

# **Democratic Republic of Congo**

## **Country Operational Plan (COP) 2017**

### **Strategic Direction Summary**

April 24, 2017



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## 1.0 Goal Statement

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In support of the National AIDS Control Program (PNLS), PEPFAR/Democratic Republic of the Congo (DRC) continues to implement a robust portfolio of programs toward the goal of epidemic control in three key provinces, which represent approximately 35 percent of the total number of people living with HIV/AIDS (PLHIV) in DRC. The strategy for the PEPFAR Country Operational Plan for the period from October 1, 2017 through September 30, 2018 (COP 2017) will continue with programmatic priorities identified and implemented in COP 2016, in addition to the introduction of new approaches with an overall emphasis on “Find, Grow and Keep Suppressed” and a special focus on Kinshasa, described in Section 4.11. The overall goals align PEPFAR with the government of DRC and the Global Fund to support the realization of 90-90-90 goals by 2020.

The PEPFAR/DRC interagency team has continued to work collaboratively with the government of DRC to develop a strategy following the rationalization that took place in FY2016, which assigned one donor per health zone (HZ) and province (DPS). Moving forward, PEPFAR/DRC will be implementing in Kinshasa and Haut-Katanga, the two provinces with the highest prevalence, as well as Lualaba, a province contiguous to Haut-Katanga which is a transportation corridor with a high concentration of sex workers and truckers. PEPFAR will support a total of 48 health zones and military sites out of 516 health zones in the country. In FY2018, PEPFAR/DRC will intensify its package of services to previously sustained support areas, providing the full saturation package in these health zones, including demand creation, with an overall goal of saturation in PEPFAR-supported areas by 2020. This will require increased investments in areas designated as sustained support in COP 2015 and 2016, as implementing partners restart targeted demand creation activities throughout all supported health zones.

Current figures put the total number of PLHIV in PEPFAR supported health zones at 135,648. Through consultations with the government of DRC and civil society, aggressive targets have been set for COP 2017 which will see an addition of 31,778 new people on treatment, leading to 62 percent coverage of PLHIV on treatment by April 2018. Intensive and zone-specific strategies are being introduced during FY2017 (post DCMM discussions) to boost the number of new and current patients, thus allowing for a steady and strong increase and retention of patients to reach saturation by 2020.

One of the main challenges to epidemic control is to identify HIV positive people (1st 90). New testing strategies will be implemented during COP 2016 and COP 2017 with the intention of further bolstering the yield, a critical step to ensure adequate case finding and optimal linkage to ART.

In order to optimize identification of PLHIV and link them to treatment, care, and support programs, PEPFAR/DRC will initiate a shift in strategy that includes:

- A. Optimizing provider-initiated testing and counseling (PITC) in outpatient departments, TB clinics, inpatient wards (including pediatrics), prevention of mother-to-child transmission (PMTCT), and nutrition services within facilities
- B. Increasing aggressive tracking of partners of index cases
- C. Scaling up community-based HIV testing services (mobile and index modalities) to find hard-to-reach men, adolescents and key populations
- D. Introducing sexual networking and partner notification strategies in order to provide HTS and treatment services to hard-to-reach key populations (KPs)
- E. Using the orphans and vulnerable children (OVC) platforms to test OVCs and children of KPs
- F. Integrating supervised self-testing to increase reach of first-time testers, people with undiagnosed HIV, and those at ongoing risk—especially key populations—who are in need of frequent retesting
- G. Ensuring youth, male, and KP-friendly services at facilities to attract and retain clients
- H. Fostering same day treatment initiation

Innovative community care and support systems will be scaled up to increase retention, such as the existing community ARV distribution points (PODI) models, as well as adherence support groups and treatment clubs.

Throughout FY2017 and FY2018, new and improved partner management strategies will be developed and implemented. At every site, partners will continuously assist providers with clinical cascade analysis. Monthly partner performance consultations will be conducted based on findings from detailed quarterly data reviews. In Kinshasa, consultations will focus on key clinical data by age and sex to ensure full implementation of the Kinshasa Intensification Strategy. Individual partner improvement plans will include strategies for increasing yield, coverage, and efficiency. Findings and improvement plans will be highlighted at quarterly PEPFAR/DRC partner meetings.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary statistics, disease burden and country or regional profile

The HIV epidemic in the DRC is generalized, with a prevalence of 1.20 percent based on the 2012/2013 DHS and, with 579,185 people living with HIV out of an estimated population of 85 million (calculated based on 2012/2013 DHS and 2015 UNAIDS estimates [version 5.51]). Prevalence is higher in urban (1.6 percent) versus rural areas (0.9 percent) and the burden of HIV is slightly higher among women than men 25 years and older (261,831 female PLHIV v. 176,197 male PLHIV). According to UNAIDS, a majority of HIV transmission in DRC is through heterosexual contact, exacerbated by high-risk sexual

practices (such as having multiple concurrent partners) and low or inconsistent condom use. Although there is insufficient data on the location, typology, and dynamics of key populations and high-risk groups, prevalence among female sex workers (FSWs) is estimated at 9.8% in Kinshasa and 10.8% in Katanga (IBBS 2013), two of the areas with the highest burden of HIV. TB incidence in the DRC is 324 per 100,000 and nationwide only 50 percent of TB patients know their HIV status, even though TB remains the primary cause of death among HIV-positive patients. Of the 12 percent of TB patients co-infected with HIV, approximately 67 percent are on ART (World Health Organization (WHO), Global Tuberculosis Report, 2016).

Population size, widespread poverty, and decades of conflict have resulted in the DRC's lack of a cohesive and functional health system. The SBOR analysis for COP 2016 identified systemic weaknesses that include a fractured and unresponsive supply chain, weak laboratory and sample transport systems, slow and incomplete information management systems, and a lack of institutionalized quality assurance systems across all areas of the program - all factors which pose challenges to the goal of achieving epidemic control.

Reporting of routine HIV program data has improved significantly in recent years in PEPFAR-supported health zones, aided by specific PEPFAR investments in SI technical assistance, including the electronic, HIV-specific reporting system (MESI). However, country-wide, reporting on key indicators continues to face significant challenges. Standardization, distribution, and training on new registers and data tools are ongoing, but gaps remain. The country is in the process of rolling out DHIS2 as the national health management information systems(HMIS), but implementation is not yet complete and has been challenged by poor internet connectivity, slow deployment and limited support at the health zone level. More generally, access to healthcare services is complicated by poor infrastructure, including inadequate roads and the lack of electricity and water at many health facilities.

**Table 2.1.1 Host Country Government Results**

	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	85,030,296	100	19,385,794	22.8%	19,730,905	23.20%	8,383,707	9.86%	8,443,688	9.93%	14,761,259	17.36%	14,324,947	16.85%	National Statistical Bureau and SPECTRUM 2017 V. 5.51 Beta20
HIV Prevalence (%)		1.20%		NA		NA		1.0%		0.8%		2.2%		1.5%	DHS 2013 Report
AIDS Deaths (per year)	14,450		1,594		1,614		463		432		5755		4592		SPECTRUM 2015 Version 5.32
# PLHIV	579,185		27,996		27,996		36,969		28,317		279,290		186,935		SPECTRUM 2015 Version 5.32 and DHS 2013
Incidence Rate (Yr)		NA		NA		NA		NA		NA		NA		NA	
New Infections (Yr)	17,222														SPECTRUM 2015 Version 5.32
Annual births	2,979,489	4%													
% of Pregnant Women with at least one ANC visit	2,413,386	81%													2015 PNLs annual report
Pregnant women needing ARVs	15,132	0.6%													2015 PNLs annual report

Orphans (maternal, paternal, double)	109,212														2015 PNLs annual report
Notified TB cases (Yr)	120,508		NA		NA		NA		NA		NA		NA		2015 Global TB report
% of TB cases that are HIV infected	18,076	12%													2015 Global TB report
% of Males Circumcised	35,861,922	97%			N/A	N/A			N/A	N/A	N/A		NA	N/A	DHS 2007 Report
Estimated Population Size of MSM	N/A	N/A													
MSM HIV Prevalence	N/A	N/A													
Estimated Population Size of FSW	N/A	N/A													
FSW HIV Prevalence	N/A	6.90 %					N/A	N/A			N/A	N/A			IBBSS 2013
Estimated Population Size of PWID	N/A	N/A													
PWID HIV Prevalence	N/A	N/A													

Estimated Size of Priority Population	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	
Truck drivers	N/A	1.20 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBSS 2013
Miners	N/A	1.80 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBSS 2013
Youth (street children)	N/A	1.30 %	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBSS 2013
Military	N/A	3.5%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	SABERS 2014*
Estimated Size of Priority Population Prevalence	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

\* FARDC HIV Seroprevalence and Behavioral Epidemiology Risk Survey

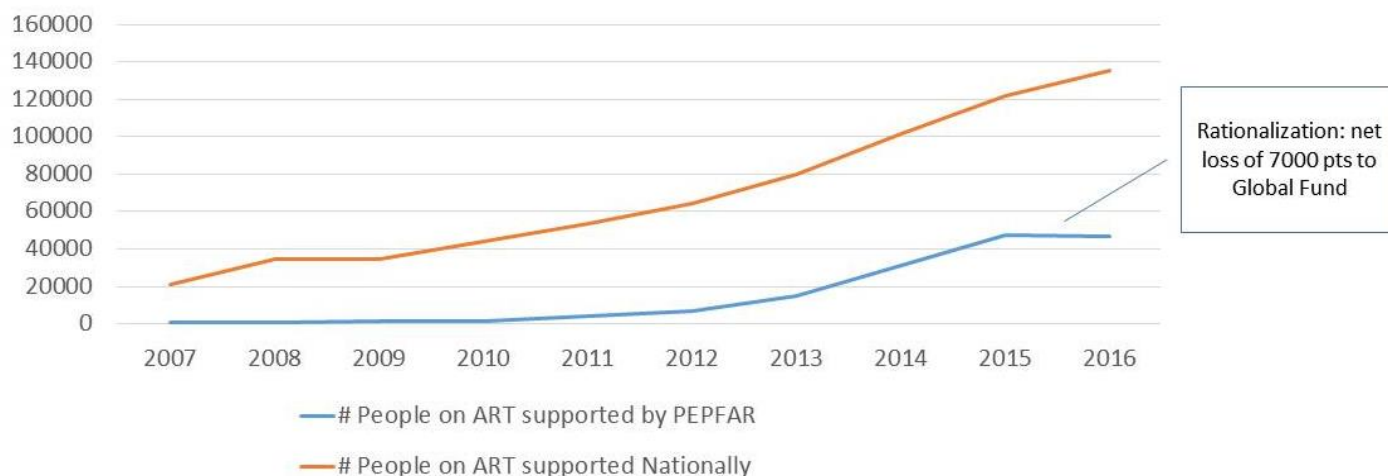


**Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression**

Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year			
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	85,030,296	1.20	579,185		*121,762	*21%	NA	*1,149,640	*45,904	*22,770
Population less than 15 years	39,116,698		47,675		*10,392	*22%	NA	NA	*3,338	NA
15-24 year olds	16,827,395		65,285							
25+ year olds	29,086,207		466,225							
MSM	NA	NA	NA		NA	NA	NA			
FSW	NA	6.90%	NA		NA	NA	NA			
PWID	NA	NA	NA		NA	NA	NA			
Priority Pop (specify)					NA	NA	NA			
Truck drivers	N/A	1.20%			NA	NA	NA			
Miners		1.80%								

\* Source: 2015 PNLS Annual Report

**Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment**



\*2016 national treatment figures not yet official.

## 2.2 Investment Profile

The DRC has one of the lowest gross national incomes (GNI) per capita in the world (\$410, World Bank, 2015), with an estimated 63.6 percent (World Bank, 2012) of the total population living below the poverty line (World Bank, 2015). According to the African Development Bank (AFDB) 2014 report, DRC’s economic growth rate increased slightly from 8.1 percent in 2013 to 8.2 percent in 2015. However, the benefits of this economic growth are spread unevenly across the population and economic growth is expected to slow to below five percent in 2017. The United Nations Development Index 2015 ranks the DRC as one of the least-developed countries in the world (176/188).

According to the most recent National AIDS Spending Accounts (FRENCH: ‘REDES’ 2013-2014) and the UNAIDS investment case, the HIV response is mostly funded privately, including by households (43.67 percent). Donors are the second largest contributors (42.66 percent) and the Government of the DRC (GDRC) contributes approximately 13.67 percent. Although still limited, the GDRC investment in HIV/AIDS has increased by 1.41 percent since 2010. The US Government’s support to DRC through PEPFAR has increased significantly from \$45 million (2014) to \$61 million (2015) and \$71 million (2017), in line with the investment approach guiding the PEPFAR 3.0 strategy.

Led by the National AIDS Control Program (PNLS), PEPFAR and the Global Fund completed a rationalization process in FY2016 to strategically align resources and to maximize joint investments.

Pre-rationalization, the Global Fund procured the majority of HIV-related commodities for the DRC, while PEPFAR/DRC made targeted investments in commodities focused on PMTCT. As PEPFAR/DRC pivoted from a focus on PMTCT to the whole continuum of care and treatment services, so have its commodity investments. Starting in FY2017, each donor is responsible for the provision of ARVs and other commodities to patients in their health zones. PEPFAR/DRC investments in HIV-related commodities will increase annually in alignment with the increasing numbers of PLHIV on treatment in PEPFAR-supported health zones. To afford the increased investment in commodities, from forecasting to last-mile distribution, PEPFAR/DRC will continue to seek efficiencies through 1) focused programming and effective partner management, 2) implementation of new policies (Test & Start, alternative service delivery models, and multi-month scripting, and 3) scaling up innovative and efficient programs. Non-PEPFAR United States Government (USG) investments in health are significant. In FY2016 and FY2017, USAID is investing more than \$126 million in non-HIV programming, including nearly \$22.5 million in co-funding in three PEPFAR implementing mechanisms. The geographic coverage of these mechanisms overlaps primarily in Haut-Katanga and Lualaba provinces.

In FY2016, the GDRC signed a ‘proof of willingness’ to provide \$15 to \$20 million USD annually as a co-investment for new Global Fund grants. In FY2017, this is proving challenging due to competing priorities for GDRC resources and a reduction in mineral prices, which has resulted in an expected decrease in the revenues. To achieve a sustainable response, PEPFAR will strengthen collaboration with other national-level donors to advocate for progressive increases in domestic resources for health and HIV/AIDS. This collaboration will also focus on establishing and strengthening a GDRC-led national forecasting and procurement system for health commodities, addressing task-shifting and other key human resource gaps, and ensuring the community systems strengthening necessary for an effective continuum of care in line with the country’s 90-90-90 goals (90% of all PLHIV know their status, 90% of all people diagnosed with HIV receive antiretroviral therapy, and 90% of all people receiving antiretroviral therapy have viral suppression).

PEPFAR/DRC continues to plan for the possibility of political unrest, increased violence, and protests due to growing tensions related to the ongoing political crisis. Contingency planning with partners will help mitigate the effect of any unrest on DRC’s progress toward epidemic control by 2020. These plans will be implemented according to agency policies and procedures, and are integrated into the partners’ work plans.

**Table 2.2.1 Annual Investment Profile by Program Area**

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country*	% Other*
Clinical care, treatment and support	\$78,891,378	32%	68%		
Community-based care, treatment, and support	\$2,758,125	91%	9%		
PMTCT	\$6,078,403	73%	27%		
HTS	\$5,540,501	78%	22%		
VMMC	-	-	-		
Priority population prevention	\$2,425,235	100%	0%		
Key population prevention	\$3,457,055	44%	56%		
OVC	\$2,943,571	100%	0%		
Laboratory	\$4,441,608	66%	34%		
SI, Surveys and Surveillance	\$7,539,028	28%	72%		
HSS	\$13,311,438	60%	40%		
<b>Total</b>	<b>\$127,386,342</b>				

\* Not available

**Table 2.2.2 Annual Procurement Profile for Key Commodities**

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country*	% Other*
ARVs	\$35,860,530	28%	72%		
Rapid test kits	\$6,384,208	18%	82%		
Other drugs	\$1,168,020	64%	36%		
Lab reagents	\$6,343,270	14%	86%		
Condoms	\$260.721**		100%		
Viral Load commodities	\$4,553,793	20%	80%		
VMMC kits	-	-	-		
MAT	-	-	-		
Other commodities	-	-	-		
<b>Total</b>	<b>\$54,570,542</b>				

\* Not available; \*\*Does not include centrally-supported PEPFAR condom procurement

**Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration**

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	\$35,500,000	\$8,050,000	2	\$1,200,000	Integrated behavior change (IBC), clinical, and supply chain (SC) strengthening services
USAID TB	\$13,000,000	\$2,250,000	1	\$600,000	Prevent and treat TB and ensure strong referral for HIV/TB co-infected patients; national and provincial TB-HIV coordination
USAID Malaria	\$50,000,000	\$7,408,480	1	\$600,000	IBC, clinical, and SC strengthening services
USAID WASH	\$9,500,000	\$500,000	1	\$600,000	IBC, clinical, and SC strengthening services
USAID Nutrition	\$2,00,000	\$2,500,000	1	\$600,000	IBC, clinical, and SC strengthening services
USAID FP	\$16,700,000	\$4,150,000	3	\$3,900,000	IBC, clinical, and SC strengthening services
CDC Influenza	\$90,000	0	0	0	Surveillance, training of health care workers and community education on influenza
CDC Monkey Pox	\$562,234	0	0	0	Surveillance, training of health care workers and community education on monkeypox
CDC FELTP/DETRA	\$222,990	0	0	0	Addressing public health workforce needs for multiple diseases
CDC (Global Health Security)	\$11,678,791	0	0	0	Reinforce outbreak investigation and epidemiologic control
<b>Total</b>	<b>\$137,254,105</b>	<b>\$24,858,480</b>			

### **2.3 Sustainability Profile**

Analyzing the sustainability of our work remains a critical process that ultimately informs the GDRC and other key stakeholders of the current and planned trajectory of HIV investments. The national sustainability profile update here is meant to provide insights on the progress achieved since the last Sustainability Index Dashboard (SID) was completed under PNLS leadership in FY2016.

