

Approved



# **Democratic Republic of the Congo**

## **Country Operational Plan**

### **FY 2014**

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



## Operating Unit Overview

### OU Executive Summary

DRC Country Operational Plan FY 14

Executive Summary

#### I. Country context

The Democratic Republic of Congo (DRC) has one of the lowest Gross National Incomes per capita in the world (\$230 per 2012 World Bank estimates). An estimated 80% of the total population of 70 million live below the poverty line and 60% live in rural areas where seven out of ten households are poor. In 2011, the United Nations Development Fund (UNDP) ranked the DRC the least developed country in the world (187/187); it is ranked the second most fragile state on USAID's Alert list, and almost last on Doing Business 2013. Due to the population size, the scale of poverty, and decades of conflict, the health system is fragile and functions poorly.

Limited financing and poor management of resources are among the many challenges that DRC faces in providing quality basic health services. Various reforms have been initiated to improve revenue collection and to streamline the management of public expenditure, but have not come to fruition. In 2012, the government disbursed only 22 % (\$119 million) of the amount legislatively authorized for health care spending. According to National Health Account data \$13 per capita was spent on health; of which 43% was paid by individual households and 15% by the government. The health sector continues to be largely financed by private donors, bilateral and multilateral. According to the recently published HIV/AIDS Investment Case for DRC, public financing of DRC's HIV/AIDS interventions does not reflect a prioritization of the fight against HIV/AIDS. The Government of DRC's (GDRC) contributions have been inconsistent between 2008 and 2012: 2008 (3.8%), 2009 (1%), 2010 (2.8%), 2011 (2%), and 2012 (2%). In addition to insufficient health sector financing, existing health facilities have high operating costs, logistical constraints, coupled with weak supervision and oversight. Poor infrastructure, including inadequate roads and the lack of electricity and water at many health facilities, further complicates access to basic health care. Infrastructural challenges also impede movement of resources including personnel and supplies.

#### Epidemiology and Other Contextual Factors

DRC's HIV epidemic is generalized, with a prevalence of 1.0–1.2% (ages 15-49) based on 2012 UNAIDS estimates. According to the same estimates there are an estimated 480,000 persons living with HIV with 32,000 annual deaths due to AIDS.



According to the 2007 Demographic and Health Survey (DHS), there are regional, urban/rural, and gender variations in HIV prevalence. Prevalence is twice as high in urban vs. rural areas (1.9 % vs. 0.8 %) and higher among women than men (1.6 % vs. 0.9 %), while 86% of persons who tested HIV positive were unaware of their status. The majority of HIV transmission in DRC is through heterosexual contact, exacerbated by high-risk sexual practices (such as multiple concurrent partners) and low or inconsistent condom use. Although there is insufficient data on the location, typology, and dynamics of key populations and high-risk groups, the 2012 Integrated Biological and Behavioral Surveillance Survey (IBBS) indicated that HIV prevalence among female sex workers (FSW) in Kinshasa and Katanga is ten times higher compared to the general population in Kinshasa and Katanga, with FSWs also reporting low condom usage during transactional sex.

ANC data from 2011 show variation among pregnant women depending on province: Katanga (4.6%), Orientale (4.2%), Kasai Occidental (5.7%) and Kasai Oriental (6.1%) had relatively higher HIV prevalence. Although HIV prevalence in Kinshasa and Bas Congo provinces were relatively lower (2.8 and 2.4 respectively), these provinces have densely populated urban areas. Kinshasa is the capital city and has the largest population in the country and Bas Congo is the only province with access to the ocean and with large transient population.

