Dominican Republic

Country Operational Plan

COP2020

Strategic Direction Summary

April 1, 2020

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1.0 Goal Statement

The 2020 PEPFAR Country Operational Plan (COP20) for the Dominican Republic (DR) details the revised strategy to achieve the goal of epidemic control among Focus Clients[1], defined as individuals of Haitian descent residing in the DR. In this country of 10.4 million inhabitants, there are approximately 751,080 FC[2]. Of the estimated 70,777 people living with HIV (PLHIV) nationwide, approximately 26,316 are FC, and the PEPFAR supported provinces contain nearly 2/3 of all FC. While the Dominican Republic has an overall HIV prevalence of 0.9%, FC estimates indicate a prevalence between 3-5%, higher than any key population group and higher than in the overall prevalence in Haiti (2%, UNAIDS 2018). Among FC PLHIV, only 40.7% are aware of their status, and only 17.5% are currently on treatment. In comparison, antiretroviral treatment (ART) coverage for non-FC PLHIV is 67.5%.

For FC living with HIV/AIDS in the DR, a series of political, economic, and cultural factors hinder initiation, retention, and adherence to ART. 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 people from Haiti 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 FC in the DR creates obstacles, both real and perceived, to accessing public services. The Dominican government passed Judgment 168-13 in 2013 stripping citizenship from nearly 200,000 individuals of Haitian descent (UNHCR 2013) born in the DR[3], creating a group of stateless individuals, not recognized as citizens in either country leading to an increase in indiscriminate deportation activities. While the law has since been rescinded as a result of international pressure, few of the affected population have regained legal status.

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.

The DR COP20 strategy to reduce the gaps under the HIV treatment cascade for FC:

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

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

1. **Decentralize USG-supported prevention, treatment and clinical care entry points** accessible to FC in addition to the sites currently supported by PEPFAR and outside the network of 74 Integrated HIV Care sites nationwide. This will also include community care teams.

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

3. **Operationalize COP19 fast track policy changes** within 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. **Ensure warm handoffs at clinical sites to Orphans and Vulnerable Children (OVC) program for HIV positive FC clients** to further identify and support those affected by HIV/AIDS by reducing barriers to linkage and retention in care.

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

6. **Institutionalize technical assistance** to the Government of Dominican Republic (GoDR) to increase laboratory capacity to improve country-wide viral load suppression.

7. **Address stigma and discrimination** among entities that interact with FC on a regular basis.

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 10,448,499 in 2020. According to the World Bank, the DR's Gross National Income per capita was $7,760 in 2018 (current USD)[4]. Despite being an upper middle-income country, over 30% of Dominicans lived in poverty in 2016[1], with the wealthiest 10% of the population accounting for more than 30% of the country's income[5]. In 2017, health expenditures represented 6.1% of the Gross Domestic Product[6].

The DR has a concentrated HIV epidemic, with an estimated HIV prevalence of 0.9% in adults aged 15-49. The 2019 Spectrum model estimates that in 2020 69,558 adults aged 15 years and above are

[4] https://data.worldbank.org/country/dominican-republic, accessed on March 9, 2020
[5] https://databank.worldbank.org/reports.aspx?source=world-development-indicators, accessed on March 9, 2020
[6] http://apps.who.int/gho/data/view.main.GHEDCHEGDPSHA2011v?lang=en, accessed on March 9, 2020

living with HIV in the DR and predicts that 1,988 new HIV infections and 702 HIV-related deaths will occur in 2020. Spectrum estimates that the number of PLHIVs in the country decreased from 2000 to 2015 but has been increasing slightly every year since (Figure 2.1.1), as new infections remain higher than all-cause mortality in PLHIVs (Figure 2.1.2).

Figure 2.1.1 Trend in Number of PLHIVs, Spectrum 2019

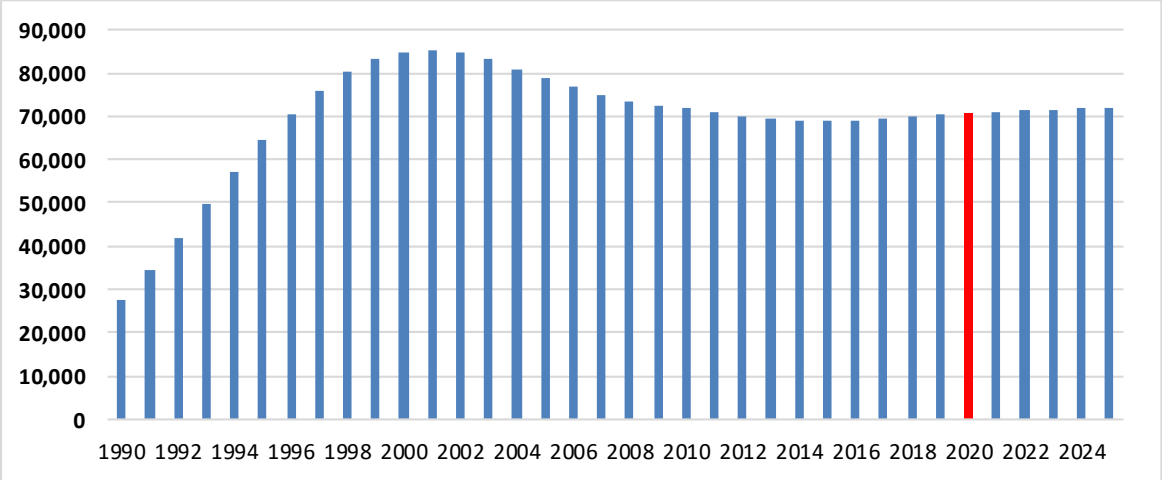
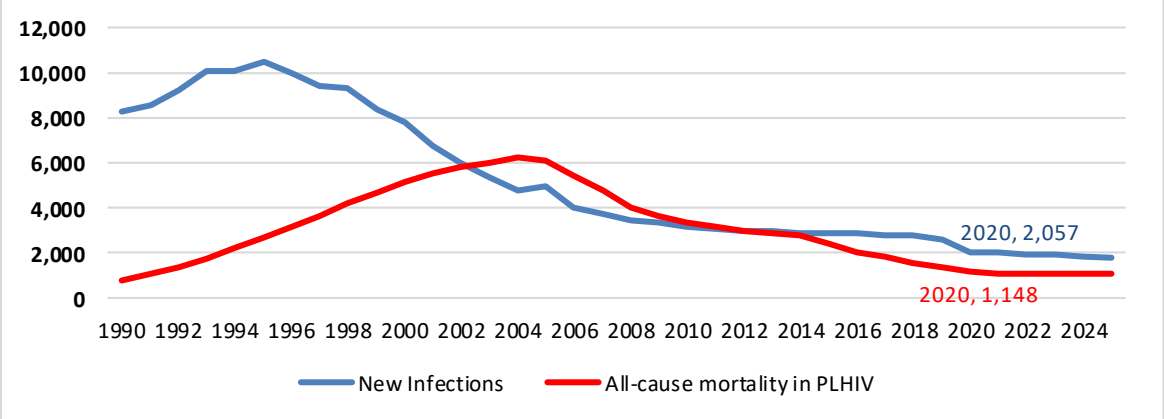


Figure 2.1.2 Trend in New Infections and All-Cause Mortality Among PLHIV, Spectrum 2019



Populations disproportionately burdened by HIV include men who have sex with men (MSM) with an HIV prevalence between 2.4-6.4% , female sex workers (FSW) with an HIV prevalence between 1.1-5.9%, transgender women (TG), and FC in particular with an HIV prevalence between 2.5-5% but accounting for 46% of all newly infected individuals in Dominican Republic.

According to the National Immigrants Survey (NIS), the number of migrants living in the DR was estimated at 570,933 in 2017. Among them, 497,825 (or 87.2%) were born in Haiti, an 8.6% increase over 2012 NIS results. In addition, 253,255 persons born in the DR had at least one Haiti-born parent, a 20.6% increase since 2012. Per the 2017 Integrated Biological and Behavioral

Surveillance Survey (IBBSS, unpublished), HIV prevalence among migrants from Haiti ranges from 2.5 to 5.0% across the five provinces surveyed (La Altagracia, Barahona, Puerto Plata, Santiago and Santo Domingo). The 2019 Spectrum model posits a migrant population aged 15 and above of 556,744 for 2020, including 350,947 (63.0%) men. The Spectrum model also estimates that there are 26,316 Haiti-born PLHIV throughout the DR, including 15,029 (57.1%) men. This represents a 2.2% increase over the estimation for 2019. PLHIVs of Haitian descent now represent 37.8% of all PLHIVs, the single largest priority group in the DR. Out of 2,153 AIDS-related deaths reported in 2016 in the Dominican Republic, 660 (30.7%) are estimated to have occurred among migrants from Haiti (Dolores & Caballero, 2017).

Certain subgroups within the Haiti migrant population have been shown to be at increased risk of contracting HIV infection: the 2012 IBBSS found that in Haitian-borne 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 reported having 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. The 2017 IBBSS continued to show increased risk and poor access to services among Haitian migrants: 25.0-39.0% of respondents, depending on the province, reported never having been tested for HIV, even though 17.0-35.0% considered themselves at risk for HIV infection, primarily for having unprotected sexual intercourse (48.0-89.0%) or having sex with multiple partners (11.0-45.0%).

Information on HIV status among descendants of Haitian-borne parents in the DR is scarce. The unresolved legal status or citizenship of many Haitian and Haitian-descent families already living on the Dominican territory (Wooding, 2018), makes them formally invisible for social protection policies, exacerbating their limited access to public health services. Based on the results from 2017 NIS, 95.0% of Haitian migrants and 80.9% of their descendants lack any type of health insurance, a percentage that is slightly higher than the one observed in 2012. National policies and health information systems in the Dominican Republic define Haitian migrants exclusively based on their place of birth (i.e., persons born in Haiti who currently reside on Dominican territory), although it is widely acknowledged that vulnerability factors, including extreme poverty, structural violence, and frequent mobility, usually extend to the first and second generation of their descendants as well.

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).

In addition to FCs, other disproportionately affected populations kin the DR are Key Populations. PEPFAR DR will continue implementing activities in support of viral load suppression and adherence among non-FCs and will continue collaborating with other partners, e.g., Global Fund and UNAIDS -sharing lessons learned, tools and methodologies. 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 reported 124,472 MSM, or 4.2% of the adult male population. The 2016 Priorities for Local AIDS Control Efforts (PLACE) Lite study estimated a much lower figure of 32,416 MSM, or 1.24% of all men aged 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 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 10.8% (7,491) of all PLHIV in the country in 2020. The IBBSS also indicated that only 11.0-31.0% of MSM had access to an HIV test in the prior 12 months. Moreover, 48.0% 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 70.0-94.0% of MSM reported having sex for some material benefit, and condom use was low: between 42.0-71.0% in most recent anal receptive sexual intercourse, and between 21.0-39.0% in most recent insertive anal sexual intercourse.

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 aged 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, 27.0-75.0% of FSW reported having used a condom during their most recent commercial sexual intercourse, but only 1.0-11.0% during their most recent intercourse with a trusted or stable partner. The 2019 Spectrum model estimated that 3,432 PLHIVs in the DR are FSWs, or 5.1% of all PLHIVs.

In 2014, the number of TG women in DR was estimated at 8,891 (Experts Focus Group for CONAVIHSIDA, 2014). 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 estimated that 1,678 PLHIV in the DR are TG women, or 2.4% of all PLHIV.

Table 2.1.3 Host Country Government Results

Table 2.1.3 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	10,448,499	100%	1,408,907	13.48%	1,462,378	13.99%	926,328	8.86%	937,542	8.97%	2,895,423	27.71%	2,817,923	26.96%	National Office of Statistics,
HIV Prevalence (%)		0.92% (15-49)		0.05-0.1%		0.05-0.1%		0.24-0.53%		0.17-0.24		0.23-1.78%		0.07-0.22%	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
# PLHIV	90,500		974		1,011		3,219		3,042		36,997		31,460		Spectrum 2019
Incidence Rate (2019)		0.024%		N/A		N/A		0.034 - 0.035%		0.030-0.079%		0.02-0.029		0.02-0.285%	Spectrum 2019
New Infections (2019)	1,992														Spectrum 2019
Annual births	159,130	100%													National Office of Statistics, Vital Statistical Records, 2018
% 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, 2017
Pregnant women needing ARVs	843														Spectrum 2019
Orphans (maternal, paternal, double)	35,372														Spectrum 2019
Notified TB cases (Yr)	4,224														National TB Program, National TB Information System, 2018
% of TB cases that are HIV infected		25%													National TB Program, National TB Information System, 2017
% of Males Circumcised	N/A	N/A			N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	30,496														PLACE Lite, 2016
MSM HIV Prevalence	2.4-6.4%														2017 IBBSS
Estimated Population Size of FSW	87,780														PLACE Lite, 2016
FSW HIV Prevalence	1.1-5.9%														2017 IBBSS
Estimated Population Size of PWID	N/A														
PWID HIV Prevalence	N/A														
Estimated Size of Priority Populations (specify)	759,080		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			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

Table 2.1.4 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

Table 2.1.4 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART, 2019		
	Total Population Size Estimate	HIV Prevalence (%)	Estimated Total PLHIV	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	10,488,499[1]	0.91% (15-49)	70,777[5]	N/A	36,847[6]	52.1%	25,044(67.9%)	775,045[7]	11,393[7]	6,747
Population <15 years	2,871,295[1]	0.05-0.1%	1,220[5]	N/A	669	54.8%	335 (50.1%)	N/A	N/A	110
Men 15-24 years	937,540[1]	0.17-0.24	2,686[5]	N/A	892	33.2%	438 (49.1%)	N/A	N/A	387
Men 25+ years	2,817,913[1]	0.07-2.0%	61,815[5]	N/A	16,306	26.4%	10,682 (65.5%)	N/A	N/A	2,946
Women 15-24 years	926,328[1]	0.24-0.53%	2,679[5]	N/A	1,256	46.9%	569 (45.3%)	N/A	N/A	570
Women 25+ years	2,895,423[1]	0.23-1.78%	31,279[5]	N/A	17,724	56.7%	12,120 (68.3%)	N/A	N/A	2,734
MSM	32,416[2]	2.4-6.4% [4]	7,295[5]	N/A	1,903[6]	26.1%	1,323 (69.5%)	N/A	N/A	513
FSW	87,782[2]	1.1-5.9% [4]	3,545[5]	N/A	887[6]	25.0%	510 (57.5%)	N/A	N/A	180
PWID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Dominicans of Haitian Descent and Haitian Migrants	751,080[3]	1.1-5.0% [4]	25,599[5]	N/A	4,280[6]	16.7%	2,066 (48.3%)	N/A	N/A	1,943

