Democratic Republic of the Congo

Country Operational Plan

(COP/ROP) 2018

Strategic Direction Summary

April 2, 2018

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

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1.0 Goal Statement

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 achieving epidemic control in three key provinces, which represent approximately 30 percent of the total number of people living with HIV/AIDS (PLHIV) in the DRC. The strategy for the PEPFAR Country Operational Plan (COP) for the period from October 1, 2018 through September 30, 2019 (COP 2018) will continue and intensify the programmatic priorities identified and implemented in COP 2017, with the introduction of a strategy to increase focus and strengthen activities in Haut Katanga and Lualaba to achieve attainment while streamlining interventions in Kinshasa. Starting now and during the COP18 implementation period, the PEPFAR/DRC interagency team will continue to work collaboratively with the government of the DRC and other donor partners to transition to the new antiretroviral (ARV) regiment of tenofovir disoproxil fumarate/lamivudine/dolutegravir (TLD) by April 2019. The overall goals and shifts in programming align with the government of the DRC and the Global Fund to support the realization of 95-95-95 by 2030.

Over the past few years, PEPFAR/DRC has made steady progress and shown strong results in Haut-Katanga and Lualaba. Given this success, epidemic control is now in reach, and additional resources and effort will be transitioned to these two provinces during COP18. PEPFAR/DRC believes it is possible to move closer to 95/95/95 in Haut-Katanga and Lualaba, while streamlining services and optimizing case findings in Kinshasa with a greater focus on finding men. This shifting of targets that began in COP17 will continue in COP18, with 62% of TX_new targets in Haut-Katanga and Lualaba compared to 38% in Kinshasa. Overall, PEPFAR will continue with saturation efforts in a total of 52 health zones and military sites, reaching patients in over 500 clinical sites.

COP18 Strategies for Epidemic Control

- Transition of targets and resources to Haut-Katanga and Lualaba provinces.
- Streamlining efforts in Kinshasa and optimizing case finding.
- Implementing partner consolidation and intensive partner management.

Current figures put the total number of PLHIV in PEPFAR-supported health zones at 153,648. Through consultations with the government of DRC and civil society, aggressive targets have been set for COP18, which will see an additional 38,052 people on treatment, leading to approximately 80 percent coverage of PLHIV on treatment by September 2019. Intensive and zone-specific strategies were introduced during FY17 and are scaling up over COP18 to boost the number of new and current patients, thus allowing for a steady and strong increase of linkage and retention of patients to reach saturation in Haut Katanga by 2020.

One of the main challenges to epidemic control is identifying HIV positive individuals (1st 95), therefore new testing strategies were initiated in COP17 with the intention of further bolstering testing yield, a critical step to ensuring adequate case finding and optimal linkage to treatment. In order to optimize identification of PLHIV and link them to treatment, care, and support programs, PEPFAR/DRC will continue to support and implement with fidelity strategies that include:

A. Optimizing provider-initiated testing and counseling (PITC) in outpatient departments, tuberculosis (TB) clinics, inpatient wards (including pediatrics), and prevention of mother-to-child transmission (PMTCT) with 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 (KPs).
D. Introducing sexual networking and partner notification strategies in order to provide HIV testing services (HTS) and treatment services to hard-to-reach KPs.
E. Using the orphans and vulnerable children (OVC) platforms to not only test OVCs and children of KPs, but to assist with patient retention.
F. Integrating supervised self-testing to increase reach of first-time testers, people with undiagnosed HIV, and those at ongoing risk—especially key populations, including men who have sex with men (MSM)—who are in need of frequent retesting.
G. Ensuring youth, male, and KP-friendly services at facilities to attract and retain clients
H. Ensuring scale up of same day, or at minimum, same week treatment initiation in all PEPFAR-supported sites
I. Improving tacking and reminder systems to track clients due for viral load appointments to achieve viral load (VL) suppression among all age and sex groups.
J. Continuing to provide support to maintain the high coverage of HIV screening and antiretroviral therapy (ART) initiation among TB patients and strengthen TB screening for PLHIV.
K. Continuing to scale up community care and support systems to increase retention, such as the existing community ARV distribution point (PODI) models, as well as encouraging adherence through support groups and treatment clubs.

Throughout FY18 and FY19, PEPFAR/DRC will also continue to intensify partner management strategies that were developed and implemented in FY17. DRC-specific partner management tools enable PEPFAR/DRC to create site-level management plans that address any deficiencies associated with 95-95-95 and hold site-level supervisors accountable. Best practices from high performing sites will be disseminated to strengthen low performing sites. At every site, partners will continuously assist providers with clinical cascade analysis. Monthly partner performance consultations will be conducted. 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

2.1 Summary statistics, disease burden and country profile

The HIV epidemic in the DRC is generalized, with a prevalence of 1.20 percent based on the 2013/2014 DHS, with 516,921 people living with HIV out of an estimated population of 90 million(calculated based on UNAIDS estimates [version 5.63]). Prevalence is higher in urban areas (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 (247,896 female PLHIV v. 161,279 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 COP16 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. Generally, access to healthcare services is complicated by poor infrastructure, including inadequate roads and the lack of electricity and water at many health facilities - 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 scale-up of using the electronic, HIV-specific, patient-level reporting system known as Tier.net. The country also continues 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.

Table 2.1.1 Host Country Government Results

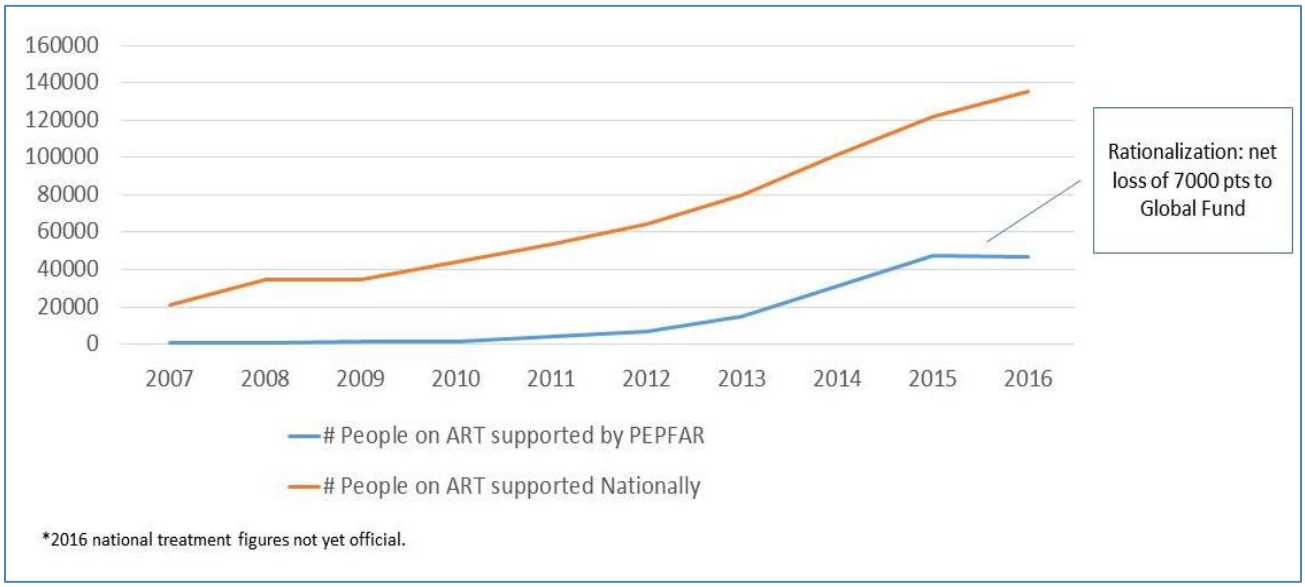
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	90,029,015	100%	20,460,160	22.7%	20,833,636	23.1%	8,893,554	9.9%	8,961,805	10.0%	15,647,790	17.4%	15,232,070	16.9%	Institut National de Statistiques

HIV Prevalence (%)		1.2		NA		NA		1.00 %		0.80 %		2.20 %		1.50%	DHS 2013-2014 Report
AIDS Deaths	18,287		1,507		1,538		839		759		6,318		7,326		SPECTRUM 2018 Version 5.63
(per year)															
# PLHIV	516,921		24,974		25,845		32,810		24,120		247,896		161,276		SPECTRUM 2018 Version 5.63
Incidence Rate (Yr)		NA		NA		NA		NA		NA		NA		NA	
New Infections (Yr)	16,252														SPECTRUM 2018 Version 5.63
Annual births	3, 578,154	5.57 %													SPECTRUM 2018 Version 5.63
% of Pregnant Women with at least one ANC visit	2, 916,940	81%	NA	NA			NA	NA			NA	NA			20156PNLS annual report
Pregnant women needing ARVs	24,221	83%													SPECTRUM 2018 Version 5.63
Orphans (maternal, paternal, double)	210496		NA		NA		NA		NA		NA		NA		SPECTRUM 2018 Version 5.63
Notified TB cases (Yr)	132,515		NA		NA		NA		NA		NA		NA		2016 TB program annuel report
% of TB cases that are HIV infected	15,902	12.00%	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	2016 TB program annuel report
% of Males Circumcised	43, 676,686	97%			NA	NA			NA	NA			NA	NA	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 %					NA	NA			NA	NA			BSS 2013

Estimated Population Size of PWID	NA	6.90 %													
PWID HIV Prevalence	NA	NA													
Estimated Size of Priority Populations (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Estimated Size of Priority Populations Prevalence (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

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	90,029,015	1.20%	516,921	206,380	157,072	30%	6%	2, 884,037	68,456	54,495
Population <15 years	41,293,796		50,819	NA	14,333	28%	NA	NA	NA	3,941
Men 15-24 years	17,855,359		24,120	NA	NA	NA	NA	NA	NA	NA
Men 25+ years	30,879,860		161,276	NA	NA	NA	NA	NA	NA	NA
Women 15-24 years	8,893,554		32,810	NA	NA	NA	NA	NA	NA	NA
Women 25+ years	15,647,790		247,896	NA	NA	NA	NA	NA	NA	NA
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	NA	6.90%	NA	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Truck drivers	NA	1.20%	NA	NA	NA	NA	NA	NA	NA	NA
Miners	NA	1.80%	NA	NA	NA	NA	NA	NA	NA	NA
Military	NA	3.5%	NA	NA	NA	NA	NA	NA	NA	NA

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment



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. Economic growth did however slowdown in more recent years. It also needs to be noted that the benefits of economic growth are spread unevenly across the population. The United Nations Development Index 2015 ranks the DRC as one of the least-developed countries in the world (176/188).

According to the 2013-2014 National AIDS Spending Accounts (FRENCH: 'REDES') and the UNAIDS investment case, the HIV response is mostly funded privately, including by households (44 percent). Donors are the second largest contributors (43 percent) and the Government of the DRC (GDRC) contributes approximately 13 percent. Although still limited, the GDRC investment in HIV/AIDS has increased by 1.4 percent since 2010. HIV services are integrated into the standard care packages delivered by health facilities all over the country. The host government contribution comes mostly through the provision of health infrastructure and health staffing. The US Government's support to DRC through PEPFAR has increased significantly from $45 million (COP13) and $71 million (COP17) and will decrease by about 10% in the current COP cycle.

Led by the PNLS, PEPFAR and the Global Fund completed a rationalization process in FY16 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 FY17, each donor has been responsible for the provision of ARVs and other commodities to patients in their health zones. PEPFAR/DRC investments in HIV-related commodities will continue to increase annually in alignment with the increasing numbers of PLHIV on treatment in PEPFAR-supported health zones.

To achieve a sustainable response, PEPFAR continues to work with other national-level donors to advocate for progressive increases in domestic resources for health and HIV/AIDS. This is challenging due to competing priorities for GDRC resources (such as national elections), volatility in mineral prices, and more recently a decrease in economic growth that has resulted in a slowdown of government revenues. Donor collaboration will continue to focus on establishing and strengthening a GDRC-led national forecasting and procurement system for health commodities, while integrating innovations that result in efficiencies. Another focus will be ensuring that the community systems strengthening necessary for an effective continuum of care in line with the country's 95-95-95 goals is realized.

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, FY17

Table 2.2.1 Annual Investment Profile by Program Area[1]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support	$40,254,632	51%	49%		
Community-based care, treatment, and support	$ 3,911,925	57%	43%		
PMTCT	$11,916,048	35%	65%		
HTS	$9,518,298	56%	44%		
VMMC					
Priority population prevention	$4,001,090	30%	70%		
AGYW Prevention					
Key population prevention	$6,686,309	37%	63%		
OVC	$3,299,142	100%	0%		
Laboratory	$6,534,649	91%	9%		
SI, Surveys and Surveillance	$8,895,429	78%	22%		
HSS	$43,892,532	17%	83%		
Total	$138,910,054				

* HIV services are integrated into the standard care packages delivered by health facilities all over the country. The host government contribution comes mostly through the provision of health infrastructure and health staffing.

[1] (GRP, National AIDS Spending Assessment , 2012), all amounts in 2012 USD

Care, treatment and support remains the top spending program area for both PEPFAR and the Global Fund. Spending on the laboratory program area is increasing because of the strong focus on scale up both VL and early infant diagnosis (EID).

Table 2.2.2 Annual Procurement Profile for Key Commodities, FY17

Table 2.2.2 Annual Procurement Profile for Key Commodities					
Commodity Category	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
ARVs	$14,502,251	51%	49%		
Rapid test kits	$4,788,392	28%	72%		
Other drugs	$1,477,390	30%	70%		
Lab reagents	$1,287,670	100%	0%		
Condoms	$1,962,116	28%	72%		
Viral Load commodities	$6,164,420	57%	43%		
VMMC kits					
MAT					
Other commodities	$180,965	100%	0%		
Total	**$30,363,204**				

ARVs remain the top spending commodity category in 2017. The spending on commodities slowed down in 2017 on the GF side. This is normal as a large amount of commodities had been frontloaded as part of the 2016 budget. A sharp increase in GF spending on commodities in 2018 is expected. This is the first year of the new 2018-2020 grant.

Table 2.2.3 Annual USG Non-PEPFAR Investments and Integration, FY17

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	$34,750,000	$12,555,278	3	$16,762,193	Procurement (PSM), Service delivery (IHP Plus and SIFPO)
USAID TB	$13,000,000	$4,750,000	1	$600,000	Service Delivery (IHP Plus)

USAID Malaria	$50,000,000	$10,733,857	2	$16,162,193	Procurement (PSM) and Service Delivery (IHP Plus)
Family Planning	$16,700,000	$9,450,000	5	$21,002,372	Procurement (PSM) and Service Delivery (IHAP-Katanga, E2A Bridge Provic, IHP Plus and SIFPO)
NIH					
CDC (Global Health Security)	$6,000,000				
Peace Corps					
DOD Ebola					
MCC					
Total	**$120,450,000**	**$37,489,135**			

In FY17, USAID invested more than $120 million in non-HIV programming, including nearly $37.5 million in co-funding in PEPFAR-supported provinces. The geographic coverage of these mechanisms overlaps primarily in Haut-Katanga and Lualaba provinces.

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	N/A	N/A	N/A	N/A	N/A	
VMMC – Central Funds	N/A	N/A	N/A	N/A	N/A	
Other PEPFAR Central Initiatives	N/A	N/A	N/A	N/A	N/A	
Other Public Private Partnership	N/A	N/A	N/A	N/A	N/A	
Total	N/A	N/A	N/A	N/A	N/A	

2.3 National Sustainability Profile Update

Sustainability Index Dashboard (SID) Process: In October 2017, the U.S. Embassy in DRC, UNAIDS, and the National HIV/AIDS Program co-convened four days for a SID workshop with select participants from the multi-sectoral HIV control program committee (PNMLS), UNAIDS, WHO, UNICEF, civil society, representatives of the private corporations HIV control board, Global Fund Principal Recipients and members of the CCM (Country Coordinating Mechanism). Participants discussed progress towards sustainability across the four SID domains: Governance, Leadership & Accountability; National Health System& Service Delivery; Strategic Investments, Efficiency, & Sustainable Financing; and Strategic Information On the 7th of November 2017, after an opening speech by the U.S. Deputy Chief of Mission, the full group then reconvened for a half day to review the completed tool, discuss the findings, and identify priorities.

Sustainability Strength:

Planning and Coordination (9.79, dark green): Under the leadership of the National HIV/AIDS Program, the DRC has made significant strides in its capacity to plan and coordinate the national response. More than any other element in the SID, this is an area where strong domestic leadership by the PNLS is playing a prominent role, as they hold the majority of national and provincial-level planning, coordination, and results review meetings. An example of PNLS's leadership was the successful completion of the national rationalization process that helped avoid overlapping and counterproductive or concurrent investments between the Global Fund, PEPFAR and all donors. In contrast, there is a need for greater leadership from the PNMLS, which is meant to oversee the multi-sectoral response for the country, notably declining in influence since funding from the World Bank was phased out. Also, strong planning must lead to implementation and the SID Working Group noted that many plans exist, but plans are not necessarily guiding interventions.

Sustainability Vulnerabilities and COP18 priorities : All the remaining elements were found vulnerable with 1) Quality Management, 2) Domestic Resource Mobilization and 3) Technical and Allocative Efficiencies still in red (1.67, 1.79 and 3.47 respectively). Policies and Governance, Civil Society and Private Sector Engagements, Public Access to Information, Service Delivery, Human Resource for Health, Commodity Security and Supply Chain, Laboratory and the entire range for Strategic Information were all found with emerging sustainability or yellow. Among these SID elements identified as sustainability vulnerabilities, the team considered as priorities for COP18 following elements: performance data, commodity security and supply chain, and laboratory.

Current investments

Performance data: PEPFAR has been at the frontline of enhancing performance and health data as GF greatly invested in epidemiologic data (ANC surveillance, Key Population mapping and size estimation and IBBS).

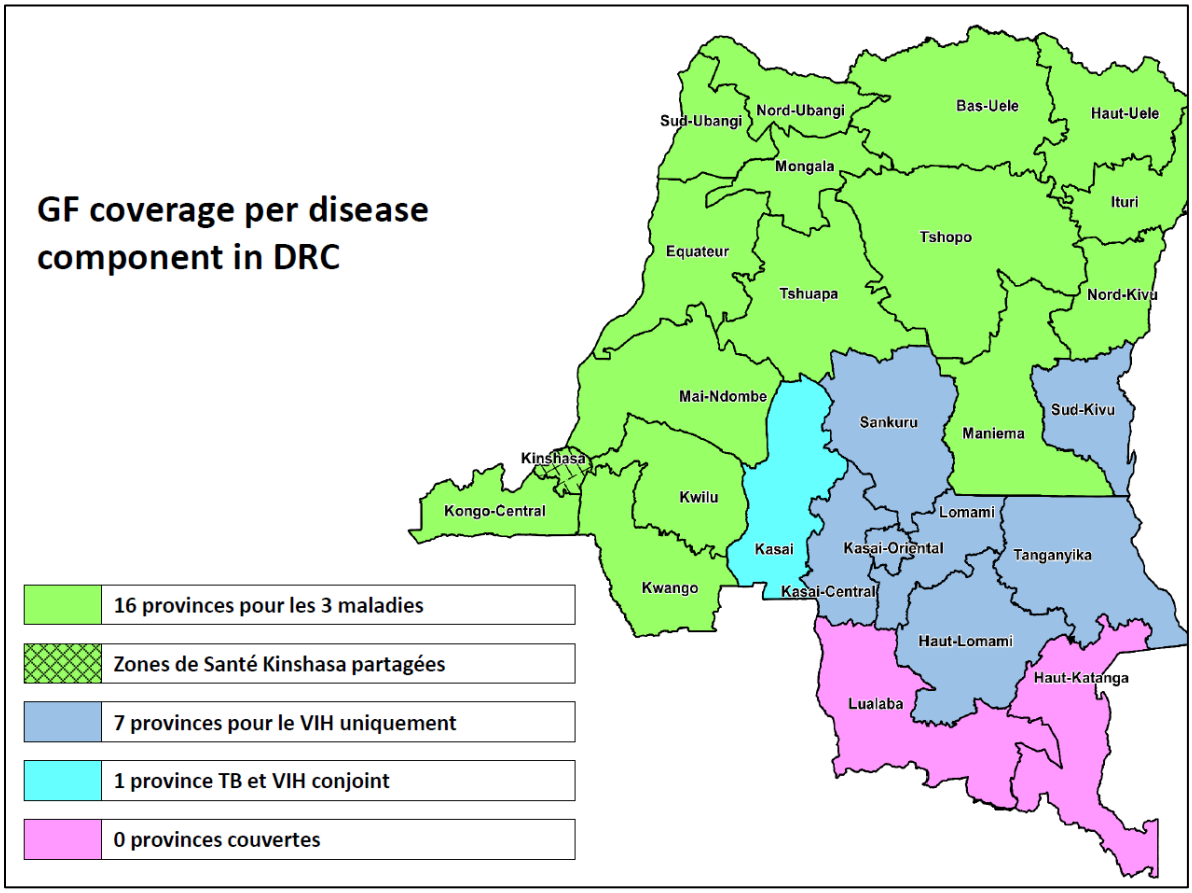
Commodity Security and Supply Chain: PEPFAR and GF remain the principal backbone of the supply chain system in DRC for HIV-related supplies.

