Democratic Republic of the Congo

Country Operational Plan

(COP) 2019

Strategic Direction Summary

April 12, 2019

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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 with the goal of achieving epidemic control in three key provinces, which represent approximately 50 percent of the total number of people living with HIV (PLHIV) in the DRC. The strategy for the PEPFAR Country Operational Plan (COP) for the period from October 1, 2019 through September 30, 2020 (COP 2019) will continue and intensify the programmatic priorities identified and implemented in COP 2018, including strategically focusing and strengthening activities in Haut Katanga and Lualaba to attain epidemic control while strengthening interventions in Kinshasa.

Over the past year, PEPFAR/DRC has made steady progress and shown strong results in Haut-Katanga and Lualaba. Given this success, epidemic control is now within reach, and additional resources and effort will be transitioned to these two provinces during COP19. PEPFAR/DRC will continue to move closer to 95/95/95 in Haut-Katanga and Lualaba, while strengthening services and optimizing case finding in Kinshasa with a greater focus on finding men. Overall, the PEPFAR team will continue saturation efforts in a total of 52 health zones and select military sites, reaching patients in over 500 clinical sites.

COP19 Strategies for Epidemic Control

- Scale up case finding through index testing, PITC optimization, and targeted community – based testing
- Strengthen efforts on case finding among adult men
- Improve viral load testing coverage gap and suppression
- Rapid TLD transition and ART optimization

Current figures put the total number of PLHIV in PEPFAR-supported health zones at 202,401. Through consultations with the government of DRC and civil society, aggressive targets have been set for COP19, which will see an additional 46,212 people on treatment compared to COP18 targets, leading to approximately 74% percent coverage of PLHIV on treatment by September 2020. Intensive and zone-specific strategies introduced during FY17 and scaled-up in COP18, will continue to boost the number of new and current patients, allowing a steady and strong increase in linkage and retention, and reaching 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 and scaled in COP18 to further bolster the yield, a critical step to ensuring adequate case finding and optimal linkage to treatment. COP19 will focus on further refinement of those strategies.

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:

A. Optimize provider-initiated testing and counseling (PITC) in outpatient departments, tuberculosis (TB) clinics, inpatient wards (including pediatrics), and antenatal care (ANC)

and nutrition services within facilities, including addressing user fees, especially in the TB and ANC departments;

B. Aggressively track partners of index cases and biological children of HIV-positive women;
C. Scale-up community-based HIV testing services (mobile and index modalities) to find hard-to-reach men, adolescents, and key populations (KPs);
D. Ramp up sexual network and partner notification strategies in order to provide HIV testing services (HTS) and treatment services to hard-to-reach KPs;
E. Utilize the orphans and vulnerable children (OVC) platforms to not only test OVCs and children of KPs, but to assist with linkage to and retention on treatment as well as uptake of viral load testing especially for pediatric patients;
F. Integrate supervised self-testing into existing modalities 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. Ensure youth, male, and KP-friendly services at facilities attract and retain clients, ensuring that all these services contribute to finding HIV+ men;
H. Ensure scale-up of same-day, or at minimum, same-week treatment initiation in all PEPFAR-supported sites;
I. Improve tacking and reminder systems to identify clients due for viral load appointments and to achieve viral load (VL) suppression among all age and sex groups;
J. Maintain the high coverage of HIV screening and antiretroviral therapy (ART) initiation among TB patients and strengthen TB screening for PLHIV;
K. Maximize multi-month dispensing so that at least 60 percent of patients receive three-month ARV supplies, and 10 percent receive six-month ARV supplies;
L. Optimize adult ART by completing the transition to TLD; and
M. Optimize pediatric ART by implementing the new first-line regimen.

Community care and support systems, such as the existing community ARV distribution point (PODI) models, will be scaled up to increase retention, as well as encouraging adherence through support groups and treatment clubs. Throughout FY19 and FY20, PEPFAR/DRC will continue to intensify partner management strategies that were previously developed and implemented. 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 and 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 404,894 people living with HIV out of an estimated population of 92 million (calculated based on UNAIDS estimates [version 5.751]). Prevalence is higher in urban areas (1.6 percent) versus rural areas (0.9 percent) and the burden of HIV is higher among women than men 25 years and older (218,678 female PLHIV v. 80,467 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 percent in Kinshasa and 10.8 percent 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, making TB 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 updated Sustainability Index and Dashboard (SID) 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 strategic information (SI) technical assistance, including the scale-up of 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	92,173,184	100	20,735,460	22%	21,114,129	23%	9,054,732	10%	9,125,752	10%	16,254,242	18%	15,888,869	17%	INS SPECTRUM 2019 Version 5.751
HIV Prevalence (%)		1.2		NA		NA		1.00%		0.80%		2.20%		1.50%	DHS 2013-2014 Report
AIDS Deaths (per year)	10,535		1,556		1,557		511		481		2,172		1,364		SPECTRUM 2019 Version 5.751
# PLHIV	404,894		26,630		27,504		31,769		19,845		218,678		80,467		SPECTRUM 2019 Version 5.751
Incidence Rate (Yr)		2.6%		0.4%		0.4%		0.1%		0.1%		0.7%		0.3%	SPECTRUM 2019 Version 5.751
New Infections (Yr)	10,603														SPECTRUM 2019 Version 5.751
Annual births	3,628,106	4%													SPECTRUM 2019 Version 5.751
% of Pregnant Women with at least one ANC visit	2,380,400	81%													SPECTRUM 2019 Version 5.751
Pregnant women needing ARVs	16,588		N/A		N/A		N/A		N/A		N/A		N/A		SPECTRUM 2019 Version 5.751
Orphans (maternal, paternal, double)	151,832		N/A		N/A		N/A		N/A		N/A		N/A		2018 Global TB report
Notified TB cases (Yr)	9,686	10%	N/ADHS 2007 Report	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2018 Global TB report
% of TB cases that are HIV infected	22,876	1%													SPECTRUM 2019 Version 5.751
% of Males Circum-cised	44,744,888	97%			N/A	N/A			N/A	N/A			N/A	N/A	DHS 2007 Report

*Estimated Population Size of MSM**	*N/A*	*N/A*													
MSM HIV Prevalence	*N/A*	*N/A*													
Estimated Population Size of FSW	*N/A*	*N/A*													
FSW HIV Prevalence	*N/A*	*6.90%*					*NA*	*NA*			*NA*	*NA*			*BSS 2013*
Estimated Population Size of PWID	*N/A*	*N/A*													
PWID HIV Prevalence	*N/A*	*N/A*													
Estimated Size of Priority Populations (specify)	*N/A*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	*NA*	
Estimated Size of Priority Populations Prevalence (specify)	*N/A*	*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	92,173,184	0.4%	404,894	256,303	215,471	53%	74%	5,086,282	83,444	70,172
Population <15 years	41,849,589	0.1%	54,134	NA	17,465	28%	NA	NA	NA	17,465
Men 15-24 years	9,125,752	0.2%	19,845	NA	NA	NA	NA	NA	NA	NA
Men 25+ years	15,888,869	0.5%	80,467	NA	NA	NA	NA	NA	NA	NA
Women 15-24 years	9,054,732	0.4%	31,769	NA	NA	NA	NA	NA	NA	NA
Women 25+ years	16,254,242	1.3%	218,678	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

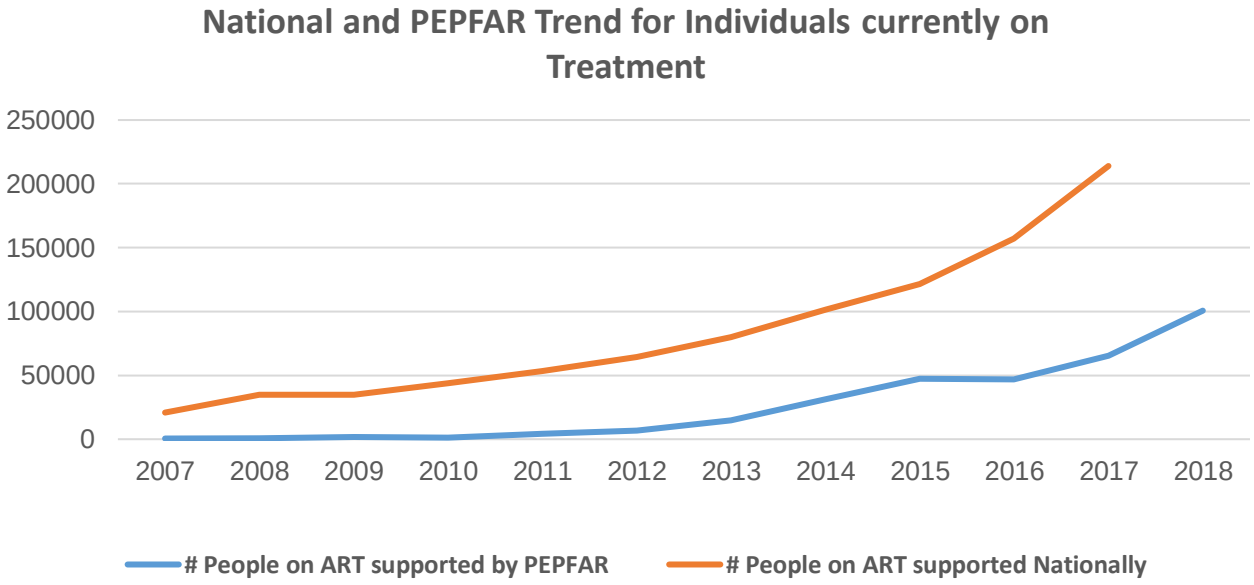
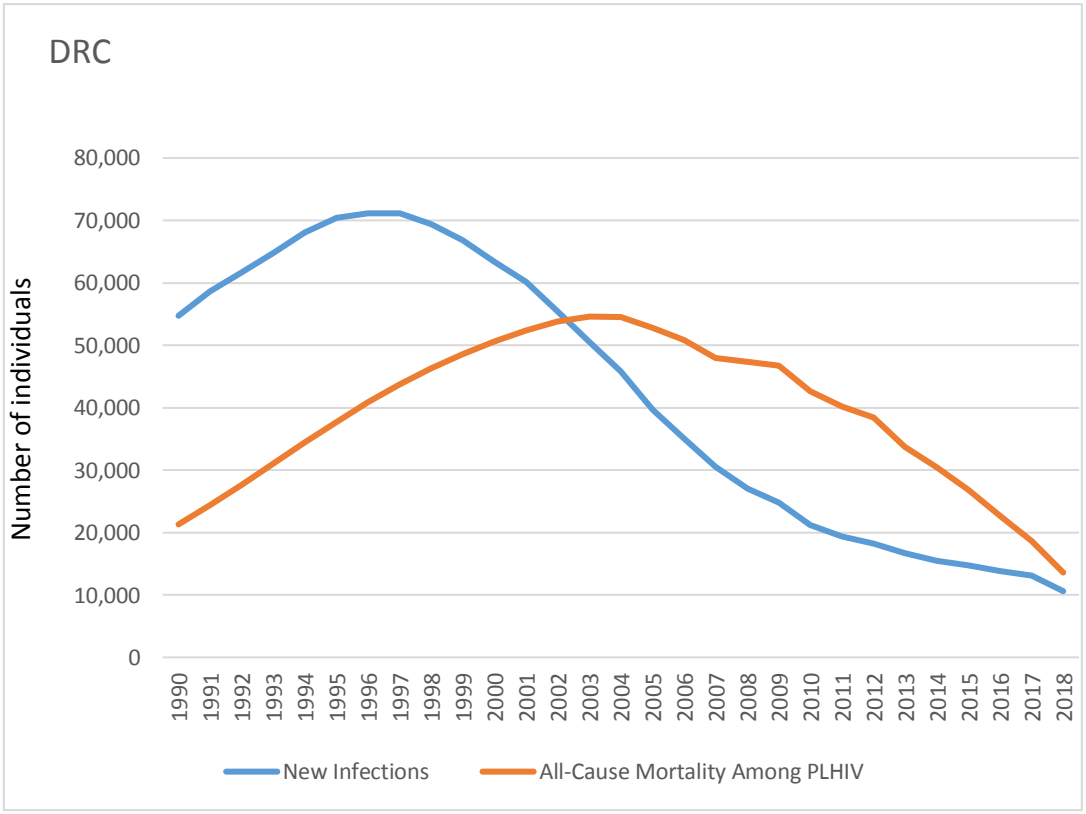


Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV



2.2 Investment Profile

The DRC has one of the lowest gross national incomes (GNI) per capita in the world ($460, World Bank, 2017), with an estimated 63.9 percent of the total population living below the poverty line (World Bank, 2012). Although DRC's economic growth increased from 6.9 percent in 2012 to 9.5% in 2015, it has slowed down in recent years, to 3.7 percent in 2017 (World Bank, 2017). It also needs to be noted that the benefits of economic growth are spread unevenly across the population. The top quintile of the population holds 48.4 percent of total income, while the bottom quintile holds 5.5% of income (World Bank, 2012). The United Nations Human Development Index 2017 ranks the DRC as one of the least-developed countries in the world (176/189).

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 has increased from 1.4 percent in 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) to $77.4 million in COP19.

Led by the PNLS, PEPFAR and the Global Fund completed a rationalization process in FY2016 to strategically align resources and to maximize joint investments. Pre-rationalization, the Global Fund procured the majority of HIV-related commodities for the DRC, while PEPFAR/DRC made targeted investments in commodities focused on PMTCT. As PEPFAR/DRC pivoted from a focus on PMTCT to the whole continuum of care and treatment services, so have its commodity investments. Starting in FY17, each donor has been responsible for the provision of ARVs and other commodities to patients in health zones assigned to them. 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. This is challenging due to competing priorities for GDRC resources, 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 to ensure that the community systems strengthening necessary for an effective continuum of care in line with the country's 95-95-95 goals is realized.

With a new president, Felix Tshisekedi, having been sworn into office in recent months, there is renewed optimism in the country.

Table 2.2.1. Annual Investment Profile by Program Area, FY18

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	53,942,799	62%	38%	*	
Community-based care, treatment, and support	7,324,314	100%	0%	*	
PMTCT	4,385,741	97%	3%	*	
HTS	12,098,341	69%	31%	*	
VMMC	-			*	
Priority population prevention	617,179	10%	90%	*	
AGYW Prevention (sub-set of Priority Pop)	-			*	
Key population prevention	3,681,889	55%	45%	*	
OVC	5,072,936	100%	0%	*	
Laboratory	1,244,621	73%	27%	*	
SI, Surveys and Surveillance	4,023,764	62%	38%	*	
HSS	3,237,556	40%	60%	*	
Total	95,629,140				

* 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.

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 of both VL and early infant diagnosis (EID). Global Fund reported low spending in the first year of its new 2018-2020 grant.

Table 2.2.2 Annual Procurement Profile for Key Commodities, FY18

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	19,357,472	67%	33%		
Rapid test kits	3,744,500	33%	67%		
Other drugs	298,598	89%	11%		
Lab reagents	212,372	49%	51%		
Condoms	-				
VL/EID commodities	5,122,606	86%	14%		
VMMC kits	-				
MAT	-				
Other commodities	-				
Total	**28,735,548**				

Expenditure on commodities is increasing as a proportion of overall investments. This reflects the increasing size of the patient cohort. ARVs remain the top spending commodity category followed by VL/EID and rapid test kits. The expenditure on HIV rapid tests is decreasing on the PEPFAR side (because of increase in index testing and better use of screening tools for PITC). The expenditure on VL/EID increased by almost 30 percent on the PEPFAR side. This reflects the rapid scale up of VL/EID coverage.

Table 2.2.3 Annual USG Non-PEPFAR Investments and Integration, FY18

Funding Source	Total USG Non-PEPFAR Resources (FY18)	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution (COP17)	Objectives
USAID MCH	40,000,000	2,449,050	2	19,787,449	Procurement (PSM)

USAID TB	13,000,000	-	-	-	
USAID Malaria	50,000,000	23,155,590	1	19,787,449	Procurement (PSM)
USAID Family Planning	20,350,000	250,000	1	4,326,816	Service Delivery (IHAP-Kinshasa)
NIH	-	-	-	-	N/A
CDC (Global Health Security)	6,000,000	-	-	-	N/A
Peace Corps	-	-	-	-	N/A
DOD Ebola	-	-	-	-	N/A
MCC	-	-	-	-	N/A
Total	**129,350,000**	**25,854,640**			

In FY18, USAID invested more than $129 million in non-HIV programming, including $24 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 and Dashboard (SID) Process: In October 2017, the U.S. Embassy in DRC, UNAIDS, and the National HIV/AIDS Program co-convened a four day SID workshop with selected 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 Country Coordinating Mechanism (CCM). The 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 reconvened to review the completed tool, discuss the findings, and identify priorities.

Sustainability Strengths:

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 eliminated overlapping and counterproductive or concurrent investments between the Global Fund, PEPFAR and other 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. The influence of the PNMLS has noticeably declined since funding from the World Bank was phased out. 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 and 19 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 and 19 following elements: performance data, commodity security and supply chain, and laboratory.

Current investments

Performance data: The PEPFAR team has been in the frontline of enhancing performance and health data as the Global Fund has invested a great deal in epidemiologic data (ANC surveillance, Key Population mapping and size estimation and IBBS).

