THE FUNDING GAP IN THE DOMINICAN REPUBLIC'S NATIONAL HIV AND AIDS RESPONSE

May 2017
This document was produced for review by the United States Agency for International Development. It was prepared by Claudia Valdez, Jonathan Cali, and Carlos Ávila for the Health Finance and Governance project.

The Health Finance and Governance Project
USAID's Health Finance and Governance (HFG) project helps to improve health in developing countries by expanding people's access to health care. Led by Abt Associates, the project team works with partner countries to increase their domestic resources for health, manage those precious resources more effectively, and make wise purchasing decisions. The six-year, $209 million global project is intended to increase the use of both primary and priority health services, including HIV/AIDS, tuberculosis, malaria, and reproductive health services. Designed to fundamentally strengthen health systems, HFG supports countries as they navigate the economic transitions needed to achieve universal health care.

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Disclaimer:
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ACRONYMS

ART	Antiretroviral Therapy
ARV	Antiretroviral
COIN	*Centro de Orientación e Investigación Integral*
CONAVIHSIDA	National HIV/AIDS Council
CSO	Civil Society Organization
DIGECITSS	*Dirección General de Enfermedades de Transmisión Sexual y SIDA* General Directorate for Sexually Transmitted Diseases and AIDS
DHS	Demographic and Health Survey
HFG	Health Finance and Governance project
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
IDCP	*Instituto Dermatológico y de Cirugía de la Piel* Institute for Dermatology and Skin Surgery
IEC	Information, Education, and Communication
MSM	Men Having Sex with Men
MSP	*Ministerio de Salud Pública* Ministry of Public Health
NASA	National AIDS Spending Assessment
NSP	National Strategic Plan
PAHO	Pan-American Health Organization
PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	Person Living with HIV
PROMESE/CAL	*Programa de Medicamentos Esenciales y Central de Apoyo Logístico* Essential Medications Program and Center of Logistical Support
SAI	*Servicio de Atención Integral* al VIH Comprehensive HIV Care Service
SBCC	Social and Behavior Change Communication
SNS	*Servicio Nacional de Salud* National Health Service
STI	Sexually Transmitted Infection
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
VL	Viral load

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EXECUTIVE SUMMARY

The 2014 National Strategic Plan (NSP) for the National Response to human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) runs from 2015 to 2018. The NSP is organized around four strategic areas and 46 subcategories. A National AIDS Spending Assessment (NASA) estimated that in 2012 the country's expenditures reached US $41.4 million, nearly 75 percent of which came from public sources and from international aid.

With resources from the United States International Development Agency (USAID), the Health Finance and Governance project (HFG), in March and April of 2017, gathered information from public and international development assistance funding sources. The project then conducted a gap analysis between the funds required to implement the NSP and the expenditures of public and international development assistance agencies for the period of 2015 to 2018.

Expenditures on the National HIV and AIDS Response

Expenditures for 2016 were estimated at US $32.4 million (in Dominican pesos, DOP $1.52 billion). Forty-six percent came from public sources (US $14.8 million, equivalent to DOP $695 million), and 54 percent from international development assistance (US $17.7 million, equivalent to DOP $826 million). The funders that contributed most were the Ministry of Public Health (Ministerio de Salud Pública, MSP) with 32 percent (US $10.3 million, equivalent to DOP $481 million), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) with 31 percent (US $10 million, equivalent to DOP $471 million), the National Council on HIV and AIDS (CONAVIHSIDA) with 13 percent, Social Security with 13 percent, and the Institute for Dermatology and Skin Surgery (IDCP) with 8 percent. The remaining 2 percent came from United Nations programs (UNAIDS, UNFPA, UNICEF, UNDP) and other agencies. Sixty-one percent of the expenditures were directed toward interventions in the strategic area *Comprehensive Care*, particularly the subcategory *Access to Antiretrovirals (ARVs) and Clinical Follow-up Tests* (US $13.1 million, equivalent to DOP $614 million), which includes the MSP's procurement of ARVs and reagents for CD4 and viral load (VL) tests.

The Funding Gap

For 2016, the estimated gap between the funds required to implement the NSP and the expenditures from public and international development assistance sources was US $22.5 million (DOP $1.05 billion). The strategic area *Education and Prevention* showed the largest gap (US $17.6 million, equivalent to DOP $822 million), while the area *Strengthening the National Response* showed expenditures greater than the estimated requirements. A smaller gap is projected in 2017 (US $14.1 million, equivalent to DOP $662 million) and in 2018 (US $17.8 million, equivalent to DOP $856 million), due to an anticipated increase in international development assistance for the areas of *Strengthening the National Response* and *Comprehensive Care* in *Key Populations* and in resources budgeted by the MSP for the purchase of ARVs and supplies.

In order to stimulate the development of funding alternatives through public sources, a scenario was constructed without financial contributions from international development assistance as of 2018. The gap between the NSP requirements and 2018 funding without international development assistance would be US $29.6 million (DOP $1.425 billion) in 2018, rising 66 percent (US $11.8 million, equivalent to DOP $568 million). As international development assistance currently makes important investments in screening, client linkages and retention of services, quality of care for key populations, surveillance systems, support for families and children, and ARV treatment adherence, the gap in the area *Comprehensive Care* would increase 55 percent (US $3.3 million, equivalent to DOP $168.4 million).

Analysis and Discussion

For 2018, the Government of the Dominican Republic should make efforts to close the funding gap by identifying public sources of financing. This study proposes a review and update of the NSP that considers the current context of the epidemic, ongoing health care reform, the mobilization of domestic resources, financial sustainability, and the National Response's orientation toward more cost-effective interventions. Given that the accumulated gap – based on the funds required to implement the NSP – for purchasing ARVs from 2015-2018 is US $7.7 million (an average of US $1.9 million a year), ARVs should be included in and funded by the Social Security system to guarantee sustainability of their funding in the medium and long term and to achieve the country's HIV-related goals. Additionally, the Dominican Republic can increase the efficiency of diagnosis and treatment by optimizing supply-chain operations and retaining people in first-line treatment regimens.

The increased investments in the National Response would have a positive financial and social return in the medium-term, considering that early and extended treatment is an effective strategy to reduce new infections in the future.

1. INTRODUCTION

The Health Finance and Governance (HFG) project is an initiative funded by the United States Agency for International Development (USAID) whose purpose is to increase the use of priority health care services in developing countries, especially by women, girls, and poor and rural populations. HFG supports the Government of the Dominican Republic and other institutions in the country to develop a comprehensive financial sustainability strategy for the National HIV and AIDS Response.

Several studies conducted in the Dominican Republic give an account of the financial effort that the National HIV and AIDS Response demands across various program components and strategic areas. However, the gap between the funds required to implement the NSP and the expenditures of governmental and development assistance partners funding the response has not been estimated and analyzed in depth. An updated estimate of the funding gap and its trends will make it possible to mobilize additional government and non-government resources and to identify strategies to make expenditures more efficient.

To this end, HFG conducted a gap analysis to calculate the increase in resources required to fully fund the National HIV and AIDS Response in the medium-term, including different investment scenarios. This report includes the methodology used, the estimate of funding gaps under different scenarios, and a section of analysis and conclusions that presents some alternatives to increase the efficiency of the distribution of resources to control the epidemic.

2. BACKGROUND

In 2013, technical teams from the Ministry of Public Health (MSP), the General Directorate for Sexually Transmitted Diseases and AIDS (DIGECITSS), the National Health Service (SNS), the National HIV and AIDS Council (CONAVIHSIDA), the Institute for Dermatology and Skin Surgery (IDCP), with the support of international development assistance agencies, developed the National Strategic Plan (NSP) for the response to sexually transmitted diseases, HIV, and AIDS. The implementation timeline for the plan is 2015 through 2018. As a baseline (2014), the NSP used the HIV prevalence reported by the 2013 Demographic and Health Survey (DHS) of 0.8 percent for the population between ages 15 and 49. The NSP estimated that there were 44,547 people living with HIV and AIDS (PLHIV) in 2015, according to projections from DIGECITSS and the Joint United Nations Program for HIV and AIDS (DIGECITSS and UNAIDS, 2013).[1] The number of people receiving antiretroviral therapy (ART) for 2012 was estimated at 21,388.

Though the NSP has not explicitly adopted the 90-90-90 goal of UNAIDS, the *Comprehensive Care* strategic area of the NSP cites as its purpose "to get 90 percent of the PLHIV to an undetectable viral load."

The components of the NSP were organized around four strategic areas: 1) Education and Prevention; 2) Comprehensive Care; 3) Human Rights; and 4) Strengthening the National Response. The strategic areas are broken down into 10 lines of action and 46 subcategories or products.

With regard to the cost estimates, the NSP notes only that the "third phase consisted of costing the proposed interventions by product, based on the scale and determination of the costs of the different activities that make up each one. Furthermore, it provided an overall result for the entire NSP, as well as the result corresponding to each of its four years of execution." For 2015, the requirements were estimated at US $67,342,996 (DOP $3,064,106,307). The requirements fall to US $55,116,886 (DOP $2,573,958,553) for 2016, and then rise to US $56,492,565 (DOP $2,660,799,813) for 2017 and US $58,618,820 (DOP $2,812,575,663) for 2018.

[1] DIGECITSS, UNAIDS (2013). Estimates and protections of the prevalence of HIV and disease burden.

The most recent publication of the national expenditures in the response to HIV and AIDS is the 2012 NASA.[2] The NASA organized national expenditures into three funding sources: 1) public; 2) private; and 3) international development assistance. The expenditure categories (dimensions of use of goods and services, in NASA terms) are: 1) prevention; 2) care and treatment; 3) orphans and vulnerable children; 4) administrative program management; 5) human resources; 6) social protection and social services; and 7) enabling environment (*Fundación Plenitud* 2014).

The NASA estimated the national expenditures on HIV and AIDS for 2012 at US $41.4 million. International funds accounted for 50 percent of the expenditures, including international foundations and nonprofit and for-profit organizations; public funding accounted for 24.1 percent, and private funds (out-of-pocket payments and domestic nonprofit organizations) made up 25.9 percent of the total. (Fundación Plenitud 2014).

According to the NASA, in 2012, 39.3 percent of the funds were used for prevention; 35.6 percent for care and treatment, including dispensing medication and diagnostic tests; 20.5 percent for program management and administration; and 1.7 percent for human resources payments for those involved in the National Response. ART made up the most expenditures (21.3 percent), followed by blood safety (14.6 percent), planning, coordination, and program management (12.9 percent), condoms in the public and commercial sectors (11.7 percent), other prevention activities (8.6 percent), and of HIV-related laboratories (5.1 percent) (Fundación Plenitud 2014). Table 1 gives a summary of recently published estimates of funding requirements and expenditures.

Table 1. Estimates of funding requirements and of available funds

Funding sources	Estimated funding requirements	Estimated funds available
	NSP 2015	NASA 2012
	No funding proposals or goals by source	Public, Private, International Development Assistance
Components and expenditure categories*	Four components (strategic areas): • Education and Prevention • Comprehensive Care • Human Rights • Strengthening the Response	Eight expenditure items: • Care and Treatment • Program Management and Administration • Prevention • Human Resources • Enabling Environment • HIV-Related Research • Orphans and Vulnerable Children • Social Protection and Social Services
Total Annual Expenditures in USD	US$ 67,342,966	US$ 41,450,294
Total Annual Expenditures in DOP	DOP$ 3,064,106,307	DOP$1,629,800,000

[2] Fundación Plenitud 2012.

3. METHODOLOGY

3.1 Data collection

The study was conducted in February and March of 2017. The team reviewed the documentation referred to in the previous section to understand the methodologies used in estimates of expenditures and of funding requirements for the National HIV and AIDS Response. In consultation with national stakeholders, the reference for the requirements for the National Response to HIV and AIDS was determined to be the 2015-2018 NSP. Its components and categories were used as the basis for organizing information on sources of funding. The standardization of funding and expenditure lines made it possible to identify overall gaps for the NSP as a whole and specific gaps for each strategic area and subcategory.

The study considered two funding sources (public funds and international funds) and 12 funding agents (three public and nine international development sources) (Annex 1). The study did not include private sources (out-of-pocket payments). According to the 2012 NASA, public and international sources accounted for nearly 75 percent of domestic expenditures. Table 2 presents the classification and acronyms used in this document.

Table 2. Funding sources and funding agents

Funding Source	Funding agent	Classification as used in this report
Public funds	MSP: SNS, DIGECITSS	MSP
	PROMESE/CAL: Institution affiliated with the Ministry of Health	MSP
	Social Security: Subsidized contributory scheme	Social Security
International Funds	PEPFAR: USAID, CDC, Department of Defense	PEPFAR
	PAHO (Pan-American Health Organization)*	PAHO
	COIN **	COIN **
	UNFPA (United Nations Population Fund)*	UNFPA
	UNAIDS (Joint United Nations Programme on HIV/AIDS)*	UNAIDS
	UNICEF (United Nations Children's Fund)*	UNICEF
	UNDP (United Nations Development Programme)*	UNDP
	Global Fund/CONAVIHSIDA	CONAVIHSIDA
	Global Fund/IDCP	IDCP

Note: The nomenclature as described in the 2012 NASA was used to designate sources and funding agents in this report.
*In some graphs the agencies of the United Nations System appear individually and in others they are grouped together as "United Nations." **COIN stands for *Centro de Orientación e Investigación Integral*

A template to record expenditures for 2014-2016 was sent to each of the aforementioned funding agents. The expenditure items were pre-filled with the NSP categories to ensure compatibility or harmonization between requirement and expenditure (see model in Annex 2). Annex 3 shows a table with the definition of the subcategories adopted in NSP 2015-2018. Some institutions included planned budgets for 2017-2019 if the information was available.

