

Democratic Republic of the Congo
Country Operational Plan
(COP) 2020

Strategic Direction Summary

March 9th, 2020



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, 2020 through September 30, 2021 (COP 2020) will continue the programmatic priorities implemented in COP 2019, including strategically expanding and strengthening client-centered activities to attain epidemic control in Haut-Katanga and Lualaba, and focusing interventions in Kinshasa.

PEPFAR/DRC has continued to make steady progress and has shown strong results in Haut-Katanga and Lualaba. Given this success, epidemic control now appears within reach, and additional resources and effort will be focused on these two provinces during COP20. 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 and children. 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. PEPFAR will add select sites in five neighboring health zones in the two provinces to improve retention by bringing client centered services closer to the patients.

COP20 Strategies for Epidemic Control

- Strengthen efforts on case finding among adult men
- Strengthen pediatric case finding
- Improve viral load testing coverage gap and suppression
- Complete ART optimization for children
- Ensure patients remain on continuous ART

Current figures put the total number of PLHIV in PEPFAR-supported health zones at 252,796. Through consultations with the government of DRC and civil society, achievable targets have been set for COP20, which will produce an additional 47,119 people on treatment, leading to approximately 79 percent of PLHIV receiving antiretroviral treatment (ART) by September 2021. Intensive and zone-specific strategies scaled-up in COP19, 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 2021. One of the main challenges to epidemic control is identifying HIV positive individuals (1st 95). The testing strategies scaled in COP19 used to bolster the yield will continue in COP20, a critical step to ensuring adequate case finding and optimal linkage to treatment. COP20 will refine those strategies and concentrate efforts on finding men and children.

In order to optimize the 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 KPs, including men who have sex with men (MSM)—who are in need of frequent retesting;
- G. Ensure youth, male, and KP-friendly and hospitable services at facilities attract and retain clients, ensuring that all these services contribute to finding HIV positive men;
- H. Ensure scale-up of same-day, or at minimum, same-week treatment initiation in all PEPFAR-supported sites;
- I. Maintain the high coverage of HIV screening and antiretroviral therapy (ART) initiation among TB patients and strengthen TB screening for PLHIV;
- J. Maximize multi-month dispensing so that 50 percent of patients including children receive three-month ARV supplies, and 50 percent receive six-month ARV supplies;
- K. Optimize pediatric ART by implementing the new first-line regimen;
- L. Maintain continuous quality improvement and best practices at both facility and community levels to address and improve services to ensure patients' needs are met; and

PEPFAR DRC will take a client-centered approach to HIV programming (e.g., case finding, prevention, care, supply chain modernization, and quality measures) to meet patients where they are with what they need. Key client-centered policies and practices at the site level include existing policies for optimized treatment and multi-month dispensing (MMD), convenient ARV pick up arrangements, and community and client participation in design and evaluation of services. 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 encourage adherence through support groups and treatment clubs. PEPFAR DRC will also focus on tracking and reminder systems to identify clients due for viral load (VL) appointments and to achieve viral suppression among all age and sex groups.

Throughout FY20 and FY21, PEPFAR/DRC will continue to refine and intensify previously implemented partner management strategies. 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 improve low performing sites. At every site, partners will continuously assist providers with clinical cascade analysis. Monthly partner performance consultations will continue to 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 505,707 people living with HIV out of an estimated population of 106 million (calculated based on UNAIDS estimates [version 5.86]). 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 (268,896 female PLHIV v. 97,979 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 5.4 percent in Kinshasa, 7.4 percent in Lualaba and 4.6 percent in Katanga (IBBS 2018-2019). 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 weak human and institutional capacity, 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	106,981,656	100	24,279,851	23%	24,706,524	23%	10,150,800	9%	10,212,447	10%	18,951,731	18%	18,680,306	17%	DHIS2 SPECTRUM 2020 Version 5.86
HIV Prevalence (%) 15-49		1.2		NA		NA		1.00%		0.80%		2.20%		1.50%	DHS 2013-2014 Report
AIDS Deaths (per year)	14,023		1,556		1,557		511		481		2,172		1,364		SPECTRUM 2020 Version 5.86
# PLHIV	505,707		35,042		36,094		45,543		22,153		268,896		97,979		SPECTRUM 2020 Version 5.86
Incidence Rate (Y _t)		0.20%		0.95%		0.25%		0.05%		0.01%		0.20%		0.07%	SPECTRUM 2020 Version 5.86
New Infections (Y _t)	20303														SPECTRUM 2020 Version 5.86
Annual births	3,628,106	4%													SPECTRUM 2020 Version 5.86
% of Pregnant Women with at least one ANC visit	2,380,400	81%													SPECTRUM 2020 Version 5.86
Pregnant women needing ARVs	28,818		N/A		N/A		N/A		N/A		N/A		N/A		SPECTRUM 2020 Version 5.86
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 (Y _t)	5 965	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	2019 Global TB report
% of TB cases that are HIV infected	22,876	1%													SPECTRUM 2020 Version 5.86

% of Males Circumcised	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	7.7%					NA	NA			NA	NA			BSS 2019
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 95-95-95 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 pop.	106,981,656	1.2%	505,707	NA	285,303	56.4%	74%	5,086,282	83,444	70,172
Pop. <15 years	48,986,375	0.1%	71,136	NA	17,465	28%	NA	NA	NA	17,465
Men 15-24 years	10,212,447	0.2%	21,153	NA	NA	NA	NA	NA	NA	NA
Men 25+ years	18,680,306	0.5%	97,979	NA	NA	NA	NA	NA	NA	NA
Women 15-24 years	10,150,800	0.4%	45,543	NA	NA	NA	NA	NA	NA	NA
Women 25+ years	18,951,731	1.4%	268,896	NA	NA	NA	NA	NA	NA	NA
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	NA	7.7%	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

* SPECTRUM 2020 Version 5.86

* SPECTRUM 2020 Version 5.86

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

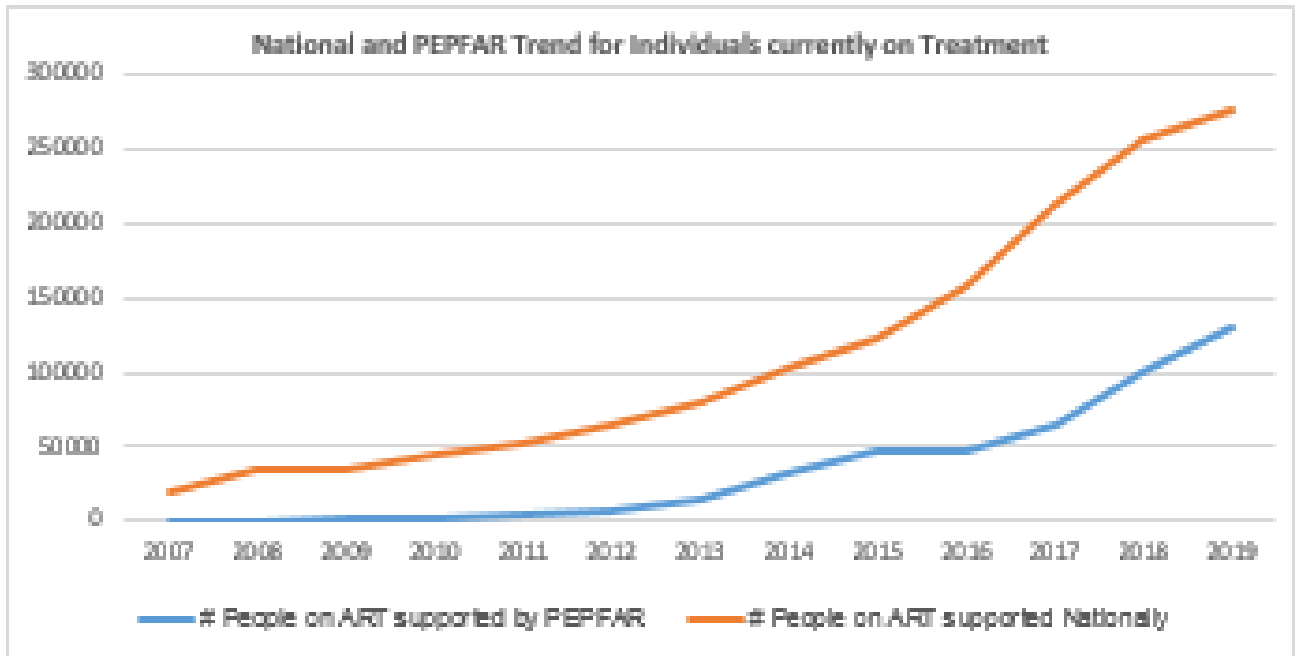


Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV

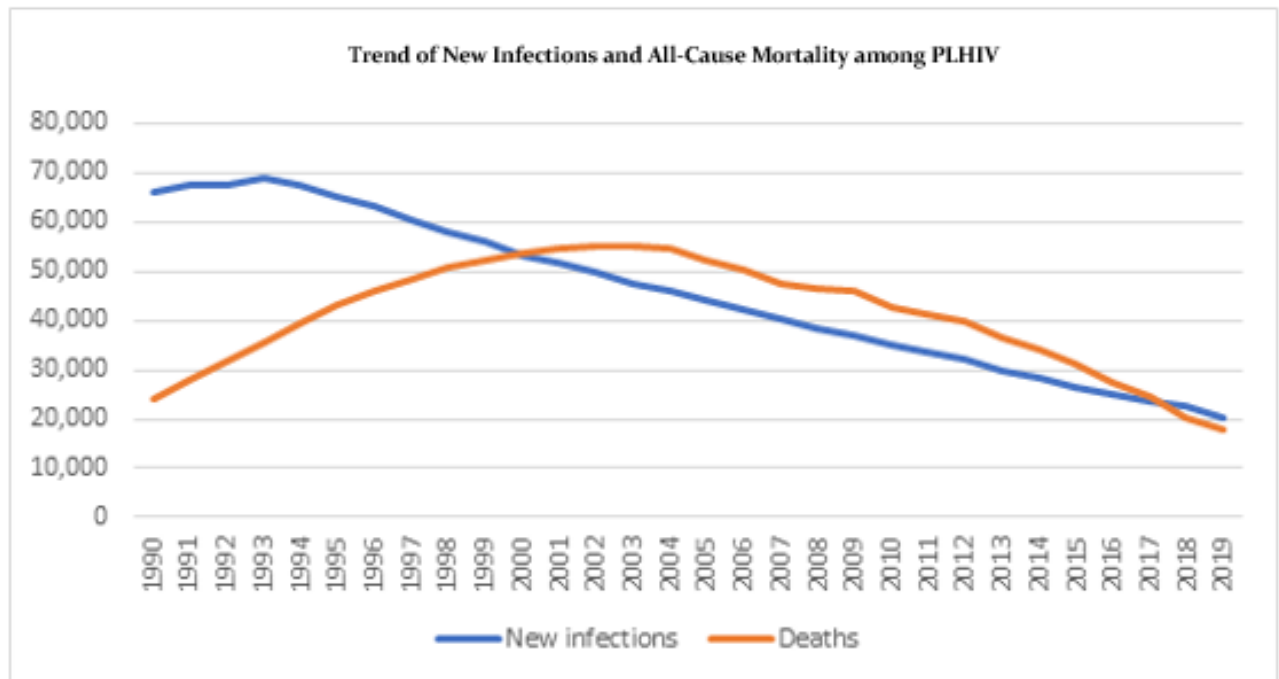


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY19

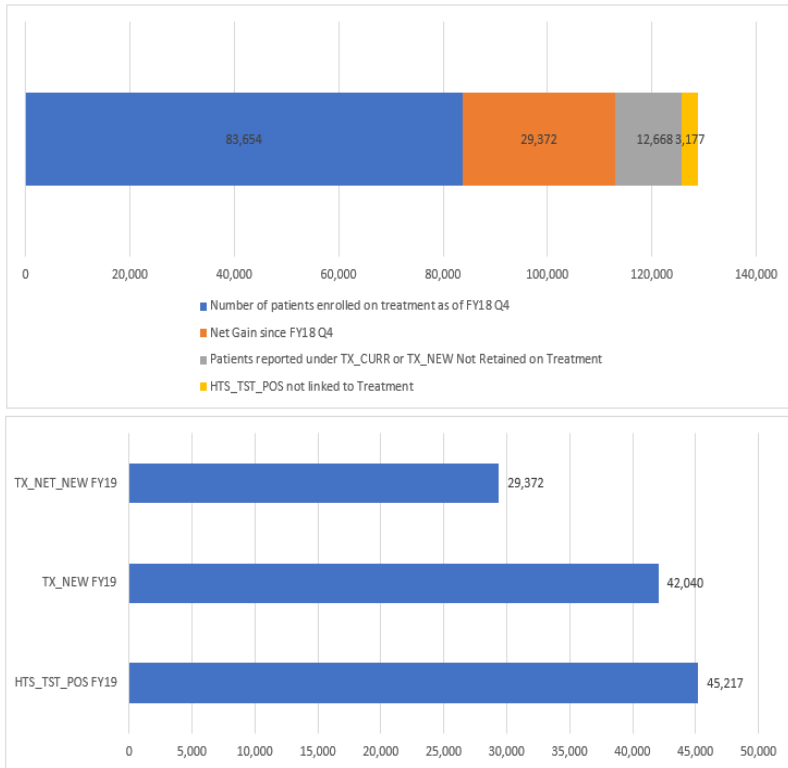


Figure 2.1.6 Proportion of clients lost from ART 2018 Q4 to 2019 Q4

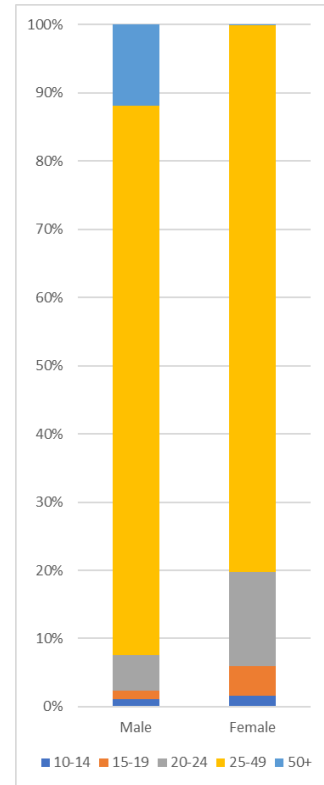
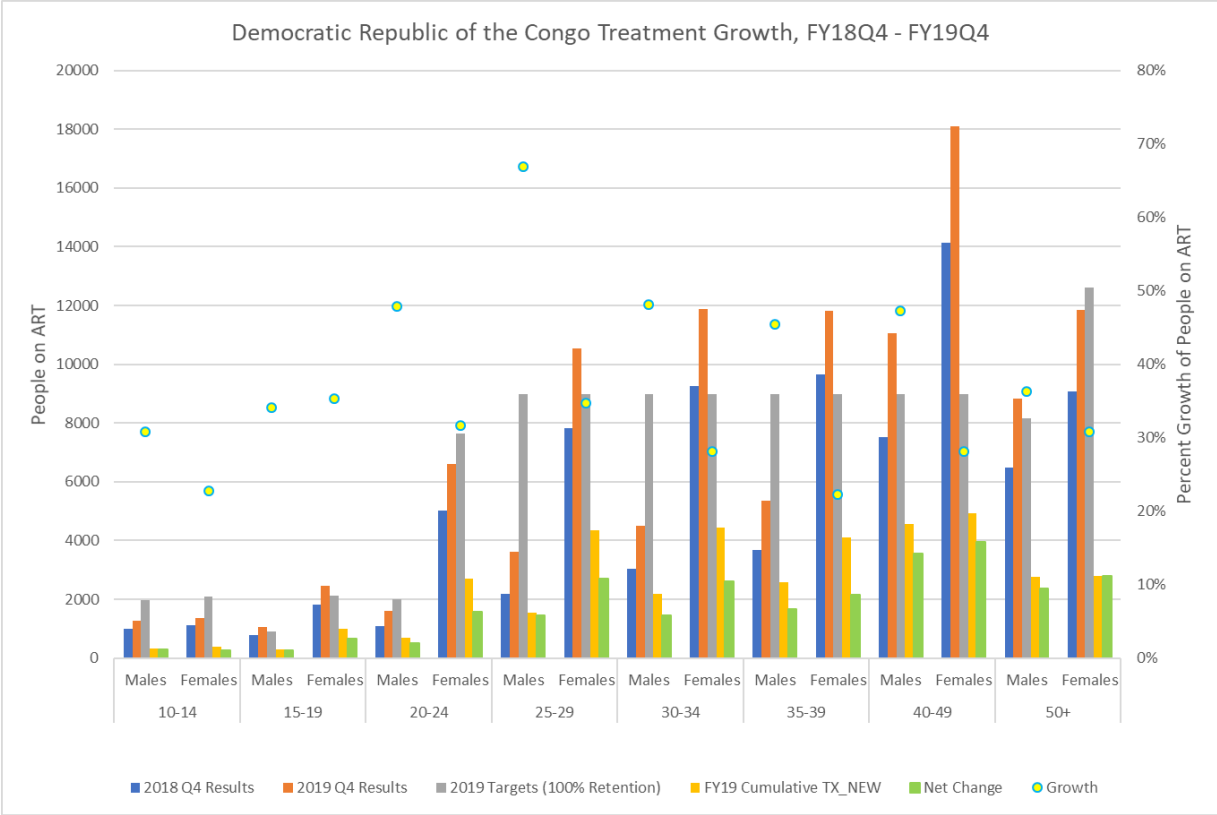


Figure 2.1.7 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.7 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

PEPFAR/DRC has the following nine priorities for accelerating toward epidemic control in COP20:

1. **Intensify case finding, particularly of children and men:**
 - a. **For pediatrics:** Focus will be given to index testing (biological children of HIV-infected women with a focus on the family tree) at community and facility level (scale index testing to 15 percent-20 percent of HTS_TST, and 30 percent-50 percent TST_POS from index). Our program will ensure index testing is implemented according to the “five Cs” (consent, confidentiality, counseling, correct result, and connect to treatment); and an assessment of intimate partner violence (IPV) is undertaken. All children under age 19 with an HIV positive biological parent will be tested for HIV. The program will also increase two-month EID testing and 18-month PMTCT_FO by incorporating the testing schedule into already existing immunization appointments, integrating DBS collection at immunization sites, and optimize HIV infant point of care testing. Efforts will be made to systematically implement standardized screening and testing tools in outpatient departments including malnutrition clinics, under five visits and OVC programming. Targeted inpatient pediatric testing based on HIV risk will also be conducted including HIV testing among all presumptive and diagnosed TB

patients. Finally, a robust partner management will be conducted to ensure strategies put in place are implemented with fidelity.