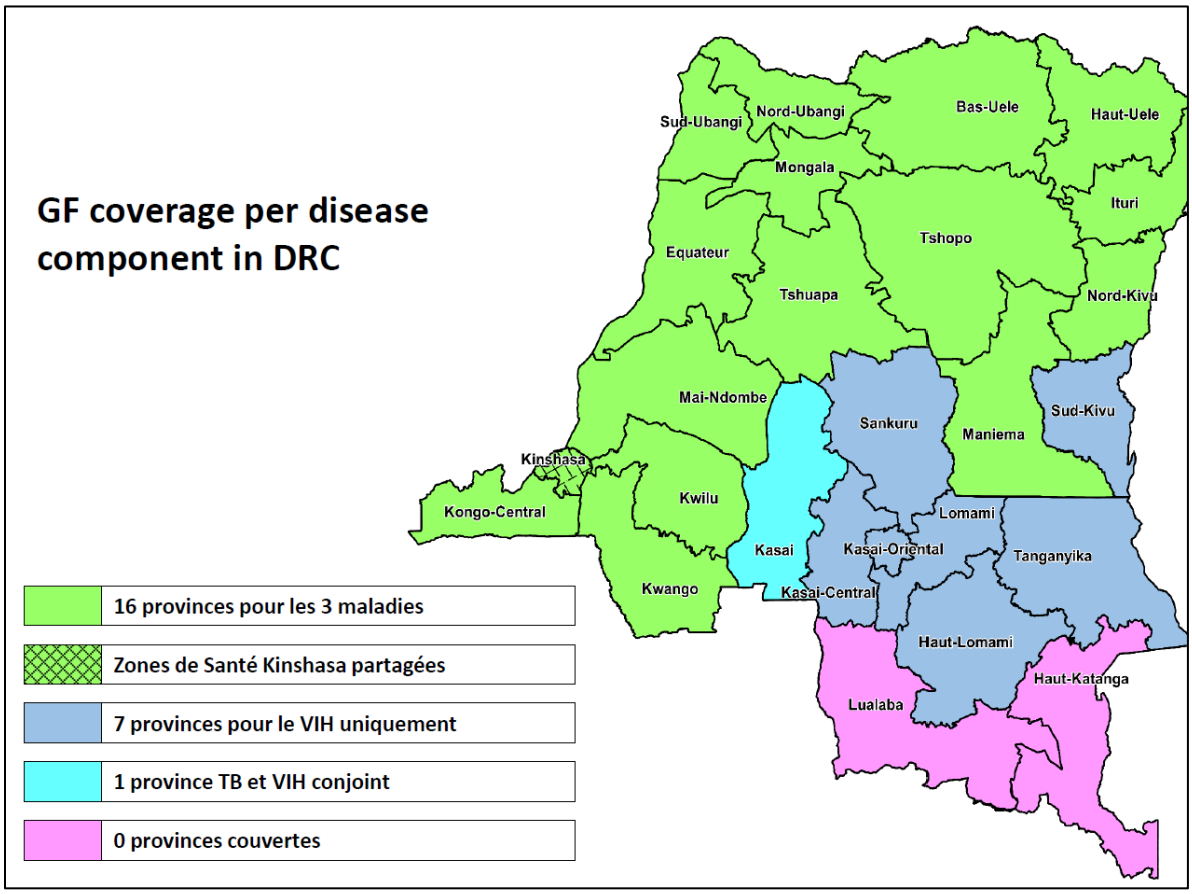
Commodity Security and Supply Chain: PEPFAR and the Global Fund remain the principal funding sources for the backbone of the supply chain system in DRC for HIV-related commodities.

Laboratory: PEPFAR and the Global Fund are responsible for their respective geographic areas. While the PEPFAR-supported zones reached viral load coverage of 61 percent by 2018, the national viral load coverage remains alarmingly low (under 20 percent) despite an unutilized current capacity of 79 percent. The Global Fund will continue to support the national response by the deployment of additional conventional platforms which will be additive to the MSF and DREAMS platforms. PEPFAR also looks to diversify the viral load platforms in all three provinces through a rental scheme with Roche. In addition, capacity will be strengthened with the use of point of care technology.

2.4 Alignment of PEPFAR investments geographically to disease burden

In DRC, three key partners lead the HIV epidemic response: the Government of DRC, the Global Fund and PEPFAR. Figure 2.4. 1 below depicts the rationalization of provinces between GF and PEPFAR, which was completed 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).

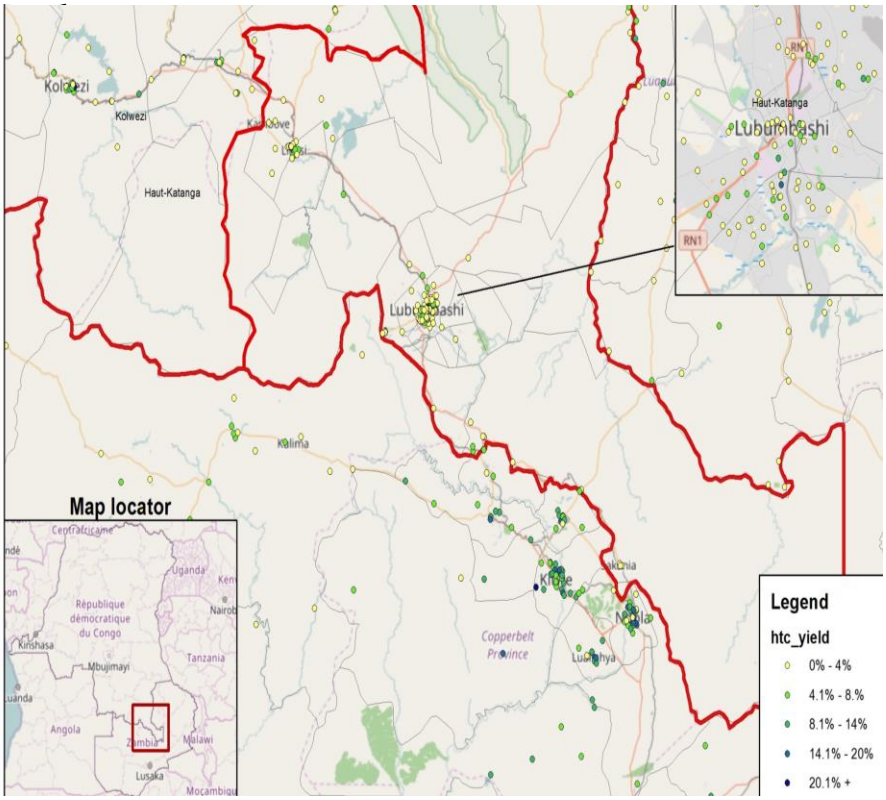
Figure 2.4. 1: Global Fund coverage per disease component in DRC



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 percent, with index testing are possible and the increased use of risk assessment tools in other entry points is providing valuable testing efficiencies. 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 linkage and retention strategies, streamlining investments to find more people living with HIV in this high burden province will be essential for epidemic control in the DRC. FY19Q1 results indicate retention issues in Kinshasa. For the remainder of COP 18 implementation and in COP19, PEPFAR implementers will continue to work to close the gap by reducing those lost to follow-up.

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. 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. During COP19, implementing partners will continue to expand index case testing and other cost-effective approaches in order to continue to find and treat higher risk populations on a larger scale in this area.

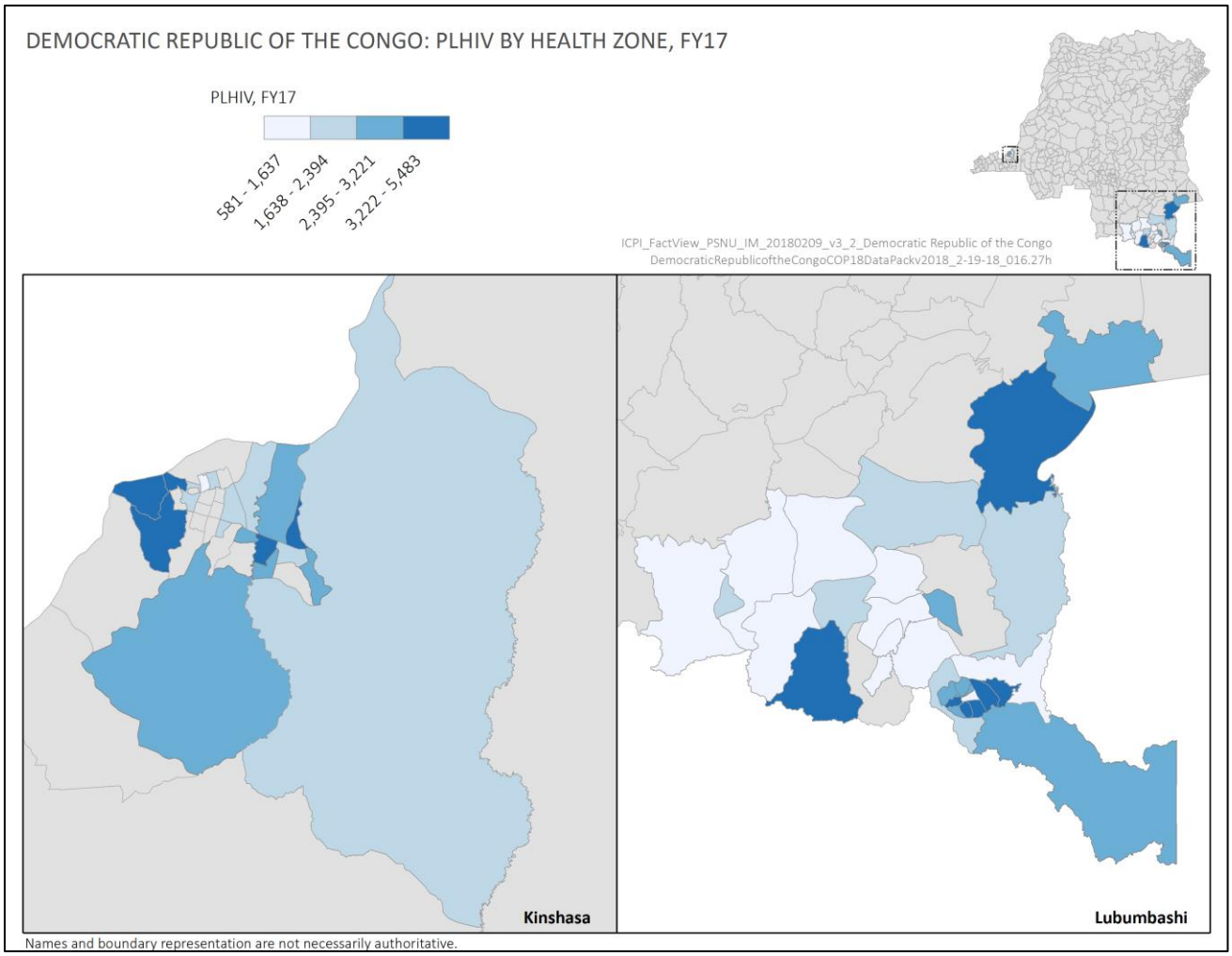
Figure 2.4.2: % HTC_TST positive, DRC/Zambia Border, April



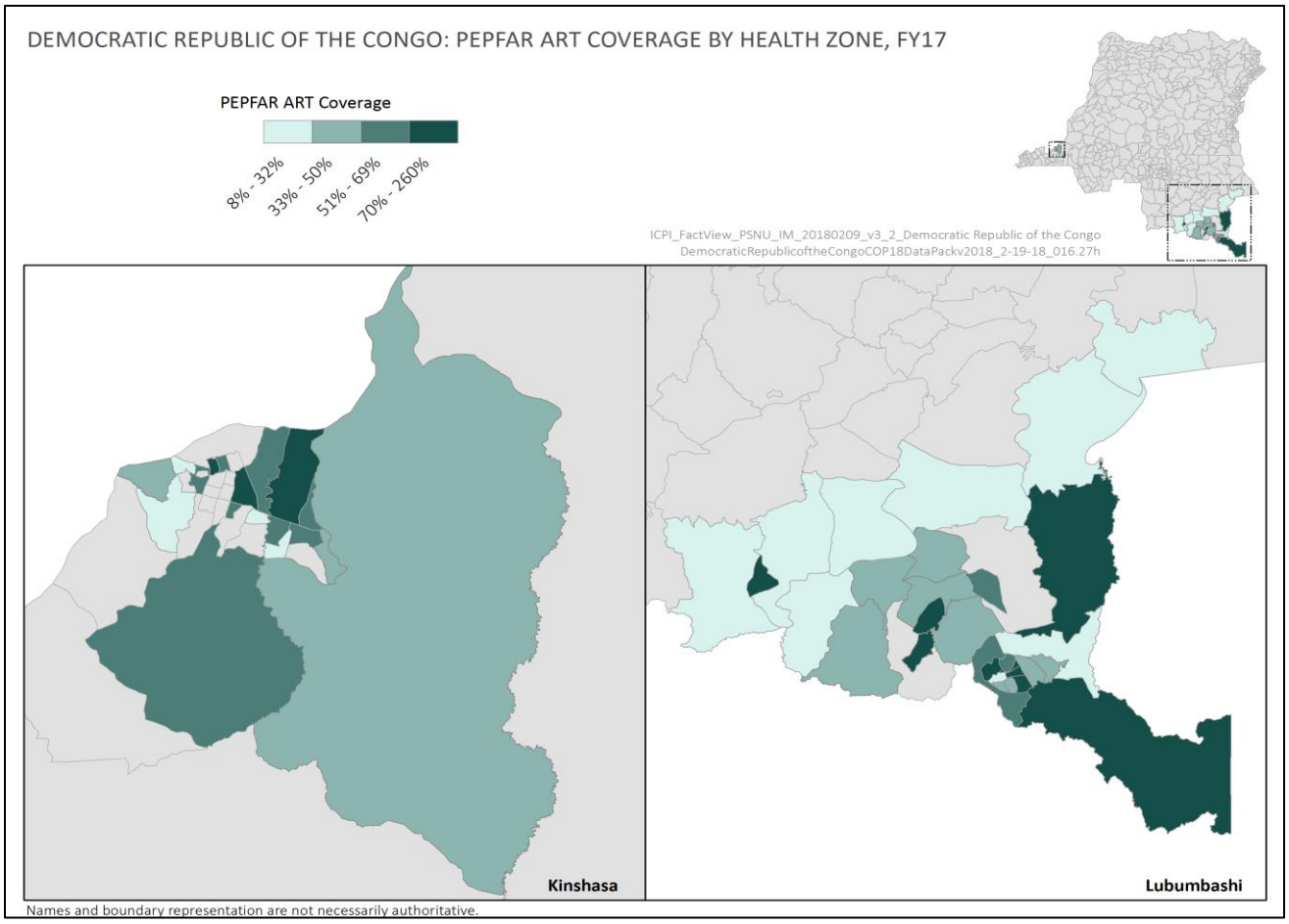
Performance data overall, as well as spectrum data in Haut-Katanga, indicates near attainment of epidemic control in several health zones. Given this, more resources and efforts will continue to be invested in this high-burden province during COP19. Contiguous to Haut-Katanga is the province Lualaba, 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, this will continue to be an area of focus.

Overall, approximately 30 percent of PLHIV live in the PEPFAR-supported provinces. In COP18, DRC/PEPFAR pivoted to increase focus in Haut Katanga and Lualaba to achieve epidemic control by 2020 and strengthening interventions in Kinshasa, which is detailed at length elsewhere in the SDS.

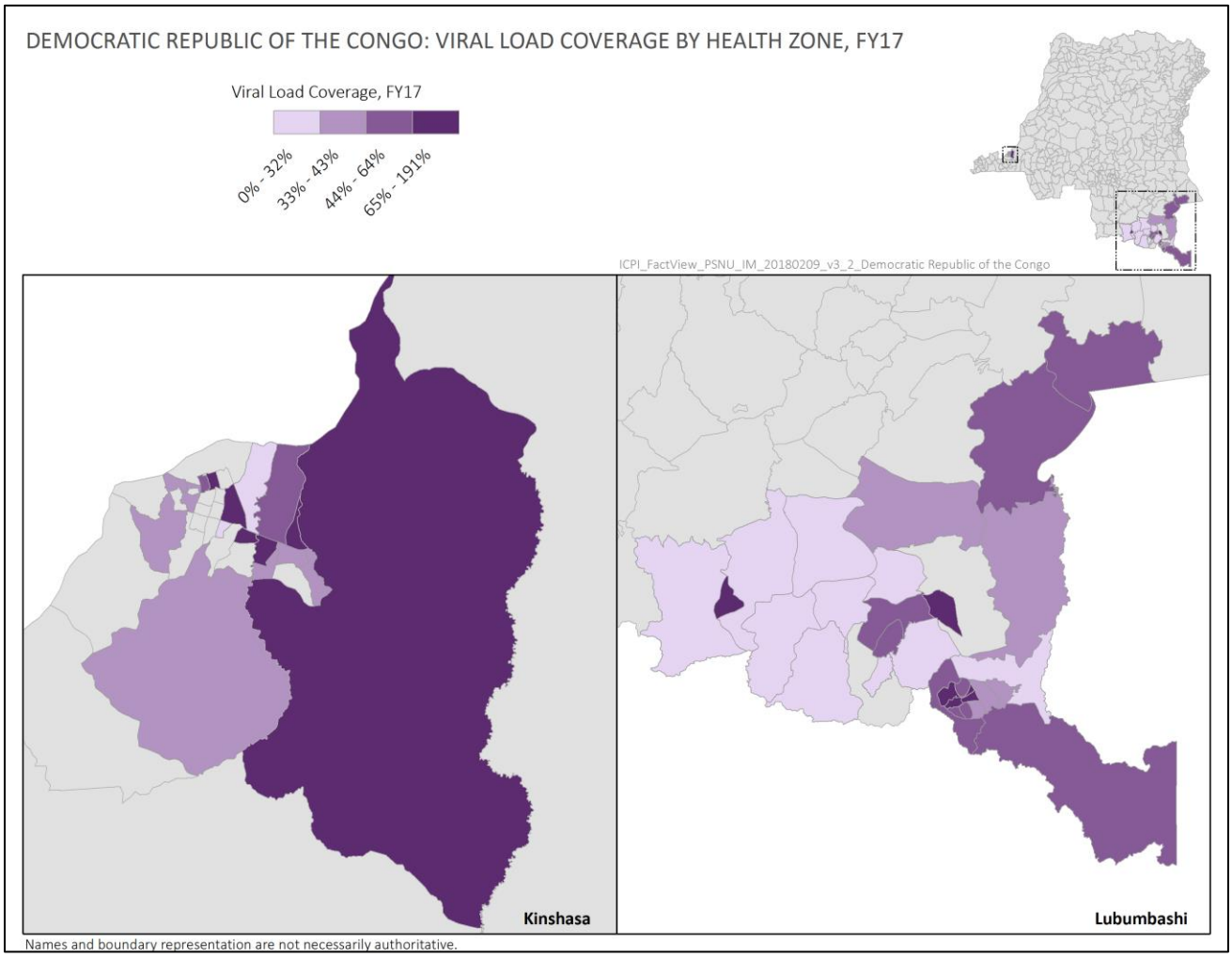
Figures 2.4.3 outlining geographic distribution of PLHIV is below:



Figures 2.4.4 outlining geographic distribution of ART coverage is below:



Figures 2.4.5 outlining geographic distribution of VL coverage is below:



2.5 Stakeholder Engagement

From the beginning of the COP19 process, PEPFAR/DRC has engaged a range of critical stakeholders including: the Government of the DRC (GDRC) through the PNLS directors, the Ministry of Health (MOH) cabinet members; the Global Fund through the DRC HIV/TB Manager; United Nations (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 COP19.