In the PEPFAR focus provinces (Kinshasa, Katanga, Orientale and Bas-Congo), 2011 ANC data, the 2012 IBBS, and the recently conducted epidemiologic profile on the burden of HIV show: HIV prevalence (Bas Congo 2.4%; Katanga 4.6%, Kinshasa 2.8%, Orientale 4.2%); HIV prevalence among FSW (Bas Congo 2.4%; Katanga 10.8%, Kinshasa 9.8%, Orientale 4.1%); HIV prevalence among blood donors (Bas Congo 1.6%; Katanga 2.9%, Kinshasa 2.7%, Orientale 5.3%); HIV prevalence among pregnant women receiving services to prevent the transmission of HIV (Bas Congo 1.1%; Katanga 2.2%, Kinshasa 1.3%, Orientale 3%); and HIV prevalence among TB patients (Bas Congo no data; Katanga 14%, Kinshasa 12%, Orientale 24%). Estimated data from the epidemiologic profile provide data on persons living with HIV (PLHIV) as follows Bas Congo-36, 874 (15,893 need antiretroviral therapy (ART)), Katanga- 105,630 (45,526 need ART), Kinshasa- 102,805 (44,309 need ART), and Orientale- 92,039 (8,320 need ART). Note that these needs reflect the previous eligibility criteria; implementation of new 2013 treatment guidelines will increase the number of people eligible for treatment. Strategic Information is a priority in COP2014; significant effort will be made to better understand the dynamics of the HIV epidemic in order to consistently improve the type, quality, and coverage of HIV interventions in the focus provinces.

The geographic size of the DRC and lack of infrastructure, especially poor transportation (i.e. roads, railroads, limited air transportation), creates complex logistical hurdles and 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 8126 health centers and 376 general reference hospitals organized in a hub and spoke model. 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. Despite efforts to strengthen FEDECAM, the system remains weak and challenges remain in the areas of financial and supply chain management, forecasting, and quantification.

Addressing gender-related violence and gender power dynamics are essential to reducing HIV risk; however, this process will take time. Gender dynamics influence individuals' status within society, social norms, behavior, and access to resources. Included in the PEPFAR/DRC portfolio are activities to counter the inferior status of women – increasing awareness on gender issues using peer to peer and mass communication, integration of HIV/AIDS and gender related modules in the curriculum of military basic training, increasing training for peer educators, and strengthening coordination of GDRC working groups on gender related activities, specifically GBV. PEPFAR/DRC will support the MoH to integrate gender-related indicators to be captured at the health facility level, and encourage synergies between the MoH and the Ministry of Gender.

#### Status of the National Response

While the GDRC's strategy on Poverty Reduction prioritizes HIV/AIDS as one of the major obstacles to development, the National Multi-Sectorial Program for the Fight against AIDS (PNMLS) is the single institutional framework for the coordination of a multi-sectorial response to HIV/AIDS in DRC. The National Strategic Plan for 2014-2017 (NSP), developed by PNMLS estimates total funding of \$2 billion for all HIV/AIDS interventions planned for 2014-2017, and the recently published Investment Case argues for a budget of approximately \$225 million per year through 2017. The NSP is divided into five axes:

- Prevention of HIV and Sexually Transmitted Infections: Reduce the number of new infections to 50% in the general and key populations.
- Eliminate mother-to-child transmission of HIV: Reduce transmission by 90%.
- Improve access to care and treatment.
- Promote an environment that is favorable for PLHIV by addressing stigma and discrimination.
- Support the implementation of HIV interventions through a coordinated response, mobilization of resources, integration of HIV into basic health care services, and reinforce the SI system.

According to the Investment Case, investments must be made in interventions that reduce the transmission of HIV from mother-to-child, increase treatment coverage, increase access to care and support services for persons living with HIV, and implement targeted interventions for key populations and high risk groups. Cross-cutting areas including increased community mobilization, advocacy for human



rights, and synergy between the health, social protection and justice sectors should also be supported.

The Investment Case points to several barriers to realizing an impact on the epidemic:

- ? a largely centralized health care system.
- ? high dependency on donors to finance HIV-related interventions; less than 2% of financing comes from public funds.
- ? poor management of resources.
- ? weak coordination with poorly aligned and harmonized interventions; and
- ? weak supply chain management systems.

The Investment Case proposes that by addressing these issues, 210,000 new HIV infections and 300,000 deaths from AIDS can be averted per year. The Investment Case also recommends that the GDRC increase its investment in HIV by exploring opportunities for financing within the provinces, capitalizing on possible contributions from the private sector, decentralizing the health system and focusing on the integration of HIV/AIDS in the health sector.

