United States Department of State

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FY 2015 Democratic Republic of Congo Country Operational Plan (COP)

The following elements included in this document, in addition to "Budget and Target Reports" posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Democratic Republic of Congo.

1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

   Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the "COP 15 Targets by Subnational Unit" sheets that follow for final approved targets.

2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the "FY 2015 Country Operational Plan Budget and Target Report."

Democratic Republic of Congo
Country Operational Plan (COP) 2015
Strategic Direction Summary

August 21, 2015

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Goal Statement

The 2015 DRC Country Operational Plan (COP) builds off the OGAC-directed strategic pivot that the PEPFAR DRC program began in 2013. This pivot reduced PEPFAR's intervention zone from seven to four provinces in the 2013 COP and from four to three provinces in the 2014 COP (Kinshasa, Katanga, and Orientale). The 2015 COP also supports the efforts of the government of the Democratic Republic of Congo (GDRC) to "rationalize" HIV/AIDS donor aid by assigning one donor per health zone (HZ[1]) by December 2016 and one donor per provincial health division (French: Division Provinçiale de Santé [DPS]) by December 2018. The goal of the COP is to achieve sustained epidemic control in 17 HZs and 1 military area[2] (17+1) by September 30, 2017. Programs are designed to scale up and achieve 80% ART coverage in these HZs by maximizing entry points, focusing on individuals lost to follow up, and targeting priority populations (i.e., pregnant women and their families, key populations (men who have sex with men [MSM], female sex workers [FSW] and their clients), TB/HIV patients and their families, military, miners, truckers, children at high risk of HIV, and adolescent girls and young women (AGYW)). To reach 80% ART coverage in the HZs PEPFAR DRC will contribute to providing care and treatment services for 33,582 people (9,109 newly enrolled) in FY2016, and for 50,638 persons (13,560 newly enrolled) by the end of FY2017.

Currently, PEPFAR DRC supports activities in 95 out of 516 HZs in the country. Of these 95[3] HZs, 17+1 will be scaled up for Scale-up to Saturation, 30 will be designated as Sustained and 46 will be transitioned to the GDRC (3 HZs) and Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) (43 HZs) by September 30, 2016. In Sustained HZs, PEPFAR DRC will implement a package of activities, which will include provider-initiated testing and counseling for TB infected patients, children exposed to HIV, and persons presenting with clinical symptoms. PEPFAR will fund routine testing of pregnant women in sites that report a yield of eight or more HIV cases per year. A full package of care and treatment services will be provided for those on treatment. The program will reinvest saved resources in supporting the GDRC's efforts to conduct active and routine surveillance in order to monitor HIV incidence and trends, strengthening laboratory capacity, and scaling up interventions needed to reach sustained epidemic control in the 17 + 1 Scale-up to Saturation HZs by the end of FY 2017.

[1] Health Zones are the lowest operational administrative unit within the health sector, sub-dividing provinces for the purposes of healthcare service delivery

[2] The military area includes several different geographic locations.

[3] The "1" military area in the priority health zones includes 2 health zones, hence the 95 total number of health zones supported by PEPFAR are: 19 scale-up to saturation, 30 sustained support, 46 central support.

1.0Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

DRC has a population of 71 million, based on updated 2015 Spectrum estimates. The HIV epidemic is generalized, with a prevalence of 0.95% (0.6-1.7% ages 15-49) based on 2015 UNAIDS estimates (version 5.30), with 560,798 people living with HIV. Prevalence is higher in urban (1.7%) versus rural areas (0.6%) and slightly higher among women than men 15 years and older (1.09% vs. 0.77%). Prevalence is higher than the national average in the three provinces PEPFAR supports: Katanga, 1.6%; Kinshasa, 1.7%; and Orientale, 2.5%. The estimated number of PLHIV living in these three provinces represents 50% of the total number of PLHIV in DRC (Spectrum 2015). The prevalence among FSWs is 9.8% in Kinshasa, 10.8% in Katanga, and 4.1% in Orientale (IBBS 2013). Multiple sexual partners and low and/or inconsistent condom use have been identified as high-risk practices.

The DRC suffers from a lack of reliable and timely epidemiologic and programmatic data. To date, there is limited reporting on key care and support indicators, such as number of persons in care and number of PLHIV whose viral load is suppressed. Part of this is due to the lack of a harmonized data collection tool and poor distribution of new tools and registers. There has been little improvement in data transmission and reporting from sites to the provincial and national levels. Efforts have been made to introduce electronic reporting systems such as the Monitoring Evaluation and Surveillance Interface (MESI), but operation has been slow due to poor internet, limited support at the HZ level, and slow deployment.

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	71,085,290	100	16,349,617	23	15,638,764	22	19,903,881	28	19,193,028	27	SPECTRUM 2015 Version 5.30
Prevalence (%)		0.95%		0.20%		0.20%		0.99%			SPECTRUM 2015 Version 5.30
AIDS Deaths (per year)	25,505		2,357		2,393		10,385		10,370		SPECTRUM 2015 Version 5.30
PLHIV	560,798		39,429		40,213		285,083		196,073		SPECTRUM 2015 Version 5.30
Incidence Rate (Yr)		N/A		N/A		N/A		N/A		N/A	SPECTRUM 2015 Version 5.26
New Infections (Yr)	28,132										SPECTRUM 2015 Version 5.30
Annual births	2,892,298	4%									SPECTRUM 2015 Version 5.30
% >= 1 ANC visit	2,303,163	81%	N/A	N/A			N/A	N/A			2012 PNSR Annual report
Pregnant women needing ARVs	2,892,298	4%									SPECTRUM 2015 Version 5.30
Orphans (maternal, paternal, double)	28,132		N/A		N/A		N/A		N/A		SPECTRUM 2015 Version 5.30
TB cases (Yr)	58,789		N/A		N/A		N/A		N/A		2014 TB program report
TB/HIV Co-infection	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Males Circumcised	34,461,758	97%			N/A	N/A			N/A	N/A	DHS 2007 Report
Key Populations	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Total MSM*	N/A	N/A									
MSM HIV Prevalence	N/A	N/A									
Total FSW	N/A	N/A									
FSW HIV Prevalence	N/A	6.9%									IBBS 2013

Total PWID	N/A	N/A									
PWID HIV Prevalence	N/A	N/A									
Priority Populations Prevalence (specify)											
Truck drivers	N/A	1.2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013
Miners	N/A	1.8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013
Youth (street children)	N/A	1.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment				HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	71,085,290	0.95%	560,798	N/A	101,324[4]	N/A	N/A	N/A	N/A	N/A
Population less than 15 years	32,228,241	0.13%	79,642	N/A	5,055	N/A	N/A	N/A	N/A	N/A
Pregnant Women	2,843,412	1.8%[5]	51,181	N/A	19,315	N/A	N/A	N/A	N/A	N/A
MSM	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
FSW	N/A	6.9%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
PWID	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Priority Populations Prevalence (specify)										
Truck drivers	N/A	1.2%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Miners	N/A	1.8%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Youth (street children)	N/A	1.3%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[4] PNLS 2014 Annual Report

5 PNLS 2013 ANC Surveillance report

1.2 Investment Profile

DRC is a low-income country with Gross National Income of $740 per capita. According to the African Development Bank (AfDB) 2014 report, DRC's economic growth rate has steadily increased from 8.1% in 2013 to 8.5% in 2014 and currently 8.6% in 2015. The increased investments are attributed to the mining, agriculture, trade, and construction sectors. External donors largely finance the health sector. GDRC's contribution is extremely low, at 3.8% in 2008, 1% in 2009, 2.8% in 2010, 2% in 2011, and 2% in 2012. The two largest donors to the HIV response are GFATM at 64% and PEPFAR at 30%, followed by other donors as well as the private sector (4%). PEPFAR's funding has grown from $3 million in 2004 to $62 million in FY 2014. Support from GFATM has also increased, especially in the recently awarded joint HIV/TB Concept Note, thereby increasing the number of HZs with HIV activities from 239 to 350 HZs.

Table 1.2.1 Investment Profile by Program Area[1]

Program Area	Total Expenditure ($)	% PEPFAR	% GF	% GDRC	% Other
Clinical and Community care, treatment and support	53, 887, 412	24	76	0	0
PMTCT	12, 525, 232	80	19	0	1
HTC	4,126,355	1	98	0	1
Prevention for other priority populations	7,198,063	37	62	0	1
Key population	196,429	100	0	0	0
OVC	3, 840, 436	85	15	0	0
Laboratory	11, 140, 710	33	52	3	12
SI, Surveys and Surveillance	1,289,797	22	11	10	57
HSS	20, 608, 016	28	49	11	12
Total	114, 812, 450				

[1] National AIDS Spending Assessment, 2012 (in French: Rapport sur l'Estimation des flux des Dépenses de lutte contre le VIH/SIDA)

Table 1.2.2 Procurement Profile for Key Commodities[1]					
Commodity Category	Total Expenditure ($)	% PEPFAR[2]	% GF[3]	% GDRC[4]	% Other[4]
ARVs	8, 521, 4828	6	90	0	4
Rapid test kits	2, 090, 560	45	53	0	2
Other drugs	8, 961, 895	2	11	33	53
Lab reagents	10, 762, 417	14	40	0	46
Condoms	2, 711, 332	0	40	11	48
Other commodities	1, 756, 643	0	18	0	82

[1]Totals not included because the data sources are different
[2]SCMS
[3]GFATM Principal Recipient, CORDAID 2012 report
[4]DRC MoH Office of Management and Support, 2012 (French: Cellule d'Appui á la Géstion des projets (CAG))

Comparatively, GFATM procures the majority of HIV-related commodities for the DRC, however PEPFAR has been gradually increasing its investments in drugs and commodities, particularly beginning in 2012 when the program started purchasing ARVs under the PMTCT Acceleration Plan. The GDRC, partners such as UNICEF, and the private sector purchase about 15% of the remaining HIV-related drugs and commodities.

Currently, PEPFAR and GFATM are co-located in 61 HZs and, in some cases, supporting services for the same patients in the same sites. This situation leads to duplication of effort and inaccurate reporting of results and presents challenges for HZ authorities and the National AIDS Control Program (French: Programme National de Lutte contre le SIDA (PNLS)) to manage. The PNLS is leading a rationalization process for HIV/AIDS activities. This progressive shift to one donor per HZ and eventually one donor per DPS serves to increase efficiencies through geographic clustering, reducing duplication of effort, and improving donor coordination. The PNLS expects donors to eventually support services in all HZs in the DPS in which they are located. The PEPFAR DRC team has explained to the PNLS that PEPFAR will consider expansion to new HZs once epidemic control is achieved in the Scale-up to Saturation HZs, depending on future COP guidance and assuming the HZ meets PEPFAR criteria for scale-up.

Non-PEPFAR United States Government (USG) investments in health have increased since 2012. In 2013, USAID invested $112,235,385 in non-HIV programming, $50,297,407 (almost 50%) in co-funded PEPFAR implementing mechanisms. However the geographic coverage of these mechanisms only overlaps in Katanga province.

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives

Funding Source[5]	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	32,355,000	24,116,601	5	1,950,000	Integrated behavior change (IBC), clinical, and supply chain (SC) strengthening services.
USAID TB	13,008,000	9,856,319	5	1,950,000	Prevent and treat TB and ensure strong referral for HIV/TB co-infected patients.
USAID Malaria	41,869,385	4,169,340	3	1,950,000	IBC, clinical, and SC strengthening services.
Family Planning	16,176,000	7,927,298	4	1,950,000	IBC, clinical, and SC strengthening services.
Nutrition	2,008,000	1,894,804	1	1,150,000	Integrated nutrition services in primary care platform.
WASH	6,269,000	1,783,045	2	1,950,000	IBC and WASH services.
CDC NCIRD Influenza Division	400,000	-	-	-	Enhanced national routine surveillance system for influenza
CDC NCEZID Poxyvirus branch	331,350	-	-	-	Monkey pox
PEPFAR Central Initiatives	5,000,000		6	-	IBC and GBV prevention services.
NEPI (HRSA)	1,360,000	-	1	-	Improve the quality and relevance of pre-service nursing/midwifery learning
Private Sector	1,031,000	-	1	200,000	Regional Laboratory Capacity Building Center at the Kinshasa School of Public Health
Total	112,966,735.00	50,297,407.00		12,250,000.00	

[5]USAID funding is from 2013; CDC funding is from 2012. No DoD funding.

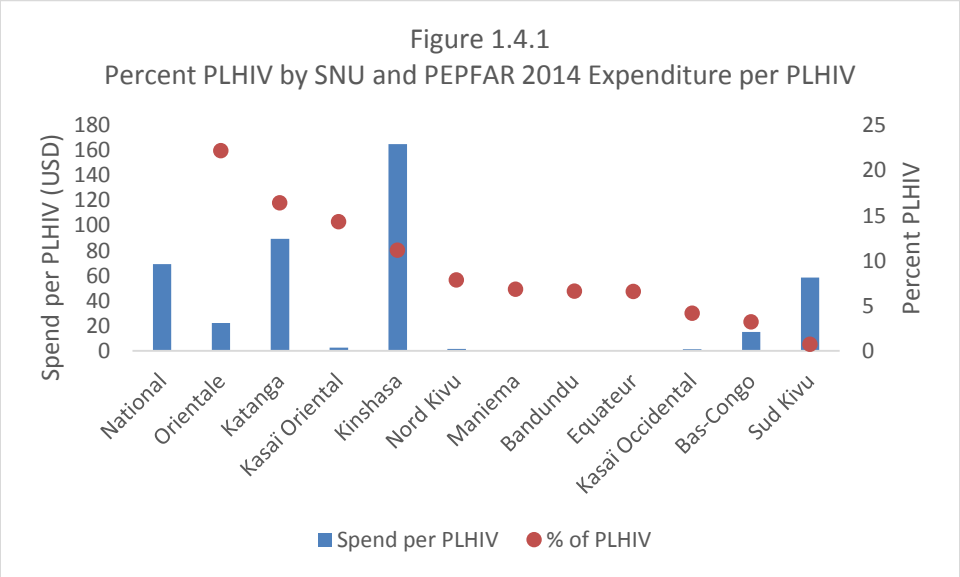
1.3 National Sustainability Profile

[REDACTED]

1.4 Alignment of PEPFAR investments geographically to disease burden

Figure 1.4.1 demonstrates that PEPFAR DRC is in the process of aligning resources with the burden of the disease by province. As mentioned in the Goal Statement, PEPFAR-funded activities ended in Bas Congo in 2014, thus concentrating PEPFAR resources in the three provinces with the highest HIV burden: Orientale, Katanga and Kinshasa.

Expenditures in the non-PEPFAR focus provinces represent targeted testing and counseling activities with the military (priority population) in Kasai Oriental and Sud-Kivu provinces and prevention expenditures for national radio programming to disseminate targeted HIV prevention messages. The expenditure was low in Orientale in 2014 because it was the first year of programming in this province. In Kasai-Oriental, Kasai-Occidental, Maniema, Nord-Kivu and Equateur provinces, GFATM funds 70% of activities while the UK's Department for International Development (DFID) funds the remaining 30%.



1.5 Stakeholder Engagement

In developing the 2015 COP, PEPFAR DRC consulted with the following stakeholders on PEPFAR's epidemic control strategy and specific direction for DRC: Ministry of Health (MoH) directorates from the PNLS, National TB Program (French: Programme National de Lutte contre la Tuberculose (PNLT)), National Blood Safety Program (French: Programme National de Transfusion et Sécurité Sanguine (PNTS)); Multi-sectorial commission on AIDS (French: Programme National Multisectoriel de Lutte contre le SIDA (PNMLS)), UNAIDS, UNICEF, WHO, GFATM, and the Proposal Development

Committee of GFATM's Country Coordinating Mechanism (CCM CEP). Consultation with Civil Society is detailed in the CSO COP15 Engagement Strategy, attached to the SDS.

MoH directorates expressed interest in using the SID as a measure of progress toward sustainability. PEPFAR DRC will use this opportunity to engage GDRC and external stakeholders on specific SID domains and elements for developing a Country Health Partnership. The SID consultation forum would be used to establish agreement on processes for information sharing, joint decision-making, and monitoring and evaluation of progress toward sustainability.

2.0 Core, Near-Core and Non-Core Activities

Prior to COP15, PEPFAR DRC had reduced its geographic focus to 3 out of 5 provinces with the highest disease burden. The package of activities was revised to include only those activities that are essential for combination prevention, targeted prevention to reach priority populations (general prevention programming was phased out), OVC, and protected investments toward procurement and supply chain, laboratory, and strategic information. The programmatic shifts in the 2015 COP are building on this initial pivot. To reach sustained epidemic control, the second pivot focuses on maximizing scale-up of entry points other than PMTCT and tracking those lost to follow up and it is based on the following goals:

- Increasing early initiation on and overall coverage of ART for HIV-infected infants, children, and adolescents;
- Closing the gap in treatment coverage by increasing access and treatment for priority populations in Saturation HZs;
- Increasing focus on evidence-based facility and community care and support interventions that have the greatest impact on morbidity and mortality of PLHIV and contribute to ensuring adherence and reducing loss to follow up;
- Continuing to focus on targeted prevention activities and strengthened linkages to care, treatment and support services for key and priority populations;
- Improving OVC programming by focusing on interventions that have been shown to impact children;
- Providing care and treatment for HIV positive pregnant women and their exposed infants;
- Improving TB screening among PLHIV and increasing access to ART for HIV-infected TB patients;
- Strengthening human and institutional capacity for SI, including data collection, data quality improvement, data use, and dissemination; and
- Strengthening coordination with GFATM and GDRC supply chain management platforms to ensure a continuous, responsive, and uninterrupted supply of relevant drugs and commodities.

See Appendix A for a full list of core, near-core, and non-core activities and transition plans. A successful implementation of activities depends on continued co-funding of TB activities by USAID, notably, procurement of Isoniazid (INH) for all PEPFAR clinical partners; successful implementation of the joint GFATM HIV/TB Concept Note; GFATM procurement of viral load reagents (including DNA PCR reagents) for the entire country as indicated in the draft national viral load scale-up strategy, and GFATM procurement of ARVs for a subset of patients enrolled in treatment services supported by PEPFAR.

3.0 Geographic and Population Prioritization

To select the highest burden health zones for scale up to reach 90-90-90, the PEPFAR DRC team categorized all 516 health zones in all 11 provinces of DRC according to the following criteria: disease burden as calculated by SPECTRUM, high unmet need according to PNLS 2014 programmatic data and for PEPFAR-supported health zones, yield of PEPFAR HTC, PMTCT, and ART sites per 2014 PEPFAR Annual Progress Results (APR) data. In addition, the team considered contextual information, such as the presence of GFATM (consistent with the PNLS's rationalization process) and key population and priority population hotspots. The three provinces where PEPFAR is currently working (Kinshasa, Orientale, and Katanga) account for over 50% of DRC's HIV disease burden. Given GFATM's presence in high burden HZs in other provinces, PEPFAR DRC refocused its analysis on the 95 HZs where it is currently working.

Of the 95 HZs where PEPFAR DRC currently supports services as of June 2015, 17 HZs plus one military area were designated as priority where activities will be scaled up to achieve epidemic control by the end of FY 2017. Ten of these HZs plus one military area make up the Lubumbashi cluster, a major urban area in Katanga province with a total population of over 1.7 million. The other seven HZs plus one military area make up the Kinshasa cluster. Per APR2014 TX_CURR results, these two clusters represent 40% of PEPFAR DRC's total volume of patients on ART. In order to reach 80% ART coverage in the selected health zones, an estimated 50,638 PLHIV must be on ARTs by the end of FY 2017 (SPECTRUM).

In addition to these Saturation HZs, hotspots with transport corridors feeding into the urban clusters which have large numbers of sex workers and clients, and men who have sex with men were identified for scale up in five Saturation HZs and nine Sustained Support HZs. Scaling up these hotspots is critical to epidemic control due to the transient nature of the population, and high levels of movement through and to the priority urban areas.

