

PEPFAR Haiti
Country Operational Plan 2017
(COP 2017)
Strategic Direction Summary
May 2017



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1.0 Goal Statement

The primary goal of the PEPFAR Haiti program is to achieve epidemic control in Haiti by supporting a data-driven response that leads to a reduction in new infections and AIDS-related mortality. This goal will be achieved through implementation of targeted testing approaches--including index case contact tracing--improved retention on treatment, and expansion of multi-month scripting, community drug distribution, and rapid pathway for stable patients. Additionally, using sex and age disaggregated data, the team will focus on scaling-up HIV clinical and community services and strategies that have demonstrated the most impact.

The COP 15 Annual Program Results validated the geographic pivots that refocused the program on 20 priority districts out of a total of 42 districts. This prioritization will largely be maintained in COP17. The Ministry of Health's (MOH) National AIDS Control Program (PNLS, French acronym) has fully rolled out the Test and Start approach, as well as revised the national guidelines to adopt WHO recommendations. For COP17, the team will focus on Same-Day Initiation and the required dialogue with MOH and PNLS to create a policy environment where this can be implemented.

A new focus for the PEPFAR team will be an expanded Orphans and Vulnerable Children (OVC) portfolio and additional programming for girls 9-14 that are similar to activities in countries implementing the **D**etermined, **R**esilient, **E**mpowered, **A**IDS-free, **M**entored, and **S**afe women (DREAMS) program. These interventions will be focused in districts with high rates of gender-based violence (GBV) and where women and girls under 24 are being diagnosed with HIV at a higher percentage than the national prevalence (Cap-Haitien, Dessalines, Saint Marc and Port-au-Prince). We will strengthen case management to ensure that the beneficiaries receive multiple, "layered" services. We will conduct size estimates, partner mapping and GBV services mapping to ensure a data-driven program.

A major challenge for the PEPFAR program is patient linkage to and retention in care (PLR). In COP16 the team began the implementation of a unique patient identifier using biometric coding (BC); BC, coupled with the use of mobile health technology and positive peer navigators, allows for micro-targeting of services, such as community drug distribution. This will improve PLR amongst the general and priority populations. BC analysis also identifies silent transfers, tracks "medical shopping", reduces Loss to Follow-Up (LTFU) and helps us determine the precise number of patients on ART. Currently, 70,000 patients have received a BC and implementation will be completed during COP17.

Furthermore, in COP15 the program initiated the roll out of viral load (VL) testing. By the end of COP16, the program plans to have VL for 100% of patients with at least six months on ART. We also plan to report on the proportion of ART patients who have achieved viral suppression.

To support our COP17 programming, PEPFAR Haiti is focusing on addressing stigma-related barriers through our civil society dialogue and funding, in collaboration with UNAIDS, to conduct the first ever Stigma Index Survey in Haiti. Finally, to ensure sustainability of these investments, the PEPFAR Haiti Team continues to engage with the newly-inaugurated Haitian Government for increased funding for the national HIV/AIDS program.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Haiti is a low-income country with a gross national income (GNI) of \$810 per capita (World Bank 2015) and a gross domestic product (GDP) of \$818.3 per capita (2015), which makes it the poorest country in the Western Hemisphere. An estimated 58.6% of the country's approximately 10.8 million people live on less than one dollar a day and cannot afford the higher quality healthcare provided in private clinics (UNDP, 2014). Haiti's estimated 141,269 people living with HIV (PLHIV) (Small Area Estimates, OGAC 2015) constitutes the greatest burden of HIV/AIDS in the Caribbean region; this is exacerbated by the highest incidence of tuberculosis (TB) in the Western Hemisphere. Haiti has a generalized HIV/AIDS epidemic with most transmission occurring from heterosexual sex and marked by higher prevalence rates in major cities. However, the last Integrated Biological and Behavioral Surveillance (IBBS, 2014) Survey has shown that there are other drivers of new infections such as unprotected transactional and commercial sexual activities as well as unsafe sexual practices among men who have sex with men (MSM). The widespread practice of multiple concurrent partnerships and the inequitable social conditions of women and youth are also considered among the key enablers of HIV transmission. Though the overall prevalence remains stable, women and youth showed a higher prevalence than men in the last Demographic and Health Survey (DHS) (2012)¹.

There is a severe shortage of health workers, low retention of nurses and doctors, and gaps in services across all levels of the health system. Furthermore, the country's health infrastructure has not kept pace with Haiti's population growth from 7.5 million people in 1993 to 10.5 million in 2014. The January 2010 earthquake compounded the already difficult development situation, destroying and damaging much of the previously existing physical infrastructure (including 30,000 commercial and government buildings) and resulting in an estimated 240,000 deaths and 300,000 injuries. Included in this large-scale human loss were untold numbers of civil servants, health professionals, medical and nursing students. Moreover, the country is still recovering from one of the largest cholera epidemics in history with more than 800,000 suspected cases reported since its onset in 2010; including over 350,000 cases in 2011 alone (DELR, February 2016). Also, in the Hurricane Matthew affected areas, service provision for 12,000 PEPFAR patients was affected. The country is currently in transition following the political turmoil surrounding the presidential election and the national currency (Haitian Gourde/HTG) has lost nearly one third of its value during the last year alone; 68.30 gourdes are now needed for 1USD compared to 43.75 gourdes in 2015. This has led to decreased buying power for most Haitians and has led to a spike in attrition rates for the PEPFAR Haiti's Locally Engaged Staff.

However, the DHS data from 2006 and 2012 indicate that HIV prevalence among adults (15-49 years old) in Haiti has remained stable at 2.2%, suggesting that a successful treatment and prevention program is keeping alive those already infected while curbing transmission at a population level. As of October 2016, over 82,000 individuals were receiving antiretroviral treatment (ART) nationally, representing approximately 58% of the estimated number people living with HIV. Over 80% of all pregnant women were tested for HIV; and of those identified as

¹Cayemittes M, Placide F, Barrere B, Mariko S, Severe B. *Enquete Mortalite, Morbidite et Utilisation des Services Haiti 2012*. Calverton, Maryland, USA: Institut Haitien de l'Enfance et ORC Macro; 2012

HIV-infected, 90% received ART. PEPFAR has been instrumental in scaling up HIV services, while building MSPP capacity to sustain the HIV response over the long term. The support to the MSPP has enabled the on-going and timely updating and alignment of national clinical guidelines with international normative guidance. Of note, the MSPP adopted Test and Start in 2016, which resulted in a dramatic increase in the number of HIV-positive persons who initiated lifelong ART. Through its regional and local units, the MSPP has also been able to enforce application of norms via training for those actively engaged in community mobilization, promotion, and regulation of services.

The major geographic shifts and technical pivots in the PEPFAR Haiti portfolio, undertaken during FY15 and FY16, have allowed for a better response to the unevenly distributed HIV disease burden among the different sub-national units (SNUs) in the country. Three departments (Ouest, Artibonite and Nord) account for 62% of all PLHIV, and they contain the majority of saturation arrondissements (districts). The district of Port-au-Prince alone accounts for 26% of all PLHIV. The prioritization exercise guided PEPFAR investments in COP15 to accelerate impact towards achieving epidemic control despite the constrained budget environment.

During recent years, concomitant to an overall decrease in external funding, the program has experienced a significant attrition among people receiving ART. As retention in care and adherence to treatment are key determinants of treatment outcomes, such level of attrition may hamper program capacity to reach saturation and to contribute to the UNAIDS 90-90-90 goals by 2020. To reduce LTFU, PEPFAR Haiti has identified successful approaches; such as the PLR program, use of mobile health technology, implementation of unique identifier using biometric codes, and use of PLHIV peers, that are being rolled out in COP16 in addition to other ongoing support and community activities described in the sections below (program activities).

Table 2.1.1 Host Country Government Results*

| | Total | | <15 | | | | 15+ | | | | Source, Year |
|---|------------|-------|-----------|-------|-----------|-------|-----------|-------|-----------|-------|---|
| | | | Female | | Male | | Female | | Male | | |
| | N | % | N | % | N | % | N | % | N | % | |
| Total Population | 10,749,925 | 100% | 1,756,185 | 50.1% | 1,750,482 | 49.9% | 3,630,742 | 50.1% | 3,612,514 | 49.9% | Avenir Health, 2014; based on 2015 IHSI/UEP estimations |
| HIV Prevalence (%) | | 1.4 | | 0.3 | | 0.4 | | 2.3 | | 1.6 | Avenir Health, 2014 |
| AIDS Deaths (per year) | 4,449 | | 196 | | 196 | | 1,857 | | 2,200 | | Small Area Estimates, OGAC 2015 |
| # PLHIV | 141,269 | | 4,164 | | 4,203 | | 78,691 | | 54,211 | | Small Area Estimates, OGAC 2015 |
| Incidence Rate (Yr) | | 0.07 | | | | | | | | | Avenir Health, 2014 |
| New Infections (Yr) | 5,257 | | 138 | | 144 | | 2,852 | | 2,123 | | Small Area Estimates, OGAC 2015 |
| Annual births | 300,000** | | | | | | | | | | Population Reference Bureau, 2015 Sheet |
| % of Pregnant Women with at least one ANC visit | | 90.3% | | | | | | | | | UNICEF, 2012 |

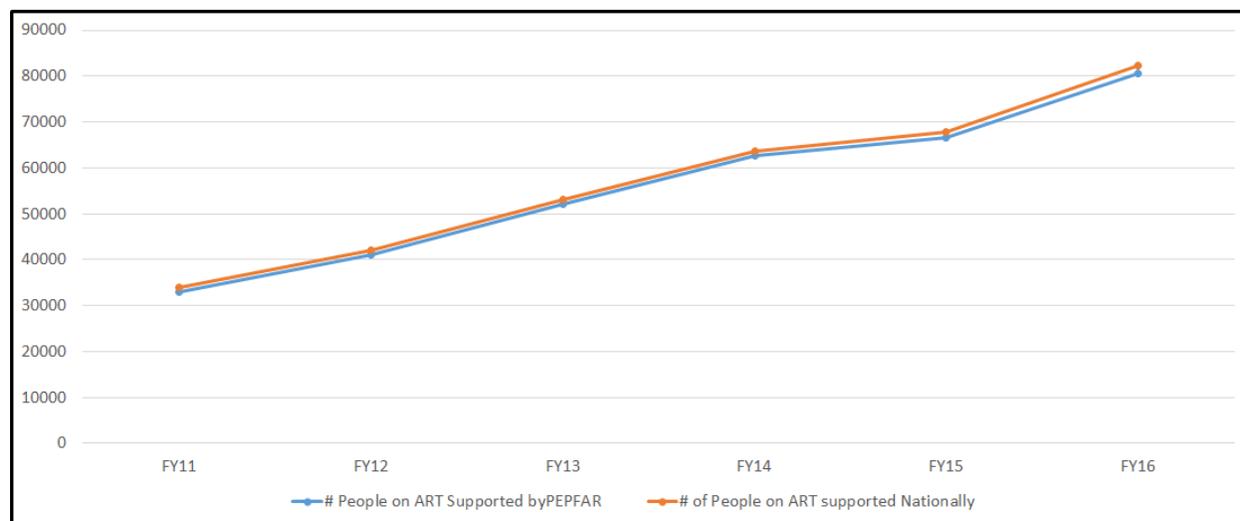
| | | | | | | | | | | | |
|---|------------|-------|-----|--------|-----|--------|-------|-------|-------|-------|---|
| Pregnant women needing ARVs | 6,164 | | | | | | | | | | Avenir Health, 2014 |
| Orphans (maternal, paternal, double) | 93,057 | | | | | | | | | | Avenir Health, 2014 |
| Notified TB cases (Yr) | 15,396 | | 923 | | 769 | | ,6621 | | 7,083 | | PNLT 2016 |
| % of TB cases that are HIV infected | 2,231 | 15.6% | 133 | 14.9%% | 112 | 14.6%% | 960 | 15.5% | 1,026 | 15.9% | PNLT, MESI:2016 |
| % of Males Circumcised | | | | | | | | | | | |
| Estimated Population Size of MSM reachable at venues | 38,300*** | 1.1% | | | | | | | | | Preliminary results, PLACE study, 2016. |
| MSM HIV Prevalence | | 12.9% | | | | | | | | | IBBS, 2014 |
| Estimated Population Size of Female Sex Workers (FSW) reachable at venues | 40,400**** | 1.1% | | | | | | | | | Preliminary results, PLACE study, 2016. |
| FSW HIV Prevalence | | 8.7% | | | | | | | | | IBBS, 2014 |
| Estimated Population Size of People who Inject Drugs (PWID) | | | | | | | | | | | |

| | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|
| PWID HIV Prevalence | | | | | | | | | | | |
| Estimated Size of Priority Populations (specify) | | | | | | | | | | | |
| Estimated Size of Priority Populations Prevalence (specify) | | | | | | | | | | | |
| <p><i>*note that estimates for the following age bands are not available: <15, 15-24, 25+</i></p> <p><i>**estimate based on birth rate (annual number of births per 1,000 total population) : 28 births per 1,000</i></p> <p><i>***among ages 15-49. The size estimates from the 2016 PLACE study should be interpreted as the size of key populations who can be reached by programs at places where people meet new sexual partners in Haiti. They are not meant to be interpreted as estimates of the total number of FSW or MSM living in Haiti.</i></p> <p><i>****among ages 18-49. The size estimates from the 2016 PLACE study should be interpreted as the size of key populations who can be reached by programs at places where people meet new sexual partners in Haiti. They are not meant to be interpreted as estimates of the total number of FSW or MSM living in Haiti.</i></p> | | | | | | | | | | | |

| Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* | | | | | | | | | | |
|---|------------------------------------|--------------------|---------------------------|-------------------------------------|------------|------------------|---|--------------------|----------------------------|----------------------|
| Epidemiologic Data | | | | HIV Treatment and Viral Suppression | | | HIV Testing and Linkage to ART Within the Last Year | | | |
| | Total Population Size Estimate (#) | HIV Prevalence (%) | Estimated Total PLHIV (#) | PLHIV diagnosed (#) | On ART (#) | ART Coverage (%) | Viral Suppression (%) | Tested for HIV (#) | Diagnosed HIV Positive (#) | Initiated on ART (#) |
| Total population | 10,749,925 | 1.4 | 141,269 | | 82,824 | 58% | 77 (n=41,965) | 1228340 | 26,856 | 22,468 |
| Population less than 15 years | 3,506,667 | 0.4 | 8,367 | | 3,216 | 38.5% | 58.7 (n=1953) | 192,078 | 1,192 | 877 |
| 15-24 year olds | | | | | | | 65.2 (n=2525) | | | |
| 25+ year olds | | | | | | | 78.2 (n=37,487) | | | |
| | | | | | | | | | | |

*These should be national data; if the data do not exist, PEPFAR data may be used if relevant. Estimates for testing, treatment, retention and suppression for key and priority population groups (below grey line) should only be included if reliable data exists.

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment



2.2 Investment Profile

A new President and several members of the parliament have recently been elected in Haiti after over a year of election contestation and subsequent political turmoil. Additionally, the inflation rate rose to 14.2% in November 2016², and the exchange rate of the HTG plummeted in the last three years, passing from 43.75 HTGs for one US dollar (USD) in October 2013, to 68.30 HTG for one USD in February 2017. Furthermore, Haiti was hit by a category 4 hurricane, the first of such

powerful category since 1964. This hurricane gravely affected five Departments of Haiti in October 2016, including Haiti's main food producing area in the Southern peninsula, with damages and losses for the country estimated at almost two billion dollars². Such conditions weakened the economy and further reduced already low revenue streams. In a country with such limited resources and competing social needs, public spending on health is likely to remain low. However, the installation of a new government and parliament is an opportunity to advocate for increasing the national health budget in the future. Only an estimated 6.1% of the national budget is allocated to the health sector (WHO, 2014). Of the national funds allocated to health, over 90% supports personnel costs of the MSPP staff; however, these funds are not sufficient to cover the actual needs of personnel in the public health sector. The lack of resources, outside of contributions in the form of limited personnel salaries and the availability of public facilities, leaves almost no room for the Government of Haiti (GOH) to earmark specific resources for health system development or the HIV program. Funding for the HIV program comes from PEPFAR (87%) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) (10%), and the in-kind contribution of the MSPP is estimated at 2%. PEPFAR Haiti continues to work closely with the Country Coordinating Mechanism (CCM) and Population Services International (PSI), the primary recipient of the GF joint HIV/TB grant, to avoid duplication and to leverage GF resources for strategic alignment with PEPFAR goals. The country is currently preparing its new submission to GF, which will aim to address epidemic control in harmony with PEPFAR.

Table 2.2.1 Annual Investment Profile by Program Area

| Program Area | Total Expenditure ⁽¹⁾ | PEPFAR FY17 (COP16) Budget allocation | % PEPFAR | GF CY17 Budget allocation | % GF |
|--|----------------------------------|---------------------------------------|------------|-----------------------------|------------|
| Clinical care, treatment and support Community-based care, treatment, and support | \$65,463,062 | \$51,872,796 | 79% | \$13,590,266 ⁽²⁾ | 21% |
| PMTCT | \$4,690,510 | \$4,584,723 | 98% | \$105,787 | 2% |
| HTS | \$7,001,374 | \$7,001,374 | 100% | | 0% |
| VMMC | \$0 | | | | |
| Priority population prevention Key population prevention | \$5,214,779 | \$3,514,944 | 67% | \$1,699,835 | 33% |
| OVC | \$9,421,604 | \$9,421,604 | 100% | | 0% |
| Blood Safety | \$1,899,361 | \$0 | 0% | \$1,899,361 | 100% |
| Laboratory | \$3,924,074 | \$3,924,074 | 100% | ⁽³⁾ | 0% |
| SI, Surveys and Surveillance | \$5,082,116 | \$4,168,282 | 82% | \$913,834 | 18% |
| HSS | \$4,092,895 | \$2,792,987 | 68% | \$1,299,908 | 32% |
| Total | \$107,288,509 | \$87,280,784 | 81% | \$20,007,725 | 19% |

(1) This represents the current budget for 2017 for these program areas

(2) This amount includes HTS and lab

(3) Lab is included in Care & Treatment for GF

² Notes sur la Politique Monétaire _ Decembre 2016, available at http://www.brh.net/documents/note_polmonit17.pdf

Table 2.2.2 Annual Procurement Profile for Key Commodities

| Commodity Category | Total Expenditure GF | Total Expenditure PEPFAR | TOTAL Expenditure | % GF | % PEPFAR |
|------------------------|----------------------|--------------------------|-------------------|---------------|---------------|
| ARVs | 6,000,000 | 10,754,814 | 16,754,814 | 35.81% | 64.19% |
| Rapid test kits (RTK) | 1,500,000 | 2,621,637 | 4,121,637 | 36.39% | 63.61% |
| Other drugs | 500,000 | 726,596 | 1,226,596 | 40.76% | 59.24% |
| Lab reagents | 1,500,000 | 1,563,631 | 3,063,631 | 35.81% | 51.04% |
| Condoms | 900,000 | 1,934,725 | 2,834,725 | 31.75% | 68.25% |
| Viral Load commodities | 1,000,000 | 1,748,275 | 2,748,275 | 36.39% | 63.61% |
| Other commodities | 1,500,000 | 645,788 | 2,145,788 | 69.90% | 30.10% |
| Total | 12,900,000 | 19,995,466 | 32,895,466 | 39.22% | 60.78% |

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration (FY 17)

| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
|--|--------------------------------|--|-----------------|------------------------------------|---|
| USAID MCH | 14,000,000 | 9,370,340 | 6 | \$19,663,475 | There are 6 USAID implementing mechanisms that receive PEPFAR MCH, and FP funds. USAID works through an integrated strategy to improve health outcomes— meaning these projects support service delivery and health system strengthening across multiple program areas. This integrated approach improves access and utilization of services and greater effectiveness in strengthening Haiti’s health system. . |
| Family Planning (FP) | 9,000,000 | 6,805,660 | 6 | 0* | |
| HHS Post Earthquake Supplemental Funding | \$3,700,000 | \$3,700,000 | 3 | \$21,156,356 | The purpose of these resources is to support the provision of high-quality integrated TB/HIV services and operation of critical supported disease surveillance systems. |
| Total | \$26,700,000 | \$19,876,000 | | \$40,819,831 | |

* There are 6 IMs receiving HIV, MCH, and FP funding, including the consolidated USAID Procurement and Supply Management (PSM) project which will receive \$12,429,765 in COP 17.

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

This does not apply to the Haiti program.

2.3 National Sustainability Profile Update

Because a new Sustainability Index Dashboard (SID) was not required for COP17, the national sustainability profile is updated from COP16 to reflect the changes that occurred over the past year or those expected to take place during COP16 implementation.

The process for COP17 consisted of reviewing last year's SID and updating the various domains and elements addressed below where necessary.

