Dominican Republic

Country Operational Plan

(COP/ROP) 2019

Strategic Direction Summary

April 1, 2019

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1.0 Goal Statement

The 2019 PEPFAR Country Operational Plan (COP19) for the Dominican Republic (DR) details the Reboot strategy to achieve the goal of epidemic control among Target Population Individuals (TPI)[1], defined as individuals of Haitian descent, residing primarily in five (5) key provinces in the DR. In a country of 10.36 million inhabitants, there are approximately 751,080 TPI[2]. Of the estimated 71,504 people living with HIV (PLHIV) nationwide, approximately 25,590 are TPI, and the five selected provinces contain nearly 2/3 of all TPI. While the Dominican Republic has an overall HIV prevalence of 0.9%, TPI estimates indicate a prevalence between 3-5%, higher than any key population group and higher than the overall prevalence in Haiti (1.9%, UNAIDS 2017). Among TPI PLHIV, only 40.7% are aware of their status, and only 17.5% are currently on treatment. In comparison, antiretroviral treatment coverage for other Dominican PLHIV is 67.5%.

For TPI living with HIV/AIDS in the DR, a series of political, economic, and cultural factors hinder initiation, retention, and adherence to antiretroviral treatment. The severe economic disparity between Haiti and the DR makes migration across a highly porous border an attractive economic option for many Haitians, and mirroring the experiences of many migrant-receiving countries, the influx of Haitians to the DR over the last century has generated a social and economic underclass that suffers stigma and discrimination in all aspects of daily life, including access to HIV services. Further, the irregular immigration status of many TPI in the DR creates obstacles, both real and perceived, to access public services. The Dominican government passed Judgment 168-13 in 2013 stripping citizenship from nearly 200,000 TPI (UNHCR 2013) born in the DR[3], creating a group of stateless individuals, neither Haitian nor Dominican citizens, and leading to an ongoing increase in deportation activities. While the law has since been rescinded as a result of international pressure, few of the affected TPI have regained legal status, and the reversal of the consequences and the perception of Haitians that led to the passage of the law are less easily done.

In the DR, the concept of "migrant" remains subject to discussion, including the criteria used to distinguish this term from the related concept of migrant descendants (Ferguson, 2003). Beyond the theoretical and legal effects of this distinction, from an operational standpoint, there are numerous potential implications for health and HIV-related public policies and programming. National policies and health information systems in the DR define migrants exclusively based on their place of birth (i.e. foreign-born persons who currently reside on Dominican territory), although it is widely acknowledged that vulnerability factors impacting this population, including

[1] As much as possible, throughout this document, TPI will refer to the population of interest for PEPFAR programming that is comprised of migrants (individuals not born in the Dominican Republic) and their descendants. When used, the term "migrant" will typically refer only to that subset of TPI, most often in reference to data sources that do not account for all TPI.

[2] Encuesta Nacional de Inmigrantes (National Immigrant Survey) 2017, National Office of Statistics.

[3] Judgement 168-13 specifically removed the right to Dominican citizenship from the children of non-resident foreigners born between 1929 and 2010. Law 169-14 in 2014 restored citizenship to those who had been registered as citizens prior to the judgement. https://www.refworld.org/docid/52a5770d4.html

extreme poverty, structural violence, and frequent mobility, usually extend to the first and second generation of their descendants as well (Discussion Group Key Stakeholders).

The DR COP19 strategy to reduce the gaps under the cascade for TPI focuses on:

1. **Expansion of USG-supported prevention, treatment and clinical care entry points** accessible to TPI in addition to the 18 sites currently supported by PEPFAR and outside the network of 74 Integrated HIV Care sites nationwide.

2. **Targeted community-focused case finding** via strategically allied community-based organizations that are culturally and linguistically responsive to TPI. These organizations will link TPI to testing and treatment, and improve retention and adherence through a network of community outreach teams.

3. **Fast track policy changes** to establish a network of new service entry points and bring the DR into compliance with World Health Organization (WHO) HIV/AIDS guidelines and best practices.

4. **Establishment of an Orphans and Vulnerable Children (OVC) program for HIV positive TPI clients** to further identify and support those affected by HIV/AIDS to reduce barriers to and retention in care.

5. **Binational collaboration with Haiti** to improve cross-border referrals and case management to retain in treatment those TPI PLHIV that travel back and forth across the Haiti-DR border.

In addition, PEPFAR DR will provide technical assistance to the GODR to increase laboratory capacity to improve country-wide viral load suppression. Successful implementation of the strategy will represent an unprecedented level of collaboration and cooperation between PEPFAR, the Government of the Dominican Republic (GODR) and civil society organizations (CSO). Under COP19, PEPFAR will support stigma and discrimination reduction efforts among those entities that interact with TPI on a regular basis, particularly the Military.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Projections based on the 2010 national census show that the DR has an estimated population of 10,358,320 in 2019. According to the World Bank (2019), the DR's Gross National Income per capita was $6,630 in 2017 (current USD). Despite being a middle-income country, more than 40% of Dominicans live in poverty, with the wealthiest 10% of the population accounting for more than 40% of the country's income. In 2014, health spending represented 4.38% of the Gross Domestic Product.

The DR has a concentrated HIV epidemic, with an estimated HIV prevalence of 0.9% in adults age

15-49. According to the 2019 Spectrum model's preliminary results, 69,739 persons are living with HIV in the DR among adults age 15 years and above, while 1,949 new HIV infections and 701 HIV-related deaths are estimated to occur in 2019. Populations disproportionately burdened by HIV include TPI, men who have sex with men (MSM), transgender women (TG), and female sex workers (FSW).

The number of migrants living in the DR was estimated at 570,933 in the 2017 National Immigrants Survey (NIS). Among them, 497,825 were born in Haiti, an 8.6% increase over 2012 NIS results. In addition, 253,255 persons were born in the DR from at least one Haiti-born parent, a 20.6% increase since 2012. The 2019 Spectrum model posits a migrant population age 15 and above of 556,744, including 350,947 (63%) men. Per the 2017 Integrated Biological and Behavioral Surveillance Survey (IBBSS, unpublished), HIV prevalence among migrants ranges from 2.5 to 5.0% across the five provinces surveyed. The 2019 Spectrum model estimates that there are 25,530 Haitian PLHIV throughout the DR, including 14,612 (57.3%) men. From these two data sets it is estimated that PLHIVs of Haitian descent represent 36.8% of all PLHIV, the single largest priority group in the DR.

Certain subgroups within the Haitian-born population have also been shown to be at increased risk of contracting HIV infection: the 2012 IBBSS found that in Haitian FSW and construction workers, HIV prevalence was 5.4% and 4.6%, respectively. In that same study, only 35.3% of migrant FSW and 13.1% of migrant construction workers had access to an HIV test within the previous 12 months, and only 48.8% of migrant FSW and 18.5% of migrant construction workers reported accessing regular medical care. IBBSS 2017 results continue to show increased risk and poor access to services among Haitian migrants: 25-39% of respondents, depending on the province, reported never having been tested for HIV, even though 17-35% considered themselves at risk for HIV infection, primarily for having unprotected sexual intercourse (48-89%) or having sex with multiple partners (11-45%).

Estimates of the number of MSM living in the country vary widely depending on the source of the information. The 2015 National AIDS Commission (CONAVIHSIDA) and UNAIDS joint study reports 124,472 MSM, or 4.2% of the adult male population. The 2016 Priorities for Local AIDS Control Efforts (PLACE) study estimated a much lower figure of 32,416 MSM, or 1.24% of all men age 15-49. One explanation for this significant difference is that PLACE Lite estimates focus on individuals that are reachable with prevention interventions. In the 2017 Integrated Biological and Behavioral Sentinel Survey (IBBSS), HIV prevalence among MSM was estimated to range between 2.4 and 6.4% across five Dominican provinces, and according to the 2019 Spectrum model, MSM represent 10.5% (7,262) of all PLHIV in the country. This same study also indicated that only 11-31% of MSM had access to an HIV test in the last 12 months. Moreover, 48% of MSM reported discrimination in health services, and 28.9% of a sample of health service providers preferred not to care for MSM or other KPs (Health Policy Project, 2014). Between 70-94% of MSM reported having sex for some material benefit, and condom use was low: between 42-71% in most recent anal receptive sexual intercourse, and between 21-39% in most recent insertive anal sexual intercourse.

In 2014, the number of TG women in DR was estimated at 8,891 (Experts Focus Group for CONAVIHSIDA, 2014), although this number was substantially reduced to 5,169 (0.2% of adult

males) in the 2016 PLACE Lite study. In the 2014 PLACE study, HIV prevalence in TG women was estimated at 17.3%, although the sample size was extremely small (n=33). In the 2017 IBBSS, which included 439 TG women, HIV prevalence was 28.0%. The 2019 Spectrum model estimates that 1,635 PLHIV in the DR are TG women, or 2.4% of all PLHIV.

In 2014, the number of FSW in DR was estimated at 91,171, representing 3.4% of all adult women (CONAVIHSIDA Experts Focus Group, 2014). This figure was supported by the 2016 PLACE Lite study (87,782 FSW, or 3.3% of all women age 15-49). Estimates of HIV prevalence in FSW ranged between 1.1 and 5.9% across the five provinces included in the 2017 IBBSS. In that same study, 27-75% of FSW reported having used a condom during their most recent commercial sexual intercourse and only 1-11% during their most recent intercourse with a trusted or stable partner.

Concurrently, the analysis of DR programmatic data consistently reports poorer rates of linkage to HIV services, enrollment in treatment, and adherence and viral load suppression among Haitian migrants and persons of Haitian descent diagnosed with HIV in the Dominican Republic, compared to other population groups (PEPFAR, COP 2017). Similarly, out of 2,153 AIDS-related deaths reported in 2016 in the Dominican Republic, 660 (30.7%) are estimated to have occurred among Haitian migrants (Dolores & Caballero, 2017).

Figure 2.1.0 Trend of New Infections and All-Cause Mortality among PLHIV (Spectrum)

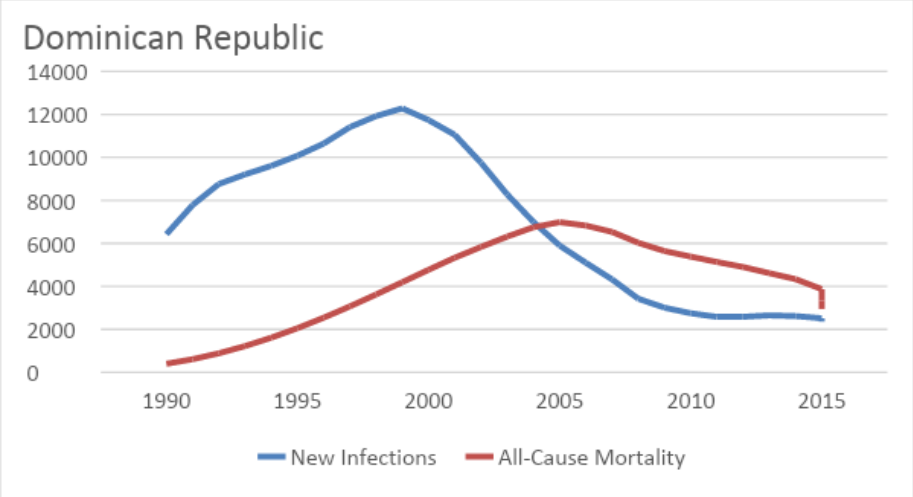


Table 2.1.1 Host Government Results

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	10,358,320	100%	1,414,169	14%	1,467,489	14%	925,924	9%	936,905	9%	2,843,884	27%	2,769,949	27%	2010 Census, 2019 projection, Office of National Statistics
HIV Prevalence (%)		0.91% (15-49)		0.05-0.1%		0.05-0.1%		0.24-0.53%		0.17-0.24		0.23-1.78%		0.07-02.0%	Spectrum 2019, from 2013 Demographic and Health Survey
AIDS Deaths (per year)	1,029		N/A		N/A		N/A		N/A		N/A		N/A		Spectrum 2019 (preliminary)
# PLHIV	71,504		972		1,011		3,019		3,042		30,997		32,460		Spectrum 2019 (preliminary)
Incidence Rate (Yr)		0.024%		N/A		N/A		0.034-0.035%		0.0030-0.079%		0.000-0.029		0.00-0.085%	Spectrum 2019 (preliminary)
New Infections (Yr)	2,592														Spectrum 2019 (preliminary)
Annual births	148,061	100%													National Office of Statistics, 2017
% of Pregnant Women with at least one ANC visit		99%	N/A	N/A			N/A	N/A			N/A	N/A			Demographic and Health Survey, 2007
Pregnant women needing ARVs															

