Dominican Republic
Country Operational Plan
COP 2022

Strategic Direction Executive Summary

April 2022

Military PSNU data are non-public

1.0 Vision and goal statement

In the health sector, the Government of the Dominican Republic (GoDR) has been moving towards attainment of the United Nations' Sustainable Development Goals (SDG) by addressing gaps in health service quality, human resource capacity building, supply chain management, and health access equity for all individuals seeking services. Specific to HIV, the DR adopted the 95-95-95 WHO/UNAIDS goal for epidemic control in late 2021, although not all planning, implementation and operational documents have fully incorporated a strategy to reach these goals. In particular, the DR still faces major challenges to closing the gaps in the second and third 95s.

The 2022 PEPFAR Country Operational Plan (COP2022) for the Dominican Republic (DR) marks a transition to increasingly balanced PEPFAR investments in direct service delivery and targeted technical assistance (TA) to achieve epidemic control in the country, accelerate progress towards sustainability, promote health service access equity for vulnerable populations, and sustain health system strengthening and adaptations implemented in the DR with PEPFAR ARPA funds and other donor support as part of a coordinated COVID-19 Response.

PEPFAR-DR prioritizes greater access to quality HIV services among Haitian migrants and their descendants residing in the DR (hereinafter referred to as Priority Population – PP), who represent approximately 7% (751,080) of the DR's estimated 10.4 million total population (World Bank 2020) and approximately 34% (24,420) of the DR's estimated 74,995 people living with HIV (UNAIDS GAM, 2020). HIV prevalence among PP is estimated between 3-5%, i.e., higher than the prevalence for any key population (KP) group, except for transgender women (TGW), and higher than the overall prevalence in Haiti (2%, UNAIDS 2019). Among PP living with HIV, 40.7% are aware of their status and, of those, only 27.5% are currently on treatment (Spectrum 2022). Out of the total number of people living with HIV (PLHIV) not on ART (national ART gap), 67% are PP, 16% are men who have sex with men (MSM), and 9% are transgender individuals. Therefore, achieving epidemic control among PP is paramount to controlling the HIV epidemic in the DR. PEPFAR focuses service delivery support in ten of the DR's 31 provinces and the national capital, Santo Domingo, which is contained within its own National District. According to the 2017 National Immigrants Survey (NIS) PEPFAR-supported provinces house nearly two thirds of PPs on an either seasonal, temporary, or permanent basis.

Historically, Afro-Dominicans, persons of Haitian descent, and Haitian migrants have experienced considerable stigma and discrimination (S&D) when accessing a variety of social and health services in the DR. Current challenges faced by migrant populations range from statelessness of Haitian migrants and their descendants who were stripped of their Dominican citizenship in 2013, systematic deportation of pregnant Haitian women who seek antenatal care and delivery services in DR health facilities, and barriers to continuity of treatment due to high mobility. Government migratory policies have restricted migrant's access to hospitals only for health emergencies, which have had a negative impact on PP attendance to facilities for fear of deportation, further limiting PP access to care, and increasing interruption in treatment. These factors, coupled with the mobility of this population within the DR and across the border with Haiti, make it all the more important that PEPFAR and its implementing partners (IP) refine and better target strategies in COP2022 to promote health service equity, continuity of treatment, and viral suppression among PP, while redoubling efforts to identify people lost to follow up and reintegrate them in treatment. PEPFAR

must identify simple yet efficient solutions to promote continuity of treatment among PP despite language, cultural, policy, and legislative barriers. This will include coordination with Dominican and Haitian civil society organizations to implement activities such as hard and/or virtual communication materials containing data about where to look for health services and adhere to treatment while in transit, and assurance that all PEPFAR-supported health services have at least one service provider who speaks Haitian Creole.

Additional challenges include the lack of recent data about PP, including population size and HIV prevalence estimates. The last National Immigrant Survey was conducted in 2017. Reliable information on migration patterns, in-country mobility, risk factors, and gaps in service access and treatment continuity are also needed to better focus investments on service delivery in COP2022. PEPFAR will coordinate with the GoDR, other donors and the scientific community in the DR to collect, compile, and analyze most recent and reliable data to increase knowledge about the specific needs of PP and to design strategies that best address them. The National AIDS Council (CONAVIHSIDA) will conduct a study to identify Priorities for Local AIDS Control Efforts (PLACE) in FY2022 (October 2021-September 2022), which will be complementary to the National Immigration Survey (ENI) planned for FY2023. Building on the UNAIDS assessment of services available to PP along the Dominican side of the border, in FY2023, PEPFAR-DR will complete the implementation of an observational study to complement knowledge building on the effectiveness of PEPFAR models and increase DR understanding of the population with the largest service delivery gap for epidemic control.

The COP2022 strategy will reinforce PEPFAR-DR's commitment to universally offer index testing both at the facility and community levels, improved HIV testing services among PP, a stronger focus on community-based services and community-led monitoring (CLM), and a boost in engagement with grassroots and community organizations addressing the needs of PP in DR's civil society. Linkage to treatment will build upon the success of the Enhanced Peer Outreach Approach (EPOA) - also known as Social Network Testing - in promoting diagnosis and linking clients to care, and to expand the lead role of communities in monitoring ART initiation, adherence to treatment, and viral load suppression.

PEPFAR-DR will continue to work toward closing the gaps in the HIV cascade among PP and KP, and particularly MSM, by sustaining pre-exposure prophylaxis (PrEP) services, reducing stigma and discrimination, and advocating for consistent GoDR and Global Fund KP programming to bridge the treatment gap among MSM and ensure continuity of treatment. In COP2022, 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, while meeting the special needs of KP identified within the PP.

On the policy side, PEPFAR-DR will continue collaboration with the Global Fund (GF), UNAIDS, and the Pan American Organization (PAHO) to strongly advocate for the expansion of Differentiated Service Delivery (DSD) models at the site level, including multi-month dispensing (MMD) and community ART distribution, which have been implemented at a slower pace due to ARV stockouts. Nonetheless, sites have rapidly advanced transition to Dolutegravir (DTG) based antiretroviral therapy (ART), pointing to continued achievement of goals in COP2022. PEPFAR-DR will continue assisting the DR on rapid ART initiation by ensuring all HIV+ individuals complete the pre-ART package of clinical and laboratorial evaluations. In COP2022, PEPFAR

will continue to advocate for community ART initiation which, at this point, is not contemplated in the GoDR policies and guidelines.

In FY2021 Q3 and Q4, and FY2022 Q1 and Q2, the GoDR experienced an unprecedented ARV crisis that resulted in limited availability of HIV, TB, and laboratory commodities, and of VL testing equipment, as well as critical stockouts of ARVs. This supply chain management (SCM) crisis required a PEPFAR Emergency Commodities Fund (ECF) donation to bridge continuity of treatment among PLHIV and to partially rebuild the Government's buffer stock of ARVs that was nearly fully used given delays in orders and deliveries.

PEPFAR-DR's COP2022 strategy includes a revamped technical assistance plan to address SCM weaknesses to prevent future stockouts; improve the GoDR's capacity to assess site, provincial and national level projections; and eliminate bottlenecks in storage and logistics systems for timely delivery of HIV-related drugs to patients. Building upon the results of the COP2021/FY2022 National Supply Chain Assessment, PEPFAR-DR will extend TA beyond the Ministry of Public Health's (MoH) National AIDS Program (DIGECITSS) to the National Health Services (SNS), which is responsible for site-level forecasting, logistics and distribution. This strategy will complement PEPFAR's successful support to transitioning commodity procurement to the GoDR's Essential Drugs and Logistics Support Center (PROMESE-CAL).

Continued laboratory strengthening and capacity building remain at the core of PEPFAR above-site interventions in the DR to promote early diagnosis and to close the gap in viral load suppression and coverage. The SCM crisis reported in late FY2021 and early FY2022 also affected the availability of laboratory reagents and delayed progress towards expansion of viral load coverage. COVID-19 impacted the collection and transportation of viral load samples, as well as the timely delivery of viral load results. PEPFAR responded promptly by supporting sample collection and transportation, in addition to accelerating delivery of results. Nonetheless, support for virtual delivery of results is yet to be implemented.

Despite these challenges, the viral suppression (VS) rate among PP increased from 69% in FY2021 Q1 to 78% in Q1 of FY2022. To increase VS rates to at least similar levels reported among non-PP populations, which reached 90% in the first quarter of FY2022, PEPFAR-DR will strengthen case management through facility, community, and household adherence counseling, and VLS monitoring among PP. These activities will involve PEPFAR-DR's peer and health promoter's approaches, in addition to greater use of telemedicine, digital health, and other information and communication technologies to enhance case management.

Furthermore, PEPFAR-DR's Orphans and Vulnerable Children (OVC) program will target HIV+ PP clients on ART and in PMTCT, enrolling their families in a comprehensive case management program that is tailored to strengthen their adherence to treatment by providing wrap-around, family-based services at the household level, and reducing the number of service provision points they need to visit and receive these services. This comprehensive strategy involves facilitation of access to health, education, social and economic benefits, and safety networks. This program also serves as an HIV prevention platform to ensure that at-risk family members know their status, support HIV-negative family members to stay negative, and implement treatment referrals for any newly identified cases.

Recent infection testing will be implemented at PEPFAR-supported sites by early FY2023 to improve surveillance of new HIV cases. Any person over 15 years of age who has recently been diagnosed with HIV and has provided consent will undergo a rapid test for recent infection. Samples will be transported to the National Public Health Laboratory for processing. In response to an SNS request, PEPFAR will also support an assessment of the quality of laboratory services and equipment availability to enhance multiplexing based on the country's installed PCR and GeneXpert capacity.

PEPFAR-DR will implement Quality Assurance (QA) tools, based on DR policies/guidelines and international best practices, through monthly in-person and virtual supervision visits to sites. PEPFAR-DR will also ensure that all IPs adopt and enforce QA tools and Continuous Quality Improvement (CQI) methodologies to improve partner performance in OVC, stigma and discrimination-free, person-centered services in PEPFAR-supported facilities. Community-led monitoring (CLM) will also be a vital source of information supporting improvement and adaptation of services for people living with HIV (PLHIV).

The National AIDS Council (CONAVIHSIDA) established a government-led, high-level donor coordination forum for discussion of common priorities, approaches, results, sustainability, and advocacy to accelerate progress towards global goals. These include, but are not limited to, CLM, community ARV initiation, multi-month dispensing, lab capacity, and SCM technical assistance. PEPFAR-DR and the GF have increased coordination in calendar years 2021/2022 and will continue to do so in 2023. A comprehensive mapping of PEPFAR and Global Fund geographic coverage and activities is ongoing and will contribute to minimizing duplication and ensuring complementarity of program areas.

The COP2022 plan prioritizes closer collaboration with community-based and grassroots organizations that provide direct support to PEPFAR-DR's PP at the community level. PEPFAR will leverage these organizations' direct access to, and knowledge of the needs of PP to further engage them in CLM and to ensure active PP participation in service quality assessments and adjustments. PEPFAR-DR is actively reaching out to over 20 grassroots organizations to launch this strategy. A few of these organizations were invited to and provided valuable input during the COP2022 planning process.

Based on the achievements and challenges, PEPFAR's COP2022 goals will include:

1. **Provide targeted and continued technical assistance in SCM to** address weaknesses, remove bottlenecks, improve the GoDR's capacity to assess site, provincial, and national level projections, and enhance logistics systems for timely delivery of HIV-related services to patients.
2. **Continue to use a network of community outreach and care teams** in connection with supported health facilities and organizations to link PP to testing and treatment and improve treatment adherence and continuity.
3. **Expand and intensify activities to identify patients lost to follow up and return clients to care and treatment**, including improved access to health services that are culturally and linguistically responsive to PP, intensive partner management, and resilient, equitable, community-engaged, and client-centered approaches to care and treatment.

4. **Enhance community-led monitoring** by further engaging community-based and grassroots organizations in active case finding and monitoring of treatment adherence, in addition to monitoring viral load suppression and preventing interruption in treatment with the goal of closing the gaps in the 95-95-95 cascade.
5. **Advocate for full implementation of minimum program requirements**, including complete transition to TLD and enrollment of eligible clients in MMD while ensuring adherence to treatment and rapid initiation of ART in alignment with MoH guidelines.
6. **Improve OVC case management in collaboration with clinics** to ensure that 90% or more of eligible PP (C/ALHIV and their parents) achieve viral suppression, are offered OVC comprehensive program enrollment, and provided tailored psycho-social, nutrition, education, and economic security services that respond to family needs while also promoting and reinforcing C/ALHIV retention in care. All OVC will be aware of their status.
7. **Sustain the PrEP program** among priority and key populations in accordance with country goals and provide TA for continued GoDR supply of PrEP drugs.
8. **Strengthen 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, in addition to promoting the use of multiplexing for HIV and viral load testing and COVID-19 diagnosis.
9. **Expand tailored interventions to reduce stigma and discrimination** among health service staff and entities that interact with PP on a regular basis, including the uniformed services and military facilities.

2.0 Epidemic, response, and program context

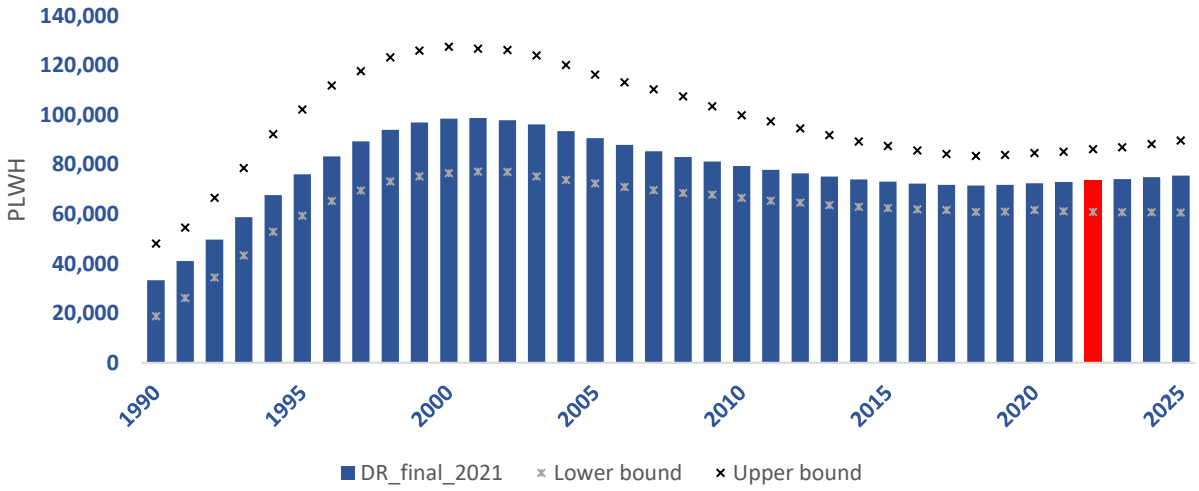
2.1 Summary statistics, disease burden and country profile

According to the 2020 census of the DR[1]The country had 10.4 million citizens in 2020, with a projected population growth towards 10.8M by the end of 2022. As stated by the World Bank[2], the DR's Gross National Income (GNI) per capita was $7,260 in 2020, a reduction from $8,080 in 2019 (current USD). This is a relevant consequence of the COVID-19 pandemic impact in the country. Similarly, and according to Forbes CentroAmerica, general poverty in the DR 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. In 2018, health expenditures represented 5.7% of the Gross Domestic Product. No new official updates were found, nevertheless, several NGOs and local health alliances[3] have situated DR health expenditure as less than 2% of the Gross Domestic Product (GDP) between 2020 and 2022.

[1] *Oficina Nacional de Estadística (ONE). (2022). Censo 2020. Retrieved April 4, 2022, from https://www.one.gob.do/#mapSeccion*
[2] *GNI per capita, Atlas method (current US$) - Dominican Republic. Data. (2022). Retrieved April 4, 2022, from https://data.worldbank.org/indicator/NY.GNP.PCAP.CD?locations=DO*
[3] *Poletika. (2020). República Dominicana destina un 1.9% del PIB a la Salud Pública. PolétikaRD. Retrieved April 4, 2022, from https://poletikard.com/republica-dominicana-solo-destina-un-1-9-del-pib-a-la-salud-publica/*

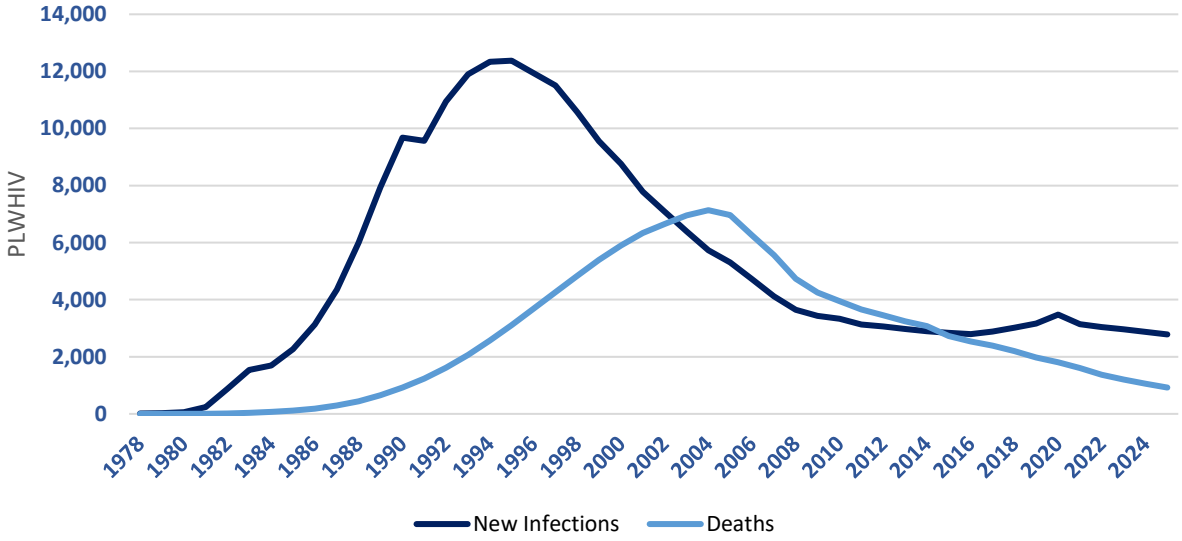
The DR has a concentrated HIV epidemic, with an estimated HIV prevalence of 0.9% in adults aged 15-49. The 2021 Spectrum (UN) estimates that in 2021, 72,913 people were infected with HIV, of whom 94% were aware of their HIV status. Of all individuals diagnosed, 43,266 (63%) are receiving treatment and of these, 24,751 (57%) are virally suppressed. The 2021 Spectrum model estimates that the number of people living with HIV (PLHIV) has been increasing slightly every year, as new infections remain higher than all-cause mortality in PLHIV (Figure 2.1.2).

Figure 2.1.1 Trend in number of PLHIV, Spectrum 2022



Source: Spectrum 2022

Figure 2.1.2 Trend for new infections and all-cause mortality among PLHIV, Spectrum 2022



Source: Spectrum 2022

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 27%, and PP with an HIV prevalence between 3-5% but accounting for 46% of all newly infected individuals in the Dominican Republic[4]. According to the National Immigrants Survey (NIS)[5]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). Based on results from the 2017 NIS, 95% of Haitian migrants and 80.9% of their descendants lack any type of health insurance.

The 2021 Spectrum model estimates that there are 27,215 Haiti-born PLHIV living in the DR, of whom 14,152 (52%) are men. PLHIV among Haitian migrants 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.

In addition to PP, KP are disproportionately affected by HIV in the DR. Although at this time PEPFAR-DR is focusing its resources on the unmet need among PP, the program tracks and provides services to KP as a subset of PP and will continue implementing activities in support of HIV prevention – including PrEP - treatment adherence, and viral load suppression among non-FCs by collaborating and ensuring complementarity with the GoDR and other stakeholders, e.g., the GF and UNAIDS.