Laboratory: Since the rationalization process, PEPFAR and Global Fund are responsible for their respective geographic areas. While the PEPFAR-supported zones reached viral load coverage of 53% by 2017, the national viral load coverage remains alarmingly low (under 20%) despite an unutilized current capacity of 79%. GF will continue to support the national response by the deployment of additional conventional platforms in addition to MSF and DREAMS platforms. PEPFAR also looks to diversify the viral load platforms in all three provinces through a rental scheme with Roche.

2.4 Alignment of PEPFAR investments geographically to disease burden

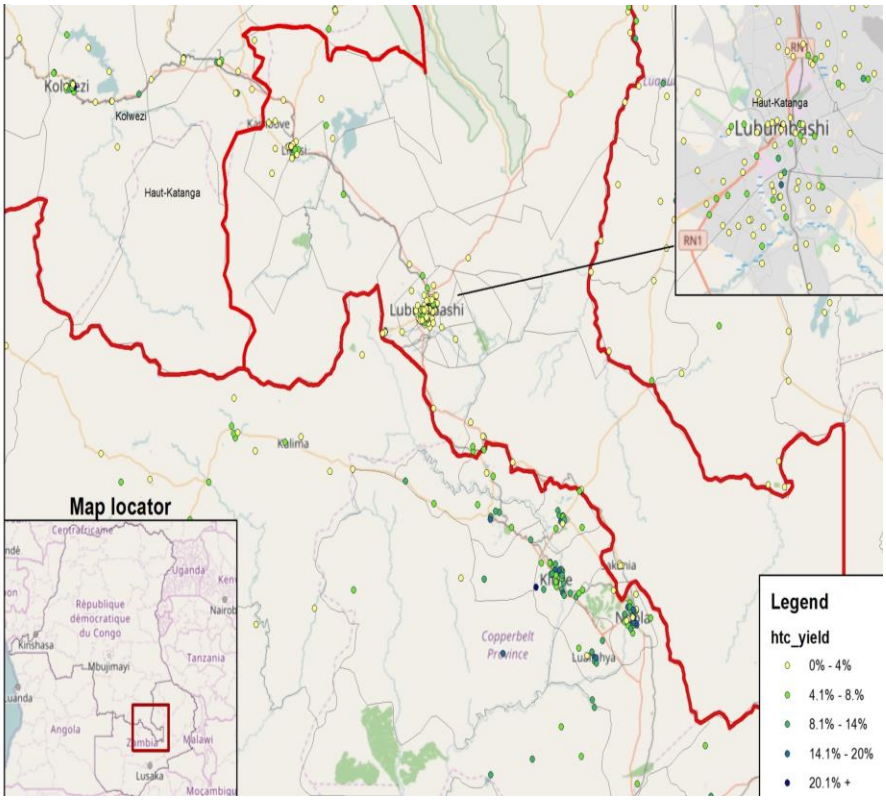
In DRC, three key partners lead the HIV epidemic response: the Government of DRC, Global Fund and PEPFAR. Figure 1 below depicts the rationalization of provinces between GF and PEPFAR, which came to completion at the end of FY16. As indicated, PEPFAR efforts are focused in three Provincial Health Divisions (FRENCH: "DPS"): Kinshasa, Haut-Katanga, and Lualaba (with the exception of military expenditures which represent targeted prevention, care, and treatment activities with the military, a priority population).

Figure 1: Global Fund coverage per disease component in DRC



Kinshasa is the capital city of the DRC and is home to over 12 million people. While epidemic control in Kinshasa is not as likely by 2020 as in Haut-Katanga or Lualaba, PEPFAR programmatic data indicates substantial potential for progress in identifying and linking individuals to treatment in Kinshasa and continued investment is essential. Performance data demonstrates that high yields, upwards of 25%, with index testing are possible and the increased use of risk assessment tools in other entry points is providing valuable testing efficiencies.

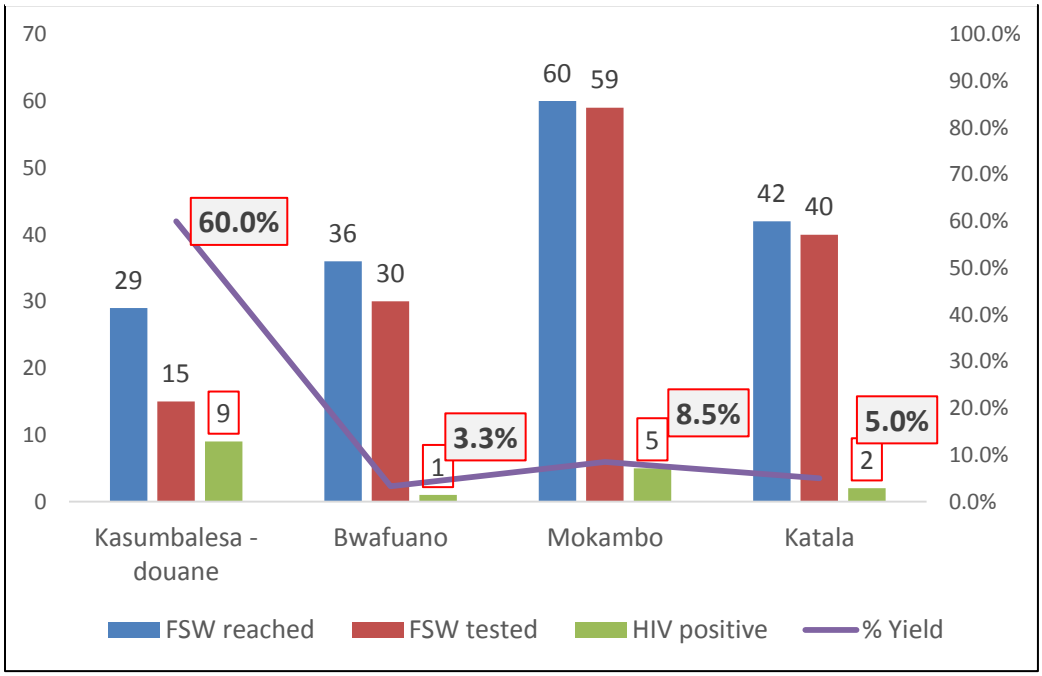
Figure 2: % HTC_TST positive, DRC/Zambia Border, April 2016



The strong upward trend in finding people living with HIV in Kinshasa over the past five quarters is expected to continue well into FY19 and beyond. Along with intensified linking and retention strategies, the streamlined investments towards finding more people living with HIV in this high burden province will prove essential for epidemic control in the DRC.

In addition to Kinshasa, PEPFAR/DRC implements programs in Haut-Katanga and Lualaba. Haut-Katanga is one of the highest burden provinces in the DRC, sharing a border with one of the highest-burden countries in sub-Saharan Africa – Zambia (Figure 2). Recent results from programming along the border with Zambia show a much higher prevalence than the national average, however, the volume of individuals found and tracked is low (Figure 3). During COP18, implementing partners will investigate cost-effective approaches in order to continue to find and treat higher risk populations on a larger scale in this area.

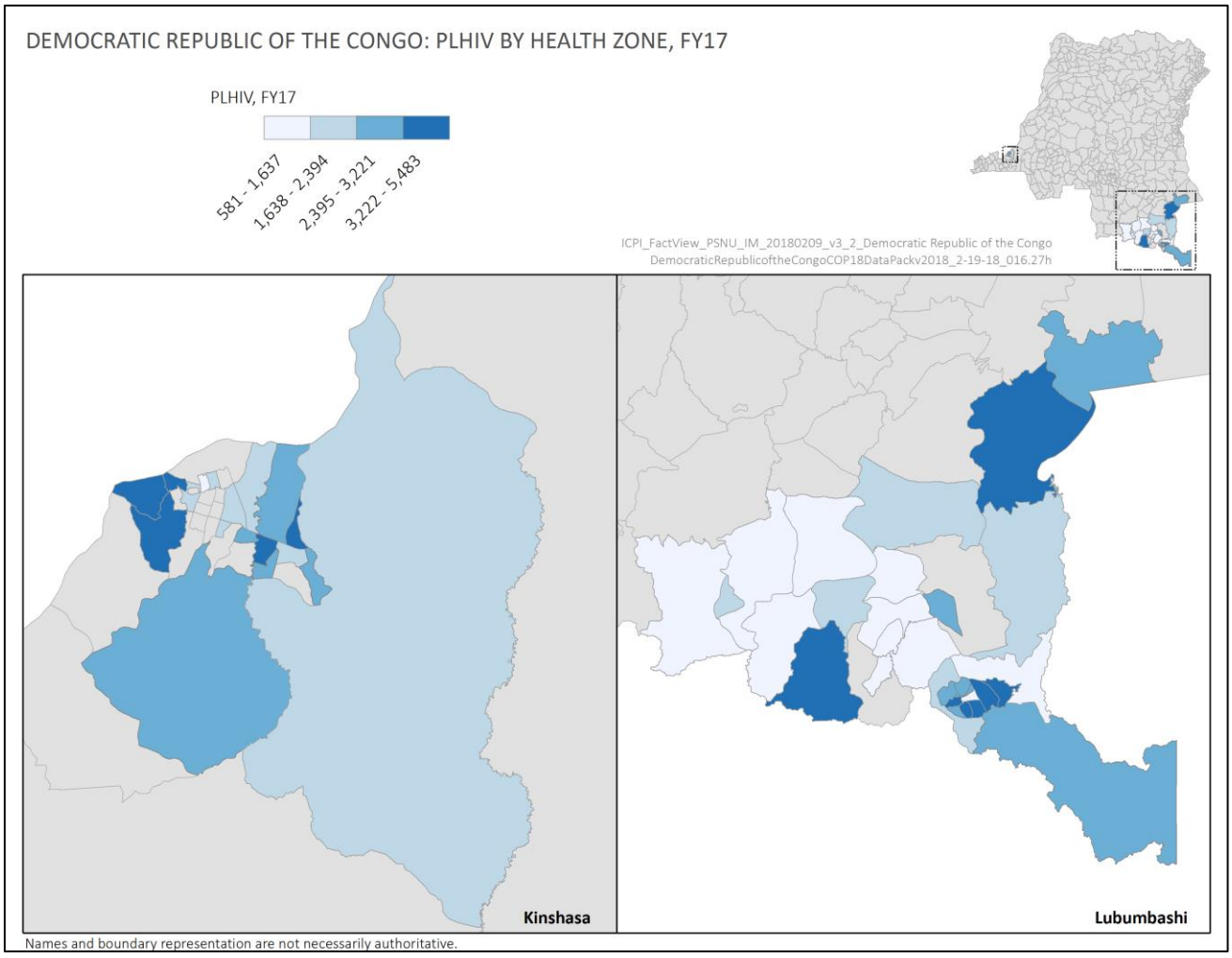
Figure 3: FSWs HIV Testing service uptake and percentage of HIV positive by health areas at the border with Zambia and DRC, April 1, 2017 to August 21, 2017

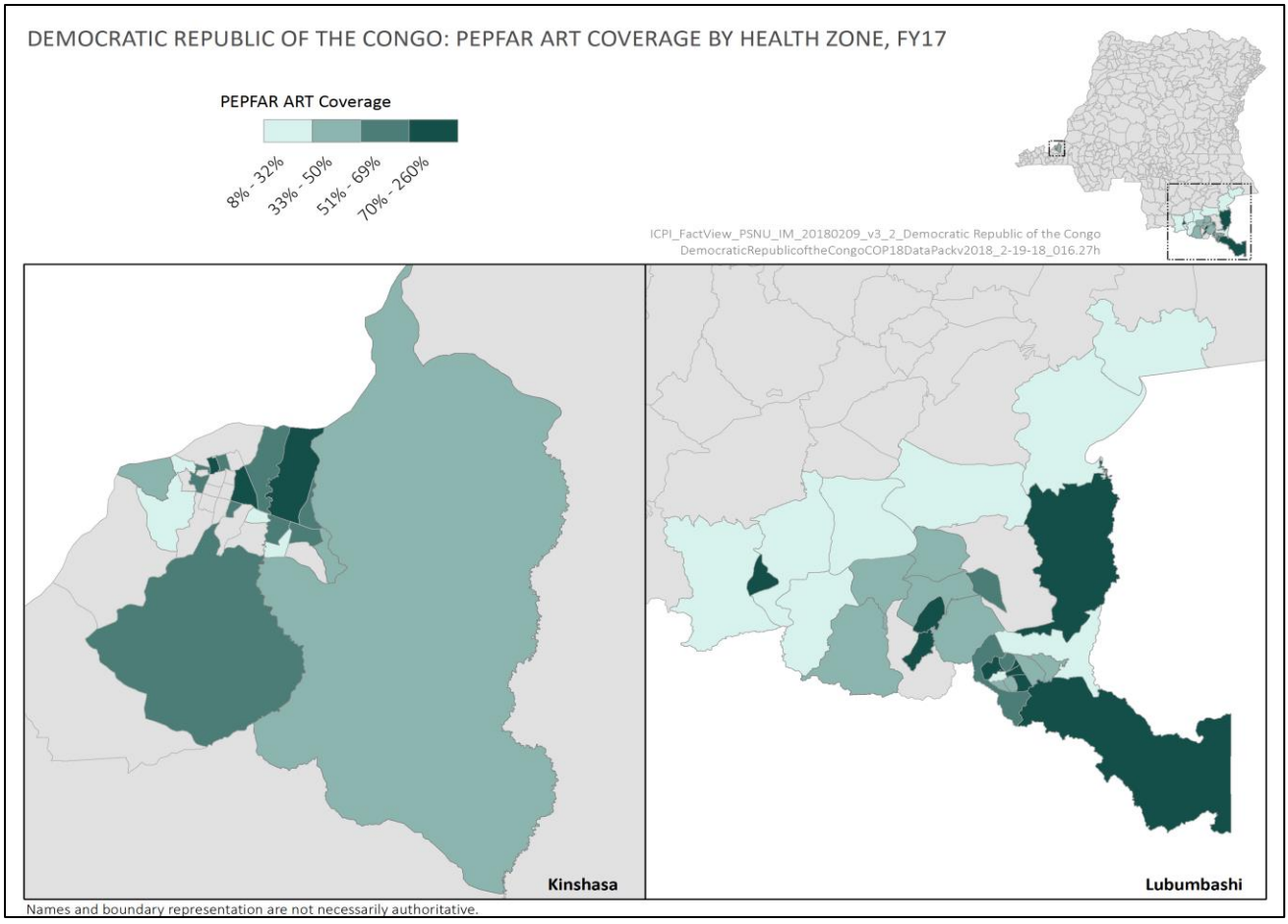


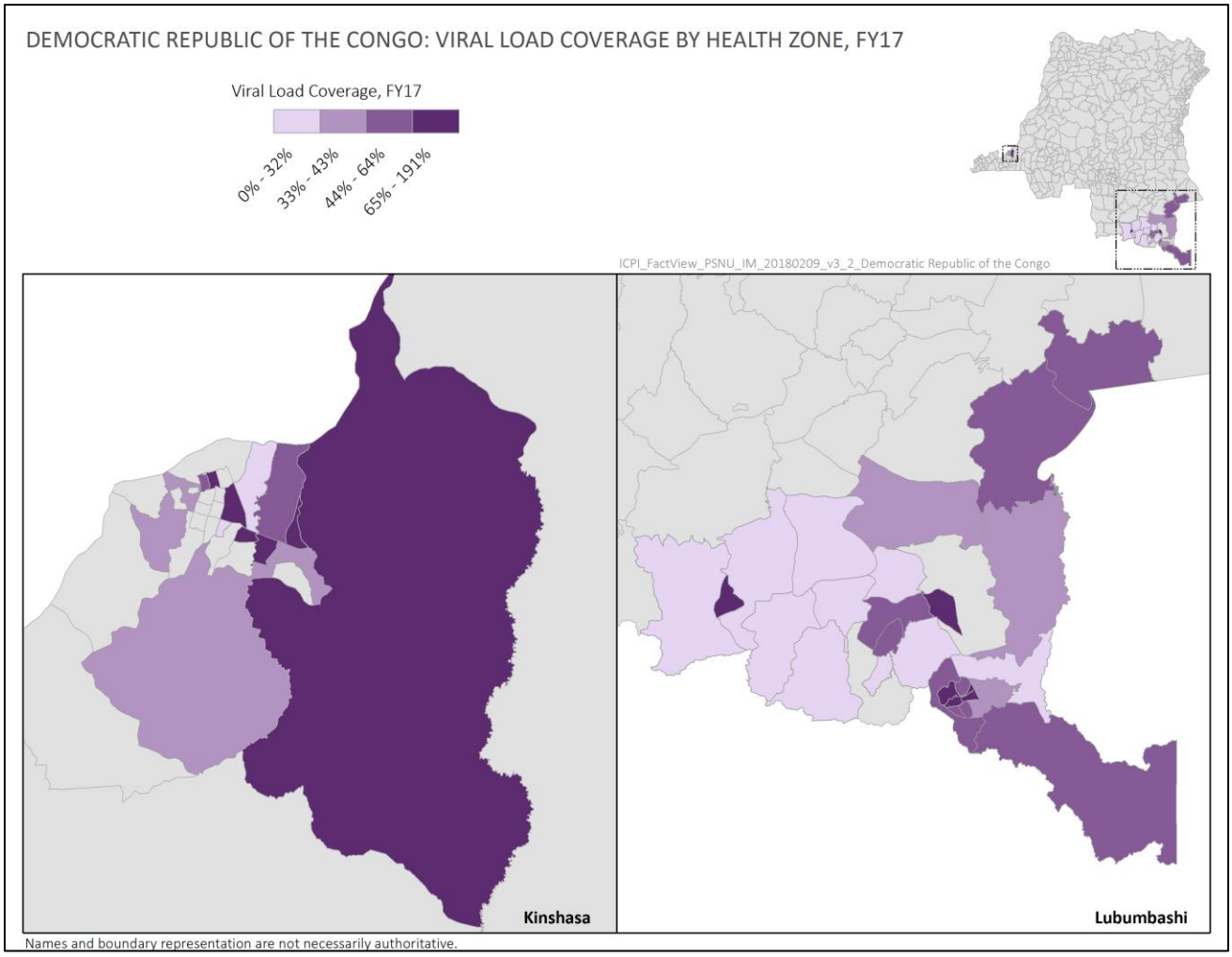
Performance data overall in Haut-Katanga indicates near attainment in several health zones. Given this, more resources and efforts will be transitioned to this high-burden province during COP18. Contiguous to Haut-Katanga is the province Lualaba, with numerous, large formal and informal mining sites. Cutting through the middle of Haut-Katanga and Lualaba is a major trans-Africa highway route, bringing a high concentration of truckers and sex workers throughout this transportation corridor. Given the high risk populations prevalent in this region, PEPFAR/DRC will expand efforts into four new health zones – two in Haut-Katanga and two in Lualaba.

