Partnership Framework Document
to Support Implementation of
the Democratic Republic of the Congo
National HIV and AIDS Response

Between

The Government of the United States of America

And

The Government of the Democratic Republic of the Congo

A Five-Year Strategy
to Support the GDRC to Jointly Implement National Goals to Reduce the Transmission of HIV and
to Minimize Negative Impacts on the Congolese People

1.1 PURPOSE

The national response to the HIV and AIDS epidemic in the Democratic Republic of the Congo is led and coordinated by the Government of the Democratic Republic of the Congo (GDRC). HIV/AIDS control is named a priority in the GDRC Poverty Reduction Strategy Paper. In response to the HIV/AIDS epidemic, the GDRC has established two bodies to coordinate HIV/AIDS activities, of which the PNMLS is in charge of overall coordination[1]:

- The Multi-sector AIDS Commission (PNMLS) – established by presidential decree in 2004, with leadership provided by the MOH and members from the Ministries of Education, Finance, Planning, and Public Works, as well as donor, private sector, and civil society representatives and financial support from the World Bank.
- The National AIDS Control Program (PNLS) – established by the Ministry of Health (MOH) in 1987 provides leadership in the health sector for aspects of HIV/AIDS control.

The GDRC works with several development donor partners, including partners from the private sector as well as faith-based, community-based and nongovernmental organizations to scale-up prevention, treatment and care activities and to minimize negative impacts. External donors, primarily the U.S. Government (USG), the Global Fund to fight AIDS, Tuberculosis, and Malaria (GFATM), the World Bank Multi-country AIDS Program (MAP), and the United Nations agencies, have the provided bulk of the financial support for HIV/AIDS activities. In general, donors have focused on the implementation of the GDRC National strategy by utilizing a regional focus with different donor funding implementing comprehensive programs in non-overlapping regions. The GFATM HIV/AIDS Round 3 Program is $113 million over 5 years (ending December 2009), covering prevention, care, and treatment funds. The GFATM HIV/AIDS Round 7 Program is $71.4 million over five years with $22.6 million approved for the phase one (started in December 1, 2008). The Round 7 award was designed to pilot the new MOH strategy to provide integrated and full HIV package of services in a 43 selected HZ. All Round 3 activities will continue to be funded for approximately $234.5 million USD under the approved GFATM Round 8 grant, which is expected to begin in 2010. GFATM Round 8 grant activities represent a significant scale-up of services within existing health zones, including an increase of people receive ARVs from 21,115 to 67,099.Most of the work is implemented by non-governmental organizations (NGO), and the Country Coordinating Mechanism (CCM) is led by the MOH, with substantial participation of donors including the USG, European Union, UN organizations, and civil society as vice-chairs. The PNLS and PNMLS provide technical leadership and guidance. The USG funds critical technical assistance to support the functioning of the CCM and the PRs to ensure good governance and transparency. The GFATM Principal Recipient, UNDP and The World Bank provide all the adult antiretroviral (ARV) first line drugs, and the Clinton Foundation provides all the pediatric ARVs and the second line drugs until 2011 in specified Health Zones (HZ).

[1] To date there is only one governing body, the PNMLS. This body takes charge of overall coordination of HIV/AIDS activities. BCC-SIDA was established in 1987, renamed PNLS, and subsequently the PNMLS was established in 2004. The Ministry of Defense (MOD) established the Military AIDS Control Program (PALS) in 2004, which currently coordinates the HIV/AIDS activities in the five military health zones comprised of seven hospitals and 88 health facilities. Through PALS, the MOD works closely with the PNMLS.

The USG has been programming limited resources through its Five-Year HIV/AIDS Strategy in the Democratic Republic of the Congo (DRC). The President's Emergency Plan for AIDS Relief (PEPFAR) initially supported the GDRC to establish facility and community-based platforms in three geographic areas of the country. The response of the USG focuses on service delivery and technical assistance. The provision of services allows for direct impact on targeted populations by increased access to service, education, and commodities to reduce transmission and minimize the impact of HIV/AIDS at the local level. The technical assistance targets both the GDRC and civil society to strengthen policy and build capacity to better coordinate and implement quality services at the national level. Additionally, PEPFAR helped develop the country's monitoring and evaluation plan for HIV and implemented behavioral surveillance studies in order to better target interventions. Finally the USG, in collaboration with the GDRC and other partners, undertook the nation's first demographic and health survey (DHS) with an HIV module and sero-prevalence testing.

In 2008, the U.S. Congress reauthorized PEPFAR for an additional five year phase (2009-2013). During the first phase, PEPFAR had succeeded in assisting host countries to save the lives of millions by partnering with the GFATM to bring ART and support to over 2 million people globally, and to strengthen programs in other critical areas including HIV prevention of sexual and mother-to-child transmission, and care for orphans and other vulnerable populations. With such phenomenal achievements, particularly in treatment, there was a recognition that the second phase of PEPFAR would focus on sustainability, in part by building local capacity, supporting country ownership and leadership, and strengthening the health systems to deliver and monitor health services for people living with HIV and AIDS (PLWHA). Equally important in this second phase is a commitment to the PEPFAR goals for prevention, treatment, care and health systems strengthening.

In the DRC, PEPFAR is supporting the continuum of care in the high prevalence provincial capitals of Bas-Congo (Matadi- 3.1 percent), South Kivu (Bukavu, located in eastern DRC- 1.6 percent) and Katanga (Lubumbashi- 6.3 percent) and their immediate transportation corridors. PEPFAR is also supporting mass media strategic communication and messaging, prevention, diagnosis and treatment of TB-HIV co-infection, laboratory support and PMTCT activities as well as family-centered continuum of care (including ART) to TB-HIV co-infected patients in primary health care settings in Kinshasa and Lubumbashi. The GFATM Round 3 grant is currently financing the provision of ARTs; the GFATM Round 8 grant will continue and expand care and treatment programs. The World Bank, through the MAP program, supported HZ that were intentionally selected based on non-presence of other donors. By the end of 2010, MAP programs will end, and GFATM Round 7 and 8 will take over activities in these health zones. So there will be no interruption of services. Through the Partnership Framework management, USG intends to engage the GDRC and other stakeholder members of the steering committee to ensure that donor resources are properly planned and are managed with evidence of good governance to prevent interruption of service delivery. The USG expects to use the Global Fund liaison position to actively interface with the GDRC and the GFATM Principal Recipients in order to facilitate and improve grant performance and coordination with USG bilateral efforts.

UNICEF programs provide intermittent support in limited geographic areas focused primarily on OVCs; this will continue over the course of following years depending on donors' response to UNICEF annual call for resources.

Through this partnership framework, the GDRC and PEPFAR Country Team have taken a strategic approach to enhance existing programming by identifying both the geographic areas to be supported under a formal partnership arrangement as well as the additional sources of funding to support the delivery of essential services. The valued added of this new approach will be clarity of the commitment of both partners to assure the continuation of essential HIV/AIDS services. Recognizing that U.S. and GDRC resources are limited and investments are subject to the availability of funds, this partnership is intended to support a coordinated, geographically targeted program employing evidence-based interventions that align with the GDRC HIV/AIDS National Multi-sector Strategic Plan (NMSP) and PEPFAR global goals and objectives. The overarching goal of this Partnership Framework is to support the GDRC efforts to reduce the transmission of HIV/AIDS and to minimize the negative impacts of this disease on the Congolese population.

The initial year of this Partnership Framework expects to focus on consolidating and expanding comprehensive and complementary activities in Kinshasa and Lubumbashi through a whole government approach in which each USG agency leverages comparative strengths synergistically to deliver comprehensive quality services addressing the GDRC's priorities. At the same time, activities in Matadi and Bukavu as well as rural PMTCT (40 HZs in Kasais, South Kivu and Katanga) and safe blood activities (57 HZs in the same provinces) are expected to continue. Over the next two to five years, with input from the steering committee (described in section 4), decisions could be made about where programming may be strategically expanded using the whole Government approach should increased funding become available.