PEPFAR DRC will continue sustained support to 30 HZs in Katanga and Kinshasa. In FY 2016, PEPFAR DRC will support approximately 20,600 PLHIVs on ARTs in these HZs. In FY 2016, PEPFAR will coordinate with GFATM and PNLS to transition 46 HZs in Kinshasa, Katanga, and Orientale and will cease support to these HZs before September 30, 2016. Upon discussions with GFATM and PNLS in July 2015, it was determined that PEPFAR

DRC would transition all supported HZs in Orientale to GFATM by the end of FY 2016; this includes five HZs in Tshopo, an urban area, and 10 HZs in Ituri, a mining area along the border of Uganda with a high concentration of FSWs. The high burden of HIV in Orientale, high unmet need, and nascent service delivery in Ituri requires the establishment of a detailed transition plan in order to ensure a smooth transition by the end of FY 2016 with minimum impact on patient care and support. Given the low level of funding provided by GDRC for HIV/AIDS services (see tables 1.2.1 and 1.2.2), GFATM's limited budget to support additional services, and PEPFAR DRC's experience transitioning ART patients in FY 2014, the decision to transition services in Sustained HZs was considered carefully and quality continuation of care for existing patients was the key factor. GDRC, GFATM and PEPFAR are committed to developing a transition plan before October 31, 2015. Of utmost importance is the assurance that individual patients on ART continue to receive quality services during and after the transition.

To determine sites requiring scale-up, sustained, or central support, PEPFAR DRC examined APR 2014 HTC and PMTCT yield, and ART volume. Sites with an HTC yield less than 12, PMTCT yield less than eight, and ART volume less than five were slated for central support. Sites slated for central support with any individuals on treatment will be individually analyzed to determine the feasibility of continuation of quality ART provision, care, and support to current patients. If ART provision can be adequately assured through central support to GFATM or referral to a neighboring site, PEFPAR DRC will fully central support the site. In sites where ART provision cannot be adequately ensured, PEPFAR DRC will ensure continued ART provision, care, and support to those patients. High volume sites (HTC yield of 12 or more, PMTCT yield of 8 or more, and ART volume of 5 or more) were classified as scale-up sites in Scale-up to Saturation HZs and Sustained Sites in Sustained HZs.

4.0 **Program Activities for Epidemic Control in Scale-up Locations and Priority Populations**

4.1 Targets for scale-up locations and priority populations

Given the geographic and population prioritization decisions made for the 2015 COP, PEPFAR DRC calculated the required number of additional persons on treatment required to reach 80% ART coverage in the Scale-up to Saturation HZs over the next two years, taking into account expected loss to follow-up in setting targets for newly initiating ART patients. In setting targets, the PEPFAR DRC team was hampered by several key data limitations, including a lack of HZ-level (SNU4) surveillance data, weak national data collection and transmission systems for HIV data, and delays in publishing program data. As a result, PEPFAR DRC, in consultation with PNLS and GFATM, used a hybrid of data provided by the PNLS, Spectrum 2015 data and PEPFAR programmatic data. The burden of PLHIV at the HZ level was attained by multiplying the provincial-level prevalence by the HZ population. This does not provide an accurate estimation of PLHIV as it assumes that prevalence is uniform throughout the province and does not take hot spots into

consideration. The number of PLHIV attained through this method does not align with PNLS's estimates of PLHIVs. For further specificity, the PMTCT yield and estimated ANC prevalence were triangulated and then multiplied by the HZ population. In addition, PEPFAR DRC used late-breaking Calendar Year 2014 programmatic data from PNLS for the current number of people on treatment. Although this data was not available until mid-April, the data was based on actual programmatic performance versus a model of estimated coverage per province, providing a more realistic estimate of the current number of PLHIV on treatment, and therefore, a better estimate of the gap needed to reach 80% ART coverage.

In FY 16, PEPFAR DRC aims to enroll 9,109 PLHIV on treatment in the Scale-up to Saturation HZs with the goal of 33,582 current on ART by APR 2016. Of the 9,109 newly initiated ART patients, 50% of those will come from the following populations: children under 15, TB/HIV patients, and HIV-positive pregnant women; 18% will come from pre-ART; and the remaining 32% will consist of key populations and other priority populations.

We anticipate cost savings in FY 17 based on the redirection of resources away from Central Support HZs, which we will reinvest in FY 17 in order to scale-up and account for the remaining 59% of the total volume of patients needed to achieve 80% coverage, including a reduction in loss to follow-up. The number of patients PEPFAR DRC supports on ART (PEPFAR TX_CURR) will also increase to account for the transition of GFATM's ART patients in HZs that PEPFAR supports, per GDRC requirements for rationalization. At a similar pace through FY 17, we expect to reach 80% coverage of PLHIV by APR 2017.

PEPFAR DRC analyzed the maximum potential volume of each entry point and the potential proportion of new patients on ART by each entry point given the overall number required to reach 80% ART coverage in the Scale-up to Saturation HZs. Historically in DRC, PMTCT has been the primary entry point for ART, accounting for 43% of new patients on ART in APR 2014. However, given the greater number of new patients on ART required to reach 80% ART coverage, the expected contribution of HIV-positive pregnant women to overall ART coverage will decrease proportionally, even as overall number of HIV-positive pregnant women on ART increases. In FY 2016 and FY 2017, the number of patients on ART from PMTCT is expected to account for 20% of all new patients on ART, given birth rate, population, and HIV prevalence. PEPFAR DRC will build on the success of its PMTCT program, continuing to enroll over 95% of HIV-positive pregnant women in care and treatment services through Option B+.

Moving forward, all entry points in addition to PMTCT will have to be tapped efficiently and completely in order to attain 80% ART coverage in two years. This requires a massive scale-up in efficiency and effectiveness in the following entry points: TB/HIV, pre-ART patients, children under 15, and key, priority and other populations. PEPFAR DRC expects 15% of new ART patients from TB/HIV, 15% from children under 15, 18% from pre-ART patients, and 32% from key, priority, and other populations (Table 4.1.2). With full

implementation of a "test and treat" approach in PMTCT, TB/HIV, and children under 5, we will actively seek to improve linkages to care and treatment in FY 2015 and FY 2016. Positivity yield may also increase as PEPFAR DRC focuses on high burden geographic areas and high burden populations within those areas.

PEPFAR DRC's targets for FY 2017 take into account the rationalization process described in section 3.0. In FY 2016, during the transition period, PEPFAR DRC and GFATM will continue to co-locate in 61 HZs, both contributing to overall targets. During FY 2016, in the Scale-up to Saturation HZs where PEPFAR DRC will eventually be the primary donor, PEPFAR DRC and GFATM will work together to execute the forthcoming transition plan, detailing beneficiaries, inventory of equipment, stock of drugs and commodities, and so on. Implementation of the plan will ensure that there is no disruption in the delivery of services, especially for persons who are on treatment.

If not addressed, loss to follow-up will affect the ability to reach the saturation by APR 2017. As described in the Program Area narratives, PEPFAR DRC will implement proven strategies to improve retention.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage[1]	Target current on ART (in FY16) TX_CURR	Newly initiated in FY16 TX_NEW
Kafubu	1,568	502	1,254	878	376
Kamalondo	1,029	514	419	639	126
Kampemba	6,506	2,467	4,647	3,861	1,394
Katuba	3,965	1,223	2,454	1,959	736
Kenya	4,293	1,796	1,730	2,315	519
Kikimi	2,019	701	1,326	1,099	398
Kimbanseke	2,210	792	1,270	1,173	381
Kingabwa	1,647	408	897	677	269
Kingasani	1,741	620	966	910	290
Kisanga	3,822	1,764	2,031	2,374	609
Lubumbashi	2,920	4,164	0	4,164	0
Masina I	2,625	556	526	714	158
Masina II	2,168	372	66	392	20
Mumbunda	4,312	1,589	2,988	2,486	896
Ndjili	25,30	1,509	171	1,561	51
Rwashi	4,080	1,302	2,719	2,117	816
Tshamilemba	3,514	1,381	2,056	1,998	617
Military	6,757	2,812	4,153	4,265	1,453
Total[2]	57,706	24,472	29,673	33,582	9,109

[1]Calculated by comparing the #PLHIV to the Current on Treatment data from PNLS 2014; TX_CURR 2015 targets have not been subtracted.
[2]Figures in this table were generated using equations based on Prevalence and Spectrum (2015) data. As such, the absolute values include decimal numbers which are rounded here. Thus, any discrepancies between the sum of the values within each column and the column totals presented in this row are due to rounding error.

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up to Saturation Health Zones (FY16)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART	N/A	N/A	1,604
TB Patients not on ART	10,599	1,378	1,366
Pregnant Women	107,836	1,725	1,822
Other priority and key populations	93,558	4,133	2,951
Children under 15	39,284	1,434	1,366
Total[1]	251,277	8,670	9,109

[1]Figures in this table were generated using equations based on Prevalence and Spectrum (2015) data. As such, the absolute values include decimal numbers which are rounded here. Thus, any discrepancies between the sum of the values within each column and the column totals presented in this row are due to rounding error.

PEPFAR DRC does not implement VMMC activities.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate (Scale-up SNUs)	Current Coverage (date)	VMMC_CIRC (in FY16)	Expected Coverage (in FY16)
[Specify age bands for focus]				
Total/Average				

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (Scale-up SNUs)	Coverage Goal (in FY16)	FY16 Target
Priority Populations: Truck Drivers, Miners, Youth (street children)	[1]N/A	N/A	52,403
Key Populations	N/A	N/A	10,134
Total			62,537

[1] Data is not yet available on mapping and size estimation of the target populations included in this table. GFATM is funding this activity and preliminary results will be available January 2016.

Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment					
	[1]Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	[2]Target # of children on ART
Kafubu	235	490	196	1,622	123
Kamalondo	154	321	129	542	90
Kampemba	976	2,034	814	6,012	541
Katuba	595	1,239	496	3,175	274
Kenya	644	1,342	537	2,238	324
Kikimi	303	3,226	1,291	1,716	154
Kimbanseke	332	3,530	1,412	1,643	164
Kingabwa	247	2,631	1,052	1,160	95
Kingasani	261	2,780	1112	1,250	127
Kisanga	573	1,194	478	2,628	332
Lubumbashi	438	912	365	0	583
Masina I	394	4,197	1,677	681	100
Masina II	325	3,462	1,385	85	55
Mumbunda	647	1,347	539	3,866	348
Ndjili	380	4,042	1,616	221	219
Rwashi	612	1,275	510	3,518	296
Tshamilemba	527	1,098	439	2,660	280
Military priority	1,014	677	271	6,268	597
TOTAL[3]	8,657	35,797	14,319	39,285	4,702

[1] The number of children PLHIV <15 is estimated as 15% of total PLHIV based on spectrum 5.30

[2] This target of children on ART include those who are expected to be currently on ART during FY16

[3]Figures in this table were generated using equations based on Prevalence and Spectrum (2015) data. As such, the absolute values include decimal numbers which are rounded here. Thus, any discrepancies between the sum of the values within each column and the column totals presented in this row are due to rounding error.

4.2 Priority and key population prevention

According to the 2013 Integrated Biological and Behavioral Survey (IBBS), 6.9% of FSWs were HIV positive. The same report revealed that 69% of FSWs reported condom use at last sex with a paying sex partner and 36.2% with a non-paying sex partner. A study conducted in Kinshasa in 2011 found that 17.9% of MSM are HIV positive and only 15.3% surveyed used a condom during their most recent sexual encounter.

In FY 2014, PEPFAR DRC reached 1,850 MSM and transgender people and 16,689 FSWs through at least one evidence-based HIV prevention intervention. Comprehensive prevention, care, and treatment services are delivered through a limited number of outreach and key population-friendly facilities in Kinshasa and Katanga. With widespread stigma and discrimination toward key populations limiting their access to HIV services, PEPFAR DRC recognizes the need to increase focus on these high-risk populations and expand service coverage in order to achieve epidemic control. PEPFAR DRC will scale up existing interventions in Kinshasa and Katanga. Innovative interventions, such as peer-driven recruitment, will be intensified to rapidly increase the number of MSM and FSW reached. Mobile strategies for HIV testing and counseling at or near hotspots will be strengthened and expanded. PEPFAR DRC will prioritize the continuum of care to ensure that HIV positive clients access care, support, and treatment services.

To address Site Improvement Monitoring System (SIMS) findings such as poor monitoring of outreach activities; PEPFAR DRC will strengthen support for community-based outreach, provision of condoms (male and female) and condom-compatible lubricant; STI screening and treatment; and HIV counseling and testing. GDRC will adopt in the near future the international directives for the "test and treat" approach; however PEPFAR DRC's planning is already based on this approach. Support for adherence through trained key population peers and support groups will be provided and viral load suppression will be monitored where laboratory services are available.

PEPFAR DRC also plans to increase training and support to health providers to facilitate the integration of services for key populations in routine clinical services. This will include sensitization training of health care providers to reduce stigma and discrimination, other structural interventions (e.g., conducive opening hours, display of patients' rights posters and other materials), and monitoring the delivery of non-discriminatory HIV and health care services at PEPFAR-supported sites. Community services will be linked to the clinical platform using skilled peer educators who will promote HTC, early diagnosis and treatment of STIs, condom use, Positive Health, Dignity and Prevention (PHDP) initiatives, and linkages to care and retention on treatment.

In addition, PEPFAR DRC will increase collaboration with civil society, especially MSM and FSW groups, to monitor cases of human rights violations and debates in the parliament on the law criminalizing homosexuality.

The National HIV/AIDS Strategic Plan (NSP) 2014-2017 notes (from the 2013 IBBS) a significant reduction of HIV prevalence among mobile populations: 6% in 2005 to 1.8% in 2012 among miners and 5.3% in 2005 to 1.2% in 2012 among truckers. It also indicates that women in the military have an HIV prevalence of 7.6%.

Despite the reductions in some groups, HIV prevalence among these populations remains higher than the national average. Therefore, PEPFAR DRC will scale up interventions among Other Vulnerable Populations (OVPs) as described below:

- Miners and Truckers: Tailored outreach using health and peer educators, targeted Behavior Change Communication, provision or linkage to mobile HTC, provision of condoms and lubricants, linkage to ART, and screening and linkage to STI and TB treatment as needed in identified hotspots (e.g., the transportation corridor in Katanga).
- Military: Risk reduction sensitization, such as reduced alcohol and drug consumption, through interpersonal and small group communication; prevention of Gender Based Violence (GBV); distribution of condoms and lubricant; and fixed and mobile HTC services.
- Provision of or referral to care, support, and treatment services, including STI screening and support to building the capacity building of the military health care

system (i.e., training, equipment upgrade, support to coordination activities such as planning/review process, and supervisory visits).

The 2014-2017 NSP identifies youth as a priority population, and the recent DHS (2014) indicates that young women ages 15-24 years are 2.5 times more at risk of contracting HIV than their male peers. This vulnerability has been partially attributed to early onset of sex, number of unprotected sex, and high occurrence of gender based violence against females in this age bracket. PEPFAR DRC will also target adolescent girls and young women (AGYW) with skills and evidence-based risk reduction prevention strategies focused on delay of sexual activity, correct and consistent condom use, and access to condoms.

In the 2015 COP, PEPFAR DRC will coordinate with the GDRC and other partners to develop a national strategy and guidelines for key populations and OVPs. To address gaps in epidemiological and behavioral data exist, particularly for MSM, FSW and miners, GFATM will fund a mapping and size estimate study of key populations.

4.3 VMMC (Not Applicable for DRC)

4.4 PMTCT

In 2013, PEPFAR, in collaboration with the GDRC, UNICEF, WHO, and UNAIDS, developed and initiated DRC's strategy for phasing in Option B+, starting with six HZs in the Lubumbashi area of Katanga province. After one year, the program was assessed and the decision was made to expand Option B+ to all PEPFAR-supported HZs in Katanga, Kinshasa, and Orientale by March 2015. The rollout of this expansion underscored challenges surrounding the management and provision of drugs (e.g., coordination of donors) and the PNLS-led rationalization process is an attempt to resolve some of these issues.

Option B+ is still in its early stages of implementation in most sites, therefore PEPFAR DRC's PMTCT costs have risen due to increased training needs of health care providers and community workers and increased procurement of commodities (mostly ARVs). Concurrent with the roll out of Option B+, DRC switched from AZT to tenofovir for pregnant women. The PEPFAR DRC team and its supply chain IP are working with the GDRC and GFATM to ensure that existing stocks of AZT are depleted and that a smooth transition takes place.

In the 2015 COP, PEPFAR DRC will continue scaling up PMTCT using Option B+ in the Scale-up to Saturation HZs. The integrated package of PMTCT services includes: HTC/PITC; ART (adult and pediatric); cotrimoxazole; nevirapine prophylaxis for infants; comprehensive family planning; TB and opportunistic infection screening and referral; GBV screening and referral where services exist; lab sample (e.g., CD4, Early Infant Diagnosis [EID], viral load [VL]) collection, transportation and analysis; and linkages to community, OVC, malaria, nutrition and Water, Sanitation, Hygiene (WASH) services. PEPFAR DRC will focus on training, coaching and mentoring health care providers to

ensure that they are equipped to provide adequate ART services to all HIV positive pregnant women, transition women currently on prophylaxis to ART, promote adherence and retention, and reduce loss to follow-up.

During the early stages of Option B+ implementation, loss to follow-up in the initial HZs in Lubumbashi was around 30%. Sites with community activities, such as Mentor-Mothers and support groups, however, were observed to have stronger links between the clinic and the community and lower loss to follow-up rates. For example, a comparison in Kinshasa between the Kikimi Hospital Center, which had Mentor-Mothers, and the Binza Meteo Maternity, which did not, showed that Kikimi increased EID, adherence and participation in support groups, whereas Binza Meteo saw a decline in these areas. Furthermore, Mentor-Mothers at Kikimi were able to provide hospital staff with helpful information about the whereabouts of patients who missed appointments. Although the PEPFAR DRC team is still analyzing results, anecdotal evidence from SIMS visits confirms these observations.

To help reduce loss to follow-up in the Scale-up to Saturation HZs, PEPFAR DRC will strengthen the network of Mentor-Mothers and health center and community peer educators. Where they exist, support groups will be reinforced to enable them to promote adherence with individual HIV-positive pregnant women (and other PLHIV) in their community. In addition to these community activities, the use of appointment registers to track patients and appointment reminders by phone or home visits by peer educators or community health workers will be promoted.

The PEPFAR DRC team will facilitate collaboration between clinical implementing partners focused on key and other vulnerable populations to ensure delivery of PMTCT services at the nearest location to these populations.