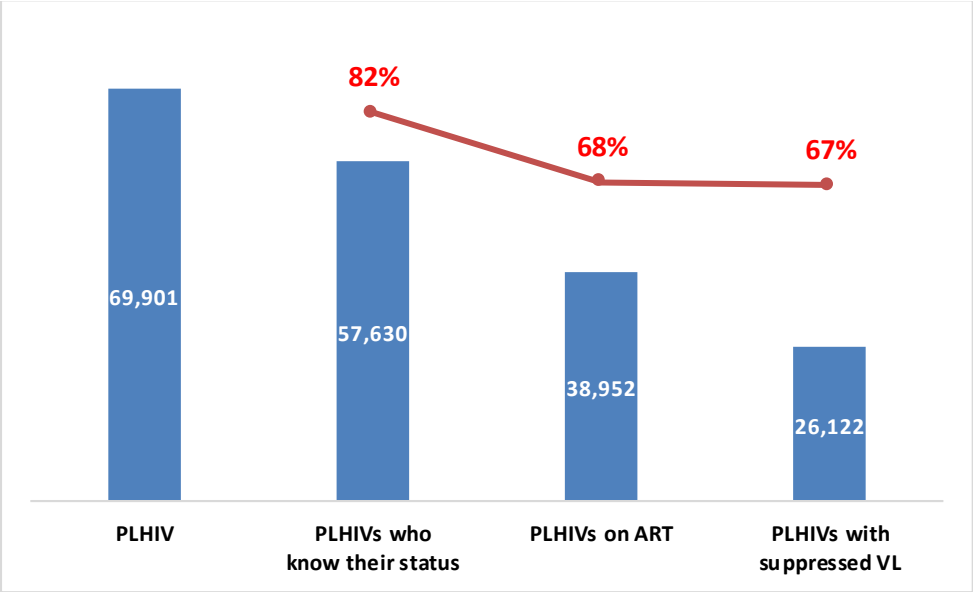
1 Estimaciones y proyecciones nacionales de población 2000-2030, Volumen IV. Oficina Nacional de Estadísticas, Santo Domingo, 2016.
2 PLACE Lite Study, 2016
3 Segunda Encuesta Nacional de Inmigrantes ENI-2017. Versión Resumida del Informe General. Oficina Nacional de Estadísticas, Santo Domingo 2017
4 2017 IBBSS
5 2019 Spectrum model, 2020 estimation
6 National HIV Patient Information Management System (FAPPS), as of December 31, 2019
7 National HIV/AIDS program

Progress toward Epidemic Control

HIV Clinical Cascade

The GoDR supports PEPFAR efforts overall. Since 2015, the government has fully assumed the costs of purchasing sufficient antiretrovirals (ARVs) and other HIV supplies to meet country needs. 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. DR's progress toward WHO's 90-90-90 is detailed in Figure 2.1.5.

Figure 2.1.5. DR's progress towards reaching 90-90-90 goals



Source: Spectrum/UNAIDS, 2018

HIV Testing Services (First 90)

In the DR, HIV testing is performed at 1,093 laboratory sites. Nationally, HTS numbers still represent the number of tests performed rather than the number of persons tested. The DR's National HIV/AIDS Program reported that in 2019, 775,045 HIV tests were performed, of which 11,393 (1.4%) were positive for HIV infection (DIGECITSS, 2019). A national person-level HIV Testing Information System is being deployed with PEPFAR support. It has been installed in 19 PEPFAR-supported and 7 non-PEPFAR-supported facilities. In 2019, the National Register HIV system (SIRENP in Spanish) registered 29,452 persons tested for HIV, including 2,087 (7.1%) who resulted positive.

During the first quarter of COP19, PEPFAR-DR's overall HIV testing yield was 3.2% (within expected rage based on estimated prevalence for FC). The facility-based yield was 4.3% with significant site-by-site variation. FC represented 24.5% of all clients tested in facilities and 30% of the positives. The positivity rate among FC was 5.4%, versus 4.0% in non-FC. In community-testing activities, the positivity yield was 2.3% with FC representing 97% of the total number of positives.

ART - adult and pediatric (Second 90)

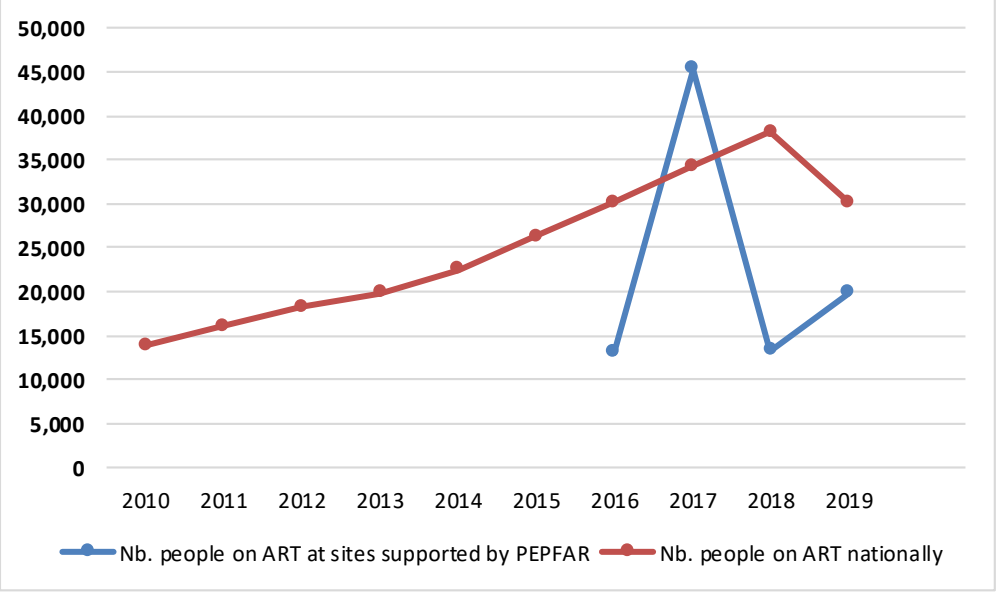
In the DR, HIV care services, including antiretroviral treatment, are exclusively delivered at only 74 Integrated HIV Care (IHC) sites throughout the country. Only three sites specialize in providing pediatric ART. Among the 74 sites, 9 sites in 4 provinces received PEPFAR support in COP17, increasing to 18 sites in 6 provinces in COP19 and to 9 provinces in COP20. PEPFAR does not currently provide support to any pediatric sites.

All patients enrolled at the IHC sites are registered in the HIV Patient Management Information System (FAPPS, per its acronym in Spanish). As of December 31, 2019, a total of 69,092 persons had ever been registered into FAPPS, including 37,252 currently active on ART per the national definition. The 18 sites receiving PEPFAR support manage 24,261 (68%) active patients. Only 615 active patients nationwide are children under the age of 14.

Among all patients active on ART in the country, 1,903 (5.1%) are characterized as MSM in FAPPS, 1,206 (3.2%) as drug users, 887 (2.4%) as FSW, and 325 (0.9%) as TG women. A total of 4,280, or 11.5%, are categorized as migrants from Haiti[7]. PEPFAR-supported sites report 1,457 MSM patients (or 76.6% of all MSM active on ART in the country), 626 (71%) FSW, and 219 (67.3%) TG women. A total of 2,787 FCs are receiving ART at PEPFAR which includes 65% of all migrant patients on ART in the country.

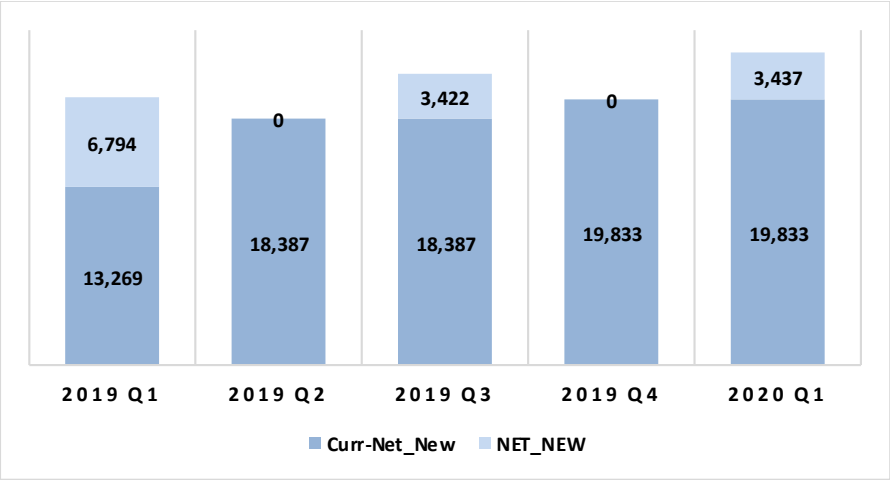
During the first quarter of COP19, 1,703 patients initiated ART nationally, including 1,355 (80%) at PEPFAR-supported IHC sites. Among them, 645 (38%), 516 (38%) at PEPFAR sites, were identified in FAPPS as born in Haiti.

Figure 2.1.6 National and PEPFAR trend in individuals active on ART



[7] 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.

Graph 2.1.7 Trends on NET_NEW, COP19



Source: PEPFAR DR programmatic data

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 undergoing a certification process to perform viral load testing and CD4 counts.

As of December 31, 2019, 31,168 patients (83.7% 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, 25,044 (80.3%) showed a viral load <1000/ml. At PEPFAR-supported sites, a total of 20,301 active patients with more than 3 months on ART had a viral load test result recorded in the past 12 months and 17,019 (83.8%) showed viral suppression.

PrEP implementation

In the DR, PEPFAR began supporting PrEP in COP17, at one site in Santo Domingo targeting MSM and TG women. In COP18, two additional sites, in Puerto Plata and La Romana, began offering PrEP, and eligibility was expanded to include FSWs. Four hundred and nine (409) new individuals started PrEP during that fiscal year. During the first quarter of COP19, 191 individuals initiated PrEP. In COP20, PEPFAR will support the expansion of PrEP to serodiscordant couples and breastfeeding women, including FCs to a total of 8 provinces with a total target of 2,316 clients active on PrEP.

Implementation of key policies

Test and Start

In 2018, through Resolution N. 000020, the Ministry of Health (MoH) 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 IHC sites throughout the country between 2016-2018.

Same-day ART initiation started in COP18, and will be expanded to all supported sites by the end of COP19 implementation. As presented in Table 2.1.8, DR sites have effectively reduced the average number of days from diagnosis to ART initiation. Rapid initiation significantly improves outcomes across the HIV treatment cascade in low- and middle-income settings, as demonstrated in several scientific studies. In COP20, PEPFAR-DR will implement same-day ART initiation for all sites in new provinces.

Table 2.1.8 Average number of days from diagnosis to ART initiation, by site and year

AVG time (in days) to initiate							
Site	2014	2015	2016	2017	2018	2019	2020
ACTIVO 20-30 (SAI)	169.4	227.1	109.4	78.7	90.5	12.3	1.3
CENTRO DE ATENCION Y ESPECILIDADES (CAE)	279.3	89.4	83.9	34.9	23.9	14.9	2.1
CENTRO DE PROMOCION Y SOLIDARIDAD HUMANA CEPROSH	139.2	127.8	81.6	15.3	16.0	6.9	0.0
CENTRO DE SALUD INTEGRAL BELLA VISTA	154.0	96.5	51.4	42.5	51.3	6.3	0.0
CENTRO DIAGNOSTICO CIEN FUEGO	120.2	116.1	13.4	64.3	11.5	22.9	MDN
CENTRO ESPECIALIZADO DE ATENCION DE SALUD JUAN XXIII	251.4	201.2	110.0	9.5	4.0	7.2	0.0
CENTRO SANITARIO	242.1	210.4	113.7	58.6	42.7	22.3	8.7
CLINICA DE FAMILIA LA ROMANA	181.3	117.2	82.1	23.2	10.3	8.1	6.1
COIN	334.9	170.1	159.7	63.3	34.8	15.6	0.8
DR. FRANCISCO ANTONIO GONZALVO	129.1	89.2	80.0	16.2	12.0	8.0	1.2
DR. VINICIO CALVENTI	225.2	243.0	94.5	94.0	56.7	10.0	0.0
ING. LUIS L. BOGAERT	223.1	112.8	63.5	81.5	37.3	14.5	4.0
INSTITUTO DOMINICANO DE ESTUDIOS VIROLOGICO (IDEV)	144.3	140.2	79.4	18.6	20.5	21.6	1.7
JOSE DE JESUS JIMENEZ ALMONTE	195.7	150.1	93.7	80.0	49.2	52.5	1.2
JOSE MARIA CABRAL Y BAEZ	126.8	110.6	59.3	18.1	9.7	35.6	6.6
LOTES Y SERVICIOS	212.3	174.0	91.4	41.1	26.4	15.5	4.0
MATERNIDAD NUESTRA SEÑORA DE LA ALTAGRACIA	814.8	15.2	1.3	0.4	10.0	5.6	0.0
NUESTRA SEÑORA DE LA ALTAGRACIA (HIGUEY)	79.2	36.1	20.2	5.0	2.0	1.8	0.9
PALAVE	89.2	142.3	19.8	12.7	2.0	2.6	MDN
RICARDO LIMARDO	129.1	144.7	76.4	21.4	16.6	8.8	0.7
SANTO SOCORRO	139.1	171.0	49.7	59.6	39.5	44.8	MDN
VERON	74.1	102.6	120.1	77.5	61.1	5.3	0.1
Grand Total	202	135	75	41	28	15	2

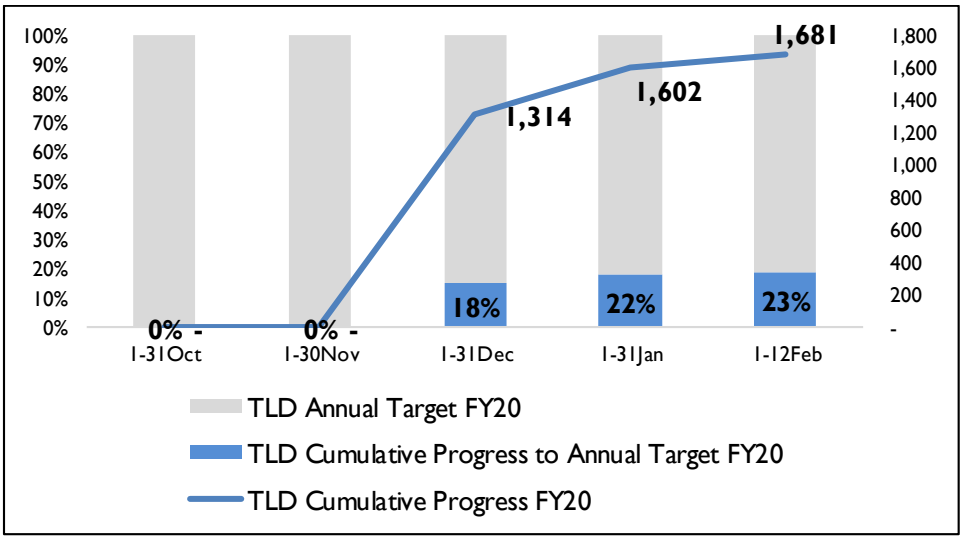
Differentiated service delivery including multi-month dispensing (MMD)

National HIV guidelines allow for 3-month scripting and dispensing 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. At least 48% of patients in Dominican Republic 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 for stable patients (patients with evidence of treatment compliance and viral suppression in the last 12 months) 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. To address these concerns, and as part of MMD expansion, PEPFAR DR will reinforce site-level training on ARV supply chain, including effective forecasting, planning and reporting. To facilitate MMD, GoDR has recently approved the increase of stock level for each site by at least 3 months in addition to reported consumption allowing for seven months' stock.

