Advancing Partners & Communities

Reaching Key Populations and Improving HIV Services:
COUNTRY PROGRAM IN REVIEW | DOMINICAN REPUBLIC

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

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JSI Research & Training Institute, Inc.

ADVANCING PARTNERS & COMMUNITIES

APC/Dominican Republic

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Reaching Key Populations and Improving HIV Services: **COUNTRY PROGRAM IN REVIEW DOMINICAN REPUBLIC**

APC/Dominican Republic

ADVANCING PARTNERS & COMMUNITIES

Advancing Partners & Communities (APC) is a cooperative agreement funded by the U.S. Agency for International Development under Agreement No. AID-OAA-A-12-00047, beginning October 1, 2012. APC is implemented by JSI Research & Training Institute, Inc., in collaboration with FHI 360. The project focuses on advancing and supporting community programs that seek to improve the overall health of communities and achieve other health-related impacts, especially in relationship to family planning. APC provides global leadership for community-based programming, executes and manages small- and medium-sized sub-awards, supports procurement reform by preparing awards for execution by USAID, and builds technical capacity of organizations to implement effective programs.

APC in the Dominican Republic is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID), and implemented by JSI Research & Training Institute, Inc.

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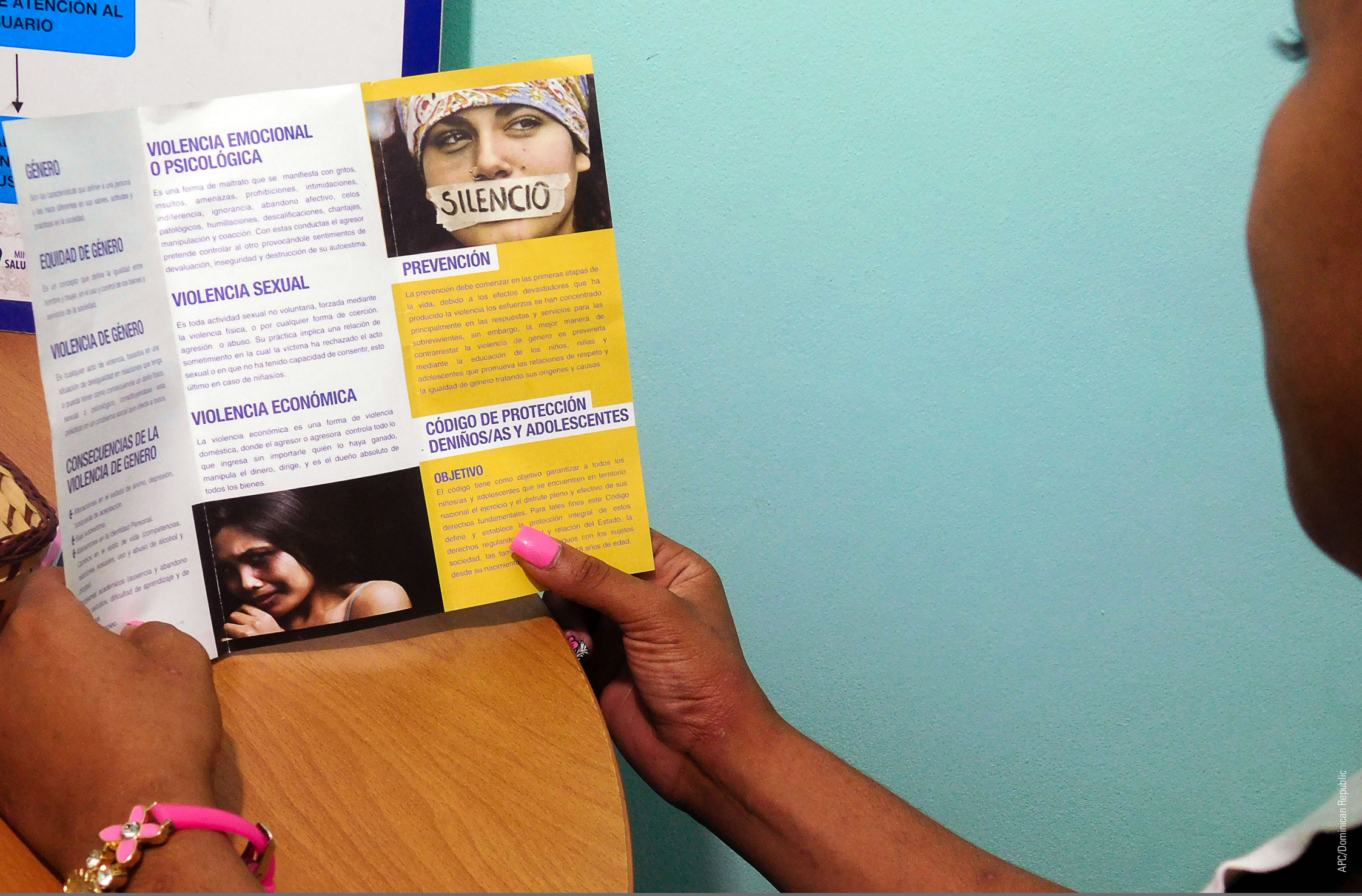

APC/Dominican Republic

Acronyms

APC	Advancing Partners & Communities
ART	antiretroviral therapy
ARV	antiretroviral
CBO	community-based organization
CSO	civil society organization
DMOC	differentiated models of care
DR	Dominican Republic
ECR	Expanded Comprehensive Response (Respuesta Integral Expandida)
FAPPS	National Health Service HIV services reporting system (Formulario de Aplicación a Programas de Políticas Sociales)
FY	fiscal year
FSW	female sex worker
GBV	gender-based violence
GODR	Government of the Dominican Republic
IDEV	Dominican Institute of Virological Studies (IDEV in Spanish)
KP	key population
LTFU	loss to follow up
MSM	men who have sex with men
NGO	nongovernmental organization
NHS	National Health Service
OCA	organizational capacity assessment
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PLHIV	people living with HIV
PP	priority population
QI	quality improvement
STI	sexually transmitted infection
TG	transgender (people)
VPR	voluntary partner referral

BACKGROUND

In the Dominican Republic (DR), HIV prevalence among the general population has remained stable at 0.8% in the adult population (15–49 years old),[1] while prevalence among gay, transgender (TG), and other men who have sex with men (MSM) is above 5% (6.1% in 2008 and 5.2% in 2012).[2] Other populations with high prevalence rates include female sex workers (FSWs), at 4.5%,[3] and 4.6% among Haitian migrant construction workers,[4] indicating an epidemic largely confined to these high-risk subpopulations. These key populations (KPs)—MSM, TG, and FSW—and priority populations (PPs)[5] in the DR have remained underserved due to large gaps in coverage and access to HIV prevention, care, and treatment, exacerbated by widespread stigma and discrimination.

Over the course of fiscal years (FYs) 14–19, the Advancing Partners & Communities (APC) project, funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) through the U.S. Agency for International Development (USAID) and implemented by JSI Research & Training Institute, Inc. (JSI), worked to improve access, delivery, and quality of HIV prevention, care, and treatment services for KPs and PPs. APC activities supported the efforts of the Government of the Dominican Republic (GODR) to control the HIV epidemic by strengthening the ability of HIV clinics at selected nongovernmental organizations (NGOs) and public hospitals to provide efficient, high-quality services and community-based care and support in four high-burden provinces and to serve as model sites for scale-up to other provinces after PEPFAR support ends.

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1 Demographic Health Survey (DHS) 2013.
2 República Dominicana, DIGECITSS. El Estado Epidémico del VIH en República Dominicana. Informe Final Sobre Tipo de Epidemia. pág: 29. Santo Domingo; 2014.
3 República Dominicana, CONAVIHSIDA, Segunda Encuesta de Vigilancia de Comportamiento con Vinculación Serológica en Poblaciones Claves. 2012. (Second round Integrated Biological and Behavioral Survey [IBBS] of Key Populations).
4 Ibid.
5 Priority populations as defined by PEPFAR in the DR are migrants of Haitian descent who are typically itinerant agricultural and construction workers, street vendors, truck drivers, and FSWs.

PROGRAM OVERVIEW

FY14–16: Outreach to Key Populations

During the first three years of the project, (FY14–16), APC provided grant awards and technical assistance to strengthen the technical and organizational capacity of local NGOs and public-sector hospitals to employ high-impact practices to improve the reach and quality of HIV prevention, testing, and treatment services for KPs and PPs. Additionally, APC worked closely with national and regional health system managers and community-based organizations (CBOs) that support HIV service delivery to establish policies against stigma and discrimination.

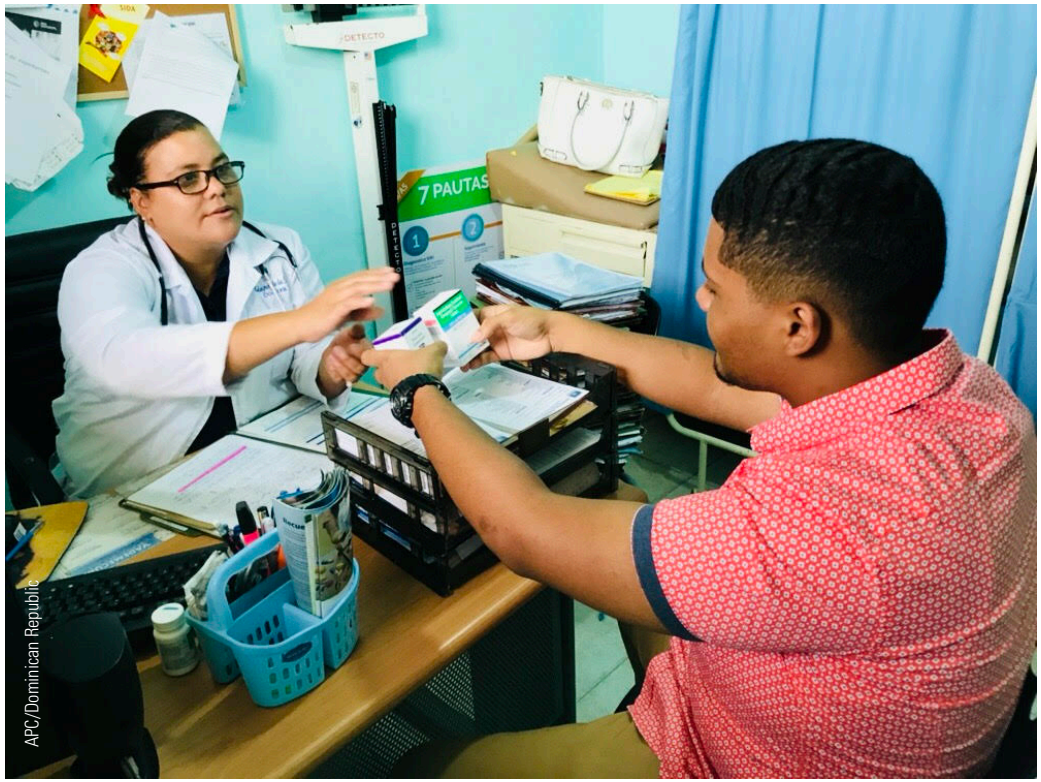
During project start-up and throughout implementation and the extension of the project through FY19, APC supported its grantee organizations to install an automated accounting system, establish internal financial control mechanisms, and conduct independent program audits. APC brought all grantees into compliance with USAID grants management and contracting procedures. This support strengthened APC grantees' readiness and ability to receive and manage USAID resources and fulfill USAID program and financial management rules, regulations, and reporting requirements.