Sustainability Strengths

Quality Management

One of the greatest sustainability strengths of the program is its quality management component. Quality management is well integrated at different levels including national, regional, and site levels with a national coordination entity chaired by the General Director of the MSPP. In a collaborative effort, health facilities develop continuous quality improvement activities to address weaknesses and improve health services. If problems or issues are noted, providers design improvement plans for their sites to address problems observed. Subsequent meetings are then held by MSPP at the departmental and national levels for sites to present on progress. Additionally, key stakeholders, including health departments (regional level) and other partners, provide technical assistance. Bi-annual national and regional forums present opportunities not only to share best practices but to publicly recognize sites and departments with notable quality improvement projects. Through the inclusion of health service consumers, the MSPP will continue to strengthen quality management.

Planning and Coordination

Over the last ten years, the MSPP, through PNLs, has made significant progress in its capacity to plan and coordinate the HIV response in Haiti. The multi-year multi-sectoral national strategic plan for HIV is revised in a timely manner to address new challenges and reflect new evidence in the fight against the epidemic. National guidelines for HIV care and treatment and for prevention of mother-to-child transmission (PMTCT) are written and regularly updated by PNLs. These are participatory processes with strong leadership from the MSPP and technical assistance from external stakeholders; however, PNLs will need to make the necessary effort to reach the private sector and foster their involvement in planning and coordinating the response and advocating for their financial contribution. Moreover, the program would greatly benefit from strengthened coordination between PNLs and the National TB Control Program (PNLT, French acronym). This will allow better integration of services and improve health outcomes for HIV/TB co-infected patients.

Public Access to Information

The GOH has improved its capacity to collect data and generate reports that are publically available; for example, this includes the periodically published "epidemiologic bulletin." This year the MSPP, with support from PEPFAR, improved HIV data sharing by developing a dashboard to allow timely access to the information. The PNLs publishes data on service delivery and overall

performance of the HIV program.

One limitation, however, is “procurement transparency.” The Haitian government does not fund the procurement of HIV/AIDS commodities and, therefore, is not able to publish detailed data on procurement activities (tenders, awards, etc) exclusively supported by PEPFAR and GF.

Sustainability Vulnerabilities

Domestic resources mobilization

One of the greatest threats to sustainability of the HIV response in Haiti is the lack of capacity to mobilize domestic financial resources. Despite the work of advocacy groups over the last few years, HIV services are funded almost exclusively through international support, namely PEPFAR (87.3%) and GF (10%) (source: Rapport REDES 2014 et 2015, MSPP, Haiti, October 2016).

Currently, Haiti has an approved national health policy, however, it does not have a national health financing strategy. The PEPFAR Haiti team is working with the MSPP through a health financing ‘task force’—including the ministries of finance and social welfare—to develop a health financing strategy for the sector. Presently, the GOH allocates very limited funding to the health sector and almost the entire budget supports salaries. Two years ago, a budget line was added to the MSPP budget to specifically support HIV/AIDS activities. However, the political turmoil, leading to the dysfunction of the parliament for an extended period of time, has prevented a vote on the new budget. Although a new president has been elected and sworn-in, there are delays in putting a government in place. Until the government is in place, the domestic funding profile for HIV is unlikely to change from last year.

Commodity Security and Supply Chain

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

Technical and Allocative Efficiency

Because the GOH does not fund any HIV/AIDS commodities and currently only has an in-kind contribution to the HIV program (infrastructure and some cross-cutting personnel), there is no system in place to ensure the maximum efficiency from HIV spending or to reprogram unused funds. On the other hand, expenditure data is available in Haiti and has been recently used to estimate costs for HIV programming.

Overall threats to sustainability of the program are closely linked to one underlying issue: the quasi-absence of funding from the GOH to support the HIV program in general.

Priorities Identified by the Stakeholders in COP16 and that are still applicable to COP17:

- Strengthen the capacity of the MSPP to advocate for and allocate domestic government resources to support the fight against HIV: As stated above, the PEPFAR Haiti team is working with the MSPP through a health financing ‘task force’ to develop a health financing strategy for the sector, in general, and for HIV, specifically.
- Evaluate and implement innovative integrated service delivery models to reduce cost and expand the HIV response despite limited resources: The MSPP had adopted the Test and

Start strategy in July of 2016 and is currently implementing a number of differentiated service delivery models, including multi-month scripting and community drug distribution.

- Make available and use good epidemiologic HIV data at the arrondissement and commune levels, including data on key populations (KPs) as well as services delivery (viral load), to support programmatic decisions and advocacy for domestic funding.
- Advocacy to increase private sector involvement in the response to the epidemic and foster their financial contribution.
- Advocacy with Parliament to pass the bill on HIV and approve the new penal code: While there are no specific laws criminalizing homosexuality or prostitution, there is no national HIV/AIDS policy or set of policies and laws fostering non-discriminatory and safe access to HIV/AIDS services.

During COP17, PEPFAR will continue its support for the implementation of innovative integrated service delivery models to reduce cost. The program will also support the GOH in increasing the availability of epidemiologic HIV data at the arrondissement level, including for KPs and the under 30 years-old population.

All priorities outlined above continue to receive some level of support from one or multiple development partners. However, in many instances this support is scarce and intermittent.

- Several partners of the Haitian Government including the US Government (USG), GF, WHO, UNICEF, and other local groups ((Fondation SEROvie, Fondation pour la Santé Reproductrice et l'Éducation Familiale (FOSREF), Greater Involvement of People Living with or Affected by HIV and AIDS (GIPA), Association de Solidarité Nationale aux Personnes Vivant avec le SIDA (ASON), and Promoteur Objectif Zéro SIDA (POZ)) are working with the MSPP to develop policies. This work has contributed to improving the environment. The PNLs has held a meeting on KPs and has integrated a module on KPs into the HIV care and treatment guidelines that were recently revised. The penal code has been revised and is awaiting approval by parliament.
- The USG, through its implementing partners, is the main donor supporting activities aimed at increasing the availability of timely and reliable epidemiologic HIV data: Antenatal Care (ANC) survey, DHS, Population-based HIV Impact Assessment (PHIA), IBBS, Priorities for Local AIDS Control Efforts (PLACE), etc. Other donors including GF and UNFPA also contribute through support to the DHS. However, in addition to its leadership in coordinating the core surveillance activities, the MSPP should continue to advocate for an increase in health expenditures in the national budget and use the domestic resources to support these activities. Good epidemiologic HIV data also depends on the availability of good census and vital registry data. The last census was conducted in 2003 and vital statistics are greatly under-reported and outdated.
- One area that needs greater focus is the engagement of the Haitian private sector in the HIV response in Haiti. To date, the private sector has not been engaged beyond very limited contributions to institutions like the Haitian Group for the Study of Kaposi's Sarcoma and Opportunistic Infections (GHESKIO, French acronym). Donors need to support the MSPP in

its advocacy efforts to engage the Haitian private sector in the national HIV response.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

In COP17, PEPFAR Haiti will continue to focus its investments in 20 prioritized districts identified through the geographic prioritization exercise and program pivots undertaken during COP15 and COP16, with slight revisions based on programmatic data.

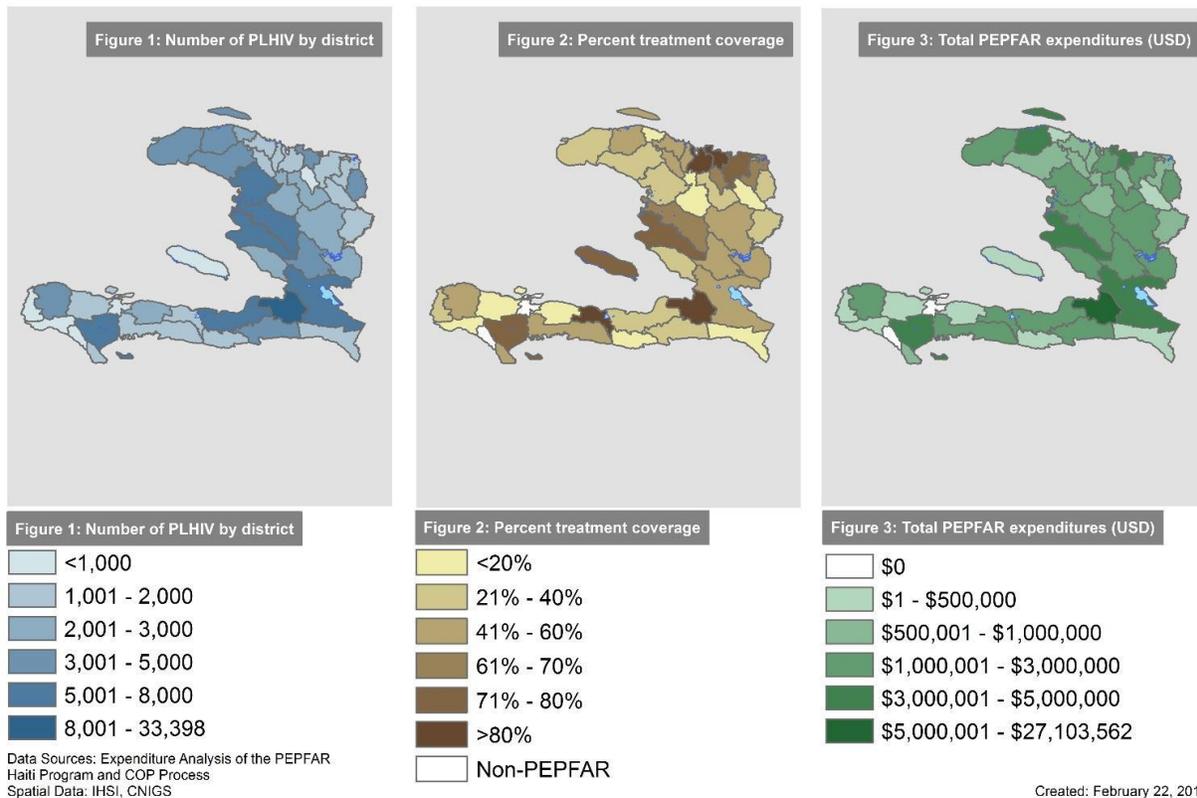
Analysis of FY16 EA data shows an overall alignment of investments with both the geographic distribution of PLHIV and the population enrolled on ART (refer to the maps in Figure 2.4.1).

According to the FY 16 site-level expenditure data, 85% of funds were disbursed across scale-up saturation and aggressive districts, while 15% were spent in sustained districts. In COP17, a similar financial alignment is proposed through PEPFAR Haiti's target based budgeting approach to ensure alignment of investments with disease burden and targets.

Figure 2.4.1



Number of People Living with HIV (PLHIV), Treatment Coverage, and Total PEPFAR Expenditures in FY 2016



2.5 Stakeholder Engagement

PEPFAR Haiti continues to maintain regular meetings and communications with the MSPP and PNLs, Global Fund's OHMASS (Global Fund PR), as well as with civil society organizations (CSOs). The most recent meeting with stakeholders was held on January 30, 2017, with the participation of PNLs, Global Fund Geneva, OHMASS, UNAIDS and several CSOs working with LGBT, youth, and PLHIV as well as gender discrimination advocacy organizations. CSOs deeply appreciate the opportunity to learn about PEPFAR processes and the priorities that guide PEPFAR's support for the HIV response in Haiti, and provided their input during the meeting. The PEPFAR Haiti team took these suggestions into account to inform the elaboration of the SDS in order to improve service delivery and technical assistance. The PEPFAR team has continued to strengthen its engagements with the GOH through the MSPP and PNLs. The PEPFAR team also continues to develop and reinforce its relationships and coordination with the GF through both its in-country and Geneva teams. Both PEPFAR and the GF are committed to sharing programmatic data and investment portfolios in order to maximize investments, limit duplication and wastages, and achieve savings to sustain the expansion of HIV services to achieve epidemic control. The last meeting held with the CSOs was followed-up with the distribution of a set of questions (listed below) in French to collect written feedback from members of the CSOs to address the different challenges facing the HIV program in Haiti.

- How to increase the testing yield while decreasing the number of unnecessary facility-based tests
- How to encourage more men to be tested, receive their results, and enroll on treatment
- Strategies to retain patients on treatment
- What are the policy and legal barriers that the communities or organizations are working to change

Among the feedback received were: to target male-attended activities and venues, such as sports, to reach more men for testing; request to address GBV; and access to family planning services. In COP17 PEPFAR Haiti will work to address GBV at a policy level, ensure all PEPFAR sites have a standard package for victims of GBV, and improve integration of FP/HIV services. The collaboration between the PEPFAR Haiti team and civil society continues to grow.

3.0 Geographic and Population Prioritization

In COP17, PEPFAR Haiti will continue to focus its investments in the 20 prioritized districts identified through the geographic prioritization exercise and program pivots. The COP15 and 16 prioritization of districts was based on the estimated disease burden and the HIV testing and counseling (HTC) yield. Upon review of program data, revisions have been made to COP17 categorization of SNUs in accordance with COP17 guidance. Given the rapid enrollment of patients on treatment and success of the program, both Miragoane and La Gonave have been re-categorized from sustained districts to Scale-up saturation and Scale-up aggressive districts, respectively. Similarly, two aggressive districts -- Trou du Nord and Acul du Nord -- are also expected to reach 80% coverage during COP17 and thus have been re-categorized to saturation districts. However, programmatic data for Mole Saint-Nicolas do not support PLHIV estimates for this district and revealed challenges and delays in reaching original goals of saturation causing it to be re-categorization to scale-up aggressive district for now. Additionally, the districts of Port au-Prince, Croix des Bouquets and Leogane have been grouped to form the “Greater Port-au-Prince Cluster” to better adjust targeting by accounting for the constant population migration and movements between the three areas. The 20 Scale-up districts/cluster (10 saturation and 10 aggressive) prioritized for COP17 represent 90% of individuals receiving HTC services, over 90% of patients in the cumulative national ART cohort, and 76% of the overall HIV-infected population (57% in the 10 saturation districts).

In Haiti, the program will focus on four priority scale-up saturation districts (Port-au-Prince, Cap-Haitien, Dessalines and Saint Marc) for the first time in COP17 for DREAMS-like activities. According to the FY16 Annual Program Result (APR) data, these four districts have high numbers of female youths testing HIV-positive and a high HTC yield. In addition, these geographic areas also have high estimates of reported cases of GBV, as reported in the 2012 DHS. Other populations to be prioritized in COP17 are KPs including prisoners who present high HIV positivity rates and TB infection, pregnant women, children, adolescent girls and women, migrant people, siblings and/or partners of HIV infected individuals. The program will focus on expanding HIV clinical and prevention services to them.

Table 3.1 Current Status of ART Saturation

| Prioritization Area | Total PLHIV/% of all PLHIV for COP17 | # Current on ART (FY16) | # of SNU COP16 (FY17) | # of SNU COP17 (FY18) |
|---------------------|--------------------------------------|-------------------------|-----------------------|-----------------------|
|---------------------|--------------------------------------|-------------------------|-----------------------|-----------------------|

Attained

| | | | | |
|---------------------|--------------|--------|----|-----|
| Scale-up Saturation | 80,618 (58%) | 58,079 | 10 | 12* |
| Scale-up Aggressive | 27,244 (19%) | 13,350 | 10 | 10 |
| Sustained | 25,787 (19%) | 9,426 | 16 | 14 |
| Central Support | 6,241 (4%) | 0 | 4 | 4 |

* Three districts (Port au- Prince, Croix des Bouquets, and Leogane) are grouped into one Cluster and when counted as one, the total is 10 scale-up saturation districts.

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

4.1 Targets for Scale-Up Locations and Populations

| | Entry Streams for ART Enrollment | Tested for HIV (APR FY18) HTS TST | Newly Identified Positive (APR FY18) HTS TST POS | Newly initiated on ART (APR FY 18) TX_NEW |
|--|-------------------------------------|-----------------------------------|--|---|
| | Adults | | | |
| | TB Patients | 10,549 | 1,489 | 1,489 |
| | Pregnant Women | 209,698 | 2,428 | 2,383 |
| | VMMC clients | | | |
| | Key populations | 64,546 | 4,198 | 3,776 |
| | Priority Populations | | | |
| | Other Testing | 450,851 | 16,042 | 12,243 |
| | Previously diagnosed and/or in care | | | 3,039 |
| | Total Adults | 735,644 | 24,157 | 22,930 |
| | Pediatrics (<15) | | | |
| | HIV Exposed Infants | 4,214 | 133 | 126 |
| | Other pediatric testing | 119,042 | 1,231 | 1,108 |
| | Previously diagnosed and/or in care | | | |
| | Total Pediatrics | 123,256 | 1,364 | 1,234 |
| | TOTAL | 858,900 | 25,521 | 24,164 |

Standard Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

This does not apply to the PEPFAR Haiti program.

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Target Populations | Population Size Estimate* (scale-up SNUs) | Coverage Goal (in FY17) | FY18 Target |
|--------------------------|---|-------------------------|----------------|
| KP_PREV_FSW | 40,400 | 22,600 | 63,581 |
| KP_PREV_MSM | 38,300 | 19,032 | 25,145 |
| KP_PREV_Prisoners | - | 5,000 | 4,600 |
| PP_PREV (Clients of FSW) | - | | 17,964 |
| TOTAL | | 46,632 | 101,290 |

*The size estimates from the 2016 PLACE study should be interpreted as the size of key populations who can be reached by programs at places where people meet new sexual partners in Haiti. They are not meant to be interpreted as

estimates of the total number of FSW or MSM living in Haiti.

| Table 4.1.4 Targets for OVC and Linkages to HIV Services | | | |
|---|---|---|--|
| SNU | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY18Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC* |
| Acul-du-Nord | 4,487 | 4,198 | 3,989 |
| Anse-à-Veau | 5,698 | 428 | 407 |
| Anse d'Hainault | 3,723 | 100 | 95 |
| Aquin | 8,002 | 2,171 | 2,062 |
| Arcahaie | 7,226 | 979 | 930 |
| Bainet | 4,969 | 50 | 48 |
| Baradères | 1,707 | | - |
| Belle-Anse | 6,390 | 383 | 364 |
| Borgne | 4,543 | 498 | 473 |
| Cap-Haïtien | 11,386 | 6,098 | 5,793 |
| Cerca-la-Source | 5,236 | 407 | 386 |
| Chardonnières | 3,166 | 130 | 124 |
| Corail | 4,805 | 37 | 35 |
| Côteaux | 2,303 | | - |
| Dessalines | 14,127 | 7,497 | 7,122 |
| Fort-Liberté | 2,290 | 1,371 | 1,302 |
| Gonaïves | 14,411 | 4,062 | 3,859 |
| Grande-Rivière-du-Nord | 2,214 | 710 | 674 |
| Greater Port-au-Prince | 110,443 | 28,493 | 27,068 |
| Gros Morne | 8,091 | 290 | 275 |
| Hinche | 9,922 | 3,063 | 2,910 |
| Jacmel | 11,749 | 715 | 679 |
| Jérémie | 8,493 | 2,852 | 2,709 |

| | | | |
|---------------------|----------------|----------------|---------------|
| La Gonâve | 3,321 | 24 | 23 |
| Lascahobas | 7,263 | 2,162 | 2,054 |
| Les Cayes | 11,884 | 3,702 | 3,517 |
| Limbé | 3,534 | 354 | 336 |
| Marmelade | 7,045 | 885 | 840 |
| Miragoâne | 4,460 | 1,054 | 1,001 |
| Mirebalais | 7,268 | 4,117 | 3,911 |
| Môle-Saint-Nicolas | 8,638 | 857 | 814 |
| Ouanaminthe | 5,787 | 3,080 | 2,926 |
| Plaisance | 4,775 | 590 | 560 |
| Port-de-Paix | 11,761 | 7,878 | 7,484 |
| Port-Salut | 2,703 | 391 | 371 |
| Saint-Louis-du-Nord | 5,269 | 173 | 164 |
| Saint-Marc | 14,425 | 6,661 | 6,328 |
| Saint-Raphaël | 6,297 | 435 | 413 |
| Trou-du-Nord | 4,399 | 1,464 | 1,390 |
| Vallières | 3,013 | 204 | 193 |
| TOTAL | 367,223 | 98,563* | 93,629 |

* This increase is related to the additional funds for DREAMS-Like activities. Most of PEPFAR Haiti's partners are already performing some DREAMS-like related activities within the existing OVC platforms.