Orphans (maternal, paternal, double)	39,587		N/A		N/A		N/A		N/A		N/A		N/A		Spectrum 2019 (preliminary)
Notified TB cases (Yr)	4,130		55		65		235		298		1,150		2,327		National TB Program, National TB Information System, 2017
% of TB cases that are HIV infected		25%		21%		25%		9%		10 %		26 %		28 %	
% of Males Circumcised	N/A		N/A		N/A	N/A	N/A		N/A	N/A	N/A		N/A	N/A	
Estimated Population Size of MSM*	32,416														PLACE Lite, 2016
MSM HIV Prevalence	2.4-6.4%														2017 IBBSS
Estimated Population Size of FSW	87,782														PLACE Lite, 2016
FSW HIV Prevalence	1.1-5.9%						N/A	N/A			N/A	N/A			2017 IBBSS
Estimated Population Size of PWID	N/A	N/A													
PWID HIV Prevalence	N/A	N/A													
Estimated Size of Priority Populations (Individuals of Haitian descent)	751,080		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Immigrant Survey, National Office of Statistics, 2019
Estimated HIV Prevalence in Priority Population (specify)			N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2017 IBBSS
	N/A: Data not available														

Table 2.1.2 90-90-90- Cascade

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[5] (#)**	**PLHIV diagnosed (#)**	**On ART[6],[7] (#)**	**ART Coverage (%)**	**Viral Suppression[7] (%)**	**Tested for HIV[8] (#)**	**Diagnosed HIV Positive[8] (#)**	**Initiated on ART[7] (#)**
Total population	10,358,320[1]	0.91% (15-49)[5]	71,504	N/A	30,787	43.0%	82.6%	946,285	13,485	6,050
Population <15 years	2,881,658[1]	N/A	1,984	N/A	482	24.3%	58.9%	N/A	N/A	*103*
Men 15-24 years	936,905[1]	N/A	3,020	N/A	580	19.2%	66.1%	N/A	N/A	*251*
Men 25+ years	2,769,949[1]	N/A	32,462	N/A	13,736	42.3%	83.2%	N/A	N/A	*2,661*
Women 15-24 years	925,924[1]	N/A	3,042	N/A	858	28.2%	64.8%	N/A	N/A	*485*
Women 25+ years	2,843,884[1]	N/A	30,998	N/A	15,131	48.8%	84.3%	N/A	N/A	*2,550*
MSM	32,416[2]	2.4-6.4%[9]	7,295	N/A	1,187	16.3%	84.8%	N/A	N/A	392
FSW	87,782[2]	1.1-5.9%[9]	3,545	N/A	528	14.9%	77.8%	N/A	N/A	*143*
PWID	N/A		-	N/A	711	-	75.9%	N/A	N/A	*271*
Priority Pop (Individuals of Haitian descent)	751,080[3]	1.1-5.0%[9]	25,599	N/A	3,041	11.9%	73.4%	N/A	N/A	*1,538*

Sources:

[1] National Office of Statistics, 2019 projection based on 2010 national Census data
[2] PLACE Lite study, 2016
[3] National Office of Statistics, National Immigrants Survey, 2017
[4] National Demographic and Health Survey, 2013
[5] Spectrum 2019 (preliminary results)
[6] Using PEPFAR definition for Lost to Follow Up
[7] National HIV Patient Management System (FAPPS), as of March 31, 2019
[8] National HIV/AIDS Program, 2018
[9] IBBSS, 2017

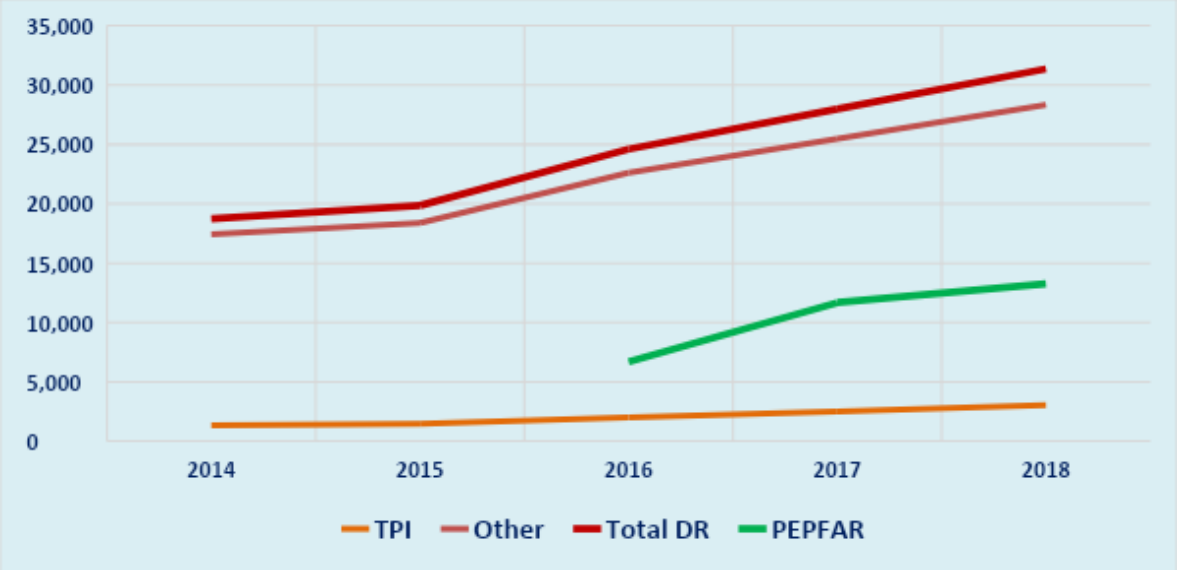
Progress toward Epidemic Control

HIV Clinical Cascade

The GODR supports PEPFAR efforts overall. Since 2015, the government has assumed the costs for ARVs and supplies for the country in sufficient measure to meet the need. Several administrative and clinical care guidelines have been updated to reflect global best practices, such as Treat All, task shifting for HIV testing, prescribing guidelines, progress toward National Health Insurance coverage of ARVs as essential medicines, and strategic planning to prioritize index testing and self-testing, as well as reducing the overall number of tests performed nationally. SENASA, the national health insurance office, is moving forward with a plan to reimburse CBO/NGO clinics for HIV services, a much-needed step to ensure the sustainability of these safety net providers.

The country overall has also made substantial progress in the enrollment of patients on ART, increasing the number of those on treatment by 63% in the last five years.

Figure 2.1.3 National and PEPFAR trend for individuals currently on antiretroviral treatment



HIV Testing Services (First 90)

In the DR, HIV testing is performed at 1,093 laboratory sites. Nationally, HTS numbers represent the number of tests performed rather than the number of persons tested. In 2018, 946,285 HIV tests were performed in the DR, of which 13,485 (1.4%) were positive for HIV infection (DIGECITSS, 2018).

During the first quarter of FY19, the overall HIV testing yield at PEPFAR sites was 5.0%. The facility-based yield was 4.4% despite substantial site-by-site variation driven primarily by challenges in on-boarding new clinical sites in FY19. In community-testing activities, which targeted migrants in three provinces, the yield was 2.7%.

ART - adult and pediatric (Second 90)

In the DR, HIV care services, including antiretroviral treatment, are delivered at 74 Integrated HIV Care (IHC) sites throughout the country. Three sites specialize in providing pediatric ART. Among the 74 sites, 9 sites received PEPFAR support in FY18, increasing to 18 sites in FY19. PEPFAR does not currently provide support to any pediatric site.

All patients enrolled at the IHC sites are registered in the HIV Patient Management Information System (FAPPS, per its Spanish acronym). As of December 31, 2018, a total of 63,871 persons had ever been registered into FAPPS, including 30,787 currently active on ART. The 18 sites receiving PEPFAR support manage 13,141 (42.7%) active patients. Only 482 patients nationwide are children under the age of 14.

Among all patients active on ART in the country, 1,187 (3.9%) are characterized as MSM in FAPPS, 711 (2.3%) as drug users, 528 (1.7%) as FSW, and 235 (0.8%) as TG women. A total of 3,041, or 9.9%, are categorized as migrants from Haiti[4]. PEPFAR-supported sites report 668 MSM patients (or 56.3% of all MSM active on ART in the country), 375 (71%) FSW, and 136 (57.9%) TG women. A total of 1,954 migrant patients from Haiti are receiving ART at PEPFAR sites, or 64.3% of all migrant patients on ART in the country.

During the first quarter of FY19, 1,457 patients initiated ART nationally, including 767 at PEPFAR-supported sites. Among them, 399 (205 at PEPFAR sites) were identified in FAPPS as migrants.

Viral Suppression (Third 90)

National HIV care guidelines stipulate that a viral load test be performed every 6 months for patients on ART. Until 2019, all viral load tests performed in DR were processed at the National Reference Laboratory in Santo Domingo, using samples collected at IHC sites and transported to the capital. Starting in 2019, three additional laboratories (in Santiago, Santo Domingo and San Pedro de Macoris) have been certified to perform viral load testing and CD4 counts.

As of March 31, 2019, 27,638 patients (86.9% of all active patients with more than 3 months on ART nationwide) had a viral load test result recorded in the past 12 months. Among them, 22,536 (81.5%) showed a viral load <1000/ml. At PEPFAR-supported sites, a total of 16,022 active patients with more than 3 months on ART had a viral load test result recorded in the past 12 months and 13,191 (82.3%) showed viral suppression.

Coverage of KP activities

In FY18, PrEP began being offered free of charge to patients at one site in Santo Domingo, with PEPFAR support. The target population for this intervention are MSM and TG women. As of September 30, 2018, 137 clients had initiated PrEP, and 117 (85.4%) were still actively receiving the

[4] Patients register in FAPPS using their national identification card (*cédula*); those without a *cédula* are recorded as migrants and their country of birth is specified.

intervention. In FY 2019, preparations are ongoing to begin offering PrEP at two additional sites, in Puerto Plata and La Romana, and to expand eligibility to include FSWs.

Implementation of Key Policies

Test and Start

In 2018, through Resolution N. 000020, the Ministry of Health (MOH) of the DR adopted its Treatment for All strategy, which follows the WHO's 2016 guidance for HIV care and treatment, including rapid ART initiation, independently of CD4 count. This policy was based on the experience gained at 11 PEPFAR-supported HIV care sites throughout the country in 2016-2018.

Differentiated service delivery including multi-month dispensing (MMD)

National HIV guidelines allow for 3-month scripting intervals in stable patients. FAPPS data shows that only 8% of appointments nationwide occur at intervals of 3 months or longer, although the percentage is higher at PEPFAR-supported sites. Most patients (48%) receive their medications in one-month increments, and 30% receive two-month supplies. Updates to national guidelines, recently approved by the MOH, will permit six-month MMD and will promote MMD as part of a differentiated model of care approach. Some sites have expressed hesitancy to prescribe longer MMD for fear of compromising ARV supplies, and part of MMD expansion will require site-level education on national ARV supplies to show that MMD scale-up is being accounted for.

