COMMUNITY PRIORITY RECOMMENDATIONS
FOR PEPFAR COP2022

COP PÈP
AYISYEN AN
HAITI
PEOPLE’S COP22
INTRODUCTION

Between 130,000 and 170,000 Haitians are currently living with HIV, of whom an estimated 80% know their status\(^1\). In the face of the joint challenges of the ongoing COVID-19 pandemic and the challenging political situation in Haiti, the PEPFAR program has successfully delivered treatment to 125,438 people at the end of Q4 and has achieved 72% coverage of six-month antiretroviral dispensing (MMD6+)\(^2\). The Haiti community-led monitoring (CLM) project, one of the earliest CLM programs to receive PEPFAR support, has entered its second year of implementation, delivering an important source of monitoring and accountability to the PEPFAR program.

Despite these successes, the PEPFAR program in Haiti continues to face key challenges in achieving the 95-95-95 targets. Viral load coverage has decreased from 86% in 2020 to 81% in 2021, particularly among ages 20-34\(^3\). Serious gaps remain in the prevention of mother-to-child transmission (PMTCT), with Haiti experiencing the second highest rate of infant HIV infection (EID-Yield) among all PEPFAR countries\(^4\) and 40% of pregnant women newly initiating antiretroviral therapy (ART) only after conception during antenatal care\(^5\). The PEPFAR program continues to face challenges with high rates of interruption of treatment among young people and with reengaging PLHIV who have withdrawn from care, particularly key populations (KP).

PREPARATION OF THE HAITIAN PEOPLE’S COP

This document represents the joint position of communities and civil society in Haiti. The priorities contained herein are the outcome of a series of convenings held with civil society organizations led by, and representing, people living with HIV, key populations, women, adolescent girls and young women, orphans and vulnerable children, religious organizations, and other constituencies impacted by the HIV epidemic.

These voices are complemented by the findings from Haiti’s community-led monitoring program (CLM). The project is led by l’Observatoire Communautaire des Services VIH (OCSEVIH), an association created in 2020 to protect the rights of PLHIV and key populations, and which has been gathering quantitative and qualitative data in health facilities and in communities since 2021. These data provide an evidence-based view of the quality, accessibility, and availability of the HIV program in Haiti.

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\(^1\) UNAIDS. AIDSInfo. 2020.
\(^2\) Information Memo for Charge D’Affairs Kenneth H. Merten, Haiti, pg. 4
\(^3\) Information Memo for Charge D’Affairs Kenneth H. Merten, Haiti, pg. 4
\(^4\) amfAR. PEPFAR Monitoring, Evaluation, and Reporting Database.
\(^5\) Information Memo for Charge D’Affairs Kenneth H. Merten, Haiti, pg. 4
KEY ISSUES

The challenges faced by the PEPFAR program in Haiti will require a collaborative partnership with civil society and communities. With this document, civil society calls for a COP22 that delivers innovative, inclusive, and high-quality care to all Haitians living with, and impacted by, HIV. The full list of civil society priorities for COP22 are detailed in the table below.

1. Wraparound services for PLHIV, including psychosocial support

Because the healthcare needs of PLHIV extend beyond HIV treatment, the PEPFAR model of standalone, ARV-dispensing clinics is not working for PLHIV. Every clinic accessed by PLHIV must offer a full suite of standard healthcare services, which must include annual medical check-ups, kidney functioning tests before initiating PrEP, cervical cancer screening and treatment, tuberculosis services, proctology and urology, and diagnosis and treatment of sexually-transmitted infections (STIs) and opportunistic infections.

JOEL

“I wish for complete healthcare for all patients. I remember [falling ill] and in the center where I am receiving my HIV treatment, they didn’t want to operate on me —or even refer me to another place. I wish that there would be additional services.”

According to data from the CLM project, one-quarter of all monitored sites do not offer any health check-ups, requiring patients to travel to distant clinics in order to receive basic healthcare. Providing the same care in all sites is not only critical for improving patient outcomes, but also for standardizing care between treatment sites to reduce duplication, patient transfers, and competition between sites.

PEPFAR must take action to address continuing failures of supply chain systems, which continue to result in stock-outs of antibiotics, condoms, lubricants, and vitamins. In addition to missing medications and commodities, patients routinely report being prescribed medications that are expired. This is unacceptable. As the supply chain modernization project is rolled out, PEPFAR must ensure the project’s scope includes non-ARV commodities and that systems are built to track and end the practice of prescribing expired ARVs.

