



FY 2015 Cameroon Operational Plan (COP)

The following elements included in this document, in addition to “Budget and Target Reports” posted separately on www.PEPFAR.gov, reflect the approved FY 2015 COP for Cameroon.

- 1) *FY 2015 COP Strategic Development Summary (SDS)* narrative communicates the epidemiologic and country/regional context; methods used for programmatic design; findings of integrated data analysis; and strategic direction for the investments and programs.

Note that PEPFAR summary targets discussed within the SDS were accurate as of COP approval and may have been adjusted as site-specific targets were finalized. See the “COP 15 Targets by Subnational Unit” sheets that follow for final approved targets.

- 2) *COP 15 Targets by Subnational Unit* includes approved COP 15 targets (targets to be achieved by September 30, 2016). As noted, these may differ from targets embedded within the SDS narrative document and reflect final approved targets.
- 3) *Sustainability Index and Dashboard*

Approved FY 2015 COP budgets by mechanism and program area, and summary targets are posted as a separate document on www.PEPFAR.gov in the “FY 2015 Country Operational Plan Budget and Target Report.”

Cameroon

Country/Regional Operational Plan

(COP/ROP) 2015

Strategic Direction Summary

August 7, 2015

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Abbreviations and Acronyms

ACT	Accelerating Children’s Treatment
AFD	French Agency for Development
AfSBT	African Society for Blood Transfusion
AGYW	Adolescent girls and young women
ANC	Antenatal care
ART	Antiretroviral treatment
ARV	Antiretroviral
BS	Blood safety
CBCT	Community-based HIV counseling and testing
CCI	Country Collaborative Initiative
C&T	Care and treatment
CHW	Community health worker
COP	Country Operational Plan
CoPT	Continuum of prevention, care and treatment
CQI	Continuous quality improvement
CSO	Civil society organization
DBS	Dry blood spot
DIC	Drop-in Centers
DPML	Directorate of Pharmacy, Medication and Laboratory
DQA	Data quality assessment
DSD	Direct service delivery
EA	Expenditure analysis
EID	Early infant diagnosis
eMTCT	Elimination of mother-to-child HIV transmission
FBCTS	Facility-based care, treatment and support
FP	Family planning
FSW	Female sex worker
FY	Fiscal Year
GF	Global Fund
GNCN	Global Nursing Capacity Building
GRC	Government of Cameroon
HCW	Health care worker
HEI	HIV-exposed infants
HSS	Health systems strengthening
HTC	HIV testing and counseling
IP	Implementing partner
KP	Key Populations
LCI	Local Capacity Initiative
LTFU	Lost-to-follow-up
LTS	Long-term strategy
M&E	Monitoring and evaluation
MOH	Ministry of Public Health
MQC	MOH Quality Corps
MSM	Men who have sex with men
NACC	National AIDS Control Committee

NPHL	National Public Health Laboratory
NSP	National HIV/AIDS Strategic Plan
NW	Northwest
OI	Opportunistic infections
OVC	Orphans and Vulnerable Children
PBAC	PEPFAR Budget Allocation Calculator
PCV	Peace Corps Volunteer
PITC	Provider-initiated testing and counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child HIV transmission
PSP	Private service providers
QA	Quality assurance
QI	Quality improvement
QMS	Quality management systems
RTK	HIV rapid test kit
RTQII	Rapid Test Quality Improvement Initiative
SI	Strategic Information
SILC	Saving and Internal Lending Communities
SID	Sustainability Index Dashboard
SOP	Standard Operating Procedure
SW	Southwest
TA	Technical assistance
TTI	Transfusion-transmissible infections
UE	Unit expenditure
USG	US Government
VL	Viral load

Goal Statement

PEPFAR/Cameroon will program for epidemic control by maximizing investments through partnerships with the Government of Cameroon (GRC), bi-/multi-lateral agencies, and civil society organizations (CSO) to implement intensive combination prevention interventions in two high burden health districts, in the Littoral and Center regions, with the highest burden of people living with HIV (PLHIV). In addition, PEPFAR will prioritize 11 hot spots focusing on the continuum of prevention care and treatment (CoPT) services for key populations (KP) with referral to priority district/military facilities.

PEPFAR/Cameroon previously focused on 91 health districts in four regions and two additional cities for KP-specific interventions. With the pivot, PEPFAR has developed a country operational plan (COP) that will realize epidemic control in two districts most burdened by HIV within a two-year timeframe. Epidemiological burden is defined as a combination of PLHIV, KP (men who have sex with men (MSM), female sex workers (FSW), and their clients and partners), HIV-positive pregnant and breastfeeding women, TB clients, and orphans and vulnerable children (OVC). Programs and funding are allocated to ensure that targeted populations access HIV testing and counseling (HTC) services; 80% of PLHIV access antiretroviral treatment (ART); and 90% of those treated have viral load suppression by fiscal year (FY) 2017.

In the two scale-up districts, there are 51,897 PLHIV and 18,973 PLHIV (36.6 %) on ART. The goal is to reach 80% ART coverage (41,517 PLHIV on ART). Strategies will include intensive demand creation and identification of PLHIV, followed by linkage, enrollment and initiation on treatment according to national guidelines. Adherence and retention services will be intensified. The key entry points are: TB programs, KP mobile testing and drop-in centers, OVC units, antenatal care (ANC), military facilities, blood donors (7.8% positive), ART clinics using infected person as the index patient, inpatient/outpatient wards, and pediatric units. Preliminary analysis, using APR and national data, shows that by targeting these populations within the two scale-up districts, PEPFAR will reach 12,481 newly identified PLHIV each year to reach epidemic control by end of FY 2017. The GRC and GF will provide ARVs for all adults (TA targets), and PEPFAR/Cameroon will support ARVs for PMTCT and pediatrics (DSD targets).

Focusing the program geographically and by population to reach epidemic control requires a substantial pivot given that resources remain flat and ARV coverage remains low. Thus, 64.7% of

PMTCT sites with 0-4 HIV positives in Northwest (NW) and Southwest (SW) regions, those with less than 2 HIV positives in the Littoral region and those with less than 1 HIV positive in the Center region will be transitioned to other funding sources by the end of FY 2015; PMTCT sites with more than 10 HIV patients and treatment sites with more than 118 patients will be scaled up; and remaining sites will be sustained until we have one year of data. A minimum package of care, treatment, and support services will be established for patients currently supported in districts other than the two scale-up districts. Patients currently on treatment, pregnant women provided ART through PMTCT sites and core services for KP will be continued in sustained areas; however, PEPFAR is working with the GF and GRC to fully transition services by the end of FY 2017.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

Cameroon is a lower-middle-income country with a GNI of 2,770 USD per capita (PPP). Politically stable, Cameroon achieved economic growth of 4.9% in 2013. Cameroon has a total population of 22 million and is among the countries with the highest overall HIV prevalence in Central Africa. UNAIDS estimated that there were approximately 600,000 PLHIV in 2013. By the end of December 2014, the government had placed 143,837 PLHIV on ART, representing 24% coverage. There are about 45,000 new infections per year and 333,000 orphans (ages 0-17) due to AIDS. The GRC has committed to a robust national HIV/AIDS response with substantial support from external donors, as evidenced by a decrease in prevalence from 5.6% in 2004 to 4.3% in 2011 (DHS). GRC is currently implementing year three of a five-year National HIV/AIDS Strategic Plan (NSP), and has made significant progress for increased coverage of ART and PMTCT services through the national scale up of Option B+.

The HIV epidemic in Cameroon is generalized with most (45%) transmission occurring from heterosexual sex, though women are disproportionately affected (UNAIDS 2013). Prevalence is five times higher among women ages 15-24 (2.7%) than among their male counterparts (0.5%). About 31% (7,908/25,360) of TB patients tested for HIV are HIV/TB co-infected, according to the National AIDS Control (NACC) 2012 report, and TB is the leading cause of AIDS-related deaths. Although the data is limited at this time, some studies estimate KP have a much higher HIV prevalence (36% among FSW and 24%-44% among MSM in two major cities).

PEPFAR/Cameroon has previously focused efforts in four regions (Northwest, Southwest, Littoral, and Center) with support for PMTCT and the recent addition of care and treatment (C&T). There is much variability in HIV prevalence across the regions in Cameroon, ranging from 1.2% in the Far North to 7.2% in some areas of the South. The regions with the highest HIV prevalence are South, Northwest (6.3%), East (6.3%), Center (6.1%) Southwest (5.7%), and Adamawa (5.1%) (DHS, 2011). There is even greater heterogeneity in the number of PLHIV among districts, ranging from 4,501 to 31,636. There are a total of 91 districts in the four PEPFAR-supported regions in Cameroon. 80% of all PLHIV in the four PEPFAR regions can be found in 41 of these districts.

MSM HIV Prevalence	-	24.2%- 44.3%									UNGASS country report
Total FSW	77,814	-									TWG Estimate
FSW HIV Prevalence	-	36%									
Total PWID	N/A	N/A									N/A
PWID HIV Prevalence	N/A	N/A									N/A
Females 15-24 years	2,257,231	2.7%									CIA World Factbook, 2014; DHS, 2011

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
National Data				HIV Care and Treatment (PEPFAR Program Data - APR 2014)				HIV Testing and Linkage to ART (PEPFAR Program Data - APR 2014)		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Total PLHIV (#)	In Care (#)	On ART (#)	Retained on ART 12 Months (#)	Viral Suppression 12 Months	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population ¹	23,130,708	4.3%	634,975	12,241 (PEPFAR)	816 (PEPFAR)	N/A	N/A	189,112	9,578	816
Population less than 15 years ²	9,929,106	<1%	93,831	N/A	0	N/A	N/A	6,624	N/A	0
Pregnant Women	1,057,162	6.23%	39,461	3,543	5,5515	N/A	N/A	151,512	11,926	5,5515
Military Population ³	207,570	5.1%	9,146	2,400	2,407	52.9%	N/A	8,392	178	54
MSM	25,598	36%	10,295							
FSW	38,582	36%	13,889							
Females 15-24 years	2,257,231	2.7%	60,945							

¹ CIA World Factbook, 2014

² CIA World Factbook, 2014

³ Total population size estimate includes military dependents (i.e. spouse and children) and 70% of civilian population attending military facilities in Cameroon. HIV prevalence is the mean for the military population (6%) and civilians (4.3%). Total PLHIV includes military population, their dependents, and civilians attending military facilities. 12-month ART retention was obtained from an assessment done by NACC in March 2015- military-specific data is not available.

1.2 Investment Profile

Key Players

While the GRC has consistently committed funding towards health in general, this only represented 3% and 5% of the public investment budget in 2013 and 2014, respectively. Principal health donors include bilateral donors such as the French and German governments and multilateral institutions such as the GF, UN agencies, and World Bank (WB). The GRC has benefitted from U.S Government (USG) health investments to address new or re-emerging zoonotic public health threats; neglected tropical diseases such as blinding trachoma and lymphatic filariasis; and some limited investments providing technical assistance to the Ministry of Public Health (MOH) in malaria and family planning (FP). With the recent Ebola outbreak in West Africa and polio outbreak in Cameroon, USG has mobilized additional resources to strengthen preventive efforts, including training health personnel and procurement of personal protective equipment.

For the HIV/AIDS national response, international donors have remained the principal investors, although it is worth noting that the level of contribution has reduced from 82% in 2009 to 60% in 2012. According to the UNAIDS Investment case (September 2014), there is increased investment in areas such as PMTCT, and C&T of PLHIV. However, the study notes significant decreases in investments in the areas of behavior change communications, procurement of condoms, and OVC programming. In 2012, the bulk of investments focused on C&T (47%), particularly procurement of commodities. Other significant investments focused on PMTCT (12%), and program coordination (18%). Limited amounts of money were divided across other strategic areas such as prevention amongst KP (2%) and OVC programming (0.5%).

The GF remains the principal donor contributing significant funds towards clinical care, treatment and support. The GF also provides minimal resources for PMTCT and prevention for key populations and other priority populations such as long distance truck drivers. As a key agency involved in the procurement of HIV/AIDS-related commodities, GF supports procurement of ARV drugs, HIV rapid test kits (RTKs), laboratory reagents, and drugs for OI. Within the funding framework of Round 10, the GF contribution of 36% (of total GF-GRC financing) for procurement of commodities was not sufficient to meet the needs of the increased number of beneficiaries. Consequently, between 2012 and 2013, the country reported stock outs caused by

delayed disbursement of additional funding from the GRC Public Investment Budget and also delays in meeting the requirements outlined in the GF New Funding Model (NFM). Significant contributions of emergency commodities from PEPFAR, the French Agency for Development (AFD), and the WB and reallocation of domestic resources from the Office of Cameroon's Presidency remedied the situation.

PEPFAR is also a major player in the HIV/AIDS sector, rapidly increasing its investments from \$11.25 million in FY 2011 to \$36.25 million in FY 2014. PEPFAR programs are implemented across five strategic pillars: PMTCT; CoPT for KP and other priority populations; blood safety; OVC; and health systems strengthening (HSS) with particular focus on laboratories, public pharmaceutical sector, and strategic information. Historically, PEPFAR funding for C&T has been limited; however, programmatic support is planned to expand. Treatment services are largely provided with support from GF (20%), other multi- and bilateral donors (36%), and the GRC (43%). Given the epidemic profile of Cameroon and its classification as a Long-Term Strategy (LTS) country, the PEPFAR program anticipates scale-up of HIV diagnosis, C&T to achieve epidemic control.

The GRC has sustained significant contributions to the HIV/AIDS national response; however, existing funding gaps may impede efforts towards the national target of 60% treatment coverage by 2017 as outlined in the HIV/AIDS NSP and GF concept note. Contributions from domestic resources have increased from 22% in 2010 to 30% in 2012. However, these efforts are highly dependent on a public health system that is weak.

Investment climate through 2017

The GRC has identified the following priority areas in its NSP (2014-2017):

- Treatment and care
- PMTCT
- Prevention in general population with particular focus on condom promotion and behavior change communications
- Prevention targeting KP and other priority populations (e.g. migrant populations, etc.)

The NSP estimates a required budget of approximately \$816 million over the four years of the plan. UNAIDS' Investment Case estimates the annual funding gap at approximately \$156 million,

taking into account GRC expenditure rates in the past three years. Given the declining fiscal environment among key donors, it is imperative to identify additional funding sources for HIV/AIDS programming (particularly procurement of commodities) required for sustained epidemic control. With Cameroon ranked as a lower-middle income country, the GRC is required to contribute a minimum level of 20% of total GRC-GF financing in the New Funding Model (NFM) to meet national response needs. However, the feasibility of mobilizing domestic resources to meet its GF HIV/AIDS commitments remains an issue, particularly with significant resources diverted towards addressing regional skirmishes in areas bordering Central Africa Republic and Nigeria.

Table 1.2.1 Investment Profile by Program Area⁴

Program Area	Total Expenditure	% PEPFAR	% GF	% GRC	% Other
Clinical care, treatment and support	\$46,443,239	13%	33%	30%	23%
Community-based care	\$333,632	77%	0%	7%	16%
PMTCT	\$8,529,462	42%	1%	5%	53%
HTC	\$798,206	55%	0%	29%	16%
VMMC	---	---	---	---	---
Priority population prevention	\$5,431,881	0%	1%	6%	93%
Key population prevention	\$2,557,034	52%	48%	0%	0%
OVC	\$1,023,697	42%	0%	0%	58%
Laboratory	\$7,720,164	83%	6%	0%	11%
SI, Surveys and Surveillance	\$4,598,994	16%	0%	12%	72%
HSS	\$13,933,706	6%	3%	5%	86%
Total	\$91,369,944	22%	18%	18%	42%

Table 1.2.2 Procurement Profile for Key Commodities²

Commodity Category	Total Expenditure	% PEPFAR	% GF	% GRC	% Other
ARVs	\$15,654,589	37%	58%	5%	0%
Rapid test kits*	\$3,865,523	88%	12%	0%	0%
Other drugs	\$213,283	0%	100%	0%	0%
Lab reagents	---	---	---	---	---
Condoms	---	---	---	---	---
VMMC kits	---	---	---	---	---
Other commodities	---	---	---	---	---
Total	\$19,733,396	47%	49%	4%	0%

*Rapid test kit expenditure amounts include laboratory reagents

⁴ (PEPFAR, COP13, 2013; GRP, National AIDS Spending Assessment, 2013), all amounts in 2013 USD (GF, UNAIDS, 2012), all amounts in 2012 USD

² (PEPFAR, GF, GRC, SIAPS reporting, 2013), amount in 2013 USD

³ (Non-COP Resources, 2013; PEPFAR, COP13, 2013), all amounts in 2013 USD

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives³

Funding Source	Total Non-COP Resources	Non-COP Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	---	---	---	---	---
USAID TB	---	---	---	---	---
USAID EPT	\$1,200,000	---	---	---	---
USAID NTD	\$2,700,000	---	---	---	---
USAID Malaria	\$250,000	---	---	---	---
Family Planning	\$524,998	---	---	---	---
NIH	---	---	---	---	---
CDC NCD	---	---	---	---	---
CDC FETP Polio	---	---	---	---	---
Peace Corps	\$28,050	\$28,050	1	\$332,140	To support 33 Peace Corps Volunteers contributing to national health priorities
DOD Ebola	---	---	---	---	---
MCC	---	---	---	---	---
Private Sector	---	---	---	---	---
PEPFAR Central Initiatives (CCI)	\$510,505	\$401,474	1	\$4,600,175	To support increased coordination between PEPFAR and GF-financed HIV programs and maximize GF grants performance
PEPFAR Central Initiatives (LCI)	\$1,582,434	\$1,582,434	1	\$4,088,000	To build the capacities of Rural Councils and Districts of Health Management Teams to deliver sustainable quality HIV/AIDS services, specifically PMTCT in the Northwest and Southwest regions of Cameroon
Total	\$6,795,987	\$2,011,958	2	\$9,020,315	

1.3 National Sustainability Profile

The Sustainability Index was assessed as a collaborative effort with engagement from PEPFAR, the GRC, GF, UNAIDS, and CSOs. The Sustainability Index Dashboard (SID) was presented and approved by the Minister of Public Health, who encouraged bi-annual reassessment.

