United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR HAMMER, Democratic Republic of the Congo

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Hammer:

First, I wanted to personally thank you and Deputy Chief of Mission Ekpuk for your dedication to PEPFAR and for working every day to achieve the most possible with U.S. taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion and their ability to translate program data into innovative solutions to constantly improve the client's experience and the program's quality. You continue to work in the highest need areas, adapting and innovating to serve the people of the country more effectively. In summary, we are very excited about your progress in the following areas:

- We are pleased to continue to see notable achievement at the country level against several targets along the cascade, particularly in testing and number of patients added on treatment, despite the many difficulties faced by the team this year.
- We are pleased to see continued progress in testing efficiency, index testing, and TLD transition (>95% of adult patients as of October 2019).

Together with the Government of the Democratic Republic of Congo and civil society leadership, we have made tremendous progress together. The Democratic Republic of Congo should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing coordination with the Global Fund and UNAIDS.
We did want to highlight both overarching issues we see across PEPFAR and a few issues specific to the Democratic Republic of Congo. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3.3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women;
2. Supporting key populations with prevention and treatment services;
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate));

4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally; suppressed (net new on treatment and treatment current growth, (retention surrogate));
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed.

There are also country-specific challenges that have hindered progress towards our goals, despite the encouraging accomplishments of the PEPFAR DRC program. These areas of concern in which PEPFAR DRC must improve if we are going to meet our ultimate goals include:

- Drastically improving the numbers in program areas for retention of all clients on treatment, viral load coverage (VLC), and early infant diagnosis (EID);
- Focusing on case finding for hard to reach populations, including children and young men;
- Solving the HIV commodities customs clearance issues, which is paramount to the success of the program moving forward.

In a recent Office of Inspector General audit around PEPFAR coordination, there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's, but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derived from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016 PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets

and others need to accelerate. Democratic Republic of Congo is not currently on track to achieve the 2020 and 2030 goals unless there is acceleration with both Global Fund and PEPFAR funds. Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment.

The PEPFAR Country Operational Plan (COP 2020) notional budget is **$77,320,000** inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY 2020 treatment current funded in COP 2019) is $61,500,000.
    a. The care and treatment budget is determined by all of your FY 2018 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY 2019 treatment current to the FY 2020 treatment current fully burdened cost of treatment services and commodities, and 100% of program management costs and data needs.
    b. This budget is broken down by:
        i. Care and treatment services including partner program management costs, FY 2020 upward adjustment, EMR and data with surveillance, recency: $39,500,000;
        ii. ARV drugs and treatment commodities (everything except RTKs): $14,000,000;
        iii. TB preventive treatment: $2,500,000;
        iv. For earmark purposes 50% of M/O costs: $5,500,000;
        v. Care and treatment qualifies for ambition funds if addresses gap #3-5.
2. Continued orphans and vulnerable children funding: $6,800,000
    a. HKID, or $5,700,000, for continued historical OVC services;
    b. 10% of M/O, or $1,100,000.
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old:
    a. Total VMMC: $100,000.
4. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets:
    a. Key Population (non-treatment): $2,700,000;
    b. PrEP total: $1,100,000;

5. RTK and service support to ANC HIV testing: $720,000;
6. Remaining 40% M/O based on COP 2019: $4,400,000.

Total COP 2020 notional budget of $77,320,000 (comprised of $73,367,529 new and $3,952,471 pipeline).

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC should be consistent with any targets above FY 2020 treatment current and be submitted with any ambition funding. Targets reflecting continued and sustained OVC programming and KP programming. For PrEP and Preventive TB, increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team in collaboration with the Government of the Democratic Republic of Congo and civil society of the Democratic Republic of Congo believes is critical for the country's progress towards controlling and maintaining the pandemic controlling.

Additionally, country teams and specifically agencies independently can request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment, with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg, South Africa, meetings.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP 2020. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of the Democratic Republic of the Congo's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM (Hilary Wolf and Sam Arkin, respectively) in a phone call, after which the detailed planning level letter will be immediately released.

Thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3.3 goal.

Together we can.