#### USG's role in the National Response

The USG's role in the national response is aligned with the Ministry of Health's (MOH) 2011-2015 National Health Development Plan (NHDP). This comprehensive plan covers major causes of mortality and morbidity in the country. The main goal of both the Global Health Initiative (GHI) and the NHDP is to support a sustainable health system where comprehensive health care services are provided through an integrated Health Zone (HZ) network to increase program efficiencies, effectiveness, and mutual accountability. PEPFAR significantly supports the implementation of the national plan to eliminate mother-to-child transmission of HIV (eMTCT). PEPFAR contributes to achieving about 85% of the PMTCT targets set by the government and has strongly supported the country's transition to Option B+ and gradual adoption of the new World Health Organization (WHO) treatment guidelines. The PEPFAR DRC team, with support from headquarters has provided consistent technical assistance to the national and provincial offices of the National AIDS Control Program (PNLS) to develop an operational plan for the B+ pilot in Katanga, and a system for capturing lessons learned in order to refine the country's larger transition and operational plan, although challenges remain with building institutional capacity and overall reinforcement of the national health system that are critical to the delivery of the aforementioned services.

PEPFAR/DRC continues to rely on funding from several other USG programs to maximize a whole-of-government approach that integrates PEPFAR and other health and development programs including malaria (Presidential Malaria Initiative), tuberculosis (TB), maternal and child health (MCH), family planning (FP), food and nutrition, and education. PEPFAR/DRC relies on USAID funding to integrate FP services into HIV activities. This is in addition to funding from partners including the United Nations Population Fund (UNFPA) and the United Kingdom's Department for International Development



(DfID). Through collaboration with the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM) and the Presidential Malaria Initiative (PMI), bed nets are made available to most beneficiaries of PEPFAR/DRC programming. PEPFAR supports the screening of non-remunerated blood in partnership with the National Blood and Transfusion Program. PEPFAR/DRC depends on USAID funds for TB Care funding to strengthen and build the capacity of community-based organizations (Club des Amis Damiens and Ligue National Anti TB au Congo) at the national and provincial levels, DOTS for co-infected clients, linkages between PLWA community groups and clinical services for steps following TB screening, as well as, referrals for ART for early initiation on treatment.

#### Other Donors' Role in the National Response

Under GFATM's Round 8 grant, DRC's Country Coordinating Mechanism (CCM) selected the MoH, CORDAID and SANRU as Principal Recipients (PR). The total HIV/AIDS budget is about \$130 million for the period of January 2012 to December 2014. Prevention, Care and Treatment activities are implemented in 239 HZs and all of the 11 provinces. In 2013, GDRC was selected as an early applicant for HIV funding under GFATM's New Funding Model. The Concept Note was submitted to GFATM in January 2014, requesting funds to cover an implementation period of January 2015 through December 2017. The Concept Note was developed based on key inputs from the NSP, the national eMTCT plan (2012-2017), and the Investment Case. The objectives of the 3 year Concept Note are to:

- ? reduce the transmission of HIV from mother-to-child from 36.2 % to 5%;
- ? reduce deaths from AIDS by 50%;
- ? reach 41% of Men who have Sex with Men (MSM), 17% of Commercial Sex Workers (CSWs) and 32% of persons aged 15-45 years with targeted prevention interventions; and
- ? increase the number of persons in care and treatment to an estimated 102,000 by 2015 (in June 2013 76, 418 persons are currently on treatment).

The base funding included in the Concept Note is \$130 million, and the incentive funding requested is \$96,091,741, for a total of \$226,091,741 of possible funding for three years. Coordination and rationalization of donor resources (including PEPFAR and the Global Fund) will enable DRC to reach key populations, fully implement the eMTCT plan, improve interventions for TB/HIV co-infection, and more importantly improve treatment outcomes.

GFATM and DfID support the strengthening of the National Strategic Information system -System National d'Information Sanitaire (SNIS). In COP14, PEPFAR/DRC will support SNIS as needed, such as for revising data collection tools. The USG, GFATM, DfID, World Bank, and other donors are procuring significant amounts of commodities and providing technical assistance to the national supply chain management system at various levels to build capacity and avoid stock outs of essential medicines; as well as, supporting the rehabilitation and management of regional distribution centers for medicines and commodities.