Only two elements were considered to be strengths (scored light green): 1) planning and coordination and 2) public access to information. Elements related to security of commodities, quality management, domestic resource mobilization, and efficiencies were found to be “vulnerable” (red). The remaining elements were jointly scored by stakeholders to have “emerging sustainability” (yellow). Over the last year, progress has been made in the following areas, increasing the sustainability of PEPFAR’s investments:

- Sustainability profile elements “policy and governance” and “service delivery” have been bolstered over the past year with the adoption and implementation of Test and Start as well as the implementation of different models of care, including multi-month refills and task-shifting policies.
- Planning and coordination continues to be a strength for PEPFAR/DRC as the geographic rationalization process between PEPFAR and the Global Fund was completed in FY2016. The rationalization of programs has increased efficiencies and accountability between donors and partners. There has also been progress in coordinated quantification of ARV and lab reagents though gaps in implementation persist. Looking forward increased planning and coordination to address concerns about inefficiencies in TB/HIV coinfection programs is needed.
- The 2016 revised GDRC national budget included 22 percent cuts due to a partial suspension of mining activities due to a drop in prices. This budget reduction has negatively impacted the already slow mobilization of domestic resources. These economic constraints continue to exacerbate an over-reliance on donor funds and out-of-pocket spending at the household level. The budgetary and economic situation discourages private sector investments as well.

### **2.4 Alignment of PEPFAR investments geographically to disease burden**

The PNLS-led rationalization with the Global Fund was completed by the end of FY2016, resulting in PEPFAR/DRC focusing primarily in three Provincial Health Divisions (FRENCH: “DPS”): Kinshasa, Haut-Katanga, and Lualaba. In FY2018, PEPFAR/DRC expenditures will reflect the post-rationalization donor footprint, with the exception of military expenditures, which represent targeted prevention, care, and treatment activities with the military (a priority population). In COP 2017, PEPFAR/DRC will continue to cover the same geographic area, as agreed to in the rationalization with the Global Fund,

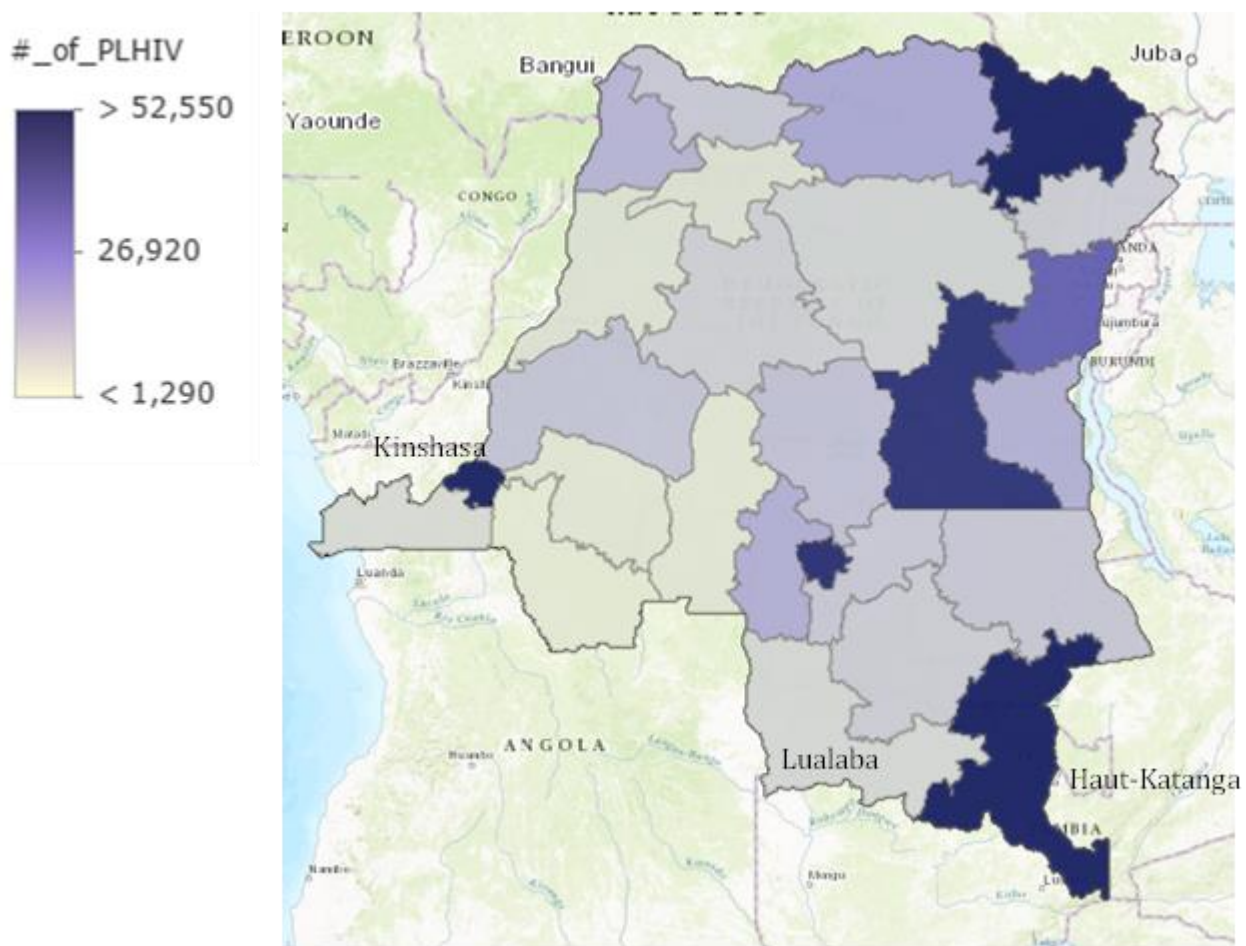
with a focus on reaching saturation in PEPFAR-supported areas by 2020.

As shown in the table below, PEPFAR/DRC operates in two of the highest burden provinces in the DRC, Kinshasa and Haut-Katanga. In addition, PEPFAR/DRC supports Lualaba, which is contiguous to Haut-Katanga, due to the high concentration of sex workers and truckers throughout this transportation corridor. Overall, 35 percent of PLHIV are in the PEPFAR-supported area.

In COP 2015 and COP 2016, PEPFAR activities were focused on key population hot spots and were concentrated in the provincial capital city, which is on the primary transportation corridor between Kolwezi and Lubumbashi. In FY2018, PEPFAR/DRC will increase its package of services to sustained support areas, providing the full saturation package in these health zones, including demand creation, with an overall goal of saturation in PEPFAR-supported areas by 2020. This will require increased investments in areas designated as Sustained Support in COP 2015, as implementing partners restart targeted demand creation activities. In COP 2017, PEPFAR/DRC will also implement targeted demand creation activities across its supported health zones.

**Figure 2.4.1A: Number of People Living with HIV by Province**

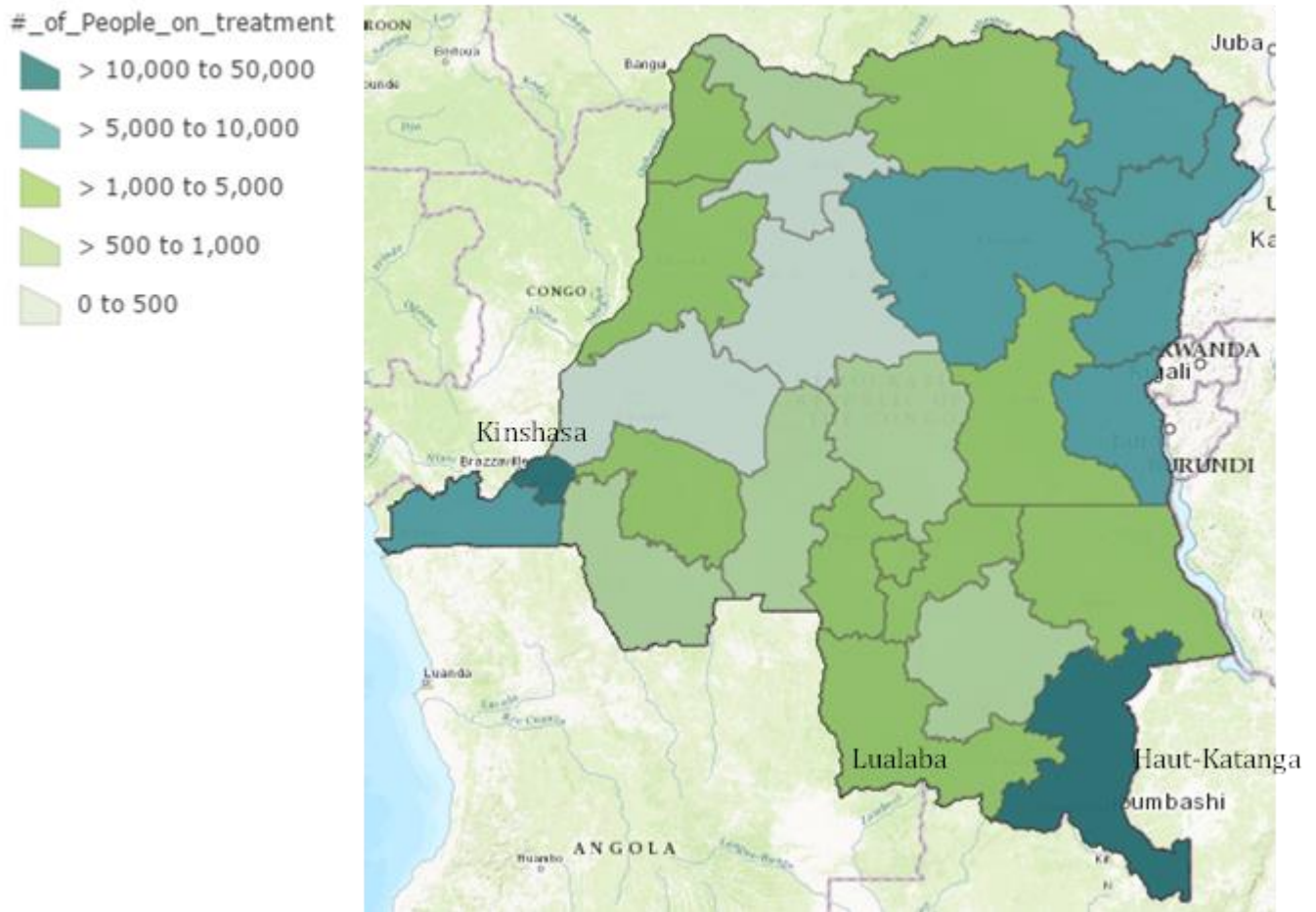
Map #1: Number of People Living with HIV - national figures





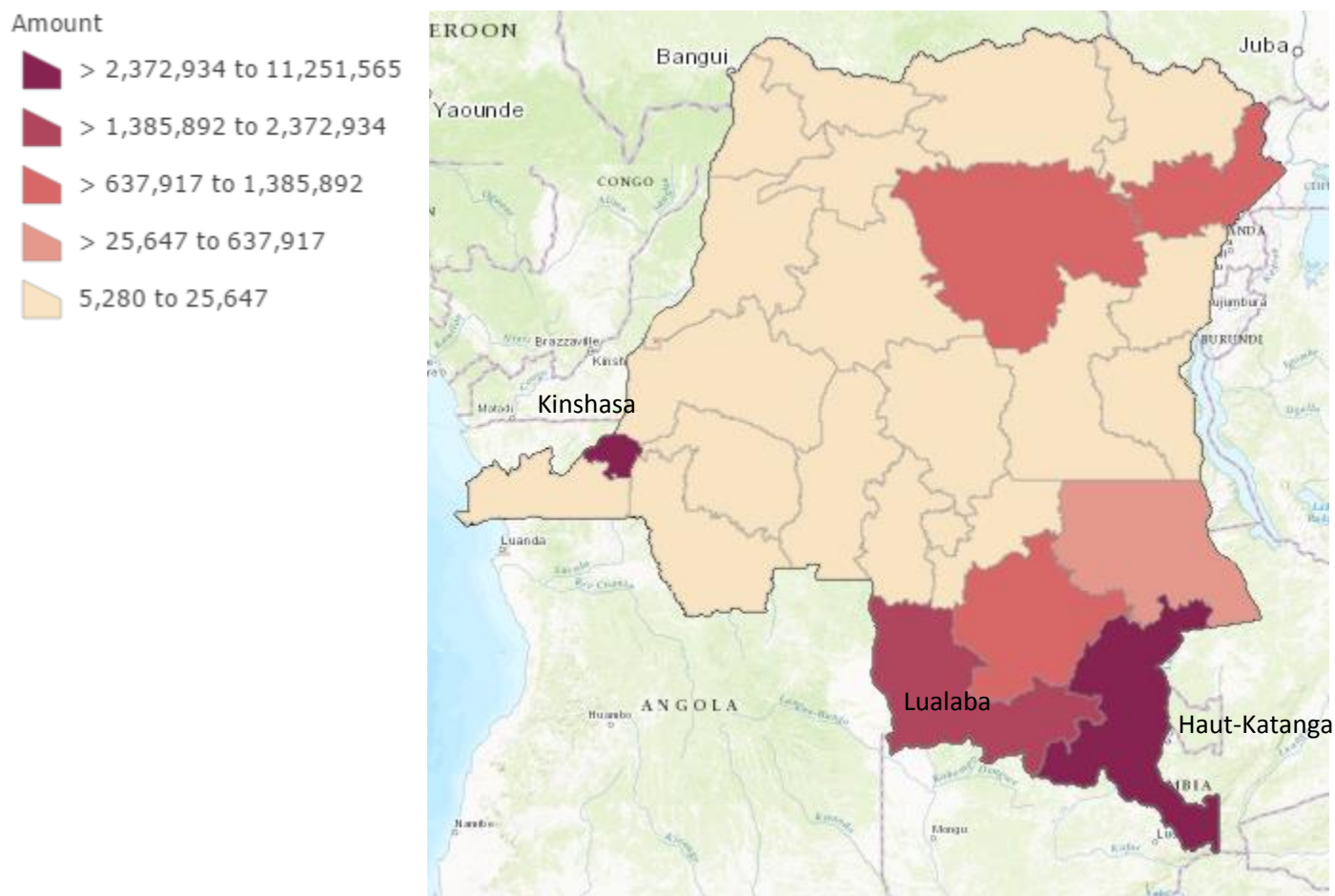
**Figure 2.4.1B: Number of PLHIV on Treatment**

Map #2: Number of PLHIV on treatment - national figures



**Figure 2.4.1C: Total PEPFAR Expenditures, FY2016, in USD**

Map #3: PEPFAR programmatic expenditure by DPS, not considering military spending and commodities



## 2.5 Stakeholder engagement

PEPFAR/DRC consulted with multiple stakeholders in developing COP 2017. Planning focused mainly on how to better identify PLHIV, improve enrollment on ART and retention of PLHIV on treatment, while ensuring the completion of the national rationalization process. Planning also focused on addressing key program barriers and improving performance in Kinshasa. A visit by the Office of Global AIDS Coordinator (OGAC) Country Chair in January 2017 allowed for discussions with representatives from civil society organizations (CSO), PNLs, UNAIDS, WHO, and UNICEF. The visit focused on key expectations for COP 2017, and specifically on creating an enabling environment for key populations to access HIV/AIDS services. In January 2017, PEPFAR/DRC facilitated a one-day discussion with all HIV stakeholders to address each 90 and to discuss all possible strategies to achieve epidemic control in the DRC by 2020.

In March 2017, the Director of the PNLs participated in the COP 2017 DC Management Meeting (DCMM)—a four-day planning event—with the PEPFAR/DRC team, in order to come to an agreement on the overarching strategic direction for COP 2017.

PEPFAR/DRC held a meeting with CSOs on March 22, 2017 to discuss and review the outcomes from the DCMM and to discuss and record additional recommendations from civil society on how to better identify PLHIV, improve retention, provide OVC support, and provide higher quality services through innovative community-level approaches. Specific recommendations included working with community organizations to help with oversight of ARV stock, ensuring that patients' rights are respected by installing complaints reporting systems through IPs, reinforcing community-based health care facilities' abilities to conduct home-based follow-up visits for patients on ARVs, and facilitating the creation of a permanent linkage system between communities and health facilities. The CSOs also recommended reinforcing the capacity of community based health care practitioners to advocate for the respect and protection of human rights for PLHIV and other vulnerable populations.

Recommendations from civil society are further detailed in the CSO COP 2017 Engagement Report, submitted as a supplemental document with COP 2017.

## 3.0 Geographic and Population Prioritization

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In FY2016, PEPFAR and the Global Fund completed the rationalization process, whereby duplication was reduced and donor accountability was increased. Per the rationalization, PEPFAR provides services in Kinshasa, Haut-Katanga and Lualaba with the goal of achieving epidemic control. In COP 2016, the PEPFAR/DRC team refined strategies and support services in saturation areas, maximizing testing yield, linking HIV positive people to treatment, and retaining patients on treatment. In COP 2017, PEPFAR/DRC will prioritize all PEPFAR-supported health zones as aggressive scale-up, with a goal of achieving sustained epidemic control in all 47 health zones by 2020.

Although significant progress has been made in increasing the number of PLHIV on ART in DRC and statistical saturation has been achieved in a number of individual health zones, programmatic data showing consistently high HIV testing yields suggest that true saturation has not been attained in these areas. In these health zones, saturation is likely attributable to care-seeking behaviors, whereby patients cross health zone lines to receive care. In COP 2017, PEPFAR/DRC will focus on increasing the number of PLHIV receiving treatment in all the health zones it supports. The team reviewed the FY2016 and FY2017 Quarter 1 testing and treatment results, disaggregated by age and sex, to identify opportunities for improved case identification. For testing, the team looked at high-yield entry points

and determined to what extent these entry points could be scaled-up further to identify more HIV-positive patients. Implementing partners will analyze, at the site level, the coverage of higher-yield entry points, such as inpatient and outpatient testing, to ensure targeted, provider-initiated testing that identifies the highest number of HIV-positive individuals.

In COP 2017, PEPFAR/DRC prevention outreach activities will focus on the following priority populations: 1) partners of diagnosed PLHIVs (index testing), 2) men, especially partners of female sex workers (FSW), 3) adolescent girls and young women, 4) key populations (men who have sex with men (MSM) and FSW). These populations were selected through review of the programmatic and national epidemiological data. By focusing on these populations, who are currently underrepresented in the PEPFAR/DRC treatment cohort, PEPFAR/DRC will fill the age and sex band gaps in order to achieve sustained epidemic control in PEPFAR-supported areas by 2020, with significant progress toward closing the gaps in FY2018. The newly-developed Kinshasa Intensification Strategy outlines the special efforts planned to improve case identification and increase the number of PLHIV receiving ART in Kinshasa. In COP 2017, intensified site-level data reviews with all implementing partners, particularly for supported health zones in Kinshasa, will help to proactively identify site-level performance barriers. With a more frequent and intentional review of these barriers, PEPFAR/DRC will be able to make the needed course corrections to improve case identification and to ensure that more HIV positive people are put on treatment.