CSOs participated in the pre-COP19 in-country retreat to help inform COP19 planning and strategy. The PEFPAR/DRC OGAC Program Manager was involved in planning the in-country retreat, and was able to directly answer questions from staff. CSOs provided feedback on the COP19 guidance and PEPFAR/DRC COP19 activities and priorities. CSO representatives and other stakeholder listed above then joined the PEPFAR/DRC delegation at the COP19 Meeting 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 COP19 Submission				
02/7/2019-02/08/2019, 02/13/2019 In –Country retreat	PEPFAR/DRC to share with internal stakeholders: The COP19 development process, the COP19 overview, COP19 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 COP19	Plan the next meeting. Share the documentation.	Meeting was held at the Sultani Hotel, Kinshasa

03/14/2019	Discuss COP 18 Q1 performance and COP19 plan Receive input from stakeholders on the COP18 strategy for DRC	Stakeholder feedback received	Continue discussion via phone and email to ensure stakeholder input into COP19 presentations	
4/5/2019	COP19 SDS Draft shared with stakeholders			SDS draft was shared via email a with CSO and all stakeholders
04/30/2019	Final SDS to be shared with CSOs and other stakeholders.			
After COP19 Submission				
05/25/2019	PEPFAR/DRC to explain how stakeholder feedback was incorporated in COP19 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 COP19, what was not, and why these decisions were made.	Share the redacted COP19 when available and approved.	The approved, redacted COP19 will be shared by email. Hard copies will be available upon request.

Information sharing strategy

UNAIDS in Kinshasa continues to allow stakeholders to use their office space and internet capabilities and host monthly civil society meetings. PEPFAR/DRC sends invitations for meetings seven days in advance via email to the CSO networks. Stakeholders located outside of Kinshasa will continue to receive information from the UNAIDS provincial offices.

All type of documentation (i.e. APR/SAPR; POART, COP19 priorities, goals, budget) is shared via email. Hard copies of documents will be provided if needed upon request from the stakeholders.

3.0 Geographic and Population Prioritization

In COP19, PEPFAR/DRC will keep the same SNU prioritizations as in COP18. The 52 scale-up aggressive health zones prioritized for COP19 represent 30 percent of patients in the cumulative national ART cohort. In COP19, the PEPFAR/DRC team will continue to implement 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 52 health zones by 2020. In addition, The PEPFAR/DRC military specific program will pursue its efforts in favor of active duty FARDC personnel, their dependents and the populations surrounding FARDC barracks or camps.

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, the illusion of saturation is likely attributable to care-seeking behaviors, whereby patients cross health zone lines to receive care. In COP19, PEPFAR/DRC will focus on increasing the number of PLHIV receiving treatment in all the supported health zones, with a particular emphasis in Haut-Katanga and Lualaba. Index and family testing will be offered to all newly identified positives in all PEPFAR-supported health facilities. In addition, medical records for all PLHIV enrolled in PEPFAR-supported facilities will be reviewed, and index/family testing will be offered to those whose records do not indicate this has been done previously. Additionally, in out-patient wards, a standardized and validated screening tool will be employed to more accurately identify high-risk clients and avoid duplicative or over-testing of lower risk clients.

In COP19, PEPFAR/DRC will continue its efforts to reach the following populations:

1) Partners and family member of diagnosed PLHIVs (index testing);
2) Younger men, including partners of FSW; 20-35
3) Adolescent girls and young women;
4) Key populations (MSM and FSW); and
5) Other priority populations such as 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 in the supported areas by 2020, with significant progress toward closing the gaps in FY19. Activities for key and priority populations will be rolled-out at hotspots and at-risk communities, based on the location and need of the identified populations in the urban areas with high number of FSW and MSM.

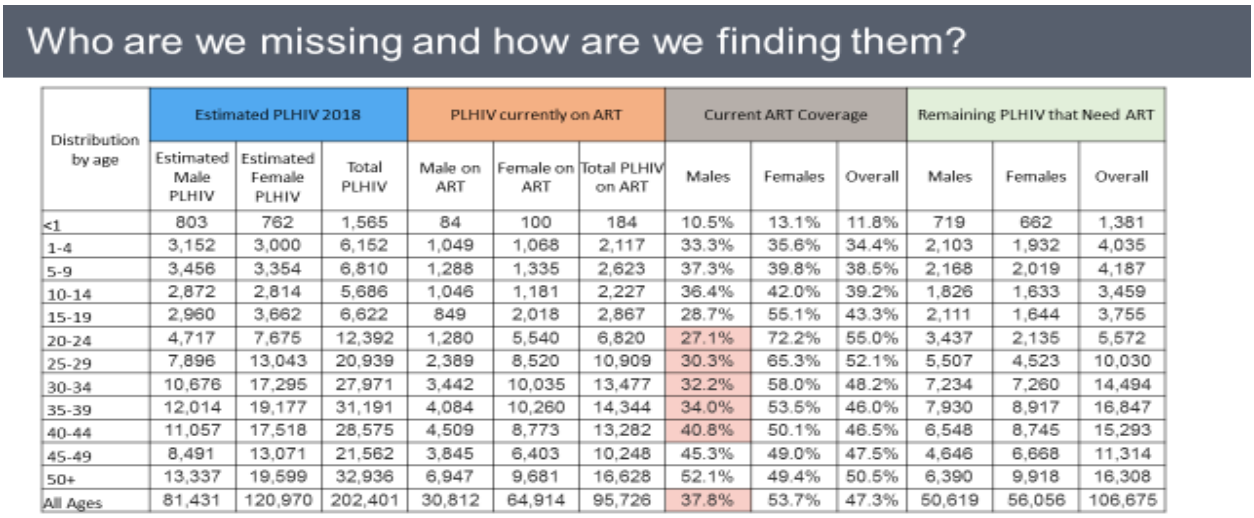
During FY20, budgets and targets will continue to prioritize Haut-Katanga and Lualaba provinces, which are closer to achieving 95-95-95 by 2020. In Kinshasa, PEPFAR/DRC will continue to find efficiencies and focus on case identification and rapid enrollment on treatment while in Lualaba

and Haut Katanga, PEPFAR/DRC will be scaling to attain epidemic control with intensified attention on retention and viral suppression.

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY18)**	**# of SNU COP18 (FY19)**	**# of SNU COP19 (FY20)**
Attained				
Scale-up Saturation not including Military	202,401 / 100%	88,488	52	52
Scale-up Aggressive				
Sustained				
Central Support				

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

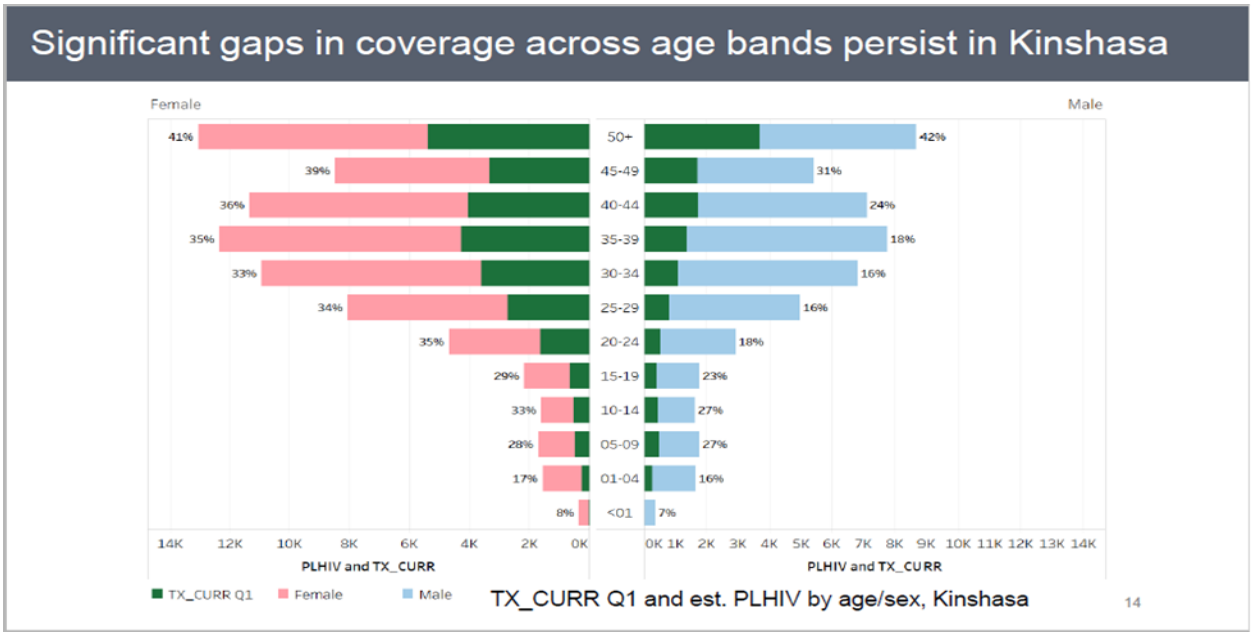
4.1 Finding the missing, getting them on treatment, and retaining them

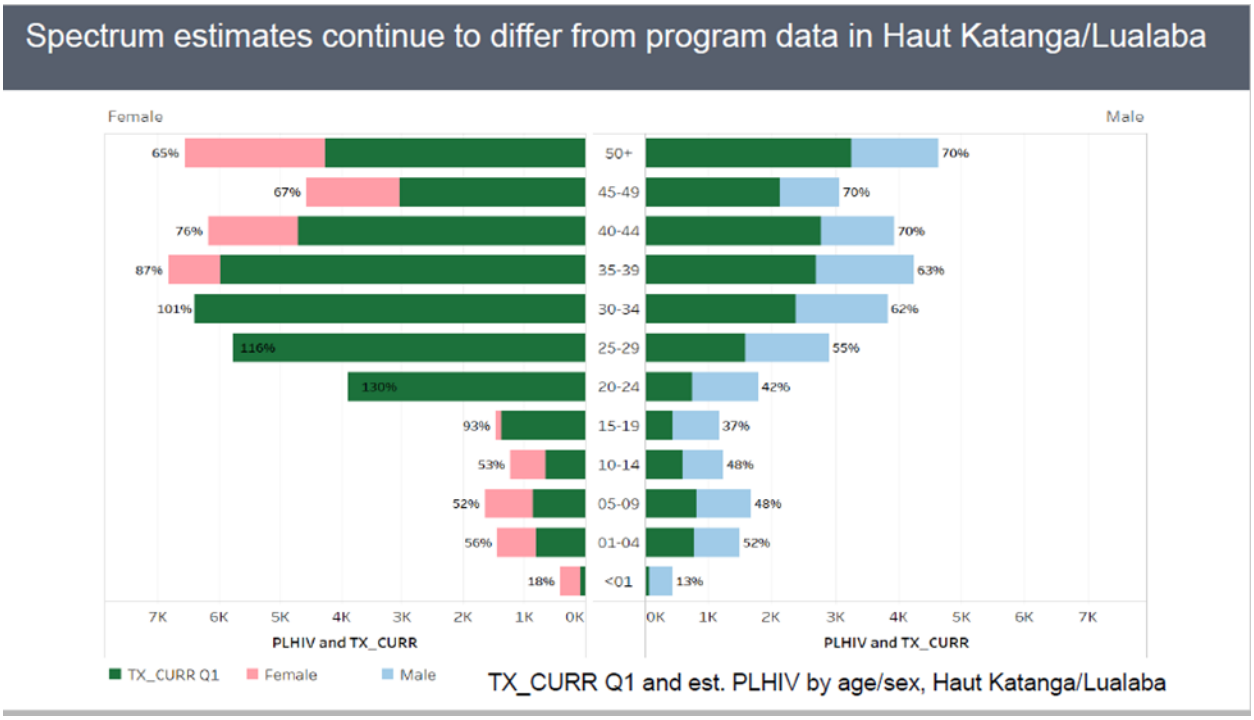


The PEPFAR/DRC team recognizes that "the missing" are mainly the partners of individuals recently identified as living with HIV, or partners of existing ART patients that have not yet been tested. In addition, "the missing" include those individuals identified as positive but who were not linked to treatment, and the PLHIV started 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.

The identification and diagnosis of healthy HIV-positive men is essential in breaking the cycle of transmitting HIV to partners, families, and social and sexual networks. Evidence suggests that men are less likely than women to seek out health care and be tested for HIV; although once men are on treatment they are as likely as women to adhere to treatment and experience the same levels of VL suppression.

Results from FY18 and Q1 FY19 allow PEPFAR/DRC to identify and address different HIV sub-epidemics in DRC based on geography and population. In Haut Katanga and Lualaba PEPFAR/DRC will scale up to attain epidemic control 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. 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. This results in a lower percentage of positive men that have been found than of positive women than have been found; however, due to the greater burden of HIV-positive women, the absolute number of women that need to be found remains larger in many age bands. Population demographics, therefore, need to be well-understood and strategies must be targeted for each individual population.

To overcome the various challenges described above and reach 95-95-95 at the national level, PEPFAR/DRC will continue to 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, especially in populations in areas such as Lualaba where there are concerns with the denominator;
- Optimizing PITC yield and right-sizing testing volume by using the risk assessment tool;
- Implementing approaches for improved linkage and adherence support; and
- Implementing strategies for improved tracking and reminder systems to retain patients on treatment.

First 95

In COP19, PEPFAR/DRC prevention outreach activities will focus on the following priority populations: 1) partners of diagnosed PLHIVs (index testing), 2) younger men, 3) adolescent girls and young women, 4) key populations (MSM and FSW), and 5) the military personnel. 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 COP19, intensified site-level data reviews with all implementing partners, and robust partner performance management, will continue to proactively identify and address 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 positive cases to treatment, and retain them in the program.

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
- Optimizing PITC yield by using the validated and harmonized risk assessment tool.
- Targeted workplace testing

Results from FY19 Q1 reveal that men are still being reached at an older 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; there is a need to scale up family tree testing to ensure that all biological 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. The overall approach will focus on "finding men at an earlier age and stage" and linking them into facility-based services. FY18 Index Testing results show encouraging trends in fulfilling this goal. Although the results are not yet optimal, PEFPAR/DRC is reaching relatively more men and identifying more PLHIV than in the past. PEPFAR/DRC is building on initial successes to expand index testing among men. Partner performance monitoring has helped to identify sites that successfully linked more than 95 percent of HIV-positive men to treatment. Practices employed at these successful sites are being explored during partner performance monitoring meetings in order to identify characteristics of testing programs that encourage service uptake among men. This includes 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 harmonized and validated high-risk screening tool, targeted workplace testing will be implemented among fishermen, taxi drivers, miners, and truckers.

Second and Third 95:

Equally important as finding those individuals who we are missing, is ensuring that those we do find are linked to treatment and are retained in the program. Efforts towards these ends will include optimizing the second and third 95, particularly in Haut Katanga and Lualaba, and will focus on improving:

- Linkage & Adherence Support: Peer Navigators/Educators to support linkage, treatment readiness, and adherence; immediate 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 Community Adherence Groups/Support Groups.
- Viral Load Monitoring: Scaling-up Viral Load coverage by implementing educational materials for children and adolescents, enhanced site monitoring using the Viral Load score card and Viral Load implementation Monitoring Guide; reinforced support and tracking of unsuppressed clients.
- Package for Advanced Disease: CD4 and LAM testing for acutely ill patients at HIV diagnosis; Integrated TB/HIV care. This package will mainly be implemented in Kinshasa in close collaboration with MSF, and will be supported by two referral hospitals where patients with more complicated opportunistic infections will be referred.

Factors leading to poor retention

- Insufficient adherence counseling
- Insufficient loss to follow up (LTFU) tracking
- Fear of stigma from family & community
- Unwelcoming patient care for some populations: KP, youth, men
- Professional/cross-border mobility: KPs, miners, itinerant traders
- Influence of some churches promoting miraculous healing

Strategies to address poor retention

- Improve early identification of patients at risk of being lost; proactively track and tracing of LTFU patients; utilize Tier.net
- Implement plan for unique identifiers for all patients in all sites
- Strengthen adherence counseling and patient treatment literacy
- Enroll all eligible patients in differentiated models of care and multi-month dispensing
- Advocate and collaborate with CSOs and the community, including: religious leaders, peer educators, CHWs, and OVC case managers, to ensure appropriate messaging about treatment and stigma reduction are shared
- Self-referral of patients to appropriate services (based on mapping of HIV services availability)
- Implement Treatment Awareness Clubs in sites with low retention and low suppression

In addition to these activities, it will be important to insure that data being used for program monitoring is accurate and up-to-date. Of particular interest is an accurate accounting of the

numbers currently on ART. Increased efforts during site visits will be paid to the accuracy of this critical number, and if issues in data collection, analysis, or reporting are identified, teams will engage with the national systems to correct and remediate as required.

