Democratic Republic of the Congo

Country Operational Plan

(COP) 2023

Strategic Direction Summary

April 28, 2023

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Vision, Goal Statement, and Executive Summary of PEPFAR's investments and activities in support of the COP plan

In support of the National AIDS Control Program (PNLS), PEPFAR/Democratic Republic of the Congo (DRC) continues to implement a robust portfolio of programs to achieve 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, 2023, through September 30, 2025 (COP 2023) will continue the programmatic priorities implemented in COP 2022, including strategically expanding and strengthening people-centered activities to attain epidemic control in Haut-Katanga, Lualaba, and select health zones in Kinshasa. Maintaining health systems critical to finding and maintaining patients on treatment will be pursued.

COP23 Strategies for Epidemic Control

- Focus on data quality
- Strengthen efforts on case finding among adult men, adolescent girls and young women (AGYW)
- Accelerate progress in pediatrics and PMTCT programming
- Improve viral load testing coverage gap and suppression
- Complete ART optimization for children
- Ensure patients remain on continuous ART
- Maintain key system strengthening activities to ascertain quality services

While PEPFAR/DRC has continued to make steady progress and has shown strong results in Haut-Katanga and Lualaba, there are questions about data quality that must be addressed during FY 2024 and FY2025. 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, adolescent girls, young women, and children. Overall, the PEPFAR team will continue saturation efforts in 57 health zones and select military sites, reaching patients in over 600 clinical sites.

Through consultations with the government of DRC and civil society and together with data quality assessments results, modest targets have been set for COP23 while we improve our program data and undertake population-based HIV incidence and impact assessment (PHIA) survey to better understand our epidemic.

PEPFAR/DRC will focus on equity for priority populations, sustainability, and health system strengthening per the new PEPFAR 5x3 strategy.

Triangulation of both survey data, the Demographic Health Survey (DHS) and the PHIA when it becomes available, and improved and validated program data will be essential to understanding the epidemic, improving programming, and ensuring accurate reporting and assessment of impact. The PEPFAR/DRC COP23 strategy emphasizes:

- Health equity for priority populations: Finding the people and populations historically missed, placing them on treatment and maintaining treatment continuity. 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 missed or lag behind other populations in the clinical cascade, to identify evidence-based short-and long-term solutions appropriate to reaching those populations, to implement and scale those solutions according to standards and fidelity.

- 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. Civil society organizations will continue to play a role in case finding, demand creation (especially for viral load), treatment continuity, quality service delivery, and advocacy for in-country contribution to HIV services.
- Continuing to implement evidence-based prevention services for children and adolescents, especially adolescent girls and young women, and pregnant and breastfeeding women with a focus on Sexual risk prevention among 10–14-year-olds (i.e., preventing sexual violence and all forms of coercion). The orphans and vulnerable children (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;
    - Ensuring site-level data cleaning and verification; and
    - Engaging in meaningful oversight and dialogue with implementing partners and facility-level healthcare workers throughout the year for continuous, real-time improvements.
- Ensuring 'above service delivery' activities are focused on sustainability and are achieving measurable outcomes related to health system strengthening and reaching epidemic control.
- Ensuring outcomes at the national level by systematically co-planning with a variety of PEPFAR/DRC stakeholders (i.e., civil society, community organizations, multilateral organizations, and host-country government at all levels.) 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.

To optimize the identification of PLHIV and link them to treatment, care, and support programs, PEPFAR/DRC will continue to support and implement 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 and immunization services within facilities, including addressing user fees, especially in the TB and ANC departments;
B. Track partners of index cases and biological children of HIV-positive women following safe and ethical index testing practices;
C. Scale-up community-based HIV testing services (mobile and index modalities) to find

hard-to-reach men, adolescent girls and young women, and key populations (KPs);

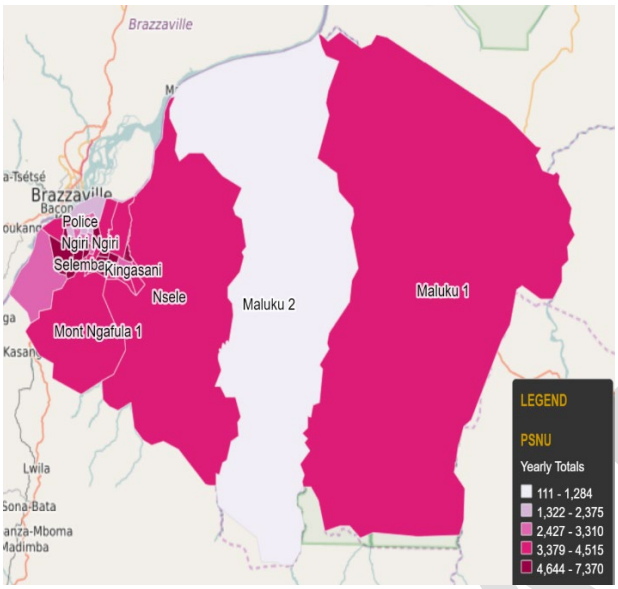
D. Ramp up sexual network and partner notification strategies to provide HIV testing services (HTS) and treatment services to hard-to-reach KPs;
E. Utilize the OVC platforms not only to assist with testing OVCs and children of KPs but to assist with linkage to and continuity of treatment as well as uptake of viral load testing, especially for pediatric patients;
F. Integrate supervised self-testing into existing modalities to increase the reach of first-time testers, people with undiagnosed HIV, and those at ongoing risk—especially KPs, including transgender women and men who have sex with men (MSM)—who need frequent retesting, adolescent girls and young women (AGYW) placed at risk;
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. Scale up use of point of care for in all PEPFAR supported for early infant diagnosis (EID) and viral coverage (to monitor effectiveness of treatment) in children, pregnant and breastfeeding women and key populations;
I. Ensure scale-up of same-day treatment initiation in all PEPFAR-supported sites;
J. Maintain the high coverage of HIV screening and antiretroviral therapy (ART) initiation among TB patients and strengthen TB screening for PLHIV;
K. Maximize multi-month dispensing (MMD) so that 30 percent of patients, including children, receive three-month ARV supplies, and 70 percent receive six-month ARV supplies;
L. Maintain continuous quality improvement and best practices at both facilities and community levels to address and improve services to meet patients' needs.

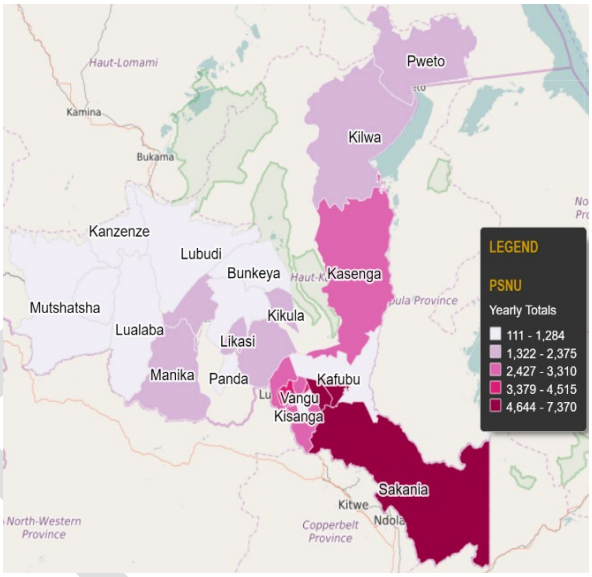
Throughout FY24 and FY25, PEPFAR/DRC will continue to refine and intensify previously implemented partner management strategies. DRC-specific partner management tools enable PEPFAR/DRC to create site-level management plans that address any deficiencies associated with 95-95-95 and hold site-level supervisors accountable. Standardized best practices from high-performing sites will be shared with low-performing sites to improve reporting and accountability. At every site, partners will continuously assist providers with the clinical cascade analysis and use of data to enhance programs. Monthly partner performance consultations will be rigorously conducted, and individual partner improvement plans will include strategies for data verification and ensure site level data quality with a focus on patient outcomes. The team will highlight findings and improvement plans at quarterly PEPFAR/DRC partner meetings.

Standard Table 1.1 95-95-95 Cascade: HIV Diagnosis, Treatment, and Viral Suppression

Table 1.1 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 population	117,010,752	1.2	624,856	NA	505,607	NA	NA	3,504,174	112,825	97,219
Population <15 years	52,948,970	NA	66,934	NA	27,551	NA	NA	624,327	11,488	6,470
Men 15-24 years	11,430,031	0.8	26,179	NA	NA	NA	NA	NA	NA	NA
Men 25+ years	20,420,632	1.5	183,012	NA	NA	NA	NA	NA	NA	NA
Women 15-24 years	11,343,848	1.0	40,263	NA	NA	NA	NA	NA	NA	NA
Women 25+ years	20,867,273	2.2	308,468	NA	NA	NA	NA	NA	NA	NA
MSM	315,133	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	124,053	NA	NA	NA	NA	NA	NA	NA	NA	NA
PWID	110,139	NA	NA	NA	NA	NA	NA	NA	NA	NA
TG	56,530	NA	NA	NA	NA	NA	NA	NA	NA	NA

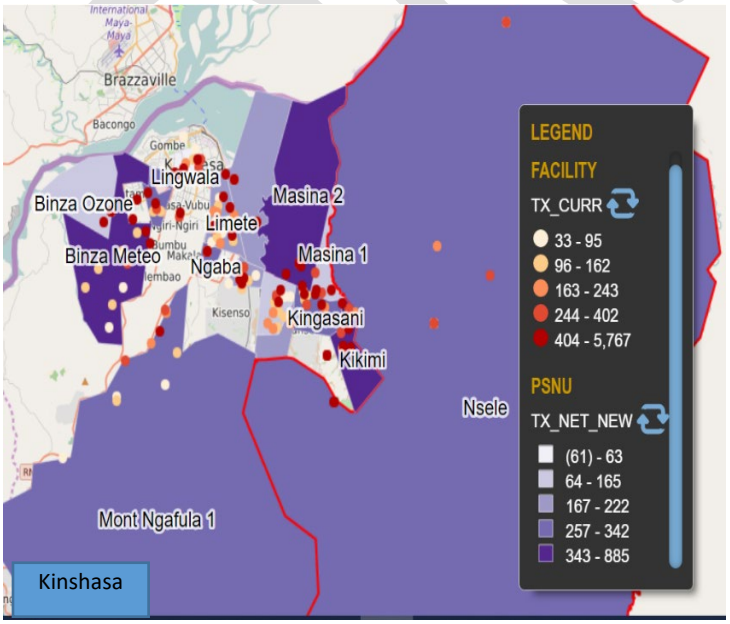
Figure 1: Democratic Republic of the Congo PLHIV by Health Zone in the three PEPFAR-supported Provinces FY19





Kinshasa **Haut Katanga and Lualaba**

Figure 2: Democratic Republic of the Congo PEPFAR ART Coverage by Health Zone in three PEPFAR-supported Provinces FY 19



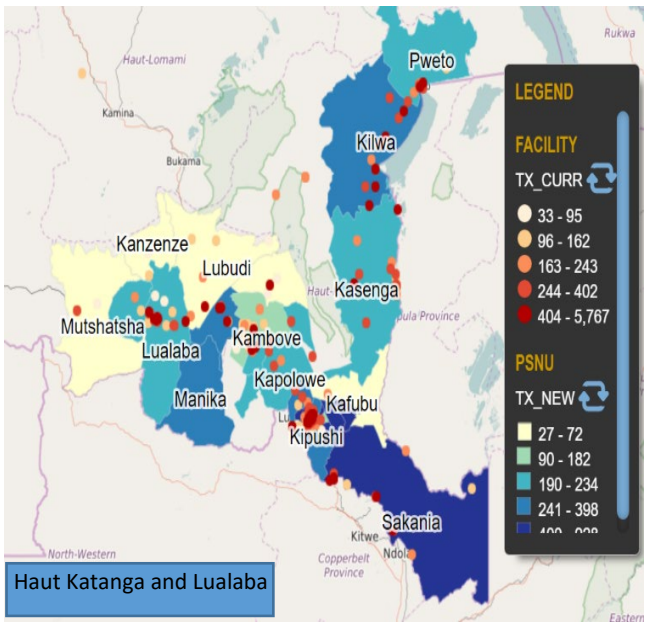


Table 1.2 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP23**	**# Current on ART (FY22)**	**# of SNU COP22 (FY23)**	**# of SNU COP23 (FY24)**
Attained	NA	NA	NA	NA
Scale-up: Saturation	NA	256,205	3	3
Scale-up: Aggressive	NA	NA	NA	NA
Sustained	NA	NA	NA	NA
Central Support	NA	NA	NA	NA
No Prioritization	NA	NA	NA	NA
Total National	489838		26	26

Pillar 1: Health Equity for Priority Populations

Plan to close gaps in the pediatric cascade

A large HIV treatment gap persists for children under the age of 15 in the DRC. In comparison to the adult ART Program which consistently meets and/or exceeds its PEPFAR targets, the treatment program for children always fails to meet its PEPFAR targets. Gradual refinement in testing approaches has led to a very slow but steady increase in case finding and the number of children receiving treatment.

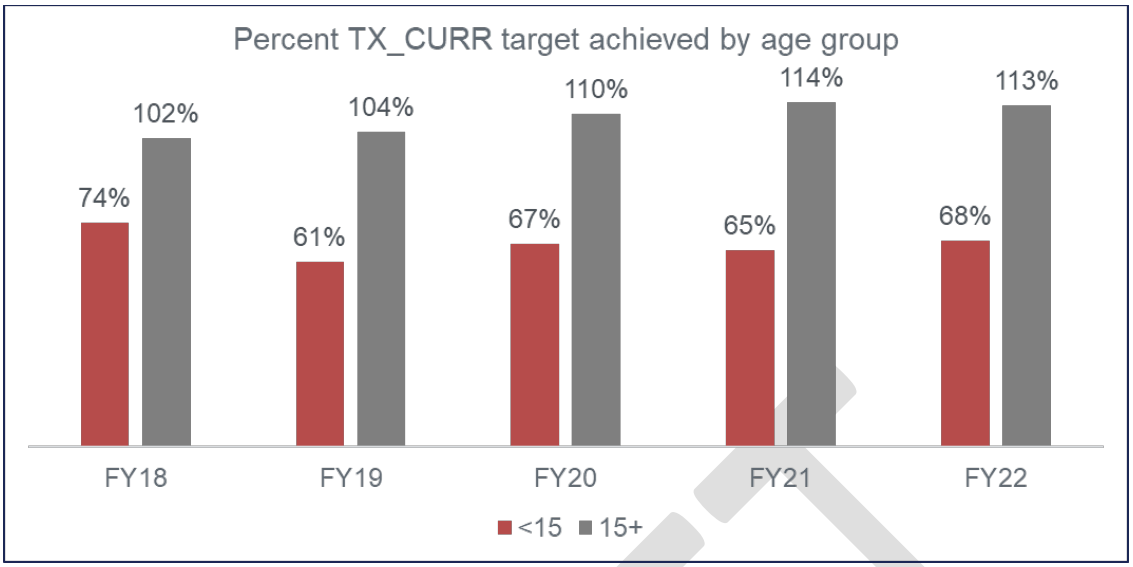


Figure 3: Percent TX_CURR target achieved by age group in PEPFAR-supported sub-national units (SNUs)

Amid the programmatic data quality concerns raised during the recent data quality audit (DQA), the pediatric cascade has areas that still need strengthening – HTS_TST (testing), HTS_TST_POS (case finding), and low TX_CURR (treatment coverage). Strategies to close the gaps across the pediatric cascade will focus on shifting our approach by lowering the yield in the most efficient testing modalities for target setting, expanding with fidelity the most comprehensive and robust testing strategies, and on new and enhanced strategies to improve case identification.

PEPFAR/DRC will expand index testing to identify children among all adults living with HIV, particularly among newly identified adults and HIV+ women in the current cohort. Emphasis will be placed on index testing, our main case finding strategy, (biological children of HIV-infected women with a focus on the family tree) at community and facility level. The 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.

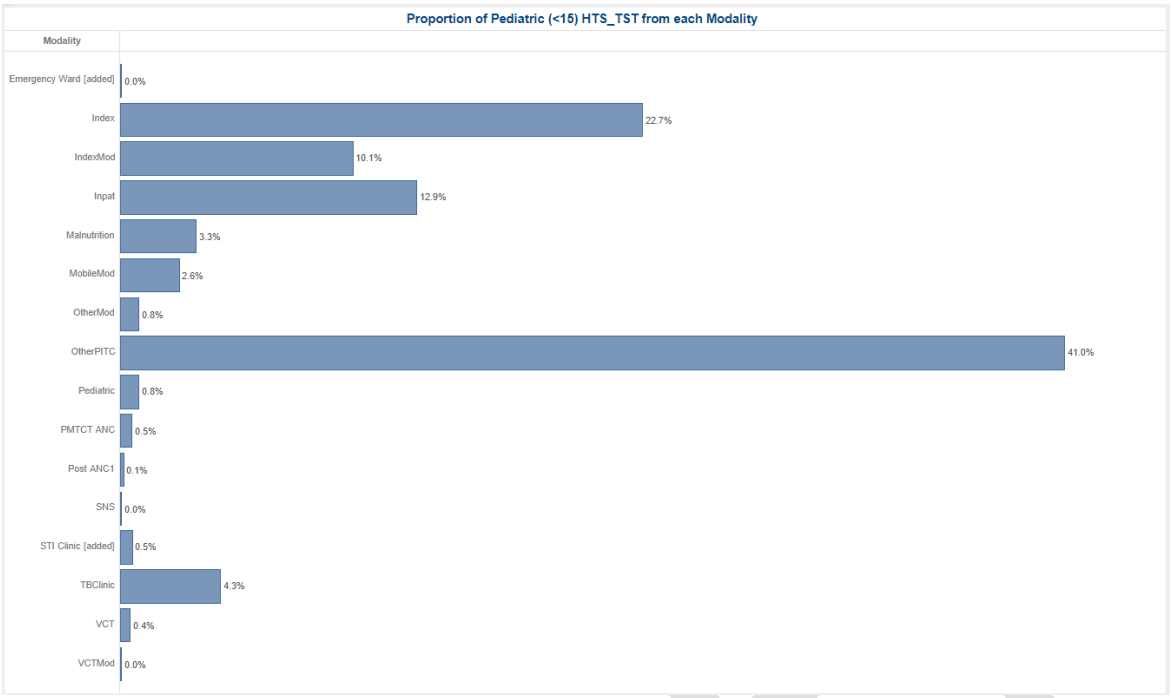


Figure 4: Proportion of Pediatric (<15) HTST_TST from each Modality

The program will also increase two-month-old early infant diagnosis (EID) testing and 18-month-old prevention of mother-to-child transmission outcome (PMTCT_FO) by incorporating the testing schedule into already existing immunization appointments, integrating dried blood spot (DBS) sample collection at immunization and community sites, and optimizing HIV infant point-of-care (POC) testing. In addition, we will leverage community partners, including OVC and outposts for KP, to expand index testing for children and HIV-exposed infants (HEI), in the community.

PEPFAR/DRC will conduct healthcare worker training on the testing children in OPD and self-testing for children and adolescents. We will systematically test all children presenting in outpatient and inpatient departments, malnutrition clinics, at under five visits and OVC programming/community testing. Targeted inpatient pediatric testing, not based on HIV risk, will be conducted. HIV testing among all presumptive and diagnosed TB patients will occur.

Finally, robust partner management will be conducted to ensure strategies put in place are implemented with fidelity. New and enhanced case-finding strategies will include index testing in clinical settings and key community sites, screening tools, and the completeness of family trees of adults living with HIV. It will also include for some selected sites the implementation of caregiver-assisted self-testing (ST) for children and adolescents and ensuring policies are in place to support ST for adolescents, particularly for high-risk AGYW.

Finding people with undiagnosed HIV and getting them started on treatment: Accelerating Progress in Pediatrics and PMTCT Programs (AP3)

The cornerstone activity will be the systematic review of family trees to identify all missing biological children under 19 years and link them to index testing services. In each high-volume facility, staff and lay workers will ensure there are complete family trees for HIV positive women. In collaboration with the women living with HIV, they will set up a plan and adequately document index testing for all eligible children. To increase early infant diagnosis (EID) coverage, peer educators (mentor mothers (MM)) will be involved in sensitizing mothers to request a dried blood sample (DBS) collection. In addition, the implementation of optimized POC technology for infant virologic testing will contribute to increase the coverage to 95 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, continuity of treatment and viral load (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 person-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 core standards: 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 (IPs) 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, will be provided with all available HIV prevention, care, and treatment services, regardless of whether they provide details about their contacts. Clients are NEVER pressured into sharing the names of their contacts for fear of being denied services. Services are NEVER withheld under any circumstances.

