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Democratic Republic of Congo

Minister of Public Health

National Program for the Fight against HIV/AIDS and STIs

Operational plan for offering differentiated services in the Democratic Republic of Congo

May 2018

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ABREVIATIONS LIST

Abbreviations	Meanings µl
	Microlitre
AMM	Mentor mother approach
Anti-TB	Anti-tuberculosis
NUMBER	Antiretrovirals
THAT	Zidovudine
BPC	Bureau provincial de coordination
CD4	Cluster of differentiation class 4
CDC	Centers for Disease Control and Prevention
CDV	Voluntary screening advice
CHK	Kabinda Hospital Center
CPN	Prenatal consultation
CrAg	Cryptococcal Antigen
CS	Health center
CSR	Reference health center
CTX	Cotrimoxazole
CV	Charge is viral
DBS	Dry Blood Spot
DCIP	Advisory screening initiated by the provider
DPS	Provincial Health Division
ECZS	Health zone management team
EDS	Demographic and health survey
EID	Early infant diagnosis
FM	Global Fund
PIT	Health training
GAS	Self-support group for people living with HIV
GCT/GCTAR ART	Community Group
HGR	General referral hospital
IS	Sexually transmitted infection
LNRS	National AIDS Laboratory
LPRS	Provincial AIDS laboratory
M1	First month
M2	Second month
M3	Third month
M6	Sixth month
MSF	Doctors Without Borders
OAC	Community-based organization
OMS	World Health Organization
NGO	Non-governmental organization
UNAIDS	Joint United Nations Program on HIV/AIDS
Well	People affected by HIV
PEC	Supported
PEPFAR	Plan of the President of the United States for the fight against AIDS

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PL	Lumbar puncture
PMA	Minimum activity package
PNLS	National program to combat HIV/AIDS and STIs
PODI	Antiretroviral distribution station
PTF	Technical and financial partners
PTME	Prevention of mother-to-child transmission of HIV
PLHIV	People living with HIV
RDC	Democratic Republic of Congo
RNOAC	National Network of Community-Based Organizations of People Living with HIV
S.ACC	Delivery room
S/ARV	Sous ARV
Like	acquired immune deficiency syndrome
SMNE	Maternal health of the newborn and child
SMS	Shot Message Service
TARV/TARV	Antiretroviral treatment
TB	Tuberculosis
TB-Lam	Tuberculosis slide
TB-MR	Multi-resistant tuberculosis
UCOP+	Congolese Union of People Living with HIV
UDI	Intravenous drug user
UNICEF	United Nations Children's Fund
US	ultrasound
HIV	Human immunodeficiency virus
Xray	X-ray
ZS	Health zone

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I. CONTEXT

According to the July fact sheet published in 2017 and the report progress towards the 90-90 targets-90 2017 of UNAIDS, the number of PLHIV is estimated at 36.7 million [30.8 million-42.9 million] in the world until the end of 2016. Regarding knowledge of status, on average 70% [51 - >84%] of these people are diagnosed, including an average of 77% [57-
>89%] are put on ART with on average 82% [60- >89%] having an undetectable viral load.
In West and Central Africa; 6.1 million [4.9-7.6 million] people live with HIV with an average of 35% [24-44%] on ARVs.

In the DRC, Spectrum 2016 estimated 369,740 people living with HIV, 54.7% of whom know their status, 77.6% are on ARV and 73.2% have an undetectable viral load among all PLHIV who have had access to the viral load.

Statements recorded in the decision-making framework for the provision of antiretroviral therapy (differentiated care manual) demonstrate the concern expressed by beneficiaries and HIV managers. Client: “I have to walk a long way to get to the clinic and on top of that, I have to go get my ART every month - but I feel fine and I have to go to other places.” Managers: “We need to get to 90-90-90 and implement the recommendation, treat everyone, how are we going to achieve that with the resources we have?” ".

The feasibility of the WHO test and treat recommendation issued in 2015 in health systems already under extreme pressure due to limited financial and human resources requires HIV program managers to review service delivery policies. Thus differentiated services, a client-centered approach, aims to simplify and adapt the HIV service cascade to take into account the preferences and expectations of different groups of people living with HIV while reducing unnecessary burdens. on the health system. This approach allows the health system to refocus resources on those who need them most.

Old models of care, within health care settings, resulted in undifferentiated services that did not meet the specific needs of individuals. However, some models of differentiated services operationalized in the country have shown promising results in achieving the 90-90-90 objectives, namely:

- In the HIV screening service offering (targeted screening, mass screening companion, home screening “One by Five approach”, school and university screening and night screening service for key populations, etc.)
- In the renewal of ARVs (PODI, Observance Club, the Community Group ART, appointment spacing and rapid circuit)
- In the viral load assay offer, the achievements of the viral load sampling campaign in the PODI, awareness raising on the viral load in the GAS and the availability of a card indicating the date of the viral load measurement to PLHIV.

Moreover the DRC is resolutely committed to controlling the HIV epidemic, linked to the strategic axes of the multisectoral PSN in the fight against HIV/AIDS, which are (I) the prevention of the transmission of HIV and STIs, (II) improving the response to HIV among adolescents and young people aged 10 to 19, (III) prevention of transmission of HIV from mother to mother

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the child, (IV) **improving access to care and treatment,** (V) **promoting an environment favorable to the HIV response** and (VI) supporting implementation.

This plan which covers the 4th and 5th strategic axes on which the overall objectives of differentiated care depend and is placed within the framework of…...

The operational plan for the provision of differentiated services mainly focuses on the strategies for implementing differentiated approaches to the provision of services in the fight against HIV.