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 5,800 of patients using EFV 600 and 10% of patients on NVP will have transitioned to EFV 400 mg. PEPFAR-DR will work with GoDR to continue transitioning the remaining eligible patients in COP20 following the reduction in the availability of EFV.

Graph 2.1.9 Monthly progress on TLD transition at 16 prioritized facilities, COP19



Scale up of index testing

In 2017, PEPFAR-supported sites began testing contacts of HIV+ individuals through Voluntary Partner Referral (VPR) among Key Populations. In COP18, 3,511 HIV+ patients were offered VPR; 1,487 accepted the intervention, referring a total of 1,161 partners/contacts. Among these contacts, 892 were tested and 258 (28.9%) resulted positive for HIV infection. Yield has been high however a major issue has been low eligibility among index patients.

Reasons for low eligibility among index patients include: the partner previously diagnosed as HIV+, the index patient is no longer in contact with the partner, the index patient feels uncomfortable with disclosing contacts 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 accept testing, yield continues to be high: 26% in Facility and 29% in Community in the first quarter of COP19.

PEPFAR DR is currently working to improve the implementation of Index Case Testing and Tracing (ICTT) with fidelity in COP19 through focusing on community-level testing. To increase ICTT effectiveness PEPFAR DR will prioritize "assisted HIV partner notification" at the community. PEPFAR mechanisms will increase the number of teams implementing ICCT at the community level and will continue implementing strategies to maintain confidentiality (additional details in pages 36-38) Successful scale-up in COP20 will involve timely site-level training and supervision to increase contact elicitation and acceptance throughout PEPFAR-supported community personnel, as well as a greater emphasis on the inclusion of biological children in conjunction with the new OVC program.

Management of TB/HIV Coinfection and Scale up of TB preventive therapy (TPT)

TPT 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 TPT. The GoDR has demonstrated its commitment to purchase sufficient quantities of INH to meet needs, and a purchasing mechanism is in place. With Global Fund support, GenXpert availability was expanded to 9 provincial laboratories, and the GoDR has undertaken enhanced supervision of TB-HIV activities at both TB clinics and IHC sites. On average, 906 HIV+ patients completed a course of TPT with INH in 2016-2018, and 1,253 in FY2019.

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 should only be offered to patients newly initiated on ART; lack of coordination/communication between HIV and TB offices; and poor recording and reporting of TPT initiation and completion dates. During FY20, PEPFAR DR is improving communication channels and implementing SOPs and job-aids to improve internal coordination and reference between HIV and TB units, apporting TB/HIV focal points, supervising supported sites for the timely and proper report of TPT initiation and completion dates,

as well as additional site-level training on SOPs and job-aids to improve TPT initiation rates for existing ART patients.

In late 2019-early 2020, the national guidelines for TB-HIV coinfection were revised. The new guidelines will be issued on March 24, 2020 (World TB Day). A notable update is the introduction of the 3-month INH/RIF regimen, which should improve TPT completion rates.

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 these situational fees for all patients enrolled into HIV care and treatment.

Alignment of orphans and vulnerable children package of services

The implementation of OVC programming will focus on strategically optimizing enrollment of most vulnerable PLHIV to improve linkage, retention, and viral suppression. The strategy will include simultaneous referral of all newly identified focus clients into clinical care and OVC programming for eligibility screening. Focus clients with high viral load will also be prioritized for referral into OVC programming. OVC programming will also include HIV testing of eligible children to both improve knowledge of HIV status and improve coverage of family index case testing.

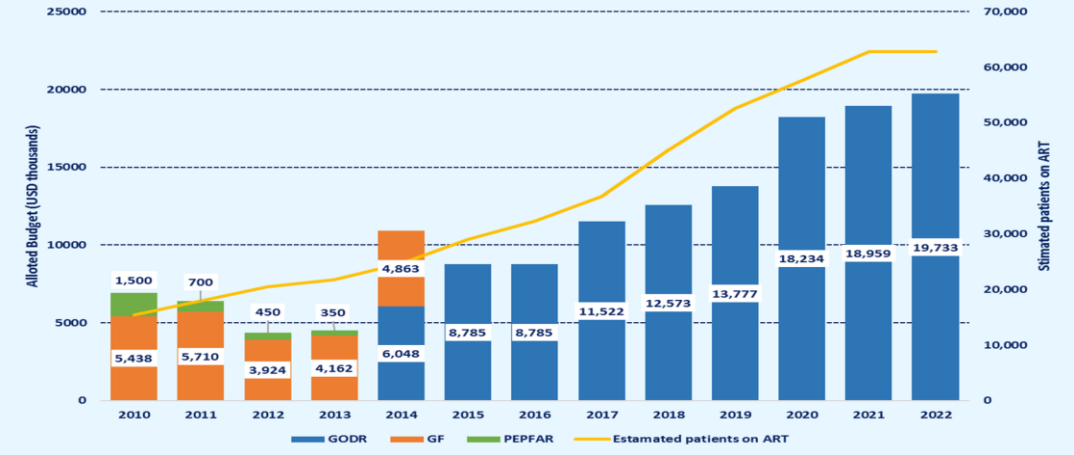
COP19 is the first year that PEPFAR/DR implemented an OVC program. Coordinating mechanisms were put into place to ensure that all OVC services align and coordinate with all PEPFAR supported testing and clinical care efforts in the country. In COP20, to continue to complement the scale-up of PEPFAR-supported clinical services, the OVC program will provide comprehensive, family-centered, community-based case management services that support case finding, enrollment, adherence, and retention in HIV services and address key barriers faced by FC in initiating and remaining engaged in HIV treatment. This is done through partnerships with HIV treatment sites, community partners, and extended referral networks. The OVC program's dual focus includes working closely with clinical partners to provide community-based services to complement their efforts to identify undiagnosed, HIV-positive household members of FC clients, ensure access to HIV testing and counseling, strengthen linkages to treatment, and support adherence and retention efforts to facilitate treatment success and viral load suppression. In addition, the OVC program will strengthen or build and operationalize bi-directional referral networks with a range of community-specific providers of social services which address other important needs of the FC client households which influence not only their treatment outcomes but other measures of health and

well-being. These services may include emergency food assistance, support for education, and facilitation of access to documentation needed to receive services.

Evidence of resource commitments by host government

The GoDR has assumed increasing financial responsibility to support the national HIV response (Figure 2.1.10). 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 $11.5 million after significant PEPFAR advocacy. In 2018, the GoDR provided additional resources towards ARVs and other supplies matching the prior year requests. The GoDR anticipates US$ 1.8 million saving in HIV procurement due to a change in national guidelines to recommend that routine viral load testing be performed every 12 (rather than every 6) months. These savings will be sufficient to ensure ART for new HIV positives and TLD transition. There is no financial gap anticipated for the procurement of ARVs in 2020 and 2021.

Figure 2.1.10 Transition of ARV & Commodity Supplies Purchases by GoDR



Progress towards local prime partner funding

In COP19, two local CSOs received PEPFAR funds as prime award recipients. These two CSOs are receiving a total of $1,205,199, up from 879,298 in FY2017. In COP20, two additional local partners will be added bringing the total to four. In addition, 12 local CSOs are sub-award recipients of $2,683,809 of PEPFAR funds. The number of local sub-awards is expected to increase to 19 by the end of COP19. 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 fake documents. The HIV Patient Management System (FAPPS, per its Spanish acronym) assigns each patient a unique number at registration. A limitation is that, 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.

As the FAPPS ID is generated when the patient is enrolling into care, it is not helpful to track individuals at the testing stage. The patient-level HIV Testing Information System (SIRENP per its Spanish acronym) that is currently being rolled out with PEPFAR support, assigns an ID at the time of testing and the functionality to link SIRENP and FAPPS IDs retrospectively to evaluate linkage to care, already exists. In addition, improvements are being made to link the HIV and TB information systems: it is now possible to access FAPPS data from the TB information system (SIOE in Spanish).

In addition, PEPFAR supported the development and implementation of a biometric register, based on a technology used in Haiti that records patient fingerprints. PEPFAR began implementing this system in three sites in the province of Puerto Plata in COP17. All IHC sites receiving support in COP18 were also equipped with this module. The MoH is currently installing it in Santiago Province, which was not a PEPFAR-supported area in COP18, and progressively continuing the expansion to non-PEPFAR sites. As of the start of Q2 in COP19, 10,200 patients (47.5%) at PEPFAR-supported sites had their index digit print registered. Patients, including FC, and HIV care sites staff have received it well. It provides advantages in terms of accurate patient identification, speed, accuracy, reliability, streamlining of the 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.

2.2 New Activities and Areas of Focus for COP20, including Focus on Client Retention

Program activities for COP 20 reflect the importance of tailoring efforts to the changeable needs of the FC population. The strategy and related activities have been designed to build on COP 19 to provide better access to HIV services and ensure differentiated and client centered approaches.

Case Finding and Program Growth

Spectrum estimations in both PEPFAR supported provinces and non-PEPFAR supported provinces in the Dominican Republic show that men above 25 years old are the most vulnerable population group with the higher proportion of PLHIV and have the lowest percentage of linkage to treatment. To optimize and tailor case-finding strategies, PEPFAR will focus on the most vulnerable FC populations (men, TB patients, older adults, etc.), implement client-centered activities, use more effective testing modalities (including ICTT in compliance with the WHO minimum standard of care), as well as expand and decentralize service provision in the community (additional details in section 4). The adoption of more efficient ICTT modalities, such as "assisted HIV partner notification" will begin immediately and will continue into COP20.

PEPFAR DR will further optimize the provision of HIV testing services by implementing risk screening tools to identify FC most likely to be HIV-positive at facility and community-level.

Since its implementation, Enhanced Peer Outreach Approach (EPOA) has shown encouraging results for positivity rates and ART initiation rates in comparison to other testing approaches at the community level. PEPFAR DR will continue building on COP19 experience and expand EPOA in the new provinces.

PEPFAR DR will also implement safe and secure biometric coding at community level in COP20. Biometric coding at community level will simultaneously strengthen information systems and provide a faster route to enrolling in ART, especially among FC, who are usually fearful to travel from the safety of their communities to health facilities for treatment enrollment.

Bridging the Treatment Gap

Q1 COP19 data demonstrates that up to 70% of PLHIV identified through community testing approaches were not linked to treatment due to the barriers to reaching the facility for ART enrollment. Planned decentralization of ART distribution in FY20, including ART initiation and refills at the community, will help reduce unnecessary burden at the health facility and fast-track ART same-day initiation. PEPFAR will implement different modalities, adjusted to local needs in supported provinces, for community distribution. These modalities include community distribution sites (e.g., public pharmacies), community worker teams, community adherence groups (CAGs) and mobile services. Decentralized ART services also facilitate the reduction of discrimination in communities as they effectively demystify HIV, demonstrating that it is a manageable chronic condition. This approach will also improve the availability of health services to PLHIV in need of complex clinical attention.

PEPFAR DR recognizes that the only way to effectively serve FC is to understand the constraints and challenges of their social contexts. Hence, PEPFAR will partner with civil society organizations (CSOs) working with FCs to better design client-centered activities. GoDR and PEPFAR work together in the implementation of the HIV program in DR, creating the necessary background for sustainable user-friendly service delivery models.

Improving Client Retention and Viral Load (VL) Suppression

The COP20 retention strategy is designed to ensure FC continue in treatment and subsequently, become virally suppressed. A loss/gain proxy analysis of FY19 Q1 – FY20 Q1 data suggests that approximately 55% of new on ART will eventually be lost to follow up (LTFU). As an effective ART initiation strategy and optimized ART regimens are vital to ensure retention, PEPFAR DR will focus on reducing FC-specific barriers for MMD and TLD transition. As COP19 sites complete TLD and MMD scale-up, PEPFAR will begin introducing these strategies in new supported provinces in COP20.

To further improve treatment retention, PEPFAR DR will strengthen country capacity building and monitoring and evaluation activities through the provision of technical assistance and training on data collection and management to better identify LTFU predictors for corrective actions.

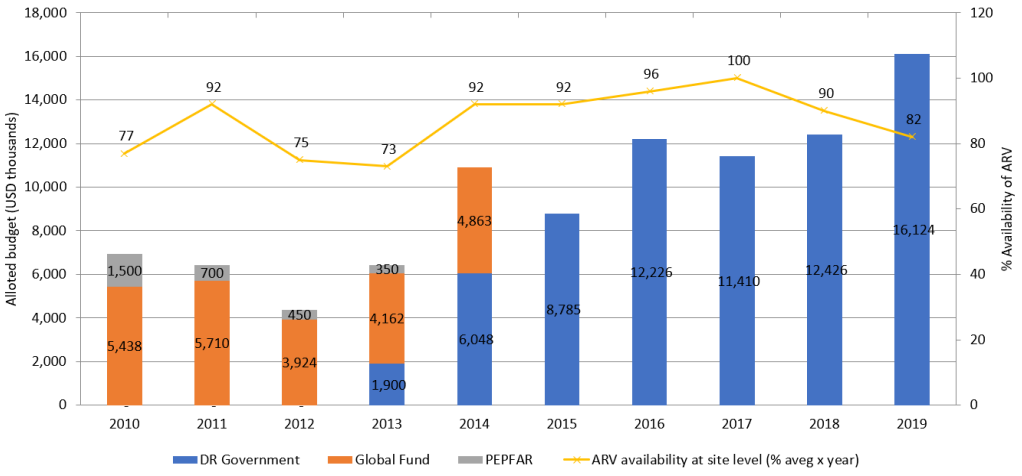
PEPFAR DR will continue improving VL Coverage and VL Suppression by expanding sample collection schedules, reducing lab turnaround time, and clinical management of VL results. PEPFAR DR will also develop a clear plan to analyze performance of VL testing to inform program implementation and identify challenges to initiate corrective action.

In addition, PEPFAR DR will strengthen patient education activities to promote compliance to ART and TB prophylaxis for effective VL suppression.

2.3 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 $16.1 million in 2019. 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. There is no financial gap anticipated for the procurement of ARVs in 2020.