HIV/AIDS IN THE DEMOCRATIC REPUBLIC OF THE CONGO

The DRC was one of the first African countries to recognize HIV/AIDS when the first case was documented in 1983. In 2007 the DRC DHS estimated that the HIV prevalence in the general population was 1.3 percent with higher prevalence among women (1.8 percent) and in urban areas (1.9 percent). For women, the highest prevalence is between ages 40-44 (4.4 percent). For men, the highest prevalence occurs between 35-39 years (1.8 percent). Adults living in urban areas are at higher risk of infection than those living in rural areas (1.9 percent versus 0.8 percent, respectively). Women who are more educated and wealthier are at greatest risk (3.2 percent and 2.3 percent, respectively). In relation to marital status, widowed women have the highest prevalence (9.3 percent). Behavioral Surveillance Studies (BSS) have shown much higher prevalence rates among Most At Risk Populations (MARPS), such as 23.3 percent among sex workers in Lubumbashi (2004) and 11.8 percent among military personnel (2008).

UNAIDS's modeling program for HIV estimates (EPP Spectrum) that 1.2 million Congolese are infected with HIV and that 250,000 Congolese will be eligible for antiretroviral (ART) treatment by 2010. However, even with GFATM Round 8 support, only 67,000 people are expected to access treatment over the next five years. In addition, the DRC 2009 OVC Rapid Assessment, Analysis, and Action Plan (RAAAP) situational analysis estimates that there are 8.2 million Orphans and Vulnerable Children (OVC), although most are not due to the HIV epidemic.

The DRC now ranks 10th among the world's 22 high-burden tuberculosis (TB) countries. The estimated incidence of TB was 392 cases per 100,000 people in 2007, according to the World Health Organization (WHO). HIV prevalence in adult- incident TB patients is estimated to be 18 percent[2]. This is consistent with some other West-Central African countries.

EPP-Spectrum estimates that 141,500 HIV+ women in DRC delivered 42,450 infected children through mother to child transmission in 2008. Although there are several major HIV/AIDS efforts ongoing in DRC, progress on some key indicators has been slow. Less than 3 percent of pregnant women nationally have access to PMTCT services, fewer than 30 percent of PLWHAs enrolled in ART programs are receiving some form of palliative care, and only 8 percent of PLWHA eligible for ART have access. Based on the data above, it is clear that there is a large unmet need for services in the DRC.

Malaria is a major health problem in the DRC, accounting for an estimated 40% of outpatient visits by children under five and more than 35% of the overall mortality in the same group. The 2007 Demographic Health Survey showed very low coverage rates of key malaria prevention and control measures. Only 9% of households owned one or more insecticide-treated nets (ITNs), and only 6% of children under five and 7% of pregnant women slept under an insecticide-treated mosquito net (ITN) the night before the survey. The proportion of children under five with fever treated with artemisinin-based combination therapy (ACT) within 24 hours of the onset of illness and the proportion of pregnant women receiving two doses of intermittent preventive treatment (IPTp) were less than 1% and 5% respectively, although it should be noted that implementation of these

[2] Data from UNC HIV/TB program in 2007. Based on data collected from the Integrated Health Care project cofounded by USAID and the European commission in Bas-Congo and North-Kivu, the National Tuberculosis program estimated the HIV the prevalence among TB patients at 16 percent.

interventions only began in 2006. Although not selected as one of the 15 countries in the President's Malaria Initiative (PMI), the level of USAID malaria funding in DRC rose significantly in FY07 and FY08 to about $7 million annually. A further increase to $15 million is proposed in FY09, pending the availability of funding.

1.2 PRINCIPLES

In implementing this Framework, PEPFAR and the GDRC intend the Partnership to be governed by the following principles:

1. High-level government commitment, national leadership and continued ownership of the response by the government and Congolese people;
2. Promotion of the principles of the "Three Ones": one national multi-sectoral strategic plan (which is the NMSP), one national authority (which is the national multi-sectoral program for the Fight Against HIV/AIDS), and one national monitoring and evaluating System. The Partnership intends to operate under independent financing arrangements for United States government foreign assistance;
3. Recognition that U.S. and GDRC resources are limited and investments are subject to the availability of funds;
4. Prioritization of geographic areas and most at-risk populations to achieve the greatest impact using strategic information and data to guide the targeting of interventions;
5. Recognition of implementation realities including logistics, existing programs and economies-of-scale;
6. Alignment of the comparative strengths of the U.S. government agencies implementing PEPFAR including technical support and strengths of implementing partners to delivery quality services;
7. Alignment of support provided by GFATM, World Bank, United Nations and other key partners, prioritizing complementary programs to ensure quality programming, thus maximizing impact;
8. Meaningful involvement of local organizations and PLWHA in program development, implementation, and evaluation;
9. Maximizing public-private partnerships to enhance sustainability, coordination, and sharing of best practices among development partners and implementers;
10. Recognition that achievement of the partnership goals requires resources beyond the provisions of any one partner, and the constraints on the availability of funding from either signatory or from other key partners could lead to a review and revision of goals.

1.2 COUNTRY OWNERSHIP

The GDRC HIV response is coordinated through the health sector PNLS Plan for 2008-2012 and the PNMLS Plan for 2010-2014. The overall goal of both plans is to reduce HIV incidence while minimizing negative impacts on individuals, families, and communities within the framework of poverty reduction. Within this plan, the PNLS was delegated the responsibility to coordinate epidemiological surveillance and clinical services. The plan focuses on four strategic axes:

- Reduced transmission of Sexually Transmitted Infections and HIV;

- Improved access to care and treatment;
- Minimized socio-economic impact of HIV and AIDS;
- Sustained implementation of the National Multi-sector Strategic Plan.

The activities prioritized for support from the USG under this Partnership Framework are intended to achieve the maximum feasible impact as well as minimize gaps in HIV/AIDS services and programming in the USG geographic focus areas. These priorities were identified through key assessments, recommendations from PEPFAR Senior Leadership (Deputy Principals), and the treatment and PMTCT technical working groups. In addition, the PEPFAR Country Team led extensive and ongoing Partnership Framework individual and group discussions with the GDRC, GFATM, World Bank, the Clinton Foundation, United Nations agencies, and other key stakeholders.

To enhance country ownership, the PEPFAR indicators and targets are drawn primarily from the NMSP. Where no adequate indicator or target was defined, information was supplemented with the MOH National Strategic Plan. Also, the PEPFAR Next Generation Indicators guidance was consulted to align as many indicators as possible. While the current GDRC five-year targets are ambitious and may be extremely difficult to achieve, PEPFAR will contribute to the achievement of the national targets to the greatest degree possible in a geographically focused manner, even though this contribution will be limited and overall represents only a small contribution to the targets as they are presently defined in the MNPLS 2010-2014.

This Partnership Framework will enhance collaboration to contribute positively to the achievement of the GDRC's national HIV/AIDS goals and objectives for greater country ownership through joint decision-making. The GDRC and the USG intend to work together to review the feasibility and underlying funding assumptions linked to the achievement of these targets within the extremely difficult country context. The USG seeks to provide technical assistance to inform the possible readjustment of targets, as appropriate and mutually agreed upon by both the GDRC and PEPFAR. PEPFAR brings a proven network of technical expertise and quality programming to support measurable results.

1.3 THE ROLE OF OTHER PARTNERS

In the DRC, donor support for basic health services, including HIV/AIDS, is geographically divided into 515 health zones (HZs) in eleven provinces. Substantial support for the national response in the DR Congo is provided by the GFATM, World Bank, the Clinton Foundation and the U.S. Government. With the exception of pediatric care, GFATM and World Bank provide a full range of HIV/AIDS services and commodities within the HZs they support, however support is not sufficient to cover the real demand for service. Pediatric care in these HZs, including commodities and forecasting, is supported by the Clinton Foundation. The GFATM and the World Bank provide all adult antiretroviral (ARV) first line drugs, and the Clinton Foundation provides all pediatric ARVs and the second line drugs nationally, even in health zones where other partners are providing the services.

Collectively, these three donors cover 308 HZs scattered across all eleven provinces. Table 3.1 below summarizes HZs, funding levels, and program dates by major donor.