Queries were made to ensure the reliability of submitted data and the appropriate allocation to NSP categories. The information was transferred to a simple database created in Excel®. The data, originally recorded in Dominican pesos (DOP), were converted to U.S. dollars (USD), using the average annual exchange rate of the Central Bank of the Dominican Republic in the NSP.

3.2 Available funds (expenditures) by funding agent and projections to 2018

This analysis updated public and international expenditures on HIV for the years 2014, 2015, and 2016, and projected expenditures for 2017 and 2018. One hundred percent of the funding agents consulted provided data for 2014, 2015, and 2016. Seven institutions (PEPFAR, UNAIDS, UNFPA, UNDP, UNICEF, IDCP, AND CONAVIHSIDA) offered estimates of budgets in some categories for 2017 and 2018. To project the remaining expenditures to 2018, those involved in the study used the following criteria and assumptions:

1. All funding agents that provided funds to the National Response until 2016 will continue to do so in the coming years unless there was explicit information on the withdrawal of overall funding or of a subcategory.
2. To estimate total funding for the National Response for the years for which data were not reported, a projection was made (using simple linear extrapolation) of the amounts allocated from 2014 to the last year reported. Consultations with funding agents made it possible to establish the investment periods with greater precision.
3. Projections were presented and revised by funding agents for adjustments and validation. In some categories where projecting the linear extrapolation gave negative values, the funding for last year reported was set as unchanged from the previous year.

3.3 Analysis of the information and estimate of funding gaps

The database completed with the information and estimates referred to in the previous section made it possible to determine the following projections for 2015-18.

Necessary funds:

1. Estimates of funding need to implement the National HIV and AIDS Response according to the NSP 2015-2018.

Available funds:

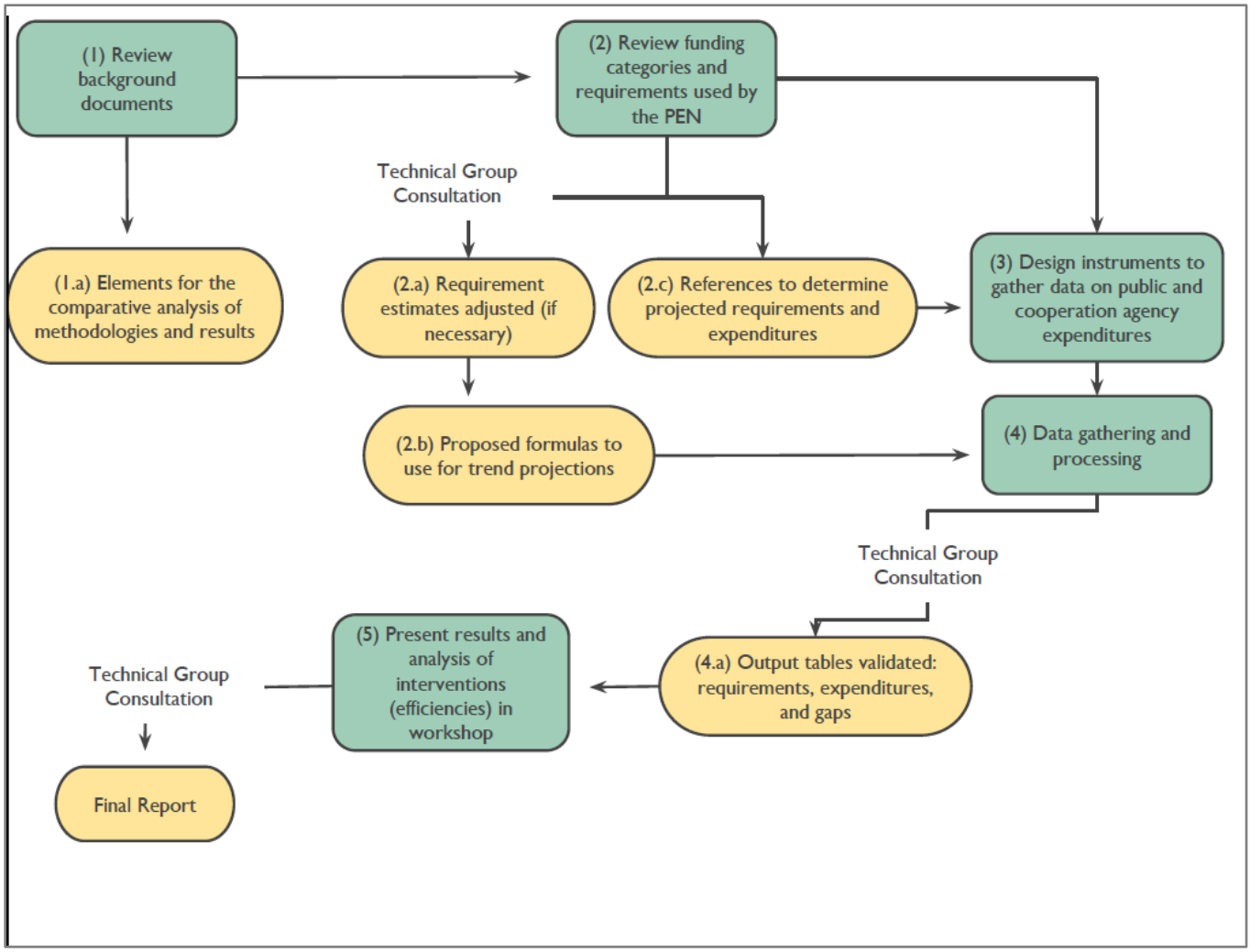
1. Estimates of expenditures from public sources and international development assistance.
2. Estimates of expenditures exclusively from public sources (excluding international development assistance as of 2018).

This makes it possible to identify funding gaps from 2015 to 2018:

1. Between the estimated funding requirements according to the NSP and the expenditure from public sources and international development assistance.
2. Between the estimated funding requirements according to the NSP and the expenditure from public sources (excluding international development assistance as of 2018).

Preliminary estimates were presented and discussed with national counterparts and representatives from the public institutions and development assistance agencies involved in the National Response. Their commentaries and suggestions were included in this report. Figure 1 shows the methodological sequence, including consultations with national counterparts.

Figure 1. Methodology for gathering and processing data on the estimated funding gaps in the National HIV and AIDS Response

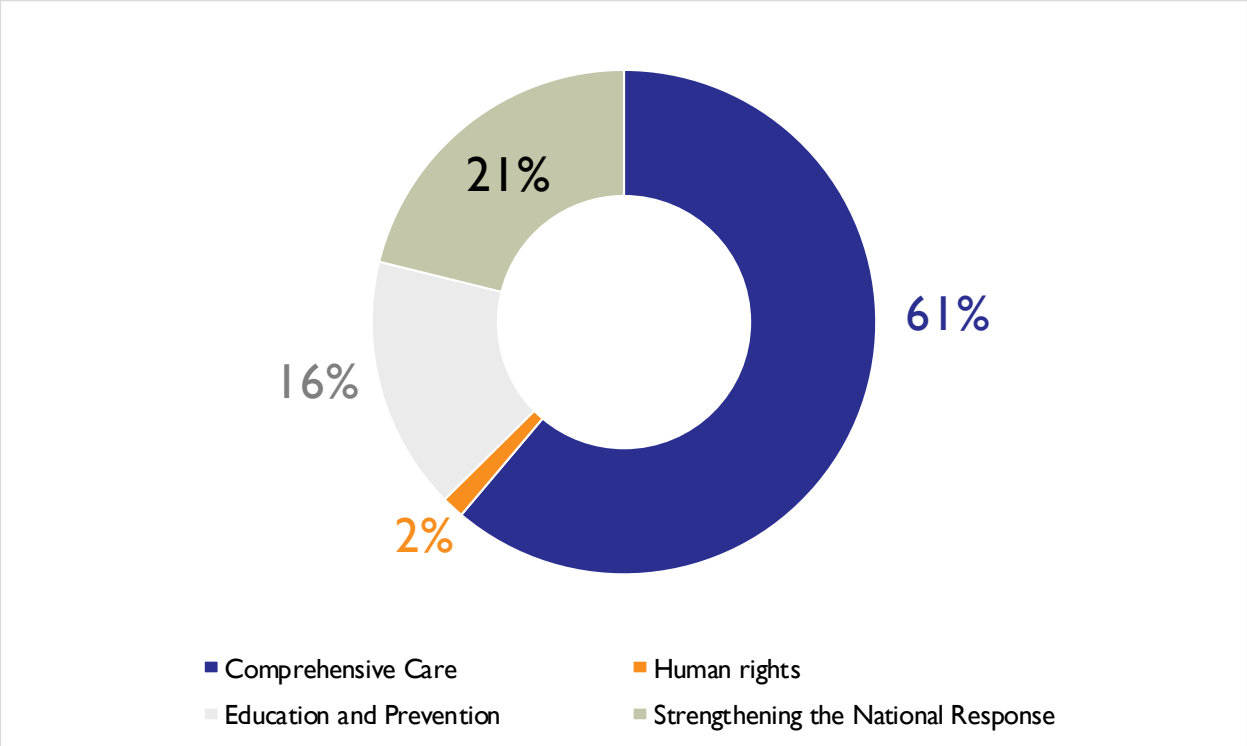


4. RESULTS

4.1 Public and international development assistance expenditures in the HIV and AIDS response

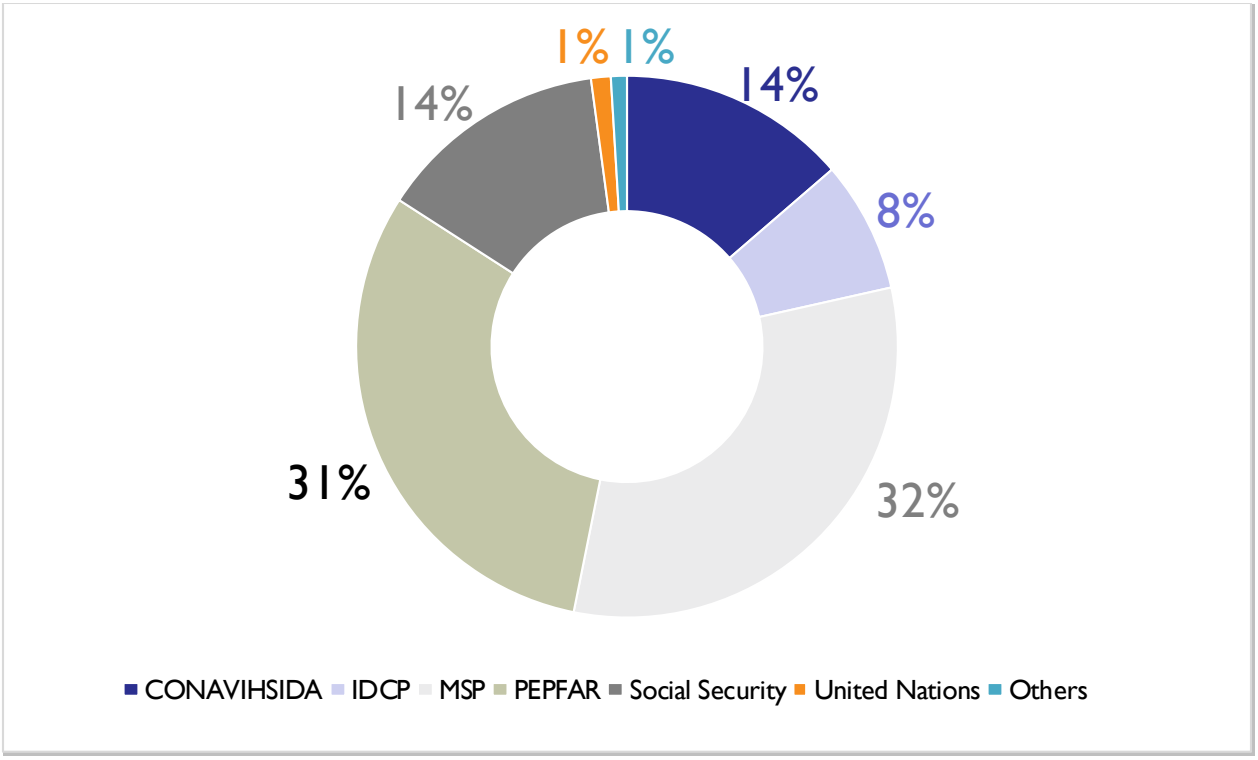
Expenditures on HIV from public and international development assistance sources for 2016 were US $32.4 million (DOP $1.517 billion). Forty-six percent came from public sources (US $14.8 million, equivalent to DOP $695 million), and 54 percent came from international development assistance (US $17.7 million, equivalent to DOP $826 million). According to the NSP strategic areas, 61 percent of expenditures were put toward *Comprehensive Care* interventions, 21 percent toward *Strengthening the National Response*, 16 percent toward *Education and Prevention*, and 2 percent toward *Human Rights* (Figure 2).