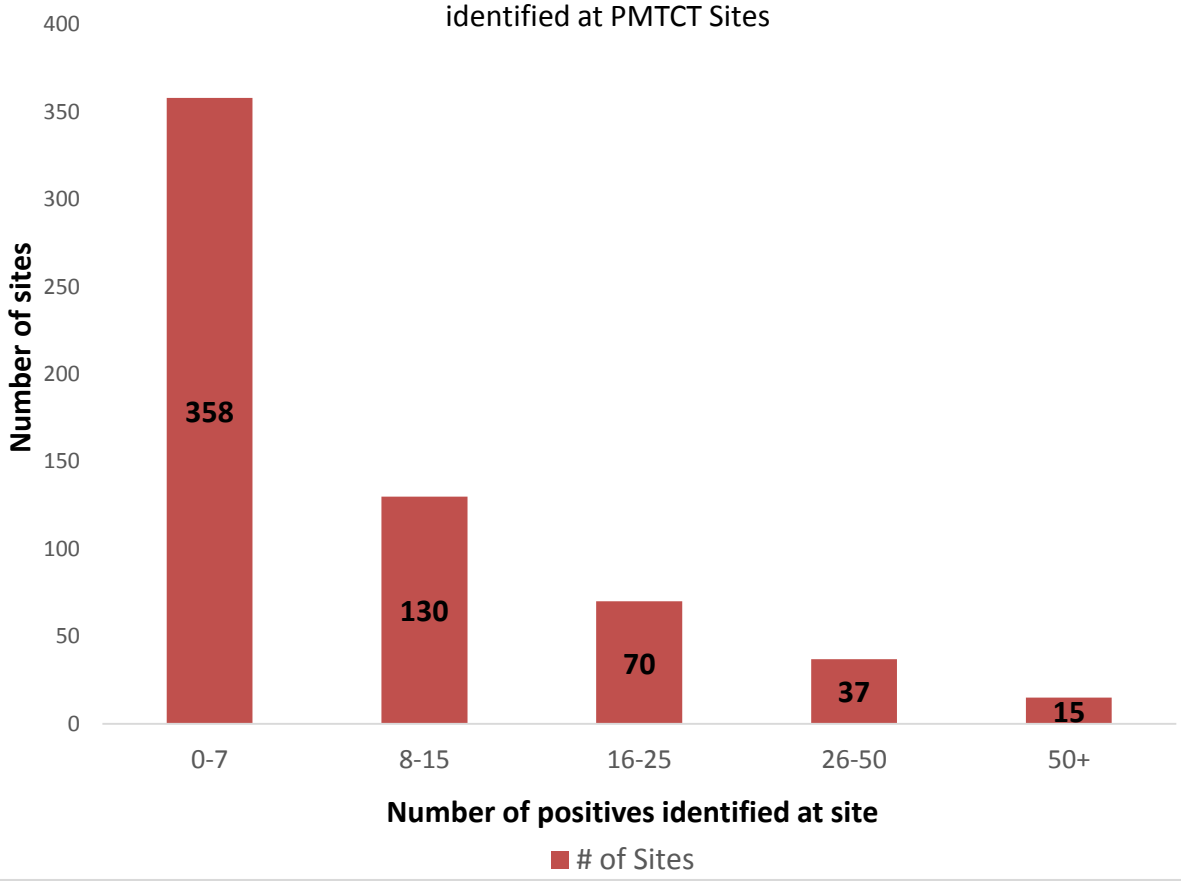
The National Reference Laboratory in Kinshasa is the main provider of early infant testing using HIV DNA PCR on Dried Blood Spot (DBS) in the DRC. As PMTCT coverage expands, improving the retention of mother-infant pairs is a priority. Initial SIMS visits have shown that improvement is needed in the timely return of test results to mother-infant pairs. PEPFAR DRC, in collaboration with other relevant national stakeholders, will continue to provide support to improve the sample transportation network.

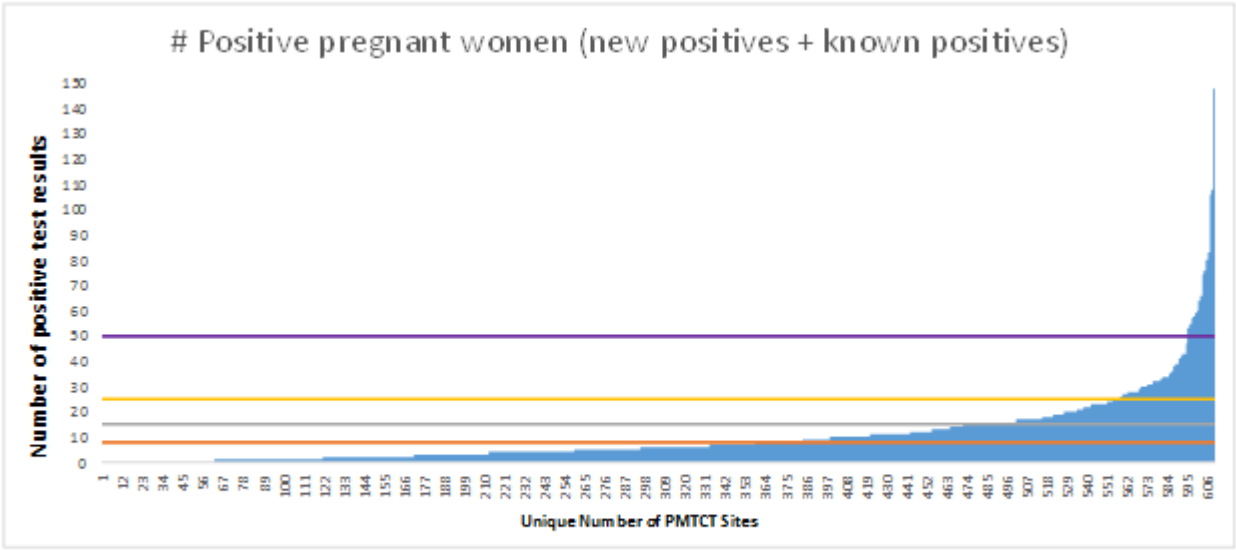
To reduce the turnaround time for receiving results, PEPFAR DRC and GFATM recently invested in a provincial laboratory in Lubumbashi to perform EID and viral load. The laboratory will be fully operational before December 2015, once staff training is completed and all needed commodities (e.g. reagents) are received. A sample transportation network (EID and VL testing), a Laboratory Information System (LIS), and a Quality Assurance (QA) system will be implemented to ensure the scale up of VL testing in the province.

Efficiency Analysis

PEPFAR supported PMTCT services at 583 sites in 2014, of which 61 reported zero positives. Forty-three percent of those reporting zero positives are in the Scale-up to Saturation HZs for FY16, 8% are in Sustained HZs, and 49% are in Central Support HZs. As shown in Figure 4.4.1, 37% of sites (218) identified 80% of positives. With current distribution, the annual average positive yield is approximately 10 positives identified per site.

Figure 4.4.1: Positive pregnant women (new positives + known positives) identified at PMTCT Sites





4.5 HTC

To reach epidemic control in the Scale-up to Saturation HZs, PEPFAR DRC will maximize testing of priority populations and thus identify the maximum number of HIV-positive individuals to link to care, support, and treatment services while also linking HIV negative clients to prevention services.

The GDRC has developed appropriate guidelines and conducted trainings necessary to fully implement PITC. Based on APR trends and national results from previous years which show a relatively high contribution of PITC to the number of HIV-positive individuals identified, PEPFAR DRC will increase its focus on PITC and HTC outreach focused on key populations and other vulnerable populations in the Scale-up to Saturation HZs. Specifically, PEPFAR DRC's HTC service delivery package for priority populations and geographical areas will include:

- PITC targeting pregnant women and their families, hospitalized patients with clinical symptomology, TB patients and their families, at risk children (i.e., malnourished children, OVC, and children born to HIV-positive adults) in clinical settings; and
- Stand-alone facility-based VCT and community-based outreach/mobile HTC for key populations (MSMs, FSWs and their clients) and other vulnerable populations (miners, truckers, AGYW, and military personnel and their dependents).

To support the Accelerating Children's HIV/AIDS Treatment Initiative (ACT), standard operating practices will be developed to scale up testing at all entry points and focus support on the highest yield entry points, resulting in over 80% of OVC and family

members being tested for HIV. For all patients identified, PEPFAR DRC will ensure linkages to care, support, and treatment services.

PEPFAR DRC will continue to engage the community in HTC activities through community-based civil society channels such as PLHIV support groups. Such groups provide feedback on the quality of HTC services and participate as lay counselors and in community-based activities.

An issue noted during SIMS visits is the weak implementation of HTC quality assurance (QA)/quality improvement (QI) at the site level. PEPFAR DRC will work with Implementing Partners (IPs), service providers and the MOH to put in place quality monitoring and evaluation mechanisms and evidence-based QA/QI practices, including effective and efficient site level HIV/AIDS proficiency testing. PEPFAR DRC will also provide support for retesting of positives before starting treatment, especially if using the "test and treat" approach.

Efficiency Analysis

In 2014, 605 PEPFAR-supported sites offered testing to 682,437 clients and yielded 24,038 positives (0.6% positivity rate). Sixteen sites reported zero positives. As indicated in Figure 4.5.1, 37% of sites (221) contributed to 80% of the yield. With current distribution, the annual average positive yield is approximately 40 positives identified per site.

Figure 4.4.3: Identification of HIV positive patients identified at HTC Sites by age group

Figure 4.4.4: HTC Sites: # of Positive Test Results

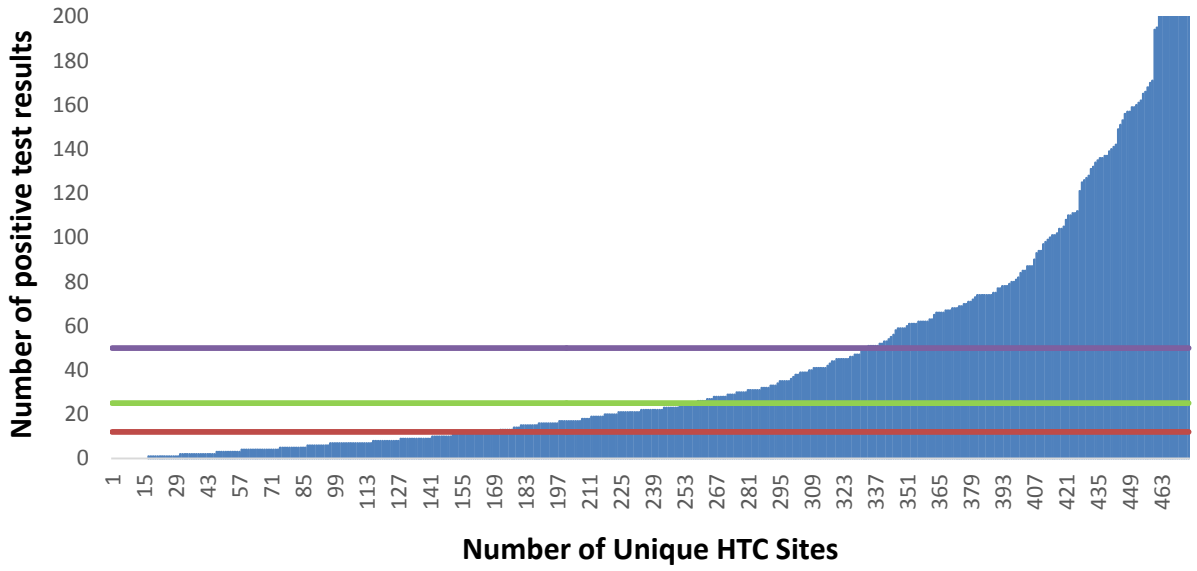
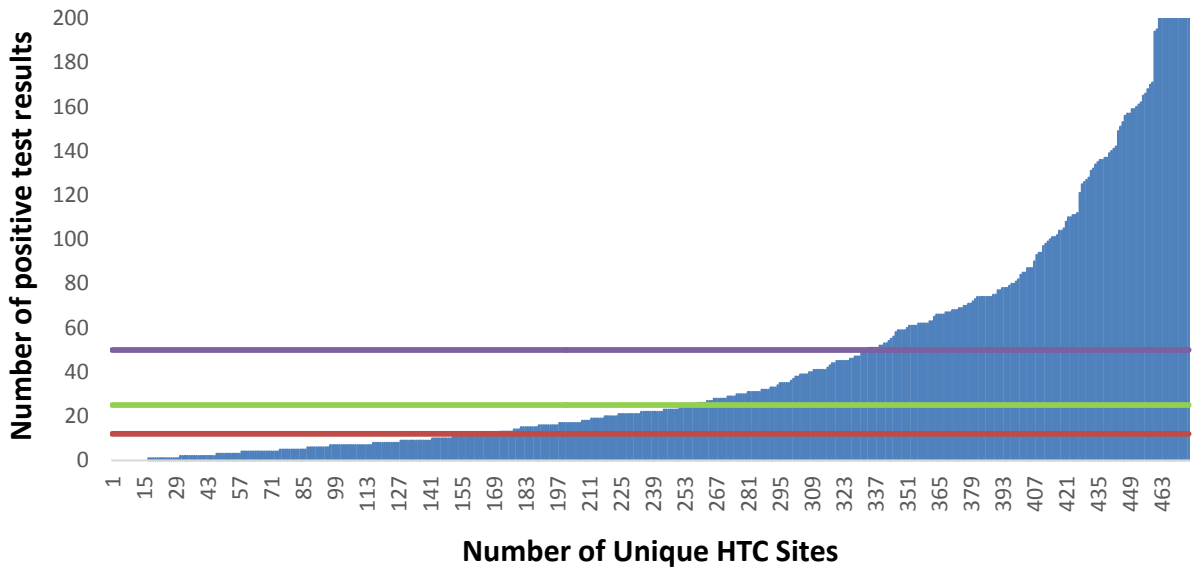


Figure 4.4.3: Identification of HIV positive patients identified at HTC Sites by age group

Figure 4.4.4: HTC Sites: # of Positive Test Results



4.6 Facility and community-based care and support

In the Scale-up to Saturation HZs, PEPFAR DRC will focus on the 4+1 strategy as the core platform for care and support. This strategy includes the four universal interventions: regular clinical and laboratory monitoring, including WHO staging, and CD_4 count and/or viral load if possible; screening for active TB or intensified case finding, with referral for diagnosis and treatment as appropriate; Cotrimoxazole prophylaxis; and evidence-based interventions to optimize retention in care and adherence to ART that address local gaps and barriers; plus positive health, dignity and prevention as the "+1".

Priorities for improving linkages and retention in care include: supporting the GDRC to develop national care and support guidelines and standards; implementing the standardized care package defined by PEPFAR DRC in the absence of a national package; increasing collaboration between GDRC's HIV/AIDS and TB control programs; and expanding the Nutrition, Assessment, Counseling and Support (NACS) model within the Option B+ platform. NACS will be scaled up at the facility level and piloted in selected communities near high-yield facilities. A strong focus will be placed on QA/QI and local capacity building and leadership in adult and pediatric care and treatment.

Since FY 2012, PEPFAR DRC has implemented several innovative approaches, such as Mentor-Mothers for PMTCT retention and support, quality improvement of care and support, and monitoring facility progress towards PEPFAR-defined standards of care. These initiatives are being assessed, and will be expanded to increase quality and coverage of services. Successful strategies and lessons learned will be used to inform a

national strategy for care and support. PEPFAR DRC is committed to supporting the inclusion of QI for community and facility-based care and support in the national M&E system, including support for designing relevant tools.

To address the increasing numbers of patients at facilities following the expansion of ART eligibility criteria and the rollout of the Option B+ program, PEPFAR DRC will support the expansion of community-based services. Early SIMS data revealed a need for systems and procedures for retention in care and treatment services, including a stronger referral and counter-referral system. PEPFAR DRC will support the most appropriate model of care and support given contextual factors such as patient barriers to retention in care, geographic barriers to accessing the health system, and regulatory or logistical constraints to ART delivery.

To improve care and support, PEPFAR DRC will work with the PNLS to expand and formalize the ongoing decentralization of ARV prescribing authority from the chief HZ physician to clinic staff, task shifting to lay health worker cadres, and "fast tracking" of medication refills.

PEFPAR DRC will explore other evidence-based interventions, such as Médecins Sans Frontières' highly successful model of community ARV distribution points (PODIs), which resulted in an increase in treatment adherence from 20% to 91% and a cost savings of $19 ($8 vs $27) per patient in 2,500 patients in Kinshasa over two years as compared to the traditional clinical model (http://www.msf.org/article/hivaids-community-models-care-explained, date consulted: March 31, 2015).

Facility-based adherence groups will be used as a stepping stone towards setting up community-based adherence clubs, in order to increase benefits for patients by allowing access to drugs closer to their homes. In order to improve adherence and retention to care and treatment services, PEPFAR DRC will expand patient-centered care, including community support groups (such as post-test clubs, self-help groups, and Mentor-Mothers) to promote retention in care and integrate and systematize patient tracking through home-based visits and mobile phone interventions.

4.7 TB/HIV

The TB prevalence in DRC is 549 [285-898] per 100,000, and only 44% of TB patients know their HIV status. Of the 14% of TB patients co-infected with HIV, only 48% are on ART (WHO, Global Tuberculosis Report, 2014). In collaboration with the National Tuberculosis Program (PNLT), PEPFAR DRC's two-year goal is to strengthen and expand TB/HIV activities in the Scale-up to Saturation HZs by: 1) improving efforts to identify TB patients within HIV clinics; 2) improving efforts to identify HIV within patients of TB clinics; 3) expanding HIV care, support, and treatment within TB clinics; 4) supporting coordination of TB/HIV activities at national and provincial levels for both HIV and TB programs; 5) strengthening the national capacity to update policies and guidelines and plan, manage and evaluate TB/HIV activities; and 8) implementing the joint TB/HIV

GFATM concept note to ensure optimal collaboration. PEPFAR DRC will support the scale up of intensified TB case finding and TB infection control. For all PLHIV without confirmed active TB, PEPFAR DRC will procure and provide Isoniazid preventive therapy. In addition, PEPFAR will continue support to the national and peripheral laboratories and the scaling up of GeneXpert to improve case finding.

PEPFAR DRC partners will harmonize strategies for referral of HIV positive clients to TB testing centers at national and provincial levels as well as screening HIV positive clients at operational and community levels. Partners will work with the PNLT and other TB actors such as Action Damien and GFATM, to prepare a detailed map of the diagnostic and treatment centers for TB (in French - Centre de Santé de Dépistage et Traitement or CSDT) and the TB treatment centers (in French - Centre de Santé et de Traitement or CST) in PEPFAR DRC intervention areas. This exercise will support the establishment of a referral and counter referral system so that providers will know where to refer patients for TB testing and treatment and where to refer TB patients for HTC if both services are not available in same site, thus strengthening TB/HIV services. For sites that provide both TB and HIV testing services within their facility, USG partners will provide ongoing capacity building to improve outreach to TB patients to receive HTC. In PEPFAR-supported health zones, PEPFAR DRC TB partners will provide all TB services to co-infected patients, complementing HIV services. This will include community health workers (including former TB patients) training for patient support, peer support to newly diagnosed TB patients, community-based Directly Observed Treatment, and referral services for patients needing to travel long distances to access TB or HIV services. Training for HTC service providers will include sessions on HIV-TB co-infection, risks, and appropriate referral procedures.

4.8 Adult Treatment

DRC has low coverage of adult treatment. In 2013, PNLS reported 261,655 adults living with HIV, of whom 79,978 (31%) were on ART.[6] DRC has adopted and will implement, in a phased approach, the WHO 2013 consolidated ART guidelines, to scale up patients with a CD4 count threshold of <500. This will increase significantly the number of adults eligible for ART. PEPFAR DRC, along with other donors, continue to advocate with GDRC to update its policy on task shifting to allow full implementation of the new ART guidelines, including allowing nurses to initiate and monitor ART.

The PEPFAR DRC ART service delivery package includes: HTC/PITC in high yield entry points (e.g., TB, inpatients, FSW, MSM); CD4 for eligibility; ART according to updated national guidelines; Cotrimoxazole prophylaxis; prevention, diagnosis and management of TB (TB screening, Infection Control, IPT); implementation of Quality Measure/Quality Indicator (QM/QI) initiatives at the facility/community level; adherence support;

[6] Pending the 2014 annual report, which mentions 388,879 adults living with HIV, of whom 101,324 (26%) were on ART.

enhanced linkage and retention along the care cascade; lab monitoring on ART (e.g., viral load); training and mentorship; and regular supportive supervision. This package has been defined in alignment with PEPFAR's core/near-core/non-core framework.

Supply chain issues include stock outs, arduous customs processes, and limited storage space for partners. PEPFAR DRC is in ongoing negotiations with the GDRC to release commodities in a more timely manner and to utilize provincial warehouses for appropriate storage space. GFATM and PEPFAR DRC are committed to increasing FEDECAME warehouse capacity in Kinshasa. Under the leadership of the PNLS and Programme National d'Approvisionnement en Medicaments (PNAM,), DRC is on track to establish a national quantification for ARVs and streamline distribution of ARVs through Regional Distribution Centers.