Overall, approximately 30 percent of PLHIV live in the PEPFAR-supported provinces Figures 4, 5, 6). In COP18, DRC/PEPFAR is pivoting once again to increase focus in Haut Katanga and Lualaba to achieve attainment by 2020 and streamlining interventions in Kinshasa, which is detailed at length in sections that follow.

Figure 4, 5, 6. Geographic distribution of PLHIV, ART coverage, and VL coverage, are below:




DEMOCRATIC REPUBLIC OF THE CONGO: PEPFAR ART COVERAGE BY HEALTH ZONE, FY17
PEPFAR ART Coverage
8% - 32%
33% - 50%
51% - 69%
70% - 260%
ICPI_FactView_PSNU_IM_20180209_v3_2_Democratic Republic of the Congo DemocraticRepublicoftheCongoCOP18DataPackv2018_2-19-18_016.27h
Kinshasa
Lubumbashi
Names and boundary representation are not necessarily authoritative.


DEMOCRATIC REPUBLIC OF THE CONGO: VIRAL LOAD COVERAGE BY HEALTH ZONE, FY17
Viral Load Coverage, FY17
0% - 32%
33% - 43%
44% - 64%
65% - 191%
ICPI_FactView_PSNU_IM_20180209_v3_2_Democratic Republic of the Congo
Kinshasa
Lubumbashi
Names and boundary representation are not necessarily authoritative.

2.5 Stakeholder Engagement

From the beginning the COP18 process, PEPFAR/DRC has engaged a range of critical stakeholders including: the GDRC through ANCP(AIDS National Control Program) directors, MoH cabinet members; the GF through the DRC HIV/TB Manager; UN organizations such as UNICEF, UNAIDS, and WHO; MSF; and the Civil Society Organization (CSO) network. The stakeholder engagement calendar below provides a detailed overview of how PEPFAR/DRC engaged these stakeholders and involved them in the development of COP18.

Critical components of the COP18 guidance were translated in French and distributed to CSOs one week before the RPMs in Johannesburg, using funds allocated in COP17 for the PCO to translate important documents for CSO engagement. CSOs participated in the pre-RPM in-country retreat to help inform COP18 planning and strategy. PEFPAR/DRC OGAC Chair Mike Ruffner was present at the in-country retreat, and was able to directly answer questions from CSO representatives and other stakeholders. CSOs provided written feedback on the COP18 guidance and PEPFAR/DRC COP18 activities and priorities. CSO representative and others stakeholder listed above then joined the PEPFAR/DRC delegation at the RPMs and provided input throughout the process.

A draft of the SDS was shared with CSOs and stakeholders one week before COP submission for feedback. The final SDS has been shared with CSOs and other stakeholders at the time of COP submission.

Date	**Objective**	**Outcomes**	**Next steps**	**Comments**
Before COP18 Submission				
01/23/2018	PEPFAR/DRC to share with stakeholders: The COP18 development process, the COP18 overview, COP18 expectations from stakeholders, timelines for future steps	Stakeholders understand the COP process and the outline of the last COP Stakeholders understand the timeline for the next steps of the COP18.	Plan the next meeting. Share the documentation.	Meeting was held at Embassy office
01/1-2/2018 In –Country retreat	Discuss COP18 guidance /orientation Receive input from stakeholders on the COP18 strategy for	Stakeholder feedback was shared.	Continue discussion via phone and email to ensure stakeholder input into RPM	

	DRC.		presentation.	
3/7/2018	COP18 SDS Draft shared with stakeholders			SDS draft was shared via email a with CSO and all stakeholders
3/9/2018	Meeting for PEPFAR/DRC to answer/clarify any concerns regarding the SDS.	PEPFAR/DRC should convene a subsequent meeting to provide details regarding the COP18 contents.		
03/14/2017	Final SDS to be shared with CSOs and other stakeholders.			
After COP18 Submission				
04/25/2018	PEPFAR/DRC to explain how stakeholder feedback was incorporated in COP18 planning and how PEPFAR will continue to engage them throughout the year.	Stakeholder understands how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP18, what was not, and why these decisions were made.	Share the redacted COP18 when available and approved.	The approved, redacted COP18 will be shared by email. Hard copies will be available upon request.

Proposed information sharing strategy

UNAIDS in Kinshasa has agreed to allow stakeholders to use their office space and internet capabilities. PEPFAR/DRC will send invitations for meetings seven days in advance via email to the CSO networks. Stakeholders located in Kinshasa will continue to receive information from the UNAIDS provincial office.

Any type of documentation (i.e. APR/SAPR; POART, COP18 priorities, goals, budget) will be shared via email. Hard copies of documents will be provided if needed upon request from the stakeholders. PEPFAR/DRC will provide a feedback form that will be used for all written feedback (i.e. on COP18, APR/SAPR).

The PEPFAR/DRC team will be encouraged to bring copies of feedback forms during their community SIMS visits to be completed. An estimated CSO engagement budget is outlined below.

3.0 Geographic and Population Prioritization

In COP17, the PEPFAR/DRC team refined strategies and support services in aggressive scale-up health zones, maximizing testing yield, linking HIV positive people to treatment, and retaining patients on treatment with a goal of achieving sustained epidemic control in all 48 health zones by 2020.

Although significant progress has been made in increasing the number of PLHIV on ART throughout PEPFAR-supported provinces and statistical saturation has been achieved in a number of individual health zones in Haut-Katanga, 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 the remainder of COP17 and into COP18, PEPFAR/DRC will look closely at individual-level data to better understand care-seeking behaviors with the aim to define saturation levels where possible in order to better target efforts.

In COP18, PEPFAR/DRC will continue its efforts to reach the following populations, with a particular emphasis in Haut-Katanga and Lualaba:

1) partners and children of diagnosed PLHIVs (index testing)
2) men, including partners of FSW,
3) adolescent girls and young women,
4) key populations (MSM and FSW) and
5) other priority populations such as HIV+ TB patients and the military

These populations were selected through review of the programmatic and national epidemiological data. By focusing on these populations, some of which are underrepresented in the current treatment cohort, PEPFAR/DRC is expecting to fill the age and sex band gaps in order to achieve sustained epidemic control specific Haut-Katanga supported areas by 2020, with significant progress toward closing the gaps in FY19.

During FY19, budgets and targets will shift from Kinshasa to Haut-Katanga and Lualaba provinces, which are closer to achieving 90-90-90 by 2020. In Kinshasa, PEPFAR/DRC is planning to find efficiencies and focus on case identification and rapid enrollment on treatment while in Lualaba and Haut Katanga, PEPFAR/DRC will be scaling towards attainment with intensified attention on retention and viral suppression.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP18	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)
Attained				
Scale-up Saturation				
Scale-up Aggressive	153,648/100%	65,385	49	53
Sustained				
Central Support				

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

4.1 Finding the missing, getting them on treatment, and retaining them

The PEPFAR/DRC team recognizes that "the missing" are mainly the partners of individuals recently identified as living with HIV or existing ART patients that did not come to be tested. In addition, "the missing" include those individuals identified as positive but were not linked to treatment and the PLHIV on ART that are lost to follow up. All unidentified and/or lost patients need to be found, put on treatment, and retained on treatment in order to reach the ultimate goal of viral load suppression and epidemic control.

Results from FY17 and Q1 FY18 allow PEPFAR/DRC to identify and address different HIV epidemics in DRC based on geography and population. In Haut Katanga and Lualaba PEPFAR/DRC will scale up towards attainment by continuing to find cases and focusing on linkage, retention, and viral suppression. In Kinshasa, PEPFAR/DRC will focus on finding efficiencies through case identification. In Haut Katanga and Lualaba, the main issue is the retention of patients on treatment. In Kinshasa, case finding is the primary issue.

The PEPFAR/DRC program continues to miss men aged 25-45, especially in Kinshasa where men are presenting at a later age. Results from FY18 Q1 reveal that 60% of men diagnosed were aged 35 years and above. The proportion of these men over the age of 50 is alarming: 15% of positive men in Haut-Katanga and 30% of positive men in Kinshasa. Regardless of age, men are not regularly accessing health services in general and HIV services in particular, waiting until they become very sick before seeking care, evidenced by lower CD4 counts upon initiation (shown in Figure 7) but also the number of positives found through inpatient and TB modalities. Finding children also remains an issue, evidenced by low Q1 testing volume and case finding for children <15 across all SNUs. Figure 8 below from the FY17 APR illustrates that PEPFAR/DRC is failing to test partners of positive patients from both sexes, link positives to treatment, and retain patients currently on treatment.

Figure 7: Tier.net analysis of percent of clients presenting with CD4<100 (red), or CD4 between 100 &200 (orange) at time of enrollment, by sex and 5 year age bands, Kinshasa, 2016-2017

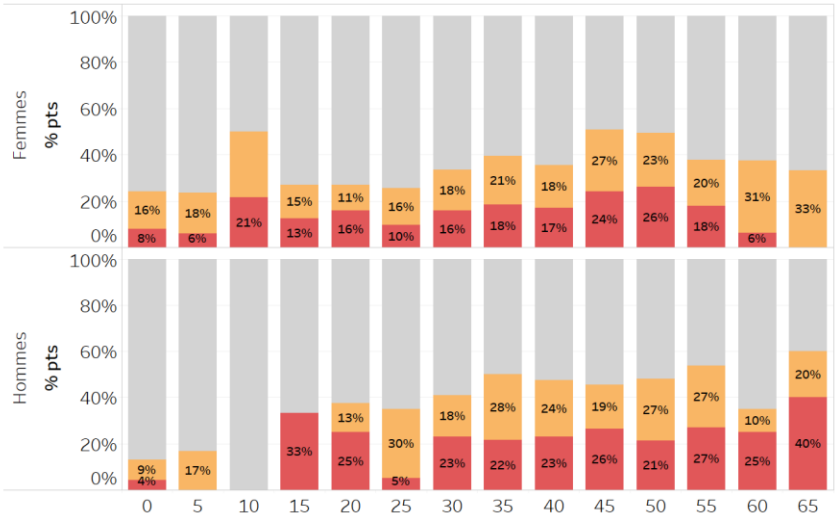
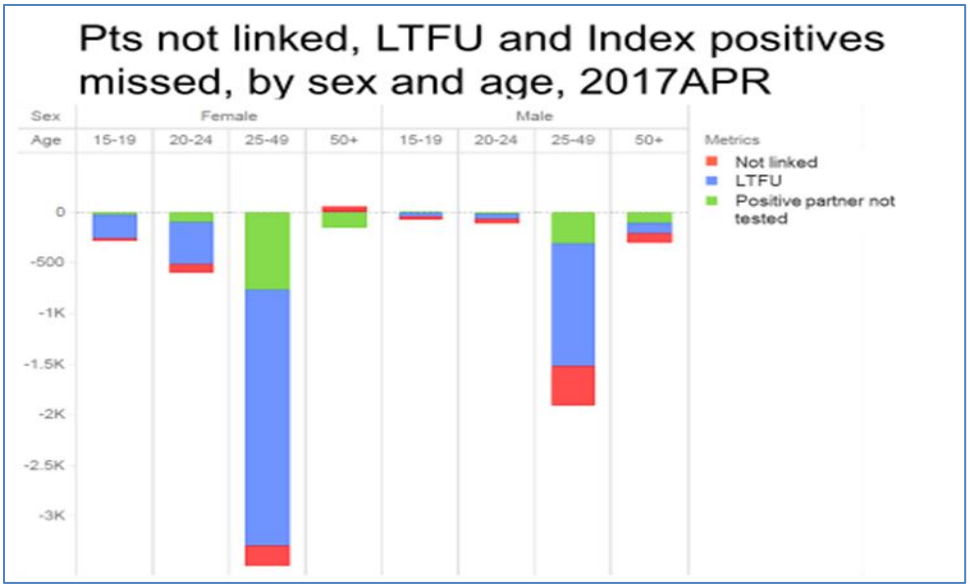


Figure 8: The "Missing" in the PEPFAR/DRC Program



To overcome the various challenges described above and reach 95-95-95 at the national level, PEPFAR/DRC will implement the following programmatic activities across both genders and all age groups, including children under 15 and adults over 15, and by male and female risk groups:

- Improving coverage and fidelity of index testing.
- Optimizing PITC yield and right-sizing testing volume by using the risk assessment tool.
- Implementing approaches for improved linkage and adherence support.
- Implementing strategies for improved tracking and reminder systems to retain patients on treatment.

First 95

In COP18, PEPFAR/DRC prevention outreach activities will focus on the following priority populations: 1) partners and children of diagnosed PLHIVs (index testing), 2) men, 3) adolescent girls and young women, 4) key populations (MSM and FSW). These populations were selected through a 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 FY19. In COP18, intensified site-level data reviews with all implementing partners, through robust partner performance management, 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, to link them on treatment and retain them in the program.

Results from FY18 Q1 reveal that men are still being reached at an old age, mainly in Kinshasa. 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. Case finding is increasing in Kinshasa in both sexes, although there is still growth opportunity with men. Improved index testing shows promise for pediatric case finding as well; there is a need to scale up family tree testing to ensure that all children <15 of HIV positive women are tested. Reaching the "un-reachable" is showing promising yields among key populations with Enhanced Peer Outreach and sexual and social network testing. In Kinshasa, a self-testing strategy will be also implemented to reach the MSM population.

Interventions to help find men at an earlier age and stage

- Intensified index-testing
- Utilizing male champions as linkage agents
- Expanding service hours
- Offering additional male-friendly services
- Targeted workplace testing

The overall approach will focus on "finding men at an earlier age and stage" and linking them into facility-based services. FY18 Q1 index testing results show encouraging trends in fulfilling this goal. Although the results are not optimal, PEFPAR/DRC is reaching relatively more men and identifying more PLHIV. 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 older men in COP18 by working with male PLHIV champions who serve as navigators and linkage agents. Partner performance monitoring has 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 characteristics 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 during targeted workplace testing will be implemented among fishermen, taxi drivers, miners, and truckers.

In facilities, screening tools will also contribute to better understand and refine the "other PITC" entry point. On one hand, refining and harmonizing the screening tools among partners continues to help refine the best instrument in order to capture the true behaviors and/or symptoms that indicate a potential HIV positive case. On the other hand, the screening tool helps to recode cases to other modalities where appropriate (especially TB and STI) and has started to show less-inflated "other PITC" modality in many zones. COP18 will maintain and expand these efforts.

Second and Third 95:

Equally as important as finding those individuals that we are missing is ensuring those we do find are linked to treatment and are retained in the program. Optimizing the second and third 95, particularly in Haut Katanga and Lualaba will be focused on different points of emphasis, which include:

- Linkage & Adherence Support: Peer Navigators/Educators to support linkage, treatment readiness, and adherence; rapid Initiation of ART.
- Improved Tracking & Reminder System: Use of Tier.net and appointment calendars to track clients due for appointments or viral load; Phone calls/SMS reminders/visits.
- Differentiated Care & Multi-Month Dispensing: Fast Track Refills at Facilities; PODIs to decongest high volume sites; and CAGs/Support Groups.
- Viral Load Monitoring: Scaling up Viral Load coverage; reinforced support & tracking for unsuppressed clients.
- Package for Advanced Disease: CD4 and LAM testing for acutely ill patients at HIV diagnosis; Integrated TB/HIV care. This package will be implemented in all 3 provinces, mainly in high volume sites. In Kinshasa PEPFAR Implementing partners will also develop close collaboration with MSF who is already providing these services in some referral hospitals where patients with more complicated opportunistic infections are referred.

4.2 Prevention, specifically detailing programs for priority programming:

a. HIV prevention and risk avoidance for AGYW and OVC

Interventions to prevent sexual violence and lower HIV risk among girls age 9-14s

- Improved violence risk screening (community and clinic)
- Increased education support for primary completion, transition to secondary, and progression in secondary
- Increase coverage of Positive Parenting and Household Economic Strengthening
- Leverage and strengthen community child protection structures for improved prevention and response (w/UNICEF and MINAS)

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 15 years of age 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% of 15-19 years old male and female 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 among females aged 25-49. Approximately 21.3% of girls aged 15-19, and 6.5% of girls younger than 15 were estimated to be married or living with a partner. According to UNAIDS, an estimated 42,000 children 0-14 years of age are living with HIV in the DRC. Supporting children who are living with, affected by, and vulnerable to HIV is essential to strengthening the HIV care continuum, preventing new infections, and achieving epidemic control.

In FY17, 41,089 OVC received services for children and families affected by HIV, 9,077 left the program (5,307 graduated & 3,770 exited without graduation), and 31,411 were active at the end of the fiscal year. During FY17, 100% of HIV-positive OVC under 18 were either enrolled or already

on ART. Among 12,579 OVCs without a known HIV status, 68% were for unknown reasons. After the successful process of rationalization of OVC activities among USG Agencies, DRC/PEPFAR is currently providing a comprehensive package of services including: health, economic strengthening, as well as safety and education programs to ensure OVC and their families are healthy, educated, stable, and safe. Once an OVC is deemed to meet these measures and is considered resilient, they graduate from the program.

In FY19, the PEPFAR/DRC OVC case management approach will prioritize enrollment of:

- HIV exposed infants, children and adolescents newly enrolled on ART,
- Children and adolescents failing ART
- Children of adults living with HIV, especially those with unsuppressed VL
- Children of female sex workers through a clinical and community entry point
- Orphans (due to HIV)
- Children experiencing violence and vulnerable adolescent girls (AG). We will prioritize the enrollment of children experiencing violence and vulnerable adolescent girls (in order to strengthen OVC program contribution to HIV prevention).

PEPFAR/DRC will expand efforts to support youth 9-14 years of age through sexual risk avoidance programming that focuses on helping them to prevent sexual violence and any form of coercive/non-consensual sex, and on enabling communities and families to support and educate these youths.

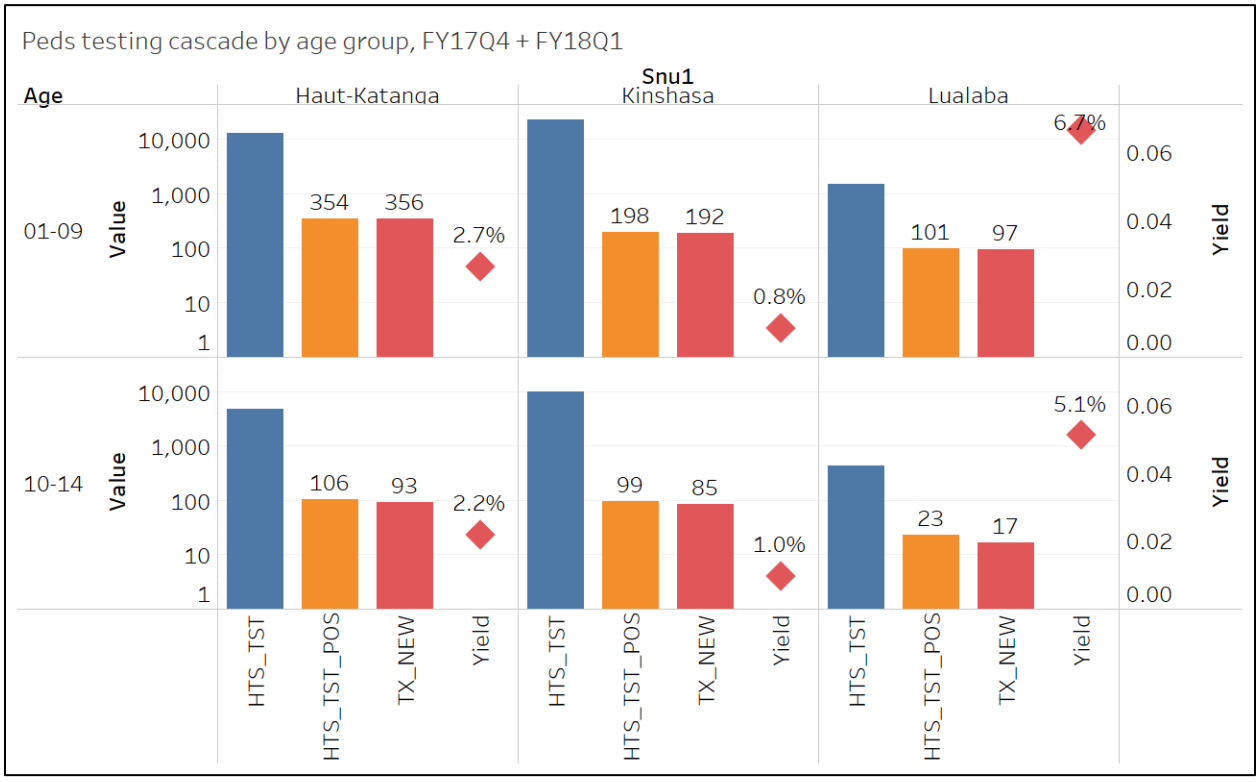
The PEPFAR/DRC OVC and pediatric testing and treatment programs will leverage each other to ensure that the needs of children living with HIV and vulnerable children are met at both clinical and community level. The strategy will focus on the systematic use of a risk assessment tool and family tree with fidelity across partners, reinforcing bi-directional referral system and tracking; strengthening family disclosure support, expanding HIV case conferencing to all health zones; and improving child outcomes through comprehensive, layered services to maximize contribution to 95-95-95 as well as prevent and reduce HIV risk among OVC targeted sub-populations. The reduction of HIV status for unknown reasons among OVCs and caregivers will be targeted by applying a harmonized, mutually reinforcing strategy for timely and positive disclosure. FY19 will see an increase of comprehensive service delivery, increased intervention coverage (e.g. adolescent girl school support, secondary transition & progression) and improved service quality.