When you feel depressed, are you able to access psychosocial services?

Patients Surveyed: 231

- Yes, in this clinic: 20.3%
- Yes, in a different clinic: 61%
- Yes, outside of a clinic (in the community, from a friend or member of my family, etc): 11%
- No: 3%
- Don’t know: 4%
In addition, mental health services must also be available routinely and on-demand, not only at the time of HIV diagnosis. According to CLM data, despite the fact that 48% of patients experience depression or suicidal ideation about their HIV status, only 61% report being able to access mental health services at their clinic when they feel depressed, and only 30% of respondents report having access to on-demand HIV counseling, psychosocial support, and other mental health care services.

PEPFAR must release guidance requiring all sites to provide psychosocial support for PLHIV, including mental healthcare services. In addition, every PEPFAR site must have on staff at least one psychologist and one social worker, and mental health services must be offered to every HIV patient at every clinic visit.

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2. Strengthen HIV prevention

As a highest priority, PEPFAR must address the unacceptable state of the PMTCT program in Haiti. PEPFAR must implement a multi-pronged approach to find all pregnant women where they are. This must include the roll-out of a full suite of community-based interventions for pregnant women who do not receive care in clinics, including testing and treatment. To support women in receiving care in facilities, PEPFAR must ensure financial support, food, and other non-monetary support. Women must be assigned a guide to support them in navigating care during and after pregnancy.

In parallel, the activities of the DREAMS program must be strengthened and expanded to provide holistic support to adolescent girls and young women. PEPFAR must conduct regular engagement with the target population to gather input about what interventions are needed and useful. The DREAMS activities must extend beyond ensuring that girls complete basic education, but must extend into the delivery of income-generating activities, entrepreneurial training, and support to help women develop careers.

Finally, while noting the scale-up of PrEP availability in Haiti, many clinics still do not have access to PrEP. PEPFAR must work with PNLS to ensure that all clinics have received training and certification in order to be able to provide PrEP. Since only 25% of patients surveyed by CLM have heard of PrEP, PEPFAR must require its clinics to offer PrEP to all eligible patients and must work with community-based organizations to conduct outreach to increase awareness.

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3. Enforce consistent patient privacy

Stigma and discrimination of PLHIV remains a significant barrier to accessing and remaining in care. The CLM project has revealed alarming and routine violations of patient privacy, including clinicians disclosing patients' HIV status to other patients, patients' family members and friends, and community members. This is unacceptable and must be urgently remediated before Haiti can reach the 95-95-95 targets.

MARIE GUIRLÈNE

“The [healthcare providers] aren’t gentle with PLHIV. It seems like we are animals or we stopped being humans because we became infected. PLHIV still remain human beings, like every other human being. We would like to see change in the system. Also, we are asking that the health care providers be well-trained, because we believe this is a consequence of lack of training. When people are diagnosed with cancer, glycemia, blood pressure issues, and they go to a clinic or a private hospital they are well-received. Why don’t PLHIV get the same treatment as everyone else? Things need to change.”

One key source of privacy violations is the separation of PLHIV from other clinic patients in 46% of monitored sites, through separate waiting rooms, queues, and examination rooms. Other reports reveal that patients are receiving colored cards that identify their HIV or KP status to others in the waiting room. CLM focus groups and interviews reveal that deep anxiety about inadvertent disclosure of their HIV or KP status is a significant barrier to reengaging PLHIV who have fallen out of care. PEPFAR must immediately ensure that 100% of clinics reorganize patient spaces to end the public separation of people receiving HIV care.

Clinic staff trainings on stigma, privacy, and discrimination have not gone far enough. Findings from CLM show that in 41% of clinics, clinical staff have not been trained in HIV, stigma, and discrimination in the last six months. All PEPFAR-supported sites must mandate that all clinical and non-clinical staff receive routine and in-depth training on ensuring patient confidentiality. All people involved in patient care must sign an employment clause or agreement committing to adhere to existing PNLS and PEPFAR guidance on confidentiality. In this document, the disciplinary actions for patient mistreatment must be clearly defined.