[4] *CONAVIHSIDA (ONE). (2018). Third IBSS. Retrieved April 4, 2022, from https://www.conavihsida.gob.do/index.php/informacion-y-estudios-especiales/estudios-especiales/category/26-encuestas-de-comportamiento-con-vinculacion-serologica*

[5] *MEPYD. (2017). Secunda encuesta nacional de inmigrantes. Retrieved April 4, 2022, from https://dominicanrepublic.unfpa.org/sites/default/files/pub-pdf/ENI-2017%20FinalWeb.pdf*

Table 2.1.1 Host country government results															
Indicators	**Total**		**<15**				**15-24**				**25+**				**Source, Year**
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Total Population	11,155,481	100%	1,499,799	13%	1,561,408	14%	951,837	9%	986,386	9%	3,139,750	28%	3,016,301	27%	Spectrum, 2022
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)	1,605		19		19		167		209		552		639		Spectrum, 2022
# PLHIV	73,513		466		483		2,678		3,240		31,112		35,530		Spectrum, 2022
Incidence rate (Yr.)		0.28%						0.37%		0.96%		0.18%		0.38%	Spectrum, 2022
New infections (Yr.)	3,037														Spectrum, 2022
Annual births	206,326														Spectrum, 2022
% of Pregnant Women with at least one ANC visit		99%													Demographic and Health Survey, 2017
Pregnant women needing ARVs	739														Spectrum, 2022
Orphans (maternal, paternal, double)	35,139														Spectrum, 2022
Notified TB cases (Yr.)	3,432		29		26		192		233		999		1,953		National TB Program, National TB Information System
% of TB cases that are HIV infected	839	24.4%													National TB Program, National TB Information System
% of males circumcised	N/A	N/A			N/A	N/A			N/A	N/A			N/A	N/A	
Estimated Population Size of MSM*	177,932														Spectrum, 2022
MSM HIV prevalence		2.4-6.4%													2017 IBBSS
Estimated population Size of FSW	138,587														Spectrum, 2022
FSW HIV prevalence		1.1-5.9%													2017 IBBSS
Estimated population size of PWID	N/A														

Table 2.1.1 Host country government results															
Indicators	**Total**		**<15**				**15-24**				**25+**				**Source, Year**
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
PWID HIV Prevalence	N/A														
Estimated size of Priority Population (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 Statistics, 2019
Estimated size of Priority Population prevalence (specify)		4% (2.6%-5.5%)	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 2.1.2. 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression*										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
Indicators	**Total Population Size Estimate [1,2] (#)**	**HIV Prevalence [2,3,4,5] (%)**	**Estimated Total PLHIV [1] (#)**	**PLHIV diagnosed (#) [6]**	**On ART[6] (#)**	**ART Coverage[6] (%)**	**Viral Suppression[6] (%)**	**Tested[8] for HIV (#)**	**Diagnosed HIV Positive[8] (#)**	**Initiated on ART [8] (#)**
Total population	11,142,549	0.88%	72,913	68,285	43,266	63%	24,751 (66%)	337,058	10,323	8,956
Population <15 years	3,059,703	0.80%	952	876	530	61%	252 (47%)	4,325	93	43
Men 15-24 years	985,745	0.31%	3,240	1,667	845	51%	457 (54%)	39,683	578	466
Men 25+ years	3,009,462	0.88%	35,530	29,809	16,950	57%	11,064 (65%)	112,769	4,170	3,476
Women 15-24 years	951,313	0.31%	2,678	3,016	1,136	38%	559 (49%)	59,149	931	727
Women 25+ years	3,136,326	0.88%	31,112	31,677	18,279	58%	12,419 (68%)	111,550	3,975	3,210
MSM	177,932	5.20%	8,445	3,896	2,489	64%	1,722 (69%)	5,304	399	613
FSW	138,587	1.71%	2,709	2,010	1,099	55%	702 (64%)	4,127	157	254
PWID				3,454	1,787	52%	1,060 (59%)	151	20	167
Priority Pop (specify)	751,080	4.64%	27,215	16,758	6,553	39%	3,204 (49%)	252,545	7,418	5,523

Sources:
1 2021 Spectrum model, 2022 estimation.
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 2021 Spectrum model, 2022 estimation.
6 National HIV Patient Information Management System (FAPPS), as of December 31, 2021.
8 DATIM MER.

2.2 Progress toward Epidemic Control

HIV Clinical Cascade

Per the national HIV cascade in figure 2.1.3, the DR still faces significant challenges in closing the gaps in the second and third 95s. The GoDR adopted the WHO/UNAIDS 95-95-95 goal in late 2021. However, a few key policies, documents, and guidelines, e.g., the National HIV Strategic Plan (PEN), do not yet reflect this commitment. PEPFAR is actively advocating for inclusion of global commitments in the next revision of those documents.

To close the gap in the second and third 95s, the MOH must nearly double the number of people currently on ART, as well as the number of virally suppressed individuals by 2030. PEPFAR-DR will be prioritizing financial and technical investments to strengthening SCM and drug logistics to ensure timely delivery of ARVs to patients and prevent stockouts in the coming years; strengthening the laboratory network through continued capacity building and decentralization of VL testing and monitoring to increase VLC and promote VLS among PP; improving HIV surveillance; promoting treatment adherence counseling; and returning to treatment those patients lost-to-follow-up.

The MoH has updated multiple administrative and clinical care and treatment policies and guidelines to reflect global best practices, such as Treat All, task-shifting for HIV testing, ARV prescription focusing on multi-month dispensing (MMD), and community ART distribution (Comm ART). Progress toward National Health Insurance coverage of ARVs as essential medicines, and the GoDR's buy-in to PEPFAR's universal offer of index testing are among other recent advances reported in the DR. The MoH has also agreed to generate programmatic evidence on feasibility and acceptability to support the introduction of self-testing in the DR.

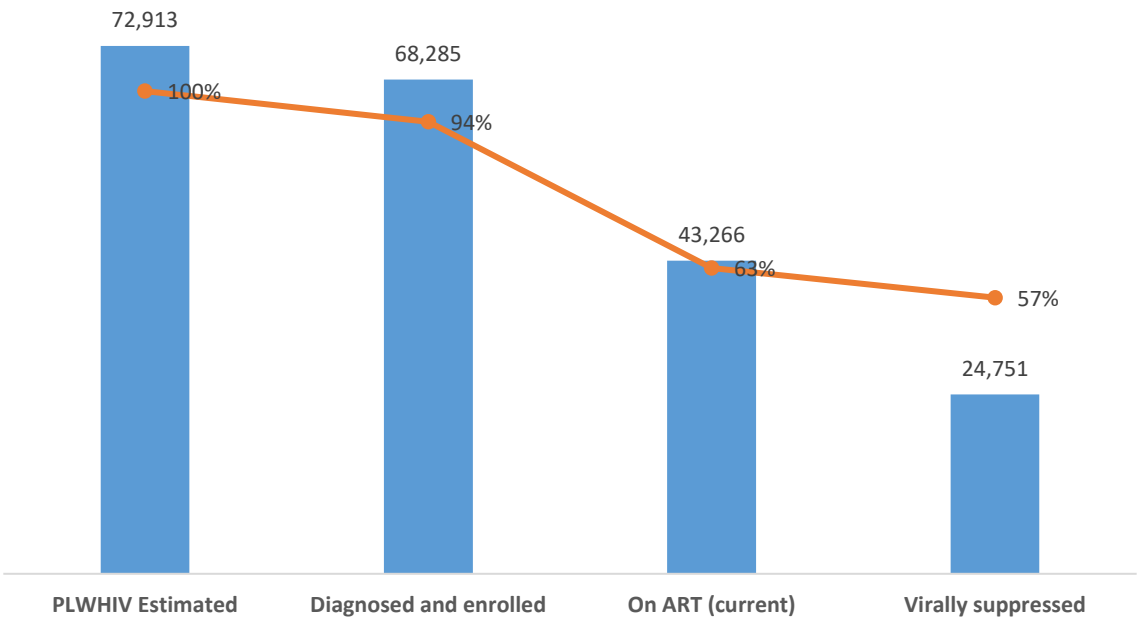
Since 2015, the GoDR has taken full responsibility for the costs of purchasing sufficient antiretrovirals (ARVs) and other HIV supplies to meet the country’s needs, which signals progress towards adequate supply chain management. Despite a one-time, yet severe shortage of ARVs - that was partially solved by a PEPFAR bridge donation of ARVs through the ECF – the GoDR has been working to regain control of stocks and has requested PEPFAR support to assess and address bottlenecks and systemic issues in the DR health commodity supply chain.

SENASA, the national health insurance office, is moving forward to reimburse community-based organizations (CBO)/non-governmental organizations (NGO) clinics for HIV services, a much-needed step to ensure the sustainability of these safety net providers and garner further buy-in to HIV service coverage.

Areas that require further discussion are MMD, CommART, and TB diagnosis requirements for ART initiation. PEPFAR will continue advocating for immediate implementation of minimum requirements.

The DR’s progress toward the WHO/UNAIDS 95-95-95 is detailed in Figure 2.1.5.

Figure 2.2.1 DR's progress towards reaching 95-95-95 goals



Source: Spectrum 2022 (PVLWH from 2021) and DR HPIMS until Dec 31, 2021.

HIV testing services (First 95)

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, although the actual number of persons tested is reported to S/GAC according to MER 2.6 guidelines. In 2019, the DR's National HIV/AIDS Program reported 775,045 HIV tests 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 2021, the National HIV Register System (SIRENP, per its acronym in Spanish) registered 198,003 persons tested for HIV, including 11,735 (5.9%) who tested positive.

Despite major limitations posed by COVID-19 in FYs 2021 and 2022, PEPFAR refined its ability to find, test, and diagnose PP, thus exceeding the target of 92,224 individual tests at the community level (COMM_HTS_TST), and reaching over 80% of the community-based positivity (COMM HTS_TST_POS) target among PP, who represented 97% of all people tested at the community level. In community testing activities, positivity was 2.3% with PP representing 97% of the total number of positives. Over that same period, PEPFAR-DR's overall HIV testing positivity rate was 3.2% (within the expected range based on the estimated prevalence for PP). The facility-based positivity was 4.3%, with significant site-by-site variation. PP represented 24.5% of all clients tested in facilities and 30% of the positive cases. The positivity rate among PP was 5.4%, versus 4% in non-PP.

ART-adult and pediatric (Second 95)

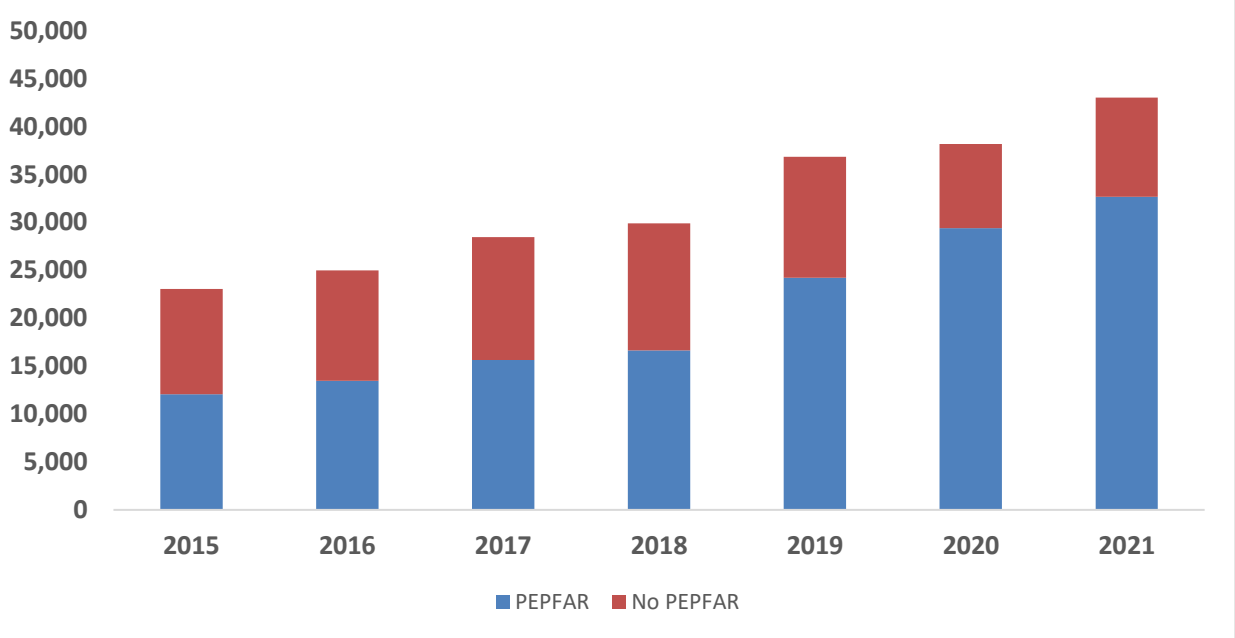
HIV care services, including ART, are exclusively delivered at 74 Integrated HIV Care (IHC) sites throughout the country. Of those, only three provide services for children and adolescents. Among the 74 sites, 32 sites in nine provinces received PEPFAR support in COP2021 and are registered in DATIM. PEPFAR does not currently provide support to any exclusively pediatric sites.

All patients enrolled in IHC sites are registered in the HIV Patient Management Information System (FAPPS, in Spanish). As of December 31, 2021, a total of 88,761 persons had been registered in FAPPS, including 42,361 currently active on ART for more than three months. The 32 sites receiving PEPFAR support managed 32,264 (76.1%) patients active on ART. Only 593 active patients nationwide are children under 14.

Among all patients active on ART in the DR, 2,805 (6.6%) are characterized as MSM in FAPPS, 1,847 (4.3%) as injecting drug users, 1,246 (2.9%) as FSW, and 457 (1%) as TGW. A total of 7,485 or 17.6%, are categorized as migrants from Haiti[6]. PEPFAR-supported sites report 2,263 MSM patients (81% of all MSM active on ART in the country), 1,044 FSW patients (or 83% of all FSW active on ART in the country), and 347 TGW (or 97% of all TGW patients in the DR). A total of 6,625 individuals from the priority population are receiving ART at PEPFAR-supported sites, which represents 88% of all migrant patients on ART in the country, a higher percentage than that reported in FY2021 (85.2%).

During FY2022 Q1, 1,960 patients initiated ART nationwide, 1,673 (85%) of whom at PEPFAR-supported sites. Among this subset, 1,001 (56.5%) were identified in FAPPS as born in Haiti.

Figure 2.2.2 National and PEPFAR trend in individuals active on ART



Source: SNS FAPPS 2021

[6] This only accounts for migrants born in Haiti. It does not count their descendants.

Viral Suppression (Third 95)

The COVID-19 pandemic has significantly impacted VL testing coverage (VLC) by requiring shared use of existing diagnostic platforms for COVID-19 testing. In addition, the DR reported a shortage of reagents and supplies due to delays in the procurement and delivery processes.

Until 2019, the National Public Health Laboratory Dr. Defilló in Santo Domingo performed all VL tests using samples collected at IHC sites and transported to the capital. In 2020, the laboratory of the Gurabo Diagnostic Center in Santiago completed the certification process and is currently fully functional and able to perform VL tests. During 2021, two additional laboratories, one in Centro Sanitario (Distrito Nacional), and another in Porvenir Diagnostic Center in San Pedro de Macoris, have been certified to perform VL and CD4 count testing. Both have been fully operational since November 2021.

As of FY2022 Q1, 26,383 patients (73% of all active patients on ART for more than three months at the national level) had a VL test result recorded in the past 12 months. Among those, 22,915 (87%) showed a viral load of <1000/ml. At PEPFAR-supported sites, a total of 19,975 active patients (72% of all active patients nationwide) on ART for more three months had a viral load test result recorded in the past 12 months, and 17,389 (87%) showed viral suppression.

In Q1 of FY2022, 5,889 individuals returned to treatment services while 12,119 were reported as patients with interruption in treatment. This also affected the overall VLS rates of the country alongside the previously detailed stockouts.

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.

More information about how PEPFAR will contribute to closing the VLC and VLS gaps can be found in section 4.

2.3 New Activities and Areas of Focus for COP2022, Including Focus on Client ART Continuity

Together with the ethical and safe implementation of universal offer of Index testing, PEPFAR-DR will scale-up case finding strategies and models, including social network testing and hot-spot mapping, and adapt them to community and facility specific conditions in PEPFAR supported sites, in addition to advocating for the GoDR and other donors to expand these strategies beyond PEPFAR focus areas.

Adoption and expansion of these strategies seeks to address barriers and gaps in the DR context where the PP has limited access to site-level HIV services and social services in general due to social, political, economic, and cultural constraints. Those enhanced and successful case identification methods return high linkage to care and treatment rates – above 90% in the case of the social network approach.

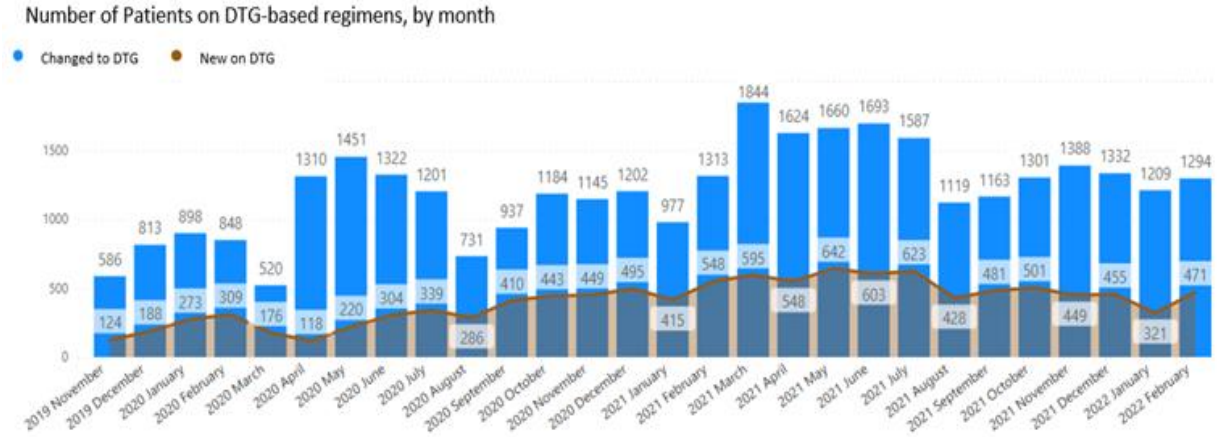
As more PPs are linked to care and treatment (C&T) services, PEPFAR-DR will increasingly target continuity of treatment and the de-stigmatization of the cycles of treatment re-engagement. Activities will be implemented at three key levels:

Individual: a) non-judgmental back to treatment campaigns; b) enhanced in-person and virtual case management for adherence counseling and monitoring; c) digital health services; d) management of comorbidities and other health needs; e) social behavior change communication; and f) nutrition and other social support.

Community and Household: a) community-based case management through health promoters and peers; b) adherence clubs and support groups; c) community ART distribution; and d) increased coordination on complementary approaches with local civil society organizations (CSOs), PEPFAR supported C&T sites, and the PEPFAR-supported Orphans and Vulnerable Children (OVC) program.

Health systems: a) complete and disseminate the use of guidelines and SOPs on Differentiated Service Delivery Models (e.g., MMD, Comm ART, transition to DTG-based regimens); b) improve tracking systems to monitor continuity of treatment; c) increase the frequency of supervision and mentorship visits to underperforming sites, apply QA and CQI tools across the board, and inform corrective actions with CLM data; d) revamp technical assistance to ensure reliable and effective SCM; and e) support laboratories to expand VLC.

Figure 2.3.1 Monthly progress in DTG transition, all sites nationwide



Source: SNS, FAPPS, 2022.

2.4 Investment Profile

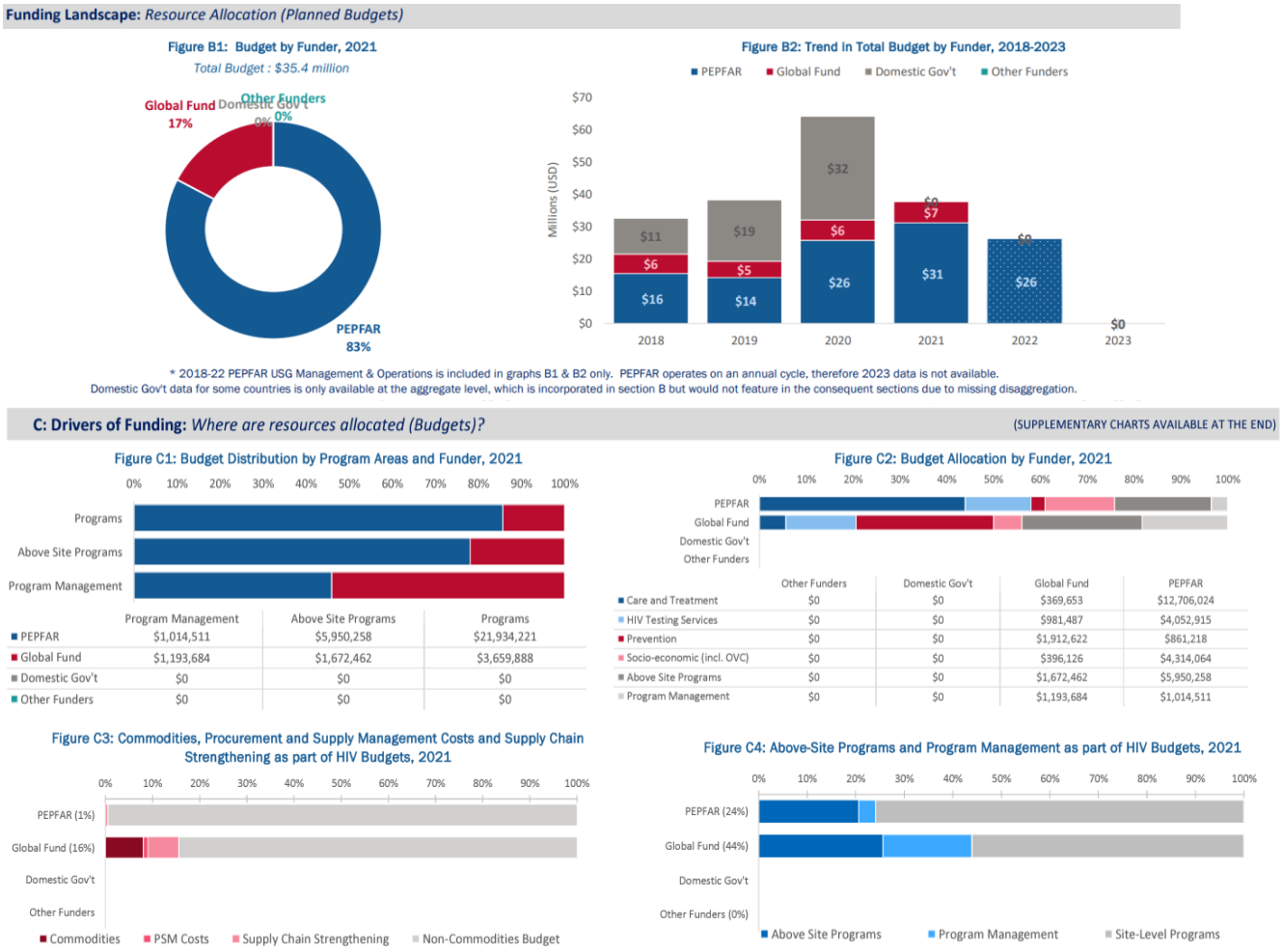
Despite considerable challenges to reach global goals, particularly in the second and third 95s, the DR Government (GoDR) has shown strong commitment to fighting the HIV epidemic in the past eight years. Nonetheless, donor support has been key to complement the GoDR's investment in the National HIV Response, including SCM, expanded diagnosis, treatment, and laboratory services. PEPFAR's investment has matched the GoDR's investment in the past three years. The Global Fund (GF) has invested an average of $6 million/year in recent years, while UNAIDS and PAHO have implemented activities in CLM, stigma and discrimination (S&D), SCM and lab strengthening in partnership with PEPFAR and the GF. PEPFAR and the GF have been the major donors to the DR National HIV Response.