4.2 Priority and Key Population Prevention

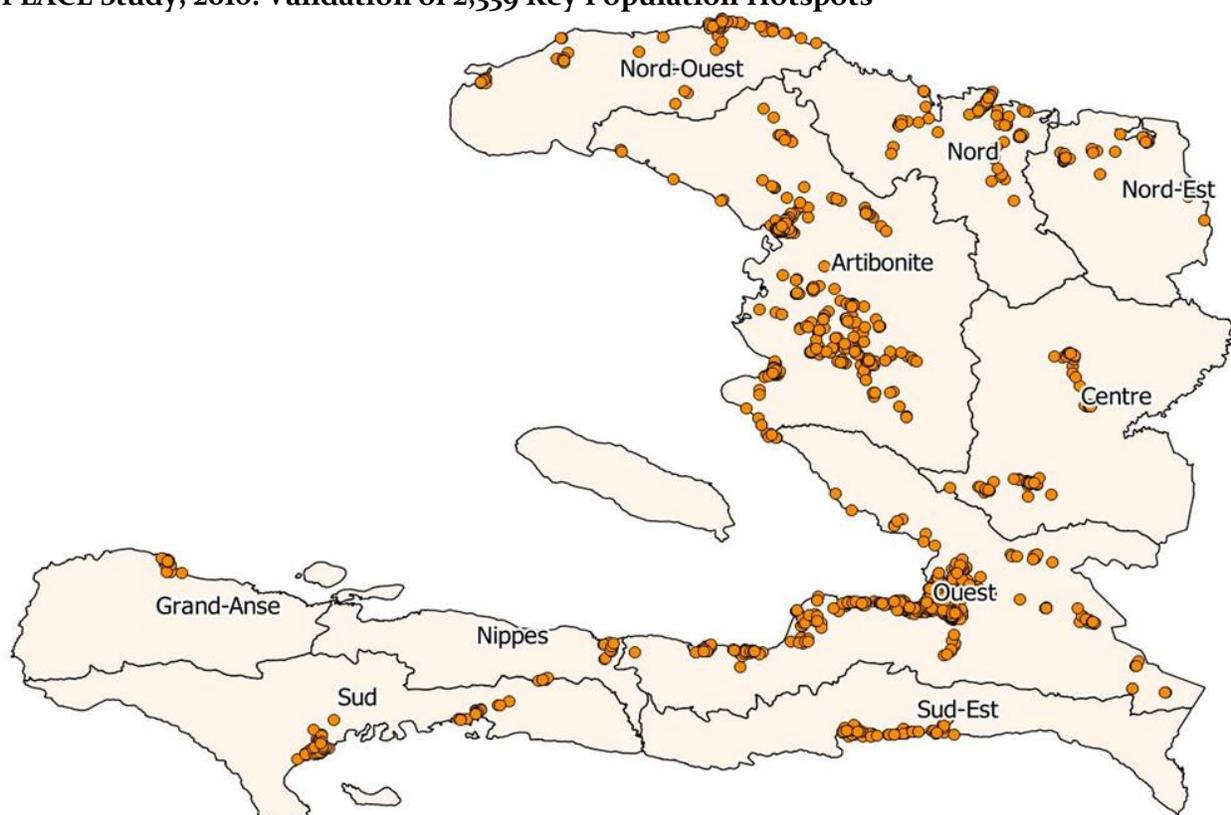
The IBBS conducted in 2014 and Priorities for Local AIDS Control Efforts (PLACE) conducted in 2016 have shown that MSM and female sex workers (FSW) contribute to the burden of HIV with prevalence rates significantly higher than the general population; respectively 12.9% and 8.7% in the 2014 IBBS. Furthermore,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

PEPFAR Haiti will support high-impact core interventions for KPs in COP17 including: targeted education and HTC for priority populations, combination prevention services extended to clients of FSW, condom/lubricant promotion and distribution, continued implementation of Test and Start, sexually transmitted infection (STI) testing and treatment services, adherence and retention support through peer navigators, as well community drug distribution. In regards to pre-exposure

prophylaxis (PrEP), PrEP is included in the draft of the new national guidelines which are set to be published later this year; the first groups considered for PrEP will be high risk populations including MSM and serodiscordant couples. The program will continue to strengthen capacity of local organizations to provide KP services and utilize local social networks to identify undiagnosed individuals living with HIV and link them to HIV treatment services.

The 2016 PLACE study included validation and mapping of 2,339 KP hotspots throughout all of Haiti's 10 departments. Data collected also included information on risk factors and access to prevention, testing, and treatment services. The PLACE data is being used at the implementing partner level to conduct microplanning and expansion of KP prevention and testing services to locations and populations not previously reached. In COP17, PEPFAR Haiti will implement targeted KP testing strategies that leverage both PLACE and programmatic data. For example, COP17 implementation will shift away from HIV testing in brothel settings where HIV testing yield has been fairly low and move toward targeted hotspot venue-based testing where HIV testing yields from PLACE were double the national average of implementing partners.

PLACE Study, 2016: Validation of 2,339 Key Population Hotspots



The results of the previous IBBS and PLACE indicate that stigmatization and violence are significant and consistently reported by a majority of MSM and FSW. 18% of MSM and 35% of FSW report being a victim of physical violence in the past 12 months, and approximately 45% of MSM and FSW report ever having been raped. Unfortunately, when seeking health services, KPs continue to face stigma and discrimination in the healthcare system with 6% of MSM and 11% of FSW reporting mistreatment by a healthcare worker. In COP17, PEPFAR Haiti will continue to rollout sensitization training to health workers and monitor facilities to ensure KP-friendly health services are provided. PEPFAR Haiti will continue to collaborate with PNLs to ensure that the different HIV-related guidelines incorporate segments about KPs.

Since the reporting gaps are greater for KPs, the PEPFAR Haiti program will strengthen the accurate reporting of indicators that inform the HIV cascade of care for the patients living with HIV and particularly the priority populations. A joint cascade assessment with the GF is planned to ensure that coverage of critical HIV services for KPs is improved and coordinated across donors. In COP17, PEPFAR Haiti will expand access of OVC services supported by other implementing partners to also include children of KPs.

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

involvement whenever possible.

4.3 Voluntary Medical Male Circumcision (VMMC)

Not applicable in the Haiti program.

4.4 Prevention of mother-to-child transmission (PMTCT)

Over the last six years, Haiti has significantly expanded access to PMTCT. During this time the country has adopted and implemented Option B+ and Test and Start and the program has seen an increased PMTCT coverage that reaches 90% for both HIV-infected pregnant women identified and enrolled on ART in FY16. In FY16, the positivity rate among HIV-exposed infants tested at two months of age was 2.56% which represents a decrease compared to the previous year (3.07%). However, the overall positivity rate of HIV-exposed infants who had a PCR within 12 months of birth was 5.7% compared to 4.7% the previous year. This represents a one point percentage increase compared to last year indicating a higher transmission rate occurring between the 2-12 months group than previously reported. This may be the result of the relatively high cumulative incidence of LTFU observed among pregnant women in the program. The PEPFAR Haiti team believes that the relatively high LTFU among pregnant women is in part due to retention issues after delivery as some women tend to stop treatment after they deliver but continue to breastfeed. PEPFAR Haiti will continue to place emphasis on case management of pregnant and post-partum women and work to address overall adherence and retention issues in the program.

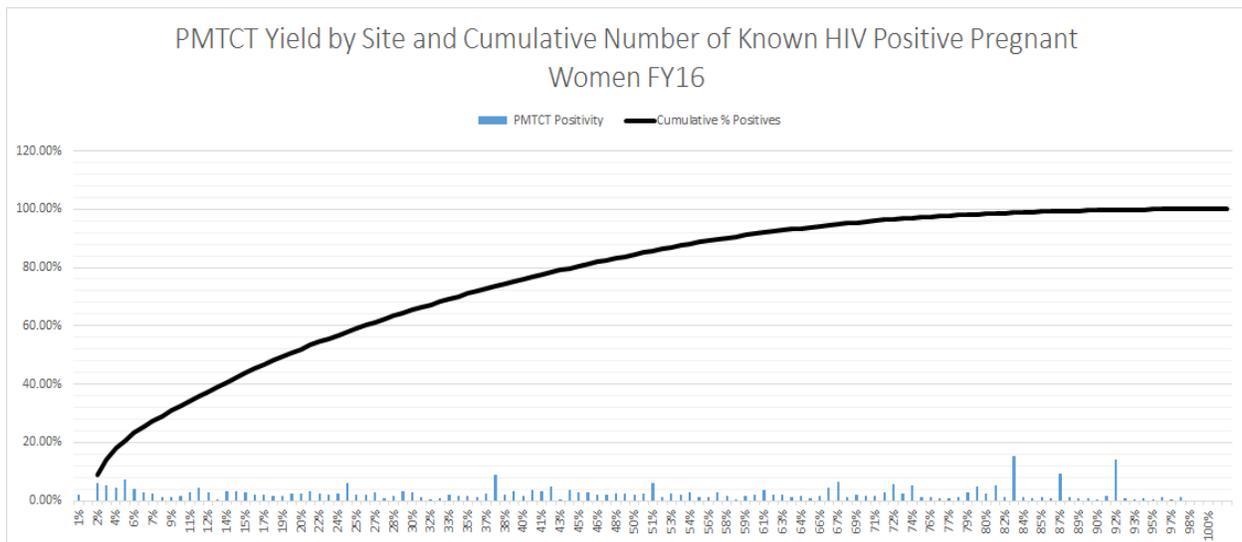
In an effort to bring more positive men into care, the program's current strategy emphasizes the importance of testing the male partners of pregnant women and conducting couple's counseling. However, testing the partners of HIV-negative pregnant women will potentially increase the number of tests and decrease the positivity yield. The team will work with partners to ensure appropriate implementation and follow-up of this strategy.

PEPFAR Haiti will support the provision of HTC services to at least 97% of pregnant women attending antenatal care (ANC) clinics at supported health facilities. In COP17, the program is expected to help 238,877 pregnant women know their HIV status; 88% of this number will come from priority districts. Although a steady decline in the positivity rate has been observed during the past years, the program will continue its efforts to identify more infected pregnant women by improving its targeted testing strategy by intensifying testing in areas with high prevalence and thus increasing testing yield. An estimated 5,012 infected pregnant women will be identified in COP17 and 88% are expected to come from scale-up districts. Based on WHO guidelines, the program will support retesting of HIV positive pregnant women before initiating ART. The program will provide ART to 95% of those who are HIV-positive and will place a particular focus on retention of HIV-positive pregnant women on treatment, which tends to be lower than that of non-pregnant adults (Domercant et al, IAS 2015). PEPFAR partners will expand the PLR program that has shown quite promising results. Analysis of data from sites implementing this program has shown nearly 50% of patients LTFU brought back to care. Providers will continue to proactively engage patients about their appointments through phone calls or text messaging as appropriate. Efficient coordination between providers, particularly the case manager and community health agents, will ensure proper follow-up for every missed appointment. The goal is to increase adherence to treatment, reduce LTFU, and ensure the continuum of services to the pair (HIV-exposed infant and mother), and to patients supported at community level.

In COP17, the program will continue to expand early infant diagnosis (EID) coverage within PEPFAR sites but will also link to networks outside the PEPFAR funded facilities. In agreement with PNLS, UNAIDS and UNICEF, a much broader population of pregnant women not reached through the PEPFAR or GF supported-sites need to be tested. If women are found to be HIV-positive in health facilities that do not offer HIV and PMTCT services, they should be referred for care and treatment as the program is aiming to achieve elimination of mother to child transmission (eMTCT). Thus, clusters will be created around PEPFAR sites for PMTCT services including EID. Strategies on how to build the clusters that will benefit from the supply of required commodities and training on dried blood spot (DBS) collection are currently in discussion with key stakeholders. In order to improve the monitoring of HIV-exposed infants, PEPFAR will continue to support partners for EID DBS specimen transportation for PCR testing and to implement longitudinal birth cohort reporting to follow HIV-exposed infants through the end of the breastfeeding period. The turnaround time between EID specimen collection and the return of results to clinics is currently exceeding four to six weeks. The PMTCT program will do an assessment on cost of using the point-of-care PCR testing services in high volume sites. If technically feasible, point-of-care or near-point-of-care PCR testing services may allow for rapid delivery of results to caregivers and the possibility for same day initiation of ART. Concurrently, the PEPFAR Haiti team will investigate the current process in order to identify the potential causes of delay in the turnaround time for PCR results and to provide appropriate support for improvement. Retention of the mother-infant pair is also critical through the innovative approaches that are being implemented in the PEPFAR Haiti program.

Efficiency Analysis

In Haiti, 42% of PMTCT sites (n=52) identified 80% of HIV-infected pregnant women in 2016 (see figure below). In COP17, PEPFAR Haiti will support 112 sites to deliver PMTCT services and cover 80% of the estimated 300,000 expected pregnancies. Close to 82% of those sites are located in priority districts. The program will continue to leverage support to foster integration of PMTCT services with family planning. Providers will engage pregnant women on the importance of using modern family planning methods in the post-partum period to reduce unwanted pregnancies and further enhance efficiencies.



4.5 HIV Testing and Counseling (HTC)

HIV testing and counseling (HTC) enables knowledge of the infection status and requires a longitudinal approach across multiple public health services, including facility and community-based service delivery points, as well as a robust laboratory network with an effective quality assurance program.

Soon after Haiti's prioritization exercise, PEPFAR Haiti started recurrent discussions with implementing partners and PNLs to promote targeted testing approaches that decrease the number of tests being administered while achieving greater yield. In COP17, in order to reduce unnecessary facility-based testing, PNLs will disseminate guidance on reducing the frequency of re-testing of low-risk negatives. Additionally, PEPFAR Haiti will intensify partner engagement to halt unnecessary testing, improve reporting of testing modalities, and introduce rapid risk screening to target high risks populations (e.g. age group, multiple partners, etc.). Lastly, with the upcoming availability of more recent and nuanced data, PEPFAR Haiti will be better equipped to identify and reach undiagnosed individuals. The PEPFAR program has worked with UNAIDS globally, to provide finer disaggregation; therefore we expect to have PLHIV numbers with more granularity. In addition, several other data sources including the DHS, national census, and the population-based HIV impact assessment (PHIA) will be available in the coming year, which will help us have more clarity on the PLHIV estimates. The combination of these approaches will ensure that implementation of HIV testing is more targeted, non-repetitive, and efficient.

In COP16, our partners have been using a variety of testing modalities (e.g. mobile HTC outreach in remote underserved areas; mixed approach of both facility-based and community testing; voluntary counselling and testing - VCT standalone, co-located, HTC services in high-yield service delivery points such as TB clinics; patients with STIs and KPs) that permitted an increased number of people to know their HIV status. However, though this allowed the program to exceed its objectives for testing, it fell short of meeting the yield targeted. In COP17, new targeted testing strategies will be implemented, including:

(1) **Index Case Contact Tracing** with tracking and active case finding where the counsellors and/or healthcare workers will work together with the "index client" to notify and test their partners. This will include reaching male partners of index women in antenatal care (ANC). With this new active approach, the burden will no longer be on the patient to disclose their status to their partner, which is often difficult, especially for women, given the socio-economical context. Instead, health care providers will use innovative ways to reach and offer testing to partners, with permission of the index cases, without disclosing their status if the patients do not wish to do so. PEPFAR Haiti will build on Health Through Walls' (HTW) experience, materials, and expertise in index case contact tracing with family of prisoners to introduce large-scale testing of index case partners within the general population.

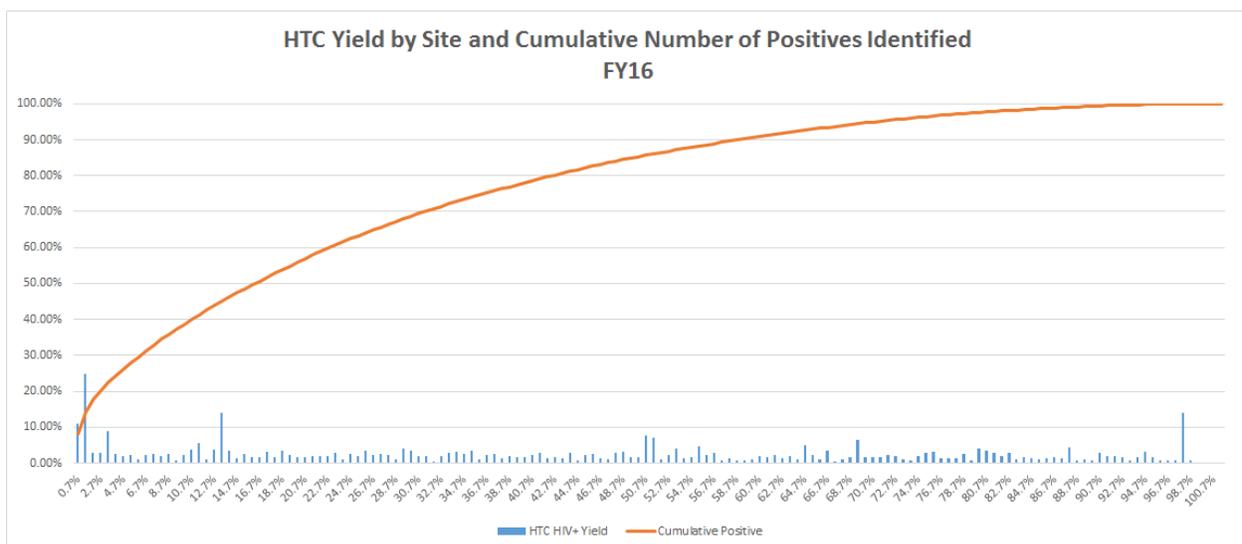
(2) **Supervised oral fluid-based testing** with a special focus on KPs and priority populations, including young adults under 30 years, to expand community access to HTC services. This new HIV testing approach will be through free and confidential counseling and rapid HIV diagnosis in stigma and discrimination-free environments in alternative venues. Training will be required for all community health workers (CHWs) and peers to support oral fluid-based testing with an additional task shifting of comprehensive HTC services.

(3) **Social Network Strategies** using KP peers to refer high risk individuals for HTC services. This program is an iterative process for growth and penetration into an untapped network of men who have sex with men and women (MSMW) who do not identify themselves as such.

Quality of HIV testing is an integral part of HTC and is accompanied with regular training and information for teams involved in testing. While nearly all HTC facilities are already participating in an External Quality Assessment (EQA) program, continuous supportive supervision to improve providers' competencies is lacking. Therefore, PEPFAR Haiti will take a more prominent role in training and oversight of HIV rapid diagnostic tests (RDTs). The team will continue with the re-training of trainers, develop more comprehensive RDT standard operating procedures (SOP), and have regular monitoring of staff/technicians that have received formal training. Furthermore, for the quality of record keeping and de-duplication in counting PLHIV identified, the PEPFAR team is moving forward with the implementation of a unique identifier using biometric code.

Efficiency Analysis

In COP16, 39% (n=60) of HTC sites were responsible for 80% of the total number of HIV-positive patients identified; of these sites, 42 were located in the scale-up saturation districts, 11 in the scale-up aggressive districts, and 7 in the sustained districts. PEPFAR Haiti supported 152 HTC sites in FY16 and data analysis showed that 42% (n=64) of HTC sites were responsible for 80% of the total number of HIV-positive patients identified during this fiscal year; of these sites, 47 were located in the scale-up saturation districts, 11 in the scale-up aggressive districts, and 6 in the sustained districts -- which confirmed PEPFAR Haiti's team prioritization process. For COP17, PEPFAR Haiti will be supporting 144 HTC sites including targeted community testing sites which will be providing services as described in the community-based approaches package. More than two-thirds of HIV testing sites (69%; n=99) will be in scale-up saturation districts during COP17. PEPFAR Haiti is expecting an overall program yield of more than 3% at the end of FY18 with the continued effective use of provider-initiated testing and counseling (PITC), the expansion of HTC models of service delivery beyond the health care facility and the implementation of the new testing strategies.



4.6 Facility and Community-Based Care and Treatment

During COP17, PEPFAR Haiti will continue to provide comprehensive clinical care and support services to PLHIV. Improving linkages between HTC and clinical services and reinforcing strategies to reduce LTFU will be core foci of the program in COP17. As a result of the adoption of the WHO recommended Test and Start approach to HIV treatment in July 2016 and the initial efforts to implement roll out of multi-month scripting, and community-based drug delivery; significant improvements in the number of positives enrolled on treatment and retained in care are expected by the program. Similarly, the program expects a significant decrease in the proportion of pre-ART patients and a reduction in the incidence of opportunistic infections as ART is initiated sooner.

The PEPFAR facility-based package of core services includes clinical assessment and staging monitoring; routine provision of CTX prophylaxis; TB screening; positive health, dignity and prevention (PHDP) services; and support groups for PLHIV including children and adolescents. This package of services will be the same in sites for all PEPFAR-supported districts. The community-based package reinforces services offered at the facility in an effort to control the attrition of patients and improve convenience of drug supply for the patient. Some examples of services offered at the community level are index testing, supervised self-testing, linkage to care and treatment activities, home-based drug distribution, treatment clubs, community adherence groups, patient tracking, and saving groups.

Additionally, in COP17, the PEPFAR Haiti program will provide targeted nutritional support (hot and/or cold meals) be limited to patients newly enrolled on ART. This intervention is aimed at addressing the problem of LTFU of patients during their first three to nine months following enrolment in treatment. Implementing partners have noted a strong correlation between provision of nutritional support and retention of patients; implementation of this intervention and the outcomes expected will be monitored closely by the PEPFAR Haiti team and the partners over the next two years and the impact will be assessed.

During COP17, the program will continue to ensure that all supported sites use continuous quality improvement methodology (HealthQual) in an effort to maintain and/or improve the quality of HIV clinical care.