**Table 3.1 Current Status of ART saturation**

Prioritization Area	Total PLHIV/% of all PLHIV for COP 2017	# Current on ART (FY2016)	# of SNU COP 2016 (FY2017)	# of SNU COP 2017 (FY2018)
Attained	--	--	--	--
Scale-up Saturation				
Scale-up Aggressive	135,648	53,734	48	49
Sustained				
Central Support	--	--	--	--

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

### 4.1 Targets for scale-up locations and populations

PEPFAR/DRC has a specific, comprehensive plan to reach its FY2018 targets. This plan, and the road to sustained epidemic control, will be described in more detail in the program area narratives in this section.

Table 4.1.1 shows the entry streams for adults and children newly initiated on ART in PEPFAR/DRC's scale-up health zones. (PEPFAR/DRC did not include Table 4.1.2, VMMC Coverage and Targets by Age Bracket in Scale-up Districts, as this program area is not applicable in DRC.) Table 4.1.3 shows the target populations for prevention interventions to facilitate epidemic control. Although accurate size estimations for the key and priority populations are not available, PEPFAR/DRC used programmatic data to set FY2018 targets for each population. Table 4.1.4 shows the FY2018 targets for OVC and linkage to HIV services. As an accurate estimate of the number of OVCs is not available at the health

zone level, PEPFAR/DRC estimated this number based the total number of OVCs in DRC (source: Humanium.org) and the percentage of PLHIVs in each health zone. More information about the program direction in COP 2017 can be found in the program area narratives, sections 4.2-4.10.

In order to ensure progress towards yearly targets, PEPFAR/DRC will conduct monthly partner performance consultations. Using the most recent quarter's data submission, the interagency PEPFAR/DRC team will conduct a full review of the data to identify partners and sites where performance is positive, as well as those with performance issues. Partners will be asked to share information and/or data particular to the issue identified so that the activity manager can assess improvement. Disaggregation by age and sex will be carefully reviewed. The monthly partner performance consultations will refocus the partners' attention, including direct mentoring and supervision, at the site level. Partners will support and mentor facility staff to review facility-level performance data and identify and address performance gaps while celebrating strengths and accomplishments. In Kinshasa, as part of the Kinshasa Intensification Strategy (described in full in Section 4.11), and in addition to the monthly performance consultation, activity managers will conduct a data review of key clinical indicators (HTC\_TST, HTC\_TST\_POS, TX\_NEW, TX\_CURR), to ensure implementation of the Kinshasa Intensification Strategy. These consultations will ensure appropriate progress towards targets and allow for early remediation and immediate sharing of best practices.

**Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts**

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY 18) TX_NEW
<b>Adults</b>			
TB Patients	23,349	3,024	3,024
Pregnant Women	258,824	2,949	2,771
VMMC clients	-	-	-
Other Testing	823,101	29,636	22,097
Previously diagnosed/in care*	-	-	-
<b>Total Adults</b>			
<b>Pediatrics (&lt;15)</b>			
HIV Exposed Infants	3,834	222	211
Other pediatric testing	185,938	3,760	3,675
Previously diagnosed/in care	-	-	-
<b>Total Pediatrics</b>	189,772	3,982	3,886
<b>TOTAL</b>	<b>1,295,046</b>	<b>39,591</b>	<b>31,778</b>

\*All pre-ART patients will have been integrated into the treatment program by end FY2017.

**Standard Table 4.1.2** (Not required for countries with no VMMC investments or targets.)

**Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY2017)	FY2018 Target
<b>Key Populations</b>			
MSM	Unknown	Unknown	5,989
FSW	Unknown	Unknown	30,754
<b>Priority Populations</b>			
Military	Unknown	Unknown	58,408
AGYW	Unknown	Unknown	50,958
Truckers	Unknown	Unknown	1,100*
Miners	Unknown	Unknown	400
Clients of FSW	Unknown	Unknown	600
<b>TOTAL</b>			<b>5,350</b>

\* This is PP\_PREV target among AGYW; others will be reached for testing and other support without full PP\_PREV package.

**Table 4.1.4 Targets for OVC and Linkages to HIV Services**

SNU	Estimated # of Orphans and Vulnerable Children*	Target # of active OVC (FY2018 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY2018 Target)
Military_DRC	7,823	2,223	1,890
Bandalungwa	4,594	500	430
Binza-Ozone	9,460	771	663
Dilala	2,643	1,084	932
Kamalondo	1,512	720	613
Kambove	2,782	234	201
Kampemba	9,555	2,000	1,698
Kasenga	3,403	771	663
Katuba	5,822	925	796
Kenya	6,305	2,313	1,967
Kikimi	6,498	1,864	1,621
Kikula	5,295	582	501
Kimbanseke	7,111	1,542	1,326
Kingabwa	5,300	2,005	1,724
Kingasani	5,601	2,087	1,774
Kinshasa	4,231	803	691
Kipushi	4,859	1,234	1,061
Kisanga	5,612	1,851	1,592
Likasi	3,212	850	731
Limete	4,746	912	784
Lingwala	2,175	384	330
Lubumbashi	4,288	1,400	1,200
Manika	1,146	1,100	946
Masina 1	6,445	2,005	1,724
Masina 2	6,974	3,800	3,225
Matete	7,290	558	480
Mont-Ngafula 1	6,239	240	206
Mumbunda	6,332	1,234	1,061
Ndjili	8,141	3,424	2,945
Ngaba	4,600	771	663
Nsele	4,468	1,080	929
Rwashi	5,992	1,450	1,234
Sakania	5,666	1,050	903
Tshamilemba	5,161	1,234	1,061
<b>Total</b>	<b>176,329</b>	<b>45,001</b>	<b>38,566</b>

\*The estimated number of OVCs for the HZ was calculated using the total number of OVCs in DRC (source: Humanium.org) x percent of total PLHIV in HZ; for Military\_DRC, number of OVC in DRC\* estimated PLHIV in the military (based on SABERS 2014)/Total PLHIV in DRC.

## Program Area Summaries 4.2-4.10

### 4.2 Priority and key population prevention

#### Key Populations (KP)

DRC lacks reliable size estimates of FSW and MSM populations. A national mapping and size estimation study targeting the country's ten most populous cities is currently underway. The first wave of this study, conducted in Kinshasa, was recently finished and preliminary results have raised concerns about the coverage and accuracy of the sampling and data collected. The size estimates from the preliminary results seem implausibly low for MSM and FSW compared to other countries in West and Central Africa when compared to PEPFAR/DRC programmatic data. In FY2016, three PEPFAR/DRC implementing partners, LINKAGES, ICAP and EGPAF, tested 20,308 FSW (7,687 in Kinshasa) and 3,476 MSM (2,675 in Kinshasa), combined, with an average positivity of 4.4 percent and

3.2 percent respectively. As the preliminary size estimates are being clarified and verified, PNLS decided to use the extrapolated average of the regional proportion of KPs.

The low positivity rates for MSM and FSW from partner data suggest that there are still social networks unreached by PEPFAR/DRC KP programming thus far, requiring more robust strategies for reaching key populations and their clients. The preliminary results of the size estimation study also highlight the need for PEPFAR/DRC to better quantify the magnitude of intravenous drug use (IDU) in-country and to better map IDU hotspots, as very little information on this group is currently available. With this key information, PEPFAR/DRC will be able to better assess the necessity of programming for IDUs in-country. One key strategy to obtain this data is through the upcoming IBBS, expected to take place within the next one to two years. PEPFAR/DRC will continue to advocate for the inclusion of IDUs in these surveys.

Clinical cascade analyses for key populations indicate a significant drop-off between numbers reached and numbers tested, and between those who are found to be HIV positive and those who are enrolled on treatment. In COP 2017, PEPFAR/DRC will implement a more varied and comprehensive set of HIV testing service delivery models (described below). These strategies, based on lessons learned and data from SIMS visits, will increase reach and uptake by improving access to services within communities. Clients who access services at the community level will be linked to the clinical platform by skilled peer educators who promote early diagnosis and treatment of STIs; condom use; Positive Health, Dignity and Prevention (PHDP) initiatives; linkage to care; and treatment adherence. Ensuring that KPs are linked to care and treatment instead of simply being given a referral will continue to be a focus for PEPFAR/DRC.

#### **Focusing on the 1st 90 and beyond: KPs**

Building on COP 2016 interventions, COP 2017 programming for KPs will continue to be comprehensive, focusing on finding KPs living with HIV and linking them to treatment. New strategies to identify hard-to-reach HIV-positive KPs as well as their partners will include: 1) partner notification; 2) family-based index case testing; and 3) social network testing. Various modalities of testing will be utilized including providing moonlight services; connecting with CSO activities such as fairs, social events, and other gatherings; identifying networks of older KPs who generally have higher prevalence; utilizing peer educators to provide targeted home and community-based testing (only for those unable/unwilling to come to clinic for testing); and the introduction of self-testing. Linkage to treatment and retention will be increased through the use of Drop in Centers (DIC) which serve as community dispensing points for ART, enabling a safe and stigma-reduced setting for KP to access services. In addition, follow-up by peer navigators tasked with ensuring all positive KPs access services will be intensified.

Numerous other critical services for KP will be provided, such as: TB screening and treatment referral; provision of Pre-exposure Prophylaxis (PrEP) for negative KP (to be piloted in COP 2017); sexually transmitted infections (STI) screening and treatment; peer education and outreach; risk reduction interventions; violence prevention and post-violence care; alcohol and substance abuse counseling; as well as structural interventions that foster an enabling environment for KP access to health services.

SIMS data will be used to monitor partner performance and enhance the tracking of both KP prevention and treatment cascades. PEPFAR/DRC will also conduct monthly partner performance consultations to ensure progress towards yearly clinical cascade targets as described in Section 4.1.

#### **Priority Populations and Vulnerable Populations**

Because of the high HIV prevalence rates among these populations, associated risk behaviors, or other characteristics which make these populations especially vulnerable to HIV, PEPFAR/DRC program



data has shown that priority populations in the DRC include uniformed personnel, truckers, miners, clients of sex workers, steady partners of sex workers, OVC, and adolescent girls and young women (AGYW). In COP 2017, 58,408 people from priority populations will be reached with essential HIV services.

#### *AGYW*

Treatment coverage for adolescents is still lacking compared to other adult age bands. The 2013-2014 DHS showed that 16.4 percent of women aged 15-19 and 27.6 percent of women aged 20-24 have experienced sexual violence, occurring more often in rural areas. The COP 2016 gender analysis showed similar results. Some AGYW have also been found to engage in transactional sex, especially in mining areas and other hotspots due to limited economic opportunities and high rates of poverty, as well as the perception that these areas are among the most lucrative places for employment. Economic vulnerability coupled with a high level of violence and physical abuse is frequently observed in both rural and urban settings around areas of economic activity, especially among small-scale street vendors.

COP 2016 strategically utilized OVC partners to provide prevention services and encourage risk avoidance practices among AGYW. In COP 2017 this strategy will be strengthened, as adolescents will be linked to reproductive health and family planning, as well as HIV prevention services (for example, how to negotiate condom use, how to properly use a condom). Special emphasis will be placed on adolescent daughters of FSWs because of their exposure to and risk of engaging in sex work. In addition, GBV prevention services and referrals for post-GBV care will be offered to AGYW in need of these services. PEPFAR/DRC is also working with the National Adolescent Health Program to support comprehensive prevention interventions through adolescent- and youth-friendly safe spaces in vulnerable communities (including hotspots, mining, and fishing areas), and by using peer navigators to refer HIV-positive adolescents to youth-friendly health facilities. The package of services will also include skills training to ensure young women are able to financially support themselves.

#### *Military*

In COP 2017, PEPFAR/DRC will continue to offer prevention services and promote HTC to military service personnel. The comprehensive priority population prevention package will include sensitization on HIV, referral to HIV testing services, and behavior change communication to encourage military personnel to seek medical attention in health facilities. Condoms, and education on correct condom use, will be made available to all military personnel, especially those going on deployment. Training modules will also include prevention of alcohol and substance abuse, as well as gender equality. Mobile testing in and around known high-prevalence barracks will be used to reinforce case identification within the military. Military personnel who test positive will be linked to the closest military treatment sites and given a modified PP\_PREV package for PLHIV, focusing on Positive Health, Dignity, and Prevention (PHDP) through PLHIV support groups. Those presenting with TB or STI symptoms will be referred to appropriate military health facilities. Linkage agents in communities will actively link those who test positive to facilities using the triplicate linkage forms developed by PEPFAR. In communities as well as in facilities, adherence education, psychosocial support, nutritional counseling, and family planning counseling will be carried out by lay counselors to improve treatment adherence and retention. OVC services will also be provided to vulnerable children and adolescents in military communities, including testing services for those at risk.

#### *Men, including truckers, miners, and clients and partners of sex workers*

Results from FY2017 Q1 reveal that men are still being reached late in the progression of the disease, and in small numbers. Most men are reached through inpatient and TB modalities, especially older men. New ways to identify-HIV positive men at earlier stages are critical. Q1 results showed that index



testing is a promising strategy for reaching men.

PEPFAR/DRC is building on initial successes to expand index testing among men. As older men appear harder to link to services than younger men, PEPFAR/DRC intends to test more older men in COP 2017 by working with male PLHIV champions who serve as navigators and linkage agents. Partner performance monitoring helped to identify sites that successfully linked more than 80 percent of HIV-positive men to treatment. Practices employed at these successful sites will be explored during partner performance monitoring meetings in order to identify qualities of testing programs that encourage service uptake among men. This may include expanding service hours and offering other health services and information concurrently (for example, on non-communicable diseases, reproductive and sexual health and HIV). Additionally, using a high-risk screening tool, targeted workplace testing will be implemented among fishermen, taxi drivers, miners, and truckers. In KP settings, social and sexual network testing as well as partner notification will be used to reach clients and regular partners of sex workers. The Zambia-DRC trans-border collaboration will help identify and trace sex workers and their clients across the border in order to provide continuous combination prevention services.

#### **4.3 Voluntary male circumcision (VMMC)**

Not applicable

#### **4.4 Preventing mother-to-child transmission (PMTCT)**

In FY2016, PEPFAR/DRC ensured that 235,232 pregnant women at 498 non-military sites knew their HIV status. Of these women, 3,609 were positive, for an overall PMTCT prevalence of 1.5 percent. PEPFAR/DRC has decreased investments in PMTCT, accounting for 30 percent of expenditures in FY14, 25 percent in FY2015, and 10 percent in FY2016. Despite the low positivity of PMTCT testing, this entry point yields a high number of HIV-positive women, and in spite of decreasing investments, quality and coverage remain high in PEPFAR-supported sites.

Option B+ was rolled out in 2013 and is now being fully implemented. In COP 2017, PEPFAR/DRC will support Option B+ in all PEPFAR supported health zones. The integrated package of PMTCT services will include the following: (1) PITC; (2) ART (adult and pediatric); (3) cotrimoxazole; (4) nevirapine prophylaxis for infants; (5) comprehensive family planning; (6) TB and opportunistic infection screening and referral; (7) gender-based violence (GBV) screening and referral; (8) lab sample (e.g., Early Infant Diagnosis [EID], viral load [VL]) collection, transportation and analysis; and (9) linkages to community, OVC, malaria, nutrition, and Water, Sanitation, Hygiene (WASH) services. PEPFAR/DRC will conduct targeted refresher trainings, coaching, and mentoring of health care providers to ensure that they are well-equipped to provide adequate ART services to all HIV positive pregnant women, promote adherence and retention, and reduce loss to follow-up, especially during the breastfeeding stage. Option B+ results in strong linkages to treatment (98 percent) and is a key entry stream for ART enrollment targets, representing a 12.5 percent contribution to TX\_NEW. EID of HIV-exposed infants is another important opportunity for case finding and pediatric ART initiation.

Identified gaps to be closely monitored include: (1) insufficient coverage of HIV-exposed infants with results within 12 months, and (2) high loss to follow-up among breastfeeding HIV positive mothers, particularly at transition from PMTCT to general care and treatment services. To help reduce loss to follow-up, especially among postpartum women, PEPFAR/DRC will strengthen the network of mentor-mothers and peer educators (facility and community-based). Support groups will be reinforced to promote adherence. In health centers, providers will continue to use appointment registers to track patients by phone or through home visits by peer educators or community health

workers.

Lessons learned from Option B+ implementation informed the current test and start strategy. Additionally, lessons learned from community support for treatment adherence initially rolled out for PMTCT and mentor mothers, have been applied to PODIs and other community support strategies.

#### 4.5 HIV testing and counseling (HTS)

In FY2016, PEPFAR/DRC tested 915,609 individuals of whom 26,219 were HIV positive, for an overall HTS positivity rate of 2.86 percent. FY2017 Q1 results show a slight increase in positives identified (2.93 percent yield). The distribution of positives by site is presented in the graph below. 80 percent of positives were identified in 40 percent of sites. 38 sites had 1-4 positives, and 4 sites had zero positives.

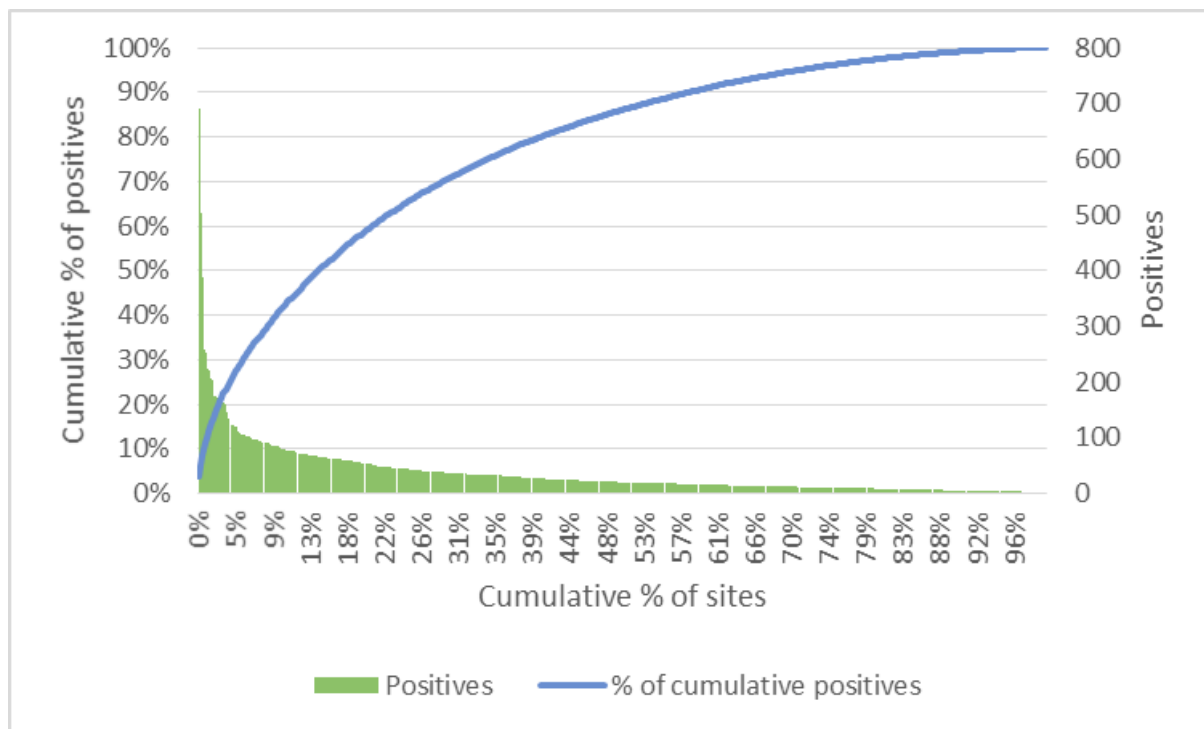


Figure 4.5.1: Distribution of positives among sites

According to the 2013-2014 DHS, 78 percent of 15-49 year old women and 84 percent of 15-49 year old men have never been tested for HIV. The DHS results indicate a continuing unmet need. Testing efficiency is critical—the PNLs 2015 report indicated recurrent test kits stock outs in many facilities across the country which could have been averted through accurate quantification and targeted testing.