Completion of TLD transition

The 2018 revision of the DR's HIV clinical guidelines included approving the use of Dolutegravir (DLG) in first line regimens starting in 2019. DLG-based regimens must now be prescribed to patients starting antiretroviral treatment, except in the case of women of childbearing age or pregnant, as well as to patients who are experiencing adverse reactions to Efavirenz (EFV). The national plan calls for transitioning 60% of the 10,490 patients currently on EFV 600 mg to Tenofovir/Lamivudine/Dolutegravir (TLD) by the end of 2020. By that date, 90% of the 3,579 patients currently on Nevirapine (NVP) will also have transitioned. In addition, it is estimated that by 2020, the remaining 5800 of patients using EFV 600 and 10% of patients on NVP will have transitioned to EFV 400 mg.

Scale up of index testing

There is no national index testing policy in the DR, although IHC sites do include investigating the status of HIV-positive patients' contacts as part of their routine procedures. Since 2017, PEPFAR-supported sites have been implementing index testing through Voluntary Partner Referral (VPR). In FY18, 2,788 HIV+ patients were offered VPR; 1,455 were eligible, and 1,175 accepted the intervention, referring a total of 1,261 partners/contacts. Among these contacts, 513 were tested and 165 (32.0%) resulted positive for HIV infection; 113 initiated ART.

Reasons for low eligibility for VPR among index patients include: the partner previously diagnosed as HIV+, the index patient no longer in contact with the partner, the index patient feeling uncomfortable with VPR when first approached, and the risk of partner violence. Key reasons for low testing rates among referred contacts include: index patients not approaching their partners about testing, and partners being tested at non-PEPFAR locations or delaying testing, which hampers recording and reporting. Among contacts who do accept testing, yield has been high: 26% in Facility and 55% in Community in the first quarter of FY19. Successful scale-up of index testing will involve additional site-level training to increase contact elicitation and acceptance, as well as the inclusion of biological children in conjunction with the new OVC program.

Scale up of TB preventative therapy (TPT)

TB preventive therapy is recommended for all HIV+ persons in DR, per national guidelines. The recommended TPT regimen consists of 6 months of Isoniazid (INH). TB and HIV Program personnel, as well as health care workers, have received training on the referral, diagnosis and prescribing procedures for TB preventive therapy. The GODR has demonstrated its commitment to purchase sufficient quantities of isoniazid to meet needs, and a purchasing mechanism is in place. With Global Fund support, GenXpert availability is being expanded to 9 provincial laboratories, and the GODR is initiating enhanced supervision of TB-HIV activities at both TB clinics and IHC sites. On average, 906 HIV+ patients have completed a course of TPT with INH in 2016-2018.

Challenges to broader TPT coverage include: weak implementation of the screening algorithm for active TB among PLHIV; the perception among IHC site staff that TPT needs only to be offered to patients newly initiated on ART; lack of coordination/communication with TB Units; and poor recording and reporting of TPT initiation and completion dates. COP19 will implement a series of measures to ensure improved coordination between HIV and TB units, more rigorous recording of TPT initiation and completion, and site-level training to improve TPT initiation for existing ART patients.

Elimination of user fees

HIV testing is available free of charge at government and private not-for-profit facilities, as the MOH provides test kits to health facilities that conduct HIV testing. ART and TB drugs are also available free of charge to patients, as are medical evaluations, viral load tests, CD_4 counts, and laboratory tests for TB diagnosis. However, patients may be charged user fees for complementary laboratory tests or chest X-rays if they must be referred to a private health facility in the event that tests cannot be performed in the public sector, for example, due to reagent shortages or faulty equipment. PEPFAR support to IHC sites includes setting up service delivery mechanisms that eliminate user fees for all patients enrolled into HIV care and treatment.

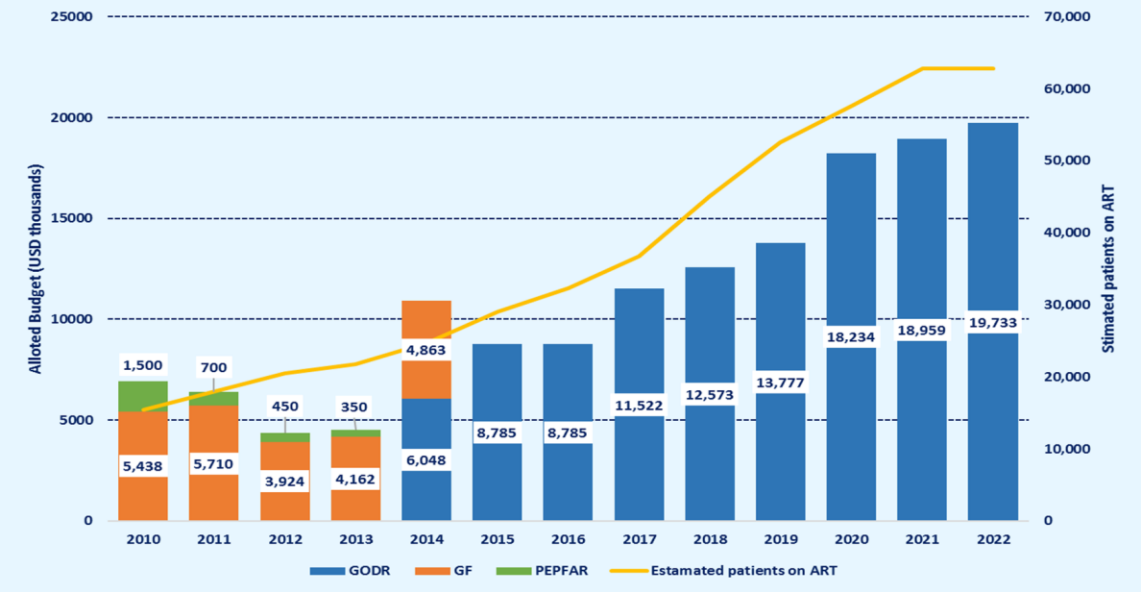
Alignment of orphans and vulnerable children package of services

COP19 will be the first year that PEPFAR/DR will implement an OVC program. Coordinating mechanisms will be put into place to ensure that all OVC services align and coordinate with all PEPFAR testing and clinical care efforts in country.

Evidence of resource commitments by host governments

The GODR has assumed increasing financial responsibility to support the national HIV response (Figure 2.1.4). In 2015, the GODR budgeted nearly $8.8 million to procure ARVs and reagents, the first time that the GODR had independently procured all HIV commodities without external resources. In 2017, the GODR met the projected need of $11.5 million after significant PEPFAR advocacy. In 2018, the GODR provided additional resources towards ARVs and other supplies matching the prior year requests. The cost for TLD coverage for COP19 TPIs is estimated at US$700,000. The GODR anticipates a savings of US$ 1.8 million in HIV procurement due to viral load reduction from 2 to 1 test per patient per year. These savings will be sufficient to ensure increased TLD coverage. There is no financial gap anticipated for the procurement of ARVs in 2020.

Figure 2.1.4 Transition of ARV & Commodity Supplies Purchases by GODR



The GODR will cover the anticipated increase in ARV and diagnostic testing in COP19. The anticipated expansion of HIV service providers will require additional support from the GODR in order to bring to scale, and PEPFAR will support a limited set of domestic resource mobilization strategies to sustain the GODR's financial leadership in the national response.

Progress towards local prime partner funding

In FY19, two local CSOs are receiving PEPFAR funds as prime award recipients. These two CSOs are receiving a total of $1,205,199, up from 879,298 in FY2017. In addition, 12 local CSOs are sub-award recipients of $2,683,809 in PEPFAR funds. The number of local sub-awards is expected to increase to 19 in FY20. Finally, three GODR entities are receiving $1,374,000 in PEPFAR funds.

Scale up of unique identifiers across all sites

Due to high patient mobility in the DR, the use of a unique identifier is a pressing need to avoid duplicate patient registration and improve patient tracking across HIV care sites. Several identifiers are currently in use. Patient registration at HIV testing and care sites includes patients' national ID card number (*cédula*), which is a unique number. However, many migrants, and even some Dominicans, do not have a *cédula*, or present falsified documents. The HIV Patient Management System (FAPPS, per its Spanish acronym) assigns each patient a unique number at registration. However, this number is generated at the time when the patient is enrolling into care, and is therefore not helpful to track individuals at the testing stage. In addition, if a patient already registered in FAPPS seeks attention at a different HIV care site and if the staff do not conduct a thorough search of the FAPPS database or if the patient claims a different identity, there is a high risk the staff will create a second/duplicate patient account.

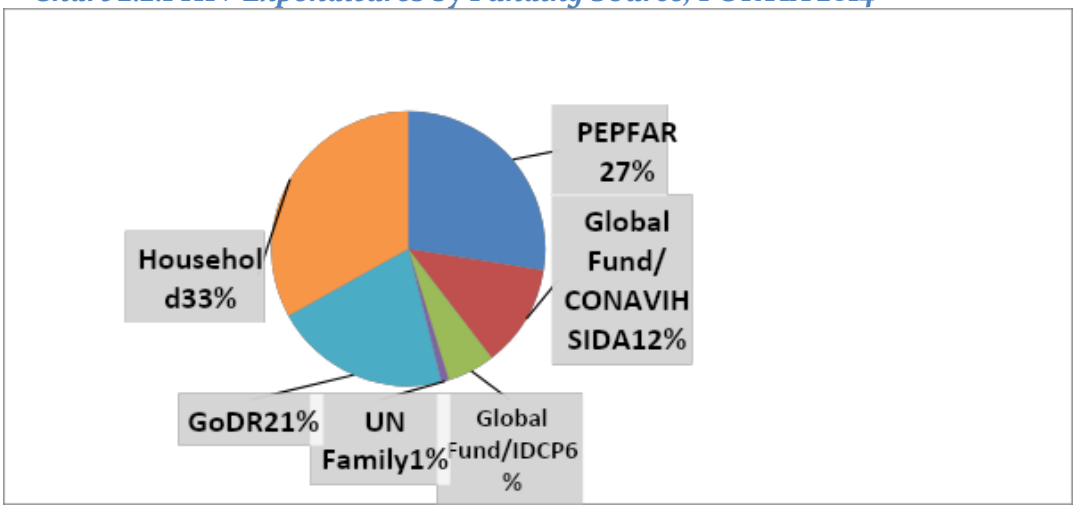
PEPFAR supported the development and implementation of a biometric register, based on a technology used in Haiti that records patient fingerprints. PEPFAR implemented this system in three sites in the province of Puerto Plata. Patients, including TPI, and HIV care sites staff have received it well. It provides advantages in terms of accurate patient identification, speed, accuracy, reliability, streamlining of admissions process and security of patients' records. The biometric module is an innovative tracking tool to avoid loss to follow up including patients crossing borders. The remaining PEPFAR supported clinics will implement biometric registry during FY19.

2.2 Investment Profile

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

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

Chart 2.2.1 HIV Expenditures by Funding Source, PORTIA 2014



Given that the 2014 PORTIA draft report shows only broad categories of expenditures, table 2.2.2 is shown in addition to Chart 2.2.1.

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

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

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

Table 2.2.2 Annual Investment Profile by Program Area, Projected 2019

Table 2.2.1 Annual Investment Profile by Program Area				
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**
Clinical care, treatment and support	18,348,309	30%	7%	63%
Community-based care, treatment, and support	3,440,164	92%	7%	1%
PMTCT	811,200			100%
HTS	6,518,511	87%	13%	
VMMC	-			
Priority population prevention	1,970,435	92%		8%
AGYW Prevention	-			
Key population prevention	2,449,587	7%	61%	31%
OVC	1,368,819	100%		
Laboratory	4,665,081	5%		95%
SI, Surveys and Surveillance	1,491,230	52%	35%	13%
HSS	1,955,217	98%	2%	
Total	**43,018,551**	48%	10%	42%

Source: CONAVIHSIDA and COP19 Draft

2.3 National Sustainability Profile Update

SID 3.0 highlighted Policies and Governance as a vulnerability, noting that the Dominican Republic was lagging in terms of policies and guidelines to match international norms related in particular to "Treat-All." With PEPFAR support, the Dominican Republic initiated Treat-All via ministerial decree on August 2018, kicking off a phased nationwide implementation.

