Dominican Republic

Country Operational Plan

COP2021

Strategic Direction Summary

May 2021

Table of Contents

1 Goal Statement

The 2021 PEPFAR Country Operational Plan (COP21) for the Dominican Republic (DR) details the continued strategy to achieve epidemic control among individuals of Haitian descent residing in the DR (hereinafter referred to as Focus Clients or FC). In this country of 10.7 million inhabitants, (World Bank 2020) approximately 7% (751,080) are FC[1]. Of the estimated 74,995 people living with HIV (PLHIV) nationwide, approximately 34% (25,410) are FC, and the 10 PEPFAR supported provinces contain nearly two-thirds of all FC. While the DR has an overall HIV prevalence of 0.9%, FC estimates indicate a prevalence between 3-5%, higher than the prevalence for any key population[2] (KP) group, except for transgender women (TGW), and higher than the overall prevalence in Haiti (2%, UNAIDS 2019). Among FC living with HIV (LHIV), 40.7% are aware of their status and, of those, only 17.5% are currently on treatment. In comparison, antiretroviral treatment (ART) coverage for non-FC LHIV is 67.5%.

A series of political, economic, and cultural factors hinder treatment initiation, retention, and adherence among FC LHIV in the DR. The severe economic disparity between Haiti and the DR makes migration across a highly porous border an attractive economic option for many Haitians. Mirroring the experiences of many migrant-receiving countries, the influx of people from Haiti to the DR over the last century, exacerbated during the COVID-19 pandemic, has generated a social and economic underclass that suffers stigma and discrimination (S&D) in all aspects of daily life, including access to HIV services. Further, the irregular immigration status of many FC in the DR creates obstacles 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 While the law has since been rescinded as a result of international pressure, a small proportion of the affected population has regained legal status.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). 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).

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1 Encuesta Nacional de Inmigrantes (National Immigrant Survey) 2017, National Office of Statistics.

[2] Defined as people who inject drugs, men who have sex with men, transgender persons, sex workers and people in closed settings or in prison. Around the world, key populations face much higher rates of HIV and AIDS than the general population and are most at risk for contracting HIV.

[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

PEPFAR DR will continue to promote HIV epidemic control among KP by expanding PrEP and other strategies tailored for these populations, e.g., reducing stigma and discrimination, and advocating for consistent GoDR and Global Fund KP programming. In COP 21, PEPFAR will maintain support to legacy KP clients living with HIV who will continue to benefit from linkage and retention strategies to ensure continuity of treatment and viral load suppression.

The DR COP21 strategy to reduce the gaps under the HIV treatment and prevention cascade for FC includes the following objectives:

1. **Community-focused case finding** via strategically allied community-based organizations and virtual outreach platforms that are culturally and linguistically responsive to FC, use of optimized, safe, ethical, and trusted index testing services
2. **Continued use of a network of community outreach and community care teams** by supported health facilities and organizations to link FC to testing and treatment and improve treatment continuity and adherence.
3. **Continue operationalization of the COP19/20 fast-track policy** within a network of service entry points.
4. **Expand and/or intensify activities implemented in COP20/FY2021 to return clients to care and prevent interruption in treatment**, including improved access to health services that are culturally and linguistically responsive to FC, intensive partner management, and resilient, community-engaged, client-centered approaches to care and treatment.
5. **Accelerate implementation of minimum program requirements**, including complete transition to TLD and transition of all eligible clients to MMD while ensuring adherence to treatment, and rapid initiation of ARV treatment in alignment with the GoDR's MoH guidelines.
6. **Enhanced community-led monitoring**
7. **Improve OVC case management in collaboration with clinics** to ensure that 90% or more FC (C/ALHIV and their parents) achieve viral suppression, are offered OVC comprehensive program enrollment and access to psycho-social, food, and economic security services; children receive index-testing; and AGYW and their infants are retained in care.
8. **Expand the PrEP program** among FC and key populations.
9. **Strengthen the national lab capacity**, including expansion of sample collection schedules, improvement of sample transportation, reduction of lab turnaround times, and improved clinical management of viral load results.
10. **Expand tailored interventions to reduce stigma and discrimination** among health service staff and entities that interact with FC on a regular basis, including the uniformed services and military facilities.

11. **Prevent and mitigate the impact of COVID-19** on PEPFAR-supported programs by implementing activities in line with the 2021 American Rescue Plan Act (ARPA) to ensure access to health services and continuity of treatment for FC LHIV.

The PEPFAR-DR team will continue to collaborate with the PEPFAR-Haiti team to advance continuity of care for migratory and binational individuals in the Dominican Republic and Haiti, aiming for seamless, continuous, client-centered services for those that seek HIV care and treatment across the two countries. In collaboration with PEPFAR Haiti and others as appropriate, PEPFA-DR will assess the need and impact of PLHIV who cross the border between Haiti and the DR and develop and implement an appropriate data-driven response.

PEPFAR-DR will continue to prioritize strong working relationships with the DR Ministry of Health to implement a supportive policy environment for PEPFAR DR's HIV services. This will require the implementation of a well-coordinated assistance approach to the Government of Dominican Republic (GoDR) that relies on high levels of collaboration and cooperation between PEPFAR, GoDR, Global Fund (GF), UNAIDS, and civil society organizations (CSO).

2 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 10.7 million in 2021. According to the World Bank, the DR's Gross National Income (GNI) per capita was $8,080 in 2019 (current USD)[4]. According to Forbes Centroamerica, general poverty in the country increased from 21% in 2019 to 23.4% in 2020 due to the COVID-19 pandemic, with the wealthiest 10% of the population accounting for more than 30% of the country's income[5]. In 2018, health expenditures represented 5.7% 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 2021 Global AIDS Monitoring Report (UNAIDS GAM) estimates that in 2020, 74,995 adults aged 15 years and above were living with HIV in the DR, of whom 82% were aware of their HIV status. Of all individuals diagnosed, 38,270 (62%) are receiving treatment and of these, 23,688 (62%) are virally suppressed. The 2020 Spectrum model estimates that the number of people living with HIV (PLHIV) has been increasing slightly every year (Figure 2.1.1), as new infections remain higher than all-cause mortality in PLHIVs (Figure 2.1.2).

[4]https://www.one.gob.do/demograficas/proyecciones-de-poblacion, accessed on April 28, 2021

[5] https://mepyd.gob.do/publicaciones/boletin-pobreza-monetaria-a6-no8, accessed on April 28,2021

[6] https://data.worldbank.org/indicator/SH.XPD.CHEX.GD.ZS?locations=DO, accessed on April 28,2021

Figure 2.1.1 Trend in Number of PLHIV, Spectrum 2020

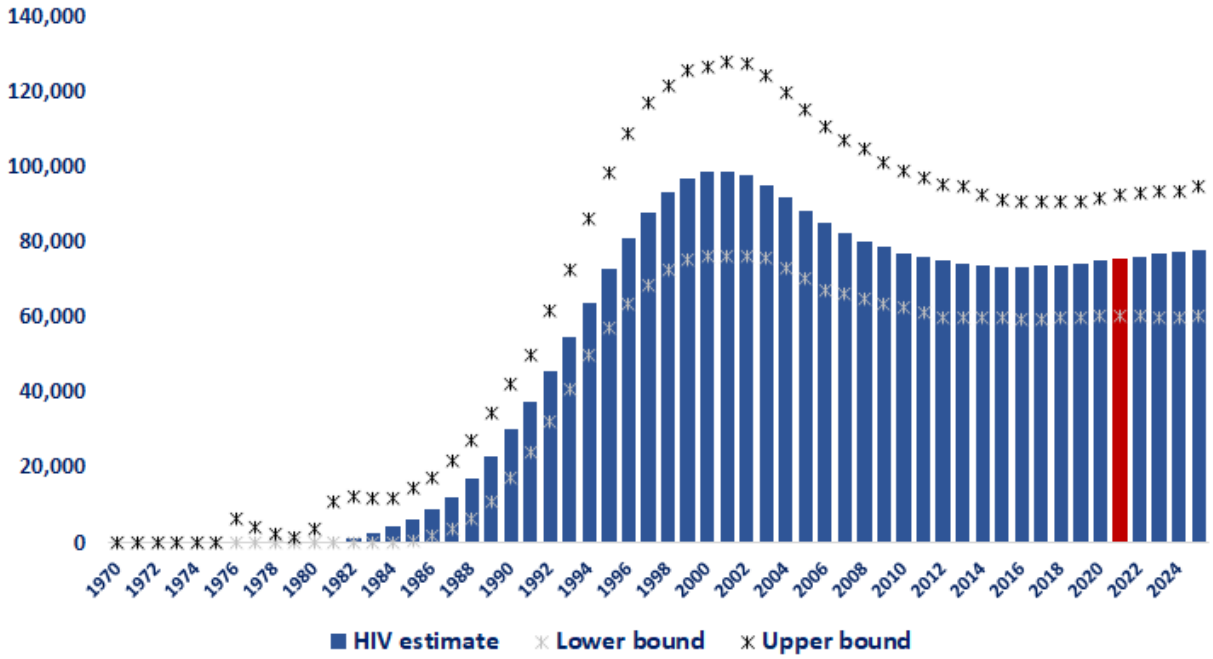
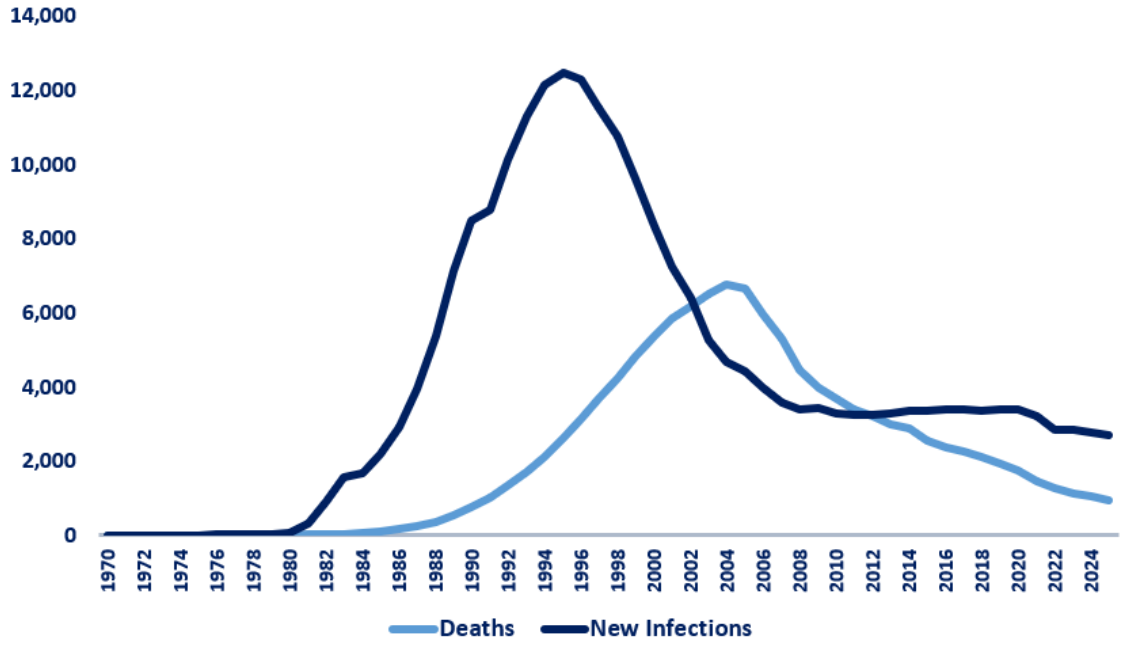


Figure 2.1.2 Trend in New Infections and All-Cause Mortality Among PLHIV, Spectrum 2020



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%, TGW with a prevalence estimated at 28%, and FC with an HIV prevalence between 3-5% but accounting for 46% of all newly infected individuals in the 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 since 2012. In addition, 253,255 persons born in the DR had at least one Haiti-born parent, a 20.6% increase since 2012. Per the 2018 Surveillance and Behavior Survey with serological linkage of key populations, HIV prevalence among migrants from Haiti ranges from 3% to 5% across the five provinces surveyed (La Altagracia, Barahona, Puerto Plata, Santiago, and Santo Domingo). The 2020 Spectrum model estimates that there are 25,410 Haiti-born PLHIV living in the DR, of whom 13,108 (52%) are men. PLHIV of Haitian descent now represent 33.8% of all PLHIV, the single largest priority group in the DR.

Certain subgroups within the Haitian migrant population have increased risk of contracting HIV infection. The 2018 Integrated Biological and Behavioral Surveillance Survey (IBBSS) shows increased risk of HIV infection and poor access to services among Haitian migrants: 25-41% of respondents, depending on the province, reported never having been tested for HIV, even though 17-35% considered themselves at risk for HIV infection, primarily for having unprotected sexual intercourse (48-89%) or having sex with multiple partners (11-45%).

Information on HIV status among descendants of Haitian-born parents in the DR is scarce. The unresolved legal status or citizenship of many Haitians and Haitian-descendent 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 and increasing their vulnerability to extreme poverty and structural violence. Based on results from the 2017 NIS, 95% of Haitian migrants and 80.9% of their descendants lack any type of health insurance.

Concurrently, the analysis of DR programmatic data consistently reports poorer rates of linkage to HIV services, enrollment in treatment, treatment adherence, and viral load suppression among Haitian migrants and persons of Haitian descent diagnosed with HIV in the Dominican Republic, as compared to other population groups (PEPFAR, COP 2020).

In addition to FC, other populations disproportionately affected by HIV in the DR are KP. Although at this time PEPFAR-DR is focusing its resources on unmet need among FC, PEPFAR-DR tracks services to KP as a sub-set of Focus Clients and will continue implementing activities in support of HIV prevention, treatment adherence, and viral load suppression among non-FCs by collaborating and ensuring complementarity with the GoDR and other stakeholders, e.g., the Global Fund and UNAIDS.

In the 2018 IBBSS, HIV prevalence among MSM was estimated between 2.4% and 6.4% across five Dominican provinces, while according to the 2020 Spectrum model, MSM represented 9.7% (7,199) of all PLHIV in the country in 2020. The IBBSS also indicated that only 11-31% of MSM had access to an HIV test in the prior 12 months. Moreover, 48% of MSM reported discrimination in health

services, and 28.9% of a sample of health service providers preferred not to care for MSM or other KPs (Health Policy Project, 2014). Between 70-94% of MSM reported having sex for some material benefit, and condom use was low: between 42-71% in most recent anal receptive sexual intercourse and between 21-39% in most recent insertive anal sexual intercourse.

Estimates of HIV prevalence in FSW ranged between 1.1% and 5.9% across the five provinces included in the 2018 IBBSS. In that same study, 27-75% of FSW reported having used a condom during their most recent commercial sexual intercourse, but only 1-11% reported use during their most recent intercourse with a trusted or stable partner. The 2020 Spectrum model estimated that 3,614 PLHIV in the DR are FSW, or 4.9% of all PLHIVs.