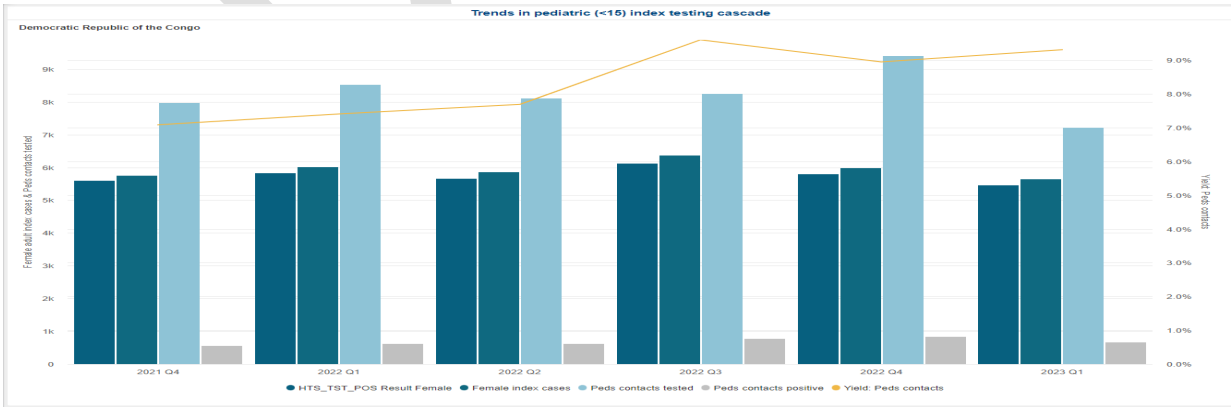


Figure 5: Trends in pediatric (<15) index testing cascade in three PEPFAR-supported Provinces

Pediatric case-finding strategies

- Systematically implement testing in out-patient departments (e.g., malnutrition clinics), inpatient, under five services, and OVC testing.

- 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 be offered HIV testing and have a documented result.
- Home testing if parent living with HIV does not want to bring child to the facility for testing.
- Testing of siblings and parents of children living with HIV (CLHIV) (0-17 years old).
- Community outreach to offer testing 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 six weeks postpartum, case workers will visit parent to encourage them to bring infant to facility for testing.
    - At eight weeks postpartum, case workers will collect EID dried blood spot (DBS) sample at home.
- 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.
- Leverage community partners, including OVC and outposts for KP, to expand index testing for children and HIV-exposed infants, in the community.
- Implement caregiver-assisted self-testing for children > 2 years old.

In addition to expanding ART (including the 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 (completeness of family trees of adults living with HIV);
- Children in inpatient settings;
- OVC identified through case management;
- Malnourished children;
- Caregiver-assisted self-testing;
- Self-testing for adolescents;
- Children with TB or suspected TB; and
- Outpatients are identified through a systematic testing approach of children.

Even though we have noticed promising results in scaling up index testing of biological children of female PLHIV (Figure 5), during FY23, we will expand testing in outpatient departments, malnutrition, and TB clinics, and inpatient departments and document testing coverage in crucial entry points at selected sites as shown in Figure 4.

The number of children receiving ART nationwide has increased by 55 percent between 2016 and 2022, with children under 15 years old accounting for approximately 6.8 percent of the

total of number of people on ART in 2022. However, national data shows that pediatric ART coverage is still disproportionately lower at 38 percent compared to 88 percent adult coverage in DRC (UNAIDS, 2021).

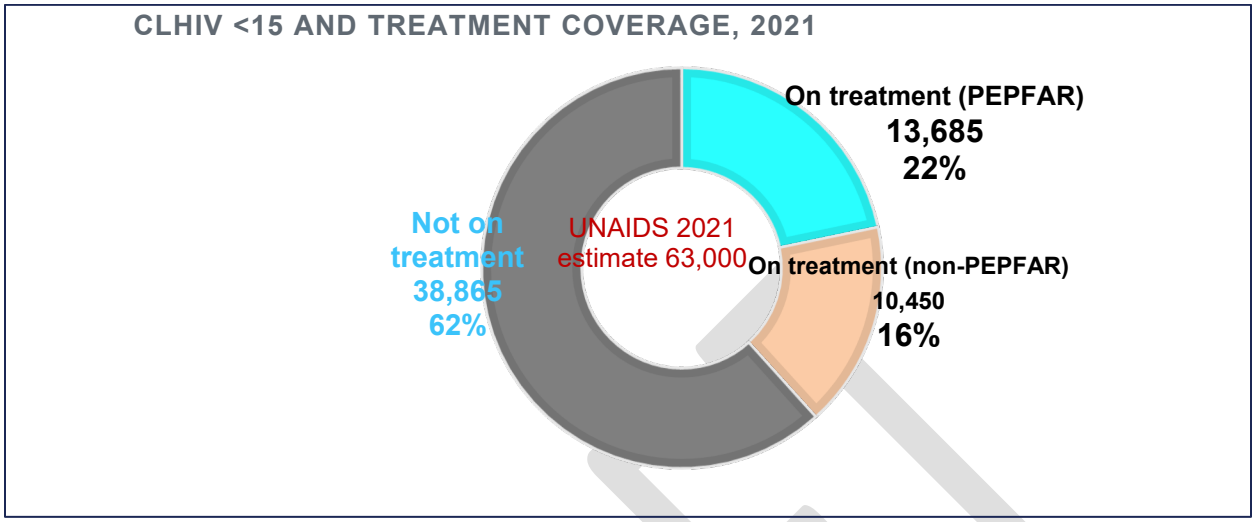


Figure 6: CLHIV <15 and Treatment Coverage in DRC in 2021

The DRC pediatric programs have not achieved the same level of performance as adults (62% of children not yet on ART). To adequately assess performance, an accurate denominator is needed. PEPFAR covers only two and a half provinces out of 26, therefore, there is a need to support efforts to understand and improve CLHIV estimates in the DRC.

Another persistent challenge is access to VL testing. In FY23 quarter one (Q1), most of the pediatric age-bands have improved VL suppression to around 92 percent. However, VL coverage is still lower and lagging for <15. The reasons for the low VL coverage are multifactorial and include blood sample collection issues (phlebotomy supplies, pediatric-sized vials, etc.), clinic-lab interface with a long turnaround time for results, POC VL low coverage and economic hardship of caregivers influencing adherence and the continuity of treatment.

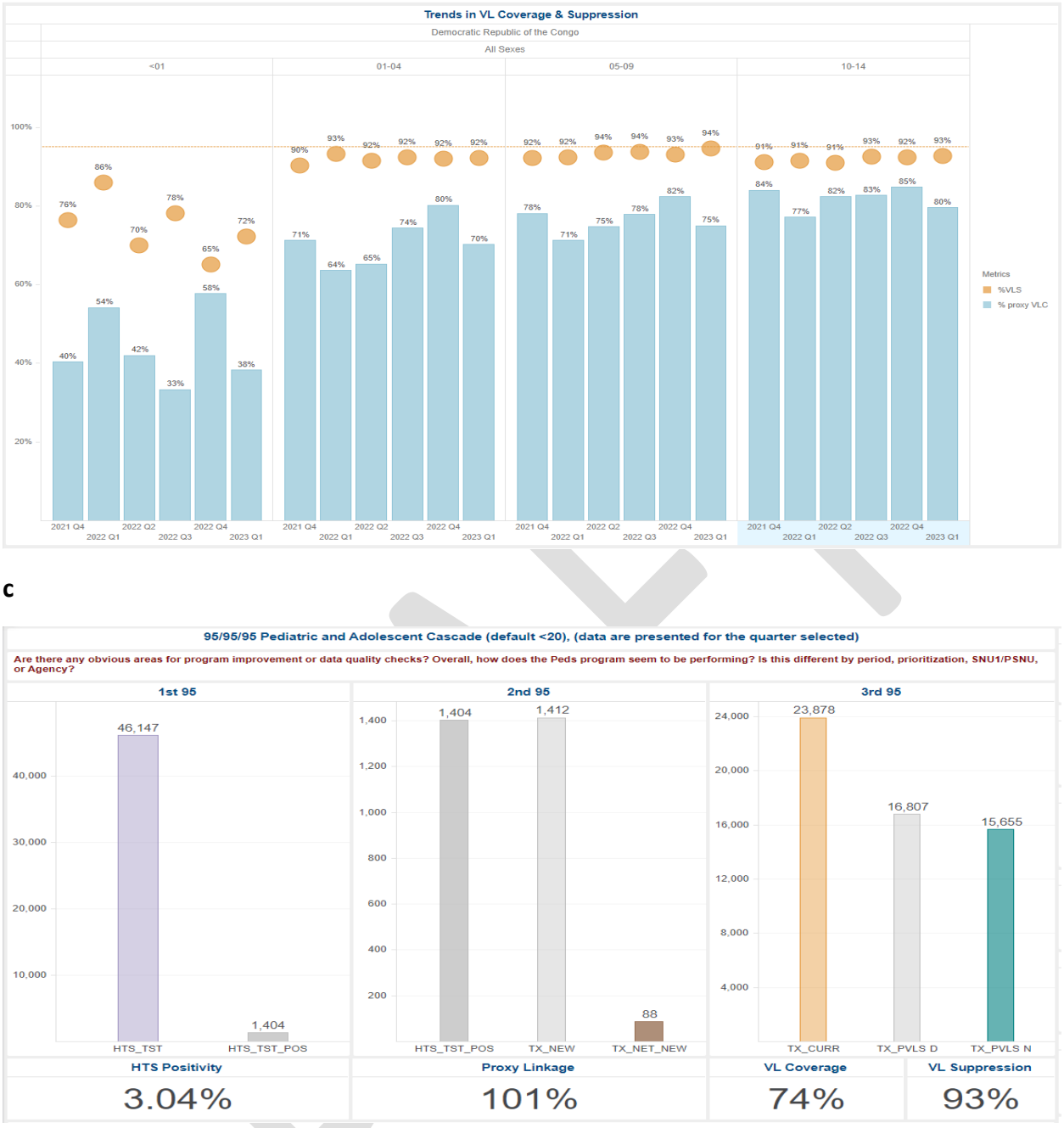


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Figure 8: Pediatric and Adolescent Clinical Cascade FY23Q1

Furthermore, in COP23, OVC partners will continue to strengthen linkages between OVC, PMTCT, 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, 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 (MOU) between treatment and OVC partners), and employing HIV case management. 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 treatment interruption, poor linkage, poor adherence, and on placing new patients on treatment.

We will enhance connections between MM and OVC to have strong clinic-community links and maximize resource utilization by mapping the MM to identify PSNUs where OVC and MM are co-located.

In addition, Pediatric Community-led Monitoring (pCLM) will evaluate and ensure accountability for child and family-centered care and child/adolescent-friendly services. It will also promote community demand-creation strategies through lay workers for optimal treatment. The pCLM will work with MM, OVC, community-based organizations (CBOs) and Teen clubs to gather input to improve service provision and support educational outreach efforts with the community.

Strategies to improve the pediatric cascade

Improve case finding of A/CLHIV:

In the facility:

Continue index testing by using the case elicitation tracker
Extend the testing focus to other modalities
Use systematic testing in OPD to improve case finding and maintain outpatient testing efficiency

In the community:

Continue to leverage the OVC program to improve community testing
Expand caregiver assisted HIVST for children of index clients and KPs
Target community HIVST for adolescents, and demand creation for HIV testing
Assess and improve the coverage of index testing for children and adolescents
Implementing dried blood collection and transportation at the community for early infant diagnosis and viral load monitoring

Improve the Linkage/Retention in Treatment for A/CLHIV

Improve linkage from 97% to 100%
Expand the HIV advanced disease package to reduce HIV related mortality
Support the Differentiated Service Delivery Model (DSD) & Expand MMD for all eligible children
Transition all eligible pediatric patients on DTG-related regime
Strengthen the patient tracking system to increase RTT
Enroll all eligible CLHIV in the OVC program (>90%)

Improve VLS/VLC for A/CLHIV on Treatment

In the facility:

Improve clinic-lab interface through DNO, ensuring that results are returned in a timely manner.
Expand use of POC VL as appropriate to reach children/adolescents in underserved areas.
Institute regular VL result test reviews-action management on a weekly basis to identify, track and reach pregnant and breast-feeding women with high viral loads.

Targeted community HIVST for adolescents, and demand creation for HIV testing
Assess and improve the coverage of index testing for children and adolescents

Plan for services for Pregnant and Breast-Feeding Women

In the PEPFAR/DRC program, more than 99 percent of all women presenting at ANC1 know their HIV status, and more than 99 percent of WLHIV at ANC1 are on ART with ART coverage consistently high across all age bands.

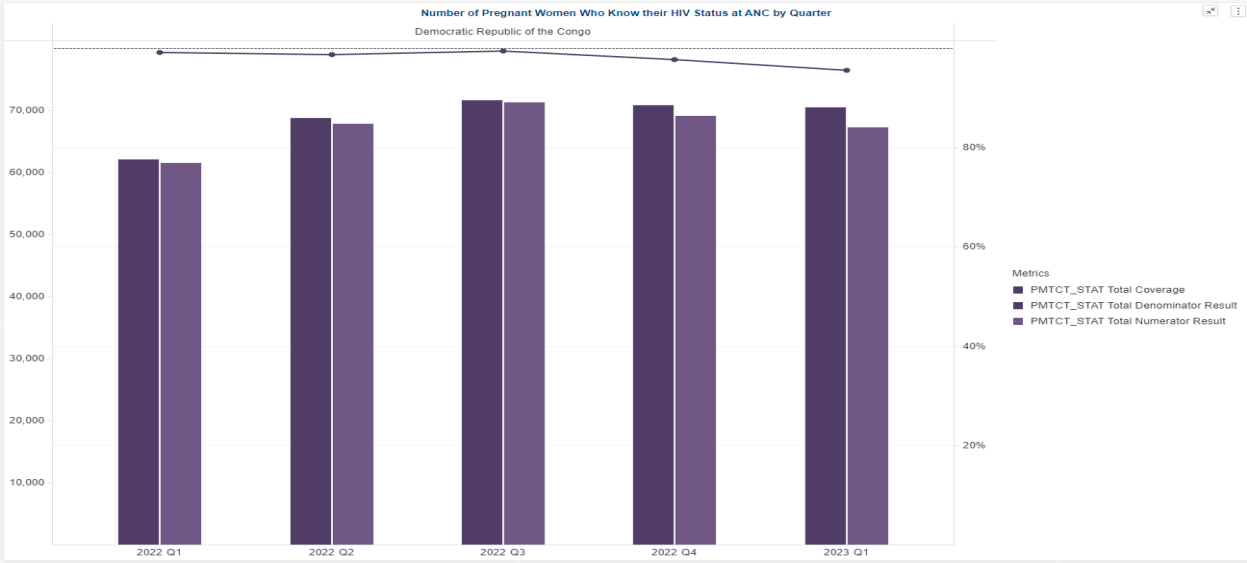


Figure 9: Number of Pregnant Women Who Know their HIV Status at ANC by Quarter

However, 68 percent of women with HIV at ANC1 were newly tested positive in FY23 Q1, with a higher proportion of newly testing positive among AGYW.

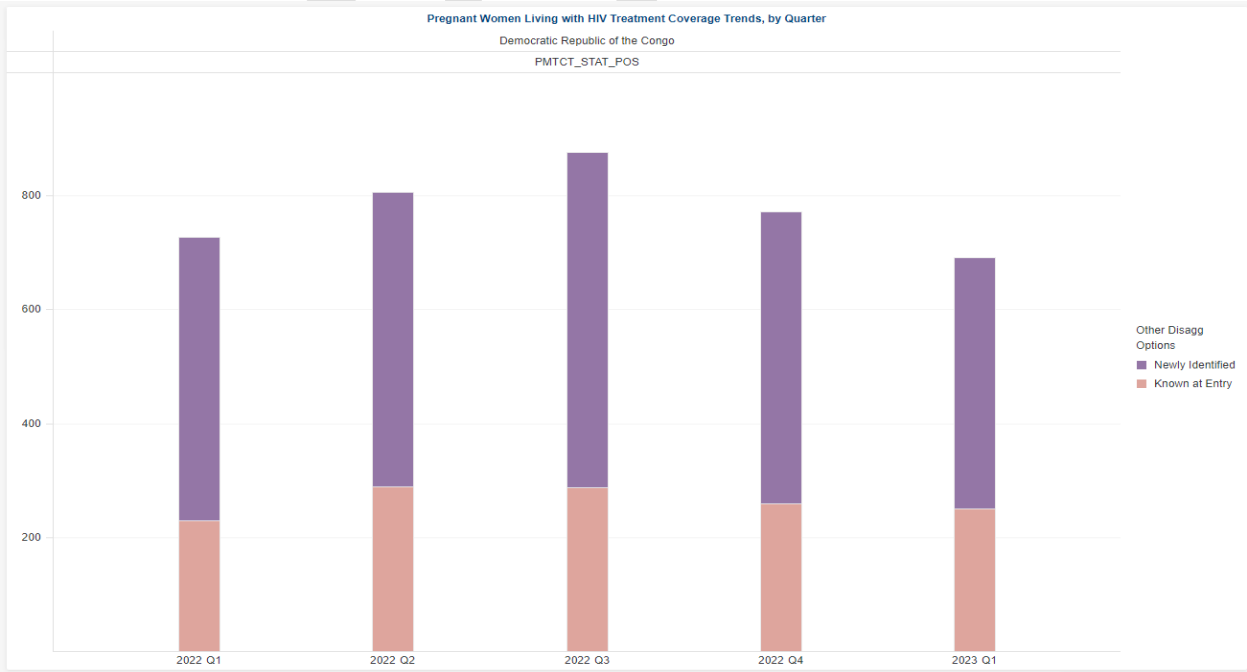


Figure 10: Pregnant Women Living with HIV Treatment Coverage Trends

The EID 2-month coverage is 59 percent, and viral load coverage (VLC) for pregnant women (PW) is 37 percent in FY23 Q1, with the lowest VLC performance in Lualaba (25%) and the Military program (21%)

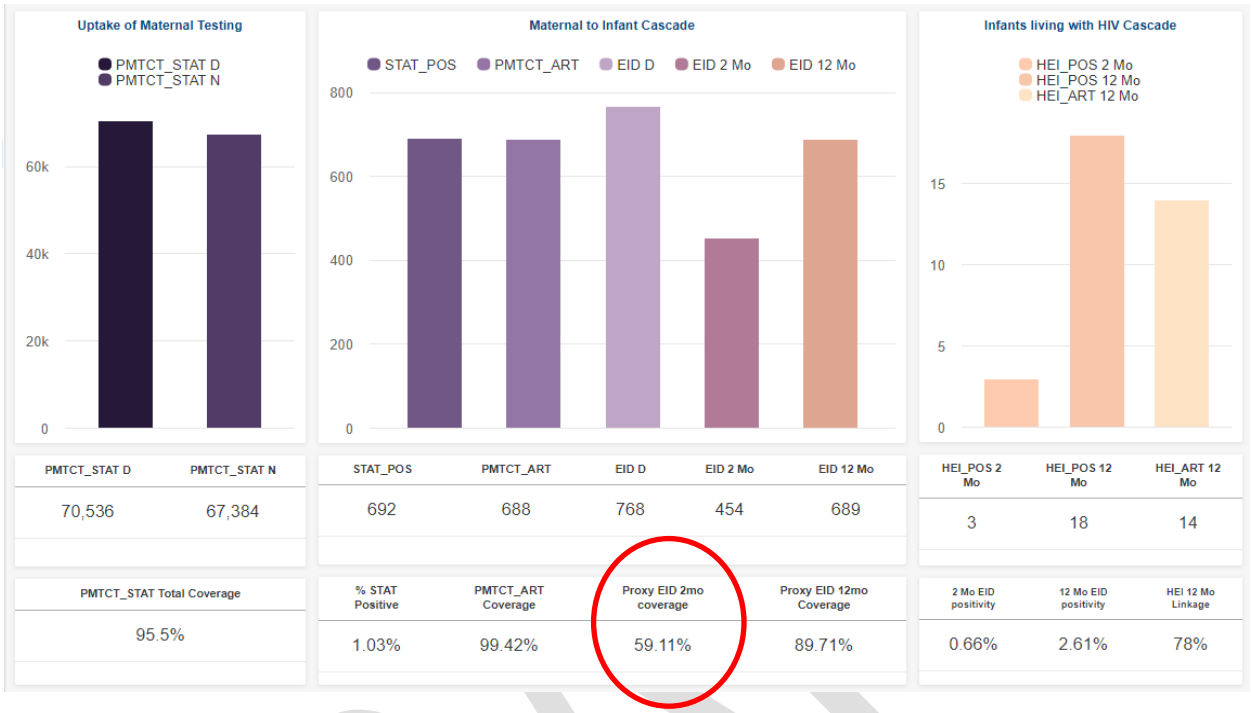


Figure 11: Maternal and Infant Testing and Clinical Cascade

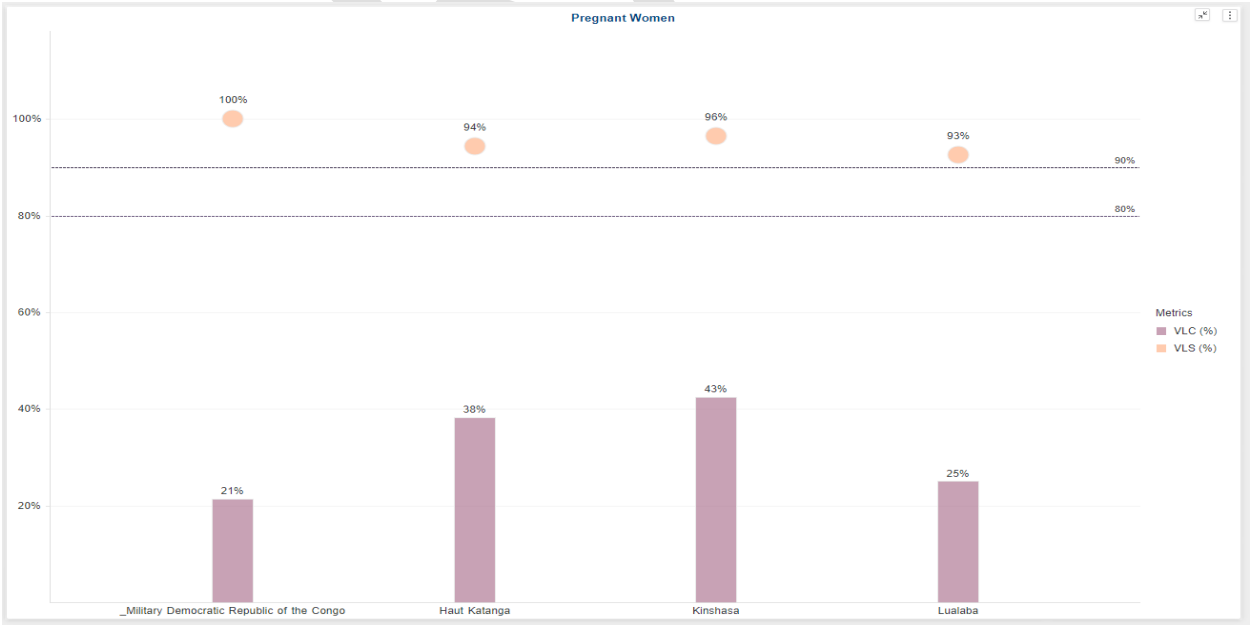


Figure 12: Pregnant Women VL Coverage and VL Suppression

COP23 Strategies to Close the Gap across the prevention of mother-to-child transmission (PMTCT) Cascade

New and enhanced strategies

- Develop M&E tools to track maternal retesting
- Develop tools to identify women at higher risk for incident infection who should be targeted for retesting, including AGYW
- Strengthen healthcare worker training for maternal retesting
- Improve demand creation by strengthening messaging provided to pregnant women during anti-natal care
- Explore self-testing as an option for high-risk pregnant and breast-feeding women (PBFW)
- Expand EID testing to non-PMTCT sites, such as immunization clinics, inpatient wards, malnutrition clinics, emergency room departments
- Develop M&E tools with custom indicators, including for EID results returned and OVC enrollment
- Enhance index testing by reviewing the completeness of family trees of adults living with HIV
- Enhance connections between Mentor Mothers and OVC to have strong clinic-community links and maximize resource utilization
- Chart review to determine which children have missed VL testing

Scale-up existing strategies

- Enhanced case management and continuity of treatment services, including referral to the OVC program, for pregnant women newly identified with HIV who may be at risk for interruptions in treatment
- Expand pre-exposure prophylaxis (PrEP) for PBFW
- Review PrEP screening tools and incorporate conversations about perceived risk
- Improve demand creation of PrEP through healthcare worker training
- Leverage community engagement to support the use of PrEP in PBFW populations
- Point-of-care EID machines scale up in selected sites
- Leverage MM, OVC, and CLM structures to expand retention activities

Improve 2-month EID coverage

In FY23 Q1, PEPFAR/DRC showed a weak EID at 2-month coverage (59 percent) resulting in poor monitoring of mother-baby pairs at the site level and challenges related to commodities (DBS and laboratory result turnaround times). In FY24, the DRC team will build on successes from the previous COP strategies for improving demand creation and systematic tracking of mother-baby cohort to ensure all HEI are offered EID. To that end, health providers, community health workers (MM, OVC case managers, peer educators) will constitute the backbone of the tracking system for mother-baby pairs. PEPFAR/DRC envisions decentralizing EID testing through strengthening laboratory services for conventional and POC testing sites, increasing data use, and management of test utilization at both site and optimized laboratory network levels.