According to CLM data, only 63% of sites had a complaint box for patients to report their concerns or complaints. PEPFAR must ensure that all its sites are monitoring patient satisfaction, that there is a process in place to respond to patient complaints, and that clinic-level data on these metrics are release publicly. Patients that are not receiving adequate or acceptable care must be granted timely transfers to a different clinic.

“What I would like to see changed is the long lines and many hours of waiting at the hospital. Let’s take, for example, a factory or domestic worker. He goes to a center at 8AM hoping that he will be able to go home quickly, but he’s still waiting 3 hours later. The day is wasted. If things get better, there would be less loss to follow-up, since people said they are discouraged from going to receive treatment.”

Although bringing ARVs to patients’ homes is an important mechanism for reaching patients outside of clinics, fear of having one’s HIV status revealed during deliveries is a common fear. Among people who do not participate in home delivery of medications, 46% have declined in order to avoid people finding out their HIV status. Clinics must fully train their delivery team on patient confidentiality. Where possible, clinics should employ a variety of people to do deliveries, to reduce the risk of inadvertent disclosure if the delivery person’s role becomes known to the community.
4. Remove financial barriers to healthcare

Costs and lack of food remain a significant barrier to accessing HIV care in Haiti. In addition, while HIV treatment is available at no costs, patients report costs such as consultation fees or charges for services like annual health checks. In addition, survey data from CLM reveal that among people who have stopped taking their medications, 43% report doing so because they didn't have enough food. Yet only 27% of patients report always receiving food and/or money when they visit the clinic.

These costs can have serious implications for patients. Evidence from the community reveals patients dying from HIV complications due to not having the financial means to reach the clinic for a medication refill. According to CLM data, the second most common reason for not participating in support groups is an inability to pay for transportation.

Holistic care for PLHIV, including routine check-ups and care for HIV-related healthcare needs, must be available free of charge. Reimbursement for transportation, as well as food and/or monetary benefits, must be made available at 100% of PEPFAR-supported sites. These benefits must be available on a consistent basis and must be provided at the same time that services are provided, so that patients don’t have to wait at the clinic or hospital.

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5. Strengthen community-based service delivery

The Haiti PEPFAR program is built on the back of peer educators, navigators, and other community health workers. These community workers are often tasked with achieving ambitious programmatic targets, yet this workforce is undercompensated and face unequal treatment and treated as second class healthcare workers. A key task for peer navigators is picking up patients and transporting them to clinics, yet in some cases the clinic does not fully reimburse these transport costs.

The implications of insufficient compensation are felt through a lack of transportation service for patients, closing down support groups and adherence clubs, and a weakening of the infrastructure that is critical to keeping patients in care. PEPFAR must work with PNLS to ensure the professionalization of peer educators and navigators. This must include employing them as regular staff, providing them with a standard wage, and ensuring that all costs associated with their work (such as transportation) are fully compensated.

In addition, local, community-based organizations are critically important to the HIV response in Haiti. Despite having local knowledge and an institutional connection to the community, these organizations are rarely selected as implementing partners and are significantly underfunded relative to their key role. PEPFAR must prioritize the funding of Haitian organizations as prime and sub-prime implementing partners and must partner with local CSOs in the reengagement of people in care, retention and support, patient literacy and U=U, and delivering community-based services.

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- **COP22 Target**: PEPFAR must require its implementing partners to involve civil society organizations in achieving the re-engagement of at least 70% of people experiencing interruptions of facility-based care.
- **COP22 Target**: PEPFAR must fund PLHIV- and KP-led civil society organizations to carry out advocacy and deliver information on treatment literacy, patient rights, and U=U.
- **COP22 Target**: PEPFAR must facilitate the strengthening of associations through at least 10 micro-grants per year.
- **COP22 Target**: PEPFAR must work with IPs to ensure a 50% increase in compensation for ASCPs, peer educators, and other community health workers, including reimbursement of transportation costs for work performed in communities.
- **COP22 Target**: PEPFAR must increase funding to local, civil society, and community organizations. Special funding mechanisms, including at least 10 microgrants per year for associations of PLHIV and KPs, should be pursued to reduce the administrative burden on small organizations.
- **COP22 Target**: Prioritize funding five new Haitian organizations per year as prime and sub-prime implementing partners.
- **COP22 Target**: The CLM program must be funded through the central PEPFAR budget.
- **COP22 Target**: PEPFAR must ensure the independence of the Observatory’s CLM activities, to not compromise the integrity of the program and findings.
- **COP22 Target**: Funding levels for the Observatory must increase by 50% to support the program in expanding its surveillance to COVID-19, tuberculosis, and malaria.
- **COP22 Target**: PEPFAR must ensure that funds are disbursed on time for CLM activities.
- **COP22 Target**: The Observatory should engage not only through the sharing of data, but as active participants in strategic discussions on the PEPFAR program.
6. Enforce a nonnegotiable commitment to human rights, respect, and dignity