The 2018 IBBSS, which included 439 TGW, pointed to an HIV prevalence of 28%. The 2020 Spectrum model estimated that 2,629 PLHIV in the DR are TGW, or 3.5% 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	10,535,535	100%	1,408,917	13.48%	1,462,378	13.99%	926,328	8.86%	937,540	8.97%	2,895,423	27.71%	2,817,913	26.96%	National Office of Statistics [1]
HIV Prevalence (%)		0.85% (15-49)		05-0.1%		05 - 0.1%		0.24-0.53%		0.17-0.24		0.23-1.78%		07-02%	Spectrum 2019, from 2013 Demographic and Health Survey
AIDS Deaths (per year)	1,851		N/A		N/A		N/A		N/A		N/A		N/A		Global AIDS Monitoring Report 2021
# PLHIV	71,600		600		620		2,510		2,890		33,290		37,260		Spectrum 2019
Incidence Rate (2020)		032%		N/A		N/A		027		04%		071%		0.155%	Spectrum 2019
New Infections (2020)	3,422														Global AIDS Monitoring Report 2021
Annual births	159,132	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

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	%	
Pregnant women needing ARVs	730														Spectrum 2019
Orphans (maternal, paternal, double)	35,372														Spectrum 2019
Notified TB cases (Yr)	4,124														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*	32,416														PLACE Lite, 2016
MSM HIV Prevalence	2.4-6.4%														2017 IBBSS
Estimated Population Size of FSW	87,782														PLACE Lite, 2016
FSW HIV Prevalence	1.1-5.9%														2017 IBBSS
Estimated Population Size of PWID	N/A														
PWID HIV Prevalence	N/A														
Estimated Size of Priority Populations (specify)	751,080		N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	National Immigrant Survey, National Office of

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	%	
															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 15-49 years	10,488,499	0.91%	74,995	N/A	38,270	513%	23,688	7,750,457	113,937	6,747
Population <15 years	28,712,951	05-0.1%	1,005	N/A	868	86.37%	281 (49%)	N/A	N/A	110
Men 15-24 years	9,375,401	0.17-0.24	3,250	N/A	890	27.38%	478 (54%)	N/A	N/A	387
Men 25+ years	28,179,131	07-2%	35,240	N/A	17,147	48.66%	10,596 (61%)	N/A	N/A	2,946
Women 15-24 years	9,263,281	0.24-0.53%	3,220	N/A	1,313	40.78%	609 (46%)	N/A	N/A	570
Women 25+ years	28,954,231	0.23-1.78%	32,280	N/A	18,348	56.84%	11,724 (63%)	N/A	N/A	2,734
MSM	324,162	2.4-6.4% 4	7,199	N/A	2,271	31.55%	1,546 (68%)	N/A	N/A	513
FSW	877,822	1.1-5.9% 4	3,614	N/A	1,112	30.77%	659 (60%)	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	7,510,803	1.1-5% 4	25,410	N/A	5,578	21.95%	2,520 (62%)	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, 2021 estimation
6 National HIV Patient Information Management System (FAPPS), as of December 31, 2020
7 National HIV/AIDS program

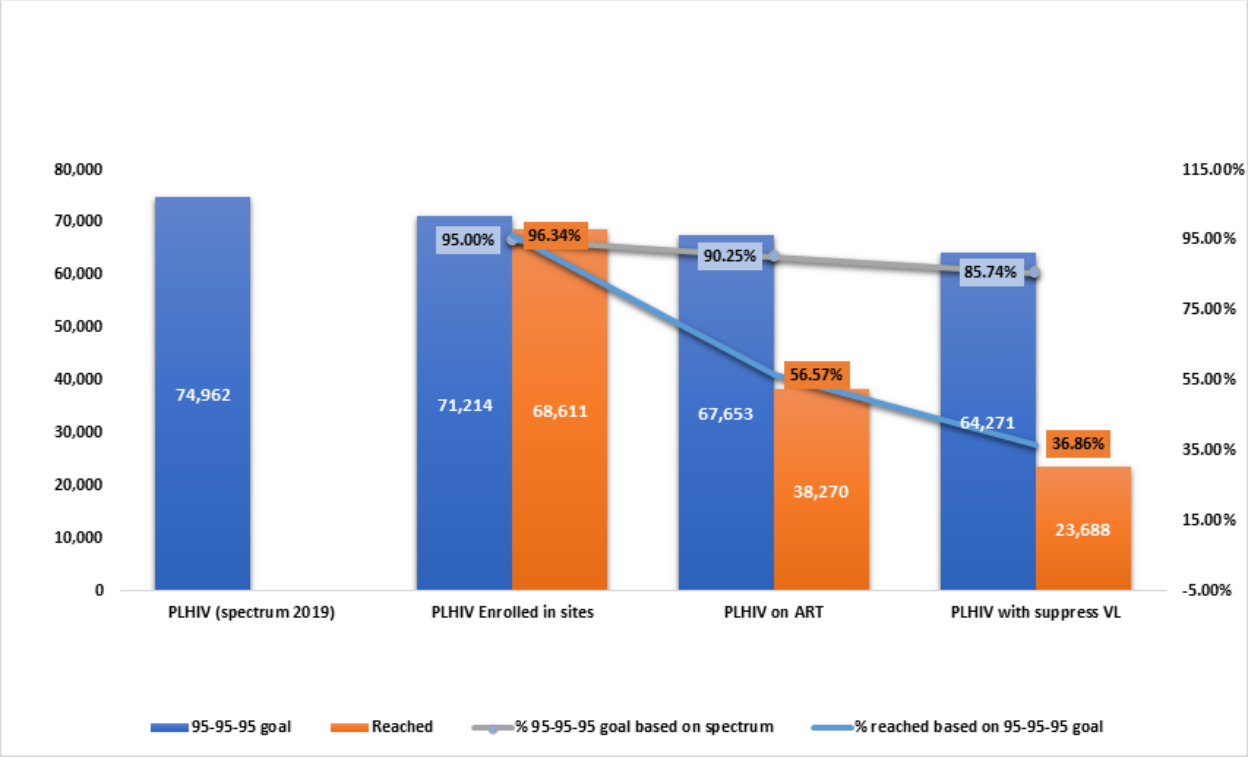
2.2 Progress toward Epidemic Control

HIV Clinical Cascade

Although the DR has not yet fully aligned with the new WHO/UNAIDS 95-95-95 global goals, considerable progress can be observed in areas that contribute to epidemic control. Since 2015, the GoDR has taken full responsibility for the costs of purchasing sufficient antiretrovirals (ARVs) and other HIV supplies to meet the country's needs. The MoH has updated multiple administrative and clinical care guidelines to reflect global best practices, such as Treat All, task-shifting for HIV testing, ARV prescription guidelines, progress toward National Health Insurance coverage of ARVs as essential medicines, and moderate but steady expansion of index testing in PEPFAR priority provinces. The MoH has also agreed to generate programmatic evidence to support the introduction of self-testing.

SENASA, the national health insurance office, is moving forward with a plan to reimburse community-based organization (CBO)/non-governmental organization (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 95-95-95 goals



Source: Spectrum/UNAIDS and DR HPIMS, 2020

HIV Testing Services (First 90)

HIV testing services (HTS) are performed at 1,100 laboratories nationwide. 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 HIV Testing Information System based on the number of persons tested is being deployed with PEPFAR support and is currently operational in 19 PEPFAR-supported and 7 non-PEPFAR-supported facilities. In 2019, the National HIV Register System (SIRENP, per its acronym in Spanish) registered 29,452 persons tested for HIV, including 2,087 (7.1%) who tested positive.

Despite major limitations posed by the COVID-19 in FY21 Q1, PEPFAR refined its ability to find, test, and diagnose FC, thus exceeding the target of 79,425 individual tests at the community level (COMM_HTS_TST), and reaching 33% of the community-based yield (COMM HTS_TST_POS) target among FC, who represented 95% of all people tested at the community level. In community testing activities, the positivity yield was 2.3% with FC representing 97% of the total number of positives. Over that same period, 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 positive cases. The positivity rate among FC was 5.4%, versus 4% in non-FC.

ART - adult and pediatric (Second 90)

HIV care services, including ART, are exclusively delivered at only 74 Integrated HIV Care (IHC) sites throughout the country. Of those, only three provide services for children and adolescents. Among the 74 sites, 18 sites in nine provinces received PEPFAR support in COP20 and 21. PEPFAR does not currently provide support to any exclusively pediatric sites.

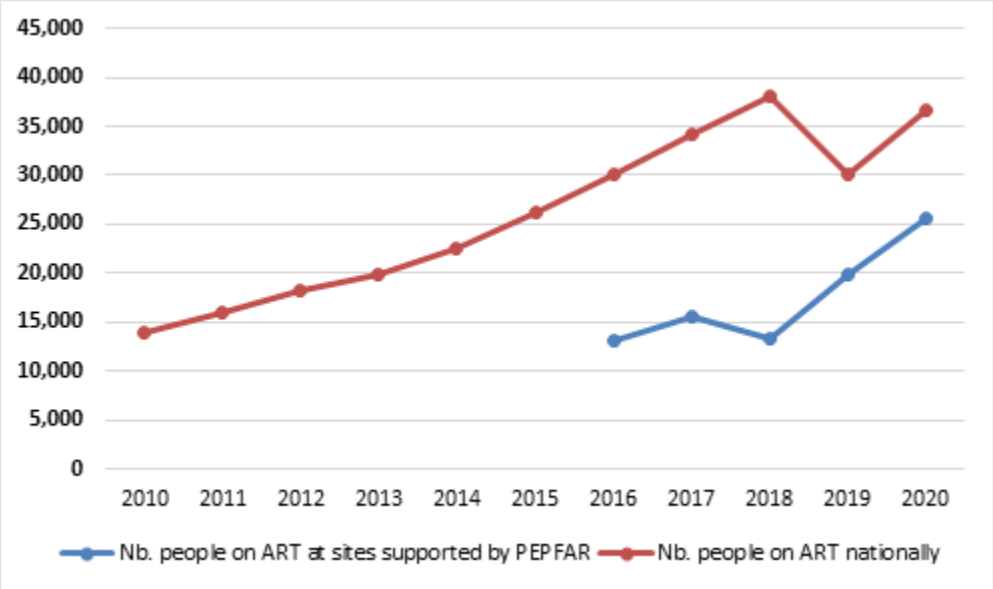
All patients enrolled at the IHC sites are registered in the HIV Patient Management Information System (FAPPS, per its acronym in Spanish). As of December 31, 2020, a total of 76,014 persons had ever been registered in FAPPS, including 38,169 currently active on ART for more than three months the 18 sites receiving PEPFAR support manage 23,677 (75.3%) active patients. Only 590 active patients nationwide are children under the age of 14.

Among all patients active on ART in the DR, 2,257(5.9%) are characterized as MSM in FAPPS, 1,513 (4.0%) as injecting drug users, 1,111 (2.9%) as FSW, and 375 (1%) as TGW. A total of 5,639, or 14.8%, are categorized as migrants from Haiti[7]. PEPFAR-supported sites report 1,828 MSM patients (81% of all MSM active on ART in the country), 915 FSW patients (or 82.4% of all FSW active on ART in the country), and 290 TGW (or 77.3% of all TGW patients in the DR). A total of 4,805 FC are receiving ART at PEPFAR-supported sites, which represents 85.2% of all migrant patients on ART in country.

[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.

During COP20/FY 21 Q1, 2,093 patients initiated ART nationwide, 1,779 (85%) of whom were initiated at PEPFAR-supported IHC sites. Among this subset, 1,005 (56.5%) were identified in FAPPS as born in Haiti.

Figure 2.1.6 National and PEPFAR trend in individuals active on ART



Source: PEPFAR-DR programmatic data (FAPPS)

Viral Suppression (Third 90)

National HIV care guidelines stipulate that a viral load (VL) test should be performed every six months for patients on ART. However, the COVID-19 pandemic has significantly impacted VL testing coverage (VLC) by requiring shared use of existing diagnostic platforms with COVID-19 testing. Courier services that transport VL results have also experienced service breaks due to COVID-19 protective measures (staff unable to show up for work, curfew during state of emergency, etc.). 40% of the annual target was achieved in Q1 FY21.

Until 2019, the National Reference Laboratory in Santo Domingo performed all VL tests using samples collected at IHC sites and transported to the capital. In 2020, the Santiago laboratory completed the certification process and is currently fully functional. Starting in 2021, two additional laboratories, one in Santo Domingo and another in San Pedro de Macoris, are being certified to perform VL and CD4 count testing.

As of Q1 of FY21, 23,305 patients (56%i of all active patients nationwide on ART for more than three months)) had a VL test result recorded in the past 12 months. Among those, 19,626 (84%) showed a viral load of <1000/ml. At PEPFAR-supported sites, a total of 18,203 active patients (43% of all active patients nationwide) on ART for more three months had a viral load test result recorded in the past 12 months, and 15,426 (85%) showed viral suppression.

PrEP implementation

PEPFAR began supporting PrEP implementation in the DR in FY18 at one site in Santo Domingo that targets services to MSM and TGW. In FY20, two additional sites (Puerto Plata and La Romana) began offering PrEP, and eligibility criteria expanded to include FSWs. I Also in 2020, the GoDR published PrEP guidelines R with PEPFAR support. PrEP expansion slowed down in FY20 due to the COVID-19 pandemic and associated delays in GoDR procurement of ARVs, which impacted planned implementation of PrEP at three additional sites. In FY 21, however, the MoH made 1,000 new PrEP treatments available to PEPFAR-supported sites through the end of FY 2021. As a result, PrEP will be offered to all HIV high-risk populations at eight PEPFAR-supported sites in six provinces. PEPFAR plans to continue scale-up in FY 2022 as an essential service for FC, KP and sero-different couples.

In addition, PEPFAR will build upon community services for PrEP demand creation and retention and utilize social media and other strategies to increase awareness about, and retention of clients in PrEP services.

2.3 Implementation of key policies

Test-and-Start

In 2018, the MoH adopted the Treatment for All strategy, which follows the WHO's 2016 guidance for HIV care and treatment, including rapid ART initiation independently of CD4 count. Rapid initiation significantly improves outcomes across the HIV treatment cascade in low- and middle-income settings, as demonstrated by several scientific studies. This policy was based on the experience gained at 11 PEPFAR-supported IHC sites throughout the country between 2016 and 2018. In January 2021, the MoH published updated HIV treatment guidelines for adults, reaffirming the importance of rapid initiation and advising that ART should be initiated immediately after blood sample collection for laboratory tests.

As presented in Table 2.1.8, PEPFAR-DR sites have effectively reduced the median number of days from diagnosis to ART initiation, although adherence to the newest guidelines by non-PEPFAR supported sites continues to be a challenge, due to slow dissemination of treatment guidelines into clinical practice, low awareness, and/or resistance from medical staff to guideline implementation and adherence. In addition, PEPFAR-supported sites have increased linkage rates to 71% and plans to continue moving rapidly towards the >95% linkage retain 2022. In COP21, PEPFAR will continue supporting GoDR in strengthening health systems at the national level to expand rapid ART initiation to non-PEPFAR-supported sites.

