

**STRATEGIC TECHNICAL ALIGNMENT FOR
RESULTS (STAR) PROCESS**

Dominican Republic

Country Operational Plan

COP 2017

Strategic Direction Summary

March 16, 2017

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1.0 Goal Statement

In COP 2017, PEPFAR will pursue two strategic outcomes: (1) implement site-level models that contribute to closing the national treatment gap for key and priority populations (KP/PP¹) and the treatment gap by 83% in the catchment areas of PEPFAR-supported facilities; and (2) address site and above-site system challenges, including viral load capacity, supply chain management, capacitated workforce, and programmatic efficiencies in the national HIV response. PEPFAR will document its quality improvement process so that the demonstrated KP/PP service package implemented at PEPFAR-supported sites can be expanded nationally to support the Government of the Dominican Republic's (GODR) HIV epidemic control efforts. Quality improvement will include a mil-mil initiative to reduce stigmatization from healthcare workers and improved coordination with the national HIV program for supply chain and data management.

PEPFAR will support a twinning model that strategically pairs local NGOs with public sector health facilities to create a technical exchange to raise the performance of clinical services in both sectors. The mobile clinic model will integrate PEPFAR-funded HIV services with GODR-funded primary health care services to ensure that hard-to-reach migrant communities receive comprehensive care in a non-stigmatizing environment. Both models will drive service demand through a combination of HIV testing modalities, including facility- and community-based index client testing.

In FY 2019, PEPFAR will evaluate and cost its KP/PP package to support the rollout of services countrywide. PEPFAR will also support domestic resource mobilization efforts to address existing and emerging financing constraints that will arise during this government-led transfer and expansion phase.

¹ Key populations consist of men who have sex with men, transgender women, and female sex workers. Priority populations consist of migrants, with a specific concentration on construction and agriculture workers as well as street vendors.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The projected 2017 Dominican Republic (DR) census data population estimate is at 10,727,199. According to the World Bank (2015), Gross National Income per capita is US\$ 6,240, with health spending accounting for 2.93% of the country's Gross Domestic Product. The DR has a concentrated HIV epidemic with an estimated adult (15-49 years of age) HIV prevalence of 0.8% (Demographic Health Survey [DHS]/2013), a figure similar to the 2007 DHS. The 2017 DR Spectrum model estimates 65,013 persons living with HIV (PLHIV), 2,110 HIV-related deaths, and 2,389 new HIV infections.

Certain populations are disproportionately burdened by HIV, specifically men who have sex with men (MSM), transgendered women (TG), female sex workers (SW), and migrant populations. The number of MSM living in the country varies widely depending on the source, with the 2010 and subsequently updated 2015 National AIDS Commission (CONAVIHSIDA) and UNAIDS study estimating 124,472 MSM, or 4.2% of the adult male population. The 2016 PLACE Lite study estimated a much lower figure of 32,416 MSM, or 1.24% of the adult male population. One explanation for this significant difference is that PLACE Lite estimates individuals that are reachable with outreach prevention interventions. MSM HIV prevalence is estimated between 3.9-6.9% across five provinces (Integrated Biological and Behavioral Sentinel Survey [IBBSS]/2012). The study also indicated that only 11-31% of MSM had access to an HIV test in the last 12 months. Moreover, 48% of MSM reported discrimination in health services, and 28.9% of a sample of health service providers preferred not to care for MSM or other KPs (Health Policy Project/2014). Between 70-94% of MSM reported having sex for some material benefit, and condom use was low: between 42-71% in most recent anal receptive sexual intercourse, and between 21-39% in most recent insertive anal sexual intercourse. The number of TG women was estimated at 8,891 (Experts Focus Group for CONAVIHSIDA, 2014), although this number was substantially reduced to 5,169 (0.20% of adult males) in the 2016 PLACE Lite study. TG HIV prevalence is estimated at 17.3% (PLACE/2014), although the sample size was extremely small (n=33).

The number of female SW is estimated at 91,171, representing 3.4% of all adult women (CONAVIHSIDA Experts Focus Group/2000, updated in 2014). This figure was supported by the 2016 PLACE Lite study that estimated 87,782 SW. SW HIV prevalence is estimated between 1.7-6.3% across five provinces. Per IBBSS 2012, only 21-52% of SW had access to an HIV test within the last 12 months, and between 86-95% of SW reported discrimination in health services. Between 61-92% of SW reported using a condom at most recent commercial sexual intercourse, and 6-23% in most recent non-commercial sexual intercourse.

Migrants living in the DR, most of who are of Haitian descent, are estimated at 458,233 (National Immigrants Survey, 2012). A secondary analysis of the DHS indicated that HIV prevalence of those who self-reported as "born in Haiti" was 3.5%. Per the IBBSS 2012, HIV prevalence among migrant

SW and migrant construction workers was 5.4% and 4.6%, respectively. Only 35.3% of migrant SW and 13.1% of migrant construction workers had access to an HIV test within the last 12 months, and only 48.8% of migrant SW and 18.5% of migrant construction workers reported accessing regular medical care.

The DR military population is approximately 64,000 individuals (91% male). HIV prevalence is estimated at 0.6%, based on a convenience study (DOD KAP study/2010). Military hospitals in Santo Domingo reported 800 patients in HIV care and treatment services, of which approximately 35% were active duty military. Gaps in supply chain, stigma-free care and data collection/use have been observed at both military hospitals.

Table 2.1.1 Key National Demographic and Epidemiological Data

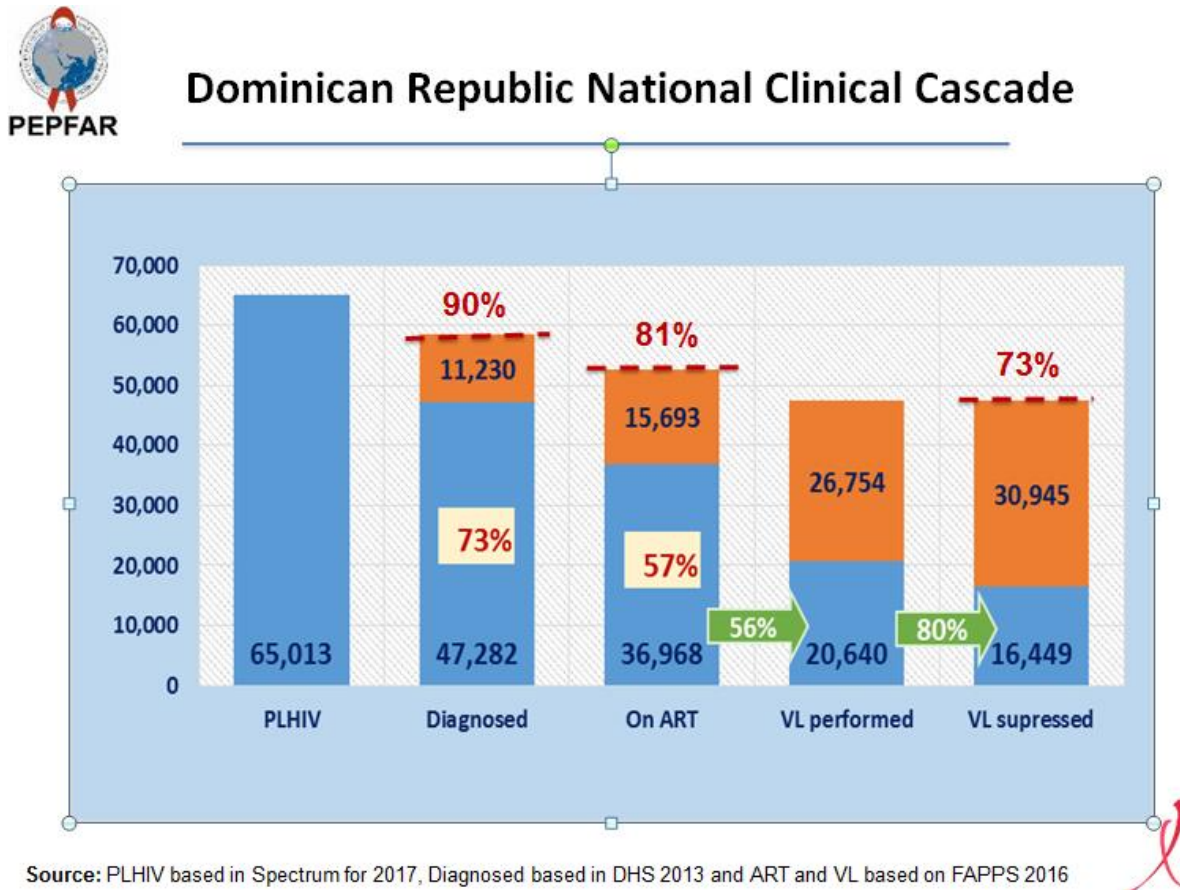
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	10,727,199	100%	1,553,283	14%	1,608,849	15%	3,738,499	35%	3,826,568	36%	United Nations Dept. of Economic and Social Affairs, 2017
HIV Prevalence (%)		0.8		N/A		N/A		0.7		0.9	DHS 2013 *15-49yrs
AIDS Deaths (per year)	2,110		N/A		N/A		N/A		N/A		Spectrum 2017
# PLHIV	65,013		647		657		32,178		31,531		Spectrum 2017
Incidence Rate (Yr)		0.04		N/A		N/A		N/A		N/A	Spectrum 2017
New Infections (Yr)	2,389										Spectrum 2017
Annual births	200,404	N/A									DR Health Statistics MOH 2014
% of Pregnant Women with at least one ANC visit	N/A	N/A	N/A	N/A			N/A	N/A			
Pregnant women needing ARVs	N/A	N/A									
Orphans (maternal, paternal, double)	N/A		N/A		N/A		N/A		N/A		
Notified TB cases (Yr)	3,847		N/A		N/A		N/A		N/A		National TB Program 2016
% of TB cases that are HIV infected	908	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National TB Program 2016
% of Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	124,472	N/A									CONAVIHSIDA-UNAIDS 2010, updated 2015
MSM HIV Prevalence	3.9-6.9 & 3.9	N/A									IBBSS 2012 & PLACE 2014
Estimated Population Size of FSW	91,171	N/A									Focus Group 2000 CONAVIHSIDA (update 2014)
FSW HIV Prevalence	1.7-6.3 & 2.5	N/A									IBBSS 2012 & PLACE 2014
Estimated Population Size of PWID	N/A	N/A									
PWID HIV Prevalence	N/A	N/A									
Estimated Size of Migrant Population	458,233	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Immigrants Survey 2013
Migrants reported "born in Haiti" Prevalence	3.5	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	Secondary analysis of DHS 2013

HIV Clinical Cascade

To develop a national clinical cascade, the national electronic HIV patient monitoring system (FAPPS) as of the end of calendar year 2016 and the estimated PLHIV from Spectrum 2017 were used. In addition, the 2013 Demographic Health Survey was used to estimate the number of HIV-positive individuals that knew their status. Finally, viral load data come from the National Reference Laboratory, the only location for viral load testing countrywide.

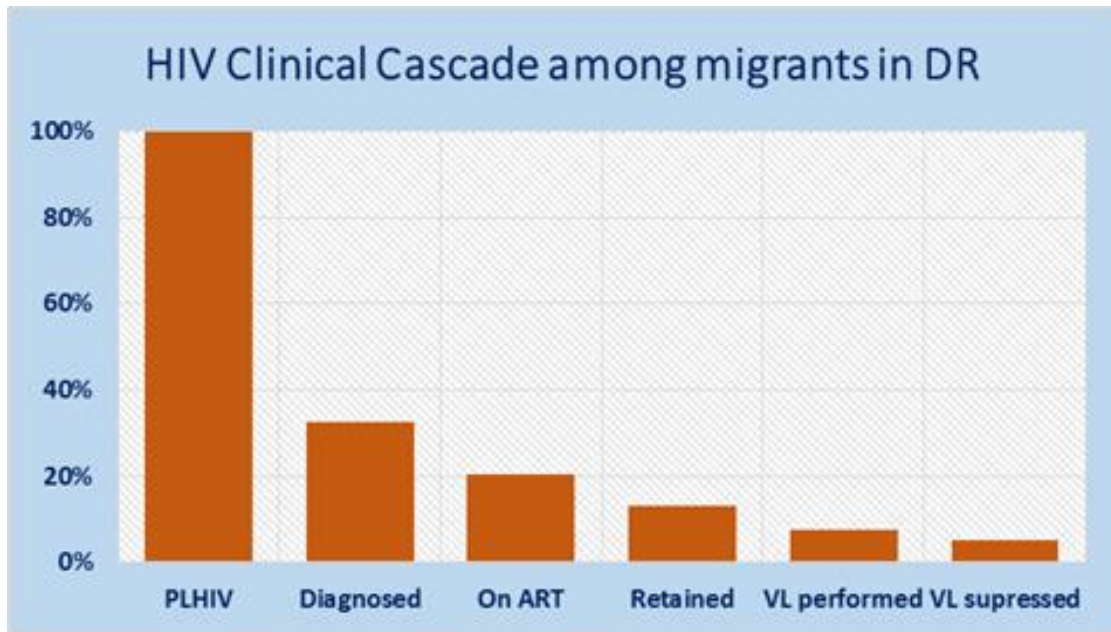
Graph 1: Dominican Republic national clinical cascade

Chart 2.1.2: Dominican Republic National Clinical Cascade



In FY 2016, identifying clinical cascades by population was not possible through the national system. With the exception of Haitian nationals, the FAPPS database did not capture population categorization information. The graph below highlights the gaps in addressing the HIV epidemic among Haitian nationals, particularly in treatment adherence and retention (as evidenced by the low viral load suppression).