Successfully implementing differentiated service delivery allows the healthcare system to save up to 20% of healthcare expenses, while preserving or even improving patient health. These approaches also make patients actors in their care, which has the effect of improving consultation attendance rates and treatment compliance. Service providers will also be able to benefit from more effective and efficient working methods, with the satisfaction of seeing the health of their patients improve.

II. ANALYSIS OF THE SITUATION IN THE DRC

The analysis of the situation concerns the panoramas of the implementation of differentiated care in the DRC. He reports:

1. the organization of HIV services in terms of reception, geographical accessibility, financial accessibility, cultural accessibility, waiting time, etc.):

   - The organization of screening services: this is based on the two classic strategies including the CDV and the DCIP to which the self-test strategy has been added since September 2016

   - The organization of care services: this describes the circuit of patients in care structures, the modalities of their care in terms of care service link, treatment and support 2. The organization of information production and support for the fight through

   the laboratory and the dispensing of medicines.

As offered in the DRC since the start of the AIDS epidemic until before the WHO declaration on the promotion and development of differentiated service delivery strategies in 2015.

II.1. Organizing HIV testing services

For more than 30 years, HIV screening has been done with two or three rapid tests depending on the prevalence of the population concerned. Thus, the three tests used until 2015 are Determine, Unigold and Double Check. After updating the integrated guide to the care of PLHIV in 2016, the DRC bases screening on a new algorithm which is made from Detemine, Vikia and Unigold. This guide also authorizes the use of self-testing with confirmation of the HIV diagnosis by providers at the FOSA level.

The organization of screening services in the country has three facets depending on the location of screening, the actors who screen and how the screening is carried out.

The table below shows the three facets of operationalization of HIV testing in the pays.

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Table I. Different methods of offering screening in the DRC

Or ? Place	Who ? Intervention actors and			Comments
	Pretest	Test	Posttest	
Establishment care	Clinician	Clinician	Clinician	ÿ The same person offers the pretest advice, the test and the posttest
	Clinician	For-clinician	Clinician	ÿ The test is integrated into the clinical assessment: ÿ Patient sent to the laboratory ÿ The paraclinician comes to take samples from the hair of the patient
	For-clinician	For-clinician	For-clinician	ÿ The paraclinician offers the patient who comes for other assessments the HIV test
Communautaires	The recommended (communauté)	For-clinician	The recommended (community uté)	ÿ The community leads the CDV or awareness ÿ The paraclinician offers the test HIV
At home	Yourself	Self even	Yourself	ÿ The use of the self-test individual way

In 2016, the DRC despite the offer of HIV screening services described above, it appears that approximately one in two PLHIV does not know their serological status, i.e. 45.3% (PNLS 2016 annual report). Regarding the identification of these PLHIV, it is important on the one hand to transcend the difficulties of access to health resources, in particular the low coverage

intervention, the distances which separate resources from beneficiaries, stigmatization within healthcare establishments in particular key and vulnerable populations, obstacles and insecurities, long waiting times and the indirect cost linked to the initial consultation and para-clinical examinations. On the other hand, increase demand by raising community awareness about HIV, reducing stigma linked to HIV in the community, breaking down socio-cultural and economic barriers, also involving the community in decision-making and its ' empowerment.

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Therefore, encouraging differentiated screening strategies will boost coverage for PLHIV who are aware of their serological status.

The operating method chosen for differentiated screening depends on the preferences of the target groups, the cost of service provision and the expected effectiveness of screening.

- ÿ At the community level the strategy is "Home-based testing" with the intervention logic anchored on the index case, Door to Door, mobile strategy for key populations, at the workplace or at school. Peer screening actions in fixed and mobile strategy PODIs and Activists used by the Dream organization, the organization of mother and child health weeks for screening of the family unit, campaigns of mass screening with a risk assessment tool (mining quarry, fair, in a school environment, etc.), screening in suitable settings (bar, hotel, meeting place for PS and their love) and at suitable times (men, Key-P …) are variants which are currently generating evidence whose good practices will be used in this plan.

- ÿ At the level of healthcare establishments, HIV screening is offered through the CDV and DCIP, patients in consultation and hospitalization as well as clients of other clinical services, prenatal consultations, tuberculosis, sexually transmitted infections, health services. malnutrition. The approach focused on index cases, partner notification and family-centered approaches are among the most likely sources of positive cases.

II.2. Organizing ART service links

Between 1996, the year the first ARV treatment "AZT" was made available, and 2017, there was the development of more than 30 antiretrovirals with more than 20,000 combinations as part of triple therapy (something which revolutionized the prognosis and management of HIV infection).
The organization of ART services assessed in the DRC as follows:

- Before 2001, care was individualized to wealthy people and it was available only in large companies (e.g. Bralima)
- From 2001-2005: this window was marked by the three by five initiative with the objective of putting 3 million PLHIV in the world on ARV by 2005. In this context, the DRC had put in place structures specialized centers for PLHIV called outpatient treatment centers not integrated into the health system
- In 2005, the DRC developed its first ARV treatment guide
- 2006-2011: the promotion of universal access to antiretroviral treatments with the offer of the minimum package of activities to combat HIV to be integrated into the health system resulted in the development of standards and directives limiting at least 2 ARV PEC structures and 5 prevention structures were the criteria which determined the functionality of a ZS having integrated the fight
- 2011-2015, the world aimed to put 15 million PLHIV on ARV while insisting on the three triple zero objectives: "0 new infections, 0 deaths and 0 discrimination". during this period the DRC subsequently developed guides to finally improve access for PLHIV to ARVs (increasing CD4 rate from 350 to 500 cells/µl, all women

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pregnant HIV, children under 5 years old, discordant couples and co-infections (TB and Hepatitis) as eligibility criteria for ARVs. The adoption of option B+ was favorable to the transformation of all PMTCT sites into ART sites, which made it possible to increase ART coverage of PLHIV

- 2016-2020, the promotion of the advent of the triple objectives 90 of UNAIDS with the vision of complete package of fight against HIV and leaving no one behind in order to achieve the global objective of eliminating HIV AIDS epidemic by 2030.
  With this in mind, the DRC revised its guide in September 2016 to integrate the new directives based on: test treat independently of the CD4 rate by favoring targeted screening.