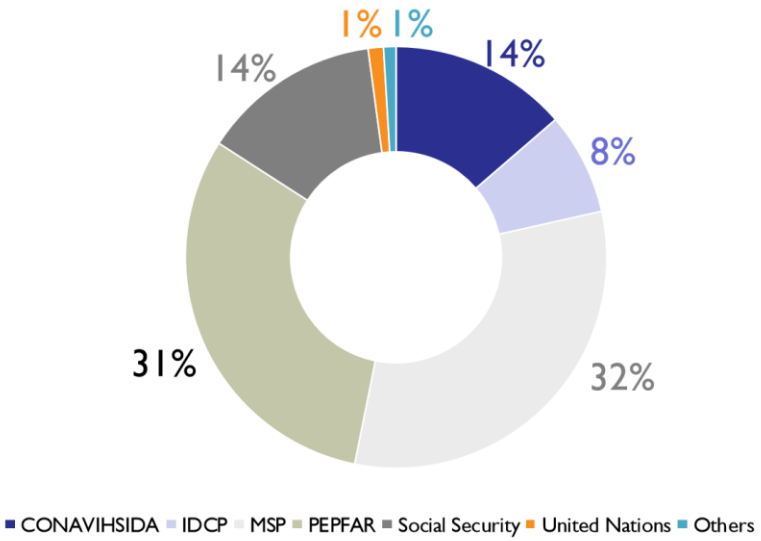
Figure 2.3.1 Transition of ARV & Commodity Supplies Purchases by GODR



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 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 $98/patient year in 2020. These cost savings allowed the GoDR to purchase optimized regimens with Dolutegravir.

Broader HIV financing data describing countrywide HIV investments in the DR continues to be scarce. The UNAIDS National AIDS Spending Assessment (NASA, or MEGAS in Spanish) is the most comprehensive HIV financial report to date.

Chart 2.3.2 Percentage of expenditures on the National HIV and AIDS Response by funding agent, Financial Gap Analysis, 2017



For 2016, the estimated gap between the funds required to implement the NSP and the expenditures from public and international development assistance sources was US $22.5 million. The program area Education and Prevention showed the largest gap (US $17.6 million), while the area of Above Site Expenditures showed greater expenditures than the estimated requirements. This gap is the result of an increased need to cover Strengthening the National Response and Comprehensive Care in Key Populations and the country roll out of the Test and START Strategy.

Table 2.3.3 Annual Investment Profile by Program Area, Projected 2020

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country
Clinical care, treatment and support	37,370,668	34%	1%	65%
Community-based care, treatment, and support	3,440,164	92%	7%	1%
PMTCT	1,011,200	-	-	100%
HTS	6,260,157	70%	15%	15%
VMMC	-	-	-	-
Priority population prevention	452,500	78%	20%	2%
AGYW Prevention	-	-	-	-
Key population prevention	$2,041,255	10%	65%	25%
OVC	3,200,000	100%		
Laboratory	5,378,774	15%	3%	82%
SI, Surveys and Surveillance	232,988	18%	82%	-
HSS	750,000	95%	5%	-
Total	60,139,706	42%	13%	44%

* HIV Resource Alignment Table and COP 20 Draft

Table 2.3.4 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	8,649,887.20	0	0	100%	0
Rapid test kits	1,087,124.00	0	0	100%	0
Other drugs	0	0	0	100%	0
Lab reagents	398,498.04	0	0	100%	0
Condoms	146,666.67	0	0	100%	0
Viral Load commodities	3,145,122.16	0	0	100%	0
VMMC kits	0	0	0	100%	0
MAT	0	0	0	100%	0
Other commodities *	2,685,459.61	0	0	100%	0
Total	16,112,757.68	0	0	100%	0

* *International insurance and freight

2.4 National Sustainability Profile Update

On November 19, 2019, PEPFAR, UNAIDS, the Ministry of Health, the National Health Service, and the National Council for HIV and AIDS, convened partners of the national HIV response to a one-day meeting to develop the SID 2019, reviewing updates in the political and legal context. Evidence was documented for each response, including a compilation of each policy, resolution, plan, studies, as documentary support. These documents were discussed prior to the event within the Senior Management Committee, which then proceeded to work and lead discussions at the workshop. The participants were divided into 8 groups, two (2) groups for each domain that included a) governance, leadership and accountability; b) national health system and service provision; b) financial strategy and market opening and e) strategic information. A hundred and thirty people (130) attended: 35% government, 36% civil society, 4% people living with HIV, 5% private sector and 20% international cooperation agency.

Strengths of Sustainability:

***Participation of civil society -CSO- (9.17 dark green)*:** The participation of CSOs at the level of policies, planning and implementation of HIV programs has been increasing. Many of them provide comprehensive care services as part of the national HIV response and complement the public network of services.

Product safety and supply chain (7.34 light green): The acquisition of HIV test kits, ARVs and other supplies is fully financed with funds from national sources; this element maintained its strength thanks to the considerable contributions of PEPFAR. The domain shows a slight decrease

compared to 2017 because the group only rated what could be verified with evidence justified with recent documents.

Mobilization of national resources (7.78 light green): The country has a financing strategy. The economic health insurance plan includes care and treatment, although they do not include ARVs, as they are covered by the Ministry of Public Health. The national budget includes explicit HIV financing. This element has had substantial assistance from the PEPFAR program.

Sustainability weaknesses:

Performance data (6.37 yellow): The reduction in the rating of this element reflects advances in international standards and guidelines that the DR has not yet adopted. In the country, there are multiple parallel information systems that routinely collect data on the provision of HIV/AIDS services. DR also need to reinforce and define reporting procedures on findings in data quality.

General: Some reductions in elements such as 1 (planning and coordination), 10 (laboratory) and 15 (financial and expense data) were caused by changes on previously established criteria, and adjustments in the qualification of some indicators. These elements remain as critical areas to be addressed within the national HIV response but do not necessarily represent a setback in sustainability in these areas.

Element 13 (market opening), which was measured for the first time, had a good rating. The country does not restrict the provision of HIV prevention services, testing or treatment, any qualified institution can do so. There are no restrictive elements for patient mobility within the comprehensive care program. Freedom of promotion or commercialization of HIV-related products or services is not limited and there is a universal quality policy.

As part of COP20 planning, the Ministry of Health committed to improve Test and Start by increasing the implementation of same-day ART initiation. Expansion of same-day initiation to all PEPFAR supported sites is planned for May 2020. This is a game changer for PEPFAR-DR since this approach will facilitate linkage to treatment for individuals with limited time and resources, especially among FC. For instance, PEPFAR-DR expects a 95% linkage to treatment after the effective implementation of same-day initiation. Differentiated models of care, especially multi-month dispensing, is on track as well as elimination of user fees in the public sector for PLHIV services. Continuous quality improvement (CQI) for site and program management expansion will continue and be implemented beyond the HIV program. PEPFAR will focus on scaling up the use of unique identifiers for patients across all sites and expansion of biometrics to all PEPFAR sites. National TB policy and co-infection TB/HIV guide exists and integrated TPT is now a routine component of the HIV clinical care package. Standard operating procedures (SOPs) for index testing exist for PEPFAR sites and are being implemented

As first implementation phase, PEPFAR is currently assessing Self HIV Testing (HIVST) to identify priority populations and its acceptability among them. PEPFAR will work with GoDR to update the country's testing policy and to ensure product registration, financing, acquisition and distribution.

PEPFAR will scale up HIVST implementation during COP20 by leveraging FC and KP service delivery platforms in four prioritized PEPFAR supported provinces (Santo Domingo, La Romana, Puerto Plata and Valverde). HIVST distribution will rely on peer networks to reach KP and FC who would not otherwise access HTS at facility and community level. PEPFAR-DR is also planning to evaluate local pharmacies as HIVST pick-up points. For FY21, PEPFAR has the following HIVST targets: 1,000 FC tested in 3 provinces; as well as 500 FSW, 500 MSM and 500 ICTT contacts tested in 2 provinces.

Since 2015, the GODR covers the entire costs of ARV. TLD transition is at 23% of annual target by February 2020 and expected to double by end of FY20. Overall, the results of the SID will support the updating of the National Strategic Plan and the upcoming proposals of the Global Fund.

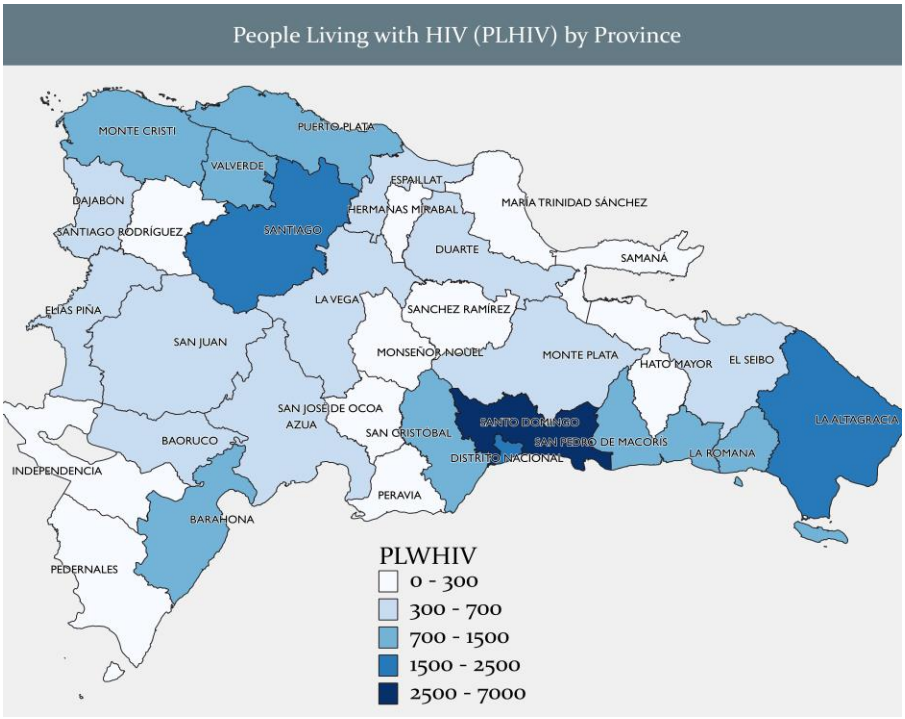
2.5 Alignment of PEPFAR investments geographically to disease burden

To broaden access to HIV services for FC, PEPFAR DR is expanding its presence to 4 provinces that border existing PEPFAR supported PSNUs: La Vega, San Cristobal, San Pedro de Macoris, and La Romana. The province of La Vega belongs to the same Health Region as Santiago and shares many socio-economic similarities. PEPFAR will make use of already established relationships with Regional authorities to help facilitate entrance into this province and further access to care for FCs. San Cristobal and San Pedro de Macoris are neighboring provinces to the greater Santo Domingo and have a significant FC population, due to their proximity to the capital city and its employment opportunities.

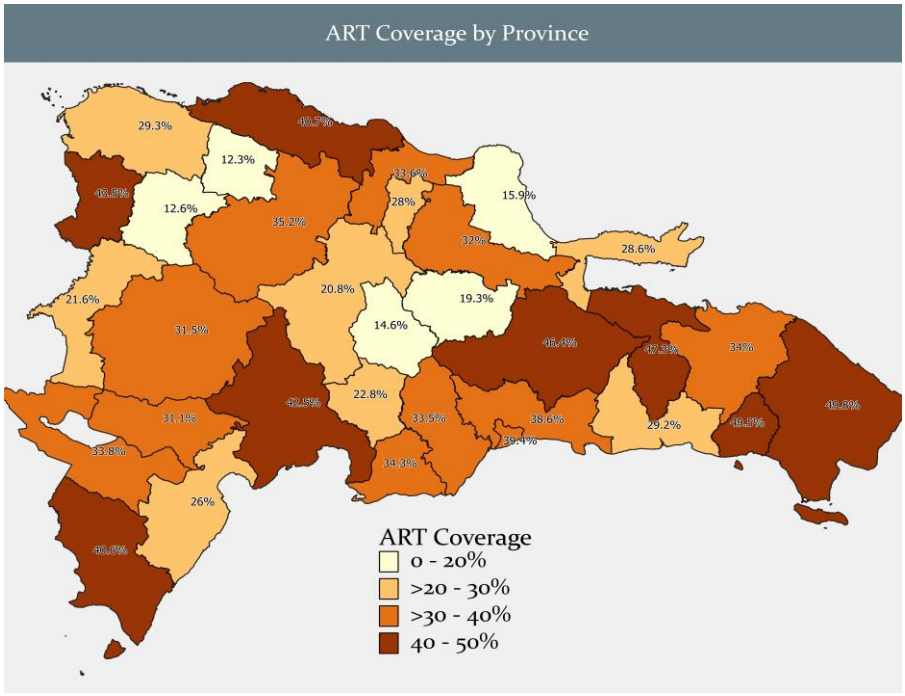
Historically, San Cristobal and La Romana were home to sugarcane plantations, which established communities (known as *bateyes*) for their workers, mainly FC. While some plantations are no longer operating, many of the descendants of the original settlers continue to live in the area. In the east, Santo Domingo, San Pedro de Macoris, and La Romana represent a natural economic corridor with a significant number of FC living with HIV.

Expanding PEPFAR's support to bordering provinces also facilitates program implementation due to existing ICH sites. For instance, Hospital Vinicio Calventi in Santo Domingo can serve FC living in San Cristobal.

Map 2.5 PLHIV in Dominican Republic, by province



Map 2.6 ART coverage in Dominican Republic, by province



2.6 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 almost two years 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 COP20 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 COP20 Planning Level Letter, particularly the directive to continue focusing toward FC 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.

A strategic planning meeting was held with key stakeholders from Civil Society, Ministry of Health, National Health Service (SNS), the Directorate for the Control of STI and HIV/AIDS (DIGECITTS), the National HIV/AIDS Council (CONAVIHSIDA) and PEPFAR partners to discuss COP19 progress and achievement of minimum program requirements. Consultations also included COP20 planning and addressing new priorities as community led monitoring and client centered approach. Community led monitoring will be based in three pillars: 1) Assessing services for meeting the needs of focused clients which will include expanding service hours, providing safe spaces and optimizing culturally and linguistically responsive services; 2) Working with healthcare provides to define and validate proposed client-centered services, Defining and assessing client centered services, mitigating stigma and discrimination in health facility and community services and engaging FC community members in services/ on staff and 3) Community Participation, which will include strengthening community engagement in PEPFAR, increasing transparent systems offering access to data and advocating for improvements/claiming a seat at the decision-making table. Several CSOs are being proposed to carry out the activities of community led monitoring and are expected to play a key role in COP20.

In COP20, with the MoH implementing partners and sub national, PEPFAR will co-sponsor activities to obtain feedback on the client centered approach and the benefits and challenges of its implementation.

The private sector, through companies and worker representative groups, are engaged through activities conducted by the National HIV/AIDS Council known as CONAVIHSIDA (Spanish acronym) and during the Sustainability Index Dashboard (SID) process. Entities such as Grupo Popular were present and showed interest in continuing discussion on possible synergies in the health sector. There is an opportunity for increased engagement with sectors that hire FCs 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.

In COP20 PEPFAR DR will continue engagement with government entities and civil society partners to ensure appropriate activities and enough coordination to reach aggressive targets. As appropriate, these meetings may include implementing partners and different government entities.