No financial gap in procurement of HIV related commodities is expected in 2023. PEPFAR-DR and its implementing partners will continue to provide critical support in forecasting and costing

HIV commodity needs and will advocate strongly for increased resources to advance the 95-95-95 goals and to promote sustainability of the National Response.

The tables below portray the Dominican Republic's investment profile by funder and program area:

Standard Table 2.4.1



Source: Dominican Republic HIV Resource Alignment Profile, 2022.

PEPFAR will operate on maintenance budget in FY 2013, with a strong focus on health equity, National Response sustainability, and health systems strengthening. In April 2022, the GF identified modest but strategic additional funds to address existing bottlenecks in PrEP expansion and deployment of HIV self-testing (HIVST) upon completion of the PEPFAR feasibility/acceptability study that was required by the MoH for decision making on HIVST implementation.

The COVID-19 pandemic had a tangible negative impact on the DR's economy. Economic recovery and incentive measures have been put in place in 2022 – and will extend into 2023 - to mitigate repercussions in all areas, including health service provision. The commitment of the GoDR to prioritizing HIV is expressed in the planned maintenance of HIV funding in 2023 and an

approximate increase of 20% in funds allocated to procurement of ARVs and other HIV-related supplies.

Standard Table 2.4.1 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID GH-ARPA-ESF	$4.5m	N/A	N/A	N/A	- Accelerate widespread and equitable access to and delivery of COVID-19 vaccinations - Reduce morbidity and mortality from COVID-19, mitigate transmission, and strengthen health systems
CDC COVID (supplement, CARES and ARPA)	$1.5m	N/A	N/A	N/A	- Support COVID-19 laboratory strengthening, emergency response, border health, immunization and pan respiratory disease surveillance activities. Funds are to be obligated by September 30th, 2022, but carryover is expected given multi-year appropriations.
Total	**$6m**				

2.5 National sustainability profile update

The 2021 SID process was initiated by CONAVIHSIDA in collaboration with DIGECITSS, SNS, UNAIDS, the Global Fund, PAHO/WHO, and PEPFAR. Two virtual meetings were convened to collect information from stakeholders, obtain responses to SID questions by domain, and review updates in the DR's political and legal context. Civil society and other key stakeholder participants were identified, including key technical experts, activists, academia, and champions of the HIV National Response.

It is worth noting that CONAVIHSIDA took the lead in convening meetings and conducting the 2021 SID process. A considerably late start and the need for a third stakeholder meeting to be convened in the near future have delayed SID scoring and submission. However, this participatory process has been tremendously useful for domain leads to focus on sustainability and identify gaps. PEPFAR-DR expects to submit the SID report and scores by June 2022. Below is a summary of the discussions to date:

Sustainability strengths

Participation of civil society (CSOs): The participation of CSOs in HIV policy development, planning and implementation has increased considerably. Several CSOs have been providing comprehensive care services as part of the National HIV Response and by efficiently complementing the public service network.

Mobilization of national resources: The country has a comprehensive health financing strategy. Affordable health insurance plans cover care and treatment for Dominican citizens, while the totality of ARVs is made available by the MoH. The national budget explicitly includes HIV financing. This element has received substantial assistance from the PEPFAR program.

Sustainability weaknesses

Product safety and supply chain management: Acquisition of HIV test kits, ARVs, and other supplies is fully financed with national resources. SCM disruptions led to fluctuations in the availability of ARVs. Many measures were taken to ensure the availability of ARVs, including a one-time donation by PEPFAR through the ECF. Recommendation: (1) continued and targeted technical assistance to optimize supply chain functions and operations with the goal of sustaining the GoDR comprehensive commodity strategy.

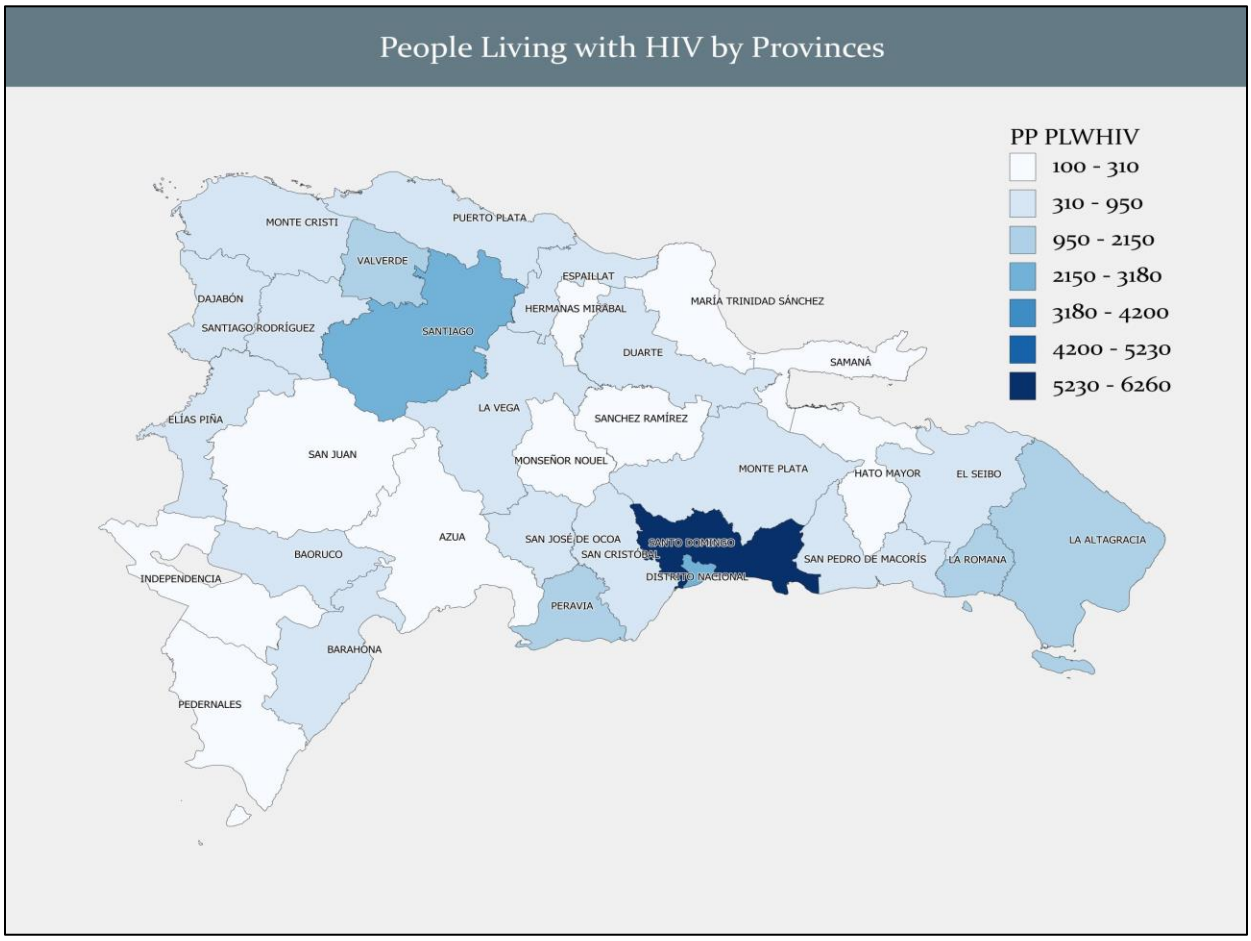
Private sector engagement: Minimal progress to improve the coordination and integration of the private sector with the existing public health structures in order to improve overall quality of care. Recommendation: (1) Map private sector organizations that may have a stake in the National HIV Response and encourage their coordination with CONAVIHSIDA to identify opportunities for collaboration. Civil construction and sugar-cane private farms are among the sectors that can be approached.

Performance data: Full implementation of unique patient identifiers system requires further support and assessment of bottlenecks that have challenged deployment. Integration of service data with administrative data is still not at the optimal level as multiple, parallel information systems routinely collect data on health service provision. These systems are not interoperable. Finally, DR needs to reinforce and refine data quality. PEPFAR and GF financial and technical resources are being used to address these pressing issues.

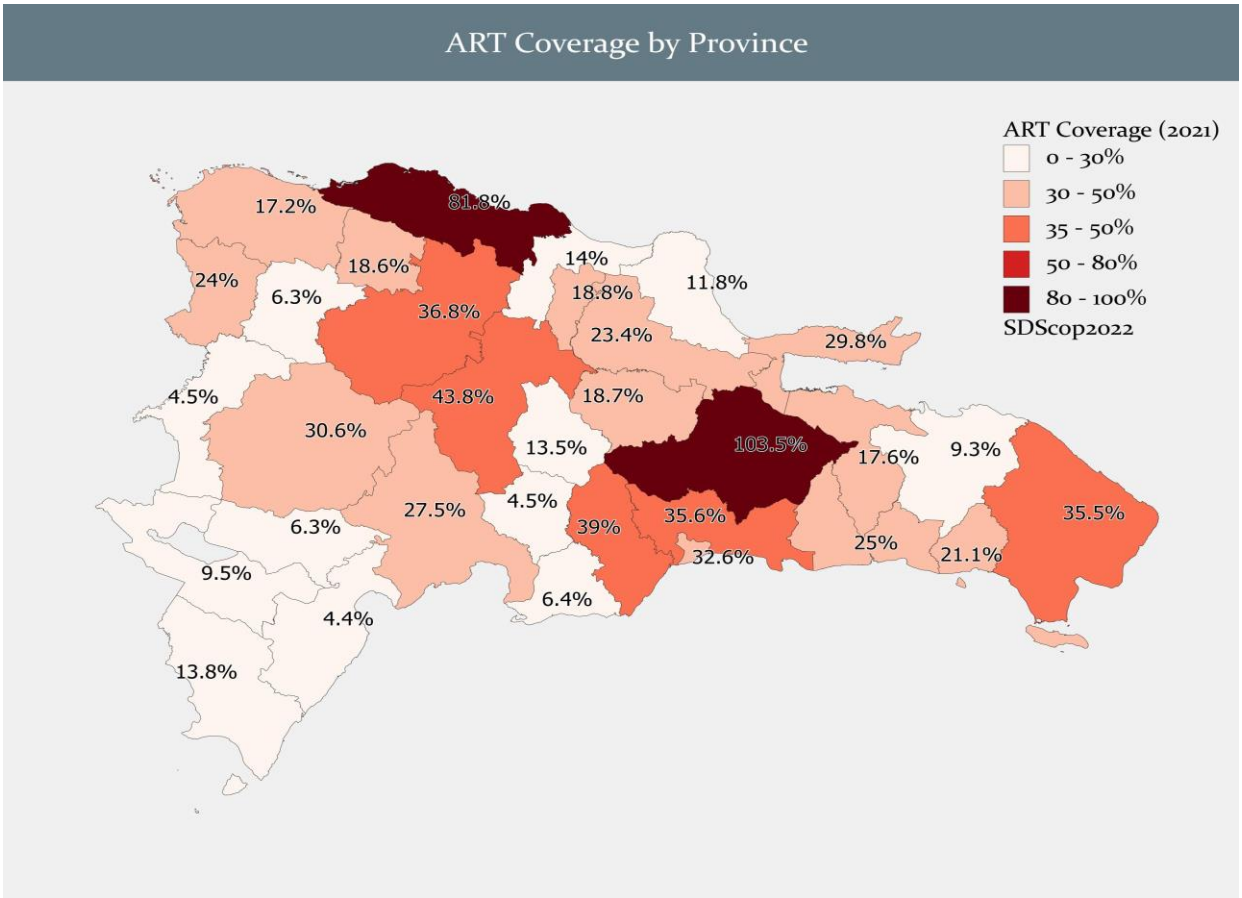
2.6 Alignment of PEPFAR investments geographically to disease burden

PEPFAR-DR will focus on the same ten highest-burdened provinces without expansion to other sites in COP2022.

Figure 2.6.1 Total PLHIV by SNU and coverage of total PLHIV with ART



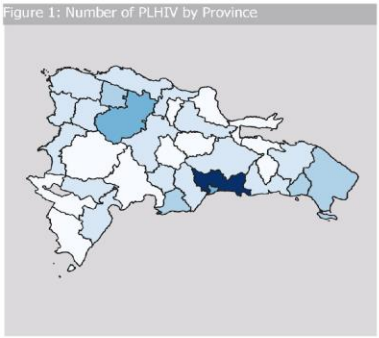
Source: Modelling of ENI
National Census and FAPPS (2019)
FAPPS 2021

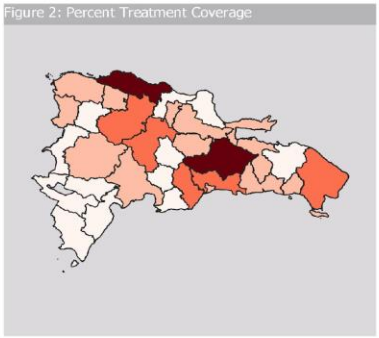


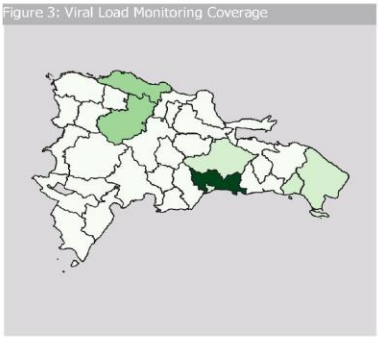
Source: FAPPS 2019

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

PEPFAR Dominican Republic: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Monitoring Coverage for ARP 21







Source: FAPPS 2019

2.7 Stakeholder Engagement

Stakeholder engagement in the development of COP2022 was significantly higher when compared to COP2021 planning. Early PEPFAR-led discussion of COP2021 results with stakeholders helped prepare them for active participation in all planning steps, including the COP2022 strategic retreat, the planning and approval meetings and, to a lesser extent - particularly due to language barriers, in the S/GAC-led Townhalls.

The GoDR co-chaired the COP2022 planning process with PEPFAR through DIGECITSS, CONAVIHSIDA, and SNS. DIGECITSS took a lead role among government organizations and provided high level input, particularly focused on the country's capacity to move forward at the pace required by the Fast Track and donor requirements, in addition to urging for the definition of roles and responsibilities of donors operating in the DR. MoH representatives also outlined their expectation that PEPFAR will fully comply with approved national guidelines and policies and support the dissemination of MoH protocols through SOPs at the site level.

New and non-traditional CSOs attended all phases of the planning process. PEPFAR-DR's efforts to reach out to PP- and KP-led, and faith and community-based organizations resulted in participation of a diverse and more vocal CSO community that significantly contributed to an operational plan that is more inclusive of CSO roles in the National Response.

The Global Fund, PAHO and UNAIDS committed to expanded coordination, better targeting of activities to avoid duplication, and responsiveness to the needs and gaps identified by the MoH.

A summary of stakeholder input and agreements between the parties is outlined below:

Policy

- Prioritizing HIV per the 95/95/95 goals and Fast-Track commitments.
- Update clinical policies to international standards for optimization of the prevention, linkage, and clinical cascades.
- Implement the Combination Prevention Plan recently approved by the GoDR.

SCM

- Support and technical assistance to supply chain management is a priority for the country and the National Response, including improved central, provincial and site level demand estimates, stock control, and distribution logistics to prevent shortages and ensure supply proportional to the demand.

PrEP

- PrEP services that had been halted due to shortages resumed in February 2022, upon publication of the MoH corresponding resolution.
- The National Response requires a concerted effort by interested parties to establish the national PrEP demand, including all the provinces where PrEP has been and will be offered. Greater coordination is needed between donors who support not only PrEP but other actions such as the implementation of self-testing and laboratory strengthening.
- Bring the discussion on new PrEP strategies, including injectable and event-driven PrEP, to the High-Level Donor Coordination Forum.
- Pending ARV needs in 2022 and 2023 projections, the GoDR will consider supporting the establishment of new PrEP targets still in FY 2022.

Community Outreach and Community Services

- Develop strategies to engage PP and KP in community-led monitoring.
- Support local organizations that work directly with PP to improve targeting, identify new cases, and promote treatment adherence.
- Strengthen the capacity of civil society organizations to provide comprehensive services to PP and KP at the community level.
- Support SAI compliance with MoH directives and protocols.
- Collaborate with counterparts in Haiti to promote better outcomes among PP.
- Conduct community mobilization and awareness talks on HIV, TB, and S&D.
- Improve dissemination of available services to PP and KP, e.g., PrEP and viral load tests for non-suppressed cases.
- Promote the decentralization and integration of HIV services in the primary health care network.
- Advocate for inclusion of community HIV services, including CommART, in the MoH's policy framework.

Laboratory Services

- Strengthen VL and CD4 sample transportation services and establish a single results delivery system, including virtual options. The SNS requires support with human resources and means of transport.
- Conduct assessments to estimate viral load demand.
- Support an external evaluation of lab service quality.
- Continue and strengthen training for laboratory staff and promote accreditation programs for the lab network.

Coordination

- Multi-stakeholder dialogue is needed to define the best approaches to bridge the accentuated gaps in the clinical cascade among non-PP and KP.
- Map donor funding and activities to maximize efforts and better target human and financial resources to the National Response gaps, and clearly define donor roles and responsibilities.
- Better distribute donor investment among provinces and avoid duplication of investment in technical areas.
- Involve donors in the discussions of the various technical roundtables under the leadership of the Government.
- Share SID 21 scores when completed and analyze the results to identify gaps.

Orphans and vulnerable children

- Expand activities to include vulnerable children other than PP.
- Define and rapidly design a strategy to reach 90% of the population eligible for OVC services.
- Leverage program milestones to expand index test offer and improve percentage of OVC aware of HIV status.
- Improve coordination between implementing partners and civil society organizations for POC OVC services (one-stop shop).
- Reduce the number of service provision points beneficiaries need to visit to receive child-centered, family-based comprehensive case management services that address the health, education, socioeconomic, and safety needs among the affected households in a sustainable, people-centered, and equitable manner.

- PEPFAR DR will accelerate the transition of the OVC program to a local implementing partner.

Next steps

- High-level Donor Coordination Forum to map technical, geographic, and programmatic activities and funds, as well as roles and responsibilities of donors in the National Response.
- Interact closer with civil society leaders to discuss comprehensive service strategies for PLHIV, community outreach, human rights promotion, and participation of PP and KP in community-led monitoring.
- Evaluate the capacity and quality of lab services and improve the efficiency of different diagnostic test platforms.
- Coordinate with the National Tuberculosis Program for integration of co-infection, prevention, and treatment services.
- Conduct the Supply Chain Management Assessment and identify needs and bottlenecks.
- Support the Medicine Technical Round Table and PROMESE-CAL for estimation accuracy and efficient logistics of drugs.
- Discuss strategies to correctly estimate the demand for PrEP at the national level and establish realistic goals compatible with actual demand, under the feasibility parameters of the Ministry of Health in 2023.
- Identify and address gaps in CLM implementation to ensure active participation from civil society organizations to diagnose and pinpoint persistent problems, challenges, and barriers with service uptake at the facility and community levels.

No private sector organizations participated in the planning process. At this point, the private sector is not represented in the DR National HIV Response.