Ambitious targets have been set to find additional positives through aggressive strategies, with a special emphasis on Kinshasa. The proportion of the budget based on HVCT targets doubled in COP 2017 to accommodate the ambitious targets. Testing targets were calculated from treatment targets resulting in the need for 1,345,443 individuals tested to yield 41,189 positives. The calculation took note of the estimated positivity and linkage to treatment (75 percent) for specific age/sex bands. It is anticipated that 80 percent of these positives will be recruited through facility-based modalities while 20 percent will come from community-based modalities (mostly index and mobile). The figures also support efficiencies especially when considering the cost per positive unit expenditure (UE): VCT—\$109.79, PITC—\$181.80, CBCTS—\$218.18. FY2017 Q1 data provided meaningful evidence showing that scaling up community index and mobile testing has the potential to reach specific populations (adolescents, men, key populations) that do not appear to be effectively served by PITC. Task-shifting now allows for peer educators to conduct testing, rendering this modality more feasible.

Overall, PEPFAR/DRC aims to:

- A. Optimize PITC in outpatient departments, TB clinics, inpatient wards (including pediatrics), PMTCT, and nutrition services within facilities
- B. Increase aggressive tracking of partners of index cases
- C. Scale up community based HIV testing services (mobile and index modalities) to find hard-to-reach populations such as men, adolescents and key populations
- D. Introduce sexual networking and partner notification strategies in order to provide HTS and treatment services to hard-to-reach key populations
- E. Use OVC platforms to test OVC and children of KPs
- F. Integrate supervised self-testing to increase reaching of first-time testers, people with undiagnosed HIV, and those at ongoing risk—especially key populations—who are in need of frequent retesting
- G. Ensure youth, male, and KP-friendly services at facilities to attract and retain clients
- H. Foster same day initiation
- I. Track and escort hardest to link

PEPFAR/DRC has identified the following challenges in diagnosing 90 percent of PLHIV:

- A. Current national policy prohibits minors (under 18 years) from seeking health care—including HIV care—without parental consent
- B. More adult women are currently tested than adolescents and men. The COP 2016 gender analysis depicted men as an underserved population
- C. High inpatient yield suggests late HIV diagnosis and a more passive mode of recruitment
- D. High index yields but low testing volumes indicate significant missed opportunities in finding early cases
- E. High volume, low yield testing for other PITC indicates that testing has largely been untargeted
- F. Community-based testing modalities show good potential for finding new positives, but seem poorly implemented or underreported
- G. Unexpected low yield for KPs
- H. Linkage rates vary greatly across regions with men generally linked at lower rates than women
- I. SIMS: data inconsistencies, quality control issues, and compliance with national algorithms were found to be weak in some sites.

To address policy issues related to the first 90, PEPFAR/DRC will continue to engage in discussions with PNLS for a policy lowering the age of consent for HTS from 18 years to 15 years; thus, opening a window for reaching a proportion of missed adolescents. PEPFAR/DRC is also working with PNLS in order to enforce requirements to report on index cases, sexual and social network contacts testing, as well as community-based testing modalities.

New following testing strategies will be implemented during COP 2016 and COP 2017 with the intention of further bolstering percent positivity:

**Focusing on the 1st 90 – PITC:**

- Provide 100 percent HIV testing in STI and TB
- Use risk assessment screening tool to increase yield (tools exist and in use already; in COP17, PEPFAR/DRC will work toward a standardized tool)
- Strengthen capacity of peer educators to test in facilities
- Track testing coverage and yield

**Focusing on the 1st 90 – Index:**

- Identify index cases through review of ART registers
- Complete family tree forms
- Test children of women on ART using risk assessment tool
- Test sexual partners of individuals on ART
- Ask newly diagnosed persons to identify sexual partners, especially KPs

**Focusing on the 1st 90 – Increasing access:**

- Extend testing hours for men & school-aged children
- Provide transport subsidies
- Utilize peer educators to provide targeted home and community-based testing for those unable or unwilling to come to the clinic
- Use peer educators and counselors to support status disclosure to partners and other key contacts

Innovative assisted HIV partner notification approaches will be evaluated and implemented in order to scale up the most appropriate approach for different populations and contexts: 1) clients can either be provided with a pamphlet called “Tips for Telling Your Partner about HIV” as well as a referral slip, 2) a contract referral (wherein the client is provided with a referral card as well as a disclosure script and agrees that they will refer their partner for HTS within 30 days), or 3) the provider may initiate partner contact using a telephone and a script. Clients are allowed to choose their preferred approach, and all partner notification approaches include the notion of consent.

PEPFAR/DRC will review performance, including yield and coverage with implementing partners to assess achievement towards annual targets, understand trends over time, identify where and which modalities are leading to high volumes of diagnoses, and proactively identify underperforming sites and implement quality improvement approaches as needed. The monthly partner performance consultations for Kinshasa are described fully in Section 4.1. More frequent monitoring may be initiated for partners implementing new HTS approaches to improve HIV case finding or who are conducting community-based HTS where the population or location may be not be fixed. Frequent reviews will also highlight innovative approaches (e.g. use of incentives, screening tools, etc.) and modalities that are effective at identifying PLHIV that may need to be scaled-up, as well as identifying populations not accessing testing services that may need additional targeting. These reviews should also highlight effective strategies aimed at keeping partners of priority populations HIV negative, condom availability, and appropriate prevention messages. A full package for Rapid Test Continuous Quality Improvement (RTCQI) will be implemented in COP 2017 as testing quality assurance is a key priority.

**4.6 Facility and community-based care and support**

During FY2016, facility and community care services were offered to 44,020 HIV-positive adults and children at 488 non-military sites. Among them, 21,357 HIV-positives were newly enrolled, which is higher than the number of people tested who received positive results (HTC\_TST\_POS) within the same geographic areas. This can be attributed to individuals from pre-ART becoming eligible for treatment as well as the rollout of Test and Start.

In COP 2017, PEPFAR/DRC will continue to support a standard package of care and support services in all support health zones, including TB screening and referral, provision of cotrimoxazole, viral load testing, positive health, dignity and prevention services. PEPFAR/DRC will utilize the “4+1 strategy” its core platform for care and support which includes four universal interventions: 1) regular clinical

monitoring and viral load testing, 2) screening for active TB or intensified case finding, with referrals for diagnosis and treatment as appropriate 3) cotrimoxazole prophylaxis; and 4) evidence-based interventions to optimize retention in care and adherence to ART that address local gaps and barriers. The “+1” intervention is positive health, dignity and prevention.

Priorities for improving linkage 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; and increasing collaboration between GDRC’s HIV/AIDS and TB control programs. A strong focus will be placed on quality assessment and quality improvement (QA/QI) and local capacity building in adult and pediatric care and treatment.

Since FY12, 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 have shown valuable contributions to linkage and retention and will be expanded to increase quality and coverage of services. PEPFAR/DRC is committed to supporting the inclusion of QI for community and facility-based care and support in the national monitoring and evaluation (M&E) system, including support for designing relevant tools.

SIMS data continues to reveal 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 models 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 address the increasing numbers of patients at facilities following the roll out of Test and Start, PEPFAR/DRC will build on the newly-revised PNLs guidelines on task-sharing and the decentralization of ART to community-based services to alleviate the burden of increased numbers of HIV patients at high-volume sites. PEPFAR/DRC will also continue to expand availability and access to ARVs at the community level for stable patients through community ARV distribution points (PODI). PEPFAR/DRC’s “PODI+” model provides ARVs and counseling to stable patients on a quarterly basis, lowering the frequency of required clinic visits to twice a year. Enrollment has been ongoing since Q1 FY2017 as per COP 2016 planning. In FY2018, PEPFAR/DRC will continue to refine the seven functioning PODI+ in Haut-Katanga and Kinshasa. As part of the PODI+ model, essential tasks such as symptom-based health assessments are provided by a trained peer educator or expert client who acts as a club facilitator. Assessments are captured in patient records and monitored by clinic staff via a reporting linkage between the club facilitator and the clinic. Clients of PODI+ see a nurse only twice a year, once for blood tests and once for their annual clinical check-up. Any client reporting symptoms is referred back to the main ART clinic for a prioritized assessment by a nurse.

In COP 2017, PEPFAR/DRC aims to improve the efficiency and functioning of current PODI+ that are linked to high-volume clinical sites (more than 200 patients on ART) through a robust referral/counter referral system that ensures client tracking and data accountability.

#### *DRC Strategies for Improving Retention*

As per APR16 (see figure below), 21 percent of sites account for 80 percent of PLHIV loss to follow-up in the first 12 months of treatment. The PEPFAR/DRC retention rate in FY2016 was 73 percent. PEPFAR/DRC plans to increase the retention rate from 73 percent to 85 percent for patients newly initiated on ART and to 90 percent for stable patients who have been on ART more than 12 months.

Pareto graph of patients LTFU after 12 months (TX\_RET D - TX\_RET N) by site, APR16

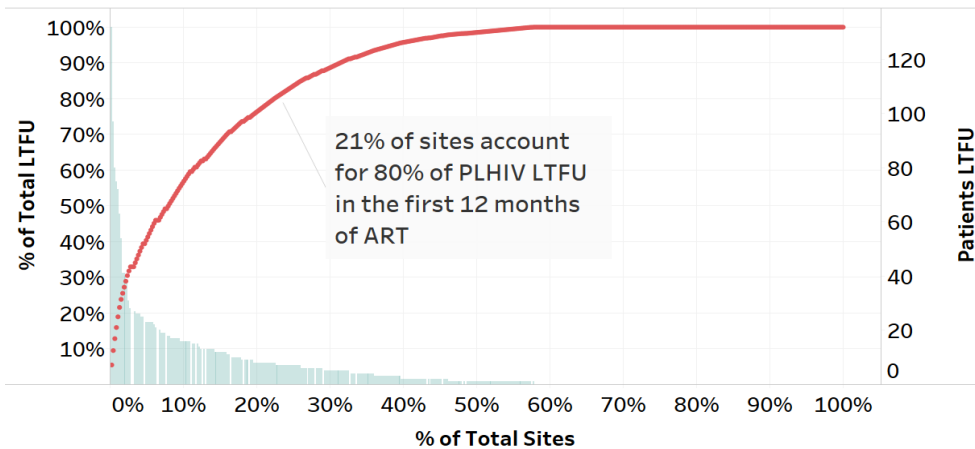


Figure 4.6: APR 16 Lost to Follow-up

In COP 2017, PEPFAR/DRC plans to implement and/or reinforce the following strategies to improve retention:

- A. Reviewing retention data for patients newly initiated on ART on a quarterly basis, and conducting monthly partner performance consultations for low-performing sites and partners
- B. Implementing new service delivery models
  1. Multi-month medication refills for stable patients including the following:
    - Fast drug refill at the health facility
    - PODI+ model
    - Community- and facility-based ART adherence clubs managed by community health workers
    - Community-based, client-run ART groups
  2. Decentralized services through facility- and community-based platforms:
    - Mentor mothers groups
    - Adolescent support groups
    - OVC platforms/interventions
    - Treatment adherence clubs to encourage retention and adherence, and to track clients who have defaulted
  3. Task-shifting
- C. Improving strategic information
  1. Electronic tracking/monitoring tools for high volume sites (e.g. Tier.net and Electronic Dispensing Tool (EDT)), facilitating timely and early identification of potential defaulters so that immediate action can be taken through community peers and health care providers
  2. Quality improvement approaches
- D. Fostering a PLHIV-friendly environment
  1. Collaboration with civil society PLHIV networks on stigma and discrimination issues (CSO small grants)
  2. Community engagement through education, information, and communication
  3. Addressing user fees issues by:
    - Investigating the problem at each facility
    - Advocating to GDRC to increase subsidies to public facilities
    - Monitoring sites and ensuring (informal) extra fees are not being charged; educating and empowering patients about their rights
  4. Addressing structural barriers identified through the gender analysis and QI process by conducting periodic focus group discussions with PLHIV to identify barriers and address them accordingly

- E. Improving supply chain health through improved long-term forecasting and efficient distribution of ARVs and other commodities to ensure the necessary medications are available at each site.

#### 4.7 TB/HIV

In FY2016, 88 percent (21,910/24,847) of registered TB patients in PEPFAR-supported health zones were tested for HIV, an increase from 69 percent in FY2015. Of the patients found to be TB/HIV co-infected, 98 percent (2,426/2,943) them were initiated on ART, an increase from 31 percent in FY2015.

The HIV prevalence among registered TB patients in the DRC is over 11 times the prevalence in the general population at approximately 12 percent (WHO, Global Tuberculosis Report, 2016), making TB an extremely important entry point for finding new HIV patients. This is especially true because TB incidence (including TB/HIV coinfection) is very high at 324 [210–463] per 100,000 persons.

Despite the considerable progress that has been made in TB/HIV, a number of challenges remain. These include the 12 percent of registered TB patients in PEPFAR-supported health zones who do not know their HIV status and the relatively low volume of TB patients who are registered and tested. Although the TB entry point showed high yields in FY2017 Q1 (around seven percent), these gaps in coverage indicate a need to scale up HIV testing in TB settings to 100 percent. (Data also show that men are overrepresented at TB entry points, suggesting that they are mainly recruited at late stages of infection.) Additional challenges have been documented through SIMS data and technical site visits: 1) at least 5 percent of HIV patients are not routinely screened for TB; 2) most clinics do not have TB infection control plans; 3) only about 25 percent of non-co-infected PLHIV are currently receiving isoniazid preventative therapy (IPT); and 4) TB treatment outcomes are often not tracked in HIV registers. Finally, gaps in coordination between the PNLs and the National TB Program (PNLT) remain, making management of co-infected patients more difficult.

In order to address these issues, the TB/HIV service delivery package in all PEPFAR/DRC health zones will include (1) intensified HIV testing among TB patients and suspects; (2) improved ART initiation among co-infected patients and expanded HIV services within TB clinics; (3) intensified TB case-finding and linkage to TB treatment among PLHIV; (4) tracking of TB treatment outcomes in PLHIV; (5) expanded TB infection control measures and support to the development of TB infection control plans; (6) IPT for all PLHIV without confirmed active TB; (7) community-based services including adherence support and prevention services; and (8) improved TB/HIV coordination and integration of TB/HIV care and treatment to ensure linkage and retention, including joint TB/HIV supervision from the national and provincial programs.

Many TB clinics do not offer ART on-site, so patients must be referred to HIV clinics to begin treatment, and they are often lost to follow-up. Regardless of where ART is initiated, co-infected patients have to be referred from TB clinics to HIV clinics at the end of their TB treatment, and ART is often interrupted at this point. To address these issues, PEPFAR/DRC will support clinics that provide both TB and HIV services to reduce the need for referrals between TB clinics and HIV clinics, and will strengthen referral systems through clear documentation and counter-referrals. In addition, partners will conduct active tracking of clients and follow-up when clients are tested positive for HIV to ensure timely enrollment onto ART.

PEPFAR/DRC will also support community-based organizations (CBO) to raise community awareness of TB and link active and suspected TB cases to HIV testing services. These activities will align with the USG's 2015-2019 Global TB Strategy and will remain core PEPFAR activities. All HIV patients will be

screened for TB at every clinical appointment. For patients who have clinical appointments less than four times a year, community groups will be used to ensure that they are screened for TB at least once every three months. Community platforms will support contact tracing of co-infected patients to identify more HIV and TB patients through their family members. Community health workers (including former TB patients) will also support hard-to-reach populations and patients needing to travel long distances to access TB or HIV services.

In addition, PEPFAR/DRC will continue to provide technical assistance to the national and provincial laboratories and support the scale-up of GenExpert to improve TB case finding and sample quality, and will help create integrated TB/HIV forms and registers. PEPFAR/DRC will support improved pharmacovigilance measures to prevent negative interactions between HIV and TB drugs, especially for PLHIV who are on treatment regimens for MDR- or XDR-TB.

Coordination activities are planned at two levels. At the national level, quarterly meetings will be held bringing together PNLs, PNLT, provincial MOH TB coordinator (supported by and in coordination with Global Fund), Challenge TB, Integrated Health Project, and Action Damian. At the provincial level, meaning Kinshasa, Haut-Katanga, Lualaba, the DPS (provincial health division) leads quarterly TB-HIV partner meetings. All parties are in attendance, including provincial TB-HIV coordination bureaus, PEPFAR/DRC clinical partners, and Action Damian. In addition to quarterly meetings, there are joint supervision trips at the provincial level as well as joint reviews workshops.

To improve the performance of implementing partners in an ongoing and timely manner, PEPFAR/DRC will conduct periodic partner meetings and regular partner performance reviews to analyze performance data and suggest corrective actions to ensure a continual quality improvement process. For example, while FY2017 Q1 data showed a relatively high overall rate of TB patients knowing their HIV status in PEPFAR-supported health zones, a few health zones showed considerably lower rates, and these zones will receive additional technical assistance for targeted case-finding. This will continue to be one of the parameters for tracking partner performance, and IPs will develop improvement plans for low-performing sites.