Deborah Birx

United States Department of State

Washington, D.C. 20520

UNCLASSIFIED

January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR MICHAEL A. HAMMER, DEMOCRATIC REPUBLIC OF THE CONGO (DRC)

SUBJECT: Country Operation Plan (COP) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTS and CAST meetings, and input from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time. Specifically, we reviewed closely the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation in planning for COP 2020.

As a part of DRC's Annual Program Results (APR) for fiscal year (FY) 2019, the following programmatic areas are a condensed set of key successes and specific areas of concern:

- *Key successes*: (1) testing efficiency, (2) adult index testing, (3) TLD transition, and (4) number of patients on treatment.
- *Specific areas of concern*: (1) retention, (2) case finding for children and young men, (3) viral load coverage (VLC), and (4) early infant diagnosis (EID).

SECTION 1: COP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP 2020 planning level is comprised as follows: (Note: all pipeline numbers were provided and confirmed by the agencies)

Table 1. COP 2020 Total Budget – Including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$ 73,367,529	$ -	$ -			$ 73,367,529
GHP-State	$ 72,542,529	$ -	$ -			$ 72,542,529
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ 825,000	$ -	$ -			$ 825,000
Total Applied Pipeline				$ 3,952,471	$ -	$ 3,952,471
DOD				$ 2,665,971	$ -	$ 2,665,971
HHS/CDC				$ -	$ -	$ -
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 1,286,500	$ -	$ 1,286,500
TOTAL FUNDING	$ 73,367,529	$ -	$ -	$ 3,952,471	$ -	$ 77,320,000

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS

Countries should plan for the full Care and Treatment (C&T) level of $61,500,000 and the full Orphans and Vulnerable Children (OVC) level of $6,800,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP 2020 Earmarks by Fiscal Year

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 45,000,000	$ -	$ -	$ 45,000,000
OVC	$ 5,700,000	$ -	$ -	$ 5,700,000
GBV	$ 450,000	$ -	$ -	$ 450,000
Water	$ 100,000	$ -	$ -	$ 100,000

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the **minimum** amounts that must be programmed in the given appropriation year.*

Table 3. All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	$ 15,800,000
VMMC	$ 100,000
Cervical Cancer	$ -
DREAMS	$ -
HBCU Tx	$ -
COP 19 Performance	$ 10,000,000
HKID Requirement	$ 5,700,000

**Note: DRC likely will not have VMMC money — same as in years past. More information forthcoming.*

Table 4. New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	$ 72,542,529	$ -	$ 825,000	$ 73,367,529
Core Program	$ 56,842,529	$ -	$ 825,000	$ 57,667,529
COP19 Performance	$ 10,000,000			$ 10,000,000
HKID Requirement ++	$ 5,700,000			$ 5,700,000

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

SECTION 3: PAST

PERFORMANCE – COP 2018 REVIEW

Table 5. OU Level FY 2019/COP 2018 Program Results and FY 2020/COP 2019 Targets

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	117,860	159,090
TB Preventive Therapy	15,449	43,083
TB Treatment of HIV Positive (TX TB)	96,274	N/A

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 6. COP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
OU			
DOD	3,546,03	2,792,965	753,065
HHS/CDC	22,161,434	24,593,531	(2,432,097)
State	814,591	106,327	708,264
State/AF	312,080	33,512	278,568
USAID	38,475,654	38,011,741	463,913
Grand Total	**65,309,789**	**65,538,076**	**(228,287)**

* State obligations and outlays have not yet been reconciled and the numbers in this table may change based on reconciliation.

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 7. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget
***** *This table was based off the FY 2019 EOFY submissions; however, this table was edited to reflect OPU's as of January 15, 2020. Agencies outlaid to the following Implementing Mechanisms 110% or more in excess of their COP18 approved planning level.*

Mech ID	Prime Partner	Funding Agency	COP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP18 Budget $)
3094	Association of Public Health Laboratories	HHS/CDC	150000	97,026	(247,026)
8316	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	HHS/CDC	100000	20,299	(120,299)
3017	American Society for Microbiology	HHS/CDC	200000	276,170	(76,170)
8090	FHI Development 360 LLC	USAID	2000004	2,716,884	(716,880)
8097	Family Health International	HHS/CDC	1000000	1,327,862	(327,862)
8096	Trustees Of Columbia University In The City Of New York	HHS/CDC	10004812	11,617,595	(1,612,783)
6963	Elizabeth Glaser Pediatric AIDS Foundation	HHS/CDC	3600000	4,099,600	(499,600)