As part of COP19 planning, the Ministry of Health committed to updating several additional policies and guidelines by ministerial decree within FY19, including: TLD transition, index testing and self-testing (previously without guidance), guidance to implement differentiated models of care and multi-month dispensing up to six months, the inclusion of recency testing and dry blood sample DBS testing in the national protocol, and the introduction of biometric unique identifier. The ministerial decree will also include a provision to allow the expansion of HIV service entry points beyond the 74 HIV HIC sites, currently the only sites that provide HIV services in the DR. This provision is essential to the implementation of the COP19 strategy and necessary to make meaningful progress toward epidemic control within the COP19 timeframe.

Commodity Security and Supply Chain and Laboratory were strengths in SID 3.0. The GoDR is the sole provider of ARVs in the country, and this ongoing commitment continues to be a strength of the national response to HIV. In light of rapid expected increases in the number of individuals on treatment as part of COP18 and COP19, PEPFAR continues to support supply chain management systems in the DR to ensure a consistent and adequate supply of medications. Similarly, the significant progress in laboratory systems noted in SID 3.0 continues as viral load testing and information system capacity expand. Initiatives in COP19 will further strengthen laboratory to

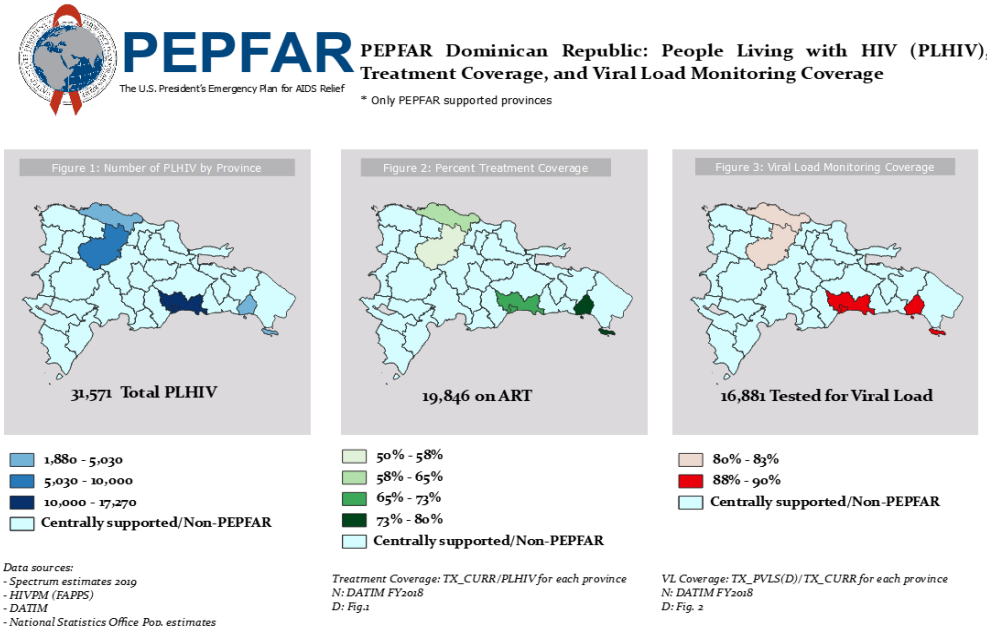
accelerate achievement of the third 90 nationwide, supporting DBS testing and improved patient tracking systems, in particular, via biometric unique identifiers.

2.4 Alignment of PEPFAR investments geographically to disease burden

In COP19, PEPFAR DR will change its focus from working with key populations (MSM, TG, FSW) to working primarily with individuals TPI in five provinces where this target population is concentrated: Santo Domingo (including the capital, or National District), Santiago, Puerto Plata, La Altagracia and Valverde. According to the NIS 2017, the majority of TPI reside in these provinces, which are among the most densely populated and economically active in the country. Noting the extremely low rates of ART coverage among TPI, PEPFAR identified initiation and retention on treatment as a key issue among TPI. In FY20, PEPFAR-DR will modify its approach to testing, linkage to treatment and retention by creating networks of facilities centered on existing IHC sites. These networks will take advantage of existing health centers, including primary care and community health points that currently have minimal capacity in the area of HIV but provide basic health services to a high volume of TPI in rural and urban areas. Within these networks, community care teams with strong cultural competency will play a key role in providing decentralized peer navigation and case management services with the specific goal of improving retention rates. In partnership with the MOH, PEPFAR will ensure that those public and NGO satellite and referral health centers are equipped and staffed to provide HIV testing, blood sample collection for VL and CD4 testing, ART drug dispensing, VL monitoring, adherence monitoring, and patient retrieval.

As part of its support to the National HIV response, PEPFAR will work to improve viral load coverage nationwide through viral load monitoring at all HIV care sites.

Figure 2.4.1 PLHIV Treatment and VL Monitoring Coverage for FY18



2.5 Stakeholder Engagement

The success of PEPFAR in the DR has always depended on the collaboration and cooperation of the Dominican government. As the GoDR's commitment to taking ownership of the national response has increased, the productive working relationship with government entities has become increasingly important. With less than one year in office, the current Minister of Health has undertaken systemic reform of the health system and has taken an active role in the HIV-related activities under his jurisdiction. As part of the COP19 planning process and in response to the directives in the Planning Level Letter, the PEPFAR team met with the Minister of Health, as well as the leadership of the National Health Service (SNS), the Directorate for the Control of STI and HIV/AIDS (DIGECITTS), and the National HIV/AIDS Council (CONAVIHSIDA). PEPFAR presented the details of the PLL, particularly the directive to pivot its focus toward TPI and the need for a novel and more intensive business approach. Importantly, the leadership of these entities all attended this same meeting, ensuring a common message and understanding both from PEPFAR and from the highest levels of the Ministry.

Similarly, civil society consultations involved active and productive discussions with fourteen organizations working with the TPI population in the DR. This group provided a rich contextual background of the needs and challenges of their target communities via a group SWOT analysis and yielded valuable input into the early development of a TPI-focused strategy. With the intensive community focus of the COP19 strategy, strengthening these linkages to TPI-focused organizations will provide valuable avenues to enhance community-based case finding and linkages to treatment.

PEPFAR also co-sponsored with the MOH a two-day workshop with implementing partners and regional clinical directorates to obtain feedback on the benefits and challenges of the COP19 strategic direction from the field/implementation level. Despite general understanding and agreement regarding the strategic pivot toward TPI, these field-level discussions brought to light many hesitations and potential roadblocks, which the PEPFAR team took into account in the continued development of COP19.

The private sector, through companies and worker representative groups, were engaged through activities conducted by the National HIV/AIDS Council known as CONAVIHSIDA (Spanish acronym). In the past the businesses from the sugarcane sector and institutions such as the Ramos group and the free trade zone associations have participated. There is opportunity for increased engagement in particular with sectors that hire TPIs given the legal framework that encourages corporate social responsibility and the continued representation of the private sector on the CONAVIHSIDA board as required by law.

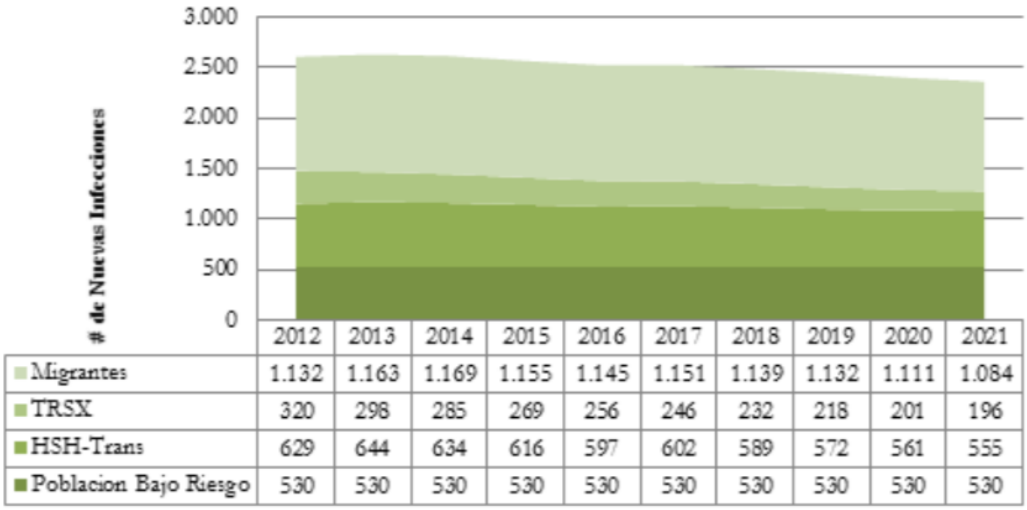
COP19 will include ongoing meetings with government entities and civil society partners to ensure appropriate activities and sufficient coordination to reach aggressive targets. As appropriate, these meetings may include implementing partners and different government entities. As issues arise, meetings and workshops may also be thematically organized to address specific challenges.

Ongoing coordination with government entities will be of particular relevance. The scale-up of entry points to serve TPI will require training, equipment, supervision, and approval for the many clinical providers not currently authorized to provide HIV services. While PEPFAR will provide technical assistance to help capacitate providers, the administrative and logistical responsibilities will fall to various government offices, and regular dialogue will be required to facilitate the initiation of numerous additional PEPFAR sites.

3.0 Geographic and Population Prioritization

The HIV epidemic in the DR is concentrated both by population and geography. Based on concentrated HIV epidemic trends, the estimated HIV prevalence is significantly higher within specific population groups, as mentioned in the previous section. Over 80% of new infections occurred in these population groups in 2016, with the largest proportion (47.83%) of all new infections occurring among TPI, a trend that is expected to remain stable over the upcoming years (see Figure 3.0.1). PEPFAR DR's proposal for FY20 is to focus efforts on TPI living in the Dominican Republic, given the considerable burden of HIV-related disease they shoulder, their higher vulnerability, and the important gaps recorded in this population's clinical cascade. Without prevention, testing and treatment interventions that specifically target this population and increase in intensity, the 90-90-90 goals in the Dominican Republic will remain elusive.

Figure 3.0.1 Distribution of new HIV infections in persons over 15 years of age, by population group. Dominican Republic, 2010-2021



	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
Migrantes	1.132	1.163	1.169	1.155	1.145	1.151	1.139	1.132	1.111	1.084
TRSX	320	298	285	269	256	246	232	218	201	196
HSH-Trans	629	644	634	616	597	602	589	572	561	555
Poblacion Bajo Riesgo	530	530	530	530	530	530	530	530	530	530

Source: Spectrum – version 5.56, 2016. Reported by Dolores & Caballero, 2017

During the last three years, PEPFAR in the Dominican Republic focused on strengthening the country's capacity for HIV service provision to key populations (MSM, TGW and FSW) and priority populations (Individuals of Haitian Descent; TPI) through the twinning model. The goal was the transfer of capacity to provide high quality, friendly and well-targeted services from local NGOs to government clinics. During this time, work had begun in areas where populations of interest were present in highest concentration and in provinces with the most experience approaching KP and

PP: Santo Domingo, La Romana and Puerto Plata (Santiago was included, but at a much smaller scale). In COP 18, the project expanded its reach to include places where the burden of HIV disease was higher in TPI, such as La Altagracia, an eastern province and popular tourist destination; and Dajabon, Montecristi and Valverde (northwest provinces that border with Haiti).

For FY20, PEPFAR/DR will build on experiences gained from working with KPs and PPs in the last 3 years, to focus on close cascade gaps among TPI. The strategy is driven by recent study findings, including:

- The 2017 IBBSS led by the National HIV Council with support from GF in five provinces (presented preliminarily in 2019) reports an HIV prevalence in TPI of 2.5-5% (similar to values for MSM and higher than those for FSW).
- The 2017 NIS, conducted by the National Office of Statistics and published in late 2018, estimates that 751,080 TPI are living in the Dominican Republic, a 12% increase relative to 2012 estimates.
- The 2019 iteration of the Spectrum model (publication pending) estimates that 25,599 TPI are living with HIV in the Dominican Republic, which represents 35% of the total number of PLHIV in the country.
- The clinical cascade in TPI shows larger gaps in each step of the cascade than in other populations. The 2nd 90 is of particular note with a reach of less than 20%.

