# Haiti

# Country Operational Plan

# (COP) 2018

# Strategic Direction Summary

April 11, 2018

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# 1.0 Goal Statement

The primary goal of the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) Haiti program is to achieve epidemic control in Haiti by supporting a data-driven response that leads to a reduction in new infections and AIDS-related mortality. This goal will be achieved through granular site-level management, implementation of targeted testing approaches--including index case contact tracing --improved treatment retention, and expansion of multi-month scripting, community drug distribution, and rapid pathways for stable patients. Additionally, using sex- and age-disaggregated data, PEPFAR Haiti will focus on scaling-up HIV clinical and community services and strategies to close the gap on underserved populations, including men, key populations (KP), and children.

The 2015 Country Operational Plan (COP) Annual Program Results validated the geographic pivots that refocused the program on 20 priority districts out of a total of 42 districts. This approach was revalidated for COP 18, applying new data from the 2017 Demographic Health Survey (DHS) and programming data to update the SPECTRUM model and people living with HIV (PLHIV) estimates down to the sub-national unit (SNU or district) level. The Haiti Population-Based HIV Impact Assessment (PHIA) fieldwork will begin during COP18, providing important results that will complement our data-driven programmatic strategies. The Ministry of Health's (MSPP, French acronym) National AIDS Control Program (PNLS, French acronym) has fully rolled out the Test and Start approach, as well as revised the national guidelines to adopt World Health Organization (WHO) recommendations. For COP18, PEPFAR Haiti will focus on implementing an aggressive transition to the single dose regimen (TLD), led by PNLS and in partnership with the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund; GF). We will also dialogue with MSPP and PNLS to create a policy environment and accompanying guidelines for providers to ensure a smooth transition to TLD and to implement a more targeted testing strategy. Recency testing will also be implemented, which will enhance index testing prioritization and case-based surveillance.

An additional priority for COP18 is to close the gap on elimination of mother-to-child transmission, by leveraging U.S. Agency for International Development (USAID)'s non-PEPFAR maternal child health platform to increase early diagnosis of HIV in pregnant women. To further strengthen HIV-TB co-infection prevention and treatment in COP18, PEPFAR Haiti will continue to work closely with the National HIV and TB Programs and implementing partners to ensure maximum tuberculosis (TB) screening and Tuberculosis Preventive Therapy (TPT) coverage, enhance harmonization between TB and HIV programs, and expand GeneXpert testing coverage.

In COP18, the PEPFAR team will build on the strength of the Orphans and Vulnerable Children (OVC) portfolio to ensure all OVC are screened for HIV and that those identified as HIV-positive are linked to treatment services. This will be an important component of aggressive efforts to find the remaining pediatric HIV cases and ensure these children are linked to treatment with targeted testing and robust social and community support. COP18 includes additional programming for girls 9-14 that are similar to activities in countries implementing the Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe (DREAMS) program. This program is focused in districts with high rates of gender-based violence (GBV) and where women and girls under 24 are being diagnosed with HIV at a higher percentage than the national prevalence (Cap-Haitien, Dessalines, Saint Marc and Port-au-Prince). PEPFAR Haiti will fully roll out an existing OVC case management platform to include all OVC and to ensure that the DREAMS beneficiaries receive multiple, "layered" services to remain HIV negative.

A major challenge for the Haiti program is patient linkage to and retention in care. In COP16 PEPFAR Haiti began the implementation of a unique patient identifier using biometric coding (BC); BC, coupled with the use of mobile health technology and positive peer navigators, allows for micro-targeting of services, such as community drug distribution. In COP17, BC will be fully rolled out across all PEPFAR-supported sites and linked across networks. This will allow PEPFAR Haiti to better identify silent transfers and focus community health workers' efforts in COP18 on actual Lost to Follow-Up (LTFU). The Patient Linkage and Retention (PLR) system facilitates a proactive approach to avoid LTFU by promoting regular contact with all patients and improving access to treatment via community-based drug distribution and multi-month scripting of ART, with community health agents serving a critical role. Over 80 health facilities in Haiti - representing 85 % of PLHIV on ART - currently use the PLR tracking tool; in COP18, PEPFAR Haiti will roll out the PLR tracking system to all remaining PEPFAR-supported sites.

Furthermore, in COP15 the program initiated the roll out of viral load (VL) testing. By the end of COP18, the program plans to achieve 100% VL coverage for all appropriate patients. The laboratory information system, coupled with the enhanced specimen referral network and linkage to the electronic medical records, supports increased VL testing. This electronic system will be reinforced by ensuring PNLS guidelines at PEPFAR-supported sites are implemented with fidelity.

To support our COP18 programming, PEPFAR Haiti is addressing stigma-related barriers highlighted by the recent Stigma Poll conducted with UNAIDS and by the 2017 DHS results. We propose to engage the highest levels of government to help reduce stigma against PLHIV and key populations, and continue to ensure access to KP-friendly services at PEPFAR-supported sites.

Finally, to ensure sustainability of these investments, the PEPFAR Haiti Team continues to advocate with the Haitian Government for increased funding for the national HIV/AIDS program. Working in close partnership with the World Bank and other partners, PEPFAR Haiti will continue its efforts with the Ministry of Finance to develop a health financing framework and an investment case for the health sector.

# 2.0 Epidemic, Response, and Program Context

**2.1 Summary statistics, disease burden and country profile**

Haiti is a low-income country with a gross national income (GNI) of $780 per capita (World Bank 2016) and a gross domestic product (GDP) of $739.60 per capita (2016), which makes it the poorest country in the Western Hemisphere. An estimated 53.9% of the country's approximately 10.8 million people live on less than one dollar and ninety cents a day and cannot afford the higher quality healthcare provided in private clinics (UNDP, 2016). Haiti's estimated 147,825 PLHIV (UNAIDS, 2018) constitutes the greatest burden of HIV/AIDS in the Caribbean region; this is exacerbated by the highest incidence of TB in the Western Hemisphere. Haiti has a generalized HIV/AIDS epidemic marked by higher prevalence rates in major cities and among men who have sex with men (MSM), female commercial sex workers (CSW), and prisoners. Drivers of new infections include unprotected transactional and commercial sexual activities as well as unsafe sexual practices among MSM and CSW. The widespread practice of multiple concurrent partnerships and the inequitable social conditions of women and youth are also considered among the key enablers of HIV transmission. Though the overall prevalence remains stable, women and youth showed a higher prevalence than men in the last DHS (2017). The DHS data from 2017-2018 shows that HIV prevalence among adults (15-49 years old) in Haiti remained stable at 2%, suggesting a successful treatment and prevention program that is keeping alive those already infected while curbing transmission at a population level.

There is a severe shortage of health workers, low retention of nurses and doctors, and gaps in services across all levels of the health system. Furthermore, the country's weak health infrastructure has not kept pace with Haiti's population growth from 7.5 million people in 1993 to 10.8 million in 2017. Moreover, the country is still recovering from a number of natural disasters and health epidemics, in addition to political and economic instabilities. Attrition among health care providers at PEPFAR-supported facilities and PEPFAR Haiti's locally engaged staff is also a challenge, and many PLHIV, like many other Haitians, are increasingly migrating to Chile, Brazil and Dominican Republic in hopes of better lives.

As of October 2017, close to 94,000 individuals in Haiti were receiving antiretroviral treatment (ART), representing approximately 75 % of of PLHIV who know their status. PEPFAR has been instrumental in scaling up HIV services, while building MSPP capacity to sustain the HIV response over the long term. The support to the MSPP and PNLS has enabled the on-going and timely updating and alignment of national clinical guidelines with international normative guidance. In fact, PNLS has led a number of initiatives that will help the country achieve our 95-95-95 goals. Of those, TLD is one of the most impactful initiatives for COP18. PNLS has taken the lead to guide this transition, which aims to transition the majority of HIV patients in Haiti to TLD by the third quarter of FY 2019.

**Table 2.1.1 Host Country Government Results**

| | Total | | <15 | | | | 15-24 | | | | 25+ | | | | *Source, Year* |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | Female | | Male | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 10,711,073 | 100 | 1,952,130 | 18,22 | 1,957,150 | 18.27 | 1,216,659 | 11.35 | 1,082,490 | *10.1* | 2,376,350 | 22.18 | 2,126,293 | 19.85 | IHSI,UNAIDS 2017 |
| HIV Prevalence (%) | | 1.4 | | 0.2 | | 0.2 | | 0.8 | | 0.3 | | 3.2 | | 2.8 | UNAIDS 2017 |
| AIDS Deaths (per year) | 3,145 | | | | | | | | | | | | | | UNAIDS 2017 |
| # PLHIV | 147,825 | | 3,788 | | 3,787 | | 10,002 | | 3,623 | | 67,996 | | 58,629 | | UNAIDS 2017 |
| Incidence Rate (Yr) | | 0.66 | | | | | | | | | | | | | UNAIDS 2017 |
| New Infections (Yr) | 6,394 | | | | | | | | | | | | | | UNAIDS 2017 |
| Annual births | 246,355 | | | | | | | | | | | | | | Population reference bureau 2017 sheet |
| % of Pregnant Women with at least one ANC visit | 91% | | | | | | | | | | | | | | DHS 2017 |
| Pregnant women needing ARVs | 5622 | | | | | | | | | | | | | | UNAIDS/ MSPP/P NLS 2018 |
| Orphans (maternal, paternal, double) | | | | | | | | | | | | | | | |
| Notified TB cases (Yr) | 15,567 | | | | | | | | | | | | | | WHO |

| | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| % of TB cases that are HIV infected | 749 | 11.29 % | | | | | | | | | | | | | MESI 2017 |
| % of Males Circumcised | | | | | | | | | | | | | | | |
| Estimated Population Size of MSM* | 38,300 | 1.1% | | | | | | | | | | | | | PLACE study 2016 |
| MSM HIV Prevalence | | 12.9 % | | | | | | | | | | | | | IBBS, 2014 |
| Estimated Population Size of CSW | 40,400 | | | | | | | | | | | | | | PLACE study 2016 |
| CSW HIV Prevalence | | 8.7% | | | | | | | | | | | | | IBBS, 2014 |
| Estimated Population Size of PWID | | | | | | | | | | | | | | | |
| PWID HIV Prevalence | | | | | | | | | | | | | | | |
| Estimated Size of Priority Populations (specify) | | | | | | | | | | | | | | | |
| Estimated Size of Priority Populations Prevalence (specify) | | | | | | | | | | | | | | | |
| | **If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.* | | | | | | | | | | | | | | |

Strategic shifts for the PEPFAR program in Haiti include roll out of Pre-Exposure Prophylaxis (PrEP) to key populations, in particular to MSM and CSW, and sero-discordant couples, and introduction of targeted oral fluid self-testing kits. The self-testing kits will be used as a tool to screen populations with high risk behaviors and to screen at-risk individuals, such as key populations and other targeted populations to be defined in collaboration with PNLS. Expansion of index case contact tracing and enhanced peer outreach approach (EPOA) for key populations will improve targeted testing within Haiti and help increase testing yield. With the collaboration of the MSPP, systematic HIV testing in the general population will be decreased to identify more HIV positive individuals.

Concomitant to an overall decrease in external funding in the recent years, the program has experienced some attrition among the cohort of people receiving ART. As retention in care and adherence to treatment are key determinants of treatment outcomes, and most important contributors to the UNAIDS 90-90-90 goals by 2020, PEPFAR Haiti has identified successful approaches to turn the tide. Expansion of the PLR program to all PEPFAR-supported sites and use of mobile health technology will help track those with missed appointments and lost to follow up. The interoperability of systems between facilities to track unique identifiers using biometric codes will continue to decrease the number of duplicates in the system. The tracking of unique identifiers will also address the medical shopping for migrant patients and those still in denial of their status. Finally, the task shifting within service delivery facilities, particularly as it relates to HIV pediatric care, and the increased use of the Agents Communautaire de Sante - Polyvalents (ASCP) (community health workers), PLHIV peers and KP peers, for better engagement with PLHIV within communities, in addition to other ongoing support activities, will further enhance the program, as described in the sections below.

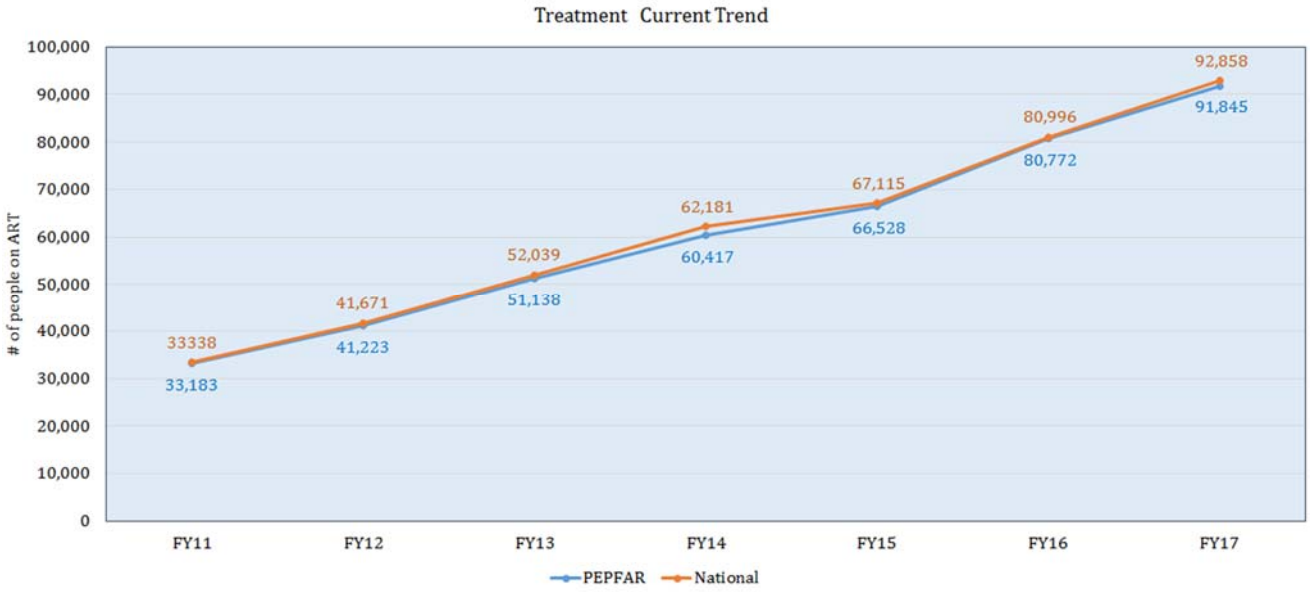
**Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression***

| Epidemiologic Data | | | | | HIV Treatment and Viral Suppression | | | HIV Testing and Linkage to ART Within the Last Year | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | **Total Population Size Estimate (#)** | **HIV Prevalence (%)** | **Estimated Total PLHIV (#)** | **PLHIV diagnosed (#)** | **On ART (#)** | **ART Coverage (%)** | **Viral Suppression (%)** | **Tested for HIV (#)** | **Diagnosed HIV Positive (#)** | **Initiated on ART (#)** |
| Total population | 10,711,073 | 1.4 | 147,825 | 126,579 | 91,838 | 62 | 64 | 1,168,796 | 24,994 | *21,798* |
| Population <15 years | 3,909,280 | 0.2 | 6,845 | 9,048 | 3,530 | 51 | 43.9 | 152,995 | 886 | *763* |
| Men 15-24 years | 1,082,490 | 0.3 | 3,623 | 5,920 | 3,353 | 97.51 | 62.2 | 100,250 | 1,228 | *1,069* |
| Men 25+ years | 2,126,293 | 2.8 | 58,629 | 39,983 | 28,877 | 49.25 | 65.1 | 196,845 | 7,938 | *6,594* |
| Women 15-24 years | 1,216,659 | 0.8 | 10,002 | 2,087 | 6,932 | 69.3 | 62.2 | 171,830 | 2,366 | *2,075* |
| Women 25+ years | 2,376,350 | 3.2 | 67,996 | 64,951 | 49,146 | 72.28 | 65.7 | 349,981 | 10,082 | *10,859* |
| | | | | | | | | | | |
| MSM | 38,300 | 12.9 | | | | | | 6,731 | 411 | *380* |
| CSW | 40,400 | 8.7 | | | | | | 21,973 | 775 | *779* |

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Prisoners | 14,000 | 4.3 | | | 1,013 | | | 19,373 | 895 | 513 |

*Some age/sex disaggregates do not add up to the totals due to some results reported without age/sex categories

**Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment**




## 2.2 Investment Profile

Weak economic conditions in Haiti continue to impact the available revenue for investment in the HIV response. There is sporadic political turmoil following Haiti's contested 2016 presidential and parliamentary elections and the inflation rate continued to rise to 14.7% in October 2017 (IMF, 2017). The Haitian Gourde (HTG) exchange rate peaked in April 2017 at 69.35 HTGs for one U.S. dollar (USD), dropped briefly in June to 2016 levels and continues to climb from its average February 2018 rate of 64.34 HTG to 1 USD[1]. Consecutive category 5 hurricanes Irma and Maria whipped through the region in September 2017, bringing excessive rain and dangerously high winds which contributed to severe flooding and mudslides throughout Haiti. Although recorded loss-of-life was low relative to the region, economic and infrastructure damage remains. In a country with such limited resources and competing social needs, Haiti's public spending on health is likely to remain low. However, the installation of a new government and parliament in early 2017 has provided an opportunity to advocate for increasing the national health budget in the future. Still, only an estimated 4.4% of the national budget is allocated to the health sector (WHO, 2017). Of the national funds allocated to health, over 90% of the operating budget supports personnel costs of the MSPP staff; however, these funds are not sufficient to cover the actual needs of personnel in the public health sector. The lack of resources, outside of contributions in the form of limited personnel salaries and the availability of public facilities, leaves almost no room for the Government of Haiti (GOH) to earmark specific resources for health system development or the HIV program. Funding

[1] Source: http://xe.com/currencycharts/?from=USD&to=HTG&view=10Y

for the HIV program comes from PEPFAR (83%) and the Global Fund (15%), and the estimated in-kind contribution of the MSPP (2%). PEPFAR Haiti continues to work closely with the Country Coordinating Mechanism (CCM) and Population Services International (PSI), the primary recipient of the GF joint HIV/TB grant, to avoid duplication and to leverage GF resources for strategic alignment with PEPFAR goals. The grant continuation was recently signed in the amount of $105M for a three-year period (2018 through the end of 2020), including $66M for HIV and $17.9M for TB. The grant continuation and above allocation request currently under consideration were developed in close collaboration with the PEPFAR Haiti team.

