for EMR	Routine update and printing of forms and registers	
	Data validation at sites		
	training of all data clerks		
	ANC Survey		
	Interoperability of existing systems (DHIS2, MESI, DATIM)		
	Platform for site level reporting		
	Implementation of DHIS2 (departmental assessment for roll out of DHIS2, commodities tracking, OVC database)		
	operation and maintenance of national server for HIV		
	support for annual statistics reports		
	salary support for all data clerks at PEPFAR sites		
	HealthQual		
	SIMS		
	Case base notification and development of tracking tool to reduce LTFU		
DHS 2017			
OVC	Core Activities	Near-core Activities	
Case Management	Identification of children and adolescent population vulnerable to HIV		
	Assessment of child adolescent and family socio-economic status		
Access and linkages to health care	Promotion of HIV testing of OVC including EID	Cross referral between clinics and social services	
	Referral to interventions focused on keeping adolescent HIV free		
	Testing of siblings and partner of index cases		
	Coordination with NACS (suspected malnutrition)		
	Facilitate access to child survival services (vaccination, Vit A, deworming)		
	Referral to age specific health care needs for FP and SRH		
	Early Child Development with Pediatric care		
Child Protection	Support to community and national level child protection (Post Rape Care Support network)	Strengthening national response (VACS)	
	Support group individual and group based	Support group individual and group based	
	Positive parenting skills	Positive parenting skills	
	Support for birth registry	Support for birth registry	
Household Economic Strengthening		Savings Group (MUSO)	

Education		identify at risk group for education support and facilitate access to primary and secondary education	
	Assessment of OVC Partners (DQA)		
Strategic Information	Support for OVC-MER essential survey indicators		
Care and Treatment	Core Activities	Near-core Activities	
Salary	Salary support for C&T providers, community health team, lab technicians	Salary support for psychologists	
Management of Opportunistic Infections and other comorbidities	Isoniazid Prophylaxis (IPT)		
	Facility intensive case finding; Community intensive case findings in slums; Linking community and facility	Contact tracing	
	Triage for infection control ; adequate ventilation; procurement of supplies	UV-lighting	
	Cotrimoxazole prophylaxis;	Procurements of other OI drugs	
		Screening for Hepatitis B	
	X-Ray for TB Diagnosis in co-infected individuals		
Psychosocial support	Community health team (CHW, Comm.Nurse, Social worker) scope expansion to include training that addresses messaging on stigma and discrimination, supporting phone calls to contact patients regularly in order to improve retention.	Peer support group	
	Provision of transport fees for patient to attend appointments	Economic Strengthening	
		Psychological support and counseling for denial, adherence reinforcement	
		Provision of psychosocial support to children and adolescents (Kids and adolescent clubs)	
		Nutritional assessment and counseling	
	Salary support for psychologist		
Lab		Screening for syphilis	
	Hematology and Chemistry as needed	Biomedical - equipment maintenance/repair	

			As VL is being roll out nationally and the HIV care and treatment guidelines being revised to adopt Test and Start CD4 testing will phase out at the end of the fiscal year
	Viral load monitoring 1 test six months post-initiation, then 1 test per year unless VL above virologic failure threshold - if above virologic failure threshold, retesting after 3-6 months	Specimen transport (EID VL and Xpert)	
	X-Ray for TB diagnosis of SMR Neg TB /	EQA/QMS/training for chemistry, hematology	
	EID testing	Gene-Xpert for TB screening	
	Microscopy for TB diagnosis (ZN/FM)		
	EQA/QMS/training for RDT, CD4, EID, VL, GeneXpert, FM/ZN)		
PEP	Post-rape capacity building		
	Post-rape care and supplies		
	Salary support for providers		
Adult and Pediatric treatment	Support to government in updating and rolling out national guidelines	Biennial HIV training for providers	
	Insuring supplies of commodities (ARV)		
	Expanding pediatric case finding in most at risk populations (out-patients, in-patients, malnourished, patients at immunization clinics)		
	Improve quality of clinical services		
	Key population friendly sites with access to care and treatment, salary for providers and ARV drugs.		
	Salary support for treatment providers		
Monitoring and Evaluation	Quarterly monitoring of sites (including SIMS, DQA)		
	SI support for priority sites	Reduced SI support package for transitioning sites with low volume	
	Salary support for providers		

Linkage to pediatric care and treatment	Active HIV case finding within OVC and linkage to care		
	Linkage to care and treatment from HTC sites, and PMTCT services		
	Combined community and facility approaches for retention, adherence, and linkage to care		
	Improve defaulter tracking mechanisms		
	Support to develop two-way referral system		

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Total Spend

\$94,500,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$4,584,723
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	\$3,514,944
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$7,219,216
HBHC	Adult Care and Support	\$7,277,717
PDCS	Pediatric Care and Support	\$3,043,175
HKID	Orphans and Vulnerable Children	\$9,421,604
HTXS	Adult Treatment	\$23,226,687
HTXD	ARV Drugs	\$11,410,002
PDTX	Pediatric Treatment	\$3,954,250
HVTB	TB/HIV Care	\$2,960,965
HLAB	Lab	\$3,924,074
HVSI	Strategic Information	\$4,168,282
OHSS	Health Systems Strengthening	\$2,792,987
HVMS	Management and Operations	\$7,219,216
TOTAL		\$94,500,000

B2 Resource Projections

To develop the COP16 budget, the team utilized all aspects of the PBAC and the FY15 Expenditure Analysis (EA) data. Building on the work that was done for COP15 with the previous EA advisor, the team, with the assistance of the new EA advisor, further revised the Unit Expenditures (UE) with the new information available.

Appropriate adjustments were made as needed for scale-up versus sustained districts, adults versus pediatrics, etc. Commodity expenditures were removed from UE calculations, but were calculated separately based on FY17 targets, and 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 codes or activity allocations were set, targeted allocations were made based on the agency proportional share of targets, while lump sums were attributed based on past/future scope of work, service delivery models, type of structures supported, FY15 EA results, current budget, and expected efficiencies with changes implemented in the program.