Table 1.3 Funding Levels, Program Dates, and Status by Donor

Donor	HZs Covered	Funding Level	Program Dates	Status
GFATM-Round 7	43	$71.4M: Phase1:$22.7M	2008-2012	Ongoing implementation
GFATM-Round 8	196	$234.5M	2009-2013	Preparing to be signed
World Bank (MAP)	69	$102M	2005-2010	Over half the budget has been expended; the remaining amount will cover activities through December 2010, and initial discussion on follow-on activity is underway
UNICEF (OVC)	70	$2.5M		Funding provided on annual basis
Clinton Foundation	Country wide	$2M (2009), $3M (2010)	2006-2011	Secure ARV treatment to every new infected child and second line treatment countrywide
DFID[3]	11 provinces	$8M	2006-2011	HBC and OVC support.
USAID (CSH)	80	$56M	Annual	Health Budget focused on non-HIVminimum package of activities in selected Health Zones of South Kivu, Katanga, East and West Kasai provinces
USAID	Kinshasa, North and South Kivu, Majniema, Katanga, Bandundu, Equateur, Orientale, West Kasai provinces	$50.4M	Annual	Other USAID development assistance including Peace and Security, Economic Growth, Education, Social Protection, and Disaster Assistance

The GFATM Round 3 grant, which ends in December 2009, supports programs in 262 HZs. The GFATM Round 8 grant will only support programs in 196 HZs of the 262 HZs. Of the remaining 66 HZs, 33 were integrated into the GFATM Round 7 grant and the other 33 are included in the World Bank program. The GDRC has submitted a Round 9 (2010-2014) proposal for HIV/AIDS that

[3] The locations of DFID OVC and HBC activities are: Kinshasa, Mbuji-Mayi (Kasai-Oriental), Kananga (Kasai-Occidental), Kikwit (Bandundu), Kindu (Maniema), Mbandaka (Equateur), Boma (Bas-Congo), Kisangani (Province Orientale), Uvira (South-Kivu), Goma (North-Kivu), and Kasumbalesa (Katanga).

targets additional HZs in Oriental, North and South Kivu provinces with an emphasis on Gender Based Violence.

The United Nations agencies are collaborating on a joint program to reduce the spread of HIV/AIDS in the transport sector, currently funded at $2 million for 2009-2010 in Kinshasa, Bas-Congo, Orientale, Katanga, North and South Kivus and the Kasais. This program focuses on "edu-tainment" activities to increase awareness and referral for additional services. In the area of PMTCT, UNICEF is providing intermittent training and commodities in 118 HZs. UNICEF also provides annual support for OVC programs in the amount of $2.5 million providing support for 110,000 OVC scattered across all eleven provinces, supporting capacity building of teachers and children found to be orphaned or vulnerable in order to exempt them from paying school fees. WFP currently provides supplementary feeding to PLWHA through 179 sites including Bukavu and Lubumbashi. MSF-Belgium supports care and treatment in Kinshasa to 3,000 PLWHA with a commitment through 2011. WHO provides technical assistance at the national level on PMTCT, blood safety, and commodity forecasting. GTZ is exploring strategies for health care financing by piloting a cash transfer approach in one HZ in Bandundu province.

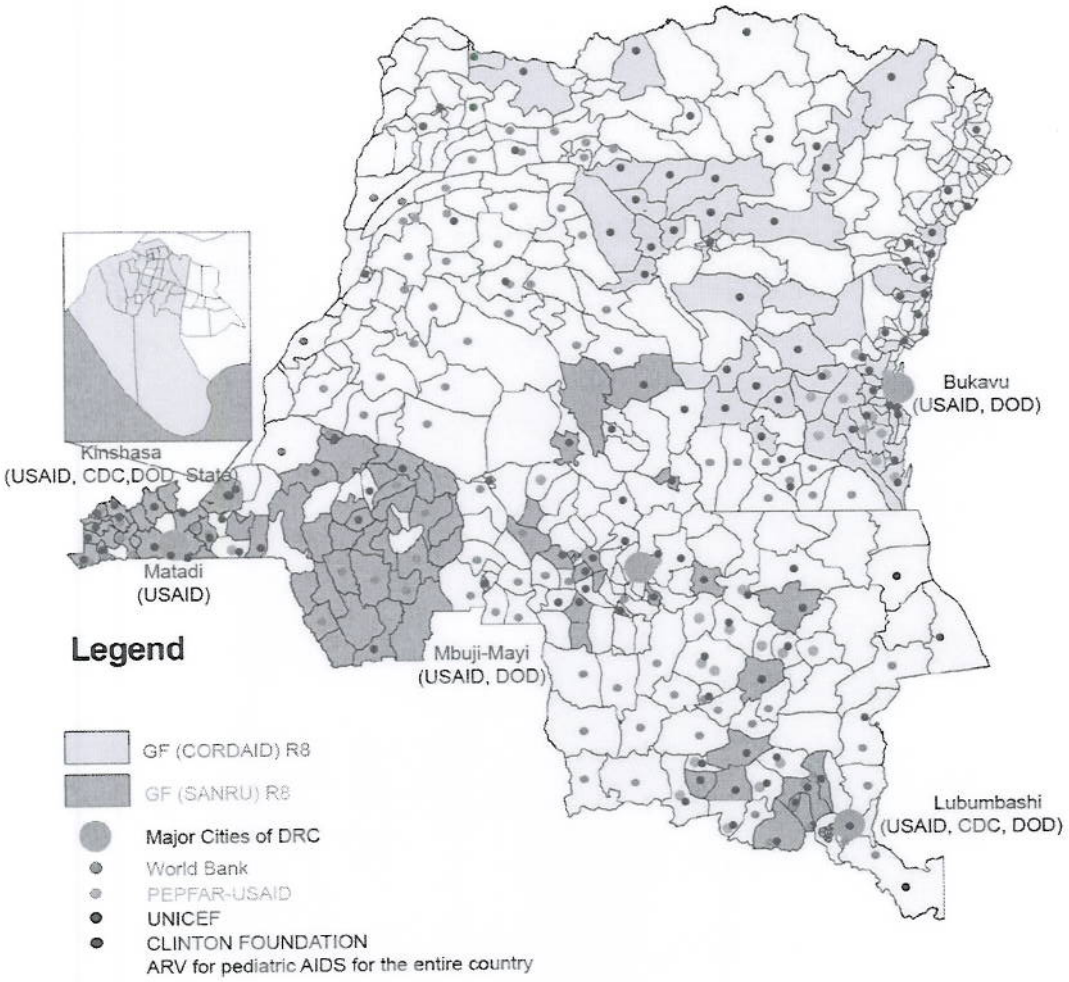
USAID/DRC Health portfolio worth $56 million is providing significant support to GDRC at national, provincial and HZ levels. The Health program strategy involves a three-pronged approach, which includes: technical assistance, capacity building and provision of services at the HZ level.

- Technical assistance is focused on the national and provincial levels in the areas of policy development and implementation across multiple health areas including: family planning and reproductive health, primary healthcare targeting children under-five and pregnant women, and surveillance and management of infectious diseases. Additional support has been targeted to strengthening the national commodities system including: procurement (including forecasting, inventorying and pricing), management, logistics, delivery and drug quality control.
- Capacity building is targeted at all levels, national, provincial and HZ, to have impact on management and implementation of services. Capacity building is facilitated through the provision of training as well as mentoring. For example, targeted support has been provided to the Kinshasa School of Public Health to strengthen overall program management and administrative abilities. Additionally scholarships are being provided to approximately 20 masters and doctoral level candidates to increase opportunities for Congolese to access post-graduate degrees in public health such as malaria, epidemiology and primary health care. An emphasis has been placed on identifying qualified women candidates to ensure gender equity.

Increased access to quality health care services across 80 HZs in four provinces: Kasai Oriental and Occidental, Katanga and South Kivu covering 11 million people. USAID funding supports the provision of the MOH complete primary health care package which includes support to the General Reference Hospitals in the four provinces. The primary health care service package ensures the provision of the following services: immunization, maternal child health, family planning and reproductive health, water sanitation and hygiene, and infectious and emerging disease management, including cholera, TB, Ebola, malaria and other diseases. The PEPFAR funding is expected to be used to leverage the other USG health investments where programs are co-located (Lubumbashi).

The DRC map below shows HIV activities implemented by major donors.