**Table 2.2.1 Annual Investment Profile by Program Area[1]**

| Program Area | Total FY19 Budget allocation | % PEPFAR | % GF | % Host Country (2) | % Other (2) |
|---|---|---|---|---|---|
| Clinical care, treatment and support Community-based care, treatment, and support | 69,174,553 | 79 % | 17 % | 4 % | |
| PMTCT | 5,636,590 | 99 % | >1 % | | |
| HTS | 11,515,565 | 93 % | 7 % | | |
| Priority population-prevention AGYW Prevention- Key population prevention | 4,453,646 | 61 % | 39 % | | |
| OVC | 11,136,438 | 97 % | 3 % | | |
| Laboratory | 4,807,716 | 79 % | 21 % | | |
| SI, Surveys and Surveillance | 3,050,902 | 100 % | | | |
| HSS | 5,213,588 | 44 % | 56 % | | |
| Administration & Management | 6,438,458 | 99 % | | 1 % | |
| **Total** | **121,427,456** | **83 %** | **15 %** | **2 %** | |

*(1) This represents the current budget for FY19 for these program areas; Global Fund reflects CY19*

*(2) The Total FY19 Budget allocation for Host Country and other donors is not available yet, but from past expenditures reports; NASA 2015-2016, MSPP, December 2017, the contribution from Host Country was 2%.*

| Table 2.2.2 Annual Procurement Profile for Key Commodities | | | | | |
|---|---|---|---|---|---|
| **Commodity Category** | **Total Expenditure** | **% PEPFAR** | **% GF** | **% Host Country** | **% Other** |
| ARVs | 17,350,170 | 65% | 35% | 0% | 0% |
| Rapid test kits | 3,172,570 | 53% | 47% | 0% | 0% |
| Other drugs | 1,268,450 | 61% | 39% | 0% | 0% |
| Lab reagents | 2,698,444 | 44% | 56% | 0% | 0% |
| Condoms | 2,478,838 | 64% | 36% | 0% | 0% |
| Viral Load commodities | 3,304,283 | 70% | 30% | 0% | 0% |
| VMMC kits | 0 | 0% | 0% | 0% | 0% |
| MAT | | | | | |
| Other commodities | 1,973,684 | 24% | 76% | 0% | 0% |
| **Total** | 32,246,439 | 54% | 46% | 0% | 0% |

| Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration | | | | | |
|---|---|---|---|---|---|
| **Funding Source** | **Total USG Non-PEPFAR Resources** | **Non-PEPFAR Resources Co-Funding PEPFAR IMs** | **# Co-Funded IMs** | **PEPFAR COP Co- Funding Contribution** | **Objectives** |
| USAID Maternal & Child Health | $14,000,000 | $9,000,000 | 4 | $7,888,761 | There are 4 USAID implementing mechanisms that receive PEPFAR, MCH, and FP funds. USAID works through an integrated strategy to improve health outcomes— meaning these projects support service delivery and health system strengthening across multiple program areas. This integrated approach improves access and utilization of services and greater effectiveness in strengthening Haiti's health system. |
| Family Planning | $6,500,000 | $5,300,000 | | $0 | |
| HHS Post Earthquake Supplemental Funding | $7,540,440 | $4,650,000 | 3 | $0 | The purpose of these resources is to support the provision of high-quality integrated TB/HIV services and operation of critical supported disease surveillance and detection systems. |
| Total | 28,040,440 | 18,950,000 | 7 | 7,888,761 | |

| Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP | | | | | | |
|---|---|---|---|---|---|---|
| **Funding Source** | **Total PEPFAR Non-COP Resources** | **Total Non-PEPFAR Resources** | **Total Non-COP Co-funding PEPFAR IMs** | **# Co-Funded IMs** | **PEPFAR COP Co-Funding Contribution** | **Objectives** |
| **PEPFAR Central Initiatives** | *$8,000,000 | 0 | 0 | 1 | *$8,000,000 | To fund the implementation of a PHIA in Haiti. This represents an estimated budget. Final budget will be available later in the year. |
| **Total** | **$8,000,000** | **0** | **0** | **1** | **$8,000,000** | |

## 2.3 National Sustainability Profile Update

SID 3.0 Process

The PEPFAR Haiti team and stakeholders followed a process that was similar to that of 2015. The two PEPFAR Sustainability Index and Dashboard (SID) workshops included participation by the MSPP, through PNLS, civil society and other multilaterals. The first workshop reintroduced the concept of the SID and shared the dashboard from the previous SID. Additionally, the tool was translated to French and UNAIDS served as the co-host of this process. At the first workshop, participants were grouped into four teams by domain and PEPFAR partners facilitated and served as rapporteurs. A great deal of discussion came from the first workshop and participants provided positive feedback on the process.

The second workshop brought together key participants to review the completed SID 3.0 tool to discuss from a policy perspective the totality of the tool, and to ensure the dashboard scores were appropriate scores based on reference documents and matched the in-country perspectives. Partnering with UNAIDS to plan and conduct the SID process was a useful way to begin the dialogue necessary for COP18.

Sustainability Strengths

*Quality Management*

One of the greatest sustainability strengths of the program is its quality management component. Quality management is well integrated at different levels including national, regional, and site levels with a national coordination entity chaired by the General Director of MSPP. In a collaborative effort, health facilities develop continuous quality improvement activities to address

weaknesses and improve health services. If problems or issues are noted, implementing partners design improvement plans for their sites to address problems observed. Another success within Quality Management is the existence of the national quality structure with a clinical data collection systems from which local performance measurement data on prioritized measures are being collected, aggregated nationally, and analyzed for local and national improvement.

*Planning and Coordination*

Over the last ten years, the MSPP, through PNLS, has made significant progress in its capacity to plan and coordinate the HIV response in Haiti. The multi-year, multi-sectoral national strategic plan for HIV is revised in a timely manner to address new challenges and a plan that extends past 2020 was recently approved. These are participatory processes with strong leadership from the MSPP and technical assistance from external stakeholders; however, there is a continued gap in the involvement of the private sector.

*Performance Data*

Since the beginning of the program, the MSPP, through PNLS, has made service delivery data collection and quality assurance a priority; the government maintains an integrated HIV case-based surveillance system, SALVH (French acronym Haitian Active Longitudinal Track of HIV System), with the support of external donors, including PEPFAR Haiti. As the program matures, data usage and sharing has become more transparent, in line with PEPFAR goals.

<u>Sustainability Weaknesses</u>

*Domestic Resource Mobilization*

One of the greatest threats to sustainability of the HIV response in Haiti is the lack of domestic financial resources. Despite the work of advocacy groups over the last few years, the HIV response is funded almost exclusively through international support, namely PEPFAR and the Global Fund. Currently, Haiti has an approved national health policy; however, the country does not have a national health financing strategy. The PEPFAR Haiti team is working with the MSPP through a health financing 'task force'—including the Ministries of Finance and Social Welfare—to develop a health financing framework for the sector. With the seating of the new government, the U.S. Government took the opportunity to discuss talking points on domestic resource mobilization for health at the highest levels of the Haitian government, including in courtesy calls with the Minister of Health and the Prime Minister. This policy issue goes beyond the HIV response and is being addressed on multiple fronts through Embassy leadership and USG interagency stakeholders.

*Commodity Security and Supply Chain*

The GOH does not provide any funding for the procurement of HIV commodities, including antiretrovirals (ARVs) and rapid test kits (RTKs) which are essential to reach the UNAIDS goals for 2020. However, the MSPP participates actively in national quantification exercises to plan for

anticipated needs of HIV commodities and is actively involved in guiding policy and strategy for an integrated national supply chain.

*Private Sector Engagement*

As the funding from external sources declines for the HIV response, the dialogue by the GOH needs to increase to allow a functional pathway to increase and utilize private sector support.

**2.4 Alignment of PEPFAR investments geographically to disease burden**

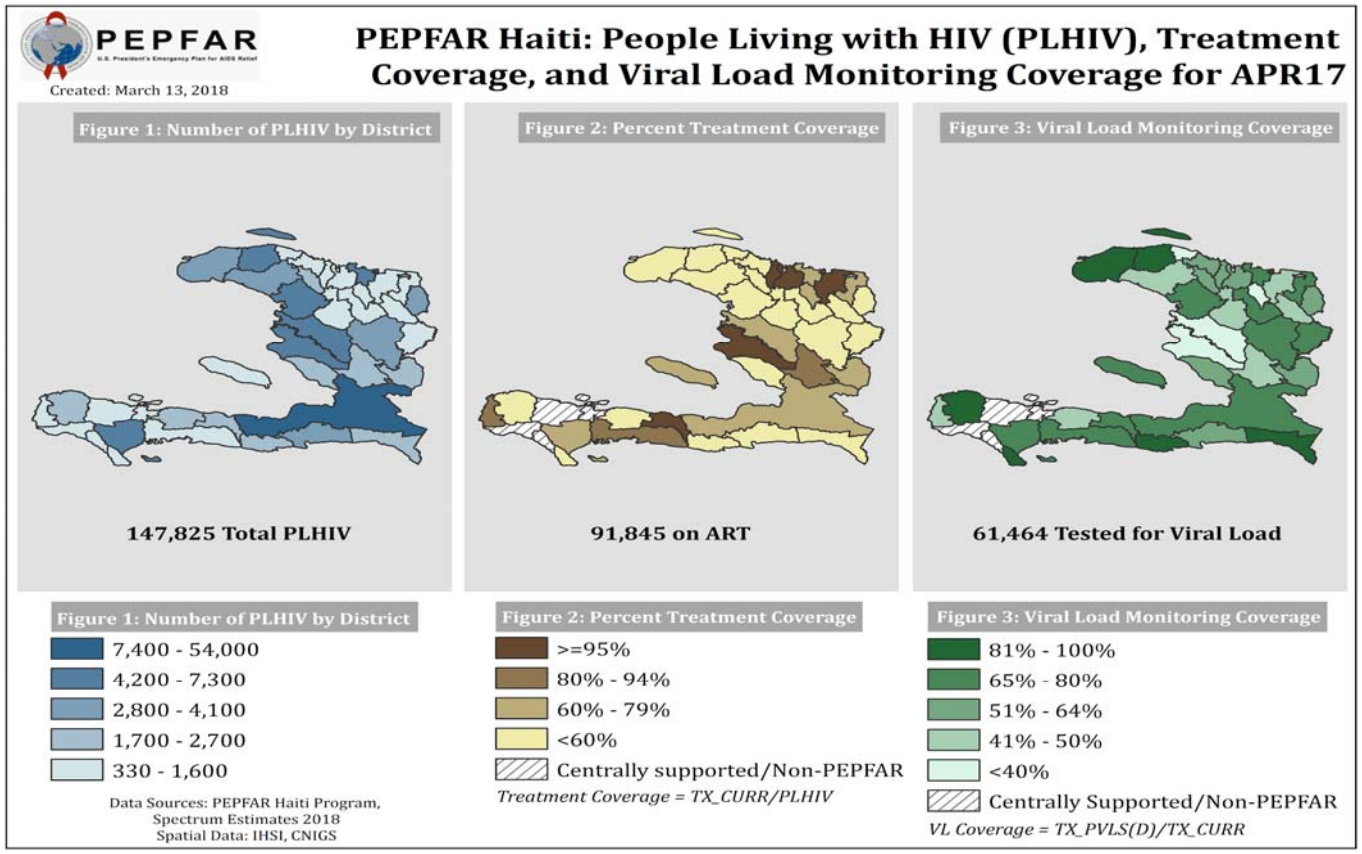
In COP18, PEPFAR Haiti will continue to focus its investments in 20 prioritized arrondissements, including a cluster of 3 arrondissements, as identified through the geographic prioritization exercise and program pivots undertaken during COP15, COP16, and COP17 with slight revisions based on programmatic data.

Analysis of programmatic and financial data shows an overall alignment of investments with both the geographic distribution of PLHIV and the population enrolled on ART. PEPFAR-supported sites and services are located in areas with high burden PLHIV, resulting in a higher volume of people being enrolled on ART in these areas. Over 90% of PLHIV newly enrolled on ART in FY17, and over 90% of PLHIV currently on ART with PEPFAR support, are located in Scale-Up arrondissements.

During FY17, viral load monitoring capacity was fully rolled out in all ART sites in the country, with training of personnel for specimen collection, and strengthening of the national system referral network to bring specimens to the two central labs in Port-au-Prince and return results. With this system, viral load tests results are available to all sites nationwide within 15 working days. Significant progress has been made in terms of coverage, with the number of VL tests done in FY16 (26,900) more than doubled in one year (62,770 in FY17). Reinforced monitoring of sites, to ensure that viral load requests are made in a routine manner for all eligible PLHIV on ART, in accordance with national guidelines, will close the remaining coverage gaps (see Figure 2.4.1) observed in some arrondissements.

In COP18, PEPFAR Haiti will continue to ensure alignment of resources and investments with prioritization of arrondissements, programmatic data, and strategic shifts.

**Figure 2.4.1**




## 2.5 Stakeholder Engagement

The PEPFAR Haiti team engaged stakeholders, including the host country government, the Global Fund and its PR and sub-recipients (SRs), and civil society at various points in the COP18 development process. Stakeholders were involved in two stages of the development of the SID in January and February 2018, and the PEPFAR Haiti team also convened a stakeholder meeting in February to solicit input on six key themes: TB/HIV, targeted HIV testing, elimination of mother to child transmission of HIV, increasing demand for viral load, improving retention and scaling up on a flat budget. Stakeholder feedback reinforced key priorities, including scaling up biometric coding across networks to reduce duplicate patients and better target available community health workers to patients truly lost to follow up. Stakeholders also discussed the challenge of eliminating perinatal transmission given the context of low levels of institutional births and incomplete coverage of ANC services with HIV testing. Stakeholder input was integrated into COP18 planning and is reflected in this document.

# 3.0 Geographic and Population Prioritization.

The COP15 and COP16 prioritizations of districts were based on the estimated disease burden and the HIV testing and counseling (HTC) yield. COP17 categorization of SNUs was made in accordance with COP17 guidance based on a saturation timeline. Two districts, Miragoane and La Gonave, were re-categorized from Sustained districts to Scale-up Saturation and Scale-up Aggressive districts respectively. In COP17, two Scale-up Aggressive districts, Trou du Nord and Acul du Nord, were re-categorized to Scale-up Saturations districts given they were at nearly 80 % ART coverage. Mole Saint-Nicolas was re-categorized down to Scale-up Aggressive given that programmatic data did not align with expected goals based on district PLHIV estimates. Additionally, the districts of Port-au Prince, Croix des Bouquets and Leogane were grouped to form the "Greater Port-au-Prince Cluster" to better adjust targeting by accounting for the constant population migration and movements between the three areas.

In COP18, the SNU prioritization will remain the same as in COP17. Four scale-up aggressive districts: Mirebalais, Fort-Liberte, Aquin, and La Gonave, are re-categorized as Scale-up saturation districts, as they will reach 90% by APR19. The 20 Scale-up districts/cluster (Saturation and Aggressive) prioritized for COP18 represent 90% of patients in the cumulative national ART cohort.

As it relates to attainment in Haiti, six districts had over 90% ART coverage at the end of FY17 including Saint-Marc, Miragoane, Acul du Nord, Trou du Nord, Aquin, and Limbe. However, only 2 of these districts, Acul-du-Nord and Saint-Marc, have reach ≥90% of coverage for adult men and women, as well as children. Further analysis is needed to ensure that the coverage of 90% is true for all 5-year age bands disaggregation in these 2 districts, as outlined in the COP18 guidance for the definition of "Attained". The remaining 4 districts may achieve saturation for specific populations and age groups at different points in time in COP18 while being fully attained in the following year. To ensure attainment across age groups and populations, ART and viral load coverage for adult men and women, children and key populations will remain among the priorities for these districts.

**Table 3.1 Current Status of ART saturation**

| Prioritization Area | Total PLHIV/% of all PLHIV for COP18 | # Current on ART (FY17 National*) | # of SNU COP17 (FY18) | # of SNU COP18 (FY19) |
|---|---|---|---|---|
| Attained | N/A | N/A | N/A | N/A |
| Scale-up Saturation | 93,987 / 63.6% | 65,790 | 10 | 13** |
| Scale-up Aggressive | 23,512 / 15.9% | 15,887 | 10 | 7 |
| Sustained | 26,220 / 17.7% | 10,663 | 14 | 14 |

| | | | | |
|---|---|---|---|---|
| Central Support | 2,832 / 1.9% | 518 | 4 | 4 |
| Not Supported | 1,273 / 0.9% | 0 | 2 | 2 |

*PEPFAR reported 99% of the national figures in FY17 (PEPFAR 91,845 National: 92,858)
**Counting Greater Port-au-Prince as three SNUs (Croix-des-Bouquet, Leogane, and Port-au-Prince)

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

**4.1 – 4.3 COP18 Programmatic Priorities for Epidemic Control**

In COP18, PEPFAR Haiti will continue to identify PLHIV and link them to treatment to achieve epidemic control. The following strategies will be used to find the missing, get them on treatment and retain them in order to achieve the 95-95-95 goals across different population sub-groups and all age groups:

1. Targeted testing: implementing partners have been using a variety of testing modalities to reach the remaining PLHIV in Haiti. Among those modalities are mobile HTS outreach in remote underserved areas, a mixed approach of both facility- and community-based testing, and voluntary counseling and testing. While these strategies have permitted an increased number of people to know their HIV status, the desired yield was often not met. To address this challenge, in COP18, the PEPFAR Haiti program will establish testing target ceilings for all implementing partners as a way to achieve better yield and improve the targeted testing results.
2. Index case contact tracing: active case finding through "index client" will be a focus in COP18. This strategy has been standardized by PNLS to help ensure all sites are implementing index case testing with fidelity, offering all contacts of HIV positive individuals HIV testing services, without disclosing the index client's status. This strategy will particularly assist in reaching missing men: partners of pregnant women in antenatal care and clients of male and female sex workers. Preliminary data from the selected number of sites that launched the initiative has shown the following after five months of implementation: (i) the yield among partners of PLHIV tested is 20 times higher than in the general population; and (ii) the approach reaches almost twice the proportion of male clients compared to the other testing activities underway. While men represent on average 35% of individuals tested each year, they comprise 57% of the partners reached through contact tracing. Test and Start has been implemented systematically with partners of index patients, and to date 92% of partners who tested positive have been started on ART. In addition, couples counseling has been used as much as possible to reinforce adherence when the parties accepted mutual disclosure.
3. Enhanced peer outreach approach (EPOA): also known as social networking, EPOA uses KP peers to refer high risk individuals for testing services. The initial roll out in COP17 has

shown the potential to penetrate untapped networks of key populations, including men who have sex with men and women (MSMW) who often do not self-identify as such.

4. Self-testing: this strategy will be used as an expansion of HTS service at the community level for key populations. This testing strategy will potentially be used with pregnant women seen in non-PEPFAR sites supported with USAID MCH funds, ensuring that pregnant women are screened for HIV and referred to appropriate care and treatment services if screened positive.
5. Patient Linkage and Retention: ART Community-based Distribution and BC will help address a major challenge for the PEPFAR program in terms of linkage to and retention in care. The Patient Linkage and Retention (PLR) electronic platform for patient tracking will be expanded to cover the remaining PEPFAR-supported sites. PLR will not only help track patients in the community who have recently missed an appointment or defaulted on treatment but also bring back to care those who were lost to follow up, and also improve the attrition rates in the program. This community tracking tool is already implemented in 80 PEPFAR supported facilities in Haiti and a full coverage is expected by the first quarter of COP18. To date, about 12,000 patients previously LTFU have been brought back to care through PLR and have remained active in the system. Additionally, close to 2,000 patients have been identified as having duplicate files in the system, although only 550 were found active at more than 1 site at the time of the APR17.
6. Interoperability and Integration: The integration of digital fingerprints/biometric coding into electronic medical records (EMRs) in all facilities will strengthen the program's capacity to detect "duplicates" by determining which patients are enrolled at more than one treatment location and thus address issues of medical shopping. Furthermore, the interoperability at the national level will allow the medical records to follow patients when they transfer care within a network using the same electronic medical record, and allow for a continuum of care and treatment, while maintaining quality of record keeping.
7. Differentiated models of care: such as multi-month scripting, community drug distribution, and rapid pathway for stable patients, continue to be a core focus of the PEPFAR Haiti program. Their expansion will help alleviate the growing needs in human resources and increase efficiency, which is key to improving retention in Haiti. Sites have used the locating capacity of the PLR to enroll more than 21,000 patients on community-based drug distribution, and these patients have demonstrated improved adherence rates.
8. Task shifting: to allow integrated ASCP to be more involved in HIV service delivery and the management of patients on treatment will help improve retention for the program. Additionally, ASCP's engagement in community drug distribution and community tracking of LTFU, and index patients' contact tracing and testing, accompanied by appropriate reinforcement of counseling messages, will further improve programmatic results.

