Democratic Republic of the Congo

Operational Plan Report

FY 2012

Operating Unit Overview

OU Executive Summary

The Democratic Republic of Congo
COP 12 Executive Summary

Country Context
The Democratic Republic of Congo (DRC) has one of the lowest Gross National Incomes per capita in the world ($160), with an estimated 80 percent of the total population of 67.8 million living below the poverty line. The United Nations Development Fund ranks the DRC the least developed country in the world (168/168). The population size, poverty scale, and decades of conflict have resulted in the lack of cohesive and functional health systems. It will require considerable resources and effort on behalf of the Government of DRC (GDRC), donors, and other partners to build quality systems based on previously existing platforms where possible. The U.S. Government (USG), through PEPFAR as part of the Global Health Initiative (GHI), is supporting activities to strengthen the foundations of existing systems and linking them together to create an improved system. There are tremendous challenges, detailed in the Technical Area Narratives (TANs), which will require government commitment, donor funding and coordination, improved governance and transparency within the civil society and the GDRC, improved information management systems, and solutions to the human resources for health crisis.

The 2007 Demographic Health Survey (DHS) in DRC indicated that the country is facing a 1.3 percent HIV/AIDS prevalence, which is considered a generalized HIV/AIDS epidemic with stark geographic and population differences. The majority of new HIV/AIDS cases are diagnosed among people less than 24 years of age. Though the overall HIV prevalence in DRC is 1.3 percent, rates are twice as high in urban vs. rural areas (1.9 percent vs. 0.8 percent) and higher among women than men (1.9 percent vs. 0.9 percent). While HIV prevalence remains higher in urban areas, it has increased in certain rural areas, particularly those near geographic hotspots, which bring together large groups with low prevalence engaging in risky behavior with groups with high prevalence rates.

Pregnant women are particularly at risk. Antenatal Care (ANC) surveillance data from 2010 indicate that pregnant women had a prevalence rate roughly twice that of other women at 2.0 percent. The 2009 ANC data showed urban prevalence rates ranging from 4.3 percent in Matadi to 9.5 percent in Kisangani and a 2007 ANC survey found a prevalence rate of 16.3 percent in rural Kasumbalesa (Katanga province). Furthermore, gender inequalities, war, and political and economic instability result in widespread sexual violence, intimate partner violence, physical abuse, and an increase in commercial sex work.

High risk and high prevalence populations often congregate in geographic “hotspots,” such as border crossings, transport corridors, ports, and regions with a large military presence. The already elevated rates of Most At Risk Populations (MARPs), which includes Commercial Sex Workers (CSWs), truckers, miners, and uniformed services (military/police) are often more than triple or quadruple the rates in the rest of the country. According to a 2006 joint UNAIDS/PNLS sero-prevalence study, truckers demonstrate a national prevalence rate of 3.3 percent, but in Katanga, long-haul truckers from southern African countries demonstrate a HIV prevalence of 7.8 percent. A sero-prevalence survey conducted in Kinshasa in 2008 indicated that prevalence in the military was 7.5 percent among female soldiers and 3.6 percent among their male counterparts. A 2006 bio-sero survey found a prevalence rate of 16.9 percent among CSWs; rates in the provincial capitals of Katanga and Kasai Oriental were elevated to 23.3 percent and 24.5 percent. Fifty-five percent of miners, 32.9 percent of the military, 75.1 percent of street boys, and 81.1 percent of street girls report multiple sex partners within the last 12 months, thereby increasing their risk for transmission.

The geographic size of the DRC and its logistical hurdles create a unique set of challenges for delivering services. Currently, the health system in the DRC has three tiers: 1) a central level which includes the Ministry of Health (MOH), the Secretary General of the MOH, and Directorates of national disease-specific programs; 2) an intermediate level composed of 11 provincial health departments and 48 administrative health districts; and 3) the peripheral level with 515 health zones (HZs) containing over 6,000 health centers (HC). Approximately an equal number of health sites are publically and privately supported. In addition, the health system relies on two types of volunteer community health workers: 1) community health providers whose activities are limited to health promotion and community mobilization activities; and 2) community treatment workers who deliver a limited set of interventions (i.e. treatment of diarrhea, fever, and referral of malnourished children to health facilities, plus distribution of a limited number of family planning commodities). Most provinces use a centralized pharmaceutical procurement system through the Federation of Essential Medicine Procurement Agencies (FEDECAME), combined with a decentralized distribution system supported by existing distribution hubs (CDRs). The USG is providing significant technical assistance and commodities in supply chain management at various levels of the system to build capacity and avoid stock outs of essential medication.

PEPFAR Focus in FY 2012

The DRC GHI Strategy is directly aligned with the MOH’s National Health Development Plan (NHDP) for 2011-2015, as well as the National Health System Strengthening Strategy. The NHDP is a comprehensive plan that covers major causes of mortality and morbidity in the country. The main goals of both GHI and the NHDP is moving toward sustainable health systems and health care services, by making the HZ network the key implementation unit and increasing HZ program efficiencies, effectiveness, and mutual accountability. The GDRC and the USG aim to achieve these goals by

improving the primary health care system through human resource development, integrated service delivery, and strengthening national health systems. If selected for scale-up, the PEPFAR DRC program would consolidate activities, ensuring first an integrated and comprehensive package of services in the health zones where it works, and if additional funding becomes available, would expand the number of HZs prioritized within the portfolio.

Under GHI, the GDRC and USG decided to focus on three cross cutting program areas to assure progress towards the Millennium Development Goals: 1) Strengthened Human Resources; 2) Improved Supply Chain Management Systems; and 3) Improved Health Care Financing Systems. These areas were selected based on GDRC's priorities, USG comparative advantages, and opportunities for leveraging USG resources as well as those of other donors and the private sector. Through its emphasis on strategic coordination amongst USG partners, GHI is an opportunity to maximize program impact by capitalizing on synergies within USG-supported programming. These programs include PEPFAR, The President's Malaria Initiative (PMI), Maternal and Child Health, Family Planning/Reproductive Health, Food for Peace's new Multi-Year Assistance Program (MYAP) activities, and the Nursing Education Partnership Initiative (NEPI). In addition, collaboration and synergies with key development partners is critical in order to complement activities, reduce costs, and avoid duplication of services. From a broader health systems perspective, these improvements at the HZ level will complement and strengthen other critical USG and DRC interest areas such as surveillance and emergency disease detection capacity building.

GHI partners have established public/private partnerships (PPP) to increase HIV prevention and treatment services to select populations. There is currently a PPP with a NGO to ensure that blood transfusions are safe and health personnel are adequately trained in safe blood procedures at health centers and the referral hospital level. Another PPP partners the USG with a large mining company in Katanga to bring comprehensive HIV/AIDS services to the HZ where it operates. A PPP with Becton Dickinson and the Kinshasa School of Public Health is also setting the stage for a Regional Laboratory Training Center, the first of its kind in Central Africa.

The USG currently supports activities that contribute to the reduction of HIV prevalence while increasing access to quality HIV/AIDS prevention, care, and support in high prevalence urban sites. There are four USG agencies (CDC, DOD, DOS, and USAID) that address health issues through an interagency Continuum of Response (CoR) approach, based on each agency's comparative advantages. Such a CoR will become fully functional with the implementation of the Prevention of Mother To Child Transmission Acceleration Plan (PMTCT-AP) and will set the stage for total interagency integration of all PEPFAR activities. Services in DRC, supported by PEPFAR in both the public and private sector, are integrated with other USG or partner activities to ensure a CoR, regardless if the USG is funding the entire

continuum. USAID provides a comprehensive package of primary health care (PHC) services in 80 HZ in South Kivu, Katanga, East and Western Kasai provinces. USAID also provides HIV prevention and care interventions in high prevalence urban sites for orphans and vulnerable children (OVCs) and people living with HIV/AIDS (PLWHAs). Both CDC and USAID provide considerable funding for addressing tuberculosis (TB). For example, CDC is strengthening the laboratory diagnosis of TB and USAID supports Directly Observed Treatment (DOTS) expansion, increasing TB case notifications and TB diagnosis and quality treatment as part of the PHC package. The CDC is strengthening HIV-specific laboratory capability, HIV/AIDS information systems and surveillance, and HIV/AIDS care and treatment. DOD is focused on providing HIV preventive services including HIV Voluntary Testing and Counseling (HVTC) to the military and their families while providing care to the surrounding communities in four sites in Kinshasa, Katanga, East Kasai, and South Kivu. DOS, as represented by the Public Affairs Section, supports small-scale awareness-raising activities across the country and works to publicize the work of PEPFAR DRC within the country. If selected for scale-up, PEPFAR DRC will further maximize synergies between agencies with focused attention on the provinces of Kinshasa, Katanga and Orientale.

In 2012, PEPFAR will continue to work toward:

- Implementation of an Interagency CoR to leverage USG resources and expertise;
- A cost-effective evidence-based care and support package;
- Increased emphasis on positive living and reducing stigma and discrimination;
- Appropriate nutrition messages and coordinating needs-based provision of high energy protein supplements and emergency food assistance;
- Streamlined referral and enrollment of those who are ineligible for Antiretroviral Therapy (ART) into comprehensive care programs;
- Strengthened collaboration with the Global Fund—provisions of technical assistance as appropriate;
- Incorporation of gender based violence screening and prevention to relevant PEPFAR activities, notably the PMTCT-AP; and
- Synergize PEPFAR programs with broader personnel development initiatives such as NEPI.

At the community level the USG will continue to provide social and palliative care services, which include nutritional support, legal aid, income generating activities, psychosocial support, support groups, anti-stigma activities, and limited clinical services, such as support to treatment adherence through health providers and home-based care volunteers. In addition, PEPFAR supports services to deliver prevention and care at the DRC/Rwanda and the DRC/Burundi borders focusing on underserved populations through local organizations.

In 2012, the USG will continue to coordinate with other donors in-country to improve governance and

health systems. The grants from the largest HIV/AIDS donor, the Global Fund (GF), are not performing well, mainly due to financial, and governance concerns among the Primary Recipients. Without GF funding available a considerable burden is placed on the USG and other donors to fill in the programmatic, technical, and commodity gaps within the GF's designated health zones. The most notable gaps remain in anti-retroviral drug (ARV) procurement and availability, because health centers and donors rely on the GF for commodities, in particular ARVs, to support patients on treatment.

The donor community and development actors work in partnership with the GDRC to reduce new infections. The GF supports drugs to treat sexually transmitted infections (STIs), condoms, mass media strategic messaging campaigns, prevention for positive and discordant couple's activities, PMTCT training, ARVs, salary support, and blood transfusion equipment and supplies. It also funds activities to support prevention in the areas of PMTCT, behavior change communication (BCC), HVTC, blood safety, and outreach to high-risk populations. The GF Round 7 grant allocated 32 percent of its budget to prevention while Round 8 allocated 38 percent. The UN agencies target MARPs with prevention messages and provision of condoms along major transportation corridors. The World Health Organization provides technical assistance for counseling and testing policies and on blood safety. The World Bank's program, which has ended due to a restructuring of its assistance priorities, was supporting a comprehensive prevention package similar to the GF in their designated health zones, including mass media campaigns, peer education, condoms, and PMTCT. Though capacity challenges remain, the GDRC has existing coordinating bodies to facilitate donor coordination in line with GDRC priorities. These include: the country coordinating mechanism (CCM), Blood Safety, PMTCT, and HVTC technical working groups as well as the BCC coordination forum. PEPFAR will provide technical assistance to the GF during the grant consolidation process in order to help transition the program from UNDP to new Primary Recipients (PRs). If selected for scale-up, PEPFAR DRC would coordinate closely with the GF in the selection of priority HZs in order to maintain the ARV procurement role of the GF and manage the PEPFAR mortgage in country. Applications for future rounds will be closely coordinated, so that appropriate synergies are established and made functional between PEPFAR and GF investments.

Gender is strong focus area under the GHI. PEPFAR supports and integrates the key intervention areas of the DRC/GHI gender strategy:

1) Ensure equitable access to essential health services at facility and community levels;
2) Monitor, prevent, and respond to gender-based violence (GBV);
3) Engage men and boys as clients, supportive partners, and role models for gender equality;
4) Utilize multiple community-based programmatic approaches, such as BCC, mobilization, advocacy, and engagement of community leaders/role models;
5) Build the capacity of individuals, with a deliberate emphasis on women as health care providers, caregivers, and decision-makers throughout health systems, from the community to the national level.

In response to widespread sexual and gender based violence (SGBV) in the DRC, the USG has become a major donor in the fight against SGBV. Throughout the overall USG strategy, SGBV and gender activities are integrated through a whole of government approach to promote protection from, community prevention of, and response to SGBV; this includes providing medical and psychosocial support for SGBV survivors. USG partners, other bilateral and multi-lateral partners, and the GDRC work closely together to reduce overlap and try to expand geographical coverage of prevention activities. The USG has an additional interagency working group on SGBV and implements synergistic programs which are linked together through the pillars of the USG SGBV strategy:

1) Reduced impunity for perpetrators of SGBV;
2) Improvement of the security sector directed at reducing acts of SGBV;
3) Increased prevention of and protection against SGBV; and
4) Increased access to quality care and treatment services for SGBV survivors.

The discrete PEPFAR-funded, GBV focused, activities linked to existing HIV platforms compliment the larger and more numerous GBV programs funded by the USG. The USG supports a range of interventions to prevent and respond to SGBV in the DRC and elsewhere in the region, including: medical services; psycho-social support; increased access to legal services; behavior change and SGBV prevention communication; and income generating activities. As part of supporting SGBV services, the PEPFAR is also increasing the availability of PEP kits for survivors of rape. PEP provisions would be integrated into priority HZs with scale-up funding. SGBV screening and treatment are also components of the PMTCT-AP. Additionally, it is planned that all USG-supported surveys in DRC will incorporate SGBV questions to help monitor the extent of the SGBV burden in the country.

Human Resources for Health is a key focus for PEPFAR programming and a critical concern regarding the ability of the GDRC to expand and sustain basic health services. The underlying hypothesis for strengthening human resources is that the health status of the Congolese people will not improve unless overall health education improves and health personnel are skilled, delivering both preventive and curative services that are accessible, and equitable. The GDRC envisions four strategies to address the issue: 1) strengthening basic training at the secondary, higher, and university levels; 2) increasing the efficient and rational use of human resources; 3) building on-the-job human resource capacities; and, 4) improving social and working conditions for health workers. The USG supports efforts to improve DRC's human resource capacity through training of service providers at the central, provincial, and community levels, as well as support to pre-service institutions. The implementation of NEPI in DRC in 2012 is a major step both in general terms and specifically for the implementation of PMTCT-AP. The USG, in close collaboration with development partners will continue to assist the GDRC in meeting human resource (HR) challenges.

Partnership Framework/Partnership Framework Implementation Plan Monitoring

In 2010, the GDRC and the USG developed and signed a Partnership Framework (PF) to increase joint

collaboration by aligning the goals of the two governments in the fight against AIDS. The Framework is based on four 'strategic axes' established in the MOH Health Sector's Strategic Plan for the Fight against HIV for 2008-2012 and the National Multi-sector Strategic Plan (NMSP) for 2010-2014 as well as the GDRC Ministry of Social Affairs OVC National Plan of Action 2010-2014. The overall goal of both plans is to reduce HIV incidence while minimizing negative impacts on individuals, families, and communities within the framework of poverty reduction. The axes were reformulated into four interlinked, strategic goals that form the foundation of the PF and which will be operationalized in the PF Implementation Plan (PFIP). Addressing gender dynamics, especially GBV, is a priority that cuts across the four goals. The PF Objectives are:

- Objective 1: PREVENTION – To reduce new HIV infections in the DRC;
- Objective II: TREATMENT, CARE AND SUPPORT – To expand access to high quality care and treatment services to HIV+ Congolese;
- Objective III: CARE FOR ORPHANS AND VULNERABLE CHILDREN – To improve protection, care and welfare of OVC through a coordinated response;
- Objective IV: HEALTH SYSTEMS STRENGTHENING – To strengthen coordination and management of HIV interventions through support to the following key areas: institutional capacity building and human resources, lab and infrastructure, logistics and pharmaceutical support, strategic information and health finance.

Under the auspices of the National HIV/AIDS Response Coordination Body, PNMLS, a steering committee will be formed to monitor the implementation of the PF in addition to providing insight into program expansion. This committee will identify best practices and lessons learned to be shared during the MOH annual review and other coordinating meeting opportunities to strengthen the development of future GF proposals. The USG will engage the PNMLS and other GDRC representatives in further discussion to develop terms of reference for the steering committee, to ensure that the expectations are clear and that it does not replicate the function of any other existing body. The steering committee will include membership of: President of DRC; Prime Minister's Office, Ministries of Health, Finance, Defense, Social Affairs, Gender, and Planning; PNMLS (acting as the secretariat); USG (USAID, CDC, US Embassy, DOD); Global Fund Principal Recipients; and UN Agencies.

It is anticipated that the USG will present progress reports from implementing partners to the steering committee semi-annually. Following these meetings, members of the committee will share the information at their relevant ministerial meetings. In addition to project reports, the results from other documents and assessments including Behavioral Surveillance Surveys, Knowledge Attitudes and Practices Surveys, and the annual National Ante-Natal Surveillance Survey will be presented to the steering committee for their review and consideration. These activities will allow the USG and the GDRC to monitor the impact of

their programs on measuring HIV prevalence and incidence, behaviors, morbidity, mortality, population well-being, and health system strengthening.

The PNMLS and the National AIDS Control Program (PNLS) technical working groups will provide technical oversight while the steering committee will provide programmatic and policy consideration to the projects. The GDRC and USG steering committee members will work together to align GDRC indicators with USG PEPFAR indicators before PNLS and PNMLS finalize their monitoring and evaluation (M&E) reporting systems. The harmonization of GDRC and USG PEPFAR indicators will improve national reporting and facilitate ease of data synthesis across organizations. The USG will also support the GDRC in the development of a single web-based indicator reporting system for all partners. The GDRC will be able to utilize this reporting system beginning at the HZ level with collection and validation of data, to the provincial level (aggregation and validation of data) and the national level (synthesis and analysis of data). For more detailed information, please see the PF and draft PFIP.

Country Ownership Assessment

Engagement with Partner Country and Civil Society

Extensive discussions and focused consultations with the GDRC and other key HIV/AIDS stakeholders has resulted in the closer alignment of USG-supported activities, permitting a more harmonized and strategic response under the COP and PFIP. For example, during the planning phase of this COP, the GDRC was heavily involved in the review of current PEPFAR activities and provided extensive input into PEPFAR's new country strategy. This is most strongly evidenced by PEPFAR's transition from facility/community based services to the global support of HZs with an integrated PEPFAR package of services. The The GDRC has also suggested that the GDRC, as the USG's partner, should actually lead the development of the annual PEPFAR COP, including exerting financial oversight of PEPFAR activities. The PEPFAR Country Team welcomes the new engagement of the GDRC and during the coming year, the PEPFAR team will work with GDRC to find ways to include them in its discussions of financial prioritization.

Capacity Building and Sustainability

The USG will continue to work in close cooperation with the GDRC to implement the GDRC's strategies and improve their systems to provide comprehensive, quality prevention services. The USG supports capacity building with PNLS, the National Nutrition Program (PRONANUT) , and the National Reproductive Health Program (PNSR). The USG also funds curriculum development at the Kinshasa School of Public Health and supports them in developing capacity at the managerial level to improve their financing and accounting systems and enhance their revenue streams to allow them to better compete for research grants and contracts. In the DRC, under USAID/Forward, USAID aims to program ten percent of its funding to local organizations or directly to the government by the end of 2015. As part of this initiative, in 2012, PEPFAR and MCH funds will be tapped to pilot test the use of the GDRC's

procurement system (FEDECAME) to directly procure test kits and PMTCT ARV prophylaxis, once a rapid appraisal approves that FEDECAME administrative and financial systems in place are transparent and accountable. Finally, partners work to improve the capacity of local organizations by providing in-depth technical assistance to implement activities and to improve their service delivery, project management, accounting, and M&E.

The USG will remain committed to building leadership and country ownership as outlined in the PF, PFIP, and COP activities. In 2012, the USG will continue investing in country-led plans and health systems while increasing impact and efficiency through implementing best practices and evidence based interventions. The governance and system inputs funded directly through PEPFAR are:

- Human Resources for Health;
- Laboratory strengthening and pharmaceutical management;
- Strategic coordination, programmatic integration, and leveraging key partnerships;
- Improving strategic information, including monitoring and evaluation; and
- Promoting research and innovation.

Specifically, the USG will strengthen the capacity of the GDRC to coordinate, monitor, and evaluate interventions; train healthcare providers in comprehensive care; and get those ineligible for ART into comprehensive CARE programs. Activities will strengthen civil society's capacity to engage and mobilize communities and PLWHA to deliver effective palliative and home-based care interventions and will work toward developing PLWHA support group networks to provide a comprehensive needs-based response. In 2012, activities will include strengthening PLWHA networks, savings and internal lending communities, vocational training, income-generating schemes, and expanded nutritional and food security services. These activities will be integrated within community and clinical services to improve civil society’s self-sufficiency and resilience, permitting PLWHAs to live positively. Linkages will be developed between other donor and PEPFAR funded activities, under the coordination of the MOH, in order to develop a strong referral network for people in need of care and treatment services.

As a key approach to ensuring improved health outcomes and accountability of the GDRC, management, coaching, and leadership training at the various levels of the health system will ensure that Government institutions and partners are held accountable to achieve results. The USG will implement problem-solving approaches and quality assurance methods that engage service providers and communities to tackle their own identified problems. In 2012, the USG will assist the GDRC to strengthen the health infrastructure from the national to the community level through: institutional and HR capacity building, lab and infrastructure, strategic information, and health finance. The USG is providing long-term in-country technical assistance to help the MOH strengthen pharmaceutical management related to forecasting, procurement, and inventory and drug management systems.

In 2012, the USG and GDRC will discuss mechanisms that can guarantee better welfare for health workers while reducing the burden on households and promoting effective and pro-poor public health services. For example, performance-based/output-based financing is one of these mechanisms, as well as the scaling up of community-based health insurance (mutuelles) and other insurance type schemes. The goal of the PEPFAR program is to assure sustainable financing for the GDRC health system. In an effort to improve cost efficiencies and streamline approaches and processes, the USG has increased coordination with other donors and the GDRC through the Country Coordination Mechanism, health donors coordination group (GIBS), and PEPFAR Steering Committee. Furthermore, given limited resources and research in the DRC, more information is needed to determine how best to focus spending. Therefore, the USG will fund a HIV/AIDS Cost-Effectiveness Study which will compare and contrast the cost-effectiveness of HIV/AIDS interventions in the DRC. The study will assist decision makers, such as the USG PEPFAR team, to maximize the impact of limited resources. The study is expected to use secondary information sources and country specific data to the greatest extent possible to develop models to determine the incremental cost-effectiveness ratio or the change in costs to the change in effects.

OVC support is highlighted as one of four critical goal areas of the PF. Strategies and activities aim to support the National Action Plan objectives to increase access to services, increase community mobilization, and ensure a political and institutional environment that enables protection as well as the provision of holistic OVC care. The child-to-child approach, applied alongside the Positive Living mobilization for PLWHAs, with the Champion Communities, and elsewhere, will empower OVCs to identify, analyze, and understand their own needs and wants, helping them to take ownership of their own destinies. Through working with peers and implementing NGOs, there will be a key focus on the range of life skills for children (up to 13 years), adolescents (14-19 years), and young adults (20-24 years). Based on the belief that children can be actively involved in their communities and in solving community problems, this approach encourages and supports discussions on key issues such as GBV, economic strengthening, health and nutrition, and psychosocial and educational support.

Challenges

The DRC is going through post-conflict stabilization. In addition to the political instability and ongoing conflict in some areas of the country, other challenges increase the difficulty of implementing effective prevention programs in DRC, where 70 percent of the population has little or no access to health care. Health system challenges include routine stock-outs of HIV test kits; generally low availability of condom and counseling services; gaps in the prevention of unwanted pregnancies and other needs in reproductive health; gaps in education of young adults in responsible sexual behavior and other life skills knowledge; inadequate procurement, distribution and health information systems; and sexual and

reproductive health services that are not integrated, leading to higher costs and missed opportunities for patients to receive a full range of services.

Infrastructural challenges in the DRC impede movement of resources including personnel and supplies. DRC does not have a functioning road or rail system (less than two percent of its 153,000 km of roads are paved) or a reasonably priced and approved air transportation network that can move people and products between major cities. Because there is no significant industrial activity, some consumables and the majority of materials for offices, clinics, and laboratories are imported. Therefore, the cost of doing business may be three to four times higher and slower than other countries. Furthermore, because of security concerns, travel of USG personnel outside of the capital region is generally restricted impeding oversight of rural HIV/AIDS sites.

From 2002 to 2011, the real economic growth in the DRC has averaged 5.7 percent per year (data for 2011 reflects a preliminary estimate by the International Monetary Fund). Inflation has averaged 17.3 percent per year over this period. The economy experienced a brief slowdown in growth and a spike in inflation in 2009 following the international economic crisis, but otherwise has maintained a steady growth path with a reasonable level of inflation. The DRC's post-conflict economy has a very narrow base and is dependent on primary commodities, thus it is vulnerable to price fluctuations. Despite this moderate level of economic growth and steady increases in the GDRC's overall budget, allocations to the health sector in recent years have been remained modest at about 4 to 5 percent of the GDRC's executed budget. This trend of a stagnant share of resources to the health sector has had adverse effects on health system development. Households have been the largest contributor to the health finance system (42 percent in 2009), followed by donors and international NGOs (36 percent), government contributions (12 percent), and private sector (10 percent), according to a recent National Health Accounts study funded by USAID. Although the number of community-based health insurance schemes in the DRC has grown to an estimated 44 in 2011, their contribution to the DRC health financing is still very low, around 0.08 percent of health expenditures. The traditional system of risk sharing insurance emerged in the DRC in 2009. It is provided by the National Insurance Corporation and contributes less than 0.01 percent to health expenditures. HIV/AIDS subaccounts reveal that 96 percent of resources mobilized for HIV/AIDS are spent for the provision of health services and for health-related activities and that 4 percent is allocated to non-health activities (e.g., orphan and vulnerable children care, income generation). The government's contribution is extremely small, less than 0.01 percent, and is limited to salaries paid to government employees who support HIV program and services.

HIV/AIDS activity coordination by the GDRC, especially at the provincial level, has not yet been developed and will require capacity strengthening. The history of development assistance in DRC, including HIV/AIDS, reflects that NGOs have often operated without coordinating with the government. As

a result, understanding HIV/AIDS interventions within the context of the government's strategic focus is a challenge. The lack of a formalized coordination system is an obstacle to ensuring that efforts are not duplicated, geographic coverage is achieved, and that consensus regarding the focus of strategies and interventions is reached. Improved coordination will eliminate duplicity and permit stakeholders to better align strategies, thus improving geographic coverage and impact.

Central Initiatives

NEPI: Under NEPI (Nurses Education Partnership Initiative), human resource capacity building will be strengthened by improving the nursing and midwifery curriculums, assessing barriers and ways to increase female participation in health occupations, increasing human resource retention, and identifying incentives required for personnel posted to inaccessible and difficult geographic regions. This pre-service initiative will contribute to the PEPFAR mandated 140,000 health workers created while strengthening the government's ability to improve the quality and quantity of their health workers.

GBV: In FY2012, the DRC will start its second year of activities under the three country HIV/GBV Prevention Program. These activities, primarily in Kinshasa and Kisangani, will focus on awareness raising and increased access to GBV prevention, care, and treatment services.

Global Fund Liaison: The Global Fund Liaison is an integral member of the PEPFAR Interagency team. The initial priority of the Liaison is to provide technical and programmatic support to the CCM and the CCM Secretariat. Working in support of donor interests on the CCM, the Liaison helps to improve communication among the CCM Members, the Global Fund Secretariat, the technical working groups, and the PRs. The Liaison works to improve the CCM's ability to oversee grant implementation by providing technical and logistical support to the CCM, its bilateral representatives, and the CCM secretariat. Responsibilities of the Liaison include evaluating and resourcing technical assistance needs, and identifying and implementing actions to strengthen Global Fund resource management in coordination with local entities and other donors.

Way Forward

Operating within the many constraints unique to the DRC, PEPFAR has emerged as the major bilateral partner of the GDRC to address the HIV/AIDS epidemic and has contributed significantly to the country's health improvement agenda. While the USG supports all major pillars of HIV/AIDS prevention, PMTCT–AP has emerged as the main platform for the USG's HIV/AIDS prevention activities. As noted above, PEPFAR DRC's strategy for scale-up would focus on selecting a set of priority HZ's within Katanga, Kinshasa, and Orientale. By reaching out to high HIV prevalence and HIV volume maternities in these provinces and implementing a family centered PMTCT strategy integrated with SGBV prevention, USG efforts will provide a comprehensive HIV/AIDS platform. Furthermore, each priority HZ would then

be targeted for service scale-up based on a minimum package (as agreed upon with the GDRC) that would address primary HIV prevention, care, and support needs, and with the expectation that GF would remain the provider of ARVs to the general population. The interagency roll-out of the scale-up will maximize strategic advantages such as CDC's expertise in lab, USAID's expertise in OVC and DOD's expertise in working with military populations. Focused on the HZ, the scale-up approach would support the HZ Management Team to improve oversight and surveillance capacity.

Embracing the reality of the entwined fates of PEPFAR and Global Fund, PEPFAR will reinvigorate its collaboration with the Global Fund, coordinating appropriate technical assistance and developing programmatic synergies wherever possible resulting in expanded geographic access to services for the people of the DRC. Implementation of human resources development programs such as the NEPI and various ad-hoc training programs offered by the USG, including support for supply chain management of drugs and essential commodities at HZ and Central level, will give the DRC the tools it needs to navigate its own destiny.

The last few years have shown that top-down HIV programs have not produced the positive results originally expected in the DRC. Focusing first on the HZ not only brings PEPFAR into closer alignment with the GDRC's national health strategy, but it also allows PEPFAR to focus on improving grass-roots systems. Building on the solid foundation of PMTCT, this approach permits PEPFAR to geographically and strategically concentrate its resources, bringing renewed focus to the basic building blocks of viable health systems, human resource development and supply chain management. These efforts, encompassed in the GHI, will not only improve the care and management of HIV, but will establish rock solid systems that have the potential to improve the health of all Congolese, regardless of their HIV status.

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV	435,000	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based			

			on the range provided in the report.			
Adults 15-49 HIV Prevalence Rate	01	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based on the range provided in the report.			
Children 0-14 living with HIV	60,000	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based on the range provided in the report.			
Deaths due to HIV/AIDS	400,000	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based on the range provided in the report.			

Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months	2,930,000	2009	State of the World's Children 2011, UNICEF.			
Estimated number of pregnant women living with HIV needing ART for PMTCT	50,000	2010	Global HIV/AIDS response: epidemic update and health sector progress towards universal access: progress report 2011			
Number of people living with HIV/AIDS	495,000	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based on the range provided in the report.			
Orphans 0-17 due to HIV/AIDS	430,000	2009	UNAIDS Report on the global AIDS Epidemic 2010.			
The estimated number of adults	300,000	2010	Global HIV/AIDS response:			

and children with advanced HIV infection (in need of ART)			epidemic update and health sector progress towards universal access: progress report 2011			
Women 15+ living with HIV	260,000	2009	UNAIDS Report on the global AIDS Epidemic 2010. This mid-point estimate is calculated based on the range provided in the report.			

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

In what way does the USG participate in the CCM?

Voting Member

What has been the frequency of contact between the Global Fund Secretariat (Fund Portfolio Manager or other Geneva-based staff) and any USG team members in the past 12 months? If there has been no contact, indicate the reason.

7+ times

What has been the frequency of contact between the Local Fund Agent (LFA) and any USG team

members in the past 12 months? If there has been no contact, indicate the reason.
4-6 times

Has the USG or is the USG planning to provide support for Round 11 proposal development? Support could include staff time, a financial contribution, or technical assistance through USG-funded project.
Yes

In any or all of the following diseases?
Round 11 HIV

Are any existing HIV grants approaching the end of their Phase 1, Phase 2, or RCC agreement in the coming 12 months?
Yes

If Yes, please indicate which round and how the end of this grant may impact USG programming. Also describe any actions the USG, with country counterparts, is taking to enable continuation of any successful programming financed through these grants.
HIV/AIDS Rounds 7-Phase 1 and 8-Phase 1 ended respectively in December 2010 and in December 2011. GF change its funding methodology and is using the "Single Stream Funding" model. To comply with this model, DRC was asked to consolidate all of its GF HIV/AIDS grants. The consolidated grant will be implemented starting July 1, 2012. To ensure service continuation from January 1 to June 31, 2012, GF authorized the implementation of important services such as PMTCT, treatment etc...PEPFAR depends on the GF to provide ARVs to its patients in health zones where GF and PEPFAR overlap. If the consolidated grant is not approved, PEPFAR patients may not receive ART. This is why the USG is supporting the consolidation process through the provision of technical assistance.

In your country, what are the 2-3 primary challenges facing the Global Fund grant implementation and performance (for example, poor grant performance, procurement system issues, CCM governance/oversight issues, etc)? Are you planning to address those challenges through any activities listed in this COP?
Redacted

Did you receive funds for the Country Collaboration Initiative this year?
Yes

Is there currently any joint planning with the Global Fund?

Yes

If Yes, please describe how the joint planning takes place (formal/informal settings; the forums where it takes place (CCM?); timing of when it takes place (during proposal development, grant negotiation, COP development, etc.); and participants/stakeholders). Also describe if this joint planning works well and its effects (has it resulted in changes in PEPFAR programming, better anticipation of stock-outs and/or TA needs, better communication with PR, etc.)
Redacted

Has the USG stepped in to prevent either treatment or service disruptions in Global Fund financed programs in the last year either during or at the end of a grant? Such assistance can take the form of providing pharmaceuticals, ensuring staff salaries are paid, using USG partners to ensure continuity of treatment, , or any other activity to prevent treatment or service disruption.