Figure 3.0.2 Estimated Burden of HIV among TPI

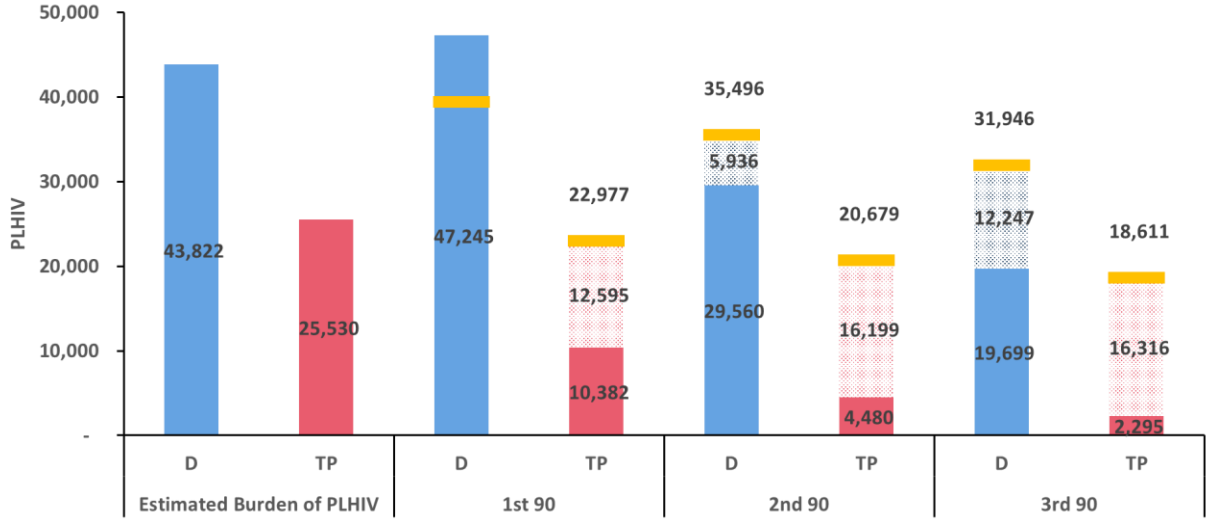
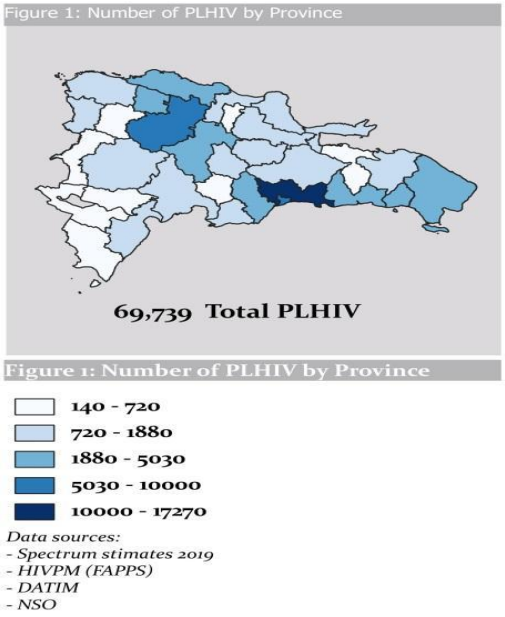


Figure 3.0.3 PLHIV by Province

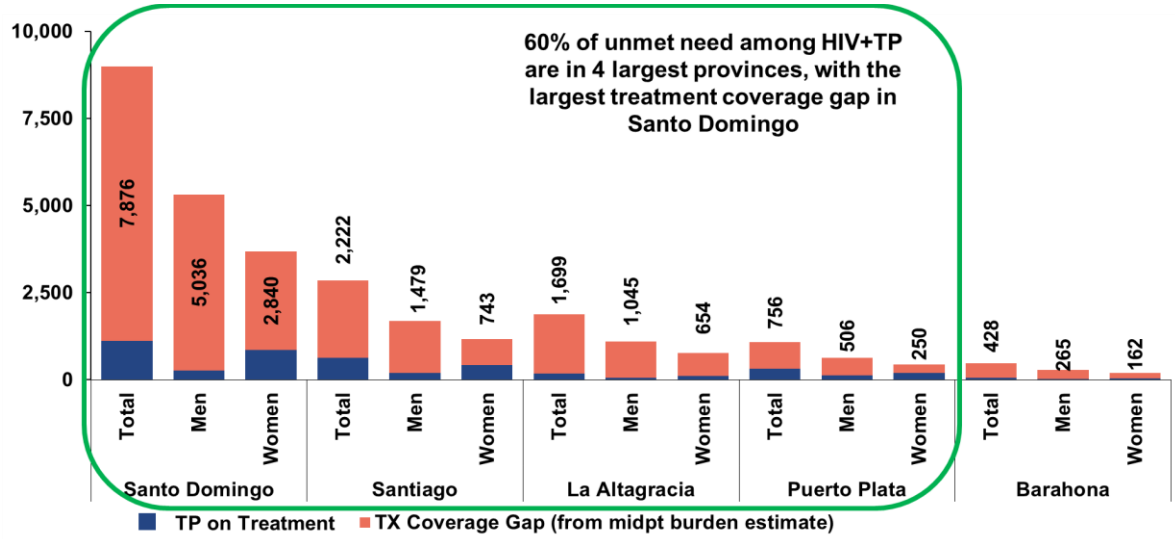


The largest HIV burden is present in the provinces of Santo Domingo, San Cristobal, Santiago, La Vega, Puerto Plata, Valverde, San Pedro de Macoris, La Romana, Altagracia, with similar patterns for all major disaggregates.

Figure 3.0.3 shows the number of PLHIV by province, rather than percent PLHIV, to better identify high burden areas that a percentage measurement would tend to mask.

Comparative analysis of unpublished TPI HIV prevalence data against PEPFAR and national treatment data was used to further identify areas with the most significant treatment gaps for TPI, and the results of this analysis form the basis for geographic targeting of PEPFAR investments for COP19. Specifically, breakdowns of numbers of individuals on treatment by province, sex, KP, and TPI reveal a distinct pattern, particularly for TPI. While the general perception has been that finding HIV+ TPI predominantly requires work in rural areas, the data instead show that the greatest gaps are in the large urban centers of the country. This same analysis also highlights, as expected, that men consistently exhibit a larger treatment gap than women. This comparative analysis led to the selection of the provinces of Santo Domingo, Santiago, La Altagracia, Valverde, and Puerto Plata as focus provinces for PEPFAR investments.

Figure 3.0.4 ART Gap in TPI, by Sex in Four of the COP19 Prioritized Provinces[5]



Source: Preliminary BSS results (2017–2018), by Province and Sex

[5] Figure 3.0.4 does not include Valverde province because it was not included in the BSS sample.

Data provided by the National Health Service (Servicio Nacional de Salud, SNS) also include information by province for the TPI population on emergency and non-emergency clinical encounters. This dataset gives an idea of the geographic areas where TPI seek medical services, and analytical results suggest that the clinical encounter data (emergency and provider visits) for TPI dovetail with the comparative gap analysis, validating the selection of the four key provinces. The provinces that delivered services to TPIs in highest numbers were Santo Domingo, Santiago, La Vega, La Altagracia, Valverde and Puerto Plata. However, these data suggest TPI HIV cascade gaps in Valverde province (not surveyed in the BSS), registered high numbers of TPI clinical encounters, leading to the addition of Valverde as the fifth PEPFAR/DR focus province for COP19. As a population group believed to be hesitant to seek medical services generally, provinces like Valverde that attract TPI into clinical facilities provide a valuable entry point for the provision of HIV services to a historically underserved area.

Figure 3.0.5 Expansion Entry Points to Reach TPI

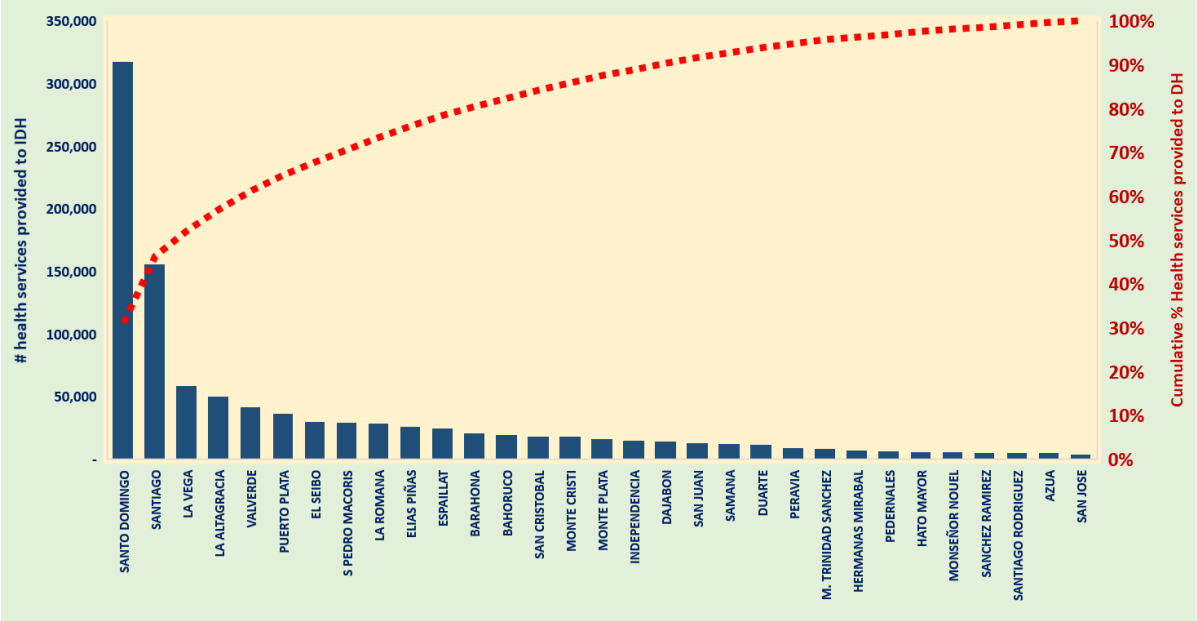
Proposed Entry Points											
				Accredited ARV sites		Future ARV sites		Non Accredited Sites			
Province	Total # TP PLHIV	ART Gap (2nd 90)	TX_NEW	Public Sites	NGO Sites	Public	NGO	Public Referral sites	Primary Care Site (UNAP)	Community Care Team	Community Team
Santo Domingo	9,002	6,289	6,988	6	2	6	5	2	6	6	11
Santiago	2,853	1,606	1,784	5	-	2	2	-	6	4	4
La Altagracia	1,876	1,259	1,398	2	-	2	2	-	4	2	2
Puerto Plata	1,084	550	611	1	1	1	1	1	-	1	2
Valverde	1,313	791	879	1	1	1	1	-		1	2

Adding VALVERDE: Patient encounter data report 17,218 clinical encounters by TP in Valverde in 2018, comparable to Altagracia and Puerto Plata, suggesting a strong potential as an entry point for TP-focused HIV services.

In Yellow: PEPFAR + NON PEPFAR Sites
In Green: Proposed Expansion Sites

COP19 will increase the number of PEPFAR-supported accredited HIV service sites from 18 to 42. None of the 23 new proposed sites are currently accredited, and PEPFAR will be working during FY19 with the MOH, SNS, other GODR entities, and sites themselves to secure accreditation as HIV service providers. The remaining 54 non-accredited sites comprise the network of community-based organizations, integral to the COP19 strategy, that will help provide culturally appropriate and on-the-ground peer navigation, referral, and case management services to TPI clients.

Figure 3.0.6 TPI health services encounters for selected provinces for 2018



Source: National Health Services Registry for 2018

This extensive triangulation of data was used to prioritize PEPFAR investments in five provinces within the DR – Santo Domingo, Santiago, Valverde, Puerto Plata and Altagracia. This data also served to further drill down to identify existing networks upon which to build the new entry points within the large urban areas of Santo Domingo.