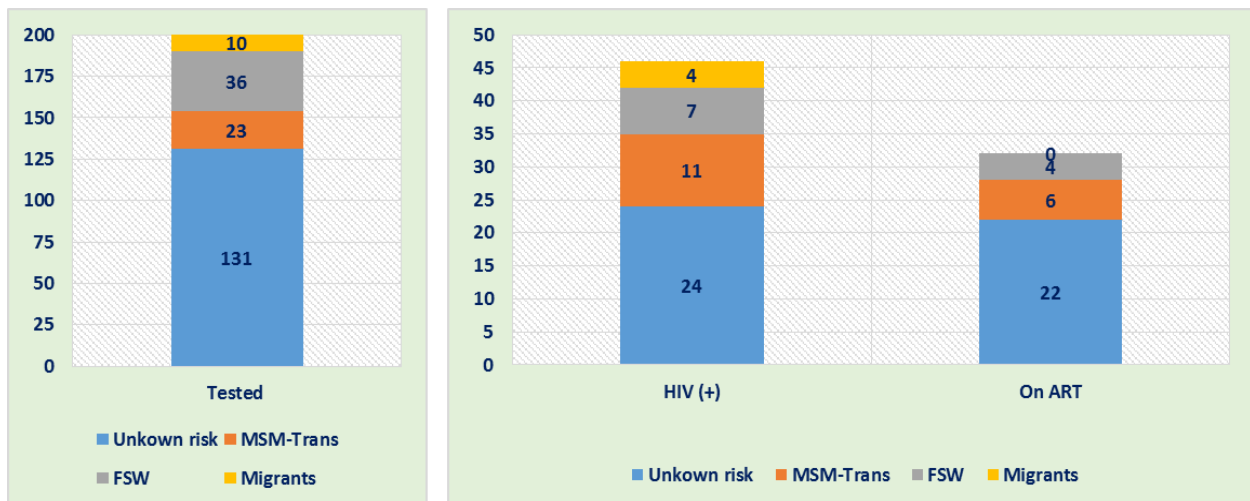
Chart 2.1.3: Dominican Republic clinical cascade among Haitian nationals



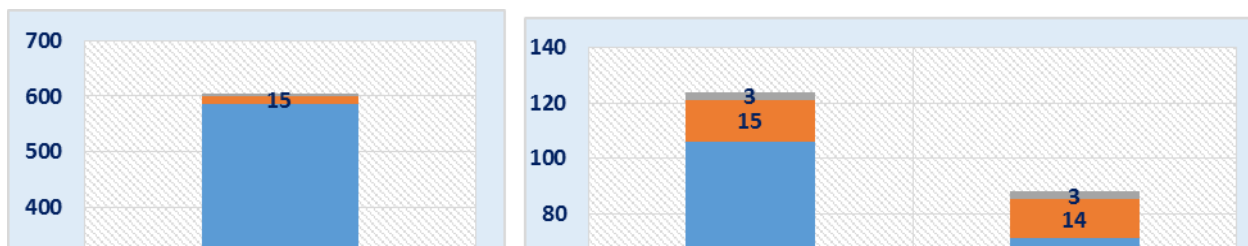
In FY 2017, population-specific cascades were only available at the nine PEPFAR-supported facilities that have instituted a parallel reporting structure. This experience has been translated into a formalized restructuring of FAPPS. Currently, PEPFAR-supported sites are using a FAPPS-sponsored paper form to collect this information. In Q3 of FY 2017, the form is anticipated to be rolled out countrywide to allow national population-specific cascades. The graphs below highlight population-specific clinical cascades at two sites – one NGO and one public sector – in Q1 FY 2017.

Chart 2.1.4: Population-specific clinical cascades at two PEPFAR-supported sites in Q1 FY 2017

COIN: Q1 FY 2017 HIV Clinical Cascade



Centro Sanitario: Q1 FY 2017 HIV Clinical Cascade



HIV Testing Services (HTS)

National HTS numbers reported represent the number of tests performed (rather than individuals tested). In 2015, 463,320 HIV tests were performed, of which 10,783 (2.3%) were HIV-positive (National Health Services, 2015). Of the tests performed in 2015, 147,511 were among pregnant women, of which 2,227 (1.5%) were HIV-positive. In FY 2016, PEPFAR-supported sites performed 84,352 HIV tests, of which 3,986 (4.7%) were HIV-positive.

During Q1 of FY 2017, the overall HIV testing yield was 4.3%. PEPFAR-supported facility-based testing yield was 8.2% while community-based testing yield was 2.0%. Facility-based testing yield varied greatly in the nine reporting facilities, ranging from 4% to 32%. Community-based testing yield was 2.0% for migrants, 1.9% for SW, and 1.5% for MSM/TG.

Viral Load Testing

In 2016, the National Reference Laboratory registered 20,640 unique clients with a viral load test. Of those tested, 80% demonstrated viral load suppression. Despite only one location in the country providing viral load services, the laboratory's capacity exceeds the country's needs. The reason for a sub-optimal percentage of clients with a viral load result stems from the logistics required for sending samples to the capital city, the untimely delivery of viral load results, and the lack of a centralized laboratory information system to document tests and results.

TB/HIV Co-Infection

The DR has one of the highest TB and multi-drug resistant TB rates in the Americas. In 2016, through the PEPFAR-supported electronic national information system, the National TB Program reported 3,847 TB cases, of which 3,656 (96%) received an HIV test and 908 (25%) were found to be co-infected. Collecting information and reporting on TB testing within HIV clinics continues to be a challenge.

Key Policy Update

The current GODR treatment guidelines, which were launched in August 2016, initiate ART at CD4<500 with immediate initiation for MSM, SW, intravenous drug user, pregnant women, adults >50 years of age, Hepatitis B or C co-infection, and sero-discordant couples. The Minister of Health approved for Test & START at 11 PEPFAR-supported clinics starting on October 1, 2016. The GODR has indicated its desire to revise the clinical guidelines to Test & START by 2018. Differentiated models of care, including multi-month scripting, same day initiation, and community-based ART distribution, are being discussed and some operational guidelines for alternative service delivery models are expected by the end of FY 2017.

Pre-exposure prophylaxis (PrEP) has not yet been utilized as a prevention intervention in the DR. To assess feasibility and acceptability, PEPFAR will support a pilot of 150 MSM in Santo Domingo in COP 2017. The pilot will be implemented at a NGO clinic and will be closely managed in collaboration with the National Health Service (SNS in Spanish).

Major Programmatic and System Gaps and Barriers

Despite important progress in several technical areas, the country response still faces significant challenges in its overall efficiency. Health workforce weaknesses present serious limitations, including insufficient provider performance measures, inequitable distribution of health workers, high health worker absenteeism, inadequate clinical capacity, and provider stigma, discrimination and disrespect towards PLHIV. Simultaneously, weak information systems and nascent laboratory infrastructure, particularly in the transport of viral load samples, creates barriers to adequate monitoring of patient care. The aforementioned challenges, coupled with a fragile supply chain management system that has historically lacked accurate site-level commodity forecasting and appropriate warehousing techniques, greatly jeopardize any advances in the treatment program.

Financing the National Response

Maximizing limited resources is critical if the GODR intends to meet its ambitious targets for HIV epidemic control. This requires the coordination of key stakeholders, including Ministry of Health, Ministry of Finance, donors, cooperating agencies, and civil society partners, to ensure continued analysis of investments based on financial projections and careful forward planning.

As illustrated in Graph 4, the GODR has assumed increasing financial responsibility in supporting the national HIV response. In 2015, for the first time, the GODR independently procured all HIV commodities without external resources. In 2017, the GODR met the projected need of \$11.5 million after significant PEPFAR advocacy. Given that annual financial projections continue to rise, PEPFAR will support a limited set of domestic resource mobilization strategies to sustain the GODR's financial leadership in the national response.

Chart 2.1.5: GODR Resources to HIV Commodities (2010-2017)

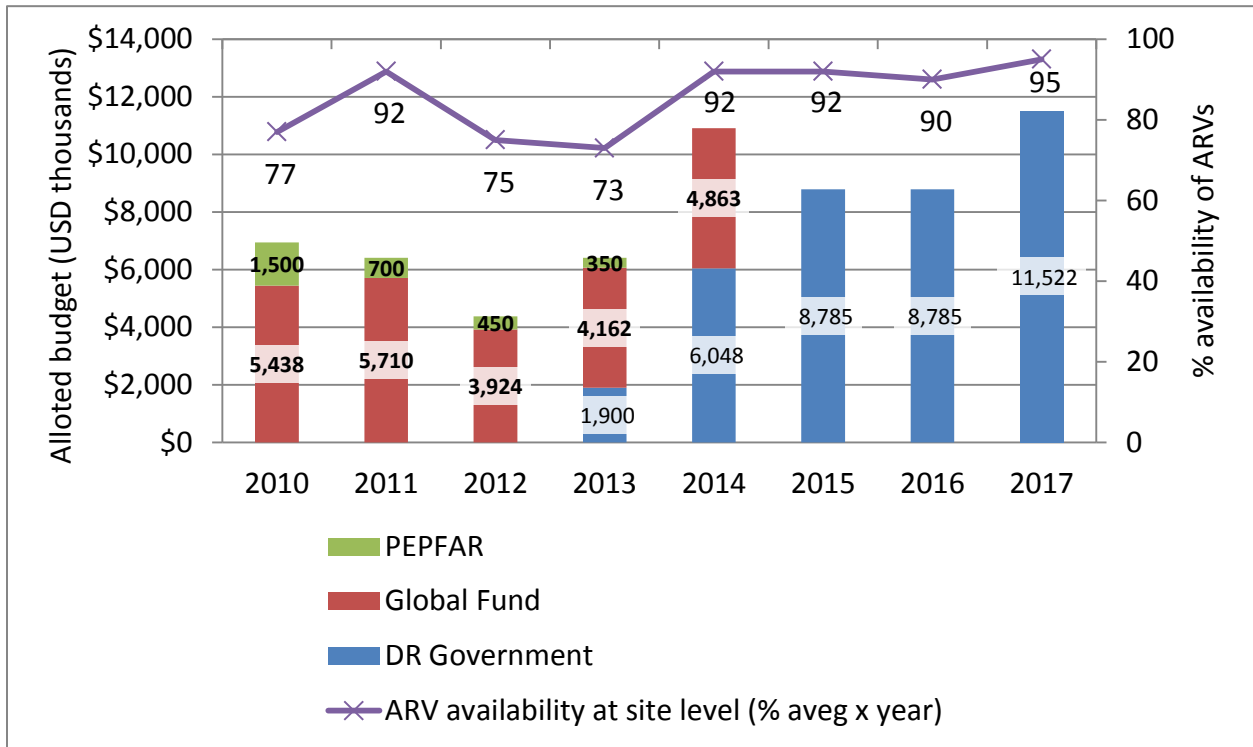
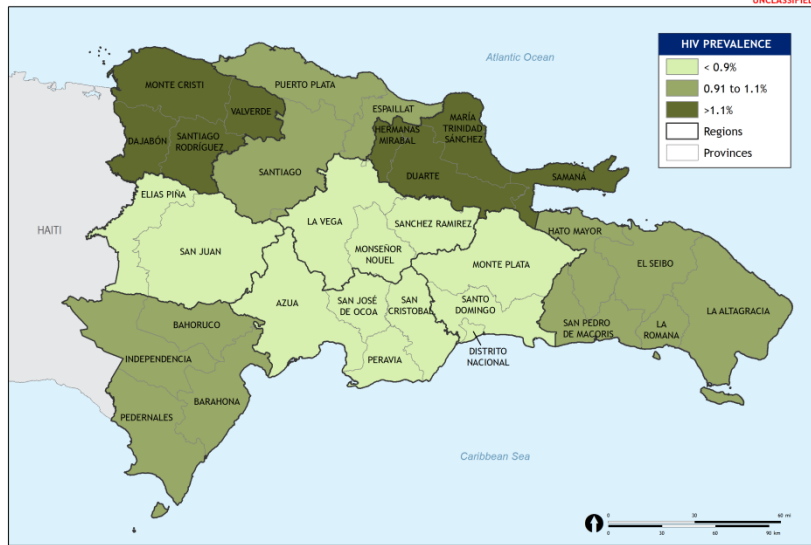


