

Democratic Republic of the Congo
Country Operational Plan
(COP) 2022
Strategic Direction Summary
April 22, 2022



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1.0 Vision and Goal Statement

In support of the National AIDS Control Program (PNLS), PEPFAR/Democratic Republic of the Congo (DRC) continues to implement a robust portfolio of programs with the goal of achieving epidemic control in three key provinces, which represent approximately 50 percent of the total number of people living with HIV (PLHIV) in the DRC. The strategy for the PEPFAR Country Operational Plan (COP) for the period from October 1, 2022 through September 30, 2023 (COP 2022) will continue the programmatic priorities implemented in COP 2021, including strategically expanding and strengthening people-centered activities to attain epidemic control in Haut-Katanga and Lualaba, and select health zones in Kinshasa.

PEPFAR/DRC has continued to make steady progress and has shown strong results in Haut-Katanga and Lualaba. Given this success, epidemic control now appears within reach, and additional resources and effort will be focused on these two provinces during COP22. 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 a total of 57 health zones and select military sites, reaching patients in over 600 clinical sites.

Current figures put the total number of PLHIV in PEPFAR-supported health zones at 374,371. Through consultations with the government of DRC and civil society, achievable targets have been set for COP22, which will produce an additional 78,872 people on antiretroviral treatment (ART) by September 2023.

PEPFAR/DRC's focus on sustainable epidemic control began in 2014, when the program pivoted to a data-driven approach, strategically focusing on geographic areas and populations where HIV is most prevalent. With those pivots long completed, COP22 focuses on progress in implementation and ensuring resources are focused on overcoming key barriers and achieving even greater impact with equity across all sex bands, gender and subpopulations.

Triangulation of both survey data, when available, and program data will be essential to understanding programming and ensuring accurate reporting. Building on program experience over the past four years, the PEPFAR/DRC COP22 strategy emphasizes:

- Finding the people and populations we have been missing, 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 being missed or which are lagging other

COP22 Strategies for Epidemic Control

- Strengthen efforts on case finding among adult men, adolescent girls, and young women
- 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

populations in the clinical cascade, to identify evidence-based short- and long-term solutions appropriate to reaching those populations, to implement those solutions according to standards (i.e., with fidelity), and then scale them up.

- Reducing stigma and discrimination against key populations to increase access to essential prevention and treatment services. PEPFAR/DRC will continue strong collaboration with civil society to enhance the supportive environment for HIV services and reduce stigma and discrimination. 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, pregnant and breastfeeding women with a focus on preventing sexual violence and HIV through sexual risk avoidance practices among 9- to 14-year-olds (i.e., preventing sexual violence and any form of coercion). The 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; and
 - Engaging in meaningful dialogue with implementing partners throughout the year for continuous, real-time improvements.
- Ensuring ‘above service delivery’ activities are mapped to key barriers and are achieving measurable outcomes related to reaching epidemic control. Reviewing and using documented outcomes from implementation of COP 21 Table 6, Sustainability Index and Dashboard (SID) results, and other contextual information will guide programming choices.

Ensuring outcomes at the national level by systematically incorporating feedback from a variety of PEPFAR/DRC stakeholders (i.e., civil society, community organizations, multilateral organizations, and host-country government at all levels) into PEPFAR-funded activities and services. Early and meaningful engagement with stakeholders helps to ensure that programs are grounded in reality; stakeholders provide valuable insights that improve the impact and accountability of programs.

In order to optimize the identification of PLHIV and link them to treatment, care, and support programs, PEPFAR/DRC will continue to support and implement with fidelity strategies that:

- A. Optimize provider-initiated testing and counseling (PITC) in outpatient departments, tuberculosis (TB) clinics, inpatient wards (including pediatrics), and antenatal care (ANC) and nutrition services within facilities, including addressing user fees, especially in the TB and ANC departments;
- B. 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 in order 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 reach of first-time testers, people with undiagnosed HIV, and those at ongoing risk—especially KPs, including men who have sex with men (MSM)—who are in need of frequent retesting, adolescent girls and young at risk women;
 - G. Ensure youth, male, and KP-friendly and hospitable services at facilities attract and retain clients, ensuring that all these services contribute to finding HIV positive men;
 - H. Ensure scale-up of same-day, treatment initiation in all PEPFAR-supported sites;
 - I. Maintain the high coverage of HIV screening and antiretroviral therapy (ART) initiation among TB patients and strengthen TB screening for PLHIV;
 - J. Maximize multi-month dispensing (MMD) so that 30 percent of patients including children receive three-month ARV supplies, and 70 percent receive six-month ARV supplies;
 - K. Optimize pediatric ART by implementing the new first-line regimen;
 - L. Maintain continuous quality improvement and best practices at both facility; and community levels to address and improve services to ensure patients' needs are met.

Throughout FY22 and FY23, PEPFAR/DRC will continue to refine and intensify previously implemented partner management strategies. DRC-specific partner management tools enable PEPFAR/DRC to create site-level management plans that address any deficiencies associated with 95-95-95 and hold site-level supervisors accountable. Best practices from high performing sites will be disseminated to improve low performing sites. At every site, partners will continuously assist providers with clinical cascade analysis and use of data to maintain and/or improve programs. Monthly partner performance consultations will continue to be conducted and individual partner improvement plans will include strategies for increasing yield, coverage, and efficiency. Findings and improvement plans will be highlighted at quarterly PEPFAR/DRC partner meetings.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

The HIV epidemic in the DRC is generalized, with a prevalence of 1.20 percent based on the 2013/2014 DHS, with 624,856 people living with HIV out of an estimated population of 117 million

(calculated based on UNAIDS estimates [version 6.16]). Prevalence is higher in urban areas (1.6 percent) versus rural areas (0.9 percent) and the burden of HIV is higher among women than men 25 years and older (348,731 female PLHIV v. 209,190 male PLHIV). According to UNAIDS, a majority of HIV transmission in DRC is through heterosexual contact, exacerbated by high-risk sexual practices (such as having multiple concurrent partners) and low or inconsistent condom use. Although there is insufficient data on the location, typology, and dynamics of key populations and high-risk groups, prevalence among female sex workers (FSWs) is estimated at 5.4 percent in Kinshasa, 7.4 percent in Lualaba and 4.6 percent in Katanga (IBBS 2018-2019). TB incidence in the DRC is 324 per 100,000 and nationwide only 50 percent of TB patients know their HIV status, making TB the primary cause of death among HIV-positive patients. Of the 12 percent of TB patients co-infected with HIV, approximately 67 percent are on ART (World Health Organization (WHO), Global Tuberculosis Report, 2020).

Population size, widespread poverty, and decades of conflict have resulted in the DRC's lack of a cohesive and functional health system. The updated Sustainability Index and Dashboard (SID) identified systemic weaknesses that include a fractured and unresponsive supply chain, weak laboratory and sample transport systems, slow and incomplete information management systems, and a lack of institutionalized quality assurance systems across all areas of the program. Generally, access to healthcare services is complicated by poor infrastructure, including weak human and institutional capacity, inadequate roads and the lack of electricity and water at many health facilities - all factors which pose challenges to the goal of achieving epidemic control.

Reporting of routine HIV program data has improved significantly in recent years in PEPFAR-supported health zones, aided by specific PEPFAR investments in strategic information (SI) technical assistance, including the scale-up of the electronic, HIV-specific, patient-level reporting system known as Tier.net. The country also continues the process of rolling out DHIS2 as the national health management information systems (HMIS), but implementation is not yet complete and has been challenged by poor internet connectivity, slow deployment, and limited support at the health zone level.

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+				
	N	%	Female		Male		Female		Male		Female		Male		
			N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	117,010,752	100	26,239,339	22%	26,709,631	23%	11,343,848	10%	11,430,031	10%	20,867,273	18%	20,420,632	17%	DHIS2 Spectrum 2022 Version 6.16
HIV Prevalence (%)		1.2%		N/A		N/A		1.0%		0.8%		2.2%		1.5%	DHS 2013 Report
AIDS Deaths (per year)	14,715		1,938		1,983		706		729		4,851		4,508		Spectrum 2022 Version 6.16
# PLHIV	624,856		33,108		33,826		40,263		26,179		308,468		183,012		Spectrum 2022 Version 6.16
Incidence Rate (Yr)		0.2%		0.1%		0.1%		0.1%		0.4%		0.2%		0.1%	Spectrum 2022 Version 6.16
New Infections (Yr)	19,690										2				Spectrum 2022 Version 6.16
Annual births	4,524,120	4%													Spectrum 2022 Version 6.16
% of Pregnant Women with at least one ANC visit	4,524,120	4%	N/A	N/A			N/A	N/A			N/A	N/A			2017 PNSR Annual report
Pregnant women needing ARVs	22,876	1%													Spectrum 2022 Version 6.16
Orphans (maternal, paternal, double)	155901		N/A		N/A		N/A		N/A		N/A		N/A		Spectrum 2022 Version 6.16
Notified TB cases (Yr)			N/A		N/A		N/A		N/A		N/A		N/A		
% of TB cases that are HIV infected	62,486	10%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	2018 Global TB report
% of Males Circumcised	56,803,487	97%			N/A	N/A			N/A	N/A			N/A	N/A	DHS 2007 Report
Estimated Population Size of MSM*	N/A	N/A													
MSM HIV Prevalence	N/A	N/A													
Estimated Population Size of FSW	N/A	N/A													
FSW HIV Prevalence	N/A	6.90%					N/A	N/A			N/A	N/A			IBBS 2013
Estimated Population Size of PWID	N/A	N/A													
PWID HIV Prevalence	N/A	N/A													
Estimated Size of Priority Populations (specify)															
Truck drivers	N/A	1.20%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013

Miners	N/A	1.80%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013
Youth (street children)	N/A	1.30%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	IBBS 2013
*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.															

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total pop.	117,010,752	0.53%	624,856	NA	520,162	87.6%	NA	NA	NA	NA
Pop. <15 years	52,948,970	0.13%	66,934	NA	27,265	42.8%	NA	NA	NA	NA
Men 15-24 years	26,709,631	0.10%	26,179	NA	20,756	83.5%	NA	NA	NA	NA
Men 25+ years	11,430,031	0.60%	183,011	NA	162,584	93.5%	NA	NA	NA	NA
Women 15-24 years	11,343,848	0.35%	40,263	NA	30,367	79.4%	NA	NA	NA	NA
Women 25+ years	20,867,273	1.48%	308,468	NA	279,189	95.2%	NA	NA	NA	NA
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	NA	7.7%	NA	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Truck drivers	NA	1.20%	NA	NA	NA	NA	NA	NA	NA	NA
Miners	NA	1.80%	NA	NA	NA	NA	NA	NA	NA	NA
Military	NA	3.5%	NA	NA	NA	NA	NA	NA	NA	NA

* Spectrum 2022 Version 6.16

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

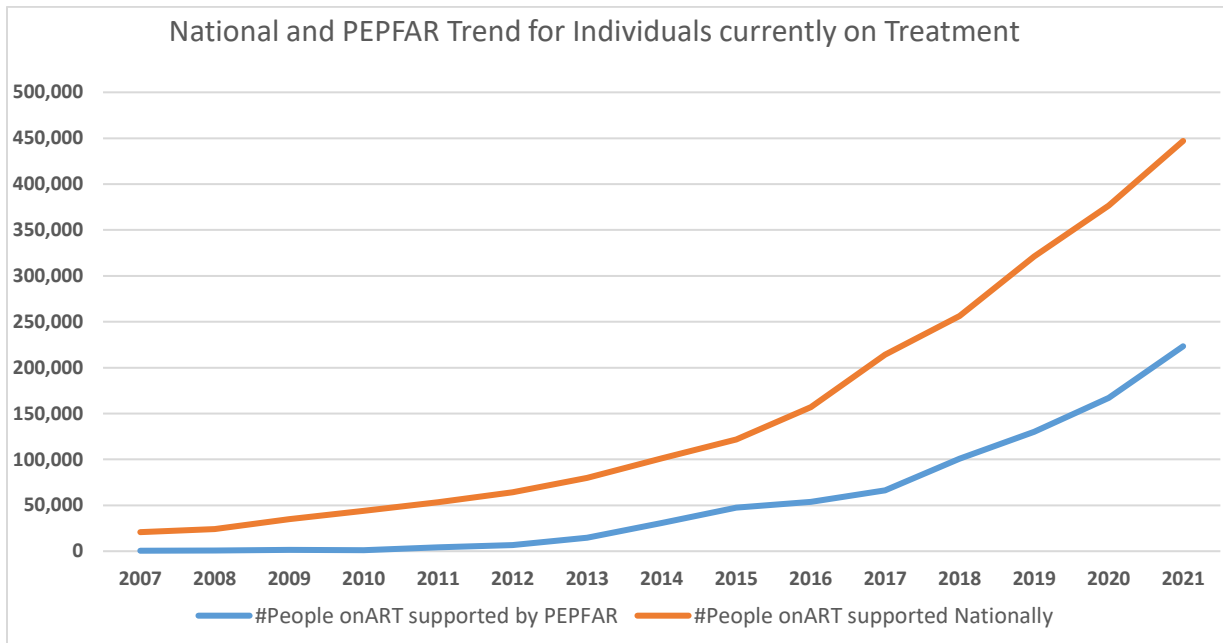


Figure 2.1.4 Trend of New Infections and All-Cause Mortality among PLHIV

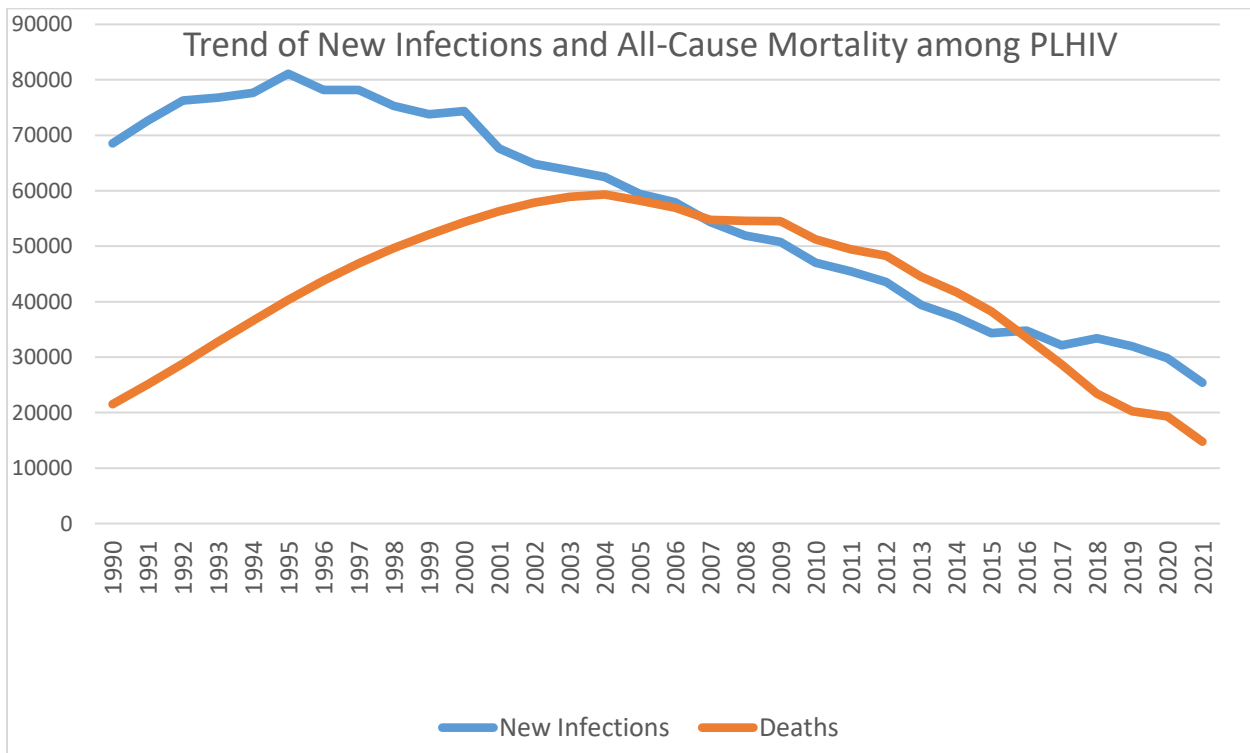


Figure 2.1.5 Progress retaining individuals in lifelong ART in FY21

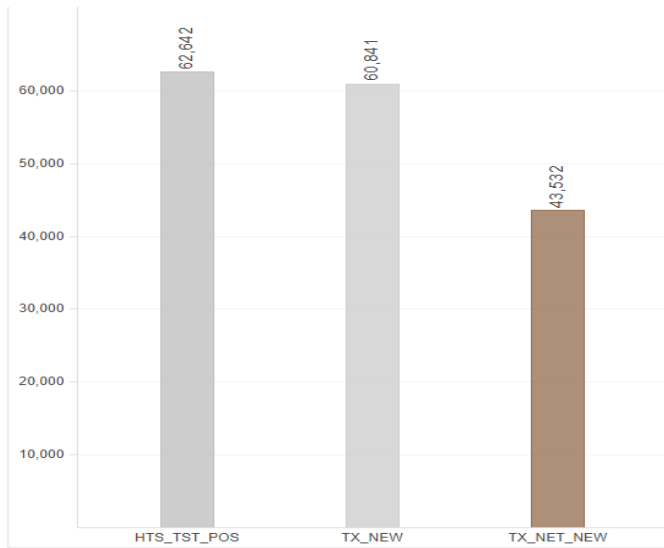


Figure 2.1.6 Proportion of clients lost from ART 2020 Q4 to 2021 Q4

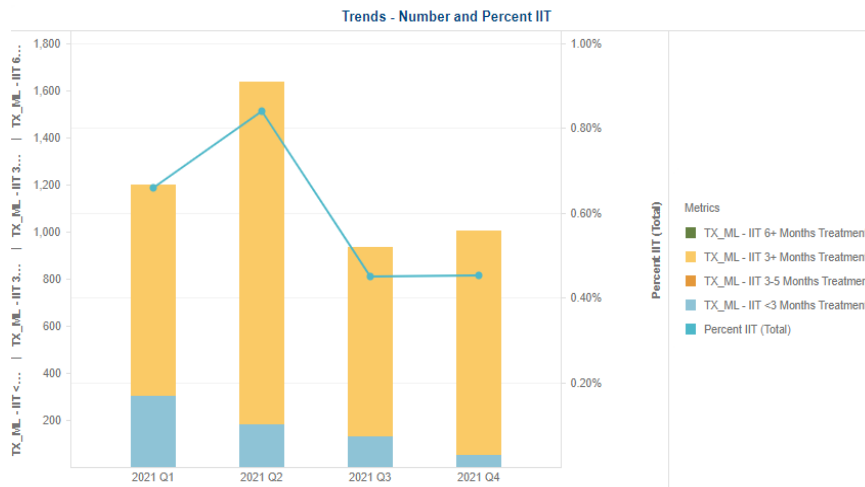
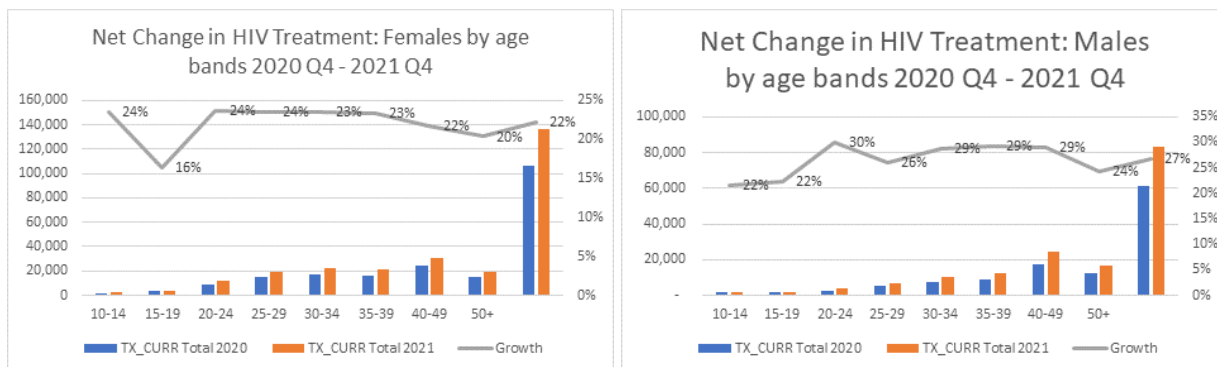


Figure 2.1.7 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.7 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

The PEPFAR/DRC program will implement strategies to support continuous and uninterrupted person-centered ART. Strategies will be put in place in each site providing HIV testing, care, treatment, and prevention services ensuring that all clients that start ARVs and have a continuous access to optimized regimens. PEPFAR/DRC will work with local health system and community stakeholders, to design and implement services that remove barriers to continuous care, especially those that drive out stigma and discrimination, increase equity, and maximize provider responsiveness, to put clients at the center of care. Services that are person-centered recognize the agency of clients—their right to make their own choices. Providers strive to enter a partnership with the person living with HIV that honors their needs, preferences, and motivations along with their family and/or significant others.

PEPFAR/DRC has the following eight priorities for accelerating toward sustained epidemic control in COP22:

1. **Intensify case finding, particularly among children and adolescent girls and young women (AGYW):**
 - a. A large HIV treatment gap persists for children under age 15 in DRC. Treatment programs for children consistently fail to meet their 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. The pediatric cascade has improved in some areas but still needs strengthening – HTS_TST (79 percent), HTS_TST_POS (89 percent), low TX_CURR (65 percent). Strategies to close the gap across the pediatric cascade will focus on expanding with fidelity existing strategies and on new and enhanced strategies to improve case identification.
 - Expand index testing to identify children among all adults living with HIV, particularly among newly identified adults and pregnant women. Focus will be given to 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.

- The program will also increase two-month early infant diagnosis (EID) testing and 18-month prevention of mother-to-child transmission final outcome (PMTCT_FO) by incorporating the testing schedule into already existing immunization appointments, integrating dried blood spot (DBS) sample collection at immunization 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, in the community.
 - Conduct healthcare worker training on use of screening tools and self-testing for children and adolescents. Efforts will be made to systematically implement standardized screening and testing tools in outpatient departments including malnutrition clinics, under five visits and OVC programming. Targeted inpatient pediatric testing based on HIV risk will also be conducted including HIV testing among all presumptive and diagnosed TB patients.
 - Finally, 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 in key community sites, use of 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, self-testing for adolescents and ensuring policies are in place to support ST for adolescents, particularly for high-risk AGYW.
- b. **For AGYW:** Expand case finding strategies to identify women living with HIV (WLHIV) through other modalities, before they become pregnant to ensure that the mother is healthy before conception and to mitigate vertical transmission. Two-thirds of WLHIV are newly identified at ANC1. Partners should proactively use a risk screening tool (for Post ANC1) to ensure that high risk women and pregnant and breastfeeding women (PBFW) are identified/linked to treatment if positive or are linked to pre-exposure prophylaxis (PrEP), if negative. Preventing and identifying incident infections are important to prevent MTCT. To fill that gap, we will implement and scale-up existing strategies, enhanced case management and continuity of treatment services, including referral to OVC, for pregnant women newly identified with HIV who may be at risk for interruptions in treatment.