A recurrent theme in discussions with community members and in focus groups in the CLM project is the poor treatment of patients in clinics. When patients who have missed a visit return to the clinic, 24% report being reprimanded by clinic staff, acting as a further barrier to reengagement in treatment and care. Among KPs, 13% have avoided seeking healthcare services out of a fear of bad treatment by clinic staff. People who do not feel comfortable with clinicians cannot get the healthcare they need. CLM survey data reveal that 28% do not feel comfortable requesting a transfer to a different clinic if they have had problems with the services, 26% do not feel comfortable asking for a different medication, and 11% of patients don’t feel comfortable talking about their symptoms with staff.

PEPFAR must ensure that all of the COP22 program in Haiti be centered around the fundamental right of all Haitians and PLHIV to be treated with dignity and respect. This must be enforced through clear guidance, trainings for all clinical and non-clinical staff, and a zero-tolerance expectation that staff who mistreat patients will be disciplined and may be fired.

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## 1. CARE AND TREATMENT

### 1.1 Ensure that clinicians treat clients with professionalism and respect

**Pg. 16.** Friendly, welcoming services to clients and intense implementing partner monitoring to follow comprehensive care guidance are critical to improving durable linkage and continuity of treatment to reach epidemic control. The Easy Start package will be specifically adapted to address stigma and discrimination from the initial encounter with a client and throughout the continued engagement to prevent treatment interruption and improve treatment adherence.

**Pg. 38.** Started in COP19, and continuing in COP21, PEPFAR support will also allow the MSPP to dedicate specific resources to protect the rights of PLHIV at health facilities and ensure services are provided free of discrimination.

- All care sites must require training for all clinical and non-clinical staff, on at least quarterly basis, on professional ethics, preventing violations of patients’ rights, interpersonal communication, and patient retention
- Increase the staff salary schedule by at least 20% to motivate better patient treatment and care
- 100% of clinics must have a suggestion box
- Monitoring and evaluation visits by PNLS must be strengthened and take place in all sites at least once per quarter
- Any client who lodges a complaint for poor treatment must receive a transfer to another clinic of their choice without difficulty. Staff who are reported for mistreatment of patients must be disciplined.

According to CLM data, 24% of patients have been reprimanded after a missed visit. 13% of KPs have avoided seeking healthcare services out of fear of bad treatment. 28% of patients do not feel comfortable requesting a transfer to a different clinic if they have had problems with the services, and 26% of patients do not feel comfortable asking for a different medication.

### 1.2 Provide wraparound services for PLHIV in all clinics

**Pg. 35.** 4.8 Cervical Cancer Program Plans – not applicable.

- By October 2023, comprehensive care must be available without user fees, including annual check-ups, cervical cancer screening and treatment, cardiovascular disease, kidney disease, urology, medications for OI, STIs, vitamins, and antibiotics, and services for people aging with HIV
- Basic services should be standardized across clinics to avoid medical shopping and ensure access. There should be no clinics that only provide ARVs
- Where clinical services are unavailable, PEPFAR must implement a referral network for patients.

The healthcare needs of PLHIV extend beyond HIV testing and treatment. Data from CLM reveal that 25% of monitored sites do not offer health check-ups.

**Pg. 16.** The Easy Start package will address treatment literacy gaps that make the treatment of good patients more challenging while building trust between patient and provider. The “Easy Start” core components include revamped post-test counseling to improve treatment literacy, intensified psychosocial support, entry into an ART treatment agreement detailing the importance of compliance and adherence, and continued client engagement for continuity of treatment over time and in between follow-up visits.