Round	Principal Recipient	Assistance Provided	Value of Assistance (If Known)	Programming Impact	Causes of Need
8	CORDAID	A loan of an emergency supply of condoms to prevent stockouts.		Involved USG staff time	
8	UNDP	During his field visits, the USG GF Liaison noticed that some of the HIV/AIDS services were disrupted due to lack of HIV test kits. He provided assistance in making successful arrangements so that sites can receive the test kits. The sites re-opened two days after.		Involved USG staff time	

Public-Private Partnership(s)

Created	Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
	HIV behavior change communication program through hotline activity	10612:PROVISION OF CAPACITY BUILDING TO EMERGENCY PLAN PARTNERS AND TO LOCAL ORGANIZATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO FOR HIV/AIDS ACTIVITIES UNDER THE PRESIDENT"S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)	Celtel, Foundation Femme Plus (FFP), Tigo, Vodacom			Behavior Change Communication (BCC) operates through the nationwide “Ligne Verte” toll-free HIV/AIDS hotline that provides callers with comprehensive HIV/AIDS prevention and referrals to available nearby HIV services since May 2005. Callers reach trained hotline counselors who are mainly PLWHA to ask questions or discuss risk reduction methods such as abstinence, being faithful, consistent condoms use,

						delayed sexual debut, and partner reduction and other relevant topic such as SGBV. Each month, the hotline manages around 40,000 calls. This partnership has engaged private telecommunicati on companies to offer this toll-free hotline. . USG resources ($350,000) leverage $350,000 private sector contributions plus $34,000 to support a 'Microwave Unit' that unifies calls from three major cellphone companies including Vodacom, Tigo and Airtel.
	Development of an emergency blood transfusion program in 57			0	0	The Global Development Alliance (GDA) with Safe Blood for Africa (SBFA)

	rural health zones supported by USAID in 4 provinces					is a 4-year Cooperative Agreement which began on October 30, 2007. The program aims to strengthen blood safety for the 8 million Congolese in the 57 health zones supported through the USAID-funded Primary Health Care program (Project AXxes). This GDA with SBFA provides support to implement an effective National Transfusion Service and to build a safe and sustainable blood supply in the DRC. Specifically, this program provides expert guidance and technical assistance in the areas of policy

						and infrastructure development, training, blood collection and testing, quality management, transfusion and blood utilization as well as monitoring and evaluation. This project also strengthens the MoH capacity in quality assurance, development of a volunteer non-remunerated blood donation program and waste management. For FY2010, PEPFAR will contribute $300,000 leveraged by a minimum private sector contribution of $477,357.
	Clinic support for HIV prevention care and treatement in			0	0	This program will follow-on activities from a previous

	Matadi.					two-year program that ended in September 2008 implemented by FHI. The GDA with MIDEMA has two goals: (1) the establishment high quality prevention and an Anti Retro Viral treatment center at the Matadi Clinic; and (2) the development of a global public-private alliance. This 3-year program will build on the past experience and pursue the same objectives to develop quality prevention care and treatment program in the Matadi clinic. MIDEMA will provide a minimum of $1 cash and in-kind cost-share for

						every USG $1 spent. Additionally, in 2009, MIDEMA contributed the Matadi clinic maternity building in support of the program. USG support will focus on strengthening technical capacity while MIDEMA support will continue to ensure the functionality of the clinic including provision of ARV, STI and OI drugs. For FY2010, PEPFAR will contribute $150,000 leveraged by a minimum private sector contribution of $200,000.
2012 COP	Freeport McMoran/Tenke Fungurume	14611:A Public-Private	Tenke Fungurume Mining			PATH and Tenke Fungurume

	Mining Company	Partnership for Mining Communities, Truckers, and Other At-Risk Populations	(Freeport McMoran)			Mining (TFM), in coordination with the Government of the Democratic Republic of Congo (DRC), developed in 2012 a two year programmatic partnership (November 14, 2012-June 27, 2014) under USAID's Global Development Alliance (GDA) mechanism to reduce HIV risk and mitigate its impact on communities in the Fungurume Health Zone (FHZ) and the town of Kasumbalesa in the Katanga Province of DRC. Data is collected on a monthly basis in accordance with PEPFAR reporting guidelines. The following key

						PEPFAR indicators are tracked: P1.1.D, P1.2.D, P7.1.D, P8.1D, P8.3D, P11.1D, C1.1D, C2.1.D, C2.2.D, C2.4.D, T1.1.D, T1.1.2.D, H2.3D.
2012 COP	Kinshasa School of Public Health	10612:PROVISION OF CAPACITY BUILDING TO EMERGENCY PLAN PARTNERS AND TO LOCAL ORGANIZATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO FOR HIV/AIDS ACTIVITIES UNDER THE PRESIDENT"S EMERGENCY PLAN FOR AIDS RELIEF	Becton Dickinson	1,000,000	1,035,000	The objective is to establish the Regional Laboratory Capacity Building Center at the Kinshasa School of Public Health and to conduct trainings in Flow Cytometry, Safe Blood Collection, and other techniques. The partnership will result in the creation of a Regional Center of Excellence for Training in Good Laboratory Practice (GLP), the improvement of capacity for HIV diagnosis, and the development of

		(PEPFAR)				a plan to sustain the laboratory system. The USG contribution of $400,000 leverages $1,035,000 provided from the private sector. This is the 1st of 3 years planned for this partnership that will focus, on the development and the implementation of a training curriculum on CD4 monitoring, hematology and on HIV serology. Indicators tracked include: percent labs with satisfactory performance in external quality assurance/proficiency testing; percent HIV rapid tests facilities with satisfactory performance for

						HIV diagnostics; number of health care workers who successfully completed in-service training program. This PPP will build workforce capacity through exposure to best practices in laboratory procedures in the diagnostic and monitoring of HIV patients.

Surveillance and Survey Activities

Surveillance or Survey	Name	Type of Activity	Target Population	Stage	Expected Due Date
N/A	2010 HIV Sentinel surveillance or pregnant women attending ANC sites	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Other	N/A
N/A	2011 HIV Sentinel surveillance of pregnant women attending ANC sites	Sentinel Surveillance (e.g. ANC Surveys)	Pregnant Women	Other	N/A
N/A	DRC Armed Forces HIV Prevalence and Behavioral Survey	Surveillance and Surveys in Military Populations	Uniformed Service Members	Development	N/A
N/A	HIV Drug resistance survey	HIV Drug Resistance	General Population	Other	N/A

N/A	HIV Sentinel surveillance	Evaluation of ANC and PMTCT transition	Pregnant Women	Development	N/A
N/A	HIV/STI Integrated Biological and Behavioral Surveillance - 2010	Behavioral Surveillance among MARPS	Female Commercial Sex Workers, Street Youth, Other	Implementation	N/A
N/A	KAP study with PLWHA	Other	Other	Development	N/A
N/A	Male uncircumcised problematic	Qualitative Research	General Population	Planning	N/A
N/A	Measure Demographic and Health Survey	Other	General Population	Development	N/A
N/A	Risk behaviors among prisoners population	Behavioral Surveillance among MARPS	Other	Planning	N/A
N/A	Size estimates of MARP	Population size estimates	Other	Planning	N/A
N/A	Surveillance of acquired HIV Drug resistance in National ART programs	HIV Drug Resistance	General Population	Planning	N/A

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHP-State	GAP	GHP-State	GHP-USAID	
DOD			0		**0**
HHS/CDC		2,415,000	7,232,845		**9,647,845**
State			203,113		**203,113**
State/AF			350,000		**350,000**
USAID			5,983,732	9,200,000	**15,183,732**
Total	**0**	**2,415,000**	**13,769,690**	**9,200,000**	**25,384,690**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency						Total
	State	DOD	HHS/CDC	State/AF	USAID	AllOther	
HBHC			296,608		2,595,027		**2,891,635**
HKID					2,940,694		**2,940,694**
HLAB			1,111,784		407,870		**1,519,654**
HMBL			610,871		261,414		**872,285**
HMIN			200,000				**200,000**
HTXD			19,116				**19,116**
HTXS			553,285		0		**553,285**
HVAB		0	200,214	100,000	846,042		**1,146,256**
HVCT		0	318,453		3,092,568		**3,411,021**
HVMS	203,113	0	2,522,448		0		**2,725,561**
HVOP		0	403,186	150,000	1,306,312		**1,859,498**
HVSI			310,631		500,100		**810,731**
HVTB			789,906		436,981		**1,226,887**
MTCT			594,760		1,781,906		**2,376,666**
OHSS		0	418,060	100,000	1,014,818		**1,532,878**

PDCS			709,072				**709,072**
PDTX			589,451		0		**589,451**
	203,113	**0**	**9,647,845**	**350,000**	**15,183,732**	**0**	**25,384,690**

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Care

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	2,891,635	0
HKID	2,940,694	0
HVTB	1,226,887	0
PDCS	709,072	0
Total Technical Area Planned Funding:	**7,768,288**	**0**

Summary:
Care and Support Technical Area Narrative
Country Context
The 2007 Demographic Health Survey (DHS) in DRC indicated that DRC is facing a generalized HIV/AIDS epidemic with stark geographic and population differences. The majority of new HIV/AIDS cases are diagnosed among people less than 24 years of age; and the epidemic has distinct geographic patterns. Though the overall HIV prevalence in DRC is 1.3%, rates are twice as high in urban vs. rural areas (1.9% to 0.8%) and among women than men (1.9% vs. 0.9%). While HIV prevalence remains higher in urban areas, it has increased in certain rural areas, particularly those near geographic hotspots, which bring together large groups of low prevalence engaging in risky behavior with other of high prevalence rates. High risk and high prevalence populations often congregate in geographic “hotspots,” such as border crossings, transport corridors, ports, and regions with a large military presence. The already elevated rates of MARPs, which includes CSWs, truckers, miners, and uniformed services are often more than triple or quadruple the rates in the rest of the country.

Pregnant women are particularly at risk; Antenatal Care (ANC) surveillance data from 2010 indicate that pregnant women had a prevalence rate roughly twice that of other women at 2.0%. The 2009 ANC data showed urban prevalence rates ranging from 4.3% in Matadi to 9.5% in Kisangani and a 2007 ANC survey finding a prevalence rate of 16.3% in rural Kasumbalesa (Katanga province). Furthermore, gender inequalities, war, and political and economic instability resulted in widespread sexual violence, intimate partner violence, physical abuse, and an increase in commercial sex work.

The geographic size of DRC, post conflict status, and the logistical obstacles create a unique set of challenges for delivering services. The majority (70%) of the population has little or no access to health care. Health system challenges include routine stock-outs of HIV test kits; generally low availability of condom and counseling services; gaps in the prevention of unwanted pregnancies and other needs in reproductive health; gaps in education of young adults in responsible sexual behavior and other life skills knowledge; inadequate procurement, distribution and health information systems; and sexual and reproductive health services that are not integrated, leading to higher costs and missed opportunities for patients to receive a full range of services. Infrastructural challenges in DRC impede movement of resources including personnel and supplies. DRC does not have a functioning road or rail system or a

reasonably priced and approved air transportation network that can move people and products between major cities leading to high cost and significant delays in all program implementation activities.

Care and Support
In DRC, GDRC expenditure on health is only about 2% of all health expenditures. In DRC, PEPFAR is the major contributor to clinical and community-based care and support services, including care to people living with HIV/AIDS (PLWHA), orphans and vulnerable children (OVC), and survivors of sexual and gender-based violence (SGBV). As the USG works towards the goal of a standardized package of care and support services in the PEPFAR-supported health zones, it also seeks to promote an integrated care approach that will strengthen the overall health system while ensuring a comprehensive continuum of care provided at both facility and community levels. At the national level, the USG strategy aligns with the GDRC's goal of integration using the family centered continuum of HIV services model. Two-year priorities include the 1)implementation of the guidelines on home-based care and psycho-social support to PLWHA and victims of SGBV, 2)expansion of standardized training, 3)provision of a standardized package of services to a greater number of clients, and 4)provision of home-based care kits.

In 2011, PEPFAR continued to encourage country ownership by contributing to larger national goals and sustainable scale up of services through existing government systems. However, challenges persist in the scale-up of integrated and comprehensive care services. Throughout DRC, poorly paid health care workers are frequently unable to provide basic care services. Cost and poor outcomes frequently deter clients from seeking care. Preventive measures including vaccination, hygiene, sanitation, and public infrastructure h were neglected for years resulting in recurrent epidemics of communicable diseases, such as measles, typhoid fever, poliomyelitis and cholera. Other challenges to HIV care include disclosure, stigma, and adequate supplies of both opportunistic infections (OI) and antiretroviral (ARV) medications. Additionally, the limited number of care and treatment facilities, compounded by poor supply chain systems decreases access to services and treatment. With the exit of the World Bank's Multi-year AIDS Program (MAP) program, the Clinton Foundation, and the challenges with the Global Fund, coordination amongst donors in care and treatment is difficult and was limited in the past year.

Currently, care services are not harmonized by the government, leaving access and quality of services varied among donor supported sites. The GDRC's Ministry of Health (MOH) envisions comprehensive health care at the site level with linkages to strengthen the continuum of care between health facilities and the communities that they serve. Using COP 2011 funding, the USG expanded care and support interventions targeting Kisangani, which has a high prevalence rate and identified "hotspots." Gap analysis indicated the need for services including prevention, cotrimoxazole (CTX) prophylaxis, palliative care, referral for other services, and improved monitoring and reporting systems. This approach to care services, where each IP can capitalize on its strategic advantage and minimize the duplication of efforts is one of the major tenants of the DRC PEPFAR 2012 strategy. As activities scale up in the country, the USG will increase the number of partners providing services to meet the increased demand.

Adult Care and Support
In 2012 PEPFAR will continue to provide basic care and support to PLWHA, in the geographic areas with ongoing activities: Bukavu; Lubumbashi, Kinshasa; Kisangani; and Matadi. In 2011, PEPFAR began working with the GDRC on finalizing support services to provide at each entry point of care. The plan outlined a package of continuum of HIV care and support services with linkages between health facilities and communities offered by different PEPFAR IPs according to their respective expertise on the ground. These interventions include services such as HIV counseling and testing (HCT), laboratory support, TB screening and treatment, OI prevention and management (including CTX prophylaxis), OVC support, food and nutrition assistance, home-based care and economic strengthening, and SGBV screening and management to ensure access to quality integrated and comprehensive support. In 2012, the USG will sustain and strengthen existing care and support services in PEPFAR supported provinces. Global Fund (GFTAM) funds will be leveraged through close collaboration and coordination while operating within the

same health zones.

USG partners will expand the use of the 'Champion Communities' approach to support communities in addressing all aspects of HIV/AIDS services, from HCT and prevention messaging to palliative care and support of OVCs. This approach underscores the importance of community engagement in project interventions. The increased demand for services such as HCT, PMTCT, and palliative care, link 'Champion Communities' with Most at Risk Populations (MARPs) and other vulnerable groups, and leads to more sustainable interventions as activities are planned and implemented. USG community programs that serve individuals, couples, and families living with HIV also target PLWHA who know their HIV status, but are not yet eligible for ART Support groups and prevention programs. Additionally, home-based care is an important avenue for providing HTC, hygiene, and CTX prophylaxis services for spouses and children of PLWHA, along with community and mobile HTC programs.

In 2012, the USG will build the capacity of PLWHA support group facilitators, peer educators, expert patients, and community care providers that interact with PLWHA to provide ongoing support and counseling for safer sex, alcohol use assessment and counseling, assessment and treatment of other Sexually Transmitted Infections (STIs), Family Planning (FP) and Safer Pregnancy Counseling, condom distribution and promotion, treatment adherence counseling and support and serve as consistent sources of condoms and other relevant commodities outside of the clinic/facility. The USG programs are expanding HCT services within community settings to identify and link HIV-infected persons to care and support programs. Mobile and home based testing and counseling services are used as an effective means of targeting vulnerable groups, especially if those groups are highly stigmatized (sex workers, MSM, etc) or reaching areas that are not easily accessible (particularly in rural areas).

Pediatric Care and Support
In 2008, the National AIDS Control Program (PNLS) reported that 4,053 children received ARVs, a coverage rate of less than 10%. Approximately 4,000 children received CTX prophylaxis yielding a coverage rate of less than 2%. Pediatric HIV care and treatment in DRC is challenged by limited pediatric HIV expertise and scarce clinical and laboratory facilities for early diagnosis and monitoring of pediatric HIV. In addition, poor coordination and referral systems between prevention of mother to child transmission (PMTCT) programs and care and treatment programs result in lost opportunities for HIV prevention and early HIV treatment and increased risk for related complications. PEPFAR strives to link exposed children identified at PMTCT sites to maternal and child health (MCH) interventions.

The lack of clinical pediatric HIV/AIDS management expertise is a critical gap to fill in order to scale-up service delivery. The USG provides support to the only pediatric hospital in the country. The support includes prevention and treatment of OIs and other HIV/AIDS-related complications including malaria and diarrhea, access to pharmaceuticals, insecticide-treated nets, laboratory services, pain and symptom relief, and nutritional assessment and support including food. Non-clinical activities include: (1) support groups targeting HIV+ children and their families led by trained volunteers, who include PLWHAs)(2) home visits and follow-up for those who miss appointments (3) assessments and promotion of adherence to ART regimens (4) linkages to available psychosocial services. Home-based health care psychological support (PSS) is includes coping with illness and care-giving as well as the grieving process following the death of a family member. Psychological support is focused on participant-centered support groups which provide opportunities for individuals to meet and discuss coping mechanisms with trained community outreach workers. Disclosure support is provided to parents or caregivers of HIV+ children and adolescents who receive counseling and support throughout the disclosure process. Community-based care programs also provide linkages to youth friendly VCT services, specifically to serve marginalized youth and OVC.

TB/HIV
Tuberculosis (TB) is one of the leading causes of death in the DRC with an estimated annual incidence of

150 per 100,000 inhabitants. The DRC has a TB case detection rate of 53% and a DOTS completion rate of 81%. According to the WHO, in 2010, the TB multi-drug resistance (MDR) rate is 2.2%. The incidence of TB among HIV positive individuals is approximately18, 000; and 24% of TB patients know their HIV status. In 2011, 9% of dually diagnosed patients were started on ARVs and 24% were receiving CTX prophylaxis.

In collaboration with the National TB program and based on the overall PEPFAR TB/HIV strategy and the current status of TB/HIV activities in DRC, the 2-year goals to strengthen and expand TB/HIV activities include: 1)improving efforts to identify PLWHA within TB clinics; 2) expanding HIV care, support, and treatment within TB clinics; 3) support coordination of TB/HIV activities at national and provincial levels for both HIV and TB programs; 4) ensure early initiation of ARV treatment among TB patients diagnosed with HIV; 5) ensure early initiation and completion of TB treatment among HIV-infected persons diagnosed with TB; 6) strengthen the national capacity to update policies and guidelines, plan, manage and evaluate TB/HIV activities; and, 7) introduce infection prevention and control at the facility level.

The USG provides the DRC National TB Program (PNT) with technical support to strengthen TB/HIV activities including case detection, care, and treatment policies and the MOH steering committee for TB/HIV. The GFATM granted the DRC $36.2 million to develop a program to strengthen the DOTS strategy, and grants were disbursed with fewer bottlenecks than HIV funds. Linkages and referrals to GFATM PMTCT and ARV programs will be supported to ensure a continuum of services. In collaboration with the National TB Program, the USG will support the scale up of (1) intensified TB case finding, and (2) TB infection control using PEPFAR platforms Isoniazid preventive therapy, which is not yet a national TB program policy. The USG is supporting the national and peripheral laboratory functioning and the implementation of new diagnostic tools as GeneXpert to improve treatment outcome. Other USAID-funded partners and other key stakeholder s are allocated specific health zones by the Government and are working together to avoid duplication.

USG partners will harmonize strategies on how to refer HIV + clients to TB testing centers at both the national and provincial levels. Partners will work with the PNT to prepare a detailed map of the diagnostic and treatment centers for TB (CSDT) and the simple diagnostic centers (CDT) in USG intervention areas, and will then establish a referral and counter referral system so that sites working with HIV+ clients know where to refer patients for TB testing and treatment sites have information on where to refer TB patients for HCT. For sites that provide both TB and HIV testing services within their facility, USG partners will provide ongoing capacity building to improve outreach to those in the community with TB to receive HIV testing. Finally, as part of training for HCT service providers, sessions on HIV-TB co-infection, the risks, appropriate referral procedures and other relevant information will be included.

Food and Nutrition

Since 2010, the USG provided comprehensive support to 11,500 children in Bukavu, Matadi, and Lubumbashi in the form of educational assistance, vocational training, nutritional support, economic support, and psychosocial support. In FY 2012, the USG plans to strengthen programming of food and nutrition activities related to PLWHA and OVC and an assessment was done in July 2011. Currently, there is no standardized national package of nutrition support for PLWHA and OVC. In FY 2012, the USG will support the national program for nutrition (PRONANUT) in revising and finalizing the national guidelines for nutrition care of PLWHA, strengthen PRONANUT capacity to plan, supervise, and monitor nutrition interventions for PLWHA, pilot the integration of the PEPFAR Nutrition, Assessment, Counseling and Support (NACS) model into routine services for OVC and PLWHA at the facility and community levels, strengthen government coordination of nutrition and HIV activities, and encourage task shifting to decentralize and improve access to services. The USG will continue to support supply chain management for the distribution of therapeutic and supplementary foods.

Orphans and Vulnerable Children

The 2009 OVC Rapid Assessment, Analysis, and Action Plan Situational Analysis estimated that the country had 8.2 million OVCs. To integrate OVC services into HIV programming, USG partners expanded the 'Champion Communities' model, to include child-to-child activities and groups. OVC support is highlighted as one of four critical goal areas of the Partnership Framework. The child-to-child approach applied alongside the Positive Living mobilization for PLWHA, with the Champion Communities, and elsewhere, will allow OVCs to identify, analyze and understand their own needs and wants. Through working with peers and implementing NGOs there will be a key focus on the range of life skills for children (up to 13 years), adolescents (14-19 years) and young adults (20-24 years). This approach encourages and supports discussions on key issues such as gender based violence, economic strengthening, health and nutrition, and psychosocial and educational support. It is based on the belief that children can be actively involved in their communities and in solving community problems. OVCs will be able to build confidence, explore fears and hopes and work together to find solutions to their problems. Child –to–child projects will involve activities that interest, challenge, and empower with the aim of achieving positive change on three levels: 1) communal impact on families, children, local professionals and others, including increased knowledge and positive changes in health attitudes and behaviors, as well as improved relations between adults and children or institutions and children; 2) personal impact on children involved including increased knowledge and skills, improved self-confidence, and the development and strengthening of friendships and other relationships; and 3) increased respect for children's ideas and abilities. In an effort to reinvigorate the national OVC task force, the USG initiated coordination meeting between MINAS, UNICEF, the World Bank (Separated & Abandoned Children project), USAID, and PNMLS as a means to harmonize and coordinate OVC interventions.

The FY 2012 goals will contribute to protect the rights of OVCs by improving capacities of Government institutions to provide access to basic social services and better care to vulnerable children. The interventions will focus on upstream efforts, and will target the Ministry of Social Affairs (MINAS) at the national level. One key activity will be the development and implementation of a standardized minimum package of services for OVC programs. There will also be more targeted, branded outreach activities focused on prevention and access to care for street children and other at-risk youth groups. The USG will use HTC and PMTCT services to identify OVC.

Gender

HIV disproportionately affects women in the DRC. Prevalence rates among women peak at 4.4% in the 40-44 age cohort; comparatively, prevalence rates among men peak at 1.8% in the 35-39 age cohort. Gender inequities, war, and instability resulted in widespread rape, sexual violence, and abuse. According to USG supported primary health care projects, the level of violence against women in eastern DRC is estimated to be around 20% and may be linked to overall gender norms in Congolese society. Cross-generational sex is cited as a common occurrence in DRC with 13% of girls between 15-19 years of age reported having sex in the past year with a man ten or more years older. The gender norms in the eastern part of DRC have led to an even higher level of gender based violence (GBV). The USG has provided care and support to over 75,000 victims of sexual violence in conflict-ridden eastern Congo since 2002.

Gender is a critical issue in HIV care, with implications for the quality and effectiveness of the care provided and the disproportionate burden on women and girls to provide care. Some key programmatic and policy actions pertinent to gender and care and support include: 1) ensuring equitable access for women and men to medicines and other care and treatment services and resources; 2) identifying child/adolescent-headed households and care-givers, and implementing targeted programs to meet needs, including programs that keep girls in schools, help them manage households, address stigma, and compensate for lost family income; 3) strengthening linkages with wrap-around FP/RH programs for child and female-headed households as well as caregivers; 4) implementing programs which target men and boys and encourage their participation in care-giving and household functions, their support for female caregivers and reduction of violence in the household; and 5) targeting programs for older women

caregivers that provide support networks and access to income-generating resources. The Champion Communities model is also designed to promote gender equity by integrating both men and women in program activities, providing and facilitating access to FP services and techniques, transforming social norms, practices and behaviors that decrease discrimination, marginalization and stigmatization of vulnerable persons and groups.

The USG funds will continue to be leveraged for care for HIV-positive victims of GBV and provide VCT and PEP as components of comprehensive palliative care programs for survivors of sexual violence. This approach includes medical assistance (including fistula repair), psycho-social support, and advocacy, socio-reintegration services, promoting judicial support and referral, and new protection laws. Furthermore, funds will support legal and judicial reform, advocacy, community education, and care and treatment for GBV survivors and partners. Programs that focus on GBV survivor support and services will leverage resources and complement other USG programs such as the GBV initiative linked to the Secretary of State's $17 Million commitment.

In effort to address male norms and behaviors, USAID and DOD will use behavior change communication (BCC) strategies to engage men and improve negative power dynamics around sexual practices such as condom use and the ability to negotiate sex. The DOD and DRC Ministry of Defense (MOD) will continue to collaboratively host training sessions for DRC armed forces on military justice with a special emphasis on GBV. This program began as an initial activity of the GDRC's efforts to implement and enforce the GBV and Anti-Trafficking legislation just signed into law. Safe blood programming will also be continued, which recognizes the increased risk women face due to unsafe blood transfusions necessitated by childbearing or trauma from violence. In addition, OVC implementing partners will continue to ensure that young girls are equally supported to attend school and will coordinate with the World Bank on their $5m project effort to address the challenges of street children, especially girls.

MARPs
The PNLS estimates that national prevalence among commercial sex workers is 16.9% and over 17% in some provincial capitals (nearly 24.5% in Kasai Oriental; 23.3% in Katanga and 18.4% in Kinshasa). The norms and traditional gender power dynamics in DRC pose barriers to mitigating some of the challenges faced by women and girls and consequently put them at greater risk for contracting HIV/AIDS. Programs focus on combating these challenges have been a USG priority, yet severe challenges remain. In addition, services for rape survivors as a MARP must be an integrated part of the health care system overall (please see the Prevention TAN).

HRH
HRH is a key focus for PEPFAR programming, and a key concern regarding the ability of the GDRC to expand and sustain basic health services. The underlying hypothesis for strengthening human resources is that the health status of the Congolese people will not improve unless overall health education improves and health personnel are skilled, delivering both preventive and curative services that are accessible, and equitable. The GDRC envisions four strategies to address the issue: 1) strengthening basic training at the secondary, higher and university levels; 2) increasing the efficient and rational use of human resources; 3) building on-the-job human resources capacities; and, 4) improving social and working conditions for health workers. The USG supports efforts to improve DRCs human resource capacity through training of service providers at the central, provincial and community levels, as well as support to pre-service institutions. The NEPI and PMTCT-AP are new opportunities for HRH improvement. The USG, in close collaboration with development partners will continue to assist the GDRC in meeting HR challenges (please see the Governance and Systems TAN).
Laboratory
A GFATM ARV assessment (September 2006) identified laboratory service fees as a barrier to treatment. A USG field survey assessment conducted by the KSPH for laboratory equipment (2007) identified the lack of equipment required to implement essential HIV services. Other challenges in which DRC needs

to address include: 1) weak coordination by the National AIDS Control Program (NACP); 2) absence of standardized protocols including demand based procurement guidelines; 3) ad-hoc fee structuring; and, 4) gaps in quality control procedures. The USG focused support in the cities of Kinshasa, Lubumbashi, Matadi and Bukavu and their Provincial laboratories needing equipment were prioritized following the USG geographic zones as defined in the Five-Year HIV Strategy and with input from collaborative partners. The USG provides reagents, lab supplies, and maintenance services to the PNLS National laboratory, as well as other important labs in Kinshasa and assures the maintenance of equipment and repair.

The USG has trained military laboratory technicians in the areas of rapid testing, data management, confidentiality, and medical waste disposal. USG technical assistance will continue to support development of TB/HIV training guides for training of trainers and nurses. TB/HIV collaborative activities and the role of the TB/HIV counselor; PICT for TB patients; management of HIV+ TB patients; TB case identification among PLWHAs, management of OIs and referral; M&E; stigma; family approach to counseling; counseling children; support groups for patients; community mobilization; and palliative care.

During FY 2012, USG will focus on quality assurance in provincial hospitals and key laboratory by revising training curricula, provide on-going training of provincial laboratory technicians, and address fundings gaps in equipment and reagents purchases. These activities will strengthen the capacity of the national reference laboratory of the LNRS (Laboratoire National de Référence Sida) to better play a role in quality assurance for sero-surveillance activities. LNRS will strengthen the capacity of 20 structures within 11 provinces, at the same time offering PMTCT services and sentinel surveillance by quality control samples. This capacity building will consist of preparing and sending panels support the 20 health facilities in provision of lab reagents and other materials, conducting regular site supervision, and purchasing laboratory software to better manage the specimen storage.

Strategic Information
The USG supports: national surveillance activities to provide HIV prevalence trend data for the general population; development of a survey protocol and a strategy to increase coverage with the addition of new sites; combining BSS and HIV testing in high risk groups (every 3 years); and the Demographic and Health Survey (every 5 years). USG is the key supporter of the Center for HIV/AIDS Strategic Information (CISSIDA) run by the KSPH to strengthen national HIV/AIDS information coordination, collection and use. CISSIDA will build and strengthen the capacity of organizations receiving direct funding to collect, use, and report quality data via effective training. The CISSIDA website contains information such as EPP Spectrum estimates, sentinel surveillance surveys, national norms and standards, and special reports such as the Mapping efforts, BSS+ studies, and DHS results. The Center provides technical assistance to the PNMLS in producing annual reports on activities. Work on the HIV, TB and Blood Safety policy matrix will continue to identify strengths, weaknesses and gaps in HIV national policy. Staff will also assist the PNMLS in the implementation of the National HIV M&E system by training donor agency M&E staff in order that all HIV donors collect data using national indicators (one of the Three Ones principles). USG technical assistance will continue on the collection of M&E indicators for OVC, in collaboration with UNICEF, DFID, WFP, and MINAS.

Capacity Building
USG support focuses on integrating quality HIV service delivery into the existing health care system, a priority recently articulated by the MOH. The USG contributed technical expertise to develop the MOH 2008-2013 National HIV Strategic Framework. The USG also promotes a National HIV Strategic Framework that uses data for decision making and institutionalizes the national response. This approach is taken to reduce duplication of efforts as well as minimize ad hoc approaches to human resource development and supply/distribution systems. To optimize quality of care, the USG supports policy activities that assist the GDRC with the development/ integration of policies for access and use of analgesics into national HIV plans and guidance. In addition, clinical care sites should assess for the

presence of pain and other symptoms as part of routine HIV care and treatment. Regular technical assistance to the GDRC and advocates for access to essential pain medications may be required. The USG will work with the GDRC to develop or revise sustainability of national interest in palliative care.

Technical Area: Governance and Systems

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	1,519,654	0
HVSI	810,731	0
OHSS	1,532,878	0
Total Technical Area Planned Funding:	**3,863,263**	**0**

Summary:
Governance and Systems Technical Area Narrative

Introduction
The Democratic Republic of Congo (DRC) has one of the lowest Gross National Incomes per capita in the world ($160), with an estimated 80 percent of the total population of 67.8 million living below the poverty line. The population size, poverty scale, and decades of conflict resulted in the lack of cohesive and functional health systems. The WHO six building blocks of Health System Strengthening are being applied in DRC; however, as systems are weak and not necessarily linked, it will require considerable resources and effort on behalf of the Government of DRC (GDRC), donors, and other partners to build quality systems based on previously existing platforms where possible. The USG, through PEPFAR as part of the Global Health Initiative (GHI), is supporting activities in each of the building block technical areas beginning with strengthening the fundamental foundations of each building block and linking them together to create an improved system. There are tremendous challenges (detailed in the TAN), which will require government commitment, donor funding and coordination, improved governance and transparency within the civil society and the GDRC, improved information management systems, and solutions to the human resources for health crisis.

The geographic size of DRC and the logistical obstacles create a unique set of challenges for building Heath Systems. Currently, the health system in the DRC has three tiers: 1) a central level which includes the office of the Minister of Health (MOH), the Secretary General of the MOH, and Directorates of national disease-specific programs 2) an intermediate level composed of 11 provincial health departments and 48 administrative health districts and 3) the peripheral level with 515 HZs containing over 6,000 health centers (HC). Approximately an equal number of health sites are publically and privately supported. The health system also relies on two types of volunteer community health workers; 1) community health providers whose activities are limited to health promotion and community mobilization activities and 2) community treatment workers who deliver a limited set of interventions (i.e. treatment of diarrhea, fever, and referral of malnourished children to health facilities, plus distribution of a limited number of family planning commodities). There is a centralized pharmaceutical procurement system through the Federation of Essential Medicine Procurement Agencies (FEDECAME), combined with a decentralized distribution system supported by existing distribution hubs (CDRs). The USG is providing significant technical assistance and commodities in supply chain management at various levels of the system to

build capacity and avoid stock outs of essential medication (see supply chain and logistics section for additional details).

Focused on improving the functionality of the health zones, in 2012 the USG will continue to coordinate with other donors in country to improve governance and health systems. The Global Fund (GF) grants are currently stagnated due to performance, financial, and governance concerns. Without GF funding available a considerable burden is placed on the USG and other donors to fill in the programmatic, technical, and commodity gaps within their designated health zones. The most notable gaps remain in ARV procurement and availability, due to the role of the GF which provides ARVs to health centers and donors, who rely on the commodities to support patients on treatment.

Technical Area Descriptions

Global Health Initiative
The approved DRC GHI Strategy is directly aligned with the DRC MOH's National Health Development Plan (NHDP) for 2011-2015, as well as the National Health System Strengthening Strategy. The main goals of both GHI and the NHDP is moving toward sustainable health systems and health care services, by making the health zone (HZ) network the key implementation unit, and increasing HZ program efficiencies, effectiveness, and mutual accountability. The GDRC and the USG aim to achieve these goals by improving the primary health care system through human resource development and integrated service delivery and strengthening national health systems.

Under GHI, the GDRC and USG decided to intensify focus on three cross cutting program areas to assure progress towards the Millennium Development Goals; 1) Strengthened Human Resources, 2) Improved Supply Chain Management Systems, and 3) Improved Health Care Financing Systems. These areas were selected based on GDRC's priorities, USG comparative advantages, and opportunities for leveraging USG resources as well as those of other donors and the private sector. Through strategic coordination, GHI is an opportunity to maximize program impact by capitalizing on synergies within USG-supported programming.

Leadership and Governance Capacity Building
The USG will remain committed to building leadership and country ownership as outlined in the Partnership Framework and the Partnership Framework implementation Plan. In 2012 the USG will continue investing in country-led plans and health systems while increasing impact and efficiency through implementing best practices and evidence based interventions. The governance and system inputs funded directly through PEPFAR are:
• Human Resources for Health
• Laboratory strengthening and pharmaceutical management
• Strategic coordination, programmatic integration, and leveraging key partnerships
• Improving strategic information, including monitoring and evaluation
• Promoting research and innovation

Specifically, the USG will strengthen the capacity of the GDRC to coordinate, monitor, and evaluate interventions, train healthcare providers in comprehensive care, and streamline the referral and enrollment of those who are ineligible for ART into care programs. Activities will strengthen civil society's capacity to engage and mobilize communities and PLWHA to deliver effective palliative and home-base care interventions and will work toward developing PLWHA support group networks to provide a comprehensive needs-based response.