2. **Strengthening linkage to treatment:** Emphasis will be given to improving HIV counseling training for providers. The use of peer educators for active linkage to care and treatment for all positives identified, with promotion of early initiation on ART will also be critical in implementation. Moreover, implementers will conduct weekly monitoring of those not linked to treatment and uncover the many factors that may lead to low linkage rates and develop appropriate interventions to address them.
3. **Prevent interruption of treatment and improving the continuity of treatment:** Activities will continue to be implemented in COP22 to further improve the continuity of treatment and prioritize client-centered approaches supported by our implementing partners at the facility and community levels. At both the facility and community levels, activities will continue to use Tier.net for early identification of missed appointments. Each trained peer educator/peer navigator/mentor mother/case manager is assigned a number of missed appointments for continuous tracking and client re-engagement in care and treatment. Differentiated service delivery (DSD) models using multi-month dispensing (MMD) and PODI+ will be fast tracked to accommodate patient needs. In addition, partner management by the USG team will be conducted through quarterly data analysis to identify the gaps in continuity of treatment performance and discussions with partners on remediation plans generated by a root cause analysis from gap statements and monitoring of performance through monthly reports. Finally, granular site management (GSM) in high volume sites and course correction during visits will continue.
4. **Address viral load (VL) testing coverage (VLC) and suppression gaps:** VLC will be scaled to 100 percent in COP22 and quality laboratory services strengthened for conventional and POC testing sites. To address challenges related to low demand for VL testing as shown by low number of specimens collected from patients eligible for a VL test, the program will continue to provide health care worker (HCW) sensitization training to systematically request VL tests for eligible patients. The team will focus on educating, empowering, and supporting patient adherence and demand for VL testing from their providers. The program will continue to advocate and raise VL awareness among PLHIV and involve CSOs to emphasize the importance of one's adherence to HIV treatment including the messaging of U=U (Undetectable equals Untransmittable). The program will promote use of DBS to improve coverage in remote sites and among the military and monitor and evaluate demand creation at site level and identification of best practices during GSM visits for rapid scale up at additional sites. Specimen referral networks will be monitored to improve where needed to ensure specimen transportation and VL results are within recommended turnaround time. To address challenges related to low VL coverage in children (less than 78 percent for those under 15 years old) the program will promote family friendly approaches such as joint appointments for the entire family as well as combining drug pick-up and VL specimen collection. The program will train phlebotomists to facilitate easy collection of pediatric specimens and ensure

availability of proper pediatric collection materials. As with adults, emphasis will be given to promote the use of DBS for children and identification of best practices during GSM visits for rapid scale up and accountability of partners for performance. In addition, activities will promote and leverage the OVC platforms to improve VL coverage. To address challenges related to low coverage in PBFW, infants and children, POC VL instruments will be strategically placed targeting high volume ANC clinics and emphasis will be placed on the correct and complete filling of the viral load request forms to ensure PBFW' status is well captured. An optimized family-centered testing strategy and improved effective use of existing and POC VL instruments (GeneXpert) will be emphasized. Furthermore, at the analytical phase, strong emphasis to laboratory technicians to test all specimen types received at the laboratory and not prioritized testing of plasma samples (for perceived ease) for a patient-centered approach and to maintain quality care for all patients.

5. **Strengthen the integration of HIV and TB services and TB preventative treatment (TPT):** Improve TB screening coverage and maintain high TPT completion - Ensure the quality of TB screening so patients with TB are not missed, particularly among those already on ART (1.6 percent screened positive in FY21Q4 which was below the expected positivity rate). TPT will be fully integrated into the HIV clinical care package at no cost to the patient. All ART patients should be screened for TB at each visit using the WHO checklist. All ART clients screened positive for TB should be eligible for TB diagnostic using GeneXpert machines. Those found TB positive should be treated for TB. The objective of the TPT program in DRC is to achieve full coverage among eligible PLHIV by the end of COP21. In COP22, the PEPFAR program will continue supporting the procurement and distribution of TPT medicines. Implementation of the shorter TPT regimen, 3HP (three months rifapentine and isoniazid) will be scaled up. The rollout of 3HP is expected to address some of the mistrust that health care workers had about 6H (six months of daily isoniazid) and increase treatment options available to patients. 3HP reduces high pill burden and improves adherence, as a once weekly regimen taken only for 3 months. The 3HP regimen is already part of national TPT guidance. In COP22, implementing partners will continue to support the Ministry of Health (MOH) in training and mentoring of health care workers on implementation of 3HP. Development of standard operating procedures, job aids, and patient communication materials will address the existing communication gaps and create demand for TPT.
6. **Maximize the OVC contribution to the clinical cascade:** The program will assign newly enrolled HIV positive patients to OVC case managers to assist with disclosure counseling, partner notification services, and index testing. Activities will include disclosure support for caregivers and children as well as linkage to peer support programs, OVC programs, and teen clubs, to prevent and address barriers to adherence among children living with HIV (CLHIV,) adolescents living with HIV (ALHIV,) and their caregivers. Clinical partners will build the capacity of OVC case managers to conduct HIV

testing and provide linkage, adherence, and continuity of treatment support to all community members living with HIV and promote and leverage the OVC platform shown to improve VL coverage and VL suppression. Alignment of the OVC package of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on: 1) actively facilitating testing for all children at risk of HIV infection; 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV; and 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regards to primary prevention of sexual violence and HIV.

7. **Maintain the successful key populations program (including PrEP):** The program will continue screening female sex workers (FSW), men who have sex with men (MSM), and transgender (TG) individuals using risk classification. Implementing partners will conduct outreach using peer educators, and social and sexual network strategies and provide self-testing services. Critical to the program will be direct and immediate screening and offering of prevention services including PrEP to HIV-negative clients with elevated risk. In COP22, emphasis will be put on improving linkage of HIV negative KPs on PrEP and increase VLC of KPs. Moreover, there will be activities that utilize 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 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 end inequalities and end HIV which will be integrated in the national HIV strategic plan 2022-2025.

8. **Engage with civil society to enhance quality improvement initiatives:** Collaboration with community groups, civil society organizations, and patients/beneficiaries can help programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers with service uptake at the site and facility level to improve service and client outcomes at the site. Civil society will be involved in monitoring patient experiences at site level through the Community-led Monitoring (CLM) program which will continue to be implemented in Kinshasa, Haut Katanga and Lualaba provinces. The CLM program will report on MMD availability (adults and pediatric) including average waiting time, friendliness and non-coercive services for patients, HIV patients' awareness of VL services to monitor effectiveness of treatment, availability of PrEP, and functioning of electronic medical records (EMR) among other qualitative aspects of the program.

2.3 Investment Profile

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 (\$490, World Bank, 2018), 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).

DRC's economy has continued to expand in recent years, with growth rates of 2.4 percent in 2016, 3.7 percent in 2017, and 4.1 percent in 2018 (World Bank, 2019). After the COVID-19 pandemic-induced slowdown in 2020, the economy is expected to rebound moderately in 2021 and 2022 due to a robust growth in mining. 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 on 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.

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 all over the country. The host government contribution comes mostly through the provision of health infrastructure and health staffing. The US Government's support to DRC through PEPFAR has increased significantly from \$45 million (COP13) to \$111 million in COP22.

Led by the Programme Nationale de Lutte Contre le SIDA (PNLS), PEPFAR and the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) completed a rationalization process in FY2016 to strategically align resources and to maximize joint investments. Pre-rationalization, the Global Fund procured most HIV-related commodities for the DRC, while PEPFAR/DRC made targeted investments in commodities focused on PMTCT. As PEPFAR/DRC pivoted from a focus on PMTCT to the whole continuum of care and treatment services, so have its commodity investments. Starting in FY17, each donor has been responsible for the provision of ARVs and other commodities to patients in health zones assigned to them. PEPFAR/DRC investments in HIV-related commodities will continue to increase annually in alignment with the increasing numbers of PLHIV on treatment in PEPFAR-supported health zones.

USAID has been appointed as lead of the health donors supply chain group and as such, co-lead of the National Medicines Commission with the National Pharmaceutical Regulatory Authority. Closer donor collaboration along with improved GDRC leadership, oversight and accountability for health commodity forecasting and procurement system management is expected to reduce

stock-outs and result in sufficient availability of commodities. Another focus will be to ensure that the community systems strengthening necessary for an effective continuum of care in line with the country's 95-95-95 goals is realized.

To achieve a sustainable response, PEPFAR continues to work with other national-level donors to advocate for ownership and progressive increases in domestic resources for health and HIV. This is challenging due to competing priorities for GDRC resources, volatility in mineral prices, and fluctuations in economic growth that has resulted in a slowdown of government revenues.

President Felix Tshisekedi and the Minister of Health have named the health care system one of the highest priorities of the Administration and efforts are being led via the special advisory committee under the Presidency and in alignment with the Ministry of Health, to improve governance, human resources, and quality service delivery with the ultimate goal of universal health coverage. Commitment to improve services was demonstrated by the PNL's leadership in the rollout of TLD in the PEPFAR supported sites to over 95 percent in six months.

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

Table 2.3.1. Annual Investment Profile by Program Area

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Care and Treatment	\$92,983,406	0%	33%	67%	0%
<i>HIV Care and Clinical Services</i>	\$69,308,746	0%	41%	59%	0%
<i>Laboratory Services incl. Treatment Monitoring</i>	\$9,905,852	0%	17%	83%	0%
<i>Care and Treatment (Not Disaggregated)</i>	\$13,768,808	0%	7%	93%	0%
HIV Testing Services	\$11,249,898	0%	25%	75%	0%
<i>Facility-Based Testing</i>	\$4,888,894	0%	54%	46%	0%
<i>Community-Based Testing</i>	\$3,449,534	0%	3%	97%	0%
<i>HIV Testing Services (Not Disaggregated)</i>	\$2,911,470	0%	0%	100%	0%
Prevention	\$9,326,017	0%	53%	47%	0%
<i>Community mobilization, behavior and norms change</i>	\$2,926,857	0%	60%	40%	0%
<i>Voluntary Medical Male Circumcision</i>	\$0				
<i>Pre-Exposure Prophylaxis</i>	\$2,522,421	0%	3%	97%	0%
<i>Condom and Lubricant Programming</i>	\$1,898,104	0%	67%	33%	0%
<i>Opioid Substitution Therapy</i>	\$0				
<i>Primary Prevention of HIV & Sexual Violence</i>	\$1,088,349	0%	88%	12%	0%
<i>Prevention (Not Disaggregated)</i>	\$890,286	0%	100%	0%	0%
Socio-economic (incl. OVC)	\$9,222,129	0%	21%	79%	0%
<i>Case Management</i>	\$2,646,692	0%	0%	100%	0%
<i>Economic Strengthening</i>	\$747,062	0%	0%	100%	0%
<i>Education Assistance</i>	\$271,946	0%	0%	100%	0%
<i>Psychosocial Support</i>	\$391,680	0%	100%	0%	0%
<i>Legal, Human Rights, and Protection</i>	\$1,540,640	0%	100%	0%	0%
<i>Socio-economic (Not Disaggregated)</i>	\$3,624,109	0%	0%	100%	0%
Above Site Programs	\$11,203,701	0%	52%	48%	0%
<i>HRH Systems</i>	\$417,210	0%	0%	100%	0%
<i>Institutional Prevention</i>	\$0				
<i>Procurement and Supply Chain Management</i>	\$804,255	0%	100%	0%	0%
<i>Health Mgmt Info Systems, Surveillance, and Research</i>	\$7,157,277	0%	71%	29%	0%
<i>Laboratory Systems Strengthening</i>	\$2,056,500	0%	0%	100%	0%
<i>Public Financial Management Strengthening</i>	\$0				
<i>Policy, Planning, Coordination and Management of Disease Ctrl Programs</i>	\$350,000	0%	0%	100%	0%
<i>Laws, Regulations and Policy Environment</i>	\$0				
<i>Above Site Programs (Not Disaggregated)</i>	\$418,459	0%	0%	100%	0%
Program Management	\$28,792,156	0%	58%	42%	0%
<i>Implementation Level</i>	\$28,792,156	0%	58%	42%	0%
Total (incl. Commodities)	\$186,123,847	13%	34%	54%	0%
Commodities Only	\$70,516,350	0%	49%	51%	0%
% of Total Budget	38%				

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Overall spending has continued to trend upwards. Care, treatment and support remains the top spending program area for both PEPFAR and the Global Fund. Spending on the laboratory

program area is increasing because of the strong focus on scale-up of both VL and EID and related systems. Global Fund spending continues to improve after the first year of implementation of its 2021-2023 grant.

Table 2.3.2 Annual Procurement Profile for Key Commodities

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022					
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders
	\$	%	%	%	%
Antiretroviral Drugs	\$35,981,951	0%	49%	51%	0%
Laboratory Supplies and Reagents	\$5,479,895	0%	20%	80%	0%
CD4	\$0				
Viral Load	\$4,120,696	0%	0%	100%	0%
Other Laboratory Supplies and Reagents	\$1,359,199	0%	82%	18%	0%
Laboratory (Not Disaggregated)	\$0				
Medicines	\$5,103,746	0%	33%	67%	0%
Essential Medicines	\$3,401,706	0%	20%	80%	0%
Tuberculosis Medicines	\$693,111	0%	0%	100%	0%
Other Medicines	\$1,008,929	0%	100%	0%	0%
Consumables	\$4,922,189	0%	58%	42%	0%
Condoms and Lubricants	\$1,257,904	0%	73%	27%	0%
Rapid Test Kits	\$3,426,266	0%	50%	50%	0%
VMMC Kits and Supplies	\$0				
Other Consumables	\$238,019	0%	100%	0%	0%
Health Equipment	\$192,456	0%	100%	0%	0%
Health Equipment	\$192,456	0%	100%	0%	0%
Service and Maintenance	\$0				
PSM Costs	\$18,836,114	0%	57%	43%	0%
Total Commodities Only	\$70,516,350	0%	49%	51%	0%

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Expenditure on commodities is increasing as a proportion of overall investments. This reflects the increasing size of the patient cohort. ARVs remain the top spending commodity category followed by VL/EID, essential medicine, and rapid test kits. The overall increase of the commodities budget is driven by the cohort growth with a high number of HIV patients that the program must maintain on ART continuity and the scale up of some activities such as PrEP and TPT. The increased investments for pediatric ARVs that started in COP21 will continue in COP22 due to the scale-up of pediatric ARV optimization and the expansion of efforts to improve the pediatric cascade. These increases were compensated through savings coming from the procurement of standardized multi-month dispensing (MMD) formulations which are cheaper. On the PEPFAR side, the expenditure on HIV rapid test kits (RTKs) continues to decrease because of increases in index testing, more targeted testing, and better use of screening tools for PITC. The recent introduction of self-testing and recency testing may result in a slight increase in HIV rapid test kits in COP22. The expenditure on VL/EID is increasing and reflects the rapid scale-up of VL/EID

coverage, especially in PEPFAR supported provinces. The investment on essential medicines is increasing mostly due to the funding of TB commodities to support the expansion of TB prevention programs in general.

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Sources	Total USG Non-PEPFAR Resources (FY21)	Non-PEPFAR Resource Co-Funding PEPFAR	# Co-funded IMs	PEPFAR COP Co-Funding contribution	Objectives
USAID MCH	\$ 35,000,000	\$ 7,800,000	2	\$ 1,066,632	Cofunding: \$6.5M TO4; \$1.3M GHSC-TA
USAID TB	\$ 14,000,000	\$ 2,050,000	2	\$ 1,960,089	Cofunding: \$1.25M Stop TB; \$800,000 GHSC-TA
USAID Malaria	\$ 54,500,000	\$ 4,300,000	2	-	Cofunding: \$14.6M TO2; \$8.7M GHSC-TA
USAID Family Planning	\$ 20,000,000	\$ 6,200,000	2	-	Cofunding: \$5M CCP; \$1.2M GHSC-TA
NIH					
CDC GHS	\$ 8,229,318	\$ 393,315			Developing capacity of healthcare systems
USAID GHSA	\$ 4,059,058				
Peace Corps					
CDC Ebola	\$ 3,082,262	\$ -			
USAID Ebola	\$ 1,150,000				Ebola preparedness
DOD Ebola					
CDC COVID-19	\$ 15,820,091	\$ 1,654,658	3		
USAID COVID-19	\$ 15,600,000				
CDC Malaria	\$ 364,396	\$ -			Ebola response activities
CDC Monkey Pox	\$ 547,463	\$ -			Covid-19 activities
CDC Flu	\$ 234,268	\$ -			Technical assistance; identify strains of influenza in the country and surveillance
CDC GID	\$ 8,641,051	\$ -			Research; technical assistance
MCC					
Total	\$ 181,227,907	\$ 22,397,973		\$ 3,026,721	

In FY2021, the USG invested \$181.2 million in non-HIV programming, including \$22.4 million in co-funding in PEPFAR-supported provinces. The geographic coverage of these mechanisms overlaps primarily in Haut-Katanga and Lualaba provinces.

2.4 National Sustainability Profile Update

Sustainability Index and Dashboard (SID) Process: In September 2021, the PEPFAR team jointly kicked off the SID development process with UNAIDS and the National Multisectoral AIDS Control Program (PNMLS). Meetings were convened at the UNAIDS office and were attended by representatives of civil society and the Government of the DRC (GDRC), UNAIDS, WHO, PEPFAR selected Implementing Partners and USG teams. Some of the participants opted for the virtual alternative offered through a zoom link in light of COVID-19 risks and recommendations. Full day working sessions assessed the progress made from SID 2019 to SID 2021 for the four SID domains and Responsibility Matrix (RM). Most of the 2019 SID and RM findings remained largely unchanged. A few elements showed a slight decline mainly because of failing to update information as per SID-recommended standard timeframes. The RM analysis also indicated that,

except for a regulatory and policy-development role, the government mostly appeared to have a secondary responsibility in almost all areas. Part of the apparent immobilization could be ascribed to Covid 19 and the negative impact especially obvious in the domains of supply chain and laboratory. Manufacturers and transporters prioritized COVID-19 related supplies. The SID validation meeting was attended by DRC government officials, UNAIDS, and other stakeholders.

1. Progress addressing sustainability strengths and vulnerabilities previously identified through the SID process

Sustainability Strength:

- **Planning and Coordination (9.50, dark green)**: This element score has slightly increased from 9.29 in 2019. Under the leadership of the PNLs, the DRC has continued to develop its capacity to plan and coordinate the national response. More than any other element in the SID, this is an area where strong domestic leadership by the PNLs is playing a prominent role, as they hold most of the national and provincial-level planning, coordination, and results review meetings. There has also been greater leadership from the PNMLS, which successfully launched the current National Strategic plan to cover the period from 2020-2023. It was noted that strong planning must lead to implementation and the SID Working Group noted that while many plans exist, they do not always guide interventions. This caveat, stressed by the PNMLS, is a recommendation to integrate more metrics for coordination into the tool which seems to be overshadowed by planning-related questions.
- **Market Openness (9.00 light green)**: This element score has slightly increased from 8.43 in 2019. Significant improvement has been seen in the collection and availability of financial and expenditure data. However, the information is not collected in a timely manner and thus is not available to decision makers for effective and timely decision making.

Sustainability Vulnerabilities: All the other remaining elements were found vulnerable with 1) Quality Management, 2) Technical and Allocative Efficiencies, and 3) Data for Decision Making Ecosystem in red (scoring 2.33, 3.00 and 1.67, respectively). 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 as emerging sustainability or yellow.

2. Key priorities for COP22

Looking at the status quo in many SID domains and potential impact towards epidemic control, the team considers as priorities for COP22 following elements:

- **Commodity Security and Supply Chain (3.96, yellow)**: The availability of life-saving antiretroviral medications and other HIV commodities is essential for epidemic control and a sustainable national response. While there have been significant improvements in supply planning and management, there is work still to be done. Lead times need to be reduced and customs clearance procedures streamlined ensuring the availability of commodities when and where they are needed.
- **Laboratory (3.81, yellow)**: Despite significant efforts in PEPFAR-supported health zones, the coverage of viral load and EID results remain concerning across the country. In COP22, emphasis will continue to be placed on enhancing the laboratories' capacity to improve quality, timeliness and completeness of data collection and reporting. Diagnostic Network

Optimization using POC machines and timely availability of lab reagents remain critical to alleviate the pressure on conventional laboratories and provide quality patient care.

- **Performance data (5.74, yellow):** Although the national program has made remarkable efforts towards a unified system for data collection, there continues to be a need to improve completeness and quality of analysis, which would support a clear process for decision-making and technical and allocative efficiencies. The entire strategic information system gives alarming signals of weakness in the decision-making process.
- PEPFAR, Ministry of Health, and the Global Fund share these priorities and will continue to work in a synergistic way to leverage resources for shared forecasting of ARVs and test kits, mapping of GeneXpert machines and multiplex POC, support for Tier.Net, and other collaborative areas for partnerships.

3. Transition to indigenous partners

Over the years, PEPFAR/DRC has empowered and developed local capacity for the implementation of its supported programs. These efforts will continue during COP22 through increased budgets for indigenous organizations but also through capacity building opportunities. Since COP20, calls for applications preferentially encouraged indigenous partners to apply.

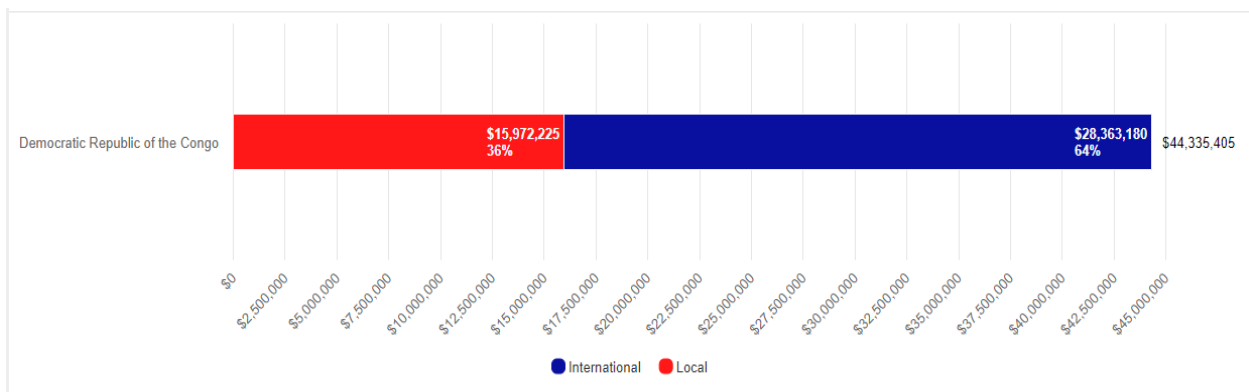
Clear evidence of agency progress toward local, indigenous partner direct funding.

COP18 funding: 2.3%; COP19: 9.2%; COP20: 10%; COP21: 15.22% (including ARPA)

This shows the progress made in resource allocation towards indigenous partners from COP18-COP21.

Below we can see the split of COP22 proposed budget between indigenous and international organizations (excluding commodities, TBD and operational costs). The slice of the pie going to local and indigenous organizations represents 36 percent of the proposed budget and also represents a more than 20 percent increase from COP21 as well as the largest increase since COP18.