MAPPING OF DRC HIV ACTIVITIES FROM MAJOR DONORS



PEPFAR is currently supporting safe blood activities in 57 HZs in Katanga, South Kivu, East and West Kasai provinces and Prevention of Mother-to-Child Transmission (PMTCT) in 40 of those same HZs. These activities are linked to USAID's integrated primary health care program. PEPFAR activities in the provincial capital of Katanga (Lubumbashi) include laboratory support and behavior change communication targeting people in uniform. PEPFAR is supporting the continuum of care in the high prevalence provincial capitals of Bas-Congo (Matadi), South Kivu (Bukavu which is located in eastern DRC) and Katanga (Lubumbashi) and their immediate transportation corridors. PEPFAR is also supporting mass media strategic communication, prevention, diagnosis and treatment of TB-HIV co-infection, laboratory support and PMTCT activities in Kinshasa and Lubumbashi. The DRC PEPFAR Country Team intends to draft a Memorandum of Understanding (MOU) with the GFATM to ensure synergies and coordination. Key elements of the MOU seek to ensure ARV treatment enrollment and supplemental salary support to ensure quality services where

PEPFAR is supporting complementary programming. In the initial year this Partnership Framework focuses on continuing existing activities described above in addition to consolidating and expanding comprehensive and complementary activities in Kinshasa and Lubumbashi, in partnership with the GDRC and other key partners. Should this approach prove successful, and increased funds become available, it may be expanded to other areas.

If U.S. assistance is provided directly to the GDRC under this Partnership Framework, GDRC contributions would be expected to meet host country cost sharing requirements under U.S. foreign assistance programs; key to the success to the programs will be continued GDRC salary support to government health personnel at public facilities. Details regarding the GDRC financial and/or in-kind contributions to programs under this Partnership Framework are to be provided in the Partnership Framework Implementation Plan.

2. FIVE-YEAR STRATEGIC OVERVIEW

2.1 High Level Partnership Framework Goals:

Recognizing the importance of country ownership and sustainability, the hallmark of the new partnership is joint decision-making in setting programming priorities for the HIV/AIDS sector, and joint commitment to greater transparency in reporting information.

During collaborations with the GDRC, other donors and Congolese stakeholders, it was envisaged the Partnership framework would strategically focus its resources on 1) providing services to the most at risk and vulnerable populations 2) work in selected geographic areas to target interventions to have a greater impact where the USG is currently working, and strengthen specific health systems to link services more effectively. Extensive consultations and discussions have occurred over the past year to define the priorities of this Framework document. Important guiding principles included alignment with the support provided by the GFATM and the comparative strengths of the USG agencies implementing PEPFAR. This includes reviewing the strengths and weaknesses of technical support provided by implementing partners to deliver services in an effort to improve the overall quality of DRC program.

Within the National Multi-sector Strategic Plan (NMSP) for 2010-2014, the GDRC will make progress on its four 'strategic axes' with support from PEPFAR and other partners. The axes were reformulated into four interlinked, strategic goals that form the foundation of this Partnership Framework. The national indicators and targets are highly ambitious given the currently available resources and challenges faced by the DRC; however the USG is committed to using PEPFAR resources to contribute to the realization of the goals. Given the limited resources of the USG, harmonizing contributions of other donors are critical. USG's support to strategic information and human resource capacity building may also be key to ensure targets and indicators are optimally defined.

Goal 1: PREVENTION – To reduce new HIV infections in the DRC

i. <u>National Indicator and Targets</u>:

- To reduce the number of new adult and infant HIV infections from 181,000 per year in 2009 to 90,500 per year by 2014, preventing an estimated total of 253,400 infections over five years.

ii. Program Areas: Sexual Prevention; PMTCT; Bio-Medical Prevention (Blood Safety and Injection Safety); HIV Counseling and Testing (HCT); Strategic Information; targeted information; Gender as a cross-cutting issue.

iii. Key Policy Reforms :

- MOH implements the new condom distribution policy for high-risk populations over the next 12 months;
- MOH evaluates the results from finger prick testing pilot to draft new HCT policy that would enable non medical personnel to provide testing services over the next 2 year etc;
- MOH approves new HCT norms and guidelines, to include Provider Initiated Counseling and Testing (PICT) and increased focus on couples counseling;
- The relevant ministries of GDRC, including Justice, Health, Defense, Social Affairs, Gender, intend to collaboratively implement and enforce the new Gender Based Violence (GBV) and anti-trafficking law recently signed by the President;
- MOH implements the new PMTCT protocol, which includes triple-dose therapy week 28th of pregnancy;
- The PNLMS anticipates leading strategic behavior change communication messaging through a newly formed coordination forum.

iv. Five Year Benchmarks/Measurement of Success

- 50 percent reduction in estimated incidence among adult populations. Annual Antenatal Care (ANC) surveillance, an AIDS indicator survey and a BSS once every two years will provide the necessary modeling prevalence data to compare to baseline estimates;
- At least 64 percent of women in uniform will have received evidence-based prevention training; at least 64 percent of men in uniform will systematically use condoms;
- Increase the proportion of youth aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission; reduce the proportion of youth aged 15-24 who have had sexual intercourse before the age of 15 from 28.1 percent to 10 percent by 2014;
- Over the next five years, test and treat 8,288,394 individuals for sexually transmitted infections including HIV; increase the proportion of patients with STI at health care facilities who are appropriately diagnosed, treated and counseled;
- At least 80 percent of pregnant women attending antenatal care use PMTCT services (are tested and know their results); the proportion of HIV+ pregnant women receiving ART will have increased from 11 percent to 58 percent by 2014.

The GDRC endorses prevention as a key strategy to address HIV/AIDS in the DRC. The Partnership Framework prevention approach seeks to have a value-added strategy that works in synergy and collaboration with in-country donors and key partners to contribute to the achievement of national goals through the scale-up of prevention services. USG investments will focus on interventions and activities to reduce risky behaviors, improve access to prevention services for Most At Risk Populations (MARPS), expand prevention of mother-to-child transmission (PMTCT) services in urban and rural sites, increase access to HCT through improved linkages to PMTCT, scale up behavior change activities and, where appropriate, introduce Provider Initiated Counseling and Testing (PICT) at ART and TB sites. Additionally, technical assistance to the MOH is intended

to improve the implementation of biomedical interventions, insuring increased access to safe blood and proper disposal of medical waste. An existing, branded mass media communication platform, 'Rien que la Vérité,' developed by the State Department's Public Diplomacy team, is expected to be used along with other strategic communication tools to link and strengthen all HIV/AIDS prevention interventions. (See Appendix A)

The USG investment in supporting the prevention goals strongly complements the GFATM-funded activities to reduce duplication and enhance coordination. Within prevention, the GFATM supports Sexually Transmitted Infection drugs, condoms, mass media strategic messaging campaigns, prevention for positive and discordant couple's activities, PMTCT training, ARVs, salary support, and blood transfusion equipment and supplies. The GFATM Round 7 grant allocated 32 percent of its budget to prevention; Round 8 allocated 38 percent. The UN agencies are targeting MARPS with prevention messaging and by providing condoms along major transportation corridors. WHO is providing TA on the counseling and testing policy as well as blood safety. The private sector is providing support to the prevention hotline. The World Bank is supporting mass media campaigns, peer education, condoms and PMTCT services in selected health zones.

The Global Fund supports prevention activities by working in the following areas in designated HZ: PMTCT, behavior change communication, HCT, blood safety, and outreach to high-risk populations. More specifically, funding is used to support HIV/AIDS prevention and care projects targeting sex workers, truck drivers, prison populations, youth, and PLWHA. The World Bank Multi-country AIDS Program (MAP) provides a comprehensive prevention package similar to the Global Fund in their designated health zones. UNICEF is a key PMTCT partner, providing support to the PNLS for the expansion of their new PMTCT protocol. In health zones where USAID is implementing the MOH's primary health care package, the prevention activities are expected to be integrated to ensure access to comprehensive services such as malaria prevention care and treatment and maternal child health as well as family planning and immunization services.

The GDRC will support Gender Based Violence (GBV) activities, including expanded Post-Exposure Prophylaxis (PEP) interventions, if they are successful in securing a Global Fund Round 9 grant. PEPFAR expects to provide counseling and support, including linkages and referrals to treatment and care service for victims of sexual violence in Eastern Congo and facility service providers in Kinshasa and Katanga.

To standardize activities, the Partnership Framework intends to use existing coordinating bodies, including the PNMLS, CCM, technical committees and task forces, to harmonize activities among partners under the leadership of the GDRC. This improves synergies, insures that there is no duplication of activities, and reduces gaps in services.