The first wave of SIMS implementation noted a lack of documentation of procedures, poor adherence support, and weak linkages to community services. Partners have begun addressing these issues, as strong linkages to care and support systems are critical to retention and achieving epidemic control. In FY 2015, PEPFAR DRC will strengthen efforts to work with CSOs, FBOs, NGOs, Mentor-Mothers, expert patients, and support groups in order to:

- Link priority populations to care and treatment services, ensuring that eligible clients have access to the full continuum of care;
- Support activities that promote adherence to and retention in care and treatment services – working in close collaboration with health facilities to ensure complete bidirectional (facility-community) referrals and identifying a standardized system for client follow-up and tracking to ensure clients are not lost during the referral process;
- Support tracking of defaulters and clients lost to follow up, escort clients to services as necessary and provide feedback to facilities;
- Strengthen the package of care and support services provided at the community level, including: PHDP services; support for adherence to Cotrimoxazole and TB preventive therapy; identification of opportunistic infections (OIs) and side effects; NACS and WASH; psychosocial support services; and identifying opportunities to leverage complementary services not provided by the program (e.g., access to condoms, FP and MCH services, food distribution programs, mosquito nets); and
- Conduct peer support group meetings (in community or at facility) and provide educational and counseling services.

Priority populations such as pediatrics, AGYW, and key populations will be reached using appropriate and specific strategies (refer to related sections).

4.9 Pediatric Treatment

DRC has low pediatric treatment coverage. In 2013, 66,000 children were living with HIV, but only 5,055 (8%) were enrolled in treatment. DRC has adopted the WHO 2013 consolidated ART guidelines, including universal treatment for children < 5 years living

with HIV regardless of CD4 count. Out of the 31,124 persons on treatment (APR 2014 TX_CURR), 3,200 (10%) were children on ART.

DRC is one of the ten ACT countries and has a goal of expanding pediatric treatment from 3,200 (FY 2014) to 4,899 (FY 2015) and 7,573 (FY 2016). During this and future COP cycles, PEPFAR DRC will continue to scale up pediatric treatment in high yield locations to contribute to epidemic control. Targets related to pediatric care and treatment do not include targets planned through ACT since final approval and notice of funding has not been received. Case finding methods such as the family-centered approach will be intensified among children born to HIV-positive adults, malnourished children, inpatients, OVC, children in TB clinics, and HIV exposed infants through EID.

The pediatric treatment service delivery package includes: EID; HTC of children for early identification; PITC and disclosure for children and adolescents; Cotrimoxazole and nevirapine prophylaxis; prevention, diagnosis and management of TB (i.e., TB screening, IC, IPT); ART for all < 5 children; adherence support and enhancing linkages and retention along the care cascade; lab monitoring on ART (e.g., VL); and training, mentorship and regular supportive supervision. This package has been defined in alignment with PEPFAR's core/near-core/non-core framework.

To increase pediatric enrollment on treatment, adherence, and retention, PEPFAR DRC will strengthen the community's role in ensuring linkages between facility and community-based services. As with adult treatment, working with CSO/FBO/NGO organizations and providing support through Mentor-Mothers, expert patients, and other support groups, PEPFAR DRC will focus on:

- Identifying and enrolling OVC into relevant social services;
- Supporting activities that promote adherence to and retention in care and treatment services, working in close collaboration with health facilities to ensure bidirectional (facility-community) referrals and identifying a standardized system for following up and tracking clients to ensure they are not lost during the referral process;
- Tracking defaulter clients and clients lost to follow up, escorting clients to services as necessary, and providing vital information about clients' whereabouts to facility staff so they can follow up;
- Strengthening package of care and support services provided at the community level including support for adherence to Cotrimoxazole and TB preventive therapy; identifying OI side effects and referring to facility; NACS; and psychosocial support services.
- Encouraging GDRC to update its official policy on task shifting to align with the WHO guidelines, which allow a nurse to lead the initiation and monitoring of ART.
- Advocating to government and public sectors to support children living with HIV and OVC.

SIMS visits have highlighted a lack of support for adolescents with HIV at health facilities. PEPFAR DRC hopes to address this weakness with the implementation of ACT. ACT funds will be used to collect data on adolescents, particularly AGYW, to develop targeted strategies and activities to meet their specific needs, such as creating more adolescent-friendly clinics.

As with adult treatment, supply chain concerns include stock outs of pediatric ARVs, long and challenging customs processes, and partners' limited storage space. As noted in Section 4.8, the PEPFAR DRC team is negotiating with the GDRC to ensure the release of commodities from Customs in a timelier manner and to obtain adequate storage space by using provincial warehouses to obtain adequate storage space.

4.10 OVC

PEPFAR DRC will focus on enhancing services and linkages for children and households affected by HIV and AIDS through a multi-component approach linking OVC services to clinical services to address the antecedents of risk for households. Age-segmentation and targeting based on different types of risks children face will be utilized to mitigate AIDS impact on households and to improve behaviors of parents and caregivers. OVC programming will clearly support the PEPFAR continuum of care in DRC by co-locating in Scale-up to Saturation HZs served by PEPFAR DRC clinical programs; encouraging testing among OVC and their caregivers and facilitating mobile testing alongside OVC activities (e.g., economic activities); referring participating families to HIV services for which they are eligible; and receiving referrals of eligible families from clinical partners especially around PMTCT and pediatric care and treatment.

PEPFAR DRC will support a range of family-based interventions depending on the needs and resources of families with the goal of ultimately graduating households from direct project support. Household Economic Strengthening (HES) activities will include savings and loan associations and microenterprise development. Other family strengthening activities, such as group-based parent education and support groups and home visits will improve the capacity of parents and caregivers to meet the psychosocial needs of vulnerable children, particularly HIV positive children, and will support children to reduce risky behaviors associated with HIV infection, protect themselves from abuse, adhere to treatment and other care regimens, and cope with prolonged illness and death.

In addition to building the capacity of families, PEPFAR will also strengthen the capacity of community and government structures and leaders to achieve sustainable, positive results for HIV affected children over the long-term. PEPFAR is seeking to improve the operational and technical capacity of both local NGOs and district governments to provide quality services for OVC. In particular, PEPFAR has and will continue to invest in efforts to strengthen the social service workforce through better planning, training, supervision, and support. Stronger families in combination with improved social services

are expected to achieve higher nutrition, education, health, and psychosocial outcomes for children.

Assuming that additional funding will be received through the ACT initiative, PEPFAR DRC will support efforts to strengthen referrals between clinical and social services through the development of common protocols and tools and coordinated case management. The OVC program will also seek to enhance ACT outcomes by scaling up integrated early childhood development activities within the OVC, health, and HIV platforms. Family-based interventions, including the HES and parenting programs described previously, will be marketed specifically to the caregivers of HIV positive children and parents participating in PLHIV and PMTCT support groups established at PEPFAR-supported treatment facilities. Key objectives will be to: 1) improve access to quality and timely diagnostic, care, and treatment services for HIV exposed infants and 2) ensure access to OVC services for HIV-exposed, infected, and affected children and their families by accessing these children through parents already engaged in ART clinics.

Recognizing unique vulnerabilities of adolescent girls, the OVC program will promote evidence-based interventions to educate young women on how to prevent HIV infection, improve relationships between parents and adolescent girls, increase access to secondary education among girls, and improve access to Adolescent Sexual and Reproductive Health (ASRH) interventions, including referrals for service delivery.

PEPFAR DRC will conduct a baseline survey including the MER (outcome and impact) indicators on OVC status and linkages to prevention, care, and treatment services. The focus of the evaluation is to collect baseline data against which PEPFAR DRC's intervention model will be assessed and to generate key information needed for further development and customization of key interventions. The design will help determine the cause-effect relationship between program interventions and potential improvements by completion of the program implementation.

Currently, a USAID OVC IP is planning activities with CDC, DOD, and USAID treatment partners to support referrals to savings and loans associations in selected Scale-up to Saturation HZs in Kinshasa. Facility based IPs will use the tool of vulnerability and evaluation criteria to identify children eligible for OVC support. Children eligible for OVC support will be referred to non-clinical OVC services.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustained package of services in other locations and populations

In sites with a positivity yield of HTC less than 12, and PMTCT less than 8, and with fewer than 5 patients on treatment, ART patients will be actively transferred to higher volume and higher quality sites where feasible. For sites where this is not possible, as a rule, no

demand creation will be promoted and activities will be reduced at minimum both in scope and in scale in these areas. No patient will be denied treatment; if a pregnant woman at ANC or another client from any clinical entry point requests HIV testing or presents with an OI (e.g., STI, TB), testing and treatment will be provided as needed. In these sustained support sites, a minimum package of services will be implemented, refer to Appendix A.4 that illustrates the difference in package of services implemented in Scale-up versus Sustained Sites. In the Sustained Sites, current patients on treatment will be maintained in care and treatment services. PEPFAR will fund routine testing of pregnant women in sites whose yield is eight or more. As the DRC PMTCT guideline requires testing for all pregnant women in ANC, PEPFAR is in discussions with the GDRC MOH to procure Rapid Test Kits (RTK) for sites that will no longer be supported by PEPFAR. The package will also include ART for adults and infants, infant Nevirapine prophylaxis, Cotrimoxazole provision, PHDP (including condoms), routine clinic visits, screening for TB, adherence and retention activities, routine lab monitoring (including one viral load or two CD4 tests per year), and EID.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support HZs

Sustained Support Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	103,582	113,940	9.09%
HTC (only sustained ART sites in FY 16)	148,428	68,661	-116.18%
*Current on care (not yet initiated on ART)	1,960	2,467	20.55%
Current on ART	13,071	16,452	20.55%
OVC	5,969	7,163	16.67%

*Calculated by subtracting TX_CURR from CARE_CURR

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and priority populations

As noted previously in 1.2, PEPFAR and GFATM are the two major donors funding HIV/AIDS activities, and GDRC's support is around 2% of overall HIV/AIDS spending. PEPFAR DRC will discontinue services in transition sites where there is no one on treatment by December 2015 and will strongly advocate for GDRC to support provision of services using designated counter-party funds. As mentioned in the Goal Statement and in Section 4.0, 46 of the 95 HZs that PEPFAR currently supports will be transitioned to GDRC and GFATM by September 30, 2016. Under PNLS' leadership, GFATM and PEPFAR are committed to the rationalization of donor support and will begin developing a transition plan. The plan will include, among other elements, a timeline, inventory of equipment, and comprehensive count of persons on treatment. The transition by September 30, 2016 in 46 HZs where PEPFAR DRC currently supports 14,539 patients on ART will be fully detailed in this plan; high quality continuation of services will be the top priority of this plan.

Non-core Care and Support activities such as palliative care, mental health and substance/alcohol abuse care, and distribution of insecticide treated bed nets to PLHIV households, will be phased out in all PEPFAR supported sites before September 30, 2016. Bed-net distribution will be continued with other USAID health funds in areas where programs are co-located.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

In order to strengthen DRC's laboratory infrastructure for improved access, quality, and coverage of HIV-related diagnostic testing, PEPFAR DRC will focus its core activities on strengthening infrastructure and human capacity building. This strategy will require: (1) continued partnership with GFATM, (2) coordination of a lab network which includes both public and private laboratories, (3) implementation of a VL scale-up plan and a specimen transportation system to increase EID/VL access, (4) increased participation in the quality assurance program and Strengthening Laboratory Management Towards Accreditation (SLMTA) process, (5) strengthening of the Logistics Management and Information System (LMIS) and, (6) establishing a maintenance contract for laboratory equipment.

For COP15, PEPFAR DRC will continue to increase the laboratory capacity by providing PCR machines, the organization of specimen transportation in a network to improve EID and VL access then the establishment of a good Laboratory information system (LIS). We will continue to provide technical assistance to Ministry of Health and will work closely stakeholders to implement the core activities listed in the table below.

Table 6.1

1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Develop viral load scale-up plan	• VL scaling plan developed (in process) • Increased access of	• VL scale-up plan developed • Extension of lab network for VL to others labs	HLAB-$ 384,500 HTXS-$ 110,000	HLAB$0 HTXS-$ 110,000	ASM	Access and demand = Red Commodity security and supply chain		X	X		X

	molecular lab in Kinshasa and Lubumbashi	(e.g., DREAM, UNIKIN, UNILU) • VL Point of Care (POC) equipment purchased for IPs				= Red					
Increase VL access for PLHIV on ART	• Container lab established in Kinshasa and Lubumbashi		HLAB-$ 865,000	HLAB $0	ASM						
Expand EID services	• EID labs expanded from one (Kinshasa) to three (addition of labs in Kisangani and Lubumbashi)	• 3 HIV provincial labs are made functional • Lab network for EID expanded to others labs (e.g., DREAM, UNIKIN, UNILU) • EID POC equipment purchased for IPs	PDCS-$ 30,000	PDCS-$ 30,000	ICAP, MALAMU, KIMIA, PROVIC, IHP, SANRU, PSI	Access and demand = Red Commodity security and Supply chain = Red	X	X	X		

Expand QA programs for HIV Rapid Diagnostic Tests (RDTs) including Proficiency Test (PT panel) and HIV related POC	• PNLS provincial labs and IPs labs involved in the QA process for each session • Technical assistance provided to Lab TWG to coordinate and sustain national HIV lab activities.	• All POC Rapid HIV testing are enrolled in the HIV DTS Proficiency testing • Technical assistance provided to Lab TWG to coordinate and sustain national HIV lab activities.	HLAB-$ 32,000	HLAB-$ 53,000	ICAP, KIMIA, MALAMU, ProVIC, IHP, PSI	Quality management = Light Green	X	X			
Implement an internal quality assurance program for all HIV core tests	• QA/QI program initiated in PEPFAR sites	• QA/QI program initiated in PEPFAR sites	HLAB-$ 31,500	HLAB-$ 31,500	ICAP, KIMIA, MALAMU	Quality management = Light Green	X	X			
Support laboratory continuous quality improvements projects	• Management improvement project implemented in 6 labs	• Mentorship of 6 labs and addition of 4 more (2 for EGPAF and 2 for ICAP)	HLAB-$ 50,000	HLAB-$ 50,000	APHL	Quality management = Light Green	X	X		X	X

Provide lab training, QA/QI, and mentoring/supervision	• Regional laboratory training center established at KSPH • Training of lab technicians for all IPs is conducted in Kinshasa	• Targeted training of lab personnel conducted at provincial and PEPFAR site level (EID and VL sample collection/ management, HIV RDTs, logbook, data tools, etc.)	HLAB-$ 40,000	HLAB-$ 100,000	ICAP, KIMIA, MALAMU, SANRU and ProVIC, IHP	Human resource for health = Yellow	X	X		X	X
Ensure proper biosafety (injection safety and waste management)	• Labs biosafety (injection safety and waste management) capacity strengthened through purchase of containers and incinerators	• Biosafety (injection safety and waste management) training conducted for staff • Lab biosafety and waste management capacity strengthened through purchase of containers and incinerators	HMIN-$ 250,000	HMIN-$ 160,000	ICAP, KIMIA, MALAMU, SANRU, PSI, ProVIC, IHP, LINKAGES, CB-HIPP	Policies, Laws and Regulations = Light Green	X	X		X	X

Strengthen national TB lab, including MDR TB monitoring and culture (system and capacity development)	• TB program supported to set up a system and to develop the capacity of the program at the national and provincial levels	• TB program supported to set up a system and to develop the capacity of the program at the national and provincial levels	HLAB-$ 25,000	HLAB-$ 25,000	ICAP, KIMIA, MALAMU, SANRU, PROVIC, IHP	Policies, Laws and Regulations = Light Green Planning and coordination = Light Green		X			
Maintain and repair laboratory equipment at PEFPAR supported clinical sites.	• Laboratory equipment maintenance program set up	• Laboratory equipment maintenance program set up	HLAB-$ 100,000	HLAB-$100,000	ICAP	Quality management = Light Green	X	X		X	

6.2 Strategic information (SI)

PEPFAR DRC provides technical assistance to GDRC to enhance data management activities. Activities include support of a web based electronic reporting system called MESI (Monitoring Evaluation and Surveillance Interface). GDRC uses MESI to collect and report data from the HZ level to the central level with data validation at all intermediate levels. MESI is operational in all 35 HZs in Kinshasa. PEPFAR DRC will assist PNLS to implement MESI nationwide.

For COP 2015, PEPFAR DRC will continue to build and strengthen in-country human and institutional capacity for SI, including data collection, data quality improvement, data use, and dissemination. PEPFAR DRC plans to supplement data from the service mapping activity with the Integrated Partner Site List (iPSL). PEPFAR DRC will support the use of geospatial data/tools to develop an understanding of relationships, patterns, and trends.

PEPFAR DRC in collaboration with Headquarter (HQ) SI counterparts will provide technical assistance with transition from Unlinked Anonymous Testing (UAT)-based ANC sentinel surveillance towards a model based on routine program data generated by PMTCT HIV testing services. PEPFAR/DRC will support PNLS' efforts to conduct HIV Drug Resistance Surveillance activities, in collaboration with other stakeholders.

PEPFAR DRC provided technical assistance to GDRC in drafting the Key Population Mapping and Size Estimation Protocol. The study is being funded by GFATM. With COP15 funding, PEPFAR/DRC will support the Integrated Bio-Behavioral Survey (IBBS) among key populations in 2016.

Table 6.2											
1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Strengthen the national Health Information System (HIS)	• Needs of national HIS enhancement assessed • Technical assistance needs for HIS development assessed	• Policy framework related to HIS enhanced/ developed • National HIV/AIDS M&E plan developed and implemented	HVSI; $100,000	HVSI	TBD, PSI	Epidemiological and Health Data = Red Performance Data = Light Green Policy Law and Regulation = Light Green	X	X	X	X	X
Build host country institutional and organizational capacity for data management	• Harmonized Data collection and reporting tools updated/developed • Standard operating procedures developed/implemented	• Providers trained on data management procedures • HIV/AIDS data collection, validation, and use are promoted at each level of the MOH pyramid	HVSI $200,000	OHSS	FHI/CDC	Performance data = Light Green Public Access to information = Red Planning and Coordination = Light Green	X	X	X	X	X
Support web based electronic reporting system, Monitoring Evaluation and Surveillance Interface (MESI)	• Providers are trained on use of MESI platform in 2 provinces • IT equipment including computers provided to 2 additional provinces	• Equipment and system maintenance provided • Accurate and reliable data available for decision making at different levels	HVSI; $400,000	HVSI	FHI/CDC	Epidemiological and Health Data = Red Performance Data = Light Green Planning and Coordination = Light Green	X	X	X	X	X

	• Internet connection provided to health zones • Equipment and system maintenance provided	of MOH pyramid									
Support Host country for Data Quality Improvement System	• Data Quality protocol updated • QI Team refreshed on QI process • QI system implemented	• Accurate, reliable, timeliness and complete data available for informed decision making	HVSI: $100,000	HVSI	FHI/CDC	Epidemiological and Health Data = Red Performance Data = Light Green Oversight and Stewardship= Red	X	X	X	X	X
Support HIV/AIDS surveillance activities & HIV impact assessment activities	• Survey Protocols updated/developed • Survey Protocols tested/ implemented	• Survey data processed • Survey Report released and shared	HVSI; $1,000,000	HVSI	TBD	Epidemiological and Health Data = Red Public access to information = Red Planning and coordination = Light Green Oversight and Stewardship= Red	X	X	X	X	X

6.3 Health System Strengthening (HSS)

Human Resources for Health (HRH): In DRC, HIV is not ranked as a top health priority and does not drive HRH decisions on recruitment, deployment, and retention. SIMS findings revealed that almost 70% of facilities do not have an appropriate ratio of HIV service providers to clients to ensure quality services. PEPFAR DRC is positioned to contribute to the improvement of quality of services through capacity building. While striving to improve the skills of 1,250 nurses and midwives through Nursing Education Partnership Initiative (NEPI), PEPFAR will continue to encourage the MOH to collaborate with the Ministry of Education for a standardized and harmonized pre-service education curriculum. PEPFAR DRC will promote an in-service curriculum that will enable providers to cope with all clients regardless of gender and sexual orientation. The curriculum will also focus on the importance of mentorship as part of in-service education. There will be a focus on supporting the development of QA/QI systems to include building knowledge, skills, and capacity for ongoing problem identification and problem-solving to improve service delivery and provider performance.