Table 2.1.7 Median number of days from diagnosis to ART initiation, by province and year

	2015	2016	2017	2018	2019	2020	2021	Trend
SANTO DOMINGO	48	37	16	15	9	0	0	
LA ROMANA	30	23	5	6	5	1	0	
PUERTO PLATA	35	26	5	2	1	0	0	
SANTIAGO	28	9	0	0	0	0	0	
VALVERDE	10	18	22	1	0	0	0	

In 2021, median of number of days for ART means at least 50% of cases had same day inititation

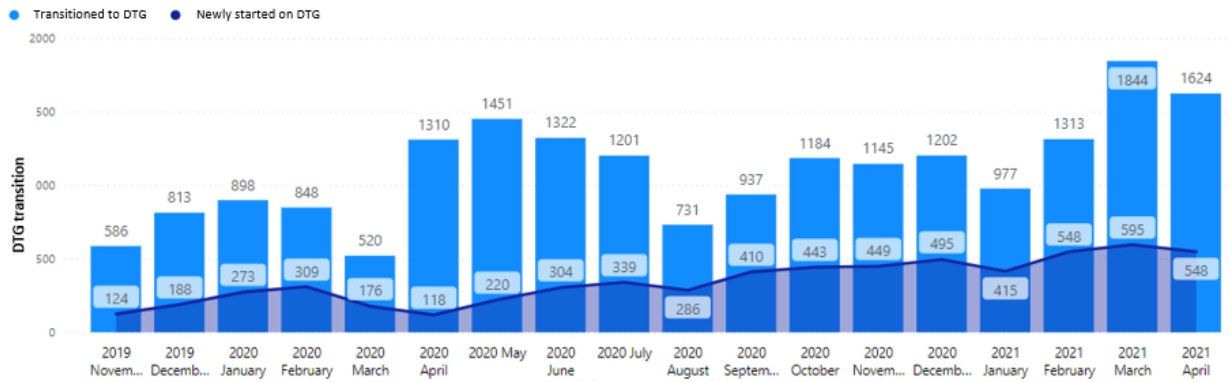
Differentiated service delivery, including multi-month dispensing (MMD)

In early 2021, the GoDR published the Differentiated Service Intervention Manual with the purpose to provide convenient patient-centered care and help to reduce unnecessary burden on HIV care services. National HIV guidelines allow for 3- to 6-month scripting and dispensing intervals for stable patients. FAPPS data shows that at least 19% of patients in PEPFAR-supported sites receive their medications in one-month increments, and 42% receive two-month supplies. The 2019/2020 clinical directives and the 2021 updated national guidelines recently published by the MoH permit six-month MMD for stable patients (patients with evidence of treatment compliance and viral load suppression in the last 12 months) and promote MMD as part of a differentiated model of care. Health workers at a few sites have expressed hesitancy to prescribe six months of MMD for fear of compromising ARV supplies. To address these concerns and as part of MMD expansion, PEPFAR-DR will reinforce capacity building on ARV supply chain management, including effective forecasting, planning, and reporting. To facilitate MMD, the GoDR recently approved an increase in stock levels by site to at least three months, in addition to reported consumption allowing for seven months of stock. In COP21, the GoDR will support the extension of MMD following approved criteria for client eligibility.

Progress on transition to new WHO-recommended HIV treatment regimens

The 2021 update of national HIV clinical guidelines recommended the use of Dolutegravir (DTG) and efavirenz 400 mg for first-line therapy. DTG-based regimens are the preferred first-line regimen for patients starting ART, except in the case of women of childbearing age or pregnant, as well as 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 TLD by the end of 2020. PEPFAR-DR will work with the GoDR to complete the transition of eligible patients in COP21.

Graph 2.1.8 Monthly progress in DTG transition, all sites nationwide



Source: FAPPS

Scale-up and optimization of index testing

In COP20 1,654 HIV-positive FC were offered index services; 962 accepted the intervention, referring a total of 1,057 partners/contacts. Among these contacts, 974 were tested and 134 (17%) resulted positive for HIV infection. Yield for HIV testing has been high despite the low eligibility among index patients. Reasons for low eligibility among index patients include partners previously diagnosed as HIV positive, index patient no longer in contact with partner, patient 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 in non-PEPFAR locations or delaying testing, which hampers recording and reporting. Among contacts who accept testing, yield continues to be high: 25% in facility and 21% in community locations in the first quarter of COP21.

During COP20 implementation, all prioritized HIV care sites (21/21) were evaluated with PEPFAR's minimum requirements for index testing. The results of these evaluations ranged from 13-28 points out of a possible 33 points. In response to these results, PEPFAR-DR revamped HIV index services to ensure compliance with PEFAR minimum requirements and improvements in overall patient experience. Focusing on patient rights and adverse event monitoring, standardized operating procedures were updated to include the LIVES strategy, systems to anonymously report experiences, and routine supervision procedures, among others. PEPFAR-DR is currently working to improve the implementation of index case testing and tracing (ICTT) with fidelity in COP21 by focusing on community-level testing. PEPFAR will increase the number of teams implementing HIV Index Testing at the community level and will continue implementing strategies to maintain confidentiality and adherence to national guidelines. Successful scale-up in COP21 will involve continued, timely site-level training and supervision to increase contact identification and acceptance by PEPFAR-supported community personnel as well as greater emphasis on testing of biological children through the OVC program.

Management of TB/HIV Co-infection and Scale-up of TB Preventive Therapy (TPT)

Per national guidelines, TPT is recommended for all PLHIV in the DR, without any symptoms of active TB. There are several recommended TPT regimens (1) six months of Isoniazid (INH), (2) 3-months daily isoniazid and rifampicin (3RH), and (3) 3-month regimen of isoniazid and rifapentine (3HP). The GoDR has kept its commitment to purchase enough INH, Rifapentine, and commodities for the GeneXpert network to meet the need. In FY2021, the GoDR has prioritized the 3HP starting in PEPFAR-supported sites and committed to keep providing enhanced supervision of TB-HIV activities at both TB clinics and IHC sites. Because of the COVID-19 pandemic, PEPFAR implementing partners (Ips) enhanced direct service delivery (DSD) models for TPT community delivery to prevent morbidity among providers and patients.

Challenges to broader TPT coverage include insufficient implementation of the screening algorithm for active TB among PLHIV because of the requirement for a chest X-ray and poor recording and reporting of TPT initiation and completion dates. To address some of these issues, the updated TB/HIV national guidelines launched in early 2021 prioritize clinical TB screening for all PLHIV instead of the chest X-ray (which is optional in the guideline). During FY21, PEPFAR-DR has prioritized site-level training in standard operating procedures (SOPs), TPT initiation reporting, and job aids to improve TPT initiation rates among ART patients at supported sites. Internal coordination and referral and counter–referral systems between the HIV and TB units must be considerably improved. In COP21, as TPT is considered part of routine HIV care, the PEPFAR program will ensure TPT initiation and completion for all PLHIV on ART. PEPFAR-DR will continue to support health providers in adhering to national guidelines on HIV/TB coinfection to close the gap both among patients newly initiated on ART as well as those already on treatment; provide technical assistance to providers to ensure TPT initiation among ART patients for whom active TB is ruled out; improve TB screening data to reduce underreporting; and promote review of medical records to follow up on completion of prophylaxis. This will include quality control monitoring at each site for recording and reporting compliance on TB screening and TB treatment and preventive therapy, in addition to monitoring of the status of HIV-positive patients on TB treatment and TPT in FAPPS. PEPFAR-DR is expected to reach 85% of ART patients with TPT coverage according to OGAC technical directives for the OU.

Table 2.1.9 Key activities to improve the scale-up of TPT and reach 85% of coverage among ART patients, COP 2021

Site level	• Improve quality of TPT data registration of in the primary sources (e.g., implementing TPT register at all PEPFAR-supported sites). • Conduct training on TB/HIV management using the 2020 updated TB/HIV guidelines (screening for symptoms should be a priority approach in ruling out active TB over the chest x-ray) • Promote and facilitate use of 3HP through community delivery and supervision.

Above-site	• Provide active follow-up through PEPFAR clinical partners, the TB Program, DIGECITSS, and SNS to improve tracking of TPT coverage.

Elimination of user fees

HIV testing is available free of charge at government and private not-for-profit facilities. ART and TB drugs are also available free of charge to patients, as are medical evaluations, viral load tests, CD4 counts, and laboratory tests for TB diagnosis. However, patients may be charged user fees for complementary laboratory tests or chest x-rays. PEPFAR support to IHC sites includes setting up service delivery mechanisms that eliminate these situational fees for all patients enrolled in HIV care and treatment.

Alignment of orphans and vulnerable children (OVC) package of services

PEPFAR-DR's OVC program is designed to provide clinical services to FC HIV-positive adults with at least one child in the household to support continuity of treatment and viral suppression. The OVC program works closely with PEPFAR clinical partners to identify and enroll eligible FC from targeted adult treatment facilities and provide them with social and economic support. In COP21, OVC programming will include simultaneous referral of all newly identified FC into clinical care and OVC activities for eligibility screening. HIV-positive FC with at least one child living in their household, including key populations, will continue to be offered enrollment into the OVC program. Additionally, and new for COP21, any FC child and adolescent living with HIV (C/ALHIV) receiving treatment at PEPFAR-supported sites and their families will be considered eligible and offered enrollment into the OVC program. OVC programming will include HIV testing referrals for biological children of FC and other household members to improve knowledge of their HIV status and coverage of family index case testing. The OVC program will strengthen coordination with pediatric facilities to ensure all pediatric beneficiaries of the OVC program living with HIV receive comprehensive HIV services.

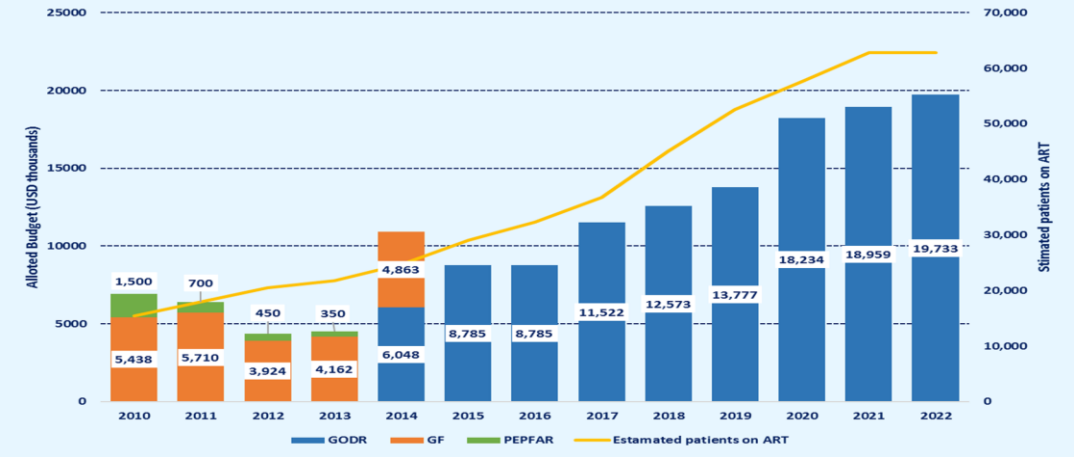
In COP21, the OVC program will continue to provide comprehensive, family-centered, and community-based case management services that support case finding, enrollment, adherence, and continuity of treatment in HIV services, while addressing key barriers faced by FC in initiating and remaining engaged in HIV treatment. Partnerships with HIV treatment sites, community partners, and extended referral networks will complement the efforts of PEPFAR clinical partners to identify undiagnosed, HIV-positive household members of FC and ensure access to HIV testing and counseling, stronger linkage to treatment, and adherence to treatment.

The OVC program will strengthen and operationalize bi-directional referral networks for FC who seek services in both countries through a range of services that address basic household needs to influence treatment outcomes and other measures of health and well-being. Among others, these services may include emergency food assistance, psychosocial support, support for education, economic strengthening interventions, and facilitation of access to documentation needed to receive services.

Evidence of resource commitments by host government

The GoDR has assumed increasing financial responsibility for support to the national HIV response (Figure 2.1.10). Since 2015, the GoDR has taken full responsibility for procurement of all HIV commodities needed in country – a clear step towards sustainability, program ownership, and graduation from financial assistance from external sources. Since 2017 no financial gaps have been reported since then, nor is any gap expected for HIV commodities in 2021 and 2022.

Figure 2.1.9 Transition of ARV & Commodity Supplies Purchases by GoDR



Progress towards local prime partner funding

In COP20, three local organizations received PEPFAR funds as prime award recipients. These three local partners are receiving 21% of the approved COP20 program budget. Efforts will continue in COP21, as one additional local partner will be added to the partner mix, bringing the total allocation to local organizations to US$5,460,031, or 28% of the COP21 budget request. In addition, 21 local organizations will be sub-award recipients of $5,995,223 in PEPFAR funds. Finally, two GoDR entities (DIGECITSS and SNS) will receive $985,000 in PEPFAR funds.

Scale-up of unique identifiers across all sites

Due to high mobility of FC and other priority populations 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. At this point, several identifiers are being used. Patient registration at HIV testing and care sites may require the patient's national ID card number (*cédula*), which is a unique number. However, many migrants, and even some Dominicans, do not have a *cédula* or any other legal documentation. FAPPS assigns each patient a different number at registration. HIV Testing Information System (SIRENP) assigns yet a different ID at the time of testing. In order to decrease duplication and improve follow up, the GoDR has developed a functionality that links SIRENP and FAPPS IDs and can be used retrospectively to evaluate linkage to care. In addition, improvements are being made to link the HIV and TB information systems, which have made it possible to access FAPPS data from the TB registration system (SIOE). PEPFAR supports these efforts by providing

technical assistance HMIS data entry, data quality, updates, and integration through compatible interface, FAPPS, SIOE, and SIREN-P.

2.3 New Activities and Areas of Focus for COP21, including Focus on Continuity of ART and Response to the COVID-19 pandemic.

Program activities for COP21 reflect the importance of tailoring efforts to the evolving needs of the FC population within the DR's public health context. The strategy and related activities have been designed to build on COP 19 and COP20 lessons learned to provide better access to HIV services and ensure differentiated and client-centered services, especially given the impact of the COVID-19 pandemic on the DR health system's capacity and on FC.

Case Finding and Program Growth

To optimize and tailor case-finding strategies, PEPFAR will continue focusing on the most vulnerable FC populations (men above 25 years old, TB patients, FC that are also KP, and older adults with advanced disease, among others), to implement client-centered activities, use more effective case-identification modalities (including index testing in compliance with the WHO minimum standards, recency testing, social network testing, enhanced community engagement through community leaders, and other community-based approaches), as well as expanded and decentralized service provision in the community in compliance with national policies and guidelines (additional details in section 4). PEPFAR-DR will continue expanding "assisted HIV partner notification" for index testing initiated in COP20.

PEPFAR-DR will further optimize the provision of HTS by implementing updated risk screening tools to identify FC most likely to be HIV-positive at the facility and community levels while safeguarding personal information to reduce risk of additional stigmatization.

Since its implementation, the Enhanced Peer Outreach Approach (EPOA), a social network testing approach, has shown encouraging results for positivity rates and ART initiation rates in comparison to other testing approaches at the community level. In COP21, PEPFAR-DR will continue enhancing EPOA implementation through continuous training and supervision in the new provinces.

Closing the Treatment Gap

FY21 Q1 data shows that 88% of PLVIH identified, both FC and non-FC, were able to initiate antiretroviral treatment (proxy treatment linkage) in comparison to 54% for the entire FY20. These remarkable results show PEPFAR-DR capacities to close linkage to treatment gaps experienced in COP19/20 implementation. In COP21 PEPFAR-DR, will further expand access to community-based services in accordance with national guidelines, including ART initiation, multi-month dispensing (MMD) for eligible clients, and refills at the community level to reduce unnecessary burden on health facilities and fast-track ART same-day initiation.

PEPFAR-DR will implement different modalities of community ART distribution, adjusted to local needs in supported provinces. These modalities include community distribution sites, community worker teams, community adherence groups (CAGs), and mobile services, in accordance with the

GoDR requirements for eligibility, including adherence to treatment. Expansion of these modalities will require the GoDR to update patient forms and guidelines. PEPFAR-DR will continue supporting the GoDR to prepare the health system at the national level for effective implementation of community ART services.

Decentralized ART services will 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 services.

PEPFAR-DR recognizes that the only way to effectively serve FC is to understand the constraints and challenges of their social contexts. Hence, PEPFAR-DR will partner with CSOs working with FC to better design client-centered activities. GoDR and PEPFAR-DR work together in the implementation of the HIV program in DR, creating the necessary background for sustainable user-friendly and client-centered service delivery models. COVID-19 emphasized the need for different types of engagement at the community level to ensure continuity of services, and GoDR and CSOs continue to agree on the importance of community-based interventions as a way forward. In COP21, PEPFAR-DR will work with all actors to analyze the short-term impact of community activities, and their relevance to achieve positive health outcomes.