Table 1.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression (January – December 2016)

	Total Population Size Estimate (#)	HIV Prev (%)	Total PLHIV (#)	HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
				On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	10,727,199	0.8% (15-49yrs)	65,013	36,968	29,134	16,449	463,320	10,783	N/A
Population less than 15 years	3,162,132	N/A	1,330	922	668	272	N/A	N/A	N/A
Pregnant Women	N/A	N/A	N/A	N/A	N/A	N/A	147,511	2,227	N/A
MSM	124,472	3.9-6.9	7,174	N/A	N/A	N/A	N/A	N/A	N/A
FSW	91,171	1.7-6.3	2,887	N/A	N/A	N/A	N/A	N/A	N/A
PWID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Pop (Migrants)	458,233	3.5% (15-49yrs)	13,547	3,126	1,846	863	N/A	N/A	N/A

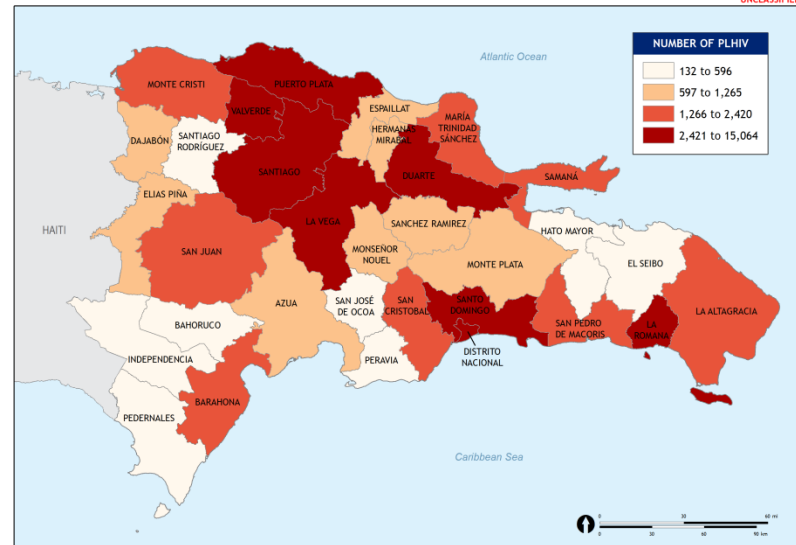
DOMINICAN REPUBLIC
HIV PREVALENCE BY REGION, 2016



Names and boundary representation are not necessarily authoritative

UNCLASSIFIED

DOMINICAN REPUBLIC
PLHIV BY PROVINCE, 2016



Names and boundary representation are not necessarily authoritative

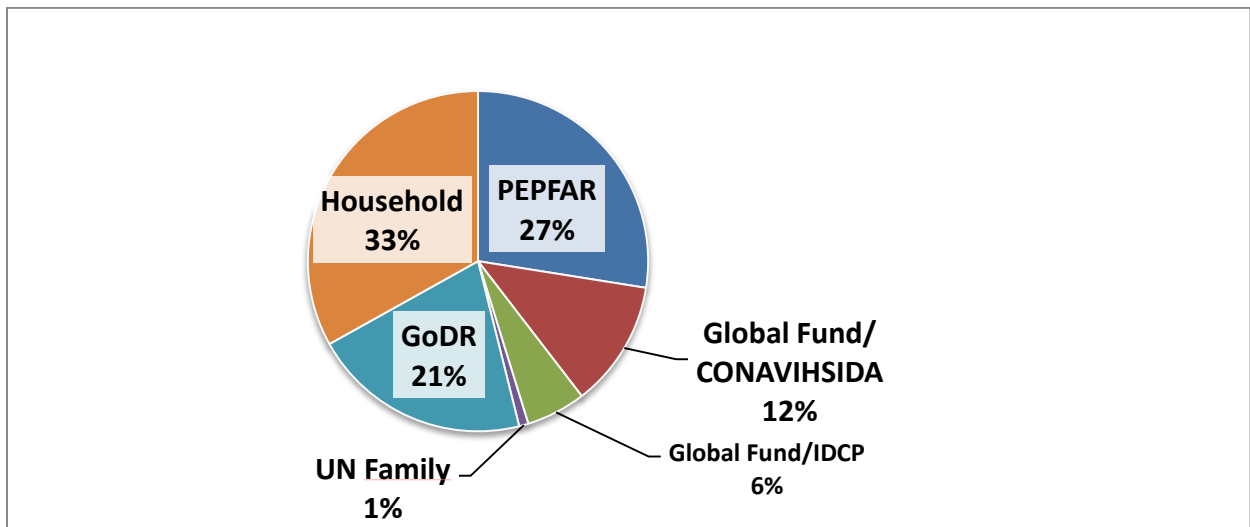
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2.2 Investment Profile

A major positive development in the national HIV financing picture has been the shift in ARV drug and commodity financing from external to domestic financing since 2013. Through the concerted effort of national HIV stakeholders, including a well-coordinated public advocacy campaign from civil society, the Ministry of Health’s central commodity budget increased from \$8.8 million to \$11.5 million for 2017. The PEPFAR program and its technical partners have provided critical support in forecasting and costing HIV commodity needs and will continue to support the national HIV response in advocating for increased resources to advance 90-90-90 goals and continued expansion of treatment guidelines toward universal Test & START.

However, broader HIV financing data describing countrywide HIV investments in the DR continues to be scarce. The 2012 UNAIDS-NASA supported report, (MEGAS in Spanish), continues to be the most comprehensive HIV financial report to date. The UNAIDS HIV expenditure study, known as PORTIA, is still unpublished (see Graph 5 below). In addition, the 2015 Global Fund (GF) Concept Note, which reported national HIV financial information was referenced.

Chart 2.2.1: HIV expenditures by funding source, PORTIA 2014 (working draft)



Given that the 2014 PORTIA draft report shows only broad categories of expenditures, the table below has been inserted in lieu of Table 2.2.1. (NOTE: Tables 2.2.2 – 2.2.4 are not applicable for the country program).

Percentages of National Expenditures by Category: 2008 and 2012

Program Area	2008	2012
Prevention	25%	39%
HIV care, treatment, and support	41%	36%

Systems strengthening	33%	22%
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With declining GF levels, the HIV financial landscape is changing. The Concept Note was funded at \$17.6 million over three years (2016-2018). Based on the GF Board’s decision in November 2016, the allocation of HIV resources for the 2017-2019 period has been set at \$15,994,956. Fortunately, the GODR has been assuming increasing financial responsibility for the HIV response, as noted earlier with their financial independence in covering the costs of all HIV commodities.

GF’s focus is similar to PEPFAR—the provision of high quality services to key and priority populations in geographic areas disproportionately burdened by the HIV epidemic. Under the current HIV grant and reporting requirements, GF’s resources are primarily focused on community prevention and HTS against national-level targets. PEPFAR is working with GF to create data sharing platforms to help improve the geographic focus and yield of these activities for capturing GF results, ensuring these resources are best leveraged to more rapidly enroll HIV-positive individuals into the ART program.

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

2.3 National Sustainability Update

The PEPFAR program conducted the Sustainability Index and Dashboard (SID) stakeholder-led analysis in COP 2016, and the program plans to carry out an update during the COP 2018 planning cycle. Key findings were that: (1) the majority (9/15) of elements scored yellow; (2) one element was scored red (laboratory); (3) both elements under the domain “strategic investments, efficiency, and sustainable financing” were scored green; and (4) there was consensus that the GODR has strong planning, coordination, policies, and governance associated with the HIV response.

PEPFAR has historically invested in many of the yellow- and red-highlighted elements with the expectation of a corresponding positive trend should the tool be reapplied. Systems-level needs identified included human resources for health, laboratory strengthening, and supply chain management. As such, these remain priorities for PEPFAR support and were put forward by the Office of the U.S. Global AIDS Coordinator as one of two strategic outcomes for COP 2017.

As part of the COP 2016 strategy, PEPFAR re-directed national-level investments to focus on addressing site-level systems issues. Relevant technical assistance partners were expected to align site-level work plans with service delivery partners under SNS’ leadership. Additionally, the PEPFAR team jointly conducted with SNS a site-level baseline assessment (in addition to SIMS and MER data) to measure site-level health system improvements over time which collectively

contribute to epidemic control. The program will maintain a limited set of national health systems strengthening activities that remove institutional barriers to quality site-level services and that facilitate the rapid expansion of KP/PP services.

2.4 Alignment of PEPFAR investments geographically to disease burden

The PEPFAR portfolio undertook a large geographic pivot in COP 2015 / FY 2016, narrowing focus to six relatively high-HIV burden provinces. In COP 2016 / FY 2017, the portfolio further narrowed its geographic and programmatic focus to 4 provinces, with a re-orientation of above-site systems activities toward intensified investments at 9 facilities and 2 mobile clinics. Therefore, analysis of the FY 2016 Expenditure Analysis (EA) should be done with an understanding that there is some lag in program expenditures reflecting the current strategy.

Nonetheless, in figures 1.4.1 and 1.4.2 (and charts 1.4.1 and 1.4.2), the COP 2016 focus provinces, represented by the dark green bars, show general alignment between PEPFAR expenditures and the geographic focus moving forward. In analyzing the provincial outliers in estimated expenditures per person living with HIV during FY 2016 (figure 1.4.1), it should be noted that the PEPFAR portfolio closed out clinical and community services in the light green-highlighted provinces, which led to high provincial expenditures per PLHIV (figure 1.4.1) against relatively low overall expenditures. Santo Domingo's expenditures appear relatively high per PLHIV, though this can be accounted for in part by its function as the headquarters for implementing partners and also by the fact that the capital city provides services to many PLHIV who travel to the province for services.