Furthermore, the ongoing implementation of the Site Improvement through Monitoring System (SIMS) activities will allow PEPFAR Haiti to monitor the capacity of partner sites to provide a standardized and quality package of HIV care and services and identify weaknesses to be addressed through HealthQual activities. SIMS data will be used to facilitate improvement of the quality of both facility and community-based services offered within the PEPFAR-supported sites.

The program will also support its partners in implementing strategies to ensure continuum of care and services for all PLHIV in order to foster retention and adherence. In COP17, the program will reinforce the implementation of strategies nationally to achieve better coordination between facility and community staff, a reduction in duplication, and improved community tracking of patients. With the use of the previously proposed activities, tools and technology support; such as proactive reminder phone calls/SMS and customized support group activities to prevent stigmatization and discrimination, significant improvement in patient linkage to and retention on treatment are expected at the end of COP17. This will be further reinforced through close and

frequent engagement with implementing partners and monitoring of their performance.

PEPFAR Haiti will continue to provide technical support to MSPP to update and develop guidelines and adapt training materials and standard operating procedures for health providers and caregivers to promote more KP-friendly and targeted services. In addition, implementing partners will work through CHWs to sensitize the general population on the negative effects of discrimination experienced by these vulnerable groups.

Finally, given the steady decrease of resources, the program is placing an emphasis on improving program efficiency and reducing cost. The program will conduct ongoing human resource optimization assessments which will assist in understanding the quantity and quality of time spent with patients by each cadre while determining administrative and reporting demands.

4.7 TB/HIV

Haiti has the highest incidence of TB in the region, 194 per 100,000 (WHO country report, 2015). TB remains the leading cause of death for patients living with HIV/AIDS in Haiti with approximately 16% of all TB patients co-infected with HIV (PNLT, 2016). The latest FY16 APR estimated that around 93% of TB patients in PEPFAR-supported sites were tested for HIV and simultaneously 98% of HIV-positive patients were screened for TB. Additionally, around 84% of the co-infected TB/HIV patients were put on ART which will be optimized with the full implementation of the Test and Start strategy.

PEPFAR TB/HIV activities in COP17 will continue to focus on the priority scale-up districts for epidemic control; with more than 88% of the co-infected population being diagnosed in scale-up districts, screening and prevention of TB will remain part of a national basic package of services across all PEPFAR-supported sites in Haiti. As a result, Isoniazid Preventive Therapy (IPT) for a duration of 36 months or more as per the revised guidelines (PNLS, July 2016) will continue to play a crucial role in the efforts to lessen the burden caused by the incidence of TB in patients living with HIV. Intensified and active case finding will be a principle mean of controlling TB infection and reduce the overall TB incidence in the 20 scale-up districts identified for COP17.

The majority of TB funding in Haiti is provided by GF which supports TB treatment and complements PEPFAR-supported TB activities in prison. However, at an implementation level, PEPFAR will provide additional TB/HIV support focused primarily on laboratory diagnostic capacity and surveillance. There are currently a total of 23 GeneXpert machines available in PEPFAR-supported scale-up sites to ensure that HIV-positive TB suspects systematically undergo appropriate evaluation for TB in addition to the fluorescent microscopy and culture. A referral GeneXpert network, already established in the West department, will expand to cover all HIV treatment sites countrywide.

PEPFAR Haiti will continue to support the integration of TB/HIV collaborative activities to ensure linkage and retention through expansion of the TB/HIV clinical service delivery model. For COP17, the PEPFAR Haiti team will continue to encourage implementing partners to increase the ART uptake among the TB/HIV population through improved linkages between TB and ART sites, training of the healthcare workers (thus allowing for TB providers to initiate ART), and

supporting the monitoring of activities such as SIMS and HealthQual. Consequently, in scale-up districts, PEPFAR Haiti will continue to provide a core package of activities and services to increase ART coverage of TB/HIV co-infected patients including human resources to accelerate planning and implementation of collaborative TB/HIV activities, enhanced TB/HIV case finding to ensure that 100% of all HIV patients are screened for TB and all TB patients and their contacts are screened for HIV, and a maximal number of TB/HIV patients are initiating ART as recommended by the national guidelines.

PEPFAR will continue to provide support to the national TB program in the implementation and expansion of MDR-TB detection and to the National Public Health Laboratory (LNSP, French acronym) network for improved diagnostic capacity. Finally, the program plans to support the integration of monitoring and evaluation for TB and HIV and continue our efforts on aligning PEPFAR and GF-financed TB-HIV activities to leverage and best utilize both investments.

4.8 Adult Treatment

PEPFAR Haiti, working in close collaboration with the GOH, has successfully expanded HIV treatment over the years and is currently supporting services in 36 out of 42 arrondissements with over 80,600 PLHIV receiving ART at the end of FY16, which represents about 58% of total estimated PLHIV (141,269) in the country.

Haiti's APR16 remarkable results, including a net gain on ART nearly four times as high as APR15 achievement primarily occurring in scale-up saturation arrondissements (districts), show the impact of the programmatic pivots made in COP15 and COP16. In COP15, PEPFAR Haiti underwent a thorough review of available programmatic and epidemiological data and implemented strategic pivots in the program in terms of prioritization of geographic areas, health facilities, and services for a more efficient and impactful approach to rapidly advance towards the UNAIDS 90-90-90 goals. These results were also made possible by the July 2016 adoption of the Test and Start policy by the country offering access to treatment to all PLHIV. With the help of the PNLs and the support of implementing partners, the PEPFAR Haiti team was able to lead the implementation of this new policy at a notably record pace. Through aggressive implementing partner engagement, intensive performance monitoring, and increased site support from the partners, PEPFAR-supported sites were able to enroll the vast majority of their pre-ART patients during the last quarter of FY16. At the end of FY16, four arrondissements already achieved saturation: Port-au-Prince, Acul-du-Nord, Cap-Haitien, and Miragoane. The country is on track to have a total of ten scale-up arrondissements/cluster reaching saturation by the end of FY17. At the same time, the team is planning to expand treatment in the scale-up aggressive arrondissements in order to reach saturation between FY18 and FY20 depending on current coverage status of the arrondissements.

After assessing ART demand/gap estimates, 12-month retention for the first year on ART, and cohort retention for each district; the team determined the necessary net gains in ART patients that will enable reaching the targeted coverage in FY18. To reach these ambitious goals, over 24,000 patients need to be initiated on ART during FY18 within the scale-up to saturation and scale-up aggressive arrondissements only, in addition to the FY17 expected results. By APR18, the team aims to enroll 25,324 new patients on ART, out of which 85% will come from scale-up saturation arrondissements, and to support 107,414 patients on ART (74% in scale-up saturation

arrondissements). This represents an overall 33% increase compared to FY16 results, with 34% growth in the scale-up arrondissements (Saturation and Aggressive).

In addition to the pivots already in place and the new national policy on Test and Start, several strategies will be implemented nationally to enroll and retain new patients in order to reach COP17 treatment targets, including: 1) emphasis on diagnostic and treatment of TB/HIV patients and priority populations; and 2) fast-tracking ART enrollment to promote same-day initiation on ART for newly diagnosed PLHIV, a strategy that has demonstrated improvement in retention. PEPFAR Haiti will also continue to roll-out new delivery models for treatment services initiated in COP16 with a mix of facility- and community-based services allowing multi-month scripting (up to six months) and community-based drug delivery, as appropriate. Task-sharing/task-shifting, when appropriate, will allow the expansion of the rapid-pathway model and reduce time at the clinic for stable patients on ART, which will alleviate the growing needs in human resources and increase efficiency. Preliminary program data analysis show that patients on multi-month scripting tend to have better retention than those who have to pick-up their drugs every month. Although there was considerable improvement during FY16, attrition remains a challenge, especially in the context of limited resources and closing of programs which have historically provided complementary social support, such as nutritional support. Further analysis of APR16 results showed that attrition is higher among patients recently enrolled (less than 12 months) than the rest of the cohort. To reach the optimal net gain for COP17, PEPFAR Haiti provide targeted nutritional support and tailored adherence counseling for the newly enrolled on ART during the first six-nine months. Additionally, the PLR program, developed last year to improve retention and linkage to treatment, will continue to be implemented.

The PLR program was presented last year as one of two PEPFAR Haiti game changer interventions. PLR uses mobile technology to allow active tracking of patients LTFU by community health agents. The PLR program is also used to ascertain patients' addresses in order to facilitate linkage to care for newly diagnosed patients, to identify patient needs, and to support alternative service delivery models -- such as home/community-based drug distribution when distance and/or costs of transportation are causing missed appointments. Over 5,000 PLHIV on ART have been placed on community-based drug distribution through the PLR program. In addition, the PLR program also facilitates a proactive approach to avoid LTFU by promoting regular contact with all patients, not only defaulters, via calls, text messages, and/or home visits and by increasing linkages between communities and facilities. The PLR program is already implemented at over 70 sites boasting promising results including about 50% of patients LTFU returning to treatment. The full rollout is expected to be completed by APR17. Appropriate reinforcement of counseling measures and availability of patient-centered options will be implemented at the site-level to help prevent re-loss of patients retrieved via the PLR.

Concurrently, the PEPFAR Haiti team started rolling out the biometric code using digital fingerprint as a unique health identifier. This project is the second game changer of the PEPFAR Haiti program and is expected to have a major impact on the program once fully implemented. Designed to respond to the absence of a reliable national unique identifier, this initiative strengthens the program capacity to detect "duplicates" by determining which patients are enrolled at more than one treatment location, even if they did not provide the same name, and will help distinguish real LTFU numbers from "silent transfers". This unique identifier, once implemented at the national level, will be the starting point of a new system to allow the medical records to follow patients where they decide to receive care and allow for a continuum of care and

treatment rather than duplication. This initiative together with the PLR's address ascertainment component will revolutionize the current system by assessing ART coverage based on a patient's SNU of residence instead of the SNU of the sites where they receive care, which might greatly vary depending on the SNU considered.

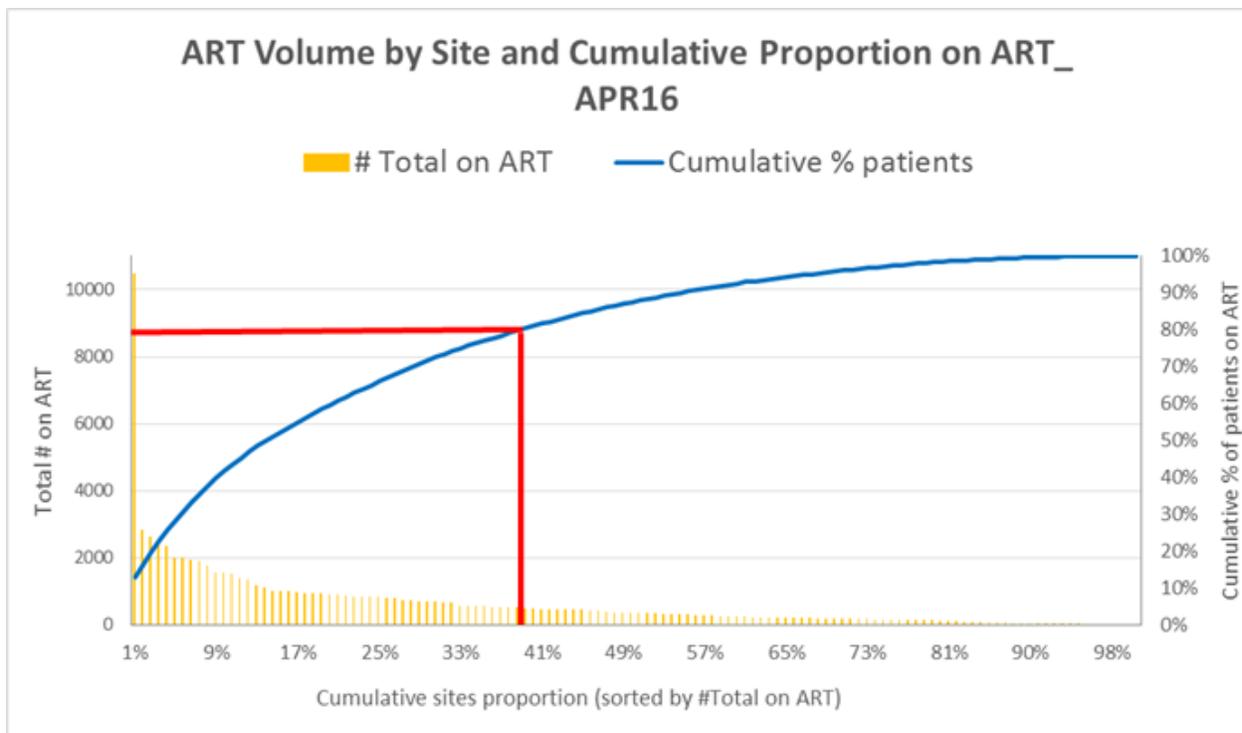
A new focus for PEPFAR Haiti during COP17 will be to ensure coverage for PLHIV under 30 years old, as evidence from our programmatic data and from various other countries show sub-optimal coverage for this group of the population. Currently, the lack of PLHIV estimates for all age groups limits the capacity to assess coverage of under 30 year olds. PEPFAR Haiti will collaborate with other national and international stakeholders, such as UNAIDS and PNLS, to obtain PLHIV estimates for all age groups for a deeper dive into disaggregated data analysis.

Building on COP15 and COP16 work to streamline the standard package of services supported and based on WHO recommendations and the core, near-core, non-core analysis; PEPFAR Haiti will continue in COP17 with the reduced frequency of lab tests and clinical visits. Recent modifications were made in the national electronic medical records (EMR) to facilitate spacing the frequency of clinical visits to up to six months. Since COP16, PEPFAR Haiti stopped supporting CD4 testing in order to allocate resources for VL expansion at the national level. Part of the support for initial CD4 testing was picked up by the GF. In order to resume CD4 testing responsibilities, the GF had to conduct an evaluation of all functioning CD4 machines. The evaluation was recently completed and GF has started distributing supplies to sites for CD4 testing and they have provisions to support the baseline CD4 test nationally. The COP16 treatment package will be maintained for COP17 and will support the provision of salaries and training of essential healthcare providers, quality improvement, VL expansion at the national level, and ARV commodities. Currently, ART patients receive ARV drugs through both PEPFAR and GF procurement with an approximate 64/36 split (see table 2.2.2).

PEPFAR Haiti anticipates that the supported package and aforementioned strategies along with the increased alignment of GF and PEPFAR programming and the continuous implementation of the Test and Start policy within the National Guidelines will contribute to the attainment of proposed treatment targets and ultimately lead to epidemic control in the near future.

Efficiency Analysis

In FY16, PEPFAR Haiti supported ART services in 124 sites across 36 arrondissements (districts). Out of these, 40% (n=49) accounted for 80% of ART patients, while the remaining 75 sites (60%) accounted for only 20% of ART patients, with a volume range between 7 and 492 patients and with 22 sites supporting <100 patients. As in previous years, in terms of ART services, APR16 results align with geographic prioritization with 88% of ART patients coming from scale-up saturation and scale-up aggressive arrondissements, as categorized in COP16. During FY16, eight low volume sites (under 40 persons on ART) were identified; out of which 4 are KP sites (including 2 prisons), located within scale-up saturation and scale-up aggressive arrondissements. Two of these low-volume sites were new sites added last year in Mole St-Nicolas. One site that reported <40 patients will no longer be supported in COP17. PEPFAR Haiti will further evaluate other sites with low performance in scale-up arrondissements to identify individual issues and provide appropriate support.



4.9 Pediatric Treatment

As of September 2016, 3,216 children (<15 years) were active on ART. This represents 54% of the 5,996 pediatric patients needed to reach 90% coverage (UNAIDS 2013 Global Report). The target for COP17 is to have 4,983 children active on ART before the end of FY18. This represents nearly a 35% increase compared to FY16 results and aligns with PEPFAR’s emphasis on increased coverage for peds. The program will focus on interventions that will permit reaching this target, despite the challenges presented by the lack of trained human resources and the dependency on caregivers who are prone to retention issues. With the MSPP’s adoption of the Test and Start strategy and efforts from partners to treat all pre-ART patients, we have observed a substantial increase of ART enrolment among the adult population in FY16. However, the same trend has not been observed in the pediatric population. Similar efforts will be needed to enroll all eligible children on ART.

DBS PCR has been now used in Haiti since 2009 and DBS is being used as the platform for VL testing. VL testing will keep expanding in COP17 to reach national coverage. With PEPFAR support, the MSPP has taken the lead to improve infrastructure for successful VL specimen transport thereby ensuring the sustainability of this intervention. PEPFAR will continue to support DBS PCR transport of specimens for EID. Additionally, PEPFAR and UNICEF have begun working together to create a larger network of sites located in hard-to-reach regions that are not part of the PMTCT program yet. The goal is to have a center/main site with satellites to more efficiently collect specimen and transport them to the two national labs equipped for PCR testing.

During COP17, saturation and aggressive districts will improve coverage in high prevalence and very populated districts. The metropolitan area of Port-au-Prince, Artibonite (second most populated department), and the North, Northwest, and Northeast departments will be the focus for expanding pediatric ART coverage. Additionally, PEPFAR, in partnership with UNICEF, is

looking to create a cadre of trained nurses for the delivery of ART to children. PEPFAR has already been engaged in discussions with PNLS and UNICEF regarding the training curricula on pediatric HIV. The training is necessary to ensure adequate task shifting from doctors to nurses and is critical to achieve the goal of increasing the number of children on ART. PEPFAR Haiti will continue to put emphasis on retention of pediatric patients by ensuring that case managers are involved to track all children using the PLR strategy. Furthermore, community networks within implementing partner organizations will be leveraged to ensure that both parents and children stay on treatment.

Testing of siblings has increased recently, but the yield is still low -- under 2%. PEPFAR will scale-up targeting of more vulnerable populations, like street children, in coordination with the OVC program. Children and youth living in and around identified KP hotspots will also be targeted in an effort to increase the proportion of children with known HIV status and the pediatric ART coverage. OVC programs will continue to ensure children and adolescents adhere to their medication and provide adequate support through peer support groups to improve retention in treatment.

4.10 Orphans and Vulnerable Children (OVC)

PEPFAR remains the main contributor to OVC activities in Haiti and has been working closely with PNLS and IBESR (Institut du Bien Etre Social et de la Recherche), the government entity responsible for OVC under the Ministry of Social Affairs (MAST).

Discussions between UNAIDS, UNICEF, GF, implementing partners, PNLS, IBESR, and MAST are ongoing to mitigate the negative impact of the PEPFAR OVC programs phase-out in certain geographical areas.

PEPFAR Haiti has been chosen as a DREAMS-like country for COP17. Consequently, a geographical focus has been placed on districts with a high yield of HIV testing among adolescent girls and young women (AGYW) ages 10-14, 15-19 and 20-24 years old. Based on a geographic analysis of the areas producing the highest yield of female youth testing HIV-positive, four districts will be targeted -- Port au Prince, Cap-Haitien, Dessalines and Saint Marc. Those districts are all in scale-up saturation areas and also located within departments (Artibonite, North and West) with a high prevalence of GBV as reported by the 2012 DHS. A package of services layered by age band 10-14 and 15-19 has been designed to address the specific needs of these age groups emphasizing prevention interventions, particularly among girls aged 10-14 and 15-19. Access to secondary education; positive parenting for caregivers; GBV prevention at the community level, including schools with social services for violence survivors; comprehensive adolescent sexual and reproductive health education and counseling; social asset building; and household economic strengthening (HES) through Savings Groups are the main components of the package.

HES is facilitating the transition for many families from PEPFAR support and is reducing dependency on OVC education programs. Access to education has been an important element of our OVC program, as it promotes resiliency among adolescent girls and reduces vulnerability. The ratio of girls to boys is currently 51:49; and the dropout rate for girls is below 1%. The Savings Group program aims to empower young women and their families through social and economic strengthening and consequently help to reduce GBV and decrease HIV risk. Other interventions aiming at risk reduction include referrals to condom promotion, access to comprehensive

adolescent sexual and reproductive health services, FP, and linkages to HIV testing services (HTS) for a strengthened continuum of care particularly focused and scaled-up in areas of high HIV prevalence. In addition to those activities, implementing partners will work with MAST, IBESR and PNLS to link violence survivors to medical, legal and psychological services -- particularly in the DREAMS-like districts.

PEPFAR Haiti will integrate new implementing partners to provide services in the DREAMS-like districts. In order to better inform the OVC portfolio with evidence-based data, a size estimate of the AGYW population will be done as well as a partner mapping survey to better inform prevention programs. Additionally, case management of individual beneficiaries to assess the child and family improvement within the OVC program will be enhanced through existing case monitoring tools and quality assurance will be carried out to ensure a multi-layered package of services are offered to OVCs.

The OVC and the pediatric AIDS program will continue to strengthen the link to HIV testing, care and treatment services. Implementing partners will ensure referral access to basic pediatric services not only related to child survival such; as immunization, deworming, Vitamin A supplementation and nutrition care, but also for identification of HIV-infected children and quick initiation on ART. Vulnerable children and youth in high risk populations (prisons, street children, children of KPs) will be prioritized. These efforts have already begun in close collaboration with some PEPFAR partners.