2.8 Stigma and Discrimination

According to the DR Stigma Index 2, stigma and discrimination (S&D) remain a problem among PLHIV and manifests internally as well as externally from different people and in different contexts, including in healthcare settings[7]. Stigma and discrimination against PLHIV contribute to poor health care quality, coercion and violence, job loss, and exclusion from social environments. Internalized stigma is high and relates to difficulty telling others about being HIV positive and hiding their status from others. External stigma is also common among Stigma Index respondents: over a fourth of respondents had experienced negative comments 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 addition to S&D against PLVIH, S&D against PP is pervasive in the DR, rooted in historical factors and fueled by cultural and language barriers. Migrants provide labor to the civil construction and sugar cane farming (bateyes) sectors, two activities that are at the base of the Dominican economy, but still face statelessness and deportations coupled with health sector

[7]Red Dominicana de Personas que Viven con VIH/SIDA, Alianza Solidaria para la Lucha Contra el VIH y SIDA, and Population Council. 2019. People Living with HIV Stigma Index 2.0 Dominican Republic Country Assessment. Washington, DC: USAID | Project SOAR

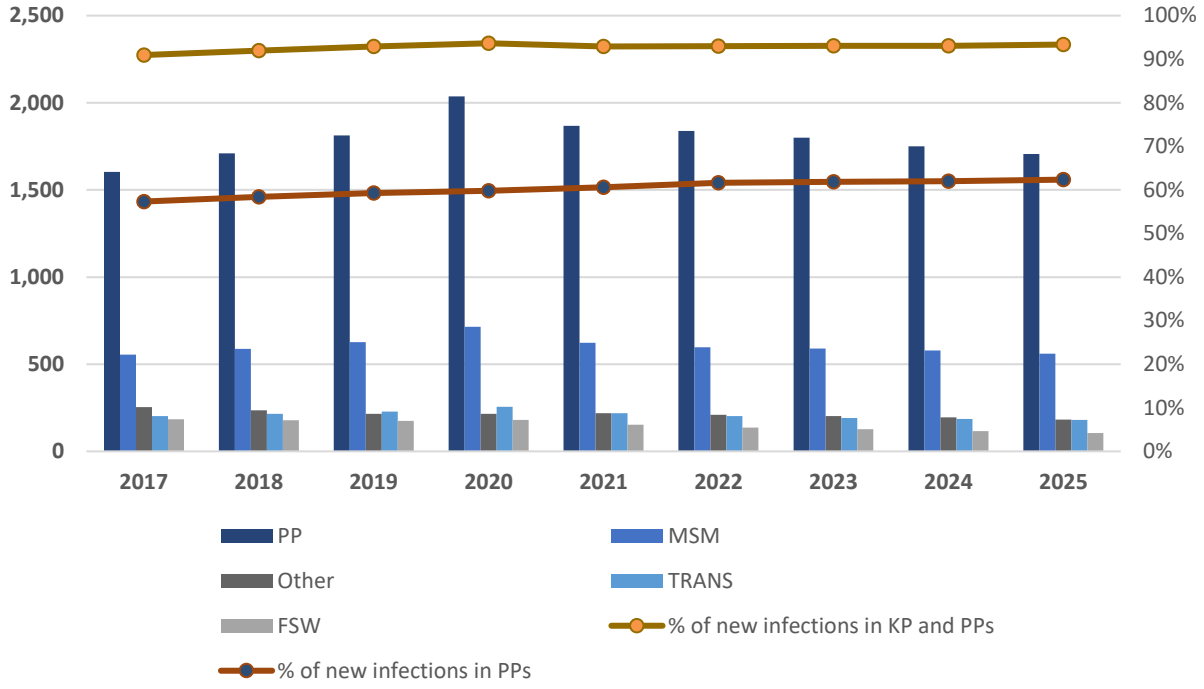
barriers. During COP2022 implementation, the DR program will continue to work with the GoDR, CSOs, and multilateral partners to achieve S&D-free services for PP living with HIV. To reduce S&D across services, PEPFAR-DR will implement continuous training and coaching for, and supportive supervision of facility and community-based healthcare providers. All teams will have either Creole-speaking health providers or access to real-time translation services. Implementing partners will disseminate key messages and images through radio, social media, and printed materials, both in Spanish and Creole, regarding clients' rights, available services, and efforts against S&D. In addition, CLM will include S&D analysis to facilitate effective and concrete feedback to IPs for further corrective actions to person-centered approaches. The DR program will seek to remove all barriers to continuous care and maximize responsiveness to personal needs.

Through DoD, the OU will provide S&D reduction training to medical personnel, military and border patrol officers and the impact of S&D on health services, including at military hospitals, include S&D reduction in digital service platforms; and update the 2012 military HIV policy to include S&D reduction.

3.0 Geographic and population prioritization

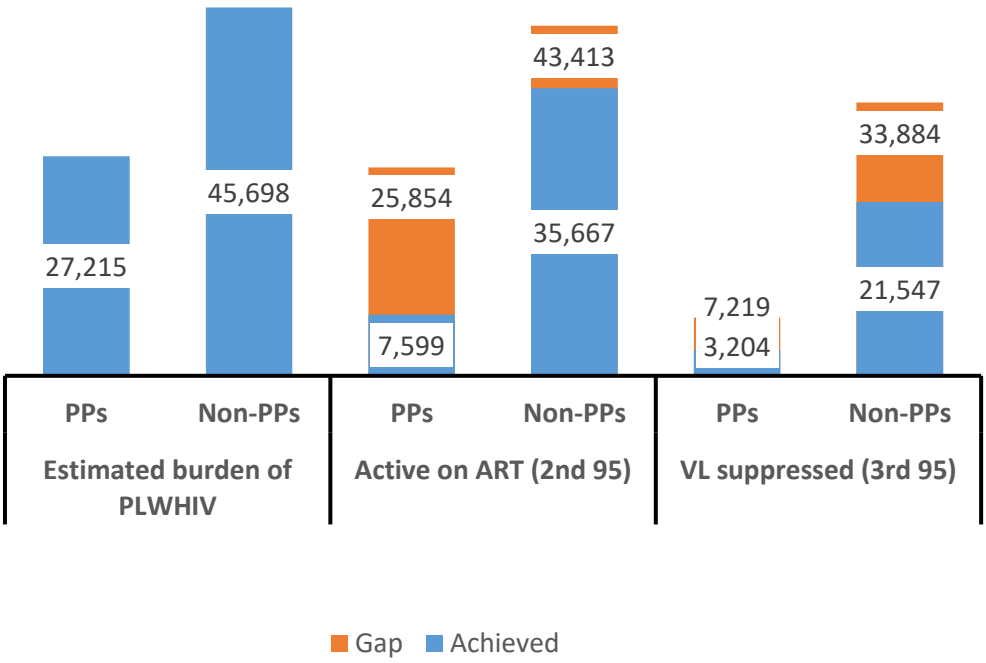
The HIV epidemic in the DR is concentrated both by population and geography. In 2021, 84% of new infections occurred among key populations and PP, with the largest proportion (58%) occurring among the latter - a trend that is expected to remain stable over the coming years (Figure 3.1). As PP are disproportionately affected by HIV and experience significant barriers to access health services in the DR, PEPFAR-DR will focus on closing the case finding, treatment, and viral suppression gaps among this population (Figure 3.2). Without intensive prevention, testing, and treatment interventions (including continuity of treatment) 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 2022

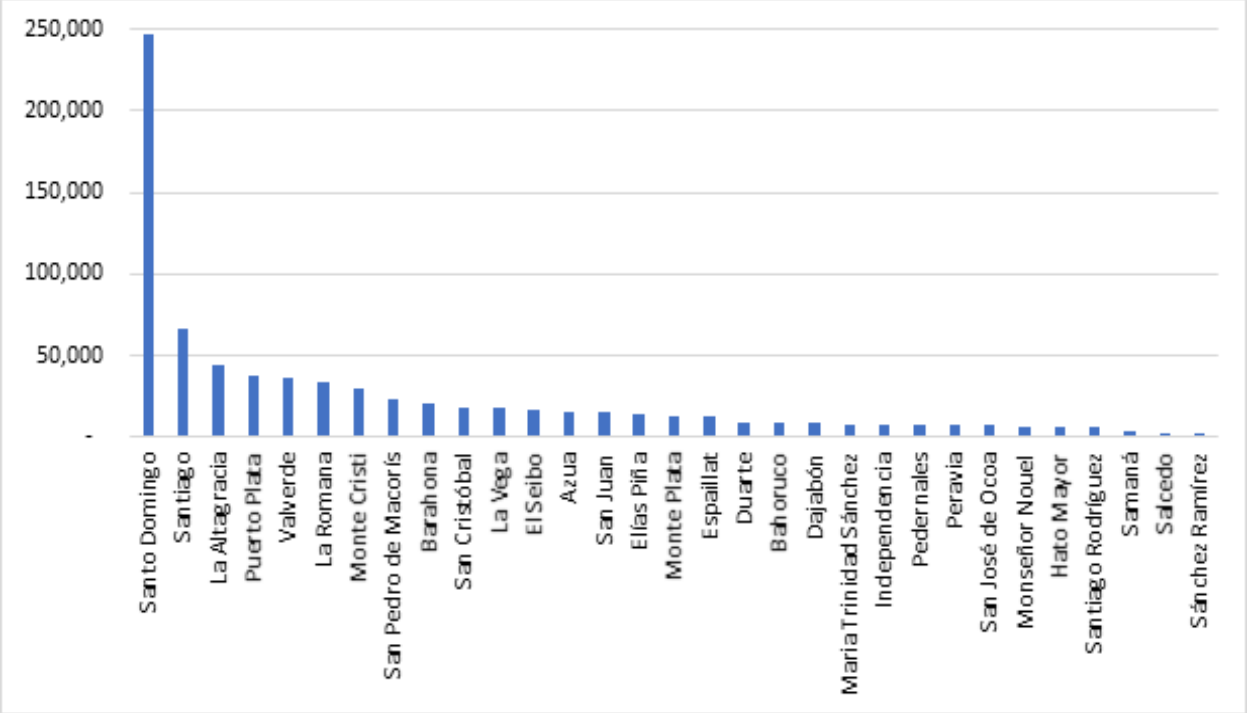
Figure 3.2 Estimated Gap in ART Cascade, PP versus all other populations



Source: Spectrum 2022, DR HPIMS

Accurate information on the geographic distribution of PP is vital for program design. In COP2020 PEPFAR-DR expanded activities to San Pedro de Macorís, La Vega and San Cristobal – provinces adjacent to Santiago and Santo Domingo with easy commute for KP and PP working in either Santo Domingo, Santiago, La Altagracia, Puerto Plata, and Valverde. In Monte Plata and La Romana, PEPFAR pivoted support from KP to PP.

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



Source: National Immigrant Survey, 2017

COP2022 will focus resources and efforts on reaching PP in high-volume sites. PEPFAR-DR will maintain its presence in the ten provinces identified for support in COP2020: Santo Domingo, Monte Plata, San Cristóbal, San Pedro de Macorís, La Romana, La Altagracia, La Vega, Santiago, Puerto Plata, and Valverde.

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV/% of all PLHIV for COP2022	# Current on ART (FY21)	# of SNU COP21 (FY22)	# of SNU COP2022 (FY23)
Attained				
Scale-up Saturation				
Scale-up Aggressive	67% (48,970)[8]	43,266[9]	10 (PSNU)	10 (PSNU)
Sustained				
Central Support				

[8] This accounts for all pops in PEPFAR supported PSNU only

[9] This accounts for all pops in both PEPFAR and non PEPFAR supported PSNU

4.0 Client-Centered Program Activities for Epidemic Control

To support the DR in moving towards 95–95-95 goals, marginalized and underserved subpopulations such as PEPFAR's PP must have access to person-centered and S&D-free services that ensure diagnosis, rapid ART initiation, continuity of treatment and VL suppression. Prioritized populations are exposed to a wide range of social, economic, and political factors that further increase their vulnerability to HIV and other health conditions. The COVID-19 pandemic exacerbated underlying vulnerabilities among PP.

PEPFAR-DR support includes direct service provision, capacity building, and supervision of healthcare providers at the facility and community levels. This helps create S&D-free environments with the required psychosocial, case-management, navigation, and 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 PP in COP2022, PEPFAR-DR will increase community-level efforts, ranging from demand creation, case-finding, accompanied linkage to treatment sites, community and household support services for PP on ART and their families, and community-led monitoring.

PEPFAR-DR will continue advocating for and support the implementation of rapid ART initiation and community ART distribution in compliance with national policies and guidelines. In COP2022, PEPFAR will further advance decentralization of HIV care and treatment and bring services closer to PP either by identifying a facility closer to their homes, or otherwise promoting linkage to services or within their communities. Shifting from HIV facilities to primary care units, mobile clinics, and community teams will take into consideration urban versus settings, demand and availability of services, and 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 trained and supervised community health workers who are able to dispense ART between regular clinical visits and trained and supervised lay providers who are able to distribute ART in the community. Provision of HIV services, including health promoter navigation and individual case-management at the community level will increase linkage to and continuity of treatment. PEPFAR-DR engagement with national and subnational health services will further strengthen implementation of coordinated activities towards epidemic control.

PEPFAR will support the GoDR in addressing systemic challenges that hinder epidemic control. This support will seek to standardize HIV service provision among health providers and sites; develop policies and/or standardized procedures for the expansion of routine HIV care and treatment at the community level; improve SCM for availability of ARVs for MMD, CommART, and transition to DTG-based regimens; strengthen ART adherence through community support; expand VL coverage and suppression; and adapt clinical care and outreach materials to be culturally and linguistically responsive to PP.

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 in an effort to reduce individual and structural barriers to access HIV services, including

S&D, and an effective and sustainable platform to improve progression through the HIV treatment cascade.

4.1 Finding people with undiagnosed HIV and getting them started on treatment

In COP2022, PEPFAR-DR will focus on innovative and cost-efficient strategies tailored to the local epidemiology and current ART coverage among PP, 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, accurate and timely results, and immediate, accompanied linkage to care and treatment services. As part of the optimization process, PEPFAR-DR will continue to focus on weekly and monthly monitoring of testing and linkage to treatment efforts based on successful FY2021-2022 monitoring approaches.

Person-centered services to optimize case finding and linkage through a diverse and complementary set of interventions for prioritized population will include:

- **Identifying and focusing on groups requiring additional attention**: Focusing efforts on those most vulnerable among PP (men, TB patients, older adults, KP, people with advanced disease, children/adolescents of PLHIV).
- **Implementing tailored strategies for PPs**: Using strategies to increase efficiency of HIV testing and ART initiation by:
    - *Introducing innovative case finding approaches* at facility and community levels combined with systematic offer of index testing for HIV+ individuals aimed at testing their sexual partners and biological children. PEPFAR-DR will offer index testing for all patients that are newly diagnosed and currently on treatment, especially among those who are not virally suppressed. PEPFAR-DR will implement most effective modalities of index testing, such as assisted partner notification, mixed Index and social network testing, and assignment of a point-of-contact for Index Testing in each site or community team. PEPFAR-DR will increase the number of teams implementing index testing at the community level and will continue implementing strategies to maintain confidentiality of Provider-Assisted Referral. Strengthening M&E tools, community-led monitoring, and remediation systems will allow PEPFAR-DR to better track and respond to potential incidents related to family and Gender-based violence (GBV).
    - *Optimizing Provider-Initiated Counseling and Testing through integrated care services.* PEPFAR-DR will increase HIV testing coverage in priority clinical areas (e.g., TB and STI services, hospital inpatient entry points, emergency rooms, nutrition services) and strengthen collaborative TB/HIV/Hepatitis activities.
    - *Improving Social-Network Testing:* PEPFAR-DR will build on the success of the Enhanced Peer Outreach Approach (EPOA) experience to scale-up the social network strategy. PEPFAR-DR will use mixed approaches (e.g., index testing and EPOA) to increase case-finding and linkage to treatment in COP2022. Based on lessons learned, PEPFAR-DR will also use social network testing as a platform to introduce HIVST through partner and/or peer testing among PP, thus, ensuring linkage to further testing, prevention, and treatment following HIVST.

- *Optimizing provision of HTS:* PEPFAR-DR will expand the implementation of flexible clinic hours to increase PP access to testing and care services outside working hours and on weekends. PEPFAR-DR will implement risk-screening tools to identify PP most likely to be HIV positive at facility and community levels and conduct micro-level mapping to identify HIV hotspots in COP2022. Community efforts to identify PP males will focus on hotspots where they congregate, including after work social gatherings and venues know for sex work. Establishing a protocol between clinical/community care efforts and the OVC program for eligible clients will also strengthen HIV index testing of partners and biological children, while ensuring appropriate linkage HIV treatment and care.
- *Reinforcing test and start:* In coordination with the GoDR, PEPFAR-DR will develop and implement SOPs for rapid initiation of ART, particularly for community-based settings. PEPFAR-DR will ensure flexibility to adapt linkage models to PP needs. In other SDS sections, PEPFAR-DR presents system level efforts to ensure availability of rapid HIV tests and antiretrovirals – a mandatory assumption to ensure rapid ART initiation.

PEPFAR-DR will review approaches monthly to adjust service models based on positivity and ART initiation rates.

- **Increasing innovative associations** with grassroots organizations, managed by, or focusing on PP, including faith based, and local and regional organizations; and ensuring the involvement of local leaders –including traditional healers.

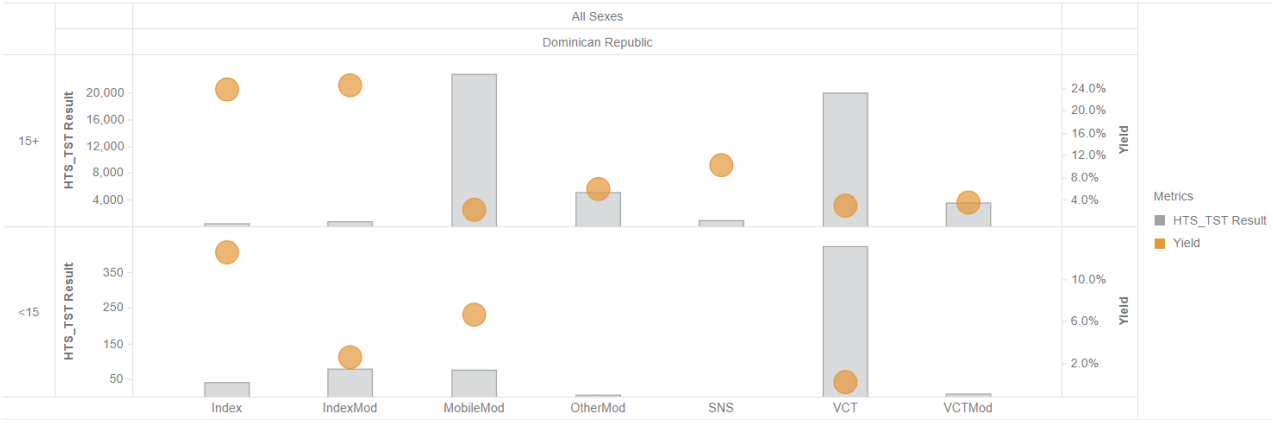
- **Adapting HIV services across the cascade**
  - *Implementing a person-centered approach:* Adapt HIV service delivery to be more person-centered, considering users' needs and preferences and shifting resources and attention to most vulnerable individuals.
    - Peer health promoters for new HIV+ individuals, 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, diminishing S&D, and using incentives to improve progression through the HIV treatment cascade.

PEPFAR-DR will continue recency testing, a new strategy that started in COP2021, to support surveillance efforts. Any person over 15 years of age who has recently been diagnosed with HIV and has provided consent will undergo a rapid test for recent infection. Samples will be transported to the National Public Health Laboratory for processing.

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 include the provision of clinical services for survivors of sexual violence, inclusive of HIV testing with referral to care and treatment as appropriate, in addition to: post-exposure prophylaxis (PEP) sought within the first 72 hours; 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 the capacity of providers to properly address GBV and how to respond to adverse events.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



Source: Panorama – Testing & Yield by age/sex/modality (Testing: Single OU dossier)

4.2 Ensuring viral suppression (VLS) and ART continuity

PEPFAR-DR activities for COP2022 will continue to expand access and quality of service for PP. The proposed strategy and related activities are designed to support an upsurge in service entry points to effectively reach HIV+ PP in targeted areas, decentralizing the provision of HIV services in close coordination with the GoDR.

PEPFAR-DR will focus on addressing PP-specific barriers for rapid ART initiation, MMD, and person-centered approaches. PEPFAR will continue supporting GoDR on scaling-up MMD and transition to DTG-based regimens. 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 also leverage the comprehensive OVC program by training Creole-speaking community case managers to reinforce MMD.

The COP2022 ART continuity strategy is designed to ensure PP are virally suppressed. As an effective ART initiation strategy and optimized ART regimens are vital to ensure retention, PEPFAR-DR focused on reducing PP-specific barriers for MMD and transition to and initiation of DTG-based regimens.

Activities to ensure continuity of treatment and VLS include, but are not limited to:

- **Enhanced case management**: Case Managers are vital to improve continuity of treatment throughout all stages of the HIV cascade. PEPFAR-DR will improve procedures at health facilities for rapid treatment initiation, viral suppression monitoring, motivational interviews and adherence counseling/monitoring, and S&D reduction. In FY2023, PEPFAR-DR will continue implementing tele-medicine, digital-health, and other communication technologies to enhance case management. Clinical implementing partners

will identify eligible clients/families and refer them to PEPFAR-DR's comprehensive OVC program for assessment and enrollment to provide increased wrap-around service for improved clinical outcomes.