- b. **For men:** Through index testing, the program will ensure sexual contact partners of newly diagnosed women are tested by offering the full menu of partner notification services at facility and community levels. PITC optimization using validated and harmonized screening tool will also be incorporated. Efforts will be made to maintain high rates of HIV testing among all presumptive and diagnosed TB patients. Activities will be implemented to meet men where they are based on their needs through a client-centered care approach (e.g. predominately male entertainment establishments, workplaces) and targeted community testing. Men friendly services at facilities such as flexible hours, trained providers on the needs of men will be offered including self-testing for male partners not willing to show up at a facility.
2. **Strengthening linkage to treatment:** Emphasis will be given to improving HIV counseling training for providers. The use of peer educators for active linkage to care and treatment for all positives identified, with promotion of early initiation on ART will also be critical in implementation. Moreover, implementers will conduct weekly monitoring of those not linked to treatment and undercover through the analysis of many factors that lead to low linkage rates and develop appropriate interventions to address them.
3. **Prevent loss to follow-up and improving retention:** New activities will be implemented in COP20 to continue improving retention and will prioritize client-centered approaches supported by our implementing partners at the facility and community level. At the facility and community levels activities will continue to use Tier.net for early identification of missed appointments. Each trained peer educator/peer navigator/mentor mothers/case manager is assigned a number of missed appointments for continuous tracking and client re-engagement in care and treatment. Differentiated service delivery (DSD) models using multi-month dispensing (MMD) and PODI+ will be fast tracked to accommodate patient needs. In addition, partner management by the USG team will be conducted through quarterly data analysis to identify the gaps in retention performance and discussions with partners on remediation plans generated by a root cause analysis from gap statements and monitoring of performances through monthly reports. Finally, granular site management (GSM) in high volume sites and course correction during visits will continue.
4. **Address viral load (VL) testing coverage and suppression gaps:** To address challenges related to low demand for VL testing as shown by low number of specimens collected from patients eligible for a VL test, the program will continue to provide health care worker (HCW) sensitization training to systematically request VL tests for eligible

patients. The team will focus on educating, empowering and supporting patient adherence and demand for VL testing from their providers. The program will continue to advocate and raise VL awareness among PLHIV and involve CSO to emphasize importance of one's adherence to HIV treatment. The program will promote use of DBS to improve coverage in remote sites and monitor and evaluate demand creation at site level and identification of best practices during GSM visits for rapid scale up at additional sites. To address challenges related to low VL coverage in peds (<46% for < 15 years) the program will promote family friendly approaches such as joint appoints for the entire family as well as combining drug pick-up and VL specimen collection. The program will train phlebotomists to facilitate easy collection of pediatric specimens and ensure availability of proper pediatric collection materials. As with adults, emphasis will be given to promote the use of DBS for peds and identification of best practices during GSM visits for rapid scale up and accountability of partners for performance. In addition, activities will promote and leverage the OVC platform showing high VL coverage. To address challenges related to low coverage in pregnant and breastfeeding women, emphasis will be given to strategically place of point of care (POC) VL targeting high volume ANC clinics and the use of existing and POC VL instruments (GeneXpert).

5. **Strengthen the integration of HIV and TB services:** TB preventive treatment (TPT) will be fully integrated into the HIV clinical care package at no cost to the patient. All ART patients should be screened for TB at each visit using the WHO checklist. All ART clients screened positive for TB should be eligible for TB diagnostic using in priority GeneXpert machines. Those found TB positives should be treated for TB. All eligible PLHIV, including children, will complete TPT by end of COP20, and cotrimoxazole, where indicated.
6. **Improve the pediatric cascade:** Identified efficient strategies for pediatric case finding, linking all the positive children with treatment using optimized ARV regimens, and retaining them on treatment for VL suppression are explained per the strategies described above in each of the entry points across the cascade.
7. **Maximize OVC contribution to the clinical cascade:** The program will assign newly enrolled HIV positive patients to OVC case managers to assist with disclosure counseling, partner notification services, and index testing. Activities will include disclosure support for caregivers and children as well as linkage to peer support programs, OVC programs, and teen clubs, to prevent and address barriers to adherence among children living with HIV (CLHIV,) adolescents living with HIV (ALHIV,) and their caregivers. Clinical partners will build the capacity of OVC case managers to conduct HIV testing and provide linkage, adherence, and retention support to all community members living with HIV and

promote and leverage the OVC platform shown to improve VL coverage and VL suppression.

8. **Maintain the successful key populations program (including PrEP):** The program will continue screening female sex workers (FSW,) men who have sex with men (MSM,) and transgender (TG) individuals using risk classification. Implementing partners will conduct outreach using peer educators, and social and sexual network strategies and provide self-testing services. Critical to the program will be direct and immediate screening and offering of prevention services including pre-exposure prophylaxis (PrEP) to HIV-negative clients with elevated risk. Moreover, there will be activities that utilize information and communication technology (ICT) platforms especially targeting MSM and TG.
9. **Engage with civil society to enhance quality improvement initiatives:** Collaboration with community groups, civil society organizations, and patients/beneficiaries can help programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers with service uptake at the site and facility level to improve service and client outcomes at the site. Civil society will be involved in monitoring patient experiences at site level through the “Observatoire” which will be expanded to Haut Katanga and Lualaba provinces. Community-led monitoring will report on, for example, MMD availability (adults and pediatric) including average waiting time, friendliness and non-coercive services for patients and returning patients, availability of PrEP, and functioning of EMR.

2.3 Investment Profile

The DRC has one of the lowest gross national incomes (GNI) per capita in the world (\$490, World Bank, 2018), with an estimated 63.9 percent of the total population living below the poverty line (World Bank, 2012). DRC’s economy has continued to expand in recent years, with growth rates of 2.4 percent in 2016, 3.7 percent in 2017, and 4.1 percent in 2018 (World Bank, 2019). The benefits of economic growth are spread unevenly across the population. The top quintile of the population holds 48.4 percent of the total income, while the bottom quintile holds 5.5 percent of the total income (World Bank, 2012). The United Nations Human Development Index 2019 ranks the DRC as one of the least-developed countries in the world, at 179 out of 189 countries (World Bank 2019).

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 \$87 million in COP20.

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 most 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.

USAID has been appointed as lead of the health donors supply chain group and as such, co-lead of the National Medicines Commission with the National Pharmaceutical Regulatory Authority. This will help to strengthen donor collaboration and improve GDRC leadership, oversight and accountability for health commodity forecasting and procurement system management efficiency that may result in permanent and sufficient availability. 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.

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 fluctuations in economic growth that has resulted in a slowdown of government revenues.

Despite the longstanding issues, under the leadership of President Felix Tshisekedi and the new Minister of Health Dr. Eteni Longondo, there is renewed optimism in the country. The health care system has become the second priority for the Administration and efforts are being led via the special advisory committee under the Presidency and in alignment with the Ministry of Health, to improve governance, human resources and quality service delivery. Commitment to improve services can be demonstrated in the PNLS's leadership in the rollout of TLD in the PEPFAR supported sites to over 95 percent in six months.

Table 2.3.1. Annual Investment Profile by Program Area

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	86,784,053	56%	44%	*	
Community-based care, treatment, and support	6,135,604	100%	0%	*	
PMTCT	2,565,270	86%	14%	*	
HTS	7,726,794	96%	4%	*	
VMMC	-			*	
Priority population prevention	1,699,449	23%	77%	*	
AGYW Prevention (sub-set of Priority Pop)	-			*	
Key population prevention	4,821,966	55%	45%	*	
OVC	6,812,489	100%	0%	*	
Laboratory	1,187,017	66%	34%	*	
SI, Surveys and Surveillance	1,445,623	97%	3%	*	
HSS	1,472,402	79%	21%	*	
Total	120,650,667				

* 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.

Overall spending has gone up by 25 percent compared to last year. 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) and related systems. Global Fund spending has picked up considerably as they have entered in the second year of their 2018-2020 grant. The Global Fund spending is based on extremely pre-liminary data from their Civil Society Principal Recipient (PR). This data was submitted at the end of February 2020 and hasn't been validated by the Global Fund.

Table 2.3.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	30,612,656	46%	54%		
Rapid test kits	5,332,414	28%	72%		
Other drugs	3,491,873	74%	26%		
Lab reagents	1,220,044	36%	64%		
Condoms	258,532	63%	37%		
VL/EID commodities	5,867,461	80%	20%		
VMMC kits	-				
MAT	-				
Other commodities	864,198				
Total	47,647,177				

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 investment for pediatric ARVs increased in COP20 due to the scale up of pediatric ARV optimization. This was compensated through savings coming from the procurement of standardized MMD formulations (which are a little bit cheaper). On the PEPFAR side the expenditure on HIV rapid test kits continues to decrease because of increases in index testing, more targeted testing and better use of screening tools for PITC. The expenditure on VL/EID is increasing and reflects the rapid scale up of VL/EID coverage, especially in PEPFAR supported provinces.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources (FY19)	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	40,000,000	8,000,000	2	26,762,919	Procurement (PSM) and GHSC-TA (supply chain)
USAID TB	13,000,000	575,768	1	3,916,638	GHSC-TA (supply chain)
USAID Malaria	50,000,000	21,000,000	2	26,762,919	Procurement (PSM) and GHSC-TA (supply chain)
USAID Family Planning	20,000,000	4,650,000	3	30,907,641	Procurement (PSM), GHSC-TA (supply chain) and 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	129,000,000	34,225,768			

In FY19, the USG invested \$129 million in non-HIV programming, including \$34.2 million in co-funding in PEPFAR-supported provinces. The geographic coverage of these mechanisms overlaps primarily in Haut-Katanga and Lualaba provinces.

2.4 National Sustainability Profile Update

Sustainability Index and Dashboard (SID) Process: In July 2019, the PEPFAR team kicked off the SID development process with a meeting at UNAIDS attended by both teams and representatives of civil society and the Government of the DRC (GDRC). This was followed up when the U.S. Embassy in DRC, UNAIDS, and the National HIV/AIDS Program co-convened five days of SID workshops with select participants from the multi-sectoral HIV control program committee (PNMLS), UNAIDS, WHO, civil society, Global Fund principal recipients and members of the CCM (Country Coordinating Mechanism) distributed among the four SID domains and the responsibility matrix group. On the 12th of September 2019, after an opening speech by U.S. Ambassador Mike Hammer, the full group then reconvened for a day-long meeting to review the completed tools, discuss the findings, and identify priorities outlined below.

Sustainability Strength:

- **Planning and Coordination (9.29, dark green):** Under the leadership of the National HIV/AIDS Program, the DRC has continued to develop 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 most of the national and provincial-level planning, coordination, and results review meetings. An example of PNLS's leadership was the successful transition from efavirenz based treatment regimens to a dolutegravir based regime, TLD, in a period of six months in the areas covered by PEPFAR. There has also been greater leadership from the PNMLS, which is organizing the evaluation of the current National Strategic Plan and the development of a new plan to cover the period from 2020-2023. It was noted that strong planning must lead to implementation and the SID Working Group noted that while many plans exist, they do not always guide interventions.
- **Private Sector Engagement (8.53, dark green):** DRC policies do not distort the market for HIV services by reducing or limiting participation. Donors are taking steps to work with more local organizations and civil society actors.
- **Market Openness (8.43 light green):** Significant improvement has been seen in the collection and availability of financial and expenditure data. However, the information is not collected in a timely manner and thus is not available to decision makers for effective and timely decision making.
- **Financial/Expenditure Data (8.33 light green):** Significant improvement has been seen in the collection and availability of financial and expenditure data. However, the information is not collected in a timely manner and thus is not available to decision makers for effective and timely decision making.
- **Performance data (7.67, light green):** Although the national program has made remarkable efforts towards a unified system for data collection, there continues to be a need to improve completeness and quality of analysis, which would support a clear process for decision-making and technical and allocative efficiencies.

Sustainability Vulnerabilities: All the remaining elements were found vulnerable with 1) Quality Management, 2) Domestic Resource Mobilization and 3) Data for Decision Making Ecosystem in **red** (2.33, 2.74 and 2.00 respectively). Policies and Governance, Civil Society Engagement, Public Access to Information, Service Delivery, Human Resource for Health, Commodity Security and Supply Chain, Laboratory, Technical and Allocative Efficiencies and Epidemiological and Health Data were all found as emerging sustainability or **yellow**. Among these SID elements identified as sustainability vulnerabilities, the team considered as priorities for COP20 following elements:

- **Commodity Security and Supply Chain (4.24, yellow):** The availability of life-saving antiretroviral medications and other HIV commodities is essential for epidemic control and a sustainable national response. While there have been significant improvements in supply planning and management there is work still to be done. Lead times need to be reduced and customs clearance procedures streamlined ensuring the availability of commodities when and where they are needed. The USG has embarked on internal and external measures, in collaboration with the GDRC, to put in place improved customs clearance procedures that will realize the diplomatic privilege for immediate removal of USG procured commodities.
- **Laboratory (3.81, yellow):** Despite significant efforts in PEPFAR zones, the coverage of viral load and EID results remain concerning across the country. In order to improve sustainability, the following are necessary: 1) the viral load scale-up plan should be effectively implemented, 2) the existing platforms should be optimized and used at their maximum potential, and 3) continued improvements in the specimen transport system and support the deployment of additional platforms funded by Global Fund as needed. In COP20, emphasis will continue to be placed on enhancing the laboratories' capacity to improve quality, timeliness and completeness of data collection and reporting.
- **Domestic Resource Mobilization (2.74, red):** The matrix responsibility dashboard Responsibility Matrix and HIV financing depicted that the Government and implementing partners are primarily responsible for 50 percent of elements whereas PEPFAR has secondary responsibility for most elements (46 percent), and primary for several others (39 percent). The government of the Democratic Republic of the Congo funds very little of the HIV response. PEPFAR will continue to track government commitment to enhanced funding as part of minimum program requirement.

Current investments

Performance data: The PEPFAR team has been on the frontlines 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).

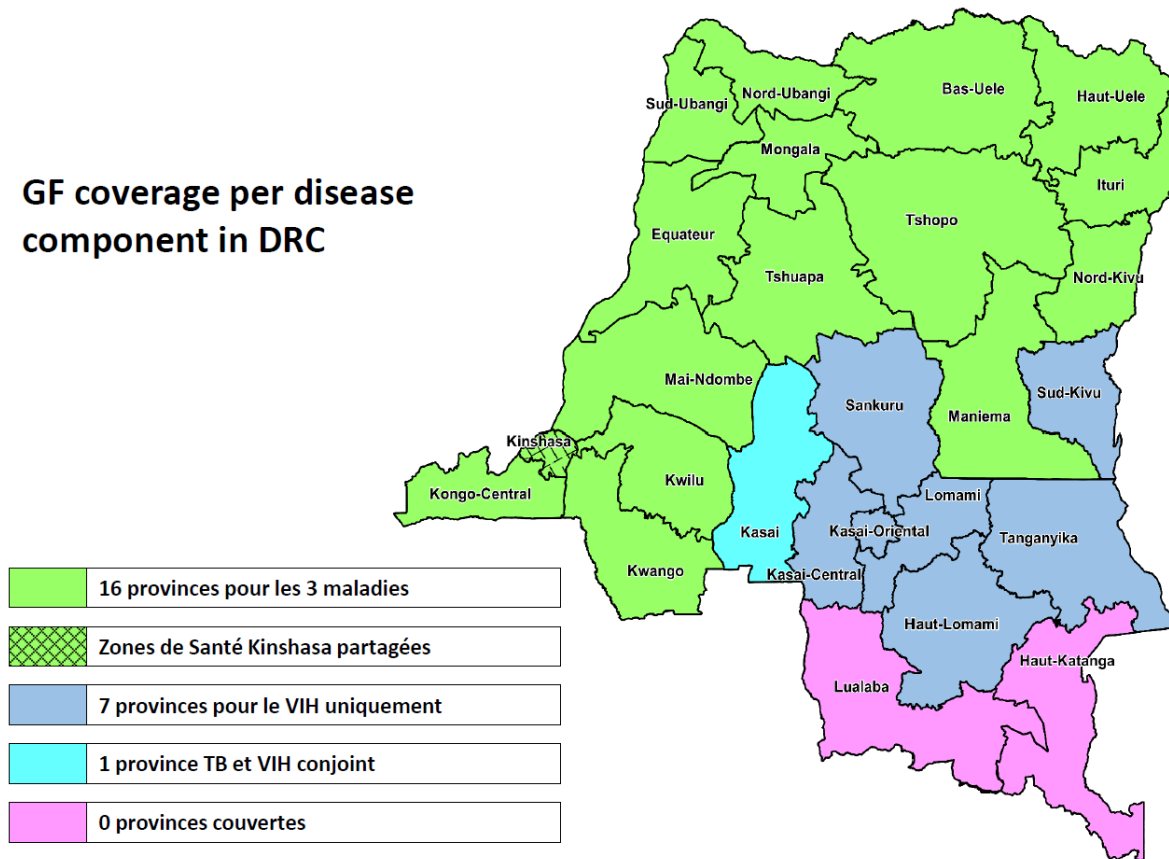
Commodity Security and Supply Chain: PEPFAR and the Global Fund remain the principal funding sources for the backbone of the supply chain system in DRC for HIV-related commodities.

Laboratory: PEPFAR and the Global Fund are responsible for their respective geographic areas. While the PEPFAR-supported zones reached viral load coverage of 67 percent by 2019, the national VL 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 including the integration of point of care technology in all three provinces through an all-inclusive pricing scheme. In addition, capacity will be strengthened with the use of point of care technology.

2.5 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 2.5. 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 2.5.1: 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 2021 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 FY20 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. In COP19, PEPFAR implementers will continue to work to close the gap by reducing those lost to follow-up.

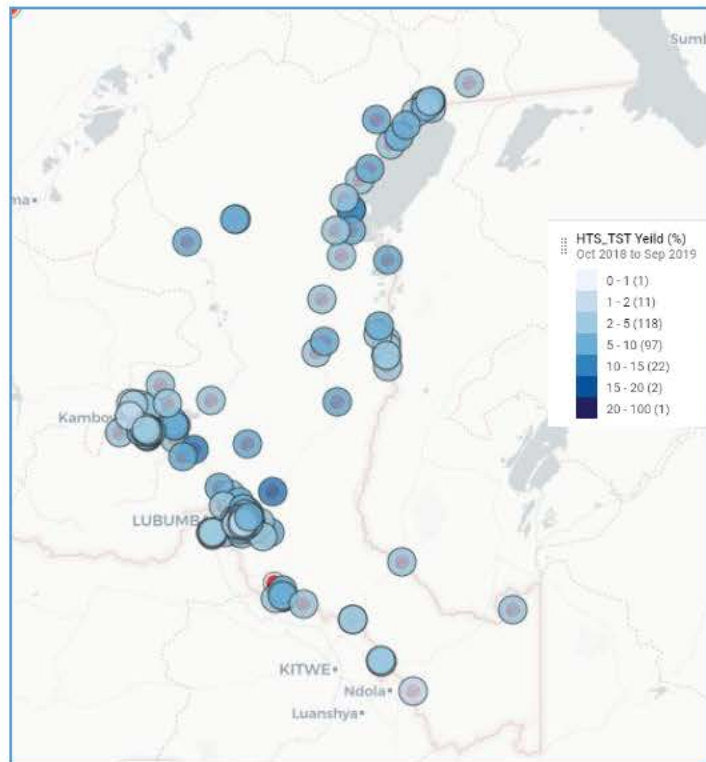
Figure 2.5.2. Percent HTS_TSE Positive DRC/Zambia Border

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 COP20, 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.

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 COP20. 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.