Strategies to improve viral load suppression

- Ensure completion of the Unsuppressed Viral Load Tool for sites with low VL 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.
- Continue the implementation of point of care VL for PBFW and children using existing GeneXpert machines.
- Ensure the impact of optimized ARV regimens on VLS for all age groups, including TLD and second line.

Scale Viral Load Coverage

Although PEPFAR/DRC has shown VLC improvement during the last two years, there are still gaps in some in geographic areas such as Kinshasa and the Military program. In addition to that, some subpopulations are poorly served, for instance, the VLC for pregnant women, Key Populations and children remains unacceptably low. In COP23, PEPFAR DRC intends to increase the VLC to 100 percent across all populations, ages, and sexes.

In FY24, PEPFAR DRC will continue strengthening VL management at the facility level to better track eligible patients through existing tracking systems and continuous assessment of key challenges encountered in each quarter. The site VL committee (doctors, nurses, peer educators, OVC platform workers, and psychologists) will continue to monitor 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 will decide on continuation or any changes that may be required to the patient's regimen. Lessons learned will be shared across the entire PEPFAR/DRC supported provinces during quarterly partner management meetings and the POART.

PEPFAR/DRC will continue to implement measures that address issues throughout the VL cascade, e.g., the lack of a uniform process across all sites to track identification of eligible patients for VL specimen collection; lab-related issues (sample backlogs, completion of patient specimen request forms, specimen rejection rate, turnaround times, and suboptimal equipment utilization); reagent and specimen collection supplies stock-out; and sample transport and results return issues between the clinical sites and the laboratories. A standard tracking process has been implemented to ensure close monitoring of those eligible for VL testing and that all samples arrive at a laboratory and results are returned promptly to clinical sites and patients. Furthermore, laboratories proactively follow up to ensure and document that results collected or transmitted from the laboratories have arrived at the referring clinics for prompt action by the service provider. Laboratory visits have revealed that some

technicians prefer to process plasma/serum samples compared to DBS due to the ease of performing the tests using plasma. Instructions and/or training will be provided to laboratory managers of these labs to ensure all specimen types (plasma/serum, DBS) for VL are processed to adhere to the recommended turnaround time for VL results.

PEPFAR/DRC learned from the inventory (human resources, type of platforms, number of platforms and the utilization of existing conventional platforms) completed in 2020. In FY23, PEPFAR/DRC will complete the Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, including the increased use of POC (GeneXpert) technology to improve VL coverage. The strategic placement of POC, availability of commodities/reagents, and improving systems including a robust sample referral network, and quality management systems to support POC sites will also be ensured.

Expand case-finding strategies for WLHIV

Despite successes, significant challenges remain to eliminate vertical transmission of HIV. Two-thirds of WLHIV are newly identified at their first antenatal care visit (ANC1.) Most of the newly identified positives were not captured through other modalities. In FY24, PEPFAR/DRC will strengthen the identification of WLHIV through different modalities before they become pregnant to ensure that the mother is healthy before conception and to mitigate vertical transmission. The use of a risk screening tool will proactively ensure that high risk women are identified/linked to treatment, if positive or are linked to PrEP, if negative. PEPFAR/DRC is implementing an Accelerating Progress in Pediatrics/PMTCT (AP3) program to address this issue in detail, which includes PrEP for breastfeeding women who have an increased risk of acquiring HIV; postnatal reinforcement strategies, such as maternal retesting for HIV, and maternal care reinforcement.

Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions to mitigate the impact of HIV

UNAIDS estimates that there are 540,000 orphans who have lost one or both parents due to HIV in the DRC (UNAIDS 2021). 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 63,000 children 0-14 years of age are living with HIV in the DRC (UNAIDS, 2021). 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
- Ensure all HIV-exposed and C/ALHIV are assessed for enrollment into the OVC program (>90%). Conduct HIV risk screening on 100 percent of enrolled OVC beneficiaries (particularly those under 18 years old) with an unknown or missing HIV status
- Increase the proportion of HEI, PBFW, and CLHIV enrolled in OVC programs based on eligibility and prioritization criteria, including socio-economic criteria
- Improve referral to OVC programs for pregnant women at higher risk of interruptions in care, including infants with missed EID, AGYW mothers, and newly diagnosed WLHIV
- 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
- Strengthen the collaboration between MM and OVC to ensure that all infants receive timely EID and are tracked until the final outcome
- Enhance connections between MM and OVC to have strong clinic-community links and maximize resource utilization
- Map MM to identify PSNU where OVC and MM are co-located
- Focus triage case for support to those most in need (Children newly diagnosed and/or initiating treatment, those with a history of poor VLS and /or adherence, those in unstable situations and with PLHIV parents/caregivers virally unsuppressed, adolescents transitioning into adult treatment, and children under 5y/o due to their higher rate of morbidity and mortality)

Considering the significant risks and vulnerabilities for infants, children, and adolescents due to HIV/AIDS despite the decline of the orphaning because of treatment expansion, in FY24 and FY25 the PEPFAR/DRC OVC program will continue to focus on key challenges faced by children such as the continued transmission of HIV from mother-to-child, the gap in pediatric treatment, advanced HIV disease and low virologic suppression rate. In addition, the higher risk of sexual violence against adolescent girls, the loss of children's caregivers resulting from treatment interruption and poor viral suppression and/or considerations around COVID-19 will be considered as factors to support enrollment in the OVC program. In FY24, 67,942 OVC and their families affected by HIV are expected to receive services and 67,942 in FY25; 13,555 OVC are expected to leave the program after graduation in FY24 and the same number in FY25. An estimated 54,351 will remain active at the end of FY 24 and 54,351 at the end of FY25.

PEPFAR/DRC will continue to provide a comprehensive package of services including health, economic strengthening, safety, and education programs to ensure OVC and their families are

healthy, educated, stable, and safe. Using a case management strategy, the program will assess eligible OVCs and their families to determine their vulnerabilities and tailor an appropriate case plan, including regular evaluation to monitor their improvements using graduation benchmarks.

Enrollment will continue to be prioritized as follows:

- Children and adolescents living with HIV;
- Children of adults living with HIV at risk of treatment interruption;
- Children who have lost parents to AIDS;
- HEI at risk of prophylaxis interruption and missed EID;
- Children of female sex workers; and
- Survivors of sexual violence and AGYW are at high risk of acquiring HIV.

To close the gap for the most vulnerable children in access to effective treatment within a secured environment, the PEPFAR/DRC OVC, PMTCT, and pediatric testing and treatment programs will leverage each other and support a family-centered approach to ensure that the needs of HEI, CLHIV, and vulnerable children are met at both the clinical and community level. The strategy will continue to focus on reinforcing bi-directional referral systems and tracking; strengthening family disclosure support and continuity of pDTG; expanding HIV case conferencing, shared confidentiality, index, and other testing support, joint case identification and data; 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. Where applicable, a formal Memorandum of Understanding (MOU) will formalize a partnership framework between clinical and OVC programs as a multidisciplinary team, outlining the roles and responsibilities of each member to address critical issues.

To improve the performance of implementing partners in an ongoing and timely manner, the PEPFAR/DRC OVC Technical Working Group (TWG) will ensure case management training, implementation of quality standards, and robust M&E systems such as IP quarterly performance review meetings, data quality assessments, and community-led monitoring (CLM) 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 community sites will continue to be an area of focus in FY24 and 25.

Provide evidence-based sexual violence and HIV prevention interventions to young adolescents (aged 10-17)

PEPFAR/DRC will continue to support youth 10-17 years of age with sexual risk prevention programming that focuses on helping to prevent sexual violence and any form of coercive/non-consensual sex as well as improving school progression and completion, and on enabling communities and families to support and educate these youths.

Strategies/activities to provide evidence-based sexual violence and HIV prevention to young adolescents

- Promoting integrated approaches with sexual and reproductive health programs for HIV prevention and family planning;
- Promotion of condom use and provision, PrEP, post-exposure prophylaxis (PEP), Lubricant, and family planning (FP). HIV testing services (HTS) (including ST), Expand & improve access to voluntary, comprehensive FP services;
- Identification of teens and youth at HIV high risk for HIV for the provision of literacy and HIV prevention activities before they become pregnant and/or HIV-positive (PrEP, PEP);
- Identifying adolescent pregnant women at ongoing HIV risk using an updated and validated HIV Risk Screening Tool;
- Ensure that M&E tools (ANC1 and Post-ANC1 tracking registers) are in place to collect information on HIV status;
- Mapping of hotspot areas, use of the updated screening tool to find HIV positive AGYW, targeting out-of-school adolescent girls;
- School-based HIV and violence prevention, community mobilization/norms change, awareness on HIV prevention in HEI, reduce the risk of sexual partners of AGYW;
- Using the OVC platform to promote family stability (saving groups, transport subsidy, education, cash transfers);
- Parenting/caregiver programs (Families Matter Program, Sinovuyo, etc.), limited educational subsidies for transition to and attendance at secondary school (out-of-school girls), and socio-economic approaches; and
- Implementation of the VL algorithm for adolescent pregnant women.

Plan for Adolescent and AGYW Services

- **Advocate to close health equity gaps among adolescents:** The age of consent for adolescents is 18, potentially limiting access to lifesaving HIV care and treatment services. To address the structural policy and legal barriers that limit access to services , the program will continue to advocate for and capacitate youth-led organizations to encourage Parliament to lower the age of consent for adolescents to access HIV prevention, testing, and treatment services. The program will ensure that HIV service delivery is integrated, person-centered and adolescent-friendly, prioritizing linkage services to improve engagement. Partners should mobilize adolescent peer support groups to provide psychosocial support to adolescents living with HIV and provide referrals to other essential services, including mental health, substance abuse and sexual and reproductive health services.
- **For AGYW:** The program will implement a comprehensive prevention approach targeting the most vulnerable and at-risk AGYW between the ages of 15 and 24. AGYW will be identified using a set of context-specific vulnerability criteria, including no regular condom use, out of school, engagements in transactional sex, high number of sexual partners and experiences of violence. A package of interventions will be defined and deployed according to AGYW age group (15-19 and 20-24) and individual need. Services will include condom distribution, PrEP, gender-based violence (GBV) and post-violence care, family planning, and curriculums designed to empower AGYW.

Plan for KP Services

- **Maintain the successful KP 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 and extend the KP program to people who inject drugs (PWID) and prisoners. Implementing partners will conduct outreach using peer educators, 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 PrEP, to HIV-negative clients with elevated risk. In COP23, emphasis will be put on improving the linkage of HIV-negative KPs on PrEP and increasing VL coverage of KPs. Moreover, activities will use information and communication technology (ICT) platforms, especially targeting MSM and TG. In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, countries must demonstrate evidence of progress toward the advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups. In DRC, the law was silent on the elimination of inequalities related to access to HIV care. With the 2021 political declaration, DRC committed to ending inequalities and end HIV which has been integrated into the national HIV strategic plan 2022-2025.

Closing the gap in KP programming

In COP 2023, DRC/PEPFAR will continue to scale up PrEP, focusing on ensuring policy and programmatic access to PrEP for higher-incidence populations, including KP, AGYW, and PBFW. Additional peer navigators (PNs) will be hired to improve their ratio to beneficiaries (#KP HIV+ per PN) to reinforce ART initiation, tracking, adherence, retention, and access to viral load monitoring.

CLM will routinely monitor clients' satisfaction with HIV services and document health providers' perspectives that may affect client experience (of violence, stigma, and discrimination). CLM activities will include provision for distinct participation and leadership of key populations. KP programming will be adjusted to ensure adequate coverage of recognized (geographic/social network) HIV transmission spots (e.g., transport/migration corridors, hard-to-reach populations placed at risk).

<u>Strategies to maintain/scale up in FY24 and FY25</u>

KP differentiated service delivery models

- KP-specific structures drop-in centers (DICs)
- Community ART distribution
- Extending or adapting service hours
- ARV multi-month dispensing (MMD)
- Community-based VL sample collection

- Engaging KP-led and KP-competent organizations

Prevention Interventions for Key Populations

- HIV testing, PrEP, PEP, sexually transmitted infections (STI) diagnosis and treatment, condoms and lubricant programming, risk reduction counseling, violence prevention, and response

Optimized testing approaches

- Social network strategy testing, index testing and risk network testing, ST, social media, and use of the ICT platforms

Care and treatment

- Rapid ART initiation, VL monitoring, TB prevention
- Facility VL sample collection (Health care providers)
- Facility and community-based VL sample collection (CHW:PN)

Stigma and Discrimination

The Government of the Democratic Republic of Congo (GDRC), through the PNMLS, is taking the lead on the Global Partnership Against Discrimination and Stigma initiative and has set up a technical working group to move this forward together with UNAIDS, PEPFAR, and the UNDP.

The DRC is among the countries that have agreed to participate in formalizing a framework for action to guide efforts and strengthen the impact of these efforts to protect human rights among vulnerable populations affected by HIV/AIDS. It has established a strategy to promote collaboration around the fight against discrimination (including the executive, legislative and judicial branches, civil society, and other partners); the mobilization of critical stakeholders to adhere to and actively participate in the initiative through their various key roles; Advocacy for improved legal frameworks and continued dissemination of existing laws and policies aimed at reducing barriers to the HIV response; Development of national strategies to accelerate the implementation of the global partnership; Adoption of a national action roadmap to eliminate stigma, discrimination, and related barriers.

The following strategies have been adopted:

- In health care settings: Define and carry out actions and/or activities to equip HIV/AIDS-related health care facilities and organizations supporting key populations to be competent in the fight against stigma, and discrimination and for the protection of health rights.
- In community settings: Define and implement actions and/or activities to reduce stigma and discrimination experienced by PLHIV and key populations in community settings.
- In legal/judicial settings: Define and implement actions and/or activities for applying more protective HIV laws/promote better access to justice for PLHIV, key populations, and survivors of sexual violence.

All PEPFAR-supported activities in the DRC will integrate and support these strategies at all levels.

HIV Testing (HTS) Plan

PEPFAR/DRC's HTS programs will increasingly focus on those at elevated risk of HIV acquisition. HIV testing will be part of prevention services and serves as a critical marker for monitoring the impact of prevention services.

PEPFAR/DRC will continue to use a mix of strategic case finding and prevention monitoring of HTS modalities to increase volume and yield, such as Ethical Index Testing (scale with fidelity) in adult and biological children/adolescents (under age 19); targeted testing in other PITC (using a screening tool); Scaling up of HIV ST to high-risk subpopulations (KP, AGYW, PBFW, and other high-at-risk populations); and, completing greater than 95 percent of infant virologic testing by two months of age.

PEPFAR/DRC will offer re-testing as a regular function of HTS programming to; key populations as part of minimum standard programming, to individuals who are HIV seronegative and in a serodiscordant relationship, to individuals recently exposed to HIV and with a recent HIV-negative result, to individuals who are taking PrEP in accordance with guidelines during antenatal, postnatal, and MCH care, and to individuals with a discrepant result (when the test results for two or more assays do not agree). Re-testing will also be used to verify test results for those newly initiating ART.

PrEP expansion

In FY22 Q4, PEPFAR/DRC showed low PrEP achievement (71 percent of PrEP_NEW and 73 percent of PrEP_CURR) with particularly low performance in Kinshasa.

In FY24, PrEP interventions will continue to be scaled up focusing on ensuring policy and programmatic access to PrEP for higher-incidence populations. Populations prioritized for PrEP will include sex workers, MSM, TG people, people in prisons, AGYW, including those pregnant and breastfeeding, and other identified higher-incidence populations.

PEPFAR/DRC will expand PrEP at facility/community entry points and strengthen the linkage between testing and other prevention services. PEPFAR/DRC will ensure direct and immediate assessment for and offer of prevention services, including PrEP, to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW 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).

The commodity supply plan will accommodate PrEP expansion in FY24 and be closely monitored to avoid stock-outs.

Military

During COP23 implementation, the PEPFAR funded Department of Defense (DOD) program for DRC will continue to offer peer-to-peer prevention services and promote HTS to active-duty personnel of the Forces Armées de la République Démocratique du Congo (FARDC), their dependents, and other high-risk populations living in and around the military barracks and camps. The prevention package will include HIV risk-reduction messaging and referral to the closest testing, care, and treatment services organized by the military. The peer-to-peer military sensitization sessions will also continue to tackle alcohol/substance abuse and gender-based violence. The PEPFAR-funded military program will also continue to promote the consistent and correct use of condoms and PrEP uptake through education and provision of sufficient supplies (male and female condoms and PrEP kits) for the FARDC personnel and other high-risk populations from military settings.

The focus for the military clinical program funded by PEPFAR/DOD will be maintained in FY24 on:

1. Increased case identification through partner notification and index testing with a reinforced focus on testing of biological children of elicited female contacts of positive military personnel. Mobile testing will continue to be offered in and around known high prevalence military barracks in close collaboration with the military community health care workers. Self-testing will be encouraged to boost case identification among at risk active-duty military personnel and their sex partners.
2. Increased access to VL testing for military personnel and other populations living with HIV treated at the FARDC hospitals and health centers. DOD will continue to encourage its IPs and the FARDC to use DBS cards for sample transportation and reinforce their VL network to increase VL coverage for hard-to-reach patients especially those from the remote military regions not covered by the existing VL capacity. The use of POC is another alternative that will be explored and rapidly turned into practice; and
3. Increased access to the OVC platform for the CLHIV and adolescents treated at the PEPFAR supported military clinics.

To reinforce the health equity for vulnerable populations and reduce the occurrence of stigma and discrimination (S&D) at the FARDC clinics offering HIV/AIDS services, DOD will implement the following S&D reduction steps in FY 24: i) Review of the military S&D policy and practices with the FARDC HIV/AIDS office and military decision/policy makers; ii) Develop a S&D reduction action plan; iii) Develop and disseminate a military S&D reduction code of conduct; iv) Train the trainers; v) and conduct cascades of trainings for the HCWs; and vi) Assign at each military health facility an S&D reduction point of contact. As a way of sustaining the response and promoting people-centered HIV/AIDS case management, in COP23, DOD will start to support the integration between HIV/AIDS and existing periodic/routine services provided to Active-Duty Military personnel including check-ups and linkage to treatment for chronic diseases (hypertension, diabetes, kidney disease) and infectious as well as other death-driving diseases. This will contribute to reducing the mortality of the diseases other than HIV/AIDS in the DOD-supported cohort of HIV patients.