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 regimens. In addition, PEPFAR-DR will strengthen patients' education activities, monitoring, and counseling to improve treatment adherence.

- **Individualized and group support:** Patients will be invited to participate in structured sessions led by trained peer counselors and/or stable patients on ART. Peer navigators and community workers will continue to implement tailored counseling and follow-up for PP. Based on existing local experiences and after a challenging COVID-19 pandemic, PEPFAR-DR will start the implementation of adherence clubs and support groups in the community to ensure continued ART 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. PP 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 PP on ART will be assigned to a health promoter for weekly check-ins and will receive appointment reminders by SMS and phone calls. Peer navigators will also provide community outreach (e.g., back-to-treatment campaigns) of individuals interrupting treatment for proper return to client-centered packages. Back-to-treatment efforts will have a non-judgmental approach in order to de-stigmatize existing cycles of ART engagement (re-engagement).
- **Decentralized ART delivery:** Decentralization of ARV delivery is one of the main priorities for PEPFAR-DR as community-based approaches better suit PP behaviors/needs and complement existing facility-based delivery. Facility-based delivery will offer ART initiation and refills using flexible hours (early morning and evenings and weekend 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. All decentralized approaches will be coordinated with GoDR to ensure national policies and guidelines are observed.
- **Simple and standardized monitoring systems:** PEPFAR-DR will continue optimizing 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 and use of tracking methodologies and distribution of SIM cards as soon as patients are recovered. PEPFAR-DR will use SMS and phone calls for pre-appointment reminders and supportive counseling –as part of digital health approaches.
- **Improve VLC and VLS:** Continue expansion of VL sample collection schedules at all sites 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 to complete the expansion of VL processing laboratories at the national level with the addition of the Porvenir (in San Pedro de Macoris) and Centro Sanitario (in Santo Domingo). Both have been fully operational since November 2021. 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.

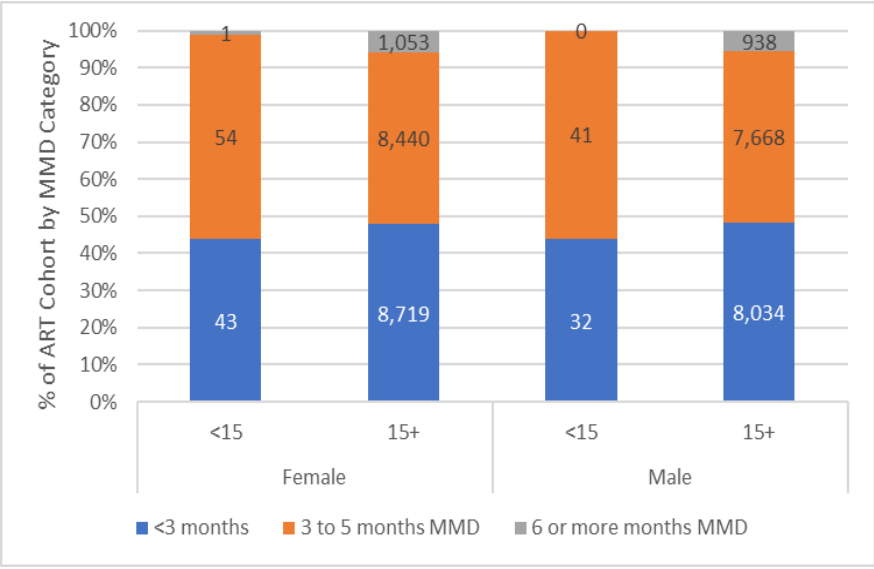
- **OVC Service Package for PP Families:** Will include interventions for children (under 18 years of age or under 20 years old if in school) and their caregivers based on an integrated approach of family case management addressing the health, stability, safety, and schooling of the household.

PEPFAR facility-level support includes personnel, clinical and monitoring 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 quality assurance and continuous quality improvement interventions. There is also a significant community-level component ranging from navigation services and adherence counseling/monitoring 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 COP2022, Community-led monitoring (CLM) will continue to complement the current quality control efforts at the community, site, and above the site levels.

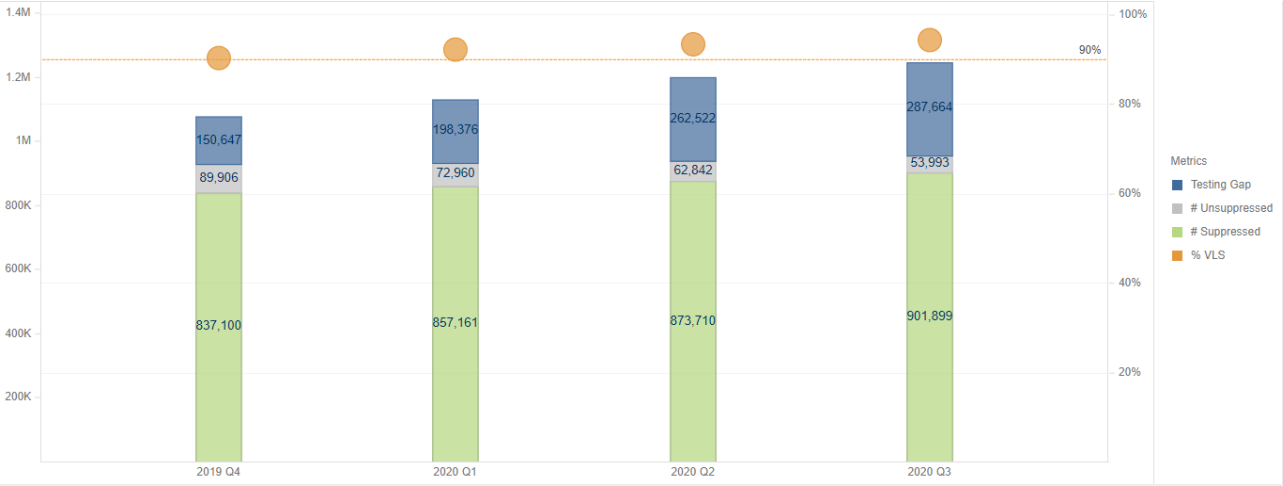
VL sample collection schedules at site level at most PEPFAR sites have expanded from 1-2 days per week, to 4-5 days per week while improving reporting systems to reduce the delivery time of results to less than 72 hours. PEPFAR-DR has worked on the expansion of VL processing laboratories nationwide and supported the implementation of a Quality Management System in the 4 Laboratories that process Viral Load and CD4 samples nationwide, these are, LNSPDD, Centro Diagnostico Gurabo, Centro Diagnostico Porvenir and Centro Sanitario Santo Domingo.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21



Source: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

Figure 4.2.2 Viral Load Outcomes, FY21

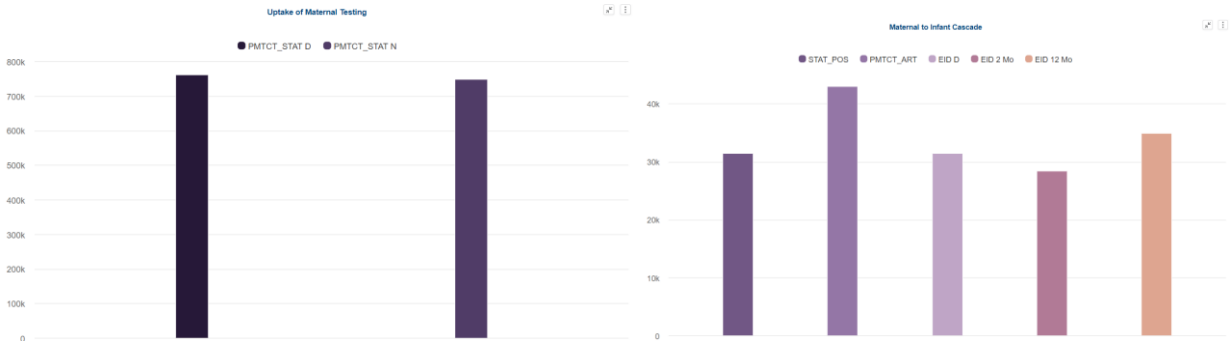


Source: Treatment Single OU Dossier; Treatment Overview chapter; Multi-month Dispensing by Age/Sex page; current quarter, by sex

4.3 Prevention, specifically detailing programs for priority programming:

PEPFAR-DR is currently implementing a feasibility/acceptability assessment of HIVST among PP. Pending a final assessment report, expected for July/August 2022, PEPFAR will support the GoDR to update the country's testing policy and to ensure product registration, financing, procurement, and distribution. If approved, PEPFAR-DR will facilitate HIVST implementation during COP2022 by leveraging service delivery platforms in priority provinces. PEPFAR-DR may use EPOA as a platform to introduce HIVST.

Figure 4.3.1 PMTCT Cascade

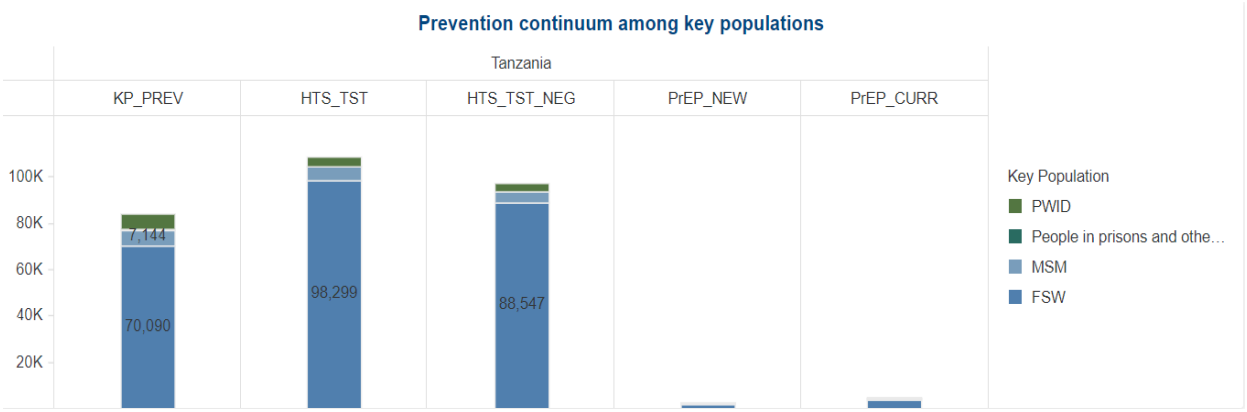


Source: PMTCT-HEI: Single OU dossier; Overview page; PMTCT and HEI Cascade pages

PEPFAR began supporting PrEP implementation in the DR in FY2018 at one site in Santo Domingo that targets services to MSM and TGW. In FY2020, two additional sites (Puerto Plata and La Romana) began offering PrEP, and eligibility criteria expanded to include FSWs. Also in 2020, the GoDR published PrEP guidelines with PEPFAR support. PrEP expansion slowed down in FY2020 and was halted in FY2021 due to the COVID-19 pandemic and associated delays in GoDR procurement of ARVs. In FY2023, PEPFAR-DR will continue expanding PrEP availability within the limits posed by the MoH given drug availability. 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 healthy sexual behavior (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 4.3.2 Prevention continuum by key population group



Source: Prevention: single OU dossier; all prevention chapters; prevention continuum by KP page.

Integrated orphans and vulnerable children (OVC) package of services

PEPFAR-DR's OVC program is designed to reduce barriers to HIV prevention and service delivery for PP children, adolescents, and their families affected by HIV by improving their access to key services across four domains: healthy, schooled, stable, and safe. Through comprehensive case management to eligible clients and their family members, the OVC program provides these child-centered, family-based services among the affected households to *strengthen adherence to treatment* and *prevent new HIV infections*. The case management model includes identification of the eligible caregiver/child, enrollment, assessment of needs, and the development, implementation, and monitoring of a case plan until the household graduates from support. The table below outlines the mix of services that the OVC program either directly provides or facilitates through referrals.

DOMAIN	KEY SERVICES
Healthy	Referral of identified at-risk individuals for community-or facility-based HIV counseling and testing; home-based and/or referrals for HIV services (adherence, retention, and disclosure counseling, linkage to treatment, viral load testing, PMTCT, community or clinic support/ adherence groups, case conferencing); referrals 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.
Schooled	Education materials, school fees, uniforms and shoes, community homework support, transportation assistance for education, referral for literacy training.
Stable	Linkage to social protection programs (including support for gas and electricity); referrals/logistical support for accessing documentation services, with focus on birth certification and national identification for eligible beneficiaries; referrals for services related to household economic strengthening (social protection grants, microenterprise services, vocational training, etc.).
Safe	Identification and reporting of child abuse or violence to relevant child protection authorities or service providers (legal support, counseling, medical care).

In COP2022, USAID is exploring ways to optimize access to referred services by making them more client friendly, such as through accompanied referrals to navigate bureaucratic social and legal protection programs, reduce the number of entry points, and facilitate communication for non-Spanish speakers more efficiently.

The PEPFAR-DR OVC program is 100% focused on comprehensive service provision targeting HIV+ clients on ART and their families in PEPFAR supported SNUs. Targeted sub-populations include HIV+ PP caregivers on ART and in PMTCT, as well as pediatric ART clients in PEPFAR-supported SNUs. It is through these primary entry points that the PEPFAR-DR OVC program recruits OVC index clients, all of whom are HIV+, and then provides comprehensive wrap-around services to all members of their respective household.

The OVC program strengthens HIV+ index client adherence to treatment, promotes diagnosis of new cases at the household and community level, and prevents new HIV infections in family members through comprehensive case management services that build the resilience of HIV affected PP families so that they can meet their health, economic, education, and social development needs.

Primary prevention of HIV is focused in three areas:

- PrEP for eligible HIV-negative adolescents ≥ 18 and adults (i.e., sero-different couples, FSWs, MSM, TG, and high-risk youth ≥ 18 years old).
- Comprehensive HIV prevention and treatment services for 0–17-year-old children and adolescents, which includes actively facilitating HTS of children at risk of HIV infection, linkage to care and treatment, providing support and case management services for HIV+ OVC, and reducing risk for 10–14-year-old youth through primary prevention of sexual violence.

- Comprehensive treatment support services for HIV+ OVC beneficiaries, which includes facilitating linkage to treatment and providing home-based adherence support and case management for HIV+ PP on ART and in PMTCT to ensure improved retention and increased, sustained VLS.

In COP2022, the OVC program will continue to address key barriers faced by PP in initiating and remaining engaged in HIV treatment. Partnerships with HIV treatment sites, community partners and civil society organizations, and extended integrated referral networks will complement the efforts of PEPFAR clinical partners to identify undiagnosed, HIV-positive household members of PP and ensure access to HIV testing and counseling, stronger linkage to treatment, and adherence to treatment.

The OVC program will also strengthen and operationalize bi-directional referral networks for PP who seek services through a range of integrated services that address basic household needs to positively influence treatment outcomes, reduce the risk of new HIV infections, and improve other measures of health and well-being. Among others, these services include emergency food assistance, psychosocial support, and adherence counseling, GBV screening and referral, support for education, economic strengthening interventions, and facilitation of access to legal documentation needed to access additional social, economic, and health services.

Finally, the PEPFAR-DR OVC program will improve the overall quality of the program by incorporating linkages with CLM, which currently only monitors the quality of HIV care and treatment services at PEPFAR- supported ART clinics. In COP2022, PEPFAR-DR will support the CLM implementer to incorporate new OVC-focused questions in the CLM data collection tools to track the quality of services provided to OVC index clients and their families at ART clinics where new clients are being actively recruited.

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

PEPFAR Dominican Republic is committed to supporting the GoDR strengthening of national HIV monitoring and surveillance systems. To that end, in collaboration with the DIGECITSS, SNS, and CONAVIHSIDA, PEPFAR-DR will support the development of annual morbidity and mortality reports for management of advanced disease, identification of underlying reasons of interruption in treatment, and assessing the impact of opportunistic diseases in HIV-related mortality. These reports will collect data from the national HIV patient registry (FAPPS) and site-level data to provide annual mortality trends, burden of disease among those on ART, TB co-infection rates and other information on infectious and non-infectious co-morbidities that can modulate disease outcomes.

In COP2021, competition processes have been put in place which are inclusive of local organizations in OVC and C&T services. These new assistance instruments might contribute to an increase in the percentage of funds allocated to local organizations, pending proposal evaluation and identification of implementing partners. PEPFAR-DR's portfolio already includes funds allocated to agreements with the GoDR (MoH, SNS) and to Indigenous organizations.

PEPFAR-DR is conducting a major exercise to gain additional knowledge about non-traditional partners (e.g., faith and community-based organizations working directly with PP), assess their capacity gaps, determine support needed, and diversify the pool of sub-grantees. The OU is also

approaching grassroots organizations that promote the human rights of PP to further engage them in community-led monitoring and explore the possibility of small grants.

However, it is worth noting that the DR's civil society has a reduced pool of organizations that are responsive to USG granting criteria. PEPFAR-DR is committed to reaching the goal of 70% by enhancing the capacity of local organizations to compete for PEPFAR grants.

The OU will be advocating for implementation of U=U messaging and user-friendly U=U materials, including age-appropriate disclosure and people-centered psychosocial services for C/ALHIV of focus clients. Advocacy will be required to decrease resistance to U=U communication campaigns.

4.5 Additional Program Priorities

PEPFAR-DR will continue working with the GoDR for the effective introduction of HIVST based on international best practices and results of the 2022 HIVST Feasibility and Acceptability assessment. In addition, PEPFAR teams will provide TA to GoDR and local NGOs to build institutional capacities for the effective and sustained implementation of community-based HIV services based on national policies and guidelines.

As the stock-outs of TPT drugs limited TB prevention activities, PEPFAR-DR will support the TB program on forecasting and planning activities to facilitate the availability of Isoniazid and Rifapentine. In addition, PEPFAR-DR will continue working with MoH to update national guidelines and strategies for the effective introduction of 2021 WHO guidelines for TB screening.

As described in the OVC section, PEPFAR-DR is working to optimize program implementation, adapting and scaling-up best practices, and introducing recommendations included in the COP2022 guidelines and stakeholder input.

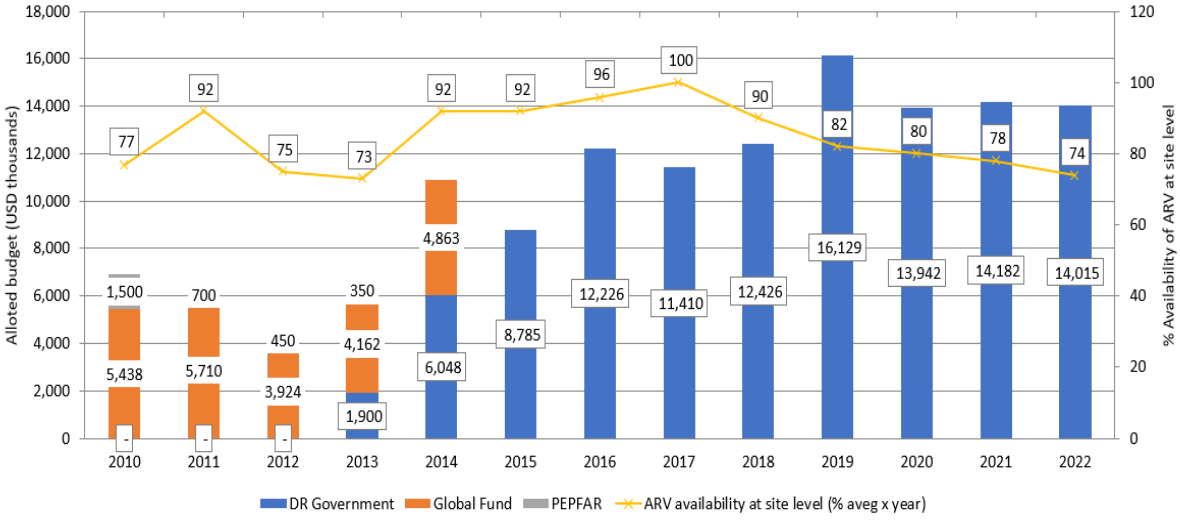
Based on 2021-2022 lessons learned, PEPFAR will adjust community-led monitoring to increase the implementation and tracking of improvement plans and advocacy actions with GoDR for system-level adaptations.

4.6 Commodities

Shifting commodity financing from external to domestic funds has been an important achievement in DR’s national HIV financing. Since 2014, the GoDR has been solely responsible for the purchase of all HIV related commodities using its own domestic resources.

Figure 4.6.1 shows the trend of GoDR expenditures on commodities over the past decade, attesting to their commitment to sustainability of drug provision to PLHIV.

Figure 4.6.1 - Trend in GoDR expenditures on Commodities – 2015-2002



Source: Valdez, C; Barillas E. (2017). Updated in 2022 by the USAID's Supply Chain Management Strengthening Project using data from the GoDR HIV commodities logistics management information system (SUGEMI)

In 2021, however, the GoDR faced an unprecedented shortage of ARVs. In October 2021, the GoDR requested an in-kind donation from PEPFAR to cover three months of consumption of five first line ARVs, including Dolutegravir. While PEPFAR has not purchased HIV commodities in the DR, S/GAC approved the use of the Emergency Commodities Fund for the Procurement of ARVs to prevent stockouts in the country. This donation was sufficient to cover for three months of treatment for those in first line regimen. The total approved cost for this donation was US$1,230,000 dollars.

