CENTRO DE PROMOCIÓN Y SOLIDARIDAD HUMANA (CEPROSH)

''Sustained Community Support for 150 People Living with HIV in the Dominican Republic" for the GlobalGiving International Organization Platform.

THIRD PROJECT REPORT #70748
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Prepared by:
Evandro Ramírez Clase

I- PROJECT SITUATION AND IMPACT

During the period from **March 1, 2026, to August 19, 2026**, the project has not been able to raise sufficient funds to cover the anticipated needs and reach its fundraising goal. However, follow-up with individuals enrolled in the care program has continued consistently, strengthening strategies aimed at ensuring adherence to antiretroviral treatment and continuity of care, despite the various social, economic, and geographic barriers they face.

One of the main strategies implemented during this period has been the provision of home by a multidisciplinary team consisting of a physician, nurse, and health promoter. These visits make it possible to bring services closer to the communities where beneficiaries live and reduce difficulties that could otherwise prevent them from accessing the care center.

During these visits, a comprehensive assessment of each user's health and socioeconomic conditions is conducted. CD4 and viral load samples are also collected, antiretroviral medications are delivered, and, when necessary, medications for the management of opportunistic infections and other health conditions are provided. This approach has made it possible to maintain contact with individuals who, due to their particular circumstances, face greater difficulties traveling to the Comprehensive Care Unit.

Among the main barriers identified are difficulties related to the immigration status of Haitian nationals, particularly given the current context and policies implemented by the Dominican Government. Economic barriers have also been identified, associated with limited employment opportunities in some vulnerable sectors, as well as geographic barriers due to the distance between the places of residence of some beneficiaries and CEPROSH.

In response to this situation, available resources have been strategically used to transport the multidisciplinary team to the communities where beneficiaries live, preventing a lack of financial resources for transportation from becoming a barrier to accessing medical follow-up, medications, and the necessary support services.

Health Conditions Identified

1. **Woman, 56 years old:** During a medical assessment conducted at her home, hypertension was identified. As part of the care protocol, she was referred to the cardiology service for specialized evaluation and follow-up, as well as to receive the appropriate treatment.

2. **Man, 51 years old:** Hypertension was identified during the home-based medical assessment. The client was referred to cardiology for specialized evaluation and follow-up of this condition.

3. **Woman, 62 years old:** The client has a history of a cerebrovascular accident (CVA/stroke) and remains bedridden as a result of the lasting effects of the event. Her condition requires continuous follow-up and comprehensive care according to her health needs and level of dependency.

4. **Woman, 72 years old:** The client was identified as having diabetes mellitus during the follow-up process. She was referred to the endocrinology service for specialized evaluation and monitoring of her health condition.

There cases demonstrate the value of home visits as a comprehensive care strategy. In addition to supporting adherence to antiretroviral treatment, home-based care makes it possible to identify other health needs in a timely manner and facilitate referrals to the appropriate specialized services.