All prevention activities are designed to link with the other three goals in the framework, and are intended to be part of a whole government approach initially focusing on Lubumbashi and Kinshasa, with the desire to scale up this model over the life of this partnership framework.

Goal II: TREATMENT, CARE AND SUPPORT – To expand access to high quality care and treatment services to HIV+ Congolese

i. National Indicator and Targets:

- The number of PLWHA receiving comprehensive care and treatment will reach 328,744 by 2014;

ii. Program Areas: Adult and Pediatric care and treatment; laboratory infrastructure (CD4 testing and early infant diagnosis); Adult home-based and palliative care; TB/HIV, Strategic Information; Health Systems Strengthening; Human Capacity Development; and Gender as a cross-cutting issue;

iii. Key Policy Reforms:

- The ministries of GDRC including Justice, Health, Social Affairs, Gender and Human rights plans to collaboratively implement and enforce the new law protecting the rights of people affected by HIV/AIDS;
- The Ministry of Health revises adult care and treatment policies and training curricula and the standardized package of care and support, focusing on positive living;
- The Ministry of Health implements the new policy on early infant diagnosis for HIV exposed children;
- The Ministry of Health develops and implements new ARV interruption policies.

iv. Five Year Benchmarks/Measurement of Success

- New training curricula for care, support and treatment programs focusing on staying healthy and living positively are available and implemented in selected targets areas such as care and treatment facilities and other community based services;
- GDRC meets its national goal of having 328,744 PLWHA receiving care and support by 2014;
- GDRC meets its national goal of having 263,154 PLWHA on quality ARV treatment by 2014;
- 239,794 PLWHA and their families have received assistance to establish a stable source of income by 2014;
- All PLWHA are actively monitored for Tuberculosis (TB); 80 percent of TB patients are tested for HIV.

The Partnership Framework care, support, and treatment approach provides a value-added strategy working in collaboration with in-country donors and key partners to support the achievement of national goals through the scale-up of quality services utilizing USG resources for services in a geographically focused manner and a broader technical assistance manner across the country. USG investments intend to build upon existing activities to strengthen and broaden the linkages between prevention and care, support and treatment services. The on-going prevention activities, including HCT, PMTCT, and PICT in TB sites, offer an entry point for expanding care and support services. The Partnership Framework will focus its support on enabling TB/HIV co-infected patients to have access to ARV services in selected TB clinics with high attendance. Through the Partnership Framework, PEPFAR plans to also seek complementary activities among USG agencies linking health facilities to community programs. This approach should enable specific agency technical competencies to wrap around each other and maximize results, such as lab services directly linked with community based HCT to enable people testing HIV positive to access CD4 testing. In addition, mass media strategic messaging, cultural events, and outreach programs focusing on living positivity should help expand quality care, support, and treatment of HIV positive Congolese.

Toward this strategic goal, five specific complementary areas in the targeted geographic areas are expected to be supported: (1) A pre–ART care program, including HIV counseling and testing, home based care and support living positively groups, staging for ART eligibility including CD4 testing and early infant diagnosis, Cotrimoxazole prophylaxis, TB screening, nutritional support, and prevention for positives; (2) Strengthening referrals and linkages to care and treatment services; (3) Expanding access by providing HIV care and treatment services for TB/HIV co-infected patients, HIV positive pregnant women and children, and their first-line family members; (4) Strengthening lab support services for HIV diagnosis and disease management; (5) Capacity building through training for selected health care and community care providers who will implement an improved quality of care and treatment.

The approach to supporting the care and treatment goals strongly complements the GFATM funded activities. The GFATM supports care, support and treatment activities by supporting programs inside the following areas: care and treatment, including provision of ARVs for adults, and HIV commodities including rapid testing and CD4 testing. The Clinton Foundation is also providing ARVs for infants and second line ARV treatment for children and adults. In addition, it is involved in early infant diagnosis activities by supporting Dried Blood Spot (DBS) transport from PMTCT sites to laboratories. UNICEF supports early infant diagnosis through supply chain support as well as training of health care workers. The GDRC plans to support care and treatment activities by the provision of ARV to all treatment sites for eligible patients through GFATM Round 7 and 8 grants, and, if successful, the Round 9 grant. Where USAID is implementing primary health care activities linkages can be developed with the PEPFAR activities for cross referrals providing greater access to those infected and affected.

All care, support and treatment activities are designed to link with the other three goals in the framework, and are intended to be part of a whole government approach with USG resources focusing in Lubumbashi and Kinshasa, with the intention, depending on resources, to be scaled up over the life of this partnership framework

Goal III: CARE FOR ORPHANS AND VULNERABLE CHILDREN – To improve protection, care and welfare of OVC through a coordinated response.

i. National Indicator and Targets:
   - The number of OVC who receive quality services, including education, economic strengthening, health, protection, nutrition, and psychosocial support, will increase from 110,831 to 657,000;

ii. Program Areas: OVC, Strategic Information; Health Systems Strengthening; Human Capacity Development; Gender as a cross-cutting issue;

iii. Key Policy Reforms:
   - The President of the DRC has signed the child protection law;
   - The Ministry of Social Affairs (MINAS) is currently finalizing its OVC National Action Plan, which will provide a more detailed framework for key policy issues that will likely include implementation guidelines, quality care standards, vulnerability criteria and community engagement;

iv. Five Year Benchmarks/Measurement of Success
   - A national system is in place to monitor and evaluate the quality of services provided to OVC;
   - The GDRC can coordinate effective care, support and protection for OVC as evidenced by quality of life improvements among Congolese children;
   - The number of OVC who receive quality services per the national standards has increased from 110,831 to 657,000.

The Partnership Framework OVC approach is to collaborate with in-country donors and key partners to support the achievement of national OVC goals through the scale-up of quality services. The USG intends to invest in selected geographically focused OVC activities that build upon other existing donor programs to strengthen the capacity for the delivery of services through enhanced coordination and leadership, while leveraging additional resources through the private sector. This approach is based on a Rapid Assessment, Analysis and Action Plan (RAAAP), which established a permanent OVC management unit within the MINAS to oversee the implementation of the National OVC Action Plan. PEPFAR will contribute selectively to the following Action Plan objectives: to increase access to a minimum package of OVC interventions, increase community mobilization to prevent and support OVC, and ensure a political and institutional environment that enables protection as well as the provision of holistic OVC care. Furthermore, targeted branded outreach activities focused on prevention and access to care can reach street children and other at risk youth groups. PEPFAR will primarily use HCT and PMTCT services as a means to identify OVC for support.

The USG will continue to engage at a policy level with the MINAS in order to further strengthen the national leadership capacity to address OVC issues and ensure a coordinated response through the existing OVC technical working group. UNICEF, in collaboration with the USG, is providing technical assistance to the MINAS for the expansion of quality community-based activities including school support, vocational training, referral for medical care, support for income-generating activities (IGA), psychosocial and recreational clubs and nutritional support, and community sensitization and advocacy related to social protection and inheritance. UNICEF is providing

limited support to 110,000 OVC, focusing on school-based OVC support and protection issues. The DRC is planning to use GFTAM financing to support 55,165 thousand OVCs while covering approximately 35% of health zones with funding from the approved Round 8 grant. Additionally, Round 9 grant intends to provide OVC support, if approved. DFID is supporting a five year program (2006-2011) which includes the provision of basic services to OVC and to PLWHA.
All OVC activities are designed to link with the other three goals in the framework, and are intended to be part of a whole government approach focusing in Lubumbashi and Kinshasa, with the intention to scale up this model over the life of this partnership framework, depending on resources.