Outside of the GFATM, various United Nations agencies have shared responsibilities that support the GDRC in the fight against HIV/AIDS. These responsibilities include: involvement in eMTCT; prevention in key populations; increasing access to ARVs; prevention of Gender-Based Violence (GBV); protection of human rights; support to coordination efforts spearheaded by PNMLS; and mobilization of resources.

## II. PEPFAR Focus in FY 2014

### USG's Top Priorities

Evolving from the PMTCT acceleration platform, PEPFAR/DRC has established a HIV Continuum of Response (CoR) strategy that strengthens the linkages between HIV prevention, care, and treatment services and ensures that comprehensive services are accessible by HIV infected/affected individuals. The PEPFAR/DRC program will further maximize synergies between agencies with focused attention in the provinces of Kinshasa, Katanga, Orientale; and for now Bas Congo. Further details are provided in the Technical Area Narratives (TANs).

Top priorities for FY2014 are based on recommendations following the March 2013 in-person review, the May COP13 review, COP13 funding approval and COP14 priority letters, PEPFAR/DRC implementing partners (IP) Portfolio Review and the PEPFAR/DRC COP14 retreat. More importantly, the team aligned its priorities with those of the NSP, Investment Case, and the Concept Note. Priorities are:

- (1) Strengthen the CoR by improving linkages between prevention, care and treatment services for HIV infected persons identified through expanded PMTCT programming and PITC in clinical services, and key populations.
- (2) Maintain targeted programs for key populations (CSW and MSM), and high-risk groups (military, miners, truckers, and youth under 24) and conduct key population mapping and size estimation study to understand the dynamics of the aforementioned groups.
- (3) Focus on the depth of programming to improve quality of services, and use data from the mapping and site verification and quality exercise to develop a phased approach to expand PEPFAR programming.
- (4) Support improved data collection and use, monitoring, evaluation and reporting in alignment with the global Strategic Information (SI) framework.
- (5) Complete reorientation of the PEPFAR portfolio toward the health zone approach by strengthening coordination with GFATM to reduce duplication of services, particularly as relates to improving treatment outcomes and strengthening health systems.

These areas are elaborated in Section IV – Program Overview.



#### Priority Changes and Pivots/Response to COP14 funding letter

PEPFAR/DRC's strategy is to improve and sustain a full CoR with an emphasis on strengthening linkages and the quality of services, strengthening SI, and implementing the HZ model. Programmatic entry points to the CoR are from PMTCT, provider initiated testing and counseling (PITC), and a small proportion from key populations.

Key shifts in FY2014 include a continued decrease in generalized HIV counseling and testing, and general abstinence/be faithful (HVAB) prevention interventions. In COP11 and COP12 for example, these activities were funded with 6% of the budget, in COP13, this was reduced to 2 % of the budget, and is now 1.3% in COP14. Implementing partners (IP) have been directed to test only where there are strong linkages to reliable care and treatment services. Resources are allocated to specifically:

- intensify care and indirect treatment support services, and strengthen linkages to ensure retention in care and treatment;
- strengthen the PMTCT program (\$30 million (\$8 million more than in COP13, representing 48% of the COP14 budget);
- procure antiretroviral drugs (ARVs) with careful consideration of the treatment targets, transition to option B+, and a phased transition to the new WHO treatment guidelines prioritizing the sickest patients;
- define the size and dynamics of key populations and high risk groups; and, lastly
- focus on the quality and rationalization of services.

Of major importance is PEPFAR/DRC's geographical transition to focus interventions in the four provinces of Bas Congo, Kinshasa, Katanga, and Orientale. Per the COP14 funding letter, prior to COP14 submission, PEPFAR/DRC provided to the Deputy Principals (DPs) programmatic and epidemiologic data to support the team's request to maintain activities in Bas Congo. Bas Congo will remain a focus province in COP14, with no expansion of activities until additional data is provided from mapping of services and verification of the quality of services. PEPFAR/DRC's transition from Kasaï Oriental, Kasaï Occidental, and South Kivu was challenging especially since the official notice to the MoH from OGAC came after the transition began. Activities from 103 PMTCT sites that were jointly supported by PEPFAR and GFATM in these provinces have been transitioned to Global Fund PRs. In HZs receiving only PEPFAR support, GFATM agreed to maintain treatment services for persons already initiated on treatment. Services previously provided by PEPFAR are now included in the GF's NFM Concept Note.