**Prevention, specifically detailing programs for priority programming:**

**HIV Prevention and Risk Avoidance for AGYW and OVC**

PEPFAR Haiti remains the main contributor to OVC activities in Haiti and has been working closely with PNLS and IBESR (Institut du Bien Etre Social et de la Recherche), the government entity responsible for OVC under the Ministry of Social Affairs (MAST). PEPFAR Haiti was chosen as a DREAMS-like country for COP17. Consequently, a geographical focus was placed on districts with a high yield of HIV testing among adolescent girls and young women (AGYW) ages 10-14, 15-19 and 20-24 years old. Based on a geographic analysis of the areas producing the highest yield of female youth testing HIV-positive, four districts are targeted -- Port au Prince, Cap-Haitien, Dessalines and Saint Marc. Those districts are all in Scale-up Saturation areas and also located within departments (Artibonite, North and West) with a high prevalence of GBV as reported by the 2012 DHS. A package of services layered by age band 10-14 and 15-19 has been designed to address the specific needs of these age groups emphasizing prevention interventions, particularly among girls aged 10-14 and 15-19. The main components of the package are: access to secondary education; positive parenting for caregivers; mentor-led risk avoidance community based GBV prevention, including schools with social services for violence survivors; comprehensive adolescent sexual and reproductive health education and counseling; social asset building; and household economic strengthening (HES) through Savings Groups.

HES is facilitating the transition for many families from PEPFAR Haiti support and is reducing dependency on OVC education programs. Access to education has been an important element of the PEPFAR Haiti OVC program, as it promotes resiliency among adolescent girls and reduces vulnerability. The ratio of girls to boys receiving educational support is currently 51:49, and the dropout rate for girls is below 1%. The Savings Group program aims to empower young women and their families through social and economic strengthening and consequently help to reduce GBV and decrease HIV risk. Other interventions aiming at risk reduction include access to comprehensive adolescent sexual and reproductive health services, including access to condoms and family planning methods, and linkages to HIV testing services (HTS) for a strengthened continuum of care particularly focused and scaled-up in areas of high HIV prevalence. In addition to those activities, implementing partners will work with MAST, IBESR and PNLS to link violence survivors to medical, legal and psychological services -- particularly in the DREAMS-like districts.

Case management of individual beneficiaries to assess the child and family improvement within the OVC program will be enhanced through existing mobile phone-based case monitoring tools such as the Open Data Kit (ODK), which will be rolled out in COP 18. Further, quality assurance activities will be carried out to ensure a multi-layered package of services are offered to OVCs.

For COP 18, the OVC and the pediatric AIDS program will continue to strengthen the link to HIV testing, care and treatment services. Lost to follow up has been an issue across all programs and the consequences have negatively impacted the pediatric population. In order to address this issue, PEPFAR Haiti is directing implementing partners to enroll all infected children into the OVC program so they can receive the corresponding support to improve retention and ensure adherence, viral load testing and viral load suppression. Within the pediatric population, the OVC program will ensure age appropriate support for AGYW through participation in adolescent clubs, peer support groups, access to education and vocational training for the most vulnerable. A key element

of the OVC program will be to help with the transition from adolescent to adult care with the goal to improve retention. Implementing partners will also ensure referral access to basic pediatric services related to child survival such as immunization, deworming, Vitamin A supplementation, screening and treatment for malnutrition. Vulnerable children and youth in high risk populations (prisons, street children, children of KPs) are prioritized.

PEPFAR Haiti will continue to work with the USAID Office of Democracy and Governance for the roll out of the response to the Violence Against Children Survey (VACS). The OVC program is coordinating with other partners involved in projects related to child protection, human rights, and human trafficking to address issues raised by the VACS survey including settings for post-rape care and networking with the GOH, UNICEF and other key stakeholders. For COP18, legal services for victims of sexual violence will be provided through leveraging with an existing partner funded under the USAID Office of Democracy and Governance.

**Children**

The most recent estimates by UNAIDS indicates that 7,575 Haitian children are living with HIV. As of Q1 of FY18, 3,813 children living with HIV (CLHIV) were active on antiretroviral treatment, which represents 53% achievement towards having 95% of CLHIV on treatment. For COP18, PERFAR Haiti and its partners will introduce new approaches to reach epidemic control in the pediatric population. The longitudinal HIV data system (SALVH) shows that between December 2016 and December 2017, 6,509 children have been newly diagnosed as HIV-positive or visited a care facility, suggesting a gap of only 687 to reach the first 95 goal. In order to reach that goal, the program will put a focus on districts with the highest testing yield and largest pediatric gaps. Furthermore, PEPFAR Haiti will stop routine testing for all kids and have a more targeted approach by testing outpatient children using a standardized screening tool, malnourished and hospitalized children, and children of key populations.

The overall linkage rates for the pediatric population are good, with over 95% of children linked to treatment. However, the program is still facing serious difficulties retaining children on treatment and ensuring that they are virally suppressed. In FY17, 763 CLHIV were enrolled in the program but at Q4 our Tx_Net_New was 281, showing a poor retention rate. Viral load data from the same period shows suppression rates under 50% for all pediatric age groups. PEPFAR Haiti will improve the technical capacity of sites to manage HIV infected pediatric clients by: (i) focusing on task shifting by training nurse practitioners in pediatric clinical management, especially at sites with the biggest burden and in districts with largest gaps; (ii) training healthcare workers, lay counselors, and expert clients on age-appropriate adherence counseling at high burden sites; and (iii) reinforcing continuous quality improvement (CQI) activities. The program will put an emphasis on retention strategies by building upon the success of the OVC program: 99% of HIV+ children enrolled in the OVC program are enrolled on ART and retention rates are over 90%. The program will prioritize for referral to the OVC program all HIV exposed infants and all CLHIV to help mitigate issues that are having a negative impact on retention and viral suppression. The introduction of parenting caregiver curricula in the OVC program will also help addressing difficult to tackle issues such as

stigma, disclosure and adherence by improving parent/children communication. The program will also work with implementing partners to ensure that pediatric formulations are available where needed and that children over 30 kg are switched to TLD as recommended by national guidelines.

**Key Populations**

The IBBS conducted in 2014 and Priorities for Local AIDS Control Efforts (PLACE) conducted in 2016 have shown that MSM and CSW contribute significantly to the burden of HIV in Haiti, with prevalence rates significantly higher than the general population; respectively 12.9% and 8.7% (IBBS 2014). Furthermore, the PEPFAR Haiti program includes prisoners and their family members among the priority populations given the continuing burden of HIV and TB co-infection in prison settings.

In COP18, PEPFAR Haiti will continue to support high-impact core intervention for KPs including targeted prevention messages and HTS for key populations, combination prevention services extended to clients of CSW and MSW, condom/lubricant promotion and distribution, use of peer navigators to enhance adherence and retention to positive KPs, and expansion of community drug distribution. PrEP roll-out will be implemented and eventually offered to all KPs who may want to access these services, including sero-discordant couples.

The previous IBBS and PLACE studies indicated that stigmatization and violence hindered MSM and CSWs' access to quality HIV services: approximately 6% of MSM and 11% of CSW reported mistreatment by a healthcare worker. Indeed, the results of the latest stigma and discrimination poll (2017) among adults indicate high levels of hate and intolerance towards key populations. As an example, 71% of surveyed adults expressed hate towards homosexuals and 60% claimed that prostitution should be illegal everywhere. In COP18, specific interventions will be implemented to tackle stigma and discrimination. Sensitization trainings will be offered to healthcare workers at the site level and the recruitment of peers (MSM, CSW, PLWHA) will be encouraged to ensure KP-friendly health services are provided. At the community level, PEPFAR Haiti will continue to sensitize law enforcement officials, including the Haitian the National Police (HNP), about the rights of KPs and to ensure that KPs have access to supportive, respectful, and appropriate services.

In regards to coverage, the program will continue to strengthen capacity of local organizations to provide KP-friendly services and utilize local social networks to identify undiagnosed individuals living with HIV and link them to HIV treatment services. The latter will be done primarily through the full roll-out of EPOA and the mobile outreach activities to increase coverage in remote areas with limited access to KP friendly services. The 2016 PLACE study included validation and mapping of 2,339 KP hotspots throughout all of Haiti's 10 departments. Data continues to be collected (an additional 421 hotspots have been identified in the last 6 months for a new total of 2760 hotspots in Haiti) and used by implementing partners for the micro-planning and targeted KP prevention and testing services.

Accurate reporting of data for KPs continues to be a key focus of the PEPFAR Haiti program to inform the HIV cascade of care. Since the reporting gaps are greater for KP, a joint cascade assessment with the Global Fund was conducted in May-June 2017 to ensure coverage of critical

services. The specific assessment aimed to better align the package of services (prevention, testing, and treatment) for key populations among different PEPFAR and Global Fund implementing partners. The key recommendations included introducing oral fluid testing, increasing the use of community-based dispensation of ART, and strengthening the peer navigation system. Other recommendations have also been taken into account to strengthen the KP program in Haiti including the use of PrEP and transitioning to the TLD ART regimen.

To foster sustainability and continuity, services for KP will be integrated within existing services where possible, while leveraging and strengthening the capacity of KP civil society organizations to support implementation of the HIV response. PEPFAR Haiti will continue to collaborate with PNLS to ensure that the different HIV-related guidelines incorporate KP and will support activities that are strategically designed to involve host government and community-level structures, including civil society. National and sub-national entities will be involved in the evaluation and the dissemination and sharing of best practices with an emphasis on obtaining community involvement whenever possible.

**VMMC**
Not Applicable

### 4.3 Additional country-specific priorities listed in the planning level letter

HIV Testing Strategies and Linkage to Treatment

For COP18, the PEPFAR Haiti team will continue to analyze its testing partners and their results against targets across geographic areas, testing modalities, age/sex disaggregates, and focus populations to ensure that partners are utilizing efficient testing modalities with target populations. Strategies for targeted testing to be scaled up include index case testing, self-testing for priority populations, and specific strategies focusing on men and children. In addition, rapid recency testing will also be implemented in COP18.

**Index Case Contact Tracing / Testing**:

Index case testing in Haiti has already demonstrated impressive results. Currently implemented in 36 sites via 3 implementing partners with ongoing scale-up, index testing to date has demonstrated a yield of 44% in 1226 partners tested. In COP17, scale-up of index testing continues; an additional 10 sites are currently rolling out index testing with 60 sites targeted by the end of FY18.

Full implementation of index case testing is planned by FY19 Q1; by the end of FY19, it is expected that nearly 38,000 partners will be tested and an anticipated 6,000 partners started on treatment.

**Enhanced Peer Outreach for Key Populations:**

In Q1 FY18, the yield more than tripled in 3 sites after EPOA was implemented. By the end of COP18, EPOA will be rolled out in all 24 key population sites for MSM and CSW: including 10

sites by the end of COP17 and 14 additional sites by the end of COP18. 4,200 HIV-positive MSM are projected to be reached via EPOA by the end of COP18.

**Self-Testing for Key Populations, Serodiscordant couples, and possibly pregnant women**

Ongoing policy planning discussions are ongoing with MSPP. Self-testing with the OraQuick test is planned for COP18, in collaboration with evolving community health worker guidelines. Self-testing will be rolled out for key populations, serodiscordant couples and potentially, for pregnant women who are not receiving HIV-testing in antenatal care sites supported by USAID MCH funds.

**HIV rapid-recency assay**

In COP18, in collaboration with PNLS PEPFAR Haiti will implement HIV recent infection surveillance among persons newly diagnosed with HIV using the Asante Rapid HIV-1 Recency Assay, including test validation, staff training and necessary EMR modifications. Recency testing will be incorporated in the Haiti HTS testing algorithm and will be implemented on a phased rollout throughout FY19.

Recency testing will have multiple benefits, including:

- At the individual-level, case-based surveillance patient-level data from recent infection surveillance system will be used to prioritize index partner testing to increase HIV case detection rates and interrupt the chain of HIV transmission among HIV-negative partners.
- At the population-level, routine epidemiological analysis will be used to monitor trends and identify hot-spot locations and sub-populations associated with HIV recent infections to inform targeted interventions.

**<u>Enhanced Case Finding and Retention Strategies for Men and Pediatric Patients</u>**

Gap analysis in Haiti demonstrates a treatment gap for men of 23,952 and a treatment gap of 3,306 for pediatric patients.

In COP18, PEPFAR Haiti will continue to improve HIV+ pediatric patients' case finding and linkage to treatment with the following strategies:

- Building upon the success of the OVC program- in which 99 % of HIV + orphans and vulnerable children are on ART with > 90% retention in the OVC program – PEPFAR Haiti will ensure that all HIV+ pediatric patients are enrolled in the OVC program;
- Prioritized targeted testing of high risk children focused in 6 priority districts with 59 healthcare workers trained in 46 facilities;
- Existing real time advisory portal established through social media (WhatsApp) expanded to include priority districts to address provider questions in real time on clinical management of HIV+ children and ARV treatment management; and
- Improved linkage and retention with family support through savings groups, psychosocial and educational support, and support for family communication, disclosure, and adherence.

In COP18, PEPFAR Haiti will continue to improve HIV+ male patients' case finding and linkage to treatment with the following strategies:

- Leveraging Social Media
- Index case contact tracing
- Social network for key populations fully implemented
- Strong commitment and training of community health workers
- Decreased waiting times for testing and counseling procedures for male patients
- Use of same sex peer PLHIV as a support to male patients
- Routine tracking and site level analysis of number of test done versus the yield

Viral Load Scale-Up

PEPFAR Haiti accomplished an ambitious viral load scale up with an increase in viral load tests of 26,843 in FY16 to 62,770 viral load tests in FY17 (an increase of 135% in one year).

PEPFAR Haiti continues to set an aggressive timeline for VL testing scale-up, with a planned total of 107,524 viral load tests in FY18 and 131,000 viral load tests by the end of FY19 (achieving 100% viral load testing coverage for eligible patients on ARV treatment) employing the following strategies:

- Focused demand creation training for clinicians serving at low performance sites/IMs
- Analysis of FY17 VL performance data with targeted capacity building to IMs with emphasis on sites with low performances.
- Ongoing site-level disaggregated monthly VL data analysis with IPs resulting in granular site work plans
- Improvement of VL suppression with targeted intensive adherence counseling and follow-up VL
- TLD transition leading to decreased side effect profile, reduced HIV drug resistance, and resulting improvements in adherence and viral load suppression

Completion and Rapid Use of Biometric Code Implementation

PEPFAR Haiti utilizes a fingerprint-based BC strategy, linked with EMR and SALVH, to enhance case-based surveillance and generate continual insight into programmatic strategies. BC is currently available in 84% of the PEPFAR-supported HIV treatment sites (118/140 sites) and will be available in all PEPFAR sites by April 2018, representing 98% of the total HIV treatment population. BC is linked to EMR in all PEPFAR-funded HIV treatment sites, with monthly data quality assessments (DQAs) conducted by MSPP and PEPFAR implementing partners. BC analysis has already demonstrated that "medical shopping" is less common than originally presumed with ~ 75% of duplicated patients visiting only 2 sites.

TLD Optimization

With the support of PEPFAR Haiti, PNLS is planning an aggressive 4-month TLD transition between October 2018 and January 2019. The TLD transition will include the following patient groups:

- All new patients (Adult & Adolescents over 30kg)
- Existing patients on 1st line: VL suppressed, or on ART for more than 5 years;
    - 78% of existing patients on 1st line are expected to transition to TLD by January 2019
- Certain patients on 2nd line, based on the transition algorithm
- Pregnant women and TB co-infected patients

Laboratory Optimization

PEPFAR Haiti's analysis of VL, Early Infant Diagnosis (EID), and GeneXpert TB testing demonstrates full capacity utilization of VL and EID testing and an underutilization of TB testing using GeneXpert (both for HIV-coinfected and HIV-negative patients). In FY18, PEPFAR Haiti is undertaking a VL and EID cost optimization study to help determine whether decentralization of EID and/or VL testing would be beneficial. This evaluation will guide COP18 implementation.

PrEP implementation

Discussions are ongoing between PEPFAR Haiti, Implementing Partners and PNLS around the implementation of PrEP. Planning includes:

- April 2018: national implementation guideline approval by PNLS
- May – October 2018: 6 months of operational plans, site selection and rollout planning
- Oct 2018: PrEP delivery for 1,000 KP and serodiscordant couples

Granular Site Management:

During COP17, PEPFAR Haiti has increasingly shifted focus from overall partner management to site level management. This process will continue throughout COP17 implementation and COP18, to include:

- Monthly United States Government (USG) staff review of site level data
- Increase in reporting frequency for lower-performing sites:
    - Sites currently submit monthly reports on Monitoring Evaluation et Surveillance Intégrée (MESI, French acronym); low-performing sites will submit bi-weekly reports on key targets
- Site Improvement Plans for low-performing sites, tailored to address specific challenges: testing yield, patient linkage, retention and viral load coverage / suppression
- Increased coordination with Global Fund on co-financed partners
- Ongoing HRH rationalization across USG and GF

- PNLS and the Priority Disease Coordination Unit to convene quarterly meetings of PEPFAR treatment partners to compare progress, share best practices and solutions to achieve epidemic control

### 4.4 Commodities

In COP18, PEPFAR Haiti will assist the Ministry of Health in the national commodities forecasting, quantification and supply planning exercise which aims to ensure the timely and uninterrupted availability of the new antiretroviral formulations at all geographic levels of the country in FY 2019 and FY 2020. Already this fiscal year, extensive coordination between the MSPP, PEPFAR and other stakeholders has been required to coordinate the procurement of new antiretroviral formulations to implement the aggressive TLD transition plan developed by the PNLS-led treatment cluster, to ensure adequate availability for prompt transition of close to 80% of existing ART patients to TLD within the first four to six months of the fiscal year 2019. PEPFAR Haiti anticipated procurement covers commodities needed for the simultaneous transition of adult and adolescents (greater than 30 kg) on first and second line ART regimens, as well as HIV and TB co-infected patients and pregnant women. PEPFAR Haiti will continue to closely coordinate with MSPP and Global Fund on forecasting, quantification and supply planning to ensure the availability of commodities to support the scale-up targets and transition to TLD while minimizing potential waste of legacy ARV regimens.

### 4.5 Collaboration, Integration and Monitoring

PEPFAR Haiti has a strong partnership with the Global Fund and other donors in the HIV/AIDS space. The team has engaged in several technical collaborations with the GF Principal Recipient and continues to work and plan collaboratively with the GOH and the GF to ensure program complementarity and avoid duplication wherever possible. In COP18 PEPFAR Haiti will work closely with the CCM and PSI, the primary recipient of the GF joint HIV/TB grant, to leverage GF resources for strategic alignment with PEPFAR 95-95-95 goals. Leveraging other donor efforts, including the GF, French Government, UNICEF and UNAIDS, PEPFAR Haiti will provide critical support to strengthen the CCM's grant management capacity through a technical advisor embedded to provide ongoing assistance, and through increasing engagement with key civil society and PLHIV and KP partners to ensure wide participation.

Despite inadequate domestic resource mobilization -- in-kind contributions estimated at only 2% of the total expenditures for HIV/AIDS -- the MSPP has begun to take initial steps to increase their budget allocation by proposing an HIV/AIDS line item in the annual MSPP budget. In COP18, PEPFAR investments will build on this and support the MSPP to develop a health financing framework, which will subsequently assist the MSPP to advocate for HIV resources. These focused investments will lead to increased national ownership of Haiti's HIV/AIDS program while promoting sustainability and accountability.

PEPFAR will continue to build on the MSPP's efforts to review and revise the roles and responsibilities of ASCPs to strengthen HIV service delivery at the community level. The PEPFAR Haiti team is working closely with the GF PR, UNICEF and others to support the MSPP to meet the conditions precedent around ASCP from the GF, including the development of a sustainability plan for ASCP as part of an overall HRH Strategy for the MSPP. Together GF and PEPFAR Haiti investments to strengthen HRH (including clinical health workers and ASCP) seek to ensure coordinated, high quality service provision and adequate service coverage in priority SNUs.