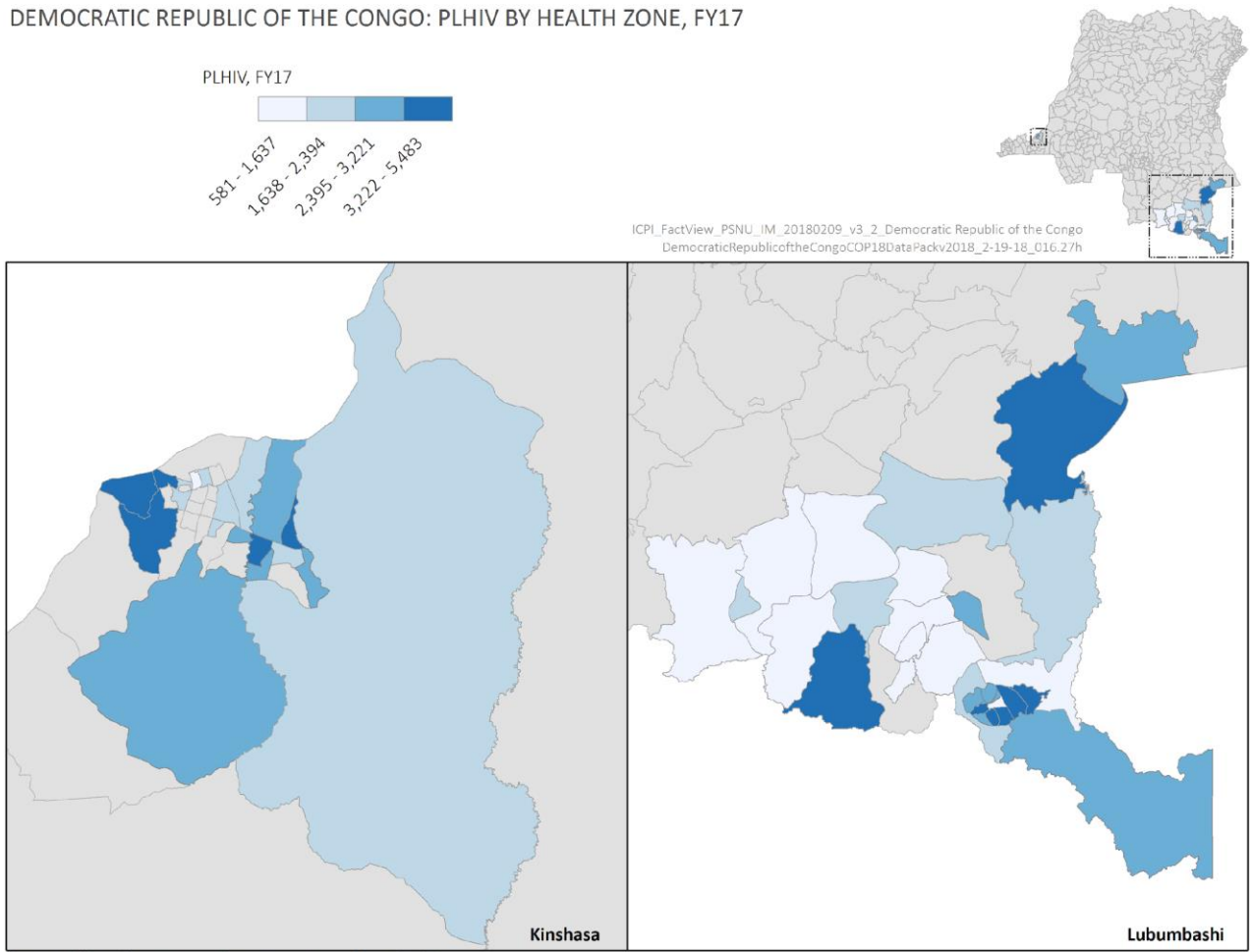
Overall, approximately 30 percent of PLHIV in DRC live in the PEPFAR-supported provinces. In COP18, DRC/PEPFAR pivoted to increase focus in Haut-Katanga and Lualaba to move towards epidemic control by 2021 and strengthening interventions in Kinshasa, which is detailed at length elsewhere in the SDS.

Figure 2.5.2. SEQ Figure * ARABIC 2: % HTC_TST positive, DRC/Zambia Border, April 2016



Figures 2.5.3 outlining geographic distribution of PLHIV is below:

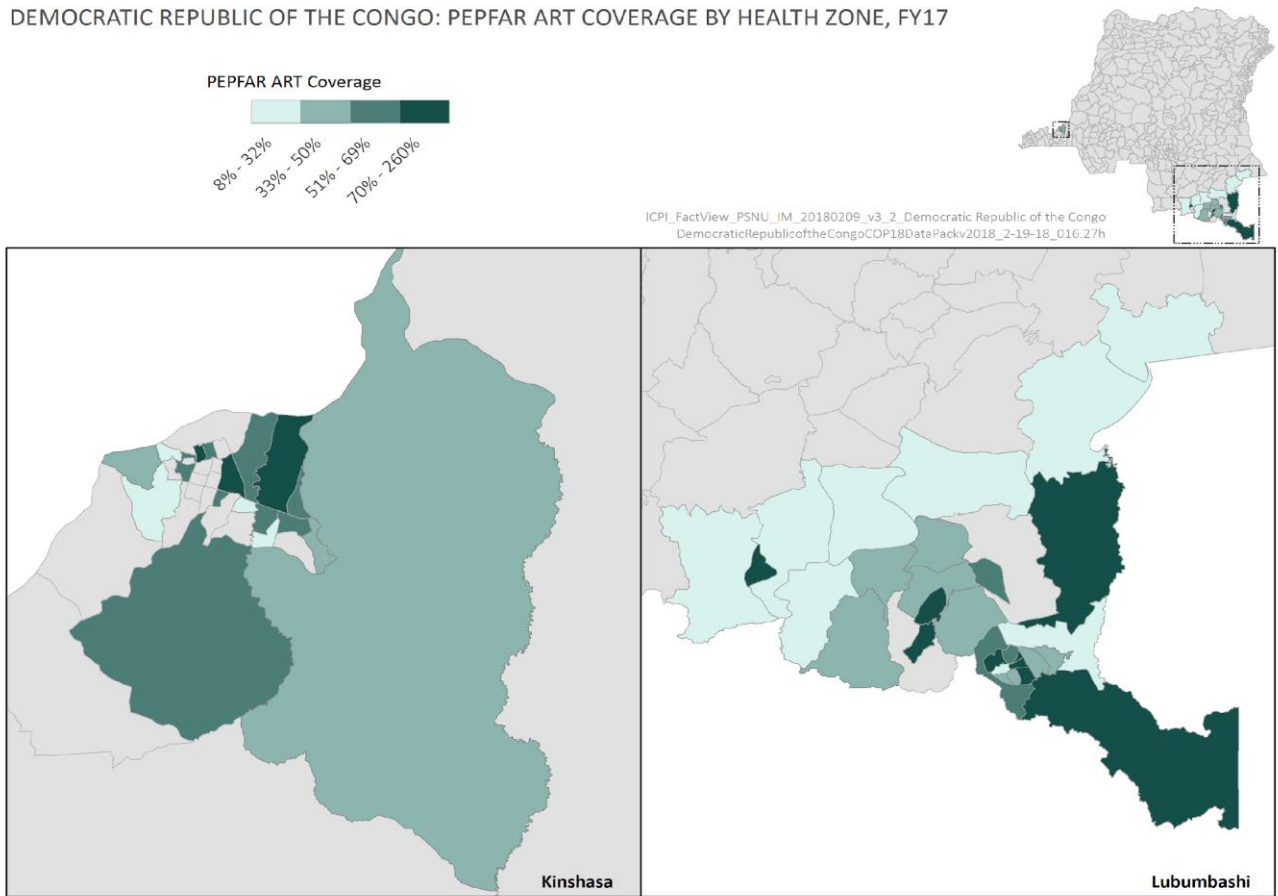
DEMOCRATIC REPUBLIC OF THE CONGO: PLHIV BY HEALTH ZONE, FY17



Names and boundary representation are not necessarily authoritative.

Figures 2.5.4 outlining geographic distribution of ART coverage is below:

DEMOCRATIC REPUBLIC OF THE CONGO: PEPFAR ART COVERAGE BY HEALTH ZONE, FY17



Names and boundary representation are not necessarily authoritative.

2.6 Stakeholder Engagement

From the beginning of the COP20 process, PEPFAR/DRC has engaged a range of critical stakeholders including: the 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 discussion and development of COP20.

CSOs participated in the pre-COP20 in-country retreat to help inform COP20 planning and strategy. The PEPFAR/DRC OGAC Chair, Program Manager and Agency Points of Contact participated in the in-country retreat and were able to directly answer questions from staff and other stakeholders. CSOs provided feedback on the COP20 guidance and PEPFAR/DRC COP20 activities and priorities. CSO representatives and other stakeholder listed above then joined the PEPFAR/DRC delegation at the COP20 Meeting and provided input throughout the process.

A draft of the SDS was shared with CSOs and stakeholders several days 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
<i>Before COP20 Submission</i>				
01/27/2020-01/28/2020, 01/30/2020 In-Country retreat	PEPFAR/DRC to share with internal stakeholders: The COP20 development process, the COP20 overview, COP20 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 COP20	Plan the next meeting. Share the documentation.	Meeting was held at the Kin Plaza Hotel, Kinshasa
02/17/2020 - 02/21/2020	Discuss COP19 Q1 performance and COP20 plan Receive input from stakeholders on the	Stakeholder feedback received	Continue discussion via phone and email to ensure stakeholder input into	

	COP20 strategy for DRC		COP20 presentations	
3/4/2020	Meeting with Civil Society to review decisions made in Johannesburg.			
3/5/2020	COP20 SDS Draft shared with stakeholders and CSOs			SDS draft was shared via email with CSO and all stakeholders
04/02/2020	Final SDS to be shared with CSOs and other stakeholders.			
<i>After COP20 Submission</i>				
04/24/2020	PEPFAR/DRC to explain how stakeholder feedback was incorporated in COP20 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 COP20, what was not, and why these decisions were made.	Share the redacted COP20 when available and approved.	The approved, redacted COP20 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, COP20 priorities, goals, budget) is shared via email. Hard copies of documents will be provided if needed upon request from the stakeholders.

Community-led monitoring in COP20

Community-led monitoring is a new activity for COP20. “Community-led monitoring trains, supports, equips, and pays members of directly affected communities to carry out routine, ongoing monitoring of the quality and accessibility of HIV treatment and prevention services.”

Community-led monitoring will constitute a critical nexus to our program as we deliver quality services. This will constitute close monitoring of services provided to clients as well as ensuring responsiveness to clients’ needs as we strive to address challenges and achieve a client-centered approach. CSO involvement in COP20 development has been well received and we treasure this privileged relationship to ensure quality services are provided to beneficiaries. Monitoring will focus on collecting quantitative and qualitative data through a wide variety of methods that reveal insights from communities about the problems and solutions to health service quality problems at the facility, community, sub-national, and national levels (Community-led Monitoring White Paper).

The process for accessing resources for community-led monitoring will be developed during FY20 for implementation in FY21.

3.0 Geographic and Population Prioritization

In COP20 PEPFAR/DRC will keep the same SNU prioritizations as in COP19. The 52 scale-up aggressive health zones prioritized for COP19 represent 46 percent of patients in the cumulative national ART cohort. In COP20, 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 2021. In addition, PEPFAR/DRC will expand services to a select number of sites in five neighboring health zones in the two eastern provinces (four in Lualaba province and one in Haut-Katanga) to increase retention by providing client-centered services closer to clients. The PEPFAR/DRC military specific program will continue to 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 are crossing health zone lines to receive care. In COP20, PEPFAR/DRC will focus on increasing the number of PLHIV receiving treatment in all the supported health zones, with an emphasis in Haut-Katanga and Lualaba. Recency testing will be rolled out in Kinshasa to provide additional data on the state of the epidemic by identifying transmission ‘hot spots’ and populations for targeted interventions including optimization of PREP implementation. 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. PEPFAR will continue to invest in community approaches to find positives through Index testing. Additionally, in out-patient wards, the 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 COP20, PEPFAR/DRC will continue its efforts to reach the following populations:

- 1) Partners and family members of diagnosed PLHIVs (index testing);
- 2) Younger men, including partners of FSW; 20-35
- 3) Adolescent girls and young women;
- 4) Children;
- 5) Key populations (MSM and FSW); and
- 6) 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 bridge the age and sex band gaps in order to achieve sustained epidemic control in the supported areas by 2021, with significant progress toward closing the gaps in FY20. 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 numbers of FSW and MSM.

During FY21, budgets and targets will continue to prioritize Haut-Katanga and Lualaba provinces, which are closer to achieving 95-95-95 by 2021. 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 focused attention on retention and viral suppression.

Prioritization Area	Total PLHIV/% of all PLHIV for COP20	# Current on ART (FY19)	# of SNU COP19 (FY20)	# of SNU COP20 (FY21)
Attained	N/A	N/A	N/A	N/A
Scale-up Saturation not including Military	252,796 / 100%	111,403	52	57
Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A
Central Support	N/A	N/A	N/A	N/A

4.0 Client-Centered Program Activities for Epidemic Control

4.1 Finding the missing, getting them on treatment

Who are we missing and how are we finding them ?												
Distribution by age	Estimated PLHIV 2019			PLHIV currently on ART			Current ART Coverage			Remaining PLHIV that Need ART		
	Estimated Male PLHIV	Estimated Female PLHIV	Total PLHIV	Male on ART	Female on ART	Total PLHIV on ART	Males	Females	Overall	Males	Females	Overall
0-4	4,548	4,326	8,875	1,526	1,582	3108	33.60%	36.60%	35.00%	3022	2744.3	5766.6
5-9	3,974	3,857	7,832	1,675	1,832	3507	42.10%	47.50%	44.80%	2299	2025.1	4324.5
10-14	3,303	3,236	6,539	1,374	1,490	2864	41.60%	46.00%	43.80%	1929	1746.1	3674.9
15-19	3,404	4,211	7,615	1,145	2,743	3888	33.60%	65.10%	51.10%	2259	1468.3	3727.3
20-24	5,425	8,826	14,251	1,880	7,419	9299	34.70%	84.10%	65.30%	3545	1407.3	4951.8
25-29	9,080	14,999	24,080	3,673	11,471	15144	40.40%	76.50%	62.90%	5407	3528.5	8935.9
30-34	12,277	19,889	32,167	5,168	12,981	18149	42.10%	65.30%	56.40%	7109	6908.3	14018
35-39	13,816	22,054	35,870	6,432	13,112	19544	46.60%	59.50%	54.50%	7384	8941.6	16326
40-44	12,716	20,146	32,861	6,586	10,923	17509	51.80%	54.20%	53.30%	6130	9222.7	15352
45-49	9,765	15,032	24,796	6,310	8,724	15034	64.60%	58.00%	60.60%	3455	6307.7	9762.3
50+	15,338	22,539	37,876	9,576	12,496	22072	62.40%	55.40%	58.30%	5762	10043	15804
All Ages	93,646	139,116	232,761	45,345	84,773	130,118	48.40%	60.90%	55.90%	48301	54343	102643

PEPFAR/DRC achieved 121 percent of our FY19 target for HIV positives identified, yet gaps persist:

1) While substantial uncertainty exists about number of PLHIV in PEPFAR-supported provinces in DRC, proxy operating unit data such as proportion of HIV positive persons knowing their status at their first visit at ANC was 22 percent in Haut-Katanga, 40 percent in Kinshasa and 29 percent in Lualaba (FY19 PEPFAR programmatic data). A similar proxy revealed the proportion of HIV positives knowing their status at entry into TB clinics at 40 percent in Haut-Katanga, 52 percent in Kinshasa and 45 percent in Lualaba (FY19 PEPFAR programmatic data). In both ANC and TB settings, testing is offered to every client, which gives an indication of the proportion of the general population who know their HIV status. The above values demonstrate that the first 95 remains a gap.

2) FY19 HTS_TST_POS targets are not reached for some subpopulations like children and young men. Nevertheless, our programmatic data show considerable numbers of women (25,836: annual target achievement of 140 percent) tested compared to men (16,062; annual target achievement of 115 percent). The gap in annual target achievement is evident in the 20-34-year-old age group of men compared to women (146 percent in women and 80 percent in men).

3) Proportion of deaths documented among Lost to Follow-Up (LTFU) patients ranged from 31 percent to 59 percent among the Haut-Katanga implementing partners and from 14 percent to 32 percent among Kinshasa implementing partners.

4) FY19 indicators on pediatric case-finding clearly indicate failure to reach annual targets for reaching children. As an illustration, only 76 percent of 1-9-year olds and 67 percent of 10-14-year-

old targeted children were reached overall by PEPFAR/DRC in FY19. The same results show weak coverage of index testing in biological children of HIV positive women. Site Monitoring System (SIMS) has confirmed many missing family trees in the medical files of HIV positive women.

5) SIMS also found that the screening tool was not systematically administered in inpatient pediatric wards.

6) The low FY19 coverage of EID at 2 months (44 percent) is another weakness we will address.

In COP20, PEPFAR will focus on scaling up index testing and self-testing, ensuring consent procedures are in place, that confidentiality is protected, and the assessment of IPV is established. Additionally, all children under the age of 19 with an HIV positive biological parent will be tested for HIV.

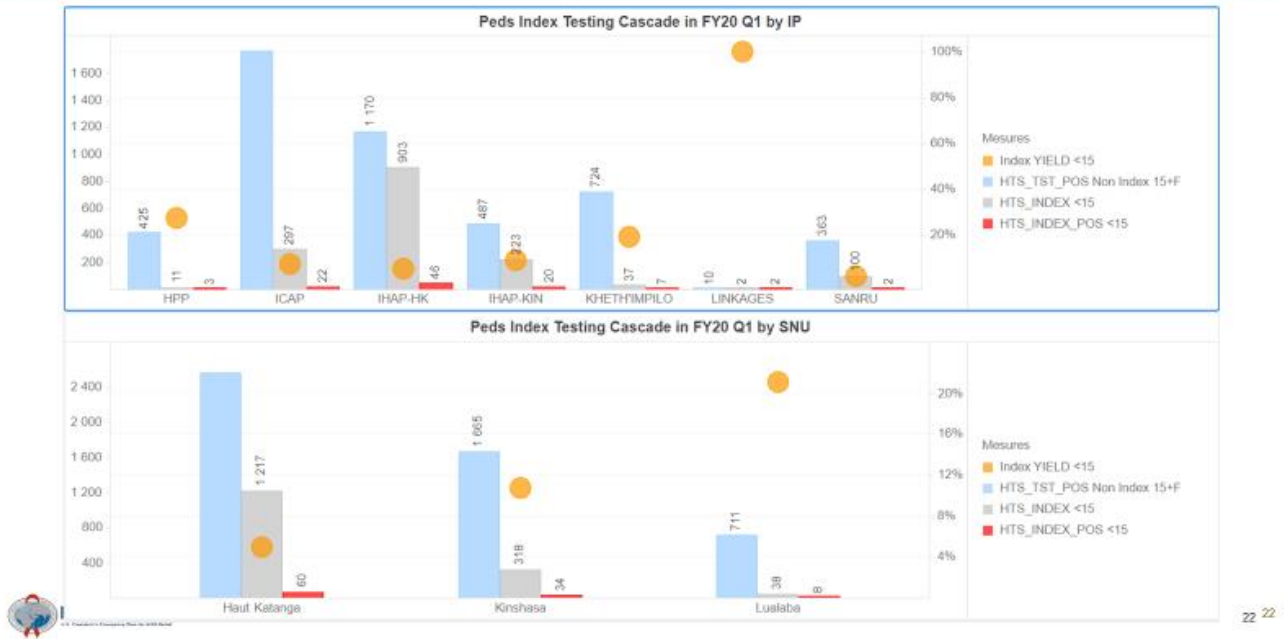
For men: As the program shows more success in reaching HIV positive women, the core strategy will be accelerating index testing to their counterpart male sexual partners. An emphasis will be put on more finely tuned messages of hope (U=U messages). The expected impact of this positive messaging is double: improved acceptance of Partner Notification Services (PNS) from HIV-positive women (currently 75 percent) and more favorable perception of testing in male contacts. Dedicated peer educators including discordant couples will be recruited, trained and added to help conduct non-coercive counselling and elicitation of contacts from HIV positive women in facilities. The steps for PNS involving eliciting and testing of HIV sexual contacts will be rigorously monitored through enhanced coaching of staff and continuous quality improvement following the PNS site certification standards. A focused supervision on use of the IPV screening form will improve the appropriate selection of the client-preferred option for PNS. Another strategy will be reaching men where they are with tailored positive and hopeful messages, especially in the mining and fishing areas in Haut-Katanga. Furthermore, self-testing will be integrated in index testing settings as another alternative for those reluctant to the existing four PNS options, and other found at-risk men not willing to be tested. All the positive men found will be linked and initiated on treatment. Case managers will be assigned to each HIV positive man to assist him with partner notification for other potential sexual contacts and disclosure. These case managers will also conduct home visits for HIV literacy, individualized adherence support, scheduling clinic visits, reminders for blood or DBS collection for VL. The use of VL champions will help to ensure results are filed in the appropriate medical charts and acted upon by the clinician.