4.0 Program Activities for Epidemic Control in TPI

Migrants and mobile populations, including TPI, are particularly vulnerable to HIV epidemics at different points in the HIV treatment cascade, posing singular challenges to the UNAIDS 90-90-90 strategy and individual health systems at local, national, and global levels. Evidence collected in different settings around the world suggests that migrants are more likely to enter late in the healthcare system and are less likely to be retained in it. Migrants are exposed to a wide range of social, economic, and political factors that further increase their vulnerability to HIV and other health conditions. These factors should be accurately identified to provide actionable knowledge in specific cultural contexts (Tanser, Bärnighausen, Vandormael, & Dobra, 2015).

While poverty and harsh living conditions constitute a major motive in Haitian migration towards the Dominican Republic (Ferguson, 2003), searching for available and better-paying job opportunities represents an important determinant of their settlement in specific regions and cities within the country (NIS-2017). The decline of the sugar cane industry by the end of the 20th century, and the gradual shift towards service industries and tourism-based economy in the Dominican Republic over recent decades, has impacted the dynamics of Haitian immigration, including the routes and migration patterns within the country (Aristy-Escuder, 2010; Wooding, Moseley-Williams, Arregui, & Paiewonsky, 2004). The devastating earthquake in Haiti in January 2010

further accentuated the disparities between the two countries, stimulating cross-border migration to the Dominican Republic, with greater participation of women and children between 2010 and 2012 (Wooding, 2018).

The changing dynamics of Haitian immigration in the 21st century led to a diversification of Haitian presence in the labor market and increased their social visibility in the formal and informal sectors, including predominantly tourism and construction, as well as agricultural rubrics beyond sugar cane, characterized by low-skill and low-wage work. According to 2017 ENI results, 56.2% of Haitian immigrants were employed in the private sector, 32.7% worked independently in low-skill occupations, and 4.8% worked in domestic services. Only 2.1% and 1.6% were business owners or independent professionals, respectively.

> "In my understanding, we have not studied sufficiently the HIV epidemic in migrant population here in the Dominican Republic. There is an obvious segmentation of this population, and there are several different social groups within it. We have migrants everywhere, in all economic activities, but also in different geographical zones, and they probably have different needs in HIV prevention and treatment. We cannot approach all of them with a one-size solution." (P09, international NGO)

In December 2013, the National Regularization Plan for Foreigners with Irregular Migration Status (PNRE) was decreed, as initiative to regularize the migration status of hundreds of thousands of irregular immigrants in the country, documented by the national surveys of immigrants conducted in 2012 and 2013 (NIS-2012, NIS-2013). However, by denying the right to nationality of the descendants of irregular migrants born in the Dominican Republic, PNRE leaves unsolved the migratory situation of many Haitian and Haitian descent families already living on the Dominican territory (Wooding, 2018), making them formally invisible for social protection policies, and constituting them into a particularly hard-to-reach population for public health services. Based on the results from the last immigrant survey (NIS-2017), 95.0% of Haitian immigrants and 80.9% of their descendants lack any type of health insurance, a percentage that is slightly higher than the one observed in NIS-2012. Poverty and social exclusion, which originally motivate Haitians to immigrate to the Dominican Republic, remain a barrier to their access to services in the country.

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

PEPFAR activities for FY20 reflect a "reboot" directive and pivot in population of focus. This necessitates developing a new strategic direction, establishing services outside the GODR current SAI system, and close coordination with the GODR. The strategy and related activities are designed to support an upsurge in service entry points to reach HIV+ TPI in targeted areas within five prioritized provinces.

Priorities include aggressive outreach and testing, rapidly linking to services, treatment with optimized regimens and enhanced retention. HIV service delivery in PEPFAR supported sites will

build on existing resources within the structure of the national health system to deliver a core package of services consisting of:

- ***Targeted Testing Strategies*** -innovative case finding approaches with index testing (facility and community) for TPI and their children, use of social networking testing and introducing a targeted self-testing approach for selected groups with guaranteed counselling.

- ***Bridging the Treatment Gap*** through strengthening linkage with same day ART initiation, enhancing peer navigation and accompanied referrals. Also decentralize ARV distribution through the existing health structure of primary care units and diagnostic centers, NGO/CBO and community care teams.

- ***Improving retention, adherence and viral load suppression*** by optimizing treatment for PLHIV through DMOC and intensive case management, while introducing TLD transition and rolling out six-month dispensing for stable patients in all PEPFAR sites. In addition, the modification of national policy to align with WHO guidelines in combination with an intensive community-based peer navigation and case management approach will help increase viral load testing coverage nearly fourfold among TPI.

- ***Site level monitoring*** to improve case finding, retention and adherence: hands-on approach at site level for robust data collection and entry, frequent analysis of findings to address bottlenecks. Streamline the distribution of tasks and adapt footprint to guarantee enough support for testing, treatment and patient tracking activities

- ***OVC Service Package for TP Families*** that will include interventions for children (up to 18 years of age) and their caregivers based on an integrated approach of family case management addressing the health, stability, safety and schooling of the children. Package will include community-based service delivery with strong clinical linkages.

Figure 4.1.1 OVC Program Package

Family Case Management	
HEALTHY	**SCHOOLED**
• Linkage to HTS, care and treatment • Adherence support with age-appropriate HIV treatment literacy • Family-centered disclosure support • Linkage to child survival services • Linkage to food/nutrition support • SRH & HIV prevention education for adolescents	• School enrollment/re-enrollment • School subsidies and/or material support • Monitoring school attendance & progression
STABLE	**SAFE**
• Psychosocial support for CLHIV and PLHIV • Household Economic Strengthening (savings groups, livelihoods development)	• Positive parenting (including violence prevention) • Screening for GBV/VAC • Linkage to comprehensive post-violence care • Linkage to legal protection services

PEPFAR site-level support includes personnel, clinical training and supervision, adherence and psycho-social support counseling, population-specific materials and interventions, data collection and use, and continuous quality improvement interventions. There is also a significant community aspect, ranging from risk-reduction counseling and HIV testing to community-based care and support services. In addition to the traditional site-level direct service delivery activities, the portfolio is structured to address a range of systems issues that are present at the site that jeopardize the quality of service provision and the ability to meet ambitious targets. This includes an adequate supply of trained health workers, management processes, sufficient commodities, information systems capable of monitoring clinical outcomes, and adequate laboratory capacity.

In COP 19, service delivery will also include adding HIV care to other fixed sites to facilitate proximity to TPI and enable their engagement. This will be considered a function shifting from the current model as it will include primary care sites (UNAPS, acronym in Spanish), public clinics (CNP), NGOs and public referral sites (main hospitals) currently not accredited for HIV services to be accredited to do so. In addition, PEPFAR will continue to work in the existing accredited service points that served TPI in the five prioritized provinces, which include Santo Domingo, Santiago, La Altagracia, Puerto Plata and Valverde. These sites will include a strong community component led by community care teams that create linkage to treatment and generate a referral network within the existing clinical structures, and community teams that promote adherence and retention through peer navigation and case management. The engagement with central and regional health services will be crucial and is expected to include strong involvement by the authorities, as there is a common interest of integrating HIV services into primary care in the country.

The rationale for this new approach is to tailor services to TPI needs and implement effective strategies to increase case finding among this population and expand their linkage and retention to services. This shift will require previously unexplored, innovative, and flexible approaches such as training personnel in the Creole language and/or ensuring access to translation services, adding extended hours to facilitate access to services by PLHIV, decentralizing ARV distribution to community sites, training lay workers for HIV testing, bolstering community engagement with higher number of peer navigators/ community health workers for case finding and monitoring; referrals and counter-referrals within the system and tracking and re-engaging with those PLHIV lost to follow-up.

The portfolio also includes above site interventions to address systemic challenges that hinder epidemic control. Activities include standardizing in-service training for HIV workforce, developing a policy for appropriately dispensing ARVs and HIV commodities, enhancing supply chain for TLD transition, strengthening adherence counseling, supporting viral load rollout and adapting clinical care and outreach materials to be culturally and linguistically responsive to TPI.

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

The DR interagency team will establish a coordinating body to work with counterparts in Haiti to improve referrals across the island and improve efforts to retain in treatment those TPI that cross

the Haiti-DR border. Immediate exchanges have already occurred with the PEPFAR program in Haiti as they have shared their educational and other outreach materials in Creole. In addition, a protocol will be developed in both countries to screen for TPI with imminent departure to Haiti or DR. A referral network will be developed among CBO/CSO organizations to provide cross-border referrals and case management support to bolster community-level follow-up for TPIs and supportive services to stay in care. Use of biometric register to track patients in the DR with an aim for future binational use will also be developed and consultations with Haiti's efforts will take place. Also, existing and dormant binational coordinating bodies will be supported to improve cross-border efforts similar to those achieved in TB.

The U.S. Department of Defense (DOD) will complement PEPFAR's clinical work via collaboration with the Dominican Military and Border Security to reduce stigma and discrimination towards TPI. CESFRONT is a specialized body in land border security and is a dependency of the Ministry of Defense (MOD) that was created through Decree 325 on 08 August of 2006. This Decree assigns responsibility for ensuring the permanence of a specialized device for security and control in the formal entry and exit points at the terrestrial Dominican Haitian border. It establishes patrols and posts supplementary control in areas throughout the land border with Haiti. This border is 376 km long and includes 3 main border crossing points: Dajabón, Elías Piña and Jimaní.

Through an IP DOD will work with CESFRONT to provide comprehensive stigma and discrimination (S+D) training for providers to reduce stigma and discrimination against PLHIV and marginalized populations, especially TPI. PEPFAR will also work with medical personnel at military facilities to ensure that TPI receive appropriate, stigma-free services as a key component in the ongoing effort to strengthen the internal and institutional capacity of the MOD Medical Directorate to improve its ability to lead, plan, and monitor the HIV response in the military health system.

4.4 Commodities

During COP18, the GODR experienced a stockout of various first, second, and third line regimens. An after-action review identified numerous issues that needed to be addressed to prevent future stockouts. The primary reasons for the stockout include:

- Delays in requesting funds for payment to international suppliers
- Problems in the global production of a few drugs
- Lack of foreign currency for payment to international suppliers
- Inaccurate orders by IHC sites to the regional stores and from these to the central warehouse
- Failure to comply with dispatch schedules
- Increased, unauthorized, unscheduled use of drugs reserved for third line treatments

The most significant contributing factor, however, was the prolonged administrative management time taken to pay (in US dollars) international suppliers, despite a budget allocation that adequately provided the financial resources required for the purchase of ARVs and HIV supplies. Much of the delay is the result of a confusing organizational structure whereby the entity tasked with planning and ordering ARVs is not the entity to which GODR allocates the funding, causing redundant

communications and misunderstandings. These bureaucratic processes contributed to a delay of more than five months (over the 14 months that the purchase normally lasts) in the request for funds for the purchase of medicines and supplies in 2018.

4.5 Collaboration, Integration and Monitoring

Both CDC and USAID support clinical care activities at site-level as well as health systems strengthening efforts to reach all PEPFAR sites. The PEPFAR Coordinator and the USAID Health Office Director participate in the Global Fund Country Coordinating Mechanism in the DR and work closely with Global Fund implementers and program officers from Geneva. Through UNAIDS, PEPFAR will not only conduct important stakeholder collaborations but will also work on binational coordination with counterparts in Haiti.

To reduce the burden of managing many small implementers, USAID consolidated the bulk of its interventions in one mechanism (HS3), strengthening the possibilities for innovative and integrated approaches while maintaining focus on performance monitoring. Both USAID and CDC are also adding necessary technical and support personnel to better deliver direct technical assistance to sites and ensure achievement, from community outreach, to linkage to treatment, to laboratory strengthening.

In COP19, PEPAR/DR will build on successful outcomes of previous and ongoing clinical care and systems strengthening efforts to improve clinical service outcomes through accelerated interventions that address both point of care service delivery management as well as health systems bottlenecks or barriers. This is to be achieved through proven and evidence-based approaches that utilize systems-thinking and build self-sustaining institutional capacity.