Figure 2.4.1

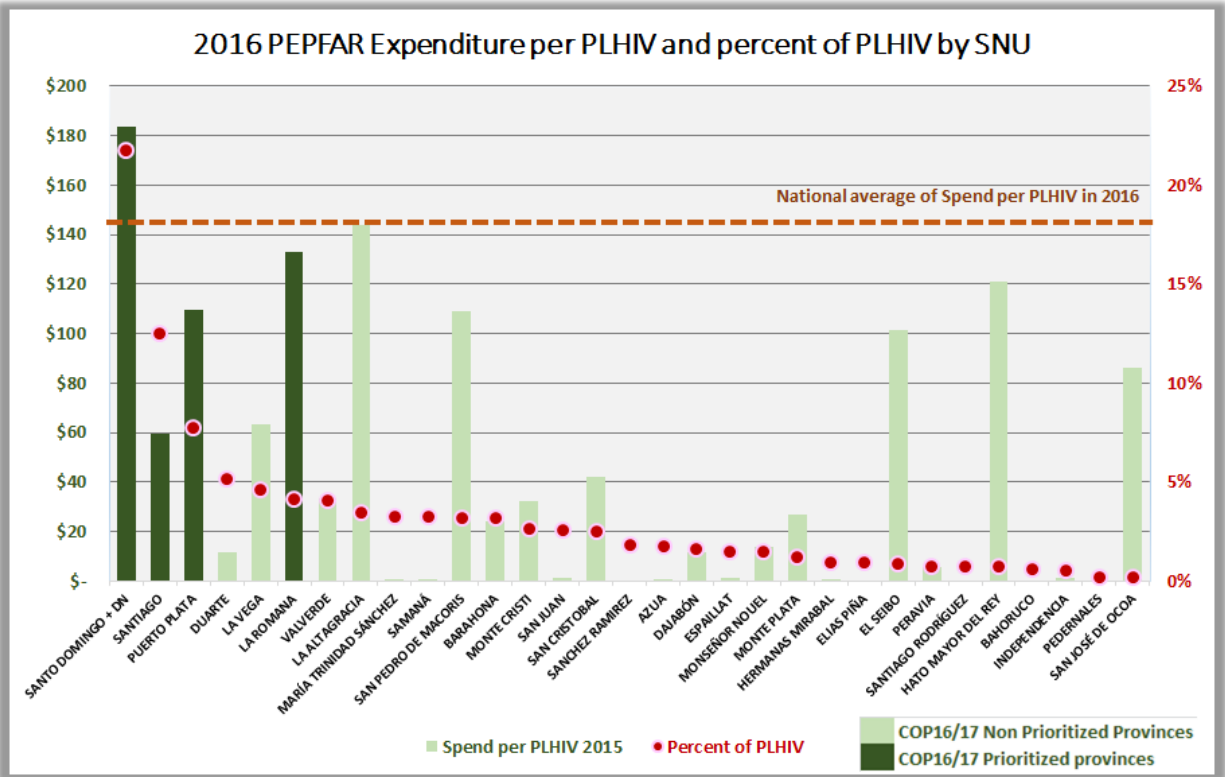


Figure 2.4.2

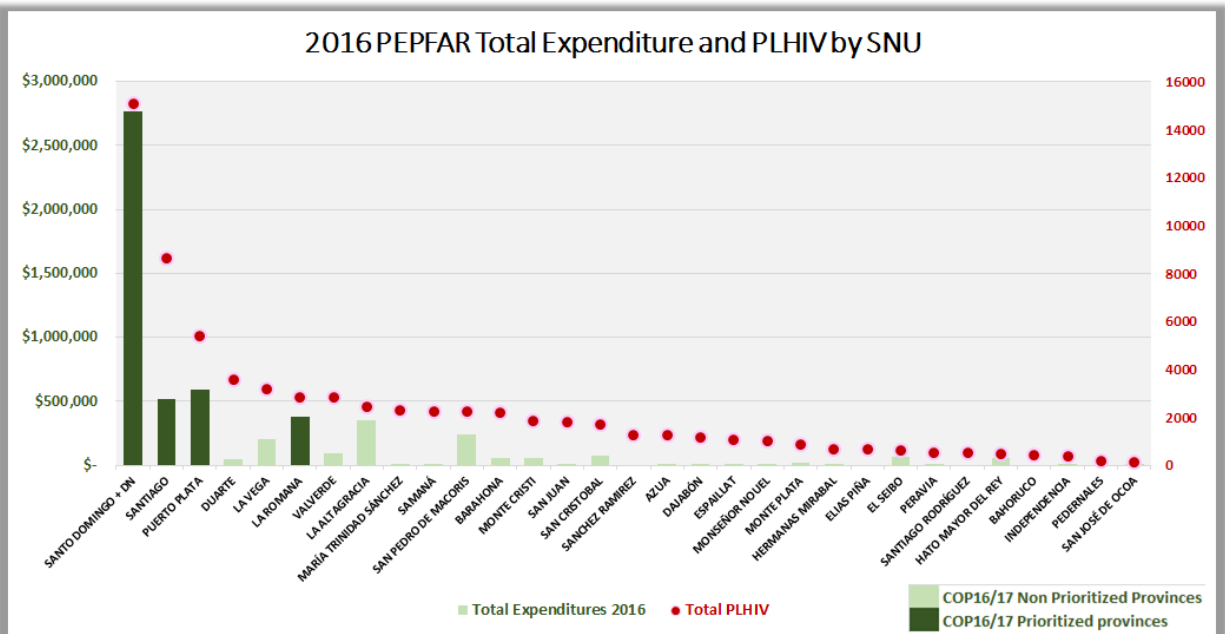


CHART 1.4.1 – PLHIV BY PROVINCE, 2016

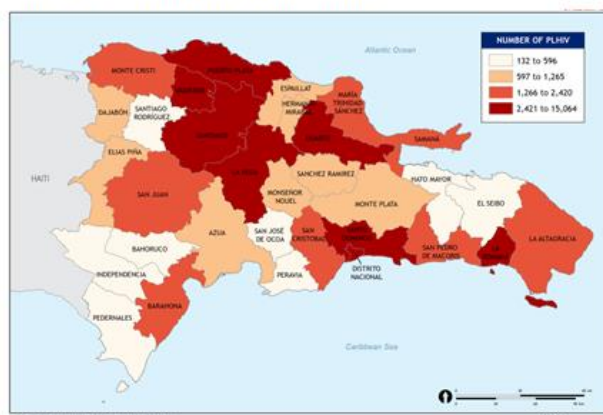
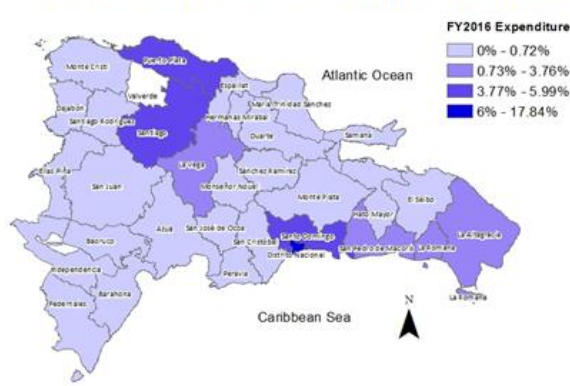


CHART 1.4.2 – PEPFAR FY 2016 EXPENDITURES BY PROVINCE



2.5 Stakeholder Engagement

PEPFAR recognizes that it plays a unique role as both: (1) a collaborator in designing, implementing, and evaluating an effective PEPFAR program within the national HIV strategy; and (2) a convener of key national stakeholders needed to put forward and resolve evidence-based programmatic, policy, and technical issues to advance HIV services that meet the needs of affected populations in the country. PEPFAR has formed technical working groups under SNS and

Constituency	Date	Pre/Post-COP Engagement
GODR	3 Aug 2016	COP16 Stakeholders meeting with the National Health Service (SNS)
GODR, Civil Society	8 Sep 2016	COP16 Stakeholders meeting with Civil Society, Regional and Clinic Health Service Staff, Implementing Partners (including launch of Baseline Assessment initiative)
GODR, IPs	Aug-Sep 2016	Launch of 4 Implementing Partner Working Groups – “Mesas Técnicas” – in Service Delivery, Capacity Building/HR, Strategic Information and Lab
GODR, UN, Global Fund	13 Sep 2016	Launch of UNAIDS-facilitated PEPFAR-Global Fund Implementation Coordination Committee
GODR, Civil Society	21-22 Sep 2016	Preliminary stakeholder engagement on global concepts and practices of ‘differentiated models of care’
GODR, Civil Society, UN	Sep – Nov 2016	Successful multi-stakeholder collaboration on national ARV budget for 2017
GODR, Civil Society	2 Dec 2016	High-level ceremonial launch of Test and Start and COP16 at PEPFAR for World AIDS Day
GODR, Civil Society, IPs	9 Dec 2016	FY16 Q4 stakeholders meeting, including portfolio reviews
GODR, IPs, UN, Global Fund	18-19 Jan 2017	2-day SNS-led workshop on partner activity mapping and work plan coordination
GODR, Civil Society	27 Jan 2017	High-level stakeholder engagement on COP16-17 strategy
GODR, Civil Society, IPs	1 Feb 2017	Stakeholder engagement on COP17 strategy and FY 2017 Q1 data
UN, Global Fund	Ongoing	PEPFAR-Global Fund Implementation Coordination Committee
GODR, IPs, UN, Global Fund	Ongoing	Mesas Técnicas – technical working groups for coordinating and executing the COP strategy
GODR, IPs, UN, Global Fund	Ongoing	Quarterly COP/POART stakeholder engagement meetings

also furthered PEPFAR-Global Fund implementation and data sharing and coordination covered under a recently signed memo of understanding (MOU). The table below illustrates the ongoing COP-related engagement the PEPFAR program has convened or supported in the development and implementation of the COP 2017 strategy.

In FY 2018-2019, in response to stakeholder engagement and feedback for COP17, PEPFAR will assist GODR to: (1) expand a quality KP/PP package of services to HIV facilities across the country; (2) update national treatment

and other guidelines for universal Test & START; (3) complete the rollout of Test & START countrywide; (4) develop operational guidelines/policies in support of differentiated models of care; (5) support the national HIV program to develop policies and protocols to pilot PrEP; and (6) create an evidence base and communication plan to advocate for increased HIV and health sector resources. In response to feedback from civil society groups, PEPFAR will facilitate stakeholder workshops to: (1) address concerns around self-identification of KP/PP groups in FAPPS; (2) engage civil society in defining and developing differentiated models of care to strengthen civil society's role in improving the clinical cascade and community-facility linkage; and (3) continue to support civil society's role as a pillar of the long-term national HIV response.

3.0 Program Activities for Epidemic Control

3.1 Description of strategic outcomes

For COP 2016, the PEPFAR team made a significant pivot by rationalizing its geographic scope while proposing two KP/PP service delivery models that would be complemented by system-level interventions at the site and above-site levels. The implementation of this new strategy was initiated in October 2016. The two proposed strategic objectives provided in the FY 2017 PEPFAR Planned Country Allocation and Strategic Direction letter confirmed that the PEPFAR program should continue with the same strategy, albeit with some specific refinements.

The first strategic objective focuses on site-level activities through a twinning model and mobile clinics (*see Appendices C and D*). PEPFAR site-level support includes personnel (largely at NGO sites and mobile clinics), clinical training and supervision, adherence and psycho-social support and counseling, population-specific materials and interventions, data collection and use, and continuous quality improvement interventions. There is also a significant site-level community aspect, ranging from risk-reduction counseling and HIV testing to community-based care and support services.

In COP 2017, the PEPFAR team will use four different HIV testing modalities to improve the efficiency of identifying new HIV-positive clients that can be linked to ART. Within facility-based testing, the program will support provider-initiated testing and counseling for those individuals that present with signs and/or symptoms of HIV infection. There will also be an expansion of partner notification testing among clients seeking and receiving HIV treatment from four NGO facilities to all PEPFAR-supported sites. For MSM and SW community-based testing, two-thirds of HIV testing will use peer promoters while one-third will use an index client social network strategy to recruit high-risk individuals for HIV testing. Among migrants, 90% of testing will be achieved through mobile testing units (separate from mobile clinics), with the remaining tests utilizing an index client approach to further penetrate these migrant communities.

Despite a heavy focus on the HIV yield of testing activities, the ultimate goal of all HIV testing interventions is to ensure successful linkage of all newly diagnosed clients to immediate initiation of HIV treatment. In two of the four PEPFAR-supported provinces (Santo Domingo and Santiago), PEPFAR does not work at even half of the existing facilities that provide HIV services. It is therefore likely that some percentage of individuals diagnosed through PEPFAR-financed testing activities will select to receive their HIV treatment at non-PEPFAR-supported facilities. In COP 2017, all HIV testing partners will be required to report (outside of DATIM) successful linkages to HIV treatment, even when clients opt to attend non-PEPFAR sites.

In addition to the traditional site-level facility and community direct service delivery activities, the portfolio is structured to address a range of systems issues that are present at the site that jeopardize the quality of service provision and the ability to meet ambitious targets. This includes an adequate supply of trained health workers, management processes and sufficient commodities, information systems capable of monitoring clinical outcomes, and adequate laboratory capacity.

Site-level performance will be monitored through and by achievement of targets and SIMS indicators, which will be greatly enhanced by the emerging capacity to monitor and track specific populations through the clinical cascade. These critical data will provide partners with needed information to determine how well the program is meeting the needs of KP/PP.

The second strategic objective highlights the importance of addressing systemic challenges that, while present at the site, require above-site interventions to permanently resolve the issue. This includes institutionalizing many of the site-level solutions that will be essential for the GODR's expansion of the KP/PP service package in the coming years. Activities include supporting viral load rollout, improving forecasting and timely distribution of ARVs, reducing provider stigma and addressing gender-based violence, and increasing domestic resources and coordination between MOD and MOH to fill existing prevention and treatment gaps. Each of these is essential to the sustainability of PEPFAR investments. Above-site activities are driven by challenges that are faced during site-level implementation that require a more systems-wide solution. Performance of above-site activities will be monitored per the FOIT benchmarks.

To ensure that PEPFAR investments and models are utilized to inform and improve the national response, continuous dialogue and diplomacy is required. In addition to regular meetings with high-level GODR decision-makers, PEPFAR will continuously review its achievement of targets, catchment area and provincial coverage levels, and the benchmarks described in the FOIT. Upon meeting thresholds described in the structured plans, PEPFAR will transition support from well-performing facilities to other high volume facilities in high burden geographic areas. Simultaneously, PEPFAR will be evaluating and costing its KP/PP package and documenting its quality improvement process to prepare the GODR for nationwide service expansion.

3.2 Site level (rationale, geographic and population prioritization)

Given the nature of a concentrated epidemic, PEPFAR plays a critical role in demonstrating how quality service provision to PLHIV, and specifically KP/PP, is critical for the broader success of the national HIV response. Since KP/PP service provision and focus often provide host governments with both technical and political challenges, PEPFAR's investments offer a roadmap for addressing many of the site-level challenges while simultaneously providing a strong economic and health argument for investing in HIV. The portfolio has also been constructed to present the GODR with two models that will generate critical data on how to utilize a quality improvement process to implement a comprehensive KP/PP package that can be expanded nationwide.