APC/Dominican Republic

FY17–19: "Treatment for All" to Support the 90-90-90 Target

In FY17, the PEPFAR 3.0 pivot resulted in a programmatic and geographic shift in the strategy to support GODR efforts to achieve HIV epidemic control by implementing the 90-90-90 treatment target. APC, as USAID's principal implementing partner, changed to focus on a more clinical services-based model, providing direct technical assistance and resources to the clinical sites and programmatic assistance to improve quality and site-level management of HIV services.

A priority focus of APC's technical assistance was implementation of the World Health Organization Test and START policy, which recommends that all people living with HIV (PLHIV) begin antiretroviral therapy (ART) as soon as possible after diagnosis, regardless of CD4 cell count. In FY17, APC, through its grantee organizations, supported implementation of Test and START, referred to as "Treatment for All" within the Dominican context, in three NGO and three public hospital clinical sites in three of the four PEPFAR-supported high-burden provinces (Santo Domingo, La Romana, and Puerto Plata).



APC/Dominican Republic

In FY18, APC implemented a range of strategies to expand outreach, testing, linkage to treatment, and retention in care for KPs and PPs. APC's efforts helped close gaps along the HIV treatment cascade, ensuring high-quality HIV service delivery and disseminating best practices in support of the GODR's efforts to reach the 90-90-90 treatment target.

These strategies were:

- Social media outreach to MSM to improve HIV testing yield.
- Implementation of differentiated models of care (DMOC) to meet the needs of KPs and the migrant population.
- Strengthened community/facility linkages by expanding the role of case navigators.
- Provision of voluntary partner referral (VPR) services.
- Tracing and re-enrollment of patients lost to follow-up (LTFU), adherence counseling, and appointment reminders by APC community care and support partners.
- Implementation of the Quality Improvement (QI) Collaborative at 16 PEPFAR-supported clinical sites and mobile clinics.

Over the course of six years, in addition to strengthening technical capacity in provision and management of HIV services, APC strengthened grantees' ability to plan, budget, implement, and report their programmatic and financial information as required of USG recipients.

RESULTS SUMMARY

- **Developed and implemented policies against stigma and discrimination and gender-based violence**
  With APC support, anti-stigma and discrimination policies were instituted at **8 NGO** and **14 public hospital HIV clinics** in **14 provinces**, and **3,113 gender-based violence (GBV) survivors** received clinical care and were referred for post-exposure prophylaxis, emergency contraception, and counseling.

- **Tailored HIV prevention and clinical services to the needs of key and PPs, and expanded outreach to increase testing and linkage to care and treatment at APC-supported clinical sites.**
  During the six-year period, APC distributed **3,262,880 condoms** and **1,911,549 lubricants**, **referred 76,212 KPs for STI treatment, referred or escorted 212,761 key and PPs** to APC-supported clinical sites for HIV testing and care, and **tested a total of 159,360** people, of whom 6,749 were diagnosed HIV-positive, resulting in an overall **HIV yield of 4.2%**.

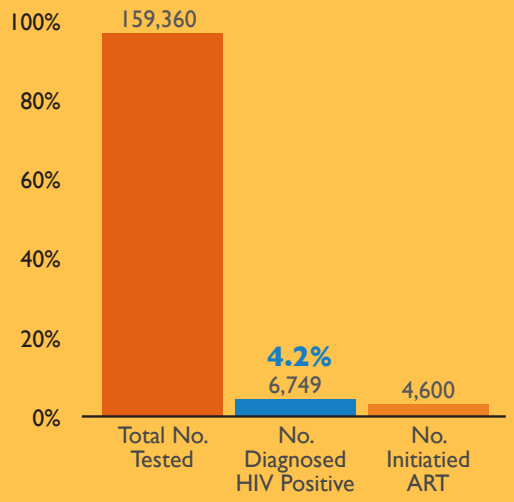
- **Adapted the PEPFAR twinning model to the Dominican Republic.**
  Collaboration between four NGO clinics, three community-based care and support partners, and five public hospitals under the PEPFAR twinning model implemented by APC **built capacity at 9 clinical sites within the government HIV services network** to provide high-quality services to key and PPs. These sites are models of service delivery for replication to other HIV clinics in the country.

- **Initiated and scaled up the GODR Treatment for All strategy.**
  Implementation of the GODR Treatment for All strategy at APC-supported clinical sites resulted in **4,600 people initiating ART** for the first time.

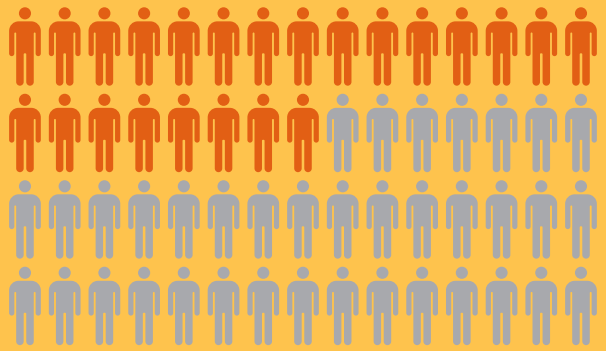
- **Implemented the QI Collaborative.**
  APC led implementation of the QI Collaborative to support expansion of the GODR Treatment for All strategy and built HIV services management capacity, service delivery, and quality of care at **16 PEPFAR-supported clinical sites and mobile clinics in five priority provinces.** The project coordinated with local, provincial, and national government authorities and donor implementing partners to ensure that the QI Collaborative continues after PEPFAR support ends.

- **Improved data quality and use for decision-making at APC-supported clinical sites.**
  Improved records management, data cleaning, and timeliness of data entry on the status of ART patients helped APC to **trace and re-enroll 2,752 patients LTFU** and improved viral load suppression reporting as much as 46.7% at one site.

Total number of people tested, diagnosed HIV positive, and initiated on treatment at APC-supported clinics, FY14–19

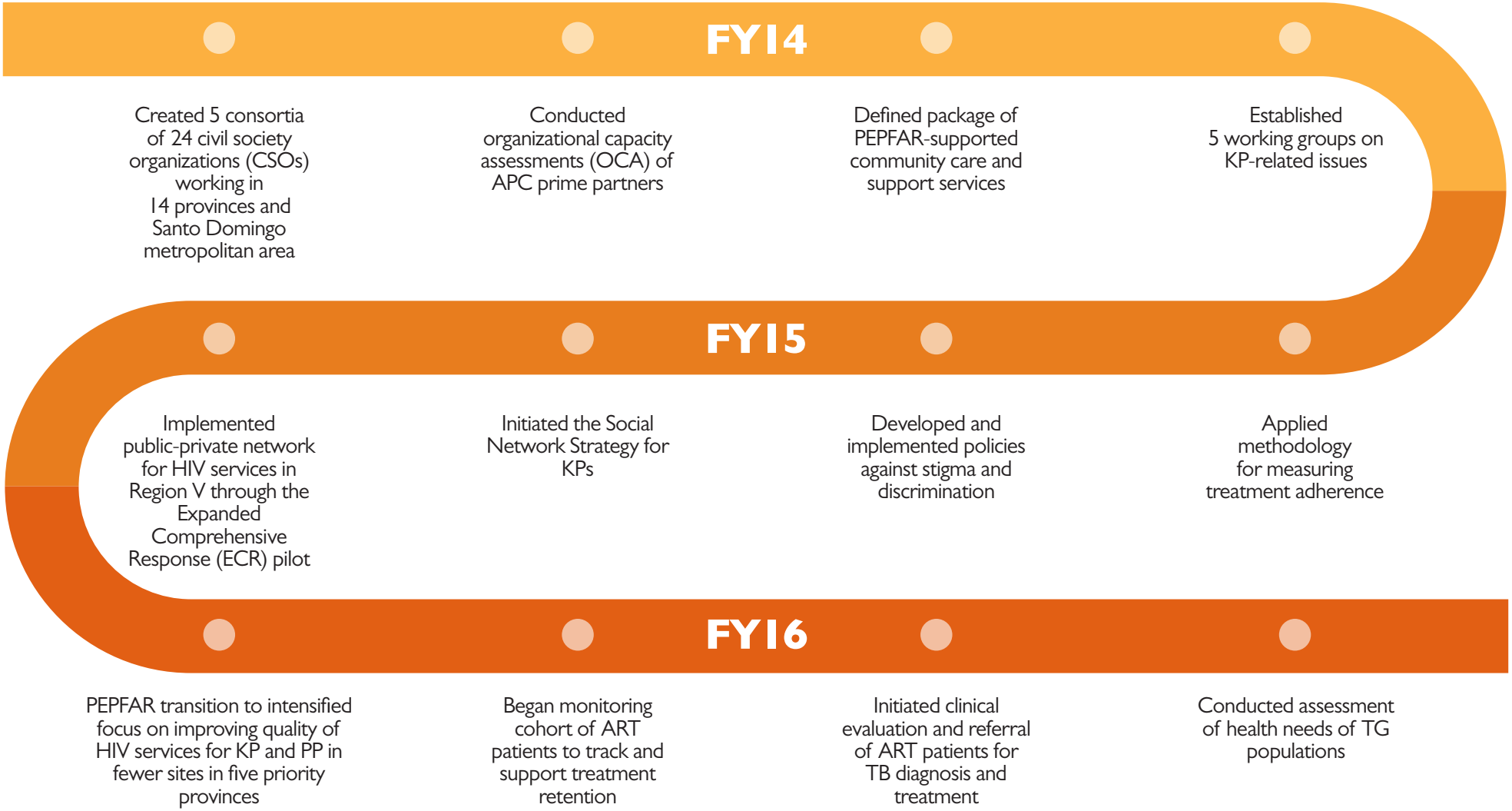


By the end of the project, of all patients on treatment at the 74 government HIV clinics, 38.6% were receiving ART at the nine APC-supported clinics



APC DOMINICAN REPUBLIC TIMELINE FY14–16

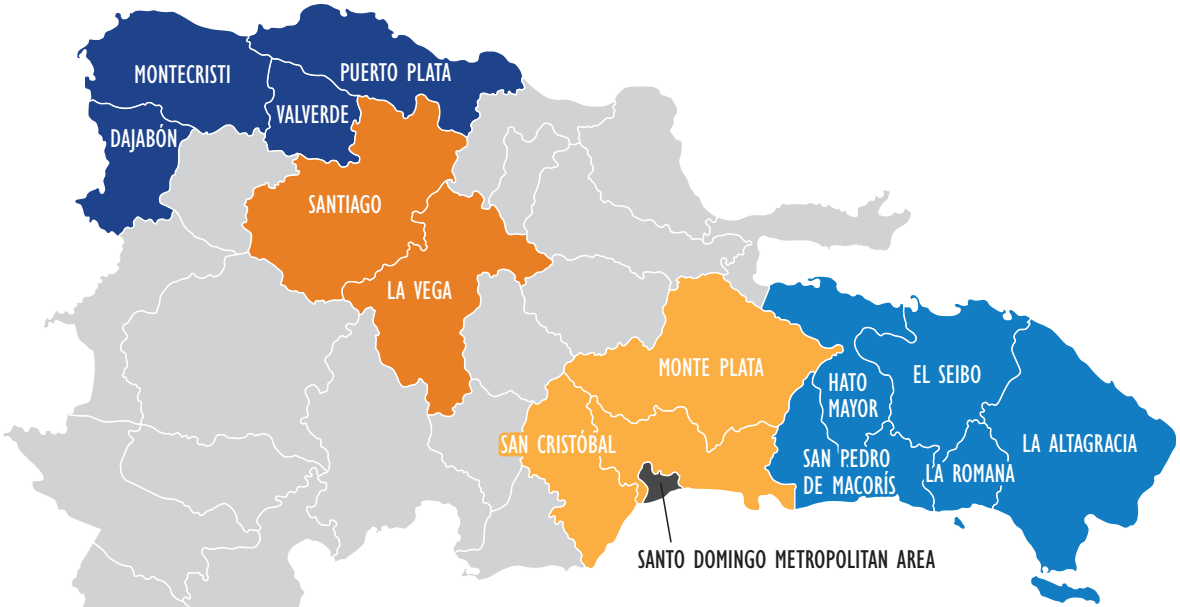
FY14–16 Outreach to Key Populations



FY14–FY16: OUTREACH TO KEY POPULATIONS

Starting in February 2014, APC created five consortia of 24 CSOs working in 14 provinces and the Santo Domingo metropolitan area to support HIV prevention, care, and support for PLHIV and improve quality of services for key and PPs in the DR. The strategic placement of these committed and skilled partners throughout the country, combined with program management and technical guidance provided by APC, enabled the impressive results achieved during this period.