4.2 Prevention, specifically detailing programs for priority programming:

4.2.1 HIV prevention and risk avoidance for AGYW and OVC

The National HIV AIDS Strategic Plan 2014-2017 (NSP 2014-2017) estimates that there are 391,053 orphans who have lost one or both parents due to HIV in the DRC (320,000, UNAIDS 2017). Vulnerable children less than 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 percent of 15-19 years old males and females have had their first sexual intercourse before the age of 15. The median age of the first union (wedding or sex partnership) was estimated at 18.7 years among females aged 25-49. Approximately 21.3 percent of girls aged 15-19, and 6.5 percent of girls younger than 15 were estimated to be married or living with a partner.

According to UNAIDS, an estimated 51,000 children 0-14 years of age are living with HIV in the DRC (UNAIDS, 2017). 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.

Strategies to Optimize or Leverage OVC Programming

- Ascertain HIV status for at least 95% of enrolled OVC beneficiaries
- Conduct HIV risk screening on 100% of enrolled OVC beneficiaries (particularly <18 years) who have an unknown or missing HIV status
- Increase the proportion of HEI and CLHIV enrolled in OVC programs Based on eligibility criteria, including socio-economic criteria
- Strengthen (and maintain) formalized linkages and referral systems between OVC and clinical programs (i.e. facility-community linkages)
- Strengthen prevention of HIV and sexual violence among 9-14 year old girls and boys.

In FY18, 50,312 OVC received services for children and families affected by HIV, 7,524 left the program (4,043 graduated and 3,481 exited without graduation), and 42,788 were active at the end of the fiscal year. The more stringent admission criteria being applied to OVC programs resulted in this high number of OVCs exiting without graduation. Now that the rolls have been cleared, that number is expected to return to previous low levels during COP19 implementation. During FY18, 99.8 percent of HIV-positive OVC under 18 were either enrolled or already on ART. Among 4,489 OVCs without a known HIV status, 16 percent were for unknown reasons.

PEPFAR/DRC is currently providing a comprehensive package of services including: health, economic strengthening, and 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 FY20, the PEPFAR/DRC OVC case management approach will continue to 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 entry point; and
- Orphans (due to HIV).

PEPFAR/DRC will continue to support youth 9-14 years of age with 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, and support a family-centered approach 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 systems 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 the number of children for whom their HIV status is unknown will be accomplished by applying a harmonized, mutually reinforcing strategy for timely and positive disclosure. FY20 will continue to see an increase of comprehensive service delivery, increased intervention coverage (e.g. adolescent girl school support, secondary transition and progression) and improved service quality.

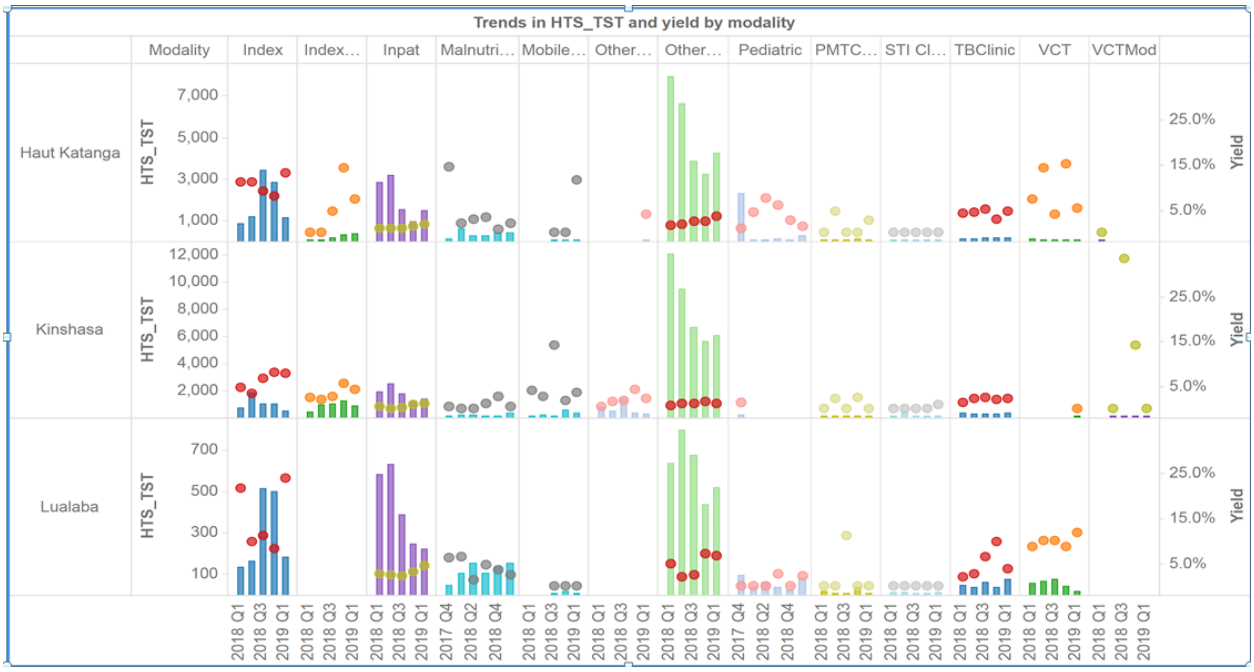
To improve the performance of implementing partners in an ongoing and timely manner, the PEPFAR/DRC OVC Technical Working Group (TWG) will ensure implementation of quality standards and strong M&E systems such as IP quarterly performance review meetings, Data Quality Assessment and Third Party Monitoring 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 continue to be an area of focus in FY20.

4.2.2 Children

The number of children receiving ART nationwide has increased by 200 percent between 2012 and 2016, with children under 15 years old accounting for approximately eight (8) percent of the total of number of people on ART in 2017. However, national data shows that pediatric ART coverage is

still proportionately lower at 28 percent compared to 41 percent adult coverage in DRC. In PEPFAR areas, pediatric treatment remains a challenge fueled by the relatively low identification of positive children. Figure 4.2.2.1 below shows a good testing yield for index testing and the use of risk screening with the PITC modality. We recognize that the current age of consent for testing (18 years) remains an issue, and we continue to advocate for a testing-enabling environment for improved adolescent access.

Figure 4.2.2.1: Trends in HTS_TST and yield by modality and SNU, age <15



Another continuing challenge is access to VL. By FY19 quarter one (Q1), half of our implementing partners had pediatric VL suppression <70 percent, which revealed significant adherence and retention issues. For retention (Figure 4.2.2.3), we still have some Health Zone with very low retention rates, while others are improving. There is a need for implementing partners to share best practices.

Figure 4.2.2.2: Pediatric Trends in VL Suppression by SNU and IP

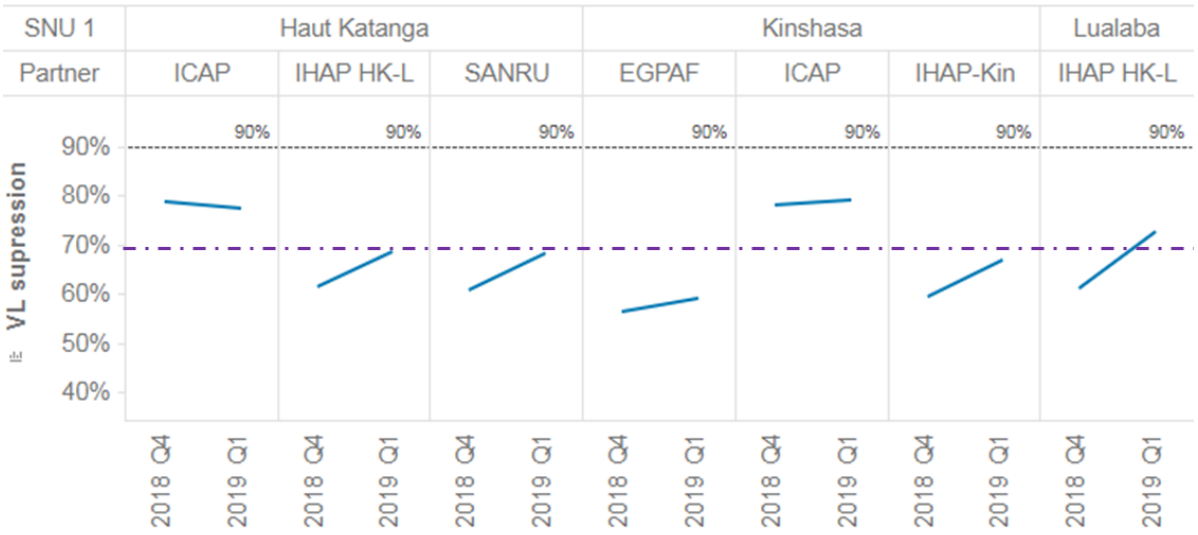
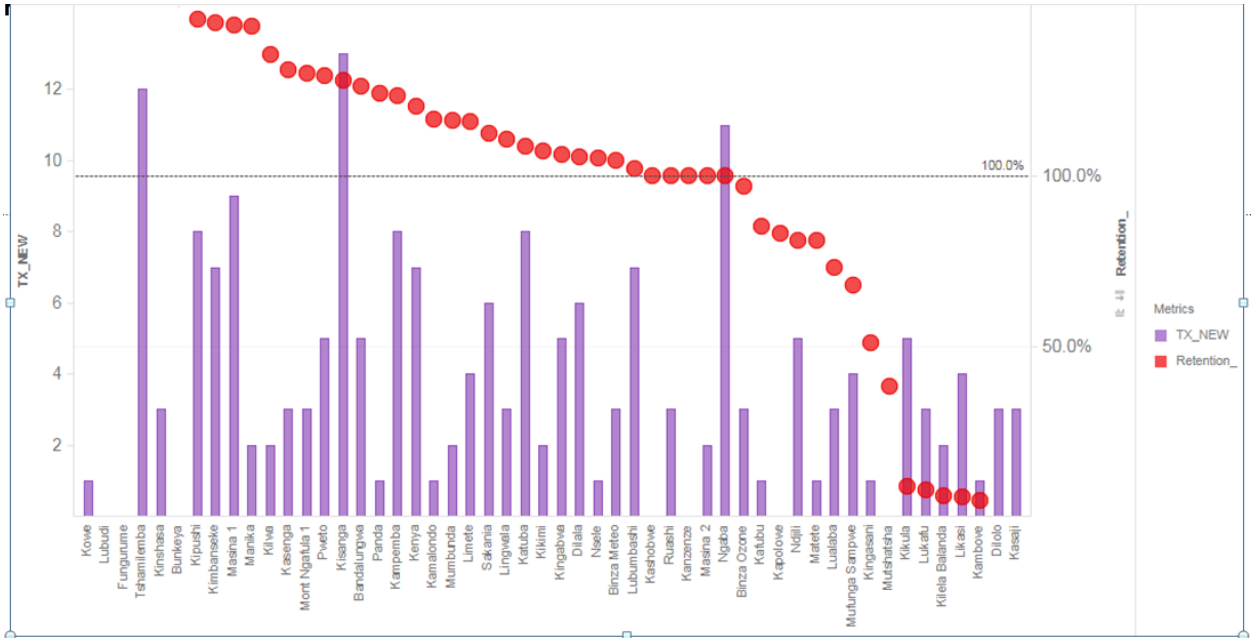


Figure 4.2.2.3: Pediatric Retention by HZ across all 3 provinces FY19Q1



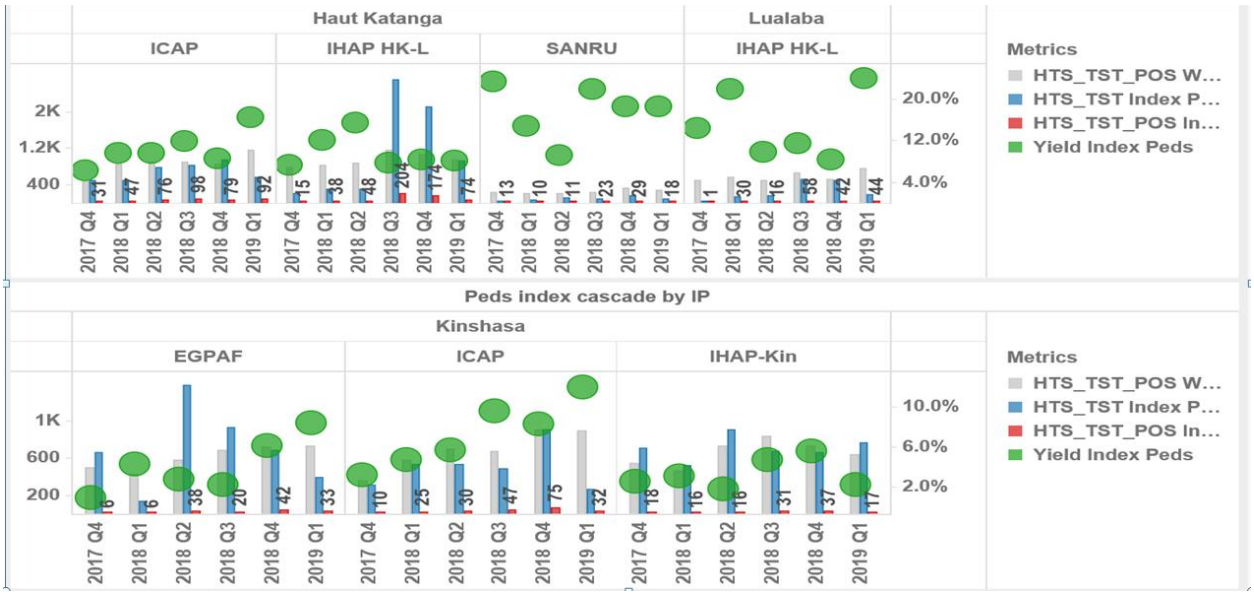
In addition to expanding ART (including inclusion of children in differentiated service delivery models and VL testing coverage, increasing Nutrition Assessment Counselors, and improving TB screening, a key priority will be increasing systematic and routine HIV testing of all children, especially:

- Family tree/index testing;

- Children in inpatient settings;
- OVC identified through a screening tool;
- Malnourished children;
- Children with TB or suspected TB; and
- Outpatients identified through a screening tool.

Promising results in scaling up index testing of biologic children of female PLHIV can be seen in Figure 10.

Figure 4.2.2.4: Pediatric Index testing cascade by SNU and IP



Furthermore, in COP19, OVC partners will continue to strengthen linkages between OVC and pediatric programs and the adolescent continuum of care through a comprehensive and high-quality service package for OVC via a family-centered, HIV-inclusive case management system prioritizing children of KPs, children living with HIV (CLHIV,) and AGYW. This will be achieved by systematically using the risk screening tool, reinforcing bi-directional referral systems between clinic and community (utilizing Memoranda of Understanding between treatment and OVC partners) and employing HIV case management. 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 loss to follow up (LTFU,) poor linkage, poor adherence; and on placing new patients on treatment.

4.2.3 Key Populations

DRC is currently undertaking an IBBS survey which is targeting FSW, MSM, PWID, truckers and fishermen. This is a broader target group than the 2013 IBBS, which was limited to FSW and street children. The final results are expected in May 2019.

Building on COP18 interventions, COP19 programming for KPs will continue scaling up existing successful strategies. We have set ambitious targets (KP_PREV: 34,120; HTS_POS: 2,267; yield: 7.5%; TX_NEW: 2,040). KP programming includes the following interventions:

1. KP prevention activities, which include:

- Screening FSW, MSM and Transgender persons(TG) using risk classification;
- Condom and lubricant programming; and
- PrEP.

2. Case finding, which employs:

- Peer education/outreach;
- Index testing;
- Social and sexual network strategies like the Enhanced Peer Outreach Approach and the RDS-like recruitment (DOR);
- Self-testing; and
- Information and communication technology (ICT) platforms especially targeting MSM and TG.

3. Improving services for KPs and their families, by offering:

- Same-day ART initiation and peer navigation;
- Community ARV initiation for positive KP found during outreach activities and community distribution of ARVs for stable KP; and
- Linking daughters of FSW to OVC program and socioeconomic strengthening opportunities.

4. Reducing Stigma and Discrimination, by introducing:

- Small grants projects;
- Sensitization training and refreshers for providers;
- Drop-in Centers;
- Community dialogs between KPs and community leaders to address their prejudices;
- Stigma index results to tailor interventions; and
- Advocacy and involvement of police for the protection of KP rights.

5. Engaging with the KP community, which includes:

- Identification of KP-led organizations for meaningful engagement and potential service delivery; and
- Continued support of the cross-border KP initiative.

4.2.3.1 Testing

Results in FY18 Q4 show that the testing yield continues to improve as well as the linkage rates for positive KP to ARV treatment.