In COP 2017, PEPFAR proposes to continue its geographic focus in four provinces (Santo Domingo/Distrito Nacional, Santiago, Puerto Plata, and La Romana). These provinces represent four of the six highest in HIV burden and are home to some of the largest size estimates for key and priority populations. The total number of PLHIV in the country come from the 2017 Spectrum model. Population size estimates come primarily from the 2013 DHS, 2012 IBBSS, 2013 PLACE study, and 2016 PLACE Lite study that established national and provincial-level estimates of MSM/TG and SW populations.

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

- Santo Domingo/Distrito Nacional (SD/DN): The capital city and its surroundings are home to 33% of all PLHIV. In addition to the greatest burden of disease, the geographic area also has the largest population size estimates for all three PEPFAR focus populations. Provincial level ART coverage (66%) at end of FY 2016 may be misleading due to significant migratory patterns of clients receiving services outside their home province.
- Santiago: Home to the second largest city in the country, Santiago has the second largest number of PLHIV (10% of national total) and second largest number of key populations. The provincial ART coverage is 62% and the province struggles with one of the highest HIV prevalence among MSM (5.3%) and sex workers (3.5%). There are many rural agricultural areas, mainly inhabited by migrants, with higher needs of care services through mobile clinics.
- Puerto Plata: Puerto Plata has the third highest burden of PLHIV (6% of national total) and has a provincial ART coverage of 53%. A strong local NGO clinic in the province is well-placed for a twinning relationship with the neighboring public facility. Also, the province contains multiple rural and agricultural areas, inhabited by migrants, with higher needs of care services through mobile clinics.
- La Romana: La Romana has the sixth highest burden of PLHIV (5% of national total) and a provincial ART coverage of 73%. This is artificially inflated as similar to the capital, La Romana is a magnet for many people in the eastern part of the country. The province has arguably the strongest local NGO partner/clinic in the country. The clinic already serves as a model site for many health interventions and can strengthen its HIV activities to highlight how high quality services for KP/PP can translate into desired results. The province also faces one of the highest HIV prevalence among MSM (5.3%) and SW (4.4%).

PEPFAR supports the only two facilities that provide HIV services in Puerto Plata and La Romana. In Santo Domingo, PEPFAR supports 4 of 23 HIV facilities while in Santiago, PEPFAR supports 1 of 9 HIV facilities. It is also important to note that patient mobility greatly impacts ART coverage estimates by province. For example, in FY 2016 in La Romana’s two HIV clinics, 29% (713 individuals) of all registered clients receiving HIV services reported living in a different province while only a fraction of La Romana residents (16 individuals) could be found seeking services outside their home province. A rapid analysis would suggest that La Romana’s ART coverage would then drop from a projected 73% to 54% when accounting for the number of La Romana residents that are receiving HIV treatment over the total estimated number of HIV positive individuals living in La Romana.

Despite challenges to account for mobility, the following table projects ART coverage by province over a four-year period. For 2016, actual numbers have been used. For 2017, historic growth at non-PEPFAR sites has been coupled with PEPFAR’s ambitious clinical targets. For 2018, the table and subsequent graph highlight the impact of the GODR expanding Test & START nationally (as has been discussed).

Table 3.2.1: Provincial ART Coverage (FY 2016 – FY 2018)

	2016			2017			2018		
	# of PLHIV*	ART^	ART Coverage	# of PLHIV*	ART%	ART Coverage	# of PLHIV*	ART^	ART Coverage
Santo Domingo	22,422	14,769	66%	22,212	18,744	84%	22,003	20,402	93%
Santiago	6,693	4,180	62%	6,630	4,706	71%	6,568	5,970	91%
Puerto Plata	3,900	2,064	53%	3,864	3,491	90%	3,828	4,437	116%
La Romana	3,269	2,381	73%	3,239	3,513	108%	3,208	4,222	132%

*2017 Spectrum estimates for 2016-2018

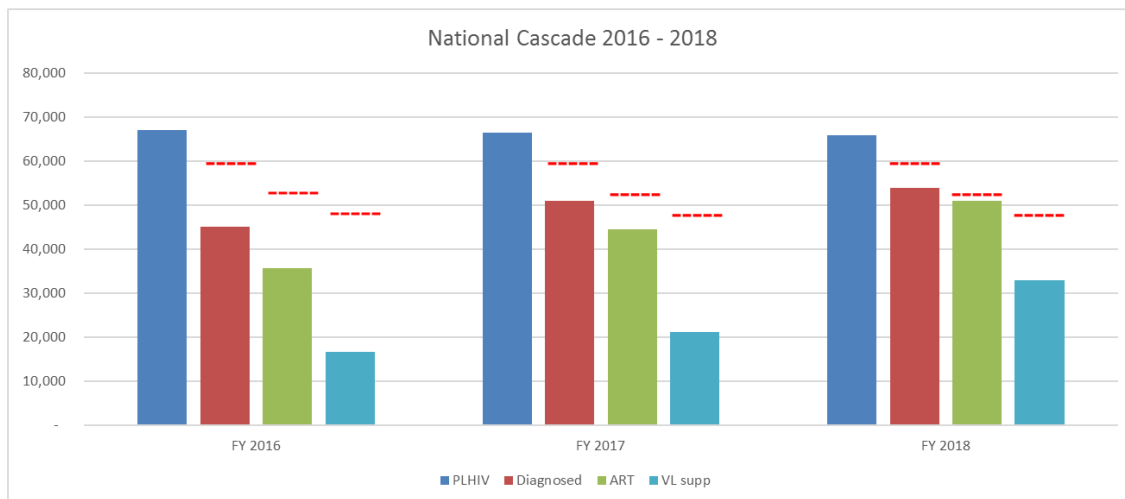
^FAPPS as of September 30, 2016

% Annual 10% increase of ART clients at all non PEPFAR-supported sites + PEPFAR site-level annual targets

†Expansion of Test & START nationally (full transition of pre-ART to ART in 2018)

Using the same assumption as Table 3.2.1, the graph below highlights the impact of PEPFAR and the national transition to Test & START in 2018.

Chart 3.2.2: National Clinical Cascades* (FY 2016 – FY 2018)



PEPFAR has strategically focused its site-level investments predominately within clinical services as a means of leveraging GF's focus on community-based activities. By closely coordinating efforts, the country's two largest donors can help maximize external resources and their contributions to the national HIV response.

In COP 2017, PEPFAR proposes to continue the use of two service delivery models to transfer a defined quality package of services for KP/PP that will facilitate the GODR's ability to achieve HIV epidemic control (90-90-90) by 2020. Each model will be well documented, evaluated, and costed to allow for a successful transition to the host government and an expansion of services based on lessons learned (see Appendices C and D for the structured plans for both service delivery models).

PEPFAR did not target for site expansion in FY 2018. Upon meeting established site-level benchmarks (which may take place in FY 2018 or FY 2019), high-performing sites may be transitioned to a less intensive level of support, allowing additional sites to be considered.

3.3 Critical above-site systems investments for achieving sustained epidemic control

The national HIV response continues to struggle with low ART coverage in certain provinces, a product of challenges with adopting new guidelines and policies as well as tailoring interventions to the marginalized populations most in need. Some of these issues can be addressed at a site-level, of which PEPFAR has significant investments to remedy site-level bottlenecks to service delivery quality. However, in a concentrated epidemic where the ARVs are entirely financed by the host government, there are genuine opportunities to strengthen above-site systems to promote and support a government-owned epidemic control response.

When site-level challenges are detected, implementing partners are expected to identify immediate solutions that will ensure that the portfolio's goals and targets can be met. In some cases, a long-term solution requires systems' changes at various levels. Institutionalizing human resources management, supply chain administration, gender-based violence response, strategic information, and laboratory systems are fundamental to successful HIV programming at the site-level. This requires interventions with provincial and regional authorities who provide direct support to facilities as well as national actors who influence policies and guidelines.

Investments in these areas are not intended to be indefinite. Once specific bottlenecks have been remedied and needed capacities have been transferred, the maintenance costs will be manageable and the technical knowledge will be sufficient for the GODR to more independently address the HIV epidemic. One critical component to ensure a sustainable response will be strengthening domestic resource mobilization efforts, particularly given the country's demonstrated willingness to assume the full cost of HIV commodity procurement. PEPFAR has proposed a limited set of interventions focused on increasing the HIV fiscal space to complement a substantial two-year investment by USAID's Sustainable Finance Initiative. Another is strengthening the Ministry of Defense Health System's relationship with the Ministry of Health to ensure they are included in ARV and HIV commodity procurement plans, they provide and receive data critical to programmatic decisions and they are trained to provide stigma-free care.

3.4 Description of how PEPFAR will support greater sustainability

Despite significant investments in directly supporting site-level activities to improve the quality of KP/PP services, perhaps PEPFAR's greatest long-term impact will be measured in its ability to promote greater sustainability of the national response. Multi-stakeholder global health diplomacy, ranging from direct funding relationships between the USG and GODR to MOUs between PEPFAR and GF prime recipients to micro-network local NGO sustainability efforts, is an effective way of transcending more volatile and emotional national-level concerns, such as services for and government focus on KP/PP. The PEPFAR team has used the weight of the Ambassador's position to help springboard the approval of Test & START at PEPFAR-supported sites and has utilized its expanding relationship with UNAIDS as an opportunity to jointly advocate for a more rapid and aggressive government-led and -financed HIV response. By supporting both the GODR's ability to finance its approach to HIV epidemic control as well as novel options for a clearly articulated long-term role for civil society within the national response,

PEPFAR boasts a range of activities that will ensure that its current investments can be leveraged for nationwide scale-up of quality services.

4.0 Management and Staffing Considerations

The PEPFAR inter-agency team conducted in-depth reviews of staffing needs for COP16 and shifted some technical roles that would be required to support and oversee this new strategy. The balance between administrative/financial and technical management staff was reviewed, along with an analysis of staffing requirements associated with SIMS' efforts. Consistent with their respective agency operating mechanisms, CDC utilizes technical subject-matter experts in a "hands-on" approach to directly deliver technical assistance (TA), while USAID combines direct TA with the utilization of implementing partners, working under staff supervision. CDC delivers TA in laboratory management, quality assurance/quality control, and strategic information, while USAID supports supply chain management, human resources, condom program support, and domestic resource mobilization. Both agencies utilize a mix of local and international staff to manage their respective portfolios.

No new positions are proposed for COP 2017. USAID has one vacant position for an HIV Project Management Specialist. This position was posted in August 2016; however, a suitable candidate was not identified. The position description was revised with the intention of attracting a high-quality pool of candidates; it will be re-posted with the aim of having a selection in July 2017. The start date will be determined by required clearances. CDC currently has two vacant positions under recruitment. There are no vacant positions at DoD. The PEPFAR Coordination Office Deputy/Strategic Information position (approved in COP16) is currently vacant and on hold due to the hiring freeze. Due to long-term staffing vacancies and other personnel specific causes, USAID had accumulated a management and operations pipeline that will be applied for a portion of its CODB. CDC has converted several positions from institutional contract mechanisms to direct hire positions to reduce costs, and also will be applying pipeline for a portion of CODB. Overall, the inter-agency team does not anticipate significant changes to CODB, nor do they foresee any major obstacles to program implementation due to these vacancies.

APPENDIX A

A.1 Planned Spending in FY 2018

Applied Pipeline	New Funding	Total Spend
\$US7,750,000	\$US7,750,000	\$US\$15,500,000

PEPFAR Budget Code	Budget Code Description	Total Amount Allocated
MTCT	Mother to Child Transmission	
HVAB	Abstinence/Be Faithful Prevention	
HVOP	Other Sexual Prevention	\$1,441,900
IDUP	Injecting and Non-Injecting Drug Use	
HMBL	Blood Safety	
HMIN	Injection Safety	
CIRC	Male Circumcision	
HVCT	Counseling and Testing	\$1,724,563
HBHC	Adult Care and Support	\$1,002,715
PDCS	Pediatric Care and Support	
HKID	Orphans and Vulnerable Children	
HTXS	Adult Treatment	\$5,445,636
HTXD	ARV Drugs	
PDTX	Pediatric Treatment	
HVTB	TB/HIV Care	\$121,828
HLAB	Lab	\$741,787
HVSI	Strategic Information	\$282,270
OHSS	Health Systems Strengthening	\$2,136,917
HVMS	Management and Operations	\$2,602,384
TOTAL		\$15,500,000

A.2 Resource Projections

The PEPFAR Team embarked on an extensive review of FY 2016 EA. This formed the basis for all target-based budgeting decisions and the workbook utilized to complete the budgeting exercise has been uploaded into FACTS Info. The following briefly describes the team's approach.