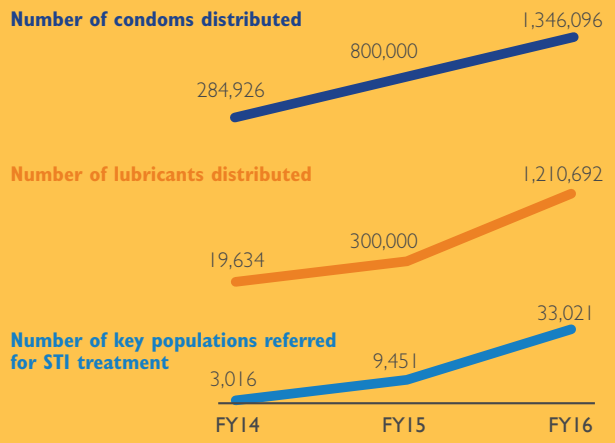
APC GRANTEES AND SUB-GRANTEES BY CONSORTIA AND PROVINCE, FY14–15



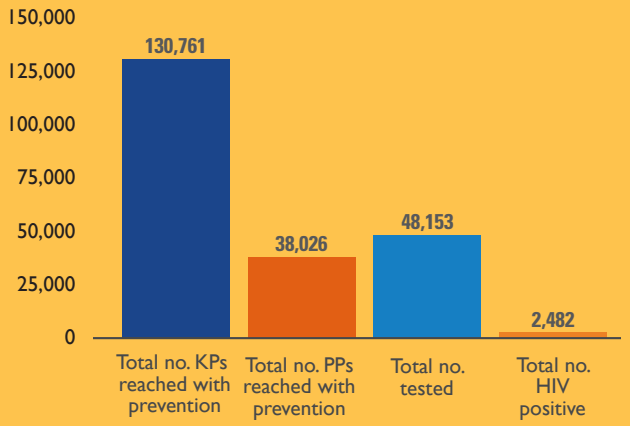
GRANTEES	CEPROSH	REDOVIH	COIN	ADOPLAFAM	IDCP	INSALUD	ASA
SUBGRANTEES	Grupo Clara	BRA	COTRAVEDT	Clinica Esperanza y Caridad	COTRAVEDT	IDEV	
	MOSCTHA	MODEMU	MODEMU	Clinica La Romana	MODEMU	GAYP	
	REVASA		FUNDOREDA	Este Amor			
	TRANSSA			Jehova Nisi			

RESULT

Distribution of condoms and lubricants and number of KPs referred for STI treatment



Total number of KPs and PPs reached with HIV prevention, total number of all populations tested and HIV-positive



HIV PREVENTION

Reaching vulnerable populations before they are infected with HIV

Comprehensive HIV prevention services are the best way to reach people who are at risk of infection and who do not know their status. Such services reduce individual risk behaviors, increase uptake of HIV testing services, and link positive patients to clinical care and treatment.

Early in FY14, APC defined and began implementing the comprehensive package of sexually transmitted infection (STI) and HIV prevention services for KPs (MSM, TG, and FSW) and PPs (clients of sex workers and batey residents).[6] HIV prevention activities were conducted through six consortia of APC-supported local organizations in the five highest-priority regions. From FY14 to FY16, the project worked to strengthen the linkage between clinical and community-based services for the different KPs in these geographical regions.

All clients reached through APC activities received a comprehensive package of prevention services that included:

- Behavior change communication provided by trained peer promoters.
- Free condoms and lubricants distributed by community promoters or through social marketing outlets.
- Promotion and accompanied referrals for HIV testing and counseling and STI treatment.
- Accompanied referrals for HIV care and treatment for those who tested positive.
- Referrals for family planning and related services.

APC implemented outreach strategies such as Amigo Educando Amigo (*Friends Teaching Friends*), developed in the U.S. for MSM to promote risk-reduction among friends within their social networks, and Community Promise, a peer-education strategy conducted in the bateyes.

[6] Residents of bateyes tend to work in large-scale agriculture or sugar cane harvesting, lack basic services, and have a higher HIV prevalence than the general population. Many batey residents are undocumented Haitian migrants.

OUTREACH AND LINKAGE TO TESTING

HIV testing and counseling is the gateway to care, treatment, and support

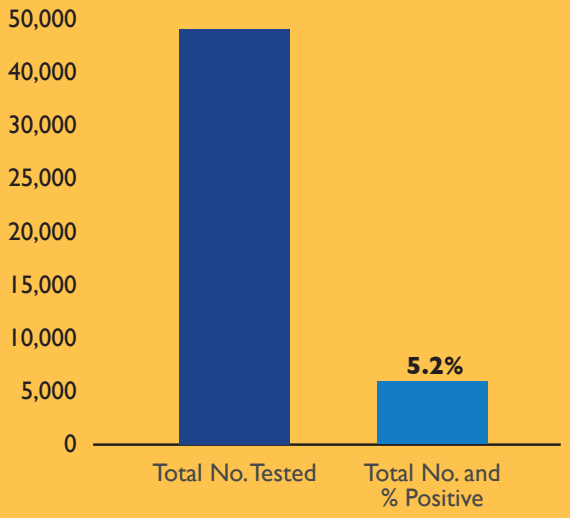
During the first three years of activities, APC achieved notable results in outreach and linkage to HIV testing for key and PPs through facility-based clinics, mobile clinics, and community-based events, and by establishing strong links with HIV prevention programs.

APC provided technical support to its NGO partners to improve HIV yield by prioritizing KPs according to risk profiles. APC also introduced the Social Network Strategy to expand testing and HIV yield in MSM during this period.

> *"It was important that the person who contacted me assure me that the test would be confidential and if the result was positive, s/he would provide me with ongoing care and support."*
>
> — FSW

RESULT

Total number of KPs and PPs tested by APC-supported partners and HIV yield, FY14–16



RESULT

Results of the ECR pilot in Health Region V

- Directory of health, legal, and social services for PLHIV.
- Standardized forms and procedures for documenting and reporting cases of stigma and discrimination at the HIV clinics.
- User satisfaction survey led to improvements in clinical services for KPs and PLHIV.
- Teófilo Hernández Hospital in El Seibo Province became a model of coordination between Health Region V, Clínica de Familia La Romana, ADOPLAFAM, and APC. The hospital's HIV clinic was remodeled, same-day HIV test results were instituted, more laboratory staff were hired, and medical staff were required to comply with established clinic hours, all of which resulted in a shorter waiting time for HIV test results.
- Routine data quality assessments with the directors of the HIV clinics in the region improved data collection.

PUBLIC-PRIVATE SERVICE NETWORKS FOR KEY POPULATIONS

Linking NGOs, CBOs, and civil society leaders with the public health system supports access to services and fills important gaps in the HIV response for KPs

The Expanded Comprehensive Response Pilot in Health Region V

The ECR pilot was an adaptation of the Comprehensive Community Response framework to support HIV programming for KPs in alignment with the National HIV/AIDS Strategic Plan for 2015–2018.

The key objective of the ECR pilot was to create an inter-institutional and multi-disciplinary forum at the regional government level to lead the GODR response to the HIV epidemic in the five provinces of Health Region V in the eastern region of the country (San Pedro de Macorís, La Romana, La Altagracia, Hato Mayor, and El Seibo).

As part of the pilot that was implemented in FY15, working groups of stakeholders from the eastern regional health service, NGOs, CBOs, and representatives of KPs from civil society focused on four technical areas: referral and counter-referral systems, monitoring and evaluation, service quality, and inter-institutional coordination.

> *"We (Health Region V) have strengthened communication channels with community groups and CSOs while keeping in mind that the main goal is to reach key populations in a holistic manner."*
>
> — Dr. Elsa Valdez, manager, Region V Health Service.

A representative from Health Region V interviewing a patient during a user satisfaction survey at the Dr. Antonio Musa Hospital, San Pedro de Macorís

APC/Dominican Republic

APC/Dominican Republic

RESULT

- Adopted and disseminated anti-stigma and discrimination guidelines and policies.
- Trained 53 facilitators to disseminate anti-stigma and discrimination guidelines within their facilities.
- Developed procedures for anonymous reporting and filing cases of stigma and discrimination with hospital management.
- Established hospital-based anti-discrimination committees that included representatives of KPs.
- Improved health provider attitudes and practices toward KPs and PLHIV.

> *"We need to provide an environment free of stigma and discrimination, where sexual diversities are treated with respect within the human rights framework."*
>
> — Fátima Colombo, coordinator of the CEPROSH HIV clinic.

REDUCING STIGMA AND DISCRIMINATION

Policies and practices to reduce stigma and discrimination increased access to high-quality HIV services

An important component of HIV service quality is mitigating the stigma and discrimination and GBV that prevent KPs from accessing services. APC, in coordination with regional health authorities, representatives of KPs, and service providers, committed to providing comprehensive HIV care and incorporating anti-discrimination policies at eight APC-supported NGO and 14 public hospital clinics. NGO partners from the APC-supported consortia led implementation of these policies in 22 HIV clinics in 14 provinces.

IMPROVING QUALITY OF CLINICAL AND COMMUNITY-BASED SERVICES

The quality management system was essential to identifying and mitigating barriers to access and retention in care, and standardizing procedures for monitoring and ensuring quality of care for KPs

APC provided technical assistance to implement a quality-management system in seven APC-supported clinics and 15 CBOs. Five advisory groups with expertise in the areas of HIV clinical services, FSWs, services for MSM and TG, community care and support, and stigma and discrimination were established to contribute to implementation of the quality management system by identifying best-practice models, structural limitations, and challenges to delivering high-quality HIV services among APC partner organizations. These advisory groups were also a way for APC to provide technical assistance and develop leadership and technical expertise among the partners.