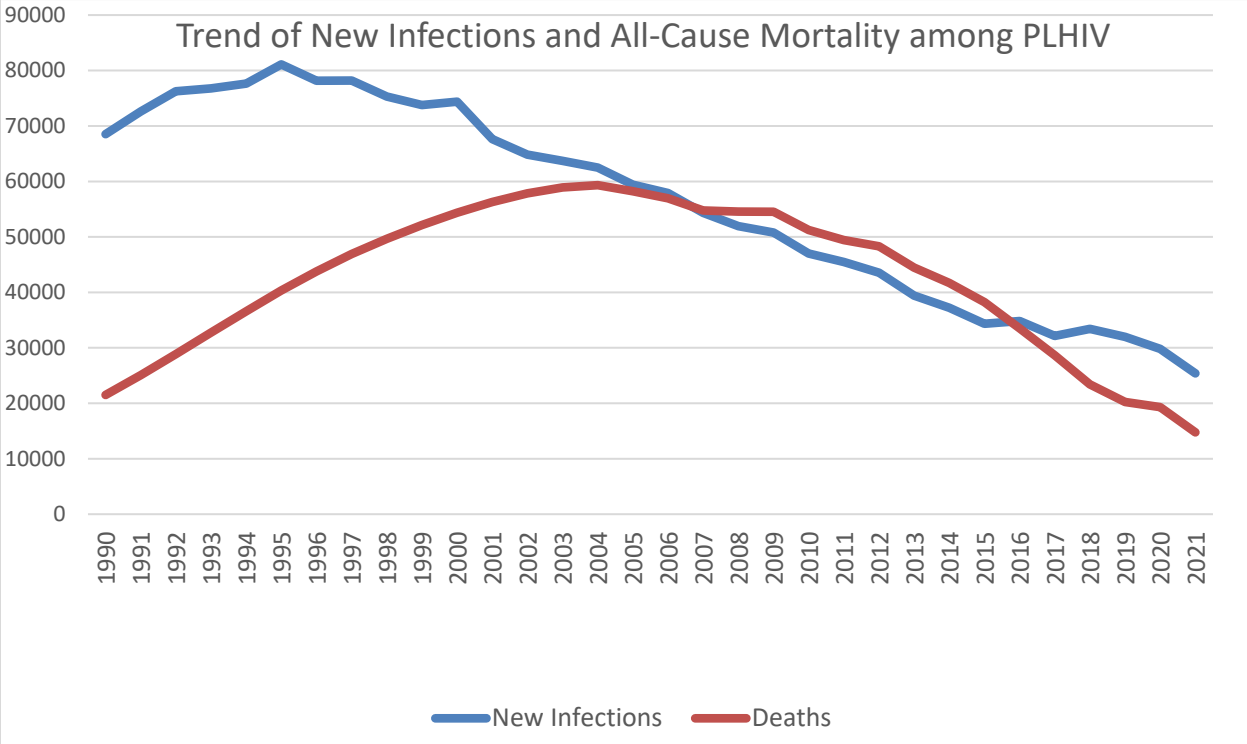
To evaluate the influence of the current DOD-funded prevention portfolio and reimagine the PEPFAR program for the military, DOD will conduct a new Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) in COP23. In FY 24, the DHAPP Epi team will closely collaborate with the partner military of the DRC to prepare for data collection. DOD will fully implement the survey and disseminate the results in FY25.

Pillar 2: Sustaining the Response

1. National Sustainability Profile Update

The government of DRC, notwithstanding the ongoing economic challenges and multiple competing health emergencies, has demonstrated strong leadership in crafting a national HIV/AIDS strategy and coordinating the national HIV response. The DRC has made solid progress in improving access to key prevention and treatment services as demonstrated by progressive declines in new HIV infections and AIDS related deaths as shown in the graph below.

Figure 13: Trend of New Infections and All-Cause Mortality among PLHIV



However, notable systemic weaknesses hinder the DRC from reaching HIV epidemic control. At the March 6-10, 2023, PEPFAR COP23 co-planning meetings in Johannesburg, South Africa, a dedicated session discussed the political, programmatic, and financial strengths and

weaknesses and related opportunities the national HIV response needs to address and/or leverage to make significant strides towards the 95-95-95 goal by 2025.

The session was a launching pad for a series of multi-stakeholder meetings under the joint leadership of the multisectoral AIDS control program (PNMLS) and the national HIV/AIDS program (PNLS) to develop a sustainability vision, roadmap, and implementation plan with concrete activities, timeline and milestones, and clearly defined roles and responsibilities for each participating stakeholder group to accelerate the achievement of the 95-95-95 goal.

The key phases and related timelines have yet to be finalized, but the roadmap is expected to be ready for launch by the start of COP23 to ensure synergy and alignment. PEPFAR will commit financial and technical support to PNMLS and PNLS throughout the process based on the collective experience from the Sustainability Index and Dashboard (SID) processes. In addition to the traditional HIV response stakeholders (GDRC, local Civil Society Organizations, Global Fund, UNAIDS, and private sector organizations), new stakeholders identified at the co-planning meetings, such as decentralized provincial entities and the newly created parastatal entities to implement the universal health coverage program will be invited to the roadmap development and implementation.

As confirmed by the conclusions of the sustainability session at the COP23 co-planning meetings, the national HIV response continues to face the same challenges as those identified in previous Sustainability Index and Dashboard (SID)-related exchanges, including the last SID process in September 2021. At the financial level, the response remains primarily funded by donors (PEPFAR and the Global Fund) and households with relatively less significant contributions from the GDRC. At the programmatic level, the most important systemic weakness remains the difficulties facing the national health information systems to generate reliable data and the underdeveloped use of data for decision-making at the national, provincial, and health zone levels. On the political front, despite the relatively strong commitment of GDRC demonstrated through the multisectoral nature of the response and regular planning and coordination activities, the active involvement of decentralized authorities, private sector entities, local organizations, particularly youth-and-KP-led organizations, and local communities in the implementation and governance of the response remains weak.

Some of the main directions already foreseen during the co-planning meetings include:

- The GDRC to work strategically to increase the domestic financing of the HIV response and fund procurement of HIV drugs and tests to close the gap on ARVs.
- All partners will work toward a clear and precise denominator of PLHIV through a survey and developing a sound surveillance system, including a unique patient identifier.
- Greater emphasis should be placed on closing the gaps in access to HIV services for Key Populations through stigma-free policies, a reliable surveillance system including size estimations and behavioral surveys, and increased investments in prevention (condoms, lubricants, and PrEP) and self-testing capabilities.

2. Investment Profile of the National Response

The DRC is the largest country in Sub-Saharan Africa, with a surface area the size of Western Europe. It has one of the lowest gross national incomes (GNI) per capita in the world ($550, World Bank, 2021), with an estimated 73 percent of the total population, or about 60 million people living on less than $1.90 a day (the international poverty rate).

Figure 14: Country Overview: Demography, Economics, Health, and HIV Profile

A: Country Overview: *Demography, Economics, Health and HIV Profile*

Demography

Capital City	**Kinshasa**	
Total Population (000s)	**95,894**	*2021*

Economics

World Bank Country Classification	Low income	*2022*
GNI Per Capita (USD - Atlas Method)	**$550**	*2021*

General Government Expenditure (% of GDP)	**8.3%**	*2021*
SID Market Openness Score	**9.00**	*2021*

Health

Gov't Health Expenditure (as a % of Total Gov't Expenditure)	**6.3%**	*2020*
Gov't Per Capita Spend on Health ($ / %)	**$3.41 / 16%**	*2020*
Domestic Private Health Expenditure (including OOP) Per Capita Spend on Health ($ / %)	**$9.87 / 46%**	*2020*
External Per Capita Spend on Health ($ / %)	**$7.97 / 37%**	*2020*

HIV

HIV Prevalence (%)	**0.7%**	*2021*
PLHIV (#)	**540,000**	*2021*
New HIV Infections (#)	**21,000**	*2021*
Total AIDS Deaths (#)	**14,000**	*2021*

Gov't HIV Expenditure* (as a % of Total Gov't Health Expenditure)	**0.00%**	*2020*
People living with HIV who know their status (%)	**82%**	*2021*
People who know their status who are on ART (%)	**N/A**	*2021*
People on ART who achieve viral suppression (%)	**N/A**	*2021*

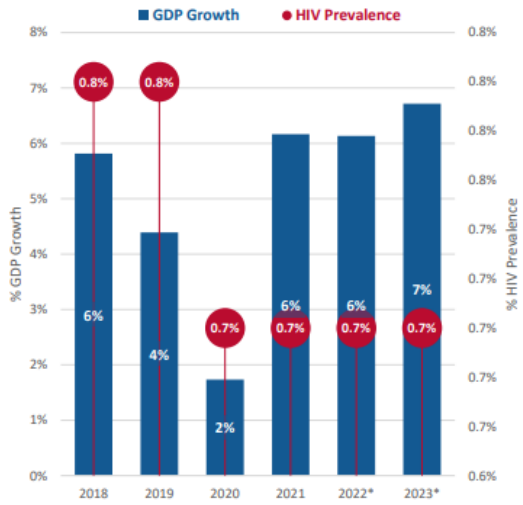
Sources: Demography/Economics/Health sections from World Bank World Development Indicators (WDI) database, 2017-2021; HIV section from UNAIDS AIDSInfo (except Gov't HIV Expenditure share, which is a combination of WDI and this Resource Alignment effort).

** Government HIV expenditure (where available) is sourced from RA, Total Govt Health Expenditure is sourced from the World Bank*

DRC's economy has continued to expand in recent years. After the COVID-19 pandemic-induced slowdown in 2020, the economy rebounded in 2021 and 2022 due to robust growth in mining and is expected to achieve a 7 percent growth in 2023, as shown in the figure below. However, 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 (HDI) 2020 ranks the DRC as one of the least-developed countries in the world, at 175 out of 189 countries. Despite improvements in some HDI indicators from 2018 to 2020, the DRC's Human Capital Index is 0.37 percent, below the Sub-Saharan Africa average of 4.0 percent.

F: Macroeconomic and Fiscal Analysis

Figure F1. GDP Growth, 2018-2022 vs HIV Prevalence, 2018-2021



** 2021 HIV Prevalence (most recent available) used for 2022 and 2023 GDP Growth is sourced from October 2022 IMF WEO*

According to the 2015-2017 National AIDS Spending Accounts (FRENCH: "2019 REDES") and the UNAIDS investment case, the HIV response is mostly funded privately, including by households (45 percent). Donors are the second largest contributors (43 percent), and the Government of the DRC (GDRC) contributes approximately 12 percent, an increase from 1.4 percent in 2010. HIV services are integrated into the standard care packages delivered by health facilities nationwide. The host government contribution comes mostly through the provision of health infrastructure and health staffing. It is expected that the gradual rollout of the GDRC's universal health coverage policy, which will first focus on pregnant women, new mothers, and newborns, along with the recent increase of the budget of the Ministry of Health (MOH) (now 10 percent of GDRC annual budget) will improve the overall government contribution to the national response.

The U.S. Government's support to the nation through PEPFAR has increased significantly from $45 million (COP13) to $117 million in COP23 Year 1 (October 2023 – October 2024) and $112 million in Year 2 (October 2024 – October 2025). The Global Fund to Fight AIDS, Tuberculosis, and Malaria (Global Fund) will contribute $190 million to the national response through its new Grant Cycle 7 (GC7) funding from January 2024 through December 2026.

B: Funding Landscape: *Resource Allocation (Planned Budgets)*

Figure B1: Budget by Funder, 2023

Total Budget : $161.0 million

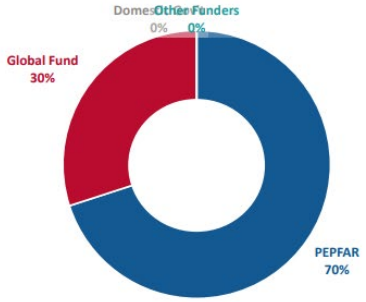
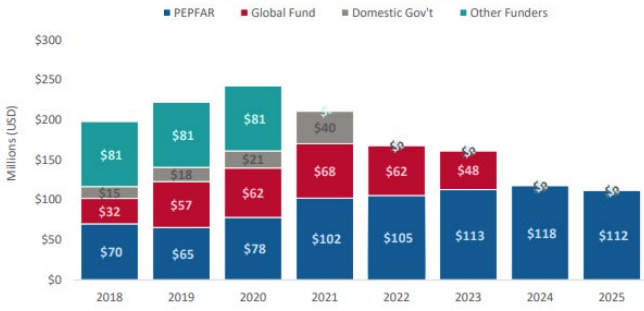


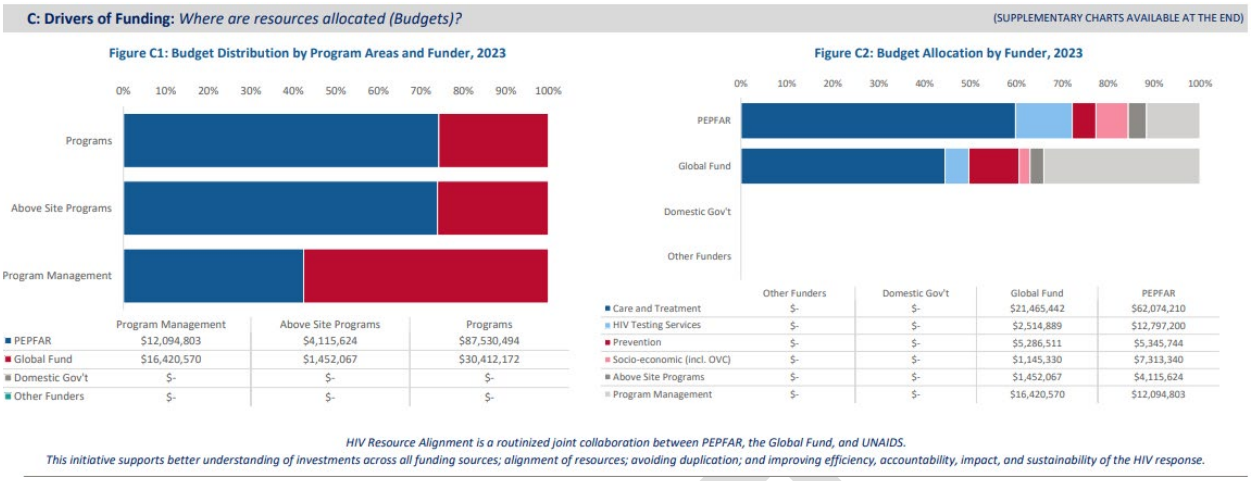
Figure B2: Trend in Total Budget by Funder, 2018-2025



Global Fund HIV Funding Allocation for Grant Cycle 7 (2023-2025), applied from the Grant Cycle 7 Implementation Period onwards, subject to the final agreed program split: $190.0 million

Note: PEPFAR USG Management & Operations is included in graphs B1 & B2 only.
PEPFAR 2024 data reflects top line budget allocation, including USG M&O. PEPFAR 2025 data, where it exists, reflects only a notional allocation, subject to change in the future.
Domestic Gov't data for some countries is only available at the aggregate level, which is incorporated in section B but would not feature in the subsequent sections due to missing disaggregation.

Overall spending on the national response has continued to trend upwards, as shown in the figure above. The breakdown by program area below shows care and treatment and program management as the top spending areas for both PEPFAR and the Global Fund. Above site spending, particularly on the lab strengthening activities, reflect the growing focus on scale-up of both VL and EID and related systems.



Expenditure on commodities is a growing proportion of the overall investments. ARVs remain the top spending commodity category, followed by VL/EID, essential medicine, and rapid test kits.

Figure 15: Trends in Commodities Budget and Expenditure by Funder

Table D2. Trends in Commodities Budget and Expenditure by Funder: 2018-2023

	PEPFAR			Global Fund			Domestic Gov't			Other Funders		
Year	Budget	Expenditure	*% Spent*	Budget	Expenditure	*% Spent*	Budget	Expenditure	*% Spent*	Budget	Expenditure	*% Spent*
2018	$17,738,296	$11,914,846	67%	$18,625,955	$18,802,934	101%						
2019	$17,250,946	$15,625,003	91%	$40,544,409	$40,128,503	99%						
2020	$24,160,824	$22,784,863	94%	$43,384,643	$43,422,118	100%						
2021	$37,719,208	$38,026,368	101%	$46,997,775	$45,203,694	96%						
2022	$36,274,050	$36,143,281	100%	$47,031,223								
2023	$45,965,329			$42,095,810								

3. Addressing Gaps and Misalignments in the National Response

The 2021 SID Process informed the immediate investment choices made in COP22 to improve the sustainability of the national response. The sustainability vulnerabilities identified in the 2021 SID included Quality Management, Technical and Allocative Efficiencies, and Data for Decision Making Ecosystem in red (scoring 2.33, 3.00, and 1.67, respectively), while Policies and Governance, Civil Society Engagement, Private sector engagement, Public Access to Information, Service Delivery, Human Resource for Health, Commodity Security and Supply Chain, Laboratory, Domestic Resource Mobilization, and Epidemiological and Health Data were all found to be improving or in yellow.

However, in COP22, PEPFAR decided to prioritize support for the following elements:

- **Commodity Security and Supply Chain:** The availability of life-saving antiretroviral medications and other HIV commodities is essential for epidemic control and sustainable national response. While there have been significant improvements in supply planning and management, continued progress is needed. PEPFAR activities

focused on reducing the lead times and streamlining the customs clearance procedures to ensure the availability of commodities when and where they are needed. This effort included ensuring the timely availability of lab reagents to alleviate pressure on conventional laboratories.

- **Laboratory:** Despite significant efforts in PEPFAR-supported health zones, V/L and EID results coverage remains concerning across the country. Investments in COP22 prioritized enhancing the laboratories' capacity to improve quality, timeliness, and completeness of data collection and reporting and to support Diagnostic Network Optimization using POC machines.

- **Performance data:** Despite remarkable efforts towards a unified system for data collection, data completeness and quality of analysis to support programmatic decision-making and technical and allocative efficiencies remain a systemic vulnerability. COP22 planned for data quality assessment activities in collaboration with the national program as an initial step.

These three priorities will receive further attention in COP23 as central components of the new 3x5 PEPFAR strategy.

PEPFAR will support an overhaul of the entire data environment of the national response. Planned investments include a Population-based impact survey for general population (PHIA) and for military (SABERS) along with a clinical cascade reset through a Data Quality Assurance (DQA). Furthermore, to help with informed decision-making and technical and allocative efficiencies, PEPFAR will support improvements in real-time data visibility through key aspects of the digital health system such as an EMR that includes a patient unique identifier.

Efforts on helping GDRC streamline its customs clearance procedures will continue in COP23 as critical to ensure the timely availability of life-saving antiretroviral medications and other essential HIV commodities, including lab reagents. PEPFAR will also strengthen data visibility capacity along the entire supply chain with planned investments in commodity trackers (using Electronic Dispensing Tools to monitor real-time data consumption) and electronic dashboards to interface with DHIS2/DATIM.

The Lab optimization priority remains center to COP23 investments to increase the overall capabilities of the laboratory system for quality services in collecting, storing, transporting, processing, and disposing samples in a multi-disease approach. Planned activities include the mapping of multiplex POC including GeneXpert machines to optimize their usage and an integrated disease surveillance through the newly created National Public Health Institute (NPHI).

The only misalignment of notice (as identified in the 2021 SID process) is that GDRC continues to play a secondary role in critical aspects of the national response other than the health workforce compensation and infrastructure. Even in these areas, more still needs to be done to ensure uninterrupted salary payment to the health workforce and continuous updating/renovation of most health facilities. Other key aspects of HRH, such as in-service

training and ongoing professional development, are still supported by donors. In FY21, PEPFAR funded $9,156,775 for stipends for healthcare providers and community lay workers for motivation. Over 20% of the Global Fund grant is also dedicated to funding coordination, supportive supervision, and incentives for healthcare providers.

PEPFAR continues to work with other national-level donors to advocate for more ownership and progressive increases in domestic resources for health and HIV. It is expected that a few new initiatives by the Ministry of Health, such as H updating the government's human resources for health (HRH) roster and creating and operationalizing a budgeting and financial management unit (Direction Administrative et Financière – DAF) will improve the situation. It is worth noting that a third of the Ministry of Health annual budget, on average, remains undisbursed due to poor financial management system and capacity.

4. Integrated National Planning of the Response

PEPFAR and the GDRC enjoy excellent collaboration through the National HIV Response. The Ministry of Health chairs the program by providing vision, guidance, and leadership to all stakeholders involved in HIV response. The Global Fund and PEPFAR remain the two major players in the HIV response in DRC and work closely with the GDRC and other stakeholders on all planning activities to ensure more integration at the funding and programmatic levels.

For example, in FY2016, under the leadership of the national HIV/AIDS program (PNLS), PEPFAR and the Global Fund completed a rationalization process to align resources strategically and maximize joint investments. Pre-rationalization, the Global Fund procured most HIV-related commodities for the DRC, while PEPFAR 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 providing ARVs and other commodities to patients in health zones assigned to them. The two donors work closely under the GDRC leadership, oversight, and accountability for health commodity forecasting and procurement to reduce stock-outs and continuously improve the sufficient availability of commodities.

The close collaboration is bearing fruit. In 2021, GDRC committed $841,425 to procure rapid test kits (Determine and Unigold) to support the national response. In 2022, GDRC committed $3.3 million to procure additional HIV commodities; a procurement of $2 million worth of rapid test kits and lab commodities for VL and EID has already been completed. Discussions are underway to identify and leverage synergies between the universal health coverage rollout in the Kinshasa province – an estimated $43 million program – and PMTCT/AP3 priorities and service packages. The rollout also provides the opportunity for PEPFAR to work with the GDRC and the Global Fund on an EMR system to replace Tier.Net as well as launch a pilot to develop a unique identifier for PLHIV, which is expected to increase confidence in new infection data and help manage patient movements across health zones and donor-supported activities.