The SID identified health financing, transparency, and quality management of national programs as areas where the national HIV/AIDS response is currently weak and unsustainable. Domestic resource mobilization falls below the Abuja commitment for government health expenditures, and public access to HIV/AIDS-related fiscal information and audit reports is limited. Although the GRC uses service delivery data to drive HIV/AIDS investment decisions, epidemiological, financial, and economic data are not consistently analyzed to inform where resources should be

allocated and which high-burden populations should be targeted. There is minimal domestic financing towards several program areas including KP-specific interventions. The absence of a national quality assurance system for clinical services hinders efforts to promote continuous quality improvement (QI). Use of performance data for QI is not well institutionalized, though there was some dissent on this issue from stakeholders involved in the sustainability index analysis. One-time pilot or study data, rather than routine monitoring data, is used to determine quality of services for programmatic decision making. These major findings require urgent attention to maintain progress towards sustained epidemic control.

Enhancing domestic health financing has not been a direct focus of PEPFAR/Cameroon though Country Collaborative Initiative (CCI) resources were used to support the 2012 National Health Account (NHA) exercise, review of the 2011-2015 National HIV Strategic Plan and finalization of the 2014 National AIDS Spending Assessment (NASA). Prioritization of PMTCT resources has been initiated following the expansion of the PEPFAR program in four regions in COP13. While funding from GRC and GF has been redirected towards the remaining six regions for PMTCT, the GRC is not fully prepared to sustain or transition sites. The same also applies to the newly scaled up C&T program that is in all ten regions. PEPFAR and GF have assumed the primary role in supporting the continuum of care for KPs. The GF concept note, currently under revision, conditions a portion of financing on KP-specific interventions, including prevention and STI diagnosis and treatment. Significant technical assistance from PEPFAR has contributed to successful laboratory strengthening. Efforts to build laboratory capacity in HIV diagnosis and biological monitoring are anticipated to be better synchronized with clinical service delivery through expanded PEPFAR support. Strategic information (SI) investments for PEPFAR have emphasized monitoring and evaluation (M&E) training, data quality, and use of data for program management.

PEPFAR plans to tackle unsustainable allocative efficiency as reflected in the SID. Regarding epidemiologic and health data, PEPFAR Cameroon has initiated plans to conduct an HIV Impact assessment (HIA) to help advance surveillance methods, fill in data gaps and support measurement of national outcomes and impact. Future investments as part of the new strategy that Cameroon will adopt for COP 2015 include planned activities in the cross-cutting areas of supply chain management, laboratory systems strengthening, strategic information, training in

leadership and good governance designed to produce strategic, targeted, and sustainable improvements in Cameroon's health system that will result in sustained epidemic control. PEPFAR Cameroon will support a cascade of training activities at the district and community levels in support of the GRC's decentralization goals and PEPFAR Cameroon's vision to improve engagement with civil society organizations. Additional advocacy items will include free monitoring tests (CD4 and viral load testing) and policies in favor of the ACT initiative goals in Cameroon. Health diplomacy efforts will be aligned with accountability in the health care sector, together with growing diplomatic engagement to address corruption, promote governance, and increase transparency in public financial management.

PEPFAR Cameroon is uniquely placed to help build quality (adult, pediatric, KP, and PMTCT) services through HRH training, support for linkages, adherence, retention, and a strong monitoring program that can gradually be transitioned to the Government of Cameroon. This is because PEPFAR Cameroon started supporting quality PMTCT programs three years ago, which provides the opportunity to draw from past experience correcting identified weaknesses and challenges within the current host country program and also working with existing experienced implementing partners. The treatment and care support recently started with COP 2014 resources and PEPFAR Cameroon will equally benefit from the PMTCT and other care the support experience. These activities (HRH training, support for linkages, adherence, retention, and a strong monitoring program) are being carried out in collaboration with the GRC and the Global Fund, wherein PEPFAR Cameroon provides HRH, quality improvement, linkages, retention, adherence, ARVs for PMTCT, and a buffer of ARVs for adults in the four PEPFAR-supported regions. The Global Fund complements PEPFAR Cameroon's contributions by providing ARVs and reagents for all PLHIV except pregnant women in four regions. It will take 2-3 years to fully transition the quality improvement and monitoring aspects of the PEPFAR Cameroon program, but the GRC and the Global Fund will purchase over 90% of the reagents and ARVs needed. Appendix A of SDS provides additional information on core and near-core activities for COP FY 2015.

1.4 Alignment of PEPFAR investments geographically to disease burden

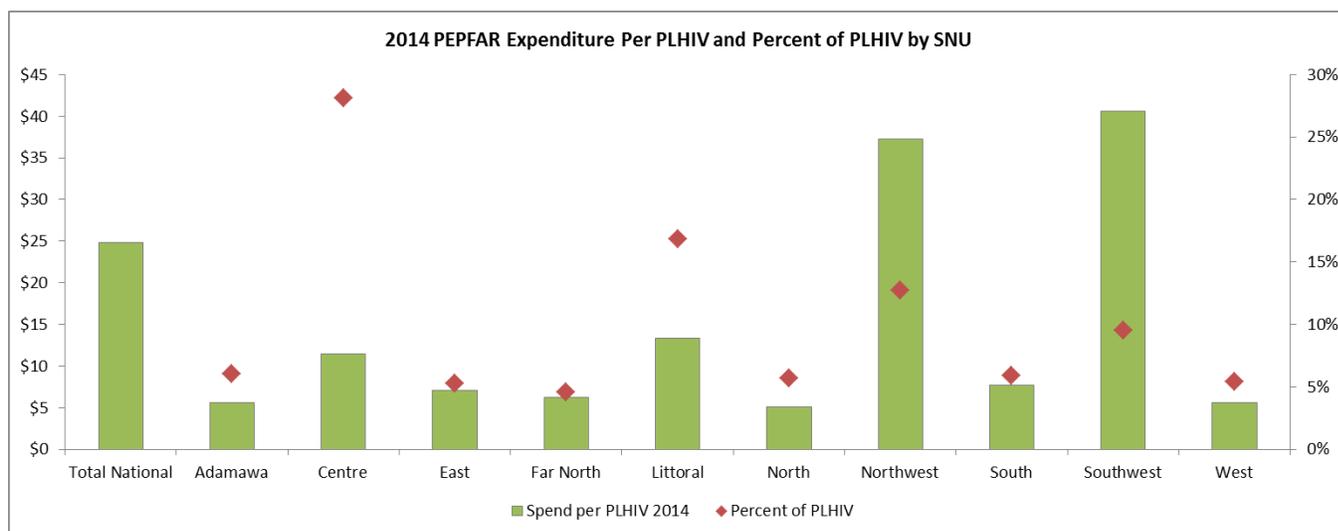
Figure 1.4.1 compares PEPFAR expenditures in FY 2014 to burden of disease by region. As Figure 1.4.1 illustrates, PEPFAR spent on average \$13.98 per PLHIV in Cameroon in 2014. Spend per

PLHIV across regions varied from \$5.05 to \$40.57. Some of this variation can be explained by PEPFAR/Cameroon's regional approach in four focus regions to implement PMTCT programs, since more than 60% of PEPFAR funding in 2012 and 2013 was allocated from one-time PMTCT acceleration funds and special PMTCT-ART integration funds. In addition, the PEPFAR program conducted a Pareto analysis in 2010/2011, when Cameroon first received PEPFAR funds. Based on the analysis, four regions (Northwest, Southwest, East, and Adamawa) were targeted for investment due to the burden of disease and limited partners and funding. Center and Littoral were prioritized over East and Adamawa following a bottleneck analysis by UNICEF and GRC. Thereafter, GRC requested PEPFAR to work in Littoral and Center regions, which have the highest number of PLHIV.

Although the current geographic alignment of PEPFAR investments is in the highest burden regions, there is the need for further granular analysis to maximize impact by investing in sub-national units with the highest HIV prevalence. Due to limited district-level ART data, clinical sites with the highest number of HIV patients, 118 and above, and/or greater than 10 HIV positive patients in PMTCT settings will be targeted for intensive scale up. Since this is the first year PEPFAR Cameroon will support FBCTS (facility-based care, treatment, and support), the goal is to focus on clinics with a high yield of HIV-positive patients within the scale-up and sustained districts in the four high burden regions. Cameroon has very few ART clinics relative to its burden of disease, leading to some clinics being overwhelmed with patients. Distance is a major factor for low retention (52% overall in Cameroon), and there is an urgent need to establish additional ART clinics, especially in settings that provide TB services with no complementary ART services and in PMTCT sites with the highest burden. This will ensure integration of PMTCT, TB and ART services within sites.

PEPFAR investments in PMTCT clinics with no and low-yield will be redirected to select medium-yield districts for sustenance. The remaining balance will be used for scaling up C&T for newly initiated patients on ART and implementation of PITC in facility and community-based settings, including TB clinics, in-patient hospital wards, and KP drop-in centers (DIC). Programming for KP will continue to target 11 hot spots in three urban centers (Yaoundé, Douala and Bamenda) in addition to the two scale-up districts.

Figure 1.4.1: Percent of PLHIV by SNU and PEPFAR 2014 Expenditure per PLHIV⁵



* Note: Implementation at the time of EA was limited, as Center and Littoral regions first received resources in 2014. Thus expenditure is low in these regions compared to the Southwest and Northwest regions.

1.5 Stakeholder Engagement

The Cameroon USG Mission coordinates consistently with all the relevant stakeholders in HIV/AIDS response in Cameroon. In the development of Cameroon’s COP 2015, PEPFAR consulted with CSOs, UNAIDS, GF, the NACC and the MOH.

PEPFAR/Cameroon briefed MOH on PEPFAR’s pivots and on the need to prioritize in Cameroon to reach epidemic control. Also, MOH was briefed and consulted on:

1. Data analysis on HTC, PMTC, OVC, KP, the military and ART site yields.
2. The investment approach to saturate areas of high HIV burden and prevalence with targeted combination prevention activities in two Scale-up and 56 Sustained Districts in four regions in Cameroon by 2017.
3. The identification of districts for PMTCT and ART sustenance and eventual transition of services to GRC or GF. Based on these consultations, PEPFAR hopes the GRC will accommodate these strategic changes in PEPFAR programming that will affect some program areas such as blood safety, KPs, routine laboratory testing and PMTCT. PEPFAR is still in the negotiation process and hopes to transition from PEPFAR to GRC over the next two years.

⁵ Center and Littoral regions just received resources in 2014, thus expenditure is low.

CSOs were also briefed and they expressed growing concern on the need to use local civil society capacity to reach an AIDS free generation in Cameroon. CSOs recommended that PEPFAR Cameroon should explore and identify ways to enable these stakeholders to become active partners in PEPFAR program in Cameroon especially at the level of the community and in prisons. As such, the PEPFAR team will develop a strategy to systematically and consistently engage GRC and CSOs at all levels to address these concerns.

The PEPFAR Cameroon program plans to begin finalizing the Country Health Partnership (CHP) with the government of Cameroon by April 2016. To begin this process, PEPFAR Cameroon will consult with and coordinate closely with the Global Fund, UNAIDS Cameroon and all other relevant multilateral and bilateral partners in Cameroon. Within the first quarter of FY 2016, PEPFAR Cameroon will develop a draft plan with the GRC. This plan will include a goal oriented schedule to ensure that the CHP process effectively begins as planned. This will include deliverables in this process such as a consistent engagement on data transparency and a path to joint financing to control the HIV/AIDS epidemic.

2.0 Core, Near-Core and Non-Core Activities

In line with the PEPFAR 3.0 strategy for epidemic control, PEPFAR Cameroon identified core, near-core and non-core activities based on the SID, country investment profile, and programmatic gaps illustrated by SIMS data. New core activities to support include HIV testing and counseling (HTC), adult and pediatric C&T, and TB screening to achieve sustained epidemic control. Since PEPFAR is a principal investor for the national response, continuing core activities include PMTCT, HSS, including HRH, laboratory strengthening, supply chain management, and aspects of CoPT for KP and some OVC services. Given the need to scale up combination prevention and C&T programs, activities related to PMTCT Option A, general food distribution, renovation of the National Public Health Lab (NPHL), and aspects of supply chain management and KP prevention are classified as non-core and will transition as described in Appendix A. See Appendix A for a full list of core, near-core, and non-core activities and transition plans.

3.0 Geographic and Population Prioritization

The four PEPFAR focus regions in Cameroon (Northwest, Southwest, Center, and Littoral) have the highest number of PLHIV. In these regions, 41 of 91 districts represent over 80% of the disease burden. PEPFAR is currently operational in all 91 districts but only 55 districts have ART sites. In

order to reach 80% ART coverage nationally, an additional 410,000 patients will need to be initiated on ART and require scale up in HIV testing and counseling, PMTCT, community outreach to KP, and investments in health systems strengthening. Previous investments for the newly supported C&T program in COP 14 have been limited to strengthening the supply chain system and one-time procurement of ARVs.

In order to have the greatest impact, PEPFAR/Cameroon has chosen to scale up PEPFAR activities in a subset of priority districts and a subset of priority and key populations. Given the current budget, the necessity for a sustenance package in the remaining areas, targeting for HTC and PMTCT using the clinical cascade, and required investments in infrastructure and human resource development, PEPFAR/Cameroon has calculated the program can support scale-up for 12,481 (67,59 adult C&T and 5,722 PMTCT B+) additional patients in the next year. Assuming this pace can be sustained over the next two years, PEPFAR/Cameroon will support the GRC to achieve epidemic control (80% of total PLHIV enrolled in ART) in two districts with the full program, two districts as highest priority for scaling up prevention activities specific to the military, and CoPT for FSW and MSM in support of national targets.

The scale-up districts selected are Djoungolo and Deido, as measured by total disease burden. These districts include both major urban centers (Yaounde and Douala). Treatment slots will be allocated to these scale-up districts in the coming cycle via existing funding mechanisms. Based on cascade analysis, HTC and PMTCT enrollment targets have been set accordingly and resources will be allocated as required to achieve the rapid scale-up required for these areas to reach 80% ART coverage (Section 4.1).

Recent IBBS and DHS data suggest that adolescent girls and young women aged 15-24 years (AGYW) (2.7% prevalence compared to 0.5% for male counterparts), military populations (5.1%), FSW (6-32%), and MSM (2-15%) contribute disproportionately to new infections in Cameroon. PEPFAR/Cameroon will focus on outreach for prevention, C&T for these prioritized populations in the selected 10 districts as follows:

District	Prioritized Population			
	AGYW	Military	FSW	MSM
Djoungolo	X	X	X	X
Deido	X	X	X	X

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

Based on the geographic and population prioritization decisions made for COP 15, PEPFAR/Cameroon used national and PEPFAR program data on current treatment coverage to calculate the total number of additional treatment slots required to reach 80% ART coverage in the two scale-up districts by 2017. A total of 41,517 patients need to be on treatment by FY 17 in order to achieve 80% ART coverage in the two scale-up districts. By the end of FY 16, PEPFAR will meet 40% of treatment coverage and 60% by FY 17. In FY 16, PEPFAR Cameroon will enroll 12,481 new patients on treatment in these two districts with the goal of 27,536 current on ART by APR 16. This represents an increase in coverage from 36% to 53% (Table 4.1.1), including a 50% increase of pediatrics on ART. Using the cascade approach to setting HIV testing targets, PEPFAR/Cameroon considered several critical program streams to most efficiently identify HIV positives and effectively link them to C&T (Table 4.1.2). Given the high burden of TB/HIV co-infection (29-44%) in Cameroon, high rates of TB-related mortality among PLHIV, and the accessibility of these patients to existing PEPFAR supported care programs and the GRC supported TB clinics, PEPFAR has committed to increasing the number of TB-HIV co-infected patients identified and the percentage initiated on ART to 80% in the first year. The remaining required to meet the target for PLHIV newly initiated on ART in scale-up districts will be identified and linked to treatment via provider-initiated, voluntary, and mobile counseling and testing models targeted to KP and priority populations (Section 4.5). Based on prior-year program data, about half of those diagnosed HIV-positive through these HTC platforms are linked to care programs. Both linkages and positivity yield are expected to improve in FY 16, given the plans to scale up linkage and retention activities, particularly in the scale-up priority districts. This provides an estimated 12,481 newly initiated on ART in FY 16 in adult treatment sites and will be funded primarily through strengthening adherence to testing protocols for both HIV care and TB sites and integration of TB and HIV services (Section 4.7).