Qualitative surveys and focus groups

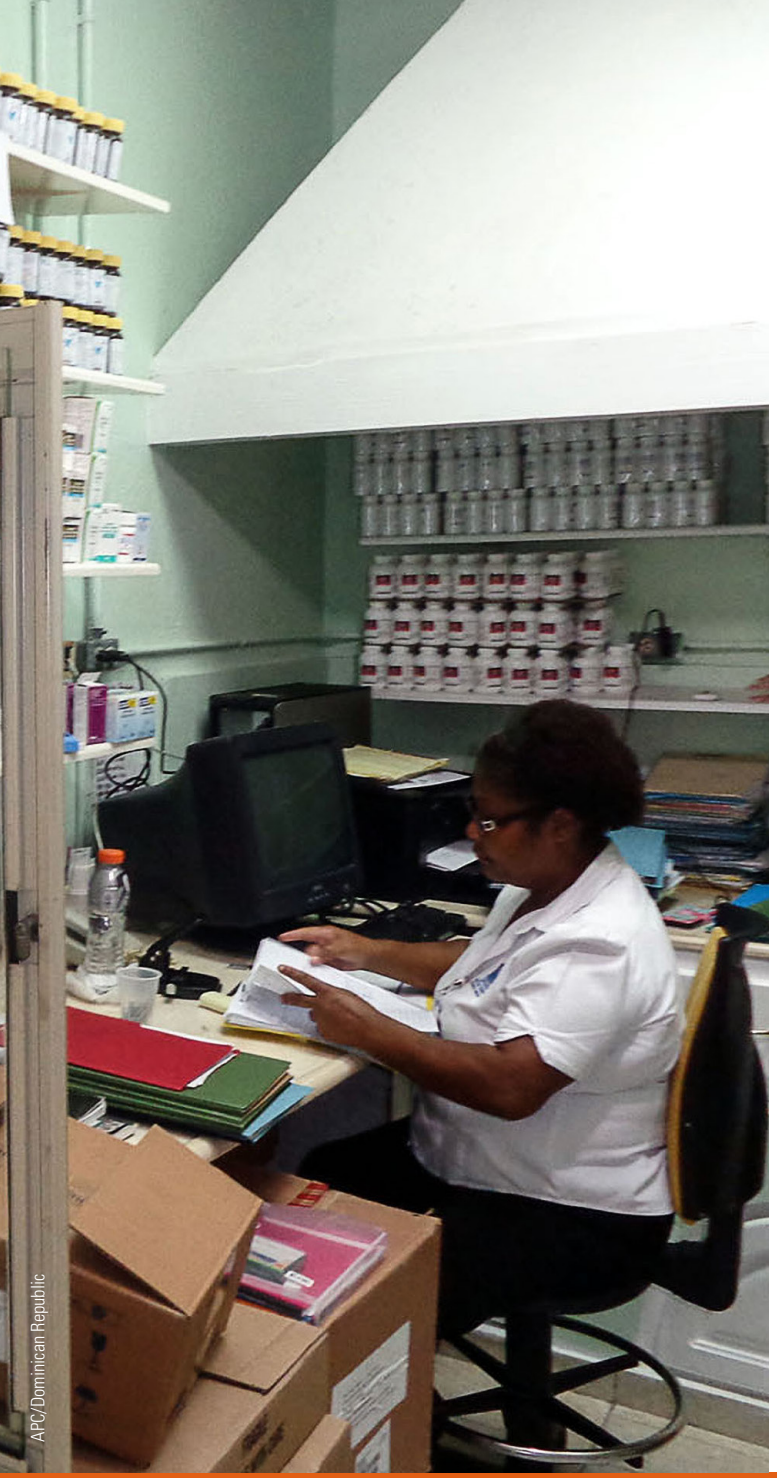
During the FY14–16 period, APC conducted a series of qualitative surveys and focus groups to assess quality of care, barriers to access, and retention in care for KPs, and pharmacy management of ARVs that informed APC programming.

Results of the baseline assessment of service quality at APC-supported CBOs

- 15 developed a referral system
- 9 implemented prevention services for PLHIV
- 9 incorporated guidelines for home visits, risk reduction, and techniques for disclosure of serostatus into their HIV prevention service package
- all offered condoms and lubricants at no charge during HIV prevention, care, and support activities
- all strengthened capacity for community-based outreach for prevention among FSWs, MSM, and TG
- all adopted written policies on patients' rights
- all adopted a tool to measure client satisfaction
- 5 began holding regular sessions on community-based care, performance improvement, and improving service quality and scale.

Components of the quality management system

- Periodic review of standards for clinical and community-based care.
- Gap analysis to assess performance of APC-supported clinical and community-based partners compared to national HIV/AIDS guidlines and PEPFAR guidance.
- Quarterly improvement plans included positive prevention; adherence counseling; pharmacy storage and dispensing practices for antiretroviral (ARV) medicines; and coordination of community care and support to improve retention in care.



APC/Dominican Republic

Study of factors affecting treatment dropout resulted in program improvements

An APC study of factors affecting treatment adherence and retention in care in March 2015 revealed barriers related to income, wait-time for medication re-supply, ARV drug side effects, and fear of stigma and discrimination. These results prompted the APC-supported clinics to add donations of fortified foods, adherence counseling, and mental health to the list of services offered at the sites, and to extend hours for pick-up of ARV medicines. In addition, standardized procedures for tracking clinic no-shows and treatment dropout were implemented.

Training in pharmacy management improved ARV drug storage and dispensing practices

The APC 2015 assessment of clinical service quality identified the need to strengthen ARV drug storage and dispensing practices in the clinic pharmacies. With support from MSH's USAID-funded Systems for Improved Access to Pharmaceuticals and Services project, APC conducted a workshop on pharmacy storage and dispensing practices. As a result, clinics re-organized their pharmacy storage spaces, instituted dispensing by prescription, and improved needs-forecasting for ARV drugs. This resulted in consolidated data-collection forms for recording drug dispensing by patient that facilitated treatment adherence measurements.

Assessment identified barriers to health services for the TG population

APC collaborated with the TG community, government officials, and local organizations to conduct an assessment of social and health needs, available services, and barriers to improve access and quality of the services offered to this population in PEPFAR-supported provinces. Transgender people were trained to conduct the interviews and focus groups in nine provinces.

Valentina, who was trained as an interviewer and strengthened her research and peer-educator skills noted that, *"more importantly, I have learned about the different needs of my community. . . mental health care, education, better job opportunities, and regular health services."*

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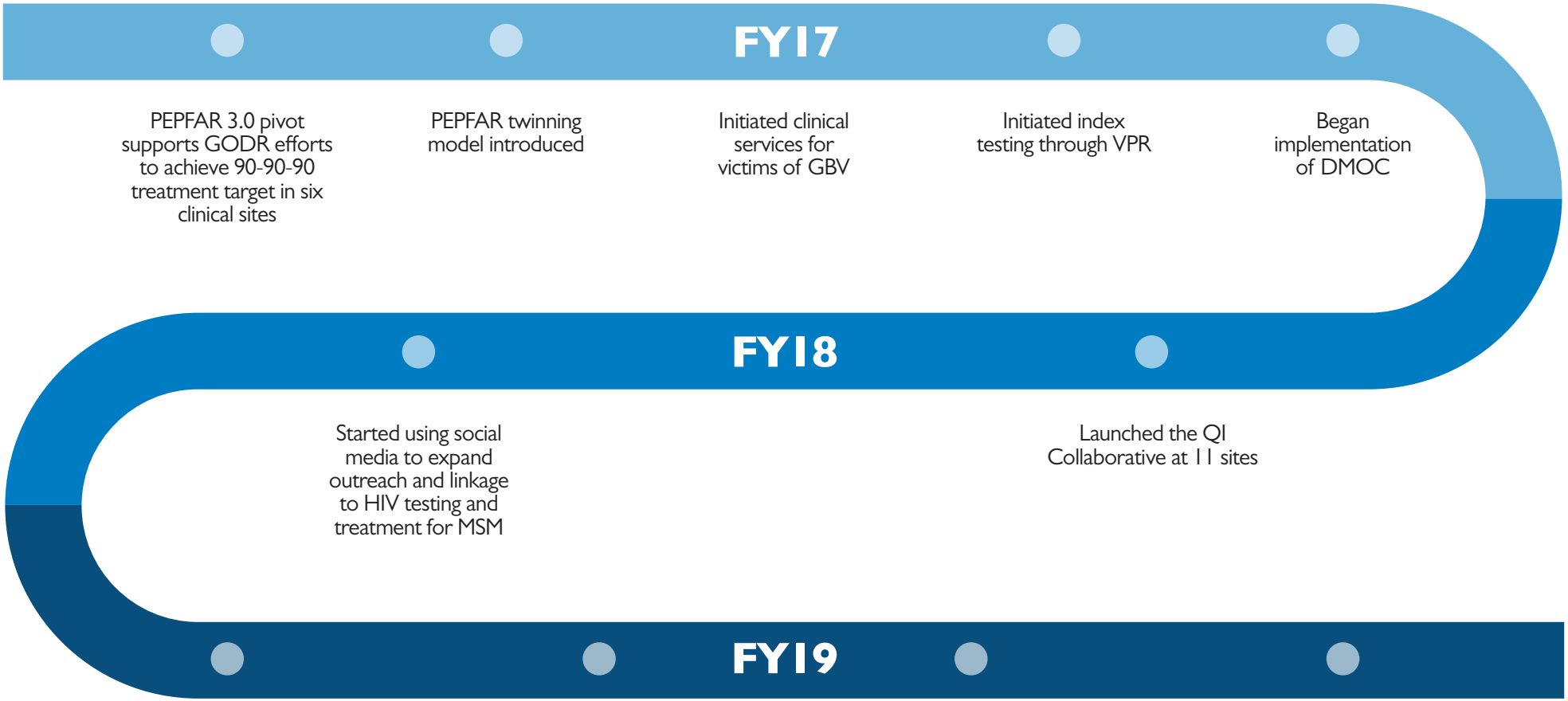
APC DOMINICAN REPUBLIC TIMELINE FY17–19