PEPFAR/DRC received a budget adjustment in COP12 due to pipeline and a reduced budget in COP13 due to the reorientation of the program. The team has been diligent in spending down pipeline and reports as of December 31, 2013 a pipeline of \$30 million primarily due to the late arrival of partial COP13 funds



(about 25% of new COP13 are waiting approval of Congressional Notification). The amount of pipeline will be expended in approximately 8-12 months taking into consideration historic spending, immediate priorities, and absorption capacity. PEPFAR/DRC was approved for an additional \$12 million of COP14 funds on February 20, 2014. The team planned on a base budget of \$62 million, \$10 million of pipeline has been applied for a total operational budget of \$72 million. Activities prioritized with the additional funds are: (1) mapping of key populations and high risk groups, a prerequisite to the size estimation study, (2) expansion of nutrition assessment, counseling, and support (NACS), (3) implementation of the AIDS Indicator Survey (AIS), and (4) increased funding of lab commodities to support the transition to option B+ and phased adoption of new treatment guidelines. The budget distribution and reorientation of the program respond to programmatic shifts based on available data, resources, and the Deputy Principals' vision for the country program.

### III. Progress and Future

#### Partnership Framework (PF)

In 2009 the USG and the GDRC signed a PF detailing the shared priorities and collaboration between both parties. Recognizing the importance of country ownership and sustainability, the hallmark of the partnership is joint decision-making in setting programming priorities for the HIV/AIDS sector, and joint commitment to greater transparency in reporting information. Important guiding principles included alignment with the support provided by the GFATM and the comparative strengths of the USG agencies implementing PEPFAR. The current planned FY 14 PEPFAR program is aligned with the goals and objectives of the partnership framework. Furthermore, the implementation of targeted activities, including the expanded PMTCT program, based on a continuum of care further supports the framework's goals and intentions.

A PF Implementation Plan was drafted but not finalized. The PF expires in 2014. In COP14 PEPFAR/DRC will use the PEPFAR Sustainability Plan as a guide to engage the GDRC in discussions around developing the next phase of a partnership agreement within the context of a gradual shift towards co-investment of GDRC, Global Fund and PEPFAR resources. GDRC completed significant processes in 2013/early 2014, namely - Investment Case, NSP, and submission of the GDRC Concept Note to the Global Fund. This is the ideal time to capitalize on the outcomes of these activities to ensure that in the upcoming discussions, stakeholders' inputs are represented, and that the next PF complements contributions from other donors. More importantly the next phase will not only ensure alignment with the NSP 2014-2017, it will set benchmarks that correlate with the NSP and the Investment Case to measure progress with the GDRC.



### Country Ownership

The USG and GDRC's response to increasing country ownership is coordinated through the health sector PNMLS Plan for 2010-2014. The overall goal of the plan is to reduce HIV incidence while minimizing negative impacts on individuals, families, and communities. Within this plan, PNLS was delegated the responsibility to coordinate epidemiological surveillance and clinical services. PNLS' priorities as presented during the COP14 retreat are to:

- ? Eliminate the transmission of HIV to children and reduce the maternal mortality rate related to HIV through increased PMTCT programming;
- ? Improve access to care and treatment for persons living with HIV/AIDS;
- ? Reduce the number of deaths from tuberculosis among persons living with HIV/AIDS;
- ? Implement targeted interventions for key populations and high risk groups; and
- ? Ensure robust laboratory services that respond to the demand created by care and treatment needs.

PEPFAR/DRC is already supporting PNLS to conduct survey and surveillance activities to describe HIV prevalence in DRC; the most recent being the ANC surveillance and the Epidemiologic Profile (jointly supported with GFATM, WHO, and UNAIDS). PNLS is also implementing several approaches to assuring data quality; however the approaches are not consistent. Data validation sessions are not routine at the HZ, provincial, and national levels which poses a challenge for PEPFAR/DRC to ensure that reported data from PEPFAR supported sites is officially validated by the PNLS. Another major challenge is the weak transmission of data from the facility to HZ to provincial and finally to the national level. While PNLS prioritizes PMTCT and key populations, there is strong concern that the incidence of HIV might increase if general prevention interventions are not available. As with PEPFAR, PNLS also has concerns over the most effective approaches to implementing and evaluating HSS.