PEPFAR will keep working with the USAID Office of Democracy and Governance for the roll out of the response to the Violence Against Children Survey (VACS). The OVC program will coordinate with other partners involved in projects related to child protection, human rights, and human trafficking to address issues raised by the VACS survey including settings for post rape care and networking with the GOH, UNICEF and other key stakeholders.

4.11 Addressing COP17 Technical Considerations

PEPFAR Haiti's COP17 programming will initiate supervised **oral fluid-based testing** with a special focus on KPs and priority populations including young adults under 30 years to expand community access to HTC services. This testing modality will allow a gateway to expanded prevention and care services for under-30, especially with men. For those individuals who test positive, they will be referred to a facility to complete the national testing algorithm – which includes an additional confirmatory test.

As referenced in the HTC section, the MSPP, as well as the PEPFAR Haiti team, are focused on a decrease in tests with an increased yield. PNLS will disseminate guidance on reducing frequency of unnecessary re-testing of negatives to decrease facility-based testing. Data on testing modalities implemented in COP16 will be used to inform targeted testing across the program in COP17, along with the new strategies.

PNLS, the PEPFAR Haiti team, and our implementing partners have focused considerable time and effort on improving our retention strategies. To reduce LTFU, PEPFAR Haiti has identified successful approaches; namely the PLR program, use of mobile health technology, implementation of unique identifier using biometric codes, and use of PLHIV peers, that are being rolled out in COP16.

The roll out of the VL testing program through LNSP and GHESKIO is still ongoing in FY17 and will be completed during FY18. The recent addition of VL testing has created an opportunity to incorporate lab data into the mix of longitudinal patient-level data.

The geographic shifts in COP15 have been validated and in COP16 new interventions were adopted, and COP17 will be a refinement of these efforts to support a quality service model for PEPFAR Haiti.

Program Area 4.12: Commodities Risk Analysis

Uncertain shifts to Second line ARV: As of September 2016, the current number of ARV patients includes 95% of patients on first line, 5% on second line and 0.09% on third line. With the expansion of VL testing and a projection that 100% of ART patients will have VL test access, PEPFAR Haiti projects that up to 15% of the patients on ART targeted by September 2018 may be expected to switch from first to second line.

This projection has not been taken into account in the current COP17 budget estimation. The timeline for complete VL rollout and adherence counseling prior to second VL test should provide additional time to project second line ARV funding requirements. PEPFAR Haiti will closely track overall switches from first line to second line, so adjustments in budgeting and procurement can be made during implementation of COP17. However, significant funding gaps for second line ARVs are possible if there is a rapid shift to second line treatment as a result of expanded VL monitoring.

Risk to RTK stock levels at health facilities: COP17 strategies reiterate the need for targeted testing and reducing the repeated testing of HIV negative patients following the revised Haiti HIV testing guidelines. The distribution of RTKs will switch from an "on demand" resupply based on consumption and available stock on hand to a periodic distribution of a fixed amount (quota) of tests determined by PEPFAR based on implementing partner and site targets for COP17. Having implementing partner and service delivery sites supplied with a quota of test kits has proved challenging in the past. It is anticipated that stock out of RTKs could repeatedly happen at sites that do not shift to targeted testing approaches. In collaboration with the MSPP and partners, the Procurement and Supply Management (PSM) project will ensure that partners and sites receive in writing their approved allocated quota of tests at least three months in advance, thus increasing their awareness and likelihood of compliance.

4.13 Collaboration, Integration and Monitoring

PEPFAR Haiti has a strong partnership with the GF. The team has engaged in several technical collaborations with the Principal Recipient and continues to work and plan collaboratively with the MSPP and the GF. During COP16, the implementation of streamlining of ART commodities procurement between GF and PEPFAR was completed and more efforts to increase collaboration are planned for COP16 and 17.

The team plans to continue the oversight and aggressive engagement with our partners that has been proven successful in COP15 and COP16, and to expand this type of oversight to all partners, not just service delivery partners. The team also takes lessons from across the PEPFAR program

globally to improve partner performance.

The recent addition of VL testing has created an opportunity to incorporate lab data into the mix of longitudinal patient-level data, and the completed roll-out of VL testing in COP16 will provide the team another analytical tool to address the epidemic.

The implementation of differentiated models of care will both improve access to the targeted populations and will also increase retention as the model of care is more patient-centered and tailored to their needs.

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

5.1.1 Targets for attained and sustained locations and populations

Based on APR 16 and FY17 Q1 results, the PEPFAR Haiti Program shows a number (4 in APR 16, 6 additional expected in APR 17) of districts that have reached (or will reach) over 80% coverage by APR 17. However, it is not certain that the 80% coverage will be true for all sex and age disaggregation; therefore for COP17, the program is not planning for “Attained Districts”.

| Sustained Support Volume by Group | | Expected result APR 17** | Expected result APR 18 |
|---|------------------------|--------------------------|------------------------|
| HIV testing in PMTCT sites | <i>PMTCT_STAT</i> | 34,042 | 27,172 |
| HTS (only sustained ART sites in FY 17) | <i>HTC_TST/HTS_POS</i> | 98,671/ 2,232 | 33,441* / 823* |
| Current on ART | <i>TX_CURR</i> | 9,724 | 8,335 |
| OVC | <i>OVC_SERV</i> | 7,220 | 6,498 |

*total adult HTC_TST needed [excluding EID and PMTCT]

** FY17 Targets aggregated for Sustained district using COP16 prioritization, please note one district has graduated from sustained to Scale up Aggressive in COP17.

5.2 Priority and Key Population Prevention

PEPFAR Haiti will continue to use programmatic data and results from the 2014 IBBS and 2016 PLACE study to target geographic locations for KP interventions. The majority of KP focused programs are also located in the scale-up districts; however, the same package of KP services will be offered within sustained districts where there is a demonstrated need for services to ensure coverage of KP-focused interventions in identified hotspots. Refer to Section 4.2 for more details on the program area specific activities.

5.3 Voluntary Medical Male Circumcision (VMMC)

Not applicable in the Haiti program.

5.4 PMTCT

The GOH has made commitments to reach virtual elimination of mother to child transmission (MTCT) of HIV by 2020. In order to support this initiative PEPFAR Haiti will continue to offer a similar package of services in both sustained and scale-up districts at supported sites to ensure that pregnant women have access to HIV testing and ART. 97% of women who seek ANC services at PEPFAR supported institutions will be tested and know their results. 95% of the newly identified HIV infected pregnant women will be placed on life-long treatment. Providers will continue to proactively engage patients about their appointments, via phone calls or text messaging as appropriate. Efficient coordination between providers, particularly the case manager and CHWs, will ensure proper follow-up for every missed appointment. The goal is to increase

adherence to treatment and ensure the continuum of services to the pair (HIV-exposed infant and mother).

As discussions are ongoing with MSPP, UNICEF, and UNAIDS about reaching out to a larger networks of sites for testing of pregnant women, DBS PCR testing will still be made available for early diagnosis of exposed infants. It is expected that 95% of children born of HIV infected mothers will benefit of PCR for EID and those that are positive will be linked to treatment.

5.5 HTC

In COP17, the program will maintain the agreed upon minimum packages of services from our prioritization exercise. All sustained sites will continue with the passive provider-initiated and pediatrics case identification (e.g. malnourished and inpatients) testing based on suggestive symptomatology, confirmed risky sexual behavior or exposure, and need as determined by the service provider. HTC will also be provided to ANC (pregnant women) and TB patients. There will be no active testing or demand creation at these sites. Furthermore, as part of key decisions on reaching the first 90 and in order to achieve greater yield, all sustained SNUs will be implementing index case contact tracing with active case finding and social network strategies for KPs.

5.6 Facilities and Community-Based Care and Treatment

PEPFAR Haiti will continue to provide comprehensive clinical care and support services to all PLHIV in sustained districts. This package of services will be the same as the one provided in scale up districts. Reference section 4.6.

5.7 TB/HIV

Tuberculosis is the most common life-threatening opportunistic infection in people living with HIV in Haiti. In FY18, PEPFAR-supported TB/HIV activities, including TB screening and prevention, will continue to be prioritized in the sustained districts for epidemic control. Passive case finding in maintenance sites will allow the healthcare providers to detect active TB disease among symptomatic patients who present to medical services for diagnosis of specific symptoms. In all sustained districts, TB and HIV programs will collaborate to ensure provision of Isoniazid Preventive Therapy (IPT) for patients living with HIV as part of the package of care when active TB is excluded.

The majority of TB funding in Haiti is provided by GF, which supports TB treatment in all the supported districts. However, at an implementation level, PEPFAR-will provide additional TB/HIV support focused primarily on laboratory diagnostic capacity and surveillance. A referral GeneXpert network will be available to cover all HIV treatment sites from the sustained districts countrywide in addition to the fluorescent microscopy and culture.

PEPFAR Haiti will continue to support the integration of TB/HIV collaborative activities to ensure linkage and retention through expansion of TB/HIV clinical service delivery model. With those efforts in FY18, the program is expected to test 1,051 TB patients for HIV in 14 sustained districts with 17% among them being coinfecting and ultimately placed on ART.

5.8 Adult Treatment

In COP17, PEPFAR-Haiti will continue to implement passive ART enrollment of identified PLHIV in accordance with the new National Guidelines in support of the Test and Start approach. About 5% of patients to be initiated on ART during FY18 will come from the sustained districts in addition to the FY17 expected results.

The COP17 treatment package is similar in all PEPFAR-supported districts and will continue, as the COP16 package, to support provision of salaries and training of essential healthcare providers, quality improvement, VL expansion at the national level, and ARV commodities. As in scale-up districts, retention will be addressed through diversified delivery models, such as multi-month scripting, community-based drug distribution, as well as various activities and programs, including PLR, proactive appointment reminders to patients, and targeted nutritional support and tailored counseling for newly enrolled on ART during the first six-nine months. The roll-out of biometric code, using digital fingerprint, will also cover sustained districts, in order to enable its capacity to serve as a unique health identifier for improved services to patients. Partner engagement for Sustained districts will focus on rapid enrollment of all pre-ART patients, and expansion of retention activities.

5.9 Pediatric Treatment

A significant increase of ART enrollment was achieved in the adult population following the adoption of the Test and Start strategy in FY16. This upward trend has been less evident in the pediatric population. The effort to increase the number of children on ART will also occur in the sustained districts so all HIV positive infected children will be placed on ART.

Implementing partners will link pediatric patients to OVC services so psychosocial support, access to sexual reproductive health for adolescents, and nutrition support will continue to be provided. Access to food support, RUTF (ready to use therapeutic food), and RUSF (ready to use supplementary food) has become even more important in the South and Grande-Anse departments, which are mostly sustained districts, as they were severely hit by Hurricane Matthew in October 2016.

Activities for children of KP highly at risk to be positive will be maintained, so all identified HIV positive will be placed on treatment immediately.

5.10 OVC

Although there has been an increase in the number of OVC served in the sustained districts compared to last fiscal year, implementing partners have been instructed to limit new enrollment and to prioritize the graduation of families. Hurricane Matthew has devastated the Southern departments where many sustained districts are located. Massive destruction of homes and businesses has eroded the resilience of those vulnerable families as some were preparing to graduate from the program.

Challenges still remain as 1.5 million Haitians are severely food insecure and about 3.6 million persons country-wide (700,000 households) are food insecure. Furthermore, Haiti has experienced one of the worst droughts in recent decades due to the ongoing El Nino

phenomenon. (*Haiti Emergency Food Security Assessment, CNSA/WFP Feb.2016*). The widespread drought caused severe loss in agricultural yields and very poor households have exhausted their food stocks, relying on market purchase to meet their food needs. Furthermore, the HTG is devaluing at an accelerated rate reflected on the increased cost of living.

This background provides a general sense of the challenges that the OVC programs are facing in Haiti and will be facing for the coming years. Additionally, the GF has ended contributions to the OVC program for those infected or affected by HIV.

The sustained districts are still being prioritized for livelihood activities. To serve as a transition plan for OVCs in sustained and centrally supported districts, the PEPFAR Haiti team is expanding the Savings Group (MUSO, French acronym) program in these areas to better enable families to address their basic needs. Implementing partners are also instructed to link vulnerable families to other USG or non-USG supported programs in those areas.

With PEPFAR support, families of PLHIV will be receiving food support as well as RUTF for children with severe acute malnutrition in response to the natural disaster (Hurricane Matthew). These examples highlight the plan to support vulnerable families in the sustained districts while maintaining the goal of graduation. Eighty percent (80%) of the current OVC _SERV results are concentrated in scale-up saturation and aggressive districts. The goal is to have less than ten percent (10%) of OVC receiving services in the sustained districts by FY18. It is not realistic, based on the current country socio-economic situation, recurrent natural disasters, the lack of other donors, and limited GOH capability, to graduate all the remaining OVC families living in sustained districts by September 2018. An additional 18 months may be necessary to complete this transition and to ensure effective coordination with other stakeholders and that follow-on programming, such as household economic strengthening activities are sustainable.

5.11 Table A.1 Prioritized Activities for Sustained SNUs

(N/A for attained districts): *PEPFAR Haiti will not be able to demonstrate at least 81% coverage of ART coverage among all males and females age bands since the age-bands data denominators are unknown.*

| Area of PEPFAR Support | DISTRICT CATEGORY |
|---|--|
| | SUSTAINED |
| HTC | <ul style="list-style-type: none"> • Passive (provider-initiated, based on suggestive symptomatology and confirmed risky sexual behavior or exposure) • Testing for all pregnant women (ANC, Labor & Delivery (L&D)) • HTC for TB clients • Index case contact tracing • No demand creation; no outreach • Pediatrics case identification based on symptoms (malnourished and in- patients with suggestive symptoms) |
| Prevention + Outreach KP | <ul style="list-style-type: none"> • Social /sexual network strategies • Condom and lubricants provision • PEP • Maintain existing STI Screening • Maintain KP friendly health services |
| Clinical Adult and Pediatric ART | <ul style="list-style-type: none"> • ART for all HIV positive patients (Test and Start) and support to improve retention of current PLHIV on ART • Routine clinic visits and regimen pick- ups (Multi-month scripting and community drug distribution) • Access to sexual reproductive health services • Psychosocial support for pediatric patients (see psychosocial support section) • PHDP (include STI screening, diagnosis and treatment) • Post-rape care |

| | |
|--|--|
| | <ul style="list-style-type: none"> • TB screening for all PLHIV • Infection control for TB (maintain existing methods) • CTX prophylaxis for all PLHIV • IPT for 36 months as per guidelines |
| | <ul style="list-style-type: none"> • Routine clinic visits (with CHW- supported regimen delivery where appropriate) • Pharmaco-vigilance • Quality management; DQAs • Standard training (biennial), and quarterly mentorship for service providers |
| PMTCT/ B+ | <ul style="list-style-type: none"> • Routine HTC at first presentation in ANC (Repeat testing if evidence of increased exposure) or in L&D (for women with unknown status admitted for delivery) • Lifelong ART for all HIV+ pregnant women • EID for exposed infants • Support for retention of pregnant women initiated on ART |
| OVC | <ul style="list-style-type: none"> • HTC for OVC (contact tracing, targeted testing); • Case management of OVCs • Bi-directional referrals between health facilities and community • Early Childhood Development Services • Child survival services at facility and community level (Vitamin A, deworming, vaccination) • Referral to identified satellite facilities for nutritional assessment and counselling • Referrals for nutritional support • Time-bound (from 2015 – 2018) Household economic strengthening (for example: savings groups) • No new enrolment in educational support; • Psychosocial support (maintain peer support groups; less personnel) |
| Facility and Community Linkages | <ul style="list-style-type: none"> • Maintain current numbers of people in community health teams (including CHWs) • Improved referral and defaulter tracking services • Transport fees to attend appointments • Improved patient monitoring platforms |

| | |
|---|---|
| | <ul style="list-style-type: none"> • Increased involvement of civil society and community based organizations and networks |
| Psychosocial Support, Adherence and Referral | <ul style="list-style-type: none"> • Facility-based counselling and support (no support for psychologist) • Additional adherence counselling by polyvalent CHWs • Patient Linkage and Retention using mobile technologies and unique patient identifier and biometric codes • Support groups (maintain existing) • Empower CHWs on adherence monitoring (training, capacity building, logistics) |
| Support for Strategic Information/ Information Systems | <ul style="list-style-type: none"> • Maintain currently existing IT equipment and infrastructure • DQAs |
| Support for Essential Laboratory Services | <ul style="list-style-type: none"> • Viral Load (6 months post initiation on ART and annual monitoring) • EID • Smear microscopy for TB diagnosis • Gene Xpert (in-facility capacity if already existing or through network) • Specimen transport (as necessary) • Screening for Syphilis • Chemistry and hematology, when necessary or clinically indicated (not routine) • X-ray for TB Diagnosis (when necessary in algorithm, not routine or screening) • EQA/ QMS/Trainings |

Program Area 5.12: Commodities

Refer to section 4.12; there are no sustained districts with specific concerns.

Program Area 5.13: Collaboration, Integration and Monitoring

The same activities and engagements around collaborations, integration, and monitoring, addressed in section 4.13 for scale up districts will apply to the sustained districts.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

In assessing its capacity to achieve epidemic control and contributing to the ambitious global UNAIDS goals of reaching 90-90-90 in Haiti, the program will continue in FY17 to monitor three main programmatic gaps identified last year. The preliminary results from implementation of these three-year focused systems investments have proven how germane the gaps and barriers identified were to the progress toward the attainment of epidemic control. New activities have been added to last year's plan to help achieve the objectives.

1. **Programmatic Gap #1:** Challenges to reach treatment coverage and retain PLHIV on ART nationally and in some specific arrondissements.

The following barriers identified under this gap are currently being addressed in COP16 through innovative approaches that will be expanded in COP17.

a) High level of attrition among patients initiating ART: The combination of interventions adopted in FY16, including: the roll-out of a community health tracking system, the expansion of multi-month scripting and community-based drug distribution, and the tweaking of the electronic medical records to support flexible drug distribution; have demonstrated to be effective tools in reducing attrition. As reported in APR16, these measures have already contributed to the return and adherence of close to 7,000 patients previously lost to follow-up. The unprecedented secure and confidential access to patients at their home and within their community will be utilized in COP17 to initiate tracking and testing services for contacts of index patients and enhance follow-up for positive pregnant women during and after pregnancy.

b) The absence of a unique patient identifier system to facilitate patient follow-up across the program: The partial rollout of the system to 50 percent of active patients has already provided insight into the scope and magnitude of duplicates in the system and opportunities to identify and resolve the issues of silent patient transfers and medical shopping. The accompanying policy package that will be fully implemented in COP17 will lead to a fully functional nationally integrated health record system to support clinical care and ensure that every patient is represented only once and with constant demographic identification and a medical record that follows the patient wherever they seek services in the country. The full implementation of the unique patient identifier system will undoubtedly improve the overall efficiency of the program.

c) The limited number of trained staff: The lack of trained personnel continues to stall the expansion of services in traditionally underserved districts and requires renewed efforts to train nurse practitioners who can run clinics and prescribe drugs. Existing curriculum will be updated and trainers refreshed in COP17. Based on funding availability, training sessions, which stopped for about two years, will resume in order to offset the high rate of staff turnover and respond to the specific needs of vulnerable districts.

d) Limited availability of population-level epidemiological data at the district level and low national analytic capacity: The existing case-based notification system has been used not only to

inform the development of the COP17 and key policy decisions for the MSPP and the USG team, but to improve community patient tracking efforts, as well. Additional analytical capacities will be built in COP17 to support district level analysis and feed national estimates exercises. In addition, mapping and estimates exercises focusing on young women, adolescents, and OVCs will be introduced in COP17 to orient efforts to reach out to these groups. The increase in analytical capacity will enable decision makers and implementers to better calibrate and target their interventions.

2. Programmatic gap #2: Unknown (very limited) number/proportion of people enrolled and active on ART who have achieved viral suppression.

To be able to report on the third 90 of the UNAIDS 2020 goals, the program needs to assess VL for the entire cohort of active ART patients. However, less than 20% of active ART patients had VL monitoring in FY16. Given the implementation of the Test and Start approach to HIV treatment, it is critically important to have an objective method to monitor treatment outcome. The VL scaling-up program will continue in FY17 to reach 100% of ART patients in Haiti. The program's target is to reach over 80% viral suppression by end of FY17 and FY18. For COP17, programmatic barriers identified last year still remain applicable.

In order to appropriately plan for VL testing scale-up in COP17, PEPFAR Haiti budgeted for viral load expansion to be completed by the end of FY17 (COP16). The VL system is currently in place at the LNSP and at the GHESKIO lab, and additional lab staff were hired and machines purchased. During FY17 we planned to train all HIV sites to be able to appropriately take specimen and request viral load tests. These training sessions are scheduled to be completed in FY17 which will permit all sites to conduct viral load tests on a regular basis. Provisions have been made in COP17 to include an additional machine and to provide commodities, and the GF will procure an increased amount of commodities to support viral load during COP17/FY18. This collaboration will allow the program to keep the same budget for VL supplies as in COP16 and is sufficient to cover the additional VL tests.