To harmonize the 90-90-90 targets with the joint goals of eliminating mother-to-child transmission of HIV (eMTCT) and accelerating children HIV/AIDS treatment (ACT), PEPFAR/Cameroon also prioritized diagnosis and ART initiation for HIV-positive pregnant women, children and adolescents. To support the eMTCT goal, PEPFAR/Cameroon in FY 16 will

test 95% of pregnant mothers in scale-up priority sites and enroll 95% of those testing HIV positive into ART programs, which is expected to yield an additional 4,292 newly initiated on ART. By the end of 2016, a cumulative 11,260 children are expected to be on ART (an increase from the current base line of 5,630), representing a net increase of 5,630 and a doubling in the national number of children receiving treatment. In addition a total of 1,000 adolescents will receive ART.

Table 4.1.1 ART Targets in Scale-up Sub-national Units for Epidemic Control

SNU	Total PLHIV	Expected current on ART (2015)	Additional patients required for 80% ART coverage	Target current on ART (in FY16) TX_CURR	Newly initiated in FY 16 TX_NEW
Djougolo	31,636	12,758	13,711	16,832	7,630
Deido	20,261	8,113	8,834	10,704	4,851
Military					
Total	51,897	20,871 (36%)	22,545 (47%)	27,536 (53%)	12,481

Table 4.1.2 Entry Streams for Newly Initiating ART Patients in Scale-up Districts (FY 16)*

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Clinical care patients not on ART			
TB-HIV Patients not on ART	7,363	2,356	2,356
HIV-positive Pregnant Women	157,047	15,706	11,779
Key populations (FSW, MSM)	11,382	1,561	1,561
Military	16,500	1,072	1,000
Total			

*Table 4.1.2 does not include remaining 17,688 new on treatment from other entry points: CBCT, PITC inpatient/out-patient wards at scale-up and sustained sites.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket

Target Populations	Population Size Estimate (priority SNUs)	Current Coverage (date)	VMMC_CIRC (in FY16)	Expected Coverage (in FY16)
Not applicable	--	--	--	--
Total/Average				

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY16)	FY16 Target
Adolescent girls and young women	181,190	36%	64,514
Military	124,542	2%	3,000
Female sex workers	38,582	33%	13,008
Men who have sex with men	28,598	18%	5,270

Total	85,792
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Table 4.1.5 Targets for OVC and Pediatric HIV Testing, Care and Treatment

	Estimated # of Children PLHIV (<15)	Target # of active OVC (FY16 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs to access HIV services (FY16 Target) OVC_ACC	Target # of children tested (FY16 Target)	Target # of children on ART
2 scale-up districts		6,583	5,094		7,218*
TOTAL		6,583	5,094		7,218

*7218 represents 64% of the 11,260 to be reached by 2016, nationally.

4.2 Priority and Key Population Prevention Summary

In the two scale-up districts and 11 hot-spots and through 26 Peace Corps volunteers based in communities, PEPFAR will harmonize targeted community activities described for community-based HTC, FBCTS, and targeted prevention programs to strengthen linkages and referral networks for maximal coverage of priority and KP given the available resources. Support for the national condom and lubricant forecasting and procurement will continue in FY 16, largely tailored to priority and KP.

Appendix A provides details on the core package of services for priority and KP.

Priority Populations

PEPFAR Cameroon will focus on AGYW, clients and intimate partners of sex workers and the military as priority populations. To avert new infections, prevention activities will be integrated into all service delivery points (i.e. TB care, ART, PMTCT) in facility-based and community-based settings in the two scale-up districts, including community sites for AGYW and in military locations. PEPFAR/Cameroon will invest in integrated behavior change communication using evidence-based models specific to each population. Priority populations will be screened for STI, and identified positives will serve as index cases for PITC to assure linkage to C&T. Additional community mobilization will create demand for free HTC services including consistent and correct use of condom, skills building and HIV testing. PEPFAR support for supply chain

management will ensure availability and distribution of male and female condoms and lubricant for priority populations. Community-based mobilization and referrals will link individuals to health facilities. A subset of activities will target AGYW specifically with life skills and sexual and reproductive health education, including gender equitable principles for dignity promotion and harmful norms related to HIV.

Key Populations

Since 2014, PEPFAR has provided technical leadership and innovations in the national KP program. As part of its sustainability agenda, PEPFAR will work with GRC, GF, UNAIDS, and WB to develop national policies, tools and standardized approaches for KP program implementation.

Geographic prioritization for KP programming assumed that the larger cities would have higher concentrations of target populations. KP activities in Cameroon have been divided geographically between PEPFAR and GF, the only funders in this area, to ensure nationwide coverage of CoPT for KP activities. Given geographic prioritization, KP programs will target the two scale-up health districts and 11 hot spots located in the urban cities of Bamenda, Douala, and Yaounde (where existing hot spots have been mapped), with plans to expand interventions (drop-in centers, mobile and outreach activities). The cities of Kribi and Bertoua will be sustained, until transfer to the Global Fund principal recipient will take place. FSWs and MSM will be targeted for enhanced KP CoPT activities, including community and facility based HTC and linkage to adult C&T programs with strong monitoring systems once in the care cascade. Data on MSM HIV-prevalence only exists for the cities of Douala and Yaounde (2011), while prevalence estimates in eleven cities based on 2009 IBBS exist for FSWs. Significant investments in surveillance including a KP cohort study and IBBS for MSM and FSWs are needed but only partially funded this year. IBBS results will be used to adjust targets and also contribute towards further focusing the Global Fund's program as well as the World Bank's technical support focused on sex workers (not MSM).

4.3 VMMC Summary

VMMC is not an applicable program area to PEPFAR/Cameroon.

4.4 PMTCT Summary

PMTCT has been a priority intervention in Cameroon in successive NSP's for HIV/AIDS, although funding has focused mostly on commodities. PEPFAR support began in 2011 in NW and SW regions and in 2014 in Center and Littoral and has rapidly expanded provision of PMTCT services. The proportion of women attending ANC has increased from 36% in 2011 to 54% in 2014. In 2014, 522,471 pregnant women were tested nationwide with 31,601 (6.0%) positive. Seventy percent (21,938) received antiretrovirals. In 2012, the GRC adopted Option B+ and used the lessons learned from a pilot to develop a national plan beginning in 2014. EID has scaled up in Cameroon with PEPFAR support, and testing of half of the EID samples nationwide occurs at the CDC reference lab.

In the two scale-up districts, targets for the PEPFAR PMTCT program were set to reach 95% of pregnant women with HTC and initiate 95% of HIV-infected women identified on ART. Sites with 0-4 yield in the NW and SW regions will be transitioned out of PEPFAR support to the GRC by September 2015. In addition, sites with less than 2 patients in the Littoral and less than 1 in the center will also be transitioned. PMTCT sites with greater than 4 yield will be sustained (see Section 5.1) in all districts while sites with greater than 10 yield will be prioritized for focused scale-up support in the two scale-up districts. PEPFAR will need to continue support for women newly-initiating ART and continuing treatment after pregnancy and breastfeeding in existing ART sites. Resources required to support these patients have been factored into the sustenance budget for the remaining areas.

Strategic interventions in the scale-up districts were developed to achieve increased testing and treatment targets. The scale up package includes: demand generation activities to increase uptake of ANC and HIV case finding; in-service training, mentorship and supportive supervision of health care workers; support for adherence, retention, and tracking of mother-baby pairs in Option B+ through community health workers (CHWs); institutionalization of M&E systems for cohort monitoring; incorporation of QA systems for HIV rapid testing; integration of FP services in PMTCT and ART facilities; screening for TB; provision of ARVs and RTKs as well as viral load (VL) testing (in pilot sites); strengthening peer support groups; and use of bikers for health sample transport. The package in sustained districts and low-yield health facilities will include provision of supportive supervision and mentorship visits for QA and ensuring clients on

treatment are followed up through the use of CHWs. GRC/GF will provide ARVs, RTKs, CTX, and TB treatment.

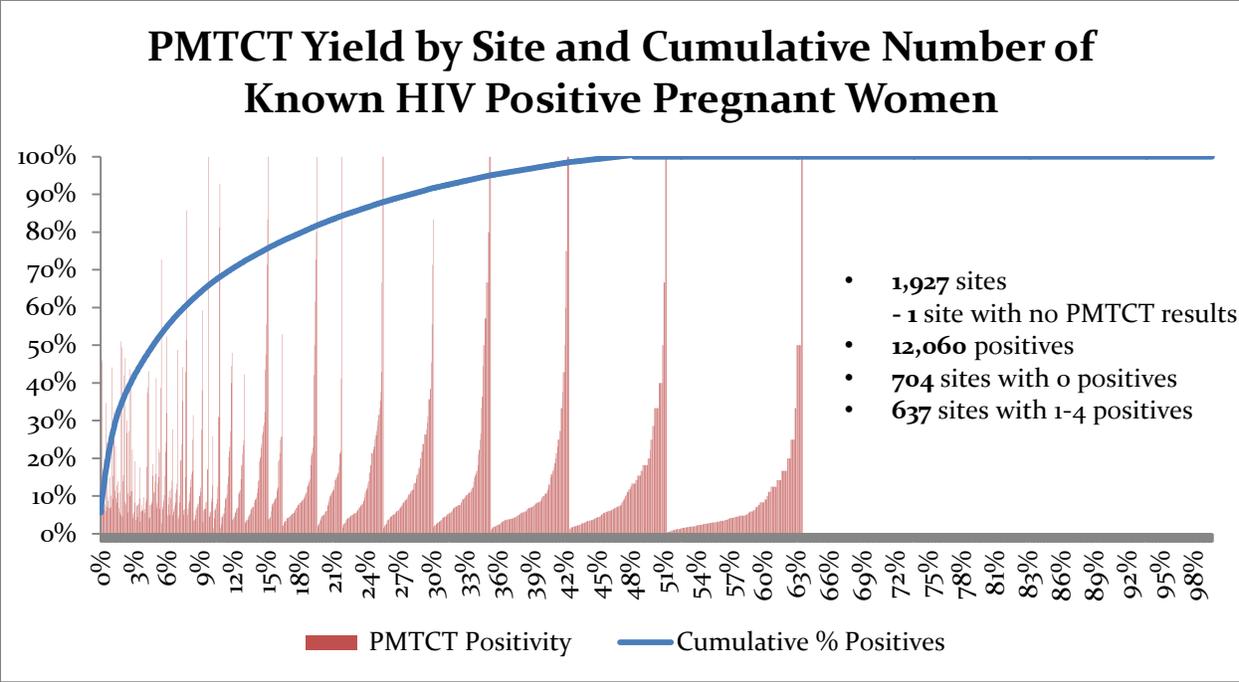
Reliable supply of ARV and EID testing commodities is of concern for PMTCT program activities due to previous stock outs and supply chain issues. Commodities issues will be addressed through systems support to the GF, GRC, and CENAME for adequate service delivery.

All PEPFAR sites will be supported to use the B+ M&E Framework. Using the PMTCT/ART integration funds, registers are being updated to meet PEPFAR/GRC specifications and will be scaled up in FY 2016. PEPFAR/Cameroon partners will be funded to do DQA and mentorship/supervision visits. Sites with red SIMS scores will be prioritized. PEPFAR supported PMTCT scale-up sites will participate in the USG Rapid Test Quality Improvement Initiative (RTQII).

Efficiency Analysis:

PEPFAR supported 1,927 PMTCT sites in 2014, of which 704 reported zero positives and 637 reported 1-4 positives in the last six months. 1,247 of the 1,927 in the four PEPFAR supported regions will be transitioned to the GRC by September 2015, while 635 others will be sustained and 45 scaled up.

Figure 4.4.1 PMTCT Facility Yield



*Based on partial data (Center and Littoral have only 2-5 months of data)

4.5 HTC Summary

In 2013 the GRC provided HTC services to 538,252 clients representing 44% of the national target (NACC, 2013). While current national guidelines for HTC in Cameroon allow for PITC and for free HIV testing for pregnant women and children under 15 years, payment is required for the general adult population. Current policy prohibits HIV testing for minors (under 15 years) without parental consent. The PEPFAR/Cameroon HTC program is just starting in FY15 in the two scale-up districts. PEPFAR has supported HTC in community VCT, PMTCT and KP since 2011. PEPFAR/Cameroon supports an annual mass VCT campaign before World AIDS Day. In FY 2016, PEPFAR/Cameroon will prioritize clinical and community based HIV testing to identify PLHIV and link to treatment, care, and support programs. PEPFAR/Cameroon targets for HTC have been calculated based on cascade analysis to meet the target number on treatment in scale-up districts (Section 4.1). To reach 80% treatment coverage in two districts by 2017, subnational data on HTC positivity were used as a baseline to calculate the number of new HIV diagnoses, as well as estimates of LTFU (15%) and linkage to HIV care. (Table 4.1.1) PEPFAR will facilitate stand-alone HTC sites in priority high yield entry points including TB clinics; adult clinics(inpatient/outpatient); KP DICs; pediatric clinics; OVC services; blood centers; STI services and military recruits.

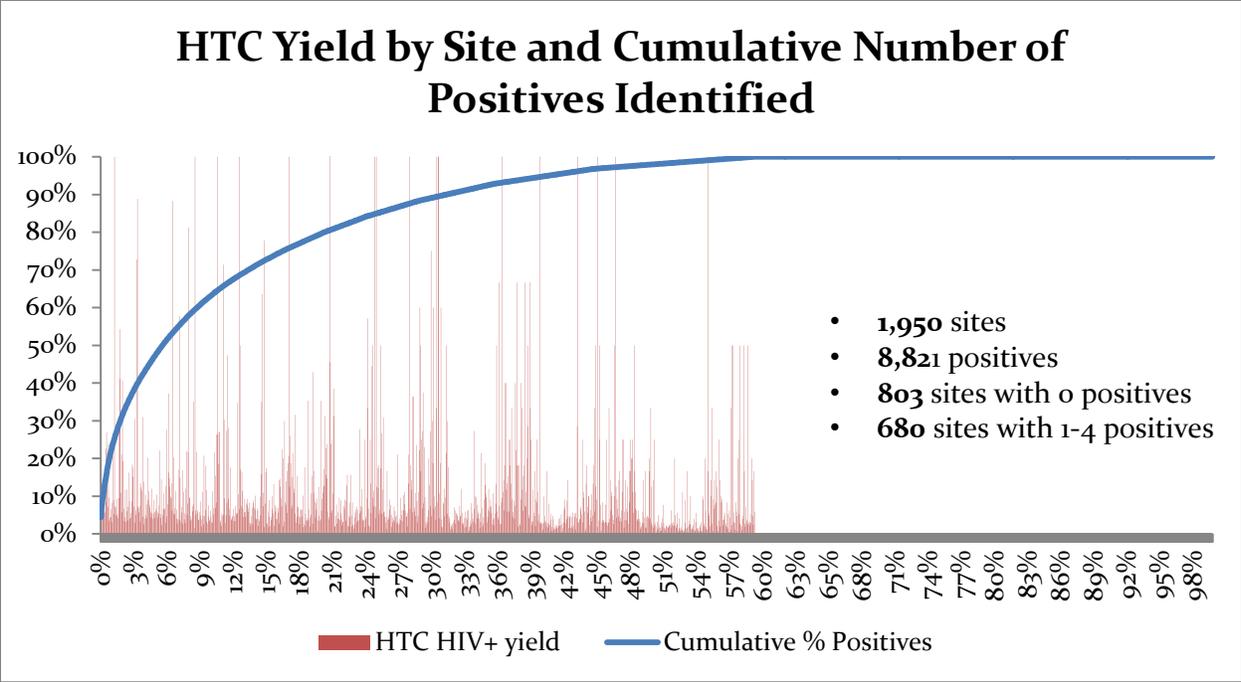
The service delivery package for HTC will include: provision of counselors as needed; community mobilization and promotion of HTC; strengthening linkages to treatment, care and support; and enhanced monitoring of linkages. USG partners will implement continuous QA/QI strategies, while providing TA at the provincial and district levels. The planned program activities align with core activities. In sustained sites, the GRC supports RTKs and staffing, and provision of HTC will continue according to national guidelines.

PEPFAR will identify 16,315 PLHIV by focusing and scaling up HTC in the two scale-up districts plus the 11 hot spots for KPs. Using the EA data by mechanism and district, the team determined the 2014 average expenditure per test of \$11 would decline by about \$2 per person as testing was focused in higher volume areas and integrated sites (Appendix B). PEPFAR/Cameroon team will reinvest cost savings in HTC from centrally supported sites to scale-up districts in high priority harder-to-reach PLHIV districts and improve linkage and enrollment to C&T.

Efficiency Analysis

PEPFAR Cameroon has historically supported HTC within the context of PMTCT, KP, and annual VCT campaigns for World AIDS Day. Given the lack of data from HTC, PEPFAR has selected high yield sites to in which concentrate testing. Based on GRC data, TB clinics should yield 32% HIV positivity, inpatient and outpatient wards 5% or higher, blood banks 7%, and FSW 25%, MSM 25%, and military recruit testing 4-5%. As HTC is implemented at scale-up sites, yields will be monitored to adjust testing strategies.