Progress has been made on enhancing collaboration to contribute positively to the achievement of the GDRC's national HIV/AIDS goals and objectives for greater country ownership through joint decision-making. The GDRC and the USG work together at the national, provincial and HZ levels to improve policies and the implementation of new protocols. Nonetheless, due to the low prevalence rates in country, HIV/AIDS remains a low priority for the GDRC, therefore continued advocacy will be necessary to encourage the GDRC to assume full financial responsibility for its HIV/AIDS programming in the future.

### Future Trajectory

#### Year 1 (COP14)

PEPFAR/DRC will prioritize maintaining a strong HIV continuum, especially considering the challenges that will be presented by the transition to Option B+, adoption of new treatment guidelines and the GDRC's continued request for PEPFAR to expand its programming and funding envelope. The team will



focus on strengthening the quality of services being provided in at least 75% of sites that have received PEPFAR support for five years or more. This means ensuring that the OGAC approved minimum package of services is available at these sites.

Prior to receipt of COP14 funds, the team's focus is to develop needed operational plans and strategies in preparation toward full implementation of COP14 activities. This requires completion of the following work (by area):

Strategic planning:

- Update and analyze mapping data. Work closely with PNLs to use the data to inform an operational plan listing supported HZs and sites and those prioritized for future support;
- Complete development of the health zone strategy defining PEPFAR/DRC's support to the HZ. Define coordination within HZs and the standard packet of activities needed to strengthen coordination and management;
- Begin site verification and quality assurance exercise. This activity was programmed in COP13, but funds are not yet available. The outcome of this exercise will help outline a timeline for ensuring a complete package of services in all PEPFAR-supported HZs.

GFATM Collaboration: Collaboration with the GFATM is critical to ensure complementarity of services and to expand coverage. PEPFAR/DRC has deepened its collaboration with GFATM from the headquarter planning level to the health zone level; the team has initiated planning sessions with PEPFAR IPs and GFATM Principal Recipients (PRs) – SANRU and CORDAID, to ensure prudent use of resources and support a sustainable system of coordination and planning within health zones.

HSS: Critically review the HSS portfolio to make certain that HSS activities are directly linked to health outcomes.

Year 2 (COP15)

The focus in COP15 will be on expanding the depth of services to at least 50% the total number of PEPFAR supported sites. Before submission of COP15, the site verification and mapping exercises would have been completed. These exercises will help the team prioritize geographical locations for expansion and develop a timeline.

Technical Assistance:

PEPFAR/DRC benefitted significantly from technical assistance provided by the PMTCT, Pediatrics, Lab, Care and Support, and Treatment technical working groups; as well as SI support. The DRC team will request technical assistance for: (1) strategic planning and HSS (to develop a roadmap for partner



rationalization), (2) Key Populations, PMTCT, Pediatrics, Care and Support, Treatment (for continued support to the transition to option B+ and portfolio wide adoption of the new treatment guidelines), and (3) ongoing SI support to the team and to IPs at the national and provincial levels.

Technical assistance from the finance and economic technical working group was not mentioned above because DRC is included in this year's group of countries scheduled for expenditure analysis. The team requests that DRC be prioritized for an early visit. This exercise will give the team a strong sense of expenses in programming, management and operations; provide critical costing information; and inform the team of appropriate staffing levels to manage current and future portfolios.

#### IV: Program Overview

The overview below describes important areas of this year's COP.

1. Strengthening the CoR: Strengthen the CoR by improving linkages between prevention, care and treatment programs for HIV infected persons identified through expanded PMTCT programming and PITC in clinical services, and key populations. This encompasses delivery of integrated clinical and community based services and improving the linkages between clinical and community services. Key activities to be implemented with COP14 funds include:

- Continue engagement with GDRC to support the country's transition to option B+, ensuring a coordinated approach to HIV Care and Treatment
- Increase treatment coverage for all eligible persons living with HIV by providing treatment for 33,000 eligible persons (COP14 and COP15 targets), an increase of 19,000. This will be accomplished by focusing on pregnant women who are HIV positive, high risk populations including hospitalized patients, and co-infected patients.
- Strengthen linkages to care and support services so as to increase biological monitoring of patients on treatment, reduce loss to follow-up, and increase effectiveness and retention. IPs have been directed to implement innovative and proven strategies such as the mentor-mother approach, increase involvement of support groups, and implement income generative activities.
- Improve integration of Family Planning by closing knowledge gaps and planning appropriately for commodities particularly in areas where there will be an increase in PMTCT sites/targets.
- Integrate pediatric services in HIV care and treatment.
- Ensure the availability of basic laboratory diagnostic and monitoring capacity, and assess laboratory equipment needs given the expansion of PMTCT and treatment services, especially PIMA machines in new sites.
- Expansion of EID laboratories from one (in Kinshasa) to three (addition of labs in Katanga and Orientale) in order to reduce delays in transporting samples.



- Support GDRC to officially inaugurate its policy on task shifting.
- Increase the uptake of services among men by focusing on prevention interventions that target men.

2. Targeted Prevention activities: Although the epidemic in GDRC is generalized, there are pockets of the population with high HIV prevalence. These include key populations, patients infected with Tuberculosis (TB), and patients hospitalized for non-emergency care. In COP13, there were strong shifts from general prevention messaging and testing and counseling, to targeted HTC. There will be no prevention interventions where strong linkages to care and treatment services are not available. Key activities that will be implemented with COP14 funds:

- Implement PITC targeting TB patients, patients with sexually transmitted infections (STI), malnourished children, and hospitalized patients (in major hospitals). Particularly for TB patients, IPs have been directed to integrate ART within the same health facility so as to reduce loss to follow-up and increase retention.
- Conduct a mapping and size estimation of key populations and high-risk groups to inform tailored prevention, care and treatment services.
- Use the outcomes of the above and existing programmatic data to support the GDRC in developing a key populations strategy and policy that is operational at the national, provincial and HZ levels.
- Maintain current programming for key populations (CSW and MSM), and high-risk groups (military, miners, truckers, and youth under 24) until data is available to expand or refine interventions.
- PEPFAR IPs have already been directed to integrate GBV activities into clinical and community platforms. They are providing assistance to SGBV survivors within existing HIV platforms through STI and HIV screening and provision of PEP kits.

3. Improve quality of services: Focus on the depth of programming to improve the quality of services, and use data from the mapping and site verification and quality exercise to develop a phased approach to expanding PEPFAR programming. As detailed in the Technical Area Narratives, PEPFAR/DRC will build on its experience in quality improvements and assurance to ensure that IPs are implementing quality services across PEPFAR's portfolio. To improve the quality of services, PEPFAR/DRC will pay increased attention to: availability of quality commodities at the health facility level, access to free of charge services for eligible persons, and innovative approaches to maintain well trained providers in health facilities.

4. Strategic Information: Progress has been made in improving data availability and quality, but there are immense SI needs. Key activities in COP14 include:

- Focus on accurate data collection and interpretation, and improve data use in planning. Strategize with GFATM, and other stakeholders on support to the SNIS.



- Support PNLs in developing the national reporting system, implement data quality assurance, and standardize registers.
- Improve PEPFAR IPs' understanding of the new PEPFAR indicators especially for indicators that will be reported for the first time in COP15.
- Assess the feasibility of conducting the surveillance and special studies that are currently in the pipeline. Priority is given to the AIDS Indicator Survey, mapping and size estimation for key populations, and the Drug Resistance Survey.

5. Reorientation of the PEPFAR portfolio toward the health zone model: PEPFAR/DRC will support an HIV CoR to ensure that there are strong linkages in services provided to HIV infected/affected individuals, with end goals to prevent new infections, improve quality of life, and contribute to strengthening the health system. This requires defined activities at the HZ level. Specific activities include:

- Defining the HZ as the focal coordination and implementation lever for PEPFAR supported activities.
- Involvement of PEPFAR IPs in the HZ planning processes to better coordinate location of intervention and distribution of resources.
- Coordination and management support to the HZ management team.
- Coordination with GFATM at the HZ level to prevent duplication of services.