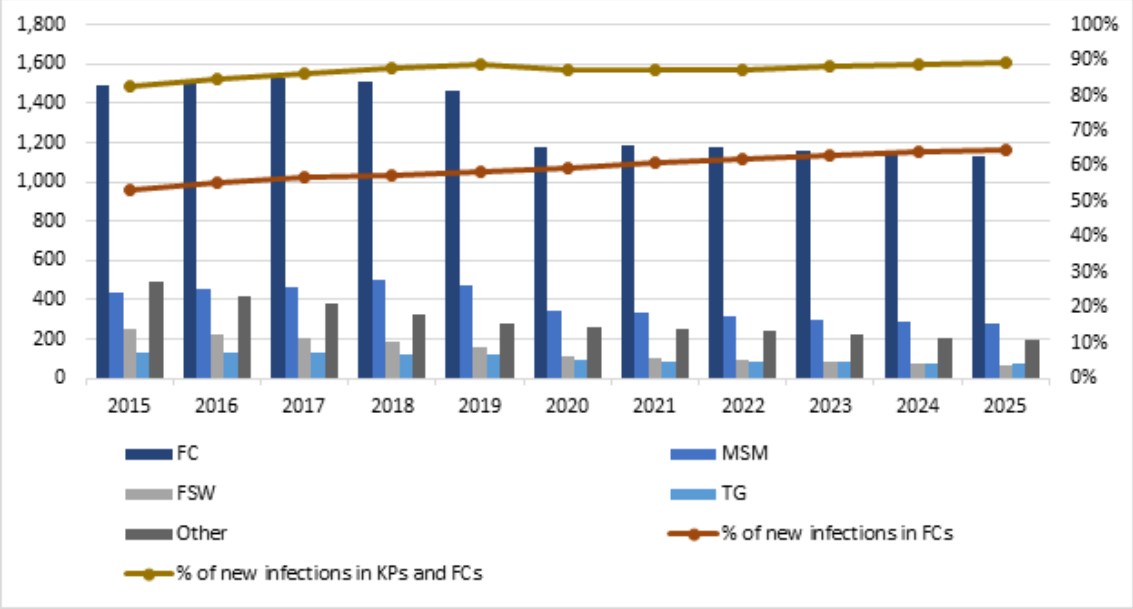
As issues arise, meetings and workshops may also be thematically organized to address specific challenges.

Coordination with government entities continues to be of relevance, especially as the shift to client centered approach requires innovative and tailored services to meet the needs of focus clients. In order to meet these needs, it is important that the GODR enable the continuum of care in mobile services and primary care centers and the delivery of ART through different distribution points, including community pharmacies (Farmacias del Pueblo) and by trained community health workers.

3.0 Geographic and Population Prioritization

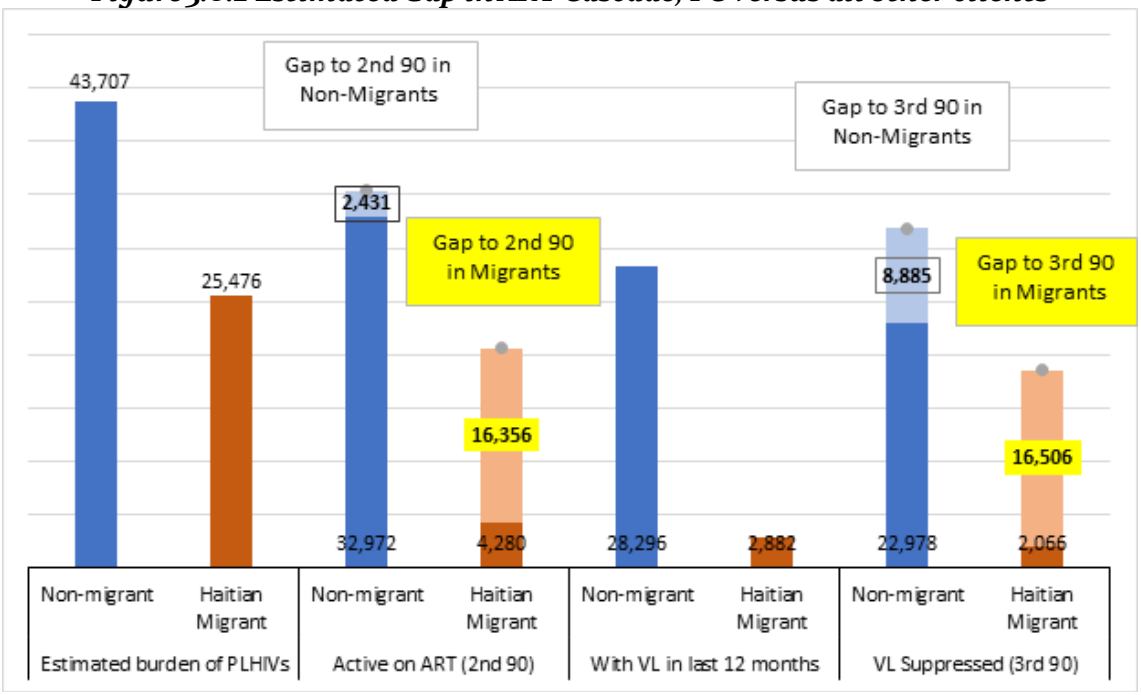
The HIV epidemic in the DR is concentrated both by population and geography. In 2020, 82% of new infections are expected to occur among key and priority populations, with the largest proportion (59%) occurring among FC, a trend that is expected to remain stable over the upcoming years (see Figure 3.0.1). As FC are disproportionately affected by HIV and have significant limitations accessing health services in Dominican Republic, PEPFAR DR will continue focusing on closing case finding and treatment gaps among this vulnerable population (Figure 3.0.2). Without intensive prevention, testing and treatment interventions that specifically target this population, epidemic control 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, 2015-2025



Source: Spectrum, 2019

Figure 3.0.2 Estimated Gap in ART Cascade, FC versus all other clients



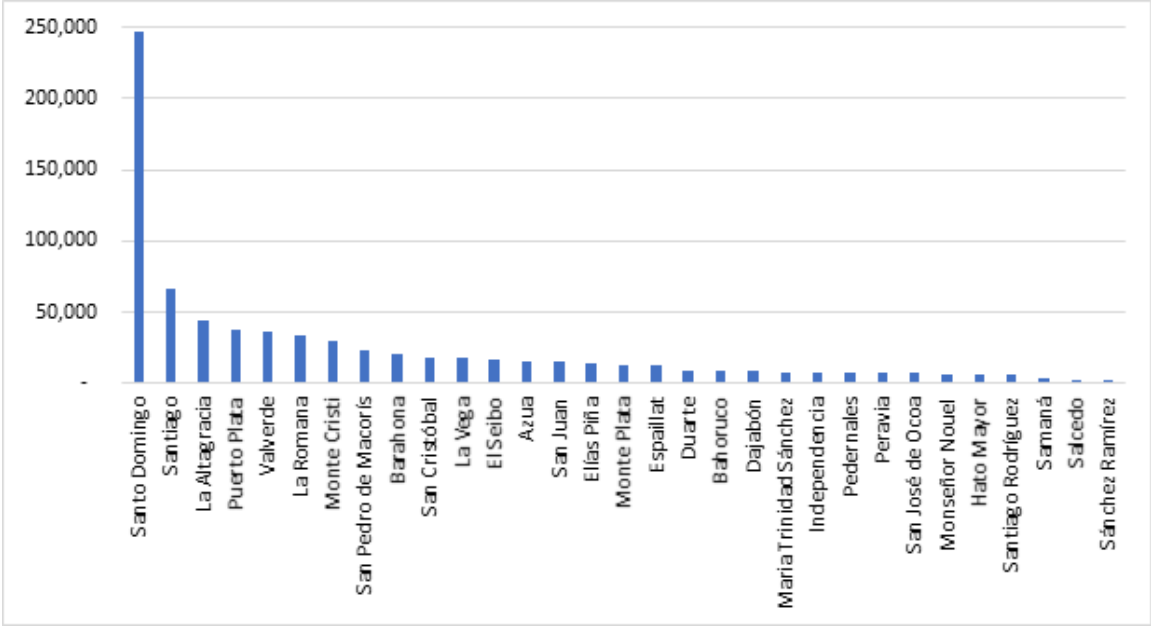
Source: Spectrum 2019, DR HPIMS

The correct understanding of geographic distribution of FC is vital for program design. Initially, the general perception had been that finding HIV+ FC predominantly requires work in rural areas. Starting in COP16/FY17, 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 or FC 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 began in areas where populations of interest were present in highest concentration and in provinces with the most experience approaching KPs and PPs: Santo Domingo, La Romana and Puerto Plata (Santiago was included, but at a much smaller scale). In COP 18/FY19, the project expanded its reach to include places where the burden of HIV disease was higher among FC, such as La Altagracia, an eastern province and popular tourist destination; and Dajabon, Montecristi and Valverde (northwest provinces that border with Haiti).

During COP18, the PEPFAR-DR team took note of various findings that highlighted the disproportionate HIV burden in FCs, and sought to build on experiences gained from working with KPs and PPs in the previous three years to focus on closing cascade gaps among FC. During the COP19 preparation phase the DR pivoted in focus population from KPs to FCs. COP19's geographic prioritization was the result of an extensive data triangulation exercise conducted in collaboration with the MoH and FC-focused community organizations. The 2017 National Immigrant Survey provided essential information about the distribution of FCs around the country (Figure 3.0.3). This information was then combined with 2017 IBBSS results to estimate the burden of HIV in FCs in each province. Triangulating FC HIV prevalence data against PEPFAR and national treatment data then helped the PEPFAR team to further identify areas with the most significant treatment gaps for FC, and the results of this analysis formed the basis for geographic targeting of PEPFAR investments for COP19. Breakdowns of numbers of individuals on treatment by province, sex, KP and, the data

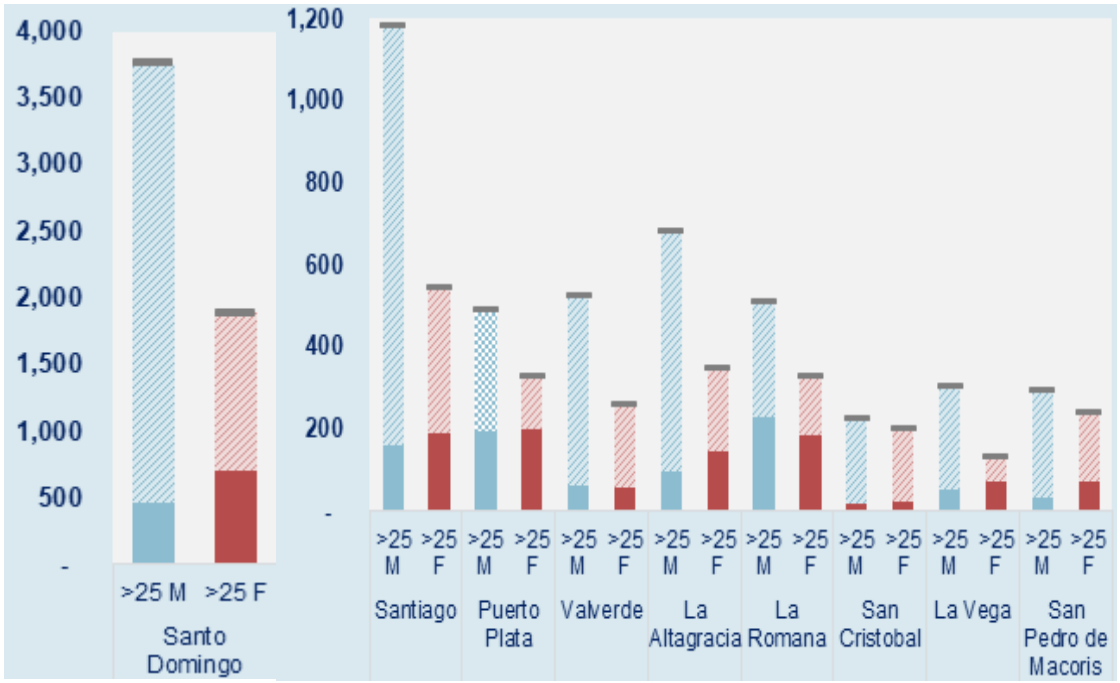
instead showed that the greatest gaps are in the country's large urban centers. This same analysis also highlighted that men consistently exhibit a larger treatment gap than women.

Figure 3.0.3 Number of Dominicans of Haitian Descent and Haitian Migrants in the Dominican Republic, by Province



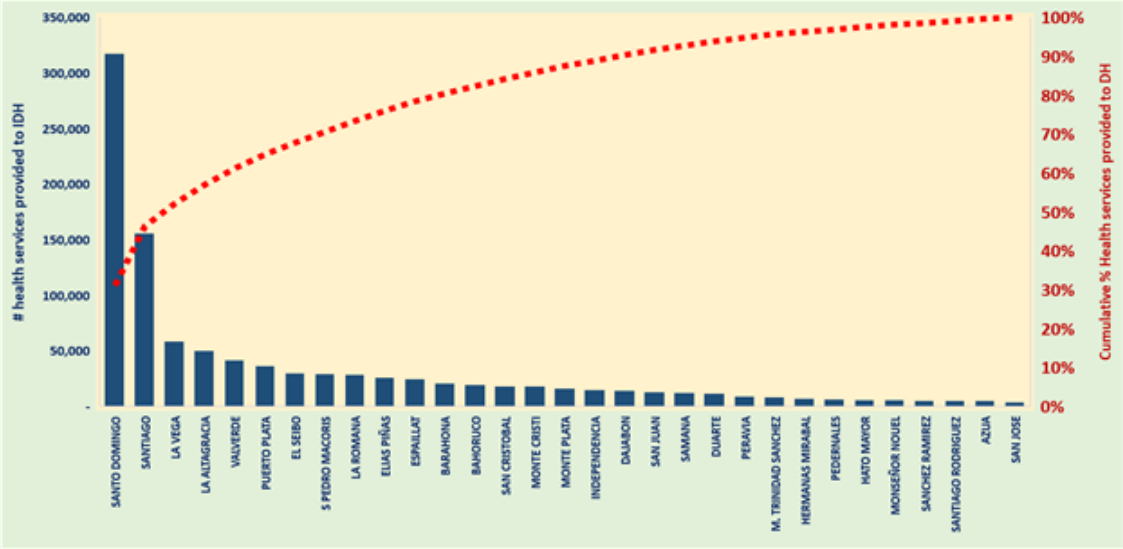
Source: National Immigrant Survey, 2017

Figure 3.0.4 ART Gap in FC by Sex in COP20 focus provinces



Statistics compiled by the National Health Service (Servicio Nacional de Salud, SNS), the MoH branch responsible for health services delivery, include information, by province, on emergency and non-emergency clinical encounters with FC clients. This information was used as a proxy for identifying geographic areas where FC are present, and health facilities where they seek medical attention. The provinces that delivered services to FCs in highest numbers in 2018 were Santo Domingo, Santiago, La Vega, La Altagracia, Valverde and Puerto Plata (Figure 3.0.6). Analysis of the FC clinical encounter data therefore largely dovetailed with the comparative gap analysis, thus validating the selection of Santo Domingo, Santiago, La Altagracia and Puerto Plata for PEPFAR support. The high number of FC clinical encounters in Valverde, in addition to data that suggested the existence of gaps in the HIV cascade among FC in that province (not surveyed in the IBBSS), led to its addition as the fifth PEPFAR-DR focus province for COP19. To reach a population group believed to be hesitant to seek medical services generally, presence in provinces like Valverde that attract FC into clinical facilities provides a valuable entry point for the provision of HIV services.