PEFPAR will also work to address stigma and discrimination among FC, KP, and PLHIV who experience high levels of S&D, human rights violations and socio-economic barriers aggravated by insufficient access to government economic support packages.

Improving Continuity of Treatment and Viral Load (VL) Suppression

The COP21 retention strategy is designed to ensure FC continue in treatment and, subsequently, become virally suppressed. In Q1 of FY21, 430 individuals returned to treatment services while 327 were reported as patients with interruption in treatment. 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 transition to and initiation of DTG-based regimens. PEPFAR-DR will continue implementing enhanced ART initiation packages (e.g., transportation, communication, and nutritional support) and will resume treatment campaigns to improve continuity of treatment. Further, PEPFAR-DR will strengthen local capacity in monitoring and evaluation through the provision of technical assistance and training in data collection and management to better identify treatment interruption predictors for corrective actions.

PEPFAR-DR will continue improving VL coverage by expanding sample collection schedules, reducing lab turnaround time, and ensuring case management for VL testing. To improve VL suppression, PEPFAR-DR will improve case management and peer navigation to effectively implement treatment adherence counseling and monitoring. 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 plans for lab and clinical partners.

COVID-19 pandemic impact on program implementation and PEPFAR-DR response

At the onset of the pandemic, the GoDR launched the "National Contingency Plan for Responding to Coronavirus" outlining the intersectoral strategic directions for preparation and response to this major health threat in the DR. Under that plan, the GoDR committed to strengthening surveillance to detect and manage cases and to ensure that health workers had access to up-to-date information about the disease. In addition, the GoDR reviewed infection prevention and control (IPC) practices in healthcare facilities and provided training to health professionals. Following the launch of the Plan, the GoDR declared a state of emergency that included nation-wide curfews, restricted mobility, and limitations on services offered at health facilities.

In November 2020, the GoDR and the Pan-American Health Organization (PAHO) released the DR COVID-19 Response Operational Plan, focusing on planning, monitoring, coordination, risk communication, community participation, surveillance, rapid response equipment, infection control, logistics, case finding and management, delivery of essential health services, and continued operation of health systems. Since January 2021, the state of emergency and related restrictions (curfews, social distancing, mobility restrictions, and reduced health teams providing services in health units, including those supported by PEPFAR) were extended through May 2021, restricting health personal to 50% working on sites, including those supported by PEPFAR.

PEPFAR-DR supported the DR's MoH in the development, dissemination, and adoption of clinical guidelines and standard operational procedures (SOP) to ensure continued supply of ART drugs for PLVIH through MMD and community ART distribution. PEPFAR-DR also contributed to the development of the "General Guidelines for the Standardization of Health Service Providers during the COVID-19 Pandemic", aimed at ensuring the protection of health personnel and clients. In addition, PEPFAR-DR reprogrammed funds for COVID-19 mitigation to train health personnel in national hospitals and PEPFAR supported sites, implement HTS door-to-door and small group strategies following biosecurity protocols, implement infection prevention and control measures, expand communication services including hotlines, use community teams and virtual tools and channels to ensure treatment adherence and retention, and provide nutritional support to vulnerable clients and their families. In FYs 2020 and 2021, PEPFAR-DR adopted mitigation measures and focused on coordinating efforts with the country's pandemic response, protecting gains in HIV prevention and treatment services; preventing the spread of disease among clients, partners, and healthcare workers; delivering services in full compliance with COVID-19 protocols; and mitigating COVID-19 impact on programs while ensuring staff safety and well-being.

Responding to the COVID-19 pandemic, PEPFAR-DR will continue implementing program adaptations initiated in 2020, including but not limited to: 1) expansion of digital health and other virtual tools, including hotline services; 2) further expansion of rapid ART initiation, MMD and community ARV distribution; 3) introduction of new service models (e.g., smaller community teams, flexible/extended service hours); 4) increase in virtual training and supervision approaches; 5) increase in social support including vocational training and nutritional support and 6) proper implementation of IPC measures –including Personal Protective Equipment (PPE) for healthcare providers and beneficiaries.

PEPFAR-DR submitted a request for $1,250,000 from the 2021 American Rescue Plan Act (ARPA). The set of activities planned by PEPFAR-DR involve a comprehensive response to COVID-19's impact on HIV services and PEPFAR programs by addressing COVID-19 prevention, readiness, and mitigation of impact. The interagency PEPFAR-DR team has defined 10 activities in Category I - Prevent, prepare for, and respond to Coronavirus; and 11 activities in Category II - Mitigate COVID-19 Impact on PEPFAR programs and beneficiaries and support program recovery from the impacts of Coronavirus. These activities were defined in coordination with the GoDR and the Global Fund.

Activities include support to PEPFAR-supported sites to improve infection prevention and control; development of protocols and SOPs to improve surveillance systems in HIV clinics; strengthened laboratory capacity to continue required testing for HIV diagnosis and viral load testing, while sharing testing platforms with COVID-19 tests; sequencing of COVID-19 and HIV for ARV resistance; support to households to meet increased household economic and nutritional needs to ensure treatment adherence; and expanded the number of beneficiaries with access to digital platforms to support ART linkage and adherence.

2.4 Investment Profile

Following an executive decision made in 2013, the GoDR has been fully responsible for procurement of HIV-related drugs and commodities. The PEPFAR-DR program and its technical partners provide critical support in forecasting and costing HIV commodity needs and will continue to advocate for increased resources to advance the 95-95-95 goals. No financial gap is anticipated for the procurement of ARVs in 2021/2022.

The Global Fund and PEPFAR have supported HIV activities in the DR since 2004. Since then, both organizations have remained main donors for HIV, contributing 54% of the expenditures on HIV/AIDS in 2016, compared to 46% of spending on HIV by the GoDR.

In 2018, with the support of the Global Fund, the GoDR, through CONAVIHSIDA, developed a sustainability and resilience strategy that was included in the NSP, which showed the 2019 projected level of resources for NSP implementation at US$68 million, 59% higher than the estimated actual spending in 2018 (US$43 million). To evaluate the possible impact of a decrease in funding from the two main donors (Global Fund and PEPFAR), two scenarios were modeled in relation to external financing of the response: gradual and accelerated. In the gradual scenario, the Global Fund begins a transition in 2025, while PEPFAR gradually reduces its contribution over the 2019-2023 period. Under the accelerated scenario, the Global Fund begins the transition in 2022, while PEPFAR reduces its financing to <50% of FY 2019 levels by 2023.

Three scenarios were examined in relation to projected expenditures on HIV/AIDS, considering the estimates to implement the NSP:

- **Conservative scenario:** If spending remains constant (i.e., growth accounts for an estimated 3.3% inflation rate per year), the expected gap would be between US$47-60 million for the period 2019-2023. The GoDR would have to increase its contributions by about 76% in 2023 as donors decrease their support.

- **Moderate scenario:** If spending maintains the growth reported in recent years (i.e., on/about 7% annually), the expected gap would be between US$ 76-89 million for the 2019-2023 period. The government would have to increase its contributions by approximately 117% in 2023 to supplement external contributions.
- **Ambitious scenario:** If spending were increased to match the needs reflected in the 2019-2023 NSP, the expected gap would be between US$ 201-214 million. Thus, the amount that the government would have to mobilize in 2023 is approximately 2.5 times the current spending level of US$ 52-55 million per year.

Given these scenarios, even the conservative option would pose considerable challenges to increasing the country's domestic financing over the next five years. If the country adheres to the commitments in the NSP, the challenge would be even greater.

However, given the GF and PEPFAR actual expending in 2019, actual budget in 2020, and expected allocation in 2022, in COP21 PEPFAR, in coordination with the Global Fund, will support the GoDR in updating this investment profile for more accurate projections that will subsidize decision-making on national budget allocations for the HIV response between 2023 and 2005.

2.5 National Sustainability Profile Update

Strengths of Sustainability:

***Participation of CSOs (9.17 dark green)*:** The participation of CSOs in HIV policy, planning, and implementation has increased. Many of them provide comprehensive care services as part of the national HIV response and complement the public service network.

Product safety and supply chain (7.34 light green): The procurement of HIV test kits, ARVs and other supplies is fully financed with national sources; this element maintained its strength thanks to the considerable contributions of PEPFAR to supply chain management and logistics, including forecasting and commodity storage. The domain shows a slight decrease as compared to 2017 because the group only rated categories that could be verified and justified with recent documentation.

***Mobilization of national resources (7.78 light green)**:* The country has a financing strategy. The health insurance plan includes care and treatment, although it does not include ARVs, as those are covered by the MoH. The national budget includes HIV financing which, to some extent, has received technical assistance from PEPFAR for funding projections and needs.

Sustainability weaknesses:

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

General: Some reductions noted in elements such as planning and coordination (1), laboratory (10) and financial and expense data (15) were caused by changes in previously

established criteria and adjustments in the qualification of some indicators. These elements remain critical areas to be addressed within the national HIV response.

Differentiated models of care, especially MMD, are 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 both in virtual and on-site modalities. PEPFAR-DR will focus on scaling up the use of unique identifiers for patients across all sites, including non-PEFAR sites. National TB policy and guidance on TB/HIV co-infection exists. Integrated TPT is now a routine component of the HIV clinical care package, with 3HP currently being introduced. SOPs for index testing, including adverse event monitoring and safe index testing practices, are in use at all PEPFAR-supported sites.

As part of the implementation phase, PEPFAR is currently assessing the acceptability of HIV self-testing (HIVST) among priority populations. PEPFAR will work with the GoDR to update the country's testing policy and to ensure product registration, financing, procurement, and distribution. PEPFAR will scale up HIVST implementation during COP21 by leveraging FC and KP service delivery platforms in four PEPFAR priority 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 the facility and community levels. PEPFAR-DR is also planning to evaluate local pharmacies as HIVST pick-up points. PEPFAR-DR will target 1,000 FC tested in three provinces; as well as 500 FSW, 500 MSM, and 500 ICTT contacts tested in two provinces with HIVST in COP21

2.6 Alignment of PEPFAR investments geographically to disease burden

PEPFAR-DR will build on previous years' experience and continue support of COP20 priority provinces without expansion to other sites in COP21. To further improve patient-centered care, priority sites will be implementing different modalities, adjusting strategies to the context of each province and site.

Figure 2.5.1 PLHIV in Dominican Republic, by province 2020

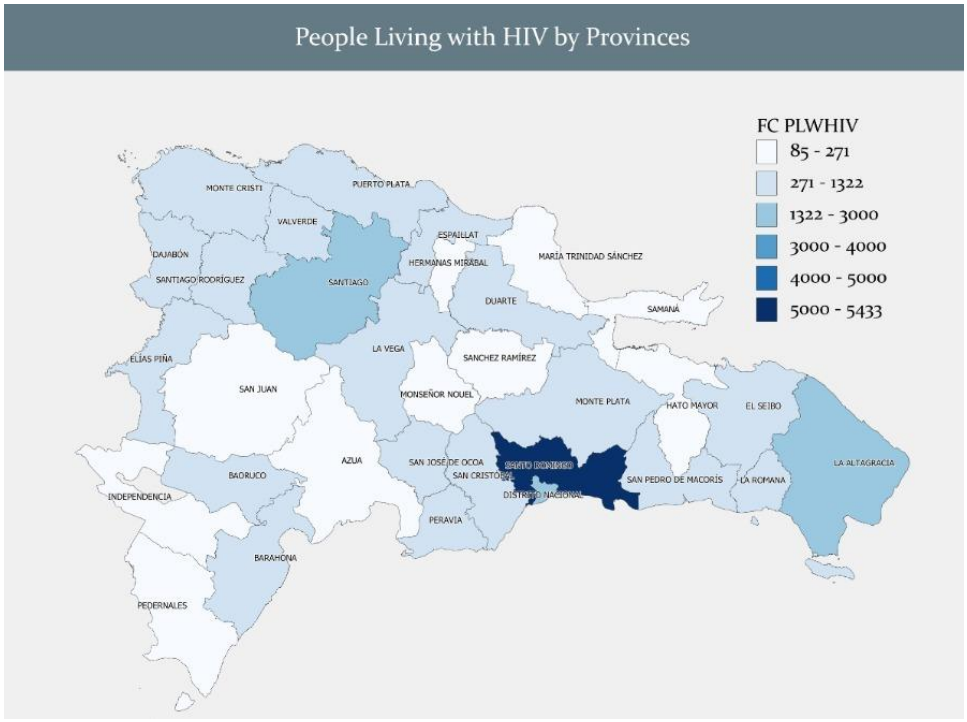
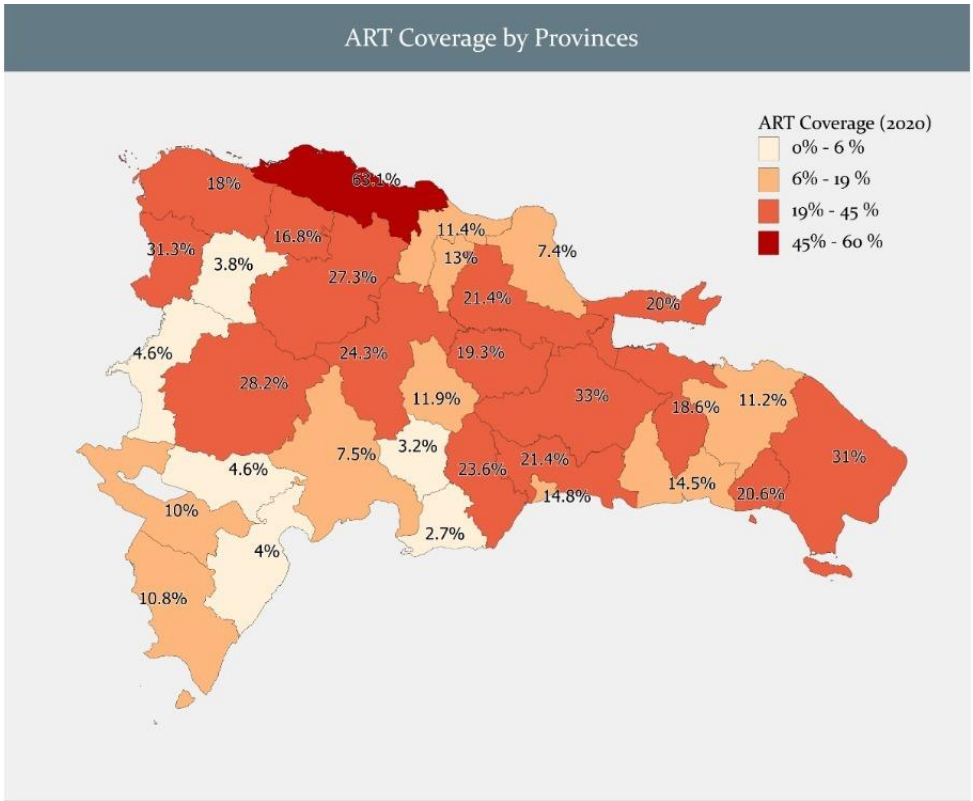


Figure 2.5.1. ART coverage in Dominican Republic by province, 2020



PEPFAR Dominican Republic: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Monitoring Coverage for ARP 20

The U.S. President's Emergency Plan for AIDS Relief

Figure 1: Number of PLHIV by Province

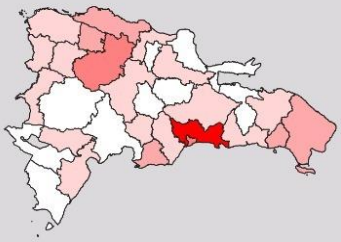


Figure 2: Percent Treatment Coverage

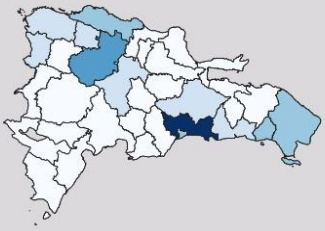
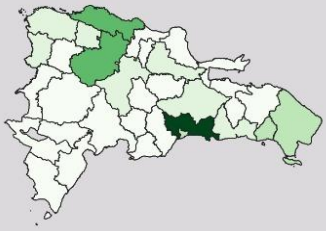


Figure 3: Viral Load Monitoring Coverage



2.7 Stakeholder Engagement

The success of PEPFAR in the DR has always depended on the collaboration and cooperation of the GoDR and other actors, including civil society. As the GoDR's commitment to taking ownership of the national response grows stronger, productive working relationship with GoDR entities has become increasingly important. The new DR government administration took office amidst the 2020 COVID-19 pandemic. This involved new leadership at the top ministerial level, including a new Health Minister who was recently replaced after only six months in office and new directors for key health-related government bodies, e.g., the National Health Service (SNS), the STI and HIV/AIDS Control Office (DIGECITTS), and the National HIV/AIDS Council (CONAVIHSIDA). These are direct counterparts working in the primary health care network, the national HIV/AIDS Strategic Plan and Policies, and in coordination with the Global Fund and civil society. As part of the COP21 planning process, the PEPFAR-DR team met with the leadership of these organizations to present the details of the COP21 Planning Level Letter, and particularly the continued focus on FC through a more intensive business approach.