Figure 4.2.3.2: PEPFAR KP Cascade FY18

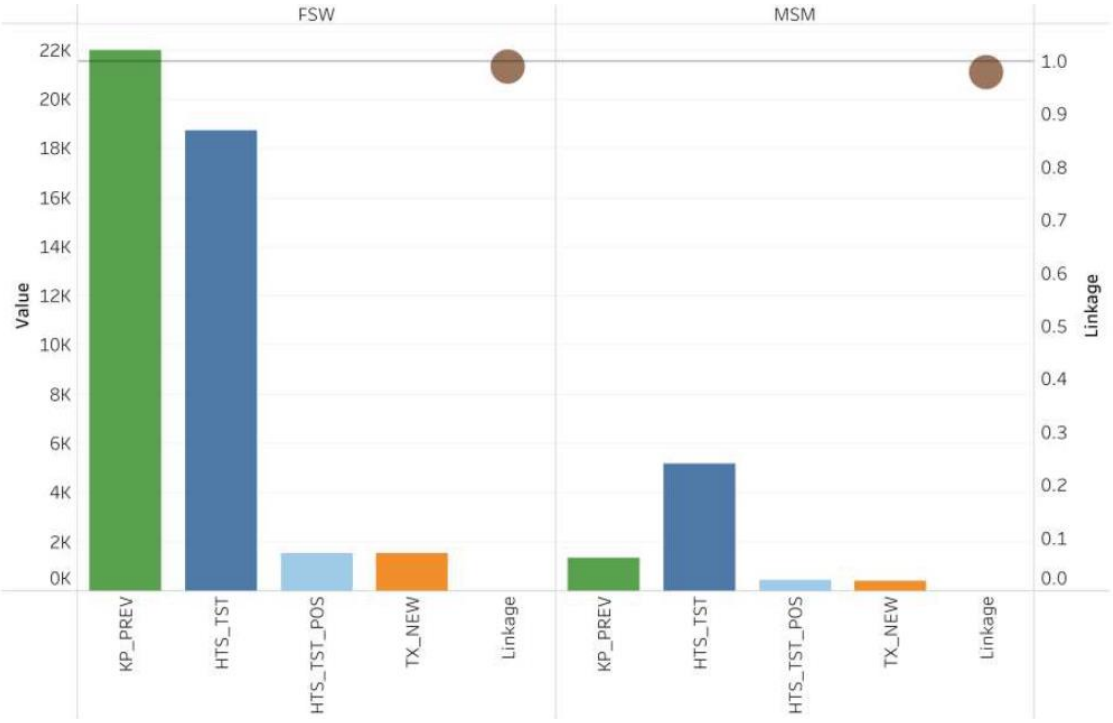
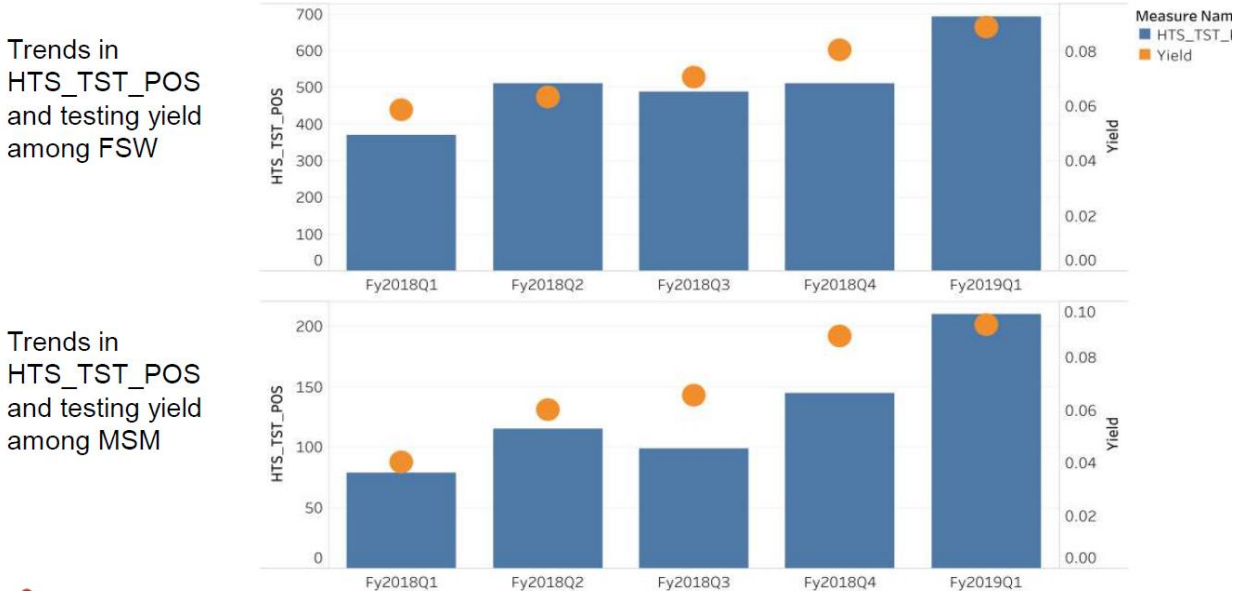


Figure 4.2.3.3: PEPFAR KP case finding and yield



PEPFAR/DRC will continue to utilize various modalities and testing approaches to increase volume and yield, such as providing moonlight services; connecting with CSO activities such as fairs, social events, and other gatherings; identifying social and sexual networks of older KPs who generally have higher prevalence; utilizing peer educators to provide targeted home and community-based testing; and scaling up of self-testing.

Scaling up KP sexual and social network approaches, such as (EPOA/DOR) and Information and Communication Technology (ICT) platforms which are targeted to reach MSM and TG, has been shown to gradually increase HTS yield in the PEPFAR/DRC KP program. These approaches are designed to increase HIV testing yield, to link HIV-positive KP with KP-friendly treatment and care, and to connect HIV-negative KP with services that will help them remain HIV negative.

4.2.3.4 Linkage to Treatment

Clinical cascade analyses for key populations indicate a significant improvement in the number of KP found to be HIV positive, as well as an increase in the number who are enrolled on treatment. In COP19, PEPFAR/DRC will continue to rely on one-stop-shops where possible, as well as active peer referrals using skilled navigators in the community. Both these activities align with the "test and start" strategy, as does Community ARV initiation for positive KP found during outreach activities, and community distribution of ARV for stable KP.

Linkage to treatment and retention is being increased through the use of Drop in Centers (DIC) which serve as community dispensing points for ART, enabling a safe and less stigmatizing setting for KP to access services. In addition, follow-up by peer navigators tasked with ensuring all positive KPs access services will continue to 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 sexually transmitted infections (STI)s, 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.

4.2.3.5 Other services

Numerous other critical services for KP will be provided such as: TB screening and treatment referral; 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 KPs to access health services. We will also continue to engage with Zambia/DRC Key population cross-border activities to ensure a continuum of prevention, care and treatment of KPs on 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 continue to conduct monthly partner performance reviews of testing and treatment progress.

4.2.4.1 TB/HIV

In FY18, 98 percent (21,448/21,981) of registered TB patients in PEPFAR-supported health zones were tested for HIV; 1,942 of those patients were found TB/HIV co-infected and 92 percent (1,942/2,114) of the co-infected patients were initiated on ART.

During FY20, 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; to ensure universal ART for all PLHIV; to ensure timely TB diagnosis and treatment completion; to scale-up TB Preventive Therapy (TPT); using the one-stop-shop model; and to sustain joint TB/HIV programming and monitoring. These core TB/HIV interventions are key evidence-based approaches to achieve the UNAIDS 90-90-90 goals.

In selected high-volume ART sites in COP19, PEPFAR/DRC will introduce the use of lateral flow urine lipoarabinomannan (LF-LAM) assay for TB diagnosis in PLHIV with low CD4 counts or those who are seriously ill. In FY20, PEPFAR/DRC will continue to support the GeneXpert network to improve the yield of TB diagnosis among PLHIV in all supported health zones. Logistic support for sputum transportation, GeneXpert tests and return of results will be provided. This will ensure prompt treatment initiation to confirmed TB cases and ensure follow up and documentation of treatment outcomes.

Programming for TPT will be prioritized, as will 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 MOH to: review the TB/HIV guidelines; introduce a new drug combination; develop systems and monitoring and evaluation tools; strengthen supply chain logistics management systems to avoid stock out; and monitor partner performance. PEPFAR, working in collaboration with the Global Fund, will support the quantification of TPT drugs needed in the country. In COP19, the PEPFAR program will provide INH for 100 percent of PEPFAR/DRC's annual targets, and The Global Fund will supply INH for the areas which they support, representing a change from past years' divisions.

Strategies to improve case finding and treatment, and decrease **mortality of TB/HIV**

- Maintain high rates of HIV testing among all presumptive and diagnosed TB patients.
- Ensure timely TB diagnosis and treatment completion.
- Prioritize programming for TPT and TB infection prevention and control.
- Develop systems and monitoring and evaluation tools, using the TB/HIV guidelines.
- Strengthen efforts for contact tracing for all HIV positive patients diagnosed with TB, especially pulmonary TB cases.

Sustain joint TB/HIV programming and monitoring.

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) in order to reduce loss to follow-up and increase the number of TB/HIV co-infected patients on ART.

4.2.4.2 Military

In COP19, PEPFAR/DRC will continue to offer prevention services and promote HTS to military service personnel. The comprehensive priority population prevention package will include sensitization to HIV issues, 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 continue to be made available to all military personnel, especially those being deployed. 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 continue 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. In FY20, an increased focus will be put on case identification through partner notification and index testing as well as on the increase of viral load coverage and suppression within the military

program. Those presenting with TB or STI symptoms will be offered treatment at PEPFAR-supported integrated TB/HIV military health facilities. The PEPFAR DRC comprehensive package of OVC services will continue to be provided to vulnerable children and adolescents from military settings.

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 COP19 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.

DRC is among the group of countries expected to scale the program with fidelity. These countries will continue to scale-up activities to reach 95/95/95 in adult men, women, and pediatric populations with the goal of epidemic control. They will have effective interventions for case finding, linking with immediate treatment initiation, and maximizing viral suppression across all sites. Site-specific data must be used to identify areas for improvement that are critical to maintain quality services for individuals.

There are continued opportunities for improvement in DRC. Focusing on a continued push for index testing will be emphasized during the coming cycle, particularly among male sexual partners. There is also a need for KP case finding to improve. Furthermore, DRC will make an effort to improve retention, in addition to improving viral load suppression rates, and viral load monitoring.

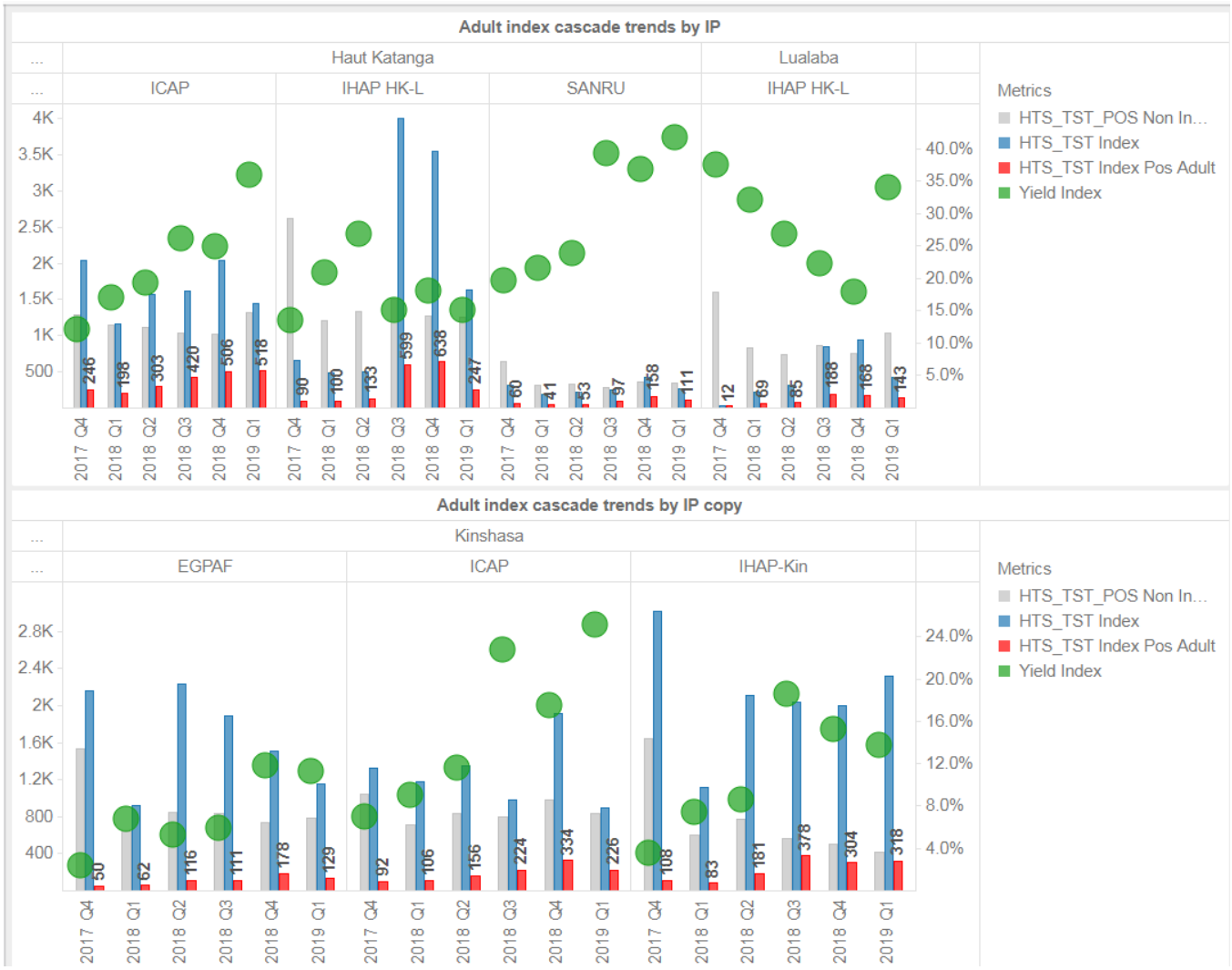
Although DRC has achieved significant progress and is on the path to epidemic control, better surveillance data is needed to understand the dynamics of the epidemic and identify remaining gaps. The COP19 strategy directs PEPFAR's investments toward addressing those gaps. PEPFAR DRC is expected to offer Tuberculosis Preventive Treatment (TPT) as a routine part of HIV care, which means that all care and treatment partners are expected to offer TPT and report on it. The program is expected to fully scale TPT over the next two years, in order that all PLHIV who are on treatment and are eligible for TPT have received a course by the end of COP20. DRC will focus on better targeting within the OVC program, making sure new targets are met. PEPFAR DRC will continue to work with Global Fund on IBBS implementation and utilize site level mapping data for program improvement. Additional funding is provided for strategic information investments, in particular for completion of the individual level data repository.

4.3.1 Scaling up Index Testing

Continued improvement of case finding through index case testing in the three provinces remains essential. PEPFAR/DRC will continue to provide enhanced technical support to partners for the scale up of this modality to ensure fidelity to strict definitions of index testing. Progress is already apparent with yields increasing during FY18 through improved implementation of index testing,

as shown in Figure 4.3.1.1 below. However in FY19 Q1, due to election related security issues in the country, there was a decrease in index testing which will be corrected in the upcoming quarters. Monthly data related to index-testing will continue to be collected and analyzed. Targeted community testing and anonymous partner notification will be strengthened through intensive mentoring and coaching. PEPFAR DRC expects 35 percent of positives will be diagnosed through this modality by maximizing index testing coverage in all high-burden sites, as well as through a concentrated community approach.

Figure 4.3.1.1: Improved yields in index testing FY17Q4 to FY19Q1



4.3.2 Finding Younger Men

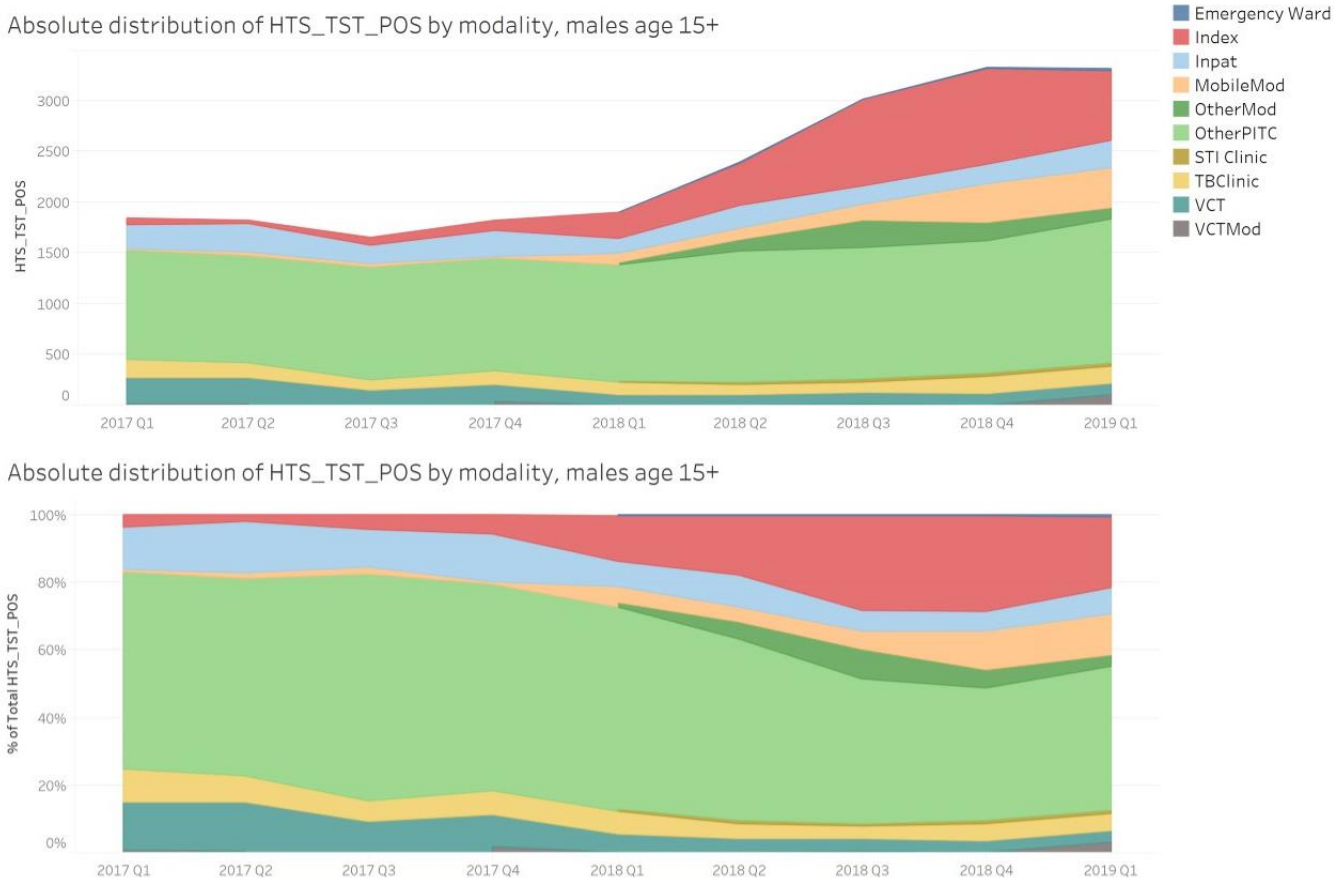
PEPFAR/DRC will continue to support the improvement of the cascade specifically for men through enhanced strategies according to defined packages of services for each province. Extended clinic hours, partner notification, targeted testing in non-communicable disease clinics,

and testing at work places (industrial and artisanal mining centers and fishing camps) will be used with adapted strategies to ensure linkage to treatment.