Figure 3.0.5 FC health services encounters by province, 2018

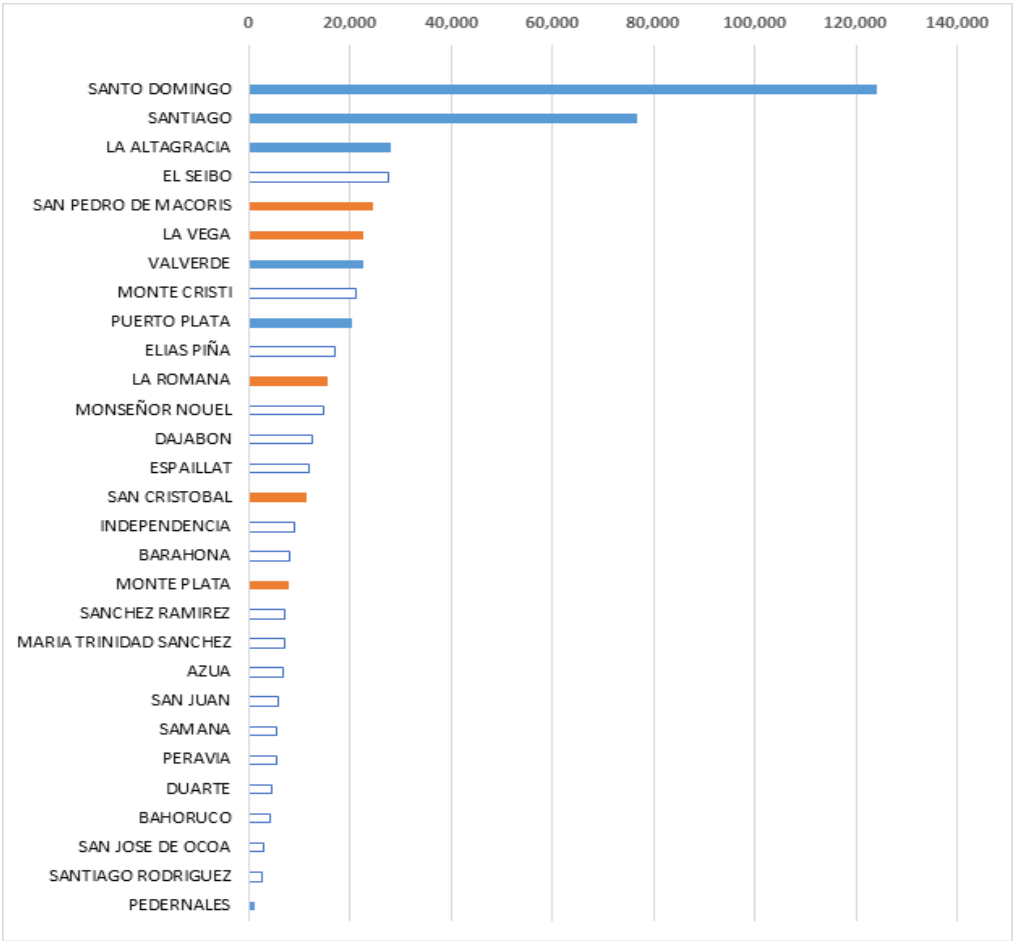


Source: National Health Services, 2018

COP20 will continue with the program pivot introduced in COP19 to focus resources and efforts in FC in high-volume sites. In COP20, PEPFAR will maintain its presence in the five provinces identified for support in COP19 and will expand to also include the provinces of La Romana, La Vega, Monte Plata, San Cristobal and San Pedro de Macoris. La Romana has been receiving PEPFAR support for work with key populations since 2015, but its COP19 programming was supported entirely through KPIF funds. The inclusion of La Romana in COP20 will benefit from previous PEPFAR and GoDR investments provided to the HIV Care sites. La Vega, San Cristobal and San Pedro de Macoris are provinces with relatively high FC presence (based on SNI results and SNS data about health services provision). In addition, all new provinces border COP19 provinces creating natural corridors within DR. For example, La Vega residents routinely travel to Santiago province for school, work, trade, leisure and health care seeking, and vice versa. San Cristobal is similarly

interconnected to Santo Domingo, and San Pedro de Macoris forms a natural corridor between Santo Domingo, La Romana and La Altagracia. In Monte Plata, HIV testing activities are already being implemented with PEPFAR support in FY20. Inclusion of the province in COP20 planning will formalize PEPFAR presence in HIV Care Sites in that province to enhance the provision of services to FC along the HIV clinical cascade.

Figure 3.0.6 FC health services encounters by province, 2019



Source: National Health Service, 2019

Table 3.0.7 Current status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	0%	N/A	0	0
Scale-up Saturation	0%	N/A	0	0
Scale-up Aggressive	100%	19,833	5	10
Sustained	0%	N/A	0	0
Central Support	0%	N/A	0	0

4.0 Client Centered Program Activities for Epidemic Control

To meet the UNAIDS 90–90-90[8] targets, marginalized subpopulations such as FC need to be reached. Migrants and mobile populations, including FC, 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 accessing health systems at local, national, and global levels. Evidence from different settings globally shows that migrants have a disparity in access to and use of HIV-related health services when compared to non-migrant populations.[9] 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.[10]

PEPFAR DR support includes strengthening the provision of HIV services through capacity building and supervision activities for health providers, to ensure HIV services are provided stigma and discrimination-free with the required psycho-social and treatment adherence support as well as supporting the distribution of population-specific materials and strengthening data collection/data management systems at sub-national and national levels. To effectively reach FC in COP20, PEPFAR DR will significantly increase community-level efforts, ranging from case-finding and HIV testing to community-based care and support services.

In COP20, provision of HIV services will be expanded through the community, as a major effort to expand access to treatment and other HIV related health services. Based on COP19 implementation, PEPFAR DR will implement same-day ART initiation and ART distribution at the

[8] Currently the DR has international agreement to 90-90-90 schema.
[9] Faturiyele, Iyiola, 2018; Bil, Janneke, 2019; Vearey, Thomson, 2017.
[10] Tanser, Bärnighausen, Vandormael, & Dobra, 2015

community level in PEPFAR-supported provinces. For COP20, HIV care and treatment will be decentralized, taking the services closer to FC, either to a facility closer to their homes or to some place within the FC communities. Shifting from HIV facilities to primary care units, mobile clinics and/or community pharmacies, will depend on assessments of the HIV prevalence and the setting (urban or rural). PEPFAR DR will work with the GoDR to institutionalize task shifting and task sharing on ART delivery so that for the provision of routine HIV care 1) trained and supervised community health workers are able to dispense ART between regular clinical visits; and 2) trained and supervised lay providers are able to distribute ART in the community. Provision of HIV health-related services from the community will increase linkage to treatment. Community peer navigation and individual-case management will promote adherence and retention. The engagement with central and regional health services will be established in COP19 and is expected to engage regional and provincial health authorities further strengthening involvement by the MoH authorities and their interest in integrating HIV services into primary care in the country.

The portfolio will also include activities to address systemic challenges that hinder epidemic control, such as standardizing the provision of HIV services among health providers, developing policy or standardized procedures for the expansion of routine HIV care and HIV treatment provision in the community, enhancing the supply chain for MMD and TLD transition, strengthening adherence activities, supporting viral load roll-out and adapting clinical care and outreach materials to be culturally and linguistically responsive to FC.

PEPFAR activities for COP20 continue to expand on the pivot to FC. The strategy and related activities are designed to support a range of targeted interventions aiming to achieve HIV epidemic control in targeted areas within nine prioritized provinces. PEPFAR DR will continue adjusting for a client-centered approach -considering patients' needs and preferences and shifting resources and efforts to reach those in greater need. In coordination with GoDR, PEPFAR will define and implement fast-track services to reduce unnecessary burden at the health facilities. In addition, PEPFAR will intensify community activities as an effort to reduce individual and structural barriers to access HIV services, including stigma and discrimination, and as effective platform to use incentives and improve progression through the HIV treatment cascade.

To reduce stigma and discrimination, PEPFAR DR will implement continuous training, coaching, and supportive supervision of facility-based and community-based health providers. All teams will have creole-speaking health providers or have access to real-time translation services. In addition, community-led monitoring will facilitate effective feedback and corrective actions at providers' levels. UNAIDS will work with local CSOs to implement community-led monitoring focusing in three pillars: assessing health services to adjust them based on FC needs (e.g., expanding service hours or providing safe spaces), defining and assessing "client centered" services, and improving community participation to ensure community engagement and accountability. PEPFAR DR will continue creating opportunities for South-to-South collaboration with regional offices (Latin America and the Caribbean) or countries, including Haiti, facing similar situations or contexts.

4.1 Finding the missing and getting them on treatment

The most recent data shows that the burden of the HIV epidemic is particularly high among migrants from Haiti, estimated to represent 30% (20,191) of all PLHIV (People living with HIV) above 15 years of age in the Dominican Republic (Dolores & Caballero, 2017). In 2018, data from the national HIV information system (Formulario de aplicación a programas de politicas sociales-FAPPS in Spanish) shows that women account for the majority (57%, n=2,382) of PLHIV within the Haitian origin population, while the majority (63%) of Haitian migrants living in the Dominican Republic are men, suggesting a potential gender-based gap among populations of Haitian origin when accessing and using HIV related health services -further analysis will be implemented with programmatic data from FY20 and FY21.

For COP20 activities, PEPFAR DR will focus on innovative and cost-efficient strategies tailored to the local epidemiology and ART coverage amongFC -with an appropriate mix of facility and community-based approaches. All HIV testing activities will follow normative guidance and protocols to ensure consent, confidentiality, adequate counseling, correct results and connection to treatment. As part of the optimization process, DR will focus on weekly and monthly monitoring of testing and linkage to treatment efforts, as well as the implementation of a risk screening tool to ensure testing efficacy and effectiveness to maximize impact.

PEPFAR will support client-centered activities to optimize case finding and linkage, through a diverse and complementary set of interventions targeting FC, that include:

- **Identifying which groups require further attention**: focusing efforts on most vulnerable FC populations (men, TB patients, older adults, key populations, etc.).
- **Implementing tailored strategies focusing on FC**: using strategies to make HIV testing and ART initiation more efficient by:
    - *Introducing innovative case finding approaches* at facility and community-level combined with a systematic offer of index case testing and tracing (ICTT) for HIV+ individuals' and their biological children. In compliance with the WHO minimum standards of HIV care, DR will offer ICTT for all newly diagnosed and current PLHIV in treatment -especially among PLHIV who are not virally suppressed. As part of COP20 implementation, negative contacts will be linked to PrEP services in selected supported facilities, amore efficient modalities of ICTT, such as assisted HIV partner notification and establishing a point-of-contact for ICTT at each site or community team, will be used. PEPFAR DR will increase the number of teams implementing ICCT at the community level and will continue implementing strategies to maintain confidentiality during the implementation of Provider Assisted Referral -for example, offering testing services to contacts as part of already planned testing services in FC communities or hot spots. Strengthening M&E tools and remediation systems will allow PEPFAR DR to better track and respond to potential incidents related with family violence or gender-based violence (GBV).

- *Optimizing Provider Initiated Counseling and Testing through integrated care services.* PEPFAR DR will increase HIV testing coverage in priority clinical areas (TB service, STI service, hospital inpatient department entry points, etc.) and strengthen collaborative TB/HIV/Hepatitis activities.
- *Improving Social Network Testing:* Enhanced Peer Outreach Approach (EPOA) has shown promising results in the DR. EPOA had a 2-fold increase in positivity rate and ART initiation rate in comparison to other testing approaches at the community level, in Q1 FY20 implementation. PEPFAR DR will continue building on EPOA and will expand the strategy from current supported sites during COP19 to the new supported province in COP20. Selected sites (3 sites planned in COP20) will implement blended ICTT and EPOA to reach FC in a timely manner. FC will identify sexual partners during ICTT elicitation and will receive coupons to refer other social network members (coupons promoting free counseling and testing, and ART initiation package). Based on COP19 lessons learned, PEPFAR DR will also use EPOA as a platform to introduce HIV self-testing (HIVST) through partner or peer distribution for FC and Key Populations. PEPFAR DR will ensure the national policy facilitates linkage to further testing, prevention and treatment following HIVST.
- *Optimizing the provision of HIV testing services:* Building on successful COP19 approaches, PEPFAR DR will expand the implementation of flexible clinic hours to increase FC access to testing and care services outside working hours and on weekends. Availability of friendly services is a priority for PEPFAR DR (more information in 4.2). Implementing risk screening tools to identify FC most likely to be HIV-positive at facility and community-level and conducting micro-level mapping to identify HIV hotspots will provide more effective HIV programming. Community efforts for FC men will focus on "hotspots" where FC men congregate - including after-work social gatherings and venues know for sex work. PEPFAR DR will review community strategies on a monthly basis to adjust based on positivity yield and ART initiation rates. Establishing a "warm handoff" protocol between Clinical/community care efforts and the OVC programming for eligible clients will also strengthen linkage to care.
- *Strengthening information systems and registries:* Safe and secure biometric coding systems will be implemented at the community level and will reinforce the registry of HIV testing activities and the adverse events reporting systems at health facilities.
- *Maximizing case finding:* PEPFAR DR will introduce recency testing in COP20 to help identify new clusters of transmissions and inform and maximize the efficiency of testing contacts.
- *Reinforcing test and start:* Through a comprehensive approach in COP19 PEPFAR DR will develop and implement SOPs for same-day-initiation packages, particularly for community-based settings and scale these up in COP20. PEPFAR DR will increase efforts to test and treat FC men, who are more reluctant to engage. PEPFAR

DR will review approaches on a monthly basis to adjust based on positivity yield and ART initiation rates.

- **Adapting HIV services across the cascade**
  - *Implementing a client-centered approach:* Adapt HIV service delivery to be more client-centered, considering patients' needs and preferences and shifting resources and attention to patients more in need.
  - Reducing unnecessary burden at the health facility, simplifying and creating fast-track refills or lines.
  - Reducing individual and structural barriers to access HIV services, by alleviating difficulties locating and tracking newly diagnosed individuals, normalizing HIV testing, diminish the stigma and discrimination and using incentives to improve progression through the HIV treatment cascade.

- **Creating opportunities for South-to-South learning**
  - Establish a closer collaboration with regional offices (Latin America and the Caribbean) and similar countries, especially Haiti.
  - Identify and share best practices among implementing partners in-country.

4.2 Retaining clients on treatment and ensuring viral suppression

PEPFAR activities for COP20 continue to expand access and quality of service for FC. This necessitates building on a new strategic direction, decentralizing the provision of HIV services, and a close coordination with the GoDR. The proposed strategy and related activities are designed to support an upsurge in service entry points to effectively reach HIV+ FC in targeted areas.