Figure 4.5.1 HTC Facility Yield



4.6 Facility and Community-based Care and Support Summary

After a critical analysis, PEPFAR/Cameroon plans to give the right package of services in the right places within its budgetary constraints to the two scale-up districts and additional 11 hot spots for KP and military sites. CHW, CSO, and peer educators will be used to increase demand and mobilize communities for HTC and active linkage into C&T. Adherence, nutritional, FP and psychological counselling, screening for TB and other OI, active tracking of cases LTFU, sample transportation, provision of EID services and, in selected sites, VL using a phased approach, will be part of this package. Continuous capacity building of HCW and supportive supervision is also included. Clients tested and not automatically eligible for treatment per national guidelines (eligible include pregnant/breastfeeding women, children under 5 years old, TB/HIV, discordant couples, and co-infected HB/HIV with concomitant chronic liver diseases) will be offered a free CD4 count to determine eligibility for ART. Initial CD4 has been a barrier to ART in Cameroon because patients have to pay. PEPFAR/Cameroon will discuss with GRC and the GF to continue provision of CTX and ARVs in scale-up sites. Forecasting for the commodities in this package will be done to ensure continuous availability.

Activities in sustained sites in the scale-up districts and in the 56 sustained districts will be similar except that additional training of HCWs from the sustained sites in the scale-up districts will be included for enhanced linkage and retention in care. PEPFAR/Cameroon implementing

partners will continue to support a package of services in sustained districts through quarterly technical assistance visits meant to improve the quality of care, linkage and retention of patients, resulting in community VL suppression. The simplified treatment package will include adherence, nutritional and FP counselling services, screening for TB and other OIs in PLHIV. CHW and CSOs funded by GRC already working in communities will continue to provide tracking of patients LTFU. Negotiations will continue with GRC for the complete transitioning of these sites to the GRC and GF by September 2016. Standard documents and SOP for linkage and documentation of LTFU being developed will be provided to the GF and GRC for use at all treatment sites in Cameroon. GRC/GF will provide all ARVs, RTKs, and some CD4 and VL reagents.

KP NGOs will implement a system to monitor and support KPLHIV through the care cascade with the final aim to ensure viral suppressions. Treatment monitors will use mobile technology and innovative tracking tools.

4.7 TB/HIV Summary

Cameroon currently has about 25,000 TB cases annually corresponding to a rate of 118/100,000. TB and HIV services are provided at separate locations outside of the larger health centers in Cameroon. Two hundred thirty-nine (239) TB treatment centers exist across the country and ~87% of TB patients have been screened for HIV, and 69% of identified patients with HIV/TB are receiving ART. With the support of the GF, the GRC has scaled-up the TB/HIV program from one site in 2000 to 239 sites in 2014. PEPFAR/Cameroon supported the GRC to adopt the consolidated WHO ART guidelines including treatment for TB/HIV clients. Currently, TB clinic staff provide HIV testing but are not able to start ART. Similarly, in ART clinics, patients are screened for TB, but require referral for diagnosis and treatment if positive. Preliminary PEPFAR support for the TB/HIV program started in FY 15 with in-service capacity building for clinicians in TB, PMTCT and ART clinics in the four PEPFAR regions and scaled up in FY 16 to saturate the two PEPFAR scale-up districts. PEPFAR/Cameroon will support a national task-shifting policy and will work with the GRC and other stakeholders to support policy change that will enable nurses in TB and ART clinics to provide ARVs. In scale-up districts, PEPFAR Cameroon will provide a core package to increase ART coverage of TB/HIV co-infected to 80% in FY 17: human resources to accelerate planning and implementation of collaborative TB/HIV activities; infection control activities; enhanced TB/HIV case finding to ensure that 100% of all HIV patients are screened for TB, all TB patients and their contacts are screened for HIV, and 95% of all TB/HIV patients are started on

ART; implementation of tracking on HIV/TB screening; and support scale-up of GeneXpert MTB/RIF testing. PEPFAR/Cameroon has supported GRC to purchase five GeneXpert machines across the country. Three other GeneXpert machines have been purchased by the GRC through the GF. PEPFAR will be working with the MOH to ensure that GeneXpert is incorporated into the diagnostic algorithm for all PLHIV in addition to those with suspected MDR TB.

While PEPFAR TB/HIV activities will be focused in the two scale-up districts for epidemic control, screening and prevention of TB will remain part of a national GRC basic package of services across all regions of Cameroon. TB infection control activities will continue in scale-up districts but will be transitioned to GRC in the remaining districts by the end of FY 16. PEPFAR will support revisions of national guidelines, TB/HIV data review meetings, TB/HIV coordinating body meetings, and technical support through mentoring of health care providers in sustained sites.

4.8 Adult Treatment Summary

The GRC has supported the adult ART program since 2000. With support from GF, the GRC scaled-up the adult ART program from one site in 2000 to 166 sites in 2014 yielding 145,038 currently on treatment in Cameroon. In November 2013, PEPFAR Cameroon supported the GRC to adopt WHO consolidated ART guidelines.

In order to reach epidemic control and 80% coverage in FY 2017, PEPFAR Cameroon will prioritize two districts for scale up and 56 others for sustenance in four high burden regions plus military facilities for adult treatment. The four regions account for 67% PLHIV and over 78% of patients receiving ART in the country as of December 2014. Focusing in the two scale-up health districts, PEPFAR will initiate 22,606 new on treatment (not including Option B+) and 12-15% will be in care in FY16; this represents 40% of our 80% saturation target by 2017. In priority districts, the PEPFAR program will focus on increasing ART coverage for patients with TB/HIV, pregnant women and their partners, children, KP, blood donors found to be HIV-positive, STI patients and military recruits. The scale up package includes clinical and lab monitoring (initial CD4, VL, WHO staging); adherence and retention of pre-ART and ART patients through counseling and community linkages; and HIV testing and provision of ART in TB treatment sites. The current national 12 month retention rate of 52.9% reported by the GRC in February, 2015 is an area of particular attention. PEPFAR/Cameroon will work with GRC to support robust community

initiatives backed with active tracking of LTFU, adherence counselling, and a minimum package of PHDP activities to increase 12 month retention to above 85% in scale-up districts. Linking KPs with ART is another area of focus for the PEPFAR team. Within the sustained sites, without creating demand, PEPFAR/Cameroon will continue to use community systems to support adherence/linkages/retention activities whilst monitoring compliance through supportive supervision (Appendix A).

The USG Local Capacity Initiative (LCI) has been central to strengthening rural councils and district management teams in two regions and will be expanded to build local capacity in ART sustained sites in preparation for transition to GRC activities by September FY 2017. As an ACT country, PEPFAR will support active scaling up of pediatric HIV treatment to double the current number (5,630) of children currently receiving ART. Family and community testing through the home based care program will ensure that clients are recruited via the ACT program and linked to adult C&T.

All the ARV drugs and commodities for the HIV program will be procured through the GRC, PEPFAR COP14 funding, and GF through December 2016. Since current forecasting does not anticipate any shortfall in ARV, PEPFAR will invest in building local capacity to enhance ARV procurement, distribution and use throughout Cameroon. PEPFAR Cameroon is currently piloting FP integration in HIV C&T in the SW region and will scale implementation in the two scale-up districts. Program implementation will be in compliance with USG legislation and will integrate a mix of methods (short, long term FP methods) in HIV C&T. UNFPA Cameroon and other stakeholders will supply the FP commodities.

PEPFAR/Cameroon will support GRC to monitor clients on ART and will fund baseline CD4 testing for adult clients on treatment in scale-up districts while ensuring routine supportive supervision in sustained sites. PEPFAR/Cameroon will build capacity for the use of VL testing, piloting use in FY2016 in selected districts (in concert with the ACT program and EID systems) to assess feasibility, acceptability and logistic issues prior to scale-up in FY 2017. PEPFAR/Cameroon will build capacity for DBS/VL, and sample transportation network for specimens; support regional and district forecasting, procurement and distribution of HIV commodities; QA activities for HIV rapid testing and for lab technicians; in-service training for nurses on HIV testing and clinical management; curriculum development for pre-service and in-service ART trainings; guideline development for laboratory technicians, HCWs and CHWs; and support for HIVDR

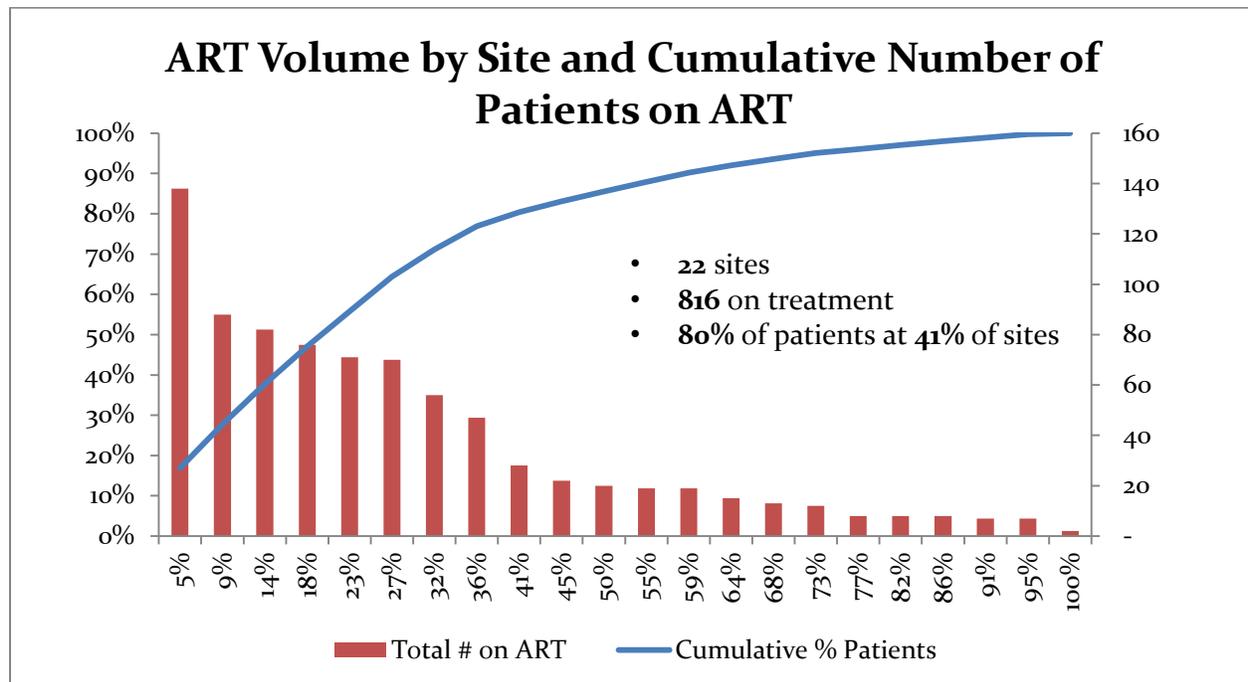
studies in adults and children as well as developing technical and operational guidelines for monitoring drug toxicity and treatment response. The last SIMS visit revealed 70% of sites with red scores. These sites will be prioritized for mentorship and supportive supervision.

Efficiency analysis

PEPFAR Cameroon’s support to service provision began in FY 2012 with PMTCT in the SW and NW regions. The program was expanded to involve activities in two additional regions of Littoral and Center in FY2014. Within COP14, PEPFAR support was expanded to include C&T in 99 health facilities across the four supported regions using the roll out of PMTCT B+ as a platform.

Currently 145,038 patients are receiving ART out of an estimated 600,000 PLHIV in the country. PEPFAR/Cameroon is just beginning to implement adult treatment in 2015. In FY16 PEPFAR will scale up ART in two high burden districts to achieve epidemic control. Health facilities in districts with more than 118 patients will be classified as scale-up sites while facilities with less than 118 clients will be sustained sites.

Figure 4.8.1 ART Facility Yield



4.9 Pediatric Treatment Summary

The PEPFAR pediatric treatment program just started in Cameroon in FY2015 with the ACT initiative in the 91 districts of the four PEPFAR regions, although PMTCT has been supported since 2011. In November 2014, PEPFAR Cameroon supported the GRC to adopt the WHO guidelines that specify treatment for all HIV-positive children under 5 years or with TB/HIV coinfection. Children above 5 years and adolescents will be initiated on ART with either WHO stage 3 or 4 or $CD4 < 500/mm^3$.

In FY 2014, PEPFAR did not provide direct clinical support to the GRC for its pediatric HIV program. For the entire country, the number of HIV-positive children on ART was 6,099 in 2014, only 6.5% of all infected children. Currently, pediatric ART is provided at 84% of the 99 PEPFAR-supported Adult ART health facilities. Cameroon will receive ACT funds to support intensified pediatric HIV case finding and linkage to C&T. With ACT, infected children will receive comprehensive pediatric treatment and care support.

Based on ACT guidance, targets for the PEPFAR pediatric program were set to the number of children under 15 years on treatment (5,630) in 2014 to double the number of children on treatment, plus an additional 1,000 adolescents 15-19 years old receiving ART by the end of FY 16 and 1,600 additional adolescents in FY2017 for a total of 14,000. To meet these ambitious targets, the approved ACT strategy will be implemented in high HIV burden districts throughout the PEPFAR regions. Accrual will be monitored closely with the plan to transition pediatric activities in districts that are not scale-up districts for other PEPFAR activities to the GRC if ACT targets are being met in the PEPFAR priority districts. The ACT strategy will include the expansion of high yield pediatric testing efforts (EID and PITC), improving follow-up of the mother-infant pairs (MIP) through improved community linkage and longitudinal cohort tracking, nutritional assessment and counseling as well as TB screening for HIV+ children, expanding availability of LPV/r-based regimens for children under 3 years, and improving reporting of age disaggregated data. Intensified efforts for adherence and retention with community support will be included. PEPFAR will expand EID from its current coverage of 68% to target all PEPFAR-supported PMTCT sites in scale-up districts and will establish aggressive PITC in all pediatric services as well as TB, malnutrition and OVC settings. Children identified with HIV at TB clinics will receive dual TB and ART at the TB clinic and will be referred to the ART service at completion of their TB treatment.

PEPFAR will support the GRC to roll out a standardized adolescent package of care at all pediatric treatment sites, including provision of adolescent friendly health services covering issues related to school, adherence, disclosure, sexuality/reproductive health and stigma in addition to usual care. Currently, the proportion of ART children on second-line treatment regimen is not known. Concerns around treatment failure in children will be addressed through a national HIV drug resistance survey in FY 2016.

In FY 14, PEPFAR Cameroon supported the GRC to optimize the national pediatric ARV formulary, and there have been no reported pediatric ARV stock outs. However, although LPV/r-based regimens are recommended as first-line for children under 3 years, the proportion of children receiving this regimen is unknown. Expanding availability of LPV/r-based regimens is a key component of the ACT package. In order to sustain the ACT initiative and to ensure growth of the pediatric HIV C&T program after FY 16, PEPFAR/Cameroon is ensuring joint ACT implementation, capacity building and a long-term sustainability plan with the GRC. Support is being provided to GRC to develop comprehensive understanding of ARVs/commodities and HRH financing needs for sustaining achievements.

The last SIMS visit revealed 60% of sites had 75% red scores. These sites will be prioritized for mentorship to address facility based issues.

4.10 OVC Summary

The GRC estimates that 304,000 children have been orphaned by HIV/AIDS in 2010, projected to increase to 350,000 by 2020. PEPFAR-funded OVC programming is nascent with the bulk of previous investments mostly focused on information gathering and limited investments for direct service provision. Since FY 2014, PEPFAR Cameroon has developed its OVC program targeting two scale-up (Djoungolo and Deido) and 16 sustained health districts to identify specific evidence-based interventions within the short-term (FY 15-FY 17) for future investment and scale up. Target sites were selected based on high HIV/AIDS burden, high OVC burden, and Peace Corps volunteer placement, to leverage joint investments.

PEPFAR Cameroon will target 6,583 OVC in FY 16 with core and near-core interventions (see Appendix A), representing 19% of total estimated number of children infected and affected by HIV/AIDS in target health districts. The community-based program considers specific risks due to gender, socio-economic status, geographic location, HIV status, etc., and provides

interventions focused on ensuring a stable social and family environment in order to ensure the effectiveness of pediatric ART; or in order to ensure that the future of an HIV-affected child is not compromised. Illustrative activities include early childhood development, sexual and reproductive health education, case management to track those lost to follow-up, facilitating access to clinical services, nutritional support for clinically malnourished children, household economic strengthening, etc.

By the end of FY 16, PEPFAR's OVC program will transition out of five districts (Manoka, Santa, Bonassama, New Bell, Cité Verte). Investments in these sites to date have been minimal, as PEPFAR recently initiated household economic strengthening activities for 52 households. PEPFAR Cameroon will no longer expand its reach in these areas, but will continue household economic strengthening interventions to strengthen families as primary caregivers (Section 5.1), informed by clear evidence that children who are cared for within families have better health, education, and nutritional status and development.