1. The team decided to create for every program area a variable cost as well as two fixed costs – program management and strategic information. The variable costs were taken directly from FY 2016 EA, except for unique cases where future program activities were likely to differ dramatically from FY 2016.

2. The team combined FBCTS and CBCTS into a single UE/UB given that care targets are no longer reported and an individual UE/UB for this suite of interventions was not possible.
3. The team used FY 2017 targets as the denominator to calculate the site-level/variable UE portion of FBCTS/CBCTS from EA FY 2016 data. Given the significant shift in strategy between FY 2016 and FY 2017, the team strongly believed that the latter was more representative of the program scope and footprint than the results from the previous strategy.
4. The team elected to carry forward the FY 2017 prevention targets for FY 2018 and FY 2019 until more site-level Global Fund data has been received and analyzed. GF sets targets at a national level by population, although the in-country prime recipients have agreed to discuss more granular provincial level plans prior to the March COP Review. This workshop may lead to potential community-based prevention and HIV testing adjustments before COP 2017 finalization.
5. Facility- and community-based HIV testing UEs were estimated using a national average that required additional data extraction from DATIM given the incompleteness of HTS data in the EA FY 2016 report. The priority population prevention UEs were copied from the EA FY 2016.
6. The USAID COP17 submission establishes required targets through September 30, 2018; however, the level of funding is not sufficient to carry the program through this timeframe. As such, there are concerns about potential violations of Anti-Deficiency Act regulations. The calculation of applied pipeline was based on an assumption of a higher pipeline amount, due to delayed disbursements that did not post to the DR accounting line by FY16 Q4.

APPENDIX B

B.1 Focused Outcome and Impact Table (FOIT) Overview attached as a separate excel worksheet

APPENDIX C

C.1 Structured Plan for Twinning Model

Goal

PEPFAR will transfer a defined quality package of services for key and priority populations (KP/PP) that will facilitate the Government of the Dominican Republic's (GODR) ability to achieve HIV epidemic control (90-90-90) by 2020.

Objectives

1. Demonstrate and document a quality improvement process that leads to meeting targets and established benchmarks of service quality
2. Identify and address system barriers that are present at the site-level
3. Provide a costed plan for the GODR to more adequately plan for service expansion

Activity Description

The twinning model consists of the strategic pairing of local non-governmental organizations (NGO) that provide clinical and/or community-based services with public sector health facilities. The model facilitates experiencing sharing, recognizing that each entity has its inherent strengths and weaknesses. Additional support is provided by partners that focus on identifying and resolving system barriers that manifest at the site-level, which affect the provision of quality care. The thematic system areas include laboratory, strategic information, human resources, supply chain administration, stigma and discrimination, gender-based violence, and policy and norms.

Stakeholder Engagement Plan

With the ultimate goal of transferring a KP/PP package for nationwide rollout, engagement with counterparts in the national HIV response is paramount. Quarterly meetings with the National Health Service, a semi-annual key stakeholder forum, an annual meeting with site-level stakeholders, a signed memorandum of understanding for consistent dialogue with the in-country Global Fund prime recipients, and a semi-annual all PEPFAR partners meeting for data sharing and lessons learned provide the team with continuous feedback and timely opportunities for course correction.

Capacity Building Elements

For the package to successfully transition from PEPFAR to GODR supported, building the capacity of local authorities to manage, monitor, and evaluate site-level activities is critical. Facility staff are being trained and supported in data analysis and data use for decision-making. Regional Health Service officials are trained and actively engaged by partners to fulfill their role in the provision of site-level supportive supervision. National authorities continue to participate in strategy development and review progress to ensure it aligns with the GODR's vision of future programming. All of this is accompanied by an expanding domestic resource mobilization portfolio, significantly backed by

USAID's global Sustainable Finance Initiative, to address the country's gaps in financing the national response.

Pathway to Scale

For the successful transfer of a quality KP/PP package, key site-level benchmarks must be met by the end of each of the three years of implementation (FY17-FY19). Through a standardized and documented quality improvement process, key barriers will be identified and addressed. The site-level benchmarks are as follows:

Quality

- FY17: ≥70% of relevant* SIMS scores are dark green
- FY18: ≥80% of relevant* SIMS scores are dark green
- FY19: ≥90% of relevant* SIMS scores are dark green

*Relevant refers only to sets of which the HIV site/program has manageable control

The site-level supply chain management partner has a comprehensive diagnostic tool that is scored on a semi-annual basis. The site-level benchmarks are similar and are as follows:

- FY17: ≥70% overall score
- FY18: ≥80% overall score
- FY19: ≥90% overall score

Quantity

- FY17: 100% of site-level targets are met
- FY18: 100% of site-level targets are met
- FY19: 100% of site-level targets are met

System Improvements

- FY17: site-level system issues are identified and addressed through a systematic quality improvement process
- FY18: ≤3 site-level systems issues negatively impact quality KP/PP service package
- FY19: ≤1 site-level systems issues negatively impact quality KP/PP service package

The expectation is that the GODR will take the documented process that PEPFAR utilized to improve its supported sites to meet quality standards and apply it to additional high burden, high volume sites. PEPFAR will provide both direct support to additional sites as well as technical assistance to the GODR in an effective rollout to HIV clinics nationwide.

Barriers to be addressed

Overcoming policy and service delivery challenges is inherent in the execution of any new health intervention. Some of the more salient challenges include:

- Accurately identifying key and priority populations at the site-level
- Creating population-specific clinical cascades for analysis
- Monitoring that adequate human resources are assigned to rapidly growing HIV clinics
- Ensuring that HIV medication is adequately forecasted
- Improving viral load turnaround times for patient management

Learning Plan

To promote the expansion of the lessons learned from the model, four primary factors will be analyzed:

1. Feasibility – to what extent do existing structures and policies support/hinder this type of intervention?
2. Quantitative achievement – to what extent did the model meet its targets and/or achieve significant results?
3. Quality – what progress was made in meeting an established quality standard?
4. Cost – what is the cost of model and what variables offer cost savings?

Simultaneously, the documentation of the quality improvement process, the benchmarks for quality service delivery (largely based on the SIMS tool), and lessons learned during the implementation process will be provided as final deliverables to the host government.

Expected Impact following Scale-Up

The scale-up of quality services for KP/PP by the GODR would guarantee that these marginalized populations, along with all HIV-positive individuals, would have greater access to HIV services across the country. This would be instrumental in supporting the GODR to meet and sustain its commitment to HIV epidemic control. In addition, the lessons learned on utilizing a quality improvement process would be applicable to other health-related challenges that the country needs to address.

APPENDIX D

D.1 Structured Plan for Mobile Clinics

Goal

A critical challenge of meeting the 90-90-90 targets is accessibility of HIV care and treatment for hard to reach populations, such as migrants living in communities with limited access to health services. To address this, PEPFAR/Dominican Republic (DR) will pilot an alternative service delivery model that provides a quality package of services for hard-to-reach populations that will facilitate the Government of the Dominican Republic's (GODR) ability to achieve HIV epidemic control (90-90-90) by 2020.

Objectives

1. To contribute to closing the HIV service gap in hard-to-reach areas, particularly among migrant communities
2. To increase the capacity of the GODR to provide access to HIV care and primary health care services to prioritized and hard-to-reach populations in Santiago and Puerto Plata provinces.
3. To develop effective linkages, establishing functional referral and counter-referral procedures, between the communities and the HIV clinics.
4. To establish the evidence regarding feasibility, acceptability and cost-effectiveness of mobile clinics as intervention model in the Dominican Republic

Activity description

While mobile units are currently used in the Dominican Republic for HIV testing and other health-related campaigns, they have not been used to provide HIV clinical services. Administered by a local NGO and spearheaded by the National Health Service (SNS), these mobile clinics will integrate HIV services funded by PEPFAR with primary health care services funded by the GODR to ensure that hard-to-reach migrant communities receive holistic care in a non-stigmatizing environment. The mobile clinics, staffed with NGO-funded doctors, nurses, and counselors, will provide HIV testing, clinical, and laboratory services in Santiago and Puerto Plata, all while being supported by robust community outreach interventions that drive demand. Each mobile clinic will be linked to existing HIV care facilities for referral and follow-up services. Additional support to clinics is provided by partners that focus on identifying and resolving system barriers that manifest at the site-level, including laboratory, strategic information, human resources, supply chain administration, stigma and discrimination, gender-based violence, and policy and norms.

Stakeholder engagement plan

With the ultimate goal of transferring a quality alternative service delivery model that can provide lessons to the GODR on scaling differentiated models of care, engagement with counterparts in the national HIV response is paramount. Quarterly meetings with SNS, a semi-annual key stakeholder forum, an annual meeting with clinic-level stakeholders, a signed memorandum of understanding for

consistent dialogue with the in-country Global Fund prime recipients, and a semi-annual all PEPFAR partners meeting for data sharing and lessons learned provide the team with continuous feedback and timely opportunities for course correction.

Capacity-building elements

For the package and clinics to successfully transition from PEPFAR to GODR support, building the capacity of local authorities to manage, monitor, and evaluate clinic-level activities is critical. Facility staff are being trained and supported in data analysis and data use for decision-making. Regional Health Service officials are trained and actively engaged by partners to fulfill their role in the provision of site-level supportive supervision. National authorities continue to participate in strategy development and review progress to ensure it aligns with the GODR's vision of future programming. All of this is accompanied by an expanding domestic resource mobilization portfolio, significantly backed by USAID's global Sustainable Finance Initiative, to address the country's gaps in financing the national response.

Pathway to Scale

For the successful transfer of a quality package, key clinic-level benchmarks must be met by the end of each of the three years of implementation (FY17-FY19). Through a standardized and documented quality improvement process, key barriers will be identified and addressed. The clinic-level benchmarks are as follows:

Quality

- FY17: ≥50% of relevant* SIMS scores are dark green
- FY18: ≥70% of relevant* SIMS scores are dark green
- FY19: ≥90% of relevant* SIMS scores are dark green

*Relevant refers only to sets of which the HIV site/program has manageable control

The site-level supply chain management partner has a comprehensive diagnostic tool that is scored on a semi-annual basis. The site-level benchmarks are similar and are as follows:

- FY17: ≥50% overall score
- FY18: ≥70% overall score
- FY19: ≥90% overall score

Quantity

- FY17: 100% of site-level targets are met
- FY18: 100% of site-level targets are met
- FY19: 100% of site-level targets are met

System Improvements

- FY17: site-level system issues are identified and addressed through a systematic quality improvement process
- FY18: ≤ 3 site-level systems issues negatively impact quality KP/PP service package
- FY19: ≤ 1 site-level systems issues negatively impact quality KP/PP service package

The expectation is that the GODR will take the documented process that PEPFAR utilized to improve its reach to hard-to-reach migrant communities and apply it to additional high burden geographic areas. PEPFAR will provide both direct support to additional sites as well as technical assistance to the GODR in an effective rollout of alternative service delivery models nationwide.

Barriers to be addressed

Given the stigma traditionally attached to HIV, the services provided in the mobile clinics will include comprehensive primary health care, in addition to HIV care, and will be promoted as such in the addressed communities. Additionally, overcoming policy and service delivery challenges is inherent in the execution of any new health intervention. Some of the more salient challenges include:

- A new model of community-based anti-retroviral therapy distribution will be implemented through mobile clinics and community health workers, ensuring compliance with the National Health Service regulations.
- Identifying how human resources will be assigned and compensated
- Ensuring that HIV medication is adequately forecasted
- Maintaining strong and consistent communication between the mobile clinic and referral facility.
- Provision of on-going care for hard-to-reach populations that may struggle to present at static sites
- Strong community-based networks and health promoters should be involved to ensure patient retention in hard to reach and frequently mobile populations.

Learning Plan

To promote the expansion of the lessons learned from the model, four primary factors will be analyzed:

1. Feasibility – to what extent do existing structures and policies support/hinder this type of intervention?
2. Quantitative achievement – to what extent did the model meet its targets and/or achieve results?
3. Quality – what progress was made in meeting an established quality standard?
4. Cost – what is the cost of model and what variables offer cost savings?

Simultaneously, the documentation of the quality improvement process, the benchmarks for quality service delivery (largely based on the SIMS tool), and lessons learned during the implementation process will be provided as final deliverables to the host government.