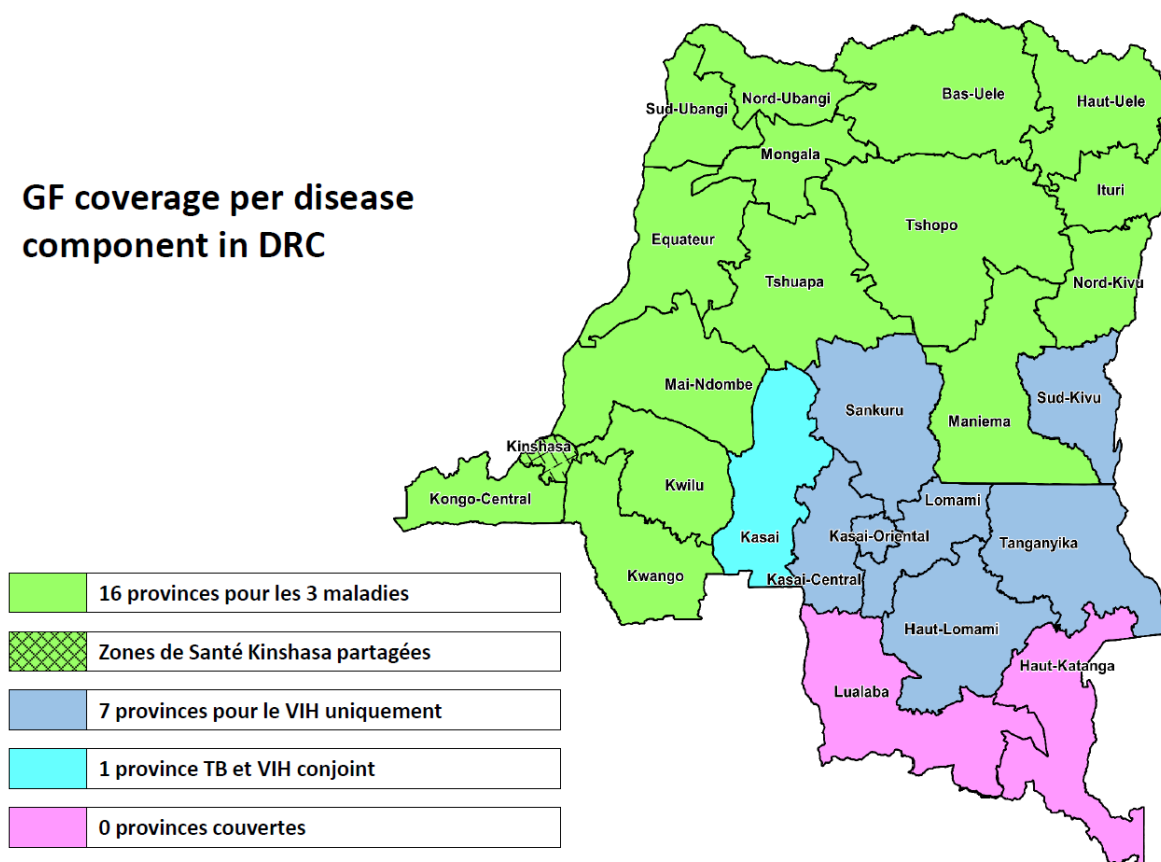
Figure representing the distribution of COP22 funding between local and international organizations



2.5 Alignment of PEPFAR investments geographically to disease burden

In DRC, three key partners lead the HIV epidemic response: The GDRC, the Global Fund and PEPFAR. Figure 2.5. 1 below depicts the rationalization of provinces between Global Fund and PEPFAR, which was completed at the end of FY16. As indicated, PEPFAR efforts are focused in three Provincial Health Divisions (FRENCH: “DPS”): Kinshasa, Haut-Katanga, and Lualaba (with the exception of the military program which covers targeted prevention, care, and treatment activities with the military, a priority population).

Figure 2.5.1: Global Fund coverage per disease component in DRC



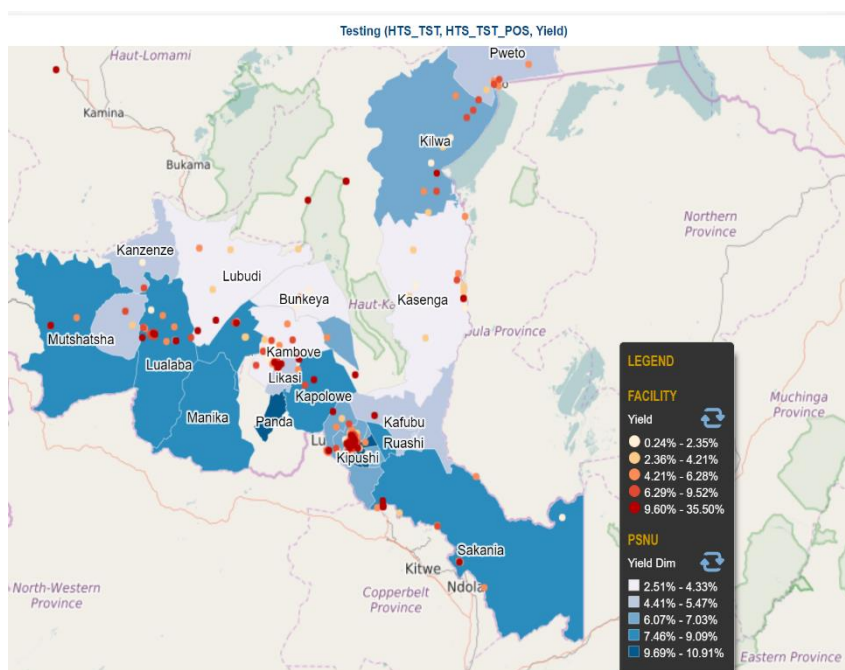
Kinshasa is the capital city of the DRC and is home to over 12 million people. While epidemic control in Kinshasa is not as likely by 2023 as in Haut-Katanga or Lualaba, PEPFAR programmatic data indicates substantial potential for progress in identifying and linking individuals to treatment in Kinshasa and continued investment is essential. Performance data demonstrates

that high yields, upwards of 25 percent, with index testing are possible and the increased use of risk assessment tools in other entry points is providing valuable testing efficiencies. The strong upward trend in finding people living with HIV in Kinshasa over the past five quarters is expected to continue well into FY23 and beyond. Along with intensified linkage and continuity of treatment strategies, streamlining investments to find more people living with HIV in this high burden province will be essential for epidemic control in the DRC. In COP22, PEPFAR implementers will continue to work to close the gap by reducing interruption of treatment among PEPFAR supported clients.

Figure 2.5.2. Percent HTS_TST Positive DRC/Zambia Border

In addition to Kinshasa, PEPFAR/DRC implements programs in Haut-Katanga and Lualaba. Haut-Katanga is one of the highest burden provinces in the DRC, sharing a border with one of the highest-burden countries in sub-Saharan Africa – Zambia. Recent results from programming along the border with Zambia show a much higher prevalence than the national average, however, the volume of individuals found and tracked is low. During COP22, implementing partners will continue to expand index case testing and other cost-effective approaches in order to continue to find and treat higher risk populations on a larger scale in this area. In addition, a better understanding of patient movement across the border will be sought to ensure patients are accounted for and covered for care and treatment services.

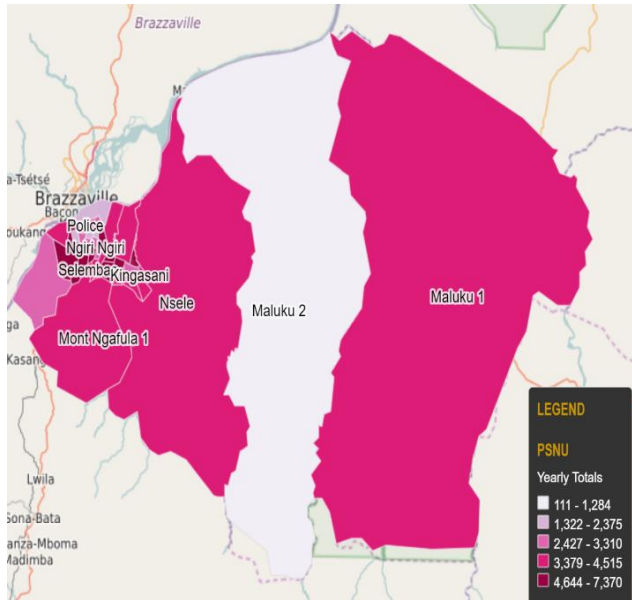
Figure 2.5.2. % HTC_TST positive, DRC/Zambia Border, 2021 Q1. PEPFAR Panorama



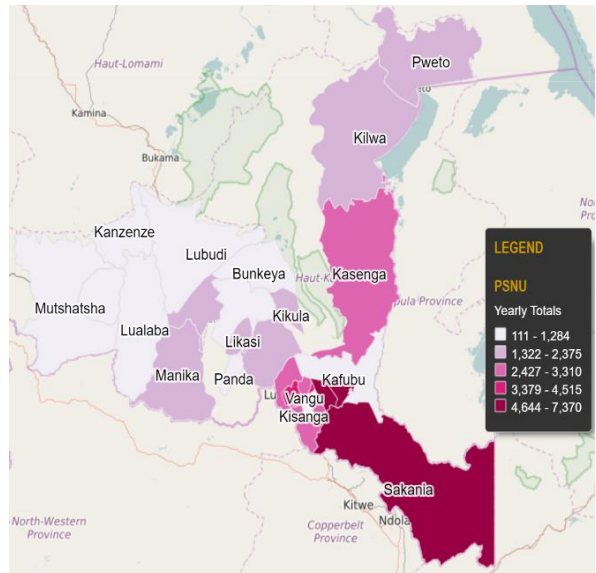
Performance data overall, as well as spectrum data in Haut-Katanga, indicates near attainment of epidemic control in several health zones. Given this, more resources and efforts will continue to be invested in this high-burden province during COP22. Contiguous to Haut-Katanga is the province Lualaba, with numerous, large, formal and informal mining sites. Cutting through the middle of Haut-Katanga and Lualaba is a major trans-African highway, bringing a high concentration of truckers and sex workers throughout this transportation corridor. Given the high-risk populations prevalent in this region, this will continue to be an area of focus.

Figures 2.5.3 outlining geographic distribution of PLHIV is below:

Democratic Republic of the Congo PLHIV by Health zones FY 19



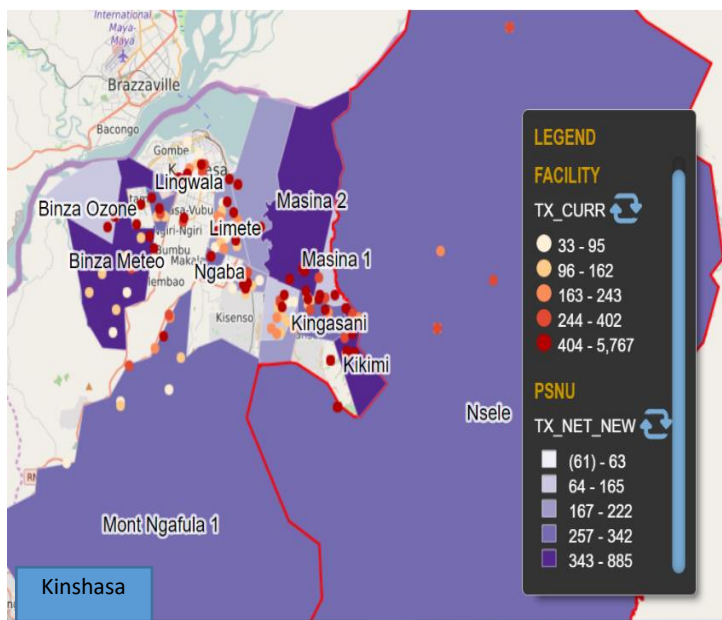
Kinshasa



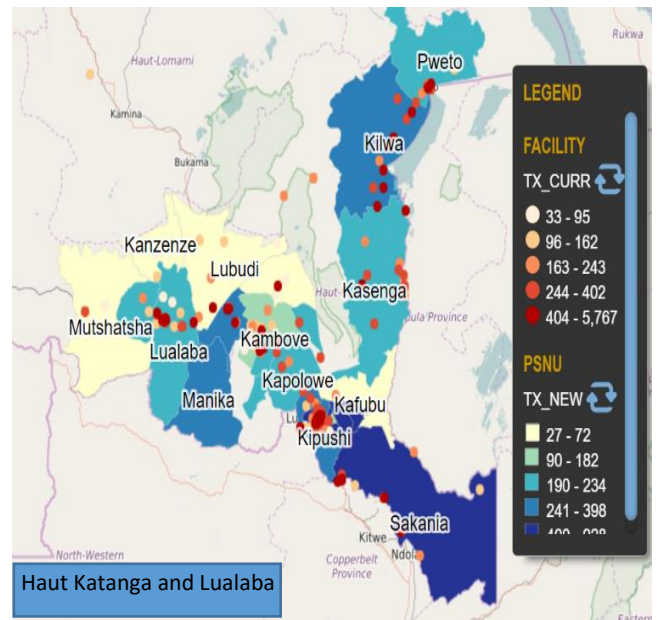
Haut Katanga and Lualaba

Figures 2.5.4 outlining geographic distribution of ART coverage is below:

Democratic Republic of the Congo PEPFAR ART Coverage by Health zones FY 19



Kinshasa



Haut Katanga and Lualaba

2.6 Stakeholder Engagement

From the beginning of the COP22 planning process, PEPFAR/DRC engaged a range of critical stakeholders including: the GDRC through the PNLs directors - the PNLT director and the PNMLS Director; the Global Fund through the Disease Fund Manager; United Nations (UN) organizations such as UNAIDS and WHO; MSF; and the Civil Society Organization (CSO) network.

CSOs participated in the pre-COP22 in-country retreat to help inform COP22 planning and strategy. The PEPFAR/DRC S/GAC Chair, Program Manager and Agency Points of Contact also participated in the virtual in-country retreat and were able to directly answer questions from the PEPFAR interagency team and other stakeholders. The CSOs provided feedback on the COP22 guidance and PEPFAR/DRC COP22 activities and priorities. CSO representatives and other stakeholders listed above then joined the PEPFAR/DRC delegation at the COP22 Virtual Planning Meeting and provided input throughout the process.

The GDRC actors have proposed to evaluate the rationalization process in order to include to include the 66 HZs that are not receiving donor support and have engaged on improving case finding, self-testing, linkage to treatment as well as improving VL demand creation. As priorities for COP22, the PNLs will work on improving the strategic information system, support the laboratory networks and support quality service delivery.

Table showing PEPFAR engagement and timeline with key stakeholders for COP22 planning

Date	Objective	Outcomes	Next steps	Comments
<i>Before COP22 Submission</i>				
01/31/2022-02/02/2022, In-Country retreat	PEPFAR/DRC to share COP22 planning with internal stakeholders: The COP22 development process, the COP22 overview, COP22 expectations from stakeholders, timelines for future steps	Stakeholders understand the COP process and the outline of the last COP Stakeholders understand the timeline for the next steps of the COP22	Plan the next meeting Share the documentation	Meeting was held virtually
03/15/2022 – 03/17/2022	Discuss COP21 Q1 performance and COP22 plan	Stakeholder feedback received	Continue discussion via phone and email to ensure	Meeting was held virtually

Virtual Planning Meeting	Receive input from stakeholders on the COP22 strategy for DRC		stakeholder input into COP22 presentations	
04/22/2022	COP22 SDS Draft shared with stakeholders and CSOs			SDS draft was shared via email with CSOs and all stakeholders
<i>After COP22 Submission</i>				
05/30/2022	PEPFAR/DRC to explain how stakeholder feedback was incorporated in COP22 planning and how PEPFAR will continue to engage them throughout the year	Stakeholder understands how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP22, what was not, and why these decisions were made	Share the redacted COP22 SDS when available and approved	The approved, redacted COP22 SDS will be shared by email. Hard copies will be available upon request

Information sharing strategy

UNAIDS in Kinshasa will continue to allow stakeholders to use their office space and internet capabilities and host regular civil society meetings once social distancing measures are relaxed. Stakeholders located outside of Kinshasa will continue to receive information from the UNAIDS provincial offices.

All types of documentation (i.e. Reports; POART presentations, COP22 presentations and materials regarding program priorities, goals, budget) is shared via email. Hard copies of documents will be provided if requested by stakeholders.

Community-led monitoring in COP22

In addition to prescribed and routine engagement during PEPFAR's annual business cycle, including around COP planning and quarterly POART processes, PEPFAR/DRC has developed, supported, and funded a community-led monitoring (CLM) grants program. The program is designed to help PEPFAR /DRC and health facilities pinpoint persistent problems, challenges, barriers, and enablers to effective client outcomes at the site level. The PEPFAR/DRC CLM program will be utilized to advance equity and to support improvement in programs, especially for populations who have not yet fully experienced the benefits of HIV epidemic control.

While the process to stand up the CLM Grants program has been onerous and time-consuming, PEPFAR/DRC has made significant progress in FY22. Five organizations have been selected from the CSOs and KP applicants to conduct this program. Implementation of the grants commenced with a kick-off meeting on April 19, 2022 to launch the CLM activities for the three provinces (Kinshasa, Haut-Katanga and Lualaba).

PEPFAR/DRC is committed to utilizing the findings from the CLM grants to improve the quality of its program and ensure the delivery of quality services. This will entail close monitoring of services provided to clients as well as ensuring responsiveness to clients' needs as we strive to address challenges and achieve a people-centered approach.

CSO involvement in COP22 development has been well received and we treasure this privileged relationship to ensure quality services are provided to beneficiaries. Monitoring will focus on collecting quantitative and qualitative data through a wide variety of methods that reveal insights from communities about the problems and solutions to health service quality issues at the facility, community, sub-national, and national levels.

2.7 Stigma and Discrimination

The GDRC through 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 key 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 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, 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 the application of 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.

3.0 Geographic and Population Prioritization

In COP22 PEPFAR/DRC will keep the same subnational unit (SNU) prioritizations as in COP21. The 57 scale-up aggressive health zones prioritized for COP22 represent 50.3 percent of patients in the cumulative national ART cohort. In COP22, the PEPFAR/DRC team will continue to implement strategies and support services in aggressive scale-up health zones, maximizing testing yield, linking HIV positive people to treatment, and maintaining the continuity of patients on treatment with a goal of achieving sustained epidemic control in all 57 health zones by 2023. The PEPFAR/DRC military specific program will continue to pursue its efforts in favor of active duty FARDC personnel, their dependents and the populations surrounding FARDC barracks or camps.

Although significant progress has been made in increasing the number of PLHIV on ART throughout PEPFAR-supported provinces, and statistical saturation has been achieved in a number of individual health zones in Haut-Katanga, programmatic data showing consistently high HIV testing yields suggest that true saturation has not been attained in these areas. In these health zones, the illusion of saturation is likely attributable to care-seeking behaviors, whereby patients are crossing health zone lines to receive care. In COP22, PEPFAR/DRC will focus on increasing the number of PLHIV receiving treatment in all the supported health zones, with an emphasis in Haut-Katanga and Lualaba. For each health zone, specific interventions for ART scale-up will be driven by granular data on burden, coverage, yield and net ART growth. Recency HIV testing will be rolled out in Haut-Katanga and Lualaba (greater than 80 percent of health facilities supported) to provide additional data on the state of the epidemic by identifying transmission ‘hot spots’ and populations for targeted interventions including optimization of PrEP implementation. Index and family testing will be offered to all newly identified positives in all PEPFAR-supported health facilities. In addition, medical records for all PLHIV enrolled in PEPFAR-supported facilities will be reviewed, and index/family testing will be offered to those whose records do not indicate this has been done previously. PEPFAR /DRC will continue to invest in community approaches to find positives through Index testing. Additionally, in out-patient wards, the standardized and validated screening tool will be employed more accurately to identify high-risk clients and avoid duplicative or over-testing of lower risk clients.

In COP22, PEPFAR/DRC will continue its efforts to reach the following populations:

1. Partners and family members of diagnosed PLHIVs (Index testing)
2. Young men aged 20-30, including partners of FSW

3. Pregnant women (1st trimester)
4. Adolescent girls and young women (AGYW)
5. Children
6. Key populations (MSM and FSW)
7. Other priority populations such as the military

These populations were selected through the review of the programmatic and national epidemiological data. By focusing on these populations, some of which are underrepresented in the current treatment cohort, PEPFAR/DRC is expecting to bridge the age and sex band gaps in order to achieve sustained epidemic control in the supported areas by 2023, with significant progress toward closing the gaps in FY22. Activities for key and priority populations will be rolled-out at hotspots and at-risk communities, based on the location and need of the identified populations in the urban areas with high numbers of FSW and MSM. The KP who test HIV-positive will be linked immediately to treatment and PrEP will be offered to all who test HIV negative.

During FY23, budgets and targets will continue to prioritize Haut-Katanga and Lualaba provinces, which are closer to achieving 95-95-95 by 2023. In Kinshasa, PEPFAR/DRC will continue to find efficiencies and focus on case identification and rapid enrollment on treatment while in Lualaba and Haut-Katanga, PEPFAR/DRC will be scaling to attain epidemic control with focused attention on continuity on ART and viral suppression.

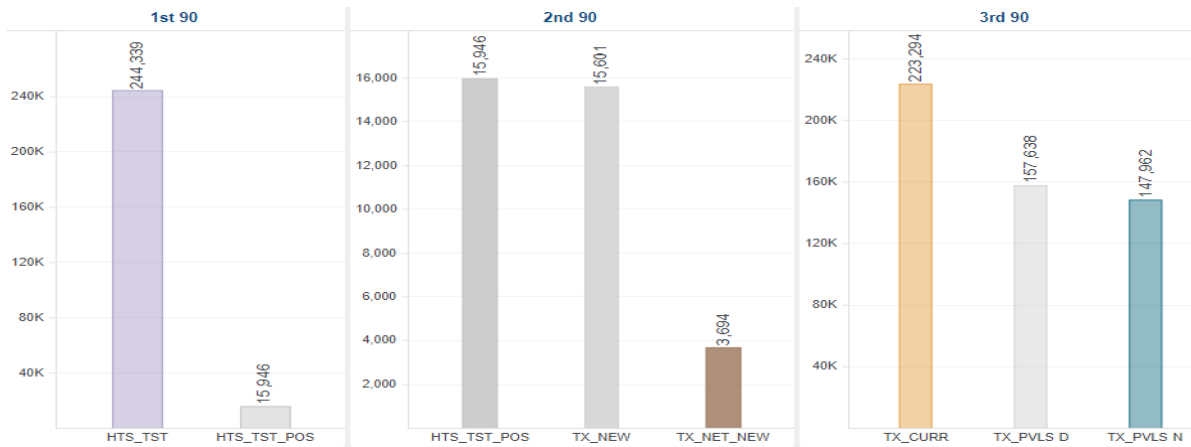
Table 3.1 Current Status of ART Saturation

Table 3.1 Current Status of ART saturation				
Prioritization Area	Total PLHIV% of all PLHIV for COP22	# Current on ART (FY21)	# of SNU COP21 (FY22)	# of SNU COP22 (FY23)
Attained				
Scale-up Saturation Not including Military	374,371/86.1%	206.978	3	3
Scale-up Aggressive				
Sustained				
Central Support				

4.0 Client-Centered Program Activities for Epidemic Control

PEPFAR/DRC is focused on attaining and maintaining epidemic control through scaling up of activities and innovative approaches in a client-centered manner. At the nexus of this goal will be analyzing and using data to identify gaps in geographies and populations for targeted interventions to address identified gaps.