#### **4.8 Adult HIV Treatment**

In FY2017, DRC supported 43,238 PLHIV on ART in 484 non-military sites. About 80 percent of ART patients are served in just 33 percent of sites. Fourteen sites have only one to four patients on ART.

DRC has a low coverage of adult treatment. In 2016, the PNLs reported 518,333 adults living with HIV, of whom only 135,661 were on ART. Since August 2016, the GDRC has adopted and implemented the new WHO treatment guidelines, with training of providers in these new guidelines now ongoing. The new guidelines will both increase the number of adults eligible for ART and increase the workload of health providers. To ensure that patients have access to ART, the GDRC has updated its policy on task shifting to allow full implementation of the new ART guidelines, including allowing nurses to initiate and monitor ART. Test and Start was rolled out in PEPFAR-supported health zones in October 2016.

Challenges encountered in FY2016 included low linkage to treatment and low retention rates. During FY2017, PEPFAR/DRC will close the treatment gap by bringing Pre-ART clients and newly-identified PLHIV for early ART initiation under Test and Start. By the end of FY2017, all pre-ART patients will be integrated into the treatment cohort; any clients refusing treatment will be followed actively. Any clients and who are lost to follow-up will continue to be actively tracked. Treatment sites will provide peer educators to continually assess adherence and other issues encountered by patients on ART. Friendly and flexible treatment services will be offered to men, key populations and adolescent girls



and young women to encourage uptake of services and retention on treatment.

To further improve on FY2016 results, PEPFAR/DRC will implement new partner management strategies to quickly identify and address challenges in reaching targets. On a regular basis, PEPFAR/DRC will share granular data analysis with implementing partners to help them improve their performance.

The PEPFAR/DRC ART service delivery package will include: (1) ART according to updated national guidelines; (2) cotrimoxazole prophylaxis; (3) prevention, diagnosis and management of TB (TB screening, Infection Control, IPT); (4) implementation of Quality Measure/Quality Indicator (QM/QI) initiatives at the facility and community level; (5) adherence support; (6) support for enhanced linkages and retention along the care cascade; and (6) lab monitoring on ART (e.g., viral load). In addition, health workers will be provided with training and mentorship, and will receive regular supportive supervision. This package has been defined in alignment with PEPFAR's core/near-core/non-core framework.

In addition to the PODI+ approach which decreases congestion and wait times at facilities, PEPFAR/DRC will provide differentiated care and treatment services to maximize efficiency of HIV services. Patients will be categorized as follow:

- Patients newly initiated on ART (defined as those who started ART in last six months): require clinic-based services
- Stable patients (defined as those with undetectable VL or meeting clinical criteria (adherent and regular clinic visits without opportunistic infections for 12 months)): require a clinic visit every six months to include required laboratory analyses, including VL, and ARV/CTX pharmacy pick-up every three months (or via PODI+)
- Patients presenting with advanced disease or failing ART: require close monitoring via monthly clinic visits with adherence counseling and support, monitoring of OIs, VL testing and transition to second line following national protocol.

Results from SIMS visits have underlined a lack of documentation of adherence support, and weak linkages to community services. In COP 2017,, PEPFAR/DRC will strengthen linkages with civil society organizations (CSOs), faith-based organizations (FBOs), non-governmental organizations (NGOs), Mentor Mothers, expert patients, and support groups in order to achieve the following:

- Link priority populations to care and treatment services, ensuring that all clients have access to same-day ART initiation and the full continuum of care
- Promote adherence and retention in care and treatment services by ensuring bidirectional (facility-community) referrals and tracking systems
- Support tracking of defaulters and clients lost to follow up by escorting clients to services as necessary and providing 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; Nutrition Assessment, Counseling, and Support (NACS) and WASH; and psychosocial support services
- Identify opportunities to leverage complementary services not provided by the program (e.g., access to condoms, family planning and maternal child health services, food distribution programs, mosquito nets)
- Conduct peer support group meetings and provide educational and counseling services

## 4.9 Pediatric Treatment

In FY2016, 3,534 children received ART in the PEPFAR/DRC program in 484 non-military sites offering ART services; this represents 7.8 percent of the total number of patients on ART. Among them, 1,217 children were newly enrolled. PEPFAR/DRC is working to expand pediatric treatment from 3,534 (FY2016) to 8,613 (FY2017) and 9,374 (FY2018) representing 10.5 percent of all patients targeted.

DRC has low pediatric treatment coverage. In 2014, 55,196 children were living with HIV, but only 8,523 (13 percent) were enrolled in treatment. In 2016, the GDRC adopted the WHO test and treat guidelines, including universal treatment for children living with HIV regardless of CD4 count.

The ACT Initiative aims to double the number of children on treatment from the 2013 baseline. ACT funding has been incorporated in the regular COP 2017 budget and will continue to focus on six pillars (policy; community engagement; case identification; linkage to care and treatment; initiation, adherence and retention; monitoring and evaluation). PEPFAR/DRC is also working to identify the highest-yield pediatric entry points.

PEPFAR/DRC will improve linkages and referrals between community and facility services through regular ACT Coordination meetings, led by the PNLS, and will continue to scale up pediatric treatment in high-yield locations to contribute to epidemic control. Case-finding methods such as the family-centered approach are being intensified among children born to HIV-positive adults, malnourished children, inpatients, OVC, children in TB clinics, and HIV-exposed infants.

The pediatric treatment service delivery package will include (1) EIDs; (2) targeted HTC of children; (3) PITC and disclosure for children and adolescents; (4) cotrimoxazole and nevirapine prophylaxis; (5) prevention, diagnosis and management of TB (i.e., TB screening, IC, IPT); (6) ARTs; (7) support to adherence and enhancing linkages and retention along the care cascade; and (8) lab monitoring on ART (e.g. VL). In addition, there will be training, mentoring and regular supportive supervision for health workers.

To increase pediatric treatment enrollment, adherence, and retention, PEPFAR/DRC will strengthen the community's role in ensuring linkages between facility- and community-based services. As with adult treatment, PEPFAR/DRC will work with community organizations, Mentor Mothers, expert patients, and other support groups, to achieve the following:

- Identifying and enrolling OVC into relevant social services
- Promoting adherence and retention in care and treatment services by ensuring bidirectional (facility-community) referrals and tracking systems
- Supporting tracking of defaulters and clients lost to follow up by escorting clients to services as necessary and providing feedback to facilities
- 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.

SIMS visits have highlighted a lack of support for adolescents with HIV at health facilities.

PEPFAR/DRC will develop targeted strategies and activities to meet adolescents' specific needs, such as creating more adolescent-friendly clinics.

#### 4.10 OVC

The National HIV AIDS Strategic Plan 2014-2017, (NSP 2014-2017) estimates that there are 391,053 orphans who have lost one or both parents due to HIV/AIDS in the DRC. Vulnerable children under the age of 15 frequently experience violence, sexual abuse, and economic hardship, and children living without parents (especially girls) are at higher risk of both maltreatment and HIV infection from sexual abuse and/or exploitation. Child marriage and early sexual debut rates are also high. As per the DRC DHS 2013-2014, 18.9 percent of 15-19 year old males and females have had their first sexual intercourse before the age of 15. The median age of the first union (wedding or sex partnership) was estimated at 18.7 years for 25-49 females. 21.3 percent of girls aged 15-19, and 6.5 percent of girls less than 15 were estimated to be married or living with a partner. According to UNAIDS, an estimated 42,000 children 0-14 years old are living with HIV in the DRC<sup>1</sup>. Supporting children living with, affected by, and vulnerable to HIV is essential to strengthening the HIV care continuum, preventing new infections, and achieving epidemic control.

In FY2016, 26,980 OVC received services for children and families affected by HIV. Of these beneficiaries, 3,463 were linked to HIV services including HTS, care, treatment and retention support. The PEPFAR/DRC OVC strategy for FY2018 will focus on delivering a comprehensive, high-quality service package to strengthen the pediatric and adolescent continuum of care, prevent new infections among AGYW 15-24 years, and mitigate the impact of HIV on children and families. In COP 2017, OVC targeting will prioritize CLHIV, ALHIV, children exposed to HIV, and children of PLHIV. Key entry points include clinics for children, adolescents and adults; CLHIV and ALHIV support groups; mentor mother or other PLHIV support groups; and prevention and treatment service providers targeting key populations. Community-based identification will prioritize orphans as well as children and adolescents (10-17 years) vulnerable to HIV infection. Facility-based and community implementing partners will use standardized tools for child vulnerability assessment and enrollment as well as a functional bi-directional referral protocol for targeting and service delivery. The following critical services will be delivered via family-centered, HIV-inclusive case management: (1) positive parenting and household economic strengthening (to mitigate HIV impact on OVC families and improve caregiving practices); (2) educational support; (3) HIV risk avoidance and reduction; (4) GBV prevention and response; (5) linkages to health and social services including comprehensive sexual and reproductive health; (6) HIV risk screening (with a focus on index case testing); (7) targeted referrals for HTS, care and treatment; and (8) support groups and monthly case conferencing for CLHIV and ALHIV.

OVC programs strongly support sustainable epidemic control (the three 90s) through their various activities. For the first 90, DRC OVC programs ensure that high-risk children are screened using an existing screening tool, and tested for HIV if needed. Additionally, OVC programs can encourage partner testing among the parents served in the program. For children or caregivers testing positively, OVC program staff are uniquely placed to provide psychosocial support and even pre-adherence counseling, supporting and improving the linkage of the HIV-positive individual to HIV care and treatment services. In support of the second and third 90, OVC programs jump off of existing groups, for example, parenting groups/classes and savings and loans groups, to provide adherence and retention support, as well as demand creation for viral load through education on patient rights and responsibilities. Finally, OVC programs are well-placed to support adolescent support services, either directly or by referral to facilities offering these services. Clearly, OVC programs in DRC provide critical support to the clinical cascade and achievement of sustainable epidemic control.

To improve the performance of OVC partners, PEPFAR/DRC will establish program quality standards and strong monitoring and evaluation systems such as regular performance reviews led by the activity

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<sup>1</sup> [http://www.unaids.org/en/dataanalysis/knowyourresponse/HIVdata\\_estimates](http://www.unaids.org/en/dataanalysis/knowyourresponse/HIVdata_estimates)

manager in order to routinely analyze program data and suggest corrective actions for continuous quality improvement.

#### **Program Area 4.11: Addressing COP 2017 Technical Considerations and Kinshasa Intensification Strategy**

PEPFAR/DRC used the COP 2017 Technical Considerations to design the strategy and activities outlined in Section 4 of the Strategic Direction Summary. While many of the activities are continuing implementation, PEPFAR/DRC will work closely with partners, sites, and GDRC, to ensure maximum efficiencies.

##### **A. Increased Focus on Prevention and Care Services for under 30 year olds**

PEPFAR/DRC will analyze entry points to identify highest-yield modalities for different age and sex bands to close the gap in the cascade, especially for adolescents less than 30 years old. Special attention will be paid to AGYW ages 10-24, especially in geographic areas with the highest HIV prevalence. Interventions prioritized for this population include GBV prevention and post-GBV care, youth-friendly sexual and reproductive health services, and skills training. Sites providing post-GBV care will provide the minimum package of services including post exposure prophylaxis and emergency contraception. These interventions will not only impact HIV incidence in adolescents and young adults, but will address intermediate outcomes such as poverty, early pregnancy, child marriage, sexual- and gender-based violence, and educational attainment.

##### **B. Increased Testing Yield and Improving Testing Modalities**

Targeted testing will be conducted using facility-based and community-based strategies. To improve yield, providers will use risk assessment tools, improve coverage of testing among TB and STI patients, optimize index testing, expand clinic hours to reach men, increase site capacity to accommodate peer educators to test in clinics, and maximize EID and pediatric entry points. Community testing will be optimized by conducting social and sexual network index testing, mobile testing, and home-based testing. For more details about COP 2017 testing strategies, refer to the testing section above (section 4.5).

##### **C. Improved Retention and Viral Suppression**

National test and start guidelines (including same-day initiation) were adopted and rolled-out in 2016. A task-sharing protocol was also adopted which included new optimized service delivery models to improve patient outcomes (PODI+ and multi-month dispensing). The current retention rate for FY2016 is 73 percent. PEPFAR/DRC plans to increase the retention rate from 73 percent to 85 percent for COP 2017. For more details about strategies to improve retention and increase viral suppression, see the “facility and community based care and support” section above (section 4.6).

##### **D. Support a sustainable, quality service delivery model**

In addition to the new national test and start guidelines and service delivery models, quality improvement activities through the supply chain aimed at improving long-term forecasting and efficient ARV distribution and commodities, as well as quality improvement activities through community and civil society platforms to reduce stigma and ensure community engagement, will support a sustainable strategy towards epidemic control. For more details about these strategies see the “facility and community based care and support” section above (section 4.6).

#### **Kinshasa Intensification Strategy**

The Kinshasa strategy, a game-changer for PEPFAR in Kinshasa, can be summarized in one word:

INTENSIFICATION. In COP 2017, PEPFAR/DRC will implement the most effective and efficient strategies across its portfolio. In Kinshasa, however, these activities will be implemented with enhanced vigor and focus, to ensure that PEPFAR-supported areas reach the goal of sustained epidemic control by 2020. In addition to the intensified intervention, PEPFAR/DRC will provide enhanced monitoring. A detailed description of PEPFAR DRC’s overall strategy, including planned monitoring can be found in Section 4; in the present section (4.11), only aspects specific to the Kinshasa strategy are highlighted.

As shown in Table 4.11.1, performance in Kinshasa has not been as strong as in Haut-Katanga. Kinshasa health zones typically have low HIV positivity (APR16: 1.9% in Kinshasa versus 3.6% in Haut-Katanga), requiring nearly twice the testing in Kinshasa to identify the same number of HIV-positive individuals. Case identification through targeted testing has been a challenge, given the low prevalence and large, homogenous population in Kinshasa. Patients in Kinshasa often seek HIV treatment outside of the health zone in which they seek initial testing, making linkage difficult. Given the proximity of Global Fund-supported health zones to PEPFAR-supported health zones, patients and their partners or sexual networks initially identified by PEPFAR programs may ultimately receive care and treatment in Global Fund-supported sites.

The Kinshasa Intensification Strategy focuses on the First 90, including intensifying case identification and linkage to treatment among underserved populations, especially a) key populations, b) men, and c) adolescent girls and young women (AGYW). In other entry points (TB, OVC, inpatient, PMTCT, etc.) efforts to maximize coverage of targeted testing to find HIV-positive individuals will continue, as outlined in Section 4. Linkage to treatment, while lower in Kinshasa than Haut-Katanga (73% vs 84%) is a focus throughout the PEPFAR program, and specific activities to address linkage are described in Section 4. The Kinshasa Intensification Strategy also includes a component of the Third 90, to address a missed opportunity of low viral load coverage in Kinshasa.

Table 4.11.1: PEPFAR-supported Health Zones in Kinshasa and Haut-Katanga by the Numbers (FY16)

	Kinshasa	Haut-Katanga
Number of health zones	17	22
Number of PLHIV in health zones	65,922	66,926
Number tested	478,346	257,334
Number HIV-positive	9,303	9,286
Percent positivity	1.9%	3.6%
Number new on treatment	6758	7,799
Percent linked (proxy)	73%	84%
ART Coverage (%)	30%	31%

### First 90: Identify HIV-positive Individuals among Critically Underserved Populations

#### a) Key Populations

PEPFAR DRC will expand KP programming in Kinshasa, to reach and test more female sex workers (FSW) and men who have sex with men (MSM ). To accomplish this, PEPFAR/DRC will increase the intensity and frequency of KP outreach activities, including moonlight testing, and community/mobile index testing, and will explore motivational practices to maximize the case identification rate of each KP peer educator/navigator. To increase the uptake of index testing among steady partners of FSWs (called “loves”), three modalities of partner notification (client referral, contract referral, and provider referral) will be rolled out in Kinshasa.

Table 4.11.2: Key Populations Prevention and Testing Achievements and Targets in Kinshasa

	APR16 achieved	COP 2017 target	Percent change
KP_PREV	14,267	20,256	42%
HTC_TST	13,617	20,256	49%
HTC_POS	254	750	195%
Percent POS	1.9%	3.7%	106%
TX_NEW	176	720	309%
Linkage (proxy)	69%	96%	27%

b) Men

In COP 2017, in all PEPFAR-supported health zones, including Kinshasa, PEPFAR DRC will fill the gaps in coverage of ART in men, particularly men 25-49 years old. In Kinshasa, PEPFAR DRC will increase the number of HIV-positive men identified from FY16 to FY18 by 154% over APR16 results. Populations of particular interest in Kinshasa include fishermen and motorcycle taxi drivers. Index/partner testing will be intensified among PEPFAR DRC's dominantly female treatment cohort to engage and identify more HIV-positive men.

Table 4.11.3: Testing and Treatment Results and Targets: Men

	APR16 achieved	COP 2017 target	Percent change
HTC_TST, males 15+*	86,501	186,800	116%
HTC_POS, males 15+*	2,030	5,165	154%
Percent positivity	2.3%	2.8%	22%
Males 15+ percent of total adult positives	33%	39%	6%
Male 15+ TX_NEW	1,386	3790	173%
Percent linkage (Proxy)	68%	74%	6%

\*Data presented is males 15+ due to data availability, although the intensification focuses on men 25-49 years old

c) Adolescent Girls and Young Women (AGYW), 10-24 years old

In FY16, HIV testing and positivity among women 10-24 years old was very low. Only 624 AGYW aged 10-24 tested positive (0.7% of total tested). In COP 2017, PEPFAR will conduct active outreach to find high-risk AGYW and link them to prevention support, including HIV testing for high-risk girls and women. In Kinshasa, this outreach will include piggybacking on existing gatherings of girls and women, such as school programs, social gathering areas, and workplaces, for example, hair salon apprentices, of which there is a substantial network in Kinshasa. With active, targeted outreach to the right girls and women, PEPFAR/DRC will implement more targeted testing to increase the number and percentage of positives identified among AGYW. Specific targets, showing a marked increase, will be discussed with partners based on initial assessments at the community level.

Table 4.11.4: AGYW Prevention, Testing & New on Treatment, 10-24 year olds

	APR16 Achieved
HTC_TST	89,657
HTC_POS	624
Percent POS	0.7
TX_NEW	447
Percent linkage (proxy)	72%

### Third 90: Viral Load Scale-up in Kinshasa

Although the Kinshasa Intensification Strategy focuses primarily on the first 90, including linkage, viral load testing is a missed opportunity in Kinshasa, where molecular laboratory capacity is readily available to support high viral load coverage. PEPFAR/DRC will work with CBOs to create demand for VL testing among patients, and IPs will work with healthcare providers to ensure adherence to the VL testing protocol. PEPFAR DRC will use SIMS results to regularly monitor VL coverage throughout the year.