Since COP17, PEPFAR Haiti has expanded aggressive oversight to all implementing partners, not only service delivery partners, as had been the previous standard. The team also takes lessons from across the PEPFAR program globally to improve partner performance. In particular, the introduction and rollout of VL testing has been challenging; the team continues to closely monitor partner performance in this area. These analyses, including our evaluation of PEPFAR-supported sites with a Site Evaluation Tool developed by the PEPFAR Haiti team, allows COP18 to maximize the PEPFAR investment across the program.

The team has worked to align all above-site and above service delivery activities with key barriers identified through SIMS, SID 3.0, and MER results for reaching epidemic control. As part of the GF grant continuation process, the PEPFAR Haiti team participated in the development of an analysis of risks to successful implementation of the grant, and identification of risk mitigation measures to address many of these same vulnerabilities summarized in the SID. Key areas of coordination between the GF and PEPFAR include health information systems and supply chain; the PEPFAR-supported above-site activities that contribute to mitigating these areas are summarized in the SID and Table 6. For more information about how PEPFAR Haiti activities are mapped to key barriers and measurable outcomes related to reaching epidemic control, please see Section 6.0.

Protecting patient's medical information continues to be a priority for the program. PEPFAR is supporting the MSPP to draft an e-health policy that will strengthen regulation related to the three core principles of information security i) Confidentiality ii) Integrity, and iii) Availability. Those three principles are a key aspect of PEPFAR supported health information systems implementation:

· Regarding confidentiality, PEPFAR ensures that patient's data is accessible only by authorized personnel, including access to electronic systems. Patient data are protected at two levels: at site level and also when requested for study purposes. Disciplinary actions can be taken for breaching patient's confidentiality. Moreover, when data is requested for study purposes, requesters are required to sign a non-disclosure agreement form.

· Regarding integrity, access to servers are filtered to prevent unauthorized connection attempts and guarantee data integrity.

· Regarding availability, to ensure data are always available, all patient's data are stored in secure servers accessible only by authorized users. Support will be provided to the MSSP to run a Help Desk and Intervention teams to troubleshoot issues and ensure timely access to health and patient information.

## 4.6 Targets for scale-up locations and populations

| Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts | | | | |
|---|---|---|---|---|
| | **Entry Streams for ART Enrollment** | **Tested for HIV (APR FY19)** ***HTS_TST*** | **Newly Identified Positive (APR FY19)** ***HTS_TST_POS*** | **Newly Initiated on ART (APR FY 19)** ***TX_NEW*** |
| | Total Men | 170,479 | 6,443 | 8,177 |
| | Total Women | 480,952 | 13,337 | 12,939 |
| | Total Children* (<15) | 59,636 | 1,022 | 1,246 |
| | Adults | | | |
| | TB Patients | 9,100 | 1,021 | 999 |
| | Pregnant Women | 180,981 | 1,852 | 1,692 |
| | VMMC clients | - | - | - |
| | Key populations | 94,273 | 4,496 | 4,573 |
| | Priority Populations | - | - | - |
| | Other Testing | 441,007 | 14,652 | 11,637 |
| | Previously diagnosed and/or in care | - | - | 2,215 |
| | Pediatrics (<15) | | | |
| | HIV Exposed Infants* | 3,622 | 17 | 16 |
| | Other pediatric testing | 56,014 | 1,005 | 1,230 |

| | | | | |
|---|---|---|---|---|
| | Previously diagnosed and/or in care | - | - | 0 |

*Includes virologic HIV testing for infants (<1)

**Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

| Target Populations | Population Size Estimate (scale-up SNUs) | Coverage Goal (in FY18) | FY19 Target |
|---|---|---|---|
| **OVC (Under-18)** | n/a | | 54,507 OVC_SERV<18<br>54,507 OVC_HIVSTAT |
| **KP - Sex Workers** | 40,400<br>(Limited geography) | | 54,050 KP_Prev FSW |
| **KP - MSM** | 38,300<br>(Limited geography) | | 20,200 KP_PREV MSM |
| **Prisoners** | ~14,000 | | 10,068 KP_PREV<br>9,545 HTS_TST |
| **TB Cases (Number of new and relapse TB cases)** | 10,437 | 100% | 10,437 TB_STAT known HIV status<br>9,682 TB_STAT newly HIV tested |
| **Pregnant women and exposed infants (Number of new ANC clients)** | 184,291 | 100% | 184,291 PMTCT_STAT known status<br>182,405 Newly Tested for HIV<br>3,648 PMTCT_ART<br>3,648 PMTCT_EID |
| **TOTAL PREVENTION TARGET** | | | 84,318 KP_PREV<br>(FSW, MSM, Prisoners)<br>35,900 PP_PREV |

| Table 4.6.4 Targets for OVC and Linkages to HIV Services | | | |
|---|---|---|---|
| **SNU** | **Estimated # of Orphans and Vulnerable Children** | **Target # of active OVC (FY19 Target)** | **Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19)*** |
| Port-au-Prince Cluster | | 28,851 | 17,846 |
| Saint-Marc | | 9,495 | 5,873 |
| Dessalines | | 8,288 | 5,127 |
| Cap-Haïtien | | 7,614 | 4,710 |
| Port-de-Paix | | 7,594 | 4,697 |
| Acul-du-Nord | | 4,048 | 2,504 |
| Mirebalais | | 3,970 | 2,456 |
| Gonaïves | | 3,917 | 2,423 |
| Hinche | | 2,954 | 1,827 |
| Cayes | | 2,715 | 1,679 |
| Lascahobas | | 2,085 | 1,290 |
| Aquin | | 1,508 | 933 |
| Trou-du-Nord | | 1,411 | 873 |
| Fort-Liberté | | 1,338 | 828 |
| Miragoâne | | 1,016 | 629 |
| Marmelade | | 853 | 528 |
| Môle-Saint-Nicolas | | 826 | 511 |
| Jacmel | | 796 | 492 |
| Jérémie | | 689 | 426 |
| Grande-Rivière-du-Nord | | 685 | 424 |
| Plaisance | | 568 | 351 |
| Borgne | | 480 | 297 |
| Ouanaminthe | | 461 | 285 |
| Saint-Raphaël | | 419 | 259 |
| Cerca-la-Source | | 392 | 243 |
| Port-Salut | | 376 | 233 |

| | | | |
|---|---|---|---|
| Limbé | | 341 | 211 |
| Gros-Morne | | 280 | 173 |
| Belle-Anse | | 272 | 168 |
| Chardonnières | | 220 | 136 |
| Anse-à-Veau | | 193 | 119 |
| Arcahaie | | 174 | 107 |
| Vallières | | 167 | 103 |
| Bainet | | 145 | 89 |
| Anse D'Hainault | | 96 | 60 |
| Saint-Louis-du-Nord | | 73 | 45 |
| Corail | | 35 | 21 |
| La Gonâve | | 23 | 14 |
| **Total** | | **95,370** | **58,992** |

*HIV_STAT target is set to 100% of the under-18 OVC_SERV population.

# 5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

**5.1 COP18 Programmatic Priorities** (Attained/Sustained)

In sustained districts, the program approaches and activities are relatively similar to those planned in scale-up locations (see sections above: 4.1-4.3). However, some specific program areas will have slight differences. As an example, in the sustained districts, HTC will be provided upon request or initiated by providers for people with relevant clinical symptomatology or high-risk behaviors, and the OVC program will not allow new enrollment in educational programs within those districts. Still, HIV testing for all pregnant woman will continue and programming for key populations remains homogeneous regardless of the nature of the district.

Based on FY 17 APR results, the PEPFAR Haiti Program did not demonstrate 90% ART coverage at sub-national levels for all sex and 5- year age bands disaggregation; therefore, for COP18, the program is not planning a package of services for "Attained Districts". However, 5 districts are expected to reach attainment by the end of COP18.

**5.2 Targets for attained and sustained locations and populations**

**Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Attained Support Districts***

| **Attained Support Volume by Group** | | **Expected result APR 18** | **Expected result APR 19** |
|---|---|---|---|
| HIV testing (all populations) | *HTS_TST* | ***N/A*** | ***N/A*** |
| HIV positives (all populations) | *HTS_TST_POS* | ***N/A*** | ***N/A*** |
| Treatment new | *TX_NEW* | ***N/A*** | ***N/A*** |
| Current on ART | *TX_CURR* | ***N/A*** | ***N/A*** |
| OVC | *OVC_SERV* | ***N/A*** | ***N/A*** |
| Key populations | *KP_PREV* | ***N/A*** | ***N/A*** |

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the Attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

| Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts | | | |
|---|---|---|---|
| **Sustained Support Volume by Group** | | **Expected result APR 18** | **Expected result APR 19** |
| **HIV testing in PMTCT sites** | ***PMTCT_STAT*** | **28,116** | **25,235** |
| **HTS (only sustained ART sites in FY 17)** | ***HTS_TST/HTS_TST_POS*** | **63,432 / 823** | **54,406/ 1,765** |
| **Current on ART** | ***TX_CURR*** | **9,646** | **11,886** |
| **OVC** | ***OVC_SERV*** | **5,471** | **5,437** |

## 5.3 Establishing service packages to meet targets in attained and sustained districts

As stated above, the PEPFAR Haiti program is not planning a service delivery package for "Attained Districts" for COP18. Although analysis of program data and PLHIV estimates calculations show a number of districts that have reached ≥ 90% ART coverage, only 2 of these districts, Acul-du-Nord and Saint-Marc, have reach ≥90% of coverage for adult men and women, as well as children. Further analysis is needed to ensure that this is true for all 5-year age bands disaggregations, as defined in the COP18 guidance, but 5 districts have targets to reach attainment by the end of COP18. In addition, review of programmatic data show that patients coming from other districts receive care in facilities in these districts.

The service packages proposed for COP18 nationwide encompasses all prioritized activities recommended for attained and sustained districts, such as limited demand creation and HIV testing; continuous provision of care and treatment services, including essential laboratory services, and an increased focus on retention. As described in section 5.1, HIV testing in the sustained districts will be further limited, provided only upon request or as indicated by clinical symptomatology or identified high risk behaviors. However, systematic HIV testing for all pregnant women will continue, to ensure the elimination of mother-to-child transmission. Outreach, prevention, and testing programs for key populations will continue in all districts. The HIV epidemic and program response will continue to be regularly monitored through the country's robust HIV case-based surveillance system and the national reporting platform in all districts.

# 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

In assessing its capacity to achieve epidemic control in Haiti, PEPFAR Haiti will build on previous COP systems interventions; proposed activities address outstanding programmatic gaps and fast track attainment of epidemic control. New activities have been added in order to improve outcomes and rekindle the synergy needed for a new surge of PLHIV on treatment. In COP18 PEPFAR Haiti's above-site activities will leverage key systems investments by the GOH and other donors.

In the COP18 Funding Allocation to Strategy Tool (FAST), the budget for above-site Strategic Objectives, which are the basis for inclusion in Table 6, sum to $8.2M (8% of total budget), whereas site-level Strategic Objectives account for $81.6M (80% of budget). Systems investments are analyzed in light of past strategic shifts and previously-identified barriers to epidemic control. On average, Haiti SID scores improved, albeit minimally, between 2015 and 2017 evaluations. All 38 above-site activities outlined in Table 6 respond to the SID 3.0 elements on which Haiti scored lowest in 2017 and can be pointed to as key gaps in the current health system which impact achievement of sustained epidemic control.

PLHIV in Haiti are rooted in the country's stagnant socio-economic situation that fosters high internal and external migration of the population, making the provision and adherence to lifelong therapies such as ART a challenge. PEPFAR Haiti systems investments in recent years have focused on adapting and building capacity of service delivery and information systems for better coverage, adherence and retention of PLHIV. Innovations in differentiated models of care and drug delivery mechanisms have included multi-month scripting, community-based drug distribution, and community-based tracking through PLR. Despite gains in these areas, system-level challenges and barriers remain across the continuum of care:

**Low capacity and demand for Viral Load testing**

A large focus of above-site activities detailed in Table 6 aim to improve Haiti laboratory system's delivery and analysis of VL testing; a gap identified in both FY17 PEPFAR Monitoring, Evaluation & Reporting 2.0 (MER) and Site Improvement through Monitoring Systems (SIMS) results and highlighted as a key area for improvement in the COP18 Planning Level Letter. The COP16 SIMS 3.0 revealed that almost 30% of monitored sites received Red/Yellow on monitoring ART patients for VL, with only 56% TX_PVLS target achievement in FY17 MER. Given continuing implementation of Test and Start, it is critically important to have an objective method to monitor treatment outcomes. The VL scale-up will continue in COP18 using targeted approaches to reach 100% of eligible ART patients in Haiti. Global Fund will continue to procure commodities to support VL, which will allow PEPFAR Haiti to have limited budget increase for VL commodities and is sufficient to cover the additional VL tests. Systems level barriers impacting PEPFAR Haiti's ability to expand VL include:

a) Procurement and training on maintenance of VL lab equipment: PEPFAR Haiti will provide training and mentorship on maintenance and repair services to National Lab technicians, including providing an additional rented machine to meet the testing need according to the laboratory instrument mapping exercise performed recently and providing commodities.

b) Policy recommendations for decentralization of lab testing: Building off ongoing work to cost model and analyze differentiated models of care, PEPFAR Haiti will work with MSPP to develop and implement recommendations for optimization of VL/EID testing, including options to strengthen patient management.

c) Targeted VL testing refresher training and demand creation: PEPFAR Haiti only achieved 72% of the target for VL monitoring in FY17. SIMS results indicate that a leading cause of this was that clinicians and nurses did not adequately request VL tests nor take appropriate follow-up actions. To address this, PEPFAR Haiti will support demand creation for 100% VL testing of ART patients and provide focused refresher training for 100% of clinicians/nurses at low-performing sites.

d) Optimize specimen referral networks (SRN): Haiti has two SRNs: an EID network which is fully supported by PEPFAR (specimen from all sites to IMIS and LNSP), and a VL, TB, and surveillance supported network partially funded by PEPFAR, with multilateral support from World Bank, WHO-PAHO, and the U.S. Department of Health and Human Services/ Centers for Disease Control and Prevention (CDC) Global Health Protection Program. Six months after the full implementation of the SRN (November 2018), the SRN will be evaluated and any gaps addressed. There is potential for the 2 SRNs to be integrated pending further evaluation.

e) Integrated laboratory information system for specimen tracking, data collection, analysis, and reporting: Building on previous successful implementation in LNSP and integration with VL & EID systems, PEPFAR Haiti will install the Soft Computer Laboratory Information System (SCC-LIS) at IMIS and link to EMR, which will allow immediate availability of results to providers. Integration of laboratory testing instruments into SCC-LIS system for VL and EID testing will improve testing efficiency, reduce transcription errors, and make VL and EID service 'one stop shopping' a reality. The interoperability, along with the integrated national SRN, will reduce EID and VL turnaround time.

f) Expanded laboratory testing capacity for MDR-TB and TB culture: The current MDR-TB capacity at GHESKIO can only test 50% of the estimated MDR-TB cases in Haiti. Through training, equipment and certification for the BSL3 laboratory at the National Lab (LNSP), PEPFAR Haiti will support the expansion of MDR-TB testing capacity in Haiti to improve MDR-TB diagnosis and treatment, and to reduce mortality for HIV-TB co-infected patients.

**Limited domestic capacity on Supply Chain**

Sustainability of the national Supply Chain has consistently been an area of weakness for Haiti's national HIV response and presents a key barrier to sustained epidemic control. As a result of HIV related procurement being almost completely donor funded, the Commodity Security & Supply Chain element was one of the lowest scores in SID 3.0. Through the Global Health Supply Chain Program, PEPFAR Haiti continues to support MSPP to procure and distribute necessary commodities at the site level, but also to improve the capacity of national systems for eventual transition. In COP18, PEPFAR Haiti will also support the MSPP in implementation of their strategic TLD transition plan and monitor stock levels to minimize potential waste of legacy ARVs.

a) Standardize and enhance LMIS for National Unified Supply Chain (SNADI): PEPFAR Haiti will assist MSPP to establish requirements for the LMIS to track key health commodities and strengthen regular monitoring of supply chain performance through facility level commodity availability. PEPFAR Haiti investments to strengthen the integrated SNADI are directly in line with and complement MSPP-led efforts to develop a joint SNADI/LMIS costed work plan. SNADI is also an area of co-investment with the GF, whose investments will focus on establishing a reliable and integrated LMIS for procurement and inventory of health products.

b) Improve MSPP capacity to coordinate and plan health commodity procurement and distribution: through secondment and TA to MSPP, PEPFAR Haiti will capacitate MSPP to utilize data for distribution and procurement planning, with a goal of increasing the percent of supply chain functions completed by host country over three years.

c) Support annual commodities forecast exercise: PEPFAR Haiti will continue to assist the Ministry of Health in the national commodities forecasting, quantification and supply planning exercise which aim to ensure the timely and uninterrupted availability of the new antiretroviral formulations at all geographic levels of the country in FY19 and FY2020. The MSPP Department of Pharmaceutical Management (DPM), together with PNLS, convenes stakeholders twice a year to review commodities forecasting and consumption data (reportedly monthly to PSM from all PEPFAR-supported sites), and adjust procurement plans as needed. However, this fiscal year has required more intense and frequent coordination between the MSPP, PEPFAR and other stakeholders to secure the procurement of new antiretroviral formulations to ensure adequate availability of commodities to support the planned transition of close to 80% of existing ART patients to TLD within the first four to six months of the fiscal year 2019. PEPFAR Haiti anticipated procurement covers commodities needed for the simultaneous transition of adult and adolescents (over 30 kg) on first and second line, as well as co-infected TB patients and pregnant women. If the forecasting, quantification and supply planning exercise results in additional commodity needs for the COP 18 implementation period, the MSPP and development partners will respond to ensure the availability of commodities and avoid stock outs.

**Lack of interoperability of HIV information platforms affects treatment coverage and retention**

a) Single Layer Exchange system incorporated into iSantéPlus expansion: The deployment of iSantéPlus at all PEPFAR-expansion sites is coupled with the implementation of single layer exchange system (HIE) to ensure interoperability with all existing platforms and systems. As a result of these investments, PEPFAR Haiti ensures: (i) access to program and management data for providers and implementers based on their level of privileges, and (ii) the availability of real time verification of biometric data for a duplicate-free enrollment system.

b) Automatic data exchange between iSantéPlus and LNSP/IMIS LIS systems: This activity will ensure seamless exchange of lab data and continuum of services between facility and community systems, resulting in a more complete registry of patient's data and better flow of data between clinical, lab and community systems.

c) Roll out Patient Linkage Retention system to all community sites: PLR has established a strong record in supporting tracking activities and community-based drug distribution. This investment will secure the technical assistance, training and mentoring that has allowed for this dramatic shift in service delivery provision within the program. PLR supported activities will be rolled out at all sites with reinforced capacity to provide feedback to network and sites. An enhanced SOP will encompass new activities such as using PLR to track and evaluate effectiveness of material support given to patients (e.g. transportation fees) and provision of PrEP to eligible negative partners of index patients' contacts. The first groups considered for PrEP will be high risk populations including MSM and sero-discordant couples.

**Absence of testing capacity to identify recent HIV infections**

HIV recency test program for newly HIV-diagnosed persons: PEPFAR Haiti will scale up index testing to improve HIV case finding and yield to ensure epidemic control by 2020. To enhance HIV case finding using case-based surveillance system in Haiti, PEPFAR will implement HIV recency test for newly HIV-diagnosed persons to prioritize index testing and identify potential HIV hotspots. The Haiti program has started the planning of the recency test program and the tiered training of site and laboratory personnel will begin in COP 18.