The PEPFAR-DR program will continue to provide support to the national HIV supply chain management (SCM) mechanisms to ensure continuous supply of ARVs and other HIV related commodities, including diagnostic supplies. Over the past years, the country has reduced the number of options for recommended HIV adult regimens (to only keep the most effective regimens), improving forecasting for commodity needs, and optimizing the cost per patient treated, reducing it from $371/patient per year in 2011 to $98/patient per year in 2021. These cost savings allowed the GoDR to purchase optimized DTG-based regimens and place an emergency order of 118,000 tablets of Isoniazid, which represents three months of stock based on historic consumption, to support TB preventive treatment (TPT) efforts.

PEPFAR-DR will provide technical assistance by participating in government-led technical work groups, implementing capacity building activities in forecasting timely and realistic planning, efficient procurement, and delivery, as well as effective distribution down to the site level to support the implementation of differentiated service delivery models, including MMD, community ART distribution, rapid initiation of ART, and transition to DTG-based regimes.

At the above-site level, PEPFAR-DR will continue to provide critical support in the forecasting and costing of HIV commodity needs and advocate for increased resources to advance 95-95-95 goals. This technical support will facilitate the reduction of financial gaps for the procurement of

ARVs in 2022, as the government is faced with many competitive priorities, including the impact of the COVID-19 pandemic.

PEPFAR-DR will oversee direct implementation of community services and update existing guidelines, SOPs, and procedures to ensure availability of HIV tests, ARVs, and lab supplies for HIV/TB services 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. Site pharmacy/warehouse management will include needs assessment, quality improvement plans, and strong coordination with clinical services for effective use of optimized regimens. PEPFAR-DR is planning to reach 100% stock status observation from storage sites showing "stocked according to plan" at the sub-national level by Q4 of FY2022.

PEPFAR-DR will support the national HIV information systems (FAPPS and SUGEMI) to provide quality information on health commodity 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.

PEPFAR will conduct data quality analysis on selected sites to ensure consumption data is being used for decision making. For COP2022 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 SCM innovations implemented, including programmatic components as well as expenditures to inform the GoDR on potential scale-up scenarios.

The 2021 drug stockout impacted the performance of all TB indicators by Q1 FY2022. Thanks to PEPFAR TA, the National HIV Program was able to purchase a batch of isoniazid for TPT among HIV patients using the global health SCM. PEPFAR-DR will continue supporting MoH on forecasting and planning of TPT related commodities to prevent future shortages.

4.7 Collaboration, Integration and Monitoring

PEPFAR-DR implementation model includes CDC and USAID support clinical care activities at the site level as well as health systems strengthening efforts to strengthen service provision, programmatic and technical collaboration. PEPFAR-DR implementing agencies have regular meetings with the MoH and the donor community to align approaches and best practices.

The PEPFAR Coordinator and representatives of implementing agencies actively participate in the Country Coordination Mechanism (CCM), and the High-Level Donor Forum, while technical team members take part in technical working groups and are included in specific technical discussions to ensure that PEPFAR activities follow international best practices and are in line with national priorities.

At the country level, PEPFAR-DR utilizes data-driven QA and CQI methodologies aimed at optimizing HIV and TB clinical care in PEPFAR-supported sites. Combining CDC and USAID's granular site management approach and key elements from the MER (2.6) guidelines, PEPFAR-DR seeks to identify bottlenecks and challenges while also introducing innovative strategies via technical support and supervision.

In COP2022, PEPFAR-DR will continue working on the CQI methodology to align PEPFAR approaches with those of the MoH, thus contributing to strengthening of health systems and data quality. These initiatives will complement the Site Improvement Management System (SIMS) application and the development of streamlined tools based on SIMS but adapted to the DR epidemiological profile, service network, and MoH protocols. This set of tools will be complemented with information gathered from community-led monitoring.

This support includes, but is not limited to, monthly site visits, high frequency weekly e-reporting, weekly calls with implementing partners, and monthly and quarterly discussion meetings with partners and stakeholders. Those discussions have lately focused on SCM, HIS, laboratory improvement, and other above-site activities. This process incentivizes teamwork and promotes cross-fertilization between implementing agencies. PEPFAR-DR adopts a collaborative approach at the site level aimed at improving performance, creating better rapport with implementing partners, increasing site capacity to use data for decision making, and improving quality of HIV services in person-centered and stigma-and-discrimination free environments. This includes support to technical data analysis and triangulation of high-frequency reporting Health Facility Registry (HFR) information to promote a data-driven culture at each site.

Community services, ranging from risk-reduction counseling, HIV testing, and community-based care are also available at the site level. QA/CQI supports patient flow at the clinic, including wait times for testing, counseling, and receiving HIV test results. Involvement of the MoH authorities, service providers, and implementers of CLM in the CQI process fosters ownership and ensures sustainability of this model.

To respond to the COP2022 Planning Level Letter (PLL), PEPFAR-DR will continue expanding data-based understanding of PP needs, risks and structural factors that limit their access to quality health services through the implementation of CLM. COP2022 CLM activities will support sites to overcome persistent system challenges/barriers and identify enablers of effective client outcomes. CLM will be used to advance equity and to support improvement in services to PP. In COP2022, PEPFAR-DR will 1) expand CLM to two new PEPFAR supported provinces: Valverde and La Altagracia, 2) continue to hold strategic meetings with CSOs, grassroots organizations, non-traditional partners, and representatives of PP and KP to greatly increase their participation in CLM, including case-finding, expansion of index testing offer, promotion of treatment adherence, and monitoring of viral load suppression; 3) advance strategic advocacy meetings with government stakeholders to present CLM results and pending system gaps; and, 4) ensure independence of CLM is maintained.

Civil society, alongside PLHIV, PP, and KP will lead several activities to ensure services are both of high quality and aligned with their needs. Their participation is expected to take place in three clusters: a) assessing person-centered services) b) assessing PEPFAR efficiency), and c) assessing COP2022 implementation. PEPFAR-DR will focus on clusters (b) and (c), PEPFAR will work directly with IPs to monitor above-site activity progress and completion and will report quarterly

to S/GAC. PEPFAR-DR will boost the use of unique identifiers – an area where improvement is urgently needed - across sites and programs (e.g., C&T and OVC) to improve monitoring and track program effectiveness.

On laboratory system strengthening, PEPFAR-DR will support the implementation of a Quality Management System in lab processing of VL samples; the external quality assessment program for HIV and VL testing (including recency testing); and quality of rapid HIV testing services at SAIS through technical assistance, training, mentorship, and CQI procedures.

4.8 Targets by population

Standard Table 4.8.1 - Targets by Population

Indicator	Age	Scale-up: Aggressive	Prioritized population by indicator
GEND_GBV	Total	1,683	PP, KP, Gen Pop
HTS_INDEX	15+	6,998	PP
HTS_RECENT	Total	5,783	PP
HTS_TST	15+	86,280	PP
HTS_TST_POS	15+	5,836	PP
OVC_HIVSTAT	Total	6,783	PP
OVC_SERV	18+	6,130	PP
	<18	6,783	PP
PP_PREV	15+	55,138	PP
	<15	98	PP
PrEP_CT	Total	1,404	PP, KP, Gen Pop
PrEP_NEW	Total	754	PP, KP, Gen Pop
TB_PREV	15+	21,547	PP, KP, Gen Pop
	<15	74	PP, KP, Gen Pop
TX_CURR	15+	48,737	PP, KP, Gen Pop
	<15	233	PP, KP, Gen Pop
TX_NEW	15+	5,576	PP
TX_PVLS	15+	44,712	PP, KP, Gen Pop
	<15	231	PP, KP, Gen Pop
TX_TB	15+	47,784	PP, KP, Gen Pop
	<15	177	PP, KP, Gen Pop

Standard table 4.8.2 - Target Populations for Prevention Interventions

Table 4.8.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY23 Target**
[Specify target populations for focus, e.g., AGYW at risk of HIV acquisition, female sex workers] *Indicator Code PP_PREV*	751,306	796.2**	55,236
TOTAL	751,306	796.2	55,236

*Population estimation from ENI 2017 for Haitian migrants and Dominicans of Haitian descent in all provinces (PEPFAR and Not PEPFAR supported)

**DALY per 100K (IHME, 2021). YLL data is also available. Data for KP+GP+PP.

Standard Table 4.8.3 - Targets for OVC and Linkages to HIV Services

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target) OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target) OVC_SERV Preventative**	**Target # of active OVC (FY23 Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC***
[Specify SNUs for focus]	1,130*	12,913	0	0	6,783
TOTAL	1,130	12,913	0	0	6,783

*Population estimation from ENI 2017 for Haitian migrants and Dominicans of Haitian descent in PEPFAR supported provinces.

4.9 Viral Load and Early Infant Diagnosis Optimization

In COP2022, 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 (POC) service delivery management, as well as health systems bottlenecks or barriers. This will be achieved through systemic evidence-based approaches and sustained institutional capacity building.

In addition to the primary focus on PP, existing data highlights the need for significant improvement in viral suppression (3rd 95) for all populations, especially after significant delays due to COVID pandemic. In COP2022, PEPFAR will continue to support the following C&T and lab interventions to increase VL coverage and suppression among PLHIV on ART:

- Support the National HIV Program implement updated 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 site level.
- Conduct Diagnostic Network Optimization (DNO)
- Work with regional health offices to optimize sample transportation to VL processing labs, through a unique sample transportation system (SUTMER in Spanish), community sample management, and ultimately reduce result delivery time.
- Incorporate plasma separator cards (PSC) for VL sample collection, facilitating sample storage and referral to the processing laboratory.
- Increase PLHIV knowledge to improve behaviors towards ART adherence by reinforcing the concept of U= U during education and counseling. PEPFAR-DR will also work with PLHIV on ART sites to increase demand for VL testing.
- Enhance site-level staff capacities, thorough training, mentorship, and tools, to support ART adherence approaches, VL sample collection, and VL monitoring for effective treatment failure management.
- Implement VL coverage and VL suppression CQI action plans based on sites' current performance across populations.

PEPFAR-DR will work with the GoDR to ensure integrated diagnostics and multiple use of conventional and POC platforms for viral load and other infections, including Tuberculosis.

PEPFAR will support the evaluation of GeneXpert systems for VL testing and Early Infant Diagnosis (EID).

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 and non- PEPFAR supported sites will 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 virologic failure may be occurring more frequently at these sites, a protocol to actively detect virologic 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 through C&T and OCV mechanisms.

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.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV epidemic in the DR is concentrated in specific subsets of the population, particularly among PP and KP. As supported by the 2019 SID report, PP face significant barriers to accessing HIV services, including but not limited to socio-economic conditions, S&D, site service hours, language barriers, and mobility. Moreover, the DR has insufficient accurate and reliable data to understand the factors driving the HIV epidemic among PP, and especially among their descendants. As stated before, PLHIV among PP now represent 33.8% of all PLHIV, the single largest affected group in the DR.

Surveillance for HIV requires timely, detailed, and robust data to systematically understand the burden of infection, direct prevention efforts, guide funding, identify new infections and predict future trends in the epidemic. In COP2022, PEPFAR will support the GoDR in the creation of a dedicated HIV surveillance department within the Ministry of Health and in an assessment of the status of existing HIV surveillance systems in the country. This support will extend to the development of an annual HIV morbidity and mortality report. In addition to these efforts,

PEPFAR-DR will conclude COP2021 efforts related to the triangulation of programmatic data and PP focused research to better understand the population with the largest service delivery gap, improve decision making capacity, and identify the potential drivers of the HIV epidemic in this group. PEPFAR-DR will also implement an observational study to complement knowledge building on the effectiveness of PEPFAR models and increase DR understanding of the population with the largest service delivery gap for epidemic control.

Building on COP2021 activities, PEPFAR-DR promotes sustainability in national systems and leverages existing strengths to ensure continued long-term impact along the cascade for all populations. 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 participating in the Technical Monitoring Group led by GoDR to enhance coordination and better align data with the GoDR for improved reporting and advancement of the implementation of minimum requirements.

Throughout FY2021, the Dominican Republic was affected by either shortages or stockouts of HIV commodities including but not limited to first line antiretrovirals, isoniazid, and viral load reagents. To contribute to GoDR efforts in SCM for the HIV response, PEPFAR will provide technical assistance on SCM strategies and models at national and sub-national levels to support GoDR forecasting and planning, procurement, distribution, and pharmacy supply management.

Additionally, with the objective of closing the financing gap in the HIV response, PEPFAR will provide technical assistance to design costing models to determine the resources necessary for sustainable service provision and alternatives for private sector engagement (PSE). COP2022 builds on the momentum of COP2020-2021 to initiate a series of additional reforms requiring PEPFAR-DR investment to promote the rollout of a nationwide rapid initiation strategy and close PP treatment gaps.

The development of a policy framework, guidelines, tools, and monitoring systems for the appropriate prescribing and dispensing of HIV commodities in alignment with transition to DTG-based regimens and differentiated service delivery (DSD), including MMD and community ART distribution, will enhance treatment initiation and client retention. In COP2022 implementation, PEPFAR will implement a system/programmatic needs assessment and Human Resources management plans to build sustainable community-based HIV services. In addition, and based on the FY2022 acceptability-feasibility assessment, PEPFAR will support the design of guidelines and SPOs for the implementation of HIV self-testing.

PEPFAR-DR investments will also continue to enhance the FAPPS, the national HIV patient registry. As of Q1 of FY2022, all HIV care sites nationwide have started implementing the biometric registry. In addition to this important milestone, PEPFAR-DR will support the interoperability of health information systems in the DR (project “Expediente Unico”). 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.

PEPFAR will continue advocating for cross-border referrals, technical dialogue, and diplomatic engagement, as applicable, between Haiti and the DR to assess and close the gaps along the HIV continuum of care for individuals needing support for ART, aiming for seamless, continuous,

client-centered services for those that seek HIV care and treatment after crossing the international border.

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

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

To support the ambitious goals in reaching PP, scaling-up the OVC program, expanding CLM, providing TA to support the DR in improving outcomes under the 2nd and 3rd third 95; and reach targets established in the clinical and prevention cascade, in COP2022 the interagency team will continue to seek staff right-sizing to meet programmatic needs.

During COP2021, PEPFAR-DR added one new position to the interagency team: a PEPFAR Deputy Coordinator who will work on M&E data and financial analytics for the interagency. CDC will hire this Locally Engaged Staff (LES) position. Once the Deputy PEPFAR Coordinator comes on board in FY2022, CDC's team will include 3 US Direct Hires, 2 Fellows, and 13 Locally Engaged Staff positions. USAID's current office footprint includes 1 US Direct Hire, three external contractors (including the PEPFAR Coordinator), and 14 Foreign Service National (FSN) positions.

This balanced staffing pattern will continue into COP2022 as it is tailored to achieve the anticipated level of effort in the coming year. Both agencies are working to fill vacancies as quickly as possible to avoid programmatic interruptions. Additionally, no new positions have been identified for DOD in COP2021. Nearly 70% of the 28-member interagency staff are dedicated to technical work, with the remaining 21% and 11% allocated to management and administrative positions, respectively. This represents minimal changes to the CODB from COP2021 to COP2022 given the maintenance budget scenario and rising inflation.

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 (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) *TX_CURR*	Newly initiated (APR FY23) *TX_NEW*	ART Coverage (APR 23)
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	16,673*	42,385**	15,630	48,970	5,576	58.7%
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total						

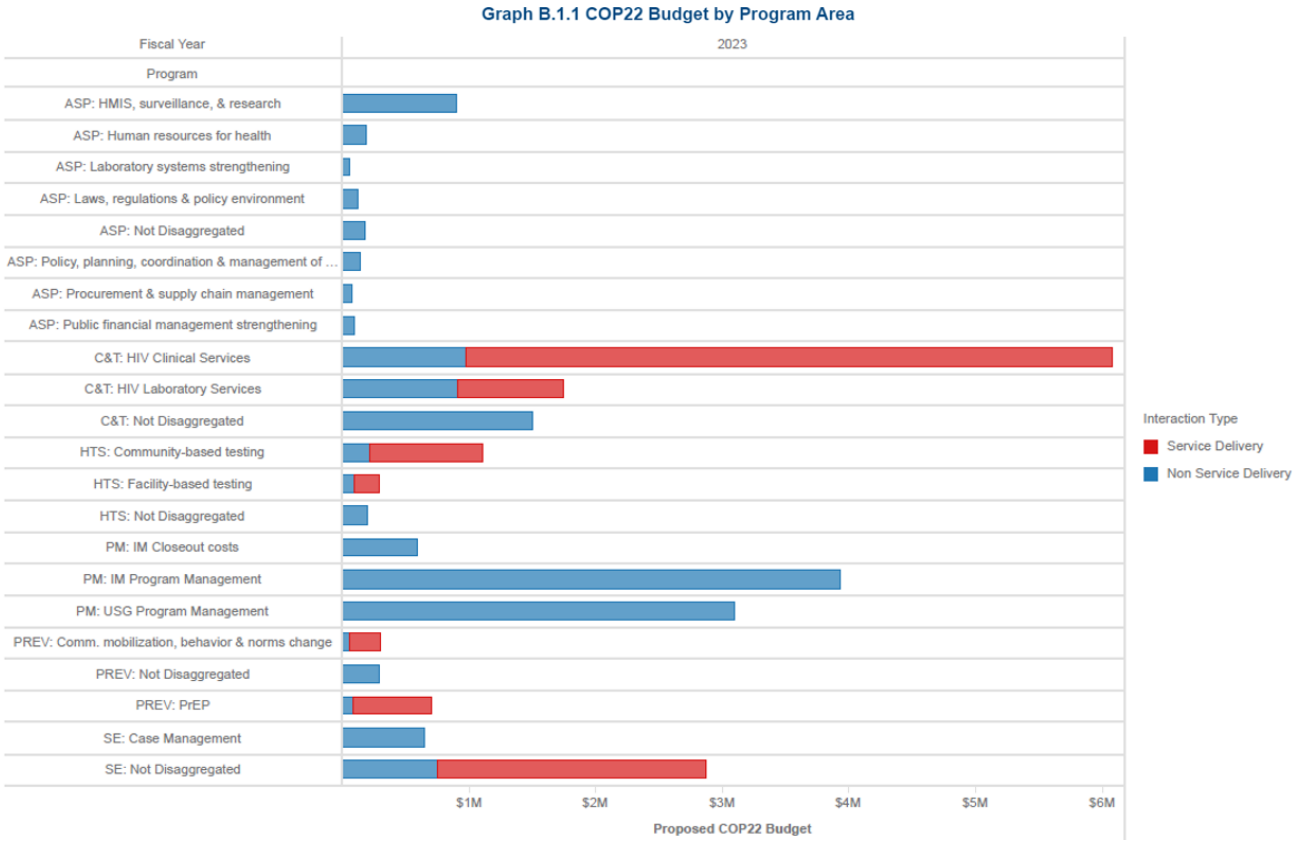
* For COP2022, the estimated total PLHIV corresponds to PP in the PEPFAR supported provinces.

**PEPFAR-supported sites only.

APPENDIX B – Budget Profile and Resource Projections

B1. COP2022 Planned Spending in alignment with planning level letter guidance.

Table B.1.1 COP2022 Budget by program area



Source: Panorama.

Table B.1.2 COP2022 Budget by program area

Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$14,997,331**	**$10,002,669**	**$25,000,000**	**60%**	**40%**	**100%**
C&T	**Total**	**$3,381,098**	**$5,930,793**	**$9,311,891**	**36%**	**64%**	**100%**
	HIV Clinical Services	$972,169	$5,099,606	**$6,071,775**	16%	84%	**100%**
	HIV Laboratory Services	$908,975	$831,187	**$1,740,162**	52%	48%	**100%**
	Not Disaggregated	$1,499,954		**$1,499,954**	100%		**100%**
HTS	**Total**	**$497,578**	**$1,087,760**	**$1,585,338**	**31%**	**69%**	**100%**
	Community-based testing	$218,660	$882,140	**$1,100,800**	20%	80%	**100%**
	Facility-based testing	$84,540	$205,620	**$290,160**	29%	71%	**100%**
	Not Disaggregated	$194,378		**$194,378**	100%		**100%**
PREV	**Total**	**$412,398**	**$868,840**	**$1,281,238**	**32%**	**68%**	**100%**
	Comm. mobilization, behavior & norms change	$48,040	$243,930	**$291,970**	16%	84%	**100%**
	Not Disaggregated	$289,388		**$289,388**	100%		**100%**
	PrEP	$74,970	$624,910	**$699,880**	11%	89%	**100%**
SE	**Total**	**$1,390,473**	**$2,115,276**	**$3,505,749**	**40%**	**60%**	**100%**
	Case Management	$639,470		**$639,470**	100%		**100%**
	Not Disaggregated	$751,003	$2,115,276	**$2,866,279**	26%	74%	**100%**
ASP	**Total**	**$1,716,333**		**$1,716,333**	**100%**		**100%**
	HMIS, surveillance, & research	$892,000		**$892,000**	100%		**100%**
	Human resources for health	$182,900		**$182,900**	100%		**100%**
	Laboratory systems strengthening	$52,000		**$52,000**	100%		**100%**
	Laws, regulations & policy environment	$115,244		**$115,244**	100%		**100%**
	Not Disaggregated	$177,189		**$177,189**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$142,000		**$142,000**	100%		**100%**
	Procurement & supply chain management	$65,000		**$65,000**	100%		**100%**
	Public financial management strengthening	$90,000		**$90,000**	100%		**100%**
PM	**Total**	**$7,599,451**		**$7,599,451**	**100%**		**100%**
	IM Closeout costs	$586,000		**$586,000**	100%		**100%**
	IM Program Management	$3,925,998		**$3,925,998**	100%		**100%**
	USG Program Management	$3,087,453		**$3,087,453**	100%		**100%**

Source: Panorama/PAW.