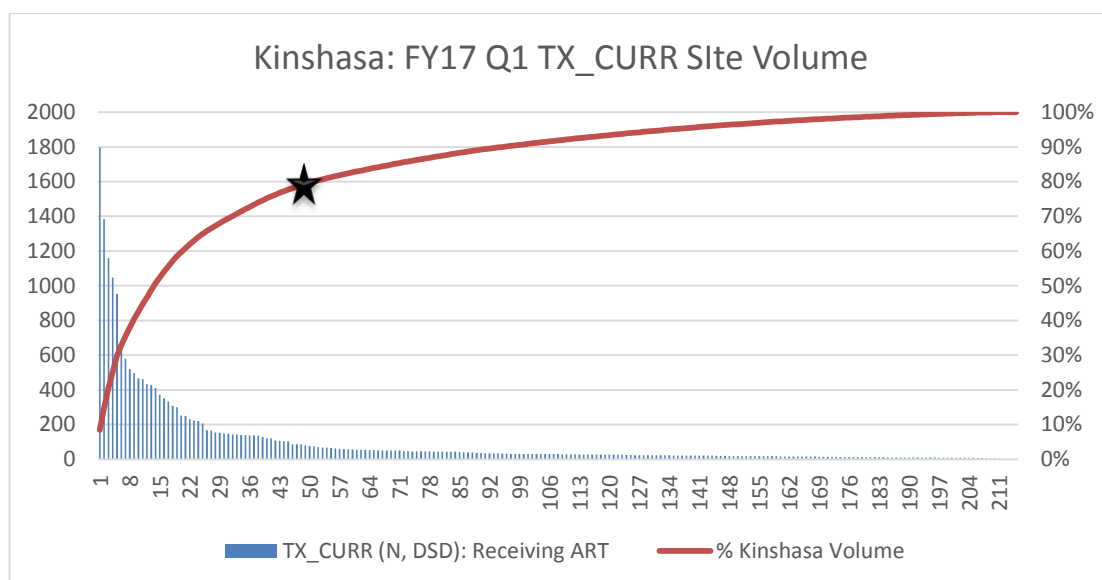
Table 4.11.5: Viral Load Results and Targets

	APR16 Achieved	COP 2017 Target	Percent Change
<b>TX_CURR</b>	28,728	34,652	21%
<b>Eligible for VL test</b>	NA	30,499	NA
<b>VL test done, results received</b>	5,724	22,874	300%
<b>VL coverage</b> (proxy: results received/eligible)	23%*	75%	NA
<b>Suppressed</b>	4,175	18,191	336%
<b>Percent suppressed</b>	73%	80%	7%

\*Estimated

### Enhanced Monitoring of Results and Targets in Kinshasa

To uphold the intensity of activities in Kinshasa, PEPFAR/DRC will conduct monthly partner performance consultations. As with the rest of the PEPFAR/DRC portfolio, activity managers will conduct monthly partner performance consultations based on findings from quarterly data reviews, as described in Section 4.1. In addition, in Kinshasa, activity managers will conduct monthly data reviews for core clinical cascade indicators. Special attention will be given to high-volume sites that have a large impact on yearly results. Based on Q1 data, 51 of 212 sites (24%) supported by PEPFAR/DRC in Kinshasa account for 80% of all PLHIV on ART.



### Kinshasa Intensification Strategy for Sustained Epidemic Control

The special focus on case finding among particular populations in Kinshasa will significantly increase the number of new patients on treatment. The PEPFAR/DRC Team will closely monitor implementation of the strategy, starting in April 2017, to ensure full implementation and rapid remediation when necessary. With the Kinshasa Intensification Strategy, PEPFAR/DRC is on track to achieve sustainable epidemic control in PEPFAR-supported health zones by 2020.

## **Program Area 4.12: Commodities**

Beginning in COP 2016, PEPFAR/DRC has been providing all commodities for PEPFAR-supported health zones, sites, and patients. This will continue in COP 2017, thereby reducing the risk of stock-outs in PEPFAR-supported health zones. Strong coordination and information-sharing among the PNLS, the Global Fund, and PEPFAR will continue to ensure that the national supply chain for HIV commodities is functioning well.

To reduce the risk of stock-outs of HIV commodities and to improve stock management, PEPFAR/DRC will accomplish the following:

- 1) Support national and provincial quantification of HIV commodities (provide tools, review parameters, conduct training on the use of Forlab and Quantimed tools)
- 2) Review stocks at the provincial level and provide quarterly supportive supervision at the site level
- 3) Ensure that the information system (LMIS) operates and that data collection takes place and ensure that data analysis and sharing takes place through the technical working group
- 4) Build health worker capacity on stock management, multi-month dispensing, and rational use
- 5) Support distribution to the last mile of HIV commodities, logistics, and management tools in all PEPFAR-supported health zones
- 6) Implement the Electronic Dispensing Tool (EDT) at selected high-volume sites
- 7) Establish and strengthen the VL/EID commodities supply chain and sample transportation

Although each donor procures commodities to cover patients in their rationalized health zones, PEPFAR and the Global Fund share the same laboratories in Kinshasa and Lubumbashi for VL/EID testing. Each donor will supply reagents to these laboratories according to their targets and planning. Any deviation from plans by either donors' partners (for example, testing in excess of planned targets or delays in reagent procurement/arrival) increases the risk of stock outs for these reagents. Improved coordination and information sharing between PEPFAR and the Global Fund on laboratory stock and usage data will be critical. To ensure accurate and timely collection of consumption data, PEPFAR is introducing a monthly tracking system for the key viral load and EID reagents and commodities, resulting in better forecasting and course correction with existing and upcoming orders. Improved tracking of sample processing will also be implemented to better follow each sample from collection at the site level to the delivery of results.

Discussions are underway with the Global Fund and PNLS to arrange for cost savings for VL commodities by committing to a minimum volume for three years. If this agreement is implemented, both PEPFAR and the Global Fund will achieve significant savings for VL reagents.

The updated HIV national guidelines introduced in September 2016 include the use of the VIKIA rapid test, as well as the new third-line treatment regimen (Darunavir, Dolutegravir, and Raltegravir). Currently, there are no patients for the third-line regimen in DRC. The Global Fund, PNLS, and PEPFAR are discussing implementation of this new regimen, including a rollout of provider training to ensure standard operating procedures for shifting patients, and ensuring availability in the supply chain while minimizing expiry risk of third-line ARVs.

## **Program Area 4.13: Collaboration, Integration and Monitoring**

The focus of COP 2017 is to strengthen implementation across the entire clinical cascade, with a special emphasis on collaboration with the Global Fund, PNLS, and civil society organizations; strengthening IP management and monitoring; implementing innovative strategies across the cascade to improve impact and increase efficiencies; and integration of key health systems interventions.



Continued strong collaboration with the Global Fund, the PNLs, and civil society organizations will be critical to achievement of sustained epidemic control in DRC. Full implementation of VL testing requires close collaboration, including joint supply planning, and sharing of commodity stock and use information. The Global Fund and PEPFAR will continue to ensure zero duplication in support of shared molecular laboratories. A memorandum of understanding would be helpful to outline the commitment of each donor to provide commodities for patients the donor supports, as well as for standard operating procedures in terms of communication and planning around potential stock outs. In areas of joint support, such as commodity, laboratory, and surveillance technical assistance, PEPFAR/DRC will work with the Global Fund and PNLs to ensure synergistic (not duplicative) support that moves the country and the systems toward sustainable epidemic control.

PEPFAR/DRC will continue strong collaboration with civil to enhance the supportive environment for HIV services and reduce stigma and discrimination, especially toward key populations. Civil society organizations will continue to play a role in case finding, demand creation including viral load, retention, and advocacy for support for HIV services.

Strengthening partner management to improve implementation across the clinical cascades is a priority for COP 2017. Elements of the partner management strategy includes systematic and regular reviews of partner data and performances, discussion of programmatic shifts to measure performance, review of SIMS results and progress toward improved quality, review of pipeline and financial information, regular joint meetings, mentorship during site and SIMS visits, and monthly performance consultations, as described in Section 4.1. In Kinshasa, these monthly consultations will include reviews of core clinical indicators to ensure implementation of the Kinshasa intensification strategy. In addition, PEPFAR/DRC commits to reinitiating formal partner meetings quarterly, in addition to ad hoc and specific technical meetings, such as Accelerating Children’s HIV Treatment (ACT) Initiative or Monitoring, Evaluating & Reporting Indicators (MER) reviews. These quarterly partner meetings will be organized around a specific theme, for example, maximizing testing yield to reach the first 90, starting in April 2017.

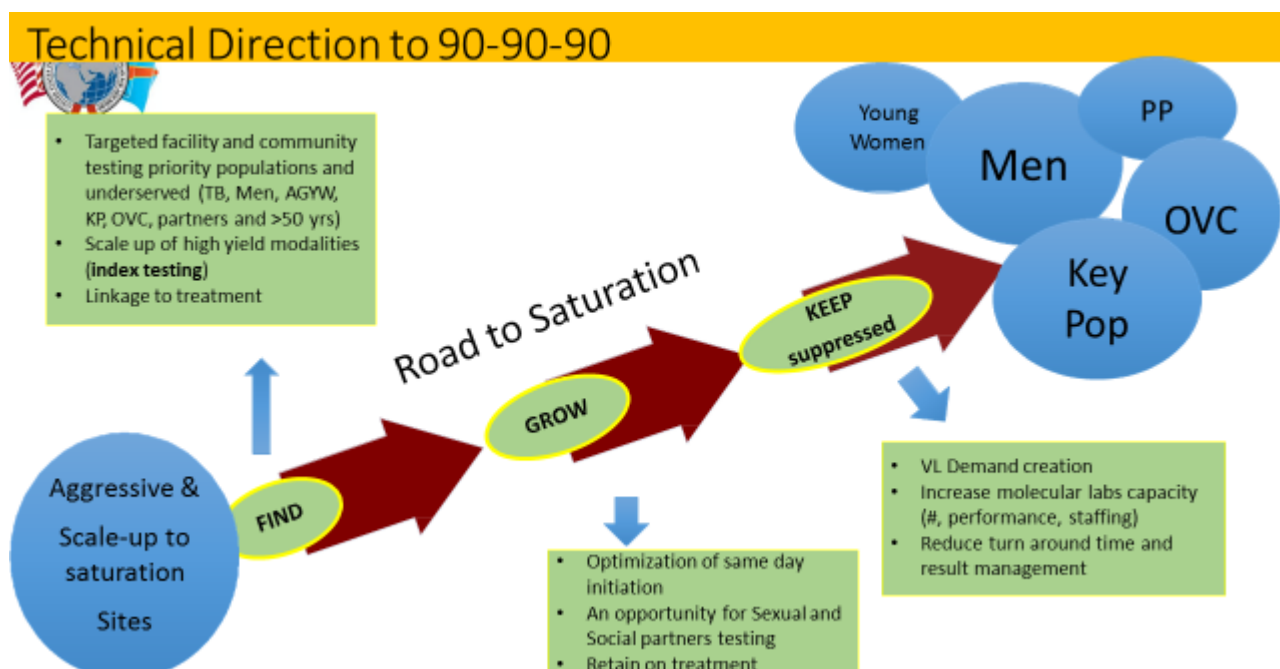


Figure 4.13

The graphic “Technical Direction to 90-90-90” outlines PEPFAR/DRC’s approach to improving partner performance across the cascades, addressing the major challenges encountered in FY2016 and the first quarter of FY2017. These challenges include identifying positives, especially in priority age and sex bands, linkage to treatment of those found HIV-positive, retention on treatment at 12 months and

beyond, and access to VL and rapid return of results.

In COP 2017, PEPFAR/DRC will continue partnering with CSOs on case finding intensification, patient tracking, and ARV dispensing at the community level, as well as general efforts to reduce discrimination and stigma and increase demand and support for HIV services, especially among key and priority populations.

## 5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

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As outlined in Section 4.0, all SNU are classified as “aggressive scale-up”. COP 2017 implementation will focus on achieving saturation across all age and sex bands in all PEPFAR-supported areas.

## 6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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In line with the broader principles of streamlining in COP 2017, the intent of PEPFAR/DRC’s systems investments is to stay the course and refine, as needed, the three-year focused systems investments and outcomes defined in COP 2016. PEPFAR/DRC validated the identified barriers and three-year outcomes listed in the tables in the COP 2016 SDS Section 6.0 and defined investment activities, budgets, and progressive benchmarks by which to assess progress towards outcomes going forward. Outcomes and annual benchmarks will be assessed annually through the POART process.

On the road to saturation, PEPFAR/DRC will maintain its systems investments in the areas of quality management, laboratories, and supply chain management to continue addressing the structural barriers to care identified in COP 2016 by strengthening the national system to improve service and data quality within the three provinces (Kinshasa, Haut-Katanga and Lualaba); ensuring improved integration of HIV and TB interventions at the national and provincial levels; ensuring access to viral load and EID and implementing continuous laboratory quality improvement initiatives to ensure accurate and timely diagnostics; re-enforcing the healthcare system through strategic service models that bridge clinical and community-based services; and measuring progress towards attaining the 90-90-90 targets.

### 6.1. Critical systems investments for achieving key programmatic gaps

To solve the first programmatic gap (Table 6.1.1, Low number of patients identified positive put on ART), socio-cultural environmental barriers that affect both health workers and patients will be addressed by providing more user-friendly services at the health facility and community levels, and by ensuring improved rates of same-day initiation. Other barriers, including the lack of alignment of treatment guidelines with WHO directives, unclear task shifting directives, lack of trained health workers, commodity stock-outs, and weak referral and counter-referral systems between health facilities and communities were mostly addressed during year 1, and PEPFAR/DRC has decided to incorporate all the proposed activities associated with those gaps into the program area target-based budgets. The rationale was that the main cost categories associated with these barriers are already cost categories within the target-based budgets.

Stronger investments will be made in HIV/TB co-infection activities, which have produced the highest

testing yield despite limited investment. SIMS data also show the need for additional investments to improve poor infection control measures within the PEPFAR-supported sites. Two priority structural barriers will be addressed: weak coordination between HIV and TB programs at the national and provincial levels, and the inadequate implementation of TB measures (Table 6.1.2, insufficient integration of HIV/TB interventions). These barriers will be addressed by strengthening the capacity of national and provincial MOH staff in management of HIV/TB coinfection activities, supporting HIV/TB technical working groups, ensuring joint supervision of HIV/TB activities, and disseminating HIV/TB guidelines and policy guidance.

To address low access to VL and EID and weak lab quality improvement initiatives to ensure accurate and timely diagnostics (Table 6.1.3), PEPFAR DRC proposes in COP17 an aggressive scale up strategy to ensure that 75% of ART patients will get at least one VL per year by optimizing the existing system. With technical assistance from PEPFAR/DRC, the GDRC will be able to rapidly scale up VL and EID activities from the three PEPFAR-supported provinces to reach national scale. In this regard, PEPFAR/DRC will strengthen the national DRC laboratory system to include the whole spectrum of VL and EID activities, from demand creation to communication of results to patient management. Also, to ensure the quality of testing, the rapid testing continuous quality improvement program will be strengthened and scaled up in all PEPFAR-supported sites. PEPFAR DRC will prioritize the following activities to improve lab-clinical interface, strengthen and address gaps within the VL testing cascade:

1. Increase demand creation as well as uptake of results and patient management system at national and clinical site level
2. Establish and reinforce VL testing commodities and procurement system
3. Support the national equipment maintenance plan
4. Develop and implement with PNLs a comprehensive EID and VL specimen referral system
5. Strengthen human capacity for expansion of use of VL for ART monitoring
6. Ensure continuous quality improvement initiatives at molecular laboratories
7. Roll out VL management system in all PEPFAR supported provinces at high volume sites, molecular laboratories and SI offices to ensure receipt of results in a reasonable TAT.

PEPFAR/DRC through ASM will be working at the national level to support the development, dissemination, and capacity building for revised policy, guidelines, and SOPs, and using data to improve scale-up of VL testing. PEPFAR/DRC clinical partners will roll out VL activities at sites while GHSC, the supply chain partner, will ensure the procurement. The partnership of clinical, laboratory, SI, and supply chain expertise are critical to success.

Ambitious viral load targets for PEPFAR/DRC have been set for COP 2017, as shown in the table below.  
Table 6.1.1: PEPFAR/DRC Cop 2017 Targets by Province

	<b>Military</b>	<b>Lualaba</b>	<b>Kinshasa</b>	<b>Haut-Katanga</b>	<b>Total</b>
<b>TX_PVLS (D, DSD) TARGET: Viral Load Documented</b>	2,676	3,732	22,866	24,857	54,131
<b>Number of Tests Needed</b>	3565	4,973	30,466	33,119	72,123

## 6.2. Critical systems investments for achieving priority policies

The PEPFAR/DRC team identified priority systems gaps in COP 2016, including the lack of a national policy for Test and Start, inadequate training of health providers, and the lack of an efficient and effective supply chain and commodities tracking system, as the top three systems barriers to successful implementation of Test and Start. In FY2016 and FY2017, PEPFAR successfully supported the MOH to develop and implement a new Test and Start policy. Through a recent national joint quantification on drugs and laboratory commodities and an analysis of supply chain issues over the past year, commodity security and supply chain, including the risk for stock outs and overstock of HIV commodities, have been identified as a barrier to test and start implementation (Table 6.2.1). Critical challenges including avoiding stock outs and ensuring a regular supply of HIV-related commodities

will continue to be addressed in order to ensure availability of critical treatment services.

Key interventions will include supporting national and provincial quantification of HIV commodities; improving information systems for collection and analysis of commodities-related data; building health worker capacity for stock management, multi-month dispensing and rational use of drugs; and supporting last-mile distribution of HIV commodities. PEPFAR will invest \$1,800,000, including last mile distribution, to overcome test and start barriers.

In COP 2016, PEPFAR successfully supported the MOH in developing policies on new service delivery models, including community-based delivery models. The remaining activities associated with this gap were incorporated into the targets-based budget.

### **6.3 Proposed system investments outside of programmatic gaps and priority policies.**

To support 90-90-90 targets, PEPFAR will invest in strategic information to obtain real time data to drive the national program. Strategic information activities include the following: strengthening the national health information system (HIS), improving the infrastructure and use of a routine electronic data system to provide advanced and granular epidemiological program data, building host country institutional and organizational capacity for data management, continuing to support the web based electronic reporting system (MESI), supporting the GDRC on the data quality improvement system and on HIV/AIDS surveillance activities, and supporting military coordination offices to ensure national data collection.