Table 8. COP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	Y19 Target	Y19 Result	% Achievement	Program Classification	Y19 Expenditure	% Service Delivery
HHS/ CDC	HTS_TST	86,443	**43,235**	65%	HTS Program Area	764,420	46%
	HTS_TST_POS	7,372	**0,326**	117%			
	TX_NEW	7,927	**9,740**	110%	C&T Program Area	7,118,804	46%
	TX_CURR	6,807	**6,759**	100%			
	OVC_SERV	1,513	**9,533**	137%	OVC Major Beneficiary	2,293,668	70%
	HTS_TST	6,738	**5,505**	140%	HTS Program Area	84,376	87%
	HTS_TST_P			152%			

DOD	**OS**	,799	**,736**				
	TX_NEW	**,709**	**,162**	127%	C&T Program Area	631,453	85%
	TX_CURR	,905	**,457**	94%			
	OVC_SERV	,267	**78**	34%	OVC Major Beneficiary		
USAID	**HTS_TST**	34,954	**94,808**	74%	HTS Program Area	3,723,184	54%
	HTS_TST_POS	8,328	**1,956**	120%			
	TX_NEW	8,526	**0,137**	109%	C&T Program Area	21,309,530	82%
	TX_CURR	6,074	**4,644**	97%			
	OVC_SERV	8,572	**4,468**	132%	OVC Major Beneficiary	1,790,450	36%
				Above Site Programs		5,226,208	
				Program Management		11,558,008	

COP 2018 | FY 2019 Analysis of Performance

PEPFAR DRC has performed well during COP 2018 implementation, making strong and consistent progress across the cascade, particularly in testing and adding new patients on treatment (e.g., 120% target achievement for HST_TST_POS, 98% target achievement for TX_CURR, and 29,372 cumulative results for TX_NET_NEW). Generally, the priorities for PEPFAR DRC going into COP 2018 were: (1) continuing to push for index testing, particularly among male sexual partners; (2) improving retention, in addition to improving the viral load suppression (VLS) and monitoring numbers; (3) focusing on partner performance, with a push to enhance performance and monitoring down to the facility level; and (4) an urgent effort in correcting overspending at the agency level, particularly in light of USAID's overspending on OVC programming without an increase in results. We are pleased to see progress in many of these areas, specifically in testing efficiency, index testing, and partner performance.

Additionally, PEPFAR DRC has made impressive progress in the TLD transition (>95% of adult patients as of October 2019).

Nonetheless, PEPFAR DRC is still falling short on several important program areas, such as retention, VLC, case finding for hard to reach populations (e.g., children and young men), EID, the pediatric care and treatment cascade with support from OVC programs, and customs clearance.

Retention, VLC, Case Finding, OVC, Above-Site

Retention continues to be an issue for this program. PEPFAR DRC's retention proxy is 90% overall. Although this percentage appears to be a positive achievement, it means we lost roughly 12,667 patients on treatment, which is approximately 30% of PEPFAR DRC's NET_NEW (29,372). Looking more closely at these retention numbers, specifically at the SNU level, Kinshasa (82% retention proxy) and Lualaba (83% retention proxy) are the most concerning — collectively losing roughly 11,800 patients on treatment. Despite some of this loss being related to the DQA conducted in FY 2019, it is not the only factor accounting for DRC's poor retention performance. These poor retention numbers highlight PEPFAR DRC's need to refocus our efforts on retention, in addition to improving record keeping to avoid counting phantom clients.

Further, the concern about PEPFAR DRC's VLC performance is significant. Notwithstanding the improvement of PEPFAR DRC's VLC numbers over the last 4 quarters of FY 2019, VLC in DRC remains far lower (69% in FY 2019 Q4) than is acceptable; with even lower numbers among pediatric populations and pregnant women. There needs to be a concerted effort to address urgently this shortcoming at the site level.