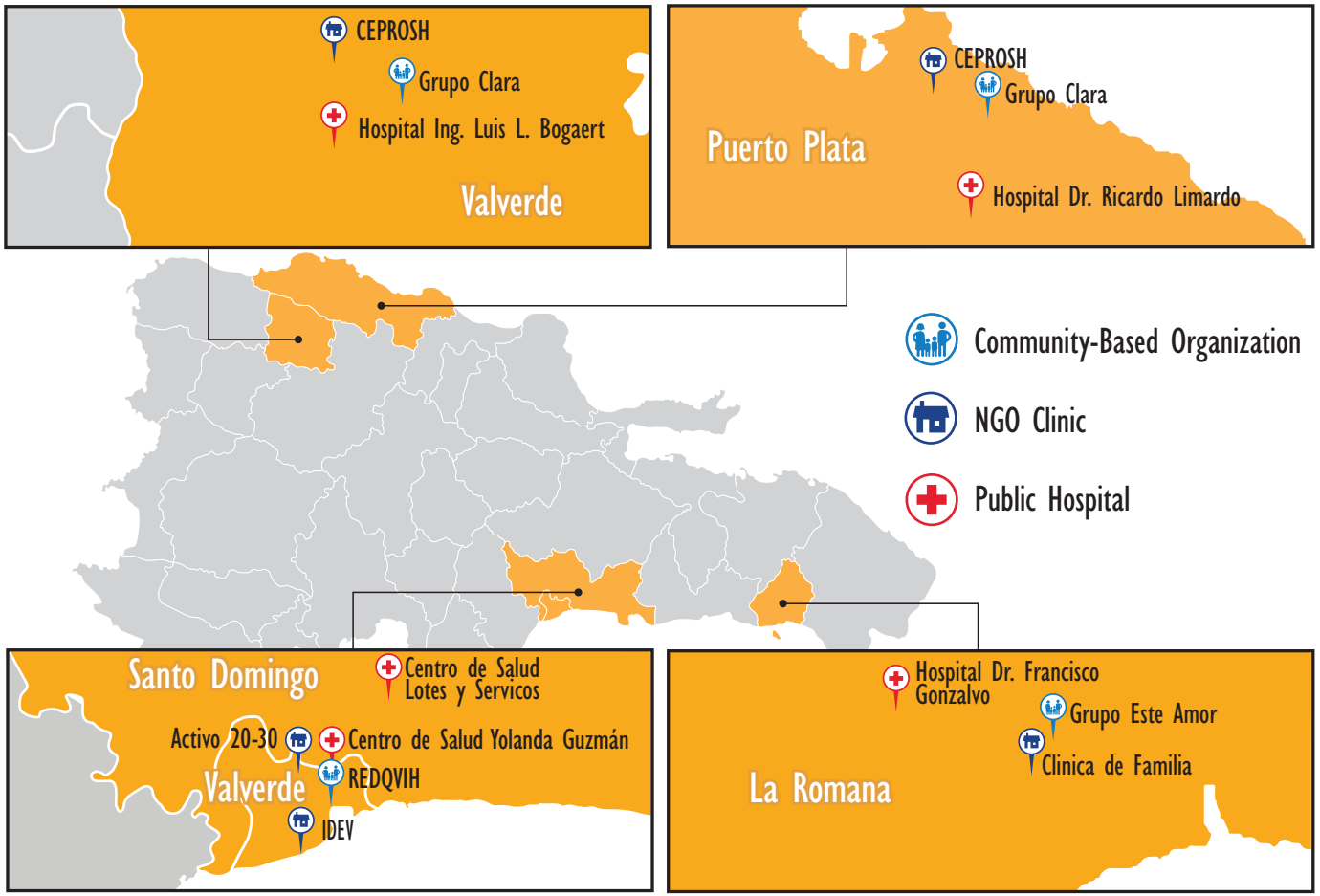
FY17–19 Treatment for All to Support the 90-90-90 Target



FY17–FY19: TREATMENT FOR ALL TO SUPPORT THE 90-90-90 TARGET

In FY17, in response to the PEPFAR 3.0 pivot and the resulting geographic and programmatic shift in strategy, PEPFAR support in the DR was reduced to four priority provinces with high HIV prevalence rates, with an intensified focus on KPs and PPs to support GODR efforts to reach the 90-90-90 treatment target and achieve epidemic control by 2020.

APC-SUPPORTED CLINICAL SITES WITH CORRESPONDING COMMUNITY CARE AND SUPPORT PARTNERS, FY19



The principal focus of APC efforts during FY17–19 was the incorporation of new approaches and evidence-based strategies to expand outreach and linkage of KPs and PPs to HIV testing services; ensure that newly diagnosed people enrolled in care and initiated treatment and that PLHIV already enrolled in care at the clinical sites transitioned to ART; support patient adherence to treatment and retention in care; and improve documentation and monitoring of viral load testing and suppression to meet the 90-90-90 treatment target by 2020. After FY18, all APC-supported strategies and interventions were implemented and coordinated with site-, local-, and national-level government and PEPFAR implementing partners within the framework of the QI Collaborative that was launched under the NHS in February 2018 and implemented with technical assistance from APC in these four high-burden provinces.

THE PEPFAR TWINNING MODEL

Alliances between APC clinical and community care and support partners improved access and quality of care for KPs and PPs at NGO and public hospital HIV clinics

APC's adaptation of the PEPFAR twinning model established collaboration between NGO clinical and community care and support partners that were paired with public hospitals to strengthen HIV service delivery and quality at their sites. The purpose was to create model sites capable of providing sustainable, high-quality clinical services tailored to the needs of key and PPs that could be replicated at other HIV clinics when PEPFAR support ends.

The APC community care and support partners played a vital role in the twinning model by reducing stigma and discrimination; reaching and referring key and PPs to clinical sites for testing and enrollment in care and treatment; providing community-based follow-up and adherence support for patients on treatment; and tracing and re-enrolling patients who had been lost to follow up.

The APC-supported twinning model transferred technical and management capacity to the public hospitals through monthly meetings between NGO and hospital sites; mentoring via case studies to solve problems; and exchange of experiences and best practices in management of HIV services, counseling, clinical practice, and laboratory support. NGO providers benefited from the twinning model by participating in public hospital clinical rounds, and NGO clinic patients received specialized care for HIV co-morbidities at the public hospitals.

APC GRANTEES AND CLINICAL SITES UNDER THE PEPFAR TWINNING MODEL FY19

Province	APC grantee/NGO HIV clinic and mentoring for public hospitals	Public hospital/ HIV clinic	APC grantee/NGO community care and support for public hospitals
Santo Domingo	IDEV	Lotes y Servicios Clinic	REDOVIH
	Activo 20-30	Yolanda Guzmán Clinic	REDOVIH
La Romana	Clínica de Familia	Dr. Francisco A. Gonzalvo Hospital	Grupo Este Amor
Puerto Plata	CEPROSH	Dr. Ricardo Limardo Hospital	CEPROSH/ Grupo Clara
Valverde	CEPROSH	Ing. Luis L. Bogaert Hospital	CEPROSH/ Grupo Clara

> *"Through collaboration with IDEV and REDOVIH, we are able to escort newly diagnosed HIV patients to get chest X-rays, which lets us rule out tuberculosis and get them on ART faster."*
>
> — Yuderkys Sánchez, psychologist, Lotes y Servicios Primary Health Care Center.

STRATEGIES TO INCREASE CASE-FINDING AND LINKAGE TO TREATMENT

Use of social media and VPR resulted in reaching greater numbers of HIV-positive individuals

Social media outreach

APC partner organizations conducted virtual outreach on social media and local dating applications. "Cyber-educators" targeted individuals exhibiting high-risk behavior online with HIV- and STI-prevention messages and referred them to APC-supported clinical sites for testing and treatment in the event of a positive result.

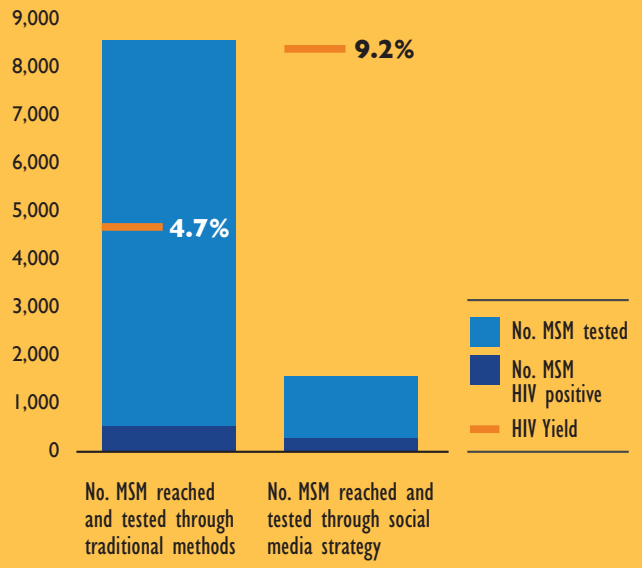
Grindr tinder mundoanuncio ADAM 4 ADAM Hornet skokka badoo

> *"The person who chatted with me was very professional and I felt a lot of trust… that is why I went and got tested."*
>
> — Lioni, 30-year-old MSM referred for HIV testing through social media outreach.

HIV testing client chatting with cyber educator.

RESULT

Number of MSM reached and tested through traditional methods versus social media and resulting HIV yield, May 2018–June 2019



APC/Dominican Republic

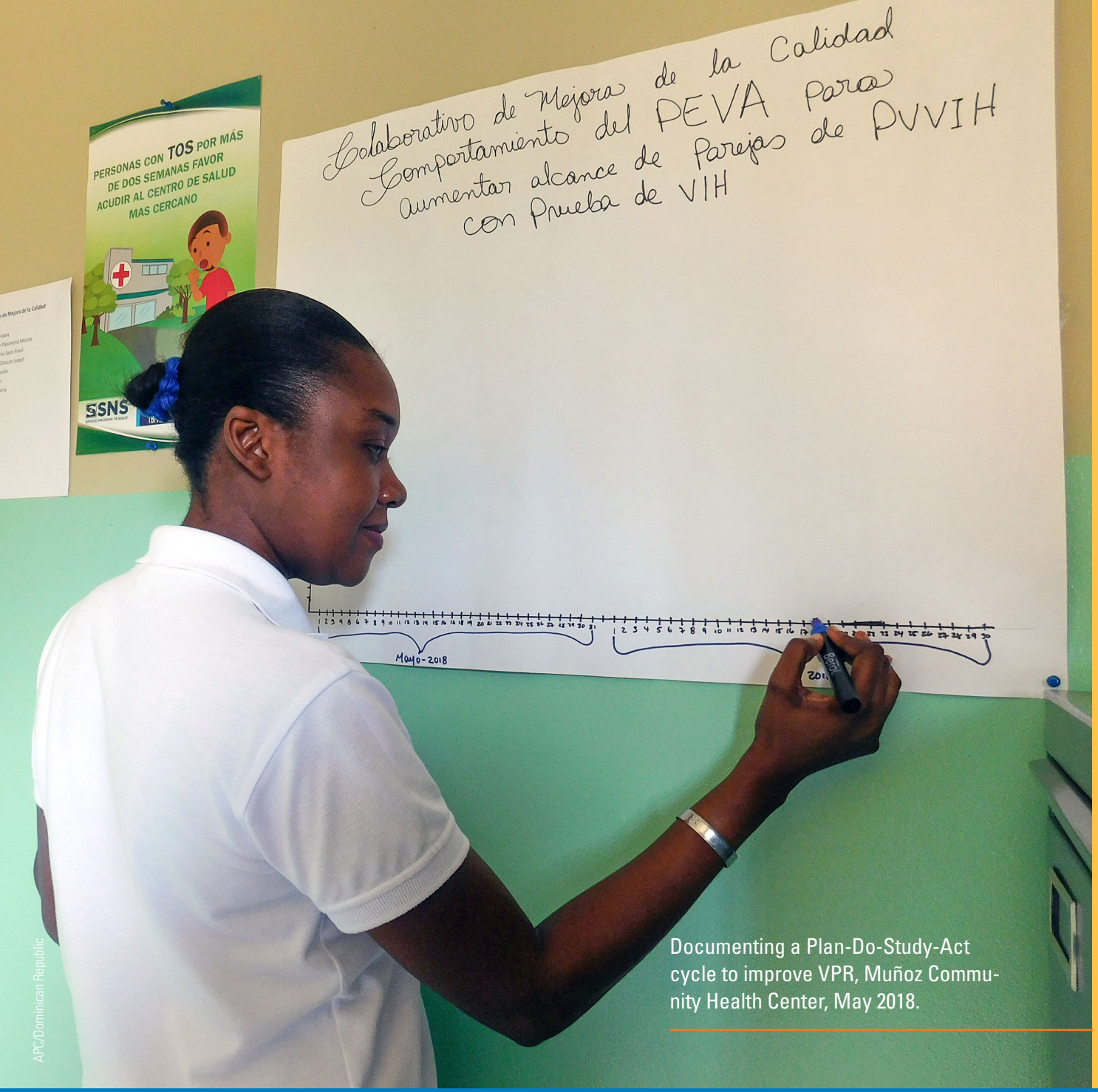
VPR team, Muñoz Community Health Center, October 2018

Voluntary partner referral

VPR is an index testing modality where the sexual partners of newly diagnosed individuals and PLHIV already receiving services at the sites are contacted then referred or escorted to a clinical site for testing and linkage to treatment in the event of a positive result. VPR services are promoted by counselors and case navigators at the clinical sites and through self-help groups, adherence support clubs, and home visits. Coupons promoting VPR are distributed at the sites and in the community, and the clinic´s VPR psychologist offers the service to PLHIV if a partner has accompanied him/her to the appointment.