DRC has a new P<sub>3</sub> national TB laboratory dedicated to quality assurance of TB testing at the national level. PEPFAR/DRC will ensure the accreditation process for this P<sub>3</sub> TB laboratory which is the sole P<sub>3</sub> TB laboratory for the entire central African region. PEPFAR/DRC will also ensure PEPFAR procured equipment will be maintained.

Addressing the three 90s, PEPFAR, through Global Health Supply Chain-Technical Assistance mechanism, will implement an electronic dispensing tool (EDT) at high volume sites and map overlapping distribution streams in the broader health system, including mapping various actors that support multiple logistics functions. This will help to facilitate accurate and efficient dispensing of the necessary commodities at the site level to ensure continuation of services.

## **7.0 USG Management, Operations, and Staffing Plan to Achieve Stated Goals**

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PEPFAR/DRC conducted a staffing assessment to determine the skills and level of effort (LOE) needed to achieve sustainable epidemic control by 2020 through the strategy defined in COP 2017, including intensive partner management. With the anticipated onboarding of the seven new positions approved in COP 2016, the PEPFAR/DRC team will have an appropriate mix of technical and administrative skills and support, with adequate LOE to implement the strategy outlined in COP 2017. No new positions are proposed in COP 2017.

To align human resources with the strategic focus in Haut-Katanga, PEPFAR/DRC plans to install a provincial team in Lubumbashi. This team will include five new positions: two Strategic Information Advisors (CDC, USAID) one Lab Advisor (CDC), one Care & Treatment Specialist (USAID), and one driver (CDC). These new staff will join the existing CDC Medical Officer currently based in Lubumbashi. The new positions were approved in COP 2016; however, recruitment cannot proceed further until a DOS-approved office space is available. Until the Haut-Katanga team is in place, USAID

and CDC will continue to ensure a strong Kinshasa-based staff presence in Lubumbashi.

On March 9, 2017, The Bureau of Overseas Building Operations approved the Lubumbashi office. Signature of the memorandum of understanding between US Embassy and Lubumbashi provincial management staff is planned for April 2017. PEPFAR/DRC continues to work closely with Embassy management and OGAC to ensure the office is set up quickly. PEPFAR/DRC is working toward filling vacant positions, including new positions approved in COP 2016. As discussed previously, the hiring of the five Lubumbashi positions is on hold until the office space is available for occupancy. Current vacancies for CDC include: Branch Chief for Service Delivery, Cooperative Agreement Manager, and Admin Assistant. Hiring for one vacant USAID position (OVC Advisor, a new position in COP 2016) has been halted due to the Presidential Memorandum Regarding the Hiring Freeze (January 23, 2017). Hiring for the Care & Support Specialist (attrition hire, vacant as of December 2016) has recently resumed and is the final phases of selection. The Department of State has two critical vacant positions: the PEPFAR Coordinator, vacant since October 2015, and the PEPFAR Interagency Strategic Information Advisor, approved in COP 2015. As of November 2015, DOD is fully staffed.

Intensifying partner management is a focus of COP 2017. One aspect of partner performance is SIMS. The PEPFAR team is planning for 35 staff members to spend an average of 11 days per quarter conducting SIMS visits, to ensure quality and remediation of poorly performing sites. Geographic size, economic and political instability, and limited transportation and infrastructure contribute to a relatively high cost of doing business in the DRC. The COP 2017 cost of doing business (CODB) request represents the minimal staffing and administrative support needed to achieve COP 2017 targets, advancing DRC on the path towards sustainable epidemic control by 2020.

## APPENDIX A: SNU Prioritization by Cluster

Table A.1: SNU Prioritization and Treatment Coverage

SNU	COP 2015 Prioritization	APR16 Achievement	COP 2016 Prioritization	Expected Achievement By APR17	COP 2017 Prioritization	COP 2017 Target: (APR 18)
<b>Kinshasa Saturation</b>	Scale-up: Saturation	31%	Scale-up: Saturation	43%	Scale-up: Aggressive	57%
<b>Lubumbashi Saturation</b>	Scale-up: Saturation	39%	Scale-up: Saturation	58%	Scale-up: Aggressive	76%
<b>Kinshasa Sustained</b>	Sustained	28%	Sustained	38%	Scale-up: Aggressive	50%
<b>Haut-Katanga Sustained</b>	Sustained	24%	Sustained	35%	Scale-up: Aggressive	46%
<b>Lualaba Sustained</b>	Sustained	124%	Sustained	217%	Scale-up: Aggressive	313%

Table A.1: ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY2017)	Additional patients required for 80% ART coverage	Target current on ART (APR FY2018) TX_CURR	Newly initiated (APR FY2018) TX_NEW	ART Coverage (APR 18)
Scale-Up Aggressive	135,648	63,567	44,951	83,840	30,086	62%
Military_DRC	N/A	4,840	N/A	5,680	1,692	N/A
<b>Total</b>	<b>135,648</b>	<b>68,407</b>	<b>44,951</b>	<b>89,520</b>	<b>31,778</b>	<b>62%</b>

## APPENDIX B: Planned Spending in COP 2017

**Table B.1.1 Total Funding Level**

Applied Pipeline	New Funding	Total Spend
\$6,182,419	\$65,495,391	\$71,677,810

**Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)**

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$3,940,955
HVAB	Abstinence/Be Faithful Prevention	\$55,452
HVOP	Other Sexual Prevention	\$1,876,580
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$57,851
HMIN	Injection Safety	\$99,324
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$7,778,233
HBHC	Adult Care and Support	\$6,806,897
PDCS	Pediatric Care and Support	\$1,768,395
HKID	Orphans and Vulnerable Children	\$4,713,726
HTXS	Adult Treatment	\$13,127,792
HTXD	ARV Drugs	\$13,686,038
PDTX	Pediatric Treatment	\$1,638,278
HVTB	TB/HIV Care	\$846,880
HLAB	Lab	\$840,641
HVSI	Strategic Information	\$2,331,295
OHSS	Health Systems Strengthening	\$1,290,055
HVMS	Management and Operations	\$4,637,000
<b>TOTAL</b>		<b>65,495,392</b>

### B.2 Resource Projections

PEPFAR/DRC worked closely with partners to collect accurate expenditure data from IMs during the FY2016 Expenditure Analysis (EA) initiative. PEPFAR unit expenditures (UE) from this analysis and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HTC, care and treatment, PMTCT, priority and KP prevention, and OVC. For the target-based portion of the budget, budgeting was done at the mechanism level where mechanism-specific UEs were applied to the mechanism targets. The UEs excluded ARVs, Non-ARV Drugs/Reagents, HIV test kits and condoms (budgeted separately in the commodities calculator). For CDC and USAID, adjustments to UEs were made at the mechanism level to account for fixed and variable costs, and outliers were analyzed and adjusted. The following categories were changed, from variable to fixed, across program areas: in-service training, construction & renovation, vehicles, equipment & furniture, other investments, personnel, building rental and utilities, program management, and strategic information. DOD did not make adjustments for fixed and variable costs. To calculate the OVC UE, the team did not use EA FY2016 as it did not represent a full year of implementation. Rather, using current Q1 financial data, anticipated FY2017 results, and expenditure data by service disaggregation from FY2016 EA, the team validated a \$100 applied UE for this COP budgeting cycle. Two new mechanisms with no EA 2016 data used the average UE. In addition to EA data, resource projections and earmarks required from the funding letter, as well as DRC-specific technical considerations,



helped guide the program decision making and budgeting process. The PEPFAR/DRC Team examined FY2016 programming and the proposed FY2017 strategy and added into the site-level activity budget any new activities that would not have been included in the FY2016 UE. For example, partners were given lump sum budget amounts to account for the increased and intensive outreach planned to bring in hard-to-reach groups. When the budget indicated that resources would be insufficient for all desired activities not tied to targets, prioritization helped PEPFAR/DRC select the most important activities to achieve epidemic control in DRC. The PBAC submitted at the DC Management Meeting was balanced with all earmarks reached.

**Table B.1.3: Weighted UEs by Program Area and Indicator**

<b>Program Area</b>	<b>Beneficiary Type</b>	<b>SNU</b>	<b>Weighted Average UE</b>
FBCTS	Adult ART	48 HZ + military area	\$168.40
	Peds ART	48 HZ + military area	\$ 196.46
PMTCT	Pregnant Women Tested	48 HZ + military area	\$9.02
	Women receiving ARV	48 HZ + military area	\$168.40
	Infants tested	48 HZ + military area	\$240.17
HTC	HTC PITC	48 HZ + military area	\$5.68
	HTC VCT	48 HZ + military area	\$6.55
	HTC CBCT	12 HZ	\$12.40
OVC	OVC	34 HZ	\$100
PP-PREV	Priority populations	12 HZ	\$19.11
KP-FSW	FSW	14 HZ	\$21.41
KP-MSM	MSM	14 HZ	\$113.16



## APPENDIX C: Section 6.o Tables

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See attached Excel file.

**Table 6.1.1 Key Programmatic Gap #1: Low Number of patients that are diagnosed positive and put on**

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
<b>1. Health System barriers Treatment guidelines not aligned to the last WHO directives, unclear task shifting approach, limited trained human resources, frequent commodity stock-outs</b>	95% of PLHIV identified in PEPFAR-supported sites initiated on ART. All PEPFAR-supported sites implement Test and Start			Number of providers trained on test and start	6.1.1.1.1.Implement test and start (update policy, train providers)	OHSS PDTX HTXS PDCS HBHC	\$0	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	2. Policies and Governance (Yellow), 6. Service Delivery (yellow)
				Availability of ART security stock	6.1.1.1.2.Strengthen national supply chain system	OHSS	\$0	GHSC-PSM, GHSC-TA	8. Commodity security and supply chain (Red)
					6.1.1.1.3.Procure ARVs, RTKs and other necessary commodities to allow for Test and Start in all PEPFAR-supported sites	HTXD,PDTX, HBHC, HTXS	\$0	GHSC-PSM, GHSC-TA	8. Commodity, security and supply chain (Red)
				Number of providers trained on post-test counseling in PEPFAR	6.1.1.1.4.Strengthen providers capacity in post-test counseling (training/refresher, clinical mentorship, supportive supervision, SOPs, ...)	PDTX HTXS PDCS HBHC	\$0	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L, IHAP	7. HRH (Yellow), 6. Service Delivery (Yellow)
				Well-functioning referral system implemented	6.1.1.1.5.Establish clear active referral system to treatment site mainly with mobile testing program to ensure continuum of care	PDTX, HTXS PDCS, HBHC	\$100,000	ICAP, EGPAF, SANRU, PIHAP-Kinshasa, IHAP-HK/L	6. Service Delivery (Yellow)

<b>2. Socio-cultural environment barriers</b>	PEPFAR-supported health facilities and communities are user-friendly for PLHIV	Train providers on confidentiality and non-discrimination	Providers near KP hotspots trained in KP-friendly HIV prevention, care, and treatment services	Patient surveys & monitoring clinic suggestion boxes	6.1.1.2.1. Review barriers and provide provider training to increase quality of KP care and treatment services	PDCS, HBHC	\$250,000	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	3. Civil Society Engagement (Yellow), 6. Service Delivery (Yellow)
	Full implementation of same-day initiation	Same-day initiation incorporated into treatment guidelines	Barriers and strategies to improve same day initiation identified and addressed	[Relevant Indicator]	6.1.1.2.2. Site- and patient-level analysis of same day initiation to identify barriers (systemic and individual) to improve same day initiation	PDCS, HBHC	\$150,000	ICAP, EGPAF, SANRU, PIHAP-Kinshasa, IHAP-HK/L	

<b>3. Weak referral and counter-referral systems between health facility and community</b>	Improved community management of ARV (PODI+)			Number of PODI+ centers implemented	6.1.1.3.1.Establish PODI+ centers in selected high volume sites in scale-up HZs	PDCS HBHC,HTXS	\$1,005,750	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	6. Service Delivery (Yellow)
	100% of HZs supported by PEPFAR have a strengthened motivation system for CHW			Tools implemented to monitor tracking system	6.1.1.3.2.Reinforce the tracking system for defaulters (registers, agenda for appointments...)	PDCS HBHC,HTXS	\$0	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	6. Service Delivery (Yellow)
	100% of HZs supported by PEPFAR implement strong patient tracking system for ART			Referral system implemented	6.1.1.3.3.Organize active referral through peer navigators/peer educators/mentor mothers	PDCS HBHC,HTXS	\$105,000	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	6. Service Delivery (Yellow)
				HCWs fees motivated	6.1.1.3.4.Establish motivation system for community health workers	PDCS HBHC,HTXS	\$85,000	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L	6. Service Delivery (Yellow)
<b>TOTAL</b>							<b>\$1,695,750</b>		

**Table 6.1.2 Key Programmatic Gap #2: Insufficient integration of HIV & TB intervention**

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Weak coordination between HIV & TB programs at the national and provincial levels	100% of HZs supported by PEPFAR use HIV/TB tools and registers jointly developed by PNLS and PNLT	50% of HZs supported by PEPFAR use HIV/TB tools and registers jointly developed by PNLS and PNLT	100% of HZs supported by PEPFAR use HIV/TB tools and registers jointly developed by PNLS and PNLT	%of HZs supported by PEPFAR using jointly developed HITTB tools	6.1.2.1.1.Workshop, dissemination, training	OHSS	\$255,000	IHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);
	100% of PNLS and PNLT staff members at national and provincial levels supported by PEPFAR are trained on management of TB/HIV	40% of PNLS and PNLT staff members at national and provincial levels supported by PEPFAR are trained on management of TB/HIV	100% of PNLS and PNLT staff members at national and provincial levels supported by PEPFAR are trained on management of TB/HIV	% of staff members of PNLS and PNLT trained on management of TB/HIV	6.1.2.1.2.Workshop	OHSS	\$255,000	IIHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);
	100% of supported HZs receive 6 joint TB/HIV supervision from national and provincial levels	100% of supported HZs have received 2 annual TB/HIV programs joint supervisions	100% of supported HZs have received 4 annual TB/HIV programs joint supervisions	% of TB/HIV programs joint visits	6.1.2.1.3.supervisions, coaching	OHSS	\$170,000	IHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);

	Quarterly TB/HIV working groups meetings at national and provincial levels supported	100% of quarterly TB/HIV working group meeting supported at national and provincial levels	100% of quarterly TB/HIV working group meeting supported at national and provincial levels	% of quarterly TB/HIV working groups meetings	6.1.2.1.4.TWG meetings supported	OHSS	\$85,000	IHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);
2. Inadequate implementation of TB prevention measures	100% of supported HZs adopt TB infection control measures	50% of PEPFAR-supported HZs have adopted TB infection control measures	100% of PEPFAR-supported HZs have adopted TB infection control measures	% of PEPFAR-supported HZs with TB infection control measures	6.1.2.2.1.trainings, dissemination of guidelines	OHSS	\$42,500	IHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);
	100% of supported HZs adopt and implement IPT	50% of PEPFAR-supported HZs have adopted and implement IPT	100% of PEPFAR-supported HZs have adopted and implement IPT	% of PEPFAR-supported HZs with IPT	6.1.2.2.2.trainings, dissemination of guidelines	OHSS	\$42,500	IHAP-Kinshasa, IHAP-HK/L, ICAP, EGPAF, SANRU and PSI	Planning and coordination ; policies and governance (Yellow);
<b>TOTAL</b>							<b>\$850,000</b>		

**Table 6.1.3 Key Programmatic Gap #3: Low access to viral load and EID and Weak lab quality improvement initiatives to ensure accurate and timely diagnostics**

Key Systems Barri	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
	95% of HIV patients on ART have at least one viral load result per year	30% of HIV patients on ART have at least one viral load result per year	75% of HIV patients on ART have at least one viral load result per year	Number of HIV patients on ART with at least one viral load result per year as documented in the Laboratory Information System (LIS) or medical records	Improve lab-clinical interface, strengthen and address all gaps within the viral load testing spectrum				
	100% Of HCW and community workers are trained on VL demand creation	30% Of HCW and community workers are trained on VL demand creation	95% Of HCW and community workers are trained on VL demand creation	% of HCW and community workers are trained on VL demand creation	6.1.3.1.1.TOT, workshop, to increase demand creation	[OHSS]	\$80,000	ASM, ICAP, EGPAF, IHAP-Kinshasa, IHAP-HK/L, SANRU, PSI	10. Laboratory (3.75)
	No VL testing commodities stock-out in all molecular labs located in PEPFAR supported provinces	100% of molecular labs have more than 1 stock-out during the year	30% of molecular labs have more than 1 stock-out during the year	Number of VL testing commodities stock-out in all molecular labs	6.1.3.1.2.To establish and strengthen VL testing commodities and procurement system	[HTXS]	\$100,000	GSHC	

**1. Low Viral Load coverage**

National equipment plan is developed and implemented	National equipment plan is developed	100% of province supported by PEPFAR implemented the national equipment plan	% of province supported by PEPFAR implemented the national equipment plan	6.1.3.1.3.To support the national equipment maintenance plan	[HLAB]	\$250,000	ASM	
Specimen referral system is developed, adopted and implemented in PEPFAR supported provinces	Specimen referral system is developed, adopted	80 % of HZs supported by PEPFAR implemented specimen referral system	Number of HZs supported by PEPFAR implemented specimen referral system	6.1.3.1.4.To establish and EID and VL specimen referral system	[HLAB]	\$170,000	ASM, ICAP, EGPAF, IHAP-Kinshasa, IHAP-HK/L, SANRU, PSI	
VL testing trainings are provided for all DRC molecular lab staff. Ongoing activity	VL testing refresher trainings provided for PEPFAR supported molecular lab staff.	VL testing refresher trainings provided for PEPFAR supported molecular lab staff.	Number of molecular lab staff trained	6.1.3.1.5.To strengthen human capacity for expansion of use of VL for ART monitoring	[OHSS]	\$60,000	ASM	