- The revolution in the fight which involves improving access for PLHIV to screening and their link with the care and treatment service requires that priorities be determined according to each patient in their environment and finally to improve the quality of life and life expectancy of PLHIV. It is in this context that the fight in the DRC is moving towards differentiated care.

From the field visit in October 2017 by the joint team, the observation below emerged in relation to the organization of ART services, the roles and responsibilities of the actors in
the initiation and renewal of ART for PLHIV as well as the modalities of care, treatment and support:

Table II. Organization of ARV treatment in the DRC

Situation NUMBER	**EG of PLHIV**	**Where? ART location**	**Who ? : actors And When? : Monitoring frequency**
Naive	Good condition	ÿ Initiation of TARVA only in the establishments care	ÿ Trained doctor and nurse ÿ MNCH speakers ÿ Suivi J0, J14, M1, M2, M3, M6, M9, M12, M15…
	Advanced AIDS	ÿ Quick focus unit (only in establishments of care	

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Not naive	Stable		ÿ Monitoring: ÿ M1: visit on the 14th day and the 30th day ÿ M2-M6: monthly visit ÿ > M6: visit M1, M2, M3 depending on the different healthcare establishments and service provider experience ÿ Possible renewal of NUMBER At level community (for stable patients)
	unstable		
Fake naive	Good condition	Initiation of the TARV only in establishments care	ÿ Trained doctor and nurse ÿ MNCH speakers
	Advanced AIDS		

Just like the screening situation, this ART service organization shows that the DRC's response to ART is still slow because 52.8% of potential PLHIV are not covered by ART. A major effort must be directed towards the identification of PLHIV in order to increase ART coverage, as demonstrated by the performance achieved in 2016 with 77.6% ART coverage for all PLHIV who know their serological status.

Improved identification of PLHIV coupled with drug availability and the development of innovative approaches to boost retention will enable an increase in PLHIV placed on ARVs.

Regarding the viral load, 89.8% of potential PLHIV did not have access to the load.
The use of GeneXpert coupled with conventional platforms in the screening of the burden as well as the increase in the identification of PLHIV and their placement on ARV will be the success factor in increasing the number and proportion of PLHIV with the access to viral load.

Furthermore, the management of co-infection also presents bottlenecks, namely:

- Low coverage (49%) of PLHIV who know their serological status have benefited from active tuberculosis research
- Low coverage (29%) of TB-negative PLHIV were placed on INH
- Access to anti-tuberculosis drugs (26%)

It is important to boost joint HIV/TB activities to significantly reduce the mortality of PLHIV and improve retention. The service model based on “one-stop shopping” is preferred. A plan for operationalizing the one-stop shop is developed concurrently with this.

For other comorbidities, an investigation into the mapping of opportunistic infections in its clinical phase is underway. It will provide information on the most common comorbidities and their treatment.

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III. PRIORITIZATION IN THE OFFERING OF DIFFERENTIATED SERVICES

The choice of strategies for implementing differentiated care models should be guided by an analysis of the local situation of data by answering questions such as: When?
Or ? Who ? What ?

Differentiated service delivery models should be put in place to address specific challenges and prioritized to fill gaps in achieving the 90-90 targets.
90.

The establishment of a model of differentiated services is oriented in the DRC by the prioritization of provinces, ZS, structures, services and categories of patients:

1. Prioritization of provinces

The choice of provinces is based on the categorization of hyper-priority DPS, medium priority and other provinces according to the two blocks of criteria:

The epidemiological profile based on considerations related to density, prevalence, incidence, mortality, expected targets of PLV, key and vulnerable populations and populations in emergency situations.

The second block is made up of elements relating to the state of the response, notably progress towards the epidemic control objectives, availability and access to the HIV service chain and the elimination of transmission of mother to child from HIV and syphilis.
The extent of susceptible TB, MDR-TB and co-infection in different provinces guided the prioritization of the implementation of the single window model.

From this description, 3 categories of DPS emerge, namely:

1. Hyper-priority DPS: these are the 9 DPS namely Haut-Uele, Maniema, Kasaï Oriental, Bas-Uélé and Kinshasa, Haut-Katanga, Ituri, Kongo Central North Kivu which covers 75% of potential PLHIV in the DRC.

It will be a question of offering the complete HIV package without leaving anyone behind with also the offer of differentiated services, these interventions include:

1. Increase in geographic coverage until saturation 2. Achieve coverage of more than 90% of PLHIV
3. Complete community dynamics package (including observatory)
4. Complete package of services
5. Use of conventional platform combined with POC (GeneXpert) for viral load and early diagnosis in exposed children 6. Implementation of the quality approach 7. Implementation of the AJF project

2. Medium priority DPS: there are 7 of them, including; Kwilu, Lualaba, Sankuru, South Kivu, North Ubangi, Tanganyika and Tshopo. Key interventions in this category are:

1. Progress towards geographical coverage of more than 80%;
2. Progress towards coverage of more than 80% of PLHIV 3. All CSDTs will become ART sites
4. Establishment of networking of intrazonal sites to improve access to services HIV
5. Offer of the minimum improved activity package

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6. Use of POC with strengthened networking for viral load screening as well as targeted biological monitoring.