As detailed in table 6.1.2, the following systems barriers have been identified as key determinants of this programmatic gap.

a) Limited VL diagnosis capacity centralized at the LNSP and GHESKIO: Because VL scale-up suffered a delayed start in 2016 due to the unavailability of the improved DBS VL test kits; only 26,000 ART patients received a VL test -- of which only 19,000 received test results. For COP17, the Haiti program plans to continue to refine the VL testing program by conducting refresher training for clinicians and lab staff. This will help to ensure that all VL testing results are returned to the ART sites and entered into the patient's medical record.

b) The existence of two parallel specimen referral networks (SRN): Haiti has two SRNs; an EID network which is fully supported by PEPFAR (specimen from all sites to IMIS and LNSP), and a VL, TB, and surveillance supported network partially funded by PEPFAR. Based on the data accumulated during the second half of FY16 and first quarter of FY17 regarding distance and shorter routes from peripheral laboratories to LNSP and IMIS, the Haiti program plans to conduct an optimization analysis to capitalize on existing capacity.

c) Limited knowledge on primary and secondary HIV drug resistance prevalence in the country to inform Haitian public health guidelines on quality of HIV care and treatment: The *testing for HIV drug resistance in patients with confirmed virological failure* survey has been completed; we plan to complete the data analysis and share the results with stakeholders in COP17. The funding requested in COP17 will be utilized to conduct HIV drug resistance surveillance in patient populations initiating ART using nationally representative sampling in Haiti as recommended by WHO.

d) Limited laboratory information system capability for specimen tracking, data collection, analysis, and reporting for timely and accurate results dissemination: The Soft Computer Laboratory Information System (SCC-LIS) has been fully implemented in the LSNP. In COP17, the Haiti program plans to install the SCC-LIS at IMIS and link SCC-LIS to EMR that will allow immediate availability of results to the providers. Integration of laboratory testing instruments into SCC-LIS system for VL and EID testing will improve testing efficiency, reduce transcription errors, and make VL and EID services 'one stop shopping' a reality.

3. Programmatic Gap #3: Limited capacity in the areas of governance, management, and regulation hinders implementation and oversight of policy; and inadequate capacity for health information integration, security, and exchange.

As detailed in table 6.1.3, the following systems barriers have been identified as key determinants of this programmatic gap and will continue to be addressed in COP 2017.

a) Limited human resources within the MSPP to develop and implement policies that supports epidemic control: With ongoing support to the MSPP, several benchmarks have been met and policy decisions adopted in COP16: including the adoption of Test and Start, multi-month scripting, and community-drug distribution. Additional efforts are needed in COP17 to ensure that: (i) information tools developed and produced by MSPP are adjusted to the new approaches, (ii) the national QA/QI program chaired by the MSPP is aligned, (iii) the MSPP continues to have a cadre of competent staff at key units to further implement new policies, (iv) the plan for a National Unified Supply Chain and logistics management information system is implemented, (v) the CCM manages grant implementation from the Global Fund and engages community based organizations (CBOs) in the oversight process, and (vi) the MSPP develops a comprehensive e-health policy that incorporates standards for biometrics and safeguards for data.

b) Limited capacity at the MSPP regional level for coordination and oversight of field interventions: Support to the MSPP regional offices has allowed multidisciplinary departmental teams to become increasingly involved in the follow up of SIMS visits as well as coaching activities and oversight of quality projects developed by the sites. This renewed support in FY18 will allow them to develop a district-level focus, which is still lacking in terms of coordination and monitoring of activities at the regional level. In addition, the regional offices will also take part in data validation at the sites level.

c) Lack of interoperability or integration among HIV information platforms limits information exchange and continuity of care: The bi-lateral arrangements currently supported for exchanging data between platforms have been too costly and labor intensive to be sustained on a permanent

basis. The recent addition of new information, such as viral load testing, has created an opportunity to incorporate lab data into the mix of longitudinal patient-level data. As part of an overarching strategy in FY18, the program will support the migration of proprietary platforms into Open MRS systems and align with interoperability standards (IHE). This will result in a single, interoperability layer to receive and send messages in a standard format from all platforms. This will, in the long run, create a more sustainable Health Management Information System.

d) The lack of hardware, software, manpower, and protocols for ensuring maintenance and security of information technology (IT) assets poses a threat to the integrity of data: The maintenance and security of IT and data assets have been chronically underfunded. This has caused frequent disruptions in the system and compromised data quality. The creation of a centralized help desk in COP16 has brought some improvements; nonetheless, materials and spare parts are needed to continue to make the efforts meaningful. Meanwhile, as the amount of individual information on patients increases, there is a need to increase security around storage and transmission of data. This will be achieved through the implementation of a security package consisting of: (i) firewalls, UPS, and routers to ensure encryption of data and filtering of incoming connection to the network, and (ii) setting up of group policies to filter links with the external world and prevent malware.

e) Data quality control has limited coverage and remains erratic: Ensuring data quality becomes increasingly vital for sustaining a well-calibrated response to epidemics. Relying only on partner reporting cannot substitute the support of an independent data validator that can help with standardization of interpretation of the indicators, training, and desk and field data validation. A new focus, which will also serve as a yardstick for the quality of data reported, will be ensuring that national data available on the HIV case-based longitudinal surveillance system (SALVH, Suivi Actif Longitudinal du VIH en Haïti) reflects site-level data and that discrepancies are resolved. These activities will be carried out through an MOH sub-contract.

f) Decrease in financial resources for HIV from external sources of funding: Support will be provided to MSPP to advocate for an increase in the budget allocated to HIV and the health sector overall. Workshops will be held with key ministries to review and select recommendations made in the Health Financing Strategy that will be utilized by the GOH to increase domestic financing for health.

6.2 Critical Systems Investments for Achieving Priority Policies

The overarching goal of the program is to achieve epidemic control of HIV in Haiti within the context of very limited availability of domestic resources and a steady decrease of external funding. It is thus critical to implement policies and efficient strategies that will facilitate the provision of ART to all individuals diagnosed with HIV soon after diagnosis while maintaining quality of care. PNLs adopted the Test and Start strategy, revised the national HIV care and treatment guidelines, and implemented the strategy and new models of service delivery starting in July 2016. The HTC guidelines were also revised concurrently. As detailed in tables 6.2.1 and 6.2.2, the following systems investments have been identified as determinant to a successful implementation of the aforementioned policies:

6.2.1 Test and Start

- a) Test and Start was adopted and implemented in FY16

- b) National rollout of viral load diagnosis capacity through the National Public Health Laboratory and GHESKIO is still ongoing in FY17 and will be completed during COP17/FY18
- c) Improving the quality of HIV diagnostic testing through implementation of the HIV Rapid Test Quality Improvement Initiative (RTQII) is an ongoing activity and will continue through COP17
- d) Supporting the External Quality Assessment program for HIV RDT EID/VL testing is an ongoing activity and will continue through COP17

6.2.2 New and Efficient Service Delivery Models

- a) Improving supply chain management capacity at the site level is an ongoing activity and will continue through COP17
- b) Revision of current national policies to adopt new models for services delivery (bi-annual clinical appointments for stable patients, VL for every patient, limited lab work at initiation and based on need; multi-month scripting and reporting tools modelled accordingly)
- c) Redefining the role of the selection committee to reduce the impact of non-medical criteria on ART enrollment
- d) National rollout of the PLR and patients unique identifier is an ongoing activity and will continue through COP17
- e) Prevention activities, focusing on risk avoidance, to reduce GBV, particularly among adolescent girls and young women.

6.3 Proposed system investments outside of programmatic gaps and priority policies.

The “other systems investments” category of activities from COP 2016 have been updated and, where possible, more accurately incorporated into the Table 6 programmatic gaps and key systems barriers outlined above. No activities were discontinued in COP 2016.

7.0 Staffing Plan

The PEPFAR Haiti team closely reviewed individual position descriptions, OGAC reporting requirements, and each agency's reporting requirements and needs to minimize duplication and ensure complementarity of efforts. The submitted staff footprint organizational structure will continue to allow both agencies to work collaboratively as we respond to requirements, identify potential performance issues, and actively review and analyze progress. The team also looked at the current approach to interagency collaboration in an effort to identify areas to consolidate activities and improve efficiency. We reviewed areas such as technical assistance to MSPP and other stakeholders, and the work currently being conducted by the GF.

Maintaining a strong link and healthy balance between solid business processes to ensure the timely and appropriate use of funds and providing technical guidance as part of a comprehensive partner management process is always a delicate juggle. The in-country team closely monitors partner target workloads, overall budget-code distribution, and staffing workload assignments to ensure there are strong administrative systems and the necessary resources to provide intra-agency partner management and technical support.

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

In order to better align with the PEPFAR business model and PEPFAR Haiti program priorities, USAID has identified three vacant positions to repurpose: the Program Support Officer will be repurposed to an HIV/AIDS Care and Treatment position, an Administrative Assistant position will be repurposed to a Budget Specialist position, and finally, the Health Team Lead position will be expanded to include a focus on gender, gender based violence, and KP HIV/AIDS programming.

At the present time, the PEPFAR Haiti team does have several vacancies to be filled. These positions became vacant over the past six to nine months, mainly due to devaluation of the HTG; 68.30 gourdes are now needed for 1USD compared to 43.75 gourdes in 2015. This resulted in decrease in spending power despite a salary raise last year. As the PEPFAR Program Locally Engaged Staff are paid in local currency, their purchasing power has diminished immensely and some have seen up to 30% loss in their salaries. This situation had resulted in many resignations and the Mission has been facing challenges in recruiting and retaining staff.

The PEPFAR Haiti Coordination office also has a TBD and is continuing the human resources process per the hiring freeze.

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

CDC's cost of doing business (CODB) increased by 1.4% between FY2017 to FY2018. This increase will allow us to cover costs related to CSCS, ICASS, ITSO and salary changes. USAID's FY2018 CODB request increased from FY17's historically low CODB (due to available M&O pipeline). The \$4.5 million request for COP17 is a decrease of 6% from COP15 and in line with actual M&O outlays.

APPENDIX A

SNU Prioritization and Percent ART Coverage, FY16 - FY18

Table A.1

| SNU | COP15 Prioritization | % ART Coverage, using FY16 APR Results* | COP16 Prioritization | % ART Coverage, using FY17 expected Results* | New COP17 SNU Classification[N CS(1)] | COP17 Prioritization | % ART Coverage, using FY18 Targets* |
|------------------------|-------------------------|---|-------------------------|--|--|---------------------------------|---|
| Cap Haïtien | Scale-Up: Saturation | 80% | Scale-Up: Saturation | 90% | unchanged | Scale-Up: Saturation | 100% |
| Croix des Bouquets | Scale-Up: Saturation | 52% | Scale-Up: Saturation | 94% | Greater Port- au-Prince | Scale-Up: Saturation | ** |
| Dessalines | Scale-Up: Saturation | 66% | Scale-Up: Saturation | 80% | unchanged | Scale-Up: Saturation | 90% |
| Gonaïves | Scale-Up: Saturation | 37% | Scale-Up: Saturation | 55% | unchanged | Scale-Up: Saturation | 80% |
| Léogâne | Scale-Up: Saturation | 34% | Scale-Up: Saturation | ** | Greater Port- au-Prince | Scale-Up: Saturation | ** |
| Les Cayes | Scale-Up: Saturation | 73% | Scale-Up: Saturation | 82% | unchanged | Scale-Up: Saturation | 95% |
| Môle Saint Nicholas | Scale-Up: Saturation | 24% | Scale-Up: Saturation | 38% | changed | Scale-Up: Aggressive | 40% |
| Port-au- Prince | Scale-Up: Saturation | 94% | Scale-Up: Saturation | ** | Greater Port- au-Prince | Scale-Up: Saturation | 108% |
| Port-de-Paix | Scale-Up: Saturation | 52% | Scale-Up: Saturation | 60% | unchanged | Scale-Up: Saturation | 80% |
| Saint-Marc | Scale-Up: Saturation | 73% | Scale-Up: Saturation | 80% | unchanged | Scale-Up: Saturation | 100% |
| Acul-du- Nord | Scale-Up: Aggressive | 168% | Scale-Up: Aggressive | 174% | changed | Scale-Up: Saturation | 200% |
| Aquin | Scale-Up: Aggressive | 58% | Scale-Up: Aggressive | 70% | unchanged | Scale-Up: Aggressive | 75% |
| Fort Liberté | Scale-Up: Aggressive | 61% | Scale-Up: Aggressive | 70% | unchanged | Scale-Up: Aggressive | 75% |
| Hinche | Scale-Up: Aggressive | 57% | Scale-Up: Aggressive | 65% | unchanged | Scale-Up: Aggressive | 68% |
| Jacmel | Scale-Up: Aggressive | 27% | Scale-Up: Aggressive | 45% | unchanged | Scale-Up: Aggressive | 50% |

| | | | | | | | |
|------------------------|-------------------------|------|-------------------------|------|-----------|---------------------------------|------|
| Jérémie | Scale-Up: Aggressive | 40% | Scale-Up: Aggressive | 60% | unchanged | Scale-Up: Aggressive | 65% |
| Lascahobas | Scale-Up: Aggressive | 58% | Scale-Up: Aggressive | 70% | unchanged | Scale-Up: Aggressive | 75% |
| Mirebalais | Scale-Up: Aggressive | 54% | Scale-Up: Aggressive | 65% | unchanged | Scale-Up: Aggressive | 70% |
| Ouanaminthe | Scale-Up: Aggressive | 23% | Scale-Up: Aggressive | 32% | unchanged | Scale-Up: Aggressive | 35% |
| Trou-du-Nord | Scale-Up: Aggressive | 73% | Scale-Up: Aggressive | 80% | changed | Scale-Up: Saturation | 100% |
| Anse-à-Veau | Sustained | 5% | Sustained | 8% | unchanged | Sustained | 10% |
| Anse d'Hainault | Sustained | 29% | Sustained | 33% | unchanged | Sustained | 35% |
| Arcahaie | Sustained | 25% | Sustained | 30% | unchanged | Sustained | 32% |
| Bainet | Sustained | 11% | Sustained | 14% | unchanged | Sustained | 14% |
| Borgne | Sustained | 51% | Sustained | 58% | unchanged | Sustained | 60% |
| Belle-Anse | Sustained | 10% | Sustained | 15% | unchanged | Sustained | 16% |
| Cerca la Source | Sustained | 24% | Sustained | 27% | unchanged | Sustained | 29% |
| Grande Rivière-du-Nord | Sustained | 67% | Sustained | 74% | unchanged | Sustained | 76% |
| Gros-Morne | Sustained | 24% | Sustained | 26% | unchanged | Sustained | 28% |
| La Gonâve | Sustained | 70% | Sustained | 75% | changed | Scale-Up: Aggressive | 75% |
| Limbé | Sustained | 51% | Sustained | 54% | unchanged | Sustained | 56% |
| Marmelade | Sustained | 8% | Sustained | 10% | unchanged | Sustained | 11% |
| Miragoane | Sustained | 143% | Sustained | 148% | changed | Scale-Up: Saturation | 150% |
| Plaisance | Sustained | 60% | Sustained | 63% | unchanged | Sustained | 66% |
| Port-Salut | Sustained | 41% | Sustained | 44% | unchanged | Sustained | 47% |
| Saint-Raphaël | Sustained | 34% | Sustained | 36% | unchanged | Sustained | 38% |
| Chardonnières | Centrally Supported | 0 | Centrally Supported | | unchanged | Centrally Supported | |
| Corail | Centrally | 0 | Centrally | | unchanged | Centrally | |

| | | | | | | | |
|---------------------|---------------------|---|---------------------|--|-----------|---------------------|--|
| | Supported | | Supported | | | Supported | |
| Saint Louis du Nord | Centrally Supported | o | Centrally Supported | | unchanged | Centrally Supported | |
| Vallières | Centrally Supported | o | Centrally Supported | | unchanged | Centrally Supported | |

*Calculations of % ART coverage used the number of PLHIV by SNU from the Small Area Estimates, OGAC, 2015.

**See the % listed for "Greater Port-au-Prince" in the same column, above.

| Table A.2 ART Targets by Prioritization for Epidemic Control | | | | | | |
|---|--------------|------------------------------------|---|---|--|-----------------------|
| District | Total PLHIV* | Expected current on ART (APR FY17) | Additional patients required for 80% ART coverage | Target current on ART (APR FY18) <i>TX_CURR</i> | Newly initiated (APR FY18) <i>TX_NEW</i> | ART Coverage (APR 18) |
| Attained | | | | | | |
| Scale-Up Saturation | 80,618 | 71,211 | 0 | 83,522 | 21,560 | 104% |
| Scale-Up Aggressive | 27,244 | 14,512 | 7,283 | 15,558 | 2,527 | 57% |
| Sustained | 25,787 | 7,868 | 12,761 | 8,335 | 1,236 | 32% |
| Central Support | 6,241 | 0 | | | | |

* This total does not include estimates for two districts that are not supported by PEPFAR

APPENDIX B

B.1 Planned Spending in 2017

| Applied Pipeline | New Funding | Total Spend |
|------------------|--------------|---------------|
| \$15,600,000 | \$85,900,000 | \$101,500,000 |

| PEPFAR Budget Code | Budget Code Description | Amount Allocated |
|--------------------|--------------------------------------|----------------------|
| HBHC | Adult Care and Support | \$6,787,309 |
| HKID | Orphans and Vulnerable Children | \$10,836,439 |
| HLAB | Lab | \$3,842,420 |
| HTXS | Adult Treatment | \$28,248,100 |
| HTXD | ARV Drugs | \$14,156,739 |
| HVCT | Counseling and Testing | \$8,792,079 |
| HVMS | Management & Operations | \$7,189,832 |
| HVOP | Other Sexual Prevention | \$2,054,791 |
| HVSI | Strategic Information | \$3,540,165 |
| HVTB | TB/HIV Care | \$2,678,948 |
| IDUP | Injecting and Non-Injecting Drug Use | \$0 |
| MTCT | Mother to Child Transmission | \$4,550,000 |
| OHSS | Health Systems Strengthening | \$3,205,494 |
| PDCS | Pediatric Care and Support | \$1,213,152 |
| PDTX | Pediatric Treatment | \$3,799,532 |
| HVAB | Abstinence/Be Faithful | \$605,000 |
| TOTAL | | \$101,500,000 |

B.2 Resource Projections

- To develop the COP17 budget, the PEPFAR Haiti team utilized all aspects of the PBAC and the FY16 EA data in coordination with the EA advisors. Building on the work that was done for COP15 and COP16, the team, with the assistance of the EA advisor, further revised the unit expenditures (UEs) with the new information available and the programmatic shifts planned. *[REDACTED]*