To improve the performance of implementing partners in an ongoing and timely manner, the PEPFAR/DRC OVC TWG will continue to program quality standards and strong M&E systems such as IP quarterly performance review meetings, Data Quality Assessment and Third Party Monitoring in order to routinely analyze program data and suggest corrective actions for continuous quality improvement and high performance across all agencies and partners. Intensifying mentorship, supervision and support at new and lower performing sites will be an area of focus in FY19.

b. Children

The number of children receiving ART nationwide has increased by 200% between 2012 and 2016, with children under 15 years old accounting for approximately 9% of the total of number of people on ART. However, national data shows that pediatric ART coverage is still proportionately lower at 30% compared to 43% adult coverage in DR Congo. The PEPFAR ACT initiative is acknowledged to have catalyzed the closing of the gap between adult ART coverage and child ART coverage countrywide. Yet, even in PEPFAR areas, pediatric treatment still remains a challenge fueled by the relatively low identification of positive children. Figure 9 below shows good testing yield and linkage in Lualaba, modest testing yield in Haut Katanga with Kinshasa lagging behind in term of yield and linkage. In Lualaba, addressing low retention through adolescent support groups, parent literacy, increased use of LPV/r pellet and close collaboration with OVC case managers will be the focus. In Haut Katanga and Kinshasa, optimizing index testing and PITC, early ART initiation and joint effort between partners (clinical and OVC clinical) will improve yield and linkage. We recognize that the current age of consent for testing of 18 years remains an issue, and we continue to advocate for a testing-enabling environment for improved adolescent access.

Figure 9: Peds Testing Cascade



Another continuing challenge is access to VL. By FY18 Q1, only 47% of eligible children have had a documented VL test, which also revealed significant adherence and retention issues. The suppression rate among those with a documented VL is low; Figure 10 below shows that VL

coverage in <15 is very low at 47% with 56% of VL suppression. For retention (Figure 11), Lualaba continues to have issues with very low retention rates, while they are improving in Haut-Katanga.

Figure 10: Peds Viral Load Cascade

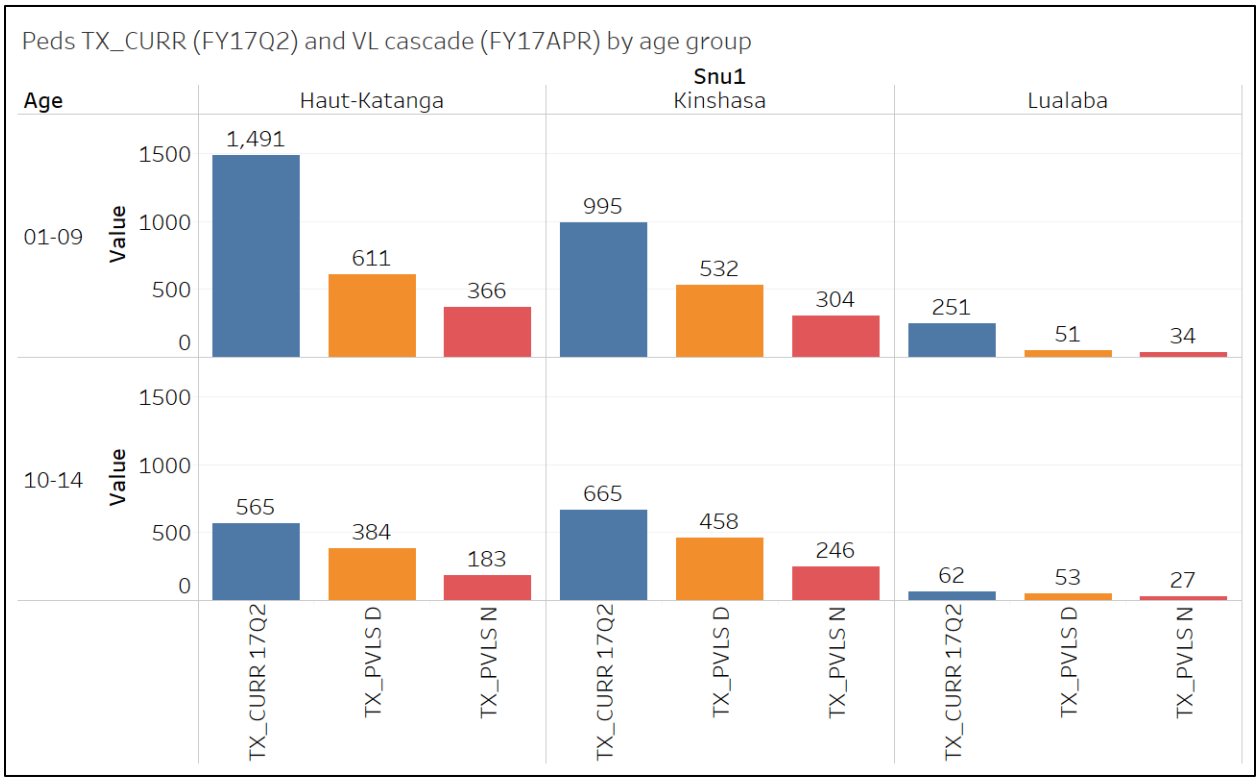
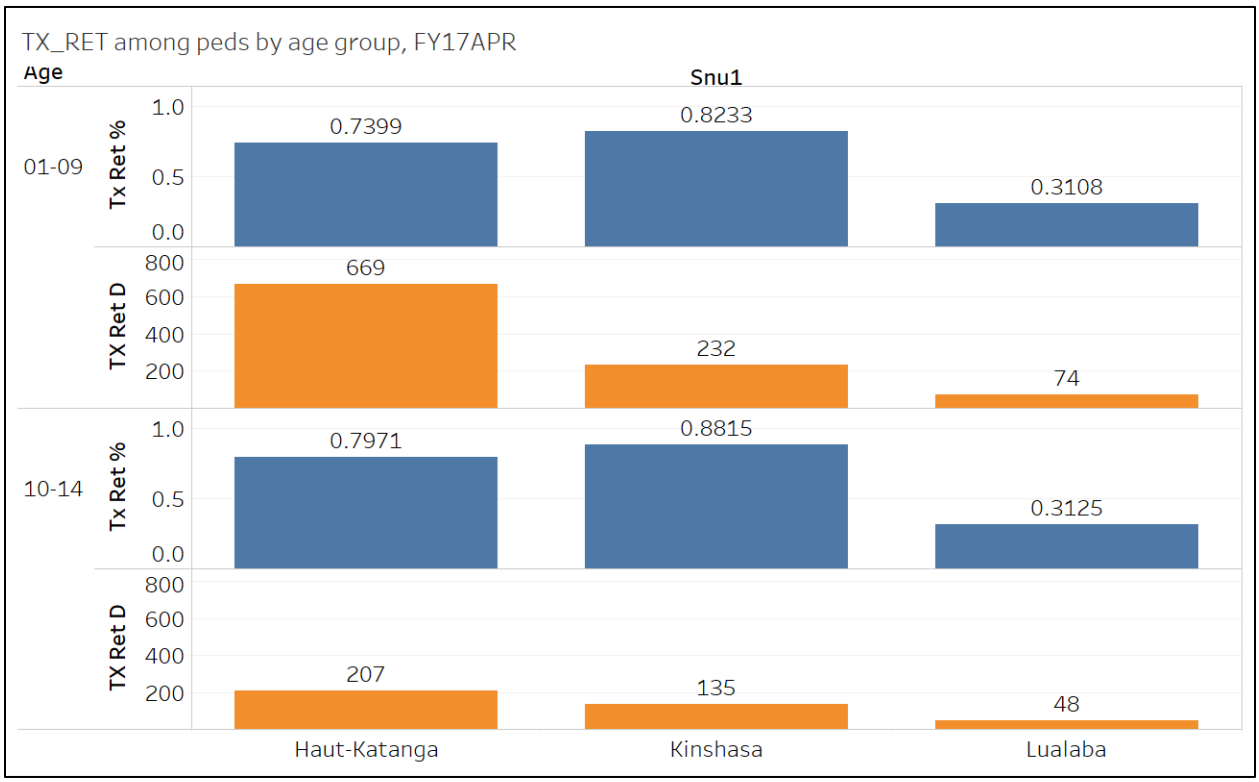


Figure 11: Peds Retention



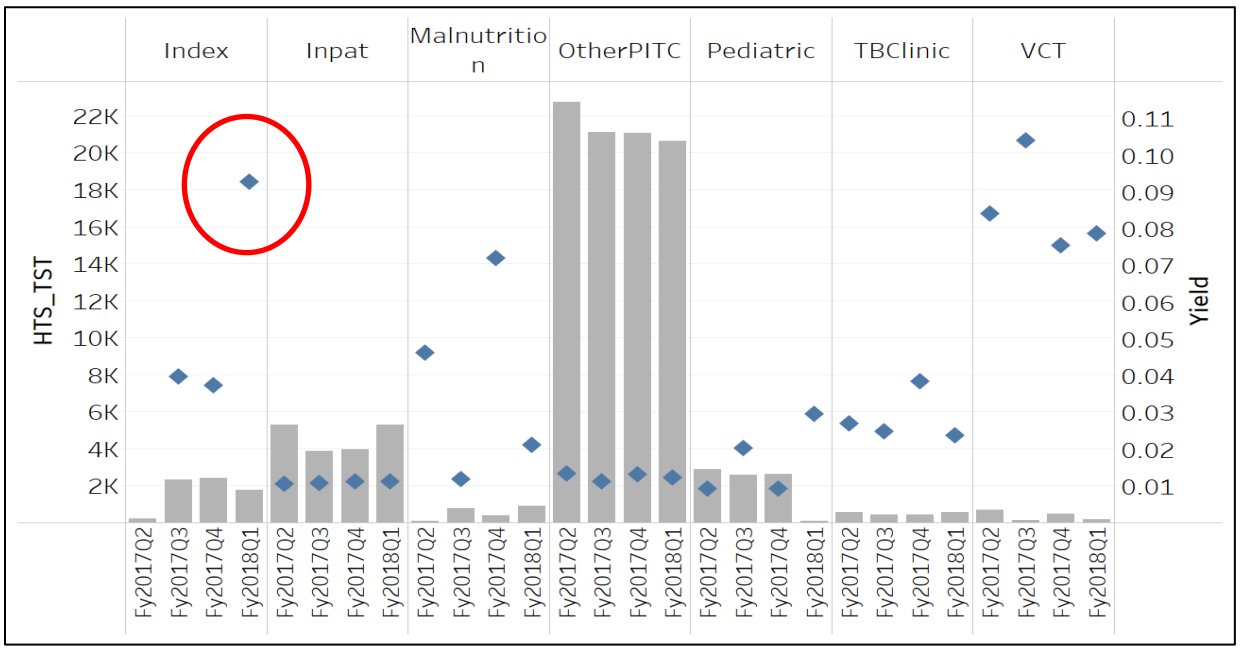
In addition to expanding ART (including inclusion of children in DSD models) and VL testing coverage, increasing NACS, and improving TB screening, a key priority will be increasing systematic and routine HIV testing of all children, especially:

- Family tree/index testing
- Children in inpatient settings
- OVC identified through screening tool
- Malnourished children
- Children with TB or suspected TB
- Outpatients identified through screening tool

The staffing footprint for pediatric/adolescents will remain a key priority for mentoring and support in COP18. This includes the TLD roll-out to include CLHIV who are 10 years of age and the implementation of key strategies with fidelity

Promising results in index testing among children <15 were seen in Q1 FY18, Figure 12.

Figure 12: Index Testing HTS_TST Results



Furthermore, in COP18, OVC partners will strengthen linkages between OVC & pediatric programs and the adolescent continuum of care through a comprehensive & high-quality service package to OVC via a family-centered, HIV-inclusive case management, prioritizing KP's children, CLHIV, and AGYW. This will be achieved by systematically using the risk screening tool, reinforcing bi-directional referral system between clinic & community (MoU's between treatment and OVC partners) and conferencing HIV cases. In order to improve key pediatric indicators, OVC programming with a strategic focus on 95-95-95 outcomes will focus on targeting enrollment of subgroups with high risk of LTFU, poor linkage, poor adherence, and getting new patients on treatment.

Building in our current positive experience with the Ariel group through EGPAF at Kalembe-lembe pediatric hospital, the following strategies will be applied:

1. Adolescent self-support group for 10-15 years old adolescent children, with the use of Ariel curriculum,
2. Targeted and focused adherence counselling for the parents/Caregivers of 7-9 years olds children in order to prepare them to the disclosure.
3. Use of OVC platform as an adherence community platform for the entire family,
4. The implementation of bidirectional reference between OVC case manager and clinical manager (Peer educators and OVC case managers to assist in tracking clients in need of extra support for adherence).

c. Key Populations

DRC has completed a mapping and size estimation study of key populations, including FSW and MSM, targeting the country's ten most populous cities. However, the preliminary results from Kinshasa have raised concerns about the coverage and accuracy of the sampling and data collected. The PNLS took these concerns into consideration and have taken actions to conduct another size estimation study for Kinshasa before validating the study. The final results are expected in April 2018.

The preliminary results of the size estimation study also highlighted 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 this year. This IBBS survey will target FSW, MSM, PWID, truckers and fishers, which is a significant improvement to the 2013 IBBS, which was limited to FSW and street children.

Building on COP17 interventions, COP18 programming for KPs will continue to be comprehensive, with identification of KPs living with HIV and linking them to treatment remaining as one of the COP18 top priorities.

Testing

Results in Q1 2018 show that testing yield continues to be a challenge, as well as linking some positive KP to treatment, as shown in Figure 13 and Figure 14 below.

Figure 13: PEPFAR KP Cascade FY18 Q1 MSM

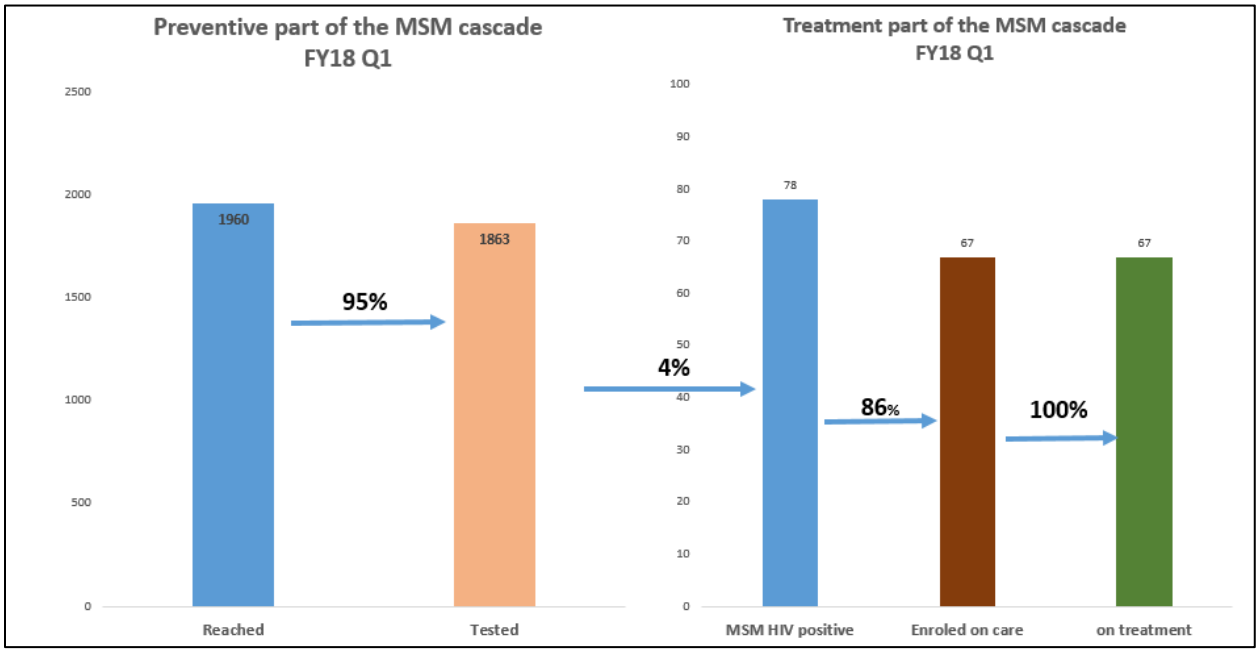
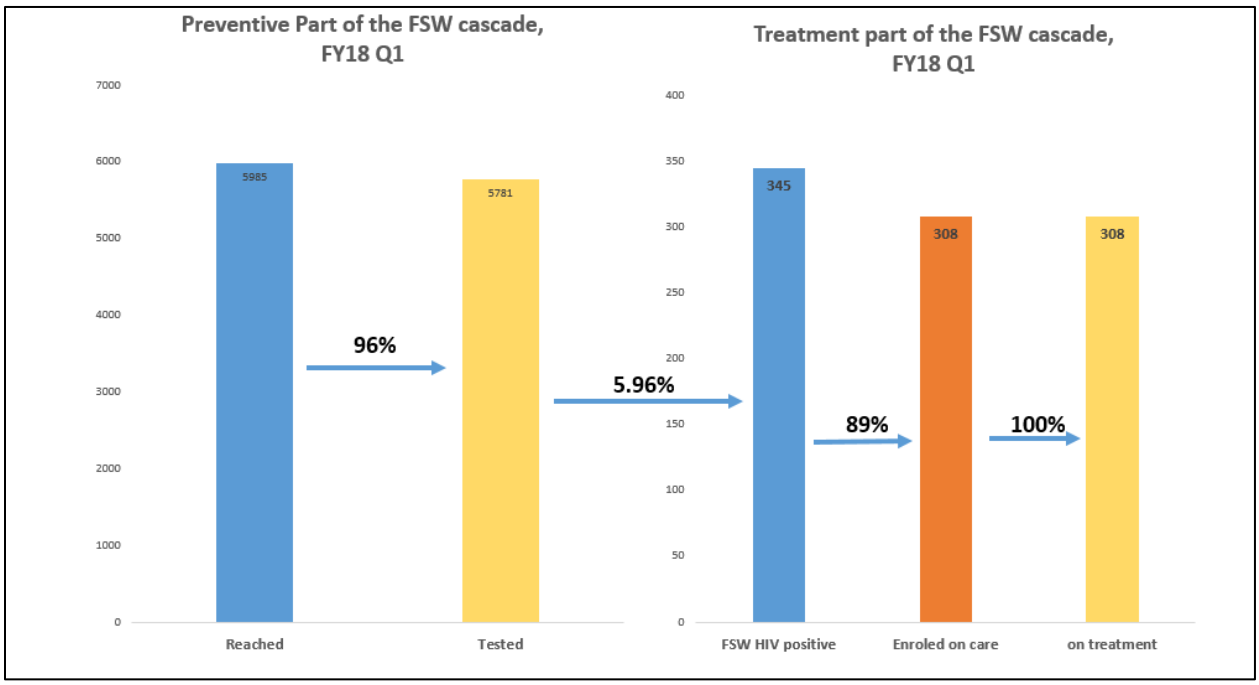


Figure 14: PEPFAR FY18 Q1 KP Cascade FSW



PEPFAR/DRC recognizes these challenges and will utilize various modalities of testing to increase volume and yield 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.