For pediatrics: The cornerstone will be the systematic review of family trees to identify all missing biological children under 19 years and linking them to index testing services. In each high-volume facility, additional staff and lay workers will be scheduled to ensure complete family trees for HIV positive women. In collaboration with the HIV positive woman, they will set a plan and adequately document index testing for all eligible children. To increase EID coverage, peer

educators (mentor mothers) will be involved in sensitizing mothers to demand DBS collection. In addition, the implementation of optimized Point of Care for infant virologic testing will contribute to increase the coverage to 85 percent by two months. All HIV positive children will be linked to services and systematically enrolled in OVC services with a dedicated case manager to accompany them along the cascade to ensure linkage, retention and VL suppression. The use of VL suppression champions will help to ensure results are filed in medical charts and acted upon by clinicians.

Index testing will be client-centered and focused on the needs and safety of the index client and his or her partner(s) and children. PEPFAR will ensure that index testing adheres to the minimum program requirements: 1) providers trained on index testing procedures, including IPV screening, adverse event monitoring, the “Five Cs,” and ethics; 2) adherence to the “Five Cs”; 3) IPV risk assessment; availability of first-line services for anyone reporting IPV (onsite or by referral); 4) a secure environment to store patient information, and 5) a site level adverse event monitoring and reporting system. All index testing clients will be provided with the full range of HIV prevention, care, and treatment services regardless of whether they provide details about their partners, and clients may opt-out of index testing services for any reason. All implementing partners serving all populations will verify that each facility providing index testing implements programming in compliance with the WHO’s Self-Testing and Partner Notification Guidelines and additional guidance developed by the PEPFAR Index Testing and KP Communities of Practice. All HIV testing clients, including index clients, should be provided with all available HIV prevention, care and treatment services, regardless of whether they provide details about their contacts. Clients must NEVER be pressured into sharing the names of their contacts for fear of being denied services. Services must NEVER be withheld under any circumstances.

Peds Index Testing Cascade in FY20 Q1 shows low coverage of testing



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 goal of viral suppression and epidemic control.

Results from FY19 and Q1 FY20 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. Taken together, newly identified cases will be rapidly linked to treatment and strategies implemented to ensure they remain on treatment to achieve viral suppression.

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. In relations to HIV services men 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 that 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. Therefore, population demographics and dynamics 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.

In COP20, 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) children, 5) key populations (MSM and FSW), and 6) 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 address the age and sex band gaps in order to achieve sustained epidemic control in PEPFAR-supported areas by 2021, with significant progress toward closing the gaps in FY20. In COP20, 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 corrective actions to improve case identification, to link positive cases to treatment, and retain them in the program.

Results from FY20 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. Innovative ways to identify HIV positive men at earlier stages are critical. FY20 Q1 results showed that index testing is a promising strategy for reaching men. Case finding is increasing in Kinshasa among both males and females, although there are still growth opportunities 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, the self-testing strategy will be scaled up 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. FY19 Index Testing results show encouraging trends in fulfilling this goal.

Although the results are not yet optimal, PEPFAR/DRC is reaching relatively more men and identifying more PLHIV than in the past. PEPFAR/DRC is building on experience and 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.

Strategies to help find men at an earlier stage and age:

- Provide men friendly and hospitable services, with flexible/expanded clinic hours and male staff;
- Offer self-testing, particularly for male partners of female index cases, and male partners who are not willing to show up at facilities;
- Maintain high rates of HIV testing among all presumptive and diagnosed TB patients;
- Meet men where they are with HTS, such as work and leisure places, with community or mobile-based HTS;
- Optimize PITC for men using validated and harmonized screening tool;
- Improve positive and hopeful messaging to men, including U=U;
- Integrate HTS with other disease wellness programs that involve on-site or mobile testing for other diseases (e.g., malaria, hypertension, diabetes); and
- Implement recency testing to identify transmission “hot spots.”

Pediatric case finding strategies:

- 100 percent of biological children of mothers who are living with HIV (or fathers with HIV and mothers of unknown HIV status; or deceased mothers) will have a documented HIV test;
- Home testing if parent living with HIV does not want to bring child to the facility for testing;
- Testing of contacts of CLHIV (0-17 years old), including parents, siblings, sexual contacts, and children of ALHIV;
- Community outreach to offer HTS to index clients identified at facilities;
- Active follow-up of HIV positive pregnant women who gave birth to an HIV-exposed infant but did not return for infant testing;
 - At 6 weeks postpartum, case workers will visit parent to encourage them to bring infant to facility for testing;
 - At 8 weeks postpartum, case workers will collect EID dried blood spot (DBS) sample at home;
- Systematically implement screening tools in out-patient departments (e.g. malnutrition clinics), under five services, and OVC testing;
- Focus on family tree index testing;
- Assign newly identified patients living with HIV to OVC case managers to assist with disclosure counseling, partner notification services, and index testing; and
- Use monthly case conferencing between clinical coordinator and OVC case managers to monitor testing coverage.

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, community health workers (CHWs,) and orphans and vulnerable children (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 suppression
- Emphasize the message of U=U during counselling of patients on treatment and testing

4.2 Retaining clients on treatment and ensuring viral suppression

Equally important as finding those individuals who we are missing, is ensuring that those we do find are rapidly 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/Community Case Managers/Mentor-Mothers will support linkage, treatment readiness, and adherence; and immediate initiation of ART. Messaging about treatment will be patient-centered, with consideration of patients' current needs and experiences; empowerment through ease of care, spaced visits, and easier treatment; and U=U.
- Improved Tracking & Reminder System: Use of Tier.net and appointment calendars to track clients due for appointments or viral load testing; and use of phone calls/SMS for visit reminders.
- Patient-centered distribution models, such as differentiated care & MMD; Fast track Refills at facilities; PODIs to decongest high volume sites; and Community adherence groups/support groups.
- With the opportunity of TLD as preferred first line, reinforce the therapeutic education and update ART adherence messages
- VL Coverage and Monitoring: Scaling-up VL Coverage by implementing educational materials for children and adolescents, enhancing site monitoring using the VL score-card and VL implementation monitoring guide, tracking performance through use of the weekly VL tracker, and reinforcing the 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.
- System/Partner Level Support: Granular site management will be conducted with monthly/quarterly reporting and analysis of reports (Tier.net and SIMS dashboard) to identify performance gaps and develop and institute remediation plans.

In addition to these activities, it will be important to ensure 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.

4.3. Prevention, specifically detailing programs for priority programming

4.3.1. HIV prevention and risk avoidance for AGYW and OVC

UNAIDS estimates that there are 410,000 orphans who have lost one or both parents due to HIV in the DRC (UNAIDS 2018). 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 64,000 children 0-14 years of age are living with HIV in the DRC (UNAIDS, 2018). 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 percent of enrolled OVC beneficiaries
- Conduct HIV risk screening on 100 percent of enrolled OVC beneficiaries (particularly those under 18 years old) 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 FY20, 44,516 OVC and their families affected by HIV are expected to receive services and 4,663 OVC are expected to leave the program after graduation. An estimated 39,853 will remain active at the end of the fiscal year. The more stringent admission criteria being applied to OVC programs in FY19 resulted in this high number of OVCs exiting without graduation. During FY20 this number is expected to return to a very low level. During FY19, 100 percent of HIV-positive OVC under 18 were either enrolled or already on ART. The 3,469 OVCs without a known HIV status were not tested based on results from the required administration of the HIV screening tool.

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 FY21, 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.

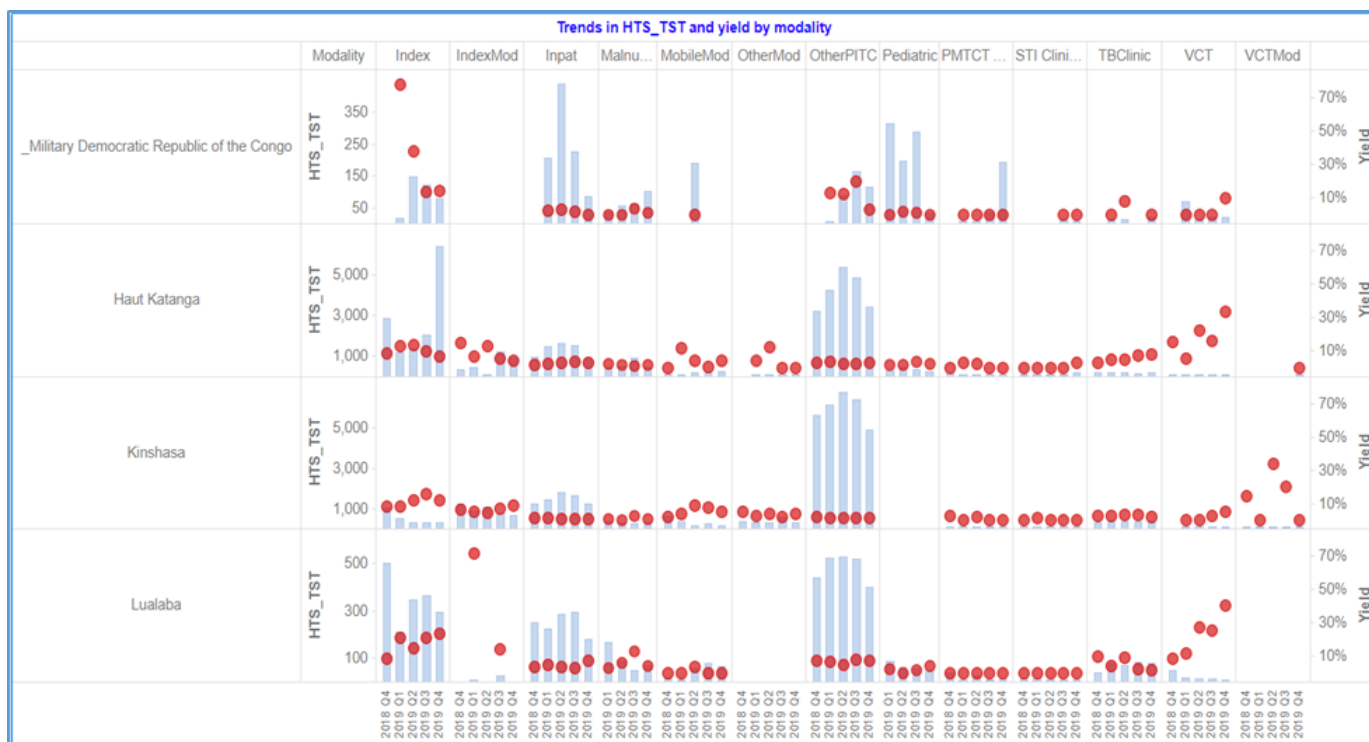
The PEPFAR/DRC OVC and pediatric testing and treatment programs will leverage each other and support a family-centered approach to ensure that the needs of children living with HIV and vulnerable children are met at both clinical and community level. The strategy will focus on the systematic use of a 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 community-led 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.

4.3.2 Children

The number of children receiving ART nationwide has increased by 316 percent between 2013 and 2018, with children under 15 years old accounting for approximately 6.2 percent of the total of number of people on ART in 2018. However, national data shows that pediatric ART coverage is still proportionately lower at 25 percent compared to 62 percent adult coverage in DRC (UNAIDS, 2018). In PEPFAR areas, pediatric treatment remains a challenge fueled by the relatively low identification of positive children. Figure 4.3.2.1 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 4.3.2.1: Trends in HTS_TST and yield by modality and SNU, age <15 (FY18Q4-FY19Q4)



Another persistent challenge is access to VL testing. By FY20 quarter one (Q1), half of our implementing partners had pediatric VL suppression lower than 70 percent, which is multifactorial (suboptimal ART regimens, psychosocial and economic hardship of caregivers influencing the adherence and retention.)

Figure 4.3.2.2: Pediatric Trends in VL Suppression by SNU and IP (FY19)

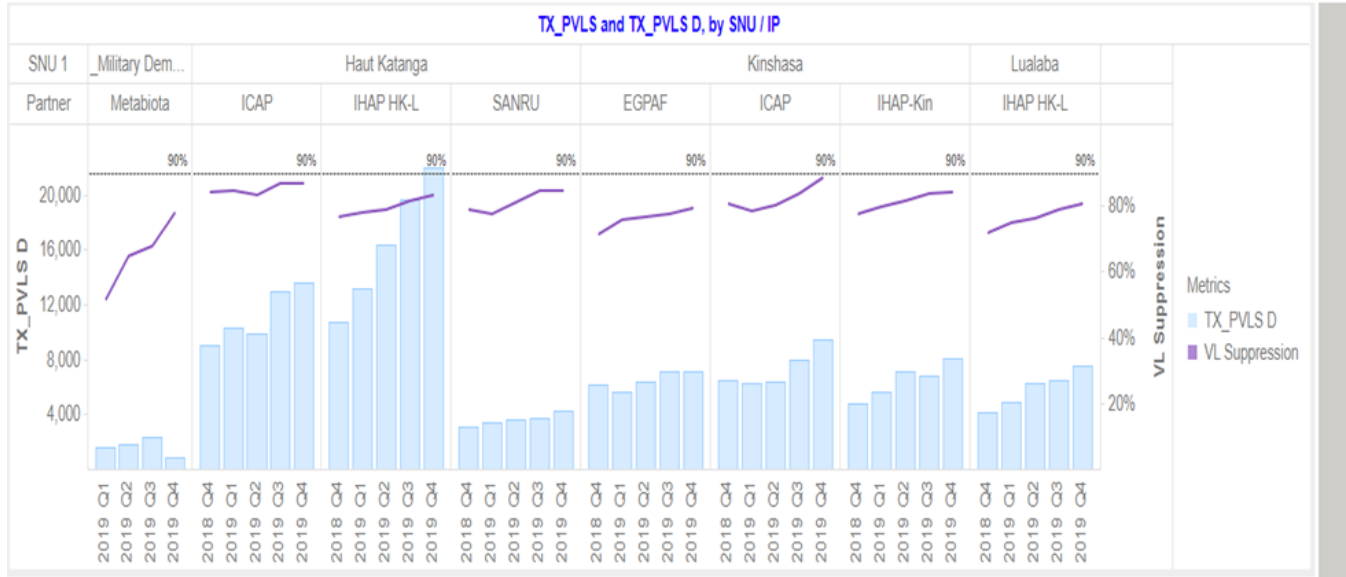
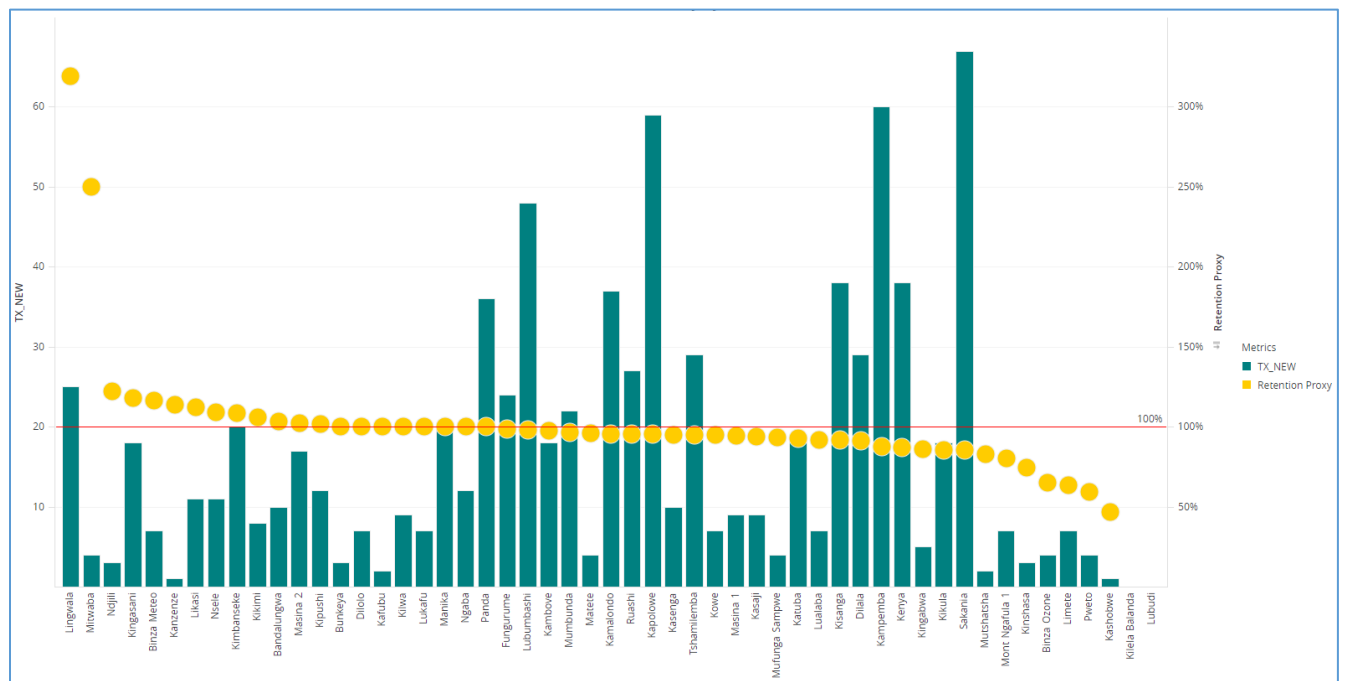


Figure 4.3.2.3: Pediatric Retention by HZ across all 3 provinces FY20Q1

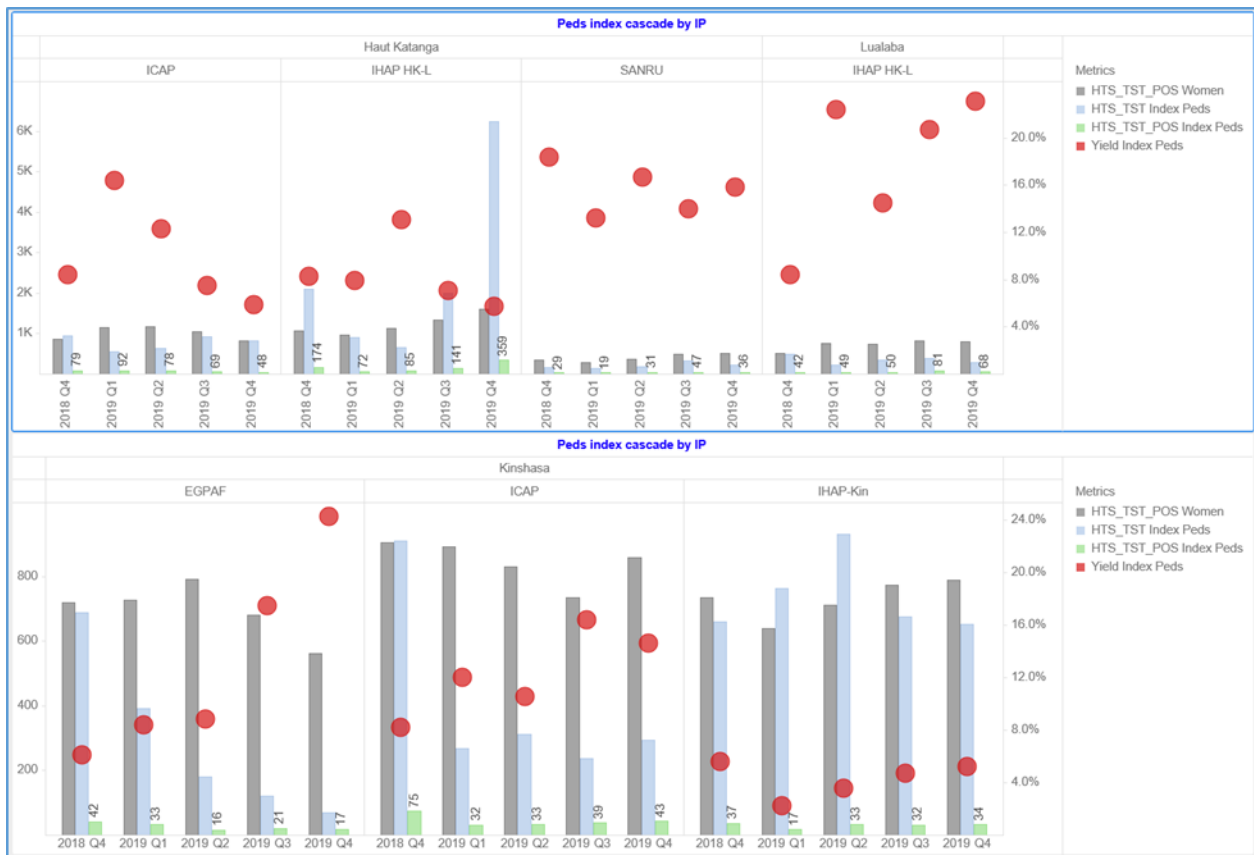


In addition to expanding ART (including inclusion of children in differentiated service delivery models), expanding VL testing coverage, increasing Nutrition Assessment Counselors, and improving TB screening, a key priority will be to increase systematic and routine HIV testing of all children, especially:

- 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 4.3.2.4.