PEPFAR-DR consulted with CSOs during the COP21 process and incorporated feedback received to support HIV self-testing demonstrative activities in the country, continue ART community distribution, increase efforts to decentralize VL tests and CD4 counts, and create a referral and counter-referral system for HIV patients seeking HIV services in both countries, DR, and Haiti. Strategic planning meetings were also held with the MoH (SNS, DIGECITTS, CONAVIHSIDA), PEPFAR implementing partners, and multilateral stakeholders. Consultations included COP21 strategic direction, priorities, and 360^0 coordination. The private sector, including companies and workers' unions, participated fully in the HIV/AIDs Sustainability Index (SID) process since 2019. Since then, their continued engagement has been done through activities led by CONAVIHSIDA. Entities such as Grupo Popular were present and showed interest in continuing discussions on possible synergies in the health sector. In FY21, the OVC program added partners from across

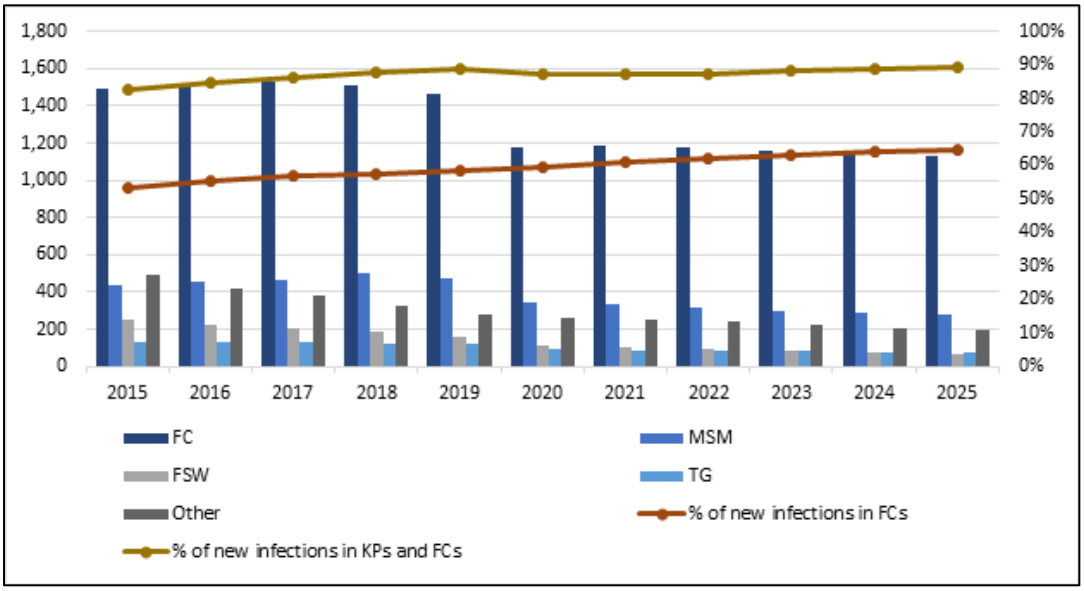
sectors to its service network including a partnership with Fundación Popular, a prominent private sector foundation, to facilitate ongoing food and medicine donations to OVC beneficiary households. The project will continue to engage the private sector in agreements to build and strengthen local service networks that support OVC beneficiaries.

There is an opportunity for increased engagement with sectors that hire FC given the legal framework that encourages corporate social responsibility and continued representation of the private sector on the CONAVIHSIDA board. In COP21, PEPFAR-DR will continue engagement with GoDR entities and CSO partners to ensure appropriate activities and continued coordination to reach aggressive targets. Coordination with GoDR entities continues to be of relevance, especially as the shift to client centered approaches requires innovative and tailored services to meet the needs of FC. To meet these needs, it is important that the GoDR enables the continuum of care in community services and primary care centers, and delivery of ART through different outlets by trained community health workers.

3 Geographic and Population Prioritization

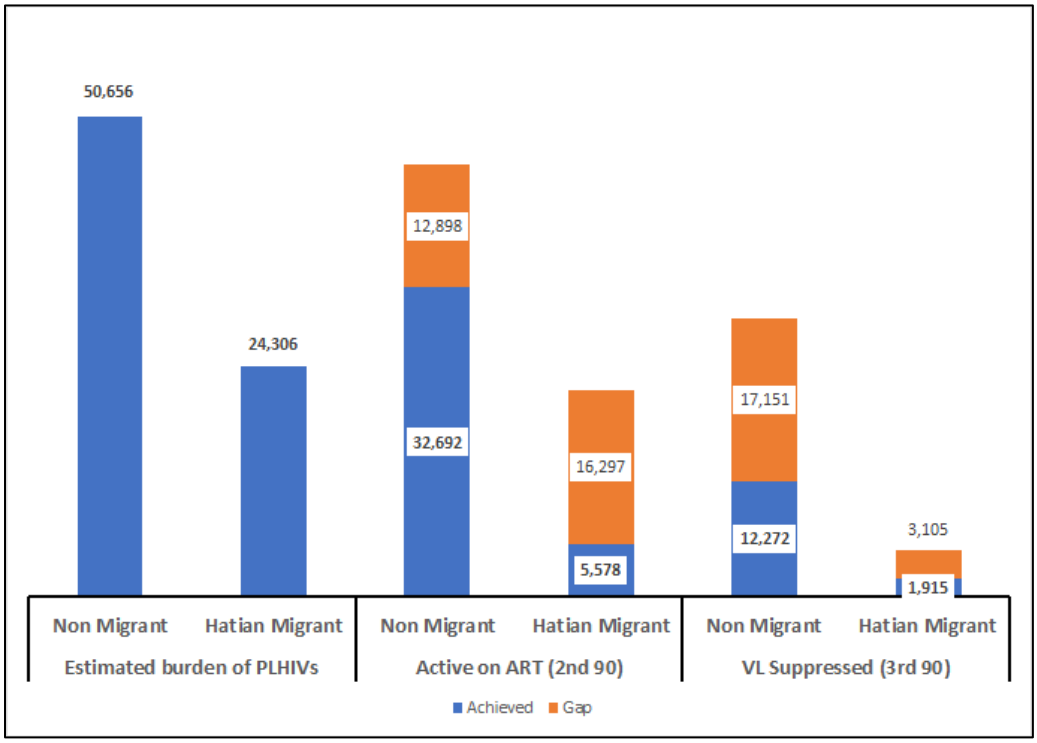
The HIV epidemic in the DR is concentrated both by population and geography. In 2021, 84% of new infections are expected to occur among key and priority populations, with the largest proportion (58%) occurring among FC, a trend that is expected to remain stable over the upcoming years (see Figure 3.1). As FC are disproportionately affected by HIV and have significant limitations accessing health services in the DR, PEPFAR-DR will continue focusing on closing the case finding and treatment gaps among this vulnerable population (Figure 3.2). Without intensive prevention, testing, and treatment interventions that specifically target this population, epidemic control in the DR will remain elusive.

Figure 3.1 Distribution of new HIV infections in persons over 15 years of age, by population group. Dominican Republic, 2015-2025



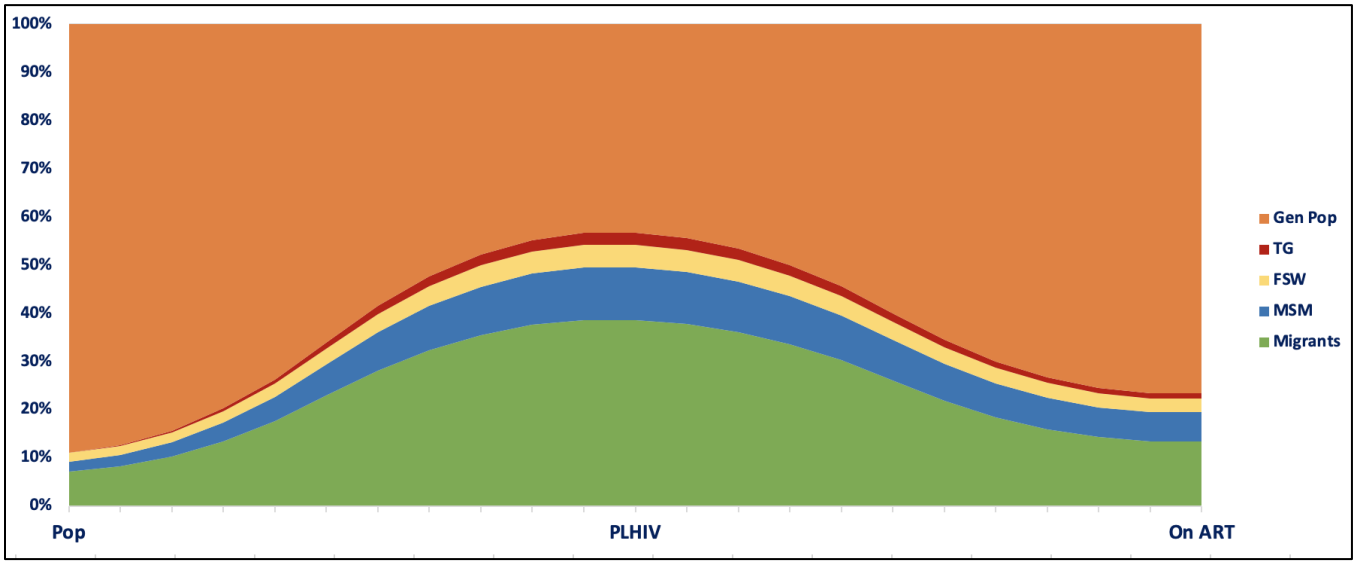
Source: Spectrum, 2019

Figure 3.2 Estimated Gap in ART Cascade, FC versus all other clients



Source: Spectrum 2020, DR HPIMS

Figure 3.3. Distribution of HIV infections and ART coverage in persons over 15 years of age, by population group. Dominican Republic, 2020



Source: Migrants in Spectrum: does not include descendants, who fall in "Other Males" or "Other Females". Also, Estimate of Migrants on ART in Spectrum is 19,357

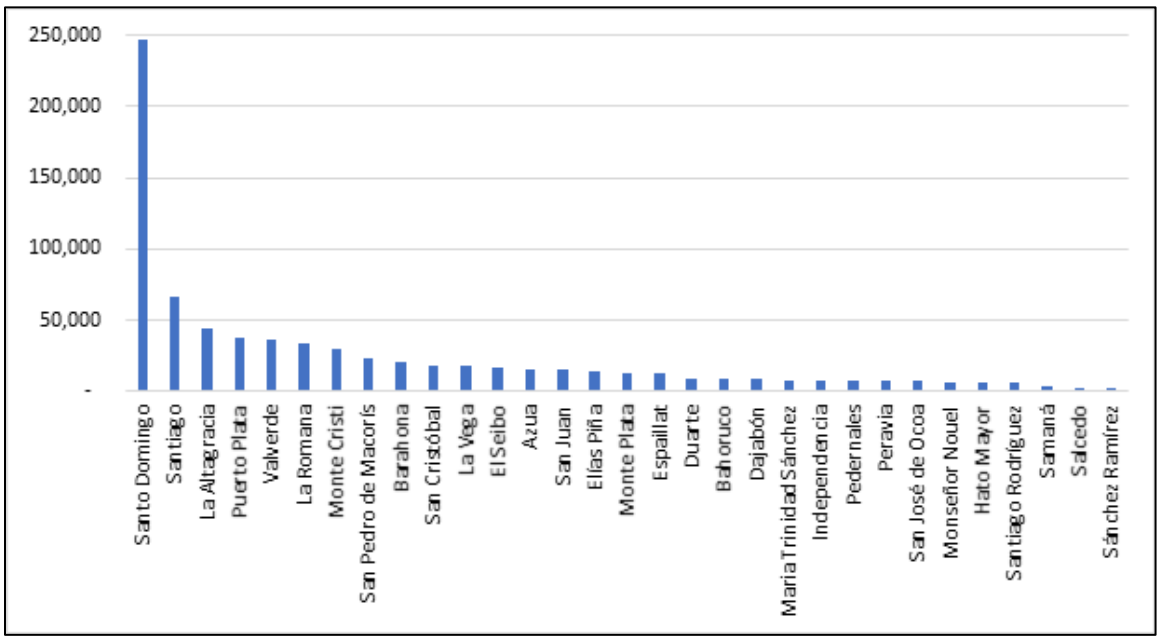
Accurate information on the geographic distribution of FC is vital for program design. Prior to COP 20, PEPFAR-DR focused on strengthening the country's capacity for HIV service provision to key

populations (MSM, TGW, and FSW) and priority populations, which included migrants, through the twinning model. The goal was to transfer NGO's capacity to provide high quality, friendly, and well-targeted services to GoDR clinics in Santo Domingo, La Romana and Puerto Plata

In COP 20/FY21 PEPFAR DR expanded activities to San Pedro de Macorís, La Vega and San Cristobal – provinces adjacent to Santiago and Santo Domingo with easy commute working in either Santo Domingo or Santiago, La Altagracia, a province with a high number of FC workers, and Puerto Plata and Valverde. In Monte Plata and La Romana, PEPFAR pivoted support from KP to FC

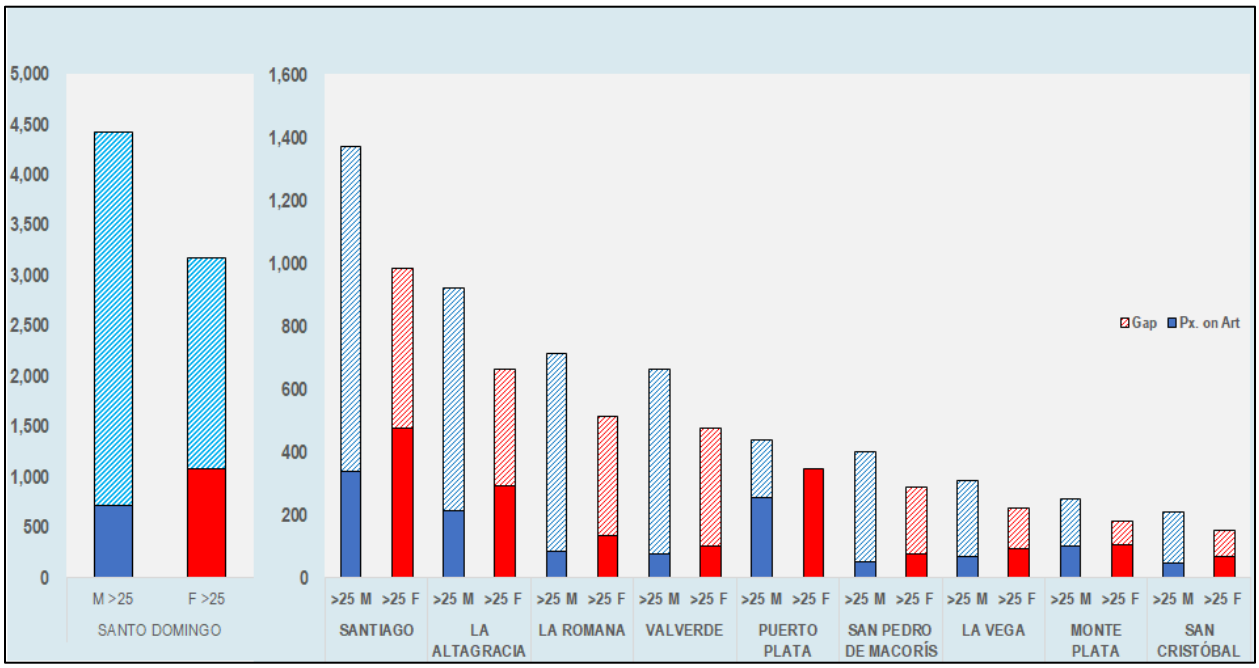
Triangulating FC HIV prevalence data against PEPFAR and national treatment data helped the PEPFAR-DR team to further identify areas with the most significant treatment gaps for FC. The results of this analysis formed the basis for geographic targeting of PEPFAR investments in the DR, including a data-driven shift from rural areas to large urban centers where the greatest gaps were found.