Supply Chain Management: Most PEPFAR-supported facilities reported few stock outs of RTKs, ARVs, and condoms (per SIMS visits); however, there is no national supply plan. The in-country stocks of commodities are not well known, and this element was scored red throughout the SID. PEPFAR DRC will continue strengthening a national supply system through forecasting, quantification, distribution, and reporting. Rationalizing the needs and gaps between GFATM Prime Recipients (PRs) and PEPFAR IPs through an assessment of current stocks will be the first step in this process.

Poor quality data, a broken commodity security system, and weak resource mobilization were identified as the top priorities to be addressed during COP15. PEPFAR DRC will continue investing in: 1) strengthening GDRC capacity for generation and use of data and evidence; 2) conducting joint planning with GFATM for supply chain; 3) reinforcing PNAM skills for driving the national supply chain system; and 4) using evidence-base data (such cost studies, investment profile) for advocacy and diplomacy.

Table 6.3											
1. Brief Activity Description	Deliverables		Budget codes and allocation ($)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Provide pre-service education for nurses	1450 nurses and midwives graduated (APR 2015 targets)	• 1250 nurses and midwives graduated	OHSS No COP funds.	OHSS No COP funds.	NEPI/ICAP	HRH = yellow	X	X	X	X	X
Provide pre-service education for masters	• 12 FELTP students graduated in 2015	• 17 FELTP students graduated in 2016	OHSS; $95,000	OHSS	FELTP (CDC operational costs)	HRH = yellow	X	X	X	X	X
Standardize pre-service HIV curriculum	• Curriculum adopted for nurses and medical schools	• Curriculum adopted for nurses and medical schools • HRH development plan drafted	OHSS; No COP funds; NEPI	OHSS; No COP funds; NEPI	ICAP	HRH = yellow	X	X	X	X	X
Expand task-sharing/scopes of practice for HIV service delivery		• National task delegation adopted	OHSS No COP funds.	OHSS No COP funds.	ICAP/ARC through ACT	HRH = yellow	X	X	X	X	X

Reinforce leadership of national council for nurses	• 4 nursing officer chiefs trained		OHSS	OHSS		HRH = yellow		X			
Expand Quality Improvement	• Institutionalized QA/ QI systems and SOP	• Institutionalized QA/ QI systems and SOP	OHSS $0	OHSS $0	All service delivery partners	HRH = yellow	X	X	X	X	X
Design a joint (GFATM and PEPFAR) supply plan	• Joint GFATM and PEPFAR supply plan implemented	• National HIV supply plan developed	OHSS 30,000 HTXD 10,000	OHSS 30,000 HTXD 10,000	SCMS	Supply Chain Plan = Red	X	X	X	X	X
Provide TA to national HIV supply chain committee	• Improved and coordinated supply chain decision-making • Stakeholder collaboration facilitated	• Improved and coordinated supply chain decision-making • Stakeholder collaboration facilitated	OHSS 10,000	OHSS 15,000	SCMS	Supply Chain Plan = Red	X	X	X	X	X
Conduct regular drugs and lab inventory assessments	• Biannual inventory assessments for all provincial warehouses (centres de distribution regionale or CDRs) conducted	• Technical expertise, personnel training, and resources provided to strengthen warehousing and inventory management systems	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $10,000	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $10,000	SCMS	Assessment = Red	X	X	X	X	X

Conduct a national and provincial quantification for ARVs, lab commodities, and drugs used to treat opportunistic infections and sexually-transmitted infections	• Quantification Stakeholders Group functional	• Prevention of overstocks and stock-outs by supporting national quantifications and forecasting	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $oK (No COP funds)	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $45,000	SCMS	ARV domestic financing = Red Test Kit domestic financing = Red Supply chain plan= Red	X	X	X	X	X
Coordinate use of existing stocks of ARVs (AZT/3TC/NVP) and prepare a smooth transition on TDF-based regimens	• A gradual transition scheme developed (timelines and details of the TDF-based regimen phase-in plan developed)	• Optimized Commodity Management	OHSS $5,000	OHSS $o	SCMS	Supply Chain Plan= Red	X	X	X	X	X
Support quarterly provincial review of consumption data, product loss, transfer, and restocking level for aggregation and use in decision-making.	• Improved supply chain collaboration and information-sharing by local partners in the HIV/AIDS community	• Enhanced field-driven approach, from initial product selection and forecasting through product delivery to patients in need	OHSS $30,000	OHSS $30,000	SCMS	Assessment = Red	X	X	X	X	X

Strengthen collaboration between GF sub-recipients (SRs) and PEPFAR IPs (consolidate stock data from GF prime recipients (PRs) and PEPFAR IPs)	• Improved collaborative relationship that will promote sustainable improvements to the HIV/AIDS commodity supply chain	• Improved collaborative relationship that will promote sustainable improvements to the HIV/AIDS commodity supply chain	OHSS $0 (No COP funds)	OHSS $0 (No COP funds)	SCMS	Supply Chain Plan= Red	X	X	X	X	X
Support DPS in their technical and material capacity to fulfill their supervisory role with the health facilities	• A logistic checklist for supervision (standard questions and a system of follow up from the visits) developed	• Improved logistic managers skills demonstrated at facilities • Reduced number of expired drugs	OHSS $15,000	OHSS $25,000	SIAPS, SCMS	Assessment = Red	X	X	X	X	X
Procure essential HIV commodities [TDF-based regimens, CTX, RKT, and essential testing supplies (gloves, capillary tubes, lancets, etc.)] Note: This is lump sum for commodities	• Lifesaving low-cost generic ARV drugs, including; drugs for PLHIV care (CTX); laboratory materials such as rapid test kits; and supplies including gowns, gloves, injection equipment, and cleaning and sterilization items available	• Lifesaving low-cost generic ARV drugs, including; drugs for PLHIV care (CTX); laboratory materials such as rapid test kits; and supplies including gowns, gloves, injection equipment, and cleaning and sterilization items available	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $12 million	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $15 million	SCMS	ARV domestic financing = Red Test Kit domestic financing = Red Supply chain plan = Red	X	X	X	X	X

Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies)	• Identification of funding resources and establishment of partnerships necessary to enable sustainability of the waste management plan	• Reduced number of expired drugs	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $5,000	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $5,000	SCMS	ARV domestic financing = Red Test Kit domestic financing = Red Supply chain plan = Red	X	X	X	X	X
Support the national supply chain strategic plan process	• Improved capacity of national supply chains to ensure long-term sustainability	• Improved capacity of national supply chains to ensure long-term sustainability	OHSS $15,000	OHSS $0	SCMS	Supply chain plan = Red Assessment = Red	X	X	X	X	X
Support CDRs to improve storage and delivery processes	• Assessment of CDR and local logistic constraints conducted • Comprehensive CDR capacity building provided	• Storage facilities report having commodities stocked according to plan	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $15,000	MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $15,000	SCMS	ARV domestic financing = Red Test Kit domestic financing = Red Supply chain plan = Red	X	X	X	X	X

Construct the Central Medical Store (warehouse-in-a-box)	• Memorandum of Understanding developed	• National central medical store renovated to be secure and temperature-controlled, using best-practice operating procedures for storing and distributing drugs	OHSS $250,000	OHSS $250,000	SCMS	Stock = Red	X	X	X	X	X
Develop and operationalize integrated distribution systems and networks and information-management systems with Family Planning program.	• Existing systems strengthened to avoid building parallel systems	• Enhanced rapid and reliable re-supply of drugs through the establishment of secure regional distribution centers.	OHSS $0 (No COP funds)	OHSS $0 (No COP funds)	SCMS	Stock = Red	X	X	X	X	X
Support the implementation of the national Logistic Management Information System	• LMIS tools standardized (stock cards, reporting forms…) available at all levels	• Improved availability and use of logistics information for supply chain decision-making at the local and national levels	OHSS 25,000	OHSS 45,000	SCMS	Stock = Red	X	X	X	X	X

Procure and distribute isoniazid.	• TB preventive drugs available at all HIV care and treatment facilities	• TB preventive drugs available at all HIV care and treatment facilities	HVTB $80,000	HVTB $80,000	SCMS	Stock = Red	X	X	X	X	X
Distribute drugs in country	• Delivery of drugs organized and facilitated from RDC to clinics/facilities	• Delivery of drugs organized and facilitated from RDC to clinics/facilities	OHSS $750,000	OHSS $750,000	SCMS		x		x		x
Transition SCMS to new mechanism	• Start-up of new mechanism is complete		MTCT, HVCT, HBHC, HTXS, PDCS, PDTX, HVTB $250,000		SCMS		x		x		x
Incorporate SI activities into FANTA and ASSIST mechanisms	• ASSIST: Support provided to PNLS to develop and roll out standards of care • FANTA: Support provided to PRONANUT to develop policies and tools on HIV and nutrition integration		HBHC $260,000 HBHC $500,000	$0 $0	ASSIST FANTA	HRH=yellow		X X	X X		X X

7.0 Staffing Plan

PEPFAR DRC emphasizes recruitment of host country nationals and individuals possessing knowledge and experience in public health, clinical care, laboratory science, program operations, and program monitoring and evaluation. These are core strengths that reflect the direction of PEPFAR programming in DRC. Geographic size, economic and political instability, and limited transportation and infrastructure contribute to increased challenges and the high cost of doing business in the DRC slows down recruitment of qualified personnel.

Agencies conducted internal staffing assessments to ensure that the staffing profile was adequate to support the PEPFAR pivot, implementation of combination prevention interventions, and support for SIMS visits. In July 2013, a Staffing Assessment was conducted by OGAC Program Support, which showed that PEPFAR DRC is experiencing about a 40% vacancy rate. Although staff recruitment continues to be challenging, 10 vacancies have been filled since March 2014. CDC filled positions for the Deputy Technical Director of Programs, Care and Support Specialist, Cooperative Agreement Specialist, Cooperative Agreement Manager, and provincial coordinators for Katanga and Oriental (to monitor PEPFAR activities given the vastness of the country). USAID filled positions for an SI/M&E Advisor, Prevention Specialist, Logistics and Commodities Manager, and an M&E Specialist. There are 5 previously approved positions which remain vacant. These include, (1) CDC: Finance Specialist, Treatment Specialist and an M&E Specialist; (2) USAID: Global Fund Liaison, however interim Global Fund Liaison has been recruited; and (3) DoD: a Finance and Administrative Assistant. The hiring process has begun for all of these positions.

With COP15 funds, the position of PEPFAR Strategic Information Liaison (in the PEPFAR Coordination Office) is proposed. This position will coordinate SI activities across the interagency space to include coordination of SIMS activities, quarterly reporting, maintaining the iPSL, etc. SI remains high priority for PEPFAR DRC, specifically with increasing data quality and use of data in planning. CDC has re-purposed two positions in response to the growing SI needs: the previously approved CDC Provincial Coordinator for Kinshasa has been repurposed to an M&E position (recruitment is underway) and an existing Care and Support Manager has been repurposed to be the Deputy SI Team Lead. PEPFAR DRC Scale-up HZs form two clusters in Lubumbashi and Kinshasa. Aside from offering the full package of activities described in Section 4, outreach and HIV testing will be intensified in five Key Population hotspots along the Lubumbashi-Zambia transport corridor. This will require increased monitoring and South-to-South collaboration with the PEPFAR Zambia team to ensure synergy in the package of activities offered and to reduce loss to follow-up.

[REDACTED]

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	**HTC** Clinical settings: PITC (pregnant women/partners/family members, EID, TB, malnourished, STI, FP and inpatients), and disclosure for children and adolescents and linkage with OVC programs Other facilities: Stand-alone VCT for KP and OVPs (CSWs, FSWs, IDUs, miners, truckers, military, AGYW and their clients) Community-based: outreach and mobile for KP and OVPs and in high prevalence areas Linkages to care and treatment, including PMTCT Procurement and distribution of RTK, including DBS, DNR. Quality Assurance and Quality Improvement (Site Level HIV Proficiency Testing)		
	Community Prevention Targeted risk assessment and provision of risk reduction information, education and/or counseling to accurately gauge and personalize risk for HIV infection for priority populations (KP, AGYW and their partners, miners, truckers, military)	**Community Prevention** Linkages to other health, social, and legal services Treatment of GBV and expansion/improvement of FP for adolescent Girls and young Women (AGYW)	

Targeted informational sessions on HIV testing and counseling for AGYW and their sexual partners and referral to appropriate HTC services Prevention with Positives Peer education and outreach for key and priority populations Sexual and drug use assessment and risk reduction counseling Condom and condom-compatible lubricant promotion and distribution for KP and other priority populations including miners, truckers, military, AGYW and their sex partners Sexually Transmitted Infections (STI) screening and treatment Male involvement in PMTCT	Prevention, diagnosis and treatment of co-infections such as Viral Hepatitis Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data safety procedures)	
Care and Treatment (including key populations) Biological monitoring (CD_4 and/or viral load) of HIV positive patients. Clinical monitoring of HIV positive patients (WHO staging). Monitoring and treatment of side effects from ART Scale up of pediatric HIV treatment Evidence-based adherence and retention programs (mentor mothers, patient experts,	**Care and Treatment** (including key populations) Strengthen HIV Support group approaches to all health facilities in order to improve follow-up and promote the continuum of care Biological monitoring (hemoglobin, creatinine, ASAT, ALAT) of HIV positive patients (including peds). Pediatric facility referral to Community care and support services	**Care and Treatment** (including key populations) Palliative care (pain and symptom management; end of life care) Mental Health and substance/alcohol abuse and HIV care Hepatitis B screening Water, Sanitation, Hygiene (WASH) Food package provision

	Quality improvement initiatives, Peer Health Workers (PHW) care). Support retention and monitoring of mothers on ART once initiated. Cotrimoxazole Preventive Therapy of HIV positive patients (including mothers and HIV-exposed infants); Clinical provision of CTX to eligible PLHIV; Integration of CPT in MCH and TB; Community distribution; Supply Chain (Procurement, distribution, logistic support, HSS) Provision of ARV and other commodities. ARVs for PMTCT according to national protocols: B+ option. Drugs, tests kits and consumables procurement (ARV,CTX, RTKs, condom, DBS) INH for HIV positive patients Support TB infection control in clinical settings (TBIC) TB screening and referral for PLHIV Integration of TB/HIV care and treatment to ensure linkage and retention ART to PLHIV with a focus on High-Risk Populations (TB/HIV co-infection, pregnant and breastfeeding women, pediatric patients, key populations) Positive Health, Dignity, Prevention (PHDP) (HIV serostatus disclosure counseling and partner HTC; FP counseling and services; Risk reduction education and condom provision; STI assessment and treatment; Adherence counseling and support, prevention interventions for PLVIV in TB clinical settings.	Nutrition Assessment Counseling and Support of HIV positive patients Demand creation for uptake of HIV services in the facility and community Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV Support functioning of Xpert MTB/RIF Developing specimen transport networks Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services Implement QM/QI initiatives at the facility /community level approach Breastfeeding support Management of other OIs. Screen and refer for treatment of opportunistic infections among PLHIV. Community Prevention Linkages to other health, social, and legal services Treatment of GBV and expansion/improvement of FP for adolescent Girls and young Women (AGYW)	Laboratory monitoring: protein testing, glucose. Distribution of insecticide treated bed nets to PLHIV and households.

Tracking mother-infant pairs

Sexually Transmitted Infections (STI) screening and treatment

OVC

Case Management

- Assessing child & family socio-economic status(across all areas: healthy, safe, stable, schooled)
- Developing care/ case management plans for children and families with monitoring of referral completion and stated case closure goals

Access to Health/ HIV Services
Promotion of EID and confirmatory HIV testing (E.g. within early childhood development (ECD) programs, etc.)

Integrating adherence assessment, counselling and support into routine household support

Coordination with NACS (E.g., referral of suspected malnutrition, education)

Facilitating uptake of and monitoring completion of referrals for:

- Nutrition and food security programs
- TB/HIV testing, treatment and care services for all children and partners of index cases
- Child survival services
- ALHIV for SRH and FH services,

Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data safety procedures)

OVC

Case Management

- Mapping services within targeted communities and developing service directories
- Supporting the development of national MIS
- Training in case management for CLHIV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas.

Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals)

Program/system support
Mapping and size estimation studies

	including AYFS **Program/system support** *SI* Implementing OVC related baseline studies *SCMS Supply Chain* Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies)	
Health Zone level	**OVC** *Case Management* •Train Child protection committee on case management. *Access to Health/ HIV Services* •Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals. *Child Protection* •Supporting Community child protection/ GBV prevention and response activities (including emergency food and shelter for abuse survivors (generally required for <10% of cases, and referrals to other services) *Economic Strengthening* •Supporting access to and uptake of social protection efforts (such as social grants, cash transfer programs, bursaries, etc.) *Education* •Providing temporary school block grants to promote enrollment and progression	**OVC** *Case Management* •Mapping services within targeted communities and developing service directories Carrying out child rights awareness school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs Succession planning Program/system support Site-level recruitment, deployment, retention of HRH Minor renovation of health facilities **Care and Treatment** (including key populations) Treatment Literacy. Training /mentoring health providers (facility

		and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services Implement QM/QI initiatives at the facility /community level approach **Program Support** *Supply Chain Management* Disseminate logistic and supply chain standard operating procedures (e.g. inventory, warehousing, etc.) Support logistic supervision and mentorship Support HZ to coordinate a pooled warehousing of second line regimens Improve warehousing conditions Reproduce and disseminate logistic tools (e.g. stock cards)
Provincial level	**OVC** Strengthen OVC Technical Working Group Support Supportive supervision Conduct network analysis and referral strengthening Revise OVC/Child protection key indicators selection, data collection and reporting tools,	**OVC** Strengthening government-managed and case management systems to prevent and respond to child abuse and support family placement and permanency for children Strengthening structures for community-based mediation of child abuse cases

Dissemination of Child protection laws

Carrying out market assessments for Income generating Activities (IGAs)

Targeted food security initiatives

Care and Treatment (including key populations)
Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management

Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV

Program/system support
LAB PMTCT

- Support procurement EID reagents and sample collection consumables
- Supply of CD4 cartridges for testing
- Ensuring the QA for CD4 test installed in sites

Program/system support
LAB PMTCT

- Support of EID reagents

LAB HIV Care and Treatment

- Support of laboratory reagents (DNA PCR and VL) in the PEPFAR focus provinces (Katanga, Kinshasa and Orientale) GF mechanism. PEPFAR's role is forecasting and distribution.
- Maintenance and/or certification of equipment

National level	**OVC** Strengthen HIV sensitive child welfare and protection knowledge and skills of Ministry of Social Affairs officials Strengthen the availability, quality and use of child-focused social welfare data for policy formulation, advocacy, budgeting, action planning, and service strengthening, including for children affected by HIV and other adversities Strengthen OVC M&E systems Support development of case management and referral guidelines to improve HIV pediatric uptake	**OVC** Strengthen the legal and policy framework for vulnerable children Conduct a Rapid HIV Sensitive Child Protection and Welfare Systems Mapping and Assessment. Strengthen Ministry of Social Affairs' capacity to advocate for increased budget allocation M&E systems for National child protection/ social welfare efforts M&E systems for National child protection/ social welfare efforts Supporting vocational training and other individual HES activities Carrying out market assessments for Income generating Activities (IGAs) Facilitating access to primary (and secondary education for girls) through long-term or open-ended subsidies Providing long-term or open-ended school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs

	Succession planning Program/system support Support MOH/NACP to develop clinical care and PHDP guidelines, standards and tools Site-level recruitment, deployment, retention of HRH HRH performance and quality assessment. Revise national HTC policies and guidelines for inclusion of disclosure process and deletion of requirement of parental consent for adolescents Support the development of national TB/HIV guidelines Support national (MoH/PNLS) revising ART guidelines and policies, including PMTCT related standard guidelines. Regular supportive supervisory visits by provincial MOH NAC office and PEPFAR IPs to ensure high quality services and data collection SI and M&E technical considerations for pediatrics (routine program monitoring, data quality and use, evaluation, assessing M&E tools and systems to support linkage and retention, quality management and QI) Surveillance for HIV drug resistance

		Ensure Testing QA Supply relevant tools (registers, medical chart, etc.) to health and community facilities Developing standard procedures for identifying and tracking ART patients (defaulted, missing appointments, etc.). Provide standard adherence support protocol for documenting all the following core elements: 1) Adherence counseling prior to ARV treatment initiation 2) Routine adherence assessments during ARV therapy 3) Counseling interventions for patients with poor adherence Scale-up of national EID plan PMTCT Training and mentoring(Tutoring) for providers	
	Program support *SCMS Routine Supply Planning* Technical assistance to GFATM PRs supply plan TA to national HIV supply chain committee Conduct regular inventory management assessment tool Conduct national and provincial (3) quantification for ARVs, lab commodities and other drugs used in OI and STI.	**Program/system support** *SCMS Routine Supply Planning* • Support to the national supply chain strategic plan process • Construct the Central Medical Store (Warehouse-in-a-box) *SCMS Supply Chain* • Procure and distribute isoniazid. *SCMS Use of Site Level Stock Data*	**Program/system support** *SCMS Routine Supply Planning* • Design a parallel supply plan (PEPFAR only) *SCMS Supply Chain Segmentation* • Store HIV commodities in partners 'offices

Coordinate use of existing stocks of ARVs and prepare a smooth transition on TDB-based regimens

SCMS Use of Site Level Stock Data
Strengthen collaboration between GF SRs and PEPFAR IPs (Consolidate stock data from GF PRs and PEPFAR IPs)

Supply Chain Segmentation
Procure and distribute essential HIV commodities [TDF-based regimens, CTX, RKT, and essential testing supplies (gloves, capillary tubes, lancets, etc.)].

Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies)

- Support the national Logistic Management Information System design roadmap implementation

- Develop and operationalize integrated distribution systems and networks, and information-management systems with Family Planning program.

LAB HIV Care and Treatment

- Supply of CD_4 cartridges for testing
- Ensuring the QA for CD_4 equipment installed in sites
- Lab biosafety (waste management, biosafety)
- Maintenance and/or certification of equipment
- Biological monitoring (Hemoglobin, Creatinine, ASAT, ALAT)
- Strengthening lab capacity (training of staff, etc.)
- Implementation of an internal quality assurance program for all HIV core tests
- Support for epidemiological surveys (RDTs, equipment and method assessment)
- Development of a VL scale-up plan
- Support of laboratory reagents (DNA PCR and VL) in the PEPFAR focus provinces (Katanga, Kinshasa

		and Orientale) GF mechanism. PEPFAR's role is forecasting and distribution. *LAB PMTCT* • Support procurement EID reagents and sample collection consumables

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
HTC	Clinical settings: PITC (pregnant women/partners/family members, EID, TB, malnourished, STI, FP), and disclosure for children and adolescents and linkage with OVC programs Other facilities: Stand-alone VCT for KP and OVPs (CSWs, FSWs, IDUs, miners, truckers, military, AGYWs and their clients) Community-based: outreach and mobile for KP and OVPs and in high prevalence areas Ensure linkage to care and treatment, including PMTCT Procurement and distribution of RTK, including DBS, DNR. Quality Assurance and Quality Improvement (Site Level HIV Proficiency Testing)		
Care and Treatment (including key populations)	Biological monitoring (CD_4 and/or viral load) of HIV positive patients. Clinical monitoring of HIV positive patients (WHO staging). Monitoring and treating side effects from ART Scaling up pediatric HIV treatment	Social Services (Economic Strengthening Services): saving groups Strengthen HIV Support group approaches to all health facilities in order to improve follow-up and promote the continuum of care Biological monitoring (hemoglobin, creatinine, ASAT, ALAT) of HIV positive patients (including peds)	Palliative care (pain and symptom management; end of life care) Mental Health and substance/alcohol abuse and HIV care Hepatitis B screening Providing food package

	Evidence-based adherence and retention programs (mentor mothers, patient experts, Quality improvement initiatives, Peer Health Workers (PHW) care). Support retention and monitoring of mothers on ART once initiated. Cotrimoxazole Preventive Therapy of HIV positive patients (including mothers and HIV-exposed infants); Clinical provision of CTX to eligible PLHIV; Integration of CPT in MCH and TB; Community distribution; Supply Chain (Procurement, distribution, logistic support, HSS) Provision of ARV and other commodities. ARVs for PMTCT according to national protocols: B+ option. Drugs, tests kits and consumables procurement (ARV,CTX, RTKs, condom, DBS) INH for HIV positive patients TB diagnosis in HIV clinics Support TB infection control in clinical settings (TBIC) TB screening and referral for PLHIV Integration of TB/HIV care and treatment to ensure linkage and retention ART to PLHIV focus on High-Risk Populations (TB/HIV co-infection, pregnant and breastfeeding women, pediatric patients, key populations) Positive Health, Dignity, Prevention (PHDP) (HIV serostatus disclosure counseling and partner HTC; FP	DNA PCR reagents Pediatric facility referral to Community care and support services Nutrition Assessment Counseling and Support of HIV positive patients Demand creation for uptake of HIV services in the facility and community Treatment Literacy. Training /mentoring health providers (facility and community) on ARV management Strengthen TB/HIV program monitoring and evaluation (M&E). Implement, track, and report on TB screening among PLHIV Support functioning of Xpert MTB/RIF Developing specimen transport networks Establish and strengthen referral mechanisms to ensure cross referral between clinic and community services Implement QM/QI initiatives at the facility /community level approach Breastfeeding support Management of other OIs. Screen and refer for treatment of opportunistic infections among PLHIV.	Laboratory monitoring: protein testing, glucose. Distribution of insecticide treated bed nets to PLHIV households

	counseling and services; Risk reduction education and condom provision; STI assessment and treatment; Adherence counseling and support, prevention interventions for PLVIV in TB clinical settings. Tracking mother-infant pairs	
Community Prevention	Targeted risk assessment and provision of risk reduction information, education and/or counseling to accurately gauge and personalize risk for HIV infection for priority populations (KP, AGYW and their partners, miners, truckers, military) Targeted informational sessions on HIV testing and counseling for AGYW and their sexual partners and referral to appropriate HTC services Prevention with Positives Peer education and outreach for key and priority populations Sexual and drug use assessment and risk reduction counseling Condom and condom-compatible lubricant promotion and distribution for KP and other priority populations including miners, truckers, military, AGYW and their sex partners Sexually Transmitted Infections (STI) screening and treatment Male involvement in PMTCT	Linkages to other health, social, and legal services Treatment of GBV and expansion/improvement of FP for adolescent Girls and young Women (AGYW) Prevention, diagnosis and treatment of co-infections such as Viral Hepatitis Implementation of the PEPFAR Ethical framework for engagement of KP (KP status disclosure policy, confidentiality protocols, informed consent and data safety procedures)

OVC	Case Management • Assessing child & family socio-economic status(across all areas: healthy, safe, stable, schooled) • Developing care/ case management plans for children and families with monitoring of referral completion and stated case closure goals • Implementing baseline studies Access to Health/ HIV Services • Promotion of EID and confirmatory HIV testing (E.g. within early childhood development (ECD) programs, etc.) • Integrating adherence assessment, counseling and support into routine household support • Coordination with NACS (E.g., referral of suspected malnutrition, education) • Facilitating uptake of and monitoring completion of <u>referrals for</u>: • Nutrition and food security programs • TB/HIV testing, treatment and care services for all children and partners of index cases • Child survival services • ALHIV for SRH and FH	Case Management • Mapping services within targeted communities and developing service directories • Supporting the development of national MIS • Training in case management for CLHIV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas. Strengthening referral mechanisms and other systems for linking non-HIV clinical and social services (cross-referrals) Carrying out child rights awareness campaigns in targeted communities Strengthening structures for community-based mediation of child abuse cases Dissemination of Child protection laws M&E systems for National child protection/ social welfare efforts Supporting vocational training and other individual HES activities Carrying out market assessments for Income generating Activities (IGAs) Linking businesses/agricultural projects to markets/value chain

services, including AYFS	development
Child Protection • Supporting Community and national level child protection/ GBV prevention and response activities (including emergency food and shelter for abuse survivors (generally required for <10% of cases, and referrals to other services) • Supporting clinic-based child abuse and GBV response services (including emergency medical services/PRC) • Facilitating birth registration • Positive Parenting skills building (including topics on adolescent risk, HIV disclosure, child health & development knowledge	Targeted food security initiatives Facilitating access to primary (and secondary education for girls) through long-term or open-ended subsidies Providing long-term or open-ended school block grants or support for ECD centers Improving education quality, especially making classroom environments gender and HIV sensitive Supporting community education councils and PTAs Succession planning
Economic Strengthening • Facilitating group-based Household Economic Strengthening (HES) activities, such as savings groups • Supporting access to and uptake of social protection efforts (such as social grants, cash transfer programs, bursaries, etc.) • Addressing psychosocial health among children and their caregivers through individual, group-based and relationship based activities	

	Education • Facilitating access to primary and secondary education through temporary and targeted support for: uniforms, school fees, exam fees, adult mentors - cost-shared • Providing temporary school block grants to promote enrollment and progression • School-based psychosocial support, (including Teacher psychosocial support for children [cash+care]) • Supporting early childhood development (ECD) – (in coordination with PMTCT & Pediatric HIV) • integrating ECD into HIV care and treatment for children under five		
Program/system support	Implementation of revised national ART (2013 WHO guidelines) Develop standard procedures for identifying and tracking ART patients (defaulted, missing appointments, etc.). Provide standard adherence support protocol for documenting all the following core elements: 1) Adherence counseling prior to ARV treatment initiation 2) Routine adherence assessments during ARV therapy 3) Counseling interventions for patients with poor adherence	Support MOH/NACP to develop clinical care and PHDP guidelines, standards and tools. Reproduce and disseminate tools (educational tools, data collection tools, etc.) Assist MoH with development of an ART transition approach (priority sub-populations, priority regimens, timeline, etc.) Assist MoH with development of QI guidelines for care and treatment. Assist MoH with development of key population protocols and tools.	*SCMS Routine Supply Planning* • Design a parallel supply plan (PEPFAR only) *SCMS Supply Chain Segmentation* • Store HIV commodities in partners 'offices • Procure AZT/3TC/NVP regimens

SCMS Routine Supply Planning

- Technical assistance to GFATM PRs supply plan
- TA to national HIV supply chain committee
- Conduct regular inventory management assessment
- Conduct national and provincial (3) quantification for ARVs, lab commodities and other drugs used in OI and STI.
- Coordinate use of existing stocks of ARVs and prepare a smooth transition on TDB-based regimens

SCMS Use of Site Level Stock Data

- Support quarterly provincial review of consumption data, product loss, transfer and restocking level for aggregation and use in decision-making.
- Strengthen collaboration between GF PRs and PEPFAR IPs (Consolidate stock data from GF PRs and PEPFAR IPs)

SCMS Monitoring and Supportive Supervision

- Support DPS in their technical and material capacity to fully play their supervisory role with the health facilities

SCMS Supply Chain Segmentation

- Procure and distribute essential HIV commodities [TDF-based regimens, CTX, RKT, and

Expanding task-sharing/scopes of practice for HIV service delivery

In service continuous professional education along HIV continuum of response

Pre-service education for nurses and at masters level

Pre-service education standardization of HIV curriculum

Reinforce leadership of national council for nurses

Promoting pre-/in-service training and mentoring on gender and diversity issues for relevant professions

Site-level recruitment, deployment, retention of HRH

HRH performance and quality assessment.

Revise national HTC policies and guidelines for inclusion of disclosure process and deletion of requirement of parental consent for adolescents

Support the development of national TB/HIV guidelines

Support national (MoH/PNLS) revising ART guidelines and policies, including PMTCT related standard guidelines.

essential testing supplies (gloves, capillary tubes, lancets, etc.)]. • Support risk mitigation (disposal of expired USG-procured ARV, redeployment of supplies) *Lab HIV Test and Counseling* • HIV RDTs • Quality assurance for HIV rapid testing including proficiency testing (PT panel) in Provincial HIV reference laboratories in Kinshasa, Kisangani and Lubumbashi • Evaluation of rapid HIV test kits, development of updated testing algorithm • Targeted training of lab personnel at provincial and PEPFAR site level (EID and VL sample collection/ management, HIV RDTs, logbook, data tools, etc.) • Proficiency test (PT panel) or Quality assurance for HIV RDTs) • TB screening and referral for PLHIV *Lab HIV Care and Treatment* • Baseline and routine CD_4 monitoring at PEPFAR supported sites (equipment, reagents, QA, training as needed) • VL testing for patients on ART • TB lab diagnosis (GeneXpert for TB /HIV patients) at national TB program and PEPFAR provincial levels	Regular supportive supervisory visits by provincial MOH NAC office and PEPFAR IPs to ensure high quality services and data collection SI and M&E technical considerations for pediatrics (routine program monitoring, data quality and use, evaluation, assessing M&E tools and systems to support linkage and retention, quality management and QI) Surveillance for HIV drug resistance Ensure Testing QA Support GDRC in the adoption and contextualization of WHO consolidated guidelines on HIV prevention, diagnosis, treatment, and care for Key Populations Minor renovation of health facilities Supply relevant tools (registers, medical chart, etc.) to health and community facilities Scale-up of national EID plan PMTCT Training and mentoring(Tutoring) for providers *SCMS Routine Supply Planning* • Support to the national supply chain strategic plan process • Support CDRs to improve storage and delivery	

- EID in PEPFAR supported provinces (lab reagents, sample collection consumables, data bases, data collection tools, distribution to collection sites)
- VL testing in PEPFAR-supported provinces
- Implementation of a reliable specimen transportation network in PEPFAR supported provinces (EID, VL, TB, biological monitoring)
- Strengthening of EID systems in PEPFAR supported provinces (data base completion, data use, reagents and consumables forecasting, SMS or phone base result return system and POC when validated)

Lab PMTCT

- HIV screening with RDTs
- Support procurement EID reagents and sample collection consumables

processes

- Construct the Central Medical Store (Warehouse-in-a-box)

SCMS Use of Site Level Stock Data

- Support the national Logistic Management Information System design roadmap implementation

SCMS Supply chain Segmentation

- Procure and distribute isoniazid.
- Develop and operationalize integrated distribution systems and networks, and information-management systems with Family Planning program.

Lab HIV Care and Treatment

- Biological monitoring (Hemoglobin, Creatinine, ASAT, ALAT)
- Strengthening lab capacity (training of staff, etc.)
- Minor renovation of laboratory facilities in high volume, high burden sites
- Implementation of an internal quality assurance program for all HIV core tests
- Support for epidemiological surveys (RDTs, equipment and method assessment)
- Development of a VL scale-up plan

		• Development of an EID scale-up plan • Maintenance and repair of laboratory equipment at PEPFAR supported clinical sites.

Table A.3 Transition Plans for Non-core Activities						
Transitioning Activities	**Type of Transition**	**Funding in COP 15**	**Estimated Funding in COP 16**	**# of IMs**	**Transition End date**	**Notes**
Care and Treatment (including key populations)						
Palliative care (pain and symptom management; end of life care)	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, MALAMU, ICAP, SANRU, PSI
Mental Health and substance/alcohol abuse and HIV care	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, MALAMU, ICAP, SANRU, PSI
Hepatitis B screening	Transition to Government or local partner		NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, MALAMU, ICAP, SANRU, PSI
Laboratory monitoring: protein testing, glucose.	Transition to Government or GFATM			7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
Distribution of insecticide treated bed nets to PLHIV and households.	Phasing out	0	NA	13	Sept 2016	PRoVIC, IHP, ROADS, LINKAGES, FANTA III, LIFT II, ASSIST, TB Challenge, KIMIA, MALAMU, ICAP, SANRU, PSI
SCMS Routine Supply Planning- Design a parallel supply plan (PEPFAR only)	Phasing out	0	NA	1	Sept 2016	SCMS
SCMS Supply Chain	Phasing out	0	NA	7	Sept 2016	ProVIC, ICAP, KIMIA,

Segmentation- Store HIV commodities in partners' offices					MALAMU, SANRU, PSI, SCMS
Lab HIV Care and Treatment:Support of laboratory reagents (DNA PCR and VL) in the PEPFAR focus provinces (Katanga, Kinshasa and Orientale)	Transition to Government or GFATM	NA	7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
LAB HIV Care and Treatment: Biological monitoring (ASAT, ALAT, creatinine, Glucose)	Transition to Government or GFATM	NA	7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
LAB HIV Care and Treatment: Lab biosafety (waste management, biosafety)	Transition to Government or GFATM	NA	7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
LAB HIV Care and Treatment: Maintenance and Certification of equipment	Transition to Government or Global Fund	NA	7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
LAB PMTCT: Support of EID Reagents	Transition to Government or GFATM	NA	7	Sept 2016	PRoVIC, IHP, KIMIA, MALAMU, ICAP, SANRU, PSI
Totals					

Table A.4: Comparison of PEPFAR DRC PACKAGE OF SERVICES (Saturation versus Sustained Support)

Health zone implementation approach	
Scale-up to Saturation	**Sustained Support**
-Saturation plan (ART saturation: FY15: 40%, FY16: 30%, FY17: 30%) - Scale-up geographically to improve accessibility - Accelerated (monthly) supportive supervisory visits to improve quality based on SIMS dashboard -Intensive technical assistance (Training and mentoring) on Adult/pediatric ART, PMTCT, TB/HIV, Care and treatment, lab, OVC, Referral system, commodities forecasting, distribution and logistics, QA/QI, Tracking for retention, SI… -Implementation of core and near core activities -Routine monitoring and surveillance	- Sustained plan: ART for current patients, passive enrollment (10% of increase each year) FY16-17 -No new sites (No geographic expansion) -Quarterly supportive supervisory visits to improve quality based on SIMS dashboard -Tailored technical assistance on care and treatment, lab, and supply chain management. -Routine monitoring and surveillance

Package of services offered at the site level		
Technical Domain	**Scale-up to saturation**	**Sustained Support**
HTC	<u>Aggressive demand creation:</u> **PITC for:** -PP (Pregnant women and their families, TB patients, military, truckers, children at high risk of HIV, and AGYW) KPs (MSM, FSW and their client) -Family members of index cases. -EID **VCT**	<u>No demand creation:</u> **PITC for:** -TB and suspected TB patients - Patients with HIV symptoms - PMTCT • Testing provided to all pregnant women in high yield sites (HTC ≥4 and PMTCT ≥ 4) • No Testing to low yield sites (HTC< 4 and PMTCT < 4) • EID - KPs (MSM, FSW and their clients) in hot spots locations
Treatment	- ART to saturate 80% of PLVHIV (adult and pediatric) by 2017	-ART to current on treatment (No saturation requirement)

	- ARVs/ commodities provision for all patients on ART - Active linkage to care -Active tracking of patients (Tier.net, paper based system, etc.) - CD_4 (eligibility), VL (once a year) sample collection and transportation	-ARVs/commodities provision -Active linkage to care -Active tracking of patients (Tier.net, paper based system, etc.) - CD_4 (eligibility), VL (once a year) sample collection and transportation
Care	**Clinical care:** -Regular clinical/WHO staging -Screen for TB and referral -Screen for STIs, and co-morbidities -CTX prophylaxis -INH prophylaxis -Nutritional assessment **Psychosocial, retention & adherence support**: -Peer support -Education in risk-reduction and prevention strategies -Expansion of innovative adherence/retention practices: mentor mothers, patients experts, Community based Point of ARV distribution (PoDi) -Active tracking of patients	**Clinical care**: -Regular clinical/WHO staging -Screen for TB and referral -Screen for STIs, and co-morbidities -CTX prophylaxis -INH prophylaxis -Nutritional assessment **Psychosocial, retention & adherence support:** -Peer support -Education in risk-reduction and prevention strategies - Innovative adherence/retention practices: mentor mothers, patients experts, community based Point of ARV distribution (PoDi) -Active tracking of patients
OVC	-Case management -Access/Referral to HIV services (EID, HTC, Care and Treatment) -Child Protection including GBV (community prevention and response, positive parenting and discipline,) -Economic Strengthening (saving groups and conditional cash transfer) -Education (block grants for primary schools, ECD)	-Training of social workers -Mapping of available services

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$10,475,794	$51,524,206	$62,000,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	4,440,000
HVAB	Abstinence/Be Faithful Prevention	173,094
HVOP	Other Sexual Prevention	2,746,122
IDUP	Injecting and Non-Injecting Drug Use	NA
HMBL	Blood Safety	0
HMIN	Injection Safety	440,000
CIRC	Male Circumcision	NA
HVCT	Counseling and Testing	3,353,977
HBHC	Adult Care and Support	9,185,227
PDCS	Pediatric Care and Support	4,285,000
HKID	Orphans and Vulnerable Children	5,059,759
HTXS	Adult Treatment	7,395,000
HTXD	ARV Drugs	5,700,000
PDTX	Pediatric Treatment	2,735,000
HVTB	TB/HIV Care	4,190,000
HLAB	Lab	1,705,000
HVSI	Strategic Information	2,160,000
OHSS	Health Systems Strengthening	1,680,000
HVMS	Management and Operations	6,751,821

B.2 Resource Projections

Adjustments were made to Unit Expenditures (UEs) as follows:

- For Sustained support HZs, geographic UEs were reduced by the amounts dedicated to investments (training, construction, motor vehicles, equipment) these amounts were calculated on the basis of the proportions dedicated to each of these input categories in the PEPFAR UE (as indicated in the PEPFAR Budget Allocation Calculator- PBAC).
- For Scale up to Saturation HZs, in general geographic UEs were used without any adjustments. Some exceptions:
    - Option B+ U: Used geographic UEs for adults on care because the cost was very high due to start-up costs for Option B+, but now that Option B+ has been scaled up, we estimate a similar cost to that for an adult on care
    - OVC UE: In Kinshasa, PEPFAR UE was used instead of the geographic UE. The DRC's OVC target significantly declined in 2013 and 2014 due to a project close-out, therefore the reported OVC UE was dramatically inflated, especially in Kinshasa. In Katanga, the PEPFAR UE was adjusted to reflect higher implementation costs outside of the capital and is roughly half of the geographic UE for Katanga ($359.08 compared to $180).
    - GPY-PREV: Used PEPFAR UE instead of the geographic UEs because the geographic level results were poorly reported.
    - KP-PREV MSM and KP-PREV FSW: Used PEPFAR UE for Orientale because IPs did not report expenditures in Orientale
- The military UEs were calculated as a weighted average across the 3 provinces using their targets because of same specificities with Military area.