As a key approach to ensuring improved health outcomes and accountability of the GDRC, management, coaching, and leadership training at the various levels of the health system will ensure that Government institutions and partners are held accountable to intended results. The USG will implement

problem-solving approaches and quality assurance methods that engage service providers and communities to tackle their own identified problems. In 2012, the USG will assist the GDRC to strengthen the health infrastructure from the national to the community level through; institutional and HR capacity building, lab and infrastructure, strategic information, and health finance. The USG is providing long-term in-country technical assistance to help the MOH strengthen pharmaceutical management related to forecasting, procurement, and inventory and drug management systems. In 2012, PEPFAR and MCH funds will pilot test the use of the GDRC's procurement system (FEDECAME) to directly procure test kits and PMTCT ARV prophylaxis, once a rapid appraisal approves that FEDECAME administrative and financial systems in place are transparent and accountable.

Under NEPI (Nurses Education Partnership Initiative), to be implemented in 2012, human resource capacity building will be strengthened by improving the nursing and midwifery curriculums, and increasing human resource retention and identifying incentives required for personnel posted to inaccessible and difficult geographic regions. This pre-service initiative will contribute to the PEPFAR mandated 140,000 health workers created while strengthening the government's ability to improve the quality and quantity of their health workers.

Strategic Information
In collaboration with major donors, the USG is a contributing member to several national steering committees tasked with strengthening coordination and implementation of the Three Ones. The USG developed a contract in 2010, which is creating one national monitoring and reporting system. The CDC and the Kinshasa School of Public Health (KSPH) jointly supervised the initial phases of the contract, and assuming no major problems arise, after approximately one more year, the hardware and software will be managed and supervised directly by the KSPH. The web-based reporting system was developed in collaboration with the National Strategic Information Taskforce. The USG will continue to promote SI as a foundation for planning and coordinating the national HIV response by identifying the following:
• Epidemiologic priorities via ANC (currently conducted annually)
• Behavior Sentinel Surveillance (BSS) and DHS surveillance
• Geographic distribution of HIV service sites by mapping
• A national M&E reporting system for service delivery

The GDRC health management information system is weak and the need for reliable data for decision-making is strongly endorsed by health stakeholders. Currently the USG provides assistance to the GDRC for 1) developing standard national indicators 2) training a national cadre in HIV/AIDS HMIS and M&E at the national level and 3) capacity building of health care providers at the decentralized level in supervision, monitoring, data quality and the use of data for decision making through training. The USG funded technical support to conduct a UNAIDS CHAT exercise (Country Harmonization Alignment Tool) and is a member of the steering committee implementing the new CHAT protocol designed to measure progress in achieving the Three Ones. In addition, the USG provides technical assistance and support in field data collection. The USG will continue to strengthen program activities through the evaluation of the national blood safety program, the evaluation of GF sub-grantees performance reporting in Phase I, and the evaluation of GF ART services. The USG continues to provide technical assistance to the PNMLS. Through this assistance, the National M&E Strategic Framework was validated and several key documents were developed: the National M&E Indicator Guide, the National M&E Training Manual, and the first National HIV/AIDS Epidemic Report. In 2012 collaborating with implementing partners, USG agencies will work towards implementation of a standardized M&E system that will accurately capture program activities supported by USG funds.
The support to the Center for HIV/AIDS Strategic Information (CISSIDA) managed by the KSPH to strengthen national HIV/AIDS information coordination, collection and use will continue in 2012. The USG support will enable the Center to provide technical assistance to national institutions such as the PNMLS, the PNLS, the PNTS, the PNT, local organizations, and international partners in the area of SI. CISSIDA will build and strengthen the capacity of organizations receiving direct funding to collect, use, and report

quality data via effective training. The CISSIDA website contains information such as EPP Spectrum estimates, sentinel surveillance surveys, national norms and standards, and special reports such as the Mapping efforts, BSS+ studies, and DHS results. The Center provides technical assistance to the PNMLS in producing annual reports on HIV activities in the various health sectors.
A countrywide gender analysis is scheduled for February 2012 with input from the USG agencies in collaboration with the GDRC, other development partners, and civil society. As part of this analysis, particular attention will be focused on how social, economic, and political barriers impact the lives and health status of women and girls in DRC. The analysis report will be finalized March 2012 and the information obtained through this analysis will be used in designing and implementing future activities.
Service Delivery
The DRC's epidemic is considered generalized, with varying prevalence in rural and urban geographic areas across the country. Prevalence among pregnant women attending ANC sentinel sites is approximately 2%, however there are regions with prevalence as high as 9.5% in urban areas of Kisangani. Approximately 5% of pregnant women nationally have access to PMTCT services, and fewer than 30% of PLWHA enrolled in ART programs are receiving some form of palliative care. Currently, PNLS estimates that 41,454 adults and children are enrolled on ART, which is approximately 10% of those eligible, primarily through GF treatment programs. Several MARP Populations are drivers of the epidemic (CSW, Uniformed Services, Truckers, and MSM), and therefore the USG's programs focus on reaching MARP populations, pregnant women, and the general population in PEFAR designated health zones (see prevention and treatment TANs for more details). The PEPFAR strategy is aligned with the epidemic in country and is implementing and programming appropriate interventions to mitigate the epidemic in the 80 health zones.

Services in DRC, supported by PEPFAR in both the public and private sector are integrated with other USG or partner activities to ensure a CoR, regardless if the USG is funding the entire continuum. USAID is providing a comprehensive package of PHC services in 80 HZ in South Kivu, Katanga, East and Western Kasai provinces. USAID also provides HIV prevention, and care interventions in high prevalent urban sites for OVCs and PLWHAs. Both CDC and USAID are supporting considerable funding for tuberculosis (TB). For example, CDC is strengthening the laboratory diagnosis of TB and USAID supports DOTS expansion, increasing TB case notifications and TB diagnosis and quality treatment as part of the PHC package. The CDC is strengthening HIV-specific laboratory capability, HIV/AIDS information systems and surveillance, and HIV/AIDS care and treatment. The USG currently supports activities that contribute to the reduction of HIV prevalence while increasing access to quality HIV/AIDS prevention, care, and support in high prevalence urban sites. DOD is focused on providing HIV preventive services including HTC to the military and their families while providing care to the surrounding communities in four sites in Kinshasa, Katanga, East Kasai, and South Kivu.

In 2012, PEPFAR will continue to work towards developing (please see Care and Support, Prevention, and Treatment TANs for additional details):
• A cost-effective evidence-based Health Zone-based care and support package
• Increase the emphasis on positive living and reducing stigma and discrimination
• Appropriate nutrition messages and coordinating needs-based provision of high energy protein supplements and emergency food assistance
• Streamline the referral and enrollment of those who are ineligible for ART into comprehensive care programs

At the community level the USG will continue to provide social and palliative care services, which include nutritional support, legal aid, income generating activities, psychosocial support, support groups, and anti stigma activities, and limited clinical services such as support to treatment adherence through health providers and home-based care volunteers. In addition, PEPFAR supports services to deliver prevention and care at the DRC/Rwanda and the DRC/Burundi borders focusing on underserved populations through local organizations.

Human Resources for Health
The DRC's human resources for health (HRH) challenges are rooted in the lack of professional development, mentoring opportunities, and dysfunctional health and financial systems, which led to the diminished capacity of the health workforce. Further challenges are exacerbated by the country's vast size, extremely poor infrastructure, and public servant salaries that are low if provided at all. The underlying hypothesis for strengthening human resources is that the health status of the Congolese people will not improve unless overall health education improves and health personnel are skilled, delivering both preventive and curative services, which are accessible, and equitable.

NEPI will be operational in 2012 and will contribute significantly to the emerging PMTCT AP and nursing and midwifery capacity in general. To contribute to the PEPFAR goal of 140,000 new health care workers trained, with PEPFAR support (pre-service) the KSPH plans to develop training materials that integrate HIV into their current standard curricula and train primarily physicians, nurses and lab technicians. The USG has chosen to support the KSPH to ensure the sustainability of HRH activities because it is a GDRC institution which trains a significant proportion of public health and laboratory workers in collaboration with training institutions around the country such as ISTM, ISETEM, (the primary nursing and laboratory training schools located in Kinshasa), and medical schools in Kinshasa, Lubumbashi, and Kisangani.

The USG acknowledges that the GDRC faces challenges in maintaining health worker motivation, primarily due to low and non-payment of salaries, which often leads to health worker strikes, low quality services, lack of motivation, and retention issues. At the request of GDRC, PEPFAR incorporated a performance based financing scheme in the PMTCT AP that will help boost staff morale and performance both in the clinical sector and in the data management sector of the HZ involved in surveillance and reporting activities. As HZs will also be provided with computer set up, such enabling activities can boost not just the outcome of PEPFAR programs, but all other health initiatives.

In 2012 the USG will continue to engage the GDRC in identifying potential solutions to these obstacles and will collaborate with GDRC and other stakeholders to:
• Develop and implement a gender balanced "human resources for health" policy in partnership ship with the MOH's Division of General Services and Human Resources to ensure a strong healthcare workforce
• Develop and implement this policy, including a HRH assessment, a HRH information system, and expanding the collection of HRH data
• Increase the underrepresentation of women as health care providers by implementing a gap analysis with the Ministry of Social Affairs (MINAS) at both central and provincial levels. Findings will inform the development of a capacity building plan and strategies to increase the number of female health providers
• Strengthen local NGO's capacity to plan, implement and evaluate HIV activities through sub-grants. Local NGOs will be offered training on how to prepare budgets and proposals, strengthening their technical and organizational skills, and improving M&E functions. NGOs demonstrating their abilities and potential will be further trained in technical approaches, budget, and administration to prepare them to manage local grants for selected HIV services and activities. Technical specialists, grants managers, and M&E specialists will support grantees to ensure compliance and the achievement of agreed-upon deliverables
• Train healthcare providers, laboratory staff, and community health workers (in-service) in the delivery of services, coordination, management and supervision, strategic information, supervision, M&E, quality assurance, and other technical aspects of HIV/AIDS prevention, care, treatment, and support
• Improve the deployment and training of community counselors and health workers. In addition to strengthening government capacity to train and monitor community workers, short term technical assistance will be provided to support the development of locally adapted incentive schemes (e.g., supportive supervision, community recognition, access to refresher trainings, and access to grants through local financial institutions)
• Implement a strong mentorship program, in which experienced, well-trained individuals provide

supervision and guidance to less-experienced, newer healthcare professionals
• Support the recruitment and retention of newly graduated and existing health workers. One particular priority is the development of a comprehensive approach to continuing education and incentive schemes to motivate and retain new health care providers
• Support a quality assurance and control program for all individuals trained in pre-service or in-service training programs to assess the quality of the trainings and their long-term impact.
• Field test and implement a performance based financing scheme in PMTCT clinics and health zones to boost staff productivity.

Laboratory Strengthening
Currently, HIV testing is not routine and laboratory services related to HIV are intended to be free of charge, although ad-hoc fees are common. The USG is collaborating with other donors to promote quality laboratory services to ensure effective diagnosis and treatment, safe blood services, and accurate epidemiologic surveillance. The GF and the European Union (EU) provide equipment and reagents at various operational levels and in different geographic areas. The GDRC provides the physical structures, personnel, salaries for personnel, as well as educational programs at the high-school and university levels for laboratory staff. However, it is clear that the current laboratory infrastructure in DRC is unable to support the HIV/AIDS laboratory services necessary for testing and disease monitoring because of sub-standard facilities, lack of trained personnel, required equipment, and necessary reagents. The USG continues to support laboratory infrastructure programs through projects managed by the KSPH and other USG partners. Through training and technical assistance, the KSPH supports the strengthening of the National Laboratory network as well as HIV surveillance. In addition, the HIV laboratory training site at the KSPH conducts pre-service and in-service training in HIV laboratory techniques and procedures for students enrolled at the Laboratory Technician Institute and the University of Kinshasa Medical School, which all contribute to the health care workers target.

In 2012, the USG will continue to provide expanded technical assistance for the development of national laboratory policy, norms, procedures and standards, and the development of a laboratory quality assurance program at the national, provincial and district hospitals as well as local clinics. The USG will focus its support in four geographic areas; Kinshasa, Lubumbashi, Matadi, and Bukavu. In 2010, the National Blood Safety Program (PNTS) was awarded a five-year cooperative agreement that contains components focused on strengthening laboratory infrastructure. The USG will continue to fund two partners providing technical assistance for the integration of a quality control/quality assurance system into the PNTS and National TB Control Program's laboratories. With 2012 funds, additional resources will concentrate on quality assurance in provincial hospitals and key laboratory sites. This will include revising the training curricula and subsequent training of provincial laboratory technicians. Funds will continue to be used to fill critical gaps in equipment purchases and reagents that are necessary for related laboratory testing. The USG will continue to strengthen laboratory capacity at health facilities based on patient care needs, cost, effectiveness and efficiency.

Health Efficiency and Financing
In DRC from 2002 to 2008, the economy grew by 6.0 percent per year and inflation decreased, to 15.9 percent per year. However, since July 2008, economic growth has slowed, due mainly to the international financial crisis, which led to the collapse of the mining sector in DRC. In 2009, growth dropped to 2.7 percent and inflation rose to 45 percent. This trend of stagnant or shrinking resources reduced financial allocations to health sector and had adverse effects on health system development. Despite government contributions, health system financing in 2008 and 2009 came mainly from households (43 percent in 2008, 42 percent in 2009) and donors and international NGOs. Although the number of community-based health insurance schemes (mutuelles de santé) in DRC has grown to an estimated 44 in 2011, their contribution to DRC health financing is still very low, around 0.08 percent of the health expenditures (THE). The traditional system of risk sharing insurance emerged in DRC in 2009. It is provided by the National Insurance Corporation (SONAS) and contributes less than 0.01 percent to THE. HIV/AIDS

subaccounts reveal that 96 percent of resources mobilized for HIV/AIDS are spent for the provision of health services and for health-related activities and that 4 percent is allocated to non-health activities (e.g., orphan and vulnerable children care, income generation).The government's contribution is extremely small, less than 0.01 percent, and is limited to salaries paid to government employees who support HIV program and services.

In 2012, the USG will discuss with the government mechanisms that can guarantee better welfare for health workers while reducing the burden on households and promoting effective and pro-poor public health services. For example, Performance-based/output-based financing is one of these mechanisms, as well as scaling up mutuelles and other insurance type schemes. The goal of the PEPFAR program is to assure sustainable financing for the GDRC health system. In an effort to improve cost efficiencies and streamline approaches and processes, the USG has increased coordination with other donors and the GDRC through the Country Coordinating Mechanism (CCM), health donors coordination group (GIBS), and PEPFAR Steering Committee. Furthermore, given limited resources and research in the DRC, more information is needed to determine how best to focus spending. Therefore, the USG will fund a HIV/AIDS Cost-Effectiveness Study which will compare and contrast the cost-effectiveness of HIV/AIDS interventions in the DRC. The study will inform decision making and assist decision makers, such as the USG PEPFAR team, in maximizing the impact of limited resources.

Supply Chain and Logistics
In DRC, drug management systems are weak and lack accountability, with multiple parallel systems in place and frequent stock-outs. The GDRC receives the majority of its commodities via the Global Fund whose granting mechanism is slow to start-up and has significant issues with forecasting of drugs supply and keeping ARVs in stock. The USG was requested by the PNLS to ensure a buffer stock of ARVs. Furthermore, USG activities are working to improve drug management, logistics and distribution, throughout the DRC. Examples of these activities include:
• Providing technical assistance for supply chain management and logistics to CDAs (Regional Distribution Centers) to strengthen pharmaceutical management related to forecasting, procurement, inventory management, and drug management systems
• Increasing the supply chain effectiveness at the provincial and heath zone levels. Information generated will permit early stock-out alerts, prompting appropriate corrective measures
• Assistance provided to the National Reproductive Health Program to build its capacity for improved coordination in the area of commodity security
• Revision of the essential commodities list. The MOH is developing a pharmaceutical pricing policy to fit within the unified procurement structure

Gender
The USG is a major donor in the response to widespread sexual and gender based violence (SGBV) in DRC. Throughout the overall USG strategy SGBV and gender activities are integrated through a whole of government approach to promote protection, community prevention of and response to SGBV, this includes providing medical and psychosocial support for SGBV survivors. The USG supports five cross-cutting gender strategic areas which are integrated into the overall USG HIV Strategic Plan: 1) increasing gender equity in HIV/AIDS activities and services, 2) reducing violence and coercion, 3) addressing male norms and behaviors, 4) increasing women's legal protection, and 5) increasing women's access to income and productive resources. As part of supporting SGBV services, the USG is increasing the availability of Post-Exposure Prophylaxis (PEP) kits for survivors of rape.
Under the GHI Strategy a gender sector wide analysis was planned to highlight and respond to the needs and gaps in-country. The USG has moved forward to create an inter-agency Gender Working Group with identified gender focal points from each agency. In addition, the USG has its own SGBV working group with the GDRC. The DRC GHI activities funded with PEPFAR resources, includes: gender consideration in the design of BCC messaging, the identification of program beneficiaries and using them in the design, implementation and evaluation of program interventions, training for community workers to identify the

signs of GBV, program trainees and fellowship recipients that focus on engaging women and girls, and WASH activities to increase access to potable water—thereby allowing more women the opportunity to explore income-generating opportunities and girls to attend school. Program activities will also seek to integrate men into counseling and testing, family planning, MNCH, and PMTCT activities.
The USG continues to implement the Secretary of State's $17m initiative for GBV efforts in the DRC. A variety of USG partners are supporting programming in the areas of GBV, medical and psychological support and working on policies, laws, and justice. These activities will continue to be supported in 2012, especially in Eastern DRC.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	2,725,561	
Total Technical Area Planned Funding:	**2,725,561**	**0**

Summary:
(No data provided.)

Technical Area: Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HMBL	872,285	0
HMIN	200,000	0
HVAB	1,146,256	0
HVCT	3,411,021	0
HVOP	1,859,498	0
MTCT	2,376,666	0
Total Technical Area Planned Funding:	**9,865,726**	**0**

Summary:
PREVENTION TECHNICAL AREA NARRATIVE

The 2007 Demographic Health Survey (DHS) in DRC indicated that DRC is facing a generalized HIV/AIDS epidemic with stark geographic and population differences. The majority of new HIV/AIDS cases are diagnosed among people less than 24 years of age; and the epidemic has distinct geographic patterns. Though the overall HIV prevalence in DRC is 1.3%, rates are twice as high in urban vs. rural areas (1.9% to 0.8%) and among women than men (1.9% vs. 0.9%). While HIV prevalence remains higher in urban areas, it has increased in certain rural areas, particularly those near geographic hotspots, which bring together large groups of low prevalence engaging in risky behavior with other of high prevalence rates.

High risk and high prevalence populations often congregate in geographic “hotspots,” such as border

crossings, transport corridors, ports, and regions with a large military presence. The already elevated rates of MARPs, which includes CSWs, truckers, miners, and uniformed services are often more than triple or quadruple the rates in the rest of the country. Truckers demonstrate a national prevalence rate of 3.3%, but in Katanga, long-haul truckers from southern African countries demonstrate a HIV prevalence 7.8%. A seroprevalence survey conducted in Kinshasa in 2008 indicated that prevalence in the military was 7.5% among women and 3.6% among men. A 2006 bio-sero survey found a prevalence rate of 16.9% among CSWs, and rates in the provincial capitals of Katanga and Kasai Oriental were elevated to 23.3% and 24.5%. Fifty-five % of miners; 32.9% of the military and 75.1% of street boys and 81.1% of street girls report multiple sex partners within the 12 months, therefore increasing their risk for transmission.
Pregnant women are particularly at risk; Antenatal Care (ANC) surveillance data from 2010 indicate that pregnant women had a prevalence rate roughly twice that of other women at 2.0%. The 2009 ANC data showed urban prevalence rates ranging from 4.3% in Matadi to 9.5% in Kisangani and a 2007 ANC survey finding a prevalence rate of 16.3% in rural Kasumbalesa (Katanga province). Furthermore, gender inequalities, war, and political and economic instability resulted in widespread sexual violence, intimate partner violence, physical abuse, and an increase in commercial sex work.

Numerous challenges increase the difficulty of implementing effective prevention programs in DRC where 70% of the population has little or no access to health care. Health system challenges include routine stock-outs of HIV test kits; generally low availability of condom and counseling services; gaps in the prevention of unwanted pregnancies and other needs in reproductive health; gaps in education of young adults in responsible sexual behavior and other life skills knowledge; weak health information systems; poor integration of services leading to higher costs and missed opportunities for patients to receive a full range of services.

In addition, DRC has one of the most logistically and politically challenging environment worldwide. Years of conflict resulted in degraded and inadequate physical infrastructure including the absence of a road network and transportation netwrok, which increases the cost of products and logistics, as well as access to health services. Political instability has led to a lack of political commitment to comprehensive health and human rights strategies, in addition to a vacuum in accountably.

Despite the challenges in DRC, there are also many opportunities for improved prevention programming. Although the GDRC lacks the necessary infrastructure and resources to enable progress and is financially dependent on donors and development partners, HIV/AIDS control is a priority in the Poverty Reduction Strategy Paper. The GDRC established a multisector (2010-2014) and a health sector (2008-2012) strategic plan to coordinate and provide HIV/AIDS activities and services and USG programs and efforts are fully aligned with these GDRC's strategies and priorities. The PNMLS first strategic axis is reduced transmission of Sexually Transmitted Infections and HIV. In the official Partnership Framework signed in 2010, the USG and GDRC agreed to collaborate to reduce the number of new adult and infant HIV infections from 181,000 per year in 2009 to 90,500 per year by 2014.

The most notable USG prevention activity in 2012 will be the acceleration of PMTCT activities that encompasses all elements of HIV/AIDS prevention and integration to sexual and gender based violence prevention. Other activities include One-on-One interpersonal HIV messaging mostly focused beyond abstinence and be faithful, HVTC, condoms, blood safety, injection safety and family planning, and the HIV/AIDS telephone hotline "ligne verte", users of which extends to neighboring countries. The DRC PEPFAR AB programmed activities which target mostly youth in the general population will not reach 50% threshold of all prevention funding due to the nature of epidemic described in the previous sections and the contribution of other donors targeting the general population.

The donor community and development partners work in partnership with the GDRC to further reduce new HIV infections. Global Fund (GF) supports drugs to treat sexually transmitted infections (STIs),

condoms, mass media strategic messaging campaigns, prevention for positive and discordant couple's activities, PMTCT training, ARVs, salary support, and blood transfusion equipment and supplies. It also funds activities to support prevention in the areas of PMTCT, behavior change communication (BCC) including AB messaging, HCT, blood safety, and outreach to high-risk populations. The GF Round 7 grant allocated 32% of its budget to prevention while Round 8 allocated 38%. The WHO provides technical assistance with counseling and testing policies and on blood safety. The World Bank was supporting a comprehensive prevention package similar to the Global Fund in their designated health zones, including mass media campaigns, peer education, condoms and PMTCT, which has now ended. The private sector through a public-private partnership with the Kinshasa School of Public Health and Foundation Femme Plus supports the USG-supported prevention telephone hotline. A local mining companies is also partnering with the USG to expand prevention activities in the country.

Though capacity challenges remain, GDRC has existing coordinating bodies to facilitate donor coordination with GDRC priorities. These include: the country coordinating mechanism (CCM), and national technical workgroups Blood Safety, PMTCT, MARPs and HIV counseling and testing (HCT) as well as the BCC coordination forum. USG provides technical input and and financial resources to elevate the capacity of these workgroups.

In conjunction with the GDRC, the PEPFAR Country Team and the PEPFAR/Partnership Framework National Steering Committee will be responsible for monitoring the enabling environment and the prevention policy reform agenda. Prevention policy areas that will be monitored include:
• MOH implementation of the new condom distribution policy for high-risk populations;
• MOH evaluation of the results from finger prick testing pilot to draft new HCT policy that would enable task-shifting of testing services;
• MOH approval of new HCT norms and guidelines, to include Provider Initiated Counseling and Testing (PICT) and increased focus on couples counseling;
• Implementation and enforcement of the SGBV and anti-trafficking by relevant ministries of GDRC, including Justice, Health, Defense, Social Affairs;
• MOH expansion of implementation of the new PMTCT protocol, which includes triple-dose therapy, beginning week 28th of pregnancy;
• Expansion of the capacity at the national telephone hotline ("ligne verte') to increase call-response volume;
• Coordination of strategic behavior change communication messaging by the PNLMS; and
• Adoption of new or revised prevention policies developed with support from the USG.

The USG Prevention strategy focuses on developing a standardized prevention package in its supported health zones. The minimum package will include: One-on-one individual counseling; condoms; PMTCT related HVTC, blood safety; injection safety; and family planning. MARP specific prevention packages will be developed in certain hot spots but will not be part of the standardized package. The USG prioritizes targeted, comprehensive prevention programs among persons engaging in high-risk behavior while also addressing risks for youth and the general population. Four our key priorities are listed below:

• Acceleration of PMTCT Prevention and Treatment Activities (please see the DRC PMTCT Acceleration Plan).

• Community involvement: This strategy, adapted for the DRC context, helps communities set and meet prevention objectives in line with their own priorities. It enables programming to be responsive to the unique risk factors in the USG geographic focus areas and allows for adaptation and targeting of MARPs communities in each area by increasing both the awareness, adoption of safer sex practices, and uptake of services and empowers and motivates communities to prevent sexual transmission. Over the next two years, the USG will expand this model into urban hot spots and work with elected members of community organizations to address the challenges of HIV and develop community-specific interventions.

• Integrated Services: Scale up small grants to community organizations to provide an integrated continuum of care to link clinical with community services including prevention, HTC, PMTCT, monitoring and treatment of TB/HIV co-infection, as well as care and support for PLWHA and Orphans and Vulnerable Children (OVC).

• Strengthened Health System: Strengthening the levels of the health system to ensure that the supply chain is solid and commodities reach the needed populations; that adequate health personnel is available to provide services in focus regions; and that health personnel have adequate capacity to deliver prevention services and messages. An addition to ongoing activities is NEPI, that will be fully leverage HIV/AIDS program activities.

The four key priorities of the USG prevention program as listed above will be implemented through the following specific interventions below.

PMTCT
The USG commits to the following targets by the end of FY2012: 94% of pregnant women in PEPFAR supported sites know their HIV status (target, at least 350,000 women), 96% of HIV infected pregnant women are receiving efficacious PMTCT regimens in PEPFAR-supported sites (target, at least 7,000 HIV infected women). Please refer to DRC PMTCT Acceleration Plan for further details.

HVTC
In the most recent reporting period, 173,963 individuals received HVTC services and their test results. HVTC will primarily be realized through PITC delivered at PMTCT and other HIV service facilities, including those serving military populations. PITC was identified as an appropriate approach to meeting the HVCT needs for pregnant women and the general population without creating high demand without access to ARVs. HVTC sites will also be linked to family planning services, offering an integrated package of prevention services. Outreach to and engagement with high risk communities is a key element of the HVTC strategy as programming will socially market HVTC to target populations. The USG will increase service utilization by optimizing multiple delivery mechanisms and by reaching out to a variety of target groups. In addition to stand alone health units, mobile units will allow health workers to adapt schedules and services according to local and epidemiologically determined needs and ongoing prevention activities; coordination with TB clinics; and link with SGBV organizations to support testing of survivors and providing them with PEP. To increase outreach to PLWHA households, community counselors will visit PLWHA families several days before mobile HVTC units arrive to reinforce messages and the importance of testing. HVTC counselors' capacity will be developed to improve service quality and demand.

USG partners will work with local partners to provide local organizational capacity-building to strengthen civil society by competitively awarding grants to CBOs and NGOs to support management and increase uptake of HVTC. To establish support systems, the project will work with community groups to develop appropriate partnerships with local authorities that will allow for effective and responsive service delivery, and will work to ensure sustainability. To promote community ownership, using standardized tools, USG partners will train community counselors to work at the HVCT centers and in the community to conduct mobilization, referrals, and outreach, as well as pre- and post-test counseling.

The referral system to treatment and care remains weak. To address this problem, CD4 machines (PIMA) will be added to mobile sites so that PLWHA can receive their CD4 count immediately. The USG will explore implementing RBF activities to reward clinics with successful referrals.

By the end of the 2014, USG partners will test and treat 8,288,394 individuals for sexually transmitted infections including HIV and increase the proportion of patients with STI at health care facilities who are

appropriately diagnosed, treated and counseled.

Condoms
Rates of condom use in DRC vary wildly. Roughly 30% of the general population currently uses condoms, a rate that is similar to the uniformed services where 32.3% of military personnel use condoms. Stock outs in the supply chain, interruptions in service delivery, and limited availability of health services in many areas are the key challenges to consistent provision of condoms. Currently, the USG procures males and females condoms and makes them available to pregnant women and the general population through PMTCT and other HIV service facilities including those serving the military in all the targeted areas. MARPS and military populations will be targeted through tailored campaigns based on the demographics within the HZ. While donors provide condoms and UN agencies provide them along transportation corridors, varying donor funding combined with logistical challenges mean that condoms are an underutilized resource in the prevention.

Voluntary Male Circumcision
According to the 2007 DHS, 97% of men between 15 and 59 years are circumcised. Because of this nearly universal rate of coverage, circumcision is not a critical element of the USG prevention strategy.

Positive Health Dignity and Prevention
USG will expand programs for PLWHA in geographic hotspots. Discordant couples and PLWHA will be targeted for prevention counseling through HVTC centers, and the USG will scale up a pilot project that focused on supporting discordant couples through home visits by community counselors. Focusing on PLWHA, using a Home-Based Care package, PEPFAR partners work to make disparate services accessible to PLWHA. These services include basic health care, prevention of opportunistic infections, psychosocial support, nutritional counseling and food support, vocational training, and income generation activities. The 'Champion Community' approach uses volunteer social workers to link PLWHAs to facility based services for support for treatment adherence. See the Care TAN for more information. USG programs will continue to link PLWHA to community based services, to caseworkers and to the PLWHA support groups established around HVTC centers.

MARPs and other vulnerable populations
Because the prevalence rate among MARPs is dramatically higher than that of the general populations, USG prevention activities focus largely on these groups. USG activities are concentrated in the geographic hotspots and areas that have the highest proportion of MARPs. In these areas, prevention activities will include one-on-one or small group sensitization sessions delivered by trained peer educators, radio spots, drama, condoms promotion and distribution, HVTC, referral for sexually transmitted infections (STIs) screening and treatment. USG partners will work with the military to ensure that military personnel, many of whom have multiple partners and work in high risk areas, have access to condoms and to HTC through military health facilities and to targeted prevention messaging. USG also provides direct support to anonymous CSW clinics, which provide a full range of services in urban areas This prevention package for MARPs will be linked to care and treatment services to ensure a continuum of care for this specific sub-group of the population.

General Population
Due to DRC's geographic size and the disproportionate effect of HIV on MARPS, the USG majority of programming focuses on MARPS in the four provinces. However, sexual prevention campaigns target the entire country, specifically youth, where the rate of infection has grown. The USG supports a strategy that promotes the reduction of multiple concurrent partnerships, abstinence, and fidelity to one partner as well as the availability of, access to, and correct usage of male and female condoms as a comprehensive and balanced approach to the prevention of HIV and STI transmission. In addition to large social media campaigns to increase HIV awareness and knowledge and decrease stigma and discrimination, programming will interpersonal communications as well as mobile video units (MVUs) to educate target

audiences on HIV/AIDS/STIs and to promote risk reducing behavior following the ABC and D (Abstinence, Be Faithful, correct and consistent use of Condoms and be tested for HIV from the French word “Dépistage”) message strategy. In addition, the USG-supported Hotline (“Ligne verte”) which provides answers to callers on a one-to-one basis through trained counselors will be expanded to accommodate more callers and provide referral to callers in need to available HIV services nationwide using an updated national directory of HIV services. It will also link to GBV prevention and care services. Leveraging other USG funding, the PEPFAR Team will implement a new prevention program targeting street children. The USG will engage with the GDRC to lead the development and implementation of standards, guidelines, job aids/tools, and promotional materials for products and services to prevent and manage HIV infection and STIs.

As a result of the various programs, by the end of the 2014, the GDRC expects its estimated incidence among adult populations to drop by 50% from 2009 levels. Additionally, the proportion of youth aged 15-24 who both correctly identified ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission will have increased while the proportion of youth who have had sexual intercourse before the age of 15 will decrease from 28.1 percent to 10 percent by 2014.

HSS/HRH
In line with the GHI strategy, the USG will implement a variety of activities to strengthen the health system and improve human resources to improve prevention services. Strengthening the skill set of the community health workers to improve their ability to deliver effective health messages around several key topics is a key priority of the USG. The USG will focus on training of all health workers on integrated messages to raise awareness around MNCH/HIV, as well as gender issues; expanded training of health care providers at the facility and community level in integrated package of health services such as MNCH/HIV/AIDS/post-partum FP will directly benefit women and girls; task shifting in order for a wider range of health providers, including midwives and nurses, will provide a fuller range of prevention services and counseling; increasing SGBV training for health workers and personnel.

Among specific activities, first and foremost is the large-scale training for PMTCT AP that targets 5 types of health workers including physicians, nurses, midwives, laboratory technicians, pharmacists and data management experts in each of the Health Management Zones and at the Central Level. The other is the NEPI introduced in DRC in 2011. PMTCT and HIV/AIDS will be integral components of the NEPI curricula.

Frequent stockouts and an inadequate logistics and distribution system have also hampered prevention efforts as the necessary condoms, testing kits, and treatment drugs are now always available. DRC currently has 19 different donor procurement systems in addition to the Federation of Essential Medicine Procurement Agencies (FEDECAME) system, making it difficult for the GDRC to track the quantity, type and destination of drugs in the country. Strengthening the supply chain management is a priority for the GDRC. The GDRC envisions: 1) an increase in funding and rational use of funding for essential drugs; 2) improved coordination of procurement of essential drugs; 3) strengthened capacity of the national supply chain system; and 4) promotion of local production of essential drugs. Currently the USG supports the GDRC in the first three aforementioned areas to improve drug management, logistics and distribution throughout the DRC. The USG places a renewed emphasis on strengthening the national drug supply chain through capacity building of FEDECAME. The USG will collaborate with other partners to support FEDECAME through a financial Management Risk Assessment that will lead to a plan to strengthen the system; to pilot limited procurement of essential drugs through FEDECDAME; to evaluate FEDECAME’s systems; and to directly procure commodities for more rapid and flexible distribution.

To increase compliance of health workers and to assure the best use of training investments, at the request of GDRC, USG will support a performance based financing system along the PMTCT AP. Capacity building challenges and opportunities are not unique to prevention; therefore, please refer to the

Governance TAN for more information in this area.