**Pg. 17.** We will support the implementation of a national psychosocial guide, and validation of new psychosocial forms for systematic routine baseline psychosocial assessment at pre-ART enrollment whether enrolled at the site or community level, as well as routine re-assessment of ART clients at least every 6 months.

- 100% of clinics must have on staff a psychologist and a social worker
- Psychosocial support must be strengthened in 100% of PEPFAR-supported sites. Services must be available at all times and offered to patients at every clinical visit
- Each newly-diagnosed person should be offered, with their consent, a support person to provide systematic support from treatment initiation to adherence.

According to CLM data, while 48% of patients experience depression or suicidal ideation about their HIV status, only 61% are able to access mental health services at their clinic. Only 30% of patients have access to HIV counseling and other mental health care services at all times.
1.3 Modernize and expand ARV distribution

Pg. 1. The program will pursue targeted and client-centered differentiated service delivery approaches for reliable and convenient ART refills including six-month (up to 12-month in exceptional cases) scripting and dispensing (MMD) at facility and community levels. At least 5 DDPs must be implemented annually at the community level in organizations and associations of PLHIV and KP, after evaluation of implementation capacity. There are currently no DDPs in LGBTI associations. Community DDPs should include comprehensive services, including accompaniment, membership clubs, nutritional support, support groups, recreation, and psychosocial services.

Pg. 7. At the end of FY20, 51% of all ART clients received ART services at the community level, mostly via home delivery. + 100% of field workers delivering medicines at home must be trained on patient privacy and confidentiality. According to CLM interviews, some PLHIV refuse to take medications because of fears of confidentiality violations during home medication delivery.

Pg. 17. By using existing sites in the community (pharmacies, grocery stores, PLHIV associations offices) with extended/flexible hours, clients can collect their ART earlier or later in the day. Commercial sites may remove the stigma associated with drug pick-up points that exclusively serve PLHIV, while the PLHIV associations offer flexibility, leveraging PLHIV networks to better reach clients. + 100% of field workers delivering medicines at home must be trained on patient privacy and confidentiality.

Pg. 17. Since clients reported forgetting their appointments is the main reason for missing appointments, a special emphasis will be placed on routinizing reminder calls from the site staff to clients to remind clients of appointments and refill dates. In between clinical visits, calls or visits will be done to inquire about patient well-being, reinforce treatment literacy, and keep offering DSD, including early refill, to prevent treatment interruption. + PEPFAR must end the prescribing of expired drugs. PEPFAR needs to conduct an analysis to identify why expired drugs are being given to patients, to find where the gaps in the supply chain are. If supply chain barriers cannot be quickly resolved, PEPFAR should start procuring ARVs with a longer shelf life. + PEPFAR must require its partners to professionalize the work of peer educators. All community workers and field health workers should be hired as regular staff and should receive uniform salaries. Expenses related to the performance of their work, such as transportation, must be fully reimbursed in addition to their regular salary. Treating all healthcare workers as equal partners in the fight against HIV has been a key civil society demand since 2019. This requires a structural change in the way non-clinical workers are treated.

1.4 Improve retention of people in treatment and care

Pg. 18. In COP21, Haiti will continue the Return to Care and Retention Surge campaigns initiated in FY19 and continued in FY20/21, coupled with the expansion of complementary community services and contingency plans. + PEPFAR must require its implementing partners to involve civil society organizations in achieving the re-engagement of at least 70% of people experiencing interruptions of facility-based care.