Generally, despite the challenges in DRC, we continue to see improvements in identification of new patients (120% of FY 2019 target for HTS_TST_POS); however, this does not account for the continued shortcomings in finding hard to reach populations. Specifically, EID numbers are discouraging – with coverage of HIV exposed infants tested by 2 months of age in DRC at 44%, and HIV exposed infants tested by 12 months of age at only 61%. The pediatric cascade

continues to be an issue (3,319 cumulative results for HTS_TST_POS, 61% of target achievement for TX_CURR, 78% VLS) and something the PEPFAR DRC team needs to focus on improving. Although the percentage of males 15+ years on treatment increased by 46% in FY 2019, DRC's program put 17% fewer males than females on treatment ages 15+ years.

Therefore, in COP 2020, our program should continue focusing on finding and reaching HIV+ men (specifically within the 25-34-year age band), adding them to treatment, and attaining viral suppression among this group.

Regarding COP 2018 financial management, PEPFAR DRC has done a commendable job addressing previous issues. Between PEPFAR DRC's COP 2018 program expenditures (approximately $56 million) and the M&O expenditures for COP 2018 (approximately $8.1 million); the team expended roughly 100% of its COP 2018 budget. Where issues arise in financial management, they are primarily related to poor pipeline buffer management and possible over outlaying of funds. However, many of these issues are already being addressed, some of which will be resolved with OPU submission and processing.

Partner Performance

- Overall, all current partners in DRC are excelling in the same programmatic areas in which DRC does well and are underperforming in the same areas in which DRC struggles – with minimal variation.
- Of note, PATH, which is a USAID-funded partner, is the only implementing partner in DRC that had a VLC (86%) of more than 80% in Q4 of FY 2019; however, VLS for adult women (77%) compared to adult men (90%) needs improvement.
- Metabiota, a DoD-funded partner, struggled in FY 2019 in part due to issues related to their grant ending prior to the end of FY 2019. Although this partner showed some improvement in VLS over the course of FY 2019, they still have an unacceptably low level of VLS (67% in Q3 of FY 2019) that must improve in COP 2019 and COP 2020.

Customs and Security Issues

HIV commodities continue to face customs issues when entering DRC. The result of this issue is that there is a razor thin margin of error in HIV commodities provision – risking patient access to HIV commodities all together. Patients' access to HIV medication is paramount, which is why this customs issue is so significant. In pursuit of maximizing the impact of PEPFAR resources, particularly HIV commodities, we are requesting that the GDRC move urgently to reinstate the establishment of immediate removal for PEPFAR HIV commodities within the customs clearance process. Without this action, the long delays in customs clearances is destructive to addressing the needs of the GDRC's national HIV/AIDS program, leading to frequent stockouts, expiring commodities, and prohibitively expensive emergency orders.

SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives. Funds for these programs have been allocated based on FY 2019 performance (see Table 3).

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP 2020, the failure to meet any of these requirements will result in reductions to the DRC budget. (*See Section 2.2. of COP Guidance*)

Table 9. COP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Policy has been adopted and overall linkage was 93% for FY 2019.	However, linkage needs to improve for FSWs (85% in Q4). Linkage for male adults and children is lower than it is for females**.**
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	DRC achieved 95.54% of adult patients on TLD for FY 2019 and removed all nevirapine regimens. As of December 2019, all children ≥20Kg were on DTG- based regimens	
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	DRC has implemented MMD and delivery models to improve identification and ARV coverage of men and adolescents. DRC plans to scale six-month multi-month dispensing in COP 2019.	.

	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	TPT has begun and is funded for COP 2019, including the procurement of INH. Cotrimoxazole is integrated into the clinical care package	
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups,	The Diagnostic Network Optimization is in progress with some aspects of the activities already completed.	This will be discussed further during the PEPFAR DRC COP 2020 retreat.

[1] Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

[2] Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019 [3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.		
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	PEPFAR DRC will look to further scale-up index testing. However, the current index yield is good. Nonetheless, there is a need to increase the volume of POS.	DRC is not self-testing, but will discuss this issue further during the PEPFAR DRC COP 2020 retreat.
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre- exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)[6]	PEPFAR DRC is not currently providing PrEP as PrEP was not procured for DRC in COP 2018. Some PEPFAR DRC PrEP funding was provided for COP 2019 and there is additional funding for PrEP in COP 2020.	PrEP needs to be scaled moving forward.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year- old girls and boys in regard to primary prevention of sexual violence and HIV.	PEPFAR DRC needs to Improve case finding of children through OVC platforms. In COP 2020, OVC and clinical implementation partners in DRC must work together to ensure that **90%** or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.	There is a need to innovate in the PEPFAR DRC OVC Program. This will be discussed further during the PEPFAR DRC COP 2020 retreat.