In COP23, PEPFAR is also funding a service package for HIV/AIDS advance disease and exploring means to address co-morbidity issues among the aging PLHIV cohort. The GDRC should play a

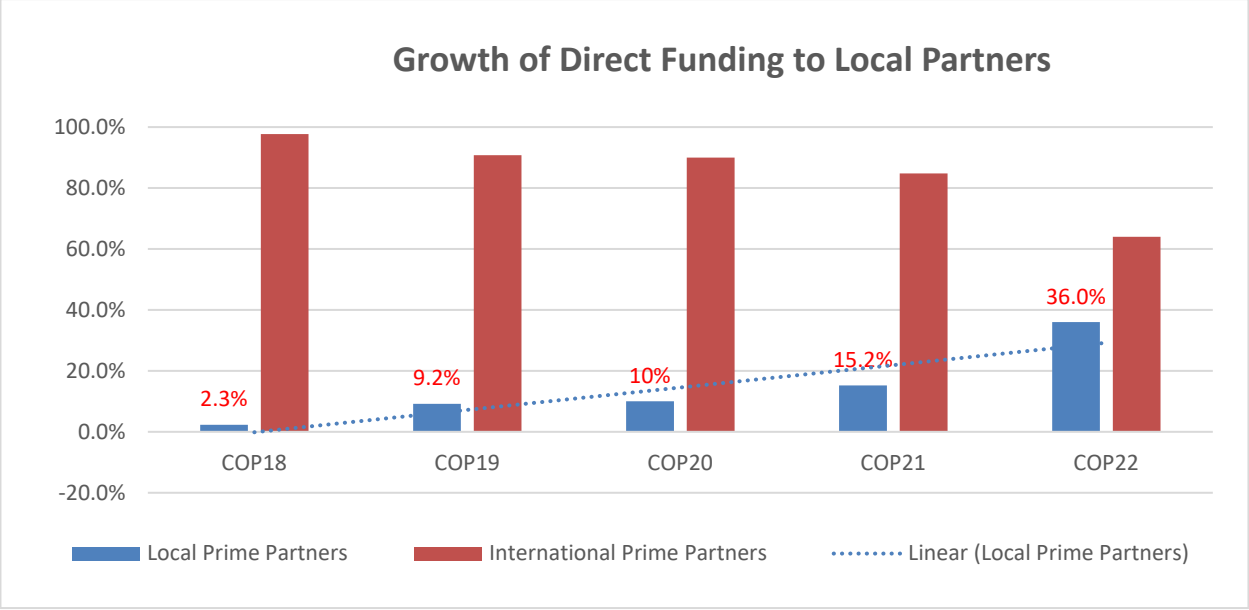
key role in the formulation and implementation of this objective as HIV services are integrated into the standard care packages delivered by health facilities all over the country.

All parties have agreed to revisit the 2016 rationalization agreement once better data on the country's current PLHIV cohort is available. In the meantime, all parties have agreed to work synergistically on select health system strengthening activities as captured in the above site investments to benefit the entire national HIV response, beyond the three PEPFAR-supported provinces.

5. **Expanding Transformative Partnerships with Local Partners**

Over the years, PEPFAR/DRC has empowered and developed the local capacity to ensure a growing leadership role of local organizations in implementing its supported activities. As demonstrated in the graph below, PEPFAR/DRC sees the increased proportion of the country-administered funding to local prime partners as significant progress toward supporting and accelerating sustainable country ownership of the HIV response. For example, in COP22, the budget split between local and international organizations (excluding commodities, TBD, and operational costs) reached 36% and 64%, respectively. This commitment to local organizations represented more than a 20 percent increase from COP21 and the largest increase since COP18.

Figure 16: Increase in Direct Funding to Local Organizations.



In COP23, PEPFAR/DRC will carry forward the trend. PEPFAR/DRC will also invest in activities seeking to understand the broader landscape and quality of the local partners in collaboration with the PNLS, UNAIDS, and local civil society networks.

DRC is amid a youth bulge in its population. Most of the new HIV infections occur in the 14-25 age groups (SPECTRUM 2022 v6.19). PEPFAR/DRC will launch a series of new strategic

partnerships with youth KP-led organizations and relevant civil society networks to further improve health outcomes in the first 95 through direct service delivery as well as advocacy to address the legal and structural barriers impeding progress toward the 95-95-95 in this age band. In the process, PEPFAR/DRC will draw from global best practices its own experience with local partners turned prime partners.

PEPFAR/DRC will identify organizations that have the potential to produce significant, long-term gains for initially focused activities, such as capacity assessments, training, and mentorship. International partners already played a key role in transferring the capacity to deliver HIV services to local partners in the previous COP. In COP23, these international partners will continue to play a critical role in supporting new local partners as mentors and -building service providers with clearly defined, time-bound, and measurable targets for transitioning the work to the local partners. Specific focus will be on sound organizational management and governance, strong financial management and reporting systems, and efficient and effective program implementation and reporting skills. PEPFAR/DRC will also encourage innovative sub-partnership arrangements between local and international partners to further facilitate capacity sharing and strengthening for local organizations as they take the lead in supporting the HIV/AIDS response in the DRC.

Pillar 3: Public Health Systems and Security

Strengthen Regional and National Public Health Institutions

PEPFAR/DRC investment in health systems strengthening in collaboration with the GDRC and other stakeholders continues to significantly improve health outcomes in the DRC. These investments include leveraging PEPFAR reagents rental agreements to obtain multiplex disease platforms for integrated disease diagnostics, laboratory information management systems for streamlining laboratory processes for efficiencies, continuous quality improvements for accurate and reliable diagnostics, diagnostic network optimization, and improvements in supply chain and commodities. The impact of this investment was highlighted during the COVID-19 pandemic when PEPFAR-supported laboratories with a multiplex testing platform were used for SARS-CoV-2 testing in three PEPFAR-supported provinces. The testing for SARS-CoV-2 testing occurred both in centralized laboratories using high throughput testing platforms and in decentralized facilities employing GeneXpert testing. These testing platforms had an installation of laboratory information systems to facilitate the processing and transmission of results. Together, these platforms and associated systems were deployed without adversely affecting other diagnostic services such as VL, EID, and TB.

Moving forward, PEPFAR DRC will continue to work with the GDRC, leverage other USG investments to build on the gains, and sustainably bolster these systems to avoid any negative impact due to outbreaks. The DRC is prone to numerous disease outbreaks, including Ebola, Mpox, COVID-19, cholera, yellow fever, typhoid, plagues, and vaccine-preventable diseases. Building resilient systems will shore the gains of HIV response and minimize the impact of outbreaks on HIV programs.

Support for Continuous Quality Improvements

PEPFAR/DRC will continue to support continuous quality improvements to ensure accurate diagnosis, efficiencies, and cost savings. Accurate diagnosis is at the nexus of key decisions involving clients or patients. For laboratory testing, such as VL, ensures quality monitoring of patients on ART. It allows caregivers to make decisions maintaining adhering patients with suppressed VL (<1000 copies/ml) on their regimens or switching to those failing therapy with unsuppressed VL (>1000 copies/ml). For HIV rapid testing, accurate diagnosis of clients allows appropriately initiating only those diagnosed with HIV infection on treatment. In contrast, HIV-negative clients will be counseled with prevention strategies to maintain their negative serostatus.

Eighteen PEPFAR-supported laboratories participating in continuous quality improvement (CQI) through employing a structured tool for standardized improvements of laboratories. Seven of the laboratories conducted a self-audit using the 5-star WHO's Stepwise Laboratory Improvement Process Towards Accreditation (WHO SLIPTA) checklist with laboratory auditors. one laboratory each was at 2, 3, and 4 stars, respectively, and four laboratories with one star. PEPFAR/DRC will continue to maintain laboratories in the continuous quality improvement (CQI) programs to maintain quality testing, support African Society for Laboratory Medicine (ASLM) audits before accreditation assessment of laboratories.

PEPFAR/DRC will continue supporting the improvement the quality of HIV rapid testing to ensure the reliability and accuracy of test results. PEPFAR/DRC recently completed the evaluation and development of a robust national HIV rapid testing algorithm. The WHO *Handbook of Improving the Quality of HIV-related Point of Care* recommends five pillars to ensure the quality of HIV rapid testing. They include national policy for HIV point of care quality assurance, certification of testers, certification of sites, proficiency testing (PT), and post-market surveillance. Currently, PEPFAR/DRC is supporting two of the five pillars, training of testers and proficiency testing (PT). HIV rapid test PT panel production units have been established in Kinshasa and Haut Katanga and have been used to provide PT panels to almost 2050 HIV rapid testing sites to monitor the quality of HIV testing. In COP23, PEPFAR will continue supporting the HIV rapid testing sites with PT panels.

Furthermore, PEPFAR/DRC will expand to implement the three other pillars, which include training and certification of sites and testers using the checklist for the stepwise process for improving the quality of HIV rapid testing including the use of the checklist for instrument-based point-of-care testing (for example, GeneXpert platforms). Additional auditors will be trained to implement certification of sites and testers. PEPFAR/DRC will support the establishment and validation of a national policy for HIV point-of-care testing. Also, the performance of different lots of HIV rapid test kits being used in the field will be monitored through post-market surveillance which is critical to identifying any defective test kits in the field. We plan to decentralize HIV PT production units to two additional provinces, Lualaba and Kisangani, to cover HIV testing sites including military testing sites in these provinces.

For TB proficiency testing, in COP22, 14 laboratories were enrolled into the TB PT program for near-point-of-care instrument-based (GeneXpert). In COP23, PEPFAR/DRC will expand to an additional 25 GeneXpert testing sites for TB. PEPFAR/ DRC will transfer the PT production competency to the national TB reference laboratory as a system-strengthening component of PEPFAR intervention to support this TB proficiency testing expansion.

All VL molecular laboratories are enrolled in an external quality assurance program to monitor the quality of VL testing laboratories. In COP23, PEPFAR/DRC will implement serologic laboratory quality assurance of specimens for viral load testing. This will entail securing HIV rapid test kits in the molecular laboratories and performing HIV rapid testing on 10% of viral load samples sent to the laboratory before their processing with documentation and sharing of results with sites.

PEPFAR DRC will conduct a full DQA and will engage in a CQI activity aiming at: 1) finalizing SOPs for data verification at the facility and Health Zone levels, 2) the description of roles and responsibilities for data verification, 3) supportive sites and HZ supervision visits with PNLS and clinical IPs and quarterly reconciliation meetings at the provincial level. The data reconciliation process will evolve in an iterative and standardized continuous quality improvement incorporating granular site management. This ongoing activity moves beyond partner management to site management to continuously monitor the quality of data continuously, identify site-level problems and generate site-level solutions, and build quality improvement capability at the site level. These activities will improve programmatic data and patient-level clinical outcomes, strengthen MoH, facility-level, and partner capacity, and capability to detect early signals of poor data quality and streamline communication across health zones. A coaching approach may be used to enhance south-to-south collaboration, which empowers strong health zones to mentor those that need more development.

In addition to tracking implementation of core standards at facilities level, Implementing Partners will be trained for conducting SIMS assessments at both health and community facilities. Supervisors from IP organizations will oversee understanding and adoption of core essential elements standards from SIMS.

Agencies will mainly use a combined approach: SIMS and granular site management. The oversight will also assess: 1) the financial and budgetary commitments of implementing partners, 2) the workplan activities and 3) triangulation of MER data, CLM findings and Expenditure Reporting.

Implementation of a national specimen retention policy

A specimen retention policy defines the length of time and conditions under which specimens must be retained to maintain specimen viability. The specimen retention times chosen are considered to be the minimum times the specimen type is supposed to be stored. The DRC has no specimen retention policy. We observed various outcomes during a recent PEPFAR inventory of viral load specimens stored in the viral load molecular laboratory. Some laboratories stored

specimens for more than a year. In contrast, most laboratories had specimens stored under one year, with some stored for less than a month due to limited storage capacity and related accessories. PEPFAR recommends a five-year specimen retention policy. PEPFAR/DRC is committed to working with the MOH Division of Laboratory Services (DLS) and other control programs such as the National AIDS Control Program (PNLS), to implement a national specimen retention policy for DRC. The policy will entail specimen type, condition of storage and duration. The policy should also differentiate between original specimen source and isolates. Per the national policy, there will be a plan for routine destruction (and method) of specimens or isolates. All laboratories will be expected to adhere to the national policy. Once the policy is developed and validated, PEPFAR is committed to supporting PEPFAR-supported provinces to ensure compliance with the policy by providing storage capacity, temperature monitoring devices and documentation.

Strengthening the National Public Health Institute

The National public health institute (NPHI) serves as the premier health institution and plays a critical role in the coordination of various public health functions. In DRC, the different public health functions (surveillance, laboratory, workforce, etc.) are disparate and lodged within different services or ministries. An NPHI coordinating the different public health functions will ensure an effective response to the outbreak. DRC has come a long way in establishing an NPHI since the President of the country first made the request in September 2019. Through CDC Division of Global Health Protection resources, the vision, mission, and public health functions of an NPHI have been established.

Furthermore, a five-year NPHI strategic plan has been developed, and an NPHI technical working group involving multiple stakeholders has been established. Through a presidential decree, the board of directors and chair of board of directors for the NPHI has been constituted. The Director General and Deputy Director General have been established. In COP23, PEPFAR will leverage on investment and progress made to strengthen workforce pillars. We aim to and improve the field epidemiologists training program (FETP) with emphasis on the laboratory "L" element (FELTP) and leadership for laboratory-based surveillance for effective response to outbreaks. This workforce will play a key role in surveillance and rapid response to outbreaks including HIV outbreaks (geographies and subpopulations identified through HIV recency) and other disease outbreaks.

Person-centered care that addresses comorbidities posing a public health threat for PLHIV

<u>Advanced HIV Disease (AHD)</u>

Advanced HIV disease (AHD) is defined in the following situations:

- For adults, adolescents, or > 5 years old: CDC4 cell count <200 cells/mm3 or with current WHO clinical stage 3 or 4 findings.
- For children: all children under 5 years old, except for clinically stable young CLHIV (<5 years of age) on ART and virally suppressed.

In COP23, PEPFAR/DRC will continue to streamline the AHD 'hub and spoke' approach which began in COP22. This approach is aligned with the GDRC health system which offers an extended package of services in general reference hospitals and the basic package of services in health centers. On a quarterly basis, PEPFAR IPs will meet with civil society organizations under the leadership of the PNLS to discuss lessons learned and to develop mitigation plans.

Packages of services

	Screening package	**Treatment package**
Spoke	CD4 (Visitect), TB_LAM. CrAg (Blood)	ARV, Cotrimoxazole, TB treatment, Fluconazole
Hub	CD4(Visitect), TB_LAM, CrAg (Blood), CrAg/LP+, CrAg CSF+ India ink, X-rays	ARVs, Cotrimoxazole, TB treatment, Fluconazole + Amphotericin B

In FY24-25, PEPFAR/DRC will expand beyond the twelve (12) hubs (reference hospitals) and approximately the fifty (50) spokes planned in COP22 to support the implementation of AHD in PEPFAR-supported provinces. However, this expansion will be progressive to provide care to people with advanced diseases as close to their place of residence or preference.

As stated in COP22, CD4 will be used to diagnose advanced disease, not for treatment monitoring. Access to CD4 will be under the following indications: 1) at initiation for all patients at WHO stage 3 and 4; in patients presenting some alert signs. 2) PLHIV re-engaging: children >5 years old and adolescents re-engaging with care after three months or greater of ART interruption; adults who have been out of care for more than a year. 3) Patients who have been documented with viremia after enhanced adherence counseling sessions.

PEPFAR/DRC will continue to expand the HIV advanced disease package in all supported provinces in collaboration with PNLS and other stakeholders (Médecins Sans Frontières Belgique, the Global Fund) to reduce HIV-related mortality documented in TX_ML.

PEPFAR/DRC considers COP23 implementation to be the best opportunity to respond to pending questions regarding AHD in the DRC, i.e., What is the prevalence of CD4 <200 among HIV+ adults/children? What proportion of those who interrupted treatment are eligible for AHD package? What proportion of naive patients enrolled in AHD care? What proportion of those enrolled in AHD care was viral load unsuppressed?

Throughout COP 23 planning, stakeholders (PNLS, Global Fund, MSF and PEPFAR DRC) have agreed to jointly work on the standardization of AHD approaches implemented in the country. As noted, there are still a lot of unanswered questions regarding the implementation of AHD in

the DRC. Technical assistance from agency headquarters will be critical to optimize the implementation of AHD services and to set up a holistic monitoring and evaluation framework. Furthermore, CLM will be critical to improving the quality of services offered to patients with AHD.

TB/HIV services

TB has been the leading cause of death from a single infectious disease globally. DRC has one of the highest incidences of TB per capita and is ranked by the World Health Organization (WHO) among the top 30 countries with high TB and TB/HIV burden countries worldwide. In 2021, the country recorded 215,787 TB cases (12 percent children and 88 percent Adults) with a case notification rate (CNR) of 318/100,000 (95 percent IC 206-455). According to the National TB Program in DRC, the rate of TB patients with known HIV status was 77 percent, with 83 percent on ART among those who tested HIV-positive. In the three provinces supported by PEPFAR in DRC in FY21 Q4 and FY22 Q1, 97 percent of TB patients had a documented HIV status. The percentage of TB HIV co-infected patients initiated on ART in FY22 has also remained high at 93 percent. In COP23, PEPFAR/DRC will continue implementing TB/HIV strategy based on three objectives designed to reduce morbidity and mortality among all PLHIV.

1. Intensified TB case-finding among all People Living with HIV

In COP23, PEPFAR/DRC aims to increase TB case findings and decrease morbidity and mortality. In FY21 Q4, 93 percent of PLHIV in the PEPFAR program were screened. In COP23, PEPFAR/DRC will reinforce the TB screening of PLHIV at every clinical encounter at the facility in all entry points (out-patient, inpatient, nutrition, ANC, etc.) and in the community (OVC, KP, etc.). The overall positivity yield of the TB screening remains low at 2.7 percent. The yield is at 1.3 percent for those already on ART and higher at 9.8 percent for newly enrolled patients. These yields for both old and new PLHIV on ART is lower than the expected thresholds set at 5 percent for patients already on ART and 15 percent for patients newly initiating ART (according to WHO systematic screening for Tuberculosis disease 2021). In addition, there has been poor reporting on the diagnostic cascade following a positive TB screen until TB treatment and the outcomes. To address the challenges in TB screening and case finding, PEPFAR/DRC will use the national monitoring and evaluation system and QI approaches to improve TB screening while ensuring regular monthly reporting on screening indicators. In addition, PEPFAR/DRC will support the programs to update the screening algorithm according to the WHO recommendation where the symptoms will be combined with the molecular diagnostic test (mWRD), Chest X-Ray (CXR), computer-aided detection software, C-reactive Protein (CRP). In COP23, PEPFAR/DRC will start with CRP with the symptom (W4SS) and organize the referrals for the sites supported by the Global Fund where we have the digital chest x-rays with computer-aided detection software in specific sites. TB contact tracing covering all household contacts will be intensified, and community HCWs will be capacitated.

In COP23, all confirmed and presumptive TB patients should be tested for HIV and linked to rapid ART for those testing positive. PEPFAR/DRC will introduce continuous laboratory support

which will be provided to increase testing capacity and continue supporting TB LAM implementation to ensure early TB diagnostic and treatment.

2. Optimized TB/HIV care and treatment

In COP23, PEPFAR DRC will work closely with the PNLT (TB National Control Program) to establish a strong referral system to allow PLHIV screening positive to have prompt clinical evaluation and specimens collected for diagnostic testing with an mWRD test or CRP.

PEPFAR/DRC will ensure an appropriate TB treatment will be initiated promptly after TB disease diagnosis; the national TB control program will provide TB medicine. Completion of TB treatment will be ensured for those who are started through the provision of psychosocial and adherence support. To optimize TB HIV Care, in COP23, PEPFAR/DRC will continue to promote the ONE STOP SHOP approach in all provinces supported.

3. TB Prevention

The results from FY 21 Q4 showed 95 percent of TPT coverage in the PEPFAR/DRC program. In COP23, DRC will continue using the shorter course TPT regimen for all eligible people living with HIV, including children and adolescents, and INH for the non-eligible. In COP23, PEPFAR/DRC will intensify TB contact tracing for all children and adults who are household contacts of PLHIV. Contacts will be screened for TB disease and offered TPT to eligible patients. This activity will be in collaboration with the National TB control program.

In COP23, PEPFAR/DRC will continue implementing Infection Prevention and Control (IPC) measures at the facilities and community settings, including TB screening. PEPFAR/DRC will continue CQI activities and strengthen the TB/HIV joint supervision and quarterly meetings to review data and organize the response according to the findings. To improve the TPT completion rate, PEPFAR/DRC will continue to scale up the service delivery models for adults, children, and adolescents (MMD ARV + TPT).

<u>Intensify supply chain support for provincial/site-level monitoring of stock</u>

PEPFAR/DRC is committed to continue to refine our supply chain support for provincial and site-level monitoring of stock levels and appropriate distribution and as needed, redistribution of commodities.

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 the ARV supply plan, with a focus on improving data quality, completeness, and usage. Data will be used to improve stock visibility and management at the facility level and increase visibility and rational use at the point of care services. PEPFAR will continue to invest in data visibility to strengthen the collection, management, and use of accurate supply chain data to enhance transparency and accountability of HIV commodities.