3. Other DPS of continuous actions: in the latter screening services, PMTCT and ART will be offered in accordance with the following interventions:
1. Offer of the minimum package of current activities continues,
2. Increase in geographic coverage to at least 60% 3. Increased prioritization of target groups (key populations and populations in situations emergency)
4. No extension to new sites, dpes of key populations ep
5. Priority use of POCs with transport of samples on DBS for viral load and early diagnosis in exposed children

2. Prioritization at the ZS level

The selection of Health Zones is guided by:

- Weight of potential patients
- Presence of at least one site in the ZS with more than 500 PLHIV in its cohort
- Low achievement of targets at the ZS level faced with the presence of significant risk factors for HIV transmission (mining explosion, population mapping keys)
- Problem of access to screening, care, treatment and support services
- Rate of growth of the cohort.
- Population density.

3. Prioritization at the site level

ART site selection is guided by:

- High contribution to achieving 80% of targets
- The number of PLHIV in the cohort (>500)
- Worker overload on the site
- Low retention in its cohort
- High technical package of services and activities
- Management of advanced AIDS
- Active connection with community dynamics

Below is the table which summarizes the hyper-priority provinces, the number of ZS concerned and the number of sites concerned by ZS.

Table III. Mapping of Health Zones with high-volume sites in the DPS HIV hyper-priority

Hyper-priority DPS number		ZS name	Number of ART sites with more than 500 PLHIV
1	Electric Bass	1	1
2	Haut-Katanga	5	6

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3	skin oils	8	10
4	Ituri	4	6
5	Kasai-Oriental	3	3
6	Kinshasa	14	19
7	Kongo Central	3	3
8	Maniema	9	10
9	North Kivu	2	5
Total		**45**	**63**

It emerges from this table in 9 hyper-priority provinces, approximately 38 ZS will be concerned by the intensification of screening and ART services with the development of differentiated approaches in approximately 42 sites.

Table IV. Mapping of health zones with high volume sites in medium priority DPS

Medium Priority DPS No.		**ZS name**	**Number of ART sites with more than 500 PLHIV**
1	Kwilu	2	2
2	Ribs	1	1
3	Nord Ubangi	3	3
4	Sankuru	0	0
5	Sud Kivu	6	6
6	Tanganyika	1	1
7	Tshopo	1	1
Total		**7**	**8**

It emerges from this table of 8 medium priority provinces, approximately 7 ZS will be concerned by the intensification of screening and ART services with the development of differentiated approaches in approximately 8 sites.

Table V. mapping of health zones with high volume sites in other DPS

N°	**DPS with medium priorities**	**Number of ZS**	**Number of ART sites with more 500 PLHIV**
1	Ecuador	1	1
2	Top Lomami	1	1
3	Kasai	·	·
4	Kasai Central	1	1
5	Congo	·	·
6	Lomami	2	2
7	Mrs Ndombe	0	0
8	The phone	?	?
9	Sud Father	1	1
10	Tshuapa	·	·
Total		9	9

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From this table, 9 health zones also have 9 ART sites with more than 500 PLHIV on ARV according to the mapping carried out based on the various reports from the provinces in mid-2017.

Table VI. Identification of potential PLHIV and performances recorded by hyper-priority province

N°	Provinces hyper-priority	Population total 2017	Prevalence EDS	PLHIV estimated	PLHIV S/ARV 2017	Blanket of the target
1	British Bass	1 238289	2,4%	26795	3008	11%
2	Haut Katanga	4483994	2,6%	61066	32015	52%
3	skin oil	2 174521	6,9%	66282	17455	26%
4	Ituri	4 801299	0,3%	34834	11332	33%
5	Kasai Oriental	3059290	2,8%	24303	7513	31%
6	Kinshasa	113664995	1,6%	100812	55798	55%
7	Kongo Central	4 227754	0,2%	12104	8478	70%
8	Maniema	2160826	3,9%	41183	8241	20%
9	North Kivu	6131192	1%	34008	15611	46%
Total		**34 801 718**		**401387**	**159451**	40%

The 8 so-called hyper-priority provinces cover 74% (401,387/542,842) of potential PLHIV in the DRC and 75% (143,840/213,995) of PLHIV placed on ARVs. Depending on the prevalence of each province, estimates show that no province has reached the target of 81% of PLHIV placed on ARVs. However, 3 provinces are in the range between 50-<81% and are colored yellow: Haut-Katanga, Kinshasa and Kongo Centrale. The other provinces are colored red because they achieved performances of less than 50%.

Table VI. From the identification of potential PLHIV and the performances recorded by medium priority provinces

Provinces priority averages	Population total	Prevalence EDS	Estimated PLHIV	PVVIH S/ARV 2017	Blanket of the target
Kwilu	4117272	0,1	6123	4099	67%
Lualaba	1845264	0.5	15362	5945	39%
Nord Ubangi	1140853	1.4	8548	2565	30%
Sankuru	1107848	1.7	12502	1262	10%
Sud Kivu	6534202	0,4	18563	12665	68%
Tanganyika	2730576	0.6	13576	2950	22%

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Tshopo	2876478	0.4	15380	7417	48%
Total	**20352493**		**90054**	**36903**	41%

The 7 so-called medium priority provinces cover only 17% (90,054/542,842) of estimated PLHIV in the DRC and 17% (36,903/213,995) of PLHIV placed on ARVs. Depends on
prevalence of each province, estimates show that no province has reached the target of 81% of PLHIV placed on ARV. However, 2 provinces are in the range between 50-
<81% and are colored yellow, these are Kwilu and South Kivu. The other provinces are colored red because they achieved performances of less than 50%.