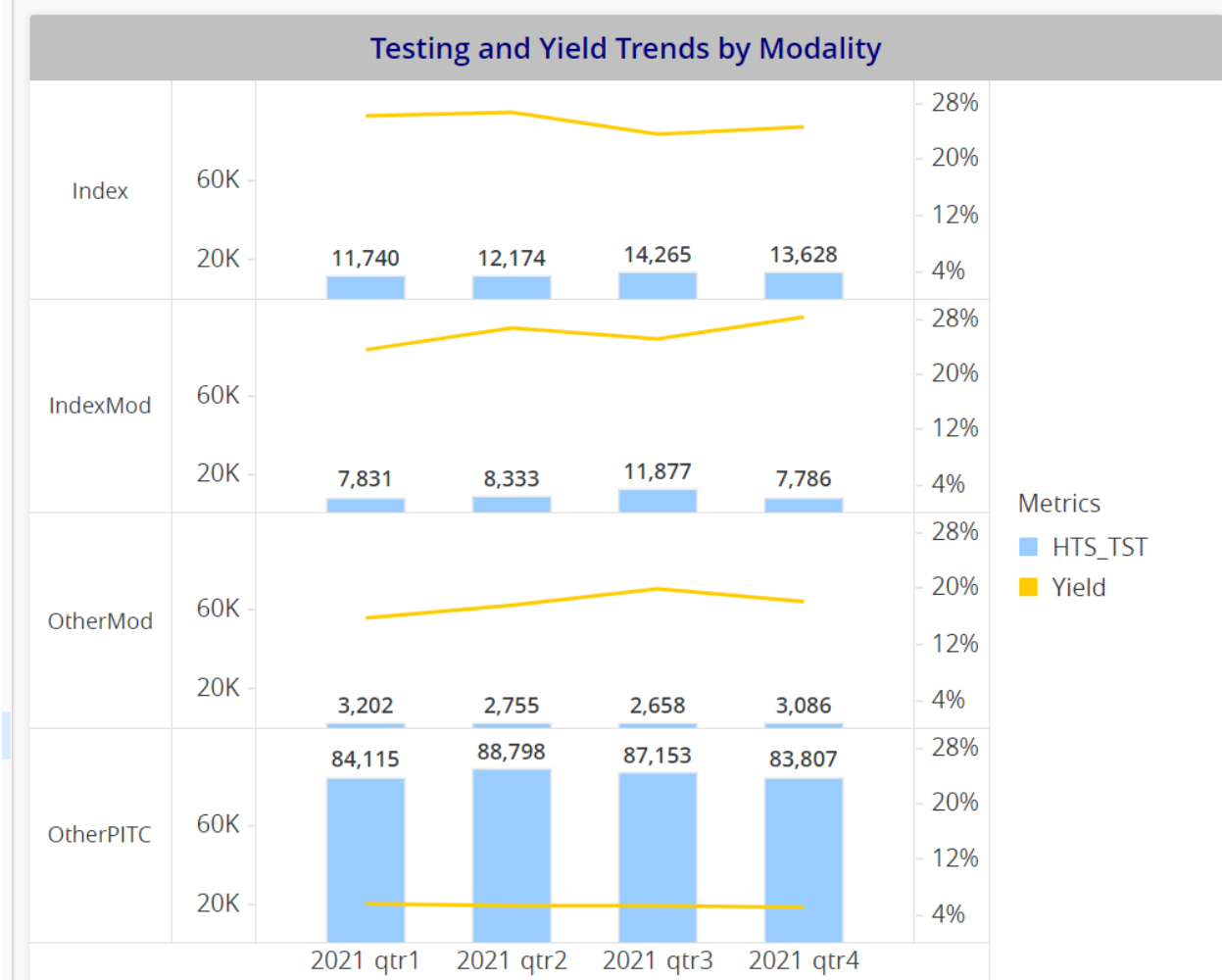
Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



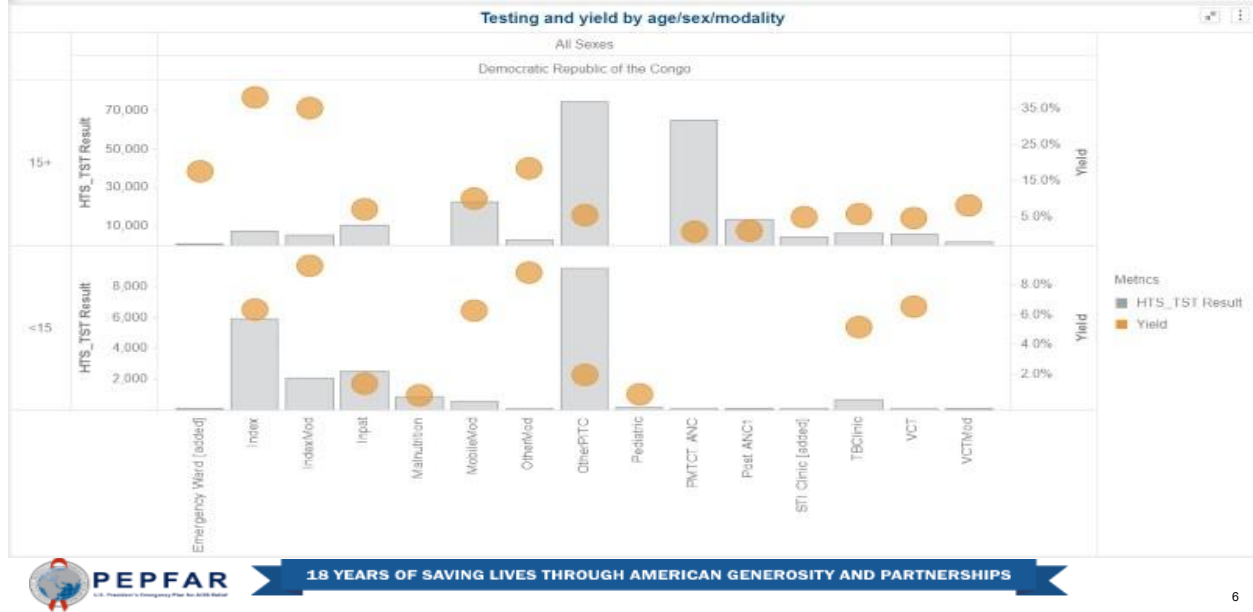
4.1 Finding people with undiagnosed HIV and getting them started on treatment

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21

Trends: HTS_TST : Testing and Yield Trends by Modality



Testing yield by Age/Sex and modality FY 21Q4



PEPFAR/DRC achieved 125 percent of its FY21 target for HIV positives identified, yet gaps persist:

- 1) While substantial uncertainty exists about number of PLHIV in PEPFAR-supported provinces in DRC, proxy operating unit data such as proportion of HIV positive persons knowing their status at their first visit at ANC was 0.39 percent in Haut-Katanga, 0.37 percent in Kinshasa and 0.51 percent in Lualaba (FY21 PEPFAR programmatic data). A similar proxy revealed the proportion of HIV positives knowing their status at entry into TB clinics at 5.67 percent in Haut-Katanga, 4.79 percent in Kinshasa and 3.56 percent in Lualaba (FY21 PEPFAR programmatic data). In both ANC and TB settings, testing is offered to every client, which gives an indication of the proportion of the general population who know their HIV status. The above values demonstrate that the first 95 remains a gap.
- 2) FY21 HTS_TST_POS targets are not reached for some subpopulations like children and young men. Nevertheless, our programmatic data show considerable numbers of women (24,130 annual target achievement of 147.1 percent) tested compared to men (25,225 annual target achievement of 103.8 percent). The gap in annual target achievement is evident in the 20-34-year-old age group of men compared to women (161.7 percent in women and 72.1 percent in men).
- 3) Proportion of deaths documented among patients who interrupted treatment ranged from 16.1 percent to 32.9 percent among the Haut-Katanga implementing partners and from 8.0 percent to 14.2 percent among Kinshasa implementing partners.
- 4) FY21 indicators on pediatric case-finding clearly indicate failure to reach annual targets for reaching children. As an illustration, only 89.7 percent of 0-14-year-old targeted children were reached overall by PEPFAR/DRC in FY21. The same results show weak coverage of index testing in

biological children of HIV positive women. Site Monitoring System (SIMS) has confirmed many missing family trees in the medical files of HIV positive women.

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

6) The low FY21 coverage of EID at two months (72 percent) is another weakness that we will address.

In COP22, PEPFAR will focus on scaling up index testing and self-testing, ensuring consent procedures are in place, that confidentiality is protected, and the assessment of IPV is established. Additionally, all children under the age of 19 with an HIV positive biological parent will be tested for HIV.

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

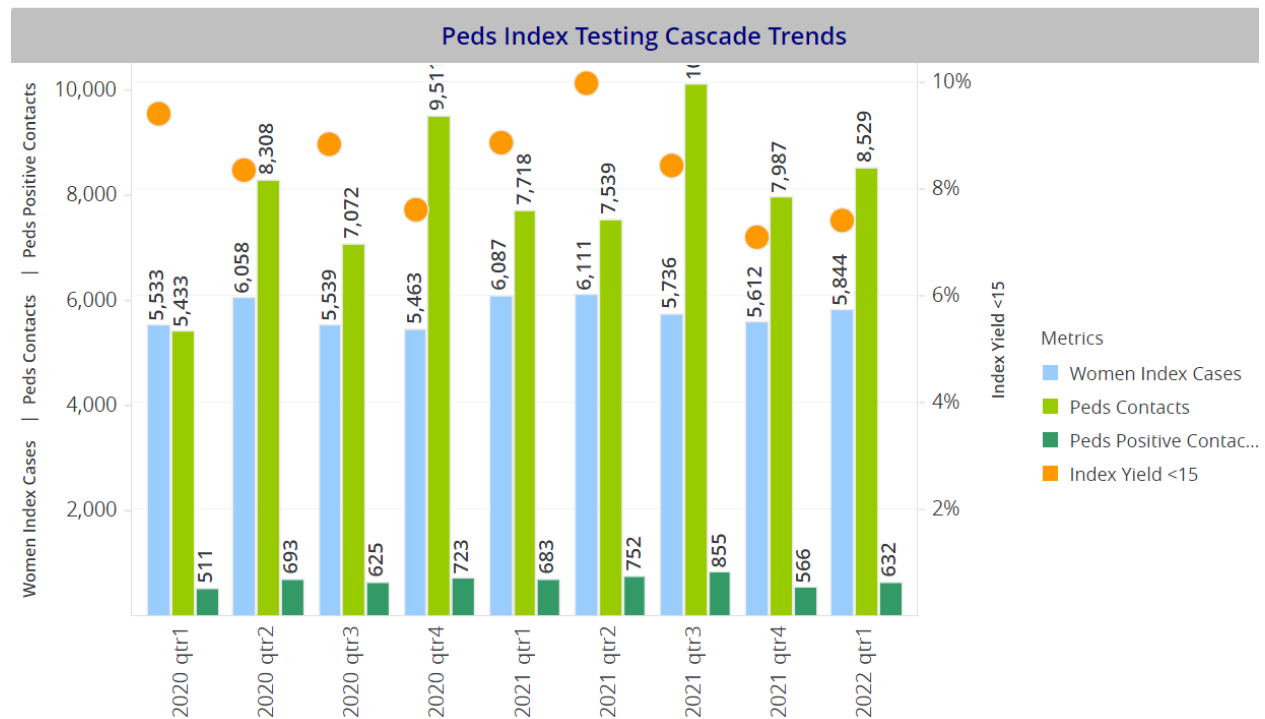
For pediatrics: The cornerstone will be the systematic review of family trees to identify all missing biological children under 19 years and linking them to index testing services. In each high-volume facility, additional staff and lay workers will be scheduled to ensure complete family trees for HIV positive women. In collaboration with the HIV positive woman, they will set a plan and adequately document index testing for all eligible children. To increase EID coverage, peer educators (mentor mothers) will be involved in sensitizing mothers to demand DBS collection. In addition, the implementation of optimized 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 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 minimum program requirements: 1) providers trained on index testing procedures, including IPV screening, adverse event monitoring, the “Five Cs,” and ethics; 2) adherence to the “Five Cs”; 3) IPV risk assessment; availability of first-line services for anyone reporting IPV (onsite or by referral); 4) a secure environment to store patient information, and 5) a site level adverse event monitoring and reporting system. All index testing clients will be provided with the full range of HIV prevention, care, and treatment services regardless of whether they provide details about their partners, and clients may opt-out of index testing services for any reason. All implementing partners serving all populations will verify that each facility providing index testing implements programming in compliance with the WHO’s Self-Testing and Partner Notification Guidelines and additional guidance developed by the PEPFAR Index Testing and KP Communities of Practice.

All HIV testing clients, including index clients, 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 4.1.1.2 Pediatric index testing cascade



The PEPFAR/DRC team recognizes that “the missing” are mainly the partners of individuals recently identified as living with HIV, or partners of existing ART patients that have not yet been tested. In addition, “the missing” include those individuals identified as positive but who were not linked to treatment, and the PLHIV started on ART that have interrupted their treatment. All unidentified and/or interrupted patients need to be found, put on treatment, and retained on treatment in order to reach the goal of viral suppression and epidemic control.

Our response: Expand and refine what is working: 1) Enhanced Index Testing, 2) Refined Other PITC, 3) Boosted targeted community testing

fiscal_yr_period	modality	% HTS_TST_POS	HTS_TST_POS	fiscal_yr_period	modality	% HTS_POS	HTS_TST_POS
2021Q1_4	OtherPITC	29.21%	18,014	2022Q1	OtherPITC	29.46%	4,584
2021Q1_4	Index	21.06%	12,987	2022Q1	Index	23.66%	3,681
2021Q1_4	IndexMod	14.93%	9,209	2022Q1	IndexMod	14.97%	2,329
2021Q1_4	MobileMod	14.62%	9,016	2022Q1	MobileMod	12.37%	1,925
2021Q1_4	Inpat	5.01%	3,088	2022Q1	Inpat	4.96%	771
2021Q1_4	PMTCT ANC	3.53%	2,177	2022Q1	OtherMod	3.47%	540
2021Q1_4	OtherMod	3.35%	2,068	2022Q1	PMTCT ANC	3.21%	500
2021Q1_4	TBClinic	2.56%	1,581	2022Q1	TBClinic	2.69%	419
2021Q1_4	VCT	1.97%	1,215	2022Q1	VCT	1.44%	224
2021Q1_4	VCTMod	1.38%	853	2022Q1	STI Clinic	1.37%	213
2021Q1_4	STI Clinic	1.16%	717	2022Q1	VCTMod	1.30%	202
2021Q1_4	Post ANC1	0.90%	558	2022Q1	Post ANC1	0.78%	121
2021Q1_4	Emergency Ward	0.21%	129	2022Q1	Emergency Ward	0.22%	34
2021Q1_4	Malnutrition	0.06%	40	2022Q1	SNSMod	0.06%	10
2021Q1_4	Pediatric	0.03%	17	2022Q1	Malnutrition	0.04%	6
2021Q1_4				2022Q1	Pediatric	0.01%	1



19 YEARS OF SAVING LIVES THROUGH AMERICAN GENEROSITY AND PARTNERSHIPS

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Results from FY21 and Q1 FY22 allow PEPFAR/DRC to identify and address different HIV sub-epidemics in DRC based on geography and population. In Haut-Katanga and Lualaba PEPFAR/DRC will scale up to attain epidemic control by continuing to find cases and focusing on linkage, continuity of treatment, and viral suppression. In Kinshasa, case finding is the primary issue and PEPFAR/DRC will focus on finding efficiencies through case identification. In Haut-Katanga and Lualaba, the main issue is the continuity of patients on treatment. In Kinshasa, case finding is the primary issue. Taken together, newly identified cases will be rapidly linked to treatment and strategies implemented to ensure they remain on treatment to achieve viral suppression.

The PEPFAR/DRC program continues to miss men aged 25-45, especially in Kinshasa where men are presenting at a later age. Regardless of age, men are not regularly accessing health services in general. In relation to HIV services men are waiting until they become very sick before seeking care. This results in a lower percentage of positive men that have been found compared to positive women that have been found; however, due to the greater burden of HIV-positive women, the absolute number of women that needs to be found remains larger in many age bands.

Therefore, population demographics and dynamics need to be well-understood, and strategies must be targeted for each individual population.

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

- Improving coverage and fidelity of index testing, especially in populations in areas such as Lualaba where there are concerns with the denominator;
- Optimizing PITC yield and right-sizing testing volume by using the risk assessment tool;
- Boosted targeted community testing;
- Implementing approaches for improved linkage and adherence support; and
- Implementing strategies for improved tracking and reminder systems to retain patients on treatment.

In COP22, PEPFAR/DRC prevention outreach activities will focus on the following priority populations: 1) partners of diagnosed PLHIVs (index testing), 2) younger men, 3) adolescent girls and young women, 4) children, 5) key populations (MSM and FSW), and 6) military personnel. These populations were selected through a review of the programmatic and national epidemiological data. By focusing on these populations, who are currently underrepresented in the PEPFAR/DRC treatment cohort, PEPFAR/DRC will address the age and sex band gaps to achieve sustained epidemic control in PEPFAR-supported areas in FY23. In COP22, intensified site-level data reviews with all implementing partners, and robust partner performance management, will continue to proactively identify and address site-level performance barriers. With a more frequent and intentional review of these barriers, PEPFAR/DRC will be able to make the needed course corrective actions to improve case identification, to link positive cases to treatment, and retain them in the program.

Results from FY22 Q1 reveal that men are still being reached at an older age, mainly in Kinshasa. Most men are reached through inpatient and TB modalities, especially older men. Innovative ways to identify HIV positive men at earlier stages are critical. FY22 Q1 results showed that index testing is a promising strategy for reaching men. Case finding is increasing in Kinshasa among both males and females, although there are still growth opportunities with men. Improved index testing shows promise for pediatric case finding; there is a need to scale up family tree testing to ensure that all biological children under age 15 of HIV positive women are tested. Reaching the “un-reachable” is showing promising yields among key populations with Enhanced Peer Outreach and sexual and social network testing. In Kinshasa, the self-testing strategy will be scaled up to reach the MSM population. The overall approach will focus on “finding men at an earlier age and stage” and linking them into facility-based services. FY21 Index Testing results show encouraging trends in fulfilling this goal. During FY22Q1, through Self Testing, 1,595 self-tests have been distributed in Index testing settings for unwilling or reluctant partners and yielded 170 positives which could have been missed otherwise. To optimize the use of self-testing, PEPFAR DRC will be

focused on improving the return rate for self-tests (currently 70 percent); ensuring availability of self-testing policy to integrate caregivers to assist with self-tests in children two years and above. In addition to self-testing, providers will be trained and supervised on negotiation skills for partner notification, safe and ethical standards for index case testing, registers, and trackers (SIMS and GSM) to monitor unreached contacts as per consent of the index.

Although the results are not yet optimal, PEPFAR/DRC is reaching relatively more men and identifying more PLHIV than in the past. PEPFAR/DRC is building on experience and initial successes to expand index testing among men. Partner performance monitoring has helped to identify sites that successfully linked more than 95 percent of HIV-positive men to treatment. Practices employed at these successful sites are being explored during partner performance monitoring meetings to identify characteristics of testing programs that encourage service uptake among men. This includes expanding service hours and offering other health services and information concurrently (for example, on non-communicable diseases, reproductive and sexual health and HIV). Additionally, using a harmonized and validated high-risk screening tool (as opposed to the symptom-based one), targeted workplace testing will be implemented among fishermen, taxi drivers, miners, and truckers.

Pediatric case finding strategies

- 100 percent of biological children of mothers who are living with HIV (or fathers with HIV and mothers of unknown HIV status; or deceased mothers) will 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 contacts of CLHIV (0-17 years old), including parents, siblings, sexual contacts and children of ALHIV;
 - 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 6 weeks postpartum, case workers will visit parent to encourage them to bring infant to facility for testing.
 - At 8 weeks postpartum, case workers will collect EID dried blood spot (DBS) sample at home;
 - Systematically implement screening tools in out-patient departments (e.g., malnutrition clinics), under five services, and OVC testing;
 - Focus on family tree index testing;
 - Assign newly identified patients living with HIV to OVC case managers to assist with disclosure counseling, partner notification services, and index testing; and
- Use monthly case conferencing between clinical coordinator and OVC case managers to monitor testing coverage.

Factors leading to poor continuity on treatment

- Insufficient adherence counseling
- Insufficient treatment interruption tracking
- Fear of stigma from family and community
- Unwelcoming patient care for some populations: KP, youth, men
- Professional/cross-border mobility: KPs, miners, itinerant traders
- Influence of some churches promoting miraculous healing

Strategies to address poor continuity on treatment

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

4.2 Ensuring viral suppression and ART continuity

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

- Linkage & Adherence Support: Peer Navigators/Educators/Community Case Managers/Mentor-Mothers will support linkage, treatment readiness, and adherence; and immediate initiation of ART. Messaging about treatment will be patient-centered, with consideration of patients' current needs and experiences; empowerment through ease of care, spaced visits, and easier treatment; and U=U.
- Improved Tracking & Reminder System: Use of Tier.net and appointment calendars to track clients due for appointments or viral load testing; and use of phone calls/SMS for visit reminders.

- Patient-centered distribution models: such as differentiated care and MMD; Fast track refills at facilities; PODIs to decongest high volume sites; and community adherence groups/support groups.
- Use of TLD as the preferred first line regimen for both adults and children as appropriate: Will reinforce the therapeutic education and update ART adherence messages.
- VL Coverage and monitoring: Scaling-up VL Coverage by providing educational materials for children and adolescents, enhancing site monitoring using the VL scorecard and VL implementation monitoring guide, tracking performance through use of the weekly VL tracker, and reinforcing the support and tracking of unsuppressed VL clients.
- The diagnostic network optimization process: the utilization of GeneXpert 4 modules in Kinshasa and the procurement of higher module GeneXpert (16-module) through PEPFAR all-inclusive pricing in Haut-Katanga and Lualaba will help clinical partners using these POC technologies to rapidly provide services to clients. The regular follow up of demand creation and results return to the facilities with the viral load tracker with community involvement will facilitate the viral load coverage improvement.
- Package for Advanced Disease: CD4 and TB lipoaribmannan (LAM) testing for acutely ill patients at HIV diagnosis; integrated TB/HIV care and treatment for Cryptococcus meningitis. This package will be implemented in all PEPFAR provinces in close collaboration with the TB program and will be supported by referral hospitals where patients with more complicated opportunistic infections will be referred.
- System/Partner Level Support: Granular site management will be conducted with monthly/quarterly reporting and analysis of reports (Tier.net and SIMS dashboard) to identify performance gaps and develop and institute remediation plans.

In addition to these activities, it will be important to ensure that data being used for program monitoring is accurate and up to date. Of particular interest is an accurate accounting of the numbers currently on ART. Increased efforts during site visits will be paid to the accuracy of this critical number, and if issues in data collection, analysis, or reporting are identified, teams will engage with the national systems to correct and remediate as required.

Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21

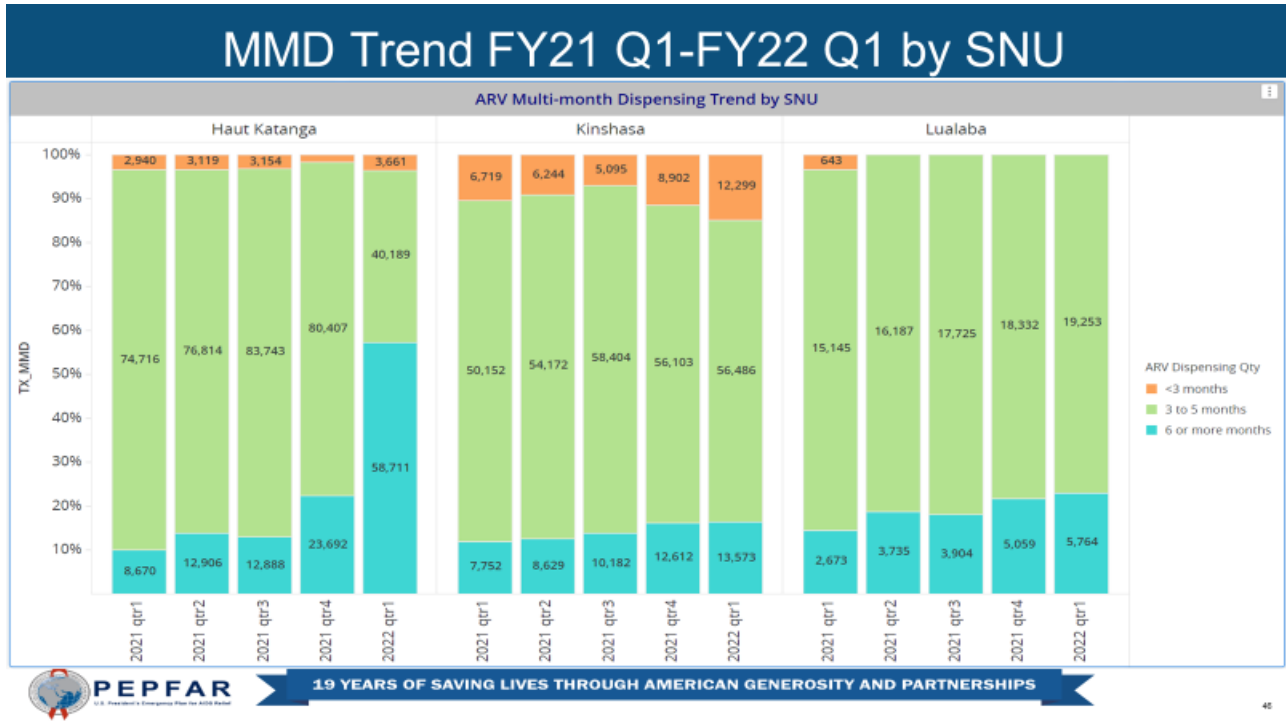
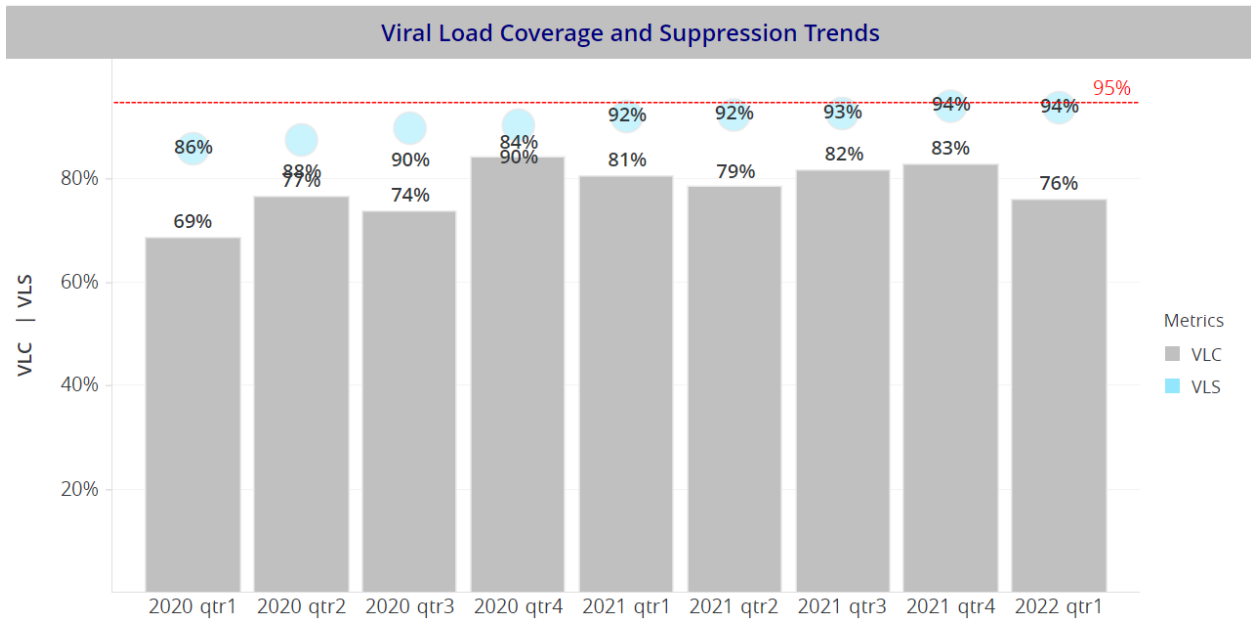


Figure 4.2.2 Viral Load Coverage and Suppression, FY21



4.3 Prevention, specifically detailing programs for priority programming:

a. Testing

PEPFAR/DRC's HTS programs will increasingly focus efforts 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 Self Testing to high-risk sub populations (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 sero-discordant 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.

b. OVC

UNAIDS estimates that there are 440,000 orphans who have lost one or both parents due to HIV in the DRC (UNAIDS 2020). 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 71,000 children 0-14 years of age are living with HIV in the DRC (UNAIDS, 2020). 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) who have an unknown or missing HIV status
- Increase the proportion of HIV exposed infants (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 Mentor Mothers (MM) and OVC to ensure that all infants receive timely EID and are tracked until 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)

In FY23, 67,942 OVC and their families affected by HIV are expected to receive services and 13,555 OVC are expected to leave the program after graduation. An estimated 54,387 will remain active at the end of the fiscal year. During FY22, 100 percent of HIV-positive OVC under 18 were either enrolled or already on ART. The 3,469 OVCs without a known HIV status were not tested based on results from the required administration of the HIV screening tool.

PEPFAR/DRC is currently providing a comprehensive package of services including health, economic strengthening, and safety and education programs to ensure OVC and their families are healthy, educated, stable, and safe. Once an OVC is deemed to meet these measures and is considered resilient, they graduate from the program.

In FY23, the PEPFAR/DRC OVC case management approach will continue to prioritize enrollment of:

- HIV exposed infants, children and adolescents newly enrolled on ART;
- Children and adolescents failing ART;
- Children of adults living with HIV, especially those with unsuppressed VL;
- Children of female sex workers through a clinical entry point; and
- Orphans (due to HIV), and
- HIV High risk adolescents, especially girls

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, children living with HIV, and vulnerable children are met at both the clinical and community level. The strategy will focus on: the systematic use of a risk assessment tool and family tree with fidelity across partners; reinforcing bi-directional referral systems and tracking; strengthening family disclosure support; expanding HIV case conferencing to all health zones; and improving child outcomes

through comprehensive, layered services to maximize contribution to 95-95-95; as well as prevent and reduce HIV risk among OVC targeted sub-populations. The reduction of the number of children for whom their HIV status is unknown will be accomplished by applying a harmonized, mutually reinforcing strategy for timely and positive disclosure. FY23 will continue to see an increase of comprehensive service delivery, increased intervention coverage (e.g., adolescent girl school support, secondary transition and progression) and improved service quality.

To improve the performance of implementing partners in an ongoing and timely manner, the PEPFAR/DRC OVC Technical Working Group (TWG) will ensure case management training, implementation of quality standards and strong M&E systems such as implementing partner (IP) quarterly performance review meetings, data quality assessments, and community-led monitoring in order to routinely analyze program data and suggest corrective actions for continuous quality improvement and high performance across all agencies and partners. Intensifying mentorship, supervision, and support at new and lower performing community sites will continue to be an area of focus in FY23.

c. Primary prevention of HIV and sexual violence among 9-14-year-olds

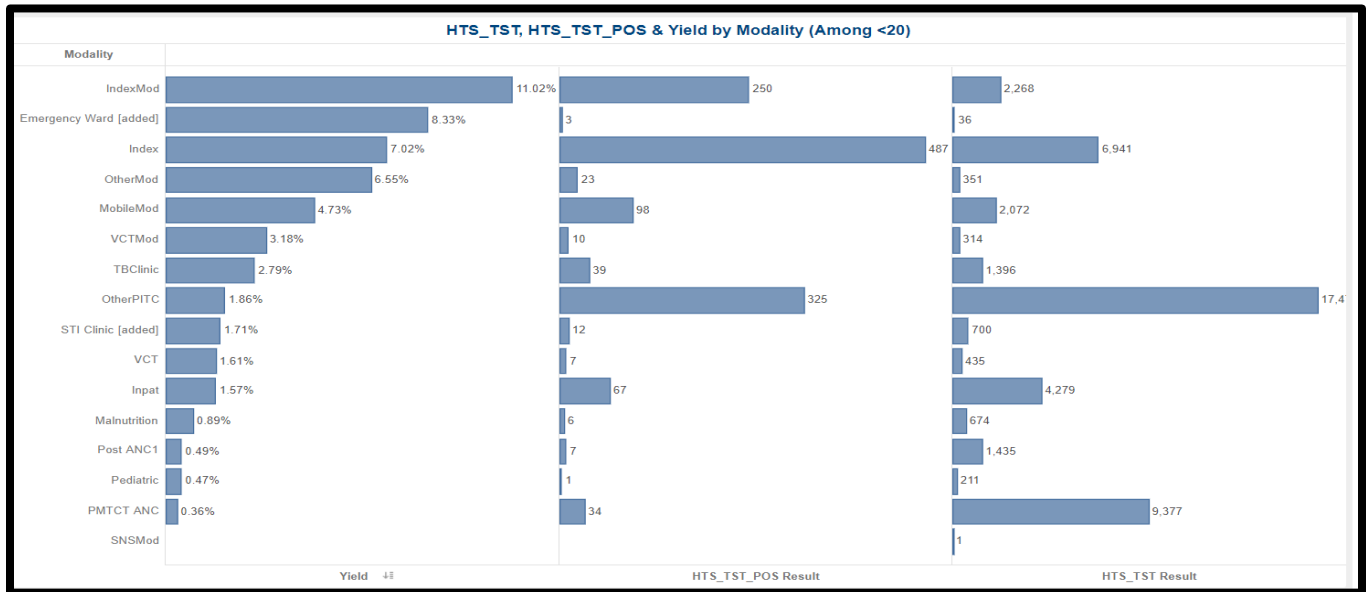
PEPFAR/DRC will continue to support youth 9-14 years of age with sexual risk avoidance programming that focuses on helping them to prevent sexual violence and any form of coercive/non-consensual sex, and on enabling communities and families to support and educate these youths.

d. Children / PMTCT

d.1. Children

The number of children receiving ART nationwide has increased by 51 percent between 2016 and 2020, with children under 15 years old accounting for approximately 5.8 percent of the total of number of people on ART in 2020. However, national data shows that pediatric ART coverage is still proportionately lower at 32.34 percent compared to 84.90 percent adult coverage in DRC (PNLS, 2021). In PEPFAR supported areas, the pediatric cascade has improved in some areas but still needs strengthening – HTS_TST (79%), HTS_TST_POS (89%), low TX_CURR (65%), and VLC (77%) – which is lowest in children 1-9 years of age. Figure 4.3.2.1 below shows a good testing yield for index testing and the use of risk screening with the PITC modality. Nevertheless, pediatric case identification is one of the areas of low performance and negatively impacting the pediatric cascade in DRC. We recognize that the current age of consent for testing (18 years) remains an obstacle, and we continue to advocate for a testing-enabling environment for improved adolescent access.

Figure 4.3.2.1: HTS_TST, HTS_TST_POS & Yield by Modality among <20 (FY22 Q1)



Another persistent challenge is access to VL testing. In FY22 quarter one (Q1), most of the pediatric age-bands have improved VL suppression to around 91 percent. However, VL coverage is still lagging, which is multifactorial; blood sample collection issues (phlebotomy supplies, pediatric-sized vials, etc.) clinic-lab interface with a long turnaround time, POC VL low coverage and economic hardship of caregivers influencing adherence and the continuity of treatment.

Figure 4.3.1.: Pediatric Trends in VL Coverage & Suppression by Age-bands (FY22Q1)

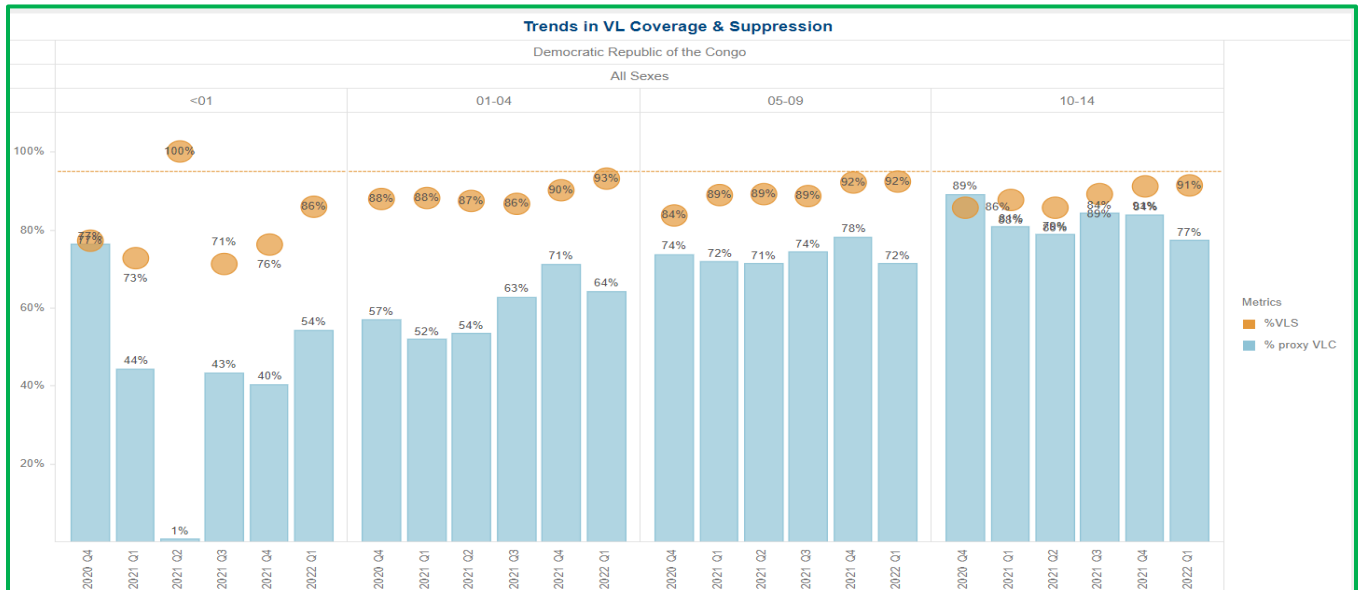
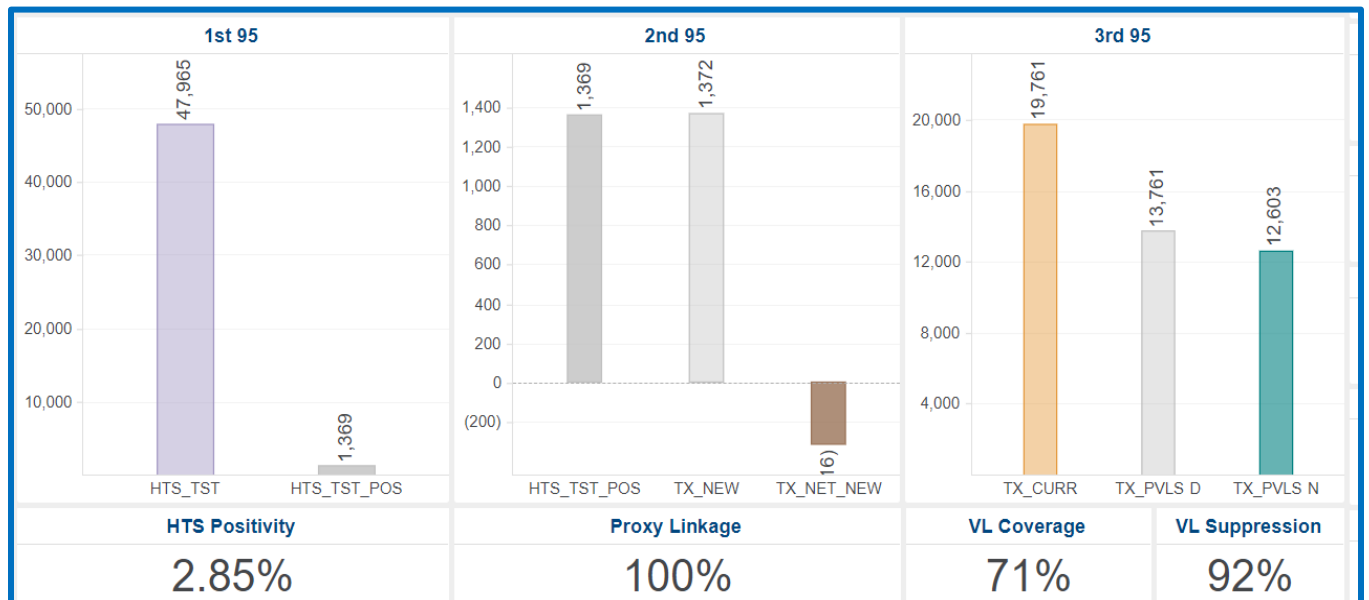


Figure 4.3.2.: Pediatric and Adolescent Clinical Cascade FY21Q1



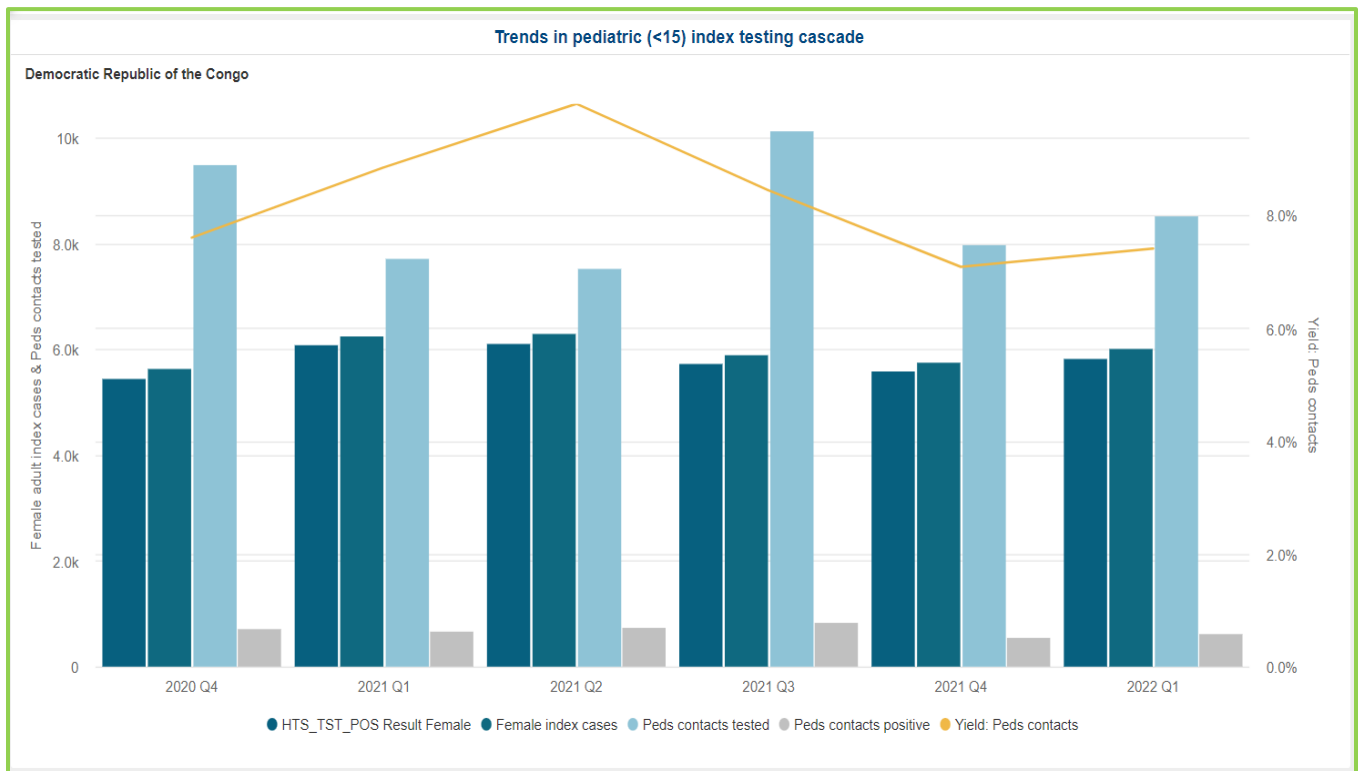
In addition to expanding ART (including the inclusion of children in differentiated service delivery models), expanding VL testing coverage, increasing Nutrition Assessment Counselors, and improving TB screening, a key priority will be to increase systematic and routine HIV testing of all children, especially:

- Family tree/index testing (completeness of family trees of adults living with HIV);
- Children in inpatient settings;

- OVC identified through a screening tool;
- Malnourished children;
- Caregiver assisted self-testing;
- Self-testing for adolescents;
- Children with TB or suspected TB; and
- Outpatients identified through a screening tool.

Even though we have noticed promising results in scaling up index testing of biological children of female PLHIV (Figure 4.3.2.4). During FY23, we will expand testing in outpatient departments, malnutrition and TB clinics, and inpatient departments and document coverage of testing in key entry points at selected sites as shown in Figure 4.3.2.5.