Medical Transmission
Bio-Medical Prevention programming focuses on increasing access to safe blood, ensuring that all blood transfusions are being tested for HIV and that there is proper disposal of medical waste. The USG provides technical assistance to support the MOH in policy and infrastructure development, blood collection, testing, quality management, transfusion and blood utilization, training, and monitoring and evaluation. The USG support has also aided in the development and dissemination of the National Blood Safety Strategic Plan as well as the Volunteer Non Remunerated Blood Donor (VNBD), Quality Assurance, and National Injection Safety Strategy policies, and ongoing assistance to implement and strengthen these policies will continue. In 2012, National guidelines will be updated and developed and training and capacity building will be offered to support clinical professionals to provide quality blood transfusions. Through a well-established monitoring and evaluation system, that uses both international and national blood safety indicators, the MOH and USG agencies will gather data for an objective assessment of the impact of this crucial health care intervention. Technical assistance will be provided directly to strengthen the capacity of the National Blood Safety Program (PNTS) to develop strategies to ensure that blood safety standards apply and that the supply is adequate, particularly for pregnant women, children, trauma victims, and other populations susceptible to contracting HIV and other blood-borne pathogens through blood transfusions.

Quality management systems, including regional blood collection and processing facilities, laboratory testing equipment and supplies, standard laboratory equipment and reagents including testing for transfusion-transmitted infections and blood grouping and cross matching are critical pieces of the USG's blood safety interventions. Supported activities will include the development of a blood collection strategy for obtaining, handling and storing, transporting, and distributing blood for use at health facilities. This will require the establishment and maintenance of a blood cold chain, developing and maintaining a network of blood donor recruiters and counselors, and encouraging repeat blood donors.

The USG implements biomedical prevention programming in all USG supported facilities. Site-specific protocols and procedures for testing blood for HIV, hepatitis B and C, and syphilis, managing blood testing facilities, collecting and storing blood tests, recordkeeping and database with a computerized system and external quality assurance will be established to ensure the quality and accurate data of blood transfusions.

Gender
Continued population displacement, insecurity, and conflict in Eastern DRC have perpetuated the cycle of violence against women and girls. While no official data are available about the prevalence of rape in non-conflict areas, anecdotal evidence suggests that intimate partner and domestic violence frequently occur. Despite the 2006 Congolese Law against Sexual and Gender-Based Violence, the legal system provides little protection to women, and support networks to address this fundamental gender inequality are minimal.

The DRC's GHI strategy outlines a comprehensive gender approach for all USG health programming. Women suffer disproportionately poor health outcomes, which are worsened by the high incidence of SGBV and cultural norms that do not value girls' education or political participation. The USG, in close collaboration with the GDRC and other development partners, will complete a gender analysis that will include all USG agencies and activities in DRC. As part of this analysis, particular attention will focus on how social, economic and political barriers impact the lives and health status of women and girls and the results will be used to design comprehensive and effective programs.

The GDRC has established a national gender coordination working group with the support of the UN agencies. Internally, the USG has an SGBV working group and is in the process of putting in place an

inter-agency gender working group and expects to have a GBV coordinator in place by next year. These working groups will provide a platform to elevate gender issues facing DRC and have a strategic and coordinated approach to support the country. The strategy and the working groups will help ensure that USG HIV activities appropriately incorporate gender sensitive programming. Activities will include an increased focus on counseling for survivors of sexual violence; training of all health workers on integrated messages to raise the awareness around MNCH/HIV, and the provision of post exposure prophylaxis to survivors of sexual violence. Integrating GBV services into all PEPFAR activities, most specifically PMTCT, HIV counseling and testing services, social and behavioral change communication (SBCC), and community based-work, will help achieve greater coverage and momentum for GBV Scale Up. Activities to support this initiative will include: adaption/revision/development of GBV protocols for health care providers ; mapping of existing GBV services; training of health care workers; a baseline survey; inclusion of GBV module to ongoing HIV/AIDS surveillance activities; Incorporation of GBV to the USG-supported Hotline ; development of post-GBV-exposure clinical care package; inclusion of GBV screening in the intake form for the PMTCT Acceleration sites; and provision/inclusion of GBV post-exposure prophylaxis in all PMTCT acceleration sites (2012, all partners). Activities will integrate GDRC national strategies to fight GBV into community-based approaches that explicitly address norms and behaviors, coercion, and women's legal rights and protection related to HIV risk reduction.

Strategic Information
The USG, with input and approval from the GDRC, will continue to promote SI as a foundation for planning and coordination. In order to fully implement innovative prevention programming, the USG requires a comprehensive picture of the following: epidemiologic priorities; geographic distribution of the epidemic and of HIV service sites; financial priorities and expenditures; and provider and partner performance. The USG will obtain this information through mapping exercise; a national M&E reporting data; studies of grantee performance; behavior surveys; and ANC, BSS and DHS surveillance and behavior surveys. The annual ANC will be used to guide PMTCT service delivery, estimate ARV needs for PMTCT and estimating the HIV prevalence in the DRC. This data will also be used to expand PMTCT program coverage and increase the number of ANC sites for the next five years. PMTCT and Blood Safety program evaluations will also be carried out in order to ascertain system capabilities and needs of the program to expand and improve upon current activities. The routine data collected by USG implementing partners will also be shared at the operational level with the HZ management team to enable them to rapidly adjust or tailor activities on ground.

Capacity Building
Challenges in capacity are present at all levels of the health system and affect all areas of the health system including: human resources, coordination and integration; logistics and information systems. The USG will continue to work in close cooperation with the GDRC to implement the GDRC's strategies and improve their systems to provide comprehensive, quality prevention services. Because the capacity building challenges and opportunities are not unique to prevention, please refer to the Governance TAN and the PFIP for more information on capacity building.

Public-Private Partnerships
All the public-private activities described in the PPP section of this DRC FY12 COP will contribute to strengthen the in-country PEPFAR prevention portfolio.

Technical Area: Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	19,116	

HTXS	553,285	0
PDTX	589,451	0
Total Technical Area Planned Funding:	**1,161,852**	**0**

Summary:
TREATMENT TECHNICAL AREA NARRATIVE (TAN)
In the Democratic Republic of Congo (DRC), with a generalized HIV epidemic and prevalence rate of 1.3% (2007 DHS), the UNAIDS HIV modeling data (EPP Spectrum) estimated that approximately 1.1 million Congolese will be infected with HIV by 2012, and that almost 260,000 Congolese will be eligible for ART treatment. However, even with support from the Global Fund (GF) Round 8, in DRC, only an estimated 10% of individuals eligible for ART are receiving treatment and only 5% of eligible women have access to PMTCT services. In part, this is largely a result of multiple factors including low funding for HIV/AIDS and weaknesses in the health system including unreliable lab services, weak consistent supply chain systems leading to stock-outs, insufficiently trained staff, stigma and discrimination. Major challenges to availability of HIV drugs are the termination of Clinton HIV/AIDS Initiative (CHAI) as a source of HIV medicines and the deficiencies in Global Fund activities, the key sources of HIV medicines in DRC.

In 2012, PEPFAR programs will continue to support the Government of DRC's (GDRC) goal of providing over 300,000 People Living with HIV/AIDS (PLWHA) with care, treatment, and support services by 2014. Two important aspects of DRC's treatment coordination in 2012 would be the focus on comprehensive program implementation at the Health Zone (HZ) level in the three USG target provinces, and the significance of PMTCT for entry to the adult treatment activities in DRC, given the size of PMTCT programming in relation to other activities. This is in addition to the urban hospital based specialized treatment centers that USG continues to support. These establishments will be at the center stage of providing technical assistance and policy guidance for the aforementioned expansion activities. Also, as significant proportion of DRC's pool of persons under AIDS treatment will be women and family members identified through the PMTCT such a linked cascade of implementation will help leverage resources and assure continuum of care. Thus, PEPFAR will focus on the following treatment improvement objectives in FY 2012:

1) Comprehensive care programs including HTC, home-based care, positive living, income generating activities (IGA), staging for ART where appropriate, including CD4 testing, cotrimoxazole (CTX) prophylaxis, TB screening, nutritional support, and prevention with discordant couples;
2) Improved referrals and linkages between care and treatment services, especially regarding community and facility based activities, including the evolution of PMTCT as point of entry for a significant proportion of persons enrolled in treatment;
3) Expanding access to care and treatment services by providing care for the management of opportunistic infections in HZ and in urban treatment centers;
4) Expanding and improving the quality of laboratory services for HIV diagnosis and monitoring;
5) Extensive investment in human resources for health (HRH) through pre and in-service training of healthcare and community care providers including the roll-out of NEPI; and
6) Strengthening the capacity of the national supply chain system.

Additionally, to address a critical shortfall in access to PMTCT services including from the termination of CHAI and challenges faced by the Global Fund activities, the USG is scaling up activities to provide 18 months of ARV treatment for mothers and infants through the PMTCT Acceleration Plan (please see the PMTCT acceleration plan for details). Currently in the DRC, the USG only purchases PMTCT-related ARVs. Building on our PMTCT Acceleration, if the PEPFAR program in DRC receives additional funds, it

will start the provision of ARVs to mothers and their families identified through PMTCT outreach.

Adult Treatment

Access and Integration
In July 2010, revisions of the ARV treatment protocols, in line with WHO recommendations, were incorporated into the DRC national HIV program. Included in the revisions is the protocol change to earlier ARV-initiation, by changing the recommended CD4 count from 200 to 350. This shift in protocol has substantial cost implications for the country, as the new protocol significantly increases the number of individuals eligible for ARV treatment. As part of the revisions, AZT and Tenofivir are the recommended first-line drugs, and Stavudine (d4T) was removed. The USG PMTCT scale-up efforts are being developed in accordance with national guidelines. ARV eligibility is assessed according to WHO recommendations. Patients are seen monthly for the first three months of participation and then every three months thereafter. For pregnant women, the following protocols were established:
Maternal ART as soon as feasible (as early as 14 weeks into pregnancy):
• For women with CD4 count =350 cells/mm3 (with the intent to leave them on lifelong therapy), a triple ARV regimen (one of three options including AZT+3TC+NVP, AZT+3TC+EFV, TDF+3TC (or FTC) + NVP, or TDF + 3TC (or FTC) + EFV), to continue for the rest of the women's life.
• For women taking ART for prophylaxis the protocol is AZT antepartum twice daily, and single dose Nevirapine (sd-NVP) at the onset of delivery, then twice daily AZT+3TC for 7 days postpartum.

At the community level, focusing on the Health Zones (HZ), the USG supports the provision of basic care and support to PLWHA in Lubumbashi, Matadi, and Bukavu through an integrated home-based care program that connects PLWHA and OVC with treatment and other health and social services. Additional comprehensive care and treatment services include prevention and treatment of opportunistic infections (OIs) and other HIV/AIDS-related complications including malaria and diarrhea. PEPFAR-supported health facilities provide access to pharmaceuticals, insecticide treated nets, laboratory services, pain and symptom relief, and nutritional assessment and support. In 2012, funds will continue to support care and treatment services in clinical and community based settings using family-centered approach.

The USG program supports TB clinics in four provinces with integrated comprehensive HIV-TB care. Other USG programs and partners are supporting the procurement of HIV tests kits, reagents for TB diagnosis, and strengthening TB laboratories to improve case detection and management of MDR-TB and XDR-TB. In FY 2011, PEPFAR supported the provision of integrated TB-HIV services, including PITC, CTX prophylaxis and referrals to treatment sites for TB/HIV+ patients, in 49 Centre de Diagnostic et de Treatment (CSDTs) in Kinshasa and 6 CSDT in Kisangani. The USG programming will continue to build on these successes, and continue expanding towards service integration in all eighty target health zones. Specific activities will be focused on strengthening local capacity to better manage TB and TB/HIV co-infection and promote PITC for TB patients. With COP12 funding, the USG partners will be expanding TB/HIV activities into 28 additional CSDTs in Kinshasa, and 7 in Kisangani.
USG partners have successfully piloted task shifting strategies in TB clinics at the primary health care level. For example, it has been found that ARV nurses were able to initiate ART for TB/HIV co-infected patients with very limited doctors' supervision. Another example is a pilot project involving adding HTC to the workload of TB nurses found that the task could be shifted with a minimal increase in burden for the TB nurses. The results of these studies are being used to develop a national policy and practice guidelines regarding task shifting for ART provision by nurses.

Quality and Oversight
In DRC there is no national or regional monitoring system of first line drug resistance. Identification and management of treatment failure are carried out by implementing partners. Data is facilitated through viral load and CD4 monitoring. A national or regional pharmacovigilance system and ARV emergency contingency plan in DRC does not exist. However, several PEPFAR partners are working in areas of

pharmaceutical systems strengthening; focusing on improving commodities policies and pharmacovigalence, and establishing monitoring and oversight mechanisms. The USG will leverage expertise and technical assistance from new partners to help develop both a pharmacovigalence system and plans for supporting ART programs in emergency situations.

Sustainability and Efficiency
Expenditure and cost modeling data is used to encourage long-term sustainability of treatment activities. As indicated above, the changes in the national treatment guidelines has significant implications for the long-term sustainability of treatment activities, especially in light of the current unmet needs and the challenges faced by the GF programs. In HZ where Global Fund (GF) and PEPFAR activities overlap, PEPFAR sites rely on the GF to provide ARVs. With the suspension of GF Round 11 development for DRC, it is expected that the country will have to face some ARV provision issues in the upcoming years. Efforts will be made to better address the issue during the GF Consolidation Plan to be taken in place by mid-March 2011.The USG and other donors are providing technical assistance to Principal Recipients (PR) and to the County Coordinating Mechanism (CCM) to strengthen their capacity in grant management.

Following a feasibility study in 2002, the GDRC established the National System for Procurement of Essential Medicines (SNAME) to centralize essential medicine procurement and decentralize the distribution of commodities through a network of Regional Distribution Centers (CDRs). The MOH has contracted with FEDECAME (private sector national medical store) for all public sector pharmaceutical procurement in order to leverage economies of scale. FEDECAME, with external technical assistance is responsible for:
• Conducting limited procurements for the public sector pharmaceutical supply system;
• Ensuring the quality of the products procured for the public health sector pharmaceutical supply system;
• Providing technical and logistical support for the CDRs within SNAME to strengthen the supply chain system.

Pediatric HIV Treatment
In DRC, young children ages 0-4 years bear the burden of pediatric HIV infection. The UNAIDS EPP projected that in 2009, 109,250 children under the age of 15 were living with HIV, of which 41,603 needed ARV and 227,542 needed CTX prophylaxis. In addition, 30,868 new pediatric HIV cases were projected in 2010. In 2010, the PNLS reported that 5,937 children received ARVs (coverage rate, <17%) and about 4,000 children received CTX prophylaxis (coverage rate, <2%). Because only 17% of pediatric cases are currently receiving ARV treatment, projections of ARV pharmaceutical needs should take into account those pediatric cases currently receiving medication, those recently diagnosed that meet criteria for treatment, as well as previously diagnosed cases now clinically eligible for treatment. Two year estimates for lifelong ARV drug regimens for pediatric cases exceed 70,000. PMTCT services are currently only available in a few selected maternities and health zones through donor programs such as the GF and only 2.2% of women receive a complete package of PMTCT services, leading to an increase in pediatric HIV.

To date, there is only one Early Infant Diagnosis (EID) laboratory in DRC based in Kinshasa. It has been a burden to ship all samples (DBS) from PMTCT sites throughout the country to Kinshasa National Referral Laboratory. Cultural norms which establish women as the sole caregivers, excluding male involvement, hinder the opportunity for a family-centered approach to reach HIV+ children. Other challenges affecting HIV pediatric care include:
(1) Procurement of ARVs, OI drugs, and other HIV commodities for infants, especially following the close-out of Clinton Foundation activities in DRC by December 2012;
(2) Low retention of children in clinical care following birth;
(3) Malnutrition and ART dosing;
(4) Cost and obtaining assent for HIV testing and disclosure to children; and

(5) Stigma, discrimination, and ill-treatment of HIV+ children by parents and guardians.

Key Priorities and Major Goals for FY12-13
Key pediatric treatment priorities for PEPFAR DRC in the next two years include:
• Improving pediatric HIV data collection, analysis and use at national levels and in USG-supported programs for program and policy improvement;
• Continuing collaborative scale-up efforts to increase the number of children accessing treatment and improve AIDS-free survival;
• Improving early treatment initiation in young infants;
• Improving outcome monitoring of children enrolled in care (morbidity, mortality, growth), HIV drug resistance;
• Increasing retention of children in clinical care; and
• Expanding quality treatment services for adolescents.

The USG will also continue to work with the GDRC to (1) ensure continuous, quality supplies of pediatric ARVs, and to strengthen policies and forecasting systems, (2) prioritize the Expansion of EID for early identification of HIV-exposed infants born from HIV positive mothers, and (3) initiate ART for those less than 18 months of age to reduce disease progression and death in infants. The USG will continue supporting the development of a Center of Excellence at Kalembelembe Pediatric Hospital, which is centrally located in Kinshasa. At this Center, capacity of clinical teams including physicians, nurses, pharmacists and social workers will be strengthened in the management of HIV/AIDS pediatric cases.

Alignment with Government Strategies and Priorities
PEPFAR, in collaboration with the GDRC and key stakeholders plans to support care and treatment activities through the provision of ARVs and will implement a new policy regarding EID for HIV-exposed children in order to improve access to care and treatment services. Furthermore, the MOH has set ambitious goals of eliminating MTCT in DRC by 2015. PEPFAR will contribute to the MOH goal of eliminating MTCT in DRC by 2015 by expanding PMTCT activities to increase testing in high-volume, high-prevalence maternities and implementing the WHO PMTCT treatment guidelines adopted by GDRC and through programmatic integration with the PNLS (national AIDS program) five-year strategic plan. In 2012, efforts will be directed toward strengthening the GDRC capacity to coordinate, monitor, and evaluate interventions, train healthcare providers in pediatric comprehensive care, and streamline the referral and enrollment of those who are ineligible for ART into comprehensive care programs. Linkages will be developed between USG funded primary health care activities and PEPFAR funded activities in order to develop a strong referral network for infants and children in need of care and treatment services. Children will also benefit from community-based care efforts and activities.

Policy Advances or Challenges (identified in PF/PFIP)
The DRC HIV guidelines were updated following WHO 2010 recommendations for treatment of children, which was a goal in the 2009 partnership framework. The new guidelines establish the following protocols for prophylaxis for infants born to pregnant women on ART:
• For infants born to mothers on ARV for their own health, daily NVP or twice daily AZT until 4-6 weeks post-partum, irrespective of mode of infant feeding.
• For infants born to women taking ARV only for prophylaxis:
• Breastfeeding (BF): NVP for 4-6 weeks and until 1 week after complete BF cessation
• Replacement feeding only: daily NVP or sd-NVP +twice daily AZT from birth until 4-6 weeks of age.

Efforts to Achieve Efficiencies
In DRC, PEPFAR is implementing an integrated model, maximizing each partner's comparative advantage to avoid any duplication in services. Efforts to achieve efficiencies while improving diagnostic opportunities and treatment have focused mainly on the integration of pediatric care into a protocol-driven family-centered model in which a comprehensive package of services is provided. For example, each

pediatric patient at the USG Center of Excellence undergoes a comprehensive baseline assessment including the collection of personal information, clinical examination, nutritional screening, TB screening, laboratory assessment and psychosocial evaluation. HIV disease staging by clinical assessment and CD4 count determines the schedule of routine follow-up visits for the patient. PEPFAR funding is strengthening community-based HIV support groups for families of infected children by creating a greater continuum of response. For example integrated interventions include: 1) home visits targeting orphans 2) follow-up for missed appointments of ARV patients 3) assessments of adherence to ARV treatment regimens 4) linkages to available social services, and 5) instructions on home-based health care. Psychological support is provided on coping with illness and care-giving, as well as the grieving process following the death of a family member.

Efforts to decentralize pediatric HIV care include the creation and maintenance of a telemedicine system through the Center of Excellence to allow consultations of expert clinicians outside of Kinshasa as well as to mentor and provide access and information to clinicians in Kinshasa. With 2012 funds the USG, in collaboration with the GDRC, plans to develop a rational list of pediatric ARVs in order to simplify drug forecasting, facilitate procurement, increase the use of FDCs, and minimize redundancies. Using PMTCT Acceleration Plan funding, USG will support the GDRC to establish a new EID laboratory for early diagnosis of HIV infected kids at the PNLS provincial laboratory in Lubumbashi, Katanga Province.

Health Systems Strengthening Efforts to improve pediatric HIV programs
PEPFAR plans to expand and improve the capacity of staff to adequately respond to increases in pediatric HIV service uptake through pre-service and in-service trainings, workshops and intensive supportive supervision to assure that an increased number of pediatric clients obtain access to adequate pharmaceuticals and medical monitoring. From a long term perspective, implementation of NEPI in DRC, and the proposed leveraging of NEPI with PMTCT plan will help DRC address some training issues of the nursing staff.

Cross-cutting Priorities
Supply Chain Management Systems
The DRC partnership framework and implementation plan are designed to complement GF programs, which are the primary ARV providers. The GF focuses on providing adult ARVs and HIV commodities such as HIV rapid tests, reagents, CD4 tests, and OI medications. However, the reliability of the supply chain for HIV commodities, including ARVs, is problematic and stock outs occur frequently. Under the GHI, the USG considers the strengthening of FEDECAME as critical to long term sustainability and has the potential to lead to better drug availability, cost effectiveness, reduction of drug stock-outs, and ultimately leading to the improved health of the population. While USG buy-in to FEDECAME is being pilot tested over the next two years, the USG will consolidate the purchase of majority of all USG commodities via SCMS. To strengthen DRC's logistic and pharmaceutical system, the USG will support the finalization of the Procurement and Supply Management (PSM) procedures manual with participation from the GF. In 2012, the USG will continue supporting the GDRC to improve drug management, logistics and distribution by 1) increasing the rational use of funding for essential drugs; 2) improving coordination of procurement of essential drugs; and 3) strengthening the capacity of the national supply chain system. Additionally, the USG and its partners are working with the PNLS on developing an ARV buffer stock system and standard operating procedures.

Laboratory
The USG supports the ongoing national laboratory policy development. USG will support a HIV laboratory training site at the KSPH that conducts pre-service and in-service training in HIV laboratory techniques and procedures for students enrolled at the Laboratory Technician Institutes, the KSPH, and the University of Kinshasa Medical School. Technical trainings are provided to improve competency in diagnosis and monitoring through the use of CD4 FACS count, DNA PCR machines, HIV rapid tests, and microscopes. The public private partnership that is being established with Benton-Dickinson, “The

Regional Laboratory Training Center" will help institutionalize and streamline and consolidate the many training activities.

Gender
HIV disproportionately affects women in DRC (2007 DHS, prevalence among 15-49 year old women, 1.6% vs. men 0.9%). Prevalence rates among women peak at 4.4% in the 40-44 age cohort. The DRC's 2011 Antenatal Care Surveillance (ANC) data revealed an HIV prevalence of 3.2% among pregnant women attending ANC sentinel sites, with prevalence as high as 6.9% in urban Tshikapa and 8.1% in rural Lodja.

According to the most recent SAPR results, treatment targets for females were met or exceeded, however only 27% of the target for males age 15 or older were met. Conversely, only 33% of the target was met for pregnant women receiving ART. In alignment with the GHI strategy, USG programs will target women, girls and mainstream gender equality in all activities.

The acceleration of PMTCT in DRC attests to PEPFAR emphasis on gender. The PMTCT acceleration plan fully incorporates gender based violence screening, prevention and treatment protocols. Each PMTCT service recipient will be screened for SGBV and referred to or provided relevant management.

Strategic Information
The national program collects data on multiple aspects of pediatric diagnosis, care, and treatment in DRC. In collaboration with partners, this information is used to project care and treatment needs inclusive of ARV procurement and distribution. The USG is currently providing assistance in rolling out an Electronic Dispensing Tool in public sector facilities. This tool facilitates data collection, reporting, and capacity building to empower staff to effectively utilize the data for treatment monitoring, drug forecasting, and decision making. Medical monitoring is a critical component of medical staff training and clinical care. Currently, HIV-infected children are monitored on therapy every three months. These patients will continue to be assessed by a nurse who monitors weight, ARV dosing, and drug adherence by administering a questionnaire and comparing responses to a pill count which is tracked in a pharmacy database. In 2012, this data will be reviewed and analyzed with the intent to improve the identification of infants that may have experienced treatment failure and/or drug resistance.

Capacity Building
PEPFAR and the GDRC, in collaboration with other stakeholders, will continue to support need-based, capacity-building objectives in FY 2012. The GDRC capacity will be strengthened to coordinate, monitor, and evaluate interventions, train healthcare providers in comprehensive care, and streamline the referral and enrollment of those who are ineligible for ART into needs-based care programs. Activities will strengthen civil society's capacity to engage and mobilize communities and PLWHA to catalyze sustainable self-help activities and provide a comprehensive needs-based response. In addition to the training opportunities provided by Pediatric Center of Excellence, NEPI, and the PMTCT AP, health care worker capacity to provide quality treatment services will continue to be facilitated by training opportunities that include instruction on ARV and laboratory supplies stock management and forecasting needs.

Public Private Partnerships
Through a partnership with Freeport McMoran/Tenke Fungurume Mining Company, a reference hospital and reference health center in Tenke will be built, and health center staff will be trained in the HIV continuum of response, including treatment services. In DRC, FBO hold more than 40 % of health facilities. In the targeted health zone with FBO facilities, their involvement will be emphasized for more sustainability. "The Regional Laboratory Training Center" based at the Kinshasa School of Public Health PPP with Becton Dickinson is to be established in 2012.

MARPS (Most-at-Risk-Populations)
DRC's generalized HIV epidemic is driven primarily through MARPs and the general population engaging in high risk activities. The PNLS estimates that national prevalence among commercial sex workers is 16.9% and higher in some provincial capitals. An HIV prevalence survey in the Kinshasa military region reports that the prevalence among women is 7.5% compared to 3.6% among men (2008). This COP will provide support to the only one existing specialized clinic for commercial sex workers (CSW) established in Kinshasa and support the GDRC to develop a comprehensive strategy to improve access to prevention, care and treatment in this population. DHS 2007 indicates that rates of condom use in DRC vary in different MARP populations (4%-72%), and also remain low in the general population (less than 30%). Nationally, truck drivers demonstrate a prevalence of 3.3%, however, in Katanga (a USG focus province); long-haul truckers from Southern African countries have an approximate prevalence of 7.8%.

The USG prioritizes targeted, comprehensive prevention programs among persons engaging in high-risk behavior while also addressing risks for youth and the general population. The USG supports projects which target MARPs in geographic hotspots, focusing on locations frequented by commercial sex workers, and transit routes traveled by truckers. These activities often focus on prevention and HTC, with linkages and referrals to treatment facilities and psychosocial support.

Human Resources for Health
Human Resources for Health are one of DRC's greatest challenges in achieving a functional and efficient health system. Primarily the qualities of facility provider's skills are weak and staffs infrequently receive their salaries. Therefore, health care workers often demand unofficial payments and are unable to provide basic care services. Cost and poor outcomes deter clients from seeking care. Preventive measures including vaccination, hygiene, sanitation, and public infrastructure have been neglected for years resulting in recurrent epidemics of communicable diseases, such as measles, typhoid fever, and cholera. Without a task-shifting policy, nurse practitioners cannot prescribe ART, which would ease some of the treatment burden currently placed on a limited number of doctors in the country.

With USG support, the Center of Excellence intends to train teams of healthcare workers in the provision of pediatric care and treatment services, including taking advantage of improved technology, thereby increasing access to training opportunities for clinicians outside of Kinshasa. In addition, PEPFAR supports human and institutional capacity development at the health facilities, health zones, and provincial levels to directly address technical issues that impede service provision. NEPI, a new addition to USG support in DRC, and the "The Regional Laboratory Training Center" will add to training resources for treatment.

Way Forward

Operating within the many constraints unique to DRC, following the withdrawal of CHAI and consolidation of GF as the two major sources of HIV treatment, PEPFAR has emerged as a major bilateral partner for treatment. USG supports all major pillars of HIV/AIDS programming and has been the pioneer in the establishment of HIV/AIDS adult and pediatric treatment centers and clinical centers of excellence and supporting laboratory infrastructure. PEPFAR DRC's strategy for scale-up would focus on continued support for the established clinical centers in urban areas and leveraging the expertise in these centers to support the 2012 priorities of expanding treatment services in HZ's within Katanga, Kinshasa, and Orientale and the use of high HIV prevalence and HIV volume maternities as point of entry for a significant proportion of a family centered treatment plan, and with the expectation that GF would remain the provider of ARVs to the general population. The interagency roll-out of the scale-up will maximizes strategic advantages such as CDC's expertise in lab, USAID's expertise in OVC and DOD's expertise in working with military/police populations. Implementation of human resources development programs such as the NEPI, ad-hoc training programs offered by USG, including support for supply chain management of drugs and essential commodities at HZ and Central level, and via the "Regional

Laboratory Training Center" will give the DRC the tools it needs to strengthen efforts to achieve its goal of elimination of MTCT by 2015. In 2012, PEPFAR programs will continue to support the Government of DRC's (GDRC) goal of providing over 300,000 People Living with HIV/AIDS (PLWHA) with care, treatment, and support services by 2014. Availability of additional external resources would help DRC realize meet these goals in expanding treatment to more women, men, children and families affected with HIV/AIDS.

Technical Area Summary Indicators and Targets

Future fiscal year targets are redacted.

Indicator Number	Label	2012	Justification
P1.1.D	P1.1.D Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	n/a	Redacted
	Number of pregnant women who were tested for HIV and know their results	367,464	
P1.2.D	P1.2.D Number and percent of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery	96 %	Redacted
	Number of HIV-positive pregnant women who received antiretrovirals (ARVs) to reduce risk of mother-to-child-transmission	6,627	
	Number of HIV-positive pregnant women identified in	6,918	

	the reporting period (including known HIV-positive at entry)		
	Life-long ART (including Option B+)	1,660	
	Newly initiated on treatment during current pregnancy (subset of life-long ART)		
	Already on treatment at the beginning of the current pregnancy (subset of life-long ART)		
	Maternal triple ARV prophylaxis (prophylaxis component of WHO Option B during pregnancy and delivery)	604	
	Maternal AZT (prophylaxis component of WHO Option A during pregnancy and deliverY)	2,841	
	Single-dose nevirapine (with or without tail)	1,522	
P6.1.D	Number of persons provided with post-exposure prophylaxis (PEP) for risk of HIV infection	1,500	Redacted

	through occupational and/or non-occupational exposure to HIV.		
	By Exposure Type: Occupational	55	
	By Exposure Type: Other non-occupational	15	
	By Exposure Type: Rape/sexual assault victims	1,430	
P7.1.D	P7.1.D Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of 'Prevention with PLHIV (PLHIV) interventions	n/a	Redacted
	Number of People Living with HIV/AIDS reached with a minimum package of 'Prevention of People Living with HIV (PLHIV) interventions	12,685	
P8.1.D	P8.1.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the	n/a	Redacted

	minimum standards required		
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are based on evidence and/or meet the minimum standards required	1,102,571	
P8.2.D	P8.2.D Number of the targeted population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of the target population reached with individual and/or small group level HIV prevention interventions that are primarily focused on abstinence and/or being faithful, and are based on evidence	419,214	

	and/or meet the minimum standards required		
P8.3.D	P8.3.D Number of MARP reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	n/a	Redacted
	Number of MARP reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	99,216	
	By MARP Type: CSW	22,870	
	By MARP Type: IDU	0	
	By MARP Type: MSM	1,785	
	Other Vulnerable Populations	74,561	
P11.1.D	Number of individuals who received T&C services for HIV and received their test results during the past 12 months	722,082	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		

	By Age: <15	10,228	
	By Age/Sex: 15+ Female		
	By Age: 15+	711,854	
	By Age/Sex: 15+ Male		
	By Sex: Female	534,680	
	By Sex: Male	187,402	
	By Test Result: Negative		
	By Test Result: Positive		
P12.5.D	By age: 0-4	0	Redacted
	By age: 10-14	11,521	
	By age: 15-17	27,372	
	By age: 18-24	64,094	
	By age: 25+	56,013	
	By age: 5-9	678	
	By geography: Districts*	0	
	By sex: Female	51,051	
	By sex: Male	108,627	
	Number of adults and children reached by an individual, small group, or community-level intervention or service that explicitly addresses gender-based violence and coercion	159,678	
P12.6.D	By age: 0-4	0	Redacted
	By age: 10-14	85	
	By age: 15-17	481	

	By age: 18-24	1,190	
	By age: 25+	4,750	
	By age: 5-9	0	
	By sex: Female	5,546	
	By sex: Male	960	
	By type of service: GBV screening	1,920	
	Number of GBV-related service-encounters	6,506	
	By type of service: Post GBV-care	4,970	
P12.7.D	P12.7.D Percentage of health facilities with Gender-Based Violence and Coercion (GBV) services available (GBV pilot indicator)	n/a	Redacted
	Number of health facilities reporting that they offer (1) GBV screening and/or (2) assessment and provision or referral to the relevant service components for the management of GBV-related health needs	15	
	Total number of health facilities in the region or country being measured.	0	
	By type of facility:	10	

	clinical		
	By type of facility: community	5	
	By type of service: GBV screening	8	
	By type of service: Post GBV-care	15	
C1.1.D	Number of adults and children provided with a minimum of one care service	165,542	Redacted
	By Age/Sex: <18 Female		
	By Age/Sex: <18 Male		
	By Age: <18	19,945	
	By Age/Sex: 18+ Female		
	By Age: 18+	145,597	
	By Age/Sex: 18+ Male		
	By Sex: Female	89,504	
	By Sex: Male	76,038	
C2.1.D	Number of HIV-positive individuals receiving a minimum of one clinical service	20,910	Redacted
	By Age/Sex: <15 Female		
	By Age/Sex: <15 Male		
	By Age: <15	2,912	
	By Age/Sex: 15+ Female		
	By Age: 15+	17,998	
	By Age/Sex: 15+ Male		

	By Sex: Female	13,693	
	By Sex: Male	7,217	
C2.2.D	C2.2.D Percent of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	97 %	Redacted
	Number of HIV-positive persons receiving Cotrimoxizole (CTX) prophylaxis	20,383	
	Number of HIV-positive individuals receiving a minimum of one clinical service	20,910	
C2.3.D	C2.3.D Number of HIV-positive clinically malnourished clients who received therapeutic or supplementary food	n/a	Redacted
	Number of clinically malnourished clients who received therapeutic and/or supplementary food during the reporting period.	2,340	
	Number of clients who were nutritionally assessed and found to be clinically malnourished during the reporting period.		