Figure 2. 2016: Percentage of public and donor expenditures on the National HIV and AIDS Response, using NSP categories



The funding agents with the greatest contribution were the MSP, with 32 percent (US $ 10.3 million, equivalent to DOP $481 million), and PEPFAR, with 31 percent (US $10 million, equivalent to DOP $471 million). Next, in descending order, came CONAVIHSIDA, with 13 percent, Social Security[3] with 13 percent, and the IDCP with 8 percent. The remaining 2 percent of funding corresponds to United Nations programs (UNAIDS, UNFPA, UNICEF, UNDP) and other agencies (Figure 3).

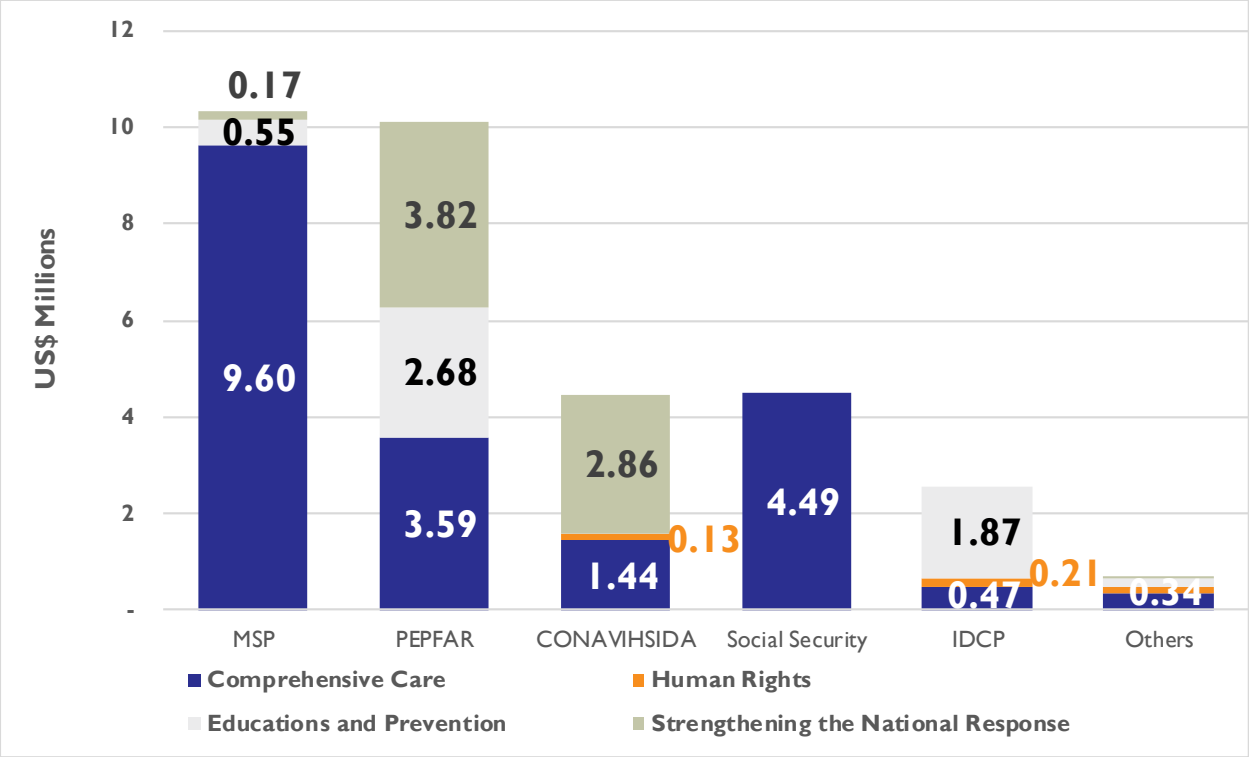
Figure 3. 2016: Percentage of expenditures on the National HIV and AIDS Response by funding agent



[3] Does not cover ARVs. Funding is concentrated on CD4 and VL tests, rapid HIV tests, and specialized HIV consultations.

Figure 4 shows 2016 expenditures by funding agent and by NSP strategic area, with *Comprehensive Care and Strengthening the National Response* receiving the highest investment from public and international sources.

Figure 4. 2016: Expenditures on the HIV and AIDS National Response by funding agent, using NSP categories (in millions of US$)



Source: Created by the authors, 2017

According to the estimates and assumptions referred to in the methodology section, expenditures would increase 29 percent, from US $32.5 million in 2016 to US $42.2 million in 2017, with a reduction in international development assistance for *Comprehensive Care* in key populations and an increase in funds allocated by the MSP to purchase ARVs and supplies (US $2.1 million, equivalent to DOP $94 million – more than in 2016).

The subcategory that received most funding in 2016 (40 percent of the total) was *Access to ARVs and Clinical Follow-up Tests* (US $13.1 million, equivalent to DOP $614 million), which includes the purchases of ARVs, screening tests, CD4 and VL reagents, condoms, and international and domestic logistics costs. The majority of this funding originated in public sources (Figure 5). The funding agents that contributed to this subcategory were the MSP, Social Security, and CONAVIHSIDA.

Other high-expenditure subcategories were the *Financial Sustainability Strategies in the National Response*[4] (16 percent of the total; US $5.2 million, equivalent to DOP $246 million). The main agents in this subcategory were CONAVIHSIDA, UNAIDS, and PEPFAR.

[4] This subcategory includes identifying and costing needs and funding sources, drafting, executing, and tracking investment budgets, and writing execution reports.

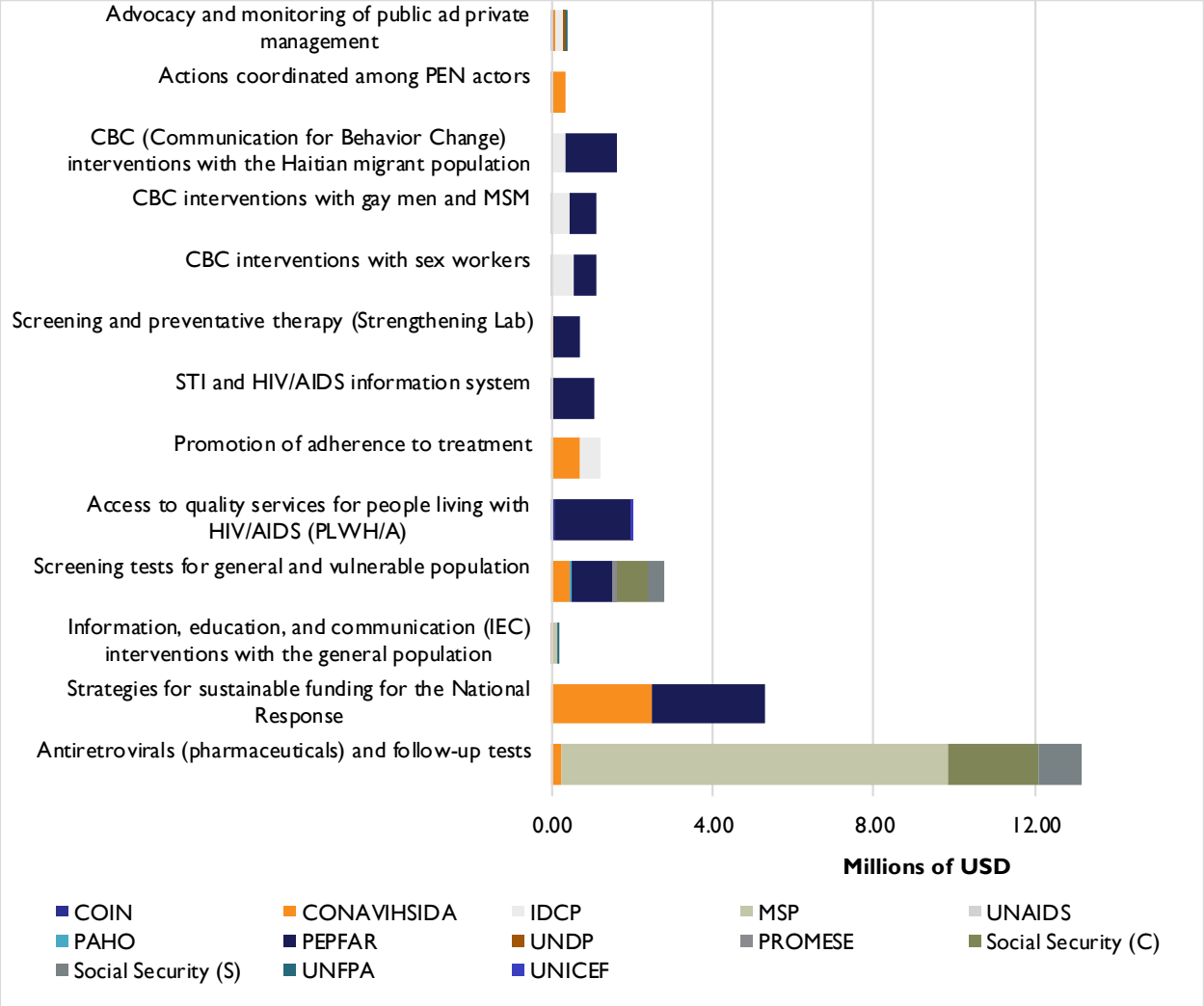
The third place is occupied by *Screening Tests for the General and Vulnerable Population* (9 percent of the total; US $2.7 million, equivalent to DOP $129 million). This last subcategory received resources from five funding agents, including CONAVIHSIDA, PAHO, PEPFAR, Social Security, and PROMESE/CAL (Figure 5).

In other subcategories with lower investment related to *Access to Quality Services*, PEPFAR, COIN, and UNICEF were identified as funding agents. Information, education, and communication (IEC) interventions for the general population are funded by COIN, CONAVIHSIDA, MSP, and UNFPA.

The subcategories related to *Promotion of Adherence to Treatment* are funded by the IDCP and CONAVIHSIDA. In the subcategories related to *SBCC intervention for key populations such as gay men and men who have sex with men (MSM), sex workers, and transpeople,* the main funding agents are IDCP, PEPFAR, UNAIDS, and COIN.

The subcategories related to *Public and Private Sector Advocacy* are funded by IDCP, UNDP, UNFPA, CONAVIHSIDA, and COIN. The subcategory on *STI, HIV, and AIDS Information Systems* is financed by PEPFAR, CONAVIHSIDA, and UNAIDS (Figure 5).

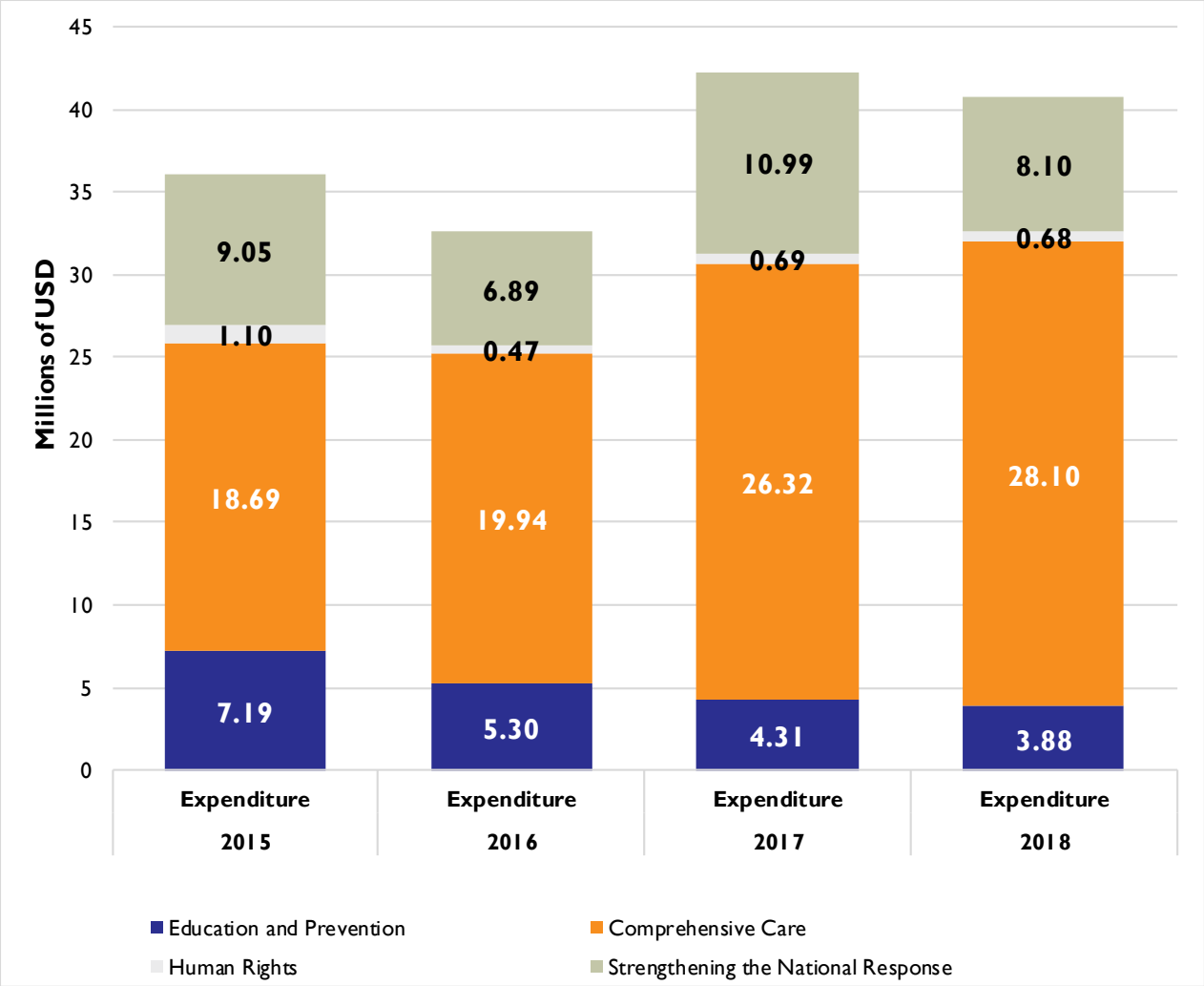
Figure 5. 2016: Expenditures by NSP subcategory and funding agent (in millions of US$)



Source: Created by the authors, 2017

Figure 6 shows expenditures from 2015 to 2018 by NSP funding area. More funding is seen in *Comprehensive Care* and *Strengthening the National Response*.