Expected Impact following Scale-Up

This pilot intervention is aiming to identify and enroll in HIV care services the largest possible number of HIV positive persons from prioritized and hard to reach populations in Santiago and Puerto Plata provinces, while establishing preliminary evidence regarding feasibility, acceptability and cost-effectiveness of mobile clinics as an intervention model in the Dominican Republic. The scale-up of quality services for hard-to-reach migrant populations by the GODR would guarantee that these communities, along with all HIV-positive individuals, would have greater access to HIV services across the country. This would be instrumental in supporting the GODR to meet and sustain its commitment to HIV epidemic control. In addition, the lessons learned on utilizing a quality improvement process would be applicable to other health-related challenges that the country needs to address.

**Focused Outcome and Impact Table (FOIT) Overview
Dominican Republic**

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Strategic Outcome #1: By the end of COP 2018 (FY 2019), implement two KP/PP service delivery models (NGO twinning and mobile clinics) to remove service delivery barriers for GoDR to transition to Test and Start							
				HTX_TST, TX_NEW			
Demonstration site: key populations	Expand partner notification testing to PEPFAR-supported sites and assess its value	<ul style="list-style-type: none"> • 100% of partner notification testing targets reached at all PEPFAR-supported sites 	<ul style="list-style-type: none"> • 100% of partner notification testing targets reached at all PEPFAR-supported sites • Completed assessment of partner notification testing activities 	HTS_TST		Disagg: HTS_TST_PN	\$150,000
Demonstration site: key populations	Midterm and final evaluations and documentation of twinning model and mobile clinics	<ul style="list-style-type: none"> • Midterm evaluation report completed • Meeting held to share midterm evaluation results, incorporate lessons learned and plan for final report and toolkit 	<ul style="list-style-type: none"> • Final report completed • KP/PP package toolkit completed • Dissemination strategy devised and implemented, with plans for hand off of toolkit 				\$250,000
Demonstration site: key populations	Improve assessment, distribution, management and performance of staff supporting HIV care and treatment and related services at PEPFAR-supported sites	<ul style="list-style-type: none"> • ≥50% of PEPFAR-supported sites have appropriate number of health workers, per WISN results • ≥75% of PEPFAR-supported sites incorporate performance measures related to quality data • ≥50% of evaluated providers by performance measures receive a passing score • ≥75% of PEPFAR-supported facilities utilize the Human Resource Information System for Health Workforce planning, distribution and training 	<ul style="list-style-type: none"> • 100% of PEPFAR-supported sites have appropriate number of health workers, per WISN results • 100% of all PEPFAR-supported sites incorporate performance measures related to quality data • ≥75% of evaluated providers by performance measures receive a passing score • 100% of PEPFAR-supported facilities utilize the Human Resource Information System for Health Workforce planning, distribution and training 	HRH_STAFF, HRH_CURR			\$228,000
Demonstration site: key populations	Support the development and implementation of differentiated models of care for PLHIV at PEPFAR-supported sites within the context of HRH for scale-up	<ul style="list-style-type: none"> • Development of an integrated HRH component to the differentiated models of service delivery protocol and SOPs (NOTE: will be completed in FY17) • ≥75% of health workers at PEPFAR-supported sites trained in differentiated models of care SOPs • ≥50% of PEPFAR-supported sites implementing at least one differentiated model of care 	<ul style="list-style-type: none"> • ≥80% of health workers at PEPFAR-supported sites trained in differentiated models of care SOPs • ≥80% of PEPFAR-supported sites implementing at least one differentiated model of care • 100% of PEPFAR-supported sites implementing at least one differentiated model of care 				\$234,000

**Focused Outcome and Impact Table (FOIT) Overview
Dominican Republic**

Area of intervention	Activity Description	1 year benchmarks	2 year benchmarks	PEPFAR Indicators	Additional indicator category that best represents activity progress (if relevant)	List specific additional indicators (if relevant)	Total Planned Amount and Applied Pipeline Amount (Column R + Column S)
Demonstration site: key populations	Reduce provider stigma and discrimination (S&D), particularly among KP/PP clients	<ul style="list-style-type: none"> • S&D training manual distributed to HIV service providers at site level • Mentoring plan implemented to complement training manual • ≥75% of health workers at PEPFAR-supported sites have successfully completed in-service training in S&D • Client satisfaction survey piloted and rolled out at all PEPFAR-supported sites • ≥50% of KP/PP PLHIV report respectful and inclusive treatment per client satisfaction survey • Feedback loop created to ensure that there improvements can be made if benchmarks are not met 	<ul style="list-style-type: none"> • ≥80% of health workers at PEPFAR-supported sites have successfully completed in-service training in S&D • ≥75% of KP/PP PLHIV report respectful and inclusive treatment per client satisfaction survey 				\$175,000
Demonstration site: key populations	Provision of community-based HIV prevention and testing services to key populations	<ul style="list-style-type: none"> • 100% of KP_PREV target met • 90% of KP_PREV beneficiaries receive an HIV test • Partner reports on all positive patients receiving care at non-PEPFAR sites • Number of PLHIV linked to care reported and barriers to linkages identified 	<ul style="list-style-type: none"> • 100% of KP_PREV • 90% of KP_PREV beneficiaries receive an HIV test • Number of PLHIV linked to care reported and barriers to linkages addressed 	KP_PREV, HTS_TST		Disagg: MSM & FSW	\$269,409
Demonstration site: key populations	Provision of community- and facility-based HIV testing services to key populations	<ul style="list-style-type: none"> • 100% of HTS_TST by population targets achieved at PEPFAR-supported sites 	<ul style="list-style-type: none"> • 100% of HTS_TST by population targets achieved at all PEPFAR-supported sites 	KP_PREV, HTS_TST		Disagg: MSM & FSW	\$363,263
Demonstration site: key populations	Oversee implementation of quality clinical KP/PP package of services to support twinning model	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥90% of relevant SIMS scores are dark green • Established quality improvement teams that meet on a quarterly basis at all PEPFAR-supported sites with 100% of quarterly meetings held • Quality Improvement Plan and tracking plan reviewed and updated quarterly 	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥95% of relevant SIMS scores are dark green • Completed assessments of quality improvement teams • Completion of detailed documentation of quality improvement process and results 	HTS_TST, TX_CURR, TX_NEW, TX_RET, TX_PLVS			\$1,930,885
Demonstration site: key populations	Technical assistance for pharmaceutical management	<ul style="list-style-type: none"> • ≥80% overall score at all PEPFAR-supported sites based on PEPFAR/DR-developed pharmaceutical management diagnostic tool • ≥95% of PEPFAR-supported sites with no stock outs of first lines ARVs 	<ul style="list-style-type: none"> • ≥90% overall score at all PEPFAR-supported sites based on PEPFAR/DR-developed pharmaceutical management diagnostic tool • 100% of PEPFAR supported SAls with no stock outs of first lines ARVs 				\$365,000
Systems: Laboratory	Support Continuous Quality Improvement (CQI) interventions for accurate, reliable, and timely reporting of HIV rapid testing	<ul style="list-style-type: none"> • Improvement in HIV Rapid Testing Continuous Quality Improvement Initiative (HIV RTCQII) in all PEPFAR supported lab-sites • 85% of PEPFAR supported LAB-sites obtain "Satisfactory scores" (85% or above) in proficiency testing (PT) 	<ul style="list-style-type: none"> • 95% of priority PEPFAR supported lab-sites obtain "Satisfactory scores" (85% or above) in proficiency testing (PT) 	LAB_PTCQI			\$200,000

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Systems: Laboratory	Strengthening the quality of laboratory services to provide accurate and reliable CD4 and VL test using SLMTA program SLMTA: Streghtening Laboratory Managemnet Toward Accreditation	<ul style="list-style-type: none"> National Reference Laboratory (NRL), and 60% of supported PEPFAR lab-sites, obtain an international standard of quality performance 	<ul style="list-style-type: none"> 80% of supported PEPFAR lab-sites obtain an international standard of quality performance 				\$300,000
Systems: Laboratory	Scale-up of viral load testing in all patients on ART at PEPFAR-supported sites	<ul style="list-style-type: none"> Implement a system that tracks VL tests performed among HIV patients and actively searches for patients without a VL test at the community level Development of sample referral system that ensures timely and appropriate use of results for clinical management 	<ul style="list-style-type: none"> 90% of patients on ART for at least 6 months with at least one VL per year at PEPFAR-supported sites System tracking VL tests performed among HIV patients and actively searches for patients without a VL test at the community level implemented and operational with system analysis and implementation report completed Sample referral system that ensures timely and appropriate use of results for clinical management implemented and operational 	TX_PLVS			\$300,000
Systems: Strategic information	Implementation of new modules to track PP/KP in all PEPFAR-supported sites	<ul style="list-style-type: none"> Implementation the following modules at all 11 PEPFAR-support sites: <ul style="list-style-type: none"> KP tracking and cascade monitoring CD4 and VL samples tracking with timely results Electronic HIV testing registry National TB registry and tracking. Modules will support health information system implementation at all PEPFAR-supported sites on: <ul style="list-style-type: none"> the HIV cascade in KP's CD4 and VL tracking HIV testing Number of HIV patients with TB 	<ul style="list-style-type: none"> Data reports from HIS at all PEPFAR-supported sites for decision making and quality improvement on: <ul style="list-style-type: none"> the HIV cascade in KP's CD4 and VL tracking HIV testing Number of HIV patients with TB (ensure that we understand the impact of the training/modules and that there is a clear deliverable-- "data" is too vague 	HRH_CURR			\$150,000
Service delivery and quality improvement: key populations	Support the strengthening of TB-HIV collaborative activities in PEPFAR supported sites	<ul style="list-style-type: none"> 100% PEPFAR-supported HIV sites trained on TB infection control plan, including 90% of infection control personnel. TB infection control plans implemented in 50% of PEPFAR-supported HIV sites At least 3 on-site follow-up visits per site completed for PEPFAR-supported HIV sites 	<ul style="list-style-type: none"> Implementation of TB Infection control plans in 100% of PEPFAR-supported sites All TB infection control plans dashboard in green 				\$200,000
Demonstration site: key populations	Implementation of a pilot to assess the feasibility of using PrEP in MSM and TG Women	<ul style="list-style-type: none"> MOH-approved protocol for implementation of pilot Enroll 150 clients on PrEP Preliminary report from the pilot on using PrEP in MSM and TG Women at 1 PEPFAR supported site 	<ul style="list-style-type: none"> Final report of feasibility of PrEP implementation in MSM and TG Women at all PEPFAR-support sites (Begin thinking of next steps in collaboration with GoDR?) 	PrEP_NEW			\$407,500

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Demonstration site: key populations	Strengthen TB screening and diagnosis, Preventive therapy (IPT) and linkages to TB care and treatment in all PEPFAR supported sites	<ul style="list-style-type: none"> • Implementation of updated TB screening, diagnosis, care and treatment program at 50% of PEPFAR-supported sites • Establish baseline of current IPT coverage at all PEPFAR-supported sites • Increase IPT coverage by 50% in all newly diagnosed HIV patients at all PEPFAR-supported sites 	<ul style="list-style-type: none"> • Implementation of updated TB diagnosis, care and treatment program at 90% of PEPFAR-supported sites • Increase IPT coverage by 50% from year 1, of all newly diagnosed HIV patients at all PEPFAR-supported sites 	TB_STAT, TB_ART, TX_TB, and TB_PREV			\$252,941
Demonstration site: key populations	Oversee implementation of quality clinical KP/PP package of services to support twinning model	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥90% of relevant SIMS scores are dark green • Established quality improvement teams that meet on a quarterly basis at all PEPFAR-supported sites with 100% of quarterly meetings held • Quality Improvement Plan and tracking plan reviewed and updated quarterly 	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥95% of relevant SIMS scores are dark green • Completed assessments of quality improvement teams • Completion of detailed documentation of quality improvement process and results 	HTS_TST, TX_CURR, TX_NEW, TX_RET, TX_PLVS			\$647,619
Demonstration site: key populations	Provision of community-based HIV prevention and testing services to key populations	<ul style="list-style-type: none"> • 100% of site-level targets are met • 90% of KP_Prev beneficiaries receive an HIV test • Implement tracking system to follow patients receiving care at non-PEPFAR supported sites • Number of PLHIV linked to care reported and barriers to linkages identified 	<ul style="list-style-type: none"> • 100% of site-level targets are met • 90% of KP_PREV beneficiaries receive an HIV test • Number of PLHIV linked to care reported and barriers to linkages addressed 	KP_PREV, HTS_TST			\$1,298,957
Demonstration site: key populations	Oversee implementation of quality clinical PP package of services through mobile clinics	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥90% of relevant SIMS scores are dark green • Established quality improvement teams that meet on a quarterly basis at all PEPFAR-supported sites with 100% of quarterly meetings held • Quality Improvement Plan and tracking plan reviewed and updated quarterly 	<ul style="list-style-type: none"> • 100% of site-level targets are met • ≥95% of relevant SIMS scores are dark green • Completed assessments of quality improvement teams • Completion of detailed documentation of quality improvement process and results 	HTS_TST, TX_CURR, TX_NEW, TX_RET, TX_PLVS			\$390,000
Systems: Institutional Capacity Building	Strengthen the M&E capabilities of the HIV clinics to improve.... (M&E is a large field--- what specific aspect of M&E is this focusing on, and what is the objective of the training, how will it benefit PEPFAR?)	<ul style="list-style-type: none"> • Train 20 HIV clinics staff of prioritized PEPFAR supported sites in M&E • More details, quantifiable benchmark to justify \$100k on these trainings 	<ul style="list-style-type: none"> • Development of a site M&E plan for all PEPFAR supported sites performed by trained staff in order to.... (explain desired benefit to PEPFAR) 		HRH_PRE		\$100,000