The highest HIV yield of people tested at the APC-supported sites was among sexual partners who were reached and tested as a result of the VPR strategy, ranging from an average of 26.3 percent in FY18 to 28.1 percent in FY19, with 85.7 percent of HIV-positive sexual partners initiating ART in FY18 and 94.1 percent initiating in FY19. All other people tested through non-index modalities had an average HIV yield of 4.1 percent in FY18 and 3.3 percent in FY19.

> *"In 2018, when we first started VPR, there were many barriers, among them patients whose partners didn't know they were HIV-positive and who wanted to keep it that way because they were afraid their partners would leave them. It was quite a challenge to convince them to disclose."*
>
> — Gina, psychologist and VPR coordinator, Muñoz Community Health Center, Puerto Plata.

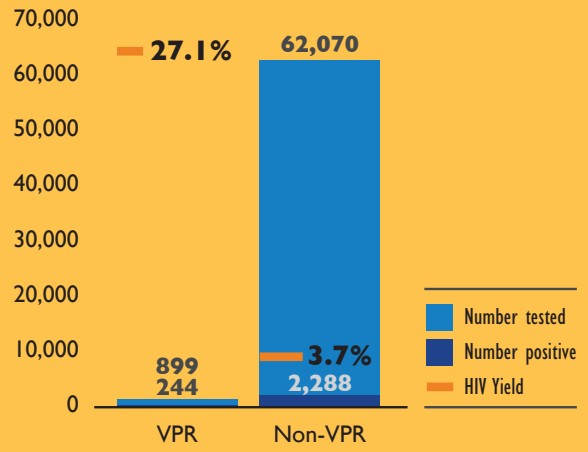


Documenting a Plan-Do-Study-Act cycle to improve VPR, Muñoz Community Health Center, May 2018.

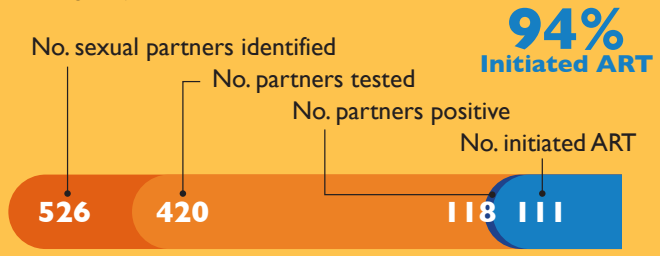
APC/Dominican Republic

RESULT

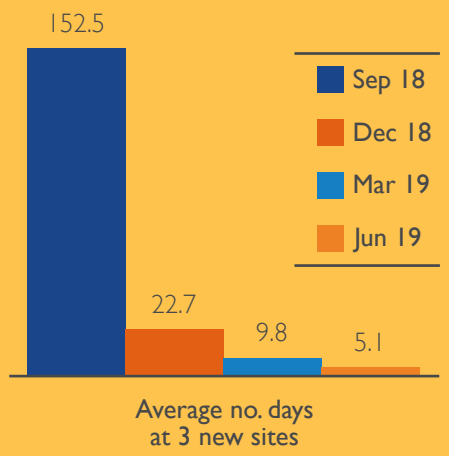
HIV yield of VPR index testing versus non-VPR testing, FY18–19



Number of sexual partners of index cases identified, tested, diagnosed HIV-positive, and initiated on ART as a result of VPR, FY18–19



Average number of days from diagnosis to initiation of treatment at the three new APC-supported clinical sites, FY19 Q1–Q3



> *"I swear I am a whole new person. I only had to wait 30 minutes to get my HIV test result, and two days later I had started my medicine."*
>
> — Altagracia, a patient at the Dr. Ricardo Limardo Hospital, Puerto Plata.

IMPLEMENTATION OF TREATMENT FOR ALL AT APC-SUPPORTED SITES

The hallmark of Treatment for All is immediate initiation of treatment after a positive HIV diagnosis

Before Treatment for All began, people were enrolled in care and monitored until their CD4 count fell below a certain threshold, at which point they started ART. Treatment for All required closing the gap between the number of patients in care (enrolled but not yet on treatment) and patients on treatment.

Interventions to accelerate Treatment for All and improve management, delivery, and quality of HIV services at the APC-supported sites from FY17 to FY19 included:

- Providing community- and facility-based HIV testing services through a variety of modalities.
- Implementing VPR services as an index testing modality to sexual partners of recently diagnosed HIV-positive people.
- Enrolling newly diagnosed HIV-positive people in care and ART initiation.
- Transitioning patients enrolled in care but not on treatment (pre-ART) to ART.
- Tracing and re-enrolling LTFU patients on treatment.
- Providing community and facility-based care and supporting ART adherence and retention.
- Improving monitoring and documentation of viral load testing and suppression in patient medical records and the national HIV services reporting system.

Initiated Treatment for All at three new APC-supported clinical sites in FY19

The main indicator for the implementation of Treatment for All is the average number of days from diagnosis to initiation of treatment. During FY19, project activities at the three new sites reduced the average number of days for initiating new patients on treatment from 153 to 5.

IMPROVING SERVICE DELIVERY AND QUALITY OF CARE

Implementing DMOC strengthened patient-service linkages and quality of care

APC implemented DMOC (a patient-centered approach that involves tailoring HIV services to patients classified as stable versus unstable) to support treatment adherence and introduce innovations for more efficient use of staff resources. The DMOC are intended to improve linkage to care and treatment for patients newly diagnosed with HIV, facilitate patient flow and provider workloads at the clinics, and ensure high-quality clinical services.

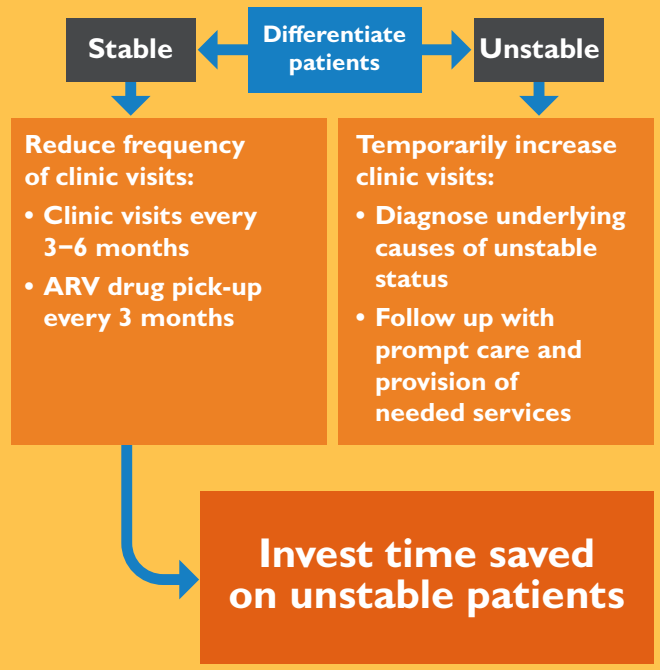
The objectives of the DMOC in the DR were to:

- Facilitate multi-scripting for adherent patients who have no clinical problems to reduce waiting time for refills and receive longer-term prescriptions.
- Establish a system for detecting patients at risk of non-adherence and linking them to the appropriate clinical, psychosocial, or community-based care.
- Contact and re-enroll patients who have interrupted treatment.

The DMOC for the APC-supported sites incorporated patient classifications based on World Health Organization definitions of stable versus unstable for patients on treatment to provide more focused care for those who have more advanced illness and problems with adherence, and more efficient and streamlined care for those who are stable. The DMOC implemented at the APC-supported sites facilitated organization and management of HIV clinical services.

> *"As a patient at CEPROSH HIV clinic, where a DMOC was established said, 'CEPROSH's extended hours were crucial and the care was humane, kind, and non-discriminatory.'"*
>
> — 36-year-old Carlos, a resident of Puerto Plata.

DMOC implemented at APC-supported clinical sites



COMMUNITY CARE AND SUPPORT FOR PEOPLE LIVING WITH HIV

Expanding the case navigator role to support treatment adherence

APC expanded the role of facility-based case navigators to support treatment adherence. Community-based peer promoters and case navigators supported patient adherence to treatment and retention in care through home visits, adherence support clubs, clinic appointment reminders, and follow-up of missed appointments.

An HIV-positive migrant patient at Muñoz Community Health Center receives a home visit and food donation from a community health worker Bella Dorville from NGO Grupo Clara, August 2016.

A case navigator guides a new patient through the process for starting ART at the Lotes y Servicios Primary Health Care Center, November 2018.

Through two training events and on-site technical assistance, APC trained 12 case navigators to:

- Participate in HIV clinic staff coordination meetings.
- Accompany patients to all hospital-related procedures.
- Facilitate newly diagnosed HIV-positive patient enrollment in care.
- Provide care and support for patients newly initiated on treatment.
- Help patients access social services at the clinic or through referrals.
- Conduct home visits to provide social/emotional support and adherence counseling.
- Support distribution of medicines to critically ill patients.
- Assist the HIV clinic in timely filing of viral load test results in patient medical records, and identifying viral load results > 1,000 copies/ml and informing clinic medical staff of such results.
- Coordinate with community promoters to trace and re-enroll LTFU patients on treatment.

> *"When Patria found me, I was emaciated. People would tell me that I had AIDS. I could not get a job. Now that my viral load has been reduced to 5,500 copies/ml, I look healthy again. I now have a steady job that allows me to provide for myself, my nutritional needs, and to support my family."*
>
> — Nany, a migrant woman who had stopped treatment and re-enrolled at the Lotes y Servicios Primary Health Care Center.