Table 6.1.1 Key Programmatic Gap #1: Challenges to reach treatment coverage and retain PLHIV on ART nationally and in some specific arrondissements (districts)

| Key Systems Barrier | Outcomes expected after 3 years of investment | Year One (COP/ ROP16) Annual Benchmark | Year Two (COP/ ROP17) Annual Benchmark | Relevant Indicator or Measurement Tool | Proposed COP/ROP 2017 Activities | Budget Code(s) | Activity Budget Amount | Implementing Mechanism | Relevant SID Element and Score (if applicable) |
|---|--|---|--|--|--|------------------------|---------------------------|--------------------------------------|--|
| 1. High level of attrition among patients initiating ART on average with excess level in some subgroups, and limited capacity for service delivery targeted to young girls under 14 and youth aged 15 to 30 | 1. Community health tracking system expanded nationally 2. New service delivery model using community distribution of ARVs implemented at 100% of ART sites 3. Modification/adjustments of EMRs to accommodate the new services delivery model completed by the end of Q1 of COP 16 4. 50% reduction in attrition among patients initiated on ART 12 months prior | - Patient Linkage and Retention (PLR) system rolled out at priority 80 sites - 1,000 Community Health Workers (CHW) trained on the use of tablets for tracking patients and distribution of drugs at community level - 80 social workers (1 SW/site) trained on use of the interface and assignment of work to | - System rolled out at 48 additional sites - An additional 3,000 CHW trained - An additional 120 SW trained | - No of patients tracked - % of patients tracked who resumed services and remained active | Activity 1: Through specialized TA provide training and mentoring for care providers to improve quality of services in the overall clinical cascade from HIV diagnosis to viral suppression; develop related policy guidance and procedures ; and support the use of related data at CDC-supported sites | HVCT, HTXS | \$300,000 | NASTAD | (7) Human Resources for Health |
| | | - Updated version of iSante with multiple features for support and reporting on Multi-Month Scripting (MMS) and Community-Based Drug Distribution (DAC) <i>Baseline analysis on prescribing patterns</i> | - Development of a dynamic monitoring system , including alerts for providers and training of providers for analysis - Progress report after full year of enhanced support | - Updated version of EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | Activity 2a: Adjust EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | HVSI, OHSS, HVCT, HTXS | \$300,000 | ITECH | (6) Service Delivery |
| | | - Updated version of GHESKIO EMR with multiple features for support and reporting on Multi-Month Scripting (MMS) and Community-Based Drug Distribution (DAC) | - Updated version of GHESKIO EMR with multiple features for support and reporting on Multi-Month Scripting (MMS) and Community-Based Drug Distribution (DAC) | - Updated version of EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | Activity 2b: Adjust EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | HVSI | \$125,000 | GHESKIO | (6) Service Delivery |
| | | - Updated version of PIH EMR with multiple features for support and reporting on Multi-month Scripting (MMS) and Community-Based Drug Distribution (DAC) | - Updated version of PIH EMR with multiple features for support and reporting on Multi-month Scripting (MMS) and Community-Based Drug Distribution (DAC) | - Updated version of EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | Activity 2c: Adjust EMR to support new approaches including multi-month scripting (MMS) and community-based service delivery (DAC) | HVSI, HTXS, HBHC | \$240,000 | PIH | (6) Service Delivery |
| | | - Module piloted at 20 sites for development of materials on counseling of patients and contacts as well as training materials for staff, establishment of workflow, development of indicators for monitoring | - Module expanded at all priority sites | - % of Index Patients who give access to contacts | Activity 3: Through specialized TA develop a module for tracking of index patients' contacts , which involve training of psychosocial teams, and community health agents | HVCT | \$220,000 | NASTAD | (7) Human Resources for Health |
| | | - Expansion of follow up for pregnant women 24 month after initiation of treatment | - % of pregnant women on prophylaxis - Retention of pregnant women after 12 and 24 month of treatment | Activity 4: Development of standardized tools for case management of pregnant women that enable longitudinal tracking of pregnant women throughout the different wards with emphasis on initiation of treatment | MTCT, PDTX | \$300,000 | NASTAD | (6) Service Delivery | |
| | | - Evaluation results published by the end of COP17 | - Evaluation results published during implementation of COP17 | Activity 5: Evaluation of community-based initiatives and community drug distribution (DAC) | HTXS | \$260,000 | ITECH | (6) Service Delivery | |
| | | - Evaluation results published during implementation of COP17 | - Evaluation results published during implementation of COP17 | Activity 6: Evaluation of the effectiveness of PLR in its capacity to track patients and help maintain them in services | HTXS | \$200,000 | NASTAD | (6) Service Delivery | |
| 2. Absence of a unique patient identifier system to facilitate patient follow-up across the program | 1. Development and implementation of a unique patient identifier system using biometrics and integration into EMR is completed 2. 100% of facilities providing HIV treatment services use the unique patient identifier system 3. 50% reduction in the proportion of silent transfers reduced by the end of COP 16 | - Functional National Integrated Health Record to support clinical care and ensure that every patient is represented only once, and with constant demographic identification | - % of duplicates files found each year | Activity 1: MOH establish a formal nationwide HIV referral system , including a modified registration process for patients that eliminate duplicates | OHSS | \$200,000 | MSPP/UGP | (6) Service Delivery | |
| | | - Evaluation results published during implementation of COP17 | - Evaluation results published during implementation of COP17 | Activity 2: Evaluation of Biometric Code effectiveness | HVSI | \$100,000 | MSPP/UGP (to subcontract) | (6) Service Delivery | |
| 3. Limited number of trained staff on HIV care and treatment services including TB and HIV information system, particularly in some saturation arrondissements due to high staff turnover | 1. Task-sharing policy developed and validated by the MOH 2. Training of 50 nurse practitioners and pediatric nurse practitioners to cover the needs, particularly in remote and underserved areas 3. HIV care and treatment training/refreshers training on revised guidelines for providers at 100% of ART sites | - Group of 20 PMTCT Case managers | - Group of 20 PMTCT Case managers | Activity 1: Resume training for PMTCT case managers to staff priority districts and make up for high staff turn over | OHSS | \$80,000 | ITECH | (7) Human Resources for Health | |
| | | - Update existing curriculum and trainers - Carry out the 6 month training sessions (classroom and practicum for group of 30 nurses) | - Update existing curriculum and trainers - Carry out the 6 month training sessions (classroom and practicum for group of 30 nurses) | Activity 2: Resume training for nurse practitioners | OHSS | \$100,000 | ITECH | (7) Human Resources for Health | |
| | | - Update existing curriculum and trainers - Carry out the 6 month training sessions (classroom and practicum for group of 30 nurses) | - Update existing curriculum and trainers - Carry out the 6 month training sessions (classroom and practicum for group of 30 nurses) | Activity 3: Resume training pediatric nurse | OHSS | \$60,000 | ITECH | (7) Human Resources for Health | |
| | | - ASCP are able to perform HTC index testing and partner index testing | - ASCP are able to perform HTC index testing and partner index testing | Activity 4: Revision of ASCP manual to reflect expanded role in HIV service delivery | OHSS | \$150,000 | HFG | (7) Human Resources for Health | |
| 4. Limited availability of population level epidemiological data down to the district level and low national analytic capacity | 1. DHS conducted 2. ANC survey conducted 3. HIA conducted 4. HASS analysis completed 5. KP PLACE and size estimation completed 6. MSPP staff analytics capacity built 7. OVC size estimate conducted 8. Mapping of young girls' and adolescents' partners conducted | - Preliminary data expected for May 2017; final report expected Q4 | - Preliminary data expected for May 2017; final report expected Q4 | Completed Activity 1: Conduct DHS | HVSI | \$0 | ICF MACRO | (13) Epidemiological and health data | |
| | | - Field work for SPA completed to include mapping of all health facilities and CHWs in surrounding catchment areas; preliminary report completed | - Field work for SPA completed to include mapping of all health facilities and CHWs in surrounding catchment areas; preliminary report completed | Activity 2: Conduct SPA (funded with non-PEPFAR monies) | HVSI | \$0 | ICF MACRO | (13) Epidemiological and health data | |
| | | - Field work conducted | - Final report | Activity 3: Conduct ANC survey (to be funded with COP16 funds) | HVSI | \$0 | MSPP/UGP (subcontract) | (13) Epidemiological and health data | |

| | | | | | | | | |
|--------------|--|---|---|---|------|-------------|--------------------|--|
| | - Protocol developed | - Final report | | Activity 4: Conduct HIA | HVSI | \$0 | HQ funded | (13) Epidemiological and health data |
| | - Surveillance data expanded beyond demographics to incorporate care and treatment information coming from all three EMRs - Analytical software mastered in-country and performing preliminary surveillance reports | - Surveillance Interface (SALVH) fully operational and generating customized reports and analysis - Deduplication process initiated at the field level to resolve silent transfers, medical shopping | - % of duplicates files found each year | Activity 5: Reinforce Data Repository (SALVH) and develop policies across the board for data security, data deduplication, sharing, and use | HVSI | \$300,000 | NASTAD | (13) Epidemiological and health data |
| | - Final Report | | | Completed Conduct the PLACE study and estimate the size of the key populations | HVSI | | | (13)- Epidemiological and health data |
| | | - Epidemiologic profile by SNU level - Performance monitoring by SNU level - Data available for future projections | | Activity 6: Provide training to MOH staff to increase their analytic skills, including use of census, surveillance and M&E data, and SNU-level analysis | HVSI | \$80,000 | MSPP/UGP | (7) Human Resources for Health |
| | | - Epidemiologic profile by SNU level - Performance monitoring by SNU level - Data available for future projections | | Activity 7: Provide training to MOH staff to increase their analytic skills | HVSI | \$100,000 | HIS | (7) Human Resources for Health |
| | - Design plan for survey in place | - Preliminary results available and shared with MSPP | | Activity 8: Estimate size of orphans and vulnerable children population | HKID | \$250,000 | US Census Bureau | (13) Epidemiological and health data |
| | - Mapping of young girls' and adolescents' sexual partners in select priority SNUs to better understand the risks | - Preliminary results available and shared with MSPP | | Activity 9: Conduct partner mapping for young women and adolescents | HKID | \$300,000 | MEASURE Evaluation | (13) Epidemiological and health data |
| TOTAL | | | | | | \$3,665,000 | | |

| Table 6.1.2 Key Programmatic Gap #2: Unknown (very limited) number/proportion of people enrolled and active on ART who have achieved viral suppression | | | | | | | | | |
|--|--|---|---|--|---|--|------------------------|------------------------|---|
| Key Systems Barrier | Outcomes expected after 3 years of investment | Year One (COP/ ROP16) Annual Benchmark | Year Two (COP/ ROP17) Annual Benchmark | Relevant Indicator or Measurement Tool | Proposed COP/ROP 2017 Activities | Budget Code(s) | Activity Budget Amount | Implementing Mechanism | Relevant SID Element and Score (if applicable) |
| 1. Limited viral load diagnosis capacity centralized at the national public health laboratory and GHESKIO | <p>1. All patients on ART have at least one viral load monitoring per year and 100% of patients newly initiated on ART have viral load monitoring at 6 and 12 months</p> <p>2. A confirmatory VL test for patients who had virologic failure at their first VL test and received subsequent intensive adherence counseling within 3 months after the 1st VL test</p> <p>3. Decentralization of VL testing for hard to reach sites using existing in country equipment for near POC VL completed (assuming validation of technology completed)</p> <p>4. Responsibility for the maintenance and repair services of the PEPFAR laboratory equipment transferred to National Lab Technicians of the MSPP</p> <p>5. Reduce turnaround time for early infant diagnosis particularly in hard to reach departments in the north and south</p> | - Technical assistance provided to national lab to develop laboratory asset management strategy - 100% of ART patients (about 80,000) receiving VL tests and 9,000 EID test performed | - 100% VL testing coverage for ART patients | - TX_PVLS | Activity 1a: Expansion of VL testing capacity through the LNSP lab to reach 100% VL test coverage for all ART patients (104, 103) and 9,000 EID tests | HLAB HBHC | \$300,000 | MSPP/JGP (LNSP) | (10) Laboratory |
| | | Activity 1b: Expansion of VL testing capacity through the GHESKIO lab to reach 100% VL test coverage for all ART patients (104,103) and 9000 EID tests | HLAB HBHC | \$200,000 | GHESKIO | (10) Laboratory | | | |
| | | Activity 2: Provide TA for VL roll out and ensure providers and PLHIV are properly trained and that VL results are used for clinical management | HBHC, HLAB | \$350,000 | EQUIP | (10) Laboratory | | | |
| | | Activity 3: Develop and provide a VL assistance package to the MOH, LNSP, the providers and the lab technicians including: the revision of national norms, training curriculum and training sessions, and modification of EMR to accommodate VL | HLAB HBHC | \$265,500 | ITECH | (10) Laboratory | | | |
| | | Activity 4: Conduct costing and optimization analysis of decentralization of lab testing (VL and EID) and provide TA at sites implementing it once validated | HBHC, HLAB | \$150,000 | EQUIP | (10) Laboratory | | | |
| | | Activity 5: Technical assistance to the MOH to enhance laboratory equipment management and quality of lab services by providing training and mentorship on maintenance and repair services to the LNSP technicians | HTXS, PDTX, HLAB | \$100,000 | Global Health Supply Chain – Procurement Supply Management (GHSC) | 8. Commodity Security and Supply Chain | | | |
| | - Supply chain advisor embedded at national laboratory | - Key lab commodities available | | | Activity 6: Support implementation of POC EID testing and provide TA at sites implementing it | MTCT, PDTX | \$150,000 | CARIS | (6) Service Delivery |
| | | - POC EID testing validated | | | | | | | |
| 2. Currently there are two parallel specimen referral networks (SRN), one for EID which is fully supported by PEPFAR (specimen from all sites to IMIS and LNSP) and the second one for CD4, VL, TB and surveillance supported in the past by USG non-PEPFAR fund | <p>1. Integrated specimen referral system implemented to achieve</p> <p>a) 50% Reduction in cost over 3 years</p> <p>b) 30% reduction in turnaround time</p> <p>c) 50% reduction in the proportion of specimen rejected</p> <p>2. Single specimen tracking system developed and implemented at LNSP</p> | - Fully functional SRN and 100% transport of samples to LNSP and GHESKIO as planned and scheduled | - 100% of SRN route data analysis completed - Optimal route determined , SOPs created and implemented nationally - Cost analysis of the different strategies to transport specimen across the country based on existing model, and cost saving analysis completed and evidence-based decision is made to evaluate the SRN system | - % of SRN route data analyzed and optimized | Activity 1: Mapping and reorganizing the SRN based on distance and shorter route from peripheral labs to LNSP and IMIS and conduct SRN route analysis to identify gap and challenges | HBHC PDCS HTXS | \$350,000 | MSPP/JGP (LNSP) | (10) Laboratory |
| 3. Limited knowledge on primary and secondary HIV drug resistance prevalence in the country to inform Haitian public health guidelines on quality of HIV care and treatment | 1. Survey on HIV drug resistance prevalence and mutations patterns completed | - HIV DR data analysis from patients with 2 consecutive VL >1000 copies/mL completed, and shared with stakeholders and disseminated | - PDR and ADR protocols developed and approved - Survey plans are developed and clinical and lab staff involved in the survey are trained | - Nationally representative PDR and ADR available to inform care and treatment decision and policy revisions | Activity 1: Develop protocols and conduct regular PDR and ADR surveys using nationally representative sampling based on WHO methodologies and obtain relative institutional ethical approvals and plan activities to conduct the surveys | HLAB | \$150,000 | MSPP/JGP (LNSP) | (10) Laboratory |
| 4. Limited Laboratory Information System (LIS) capability for specimen tracking, data collection, analysis, and reporting for timely and accurate results dissemination | <p>1. Decrease the turnaround time for VL and EID results to one week</p> <p>2. Improve data quality and specimen tracking</p> <p>3. Decrease data entry error rates by 100% by interfacing the LIS with Abbott and open MRS</p> <p>4. Generate quarterly reports on number of patients tested and level of virologic suppression</p> | - SCC is fully implemented at LNSP - Structure of integrated SCC and iSante is fully mapped | - Integration of SCC and iSante is completed and functional - Key clinical and lab indicators are reported by the integrated system | - Percent of results entered in EMR by LIS | Activity 1: Install the SCC LIS at LNSP, IMIS and ensure linkage of SCC to EMR. Develop system for urgently returning high VL results (defined as viral load greater or equal to 1000 copies/ml) to ART sites and actions needed to be taken by clinician | HLAB, HVSJ | \$200,000 | MSPP/JGP (LNSP) | (10) Laboratory, (7) Human Resources for Health |
| | | | | | Activity 2: Allow EMR to link to SCC by developing its module for data exchange | HLAB, HVSJ, PMTCT, PDTX | \$100,000 | ITECH | (10) Laboratory |
| | | | | | Activity 3: Integration of lab testing instrument into SCC system such as VL and EID | HLAB, HVSJ, PMTCT, PDTX | \$100,000 | MSPP/JGP (LNSP) | (13) Epidemiological and health data |
| | | | | | Activity 4: Train lab technicians to effectively use the system | | \$50,000 | MSPP/JGP (LNSP) | (7) Human Resources for Health |
| | | | | | Activity 5: Regular monitoring of VL data quality and generating reports for program evaluation | HLAB, HVSJ | \$150,000 | EQUIP | (13) Epidemiological and health data |
| | | | | | Activity 6: Regular monitoring of EID data quality and generating reports for program evaluation | MTCT | \$100,000 | CARIS | (13) Epidemiological and health data |
| TOTAL | | | | | | | \$2,715,500 | | |

Table 6.1.3 Key Programmatic Gap #3: Limited capacity in the areas of governance, management, and regulation hinders implementation and oversight of policy; and inadequate capacity for health information integration, security, and exchange.

| Key Systems Barrier | Outcomes expected after 3 years of investment | Year One (COP/ ROP16) Annual Benchmark | Year Two (COP/ ROP17) Annual Benchmark | Relevant Indicator or Measurement Tool | Proposed COP/ROP 2017 Activities | Budget Code(s) | Activity Budget Amount | Implementing Mechanism | Relevant SDG Element and Score (if applicable) |
|--|---|---|--|---|---|----------------|--------------------------------|---|--|
| 1. Limited human resources within MOH to develop and implement policy that supports epidemic control | <p>1. 90% of HIV patients identified within the treatment system are on ART in accordance with the National Norms</p> <p>2. The lead time to put new Patients on ART does not exceed one month after contact with a site for 90% of patients within the system</p> <p>3. 90% of stable ART patients are on 3 months or more supply of drugs</p> <p>4. 40% of Patients are supplied within their community</p> <p>5. Standardized HIV indicators and tools validated by MOH used at 100% of ART sites (both PEPFAR and GF sites)</p> <p>6. Improved allocation and retention of human resources for HIV service delivery</p> | <p>- National guidelines are available and widely distributed on Test and Start, Multi-Month Scripting, and Community Drug Distribution</p> <p>- Training curriculum updated to include these new approaches and training sessions tailored accordingly</p> <p>- 100% of "pre-ART population" on ART treatment</p> <p>Moved from outcomes and completed Guidelines updated and Policy Memo released by July 2016 to embrace Test and Start and accompany changes in service models</p> <p>- National consensus reached on new service model operationalization and related service models and implemented at all ART sites</p> | <p>- MOH carries regular data-driven reviews of new policies</p> <p>- MOH reorganize planning of HIV around districts instead of departments to facilitate achievement of saturation objectives including partner forums at the district level</p> | <p>- % prescription with interval at 3 month or more</p> <p>- % of active patients supplied at community level and adherent compared to facility level</p> <p>- % of quality project with successful outcome</p> | Activity 1: Create through MOH central a policy package for new approaches and initiatives such as Test and Treat , Multi-month Scripting and Community Drug Distribution, District-based planning including revision and dissemination of testing and treatment guidelines, partner consensus meetings | OHSS, HVSI | \$245,000 | MSPP/UGP | (2) Policies and Governance |
| | | <p>- MOH makes revised information tools incorporating new data requirements available to all HIV implementers after having chaired the validation process</p> | <p>- MOH makes revised information tools incorporating new data requirements available to all HIV implementers after having chaired the validation process</p> | <p>Activity 2: MOH ensures adjustment standardization of all information tools to support shift in service by editing, printing and distributing revised information tools (forms, log and registers)</p> | HVSI | \$200,000 | MSPP/UGP | (13) Epidemiological and health data | |
| | | <p>- HEALTH/QUAL program expanded to all 128 sites with package of coaching activities, Regional and National forum, and quality improvement projects</p> | <p>- Integrated Web Heal/Qual platform developed and allows sites and the Ministry to monitor improvement or lack there of in service quality,</p> <p>- Ongoing coaching and mentoring activities for continuous quality improvement at all 128 sites</p> | <p>Activity 3: Reinforce Quality assurance and Quality Improvement (HEALTH/QUAL) by incorporating new indicators and benchmarks related to new approaches and Tracking outcomes. Continue to support: (i) MOH's leadership in the activity (ii) expansion to all sites (iii) training of regional coaching teams and local quality circles</p> | HVSI | \$450,000 | MSPP/UGP | (9) Quality Management;(13) Epidemiological and health data; (7) Human Resources for Health | |
| | | <p>- Positions filled at MOH (National AIDS coordinating unit) for Senior Care and Treatment Specialist, Senior M&E specialist, Senior PMTCT Specialist, Senior TB/HIV Specialist</p> | <p>- Positions filled at MOH (National AIDS coordinating unit) for Senior Care and Treatment Specialist, Senior M&E specialist, Senior PMTCT Specialist, Senior TB/HIV with addition HIV Information System Specialist Specialist</p> | <p>Activity 4a: Support the hiring of senior contractuals to fill key positions at critical MOH units involved in the planning and implementation of the HIV program such as PNLs (HIV Coordination) , DSF (PMTCT Coordination), TB/HIV</p> | HTXS, OHSS | \$245,000 | MSPP/UGP | (2) Policies and Governance | |
| | | | <p>- Positions filled at MOH</p> | <p>Activity 4b: Support the hiring of senior contractuals to fill key positions at critical MOH units involved in the planning and implementation of the HIV program such as UPE</p> | HVSI | \$100,000 | HIS | (2) Policies and Governance | |
| | | <p>- Quarterly reporting on grants' progress and engagement of various sectors in the country responses to the diseases</p> | <p>- Oversight guidelines and reporting tools for community-based oversight are finalized</p> | <p>Activity 5: Strengthen the capacity of the CCM to manage grant implementation and engage CBOs in the oversight process</p> | OHSS | \$250,000 | HFG | (3) Civil Society Engagement | |
| | | <p>- SNADI central coordination unit (CU) members and departmental logistics advisors hired; office space created and set up at central level to support CU operations; SNADI members participate in the bidding and contracting process for local private sector distribution companies</p> | <p>- SNADI staff oversee and coordinate national distribution of essential medicines</p> | <p>Activity 6: Technical Assistance to the MOH to implement its plan for the creation of the National Unified Supply Chain System by financing/embedding consultants to a newly created coordination unit</p> | OHSS | \$100,000 | Global Health Supply Chain PSM | (8) Commodity Security and Supply Chain | |
| | | <p>- Revise and standardize all primary care registers and reporting forms; 134 sites reporting accurate and on time data</p> | <p>- Interoperability for MESI and SISNU and MSPP dashboards with all data accessible</p> | <p>Activity 7: Technical Assistance to the MOH to fast track the implementation of the National Unified Information System (SISNU) by financing implementation at the MOH/UEP unit</p> | OHSS | \$450,000 | HIS | (7) Human Resources for Health | |
| | | | <p>- National policy on e-health drafted</p> | <p>Activity 8: Support MSPP in developing a comprehensive e-health policy that incorporates standards for biometrics and safeguards for data</p> | OHSS | \$150,000 | HIS | (2) Policies and Governance | |
| 2. Decrease in financial resources for HIV from external sources of funding | <p>1. Increase of domestic financial resources for HIV by 10%</p> <p>2. Increased budget transparency around GOH domestic budget for HIV</p> | <p>- Health Financing Strategy drafted and validated with MSPP</p> | <p>- Workshop held with key ministries to review recommendations made in the Health Financing Strategy and select those that will be utilized by GOH to increase domestic financing for health</p> | | Activity 1: Adopt and implement broader Health Financing Strategy ; support MSPP to advocate for an increase in the budget allocated to HIV and health sector overall | OHSS | \$100,000 | HFG | (11) Domestic Resource Mobilization |