PEPFAR DR will focus on solving FC specific barriers for same-day ART initiation, multi-month dispensing (MMD), and client-centered approaches. PEPFAR will complete TLD and MMD scale-up in COP19 sites and begin implementing these strategies in new supported provinces. PEPFAR-DR will work with GoDR to continue with the gradual transition of the remaining percentages of eligible patients (40%) during COP20 based on the reduction in the availability of EFV.

The client-centered approach in COP20 will include client friendly services at the facility and community level. Health providers will be trained and sensitized to provide respectful and friendly services. Health services will be provided by creole speakers or translation will be available if needed.
Activities include:

- **Case management**: Case Managers are vital to improve retention of patients through-out all stages of the HIV cascade, PEPFAR DR will improve procedures at health facilities for immediate treatment initiation, increase viral suppression, and to work stigma and discrimination reduction. In FY21, PEPFAR DR will start implementing tele-medicine and other communication technologies for enhance case management.

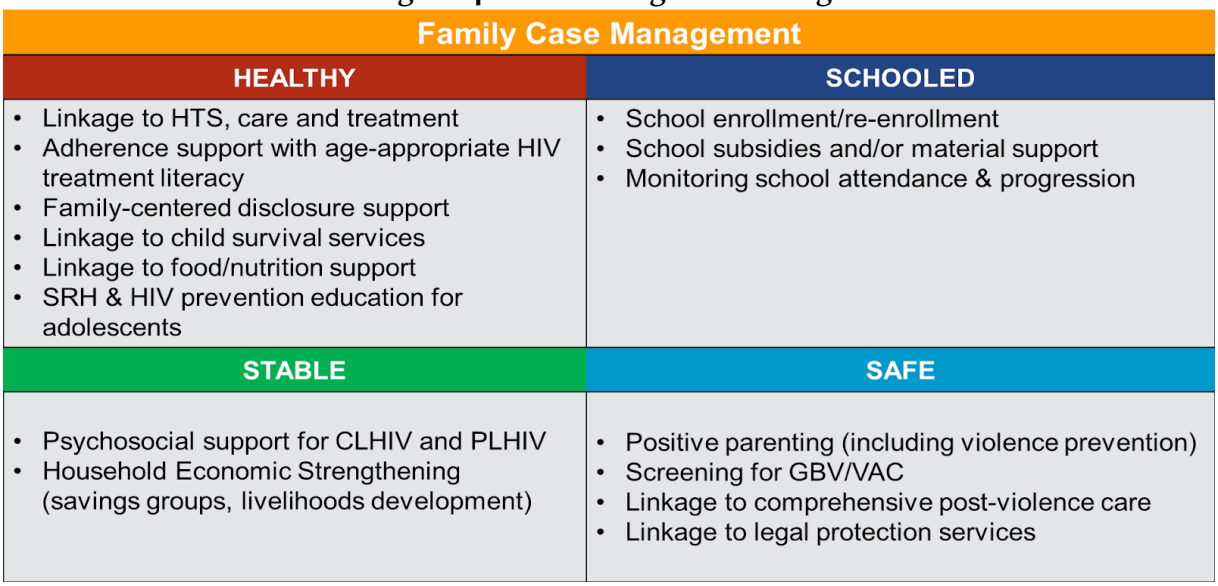
- **Individualized and group support:** Patients will be invited to participate in structured sessions led by trained peer-counselors or stable patients on ART, to give peer support among patients. Navigators and community workers will continue as the backbone approach to implement tailored counseling and follow-up for FC. Based on existing local experiences, PEPFAR DR will start the implementation of adherence clubs and support groups in the community to ensure continued adherence and viral suppression.
- **Differentiated models:** PEPFAR DR will work towards the implementation of alternative treatment delivery models, with a province-specific mix of MMD at the facility and community service delivery. FC starting ART will receive a 2 weeks start-up package -ARV for 2 weeks, SIM card for follow-up, nutrition support, transportation allowance, and paid lab test. PEPFAR support will be extended to 3 or 6 months until trust is built for effective retention. For effective follow-up, each new FC in ART will be assigned to a community worker for weekly check-in and will receive appointment reminders through SMS.
- **Decentralized ART delivery:** ARV decentralization is one of the main priorities for PEPFAR DR as community-based approaches better suit FC behaviors and need and complement existing facility-based delivery. Facility-based delivery will offer ART initiation and refills using flexible hours (early morning and evenings) and days (weekends). "Out-of-facility" models will include ART initiation packages and ART refills through community workers/teams and mobile clinics. Facility extensions at the community include the use of primary-care facilities and public community pharmacies for ART refills among stable patients -as they won't need clinical appointments.
- **Simple and standardized monitoring systems:** PEPFAR DR will optimize the implementation and use of LTFU log register for timely improvements at facilities and community sites -robust data collection, entry and analysis to address bottlenecks. DR will increase the identification of contact methods and distributing SIM cards as soon as patients are recovered. PEPFAR DR will use SMS to pre-appointment reminders and supportive counselling.
- **Improve viral load coverage and viral load suppression:** Viral load sample collection schedules at site level will be expanded from 1-2 to 4-5 days per week, while improving reporting systems aiming to reduce delivery time of results to zero. PEPFAR DR is working towards the expansion (from one to four) of viral load processing laboratories at national level, and towards improving specimen processing and handling.

  PEPFAR DR will provide technical assistance to develop and implement SOPs to identify and manage virologic failure among patients and support SOP implementation on how to switch the ART regimen. In addition, PEPFAR DR will strengthen patient education activities to improve viral load monitoring and treatment adherence.

- **OVC Service Package for FC Families** will include interventions for children (up to 18 years of age and up to 21 years old if in school) 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 4.2.1 OVC Program Package



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 COP20, service delivery will also include adding HIV care to other fixed sites to facilitate proximity to FC and their communities to enable their engagement with an active health-seeking behavior based on their current needs. In summary, this new approach will allow an efficient link to care while increasing retention rates, as FC will be able to both initiate treatment at the community level and obtain ART via community dispensation. This new approach 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 FC 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 FC.

4.3 Prevention, specifically detailing programs for priority programming

PEPFAR-supported PrEP was first offered in the DR in COP17 (Figure 4.3.1). Four hundred and nine new individuals started PrEP in COP18, and 191 in Q1 COP19. In COP20, PEPFAR will continue expanding PrEP availability within the limits set by the GoDR for medication availability (maximum of 2,400 patients active on PrEP). COP20 expansion will include offering PrEP to serodiscordant couples and breastfeeding women. The expansion will also include introducing PrEP at public facilities. PEPFAR will use a phased approach, starting with a "controlled" expansion to monitor client satisfaction and program results. If results are positive, PEPFAR will move to a second and more aggressive expansion phase. If not, PEPFAR will implement CQI actions immediately to provide for course correction. In COP201, PrEP will be available in all PEPFAR provinces.

Figure 4.3.1. PrEP expansion in the Dominican Republic, COP17-COP20

Year	Provinces	Eligibility	PrEP_NEW Target	PrEP_CURR Target
COP17/FY18	Santo Domingo	MSM TG	150	N/A
COP18/FY19	Santo Domingo Puerto Plata La Romana	MSM TG FSW	450	N/A
COP19/FY20	Santo Domingo Puerto Plata La Romana La Altagracia	MSM TG FSW	700	810
COP20/FY21	**Santo Domingo Puerto Plata La Romana La Altagracia Santiago La Vega San Cristobal San Pedro de Macoris**	**MSM TG FSW Serodiscordant partners Breastfeeding women**	**1,843**	**2,316**

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

Haiti-Dominican Republic Cross-border Collaboration and Coordination

The Haiti and Dominican Republic (DR) PEPFAR programs will establish a coordinating body to work to improve referrals across the island and improve efforts to retain in treatment those PLHV that cross the Haiti-DR border, building on a model used to coordinate TB cross-border programming. In COP19, joint site visits at the border and facility site visits within each country have been programmed.[11] The population of concern for both countries include i) HIV positive individuals of Haitian descent engaged in bidirectional travel across the border and ii) HIV positive clients living in one country but accessing services and ARTs in the bordering country. Continuing into COP20, guidance will be developed in both countries to provide the needed supply of ART and potential referral locations to PLHIV 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 PLHV and supportive services to stay in care. The team will collaborate to ensure the interoperability of technology to ensure that providers in both countries have access to their patients' clinical information in order to ensure high-quality patient-centered care.

Funds for DOD: 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 FC. 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 FC. PEPFAR will also work with medical personnel at military facilities to ensure that FC 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.

4.5 Commodities

[11] In response to COVID-19 as of the writing of this document the border between Haiti and the DR is closed and both countries are on expanded curfews. These visits will be rescheduled once the situation changes.

PEPFAR DR will continue assisting GoDR on supply chain management for HIV commodities, from testing supplies and antiretrovirals to lab supplies for effective viral load monitoring. Technical Assistance (TA) will include participation on technical working groups, direct advice for timely and realistic quantification, efficient procurement and delivery, as well as effective distribution up to site level to support the implementation of differentiated service delivery models, including Multi Month Dispensing (MMD).

PEPFAR DR will continue supporting GoDR on the transition to TLD in new PEPFAR supported provinces. The transition process includes design and distribution of a prescription job aids to promote adherence to guidelines, training, as well as monitoring and supervision plans to track effective transition to TLD.

At sub-national level, PEPFAR will support inventory management improvement, effective use of information systems and reporting/requisition procedures, and distribution to sub-national warehouses. Updated SOPs for supply chain management systems will be implemented in new provinces.

At the site level, PEPFAR DR will continue enhanced TA for warehouse/pharmacy storage, inventory management, dispensing practices, recording and reporting procedures, monitoring and evaluation, and reverse logistics for redistribution overages or disposal of expired commodities. Sites' pharmacy/warehouse management will include a needs assessment, quality improvement plans, and strong coordination with clinical services for the effective use of optimized regimens. PEPFAR DR is planning to reach one hundred percent stock status observations from storage sites showing "stocked according to plan" results at sub-national levels by Q4 FY21.

PEPFAR DR will also update current guidelines and SOPs for the implementation of models for ART initiation in the community and community ARV distribution. PEPFAR will oversee the direct implementation of community services, ensuring the availability of testing, drugs, and lab supplies. PEPFAR DR will update existing guidelines, SOPs, and procedures, to ensure the availability of HIV and TB lab supplies in PEPFAR supported sites. This process includes training and supportive supervision and monitoring.

The quality of pharmaceutical services depends critically, on the availability and quality of the pharmaceutical management information. PEPFAR DR will support the national health information systems (FAPPS and SUGEMI) to provide credible information on health commodities consumption, stock levels and utilization of HIV products (including dolutegravir). PEPFAR DR will facilitate the implementation of the ARV prescription and dispensation module to make it available in all PEPFAR supported sites.

Pharmaceutical management information systems and quarterly monitoring reports (dashboards) will be fundamental to prevent stockouts. PEPFAR will conduct data quality analysis on selected

sites to ensure consumption data is being used for decision making. For COP20 implementation, PEPFAR will increase the frequency of supportive supervisory visits to provide on-site technical assistance on a monthly basis.

As part of the process initiated in COP19, PEPFAR will systematize all supply chain innovations implemented. This systematization includes not only programmatic components but also expenditures to better inform GoDR on scale-up scenarios.

4.6 Key Populations

With Key Population Investment Fund funding, in COP20 the DR will continue to focus on optimized case identification, linkage to treatment, and reinforced retention in treatment for viral load suppression among FSW, MSM, and Transgender populations.

HIV case finding and linkage to care activities will maintain focus on risk assessments, mapping, microplanning, EPOA, HIVST, risk referral network testing, ICTT, and support for community health workers. The DR PEPFAR team, with close collaboration from SNS, CONAVIHSIDA, and DIGECITSS, will implement differentiated models of care for KPs as a priority in FY21. These activities include integrating community ART initiation and refill, with MMD, to strengthen linkage and retention to treatment.

To achieve viral load suppression among KP, ART delivery and adherence activities will be complemented by accurate and timely viral load monitoring and reporting. Community partners and peer navigators will work closely with facilities to enable timely and proactive delivery of VL results and linkage to supportive services. This includes adherence support and treatment literacy to ensure continued treatment and VL reduction, following the U=U approach. PEPFAR DR will also increase the use of information, communication technology, including social media, to help with virtual adherence support and treatment literacy, recognizing that maintaining some KPs requires innovative strategies.

DR will increase demand for and access to pre-exposure prophylaxis (PrEP) for KPs in close coordination with SNS, CONAVIHSIDA, and DIGECITSS. All KP activities will include the distribution of condoms and lubricants, through peer educators, or at hotspots, as well as strategies to mitigate stigma, discrimination, and violence. All KPIF sub-grantees will receive training on gender-based and intimate partner violence (GBV) mitigation and response strategies, such as post-exposure prophylaxis (PEP), how to appropriately detect and respond to violence, and support legal referrals.

4.7 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.

At OU level, PEPFAR DR utilizes a data-driven CQI methodology aimed at optimizing HIV/TB clinical care in PEPFAR-supported sites in the Dominican Republic (DR). Combining CDC and USAID's Granular Site Management approach and key elements from the MER (2.4) guidelines, PEPFAR DR seeks to identify bottlenecks and challenges whilst also providing solutions via both technical support and close supervision.

This CQI initiative adds necessary technical and support personnel to better deliver direct technical assistance to sites and ensure achievement, from community outreach, to linkage to treatment and viral suppression. This support includes, but is not limited to, monthly visits at the site level, high-frequency weekly e-reporting, weekly calls with IMs, monthly results discussion meetings, and quarterly results discussion meetings. This CQI methodology is meant to be a collaborative process between sites and PEPFAR DR personnel to provide solutions for challenges and bottlenecks found in HIV care sites. The process is data-driven, as PEPFAR uses high-frequency reported data to identify possible challenges and benchmark proposed solutions. The process incentivizes teamwork and promotes active participation from sites' teams. It also values solutions proposed by them. PEPFAR DR fully stands for a collaborative approach at the site level which can increase performance, create better rapport with our partners, increase sites' data-based capabilities for decision-making, and improve the quality of the service provided to PLHIV.

PEPFAR site-level support includes the CQI methodology, which also 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. More importantly, PEPFAR DR provides technical data analysis and triangulation of HFR information to promote a data-driven culture at each site. 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.

Positive outcomes and lessons learned from the CQI Collaboratives include establishing a practice of data analysis and use of data for decision-making. CQI Collaboratives 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 and reduced wait time of HIV test results; increased HIV yield of facility- and community-based testing; 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.

An additional layer of accountability will be integrated to the COP20 implementation via Community-led monitoring. Civil society, alongside PLHIV and clients of PEPFAR supported services, will lead several actions to ensure services are both of high quality and aligned with their needs. Their participation will be in three clusters: a) assessing if the services meet FC needs (assessing client centered services); b) assessing results and performance (PEPFAR efficiency), and c) assessing accountability and transparency of PEPFAR program implementation. Community-led monitoring seeks to strengthen community engagement with PEPFAR, increase transparency across the board and, most importantly, advocate for improvements while claiming empowered seats at decision-making tables.