Patient retention management practices:

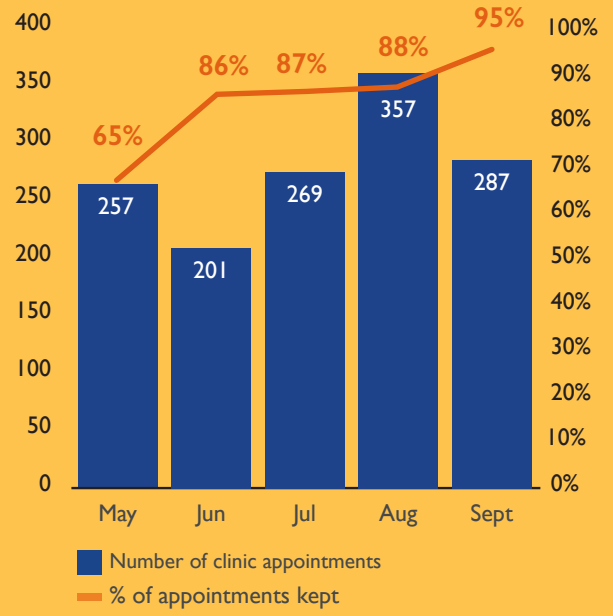
- An early-warning system to detect patients who are at risk of treatment interruption, which included:
  - daily review of clinic appointment book for missed appointments
  - contacting patients who missed their appointments
  - monthly monitoring of clinic attendance rates.
- Counseling and education sessions on treatment adherence offered at the facility.
- Community-based peer promoters identified and escorted high-risk individuals to APC-supported clinics for testing, where case navigators provided psycho-social support to those diagnosed with HIV and ensured their linkage to clinical care and ART.

Patient retention management practices improve clinic attendance

The Dr. Francisco Gonzalvo Hospital in La Romana has a large number of HIV patients of Haitian descent, a PP that has significant challenges adhering to treatment. By implementing patient-retention management practices, case navigators were able to significantly increase the percentage of appointments kept from May to September 2018.

Number of LTFU patients traced and re-enrolled on treatment, FY17–19

Clinic attendance increased through reminder calls and monitoring the daily appointment schedule, Dr. Francisco A. Gonzalvo Hospital, May–September 2018



IMPLEMENTING THE QUALITY IMPROVEMENT COLLABORATIVE

Site QI teams used data to improve service delivery and quality of care

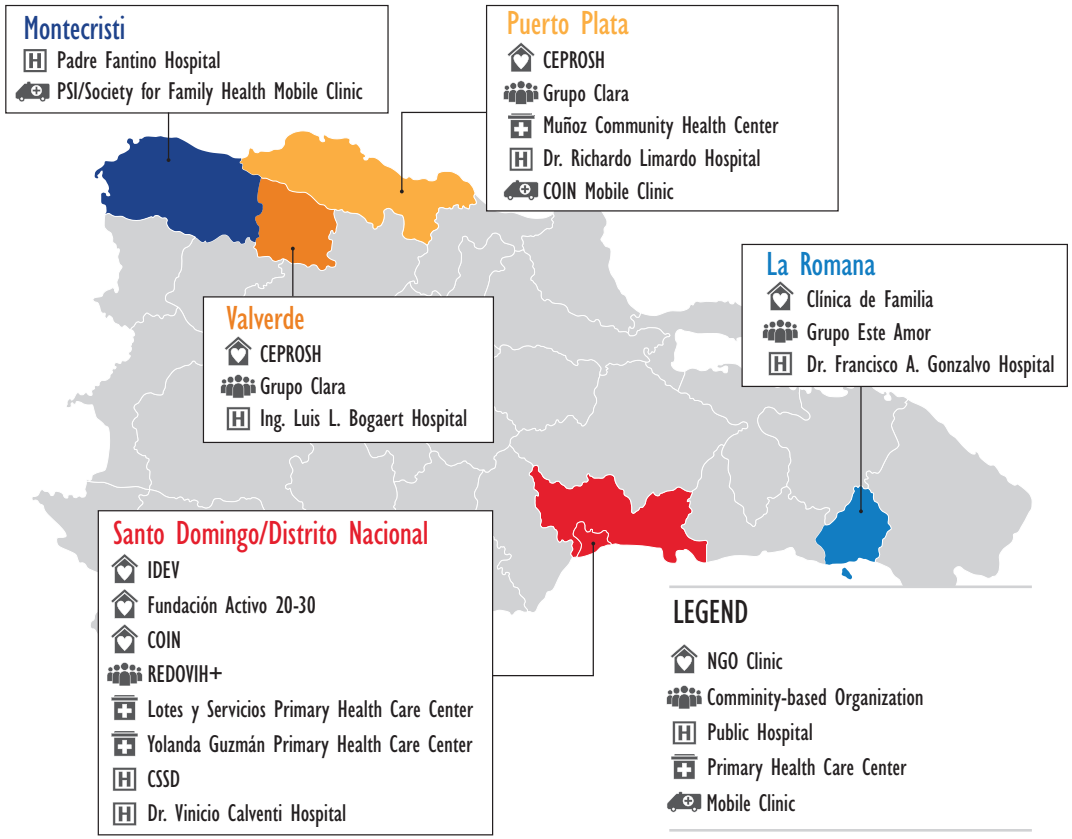
The QI Collaborative, adapted from the Institute for Healthcare Improvement, was established in FY18 and expanded to 14 PEPFAR-supported clinical sites and two mobile clinics in the five high-burden provinces where Treatment for All was being implemented in FY19. The QI Collaborative model resulted in a systematic, measurable, and sustainable QI process that supported the achievement of PEPFAR targets and quality standards that could be transferred to the GODR for rollout to additional high-burden, high-volume sites.

Launch of the QI Collaborative, February 2018 APC Dominican Republic

The QI methodology is based on the use of root-cause analysis and Plan-Do-Study-Act cycles to identify the causes of problems; plan and test changes to achieve the desired improvements; measure and adjust interventions as needed; and adopt best practices based on proven interventions. This process was supported by a team of facilitators in each province who built the capacity of the site-level QI teams to analyze and use data to inform improvement interventions using QI monitoring and reporting tools and graphic representations of data showing impact on the HIV treatment cascade.

The NHS officially recognized the QI Collaborative as the mechanism for expanding the Treatment for All strategy to all government HIV clinics. A QI Collaborative implementation guide was developed with technical assistance from APC and validated during the first round of QI facilitator training. As of APC project closeout, the NHS Quality Department had officially approved the QI Collaborative implementation guide, which has been printed for distribution to all HIV clinics.

QI COLLABORATIVE IMPLEMENTATION SITES AND PROVINCES, JUNE 2019



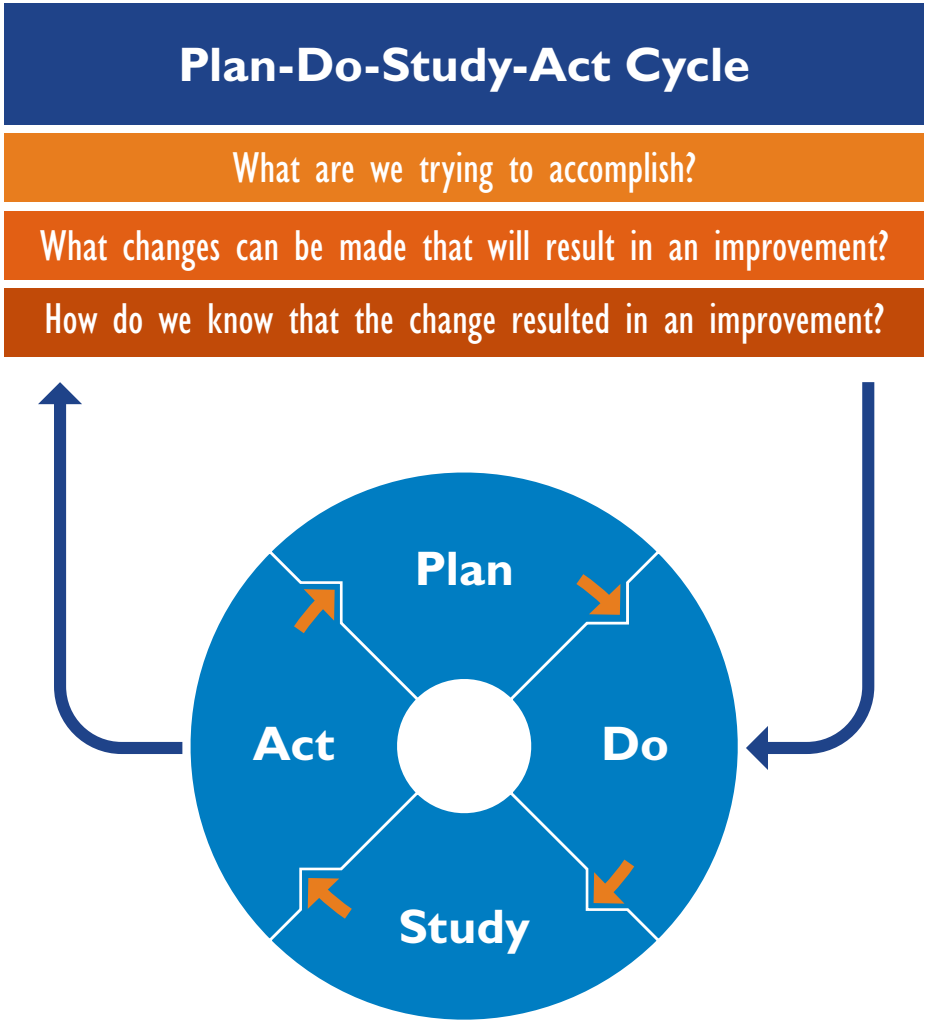
> *"Many things have changed for the better at our clinic, from the physical environment to the quality of our care. We learned there is a correct methodology for everything…managing treatment protocols, review and follow up of CD4 and viral load test results, identifying patients at risk for defaulting, and understanding the special needs of key populations. Before, patients just came and got their medicine. Now we can verify if patients are actually taking their medicine."*
>
> — Dr. Griselda Díaz, clinician at the Dr. Ricardo Limardo Hospital HIV clinic.

QI team at COIN HIV clinic, October 2018

RESULT

APC support through QI teams at the 10 USAID-supported and four CDC-supported clinical sites, and two mobile clinics resulted in:

- Reduced number of patients who came for testing but did not receive their test results.
- Increased HIV testing among MSM.
- Increased HIV yield of community- and facility-based testing for MSM.
- Reduced number of missed appointments for ARV pick-ups.
- Reduced number of new patients on ART who did not return after initiation of treatment.



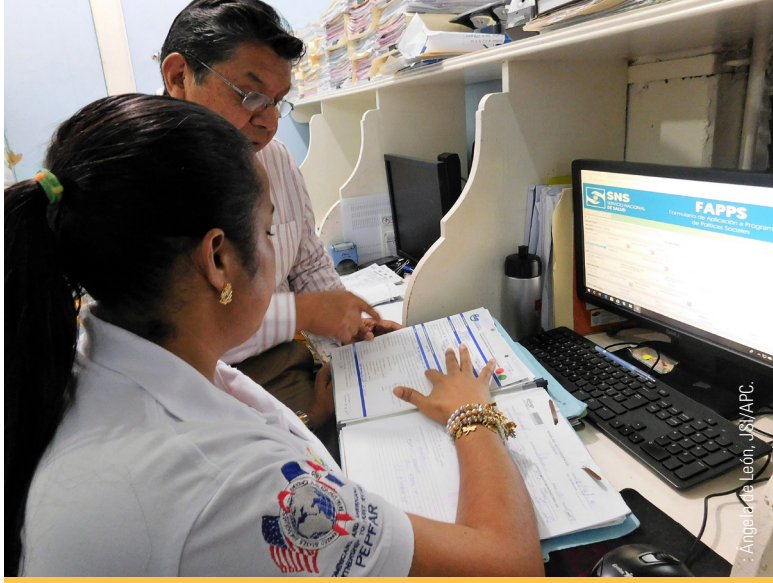
STRENGTHENING SITE-LEVEL DATA QUALITY AND USE FOR DECISION-MAKING

Strengthened data quality and use improved patient recordkeeping and quality of care

Technical support to strengthen quality, analysis, and use of data from the national HIV services information system (FAPPS for its Spanish acronym) resulted in notable improvements at the clinical sites. Specifically, improved quality and timeliness of data entry on the status of ART patients informed interventions for tracing patients who had dropped off treatment; following up with patients who missed appointments and were at risk of treatment dropout; and tracking patient viral load testing results.