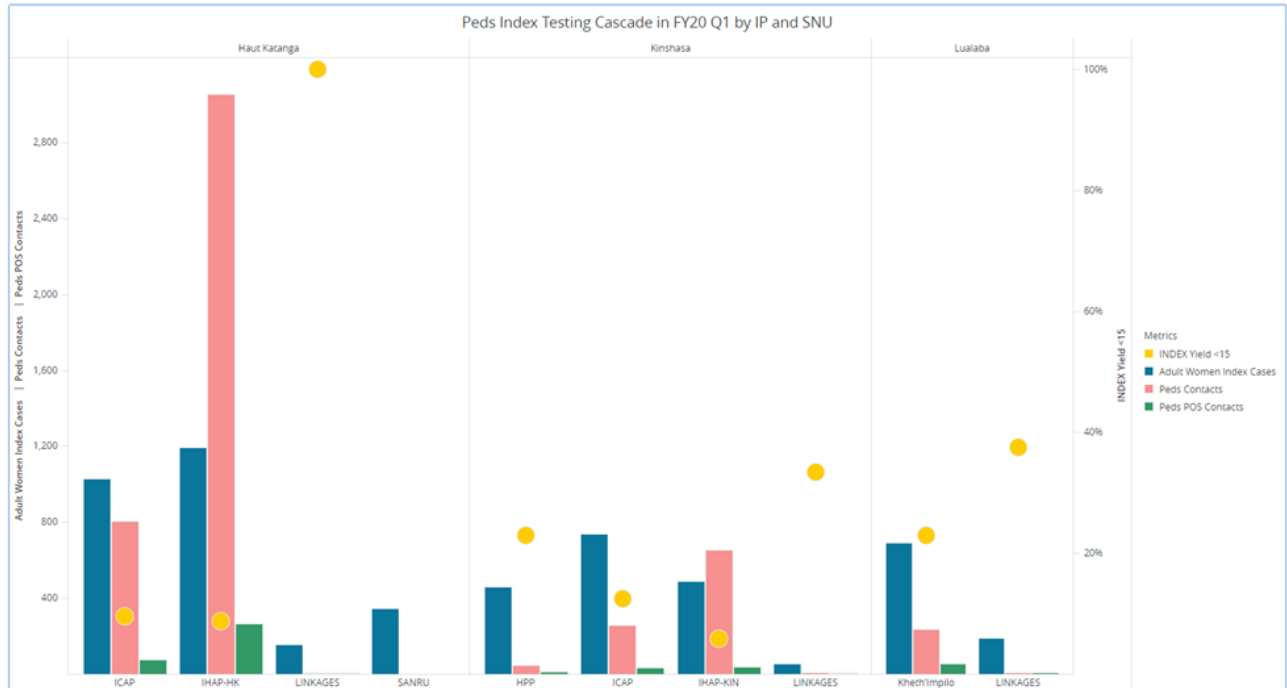
Figure 4.3.2.4: Pediatric Index testing cascade by SNU and IP (FY18Q4-FY19Q4)



Furthermore, in COP20, 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 clinics and communities (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.

Figure 4.3.2.5: FY20 Q1 Pediatric Index testing cascade by SNU and IP



4.3.3 Key Populations

Building on COP19 interventions, COP20 programming for KPs will continue scaling up existing successful strategies. We have set ambitious targets (KP_PREV: 34,120; HTS_POS: 2,270; yield: 7.5%; TX_NEW: 2,146). 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: All KP testing clients, including index clients, will be provided with all available HIV prevention, care and treatment services, regardless of whether they provide details about their contacts. Clients must NEVER be pressured into sharing the names of their contacts for fear of being denied services. Services must NEVER be withheld under any circumstances. An **Intimate partner violence (IPV) risk assessment** standard

operating procedures (SOP) will be put in place and IPV screening will be conducted for each contact elicited, with referral options to necessary services;

- Social and sexual network strategies like the Enhanced Peer Outreach Approach (EPOA) and the RDS-like recruitment (DOR) will be implemented;
- Risk network referrals (RNR) paired with index testing in order to reach high-risk networks;
- Self-testing;
- Information and communication technology (ICT) platforms especially targeting MSM and TG; and
- Traditional outreach and Drop-in-centers.

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;
- Linking daughters of FSW to the OVC program and socioeconomic strengthening opportunities;
- More community service delivery points (CSDP) to facilitate treatment initiation, PrEP, community testing, and community ARV distribution;
- Training to additional peer navigators to improve ratio of peer navigators to beneficiaries; and
- Extensive follow up by peer navigators and counselors to improve ART initiation, tracking, adherence, and retention.

4. Reducing stigma and discrimination, by introducing:

- 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: Police and other law enforcement will be trained/sensitized to reduce interference with KP programming and other public health efforts.

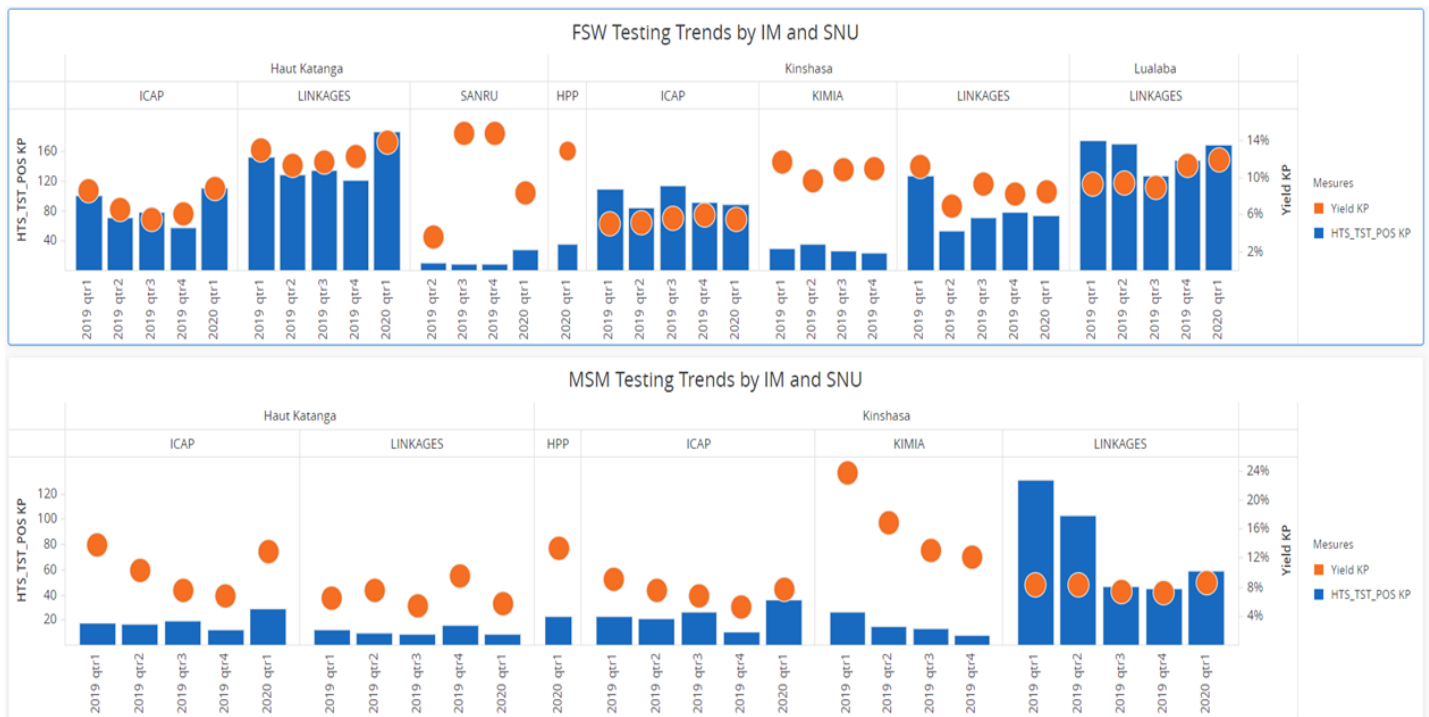
5. Engaging with the KP community, which includes:

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

The Community monitoring systems will be put in place using LINK technology-based system which routinely monitors clients' satisfaction with HIV services and documents health providers' perspectives that may affect client experience (of violence, stigma, and discrimination).

4.3.3.1 Testing

Figure 4.3.3.1.1: PEPFAR KP trend case finding and yield by IP and province (FY19Q1-FY20Q1)



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.

All KP testing clients, including index clients, will be provided with all available HIV prevention, care and treatment services, regardless of whether they provide details about their contacts. Clients must NEVER be pressured into sharing the names of their contacts for fear of being denied services. Services must NEVER be withheld under any circumstances.

4.3.3.2 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 COP20, 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 (STIs), condom use, Positive Health, Dignity and Prevention (PHDP) initiatives, linkage to care, and treatment adherence. Ensuring that KPs are linked to care and treatment instead of simply being given a referral will continue to be a focus for PEPFAR/DRC.

Additional PNs (Peers navigators) will be hired to improve their ratio to beneficiaries (#KP HIV+ per PN) in order to reinforce ART initiation, tracking, adherence, and retention.

4.3.3.3 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 the border.

SIMS data will be used to monitor partner performance and enhance the tracking of both the KP prevention and treatment cascades. PEPFAR/DRC will continue to conduct monthly partner performance reviews of testing and treatment progress.

Community monitoring systems will be put in place using LINK technology-based systems which routinely monitor client satisfaction with HIV services and documents health provider perspectives that may affect client experience of violence, stigma and discrimination.

4.3.4 TB/HIV

In FY19, 98 percent (26,388/26,913) of registered TB patients in PEPFAR-supported health zones were tested for HIV; 2,726 of those patients were found TB/HIV co-infected and 95 percent (2,590/2,726) of the co-infected patients were initiated on ART.

During FY21, 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 TB screening at all PEPFAR supported facilities; to ensure rapid ART initiation for TB/HIV co-infected; 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. All eligible PLHIV, including children, will complete TPT by end of COP20, and cotrimoxazole, where indicated, will be fully integrated into the HIV clinical care package at no cost to the patient. These core TB/HIV interventions are key evidence-based approaches to achieve the UNAIDS 95-95-95 goals.

In selected high-volume ART sites in COP20, PEPFAR/DRC will continue to use lateral flow urine lipoarabinomannan (LF-LAM) assay for TB diagnosis in PLHIV with low CD4 counts or those who are seriously ill. In FY21, 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 the MOH to: complete the review of 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 COP20, the PEPFAR program will provide INH for 100 percent of PEPFAR/DRC's annual targets, and the Global Fund will continue to supply INH for the areas which they support.

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 HIV testing services (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.

4.3.5 Military

In COP20, 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 FY21, 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.

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

PEPFAR/DRC has considered country-specific priorities listed in the planning letter to improve program results and reach ambitious COP20 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.

PEPFAR/DRC will continue to scale-up activities to reach 95/95/95 in adult men, women, and pediatric populations with the goal of epidemic control. Index testing implemented with fidelity and a focus on the “Five Cs” will be emphasized during the coming cycle, particularly among male

sexual partners. There is also a need for KP case finding to improve. In addition, DRC will continue to improve retention and 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. PEPFAR DRC will use the data from recently conducted IBBS and utilize site level mapping data for program improvement. Additional funding is provided for strategic information investments, including for the completion of the individual level data repository.

4.4.1 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 FY19 through improved implementation of index testing, as shown in Figure 4.4.1.1 below. 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. In COP20, PEPFAR will focus on the scale up of index testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. Already in FY20 Q1, as seen in Figure 4.4.1.2 and 4.4.1.3, we are seeing improvements from FY19.