Table B.1.3 COP2022 Total planning level

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	**$3,309,845**	**$21,690,155**	**$25,000,000**
Dominican Republic	$3,309,845	$21,690,155	**$25,000,000**

Source: Panorama/PAW.

Table B.1.4 COP2022 Resource allocation by program and beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Dominican Republic	**Total**	**$9,311,891**	**$1,585,338**	**$1,281,238**	**$3,505,749**	**$1,716,333**	**$7,599,451**	**$25,000,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Key Pops			$699,880		$16,000		**$715,880**			55%		1%		**3%**
	Non-Targeted Pop	$2,952,711	$40,000	$95,010	$324,228	$1,273,900	$6,521,623	**$11,207,472**	32%	3%	7%	9%	74%	86%	**45%**
	Not Specified						$108,000	**$108,000**						1%	**0%**
	OVC				$3,012,100			**$3,012,100**				86%			**12%**
	Priority Pops	$6,359,180	$1,545,338	$486,348	$169,421	$426,433	$969,828	**$9,956,548**	68%	97%	38%	5%	25%	13%	**40%**

B.2 Resource projections

Operating at an unchanged budget, PEPFAR DR carefully reviewed FY2021 and available FY2022 expenditure data to identify opportunities to better target investments in COP2022. An increase in the PrEP earmark also required the DR team to look for efficiencies in the OUs straight-lined budget. In particular, given the DR's challenges in achieving sustainability, in COP2022 PEPFAR DR will intensify technical assistance to build enduring capabilities by strengthening health systems (e.g., SCM, HIS, and surveillance), while continuing to support service delivery in ten target provinces. With that, COP2022 funds will sustain service delivery, increase monitoring of progress of above-site activities, and continue to close the PP cascade gaps.

The DR team analyzed investments across the National Response, including resources applied by the GoDR and the Global Fund, as well as the impact of other multilateral agencies' work in selected areas. Sustainability of the National Response will require additional investment by the Government as donors report maintenance budgets and look at areas for transition. Combined, funds allocated to the DR by PEPFAR and the Global Fund currently surpass the GoDR's total funding for HIV (minus investment in commodities) thus supporting PEPFAR's rationale of increasingly supporting health systems strengthening.

PEPFAR, the Global Fund, and PAHO are mapping activities and investments to better align resources, avoiding duplication, and maximize the programmatic impact of those resources.

APPENDIX C – Tables and systems investments for section 6.0

Key system barriers

Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (May duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
7. Human Resources for Health	6.1	GoDR with updated plans to meet HRH needs, including community-based modalities	Lack of sufficient HRH	Limited HRH in HIV sites to support Treat All implementation in country. The country also scored poorly in its capacity to collect, manage, analyze, and use data related to the health workforce.	4-5 years	
2. Policies and Governance	6	Updated policy-framework, clinical guidelines, and SOPs based on latest WHO and UNAIDS recommendations	Legal, policy or regulatory constraint	Incomplete policy framework of updated national guidelines to achieve HIV epidemic control in DR, according to latest WHO and UNAIDS recommendations	2-3 years	
17. Data for Decision-Making Ecosystem	5	Operational research increased in selected provinces/sites to adjust HIV approaches	Lack of technical capacity	Limited accurate and reliable data/information to understand the HIV epidemic in the DR (especially in Focus Clients) to adjust HIV response	4-5 years	
6. Service Delivery	5.1	Adequate GenExpert use and 3HP rollout	Lack of managerial capacity	Inadequate transfer of C&T policies/guidelines to site-level implementation.	2-3 years	
2. Policies and Governance	6	Increase coordination between partners working in both border sides to improve services provision for focus clients	Legal, policy or regulatory constraint	Poor binational approach/coordination for HIV epidemic control	4-5 years	
5. Public Access to Information	5.3	Easy access to information about adherence, U=U and ways to enable PLHIV to reach and maintain undetectability	Lack of Financial Resources	GoDR is accepting of u=u messaging but funding priority is in other areas.	2-3 years	
4. Private Sector Engagement	4.1	Private resources increased for epidemic control sustainability	Lack of technical capacity	Existing financing gap in the HIV response, including services for FC, threatens HIV epidemic control and sustainability	4-5 years	
8. Commodity Security and Supply Chain	6.8	a) No stock-out of HIV clinical supplies (e.g., antiretrovirals, rapid tests, coinfection supplies for treatment and prophylaxis) b) Scale-up access to MMD6 and DSD in PEPFAR supported areas	Lack of technical capacity	Limited access to HIV supplies, especially during contextual situations (e.g., COVID-19 pandemic)	2-3 years	
1. Planning and Coordination	8.5	DR is able to implement sustainable community HIV services	Lack of technical capacity	Limited technical capacities to update and implement plans to advance sustainable community services	2-3 years	
14. Epidemiological and Health Data	7	DR have access to updated and reliable information to adjust HIV program design and implementation	Lack of technical capacity	Limited technical capacity to design, implement and use epidemiological and programmatic research	4-5 years	
15. Financial/Expenditure Data	6.7	Increased financial sources to advance HIV epidemic control	Lack of Financial Resources	Limited technical capacities to identify and implement alternative financial resources for a sustainable epidemic control	2-3 years	

Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (May duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
16. Performance Data	8	Availability of Operational research data to adjust HIV approaches to better address needs of FCs.	Lack of technical capacity	Limited accurate and reliable data/information to understand the HIV epidemic in the DR (especially in Focus Clients) to adjust HIV response	2-3 years	
10. Laboratory	7.6	DR has an enhanced network of laboratories that can perform Viral Load testing nationwide	Lack of sufficient HRH	Limited capacity to test for viral load to reach epidemic control.	2-3 years	

Table 6 – Above Site Activities

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$20,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	5. Public Access to Information	-	-	5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	DR stakeholders coordinate to advance implementation of minimum requirements for epidemic control	Lack of technical capacity			Coordination and sensibilization with GoDR and other key DR stakeholders to advance implementation of minimum requirements	COP22	COP23	NA	NA	Not applicable	Limited coordination to advance PEPFAR/WHO minimum requirements	High-level coordination technical roundtable established to respond to HIV epidemic control needs, including human rights and stigma and discrimination areas, by FY23Q3	# of high-levels coordination meeting minutes submitted to USAID	No	
$35,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	8. Commodity Security and Supply Chain	-	-	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	National and Sub-national levels for HIV commodities stocked according to plan	Lack of technical capacity			Support the design and implementation of policy-framework, guidelines, tools, and monitoring systems for the effective dispensation of ARV and other HIV commodities to ensure MMD, community ART distribution and effective transition to DTG-based regimens	COP19	COP23	Recent COVID-19 pandemic has evidenced important pending gaps for supply chain security	Training of trainers completed up to Provincial levels (PEPFAR provinces) for the effective deployment/implementation MMD guidelines/SOP and DTG-plans by FY22Q4.	Partial	Limited implementation of DSD due to shortages of supplies	SCM guideline/SOPs for Differentiated Service Delivery (DSD) updated and shared	# of DSD guidelines/SOPs submitted to GoDR	No	

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$30,000	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Supply chain infrastructure	8. Commodity Security and Supply Chain	-	-	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Effective national quantification process institutionalized	Lack of technical capacity	Lack of Financial Resources		Forecasting and planning for HIV commodities to support supplies' availability for epidemic control	COP21	COP23	Recent COVID-19 pandemic has evidenced important pending gaps for supply chain security	Updated 5-year (and 2023) quantification for ARV and other HIV supplies	Not applicable	DR experienced supply chain challenges during COVID-19 pandemic	DR's 2024 quantification plan for HIV-commodities submitted to GoDR, by FY23Q4	1 HIV-related supplies quantification report submitted to GoDR	No	
$50,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	-	-	7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	HR management plan implemented for community service provision	Lack of managerial capacity			Technical assistance and support to develop and implement HR plans to respond to epidemic control needs, including HR for community-based activities	COP19	COP23	Community services are still mainly funded by international cooperation	1. HR plan for community HIV services implemented in 1 province by FY22Q3; 2. HR plans for other USAID-supported provinces transferred to GoDR by FY22Q4	Partial	HRH systems not prepared for the effective implementation of DSD	HR management plans in PEPFAR supported provinces (4 provinces)	# of HRR plans submitted to GoDR	No	

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$40,000	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Resource tracking and costing	15. Financial/Expenditure Data	-	-	15.2 Comprehensiveness of Expenditure Data: To what extent does the host country government collect HIV/AIDS public sector expenditures according to funding source, expenditure type, program and geographic area?	Increased financial sources to advance HIV epidemic control	Lack of Financial Resources			Technical assistance to design a GoDR costing model to determine necessary resources to continue HIV services (including FC) and proposed solutions for sustainable service provision	COP22	COP23	NA	NA	Not applicable	Public HIV health system has no sufficient financial input to ensure an effective person-centered service	Costing model developed based on gap analysis (including specific proposed solutions and roadmap), by FY23Q4	1 report on costing model submitted to USAID	No	
$50,000	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	-	-	1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Increased financial sources to advance HIV epidemic control	Lack of Financial Resources			Technical assistance on Private Sector Engagement (PSE) to support national HIV program implementation for epidemic control	COP22	COP23	NA	NA	Not applicable	Public HIV health system has no sufficient financial input to ensure an effective person-centered service	1. Two (2) PSE leverage workshops implemented to define PSE agenda, by FY23Q3 2. GoDR staff trained on Public/Private initiatives by FY23Q4	1) # of PSE workshop reports submitted to USAID 2) One (1) TA/training on PSE report submitted to USAID	No	

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$60,000	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	-	-	1.4 Sub-national Unit Accountability: Is there a mechanism by which sub-national units are accountable to national HIV/AIDS goals or targets? (note: equal points for either checkbox under option B)	DR is able to implement sustainable community HIV services	Lack of technical capacity			Update policy framework, guidelines and SOPs for new HIV services modalities, including HIV community services for adults and children	COP19	COP23	Community services are still mainly funded by international cooperation	1. Trainers of Trainers completed and evaluated on SOPs in 4 PEPFAR-supported provinces by FY22Q4; 2. National policy framework updated for HIV Self-Testing by FY22Q4; 3. Feasibility Assessment on family-based HIV services	Partial	DR systems with limited capacities to sustain community activities Self-testing assessment will be completed by end of FY22	1. Needs assessment for HIV community activities implemented by FY23Q4 2. Self-Testing guidelines/SOP developed	1. One (1) need assessment report submitted to USAID 2. # of self-testing guidelines/SOP submitted to GoDR	No	
$110,000	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Not disaggregated	Research	14. Epidemiological and Health Data	-	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors.	DR have access to updated and reliable information to adjust HIV program design and implementation	Lack of technical capacity			Build knowledge and understanding of the population with the largest service delivery gap for epidemic control	COP22	COP22	NA	NA	Not applicable	Limited systematic and representative information on knowledge and understanding of the population with the largest care & treatment gap	Research study on care & treatment gaps among Focus Clients and other priority populations completed, by FY23Q4	One (1) research report submitted to USAID and GoDR	Yes	

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$40,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	5. Public Access to Information	-	-	5.5 Institutionalized Education System: Is there a government agency that is explicitly responsible for providing scientifically accurate education to the public about HIV/AIDS?	Information and sensitization for public and government officials	It is not included in local HIV response plans	Lack of Financial Resources	Other	Raise awareness of the U=U strategy and enhance adherence counselling	COP19	COP23	During previous FY there were many VL stock outs and due to COVID many activities were delayed and/or indefinitely postponed	*90% of registered patients in HPMS have at least 1 VL test in the last 12 months. * 3 U=U prmotional activities	Partial	*3 U=U promotional activities rolled out, no U=U messaging developed.	*Development of 2 or more forms of U=U messaging in coordination with MoH *3 U=U promotional activities	*# of U=U activities rolled out *# of U=U messaging developed	No	
$16,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	-	-	1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Increase coordination between partners working in both border sides to improve services provision for focus clients	Legal, policy or regulatory constraint	It is not included in local HIV response plans	Poor binational approach/coordination for HIV epidemic control	Improve cross-border coordination, communications and partnerships for HIV patients, focused primarily in TPT and TB care.	COP21	COP23	No cross-border activities initiated due to factors like: COVID, social and political turmoil in Haiti, etc.	Quarterly Meetings with binational working group to discuss HIV/TB priorities	Not applicable	No binational working group or recurring meetings with US agencies.	Quarterly Meetings with binational working group to discuss HIV/TB priorities	# of binational working group meetings in a FY (evidenced by meeting minutes)	Yes	

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$12,000	ASP: Human resources for health-NSD	Priority Pops: Not disaggregated	Institutionalization of in-service training	7. Human Resources for Health	-	-	7.6 In-service Training: To what extent does the host country government (through public, private, and/or voluntary sectors) plan and implement HIV/AIDS in-service training necessary to equip health workers for sustained epidemic control?	Adaquate GenExpert use and 3HP rollout	Inadequate transfer of C&T policies/guidelines to site-level implementation.	Lack of technical capacity		Implement a comprehensive TB/HIV training with focus on community delivery services, GenXpert use and 3HP.	COP21	COP22	Supply chain issues delayed 3HP rollout	Completion of comprehensive TB/HIV trainings for healthcare workers in PEPFAR prioritized provinces	Not applicable	TX_TB_DEN at aprox 48% for FY21	Completion of comprehensive TB/HIV trainings for healthcare workers in 100% of PEPFAR prioritized provinces.	TX_TB, TB_PREV	No	
$12,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Not disaggregated	Program and data quality management	16. Performance Data	-	-	16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	Operational research increased in selected provinces/sites to adjust HIV approaches	Lack of sufficient HRH	Lack of technical capacity	Lack of Financial Resources	Conduct a triangulation of HIV programmatic and research data for all populations, including FCs, in order to improve decision making capacity and quality of care	COP21	COP23	GoDR requires TA and funding for continued FC driven data analysis	Final triangulation report completed	Not applicable	Insufficient data on the potential drivers of the HIV epidemic in FC population groups	Completion of FY23 Data triangulation Final report	# of data triangulation reports submitted in a FY.	Yes	

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$100,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	-	-	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	DR has an HIV/STI Surveillance and SI Department Unit operating in the National HIV response, with identified needs to be addressed	Lack of Financial Resources	It is not included in local HIV response plans	Lack of technical capacity	Incorporate a department of HIV surveillance and SI into the GoDR HIV Response	COP22	COP24	NA	NA	Not applicable	Lack of staff dedicated to HIV surveillance and SI activities completed in the GoDR, lack of an integrated framework, lack of information on the performance of the HIV Surveillance System and fragmented rollout of activities	National HIV Surveillance framework developed along with establishing a team and HIV surveillance assessment conducted by Q4 FY23	# of meetings held to develop Surveillance network.# of personnel working in HIV surveillance department	Yes	
$12,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	-	-	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	DR HIV Response has the knowledge of the morbidity and mortality outcomes of the HIV patients in service to adapt their services to the needs	Lack of technical capacity	Lack of sufficient HRH		Develop an annual national Morbidity and Mortality Report of HIV patients in the DR	COP22	COP25	NA	NA	Not applicable	Lack of information on morbidity and mortality of HIV patients in country	Annual Report on Morbidity and Mortality of HIV patients developed	# of morbidity and mortality report submitted in a FY.	Yes	

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12,000	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	Program and data quality management	16. Performance Data	-	-	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	DR has reliable data for retention of clients in PrEP services	Lack of Financial Resources	It is not included in local HIV response plans		Conduct a rapid assessment for retention of PrEP clients, identifying treatment interruptions and to address any weaknesses in programming that can be improved (advocating for event driven PrEP)	COP22	COP24	NA	NA	Not applicable	Lack of information about the retention of PrEP clients in care in DR	Rapid assessment conducted by Q4 FY23	# of PrEP sites with rapid assessments applied	Yes	
$16,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	-	-	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	DR has reliable information of the clinical status of HIV patients accessing services and can adapt services to patient needs	Lack of sufficient HRH	Lack of technical capacity		Conduct a rapid assessmet of the clinical status of HIV patients initiated in ART	COP22	COP24	NA	NA	Not applicable	Lack of information on the clinical status of patients inititaing ART	Rapid assessment conducted by Q4 FY23	# of HIV sites with rapid assessments applied	Yes	

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$8,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	-	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	DR has implemented an Electronic Medical Record (EMR) for HIV patients	Lack of technical capacity	It is not included in local HIV response plans		Provide technical assistance to GoDR in the implementation of an Electronical Medical Record for HIV patients	COP22	Post COP25	NA	NA	Not applicable	Lack of standardized and automated documentation of medical information of HIV patients	Framework and SOP for developing interoperability layers and standards of an eHealth system: requirements for Electronic Medical Record development	# of SOPs developed for interoperability of ehealth systems.	Yes	
$40,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	-	-	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	DR has an enhanced network of laboratories that can perform Viral Load testing nationwide	Lack of sufficient HRH	Lack of technical capacity		Enhance the Viral Load testing capabilty of the GoDR in serving HIV patients nationwide with development and roll out of of National laboratory netwrok	COP22	COP25	NA	NA	Not applicable	Viral Load testing coverage in country is still low despite the capacity for PCR testing available in country	1. National Laboratory network improvement plan developed by Q4 FY23. 2. Roll out in all processing labs has begun.	# Meetings held to discuss national laboratory improvement plan # Number of processing lab implementing improvement plans	Yes	

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												improvement plan.										
$25,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	-	-	10.4 Capacity of Laboratory Workforce: Does the host country have an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression	DR has a network of laboratories with improved quality of HIV services provided	Lack of technical capacity	Lack of sufficient HRH	Lack of sufficient HRH	Intregrate holistic and data driven quality assurance processes like VL PoC evaluations and diagnostic network optimization (DNO) approach to strengthen and scale up laboratory services for HIV and Viral Load testing activities in the DR.	COP22	COP25	NA	NA	Not applicable	A third of HIV laboratories nationwide do not meet minimum quality criteria for HIV testing and 70% are not certified	Establishment of a quality assurance program: 80% of labs meet quality criterias for HIV and VL testing 75% of labs certified for HIV and VL testing	# of DNO Evaluations completed # of labs certified for HIV VL testing	Yes	
$40,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	-	-	1.1 Content of National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?	DR has an update regulation for PrEP services according international recommendations	It is not included in local HIV response plans	Lack of technical capacity		Update national PrEP guidelines in line with most recent WHO recommendations	COP22	COP23	NA	NA	Not applicable	Country does not have updated PrEP services according last WHO reccomendations	National PrEP Guidelines updated	Guidelines published by Q4 FY23	Yes	

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$14,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Assessing impact of policies and regulations on HIV	2. Policies and Governance	-	-	2.9 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, all epidemiologically significant key populations, and those	Measured Reduction in post-training assessment of Stigma and Discrimnation of PLHIV by HCW and border personnel	Lack of technical capacity			Continue ToT to HCW and NHCW, replicate stigma-reduction messaging in clinical and border military settings.	COP20	COP25	NA	1) Workshop delivered; 2) Code of Conduct and Action Plan developed; 3) Plan for follow-on sessions conducted by master facilitators developed	Partial	Inital data has shown high levels of stigma against PLHIV, HCW who work in HIV, and FC PLHIV. Initial trainings will have taken place by the end of FY22	Measured reduction of Stigma and Discrimination from baseline assessment scores.	# of follow-up assessments completed.	Yes	
$115,244	ASP: Policy, planning, coordination & management of disease control programs-NSD	Priority Pops: Military & other uniformed services	Clinical guidelines, policies for service delivery	6. Service Delivery	-	-	6.4 Domestic Provision of Service Delivery: To what extent do host country institutions (public, private, or voluntary sector) deliver HIV/AIDS services without external technical assistance from donors?	DR MOD to have updated HIV policy to match WHO and MOH guidelines as well as implementation plan	Lack of managerial capacity			provide TA to update HIV Policy in Military settings. Continuing Medical Education specific to updated best practices utilizing Project ECHO.	COP22	COP23	NA	N/A	Not applicable	Military does not have an updated HIV policy that matches the GoDR Strategic Plan	Military HIV Policy updated, including implementation.	Published HIV Policy, site presentations in regular ECHO calls	Yes	

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$30,000	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	14. Epidemiological and Health Data	-	-	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	Military hospital has reliable and timely data and capacity to analyze for decision making	Lack of technical capacity			Continue to provide TA for data analysis, utilizing FAPPS data from military sites to update MOD workbook and quarterly review for data-based decision making.	COP21	COP24	NA	1) Baseline assessment of local data and status of indicators at both military hopsitals 2) Plan, do, study, act (PDSA) quality imporvement workshop completed.	Partial	Regular data review in place, but access to data still poor. Lack of standarized and automated documentation of medical information of HIV patients due to unreliable and out of date information	Plan for reliable data entry implemented, data workbook for progam analysis developed and utilized.	Analysis of data and updated information system	Yes	

SRE – Surveillance, Surveys, and Research Activities

COP22 Activity Budget	Activity Description	Filter Here - Select Surveillance and Research	Activity Type	Country	Total budget planned for the activity (across all COP years)	Planned start date of data collection	Expected end date of data collection	Budget planned for the closeout year of the activity	Activity Title	Name of USG Agency POC for this activity	USG Agency POC Official email address (typically ending in .gov/.mil) of the USG Agency POC for this activity.	PI Name (s)	PI Official email address (typically associated with the affiliated organization) of the principal investigator or project lead POC for this project.	Primary evaluation or study questions	Activity objectives	Activity's primary study population	Additional populations studied	Planned activity sample size	Planned sampling methodology	HIV biomarkers to be assessed as part of protocol	COP or HOP funded?	Activity Start COP/FY Year	Activity End COP/ FY Year	Current Stage of activity (as of COP22)	COP22 Baseline Status (major)	COP22 Baseline Status (detail)	How does this activity advance COP priorities?
$110,000	Build knowledge and understanding of the population with the largest service delivery gap for epidemic control	Research	Observational study	Dominican Republic	110000	02/15/ 2023	07/30/ 2023	TBD	TBD	USAID	TBD	TBD	TBD	What are the individual, community, and system pending needs, gaps or barries among focus clients and other priority populations limiting epidemic control in the DR?	Build knowledge and understanding of the population with the largest service delivery gap for epidemic control	Focus clients, defined as Haitian migrants and their descendents residing in the Dominican Republic	Other priority populations include MSM, FSW and TG	TBD	Stratified randomization	TBD	COP	COP22/ FY23	COP22/ FY23	Proposed in COP	Protocol Scope	Not started	Build knowledge and understanding of the population with the largest service delivery gap for epidemic control
$12,000	Develop an annual national Morbidity and Mortality Report of HIV patients in the DR	Surveillance	HIV case surveillance	Dominican Republic	12,000	TBD	TBD	TBD	TBD	CDC	TBD	TBD	TBD	What factors contribute to the morbidity and mortality of HIV patients in the Dominican Republic?	Establish an annual HIV morbidity and mortality report.	PLHIV		TBD	TBD	No	COP	COP22/F Y23	COP23/ FY24	Proposed in COP	Protocol_Scope	Not started	Operational research increased in selected provinces/sites will contribute to adjusting HIV approaches and improving overall service provision.