Policy & Public Health Systems	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	DRC should verify that user fees are not a barrier to HIV services.	N/A
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by	Through Partner Management and Granular Management sites, PEPFAR DRC is working to inculcate MOH and implementing partners for continuous Quality Improvement. PEPFAR DRC ensures that local staff at sites participate	

5 Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016, https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

6 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

7 The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

	IP work plans, Agency agreements, and national policy.[8]	in root cause analysis and remediation plans developed by Implementing Partners to respond to identified gaps. PEPFAR DRC is prompting sites to constitute CQI committees. Current Quality assurance endeavors are evident through SIMS activities with an active involvement of Implementing Partners (IP) and notable interest of MOH in acquiring skills for SIMS.	
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	In 2019, the country, under the leadership of PNLS and PNMLS (National AIDS Councils) with the financial support of PEPFAR, held a Training of Trainers to HIV Program managers and civil society organization leaders on VL demand creation (including VL literacy) to improve the quality of treatment (ART). Specific sensitization sessions were organized with community-based organizations and healthcare providers under PNLS/MoH's lead and implemented by the implementing partners.	
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	CDC has begun to address this, and it is expected that USAID will address this in COP 2020.	This has been difficult due to unique circumstances in DRC.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.		

	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	PEPFAR DRC is monitoring and reporting morbidity and mortality outcomes routinely. In particular, peer educators are responsible for tracking all defaulting clients. The national Information system also tracks the number of deaths among PLHIV and opportunistic infections routinely but cannot yet report disaggregated causes of death even if this is recorded in individual medical charts.	
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	There are no unique identifiers for PLHIV in PEPFAR-supported sites except for in three KP sites. PEPFAR DRC has not scaled-up case-based surveillance at this point. Plans are in place to pilot case-based surveillance in COP 2019.	Implementation of unique identifiers for patients is planned by MOH with GF funding. Updates on this activity are expected from GF and MOH during the PEPFAR DRC COP 2020 retreat.

8 Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

In addition to meeting the minimum requirements outlined above, it is expected that DRC will:

Table 10. COP 2020 (FY 2021) Technical Directives

DRC –Specific Directives
HIV Treatment
1. Viral load coverage rates must be ≥80% at the site level for ≥15 and <15 clients. EID rates at 2 months must also be ≥80%.
2. Case finding must improve for hard to reach populations, including children and young men.
3. PEPFAR DRC must make every effort to retain new and existing clients on treatment through client and family centered care.

4. The Pediatric Care and Treatment cascade must improve.
HIV Prevention
1. N/A
Other Government Policy or Programming Changes Needed
1. GDRC must urgently reinstate the establishment of immediate removal for PEPFAR HIV commodities within the customs clearance process.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. DRC must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 2020, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing, but remaining at increased risk of HIV acquisition, by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls, and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP 2020; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

OVC

To support the Minimum Program Requirement described above, in COP 2020, clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. Government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 2020, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional, and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP 2020 remains a requirement for all PEPFAR programs, and as such the COP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA, where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and

multilateral partners. Specific guidance for the COP 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP 2020 development and finalization process. As in COP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment: If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the Planning Level Letter across all funding sources. Additionally, due to Congressional earmarks, some of the Care and Treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. DRC's Care and Treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, and PDCS budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

HKID Requirement: DRC's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. DRC's COP 2020 HKID requirement is derived based upon the approved COP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): DRC's COP 2020 minimum requirement for the GBV earmark is reflected in Table 2. DRC's GBV earmark requirement is calculated as the total ***new FY 2020*** *funding programmed to the GBV cross-cutting code. DRC's COP 2020 earmark is derived by using the final COP 2019 GBV earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

Water: DRC's COP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total ***new FY 2020 funding*** *programmed to the water cross-cutting code. DRC's COP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal ***by agency*** *by the end of FY 2020 and must meet 40% by FY 2019. Each country must contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY 2020 as appropriate through their COP 2019 submission.*

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in DRC should hold a 3 month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.