Figure 3.3 Number of Dominicans of Haitian Descent and Haitian Migrants in the Dominican Republic by Province, 2017



Source: National Immigrant Survey, 2017

Figure 3.4 ART Gap in FC by Sex in COP20 focus provinces in 2020



COP21 will continue with the program pivot introduced in COP19 to focus resources and efforts on reaching FC in high-volume sites. In COP21, PEPFAR will maintain its presence in the ten provinces identified for support in COP20: Santo Domingo, Monte Plata, San Cristóbal, San Pedro de Macorís, La Romana, La Altagracia, La Vega, Santiago, Puerto Plata, and Valverde.

4 Client-Centered Program Activities for Epidemic Control

To support the DR in moving towards and meeting the UNAIDS 95–95-95[8] targets, marginalized subpopulations such as FC must be reached to ensure diagnosis, rapid ART initiation, continuity of treatment and VL suppression. Evidence from different settings globally shows that migrants and mobile populations 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. Exposure to these factors likely increased during the FY20/21 COVID-19 pandemic, exacerbating underlying vulnerabilities among FC. 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 of healthcare providers at facility and community levels. This helps create S&D-free environments with the required psycho-social, case-management, navigation, and

[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

treatment adherence support. Targeted social behavior change communication materials are designed in creole and use Haitian cultural symbols to increase accessibility during outreach. To effectively reach FC in COP21, PEPFAR-DR will continue to increase community-level efforts, ranging from demand creation, optimizes case-finding, and HIV testing to community-based and client-centered care and support services.

In COP21, provision of HIV services will be expanded through community services to expand access to testing, treatment, and other HIV services. Based on FY20-21 experiences, PEPFAR-DR will continue advocating for and support the implementation of same-day ART initiation and ART distribution at the community level in PEPFAR-supported provinces, in compliance with national guidelines. In COP21, HIV care and treatment will continue to be decentralized in coordination with the GoDR, taking the services closer to FC, either to a facility closer to their homes or within their communities. Shifting from HIV facilities to primary care units, mobile clinics, or community teams will depend on several factors: urban/rural settings, number of clients, availability of services, feasibility of community strategies, among others. PEPFAR-DR will work with the GoDR to institutionalize task shifting and task sharing on ART delivery and provision of routine HIV care to ensure 1) trained and supervised community health workers who are able to dispense ART between regular clinical visits; and 2) trained and supervised lay providers who are able to distribute ART in the community. Provision of HIV health-related services, including peer navigation and individual case-management, at the community level will increase linkage to and continuity of treatment. PEPFAR-DR engagement with national and sub-national health services established in COP19 will continue for further strengthening and synergistic partnerships with MoH authorities and multilateral partners for the effective implementation of coordinated activities towards epidemic control.

The PEPFAR-DR portfolio will continue supporting the GoDR 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 transition to DTG-based regimens, strengthening adherence activities, supporting VL coverage and suppression, and adapting clinical care and outreach materials to be culturally and linguistically responsive to FC.

PEPFAR activities for COP21 will continue to consolidate the pivot to FC. The strategy and related activities are designed to support a range of targeted interventions aiming to achieve HIV epidemic control within the ten prioritized provinces. PEPFAR DR will continue developing a client-centered approach that prioritizes patients' needs and preferences and shifting resources and efforts to reach those in greater need. In coordination with the GoDR, PEPFAR DR 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 S&D, and as effective platform to use incentives and improve progression through the HIV treatment cascade.

Stigma and discrimination (S&D)

According to the DR Stigma Index 2, stigma remains a problem among PLHIV and manifests internally as well as externally from different people and in different contexts, including in health care settings. Stigma and discrimination (S&D) against PLHIV contribute to poor health care quality, coercion and violence, job loss, and exclusion from social environments. In the DR, participants reported high levels of internalized stigma. The most common form of internalized stigma relates to difficulty telling others about being HIV positive and hiding their status from others. External stigma was also common among Stigma Index respondents: over a fourth of respondents had experienced negative comments made about their HIV status from family members and 36% reported hearing negative comments about them from other individuals; 14% had experienced at least one form of stigma while using HIV services. The most common forms were negative comments, gossip, and verbal abuse. In COP21, the DR program will continue to work with the GoDR, CSOs, and multilateral partners to achieve S&D-free services.

To reduce S&D, PEPFAR-DR will implement continuous training and coaching for, and supportive supervision of facility and community-based healthcare providers. All teams will have creole-speaking health providers or will have access to real-time translation services. In addition, community-led monitoring (CLM) will facilitate effective feedback and corrective actions at the provider level. UNAIDS will work with a local CSO to implement CLM that focuses on three pillars: assessing health services for adjustment to FC needs (e.g., expanding service hours or providing safe spaces), defining and assessing "client-centered" services, and improving community participation to ensure engagement and accountability.

CLM incorporates client perspectives and aims to identify persistent problems, challenges, and barriers to service uptake and to identify workable solutions to overcome these barriers and ensure beneficiaries have access to services. CLM includes input from recipients of HIV services in a routine and systematic manner that will translate into advocacy, action, and change in services.

The process of CLM in the DR has already included the creation of a technical advisory group (TAG) with different stakeholders, including national and PLHIV representatives. The local CSO identified will coordinate with this advisory group to build upon their knowledge and understanding of HIV service delivery and networks of PLHIV.

For COP21, CLM will complement the client centered approach (CCA). The DR program will continue its work to remove all barriers to continuous care and maximize responsiveness to client needs.

4.1 Finding clients with interruption in treatment and getting them on treatment.

For COP21 activities, PEPFAR-DR will focus on innovative and cost-efficient strategies tailored to the local epidemiology and current ART coverage among FC, with an appropriate mix of facility and community-based case-finding approaches. All HIV testing activities will follow normative guidance and protocols to ensure consent, confidentiality, adequate counseling, correct results, and immediate connection to care and treatment services. As part of the optimization process, PEPFAR-

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, thus maximizing impact.

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

- **Identifying and focusing on groups requiring additional attention**: Focusing efforts on most vulnerable FC populations (men, TB patients, older adults, key populations, people with advanced disease, etc.).
- **Implementing tailored strategies focusing on FC**: Using strategies to increase efficiency of HIV testing and ART initiation by:
    - *Introducing innovative case finding approaches* at facility and community levels combined with a systematic offer of index testing for HIV+ individuals to test their sexual partners and biological children. In compliance with the WHO minimum standards of HIV care, DR will offer index testing for all newly diagnosed and current PLHIV on treatment, especially among those who are not virally suppressed. As part of COP21 implementation, negative contacts will be linked to PrEP services in selected supported facilities and most efficient modalities of index testing, such as assisted partner notification and establishing a point-of-contact for Index Testing at each site or community team, will be used. PEPFAR-DR will increase the number of teams implementing index testing at the community level and will continue implementing strategies to maintain confidentiality during the implementation of Provider-Assisted Referral - for example, PEPFAR-DR will offer 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 to family violence or gender-based violence (GBV). As part of a comprehensive HIV program, PEPFAR-DR programs support a human-rights-based approach that responds to community priorities and decreases HIV risk while promoting social inclusion across the HIV clinical cascade. Activities included provision of post-GBV clinical services for survivors of sexual violence, inclusive of HIV testing with referral to care and treatment as appropriate; post-exposure prophylaxis (PEP) , reached within the first 72 hours, sexually transmitted infections (STI) screening and treatment, psychosocial services for emotional and physical violence, and active referral to other services required by the GBV survivor, such as connecting them with the District Attorney's office, Ministry of Women, or other services in the public sector. PEPFAR-DR will continue to address gaps and service bottlenecks and strengthen capacity of providers to properly address GBV and how to respond to adverse events. In COP21, areas for possible expansion include demand creation by peer promoters, increasing GBV screening outreach services, and linkage of clients to clinical sites.

- *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-based Testing:* PEPFAR-DR will continue building on EPOA experience that has continued to show positive results and will scale-up the strategy in COP21 supported sites. PEPFAR-DR will continue using mixed approaches (index testing and EPOA) to increase case-finding during FY22. Based on lessons learned, PEPFAR-DR will also use EPOA as a platform to introduce HIV Self Testing (HIVST) through partner or peer testing among FC and KP if self-testing is approved for implementation in FY22, ensuring linkage to further testing, prevention, and treatment following HIVST.
- *Optimizing the provision of HTS:* Building on successful COP19-20 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 levels and conducting micro-level mapping to identify HIV hotspots will be part of the COP21 activities. Community efforts to identify FC men will focus on "hotspots" where FC men congregate, including after-work social gatherings and venues know for sex work. Establishing a "warm handoff" protocol between clinical/community care efforts and the OVC programming for eligible clients will also strengthen linkage to care.
- *Maximizing case finding:* PEPFAR-DR will introduce recency testing in COP21 to help identify new clusters of transmissions and inform and maximize the efficiency of testing services.
- *Reinforcing test and start: In* coordination with the GoDR, PEPFAR-DR will develop and implement SOPs for same-day initiation of ART, particularly for community-based settings. PEPFAR-DR will increase efforts to test and treat FC men, who are more reluctant to access services. PEPFAR-DR will review approaches monthly to adjust service models 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 users' needs and preferences and shifting resources and attention to most vulnerable individuals.
    - Peer navigators for new HIV+ individuals, including navigation from community to facility for ART initiation and navigation to community services, including community ARV distribution outlets.

- Reducing unnecessary burden at the health facility, simplifying, and creating fast-track lines for service delivery and streamlined lab processes.
- Reducing individual and structural barriers to access HIV services by alleviating difficulties locating and tracking newly diagnosed individuals, normalizing HIV testing, diminish the S&D, and using incentives to improve progression through the HIV treatment cascade.

4.2 Continuity of treatment, ensuring viral suppression.

PEPFAR activities for COP21 will continue to expand access and quality of service for FC. The proposed strategy and related activities are designed to support an upsurge in service entry points to effectively reach HIV+ FC in targeted areas, decentralizing the provision of HIV services in close coordination with the GoDR.

PEPFAR-DR will focus on addressing FC-specific barriers for same-day ART initiation, MMD, and client-centered approaches. PEPFAR will continue scaling-up MMD and transition to DTG-based regimens. PEPFAR-DR will work with the GoDR to complete the transition of the eligible patients during COP21 based on the reduction in the availability of EFV.

The client-centered approach in COP21 will include client- friendly services at the facility and community levels. Healthcare 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 to ensure continuity of treatment and VL suppression include, but are not limited to:

- **Enhanced case management**: Case Managers are vital to improve continuity of treatment through-out all stages of the HIV cascade. PEPFAR-DR will improve procedures at health facilities for rapid treatment initiation, viral suppression monitoring, continuous retention, motivational interviews and adherence counseling, and S&D reduction. In FY22, PEPFAR-DR will continue implementing tele-medicine, digital-health, and other communication technologies to 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 for peer support among patients. Peer 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 for 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 levels. FC starting ART will receive a 1-month start-up package that includes a SIM card for follow-up, nutritional support, transportation allowance, and paid supplementary lab tests. PEPFAR DR support will continue for 3 to 6 months until trust is

built for effective continuity on treatment. For effective follow-up, each new FC on ART will be assigned to a community worker or peer navigator for weekly check-ins and will receive appointment reminders by SMS. Peer navigators and health promoters will also provide community outreach (e.g., back-to-treatment campaigns) of individuals interrupting treatment for proper return to client-centered packages.

- **Decentralized ART delivery:** Decentralization of ARV delivery is one of the main priorities for PEPFAR DR as community-based approaches better suit FC behaviors and needs and complement existing facility-based delivery. Facility-based delivery will offer ART initiation and refills using flexible hours (early morning and evenings and weekends hours). "Out-of-facility" models will include ART initiation packages and ART refills through community workers/teams and mobile clinics. Facility extensions at the community level may include the use of primary care facilities for ART refills among stable patients -as they will not need clinical appointments.
- **Simple and standardized monitoring systems:** PEPFAR DR will optimize the implementation and use of log registers to track treatment interruption, ensure timely improvements at facilities and community sites to address bottlenecks. PEPFAR-DR will increase the identification of tracking methodologies and distribution of SIM cards as soon as patients are recovered. PEPFAR DR will use SMS for pre-appointment reminders and supportive counselling.
- **Improve viral load coverage and VL suppression:** VL sample collection schedules at site level will be expanded from 1-2 to 4-5 days per week while improving reporting systems aimed to reduce delivery time of results to zero. PEPFAR DR is working towards the expansion of VL processing laboratories at the national level with the addition of the Centro Sanitario (in Santo Domingo) and Porvenir (in San Pedro de Macoris) labs and towards improving specimen processing and handling.

  PEPFAR-DR will continue providing technical assistance to develop and implement SOPs to identify and manage virologic failure among patients and support SOP implementation on how to switch ART regimen. In addition, PEPFAR-DR will strengthen patient

  education activities and counseling to improve VL monitoring and treatment adherence.
- **OVC Service Package for FC Families:** Will include interventions for children (under 18 years of age or under 20 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 household. The package will include community-based service delivery with strong clinical and other service provider linkages.