	By Age: <18		
	By Age: 18+		
C2.4.D	C2.4.D TB/HIV: Percent of HIV-positive patients who were screened for TB in HIV care or treatment setting	66 %	Redacted
	Number of HIV-positive patients who were screened for TB in HIV care or treatment setting	13,733	
	Number of HIV-positive individuals receiving a minimum of one clinical service	20,910	
C2.5.D	C2.5.D TB/HIV: Percent of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	9 %	Redacted
	Number of HIV-positive patients in HIV care who started TB treatment	1,859	
	Number of HIV-positive individuals receiving a minimum of one clinical service	20,910	
C4.1.D	C4.1.D Percent of infants born to	39 %	Redacted

	HIV-positive women who received an HIV test within 12 months of birth		
	Number of infants who received an HIV test within 12 months of birth during the reporting period	2,283	
	Number of HIV-positive pregnant women identified in the reporting period (include known HIV-positive at entry)	5,838	
	By timing and type of test: either virologically between 2 and 12 months or serology between 9 and 12 months	632	
	By timing and type of test: virological testing in the first 2 months	1,651	
C5.1.D	By Age: <18	5,803	Redacted
	By Age: 18+	8,060	
	Number of adults and children who received food and/or nutrition services during the reporting period	13,863	
	By: Pregnant Women or Lactating Women	2,444	
T1.1.D	By Age/Sex: <15 Female	518	Redacted

	By Age/Sex: <15 Male	492	
	By Age/Sex: 15+ Female	3,284	
	By Age/Sex: 15+ Male	2,011	
	By Age: <1	334	
	By: Pregnant Women	1,424	
	Number of adults and children with advanced HIV infection newly enrolled on ART	6,305	
T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART)	9,182	Redacted
	By Age/Sex: <15 Female	834	
	By Age/Sex: <15 Male	760	
	By Age/Sex: 15+ Female	4,380	
	By Age/Sex: 15+ Male	3,208	
	By Age: <1	77	
T1.3.D	T1.3.D Percent of adults and children known to be alive and on treatment 12 months after initiation of antiretroviral therapy	86 %	Redacted
	Number of adults and children who are still alive and on treatment at 12 months after	1,579	

	initiating ART		
	Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.	1,828	
	By Age: <15	250	
	By Age: 15+	1,329	
H1.1.D	Number of testing facilities (laboratories) with capacity to perform clinical laboratory tests	53	Redacted
H1.2.D	Number of testing facilities (laboratories) that are accredited according to national or international standards	1	Redacted
H2.1.D	Number of new health care workers who graduated from a pre-service training institution or program	3,787	Redacted
	By Cadre: Doctors	305	
	By Cadre: Midwives	325	
	By Cadre: Nurses	3,157	
H2.3.D	The number of health care workers who	4,013	Redacted

	successfully completed an in-service training program		
	By Type of Training: Male Circumcision	0	
	By Type of Training: Pediatric Treatment	0	

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7500	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-USAID	8,205,402
10610	University of North Carolina	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,296,803
10612	Kinshasa School of Public Health	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1,235,000
11054	Population Services International	NGO	U.S. Department of Defense	GHP-State	0
11060	CONGO AMERICAN LANGUAGE INSTITUTE	NGO	U.S. Department of State/Bureau of African Affairs	GHP-State	50,000
12041	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	50,000
12991	TBD	TBD	Redacted	Redacted	Redacted
12996	U.S. Department	Other USG	U.S. Department	GHP-State	50,000

	of State	Agency	of State/Bureau of African Affairs		
13009	Population Services International	NGO	U.S. Department of Defense	GHP-State	0
13010	Management Sciences for Health	NGO	U.S. Agency for International Development	GHP-State	1,537,727
13017	American Society for Microbiology	Private Contractor	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1
13094	Association of Public Health Laboratories	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	1
13183	Programme National de Lutte contre le VIH/SIDA et IST	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	200,001
13338	Tulane University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	79,769

13386	Population Services International	NGO	U.S. Agency for International Development	GHP-State	0
13476	International Center for AIDS Care and Treatment Programs, Columbia University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	2,273,585
13537	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-State	0
13542	Programme National de Transfusion et Sécurité Sanguine	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	722,639
13595	FHI 360	NGO	U.S. Agency for International Development	GHP-State, GHP-USAID	200,000
13623	FHI 360	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	50,000
13696	Partnership for Supply Chain Management	Private Contractor	U.S. Agency for International Development	GHP-State	2,719,133
13703	Management Sciences for	NGO	U.S. Agency for International	GHP-State, GHP-USAID	610,000

	Health		Development		
13730	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHP-State	178,000
14611	Program for Appropriate Technology in Health	NGO	U.S. Agency for International Development	GHP-State	257,000
14612	World Health Organization	Multi-lateral Agency	U.S. Agency for International Development	GHP-State	0
14809	FHI 360	NGO	U.S. Agency for International Development	GHP-USAID	251,200
14815	TBD	TBD	Redacted	Redacted	Redacted
14827	ICF Macro	Private Contractor	U.S. Agency for International Development	GHP-State	250,000
14831	U.S. Department of State	Other USG Agency	U.S. Department of State/Bureau of African Affairs	GHP-State	200,000

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7500	**Mechanism Name: AIDS Support and Technical Resources (AIDSTAR) - INTEGRATED HIV/AIDS PROGRAM IN DRC (ProVIC: Program de VIH Intégré au Congo)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 8,205,402	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	8,205,402

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The DRC Integrated HIV/AIDS Project (ProVIC) aims at reducing the incidence and prevalence of HIV and mitigate its impact on people living with HIV/AIDS (PLWHA) and their families. This objective will be achieved by: improving HIV/AIDS prevention, care and treatment services in 40 Champion Communities located in the 5 provinces of project (Bas Congo, Katanga, Kinshasa, Sud Kivu, and Orientale); increasing community involvement in health issues and services through sustainable community-based approaches; increasing the capacity of government and local civil-society partners — and thereby empowering new local organizations and communities — to plan, manage, and deliver quality HIV/AIDS services. ProVIC intends to work with and through grantees, and in collaboration with national government programs and other USG partners to ensure the achievement of its three intermediate results (IR): 1) HIV counseling, testing and prevention expanded and improves in target areas; 2) are, support, and treatment for PLWHA and (OVC) improved in target areas; and 3) health systems supported and

strengthened in target zones. The project is closely working with government counterparts and the Champion Communities to ensure ongoing capacitation and effective transfer of skills, knowledge and best practices.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	1,000,000
Food and Nutrition: Commodities	300,000
Food and Nutrition: Policy, Tools, and Service Delivery	200,000
Gender: Reducing Violence and Coercion	500,000
Human Resources for Health	300,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Mobile Population
TB
Family Planning

Budget Code Information

Mechanism ID:	7500
Mechanism Name:	AIDS Support and Technical Resources (AIDSTAR) - INTEGRATED HIV/AIDS PROGRAM IN DRC (ProVIC: Program de VIH Intégré au Congo)
Prime Partner Name:	Program for Appropriate Technology in Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	1,312,864	0

Narrative:

Since Year 2, three approaches have been introduced to work with adult PLWHA in the community: the positive living; the positive prevention strategy; and the palliative care strategy. The target populations are adolescents, adults and their families living in and around champion communities. Year 3 will continue these approaches, framed within an overarching strategy to build both resilience and capacity in the community increasing the number of people in target groups reached. Self-help groups (SHG), introduced in year 2, will be developed and strengthened and most importantly linked into the champion communities and health services in their community. The SHG will use a problem solving approach to look at common issues and use the forum to discuss and address these issues. The care givers will make regular visits to SHGs to identify those who need specific support and will make home care visits providing psychological, social, spiritual support and/or palliative care. They will also follow up on missing PLWHA, sick persons, families facing death, family facing stigma/discrimination, etc. PLWHA will be referred to SHG from other components of ProVIC project (HTC, PMCTC and medical or community structures) and they will be referred from SHG to community health facilities to address malnutrition and other OI, to NGO specialized in protection of vulnerable people to address legal issues. PLWHA will be linked to microfinance institutions in their area to get money for IGA to ensure their autonomy. Through the strategy above, the project responds to 2 and 3 priorities actions area of National strategic Plan against HIV/Aids and PEPFAR guidelines.

To ensure the quality of services, the project will create a format for keeping individual social and medical records. The Care and Support Specialist will train the nutritionist and care givers or social workers on how to complete these forms and also train the grantees on how to analyze the forms. They in turn will train the facilitators and members of the group on how to maintain the form and how to review them on a regular basis so that health and social needs are monitored and needs are referred, with the end result of improving overall wellbeing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	2,133,405	0

Narrative:

The ProVIC strategy is family focused, offering both comprehensive and coordinated care that addresses

the needs of adults and children in a family. It meets the health and social care needs of OVCs, either directly or indirectly through strategic partnerships and/or referrals to other service providers. The project links care and support work for OVC with care and support with the families in which they are situated because it's in the families where decisions are made concerning a child's welfare.

The project focuses on children between 0 and 17 year old distributed in different groups (0-1, 2-5, 6-14, 15-17 years). Focus is on girls and boys living in and around champion communities. The main activities are centered on children's welfare by providing health referral, food and nutritional support, access to school or training OVC in social entrepreneurship to get them autonomous, addressing child protection issues and OVC's phase-out plan.
The child to child approach is the main strategy for addressing the care and support needs of OVC. This approach, rooted in health communication, encourages children to play an active and central role in their own development. It is based on the belief that children can be actively involved in their communities and in solving community problems. it involves children in activities that interest, challenge and empower them with the aim of achieving positive change on three levels: 1) Communal impact on families and positive changes in health attitudes and behaviors; 2) personal impact on children involved and strengthening of friendships; and 3) increased respect for children's ideas and abilities.

The success of this project is the creation of child to child group witch help children to find solutions of their own problems to improve families and community's welfare. However, the biggest challenge was to ensure a quality service delivered. The project is planning new improvements. For example in OVC schooling, the project will progressively move from paying school fees and kits to one time "block grant" investment to ensure sustainability. At the same time, grantees will be trained on strategies to help communities become more autonomous.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	328,216	0

Narrative:

In year 2, ProVIC provided prophylactic cotromoxazole to 95% of targeted PLHWAs. In 2012,The project will ensure that 100% of PLWHAs are consistently provided with prophylactic cotrimoxazole either by the project or a local health provider, the project will work closely the care givers/facilitators and SHGs through the grantees to ensure there is well stocked supply chain of contrimoxazole to meet the gaps. The project will encourage grantees to work with SHGs to identify which health centres are not providing cotrimoxazole and encourage them to lobby for it to be provided. The importance of cotrimoxazole will be raised with the SHG by the facilitators trained in the key messages on prevention.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	OHSS	574,379	0

Narrative:

"ProVIC Health Systems Strengthening is designed to address all issues related to the poor quality of service delivery. Support is provided at the national level to refine policies, norms and directives, and activities are rolled out at the provincial level to reinforce providers competency and address some key issues such retention of human resource in their setting, incentive.

In regards to the DRC's highly international aid dependent system and the low financial contribution in the health sector, capacity building faces many challenges which undermine effectiveness of interventions. Planned activities intend to address these challenges by increasing the competency of service's providers, others actors, and also strengthening the system in the provision of the needed resources. ProVIC will work to build sustainability by empowering the community to take over all activities aimed at their wellbeing.

All program intervention areas are concerned with improving the quality of beneficiary's life as a final goal of the program. Activities are driven by program results and limited by the available resources. Integrated services are delivered through the partnership with others actors. Services providers will be trained in PMTCT, HCT, sensitization, laboratory, bio medical waste management, care & support to PLWA, and OVC
NGOs partners will be trained in the organizational development for a greater impact of community interventions.

Collaboration with others partners is a key issue for success. Activities are implemented closely in collaboration with its government counterpart, and achievements are designed according to the national HIV strategic plan. The government provides trainers, and USG partners provide any others needed resources to organize workshops, trainings. Support to the joint supervision and coordination meetings improves the quality of service delivery, and allows for needs based intervention adjustments.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	656,432	0

Narrative:

"The project will use evidence based AB interventions for specific target groups that include young women and men aged 10-14, and 15-24 for abstinence and the couples for being faithful interventions.

The project, via NGOss, will establish collaboration mechanisms with selected schools in the target areas to identify leaders among students, developing and reinforcing their skills based sexuality, knowledge, fidelity practices and norms for mutual respect and open sexual communication. « Champion Youth Club" or student associations will be developed and be used to increase AB behaviors among these specific groups. The members of champion youth club teach themselves to stop the spread of HIV/AIDS. Each leader of the club will receive a kit that contains: HIV visual aids, flyers, pamphlets, any other items.

For young men and women not attending school and street kids, the project will collaborate with NGOs, churches and other community associations involved in care, support and treatment for OVC in project sites. The project will reinforce the capacity of these NGOs/Churches/community associations to identify emerging leaders among young men and women not attending school and street kids, sharpening their skills based sexuality, improve their knowledge about HIV and responsible sexual behaviors and promote fidelity practices, mutual respect and open sexual communication. These young leaders will provide education and information among this specific group; a mobilization kit based on the activities above will be given to each young leader.

With regards to couples, the project via NGOs will collaborate with selected Churches involved in providing programs and services to couples to promote mutual fidelity and respect, open sexual communication, to discourage multiple partnership, sexual violence, provide information and knowledge on HIV-AIDS. The project will reinforce the capacity of these organizations by providing them with materials, training modules and skills needed to achieve the stated activities.

The project expects to reach 129,000 peoples with interventions focused on abstinence and being faithful.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,723,134	0

Narrative:

Three types of HCT services are implemented in ProVIC sites: mobile HCT service, Community based HCT and the provider initiated counseling & testing (PICT)

Adapted equipments (tents) were acquired to run the mobile HCT services for outreach to deliver testing services for MARPS in their setting.
Peer educators are trained to sensitize their peers to adhere to the services. Innovative strategy for instance running the service tonight to reach CSW, MSM is succefully used in different sites. In the

community based HCT, sensitization is done within the champion community's sites, this service is mainly addressed to the Champion Community in order to promote testing & counseling. Community workers refer the clients to the needed services in health or community facilities.

In fact, the PICT strategy, service's providers are trained to initiate the counseling & testing at any contact with the clients and their families during the out-patient or any consultation in the health facility. As needed, referrals are usually used between the PICT and other services within the hospital or community's based service

In order to reduce barrier for access to services, Champion community approach offers an opportunity to reinforce the link between the community and the health facility. The patient seeking behavior is addressed through the identification of available services. In order to ensure the quality of testing services, the facilities perform an internal quality control of sample monthly, and the national laboratory ensures a quarterly randomized control of samples.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,066,702	0

Narrative:

Target Population

Number to be reached by each intervention component

Activity

CSW 14,400 sensitization

MSM 1440 sensitization

TRUCKERS 21,600 sensitization

FISHERMAN 18,000 sensitization

MINERS 16,560 sensitization

GENERAL POPULATION 516,000 sensitization

The project will use a series of interventions based on current evidence-based sexual prevention strategies to reach the general population and specific target group that include MARPs (CSW, MSM, Truckers, Fishermen, Miners and other uniformed services), women and men aged 15-24, 25-34, 35-44 and more than 45. The program strategy is focused on targeting high-risk population through the champion community approach. This will be done by reaching 516,000 people and 72,000 MARPS in 40 traditional communities through 4 ProVIC regions of intervention (Kinshasa, Matadi, Lubumbashi, and Bukavu).

Each Champion Community has at least 40,000 people .

Communities are aware of vulnerable populations and their specific locations. These sites include youth hang-outs, police stations, truck stops, hotels, bars or informal meeting place for commercial sex workers. As such, local communities are key to bringing the problem to light and dealing with it. Through effective communications, open dialogue and interpersonal outreach; community members will encourage people to reject unhealthy behaviors and seek testing, counseling and or care and support.
I
n our work with the communities, we facilitate the development of community objectives and actions that target MARPs. In this way the community becomes responsible for its MARPs, Community volunteers are identified and recruited among all specific groups during the champion community process to provide education and information and to raise awareness and knowledge about the importance of prevention. Those volunteers are used as local resources and community liaisons to promote services. Each community volunteers receives a kit that contains: HIV visuals aids, flyers, pamphlets, any other items required for their activities. Peer educator's training for the community's volunteers is conducted based on the PNLS modules.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	410,270	0

Narrative:

ProVIC PMTCT team will implement "peer to peer sites" in Kinshasa and Katanga. The existing ProVIC sites will serve as central sites to reinforce capacities of peripherals sites in terms of PMTCT. Also, we will organize a tailored TOT for the mentors across the targeted two provinces in 2012 and three others provinces in 2013. The pool of trained trainers and providers will help to scale up PMTCT activities across 5 provinces. In addition, in 2012, we will implement PMTCT activities in 6 news PTMTCT sites in Kisangani. The central sites will become the center of a mentorship and training network for the satellite sites, with providers from the central sites visiting the satellite sites to initiate clients on ART and provide guidance and supportive supervision to PMTCT providers at the satellite sites. The providers from the 6 news PMTCT sites will be trained during the Integrated HIV training. ProVIC PMTCT team will ensure the supplies and commodities provisions in those sites as well as PMTCT implementation. Based on the PMTCT cost estimation in DRC context, ProVIC found that the unit cost for PMTCT is ebtwen US$ 102- US$ 150. Given limited resources but striving to maximize impact and results, ProVIC plans to employ a decentralized approach to PMTCT service provision. At the national level:
In 2012, ProVIC PMTCT team will participate and reinforce the National PMTCT technical group. During this period, the National Technical group will be focused on the Elimination plan development and global fund R11 proposal development, which is focused in PMTCT.
Best practices: In 2012, ProVIC PMTCT team will supervise an international expert who will help to develop a plan to implement "quality improvement" strategies at ProVIC PMTCT sites. Keys ProVIC

technical staff will be trained on the QI approach. QI model will be rolled out to all ProVIC PMTCT sites. We will ensure that the medical wastes are well managed in all the PMTCT sites. . ProVIC PMTCT team will continue working together with Community mobilization team to reinforce the integration of PMTCT targets into the Community Champion model, leading to increased uptake of PMTCT services and male involvement.

Implementing Mechanism Details

Mechanism ID: 10610	**Mechanism Name: PACT – Providing AIDS Care & Treatment in the Democratic Republic of the Congo under the President's Emergency Plan for AIDS Relief (PEPFAR)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,296,803	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,296,803

Sub Partner Name(s)

(No data provided.)

Overview Narrative

UNC- PACT aims to increase access to services and improve health outcomes of beneficiaries by strengthening capacity to provide HIV testing and counseling, family-centered HIV prevention and care and treatment in 50 maternities and 50 TB clinics in Kinshasa and 13 TB clinics in Kisangani. Integration of sexual and gender-based violence (SGBV) activities will be included in maternities and care and treatment centers in both cities. Technical assistance will be provided to continuum of care services including PMTCT, post-delivery monitoring and care of HIV+ women and newborns of unknown status, TB/HIV co-infection support, and family-based HIV treatment services: diagnosis, care, antiretroviral

therapy and community and clinic-based psychosocial support. Information on family planning, tuberculosis, malaria prevention, and safe motherhood will be provided to patients; male partners can be tested. UNC will strengthen the referral system between maternities and treatment centers to improve retention of pregnant women post -delivery, expand PMTCT services in Kisangani, cover delivery costs, and maintain PSS groups for HIV/AIDS patients. UNC will collaborate with global health organizations. Via additional funding in FY 4 we will add 41 satellite sites to our network of 49 maternities. Our FY5 goal is to test 97,361 women for HIV, and create a network of a total of 90 maternities to work together in a decentralized arrangement to provide PMTCT services. In FY2012 the awarded amount of $3,148,000 and an additional $1,000,000 in SGBV funding will support project activities. For FY2013 the project may see a reduction to $2,822,000 with an additional $600,000 for SGBV services.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	466,047
Human Resources for Health	733,557

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Safe Motherhood
TB

Budget Code Information

Mechanism ID:	**10610**
Mechanism Name:	**PACT – Providing AIDS Care & Treatment in the Democratic Republic of the Congo under the President's Emergency Plan for AIDS Relief (PEPFAR)**
Prime Partner Name:	**University of North Carolina**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	128,000	0

Narrative:

There are 2 care and treatment centers in Kinshasa, Bomoi Health Center in N'Jili and Kalembelembe Pediatric Hospital in Lingwala. The target population includes HIV+ pregnant or post-partum women, HIV/TB co-infected patients, HIV infected men from non- HIV women found at PMTCT care, exposed and infected children and first in line family members as well as other sexual partners. Services provided include provider initiated voluntary testing and counseling, provision of prophylaxis for the treatment and prevention of opportunistic infections and malaria, ART to eligible patients currently provided by the Global Fund and Clinton Foundation, family planning and prevention of sexually transmitted infections, biological and clinical follow up, psychosocial support to help with patient retention (including support group meetings for enrolled patients, home visits, accompaniment for disclosure). UNC-DRC will continue to train providers who provide care to HIV+ individuals and their families and continue to develop a mentoring program to support clinicians trained as a part of this initiative.To address food and nutrition insecurity among HIV+ affected patients, in collaboration with Action Contre la Faim (ACF) and FANTA (Food and Nutrition Technical Assistance) and the LIFT (Livelihood and Food Security Assistance) programs funded by USAID, UNC-DRC's patient population will benefit from nutritional support services at the care and treatment sites as well as those living in communities where nutritional support is provided to HIV+ affected patients within assigned jurisdiction. Beneficiaries will also benefit from economic strengthening activities provided throughout the community through organizations funded by USAID and other PEPFAR collaborators. Continuous monitoring and evaluation will occur through database review and regular meetings based on specific program quality indicators such as: frequency of CD4 monitoring, cotrim prophylaxis, DNA PCR at 6 weeks, tracking of adherence and reports, choice of family planning method documented in charts. The outcomes of all of the monitoring and evaluation activities will be translated and documented in a final year -end report. The cost per patient for HBHC is

$82.70.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	240,280	0

Narrative:

With additional funding, UNC-DRC will be active in 50 TB clinics in Kinshasa and 13 TB clinics in Kisangani, and will oversee HIV VCT activities in each location. All HIV+ and TB co-infected patients and infected family members will receive cotrim prophylaxis and will be screened for ARV eligibility based on CD4 count and clinical staging.Co-infected patients will be provided HIV-related palliative care with cotrimoxizole prophylaxis.All TB/HIV co-infected patients will be referred to a PSS group.Regular screening for TB on all enrolled patients in care will be performed routinely to ensure that eligible patients are placed on treatment as soon as possible. All of these activities will be monitored regularly by program staff through direct observation and review of patient registers and records.To help address food and nutrition insecurity among HIV+ affected patients, in collaboration with ACF and FANTA and the LIFT programs funded by USAID, UNC-DRC's patient population will benefit from nutritional support services at the care and treatment sites as well as those living in communities where nutritional support is provided to HIV+ affected patients within assigned jurisdiction. Beneficiaries will also benefit from economic strengthening activities provided throughout the community through organizations funded by USAID and other PEPFAR collaborators.Data will be reviewed for program evaluation, and UNC-DRC will support a rapid skills transfer to the local health care personnel at those clinics formerly managed by UNC-DRC that provided ART at the clinic level. Also at this time, UNC-DRC will intensify their technical assistance work for the National program by developing simplified database and data collection forms for ongoing use by the National program and their partners.UNC-DRC will expand supportive supervision activities to assist the National program in expansion of its HIV testing activities, and UNC-DRC will also provide program evaluation for the National program. Program evaluation will consist of documentation of acquired training knowledge through pre and post test results, clinical skills observation checklists and periodic quality assurance panel testing.The cost per patient for HVTB is $29.91

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	125,000	0

Narrative:

UNC-DRC is the leading partner in pediatric treatment of HIV in Kinshasa. In collaboration with the Global Foundation and the Clinton Foundation (through December 2012) will provide pediatric ARVs to HIV+ children (and co-infected with TB) referred to PACT care and treatment sites. Each HIV+ pediatric participant receives a comprehensive package of primary HIV care including: clinical follow-up with CD4 testing, prevention and treatment of opportunistic infections, malaria prevention and treatment, ART,

reproductive health services, nutritional support and counseling, PSS, testing of family members and sexual partners at Bomoi Health Center and KLL. To address food and nutrition insecurity among HIV+ affected patients, in collaboration with ACF and FANTA and the LIFT programs funded by USAID, UNC-DRC's patient population will benefit from nutritional support services at the care and treatment sites as well as those living in communities where nutritional support is provided to HIV+ affected patients to reduce barriers to adherence, and providers will be trained in nutrition for those on ART. Issues specific to pediatric HIV care, such as status disclosure, will be included in training sessions for program personnel. Additional aid and education is arranged for patients through PSS groups, both for those informed of their status and those unaware of their status. Continuous monitoring and evaluation will occur through database review and regular meetings based on specific program quality indicators such as: frequency of CD4 monitoring as compared to protocol recommendations, percentages of eligible patients who receive cotrim prophylaxis, percentage of clients with documented HIV status in the chart, tracking of adherence and reports, and tracking of disclosure status. As a center of excellence, UNC-DRC will also conduct two "PDSA" quality improvement activities, and share the processes and outcomes to the rest of the medical community. The outcomes of all of the monitoring and evaluation activities will be translated and documented in a final year-end report. Additional resources will be located as compensation for the end of the Clinton Foundation services. The cost per patient for PDCS is $94.69

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	55,000	0

Narrative:

Provider-initiated rapid testing is implemented at all ANC centers, Bomoi Health Center, and the TB clinics according to national guidelines.Target population include pregnant women visiting ANC centers, the 2 care and treatment centers supported by UNC-DRC, patients infected with tuberculosis in the 63 TB UNC-DRC supported clinics, male partners through sensitization activities, and first line family members of enrolled patients in care.Provider initiated testing and counseling is also offered to malnourished pediatric patients hospitalized at KLL, at which point referral is made for eligible patients for clinical follow up services. In fiscal year 2012, UNC-DRC will strengthen the implementation of the provider-initiated testing and counseling policy at KLL and Sango Plus, and will increase the HIV testing rate of first-line family members and sexual partners of UNC-DRC program's patients at ANC maternity sites and the two care and treatment centers. UNC-DRC will provide technical assistance to PNLT for VCT at TB clinics in Kinshasa and Kisangani.The collaboration with PEPFAR and the Global Fund's Round 11 will assist in complementing program's activities by supplying test kits, laboratory supplies and other consumables, along with ARVs for care and treatment. In collaboration with the PNLS, UNC-DRC will also design and implement training sessions on testing and counseling and data quality assurance to

healthcare workers in IMAI, PVV lay-health workers, expert patients, and maternity lab and clinical personnel and provide resources to ensure retention along the continuum of care for pregnant women and their infants through HIV diagnosis, care and treatment for the mother, and HIV testing and care and treatment (if indicated) of the exposed infant.Affected male partners of women identified through ANC at UNC-DRC supported maternities will also trained in counseling and peer education.All of these activities will be monitored regularly by program staff through direct observation, provision of periodic quality assurance panel testing and review of patient registers.The cost per patient of HVCT is $10.69 (calculation includes 5146 testing patients at ANC, TB clinics, C&T centers).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	55,000	0

Narrative:

Individuals who are sexually active and are HIV tested at UNC-DRC's supported health centers are provided information at time of testing on condom use; STI transmission, prevention and treatment methods; and other risk-reducing behaviors, in addition to information on fidelity and reducing the number of partners. UNC-DRC provides this message to those presenting for care at participating maternities and PACT care and treatment centers and at educational presentations in the local communities in which UNC-DRC operate. Through the social marketing of condom usage and safer sex, this activity will be leveraged by the partnership and collaboration with USAID's family planning initiative and PSI to acquire condoms and other family planning commodities for program beneficiaries. Participants interested in family planning services are referred to closest service provider. As couple's counseling is highly suggested and honored, men are specifically targeted through sensitization sessions, which are linked to testing opportunities for those who choose to be tested. Training is provided to healthcare providers at participating health centers at program initiation and through periodic refresher training sessions. UNC-DRC will continue these activities in FY13, will integrate SGBV messaging, and will monitor and evaluate the delivery of this information by quarterly input/output monitoring. The cost per person in HVOP is $0.85

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	319,253	0

Narrative:

UNC-DRC provides technical assistance for rapid HIV testing, prenatal and post-delivery monitoring and care of HIV+ women and their newborns, family-based HIV treatment services and community and clinic-based psychosocial support (PSS). The UNC-DRC PMTCT team applies criteria set by the National AIDS Control Program for selecting maternities. Staffs at the maternities are trained on PNLS-approved curriculum and data is shared at the program, district, provincial and national level. PMTCT activities

are integrated into existing antenatal care services including rapid HIV testing and counseling, TB screening, sulfadoxine-pyrimethamine for presumptive malaria treatment, promotion of insecticide-treated bed net use, tetanus vaccinations, routine iron and folate supplementation, and family planning counseling. HIV+ mothers and their infants are given prophylactic ARVs provided by the Global Fund and Clinton Foundation, and cotrimoxizole prophylaxis, and delivery costs are paid to encourage delivering at the maternities. HIV+ women are asked to join one of 20 monthly PSS groups for informal life skills training, and program efforts are made to strengthen male partner involvement. Training and monitoring is provided to midwives, clinic nurses, and laboratory staff on new PMTCT best practices and patient care. Complemented by a network of partnerships between UNC-DRC, USAID and PEPFAR funded organizations GBV education, screening, and referral for psychosocial community based services and care and treatment for STI, HIV and pregnancy prevention are provided through integrated network of PMTCT and care and treatment in 50 maternities in Kinshasa and Kisangani. HIV+ pregnant women and their children benefit from nutritional assistance provided by the ACF in selected communities. If awarded additional funding in FY12, we will implement the PMTCT acceleration plan. This plan adds 14 mobile teams to provide all PMTCT services to an additional 37 sites in Kinshasa, and an additional 10 sites in Kisangani. We plan to create a network of a total of 90 maternities that will work together in a decentralized, "hub and spoke" arrangement to provide comprehensive PMTCT services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	179,430	0

Narrative:

The same population is targeted for this activity as for adult HIV care; a system that includes a family-centered approach to care and treatment. The Global Fund and Clinton Foundation provided ARVs to 993 HIV+ individuals through its activities so far. Each patient undergoes a comprehensive baseline assessment at program enrollment including clinical examination, nutritional and laboratory assessment, and psychosocial evaluation. HIV disease staging by clinical assessment and CD4 testing will determine ARV eligibility and patient visit schedules. Patients on ART are scheduled for monthly visits, until deemed clinically stable after which they may be seen every six months. Those who are seen every six months continue to be assessed by a nurse dispensarist on weight, ARV dosing, and drug adherence through questionnaires and pharmacy databases. At each visit, drug toxicity assessment is conducted, and counseling on treatment adherence is provided. As part of its centers of excellence activities, clinical patient outcomes such as improvements in CD4 counts and weights are tracked and monitored quarterly through streamlined data collection forms and review of patient and pharmacy databases that collect program quality indicators such as: frequency of CD4 monitoring, percentages of eligible patients who receive cotrim prophylaxis, adherence to protocol requirements of confirmatory testing, percentage of clients with documented HIV status in his/her chart, tracking of adherence and

toxicity reports, and choice of family planning method documented in his/her chart. Activities to support patient adherence include psychosocial support group meetings and intensive follow up of patients by providers as well the use of the PVV volunteers to track patients and provide support outside of the clinical setting. UNC will also conduct two “PDSA” quality improvement activities, and share the processes and outcomes with the regional medical community. The outcomes of all of the monitoring and evaluation activities will be translated and documented in a final yearend report. The cost per patient for HTXS is $105.31.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	194,840	0

Narrative:

The same population is targeted for this activity as for pediatric HIV care. Each patient undergoes a comprehensive baseline assessment at program enrollment including clinical examination, nutritional and laboratory assessment, and psychosocial evaluation. ARV eligibility and patient visit schedule will be assessed according to age and WHO recommendations. Patients will be seen every month for the first three months of participation and then every three months thereafter. Patients who are seen every three months will continue to be assessed by a nurse dispensarist on weight, ARV dosing, and drug adherence through questionnaires and pharmacy databases. At each visit, drug toxicity assessment is conducted, and counseling on treatment adherence is provided. Outreach workers made up of PVV volunteers will assist with patient tracking to improve adherence. Construction of internet-wired and better equipped conference rooms have been partially completed to effectively implement a telemedicine program at Bomoi and KLL, and enable the centers to host medical conferences and regional clinician training sessions. Nutrition programs funded by USAID will benefit patients at the care and treatment sites as well as those living in communities where nutritional support is provided to HIV+ affected patients within assigned jurisdiction. As centers of excellence, HIV pediatric treatment mentorships will occur at KLL and Bomoi, and expert opinions and best practices in pediatric ART treatment will be shared with other providers. Clinical patient outcomes such as improvements in CD4 counts and weights will be tracked and monitored quarterly through streamlined data collection forms and review of patient and pharmacy databases that collect program quality indicators such as: frequency of CD4 monitoring, percentages of eligible patients who receive cotrim prophylaxis, adherence to protocol requirements of DNA PCR at 6 weeks, percentage of clients with documented HIV status in his/her chart, tracking of adherence and toxicity reports, and choice of family planning method documented in his/her chart. The cost per patient for PDTX is $147.42.

Implementing Mechanism Details

Mechanism ID: 10612	Mechanism Name: PROVISION OF CAPACITY

	BUILDING TO EMERGENCY PLAN PARTNERS AND TO LOCAL ORGANIZATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO FOR HIV/AIDS ACTIVITIES UNDER THE PRESIDENT''S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Kinshasa School of Public Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,235,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,235,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Introduction

This project is a CoAg between CDC and the KSPH which main objective is to contribute to the reduction of HIV/AIDS and STI transmission and attenuate their impact. Its specific objectives are the following:(1) achieve primary HIV prevention such as HVCT programs; (2) strengthen the capacity of the country in HIV data management; (3)strengthen HIV lab support; (4) support the development/updating of GBV protocols and training manuals for stakeholders; (5) strengthen community outreach/mobilization/referrals through the national GBV and HIV hotline(6)generate strategic information.

KSPH will provide training to health professionals at the MPH level and technical assistance to National programs and institutions. The activities are mainly concentrated in USG-supported provinces (Kinshasa, Bas Congo, Katanga, Sud Kivu, Kasai Oriental and Province Orientale) and target youth, health workers, PLWHA, students, social workers, and MOH staff.