Figure 6. 2015-2018: Expenditures by NSP Strategic Area (in millions of US$)



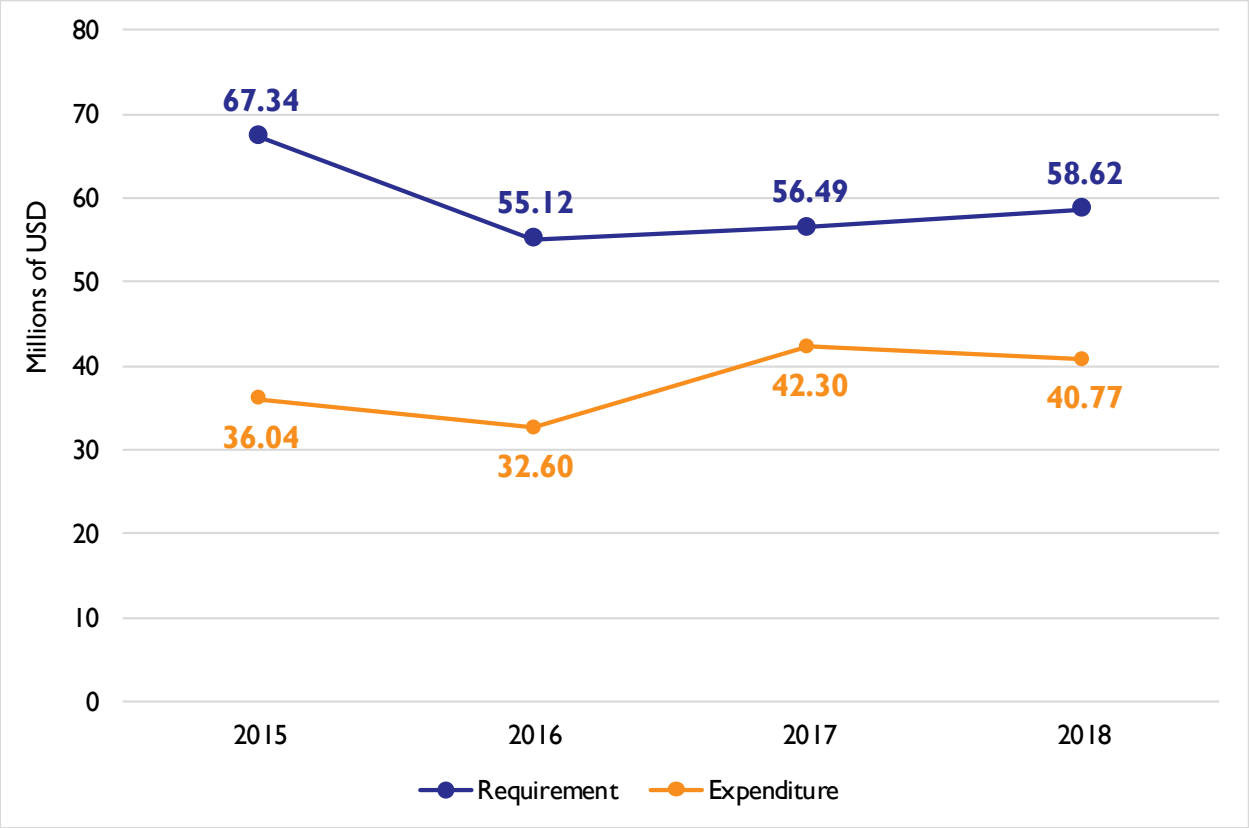
Eighteen subcategories were unfunded or had investment of less than US $4,000 (DOP $196,000) in 2016. Of these, the most significant are: Post-Exposure Prophylaxis for Victims of Sexual Violence; Social and Behavior Change Communication (SBCC) Interventions among the Batey Population; SBCC Interventions for people in prison; Case Notification and Risky Sexual Behaviors; Training for Civil Society Organizations (CSOs); Newborn Prevention and Care Interventions; Binational Interventions with Haiti to Control STIs and HIV, and Prevention of Stigma and Discrimination by Opinion Leaders and the General Population.

4.2 Gap between the NSP funding needs and public and international development expenditures

The country's overall gap for all NSP categories in 2015 was **US $31.3 million (DOP $1.424 billion)**; in 2016, it was **US $22.5 million (DOP $1.051 billion)**; for 2017, it is estimated at **US $14.1 million (DOP $668 million)**; and for 2018 at **US $17.8 million (DOP $856 million)** (Table 3).

Figure 7 shows the gap between NSP funding needs and expenditure trends through 2018. The gap decreases in 2016 and 2017 owing to an increase in international development assistance directed toward *Strengthening the National Response* and *Comprehensive Care* in *Key Populations* and an increase in funds budgeted by the MSP for purchasing ARVs and supplies, as stated in the previous section.

Figure 7. 2015-2018: Funding gap between NSP funding needs and public and international development assistance expenditures (in millions of US$)



Source: Created by the authors, 2017.

In 2016, the largest gap by NSP strategic area was in *Education and Prevention*, with a total of US $17.6 million (DOP $822 million). *Comprehensive Care,* for that same year, showed a gap of US $5.1 million (DOP $242 million) and *Human Rights* of US $4.7 million (DOP $221 million). The area *Strengthening the National Response* showed no gap. The gap increases progressively to 2018 in the areas of *Education and Prevention* and *Comprehensive Care*, but continues to be proportionally larger in *Education and Prevention*. The area *Strengthening the National Response* has funding that is greater than the estimated requirement in the NSP (Table 3).

Table 3. 2015-2018: Funding gap between the requirements by NSP Strategic Area (trend scenario) and public and international development assistance expenditures (in millions of USD)

NSP Categories	2015	2016	2017	2018
Comprehensive Care				
Requirement	32,274,467	25,129,418	27,746,382	30,709,917
Expenditures	18,689,954	19,935,713	26,317,898	28,097,260
Gap	-13,584,513	-5,193,705	-1,428,484	-2,612,657
Human Rights				
Requirement	7,039,954	5,213,226	4,608,326	4,522,722
Expenditures	1,104,915	469,282	685,736	683,136
Gap	-5,935,039	-4,743,943	-3,922,590	-3,839,586
Education and Prevention				
Requirement	25,147,376	22,916,234	22,560,082	21,858,484
Expenditures	7,192,819	5,298,260	4,305,043	3,880,267
Gap	-17,954,557	-17,617,975	-18,255,040	-17,978,217
Strengthening the National Response				
Requirement	2,881,199	1,858,007	1,577,774	1,527,698
Expenditures	9,049,555	6,894,341	10,987,836	8,104,443
Gap	6,168,356	5,036,334	9,410,061	6,576,746
Total				
Requirement	67,342,996	55,116,88	56,492,565	58,618,820
Expenditures	36,037,243	32,597,596	42,296,513	40,765,105
Overall Gap	-31,305,753	-22,519,290	-14,196,052	-17,853,715

The area *Comprehensive Care* has 11 subcategories. The largest gap in 2016 was concentrated in three subcategories: 1) *Access to Screening Tests with Pre- and Post-Test Counseling in the General Population and Vulnerable Population*; 2) *Access to ARVs and Clinical Follow-up;* and *3) Interventions with PLHIV to Promote Adherence*. Table 4 shows the categories mentioned with the largest gap. Appendix 5 includes the table of requirements, expenditures, and gap for this entire category.

Four categories are listed as unfunded in *Comprehensive Care*: 1) *Screening and Preventative Therapy for Tuberculosis and Other Diseases*; 2) *ARV Drug Resistance Surveillance Developed*; 3) *Surveillance System Developed for Adverse Reactions to ARVs*; 4) *Health Surveillance for Drugs Used in HIV Treatment Guaranteed*.

Table 4. 2015-2018: Three subcategories with the biggest funding gap in Comprehensive Care (in millions of US$)

Comprehensive Care Expenditure Subcategory (NSP Products)	2015	2016	2017	2018
Access assured to screening tests with pre- and post-test counseling in the general population and the vulnerable population for early HIV detection	-10,836,218	-4,548,923	-3,942,703	-3,681,388
Access to ARVs and clinical follow-up tests: pharmaceutical products	-1,495,803	-1,601,600	-858,226	-3,837,329
PLHIV reached with a package of interventions to promote treatment adherence	-1,000,708	-456,923	-639,683	-700,265

The area *Education and Prevention* has 16 subcategories. The largest gap in 2016 was concentrated in eight subcategories: 1) *Timely, standardized treatment for people who demand services for STIs in health centers*; 2) *Implementation of the national strategy for addressing the link between violence against women and girls and HIV and AIDS*; 3) *SBCC interventions with drug users; 4)SBCC interventions with transpeople*; 5) *Post-exposure prophylaxis services to prevent HIV and STIs in victims of sexual violence*; 6) *SBCC interventions with MSM*; 7) *Prevention of mother to infant transmission*; 8) *IEC interventions for the general population intended to increase the perception of risk and promote health services*. Table 5 shows the eight subcategories with the largest gaps. Annex 5 shows the table of requirements, expenditures, and gaps for this entire category.

There are three unfunded subcategories, including interventions for people in prison and those living in bateyes (migrant sugar cane farm settlements).

Table 5. 2015-2018: The eight subcategories with the largest funding gap in the area Education and Prevention (in millions of US$)

Education and Prevention	2015	2016	2017	2018
Timely, standardized treatment for people who demand STI services in health centers.	-3,744,156	-3,401,661	-3,312,231	-3,247,966
Implementation of a national strategy for addressing the link between violence against woman and girls and HIV and AIDS	-3,276,777	-2,956,539	-3,015,663	-2,963,402
SBCC interventions with drug users	-2,595,506	-2,596,002	-2,578,451	-2,538,496
SBCC interventions with transpeople	-2,051,267	-2,016,801	-1,964,415	-1,927,636
Post-exposure prophylaxis services for preventing HIV in victims of sexual violence.	-1,497,932	-1,419,593	-1,394,976	-1,100,161
SBCC interventions with MSM	-1,340,656	-1,021,089	-1,022,233	-1,122,147.74
Prevention of mother to infant transmission	-1,058,295	-2,103,046	-2,056,787	-2,020,499
IEC interventions for the general population intended to increase the perception of risk and promote health services	-671,321	-1,244,514	-1,253,554	-1,228,289

Ten subcategories are included in the area *Human Rights*. The largest gap in 2016 was concentrated in four subcategories: 1) *Guaranteed right for PLHIV and vulnerable groups to quality health care, free of stigma and discrimination; 2) Decreased stigma and discrimination toward PLHIV and vulnerable groups among opinion leaders and the general population; 3) Increased access to justice and public defense services as a guarantee and protection of human rights for PLHIV and vulnerable groups; 4) Reduced stigma and job discrimination against PLHIV in state institutions, the private sector, and CSOs*. Table 6 shows the four subcategories with the largest gaps. Annex 5 shows the table of requirements, expenditures, and gaps for this entire category.

Six subcategories remain without funding, including: *Increased access for PLHIV, vulnerable groups, and others affected to social protection programs; decreased workplace stigma and discrimination toward PLHIV in state institutions, the private sector, and CSOs*; and *legal frameworks created and/or modified guaranteeing the full exercise of citizenship for PLHIV and vulnerable groups (policies)*.

Table 6. 2015-2018: Four subcategories with the largest financial gap in the area Human Rights (in millions of US$)

Human Rights	2015	2016	2017	2018
Guaranteed right to quality health without stigma and discrimination for PLHIV and vulnerable groups	-1,791,530	-1,695,262	-1,227,008	-1,185,191
Decreased stigma and discrimination toward PLHIV and vulnerable groups among opinion leaders and the general population	-1,311,953	-778,929	-771,334	-756,416
Increased access to justice and public defense services as a guarantee of and protection for the human rights of PLHIV and vulnerable groups	-1,010,675	-784,807	-772,294	-761,056
Decreased stigma and job discrimination toward PLHIV in state institutions, the private sector, and CSOs	-500,915	-584,180	-551,289	-541,195

Nine subcategories are included in the area Strengthening the National Response. The largest gap in 2016 was concentrated in two subcategories: 1) Implementation of an annual institutional development program for CSOs in the National Response; and 2) Implementation of the mandates of Law 135-11. For 2016, three subcategories were unfunded: 1) Training for prevention and care for CSOs in the National Response; 2) Actions among National Response actors coordinated for access to required care and prevention services to carry out the NSP; 3) Binational STI and HIV interventions implemented. In four subcategories there is no gap because they received an investment greater than the requirement estimated in the NSP.