**Low engagement with Private Sector**

Coordinate with MSPP on private sector outreach for data reporting and sharing: Higher income groups, particularly men, are more likely to utilize private sector health services. Currently there is limited private sector input into national HIV/AIDS processes and data systems; the 'Private Sector Engagement' element of SID 3.0 was the lowest-scoring for Haiti at 1.67. PEPFAR will work with MSPP to improve these relationships and increase the number of private sector sites reporting key HIV/AIDS indicators into the Strategic Health Information System (SISNU).

**Limited Human Resources for Health (HRH) coverage and task sharing**

Improve planning for distribution of HRH: Although SID 3.0 scored well in the Human Resources for Health element in comparison to 2015, a proposed Table 6 activity would build on MSPP efforts to standardize the national ASCP package of services, training curricula, and tools. PEPFAR, along with other donors and stakeholders, will work closely with the MSPP to advocate for inclusion of key HIV interventions, including community-based distribution of ARV, etc. into the ASCP package of services. The MSPP HRH Strategy, developed with USG support, will be rolled out, including a component on gradual absorption by the MSPP of approximately 7,000 contracted MSPP personnel financed by donors. PEPFAR Haiti will also contribute to MSPP-led effort to re-distribute limited HRH according to the essential package of services (PES), using the ongoing Service Provision Assessment financed by USAID non-PEPFAR funds, the Global Fund and the World Bank as the baseline.

**High level of attrition among patients**

Prioritization of TLD transition: The PEPFAR Haiti program has initiated the transition to TLD and aims to have the majority of patients to be fully transitioned by 2019 Q2. Benefits of the TLD transition include improved tolerability, higher antiretroviral efficacy, lower rates of treatment discontinuation, a higher genetic barrier to resistance, and fewer drug interactions that other ARV drugs.

**Stigma and Discrimination**

a) Policy and Community-level interventions to reduce stigma: PEPFAR Haiti will expand community interventions to address stigma and other issues related to access and adherence to services for key populations. The program will also work with MSPP to develop relevant policies to reduce stigma and discrimination and improve access to services.

b) Expanding KP access to HIV/AIDS services: Along with PEPFAR Haiti, the GF will support the PNLS to build governance capacity to better manage KP activities. GF will also equip centers and train personnel providing tailored services to MSM and commercial sex workers (CSWs) in HTS, behavior change communication, treatment promotion, and sensitization related to stigma and discriminatory attitudes. This will link to PEPFAR's work in COP18 of expanding activities to KP, including PreP, as well as to broader efforts to decrease stigma and discrimination across all supported activities. GF is also focusing investments to better understand and address the issue of retention of patients on ARV. The findings from this work will be shared across all relevant stakeholders and will inform future program investments.

**Survey, Evaluation and Research Activities in Table 6:**

| Activity Description | USG Agency | Implementing Mechanism | Implementation Timeline |
|---|---|---|---|
| Population-Based HIV Impact Assessment in Haiti | HHS-CDC | MSPP/UGP | FY19 |
| Sentinel Serosurvey of pregnant women attending ANC in Haiti based on routine PMTCT data with quality monitoring and strengthening framework | HHS-CDC | MSPP/UGP | FY17-18 |
| The Demographic and Health Survey 2016-2017 | USAID | ICF International, Inc. | FY17 -18 |
| Survey Protocol on HIV Drug Resistance (HVDR) Among Patients Initiating Antiretroviral Therapy (Pre-treatment DR, PDR) in Haiti | HHS-CDC | MSPP/UGP | FY18 |
| Ongoing National HIV Case-Based Surveillance System (SALVH) | CDC | NASTAD | FY19 |
| Impact of Community Adherence Groups (CAGs) on Treatment Outcomes for OVC (working title) | USAID | SOAR | FY19 |
| Assessment of Stigma and Discrimination towards People Living with HIV/AIDS in Haiti (Stigma Index) | HHS-CDC | MSPP/UGP | FY19-20 |
| Costing and optimization analysis of decentralization of lab testing (VL and EID) | USAID | EQUIP | FY18 |
| Monitoring Outcomes of Two PEPFAR-supported Projects Serving Orphans and Vulnerable Children in Haiti (OVC-MER) | USAID | Measure Evaluation | FY18 |

Table 6 Excel workbook attached in Appendix C.

# 7.0 Staffing Plan

Following PEPFAR's business model, the PEPFAR Haiti team has continued to focus on regular data analysis and use for decision-making. To maximize effectiveness and efficiency the team closely reviewed our staffing footprints and organizational structures. Our review placed special emphasis on how our teams could meet critical tasks, perform core PEPFAR functions, oversee partner performance, ensure achievement of goals and targets in a timely manner and ensure complementarity of efforts. We have reviewed the HQ Subject Matter Experts (ISMEs) assigned to Haiti and how to create a symbiotic relationship.

We have identified key staff who will continue to dedicate a significant portion of their time to implementing SIMS requirements--including site visits, providing feedback to partners and following up on any issues identified during visits. As we continue to expand and improve our

partner management processes, we continue to strengthen our standard operating procedures geared towards constant and consistent feedback to partners and individual sites.

Since last fiscal year, the PEPFAR team has been able to overcome multiple hurdles to address staff vacancies. The loss of purchasing power by locally employed staff, caused by the devaluation of the HTG, was addressed in FY17 by revising salaries based on market review. Now that the hiring freeze has been lifted, the team has been able to reduce the number of vacancies by 33% (from 15 to 10). Also, the PEPFAR Haiti Coordination office is diligently working on identifying a suitable candidate to hire (see staffing table below) and will utilize COP funding for hiring, program and office support.

| **Funding Agency** | **Num. of Filled: Individuals** | **Num. of Planned (new requests): Individuals** | **Num. of Vacant (previously approved): Individuals** | **Num. of TOTAL Individuals** |
|---|---|---|---|---|
| USAID | 38 (18.1 FTEs) | 0 | 6 (3.75 FTEs) | 44 (21.85 FTEs) |
| CDC | 62 (56.5 FTEs) | 0 | 4 (4 FTEs) | 66 (60.5 FTEs) |
| U.S. Department of State | 1 (1 FTE) | 0 | 1 (1 FTE) | 2 (2 FTEs) |
| **Grand Total** | **101 (75.6 FTEs)** | **0** | **11 (8.75 FTEs)** | **112 (84.35 FTEs)** |

The PEPFAR Haiti team is not requesting to add any new positions in COP18.

CDC's cost of doing business (CODB) was reduced by 2.2% between COP17 and COP18. This reduction is primarily reflective of a reduction in our CSCS and ITSO costs. USAID's FY2019 CODB request decreased from FY18 by 15.8% and will apply $214,157 of the available pipeline for COP18.

# APPENDIX A -- PRIORITIZATION

**Table A.1**

| SNU | COP | Prioritization | Results reported | Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | 0-9 | Male 10-14 | Female 10-14 | Male 15-19 | Female 15-19 | Male 20-24 | Male 25-49 | Male 50+ | Female 20-24 | Female 25-49 | Female 50+ | Total |
| Greater Port-au-Prince Cluster | COP15 | ScaleUp Sat | APR 16 | | 57% | | 206% | 120% | | 55% | | | 74% | | 67% |
| | COP16 | ScaleUp Sat | APR 17 | 47% | 66% | 77% | 117% | 68% | 190% | 65% | 38% | 109% | 84% | 82% | 75% |
| | COP 17 | ScaleUp Sat | APR 18 | | 117% | | | | | 80% | | | 90% | | 87% |
| | COP 18 | ScaleUp Sat | APR 19 | 86% | 120% | 141% | 164% | 94% | 263% | 91% | 53% | 152% | 117% | 113% | 105% |
| Saint-Marc | COP15 | ScaleUp Sat | APR 16 | | 70% | | 21% | 9% | | 79% | | | 106% | | 90% |
| | COP16 | ScaleUp Sat | APR 17 | 82% | 118% | 112% | 84% | 73% | 91% | 95% | 91% | 114% | 117% | 168% | 108% |
| | COP 17 | ScaleUp Sat | APR 18 | | 82% | | | | | 118% | | | 136% | | 126% |
| | COP 18 | ScaleUp Sat | APR 19 | 186% | 268% | 255% | 132% | 116% | 147% | 151% | 145% | 182% | 187% | 267% | 176% |
| Dessalines | COP15 | ScaleUp | APR 16 | | 33% | | 12% | 16% | | 44% | | | 73% | | 57% |
| | COP16 | ScaleUp Sat | APR 17 | 36% | 30% | 38% | 59% | 74% | 70% | 55% | 42% | 107% | 83% | 89% | 68% |
| | COP 17 | ScaleUp Sat | APR 18 | | 54% | | | | | 69% | | | 88% | | 78% |
| | COP 18 | ScaleUp Sat | APR 19 | 51% | 41% | 53% | 93% | 118% | 110% | 88% | 66% | 169% | 131% | 141% | 107% |
| Cap-Haitien | COP15 | ScaleUp | APR 16 | | 48% | | 47% | 37% | | 52% | | | 68% | | 60% |
| | COP16 | ScaleUp Sat | APR 17 | 44% | 93% | 62% | 76% | 40% | 51% | 49% | 86% | 46% | 68% | 162% | 67% |
| | COP 17 | ScaleUp Sat | APR 18 | | 87% | | | | | 72% | | | 76% | | 75% |
| | COP 18 | ScaleUp Sat | APR 19 | 73% | 152% | 102% | 102% | 57% | 69% | 67% | 118% | 63% | 94% | 221% | 93% |
| Cayes | COP15 | ScaleUp | APR 16 | | 18% | | 148% | 82% | | 58% | | | 71% | | 63% |
| | COP16 | ScaleUp Sat | APR 17 | 26% | 68% | 88% | 101% | 40% | 64% | 70% | 52% | 37% | 73% | 101% | 67% |
| | COP 17 | ScaleUp Sat | APR 18 | | 62% | | | | | 72% | | | 91% | | 82% |
| | COP 18 | ScaleUp Sat | APR 19 | 106% | 275% | 353% | 116% | 46% | 77% | 81% | 60% | 43% | 85% | 117% | 84% |
| Gonaives | COP15 | ScaleUp | APR 16 | | 21% | | 62% | 19% | | 21% | | | 34% | | 28% |
| | COP16 | ScaleUp Sat | APR 17 | 25% | 25% | 27% | 26% | 15% | 26% | 25% | 24% | 31% | 40% | 56% | 33% |
| | COP 17 | ScaleUp Sat | APR 18 | | 36% | | | | | 59% | | | 66% | | 61% |
| | COP 18 | ScaleUp Sat | APR 19 | 47% | 49% | 51% | 47% | 25% | 44% | 43% | 41% | 53% | 69% | 97% | 57% |
| Port-de-Paix | COP15 | ScaleUp Sat | APR 16 | | 45% | | 41% | 34% | | 39% | | | 59% | | 49% |
| | COP16 | ScaleUp Sat | APR 17 | 50% | 14% | 69% | 46% | 47% | 23% | 46% | 40% | 43% | 65% | 114% | 56% |
| | COP 17 | ScaleUp Sat | APR 18 | | 50% | | | | | 70% | | | 83% | | 75% |
| | COP 18 | ScaleUp Sat | APR 19 | 64% | 18% | 89% | 66% | 68% | 33% | 68% | 58% | 63% | 95% | 167% | 82% |
| Acul-du-Nord | COP15 | ScaleUp | APR 16 | | 179% | | 205% | 146% | | 159% | | | 264% | | 213% |
| | COP16 | ScaleUp Agg | APR 17 | 166% | 174% | 406% | 270% | 179% | 133% | 200% | 165% | 156% | 292% | 403% | 244% |
| | COP 17 | ScaleUp Sat | APR 18 | | 201% | | | | | 223% | | | 284% | | 254% |
| | COP 18 | ScaleUp Sat | APR 19 | 276% | 282% | 666% | 378% | 254% | 197% | 288% | 237% | 223% | 419% | 578% | 352% |
| Mirebalais | COP15 | ScaleUp Agg | APR 16 | | 98% | | 0% | 0% | | 62% | | | 68% | | 65% |
| | COP16 | ScaleUp Agg | APR 17 | 199% | 219% | 242% | 120% | 132% | 80% | 69% | 64% | 88% | 88% | 90% | 85% |
| | COP 17 | ScaleUp Agg | APR 18 | | 112% | | | | | 85% | | | 101% | | 95% |
| | COP 18 | ScaleUp Sat | APR 19 | 758% | 828% | 922% | 150% | 163% | 100% | 85% | 79% | 110% | 108% | 112% | 124% |
| Miragoâne | COP15 | Sustained | APR 16 | | 77% | | 117% | 38% | | 78% | | | 94% | | 86% |
| | COP16 | Sustained | APR 17 | 58% | 126% | 127% | 117% | 40% | 59% | 70% | 130% | 60% | 92% | 232% | 94% |
| | COP 17 | ScaleUp Sat | APR 18 | | 107% | | | | | 84% | | | 93% | | 90% |
| | COP 18 | ScaleUp Sat | APR 19 | 59% | 126% | 127% | 154% | 53% | 78% | 94% | 174% | 81% | 123% | 311% | 125% |
| Trou-du-Nord | COP15 | ScaleUp Agg | APR 16 | | 93% | | 97% | 97% | | 59% | | | 94% | | 79% |
| | COP16 | ScaleUp Agg | APR 17 | 130% | 85% | 103% | 73% | 128% | 60% | 84% | 61% | 139% | 120% | 94% | 99% |
| | COP 17 | ScaleUp Sat | APR 18 | | 111% | | | | | 93% | | | 119% | | 107% |
| | COP 18 | ScaleUp Sat | APR 19 | 335% | 212% | 264% | 121% | 214% | 106% | 142% | 102% | 233% | 202% | 157% | 170% |
| Aquin | COP15 | ScaleUp | APR 16 | | 75% | | 127% | 56% | | 64% | | | 84% | | 74% |
| | COP16 | ScaleUp Agg | APR 17 | 52% | 160% | 163% | 115% | 87% | 73% | 76% | 85% | 78% | 89% | 207% | 92% |
| | COP 17 | ScaleUp Agg | APR 18 | | 88% | | | | | 83% | | | 108% | | 96% |
| | COP 18 | ScaleUp Sat | APR 19 | 71% | 217% | 221% | 196% | 149% | 123% | 128% | 144% | 132% | 151% | 353% | 155% |
| Fort-Liberté | COP15 | ScaleUp | APR 16 | | 140% | | 66% | 39% | | 46% | | | 67% | | 60% |
| | COP16 | ScaleUp Agg | APR 17 | 147% | 170% | 151% | 56% | 49% | 63% | 52% | 43% | 47% | 78% | 104% | 69% |
| | COP 17 | ScaleUp Agg | APR 18 | | 128% | | | | | 66% | | | 77% | | 74% |
| | COP 18 | ScaleUp Sat | APR 19 | 205% | 238% | 215% | 84% | 78% | 97% | 81% | 68% | 72% | 122% | 161% | 106% |
| Jacmel | COP15 | ScaleUp Agg | APR 16 | | 20% | | 22% | 15% | | 25% | | | 31% | | 27% |
| | COP16 | ScaleUp Agg | APR 17 | 14% | 35% | 40% | 19% | 21% | 20% | 25% | 36% | 16% | 33% | 78% | 31% |
| | COP 17 | ScaleUp Agg | APR 18 | | 27% | | | | | 46% | | | 59% | | 51% |
| | COP 18 | ScaleUp Agg | APR 19 | 13% | 35% | 40% | 30% | 32% | 31% | 39% | 54% | 25% | 50% | 119% | 47% |
| Môle-Saint-Nicolas | COP15 | ScaleUp Sat | APR 16 | | 26% | | 75% | 49% | | 19% | | | 34% | | 27% |
| | COP16 | ScaleUp Sat | APR 17 | 16% | 21% | 28% | 39% | 35% | 90% | 26% | 10% | 61% | 36% | 29% | 30% |
| | COP 17 | ScaleUp Agg | APR 18 | | 64% | | | | | 36% | | | 50% | | 45% |
| | COP 18 | ScaleUp Agg | APR 19 | 18% | 24% | 31% | 51% | 47% | 121% | 34% | 13% | 80% | 48% | 39% | 39% |
| Ouanaminthe | COP15 | ScaleUp Agg | APR 16 | | 15% | | 8% | 27% | | 17% | | | 32% | | 25% |
| | COP16 | ScaleUp Agg | APR 17 | 18% | 14% | 22% | 8% | 27% | 13% | 21% | 22% | 25% | 36% | 41% | 28% |
| | COP 17 | ScaleUp Agg | APR 18 | | 37% | | | | | 34% | | | 39% | | 37% |
| | COP 18 | ScaleUp Agg | APR 19 | 34% | 28% | 40% | 16% | 38% | 19% | 30% | 31% | 37% | 52% | 59% | 41% |
| Hinche | COP15 | ScaleUp Agg | APR 16 | | 62% | | 0% | 0% | | 36% | | | 46% | | 41% |
| | COP16 | ScaleUp Agg | APR 17 | 67% | 68% | 105% | 40% | 37% | 32% | 44% | 33% | 52% | 58% | 44% | 49% |
| | COP 17 | ScaleUp Agg | APR 18 | | 57% | | | | | 44% | | | 52% | | 49% |
| | COP 18 | ScaleUp Agg | APR 19 | 121% | 122% | 191% | 63% | 59% | 48% | 70% | 53% | 82% | 91% | 69% | 78% |
| Jérémie | COP15 | ScaleUp Agg | APR 16 | | 32% | | 26% | 44% | | 48% | | | 61% | | 53% |
| | COP16 | ScaleUp Agg | APR 17 | 12% | 19% | 31% | 78% | 64% | 233% | 62% | 15% | 120% | 68% | 40% | 58% |
| | COP 17 | ScaleUp Agg | APR 18 | | 40% | | | | | 69% | | | 86% | | 75% |
| | COP 18 | ScaleUp Agg | APR 19 | 24% | 39% | 61% | 107% | 82% | 306% | 83% | 20% | 160% | 89% | 54% | 78% |
| Lascahobas | COP15 | ScaleUp Agg | APR 16 | | 7% | | 0% | 0% | | 16% | | | 17% | | 16% |
| | COP16 | ScaleUp Agg | APR 17 | 59% | 84% | 52% | 37% | 18% | 37% | 63% | 46% | 36% | 77% | 66% | 63% |
| | COP 17 | ScaleUp Agg | APR 18 | | 78% | | | | | 64% | | | 78% | | 72% |
| | COP 18 | ScaleUp Agg | APR 19 | 119% | 168% | 104% | 49% | 25% | 51% | 85% | 63% | 49% | 105% | 90% | 87% |
| Gros-Morne | COP15 | Sustained | APR 16 | | 23% | | 38% | 128% | | 19% | | | 24% | | 24% |
| | COP16 | Sustained | APR 17 | 26% | 30% | 29% | 38% | 126% | 145% | 23% | 14% | 143% | 21% | 14% | 29% |
| | COP 17 | Sustained | APR 18 | | 19% | | | | | 21% | | | 27% | | 24% |
| | COP 18 | Sustained | APR 19 | 47% | 55% | 52% | 61% | 205% | 235% | 38% | 22% | 231% | 34% | 22% | 48% |