Goal IV: HEALTH SYSTEMS STRENGTHENING – To strengthen coordination and management of HIV interventions through support to the following key area: institutional capacity building and human resources, lab and infrastructure, logistics and pharmaceutical support, strategic information and health finance.

i. National Indicator and Targets:
- **Laboratory Systems for Service Delivery (Lab)**: 515 health zone laboratories with capacity to perform clinical HIV laboratory tests;
- **Health Management Information Systems (HMIS)**: Quality data is regularly produced; availability of HIV prevalence data for relevant surveillance populations published within 12 months of preceding year;
- **Commodities/Procurement**: Reduced number of health facilities reporting stock-outs of test kits and/or ARVs in the past three months (baseline not yet established);
- **Human Resources**: Increased number of health care workers who successfully completed a specified in-service training program;
- **Health Finance**: GDRC budgetary line item for HIV/AIDS; increased domestic and international AIDS spending by categories of financial sources (National Health Accounts);

ii. Program Areas: Laboratory infrastructure; Strategic Information; Health Systems Strengthening; Supply Chain Management; Human Capacity Development.

iii. Key Policy Reforms:
- **Laboratory Systems for Service Delivery**: Develop National five-year lab and quality assurance plans;
- **Health Management Information Systems (HMIS)**: Plan to align output and national indicators to the extent possible;
- **Commodities/Procurement**: Revise the essential commodities list; MOH is developing a pharmaceutical pricing policy to fit within the unified procurement structure;
- **Human Resources**: Develop and implement health provider retention strategies and related HIV curricula;

iv. **Health Finance**: Develop and institutionalize National Health Accounts (NHA; National AIDS Spending Accounts (NASA));

v. **Five Year Benchmarks/Measurement of Success**
- **Lab Systems for Service Delivery**: Increased percentage of laboratories with satisfactory performance in external quality assurance/ proficiency testing (EQA/PT) program for HIV rapid test (baseline and target TBD);
- **Health Management Information Systems (HMIS)**: Increased proportion of public facilities submitting a completed report on time (baseline and target TBD);

- **Commodities/Procurement**: Increased percentage of facilities whose stock levels ensure near term product availability (baseline and target TBD);
- **Human Resources**: Reduced staff turnover rate (baseline and target TBD);
- **Health Finance**: Appropriate indicators and targets are set as part of the National Health Accounts.

The Partnership Framework Health Systems Strengthening goal will implement a value-added strategy that works in synergy and collaboration with in-country donors and key partners to support the achievement of national goals through the strengthening of key systems that expects to improve the GDRC's capacity to delivery services. Strategically targeted investments in the five systems strengthening areas are critical to enable the achievement of the Framework's other three goals. The five-year strategy for Health Systems Strengthening should directly support the GDRC's strategic objectives to: (1) develop laboratory systems for service delivery, (2) strengthen strategic information capabilities, (3) support logistics and pharmaceutical management, (4) develop human and institutional capacity, and (5) sustainable financing. The Partnership Framework intends to support these objectives at the national level as well as provincial levels in areas where the U.S. Government investments are established.

The GFATM and World Bank procure lab equipment and supplies as well as ARVs and other HIV commodities within the MOH assigned HZs. WHO and the Clinton Foundation provide technical assistance for commodity forecasting that is complementary to the current USG support to strengthen the pharmaceutical system and plan to work with the Round 8 PR to improve GFATM procurements through with the Round 8 grant. Through the USAID health program, the USG provides support for pharmaceutical systems strengthening at the national, provincial and health zone levels. This activity provides assistance to the GDRC to improve governance in the areas of policy, regulation, commodity forecasting, and quality assurance. The GFATM, World Bank and UNICEF are providing direct budget support to the GDRC to strengthen coordination and build institutional capacity. USAID is financing a sector-wide National Health Accounts activity which is leveraged against the PEPFAR financing activity to include an HIV/AIDS sub-analysis in order to support tracking of budgetary line items for HIV/AIDS, including domestic and international spending by categories of financial sources. The National Health Accounts activity, including a household study, HIV/AIDS, and family planning sub-analyses, was launched to better understand health expenditures at government, household and private sector levels. Across all activities support is provided for human and institutional capacity building. The USAID Health portfolio is comprehensive, supporting health activities in malaria, TB, maternal child health, immunization, infectious diseases and water, sanitation and hygiene. The GDRC has recognized the importance of an integrated health system, which makes health systems strengthening a key strategic priority.

The service delivery support for laboratory systems includes HIV testing, early infant diagnosis capability, quality assurance, and TB-HIV capacity. The aim of the Partnership Frameworks is to engage with the MOH in developing a five-year lab strategic plan, and assist the MOH in improving the maintenance of selected equipment. Strategic information will focus support to conduct periodic ANC, behavioral surveillance and other targeted surveys as well as develop and implement a unified national reporting system. Logistics and pharmaceutical support assists the MOH to improve governance in the areas of policy, regulation, quality assurance, improve pharmaceutical management at the health facility level, and support the establishment and management of buffer stocks for ARVs, condoms and other key HIV related commodities. Human resource development

focuses on pre-service and in-service training for nurses, lab technicians, health managers, and social welfare professions as well as English language training. Health finance supports the tracking of budgetary line items for HIV/AIDS, including domestic and international spending by categories of financial resources (National Health Accounts) as well as the inclusion of an HIV module within a national household health expenditure survey.

2.2 Table 1. Goals and High-Level Commitments Table

GOAL 1: PREVENTION- To reduce new HIV infections in the DRC National Indicator and Target: To reduce the number of new adult and infant HIV infections from 181,000 per year in 2009 to 90,500 per year by 2014, preventing an estimated total of 253,400 infections over five years			
	Anticipated Partner Contributions		
Objectives	USG	National	Other Partners
Reduce risky sexual behavior and improve access to prevention services for MARPS and other high-risk populations	Increase access to evidence-based interventions including a branded BCC strategy and condom distribution among MARPS, including uniformed people, CSW, IDPs, refugees, truckers, miners, MSM, victims of sexual violence, and vulnerable populations Increase support to youth (15-24 years) using targeted sexual prevention programs including mass media communications, teacher training, large community-based outreach events, peer educators, programs tailored for street children Increase the telephone hotline capacity to provide HIV and STI information and referrals to callers in general population Improve access, quality and impact of HCT interventions (health facility, community, and mobile) and service linkages Strengthen local NGO and PLWHA capacity to plan, implement and evaluate HIV prevention activities through sub-grants Integrate activities for discordant couples, multiple concurrent partners, prevention for positives and prevention for negatives into existing programs	MOH to initiate new national prevention and communication strategies MOH to implement national condom policy through product dissemination and develop tracking tools for forecasting needs MOD to identify and implement innovative approaches to motivate and maintain in action the military health workers trained. GDRC to disseminate and implement the anti-GBV and sexual violence law MOH to support the training of health care providers for STI treatments MOH to promote best practices on male circumcision MOH to disseminate and, where appropriate, implement new PICT and couple CT guidance PNMLS to involve civil society and PLWHA in designing, implementing, and evaluating HIV prevention activities	GFATM Rounds 7 and 8 (if signed) to provide STI drugs (MOU to be signed) UN agencies to target MARPS along major transport corridors GFATM and UN agencies to provide additional condoms for distribution through free and social marketing channels GFATM to support prevention mass media campaigns Private sector committee to work with cell phone companies to renew and increase commitments to host the hotline WHO to provide TA to the MOH on PICT policy dissemination GFATM to target support to local NGOs including PLWHA organizations to integrate prevention for positives and discordant couples' activities

Expand access to mother-to-child transmission services (PMTCT)	Expand access to comprehensive, quality PMTCT services in urban and rural sites Increase the number of mothers delivering in health facilities, targeting HIV positive women Strengthen linkages between PMTCT and family-centered HIV care and treatment as well as community-based support Evaluate the effectiveness and applicability of the new ARV prophylaxis regimen policy Strengthen male involvement in partner testing at PMTCT sites	MOH to lead an assessment of the 2007-2010 PMTCT national implementation plan and develop a follow-up plan based on lessons learned MOH to lead the dissemination and training of the new complex ARV regimen policy MOH to train health care workers in the integration of MCH interventions MOH to identify innovative approaches to retain motivated and qualified PMTCT service delivery staff	GFATM to provide resources for training of trainers and providers GFATM to supply ARV and other HIV related commodities in all USG geographical areas (MOU to be signed) GFATM to ensure incentive payments at joint sites,(MOU to be signed) World Bank to provide PMTCT package of services in selected health zones UNICEF to provide continued support to PNLS
Increase access to safe blood and proper disposal of medical waste	Provide TA for the development and dissemination of the blood safety strategic plan as well as the Volunteer Non Remunerated Blood Donor (VNBD) and quality assurance policies Ensure that all blood transfusions are being tested for HIV in targeted HZs Assist the MOH in organizing a regional forum to exchange experiences and best practices of blood safety Assist the MOH to implement the Injection Safety policy thru the training of service providers in targeted HZs Provide TA for the development of a national injection safety strategy	MOH to develop and disseminate blood safety strategic plan as well as the VNBD and quality assurance policies MOH to identify innovative approaches to retain and motivate qualified health staff to deliver quality services MOH to train health care workers on blood exposure prevention and management MOH to provide targeted health care facilities with PEP kits	GFATM to provide blood transfusion equipment and supplies at the national, provincial and hospital levels WHO and USG to coordinate TA to the National Blood Transfusion Program GFATM to procure medical injection safety boxes under the Round 8 grant