The Supply Chain/Lab TWGs (interagency team, provincial, health zone) will meet monthly to discuss consumption data and stocks at the regional warehouse, sites, and laboratory for decision-making. The PEPFAR/DRC Supply Chain/Lab TWG will meet bi-weekly with the constituted interagency HQ supply chain group to follow up on DRC challenges and needs.

Procure High-quality HIV Commodities

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

Efforts are currently underway and will continue in COP23 to reinforce the optimized ARV regimen for both children and multi month dispensation, differential services of care, and strong coordination and data-based management of the PEPFAR and Global Fund stock to ensure the national good availability and high quality of HIV commodities.

In COP23, PEPFAR plans to procure commodities to support the full implementation of the HIV program in the three supported provinces, including ARVs, RTKs, and lab reagents, without any anticipated gaps. Risks of stock-out and expiration will be mitigated through close management and monitoring of forecasts, deliveries, buffer replenishment, a rapid expedition of pipeline orders, and reallocation. PEPFAR/DRC will continue to strengthen the collaboration with the Global Fund and other stakeholders regarding loans, exchanges, and reimbursement of products to mitigate stock outs, overstock situations, and optimize the rational use of products.

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 adult and pediatric ARVs.** In COP23, PEPFAR will continue to procure 90 and 180-count TLD as the main first line, with the goal that 30 percent of patients will collect ARVs every three months and 70 percent of patients will collect ARVs every six months. A 30-count TLD will not be procured except for specific cases. PEPFAR/DRC will continue to closely monitor for possible Dolutegravir side effects and procure other alternative first-line drugs for patients not eligible for Dolutegravir (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, and ABC/3TC +DTG 10 mg for children under 20 kg. PEPFAR will prioritize -dose drug combinations for adults and children, depending on their availability on the market. Few non-fixed dose regimens will be procured for patients unable to support fixed-dose ARV combination for any reason.
- **Continue to optimize pediatric ART regimens per PEPFAR guidance.** As the transition to DTG 10 mg for children < 20 kg for pediatric patients has already been completed in DRC, PEPFAR/DRC will continue to monitor sites to ensure that pediatric patients are on optimized regimens in COP23. Only optimized regimens will continue to be procured for pediatric patients. No nevirapine-based regimen will be procured, except nevirapine 50 mgs for HIV-exposed infants. Pediatric fixed dose ABC/3TC/DTG (60/30/5 mg; pALD) for children will be prioritized once approved by the FDA and PEPFAR.

- **Support** through adequate quantification, forecasting, procurement, and distribution of commodities related to **expanding new initiatives** such as PrEP, TPT, AHD, self-testing, and recency testing.
- **Procure ARVs for PrEP** for PEPFAR-supported health zones to support the scale-up of PrEP programming. Truvada™ will be the preferred ARV for the DRC PrEP program.
- Procure commodities to support the implementation and the **scale up of HIV advanced disease management**, including Amphotericin B, Fluconazole, test CrAG, TB Lam and CD4 Omega visitech tests.
- **Ensure provision of rapid tests to support the overall needs of COP23** testing targets, including HIV tests for self-testing (mainly OraquickTM) and Asante™ tests for HIV recency testing,
- **Support procurement and availability of TPT** commodities to prevent TB among HIV patients. In COP23, PEPFAR will continue to optimize the TB prophylaxis regimen using the shorter course TPT based on 3HP for adults and INH for children. For TB diagnosis, PEPFAR will procure the Determine™ TB LAM Ag tests to streamline and improve screening and case finding of active TB among HIV-positive patients. PEPFAR DRC will continue to work closely with the PNLT (TB National Control program) and the Global Fund to ensure the availability of first- and second-line TB drugs for HIV-TB co-infected patients and the provision of GeneXpert cartridges as well as other products to support early TB diagnosis.
- **Procure and ensure availability of other essential medicines** including Trimethoprim-Sulfamethoxazole to prevent opportunistic infections and specific drugs to treat STIs.
- **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.

Since PEFAR is the only donor supporting HIV programs in our dedicated health zones, the team has planned to support all commodity needs based on COP23 targets without any anticipated gaps. PEPFAR will continue to advocate for more engagement of the host country in the mobilization of domestic resources to support HIV commodities to cover existing and future gaps in ARV provision, HIV rapid tests, and VL/EID testing. To conduct accurate forecasting for COP23 commodities to mitigate the shortage of essential products, the team has taken into consideration patient months of treatment, multi-month dispensing, buffer stocks, expiry dates, warehousing and distribution chain, lead time for delivery to country and delivery to points of service, eventual stock-outs, and other influences on the ART supply chain during the planning process.

Custom clearance efforts

PEPFAR/DRC saw significant improvement in the commodity customs clearance process, with lead time reducing from six months to two months or less during the past two fiscal years. PEPFAR/DRC will continue to collaborate 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. The GDRC is interested in streamlining

the customs clearance process. COP23, PEPFAR/DRC will support this process and engage with the GDRC to consolidate and reduce the customs clearance steps and time.

Support MOH supply chain coordination and quantification

PEPFAR will continue to support the PNLS and PNAM Coordination to oversee commodity management in PEPFAR-supported Health Zones (HZs), support the group managing commodity purchases and stocks (Groupe de Gestion des Approvisionnements et de stock, GAS) coordinate stakeholders involved at the provincial level in the management of HIV commodities, including policy updates, custom clearance efforts, and training on supply chain management.

- In COP23, PEPFAR will provide technical support to the MOH in planning, operationalizing, and monitoring the implementation of the national supply chain strategic plan; technically assist the GDRC supply chain working groups to conduct quantification of HIV commodities, including ARVs, laboratory reagents, and to develop an annual supply plan (refresher training on the use of Forlab, pipeline, and Quantimed tools.)
- Reinforce national and provincial coordination of HIV commodity management. PEPFAR/DRC, through USAID, will continue to participate in the Health Donors Supply Chain Group and the National Medicines Commission with the National Pharmaceutical Regulatory Authority. This will help to strengthen donor collaboration, mitigate gaps, and improve GDRC leadership, oversight, and accountability on health commodity forecasting and procurement system management.

Supply chain visibility strengthening

To reinforce supply chain visibility, PEPFAR/DRC supported developing a functional LMIS with some weaknesses.

- In COP23, PEPFAR intends to work with the MOH to improve the quality of the national LMIS to 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 the stock status at the provincial and site levels and provide mentoring and coaching in stock management quarterly, including regular review and necessary updates of the ARV supply plan, with a focus on improving data quality, completeness, and usage.
- Ensure that the information system (LMIS) is operational.
- Ensure that data collection takes place at all levels, are analyzed, and used for making decisions. PEPFAR/DRC will continue to strengthen the use of the national LMIS program, InfoMed, in PEPFAR-supported health zones and will provide technical support for its expansion in Global Fund-supported provinces. PEPFAR will ensure that data sharing takes place, the quality assurance process is implemented, and results are shared through the technical working group and in inter-agency space and are used at all levels for decision-making.

- Continue to support the collection of data for the Procurement Planning and Monitoring Report and to provide technical support for warehousing and logistics management and provide management tools for all PEPFAR-supported health zones.
- Support coordination between the IPs and clinics will be strengthened to improve the completeness of data going into DHIS2 which will inform the commodity visualization platform, InfoMed, adopted by the GDRC.
- In addition to InfoMed, PEPFAR will expand the use of an electronic system to capture consumption data at delivery points for ARVs, including health facilities and the main ART community distribution centers (Electronic Dispensing Tool). This electronic system will help to improve the visibility and accuracy of consumption data related to HIV commodities as well as the overall management of those products at all levels. It will close the gap of unreliable consumption data found during the 2022 DQA. The first phase will be implemented in COP23 Year 1 and will cover approximately 200 high-volume sites and will include training of pharmacies, provision of computers, supervision, and mentorship. Capturing accurate consumption data at facilities and all delivery points will strengthen the transparency of supply chain and the quality of HIV services delivered.

Lab supply chain management

Lab supply chain management remains a challenging area for DRC. PEPFAR will work closely with the MOH and labs to improve lab stock management at all levels by undertaking the following activities:

- Continue to strengthen the forecasting and procurement of VL/EID lab commodities, closely monitoring to mitigate gaps and optimize the availability of lab reagents for all existing and future platforms (Abbott, Roche, Cepheid).
- 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 gaps in 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 to improve their ability to reach 95 percent VL coverage and maintain it through FY24.
- Provide rapid test kits (RTKs) to support HTS in all PEPFAR-support health zones and technical support to IPs and health providers for the best management of RTKs at HZ and site levels.
- To improve PNLS coordination and lab reagents stock information sharing between PEPFAR/DRC, the Global Fund, and all stakeholders, PEPFAR/DRC will implement and maintain a monthly tracking system for the key VL and EID reagents and commodities, resulting in better forecasting and supply chain management. In addition, PEPFAR will network with other donors, the Global Fund, CHAI, supply chain IPs, and CDC lab colleagues to harmonize the pricing model for lab reagents. PEPFAR will collaborate with the Global Fund and the GDRC to develop a common strategy to support the rational scale-up of laboratory monitoring (programmatic, financing, procurement.)

- Support PNLS to train labs, provincial level MOH offices and facilities to manage the lab reagent supply chain.

Health waste management system strengthening

DRC is facing issues with the waste management system, including:

- Weaknesses in the policies, regulations, specific laws, and clear plans related to biomedical waste management,
- Expired drugs from many projects over 10 years and the transition to new regimens have resulted in a huge quantity of legacy ARVs and expired medicines (20 40 ft. containers),
- Lack of appropriate and standardized technology for the safe disposal of hazardous wastes.

In COP23, PEPFAR will ensure that medical waste is handled, treated, and disposed of without harming public health or the environment. PEPFAR will support the MOH in developing a pharmaceuticals and health care waste management system. This is an opportunity to improve current practices. The following activities will be undertaken:

- Support the GDRC to update the existing national guideline for waste management and the new Road Map defining strategies for the disposal of health and pharmaceutic waste, considering the specificities of HIV commodities.
- Support training on and dissemination of DRC health waste management guidelines.
- Ensure safe disposal of existing legacy and expired ARVs in respect of DRC and PEPFAR norms and policies.
- Provide technical support to the MOH specialized services under the DPM in charge of coordinating pharmaceutical waste management.
- Provide technical assistance to the GDRC to ensure an innovative, sustainable, and appropriate medical waste management approach - including synergy with the Global Fund and other donors to support the DRC waste management plan and public and private partnerships highlighting country ownership and long-term viability.

Health system pharmacovigilance strengthening

- Provide technical assistance to health zone staff on ARV stock management, Dolutegravir pharmacovigilance data collection for transition follows up, MMD management, and rational use of rapid tests and other key HIV commodities.
- 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.

Efforts to be implemented in COP23 to mitigate the effects of the COVID-19 pandemic on supply chain management will focus on the continuity of HIV treatment and prevention services through drug delivery to clinics and other differentiated models of care such as private

pharmacies, the increase of multi-month dispensing of ART, especially six-month packs, including PrEP, and making delivery of medication more convenient and decentralized.

As the DRC promotes local entities, PEPFAR will work in alignment with DRC regulation of local procurement of essential medicine such us cotrimoxazole and metronidazole. Finally, in COP23, PEPFAR will continue to support in collaboration with other donors, efforts to advocate for increasing domestic mobilization funds to support ARVs.

Viral Load and Early Infant Diagnosis Optimization

PEPFAR/DRC faces challenges with reaching children and PBFW with EID and VL services needed to attain epidemic control. Challenges related to these specific populations include low demand creation from practitioners due to children not returning to the facility for blood collection and the incomplete or lack of filling out the VL requisition forms for PBFW. There are also delays related to equipment breakdowns and reagent reallocations. To address these, PEPFAR/DRC has improved the supply chain and will work as quickly as possible to reallocate reagents to functional laboratories. We will encourage DBS utilization over plasma for viral load and encourage rapid processing of all VL specimens arriving at the laboratory. We will also implement community DBS collection for infants and adults who do not access facilities for VL testing. We will continue to optimize the use of GeneXpert to improve VL and EID uptake of services. The PNLS has concurred with our request to use POC machines located in Kinshasa. We will continue to work with the Global Fund to improve equipment maintenance around the country to avoid equipment downtime and accumulation of backlogs. PEPFAR/DRC purchased the GeneXpert 16 modules through the all-inclusive pricing to bring services closer to these different targeted populations and allow for the quick release of results for patient management. With diagnostic network optimization, we will follow up at site level on the use of POC machines for specific targeted sub-groups and ensure integration and alignment with continuous use of conventional machines.

Strategic Information

To improve the quality of strategic Information in COP23, PEPFAR/DRC will employ comprehensive strategies, activities, and responses to improve DRC strategic information systems. The approaches will continue supporting the GDRC and implementing partners to ensure that strategic information systems provide accurate information, mitigate data inconsistencies, are streamlined, and align with the national standardized guidance. DRC continues to roll out DHIS2 as the national health management information system (HMIS). The GDRC has put in place the “Ministere de Numerique,” which oversees the digitalization process of the country. The MOH requires a unique identifier for patients utilizing the health system, which is part of the expected outcomes of the new ministry. PEPFAR/DRC will assist with needs gathering and requirements for GDRC to set up Unique Identifiers for the PLHIV cohort.

The strategic information activities below will contribute to the deliberate and progressive move toward digital health adaptation.

- Build institutional capacity and capability related to the digitalization of systems to ensure sustainable and secure strategic information systems are in place.
- Set up policy and governance structures and build capacity at the central MOH level to lead/oversee EMR and Patient Identification Management (PIM) implementation.
- Incorporate continuous quality improvement activities into routine monitoring activities across sites to assess the quality of reported data among PEPFAR-supported sites and data validation across the DRC health pyramid.
- Increase the Health Information Systems (HIS) capacity and sustainability to enhance health informatics systems to collect accurate and high-quality data.
- Bring technical assistance to IPs and the government to improve the accuracy and completeness of HIV data.
- Support the functionality of MOH-DHIS2 to consolidate data quality management capacity and use of DHSI2 for MOH staff.
- Develop user-friendly dashboards to increase the ability to detect errors in the DHIS2 HIV module and report back to the site for correction.
- Advocate for a better understanding of true denominators to provide more accurate PLHIV estimates.
- Increase data quality and usability for planning and decision-making.

Pillar 4: Transformative Partnerships

Partnership has always been central to the way PEPFAR operates. Resources are increasingly constrained; PEPFAR cannot do everything alone and at once. We need to design more ambitious, scalable partnerships that can truly transform programmatic impact.
COP 23 has marked a watershed moment for implementing HIV/AIDS activities in PEPFAR-supported provinces which will inevitably impact the DRC's roadmap toward epidemic control by 2030. This decisive turning point is marked by adopting the PEPFAR Global 5x3 strategy. PEPFAR/DRC will ensure the sustainability of cumulative achievements over years of implementation under the countries' ownership and leadership. To this end, PEPFAR/DRC intends to strengthen all partnerships which helped to deliver quality services to priority populations and support the national HIV/AIDS coordinating bodies (PNLS, PNMLS) in their regulatory roles to align the DRC HIV response to the 95/95/95 goals.

PEPFAR/DRC will strengthen collaboration across agencies and external stakeholders, especially with the Global Fund, the Ministry of Health, and civil society. As discussed during the COP23 co-planning meeting with external stakeholders, PEPFAR/DRC will participate in quarterly technical meetings under the MOH/PNLS leadership. During these meetings implementing partners (PEPFAR, Global Fund, Médecins Sans Frontières, and others) will share their performance and best practices depending on the theme proposed by the MOH.

Coordinating with the GDRC and the Global Fund is critical to ensure the availability of lifesaving commodities for all HIV clients on treatment through information sharing and commodity

pooling. 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 ARV provision, HIV testing and VL/EID testing.

In the DRC, the World Bank is a major donor that supports primary health care in more than one hundred health zones. In COP23, PEPFAR DRC will continue to partner with the World Bank to ensure the alignment of interventions to improve the quality of services provided to people living with HIV/AIDS in supported health zones in Lualaba and Haut-Katanga provinces. PEPFAR DRC envisions to intensify its collaboration with the World Bank on other aspects such as human resources, governance and essential medicines procurement.

In COP23, PEPFAR/DRC will continue strategically optimizing its collaboration with the Global Fund and other national donors/stakeholders (National TB program, PNLS, CHAI) to mitigate stock-outs and overstock situations through an MOU regulating the loan, reimbursement, and donation of commodities to avoid any service disruption.

PEPFAR/DRC intends to intensify collaboration with the Global Fund on the supply chain where there continues to be a need to leverage interventions to avoid service disruptions. In addition, PEPFAR/DRC will strengthen collaboration with Médecins Sans Frontières around specific topics such as AHD 'Hub and Spoke' approach, management of kidney failure among HIV patients, viral load testing and commodity support in locations where both operate.

Over the past years, PEPFAR/DRC has increasingly focused its partnership on services delivered to priority populations by contracting with public and private-faith-based and other- owners of health facilities, and to a certain extent, to public and private molecular laboratories in Kinshasa, Lualaba, and Haut-Katanga provinces.

In COP23, PEPFAR/DRC will continue to build on successful established partnerships and actively seek out other partnerships essential to realize the new goals of the 5x3 strategy. Partnership with the youth, civil society and others underserved populations such as key populations will be prioritized and by putting them at the center of interventions as not only beneficiaries, but also as key actors so that they can impact the HIV response sustainably.

USG agencies will analyze how implementing partners in their respective health zones engage CSOs, youth, key populations led organizations, and others, so that these groups can contribute to the ongoing interventions and share their wishes to plan better, implement, and monitor the interventions for greater impact.

PEPFAR/DRC will continue to hold quarterly implementing partner meetings. During these meetings, implementing partners will present their performance, challenges, and corrective actions taken to guarantee the trajectory toward epidemic control goals. PEPFAR/DRC will also invite civil society organizations engaged in monitoring the PEPFAR/DRC program to share their findings, and together as a team, agree on solutions, and follow-up actions.

PEPFAR/DRC will reinforce community-led monitoring activities under civil society organizations started during FY22. In COP23, PEPFAR/DRC will intensify meetings with these organizations to

share their feedback with implementing partners to improve treatment outcomes and patient's satisfaction with services received at both facility and community levels. Quarterly meetings will be organized to review observations and make recommendations and set in place follow-up action plans, as needed. However, PEPFAR/DRC will encourage local civil society organizations engaged in community-led monitoring and PEPFAR/DRC implementing partners to constantly engage on urgent issues impeding the quality of services and immediately find adequate corrective responses to maintain patients on treatment and boost demand creation for available services.

PEPFAR/DRC will collaborate with stakeholders intervening on key health system interventions such as human resources for health, supply chain, service delivery, strategic information, and laboratory, contributing to improving the clinical cascade. In DRC, the MOH receives support from its partners, including the Global Fund, UNAIDS WHO, UNICEF, Médecins Sans Frontières and private sector, to strengthen key health interventions mentioned above.

Given the proposed priorities for COP23, including improvement of data quality through the provision of reliable epidemiological data (through PHIA, DHS, SABER), and the review of programmatic data through continuous quality improvement exercises, reconciling patient data with data source tools and an exhaustive data quality assurance to certify the number of patients on antiretroviral treatment, PEPFAR DRC will expand its collaboration with the GDRC entities (PNLS and others), the Global Fund, and other donors to ensure data are collected under the leadership of the Ministry of Health.

In COP23, PEPFAR DRC has committed to improve the digitalization of interventions to better track data collected at the implementation and the above site levels. To do so, innovative, and transformative partnerships are essential. Strategically partnering with private sector telecom and informatics technology companies will facilitate a cost-effective and sustainable transition to digitalization.

In Lualaba and Haut Katanga mining provinces, PEPFAR/DRC will continue to build on best practices such as the private-public-partnership established in Kolwezi between PEPFAR/DRC, the PNLS and the Kamoto Copper Company (KCC) for laboratory strengthening. The KCC has hosted the molecular lab, provided the operational costs, and offered free viral load testing. Furthermore, in COP23, PEPFAR/DRC will foster synergies with USG investments in different sectors - education, economic growth, democracy and governance, and humanitarian affairs - in PEPFAR-supported provinces. More details will be provided as we make progress. POART calls are an excellent opportunity to share any updates on how these synergies are evolving.

Pillar 5: Follow the Science

PEPFAR DRC is committed to working with the MOH and stakeholders to use data to inform HIV programming. The mantra 'know your epidemic know your response' is grounded on using

accurate data for programming while enabling reliable measurement of interventions to curb HIV transmission and maintain quality care.

As the PEPFAR program strives towards 95-95-95 goals, tools and data that enable pinpointing high HIV transmission will continue to be used. PEPFAR/DRC and the PNLS have rolled out HIV recency testing in all three PEPFAR-supported provinces. The HIV recency surveillance will allow identification of subpopulations and geographies with high transmission and enable appropriate and targeted public health interventions to disrupt further transmission of HIV.

HIV drug resistance poses a serious threat to achieving epidemic control if it is not properly monitored and regimens adapted, if needed. The DRC rapid scale up of DTG based regimens in FY21 has been effective in ensuring viral suppression as demonstrated by our viral load data. It is important to monitor the type and prevalence of mutations that may be associated with resistance to DTG based regimens. In FY23/FY24, PEPFAR/DRC will be implementing a cyclical acquired HIV drug resistance patient monitoring activity in PEPFAR supported provinces to understand whether there are mutations that may be associated with resistance.

PEPFAR/DRC will continue to apply scientifically sound and innovative tools for its programs. PEPFAR/DRC will continue to invest in multi disease and multiplexing platforms to facilitate integrated care of HIV patients. In FY23, PEPFAR/DRC obtained two 16 modules GeneXpert multiplexing platforms with capability of viral load, early infant diagnosis, TB, COVID-19 and Ebola. These strategies or approaches align with the diagnostic network optimization and promote efficiencies while saving cost.