Table V. Identification of potential PLHIV and performances recorded by other provinces

Provinces hyper-priority	Population total	Prevalence EDS	Estimated PLHIV	PVVIH S/ARV 2017	Blanket of the target
Ecuador	1238289	.	3338	1992	60%
Top Lomami	2875555	.	6351	2851	45%
Kasai	3622442	0,1	5350	1603	30%
Kasai Central	3369898	0,8	7511	3172	42%
Congo	2257351	.	2429	1415	58%
Lomami	2319392	0,7	8646	2322	27%
Mrs Ndombe	2001837	0,9	4908	874	18%
Mongala	2030407	0,3	1629	495	30%
Sud Ubangi	3106740	0,8	8476	2406	28%
Tshuapa	1490747	0,9	2763	511	18%
Total	24312658		51401	17641	34%

The other 10 provinces cover only 9% (51401/542842) of estimated PLHIV in the DRC
and 8% (17,641/213,995) of PLHIV placed on ARV. Depending on the prevalence of each province, estimates show that no province has reached the target of 81% of PLHIV placed on ARVs. However, 2 provinces are in the range between 50-<81% and are colored yellow, these are Equateur and Kwango. The other provinces are colored red because they achieved performances of less than 50%.

IV. GOALS

1. General objective

As part of strengthening the health system, the plan for offering differentiated services to combat HIV will have the general objective of improving access to care and treatment by aiming
the quality of life of people living with HIV.

2. Specific objectives

The main specific objectives of this plan are to meet 5 objectives which are:

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1. Increase the proportion of PLHIV who know their HIV status from 54.7% to more than 85% by 2020

2. Increase the proportion of PLHIV who know their serological status on ARV from 77.6% to 100% by 2020

3. Increase the proportion of PLHIV placed on ARV with access to viral load (12 months of ART) from 19% to more than 60% by 2020
4. Increase the retention of PLHIV in the active queue from 56% (17-89%) to 85%

IN. IMPLEMENTATION STRATEGIES

V.1.Evidence **-based strategies for differentiated approaches to HIV services**

Achieving testing and treatment targets relies on a strengthened health system capable of integrating patients at all levels of the HIV prevention and care service chain and retaining them there using different approaches focused on the needs and constraints of PLHIV.

Clinical and community care services will ensure that PLHIV:

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- Have access to effective screening services,
- Receive a diagnosis and understand it
- Are referred to the competent prevention services or treatment services charge
- Are quickly put on antiretroviral therapy if a diagnosis of HIV positivity is laid
- Receive ongoing effective treatment to sustainably suppress viral load
- Are placed on other antiretroviral protocols in the event of treatment failure
- Have access to chronic and palliative care, including prevention and management of main co-infections and other comorbidities.

Thus, the following main strategic axes were retained in this plan for the 2018 financial year-2020 :

Axis 1. Increase in the proportion of PLHIV who know their serological status			
Differentiated strategies	**Differentiated activities**	**DPS priority**	**Other DPS**
Targeted community testing	Organize mass screening campaigns	x	
	Mobile screening	x	
	Advanced strategy screening	x	x
	Night screening	x	x
	Screening in the prison environment	x	
	Screening in wellness clinics and friendly centers	x	
Community Integrated Testing	Screening integrated into sputum collection campaigns for all coughers	x	
	Screening integrated into chronic disease screening campaigns	x	
	HIV/TB screening integrated into outreach activities aimed at mothers and children	x	
	Integrated HIV/TB screening in landlocked populations with PMA	x	
	Screening integrated into the distribution of health kits HIV prevention among IDUs	x	
	Screening integrated into men's leisure activities including depending on their availability like Saturday	x	

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In establishments care (Integrated screening at the initiative of the provider)	Systematic screening of all clients in consultation and hospitalisation	x	
	Targeted screening for clients with suspicious symptoms Screening of male	x	x
	partners of women who consult CPN, S.ACC, postpartum	x	x
	Screening of index cases	x	x
	Screening of street children, orphans and demobilized persons Screening of	x	
	index cases		
Home screening	Using the self-test	x	
Axis 2. Increase in the proportion of PLHIV placed on ARV			
Differentiated strategies	**Differentiated activities**	**DPS priority**	**Other DPS**
Test and treat	To all naive stable patients or in WHO stage I and II To all falsely naive patients but still stable or in stage I and II	x	x
Adaptation of services TAR according to the state of patients	Strengthening the reference and counter-reference system for advanced stage patients at CSR or HGR who have a rapid development unit	x	
Axis 3. Increase in the proportion of PLHIV placed on ARV with access to viral load (12 months of ART)			
Differentiated strategies	**Differentiated activities**	**DPS priority**	**Other DPS**
Centralized viral load testing	Sample delivery viral load to conventional dishes using SMS and/or internet for rendering results	x	x
Decentralized VL screening	Sample delivery viral load to GeneXpert using SMS and/or internet for rendering results	x	
Viral load campaigns	Use of conventional or GeneXpert platforms	x	

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Axis 4. Increase in the retention of PLHIV in the active queue			
Differentiated strategies	**Differentiated activities**	**DPS priority**	**Other DPS**
Differentiated schedules	Service schedules that take into account the availability needs of PLHIV	x	
Differentiated locations	Offers services in spaces dedicated to different categories of customers (patient TB, key population and children, adolescents and young people)	x	
	Peer experts distribute the ARV in a suitable place	x	
	Initiation and renewal of decentralized medicines in les CS, CSR	x	x
	Renewal of ARVs decentralized in the community provided by a health professional	x	
	Renewal of ARVs decentralized in the community provided by expert patients	x	
Differentiated routes	Adaptation of the course in the establishment according to the patient groups	x	
	Patient stable		
	Dispensing of ARVs for 3 to 6 months	x	x
	Rapid ARV renewal circuit	x	
Specific organization of care for PLHIV in advanced stage	**Unstable patient (advanced AIDS):**	x	x
	Health zone/care package approach by level	x	x
	At the community level (PODI, clubs and GCT) :	x	
	The community ; look for danger signs and reference	x	
	CS; look for danger signs and reference	x	