The scaling up of KP sexual and social network approaches such as EPOA (Enhance Peer Outreach Approach) and Respondent Driven Sampling (RDS)-like recruitment approaches shows a gradual increase in HTS yield in the PEPFAR/DRC KP program. These two approaches are to increase HIV testing yield, link HIV-positive KP with treatment and care, and connect HIV-negative KP with services that will help them remain HIV negative. It focuses on those who are not found at traditional hot spots.

The enhanced peer outreach approach (EPOA) in USAID zones complements peer outreach by engaging previously unidentified KP members for HIV prevention and testing — particularly those who are hard to reach and who may be at high risk of HIV, or are HIV positive. The EPOA is led by KP members who have been tested for HIV (or are enrolled in ART if they are living with HIV), and who volunteer to pass referral slips for HIV testing to KP members (peers) in their social or sexual network.

Selected HIV positive KP members are asked to become Peer Mobilizers (PM) — to reach other KP members in their social network who may not frequent those hot spots, and to encourage them to get tested. Thus, the EPOA uses the social networks of KP members to extend program

coverage and to target hard-to-reach and highest-risk individuals who may be underserved by hot-spot-based outreach approaches. Each PM receives a number of referral slips as per the size of his network. Sometimes, the program yield experience over time has guided on the number of slips to be given to PM. For example, after 5 referrals testing negative from the Peer Mobilizer, the network testing is considered as low yield and stopped. The PM is instructed to give referral slips only to eligible peers from his network. In practice, the use of a risk screening tool has also helped PMs to identify those most at-risk to be referred for testing. As the EPOA is implemented over time, analysis of program data will show the testing yield and will help to refine the selection criteria of peers to be given the coupons. Any successful reference receives monetary incentive in compensation for effort and transportation fees.

Those peers who test HIV negative are connected with a peer outreach worker for regular HIV prevention services. Those who are living with HIV are referred to treatment and care, with support from a peer navigator to reduce loss to follow-up and to help people increase adherence and maintain a suppressed viral load.

The RDS-like recruitment approach in CDC zones consists of a network-based testing strategy currently implemented at four KP-friendly sites in Kinshasa. The strategy is modeled after "Respondent driven sampling," a network-based sampling methodology that has become the standard for HIV bio-behavioral studies among key populations. The programmatic application of RDS methods is innovative and has the potential to assist in reaching hard-to-reach populations, including sub-populations of key populations.

The implementation sites identify "Index" clients to engage in the strategy. These index participants are defined as: HIV-positive clients, high-risk negatives, and hard-to-reach sub-populations (for example, MSM and CSW aged >35 years). Index clients are provided with three coupons to share with "contacts" in their network. The definition of a contact depends on the class of Index client:

- HIV-positive clients --> Contacts are sexual partners
- High-risk negatives --> Contacts are sexual partners
- Hard-to-reach Sub-populations --> Contacts are peers in the same demographic category (e.g. MSM aged >35 years)

Index clients are incentivized through a modest monetary award for each contact they bring into the clinic. The Contacts themselves are also incentivized with the same monetary award if they come to the clinic. Monetary awards are only provided upon verification of the contact's status as a member of the KP community (through routine behavioral screening tool).

Contacts are provided the standard package of HIV-related services, including HIV and STI screening. Contacts who meet the definition of an Index client (HIV-Positive, high risk negative, sub-population hard to reach) are "recycled" and offered enrollment as an Index client and three coupons to distribute.

All coupons contain a non-information-baring code number, and all Index and Contact information is documented in a register specific to the RDS strategy. Therefore, the site is able to closely monitor, in real time, the implementation of the strategy, including: the rate of coupon return among specific populations, and the rate of HIV-positivity among Contacts in specific populations.

Continuous evaluation of the two approaches will inform the impact and efficiency of reaching hard-to-reach KP.

Linkage to Treatment

Clinical cascade analyses for key populations indicate a significant drop-off between the number of KP found to be HIV positive and those who are enrolled on treatment. In COP18, PEPFAR/DRC will continue to rely on one stop shops where applicable and active peer referral using skilled navigators in the community in alignment with the "test and start" strategy.

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 to ensure that all positive KPs are accessing services will be intensified.

Clients who access services at the community level will be linked to the clinical platform by skilled peer navigators who also 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.

Other services

Numerous other critical services for KP will be provided, such as: TB screening and treatment referral; 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. We will also continue with Zambia/DRC Key population cross-border activities to ensure continuum of prevention, care and treatment of KP to both sides of border.

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 reviews of testing and treatment progress.

Epidemiological pattern and program results will continue to inform PEPFAR DRC strategy for KP. In COP18, in Kinshasa, the program continues to target FSW. For MSM, the program will mainly shift to network-testing and self-testing. In Haut-Katanga, the program targets FSW through peer education outreach including in Zambia-DRC cross-border settings. For MSM, the

peer educator outreach, network-testing and self-testing will be used synergistically. In Lualaba, however, as the MSM program is ending, only FSW and their clients will be targeted.

d. Others

TB/HIV

In FY17, 98 percent (169,90/177,46) of registered TB patients in PEPFAR-supported health zones were tested for HIV, 1,942 patients were found TB/HIV co-infected, 94 percent (1,942/2,077) of them were initiated on ART.

In FY 19, PEPFAR/DRC will continue to prioritize TB/HIV activities to combat the dual infection of HIV and TB. This support will focus on key interventions to maintain high rates of HIV testing among all TB and TB presumptive cases; ensure universal ART for all PLHIV; ensure timely TB diagnosis and treatment completion; scale up TB Preventive Therapy (TPT); using the one-stop-shop model; and sustained joint TB/HIV programming and monitoring. These core TB/HIV interventions are key evidence-based approaches to achieving the UNAIDS 90-90-90 goals.
In COP18, PEPFAR/DRC will introduce the use of lateral flow urine lipoarabinomannan (LF-LAM) assay for TB diagnosis for PLHIV with low CD4 count or those who are seriously ill. In Kinshasa, PEPFAR DRC will establish close collaboration with MSF facilities offering who is a full package for advanced HIV/AIDS disease.

In FY19, PEPFAR/DRC will continue to support GeneXpert network and diagnosis among PLHIV for improved TB yield in all supported health zones. Support will be provided for septum transportation logistics for GeneXpert tests and return of results, and will provide prompt treatment initiation to confirmed TB cases and ensure follow up and documentation of treatment outcomes.

Programming for TPT will be prioritized as well as TB infection prevention and control measures (administrative, environmental, personal protection). The PEPFAR/DRC care and treatment program will continue to scale up TPT and support the Ministry of Health (MOH) to: review the TB/HIV guidelines; develop systems and monitoring and evaluation tools; strengthen Isoniazid medication (INH) logistics management systems to avoid stock out; and monitor partner performance.

Efforts will be intensified to ensure contact tracing for all HIV positive patients diagnosed with TB, especially pulmonary TB cases. This will improve TB case detection among HIV patients and their households and will contribute to increased HTS uptake. Through systematic TB screening for PLHIV, PEPFAR/DRC will also intensify TB case finding among KP, children, and pregnant women attending ANC in all health facilities.

Significant progress has been made integrating TB/HIV services into TB clinics, using the one-stop-shop model. PEPFAR/DRC will continue to support this model at the national level with

other stakeholders (MOH, GF) and contribute to avoid the loss to follow-up and increase the number of TB/HIV co-infected patients on ART.

Military

In COP18, PEPFAR/DRC will continue to offer prevention services, and promote HTS 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 consistent and correct use of condoms will be made available to all military personnel, especially those going on deployment. Training/sensitization modules will also include prevention of alcohol and substance abuse, as well as prevention of gender-based violence. 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 to the nearest PLHIV support group for PHDP support and in FY19, an emphasized focus will be put on increased case identification through partner notification and index testing. Those presenting with TB or STI symptoms will be offered treatment at PEPFAR-funded military health facilities. OVC services will also be provided to vulnerable children and adolescents in military communities, including testing services for those at risk.

4.3 Additional country-specific priorities listed in the planning level letter

PEPFAR/DRC has taken into account country-specific priorities listed in the planning letter to improve program results and reach ambitious COP18 targets. Several areas of emphasis have already been discussed in previous sections, including measures to increase finding those individuals that we are "missing"; approaches to improve results with key populations; as well as a comprehensive package to reach OVC and adolescent girls and young women.

In this section, we will present and, in some cases. re-emphasize the importance of several priorities that will be the focus during COP18.

Before addressing the various priorities, it is important to note the status of several key national HIV policies. The test and start policy that was adopted in 2016 and the same-day initiation approach is widely implemented in PEPFAR settings, which has had a significant impact on the number of patients newly enrolled on ART. In addition, self-testing guidelines are in place and the National AIDS Control Program is working to quickly undertake an evaluation of tests to be used. Small scale roll-out self-testing projects are anticipated in DRC during Q3 FY18. The PEPFAR-funded project LINKAGES expects to introduce self-testing among key populations as soon as the evaluation is complete and test kits are available. Another important approach to enhance retention is the multi-month scripting for stable patients. Guidelines for multi-month scripting exist and scale up will be a focus during COP18.

Worth mentioning again here is the strategic expansion in two (Kasaji and Dilolo) of the six orphan health zones in Lualaba province. PEPFAR/DRC aims to leverage support through the

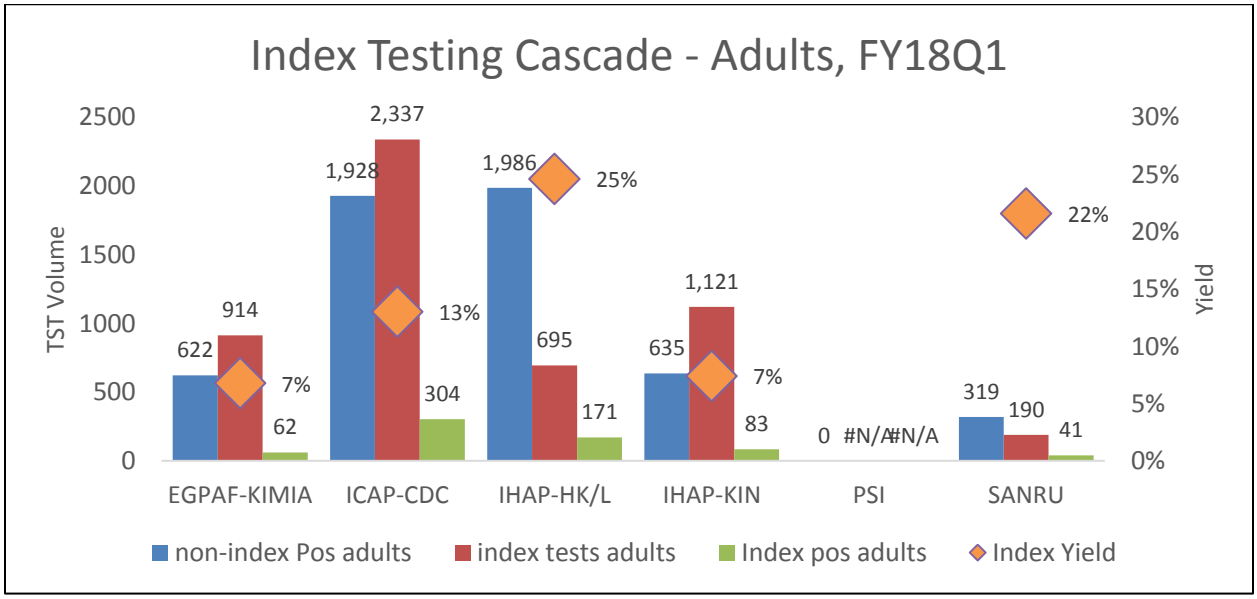
upcoming USAID primary health care project (Integrated Health Project), which will also be operating in Lualaba. This synergy will minimize operational costs in the context of limited resources, and allow for a more sustainable approach in this rural, hard-to-reach area. In Haut Katanga, PEPFAR/DRC will expand to Kilela Balanda and Lukafu health zones (two of three orphaned health zones in Haut-Katanga). However, due to security reasons, expansion into Mitwaba health zone is postponed. PEPFAR DRC recognizes that this geographic expansion is necessary to meet attainment in these two provinces, and hence, is shifting resources in FY19.

With the shifting of resources to the Haut-Katanga and Lualaba provinces, PEPFAR/DRC will work closely with partners in Kinshasa to tighten implementation and find increased efficiencies in their programming. This may involve site consolidation, which will be investigated further during FY18 to understand risks and rewards of closing smaller sites and/or creating a hub-and-spoke model. Numerous factors will be investigated including: patient dynamics in each site that may be consolidated, the nature of cost savings, measures to mitigate patient loss to follow up, ensuring service availability and host country buy in.

Responding to the Planning Letter Priorities: Key Strategies:

Improving case findings through index case testing in the three provinces is essential. PEPFAR DRC will provide more technical support to partners for the scale up of this modality to ensure fidelity. Progress is already apparent with yields increasing during Q12018 through improved implementation of index testing, as shown in Figure 15 below. Partners will be encouraged to develop SOP and adapted tools to track the intervention. Monthly data related to index-testing will be collected and analyzed. Targeted community testing and anonymous partner notification will be strengthened through intensive mentoring and coaching. PEPFAR DRC expects 20% of positives will be diagnosed through this modality by maximizing index testing coverage in all high sites, as well as through a concentrated community approach.

Figure 15: Improved yields in index testing during Q1 2018 implementation



PEPFAR DRC will continue to support the improvement of the cascade specifically for men through enhanced strategies according to defined packages of services for each province. Extended clinic hours, partner notification, targeted testing in non-communicable disease clinics, testing at working places (industrial and artisanal mining, fisher camp) will be used with adapted strategies to ensure linkage to treatment.

The planning letter mentioned low PMTCT performance with regard to testing all pregnant women and ensuring all women found HIV positive receive ART to prevent transmission. Deep analysis is showing low coverage of PMTCT interventions in some health zones in Lualaba. The lack of maternities and PMTCT interventions in non-supported facilities constitute missed opportunities. PEFPAR DRC will encourage mapping of those facilities to offer PMTCT interventions to pregnant women attending ANC. Doing so, PMTCT coverage will improve.

Concerning a strategy for monitoring unsuppressed patients, PEPFAR-RDC recognizes the lack of a uniform process across all sites in order to track samples to the labs and results back to the clinical sites. Measures are currently being implemented during FY18 to address this issue. Moving forward, strict tracking processes will be implemented in all sites to ensure all samples arrive at a laboratory and results are returned in a timely manner. Demand creation for viral load testing is also a priority during COP18.

PEPFAR/DRC will focus on the management of unsuppressed patients. To that end, VL monitoring tools and SOPs will be standardized across partners. The plan for monitoring unsuppressed patient includes adherence assessments to understand individual factors impeding treatment observance and individualized solutions to improve adherence. After three months of adherence support, VL exam will be requested. Patient showing VL result improvement will continue with the same regimen however those not improving will be shifted on second line based on the therapeutic committee guidance. For illustration of best practices, certain sites have established a small viral load committee (doctors, nurses, peer- educators, psychologists) to manage viral load results with attention to VL coverage, VL result return and management in particular for unsuppressed patients.

For illustration of best practices, certain sites have established a small viral load committee (doctors, nurses, peer educators, psychologists) to manage viral load results with attention to unsuppressed patients requiring adherence monitoring and support over three months or more, depending on patient compliance. After this period of time, the committee decides on continuation or any changes that may be required to the patient's regimen.

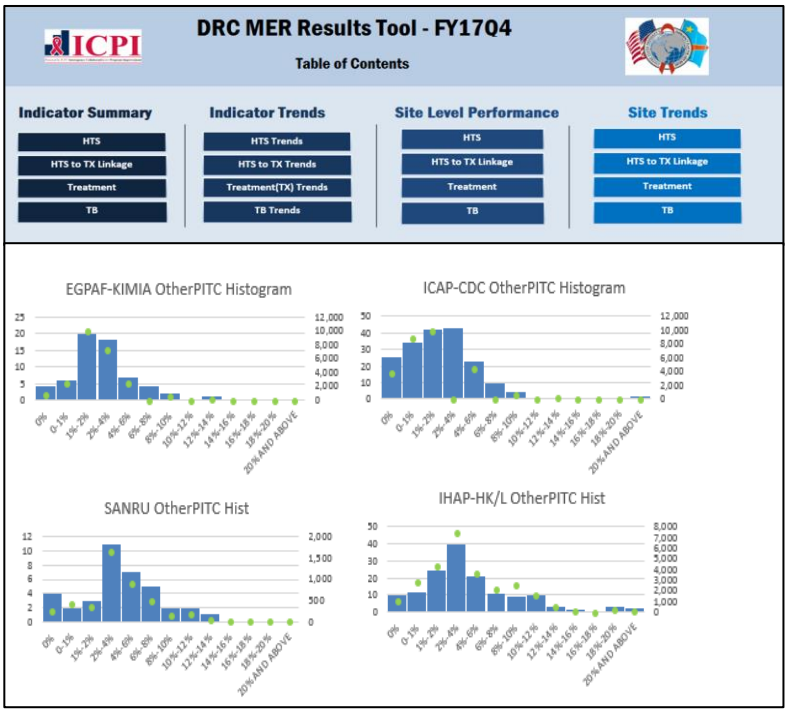
Partner Management for Epidemic Control

PEPFAR/DRC recognizes that the successful implementation of any of these approaches depends on the close management of implementing partners—at the site level—to ensure alignment with program strategy to improve performance in an ongoing and timely manner. To that end, in addition to the use of conventional tools (DATIM, PANORAMA, FACT View), PEPFAR/DRC is and will continue to use complementary partner management tools, including:

- A targeted partner management analysis tool developed in conjunction with ICPI, that focuses on key metrics at the site level (Figure 16)
- A Partner Management Plan that provides structure, standardized processes, defined roles and responsibilities, root-case analysis, remediation plans and monitoring of remediation plans (Figure 17)
- A site-level dashboard to empower PEPFAR, IP and clinic staff to be aware of and use data during visits and interventions at the site (Figure 18)
- Structured Monthly reporting and analysis tools focused on key metrics, including scale up of index testing, viral load and differentiated service delivery.

These tools identify necessary site-specific corrective measures and create remediation plans. These plans employ standardized processes, identify roles and responsibilities and ensure accountability. Plans are monitored bi weekly, monthly and quarterly to improve recognition of issues and implementation of relevant interventions to improve outcomes. Simultaneously, PEPFAR/DRC agencies have set financial review processes that scrutinize monthly burn rates against performances. Monthly calls, quarterly financial reviews and regular inter-agency financial meetings will be formalized to track financial performances to avoid both overspending and underperforming across partners. With the support of the agency headquarters , PEPFAR DRC plans to understand partner costs per client identified and linked to treatment in the three provinces in order to improve efficiency in implementation.