| | | | | | | | | | |
|---|--|--|--|--|--|------------|-------------|-------------------------------------|--|
| 3. MOH departmental (DD) level's lack of capacity to coordinate and oversee field interventions, slows down scale up, and does not foster harmonization and quality of services | 1. Test and Treat policy is implemented at 100% of ART sites 2. New models of services rolled out at 100% of priority districts 3. Program and service quality objectives (as evidenced by MER indicators and 50% reduction in red (SIMS)) are met as a result of DD staff participating in SIMS and HealthQual coaching 4. Integrated health information system based on the DHIS2 platform(SISNU) deployed and available at all health facilities | 1. Test and Treat policy is implemented at 100% of ART sites 2. New models of services rolled out at 100% of priority districts 3. Program and service quality objectives (as evidenced by MER indicators and 50% reduction in red (SIMS)) are met as a result of DD staff participating in SIMS and HealthQual coaching 4. Integrated health information system based on the DHIS2 platform(SISNU) deployed and available at all health facilities | - Multidisciplinary departmental team held to a standard of 1 visit/site/quarter - Districts have annual operational plan - SIMS problems are acted upon | - % of sites visited quarterly by departmental team - % of districts with annual operational plan | Activity 1: Sustain the hands-on support provided by selected Departmental Directorates to the scale-up services , and the shift toward new models of services by enabling them to perform regional partner forum, regular site supervision, and community mobilization | OHSS | \$500,000 | MSPP/UGP | (6) Service Delivery; (1) Planning and Coordination |
| | | | - Sites are visited once a quarter by M&E departmental team who share the burden with the central mechanism | | Activity 2: Support Desk and Field Data Validation through Regional M&E officers | HVSI | \$245,000 | MSPP/ UGP | (13) Epidemiological and health data; (15) Performance Data |
| 4. Lack of interoperability or integration among HIV information platforms jeopardizes information exchange and continuity of care | 1. All platforms comply to open architectures and interoperability standards (IHE) 2. Existence of a national shared electronic health records system fed by the 3 EMR 3. Patients level system directly linked to aggregate system, and reports are generated automatically without human intervention in order to minimize reporting errors. Patients' health information data readily available to authorized end users to support patients' care, program management, and decision making. | - An instance of the national web-based reporting system (MESI/SALVH) including forms and reports is developed in open systems | - System is piloted and rolled out at all sites including debugging and training sessions | - % of patients with data consolidated into a unique file (demographic, clinical) | Activity 1a: Migration of proprietary platforms into Open MRS systems to facilitate openness and tapping of existing community of developers | HTXS, HVSI | \$300,000 | MSPP/UGP (Subcontract to SOLUTIONS) | (7) Human Resources for Health |
| | | - An instance of the National Electronic Medical Record (ISante) including forms and reports is developed in open systems | - System is piloted and rolled out at all sites including debugging and training sessions | - % of sites with audited data matching reported data | Activity 1b: Migration of proprietary platforms into Open MRS systems to facilitate openness and tapping of existing community of developers. | HTXS, HVSI | \$360,000 | ITECH | (6) Service Delivery |
| | | - Data transfer modules developed by SOLUTIONS for connection of MESI/SALVH to the 3 EMR, PLR and COMCARE | - Data transfer modules developed by SOLUTIONS for connection of MESI/SALVH to LIS, and SISNU - SOLUTIONS leads the Health Information Exchange (HIE) effort, which will result into a single Interoperability layer to receive and send messages in a standard format from all | - Average number of downtime per unit (site, national server) | Activity 2a: Development of data transfer modules by each platform to ensure interoperability including mapping of data elements, writing of scripts for exchange, piloting and roll out of module | HTXS, HVSI | \$100,000 | MSPP/UGP (Subcontract to SOLUTIONS) | (6) Service Delivery |
| | | - Data transfer modules developed by FUTURES GROUP for connection of COMCARE to MESI/SALVH | Data transfer modules developed by FUTURES GROUP for connection of SISNU to MESI/SALVH | | Activity 2b: Development of data transfer modules by each platform to ensure interoperability including mapping of data elements, writing of scripts for exchange, piloting and roll out of module | HTXS, HVSI | \$100,000 | HIS | (6) Service Delivery |
| | | - Data transfer modules developed by ITECH for connection of iSante to PLR, National Lab Information System (LIS) , MESI/SALVH. | - ITECH Powered platform becomes part of the Health Information Exchange | | Activity 2c: Development of data transfer modules by each platform to ensure interoperability including mapping of data elements, writing of scripts for exchange, piloting and roll out of module | HTXS, HVSI | \$100,000 | ITECH | (6) Service Delivery |
| 5. Lack of hardware, software, manpower and protocols for ensuring maintenance and security of IT assets poses a threat to the integrity of data | 1. Data replication interruptions do not extend beyond 1 month, regardless of the cause (hardware, software etc) 2. Electronic Data collection and transmission is seamless and not affected by absence of Internet at any site. | - Help Desk fully operational and have procedure in place for receiving and answering requests from sites - Local area network (LAN) expanded to 40 remaining sites | - Local field data personnel trained in basic troubleshooting and maintenance at all sites - Minimal stock of spare parts are maintained available | - % of patients with data consolidated into a unique file (demographic, clinical) - % of sites with audited data matching reported data | Activity 1: Maintenance of the IT infrastructure for the entire PEPFAR network in the form of Support Help Desk and Intervention teams, hardware and software acquisition, installation, troubleshooting and repair | HTXS, HVSI | \$500,000 | MSPP/UGP | (15) Performance Data |
| | | - National server upgraded to support data from all applications: MESI, SALVH, ISANTE, BIOMETRIC CODING, PLR, SISENSE, COMMCare | - Adequate redundancy measures in place through mirroring of the national server to anticipate losses of information in case of system crashes | - Average number of downtime per unit (site, national server) | Activity 2: National server upgraded in hardware, software and licensing to support storage and transmission of data for all applications | HTXS, HVSI | \$200,000 | MSPP/UGP | (15) Performance Data |
| | | - 70 sites have a security package consisting of : (1) firewall, ups, routers to ensure encryption of data and filtering of incoming connexion to the network (2) setting up of group policy to filter linkages to external to prevent malware | - 60 remaining sites have the security package | | Activity 3: Enhanced security measures for the IT System both at central and peripheral level including firewalls, encryption | HTXS, OHSS | \$100,000 | MSPP/UGP | (15) Performance Data |
| 6. Data quality control has limited coverage and remains erratic | 1. Availability of quality and accurate data in a timely manner to authorize end users to support patients' care, program management, and decision making. | | - High volume sites receive at least 1 visit per quarter and low volume site 1 per semester | - % of patients with data consolidated into a unique file (demographic, clinical) - % of sites with audited data matching reported data - Average number of downtime per unit (site, | Activity 1: Reinforce mechanisms for independent validation of site data including desk validation and regular site visits to all 128 sites | HVSI, OHSS | \$400,000 | MSPP/UGP (to subcontract) | (9) Quality Management |
| TOTAL | | | | | | | \$5,195,000 | | |

| Table 6.2.1: Test and START | | | | | | | | | |
|--|--|---|--|---|--|----------------------|------------------------|------------------------|---|
| Key Systems Barrier | Outcomes expected after 3 years of investment | Year One (COP/ ROP16) Annual Benchmark | Year Two (COP/ ROP17) Annual Benchmark | Relevant Indicator or Measurement Tool | Proposed COP/ROP 2017 Activities | Budget Code(s) | Activity Budget Amount | Implementing Mechanism | Relevant SDG Element and Score (if available) |
| 1. Current national HIV care and treatment guidelines recommend ART initiation at CD4 ≤ 500 for adults and adolescents | 1. The revision National HIV care and treatment guidelines for adolescents and adults is completed and recommend TEST and START for all patients diagnosed HIV positive regardless of WHO stages or CD4 count | - 100% of ART providers have attended HIV care and treatment refresher trainings on the newly revised guidelines | | | completed Activity 1: Provide technical and financial assistance to National AIDS control program for the revision of the national HIV care and treatment guidelines according to the new TEST and START WHO guidelines | HTXS | See table 6.1.3 | UGP | (2) Policies and Governance |
| | | | | | completed Activity 2: Provide technical and financial assistance to National AIDS control program for the revision of the national HTS guidelines according to the WHO HTS guidelines | HTXS | See table 6.1.3 | UGP | (2) Policies and Governance |
| | | | | | Activity 1: Provide refresher training for health providers on the new guidelines (care and treatment and HTS guidelines) | HTXS | See table 6.1.1 | UGP, I-TECH EQUIP | (7) Human Resources for Health |
| 2. Limited viral load diagnosis capacity centralized at the national public health laboratory and GHESKIO | 1. Viral Load test capacity is expanded nationally. 2. All patients on ART have at least one viral load monitoring per year and 100% of patients newly initiated on ART have viral load monitoring at 6 and 12 months. 3. A confirmatory VL test for patients who had virologic failure at their first VL test and received subsequent intensive adherence counseling within 3 months after the 1st VL test 4. Decentralization of VL testing for hard to reach sites using existing in country equipment for near POC VL completed | See Table 6.1.2 | See Table 6.1.2 | See Table 6.1.2 | Activity 1: Perform 40,000 HIV VL tests and 9000 EID test for FY16 and to target at least 80,000 patients receiving VL tests and 9000 EID test for FY17 Evaluation of DBS for VL testing using the high output Abbott m2000 VL testing platform Evaluation and validation of GeneXpert for VL testing at strategically selected high burden ART sites Train technicians if the evaluation meet the predetermined standards for VL testing | See Table 6.1.2 | See Table 6.1.2 | See Table 6.1.2 | See Table 6.1.2 |
| 3. Improve the quality of HIV diagnostic testing through implementation of the HIV Rapid Test Quality Improvement Initiative (RTQII) | 1. Revision of The national HTS guidelines to adopt the new WHO standards completed and validated 2. 100% of technical staff within HTC sites proficient in HIV RDT using RTQ II guidelines 3. 100% of HTC sites recording results in standardized RTQII HIV RDT log books | - Revision of national HIV testing algorithm completed | - New HIV testing algorithm is fully implemented and HIV verification testing becomes a norm | - % of HTC testers are trained for RTQII and certified for RT testing | Activity 1: Develop new HIV RDT algorithm based on WHO recommendations including re-testing | HLAB HTXS HVCT | \$300,000 | MSPP/UGP | (10) Laboratory |
| | | | | | Activity 2: Train technical staff (implementing partners' lab specialists, laboratory technicians, nurses) at HTC on the new HIV algorithm and quality assurance | | \$200,000 | MSPP/UGP | (7) Human Resources for Health |
| | | | | | Activity 3: Work with the National HIV/AIDS program to update the national guidelines with the new HIV RDT algorithm, print and share revised guidelines with all stakeholders | | \$200,000 | MSPP/UGP | (10) Laboratory |
| 4. Support the External Quality Assessment program for HIV RDT EID/VL testing | 1. 100% of PEPFAR HTC sites enrolled in the HIV RDT EQA program 2. 100% of PEPFAR HTC sites with a score of 100% on HIV proficiency testing 3. 30% reduction in turnaround-time of EQA results and subsequent follow-up of mentoring/training at low-performing HTC sites 4. Establish a DBS VL PT program to ensure the quality of VL testing for patient care | - 100% of HTC sites are enrolled into the RT PT program and 95% pass the PT evaluation; All EID/VL testing labs enroll into EID/VL PT and obtain passing scores | - 100% of HTC sites are enrolled into the RT PT program and 100% pass the PT evaluation; All EID/VL testing labs enroll into EID/VL PT and obtain passing scores | - LAB_PTQI (Laboratory) - LAB_PTQI (POCT) | Activity 1: Preparation of Proficiency Testing (PT) panels for HIV RDT to support quarterly EQA for all HTC. Preparation of PT panels for DBS HIV VL for NPHL and IMIS Activity 2: Onsite technical assistance and refresher training for HTCs that performed poorly on EQA Activity 3: Certification of laboratories that perform well on HIV RDT EQA and follow-up onsite assessments, certification of laboratory technicians on HIV RDT | HLAB | \$300,000 | MSPP/UGP | (10) Laboratory (10) Laboratory (10) Laboratory |
| | | | | | | | | | |
| | | | | | | | | | |
| TOTAL | | | | | | | | \$1,000,000 | |

Table 6.2.2: New and efficient service delivery models

| Key Systems Barrier | Outcomes expected after 3 years of investment | Year One (COP/ ROP16) Annual Benchmark | Year Two (COP/ ROP17) Annual Benchmark | Relevant Indicator or Measurement Tool | Proposed COP/ROP 2017 Activities | Budget Code(s) | Activity Budget Amount | Implementing Mechanism | Relevant SDG Element and Score (if available) |
|---|--|--|---|--|---|-----------------|------------------------|---|---|
| 1. Limited supply chain management capacity at the site | 1. Storage capacity assessed at 100% of PEPFAR ART facilities; and storage capacity improvements made at ART sites as per assessment recommendations. 2. Supply chain data collection and reporting tools modified to reflect the need of the new approach to ARV drugs dispensation 3. 280 facility staff managing and dispensing ARV Stock trained on LMIS 4. Adequate Forecasted quantity of Drugs delivered to the sites to match the twice a year ARV dispensation 5. SCMS delivery schedule adapted (Number of distribution sessions modified as needed) to ensure cost efficiency | - Storage capacity assessed and improved at 60% of sites | - Storage capacity assessed and improved at 100% of sites | | Activity 1: In collaboration with PNLAs and MOH, conduct a site assessment for all ART facilities , to define a site profile that captures storage capacities, drug dispensing pharmacies/points capacities, LMIS capacities, weaknesses and recommendations for improvement | HTXS, PDTX | \$35,000 | Global Health Supply Chain – Procurement Supply Management (GHSC) | (8) Commodity Security and Supply Chain |
| | | - Short term technical assistance provided to MOH to improve LMIS, integrate existing parallel programs' LMIS and identify e-LMIS requirements | - Integrated reporting tools piloted at ARV sites | | Activity 2: Assist the MOH in designing a logistics management information system (LMIS) for the unified national supply chain system. The LMIS will capture stock availability at facility level and distribution through facilities and CHWs, using existing innovating strategies with smartphones (with a logistics module) | HSVI | \$140,000 | Global Health Supply Chain – Procurement Supply Management (GHSC) | (8) Commodity Security and Supply Chain |
| | | - ARV quantities delivered to sites increased | - Resupply frequency and delivery scheduled adjusted based on improved storage capacity | | Activity 3: Assist the MOH and partners to develop an implementation plan for the MMS strategy , including: a) revised/adapted LMIS reporting tools to better capture community based distributions and facility based drug dispensation, b) implementing partners and sites (PNLAs, Pharmacists, CHW etc.) training plan on revised LMIS tools, c) supplies procurement plan (back packs, and cool boxes for CHW to transport the medication), d) data quality audit plan to validate stock and consumption data at site level, e) monitoring plan of the country stock levels, the resupply frequency and quantities to facilities. In addition, a phased approach should be followed and the definition of "Stable Patients" eligible for MSS will be determined. | HSVI | \$100,000 | Global Health Supply Chain – Procurement Supply Management (GHSC) | (8) Commodity Security and Supply Chain |
| | | | - Continue and improve quantification process to address ARV forecast and supply plan | | Activity 4: Assist the MOH DPM to lead the quantification process to better adjust the ARV forecasts and supply plans before the implementation of the new treatment guidelines (6-9 month notice to adjust procurement needs) | HTXD, PDTX, | \$100,000 | Global Health Supply Chain – Procurement Supply Management (GHSC) | (8) Commodity Security and Supply Chain |
| 2. Current national policies recommend clinical appointments at least every 3 months, lab work at initiation; and reporting tools are modeled accordingly | 1. The National HIV Care and Treatment guidelines revision to include the new service delivery model is completed and validated 2. EMR and reporting tools modified to accommodate the changes in the service delivery model 3. Training for CHW completed | | | | Activity 1: Provide technical and financial assistance to National AIDS control program for the revision of the national guidelines allowing multi-month scripting | See table 6.1.3 | See table 6.1.3 | See table 6.1.3 | (2) Policies and Governance |
| | | | | | Activity 2: Revise EMRs and other electronic tools to accommodate the changes in the service delivery model including biannual appointment, etc. | See table 6.1.1 | See table 6.1.1 | See table 6.1.1 | (15) Performance Data |
| | | | | | Activity 3: Develop/adapt curriculum for CHW on new service delivery model and the use of monitoring tools | See table 6.1.1 | See table 6.1.1 | See table 6.1.1 | (2) Policies and Governance |
| | | | | | Activity 4: Train CHW on new services delivery model | See table 6.1.1 | See table 6.1.1 | See table 6.1.1 | (7) Human Resources for Health |

| | | | | | | | | | |
|---|--|--|---|--|---|-----------------|-----------------|-----------------|---|
| 3. Limited integration and oversight of quality clinical services | 1. Role of selection committee revised to focus more on strengthening adherence 2. Providers trained on the new services delivery model reinforcing the importance of adherence counseling post-ART initiation 3. Ensure that quality integrated FP/HIV services are provided or available at all PEPFAR sites | | | | Activity 1: Conduct training/refresher training on new HIV care and treatment guidelines | See table 6.1.1 | See table 6.1.1 | See table 6.1.1 | (7) Human Resources for Health |
| | | - Baseline evaluation for PREP among KPs | - Evaluation of PREP among KPs | | Activity 2: Initial activities related to Pre-Exposure Prophylaxis with KP | HTXS | \$200,000 | EQUIP | (6) Service Delivery |
| | | - All providers of FP/HIV services are trained on service provision including long acting reversible contraception | - High volume ART sites have a designated FP provider who collaborates closely with the HIV provider to ensure patients can receive FP services at the same time as ART | | Activity 3: Quality assurance/Quality improvement activities carried out to improve FP/HIV integration at all PEPFAR sites where USG-funded FP commodities are provided | MTCT, PDTX | \$400,000 | EQUIP | (6) Service Delivery |
| | | | - Evaluation complete | | Activity 4: Analysis of extent of implementation of test and start strategy | HTXS | 200,000 | ITECH | (15) Performance Data |
| | | | - Evaluation complete | | Activity 5: Evaluation of the impact and cost effectiveness of MMS and differentiated care on clinical outcomes | HTXS | \$150,000 | EQUIP | (15) Performance Data |
| | | | - Finalize tools for QA/QI and training in coordination with local stakeholders - Dissemination across all OVC partners | | Activity 6: Systematic quality assessment and quality improvement for PEPFAR service delivery sites providing OVC support and services | HKID, HVAB | \$250,000 | 4C | (6) Service Delivery |
| | | | - Finalize the map of GBV services and disseminate to MSPP, partners, and civil society organizations | | Activity 7: Mapping of GBV support services and targeted capacity building | HKID, HVAB | \$250,000 | 4C | (5) Public Access to Information; (6) Service Delivery |
| | | | - Finalize tools for QA/QI, training and dissemination across all service delivery partners and HNP (in coordination with INL) | | Activity 8: Systematic quality assessment and quality improvement for PEPFAR service delivery sites providing GBV support and services | HKID, HVAB | \$150,000 | 4C | (5) Public Access to Information; (6) Service Delivery |
| | | | - Finalize tools for QA/QI, training and dissemination across all service delivery partners and HNP (in coordination with INL) | | Activity 9: Systematic quality assessment and quality improvement for PEPFAR service delivery sites providing GBV support and services | HKID, HVAB | \$60,000 | GHESKIO | (6) Service Delivery |
| TOTAL | | | | | | \$2,035,000 | | | |

*Reference Appendix C for a list of activity types that fit in each category.

** Note: Other systems investments have been updated and elements incorporated into other barriers above

Total for all of Table 6

\$14,610,500