Figure 4.3.3.: Trends in pediatric (<15) index testing cascade FY20Q4-FY22Q1

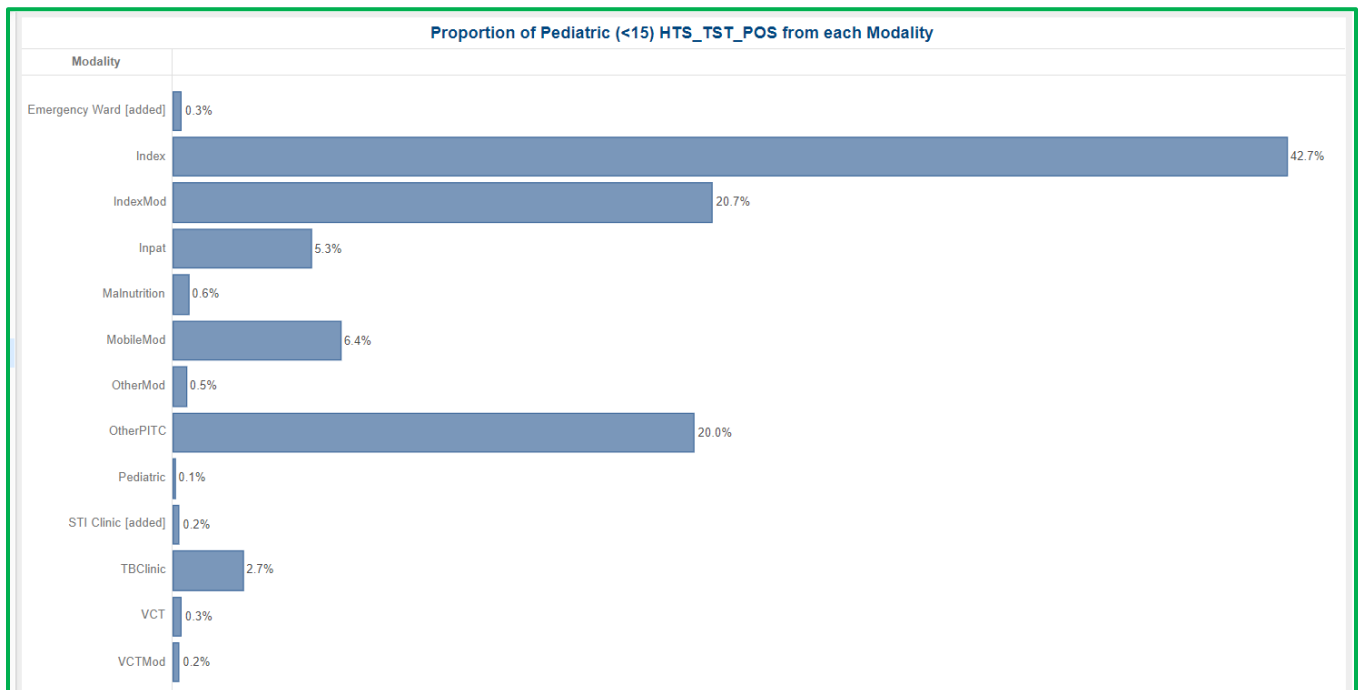


Furthermore, in COP22, OVC partners will continue to strengthen linkages between OVC, PMTCT, and pediatric programs and the adolescent continuum of care through a comprehensive and high-quality service package for OVC via a family-centered, HIV-inclusive case management system prioritizing children of 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 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 CBO's, and Teen clubs to gather input to improve service provision, and support educational outreach efforts with the community.

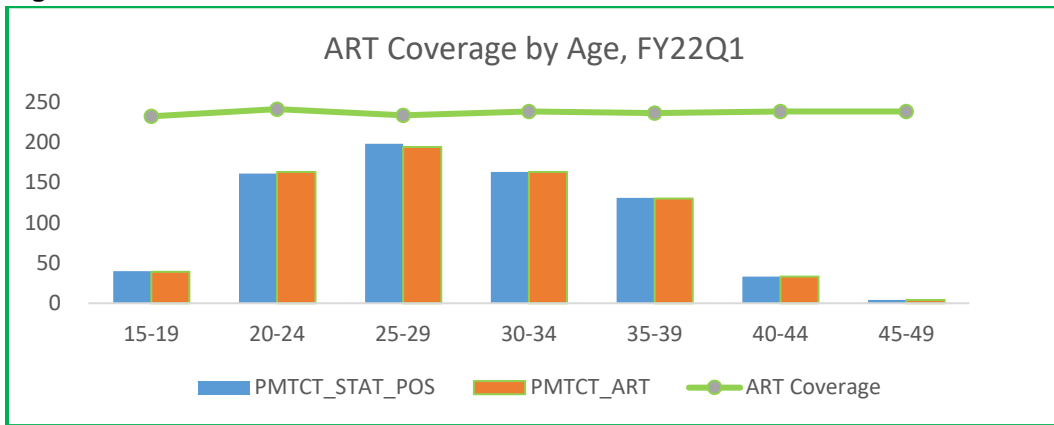
Figure 4.3.4.: FY22 Q1 Proportion of Pediatric (<15) HTS_TST_POS from each modality



d.2. PMTCT

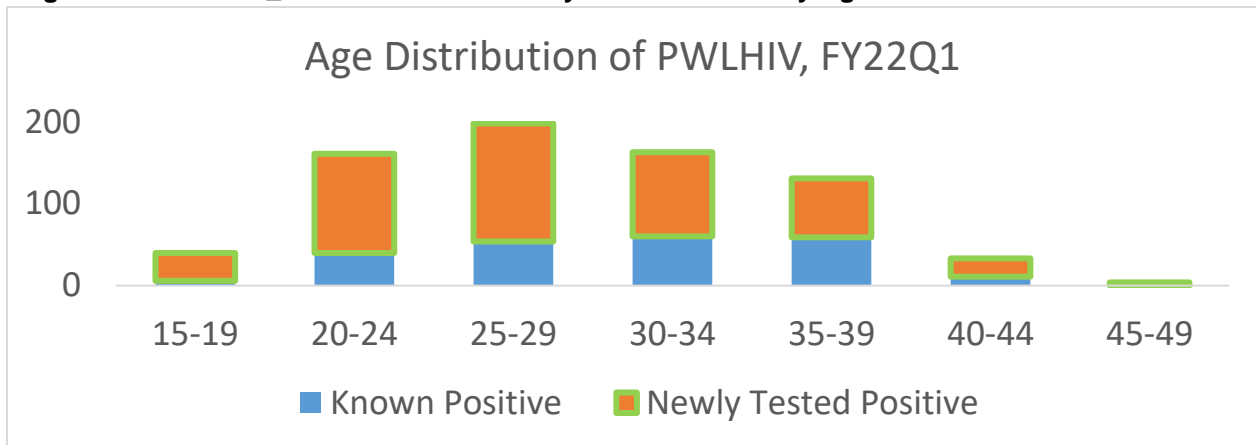
In the PEPFAR/DRC program, more than 99 percent of all women presenting at ANC1 know their HIV status, more than 99 percent of WLHIV at ANC1 are on ART with ART coverage consistently high across all age bands. PMTCT_STAT exceeded the target for FY21.

Figure 4.3.5 PMTCT Cascade

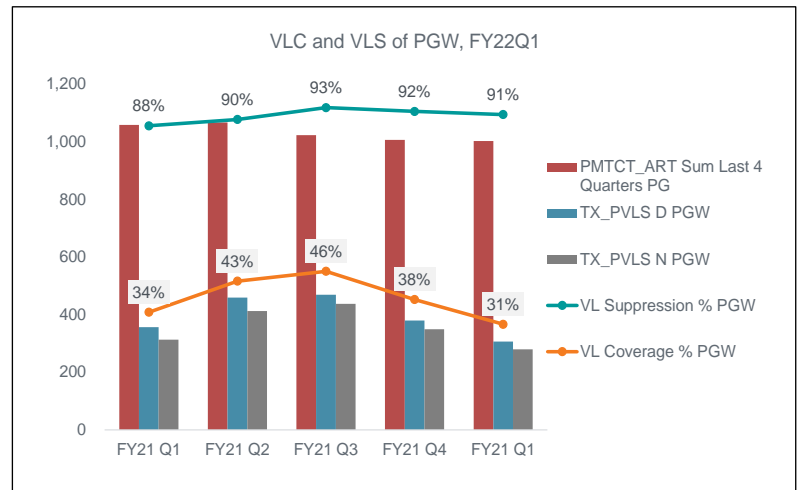
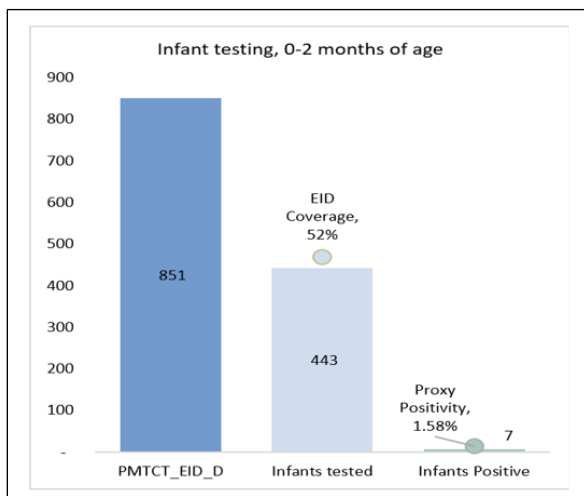


However, 68 percent of women with HIV at ANC₁ were newly tested positive in FY21, with a higher proportion of newly testing positive among AGYW.

Figure 4.3.6 PMTCT_POS: Known and newly tested Positive by Age



The EID 2-month coverage is 52 percent and VLC 31 percent in FY22 Q1, with lowest VLC performance in Kinshasa and the Military program.



COP22 Strategies to close the gap across the Pediatric Cascade and PMTCT

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 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 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 viral load testing

Scale-up existing strategies

- Enhanced case management and continuity of treatment services, including referral to OVC, for pregnant women newly identified with HIV who may be at risk for interruptions in treatment
- Expand 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 use of PrEP in PBFW populations
- Point-of-care EID machines scale up in selected sites
- Leverage Mentor Mothers, OVC, and CLM structures to expand retention activities

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

PEPFAR/DRC has considered country-specific priorities listed in the planning letter to improve program results and reach ambitious COP22 targets.

4.4.1. Improve 2-month EID coverage

In FY21 Q4, PEPFAR DRC showed a weak EID 2-month coverage (72 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 FY23, 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.

4.4.2. 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 COP22, PEPFAR DRC intends to increase the VLC to 100 percent across all populations, ages, and sexes.

In FY23, PEPFAR DRC will continue to strengthen 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);

Strategies to improve viral load suppression

- Ensure completion of the Unsuppressed Viral Load Tool for sites with low viral suppression to reduce leaks in the cascade.
- Utilize results from Viral Load Implementation Monitoring and High Viral Load Register to ensure patients stay in the VL cascade.
- Continue the implementation of point of care VL for PBF women using existing GeneXpert machines.
- Ensure the impact of optimized ARV regimens on VLS for all age groups, including TLD and second line.

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 in a timely manner to clinical sites and patients. Furthermore, laboratories are proactively following up to ensure and document that results collected or transmitted from the laboratories have arrived at the referring clinics for prompt action by the service provider. Also, laboratory visits have revealed that some technicians prefer to process plasma/serum samples compared to DBS for perceived ease with the former. 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 has 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.

4.4.3. Strengthen the pediatric cascade

The PEPFAR/DRC pediatric cascade has improved in some areas but still needs strengthening. In FY21 Q4, the pediatric cascade was as follows: HTS_TST (79%), HTS_TST_POS (89%), low TX_CURR (65%), and low VLC (77%) – which is lowest in children 1-9 years of age.

Improving case finding through robust pediatric testing strategies for populations by age and sex specifically and OVC integration are key to close the gaps in reaching the pediatrics 1st 95.

The transition to Dolutegravir containing regimens in collaboration with the MOH will allow all infected children who weigh more than three kilograms and for those less than 20 kgs to benefit from Dolutegravir optimized regimen. The utilization of the advanced disease package of care will indubitably contribute to reduce mortality among pediatric clients. PEPFAR/DRC will be looking deeper into pediatric age bands to tailor targeted interventions to improve VLC and VLS of children, especially in the younger age bands.

Strategies to improve the pediatric cascade

Improve case finding of A/CLHIV:

In the facility:

- Continue the index testing by using the case elicitation tracker
- Extend the testing focus to other modalities
- Update the HIV risk screening tool to improve outpatient testing efficiency

In the community:

- Continue to leverage OVCP to improve community testing
- Expanding caregiver assisted HIVST for children of index clients and KPs
- Targeting community HIVST for adolescents, and demand creation for HIV testing
- Assess and improve the coverage of index testing for children and adolescents

Improve the Linkage/Retention in Treatment for A/CLHIV

- Improve the linkage from 97% to 100%
- Expand the HIV advanced disease package to reduce HIV related mortality
- Support the differentiated Service Delivery Model & 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 OVCP (>90%)

Improve VLS/VLC for A/CLHIV on Treatment

In the facility:

- Continue the index testing: based on family tree data (weekly tracking tool)
- Extend the testing focus to other modalities than index testing
- Update the HIV risk screening tool to improve outpatient testing efficiency

In the community:

- Continue to leverage OVC platform to improve community testing
- Expand caregiver assisted HIVST for children of index clients and KPs
- Targeted community HIVST for adolescents, and demand creation for HIV testing
- Assess and improve the coverage of index testing for children and adolescents

4.4.4. 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 FY23, PEPFAR/DRC will strengthen the identification of WLHIV through other 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 has developed an Accelerating Progress in Pediatrics/PMTCT (AP3) proposal 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.

4.4.5. KP programming

In COP 2022, DRC/PEPFAR will continue to scale up PrEP with a focus 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) in order to reinforce ART initiation, tracking, adherence, retention and access to ViL.

Community-led monitoring will routinely monitor clients' satisfaction with HIV services and documents health providers' perspectives that may affect client experience (of violence, stigma, and discrimination). Community-led Monitoring 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 vectors (e.g., transport/migration corridors, hard-to-reach at risk pops).

Strategies to maintain /scale up in FY23

KP differentiated service delivery models

- KP-specific structures drop-in centers (DICs)
- Community ART distribution
- Extending or adapting service hours
- ARV multi-month dispensing
- Community based viral load sample collection
- Engaging KP-led and KP-competent organizations

Prevention interventions for Key Populations

- HIV testing, PrEP, post exposure prophylaxis (PEP), 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, self-testing, social media, and use of the ICT platforms

Care and treatment

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

4.4.6. Scale up 6+ multi-month dispensing (MMD) for adults and children

MMD coverage among the adult population continues to grow but DRC struggles to scale for pediatrics. In DRC, the MMD policy was formally adopted (with COVID-19) and national guidelines have been updated to reflect the same. The adoption and implementation of MMD are critical to improve ART coverage and continuity for different demographic and risk groups.

However, the six-month MMD coverage remains stagnant especially for children in PEPFAR/DRC supported sites. COP22 commodity planning has significantly increased the availability of six-months packs for adults and children.

The main barriers to scale up MMD-6 for children are: provider hesitancy, mother-baby pair refill appointments, caregivers/patient literacy and misinterpretation of existing guidelines.

PEPFAR/DRC is working with health providers and the PNLs to mitigate challenges and barriers by developing additional tools, such as standard operating procedures, and mentoring approaches to increase MMD-6 months for all populations including children.

4.4.8. PreP expansion

In FY21 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 FY23, PrEP interventions will continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP will include sex workers, men who have sex with men, transgender people, people in prisons and, adolescent girls and young women including those pregnant and breastfeeding, and other identified higher-incidence populations.

PEPFAR/DRC will expand PrEP at facility/community entry points and strengthen linkage between testing and other prevention services. PEPFAR/DRC will ensure direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (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 FY23 and will be closely monitored to avoid any stock-outs.

4.4.9. Expand HIV Advanced disease package

In FY23, 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 will strengthen the integration of the advanced disease package of care into clinical sites with the highest burden of HIV related morbidity and mortality. Implementing partners will constantly analyze their sites and establish in which sites to implement advance HIV disease package. Support will include an agreed-upon list of diagnostics and therapeutics including those for tuberculosis and cryptococcal meningitis.

To achieve optimal CD4 testing, PEPFAR/DRC IPs including the PNLS and the Network of People living with HIV/AIDS (UCOP+) at the provincial level will review the access of CD4 testing services to support facilities' HIV care and treatment.

The 'hub and spoke' approach with the defined package will be maintained in alignment with the GDRC health system which confers to general reference hospitals, an extended package of services while health centers offer the basic package of services. On quarterly basis, PEPFAR implementing partners (IPs) will meet with the civil society organizations under the leadership of the PNLS to discuss lessons learned and to develop mitigation plans.

Proposed 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)	ARVs, Cotrimoxazole, TB treatment, Fluconazole+ Amphotericin

4.4.10. Improve TB screening coverage and maintain high TPT completion rates

In FY21Q4, PEPFAR/DRC TB screening for patients already on ART has shown that only 1.6 percent screened positive which was below the expected positivity rate. In FY23, PEPFAR/DRC will ensure that all eligible ART patients are screened to avoid missing patients with TB. The revision of tools used by the IPs will be assessed and monthly monitoring of achievements will be conducted in all supported sites. Among the weaknesses noted at the implementation level, is the lack of an appointed person in charge of TB at the IP level. This major issue will be corrected in FY23.

The TPT transition (INH to 3HP) is currently being rolled-out. Many sites have already started with the short-course combination regimen (3HP). According to patients who started 3HP, the acceptability is excellent. The short length of the preventive therapy will improve the completion rate. The main barrier is still the availability of the product at the site level due to market constraints. In conjunction with the PNLS and the Global Fund, PEPFAR/DRC will monitor any issues that will impede the transition and when needed, apply alternative approaches.

4.4.11. Intensify supply chain support for provincial/site level monitoring of stock

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 service. 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.

In FY23, the coordination between the IPs and clinics will be strengthened to improve the completeness of data going into DHIS2 to inform the commodity visualization platform, InfoMed, adopted by the GDRC.

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

4.4.12. Coordinate with GDRC and Global Fund

Coordinating with GDRC and 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 COP 22, PEPFAR/DRC will strategically optimize its collaboration with the Global Fund and other national donors/stakeholders (National TB program, PNLs, CHAI) to mitigate stock-outs and overstock situations through a Memorandum of Understanding regulating the loan, reimbursement, and donation of commodities in order to avoid any service disruption.

4.4 Additional Program Priorities

In addition to the priorities listed above, the PEPFAR/DRC program will also focus on the following areas.

4.5.1 User Fees

PEPFAR/DRC is working with different stakeholders to eliminate all formal and informal user fees in the public sector to improve access to direct HIV and related (ANC, TB) services which affect access to HIV testing, treatment, and prevention. In DRC, there are no user fees for HIV direct services, but there are nominal fees to enroll in the general health care system. The GDRC has announced a plan to provide free ANC services to HIV positive women as part of their move towards universal health care. PEPFAR/DRC will continue to monitor fees and the barriers to access for HIV services which they represent, by engaging civil society through the CLM program to hold facilities and community sites accountable to elimination of all forms of user fees as well as ensure the information from civil society is acted upon.

4.5.2 Unique Identifiers

The GDRC has put in place the “Ministere de Numerique” who 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 monitor progress for unique identifier development and will provide technical assistance when needed. The program will identify policy constraints for which we can advocate, ensuring that any hurdles that need diplomatic/government attention are identified and addressed.

4.5.3 Military

In FY23, 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 FARDC personnel, 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 continue to promote consistent and correct use of condoms as well as PrEP uptake through education and provision of sufficient supplies (male and female condoms and PrEP kits) for the FARDC personnel and other at high-risk populations from military settings.

The key priorities for the military clinical program funded by PEPFAR/DOD in FY23 will be:

- 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.

The above described prevention and clinical activities were designed based on behavioral and prevalence information generated by a survey conducted within the FARDC in 2013-2014 and military programmatic data. In FY23, DOD will work with the FARDC to prepare a new survey to be implemented in COP23 to collect up-to-date data that will be used to properly evaluate the impact of the current portfolio and inform future programming.

4.5.4 Cross-border Activities

In COP 22, we will continue with Zambia/DRC key population cross-border activities to ensure a continuum of prevention, care and treatment of KPs on both sides of the border. The KP cross-border program will be extended to two Health Zones in Lualaba province (Dilolo and Kasaji) along the Angola border.

In addition to KP cross-border activities, the PEPFAR/DRC program will set up custom indicators that will be collected by all PSNUs along Angola and Zambia borders to better understand the epidemic in Lualaba and Haut-Katanga provinces and follow the movement of populations those areas.

Regular meetings will be organized between Angola/DRC and Zambia/DRC to harmonize M&E tools and ART protocols ensure a continuum of prevention, care and treatment of populations on both sides of the borders under the leadership of the respective Ministries of Health (Angola, DRC and Zambia).

4.6 Commodities

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

Efforts are currently underway and will continue in COP22 to reinforce stock management, ARV optimization and patient centered services, in addition to strong coordination and data-based management of the PEPFAR and Global Fund stock to ensure the national supply chain for HIV commodities is functioning well.

In COP22, PEPFAR/DRC plans to procure commodities to support the full implementation of the HIV program in the three supported provinces including ARVs, RTKs, lab reagents and other commodities without any anticipated gaps. Risk of stock-outs will be mitigated through close collaboration with the Global Fund in terms of loans and reimbursements of products. In addition, PEPFAR/DRC will continue to incorporate internal processes to mitigate stock-outs, such as the close monitoring of last mile deliveries with the partner, the replenishment and sustainability of the buffer stock across commodity types, the reallocation of products from one site to another and the early procurement of COP22 orders to minimized lead time.

PEPFAR/DRC priorities for commodities are: 1) ensuring timely customs clearance; 2) end-to-end data use to improve visibility, transparency, and accountability of HIV commodities; 3) strengthening last mile distribution and patient-driven approaches; 4) increasing MMD for adults and children by placing 30 percent on 3-month packs and 70 percent on 6-month packs; 5) monitoring pediatric post DTG 10 mg transition for children under 20kg; 6) completing the optimized TB prophylaxis (3HP) in PEPFAR-supported health zones; and 7) ensuring the smooth transition, without any interruption of services, from the current supply chain system to the next.

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 COP22, PEPFAR will continue to procure 90 and 180-count TLD as the main first line regimen, 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 and the TLE regimen will not be procured except for specific cases. As the transition to DTG 10 mgs will be completed by June 2022, PEPFAR/DRC will monitor for possible Dolutegravir side effects and procure orders of 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 kgs.
- **Procure 50 mg single dose for co-infected patients (TB/HIV)**
- **Continue to optimize pediatric ART regimens per PEPFAR guidance.** In COP22, PEPFAR/DRC will complete the ARV optimization with the introduction of DTG 10 mg for children weighing less than 20 kgs for pediatric patients in FY22 Q2. In COP22, PEPFAR/DRC will continue to monitor sites to ensure that pediatric patients are on optimized regimens. 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.
- Support, through adequate quantification, forecasting, procurement, and distribution of commodities related to the expansion of new initiatives such as PrEP, TPT, AHD and self-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 COP22 testing targets, including Oraquick tests for self-testing and ASANTE tests to determine recent HIV infection.
- 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.
- **To conduct an accurate forecasting for COP22 commodities** to mitigate shortage of essential products, teams have taken into considerations patient months of treatment, multi-month dispensing, buffer stock, expiry, warehousing and distribution chain, lead time for delivery to country and delivery to point of service, eventual stock-outs, and other influences on the ART supply chain during the planning process. PEPFAR/DRC will continue to advocate for more engagement of the host country in the mobilization of

domestic resources to support HIV commodities in order to cover existing and future gaps in ARV provision, HIV rapid tests and VL/EID testing.