To become more efficient overtime, the KSPH will use approaches based on results to reach targets in

reducing the cost.
KSPH will reinforce the national health system by supporting the MOH human capacity development, laboratories at the central and provincial levels, and providing technical assistance in strategic information and HIV M&E.
KSPH will strengthen the health system by providing training (pre-and in-service) to DRC National Institutions/Programs staff at different levels, to local and international partners.
Concerning the PMTCT AP, the KSPH will provide equipment, lab supplies, reagent, and HIV rapid test to USG CDC partners: ICAP, UNC/ESP, EGPAF and KSPH lab, and train lab technicians in HIV diagnosis and biological follow up.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	200,000
Human Resources for Health	575,200

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10612**
Mechanism Name:	**PROVISION OF CAPACITY BUILDING TO EMERGENCY PLAN PARTNERS AND TO LOCAL ORGANIZATIONS IN THE DEMOCRATIC REPUBLIC OF CONGO FOR HIV/AIDS ACTIVITIES UNDER THE PRESIDENT"S EMERGENCY PLAN FOR AIDS RELIEF (PEPFAR)**
Prime Partner Name:	

	Kinshasa School of Public Health		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	406,000	0

Narrative:

During the COP12, 5 laboratories will be provided with reagents, lab supplies and maintenance services (PNLS national laboratory, Kinshasa provincial hospital, KSPH, Kalembelembe and Sendwe). In collaboraion with the BD firm, the KSPH will set up a regional training center.This center will also deal with QC&QA. In addition, the KSPH will support plans and activities that will result in sustainable accredited laboratory programs. About trainings, 1500 finalist students in medical and nurse schools (pre-service), 120 midwives and 200 lab technicians in health care institutions (in-service) will be trained. Those trainings are focused on HIV rapid testing, Malaria and Tuberculosis microscopy for students; diagnosis of HIV and opportunistic infections, STI and biological follow-up of PLWHA, Dried Blood Spot (DBS) techniques in PMTCT sites,and HIV early infant diagnosis with PCR DNA for lab technicians. Participants will be selected in Kinshasa, Lubumbashi and Kisangani. Trainings will be organized in collaboration with the PNLS, and conducted by experts from the pool of national and local lab trainers.
Supporting the Lab Task Force: Under the PNLS leadership, a lab task force gathering members from KSPH, MOH Programs and other actors involved in the HIV lab area was implemented in order to coordinate TB, HIV/AIDS and blood safety laboratory activities.
According to the PMTCT acceleration plan, the KSPH will provide equipment, lab supplies, reagent, and HIV rapid test to USG CDC partners : ICAP, UNC/ESP , EGPAF and KSPH lab. The equipment to be purchased is the following: Fascount, PIMA, and Elisa chain and will permit the HIV diagnosis and the biological follow up of the HIV positive pregnant women and their infants.
In addition, KSPH will train lab technicians to strengthen their capacities in HIV diagnosis and the biological follow up
Outputs: 8 laboratories supported with reagent, tests and student, midwives and lab technicians trained

Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HVSI	0	0

Narrative:

SURVEYS
During COP12, KSPH will conduct two surveys on size estimation of MARPS and Biological ARV Drug resistance. The first one will be organized in Kinshasa and Lubumbashi and will mainly target sex workers, soldiers, militaries, trackers. The results will permit to update the prevalence among this group

category. The second survey will concern the Biological ARV Drug resistance. The survey will target person living with HIV/AIDS, PLWHA and benefiting ARV treatment in Kinshasa.
For each survey, a protocol will be elaborated and transmitted to the local ethics committee as well as Atlanta committee for approval. The data will be collected, analyzed and results diffused.
REPORTING SYSTEM: the KSPH will continue to set up the operation and maintenance of the national reporting system started in COP 10 in collaboration with PNLS and a consulting firm. In COP12, the functioning of the central level and 75 health zones, funded by PEPFAR will be supported.
Direct beneficiaries: decision makers, PLWHA
Output: 2 survey reports produced and disseminated.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	100,000	0

Narrative:

In order to reinforce the formal trainings of health care professional in DRC, the KSPH organizes trainings in , M & E, GBV, and management of health system (MPH)
M&E : with the PNMLS,KSPH developed training manuals in M&E targeting decision-makers and field workers who are conducting interventions. The KSPH will organize 5 training sessions of 30 participants, in 5 provinces. The trainings aim to reinforce the HIV reporting system. Participants will be decision-makers, data managers and M&E officers from different levels within donor community and key partner organizations. Trainings will be conducted by the national experts from the M&E training pool.
MPH : in order to reinforce MOH capacity, KSPH will provide scholarships to 5 individuals for MPH degree.
GBV: the KSPH proposes to reinforce the Hotline capacity to respond to information needs in relation to GBV through the following activities (1) promote the Hotline through medias ;(2) implement the methods for automatic answering of calls;(3) support the Hotline functioning.
Direct beneficiaries: DRC overall population
Output: 150 individuals trained in M&E and 5 individuals trained for MPH degree; Hotline capacities reinforced to respond to questions related to GBV.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	50,000	0

Narrative:

The injection safety is one of the strategies set up to prevent HIV and other diseases contamination for health professional , patients and general population. Blood exposure accidents are frequently reported in health care Institutions although their importance is not yet measured through all the country. Thank to

CDC-PEPFAR support, the KSPH and the MOH produced modules and guidelines on injection safety and biomedical waste management. Those modules are used for the healthcare providers training in Kinshasa and other provinces. For these trained individuals, different health structures where they work will be provided with appropriate and adequate materials, such as single-use syringes and needles, safety boxes,blouses and gloves to ensure injection safety, as well as other related procedures notably phlebotomy and lancet procedures .Appropriate equipment will also be provided to those health care institutions for health care waste management, such as incinerators and dustbins. The package of that support will include institutional support for the management of health care workers occupational exposure to bloodborne pathogens.

Direct beneficiaries: Health care providers, patients and general population.
Output: Ten health care structures supported.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	140,000	0

Narrative:

According to the 2008, 2009,2010 ANC and DHS survey reports, it is stated that the Democratic Republic of Congo has a stable HIV/AIDS generalized epidemic. Despite the Government's ongoing efforts to control HIV/AIDS, through its various specialized programs such as, notably the PNLS and the PNMLS as well as the other stakeholders (NGO, CBOS, funding providers, ..), there is a constant need to promote HIV/AIDS information to people about the spreading of the disease, its transmission routes, and also about several services being developed throughout the country.
The foundation Femme Plus, through the hotline call center aimed to respond the population needs in providing HIV/AIDS information to callers. This call-center functions with counselors 24 hours per day, 7 days a week. There are permanent and voluntary counselors. The phone lines are provided free of charge by local phone firms but administrative and maintenance costs need to be covered. For the next year , this project will continue to assist the ongoing effort by providing administrative, technical and logistics support.
Direct Beneficiaries: Overall population, essentially for youth population from 15 to 24 for abstinence. Concerning being faithful, the target is non single population up to 18 years.
GEOGRAPHIC COVERAGE
All the eleven DRC provinces and some neighboring countries (Angola,Zambia, Republic of Congo and RCA)
In addition, counselors will benefit trainings related to Sexual Gender Based Violences and HIV prevention communication techniques. The callers are referred to appropriate HIV services.

Output: 233,472 individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or faithfulness; 60 individuals trained to promote HIV/AIDS prevention through abstinence and/or faithfulness; and 60 individuals trained in other prevention services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	230,000	0

Narrative:

HIV voluntary counseling and testing (HVCT) programs have demonstrated their ability to increase safe sexual behavior and use of care and support services among individuals. HVCT activities help clients to know about their HIV serostatus and to create a personalized HIV risk reduction plan. Counseling, both before and after the test, and a risk reduction plan are the key features that distinguish HVCT from other HIV testing services.

In DRC, many youth organizations are proactive in HIV voluntary testing and counseling activities. They sensitize their peers in the knowledge of their HIV serostatus. For the next fiscal year, the project plans to collaborate with 8 youth associations that will test and give back the test results in Kinshasa. They will organize counseling and testing sensitization campaigns towards militaries, police, students and prisoners. For the last twelve months, the HIV prevalence for prisonners and militaries was 0,9% and for the overall population 0,8% for the people recruited and tested during HVCT campaigns in Kinshasa.The mobile voluntary counseling and testing, special events are the approaches used to reach the target population. The national algorithm is used.

The project through this activity will collaborate with other USG partners for the referral system to available nearest services for HIV positive cases and their follow up. In order to reinforce their capacity building, peer recruiters from those organizations will be trained in ABC prevention counseling and testing. The project will also provide technical and administrative support to these youth organizations.

Direct Beneficiaries: Overall population, Youth of any categories

Output: 8 youth associations with HVCT activities strengthened; 28,800 individuals counseled and tested for HIV and received their results; 120 peer recruiters from those youth associations trained in counseling and testing according to national and international standards.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	309,000	0

Narrative:

According to the 2008, 2009, 2010 ANC and 2007 DHS surveys reports, it is stated that the Democratic Republic of Congo has a stable HIV/AIDS generalized epidemic. Despite the Government's ongoing efforts to control HIV/AIDS, through its various specialized programs such as, notably the PNLS and the PNMLS as well as the other stakeholders (NGO, CBOS, funding providers, ..), there is a constant need to

promote HIV/AIDS information to people about the spreading of the disease, its transmission routes, and also about several services being developed throughout the country.
The foundation Femme Plus, through the hotline call center aimed to respond the population needs in providing HIV/AIDS information to callers. This call-center functions with counselors 24 hours per day, 7 days a week. There are permanent and voluntary counselors. The phone lines are provided free of charge by local phone firms but administrative and maintenance costs need to be covered. For the next year , this project will continue to assist the ongoing effort by providing administrative, technical and logistics support. .
Direct Beneficiaries: Overall population
GEOGRAPHIC COVERAGE
All the eleven DRC provinces and some neighboring countries (Angola,Zambia, Republic of Congo and RCA)
In addition, counselors will benefit trainings related to Sexual Gender Based Violences and HIV prevention communication techniques. The callers are referred to appropriate HIV services.
The KSPH will strengthen the PNLS – Matonge clinic activities for STI management for Commercial Sex workers (CSW) and other Multiple at risk populations (MARPS).

Output: 534,528 individuals reached with preventive interventions that are based on evidence and/or meet the minimum standards required; 60 individuals trained to promote HIV/AIDS prevention through abstinence and/or faithfulness; and 60 individuals trained in other prevention services.

Implementing Mechanism Details

Mechanism ID: 11054	**Mechanism Name: PSI BCC and TC in the DRC Armed Forces**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

FHI 360		

Overview Narrative

The DRC Armed Forces AIDS Prevention Program aims to contribute to reduce in 10 HZ new HIV infections among the military personnel, their family members and neighboring communities by strengthening: (1) their perception of personal risk of contamination from unsafe sex; (2) the awareness and the uptake of high quality HTC services; (3) the promotion of consistent and correct condom use; (4) the referral of infected people to care and treatment services. These objectives are aligned with the defense AIDS program strategic plan 2008-2012 and contribute to the first goal of the partnership framework the USG signed with the GDRC. To increase sustainability, members of target groups are routinely included in the implementation of project activities. Behavior change techniques and Information, Education, and Communication (IEC) tools are also produced and disseminated to facilitate behavior change communication activities amongst target population groups while target population supervisors within each intervention area ensure the monitoring of interventions and the quality of services. PSI will increase demand for HTC services among military personnel and their families, and refer them to the military health facilities (SMS) for HIV testing; and FHI360 will continue to support military sites in delivering HTC services and in regularly leading outreach activities to reach target populations in the surrounding area. The existing network of condom sales will be reinforced. PSI/ASF will continue to implement M&E activities to ensure service quality based on national and USG requirements and will report to DOD quarterly program results and ad hoc requested program data. Vehicle purchased with FY2008 money =2. New request=0

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services
Military Population

Budget Code Information

Mechanism ID:	**11054**		
Mechanism Name:	**PSI BCC and TC in the DRC Armed Forces**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVAB	0	0

Narrative:

The overall goal of this activity is to decrease new HIV infection through behavior change communication focused on the value of abstinence and faithfulness and targeting specifically youth aged 15-24. In 2012, the project will build upon previous experiences to expand prevention interventions in existing locations, adding new sites in Oriental province especially in Kisangani. Key activities in this area will include: 1) training of master trainers and peer educators/animators(military and civilian especially youth) 2) Behavior Change Communication including IPC sessions (one-on-one and small group discussions), edutainement (Mobile Video Units) and mass communication(HIV/AIDS radio and TV spots focus on AB) and 3) promotion of counseling and Testing services. in 2012, an average of 8,200 people will be reached through 2,880 IPC sessions focus on AB held by 60 PEs. PSI and the MOD HIV/AIDS will continue to upadate the communication materials to reflect best practices in the following

areas: abstinence and being faithful(AB) with a focus on the delay of sex debut for youth, couples counseling and testing, gender-based violence and prevention of alcool abuse. As stated in the Overview Narrative, five province will be concerned by this program. Quality of service delivery will be assured by a good selection of PEs conducted in closed collaboration with local communities and MOD instances ; evidence based training sessions highly involving MOH's experts in communication activities; technical supervisions conducted by local NGOs themselves and joinly conducted by PSI/ASF, MOD HIV/AIDS services and other GDRC instances as well as USG agencies. PSI/ASF will continue to implement an M&E plan to ensure service quality based on national and USG requirements and will report to DOD quarterly program results and ad hoc requested program data. Data will be collected periodically.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	0	0

Narrative:

This activity will continue to support the DRC Ministry of defense's HIV/AIDS program by providing counseling and testing services to the military personnel, their family members and the communities surrounding military camps or barracks. VCT services will be provided by both VCT centers and mobile units established in 5 sites: Mbuji-Mayi, Lubumbashi, Kinshasa, Bukavu and Kisangani. HVCT interventions will include: refresher training for existing counseilors with a focus on strenthening lay counselors's capabilities of performing HIV tests(task shifting); provion of needed equipments, HIV test kits and other medical consumables in closed collaboration with Supply Chain Management System(SCMS); and development of VCT IEC materials and their dissemination to all the military VCT centers. An average of 16,349 clients will be reached by this HVCT program in 2012.
Tested people will be referred to condom points of sale established in and around military camps and encouraged to attend STI clinics and those tested positive will be reffered to HIV care, treatment and support services provided by other USG acgencies's partners or GF funded projects. This HVCT program will be implemented in the five provinces stated in the overview narrative. Quality of service delivery will be assured through: a good selection of counselors and lab technicians in closed collaboration with GDRC instances, evidence based training sessions highly involving the PNLS(National HIV/AIDS Control Program), and technical supervisions of activities jointly conducted by PSI/ASF, FHI, GDRC/MOD staff and local USG experts. In closed collaboration with the military HIV/AIDS office and FHI, PSI/ASF will collecte on a daily basis all the VCT data as per the national standards and PEPFAR requirements and will submit quarterly results reports to DOD.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

With FY12 funds, the project will build upon previous project activities to expand prevention interventions in existing project sites, adding some sites in Province Orientale for the same interventions. Key activities in this area will include: prevention interventions specifically targeting the military personnel, their families and surrounding communities. An average of 40,800 people will be sensitized in 2012 through 163200 IPC sessions focus on OP held by 340 PEs . Mobile Video Units, mass campaigns, Radio and TV spots will also be part of these prevention activities taking place in five provinces (see Overview Narrative). Quality of communication service delivery will be ensured through a good selection of PEs by PSI/ASF in closed collaboration with the MOD HIV/AIDS office and local communities(NGOs); training and refreshment sessions of the selected PEs; supervisions conducted by local NGOs themselves, and joint supervisions by PSI/ASF and government instances as well as USG's agencies. Sensitized people will be referred to condom points of sale available in provinces, and encouraged to get tested, attend STI clinics and access HIV care. As for HVAB activities, PSI/ASF will also ensure that USG requirements and technical guidelines as well as GDRC statandars for sensitization activities are met and will report to DOD quarterly program results and had hoc requested data.

Implementing Mechanism Details

Mechanism ID: 11060	**Mechanism Name: Congo American Language Institute Scholarships**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Contract
Prime Partner Name: CONGO AMERICAN LANGUAGE INSTITUTE	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Public Diplomacy (PD) section at the US Embassy, Kinhsasa is a critical element of the DRC PEPFAR

activity and serves as a link between the Embassy and the community, policy makers, and the media. To achieve the various objectives of PD, PD utilizes 4 mechanisms namely small grants, support for CALI (Congo American Language Institute), Public Official Workshops, and Journalism Workshops. With the introduction new activities such as PMTCT-AP and NEPI, and continuation of ongoing activities, PD can play a crucial role in garner country political and leadership support for needed HIV policy and sustain the governmental commitment.
CALI: Scholarships are provided to policy makers to attend English language training as part of capacity building endeavor of governmental staff, who work closely with PEPFAR activities. Improved capacity in English increases their exposure to HIV/AIDS information and dialogue.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	**11060**
Mechanism Name:	**Congo American Language Institute Scholarships**
Prime Partner Name:	**CONGO AMERICAN LANGUAGE INSTITUTE**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	50,000	0
Narrative:			

Implementing Mechanism Details

Mechanism ID: 12041	**Mechanism Name: Journalist Workshops**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Inter-Agency Agreement
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Public Diplomacy (PD) section at the US Embassy, Kinhsasa is a critical element of the DRC PEPFAR activity and serves as a link between the Embassy and the community, policy makers, and the media. To achieve the various objectives of PD, PD utilizes 4 mechanisms namely small grants, support for CALI (Congo American Language Institute), Public Official Workshops, and Journalism Workshops. With the introduction new activities such as PMTCT-AP and NEPI, and continuation of ongoing activities, PD can play a crucial role in garner country political and leadership support for needed HIV policy and sustain the governmental commitment.

Journalism Workshop: In DRC although journalists play a significant role in information sharing, they lack formal training, especially on sensitive topics such as HIV/AIDS. Periodic training workshops help fill such

training gap

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	**12041**		
Mechanism Name:	**Journalist Workshops**		
Prime Partner Name:	**U.S. Department of State**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HVOP	50,000	0
Narrative:			

Implementing Mechanism Details

Mechanism ID: 12991	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 12996	**Mechanism Name: Public Health Official Workshop**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Grant
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Public Diplomacy (PD) section at the US Embassy, Kinhsasa is a critical element of the DRC PEPFAR activity and serves as a link between the Embassy and the community, policy makers, and the media. To achieve the various objectives of PD, PD utilizes 4 mechanisms namely small grants, support for CALI (Congo American Language Institute), Public Official Workshops, and Journalism Workshops. With the introduction new activities such as PMTCT-AP and NEPI, and continuation of ongoing activities, PD can play a crucial role in garner country political and leadership support for needed HIV policy and sustain the governmental commitment.

Public Official Workshop: The beneficiaries are government staff involved in health policy decision making drawn from all ministries. This informational activity usefully complements USG efforts to garner country commitment and ownership of PEPFAR programs.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	**12996**		
Mechanism Name:	**Public Health Official Workshop**		
Prime Partner Name:	**U.S. Department of State**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	50,000	0
Narrative:			

Implementing Mechanism Details

Mechanism ID: 13009	**Mechanism Name: Support to DRC Ministry of Defense: Capacity building of the PALS (MOD HIV/AIDS Coordinating Body)**

Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The US DOD PEPFAR efforts are implemented on field by DRC Armed Forces' trained personnel and their dependants under the technical assistance/supervision of PSI. PSI was tasked to train master trainers, peer educators and counselors and testers. Since FY10, the US DOD has been planning OHSS funds, separetly tracked, to support a range of activities aiming to build the capabilities of the local military to coordinate by itself all HIV/AIDS related interventions across the country. This will contribute to build a real leadership supporting an effective ownership of HIV/AIDS activities by the DRC Armed Forces.
The significant shift or focus in this area during FY2012 and FY 2013 will be to invest in concret activities that will effectively contribute to respond to the need of strengthening the institutional and technical capabilities of the local military for the final purpose of increasing country ownership and leadership for HIV/AIDS activities. Using past COP's money, PSI has purchased 1 vehicle and 1 motorcycle for the MOD HIV/AIDS national coordinating body plus 5 other motorcyles for the military HIV/AIDS coordinating offices located in the 5 military regions covered DOD PEPFAR's Activities. No vehicle will be purchased with 2012 money.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?

(No data provided.)

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Military Population
Mobile Population

Budget Code Information

Mechanism ID:	**13009**		
Mechanism Name:	**Support to DRC Ministry of Defense: Capacity building of the PALS (MOD HIV/AIDS Coordinating Body)**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0
Narrative:			
The money requested from the FY 2012 COP will be used for a range of activities including: - Utilizing the military master trainers trained in past years' BCC and HTC projects for all training sessions			

occurring in the military. - Supporting supervions visits held by the military supervisors and coordination office's personnel at both national and provincial as well as local levels. - Organizing learning visits across the DRC provinces and out of the Country for military's HIV/AIDS national coordinator, provincial coordinators and other military health providers, - Encouraging the participation of DRC military's HIV/AIDS officers in regional technical workshops and other HIV/AIDS initiatives. - Continuing to reinforce the military health institutions' capacity of managing health services and pursuing their provision with data management tools at both national and provincial levels. - Supporting a national HIV/AIDS military forum, quarterly review meetings and planning activities (development of military HIV/AIDS strategic plans and policy). - Supporting advocacy and informative meetings held by the DRC Armed Forces HIV/AIDS office in favor on military high rank members and ministry officials for their leadership's role in all military HIV/AIDS activities.

Implementing Mechanism Details

Mechanism ID: 13010	**Mechanism Name: Integrated Health Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1,537,727	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1,537,727

Sub Partner Name(s)

International Rescue Committee	Overseas Strategic Consulting	

Overview Narrative

Overall, IHP will contribute to strengthening prevention interventions, care, treatment and support for the

virtual elimination of mother to child transmission, reducing the occurrence of new infections among newborn to HIV positive mothers in 250 PMTCT sites through target 80 health zones. The project also aims to improve the quality of life for PLWHA, especially women, mothers and children HIV-positive in promoting and facilitating their active participation in planning and services provision, advocacy and community engagement, and to build capacity of community health workers by involving them in PMTCT activities.

Specific objectives are focused on increasing availability of and access to quality PMTCT services and products in 250 PMTCT sites conducting BCC activities and trainings on ETL approach at both PMTCT sites and the community and strengthening management of PMTCT activities on providing technical and financial support to health zones, districts and provinces to ensure regular supervision, data collection and data quality control activities as well as timely reporting on PEPFAR indicators.
Monitoring and evaluation will be jointly organized with BCZ, PNLS and other partners and data regular monitoring in monthly basis will also be required in each supported health zone and health area.

IHP HIV funding contributes to strengthening the health system at health zone and provincial levels. That includes development of managerial and leadership capacities of health management teams through trainings and mentoring, elaboration of HZ 5-year development plans and annual operational plans, and provision of integrated supervision, quality improvement and M&E tools. These cross-cutting health system strengthening activities will benefit to GF implementation program.

Cross-Cutting Budget Attribution(s)

Construction/Renovation	375,000
Economic Strengthening	320,000
Education	375,000
Food and Nutrition: Commodities	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	39,000
Gender: Reducing Violence and Coercion	108,000
Human Resources for Health	57,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13010**
Mechanism Name:	**Integrated Health Project**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	522,827	0

Narrative:

IHP will provide cotrimoxazole as prophylaxis and we estimate 50% will benefit. IHP will work closely with other partners such as UNICEF, WFP, ACF to make food available. The project plans also to train 1000 community health workers to support HIV-positive pregnant women and PLWHA

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	261,414	0

Narrative:

The objective of this sector is to reduce HIV / AIDS transmission through the blood transfusion from 10% to less than 2% in intervention areas by ensuring transfusion good practice according to national

standards.
The project will ensure that a transfusion mapping sites per health zones will be set up and clearly defined. Supplies, transfusion kits and equipment are identified, ordered and available at all selected health facilities so that 99 % of blood transfusion is completely safe. Cold chains will be awarded in a progressive manner according to the needs of the respective health centers. Health zones team, health providers, peers recruiters and community health workers capacities on blood transfusion will be strengthened and this capacity building will be coordinated with SBFA(Safe blood for Africa)
Strategies are developed to educate communities about the need for voluntary blood donation and loyalty of voluntary donors of blood will improved .A coordination and technical exchanges framework with all partners to support the sector is in place and monitoring and evaluation system of blood safety activities are provided at all sites of implementation.
Finally, the project prints and distributes guides, standards, and modules.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	753,486	0

Narrative:

PMTCT is the main activity that IHP will undertake during this period:
1. Increase availability and access to quality PMTCT services in 250 health facilities (138 existing and 112 revitalized and new sites including PMTCT acceleration plan). An assessment of new sites will be continued before integrating PMTCT and 690 people (5*138 sites) from the 138 existing sites will refreshed and 560 peoples from the new 112 sites will be trained on integrated HIV modules and infection control and the new PMTCT protocol including early diagnosis and prevention of infections. Utilization of finger prick will be piloted in 24 selected PMTCT sites (3 sites per 8 health zones to be selected) and supplies, equipments needs for 5000 pregnant women will be ordered directly by PEPFAR .IHP will provide HIV rapid tests and DDF kits for the 250 PMTCT sites and support CD4 testing for approximately 20% of pregnant women HIV+.
2. Conduct BCC awareness and community mobilization activities:
10 local organizations and PLWHA associations will selected and provide technical and financial support to community-based organizations (local NGOs, faith-based organizations ...). It also promotes and facilitates the active participation of PLWHA, especially women and mothers living with HIV in planning and providing services, advocacy and community engagement. 1600 community health workers will be trained on how to fight against HIV / AIDS focused on the prevention. A space for confidential psycho social, counseling and referral support is created to discuss sensitive issues related to HIV through the SMS system (we will work with other partners such as Provic and TB/2015).The project will signed contracts with community radio broadcasting to improve community awarness about HIV/AIDS.IEC materials will produced and printed for 1200 community outreach

3. Strengthen management of PMTCT activities: Provide technical and financial support to health zones, districts and provinces to ensure regular supervision data collection (including provision of data collection tools) and data quality control activities, print and distribute 500 units of new PMTCT protocol.

Implementing Mechanism Details

Mechanism ID: 13017	**Mechanism Name: Global Laboratory Capacity Strengthening Program**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: American Society for Microbiology	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	1

Sub Partner Name(s)

(No data provided.)

Overview Narrative

1. The major goal of this activity is local organizational and human capacity development in quality assurance and quality improvement of laboratory testing. The objectives are for ASM to develop training programs provided to Congolese laboratorians working in clinical health care facilities for improved diagnosis of HIV. ASM will also improve the infrastructure of laboratories where these individuals currently work. Key expected intermediate outcomes include increased skills required to carry out quality-assured diagnosis of HIV.

2. ASM will continue to explore partnership opportunities, both public-private and other kinds that help leverage funds, and the strategy, which involves transferring knowledge through onsite mentorship, is a cost-efficient manner to effect major changes.

3. ASM will continue to work with Congolese laboratory technical working groups at the central level to adapt training materials for DRC's particular circumstances, so as to ensure country ownership. Furthermore, ASM will work directly with the Ministry of Health's national reference laboratories for HIV and Blood Tranfusion and national HIV control program to transfer proper management expertise via onsite mentorship and training programs.

4. ASM has an in-house M&E Specialist whose sole responsibility is to develop indicators to measure program activities. As part of the M&E strategy, the M&E Specialist will offer technical assistance to the Congolese stakeholders in defining an M&E plan that is manageable and most appropriate for measuring program progress.

5. N/A – No vehicle will be purchased.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing women's access to income and productive resources
Mobile Population

Budget Code Information

Mechanism ID:	13017

Mechanism Name:	Global Laboratory Capacity Strengthening Program		
Prime Partner Name:	American Society for Microbiology		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	HLAB	1	0

Narrative:

Under COP2012, the American Society for Microbiology (ASM) technical experts (mentors) will continue to provide in-country support for quality-assured HIV diagnosis, laboratory systems and strategic planning, standardization of protocols for cost effective testing, and good laboratory and clinical practice. ASM's major emphasis area will continue to be human capacity development. Of major emphasis under COP2012, ASM will look to expand training to regional laboratories. Other activities that will be followed up from the previous year will include: 1) improvement of training for HIV diagnosis; 2) development of a comprehensive, integrated quality management system for HIV diagnostics, 3) assisting via onsite mentoring and guidance with providing technical support for development of a proficiency program for HIV to begin assisting with accreditation processes; 4) offering technical assistance for quality management systems (QMS) implementation for HIV diagnosis moving towards accreditation. ASM will continue to work closely with the DRC's Lab Technical Working Group (LTWG) to ensure that these activities are coordinated with other organizations supporting HIV diagnosis and treatment in DRC. ASM will work through the LTWG to ensure that activities and deliverables are developed and implemented in a harmonized fashion. Expected outcomes include development of a local cadre of well-trained individual laboratorians, so that they can continue forward with laboratory trainings at lower levels of the laboratory network, as well as assisting with maintaining achieved levels of diagnosis.

Implementing Mechanism Details

Mechanism ID: 13094	**Mechanism Name: Association of Public Health Laboratories Centrally funded CoAG**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Association of Public Health Laboratories	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 1	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	1

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Association Public Health Laboratories (APHL)has diverse expertise to support HHS/CDC including strategic planning for national laboratory networks, implementing laboratory management information systems, and providing US-based and in-country advanced training for laboratory professionals.
In PEPFAR supported countries, the five-year strategic plan for APHL activities include core training initiatives that support laboratory strengthening, and country-specific action plans.
APHL provides training and technical assistance to strengthen key areas of laboratory capabilities and capacities: 1) Laboratory management training provides supervisors and directors with the knowledge, skills and abilities 2) Strategic and operational planning workshops provide laboratory professionals with knowledge, skills and tools to develop effective strategic plans 3) Twinning agreements between major US public health laboratories and national referral laboratories 4) Implementation of laboratory information systems (LIS) 5) Technical assistance in QA and EQA programs.
APHL activities build sustainable capacity through TOT, long-term twinning agreements and internships at U.S. public health laboratories.
APHL also collaborates with WHO/AFRO to support a national laboratory communications network. In Africa, APHL supports training courses at the African Center for Integrated Laboratory Training with faculty and curricula.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13094**
Mechanism Name:	**Association of Public Health Laboratories Centrally funded CoAG**
Prime Partner Name:	**Association of Public Health Laboratories**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	1	0

Narrative:

Through the collaboration with CDC-DRC, APHL has identified the key priorities for DRC as:

1. Laboratory Policy and Strategic Planning development and implementation
APHL will continue to provide technical assistance with a focus on the review and development of DRC laboratory policy and strategic planning. The activity will include ensuring the implementation of the strategic plan goals developed for the National laboratory network in DRC.
2. Strengthening of the National Laboratory Information Systems
APHL will provide technical assistance to CDC-DRC IT team in LIS activities identified following BLIS pilot phase by CDC Atlanta representative Mark DeZalia. Activity will include field testing in three facilities.
3. One trip is needed for one APHL staff to coordinate work and provide support to the program

Implementing Mechanism Details

Mechanism ID: 13183	**Mechanism Name: Programme National de Lutte contre le VIH/SIDA et IST/ National AIDS Control Program**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Programme National de Lutte contre le VIH/SIDA et IST	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,001	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,001

Sub Partner Name(s)

(No data provided.)

Overview Narrative

IM 14824: OVERVIEW NARRATIVE

The first component of PNLS activity is aimed at providing reliable and accurate HIV data for planning and evaluating the impact of the HIV/AIDS interventions in DRC by conducting consecutive annually rounds of ANC sentinel surveillance targeting pregnant women. Reports including HIV prevalence trends will be produced and disseminated among the MOH and all the stakeholders for planning and program evaluation purposes.

The second component focuses on the setting up and the management of an unique countrywide reporting system using standardized forms starting at service delivery points, at the intermediate level to the central M&E level at the PNLS. This information will be made available through a web-based reporting system. The system will be led by the PNLS, as the National Control Program and will therefore be used throughout the country in order to have reports on-time, avoid reporting delays and make DRC's relevant data available for PEPFAR’s partners and all stakeholders.

The third component is to develop and manage a quality assurance system at the national referral lab (the lab branch of the PNLS) which will provide QA/QC services through 3 of its provincial labs and subsequently to some labs involved in HIV testing and HIV /AIDS disease monitoring.

PNLS will work closely with CDC/DRC and key partners to achieve the goals of this project. For this purpose, a focus will be maintained on the strengthening capacity of the PNLS in PEPFAR program management.

Finally, in the framework of the PMTCT Acceleration plan, the PNLS will ensure QA/QC services to PEPFAR-supported sites, through its lab branch, the national referral lab (NRL) and will monitor the efficacy of interventions by conducting pediatric HIV surveillance activities in

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	48,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13183**
Mechanism Name:	**Programme National de Lutte contre le VIH/SIDA et IST/ National AIDS Control Program**
Prime Partner Name:	**Programme National de Lutte contre le VIH/SIDA et IST**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	HLAB	200,001	0

Systems			

Narrative:

The third component is to develop and manage a quality assurance system at the national referral lab (the lab branch of the PNLS) which will provide QA/QC services through 3 of its provincial labs and subsequently to some labs involved in HIV testing and HIV /AIDS disease monitoring.
To accelerate the setup of national laboratory network with an efficient quality control system.
This activity will strengthen the capacity of the National referral laboratory of PNLS (NRL) to better play its role of ensuring quality assurance of lab activities. Thus, It will support the QC of lab analysis performed by 09 health facilities located in 3 PEPFAR supported-provinces (Kinshasa, Katanga and Orientale). The main activities will consist (1) in preparing and sending each month the DTS panels (a set of 6 samples) to the lab of the selected health facilities. They wil perform analysis on the DTS; they will re-send DTS results and additional DBS samples to the NRL for control and feedback.
(2) support the 09 health facilities in providing lab reagents and other materials for avoiding stock-outs.
(3) in conducting regular sites formative supervision (on-site mentoring each quarter). Findings from QC will determine the kind of training needed for improving on-site lab analysis.
(4) in purchasing a laboratory software for lab data management system. It will permit a better lab data record keeping, analysis and using for decision-making.
and (5) in strengthening lab staff capacity in data management.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	0	0

Narrative:

The first component for the program is related to the conduct of ANC sentinel surveillance activities. The overall aim of establishing routine sentinel surveillance among ANC attendees in DRC is to collect data for the estimation of HIV prevalence rates. In addition, it is in line with the 2011-2015 national strategic plan. It relies on a cross-sectional, biological survey using the UAT approach. Due to ethics issues, in 2012, PNLS will start in 9 pilot sites offering quality PMTCT services and enrolled in QA/QC program, equally to collect data in order to assess the feasibility of using PMTCT program data for surveillance purpose by comparing them with data yield by routine UAT methodology. In addition, the number of sentinel site will increase from 47 to 54 throughout the country among them 70% will be located in rural areas. This is to be consistent with the geographical split of the population in DRC. To strengthen the capacity of the PNLS's Surveillance team, they will attend regional trainings such as the 2013 Regional Meeting on updating of HIV prevalence estimates and projections (EPP Spectrum).
The second component focus on the setting up and the management of an unique countrywide reporting system using standardized forms starting at service delivery points, at the intermediate level to the

central M&E level at the PNLS to improve the accuracy, reliability, timeliness, completeness and the precision of the data produced for decision-making.
The reporting system is a critical HIV M&E tool linked to the National Health Information System comprised of in the 2011-2015 National Health Development Plan. It aims to facilitate the collection, transmission, analysis and the dissemination of routine HIV program data and the results of relevant surveillance surveys.
For COP 12, activities will be focusing on updating and standardizing data collection and reporting tools and building capacity of MOH staff at all level (Health District, Province and Central).
In addition, the PNLS will also support the organization of monthly meeting organized for validation of data at all level prior to their posting at the web.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

In DRC, there is little capacity to follow HIV exposed babies at maternities and as such they are referred to specialized centers based on a family care model. Due to several factors, including the low coverage rates of PMTCT, rates of EID are low as are the number of infants on ART.
However, as a key component of PMTCT for diagnosis and treatment, laboratory capacity for providing an HIV test within 12 months of birth to infants born to HIV positive women must be enhanced.
Currently all the specimens are tested at the national referral lab (NRL) that is the single unit running the EID in the country. This lab was appropriately equipped with CDC support and thanks to PEPFAR, lab reagents and other consumables are somehow provided. However, it faces the daily challenges of a shortage of test kits, an inconsistent supply of reagents, and frequent electricity supply interruption.
There is also a provincial referral lab in Lubumbashi, not fully functional but equally equipped and staffs trained that can be leveraged for long term scale up of EID services.
Furthermore, with PEPFAR support, a QA/QC process targeting 9 sites started in FY 12, but the national referral lab (NRL) did not have the capacity to scale-up.