2015 results are reported in 0-14, 15-19, and 20+ age/sex bands, and 2018 targets are set for 0-14 and 15+ age/sex bands. Data for age groups 20+ in FY18 also applies to 15-19 bands, but could not be displayed on this table due to the required grouping to allow the most data to be presented

| | Table A.2 ART Targets by Prioritization for Epidemic Control | | | | | | |
|---|---|---|---|---|---|---|---|
| **Prioritization Area** | **Total PLHIV** | **Expected current on ART (APR FY 18)** | **Additional patients required for 80% ART coverage** | **Additional patients required for 90% ART coverage** | **Target current on ART (APR FY19) *TX_CURR*** | **Newly initiated (APR FY 19) *TX_NEW*** | **ART Coverage (APR 19)** |
| Attained | **0** | **0** | **0** | **0** | **0** | **0** | **0** |
| Scale-Up Saturation | 93,987 | 83,522 | **0** | **1,301** | **102,084** | **19,365** | **109%** |
| Scale-Up Aggressive | 23,512 | 14,980 | **3,829** | **6,239** | **18,757** | **3,759** | **79.7%** |
| Sustained | 26,220 | 8,913 | **12,063** | **14,750** | **12,047** | **2,240** | **46%** |
| Central Support | 2,832 | n/a | | | | | |
| Not Supported | 1,273 | n/a | | | | | |
| Commodities (if not included in previous categories) | | | | | | | |
| **Total** | **147,825** | **107,414** | **10,846** | **25,998** | **132,888** | **25,364** | **90%** |

# APPENDIX B – Budget Profile and Resource Projections

## B1. COP 18 Planned Spending

### Table B.1.1 COP18 Budget by Approach and Program Area

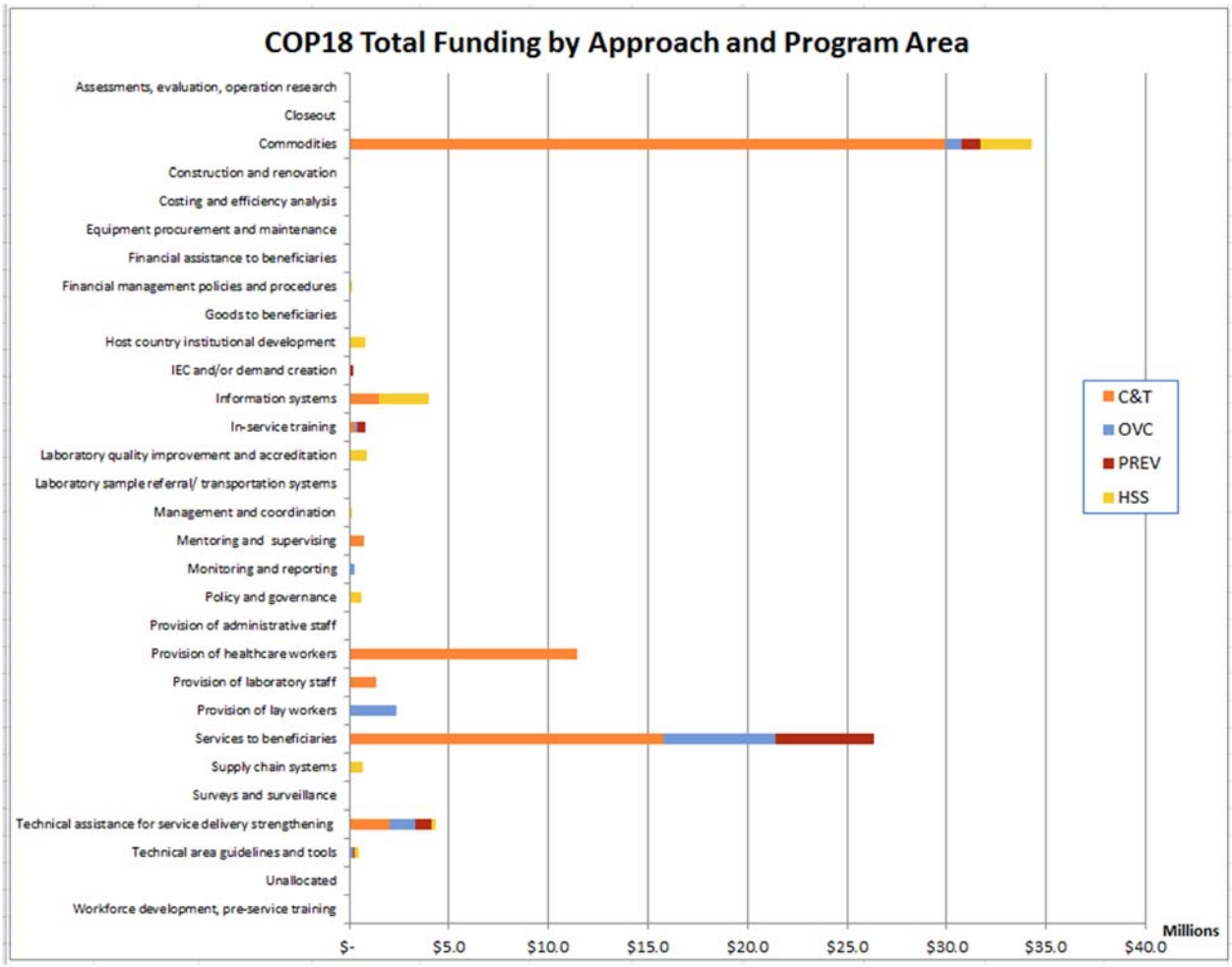



**Table B.1.2 COP 18 Total Planning Level**

| Applied Pipeline | New Funding | Total Spend |
|---|---|---|
| $614,157 | $100,373,343 | $100,987,500 |

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

| Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only) | | |
|---|---|---|
| **PEPFAR Budget Code** | **Budget Code Description** | **Amount Allocated** |
| MTCT | Mother to Child Transmission | $4,987,548 |
| HVAB/Y | Abstinence/Be Faithful Prevention/Youth | $757,927 |
| HVOP | Other Sexual Prevention | $1,882,272 |
| IDUP | Injecting and Non-Injecting Drug Use | - |
| HMBL | Blood Safety | - |
| HMIN | Injection Safety | - |
| CIRC | Male Circumcision | - |
| HVCT | Counseling and Testing | $10,826,488 |
| HBHC | Adult Care and Support | $8,702,186 |
| PDCS | Pediatric Care and Support | $2,693,873 |
| HKID | Orphans and Vulnerable Children | $10,836,438 |
| HTXS | Adult Treatment | $19,738,724 |
| HTXD | ARV Drugs | $14,900,350 |
| PDTX | Pediatric Treatment | $4,331,211 |
| HVTB | TB/HIV Care | $5,197,475 |
| HLAB | Lab | $3,212,711 |
| HVSI | Strategic Information | $3,244,193 |
| OHSS | Health Systems Strengthening | $2,687,879 |
| HVMS | Management and Operations | $6,374,073 |
| **TOTAL** | | **$100,373,348** |

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

**B.2 Resource Projections**

In accordance with COP18 Guidance, PEPFAR Haiti calculated incremental budgets for each Strategic Objective in the FAST using a combination of historical program and financial data, expected scope of work and programmatic shifts planned, to determine allocations across each implementing partner and budget code. Strategic objectives submitted by Implementing Partners in COP17 were reviewed and modified to encompass all aspects of the program. Provisions were also made to account for scale-up of new strategies of testing, including "Index case contact testing", "Social networking for KP", targeted "self-testing", and a rapid transition to TLD. M&O information was provided by agencies based on analysis of costs and projected needs. All budgetary earmarks have been met to align with the COP18 Planning Level Letter.

# APPENDIX C – Tables and Systems Investments for Section 6.0

# Table 6 Attachment

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
|---|---|---|---|---|---|---|---|
| 1 | HHS/CDC | ITECH 1331 | HSS | Improve and reinforce national health information systems including iSante plus (EMR) and lab information systems (SCC and OpenELIS) to improve the capacity of MSPP to manage the National HIV response | Information Systems | Ensure interoperability between EMR (iSante plus) at facility level and lab information systems (SCC and OpenELIS) | Lack of interoperability or integration among HIV information platforms jeopardizes information exchange and continuity of care |
| 2 | HHS/CDC | ITECH 1331 | HSS | Deploy iSanté Plus at all PEPFAR-expansion-sites; and implement single layer exchange system (HIE) to ensure interoperability with all existing platforms and systems | Information Systems | | Lack of interoperability or integration among HIV information platforms jeopardizes information exchange and continuity of care |
| 3 | HHS/CDC | ITECH 1331 | C&T | Improve patient monitoring through HIV care continuum | Information Systems | Ensure the exchange of information between the PLR community system and the facility - to include PLR tracking patient-level updates and community drug distribution | Lack of interoperability or integration among HIV information platforms jeopardizes information exchange and continuity of care |
| 4 | HHS/CDC | ITECH 1331 | PREV | Initiate Prep Roll out in KP sites | Technical area guidelines and tools | Train healthcare providers at KP sites and other designated sites to implement PrEP | Fear of stigma, discrimination Lack of community engagement for awareness and mobilization about stigma.<br>Absence of policies targeting the delivery of stigma-free care for vulnerable groups.<br>Lack of evidence-based protection for high risk group susceptible to acquire HIV. |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
|---|---|---|---|---|---|---|
| 1 | 15. Performance Data | 6.83 | Interoperability between the national health information systems and iSantéPlus. SCC and OpenELIS interoperability is established at 100% of PEPFAR supported Facilities | 3 years | % of facilities with OpenELIS interoperability established<br><br>% of sites with audited data matching reported data<br><br>Average number of downtime per unit (site, national server) | The Full interoperability and Exchange of data between EMR and OPENELIS will be functional at 20 sites |
| 2 | 15. Performance Data | 6.83 | Interoperability between the national health information systems and iSantéPlus.<br><br>Interoperability iSantéPlus with (LIS at LNSP and IMIS). | 3 years | % of patients with data consolidated into a unique file (demographic, clinical)<br><br>% of sites with audited data matching reported data<br><br>Average number of downtime per unit (site, national server) | Isante Plus is beta tested at 2 sites |
| 3 | 15. Performance Data | 6.83 | Information exchange between PLR community system and facility system<br><br>Interoperability between the national health information systems and iSantéPlus | 3 years | % of sites with audited data matching reported data<br><br>Average number of downtime per unit (site, national server) | Data from community level can be captured manually into Isante for updates of the Patient charts |
| 4 | 6. Policies and Governance | 6.29 | Reduction in risk behaviors among key populations and other individuals with high risk behaviors<br><br>Reduction in incidence of HIV in Key Populations | 3 years | % of healthcare workers trained in stigma-discrimination.<br># of MSM, Serodiscordant Couple, female sex workers on PREP<br><br># of individuals screened with a standardized risk assesment tool | Ministry Approval of Prep Roll Out |

| Row | Year One (COP18) Annual Benchmark (Planned) | Note: FY19 Q2 and Q4 results will be recorded here for monitoring. | Year Two (COP/ ROP19) Annual Benchmark | Note: FY20 Q2 and Q4 results will be recorded here for monitoring. | Year Three (COP/ ROP20) Annual Benchmark | Note: FY21 Q2 and Q4 results will be recorded here for monitoring. |
|---|---|---|---|---|---|---|
| 1 | Real-time exchange of registrations and encounters between the different platforms.<br>60% of facilities have Open ELIS interop established | | 70% of facilities have Open ELIS interoperability established | | 100% of facilities have Open ELIS interoperability established | |
| 2 | The single layer exchange server will be functional at 30 % of the sites and will have bi-directional exchanges with the central server<br>40 % of the Lab orders and results will flow back and forth and data shared between Isante Plus and the LIS system supporting key tests such as viral load, improving the accuracy of information | | The single layer exchange server will be functional at 75 % of the sites and will have bi-directional exchanges with the central server<br>80 % of the Lab orders and results will flow back and forth and data shared between Isante Plus and the LIS system supporting key tests such as viral load, improving the accuracy of information | | The single layer exchange server will be fully functional (100%)<br>All Isante Plus sites will have bi-directional exchanges with the central server<br>All the Lab orders and results will flow back and forth and data shared between Isante Plus and the LIS system supporting key tests such as viral load, improving the accuracy of information. | |
| 3 | 30 % of Patient records in Isante Plus can be updated automatically with data collected through tracking at the community level | | 80 % of Patient records in Isante Plus can be updated automatically with data collected through tracking at the community level | | All Patient records in Isante Plus can be updated automatically with data collected through tracking at the community level | |
| 4 | SOP and Training Materials reviewed and adapted as necessary. Training starts for providers at designated sites. | | KP sites and other designated sites trained on policies and guidelines.<br><br>70% of MSM, Sex workers, and HIV negative people from serodiscordant couples in designated sites screened with risk assessment tool .<br><br>60% of eligible MSM, Sex workers, and HIV negative people from serodiscordant couples reached in designated sites receive PrEP | | Reduction in risk behaviors for people receiving PrEP. Reduction in number of recent HIV cases among key populations | |

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
|---|---|---|---|---|---|---|---|
| 5 | HHS/CDC | NASTAD 1525 | C&T | Institutionalize the HIV community-based approach to not only track missing patients but also better serve active patients | Information Systems | Expand use of PLR and continue technical assistance, training and mentoring and increase feedbacks to network and sites<br><br>Refine the SOP for the use of PLR for (i) Existing activities such as tracking activities; and Community-based Drug distribution (ii) Tracking new activities, including material support such as transportation fees; tracking of special categories of patients such as those in specific age bands those needing viral load or with high viral load<br><br>Provide technical assistance and training for community drug distribution.<br><br>Monitor outcomes of providing material support such as food and cost transportation etc. and develop a blueprint for future effort<br><br>Monitor supervised Self Testing through Community-health agents during their visits | Limited patient information to accurately find households and facilitate patient follow-up across the program<br><br>Lack of interoperability or integration among HIV information platforms to facilitate patient de-duplication across the program |
| 6 | HHS/CDC | FOSREF | HSS | Reduce Stigma and discrimination against key populations | IEC/Demand Creation | Expand Community interventions to address stigma and other issues related to access to services for key populations<br><br>Subcontract with COIN-Fighting stigma against KP and PLHIV in the community | Fear of stigma, discrimination Lack of community engagement for awareness and mobilization about stigma.<br>Absence of policies targeting the delivery of stigma-free care for vulnerable groups. |
| 7 | HHS/CDC | GHESKIO 1924 | HSS | Contribute to the Nationwide Laboratory Infrastructure by providing Viral load and EID services and align HIV information system to improve diagnosis and treatment of people living with HIV | Host Country Institutional Development | Continue to improve viral load and EID services to improve treatment outcomes and HIV diagnosis to achieve epidemic control by provide targeted technical assistance. | 1. Almost 30% of the ART sites received RED/YELLOW scores on ART monitoring for VL (CEE# F_2.11 [31] in FY17 SIMS report.<br><br>2. Insufficient conventional VL testing capacity at the central testing labs identified by recent Instrument Mapping Exercise.<br><br>3. Less than 100% of VL testing results were recorded in EMR.<br><br>4. In FY17, although national-wide VL scaling up training for lab and clinical staff members were completed, no reagent and specimen collection supplies stocked out and adequate lab testing capacity Haiti program only achieved 72% of its VL monitoring target. |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
|---|---|---|---|---|---|---|
| 5 | 15. Performance Data | 6.83 | PLR reports from the field will feed EMRs to improve accuracy in recording patients outcomes.<br>Differentiated service delivery models (community drug distribution) and patient tracking activities will be monitored through PLR<br>The new PLR module will act as a GPS navigator for field agents to locate a patient's home . | 2 years | # of patients found and returned to care through the new GPS module<br><br>% of sites with audited data matching reported data | PLR is fully deployed in 80 sites. However biodirectional updates are not occuring. It is important to capture, in the EMRs, patients updates gathered at the community level. |
| 6 | 6. Policies and Governance | 6.29 | Reduction in stigma and discrimination levels; improved access to services; reduction of loss to follow-up | 3 years | % of healthcare workers trained in stigma-discrimination.<br># of Communities sensitized<br># of community score-card implemented | Results of stigma poll published showing high levels of stigma. No policies about the delivery of stigma-free care for vulnerable groups. |
| 7 | 10. Laboratory | 5.67 | 1. 100% of VL tests requested for all ART patients from the ART sites that supported by GHESKIO, especially from those low VL performance sites. 2. High VL registry implemented in the GHESKIO supported ART sites. 3. Adherence counselling and repeated viral testing are provided to those patients with viral failures when the first viral load is performed. 4. 100% of the viral load results were recorded in patient's medical records for those ART sites supported by GHESKIO. | 3 years | 1. % of ART patients have VL tested requested and those with treatment failure have follow-up VL done, and % of VL results are recorded in EMR. 2. % of HIV exposed infants have EID tests performed. | Nationally Haiti achieved 72% of the VL target and 2% of VL results were not recorded in EMRs |

| Row | Year One (COP18) Annual Benchmark (Planned) | Note: FY19 Q2 and Q4 results will be recorded here for monitoring. | Year Two (COP/ ROP19) Annual Benchmark | Note: FY20 Q2 and Q4 results will be recorded here for monitoring. | Year Three (COP/ ROP20) Annual Benchmark | Note: FY21 Q2 and Q4 results will be recorded here for monitoring. |
|---|---|---|---|---|---|---|
| 5 | New PLR features deployed at 50% of sites | | New PLR features deployed at 100% of sites | | | |
| 6 | Communities sensitized, community score-card implemented and Healthcare Workers trained. Collaboration with DSPE/MOH to develop relevant policies around stigma | | Increased number of KP-Friendly sites and available KP-Friendly services.<br>Increase disclosure of HIV status within communities | | Sensitization of government officials through community mobilization. | |
| 7 | 1. 90% of VL tests are requested for all ART patients from the ART sites supported by GHESKIO, especially from those low VL performance sites. 2. The newly rented Abbott m2000 platform is installed in IMIS lab, calibrated and conducing VL and EID testing. 3. 50% of the patients with High VL results are registered in the high VL registry and have 2nd VL tests done after intensive adherence counselling. 4. All HIV-exposed infants designed to IMIS lab are tested for EID and resutls returned to sites. | | 1. 95% of VL tests requested for all ART patients from the ART sites supported by GHESKIO, especially from those low VL performance sites. 2. 75% of the patients with high VL are registered in the high VL registry and have repeat VL tests after intensive adherence counselling and VL suppression rate is improved by 5-10%. 3. All HIV-exposed infants designed to IMIS lab are tested for EID and resutls returned | | 1. 100% of VL tests requested for all ART patients from the ART sites supported by GHESKIO. 2. 100% of the patients with high VL are registered in the high VL registry, 2nd VL tests are performed after intensive adherence counselling and viral suppression rate increased by 10-20%. 3. All HIV-exposed infants designed to IMIS lab are tested for EID and resutls returned to sites. | |