Pg. 25. IPs will make sure providers follow guidelines for clinical appointments, and assess the needs of other services such as VL specimen collection, psychosocial support. Patients will receive appropriate therapeutic education. + Remove financial barriers to healthcare by providing sufficient reimbursement of travel costs adjusted to where the patient is coming from. + Facilitate the provision of a dry food ration to the most vulnerable patients through the development of partnerships with WFP, UN organizations, and others. + PEPFAR IPs must ensure the regular maintenance of clinics and that damaged healthcare structures are promptly repaired. According to CLM, only 27% of patients always receive food and/or money when they visit the clinic. Yet 43% of people who stop taking medications do so because they don’t have enough food. CLM data reveal that 50% of clinics are in poor or passable condition, with reports of broken furniture, walls, roofs, and toilets.
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<td><strong>1.5 End violations of privacy and confidentiality in all sites</strong></td>
<td>Ensuring that all staff contracts have an anti-stigma and anti-discrimination clause, which if violated will result in disciplinary action, including termination.</td>
<td>+ All clinical and non-clinical staff must sign a confidentiality clause that defines the disciplinary actions for breaches of patient privacy. Stigma and discrimination of PLHIV remains a significant barrier to accessing and remaining in care in Haiti.</td>
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<td></td>
<td>+ Clinics must be reorganized and restructured to end the separation of PLHIV from other chronic rooms in waiting rooms, queues, and examination rooms. There are currently facilities that are successfully integrating patients, so PEPFAR should take lessons learned from these sites.</td>
<td>The CLM project show routine violations of patient privacy, including clinicians disclosing patients' HIV status to other patients, patients' family members and friends, and community members.</td>
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<td><strong>1.6 Deliver integrated tuberculosis services</strong></td>
<td>TB care should be integrated into all clinics serving PLHIV, including the development of TB clinics in all large facilities.</td>
<td>+ TB care should be integrated into all clinics serving PLHIV, including the development of TB clinics in all large facilities. + All HIV-positive patients should be screened for TB once every six months. + Clinics should designate HIV/TB focal points to support patients to receive integrated care and to communicate between clinics. The current practice of providing TB care in separate clinics means patients have to move between clinics and there is no integration or visibility into the care received across sites.</td>
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<td><strong>2. DIAGNOSIS</strong></td>
<td>+ Ensure that 100% of candidates for index screening are screened for intimate partner violence and are informed of their right to refuse.</td>
<td>Index testing is an important tool to identify PLHIV and bring them into care. However, index testing can only be expanded if clinicians strictly adhere to guidance about screening for IPV and ensuring that no one is coerced or pressured into participating.</td>
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<td><strong>2.1 Index testing</strong></td>
<td>The prioritized case finding modalities will be index testing, TB and STI testing, and PMTCT testing.</td>
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<td><strong>3. PREVENTION</strong></td>
<td>+ PEPFAR must fund PLHIV- and KP-led civil society organizations to carry out advocacy and deliver information on treatment literacy, patient rights, and U=U campaigns. + PEPFAR must facilitate the strengthening of associations through at least 10 micro-grants per year.</td>
<td>Haiti has the second highest percentage of babies born to HIV-positive women who test HIV-positive</td>
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<td><strong>3.1 Improve treatment literacy</strong></td>
<td>The focus will be placed on the prevention of treatment interruption through activities improving treatment literacy, Undetectable = Untransmittable (U=U) campaigns,</td>
<td>+ PEPFAR must fund PLHIV- and KP-led civil society organizations to carry out advocacy and deliver information on treatment literacy, patient rights, and U=U campaigns. + PEPFAR must facilitate the strengthening of associations through at least 10 micro-grants per year.</td>
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<td><strong>3.2 Reduce high rates of mother-to-child transmission of HIV</strong></td>
<td>Outreach/community services will be effectively rolled out to support pregnant and breastfeeding women (PBFW) as part of PEPFAR-Haiti's efforts to enhance testing of infants (Early Infant Diagnosis (EID) at less than two months, ensuring that HIV-positive infants are initiated and retained on ART and that HIV-positive children have viral load tests done on time and are kept virally suppressed.</td>
<td>+ The budget allocated to pregnant women is too low and must be increased to cover the strengthening of mothers' clubs, adherence clubs, and the reimbursement of transport costs according to where the women are traveling from. Pregnant and lactating women must receive food incentives. + At the community level, women must be supported in receiving PMTCT services like testing and services much earlier. Additional support must be provided to rural health centers to ensure that 100% pregnant women are tested for HIV in the first prenatal visit. + Train and fund all multipurpose community health workers to go into the community to find pregnant women and bring them back to care. + Set up departmental birth centers to care for high-risk and vulnerable pregnant women living in remote areas. + Pediatric services should be provided and available at the community level, for women who do not go to clinics.</td>
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<td>Household Economic Strengthening (HES) is facilitating the transition for many families from PEPFAR-Haiti support and reducing dependency on OVC education programs. The savings group program aims to empower young women and their families through social and economic strengthening and consequently, helps to reduce gender-based violence (GBV) and decrease HIV risk. Other HES activities include vocational training, and credit towards small enterprises, etc.</td>
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<td>Index testing is an important tool to identify PLHIV and bring them into care. However, index testing can only be expanded if clinicians strictly adhere to guidance about screening for IPV and ensuring that no one is coerced or pressured into participating.</td>
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3.3 Strengthen the DREAMS program