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	CSR and HGR: having a unity of rapid focus having the possibility of offering in 2 hours following the CD4 count, TB-Lam, CrAg and/or Indian ink, GeneXpert, Xray, US, PL, la CV and malaria test	x	
Mother mentor approach in PMTCT	Support women who are PMTCT to ART adherence	x	
	Support women who are PMTCT to disclosure of HIV status to their husbands	x	
	Ensures the search for those presumed lost to follow-up and those lost to follow-up in PMTCT	x	
Pair education and activists	Supporting their peers in ART adherence	x	
	Support their peers in sharing their HIV status with their confidants	x	
	Ensures the search for presumed lost to follow-up and those lost to follow-up	x	
Self-support group (GAS)	Organize monthly experience sharing sessions between peers	x	
	Animate the different themes on HIV: - The importance of doing screen family members - The importance of taking ARVs for life - The importance of a healthy diet - The importance of carrying out monitoring viral load testing etc.	x	
Axis 5. Strengthening the health system through HIV support and support			
Differentiated strategies	**Activities**	**DPS priority**	**Other DPS**
Development of Human Resources for Health	train trainers national, provincial and ECZS on differentiated HIV services	x	

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	Train clinical and para-clinical providers on the offer of differentiated services	x	
	Organize tutoring for providers on differentiated services	X	x
	Supervise differentiated service providers	x	
Improved supply of health training in tests, ARVs and other control drugs against IOs	Train providers on the logistics management system for HIV inputs in differentiated renewal periodicity function NUMBER	X	
	Development of storage spaces existence of ARVs and other inputs at the ZS level and healthcare establishments	x	
	Carry out monthly surveys to assess the availability of tracer inputs in the FOSA (tests, ARV and anti-TB): UCOP+	x	
	Carry out quality surveys with PLHIV	x	
Strengthening the System health information	Updating tools in depending on the few indicators on the supply of differentiated services	x	
	Development of collection tools community		
	Integration of all data produced in the health area	x	x
	hold taks meetings force PEC stolen service organization and community support		

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VI. **PROGRAMMATIC FRAMEWORK**

	Activities	Responsible	2018	2019	2020	Budget a $
Result 1. Reach 85% (171,244) of PLHIV know their HIV status by 2020	Screen 23,975 PLHIV through community screening (mass screening campaigns, mobile screening, advanced strategy screening, night screening and prison screening)	Community agents				922 085
	Screen 10,276 PLHIV through integrated screening at the community level (Screening integrated into preventive activities in the community)	Community agents				395 179
	Targeted screening of 102,749 PLHIV in all provider locations	Health professionals				3 951 791
	Motivate professionals from 45 sites including 25 HGR and 20 CS	PTF				3 438 000
Under total						**8 707 055**
Result 2. 95% of PLHIV are put on ARV by 2020	Ensure the supply of ARVs in a test and treat strategy to 162,682 PLHIV identify	Service providers care				PM
	Ensure ARV renewal at 50% (134645) Stable PLHIV according to different differentiated community approaches					PM
	Ensure the renewal of ARVs at 15% (40393) Stable PLHIV according to different differentiated community approaches	Service providers and actors community				4 104 000
	Set up rapid response units in 25 HGRs for the management of PLHIV in the advanced stage estimated at 30% (80,786) and whose technical platform includes: CD4, TB-Lam, CrAg, Xpert, Xray, US, PL, CV, rapid HIV and malaria test, hepatitis tests and liver and kidney assessment					PM

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Under total						**4 104 000**
Result 3. 60% of PLHIV placed on ARV had access to the load	Optimize the operation of the platforms - conventional forms	LNRS, LPRS, La Dream and work CHK and the PTF				PM
	Equip 38 GeneXpert due to 1 per HGR of the 38 ZS of the 8 hyper-priority DPS and ensure their availability in CV, EID and TB Diagnostic cartridges	PTF				PM
	Provision the platforms conventional and GeneXpert in reagents for their operations					PM
	Train 3 peer sample collectors DBS CV and EID per site, i.e. 126 for 42 sites ART in collection and transport to BCZS for its transportation to the easily accessible molecular biology laboratory by ensuring monthly transportation reimbursement	Community organization of PLHIV				90 060
Under total						**90 060**
Result 4. 85% of PLHIV are retained in the cohort	Organize a monthly meeting of the therapeutic committee comprising 10 members in 38 ZS concerned	zs				76 000
	Set up compliance clubs in 42 sites with more than 500 PLHIV in the cohort	PTF				151 200
	Implement GCTARs in the rural sites of the 38 ZS of the 8 hyper-priority DPS	PTF				1 368 000
	Implement community approaches for adherence support (GAS, AMM and Activists) in 60 community sites					1 666 800