Figure 4.2.1 OVC Program Package

Family Case Management	
HEALTHY	**SCHOOLED**
• HIV risk assessment for those with unknown HIV status • Referral of identified at-risk individuals for community- or facility-based HIV counseling and testing • Home-based delivery and/or referral for HIV services (adherence, retention, and disclosure counseling, linkage to treatment, viral load testing, PMTCT, community or clinic support/adherence groups, case conferencing) • Referral for reproductive health, nutrition, HIV prevention, TB, immunization, and other health services • Health education (e.g. WASH, nutrition) • Distribution of hygiene/sanitation supplies • Food and nutritional support	• Education materials support • School fees, uniforms and shoes • Community homework/tutoring support • Transportation assistance for education • Referral for literacy training
STABLE	**SAFE**
• Linkage to social protection programs (including support for gas and electricity) • Referral/logistical support for accessing documentation services, with focus on birth certification and national identification for eligible beneficiaries • Referral for services related to household economic strengthening (social protection grants, microenterprise services, vocational training, etc.)	• Identification and reporting of child abuse or violence to relevant child protection authorities • Referral to relevant service providers (legal support, counseling, medical care)

PEPFAR facility-level support includes personnel, clinical training, technical assistance, and supervision, on effective case-management and navigation services, adherence and psycho-social support and counseling using population-specific materials and interventions, tools for data collection and use, and continuous quality improvement interventions. There is also a significant community-level component ranging from navigation services and adherence counseling to community ART distribution. In addition to the traditional site-level DSD 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 COP21, service delivery will also include HIV community services. 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 linkages to treatment and generate a referral network within existing clinical structures and community teams that promote adherence and retention through peer navigation and case management. The engagement with national and sub-national health services will be crucial and is expected to include strong involvement by the MoH authorities, given the common interest in integrating HIV services into primary care in the country.

4.3 Prevention, specifically detailing programs for priority programming

PEPFAR-DR will continue expanding PrEP availability within the limits posed by the MoH given drug availability. In FY22, PrEP will be available in all PEPFAR-supported provinces. COP21 expansion will also include introducing PrEP at public facilities.

Strategies for maximizing retention in PrEP include setting up separate, non-stigmatizing spaces within health facilities for consultations, fast-tracking patients through medication pick-up, emphasizing sexual health (rather than disease control) messages, and tailoring approaches to the characteristics and needs of each eligible sub-population. PEPFAR-DR will continue to use a phased approach, keeping a "controlled" expansion to monitor client satisfaction and program results.

Figure 4.3.1. PrEP expansion in the Dominican Republic, COP17-COP21

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 Pedro de Macorís**	**MSM TG FSW Sero-different partners Breastfeeding women**	**1,849**	**2,302**
COP21/FY22	**Same as COP/FY21**		**2,219**	**3,220**

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

Haiti-Dominican Republic Collaboration and Coordination

The Haiti and DR PEPFAR programs will continue to collaborate to improve referrals along the border and ensure continued treatment among PLHIV that cross the Haiti-DR border. The

populations 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 COP21, PEPFAR DR will take into consideration the challenges posed to binational collaboration due to the COVID-19 travel restrictions and impact on services in both countries, differences in the health service structure in each country, and language and cultural barriers. Referrals will involve questions to FC in the community and health facilities about their mobility and plans to travel or move back to Haiti. Clients showing a high probability of crossing the border will receive information by phone, SMS, or paper about a hotline number that will be embedded in either PEPFAR or GoDR services whereby FC patients will be able to obtain information on health services and treatment enrollment in Haiti.

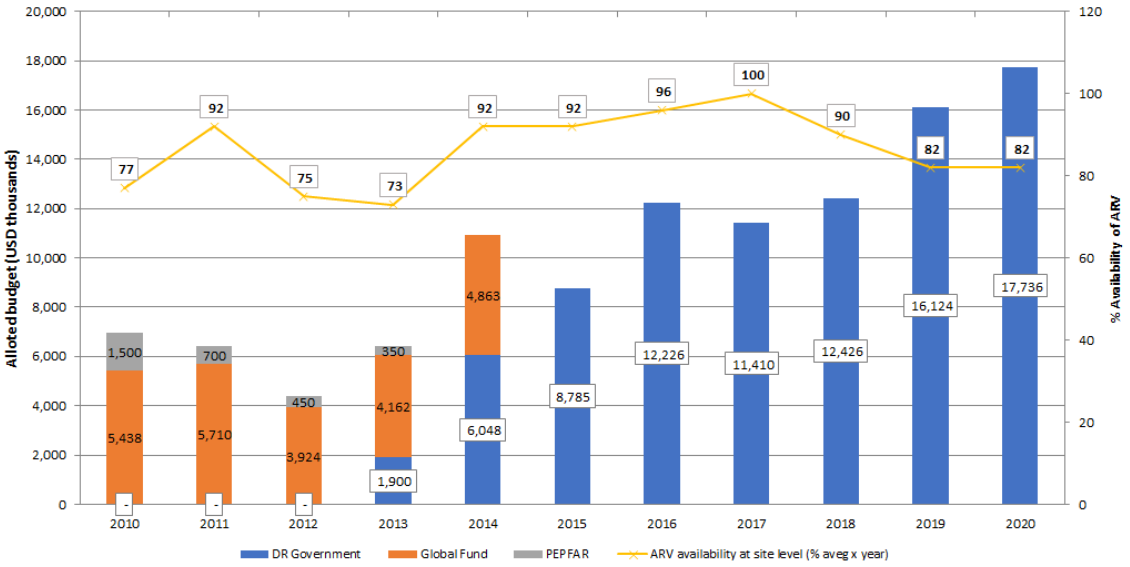
Funds for U.S. Department of Defense (DOD)

The DOD will complement PEPFAR's clinical work via collaboration with the Dominican Military and Border Security to reduce S&D towards FC and PLHIV. 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 August 2006. TCESFRONT is responsible to establish patrol and control in areas throughout the land border with Haiti, which is 376 km long and includes three main border crossing points: Dajabón, Elías Piña and Jimaní.

Through an implementing partner, DOD will work with CESFRONT to provide comprehensive S&D) training for providers to reduce S&D 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

ARV & Commodity Supplies Purchases by the GoDR and Donor Partners, 2010 to 2020



Shifting the commodity financing from external to domestic financing has been an important achievement in DR's national HIV financing. As mentioned before, the GODR remains responsible since 2015 for purchase of all ARVs and HIV supplies using its own domestic resources. However, while PEPFAR does not purchase HIV commodities, the Program provides support to the national pharmaceutical procurement and supply chain systems to ensure 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 DTG.

PEPFAR DR will continue assisting GoDR on supply chain management for HIV commodities at national and sub-national levels to reach HIV epidemic control in the country. Technical Assistance will include participation on technical working groups, training in forecasting and logistics, 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 MMD.

Broader HIV financing data indicates that DR's national HIV investments continue to be scarce. At the above-site level, PEPFAR DR will continue to provide critical support in the forecasting and costing of HIV commodity needs and will continue to advocate for increased resources to advance 95-95-95 goals. This support will ensure there is no financial gap for the procurement of ARVs in 2022, as the new government is facing many competitive priorities, including the impact of the COVID-19 pandemic.

PEPFAR DR 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.

At the sub-national level, PEPFAR-DR will support inventory management improvement, effective use of information systems and reporting/requisition procedures, and distribution to sub-national warehouses.

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 100% stock status observations from storage sites showing "stocked according to plan" results at sub-national levels by Q4 of FY21.

PEPFAR-DR will continue supporting the GoDR to complete the transition to TLD in 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.

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 quality information health commodities consumption, stock levels, and utilization of HIV products (including DTG). 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 COP21 implementation, PEPFAR-DR will increase the frequency of supportive supervision visits to provide on-site technical assistance on a monthly basis.

PEPFAR-DR will continue to document all supply chain innovations implemented, including programmatic components as well as expenditures to better inform the GoDR on scale-up scenarios.

4.6 Key Populations (KP)

In COP21, PEPFAR-DR will continue KP support through core interventions as PrEP and legacy KP clients within treatment programming. PEPFAR-DR will maintain inclusive services for both KP and FC and will work with supported sites to better track clients. As FC are a marginalized and diverse group in the DR, it is important to understand potential KP dynamics within the FC population, as these might be different from those observed among other KP living in the DR.

KP activities will build on effective experiences of the FC approach while prioritizing community and civil society engagement, addressing S&D, and building KP-competency among health providers. PEPFAR-DR will work with local organizations to strengthen services that are non-judgmental and non-stigmatizing, meeting the unique needs of KP clients and recognizing inherent challenges in rights-constrained settings for KP programming. To understand and tailor services

to FC and KP needs, activities such as CLM will facilitate independent feedback from members of both populations. CLM will also assist in direct engagement with FC/KP community-based organizations and networks.

In COP21, the DR will continue to focus on linkage to treatment and reinforce retention in treatment for VL suppression among KP. ART delivery and adherence activities will be complemented by accurate and timely VL 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 Undetectable=Untransmittable (U=U) approach.

PEPFAR DR will also increase the use of information and communication technology, including social media and virtual platforms, to provide virtual adherence support and treatment literacy. Due to the COVID-19 pandemic, services were modified in FY2020 using a mixed approach that incorporated both in-person and virtual services, which were well received by KP. This approach will be maintained with digital health support (hotline, social-media, direct calls) to FC and KP. New opportunities will be explored for virtual case management and community monitoring with client feedback from multiple sources, including online surveys.

4.7 Collaboration, Integration and Monitoring

Both CDC and USAID support clinical care activities at the site level as well as health systems strengthening efforts to strengthen service provision. The PEPFAR Coordinator and the USAID Health Office Director participate in the Global Fund Country Coordinating Mechanism (CCM). Through UNAIDS, PEPFAR will also work on cross-border referrals with counterparts in Haiti.

At the OU level, PEPFAR-DR utilizes a data-driven CQI methodology aimed at optimizing HIV/TB clinical care in PEPFAR-supported sites. 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. In COP21, PEPFAR DR will continue work on the CQI methodology and focus on aligning PEPFAR approaches with those of the MoH, thus contributing to health system strengthening and strengthening data quality.

This CQI initiative adds necessary technical and support to personnel to better deliver services and ensure access to linkage to treatment and viral suppression to patients coming from community outreach. This support includes, but is not limited to, monthly visits at the site level, high frequency weekly e-reporting, weekly calls with implementing partners, monthly results discussion meetings, and quarterly results discussion meetings. The 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 incentivizes teamwork and promotes active participation from teams, and 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 HIV services.

PEPFAR DR's 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 CQI interventions. More importantly, PEPFAR DR provides technical data analysis and triangulation of high frequency reporting Health Facility Registry (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 DSD activities, the portfolio is structured to address a range of systems issues that are present at the site that jeopardize quality of service provision and the ability to meet ambitious targets.

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 improving access to HIV testing by analyzing patient flow at the clinic, including monitoring patient wait times for testing, counseling, and receiving HIV test results. 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 MoH authorities and service providers in the CQI process will create ownership and ensure sustainability of this model.

An additional layer of accountability will be integrated into the COP21 implementation via Community-led monitoring (CLM). Civil society, alongside PLHIV and clients of PEPFAR-supported services, will lead several activities 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. CLM seeks to strengthen community engagement with PEPFAR, increase transparency, and, most importantly, advocate for client-driven improvements.

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 COP21, PEPAR-DR will continue building on successful outcomes of clinical care and systems strengthening efforts to improve VL outcomes through accelerated interventions that address both point of care service delivery management as well as health systems bottlenecks or barriers. This

will 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, existing data highlights the need for significant improvement in viral suppression (3rd 95) for all populations. In COP21, PEPFAR will continue to support the following interventions to increase VL coverage and suppression among PLHIV on ART:

- Support the National HIV Program in updating guidelines and SOPs according to WHO recommendations to include one VL test per year (down from the current recommendation of one VL every 6 months) and promote extended working hours and workdays for VL sample collection at the clinic level.
- Work with regional health offices to optimize sample transportation to VL processing labs and ultimately reduce result delivery time.
- Incorporate plasma separator cards (PSC) for VL sample collection, facilitating sample storage and referral to the processing laboratory.
- Empower PLHIV to achieve and maintain viral suppression by reinforcing the concept of 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, reinforcing to health personnel the importance of VL 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.

All sites will receive a first series of interventions, which will be centered on transitioning patients to DTG-based regimens, scaling-up MMD and returning patients to care and treatment. The intervention packages will be tailored to specific sites' performance, needs, and possible impact on the DR epidemic (e.g., site' patient volume).

In the highest performing sites, 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 treatment adherence among PLHIV.

Most of the PEPFAR- supported sites and the majority PEPFAR-supported clients need a more comprehensive approach to improve their VL coverage and suppression. Updated SOPs regarding VL, CD4, and TB test collection (including sample referral) will be prepared and implemented, 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.

Finally, the sites with the greatest need for support, assistance, and close supervision will receive updated SOPs, training, and continuous education based on these new documents. 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 VL sample collection, PEPFAR-DR will support the implementation of routine VL monitoring at community levels to identify patients due for VL sample collection.

The results of the PEPFAR VL Scale-Up Clinical Facility Readiness Assessment and HIV VL Testing Scorecard will also be used alongside site analysis to revamp PEPFAR-DR's strategy around the 3rd 95·

5 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV epidemic in the DR is concentrated within specific subsets of the population, particularly among FC. As supported by the 2019 SID report, FC face significant barriers to accessing HIV services, including S&D, mobility, and insufficient availability of accurate and reliable data to understand the factors driving the HIV epidemic among FC.

In COP21, PEPFAR will support the GoDR in the triangulation of programmatic data and FC focused research data to improve decision making capacity and quality of care for FC and identify the potential drivers of the HIV epidemic in this group.

In addition to intensive and high frequency site-level interventions, PEPFAR DR promotes sustainability in national systems and leverages existing strengths to ensure continued long-term impact along the cascade for all populations. The HRH management rapid assessment tool, which 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 COP21-22 will provide valuable information for HRH decision-making to ultimately strengthen HIV services. GoDR stakeholders and CSOs have stressed the importance of developing sustainable strategies. PEPFAR DR will continue prioritizing public health service workers for in-service training, capacity building events, and mentorship in index testing and service provision. In addition, PEPFAR remains committed to actively participate in the Technical Monitoring Group led by GoDR to enhance coordination and better align data with the GoDR for improved reporting.

To help GoDR efforts close the financing gap in the HIV response, PEPFAR will provide technical assistance to implement mechanisms to integrate financing for ARV procurement into the Social Security System and to increase MoH organizational capacities to purchase ARVs directly.

COP21 builds on the momentum of COP19-20 to initiate a series of additional reforms requiring PEPFAR-DR investment to promote the rollout of a nationwide rapid initiation strategy and close FC treatment gaps. The development of policy and monitoring systems for the appropriate prescribing and dispensing of HIV commodities in alignment with transition to DTG-based regimens and differentiated models of care (DMOC), including MMD and community ART distribution, will enhance treatment initiation and client retention. Similarly, the production of SOPs for community-based service delivery and referral and counter referral guidelines will pave the way to standardized same day initiation and decentralization of HIV services.

PEPFAR-DR investments will also continue to enhance the FAPPS, the national HIV patient registry. As of Q1 of FY21, 98% of HIV care sites nationwide have started implementing the biometric registry and it is projected that all HIV care sites will be doing so by the end of FY21. In addition to this important milestone, PEPFAR-DR 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-DR

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 ensuring effective and continuous ART services for mobile populations, including those that cross international borders, PEPFAR will continue advocating for cross-border referrals, technical dialogue, and diplomatic engagement, as applicable, between Haiti and the DR.

Altogether, these system-level investments will directly impact PEPFAR performance, the achievement of targets along the cascade for FC, KP, and general populations and promote sustainability and country ownership of the DR's HIV response.

6 USG Management, Operations and Staffing Plan

The PEPFAR-DR program continues to focus its efforts on FC and to work towards intensifying prevention, testing, treatment initiation, and continuity of treatment efforts at the community and primary care levels. This requires the interagency PEPFAR-DR technical teams to prioritize provision of close technical assistance/supervision to implementing partners' field operations. To support ambitious goals in reaching FC, scaling up the OVC program, and providing technical assistance to support the DR in improving outcomes under the third 95, in COP21 the interagency team will continue to prioritize staff right-sizing to meet programmatic needs.