Table 7 shows the four subcategories with the largest gaps for 2015-2018.

Table 7. 2015-2018: The four subcategories with the largest funding gap in the Area Strengthening the National Response (in millions of US$)

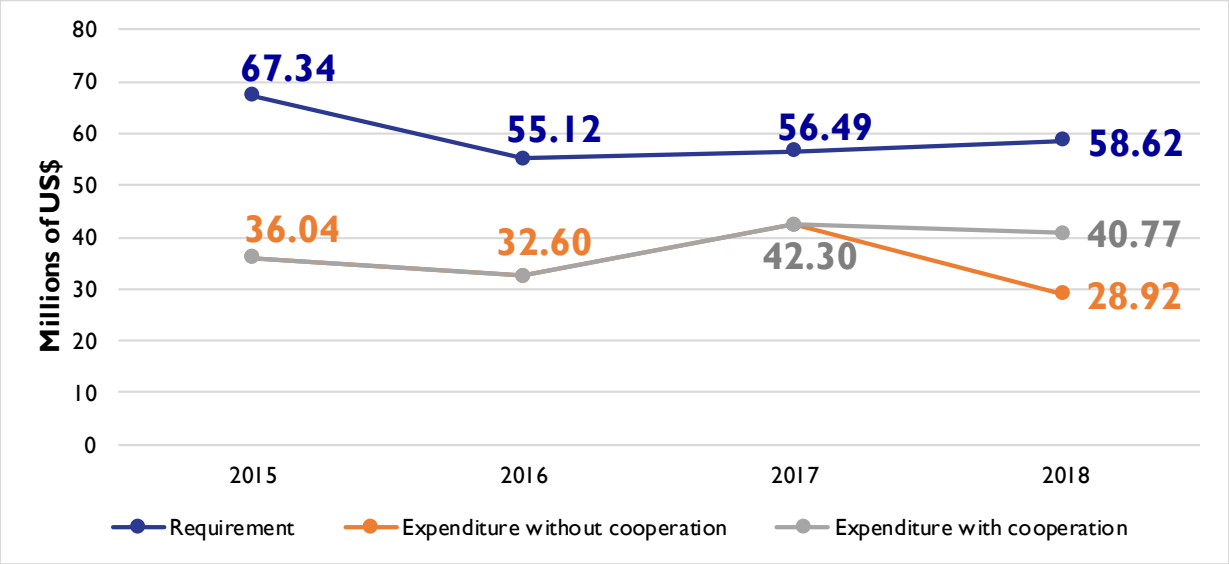
Strengthening the National Response	2015	2016	2017	2018
Implementation of binational STI and HIV interventions	-602,826	-270,687	-216,864	-212,741
Cases and behavior at risk of STIs and HIV reported	-87,099	-73,584	-46,256	-45,409
Implementation of an annual institutional development program for the CSOs in the National Response	-298,411	-350,927	-262,982	-257,593
Implementation of the mandates of Law 135-11	-388,274	-270,699	-268,520	-255,690

4.3 Gap between NSP funding needs and expenditures without international development assistance

In 2016, international development assistance contributed 54 percent of the expenditures of the National Response. For the purposes of this analysis, a scenario was created to explore the domestic resources needed to fund the National HIV and AIDS Response in the absence of international development assistance, starting in 2018.

For the purposes of this scenario, no significant expenditure increase was anticipated by public sources to compensate for the lack of international funds. The gap to meet NSP requirements without international development assistance would be US $29.6 million (DOP $1.425 billion) in 2018, a 66 percent increase (US $11.8 million, equivalent to DOP $568 million) over the scenario maintaining such assistance (Figure 8).

Figure 8. 2015- 2018: Funding gap between NSP National Response needs and public expenditure only (without international development assistance) (in millions of US$)



Source: Created by the authors, 2017.

In this scenario the gap in the strategic area *Education and Prevention* would increase by 13 percent (US $2.2 million, equivalent to DOP $119.3 million) compared with the scenario with international development assistance. In the strategic area *Comprehensive Care*, the gap would increase by 55 percent (US $3.3 million, equivalent to DOP $168.4 million). This is due to the fact that the trend in 2017 and 2018 is toward increased expenditure on the part of international development assistance in interventions such as screening, linking the population to services, patient retention, quality of care for key populations, surveillance systems, support for families and children, and adherence to ARV treatment.

In this scenario, the public funds should increase from 2018 by 65 percent (US $2.2 million) per year on average, due to the expected increase in expenditures by Social Security, PROMESE, and MSP, but the increase would not be sufficient to close the gap in a substantive way.

The gap between most of the 46 NSP subcategories and projected public expenditures (in the absence of international development assistance) increases significantly, particularly in the subcategories where outside development assistance made the largest contributions up to 2016, such as *Access to HIV tests with pre- and post-test counseling for the general population and key groups*.

The subcategories funded by public funds, such as *Ensuring Access to ARVs and Follow-up Tests*, still show a significant gap, since domestic resources are not sufficient to cover the needs. In the absence of international development assistance, interventions in 30 subcategories would cease to be funded in 2018. Some worth mentioning due to their outsize significance in the National Response: *SBCC in key populations*, *self-care and social protection program for children and women*, *service quality*, *capacity of CSOs and organizations for PLHIV and vulnerable groups*, *the right to quality health care, stigma and discrimination against PLHIV and vulnerable groups*, and *disease surveillance systems*.

5. ANALYSIS AND DISCUSSION

This study used the NSP 2015-2018 as a reference to estimate funding gaps given its role as the national strategic framework for responding to HIV and AIDS. It was made under the assumptions included in the *2013 National Estimates of Prevalence and Disease Burden* which established a lower number of PLHIV in the country, and the *2014 National Treatment Guidelines*, which established the initiation of ART at a CD4 count of 350. On the other hand, when the NSP was drafted, the country had not yet committed to a fast-track strategy to control the epidemic for which the 90-90-90 goals were not considered. It could therefore be assumed that several of the funding needs were thus underestimated and that the NSP would need to be updated to adjust to the current status of the epidemic, changes in funding sources, and national and international goals to which the country has committed itself.

This study constitutes a first effort to align NSP budget categories and subcategories with financial resources from public and international sources and to identify funding gaps. The study identified public funding sources that are little known or accounted for, such as the purchase of CD4 and VL clinical tests by Social Security and rapid HIV diagnostic tests by PROMESE. Importantly, it shows that the current and projected expenditures on HIV and AIDS are insufficient to cover the requirements of the National Response as set in the NSP (Figure 9).

The study shows an important increase in public resources starting in 2015 only in the subcategories of the area *Comprehensive Care*. The only expenditure items on which MSP and Social Security funding has concentrated are purchases of ARVs and clinical follow-up tests. Funding from international development assistance has focused on screening interventions of key groups, access to quality services for vulnerable groups, and adherence to treatment. Within this area, public funding does not provide resources for interventions related to pharmacovigilance, second-generation epidemiological surveillance, the promotion of healthy lifestyles, and HIV-tuberculosis co-infection.

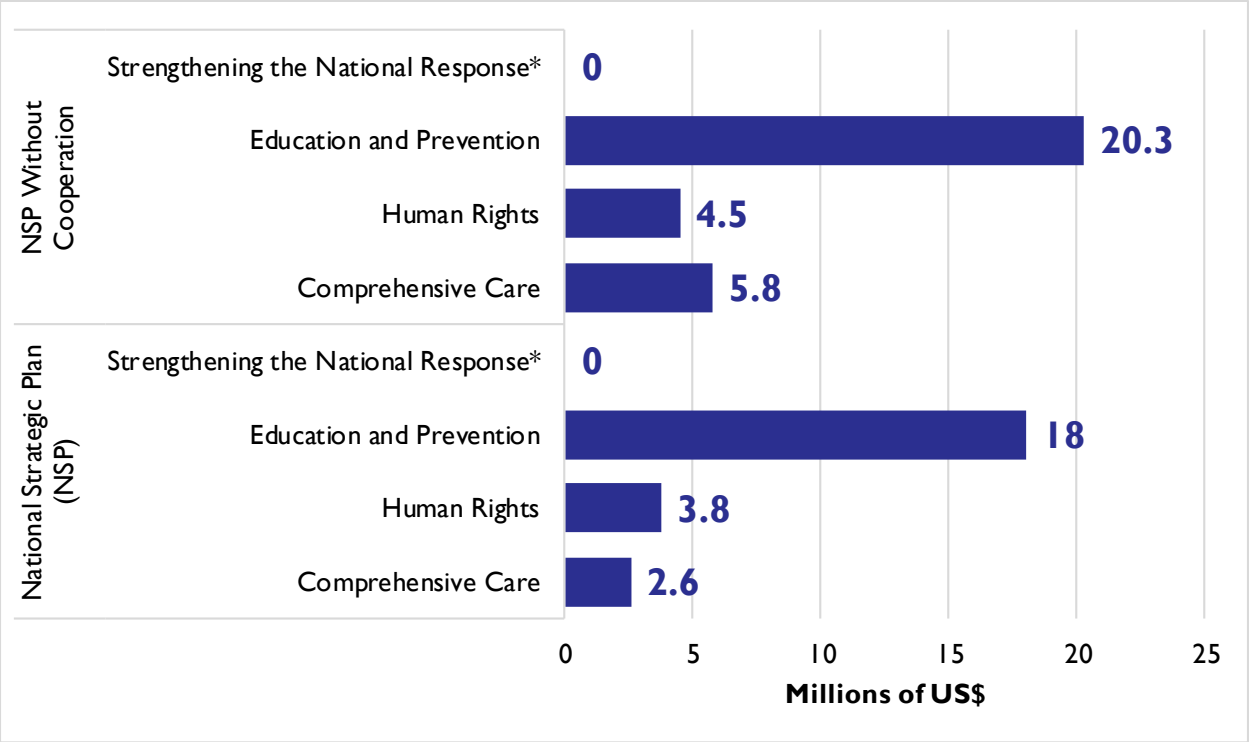
In the area *Strengthening the National Response,* expenditures exceed the requirements set in the NSP as a result of important contributions from international development assistance. This area includes the following subcategories, among others: *Strengthening Civil Society Organization*, *the Financial Sustainability of the National Response,* and *Equitable Distribution among Vulnerable Groups.* The interventions included in these subcategories may therefore be revised to mobilize public funds toward underfunded interventions.

The area *Human Rights* has been the least funded since 2015, and its trend in the coming years is uncertain. Five subcategories did not receive any public funding in 2016: 1) *Access to Justice and Public Defense Services,* 2) *Protection of Human Rights for PLHIV and Vulnerable Groups,* 3) *Decreased Stigma and Discrimination at Work toward PLHIV in State Institutions, the Private Sector, and CSOs*; 4) *Increased access to social protection programs for PLHIV, vulnerable groups, and others affected*; 5) *Guaranteed right to quality education free from stigma and discrimination for PLHIV and vulnerable groups*.

Funding for the area *Education and Prevention* has decreased since 2015, leaving without public or international development assistance funding such subcategories as *Post-Exposure Prophylaxis*, *Prevention-oriented SBCC Interventions with people in prison*, *Batey Populations*, *STI Services*, and *Blood Safety*.

The scenario that is both most feasible and most desirable is for the public sector to increase its funding allocations, especially for priority programs, and fill the gap in 2018. The public funds needed to meet the commitments in the NSP should be increased by 65 percent from 2017 to 2018, up to US $23.4 million (DOP $1.2 billion) in 2018.

Figure 9. 2018: Funding gap to finance the National HIV and AIDS Response



* Because a funding gap does not exist for *Strengthening the National Response*, there is no gap reported here for 2018.
Source: Created by the authors, 2017.

Given the existing funding gap in 2017 and the fact that a decrease in international development assistance funds can be anticipated in the future, public sources should be identified to close the gap starting in 2018. The results given in this report make it possible to identify potential strategies:

1. **Development of the NSP 2019-2025**: A revision should consider various funding scenarios, epidemiological and demographic updates, the goals that the Dominican Republic has committed to meet in the coming years, and a focus on high-impact priorities and programs**.** This would allow for a reevaluation of the funding gap, based on the country's current and future situation.
2. **Dissemination and monitoring of the NSP 2019-2025**: The NSP 2019-2025 should be an instrument for coordinating among funding agents and other decision makers so that its areas and subcategories help structure funding plans and expenditure monitoring. Clear coordination mechanisms should be established among funding agents to establish priorities, and also to avoid duplicating expenditures in some interventions.
3. **Increase Social Security coverage:** Given that the accumulated gap – based on the NSP requirements – for purchasing ARVs from 2015-2018 is US $7.7 million (an average of US $1.9 million per year), to have sustainable funding in the medium and long term and to achieve the country's goals, ARVs should be included and funded in Social Security. Regulation 4 of the Family Health Insurance[5] and the Basic Table of Medications[6] support coverage of ARVs by

[5] Medication control regulations in the Basic Health Plan. 2002. National Social Security Council. http://www.sisalril.gov.do/pdf/reglamentos/Reglamento4_version_final.pdf (Consulted by Claudia Valdez on March 21, 2017).

Social Security (CNSS 2002 y MSP 2015). In 2015, there were a total of 6,700 PLHIV. Approximately 17 percent of all PLHIV linked to public services are enrolled in the Social Security contributory scheme.