For sustainability, investments will focus on the development of national guidelines, tools and policy for standardized provision of services for OVC. To facilitate documentation for future investments, continuous gathering of information will occur through implementation of a robust M&E system. If the project is continued in FY2017, a mid-term evaluation will identify key lessons learned and best practices, including measuring changes along MER Level 4 Essential Survey Indicators.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Sustenance package of services in other locations and populations

For these districts, current clients on ART treatment will be maintained in HIV care and treatment services through FY 16 in both ART and PMTCT sites. In collaboration with the GRC, lower volume health facilities (0-4 yield) will transition patients to higher volume and higher quality facilities. Clients attending sustained sites within scale-up and sustained districts (see site classification in Supplemental Documents) will also be provided a minimum package of HIV care

and treatment services and PMTCT provided by GRC with mentoring and supportive supervision visits by PEPFAR IPs. The PEPFAR supported package at sustained sites includes:

- Counseling support to eligible clients (where needed)
- Routine laboratory quality assurance systems for HIV and CD4 testing and use of electronic and paper based systems to monitor quality.
- Quarterly site supportive supervision, mentorship, on the job training (as needed) to ensure quality
- EID for HEI
- Use of CHWs to:
 - Ensure linkage to community-based activities and back to clinics to reduce loss to follow-up and improve long-term outcomes
 - Follow up and track defaulters
- Use of bikers for health to pick up and drop off samples, results, data

GRC will provide doctors and nurses at these sites. Additionally, ARVs, RTKs, VL, and CTX will be provided through GF and GRC via the national supply chain system. PEPFAR/Cameroon will support regional warehouses to preposition pre-determined quantities of ARVs at low-volume PMTCT sites in anticipation of the rare cases of pregnant women testing positive. Due to fast stock rotation, RTKs will be distributed based on demand together with other essential medications. While there will be no supply chain-related supervision activities conducted at medium and low-volume PMTCT sites, spot checks will be conducted for a random sample of sites if deemed necessary. Simple capacity building activities for sustained sites will include dissemination of information notes and job aids to improve ARV and RTKs management, and participation in focus group discussions organized by topics. ARV and RTK stock will be monitored through existing formal reporting channels.

Passive enrollment into HIV care and treatment will occur in these districts. No patient will be denied HIV treatment, so if a person presents for PMTCT services, is requesting HIV testing or presents with an OI, HIV testing and treatment will be provided as needed. There will be no demand generation for testing and no active scale-up of HIV care and treatment or PMTCT services in these districts. Pregnant and breastfeeding women newly initiated on treatment will be provided with support related to: clinical and laboratory monitoring, EID, and adherence and retention support.

Outside of ANC and passive testing and linkage to care in PMTCT and ART sites, PEPFAR support for HTC will be discontinued in these districts and populations.

The expected volume of patients needing the minimum package of services in these areas has been calculated by district and overall (Table 5.1.1). The expected number tested through PMTCT sites was derived based on the assumption that these sites in FY 16 would continue to test 95% of pregnant women and will continue to link 85% of those identified as HIV-positive to treatment per standard of care and national guidelines; however, testing by PEPFAR will be discontinued immediately in no and low yield (0-4) sites without ART patients.

PEPFAR supports 26 Peace Corps Volunteers (PCV) and will maximize their placements in the scale-up districts in FY 16 and FY 17 as much as possible. For sustained sites, volunteers will continue their activities, excluding those that will create demand for services such as mobilization for HTC.

By the end of FY 16, PEPFAR will transition OVC programming out of 5 health districts, with an estimated total OVC (children infected and affected by AIDS) population of 25,500. Investments in these sites will mainly focus on household economic strengthening interventions to improve family investments in the essential needs of vulnerable children and adolescents in their care. In FY 15, PEPFAR introduced a community-based savings group approach, known as Savings and Internal Lending Communities (SILC) in these health districts. Through the SILC approach, OVC caregivers, PLHIV, and youth have access to appropriate and affordable financial services, such as savings, loans, and a social fund for emergencies. This intervention is appropriate for many families, particularly those with access to income sources but still unable to invest adequately in their children. An independent evaluation of this approach in 2009 based on evidence from Kenya and Tanzania, found this approach to be a cost-effective method for improving food security in vulnerable households.

PEPFAR's transition model includes training private service providers (PSP) – a well-documented, cost effective and sustainable approach to SILC service delivery, which is operational in ten countries in Africa – who will support savings groups on a fee-for-service basis. SILC groups will be expected to pay a market rate for PSP services, which have been shown to be possible by even very poor households. Where this remains a significant barrier for more economically vulnerable

SILC groups, PEPFAR will explore options such as matching subsidy of 25%-50% of the PSP fee, to be phased out over time, as the groups earn more and are able to absorb the full service cost.

Support to two KP DICs will be sustained until the new GF grant begins and then they will be transitioned. PEPFAR will continue providing CoPT in Kribi and Bertoua. PEPFAR will provide technical assistance to GF principal recipients and national and local authorities to develop national systems and standards for service provision, QA and a supportive human rights environment to ensure quality services for KP including robust linkages into the care cascade.

Expected volumes for current on care and current on ART were derived using MOH data and account for (1) differential positivity rates for PITC entry points, (2) the recent adoption of the WHO guidelines for early initiation of ART (CD4 \leq 500 cells/mm³), (3) estimated rates for linkage to care, and (4) estimated LTFU.

Resources required to support PMTCT, treatment and care in sustained sites districts are projected at \$2.5 million using adjusted EA data. These activities were budgeted for prior to setting targets for scale-up in priority districts (Appendix B).

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Districts

Sustained Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	90,301	163,078	45%
HTC (only sustained ART sites in FY 16)	90,301	211,314	57%
Current on care (not yet initiated on ART)	N/A	10,866	(CARE CURR FY 15 district level targets unavailable for analysis)
Current on ART	N/A	72,427	FY 15 district level Tx_CURR targets unavailable
OVC	0	0	0%

5.2 Transition plans for redirecting PEPFAR support to priority locations and populations

Out of the 1,927 sites in the four PEPFAR supported regions, 45 were selected for scale up, 656 for sustenance and 1,247 for transition. PEPFAR/Cameroon is actively engaging in discussions with key stakeholders and other donors on transition plans. PEPFAR expects the GRC/GF to continue providing RTKs, ARVs and CTX for all sites and baseline and subsequent CD4 reagents; GRC will provide HCWs (Nurses/Doctors), and engage District Medical Officers in Data Quality

Assessments (DQA), mentoring and supervision visits; while ESTHER will support trainings and electronic individual client data in 13 major centers. None of the sites in scale-up districts having an ART center was transitioned as it was determined that these sites will significantly contribute to the pediatric HIV targets within Cameroon's ACT strategy. In addition, most see more than 118 adultson treatment.

In FY16, PEPFAR will begin transitioning part of the blood safety portfolio, notably, blood donor mobilization, blood collection and advocacy, to the GRC, while continuing to support the strengthening of M&E systems and the improvement of linkages between blood banks and HTC, prevention, care and treatment services. In FY16 and FY17, PEPFAR support will focus on four high volume blood banks which together account for over 60% of all transfusion activities in the country with over 7% HIV prevalence among blood donors. PEPFAR hopes to transition 11 other blood banks which currently receive some support from PEPFAR to GRC, as the MoH now has a line item budget for blood safety (although it is yet to be funded).

KP scale-up investments will occur in two scale-up health districts and 11 hot spots in the cities of Bamenda, Douala, and Yaoundé.

The OVC program will transition five health districts (Manoka, Cité Verte, Bonassama, New Bell and Santa) with activities mostly focused on strengthening family as primary caregiver, through household economic strengthening activities. PEPFAR Cameroon will implement money management interventions for saving financial and other assets, accessing prudent consumer credit, and fostering the knowledge and behaviors families need to better match their expenses. An estimated 52 OVC households will benefit from this package (about 260 children).

Resources required to support sustenance districts are projected at \$600,000 for KP and \$16,510 for OVC. These budgets are based on adjusted PBAC costing, on pre-existing sub-agreements with NGO working in these districts.

PCVs currently placed outside of scale-up and sustenance locations cannot be terminated abruptly and will continue to serve those communities until the end of service to ensure a smooth handover of activities to host institutions/counterparts. PEPFAR/Cameroon will leverage PCV placements in central support locations to support ACT activities.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

Since 2011, laboratory strengthening activities have always been designed to apply resources towards epidemic control. In FY 2014, PEPFAR/Cameroon support to GRC focused its efforts largely on Quality Management Systems (QMS), supporting 14 laboratories at the central and regional levels to engage in the WHO-AFRO stepwise SLIPTA process towards international accreditation, and currently has two laboratories at three stars of QI and one already in the final stages towards SANAS accreditation. Capacity building and central level coordination of QMS was supported through implementation of Quality Assurance (QA) and biosafety in 3,466 testing facilities in the NW and SW regions. PEPFAR also provided assistance through NACC to support the Directorate of Pharmacy, Medication and Laboratory (DPML) to coordinate activities of 615 laboratories enrolled in external QA system for HIV rapid testing. Cameroon was also the first country to implement the PEPFAR Rapid Test Quality Improvement Initiative (RT-QII) in 75 facilities using MOH Quality Corps (MQCs) and Volunteer Quality Corps (VQC) for panel distribution and on-site corrective action. In 2014, PEPFAR supported procurement and installation of the Abbott system and training of laboratory staff in two of the six reference labs (Bamenda and Mutengene) selected by the government for VL testing. In FY14, the GRC tested 14,733 PLHIV (10%) on treatment, giving a total of 18,122 viral load tests done following the national algorithm, which includes about 10% for controls and repeats for errors; this represents only 5% of the total VL need. In FY15, using the current six selected VL reference laboratories, the GRC plans to test 33,898 (20%) PLHIV on treatment. This will give a total of 42,197 viral load tests done using all six reference laboratories.

To align with the COP15 geographic focus to achieve epidemic control, and in line with the UNAIDS 90-90-90 goals, the PEPFAR Cameroon laboratory program will support the GRC to scale-up viral load testing in selected sites within two scale-up districts whilst GRC will continue providing support in the 56 sustained districts. With the limited resources available, a phased approach will be used starting with a selection of a few high volume scale-up sites which will include PMTCT only and also a combination of ART and PMTCT sites. Enhanced monitoring and evaluation will be implemented to document and track turn-around-time for getting results back to patients and the impact on patient management. Data obtained will be useful in planning

scale-up to more sites in subsequent years. Clinicians will also be trained on how to interpret and use results for patient management. In accordance with the country's viral load implementation plan and to maximize available resources, PEPFAR will support the use of DBS for viral load testing and will use the existing sample transport network for EID to transport DBS for viral load from sites to reference labs and results back to sites. Through this effort, PEPFAR will also support expansion of the hub and spoke system based on selected sites. In FY 2016 (i.e. COP 2015 funds), PEPFAR Cameroon will support viral load testing for 35% (4,322) of the 12,481 new on treatment that PEPFAR will support within the two scale-up districts, to add to the numbers currently targeted for testing in 2016 by the GRC. All training and EQA costs for VL testing have been included as part of the overall lab systems strengthening training package. Although VL testing presents a new challenge to the continuum of care, the GRC has adopted the WHO Technical and Operational Considerations for Implementing HIV VL Testing (2014) as guidelines for implementation and strengthening of logistics and network to improve access to VL testing.

In order to align with the COP15 geographic program focus, PEPFAR/Cameroon will refocus laboratory activities in two scale-up and 56 sustained districts to strengthen quality management systems in support of diagnosis, care and treatment services, strengthen infrastructure to improve coverage and ensure sustainable access to and continuous QI of HIV related diagnostic testing. To achieve this, PEPFAR/Cameroon will build on previous achievements to:

1. Ensure Continuous Quality Improvement (CQI) which will include scaling-up of proficiency testing for HIV rapid testing, CD4 and VL in high burden PMTCT and ART sites within the two scale-up districts and use the RT-QII program to enhance CQI at facilities in these districts. The country still depends on CD4 results to start treatment. To maintain the quality of services and patient results, CQI tools such as SLMTA and SLIPTA will be implemented in facilities. Workforce development will be strengthened through pre-and in-service training to sustain these efforts. SIMS will support laboratory program monitoring and evaluation for QI.
2. Strengthen Sample referral networks for specimens and results for quality HTC, PMTCT and ART coverage – HIV EID, CD4 testing for staging, VL for monitoring patients on treatment, proficiency testing panels for CQI in HIV rapid testing.
3. Strengthen laboratory systems to support care and treatment services, including support for laboratory policy and strategic plan finalization, national guidelines on equipment

maintenance and standardization, biosafety and QMS to minimize testing interruptions. To ensure sustainability, there will be targeted training of staff for re-certification of testers and testing sites within the two scale-up districts as well as establishment of a national board certification and continuous assessment for laboratory personnel.

4. Support facility improvement within scale-up districts, including operationalization of the NPHL and supporting minor renovations within scale-up facilities to improve the quality of service delivery.
5. Support HTC for adults within scale-up districts including 11 hotspots for key populations and support laboratory clinical monitoring including EID of HEI and VL testing for adults.
6. Support sample transport, site supervision, panel and results distribution for EQA participation (with follow-up corrective action by trained GRC staff) in all 56 sustained districts.

Regarding blood safety, and focusing on blood centers located in scale-up districts, PEPFAR/Cameroon will support QMS and SI through trainings on TTI testing, supervision and rollout of Blood Safety Information System (BSIS). Specific focus will also be put on linkage activities whereby donors that test HIV positive will actively be linked to HTC, C&T services.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Infrastructure											
Support CQI to lab facilities in scale-up districts	Support QA implementation and EQA for HIV testing, EID, CD4 and viral load	Support QA implementation and EQA for HIV testing, EID, CD4 and viral load	HLAB (250,622)	HLAB (250,000)	GHSS	7- Quality Management	X	X	X		x
Strengthen sample referral network	Transport DTS proficiency testing panels, DBS for EID and viral load and PT tubes for CD4 from facilities to reference labs and transport of results back to sites.	Transport DTS proficiency testing panels, DBS for EID and viral load and PT tubes for CD4 from facilities to reference labs and transport of results back to sites.	HLAB (50,640)	HLAB (50,000)	GHSS	4- Access and Demand 7- Quality Management	x	x	x		x
Support equipment standardization and maintenance	Work with MOH to establish maintenance contracts. Train biomedical engineers on equipment maintenance. Train staff on-site on equipment calibration. Work with MOH on standardizing equipment for EID, CD4 and viral testing	Work with MOH to establish maintenance contracts. Train biomedical engineers on equipment maintenance. Train staff on-site on equipment calibration. Work with MOH on standardizing equipment for EID, CD4 and viral testing	HLAB (40,000)	HLAB (50,000)	GHSS	7- Quality Management	x	x			x
HIV related Diagnostic testing											
Provide laboratory reagents for HIV testing	Provide reagents to support HIV screening in scale-up sites only	Provide reagents to support HIV screening in scale-up sites only	HLAB (500,000-applied pipeline)	HLAB (500,000)	SCMS	6- Commodity Security and Supply Chain	x	x	x		

Provide reagents to support CD4 testing	Provide reagents to support baseline testing only in scale-up districts	Provide reagents to support baseline testing only in scale-up districts	HLAB (500,000-applied pipeline)	HLAB (500,000)	SCMS	6- Commodity Security and Supply Chain		X	X			
Provide reagents to support viral load testing	Provide reagents to support viral load testing in scale-up districts	Provide reagents to support viral load testing in scale-up districts	HLAB (249,000-applied pipeline)	HLAB (500,000)	SCMS	6- Commodity Security and Supply Chain	x	x	x			x
1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control					
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression	
Training												
Training on QMS	Train laboratory staff in 45 facilities on QA, DTS use and LIS	Train laboratory staff in targeted facilities within scale-up districts on QA, DTS use and LIS	HLAB (100,000)	HLAB (150,000)	GHSS	5- Human Resources for Health 7- Quality Management	X	X	X	X		x
Training on SLMTA	Train lab staff in targeted facilities within the 2 scale-up districts on SLMTA	Roll-out SLMTA training to more scale-up districts	HLAB (100,000)	HLAB (150,000)	GHSS	5- Human Resources for Health 7- Quality Management	x	x	x	x		x
Training on biosafety and biosecurity	Train HCW in scale-up districts on biosafety and biosecurity	Roll-out biosafety training to more scale-up districts	HLAB (40,000)	HLAB (40,000)	GHSS	5- Human Resources for Health 7- Quality Management	x			x		x
Work to improve and enhance curriculum development, pre-service training and staff retention for laboratory staff	Implement revised curriculum in 12 selected training schools Support creation of database for all laboratory staff	Support capacity building in creating Regional Centers of excellence for laboratory professionals	HLAB (100,000)	HLAB (100,000)	ASLM	5- Human Resources for Health 7- Quality Management	X	X	X	X		X

Policy											
Support establishment and implementation of policies	Work with MOH to finalize and implement laboratory policy	Work with MOH to implement and monitor laboratory policy	HLAB (75,000)	HLAB (75,000)	MOH (NACC/DPML) WHO	7- Quality Management 15- Planning and Coordination	x				
Support establishment and implementation of national strategic plan for labs	Work with MOH to finalize and implement national strategic plan for labs	Work with MOH to implement and monitor national strategic plan for labs	HLAB (40,000)	HLAB (40,000)	MOH (NACC/DPML) WHO	7- Quality Management 15- Planning and Coordination	x				
Support establishment of national guidelines	Work with MOH to establish and implement guidelines for CQI, equipment standardization and biosafety	Work with MOH to establish and implement guidelines for CQI, equipment standardization and biosafety	HLAB (35,000)	HLAB (35,000)	MOH (NACC and DPML) WHO GHSS	7- Quality Management 15- Planning and Coordination	x				x

Blood Safety

In FY14, over 45,000 blood bags were collected and tested by the national network of Cameroon's blood banks and significant positivity rates of transfusion transmissible infections (TTIs) were found: 7% HIV, 14% HBV, 1.7% HCV and 2.6% syphilis. Blood collected from low risk voluntary donors increased from 7.3% in 2013 to 12% in 2014. National stakeholder engagement and GRC commitment to BS increased and resulted in the establishment of a Technical Working Group charged with the development of a National Blood Safety Strategic Plan with increased emphasis on screening blood donors. A national communication strategy to increase blood donation was adopted and is now being implemented. While BS COP15 funds will reduce by about 50% from last year, the limited funds will support the consolidation of the gains already made in the various technical areas, added attention will be given to QI/QA; strengthening the M&E system for linkage to C&T. To contribute to HIV care continuum, blood safety staff in collaboration with CHWs will actively link HIV positive donors to prevention, C&T services and help reduce the current high rate of lost to follow-up among donors who test HIV positive. In COP15 implementation, USG will begin transitioning part of the BS portfolio, notably the non-core activities such as blood donor mobilization, blood collection, advocacy, etc., to the GRC, while supporting the strengthening of the M&E systems and the improvement of linkages between blood banks and HTC, C&T services.