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	Provide 40 ZS with hyper-priority DPS PIMA and ensure its availability in cartridges for 70% of new inclusions under ARV and 30% of former PLHIV under NUMBER					PM
	Ensure the availability of TB-Lam for 70% of the three categories of PLHIV (naïve, non-naïve who have abandoned ART and non-naïve who have failed treatment) with <200 CD4 cells/µl	PTF				PM
	Ensure the availability of CrAg for 30% of PLHIV in the three categories of PLHIV (naïve, non-naïve who have abandoned ART and non-naive who have failed treatment) with CD4 <100 cells/µl	PTF				PM
	Ensure the availability of Amphotericin B (7/14 days) and fluconazole in 8% of PLHIV with neuro-meningeal cryptococcosis	PTF				PM
	offer anti-TB to all PLHIV co-infected with HIV/TB	Providers				PM
	Offer prophylaxis to all PLHIV CTX	providers				PM
Under total						**3 262 000**
Result 5. Strengthening the health system through HIV support and support	Develop the guide to offering differentiated HIV services	Direction nationale PNLS				16 500
	train 48 national and provincial trainers					23 400
	Train 114 ECZS trainers on differentiated HIV services					27 360
	Train clinical and para-providers clinics on the offer of differentiated services					15 120

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	Organize tutoring for providers on differentiated services					756 000
	Train providers on the logistics management system for HIV inputs based on differentiated ARV renewal intervals					PM
	Provide 38 HGRs with PIMA and make reagents available for 162,682 PLHIV in need					PM
	Arrangement of storage spaces existence of ARVs and other inputs at the level of HZs and healthcare establishments					PM
	Carry out monthly surveys to assess the availability of tracer inputs in the FOSA (tests, ARV and anti-TB) : UCOP+					PM
	Carry out quality surveys with PVVIHs (UCOP+)					PM
	Updating tools based on some indicators on the offer of differentiated services					2 250
	Development of collection tools community					900
	Hold 12 meetings of taks force PEC stolen service organization and community support					12000
Under total						**853530**
TOTAL GENERAL						**17 016645**

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VII. NEED FOR TECHNICAL ASSISTANCE

The operationalization of differentiated services for the fight against HIV in the DRC faces the need for specialized technical assistance in this area. To do this, technical assistance is necessary as part of the operationalization of this plan.

However, immediate technical assistance needs are listed in the table below.

Table 1: Immediate technical assistance needs

Needs	Period	Duration
1. Development of manual and tools on the 2018 offer differentiated services		S1
2. Analysis of the situation on the variants of Year 2018 the organization of differentiated services with a view to consolidating the supply map of differentiated services in the DRC		S1
3. Documentation of good practices in the 8 priority provinces Year 2018-2019 including categories of specific populations (children, adolescents and young people, prisoners and key populations)		S2 2018- S2-2019
4. Revitalization of biological monitoring of PLHIV Year 2018 according to their status (CD4, CV and comorbidity)		S1
5. Organization of viral load campaigns in 8 Priority DPS		

To guarantee the effective implementation of these formulated technical assistances, the PNLS undertakes on the one hand to produce the Terms of Reference for these missions and put in place competitive mechanisms.

VIII. Budget

N°	**Strategic axes Axis** 1.	**Budget a $**
1	Increase in the proportion of PLHIV who know their serological status from 54.7% to more than 85% by 2020 **Axis 2.** Increase in the proportion of PLHIV	8 707 055
2	who know their serological status from 77, 6% to 100% from here 2020	4 104 000
3	**Axis 3.** Increase in the proportion of PLHIV placed on ARV with access to viral load (12 months of ART) from 19% to more than 60% by 2020	90 060
4	**Axis** 4. Increase in the retention of PLHIV in the active queue from 56% (17-89%) to 85% 5 **Axis 5.** Strengthening	3 262 000
the health system **General total**		853530
		17 016645

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IX. IMPLEMENTATION FRAMEWORK

The operational plan for offering differentiated services will be implemented by the three levels of the national health system according to the responsibilities of each of them, so as to involve all stakeholders under the coordination of the Government in a spirit of mutual accountability.

Responsibilities for the implementation of this plan are shared between the different stakeholders, in particular government structures, technical and financial partners as well as Civil Society.

1. Roles and responsibilities of political-administrative authorities

The political-administrative authorities will have the role of encouraging NGOs, OACs, community actors who intervene in the fight against HIV/AIDS. They will ensure the safety of the latter and will provide both material and financial support to OACs, HIV peers and community stakeholders with a view to enabling the implementation of differentiated services for the care of PLHIV in the community under the supervision of providers. Services.

2. Roles and responsibilities of health authorities

The central level health authorities will have the role of developing and popularizing policies, strategies, legal texts, regulations and standards for the implementation of differentiated service offerings. They will also be responsible for supporting and supervising the provincial divisions in the organization of the provision of differentiated services to PLHIV, the monitoring and evaluation of different approaches and the production of strategic information. Furthermore, the central level will also ensure the mobilization and provision of resources to enable the execution of this plan at the operational level. At this level, a composite task force is set up and meets quarterly to monitor the operationalization of the different approaches opted for by the DRC. The latter is under the direction of the Ministry of Health through its technical body PNLS and is organized with the support of its technical and financial partners, civil society and the actors of the Ministry of Health involved in the offer of differentiated services. .

The health authorities at the provincial level, through the DPS, will have the role of local supervision of the health zones for the implementation of the differentiated approach retained in this plan. They will also translate into operational instructions the standards and directives of differentiated approaches decreed by the Central Level and will coordinate all differentiated activities within their area of responsibility. To this end, a provincial operational plan for differentiated services will be developed and this will guide the implementation of the differentiated approaches that the province will opt for.

The authorities at the operational level (the Health Zones) will have the mission of implementing, according to the needs of the health zone, differentiated approaches adapted to the geographical, environmental, cultural context and the weight of PLHIV in their Health Zones. To do this, the Health Zones will integrate activities related to the offer of differentiated services into their operational plan and the Health Zone authorities will support providers in the implementation of these approaches.