GOAL II: TREATMENT ,CARE AND SUPPORT – To expand access to high quality care and treatment services to HIV+ Congolese			
National Indicator and Target: The number of PLWHA receiving comprehensive care and treatment will reach 328,744 by 2014			
Objectives	Anticipated Partner Contributions USG	National	Other Partners
Psychosocial support and home-based care	Provide support to PLWHA including CTX, nutrition and linkages to ARV and home-based care providers Provide positive living and psychosocial support to delay initiation of ARV enrollment Provide TA to develop policy and guidelines on HBC Strengthen "support-groups" working with PLWHA	MOH to develop HB and palliative care policy and guidelines	WFP to provide supplementary food assistance
Reduce economic impact	Provide positive living and psychosocial support to delay initiation of ARV enrollment Provide economic support activities to PLWHA	The GDRC to develop strategy that engages private sector and donors to create and protect PLWHA jobs and to improve the PLWHA and their family economic autonomy.	DFID, thru Christian AID, to provide HBC, food assistance, economic strengthening assistance, and assist the support group of PLWHA UNICEF to provide economic support to OVC families including PLWHA families.
Decrease stigma and discrimination	Support local organizations and PLWHA groups to disseminate and educate target groups on the anti-discrimination law	The GDRC is committed to implement the laws signed by the president protecting the rights of people with HIV/AIDS	UNICEF is funding local NGOs to implement limited activities to educate the public about HIV stigma and discrimination.
Improve medical treatment for PLWHA	Support laboratory services for HIV diagnosis and management (HIV testing, early infant diagnosis,) Support appropriate integration of provider initiated counseling and testing (PICT) in TB clinics Provide support to improve referrals and linkages to strengthen the family-centered continuum of care	MOH to coordinate laboratory supplies and HIV reagents in targeted health facilities MOH to provide laboratory reagents for TB and OIs diagnosis MOH to train laboratory technicians on TB and OIs diagnosis MOH to ensure the implementation of PICT policy	Clinton Foundation to provide pediatric and second line ARVs as well as EID commodities GF to provide laboratory infrastructure, equipment and supplies, training and first line ARVs (MOU to be signed) WB to provide laboratory equipment and supplies

	between PMTCT and TB sites and HIV care and treatment services	MOH to provide CTX prophylaxis to HIV positive patients MOH to assure existing ARV and supply commitments are maintained and increased Train HCWs on HIV care and OIs management MOH to develop key policies including ARV treatment interruption policy MOH to ensure pipeline and quality of ARVs and services MOH to train HCWs on ART management at all levels	UNICEF to provide support for training of HCW on EID sampling as well as the cold chain.

GOAL III: CARE FOR ORPHANS AND VULNERABLE CHILDREN – To improve protection, care and welfare of OVC through a coordinated response

National Indicator and Target:
The number of OVC who receive quality services, including education, economic strengthening, health, protection, nutrition, and psychosocial support, will increase from 110,831 to 657,000

Objectives	Anticipated Partner Contributions		
	USG	National	Other Partners
Increase community mobilization to prevent and take care of OVCs	TA and support provided to community and family thru economic strengthening food and nutrition programs	MINAS to develop innovative approaches to strengthen family and community income to take care of orphan MINAS to develop, disseminate and implement community engagement strategy	GTZ implements cash transfer approach for OVC care DFID, thru Christian AID, to provide basic services to OVC
Ensure a political, institutional environment that enables protection, and provision of holistic care to OVC	Provide TA and support to MINAS to oversee implementation and the NPA and collect data and inform programming	MINAS to establish adequate structures, appropriate HR and effective systems to implement, monitor and supervise OVC programs MINAS to create a political and institutional environment to decrease stigma related with OVC through advocacy methods GDRC to develop a national OVC policy	UNICEF to provide institutional capacity support at the national and provincial level

GOAL IV: HEALTH SYSTEMS STRENTHENING – To strengthen coordination and management of HIV interventions through support to the following key area: institutional capacity building and human resources, lab and infrastructure, logistics and pharmaceutical support, strategic information and health finance

National Indicator and Targets:

Laboratory Systems for Service Delivery (Lab): 515 health zone laboratories with capacity to perform clinical HIV laboratory tests;

Health Management Information Systems (HMIS): Quality data is regularly produced; availability of HIV prevalence data for relevant surveillance populations published within 12 months of preceding year;

Commodities/Procurement: Reduced number of health facilities reporting stock-outs of test kits and/or ARVs in the past three months (baseline not yet established);

Human Resources: Increased number of health care workers who successfully completed a specified in-service training program;

Health Finance: GDRC budgetary line item for HIV/AIDS; increased domestic and international AIDS spending by categories of financial sources (National Health Accounts);

Objectives	Anticipated Partner Contributions		
	USG	National	Other Partners
Strengthen coordination and institutional capacity building	Provide TA and support to the GDRC in institutional capacity and organizational development for planning, managing, monitoring, and evaluating programs	GDRC to restructure the PNMLS based on the 2007 institutional audit recommendations GDRC to develop and implement a NMSP M&E plan	WB provides financial support to the PNMLS thru 2010 GFATM provides budget support to PNMLS and PNLS UNICEF provides budget support to PNLS
Human capacity development	Support pre-service and in-service training for nurses, lab technicians, health managers, and social welfare professionals	MOH to develop and implement updated human resources development plan regarding HIV and AIDS MOH to integrate HIV/AIDS in medical pre-service training curriculum MOH to improve staff retention by implementing innovative approaches that motivate staff	GF, WB and UNICEF to provide support for training of trainers and providers
Logistics and pharmaceutical support	Provide assistance to GDRC to improve governance in the areas of policy, regulation, commodity forecasting, and quality assurance Improve pharmaceutical management at the national, provincial and health zone levels (quantification, drug use,	GDRC to ensure leadership and coordination of a central, unified procurement system of ARV and other HIV related commodities MOH to develop pharmaceutical pricing policy	WHO and Clinton Foundation to provide TA for forecasting WB and GFATM to support procure, distribute and manage HIV commodities including lab equipment and supplies as well as ARVs

	management) thru training and supervision by the provincial and district managers Support the establishment and management of buffer stocks for ARV, condoms and other key HIV related commodities	MOH to ensure a smooth transition of GFATM grants to avoid commodities stock-outs	
Strategic Information	Support the MOH to conduct periodic ANC, behavioral surveillance, and other targeted studies Support to develop and implement a unified national reporting system	GDRC to ensure one M&E system as per the "Three Ones" MOH to provide accurate data and management of strategic information	WB to support special studies WB and GFATM to procure IT equipment in their respective geographic areas of intervention
Laboratory systems for HIV/AIDS service delivery	Support HIV testing, early infant diagnosis capability, and related quality assurance system Support the MOH to improve targeted TB and HIV referral lab capacities Support MOH to develop a 5-year laboratory strategic plan Assist the MOH to improve the maintenance of selected HIV lab equipments	MOH to organize one lab for HIV related analysis and viral load at provincial level MOH to strengthen the NACP referral lab and at least two additional labs to perform basic HIV and genotyping analysis	GFATM and WB to procure and equip HIV laboratories at all levels. (MOU to be signed)
Health Financing	Support tracking of budgetary line items for HIV/AIDS including domestic and international spending by categories of financial sources (National Health Accounts)	GDRC to draft financial management procedure manual GDRC to implement cost-effective and accountable programming GDRC to guarantee financial transparency	WHO to support National Health Accounts WB and UNICEF to provide financial information