Pg. 20. The Haiti DREAMS program aims at improving completion of services for all adolescent girls and young women by:

- Implement DREAMS in municipalities in the departments most affected by the August 14, 2021 earthquake (Grand’Anse, Nippes, and South) and ensure the enrollment of at least 2,000 new adolescent girls and young women
- Increase the reimbursement of basic transport costs for adolescent girls and young women by 50%
- Strengthen income-generating activities (for example, with trainings in making liquid soap and agricultural products like chocolate, peanut butter, and jam)
- PEPFAR should engage directly on an annual basis with adolescent girls and young women to understand the types of activities, training, and education they need
- DREAMS activities need to be more substantial and routine. Adolescent girls and young women need more than completing basic education, but also entrepreneurship training, mentoring, higher education support and professional development support to help them develop their careers.

Pg. 23. In COP 21, PrEP is expected to be available in all the 10 geographical departments, with the contribution of both PEPFAR and GF

Pg. 24. Discussions are ongoing to update the PrEP guidelines to include non-key populations high-risk groups in the eligible populations and offering PrEP on-demand as another alternative for men who have sex with men. PrEP services will also be expanded to target young women as vulnerable populations.

Pg. 22. An updated national HIV prevalence for MSM and commercial sex workers (CSW) is expected with the Global Fund-financed new IBBS, planned to start in FY22.

4. KEY POPULATION FRIENDLY SERVICES

4.1 Address the needs of transgender people

Pg. 22. With the increased number of people identifying themselves as transgender, the positivity rate (21.11%), and the poor linkage to care (68%), PEPFAR-Haiti will explore and initiate transgender-friendly services in the key populations’ packages.

Pg. 22. All medical staff should be trained on the medical needs of transgender people, including sexual orientation and gender identity

Pg. 22. Refresher training sessions on the specific needs of transgender people, including sexual orientation and gender identity, must be provided to clinical staff at least twice a year.

5. HEALTH SYSTEMS STRENGTHENING

5.1 Build a stronger clinical and non-clinical workforce

Pg. 10. The MSPP has developed and validated an HRH transition plan designed to address the sustainable financing of HRH in Haiti. The transition plan provides a general framework for the gradual transfer of donor-paid health workers’ salaries to the national system, especially of those assigned to HIV to ensure the continuity of health services.

Pg. 22. Insufficient training and compensation are an important driver of high turnover and poor staff attitudes.

According to CLM data, just 25% of patients surveyed have ever heard of PrEP. Increasing awareness and generating demand is key in strengthening the prevention program Despite a commitment in COP21 to roll out PrEP in all departments, only 29% of facilities surveyed offer PrEP. The top reasons PrEP is not offered are lack of availability and lack of training.