4.8 Targets by population

Targets included in DATIM

4.9 Cervical Cancer Program Plans

PEPFAR DR is not implementing cervical cancer programming.

4.10 Viral Load and Early Infant Diagnosis Optimization

In COP20, PEPAR DR will continue building 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 FC, PEPFAR and national data point to the need for significant improvement in viral suppression (3rd 90) for all populations. In COP20, PEPFAR will continue to support the following interventions to promote viral suppression among all PLHIV on ART:

- Support the National HIV Program in the updating of guidelines according to 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 workdays 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 PLHIV 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 sample collection to monitor success in ARV treatment.
- Implement VL coverage and VL suppression CQI action plans based on sites' current performance across FC and non-FC populations. An in-depth VL coverage and suppression analysis was implemented in February 2020 (see figure 4.9.1). Results will orient the CQI actions based on site volume and performance score.

Figure 4.10.1. PEPFAR-DR sites scatterplot of current VL coverage and suppression

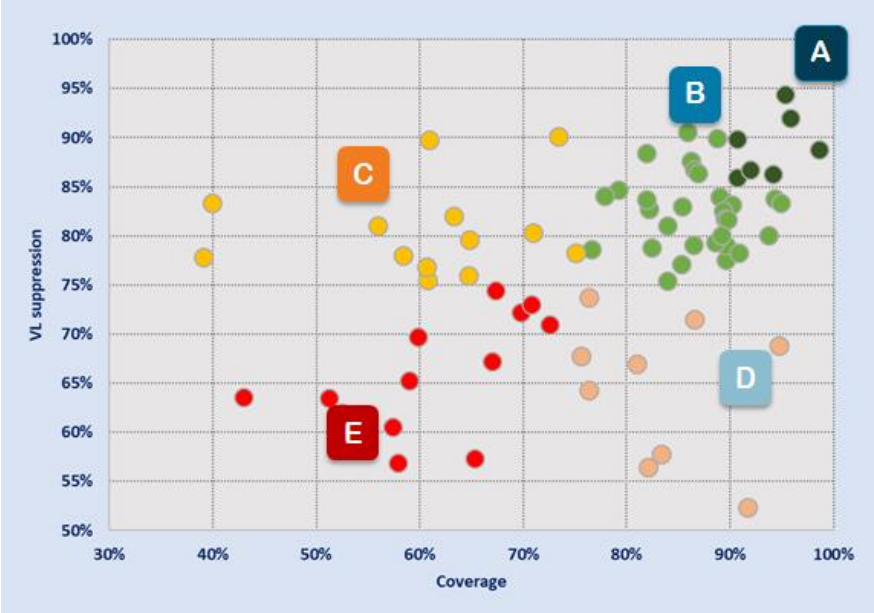


Figure 4.9.1 highlights site performance based on VL coverage and suppression rates. Sites were grouped according to their results along these two dimensions, and actions will be rolled out during COP20 to increase overall VL coverage and suppression, starting with high-volume and/or underperforming sites.

All five categories of sites will receive a first series of interventions, which will be centered on transitioning patients to TLD, implementing MMD and returning patients to care. The following packages of interventions will be tailored to specific sites' performance, needs and possible impact on the DR epidemic (e.g. site' patient volume).

In Cluster A, which includes the highest performing sites, only the 4 sites with the highest patient volume will receive a first round of interventions. These sites are also the ones that perform less well in this group. Interventions will focus on supporting patient education, introducing a U=U campaign and implementing a continuing education program for clinical teams regarding motivational techniques to support individual adherence.

Clusters B and C encompass most of the PEPFAR-supported sites and the majority of PEPFARs-supported clients. These sites need a more comprehensive approach to improve their VL coverage and suppression performance. As for Cluster A, priority will be given to the largest sites. Updated SOPs regarding VL, CD4 and TB test collection (including sample referral) will be prepared and shared, adherence sessions will be conducted, and U=U will be promoted. As sample collection and transportation issues may be affecting performance at these sites, extended hours and additional days for VL sample collection will be instituted. Additional lab staff training will be provided alongside the dissemination of the SOPs, as previous M&E visits highlighted a need for updated training and continuing education at these sites.

Finally, clusters D and E encompass the sites with the greatest need for support, assistance and close supervision. As for other clusters, PEPFAR DR will prioritize the largest sites in these groups. SOPs will be revised, updated and shared with clinical personnel, and continuing education based on these new documents will be implemented. As viral failure may be occurring more frequently at these sites, a protocol to actively detect viral failure will be implemented. These sites will also adopt extended hours/days for sample collection and run the U=U campaign.

In addition to facility-level interventions, and to ensure that PLHIV on ART have access to reliable and timely viral load sample collection, the PEPFAR team will support the implementation of routine viral load monitoring at community levels to identify patients due for viral load sample collection.

The results of PEPFAR Viral Load Scale-Up Clinical Facility Readiness Assessment and HIV Viral Load Testing Scorecard will also be used alongside the VC/VS site analysis to overhaul PEPFAR DR strategy around the 3rd 95.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV epidemic in the Dominican Republic is concentrated within specific subsets of the population, particularly among FC. As supported by the 2019 SID report, there are significant barriers to accessing HIV services among FC, including stigma and discrimination, limited distribution of HRH, and the insufficient availability of accurate and reliable data to understand this aspect of the country's HIV epidemic.

Previously, the Dominican Republic was considered to be at the forefront of innovation in terms of HIV policies and guidelines. Complacency and the transition from a generalized to a concentrated epidemic drained the policy impetus. 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 within a foreseeable time horizon. However, since COP 19, the Dominican Republic,

actively supported by PEPFAR investments, has taken action to change this pattern and reposition the DR within a policy framework that promotes an aggressive and successful HIV plan.

In addition to intensive and high frequency 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. Human Resources for Health (HRH) management rapid assessment tool that evaluates the cost efficiency of site personnel and activities was utilized with the MoH. However, with the National Health Service (SNS) separating its workforce from that of the MoH, use of this tool at HIV clinical care sites was significantly delayed. Its roll out in COP20 will provide valuable information for HRH decision-making and ultimately, strengthen HIV services. In addition, PEPFAR will provide training and mentorship in assisted partner referral methods and other index testing modalities in prioritized sites.

COP20 builds on the momentum of COP19 to initiate a series of additional reforms requiring PEPFAR investment in order to promote the rollout of nationwide Test and Start and close FC treatment gaps. The development of policy and monitoring systems for the appropriate prescribing and dispensing of HIV commodities in alignment with TLD transition and DMOC will enhance treatment initiation and client retention. Similarly, the production of SOPs for mobile service delivery and referral and counter referral guidelines, will pave the way to standardized same day initiation and decentralization of HIV services.

PEPFAR investments will also continue to endorse the development of FAPPS, the national HIV patient registry. As of Q1 FY20, all PEPFAR prioritized sites have started implementing the biometric registry and it is projected that 80% of non-PEPFAR sites will be doing so by the end of FY20. To reach this important milestone, PEPFAR will support a national policy regarding the use of the registry in all HIV clinics, and support its integration with SIREN-P, the national HIV testing information system to include safe-guarding of patient confidentiality. In this way, PEPFAR will help build national capacity to collect, manage, analyze and use data from existing national HIV information systems for planning and budgeting purposes.

To mark the importance of approaching the HIV epidemic from a "whole island" perspective, PEPFAR will encourage coordination, logistic support, technical dialogue, and diplomatic engagement between Haiti and the DR. During COP19 a bi-national cross-border coordinating body is to be established to address HIV treatment and care for Haitian migrants in the DR.

All together, these system-level investments will directly impact PEPFAR performance, the achievement of targets along the cascade for FCs, key and general populations, and promote sustainability and country ownership of the HIV response in the DR.

6.0 USG Management, Operations and Staffing Plan

COP20 is the second year of a major strategic shift for PEPFAR in the DR. The refocusing of PEPFAR activities on FC and the intensifying of prevention, testing and treatment initiation and retention efforts at community and primary care levels has required that interagency technical teams prioritize providing close technical assistance/supervision to implementing partners' field operations. To support ambitious goals in reaching FCs, establishing/scaling an OVC program, and providing TA to support the country in improving outcomes under the third 90, in COP19 the interagency requested to increase staffing patterns. Bringing on board additional staff has been challenging both in terms of securing Mission and Bureau approvals and in identifying/attracting qualified applicants. To date less than 20% of staff have been brought on board and the DR continues without a permanent PEPFAR Coordinator. No new positions have been identified by USAID for COP20.

After assessing program needs, it was determined that no additional positions will be proposed for CDC. The current office footprint of 3 US Direct Hires, 3 external contractors and 11 Locally Engaged staff positions will remain and are sufficient for executing the anticipated level of effort in the coming year. Two USDH positions, although currently vacant, are scheduled to be filled in the coming months with the Deputy Country Director arriving in April and the Country Director before the end of COP19/FY20, bolstering CDC's leadership team. Two contractor positions are also vacant – one of which will be repurposed from Lab to a Care & Treatment Advisor in order to strengthen CDC's Clinical Team and improve/increase direct technical assistance to implementing partners. CDC's clinical M&E staff will continue to perform SIMS visits and monitor partner performance against baseline data.

Additionally, no new positions have been identified for DOD for COP20.

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	0	N/A	N/A	N/A	N/A	N/A
Scale-Up Saturation	0	N/A	N/A	N/A	N/A	N/A
Scale-Up Aggressive	16,128*	21,735 (1,664 FC)	11,238 FC	25,645 (13,063 FC)	11,637 FC	81%
Sustained	0	N/A	N/A	N/A	N/A	N/A
Central Support	0	N/A	N/A	N/A	N/A	N/A
Commodities (if not included in previous categories)						
Total						

* For COP19, estimated total PLHIV represents FC 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 COP20 Budget by Program Area

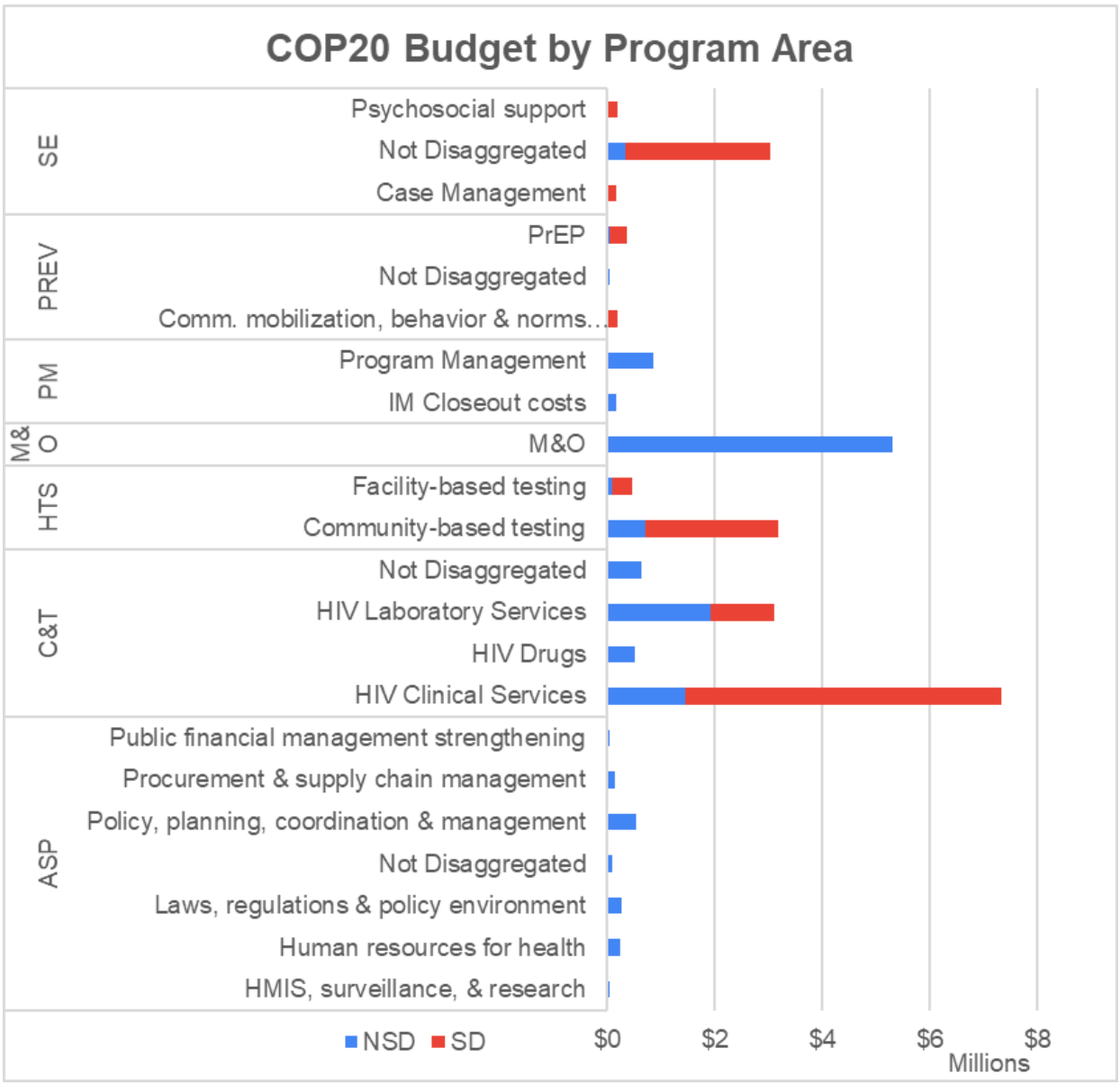


Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US5,360,250	**$US21,548,711**	**$US26,908,961**

*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 COP20 Total Planning Level by Agency

Initiative Type	Fiscal Year	2020
	Funding Agency	Amount
Planning Level	DOD	$367,011
	HHS/CDC	$11,975,710
	USAID	$4,566,240

Table B.1.3 COP20 Total Planning Level by Budget Code $21,608,961

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	HBHC	$764,211
	HKID	$3,730,000
	HLAB	$0
	HTXS	$9,865,866
	HVCT	$2,929,918
	HVMS	$1,443,087
	HVOP	$477,634
	HVSI	$60,250
	HVTB	$705,000
	OHSS	$1,305,495
	HTXD	$327,500

APPENDIX C – Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	Servicio Nacional de Salud	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Insufficient availability of accurate and reliable data/information to understand the HIV epidemic in DR (especially in migrants) and lead a comprehensive HIV response	COP17	COP21	100% of HIV clinics in the DR have implemented biometric registry.
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Adults	Assessing impact of policies and regulations on HIV	Poor approach of the HIV epidemic in an island perspective	COP19	COP21	Two (2) bi-national coordination meeting held by Q3FY21
USAID	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	Incomplete framework of updated national guidelines to achieve HIV epidemic control in DR according to latest WHO and UNAIDS recommendations	COP18	COP21	Updated Ministry/PEPFAR /SNS MOU

No SRE activities are planned in COP20

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.*