In addition to the primary focus on TPI, PEPFAR and national data point to the need for significant improvement in viral suppression (3rd 90) for all populations. In COP19, PEPFAR will thus also support the following interventions to promote viral suppression among all PLHIV on ART:

- Support the National HIV Program in the updating of guidelines according the WHO recommendations, to include one VL test per year (down from the current recommendation of one VL every 6 months)
- Promote extended working hours and work days for VL sample collection at clinic level;
- Incorporate dry blood sample (DBS) collection for VL, which will facilitate transportation and referral of the samples to the processing laboratory, and reduce result delivery time;
- Empower PLHIVs to achieve and maintain viral suppression by reinforcing the concept of Undetectable = Untransmittable (U = U) during counseling, to promote treatment adherence as a transmission prevention practice
- Support the strengthening of adherence counseling in comprehensive HIV care services throughout the country, and reinforcing to health personnel the importance of viral load testing to monitor success in ARV treatment.

In addition, to ensure that PLHIV on ART have access to reliable and timely viral load testing, the PEPFAR team will support the implementation of routine viral load monitoring, at clinical and

community levels, to identify patients due for viral load testing. The monitoring tools developed by CDC (Viral Load Scale-Up Clinical Facility Readiness Assessment and HIV Viral Load Testing Scorecard) will be used for this purpose.

Site-level HRH interventions will be determined by barriers experienced at the service delivery level that affect the reach of case identification and HIV treatment. With the support of the MOH, illustrative activities may include policy and guidance for task sharing of HIV testing to lay workers in the community, task sharing of ART initiation to nurses, increasing service availability when doctors are not present, and technical assistance for targeted recruitment and placement with lessons that can be scaled.

PEPFAR site-level support includes personnel, clinical training and supervision, adherence and psycho-social support counseling, population-specific materials and interventions, data collection and use, and continuous quality improvement interventions. There is also a significant site-level community aspect, ranging from risk-reduction counseling and HIV testing to community-based care and support services. In addition to the traditional site-level direct service delivery activities, the portfolio is structured to address a range of systems issues that are present at the site that jeopardize the quality of service provision and the ability to meet ambitious targets. This includes an adequate supply of trained health workers, management processes and sufficient commodities, information systems capable of monitoring clinical outcomes, and adequate laboratory capacity.

Strategies implemented in PEPFAR sites to accelerate “”Treatment for All” include mentoring sessions for service providers at the HIV clinics to ensure quality of clinical care; daily monitoring of the Pre-ART to ART transition of patients at the HIV clinics; sharing Test and START policy; mentoring new HIV sites to ensure rapid initiation of ART in recently diagnosed individuals; and integrating Voluntary Partner Referral (VPR) strategy for index testing.

Voluntary Partner Referral is a modality of index testing for case finding and linkage to care and treatment. It has been used in DR taking into account PLHIV sexual networks, preferences, and outcomes of referral processes with screening for intimate partner violence. The cumulative VPR results in country have been positive and suggest that this approach is an acceptable method to safely improve case detection and linkage to care.

Quality Improvement (QI) Collaboratives form the basis of the quality monitoring of the service delivery model. PEPFAR donor agencies, implementing partners, community organizations and national authorities have used a quality improvement methodology to identify, assess, and solve site level challenges directly linked to target-reporting activities. QI teams have been created at sites to tackle challenges through Plan-Do-Study-Act (PDSA) cycles.

Positive outcomes and lessons learned from the QI Collaboratives including establishing a practice of data analysis and use of data for decision-making. They address common problems like access to HIV testing through simple activities, such as analyzing patient flow at the clinic and monitoring patient wait time for testing and counseling and for receiving HIV test result. Clear impact on the HIV treatment cascade is evident with increased HIV testing for all populations and reduced wait time of HIV test results; increased HIV yield of facility- and community-based testing of MSM; and

reduction of the gap between newly diagnosed HIV positive individuals and linkage to care at some clinical sites. Involvement of the authorities in the CQI process will create ownership and ensure sustainability of this model.

4.6 Targets for TPI populations

Standard Table 4.6.1

Note: In FY2020, DR targets in DATIM also include KPIF targets. Therefore, DATIM targets will differ slightly from COP targets reported in table 4.6.1.

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 FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
	Total Men	**111,977**	**7,719**	**6,980**
	Total Women	**74,672**	**5,220**	**4,657**
	Total Children (<15)	**331**	**24**	**172**
	Total from Index Testing	**9,756**	**1,943**	**1,749**
	Adults			
	TB Patients	***0***	**0**	**0**
	Key Population	***0***	**0**	**0**
	Priority Population	***186,649***	**12,939**	**11,637**
	Other Testing	***0***	**0**	**0**
	Previously diagnosed and/or in care	-	-	-

(Standard Table 4.6.2: Not required for DR)

Standard Table 4.6.3

Table 4.6.3 Target Population for Prevention Interventions to Facilitate Epidemic Control			
Target Population	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY20)**	**FY20 Target**
Individuals of Haitian descent	**387,757**	**40%**	**152,464**
TOTAL	**387,757**	**40%**	**152,464**

Standard Table 4.6.4

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY20Target) OVC_SERV**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC***
Santo Domingo/Distrito Nacional	**7,686**	**7,116**	**5,381**
Santiago	2,436	2,255	1,705
La Altagracia	1,602	1,483	1.121
Puerto Plata	925	857	648
Valverde	1,120	1,037	784
TOTAL	**13,769**	**12,748**	**9,639**

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV epidemic in the Dominican Republic is concentrated, as opposed to generalized, meaning that the epidemic is focused on specific subsets of the population within the country, in particular, key and target populations. Further, despite the rapid scale-up of interventions since 2017, gaps remain along the cascade for all geographic areas and all relevant population groups. As such, the Dominican Republic does not meet the definition of attained or sustained for any area or population, and all programming is directed toward Scale-up: Aggressive.

In conjunction with intensive site-level interventions, PEPFAR promotes sustainability in national systems and leverages existing strengths to ensure continued long-term impact along the cascade for all populations.

Once at the forefront of innovation in terms of HIV policies and guidelines, complacency and the transition from a generalized to concentrated epidemic drained continued policy impetus, and the Dominican Republic has lagged in recent years, continuing to apply outdated approaches to testing, care, and treatment, limiting the potential to reach 90-90-90 goals within a foreseeable time horizon. However, recent changes, strongly supported by PEPFAR investments, take action to reverse this pattern and reposition the DR in favor of a policy framework that promotes an aggressive and successful HIV plan.

With PEPFAR support and advocacy from civil society, the Dominican Republic enacted a Test & Start policy in August 2018. This major achievement marks the first step in bringing the DR in line with international best practices to improve treatment initiation, adherence, and retention. Throughout COP19, PEPFAR will continue to support the scale-up of Test & Start from PEPFAR sites to nationwide coverage. While this effort involves an important logistical and supply chain component, training and sensitization of clinical personnel remains a significant obstacle to full implementation of Test & Start, particularly for TPI. PEPFAR's intensive work to date with key populations of MSM and FSW have significantly improved the access to and quality of HIV services they receive, but HIV positive TPI continue to face disincentives to initiate and continue on treatment. PEPFAR's continued above-site investments will thus directly contribute to program performance by ensuring that the most appropriate treatments are delivered to all patients in the most effective manner.

COP 18 and 19 build on the momentum of Test & Start to initiate a series of additional reforms requiring PEPFAR investment in order to meet aggressive clinical targets in COP19. Rapid scale-up of the TLD transition to enhance treatment initiation and retention, previously limited by the high price of Dolutegravir for the DR, will require above-site policy intervention and ongoing PEPFAR supply chain assistance. Similarly, the approval of HIV self-testing, not allowed by current guidelines, will necessitate PEPFAR support to modify clinical guidelines and establish a commodity supply chain for the provision of self-test kits.

PEPFAR investments will also continue to leverage and support the development of FAPPS, the national HIV patient registry. Never intended as a case management system, FAPPS has traditionally been utilized to attempt to track national demand for HIV services and forecast the need for ARV supplies. However, particularly for PEPFAR sites, PEPFAR assistance has leveraged the existing FAPPS architecture and promoted its evolution to yield more data on site-level performance and patient-level behavior. This data, however, has been poorly utilized as a tool to minimize loss to follow-up behavior or promote retention in treatment, and COP19 investments, rather than continuing to build the capacity of the FAPPS system, as in the past, will focus on assistance to optimize the use of available data by clinical sites to improve patient tracking and follow-up.

Taken together, these system-level investments will directly impact PEPFAR performance, the achievement of targets along the cascade for both TPI and the general population, and promote sustainability and country ownership of the HIV response in the DR.

7.0 Staffing Plan

Due to the major pivot in target population, requirements of the reboot and related increase in investment, the PEPFAR inter-agency team reviewed staffing needs for COP19, identifying positions within each agency that would be required. The balance between administrative/financial and

technical management staff was reviewed, along with an analysis of staffing requirements associated with increased monitoring efforts anticipated will be needed to stand up the multiple new entry points into HIV care.

COP19 represents a major strategic shift for PEPFAR in the DR. The refocusing of PEPFAR activities on TPI and the intensifying of prevention, testing and treatment initiation and retention efforts at community and primary care levels will require that interagency technical teams prioritize providing close technical assistance/supervision to implementing partners' field operations. To support ambitious goals in reaching TPIs, establishing an OVC program, and providing TA to support the country in improving outcomes under the third 90, the interagency will add a total of nine positions.

Consistent with their respective agency operating mechanisms, CDC utilizes technical subject-matter experts in a "hands-on" approach to directly deliver technical assistance (TA), while USAID combines direct TA with the utilization of implementing partners, working under staff supervision. CDC delivers TA in laboratory management, quality assurance/quality control, and strategic information, while USAID supports supply chain management, human resources, condom program support, and domestic resource mobilization. Both agencies utilize a mix of local and international staff to manage their respective portfolios.

APPENDIX A – Prioritization

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	Fiscal Year	<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		Total	Target	%
		F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M			
DAJABON	2017	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2018	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2019	-	-	-	-	3	1	2	1	5	4	15	4	18	10	29	13	35	21	34	33	23	34	55	83	425	341	125%
SANTO DOMINGO	2017	-	-	4	8	29	30	48	34	70	47	111	145	240	240	364	303	520	380	553	472	602	526	1,129	1,166	7,019	7,471	94%
	2018	-	-	4	8	33	34	54	38	79	53	126	165	273	273	416	345	593	434	630	537	685	599	1,286	1,327	7,992	7,555	106%
	2019	-	-	6	11	24	23	43	34	99	57	179	239	394	438	603	536	868	621	930	798	997	884	1,977	2,029	11,792	13,583	87%
LA ALTAGRACIA	2017	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2018	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2019	-	-	-	-	1	-	-	-	8	2	23	12	58	30	92	57	107	82	78	93	63	78	124	167	1,078	1,310	82%
LA ROMANA	2017	-	-	6	1	19	7	19	21	38	16	47	43	100	59	161	89	203	111	202	165	148	162	316	285	2,219	3,258	68%
	2018	-	-	7	1	21	8	21	23	42	17	52	48	111	65	178	99	224	122	223	182	164	179	349	315	2,454	3,421	72%
	2019	-	-	6	1	17	6	20	12	35	15	61	44	107	66	183	94	248	116	248	177	189	163	400	313	2,522	2,435	104%
MONTE CRISTI	2017	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2018	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2019	1	1	2	1	-	1	2	4	6	4	13	4	23	12	38	25	40	40	35	46	46	45	69	132	591	638	93%
PUERTO PLATA	2017	-	-	-	1	1	2	13	9	35	11	60	19	88	44	125	63	188	132	166	152	149	170	295	357	2,080	3,466	60%
	2018	-	-	-	1	1	2	15	10	40	12	69	22	101	50	144	73	217	152	191	176	172	196	340	412	2,396	3,859	62%
	2019	-	-	-	1	2	4	12	10	32	14	59	23	93	51	142	79	200	160	194	184	174	208	338	461	2,442	2,761	88%
VALVERDE	2017																											
	2018																											
	2019	-	-	1	-	1	-	-	-	7	-	27	5	63	21	62	40	81	44	89	60	78	65	182	179	1,008	1,037	97%
SANTIAGO	2017	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	0%
	2018	-	-	-	-	-	-	-	-	3	3	8	9	6	27	27	16	23	38	25	24	25	27	42	57	358	665	54%
	2019	-	-	-	-	-	-	-	-	5	3	9	11	8	32	32	20	27	45	30	29	30	32	50	68	427	805	53%
Total																										20,285	22,910	89%

* Note: Available data are inadequate to derive PLHIV estimates disaggregated by province, age, and sex. Table instead presents numerical targets where relevant and percentage of ART coverage at the levels where a reliable denominator is available. Also, while the data is intended to show a progression toward Attainment for each age/sex category, the shift from COP18 to COP19 represents a change in focus population such that numbers are not directly comparable.