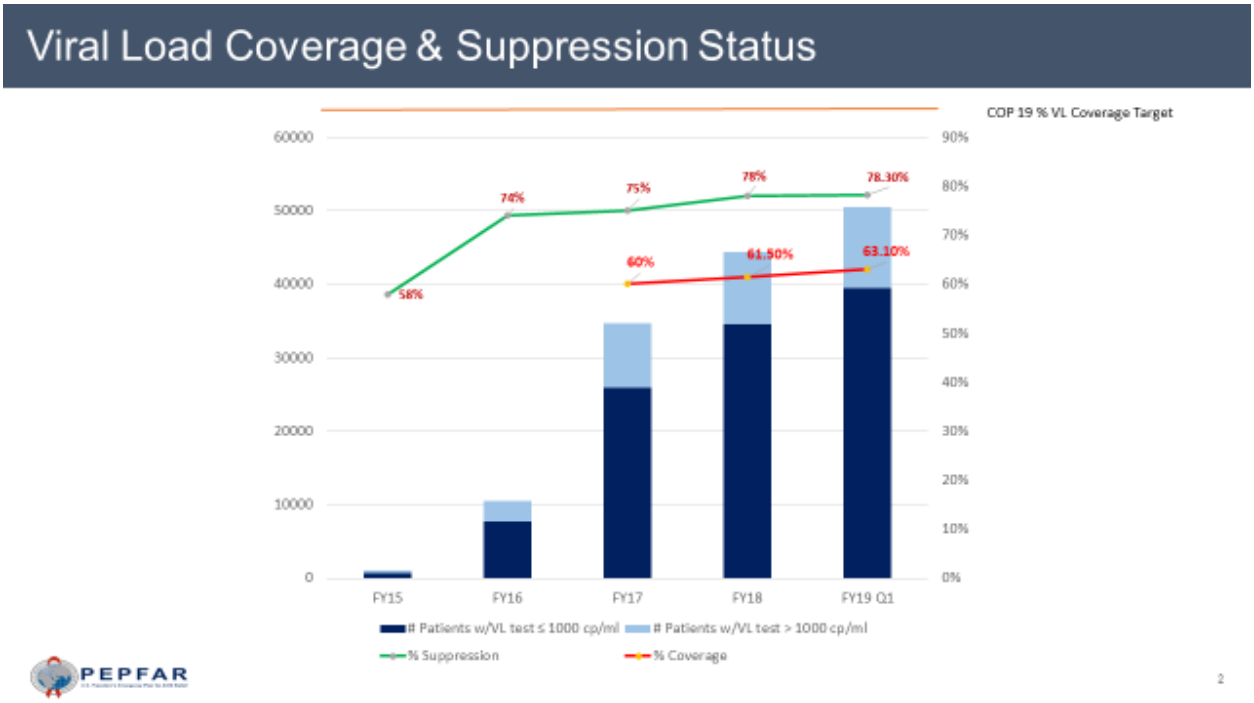
The transmission hypothesis in DRC is based on the belief that older men, who have been infected for a number of years, are key drivers of transmission via their numerous sexual partners. This hypothesis will be tested in a limited manner, utilizing recency testing to identify more recent transmission and better understand the drivers of the epidemic.

As shown in the figure below, index testing is the main strategy for finding younger men. The figure below shows that we are finding more positives in "early" modalities (index and mobile) vs "late" (TB, inpatient.)

4.3.2.1 Distribution of HTS_TST_POS



4.3.3 Viral Load Scale-up and Suppression



Despite efforts made in terms of coverage, the increase since FY17 is not striking. PEPFAR/DRC recognizes this could be due to a number of factors, including the lack of a uniform process across all sites to track identification of eligible patients for VL blood collection; a host of lab-related issues (including sample backlogs, turnaround times, optimal equipment utilization); and sample and results transport issues between the clinical sites and the labs. Measures are currently being implemented at site level during FY19 to address these issues throughout the VL cascade. Moving forward, strict tracking processes will be implemented in all sites to ensure that all samples arrive at a laboratory and results are returned in a timely manner. Demand creation for viral load testing is also a priority to improve coverage during COP19.

Strategies to improve viral load suppression

- Implement the Unsuppressed Viral Load Tool for sites with low viral suppression to reduce leaks in the cascade.
- Utilize results from Viral Load Implementation Monitoring and High Viral Load Register to ensure patients stay in the VL cascade.
- Conduct analyses to determine sites best suited for implementation of point of care VL for PBF women using existing GeneXperts
- Ensure availability of appropriate ARVs for all age groups, including TLD and second-line.

For illustration of best practices, certain sites have established a small viral load committee (doctors, nurses, peer-educators, and psychologists) to manage viral load results with attention to unsuppressed patients requiring adherence monitoring and support during 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.

Rapid transition to TLD and adoption of optimized pediatric regimens will also improve adherence and therefore improve VL suppression.

4.3.4 Linkage to Treatment

Test and start is fully implemented in all PEPFAR supported sites resulting in a very good linkage of all positives to HIV treatment. Direct and immediate (>95 percent) linkage of clients from testing to treatment across age, sex, and risk groups is one of the thirteen requirements that will be completed by the end of FY19 implementation. In FY19Q1, linkage was 94 percent, IPs are implementing same-day initiation for all HIV positive patients. PEPFAR DRC will continue to routinely monitor linkage across age, sex and risk groups.

4.3.5 User Fees

PEPFAR DRC is working with different stakeholders to eliminate all formal and informal user fees in the public sector to improve access to direct HIV and related (ANC, TB) services which affect access to HIV testing, treatment, and prevention. In DRC, there are no user fees for HIV direct services, but there are nominal fees to enroll in the general health care system. This is of particular concern in the ANC where user fees could present barriers to PMTCT. PEPFAR DRC will continue to monitor fees, and the barriers to access for HIV services which they represent, by engaging civil society through an "Observatoire", and will ensure the information from civil society is acted upon.

UNAIDS is conducting a study on existing user fees and their impact on HIV services, while PNLS will establish a Technical Working Group to track and routinely monitor "user fees". PEPFAR DRC will participate in both these initiatives.

4.3.6 Unique Identifiers

The Global Fund is funding an activity to develop and scale up unique identifiers for patients across all sites. PEPFAR DRC will provide TA to ensure a successful process; PEPFAR is currently engaging the consultant funded by the Global Fund to undertake a situational analysis and develop a roadmap. Next steps include the rollout of unique identifiers in collaboration with government. PEPFAR/DRC will monitor plans for unique identifier implementation by developing short term milestones which show progress. We will identify policy constraints for which we can advocate, ensuring that any hurdles that need diplomatic/government attention are identified and addressed. The situational analysis is expected to be complete before the end of FY19.

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 COP19 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.

Due to the Trafficking–in-Persons (TIP) Report Tier 3 status, USAID has not been able to obligate FY18 funds to the GHSC-TA mechanism as required. This mechanism is responsible for last mile delivery of all commodities and provides technical assistance for the strengthening of the supply chain. Consequently GHSC-TA is approaching the end of its current obligation. If this situation is not resolved, last mile distribution of lifesaving commodities could be suspended as early as April 2019. Any suspension of this activity will hinder **119,374 HIV/AIDS patients** from accessing life-saving HIV treatment. A lengthy delay will also lead to significant expiry of commodities in the warehouse. This will not only waste existing PEPFAR investments, but will also compromise HIV interventions in the DRC including the transition to TLD. This situation could lead to a foreseeable and preventable humanitarian disaster in country.

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

1) Implement appropriate multi-month dispensing so that 60 percent of patients are collecting ARVs every three months, and 10 percent are collecting every six months (remainder utilizing monthly pick-ups);
2) Implement the transition to TLD as planned per WHO guidance;
3) Eliminate Nevirapine-based regimens with minimal wastage;
4) Optimize delivery of pediatric ART by implementing the new regimens per WHO guidance;
5) Support to the MOH in planning, operationalizing and monitoring the implementation of the national supply chain strategic plan;
6) Capacitate the national and provincial supply chain working groups to conduct the annual national and provincial quantification exercises to quantify HIV commodities including laboratory reagents, and to develop a related annual supply plan (provide tools, review parameters, conduct training/refresher training on the use of Forlab, pipeline and Quantimed tools);
7) Monitor stock status at the provincial and site levels and provide mentoring and coaching in stock management on a quarterly basis including regular review and necessary updates of ARV supply plan;
8) 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;
9) Support distribution to the last mile of HIV commodities, logistics, and management tools in all PEPFAR-supported health zones;
10) Implement Web Based Dashboard for Early Warning System (EWS) in all sites supported by both PEPFAR and Global Fund with the aim to enhance data visibility for informed decision making.;

11) Establish and strengthen the VL/EID lab commodities forecasting and supply chain system;
12) Provide technical assistance to health zone staff on stock management, TLD transition follow up, optimization of pediatric ARV, and rational use of HIV commodities; and
13) Provide technical assistance to the MOH for TLD pharmacovigilance data collection, analysis and use.

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 support the country initiative to scale up VL/EID testing by increasing the capacity of the laboratories in the country and providing necessary reagents and consumables to them in order to improve their ability to reach 95% VL coverage by the end of FY19 and maintain it through FY20.

Improving PNLS coordination and information sharing between PEPFAR, the Global Fund and all stakeholders regarding 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 sample processing to better follow each sample from collection at the site level to the delivery of results.

Using lessons learned from the LNZ to TLE regimen transition in 2016, PEPFAR ensured a smooth transition to TLD on April 1st, 2019. PEPFAR will continue supporting discussions on updated national guidelines, dissemination and implementation of this new regimen country-wide, 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. All PEPFAR eligible patients will be transitioned to TLD by September 30, 2019 in the three supported provinces.

Figure 4.4.1: TLD Transition Timeline

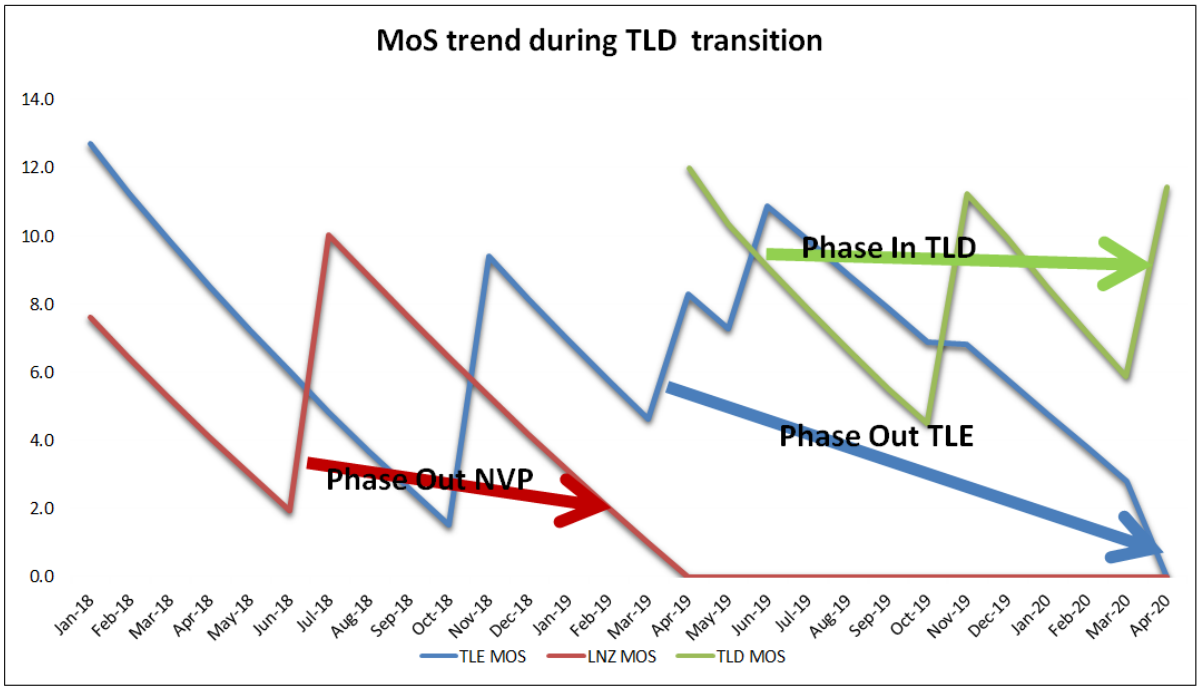


Figure 4.4.2: The official ceremony for the launch of the TLD transition was successfully held in Lubumbashi (Sendwe Hospital) on April 1, 2019

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 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, COP19 focuses on progress in implementation and ensuring resources are focused on overcoming key barriers and achieving even greater impact.

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 three years, the PEPFAR/DRC COP19 strategy emphasizes:

- Finding the people and populations we have been missing, placing 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 which are lagging behind other populations in the clinical cascade, to identify evidence-based short- and long-term solutions appropriate to reaching those populations, to implement those solutions according to standards (i.e. with fidelity), and then 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 in 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; and
    - 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 are achieving measurable outcomes related to reaching epidemic control. Reviewing and using documented outcomes from implementation of COP 18 Table 6, Sustainability Index and

Dashboard (SID) 3.0 results, and other contextual information will guide programming choices.

- 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 host-country government at all levels) into PEPFAR-funded activities and services. Early and meaningful engagement with stakeholders helps to ensure that programs are grounded in reality; stakeholders provide valuable insights that improve the impact and accountability of programs.

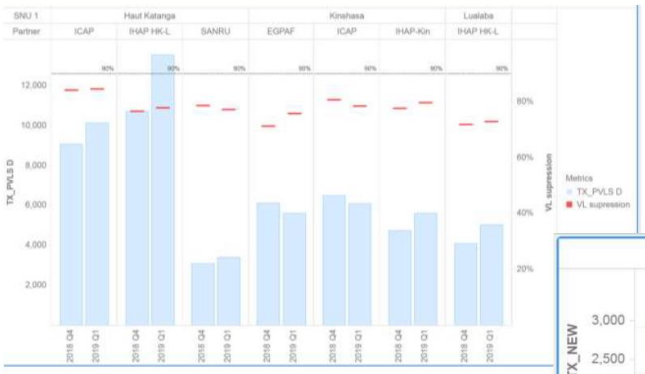
4.5.1 Partner Management for Epidemic Control

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 using, and will continue to use, complementary partner management tools, including:

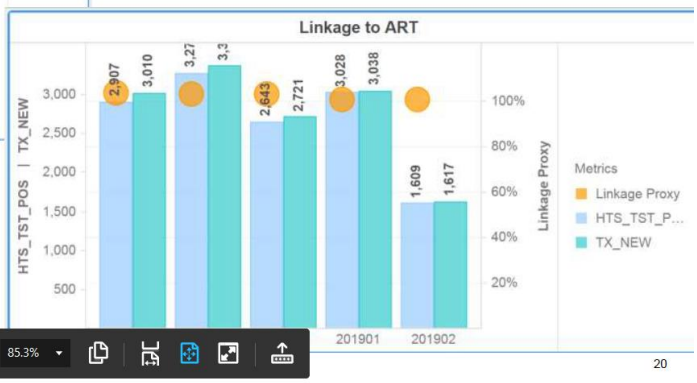
- A targeted partner management analysis tool developed in conjunction with ICPI, that focuses on key metrics at the site level;
- A Partner Management Plan that provides structure, standardized processes, defined roles and responsibilities, root-case analysis, remediation plans and monitoring of remediation plans;
- 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; and
- 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. They 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. See several examples below:

Quarterly and monthly analysis by SNU/IP

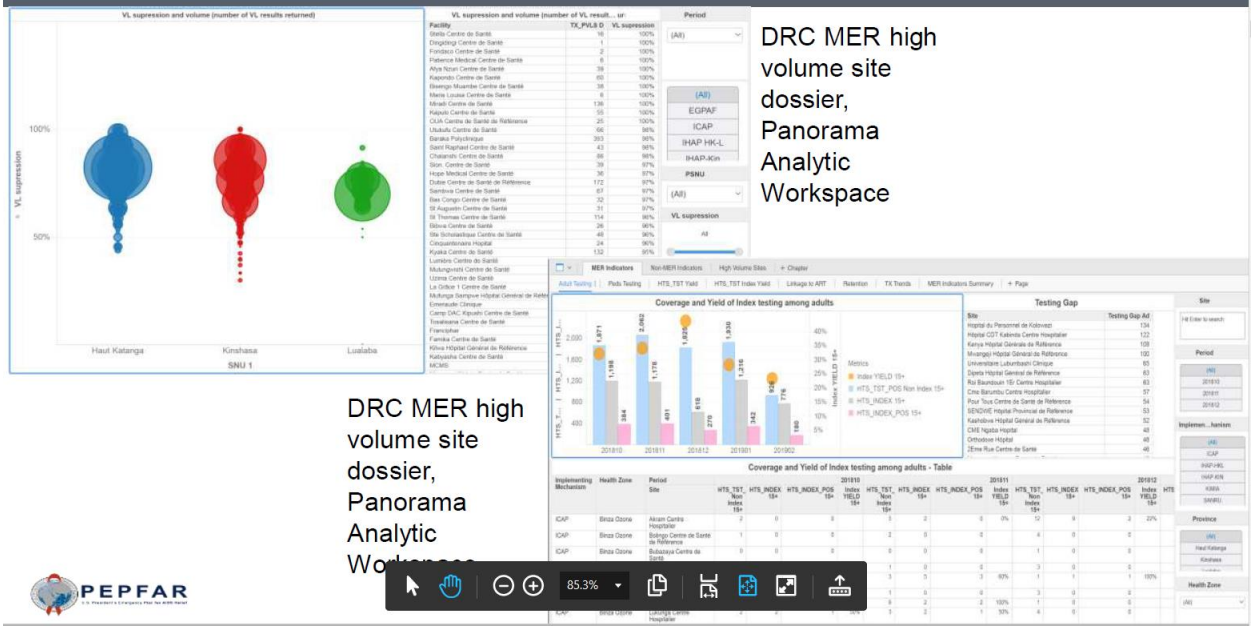


DRC MER dossier, Panorama Analytic Workspace



DRC monthly reporting dossier, Panorama Analytic Workspace

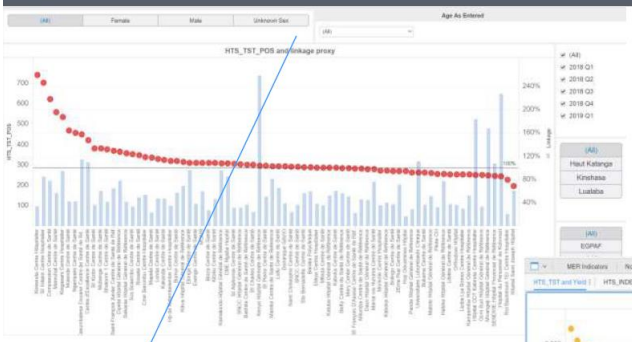
Analyze quarterly and monthly data at site level



DRC MER high volume site dossier, Panorama Analytic Workspace

DRC MER high volume site dossier, Panorama Analytic Wo

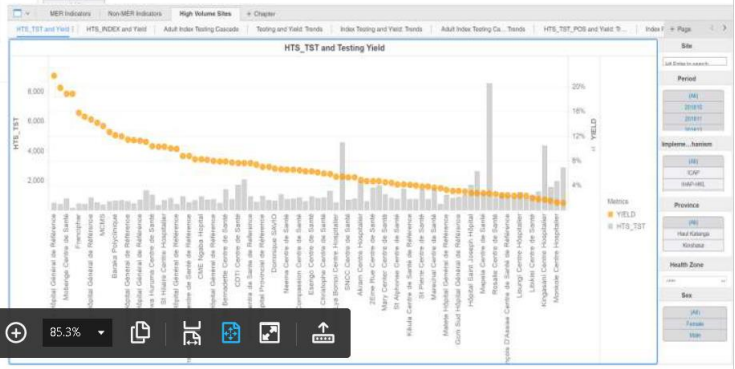
….with a focus on high volume sites



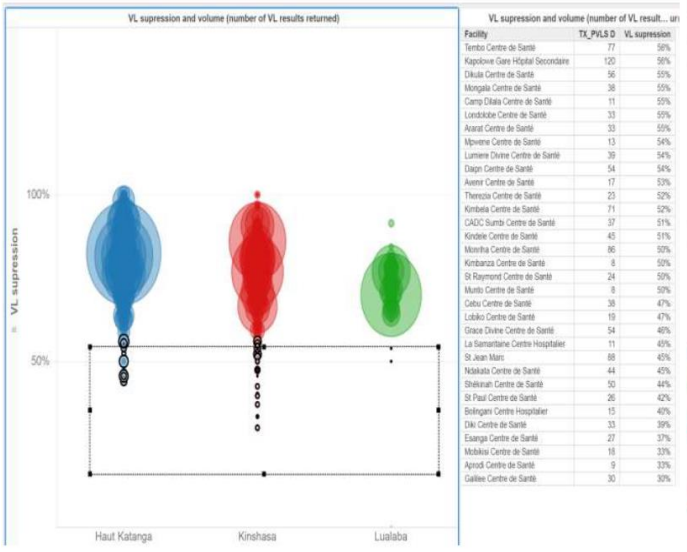
DRC MER high volume site dossier, Panorama Analytic Workspace

Can specify by age/sex groups

DRC monthly reporting dossier, Panorama Analytic Workspace



Communication and meetings with IP to discuss underperforming sites



Facility	TX_PVLS D	VL supression
Tembo Centre de Santé	77	58%
Kapolowe Gare Hôpital Secondaire	120	58%
Dikula Centre de Santé	56	55%
Mongala Centre de Santé	38	55%
Camp Dilala Centre de Santé	11	55%
Londolobe Centre de Santé	33	55%
Ararat Centre de Santé	33	55%
Mpwene Centre de Santé	13	54%
Lumiere Divine Centre de Santé	39	54%
Daign Centre de Santé	54	54%
Avenir Centre de Santé	17	53%
Thereza Centre de Santé	23	52%
Kimbela Centre de Santé	71	52%
CADC Sumbi Centre de Santé	37	51%
Kindele Centre de Santé	45	51%
Monitha Centre de Santé	86	50%
Kimbanza Centre de Santé	8	50%
St Raymond Centre de Santé	24	50%
Munto Centre de Santé	8	50%
Cebu Centre de Santé	38	47%
Lobiko Centre de Santé	19	47%
Grace Divine Centre de Santé	54	46%
Le Samaritaine Centre Hospitalier	11	45%
St Jean Marc	88	45%
Ndakata Centre de Santé	44	45%
Shekinah Centre de Santé	50	44%
St Paul Centre de Santé	26	42%
Bolingani Centre Hospitalier	15	40%
Diki Centre de Santé	33	39%
Esanga Centre de Santé	27	37%
Mobikisi Centre de Santé	18	33%
Aprodi Centre de Santé	9	33%
Galilee Centre de Santé	30	30%

Performance Gap Documentation

Partner: ICAP | **MER: X SIMS:**

Date: 8/30/2018 | **Results Quarter/FY: Q3/FY18** | **CDC responsible: Henri Longuma**

Performance Gap Statement:

For MER:

- Low Proxy retention rate affecting the both ICAP Provinces with more than 36 sites under 90% comparing to the threshold
  Men are more affected
  Instable Retention trend with yoyo
- 86 sites with low VL suppression(attached list)
- SIMS data: NA

Program Area: Retention & VL | **Problem Level:** 2 ☐ X 3 ☐

Problem overview:

The highlighted are the high volume site witch contribute more in our cohort.

Facility	Retention	TX_NEW	TX_NET_NEW	LTFU
Paul Medical Center CM	0%	1	0	(1)
Aux Bons Soins CH	33%	3	1	(2)
Kaboka HGR	39%	18	7	(11)
Mfinda	42%	19	8	(11)
Etonga	45%	20	9	(11)
OUA	50%	2	1	(1)
St Raymond - Nsele	50%	2	1	(1)
VIRGINIKA	50%	2	1	(1)
SNCC - Lubumbashi HGR	52%	23	12	(11)
Diwn Messe	60%	5	3	(2)
Le Rocher CS	67%	3	2	(1)
MLK POLYCLINIQUE	67%	3	2	(1)
PACIFIQUE	67%	3	2	(1)
Esengo - Masina1 CS	73%	30	22	(8)
St Jean (Kisameno) CSR	75%	8	6	(2)
Radem CH	78%	9	7	(2)
Emeraude - Nsele CS	80%	5	4	(1)
Methodiste - Nsele CS	80%	5	4	(1)
Sloe - Ozone CM	80%	5	4	(1)

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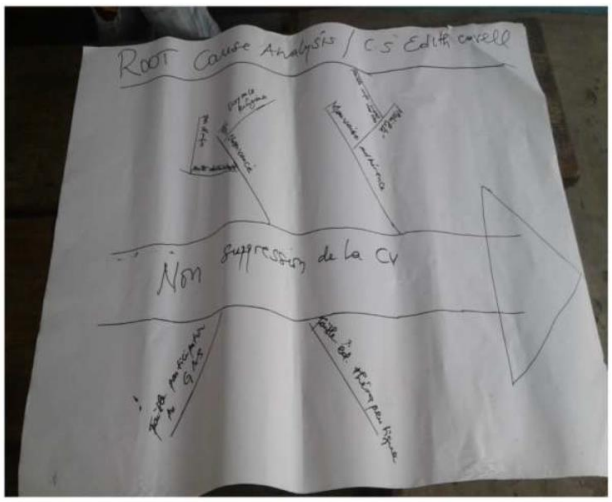
IP prepares a root cause analysis and remediation plan



Submission Date: 24/09/2018 IP Staff Responsible: Désiré BAYOKA
Validation Date: CDC Staff Responsible: Francois Kitenge

Root cause(s) *Describe in 2-3 sentences – 1 cause per box*	**Action steps** *Describe the action step(s) – 1 activity per row*	**Process indicators** *Method of Measurement*	**Due Date** *For activity implementation*	**Process Indicator Results** *At designated due date*	**Comments**
Mauvaise adhérence et observance du TARV de certains patients	Identifier précocement les patients non adherents pour un counseling individualisé du TARV	Nombre de patients identifiés	03/10/2018	Tous les patients non adherents sont identifies et suivis	

PEPFAR

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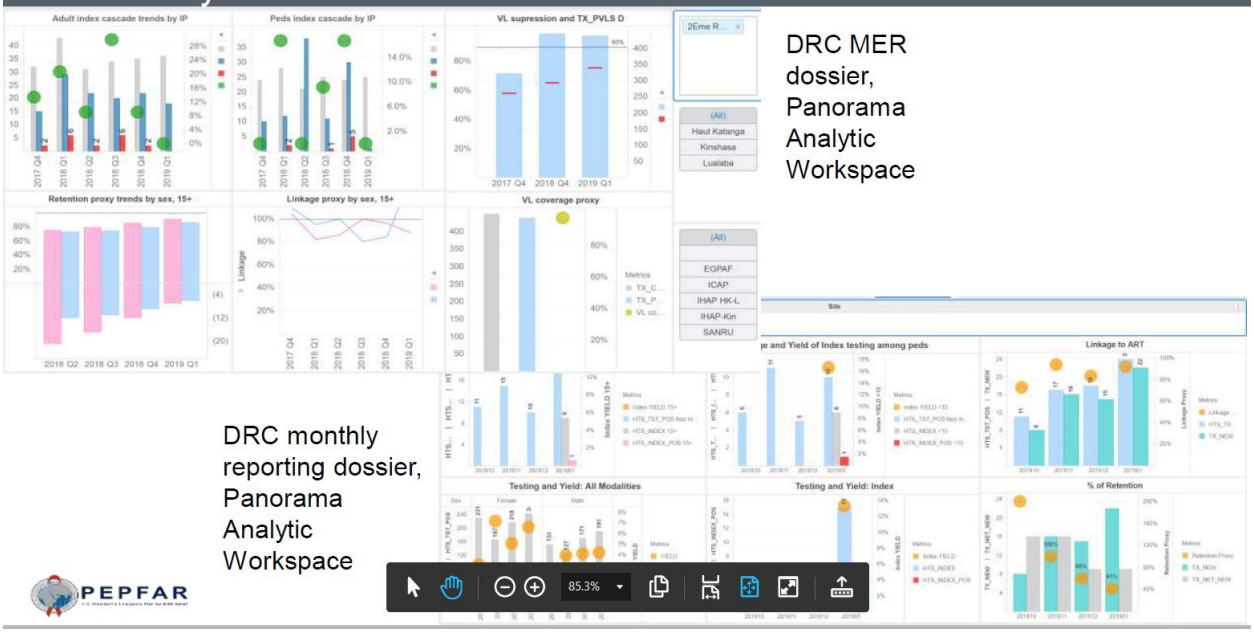
Follow up site visits for underperforming sites and high volume sites—informed by site dashboards



DRC MER dossier, Panorama Analytic Workspace

DRC monthly reporting dossier, Panorama Analytic Workspace

PEPFAR

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).

PEPFAR DRC has reviewed the Epidemic Control Solution Platform and is incorporating relevant applications into our programming. Evidence-based solutions such as adolescent support groups (Ariel Clubs), peer navigators and community ART dispensing models will continue to be scaled-up during COP19.

4.6 Targets for scale-up locations and populations

This section presents a summary of FY20 targets.

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 FY20) *HTS_TST*	Newly Identified Positive (APR FY20) *HTS_TST_POS*	Newly Initiated on ART (APR FY20) *TX_NEW*
Total Men (>15)	215,265	17,504	16,765
Total Women (>15)	552,072	30,739	29,224
Total Children (<15)	182,277	4,508	4,463
Adults	**767,337**	**48,243**	**45,989**
TB Patients	22,664	1,141	1,141
Pregnant Women	250,908	2,481	2,395
VMMC clients	-	-	-
Key populations	30,236	2,267	2,144
Priority Populations			
Other Testing	463,529	42,354	40,309
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)	**182,277**	**4,508**	**4,463**
HIV Exposed Infants	3,225	132	132
Other pediatric testing	179,052	4,376	4,331
Previously diagnosed and/or in care	-	-	-

Table 4.6.2 VMMC Coverage is non-applicable to DRC.

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 FY20)**	**FY20 Target**
Key Populations			
MSM	Unknown	Unknown	**4,375**
FSW	Unknown	Unknown	**29,745**
Priority Population			
Military	Unknown	Unknown	**59,418**
AGYW	Unknown	Unknown	**2,105**
Truckers	Unknown	Unknown	**2,341**
Miners	Unknown	Unknown	**2,648**
Clients of FSW	Unknown	Unknown	**980**
TOTAL			**101,612**

Table 4.6.4 below presents FY20 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 (F20Target) OVC_SERV*	*Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC**
Military DRC	*8,136*	*2,482*	*2,150*
Bandalungwa	*4,778*	*504*	*432*
Dilala	*2,749*	*1,088*	*936*
Kamalondo	*1,572*	*887*	*763*
Kambove	*2,893*	*230*	*196*
Kampemba	*9,937*	*2,457*	*2,113*
Kasenga	*3,539*	*744*	*638*
Katuba	*6,055*	*892*	*767*
Kenya	*6,557*	*2,839*	*2,442*
Kikimi	*6,758*	*1,880*	*1,616*
Kikula	*5,507*	*564*	*484*
Kimbanseke	*7,395*	*1,485*	*1,277*
Kingabwa	*5,512*	*1,935*	*1,664*
Kingasani	*5,825*	*2,100*	*1,805*
Kinshasa	*4,400*	*778*	*668*
Kipushi	*5,053*	*1,190*	*1,022*
Kisanga	*5,836*	*1,788*	*1,537*
Likasi	*3,340*	*820*	*706*
Limete	*4,936*	*880*	*758*
Lingwala	*2,262*	*367*	*315*
Lubumbashi	*4,460*	*1,,716*	*1,475*
Manika	*1,192*	*1,110*	*954*
Masina 1	*6,703*	*1,936*	*1,665*
Masina 2	*7,253*	*3,825*	*3,289*
Matete	*7,582*	*542*	*466*
Mont-Ngafula 1	*6,489*	*244*	*210*
Mumbunda	*6,585*	*1,193*	*1,026*
Ndjili	*8,467*	*3,299*	*2,837*
Ngaba	*4,784*	*744*	*638*
Nsele	*4,647*	*1,042*	*894*
Rwashi	*6,232*	*1,779*	*1,529*
Tshamilemba	*5,367*	*1192*	*1,025*
TOTAL	***188,532***	***44,532***	***38,297***

4.8 Viral Load and Early Infant Diagnosis Optimization

PEPFAR/DRC is not reaching a sufficient number of children or pregnant and breastfeeding woman with VL and EID services to attain epidemic control. An initial phase of multi-stakeholder

Genexpert use at site level for TB, EID and VL is ongoing. This phase is to determine how laboratory technicians at site level will manage the use of this equipment with TB, EID and VL specimens. PEPFAR DRC is mapping Genexpert machines, conventional EID/VL platforms, and high volume sites that have maternity services in which coverage and suppression in children and pregnant and breastfeeding woman is not optimal, in order to strategically utilize Genexpert machines in these facilities. In this way, PEPFAR/DRC will optimize the use of Genexpert to improve VL and EID uptake.

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". COP19 implementation will focus on achieving saturation across all age and sex bands in all PEPFAR-supported areas. We will continue performing site level analyses to focus programmatic development and problem solving and make sure the focus of programs is at patient and site levels (for example, analyze whether unsuppressed patients are being changed to second line appropriately or not). The PEPFAR team has set up a Monday Morning Check list detailing specific priorities to be addressed within a defined timeline with clear monitoring and evaluation plans.

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. Program data shows that PEPFAR/DRC primarily misses men aged 25-45, children, and KP. 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 periodic suboptimal functionality of molecular laboratories with occasional shortage in reagents contributed to this reduced access to timely 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 in KPs.

Table 6 investments with site-level approaches synergistically address COP19 strategic priorities. Within the context of a domestically under-funded health sector, key systems interventions tackle 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.

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 Global Fund will purchase an additional six VL machines and PEPFAR will enter into rental agreements for one additional VL machine for Lualaba. This will help increase national VL coverage (currently less than 20 percent), and specifically, coverage in PEPFAR-supported zones (currently at 61 percent of eligible patients). As the supply chain mechanism concurrently strengthens the 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 100 percent VL coverage in the PEPFAR zones. PEPFAR/DRC continues to support the MSF-owned molecular lab for increasing VL coverage. PEPFAR/DRC also quantified the unutilized capacity of existing laboratories and proposed practical optimization options to relevant stakeholders (MSF, Global Fund, TB program, DREAMS lab and PNLS).