3. Roles and responsibilities of providers

Providers will offer HIV testing and care services as well as support to PLHIV and PA according to the undifferentiated approach and differentiated approaches. They will help the proper implementation of differentiated community approaches such as PODI, the Club

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compliance and the ART Community Group by ensuring awareness of PLHIV from the initiation of ARVs, until the stabilization of the general condition attested by the undetectable viral load, the no change in the therapeutic regimen for the last 3 months, the good patient adherence and retention in treatment, and the absence of opportunistic infections for the last 3 months. They will direct all stable PLHIV into one of the differentiated approaches to patient choice and will ensure clinical and biological monitoring of patients who collect their ARVs in the community as appropriate, once or twice a year.

4. Roles and responsibilities of community actors including civil society

Religious denominations, health NGOs, OACs, professional orders and associations will strengthen the partnership with the Government as health actors. They participated in the development of this plan and will participate in all stages, from the development of the provincial and zonal operational plan for the provision of differentiated services, its implementation and evaluation including the mobilization of resources additional.

Religious denominations will ensure the effective participation of their health facilities in the implementation of differentiated approaches. Health NGOs will participate in building the capacities of providers and community stakeholders on differentiated care.

International NGOs will network with national NGOs with a view to strengthening capacities of the latter on differentiated approaches.

Their active participation in the implementation of differentiated care approaches must be guaranteed by taking an active part in Technical Commissions such as Working Groups.

care of PLHIV at the national and provincial level.

The unions of health professionals and staff will ensure compliance with contractual obligations by the employer-State and by employees.

5. Roles and responsibilities of technical and financial partners

The technical and financial partners are responsible for:

- The mobilization of external resources to support the implementation of different differentiated approaches and ensure their efficient use
- Strengthening the technical capacities of actors responsible for implementing differentiated services and coordination bodies (PNLS and BPC)
- Participation in the monitoring and joint evaluation of the operational plan for differentiated services through the HIV care Commissions and Working Groups

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X. COORDINATION, MONITORING AND EVALUATION FRAMEWORK

The implementation of the operational plan for offering differentiated services will be coordinated by the National Program for the Fight against AIDS through the rationalization mechanism, prioritization and the consultation framework for the care of people living with HIV in its theme organization of community services and care focus differentiated care.

The National AIDS Control Program has set up this coordination and rationalization mechanism to limit duplication and ensure the complementarity of interventions at the national and operational level.

- At national level, quarterly meeting to evaluate the implementation of the plan: the PNLS, civil society (RNOAC and UCOP+) and technical and financial partners (main beneficiaries and implementation of the FM and PEPFAR, CDC, WHO, UNICEF, UNAIDS and MSF)

- The operational plan for offering differentiated services will be included as a priority in the agenda of this system and will make it possible to bring together technical and financial partners and implementing agencies every 90 days to share data on the progress made on the field as well as the main challenges and bottlenecks with a view to adjusting interventions.

At the Provincial level, monthly operational monitoring meeting bringing together the following actors: civil society, Global Fund sub-recipients, PEPFAR sub-recipient NGOs and the decentralized joint United Nations team. At the provincial level, implementation partners implementation will meet every month under the
leadership of the provincial coordination office of the PNLS to monitor the progress of the operational plan for offering differentiated services and the status of the implementation of recommendations to remove bottlenecks at the operational level The national system monitoring and evaluation will serve as a system for collecting and analyzing indicators to guide interventions and inform programs about progress towards achieving the 90-90-90
objective.

The tier.Net will be used to collect patient data to help track the progressive reduction of cascades and programmatic gaps at the health zone level.

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ANNEX

Appendix 1. Table of mapping of Health Zones with high-volume sites in hyper-priority DPS according to convergence or non-convergence between HIV and TB

N°	Hyper-priority DPS category	Hyper-priority DPS	ZS with sites ÿ500	Sites (Number of PLHIV Mid-2017)
1	Convergent DPS	Haut-Katanga	Kamalondo	HGR (686)
			Kenya	HGR (1779)
			Lubumbashi	CUL (762)
				Sendwe/CE (4317)
			Panda	HGR (657)
			Mine	My HMR (1107)
2		Kasai-Oriental	Bonzola	H. Pumpkins (545)
			Dibindi	HGR CHPM (525)
			Chancel	HGR St JB Chancels (788)
3	HIV divergent DPS	skin oil	Doruma	HGR (684)
			Stupid	HGR (1591)
			Mathematics	HGR (2280)
				H. Notre de Dame (1920)
			Niangara	HGR (704)
			lining	HGR (1265)
				H. Nebobongo (704)
			Mace	HGR (602)
			Ordinary	HGR (530)
			Disperse	HGR (2678)
4		Maniema		
5		British Bass	0	0
6	TB Divergent DPS	Kinshasa	Bandalungu	Bibiki (569)
			Barumbu	Reception (929)
			Spice	Libondi (504)
			1 pen	CS Brotherhood (535)
			Country-Vubu	I Love Congo/Bon Berger (1986)
			Kingasani	CH Kingsani (523)
			Kinshasa	CME/Slaves (774)
			Kintambo	HGR (713)
			Crawl	HMR Kokolo (618)
			Write it down	CH Kabinda (1488)
				HPKLL (1907)
				CDT Kabinda (711)
			Month I	CS Joy (632)
				Pilot/Month (507)
				Roi Baudouin Ier (540)
			Car II	CS Victory (1195)
			Mont-Ngafula I	CH Monkole (1132)
			Dear	CS Bomoi (1448)
				CS Favorites (1434)
7		Kongo Central	Government	HGR (899)
			Kitona	HGR (572)
			I do	HGR Kiamvu (780)
8		Ituri		