Figure 16: Examples from Partner Management Analysis Tool



PrimePartner	SiteName	HTS_TST	TS_TST_	TS_TST_I	Yield
EGPAF-KIMIA	Itaga CS_EGPAF-KIMIA	22	22		0.0%
EGPAF-KIMIA	Bolia CS_EGPAF-KIMIA	38	33	5	13.2%
EGPAF-KIMIA	-Dame La Providence_EGPAF-	38	38		0.0%
EGPAF-KIMIA	Lunionzo CS_EGPAF-KIMIA	50	48	2	4.0%
EGPAF-KIMIA	Mombele CH_EGPAF-KIMIA	92	87	5	5.4%
EGPAF-KIMIA	St Amand CS_EGPAF-KIMIA	101	100	1	1.0%
EGPAF-KIMIA	Raymond - Matete_EGPAF-KIM	103	103		0.0%
EGPAF-KIMIA	apha - Limete CH_EGPAF-KIMI	107	99	8	7.5%
EGPAF-KIMIA	rovidence St Joseph_EGPAF-K	116	114	2	1.7%
EGPAF-KIMIA	Kimbangu CH_EGPAF-KIMIA	117	110	7	6.0%
EGPAF-KIMIA	Beau Sejour CS_EGPAF-KIMIA	139	135	4	2.9%
EGPAF-KIMIA	Fatima CS_EGPAF-KIMIA	151	148	3	2.0%
EGPAF-KIMIA	Apv CS_EGPAF-KIMIA	159	154	5	3.1%
EGPAF-KIMIA	Promedis_EGPAF-KIMIA	172	172		0.0%
EGPAF-KIMIA	Mososo CS_EGPAF-KIMIA	173	171	2	1.2%
EGPAF-KIMIA	Vitamine_EGPAF-KIMIA	179	171	8	4.5%
EGPAF-KIMIA	DGI Limete CM_EGPAF-KIMIA	182	170	12	6.6%
EGPAF-KIMIA	Bangba CS_EGPAF-KIMIA	186	180	6	3.2%
EGPAF-KIMIA	Meravie CS_EGPAF-KIMIA	192	189	3	1.6%
EGPAF-KIMIA	OSD Clinic_EGPAF-KIMIA	193	181	12	6.2%
EGPAF-KIMIA	Mawagali_EGPAF-KIMIA	197	191	6	3.0%
EGPAF-KIMIA	Matete CHR_EGPAF-KIMIA	198	182	16	8.1%
EGPAF-KIMIA	Mitia CS_EGPAF-KIMIA	221	209	12	5.4%
EGPAF-KIMIA	Moderne CH_EGPAF-KIMIA	223	219	4	1.8%
EGPAF-KIMIA	Mokengeli_EGPAF-KIMIA	225	216	9	4.0%
EGPAF-KIMIA	Kindele CS_EGPAF-KIMIA	233	231	2	0.9%
EGPAF-KIMIA	ndeko - Limete CL_EGPAF-KIM	260	244	16	6.2%
EGPAF-KIMIA	ta - Mont-Ngafula1 CM_EGPAF	264	257	7	2.7%

Figure 17: Roles and Responsibilities in Partner Management Strategy

Roles/Steps	1. Analyze the Data	2. Define the Problem & CDC Response	3. Plan for Partner Meeting	4. Engage with Partners	5. Follow up & Monitor Remediation plan
Activity Managers	• Review data prior to meeting	• **Lead discussion on problem finalization and CDC response** • **Create/Update Partner Matrix and Tracker**	• **Contact IP to share materials and organize meeting**	• **Lead meeting to review and discuss identified problems** • **Update Partner Matrix and Tracker**	• **Provide feedback in finalization of remediation plan** • **Validate implementation of remediation plan against process indicators** • **Engage CDC and IP leadership when needed** • **Update Partner Matrix & Tracker**
Program Area Leads	• **Review program area results and prepare presentation for internal data review meeting (SIMS, MER)**	• **Lead data reviews for respective program areas** • Provide technical input into review			• Support ongoing monitoring of problem remediation
SI Team	• Support and participate in the data review	• Support and participate in the data review		• Support Activity Managers as needed	• Support ongoing monitoring problem remediation
SIMS Leads	• Support and participate in the data review	• Support and participate in the data review		• Support Activity Managers as needed	• Support ongoing monitoring problem remediation
CDC Leadership			• If needed, engage IP leadership	• If needed, engage IP leadership	• Provide overall leadership and monitoring of Partner Management Strategy • If needed, engage IP leadership
IP	• Routinely review all available program data, including MER & SIMS		• **Confirm meeting with CDC** • **Review identified problems and trends for active problems**	• **Conduct RCA on identified problems** • **Create and update remediation plans**	• **Implement and monitor programs and remediation plans** • **Communicate updates to CDC AM as needed and requested**

Figure 17: Overview of Partner Management Strategy Process

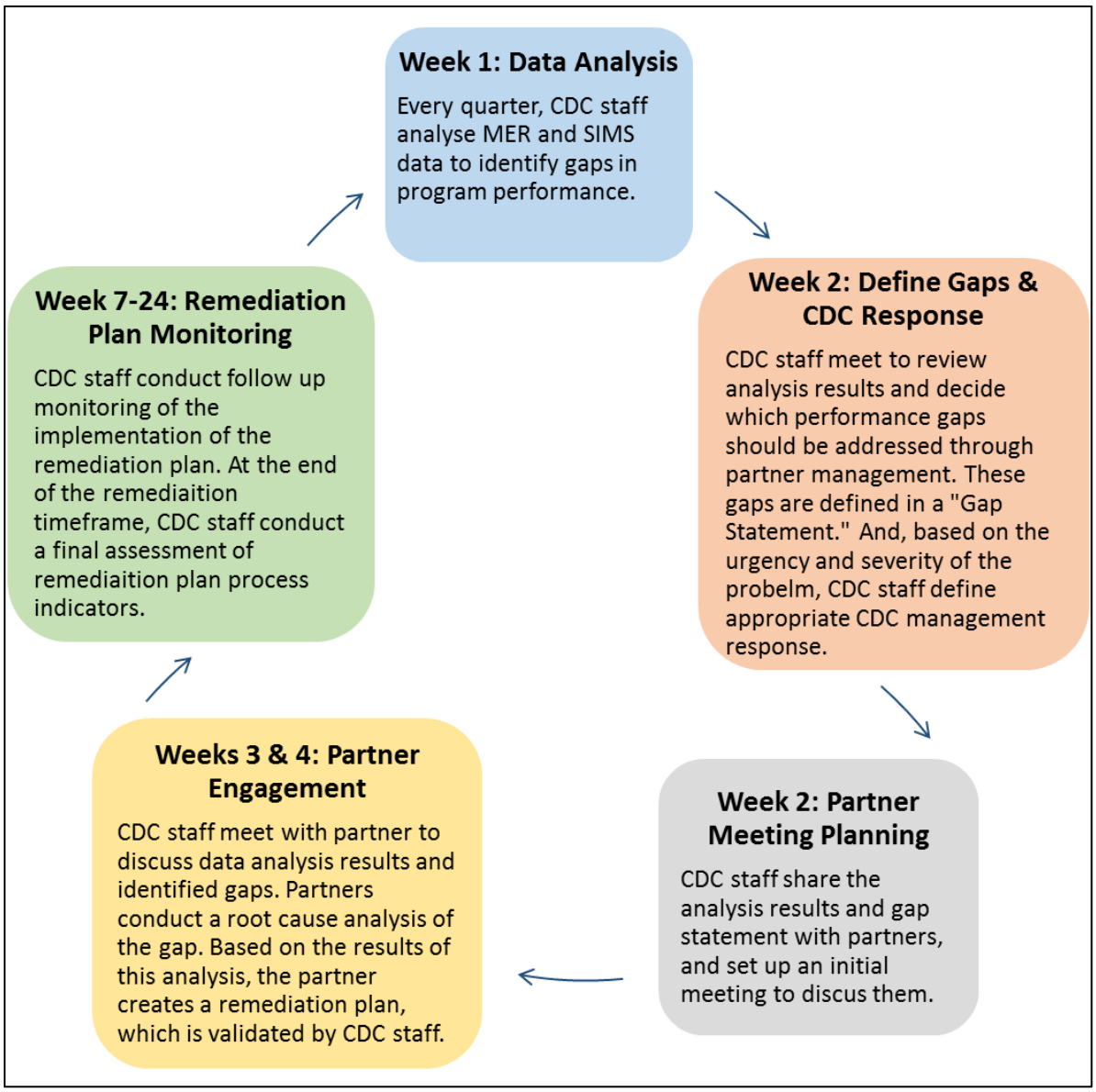
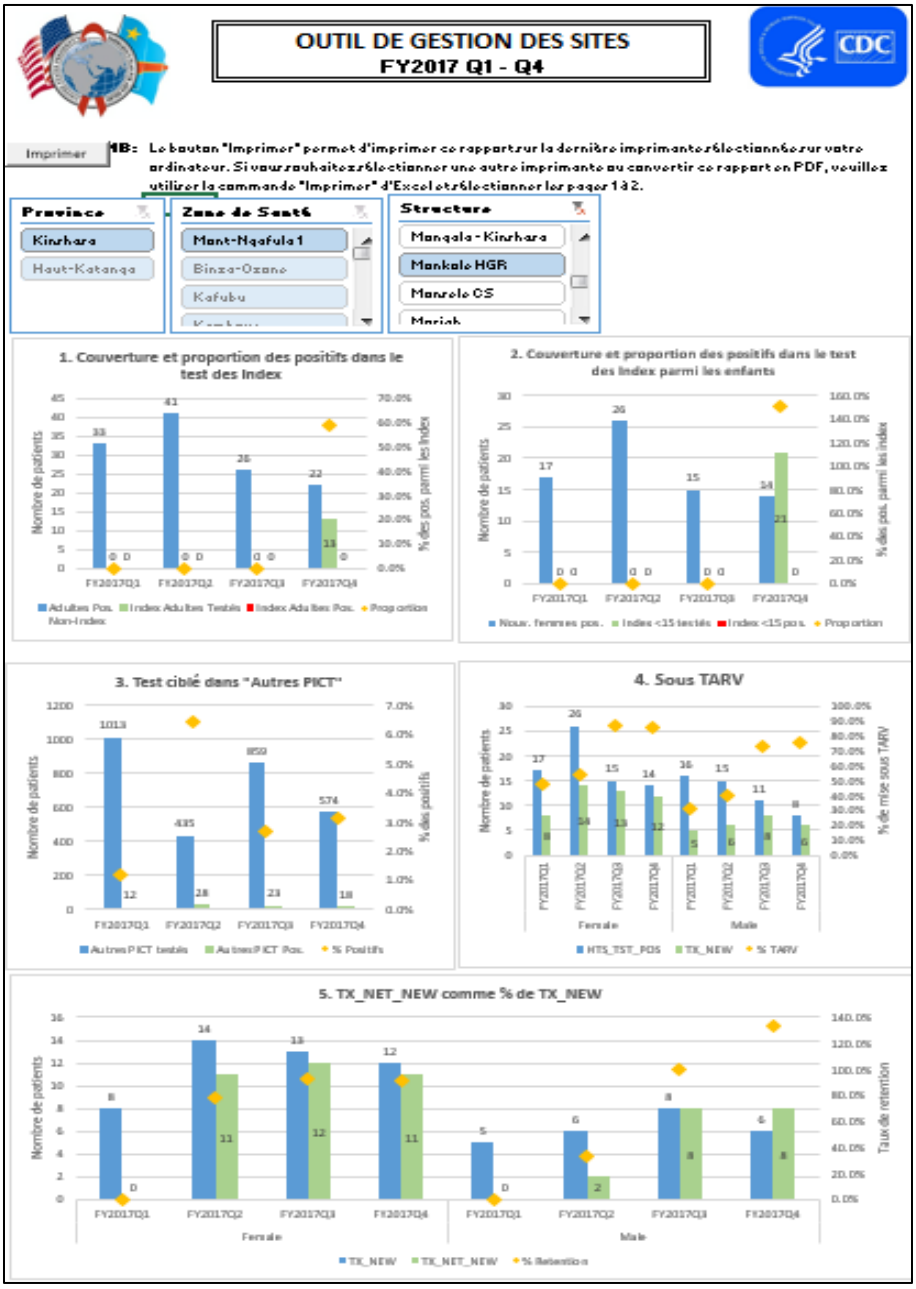
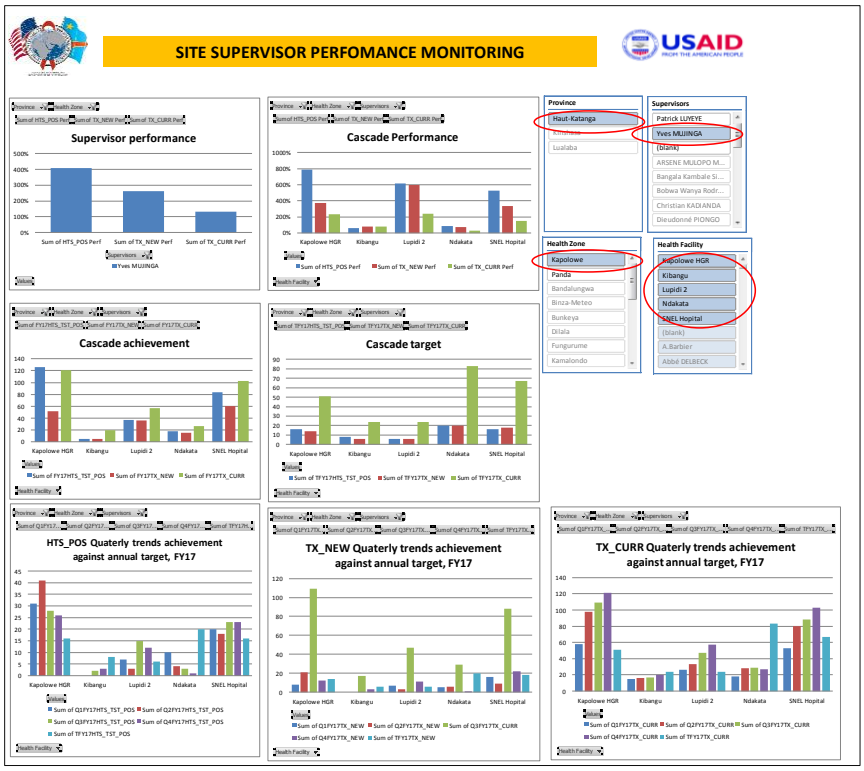


Figure 18: Example of Site Level Dashboard





In addition to stronger partner management, better surveillance data are key for program improvement. PEPFAR/DRC is currently providing technical assistance and collaborating with the PNLS, Global Fund and DRC UNAIDS in the ongoing surveys (IBBS, ANC surveillance), Key Populations mapping and size estimations.

PEPFAR DRC has reviewed the Epidemic Control Solution Platform and is incorporating relevant applications into our programming. Evidence -based solutions such as adolescent supports groups (Ariel Clubs), peer navigators and community ART dispensing models will be scaled up during COP18.

4.4 Commodities

PEPFAR/DRC provides all HIV-related commodities to PEPFAR-supported health zones in Kinshasa, Haut-Katanga and Lualaba provinces in support the goal of 95-95-95 by 2030.

Efforts are currently underway and will continue in COP18 to reinforce optimized stock management, in addition to strong coordination and data-based management of the PEPFAR and Global Fund stock to ensure the national supply chain for HIV commodities is functioning well.

In alignment with the global objective of building a sustainable national supply chain system while ensuring the reliable availability of HIV commodities and to improve stock management at all levels, PEPFAR/DRC will provide the following technical assistance related activities:

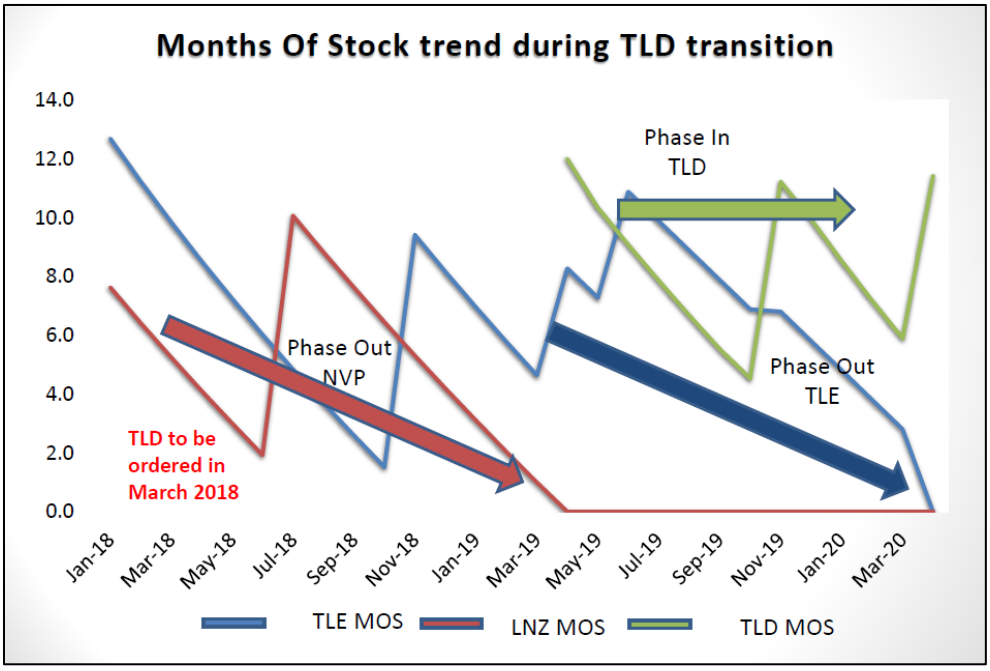
1) Support the National HIV Program to conduct a smooth transition to the new first line HIV treatment of TLD by April 2019 (DRC Transition plan, templates, guidelines review, training, etc.).
2) Support to the MoH in planning, operationalizing and monitoring the implementation of the national supply chain strategic plan.
3) Support to the national and provincial supply chain working groups to conduct the annual quantification exercise of HIV commodities including laboratory reagents and the annual supply plan development (provide tools, review parameters, conduct training/ refresh training on the use of Forlab and Quantimed tools).
4) Monitor stock status at the provincial and site levels and provide mentoring and coaching in stock management on a quarterly basis.
5) Ensure that the information system (LMIS) is operational and that data collection takes place to populate the PPMR-HIV tool and ensure that data analysis and data sharing takes place through the technical working group.
6) Support distribution to the last mile of HIV commodities, logistics, and management tools in all PEPFAR-supported health zones.
7) Implement an Early Warning System (EWS) in Kinshasa at selected sites supported by both PEPFAR and Global Fund.
8) Establish and strengthen the VL/EID lab commodities forecasting and supply chain system.

Although each donor procures commodities to cover patient needs in their supported health zones, PEPFAR and the Global Fund, as the main donors, will continue to take into consideration the country initiative of scaling up VL/EID testing by providing necessary reagents and consumables to the laboratories to improve their testing result to reach 95% VL coverage by the end of FY19.

Improving PNLS coordination and information sharing between PEPFAR, the Global Fund and all stakeholders on laboratory stock and usage data will be critical. To ensure accurate and timely collection of consumption data, PEPFAR maintains support for a monthly tracking system for the key viral load and EID reagents and commodities, resulting in better forecasting and supply chain management, while tracking of sample processing will continue to improve to better follow each sample from collection at the site level to the delivery of results.

Based on lessons learned from the LNZ to TLE regimen transition in 2016, PEPFAR will support a smooth transition to TLD and continue supporting discussions on updated national guidelines, dissemination and implementation of this new regimen, including a rollout of provider training to ensure standard operating procedures for shifting patients and also ensuring availability of TLD while minimizing expiry risk of TLE stock.

Figure 19: TLD Transition Timeline



4.5 Collaboration, Integration and Monitoring

PEPFAR's focus on sustainable epidemic control began in 2014, when PEPFAR/DRC pivoted to a data-driven approach, strategically focusing on geographic areas and populations where HIV/AIDS is most prevalent. With this approach, PEPFAR, in collaboration with the Global Fund, PNLS, and civil society organizations, is strengthening IP management and monitoring; implementing innovative strategies across the cascade to improve impact and increase efficiencies; and integrating key health systems interventions, to achieve the greatest impact.

With these pivots now completed, COP18 focuses on progress in implementation and ensuring resources are focused on overcoming key barriers and achieving even greater impact.

For COP18, the PEPFAR/DRC team will continue to work toward 95-95-95 across all genders; by age groups, including children (under 15), youth (15-19 and 20-24) and adults (25 and over); and by male and female risk groups. By focusing on specific provinces and populations, Haut Katanga and Lualaba will be working towards attainment across all populations while Kinshasa will be refocusing towards efficiencies through site and implementing partner's consolidation to shift more resources in Haut Katanga and Lualaba provinces.