PEPFAR/DRC and the PNLS will continue to explore science-based interventions that can catalyze rapidly attaining epidemic control through evaluations of new diagnostics as well as proven youth targeted interventions.

In COP23, PEPFAR/DRC hopes to accomplish three main objectives related to data: the population-based assessment, bio-behavioral survey, and intensive reconciliation and certification of program data. PEPFAR/DRC will support a population-based HIV-focused household assessment (PHIA) in COP23 and COP24. The PHIA aims to provide a better understanding of the HIV epidemic. PHIA survey will serve as the most objective measure of the prevalence and incidence of HIV that can be used by all stakeholders, including the national HIV program, PEPFAR, the Global Fund, and other donors and multilateral organizations, such as the World Health Organization (WHO) and UNAIDS. The PHIA is planned to be implemented in two PEPFAR-supported provinces (Haut-Katanga and Lualaba). PEPFAR/DRC will work with local institutions, the PNLS and the Kinshasa School of Public Health (which is a component of the National Public Health Institute), to ensure ownership, and that capacity is built for conducting surveys, undertaking data analyses, and that the data is used for tailoring interventions.

One of the priority populations in DRC, considered as such based on the results of a Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) conducted in 2013, is the active-duty military personnel. Lessons learned from that survey informed the design of the military-specific prevention program currently being implemented. Considering that the data from the 2013 study are out of date, PEPFAR/DRC will conduct another SABERS to evaluate the impact of the current PEPFAR/DOD-funded prevention portfolio on the epidemics in the

military members and gather more evidence to reimagine the PEPFAR activities in this at high-risk sub-population for the coming years.
Assessing the quality of and validating reported data among PEPFAR-supported sites and validating is key to understanding the impact of PEPFAR programs in controlling the epidemic. The data quality assurance methodology that will be applied is developed by PEPFAR, WHO, Global Fund, and PNLS. The findings from each site will be used internally for routine monitoring to ensure that sites accurately collect, report, and interpret the data. By improving the performance of implementing partners in an ongoing and timely manner by using data quality improvement methods, PEPFAR/DRC will be able to assess the trajectory towards epidemic control and address early programmatic signals that influence achieving epidemic control.

Strategic Enablers

Community Leadership
As stated in the COP/ROP23 guidance, CLM remains a PEPFAR requirement, and a component of PEPFAR's strategy. In this regards, CLM implementers gather quantitative and qualitative data about HIV services and develop and advocate for solutions to the gaps identified during data collection, in collaboration with service providers and health care leadership.

During the past fiscal year, PEPFAR/DRC team worked with five CLM actors within all PEPFAR supported provinces (Kinshasa, Haut-Katanga and Lualaba) and through their activities there have been findings that pinpointed gaps/challenges/barriers based on key questions on HIV service delivery (availability, accessibility, affordability and acceptability) on one hand and on the other hand, on demand creation (to make sure beneficiaries are informed about the importance and availability of HIV/AIDS services to make decisions and also making sure they are well supported when using those services.)

From the CLM findings, the most common is the stock out of some HIV/AIDS commodities in some health zones, the long delay in the return of viral load results to beneficiaries, reception of some ARVs with short shelve lives, and stigmatization and discrimination. After disseminating the CLM results, urgent remediation actions were taken (especially for ARV stock-outs and ARV expiration) to address them.

PEPFAR/DRC will continue to utilize CLM results/findings and recommendations for program improvement on HIV service delivery and will align with the new 5x3 strategy focus on equity, efforts to strengthen community leadership with particular attention on people living with HIV as well as those most vulnerable to inequitable HIV outcomes, including AGYW, children, and KP.

PEPFAR/DRC will reinforce the partnership between the CLM actors and the IPs to closely collaborate on urgent issues impeding the quality of service and immediately find adequate corrective actions for the continuum of service delivery and boost demand creation for available services.

PEPFAR/DRC will work closely with other donors (the GF and UNAIDS) to facilitate information sharing and for efficiency to build a sustainable CLM program that contributes continually and tangibly to program improvement. UNAIDS in Kinshasa will continue to allow community stakeholders to use their office space and internet capabilities and host the regular civil society meetings. The PEPFAR in-country team will attend as well.

Civil society has been a leading force in response to HIV since the beginning of the epidemic, and there is full participation of community stakeholders (including all affected populations) and civil society in every stage of COP23 (planning, development, implementation, and monitoring) as they provide an understanding of the political and cultural environment.

In particular:

- CSOs participated in the pre-COP23 in-country retreat to help inform COP23 planning and strategy.
- CSOs provided feedback on the COP23 guidance and PEPFAR/DRC COP23 activities and priorities. CSO representatives and other stakeholders joined the PEPFAR/DRC delegation at the COP23 Co-Planning Meetings in Johannesburg, South Africa, and provided inputs throughout the process.
- PEPFAR/DRC will consider and support the capacity-building needs of implementing CSOs in health service monitoring, data collection and analysis, and evidence-based advocacy by highlighting some of the priorities identified by civil society during the COP23 process.

Table showing PEPFAR engagement and timeline with key stakeholders for COP23 planning

Date	**Objective**	**Outcomes**	**Next steps**	**Comments**
Before COP23 Submission				
10/01/2022-11/15/2022	PEPFAR/DRC shared the COP23 planning process with internal stakeholders.	Stakeholders understand the COP process and the outline of the last COP.	Plan the next meeting.	Meeting was held in-person

11/14/2022- 11/15/2022 Pre-COP23 In–Country retreat	Review the COP23 development process, overview, and expectations from stakeholders. Share timelines for future steps	Stakeholders understand the process and timeline for the next steps of COP23 and provide feedback	Share the documentation	Meeting was held in-person
02/22/2023- 02/23/2023 Pre-Johannesburg meeting	Stakeholders prepared for the presentation of their priorities for next year at the COP23 Co-Planning meetings.	Stakeholders presented their priorities for the COP23 Co-Planning meetings		Meeting was held in-person
03/6/2023- 03/10/2023 Johannesburg Co-Planning Meeting	Received input from stakeholders on the COP23 strategy for DRC			Meeting was held hybrid (in-person and virtual)
04/3/2023- 04/5/2023 In-country meeting	Receive final input from stakeholders on the COP23 strategy for DRC			Meeting was held hybrid (in-person and virtual)
04/18/2023	COP23 SDS Draft shared with stakeholders and CSOs			SDS draft was shared via email with CSOs and all stakeholders

05/04/2023 COP23 Presentation/Approval meeting	Stakeholders and CSOs attend the COP23 Presentation/Approval meeting			Meeting will be virtual
After COP23 Submission				
06/05/2023	PEPFAR/DRC to explain how stakeholder feedback was incorporated in COP23 planning and how PEPFAR will continue to engage them throughout the year	Stakeholders understand how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP23, what was not, and why these decisions were made	Share the redacted COP23 SDS when available and approved	The approved, redacted COP23 SDS will be shared by email. Hard copies will be available upon request

Innovation

The PEPFAR/DRC team will innovate by building the national CSO platform (ANORS) capacity with in-country team technical assistance on community-led monitoring at the site level. PEPFAR/DRC will work with UNAIDS and the Global Fund on CSO capacity building to build synergy and avoid duplication of efforts.

PEPFAR DRC will work with CSO to implement community specimen collection and transport to improve viral load coverage.

Leading with Data

PEPFAR, in collaboration with the Ministry of Health, is strategically strengthening the activities that will inform an appropriate EMR for DRC that will enhance the existing and new health informatics systems to collect accurate, high-quality, de-duplicated data. GDRC is continuing the scale-up of unique identifiers across all sites to deliberately and progressively move towards digital health integration and alignment within the country.

PEPFAR/DRC will assist with implementing findings from the Electronic Medical Record (EMR) assessment conducted in COP22, improving interoperability, and bringing together the health data ecosystem across stakeholders. PEPFAR/DRC will assist with enhancing HIV/TB services delivery through updating policy/governance standard operating procedures, assessing relevant policies, developing the management, and accountability, which includes implementation of administrative and technical safeguards for data security and confidentiality accountability, development of the Patient Identification Management (PIM) system to improve data quality, eliminate duplicate patient records, mitigating loss of patient privacy, and ensuring the ability of data exchanges and/or interoperability with other systems. PEPFAR will continue to support the reliable and secure transfer of critical data from sites to a central data repository connected to the MOH-led Health Information Systems (HIS).

Unique Identifiers

The GDRC instituted the "Ministere de Numerique," which oversees the digitalization process of the country. As part of the initiatives of the new ministry, a unique identifier for patients utilizing the health system is required. PEPFAR/DRC will monitor the progress of the unique identifier initiative and will provide technical assistance related to identifying policy constraints or other hurdles that will require diplomatic/government attention. The unique identifier initiative is central to the overall PEPFAR/DRC data systems work.

Target Tables

Target Table 1 ART Targets by Prioritization for Epidemic Control							
Prioritization Area	**Total PLHIV (FY23)**	**New Infections (FY23)**	**Expected Current on ART (FY23)**	**Current on ART Target (FY24)** ***TX_CURR***	**Newly Initiated Target (FY24)** ***TX_NEW***	**ART Coverage (FY24)**	**ART Coverage (FY25)**
Attained	**NA**	**NA**					

Scale-Up Saturation	**NA**	**NA**					
Scale-Up Aggressive	**NA**	**NA**	**202,450**	**220,018**	**22,211**	**NA**	
Sustained	**NA**	**NA**					
Central Support	**NA**	**NA**					
Commodities (if not included in previous categories)	**NA**	**NA**					
No Prioritization	**NA**	**NA**					
Total							

Target Table 2: Target Populations for Prevention Interventions to Facilitate Epidemic Control				
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY24 Target**	**FY25 Target**
PP_PREV	NA	NA	77,156	77,156
KP_PREV	NA	NA	64,474	64,474
TOTAL				

Target Table 3 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC OVC_SERV Comprehensive**	**Target # of OVC OVC_SERV Preventative**	**Target # of active OVC OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files OVC_HIVSTAT**
_Military DRC	11,174	3,447	NA	NA	3,060

Haut-Katanga	99,963	30,827	NA	NA	27,048
Kinshasa	86,923	26,794	NA	NA	23,183
Lualaba	22,255	6,874	NA	NA	6,228
FY24 TOTAL	**220,315**	**67,942**	**-**	**-**	**59,519**
FY25 TOTAL	**253,362**	**78,133**	**-**	**-**	**68,447**

Core Standards

1. **Offer safe and ethical index testing to all eligible people and expand access to self-testing**. Ensure that all HIV testing services are aligned with WHO's 5 Cs. Index testing services should include assessment and appropriate follow-up for intimate partner violence. Offer HIV testing to every child under the age 19 with a biological parent or sibling living with HIV.

Testing portfolio is steadily growing to meet the core standards:

- 100% of PEPFAR-supported sites implemented index testing in FY2022. Sites assessed in FY22 for standards for index testing delivery are in the remediation stage.
- A system is also in place for assessing IPV before and after index testing services.
- HIVST achievement in FY22 surpassed annual targets.

2. **Fully implement "test-and-start" policies.** Across all age, sex, and risk groups, over 95% of people newly identified with HIV infection should experience direct and immediate linkage from testing to uninterrupted treatment.

"Test and Start" is the Care and Treatment standard mandated by the national HIV guidance since 2016. Overall proxy linkage in FY21 (Oct 2020 – Sep 2021) was 96.7 percent.

3. **Directly and immediately offer HIV-prevention services to people at higher risk.** People at a higher risk of acquiring HIV must be directly and immediately linked with prevention services aimed at keeping them HIV-free, including pre-exposure prophylaxis (PrEP) and post-exposure prophylaxis (PEP).

The PrEP program will continue to scale-up. In FY21, PEPFAR DRC achieved 73% of annual PrEP_CURR targets. PEPFAR will continue to support the adoption by MOH of a demand

creation strategy for PrEP. PEPFAR DRC will continue expanding PrEP by including eligible AGYW and Pregnant and Breastfeeding women. MMD for PrEP is the now the rule.

4. **Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions supporting HIV prevention and treatment outcomes**. Provide evidence-based sexual violence and HIV prevention interventions to young adolescents (aged 10-14).

The multi-disciplinary team (case managers, clinical staff, and peers) is already in place to support testing of children at risk of HIV infection. Community workers will be empowered in self-testing better to support case finding (community and facility), while clinical staff will be trained to facilitate community referral of CLHIV. In COP23, the team will continue this collaboration to find CLHIV.

In close collaboration with clinical staff, the Case Managers ensure that all children who tested positive in the community are linked to facilities for treatment and offer enrollment for CLHIV in the OVC program. In Q4 FY 21, 46 percent of CLHIV in PEPFAR supported SNUs were linked to OVC platform for case management; in COP23, this linkage will continue to increase the enrollment at 90 percent or beyond.

Education of primary prevention of sexual violence and HIV, including strategies to actively explore violence symptoms within households were added to the case management curriculum to identify victims and refer them for appropriate support. Case Managers will continue with this activity during home visits and through advocacy.

To improve the OVC Program footprint, PEPFAR/DRC will assess the cohort of A/CLHIV under ARV treatment to determine those living out of their OVC Program geographic coverage area. This strategy will help to set the number of additional community cadres for an efficient ratio of case managers. The local representatives of the Ministry of Social Affairs and, where possible, the local faith-based organizations and private entity members will be selected and trained as Case Managers to improve sustainability. Finally, PEPFAR/DRC will ensure OVC enrollment is offered to 100 percent of those C/ALHIV on treatment but living outside their geographic coverage area. This will help to support those who wish to mitigate the burdens of the epidemic and improve their clinical outcomes.

5. **Ensure HIV services at PEPFAR-supported sites are free to the public.** Access to HIV services, medications, and related services (e.g., ART, cotrimoxazole, ANC, TB, cervical cancer, PrEP, and routine clinical services for HIV testing and treatment and prevention) must not have any formal or informal user fees in the public sector.

There are no formal fees for HIV services. Informal fees are sometimes charged, but our CLM partners are vigilant and working to eliminate these.

6. **Eliminate harmful laws, policies, and practices that fuel stigma and discrimination, and make consistent progress toward equity.** Programs must consistently advance equity, repudiate stigma and discrimination, and promote human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, children, and other vulnerable groups. This progress must be evidence-based, documented, and included in program evaluation reports.

A key activity is the training of HCWs in the provision of KP-friendly health services, which addresses stigma and discrimination, improves the treatment outcomes for KPs, increases knowledge of the rights of KPs, and more KP organizations running safety and security interventions. PEPFAR/DRC is exploring the magnitude of injecting drug occurrence and will provide an HIV response for prisoners.

However, cultural and religious beliefs fundamentally hinder acceptance and tolerance towards KPs, mainly MSM and TG. PEPFAR/DRC will participate in the development of the Stigma Index 2.0 for the country.

7. **Optimize and standardize ART regimens.** Offer DTG-based regimens to all people living with HIV (including adolescents, women of childbearing potential, and children 4 weeks of age and older.)
    - TLD transition completed for adults resulted in commendable Viral suppression of 94 percent in adults in FY21.
    - DTG 10 mg: started on November 27, 2021; Transition of approximately 95 percent of eligible children; completion of optimization projected by June 2022.
    - EFV and NVP regimens phased out: Completed

8. **Offer differentiated service delivery models.** All people with HIV must have access to differentiated service delivery models to simplify HIV care, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve ART coverage and continuity for different demographic and risk groups and to integrate with national health systems and services.

Offer differentiated service delivery models

Differentiated Service Delivery, Multi-Month Dispensing, and Differentiated Service Delivery (DSD) continue to be scaled up in all sites supported by PEPFAR/DRC. At the end of FY22, DRC rolled out different models of service delivery, such as:

- Community Adherence Groups (CAGs): In this group, clients receive ART as a group, and the clients themselves manage the group.

- PODI: Community distribution: In this group, the ART refills are done outside of the facilities, with plans for the clinical visits given to clients. PEPFAR/DRC will continue supporting nine PODIs in the three supported provinces.
- Fast-track: Clients receive their ART refills at the facility or from pharmacies in the community, managed by a health worker or peer educator.

The number of patients enrolled in different models continued to increase year-by-year. In FY22, more than 80 percent of PLHIV in the cohort were enrolled. In COP23, DSD models will be offered to all subpopulations established on ART including children, adolescents, pregnant and breastfeeding women, and men. The MOH is committed to PEPFAR/DRC MMD scale-up from three to six MMD, and PEPFAR/DRC plans to increase the proportion of patients on six months to 70 percent. The proportion of clients receiving six MMD in FY22 was 63 percent. These results directly result from the ART/TB Supply Chain TWG that convened at the beginning of the COVID-19 pandemic in 2020 and continued to meet regularly to ensure MMD. In COP23, PEPFAR/DRC will continue to collaborate with the MOH to scale up six MMD for children and support the survey requested by the MOH on the quality of drugs in the hands of patients after six months.

The DSD model remains a critical component of ensuring continuity in treatment. In COP23, PEPFAR/DRC will enhance the quality of services and implement equitable DSD models for those new on ART (three months of ART at the initiation of treatment), sub-populations (children, adolescents, PBFW), PLHIV with an unsuppressed viral load and those returning to care after an interruption. In COP23, PEPFAR/DRC will routinely review the continuity of treatment indicators by disaggregated sex and fine age bands to identify challenges and gaps for each subpopulation and put in place the corrective action to improve retention in DSD. In addition, PEPFAR will continue to work on aligning the VL appointment, and ART refills on the same day to avoid transportation issues for the beneficiaries. To promote continuity of treatment for CLHIV, PEPFAR/DRC will ensure the inclusion of all children on ART in DSD models within a family-centered approach.

9. **Integrate tuberculosis (TB) care.** Routinely screen all people living with HIV for TB disease. Standardized symptom screening alone is insufficient for TB screening among people living with HIV and should be complemented with more-sensitive and setting-specific, WHO-recommended screening tools. Ensure all people living with HIV who screen positive for TB receive molecular WHO-recommended diagnostic and drug susceptibility testing, all those diagnosed with TB disease complete appropriate TB treatment, and all those who screen negative for TB complete TB Preventive Treatment.

TB has been the leading cause of death in PLHIV globally; DRC has one of the highest TB incidences per capita and is ranked among the top 30 high TB and TB/HIV burden countries in worldwide, according to WHO. In COP23, PEPFAR DRC will continue implementing TB/HIV strategy based on three objectives designed to reduce morbidity and mortality among all

PLHIV: Intensified TB case-finding among all PLHIV, Optimized TB/HIV care and treatment, and TB Prevention.

PEPFAR/DRC data shows an important gap in TB screening for PLHIV, which remains very low. PEPFAR/DRC will support the national TB and HIV programs to update the screening algorithm according to the latest WHO recommendation where the symptoms will be combined with the molecular diagnostic test (mWRD), Chest X-Ray (CXR), computer-aided detection software, C-reactive Protein (CRP). TPT using an optimized regimen of 3HP will be scaled up for eligible PLHIV and enhanced IPC measures will continue in all three PEPFAR-supported provinces for optimal TB prevention in PLHIV populations to mitigate morbidity and mortality.

10. **Diagnose and treat people with advanced HIV disease (AHD).** People starting treatment, re-engaging in treatment after an interruption of ≥ 1 year, or virally unsuppressed for ≥1 year should be evaluated for AHD and have CD4 T cells measured. All children <5 years old who are not stable on effective ART are considered to have advanced HIV disease.

Individuals with advanced HIV disease require a more intensive level of care and experience greater morbidity and mortality than those without advanced disease. DRC now has a policy addressing advanced HIV disease according to WHO recommendations.

For adults, adolescents, and children five years or older, advanced HIV disease (AHD) is defined as having a CD4 cell count <200 cells/mm3 or with current WHO clinical stage three or four findings. All children under five who are not on effective ART are considered to have AHD because, in the absence of effective treatment, children with HIV have higher viremia and more rapid disease progression with high mortality. PEPFAR/DRC has a hub and spoke delivery approach with a specific minimum package of AHD services for diagnosis and treatment at each level.

PEPFAR/DRC has adopted a package of interventions to reduce morbidity and mortality in individuals with AHD: rapid ART initiation, cotrimoxazole prevention, TB action-screening and treatment, cryptococcal action-screening and treatment, and intensive follow-up for immune reconstitution inflammatory syndrome (IRIS) events.

11. **Optimize diagnostic networks for VL/EID, TB, and other coinfections**. In coordination with other Donors and National TB Programs, complete diagnostic network optimization (DNO) and transition to integrated diagnostics and multiplex testing to address multiple diseases. Ensure 100% EID and VL testing coverage and return of results within stipulated turn-around time.

The PEPFAR/DRC team will finalize the optimization of diagnostic networks by adding new laboratories set up in Haut-Katanga with conventional platforms and POC GeneXpert (installed in Likasi and Kolwezi). With these new laboratories inserted into the network, the mapping will be optimized by localizing clinical sites and laboratories. Specimen referral transport will be reorganized with contextualized mechanisms (car, bikers, drones, etc.) to allow easy access to the laboratories and avoid excessive workloads. The referral transport system will be an integrated system supporting specimens from other suspected co-infectious diseases.

The team will continue informed deployment of laboratory resources, inputs and capabilities in PEPFAR-supported areas. Standard Operating Procedures (SOPs) for specimen transportation and logs for specimen reception to easily identify where specimens are located will be developed during COP22. Thus, in COP23, these documents will be deployed in the field. The team will train bikers and procure items to meet the requirements for the safe transport of specimens.