1. Brief Activity Description	Deliverables		Budget codes and allocation (\$)		6. Implementing Mechanism(s) ID	7. Relevant Sustainability Element and Score	Impact on epidemic control				
	2. 2015	3. 2016	4. 2015	5. 2016			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Blood Safety											
Training: support training of blood bank staff in various technical areas	Conduct trainings in TTI testing, quality assurance and quality improvement	Implement some quality improvement projects	HMBL (75,000)	HMBL (75,000)	Safe Blood for Africa Foundation (SBFA)	5- Human Resources for Health	X	X		X	
Implement linkage activities	Donors that test HIV positive are actively linked to HTC, C&T services	Continue to refine and streamline positive donor linkage to care	HMBL (45,000)	HMBL (45,000)	NACC	4- Access and Demand		X		X	
SI for blood bank support	Support rollout of the Blood Safety Information Systems (BSIS)	Continue support for rollout of BSIS	HMBL (25,000)	HMBL (25,000)	NACC	1- Epidemiological and Health Data 3- Performance Data	X				
Program management support activities	Supervision and coordination of the national network of blood banks	Supervision and coordination of the national network of blood banks	HMBL (55,000)	HMBL (55,000)	NACC	7- Quality Management 15- Planning and Coordination	X				

6.2 Strategic information (SI)

SI efforts in Cameroon are still underfunded and poorly coordinated, with unavailable timely, reliable information on program implementation and supply-chain management. The National M&E Plan was updated to support the revised NSP for HIV/AIDS. With support from PEPFAR, the NACC has standardized paper-based M&E tools for selected NSP indicators, but these tools are yet to be widely available, and not all end-users have been trained.

For FY 2016 PEPFAR Cameroon SI priorities working with MOH are:

- M&E:
 - o Improvement of data quality through training, supervision, and data quality assessments (DQAs). A DQA exercise focusing in PEPFAR supported scale-up districts will be conducted
 - o Enhancement of data use for planning, policy-making, and improved coordination of HIV/AIDS activities
- HIS
 - o Finalize development and implementation of standardized M&E registers and tools for PMTCT/ART including community level tools for retention as a step toward a national M&E system and in preparation for transitioning sites.
 - o Continue rolling out the DHIS with specific focus on the PEPFAR scale-up districts
- Surveillance and surveys
 - o Support two evaluation studies.

Building on the USG lead DQA exercise on PMTCT/ART and KP activities in 2014, DQA will continue to be a focus in COP15 actively involving MOH staff preparing them for transition. Financial and technical support will strengthen the M&E TWG in the collection and use of information.

District Health Information System (DHIS₂) software and hardware will continue to be implemented to support reporting for the national PMTCT, KP, and ART programs, with emphasis on scale-up districts to provide a model for the rest of the country.

Finally, with HQ funding and in order to assess HIV service coverage and impact, the USG will support an HIV Impact Assessment (HIA).

Activities	Impact on clinical cascade:					Sustainability Index Elements	Deliverables		Budget Codes	Associated IMs
	HIV testing	In Care	On ART	Re-tained	Adhering		2015	2016		
HIS										
Finalize development and implementation of standardized M&E registers and tools for PMTCT/ART	X	X	X	X	X	3- Performance Data	<ul style="list-style-type: none"> Developed tools available at sites End-user staff trained 	<ul style="list-style-type: none"> Developed tools available at sites 	HVSI	DFH, ICAP, CBCHB,
Continue rolling out the DHIS with specific focus on the PEPFAR scale-up districts	X	X	X			3- Performance Data	<ul style="list-style-type: none"> DHIS scaled up and operational 	<ul style="list-style-type: none"> DHIS scaled up and operational 	HVSI	NACC
Surveys & Surveillance										
Evaluation to determine the efficiency and impact of the current PMTCT program in averting HIV infections	X	X	X	X	X	1 – Epidemiological and health data	<ul style="list-style-type: none"> Impact evaluation conducted 		HVSI	CBCHB
To assess the impact of community	X	X	X	X	X	1 – Epidemiological and health data	<ul style="list-style-type: none"> HIV Impact Assessment conducted 		HVSI	CBCHB

interventions on the PMTCT cascade and pediatric ART outcomes										
IBBS for MSM, FSWs, and long distance truck drivers	X	X	X	X	X	Epidemiological and health data	Protocol approved	IBBS completed	HVSI	CHAMP
KP cohort monitoring (three-year study)	X	X	X	X	X	Epidemiological and health data	<ul style="list-style-type: none"> • Protocol approved 	Implementation ongoing	HVSI	CHAMP
Evaluation of the impact of all HIV /AIDS related activities among the CAF by reevaluating seroprevalence 5 years after the first.	X	X	X	X	X	1 – Epidemiological and health data	<ul style="list-style-type: none"> • Development of survey protocol and • Advocacy within the military high command 	<ul style="list-style-type: none"> • Protocol ready and available to start the survey Permission for survey implementation received	HVSI	GV

M&E										
• Data quality through training, supervision, DQAs	X	X	X	X	X	3- Performance data 7- Quality management	• DQA exercise conducted	• DQA exercise conducted	HVSI	ICAP, NACC
• Enhancement of data use for planning, policy-making, and improved coordination of HIV/AIDS activities		X	X	X	X	15- Planning and coordination	• System set up to enhance data use for planning, policy making and improved coordination	• System set up to enhance data use for planning, policy making and improved coordination	HVSI	NACC, ICAP

6.3 Health System Strengthening (HSS)

Based on health systems bottlenecks to delivery of HIV services, PEPFAR/Cameroon's core systems strengthening activities focus on: 1) Technical area specific guidelines, tools and policy including HRH; 2) General Policy and other governance; and 3) supply chain management.

Major systems strengthening-related limitations that most directly impact scale-up and quality of HIV services in Cameroon include: High vacancy rates of clinicians in high-volume sites that limit treatment scale-up; unstandardized CHW training and lack of systematic integration into delivery of HIV services that adversely impacts linkage and retention; lack of guideline and standardized tools availability at all levels including data quality; and general coordination of the national HIV/AIDS program.

Activities 1 and 2 above based on PEPFAR/Cameroon's budget ceiling are listed as core to COP15 while the third will be addressed within Cameroon's ACT strategy through advocacy. Addressing high vacancy rates, PEPFAR/Cameroon in FY13 supported the GRC with development of integrated MNCH training curricula including option B+ used across the country. PEPFAR/Cameroon is also supporting GRC's ongoing task shifting policy to enable nurses and midwives to prescribe and monitor ART. HRSA funds through ICAP are also being used to support Global Nursing Capacity Building (GNCN) to provide pre-service HIV/AIDS training. This training involves on-site clinical and on-campus didactic mentoring as well as curricula review and development trainings.

In COP15 focus will be on in-service training for Option B+ and care and treatment services in high priority districts. Training of trainer model will be used facilitate and rapidly expand the scope of trainings. Mentoring will also be crucial to ensure sustained quality. PEPFAR/Cameroon will also continue supporting the GRC in implementing its task shifting policy.

As highlighted previously, linking HIV-positives and retaining in care/ART/PMTCT services remains a persistent challenge. CHWs have played a pivotal role in PEPFAR/Cameroon's efforts to mitigate drop offs in the cascade. As a core activity, CHW will continue to be recruited, trained and regularly supervised to support linkages, adherence and retention of PLHIV.

In FY14 and FY15, PEPFAR supported the revision, standardization, printing and distribution of integrated MNCH and ART tools. In FY16 PEPFAR Cameroon will ensure availability of validated tools especially at scale-up districts. Funds will support improved overall coordination of national HIV/AIDS program and ART/PMTCT program and support data management and data quality through implementing DQA and DHIS2 and improving the national HIS.

To prepare for a national KP program in which GF recipients can also implement quality KP programs, an 18-month systems strengthening program will be carried out to develop and validate national tools, procedures and policies.

M&E tools will be reviewed and updated based on the development of a unique identifier code that will be used in both community-based and clinic-based activities that will allow an individual to be followed through the cascade of testing and care.

SOPs will be developed for all areas of KP work and curricula will be developed based on these SOPs, including modules targeting peer educators; mobile testing staff, DIC staff, community and clinical care-givers as well as police personnel and journalists. PEPFAR will support training of trainers to ensure a critical mass of well-trained staff nationwide.

Best practices relevant for gender-based violence interventions and innovative methods to increase testing yield will be introduced and tested on a pilot basis. Once proven effective and validated by the GRC, NGOs will be introduced in these practices to scale them up.

Activities	Impact on clinical cascade:				Sustainability Index Elements	Deliverables		Bud-get Codes	Associated IMs
	In Care	On ART	Retained	Adhering		2015	2016		
Guidelines, tools, HRH, governance									
In-service trainings for healthcare staff	x	x	x	x	5 – Human Resources for Health	<ul style="list-style-type: none"> 1000 healthcare staff trained 	<ul style="list-style-type: none"> 1000 healthcare staff trained 	OHSS	CBCHB, GHSS, ICAP, EGPAF, SBFA, GV
Task sharing in delivering ART/PMTCT services	x	x	x	x	5 – Human Resources for Health	<ul style="list-style-type: none"> Policy drafted 	<ul style="list-style-type: none"> Policy adopted by MOH 	OHSS	CBCHB, GHSS, ICAP, GV
Reinforce capacity of CHW systems	x		x	x	4- Access and Demand 5- Human Resources for health	<ul style="list-style-type: none"> 400 CHW trained 	<ul style="list-style-type: none"> 400 CHW trained 	OHSS	CBCHB, GHSS, ICAP, GV
National level coordination of the HIV program and specifically the ART/PMTCT programs	x	x			15 – Planning & Coordination	<ul style="list-style-type: none"> 6 Coordination meetings and supervision visits 	<ul style="list-style-type: none"> 6 Coordination meetings and supervision visits 	OHSS	NACC, DFH, EGPAF
Data management and quality through DQA and DHIS	x	x			1- Epidemiological and Health data	<ul style="list-style-type: none"> 200 DQA visits 64 districts with functioning DHIS 	<ul style="list-style-type: none"> 200 DQA visits 140 districts with functioning DHIS 	OHSS	ICAP
Supply Chain Management									
Support MOPH, regional warehouses, and health facilities to coordinate stakeholders for management of pharmaceutical information, quantification, procurement and distribution	X	X			6 – Commodity security and supply chain	<ul style="list-style-type: none"> Quantifications done through coordinated mechanisms; infrastructure upgrades to regional warehouses; implementation of optimized distribution system 	<ul style="list-style-type: none"> Quantifications done through coordinated mechanisms; infrastructure upgrades to regional warehouses; implementation of optimized distribution system 	MTCT; PDCS; HTXS; OHSS; HVCT	SIAPS
Work with civil society organization to improve supply chain oversight, including use of information, operational performance and resource mobilization	X	X			6 – Commodity security and supply chain	<ul style="list-style-type: none"> Partnership with association of PLHIV establish 	<ul style="list-style-type: none"> Association of PLHIV provided with technical assistance to monitor end-user access 	MTCT; PDCS; HTXS; HVCT	SIAPS
Support regional warehouses and health facilities to improve	X	X	X	X	6- Commodity security and supply chain	<ul style="list-style-type: none"> 70% of storage sites meet 80% of good storage practices 	<ul style="list-style-type: none"> 80% of storage sites meet 80% of good storage practices criteria 	MTCT; PDCS; HTXS; HVCT	SIAPS

warehouses and inventory management capacity						criteria			
						•	•		
Policies (tracked through Policy Tracking Table)									
						•	•		

7.0 Staffing Plan

The PEPFAR Cameroon team has conducted an initial assessment of 1) programmatic alignment of staff towards sustained epidemic control and 2) the ability to successfully implement the new PEPFAR business model. As a result, PEPFAR staff percent of time and number of FTEs were found to be aligned closely to the core activities. This includes an emphasis on staff support in technical areas that are wholly or primarily supported by PEPFAR such as PMTCT, clinical care and treatment, supply chain management, KP, OVC, community care, and HTC. At a more granular level each PEPFAR agency that is managing site level data has completed a skills assessment of current staff to determine current in-house abilities to conduct advanced data analysis and interpretation, and identified where gaps exist to better align with and implement the new PEPFAR business model. As a result, PEPFAR/Cameroon will need to create three new positions and repurpose four existing positions as described below:

New Staff Positions

1. Department of State Deputy PEPFAR Coordinator
2. USAID Strategic Information Advisor
3. Department of Defense Program Assistant

Repurposed Positions

1. HHS/CDC is repurposing a Laboratory Technician position to include SIMS Coordination
2. HHS/CDC is repurposing a Laboratory Technician position to Biosafety and Logistics Officer
3. HHS/CDC is repurposing a Blood Safety Specialist position to ADS/Science
4. USAID is repurposing a Logistics Officer position to Supply Chain Management Advisor

Regarding SIMS coordination listed above, the Laboratory Technician in addition to her duties as laboratory technician for PMTCT/ART activities, will also serve as SIMS Coordinator for CDC Cameroon. As such, her duties will be expanded to take on the full responsibilities of planning, tracking, conducting and reporting on SIMS activities and site visits, as well as coordinating across the USG agencies.

In terms of the estimated impact on the overall cost of doing business, a number of factors were taken into account, including global increases in ICASS rates and Capital Security Cost Sharing rates and the lifting of the LE staff pay freeze. The impact of the necessary additional staff and the

full implementation of SIMS were analyzed while recognizing that the PEPFAR prioritization of sites and geographic areas would reduce the total number of sites requiring visits by 21%. Given that PEPFAR has not yet conducted a full year of SIMS, specific CODB cost center increase estimates are based on 23% coverage of all implementation sites to be monitored with COP15 funds. An overall CODB increase of 9% is estimated, with the primary drivers being proposed new staff positions, ICASS, CSCS, LE staff pay, and program travel costs.