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

PEPFAR/DRC continues to work with the Global Fund and the 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 the Global Fund, including size estimation studies for KP, IBBS protocol development for KP, and ANC surveillance.

Drawing from lessons learned from the "Observatoire", a Global Funded-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 COP19, 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 COP19. 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 levels of effort to implement the strategy outlined in COP19. New positions to support the increase of direct funding to local partners are proposed in COP19.

To align human resources with the strategic focus in Haut-Katanga and Lualaba, PEPFAR/DRC agreed to place a provincial team in Lubumbashi. This team was to 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 COP16 and initially budgeted for. Due to unavoidable delays, and in an effort to keep pipeline to a minimum, these positions were not budgeted in COP 18 or 19. Therefore, the team has not budgeted for the four (5) positions, required to effectively and efficiently implement and monitor program in Haut Katanga.

Recently the DOD has made progress on the construction of the Lubumbashi office and we may be in a position to recruit by the end of FY19. If necessary, CDC will seek additional COP19 funds to hire and fill the four (4) Locally Employed Staff (LES) vacant positions in Lubumbashi. Given this delay, USAID will explore the possibility of embedding technical personnel in implementing partners' offices, and/or local Ministry facilities as this on-the-ground presence will be key to build both the institutional and technical capacity that local partners will need to implement HIV programming using USG standards.

Current vacancies:

- USAID: HIV Team Leader, Pharmacist, SI Advisor; (new in COP19) SIMS Specialist, SI Specialist (additional FTEs added in JHB) 2 A&A Specialists, 1 FMO specialist, 1 Program Assistant, 1 KP Specialist, 1 Supply Chain Specialist, 2 M&E Specialists, 2 Care and Treatment Specialists, 1 voucher examiner/budget analyst, 1 OVC technical specialist
- Department of State: PEPFAR Deputy Coordinator, PEPFAR Interagency Strategic Information Advisor, and the Administration/Finance Officer. All three of these are critical positions
- DOD: Fully staffed
- CDC: Kinshasa is fully staffed

Intensifying partner management remains a focus of COP19, 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 COP19 cost of doing business (CODB) request represents the minimal staffing and administrative support.

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	Saturation	APR 17	56%		46%	24%	92%	50%	53%	32%	NA	NA	NA	NA	NA	NA	NA	NA	51%	46%
	COP17	Saturation	APR 18	43%		72%	32%	99%	33%	75%	NA	92%	43%	81%	45%	75%	49%	63%	54%	60%	60%
	COP18	Saturation	APR 19	72%		80%	39%	154%	76%	60%	NA	86%	143%	69%	108%	64%	98%	41%	60%	71%	67%
Kinshasa	COP16	Saturation	APR 17	29%		15%	12%	18%	6%	21%	10%	NA	NA	NA	NA	NA	NA	NA	NA	25%	24%
	COP17	Saturation	APR 18	20%		24%	19%	26%	12%	30%	NA	27%	12%	27%	12%	30%	14%	33%	23%	36%	36%
	COP18	Saturation	APR 19	39%		26%	19%	34%	11%	25%	NA	38%	61%	29%	45%	26%	41%	16%	25%	41%	41%
Lualaba	COP16	Saturation	APR 17	110%		115%	33%	160%	65%	98%	127%	NA	NA	NA	NA	NA	NA	NA	NA	91%	127%
	COP17	Saturation	APR 18	89%		186%	56%	288%	67%	155%	NA	211%	165%	178%	213%	139%	200%	127%	214%	112%	204%
	COP18	Saturation	APR 19	207%		303%	78%	443%	155%	169%	NA	279%	872%	195%	642%	174%	523%	109%	281%	187%	259%

Table A.2

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY 19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR20)**
Attained						
Scale-Up Saturation (does not include military)	202,401	112,343	49,578	149,869	47,493	74%
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	202,401	112,343	49,578	149,869	47,493	74%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Approach and Program Area

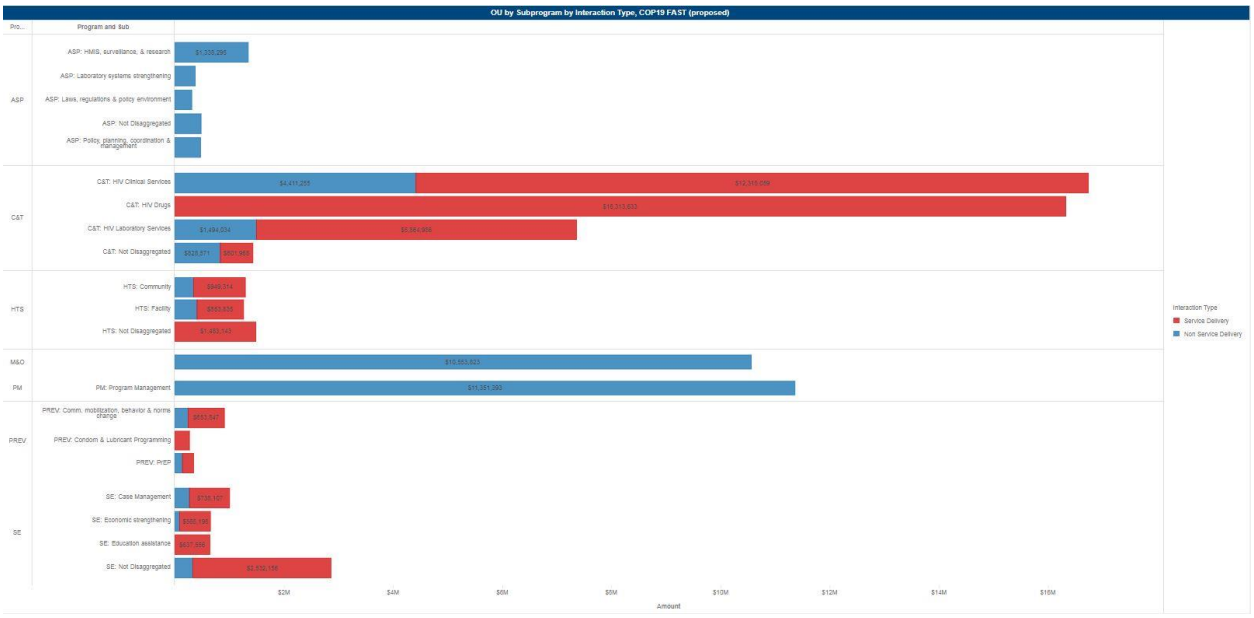


Table B.1.2 COP 19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$8,933,150	**$ 69,070,301**	**$ 78,003,451**

*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	**Amount Allocated**
APPLIED PIPELINE	$8,933,150
HBHC	$5,060,050
HKID	$5,736,535
HLAB	$780,502
HMBL	$6,001
HMIN	$15,133
HTXD	$21,884,543
HTXS	$11,436,386
HVAB	$321,340
HVCT	$6,166,308
HVMS	$4,204,757
HVOP	$2,322,938
HVSI	$1,632,780
HVTB	$2,515,581
IDUP	$0
MTCT	$1,801,339
OHSS	$835,322
PDCS	$1,920,823
PDTX	$2,429,968

*Data included in Table B.1.3 should match FACTS Info records, and can be double-checked by running the "Summary of Planned Funding by Budget Code" report

B.2 Resource Projections

Resource Projection

Per COP19 guidance, the DRC team used a program-based, incremental budgeting approach (Funding Allocation to Strategy Tool - FAST) to develop the COP19 budgets. This was done by reviewing implementing mechanisms, searching for management efficiencies, and reductions in operating costs. This inter-agency consultation considered inputs from the following sources of information:

1) 2017 PEPFAR Expenditure Reporting (ER) data, partner financial data and estimates, pipeline and outlay review;
2) 2017 partner performance for C&T mechanisms and COP19 targets;
3) Base funding from COP18 (level of funding) complemented by critical review of work plans and interventions in consultation with implementing partners to account for the COP19 strategy across beneficiary, population and geographic areas;
4) Flat line budgeting based with no major shifts in geographic prioritization and no major strategic shifts except for scaling-up for priority interventions: index-testing, retention and

Viral Load suppression in general population and targeted beneficiaries (Pediatrics, adolescents, OVC and KP);

5) Implementing Partner performance reports to refine lessons learned, identify innovations and best practices to replicate/scale-up, and strategies to de-emphasize; doing more with less money to reflect implementation with fidelity;
6) Policy Changes: Budget shifts have been made to reflect investment to address programmatic shifts and policy approvals (support implementation of self-testing, PrEP, ambitious TPT targets, scale-up of index-testing and recency testing);
7) New initiative guidance such as for Performance Initiative Funds apportioned between best performing C&T mechanisms reaching 25% achievement of FY19 annual targets in Q1 and robust supply chain with focus on the TB/HIV program and the availability of ARVs in compliance with an optimized pediatric regimen and TLD; and
8) The mandate from headquarters to increase the percentage of the PEPFAR DRC budget that is directly awarded to indigenous organizations and institutions as "prime" awardees.

The next step was allocating commodity and the M&O budgets ensuring that required earmarks were met. We note that Commodities account for 34% of the entire budget.

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups (required in COP16): Test and start is implemented at scale. During COP18 and 19, we continue to monitor same-day initiation.

2. Adoption and implementation of differentiated service delivery models, including six-month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents (required in COP16): Multi-month scripting is approved for six months with three-month dispensing. During COP19, we will move to six months dispensing. Of the COP19 TLD orders, 10 percent is TLD 50 mg, 180 Tab.

3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of Nevirapine-based regimens (required in COP18): The circular to use TLD starting 1st April has been released on 15th March. Stock are in hand in country and trainings are ongoing. Transition to TLD including women of childbearing potential will be completed by September 30, 2019.

4. Scale up of index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established (required in COP18): As of FY19Q1, all facilities are conducting index testing with >20 percent yield in community and facility testing in adults; self-testing also continues to scale up. We expect a ten-fold increase of HTS_SELF from FY19Q1 (403) by the end of COP19 (5000). Contribution of index testing to pool of positives expected to be 30 percent at least by September 2019 and 35 percent in COP19.

5. TB preventive treatment (TPT) for all PLHIV must be scaled-up as an integral and routine part of the HIV clinical care package (required in COP18): Supplies are available and staff are trained. The expectation is that we reach, at a minimum, 50 percent of eligible PLHIV completing a course of TPT by September 2020. But with aggressive targets and robust supply chain planning we aim to exceed this PLL target.

6. Direct and immediate (>95 percent) linkage of clients from testing to treatment across age, sex, and risk groups: In FY19Q1, linkage was 94 percent. All efforts are put in place to maintain 95 percent across all ages, sex and risk groups.

7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC, TB, and routine clinical services, affecting access to HIV testing and treatment and prevention (required in COP17 and COP18): There are no user fees for direct HIV services but rather there are minimal fees to enroll in the general health care system. We continue to monitor fees, quality, and barriers to access for HIV services through the civil society HIV "observatoire" and the "user fees" Technical Working Group established by the PNLS. An ongoing study from UNAIDS will also inform on existing user fees and their impact.

8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including >80 percent access to annual viral load testing and reporting: VL capacity increased with two new laboratories in FY19Q1 in Kinshasa. This capacity will reach full expansion as we scale up access to POC for EID and possibly VL for pregnant and breastfeeding women and as we add a new laboratory in Lualaba in FY19Q3.

9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity (required in COP18): Data collection improved to better report on patient outcomes (TX_ML). DRC will continue to leverage on ongoing investments to have a national individual data system linked to a strengthened HIV tracking system for LTFU outcomes (data repository/warehouse.)

10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management (required in COP17 and COP18): Rebalanced targets with focus on 9-14 age bracket. We continue to assess OVC with unknown status to ensure all

at-risk OVC receive HIV testing and all HIV+ OVC are on ART. During COP18, we prioritize graduation of older OVC to ensure enrolment in the prioritized 0-17 age range and for COP19, we will focus on 9-14 girls age bracket for prevention activities.

11. Evidence of resource commitments by host governments with year after year increases (required in COP14): The GDRC acknowledges the need to increase domestic resource mobilization for HIV. The new DRC leadership has expressed a focus on increasing health funding especially universal primary health care coverage. This dialogue will continue as we ensure adequate health budgeting and disbursement. As part of this dialogue, we continue also to advocate for DRC government to meet the counterpart financing required for Global Fund grants.

12. Clear evidence of agency progress toward local, indigenous partner prime funding (required in COP18): Each agency continue to work towards this global goal. New funding opportunities are planned accordingly. In COP19, between 19 and 40 percent of funds will be to local/indigenous partners.

13. Scale up of unique identifiers for patients across all sites: We are engaging with the consultant funded by the Global Fund to do a situational analysis and roadmap. The consultancy will define next steps in the roll-out of unique identifier code.

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNAIDS JOINT UNITED	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 88,295.00	HMIS systems	Lack of unique identifier for PLHIV to ensure their optimal tracing	COP18	COP20	25% PLHIV with an UIC across the 3 PEPFAR provinces
HHS/CDC	Family Health International	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 350,000.00	HMIS systems	Lack of reliable data at the national level	COP18	COP19	85% national sites with Tier.Net onboarded and active in the national data warehouse. Routine quarterly system established and producing quality monitoring and program monitoring reports.
HHS/CDC	Family Health Internatio	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 200,000.00	Program and data quality management	Lack of reliable data at the national level	COP17	COP19	100% of PEPFAR supported HZ have routine DQA activities taken to scale at high volume sites
HHS/CDC	Family Health International	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 100,000.00	HMIS systems	Lack of reliable data at the national level	COP18	COP19	98% completenes of HIV data in DHIS2 in PEPFAR HZ. HIV-focused DHIS2 dashboards developed, produced and used for informed decision making. DHIS2 is used for routine data reviews at HZ-level in all PEPFAR-supported HZ. Routine biannual epi bulletins are produced using DHIS2
HHS/CDC	Global Health Systems	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 60,000.00	Lab quality improvement and assurance	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely	COP16	COP20	100% of testing point enrolled in the national PT program. 95% of enrolled testing points achieve passing scores.
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 20,000.00	Lab policy, budgets, and strategic plans	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP17	COP20	<21 days TAT for VL and EID specimens
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 50,000.00	Training in laboratory systems strengthening	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP17	COP20	80% of MoH laboratory and testing point staff trained, mentored or provided TA in RTCQI in PEPFAR-support provinces.
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 50,000.00	Lab policy, budgets, and strategic plans	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP17	COP20	VL management system is fully implemented in 7 molecular labs and 6 high volume sites

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 25,000.00	Training in laboratory systems strengthening	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP19	COP20	90% of patients eligible for VL and EID receive testing
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 90,000.00	Lab quality improvement and assurance	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP16	COP18	80% of molecular conventional lab equipments covered by a maintenance contract
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 5,000.00	Lab quality improvement and assurance	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP17	COP20	100% of molecular labs implemented VL scorecard
HHS/CDC	Global Health Systems Solutio ns	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 75,000.00	Lab accreditation	Suboptimal lab quality assurance and continuous quality improvement (CQI) initiatives to assure accurate and timely HIV-related tests, including VL/EID for diagnosis and monitoring epidemic control	COP16	COP20	7 molecular labs enrolled, 6 audited; one accredited
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ -	Forecasting, supply chain plan, budget, and implementation	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP19	Custom clereance time reduced to 1 month
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 40,000.00	Product selection, registration, and quality monitoring	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP19	Early warning system against stock-out risk used by national stakeholders for decision making in PEPFAR-supported provinces
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 80,000.00	Forecasting, supply chain plan, budget, and implementation	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP19	Minimal stock out and expiration of core HIV commodities at warehouse and at HZ levels
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 80,000.00	Training in supply chain systems	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP19	100% of adults and peds are receiving on optimized ARV regimens in all DRC HZs implementing HIV programs
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 150,000.00	Product selection, registration, and quality monitoring	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP19	100% 0f HZs are reporting on TLD side effects/intolerance and corrective actions are taken
USAID	Chemonics Internatio nal, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 80,000.00	Product selection, registration, and quality monitoring	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP20	PPMR HIV data from 95% of HZs are collected on time, analysed, and used for decision making

Table 6-E (Entry of Above Site Programs Activities)								
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
State/AF	DEPARTMENT OF STATE	ASP: Laws, regulations & policy environment	Key Pops: Not disaggregated	$ 54,756.00	Information and sensitization for public and government officials	Socio-culturel barriers including stigma and discrimination for KP and PLHIV	COP18	COP19	Stigma index 2019 results
State/AF	DEPARTMENT OF STATE	ASP: Laws, regulations & policy environment	Non-Targeted Pop: Not disaggregated	$ 229,961.00	Information and sensitization for public and government officials	Socio-culturel barriers including stigma and discrimination for KP and PLHIV	COP18	COP19	Stigma index 2019 results
HHS/CDC	Trustees Of Columbia University In The City	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 200,000.00	Clinical guidelines, policies for service delivery	Need for updated guidelines and tools to support implementation of updated programmatic initiatives including evolving MMP/TLD, pediatric regimen optimization, and TB prevention	COP18	COP19	Updated national policies implemented at site levels
State/AF	DEPARTMENT OF STATE	ASP: Laws, regulations & policy environment	Non-Targeted Pop: Children	$ 27,362.00	Clinical guidelines, policies for service delivery	Need for updated guidelines and tools to support implementation of updated programmatic initiatives including evolving MMP/TLD, pediatric regimen optimization, and TB prevention	COP18	COP19	Updated national policies implemented at site levels
HHS/CDC	Family Health International	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 271,000.00	HMIS systems	Lack of reliable data at the national level	COP19	COP19	98% completenes of HIV data in DHIS2 in PEPFAR HZ. HIV-focused DHIS2 dashboards developed, produced and used for informed decision making. DHIS2 is used for routine data reviews at HZ-level in all PEPFAR-supported HZ. Routine biannual epi bulletins are produced using DHIS2