The success of the HZ model depends on a well-defined partner rationalization plan between PEPFAR IPs although GDRC has unofficially expressed strong interest in regionalization of support provided by PEPFAR and GFATM. Defining the partner rationalization plan begins with determining its basis, assessing the technical capacity of IPs in order to expand services and ensuring better coordination.

HSS at the provincial and HZ levels: Funding for HSS includes support to the HZ management team. The following key activities are crucial to PEPFAR programming as they serve as a vehicle for engaging different levels of leadership, creating buy-in and ownership of program activities, particularly during the planning phase. These activities are linked to and impact health outcomes.

- Conduct routine joint supervisory and mentorship site visits with the HZ management team and PEPFAR IPs; as well as joint site visits with the GFATM, IPs, and PNLs.
- Participate in coordination workshops/meetings, annual provincial review, and data validation meetings.

#### V. GHI, Program Integration, Central Initiatives, and Other Considerations

GHI: The GHI strategy focuses 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. One of the key results of the GHI strategy is PEPFAR's adoption of the HZ model. PEPFAR/DRC's contribution to progress in these focal areas include:

- (1) Building institutional capacity through the Nursing Education Partnership Initiative (NEPI), and through the Field Epidemiology Training Program, and through TA support to PNLs.
- (2) Increased funding to SCMS to rehabilitate distribution hubs (CDRs) in PEPFAR's priority provinces.

Central Initiatives: There are three PEPFAR central Initiatives in DRC.

(1) NEPI: Major challenges to building human resource capacity in DRC are the lack of reliable, up to date quantified information on human resources and staffing needs. In some areas, the country's transition from humanitarian (free) assistance to a fee-for-service system has been a management and financial challenge, especially given the high level of poverty. Under NEPI, human resource capacity building will be strengthened by improving curriculums for training nurses and midwives, 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. In COP14, NEPI will support the purchase of textbooks and equipment for clinical simulation, curriculum reviews, and capacity building of faculty using central funds. NEPI has been included for the first time in PEPFAR/DRC base funding (at \$728,000). These funds will expand the number of supported schools from four to seven – adding two schools in Province Orientale, and one school in Bas Congo (Military Nursing School).

(2) Global Fund Country Collaboration Grant: To strengthen PEPFAR-GFATM collaboration and implementation in DRC, funds from this central initiative were used to support coordination meetings; joint program monitoring with the GFATM and MoH; technical assistance to improve management of CCM (training on Dashboard); and support to the GFATM proposal development.

(3) Gender Based Violence Initiative (GBVI): Funds for Year three were placed on hold during the March and May 2013 reviews of COP13 until the team is: (1) able to review and realign GBVI programming so that activities are fully integrated with PEPFAR programming. GBVI activities have been integrated into PEPFAR/DRC's portfolio, with funding included in the COP14 base budget. Technical assistance has already been requested for a programmatic review of the initiative and assistance with strengthening the integration of GBV across PEPFAR/DRC's portfolio.

#### Way Forward

Operating within the many constraints unique to DRC, PEPFAR continues to be a major bilateral partner of the GDRC in addressing the HIV/AIDS epidemic and has contributed significantly to the country's



health improvement agenda. Previous years' results have shown that top-down HIV programs have had minimal impact on the epidemic. PEPFAR/DRC's future strategy is to provide a comprehensive HIV/AIDS platform focused on ensuring a full continuum of response within each priority health zone. This approach is aligned with that of the GDRC and increases our contribution to institutional capacity building at the grass-roots level. The team has been thorough in pivoting PEPFAR programming – redirecting resources, transitioning supported sites in order to geographically concentrate activities and resources, and responding to recommendations from GDRC and OGAC. These efforts and the team's commitment to program shifting will result in progress toward preventing new infections, improving the quality of life, and strengthening the health system. The team rejuvenated planning discussions with Local Civil Society as a platform to further advocacy efforts and increase community involvement. PEPFAR/DRC has actively engaged GFATM, UNAIDS, UNICEF, WHO, and other partners to increase coordination, facilitate better joint planning, and achieve better harmonized programs. Outcomes of this engagement with multilateral partners will improve technical assistance to the GDRC, prevent duplication of services, increase complementarity, and increase coverage and program efficiencies overall.