4. **Reorientation of expenditures toward subcategories with proven cost-effectiveness.** The funding sources and agents have to analyze the relevance of investments in the areas and subcategories where expenditures exceed funding requirements. Based on the results of this report, the following interventions may be considered:

   A. ***A progressive increase in expenditures in subcategories in the area Comprehensive Care.*** The most cost-effective investment for controlling the epidemic is early diagnosis and a strict treatment that suppresses the viral load[7] among PLHIV in the general population and key groups (UNAIDS 2014). This strategy not only avoids deaths and improves the quality of life of PLHIV, but also prevents further transmission of the disease. Accelerated increase of coverage therefore makes sense to reach the 90-90-90 goals in 2020. Public funding agents should expect to have to invest the required resources in 2018 and increase expenditure in this area until 2020.

   B. ***Investment review and adjustment in subcategories of the area Strengthening the National Response:*** This study shows that expenditures in this area exceed the requirements set in the NSP. It could be inferred that the expenditures in this strategic area were underestimated during the original NSP costing exercise and do not meet current requirements. This scenario was not explicitly encouraged in the NSP, and it is critical for implementing strategies that encourage the financial sustainability of the National Response and ensure equitable distribution of resources among vulnerable groups and key populations. However, assuming that the NSP cost accounting met the country's needs, the investment from partners in this category should be reviewed to avoid duplication.

   C. ***Optimization in managing the supply of ARVs and reagents and diagnostic materials***: Three interventions should be considered:

      i. **Joint purchase of diagnostic and tracking tests**: Currently PROMESE/CAL acquires these materials outside the acquisitions managed by CONAVIHSIDA/MSP. Consolidating purchases would benefit all funding agents.

      ii. **Retention of PLHIV on first-line treatment**: Recently conducted studies in the Dominican Republic have shown early migration of PLHIV to second- and third-line regimes (Valdez y Barillas 2016). This gap analysis showed a low investment in interventions to ensure adherence to treatment. Investments in these expenditures items would achieve savings in costly second- and third-line therapies.

      iii. **Adjust budget planning to the capacity of service response**: Reducing unnecessary CD4 tests and reducing the price of purchasing and storing ARVs would make it possible to save resources without harming diagnostic services.

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[6] Basic Table of Essential Medications (Cuadro Básico de Medicamentos Esenciales, CBME) of the Dominican Republic. 2015. Ministerio de Salud Pública. http://www.msp.gob.do/oai/documentos/Resoluciones/2015/Cuadro%20Basico%20de%20Medicamentos%20Esenciales%20de%20RD.%202015.pdf (Consulted by Claudia Valdez on March 21, 2017).

[7] 90-90-90. An ambitious treatment target to help end the AIDS epidemic. UNAIDS. 2014.

ANNEX I. ACTOR MAPPING

HIV ACTOR MAPPING	
Advising	Analysis of funding gaps in the National Response to HIV in the Dominican Republic.
Client	HFG
Location	Dominican Republic
Advisor	Dr. Claudia Valdez

Name	Type	Category	Contact
Ministry of Public Health (MSP)	Public	Funder/Donor	Dania Guzmán, Planning Director
National Council for HIV and AIDS (CONAVIHSIDA)	Public	Funder/Donor	Ivelisse Sabbagh, Technical Director
DIGECITSS	Public	Funder/Donor	Dr. Feliz Báez, Director
Institute for Dermatology and Skin Surgery (IDCP), Dr. Huberto Bogaert	Private	Funder/Donor	José Vicente Ruiz, Technical Director
PROMESE/CAL	Public	Funder/Donor	Mauricio Sánchez, Alberto Mena
Joint United Nations Programme on HIV/AIDS (UNAIDS)	International	Funder/Donor	Bethania Betances Julian UNAIDS Country Director
United Nations Children's Fund (UNICEF)	International	Funder/Donor	Rosa Elcarte, Representative
United Nations Population Fund	International	Funder/Donor	Sonia Vásquez, Auxiliary Representative
PEPFAR	International	Funder/Donor	Christopher T. Detwiler, Country Coordinator
United Nations Development Program (UNDP)	International	Funder/Donor	Lorenzo Jiménez, Resident Coordinator of the United Nations System
PAHO/DR	International	Funder/Donor	A. Morales Salinas, Representative
COIN **	Private/NGO	Funder/Donor	Santo Rosario

ANNEX 2. SAMPLE TEMPLATE FOR GATHERING EXPENDITURE DATA

			RD Costs					
Strategic Area	**Line of Action**	**Category**	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**
Education and Prevention	Implementation of support programs for victims of violence and workplace exposure	Post-exposure prophylaxis care for health care personnel with workplace exposure to HIV according to national protocol						
		Implementation of a national strategy for addressing the link between violence against woman and girls and HIV and AIDS						

ANNEX 3. VARIABLE DEFINITION MATRIX

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Education and Prevention	Implementation of support programs for victims of violence and workplace exposure	Post-exposure prophylaxis care for health care personnel with workplace exposure to HIV according to national protocol	Health care personnel exposed to HIV at work recruited and cared for according to the national protocol.	Create baseline for information and awareness-raising campaigns, defining coordination between institutions, updating the post-exposure prophylaxis guideline, training health care personnel and others, and facilitating access to medications for post-exposure prophylaxis. Design an information system on cases of workplace exposure
Education and Prevention	Implementation of support programs for victims of violence and workplace exposure	Implementation of a national strategy for addressing the link between violence against woman and girls and HIV and AIDS	Women who are victims of violence reached with the national strategy to address violence against women and girls and HIV and AIDS	Create baseline for education for people in the community and involvement of local authorities on the importance of relationships based on gender equality and equity and the prevention of violence against women and girls that leads to transmission of HIV. Implement campaigns. Design and publicize educational methodologies that incorporate treatment of the link between HIV and violence against women and girls according to the needs of different population groups. Monitor, evaluate, and measure implementation impact studies
Education and Prevention	Strengthening STI/HIV and AIDS education and prevention programs	Implementation of sex education curriculum with a gender and human rights focus in elementary and secondary education centers	Implementation of the curriculum in public education centers.	Advocate inclusion of the diversity focus, the application of policies, and the curriculum focused on gender and human rights. Integrate MSP bodies with sex education intervention in the education system. Strengthen the Sex Education Unit. Design educational materials. Train teachers, implement curricula, supervise implementation, and evaluate

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Education and Prevention	Strengthening STI/HIV and AIDS education and prevention programs	Prevention of mot her-infant transmission	Pregnant women diagnosed with HIV receive ARVs to reduce the risk of mother-infant transmission.	Perform HIV and syphilis tests. Get pregnant women with HIV and/or syphilis into treatment. Record and notify all cases treated. Train staff. Acquire materials and inputs according to the protocol. Adjust physical structures and acquire equipment and materials to attend to pregnant women and their children. Supervise compliance and perform evaluations
Education and Prevention	Implementation of social and behavior change communication (SBCC) programs with the most at-risk populations	SBCC interventions with the batey-dwelling population	Batey-dwelling population reached by the national strategy for this key population.	Map the population, define approach criteria, train peer multipliers, hold workshops, follow up on interventions, implement the campaign, evaluate results. Distribute condoms
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with people who are imprisoned	People who are imprisoned who used a condom in their last sexual intercourse and are reached by the appropriate HIV prevention strategies for that population. Distribute condoms.	Map the population, define approach criteria, train peer multipliers, hold workshops, follow up on interventions, implement the campaign, evaluate results. Distribute condoms
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with women with low education levels	Women with low levels of education who used condoms in their last sexual intercourse and were reached by the appropriate education strategy for this population. Condom distribution.	Map the population, define approach criteria, train peer multipliers, hold workshops, follow up on interventions, implement the campaign, evaluate results. Distribute male and female condoms. Design and implement a sex education program at the community level in coordination with the literacy program "Quisqueya Aprende" ("Quisqueya Learns") and other educational social programs

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with transpeople	Trans population that used a condom in their most recent sexual intercourse reached by HIV prevention programs through individual or small-group interventions.	Create access to condoms, lubricants, and hand gel. Map the population, train the trans multiplier network, and carry out individual and group education activities, supervision, and evaluation
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with sex workers	Sex workers reached by HIV prevention programs with individual or group interventions.	Promote and distribute male and female condoms, including a campaign to promote and create educational materials. Design and implement a strategy for a comprehensive approach for clients of sex workers for behavior change. Recruit and train a network of peer multipliers for sex workers. Carry out individual and group activities in open spaces. Supervision and evaluation of results
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with drug users	Drug-using population reached with SBCC to change condom use behavior	Create educational materials, form networks of peer multipliers, carry out group HIV prevention educational activities, and distribute condoms, lubricant, syringes, and Vaseline. Supervise and evaluate results
Education and Prevention	Implementation of SBCC programs with the most at-risk populations	SBCC interventions with gay men and MSM	Gay and MSM population reached by HIV prevention programs through individual or small-group interventions.	Revise, adapt, and implement a national strategy for gay men and MSM that includes specified interventions and addresses behavior change regarding condom use by partner type. Foster creation of organizations and strengthen existing ones. Foster gay and MSM networks with interventions on equal footing. Provide multiplier training. Deliver individual and group educational activities. Conduct regional and national surveys and forums. Supervise results of evaluation studies and condom distribution studies

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Education and Prevention	Implementation of SBCC programs with the most at-risk populations.	SBCC interventions with the Haitian migrant population	Migrant population reached by HIV prevention programs with individual or group interventions.	Map the population, define approach criteria, set up and train the trainer network, hold community activities, follow up on interventions, evaluate results. Distribute condoms
Education and Prevention	Implementation of SBCC programs with the most at-risk populations.	IEC interventions for the general population intended to increase the perception of risk and promote health services.	Programs aimed at the general population (men and women between the ages of 15 and 49) to increase the perception of risk and promote health services.	Design and make a mass media campaign, distribute condoms, conduct surveys
Education and Prevention	Implementation of support programs for victims of violence and workplace exposure	Post-exposure prophylaxis service for preventing HIV in victims of sexual violence.	Therapeutic interventions for victims of sexual violence.	Create baseline study. Implement care guidelines. Train staff. Design an educational campaign
Education and Prevention	Implementations of blood safety and STI diagnosis programs	Blood screening for HIV in the context of blood safety for the whole population	Units of donated blood screened according to protocol.	Articulate interventions for HIV screening in all units. Participate in the creation of regulations, guidelines, and protocols for blood units screening. Ensure existence and appropriate management of inputs and reagents necessary for screening. Support the management of necessary resources and skills in blood banks to screen units of blood. Watch, monitor, and evaluate implementation of regulations, guidelines, and protocols related to HIV screening and blood safety
Education and Prevention	Implementations of blood safety and STI diagnosis programs	Timely, standardized treatment for people who require STI care in health centers	Population recruited treated with synchronic management by syndrome type.	Implement prevention training, care for STIs and HIV for treating and non-treating health personnel of the national system ES. Acquire and distribute pre-packaged therapy. Create and distribute informational and promotional materials for synchronic management and pre-packaged therapy. Create and distribute control and registration of pre-packaged therapy. Record data and report notification. Supervise

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Second-generation epidemiological monitoring system coverage expanded	Interventions related to the monitoring system.	Create research and study timeline. Investigate contracts. Popularize and publicize the research.
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Support for families of HIV+ children and adolescents (0-17 years old) to promote self-care, social protection, and adherence to treatment	Children ages 0-17 living with HIV in treatment, with support for families to ensure adherence and self-care, with social and financial support for their families.	Publicize the national children and adolescent protection policy and monitor its implementation. Create a reference mechanism. Create counseling guides for parents, guardians, and children. Provide technical assistance [?] for legal support, generating income, and creating social and community support networks
Comprehensive Care	Detection and recruitment of HIV+ people	Access assured to screening tests with pre- and post-test counseling in the general population and the vulnerable population for early detection of HIV	Access to HIV tests with pre- and post-test counseling for the general population ages 18-49 and vulnerable groups, gay men, MSM, sex workers, transpeople, people who are imprisoned, batey dwellers, and migrants.	Ensure availability of HIV tests, expand the available pre- and post-test counseling in services that work with vulnerable populations. Ensure access to laboratory services, strengthen the information system
Comprehensive Care	Detection and recruitment of HIV+ people	Access to ARVs and clinical follow-up tests: pharmaceutical products	Acquisition of tests and ARVs available to the population	Purchases of ARV medications and special tests

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Comprehensive Care	Detection and recruitment of HIV+ people	Access to quality services for all PLHIV in accordance with the strategy established by the National Program	Quality services assured for PLHIV in treatment and follow-up.	Increase the number of patients in treatment each year; through training supervision and health monitoring, update and ensure implementation of the HIV care guidelines and protocols progressively aligned with international recommendations. Adjust care services to a model that fosters equity, solidarity, and universality and is suited to patient vulnerability factors. Ensure access to laboratory services to run routine and special tests for the comprehensive care of PLHIV. Implement a monitoring and evaluation plan based on information systems and nominal subsystems that can electronically record care provided to PLHIV. Guarantee prophylaxis, detection, and treatment of opportunistic infections in accordance with national norms, doing the diagnosis and clinic follow-up of PLHIV and assuring availability of the necessary medications and inputs
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Screening and preventive therapy for tuberculosis	PLHIV with access to tuberculosis diagnoses through basciloscopy tests and prophylaxis with isoniazid.	Guarantee HIV screening for all tuberculosis patients for early detection of TB/HIV coinfection. Guarantee delivery of preventative therapy with isoniazid, early screening for tuberculosis, and screening for TB/HIV coinfection for all PLHIV. Train health care personnel in the application of TB/HIV coinfection guidelines. Implement the sample transport network from all Servicio de Atención Integral (Comprehensive HIV Care Service or SAI) to quick-diagnosis points with molecular tests (complementary to the funding of the MSP's sample transport network. Oversee compliance with rules and TB/HIV coinfection guidelines. Hold collaborative joint analysis meetings between the TB program and SAIs to ensure timely treatment for any patients with coinfection detected (the information system will be addressed in the service provision module).