3. PARTNERS: ROLES AND COMMITMENTS

Substantial support for the national response in the DRC is provided by the GFATM, World Bank, the Clinton Foundation, and the United Nations agencies, among others. The GFATM for HIV/AIDS, Round 3, is $113 million over five years, covering prevention, care and treatment. Most of the work is implemented by NGOs, and the Country Coordinating Mechanism (CCM) is led by the MOH, with involvement from the PNLS. The GFATM disbursed $46.7 million in funding to the DRC for the first phase of a third-round grant of $113.65 million to support HIV/AIDS prevention, care and treatment program with UNDP as the PR. The project targets at-risk populations (sex workers, truck drivers, prison populations, and youth), PLWHA, and HIV-positive mothers and their newborns. In addition, the Government has been awarded $71.4 million for HIV GFATM Round 7 to support the five-year prevention, care and treatment program from 2008–2012, and an additional $262.9 million in Round 8. The GDRC has submitted a Round 9 proposal for HIV/AIDS. Under the GFATM Round 8 award, a total of 196 (out of 515) health zones (HZs) in all eleven provinces will be covered. In these HZs, the package of services will be completed in 70 HZs in the first year and the continuation of prevention, care, treatment and support services (complete packet) will be extended to the remaining HZs in year two. The World Bank's MAP program covers 69 HZs in Bandundu, Equateur, Katanga, Kinshasa and Maniema provinces. PEPFAR is currently supporting safe blood activities in 57 HZs in Katanga, South Kivu, East and West Kasai provinces and Prevention of Mother-to-Child Transmission (PMTCT) in 40 of those same HZs.

Commodity supply and management is a key element for success of the program. This is particularly challenging in the vast territory of the DR Congo where transportation and health system infrastructure is limited. Learning from the GFATM Round 3 challenges, UNDP has established a team who have developed a new strategy for procurement and logistic management. A procurement task force involving sub-recipients has been established, and data collections tools exist, and commodity management information is collected and tracked monthly. UNDP is in the process of assessing capacity in regional distribution centers.

Ongoing commodity supply and management challenges that need technical assist include development of the Principle Recipient procurement management plan, import and customs procedures, transportation, and establishment of buffer stocks.

The GDRC MOH developed a PMTCT strategy in 2007 with the assistance of the USG and UNICEF calling for a scaling up of PMTCT services. The following criteria for scale up were defined for site selection:

- Geographic location: USAID identified a minimum of 2 HZs within the currently supported Provinces;
- Epidemiology and prevalence rates: sites with highest prevalence were prioritized; and,
- Experience implementing PMTCT activities: Sites previously supported by 'Médecins Sans Frontières' and Merlin through emergency response funding were picked up with PEPFAR funding to ensure continuity of services when the emergency funding ended.

These activities are leveraging USAID's integrated primary health care program providing, for the first time, a comprehensive health care package to pregnant women.

PEPFAR activities in the provincial capital of Katanga (Lubumbashi) include laboratory support and behavior change communication targeting uniformed people. PEPFAR is supporting the continuum of care in the high prevalence provincial capitals of Bas-Congo, South Kivu and Katanga and their immediate transportation corridors. PEPFAR is also supporting mass media strategic communication, prevention, diagnosis and treatment of TB-HIV co-infection, laboratory support and PMTCT activities in Kinshasa and Lubumbashi. The DRC PEPFAR Country Team intends to draft a Memorandum of Understanding (MOU) with the GFATM to ensure synergies and coordination. Key elements of the MOU are expected to ensure ARV treatment enrollment and supplemental salary support to ensure quality services where PEPFAR is supporting complementary programming.

In 2004, the World Bank approved a five year $102 million grant to support implementation of the National Strategic Framework and provide resources to improve service delivery mechanisms. The DRC is also part of the World Bank Multi-Country AIDS Program (MAP) which provides $114 million over 5 years covering prevention, care, and treatment. The PNMLS was created in part to manage MAP on behalf of the GDRC. Over half the budget has been expended; the remaining amount will cover activities through December 2010.

In addition to the GFATM and MAP, there are several other funders of HIV/AIDS activities, including the United Nations agencies, Clinton Foundation, Belgian Cooperation, DFID, UNAIDS, WHO, UNICEF, German Development Agency (GTZ), the EU, The Canadian Development Agency (CIDA), the African Development Bank, "Medecins du Monde," and "Medecins Sans Frontieres" (MSF).

The Partnership Framework intends to support a coordinated, geographically targeted program, employing evidence-based interventions that align with the HIV/AIDS National Multi-sector Strategic Plan and PEPFAR Global goals and objectives.

The USAID non-HIV health portfolio provides technical assistance and capacity development targeting government personnel at national, provincial and HZ levels as well supports the provision of the MOH's approved complete primary health care package in 80 HZs with a population of approximately 11 million people. Within those 80 HZs commodities, including essential medications, contraceptives, equipment and support to the General Reference Hospitals, are also provided. Due to limited HIV funding and actual prevalence rates, currently Lubumbashi is the only site where the PEPFAR program is offered along with USAID primary health care services, ensuring a comprehensive health care package that also includes HIV services.

4. PLANS FOR DEVELOPING THE PARTNERSHIP FRAMEWORK IMPLEMENTATION PLAN

Success of this Partnership Framework is dependent on an effective implementation plan jointly implemented by the GDRC, PEPFAR and donor partners. Expanded U.S. Government support through PEPFAR combined with the GFATM Round 7 and 8 awards represent an unprecedented opportunity to harmonize and align HIV/AIDS programming, collectively scaling-up prevention,

care and support activities while strengthening health systems. In order to continue to ensure a synergistic and coordinated implementation, a joint PEPFAR and GDRC task force has been established to undertake the development of the implementation plan.

5. MANAGEMENT AND COMMUNICATION

To ensure an effective governance plan, the GDRC and the USG have implemented the following structures to standardize and harmonize activities and ensure there is no duplication of activities. The Partnership Framework management unit should be flexible and adaptable to support the GDRC's ongoing efforts to improve coordination.

The PEPFAR country team plans to strengthen its collaboration with the GDRC and key stakeholders to oversee the management of the Partnership Framework by using existing coordinating and technical working structures as a way to strengthen government leadership, ownership and sustainability.

A steering committee has been established under the PNMLS authority to oversee the implementation of the Partnership Framework.

- **High level government oversight:** Senior level oversight is expected to take place through periodic meetings between the U.S. Ambassador to the DRC and the DRC President, Prime Minister, Ministers of Health, Finance, Defense, Social Affairs, and Planning.

- **Strategic oversight:** The steering committee led by the Prime Minister's office and including membership from USG, Ministries of Finance, Budget, Health, Social Affaires, Defense, and representation from GFATM Prime Recipients, UN agencies, civil society and PLWHA supports the PNMLS, which intends to act as the secretariat to the steering committee. Biannual meetings of the steering committee allow for review and monitoring of the implementation progress as well as insight into program expansion. The steering committee should assure coordination and synergies across other donor and government programs and investments in HIV/AIDS as well as malaria and other primary health care services. This committee can identify best practices and lessons learned to be shared during the MOH annual review and other coordinating meeting opportunities to strengthen the development of future GFATM proposals.

- **Technical oversight:** Technical oversight may be conducted primarily through existing technical working groups (TWG) led by the PNLS and the PNMLS. PEPFAR TA should improve the functioning of the TWGs. Currently the PMTCT, Lab, and Surveillance TWGs (PNLS), the M&E, Public-Private Partnership TWGs (PNMLS), as well as the OVC task force (MINAS) are functioning and could fulfill this function. TWGs may also serve as a platform from which to share best practices and lessons learned among relevant stakeholders are shared. Additionally, two TWGs may be formed by the GDRC to provide technical oversight in the areas of treatment/ARV drugs and establish a strategic communication coordinating committee.

- **Using other opportunities to improve coordination between PEPFAR and other donors:**
    - The HIV Partner's forum was established by a MOH decree in 2007 to improve the management, support, and coordination of National HIV/AIDS in DRC;
    - The CCM, where USAID currently represents the USG (and other bi-lateral donors) as the second bureau vice president.

Additionally, the USG expects to use the Global Fund liaison position to actively interface with the GDRC and the GFATM Principal Recipients in order to facilitate and improve grant performance and coordination with USG bilateral efforts.

6. SIGNATURES

For the Government of the United States of America

By: Johnnie Carson
Assistant Secretary of State for African Affairs

Date: APRIL 16. 2010

For the Government of the Democratic Republic of the Congo

By: Alexis Thambwe Mwamba
Minister of Foreign Affairs

Date: 16.04.2010