Triangulation of both survey data, when available, and program data will be essential to understanding programming and ensuring accurate reporting. Building on program experience over the past two years, the PEPFAR/DRC COP18 strategy emphasizes:

- Continuing to focus on finding the people and populations we have been missing, getting them on treatment and retaining them. To successfully address challenges in reaching

sustained levels of epidemic control, it is critical to routinely assess data to understand which populations (gender, age, risk groups) are being missed or are tailing the clinical cascade, identify evidence-based short- and long-term solutions appropriate to reaching those populations, implement those solutions according to standards (i.e. with fidelity), and scale them up.

- Reducing stigma and discrimination against key populations to increase access to essential prevention and treatment services. PEPFAR/DRC will continue strong collaboration with civil society 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 (especially for viral load), retention, and advocacy for in-country contribution to HIV services.
- Continuing to implement evidence-based prevention services for children and adolescents with a focus on preventing sexual violence and HIV through sexual risk avoidance among 9 to 14 year olds (i.e. preventing sexual violence and any form of coercion). The OVC platform will be leveraged to strengthen these approaches and identify, link and retain children and adolescents living with HIV on services.
- Increasing program impact and outcomes by:
    - Implementing activities with fidelity and at scale.
    - Ensuring implementing partner work plans are aligned with PEPFAR program planning, target setting, budgeting processes and strategies.
    - Engaging in meaningful dialog with implementing partners throughout the year for continuous, real-time improvements.
- Ensuring 'above service delivery' activities are mapped to key barriers and achieving measurable outcomes related to reaching epidemic control by reviewing and using documented outcomes from implementation of COP 17 Table 6, Sustainability Index and Dashboard (SID) 3.0 results, and other contextual information.
- Ensuring outcomes at the national level by systematically incorporating feedback from a variety of PEPFAR stakeholders (i.e., civil society, community organizations, multilateral organizations, and partner governments) into PEPFAR-funded activities and services. Early and meaningful engagement with stakeholders will help ensure that programs are grounded in reality; stakeholders provide valuable insights that improve the impact and accountability of programs.

Throughout FY18 and FY19, improved partner management strategies will be 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. Index testing yield, linkage and retention rate as well as viral suppression will be among the indicator used for a quality partner performance evaluation.

Managing partners to improve recognition of issues and implement interventions to improve outcomes will be done through standardized processes with clear roles & responsibilities in the remediation plans. The agency will be evaluating partners through monitoring of remediation

plans.

4.6 Targets for scale-up locations and populations

This section presents a summary of FY19 targets. As shown in Figure 20, FY19 continues a dramatic shift of targets away from Kinshasa and towards Haut-Katanga and Lualaba, reflecting shifts in program focus and strategy.

Figure 20: Change in distribution of targets between provinces, FY17 to FY19

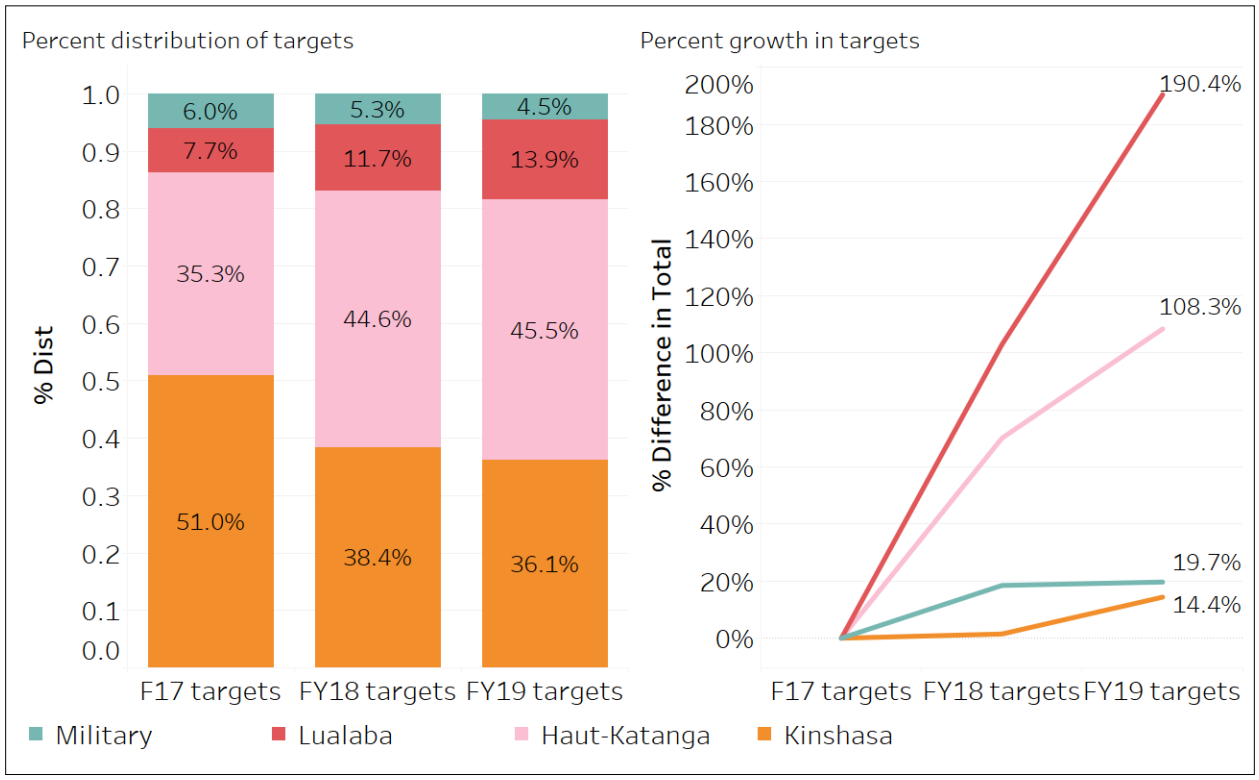


Table 4.6.1 below presents ART entry streams for adults and pediatrics in scale-up districts.

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY19) *HTS_TST***	**Newly Identified Positive (APR FY19) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 19) *TX_NEW***
Total Men (>15)	315,094	13,510	14,896
Total Women (>15)	623,588	17,824	18,476
Total Children (<15)	303,908	4,962	4,665
Adults			
TB Patients	21,459	1,390	1,188
Pregnant Women	238,207	2,494	2,447
VMMC clients	-	-	-
Key populations	35,999	1,299	1,588
Priority Populations			

Other Testing	645,392	26,338	28,149
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)			
HIV Exposed Infants	3,523	179	170
Other pediatric testing	303,908	44,962	4,665
Previously diagnosed and/or in care	-	-	-

Table 4.6.3 below presents FY19 prevention targets for key and priority populations to contribute to epidemic control.

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY18)**	**FY19 Target**
Key Populations			
MSM	Unknown	Unknown	**4,775**
FSW	Unknown	Unknown	**29,095**
Priority Population			
Military	Unknown	Unknown	**56,054**
AGYW	Unknown	Unknown	**1,920**
Truckers	Unknown	Unknown	**2,135**
Miners	Unknown	Unknown	**2,415**
Clients of FSW	Unknown	Unknown	**980**
TOTAL			**97,374**

Table 4.6.4 below presents FY19 targets for OVC_SERV and OVC_HIVSTAT, reflecting the leveraging of OVC programming to support pediatric case finding.

	Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY19Target) OVC_SERV (<18 and >18 years old)**	**Target # of active beneficiaries receiving support from PEPFAR OVC (FY19 Target) OVC_SERV <18 years old)**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC***
Military DRC	8,136	2,267	1,950	1,950
Bandalungwa	4,778	479	412	412
Binza-Ozone	9,838	708	609	609
Dilala	2,749	1,039	894	894
Kamalondo	1,572	691	594	594
Kambove	2,893	215	185	185
Kampemba	9,937	1,918	1,649	1,649
Kasenga	3,539	708	609	609

Katuba	6,055	849	730	730
Kenya	6,557	2,219	1,908	1,908
Kikimi	6,758	1,788	1,538	1,538
Kikula	5,507	534	460	460
Kimbanseke	7,395	1,415	1,217	1,217
Kingabwa	5,512	1,841	1,583	1,583
Kingasani	5,825	2,000	1,720	1,720
Kinshasa	4,400	737	634	634
Kipushi	5,053	1,133	975	975
Kisanga	5,836	1,699	1,461	1,461
Likasi	3,340	780	671	671
Limete	4,936	837	720	720
Lingwala	2,262	353	304	304
Lubumbashi	4,460	1,342	1,154	1,154
Manika	1,192	1,055	907	907
Masina 1	6,703	1,841	1,583	1,583
Masina 2	7,253	3,643	3,133	3,133
Matete	7,582	513	441	441
Mont-Ngafula 1	6,489	220	189	189
Mumbunda	6,585	1,133	975	975
Ndjili	8,467	3,144	2,704	2,704
Ngaba	4,784	708	609	609
Nsele	4,647	991	853	853
Rwashi	6,232	1,390	1,196	1,196
Sakania	5,893	1,007	866	866
Tshamilemba	5,367	1,133	975	975
TOTAL	**188,532**	**42,333**	**36,406**	**36,406**

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

As outlined in Section 4.0, all SNU are classified as "aggressive scale-up". COP 2018 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

The HIV national landscape, including the recent SID 3.0, continues to be characterized by restricted availability of accurate and reliable epidemiologic and health data, which is necessary in order to reach attainment. Programs data shows that PEPFAR/DRC primarily misses men aged 25-45, children, and KP. In addition, the rate of HIV positive pregnant women with known status at ANC has been found to be alarmingly low. Regardless of population, retention remains another challenge. This has been confirmed by the relatively weak suppression rates among the limited number of patients with access to VL. The periodical suboptimal functionality of molecular laboratories with occasional shortage in reagents contributed to this reduced timely access to VL

testing. Overall, the poor level of awareness coupled with high stigma and discrimination continue to fuel the epidemic as demonstrated by SIMS findings. This has greatly contributed to low demand and uptake of HIV services.

Table 6 investments with site-level approaches synergistically address COP18 strategic priorities. Within the context of a domestically under-funded health sector, key systems interventions tackle the weak commodity and logistics management and sub-optimal coverage of viral load facilities. There are also systems activities aimed at improving data collection and analysis, as well as analysis and surveillance which are required to validate results. In addition, systems investments are increasingly oriented to address HIV awareness gaps, stigma, and discrimination through CSO engagement.

The SID 3.0 analysis reiterated that the financial contribution from the government is primarily limited to health worker salaries; health workers are vital to the successful implementation of activities. The SID 3.0 also recognized the efforts of the GDRC in the areas of governance and leadership. This has been demonstrated through the development of harmonized national VL scale-up plan. As part of the scale-up plan, the GF will purchase an additional six VL machines and PEPFAR will enter into rental agreements for two additional VL machines, one for Lumubashi and one for Lualaba. This will help increase national VL coverage (currently less than 20%), and specifically, coverage in PEPFAR-supported zones (currently at 53% of eligible patients). As the supply chain mechanism concurrently strengthens national forecasting and the ARV/reagents distribution system, the simultaneous demand creation for VL and efforts of retention in clinics will help PEPFAR/DRC reach 85% of VL suppression in PEPFAR zones. PEPFAR/DRC continues to support the MSF-owned molecular lab for increasing VL coverage. PEPFAR/DRC also identified the unutilized capacity of existing laboratories and proposed practical optimization options to relevant stakeholders (MSF, GF, TB program, DREAMS lab and PNLS).

PEPFAR/DRC is also leveraging GenXpert machines to increase TB diagnosis among PLHIV, as well as increase coverage for EID in assigned zones. PEPFAR/DRC has initiated discussions on TLD transition and has galvanized WHO, GF and other stakeholders to cooperate with PNLS to ensure a harmonized transition timeline.

PEPFAR/DRC continues to work with GF and PNLS to set up a repository system for warehousing HIV data. PEPFAR/DRC has already initiated an intensive data exchange in order to better understand the HIV epidemic in Kinshasa. PEPFAR/DRC provides technical assistance for surveys and surveillance which are currently funded by GF, including size estimation studies for KP, IBBS protocol development for KP and ANC surveillance.

Drawing from lessons learned from “Observatoire”, a GF-funded platform for collecting client-satisfaction indicators, PEPFAR/DRC will support the extension of this mechanism to Haut-Katanga and Lualaba. Additionally, PEPFAR/DRC will begin using a small grant mechanism to use CSOs to monitor violence, abuse, and discrimination against KP and PLHIV. These CSOs will also

empower other local organizations to combat stigma and discrimination and provide accurate information on HIV.

An interagency team conducted a thorough review of outcomes to address system barriers and benchmarks that require modification in light of progress to date. For COP18, certain outcomes, benchmarks and commensurate activities were modified to better align with the current context. Relevant surveys, evaluations and research activities include:

- IBBS: Global Fund
- Size estimation & mapping: Global Fund
- ANC Sero-Surveillance based on routine data: Global Fund
- HIV-focused Households survey: PEPFAR
- Individual level data interoperability and analysis systems: Global Fund and PEPFAR

7.0 Staffing Plan

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 2018. This includes intensive partner management with weekly agency level meetings, quarterly inter-agency level meetings and monthly Inter-agency meetings as needed to resolve issues that may arise. 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 2018. No new positions are proposed in COP 2018.

To align human resources with the strategic focus in Haut-Katanga and Lualaba, PEPFAR/DRC agreed 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). The new positions were approved in COP 2016; however, recruitment cannot proceed until an office is established by DOD. Several vendors have submitted bids to build the modular office, and submissions are currently under review by DOD. Since the implementing partner that was originally selected can no longer operate in the DRC, DOD is exploring the use of current IMs while they develop a grant for a new partner. Once an IM is selected, DOD will reprogram the funds to this new partner to have the office available by the end of FY2019. USAID and CDC will continue to ensure a strong Kinshasa-based staff presence in Haut-Katanga and Lualaba until the office is operational.

PEPFAR/DRC is working to fill vacant positions under the hiring freeze. As discussed previously, the hiring of the five Lubumbashi positions is on hold until the office space is available for occupancy.

Additional current vacancies:

- USAID: Supply Chain specialist
- Department of State: PEPFAR Coordinator (vacant since October 2015) and PEPFAR Interagency Strategic Information Advisor. These are both critical positions.
- DOD is fully staffed
- CDC is fully staffed

Intensifying partner management is a focus of COP18, and 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 COP18 cost of doing business (CODB) request represents the minimal staffing and administrative support needed to achieve COP18 targets, advancing DRC on the path towards sustainable epidemic control by 2020.

APPENDIX A -- PRIORITIZATION

SNU Prioritization

Table A.1

SNU	COP	Prioritization	Results Reported	*Attained: 90-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall*																	
				<15		15-19		20-24		25-49		25-29		30-34		35-39		40-49		50+	
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Haut-Katanga	COP16		APR 17	41%		56%	28%	113%	60%	58%	36%									46%	41%
	COP17		APR 18	78%		75%	37%	149%	79%	73%	46%									53%	49%
	COP18		APR 19	108%		88%	64%	173%	91%	90%	74%	135%	86%	103%	87%	91%	75%	66%	63%	70%	68%
Kinshasa	COP16		APR 17	35%		28%	25%	27%	10%	43%	19%									50%	47%
	COP17		APR 18	69%		40%	35%	37%	14%	55%	25%									64%	61%
	COP18		APR 19	92%		75%	56%	50%	62%	58%	48%	46%	35%	53%	33%	76%	53%	58%	64%	69%	80%
Lualaba	COP16		APR 17	20%		34%	12%	39%	18%	35%	43%									39%	52%
	COP17		APR 18	54%		56%	19%	64%	28%	54%	63%									57%	72%
	COP18		APR 19	80%		91%	90%	90%	90%	82%	85%	81%	80%	75%	69%	91%	90%	80%	93%	87%	90%

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 18)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY19) *TX_CURR***	**Newly initiated (APR FY 19) *TX_NEW***	**ART Coverage (APR 19)**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	153,648	89,535	33,383	119,770	38,156	78%

Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	**153,648**	**89,535**	**33,383**	**119,770**	**38,156**	**78%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP 18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

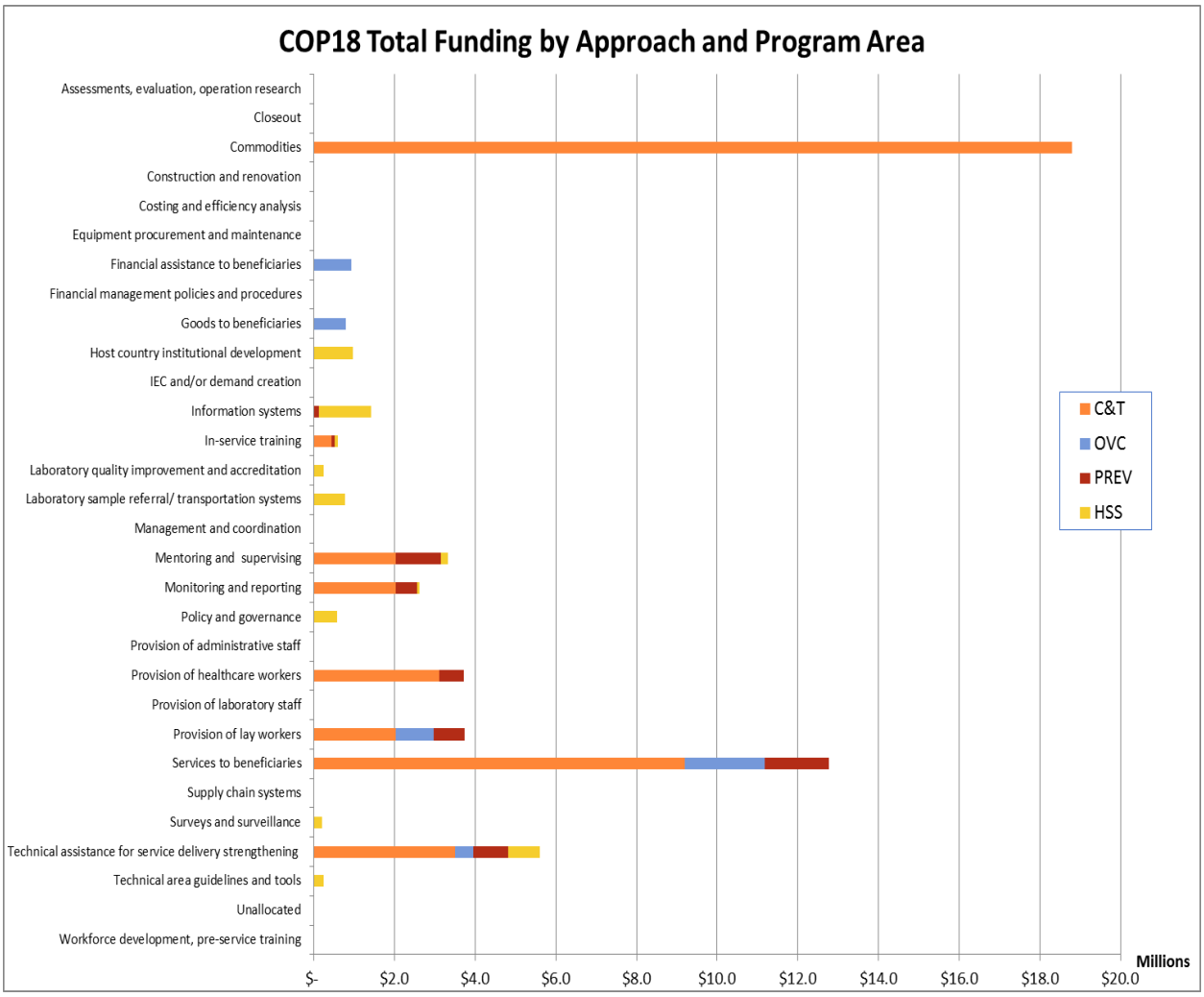


Table B.1.2 COP 18 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$12,212,368	**$ 53,282,632**	**$ 65,495,000**

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Agency" report.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	3,329,112
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	140,676
HVOP	Other Sexual Prevention	1,998,756
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	44,206
HMIN	Injection Safety	90,388
CIRC	Male Circumcision	-
HVCT	Counseling and Testing	2,557,939
HBHC	Adult Care and Support	5,809,113
PDCS	Pediatric Care and Support	1,627,212
HKID	Orphans and Vulnerable Children	4,718,295
HTXS	Adult Treatment	9,576,870
HTXD	ARV Drugs	11,693,321
PDTX	Pediatric Treatment	1,908,869
HVTB	TB/HIV Care	1,738,665
HLAB	Lab	633,643
HVSI	Strategic Information	1,395,630
OHSS	Health Systems Strengthening	2,623,543
HVMS	Management and Operations	3,396,404
TOTAL		**53,282,642**

B.2 Resource Projections

PEPFAR/DRC used the COP17 budget allocation as baseline, which was calculated using the PBAC, allocated by program area, strategic objectives and approaches as required by the new COP18 budgeting process and FAS Tool. In COP18, OGAC instructed operating units to use strategic objectives and approaches to determine IM budgets. In COP18, all costs are captured in the strategic objectives, ensuring that PEPFAR/DRC has allocated funds to strategies that will achieve the greatest impact towards epidemic control. The COP18 budget reflects overall PEPFAR/DRC strategies; resources were shifted among implementing partner mechanisms and agencies in order to achieve the intensification strategies in Haut-Katanga and Lualaba, and the streamlining strategy in Kinshasa.