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Monitoring developed for drug resistance to ARVs	Establishment of a pharmacovigilance system for ARVs.	Include ARV medications in the monitoring system. Create a plan tied to clinical care to improve registration, control, and delivery of medications to HIV patients. Design and implement an operating plan to develop monitoring, establishing the roles and responsibilities of the various actors involved in the health system. Manage resources and train all personnel in care services.
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Monitoring system developed for monitoring reactions to ARVs	Interventions made in pharmacovigilance of ARVs	Adapt the ARV pharmacovigilance system. Develop operating plans, design resources, train human resources, and distribute the results of the pharmacovigilance system
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	Guaranteed health monitoring for drugs used to treat HIV	Interventions in the pharmacovigilance of the drugs used in HIV treatment	Adapt the ARV pharmacovigilance system. Develop operating plans, design resources, train human resources, and distribute the results of the pharmacovigilance system
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	PLHIV reached with an intervention packet to promote adherence to treatment	People reached by at least one of the intervention departments to promote adherence to treatment	Study measuring adherence to treatment. Design an intervention packet. Include intervention packets in home visits. Monitor and evaluate adherence to treatment. Manage resources. Train the support networks
Comprehensive Care	Universal, early access to ARV care, ART, and monitoring tests	PLHIV reached by the national strategy promoting a healthy lifestyle and self-care	People reached by interventions to promote a healthy lifestyle and self-care practices	Review the national strategy on promoting a healthy lifestyle and self-care practices. Manage and assign resources to implement the strategy. Monitor and evaluate skills. Create skills and support networks to implement the strategy
Human Rights	Environment free of stigma and discrimination for access to health and education services.	Increased access to justice and public defense services as a guarantee of and protection for the human rights of PLHIV and vulnerable groups	Increased access to justice and public defense services as a guarantee of and protection for the human rights of PLHIV and vulnerable groups	Engage in advocacy for the implementation of policies that favor access to justice services. Develop HR skills. Implement the promotion campaign. Establish a watchdog for registration and complaints. Expand legal services (advice, information, and legal representation)

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Human Rights	Environment free of stigma and discrimination for access to health and education services	Increased access to social protection programs for PLHIV, vulnerable groups, and others affected	PLHIV and people from vulnerable groups included in social protection programs	Carry out political impact actions with decision-makers and PLHIV and vulnerable groups. Conduct studies of the socio-economic situation with a gender focus. Implement training and management programs for self-employment. Implement food and nutritional assistance programs. Design an incident system. Design and implement a monitoring and evaluation program. Identify and prioritize affected families
Human Rights	Strengthening social participation	Auditing and advocacy mechanisms created and working to protect the rights of PLHIV and vulnerable groups	Interventions in the area of auditing and advocacy to protect PLHIV and vulnerable groups	Make up auditing teams. Train the auditing team. Create and implement auditing and advocacy plans. Promote and foster strategic alliances with human rights organizations and mechanisms. Create and submit alternate reports and process tracking
Human Rights	Environment free of stigma and discrimination for access to health and education services	Decrease violence on the part of military forces toward vulnerable groups for reasons of gender, sexual identity, sex work, drug use, or migrant status	Interventions or actions directed at military forces to decrease violence toward vulnerable groups	Design and implement an agreement to foster non-violence toward vulnerable groups. Design and implement a protocol/guideline for the national police that promotes non-violence toward vulnerable groups. Educate Human Resources
Human Rights	Environment free of stigma and discrimination for access to health and education services	Decreased stigma and discrimination toward PLHIV and vulnerable groups among opinion leaders and the general population	Communication and promotion activities to reduce stigma and discrimination toward PLHIV and vulnerable groups	Design and implement a campaign focused on human rights through mass media. Evaluate the campaigns

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Human Rights	Environment free of stigma and discrimination for access to health and education services.	Decreased stigma and job discrimination toward PLHIV in state institutions, the private sector, and CSOs	Communication and promotion activities to reduce stigma and job discrimination toward PLHIV in state institutions, the private sector, and CSOs	Create and implement a plan to strengthen institutions to monitor compliance with the legal framework. Carry out awareness-raising campaigns. Develop a plan to reduce stigma and discrimination in free zones. Implement a support and technical assessment process in free zones and among other companies to carry out human rights activities
Human Rights	Strengthening social participation	Strengthened capacities for CSOs and organizations of PLHIV and vulnerable groups to take advocacy and monitoring actions on public and private management to effectively protect human rights	Interventions or actions carried out with CSOs in advocacy and the defense of human rights	Design educational curricula. Provide training. Do a survey of CSOs. Implement work plans. Monitor and evaluate the results
Human Rights	Environment free of stigma and discrimination for access to health and education services	Guaranteed right to quality education without stigma or discrimination for PLHIV and vulnerable groups	Interventions to guarantee that academic institutions implement non-exclusion policies	Design a model institutional policy for academic organizations. Train personnel. Promote rights to discrimination-free education for PLHIV
Human Rights	Environment free of stigma and discrimination for access to health and education services.	Guaranteed right to quality health without stigma or discrimination for PLHIV and vulnerable groups	Interventions to guarantee that health institutions implement non-exclusion policies	Adapt guidelines, protocols, and regulations to the service needs of PLHIV and key populations. Carry out an awareness-raising campaign. Supervise, monitor, and evaluate

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Human Rights	Environment free of stigma and discrimination for access to health and education services.	Modification and/or creation of legal frameworks to guarantee the full exercise of citizenship for PLHIV and vulnerable groups	Intervention or actions intended to modify the legal framework for PLHIV and vulnerable groups	Adjust laws and regulations. Modify the Drug Law, the Labor Code, and the Migration Law. Promote the creation of an anti-discrimination law and a sex worker protection law. Ensure comprehensive care in Social Security. Socialize these interventions. Implement an advocacy plan
Strengthening the National Response	Sustainability of the National Response	Prevention and care CSOs in the National Response trained	Actions aimed at training CSOs	Make a diagnosis of the situation. Design and implement the training plan
Strengthening the National Response	Sustainability of the National Response	Implementation of actions coordinated among National Response actors for access to the care and prevention services required for the execution of the NSP.	Actions coordinated among National Response actors for access to the care and prevention services required for the execution of the NSP	Identify in the NSP the actions that require coordination. Implement agreed-upon actions. Monitor and evaluate results
Strengthening the National Response	Sustainability of the National Response	Implementation of financial sustainability strategies for the National Response, ensuring equitable distribution of funds among vulnerable groups	Actions aimed at strengthening financial stability	Identify needs and do a cost accounting of them. Identify funding sources. Create an investment budget. Execute and track budget. Create a budget execution report
Strengthening the National Response	Sustainability of the National Response	Implementation of an annual institutional development program for the CSOs in the National Response	Actions aimed at strengthening the institutional development of CSOs	Identify and prioritize institutional development needs. Create and implement an institutional development plan. Monitor and evaluate the plan

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Strengthening the National Response	Sustainability of the National Response	Implementation of the mandates of law 135-11, HIV/AIDS Law	Actions aimed at implementing Law 135-11, the HIV/AIDS Law	Make an inventory of mandates. Implement it. Create an agenda to track compliance. Create execution report
Strengthening the National Response	Strengthening the STI, HIV, and AIDS information system for evidence-based decision making	Cases and behavior at risk of STIs and HIV reported	Actions aimed at strengthening the notification of cases.	Train personnel. Maintain the physical infrastructure. Supervise the personnel involved
Strengthening the National Response	Strengthening the STI, HIV, and AIDS information system for evidence-based decision making	STI, HIV, and AIDS information system fed through the indicator report	Actions to strengthen the notification of cases of STIs, HIV, and AIDS	Involve national authorities to achieve operation of the Monitoring and Evaluation System. Implement an STI/HIV information system strengthening plan. Create an NSP monitoring and evaluation plan. Re-adjust the monitoring and evaluation system for STIs and HIV, including service networks, aligned with the World Health Organization's monitoring and evaluation framework and compliance with national commitments. Standardize the guidelines and instruments used to carry out monitoring and evaluation, including the Single File (Ficha Única) to constitute the primary source of information for the monitoring and evaluation plan. Develop interfaces with different components. Train technical monitoring and evaluation teams. Create consolidated monitoring and evaluation reports. Circulate monitoring and evaluation reports. Implement a clinical auditing plan. Create annual situation analysis reports for STIs, HIV, and AIDS

Component: NSP Strategic Area	Category: NSP Action Lines	Expenditure Subcategory (NSP Products)	Definition subcategories	Activities
Strengthening the National Response	Strengthening the STI, HIV, and AIDS information system for evidence-based decision making	Second-generation epidemiological monitoring system coverage expanded	Actions to expand coverage of the second-generation epidemiological monitoring system	Complete the design of the protocols. Allocate the funds. Train health care personnel. Analyze and publicize the results
Strengthening the National Response	Sustainability of the National Response	Implementation of binational STI and HIV interventions	Actions to implement the binational agenda in STIs, HIV, and AIDS	Hold binational workshops. Map out the organizations. Create procedure protocols for protecting defenders of human rights of vulnerable groups. Create a binational communication system. Hold binational workshops. Hold protocol exchanges. Incorporate HIV and AIDS issues on the binational agenda. Commemorate HIV and AIDS day in the border area

ANNEX 4. TABLES WITH COMPLETE SERIES OF THE GAP FOR 2015-2018

Categories	2015	2016	2017	2018	Cumulative
NSP Scenario					
Comprehensive Care					
Requirement	32,274,467.40	25,129,418.28	27,746,382.37	30,709,917.06	115,860,185.11
Expenditures	18,689,954.24	19,935,713.17	26,317,898.42	28,097,259.81	93,040,825.64
Gap	-13,584,513.16	-5,193,705.11	-1,428,483.94	-2,612,657.25	-22,819,359.47
Human Rights					
Requirement	7,039,953.55	5,213,225.78	4,608,326.05	4,522,721.57	21,384,226.95
Expenditures	1,104,914.51	469,282.32	685,736.16	683,135.53	2,943,068.53
Gap	-5,935,039.04	-4,743,943.45	-3,922,589.89	-3,839,586.04	-18,441,158.42
Education and Prevention					
Requirement	25,147,376.16	22,916,234.44	22,560,082.36	21,858,483.72	92,482,176.69
Expenditures	7,192,819.18	5,298,259.56	4,305,042.84	3,880,266.61	20,676,388.20
Gap	-17,954,556.97	-17,617,974.88	-18,255,039.52	-17,978,217.11	-71,805,788.49
Strengthening the National Response					
Requirement	2,881,198.65	1,858,006.99	1,577,774.25	1,527,697.90	7,844,677.79
Expenditures	9,049,554.74	6,894,340.90	10,987,835.99	8,104,443.41	35,036,175.03
Gap	6,168,356.09	5,036,333.91	9,410,061.74	6,576,745.50	27,191,497.25
General Total					
Requirement	67,342,995.75	55,116,885.49	56,492,565.03	58,618,820.25	237,571,266.53
Expenditures	36,037,242.68	32,597,595.95	42,296,513.41	40,765,105.36	151,696,457.40
Overall Gap	-31,305,753.08	-22,519,289.54	-14,196,051.61	-17,853,714.90	-85,874,809.12

Categories	2015	2016	2017	2018	Cumulative
NSP scenario with no international development assistance					
Comprehensive Care					
Requirement	32,274,467.40	25,129,418.28	27,746,382.37	30,709,917.06	115,860,185.11
Expenditures	18,689,954.24	19,935,713.17	26,317,898.42	24,864,141.66	89,807,707.49
Gap	-13,584,513.16	-5,193,705.11	-1,428,483.94	-5,845,775.40	-26,052,477.62
Human Rights					
Requirement	7,039,953.55	5,213,225.78	4,608,326.05	4,522,721.57	21,384,226.95
Expenditures	1,104,914.51	469,282.32	685,736.16	0.00	2,259,933.00
Gap	-5,935,039.04	-4,743,943.45	-3,922,589.89	-4,522,721.57	-19,124,293.95
Education and Prevention					
Requirement	25,147,376.16	22,916,234.44	22,560,082.36	21,858,483.72	92,482,176.69
Expenditures	7,192,819.18	5,298,259.56	4,305,042.84	1,589,166.38	18,385,287.97
Gap	-17,954,556.97	-17,617,974.88	-18,255,039.52	-20,269,317.34	-74,096,888.72
Strengthening the National Response					
Requirement	2,881,198.65	1,858,006.99	1,577,774.25	1,527,697.90	7,844,677.79
Expenditures	9,049,554.74	6,894,340.90	10,987,835.99	2,469,081.00	29,400,812.63
Gap	6,168,356.09	5,036,333.91	9,410,061.74	941,383.10	21,556,134.84
General Total					
Requirement	67,342,995.75	55,116,885.49	56,492,565.03	58,618,820.25	237,571,266.53
Expenditures	36,037,242.68	32,597,595.95	42,296,513.41	28,922,389.04	139,853,741.09
Overall Gap	-31,305,753.08	-22,519,289.54	-14,196,051.61	-29,696,431.22	-97,717,525.44