Figure 4.4.1.1: Improved yields in index testing FY19

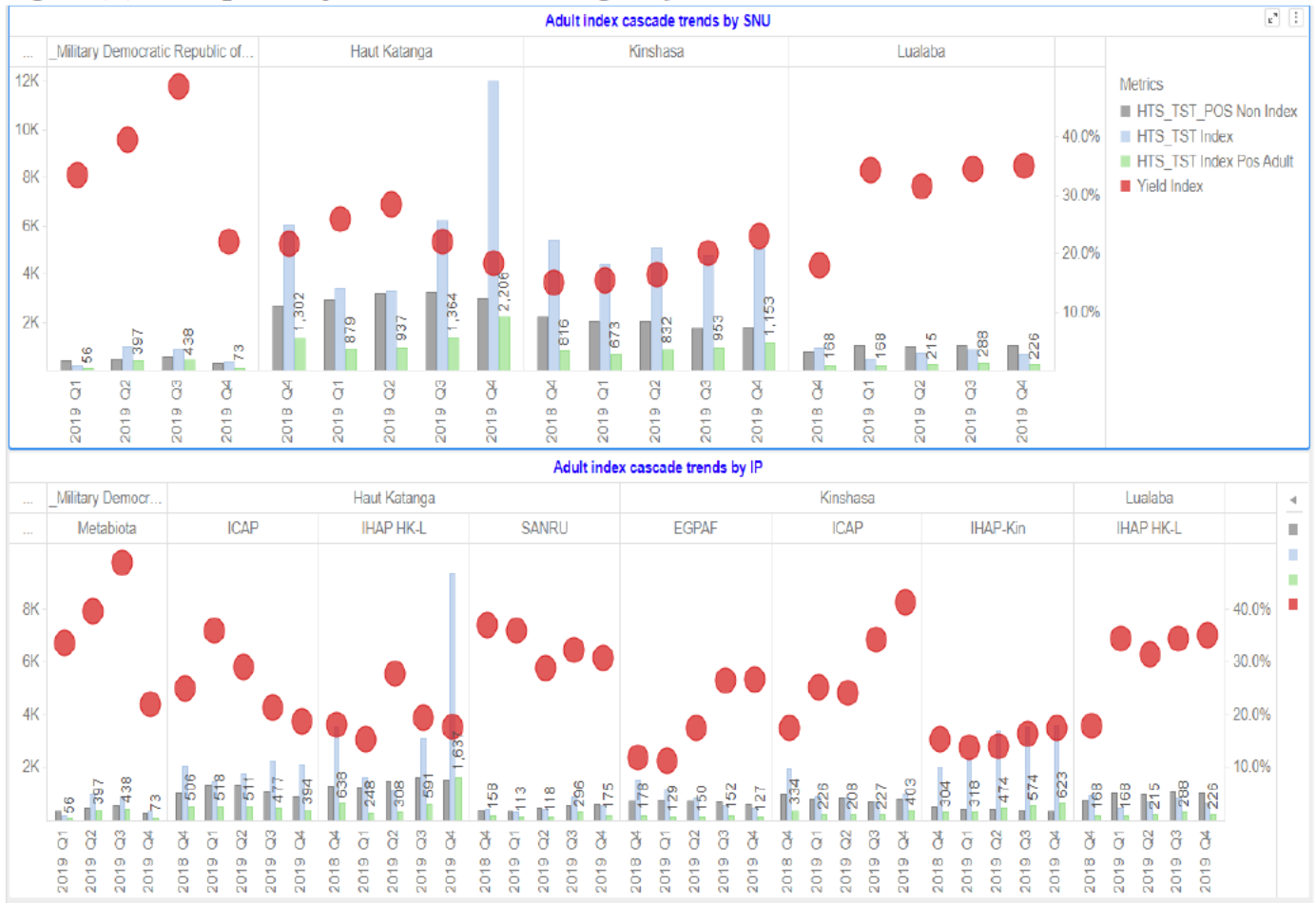


Figure 4.4.1.2: Improved yields in index testing FY20Q1

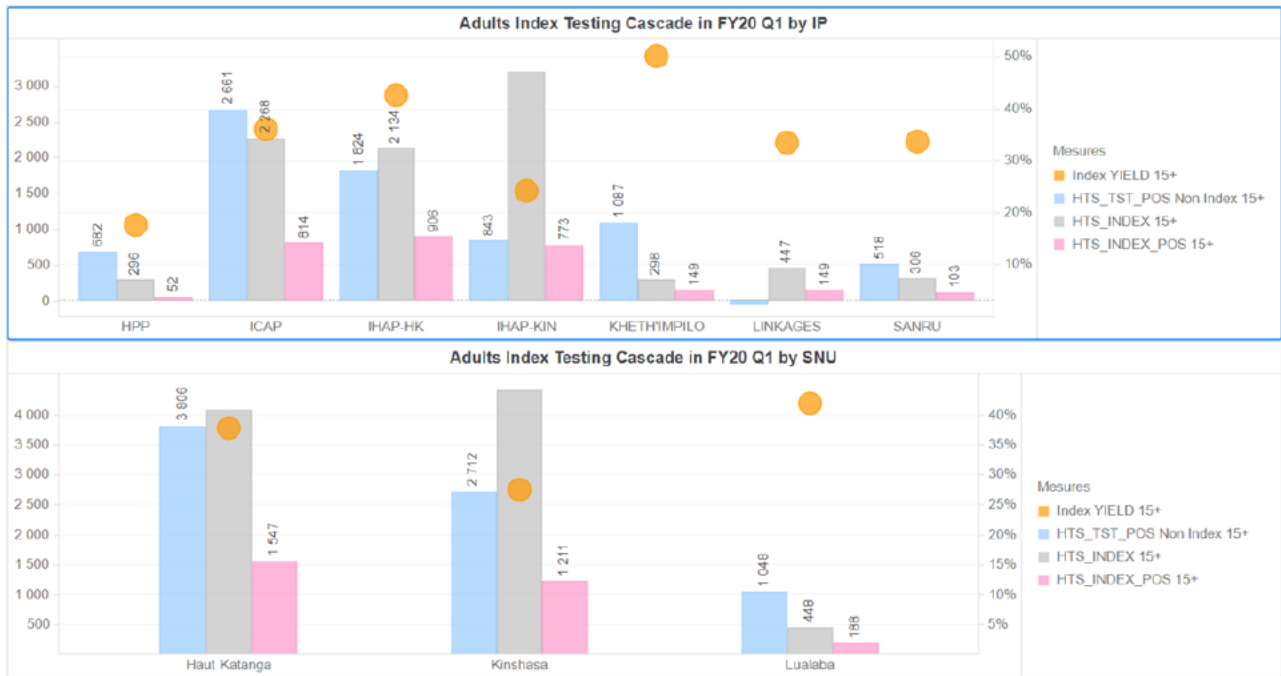
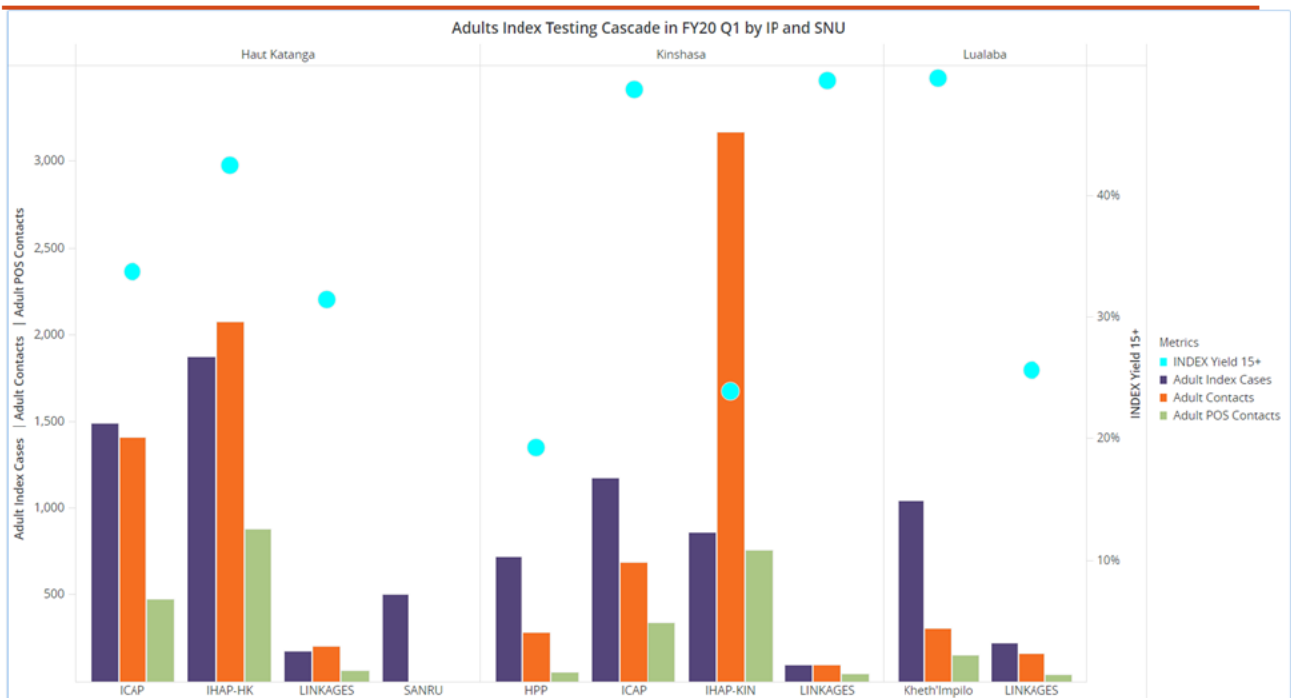


Figure 4.4.1.3: Adult Index Testing Cascade in FY20Q1 by IP and SNU



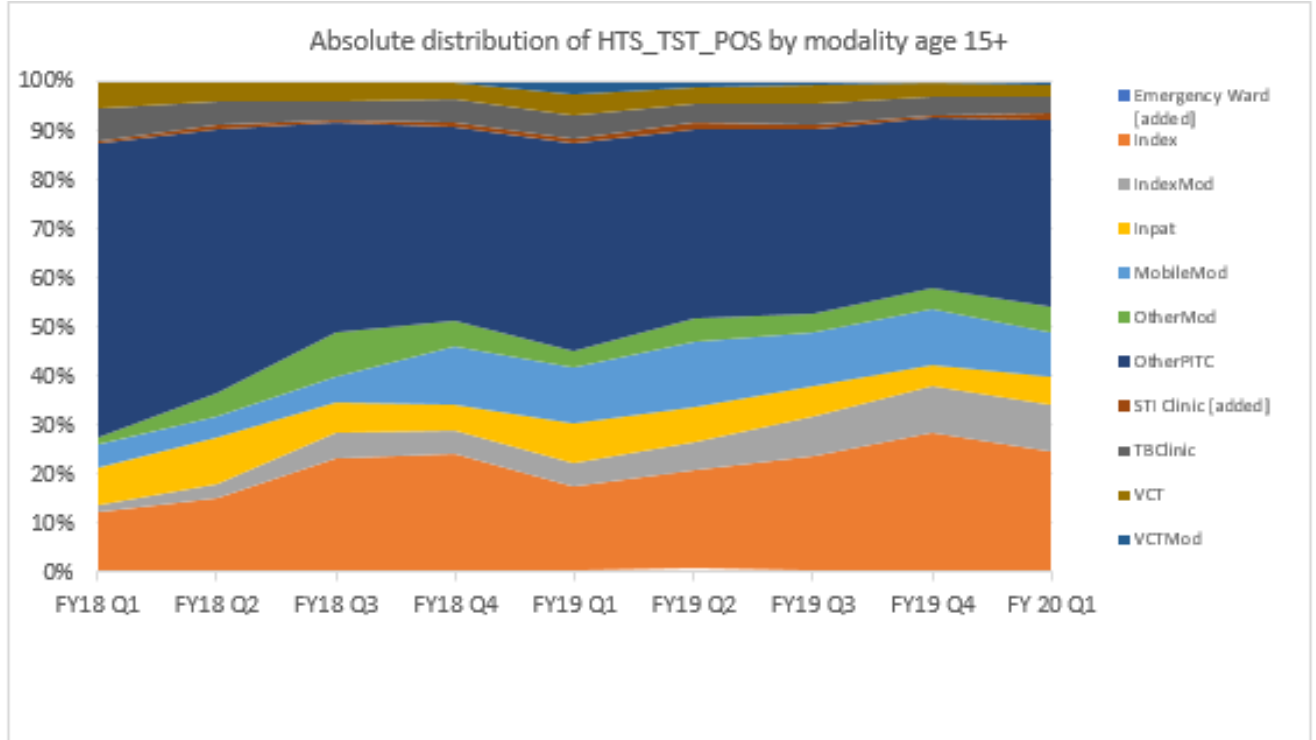
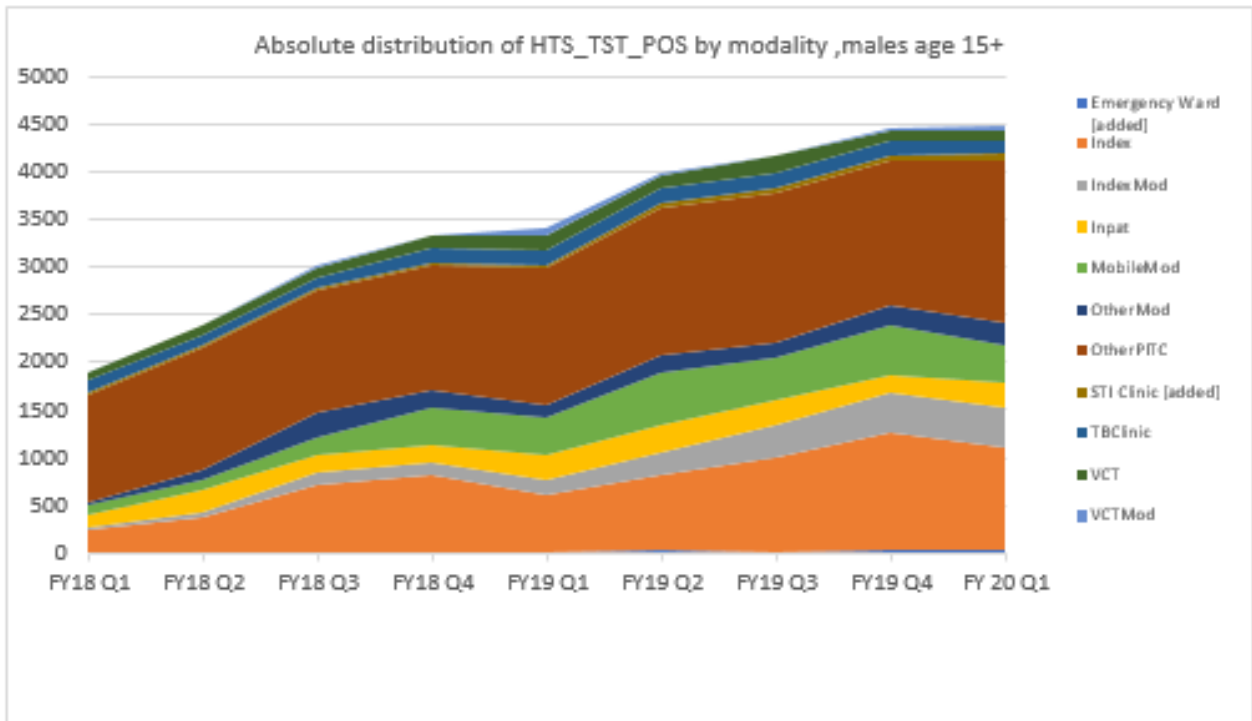
4.4.2 Finding Younger Men

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

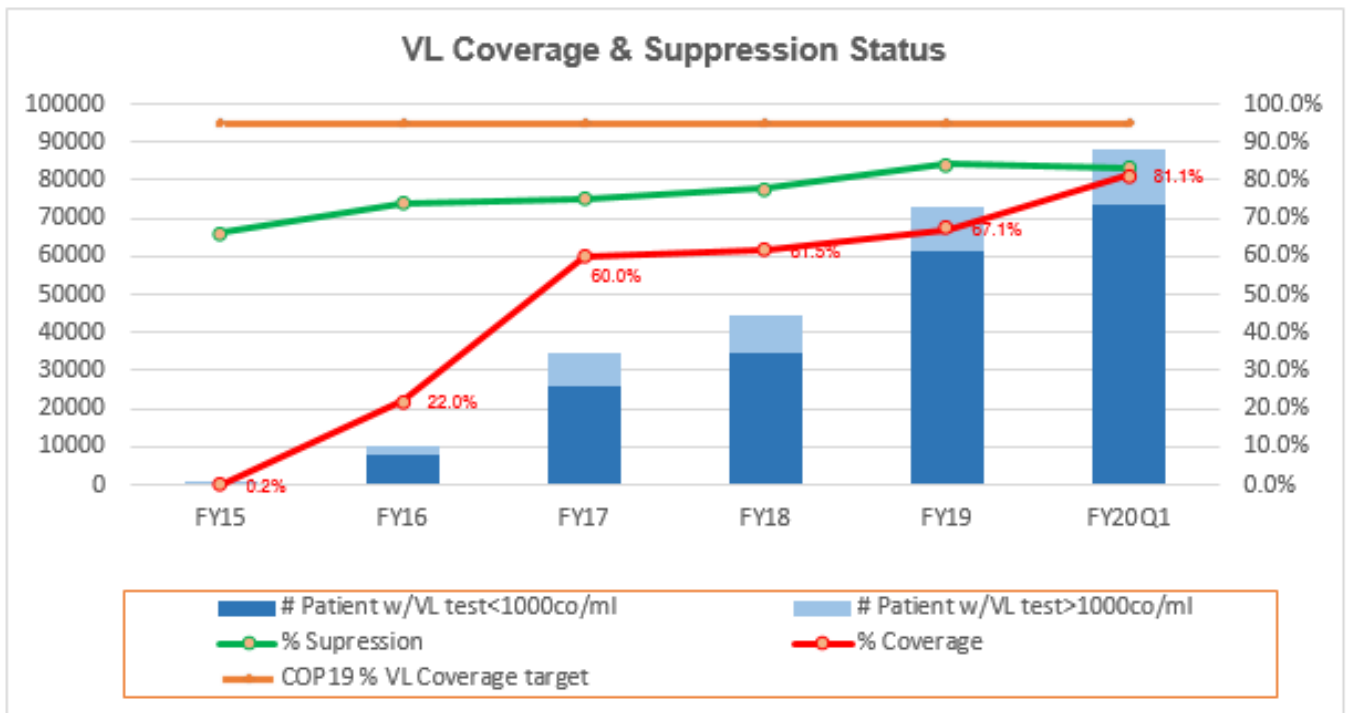
The transmission hypothesis in DRC is based on the belief that older men, who have been infected for a number of years, are key drivers of transmission via their numerous sexual partners. This hypothesis will be tested in Kinshasa, utilizing recency testing to identify more recent transmission and better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

As shown in the figures 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.)

4.4.2.1 Distribution of HTS_TST_POS (FY18-FY20Q1)



4.4.3 Viral Load Scale-up and Suppression



PEPFAR/DRC’s efforts to scale up VL coverage and improve viral suppression have come a long way. In FY19, VL coverage and suppression was at 67 percent and 84 percent and short of the 80 percent and 95 percent targets for VL coverage and suppression, respectively. Several barriers, especially site specific, have been identified within the VL cascade responsible for the less than optimal scale up. Measures are currently being implemented at site level during FY20 to address issues throughout the VL cascade. Issues being tackled include the lack of a uniform process across all sites to track identification of eligible patients for VL specimen collection; lab-related issues (e.g. sample backlogs, completion of patient specimen request form, specimen rejection rate, turnaround times, and suboptimal equipment utilization); reagent stockouts; and sample transport and results return issues between the clinical sites and the laboratories. A standard tracking process has been implemented in all sites to ensure close monitoring of those eligible for VL testing, and that all samples arrive at a laboratory and results are returned in a timely manner to clinical sites and patients. Furthermore, laboratories are proactively following up to ensure and document that results collected or transmitted from the laboratories have arrived at the referring clinic sites for prompt action by the caregiver. In COP20, PEPFAR will focus on ensuring 100 percent access to EID and annual VL testing, optimal scale up. Measures are currently being implemented at site level during FY20 to address issues throughout the VL cascade. Issues being tackled include the lack of a uniform process across all sites to track identification of eligible patients for VL specimen collection; lab-related issues (e.g. sample backlogs, completion of patient specimen request form, specimen rejection rate, turnaround times, and suboptimal equipment utilization); reagent stockouts; and sample transport and results return issues between

the clinical sites and the laboratories. A standard tracking process has been implemented in all sites to ensure close monitoring of those eligible for VL testing, and that all samples arrive at a laboratory and results are returned in a timely manner to clinical sites and patients. Furthermore, laboratories are proactively following up to ensure and document that results collected or transmitted from the laboratories have arrived at the referring clinic sites for prompt action by the caregiver.

In COP20, PEPFAR will focus on ensuring 100 percent access to EID and annual VL testing, with results delivered to the caregiver within five days including the rollout of point of care (POC) technology for same day results delivery. Demand creation, including treatment literacy activities for VL testing will continue to be a priority to improve coverage. Healthcare workers will also be sensitized to systematically request viral load tests for eligible patients. A viral load champion will be identified at each site to immediately file viral load results in the patient's chart and at the same time notify the provider and the patient. Logistics will be improved to allow for optimized specimen collection from site to laboratory and return of results to site. Our results continue to show disproportional VL coverage and suppression within particular populations such as pediatrics and pregnant and breastfeeding women. To address this gap, we will promote DBS collection for pediatrics and use of POC for pregnant women and breastfeeding women, children and unsuppressed patients.

As part of the laboratory network optimization, PEPFAR/DRC has completed an inventory (human resources, type of platform, number of platforms) of PEPFAR-supported VL/EID laboratories-clinical site networks and assessed the utilization capacity of conventional platforms. This has shown an underutilization of existing conventional platforms. PEPFAR/DRC will continue to leverage existing conventional platforms and improve related systems together with integration of POC technology for VL and EID scale up. This will entail strategic placement of POC, availability of commodities/reagents, and systems including quality management systems to support POC sites.

As an illustration of best practices, certain sites have established VL committees (doctors, nurses, peer-educators, and psychologists) to manage VL results and give attention to unsuppressed patients requiring adherence monitoring and support for three months or more depending on patient compliance. Following this, the committee decides on continuation or any changes that may be required to the patient's regimen.

PEPFAR/DRC's rapid transition to TLD and adoption of optimized pediatric regimens is showing improvements in adherence and VL suppression.

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.
- Complete 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.

4.4.4 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 requirements of the program. In FY20Q1, linkage was 97 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.

4.4.5 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. The GDRC has recently announced a plan to provide free ANC services to HIV positive women as part of their move towards universal health care. PEPFAR/DRC will continue to monitor fees and the barriers to access for HIV services which they represent, by engaging civil society through a community-led monitoring system building on the work of the “Observatoire”, to hold facilities and community sites accountable to elimination of all forms of user fees as well as ensure the information from civil society is acted upon.

4.4.6 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. Moreover, PEPFAR/DRC 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 the government. PEPFAR/DRC will monitor plans for unique identifier implementation by developing short term milestones which show progress. The program 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 FY20.

4.5 Commodities

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

Efforts are currently underway and will continue in COP20 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.

PEPFAR/DRC priorities for commodities are: 1) ensuring timely customs clearance; 2) end-to-end data use to improve visibility, transparency and accountability of HIV commodities; 3)

strengthening last mile distribution and patient-driven approaches; 4) increasing MMD for adults and children by placing 50 percent on 3-month packs and 50 percent on 6-month packs; 5) completing pediatric regimen optimization; and 6) scaling up optimized TB prophylaxis (3HP) in PEPFAR-supported health zones.