With the PMTCT acceleration plan opportunity, in FY 2012, the national referral lab (NRL) in Kinshasa and the provincial lab in Lubumbashi (Katanga) will be technically and financially supported in order to expand EID services (create a system of referral documentation and follow up for all mothers and infants who need ART in place and utilized by PEPFAR-supported sites, develop and adopt a national HTC curriculum including QA at point of care for HIV rapid testing, etc.) and scale up QA/QC activities for HIV testing, EID and CD4 testing capacities to PEPFAR supported sites in Kinshasa and in Lubumbashi.
The second main activity for evaluating efficacy of the PMCT acceleration interventions will be the rolling out of routine pediatric HIV surveillance activities in some selected MCH facilities in Kinshasa. The

overall methodology will consist in estimating HIV prevalence trends in using for testing purpose the leftover blood drawn from babies for routine testing.

Implementing Mechanism Details

Mechanism ID: 13338	**Mechanism Name: Technical Assistance in Support of the President''s Emergency Plan for AIDS Relief**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Tulane University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 79,769	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	79,769

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Under its CoAg with CDC PEPFAR and during the Yr3 of its activities in DRC, Tulane University proposes to reinforce Health Information Systems and to strengthen the capacities of PNLS/MoH staff for data management up to HIV/AIDS Strategic Information production.

Objectives include: 1) to make available every semester the unified HIV data collection tools in Health Zones where PEPFAR activities are being implemented; 2) to train 450 Data Managers in the HZ in the use of the unified HIV data collection tools; 3) to train 150 supervising nurses and/or administrative managers at the coordinating level of the HZ in the use of unified HIV data collection tools and the treatment of collected data; 4) to train 28 HIV Data managers from the PNLS provincial and national to the production of SI and the use of the reporting system (RS); 5) to train 30 M&E staff among PEPFAR IPs in the use of the unified HIV data collection tools and of the RS; and 6) to lead follow-up capacity building activities for all trained staff through mentoring and coaching activities.

In order to reach the proposed objectives, we offer to implement the following activities: 1) Providing PEPFAR HZ with unified HIV data collection tools every six months; 2) Training in HIV data collection using the revised and unified HIV data collection tools (registers) and the HZ (canvas) and in the treatment of the collected Data; 3) Training in the use of Excel, SPSS and GIS tools for the production of SI (treatment and analysis of the HIV Data collected using the revised unified tools); 4) Capacity Strengthening Workshop for PEPFAR IPs M&E staff on NGI, the use of unified HIV Tools and the use of the RS; and 5) Capacity building Follow-up (Field visits) of the Training's participants' skills and competences.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	20,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13338**
Mechanism Name:	**Technical Assistance in Support of the President''s Emergency Plan for AIDS Relief**
Prime Partner Name:	**Tulane University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	79,769	0

Systems			

Narrative:

1) Providing PEPFAR Health Zones with unified HIV data collection tools every six months: $12,560. - In order to reduce the unavailability of data collection tools, Tulane project will help providing the 75 PEPFAR Health Zones with unified data collection tool. A total of 16,200 copies will be made available every six months.
2) Training on HIV data collection using the revised and unified data collection tools in the healthcare infrastructures and the Health Zone: $22,640. - In order to have HIV data of better quality, Tulane will help strengthening the skills and competences of database managers of healthcare infrastructures and CBHZ. A first training will be focused on data collection and will target the healthcare data managers; a total of 450 data managers will be trained. The second will be focused on data collection and data treatment will target the supervising nurses of the CBHZ; a total of 150 supervising nurses will be trained.
3) Training in the use of the Excel, SPSS and GIS tools for the production of Strategic Information (treatment and analysis of the HIV Data collected using the revised unified tools) and of the reporting system: $ 14,560. - In order to produce and disseminate quality strategic information on HIV/Aids, Tulane will help strengthening skills and competencies of technical database managers of PNLS PC bureaus and those of PNLS national divisions. A total of 28 participants will be trained.
4) Capacity Strengthening Workshop for PEPFAR Implementing Partner's M&E staff on NGI, the use of unified HIV Data Collection Tools and the use of the reporting system: $ 10,160. - In order to familiarize PEPFAR implementing partners with NGI, the use of new HIV data collection tools and of reporting system, Tulane will organize a 3-day workshop targeting PEPFAR Implementing Partner's M&E Staff. A total of 30 participants will attend.
5) Capacity building Follow-up (Field visits) of the Trainees' skills and competences through mentoring and coaching: $ 20,080. - Tulane will organize two supervisions per year, for the 9 PNLS PC bureaus and the 75 PEPFAR CBHZ in order to follow-up database managers on HIV data collection, data treatment and production of strategic information.

Implementing Mechanism Details

Mechanism ID: 13386	**Mechanism Name: Advancing Social Marketing in DRC-AIDSTAR**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A

Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PSI/ASF aims to improve the health status of the people of the Democratic Republic of the Congo. The main objectives of the project are: (1) Increase the supply and diversity of health products and services that are to be distributed and delivered through the private sector, in conjunction with the public sector, for disease prevention and control as well as integrated health service delivery. (2) Increase awareness of and demand for health products and services to emphasize prevention of HIV infection and STIs, and to build an informed, sustainable consumer base. (3) Develop and/or enhance the ability of commercial/private sector entities to socially market health products and services including behavior change communication activities. (4) Integrate service delivery and other activities, emphasizing prevention, at national, provincial, district, facility, and community levels through joint planning with the GDRC, other United States Government (USG), and non-USG partners. Seven provinces are concerned by HIV interventions: Bas-Congo, Kinshasa, Katanga, Kasai Occidental, Kasai Oriental and Sud-Kivu.

In each of these provinces, we intervene in provincial capitals, medical districts and health zones. These prevention interventions specifically target sex workers, uniformed service personnel, mobile populations, miners, truck drivers, other transporters and people living with HIV/AIDS (PLWHA). Nevertheless, youth aged 15-24 years and general population (men and women aged 20-49) will also be targeted. Sustainability is a major priority of the PSI/ASF program and has been a key component to strategy development and activity implementation.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Principal Recipient**

3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
OHSS	Ministry of Health	0	Bednet campaign, Human ressources for health and Monitoring and evaluation

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Military Population
Mobile Population
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**13386**		
Mechanism Name:	**Advancing Social Marketing in DRC-AIDSTAR**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**

Prevention	HVAB	0	0

Narrative:

With FY12-13 funds, the project will build upon previous project activities to expand prevention interventions in existing project sites, adding some sites for specific interventions. Key activities promoting HIV prevention through Abstinence messages will include prevention interventions specifically targeting youth aged 15-24,and through Being Faithful messages targeting people living in couple (police officers, military personnel, truckers). With peer education on AB activities, we will reach 19,942 people in FY12 and 21,437 in FY13. This means that for FY12, each PE will reach 13 youth each month repeatedly through 4 IPC sessions. These 4 sessions will be held with the same 13 attendees on different evidence-based factors contributing to increase the opportunity of behavior change within the respective target groups. In total, 6,556 individual and/or small group sessions will be held during FY12. The messages given to target groups during IPC sessions will be reinforced with video-forum and audiovisual mass animations. According to DHS 2007, young men aged 15-19 have a seroprevalence (1.7%) higher than the national average (1.3%) and young girls' of same age (0.7%). Six provinces are concerned by HIV interventions (see Overview Narrative). Quality of service delivery is assured by (1) the selection of PEs conducted by PSI/ASF, local NGOs and government agencies, (2) their training by experimented national trainers, (3) supervisions conducted by local NGOs themselves, and joint supervisions by PSI/ASF and government agencies, PSI/ASF and USG's agencies. We will strengthen the primary prevention for youth who have never had sex and a secondary prevention for those who have already started sexual activities through behavior change communication (BCC) activities. Young adults reluctant to abstain will be counseled on proper condom use and where to obtain them, and others will be referred to VCT centers. PSI/ASF will continue to implement M&E activities to ensure service quality based on national and USG requirements and will submit to PEPFAR semiannual program results and ad hoc requested program data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

With FY12-13 funds, the project will build upon previous project activities to expand prevention interventions in existing project sites, adding some sites for specific interventions. Key activities promoting HIV prevention through other means of prevention (OP) messages will include prevention interventions specifically targeting commercial sex workers (CSWs), uniformed service personnel, truck drivers, men who have sex with men (MSM) and people living with HIV/AIDS (PLWHA). With peer education on OP activities, we will reach 16,566 people in FY12 and 17,286 people in FY13. This means that for FY12, each PE will reach approximately 13 people each month repeatedly through 4 IPC

sessions. These 4 sessions will be held with the same 13 attendees on different evidence-based factors contributing to increase the opportunity of behavior change within the respective target groups. In total, 5,628 individual and/or small group sessions will be held during FY12. The messages given to target groups during IPC sessions will be reinforced with video-forum and audiovisual mass animations. Six provinces are concerned by HIV interventions (see Overview Narrative). Quality of service delivery is assured by (1) the selection of PEs conducted by PSI/ASF, local NGOs and government agencies, (2) their training by experimented national trainers, (3) supervisions conducted by local NGOs themselves, and joint supervisions by PSI/ASF and government agencies, PSI/ASF and USG's agencies. Condom distribution and referral to counseling and testing, and STI management facilities will be key prioritary interventions under OP activities. PSI/ASF will continue to implement M&E activities to ensure service quality based on national and USG requirements and will submit to PEPFAR semiannual program results and ad hoc requested program data.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

As DRC will implement the PMTCT acceleration plan, PSI will bring his Family planning expertise to train all PEPFAR implemeting partners in Family planning and USG compliance. Therefore, Family planning will be implemented as a wraparound activity and be intergrating in MCH/HIV platform.

Implementing Mechanism Details

Mechanism ID: 13476	**Mechanism Name: Technical assistance in support of HIV prevention, care, and treatment programs and other infectious diseases that impact HIV-infected patients in the Democratic Republic of Congo in support of the President''s Emergency Plan for AIDS Relief (PEPFAR)**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: International Center for AIDS Care and Treatment Programs, Columbia University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,273,585	Total Mechanism Pipeline: N/A
Funding Source	**Funding Amount**
GHP-State	2,273,585

Sub Partner Name(s)

Action Contre la Faim	Armee du Salut	

Overview Narrative

ICAP will build on its Year 2 work in supporting the PNLS, PNLT and LNR to expand the availability, quality and uptake of HIV-related services. ICAP-DRC will provide intensive technical support to build the capacity of provincial and health zone authorities and site-level health workers to deliver family-centered comprehensive HIV/AIDS services. ICAP will continue to strengthen the service capacity of 4 zonal hospitals and 30 TB clinics in Kinshasa to provide a sustainable, evidence-based model of comprehensive, evidence-based family-centered HIV prevention, care and treatment services; and will newly extend support to 1 provincial and 1 zonal hospitals in Lubumbashi. As components of this intervention, ICAP will support facilities to develop strong, integrated PMTCT and TB/HIV co-infection programs, to strengthen their laboratory networks for HIV-related diagnostics, and to develop comprehensive program monitoring and quality improvement systems. As part of support the elimination of pediatric HIV (acceleration plan), with COP11 additional funds, we will expand PMTCT activities in 97 sites in Kinshasa and 49 in Lubumbashi.

Overall project strategies will be guided by ICAP's experience establishing family-centered, comprehensive HIV services. Key strategies are family-centered care, multidisciplinary teams, community involvement and health systems strengthening.

ICAP will establish an overall project advisory committee in the two intervention cities composed of key representatives from CDC, provincial and zonal health authorities, NGO/CBO stakeholders, and PLHIV groups.

Two vehicles are already purchased, procurement of 3 is ongoing. In order to support PMTCT expansion to cover 129 supplementary sites, we will request 2 additional vehicles.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**

2. Is this partner also a Global Fund principal or sub-recipient? **Neither**

3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HBHC	PLWHA, HEI, HIV infected pregnant women	1134200	Nutritional support , adherence and psychosocial activities, OI prevention and treatment activities
HLAB	HIV patients and health facilities	571970	HIV testing and HIV disease monitoring
HTXS	HIV infected patients	331800	ARV treatment
HVTB	TB patients and HIV infected patients	487500	HIV Testing for TB patients and TB screenning for HIV patients
PDCS	HEI, infants and children	564000	Testing for HEI (PCR), support nutritional, peer education, support group, OI prevention activities
PDTX	HIV infected Infants and children	300000	ARV treatment

Cross-Cutting Budget Attribution(s)

Construction/Renovation	10,000
Food and Nutrition: Commodities	600,000
Food and Nutrition: Policy, Tools, and Service Delivery	200,000
Human Resources for Health	510,130

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Military Population
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**13476**
Mechanism Name:	**Technical assistance in support of HIV prevention, care, and treatment programs and other infectious diseases that impact HIV-infected patients in the Democratic Republic of Congo in support of the President''s Emergency Plan for AIDS Relief (PEPFAR)**
Prime Partner Name:	**International Center for AIDS Care and Treatment Programs, Columbia University**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	134,200	0

Narrative:

ICAP will support sites to increase use of comprehensive care services by HIV-infected individuals and families. ICAP will assist sites to provide high quality HIV care in accordance with national guidelines, supporting site staff to introduce the adapted Clinical Systems Mentoring tools, including Model of Care initial assessment and Standard of Care quality improvement tools, to initiate a standard package of care and support services and apply the standard of care tools to assess the quality of care provided. The package introduced at each site will include clinical and immunological monitoring and ART eligibility assessment, routine weight and nutritional assessment and support, OI prophylaxis and treatment, counseling, patient education, peer support, and food supplements as needed. Patients in HIV care not

yet requiring ART will be monitored regularly so that ART eligibility is promptly identified and ART initiated accordingly. Routine TB screening using a simple symptom questionnaire will be offered to all patients and at each visit. PwP interventions will include counseling and education on serostatus disclosure, partner HIV testing, adherence support, support for alcohol reduction and condom use; diagnosis and management of STIs; and contraception and safer pregnancy counseling. ICAP will train and mentor MDTs, to shift from a traditional nonintegrated care model to a more effective integrated, chronic care model. Facilities will be supported to implement patient flow algorithms, appointment systems, national treatment protocols, adherence support, family testing chart and will develop patient tracking systems to support linkages and retention. HIV care and treatment will be integrated with other clinical services. ICAP will partner with Action Contre la Faim to provide nutritional support to patients at facilities in Kinshasa. ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained to disseminate messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	487,500	0

Narrative:

During FY12, ICAP will continue support facilities to decrease the burden of TB in HIV-infected individuals and their family members through the provision of comprehensive HIV/TB services, including: technical assistance to improve TB diagnostic capacity and quality control at clinical laboratories; and palliative care and treatment for co-infected clients. ICAP's efforts will continue focus on three approaches: integrating TB services into HIV care and treatment; integrated HIV service into TB services at CSDT and improve TB infection control.

Integration of TB services into HIV care and treatment
ICAP will ensure that TB case finding among adults and children is consistently implemented at enrollment and at follow-up visits using a simple symptom checklist adapted from national guidelines and other ICAP programs, and that those who screen positive are assessed via sputum smear microscopy, chest X-ray and, where possible, TB culture, ensuring that those diagnosed with TB are treated at CSDT. TB screening will be extended to the families of HIV-infected patients, particularly children and other family members at risk of contracting latent TB infection and developing TB disease, TB screening will be introduced at all facilities.

Integration of HIV into TB services at CSDT
During FY11, with ICAP support, the supported TB clinics have improved the rate of tested TB patients

from 54 to 85%.
ICAP will continue ensure that TB patients at CSDT are systematically offered PICT, and that those testing positive for HIV are given CPT, enrolled in care and promptly started on ART at health centers or zonal hospitals. Further, to protect HIV infected individuals and health care workers from nosocomial TB, ICAP will promote infection control measures that minimize the risk of TB transmission.
These activities will be extended to 10 additional TB clinics in Kinshasa and Lubumbashi. ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained so that they disseminate key messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	564,000	0

Narrative:

ICAP will support health facilities to improve health outcomes of HIV-infected children and HIV exposed infants and adolescents through the provision of comprehensive medical care, including early identification of HIV infection, no-cost ART and psychosocial support to HIV-infected children and their nuclear family members. ICAP will support sites to ensure that care of HIV infected infants, children and adolescents form an integral part of maternal and child health, covering ANC, PMTCT, labor and delivery, postpartum and pediatric services. Most sites will need support to address gaps in equipment, supplies and medications. ICAP will train teams of providers at each site in pediatric HIV. The training will consist of a didactic training, followed by an in-service training during service initiation, and follow-up support until each site has mastered the necessary clinical skills. The training will address care of HIV-exposed and infected infants, children and adolescents, including provision of integrated clinical care for infants (vaccinations, nutritional support, and growth/developmental monitoring), ARV prophylaxis for exposed infants ensuring ARV protected breastfeeding, medications for prophylaxis and treatment of OI, and preventive therapy against TB in HIV exposed and infected children (TB screening and provision of IPT to children who are close contacts of TB cases),HAART for all children < 2y and timely determination of ART eligibility for older children. ICAP will work with peer educators and community relay teams to support facilities to provide psychosocial and adherence support and refer infants, children, and adolescents to the health services for ART. ICAP will coordinate activities with others implementing partners to avoid duplication of efforts. ICAP will partner with Action Contre la Faim to provide nutritional support to patients served at facilities throughout Kinshasa. ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained so that they disseminate key messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Governance and Systems	HLAB	371,970	0

Narrative:

ICAP lab support in DRC will continue to tackle the deficits of skilled human resources, to address inadequate infrastructure, to equip labs for proper diagnostics, to improve lab supply chain management, and to strengthen lab leadership by improving management and operational mechanisms. Emphasis will continue to be put on development of quality assurance (QA) systems.
ICAP will continue to strengthen the HIV laboratory network in Kinshasa, increasing capacity of district and zonal labs to perform HIV rapid testing ensuring same day results, DNA PCR testing for early infant diagnosis, CD4 and other lab tests necessary for HIV care and treatment. In addition, 10 CSDT will be provided with LED microscopes for improving TB diagnosis.
The zonal lab networks and transportation systems will continue to be strengthened to enable facilities without hematology, biochemistry and CD4 capacity to access such services, for instance for PMTCT sites to determine ART eligibility of HIV-infected pregnant women. Funds will be provided to each health facility for sample transportation. Transporting results back to the facilities will use the same transportation system.
ICAP will provide TA in the use of CD4 PIMA machines, capacity for blood draw of DNA PCR samples and storage, centrifuge and solar panel in all PMTCT and TB sites with care and treatment services.
ICAP will continue to support the implementation of quality assurance measures, and will continue to use a lab system mentorship approach to improve the overall management and quality of the lab networks.
Equipment will be installed by ICAP once planned renovations have been completed.
ICAP will continue assess lab system and provide ongoing training and mentoring in reagent forecasting and stock management to ECS and site lab staff. ICAP will also support systems and coordinate with the MOH, the Global Fund, KSPH and the Clinton Foundation to ensure that reagents are delivered in a timely manner to site in each health facility. ICAP will also continue to upgrade stock rooms and data management systems.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	200,000	0

Narrative:

ICAP will continue support GODRC and health facilities to improve health outcomes of HIV-infected pregnant women through the provision of comprehensive PMTCT services at 17 sites in Kinshasa for COP12 while will expand to 80 new sites in Kinshasa and 49 in Lubumbashi regrouped in 33 hubs and their satellites, with PMTCT expansion funds both in public and private clinics. The package of services will include: counseling and testing services at ANC, delivery wards and post natal services; biological

monitoring; and comprehensive medical care, including no-cost ART, psychosocial support and palliative care, to HIV-infected pregnant women and their first degree family members, HEI follow up, provision EID and nutritional support. We expect to test 140,000 pregnant women over 2 years.
In coordination with GODRC, ICAP will continue conduct site assessments and site-level supervision and mentoring. ICAP will continue support site staff, health zone and provincial PMTCT focal points to reorient and streamline services, ensuring the provision of more efficacious PMTCT regimens and HAART for eligible women throughout the PMTCT care spectrum. ICAP-supported sites will provide high-quality counseling to maximize the uptake of counseling and testing in the ANC setting and the uptake of and adherence to PMTCT services using peer educators. Within ANC, HIV-infected pregnant women will receive a complete package of services including same day blood draw for CD4 to rapidly determine ART eligibility, STI screening, OI and ART prophylaxis, HAART, TB screening, prophylaxis for malaria, family planning and insecticide-treated bed nets. To minimize loss to follow up, finger prick will be implemented in all sites to ensure same day result. To improve male partners involvement community mobilization activities will be carried out. ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained so that they disseminate key messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXS	331,800	0

Narrative:

ICAP will expand support 58 care and treatment facilities to implement patient-flow algorithms, patient appointment systems, and national protocols for pre-ART and ART care. Capacity building of health care workers will be reinforced via workshop, on-site training and mentorship. Mentoring and supervision visits are conducted on weekly basis.
Stock management, forecasting, managerial and pharmacy operations will be enhanced, and appropriate medical records systems (appointment books, logs, patient files/forms) and data management and use will be introduced.
ICAP will support sites to implement the model of care through intensive hands-on support including provider-level mentorship, development of Multi-Disciplinary Teams (MDT), service integration and provision, and ongoing supportive supervision to ensure quality of care as described above
In the supported sites, ICAP will institute or strengthen on-site coordination meetings to identify and address care-system challenges and regular multidisciplinary team (MDT) meetings in facilities to share patient outcomes and experience. ICAP will train the zonal health team and hospital staff on mentorship and supervision.
Facilities will be supported to implement patient flow algorithms, appointment systems, national treatment

protocols, adherence support, family testing chart and will develop patient tracking systems to support linkages and retention to minimize loss to follow-up. HIV care and treatment will be integrated with other clinical services, including ANC, adult outpatient departments.
ICAP will continue manage a security stock of ARVs ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained so that they disseminate key messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	184,115	0

Narrative:

ICAP will target several entry points to increase access to HIV testing and treatment for HIV exposed and infected infants, children and adolescents ensuring pediatric provided initiated testing (PITC) including PMTCT services, and integrated into immunization services, pediatric wards, outpatient department, nutrition services and the nuclear family members enrolled into HIV care and treatment services. Capacity building of health care workers will be reinforced via workshop, on-site training and mentorship. Supervision visits will be conducted on weekly basis. For scaling up, ICAP will continue support site staff, health zone and provincial PMTCT/pediatric focal points to reorient and streamline services, ensuring effective PITC at all health sector levels, referral to care and treatment services and optimizing retention in care. These Focal points will supervise the program, routinely collect data, offer mentoring and monitor the quality of services. ICAP will work with peer educators and community relay teams to support facilities to provide needed psychosocial and adherence support and refer infants, children, and adolescents to the health services for ART when not possible to offer care and treatment services at same site. ICAP will make every effort to coordinate activities with others implementing partners to avoid duplication of efforts.
All supported facilities caring for HIV exposed and infected infants will be linked to ICAP lab network for HIV disease monitoring. For EID, ICAP will strengthen sample transportation system and result return between supported facilities and LNRS. ICAP will also provide TA to sites and PLHIV associations to recruit male community volunteers to be trained so that they disseminate key messages about SGBV awareness and prevention. ICAP will work with site MDTs and health authorities to implement a system approach to integrate SGBV and HIV services for survivors

Implementing Mechanism Details

Mechanism ID: 13537	**Mechanism Name: TB IQC: TB Task Order 2015-Support for Stop TB Strategy Implementation - DRC**

Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

Management Systems for Health		

Overview Narrative

Objective: Improve management of TB/HIV co-infected patients in supported provinces and cities.
TB 2015 will continue capacity-building activities for joint TB/HIV planning, monitoring, and evaluation; scale-up active TB case finding in people living with HIV/AIDS; support HIV counseling and testing in TB patients, cotrimoxazole preventative therapy, referral of HIV+ patients to treatment services, and TB infection control in health facilities and congregate settings. Specifically, TB 2015 will continue supporting quarterly and annual coordination meetings between the TB and HIV programs and their partners at the national and provincial levels; facilitate roll-out of the “TB Screening Checklist to PLWHA” and “Referral Forms”; quality HIV testing and counseling services, as well as re-activate any relevant support groups. TB 2015 will also continue the roll-out and training of health providers on the national Infection Control guidelines and corresponding job aids.
Particularly, TB 2015 will strengthen integrated TB-HIV services in the 30 existing sites (7 in Bukavu, 4 in Mbujimayi, 5 in Kananga, 4 in Tshikapa, 1 in Kinshasa, 3 in Lubumbashi, 1 in Kisangani, 2 in EQE, 2 in Maniema and 1 in Sankuru. With availability of funds, TB 2015 plans to increase the number of sites at 35 with 5 more sites in interventions areas.
We will reach 35 sites with TB/HIV integrated activities by the end of september 2013. In other hand, TB 2015 will ensure synergies and leverage opportunities with other partners like ProVIC and MSH for further scale-up of TB-HIV activities. As the funding for this component is from PEPFAR, TB 2015 will collaborate on relevant PEPFAR reporting.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

TB

Budget Code Information

Mechanism ID:	**13537**
Mechanism Name:	**TB IQC: TB Task Order 2015- Support for Stop TB Strategy Implementation - DRC**
Prime Partner Name:	**Program for Appropriate Technology in Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	0	0

Narrative:

By using carrying-over funds, TB 2015 will continue capacity-building activities for joint TB/HIV planning, monitoring, and evaluation; scale-up active TB case finding in people living with HIV/AIDS; support HIV counseling and testing in TB patients, cotrimoxazole preventative therapy, referral of HIV+ patients to treatment services, and TB infection control in health facilities and congregate settings. Specifically, TB 2015 will continue supporting quarterly and annual coordination meetings between the TB and HIV programs and their partners at the national and provincial levels; facilitate roll-out of the “TB Screening

Checklist to PLWHA" and "Referral Forms"; quality HIV testing and counseling services, as well as re-activate any relevant support groups. TB 2015 will also continue the roll-out and training of health providers on the national Infection Control guidelines and corresponding job aids. TB 2015 will strengthen integrated TB-HIV services in the 30 existing sites (7 in Bukavu, 4 in Mbujimayi, 5 in Kananga, 4 in Tshikapa, 1 in Kinshasa, 3 in Lubumbashi, 1 in Kisangani, 2 in EQE, 2 in Maniema and 1 in Sankuru. With availability of funds, TB 2015 plans to increase the number of sites at 35 with 5 more sites in interventions areas. We will reach 35 sites with TB/HIV integrated activities by the end of september 2013. Main activities: 1. Support coordination of TB/HIV activities at national and provincial levels 2. Strengthen national capacity to plan, manage, and evaluate TB/HIV activities. 3. Strengthen and scale up integration of TB and HIV services at health facility level 4. Ensure adequate commodities and commodity management to supported sites. 5. Introduce infection prevention and control at facility level in high-risk settings. 6. Increase case-finding and provide support to HIV-positive individuals through community-based outreach services. 7. Support laboratory strengthening and plan for introduction of new diagnostic technologies that can increase TB case-finding in HIV-positive individuals.

Implementing Mechanism Details

Mechanism ID: 13542	**Mechanism Name: Programme National de Transfusion et Sécurité Sanguine (PNTS) / National Blood Safety Program**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Programme National de Transfusion et Sécurité Sanguine	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 722,639	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	722,639

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This project will allow PNTS to improve the cover of needs through activities aligned with PEPFAR objectives regarding prevention by avoiding the new infections. The project contributes to reduce mortality and morbidity due to HIV/AIDS through assuring safe and adequate blood products for transfusion.
In general, ours objectives are:(I) rehabilitating infrastructures and equipping Provincial Blood Transfusion Centers (CPTS) and Reference Hospital Transfusion Centers (CHRTS) , (II) mobilizing the community to increase the number of non-remunerated voluntaries blood donors, (III) supplying CPTS and CHRTS in reagents and consumables for blood safety, and(iv) assuring trainings of healthcare providers, peer recruiters and others personnel according to the needs.
Specifically for year 3 we plan to: (i) equip 12 CHRTS & 2 others CPTS;
(ii) collect and test 24,000 blood units, (iii) training of 100 healthcare workers in several aspects of blood transfusion and 100 peer recruiters, (iv)recruit 10000 news non-remunerated donors and (v) retain 1334 non-remunerated donors,(vi) training of CNTS or CPTS staff in public health,(vii) strengthen 2 monitoring and evaluation unities,(viii) supporting central or provincial level staff participation in international conferences and (ix)coordinate all activities of blood safety in DRC. The amount of money requested is 900,000 USD for the year 3.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Sub Recipient**
3. What activities does this partner undertake to support global fund implementation or governance?
(No data provided.)

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**13542**
Mechanism Name:	**Programme National de Transfusion et Sécurité Sanguine (PNTS) / National Blood Safety Program**
Prime Partner Name:	**Programme National de Transfusion et Sécurité Sanguine**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMBL	572,639	0

Narrative:

Fringe :The fringe was calculated at 1.0% of the Total for salaries. Total Fringe Benefits is $ 2,194. 20. $ 219,420 reserved for the personal salaries.
Consultant Costs: A translator will be employed to translate official documents including reports, forms and submissions for CDC-DRC/CDC-ATL. The cost is $ 8 ,090 according to the volume of materials.
Equipment: For this year, the CNTS will be equipped with (i) one immuno hematology automate for $ 6,000 . This equipment will help CNTS to increase its capacity to manage the volume of safe blood products. Also, CNTS will buy 2 Elisa chains for $ 19,000; 11 solar blood banks for each province for $ 150 000. The total cost for equipment is $ 175 ,000.
Supplies : Reagents and consumables will be purchased for blood collection and screening. These include rapid tests for HIV 1&2, Hepatitis B, Hepatitis C, and syphilis; anti-serum for blood groups A, B, AB, and D; Elisa tests, specific tests for the serological automate, empty blood units in 250 and 450 ml sizes transfusion tubing and disposable gloves. These reagents & consumables will be provided to 11 CHRTS, 5 CPTS and CNTS. The budget for these reagents are $ 181,847.60
Travel: In order to ensure quality control of the project activities, a mission of 7 day M&E supervision is planned in each province within the program: Bas Congo, Kasai Or., Katanga, Province Or., and Sud

Kivu. For each province, one personnel from the central level will go on a five to seven day supervision project. Perdiem and transport costs between provinces are averaged based on the rates provided by the MOH. The total cost for travel between all five provinces (non including Kinshasa) is $ 9250.
Others costs include: (i) Blood collection campaigns for $ 71000,(ii) Blood donor recruitment for $20,000,(iii)Blood donor retention for $ 20,010;(iv) Strengthening M&E capacity unities for $ 5500,(vi) Vehicles for $ 105,000 , (vii)Operations Costs : for $19,170 (CNTS)and $ 64,160 for the(CPTS).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	150,000	0

Narrative:

Implementing Mechanism Details

Mechanism ID: 13595	**Mechanism Name: ROADS II**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0
GHP-USAID	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This project will further strengthen sustainable prevention, care and support activities and linkages to services reaching the most at-risk and vulnerable populations along the transport corridor. We do not envision ROADS as a large stand-alone project. It is a gap-filler and will need to closely integrate its

activities into PEPFAR activities already on the ground. The project will established a Safe-T-Stops resource center in various sites that provides prevention services to the truckers and vulnerable populations (such as FSW and women engaged in transactional sex) and works within the community to promote services at the Health Center (including counseling and testing) and provide prevention programming and outreach at high-risk venues through community events and through peer education.
The following are key tenets of the project's strategic approach:
1) Focused Interventions: This project will be a focused set of gender and HIV prevention sensitive interventions targeting specific clearly defined problems to be resolved within a 3-year timeframe;
2) Evidence-based strategies: This project will adapt an innovative mix of strategies and risk-reduction approaches that are based on current epidemiological and programmatic evidence, to target priority audiences with simultaneous behavioral social normative and structural interventions that respond to local realities;
3) Coordination with other USG-funded partners: Within targeted provinces, this program will work in close coordination with other USG implementing partners focused on supporting province-level capacity and governance, economic growth, health, HIV/AIDs, social protection, peace and security, to ensure USG funded programming is having the maximum possible impact.

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Mobile Population
TB
Family Planning

Budget Code Information

Mechanism ID:	**13595**
Mechanism Name:	**ROADS II**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	50,000	0

Narrative:

HIV prevention with PLHIV integrated into routine care will be a core component of a comprehensive and integrated HIV prevention, care, and treatment strategy.The key elements of a strong care and support program are interventions that lead to: a) Early identification of HIV-infected persons, linkage, and retention in care. Most HIV-infected persons enter HIV treatment and care programs with advanced disease. There is a need to identify persons earlier in their illness and to create effective linkage and retention mechanisms to maximize the benefits of HIV treatment and care;b) Reduction in HIV-related morbidity and mortality. Because of proven effectiveness and cost-effectiveness for reducing mortality, provision of cotrimoxazole to PLHIV support groups (CTX) prophylaxis and TB identification and treatment are very high priority interventions. Other services (prevention of malaria, WASH, food and nutrition, and others) that can reduce early morbidity or mortality outcomes will be implemented, depending on funding; c) Improved quality of life. The provision of appropriate psychological, social, and spiritual support are important elements in improving the quality of life for HIV-infected persons and family members and other contacts affected by HIV disease and d) Reduction in transmission of HIV infection from HIV-infected to uninfected persons. PwP programming, integrated into HIV care services, is critical for reducing the risk of ongoing HIV transmission. PwP activities include short term and ongoing behavioral counseling to reduce high-risk behaviors, distribution of condoms, attention to risks imposed by alcoholism and use of other drugs, and screening and treatment of sexually transmitted infections. Each of the above elements will be supported within a framework of key cross cutting considerations, including sensitivity to gender-specific issues, linkage of facility-based and community/home-based services, equitable distribution of services across geographic areas and populations; sustainable improvement in health care systems; improvement in the quality of programs, and appropriate monitoring and evaluation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	50,000	0

Narrative:

A specific focus of the strategic communication strategy including training) to promote abstinence, including delay of sexual activity or secondary abstinence, fidelity, reducing multiple partners and concurrent partners, and related social and community norms that influence these behaviors. Activities will address programming for both adolescents and adult, with a particular focus on HCT as an entry point. Part of bridging community to care will be involving health providers in developing and refining educational content and approaches. Encouraging involvement of providers and training them on HIV stigma and discrimination will help cement community trust of health facilities that are often viewed with mistrust. In this context, the project will partner with local health facilities in developing and adapting materials for PLHIV and the general public to enhance client-provider interaction on all services. It will be essential to involve facility, government and community opinion leaders as spokespersons in local radio, newspapers and public events. Working with health care providers on interpersonal communication skills to minimize stigma within the care setting is critical. Comprehensive HIV prevention package of best-practice interventions and SGBV awareness, with a focus on the high prevalence areas along transport corridor and other critical “hot spots” are provided to MARPs and vulnerable populations.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	0

Narrative:

Comprehensive HIV prevention package of best-practice interventions and SGBV awareness, with a focus on the high prevalence areas along transport corridor and other critical “hot spots” are provided to MARPs and vulnerable populations, specifically targeting HIV preventative efforts among MARPs (MSM, SWs, and SW clients) and vulnerable populations such as alcohol and other drug-using populations, mobile populations, and persons engaged in transactional sex. Additionally, the program will cover activities that target condom and other prevention other than “abstinence and be faithful” programs for the general population.