APC strengthened the monitoring and evaluation systems at the clinical sites to improve data quality and build staff capacity in data analysis and use for decision-making by:

- Improving provider documentation on patient medical records.
- Improving timeliness and accuracy of data entry in the FAPPS.
- Conducting data-cleaning exercises to validate and update the number of patients reported as on treatment in the FAPPS.
- Purchasing computers and assigning staff to support quality and timeliness of data entry into the FAPPS.
- Joint planning and training with the National HIV/AIDS Council for implementation of the FAPPS module for reporting on HIV prevention activities and referrals for testing KPs.
- Empowering local staff in management and use of data to assess performance against established targets and benchmarks.
- Reviewing and standardizing use of the APC data collection and reporting tools for PEPFAR indicators and targets at the public hospital clinics



Angel de Leon, JSI/APC.

Data entry clerk Jasmine Sosa receives training from APC/DR monitoring and evaluation officer Franz Gonzales at the CEPROSH HIV clinic, October 2018.

> *"Before the APC project, the patient medical records were disorganized, viral load test results piled up, and everything was centralized. Now we have integrated and organized processes that allow us to provide better service to patients, including closer monitoring of their health status."*
>
> — Mery Álvarez, case navigator, Lotes y Servicios HIV Clinic, Santo Domingo.

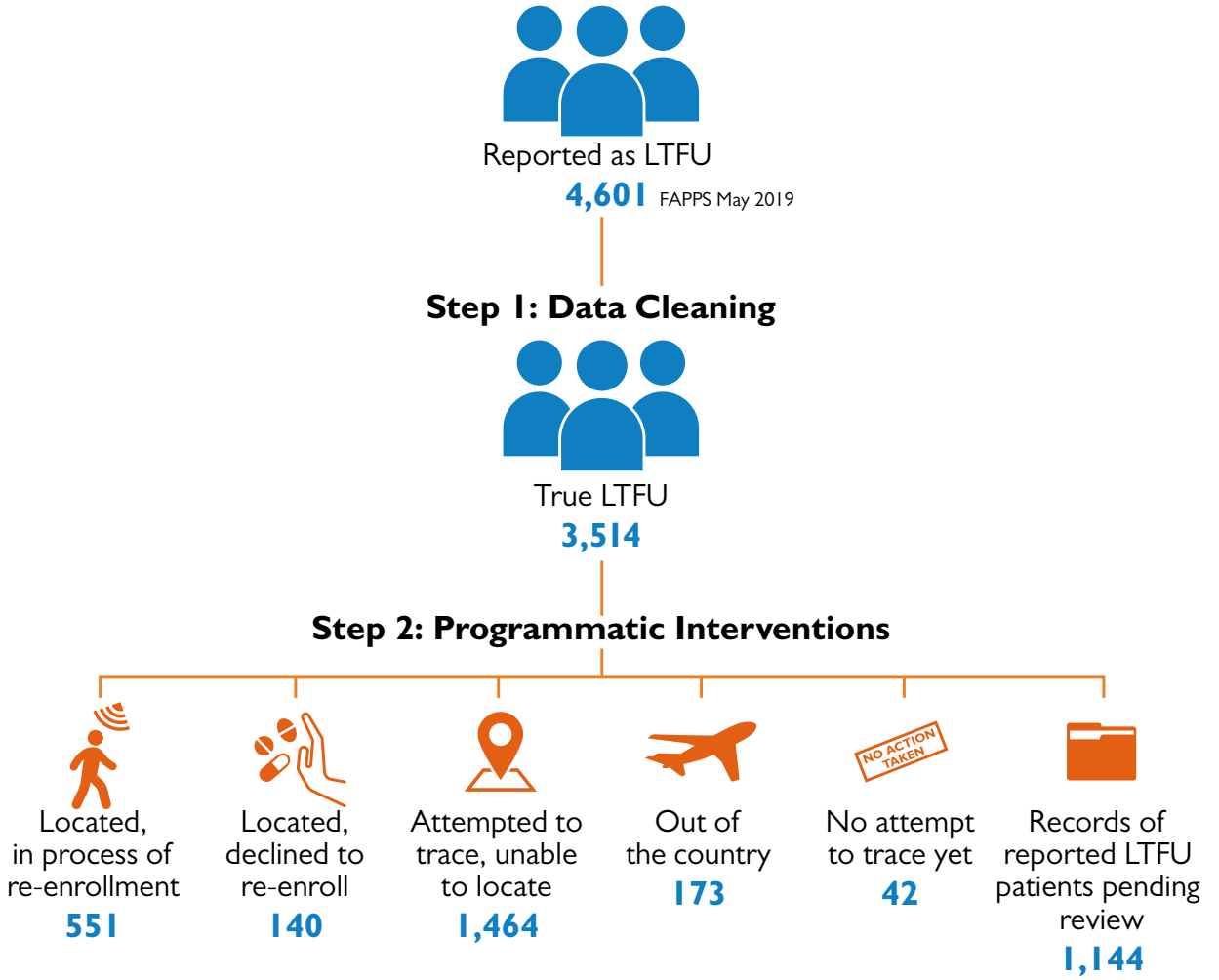
RESULT

The data cleaning and updating exercise at the nine APC-supported clinical sites resulted in a 23.6% reduction in the number of patients reported as LTFU.

The reasons for incorrect reporting were related to disorganized records management and delays in data entry.

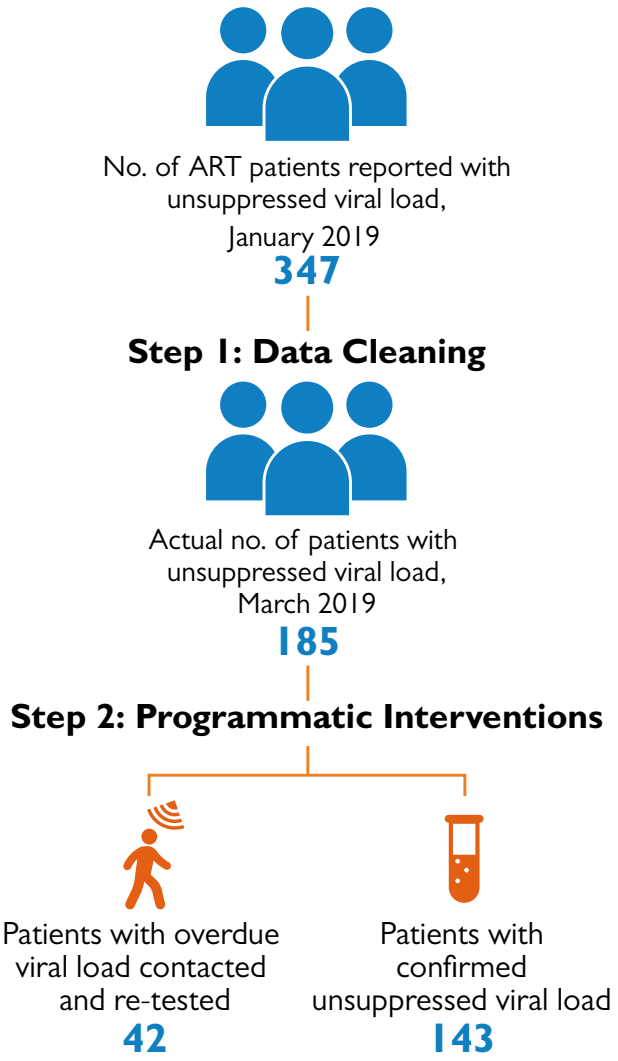
The resulting true LTFU cases were traced for re-enrollment on treatment.

Results of the LTFU data cleaning exercise



Results of the viral load data cleaning exercise

As a result of the APC-led data cleaning exercise to improve documentation and reporting of viral load results and viral suppression at the APC-supported clinical sites, 162 ART patients who were inaccurately reported as unsuppressed at the Lotes y Servicios HIV clinic in January 2019 were reclassified as virally suppressed with a confirmed viral load of < 1,000 copies/ml by the end of March 2019.



ADVANCING SELF-RELIANCE THROUGH QUALITY AND EMPOWERMENT OF LOCAL PARTNERS AND GOVERNMENT

The transformational strategies highlighted below strengthened local capacity to improve quality of HIV services and established a foundation for self-reliance and institutional empowerment.

APC/Dominican Republic

- Use of the QI Collaborative methodology and tools empowered local partners and government to progress toward the GODR 90-90-90 treatment targets and ensure longer-term sustainability of high-quality HIV care.
- APC activities through the PEPFAR twinning model resulted in NGO, CBO, and government partner collaboration to leverage local expertise and experience, and meet the needs of local providers and organizations.
- APC capacity-building activities introduced evidence-based strategies and patient-centered approaches that improved outreach to hidden and high-risk vulnerable populations, linked them to testing and treatment, and supported their adherence and retention in care to achieve long-term viral suppression. These strategies were adapted and implemented at the clinical sites, thereby helping to control the HIV epidemic and improve the quality of care and life for PLHIV.
- APC empowered local staff to resolve problems at the site level through the use of standardized data collection and reporting procedures, routine data quality checks, timely data entry, and analysis and use of data to fill programmatic gaps and improve quality of care. The improved site-level data quality in the FAPPS provided the government, international implementing partners, and donors with reliable data on the status of HIV treatment in the DR.

RECOMMENDATIONS

- Continue support for national roll-out, monitoring, and supervision of the QI Collaborative to ensure its sustainability and effectiveness within the government structure.
- Continue to scale up outreach and case-finding strategies and look for new approaches for reaching hidden high-risk KPs and hard-to-reach migrant populations.
- Expand linkages and collaboration between CBOs and HIV clinics to provide community care and support for KPs and PPs and all PLHIV as a critical component of service quality and treatment success.
- Scale up the patient-centered DMOC to other HIV clinics to improve management and quality of care for all PLHIV. Expand ARV drug-dispensing for stable patients from 3- to 6-months as soon as possible.
- Adapt an integrated clinical and psycho-social approach to investigate, identify, and understand the root causes of treatment dropout.
- Position the plight of the migrant population, which is disproportionately affected by HIV in the DR, within the national agenda as a bi-national (DR and Haiti) public health issue.
- Institute a systemic approach to strengthen site-level data quality, reporting, and use for decision-making, and coordinate donor and government efforts to manage strategic information at the national level.

APC/Dominican Republic

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