PEPFAR/DRC in close consultation with implementing partners, completed the FAS Tool for COP18 signifying a shift away from target-based budgeting using unit expenditures towards program-based incremental budgeting, in order to ensure that PEPFAR/DRC budgets are in line with the program's priorities and strategic objectives. The FAST submitted at the Johannesburg RPM was balanced with all earmarks reached. A considerable amount of the budget (30%) was also allocated to commodities in order to ensure all PEPFAR-supported PLHIV receive an appropriate package of services. When the budget indicated that resources would be insufficient for all desired activities not tied to strategic objectives, prioritization helped PEPFAR/DRC select the most important activities to achieve epidemic control. Table 6 activities and associated budgets were carefully considered to ensure activities are focused in addressing barriers and gaps of the program.

APPENDIX C – Tables and Systems Investments for Section 6.0

Supplemental Table 6 Attachment.

Table 6 Attachment

Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
1	DOD	<Placeholder - 70063 Democratic Republic of the Congo DOD>	HSS	Strengthening the capacity of the military HIV/AIDS coordination Office ''PALS'' and health zone's teams to plan, implement, monitor and evaluate services provided to beneficiaries at both clinical and community levels	Host country institutional development	Support military HIV/AIDS planning, coordination and review meetings, improve the military HIV/AIDS data base for an accurate reporting, support supervisory visits held by PALS, military HZ management teams and MOH experts	low coordination and weak data reporting system
2	HHS/CDC	Global Laboratory Capacity Strengthening Program	HSS	Facilitate scale up and quality of HIV early infant diagnosis (EID) and viral load (VL) testing and monitoring	Laboratory sample referral/ transportation systems	Improve lab-clinical interface, strengthen and address all gaps within the viral load testing spectrum	low Viral load coverage
3	HHS/CDC	Association of Public Health Laboratories Centrally funded CoAG	HSS	Support strengthening of labs to improve quality of laboratory testing and practice	Laboratory quality improvement and accreditation	Implement the national equipment maintenance plan: equipment maintenance contracts with MOH, preventive maintenance	low Viral load coverage
4	HHS/CDC	Association of Public Health Laboratories Centrally funded CoAG	HSS	Support strengthening of labs to improve quality of laboratory testing and practice	Laboratory quality improvement and accreditation	To ensure continuous quality improvement initiatives	low Viral load coverage
5	HHS/CDC	Global laboratory capacity strenghtening program	HSS	Facilitate scale up and quality of HIV VL testing and monitoring	Laboratory sample referral/ transportation systems	Lualaba implementation of the VL management system	low Viral load coverage
6	HHS/CDC	Global laboratory capacity strenghtening program	HSS	Facilitate scale up and quality of HIV EID testing and monitoring	Laboratory sample referral/ transportation systems	Implement the EID management system to improve result return system	low EID coverage
7	HHS/CDC	<Placeholder - 70065 Democratic Republic of the Congo HHS/CDC>	HSS	Facilitate scale up and quality of HIV early infant diagnosis (EID) and viral load (VL) testing and monitoring	Laboratory sample referral/ transportation systems	Implement the EID and VL management system to improve result return system	low EID and VL coverage
8	HHS/CDC	<Placeholder - 70065 Democratic Republic of the Congo HHS/CDC>	HSS	Support strengthening of labs to improve quality of laboratory testing and practice	Laboratory quality improvement and accreditation	To ensure continuous quality improvement initiatives (CQI activities)	low Viral load coverage
9	HHS/CDC	Association of Public Health Laboratories Centrally funded CoAG	HSS	Support strengthening of labs to improve quality of laboratory testing and practice	Laboratory quality improvement and accreditation	Quality assurance activities and capacity building of military lab network	low Viral load coverage

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
1	performance data + Epidemiogical and health data	4.21	Fully functional coordination of activities by the military HIV/AIDS Office /PALS.	2 years	% of coordination meeting's decisions implemented	PALS annual report not produced to inform on decisions taken and their implementation
2	laboratory	5.42	• Reduced turnaround time for specimen from clinic sites to lab • Reduced turnaround time for results return from lab to clinic	1 year	Time Around Time	30 days of Time around time
3	laboratory	5.42	effective and responsive maintenance contract for all molecular labs in DRC in PEPFAR provinces	2 years	# of work days lost to equipment issues in the last quarter	60 days of work days lost to equipment issues in the last quarter
4	laboratory	5.42	efficient Continuous Quality Improvement (CQI) program in HK, Kinshasaa and Lualaba	3 years	Monitor improvement through WHO SLIPTA + MER CQI	2 Kinshasa labs score 2 stars WHO SLIPTA
5	laboratory	5.42	implemented VLMS in Lualaba	2 years	TX_PVLS (D)	35% of VL coverage in Lualaba
6	laboratory	5.42	fully functional EID electronic system in Lualaba	1 year	PMTCT_EID.	65% of PMTCT_EID in Lualaba
7	laboratory	5.42	fully functional EID and VL electronic system in Kinshasa, HK and Lualaba	2 years	PMTCT_EID. And TX_PVLS	65% of EID and VLcoverage
8	laboratory	5.42	efficient CQI program in HK, Kinshasaa and Lualaba	3 years	Monitor improvement through WHO SLIPTA + MER CQI	2 Kinshasa labs score 2 stars WHO SLIPTA
9	laboratory	5.42	implement RTCQI in all military sites located in Kinshasa, HK and Lualaba	1 year	% of sites implementing RTCQI	NA

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
1	75% of decisions taken at the coordination meetings held by the military HIV coordination office are implemented.		100% of decisions taken at the coordination meetings held by the military HIV coordination office are implemented.		
2	10 working days for Time around time				
3	<10 days per instrument/failure of work days lost to equipment issues in the last quarter		<5 working days of work days lost to equipment issues in the last quarter		
4	3 labs score 3 stars WHO SLIPTA		2 lab score 4 stars and the remaining labs maintains the 3 stars accreditation		1 lab score 5 stars and the remaining labs maintain aquired accreditation level
5	75% of VL coverage in Lualaba		95% of VL coverage in Lualaba		95% of VL coverage in Lualaba
6	100% of PMTCT_EID in Lualaba				
7	90% of EID and Vlcoverage		95% of EID and Vlcoverage		
8	3 labs score 3 stars WHO SLIPTA		2 lab score 4 stars and the remaining labs maintains the 3 stars accreditation		1 lab score 5 stars and the remaining labs maintain aquired accreditation level
9	100% of PEPFAR military sites are using E-logbook tools				

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
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Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
10	HHS/CDC	Increase Access to Comprehensive HIV/AIDS Prevention Care and Treatment Services in the Democratic Republic of Congo under (PEPFAR) (KIMIA)	HSS	Support capacity to manage and oversee laboratories, M&E, and other HIV programs in Kinshasa	Host country institutional development	Provide training and stipends for provincial External Quality Assurance (EQA) and maintenance of instruments for national laboratory LNRS	low Viral load coverage
11	HHS/CDC	Increase Access to Comprehensive HIV/AIDS Prevention, Care, and Treatment Services in DRC under PEPFAR	HSS	Support PNLT and PNLS to strengthen TB/HIV collaborative activities	Host country institutional development	Provide training and stipends for provincial EQA and maintenance of instruments for provincial laboratory LPRS	low Viral load coverage
12	HHS/CDC	Increase Access to Comprehensive HIV/AIDS Prevention, Care, and Treatment Services in DRC under PEPFAR	HSS	Support PNLT and PNLS to strengthen TB/HIV collaborative activities	Information systems	develop the biometric fingerprint unique identifier system for KP	lack of KP size estimation and tracking system
13	HHS/CDC	Increase Access to Comprehensive HIV/AIDS Prevention, Care, and Treatment Services in DRC under PEPFAR	HSS	Support PNLT and PNLS to strengthen TB/HIV collaborative activities	Host country institutional development	support joint supervision, TB/HIV planning and validation meetings and policy development	Weak coordination between HIV & TB programs at the national and provincial levels
14	HHS/CDC	Capacity Strengthening for Strategic Information	HSS	Strengthen routine HIV M&E and reporting (HMIS) systems to improve program performance	Information systems	set up standardized Health Data Exchange/Repository for HIV Epidemic Control	lack of reliable data at the national level
15	TBD	TBD	HSS	Strengthen routine HIV M&E and reporting (HMIS) systems to improve program performance	Information systems	Additional data collection activity integrated into routine activities in Kinshasa	lack of comprehensive data on the HIV epidemic in Kinshasa
16	HHS/CDC	Capacity Strengthening for Strategic Information	HSS	Strengthen routine HIV M&E and reporting (HMIS) systems to improve program performance	Information systems	Support host country in implementing routine data quality continuous quality improvement (CQI)--including processes, structures, protocols, roles and responsabilities, standards--at the Health Zone level	lack of reliable data at the national level

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
10	laboratory+ Human Resource for Health	5.42	LNRS receive support for standard functions for Human Resource and small equipments	2 years	# of days off related to HR shortage or shortage of small equipment last quarter	4 days off related to HR shortage
11	laboratory+ Human Resource for Health	5.42	Katanga LNRS receive support for standard functions for Human Resource and small equipments	2 years	# of days off related to HR shortage or shortage of small equipment last quarter	1 day off related to HR shortage
12	Epidemiological and Health data	4.33	Biometrics unique identifier system in place for KP	2 years	% of KP registered using unique identifier	0%
13	policies and governance	5.37	Integration of HIV/TB program	1 year	# of policy/ guidelines TB/HIV one stop	0
14	Epidemiological and Health data	4.33	Granular, systematized, timely individual-level data use drives strengthened routine data systems, improved micro-targeted program monitoring and program management, resulting in improved testing yield, linkage, and retention.	2 years	completeness of individual information on PLHIV at national level	0% of national sites with Tier.Net onboarded in the national data warehouse
15	Epidemiological and Health data	4.33	Granular information on HIV sexual transmission networks	1 year	System in place and information completed.	No system in place
16	Epidemiological and Health data	4.33	Capacity to monitor data systems quality issues and respond appropriately at national and sub-national levels is strengthened	1 year	% of Routine DQA process supported	10% of PEPFAR supported HZ have rourine DQA activities taken to scale at high volume sites

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
10	0 days off related to HR shortage		0 days off related to HR shortage		
11	0 day off related to HR shortage		0 day off related to HR shortage		
12	50% of KP of the CDC KP cohort enroled in Unique Identifier system		80% of KP of the CDC cohort enroled in Unique Identifier system		
13	one stop TB/HIV policy/Guideline developed				
14	50% national sites with Tier.Net onboarded in the national data warehouse		70% national sites with Tier.Net onboarded in the national data warehouse		
15	Additional data collection activities in place and complete in 100% of PEPFAR supported sites in Kinshasa				
16	50% of PEPFAR supported HZ have rourine DQA activities taken to scale at high volume sites				

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
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Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
17	HHS/CDC	Capacity Strengthening for Strategic Information	HSS	Strengthen routine HIV M&E and reporting (HMIS) systems to improve program performance	Information systems	Support the integration of the National AIDS Control Program routine reporting system into the recently adopted national health management information system (DHIS2), including improving the completeness, timeliness and use of data reported into DHIS2	lack of reliable data at the national level
18	HHS/CDC	Capacity Strengthening for Strategic Information	HSS	Strengthen routine HIV M&E and reporting (HMIS) systems to improve program performance	Information systems	Strengthen the HIV routine health management information system through support (technical assistance/accompanying and logistics support) to routine, timely, complete and rigorous data collection, cleaning and validation at the Health Zone level	lack of reliable data at the national level
19	HHS/CDC	Strengthening Public Health Capacity and Strategic Information Systems	HSS	Strengthen the capacity of country to generate national and subnational HIV incidence and prevalence	Surveys and surveillance	Support the creation of national and SNU HIV estimates through the USAIDS Spectrum process	lack of reliable data at the national level
20	USAID	Global Health Supply Chain Program	HSS	Improved Policy, Governance, Strategy, Coordination	Supply chain systems	Support MoH to develop and disseminate the TLD transition guideline,policies	No updated guideline including TLD use as first line
21	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Train national Pharmaceutical Division and distribution regional centers on quantification and implement national and provincial quantification of HIV commodities (provide tools, review parameters, training)	Lack of qualified human resources especially in areas such as quantification (including forecasting and supply planning);

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
17	Epidemiological and Health data	4.33	Complete, timely, accurate, representative data at the national level to support the Country to perform timely, granular and impactful program monitoring to improve program performance	1 year	Completeness (% of sites) reporting monthly routine data into DHIS2	40% completenes of HIV data in DHIS2 in PEPFAR HZ
18	Epidemiological and Health data	4.33	To build national capacity in routine data management, validation and use, in order to support the Country to perform timely, granular and impactful program monitoring to improve program performance	1 year	% of PPEFAR supported HZ holding (in a timely fashion) routine data validation, analysis and retro-information meetings on a monthly basis.	80% of PPEFAR supported HZ holding (in a timely fashion) routine data validation, analysis and retro-information meetings on a monthly basis.
19	Epidemiological and Health data	4.33	Robust, validated, consensus HIV estimates at the SNU1 level to inform strategic planning	1 year	% of SNU1 with updated (with new data), finalized and validated HIV estimates	0% of SNU1 with updated (with new data), finalized and validated HIV estimates
20	supply chain	4.41	95% of HIV patients have been shifted from TDF to TLD	1 year	Existence of update policies and guidelines on TLD	0% (There is no policy document on TLD transition)
21	8.4 Supply Chain Plan: The country have not an agreed-upon national supply chain plan that guides investments in the supply chain?	4.41	Annual forecast of needs for HIV/AIDS programs Quarterly supply plans for HIV/AIDS (ARVs, RTKs, VL and EID reagent kits). Recommendations for GHSC-PSM and GHSC-RTK orders	1 year	A annual forcasting and supply chain plan for HIV commodities at national level developed and implemented	0 (No agreed national forcasting and supply chain plan for HIV commodities)

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
17	98% completenes of HIV data in DHIS2 in PEPFAR HZ				
18	100% of PPEFAR-supported HZ conducting (in a timely fashion) monthly routine data validation, analysis and retro-information				
19	100% of SNU1 with updated (with new data), finalized and validated HIV estimates				
20	90% of HIV patients have been shifted from TDF to TLD				
21	No stock out and no expiration of core HIV commodities at warehouse and at site level				

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
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Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
22	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Supporting MoH regular review of supply plan, stock and assumption at provincial level and supportive supervision at warehouse level	Absence of regular reviews and lack of functional supervision system
23	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Enhance data visibility (web based dashboard0 and improve stock monitoring	Lack of a strong system for stock data
24	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Implement Electronic Dispensing Tool (EDT) in 5 high volume sites	Unavailability of reliable supply chain data and poor and erratic data reporting
25	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Facilitate customs clearance of USG products and their timely deliveries to various warehouses	Cumbersome and lenghtly commodities clearance process up to 6 months lead time
26	USAID	Global Health Supply Chain Program	HSS	Optimized forecasting and procurement process are implemented	Supply chain systems	Train Health Zone staffs on stock management, TLD transition and rational use of commodities	Lack of stock management capapcity and qualified human resources in supply chain

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
22	8.6 Stock: The host country government does not manage processes and systems that ensure appropriate ARV stock in all levels of the system?	4.41	Quality consumption data are available to conduct annual forecast of needs for HIV/AIDS programs. Quarterly review of HIV/AIDS supply plan are conducted.	1 year	Biannual reviews and quartely supervisions conducted	0 (No quality consumption data available)
23	8.6 Stock: The host country government does not manage processes and systems that ensure appropriate ARV stock in all levels of the system?	4.41	A web-based dashboard that provides an early warning system (EWS) for HIV&AIDS commodities successfully implemented	1 year	Realtime visibity of HIV commodities at site, provincial and national level	0 (No system for realtime visibility of HIV commodities)
24	8.6 Stock: The host country government does not manage processes and systems that ensure appropriate ARV stock in all levels of the system?	4.41	Electronic dispensing system implemented at 5 additional PEPFAR supported high volume sites in Kinshasa Monthly HIV/AIDS commodities stock status reports	1 year	EDT available and functional in 5 high volume sites	5 high volume sites with functional EDT
25	8.6 Stock: The host country government does not manage processes and systems that ensure appropriate ARV stock in all levels of the system?	4.41	Requisition orders are issues Note Verbales and Importation waivers obtained as quickly and efficiently as possible Proof of delivery reports Clearance lead time reduced Stock status of USG commodities available	1 year	Reduction of clearance process duration within 4 weeks	Current clearance duration is 6 months
26	8.6 Stock: The host country government does not manage processes and systems that ensure appropriate ARV stock in all levels of the system?	4.41	ARVs, TLD included and other HIV&AIDS commodities are continualy avaialble to ensure adequate care and treatment of patients	1 year	HZ staffs trained on stock management	40% staffs of HZs already trained on stock management

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
22	No stock out and no expiration of core HIV commodities at warehouse and at site level				
23	Early warning system against stock-out risks in place				
24	No stock out of HIV/AIDS commodities at patient service delivery point (whether facility, community PODI, or lab sites)				
25	No stock out of HIV/AIDS commodities at patient service delivery point (whether facility, community PODI, or lab sites)				
26	47 staff form HZs trained on stock management				

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
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Row	Funding Agency	Implementing Mechanism Name	Program Area	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
27	State/AF	Small Grant Programs	PREV	CSO capacity building ;Build capacity within cso to combat LGBT stigma and discrimination ; developping network of PLHIV to increase retention in care	IEC and/or demand creation	Build capacity of NGO on data collection and analysis via training and data analysis assistance ; application practices to address LGBTI stigma and discrimination in the community	stigma and discrimination
28	State/AF	Small Grant Programs	HSS	Training to local press to effectively cover HIV/AIDS	IEC and/or demand creation	Build capacity of local press via training to effectively cover HIV/AIDS through Broadcasting sessions .	stigma and discrimination

Row	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)	Relevant Indicator or Measurement Tool	COP18 Baseline Data
27	civil society engagement	4.67	local NGO skilled to equip local leaders to address LGBTI stigma and discrimination	2 years	# of quarter monitoring reports from local skilled NGOs	No report
28	civil society engagement	4.67	local press skilled to provide accurate information and create demand for HIV testing, treatment and suppression	2 years	# of quarter reports from community listening group	0

Row	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
27	4 quarter reports from local NGO every year		4 quarter reports from local NGO every year		
28	4 quarter reports from community listening clubs every year		4 quarter reports from community listening clubs every year		

Row	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.
27	
28	