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
|---|---|---|---|---|---|---|---|
| 8 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Improve MSPP capacity to implement and advance existing HMIS platforms | Information Systems | Maintenance of the IT infrastructure for iSantéPlus, PLR, MESI,BC,EMR,PS, in the form of Support Help Desk and Intervention teams, hardware and software acquisition, installation, troubleshooting and repair<br><br>Adjust EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC)<br><br>All systems upgraded in hardware, software and licensing to support storage and transmission of data for all applications<br><br>Reinforce the MESI platform and enable it to offer (i) one login for all applications on the platform (M&E, Surveillance, Patient Tracking, Partner services, HEALTH/QUAL, Biometric coding), (ii) the automatic deduplication of cases across sites (iii) the use of the tracking capacity for viral load monitoring (iv)the monitoring of recency testing<br><br>Ensure system functions properly through enhanced security measures for the IT System both at central and peripheral level including firewalls, encryption, terminals, and wiring | Lack of hardware, software, manpower and protocols for ensuring maintenance and security of IT assets poses a threat to the integrity of data<br><br>High level of attrition among patients initiating ART on average with excess level in some subgroups, and limited capacity for service delivery targeted to young girls under 14 and youth aged 15 to 30 |
| 9 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Improve MSPP capacity to coordinate and manage the delivery of HIV services | Policy and Governance | Capacitate the Ministry of Health to continue to support Planning and Coordination of the HIV program and shore up its multi-sectorial aspects.<br><br>Ensure through the National AIDS Coordinating unit the updating of norms and guidelines and the enforcement of the policies adopted<br><br>Harmonize indicators and Tools; and Support Data Validation across all PEPFAR sites<br><br>Maintain the MOH lead role in Health/Qual and give it the capacity to act on barriers identified during the process<br><br>Create capacity to integrate the HIV system into larger HMIS and support the public and the high Level Official access to HIV Information<br><br>Support selected departmental directorates in their effort to assist the scale up of services and the implementation of the district concept | Limited availability of population level epidemiological data down to the district level; limited human resources within MOH to develop and implement policies that support epidemic control |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
|---|---|---|---|---|---|---|
| 8 | 15. Performance Data | 6.83 | 1. Data replication interruptions do not extend beyond 1 month, regardless of the cause (hardware, software etc.)<br>2. Electronic Data collection and transmission is seamless and not affected by absence of Internet at any site.<br><br>3. Reduction in attrition among patients initiated on ART 12 months prior | 3 years | % of patients with data consolidated into a unique file (demographic, clinical)<br><br>% of sites with audited data matching reported data<br><br>Average number of downtime per unit (site, national server) | Maintenance teams are overwhelmed by the scope of the work that encompasses both hardware and software works<br><br>Expansion of capacities are at time limited by underfunding of licensing, like in the case of Biometric Coding |
| 9 | 2. Policy and Governance | 6.29 | National guidelines updated and widely distributed; MOH makes revised information tools incorporating new data requirements available to all HIV implementers after having chaired the validation process | 3 years | Guidelines, Policies and DQA widely disseminated. | Guidelines and strategic plan needs to be updated. Capacity of the Ministry to mobilize other sectors is limited. Involvement of the other Ministries and the private sector is almost non existent |

| Row | Year One (COP18) Annual Benchmark (Planned) | Note: FY19 Q2 and Q4 results will be recorded here for monitoring. | Year Two (COP/ ROP19) Annual Benchmark | Note: FY20 Q2 and Q4 results will be recorded here for monitoring. | Year Three (COP/ ROP20) Annual Benchmark | Note: FY21 Q2 and Q4 results will be recorded here for monitoring. |
|---|---|---|---|---|---|---|
| 8 | The establishment of a Support Help Desk with a ticket system allows more transparency and efficiency through establishment of priorities, monitoring of response to requests. | | Data replication interruptions do not extend beyond 2 weeks, regardless of the cause (hardware, software etc.) | | Data replication interruptions do not extend beyond 1 week, regardless of the cause (hardware, software etc.) | |
| 9 | Strategic Plan and guidelines updated. Other sectors are involved in the fight against HIV/AIDS in the Country. | | Involvement of other Ministries and private sector in the fight against HIV/AIDS | | Service delivery of HIV is decentralized and carried out by public and private partners. | |

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
|---|---|---|---|---|---|---|---|
| 10 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Improve MSPP capacity to coordinate and manage the delivery of HIV services | Assessments, evaluation, operation research | Begin the PHIA Survey (HQ PEPFAR funding)<br><br>Assessment of Stigma and Discrimination towards People Living with HIVAIDS in Haiti (Stigma Index) (No PEPFAR funds requested_Non-PEPFAR funds being explored)<br><br>Evaluation of Quality Improvement Program in Haiti for HIV Care and Treatment (Continued; no COP18 funding)<br><br>Disseminate ANC results (no COP18 funds) | Limited availability of population level epidemiological data down to the district level and low national analytic capacity.<br><br>These information will support the refinement of strategies to address stigma and discrimination. |
| 11 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Host country institutional development | Strengthen Biosafety level 3 (BSL-3) _ Building local capacity for certifying biosafety cabinets, procuring equipment and spare parts required for BSL-3 laboratory maintenance, repairing BSL-3 equipment, training BSL-3 maintenance staff, and training laboratory technicians in performing TB cultures. | 1. Limited TB culture capacity. Based on PNLT data, only 50% of estimated MDR-TB case had culture results in FY17. 2. The national reference laboratory will soon have a BLS-3 level laboratory for supporting MDR-TB survey and patient diagnosis, but will need additional support to increase detection of MDR-TB among HIV/TB patients. 3.20% of GeneXpert capacity is being utilized in FY17 based on the instrument mapping exercise. |
| 12 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Laboratory quality improvement and accreditation | 1.Optimize and integrate current SRN, and improve operational efficiency and reliability by mapping and reorganizing the SRN from peripheral sites to testing labs at hubs, and from hubs to testing labs at LNSP and IMIS;<br><br>2. Develop standard operating procedure (SOPs) conduct training for newly integrated SRN to drivers, sites, hubs and central-level staffers<br><br>3.Integrate SCC-LIS with the newly established SRN operation system to improve monitoring of SNR at sites, hubs and central levels in Real-Time. | 1. Inadequate specimen referral network (SRN) and timely returning results (Currently there are two paralleled SRNs one for EID which is fully supported by PEPFAR (DBS specimens from all sites to IMIS and LNSP for testing) and the second one is for transport CD4, VL, TB and surveillance and supported in the past by USG non-PEPFAR fund). No systematic monitoring system for the SRN. |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
|---|---|---|---|---|---|---|
| 10 | 13. Epidemiological and health data | 6.67 | **PHIA:** Comprehensive picture on HIV Prevalence & Incidence in Haiti by department, age, and sex.<br><br>**ANC:** The data generated through this round of sentinel surveillance will be used for program advocacy and improvement, targeting the MSPP and donors as well as used to inform a variety of HIV prevention and treatment services.<br><br>**Stigma Index:** The finding from this study will provide additional data to inform strategies addressing stigma and discrimination of PLHIV and minority groups.<br><br>**QI**: Quality improvement interventions are key for HIV patient management for epidemic control. The recommendations from this evaluation will support the implementation efforts of the Haiti HIV program. | 2 years | HIV Prevalence by department, age, and sex; National HIV Incidence, Population Viral suppression rates<br><br>QI: Number of health care professionals at sites who will be well equipped to care for PLHIV. (HTC_POS) | **ANC** survey data collection is completed.<br><br>**PHIA Survey** will start this Fiscal Year (training portion).<br><br>**Stigma Index:** Protocol/statement of work: under development<br><br>Evaluation of **Quality Improvement:** Report writing is in progress |
| 11 | 10. Laboratory | 5.67 | 1. Strengthen TB diagnostic capacity by working with the National TB Program, the National Public Health Laboratory, and key partners, GHESKIO and PIH/ZL, to increase the MSPP/LNSP BSL-3 facility's capacity to conduct TB cultures for PLHIV and patients with MDR-TB. 2. The BSL-3 laboratory in LNSP is certified for TB culture and perform tests for TB MDR survey and patient cares. 3. Bioengineers is trained and certified on maintain biocabinet. 4. Spare parts of BSL-3 lab is procured. 5. Refresher training for TB culture is conducted and lab tech from LNSP is certified to perform tests. | 3 years | 1. % of MDR-TB specimens are tested at national level and at LNSP. 2. % of increase of utilization of GeneXpert machines for TB diagnosis and RIF resistance testing in HIV-TB coinfected patients. 3. Number of bioengineers are trained for biosafety cabinet certifications. 4. Enough BSL-3 lab spare parts are procured to ensure the lab is full and regularly functions. | 1. LNSP BSL-3 lab is not functional; 2. No bioengineers in Haiti are trained and certified for maintaining biosafety cabinets. 3. No spare parts for BSL-3 lab is procured. 4. 20% of GeneXpert capacity is being used. |
| 12 | 10. Laboratory | 5.67 | 1. Integrated SRN is implemented to achieve and Linked to SCC-LIS for greater improvement of SRN management and better serving patient care and services.<br>a) 50% reduction in cost over 3 years<br>b) 75% reduction in turnaround time<br>c) 90% reduction in proportion of specimen rejected;<br><br>2. Reduced turnaround time for early infant diagnosis particularly in hard to reach departments in the north and south;<br><br>3. Single specimen tracking system developed and implemented at LNSP and interfaced SCC-LIS. 4. Monthly/quarterly SRN service data analyzed and reported; 5. Real-Time monitoring SRN and report gap/challenges and acted on them. | 3 years | TX_PVLS; PMTCT_EID; FPINT_SITE. 1. Integrated SRN implemented to achieve and Linked to SCC-LIS for greater improvement of SRN management and better serving patient care and services.<br>a) 25% reduction in cost over 3 years<br>b) 75% reduction in turnaround time<br>c) 90% reduction in proportion of specimen rejected; | 1. Incomplete integrated SRN is transporting VL DBS. 2. Initial integration of EID and VL SRN started. 3. Lack of systematic monitoring the SRN. |

| Row | Year One (COP18) Annual Benchmark (Planned) | Note: FY19 Q2 and Q4 results will be recorded here for monitoring. | Year Two (COP/ ROP19) Annual Benchmark | Note: FY20 Q2 and Q4 results will be recorded here for monitoring. | Year Three (COP/ ROP20) Annual Benchmark | Note: FY21 Q2 and Q4 results will be recorded here for monitoring. |
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| 10 | **ANC survey** results disseminated<br>**PHIA** survey: Data collection completed<br>**QI**: Information on quality improvement programs and their impact in the HIV program in Haiti. | | **PHIA:** The findings of this survey will inform the program on community viral characteristics as well as EID. Proxy for HIV incidence will be generated. | | | |
| 11 | 1. LNSP BSL-3 lab is commissioned and conduct TB culture tests and 70% of MDR-TB cases are tested nationally in all the TB labs. 2. Bioengineers are enrolled into biosafety cabinet certification courses and completed initial courses. 3. Spare parts for BSL-3 lab is procured. 4. Refresher TB culture training is conducted and LNSP TB lab staff members are certified to conduct TB culture tests. 5. 30% of the GeneXpert capacity is being utilized for TB diagnosis and RIF resistance testing. | | 1. LNSP BSL-3 lab continues functional and conduct TB culture tests and 80% of MDR-TB cases are tested nationally in all the TB labs. 2. Bioengineers continue to enroll into biosafety cabinet certification advanced courses and have hands on practice on the certification of Biosafety cabinets. 3. Spare parts for BLS-3 lab continues to be procured. 4. 40% of the GeneXpert capacity is being utilized for TB diagnosis and RIF resistance testing. | | 1. LNSP BSL-3 lab continue to conduct TB culture tests and 90% of MDR-TB cases are tested nationally in all the TB labs. 2. Bioengineers receive biosafety cabinet certification certificates and started to certify and maintain biosafety cabinets. 3. Spare parts for BLS-3 lab continue to be procured. 50% of the GeneXpert capacity is being utilized for TB diagnosis and RIF resistance testing. | |
| 12 | 1. Fully integrated specimen referral system is implemented and Linked to SCC-LIS for better serving patient care and services<br>2. 25% reduction in turnaround time both for EID and VL testing<br>3. 50% reduction in the proportion of specimen rejected. | | 1. Integrated SRN implemented to achieve and Linked to SCC-LIS for greater improvement of SRN management and better serving patient care and services.2.10% reduction in cost<br>3. 50% reduction in turnaround time<br>4. 75% reduction in proportion of specimen rejected. | | 1. Integrated SRN implemented to achieve and Linked to SCC-LIS for greater improvement of SRN management and better serving patient care and services.2.25% reduction in cost . 3. 75% reduction in turnaround time. 4. 90% reduction in proportion of specimen rejected. | |

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
|---|---|---|---|---|---|---|---|
| 13 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis and patient monitoring services | Information Systems | 1. Integration of SCC-LIS and iSantePlus is completed at LNSP and VL/EID results are automatically transferred/reported to EMR at site levels<br><br>2. IMIS lab is linked to the SCC-LIS and SCC-LIS at IMIS is integrated into iSantePlus EMR at site levels.<br><br>3. VL/EID testing instruments are capable to interface with the SCC-LIS at IMIS;<br><br>4. ART-patients with VL results equal or greater than 1000 copies/ml flagged in EMR and corrective actions are taken by clinicians. | 1. Insufficient Laboratory Information System (LIS) capability for quality patient services, data collection and analysis for commodity forecasting, data-driven interventions quality improvement, and timely and accurately reporting results for patient care.<br><br>2. Fragmented/siloed National public Health information systems. |
| 14 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Laboratory quality improvement and accreditation | 1. Continue to provide support on national EQA-PT programs to ensure quality-assured lab testing and services. 2. Continue the quality of HTS to ensure only HIV infected persons are identified and place on ART. 3. Support of continuous quality improvement at LNSP and obtaining international accreditation body accreditations. | 1. Not 100% of HTS sites received 100 scores on RTQ-PT program. 2. LNSP is striving to receive international accreditation body accreditation and gaps are identified in this process. 3. LNSP is the only organization in Haiti where EQA-PT program is being conducted and corrective actions are taken when needed. |
| 15 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Provision of administrative staff | Provide administrative staff for essential admin support. | The MSPP provides minimal support (Less than 10%) for admin staff members who are essential to support PEPFAR activities and services to ensure PEPFAR targets and goals are achieved. |
| 16 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Technical area guidelines and tools | 1. Revision of current HTS algorithm to include recency tests for all newly HIV-diagnosed persons<br><br>2.Recency testing training package is developed | Currently, there is an absence of testing capacity in Haiti to identify recent infections from newly HIV infected persons. |
| 17 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Laboratory quality improvement and accreditation | 1. Clinical and lab staff for 5 sites are trained on recency test package<br>2. Asante HIV-1 recency test is validated in Haiti<br>3. Conduct HIV recency tests for 5 sites.<br>4. Modification of IsantePlus, MESI to ensure recency test results are reported appropriately. The reported data are analyzed monthly at central level to support targeted HTS. | Currently, there is an absence of testing capacity in Haiti to identify recent infections from newly HIV infected persons. |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
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| 13 | 10. Laboratory | 5.67 | 1. full integration of SCC_LIS with IsantePlus (EMR) and real-time reporting of patient testing results for VL and EID at LNSP;<br><br>2. 100% error-free testing results reporting through integrated SCC-LIS and EMR at LNSP;<br><br>3. Generate monthly reports on number of patients tested and level of virology suppression;<br><br>4. IMIS lab is linked to SCC-LIS and functional; 5. Interfacing of IMIS SCC-LIS with VL/EID instrument is completed and functional.<br><br>5. IMIS SCC-LIS is linked to iSantePlus and testing results are returned to EMR at site levels.<br>6. Full functional SCC-LIS and regular scheduled maintenance. | 3 years | 1. TX_PVLS; PMTCT_EID; TB_STAT; LAB_PTCQI. 2. Fully integrated SCC-LIS with iSantePlus (EMR). 3. % of patient lab test results are recorded in EMR . 4. Routine maintenance of SCC-LIS conducted and the LIS is fully functional without interruptions. | 1. In FY17, with the utilization of gmail result reporting system, not 100% of VL results were recorded into EMR. 2. SCC-LIS is not interoperational with EMR. 3. It is essential to support maintain the SCC-LIS maintenance cost to ensure a functional lab information system to support lab testing and reporting for patient services to achieve PEPFAR goals. |
| 14 | 10. Laboratory | 5.67 | 1. 100% of needed panels are prepared and distributed to all HTS sites. 2. 100% of functional GeneXpert sites are enrolled into CDC GeneXpert PT program. 3. All labs performing VL/EID testing are enrolled into CDC PT program. 4. ≥95% of enrollees pass the PT programs. 5. % of RHT testers are certified following the newly establish national HIV testing algorithm | 3 years | 1. LAB_PTCQI, HTS_TST, PMTCT_HEI_POS; OVC_HIVSTAT. 2. % of RHT testers are certified. | 1. Not 100% of HTS sites received 100 scores on RTQ-PT program. 2. Gaps are identified at LNSP for achieving international accreditation body accreditation. 3. LNSP is the only organization in Haiti where EQA-PT program is being conducted and corrective actions are taken when needed. |
| 15 | 10. Laboratory | 5.67 | A full admin functional program for support PEPFAR program and regulations | 3 years | 1. HRH_CURR, TX_PVLS; PMTCT_EID; TB_STAT; LAB_PTCQI. 2. Staff has minimal turn over rate (<10%) | PEPFAR has been providing salary and benefits for administrative staff at LNSP in order to have a functional PEPFAR program and following regulations since the inception of PEPFAR Haiti program. |
| 16 | 10. Laboratory | 5.67 | 1. Recency testing algorithm is incorporated in the current HTS algorithm and the new algorithm is reviewed and approved by PNLS<br><br>2.Recency testing training package is developed; | 1 year | Recency testing policy is integrated into the national HIV RT algorithm and training package is developed. | Currently, there is an absence of testing capacity in Haiti to identify recent infections from newly HIV infected persons. |
| 17 | 10. Laboratory | 5.67 | 1. Asante HIV-1 recency test is validated in Haiti<br><br>2. Implementation of recency tests to all newly HIV- diagnosed persons and results are reported in EMR;<br><br>3. IsantePlus and MESI systems are modified, recency test and recent infection confirmatory VL data are captured in the systems<br><br>4. These data are analyzed monthly and reported back to program managers for prevention purposes.<br><br>5. Quality management system established for recency tests including PT program | 3 years | % of Clinical and lab staff members who performing HIVRT are trained for Asante tests. 2. % of sites perform Asante tests for newly HIV diagnosed people. 3. % of Newly HIV diagnosed persons have Asante tests performed. 4. % of EMR at sites are modified for recording Asante tests. 5. MESI is updated to include Asante tests and analysis data. | Currently, there is an absence of testing capacity in Haiti to identify recent infections from newly HIV infected persons. |

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| 13 | 1. 60% of ART sites have integrated EMR with SCC-LIS, and testing results are quality-assured lab results are directly reported into EMR for VL and EID at LNSP<br>2. SCC-LIS at LNSP generates quarterly reports on number of<br>patients tested and level of virology suppression.<br>3. Routine LIS maintenance is carried out.<br>4. IMIS lab is linked to SCC-LIS at LNSP and interfacing of IMIS VL/EID testing systems with SCC-LIS is completed and functional. | | 1. 70% of ART sites have integrated EMR with SCC-LIS, and testing results are quality-assured lab results are directly reported into EMR for VL and EID at LNSP.<br>2. Routine LIS maintenance is carried out.<br>3. 50% of ART sites at IMIS VL/EID testing network is integrated into SCC-LIS at IMIS and VL/EID results are directly reported to EMR. | | 1. 100% of ART sites have integrated EMR with SCC-LIS, and testing results are quality-assured lab results are directly reported into EMR for VL and EID at LNSP. 2. Routine LIS maintenance is carried out.<br>3. 100% of ART sites at IMIS VL/EID testing network is integrated into SCC-LIS at IMIS and VL/EID results are directly reported to EMR. | |
| 14 | 1. 100% of HTS sites enrolled into the RHT PT programs and 95% passed the PT. 100% of functional GeneXpert sites are enrolled into CDC GeneXpert PT program and 95% pass the PT. 3. All labs performing VL/EID testing are enrolled into CDC PT program and 100% pass PT. 4. 50 % of RHT testers are certified following the newly establish national HIV testing algorithm | | 1. 100% of HTS sites pass the PT. 100% of functional GeneXpert sites are enrolled into CDC GeneXpert PT program and 100% pass the PT. 3. All labs performing VL/EID testing are enrolled into CDC PT program and 100% pass PT. 4. 75 % of RHT testers are certified following the newly establish national HIV testing algorithm. | | 1. 100% of HTS sites pass the PT. 100% of functional GeneXpert sites are enrolled into CDC GeneXpert PT program and 100% pass the PT. 3. All labs performing VL/EID testing are enrolled into CDC PT program and 100% pass PT. 4. 100 % of RHT testers are certified following the newly establish national HIV testing algorithm. | |
| 15 | 1. A full admin functional program for support PEPFAR program and regulations. 2. Less than 10% staff turn over rate to ensure program support continuity. | | A full admin functional program for support PEPFAR program and regulations. 2. Less than 10% staff turn over rate to ensure program support continuity. | | A full admin functional program for support PEPFAR program and regulations. 2. Less than 10% staff turn over rate to ensure program support continuity. | |
| 16 | 1. Recency testing algorithm is developed incorporated into the current HTS algorithm<br><br>2. The new algorithm is reviewed and approved by PNLS. 3. Training package is developed. | | | | | |
| 17 | Asante test is validated at LNSP<br>Clinical and lab staff members at 5 of the HTS sites are training on the recency testing training package<br>50% newly HIV- diagnosed persons from those sites of implementing Asante tests are tested for recency tests.<br>100% of recency test positive samples are confirmed VL data are captured in the systems. MESI is updated to include Asante positive test results. | | 1. Clinical and lab staff members from 5 HTS sites are trained for Asante test.<br><br>2. 50% newly HIV- diagnosed persons are tested for recency tests<br><br>3. 100% of recency positive samples are tested for VL for confirmation and confirmed cased are recorded in EMR. 4. 100% of recency positive results are recorded in MESI and analyzed monthly. | | 1. Clinical and lab staff members from 5 HTS sites are trained for Asante test.<br><br>2. 100% newly HIV- diagnosed persons from 5 sites are tested for recency tests<br><br>3. 100% of recency positive samples are tested for VL for confirmation and confirmed cased are recorded in EMR. 4. 100% of recency positive results are recorded in MESI and analyzed monthly. | |