The PEPFAR Cameroon team has three vacancies that are in various stages of recruitment. Two of the three vacancies will be filled by individuals with program or monitoring/evaluation experience to ensure competency to analyze epidemiological data and assess implementation sites covering all SIMS domains.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 15

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	X	X	X
Sub-national level	X	X	X
National level	X		

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 15

	Core Activities	Near-core Activities	Non-core Activities
Adult Care and Treatment	<ul style="list-style-type: none"> Clinical and lab monitoring (CD4, viral load, WHO staging) Provision of comprehensive community-based services (psychosocial counseling, nutritional education, management of mental health disorders, etc.) for HIV-positive clients Adherence and retention of pre-ART and ART patients Procurement and distribution of HIV/AIDS-related commodities (ARV, cotrimoxazole, CD4 and viral load reagents, condoms, lubricant) Identification of HIV-positive clients and provision of ART in TB treatment and ANC settings TB screening and prevention 	<ul style="list-style-type: none"> Nutritional assessment and counseling 	<ul style="list-style-type: none"> General food distribution TB treatment
Pediatric Care and Treatment	<ul style="list-style-type: none"> Early identification of children for HIV treatment, including EID Focus on pediatric and adolescent HIV treatment initiation and retention Adherence and retention of pre-ART and ART patients Clinical and lab monitoring (CD4, viral load, WHO staging) Linkage to community-based support groups Ensure appropriate dispensation of cotrimoxazole for children TB screening and prevention 	<ul style="list-style-type: none"> Nutritional assessment and counseling 	<ul style="list-style-type: none"> TB treatment
Prevention	<ul style="list-style-type: none"> Scale up PMTCT Option B+ in MCH settings and linkage to ART treatment programs Targeted HIV prevention 	<ul style="list-style-type: none"> Procurement and distribution of HIV rapid test kits, lab reagents, condoms, 	<ul style="list-style-type: none"> PMTCT Option A Standalone mass media education and life skills

	<ul style="list-style-type: none"> interventions reaching key and priority populations, and linkage to ART treatment programs Support community-facility linkages and systems to ensure timely access to services in ARV treatment and adherence, care and support, and PMTCT 	<ul style="list-style-type: none"> and lubricant Integrated behavioral change communication Family planning and HIV/AIDS integration Implementation of sexual and gender-based violence security plan of action for key population service providers Research studies (IBBS for KP and long distance truck drivers, PMTCT effectiveness studies) 	
	<p>Core Activities</p> <ul style="list-style-type: none"> Direct service provision to target number of orphans and vulnerable children (OVC) and households Household economic strengthening Development of standard operating procedures and standardized approaches for OVC service provision and child protection Establish formal linkages and referrals for OVC in a continuum of care approach including particular attention to health services 	<p>Near-core Activities</p> <ul style="list-style-type: none"> Training and engaging social service professionals, para-professionals, civil society organizations, and volunteers involved in OVC programming Strengthening OVC management information system, including gap analysis and population size estimation 	<p>Non-core Activities</p>
OVC			
Lab	<ul style="list-style-type: none"> QA/QC and continuous QI (SLIPTA, SLMTA, PT, EQA, RT-Corps) Biosafety EID sample and result transportation system CD4 and viral load monitoring Linkage of HIV-positive identified blood donors to care, treatment and support 	<ul style="list-style-type: none"> Technical assistance to GRC on National Public Health Lab (NPHL) system Procurement and distribution of equipment and commodities Blood safety 	<ul style="list-style-type: none"> Renovation of NPHL
Health Systems Strengthening	<ul style="list-style-type: none"> Forecasting, supply planning and procurement to support and ensure uninterrupted availability of ARVs, rapid test kits, and other HIV-related commodities In-service training, mentorship and supportive supervision of biosafety infection control In-service training, mentorship and supportive 	<ul style="list-style-type: none"> Support CENAME and four regional warehouses to improve warehousing, storage, and inventory management capacity Support MOPH to improve supply management oversight capacity including coordination of 	<ul style="list-style-type: none"> Implementation of electronic dispensing tool at six high-volume health facilities Supporting NACC to organize quarterly logistics data review meetings at national and regional level

<p>supervision of Option B+ and care, treatment and support, including Community Health Workers</p> <ul style="list-style-type: none"> • Routine SIMS visits to ART and PMTCT program 	<p>technical and financial partners to improve supply chain management-related indicators</p> <ul style="list-style-type: none"> • Providing scale-up package of supply chain management interventions (e.g. infrastructure development, supportive supervision) to 159 health (49 full package; 110 basic) facilities in target health districts • PMTCT and HIV C&T guideline development and curriculum revision • HIV Impact Assessment and HIV drug resistance studies • District Health Information System (DHIS) • Routine data quality assessments to ART and PMTCT program
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Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 15	Estimated Funding in COP 16	# of IMs	Transition End date	Notes
PMTCT Option A	Programmatic	\$0	\$0	3	2015	All PMTCT option A activities for those sites out of PEPFAR scale-up but within sustenance districts, that the GRC has not yet rolled out to option B+.
Standalone mass media and lifeskills	Programmatic	\$0	\$0	1	April 2015	Activities will be incorporated
General food distribution(moving from general food distribution for economically vulnerable KP to provision of RUTF/RUSF to clinically	Programmatic	\$0	\$0	1	April 2015	USAID in discussion on feasibility of mobilizing non-PEPFAR funds to support RUSF/RUTF provision.

malnourished KP PLHIV)							
Renovation of the NPHL		\$0	\$0	1			The national EQA program for lab and EID testing once the NPHL becomes operational in 2016.
Supporting NACC to organize quarterly logistics data review meetings at national and regional level	Programmatic					September 2016	Exploring option of Global Fund financing to support this activity.
KP package of services in Kribi, Cite des Palmiers, Bertoua, Nylon, and Bonassama health districts (These will be sustained sites as KP program builds capacity of Global Fund service providers to take on management of these sites)	Geographic shift	\$92,444	\$0	1		FY 2017	
Geographic shifts of OVC activities in health districts of Manoka, Santa, Cite Verte, New Bell, and Bonassama	Geographic shift	\$16,510	0	1		November 2016	Continue implementation of community-based savings and group approach, Savings and Internal Lending (SILC).
Transition out full package of capacity and supervision at 60 HIV treatment units located in centrally supported sites	Geographic shift						Supervision activities in centrally supported districts will be absorbed by the Global Fund if budget approved. In these health facilities top priority activities will be strategically identified and addressed during COP 15 to ensure smooth transition.
Development of national-level standardized approaches to address inability to achieve 80% coverage of KP targets at national level	Programmatic	\$986,000	0	1		FY 2017	Key activities will include development of national processes, tools, and standardized approaches for KP implementation (including GBV mitigation activities)
Totals							

APPENDIX B REQUIRED

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$5,330,960	\$30,919,040	\$36,250,000

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$1,451,487
HVAB	Abstinence/Be Faithful Prevention	\$0
HVOP	Other Sexual Prevention	\$2,008,306
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$426,391
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$2,013,165
HBHC	Adult Care and Support	\$2,536,977
PDCS	Pediatric Care and Support	\$1,350,692
HKID	Orphans and Vulnerable Children	\$1,046,895
HTXS	Adult Treatment	\$12,714,459
HTXD	ARV Drugs	\$3,000,000
PDTX	Pediatric Treatment	\$799,288
HVTB	TB/HIV Care	\$521,782
HLAB	Lab	\$841,262
HVSI	Strategic Information	\$1,015,387
OHSS	Health Systems Strengthening	\$1,427,596
HVMS	Management and Operations	\$5,096,313
TOTAL		\$36,250,000

B.2 Resource Projections

PEPFAR unit expenditures (UE) from the most recent 2014 data and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HC, care and treatment, PMTCT, priority and KP prevention, and OVC. Adjustments to UEs were made to account for anticipated changes to the program in the coming implementation year due to changes to models/packages of service delivery and support.

HTC

- PITC: PEPFAR has supported PITC among pregnant women and supported voluntary counseling and testing in the community through some IPs. There are no estimates for EA from the 2014 EA for Cameroon. Taking costing data from the national program that is, overall program spending by people reached the UE is estimated at \$7.9 in 2010; \$6 in 2011 and \$3.5 in 2012 (NACC, UNAIDS 2012). Using this information and adjusting with data from IPs provided the expected UE for PITC in 2016. As PEPFAR will just be beginning PITC FY2016 it is anticipated that this unit cost will reduce in subsequent years.
- CBTC: PEPFAR has supported CBCT through the military and World AIDS Day activities; however, there is no historical UE for CBTC from the 2014 EA. The UE was estimated using data from IPs. To account for the variability among IPs, we divided the cost of previous activities by the number of patients tested to reach a unit cost of \$22.70; we used \$24 for costing purposes.

Care, Treatment, and Support

PEPFAR/Cameroon is just beginning support for care, treatment and support therefore no data is available in the 2014 EA for this expenditure category. UE was calculated using data from the national program and those provided by some IPs who have been implementing care and treatment programs with non-PEPFAR funds. For instance, in the national program using overall program spending per people reached, the UE was \$177 in 2012; and \$199 in 2012 (NACC, UNAIDS, 2012). An assumption made was that 50% of the estimated UE for pediatric and adult care treatment and support (both pre-ART and ART) will apply for those current on treatment. Another assumption was made for the provision of a lump sum per site for sustained sites. This was calculated based on information provided by IPs covering supervision visits and minimal mentoring, CHWs to ensure for follow-up, linkage and retention for those on treatment and bikers for health for sample, data and result transportation; in order to avoid elaborate and more costly trainings.

PMTCT

The UE cost for PMTCT was based on a pilot study and we expected cost to be higher. Also Option A cost was extremely high. We tried to find a balance between the two. In addition,

PEPFAR/Cameroon had not done EA for treatment and care as this is our first year, so we requested the cost data from partners who have been doing treatment and care to come up with the UEs for PMTCT option B+. Considering all treatment centers will have a PMTCT program, we divided some of the cost to leverage the two since activities are occurring at same site e.g. 1 CHW working in PMTCT can assist with retention, follow up and linkages for treatment and care at the same location. One site visit can be used to cover both PMTCT and treatment and care.

Lab

PEPFAR Cameroon laboratory support for adult care and treatment as well as Option B+ has been towards Continuous Quality Improvement including external quality assessment of HIV and CD4 testing and procurement of equipment to support testing services. In line with changes to the program focus in the coming implementation year, PEPFAR Cameroon laboratory support will start providing testing support hence, there are no estimates for EA from the PEPFAR Cameroon 2014 EA estimates. Using costing data from the national program, the Unit Expenditure per person tested for HIV is estimated at \$4-\$10 depending on facility and for CD4 is \$6 (NACC, 2015). Using this information and field data from our implementing partners, adjustments were made considering new testing guidelines and quality needs to determine the expected unit costs for adult care and treatment at \$10 and option B+ at \$16(including baseline CD4 test). These costs include reagents and supplies. Since this is a new laboratory support activity for PEPFAR Cameroon in 2016, these unit costs are expected to vary in subsequent years based on changes in testing guidelines and policies as well as types and cost of new testing devices adopted for use by the GRC.

KP: FSW

Unit expenditures for FSW programming ranged from \$83.86 in FY 2013 (the final year of a 5-year project) to \$123.13 in FY 2014 (the start-up year of a new 5-year project). Based on only two years of performing expenditure analyses in Cameroon, there is insufficient historical data that would allow the team to examine trends in spending, which can be used to project unit expenditures in COP FY 2015. Consequently, PEPFAR Cameroon has applied the FY 2014 unit expenditure of \$123.13. It is anticipated that the results of the FY 2015 Expenditure Analysis exercise, will allow the team to examine trends in spending and results over three-year period (2013 – 2015), therefore improving resource projections for future programming.

KP: MSM

Unit expenditures for MSM programming ranged from \$119.67 in FY 2013 to \$253.64 in FY 2014. Similarly, the first year is the final year and the second year the start-up year of the same projects as above. While there exists a huge variation between 2013 and 2014, not to mention the challenge in comparing interventions between dissimilar projects, PEPFAR is applying the FY 2014 unit expenditure of \$253.64. It is unclear at this time, whether the projected unit expenditure is on the high- or low-end of the MSM costing spectrum. The FY 2015 Expenditure Analysis exercise presents an opportunity for PEPFAR to examine trends in spending and results over a three-year period (2013 – 2015), therefore improving resource projections for future MSM programming.

OVC

FY 2014 unit expenditure is estimated at \$349.64 based on 579 beneficiaries reached. This estimate is significantly reduced compared to FY 2013's unit expenditure of \$8,130.59 based on 73 beneficiaries reached. Recognizing the need to keep costs low in order to serve more beneficiaries and sustain programming over the long term, PEPFAR performed a rapid cost realism analysis using the following approaches: a) requesting implementing partners (USAID-funded and Peace Corps) to project unit expenditures; b) literature review of OVC costing studies carried out in Sub-Saharan Africa; c) rapid expenditure analysis of the GF-financed OVC project in Cameroon. The costing analysis compared institutional versus family-based programming, including unit expenditures per service areas. Due to huge variations depending on package of services provided, and also in the absence of additional information on program effectiveness or quality, it was difficult to estimate appropriate unit expenditure for the Cameroon context. Consequently, the team initially used the projected unit expenditure of \$96.27 (based on implementing partner feedback) to cost the OVC program. FY 16 will be the first time PEPFAR provides direct services to a larger number of beneficiaries (6,583 OVC_SERV) – therefore the team believes FY 2015 EA may provide a more realistic estimate of OVC unit expenditures.

Table B.2.1 Adjustments to Unit Expenditures for Resource Projections

Program Area	Indicator	UE 2014	Adjustment for program/model pivots	Expected UE 2016
HTC	PITC	--	\$9.00	\$9.00
	VCT	--	--	--
	CBCTS	--	\$24.00	\$24.00
	Tested (not classified by modality)	\$11.57	--	--
FBCTS	Adult pre-ART patients- new	--	\$419.00	\$419.00
	Pediatric pre-ART patients- new	--	\$419.00	\$419.00
	Adult pre-ART patients- current	--	\$419.00	\$419.00
	Pediatric pre-ART patients- current	--	\$419.00	\$419.00
	Adult ART patients- new	--	\$419.00	\$419.00
	Adult ART patients- current	--	\$419.00	\$419.00
	Pediatric ART patients- new	--	\$419.00	\$419.00
	Pediatric ART patients- current	--	\$419.00	\$419.00
	Lumpsum per sustained site	--	\$2,255.00	\$2,255.00
	CBCTS	CBCTS beneficiaries	--	
PMTCT	Pregnant women tested	\$1.67	\$7.33	\$9.00
	Option B+	\$593.53	(\$174.53)	\$419.00
	Infants tested	\$60.17		\$60.17
	Infants receiving care	--	\$216.27	\$216.27
Priority Population Prevention	PP reached	\$1.94	\$2.89	\$4.83
Key Populations- Female Sex Workers	FSW reached	\$123.13		\$123.13
Key Populations- Men who have sex with men	MSM reached	\$253.64		\$253.64
Orphans and Vulnerable Children	OVC reached	\$349.64	(\$253.37)	\$96.27
Lab	Adult care and treatment	--	\$10.00	\$10.00
	Pediatric care and treatment	--	--	--
	Testing infants	--	--	--
	Option B+	--		\$16.00

Cameroon COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Abo	-	-	-	-	-
Abong Mbang	-	-	-	-	-
Ako	-	-	-	-	-
Akonolinga	1,813	120	696	120	605
Akwaya	-	-	-	-	-
Ambam	-	-	-	-	-
Awae	-	-	-	-	-
Ayos	1,010	70	458	70	398
Bafang	-	-	-	-	-
Bafia	6,256	341	1,372	334	1,392
Bafut	826	67	577	67	486
Baham	-	-	-	-	-
Bakassi	-	-	-	-	-
Bali	702	58	496	58	431
Bamenda	11,705	1,099	11,747	1,103	10,215
Bamendjou	-	-	-	-	-
Bandja	-	-	-	-	-
Bandjoun	-	-	-	-	-
Bangangte	-	-	-	-	-
Bangem	248	20	151	20	131
Bangourain	-	-	-	-	-
Bankim	-	-	-	-	-
Banyo	-	-	-	-	-
Batcham	-	-	-	-	-
Batibo	2,046	146	1,024	146	890
Batouri	-	-	-	-	-
Benakuma	-	-	-	-	-
Bertoua	333	-	-	-	-
Betare Oya	-	-	-	-	-
Bibemi	-	-	-	-	-
Biyem Assi	22,654	1,375	6,675	1,375	5,803
Bogo	-	-	-	-	-
Boko	-	-	-	-	-
Bonassama	7,711	615	5,513	615	4,794
Bourha	-	-	-	-	-
Buea	4,545	312	1,988	312	1,729
Cite Des Palmiers	9,339	600	3,567	600	3,102
Cite Verte	23,703	1,788	14,100	1,788	12,262
Deido	24,028	5,704	11,240	4,456	9,578
Dibombari	-	-	-	-	-
Djohong	-	-	-	-	-
Djoum	-	-	-	-	-
Djoungolo	76,471	7,956	17,429	6,763	14,815
Doume	-	-	-	-	-
Dschang	-	-	-	-	-
Ebebda	775	44	139	44	121
Ebolowa	-	-	-	-	-
Edea	4,907	316	1,716	316	1,492
Efoulan	14,140	745	3,221	745	2,798
Ekondo Titi	1,410	97	599	97	512
Elig Mfomo	-	-	-	-	-
Eseka	1,765	101	353	101	307
Esse	-	-	-	-	-
Evodoula	-	-	-	-	-
Eyumodjock	-	-	-	-	-
Figuil	-	-	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Centre - FRPS-Centre	-	-	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Littoral	-	-	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Sud Ouest	-	-	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Nord Ouest - FRPS-Nord Ouest	-	-	-	-	-
Fontem	800	58	408	58	355
Foumban	-	-	-	-	-
Foumbot	-	-	-	-	-
Fundong	4,134	339	2,976	339	2,588
Galim	-	-	-	-	-
Garoua 1	-	-	-	-	-
GAROUA 2	-	-	-	-	-
Garoua Boulai	-	-	-	-	-

Cameroon COP15 Targets by District: Clinical Cascade

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Gaschiga	-	-	-	-	-
Gazawa	-	-	-	-	-
Golombe	-	-	-	-	-
Goulfey	-	-	-	-	-
Guere	-	-	-	-	-
Guider	-	-	-	-	-
Guidiguis	-	-	-	-	-
Hina	-	-	-	-	-
Japoma	-	-	-	-	-
Kaele	-	-	-	-	-
Kar Hay	-	-	-	-	-
Kekem	-	-	-	-	-
Kette	-	-	-	-	-
Kolofata	-	-	-	-	-
Konye	-	-	-	-	-
Kouoptamo	-	-	-	-	-
Kousseri	-	-	-	-	-
Koza	-	-	-	-	-
Kribi	356	-	-	-	-
Kumba	8,594	656	5,132	656	4,463
Kumbo East	2,979	237	1,978	237	1,720
Kumbo West	1,181	179	2,563	179	2,229
Lagdo	-	-	-	-	-
Limbe	4,286	403	4,148	403	3,607
Logbaba	8,463	445	854	445	743
Lolodorf	-	-	-	-	-
Lomie	-	-	-	-	-
Loum	-	-	-	-	-
Mada	-	-	-	-	-
Maga	-	-	-	-	-
Makary	-	-	-	-	-
Malentouen	-	-	-	-	-
Mamfe	2,130	184	1,733	184	1,507
Manjo	-	-	-	-	-
Manoka	-	-	-	-	-
Maroua 1	-	-	-	-	-
Maroua 2	-	-	-	-	-
Maroua 3	-	-	-	-	-
Massangam	-	-	-	-	-
Mayo Oulo	-	-	-	-	-
Mbalmayo	4,565	294	1,566	294	1,361
Mbandjock	1,372	79	285	79	248
Mbang	-	-	-	-	-
Mbanga	-	-	-	-	-
Mbangué	4,374	544	6,700	544	5,826
Mbankomo	-	-	-	-	-
Mbengwi	647	57	668	62	581
Mbonge	-	-	-	-	-
Mbouda	-	-	-	-	-
Meiganga	-	-	-	-	-
Melong	-	-	-	-	-
Meri	-	-	-	-	-
Messamena	-	-	-	-	-
Meyomessala	-	-	-	-	-
Mfou	2,718	173	895	173	778
Mifi	-	-	-	-	-
Mindif	-	-	-	-	-
Mogode	-	-	-	-	-
Mokolo	-	-	-	-	-
Moloundou	-	-	-	-	-
Monatele	1,910	106	311	106	270
Mora	-	-	-	-	-
Moulvoudaye	-	-	-	-	-
Moutourwa	-	-	-	-	-
Mundemba	-	-	-	-	-
Muyuka	2,680	169	860	169	748
Mvangan	-	-	-	-	-
Nanga Eboko	1,910	110	409	110	356
Ndelele	-	-	-	-	-
Ndikinimeki	659	45	271	45	236