- In COP21, PEPFAR/DRC saw significant improvement in the commodity customs clearance processes, with certain commodities seeing a reduction from six months to as low as two months or less. PEPFAR/DRC will continue to work in collaboration with the GDRC, the Global Fund and other donors to reduce the lead time to get products through customs clearance and in country efficiently. Customs clearance remains a top priority for PEPFAR. In COP22, PEPFAR/DRC will continue to engage with the GDRC to reduce the customs clearance steps and time.
- Provide technical support to the MOH in planning, operationalizing, and monitoring the implementation of the national supply chain strategic plan; assist technically the GDRC supply chain working groups to conduct the quantification of HIV commodities including ARVs and laboratory reagents, and to develop a related annual supply plan (refresher training on the use of Forlab, pipeline and Quantimed tools). PEPFAR will continue to promote capacity building to better manage supply chain sector in the DRC.
- Strengthen the collection, management, and use of supply chain data to enhance transparency and accountability of HIV commodities. Data will be used to improve stock visibility and management at the facility level and increase visibility and rational use at the point of service. PEPFAR/DRC will monitor stock status at the provincial and site levels and provide mentoring and coaching in stock management on a quarterly basis including regular review and necessary updates of the ARV supply plan, with a focus on improving data quality, completeness, and usage.
- Ensure that the information system (LMIS) is operational, and that data collection takes place at all levels and ensure that data collected is 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, a quality assurance process is implemented, and results are shared through the technical working group and in the inter-agency space and are used at all levels for decision making.
- Continue to support the collection of PPMR data, as well as supply chain MER indicators and provide technical support to analyze logistics data and triangulate it with clinical data to better understand and address supply chain challenges. The improvement of supply chain visibility will include enhanced technical support to warehousing, logistics management, and provision of management tools in all PEPFAR-supported health zones.
- Continue to strengthen the forecasting and procurement of VL/EID lab commodities and close monitoring to mitigate gaps and to optimized availability of lab reagents for all existing and future platforms (Abbott, Roche, Cepheid).
- 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.

- Reinforce national and provincial coordination of HIV commodity management. PEPFAR/DRC, through USAID, will continue to participate into the health donors supply chain group and the National Medicines Commission with the National Pharmaceutical Regulatory Authority. This will help to strengthen donor collaboration, to mitigate gaps and improve GDRC leadership, oversight and accountability on health commodity forecasting and procurement system management.
- Continue to provide technical assistance to the MOH, the Global Fund, and other implementing partners for TLD pharmacovigilance data collection roll out, analysis and use.
- Provide RTKs to support HIV testing in all PEPFAR-support health zones and provide technical support to IP and health providers for the best management of RTKs at health zone and site levels.
- PEPFAR/DRC will continue to support the MOH in the reintroduction of a third HIV test in the algorithm. This new rapid test will be procured to align the program with the DRC guidelines.

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 in order to improve their ability to reach 95 percent VL coverage by the end of FY22 and 100 percent coverage in FY23. In COP 22, PEPFAR/DRC will continue to strategically integrate the use of GeneXpert for VL/EID testing in collaboration with the National TB program, especially to cover remote areas.

To improve PNLs coordination and sharing lab reagent 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 to that, PEPFAR will work in network with other donors, the Global Fund, and CHAI as well as supply chain IPs and lab colleagues to harmonize pricing model for lab reagents. PEPFAR will collaborate with the Global Fund and the GDRC to develop a common strategy to support the national scale-up of laboratory monitoring of HIV (programmatic; financing; procurement.)

In COP22, efforts to mitigate any effects of the COVID 19 pandemic on supply chain management will be done to maintain continuity of HIV treatment and prevention services through the delivery of ART to both clinics and community level. PEPFAR/DRC will support the provision of commodities in differential models of care, including PODI and private pharmacies, and will reinforce multi-month dispensing of ART, especially six month packs, including PrEP, to make delivery of medication more convenient and decentralized.

As the DRC is promoting the development of local entities, PEPFAR will work in alignment with DRC USG supply chain regulations to procure locally some essential medicine such as cotrimoxazole and metronidazole. Finally, in COP22, PEPFAR will continue to support advocacy efforts to increase domestic funding to support the procurement of ARVs and other HIV commodities.

4.7 Collaboration, Integration and Monitoring

In FY23, PEPFAR/DRC will strengthen collaboration across agencies, and external stakeholders especially with the Global Fund and the Ministry of Health. As discussed during the COP22 retreat 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.

PEPFAR/DRC is engaged to advance good health and epidemic control in conjunction with stakeholders. To that end, collaboration with the MOH will foster filling policy gaps, support the country PLHIV estimates process, and ensure continuous quality improvement of interventions.

PEPFAR/DRC intends to intensify collaboration with the Global Fund especially on supply chain where there continues to be a need to leverage interventions to avoid service disruptions. The Global Fund has expressed a willingness to learn from PEPFAR's package of interventions. In FY23, under the leadership of the PNLS, joint site visits will be planned and technical discussions will be held on quarterly basis.

In addition, PEPFAR/DRC will strengthen collaboration with Médecins Sans Frontières around specific topics such as Advanced HIV Disease 'Hub and Spoke' approach, management of kidney failure among HIV patients, viral load testing and commodity support in locations where both operate.

PEPAFAR/DRC will continue to hold quarterly implementing partner meetings and will incorporate experience gained during the COVID-19 pandemic which led to the development of alternative approaches to monitor program implementation. PEPFAR/DRC will mix in-person and virtual meetings. During these meetings, implementing partners will present their performance, challenges, and corrective actions taken to guarantee the trajectory towards epidemic control goals. PEPFAR/DRC will also invite civil society organizations engaged in monitoring of the PEPFAR/DRC program to share their findings, and together as team, agree on solutions, and follow-up actions.

PEPFAR/DRC will support continuous quality improvement interventions across the clinical cascade and community services provided to beneficiaries. Implementing partners will be required to share interventions undertaken to improve the quality of services during past quarters. In FY23, PEPFAR/DRC will implement differentiated models of care delivery at both

facility and community levels. As stated in the previous sections of this document, PEPFAR/DRC will continue to support models of service delivery that fit patients' needs, especially for testing and treatment services. Additionally, PEPFAR/DRC will pursue task-sharing to allow community health workers to deliver continued services in accordance with the DRC regulations.

PEPFAR/DRC will formalize community-led monitoring activities under civil society organizations selected in FY22. In COP22, PEPFAR/DRC will intensify meetings with these organizations to share their feedback with implementing partners to improve treatment outcomes and patients' satisfaction with services received at both facility and community level. Quarterly meetings will be preferred to review observations and recommendations with representatives 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 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 improve the clinical cascade. In DRC, the MOH receives support from its partners among which, Global Fund, UNAIDS, WHO, UNICEF, Médecins Sans Frontières and private sector to strengthen key health interventions mentioned above.

In FY23, PEPFAR/DRC will promote the use of human resource for health across technical areas and will work with the MOH for more integration to ensure efficacy and efficiency throughout the clinical cascade. The ratio of human resource for health will be closely monitored and gaps (number, quality) will be discussed and addressed in collaboration with the MOH. PEPFAR/DRC will commit to support laboratory operations and the viral load cascade from sample collection and transport and results return to all supported sites.

4.8 Targets by population

This section presents a summary of FY23 targets.

Entry Streams for ART Enrollment	Tested for HIV (APR FY23) <i>HTS_TST</i>	Newly Identified Positive (APR FY23) <i>HTS_TST_POS</i>	Newly Initiated on ART (APR FY23) <i>TX_NEW</i>
Total Men (>15)	397,832	36,083	35628
Total Women (>15)	607,570	33575	33072
Total Children (<15)	125,160	4,662	4627
Adults	1,005,402	69658	68,700

TB Patients	31,813	916	916
Pregnant Women	239,688	1,701	1,688
VMMC clients	-	-	-
Key populations	43270	4327	4116
Priority Populations			
Other Testing	670,792	44,859	42,523
Previously diagnosed and/or in care	-	-	-
<u>Pediatrics (<15)</u>	125160	4,662	4627
HIV Exposed Infants	4,789	107	107
Other pediatric testing	120,371	4,555	4,520
Previously diagnosed and/or in care	-	-	-

Table 4.8.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY22)	FY22 Target
Key Populations			
MSM	Unknown	Unknown	5,686
FSW	Unknown	Unknown	39,168
Priority Population			
Military	Unknown	Unknown	61,003
Others*	Unknown	Unknown	4,906
TOTAL			110,763

(*) Truckers, Miners, Clients of FSW

Table 4.7.3 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target)	Target # of OVC (FY23 Target)	Target # of active OVC (FY23 Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target)
		OVC_SERV Comprehensive	OVC_SERV Preventative	OVC_SERV DREAMS	OVC*
Military	11,174	3,447	0	0	3,060
Bandalungwa	1,893	582	0	0	500
Binza Meteo	3,379	1,043	0	0	990
Binza Ozone	2,633	812	0	0	756
Bunkeya	1,012	313	0	0	298
Dilala	4,071	1,257	0	0	1,080

Dilolo	1,000	310	0	0	295
Fungurume	4,010	1,238	0	0	1,175
Kafakumba	331	103	0	0	80
Kafubu	2,893	893	0	0	823
Kalamba	331	103	0	0	80
Kamalondo	3,379	1,043	0	0	990
Kambove	865	266	0	0	227
Kampemba	9,248	2,852	0	0	2,453
Kanzenze	666	204	0	0	194
Kapanga	331	103	0	0	80
Kapolowe	5,064	1,562	0	0	1,484
Kasaji	666	204	0	0	194
Kasenga	2,780	855	0	0	735
Kashobwe	1,603	493	0	0	442
Katuba	3,345	1,033	0	0	888
Kenya	10,639	3,278	0	0	2,818
Kikimi	7,080	2,183	0	0	1,878
Kikula	2,118	654	0	0	562
Kilela Balanda	1,614	499	0	0	448
Kilwa	4,519	1,393	0	0	1,277
Kimbanseke	5,557	1,712	0	0	1,471
Kingabwa	7,257	2,238	0	0	1,923
Kingasani	7,901	2,437	0	0	2,095
Kinshasa	2,912	898	0	0	773
Kipushi	4,454	1,374	0	0	1,180
Kisanga	6,705	2,068	0	0	1,778
Kowe	1,614	499	0	0	448
Likasi	3,077	947	0	0	815
Limete	3,310	1,023	0	0	880
Lingwala	1,354	418	0	0	358
Lualaba	3,345	1,033	0	0	980
Lubudi	1,000	310	0	0	295
Lubumbashi	6,438	1,985	0	0	1,705
Lukafu	1,614	499	0	0	448
Manika	4,161	1,283	0	0	1,102
Masina 1	7,295	2,249	0	0	1,934
Masina 2	14,342	4,418	0	0	3,797
Matete	2,021	622	0	0	533
Mitwaba	1,058	326	0	0	200
Mont Ngafula 1	891	274	0	0	234
Mufunga Sampwe	1,577	487	0	0	436
Mumbunda	4,481	1,381	0	0	1,186

Mutshatsha	1,000	310	0	0	295
Ndjili	12,390	3,821	0	0	3,286
Ngaba	2,780	855	0	0	735
Nsele	3,928	1,209	0	0	1,040
Panda	1,667	514	0	0	489
Pweto	3,687	1,138	0	0	976
Ruashi	6,675	2,059	0	0	1,771
Sakania	4,391	1,354	0	0	1,287
Sandoa	331	103	0	0	80
Tshamilemba	4,458	1,375	0	0	1,182
TOTAL	220,315	67,942	-	-	59,519

4.9 Viral Load and Early Infant Diagnosis Optimization

PEPFAR/DRC is facing challenges with reaching some children and pregnant and breastfeeding woman 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 viral load requisition forms for pregnant and breast-feeding women. There are some 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 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, and we will continue to work with the Global Fund to improve equipment maintenance around the country to avoid equipment down-time and accumulation of backlogs. PEPFAR/DRC initiated discussions to obtain GeneXpert 16 modules including pricing to bring services closer to these different targeted populations and allow for the quick release of results. With diagnostic network optimization, we will follow-up at site level on the use of POC machines for specific targeted sub-groups and will ensure integration and alignment with continuous use of conventional machines.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The HIV national landscape, including the recent SID 2021, continues to be characterized by restricted availability of accurate and reliable epidemiologic and health data, which is necessary to reach epidemic control. Program data shows that PEPFAR/DRC primarily missed KPs, children and prevention interventions especially for adolescent girls and young women. EID at two months remained concerning at 10 percent in FY22Q1. The entire pediatric cascade suffered drops which

reflect various shortcomings of the pediatric treatment program. Regardless of population, interruption in treatment represents another challenge although some improvement was noticed in FY21. VL suppression is one of the programmatic areas where PEPFAR/DRC made improvements when comparing FY20 results to previous fiscal years but, in FY21, we noticed a decline.

A poor level of HIV awareness coupled with high stigma and discrimination continue to fuel the epidemic as demonstrated by SIMS findings. This has greatly contributed to low demand and uptake of HIV services in specific subpopulations like KPs and men. SIMS showed excellent scores in supply chain CEEs (availability of cotrimoxazole, RTKs, ARVs, and INH.) MMD is one of the key areas where PEPFAR/DRC is performing well for adults with more than 90 percent of patients receiving MMD but, MMD-6 months for children is struggling. For PEPFAR/DRC, complex customs clearance proceedings have been identified as one of the major impediments to adequate service delivery and efforts are continuing to mitigate this issue.

These findings are also confirmed by SID 2021 that depicted issues of national supply chain forecasting, timely arrival, and distribution to the last mile. In the PEPFAR/DRC space specifically, complex customs clearance proceedings have been identified as one of the major impediments to achieve adequate service delivery.

Investments with site-level approaches synergistically address COP22 strategic priorities. Within the context of a domestically under-funded health sector, key systems interventions tackle weak commodity and logistics management and sub-optimal coverage of viral load facilities. There are also systems activities aimed at improving data collection and analysis, as well as analysis and surveillance which are required to validate results.

The SID 2021 analysis reiterated that the financial contribution from the government is primarily limited to health worker salaries; health workers are vital to the successful implementation of activities. The SID 2021 also recognized the improved efforts of the GDRC in the areas of governance and leadership. This has been demonstrated among others through the prompt adoption and support of the TLD transition. Building on the experience of successful TLD transition, PEPFAR/DRC will continue to work with PNLS for stepwise adoption and updating of pertinent WHO policies.

Under GDRC leadership, PEPFAR/DRC will continue to monitor TLD pharmacovigilance activities as well as an HIV drug resistance study. This adoption and implementation of TLD constituted an important milestone towards improvement of VL suppression in PEPFAR zones. As the supply chain mechanism concurrently strengthens the national forecasting and the ARV/reagents distribution system, improved demand creation for VL, diagnostic network optimization coupled with education and treatment continuity efforts at clinics will help PEPFAR/DRC to reach 100 percent VL coverage in the PEPFAR zones.

PEPFAR/DRC also assessed the unutilized capacity of existing VL/EID laboratories and proposed practical optimization strategies to relevant stakeholders (MSF, the Global Fund, TB program, DREAMS lab and PNLs). PEPFAR/DRC is also leveraging GeneXpert machines to increase TB diagnosis among PLHIV, as well as increase coverage for EID in strategically placed locations in assigned zones.

PEPFAR/DRC continues to work with the Global Fund and the PNLs to set up a repository system for warehousing HIV data. PEPFAR/DRC has already initiated an intensive data exchange in order to better understand the HIV epidemic in Kinshasa, including a recency testing rollout which is now extended to Haut Katanga and Lualaba province. PEPFAR is also keenly involved in PLHIV estimates through SPECTRUM modeling.

Drawing from lessons learned from the “Observatoire”, a Global Funded-funded platform for collecting client-satisfaction indicators, PEPFAR/DRC developed the CLM program for Kinshasa, Haut-Katanga and Lualaba. Using the Department of State’s AQM grant mechanism, PEPFAR/DRC is supporting community-led monitoring activities designed to improve people-centered HIV services at facility and community level.

6.o 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 2023 through the strategy defined in COP22. 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 COP22. 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	27	26	1	-
DOD	2	2	-	-
State	4	4	-	-
USAID	46	19	23	4
TOTAL	79	51	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 COP22.

Below are the current staffing updates by agencies:

- USAID: There are 12 current vacancies in the process of recruitment in FY22: 2 Care and Treatment Specialists, 1 Supply Chain and ARV logistic Specialist, 1 OVC technical specialist, 1 Financial Analyst, 2 M&E Specialists, 1 Laboratory Specialist, 1 Data Quality Specialist, 1 SI Specialist, 1 A&A Specialists, 1 Local Development Specialist, and 1 KP Specialist. The previously vacant Program Assistant has been hired. The Supply Chain Specialist and the Laboratory Specialist positions are in the final stages of the recruitment process: the selected candidates are undergoing security clearance and are expected to start in the near future. The M&E Specialist and KP Specialist positions have been advertised and technical teams are in place to start the evaluation of candidates. The remaining recruitment processes will be implemented through a phased approach with assistance from USAID headquarters.
- Department of State: There are currently two vacancies, the PEPFAR Deputy Coordinator, position and the Strategic Information Advisor, both of which are critical for the smooth running of the office.
- DOD: Fully staffed
- CDC: There are six current vacancies in the process of recruitment in FY22: One data analyst, one care and treatment, one SI officer and one lab advisor. One IT specialist and one cooperative agreement/finance specialist position will be repurposed.

Intensifying partner management remains a focus of COP22, and one aspect of partner performance is SIMS. The PEPFAR/DRC team is planning for 35 staff members to spend an average of 11 days per quarter conducting SIMS visits, to ensure quality and remediation of poorly performing sites. Geographic size, economic and political instability, and limited transportation and infrastructure contribute to a relatively high cost of doing business in the DRC. The COP22 cost of doing business (CODB) request represents the minimal staffing and administrative support.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

SNU	COP	<15		15-19		20-24		25-49		25-29		30-34		35-39		40-49		50+		
		F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Haut-Katanga	COP16	APR 17	56%	46%	24%	92%	50%	53%	32%	NA	NA	NA	NA	NA	NA	NA	NA	NA	51%	46%
	COP17	APR 18	43%	72%	32%	99%	33%	75%	NA	92%	43%	81%	45%	75%	49%	63%	54%	60%	60%	60%
	COP18	APR 19	72%	80%	39%	154%	76%	60%	NA	86%	143%	69%	108%	64%	98%	41%	60%	71%	67%	67%
	COP19	APR 20	90%	110%	49%	214%	97%	NA	NA	121%	181%	96%	138%	89%	124%	57%	76%	98%	84%	84%
	COP20	APR 21	57%	100%	50%	130%	49%	NA	NA	125%	62%	111%	62%	101%	75%	84%	100%	74%	95%	95%
	COP21	APR 22	23%	88%	52%	105%	37%	NA	NA	90%	31%	75%	36%	80%	46%	92%	47%	72%	53%	53%
Kinshasa	COP16	APR 17	29%	15%	12%	18%	6%	21%	10%	NA	NA	NA	NA	NA	NA	NA	NA	25%	24%	24%
	COP17	APR 18	20%	24%	19%	26%	12%	30%	NA	27%	12%	27%	12%	30%	14%	33%	23%	36%	36%	36%
	COP18	APR 19	39%	26%	19%	34%	11%	25%	NA	38%	61%	29%	45%	26%	41%	16%	25%	41%	41%	41%
	COP19	APR 20	45%	36%	23%	48%	14%	NA	NA	53%	77%	39%	56%	35%	50%	19%	27%	55%	50%	50%
	COP20	APR 21	31%	35%	29%	55%	38%	NA	NA	58%	36%	58%	39%	59%	45%	60%	64%	75%	95%	95%
	COP21	APR 22	19%	56%	47%	77%	43%	NA	NA	76%	32%	59%	30%	64%	34%	92%	47%	77%	61%	61%
Lualaba	COP16	APR 17	110%	115%	33%	160%	65%	98%	127%	NA	NA	NA	NA	NA	NA	NA	NA	91%	127%	127%
	COP17	APR 18	89%	186%	56%	288%	67%	155%	NA	211%	165%	178%	213%	139%	200%	127%	214%	112%	204%	204%
	COP18	APR 19	207%	303%	78%	443%	155%	169%	NA	279%	872%	195%	642%	174%	523%	109%	281%	187%	259%	259%
	COP19	APR 20	96%	149%	35%	227%	60%	NA	NA	152%	278%	115%	210%	105%	185%	58%	98%	113%	103%	103%
	COP20	APR 21	42%	87%	25%	111%	27%	NA	NA	80%	45%	79%	58%	67%	58%	65%	68%	65%	71%	71%
	COP21	APR 22	34%	155%	53%	135%	32%	NA	NA	91%	36%	83%	40%	83%	46%	100%	50%	70%	41%	41%

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

Table A.2. ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 80% ART coverage	Target current on ART (APR FY23) TX_CURR	Newly initiated (APR FY23) TX_NEW	ART Coverage (APR 23)
Attained						
Scale-Up Saturation	374,371	206,978	92,519	304,765	73,327	81.4%
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
Total	374,371	206,978	92,519	304,765	73,327	81.4%