After assessing program needs, PEPFAR DR determined to add one position to the interagency team, a PEPFAR Deputy Coordinator who focuses on M&E data and financial analytics for the interagency. This Locally Engaged Staff (LES) position will be hired by CDC. Once the Deputy PEPFAR Coordinator comes on board in FY22, CDC's team will be complete with 3 US Direct Hires, 1 external contractor, and 13 Locally Engaged Staff positions.

USAID's current office footprint includes 1 US Direct Hire, 3 external contractors, and 14 Foreign Service National (FSN) positions in addition to the hiring of the PEPFAR Coordinator. This staffing pattern will remain and is sufficient to execute the anticipated level of effort in the coming year.

Additionally, no new positions have been identified for DOD in COP21.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (Q2 FY21)	Additional patients required for 95% ART coverage	Target current on ART (FY22) *TX_CURR*	Target newly initiated (FY22) *TX_NEW*	ART Coverage (FY22)
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	16,424*	31,252** (5,417 FC)	11,007 FC	42,389 (14,788 FC)	7,607 FC	83%
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)	0	N/A	N/A	N/A	N/A	N/A

** For COP21, estimated total PLHIV corresponds to FC in the target provinces of Santo Domingo, Santiago, La Altagracia, Valverde, and Puerto Plata.*

***PEPFAR-supported sites only.*

APPENDIX B – Budget Profile and Resource Projections

PEPFAR-DR uses visuals and tables generated from the approved version of the consolidated FAST, inclusive of ARPA funding.

Table B.1. COP21 Total Planning Level

Applied Pipeline	New Funding	Total Spend
US $1,267,435	US $24,982,565	US $26,250,000

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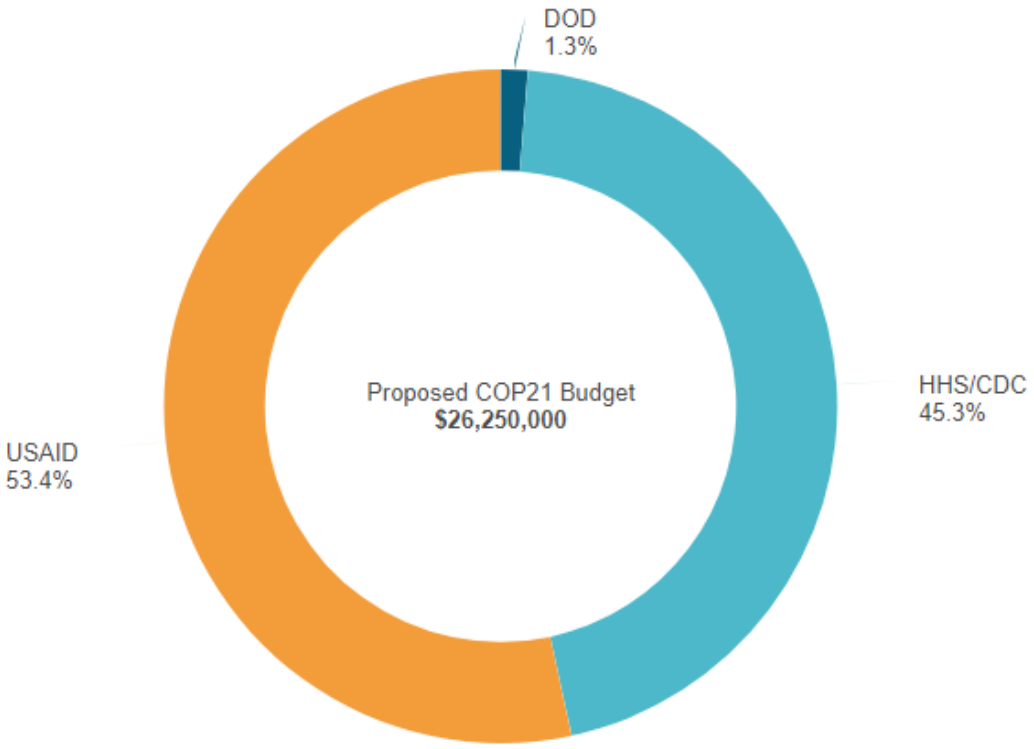

COP21 Budget by Program Area

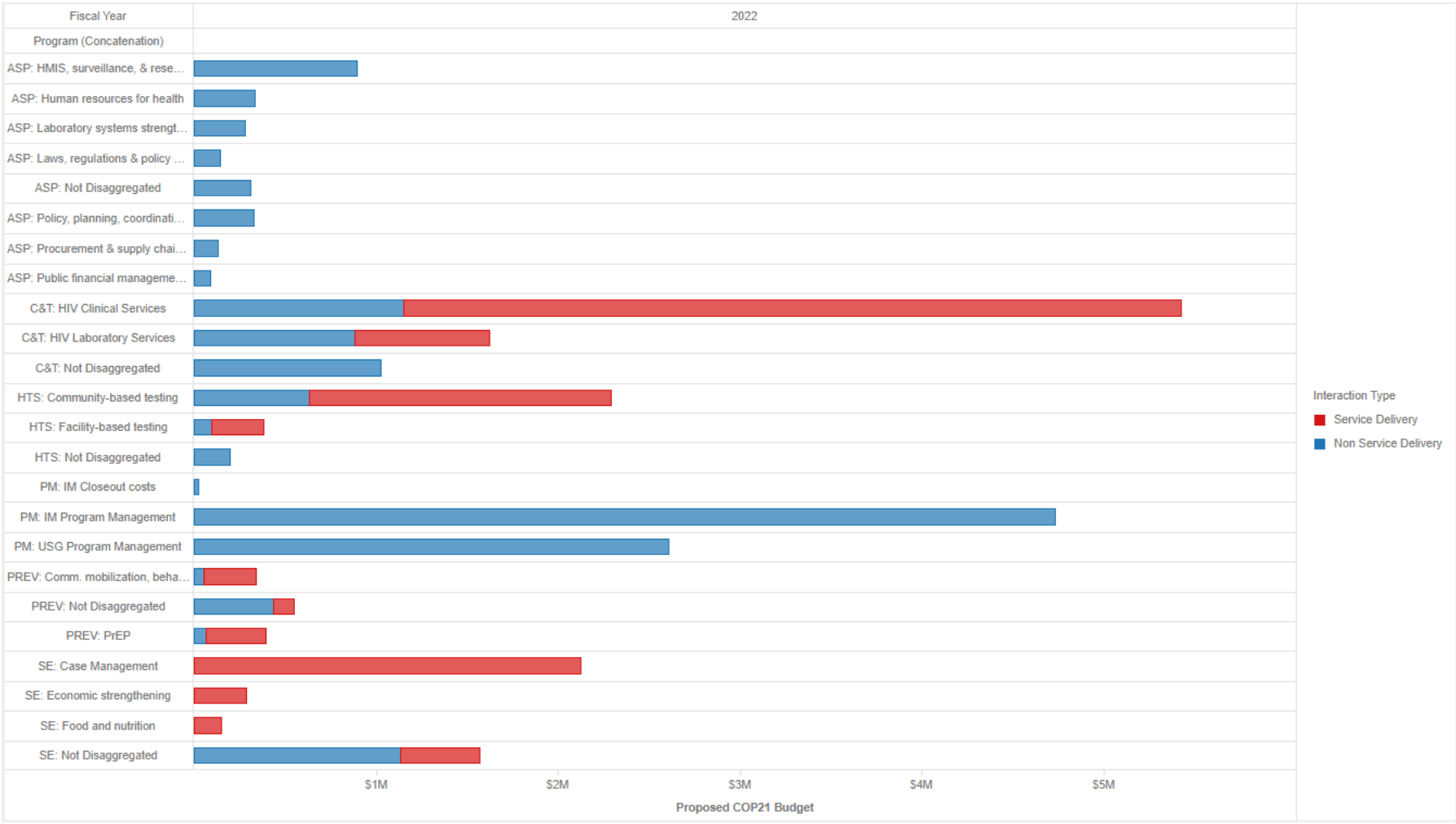

Table B.2. Resource Allocation by Program Area

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non-Service Delivery	Service Delivery	Total	Non-Service Delivery	Service Delivery	Total
Total		**$15,557,947**	**$10,692,053**	**$26,250,000**	**59.27%**	**40.73%**	**100.00%**
C&T	**Total**	**$3,066,619**	**$5,017,232**	**$8,083,851**	**37.94%**	**62.06%**	**100.00%**
	HIV Clinical Services	$1,153,906	$4,275,915	**$5,429,821**	21.25%	78.75%	**100.00%**
	HIV Laboratory Services	$885,105	$741,317	**$1,626,422**	54.42%	45.58%	**100.00%**
	Not Disaggregated	$1,027,608		**$1,027,608**	100.00%		**100.00%**
HTS	**Total**	**$924,317**	**$1,944,000**	**$2,868,317**	**32.23%**	**67.77%**	**100.00%**
	Community-based testing	$632,739	$1,662,000	**$2,294,739**	27.57%	72.43%	**100.00%**
	Facility-based testing	$97,200	$282,000	**$379,200**	25.63%	74.37%	**100.00%**
	Not Disaggregated	$194,378		**$194,378**	100.00%		**100.00%**
PREV	**Total**	**$552,038**	**$734,680**	**$1,286,718**	**42.90%**	**57.10%**	**100.00%**
	Comm. mobilization, behavior & norms change	$52,500	$289,500	**$342,000**	15.35%	84.65%	**100.00%**
	Not Disaggregated	$435,278	$115,600	**$550,878**	79.02%	20.98%	**100.00%**
	PrEP	$64,260	$329,580	**$393,840**	16.32%	83.68%	**100.00%**
SE	**Total**	**$1,134,258**	**$2,996,141**	**$4,130,399**	**27.46%**	**72.54%**	**100.00%**
	Case Management		$2,127,296	**$2,127,296**		100.00%	**100.00%**
	Economic strengthening		$285,785	**$285,785**		100.00%	**100.00%**
	Food and nutrition		$150,000	**$150,000**		100.00%	**100.00%**
	Not Disaggregated	$1,134,258	$433,060	**$1,567,318**	72.37%	27.63%	**100.00%**
ASP	**Total**	**$2,511,673**		**$2,511,673**	**100.00%**		**100.00%**
	HMIS, surveillance, & research	$892,691		**$892,691**	100.00%		**100.00%**
	Human resources for health	$334,060		**$334,060**	100.00%		**100.00%**

Program	Fiscal Year	2022					
	Metrics	Proposed COP21 Budget			Percent of COP 21 Proposed Budget		
	Subprogram	Non-Service Delivery	Service Delivery	Total	Non-Service Delivery	Service Delivery	Total
	Laboratory systems strengthening	$281,100		**$281,100**	100.00%		**100.00%**
	Laws, regulations & policy environment	$142,000		**$142,000**	100.00%		**100.00%**
	Not Disaggregated	$311,322		**$311,322**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$330,500		**$330,500**	100.00%		**100.00%**
	Procurement & supply chain management	$130,000		**$130,000**	100.00%		**100.00%**
	Public financial management strengthening	$90,000		**$90,000**	100.00%		**100.00%**
PM	**Total**	**$7,369,042**		**$7,369,042**	**100.00%**		**100.00%**
	IM Closeout costs	$25,000		**$25,000**	100.00%		**100.00%**
	IM Program Management	$4,732,454		**$4,732,454**	100.00%		**100.00%**
	USG Program Management	$2,611,588		**$2,611,588**	100.00%		**100.00%**

Table B.3 COP21 Resource Allocation by Program and Beneficiary

Fiscal Year	2022													
Program	C&T		HTS		PREV		SE		ASP		PM		Total	
Beneficiary	Proposed COP21 Budget	% to Total	Proposed COP21 Budget	% to Total	Proposed COP21 Budget	Percent to Total	Proposed COP21 Budget	% to Total	Proposed COP21 Budget	% to Total	Proposed COP21 Budget	% to Total	Proposed COP21 Budget	% to Total
Total	**$8,083,851**	**100%**	**$2,868,317**	**100%**	**$1,286,718**	**100%**	**$4,130,399**	**100%**	**$2,511,673**	**100%**	**$7,369,042**	**100%**	**$26,250,000**	**100%**
Key Pops					$393,840	31%							**$393,840**	**2%**
Non-Targeted Pop	$2,026,262	25%	$96,000	3%	$356,500	28%	$514,014	12%	$2,104,351	84%	$6,628,766	90%	**$11,725,893**	**45%**
OVC							$3,312,024	80%					**$3,312,024**	**13%**
Priority Pops	$6,057,589	75%	$2,772,317	97%	$536,378	42%	$304,361	7%	$407,322	16%	$740,276	10%	**$10,818,243**	**41%**

APPENDIX C– Minimum Program Requirements

Care and Treatment

1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate linkage rate of over 95% of clients from testing to treatment across age, sex, and risk groups. In 2020, the average linkage rate was 71%. *Country team advocating for 95-95-95 commitment, set to be confirmed upon approval of country's official proposal to Global Fund. Team working on reducing the need for all complementary lab results to initiate ART in non-PEPFAR sites.*

2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens. TLD transition in progress,65% of national target achieved. Continued support for ARV/TB drug supply chain management; PEPFAR sites receiving additional TA to avoid stock outs during government transition. *PEPFAR supporting TA to national authorities to ensure smooth transition of ARVs warehousing.*

3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.

DMOC SOPs rolled out to all PEPFAR-supported sites. Adopted, and on-going implementation, and scale-up of MMD in COP19/FY20 during COVID-19 crisis. PEPFAR-DR team continues to advocate for the institutionalization of MMD6+ beyond state of emergency, including MMD6+ at the community level. Ongoing conversations with national authorities and set as a priority in all engagements.

4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient. *Set priority to update HMIS for better tracking of co-infection and TB screening.*

5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks. *Continue to expand VL testing and processing capacity.*

Testing

1.Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV. *Implementation of index testing is being optimized and scaled-up. Ongoing collaboration with OVC program to reach*

biological children of FC. Approval HIV self-testing pilot has been granted by authorities and will take place in COP21

Prevention and OVC

1.Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices). *PrEP coverage expansion being planned for COP21.*

2.Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV. *DR's OVC program facilitates risk assessments of all members of beneficiary households and testing for adults and children found to be at risk. The OVC program works closely with clinic partners in PEPFAR-supported sites to scale up index testing, link HIV+ individuals to services, and provide case management to improve household stability across OVC service domains and contribute to continuity of treatment and viral suppression.*

Policy & Systems

1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention. *Fully implemented. Advocacy to increase domestic funding for HIV/TB for COP21 continues although acknowledging the impact of COVID19 pandemic. Most TB services are provided free of charge. Patients may, however, be required to pay for a chest X-ray and complementary lab exams.*

2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. *PEPFAR-DR will continue to implement CQI practices in its COP21 implementation, both through implementing partners as well as by utilizing OU tools to manage partner performance*

3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.

Activity implemented by a DOD/IP to reduce stigma and discrimination against military PLHIV and marginalized population, including migrants. In FY2020, a study protocol was designed to address HIV and FC-related stigma in military and non-military hospitals, and in border region military personnel. Its implementation is planned for FY 2021.

PEPFAR-DR will incorporate in COP21 FC and KP-specific U=U messages developed by an adaptation of the global campaign to the DR context.

4. Clear evidence of agency progress toward local, indigenous partner direct funding. Percentage to be allocated to local partners in FY 2022 will be increased beyond the 1% in FY201.

5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. P*EPFAR team continues advocacy with national authorities to increase domestic funding for HIV/TB to reach 95-95-95 goals.*

6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. *To be further discussed and addressed in COP 21.*

7. Scale-up of case surveillance and unique identifiers for patients across all sites. All PEPFAR-supported sites with biometric module installed and in use. Scale up to all national sites to be discussed with national authorities. Due to COVID-19 epidemic, GoDR paused the use of biometric scanners to reduce potential transmission.