Resource allocation versus PBAC budget: The submitted resource allocation (Table B.1.2) and the PBAC generated budget are different for the following reasons:

- MTCT (difference of $959, 401) the current UEs reported by IPs show a large discrepancy between ICAP (with a lower UE) and EGPAF (with a higher UE). A deeper analysis revealed that most of the ICAP Health Zones (HZ) overlap with GFATM interventions whose investments contribute to lowering the expenditure as result of co-location. Due to the rationalization process and expected withdrawal of GF investments from health zones starting in FY 2016, the UE in those zones will increase.
- An interagency TDY to Katanga and Kinshasa in September 2013 identified several weaknesses in HIV care and treatment outcomes in DRC, such as low adherence and retention rates. Over the past two years, PEPFAR DRC has

focused on filling these gaps at the site level by reinforcing facility and community providers' capacity and introducing innovative approaches to patient adherence and retention, such as electronic-based tracking. While some progress has been made, improvements are still needed for both PEPFAR DRC as well as for GFATM-supported sites, as the loss to follow-up rate is over 30%. In order to achieve significant improvements, additional investment in HBHC and HTXS budget codes in COP15 is required. This investment is even more critical given that, during FY15 and 16, PEPFAR will 'inherit' several sites previously supported by GFATM as part of the PNLS-led health zone rationalization process—and many GF sites will need intensive capacity building to address poor performance. Therefore, PEPFAR DRC has included lump sums of $971,681 and $1,000,000 within the planned budget amounts for HBHC and HTXS, respectively. These lump sums will support additional capacity building activities directly linked to improved patient outcomes and epidemic control, including the training of facility and community –based health care providers, training for peer support groups and other community support mechanisms, and training on the PEPFAR package of care and support. In addition, the lump sums will support enhanced patient monitoring and follow-up.

Table B.2.1 Adjustments to the Key Unit Expenditures				
	Key unit expenditures	**2014 EA UE**	**Adjusted Scale-Up UE**	**Adjusted SustainedUE**
KINSHASA	Adult ART (less ARVs)	$254.67	$254.67	229.00
	Pediatric ART (less ARVs)	$285.15	285.15	$276.57
	Adult Pre-ART	$142.74	$142.74	137.89
	Pediatric Pre-ART	$195.26	$195.26	$188.59
	Option B+	$612.63	$254.67	$229.00
	Pregnant women tested	$9.00	$9.00	$8.82
	Infants tested	$291.00	$291.00	$279.36
	Infant in care	2,659.91	2,659.91	2,659.91
	HTC (all modalities)	$7.00	7.00	6.58
	OVC	$19,589.00	$116.32	116.32
	GPY-PREV (all sub-categories)	$231.00	$6.18	5.23
	KP-PREV FSW	$53.00	$53.00	45.58
	KP-PREV MSM	$274.00	$274.00	243.86
KATANGA	Adult ART (less ARVs)	$170.20	$170.20	$129.95
	Pediatric ART (less ARVs)	$206.53	$206.53	$202.40
	Adult Pre-ART	$111.88		$108.52
	Pediatric Pre-ART	$141.65	$141.65	$137.40

	Option B+	$672.90	$170.20	$129.95
	Pregn. Women tested	$9.00	$9.00	$8.82
	Infant Tested	$495.62	$495.62	$475.80
	Infant in care	$2,249.53	$2,249.53	$2,249.53
	HTC (all modalities)	$13.00	13.00	$12.22
	OVC	$808	$180	$71.82
	GPY-PREV (all sub-categories)	$17.00	$6.18	$5.23
	KP-PREV FSW	$49.00	$49.00	$42.14
	KP-PREV MSM	$135.19	135.19	$120.32
ORIENTALE	Adult ART (less ARVs)	$694.11	NA	$673.87
	Pediatric ART (less ARVs)	$644.95	NA	$625.59
	Adult Pre-ART	$373.82	NA	$362.61
	Pediatric Pre-ART	$436.00	NA	$422.66
	Option B+	$2,930	NA	$673.87
	Pregn. Women tested	$13.00	NA	$12.74
	Infant Tested	$331.15	NA	$317.90
	Infants in care	$8,808.88	NA	$8,808.88
	HTC (all modalities)	$12.00	NA	$11.28
	OVC	$344	NA	$180
	GPY-PREV (all sub-categories)	$3,324.00	NA	$5.23

	KP-PREV FSW	$29.38	NA	$25.27
	KP-PREV MSM	$135.19	NA	$120.32
MILITARY	Adult ART (less ARVs)		$224.68	
	Pediatric ART (less ARVs)		$272.17	
	Adult Pre-ART		$143.15	
	Pediatric Pre-ART		$180.08	
	Infant Tested		$363.63	
	Infant in care		$2,542.66	
	Option B+		$244.9137	
	Pregn. Women tested		$8.78	
	HTC (all modalities)		$9.95	
	OVC		$270.21	
	GPY-PREV (all sub-categories)		$6.18	
	KP-PREV FSW		$29.38	
	KP-PREV MSM		$135.19	

Democratic Republic of the Congo FY15 Targets by Health Zone: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Abanagomo	-	-	-	-	-
Adi	-	-	-	-	-
Adingi CS	-	-	-	-	-
Amee CH	-	-	-	-	-
Anoalite	-	-	-	-	-
Ariwara	-	-	-	-	-
Avu CS	-	-	-	-	-
Babia	-	-	-	-	-
Badara	-	-	-	-	-
Bagoya	-	-	-	-	-
Bahumbu 1	-	-	-	-	-
Bahumbu 2	-	-	-	-	-
Bambole	-	-	-	-	-
Bambu	-	-	-	-	-
Bandalungwa	2,592	48	239	50	208
Bandalungwa	1,111	21	103	21	89
Barumbu	3,930	145	725	187	781
Bavemo	-	-	-	-	-
Bayenga	-	-	-	-	-
Bibwa	-	-	-	-	-
Binza Meteo	596	40	164	60	200
Binza Météo	-	-	-	-	-
Binza-Meteo	2,081	79	431	138	621
Binza-Meteo	1,220	54	271	90	374
Binza-Ozone	4,899	128	1,176	132	1,024
Binza-Ozone	732	142	176	150	153
Biyela	2,406	89	443	93	386
Boma	-	-	-	-	-
Boma	-	-	-	-	-
Boma	-	-	-	-	-
Bombula	-	-	-	-	-
Bondeko	-	-	-	-	-
Bondeko-Mangobo CS	-	-	-	-	-
Boyoma	-	-	-	-	-
Bozunzu	-	-	-	-	-
Bukama	-	-	-	-	-
Bukama	-	-	-	-	-
Buma	-	-	-	-	-
Bumbu	6,159	227	1,136	238	987
Bunia	-	-	-	-	-
Bunia	-	-	-	-	-
Bunkeya	-	-	-	-	-
Camp Munganga	-	-	-	-	-
Cite des anciens combattants	-	-	-	-	-
De La Paix	-	-	-	-	-
Dilala	-	-	-	-	-
Dilala	-	-	-	-	-
Dingi Dingi	-	-	-	-	-
Etakamukongo	-	-	-	-	-
Fataki	-	-	-	-	-
Fleuve	-	-	-	-	-
Foyer	-	-	-	-	-
Fungurume	-	-	-	-	-
Gombe	303	34	166	12	49

Democratic Republic of the Congo FY15 Targets by Health Zone: Clinical Cascade

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Gwoknyeri CS	-	-	-	-	-
Ibambi Etat	-	-	-	-	-
Irumu	-	-	-	-	-
Kabondo	243	11	56	12	49
Kabondo	-	-	-	-	-
Kabongo	-	-	-	-	-
Kafubu	10,144	202	1,009	376	878
Kalamu 1	8,362	225	1,127	235	980
Kalamu 2	2,185	81	403	84	350
Kalamu 2	68	2	12	3	11
Kamalondo	4,836	147	735	126	639
Kambove	774	33	167	35	145
Kamina	-	-	-	-	-
Kampemba	3,952	47	369	73	326
Kampemba	4,689	157	652	248	562
Kanzenze	-	-	-	-	-
Kapolowe	-	-	-	-	-
Kasa-Vubu	550	14	72	15	62
Kasa-Vubu	3,341	87	436	91	379
Kasenga	2,193	104	519	110	452
Kashobwe	396	16	80	17	70
Katuba	20,062	451	2,253	736	1,959
Kayamba	-	-	-	-	-
Kenya	273	4	10	3	8
Kenya	1,877	76	389	75	339
Kikimi	-	-	-	-	-
Kikimi	10,927	265	1,277	401	1,111
Kikimi	-	-	-	-	-
Kikondja	-	-	-	-	-
Kikula	322	15	38	16	39
Kikula	850	40	238	42	201
Kilwa	3,826	182	909	190	790
Kimbanseke	3,551	270	1,349	381	1,173
Kimbondo	-	-	-	-	-
Kingabwa	7,532	84	238	269	677
Kingabwa 1	-	-	-	-	-
Kingasani	-	-	-	-	-
Kingasani	3,851	101	503	139	437
Kingasani	476	156	62	17	54
Kinshasa	2,573	120	602	126	523
Kinshasa	-	-	-	-	-
Kinsuka pecheurs	-	-	-	-	-
Kintambo	13,327	493	2,458	518	2,137
Kipushi	5,448	260	1,300	271	1,131
Kisanga	7,641	227	1,530	267	1,504
Kisanga	9,143	319	1,200	342	870
Kisenso	563	20	104	42	178
Kitenge	-	-	-	-	-
Kiwanuka	-	-	-	-	-
Kokolo	-	-	-	-	-
Kokolo	-	-	-	-	-
Kokolo	-	-	-	-	-
Kokolo	-	-	-	-	-
Kokolo	-	-	-	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Clinical Cascade

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Kokolo	-	-	-	-	-
Kondima	-	-	-	-	-
Kongolo	2,481	43	214	95	186
La Famille	-	-	-	-	-
Lemba	5,784	214	1,067	222	928
Likasi	7,044	286	1,429	349	1,243
Limete	2,608	123	610	128	531
Lingwala	14,339	693	3,464	723	3,012
Losoko	-	-	-	-	-
Lualaba	-	-	-	-	-
Lubudi	-	-	-	-	-
Lubumbashi	481	539	2,656	-	2,295
Lubumbashi	68	9	26	-	37
Lubunga	341	12	61	13	53
Luga CS	-	-	-	-	-
Luilu	-	-	-	-	-
Lukula	-	-	-	-	-
Lukunga	-	-	-	-	-
M'Finda	-	-	-	-	-
Makala	2,827	105	521	109	454
Makiso	-	-	-	-	-
Makiso-Kisangani	2,443	114	571	119	497
Makiso-Kisangani	-	-	-	-	-
Mako	-	-	-	-	-
Malemba-Nkulu	-	-	-	-	-
Maluku 1	2,604	90	480	5	21
Maluku 2	70	3	13	3	11
Maman Kahenga	-	-	-	-	-
Maman Yemo	-	-	-	-	-
Mangobo	589	24	119	25	103
Mangobo	-	-	-	-	-
Manika	-	-	-	-	-
Manika	-	-	-	-	-
Manono	2,014	35	174	77	151
Masina 1	4,391	164	821	158	714
Masina 2	-	-	-	-	-
Masina 2	3,002	64	320	13	278
Matadi	-	-	-	-	-
Matete	4,003	187	939	196	816
Matete	-	-	-	-	-
Mayamba	-	-	-	-	-
Mayogo	-	-	-	-	-
Medje	-	-	-	-	-
Mikondo	-	-	-	-	-
Mikonga	-	-	-	-	-
Moanda	-	-	-	-	-
Moba	2,281	39	197	88	171
Mokili	-	-	-	-	-
Mokili CS	-	-	-	-	-
Mongbwalu	-	-	-	-	-
Mont Ngafula 1	1,457	62	337	69	298
Mont Ngafula 2	520	-	-	-	-
Mont-Ngafula 1	727	19	66	15	52
Mont-Ngafula 1	2,098	77	387	81	337

Democratic Republic of the Congo FY15 Targets by Health Zone: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Mont-Ngafula 2	5,988	313	1,564	326	1,360
Mont-Ngafula 2	343	16	82	17	72
Mpasa 1	-	-	-	-	-
Mpasa 2	-	-	-	-	-
Mulongo	-	-	-	-	-
Mumbunda	24,383	572	2,858	896	2,485
Musey	-	-	-	-	-
Mutshatsha	-	-	-	-	-
Muungano	-	-	-	-	-
N'sele (Isiro)	-	-	-	-	-
N'sele (N'sele)	-	-	-	-	-
Ndanu 1	-	-	-	-	-
Ndjili	2,462	359	1,794	51	1,561
Nehema	-	-	-	-	-
Neisu	-	-	-	-	-
Ngaba	4,099	196	977	204	849
Ngiri Ngiri	967	36	178	37	155
Ngiri-Ngiri	171	6	31	7	27
Ngote CS	-	-	-	-	-
Nizi	-	-	-	-	-
Nsele	3,221	152	748	159	662
Nyemba	2,305	40	199	89	173
Nyunzu	1,921	33	166	74	144
Nzanza	-	-	-	-	-
Panda	-	-	-	-	-
Panda	665	32	159	33	138
Pawa	-	-	-	-	-
Pecheur	-	-	-	-	-
Pende	-	-	-	-	-
Police	413	14	38	16	45
Police	493	19	129	19	100
Police	1,417	52	261	55	227
Pweto	2,490	117	584	123	508
Pêcheur d'Homme	-	-	-	-	-
Rethy	-	-	-	-	-
Rimba CH	-	-	-	-	-
Ruashi	703	15	64	22	44
Rwampara	-	-	-	-	-
Rwashi	9,460	209	1,056	353	930
Sakania	-	-	-	-	-
Sakania	-	-	-	-	-
Sakania	7,155	266	1,331	278	1,158
Selembao	4,082	151	753	157	654
Songa	-	-	-	-	-
St André	-	-	-	-	-
St Camille	-	-	-	-	-
TBD1 - Kabondo	-	-	-	-	-
TBD1 - Mangobo	-	-	-	-	-
TBD2 - Kabondo	-	-	-	-	-
TBD2 - Mangobo	-	-	-	-	-
TBD3 - Kabondo	-	-	-	-	-
TBD3 - Mangobo	-	-	-	-	-
TBD4 - Kabondo	-	-	-	-	-
TBD4 - Mangobo	-	-	-	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Clinical Cascade

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TBD5 - Kabondo	-	-	-	-	-
TBD6 - Kabondo	-	-	-	-	-
TBD7 - Kabondo	-	-	-	-	-
TBD8 - Kabondo	-	-	-	-	-
TBD9 - Kabondo	-	-	-	-	-
Tely	-	-	-	-	-
Tshamilemba	16,663	460	2,298	617	1,998
Tshopo	414	17	96	19	82
Tshopo	303	14	60	14	53
Umoja	-	-	-	-	-
Unyebo CS	-	-	-	-	-
Uzima	-	-	-	-	-
Vangu	-	-	-	-	-
Wandugu	-	-	-	-	-
Total	312,294	11,207	55,025	12,485	48,519
TBD3 - Mangobo	-	-	-	-	-
TBD4 - Kabondo	-	-	-	-	-
TBD4 - Mangobo	-	-	-	-	-
TBD5 - Kabondo	-	-	-	-	-
TBD6 - Kabondo	-	-	-	-	-
TBD7 - Kabondo	-	-	-	-	-
TBD8 - Kabondo	-	-	-	-	-
TBD9 - Kabondo	-	-	-	-	-
Tely	-	-	-	-	-
Tshamilemba	16,663	460	2,298	617	1,998
Tshangu	36,961	1,713	7,810	1,420	6,408
Tshopo	4,333	192	963	202	837
Tshopo	414	17	96	19	82
Tshopo	303	14	60	14	53
Umoja	-	-	-	-	-
Unyebo CS	-	-	-	-	-
Uzima	-	-	-	-	-
Vangu	-	-	-	-	-
Wandugu	-	-	-	-	-
Total	**624,588**	**22,414**	**110,050**	**24,970**	**97,038**