APPENDIX D– Minimum program requirements

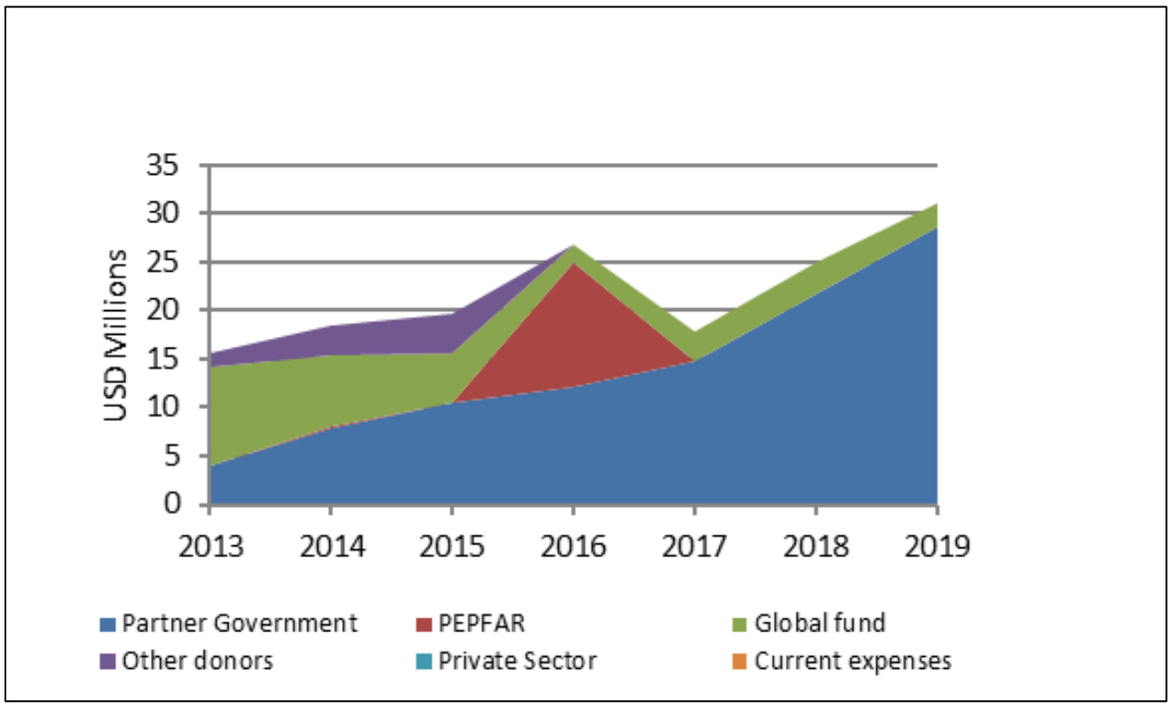
Care and Treatment	Status
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	In FY2022 Q1, the average linkage rate reached 84%. Community teams ensure individuals identified in the community are immediately accompanied to a site for enrollment and ART initiation. Required complementary test are expedited. Country team advocated for 95-95-95 commitment which was confirmed upon approval of country's official proposal to Global Fund and MoH policies.
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.	DTG based regimen transition in progress. By March 2022, a total of 35,051 individuals migrated to and a total of 11,822 initiated in a DTG-based regimen. PEPFAR and GoDR sites received technical assistance to avoid stock outs during government transition and the COVID-19 pandemic. Emergency GoDR procurement and PEPFAR donation of TLD mitigated the impact of shortages and stockouts.
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 adopted and rolled out to all PEPFAR-supported sites. MMD and Community ART distribution limited or halted due to ARV shortages and stock-outs as recently as March 2022. GoDR procurements and PEPFAR donation of ARV have facilitated the restart of MMD in PEPFAR-supported sites. PEPFAR-DR team continues to advocate for the institutionalization of MMD6+ and DDD beyond PEPFAR supported sites. Ongoing conversations with national authorities are in progress to set MMD as a country priority.
4) All eligible PLHIV, including children and adolescents, - should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	Stockouts of Isoniazid and Rifapentine have severely limited sites' capacity to ensure initiation and completion of TPT. PEPFAR-DR team continues to advocate for timely procurement and distribution of TB medications. PEPFAR will also provide TA on TPT drug forecasting. PEPFAR will advocate updating 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.	Viral load testing coverage severely impacted by limited reagents and reading machines due to COVID-19 pandemic. PEPFAR will continue to expand VL testing and processing capacity, including DNO activities in COP2022.
Case Finding	
6) 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.	Universal offer of index testing will be the standard of care in COP2022, including increased collaboration with the OVC program to reach biological children of PP. HIV self-testing (HIVST) feasibility/acceptability assessment to be completed by FY2022 Q3. Based on the results, PEPFAR will support HIVST policy and guidelines for effective adoption in the DR. The Global Fund has identified additional resources in FY2022 to procure HIVST kits once HIVST introduction has been approved.
Prevention and OVC	
7) 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)	PEPFAR-DR is advocating with GoDR for the effective increase of sites offering PrEP services. However, the MoH currently has limited stocks of ARVs, which has impacted PrEP expansion and COP2022 target setting. Negotiations continue with the MoH to review targets during FY2022.
8) 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)	OVC program adjusted to ensure service packages for groups aged 0-17 and adolescents are available, promoted and used.

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, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	C&T and OVC programs will increase collaboration to ensure timely case identification and linkage to C&T services.
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	All PEPFAR-supported C&T teams will have Creole- speaking health providers or will have access to real-time translation services. IPs will ensure to include informative key messages and images, through radio, social media, and printed materials, both in Spanish and Creole regarding clients' rights, available services, and efforts against S&D. In addition, community-led monitoring (CLM) will include S&D analysis to facilitate effective and concrete feedback to implementors for further corrective actions to ensure a person-centered approach.
10) 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, treatment, and prevention.	Fully implemented. Advocacy to increase domestic funding for HIV/TB for COP2022 continued. Most TB services are provided free of charge. Patients may, however, be required to pay for a chest X-ray and complementary lab exams.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	PEPFAR-DR will continue to implement CQI, and QA practices in its COP2022 implementation, both through implementing partners as well as by utilizing OU tools to manage partner performance.
12) Evidence of treatment literacy 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 MoH and DR military to reduce stigma and discrimination against PLHIV and marginalized population, including migrants. In COP2022 PEPFAR-DR will scale-up U=U messages adapted to the DR context.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	PEPFAR-DR will continue working towards reaching at least 70% of program funds under agreements with local organizations.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	PEPFAR team continues advocacy with national authorities to increase domestic funding for HIV/TB to reach 95-95-95 goals. In COP2022, PEPFAR-DR will assist in developing costing models and exploring opportunities for Private Sector Engagement.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Surveillance and monitoring activities including the creation of an HIV surveillance department within the MOH and an annual morbidity and mortality report included in COP2022 proposed activities.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	All PEPFAR supported sites with biometric module installed and in use. PEPFAR will continue supporting to ensure 100% deployment /use on non-PEPFAR supported sites.

NEW APPENDIX E – Assessing progress towards sustainable control of the HIV/AIDS epidemic

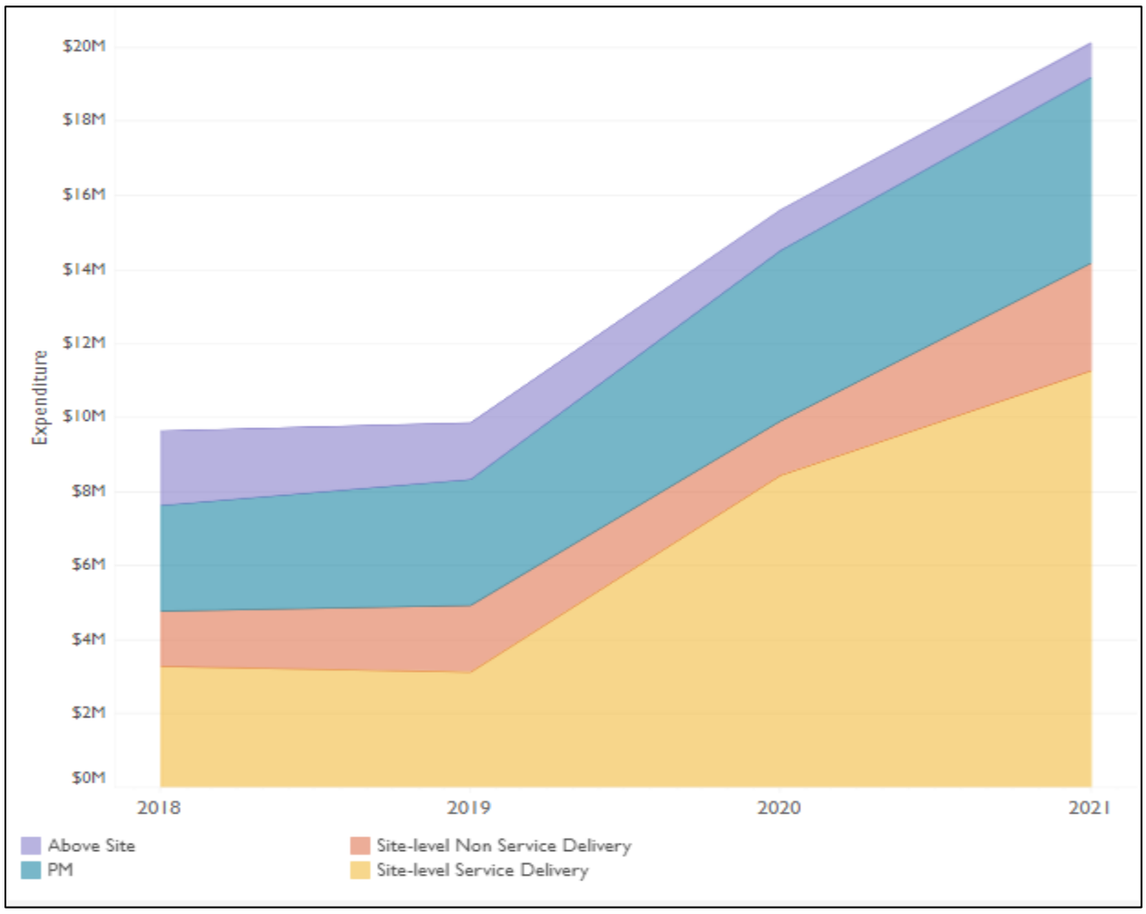
Investments and Outcomes towards HIV Epidemic Control in the Dominican Republic

Figure E.1.1 Total financing response by source, Dominican Republic, 2013-2019



The graph below shows the PEPFAR DR expenditure trends over time (2018-2021) for service delivery, non-service delivery, above-site programs, and program management. Since the program pivot in 2019 to target PP, funding has steadily increased until COP2021. On the other hand, the proportional distribution across these four budget categories has remained steady, with 40% allocated to service delivery, 23% to non-service delivery, 7% to above site programs, and 30% to program management (for both USG and program implementation). The only exception was in COP2020 when the percentage allocated to site level service delivery decreased and the percentage allocated to site-level non-service delivery increased.

Figure E.1.2 Total Expenditures by Interaction Type



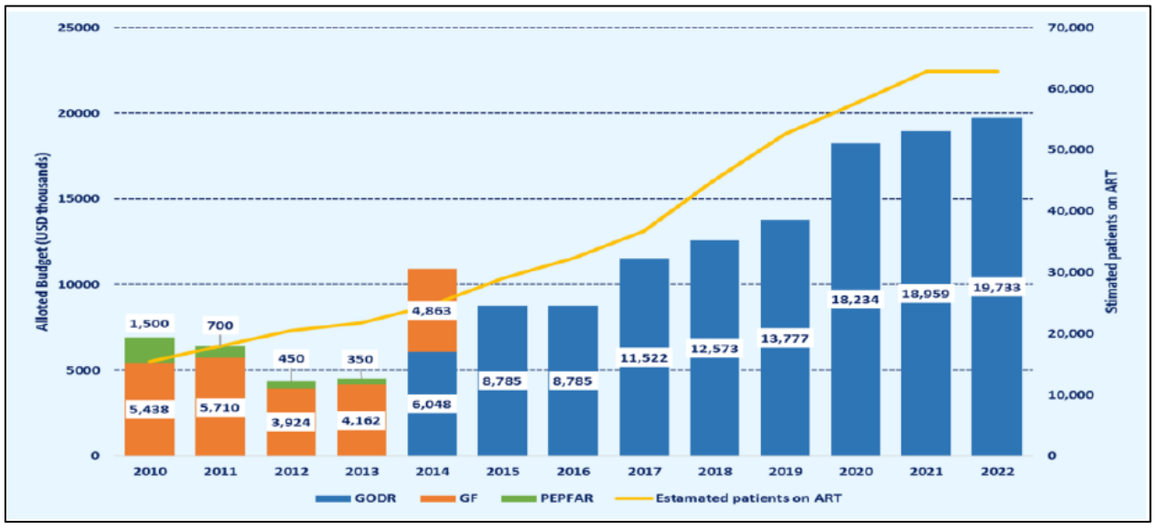
Source: Dominican Republic, PEPFAR Expenditure

In terms of the country's status towards achieving epidemic control, the table below represents the latest Spectrum estimates presented at the COP2022 planning meeting. While the PP has only the third highest HIV prevalence in the country, this population reports the highest ART gap at 67% (i.e., the highest number of HIV positives residing in the DR who are not on ART). However, there has been substantial progress in closing the gap among PP with the percentage of HIV+ PP accessing ART increasing from 17.5% in FY2020 to 27.7% by the end of FY2021. Additional information on 95-95-95 results included in Figure 3.2. Please also reference **Table 2.1.1 Host country government results** for Spectrum estimates.

1. Commodities

The PEPFAR-DR program does not support the purchase of any HIV-related commodities (equipment or supplies) in the country. 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. ARV stockouts and limited access to VL testing in 2021-2022 were directly related to the impact of COVID pandemic on DR's financial systems, global procurement and delivery systems, and national health system capacities to respond to concomitant priorities. The country is currently working on the Annual National Quantification of HIV commodities and no financial gap is expected in 2023. Based on 2022 National Supply Chain Assessment, PEPFAR-DR will continue providing TA and training at national and sub-national level to improve SCM activities beyond effective quantification and procurement, focusing on effective and planned distribution (and redistribution) of HIV supplies, pharmacy management and warehousing, as well as the implementation of electronic Logistics Management Information Systems.

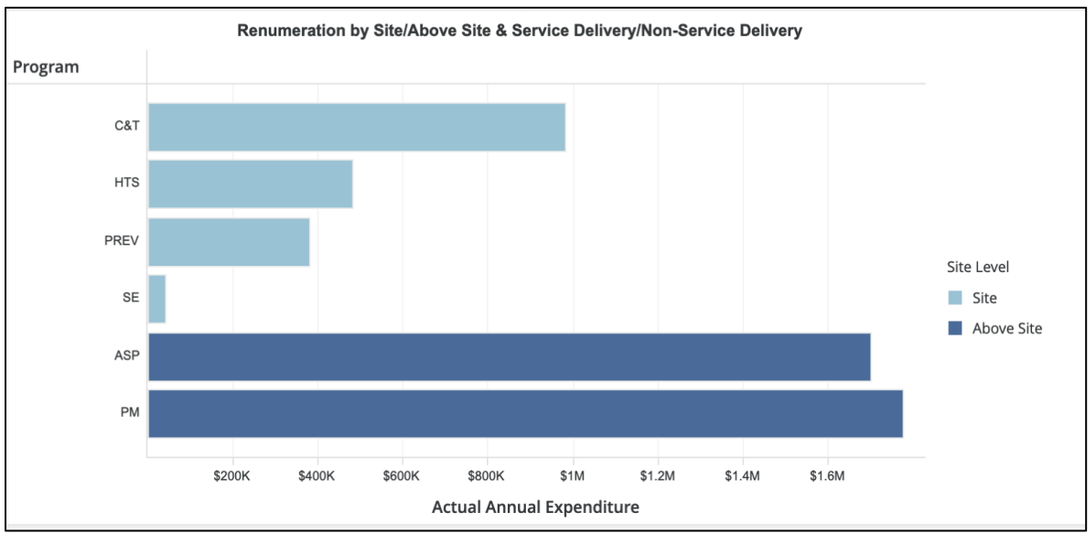
Figure E.1.3 Transition of ARV & commodity supplies purchases by GoDR



Source: Valdez, C; Barillas E. (2017). Updated in 2022 by the USAID's Supply Chain Management Strengthening Project using data from the GoDR HIV commodities logistics management information system (SUGEMI).

HRH remuneration by site/above site & service delivery/non-service delivery

Figure E.1.4. Remuneration by site/above site & service delivery/non-service delivery



Source: Dominican Republic 2021 PEPFAR HRH Inventory.

2. Areas for transition

PEPFAR-DR will continue providing TA assistance for health systems strengthening (HSS), including but not limited to governance and policy, health financing, supply chain management (SCM), human resources management, health information systems, and laboratory. All PEPFAR-DR's HSS activities are designed to strengthen national priorities, norms, and strategic planning and build lasting and enduring capabilities. PEPFAR-DR will continue close coordination with GoDR authorities to define potential areas of transition to take greater responsibility in the short-to-medium term for the effective control of HIV epidemic.

3. Engagement with partner country governments in COP2022 to ensure sustainability of core elements of the HIV response

Building on COP2021 activities, PEPFAR-DR promotes sustainability in national systems and leverages existing strengths to ensure continued long-term impact along the cascade for all populations. GoDR stakeholders and CSOs have stressed the importance of developing sustainable strategies. PEPFAR-DR will continue prioritizing targeted program support to achieve sustained epidemic control, including but not limited to technical assistance on SCM strategies and models at national and sub-national levels to support GoDR forecasting and planning, procurement, distribution, and pharmacy management (more details in section 5.0).

4. Agreements and plans on data use and sharing and quality control (including central support reporting).

As stated throughout the document, data sharing and collaboration with GoDR and relevant stakeholders will be maintained and promoted. PEPFAR will continue to meet quarterly with GoDR to share progress, challenges, and updated data regarding MER performance. Additionally, data triangulation efforts and community-led monitoring will be prioritized to obtain a more robust information picture of PP and their HIV acquisition risks.