ANNEX 5. REQUIREMENTS, EXPENDITURES, AND GAP FOR EACH SUBCATEGORY OF THE NSP STRATEGIC AREAS 2015-2018

Comprehensive Care	2015			2016			2017			2018		
Cost category (Products)	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Second-generation epidemiological monitoring system coverage expanded (Health facilities)	224,521.49		-224,521.49	51,339.80	8,778.64	-42,561.17	80,816.75		-80,816.75	41,819.28		-41,819.28
Support for families of HIV-positive children and adolescents (0-17 years old) to promote self-care, social protection, and adherence to treatment	471,502.01	169,897.55	-301,604.46	53,045.14	2,283.30	-50,761.84	52,618.32	18,157.54	-34,460.78	51,654.96	16,457.58	-35,197.38
Access assured to screening tests with pre- and post-test counseling in the general population and the vulnerable population for early detection of HIV	14,187,336.91	3,351,119.17	-10,836,217.74	7,328,872.01	2,779,948.86	4,548,923.15	7,529,939.26	3,587,236.60	3,942,702.65	7,144,216.58	3,462,828.36	-3,681,388.22
Access to quality services for all PLHIV in accordance with the strategy established by the National Program	723,297.55	1,832,978.02	1,109,680.46	412,185.28	2,046,362.63	1,634,177.35	408,868.67	5,111,238.33	4,702,369.66	401,382.93	6,412,889.85	6,011,506.92

Comprehensive Care	2015			2016			2017			2018		
Cost category (Products)	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Access to ARVs and clinical follow-up tests: pharmaceutical products	13,690,190.86	12,194,387.47	-1,495,803.39	14,768,616.71	13,167,016.56	1,601,600.15	17,243,726.72	16,385,500.77	-858,225.95	20,619,428.09	16,782,099.00	-3,837,329.09
Screening and preventive therapy for tuberculosis and other illnesses. (LAB Strengthening)	418,765.42	409,639.66	-9,125.75	414,390.78	720,238.48	305,847.71	417,482.81	216,682.56	-200,800.25	475,338.98	514,341.33	39,002.35
Monitoring developed for drug resistance to ARVs	51,315.92		-51,315.92		4,207.79	4,207.79		86.41			86.41	
Monitoring system developed for monitoring reactions to ARVs	192,036.86		-192,036.86	66,880.68		-66,880.68	63,188.40		-63,188.40	62,031.52		-62,031.52
Guaranteed health monitoring for drugs used to treat HIV	456,853.25		-456,853.25	282,579.54		-282,579.54	267,842.31		-267,842.31	262,938.53		-262,938.53
PLHIV reached with an intervention packet to promote adherence to treatment	1,708,138.26	707,429.84	-1,000,708.42	1,654,887.74	1,197,964.45	-456,923.29	1,630,801.22	991,117.87	-639,683.36	1,600,943.80	900,678.93	-700,264.87
PLHIV reached by the national strategy promoting a healthy lifestyle and self-care (Community)	150,508.87	24,502.53	-126,006.34	96,620.60	8,912.46	-87,708.14	51,097.91	7,878.34	-43,219.57	50,162.39	7,878.34	-42,284.05
Subtotal	32,274,467.40	18,689,954.24	-13,584,513.16	25,129,418.28	19,935,713.17	-5,193,705.11	27,746,382.37	26,317,898.42	-1,428,570.35	30,709,917.06	28,097,259.81	-2,612,657.25

Human Rights	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Increased access to justice and public defense services as a guarantee of and protection for the human rights of PLHIV and vulnerable groups	1,010,675.12		-1,010,675.12	784,806.83		-784,806.83	778,491.97	6,198.31	-772,293.66	764,239.00	3,182.51	-761,056.49
Increased access to social protection programs for PLHIV, vulnerable groups, and others affected	273,710.92	4,604.95	-269,105.98	209,518.41		-209,518.41	132,834.97		-132,834.97	126,924.60		-126,924.60
Auditing and advocacy mechanisms created and working to protect the rights of PLHIV and vulnerable groups	89,270.86	3,423.69	-85,847.16	87,016.10	4,209.21	-82,806.89	21,832.94	6,960.76	-14,872.18	21,433.22	7,528.44	-13,904.78
Decrease violence on the part of military forces toward vulnerable groups for reasons of gender, sexual identity, sex work, drug use, or migrant status	230,440.70	5,752.00	-224,688.70	114,778.12		-114,778.12	29,065.38		-29,065.38	28,533.24		-28,533.24
Decreased stigma and	1,381,420.39	69,467.00	-1,311,953.39	821,443.94	42,515.00	-778,928.94	814,834.28	43,500.00	-771,334.28	799,915.94	43,500.00	-756,415.94

Human Rights	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
discrimination toward PLHIV and vulnerable groups among opinion leaders and the general population												

Human Rights	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Decreased stigma and job discrimination toward PLHIV in state institutions, the private sector, and CSOs	687,064.83	186,149.84	-500,914.99	584,180.10		-584,180.10	551,288.53		-551,288.53	541,195.30		-541,195.30
Strengthened capacities for CSOs and organizations of PLHIV and vulnerable groups to take advocacy and monitoring actions on public and private management to effectively protect human rights	240,141.43	743,441.24	503,299.80	96,100.14	341,669.75	245,569.61	52,932.28	300,711.19	247,778.91	51,963.17	287,218.71	235,255.54
Guaranteed right to quality education without stigma or discrimination for PLHIV and vulnerable groups	979,709.38		-979,709.38	714,667.11		-714,667.11	650,027.03		-650,027.03	638,126.05		-638,126.05
Guaranteed right to quality health without stigma or discrimination for PLHIV and vulnerable groups	1,861,939.77	70,409.80	-1,791,529.97	1,776,150.38	80,888.37	-1,695,262.01	1,555,373.58	328,365.90	-1,227,007.68	1,526,897.12	341,705.88	-1,185,191.24

Human Rights	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Modification and/or creation of legal frameworks to guarantee the full exercise of citizenship for PLHIV and vulnerable groups (policies)	285,580.14	21,666.00	-263,914.14	24,564.64		-24,564.64	21,645.09		-21,645.09	23,493.94		-23,493.94
Subtotal	**7,039,953.55**	**1,104,914.51**	**-5,935,039.04**	**5,213,225.78**	**469,282.32**	**-4,743,943.45**	**4,608,326.05**	**685,736.16**	**-3,922,589.89**	**4,522,721.57**	**683,135.53**	**-3,839,586.04**

Education and Prevention	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
Post-exposure prophylaxis care for health care personnel with workplace exposure to HIV according to national protocol	950,807.24	68,166.32	-882,640.92	937,577.10	134,513.06	-803,064.04	920,766.78		-920,766.78	584,790.73		-584,790.73
Implementation of a national strategy for addressing the link between violence against woman and girls and HIV and AIDS	3,286,918.74	10,141.84	-3,276,776.91	3,128,187.06	171,647.65	-2,956,539.42	3,071,647.62	55,984.85	-3,015,662.77	3,016,142.73	52,740.36	-2,963,402.37
Implementation of sex education curriculum with a gender and human rights focus in elementary and secondary education centers	752,678.46	30,989.01	-721,689.45	518,975.71	37,237.69	-481,738.02	459,307.92	37,237.69	-422,070.24	410,925.78	37,237.69	-373,688.10
Prevention of mother-infant transmission	2,380,464.94	1,322,169.47	-1,058,295.46	2,281,972.72	178,926.87	-2,103,045.86	2,243,559.28	186,772.50	-2,056,786.78	2,202,483.22	181,984.23	-2,020,498.99

Education and Prevention	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
SBCC interventions with the batey-dwelling population	1,326,551.40	14,358.24	-1,312,193.16	1,145,680.95		-1,145,680.95	1,194,581.20		-1,194,581.20	1,253,830.14		-1,253,830.14
SBCC interventions with people who are imprisoned	829,953.45		-829,953.45	298,229.23		-298,229.23	295,829.56		-295,829.56	306,080.92		-306,080.92
SBCC interventions with women with low education levels	207,839.46	181,587.12	-26,252.34	127,379.53	266,257.50	138,877.97	81,102.09	324,493.68	243,391.59	85,382.24	297,922.57	212,540.33
SBCC interventions with transpeople	2,233,586.71	182,319.22	-2,051,267.49	2,119,370.90	102,570.02	-2,016,800.87	2,102,578.45	138,163.52	-1,964,414.93	2,066,504.83	138,868.84	-1,927,635.99
SBCC interventions with sex workers	729,068.50	1,225,450.74	496,382.24	612,831.50	1,137,080.05	524,248.56	607,900.41	959,738.73	351,838.32	707,748.88	827,256.90	119,508.02
SBCC interventions with drug users	2,694,154.66	98,648.21	-2,595,506.45	2,606,361.16	10,359.23	-2,596,001.93	2,585,389.36	6,937.99	-2,578,451.37	2,545,434.12	6,937.99	-2,538,496.13
SBCC interventions with gay men and MSM	2,369,197.76	1,028,542.00	-1,340,655.76	2,130,806.56	1,109,718.00	-1,021,088.56	2,113,661.26	1,091,428.49	-1,022,232.77	2,076,462.32	954,314.58	-1,122,147.74
SBCC interventions with the Haitian migrant population	498,387.23	1,982,923.77	1,484,536.55	419,451.37	1,648,293.72	1,228,842.35	416,076.30	1,019,170.28	603,093.98	520,461.55	898,590.12	378,128.57

Education and Prevention	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
IEC interventions for the general population intended to increase the perception of risk and promote health services	1,466,846.34	795,524.96	-671,321.39	1,429,797.48	185,283.14	-1,244,514.34	1,418,292.77	164,739.20	-1,253,553.57	1,392,326.05	164,037.32	-1,228,288.73
Post-exposure prophylaxis service for preventing HIV in victims of sexual violence	1,501,413.03	3,481.00	-1,497,932.03	1,419,592.81		-1,419,592.81	1,397,475.92	2,500.00	-1,394,975.92	1,102,661.03	2,500.00	-1,100,161.03
Blood screening for HIV in the context of blood safety for the whole population	114,587.53	187,751.37	73,163.85	21,983.40		-21,983.40	21,806.52		-21,806.52	21,407.27		-21,407.27
Timely, standardized treatment for people who require STI care in health centers	3,804,920.72	60,765.17	-3,744,155.55	3,718,036.97	316,375.90	-3,401,661.07	3,630,106.93	317,875.90	-3,312,231.03	3,565,841.89	317,875.90	-3,247,965.99
Subtotal	25,147,376.16	7,192,818.45	-17,954,557.71	22,916,234.44	5,298,262.82	-17,617,971.62	22,560,082.36	4,305,042.84	-18,255,039.52	21,858,483.72	3,880,266.50	-17,978,217.22

Strengthening the National Response	2015			2016			2017			2018		
Cost category (Products	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap	REQ	Expenditures	Gap
STI, HIV, and AIDS information system fed through the indicator report	899,062.46	1,834,972.03	935,909.56	460,993.14	1,059,400.60	598,407.46	386,732.71	2,361,680.08	1,974,947.37	366,529.12	262,245.00	-104,284.12
Second-generation epidemiological monitoring system coverage expanded (Establishments)	22,944.26	58,686.53	35,742.27	22,364.75	166,122.00	143,757.25	22,184.79	166,122.00	143,937.21	21,778.62	166,122.00	144,343.38
Prevention and care CSOs in the National Response trained	42,631.85		-42,631.85									
Implementation of actions coordinated among National Response actors for access to the care and prevention services required for the execution of the NSP	234,414.60	114,665.68	-119,748.92	199,330.45	360,463.59	161,133.14	197,726.56	253,750.91	56,024.35	194,106.50	159,569.31	-34,537.19
Implementation of financial sustainability strategies for the National Response, ensuring equitable distribution of funds among vulnerable groups	200,812.13	6,936,506.85	6,735,694.72	176,851.50	5,275,784.62	5,098,933.12	175,428.48	8,205,203.90	8,029,775.41	172,216.66	7,514,873.72	7,342,657.06
Implementation of binational STI and HIV interventions	609,772.24	6,946.00	-602,826.24	270,687.33		-270,687.33	216,863.71		-216,863.71	212,740.63		-212,740.63
Implementation of an annual institutional development program for the CSOs in the National Response	393,434.35	95,023.80	-298,410.55	383,497.18	32,570.10	-350,927.08	264,061.31	1,079.10	-262,982.21	259,226.76	1,633.37	-257,593.39
Implementation of the mandates of law 135-11	391,027.54	2,753.85	-388,273.70	270,698.57		-270,698.57	268,520.43		-268,520.43	255,690.24		-255,690.24
Cases and behavior at risk of STIs and HIV reported	87,099.21		-87,099.21	73,584.07		-73,584.07	46,256.25		-46,256.25	45,409.37		-45,409.37
Subtotal	2,881,198.65	9,049,554.74	6,168,356.09	1,858,006.99	6,894,340.90	5,036,333.91	1,577,774.25	10,987,835.99	9,410,061.74	1,527,697.90	8,104,443.41	6,576,745.50

ANNEX 6: BIBLIOGRAPHY

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