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Abanagomo	-	-	-
Adi	-	-	-
Adingi CS	-	-	-
Amee CH	-	-	-
Anoalite	-	-	-
Ariwara	-	-	-
Avu CS	-	-	-
Babia	-	-	-
Badara	-	-	-
Bagoya	-	-	-
Bahumbu 1	-	-	-
Bahumbu 2	-	-	-
Bambole	-	-	-
Bambu	-	-	-
Bandalungwa	-	-	-
Bandalungwa	-	-	-
Barumbu	-	-	-
Bavemo	-	-	-
Bayenga	-	-	-
Bibwa	-	-	-
Binza Meteo	-	561	-
Binza Météo	-	-	-
Binza-Meteo	-	-	-
Binza-Meteo	-	-	-
Binza-Ozone	-	-	-
Binza-Ozone	-	-	-
Biyela	-	-	-
Boma	-	-	-
Boma	-	-	-
Boma	-	-	-
Bombula	-	-	-
Bondeko	-	-	-
ondeko-Mangobo C	-	-	-
Boyoma	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Bozunzu	-	-	-
Bukama	-	-	-
Bukama	-	-	-
Buma	-	-	-
Bumbu	-	-	-
Bunia	-	-	-
Bunia	-	-	-
Bunkeya	-	-	-
Camp Munganga	-	-	-
des anciens combat	-	-	-
De La Paix	-	-	-
Dilala	-	-	-
Dilala	-	-	-
Dingi Dingi	-	-	-
Etakamukongo	-	-	-
Fataki	-	-	-
Fleuve	-	-	-
Foyer	-	-	-
Fungurume	-	-	-
Gombe	-	-	-
Gwoknyeri CS	-	-	-
Ibambi Etat	-	-	-
Irumu	-	-	-
Kabondo	-	-	-
Kabondo	-	-	-
Kabongo	-	-	-
Kafubu	-	-	-
Kalamu 1	-	2,520	-
Kalamu 2	-	-	-
Kalamu 2	-	-	-
Kamalondo	-	2,005	-
Kambove	-	-	-
Kamina	-	-	-
Kampemba	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Kampemba	-	-	-
Kanzenze	-	-	-
Kapolowe	-	-	-
Kasa-Vubu	-	1,400	-
Kasa-Vubu	-	-	-
Kasenga	-	-	-
Kashobwe	-	-	-
Katuba	-	-	-
Kayamba	-	-	-
Kenya	-	-	-
Kenya	-	-	-
Kikimi	-	-	-
Kikimi	-	-	-
Kikimi	-	-	-
Kikondja	-	-	-
Kikula	-	-	-
Kikula	-	-	-
Kilwa	-	-	-
Kimbanseke	-	-	-
Kimbondo	-	-	-
Kingabwa	-	-	-
Kingabwa 1	-	-	-
Kingasani	-	-	-
Kingasani	-	-	-
Kingasani	-	-	-
Kinshasa	-	-	-
Kinshasa	-	-	-
Kinsuka pecheurs	-	-	-
Kintambo	-	-	-
Kipushi	-	-	-
Kisanga	-	-	-
Kisanga	-	1,336	-
Kisenso	-	-	-
Kitenge	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Kiwanuka	-	-	-
Kokolo	-	-	-
Kokolo	-	-	-
Kokolo	-	-	-
Kokolo	-	-	-
Kokolo	-	-	-
Kokolo	-	-	-
Kondima	-	-	-
Kongolo	-	-	-
La Famille	-	-	-
Lemba	-	-	-
Likasi	-	-	-
Limete	-	-	-
Lingwala	-	-	-
Losoko	-	-	-
Lualaba	-	-	-
Lubudi	-	-	-
Lubumbashi	-	-	-
Lubumbashi	-	-	-
Lubunga	-	-	-
Luga CS	-	-	-
Luilu	-	-	-
Lukula	-	-	-
Lukunga	-	-	-
M'Finda	-	-	-
Makala	-	-	-
Makiso	-	-	-
Makiso-Kisangani	-	-	-
Makiso-Kisangani	-	-	-
Mako	-	-	-
Malemba-Nkulu	-	-	-
Maluku 1	-	-	-
Maluku 2	-	-	-
Maman Kahenga	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Maman Yemo	-	-	-
Mangobo	-	-	-
Mangobo	-	-	-
Manika	-	-	-
Manika	-	-	-
Manono	-	-	-
Masina 1	-	-	-
Masina 2	-	-	-
Masina 2	-	-	-
Matadi	-	-	-
Matete	-	-	-
Matete	-	-	-
Mayamba	-	-	-
Mayogo	-	-	-
Medje	-	-	-
Mikondo	-	-	-
Mikonga	-	-	-
Moanda	-	-	-
Moba	-	-	-
Mokili	-	-	-
Mokili CS	-	-	-
Mongbwalu	-	-	-
Mont Ngafula 1	-	-	-
Mont Ngafula 2	-	-	-
Mont-Ngafula 1	-	-	-
Mont-Ngafula 1	-	-	-
Mont-Ngafula 2	-	-	-
Mont-Ngafula 2	-	-	-
Mpasa 1	-	-	-
Mpasa 2	-	-	-
Mulongo	-	-	-
Mumbunda	-	-	-
Musey	-	-	-
Mutshatsha	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Muungano	-	-	-
N'sele (Isiro)	-	-	-
N'sele (N'sele)	-	-	-
Ndanu 1	-	-	-
Ndjili	-	2,520	-
Nehema	-	-	-
Neisu	-	-	-
Ngaba	-	-	-
Ngiri Ngiri	-	-	-
Ngiri-Ngiri	-	-	-
Ngote CS	-	-	-
Nizi	-	-	-
Nsele	-	-	-
Nyemba	-	-	-
Nyunzu	-	-	-
Nzanza	-	-	-
Panda	-	-	-
Panda	-	-	-
Pawa	-	-	-
Pecheur	-	-	-
Pende	-	-	-
Police	-	-	-
Police	-	-	-
Police	-	-	-
Pweto	-	-	-
Pêcheur d'Homme	-	-	-
Rethy	-	-	-
Rimba CH	-	-	-
Ruashi	-	-	-
Rwampara	-	-	-
Rwashi	-	-	-
Sakania	-	-	-
Sakania	-	-	-
Sakania	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Selembao	-	-	-
Songa	-	-	-
St André	-	-	-
St Camille	-	-	-
TBD1 - Kabondo	-	-	-
TBD1 - Mangobo	-	-	-
TBD2 - Kabondo	-	-	-
TBD2 - Mangobo	-	-	-
TBD3 - Kabondo	-	-	-
TBD3 - Mangobo	-	-	-
TBD4 - Kabondo	-	-	-
TBD4 - Mangobo	-	-	-
TBD5 - Kabondo	-	-	-
TBD6 - Kabondo	-	-	-
TBD7 - Kabondo	-	-	-
TBD8 - Kabondo	-	-	-
TBD9 - Kabondo	-	-	-
Tely	-	-	-
Tshamilemba	-	-	-
Tshopo	-	-	-
Tshopo	-	-	-
Umoja	-	-	-
Unyebo CS	-	-	-
Uzima	-	-	-
Vangu	-	-	-
Wandugu	-	-	-
Total	-	10,342	-
TBD3 - Mangobo	-	-	-
TBD4 - Kabondo	-	-	-
TBD4 - Mangobo	-	-	-
TBD5 - Kabondo	-	-	-
TBD6 - Kabondo	-	-	-
TBD7 - Kabondo	-	-	-
TBD8 - Kabondo	-	-	-

Democratic Republic of the Congo FY 15 Targets by Health Zone: Key, Priority, Orphan and Vulnerable

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
TBD9 - Kabondo	-	-	-
Tely	-	-	-
Tshamilemba	-	-	-
Tshangu	-	2,520	-
Tshopo	-	-	-
Tshopo	-	-	-
Tshopo	-	-	-
Umoja	-	-	-
Unyebo CS	-	-	-
Uzima	-	-	-
Vangu	-	-	-
Wandugu	-	-	-
Total	**-**	**20,684**	**-**

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Abanagomo	-	-
Adi	-	-
Adingi CS	-	-
Amee CH	-	-
Anoalite	-	-
Ariwara	-	-
Avu CS	-	-
Babia	-	-
Badara	-	-
Bagoya	-	-
Bahumbu 1	-	-
Bahumbu 2	-	-
Bambole	-	-
Bambu	-	-
Bandalungwa	587	10
Bandalungwa	252	4
Barumbu	1,779	30
Bavemo	-	-
Bayenga	-	-
Bibwa	-	-
Binza Meteo	247	1
Binza Météo	-	-
Binza-Meteo	1,214	24
Binza-Meteo	666	11
Binza-Ozone	2,888	49
Binza-Ozone	432	7
Biyela	1,089	19
Boma	-	-
Boma	-	-
Boma	-	-
Bombula	-	-
Bondeko	-	-
Bondeko-Mangobo CS	-	-
Boyoma	-	-
Bozunzu	-	-
Bukama	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Bukama	-	-
Buma	-	-
Bumbu	2,788	47
Bunia	-	-
Bunia	-	-
Bunkeya	-	-
Camp Munganga	-	-
des anciens combatt	-	-
De La Paix	-	-
Dilala	-	-
Dilala	-	-
Dingi Dingi	-	-
Etakamukongo	-	-
Fataki	-	-
Fleuve	-	-
Foyer	-	-
Fungurume	-	-
Gombe	408	6
Gwoknyeri CS	-	-
Ibambi Etat	-	-
Irumu	-	-
Kabondo	138	2
Kabondo	-	-
Kabongo	-	-
Kafubu	4,750	75
Kalamu 1	2,767	47
Kalamu 2	989	16
Kalamu 2	31	1
Kamalondo	1,587	25
Kambove	409	7
Kamina	-	-
Kampemba	1,982	28
Kampemba	2,066	36
Kanzenze	-	-
Kapolowe	-	-
Kasa-Vubu	176	3

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Kasa-Vubu	1,070	18
Kasenga	1,275	22
Kashobwe	197	3
Katuba	9,295	147
Kayamba	-	-
Kenya	73	1
Kenya	910	15
Kikimi	-	-
Kikimi	5,072	80
Kikimi	-	-
Kikondja	-	-
Kikula	139	1
Kikula	538	11
Kilwa	2,231	38
Kimbanseke	4,810	76
Kimbondo	-	-
Kingabwa	3,397	54
Kingabwa 1	-	-
Kingasani	-	-
Kingasani	1,758	28
Kingasani	217	3
Kinshasa	1,477	25
Kinshasa	-	-
Kinsuka pecheurs	-	-
Kintambo	6,034	103
Kipushi	3,192	54
Kisanga	2,617	39
Kisanga	5,075	83
Kisenso	245	4
Kitenge	-	-
Kiwanuka	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Kokolo	-	-
Kondima	-	-
Kongolo	1,124	19
La Famille	-	-
Lemba	2,619	45
Likasi	4,104	70
Limete	1,498	26
Lingwala	8,504	145
Losoko	-	-
Lualaba	-	-
Lubudi	-	-
Lubumbashi	-	-
Lubumbashi	-	-
Lubunga	149	3
Luga CS	-	-
Luilu	-	-
Lukula	-	-
Lukunga	-	-
M'Finda	-	-
Makala	1,280	22
Makiso	-	-
Makiso-Kisangani	1,402	24
Makiso-Kisangani	-	-
Mako	-	-
Malemba-Nkulu	-	-
Maluku 1	1,179	20
Maluku 2	32	1
Maman Kahenga	-	-
Maman Yemo	-	-
Mangobo	292	5
Mangobo	-	-
Manika	-	-
Manika	-	-
Manono	911	15
Masina 1	1,992	32
Masina 2	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Masina 2	176	3
Matadi	-	-
Matete	2,305	40
Matete	-	-
Mayamba	-	-
Mayogo	-	-
Medje	-	-
Mikondo	-	-
Mikonga	-	-
Moanda	-	-
Moba	1,033	18
Mokili	-	-
Mokili CS	-	-
Mongbwalu	-	-
Mont Ngafula 1	1,201	23
Mont Ngafula 2	-	-
Mont-Ngafula 1	659	8
Mont-Ngafula 1	950	16
Mont-Ngafula 2	3,840	65
Mont-Ngafula 2	202	3
Mpasa 1	-	-
Mpasa 2	-	-
Mulongo	-	-
Mumbunda	11,317	179
Musey	-	-
Mutshatsha	-	-
Muungano	-	-
N'sele (Isiro)	-	-
N'sele (N'sele)	-	-
Ndanu 1	-	-
Ndjili	648	10
Nehema	-	-
Neisu	-	-
Ngaba	2,398	41
Ngiri Ngiri	438	7
Ngiri-Ngiri	77	1

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ngote CS	-	-
Nizi	-	-
Nsele	1,870	31
Nyemba	1,044	18
Nyunzu	870	15
Nzanza	-	-
Panda	-	-
Panda	390	7
Pawa	-	-
Pecheur	-	-
Pende	-	-
Police	168	3
Police	242	4
Police	642	11
Pweto	1,434	24
Pêcheur d'Homme	-	-
Rethy	-	-
Rimba CH	-	-
Ruashi	324	4
Rwampara	-	-
Rwashi	4,413	71
Sakania	-	-
Sakania	-	-
Sakania	3,268	56
Selembao	1,849	31
Songa	-	-
St André	-	-
St Camille	-	-
TBD1 - Kabondo	-	-
TBD1 - Mangobo	-	-
TBD2 - Kabondo	-	-
TBD2 - Mangobo	-	-
TBD3 - Kabondo	-	-
TBD3 - Mangobo	-	-
TBD4 - Kabondo	-	-
TBD4 - Mangobo	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Breastfeeding and

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
TBD5 - Kabondo	-	-
TBD6 - Kabondo	-	-
TBD7 - Kabondo	-	-
TBD8 - Kabondo	-	-
TBD9 - Kabondo	-	-
Tely	-	-
Tshamilemba	7,787	123
Tshopo	217	4
Tshopo	165	3
Umoja	-	-
Unyebo CS	-	-
Uzima	-	-
Vangu	-	-
Wandugu	-	-
Total	151,880	2,499
TBD3 - Mangobo	-	-
TBD4 - Kabondo	-	-
TBD4 - Mangobo	-	-
TBD5 - Kabondo	-	-
TBD6 - Kabondo	-	-
TBD7 - Kabondo	-	-
TBD8 - Kabondo	-	-
TBD9 - Kabondo	-	-
Tely	-	-
Tshamilemba	7,787	123
Tshangu	18,843	303
Tshopo	2,363	41
Tshopo	217	4
Tshopo	165	3
Umoja	-	-
Unyebo CS	-	-
Uzima	-	-
Vangu	-	-
Wandugu	**-**	**-**
Total	**303,760**	**4,998**

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Abanagomo	-	-
Adi	-	-
Adingi CS	-	-
Amee CH	-	-
Anoalite	-	-
Ariwara	-	-
Avu CS	-	-
Babia	-	-
Badara	-	-
Bagoya	-	-
Bahumbu 1	-	-
Bahumbu 2	-	-
Bambole	-	-
Bambu	-	-
Bandalungwa	-	-
Bandalungwa	25	3
Barumbu	133	17
Bavemo	-	-
Bayenga	-	-
Bibwa	-	-
Binza Meteo	-	-
Binza Météo	-	-
Binza-Meteo	144	19
Binza-Meteo	-	-
Binza-Ozone	283	14
Binza-Ozone	-	23
Biyela	107	14
Boma	-	-
Boma	-	-
Boma	-	-
Bombula	-	-
Bondeko	-	-
Bondeko-Mangobo CS	-	-
Boyoma	-	-
Bozunzu	-	-
Bukama	-	-
Bukama	-	-
Buma	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Bumbu	261	33
Bunia	-	-
Bunia	-	-
Bunkeya	-	-
Camp Munganga	-	-
des anciens combatt	-	-
De La Paix	-	-
Dilala	-	-
Dilala	-	-
Dingi Dingi	-	-
Etakamukongo	-	-
Fataki	-	-
Fleuve	-	-
Foyer	-	-
Fungurume	-	-
Gombe	8	1
Gwoknyeri CS	-	-
Ibambi Etat	-	-
Irumu	-	-
Kabondo	14	2
Kabondo	-	-
Kabongo	-	-
Kafubu	-	-
Kalamu 1	271	35
Kalamu 2	2	-
Kalamu 2	-	-
Kamalondo	146	19
Kambove	40	5
Kamina	-	-
Kampemba	171	21
Kampemba	203	27
Kanzenze	-	-
Kapolowe	-	-
Kasa-Vubu	-	-
Kasa-Vubu	37	5
Kasenga	125	16
Kashobwe	19	2
Katuba	858	110

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Kayamba	-	-
Kenya	-	-
Kenya	91	12
Kikimi	-	-
Kikimi	357	46
Kikimi	-	-
Kikondja	-	-
Kikula	31	4
Kikula	82	11
Kilwa	219	28
Kimbanseke	444	57
Kimbondo	-	-
Kingabwa	313	40
Kingabwa 1	-	-
Kingasani	-	-
Kingasani	162	21
Kingasani	-	-
Kinshasa	145	19
Kinshasa	-	-
Kinsuka pecheurs	-	-
Kintambo	592	78
Kipushi	313	41
Kisanga	348	47
Kisanga	362	44
Kisenso	25	3
Kitenge	-	-
Kiwanuka	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kokolo	-	-
Kondima	-	-
Kongolo	110	18
La Famille	-	-
Lemba	108	14
Likasi	402	52

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Limete	861	112
Lingwala	834	108
Losoko	-	-
Lualaba	-	-
Lubudi	-	-
Lubumbashi	-	-
Lubumbashi	-	-
Lubunga	15	2
Luga CS	-	-
Luilu	-	-
Lukula	-	-
Lukunga	-	-
M'Finda	-	-
Makala	109	14
Makiso	-	-
Makiso-Kisangani	138	18
Makiso-Kisangani	-	-
Mako	-	-
Malemba-Nkulu	-	-
Maluku 1	116	15
Maluku 2	-	-
Maman Kahenga	-	-
Maman Yemo	-	-
Mangobo	29	4
Mangobo	-	-
Manika	-	-
Manika	-	-
Manono	89	14
Masina 1	184	24
Masina 2	-	-
Masina 2	11	1
Matadi	-	-
Matete	226	30
Matete	-	-
Mayamba	-	-
Mayogo	-	-
Medje	-	-
Mikondo	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Mikonga	-	-
Moanda	-	-
Moba	101	16
Mokili	-	-
Mokili CS	-	-
Mongbwalu	-	-
Mont Ngafula 1	75	12
Mont Ngafula 2	8	-
Mont-Ngafula 1	21	-
Mont-Ngafula 1	-	-
Mont-Ngafula 2	369	49
Mont-Ngafula 2	-	-
Mpasa 1	-	-
Mpasa 2	-	-
Mulongo	-	-
Mumbunda	1,045	135
Musey	-	-
Mutshatsha	-	-
Muungano	-	-
N'sele (Isiro)	-	-
N'sele (N'sele)	-	-
Ndanu 1	-	-
Ndjili	60	7
Nehema	-	-
Neisu	-	-
Ngaba	214	28
Ngiri Ngiri	43	6
Ngiri-Ngiri	8	1
Ngote CS	-	-
Nizi	-	-
Nsele	13,950	1,814
Nyemba	102	16
Nyunzu	85	14
Nzanza	-	-
Panda	-	-
Panda	38	5
Pawa	-	-
Pecheur	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Pende	-	-
Police	7	2
Police	33	3
Police	63	8
Pweto	141	18
Pêcheur d'Homme	-	-
Rethy	-	-
Rimba CH	-	-
Ruashi	-	-
Rwampara	-	-
Rwashi	437	56
Sakania	-	-
Sakania	-	-
Sakania	320	42
Selembao	181	23
Songa	-	-
St André	-	-
St Camille	-	-
TBD1 - Kabondo	-	-
TBD1 - Mangobo	-	-
TBD2 - Kabondo	-	-
TBD2 - Mangobo	-	-
TBD3 - Kabondo	-	-
TBD3 - Mangobo	-	-
TBD4 - Kabondo	-	-
TBD4 - Mangobo	-	-
TBD5 - Kabondo	-	-
TBD6 - Kabondo	-	-
TBD7 - Kabondo	-	-
TBD8 - Kabondo	-	-
TBD9 - Kabondo	-	-
Tely	-	-
Tshamilemba	719	93
Tshopo	38	5
Tshopo	-	-
Umoja	-	-
Unyebo CS	-	-
Uzima	-	-

Democratic Republic of the Congo FY15 Targets by Health Zone: Tuberculosis (TB)

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Vangu	-	-
Wandugu	-	-
Total	27,621	3,596
TBD3 - Mangobo	-	-
TBD4 - Kabondo	-	-
TBD4 - Mangobo	-	-
TBD5 - Kabondo	-	-
TBD6 - Kabondo	-	-
TBD7 - Kabondo	-	-
TBD8 - Kabondo	-	-
TBD9 - Kabondo	-	-
Tely	-	-
Tshamilemba	719	93
Tshangu	15,391	1,999
Tshopo	234	31
Tshopo	38	5
Tshopo	-	-
Umoja	-	-
Unyebo CS	-	-
Uzima	-	-
Vangu	-	-
Wandugu	-	-
Total	**55,242**	**7,192**