These will be the mechanisms to significantly increase the coverage and intensity of messages promoting consistent condom use and HCT, for example, and to directly provide relevant community based prevention services. This strategic thinking needs to be guided by the local epidemiology of the HIV epidemic, including consideration of populations at elevated risk, the drivers of that risk, and geographic areas of high transmission. Once identified, these populations should be reached with interventions that include the core components of evidence-based interventions. Comprehensive, accessible, acceptable, sustainable, high-quality, user-friendly HIV prevention, treatment, care and

support services will be scaled up and adapted to different local contexts. Even where services are theoretically available, sex workers face substantial obstacles to accessing HIV prevention, treatment care and support, particularly where sex work is criminalized. Ensuring that sex workers and their clients have meaningful access to essential services demand sconcerted action to overcome structural factors that limit access. Stigma and discrimination will be effectively addressed through engagement of civil society and policymakers

Implementing Mechanism Details

Mechanism ID: 13623	**Mechanism Name: Providing Capacity-Building Assistance to Government and Indigenous Congolese Organizations to Improve HIV/AIDS Service Delivery in the Democratic Republic of Congo under PEPFAR**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 50,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In this period budget, FHI360 will provide capacity building assistance in 3 main domains: PMTCT acceleration, OHSS and GBV. FHI360 will be involved in strategic information by strengthening the health system with computer equipment. All interventions will be implemented in Kinshasa, Lubumbashi and Kisangani, by working closely with the GRDC and local organizations, in collaboration with PEPFAR partners to improve HIV/AIDS service delivery.

Goal: to strengthen the human and institutional capacity of local partners focusing on SI; HIV/AIDS Prevention, Care & Treatment; and Policy Analysis & Development.
Objectives:
• Strengthen human and technical capacity to deliver HIV/AIDS and SGBV-related health services
• Strengthen the effectiveness of the national SI system for HIV/AIDS-related PMTCT services
• Enhance selected GDRC national programs' human and institutional capacities to develop evidence-based HIV and SGBV-related policies adapted to the local context.
Key Activities:
• Strengthen capacity of 30 trainers of trainers with the revised PMTCT training curriculum
• Capacity building of 750 PMTCT health care providers
• Increase PMTCT Technical Working functionality
• Identify and establish task forces for Training and for Policy
• Strengthen technical and organizational capacity of PNLS and PNSR
• Establish Project Advisory Committee and SI Task Force to meet & advise the project
• Strengthen the national SI with computer equipment in Kisangani, Lubumbashi and Kinshasa' health facilities
• Supporting the establishment of a reference-counter reference system taking into account the health and community services including SGBV in Kinshasa, Lubumbashi and Kisangani
• Provide ligne verte with SBGV updated information-related

Cross-Cutting Budget Attribution(s)

Human Resources for Health	10,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**13623**
Mechanism Name:	**Providing Capacity-Building Assistance to Government and Indigenous Congolese Organizations to Improve HIV/AIDS Service Delivery in the Democratic Republic of Congo under PEPFAR**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	50,000	0

Narrative:

In the fight against HIV/AIDS, the DRC's national response faces multiple challenges including weakness in the coordination of interventions; need to strengthen health system and inadequate training for health care providers, more specifically in PMTCT as the country is engaged in the «Mother to Child Elimination"

FHI360 will serve as the technical lead and all FHI360' interventions will be implemented in Kinshasa, Kisangani and Lubumbashi

• Strengthen capacity of 30 trainers of trainers and 750 PMTCT health providers with the leadership of the PNLS and the collaboration of key PEPFAR partners involved in PMTCT services delivery.

• Increase the PMTCT Technical Working functionality by formalizing the PMTCT TWG through a signed decision of the MOH. Follow PNLS and PNLS for the PMTCT TWG meetings held

• Strengthen the national SI with computer equipment in health facilities; based on the findings of a rapid evaluation of informatics equipment in these 3 provinces

• Build PNLS and PNSR technical and organizational capacity, based on previous capacity building interventions conducted by PEPFAR and no PEPFAR partners, FHI360 will identify gaps in technical and organizational areas by using FHI360' Technical and Organizational Capacity Assessment Tools in a participative approach in these 2 national structures

• Identify and establish task forces for Training and for Policy

• Establish Project Advisory Committee and SI Task Force to meet & advise the project

• Conduct an assessment of SI system and use findings to design an improved national SI system; develop an action plan to implement changes and increase capacity to operate, manage and use the system

• Revitalize the existing reference/counter reference system in 3 principal cities Kinshasa, Lubumbashi

and Kisangani, and then "la ligne verte" database will be updating • Analyze the needs of knowledge and skills in the area of SGBV of PEPFAR partners to strengthen SGBV service delivery • Develop an appropriate SGBV capacity building plan for each PEPFAR partner • Extend the coverage of RCR system with taking into account HIV/AIDS and SGBV in Katanga, Orientale province and Bas Congo.

Implementing Mechanism Details

Mechanism ID: 13696	**Mechanism Name: Supply Chain Management System**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: Partnership for Supply Chain Management	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 2,719,133	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	2,719,133

Sub Partner Name(s)

Management Sciences for Health		

Overview Narrative

SCMS is a multi-billion dollar PEPFAR Program managed by USAID and implemented by Partnership for Supply Chain Management (PfSCM). The purpose of SCMS is to ensure the supply of quality essential medicines and other products to people impacted by HIV/AIDS, and to promote sustainable supply chains in partner countries, in collaboration with US agencies and other stakeholders. SCMS supports the rapid scale up of HIV/AIDS prevention, care, and treatment through providing an uninterrupted supply of key commodities. As part of the USG strategy, the USG team is moving away from individual partner commodity procurement to this centralized mechanism. During FY 2012, only USAID will be putting money into this mechanism for its partners, but depending on the success of this procurement

mechanism, CDC plans to program their commodities through this mechanism during COP 2013.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Commodities	100,000
Gender: Reducing Violence and Coercion	200,000
Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Child Survival Activities
Military Population
Safe Motherhood
TB
Workplace Programs

Budget Code Information

Mechanism ID:	**13696**		
Mechanism Name:	**Supply Chain Management System**		
Prime Partner Name:	**Partnership for Supply Chain Management**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	299,105	0
Narrative:			

This is for the procurement of cotrimoxazole and limited therapeutic feeding supplements in USAID supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVTB	108,765	0

Narrative:

These funds will be used for the purcahse of TB-related test kits. Due to large pipeline issues, we gave USAID's main TB partner, TB2015, only minimal funding. These additional resources reflect the country's strategy of moving away from indvidual partner procurements for drugs to a centralized mechanism.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HLAB	407,870	0

Narrative:

These funds will be used to purchase lab commodities for USAID supported sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	OHSS	190,339	0

Narrative:

The USG considers the use of and strengthening of FEDECAME as critical to long term sustainability and has the potential to lead to better drug availability, cost effectiveness, reduction of drug stock-outs, and ultimately to the improved health of the population. Under GHI, the USG will collaborate with other development partners to complement and not duplicate efforts. SCMS will work in partnership and collaboration with SIAPS to improve the supply management system within the DRC and will support the USG efforts to pilot direct procurement through the FEDECAME.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	1,305,184	0

Narrative:

These funds will be used for mobile and facilities based counseling and testing commodities sites supported by USAID.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	407,870	0
Narrative:			
Most PMTCT commodities are budgeted with Acceleration Funding money ($3,410,000). This additional funding reflects the requirement that the DRC country team still needed to budget for PMTCT commodities in its normal budget.			

Implementing Mechanism Details

Mechanism ID: 13703	**Mechanism Name: Systems for Improved Access to Pharmaceuticals and Services (SIAPS)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 610,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	66,602
GHP-USAID	543,398

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of the new Systems for Improved Access to Pharmaceuticals and Services (SIAPS) is to assure the availability of quality pharmaceutical products and effective pharmaceutical services to achieve desired health outcomes. The SIAPS objective is to promote and utilize a systems strengthening approach consistent with the Global Health Initiative (GHI) that will result in improved and sustainable health impact. To this end, the SIAPS guiding framework and results areas reflect a comprehensive set of dynamic relationships among five health systems building blocks (governance, human resources, information, financing, and service delivery), with a Medical Products Building Block overlay to provide

technical content and identify substantive areas of concern. This represents a significant advance over the technical approach of predecessor programs.SIAPS expands the prevailing product availability paradigm to include a continuum of activities that embraces all pharmaceutical management functions, including supply chain management and which extends to patient-centered pharmaceutical services such as counseling to promote adherence to therapy, and pharmacovigilance to ensure patient safety and therapeutic effectiveness. SIAPS solutions will optimize investments in the pharmaceutical sector by the USAID health program elements and donors, address the immediate challenges of ensuring availability of essential medicines, yield measureable results, and demonstrate sustainable systems strengthening. Developing corresponding supportive roadmaps and guidance, and tools to support measurement of success from a health systems strengthening perspective, are among the key activities expected under SIAPS technical leadership and research.

Global Fund / Programmatic Engagement Questions

1. Is the Prime Partner of this mechanism also a Global Fund principal or sub-recipient, and/or does this mechanism support Global Fund grant implementation? **Yes**
2. Is this partner also a Global Fund principal or sub-recipient? **Neither**
3. What activities does this partner undertake to support global fund implementation or governance?

Budget Code	Recipient(s) of Support	Approximate Budget	Brief Description of Activities
HVSI		250000	Technical Assistance for drugs managenment with software tools
MTCT		110000	Improved coordination of supply chain management activities by national programs
OHSS		250000	Technical assisatance for drugs management

Cross-Cutting Budget Attribution(s)

Construction/Renovation	50,000
Human Resources for Health	50,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Malaria (PMI)
TB
Family Planning

Budget Code Information

Mechanism ID:	**13703**
Mechanism Name:	**Systems for Improved Access to Pharmaceuticals and Services (SIAPS)**
Prime Partner Name:	**Management Sciences for Health**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	250,100	0

Narrative:

By ensuring that pharmaceutical management information of adequate quality is produced, transmitted to the appropriate persons, and used, SIAPS will improve patient's access to pharmaceuticals by ensuring that stock outs are reduced. This objective will also serve to increase access by reducing losses through expiry of medicines by ensuring that timely action is taken to redistribute medicines from areas with oversupply to areas with insufficient stock. SIAPS will continue support to implementation of the Electronic Dispensing Tool (EDT) in more ART and PMTCT sites. Build on existing national systems to introduce mechanisms for collecting using pharmaceutical information that includes data on both patients and commodities on HIV diseases areas

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and	OHSS	250,100	0

Systems			

Narrative:

By improving the physical storage capacity and conditions of institutions that store and distribute medicines, SIAPS will increase the likelihood that quality pharmaceutical products reach health facilities and patients. Partnering with local institutions to strengthen pharmaceutical systems will increase the availability of local professionals capable of delivering both technical assistance in pharmaceutical management and direct implementation of solutions to problems emerging in the pharmaceutical sector. Pharmaceutical management capacity of individuals, institutions, organizations will be increased by : a) Developing in-service pharmaceutical management training materials for health workers at all levels of the health system and subsequently train health workers using these materials; b) Conduct training of pharmaceutical warehouse managers in inventory management followed by supportive supervision. SIAPS will contribute to the improvement of the skills of health practitioners in the PMTCT sites by collaborating with the National HIV/AIDS program (PNLS) to conduct training in pharmaceutical management for HIV/AIDS commodities using the PMTCT Guidelines and Training Module on pharmaceutical management of ARVs and other HIV/AIDS commodities that were recently updated.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	109,800	0

Narrative:

Through an improved coordination of supply chain management activities by national programs. SIAPS will a) assist the Ministry of Health and other stakeholders to develop appropriate governance mechanisms to support improved procurement planning and use of pharmaceutical management information produced by information systems; b) Support development and functioning of regional government-led mechanisms for sharing information and coordinating pharmaceutical activities among stakeholders; and c) Promote an inclusive and participatory approach to strategic planning for the pharmaceutical sector at both national and regional (provincial) levels.

Implementing Mechanism Details

Mechanism ID: 13730	**Mechanism Name: Malamu**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A

Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 178,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	178,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goal of MALAMU: To support the MOH in its goal of Eliminating Pediatric AIDS in DRC. The broad objectives of MALAMU are:

• Increasing access to PMTCT including expanded delivery of services to achieve elimination of mother to child transmission of HIV.

• Sustained Quality, Comprehensive, Integrated PMTCT services at supported facilities.

• Strengthened National Health System by working directly with Health Zones in accordance with the MOH's plans for Health Zones.

• MOH's policies, protocols and guidelines for PMTCT services to be reviewed and improved on a regular basis.

Links to Partnership Framework Implementation Plan Objectives:

As described in the PF, improving the quality of PMTCT services and the integration into broader MCH and HIV care and treatment programs will be a priority for MALAMU in FY2012. EGPAF's program is closely linked to the following key interventions identified in the PF: decentralized and improved quality of HIV services. To minimize disruption of service provision caused by the MOH policy of frequent staff rotation, EGPAF will continue to provide ongoing training and site support, M&E Plan

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**13730**
Mechanism Name:	**Malamu**
Prime Partner Name:	**Elizabeth Glaser Pediatric AIDS Foundation**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	0	0

Narrative:

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

During the Y1, MALAMU project will implement the “peer to peer site” strategy in order to improve the coverage and quality of PMTCT services in Kinshasa and Lubumbashi. This strategy consists of organizing the health facilities into service delivery networks in order to implement PMTCT services in the most cost effective manner within the targeted health zone. Under this model, high volume sites, serve as central sites in charge of supporting the peripheral sites.

Central sites:

EGPAF team has identified 13 central's sites in Kinshasa and 5 in Lubumbashi. Central sites will be validated based on transparent criteria established in consultation with PNLS, including presence of highly trained and functioning staff able to serve as mentors, adequate infrastructure, and working systems and procedures. The highest volume facilities have been visited and selected as central sites based on pre-determined criteria including presence of PMTCT services, presence of skilled staff, and strength of maternal and child health services at the sites, etc

Satellite sites:
In collaboration with the health zones and provincial PNLS teams, all potential health facilities surrounding the main PMTCT sites were identified and classified by volume of catchment area populations seeking services, e.g. the number of pregnant women attending ANC services at those sites. The satellite sites will be linked to the central sites via a network of training, cross visits, and ongoing mentorship and support. EGPAF team has identified 40 satellite's sites in Kinshasa and 17 in Lubumbashi.The EGPAF team will use the tools to identify SGBV risk for pregnant women attending ANC in the EGPAF supported PMTCT sites

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	PDTX	178,000	0

Narrative:

EGPAF's strategy for PDTX activities will include early identification of infected children and provision of a basic package of services: ART, vaccinations, malaria prevention, vitamin A, and nutritional status assessments, to reduce morbidity and mortality and improve quality of life. EGPAF will work closely with health zones and other partners to establish referral systems to capture children in need of care, including siblings of those enrolled. Establishment of strong formal linkages between communities and health facilities will increase access and retention in care for HIV-exposed, -affected, and -infected children. Family-centered HIV care and support services will be performed at all entry points (PMTCT, family planning, vaccination, and CPS). Facilities will reach out to families of index children or mothers. Activities will provide high quality and efficient care and support to improve children's quality of life. These services may include: palliative care and psychosocial support programs for children families; Referral to care and TX services. Malamu will focus on the integration of HIV services within MCH settings, and integrated follow-up of mother-baby pairs. EGPAF will introduce a bidirectional referral system by integrating messages to families of HIV-exposed, affected, and infected children to improve quality of life, promote family centered care and support activities, and strengthen care networks. We will support clinical pediatric ART and care by:1. Organize trainings in PDTX for site and health zone staff; 2. Training in clinical pediatric ART; 3. Using pediatric patients as entry points for testing parents/guardians in order to improve parent/guardian health and c child survival; We will provide pediatric adherence counseling

and psychosocial support by: 1. Identify and train peer educators in pediatric adherence counseling of children on ART; 4. Training peer educators in disclosure counseling; 5. Strengthen referrals and awareness on child sexual abuse and the availability of HIV prevention strategies for abused children. The EGPAF team will use the tools to identify SGBV risk for pregnant women attending ANC in the EGPAF supported PMTCT sites.

Implementing Mechanism Details

Mechanism ID: 14611	**Mechanism Name: A Public-Private Partnership for Mining Communities, Truckers, and Other At-Risk Populations**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Program for Appropriate Technology in Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 257,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	257,000

Sub Partner Name(s)

Chemonics International	Elizabeth Glaser Pediatric AIDS Foundation	The International HIV/AIDS Alliance

Overview Narrative

PATH and Tenke Fungurume Mining (TFM), in coordination with the Government of the Democratic Republic of Congo (DRC), will develop a programmatic partnership under USAID's Global Development Alliance (GDA) mechanism to reduce HIV risk and mitigate its impact on communities in the Fungurume Health Zone (FHZ) and the town of Kasumbalesa in the Katanga Province of DRC. To help TFM expand the reach of HIV prevention, care, support, information, and services beyond its workers, PATH will provide a range of technical assistance to reach the wider community of Fungurume as well as Kasumbalesa. The project's objectives center around establishing a Champion Community (CC) in

Fungurume through which prevention and mobilization activities will occur, providing HIV testing and increasing access to HIV/AIDS care and support services. This project will also seek to mitigate the impact of HIV/AIDS in communities along the trucking route of Fungurume to Kasumbalesa by providing targeted prevention, testing, and referral services to truck drivers, commercial sex workers (CSWs), and other high-risk individuals, including persons with disabilities, as well as to the general population within these communities.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Military Population
Mobile Population
Workplace Programs
Family Planning

Budget Code Information

Mechanism ID:	**14611**

Mechanism Name:	A Public-Private Partnership for Mining Communities, Truckers, and Other At-Risk Populations
Prime Partner Name:	Program for Appropriate Technology in Health

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HBHC	64,250	0

Narrative:

The project will adopt the US Government's strategy of integrating care and support services into the framework of the family-centered continuum of HIV services and involve PLWHA and OVC in every step of the project. The CC will set up auto-support groups of PLWHA which will become the center of the care and support activity. They will receive support as needed, including some medical care (cotrimoxazole) and ARV adherence support and opportunistic infection control. Providers at the health facility will be responsible for the medical care of patients referred by the CC. TFM will cover the costs of drugs for sexually transmitted and opportunistic infections if there are gaps. In order to plan, TFM will coordinate with ProSANI and other programs to identify the needs.Building on local resources and capacities, the project will seek strategies to deliver low-cost, evidence-based care and support activities including nutritional counseling, psychosocial support for PLWHA and their families through support groups, home-based care, and CD4 count monitoring. Existing community support groups such as a local charity for OVC, the three Fungurume-based human rights organizations, scouts, and religious groups will be tapped. SODEXO Management, the TFM food provider, has agreed to provide nutritional support and counseling for PLWHA in need and identified by the project. SODEXO will to providing PLWHA with nutritional support in the form of limited meals, as well as training in nutrition counseling for PLWHA. Please see Attachment 3 for SODEXO's letter of intent for these contributions.
Longer-term economic strengthening activities will be fostered, where feasible, through TFM's economic development initiatives for small and micro business development. PLWHA will have access to TFM-sponsored workshops, training and mentoring in business development and in applying to the TFM Social Community Fund for grants to develop

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	64,250	0

Narrative:

The project will use ProVIC's Champion Community approach to introduce innovative and sustainable strategies to increase community ownership over HCT and prevention activities within the communities surrounding the Tenke Fungurume mine. Some CCs—established under ProVIC—already exist in the Kasumbalesa area, so this project will not initiate others. Prevention strategies will address underlying causes of people's vulnerability and will create changes in individual and community behavior, reducing

stigma and encouraging adequate counseling and testing. Via the CCs and the sectors of the population it represents, the project will conduct prevention activities to MARPs, particularly TFM employees and their families, truck drivers, CSWs, and youth. TFM has two separate HIV programs. The workforce program is managed by International SOS for all employees and dependents, and that will continue in parallel with this project. Through this partnership, TFM will focus on the communities living within its concession of approximately 1,600 km and Kasumbalesa. Although the focus is not specifically on the employees and their dependents living with the target communities (so as not to be redundant with International SOS), there will be a spillover benefit to these people.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVCT	64,250	0

Narrative:

PATH and TFM will look for opportunities to offer community-based HCT services, including mobile HCT targeting MARPs including truckers, TFM employees living in the community, CSWs, and youth. In addition, the government referral clinic will provide HCT. PATH will work with International SOS, the TFM health care provider, to evaluate and reinforce company HCT activities for TFM contract truckers. The staff of the TFM-supported mobile clinic—which reaches remote uncovered areas of the FHZ—and all 23 FHZ health center staff will be educated regarding HCT services available in the FHZ so that they can orient clients to services. BAK-Congo mobile units will be deployed in the communities within TFM concession to identify high-risk locations and populations and will refer people to FHZ for testing and treatment, if necessary. Artisanal miners, CSWs, truckers, and people who frequent hotels and bars will be targeted for interventions.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	64,250	0

Narrative:

The project will use ProVIC's Champion Community approach to introduce innovative and sustainable strategies to increase community ownership over HCT and prevention activities within the communities surrounding the Tenke Fungurume mine. Some CCs—established under ProVIC—already exist in the Kasumbalesa area, so this project will not initiate others. Prevention strategies will address underlying causes of people's vulnerability and will create changes in individual and community behavior, reducing stigma and encouraging adequate counseling and testing. Via the CCs and the sectors of the population it represents, the project will conduct prevention activities to MARPs, particularly TFM employees and their families, truck drivers, CSWs, and youth. TFM has two separate HIV programs. The workforce program is managed by International SOS for all employees and dependents, and that will continue in parallel with this project. Through this partnership, TFM will focus on the communities living within its

concession of approximately 1,600 km and Kasumbalesa. Although the focus is not specifically on the employees and their dependents living with the target communities (so as not to be redundant with International SOS), there will be a spillover benefit to these people.

Implementing Mechanism Details

Mechanism ID: 14612	**Mechanism Name: Health Zone Strengthening Award**
Funding Agency: U.S. Agency for International Development	Procurement Type: Umbrella Agreement
Prime Partner Name: World Health Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 0	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	0

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In the vision of scaling up HIV interventions, the PNLS advocates a health zone integrated package approach to ensure complementarity of services for prevention, care and treatment, and the continuum of care. The HZ health management (ECZ) teams are essential for long-term sustainability, achieving accountability through planning, implementation, and monitoring and evaluation of interventions of HIV and AIDS.
As part of capacity building, these HZ teams need to be better equipped and trained for management.

To meet this need, WHO has supported the PNLS in developing a training manual for management teams of health zones focusing on the technical management of HIV/AIDS and a manual management training in the management of the NAP program. To date there is no technical reference document that can be made available to the provincial coordinator or another program that has just been assigned to organize work.

This project would provide a response to these concerns by strengthening the managerial capacities of ECZs oversee HIV/AIDS interventions in their respective health zones. This is a necessary for the success of other ongoing interventions concerning the strengthening of monitoring and data evaluation and procurement system for ARVs and other inputs and. To achieve this, building support for the provincial coordination and ECZS is essential.

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**14612**		
Mechanism Name:	**Health Zone Strengthening Award**		
Prime Partner Name:	**World Health Organization**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Governance and Systems	OHSS	0	0
Narrative:			

The project will strengthen the coordination mechanisms at the provincial level and support the management skills of ECZS in the management of interventions against HIV / AIDS
Illustrative activities include:
- Coordination of projects at the provincial level is enhanced
o Support PNLS and other GFATM sub-recipients in the development and implementation of work plan
o Support the establishment of a framework for dialogue around the MIP to track projects against HIV / AIDS
o Support the follow-up meetings of ARVs and other inputs at the provincial level
o Assess the performance of provincial Coordinations
o Provide technical support proximity (NPO)
- The managerial capacities of ECZS in the management of interventions against HIV / AIDS are supported
o Reproduce and disseminate fact sheets produced
To ensure the training of provincial trainers
o Support training of ECZS
o Provide support to the production of micro-plans ZS in the fight against HIV / AIDS
o Document and share lessons learned
o Support the production of periodic reports

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	0	0

Narrative:

WHO will use its management model to work with health zone management teams to provide technical oversight of PMTCT intervention activities. They will look at both technical aspects as well as issues surrounding the quality of services.

Implementing Mechanism Details

Mechanism ID: 14809	**Mechanism Name: C-Change/DRC – Social and Behavior Change Communication (SBCC) Capacity Building in the Democratic Republic of Congo / USAID Leader with Associates Cooperative Agreement No. GPO-A-00-07-00004-00**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: FHI 360	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 251,200	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-USAID	251,200

Sub Partner Name(s)

Search for Common Ground		

Overview Narrative

GOAL: Contribute to improving the health of the Congolese people through social and behavior change Communication (SBCC). Three objectives:1. Support the government partners and local organizations; 2. Capacity building; and 3. Develop educational materials. C-Change through Search For Common Ground (SFCG) covers South Kivu, Katanga and East Kasaï provinces. SFCG works with a network of 80 national and community radio stations and 20 TV channels working towards urban area. 3 main strategies: Advocacy, social mobilization and Behavior Change Communication.
Targeting youth (Age 15-24), the project will implement the following activities in FY2012: 1) IPC (Interpersonal Communication): "Duel des Jeunes democrates" (DJD) (Young Democrats) is a match (competition) of question and answer moderated by a journalist in which two opposing schools. This match challenge knowledge, attitudes and behavior of youth pupils about HIV. At the end of the match the moderator gives the correct answers and gives students and teachers DJD pamphlets on the topic of the session.The Team is a television series about a female football team which addresses governance, gender, justice and HIV. 4 episodes will contain messages about HIV. Video forum is organized for young boys and girls in selected Faith based schools conveying messages promoting sexual abstinence and delaying sexual debut. C-Change vehicles:1 older vehicle inherited from former project. During FY12, C-Change plans to buy 3 vehicles one support the current activities of the project in Kinshasa, one to support GBV/HIV activities in Kinshasa and an other one for GBV/HIV in Kisangani. The total for the life of the project is 4.

Cross-Cutting Budget Attribution(s)

Education	100,000
Food and Nutrition: Policy, Tools, and Service Delivery	25,000
Gender: Reducing Violence and Coercion	30,000
Human Resources for Health	100,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**14809**
Mechanism Name:	**C-Change/DRC – Social and Behavior Change Communication (SBCC) Capacity Building in the Democratic Republic of Congo / USAID Leader with Associates Cooperative Agreement No. GPO-A-00-07-00004-00**
Prime Partner Name:	**FHI 360**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	75,360	0

Narrative:

With this fundingfor FY12, C-Change plans to strengthen communication activities through the production of educational materials and extension of the normative documents which will be developed in collaboration with national programs against HIV / AIDS (PNLS). As capacity building of local organizations selected in collaboration with PNLS, in SBCC. Activities include:

1) Produce in collaboration with SFCG educational materials on HIV. This amount will cover all costs of production including human resources and pre-test.

2) Support capacity building of national and local organizations by maintaining the Communication Working Group and the production of standard documents to guide interventions in the field of HIV / AIDS in DRC.

3) Support for human resources including salaries, consultants, staff training, etc.

4) Assist in cross-productions with other programs including watsan, malaria, sexual and gender based violence in the integration of HIV messages.

5) other administrative costs and financial locally and in Washington for technical support.

For FY 13, C-Change will place special emphasis on monitoring and evaluation of communication activities in collaboration with the PNLS to identify new needs in the implementation of communication plan and provide technical support necessary.

C-Change also plans to build the capacity of partners in the fields below with regards to:

1) Advocacy to identify new potential funding sources;

2) SBCC

3) Monitoring and Evaluation

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	75,360	0

Narrative:

C-Change will: 1) work Search for Common Ground to revise HIV SBCC strategy and develop second set of HIV programming; 2) Support behavior change communication interventions which promote safer sex practices, inlcuding condoms, and HIV prevention as well as address stigma and discrimination through balanced strategies that include the development of branded promotional/educational television and radio dramas; 3) Continue SBCC training and capacity building for HIV Partnersincluding PNLSGain consensus on HIV messaging and develop an SBCC guide for HIV messaging; 4) Promote preventive behaviors during special events like World AIDS Day.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	100,480	0

Narrative:

C-Change will work with the Government of the Democratic Republic of Congo (GDRC), IHP, and other partners to plan and implement a strategy to institutionalize the capacity of communities, government, and the media to create a supportive and inclusive environment fostering positive behaviors to address key health issues surrounding PMTCT such as early early and regular ANC visits, the importance of couple's testing, and male involvement.

Implementing Mechanism Details

Mechanism ID: 14815	**TBD: Yes**
REDACTED	

Implementing Mechanism Details

Mechanism ID: 14827	**Mechanism Name: 2012 Demographic Health Survey**
Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: ICF Macro	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 250,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	250,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Democratic Republic of the Congo (DRC) supports the Millenium Development Goals (MDG) defined by the heads of state during the world summit for the Millenium held in New York in September 2000. These goals envisage positive improvement by 2015 in the well-being of the population, especially for women and children, in all the basic areas of human life. Therefore, the DRC has set out to build « a

world worthy of the children of the DRC » from the ten worldwide commitments delineated by the Special Session of the United Nations devoted to children, held in New York in May 2002.

The government of the Democratic Republic of the Congo plans to complete the second Demographic and Health Survey in 2012 conforming to the activity program of the National Institute of Statistics. This survey combines data collection programs from the first Demographic and Health Survey (DHSI-DRC) and the Multiple Indicators Survey of 2010 (MICS-III).

The second Demographic and Health Survey (DHSII-DRC) will make available information on fertility levels, sexual activity, fertility preferences, knowledge and use of family planning methods, breastfeeding practices, nutritional status of women and children under the age of five, child and infant mortality, maternal mortality, maternal and child health and on knowledge, attitudes and behavior with regard to AIDS and other sexuallly trasmitted diseases. New sections are included in the questionnaires; they include use of bednets and testing for HIV, malaria parasitemia and anemia.

The information collected will comprehensively update basic socio-demographic and health indicators that date most recently from the 2007 DHS and the 2010 MICS. The data will be representative at the level of the 11 former administrative provinces, as was the case f

Cross-Cutting Budget Attribution(s)

(No data provided.)

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services

Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**14827**
Mechanism Name:	**2012 Demographic Health Survey**
Prime Partner Name:	**ICF Macro**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Governance and Systems	HVSI	250,000	0

Narrative:

The second Demographic and Health Survey in the Democratic Republic of the Congo (DHSII-DRC 2012) will be undertaken in 2012 on a representative sample of women age 15-49 and men age 15-59. The DHSII-DRC will collect data at the national and provincial (11 provinces) levels in order to achieve the following main objectives: 1. Calculate essential demographic indicators, especially rates for fertility and infant and child mortality rates and analyze the direct and indirect factors that determine levels and trends in fertility and infant and child mortality; 2. Measure primary and secondary school attendance and completion indicators (Crude Rates, Net Rates of Primary schooling, Completion rates for the 5th year of primary school); determine the level of illiteracy in the adult population;
3. Measure levels of knowledge, attitudes and practice of contraception among women by method; evaluate health and reproductive behavior of adolescents (contraception, sexuality, use of services); This study will also include an AIDS Indicator Survey.
4. Appraise the status of family health: immunizations, prevalence and treatment of diarrhea and other illnesses among children under five years old, antenatal visits, delivery assistance and postnatal visits; 6. Evaluate the nutritional status of children and women, appraise nutritional practices of children, including breastfeeding; measure the household iodized salt consumption level;
7. Evaluate anemia prevalence among children under the age of five, women age 15-49 and men age 15-59;9. Appraise the knowledge, attitudes and practice of women and men concerning STI and AIDS;
10. Estimate HIV prevalence in the adult population of reproductive age by means of blood samples for

the anonymous screening of HIV among women age 15-49 and men age 15-59;12. Estimate the level of adult and particularly maternal mortality at the national level; 13. Measure the status of women and domestic violence.

Implementing Mechanism Details

Mechanism ID: 14831	**Mechanism Name: Small Grant Program**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Inter-Agency Agreement
Prime Partner Name: U.S. Department of State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	New Mechanism: N/A
Global Fund / Multilateral Engagement: N/A	
G2G: N/A	Managing Agency: N/A

Total Funding: 200,000	**Total Mechanism Pipeline: N/A**
Funding Source	**Funding Amount**
GHP-State	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Public Diplomacy (PD) section at the US Embassy, Kinhsasa is a critical element of the DRC PEPFAR activity and serves as a link between the Embassy and the community, policy makers, and the media. To achieve the various objectives of PD, PD utilizes 4 mechanisms namely small grants, support for CALI (Congo American Language Institute), Public Official Workshops, and Journalism Workshops. With the introduction new activities such as PMTCT-AP and NEPI, and continuation of ongoing activities, PD can play a crucial role in garner country political and leadership support for needed HIV policy and sustain the governmental commitment.

Small Grants: PD utilizes small grants to indigenous organizations interested in awareness raising activities, examples of which included national television programs, concert tours to discuss prevention and testing, the production of a theater group.

Cross-Cutting Budget Attribution(s)

Human Resources for Health	25,000

TBD Details

(No data provided.)

Motor Vehicles Details

N/A

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	**14831**
Mechanism Name:	**Small Grant Program**
Prime Partner Name:	**U.S. Department of State**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	100,000	0
Narrative:			

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	0
Narrative:			

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business

U.S. Agency for International Development

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
USG Staff Salaries and Benefits		0			0
Total	**0**	**0**	**0**	**0**	**0**

U.S. Agency for International Development Other Costs Details

U.S. Department of Defense

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing		0			0
Computers/IT Services		0			0
ICASS		0			0
Management Meetings/Professional Developement		0			0

Staff Program Travel		0			0
USG Staff Salaries and Benefits		0			0
Total	**0**	**0**	**0**	**0**	**0**

U.S. Department of Defense Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHP-State		0
Computers/IT Services		GHP-State		0
ICASS		GHP-State		0
Management Meetings/Professional Developement		GHP-State		0

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Capital Security Cost Sharing	113,391	163,390			276,781
Computers/IT Services	30,000				30,000
ICASS	100,000	458,219			558,219
Institutional Contractors	88,597				88,597
Management Meetings/Professional Developement	95,000				95,000
Non-ICASS Administrative	651,876				651,876

Costs					
Staff Program Travel	221,581				221,581
USG Staff Salaries and Benefits	1,114,555	575,437			1,689,992
Total	**2,415,000**	**1,197,046**	**0**	**0**	**3,612,046**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GAP		113,391
Capital Security Cost Sharing		GHP-State		163,390
Computers/IT Services		GAP		30,000
ICASS		GAP		100,000
ICASS		GHP-State		458,219
Management Meetings/Professional Developement		GAP		95,000
Non-ICASS Administrative Costs		GAP		651,876

U.S. Department of State

Agency Cost of Doing Business	GAP	GHP-State	GHP-USAID	Central GHP-State	Cost of Doing Business Category Total
Management Meetings/Professional Developement		75,613			75,613
Non-ICASS Administrative Costs		14,500			14,500

Staff Program Travel		13,000			13,000
USG Staff Salaries and Benefits		100,000			100,000
Total	**0**	**203,113**	**0**	**0**	**203,113**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Management Meetings/Professional Developement		GHP-State		75,613
Non-ICASS Administrative Costs		GHP-State		14,500