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<p align="center">Strategic Outcome #2: By the end of COP 2018 (FY 2019), provide technical assistance to GODR to: 1) specifically strengthen laboratory capacity to increase access to VL testing to 90%; 2) support commodities forecasting and supply chain management to address distribution and other system issues; and 3) build capacity and support human resources for health management to meet demand for GoDR Test and Start</p>							
Service delivery and quality improvement: key populations	Expand GBV network development to two additional provinces, assess its outcome, and develop a national GBV strategy	<ul style="list-style-type: none"> • All four PEPFAR priority provinces have an established GBV referral network and provider directory • National GBV Strategy updated with regular meetings with NGO and GoDR champions • All four PEPFAR priority provinces have workplans aligned with national strategy 	<ul style="list-style-type: none"> • Assessment completed on added value of GBV networks to HIV National Response • Assessment on status of provincial workplans with recommendations based on lessons learned 			GEND_GBV	\$250,000
Service delivery and quality improvement: key populations	Provide technical assistance to Global Fund HTS partners to improve testing yield and KP outreach	<ul style="list-style-type: none"> • ≥40% of Global Fund HTS partners demonstrate increase in HIV yield between FY18 Q1 and Q4 • Update testing modalities and develop SOPs 	<ul style="list-style-type: none"> • ≥80% of Global Fund HTS partners demonstrate increase in HIV yield between FY19 Q1 and Q4 				\$150,000
Systems: Governance (including policy)	Technical assistance and support to GODR to establish sufficient supply of trained health workers that are prepared to handle the unique challenges of serving PLHIV, especially KP/PP	<ul style="list-style-type: none"> • Five-year National HRH plan developed • Health worker incentive package established • Incorporation of S&D reduction component in national training plan (to include mentoring component) • Peer/Lay counselors included in the restructured compensation system and as beneficiaries of the Health Career Law • Use of iHRIS at Ministry-level for health workforce planning and distribution • ≥50% of regions using iHRIS for health workforce planning and distribution 	<ul style="list-style-type: none"> • Health worker incentive package implemented nation wide • Incorporation of S&D component in health worker pre-service training • 100% of regions using iHRIS for health workforce planning and distribution 				\$113,000
Service delivery and quality improvement: key populations	Provide technical assistance to GODR, stakeholders and PEPFAR partners to identify, address and take action on health system barriers that hinder or limit PEPFAR supported sites to reach quality improvement benchmarks to improve the care of people living with HIV	<ul style="list-style-type: none"> • ≥30% reduction in identified systems' barriers to care identified through Collaborative QI process • ≥4 meetings annually with GODR and PEPFAR implementing partners to address system bottlenecks to providing quality care needed to implement Test & START • Quarterly collaborative meetings held with GODR and PEPFAR supported site quality teams to share lessons learned, challenges and success of quality improvement efforts 	<ul style="list-style-type: none"> • ≥60% reduction in identified systems' barriers to care identified through Collaborative QI process. • ≥4 meetings annually with GODR and PEPFAR implementing partners to address system bottlenecks to providing quality care needed to implement Test & START • Quarterly collaborative meetings held with GODR and PEPFAR supported site quality teams to share lessons learned, challenges and success of quality improvement efforts 				\$636,443
Systems: Governance (including policy)	Advocate with GODR for nationwide rollout of Test & START, 90-90-90 by 2020, and increased domestic resources for HIV	<ul style="list-style-type: none"> • National treatment guidelines reflect Test & START and rollout outside of PEPFAR-supported sites has begun • Policy guidance developed and with implementation plan on transition of pre-ART patients 	<ul style="list-style-type: none"> • New national HIV strategic plan incorporates 90-90-90 and Test & START strategies • TA provided on the implementation of transition of pre-ART patients as needed 				\$100,000

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Systems: Governance (including policy)	Further strengthen coordination between Global Fund and PEPFAR and align efforts with the imminent development of a new HIV National Strategic Plan	• Quarterly meetings, including data sharing, established	• New national HIV strategic plan finalized and aligned with Global Fund and PEPFAR approaches				\$100,000
Systems: Supply chain and essential medicines	Support GODR to address findings from condom availability gap assessment	• TA to support GODR to take action in order to address ≥30% of identified gaps within condom availability assessment	• TA to support GODR to take action in order address ≥75% of identified gaps within condom availability assessment				\$128,000
Systems: Supply chain and essential medicines	Customs clearance and warehousing of no logo condoms and lubricants for PEPFAR partner distribution	• All no logo condoms are cleared without demurrage fees and warehoused	• All no logo condoms are cleared without demurrage fees and warehoused • Transition plan developed and agreed upon				\$25,000
Systems: Health Financing	Support GODR implementation of national domestic resource mobilization strategy	• TA provided to GoDR to support them in covering ≥20% of the financing gap based on the results of the financial gap analysis	• TA provided to GoDR to support them in covering ≥40% of the financing gap based on the results of the financial gap analysis				\$150,000
Systems: Health Financing	Costing study on PEPFAR-supported KP/PP package	• Approved costing study protocol and all preparation completed (start in late FY2018)	• Study executed and results disseminated to key stakeholders including GoDR				\$100,000
Systems: Supply chain and essential medicines	Strengthen the national pharmaceutical supply chain system	• 90 clinical care professionals trained in rational use of HIV medicines, including ARVs • 80% of Regional Health Services personnel trained on pharmaceutical management knowledge and abilities to manage ARV storage and distribution to maximize supply chain efficiencies	• 120 clinical care professionals trained in rational use of HIV medicines, including ARVs • 100% of Regional Health Services personnel trained on pharmaceutical management knowledge and abilities to manage ARV storage and distribution to maximize supply chain efficiencies • Develop long term transition strategy for supply chain				\$65,000
Systems: Supply chain and essential medicines	Support decentralized programming for procurement, warehousing, and distribution of HIV and other essential medications	• ≥80% of commodities storage sites are stocked according to forecast plan, by level in supply system	• ≥90% of commodities storage sites are stocked according to forecast plan, by level in supply system			• Number of sites reporting stock outs of essential HIV treatment commodities	\$530,000
Systems: Institutional Capacity Building	Support civil society networks/coalitions to improve governance, accountability, and transparency of member NGOs/CBOs to increase access to public and private financing	• Association of NGOs/CBOs meets requirements of financial institutions to secure credit for its members	• Association secures ≥50% financing for continued operations from non PEPFAR funds			• Number of organizations with business plans • Number of organizations approved for external funding	\$150,000

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Systems: Health workforce (including CHWs)	HIV update training package for Health Care Workers focused on Stigma and Discrimination and Quality Improvement	<ul style="list-style-type: none"> • Baseline assessments of Stigma and Discrimination in health services in 2 military hospitals carried out. • Existing Stigma and Discrimination training materials adapted to Dominican military health environment. • S&D training carried out with 60 healthcare workers at hospitals and health administrators. • Pre and post training knowledge and attitudes tests indicate improvement in knowledge as well as reduction in stigma. • TB-HIV referral system and documentation in place. 	<ul style="list-style-type: none"> • S&D training carried out with 80 healthcare workers at hospitals and health administrators. • Pre and post training knowledge and attitudes assesment indicate improvement in knowledge as well as reduction in stigma. • GBV referral system and documentation in place. TB-HIV referral system and documentation in place. • PHDP utilized and documented in 80% of PLHIV patient visits 				\$36,000
Systems: Institutional Capacity Building	HIV Policy, SABERS data analysis and use workshop for MOD personnel including SABERS, mil hospital and National system data.	<ul style="list-style-type: none"> • Workshop carried out with 10 Medical Corps and 10 or more MOD participants. • A data analysis plan has been created for 100% of military data collected by national program, containing routine national indicators and analytic questions/output for program review and planning . • First SABER data review planned • MOD HIV policy implementation plan developed and disseminated. • PHDP implementation documented at least 70% of HIV patient visits partner notification documented for at least 60% of new HIV+ who report a regular partner 	<ul style="list-style-type: none"> • At least one SABER data review executed. • Programmatic modification plan based on SABER data review developed and in execution. • SIMS visits demonstrate green/light green in 80% of relevant sets. • PHDP implementation documented for at least 80% of HIV patient visits • Partner notification documented for at 80% of new HIV+ who report a regular partner 				\$17,600
Service delivery and quality improvement: general population	Enhance program QA to improve collection of cascade data and coordination between the MOD and MOH and Partner Mil	<ul style="list-style-type: none"> • Implementation of monitoring tool for 100 of PEPFAR supported military hospitals with all sets pertinent to the military program. • 2 remediation visits (one per military hospital) with remediation plans developed. • Identify gaps in military data in MOH system, add missing military information, and update MOH Data System on a regular bases for comparison with military data. • Supply chain management plan developed with MOD and MOH 	<ul style="list-style-type: none"> • At least one regular monitoring visit per hospital in addition to remediation visits to units who scored red or yellow. • 80% of red and yellow-scoring section of SIMS-like indicators moved up (red to yellow or yellow to light green). • All visits in year 2 conducted by military with supervision by DOD. • Inclusion of Military Status in MOH Data Systems. • Supply chain plans developed for new year, no stock outs reported in 12 mosdod 				\$11,000

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Systems: Laboratory	Purchase, install and train on use of Gene Expert 8 for TB diagnosis	Machine installed in Central Hospital and lab personnel trained on use for TB Purchase first 6 months of cartridges and sign MOU country provision of cartridges after first 6 months. At least 80% of TB and HIV patients confirmed tested for coinfection	• At least 90% of TB and HIV patients confirmed tested for coinfection				\$40,000
Systems: Laboratory	Update HIV testing guidelines (Rapid testing (RT) and Viral Load (VL)) to align with WHO recommendations	• Updated HIV testing guidelines are developed for RT and VL that align with WHO recommendations	• Training workshop executed for key regional HIV personnel • Roll out of updated guidelines at all HIV sites nationally • Continued TA provided for monitoring of HIV guidelines adherence				\$30,000
Systems: Strategic information	Development and maintenance of new modules to track patients, including PP/KP in the HIV clinics	• Development and evaluation of the following modules to track patients: - KP tracking and cascade monitoring - CD4 and VL samples tracking with timely results - Electronic HIV testing registry -National TB registry and tracking.	• Implementation of information systems that provide data on HIV, CD4,VL and TB monitoring • Development and implementation of strategies for the interoperability between information systems • Development and implementation of confidentiality policies				\$174,000
Systems: Institutional Capacity Building	Setting-up a space for sharing of best-practices and lessons learned, between HCWs that provide HIV services across all PEPFAR supported sites	• Develop summary of best practices of outreach, clinical and supply chain/ lab to be shared among sites for implementation during year 2	• Develop and update best practices document • Evaluation of implementation of best practices from year 1		HRH_CURR		\$100,000
Systems: Institutional Capacity Building	Strengthen the HIV, TB and STI surveillance and epidemiology capability among HCWs	• Training of all program mentors in areas of HIV, TB and STI surveillance; teaching and mentoring techniques; and working with key populations to improve HIV, TB, STI case notification by 25% • Training 20 staff of the Ministry of Public Health (provincial, regional and central level) in field epidemiology to improve regional epi capacity so staff are able to independently complete HIV/STI/TB data analyses	• Development of an updated HIV and TB national status update report (national, regional and/or provincial) performed by trained staff • Training 20 additional staff of the Ministry of Public Health (provincial, regional and central level) in field epidemiology				\$200,000
Systems: Institutional Capacity Building	Support the development and implementation of new HIV clinical guidelines that incorporates Test & Start (nationwide)	• Update of HIV clinical guidelines to include Test & Start • Provide TA to assist with transition of pre-ART patients	• Implementation of updated HIV clinical guidelines that includes Test & Start • Implementation of a quarterly supportive supervision system in all regions. • Revised norms to account for differentiated service delivery models				\$150,000