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| 18 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | HSS | Strengthen Lab capacity, infrastructure and specimen referral network in Haiti for better diagnosis, patient monitoring services | Assessments, evaluation, operation research | HIV DR Survey will continue (in COP18, survey will be completed and data analyzed )<br><br>Dissemination of findings to stakeholders in COP 18 (No COP18 PEPFAR Funding). | Limited knowledge on primary and secondary HIV drug resistance prevalence in the country to inform Haitian public health guidelines on quality of HIV care and treatment |
| 19 | HHS/CDC | MSPP/UGP (National AIDS Strategic Plan) | OVC | Provide a supportive package of social services and strengthen the capacity of families and communities to care for orphans and vulnerable children including risk avoidance and the reduction of gender based violence among Adolescent Girls/Young Women | Policy and Governance | Collaboration with other stakeholders on enrollment and case management approaches for psychosocial support programs and orphans and vulnerable children programs, to ensure that standardized tools and graduation benchmarks are disseminated and implemented at the sites. | Lack of standardized tools for the management of OVC beneficiaries and their families |
| 20 | HHS/CDC | NASTAD 1525 | HSS | Reinforce the utility of the Data Repository for HIV case-based notification (SALVH) and enable it to support an outcome evaluation of the program, improve case matching and feedback into the EMR | Information Systems | Incorporate additional variables, including viral load, recency testing; develop new analysis plan; perform data cleaning and run analysis. Enable BC to be fully integrated in case matching and deduplication | Lack of interoperability or integration among HIV information platforms to facilitate patient de-duplication across the program |
| 21 | USAID | Global Health Supply Chain Program | HSS | Harmonizing commodity ordering processes, thus decreasing parallel systems by revision and rollout of LMIS reporting tools, increasing availability of data for decision-making. | Supply chain systems | Assist the MOH in designing and standardizing an enhanced LMIS for the unified national supply chain, then developing an M&E plan to support LMIS data use and regular monitoring of supply chain performance through the outcome of facility level commodity availability. | Limited supply chain management capacity at the site |
| 22 | USAID | Global Health Supply Chain Program | HSS | In collaboration with donor partners provide technical assistance to the Ministry of Health for HIV quantification and implementation of the National Unified Supply Chain Coordination Unit, increasing country ownership of the supply chain and health system. | Supply chain systems | Support through secondment and TA to the MOH to coordinate procurement and distribution of health commodities, as well as data collection and utilization | Limited capacity related to procurement and distribution planning as well as data collection, management and utilization |
| 23 | USAID | Global Health Supply Chain Program | HSS | In collaboration with donor partners provide technical assistance to the Ministry of Health for HIV quantification and implementation of the National Unified Supply Chain Coordination Unit, increasing country ownership of the supply chain and health system. | Supply chain systems | Support annual forecast exercise to quantify national need for ARVs and OIs, as well as convening relevant stakeholders to do a quarterly review of the upcoming procurements to ensure they align with all stakeholder commodity requirements and national need. | Limited capacity to forecast national need for HIV products. |
| 24 | USAID | TBD - HIS | C&T | Improve MSPP capacity to implement and advance existing HMIS platforms | Information systems | Scale-up of DHIS2 tracker module within SISNU, including TB tracker to allow community tracking of individual TB treatment and data transfer modules to integrate key HIV data | Limited availability of population level epidemiological data down to the district level and low national analytic capacity |
| 25 | USAID | TBD - HIS | HSS | Improve MSPP capacity to implement and advance existing HMIS platforms | Information systems | Technical Assistance to the MSPP to continue expansion of the National Unified Information System (SISNU) by financing implementation at the MOH/UEP unit | Limited human resources within MOH to develop and implement policies that support epidemic control |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
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| 18 | 10. Laboratory | 5.67 | Nationally representative HIVDR available to inform care and treatment decision and policy revisions. | 2 years | TX_PVLS | No systematize PDR and ADR data are available for data-driven ART program improvement and revision of treatment guidelines. |
| 19 | 6. Service Delivery | 4.31 | The most vulnerable OVC are enrolled, there is Improve of case management and patient are graduated based of defined criteria | 1 year | OVC_SERV | No standardized enrolment tool, case management system and graduation benchmarks across the OVC portfolio |
| 20 | 15. Performance Data | 6.83 | Patients level system directly linked to aggregate system, and reports are generated automatically without human intervention in order to minimize reporting errors. Patients' health information data readily available to authorized end users to support patients' care, program management, and decision making | 2 years | % of patients with data consolidated into a unique file (demographic, clinical) | SALVH receives data transfer from the Three (3) EMRS |
| 21 | 8. Commodity security and supply chain | 2.56 | Unified form, available and used by all facilities without antiquated legacy products included, leading to development of a national master product list and requirements for an e-LMIS | 3 years | -LMIS reporting (PSM metric)<br>-SIMS Above-Site Data Availability,<br>-SIMS Facility supply chain reliability commodity availability CEEs. Number of facilities using the unified form | current LMIS reporting rate |
| 22 | 8. Commodity security and supply chain | 2.56 | MOH utilization of existing data to plan distributions and procure commodities and equipment. Percent of supply chain functions completed by host country increased. | 3 years | -SID Commodities section score improved,<br>-Above-Site SIMS data utilization improved,<br>-PSM metric | SID. 8. Commodity security and supply chain. Score 2.56 |
| 23 | 8. Commodity security and supply chain | 2.56 | Commodities available at the central level for distribution to facilities with limited stock irregularities. | 3 years | -Above site SIMS Commodities Data Availability CEEs,<br>-PSM Forecast Error Rate and<br>-MER SC_STOCK (Stocked According to Plan) | Same SIMS listed, PSM metric and MER SC_STOCK<br>Forecast error rate: 10%; MER SC_STOCK: 80% |
| 24 | Epidemiological and health data | 6.67 | Enrolled of 100% suspected and diagnosed case, 100% providers trained on TB tracker | 2 years | Above site SIMS-Set2 related CEE (2.05: data collection and review)-Set 6: Strategic information: surveillance, survey and evaluation; Number of provider trained in TB tracker | MER indicators: TB_ART, TX_TB; TB_STAT |
| 25 | 13. Epidemiological and health data | 6.67 | Increased number and quality of MSPP facilities reporting into SISNU | 2 years | Above site SIMS -Set2 related CEE (2.05: data collection and review)-Set 6: Strategic information: surveillance, survey and evaluation; Number of facilities reported at the SISNU platform | SISNU Metrics (electronic and paper) |

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| 18 | HIVDR protocol developed and approved by Haiti Bioethical committees and CDC NRD is also approved; Survey implementation and data collection completes. | | Results are disseminated to stakeholder and used for public action to improve treatment outcomes | | | |
| 19 | All OVC enrolled beneficiaries have a documented enrolment form, the family case file is well maintained and updated at least quarterly and client meet graduation benchmark before graduation | | | | | |
| 20 | SALVH is expanded t include 70% of treatment and lab related variables that could allow an outcome evaluation of the program, following intensive work with the three EMR and the lab supported platforms | | SALVH is expanded to include all (100%) treatment and lab related variables that could allow an outcome evaluation of the program, following intensive work with the three EMR and the lab supported platforms | | | |
| 21 | Harmonized product list, with form by program developed and validated by MOH. | | Forms rolled out to sites, sites trained in their use | | MOH, donor partners, and PSM using LMIS data to make decisions regarding forecasting, redistribution of supplies to avoid stockouts and waste. | |
| 22 | Local consultants embedded at the MOH as the National Unified Supply Chain Coordination Unit (SNADI) and Departmental Logistics Coordinators using USG funding through PSM. | | SNADI coordination unit and Departmental Logistics Coordinators participating in procurement and distribution planning. Improve next SID score for this domain. | | SNADI Coordination Unit and Departmental Logistics Coordinators absorbed by the MOH, officially integrated into the MOH Organigram and budget. | |
| 23 | Improved forecast error rate, improved MER SC_STOCK (Stocked according to plan); targets to be established based on the roll-out of TLD; performance, ordered products matching the validated national master product list/updated STGs. | | Harmonized ARV regimens, legacy regimens removed from the system to encourage rational use of TLD. Improved forecast error rate. Improvement within the Above-Site SIMS data on forecasting and data use. | | Improved forecast error rate, improvement within the SIMS above-site CEEs and decreased waste in Haiti. | |
| 24 | Training to PNLT (National TB Program) on TB Tracker completed; expansion of TB Tracker pilot to additional departments | | National roll out of TB Tracker | | | |
| 25 | Timely exchange of key data occurs quarterly between MESI and SISNU | | 100% of MSPP's facilities reporting in SISNU in a timely manner. | | | |

| Row | Funding Agency | Implementing Mechanism Name | Program Area | COP18 Strategic Objective | Approach | COP18 Activity (above-site, above-service delivery) | Key Systems Barrier |
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| 26 | USAID | TBD - HIS | HSS | Expand DHIS2 aggregated HIV reporting to private sector providers | Information systems | Coordinate with MSPP on private sector outreach for data reporting and sharing | Lack of visibility on prevalence among higher income groups (particularly men) who utilize private sector for health services. Limited private sector input into national HIV/AIDS processes. |
| 27 | USAID | <Placeholder - 70102 Haiti USAID> | HSS | Improve planning for distribution of human resources for health | Management and coordination | Implementation of MOH HRH Strategy including operationalizing the role of ASCPs and task-shifting for HIV | Limited HRH coverage and task sharing to provide adequate and high quality services to PLHIV |
| 28 | USAID | <Placeholder - 70102 Haiti USAID> | HSS | Provide technical assistance to MSPP to mobilize sufficient resources for the HIV response | Financial management policies and procedures | Support MSPP to advocate for an increase in the budget allocated to HIV and the health sector overall | Decrease in financial resources for HIV from external sources of funding |
| 29 | USAID | <Placeholder - 70102 Haiti USAID> | HSS | Improve capacity to coordinate and manage the health sector including support to the Global Fund CCM | Host country institutional development | Strengthen the capacity of the CCM to manage grant implementation and engage CBOs in the oversight process | Limited coordination with civil society. |
| 30 | USAID | <Placeholder - 70104 Haiti USAID> | HSS | Strengthen the MOH and National Reference Lab to enhance laboratory equipment management, procurement of lab consumables, and quality of lab services | Host country institutional development | Technical Assistance to the MOH and National Reference Lab to enhance laboratory equipment management, procurement of lab consumables, and quality of lab services by providing training and mentorship on maintenance and repair services to the National Lab Technicians. | Limited viral load diagnosis capacity and limited supply chain management capacity at the national level, limited ability to procure and manage lab consumables and inconsistent practices across labs in-country. |
| 31 | USAID | EQUIP | C&T | Implement recommendations of analyses to improve EID and viral suppression | Technical area guidelines and tools | Support MSPP/PNLS to update guidelines and tools to Implement recommendations of analyses to improve EID and viral suppression. | Limited Laboratory Information System (LIS) capability for specimen tracking, data collection, analysis, and reporting for timely and accurate results dissemination |
| 32 | USAID | EQUIP | HSS | Implement recommendations of analyses to improve EID and viral suppression | Technical Area Guidelines and Tool | Implement recommendations of analyses to improve EID and viral suppression | Lab testing for VL and EID takes several weeks thus delaying linkage to treatment |
| 33 | USAID | Measure Evaluation | OVC | Not included in COP18, no funding requested | Assessments, evaluation, operation research | Monitoring Outcomes of Two PEPFAR-supported Projects Serving Orphans and Vulnerable Children in Haiti (OVC-MER) | Limited information regarding impact of OVC activities |
| 34 | USAID | SOAR | OVC | Not included in COP18, HOP funded activity from previous year | Assessments, evaluation, operation research | Impact of Community Adherence Groups (CAGs) on Treatment Outcomes for OVC (working title) | Evidence on the effectiveness of community adherence groups among OVC and their caretakers is limited |
| 35 | USAID | DHS | HSS | Not included in COP18, no funding requested | The Demographic and Health Survey 2016-2017 | Preliminary data available; final report writing: in progress | Limited availability of population level epidemiological data. |
| 36 | HHS/CDC | NASTAD 1525 | HSS | Reinforce the utility of the Data Repository for HIV case-based notification (SALVH) and enable it to support an outcome evaluation of the program, improve case matching and feedback into the EMR | Surveys and Surveillance | Ongoing National HIV Case-Based Surveillance System (SALVH) | Limited capacity to prioritize index testing and identify potential HIV hotspot |

| Row | Related SID 3.0 Element | SID 3.0 Element Score | Expected Outcome | Expected Timeline for Achievement of Outcome (1, 2, or 3 years) | Relevant Indicator or Measurement Tool | COP18 Baseline Data |
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| 26 | 4. Private Sector Engagement | 1.67 | Increased number of private sector sites reporting on SISNU | 2 years | Above site SIMS. Set2 related CEE (2.05: data collection and review). Set 6: Strategic information: surveillance, survey and evaluation; Set 8: Public/Private partnership related CEEs | SISNU Metrics (electronic and paper) |
| 27 | 7. Human resources for health | 7.01 | HRH strategy implemented; ASCP training materials adapted and approved by MSPP | 3 years | Above site SIMS -Set3 related CEE (HRH) | DATIM; MER indicators: HRH_STAFF, HRH_CURR; HRH_PRE;. No HRH strategy in place. |
| 28 | 11. Domestic resources mobilization | 3.85 | MOH increases health budget allocation to 3% for HIV. | 3 years | Total MOH health budget attributed to HIV | HIV line item recently added to the MOH annual budget but 0%; Per the National health Account (REDES), the part of the National Budget allocated to health is very small (less than 5%). 2013-2014 NACs and the 2014-15 NASA (NASA) indicates that only 2% of HIV / AIDS expenditure. |
| 29 | 3. Civil society engagement | 4.46 | Capacity of CCM to manage grants through engaging CSOs strengthened | 3 years | Above site SIMS -Set2 related CEE (Planning and management-Health) | External review of CCM. There is a limited coordination with the civil society |
| 30 | 8. Commodity security and supply chain | 2.56 | MOH institutional capacity to establish and operate the HIV lab system increased. Quality of lab services increased. VL testing increased. | 3 years | - SIMS Facility lab CEES (Testing Interruptions, Waste management, EID/VL)<br>- PSM Molecular Instrument up-time improved, | SAME SIMS Listed and PSM metric on molecular instrument up-time. |
| 31 | 6. Service delivery | 4.31 | Revised guidelines and tools disseminated at all health facilities. | 2 years | Above site SIMS. Set3: HR related CEEs - Set7 related CEE (Advocacy and health communication). Set 11 (Comprehensive support partner) related CEE | Guidelines and tools on EID and VL not updated |
| 32 | 10. Laboratory | 5.67 | This study will provide actionable recommendations for VL test results return to patients for timely care. It will allow the program to bring the services (viral load and EID) closer to the patients. | 1 year | TX_PVLS; PMTCT_EID; LAB_PTCQI, | Protocol/statement of work/SOW: Study completed with recommendation to improve EID and Viral Supression |
| 33 | 15. Performance Data | 6.83 | Results will be used to inform program planning by PEPFAR OVC policy makers and program managers in Haiti and at PEPFAR headquarters. | 1 year | OVC_SERV | Protocol/ Statement of work: finalized |
| 34 | 13. Epidemiological and Health Data | 6.67 | This study will assess the feasibility, acceptability, and/or fidelity of either potential or existing models of OVC community adherence groups (CAGs) to enhance ART adherence and program retention under current standards of care. | 1 year | TX_RET, TX-CURR, OVC_SERV | The research is ongoing |
| 35 | 13. Epidemiological and Health Data | 6.67 | The DHS will generate PLHIV prevalence information and other data to estimate the PLHIV, therefore adjust for programming and resource allocations to geographic areas. | 1 year | TX_RET, TX-CURR, HIV Prevalence | Preliminary data available; final report writing: in progress |
| 36 | Epidemiological and health data | 6.67 | Case-based surveillance combined with recency testing will allow to identify be added to help to prioritize index testing and identify potential HIV hotspots; SALVH provides HIV case-based surveillance to target epidemic control efforts. | 3 years | Number of recently infected persons identified and number of index cases linked to HTS; How many HIV-positive ones put on ART | FOR RECENCY: Protocol/statement of work: under development;<br>FOR CASE-BASE: Data collection: in progress |

| Row | Year One (COP18) Annual Benchmark (Planned) | Note: FY19 Q2 and Q4 results will be recorded here for monitoring. | Year Two (COP/ ROP19) Annual Benchmark | Note: FY20 Q2 and Q4 results will be recorded here for monitoring. | Year Three (COP/ ROP20) Annual Benchmark | Note: FY21 Q2 and Q4 results will be recorded here for monitoring. |
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| 26 | Improved Health Statistics from the private health sector with an emphasis on select HIV AIDS indicators | | 100% of private sector clinics providing HIV services reporting into SISNU | | | |
| 27 | HRH strategy implemented to rationalize HRH footprint at site level according to essential package of services; ASCP training materials finalized adapted for re-training of existing CHW cadres | | Roll out of training materials; task shifting policy for pediatric HIV services developed and adopted by MSPP | | all ASCP trained on HIV-specific materials | |
| 28 | Health financing framework developed and validated by MSPP. MOH increases health budget allocation to 1% for HIV. | | MTEF developed with MOH and MEF; MOH increases health budget allocation to 2% for HIV. | | MOH increases health budget allocation to 3% for HIV. | |
| 29 | Implementation of components of CCM Action Plan related to civil society engagement; successful bi-annual election of CCM members | | Quarterly reporting on grants' progress and engagement of various sectors in the country responses to the diseases | | Quarterly reporting on grants' progress and engagement of various sectors in the country responses to the diseases | |
| 30 | Staff member embedded and working at the LNSP, working to increase capacity to operate and establish labs. | | Increased numbers of VL/EID tests performed aligning with TX_NEW | | Increased numbers of VL/EID tests performed, aligning with TX_CURR. | |
| 31 | Guidelines and monitoring tools updated and standardized across all health facilities for increased viral load suppression and improved EID coverage | | Viral suppression achieved for 80% of PLHIV on treatment | | | |
| 32 | Guidelines and Tool Developed to Improved EID & Viral Suppression | | | | | |
| 33 | Study completed | | | | | |
| 34 | Study completed and results disseminated | | | | | |
| 35 | Study completed and results used to inform programming | | | | | |
| 36 | 50% of newly HIV diagnosed persons in 5 designated sites are tested by recency tests. | | 100% of newly HIV diagnosed persons in 5 designated sites are tested by recency tests. | | 50% of newly HIV diagnosed persons are tested by recency tests. | |