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	**16,128***	**21,735 (1,664 TPI)**	**11,238 TPI**	**25,645 (13,063 TPI)**	**11,637 TPI**	**81%**
Sustained						
Central Support						

Commodities (if not included in previous categories)						
Total						

* For COP19, estimated total PLHIV represents TPI in the target provinces of Santo Domingo, Santiago, La Altagracia, Valverde, and Puerto Plata.

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Figure B.1.1 COP19 Budget by Program Area

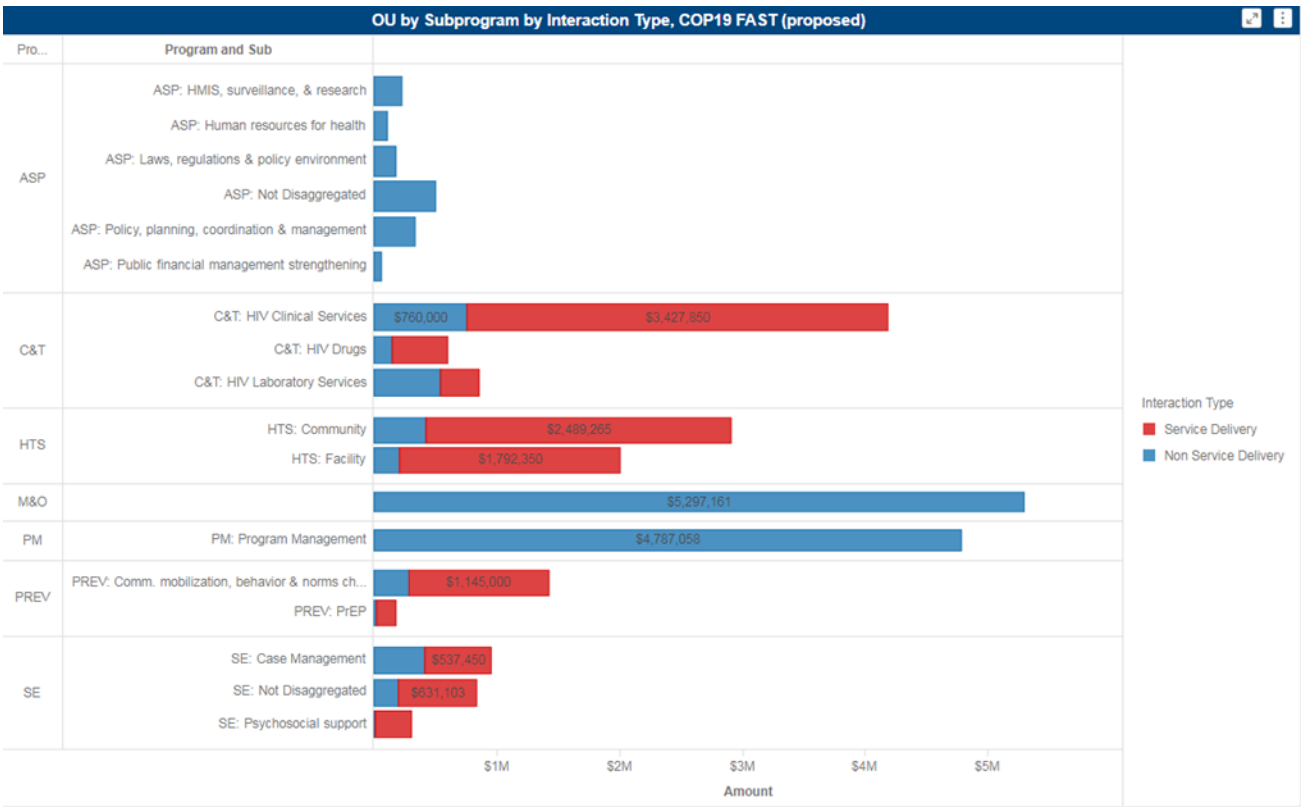


Table B.1.2 COP19 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US3,130,907	**$US22,615,748**	**$US25,746,655**

*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.1.2 COP19 Total Planning Level by Agency

Initiative Type	Fiscal Year	2020
	Funding Agency	Amount
Planning Level	DOD	$313,666
	HHS/CDC	$11,845,710
	USAID	$13,587,278

Table B.1.3 COP19 Total Planning Level by Budget Code

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	APPLIED PIPELINE	$3,130,907
	HBHC	$3,248,413
	HKID	$3,204,939
	HLAB	$132,453
	HTXS	$4,697,716
	HVCT	$5,195,075
	HVMS	$1,238,380
	HVOP	$1,922,193
	HVSI	$522,732
	HVTB	$555,501
	OHSS	$1,898,345

APPENDIX D – Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16). *The Dominican MOH issued a ministerial resolution on August 2018 reinforcing country's commitments to reaching the 90-90-90 targets for epidemic control. Scale-up of Test and Start by GODR is expected in FY20.*
2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16). *No national policy for DMOC. A guide drafted for PEPFAR sites but not fully adopted due to challenges with national system. Partially implemented in some PEPFAR sites with multi-month dispensing (MMD) for stable patients.*
3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18). *DLG available in country but limited to second and third line regimen options. TLD transition considering women of childbearing potential and adolescents, and removal of nevirapine-based regimens.*
4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18). *Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established.*
5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18). *PEPFAR sites will integrate tracking of TB services for PLHIV. Depending on sites characteristics counseling, testing and treatment to be carried out on site or referral to services closely monitored to guarantee services.*
6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. *Ongoing efforts to achieve higher linkage of clients from testing to treatment.*

7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18). *Ongoing discussions to decrease user fees and have a higher coverage of services by the national insurance scheme.*
8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80% access to annual viral load testing and reporting.
9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18). *In DR, mortality is reported to the Dirección Provincial de Salud (DPS) by the hospitals/clinics through death certificates but it is not integrated in a system like FAPPS. HIV sites update the information one- by -one when they find out patients have deceased commonly due to the patient's tracking.*
10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18). *New Activity for DR in COP19.*
11. Evidence of resource commitments by host governments with year after year increases (required in COP14). *In the last four years, the GODR has steadily increased budget allocations for the ARVs. In 2018, GODR increased its budget for ARV by 30 % more (3.6 M US$).*
12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18). *In FY20, PEPFAR supported agencies will have an increase of local partners for direct site interventions and community engagements*
13. Scale up of unique identifiers for patients across all sites. *In FY19, TP focused programming in Puerto Plata with plans to institutionalize with broader TP population*

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**PrimePartner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	Servicio Nacional de Salud	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 50,000.00	HMIS systems	Insufficient availability of accurate and reliable data/information to understand the HIV epidemic in DR (especially among TPI) and lead a comprehensive HIV response	COP17	COP21	80% of HIV clinics in the DR have implemented the biometric registry
USAID	Abt Associates Inc.	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	$ 60,000.00	Administrative and financial systems	The financing gap in the HIV response and lack of integration of KP/PP safety-net providers into the National health system threatens sustainability.	COP19	COP20	Prepare at least 5 NGOs to receive social security insurance reimbursements.
HHS/CDC	Centro de Orientacion e Investigacion Integral	ASP: Policy, planning, coordination & management	Priority Pops: Not disaggregated	$ 25,000.00	Clinical guidelines, policies for service delivery	Incomplete framework of updated national guidelines to achieve HIV epidemic control in DR according to latest WHO and UNAIDS recommendations	COP19	COP19	• A package of service has been developed • 25% of Q3-Q4 TPI patients initiate ART on same day as diagnosis
HHS/CDC	Secretaria De Estado De Salud Publica y Asistencia Social	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	$ 60,000.00	Institutionalization of in-service training	Insufficient availability of updated and reliable data/information to understand the evolving HIV epidemic in DR (especially in male TPI and TPI KP).	COP19	COP21	20 persons trained

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	**PrimePartner**	**COP19 Program Area**	**COP19 Beneficiary**	**Activity Budget**	**COP19 Activity Category**	**Key Systems Barrier**	**Intervention Start**	**Intervention End**	**COP19 Benchmark**
HHS/CDC	Secretaria De Estado De Salud Publica y Asistencia Social	ASP: Policy, planning, coordination & management	Priority Pops: Not disaggregated	$ 50,000.00	Clinical guidelines, policies for service delivery	Incomplete framework of updated national guidelines to achieve HIV epidemic control in DR according to latest WHO and UNAIDS recommendations	COP17	COP21	• Policy framework/guidance in place • x HIV Care Site distribute self-testing kits as part of options available to contacts identified through index testing • All HIV Care Sites receiving PEPFAR support since at least FY2018 implement at least some differentiated models of care
HHS/CDC	Secretaria De Estado De Salud Publica y Asistencia Social	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 50,000.00	Clinical guidelines, policies for service delivery	Incomplete framework of updated national guidelines to achieve HIV epidemic control in DR according to latest WHO and UNAIDS recommendations	COP19	COP21	• Policy in place • 300 self-testing kits distributed as part of index testing
USAID	Panagora Group LLC	ASP: HMIS, surveillance, & research	Priority Pops: Mobile Pops	$125,000.00	Program and data quality management		COP19	COP20	Analysis of Year 1 operations post-baseline and results disseminated to key stakeholders.
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$35,000.00	Clinical guidelines, policies for service delivery	Inadequate policy guidelines and implementation practices to deliver effective safe, quality and efficient HIV interventions to KP/PP	COP19	COP20	Bi-national cross-border coordinating body established to address HIV treatment and care for TPI in the DR.
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$75,000.00	Institutionalization of in-service training	Inadequate policy guidelines and implementation practices to deliver effective safe, quality and efficient HIV interventions to KP/PP	COP19	COP20	Training updates delivered through national systems.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$70,000.00	HRH recruitment and retention	Limited distribution of HRH in HIV sites to support Treat All implementation in country. The country also scored poorly in its capacity to collect, manage, analyze, and use data related to the health workforce	COP19	COP20	Ihris utilized to assign staff to HIV clinics
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$75,000.00	Forecasting, supply chain plan, budget, and implementation	A nascent supply chain management system that lacks effective site-level commodity forecasting as well as appropriate inventorying and warehousing of mediciines threatens advances in the HIV treatment program and implementation of Test and START	COP19	COP20	Integrated medication monitoring and patient case management in the National HIV Patient Registry System.
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$85,000.00	Training in supply chain systems	A nascent supply chain management system that lacks effective site-level commodity forecasting as well as appropriate inventorying and warehousing of mediciines threatens advances in the HIV treatment program and implementation of Test and START	COP19	COP20	No stockout of first, second and third line of treatment.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$75,000.00	Clinical guidelines, policies for service delivery	Inadequate policy guidelines and implementation practices to deliver effective safe, quality and efficient HIV interventions to KP/PP	COP18	COP20	Monitoring visits institutionalized into the regional and provincial health services.
USAID	Family Health International	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$70,000.00	Clinical guidelines, policies for service delivery	Inadequate policy guidelines and implementation practices to deliver effective safe, quality and efficient HIV interventions to KP/PP	COP19	COP20	Validation and scale-up of mobile modality.