The team will continue to monitor variables like the turnaround time, the specimen rejection rate, etc. to ensure smooth operation of the laboratories.

12. **Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management.** Program management must apply ongoing program and site standards assessment, including consistently evaluating site safety standards and monitoring infection prevention and control practices. PEPFAR-supported activities, including implementing partner agreements and work plans should align with national policy in support of QA/CQI.

    - The country has quality improvement systems and structure in place from national to site level.
    - With the advent of COVID, the MOH has established IPC standards and safety measures to be implemented at facilities. Compliance is measured through metrics translated into an IPC dashboard. PEPFAR/DRC is ensuring IPC are sustainably implemented.

13. **Offer treatment and viral-load literacy.** HIV programs should offer activities that help people understand the facts about HIV infection, treatment, and viral load. Undetectable=Untransmittable (U=U) messaging and other messaging that reduces stigma and encourages HIV testing, prevention, and treatment should reach the general population and health care providers.

The Ministry of Health, PEPFAR, the Global Fund, and CSOs continue with efforts to promote continuity of treatment, adherence, and compliance to quality treatment. These awareness efforts target health providers, community health workers, peer educators, PLHIV, civil society activists, parents, and caregivers. These efforts have translated into commendable outcomes regarding: six MMD, retention in treatment, and VL suppression. During COP22 and COP23, these efforts also aim to improve VL coverage.

14. **Enhance local capacity for a sustainable HIV response.** There should be progress toward program leadership by local organizations, including governments, public health institutions, and NGOs. Programs should advance direct funding of local partners and

increase funding of organizations led by members of affected communities, including KP-led and women-led organizations.

During COP22 and COP23, PEPFAR DRC will continue a phased approach to expansion of funding of KP-led and women-led organizations:

i. Conduct an Organizational Capacity Assessment (OCA) to determine needs;
ii. OCA will define capacity-building priorities for the respective CSOs;
iii. OCA findings will orient next steps for organization eligibility to receive funding, initially as a sub-grantee to an experienced implementing partner.

15. **Increase partner government leadership.** A sustainable HIV response requires coordinated efforts that enable governments to take on increasing leadership and management of all aspects of the HIV response—including political commitment, building program capacities and capabilities, and financial planning and expenditure.

PEPFAR/DRC recognizes the widely complex health sector challenges characterized by many unpredictable outbreaks. PEPFAR/DRC also acknowledges the critical role of GDRC in supporting the salaries of health personnel and counterpart contribution match funding to the Global Fund. However, PEPFAR will continue to advocate for a clear HIV budget and promotion of additional domestic resources for HIV response for the provision of low-hanging fruit like tests and condoms for prevention, the acquisition of POC machines for expansion of VL and EID testing capabilities.

16. **Monitor morbidity and mortality outcomes.** Aligned with national policies and systems, collect, and use data on infectious and non-infectious causes of morbidity and mortality among people living with HIV to improve national HIV programs and public health response.

    Though completeness, promptness, and accuracy are debatable, mortality and morbidity are recorded through a nationwide health system, the DHIS2. Death audits also exist in the MOH framework but are currently not implemented.

    PEPFAR DRC will continue to track causes of death through the TX_ML indicator and emphasize screening, diagnosing, and treating presumed and confirmed AHD cases.

17. **Adopt and institutionalize best practices for public health case surveillance.** Transfer/deduplication processes and a secure person-based record should be in place for all people served across all sites. Unique identifiers should also be in place, or a plan and firm, agreed-upon timeline for scale-up to completion should be established.
    - PEPFAR/DRC foresees a deliberate and progressive move towards digital health.

- PEPFAR will continue to work with the MOH to support the use of an EMR at different levels and to amplify the interface EMR-Viral Load and interoperability with VLSM.
- PEPFAR also will continue to support the existence of reliable and secure transfer of critical data from EMR implementation sites to a central data repository which should ultimately by connected to the MOH-led Health Information Systems (HIS).
- PEPFAR is also pioneering the recency testing platform and intends to transition the ownership to MOH for a surveillance system.

USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR/DRC continues to monitor the skills and level of effort (LOE) needed to achieve sustainable epidemic control by 2025 through the strategy defined in COP23. 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 COP23. 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	28	27	1	-
DOD	2	2	-	-
State	4	4	-	-
USAID	46	19	23	4
TOTAL	80	52	24	4

To align human resources with the strategic focus in Haut-Katanga and Lualaba, PEPFAR/DRC continues to work on the logistical and security issues related to placing a provincial co-located team in Lubumbashi. This team expects to include 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 are budgeted in COP23.

Below are the current staffing updates by agencies:

- USAID: There are 9 current vacancies in the process of recruitment in FY23: 1 Care and Treatment Specialist, 1 OVC technical specialist, 2 M&E Specialists, 1 Data Quality Specialist, 1 SI Specialist, 1 Local Development Specialist, 1 Program assistant and 1 KP Specialist. The previously vacant Supply Chain Specialist and the Laboratory Specialist

positions have been filled. The M&E Specialist, Data Quality Specialist and Key Populations specialist for the Kinshasa office are in the process of recruitment. The remaining provincial positions will be advertised through a phased approach taking into consideration the DRC security context.
A staffing plan will be developed as soon as possible.

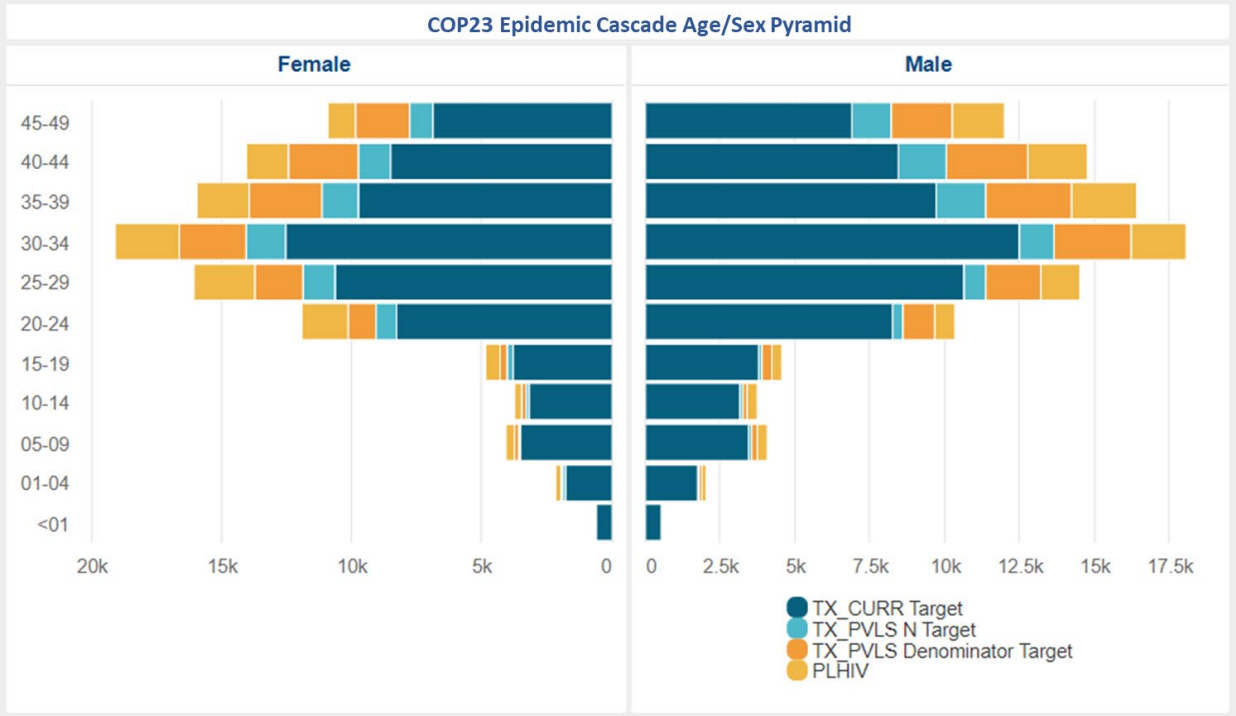
- Department of State: There is currently one vacancy, Strategic Information Advisor, which is critical for the smooth running of the office.
- DOD: Fully staffed.
- CDC: There are six current vacancies in the process of recruitment in FY23: One SI Branch Chief, one care and treatment specialist, one SI officer, and one lab advisor, one IT specialist and one finance assistant position.

Intensifying partner management remains a focus of COP23, and one aspect of partner performance is Site Improvement through Monitoring System (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. The geographic size, economic and political instability, and limited transportation and infrastructure contribute to a relatively high cost of doing business (CODB) in the DRC. The COP23 COBD request represents minimal staffing and administrative support.

APPENDIX A – Prioritization

Epidemic Cascade Age/Sex Pyramid

Figure A.1 This figure can be found in the SDS chapter of the COP23 Target Setting Tool dossier in PAW.



APPENDIX B – Budget Profile and Resource Projections REQUIRED

Table B.1.1 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Intervention

Operating Unit	Country	Intervention	Budget		
			2023	2024	2025
Total			**$112,725,000**	**$115,088,413**	**$139,684,182**
Democratic Republic of the Congo	**Total**		**$112,725,000**	**$115,088,413**	**$139,684,182**
	Democratic Republic of the Congo	ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$1,340,000		
		ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Military		$169,794	$201,192
		ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations		$6,273,269	$4,144,809
		ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$1,675,000	$5,063,857	$4,627,033
		ASP>Laws, regulations & policy environment>Non Service Delivery>Military		$71,103	$67,064
		ASP>Management of Disease Control Programs>Non Service Delivery>Military		$177,758	$268,256
		ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations		$530,000	$503,373
		ASP>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$376,474		
		ASP>Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations		$2,407,622	$3,385,909
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Military		$556,000	$0
		ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations		$10,000,000	$10,000,000
		C&T>HIV Clinical Services>Non Service Delivery>Key Populations	$409,000	$916,171	$1,170,143
		C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$3,101,591	$3,856,407	$4,863,848
		C&T>HIV Clinical Services>Service Delivery>AGYW		$164,322	$151,397
		C&T>HIV Clinical Services>Service Delivery>Children	$658,750	$1,539,704	$1,847,981
		C&T>HIV Clinical Services>Service Delivery>Key Populations	$665,000	$833,029	$1,523,017
		C&T>HIV Clinical Services>Service Delivery>Military	$1,679,972	$1,748,319	$1,559,834
		C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$12,462,060	$5,269,773	$7,621,053
		C&T>HIV Clinical Services>Service Delivery>Pregnant & Breastfeeding Women	$362,000	$904,527	$1,461,132
		C&T>HIV Drugs>Service Delivery>Children	$7,145,941	$2,502,672	$4,000,000
		C&T>HIV Drugs>Service Delivery>Non-Targeted Populations	$15,596,730	$13,270,251	$19,998,241
		C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$1,875,891	$1,788,193	$1,939,919
		C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$12,805,922	$7,539,560	$11,667,808
		C&T>HIV/TB>Service Delivery>Non-Targeted Populations		$793,385	$851,460
		C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$1,352,101		
		C&T>Not Disaggregated>Service Delivery>Military	$396,234		
		HTS>Community-based testing>Non Service Delivery>Key Populations	$462,877	$436,635	$462,618
		HTS>Community-based testing>Non Service Delivery>Non-Targeted Populations	$435,816	$915,030	$966,761
		HTS>Community-based testing>Service Delivery>AGYW		$313,191	$474,400
		HTS>Community-based testing>Service Delivery>Children	$64,995	$152,758	$146,786
		HTS>Community-based testing>Service Delivery>Key Populations	$174,144	$1,233,917	$2,087,765

HTS>Community-based testing>Service Delivery>Non-Targeted Populations	$1,277,699	$676,122	$1,427,972
HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations	$446,137	$1,801,655	$1,782,219
HTS>Facility-based testing>Service Delivery>Children	$325,000	$644,350	$940,498
HTS>Facility-based testing>Service Delivery>Military		$296,029	$266,323
HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$1,770,387	$3,015,760	$4,065,843
HTS>Facility-based testing>Service Delivery>Pregnant & Breastfeeding Women		$417,690	$577,132
HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	$3,437,057		
PM>IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$420,000	$750,000	$1,012,320
PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$11,674,803	$16,636,992	$19,497,701
PM>USG Program Management>Non Service Delivery>Military	$44,759	$44,759	$44,759
PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	$8,939,320	$9,586,913	$9,571,457
PREV>Condom & Lubricant Programming>Service Delivery>Military	$97,472	$100,182	$91,333
PREV>Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations	$936,516	$1,069,457	$1,077,999
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>AGYW		$100,694	$71,920
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations		$1,058,502	$1,787,545
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Military		$188,510	$178,424
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations		$75,389	$71,018
PREV>Not Disaggregated>Service Delivery>AGYW		$77,291	$73,408
PREV>PrEP>Non Service Delivery>Non-Targeted Populations	$60,000	$35,000	$83,242
PREV>PrEP>Service Delivery>Key Populations	$169,121	$183,420	$375,746
PREV>PrEP>Service Delivery>Non-Targeted Populations	$2,489,903	$1,427,615	$1,562,604
PREV>Violence Prevention and Response>Service Delivery>OVC		$171,830	$334,209
SE>Case Management>Non Service Delivery>OVC	$1,981,591	$2,144,597	$2,426,552
SE>Case Management>Service Delivery>OVC	$1,003,995	$2,152,413	$2,699,417
SE>Economic strengthening>Non Service Delivery>OVC	$102,044	$208,318	$334,966
SE>Economic strengthening>Service Delivery>OVC	$660,647	$1,167,496	$1,399,382
SE>Education assistance>Non Service Delivery>OVC	$128,657	$261,395	$312,430
SE>Education assistance>Service Delivery>OVC	$361,406	$1,002,787	$1,130,352
SE>Psychosocial support>Service Delivery>OVC		$366,000	$495,612
	$13,357,988		

Table B.1.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

Table B.1.2: COP22, COP23/FY 24, COP 23/FY25 Budget by Program Area

Operating Unit	Country	Program	Budget		
			2023	2024	2025
Total			$112,725,000	$115,088,413	$139,684,182
Democratic Republic of the Congo	Total		$112,725,000	$115,088,413	$139,684,182
	Democratic Republic of the Congo	C&T	$62,074,210	$41,126,313	$58,655,833
		HTS	$12,797,200	$9,903,137	$13,198,317
		PREV	$5,345,744	$4,487,890	$5,707,448
		SE	$7,313,340	$7,303,006	$8,798,711
		ASP	$4,115,624	$25,249,403	$23,197,636
		PM	$21,078,882	$27,018,664	$30,126,237

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Table B.1.3: COP22, COP23/FY 24, COP 23/FY25 Budget by Beneficiary

Operating Unit	Country	Targeted Beneficiary	Budget		
			2023	2024	2025
Total			$112,725,000	$115,088,413	$139,684,182
Democratic Republic of the Congo	Total		$112,725,000	$115,088,413	$139,684,182
	Democratic Republic of the Congo	AGYW	$87,135	$655,498	$771,125
		Children	$9,543,653	$4,839,484	$6,935,265
		Key Populations	$4,759,554	$4,661,674	$7,406,834
		Military	$2,656,752	$3,352,454	$2,677,185
		Non-Targeted Populations	$87,118,771	$92,782,250	$110,722,589
		OVC	$7,492,503	$7,474,836	$9,132,920
		Pregnant & Breastfeeding Women	$1,066,632	$1,322,217	$2,038,264

Table B.1.4 COP 22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

Table B.1.4: COP22, COP23/FY 24, COP 23/FY25 Budget by Initiative

Operating Unit	Country	Initiative Name	Budget		
			2023	2024	2025
Total			$112,725,000	$115,088,413	$139,684,182
Democratic Republic of the Congo	Total		$112,725,000	$115,088,413	$139,684,182
	Democratic Republic of the Congo	Community-Led Monitoring	$500,000	$500,000	$500,000
		Condoms (GHP-USAID Central Funding)	$525,000	$525,000	$525,000
		core Program	$103,286,660	$96,104,407	$120,672,473
		General Population Survey		$10,000,000	$10,000,000
		One-time Conditional Funding	$1,000,000		
		Other Surveys		$556,000	$0
		OVC (Non-DREAMS)	$7,413,340	$7,403,006	$7,986,709

B.2 Resource Projections

Per COP23 guidance, the DRC team used a program-based, incremental budgeting approach (Funding Allocation to Strategy Tool - FAST) to develop the COP23 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) The OU envelop as described in the PLL with Population-based survey and a To-be-Determined (TBD) envelop of $5,000,000
2) 2022 PEPFAR Expenditure Reporting (ER) data, partner financial data and estimates, pipeline, and outlay review.
3) 2022 partner performance for C&T mechanisms and COP22 targets.
4) 2024 closing out mechanisms and projected to-be-determined (TBD) 2024 incoming mechanisms.
5) The adjusted methodology of target setting referring to commodities data lowered the estimated cohort trajectory for FY23 and FY24. This impacted the reach of Care and Treatment earmark as we the commodities needs in ARV were reduced to commensurate the new TX_Curr targets
6) Savings from Commodities have been mainly reallocated for above-sites programs to respond to 5X3 strategy pillar 3: “health system strengthening which meets GDRC health priorities
7) The SGAC state TBD reserve also has been totally devoted for health system strengthening including a Full Data Quality Assurance (DQA) activity aiming at validating the clinic cascade in PEPFAR areas under PNLS leadership
8) Factoring-in increased testing and treatment targets, most clinical Implementing Partners have been reduced. However, within clinical IP budgets, priority populations have a relative increased budget to reflect the deliberate shift for closing the gap and ensuring health equity for these subpopulations: Children, Key Populations, AGYW and PBFW. In top of core programs LIFT-UP funds have been an opportunity to laser-focus on these subpopulations with additional $1.8 million
9) Policy Changes: Budget shifts have been made to reflect investment to address programmatic shifts and policy approvals (support revamped implementation of self-testing, and PrEP scale-up ambition); and
10) Year-2 budget has been proposed and expected refinements will happen has we continue monitoring Year 1 budgeting and implementation

APPENDIX C – Above site and Systems Investments from PASIT and SRE

Through COP23 stakeholder consultations and co-planning sessions, PEPFAR DRC was delighted to notice the convergence of views among stakeholders and GDRC health priorities and vision. Health system strengthening was found a significant gap, yet a game changer for the country Universal Health Coverage (UHC) vision. As a broad, the entire health system needs to be revamped: strategic information, laboratory networks, human resources for health, health financing, supply chain management and leadership and governance. In general, the needs are huge and require stepwise, yet steady investments, beyond one-year timeframe to allow initial investments, consolidation, and transition for Government ownership. PEPFAR DRC is committed to contribute to tackle these challenges and has thus budgeted almost 25% of COP23 for above-sites activities.

PASIT investments in COP23 were intently chosen to advance the sustainability of national HIV response. The most critical ones cover improvements in the areas of lab optimization, programmatic data quality, and supply chain management. In addition, we expect the USG investments to effectively operationalize the newly created NPHI to play a catalytic role in advancing the integration of HIV services into the common health service packages offered at all health facilities as well as in deepening the multi-disease approach we are adopting, especially in the lab system strengthening area, to improve the resiliency of the overall health system to manage current and unforeseen health challenges. Data and Health Information Management system was another convergent urgent need for effectiveness of DRC program. To compliment the upcoming DHS, PEPFAR DRC will implement a Population-based impact survey for general population (PHIA) and for military (SABERS). As part of transition and country ownership, skills and competence transfer to local organizations and staff is critical for implementing next iterations of these studies. In addition, under PNLS leadership, PEPFAR DRC is looking at a clinical cascade reset through a Data Quality Assurance (DQA) exercise to be sustained by a continuous Quality Improvement program. Furthermore, endeavors for improved real-time data visibility will be enhanced through the move towards digital health system including EMR, commodity trackers/electronic dashboards and interoperability DHIS2/DATIM. PEPFAR intends to bring its contribution for leveraging current GDRC investments for building infrastructure and legal framework development for digital health systems. The ongoing Cyclical Acquired Drug Resistance Evaluation (CADRE) will provide additional information on potential acquired drug resistance (ADR) among children and adult receiving Dolutegravir based regimen and not virally suppressed. To fuel the objective of closing the gap in equity, PEPFAR will contribute to fund the stigma index survey in partnership with UNAIDS and PNLS.

Meaningful resources are put on provision of commodities. As one of the major players for supply chain, PEPFAR DRC provides support for forecasting, importation, storage, distribution, and disposal of key HIV items. Our Supply Chain model ambitions to remain reactive and resilient to respond the needs for prevention, testing and treatment of all populations, especially those previously left behind. Supply chain program will invest to capture real time data, including those reported by CLM organizations. The recent small-scale DQA demonstrated and underscored the importance of commodity data at site, health zone and warehouse level. In COP23, overall Technical Assistance to the supply chain continuum will also include sound

stocks and supplies data management through improved forecasting, timely delivery to the last mile and real-time commodity consumption data visibility.

The investments set out the PASIT for COP23 are to complement the work of the government, which leads on almost all the elements identified for investments. Additionally, opportunities have emerged for co-investments with Global Fund through GC7 grant. Synergetic investments between Global Fund and PEPFAR are expected in the areas of lab optimization, programmatic data quality improvements, and supply chain improvements. The GC7 grant has a dedicated component on Heath Systems Strengthening, which includes specific investments targeting these three critical priorities. It is worth noting the Global Fund procures most of the GeneXpert machines in country as well as significant quantities of HIV testing and treatment commodities and lab reagents.

Proposed investments in the PASIT have benchmarks and outcomes SMARTly set and will be convenient to track.