Score card activity is completed and recommendations are implemented regularly at all molecular labs in PEPFAR supported provinces	Score card activity is completed and recommendations are implemented regularly at all MoH molecular labs in PEPFAR supported provinces	Score card activity is completed and recommendations are implemented regularly at all molecular labs in PEPFAR supported provinces	Number of molecular lab staff with score card activity completed	6.1.3.1.6.To ensure continuous quality improvement initiatives	[HLAB]	\$50,000	ICAP, EGPAF	
VL management system is implemented to allow 2 week TAT for VL results and data linked to the electronic SI system	VL management system is developed and pilot phase implemented	VL management system is rolled out in all PEPFAR supported provinces	Number of HZs supported by PEPFAR implemented VL management system	6.1.3.1.7.Country wide implementation of the VL management system.	[HVSI]	\$200,000	ASM, ICAP, EGPAF, IHAP-Kinshasa, IHAP-HK/L, SANRU, PSI	
100% of HCW are trained on VL patient management	30% Of HCW and community workers are trained on VL patient management	95% Of HCW and community workers are trained on VL patient management	Number of HCW and community workers trained on VL patient management	6.1.3.1.8.To conduct regular training on uptake of results and patient management at site and above site level	[OHSS]	\$80,000	ASM, ICAP, EGPAF, IHAP-Kinshasa, IHAP-HK/L, SANRU, PSI	

	100% of testing points are enrolled in national RHIV testing PT and have successfully passed the test	80% of testing points are enrolled in the national PT DTS and have achieved acceptable successful passing criteria	95% of testing points are enrolled in the national PT DTS and have achieved acceptable successful passing criteria	Number of testing point or laboratories enrolled in the national PT DTS and that achieved acceptable and successful passing criteria	6.1.3.2.1.To implement Rapid Testing Continuous Quality Improvement Program in DRC				
	MOH endorse the RTCQI program and include the program in the national HIV quality assurance policy	MOH developed and endorsed the RTCQI program	MOH include RTCQI program into the national HIV quality assurance policy	RTCQI HIV quality assurance policy available	6.1.3.2.2.To engage with WHO and MOH to develop national policy that address quality and monitoring of HIV RTs and testing	[HVCT]	\$80,000	APHL	

**2. Weak lab quality improvement initiatives to ensure accurate and timely diagnostics in era of "test and treat"**

Lab staff in all labs are trained and certified for quality management system (QMS)	30% of lab staff in all labs are trained and certified for quality management system (QMS)	70% of lab staff in all labs are trained and certified for quality management system (QMS)	Number of lab staff trained and certified for quality management system (QMS)	6.1.3.2.3.HR development through training and certification	[HVCT]	\$50,000	APHL	
100% testing point in PEPFAR supported provinces enrolled in continuous quality improvement (CQI) program.	30% testing point in PEPFAR supported provinces enrolled in continuous quality improvement (CQI) program.	70% testing point in PEPFAR supported provinces enrolled in continuous quality improvement (CQI) program.	Number of testing points in PEPFAR supported provinces enrolled in continuous quality improvement (CQI) program	6.1.3.2.4.To implement tools to support the implementation of quality assurance activities and to facilitate program monitoring and evaluation	[HVCT]	\$100,000	APHL	
Logbooks are used and yearly analysis is realized in high volume sites	Logbooks are used and analysis is realized in high volume sites	Logbooks are used and analysis is realized in all care and treatment sites	Number of site with logbooks used and yearly analysis realized	6.1.3.2.5.Logbook use and analysis for quality assurance purpose	[HVCT]	\$50,000	APHL	
				6.1.3.2.6.RT lot release testing for RT post marketing surveillance	[HLAB]	\$20,000	APHL	

	100% of trained lab staff are implementing biosafety standards in clinical sites (ongoing activity)	75% of trained lab staff are implementing biosafety standards in clinical sites	100% of trained lab staff are implementing biosafety standards in clinical sites	Number of trained lab staff who are implementing biosafety standards in clinical sites	6.1.3.2.7.biosafety and biosecurity training and material	[HMIN]	\$60,000	ICAP, SANRU, EGPAF, IHAP-Kinshasa, IHAP-HK/L, PSI	
<b>3. Low infant virologic testing coverage</b>	100% of all HIV exposed infants are tested at 4-6 weeks of age using DNA PCR or POC.	50% of all HIV exposed infants are tested at 4-6 weeks of age using DNA PCR or POC	90% of all HIV exposed infants are tested at 4-6 weeks of age using DNA PCR or POC	Number of HIV exposed infants who are tested by 4-6 weeks of age using DNA PCR or POC test with results documented in the Laboratory Information System (LIS) or in medical records	6.1.3.3.1.Improve lab-clinical interface, strengthen and address all gaps within the infant virologic testing spectrum to include demand creation, use of functional referral systems, POC, and DBS.	[PDCS], [HLAB]	\$70,000	ICAP, SANRU, EGPAF, IHAP-Kinshasa, IHAP-HK/L, ASM, PSI	10. Laboratory (3.75)
					6.1.3.3.2.Extend the lab network for EID to all DRC molecular labs	[PDCS]	\$30,000	ICAP, SANRU, EGPAF, IHAP-Kinshasa, IHAP-HK/L, PSI	10. Laboratory (3.75)
						6.1.3.3.3.Increase DBS collection for HEI	[PDCS]	\$36,000	ICAP, SANRU, EGPAF,IHAP-Kinshasa, IHAP-HK/L, PSI

	EID management system to allow results within 2 weeks and data linked to the electronic SI system.	30% HZs supported by PEPFAR implemented EID management system	90% HZs supported by PEPFAR implemented EID management system	Number of HZs supported by PEPFAR implemented EID management system	6.1.3.3.4.Implement the EID management system to improve result return system	[HVSII]	\$100,000	ASM	
<b>TOTAL</b>							<b>\$ 1,586,000</b>		

**Table 6.2.1: Test and START**

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
	Sufficient stock to cover patient needs, avoid stock-out/overstock	Quarterly last mile distribution to sites based on accurate data	Commodities delivered on time, stock management optimized and patient data accurate	Stock-out (Yes/No, Number of days: xxxx. Quarterly monitoring of stock cards and stock management report	Support national and provincial quantification of HIV commodities (provide tools, review parameters, training)	OHSS	\$100,000	GHSC-TA	
					<del>Support/ establish central and provincial level technical groups and committees: share best practices, discuss issues.</del>	OHSS	\$0	GHSC-TA	
	Sufficient stock to cover patient needs, avoid stock-out/overstock	Quarterly last mile distribution to sites based on accurate data	Early warning system against stock-out risks in place	Stock-out (Yes/No, Number of days: xxxx. Quarterly monitoring of stock cards and stock management report	<del>Develop provincial performance management plans with indicators and incentives.</del> Regular review of stock and assumption at provincial level and supportive supervision at site level	OHSS	\$150,000	GHSC-TA	

1. Commodity security and supply chain: stock-out and overstock of HIV commodities.	Sufficient stock to cover patient needs, avoid stock-out/overstock	Quarterly last mile distribution to sites based on accurate data	Commodities delivered on time, stock management optimized and patient data accurate	Stock-out (Yes/No, Number of days: xxxx. Quarterly monitoring of stock cards and stock management report	Ensure operational information system (LMIS): data collection, analysis, and sharing	OHSS	\$110,500	GHSC-TA	Commodity Security and Supply Chain (Red)
	Sufficient stock to cover patient needs, avoid stock-out/overstock	Quarterly last mile distribution to sites based on accurate data	Early warning system against stock-out risks in place	Stock-out (Yes/No, Number of days: xxxx. Quarterly monitoring of stock cards and stock management report	<del>Re-design overlapping distribution streams in the broader health system and various actors and levels that support multiple logistics functions, including sample transportation.</del> Health worker Capacity building on stock management, multi-month dispensing and rational use	OHSS	\$100,000	GHSC-TA	
	ALL three 90s fully supported by adequate supply of commodities	90% of PLHIV tested; 90% of those on treatment are monitored for VL suppression	90% of PLHIV tested; 90% of those on treatment are monitored for VL suppression	Stock-out (Yes/No, Number of days: xxxx.	Support warehousing and last mile distribution of HIV commodities	HTXS, HVCT, HBHC, PDCS, MTCT	\$1,622,827	GHSC-TA	
<b>TOTAL</b>						<b>\$ 2,083,327</b>			

**Table 6.2.2: New and efficient service delivery models: Community-Based ART Dispensing Point**

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
1. Policy: current policy lacks conformity with most recent WHO guidelines = POLICY ALREADY UPDATED	Updated policy based on WHO guidelines for efficient service delivery models. Implementation plan for more efficient service delivery model based on better understanding of the barriers and enablers	Updated policy based on WHO guidelines for efficient service delivery models. Implementation plan for more efficient service delivery model based on better understanding of the barriers and enablers	Implementation and roll out of updated policy based on 2016 WHO guidelines. Implementation and roll out of the new efficient service delivery model plan	Availability of new ART and care guidelines	6.2.2.1.1. Provide technical assistance to the MOH to <del>revise and</del> disseminate ART and care guidelines	HTXS, HBHC	\$0	ICAP, IHAP-Kin, IHAP-HK/L	Policies and Governance (Yellow), Service Delivery (Yellow), Technical & Allocative Efficiencies (Red).
				Availability of task-shifting guidelines	6.2.2.1.2. Provide technical assistance to the <del>MOH/PNLS to develop and</del> disseminate a comprehensive task-sharing policy, guidelines and tools	OHSS, HBHC	\$0	ICAP	



				Health providers briefed on new WHO guidelines (presence list). Briefing session report	6.2.2.1.3.Strengthen clinic and community sites capacity to pilot more efficient service delivery models for stable patients through clinical mentoring	HTXS, HBHC	\$0	ICAP, EGPAF, IHAP-Kin, IHAP-HK/L, LINKAGES	
2- <del>HRH</del> : Staff not adequately trained in commodity management and forecasting.				Availability of community service delivery	6.2.2.1.4.Support Adoption of policy, guidelines and reporting tools related to the community drug distribution points (PODI+)	HTXS, HBHC	\$0	ICAP, IHAP-Kin, IHAP-HK/L, LINKAGES	Commodity Security and Supply Chain (Red), Human Resource for Health (Yellow)
				Availability of community service delivery	6.2.2.1.5. Implement 10 PODI+ and/or other type of differentiated model for stable patients in high volume health zones; this activity represents ongoing community-based service delivery; in COP18, it will no longer be included in Table 6, as it is site-level implementation responding to an ongoing need for services.	HTXS, HBHC	\$1,450,000	ICAP, EGPAF, IHAP-Kin, IHAP-HK/L, LINKAGES	

	Health facilities able to manage 3-monthly patient visits and provide 3-months of ARVs.	Health facilities able to manage 3-monthly patient visits and provide 3-months of ARVs.			6.2.2.2.1. Support cascade training on logistic and supply chain improvements	OHSS	\$0	GHSCP	
	Regional Drug Stores (CDR) and site level staff working together to	Regional Drug Stores (CDR) and site level staff working together to		Trained health system personnel consistently follow SOPs for logistics activities	6.2.2.2.2. Conduct supportive logistic supervision within PEPFAR-supported health zones	OHSS	\$0	GHSCP	
					6.2.2.2.3. Develop standard operating procedures, supervision and monitoring tools	OHSS	\$0	GHSCP	
3. Commodity procurement and supply not aligned with policy requirements of	An established LMIS and reporting system supports	An established LMIS and reporting system supports visibility of	An established LMIS and reporting system supports visibility of demand at relevant	Availability of ARV dispensing tools at PEPFAR supported clinic and community sites	6.2.2.3.1. Conceive and disseminate ARV dispensing register	OHSS	\$0	GHSCP	Commodity Security and Supply Chain (Red)
					6.2.2.3.2. Endow PODI+ with supply chain management tools	OHSS	\$0	GHSCP	

4. Structural and legal barriers, including discrimination and stigma hampered community service models	Improved enabling environmental and structural factors impacting the HIV community care and treatment programming. PLHIV access community care and treatment services without fear of discrimination	<del>Improved-enabling-environmental-and-structural-factors-impacting-the-HIV-community-care-and-treatment-programming. PLHIV-access-community-care-and-treatment-services-without-fear-of-discrimination</del>	<del>Improved-enabling-environmental-and-structural-factors-impacting-the-HIV-community-care-and-treatment-programming. PLHIV-access-community-care-and-treatment-services-without-fear-of-discrimination</del>		6.2.2.4.1. Assessment of which differentiated service models approach is relevant to the site among the options, populations with increased risk of HIV infection and specific needs	OHSS	\$0	ICAP,EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L, ASF/PSI	Civil Society engagement (Yellow), Quality Management (Red)
				<b>Data are reviewed and used for program improvement</b>	6.2.2.4.2 Build capacity of NGO on data collection, analysis, application practices	HVSI	\$336,500	TBD/PD Small grant	
					6.2.2.4.3. Community support/dialogue for addressing stigma and discrimination issues	HVOP	\$13,500	TBD/PD Small grant	
<b>TOTAL</b>							<b>\$1,800,000</b>		

**Table 6.3 Other Proposed Systems Investments**

**Strategic Information**

Activity	Indicate 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Strengthen the national health information system (HIS)	First 90; Second 90; Third 90; Sustained Epi Control	Strong policy framework in place supporting robust routine health data systems.	<del>Policy Developed and Disseminated</del>	Revised policy based on updated national health strategic plan	Revised SI policy based on updated national health strategic plan developed and disseminated.	HVSI	\$200,000	TBD	Policies and Governance (Yellow), Epidemiological and Health Data (Light green)
2. Build host country institutional and organizational capacity for data management	First 90; Second 90; Third 90; Sustained Epi Control	Accurate, reliable, complete, timely data available and used, supporting improved program management decision making at national and sub-national levels	<del>Data managers are trained HIV/AIDS data collection validated and promoted at each level of the MOH pyramid</del>	(many activities are continuous) Data managers receive regular coaching Workshop for National Data Needs for HIV/AIDS Management	Ongoing regular coaching for HZ Data Managers performed National HIV/AIDS data needs workshop organized and report disseminated	OHSS	\$0	TBD	Human Resources for Health (Yellow), Quality Management (Red), Epidemiological and Health Data (Light green)

<p>3. Support web based electronic reporting system, monitoring evaluation and surveillance interface (MESI)</p>	<p>First 90; Second 90; Third 90; Sustained Epi Control</p>	<p>Accurate, reliable, complete, timely data available and used, supporting improved program management decision making at national and sub-national levels</p>	<p><del>Equipment and maintenance provided</del> <del>MESI-implementation-extended</del> Quarterly validation meeting at provincial level supported Provincial level</p>	<p>(many activities are continuous) Quarterly validation meeting at provincial level supported Provincial level supported</p>	<p>Ongoing quarterly data validation meetings at HZ and provincial levels supported</p>	<p>HVSI</p>	<p>\$100,000</p>	<p>TBD</p>	<p>Epidemiological and Health Data (Light green)</p>
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<p>4. Support host country for data quality improvement System</p>	<p>First 90; Second 90; Third 90; Sustained Epi Control</p>	<p>Accurate, reliable, complete, timely data available and used, supporting improved program management decision making at national and sub-national levels</p> <p>Capacity to monitor data systems quality issues and respond appropriately at national and sub-national levels is</p>	<p>DQI process and data use decision making initiated and effective</p> <p>Technical capacity at provincial and national levels for implementation, coordination, and supervision of activities related to HIV data management process reinforced</p> <p>Routine DQA process supported</p>	<p>(many activities are continuous)</p> <p>DQI process and data use decision making initiated and effective</p> <p>Technical capacity at provincial and national levels for implementation, coordination, and supervision of activities related to HIV data management process reinforced</p> <p>Routine DQA process supported</p>	<p>(many activities are continuous)</p> <p>Regular DQI, data use, and decision making activities are implemented</p> <p>New change about findings from DQI pilot applied across the national data system</p> <p>Technical capacity at provincial and national levels for implementation, coordination, and supervision of activities related to HIV data management process reinforced</p> <p>Routine DQA process supported and report disseminated</p>	<p>HVSI</p>	<p>\$0</p>	<p>TBD</p>	<p>Epidemiological and Health Data (Light green)</p>
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5. Strengthen host country in strategic information systems	First 90; Second 90; Third 90; Sustained Epi Control	Improved capacity to identify and respond to service quality gaps  Robust PLHIV denominators that improve program planning at national and sub-national levels	Provincial level estimates developed  Integrated HIV & TB and community database developed	Provincial level estimates developed  Integrated HIV & TB and community database developed  System to monitor patient experience at site (stigma, service quality, stock outs) in place	Provincial level estimates developed and disseminated  Integrated HIV & TB and community database developed  System to monitor experience at site (stigma, service quality, stock outs) put in place	HVSI	\$375,000	UNAIDS	Epidemiological and Health Data (Light green)
6. Support HIV/AIDS surveillance activities	Third 90; Sustained Epi Control	National ART strategy optimized to achieve viral suppression among PLHIV	Survey data processed  Survey report released and shared	Protocol developed and approved  Surveillance data collected and analyzed	Protocol developed and approved  Surveillance data collected and analyzed  Surveillance report disseminated	HVSI	\$500,000	TBD	Epidemiological and Health Data (Light green)
7. Supporting the military coordination offices to ensure the national data collection	First 90; Second 90; Third 90; Sustained Epi Control	Robust program monitoring data on activities with military communities to improve program performance			Military coordination office staff capacitated and able to monitor data management	HVSI	\$100,000	ASF/PSI	Epidemiological and Health Data (Light green)





## Laboratory

1. National TB lab strengthening including GeneXpert, MDR TB monitoring and culture (system and capacity development)	Second 90;	100% screening rate for HIV among TB co-infected patients	80% screening rate for HIV among TB co-infected patients	95% screening rate for HIV among TB co-infected patients	Number of patients TB screened for HIV per year	HLAB	\$30,000	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L, PSI	
2. Maintenance and repair of laboratory equipment at PEPFAR supported clinical sites	Second 90; Third 90;	No service interruption experienced due to equipment issues	75% of laboratories implement a laboratory equipment maintenance program	90% of laboratories implement a laboratory equipment maintenance program	Number of laboratory maintenance contracts signed	HLAB	\$288,500	ICAP, EGPAF, SANRU, IHAP-Kinshasa, IHAP-HK/L, PSI	
3. Quality assurance activities and capacity building of military lab network	First 90;	100% of military labs implemented QA activities	40% of military labs implemented QA activities	80% of military labs implemented QA activities	SIMS_CEE #: F_10.06 [097] Testing Interruptions [LAB]	HLAB	\$30,000	PSI	
<b>TOTAL</b>							<b>\$348,500</b>		



Map overlapping distribution streams in the broader health system and various actors and levels that support multiple logistics functions, including sample transportation	First 90; Second 90; Third 90;	Streamlined HIV/AIDS commodities distribution system in PEPFAR SNU's	Mapping completed in Kinshasa and Katanga provinces	Synergies identified and streamlining plan implemented	Performance on PP_PREV, TX_New, TX_NetNew, TX_PVLS	OHSS	\$100,000	GHSC-TA	Element 8: Commodities
<b>TOTAL</b>							<b>\$200,000</b>		