APPENDIX B – Budget Profile and Resource Projections

B1. COP 22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

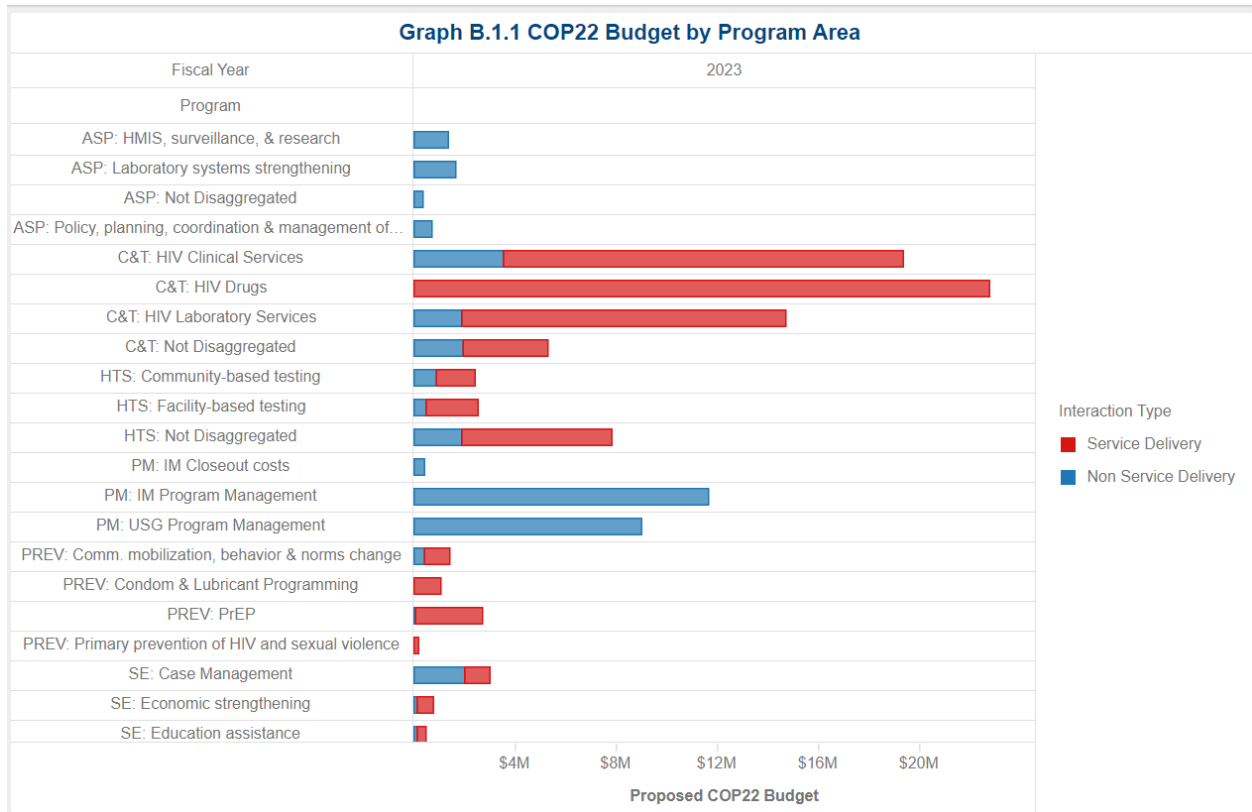


Table B.1.2. COP21 Budget by Program Area

Table B.1.2 COP22 Budget by Program Area							
Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		\$38,953,191	\$73,771,809	\$112,725,000	35%	65%	100%
C&T	Total	\$7,320,429	\$54,753,781	\$62,074,210	12%	88%	100%
	HIV Clinical Services	\$3,510,591	\$15,827,782	\$19,338,373	18%	82%	100%
	HIV Drugs		\$22,742,671	\$22,742,671		100%	100%
	HIV Laboratory Services	\$1,875,891	\$12,805,922	\$14,681,813	13%	87%	100%
	Not Disaggregated	\$1,933,947	\$3,377,406	\$5,311,353	36%	64%	100%
HTS	Total	\$3,199,560	\$9,597,640	\$12,797,200	25%	75%	100%
	Community-based testing	\$898,693	\$1,516,838	\$2,415,531	37%	63%	100%
	Facility-based testing	\$446,137	\$2,095,387	\$2,541,524	18%	82%	100%
	Not Disaggregated	\$1,854,730	\$5,985,415	\$7,840,145	24%	76%	100%
PREV	Total	\$481,404	\$4,864,340	\$5,345,744	9%	91%	100%
	Comm. mobilization, behavior & norms change	\$421,404	\$1,018,239	\$1,439,643	29%	71%	100%
	Condom & Lubricant Programming		\$1,033,988	\$1,033,988		100%	100%
	PrEP	\$60,000	\$2,659,024	\$2,719,024	2%	98%	100%
	Primary prevention of HIV and sexual violence		\$153,089	\$153,089		100%	100%
SE	Total	\$2,757,292	\$4,556,048	\$7,313,340	38%	62%	100%
	Case Management	\$1,981,591	\$1,003,995	\$2,985,586	66%	34%	100%

Table B.1.3 COP22 Total Planning Level

Table B.1.3 COP22 Total Planning Level			
Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	\$799,964	\$111,925,036	\$112,725,000
Democratic Republic of the Congo	\$799,964	\$111,925,036	\$112,725,000

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

Table B.1.4: COP22 Resource Allocation by Program and Beneficiary								
Operating Unit	Metrics	Proposed COP22 Budget						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total
Democratic Republic of the Congo	Total	\$62,074,210	\$12,797,200	\$5,345,744	\$7,313,340	\$4,115,624	\$21,078,882	\$112,725,000
	Females			\$87,135				\$87,135
	Key Pops	\$1,655,846	\$1,772,523	\$1,331,185				\$4,759,554
	Males	\$1,762,119	\$735,753					\$2,497,872
	Non-Targeted Pop	\$56,191,965	\$9,257,076	\$3,565,764		\$4,115,624	\$21,034,123	\$94,164,552
	OVC	\$26,074		\$153,089	\$7,313,340			\$7,492,503
	Pregnant & Breastfeeding Women	\$362,000	\$704,632					\$1,066,632
	Priority Pops	\$2,076,206	\$327,216	\$208,571			\$44,759	\$2,656,752

B.2 Resource Projections

Per COP22 guidance, the DRC team used a program-based, incremental budgeting approach (Funding Allocation to Strategy Tool - FAST) to develop the COP22 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) 2021 PEPFAR Expenditure Reporting (ER) data, partner financial data and estimates, pipeline, and outlay review;
- 2) 2021 partner performance for C&T mechanisms and COP21 targets;
- 3) 2022 closing out mechanisms and projected to-be-determined (TBD) 2023 incoming mechanisms;
- 4) Excluding the one-time COVID-associated ARPA funds, we considered base funding from COP21 (level of funding) complemented by critical review of work plans and interventions in consultation with implementing partners to account for the COP22 strategy across beneficiary, population, and geographic areas. We factored in the increased testing and treatment targets;
- 5) Flat line budgeting based on no major shifts in geographic prioritization and no major strategic shifts except for scaling-up for priority interventions: index-testing, retention and viral load suppression in general population and targeted beneficiaries (pediatrics, adolescents, OVC and KP); We integrated the new AP3 initiative in the scope of clinical partners mandated to close the Pediatric, PMTCT gap;
- 6) Implementing Partner performance reports to refine lessons learned, identify innovations and best practices to replicate/scale-up, and strategies to de-emphasize; doing more with less money to reflect implementation with fidelity;
- 7) Policy Changes: Budget shifts have been made to reflect investment to address programmatic shifts and policy approvals (support implementation of self-testing, PrEP, ambitious TPT targets, scale-up of index-testing and recency testing); and
- 8) The mandate from headquarters to increase the percentage of the PEPFAR/DRC budget that is directly awarded to indigenous organizations and institutions as “prime” awardees.

The next step was allocating commodity and the M&O budgets ensuring that required earmarks were met. We note that commodities account for 43 percent of the entire budget. In a context of

rationalization of investments, PEPFAR is accountable for ensuring all supplies and commodities are available in supported provinces and Health Zones.

APPENDIX C – Tables and Systems Investments for Section 6.0

The Key Systems Barriers-E, Table 6-E tab, and SRE Tool-E tab of the Table 6 and SRE Excel workbook should be saved as a PDF and attached here in Appendix C.

The final Excel workbook should be considered a part of the SDS and submitted at the same time.



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APPENDIX D– Minimum Program Requirements

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	Completed “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 %.
2) Rapid optimization of ART by offering TLD to all PLHIV weighing ≥ 30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are ≥ 4 weeks of age and weigh ≥ 3 kg, and removal of all NVP- and EFV-based ART regimens.	In progress: <ul style="list-style-type: none"> • TLD transition completed for adults resulted in commendable Viral suppression of 94% in adults in FY21. • DTG 10 mg: started on November 27, 2021; Transition of approximately 65% of eligible children; completion of optimization projected by June 2022. • EFV and NVP regimens phased out: Completed
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	In progress: <ul style="list-style-type: none"> • MMD transition almost completed (>90% on multi-month); • Expansion to MM6 in progress (~ 38% on MM6, 60% expected by September 22); and • DDD implementation in progress (Including private pharmacies, PODI, home deliveries, and support groups).
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	In progress: Cotrimoxazole and TB preventive therapy is fully integrated into HIV clinical care package at no cost to the patient. <ul style="list-style-type: none"> • 100% completion for Cotrimoxazole • 95.4% Completion TPT in FY21Q4 - 3HP regimen being scaled up for eligible patients
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	In progress: DNO is ongoing and will continue to inform deployment of lab resources, inputs, and capabilities: <ul style="list-style-type: none"> • Network mapping is on-going; • Installation of new Xpert 16 modules still in discussion; and • Access of Xpert operationalization in Kinshasa pending written PNLs approval.

Case Finding	
<p>6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	<p>Testing portfolio is steadily growing to meeting the minimum program requirements:</p> <ol style="list-style-type: none"> 1. 100% of PEPFAR supported sites implemented index testing in FY2021. - sites assessed in FY21 for standards for index testing delivery are in remediation stage. 2. There is also a system in place for assessing IPV before and after index testing services. 3. HIVST achievement in FY21 surpassed annual targets.
Prevention and OVC	
<p>7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (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)</p>	<p>In progress</p> <p>The PrEP program will continue to scaleup. In FY21, PEPFAR DRC achieved 73% of annual PrEP_CURR targets.</p> <ul style="list-style-type: none"> • PEPFAR will continue to support the adoption by MOH of a demand creation strategy for PrEP. • PEPFAR DRC will continue the expansion of PrEP by inclusion of eligible AGYW and Pregnant and Breastfeeding women. • MMD for PrEP is the now the rule.
<p>8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p>In progress</p> <ul style="list-style-type: none"> • 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, testing to better support finding (community and facility) while clinical staff will be trained to facilitate community referral of CLHIV. In COP 22, the Team will continue this collaboration in finding of CLHIV. • The Case Managers in close collaboration with clinical staff, ensure that all children 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 % of CLHIV in PEPFAR supported SNU were linked to OVC platform for case management; in COP 22, this linkage will continue to increase the enrollment at 90 % or beyond.

	<ul style="list-style-type: none"> • Education of primary prevention of sexual violence and HIV, including strategies to actively explore violence symptoms within households were added in 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.
Policy & Public Health Systems Support	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward 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.</p>	<p>In progress</p> <ul style="list-style-type: none"> • Activities include training of HCWs in the provision of KP-friendly health services, which addresses stigma and discrimination, and improves the treatment outcomes for KPs, increased knowledge of rights of KPs, and more KP organizations running safety and security interventions. • PEPFAR DRC continues to explore the magnitude of injecting drug phenomenon and investigate the possibility to provide an HIV response for prisoners. <p>However, cultural, and religious beliefs are fundamentally a hindrance to acceptance and tolerance towards KPs, mainly MSM and TG.</p>
<p>10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.</p>	<p>Completed</p> <ul style="list-style-type: none"> • Political vision for phased universal coverage. • The law prohibits formal and informal user fees in the public sector for ANC, TB, routine clinical services, and consultations related to HIV.
<p>11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p>In Progress</p> <p>The country has quality improvement systems and structure in place from national level to all the way to site level. With the advent of Covid, the MOH has set Infection Prevention and control standards and safety measures to be observed at facilities. Compliance is measured through metrics translated in IPC dashboard. Through ARPA initiative, PEPFAR DRC is ensuring IPC are sustainably implemented.</p>

<p>12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.</p>	<p>In progress</p> <p>The Ministry of Health, PEPFAR, GF and CSO continue with efforts to promote continuity of treatment, adherence, and compliance to quality treatment. These awareness efforts are targeting health providers, community health workers, peer educators, PLHIV, civil society activists, parents, and caregivers. These efforts have translated in commendable outcomes in regard of: 6MMD, retention in treatment, and VL suppression. During COP21 and COP22, these efforts aim at improving VL coverage as well.</p>
<p>13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses</p>	<p>In progress</p> <p>During COP21 and COP22, PEPFAR DRC will continue a phased approach to expansion of funding of KP-led and Women-led organizations:</p> <ul style="list-style-type: none"> • Conduct Organizational Capacity Assessment (OCA) to determine needs; • OCA will define capacity building priorities for the respective CSOs; • OCA findings to orient next steps for organization eligibility to funds, in first intention as subgrantees.
<p>14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended</p>	<p>In progress</p> <p>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 salaries of health personnel and contribution to counterpart match funding to the GF. However, PEPFAR will continue to advocate for a clear HIV response budget and promotion of additional domestic resources for HIV response for provision of low hanging fruit like tests and condoms for prevention, acquisition of PoC machines for expansion of VL and EID testing capabilities. Advocacy will prompt also GDRC to take</p>

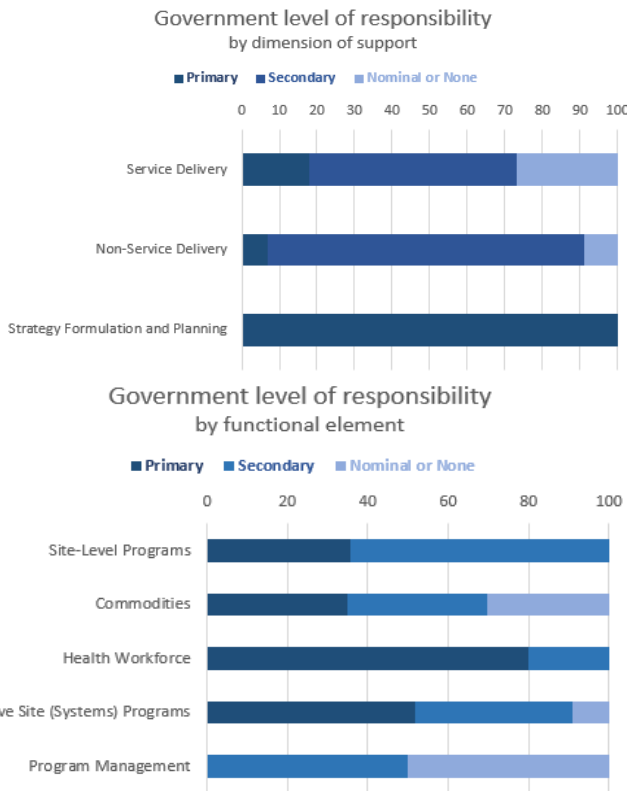
	responsibility of few “orphan” health zones to start.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	<p>In progress</p> <p>Though completeness, promptness and accuracy are debatable, mortality and morbidity are recorded through a nationwide health system, the DHIS2. Death audits also exist in the MoH framework but not implemented. PEPFAR DRC will continue to track causes of deaths through the Tx_ML indicator and put more emphasis in screening, diagnosing and treatment of presumed and confirmed AHD cases.</p>
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	<p>In progress</p> <ul style="list-style-type: none"> • PEPFAR DRC foresees a deliberate and progressive move towards digital health. • PEPFAR will continue to work with the MoH to support the use of EMR (Tier.Net) 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 be 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.

APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

PEPFAR and the Government of DRC enjoy excellent collaboration through the National HIV Response. The Ministry of Health chairs the program through provision of 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. Except for salaries for Human Resources for Health (HRH), the trends for domestic funding -either from Government or from the private sector- have remained modest as illustrated by the SID Financing element as shown in the figure below.

SID: Financing by Domestic Sources

SID: Financing by Domestic Sources				
	2017 Response	2019 Response	2021 Response	Change Over Time
National HIV Response				
% financed with domestic public and private sector funding	Very little (1-9%)	Very little (1-9%)	Very little (1-9%)	
Service Delivery				
% financing for service delivery from host country	Very little (1-9%)	Very little (1-9%)	#N/A	
% financing for service delivery to key populations from host country	None	None	Very little (1-9%)	
Health Workforce				
% health worker salaries provided by host country institutions	Most (50 – 89%)	All or almost all (90%+)	All or almost all (90%+)	
Commodities				
% financing for ARVs from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for rapid test kits from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for condoms from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
Supply Chain Plan				
% financing for supply chain plan from host country	Minimal (1-9%)	Unknown	Unknown	
Laboratories				
% financing for laboratories from domestic public or private sources	Very little (1-9%)	Very little (1-9%)	Very little (1-9%)	
Surveys and Surveillance				
% financing for general population surveys and surveillance from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
% financing for key population surveys and surveillance from host country	Minimal (1-9%)	Minimal (1-9%)	Minimal (1-9%)	
Service Delivery Data				
% financing for service delivery data collection from host country	Minimal (1-9%)	Some (10-49%)	Minimal (1-9%)	



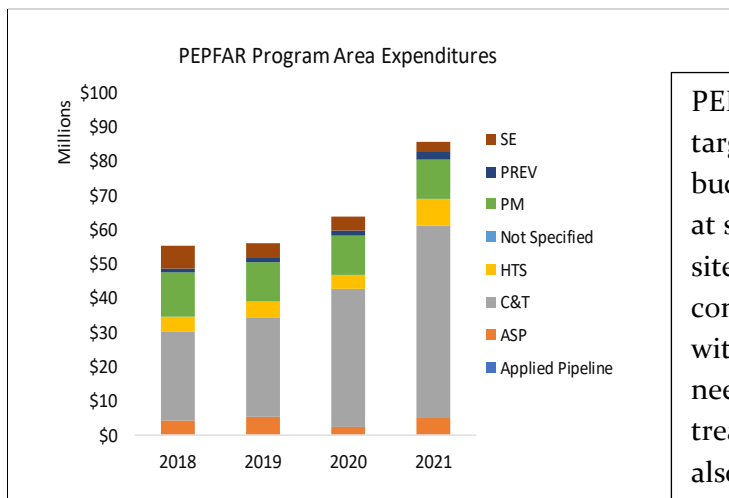
Without downplaying the critical contribution of government to health system, the Responsibility Matrix shows that the primary responsibility of government falls mainly in assuring the health workforce is paid. Other aspects of HRH are still supported by donors. The in-service training and continuous professional development functions are illustrations.

In addition, in many regards PEPFAR yields commendable results in the HIV service cascades (testing, linking, treating, continuity of treatment and suppressing). However, these results are achieved at the expense of PEPFAR providing significant contribution to remuneration. In FY21, PEPFAR funded \$9,156,775 for stipends for health care providers and community lay workers for motivation.

Beside HRH-salaries, Government also scored highly in the areas of strategy formulation and planning.

1. Misalignment between Investments and Outcomes

To remain focused on achieving 95-95-95, PEPFAR/DRC sets ambitious testing and treatment targets. Investments have been orientated to respond to local needs and towards achievement of expected outcomes.

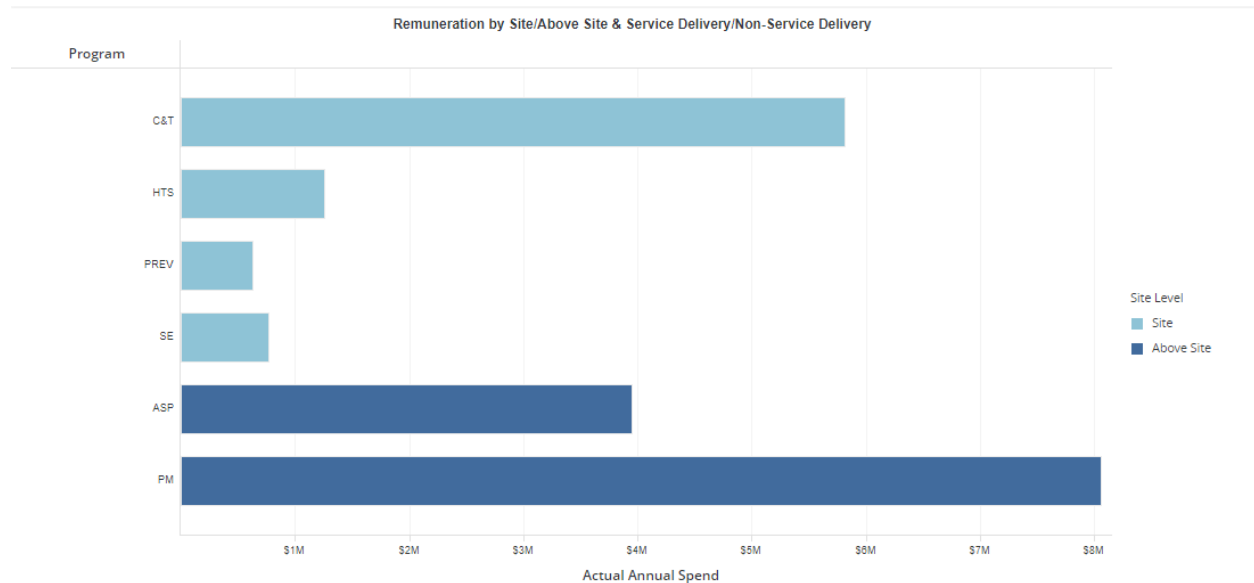


PEPFAR/DRC's increasing care and treatment targets have translated into increased site level budgets and a proportional increase in expenditures at site level. Strategic Information and other above site program (ASP) investments have remained consistent over time, with increases commensurate with commodity needs and laboratory requirements needed to support the increasing care and treatment targets. Above site program investments also support the country's adoption of key WHO policies.

Investments for the above site program are also in alignment with vulnerability areas depicted by the SID over time. Indeed, three main components were targeted for impactful above site investment: 1) Laboratory systems capabilities, 2) Interoperable Health Information Management Systems (HMIS) and 3) Resilient and robust supply chain systems.

SID Scores Reported in Table 6				Above Site Activities and Budget Reported in Table 6						
SID Element	SID Score			SID Budget Activity	COP18		COP19		COP20	
	2017	2019	2021		Activities	Activities	Budget	Activities	Budget	
1. Planning and Coordination Score:	9.79	9.29	9.50	⊗ Planning and Coordination				1	\$250,000	
2. Policies and Governance Score:	5.37	5.20	4.75	⊗ Policies and Governance	1					
3. Civil Society Engagement Score:	4.67	5.83	5.83	⊗ Civil Society Engagement	2	2	\$312,080			
4. Private Sector Engagement Score:	4.89	8.53	5.76	⊗ Service Delivery		8	\$675,000	1	\$150,000	
5. Public Access to Information Score:	6.00	5.11	4.67	⊗ Laboratory	10	8	\$375,000	8	\$450,000	
6. Service Delivery Score:	3.94	4.38	4.07	⊗ Epidemiological and Health D:	7			4	\$1,250,000	
7. Health Workforce Score:	4.79	6.17	6.19	⊗ Epidemiological and Health Data		5	\$1,588,295			
8. Commodity Security and Supply Chain Score:	4.41	4.24	3.96	⊗ Performance Data				1	\$40,000	
9. Quality Management Score:	1.67	2.33	2.33							
10. Laboratory Score:	5.42	3.81	3.81							
11. Domestic Resource Mobilization Score:	1.79	2.74	3.65							
12. Technical and Allocative Efficiencies Score:	3.47	4.11	3.00							
13. Market Openness Score:		8.43	9.00							
14. Epidemiological and Health data Score:	4.33	5.56	5.08							
15. Financial/Expenditure data Score:	6.67	8.33	6.67							
16. Performance Data Score:	4.21	7.67	5.74							
17. Data for Decision-Making Ecosystem Score:		2.00	1.67							

However, we would expect that with time, the portion of salaries and Above Site Program investments would decrease as the expertise is slowly transferred.



2. Areas for Transition

The Government of DRC should strategically work to increase domestic financing for HIV. One opportunity would be to organize the large and diverse private sector which generates enormous income. A portion of their taxes paid could be channeled for the purchase of HIV drugs and tests, to close the gap on ARVs.

Centralized Health Management Information for HIV is critical, and the priority number one should be to come up with a clear and accurate denominator of PLHIV through a survey and the development of a sound surveillance system including a unique patient identifier.

Key Populations are cited as the main driver of HIV in the country according to mode of transmission of HIV modeling. Greater emphasis should be placed on resources to close the gaps in Key Populations: 1) clear stigma-free policies; 2) surveillance including size estimations and behavioral surveys; 3) means of prevention (condoms, lubricants, and PrEP); and 4) self-testing capabilities.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

PEPFAR/DRC will engage UNAIDS, the Global Fund and local CSOs in biannual fora around sustainability issues, advocating for and triggering accountability through the areas of vulnerability found in SID and functions where government currently plays a secondary role or has no responsibility according to Responsibility Matrix.