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

- Procure adults and pediatrics ARV. In COP20, PEPFAR will procure 90 and 180-count TLD as the main first line, with the goals that 50 percent of patients will collect ARVs every three months, and 50 percent of patients will collect ARVs every six months. A 30-count TLD will no longer be procured. As the TLD transition was completed as of September 2019, PEPFAR/DRC will monitor for possible TLD side effects and procure orders of TLE 400 as an alternative first line for patients not eligible for TLD (estimated to be less than one percent of patients). TLD will remain the main first line regimen for adults and children weighing more than 30 kgs, including pregnant and breastfeeding women and women of childbearing age.
- Procure ARVs for PrEP for PEPFAR-supported health zones to support the scale up of PrEP programming.
- Continue to optimize pediatric ART regimens per PEPFAR guidance. In COP19, PEPFAR/DRC completed the optimization of pediatric ARV regimens away from Nevirapine-based regimens for pediatric patients weighing less than 20 kgs and more than 10 kgs. The transition for patients weighing less than 10 kg and more than 20 kg has been delayed due to global production constraints of LPVr 100/25 mg. The expected completion date of ARV optimization for these pediatric patients is FY20 Q2. In COP20, PEPFAR/DRC will monitor sites to ensure that pediatric patients are on optimized regimens. Only optimized regimens will be procured for pediatric patients. No nevirapine based regimen will be procured, except nevirapine 50 mgs for HIV exposed infants.
- Strengthen partners' capacity to provide patient-driven approaches to ARV distribution (e.g. decentralized drug distribution at locations and pickup points more convenient to patients) through developing and disseminating monitoring tools and job aids.
- PEPFAR/DRC saw significant improvement in the commodity custom's clearance process, with lead time reducing from six months to two months since the beginning of FY19. PEPFAR/DRC will continue to work in collaboration with the GDRC, the Global Fund and other donors to reduce the lead time to get products through customs clearance and in country efficiently. Customs clearance remains a top priority for PEPFAR.
- Support the MOH in planning, operationalizing and monitoring the implementation of the national supply chain strategic plan; 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

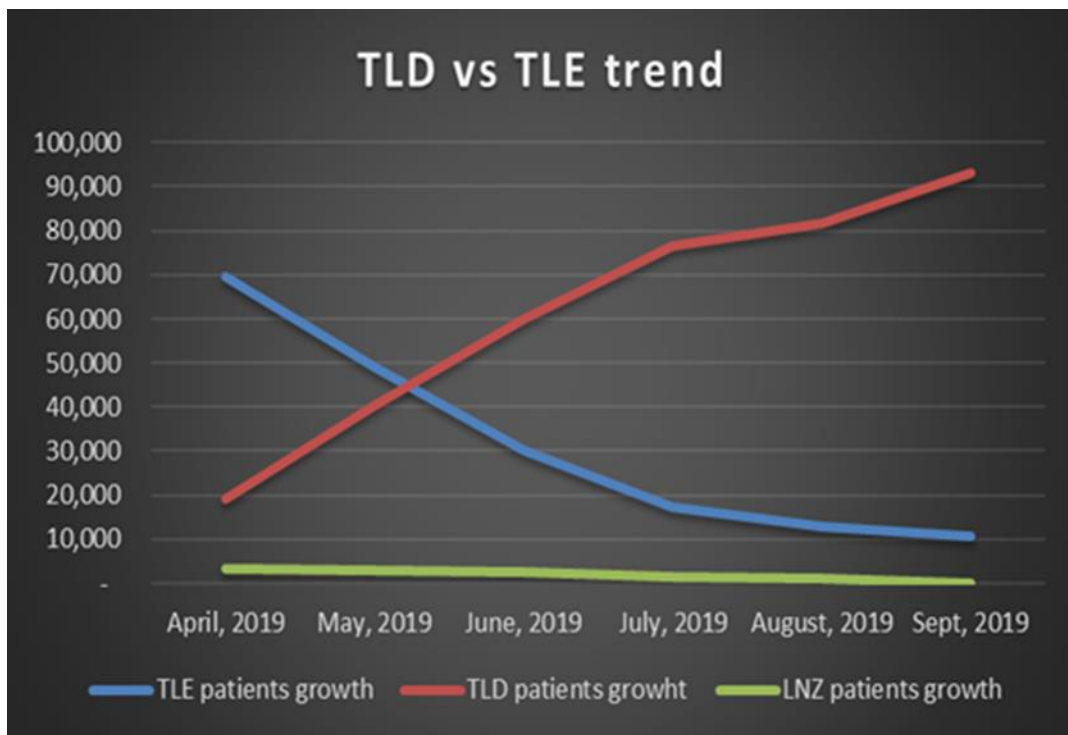
related annual supply plan (provide tools, review parameters, conduct training/refresher training on the use of Forlab, pipeline and Quantimed tools)

- Strengthen the collection, management and use of supply chain data to enhance transparency and accountability of HIV commodities. Data will be used to improve stock visibility and management at the facility level and increase visibility and rational use at the point of service. PEPFAR/DRC will 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, with a focus on improving data quality, completeness, and usage.
- Implement web-based dashboard for Early Warning System (EWS) in all sites supported by both PEPFAR/DRC and the Global Fund to enhance data visibility for informed decision-making.
- Ensure that the information system (LMIS) is operational and that data collection takes place at all levels and ensure that data collected are analyzed and used for making decisions. PEPFAR/DRC will strengthen the use of the national LMIS program, InfoMed, in PEPFAR-supported health zones, and will provide technical support to implement InfoMed in Global Fund-supported provinces. PEPFAR will ensure that data sharing takes place and results are shared through the technical working group.
- Support distribution to the last mile of all HIV commodities (ARV and RTK included). PEPFAR will also support warehousing, logistics management; and provision of management tools, in all PEPFAR-supported health zones.
- Establish and strengthen the VL/EID lab commodities forecasting and supply chain system.
- Provide technical assistance to health zone staff on stock management, TLD pharmacovigilance data collection for transition follow up, optimization of pediatric ARV follow up, MMD management and rational use of HIV commodities.
- Reinforce national and provincial coordination of HIV commodities management. PEPFAR/DRC, through USAID has been appointed recently as lead of the health donors supply chain group and as such, co-lead the National Medicines Commission with the National Pharmaceutical Regulatory Authority. This will help to strengthen donor collaboration and improve GDRC leadership, oversight and accountability on health commodity forecasting and procurement system management.
- Continue to provide technical assistance to the MOH, the Global Fund, and other implementing partners for TLD pharmacovigilance data collection roll out, analysis and use.
- Provide RTKs to support HTS in all PEPFAR-support health zones and provide technical support to IP and health providers for the best management of RTKs at HZs and sites levels.

Although each donor procures commodities to cover patient needs in their supported health zones, PEPFAR/DRC and the Global Fund, as the main donors, will continue to support the country’s initiative to scale up VL/EID testing by increasing and/or optimizing 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 percent VL coverage by the end of FY20 and maintain it through FY21. In COP 20, PEPFAR/DRC will strategically integrate the use of GeneXpert for VL/EID testing in collaboration with the National TB program in COP20, especially to cover remote areas.

Improving PNLS coordination and information sharing between PEPFAR/DRC, 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/DRC maintains support for a monthly tracking system for the key VL 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.

Figure 4.5.1: TLD Transition Timeline



4.6 Collaboration, Integration and Monitoring

PEPFAR/DRC’s focus on sustainable epidemic control began in 2014, when the program pivoted to a data-driven approach, strategically focusing on geographic areas and populations where HIV is most prevalent. With this approach, PEPFAR/DRC, 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, COP20 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 COP20 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 practices 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/DRC program planning, target setting, budgeting processes and strategies; and
 - Engaging in meaningful dialogue 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 19 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/DRC 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.

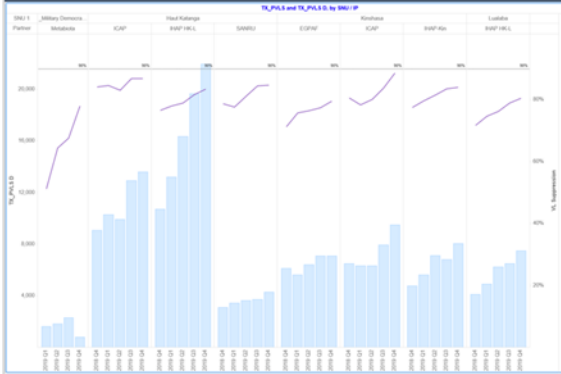
4.6.1 Partner Management for Epidemic Control

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-cause analysis, remediation plans and monitoring of remediation plans;
- A site-level dashboard to empower PEPFAR/DRC, 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 sale up of index testing, viral load, and differentiated service delivery.

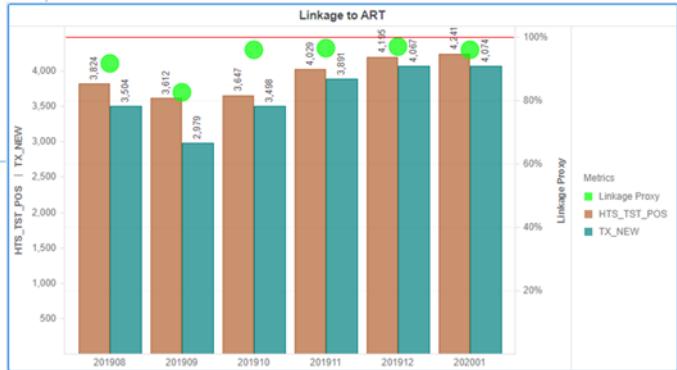
These tools identify necessary site-specific corrective measures and create remediation plans. They employ standardized processes, identify roles and responsibilities and ensure accountability. Plans are monitored bi-weekly, monthly and quarterly to improve recognition of issues and implementation of relevant interventions to improve outcomes. Simultaneously, PEPFAR/DRC agencies have set financial review processes that scrutinize monthly burn rates against performance. Monthly calls, quarterly financial reviews and regular inter-agency financial meetings track financial performance 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

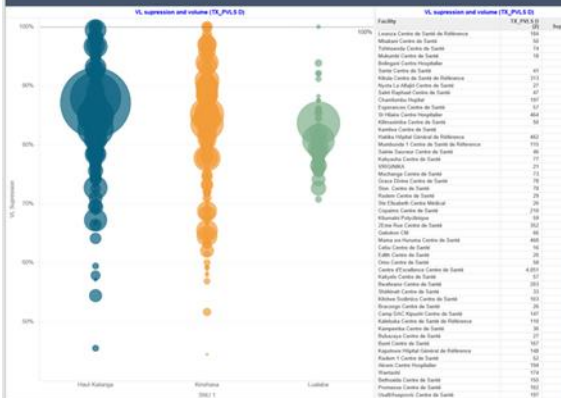
DRC monthly reporting
dossier, Panorama
Analytic Workspace



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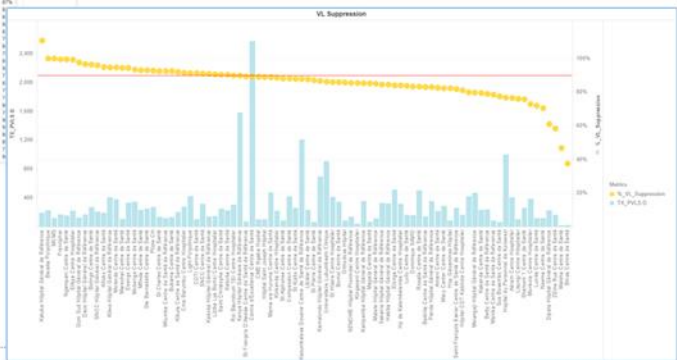
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Analyze quarterly and monthly data at site level



DRC MER dossier,
high volume site
dossier, Panorama
Analytic Workspace

DRC monthly reporting
high volume site
dossier, Panorama
Analytic Workspace



Click to add text

...with a focus on high volume sites

Can specify by age/sex groups

DRC MER high volume site dossier, Panorama Analytic Workspace

Communication and meetings with IP to discuss underperforming sites

Performance Gap Documentation

Partner: ICAP | MER: X SIMS

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

Performance Gap Statement:

- 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** 3

Problem overview:

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

Facility	Retention	TX_NEW	TX_NET_NEW	LTFU
Paul Medical Center CM	0%	1	0	(1)
Aux Bona Sains CH	33%	3	1	(2)
Katinka HGR	39%	19	7	(11)
Minda	42%	16	8	(11)
Eberga	45%	20	9	(11)
OUA	50%	2	1	(1)
St Raymond - Kisse	50%	2	1	(1)
VIRONGOLA	50%	2	1	(1)
SINGU - Lubumbashi HGR	52%	23	12	(11)
Don Meehan	60%	5	3	(9)
La Rocher CS	67%	3	2	(1)
MLX POLYCLINIQUE	67%	3	2	(1)
PACIFIQUE	67%	3	2	(1)
Eberga - Massinzi CR	73%	30	22	(8)
St Prosper CM	75%	8	6	(9)
St Jean (Kisumu) CSR	75%	8	6	(9)
Rukeni CM	78%	9	7	(9)
Emeraude - Nsoke CS	80%	5	4	(1)
Methodiste - Nsoke CS	80%	5	4	(1)
Silve - Ozone CM	80%	5	4	(1)
	87%	37	20	(7)
	88%	8	5	(1)

IP prepares a root cause analysis and remediation plan

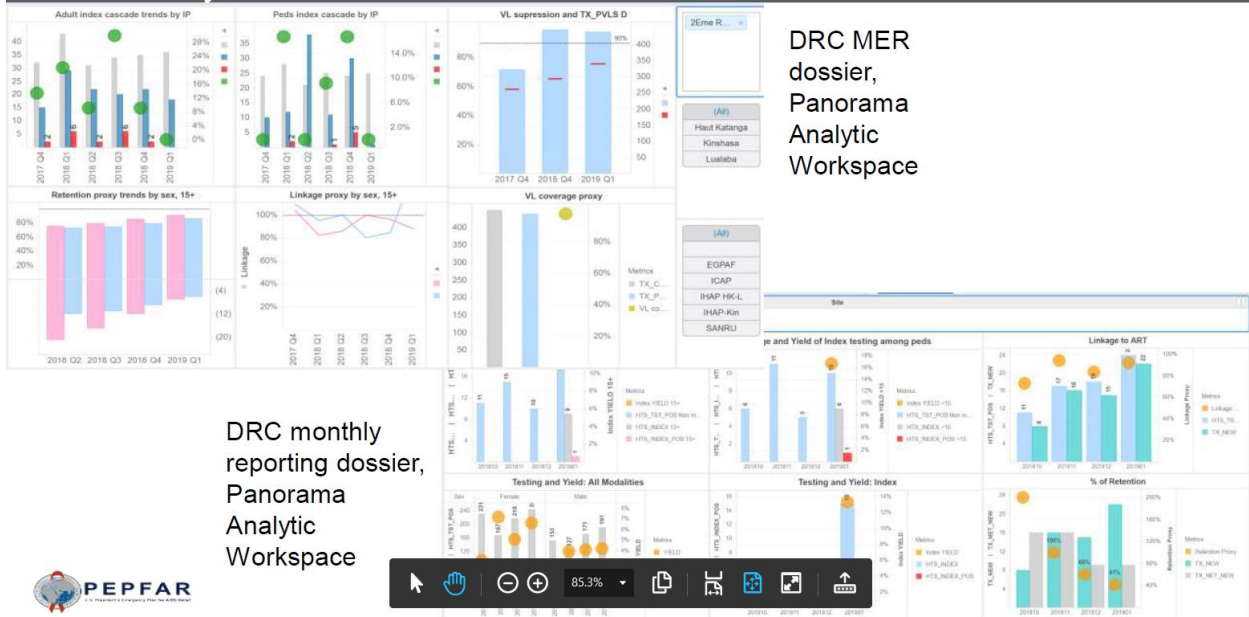


Submission Date: 24/09/2018 IP Staff Responsible: Désiré BAYOKA
 Validation Date: CDC Staff Responsible: Francois Kitenge

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 adhérents pour un counseling individualisé du TARV	Nombre de patients identifiés	03/10/2018	Tous les patients non adhérents sont identifiés et suivis	



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



DRC monthly reporting dossier, Panorama Analytic Workspace

In addition to stronger partner management, better surveillance data are key for program improvement. PEPFAR/DRC is currently reviewing the recently completed IBBS survey results

and collaborating with PNLs, Global Fund, and DRC UNAIDS on other surveillance activities (IBBS, ANC surveillance).

4.7 Targets for scale-up locations and populations

This section presents a summary of FY21 targets.

Table 4.7.1 below presents ART entry streams for adults and pediatrics in scale-up districts.

Table 4.7.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	Tested for HIV (APR FY21) <i>HTS_TST</i>	Newly Identified Positive (APR FY21) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY21) <i>TX_NEW</i>
Total Men (>15)	343,774	23,231	22,103
Total Women (>15)	657,640	21,075	20,238
Total Children (<15)	143,434	4,970	4,778
Adults	1,001,412	44,306	42,341
TB Patients	14,228	1,835	1,799
Pregnant Women	244,951	2,156	2,100
VMMC clients	-	-	-
Key populations	29,715	2,270	2,146
Priority Populations			
Other Testing	712,518	38,045	36,296
Previously diagnosed and/or in care	-	-	-
Pediatrics (<15)	143,434	4,970	4,778
HIV Exposed Infants	9,692	188	179
Other pediatric testing	133,742	4,782	4,599
Previously diagnosed and/or in care	-	-	-

Table 4.7.2 below presents FY21 prevention targets for key and priority populations to contribute to epidemic control.

Target Populations	Population Size Estimate (scale-up SNU's)	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
Others*	Unknown	Unknown	4902
TOTAL			93,538

(*) Truckers, Miners, Clients of FSW

Table 4.7.3 below presents FY21 targets for OVC_SERV and OVC_HIVSTAT, reflecting the leveraging of OVC programming to support pediatric case finding.

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target)
Military DRC	8,136	2,944	2,611
Bandalungwa	4,778	503	432
Binza Meteo	4,918	896	853
Binza Ozone	3,752	700	652
Bunkeya	1,015	269	256
Dilala	2,749	1,088	935
Dilolo	431	269	256
Fungurume	6,271	1,076	1,023
Kafubu	809	767	709
Kamalondo	1,572	896	853
Kambove	2,893	230	197
Kampemba	9,937	2,458	2,114
Kanzenze	935	179	169
Kapolowe	3,126	1,345	1,279
Kasaji	431	179	169
Kasenga	3,539	743	639
Kashobwe	756	433	390
Katuba	6,055	893	768

Kenya	6,557	2,839	2,442
Kikimi	6,758	1,882	1,619
Kikula	5,507	566	487
Kilela Balanda	1,063	433	390
Kilwa	4,007	1,205	1,106
Kimbanseke	7,395	1,483	1,275
Kingabwa	5,512	1,937	1,666
Kingasani	5,825	2,100	1,805
Kinshasa	4,400	778	670
Kipushi	5,053	1,190	1,023
Kisanga	5,836	1,789	1,539
Kowe	924	433	390
Likasi	3,340	822	707
Limete	4,936	880	757
Lingwala	2,262	361	309
Lualaba	1,562	896	853
Lubudi	795	269	256
Lubumbashi	4,460	1,718	1,477
Lukafu	430	433	390
Manika	1,192	1,112	956
Masina 1	6,703	1,939	1,668
Masina 2	7,253	3827	3,291
Matete	7,582	540	464
Mont Ngafula 1	6,489	238	204
Mufunga Sampwe	1,131	433	374
Mumbunda	6,585	1,196	1,028
Mutshatsha	321	269	256
Ndjili	8,467	3,293	2,832
Ngaba	4,784	743	639
Nsele	4,647	1,044	899
Panda	2,723	448	425
Pweto	2,145	992	854
Ruashi	6,232	1,781	1,533
Sakania	9,631	1,167	1,109
Tshamilemba	5,367	1,190	1,024
Grand Total	211,841	58,094	51,022

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 EID and VL services to attain epidemic control. After the initial phase of multi-stakeholder GeneXpert use at site level for TB, EID and VL completed in FY19 in Kongo Central, PEPFAR/DRC has planned a training phase in Haut-Katanga and Kinshasa to update laboratory technicians in usage of GeneXpert for multiplex testing in FY20. PEPFAR DRC has mapped 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 FY20, PEPFAR/DRC will optimize the use of GeneXpert to improve VL and EID uptake and services.

4.9 Monitoring for HIV Drug Resistance

HIV drug resistance (HIVDR) poses a serious threat to viral suppression and a barrier to achieving the third 95 goal, defined as 95 percent of people on antiretroviral therapy having durable viral suppression. TLD transition in DRC has been aggressive in PEPFAR-supported regions with all adults transitioned to TLD to ensure quality patient centered care as of September 2019. It is important to monitor for acquired HIV drug resistance to ensure its efficacy and durability as well as guide treatment and policy decisions.