The last survey was carried out in 2014.
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<td>Pg. 10. Continued emphasis on the role of polyvalent community health workers (CHWs) and peers in service delivery is an important contingency measure to offset this deficiency.</td>
<td>+PEPFAR must work with IPs to ensure a 50% increase in compensation for ASCPs, peer educators, and other community health workers, including reimbursement of transportation costs for work performed in communities.</td>
<td>The Haiti PEPFAR program is built on the back of peer educators, navigators, and other community health workers. Yet they are undercompensated and face unequal treatment and treated as second class healthcare workers. Even though peer navigators must pick up patients and transporting them to clinics, sometimes the clinic does not fully reimburse these transport costs.</td>
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<td>Pg. 18. For COP21/FY22, PEPFAR-Haiti will ensure that all partners provide appropriate support to a peer approach in the program.</td>
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<td>5.2 Strengthen the capacity of local organizations</td>
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<td>+PEPFAR must increase funding to local, civil society, and community organizations. Special funding mechanisms, including at least 10 microgrants per year for associations of PLHIV and KPs, should be pursued to reduce the administrative burden on small organizations.</td>
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<td>Pg. 11. In COP20, about 32% of USAID funding and 50% of the CDC funding went to local organizations.</td>
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<td>+Prioritize funding five new Haitian organizations per year as prime and sub-prime implementing partners.</td>
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<td>Pg. 8. The engagement of civil society organizations (CSOs), particularly PLHIV and key population associations, will be a key component of the COP21 overall strategy.</td>
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<td>Pg. 23. In regards to coverage, the program will continue to strengthen the capacity of local key populations-led organizations to identify new hotspots to provide key populations-friendly services and to scale up innovative, evidence-based strategies to achieve epidemic control for key populations including utilization of local social networks to identify undiagnosed individuals living with HIV and link them to HIV services.</td>
<td>+Clinics without electricity cannot use electronic medical records or submit reports on MESI. PEPFAR should therefore require all implementing partners to provide generators or other renewable energy systems to clinics.</td>
<td>Universal health coverage (UHC) for Haitians living with HIV and key populations is a fundamental human right. We ask that PEPFAR prioritize UHC by expanding the package of services available in its sites, while prioritizing its financial support to the Haitian government.</td>
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<td>5.3 Prioritize universal healthcare (UHC)</td>
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<td>+PEPFAR must advocate with the Haitian government to prioritize Universal Health Coverage (UHC) by expanding the package of services available at its sites.</td>
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<td>Pg. 8. Domestic health financing remains stalled at 4.1% of the national budget for FY20-21 with 77.6% of the MSPP’s operating budget covering salary support for human resources for health (HRH). This limited investment cannot optimally support health infrastructure needs.</td>
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<td>5.4 Strengthen health information systems</td>
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<td>+Clinics without electricity cannot use electronic medical records or submit reports on MESI. PEPFAR should therefore require all implementing partners to provide generators or other renewable energy systems to clinics.</td>
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<td>Pg. 2. Sustaining epidemic control in Haiti requires having robust systems. In COP21, PEPFAR-Haiti will continue strengthening the client-level and aggregate health information systems and ensure their interoperability with the laboratory and supply chain information systems which are currently in development.</td>
<td></td>
<td>+Clinics without electricity cannot use electronic medical records or submit reports on MESI. PEPFAR should therefore require all implementing partners to provide generators or other renewable energy systems to clinics.</td>
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<td>Pg. 30. Haiti introduced the unique identification system through biometric coding (BC) in 2016 as part of its strategy to support continuity of care among a population that has become increasingly mobile.</td>
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<td>+Clinics without electricity cannot use electronic medical records or submit reports on MESI. PEPFAR should therefore require all implementing partners to provide generators or other renewable energy systems to clinics.</td>
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<td>+Providing the full package of health services, including non-HIV care, in 100% of PEPFAR-supported clinics is key to preventing patients from switching facilities and therefore improving data quality.</td>
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<td></td>
<td>+Clinics without electricity cannot use electronic medical records or submit reports on MESI. PEPFAR should therefore require all implementing partners to provide generators or other renewable energy systems to clinics.</td>
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</table>
### 5.5 Support the community-led monitoring project

**Pg. 8.** The CSO observatory established during COP19 will continue to be supported in COP21 with the Ambassador’s small grants program, to ensure that clients’ feedback and needs are properly addressed. The CLM program must be funded through the central PEPFAR budget. PEPFAR must ensure the independence of the Observatory’s CLM activities, to not compromise the integrity of the program and findings. Funding levels for the Observatory must increase by 50% to support the program in expanding its surveillance to COVID-19, tuberculosis, and malaria. PEPFAR must ensure that funds are disbursed on time for CLM activities.

**Pg. 30.** The CSO observatory will be supported in COP21 with the Ambassador’s small grants, along with a network of ombudsmen, to improve the monitoring of the quality of services provided throughout the country. The PEPFAR Small Grants Program does not allow CLM to strengthen its structure nor expand to additional sites, departments, and thematic areas for monitoring. During the last two years of CLM implementation, the program was dependent on Housing Works providing funding advances while waiting for delayed PEPFAR funding. Funding must be released on time.

### 5.6 Strengthen laboratory capacity

**Pg. 25.** Additionally, a fifth high-throughput machine for centralized testing will be positioned in the North department to increase sample processing capacity and further reduce the turnaround time, affected by external factors in the country (e.g. roadblocks, protests, etc.). PEPFAR must ensure that the South laboratory is functional, strengthen the capacity of the North one and the National Public Health Laboratory (LNSP). Note that this request has already been made in COP20 and COP21.