PEPFAR/DRC will monitor HIVDR using the preferred laboratory based HIVDR surveillance methodology. Remnant specimens, which otherwise will be discarded, of eligible patients on TLD treatment and who are being monitored by VL will be used. The specimens of patients with unsuppressed VL (WHO definition VL>1000 copies/ml) will be used for extraction of RNA and PCR amplification. The generated amplicons will be genotyped and analyzed for resistance mutations to TLD to ascertain efficacy and durability and ensure patients continue to benefit from these life-saving medications.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV national landscape, including the recent SID 2019, 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, KP, and children. In children specifically, the EID at two months remained concerning at 44 percent in FY19Q4. The entire cascade in children suffered drops which reflects various shortcomings of the Peds program. Regardless of population, retention represents another

challenge although some improvement was noticed in FY19 and FY20Q1. VL suppression is one of the programmatic areas where PEPFAR/DRC made improvements when comparing FY19 results to previous fiscal years. This has been confirmed by the 14 percent increase of VL coverage from 67 percent to 81 percent in all PEPFAR/DRC supported provinces. The strengthening of five molecular laboratories and good provision and management of reagents contributed to the decrease of VL testing turn-around times. Transition to TLD, optimized pediatric regimens and improved management of HIV patients at site level are other factors behind this success in VL suppression.

However, a poor level of HIV 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 specific subpopulations like KPs and men. SIMS showed excellent scores in supply chain CEEs (availability of cotrimoxazole, RTKs, ARVs), but less success with INH, peds ARVs and availability of MMD. These findings are also confirmed by SID 2019 that depicted issues of national supply chain forecasting, timely arrival, and distribution at last mile. In PEPFAR/DRC space specifically, complex customs clearance proceedings steps have been identified as one of the major impedances to adequate service delivery.

The SID 2019 and monitoring of Minimum Program Requirements indicates adoption of key policies. Areas of concerns remain however, the lack of implementation of MMD in children, DSD for specific subpopulations (children, pregnant women and KP), incomplete application of family tree testing and inconsistent availability of VL outcomes in subpopulations (pregnant and breastfeeding women, and KPs)

Table 6 investments with site-level approaches synergistically address COP20 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 2019 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 2019 also recognized the efforts of the GDRC in the areas of governance and leadership. This has been demonstrated among others through the prompt adoption and support to TLD transition. Building on the experience of successful TLD transition, PEPFAR/DRC will continue to work with PNLs for stepwise adoption and updating of pertinent WHO policies.

Under GDRC leadership, PEPFAR/DRC will continue to monitor TLD pharmacovigilance activities as well as HIV drug resistance study. This adoption and implementation of TLD constitutes an important milestone towards improvement of VL suppression in PEPFAR zones.

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.

The operationalization of Lualaba molecular lab, the weekly VL tracker and use of VL champions committees will continue to improve VL coverage and as demonstrated in FY20Q1 at 81 percent of eligible patients in PEPFAR zones and contribute to the amelioration of national VL coverage which currently remains weak (less than 20 percent). PEPFAR/DRC also assessed the unutilized capacity of existing VL/EID laboratories and proposed practical optimization options to relevant stakeholders (MSF, the 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 strategically placed locations in assigned zones.

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, including a recency testing study which may be jointly conducted with Global Fund. PEPFAR/DRC provided 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. PEPFAR is keenly involved in the momentum of getting a unique identifier for PLHIV as well as robust estimates through SPECTRUM modeling.

Drawing from lessons learned from the “Observatoire”, a Global Funded-funded platform for collecting client-satisfaction indicators, PEPFAR/DRC will develop a community-led monitoring system for Kinshasa, Haut-Katanga and Lualaba. Using the US Ambassador’s small grant mechanism, PEPFAR/DRC will support community-led monitoring activities designed to improve client-centered HIV services at facility and community level.

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 COP20, certain outcomes, benchmarks and commensurate activities were modified to better align with the current context.

6.0 Staffing Plan

PEPFAR/DRC, under the guidance of S/GAC, conducted a staffing assessment to determine the skills and level of effort (LOE) needed to achieve sustainable epidemic control by 2021 through the strategy defined in COP20. This includes intensive partner management with weekly agency level meetings, quarterly intra-agency level meetings and monthly inter-agency meetings as needed to resolve issues that may arise as well as find successes for replication. 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 COP20. Below is a summary of PEPFAR/DRC's staffing footprint:

PEPFAR/DRC COP20 Staffing Footprint				
AGENCY	Total Existing (Filled & Vacant)	100% PEPFAR Funded	Partially PEPFAR Funded	Non PEPFAR Funded
CDC	26	25	1	-
DOD	2	2	-	-
State	4	4	-	-
USAID	32	19	9	4
TOTAL	64	50	10	4

To align human resources with the strategic focus in Haut-Katanga and Lualaba, PEPFAR/DRC has placed a provincial co-located team in Lubumbashi. This team includes six positions: two Strategic Information Advisors (CDC, USAID) one Lab Advisor (CDC), two Care & Treatment Specialists (CDC, USAID), and one Local Development Specialist (USAID). The new positions were approved in COP16 and have are budgeted in COP20. In addition, PEPFAR/DRC State Coordinator's Office will occupy USAID office space for a total of four staff. The non-ICASS related costs for State's use of USAID's space are incorporated into USAID's COP20 management and operations costs.

Below are the current staffing updates by agencies:

- **USAID:** There are 15 current vacancies in the process of recruitment in FY20: HIV Team Leader (FSO), 2 Care and Treatment Specialists, 1 Supply Chain and ARV logistic Specialist (repurposed from OVC Specialist), 1 OVC technical specialist, 1 Financial Analyst, 2 M&E Specialists, 1 Laboratory Specialist, 1 Data Quality Specialist, 1 SI Specialist, 1 A&A Specialists, 1 Local Development Specialist, 1 Program Assistant, and 1 KP Specialist. In COP20 removed 2 A&A positions (one full and one partial).
- **Department of State:** There is currently one vacancy, the PEPFAR Deputy Coordinator, position which is critical for the smooth running of the office.
- **DOD:** Fully staffed
- **CDC:** There are five current vacancies in the process of recruitment in FY20: One Country Director, one data analyst, one care and treatment, one SI officer and one lab advisor. In COP20, CDC is approved to continue funding the Global Health Security Agenda (GHSA) Program Director position.

Intensifying partner management remains a focus of COP20, and one aspect of partner performance is SIMS. The PEPFAR/DRC 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 COP20 cost of doing business (CODB) request represents the minimal staffing and administrative support.

APPENDIX A – PRIORITIZATION

SNU Prioritization

Table A.1

SNU	COP		<15		15-19		20-24		25-49		25-29		30-34		35-39		40-49		50+	
			F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M
Haut-Katanga	COP16	APR 17	56%	46%	24%	92%	50%	53%	32%	NA	NA	NA	NA	NA	NA	NA	NA	NA	51%	46%
	COP17	APR 18	43%	72%	32%	99%	33%	75%	NA	92%	43%	81%	45%	75%	49%	63%	54%	60%	60%	60%
	COP18	APR 19	72%	80%	39%	154%	76%	60%	NA	86%	143%	69%	108%	64%	98%	41%	60%	71%	67%	67%
	COP19	APR 20	90%	110%	49%	214%	97%	NA	NA	121%	181%	96%	138%	89%	124%	57%	76%	98%	84%	84%
Kinshasa	COP16	APR 17	29%	15%	12%	18%	6%	21%	10%	NA	NA	NA	NA	NA	NA	NA	NA	NA	25%	24%
	COP17	APR 18	20%	24%	19%	26%	12%	30%	NA	27%	12%	27%	12%	30%	14%	33%	23%	36%	36%	36%
	COP18	APR 19	39%	26%	19%	34%	11%	25%	NA	38%	61%	29%	45%	26%	41%	16%	25%	41%	41%	41%
	COP19	APR 20	45%	36%	23%	48%	14%	NA	NA	53%	77%	39%	56%	35%	50%	19%	27%	55%	50%	50%
Lualaba	COP16	APR 17	110%	115%	33%	160%	65%	98%	127%	NA	NA	NA	NA	NA	NA	NA	NA	NA	91%	127%
	COP17	APR 18	89%	186%	56%	288%	67%	155%	NA	211%	165%	178%	213%	139%	200%	127%	214%	112%	204%	204%
	COP18	APR 19	207%	303%	78%	443%	155%	169%	NA	279%	872%	195%	642%	174%	523%	109%	281%	187%	259%	259%
	COP19	APR 20	96%	149%	35%	227%	60%	NA	NA	152%	278%	115%	210%	105%	185%	58%	98%	113%	103%	103%

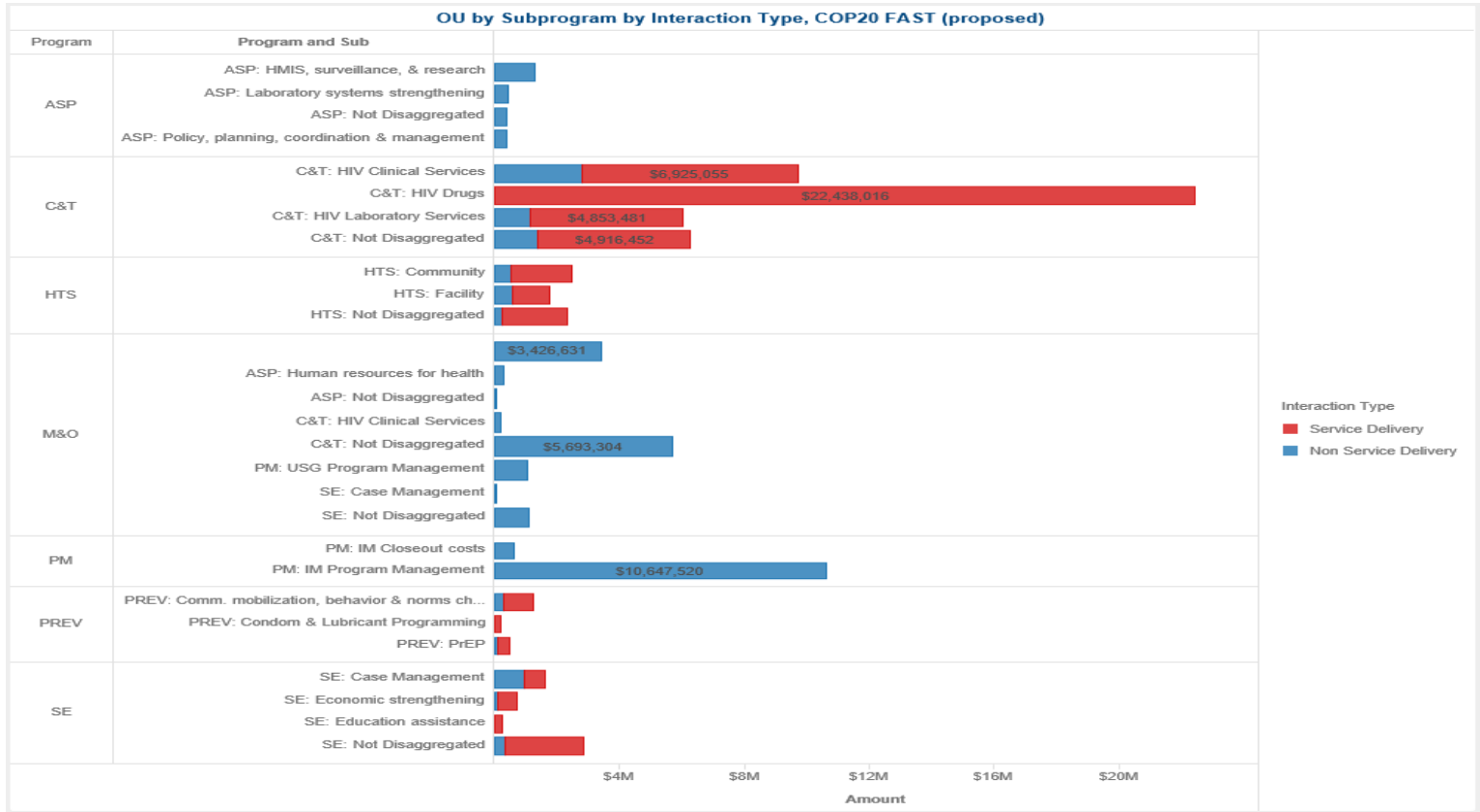
Table A.2. ART Targets by Prioritization for Epidemic Control

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY 20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) TX_CURR	Newly initiated (APR FY21) TX_NEW	ART Coverage (APR21)
Attained						
Scale-Up Saturation (does not include military)	252,796	159,094	49,578	202,136	47,119	79%
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	252,796	159,094	49,578	149,869	47,119	79%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 20 Planned Spending

Table B.1.1 COP20 Budget by Approach and Program Area



Applied Pipeline	New Funding	Total Spend
\$3,952,471	\$ 82,965,577	\$ 86,965,537

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

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	1,297,876
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	
HVOP	Other Sexual Prevention	2,135,275
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	
HMIN	Injection Safety	12,000
CIRC	Male Circumcision	-
HVCT	Counseling and Testing	9,777,614
HBHC	Adult Care and Support	4,381,222
PDCS	Pediatric Care and Support	3,023,994
HKID	Orphans and Vulnerable Children	8,244,053
HTXS	Adult Treatment	19,526,135
HTXD	ARV Drugs	16,458,785
PDTX	Pediatric Treatment	8,938,950
HVTB	TB/HIV Care	2,500,000
HLAB	Lab	534,375
HVSI	Strategic Information	1,736,685
OHSS	Health Systems Strengthening	1,391,325
HVMS	Management and Operations	3,007,291
TOTAL		82,965,580

*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 COP20 guidance, the DRC team used a program-based, incremental budgeting approach (Funding Allocation to Strategy Tool - FAST) to develop the COP20 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) 2018 PEPFAR Expenditure Reporting (ER) data, partner financial data and estimates, pipeline and outlay review;
- 2) 2018 partner performance for C&T mechanisms and COP19 targets;
- 3) Base funding from COP19 (level of funding) complemented by critical review of work plans and interventions in consultation with implementing partners to account for the COP20 strategy across beneficiary, population, and geographic areas;
- 4) Flat line budgeting based 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); and
- 7) 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 percent of the entire budget.

APPENDIX C – Tables and Systems Investments for Section

5.0

Funding Agency	Prime Partner	COP20 Program Area	COP20 Beneficiary	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HIMS, surveillance, & research-NSD	Non-Targeted Pop: Adults	Lack of reliable data at the national level	COP18	COP20	Roadmap for unique identifier system in place
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HIMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lack of reliable data at the national level	COP19	COP20	spectrum with reliable estimates at the Health Zone level
HHS/CDC	Family Health International	ASP: HIMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lack of reliable data at the national level	COP18	COP20	100% of PEPFAR supported HZ have routine DQA activities taken to scale at high volume sites
HHS/CDC	Family Health International	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Lack of reliable data at the national level	COP18	COP20	100% of PEPFAR supported HZ have routine DQA activities taken to scale at high volume sites
HHS/CDC	Family Health International	ASP: HIMS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lack of reliable data at the national level	COP18	COP20	100% completeness 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 DHIS3
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP22	100% of testings point enrolled in the national PT program. 100% of enrolled testing points achieve passing scores.
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	<14 days TAT for VL and <5 days for EID specimens
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	100% of MoH laboratory and testing point staff trained, mentored or provided TA (in RTCO) in PEPFAR-support provinces.
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	VL management system is fully implemented in 7 molecular labs and 14 high volume sites
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	95% of patients eligible for VL and 100% EID receive testing
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	100% of molecular conventional lab equipments covered by a maintenance contract
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP20	100% of molecular labs implemented VL scorecard
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	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	COP18	COP22	7 molecular labs enrolled, 7 audited and 2 accredited
USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	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	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP20	Minimal stock out and expiration of core HIV commodities at warehouse and at HZ levels

USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Weak supply chain system imperils sustainable HIV epidemic control	COP18	COP20	100% of adults and peds are receiving on optimized ARV regimens in all DRC HZs implementing HIV programs
USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Weak supply chain system imperils sustainable HIV epidemic control	COP19	COP20	100% of HZs are reporting on TLD side effects/intolerance and corrective actions are taken
USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Weak supply chain system imperils sustainable HIV epidemic control	COP19	COP20	95% of HZs are reporting on TLD side effects/intolerance and corrective actions are taken
USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated				
USAID	Chemionics International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated	Weak supply chain system imperils sustainable HIV epidemic control	COP20	COP20	100% of TLE disposed as per national legislation and protocol
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Need for updated guidelines and tools to support implementation of updated programmatic initiatives including evolving MMF/TLD, pediatric regimen optimization including MMD for peds, and TB prevention	COP18	COP20	
HHS/CDC	Global Health Systems Solutions	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Lack of reliable data at the national level	COP20	COP21	

APPENDIX D– Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

Care and Treatment	<p>1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.¹</p> <p>Test and start is implemented at scale.</p>
	<p>2. Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥ 20kg, and removal of all nevirapine-based regimens.²</p> <p>TLD for PLHIV weighing ≥ 30 and DTG-based regimens for children weighing >20kg: implemented at scale</p>
	<p>3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.³</p> <p>Implemented at scale</p>
	<p>4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.⁴</p> <p>Implemented at no cost, targeting 100% completion by FY21</p>
	<p>5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.</p> <p>VL coverage improving (81% Coverage in FY20Q1); need to improve EID at 8 weeks (44%); continue to enhance VL monitoring in Pregnant and Breastfeeding women</p>

¹ Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

² Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

³ Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

⁴ Latent Tuberculosis Infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

Case Finding	<p>1. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.⁵</p> <p>Index testing at scale but endeavors to improve fidelity in adult contact and expansion in biological children; certification of sites starting in COP19</p> <p>Self-testing implemented; should increase in scale</p>
Prevention and OVC	<p>1. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PFBW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices).⁶</p> <p>Increasing COP19 PrEP_CURR aiming 2,250; target for COP20 PrEP_CURR 11,000</p> <p>2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p> <p>During COP19, we prioritize graduation of older OVC to ensure enrolment in the prioritized 0-17 age range and for COP19 and COP20, we will focus on 9-14 girls age bracket for prevention activities.</p>
Policy & Public Health	<p>1. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.⁷</p> <p>Government of DRC enacted free ANC and Infant services as a step towards universal coverage</p> <p>2. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.⁸</p>

⁵ Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 <https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/>

⁶ Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (<http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en>).

⁷ The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

⁸ Technical Brief: Maintaining and Improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

	<p>CQI is part of IP work plans; CQI committees in place</p>
	<p>3. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p> <p>In development</p>
	<p>4. Clear evidence of agency progress toward local, indigenous partner direct funding.</p> <p>COP18 funding: 2.3%; COP19: 9.2%</p>
	<p>5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.</p> <p>GDRC matched \$6,000,000 to GF as part of counterpart funds</p>
	<p>6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.</p> <p>TX_ML reported quarterly with reasons of defaulting</p> <p>Deaths disaggregated by reasons</p>
	<p>7. Scale-up of case-based surveillance and unique identifiers for patients across all sites.</p> <p>Roadmap for unique identifier code system in development</p>

Site level MPRs related to linkage and retention: During FY 2020 (COP19 implementation), all OUs are expected to fully implement retention-related PEPFAR Minimum Program Requirements at every PEPFAR-supported site, as these have a known impact on continuity of ART. Site level implementation of these 4 elements must be assessed to inform COP20 planning. In addition, an effective tracking and tracing system must be in place at each site.

<p>Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.</p> <p>At scale</p>
<p>Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥ 20kg, and removal of all nevirapine-based regimens.</p> <p>At scale</p>
<p>Elimination of all formal and informal user fees affecting access to HIV testing and treatment and prevention in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, Cotrimoxazole, cervical cancer, PrEP and routine clinical services.</p> <p>Government of DRC enacted free ANC and Infant services as a step towards universal coverage, will continue to be monitored including through Community-led platforms</p>
<p>Adoption and implementation of differentiated service delivery models for clinically stable clients that ensures choice between facility and community ART refill pick-up location and individual or group ART refill models. All models should offer patients the opportunity to get 6 months of medication at a time without requiring repeat appointments or visits.</p> <p>MMD implemented in adults; policy for MMD for children in revision</p>