Cameroon COP15 Targets by District: Clinical Cascade

	Number of individuals who received HIV Testing and Counseling services for HIV and received their test results	Number of HIV-positive adults and children newly enrolled in clinical care who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of HIV positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load	Number of adults and children newly enrolled on antiretroviral therapy (ART)	Number of adults and children currently receiving antiretroviral therapy (ART)
Ndom	-	-	-	-	-
Ndop	5,775	401	2,638	401	2,387
Ndu	2,132	162	1,170	158	1,021
New Bell	10,130	535	1,841	535	1,536
Ngambe	-	-	-	-	-
Ngaoundal	-	-	-	-	-
Ngaoundere Rural	-	-	-	-	-
Ngaoundere Urbain	-	-	-	-	-
Ngog Mapubi	1,141	63	170	63	148
Ngong	-	-	-	-	-
Ngoumou	1,136	89	714	89	621
Nguelemendouka	-	-	-	-	-
Nguti	-	-	-	-	-
Njikwa	-	-	-	-	-
Njombe Penja	1,813	153	388	153	1,207
Nkambe	3,284	221	1,355	221	1,178
Nkolbisson	-	-	-	-	-
Nkolndongo	26,606	1,385	2,676	1,385	2,334
Nkondjock	-	-	-	-	-
Nkongsamba	3,129	432	5,926	432	5,153
Ntui	3,455	165	299	167	253
Nwa	-	-	-	-	-
Nylon	13,611	688	1,098	688	955
Obala	6,027	363	1,570	363	1,366
Okola	2,872	145	177	145	154
Oku	-	-	-	-	-
Olamze	-	-	-	-	-
Penka Michel	-	-	-	-	-
Pette	-	-	-	-	-
Pitua	-	-	-	-	-
Poli	-	-	-	-	-
Pouma	316	18	62	18	54
Rey Bouba	-	-	-	-	-
Roua	-	-	-	-	-
Saa	2,689	154	544	154	473
Sangmelima	-	-	-	-	-
Santa	-	-	-	-	-
Santchou	-	-	-	-	-
Soa	2,477	131	260	131	226
Tchollire	-	-	-	-	-
Tibati	-	-	-	-	-
Tignere	-	-	-	-	-
Tiko	4,618	467	5,154	467	4,482
Tokombere	-	-	-	-	-
Tombel	749	62	542	62	471
Touboro	-	-	-	-	-
Tubah	-	-	-	-	-
Vele	-	-	-	-	-
Wabane	-	-	-	-	-
Wum	2,886	181	904	181	786
Yabassi	421	46	557	46	484
Yagoua	-	-	-	-	-
Yokadouma	-	-	-	-	-
Yoko	-	-	-	-	-
Zoetele	-	-	-	-	-
Other_ Cameroon	12,945	453	2,203	504	3,000
Total	378,357	31,966	145,066	29,576	127,766

**Cameroon COP15 Targets by District: Key, Priority,
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Abo	-	-	-
Abong Mbang	-	-	-
Ako	-	-	-
Akonolinga	-	-	-
Akwaya	-	-	-
Ambam	-	-	-
Awae	-	-	-
Ayos	-	-	-
Bafang	-	-	-
Bafia	-	-	-
Bafut	-	-	-
Baham	-	-	-
Bakassi	-	-	-
Bali	-	-	-
Bamenda	4,454	759	491
Bamendjou	-	-	-
Bandja	-	-	-
Bandjoun	-	-	-
Bangangte	-	-	-
Bangem	-	-	-
Bangourain	-	-	-
Bankim	-	-	-
Banyo	-	-	-
Batcham	-	-	-
Batibo	-	-	-
Batouri	-	-	-
Benakuma	-	-	-
Bertoua	338	759	-
Betare Oya	-	-	-
Bibemi	-	-	-
Biyem Assi	338	759	-
Bogo	-	-	-
Boko	-	-	-
Bonassama	338	759	-
Bourha	-	-	-
Buea	1,372	-	26
Cite Des Palmiers	338	759	-
Cite Verte	338	759	-
Deido	887	3,093	1,575
Dibombari	-	-	-
Djohong	-	-	-
Djoum	-	-	-
Djoungolo	1,024	3,573	2,461
Doume	-	-	-
Dschang	-	-	-
Ebebda	-	-	-
Ebolowa	-	-	-
Edea	-	-	-
Efoulan	338	759	-
Ekondo Titi	-	-	-
Elig Mfomo	-	-	-
Eseka	-	-	-
Esse	-	-	-
Evodoula	-	-	-
Eyumodjock	-	-	-
Figuil	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Centre - FRPS-Centre	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Littoral	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Sud Ouest	-	-	-
Fonds Régionaux pour la Promotion de la Santé du Nord Ouest - FRPS-Nord Ouest	-	-	-
Fontem	-	-	-
Foumban	-	-	-
Foumbot	-	-	-
Fundong	1,372	-	26
Galim	-	-	-
Garoua 1	-	-	-
GAROUA 2	-	-	-
Garoua Boulai	-	-	-

**Cameroon COP15 Targets by District: Key, Priority,
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Gaschiga	-	-	-
Gazawa	-	-	-
Golombe	-	-	-
Gouffey	-	-	-
Guere	-	-	-
Guider	-	-	-
Guidiguis	-	-	-
Hina	-	-	-
Japoma	-	-	-
Kaele	-	-	-
Kar Hay	-	-	-
Kekem	-	-	-
Kette	-	-	-
Kolofata	-	-	-
Konye	-	-	-
Kouoptamo	-	-	-
Kousseri	-	-	-
Koza	-	-	-
Kribi	338	759	-
Kumba	4,116	-	78
Kumbo East	1,372	-	26
Kumbo West	-	-	-
Lagdo	-	-	-
Limbe	-	-	-
Logbaba	-	-	-
Lolodorf	-	-	-
Lomie	-	-	-
Loum	-	-	-
Mada	-	-	-
Maga	-	-	-
Makary	-	-	-
Malentouen	-	-	-
Mamfe	2,746	-	52
Manjo	-	-	-
Manoka	-	-	-
Maroua 1	-	-	-
Maroua 2	-	-	-
Maroua 3	-	-	-
Massangam	-	-	-
Mayo Oulo	-	-	-
Mbalmayo	-	-	-
Mbandjock	-	-	-
Mbang	-	-	-
Mbanga	-	-	-
Mbangue	-	-	-
Mbankomo	-	-	-
Mbengwi	4,116	-	78
Mbonge	-	-	-
Mbouda	-	-	-
Meiganga	-	-	-
Melong	-	-	-
Meri	-	-	-
Messamena	-	-	-
Meyomessala	-	-	-
Mfou	-	-	-
Mifi	-	-	-
Mindif	-	-	-
Mogode	-	-	-
Mokolo	-	-	-
Moloundou	-	-	-
Monatele	-	-	-
Mora	-	-	-
Moulvoudaye	-	-	-
Moutourwa	-	-	-
Mundemba	-	-	-
Muyuka	-	-	-
Mvangan	-	-	-
Nanga Eboko	-	-	-
Ndelele	-	-	-
Ndikinimeki	1,372	-	26

**Cameroon COP15 Targets by District: Key, Priority,
Orphan and Vulnerable Children Indicators**

	Number of the target population who completed a standardized HIV prevention intervention including the minimum components	Number of key populations reached with individual and/or small group level HIV preventive interventions that are based on evidence and/or meet the minimum standards required	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS
Ndom	-	-	-
Ndop	-	-	-
Ndu	-	-	-
New Bell	338	759	-
Ngambe	-	-	-
Ngaoundal	-	-	-
Ngaoundere Rural	-	-	-
Ngaoundere Urbain	-	-	-
Ngog Mapubi	-	-	-
Ngong	-	-	-
Ngoumou	-	-	-
Nguelemendouka	-	-	-
Nguti	1,372	-	26
Njikwa	-	-	-
Njombe Penja	-	-	-
Nkambe	4,116	-	78
Nkolbisson	-	-	-
Nkolindongo	338	813	2,134
Nkondjock	-	-	-
Nkongsamba	1,372	-	26
Ntui	-	-	-
Nwa	-	-	-
Nylon	338	759	-
Obala	1,372	-	26
Okola	-	-	-
Oku	-	-	-
Olamze	-	-	-
Penka Michel	-	-	-
Pette	-	-	-
Pitca	-	-	-
Poli	-	-	-
Pouma	-	-	-
Rey Boubou	-	-	-
Roua	-	-	-
Saa	-	-	-
Sangmelima	-	-	-
Santa	-	-	-
Santchou	-	-	-
Soa	-	-	-
Tchollire	-	-	-
Tibati	-	-	-
Tignere	-	-	-
Tiko	-	-	-
Tokombere	-	-	-
Tombel	4,116	-	78
Touboro	-	-	-
Tubah	-	-	-
Vele	-	-	-
Wabane	-	-	-
Wum	1,372	-	26
Yabassi	-	-	-
Yagoua	-	-	-
Yokadouma	-	-	-
Yoko	-	-	-
Zoetele	-	-	-
Other_ Cameroon	3,000	-	-
Total	42,931	15,069	7,233

**Cameroon COP15 Targets by District:
Breastfeeding and Pregnant Women**

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Abo	-	-
Abong Mbang	-	-
Ako	-	-
Akonolinga	1,583	79
Akwaya	-	-
Ambam	-	-
Awae	-	-
Ayos	882	44
Bafang	-	-
Bafia	5,022	253
Bafut	721	36
Baham	-	-
Bakassi	-	-
Bali	613	31
Bamenda	9,928	496
Bamendjou	-	-
Bandja	-	-
Bandjoun	-	-
Bangangte	-	-
Bangem	216	11
Bangourain	-	-
Bankim	-	-
Banyo	-	-
Batcham	-	-
Batibo	1,786	88
Batouri	-	-
Benakuma	-	-
Bertoua	-	-
Betare Oya	-	-
Bibemi	-	-
Biyem Assi	19,490	981
Bogo	-	-
Boko	-	-
Bonassama	6,441	332
Bourha	-	-
Buea	3,968	198
Cite Des Palmiers	7,864	391
Cite Verte	20,403	1,018
Deido	24,306	2,892
Dibombari	-	-
Djohong	-	-
Djoum	-	-
Djoungolo	25,697	2,990
Doume	-	-
Dschang	-	-
Ebebda	676	34
Ebolowa	-	-
Edea	4,282	214
Efoulan	12,045	608
Ekondo Titi	1,231	62
Elig Mfomo	-	-
Eseka	1,541	77
Esse	-	-
Evodoula	-	-
Eyumodjock	-	-
Figuil	-	-
Fonds Régionaux pour la Promotion de la Santé du Centre - FRPS-Centre	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Littoral	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Sud Ouest	-	-
Fonds Régionaux pour la Promotion de la Santé du Nord Ouest - FRPS-Nord Ouest	-	-
Fontem	698	35
Foumban	-	-
Foumbot	-	-
Fundong	3,609	180
Galim	-	-
Garoua 1	-	-
GAROUA 2	-	-

**Cameroon COP15 Targets by District:
Breastfeeding and Pregnant Women**

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Garoua Boulai	-	-
Gaschiga	-	-
Gazawa	-	-
Golombe	-	-
Gouffey	-	-
Guere	-	-
Guider	-	-
Guidiguis	-	-
Hina	-	-
Japoma	-	-
Kaele	-	-
Kar Hay	-	-
Kekem	-	-
Kette	-	-
Kolofata	-	-
Konye	-	-
Kouoptamo	-	-
Kousseri	-	-
Koza	-	-
Kribi	-	-
Kumba	7,503	375
Kumbo East	2,601	130
Kumbo West	1,031	52
Lagdo	-	-
Limbe	3,742	187
Logbaba	7,384	369
Lolodorf	-	-
Lomie	-	-
Loum	-	-
Mada	-	-
Maga	-	-
Makary	-	-
Malentouen	-	-
Mamfe	1,859	93
Manjo	-	-
Manoka	-	-
Maroua 1	-	-
Maroua 2	-	-
Maroua 3	-	-
Massangam	-	-
Mayo Oulo	-	-
Mbalmayo	3,983	199
Mbandjock	1,197	60
Mbang	-	-
Mbanga	-	-
Mbangué	3,817	192
Mbankomo	-	-
Mbengwi	565	28
Mbonge	-	-
Mbouda	-	-
Meiganga	-	-
Melong	-	-
Meri	-	-
Messamena	-	-
Meyomessala	-	-
Mfou	2,373	119
Mifi	-	-
Mindif	-	-
Mogode	-	-
Mokolo	-	-
Moloundou	-	-
Monatele	1,667	83
Mora	-	-
Mouivoudaye	-	-
Moutourwa	-	-
Mundemba	-	-
Muyuka	2,340	117
Mvangan	-	-
Nanga Eboko	1,667	83
Ndelele	-	-

**Cameroon COP15 Targets by District:
Breastfeeding and Pregnant Women**

	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	Number of HIV-positive pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission during pregnancy and delivery
Ndikinimeki	575	29
Ndom	-	-
Ndop	5,042	252
Ndu	1,861	93
New Bell	8,169	408
Ngambe	-	-
Ngaoundal	-	-
Ngaoundere Rural	-	-
Ngaoundere Urbain	-	-
Ngog Mapubi	995	50
Ngong	-	-
Ngoumou	991	50
Nguemendouka	-	-
Nguti	-	-
Njikwa	-	-
Njombe Penja	1,583	79
Nkambe	2,867	143
Nkolbisson	-	-
Nkolondongo	22,893	1,468
Nkondjock	-	-
Nkongsamba	2,730	137
Ntui	3,016	151
Nwa	-	-
Nylon	11,590	580
Obala	5,261	263
Okola	2,507	125
Oku	-	-
Olamze	-	-
Penka Michel	-	-
Pette	-	-
Pitua	-	-
Poli	-	-
Pouma	275	14
Rey Bouba	-	-
Roua	-	-
Saa	2,348	117
Sangmelima	-	-
Santa	-	-
Santchou	-	-
Soa	2,163	108
Tchollire	-	-
Tibati	-	-
Tignere	-	-
Tiko	4,031	202
Tokombere	-	-
Tombel	654	33
Touboro	-	-
Tubah	-	-
Vele	-	-
Wabane	-	-
Wum	2,520	126
Yabassi	368	18
Yagoua	-	-
Yokadouma	-	-
Yoko	-	-
Zoetele	-	-
Other_ Cameroon	3,000	168
Total	280,170	17,751

**Cameroon COP15 Targets by District:
Tuberculosis (TB)**

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Abo	-	-
Abong Mbang	-	-
Ako	-	-
Akonolinga	51	20
Akwaya	-	-
Ambam	-	-
Awae	-	-
Ayos	43	34
Bafang	-	-
Bafia	159	49
Bafut	39	16
Baham	-	-
Bakassi	-	-
Bali	47	36
Bamenda	-	-
Bamendjou	-	-
Bandja	-	-
Bandjoun	-	-
Bangangte	-	-
Bangem	-	-
Bangourain	-	-
Bankim	-	-
Banyo	-	-
Batcham	-	-
Batibo	66	39
Batouri	-	-
Benakuma	-	-
Bertoua	-	-
Betare Oya	-	-
Bibemi	-	-
Biyem Assi	-	-
Bogo	-	-
Boko	-	-
Bonassama	353	195
Bourha	-	-
Buea	-	-
Cite Des Palmiers	479	206
Cite Verte	411	237
Deido	1,000	-
Dibombari	-	-
Djohong	-	-
Djoum	-	-
Djoungolo	2,158	-
Doume	-	-
Dschang	-	-
Ebedda	-	-
Ebolowa	-	-
Edea	228	119
Efoulan	431	231
Ekondo Titi	31	16
Elig Mfomo	-	-
Eseka	60	30
Esse	-	-
Evodoula	-	-
Eyumodjock	-	-
Figuil	-	-
Fonds Régionaux pour la Promotion de la Santé du Centre - FRPS-Centre	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Littoral	-	-
Fonds Régionaux pour la Promotion de la Santé du Littoral FRPS-Sud Ouest	-	-
Fonds Régionaux pour la Promotion de la Santé du Nord Ouest - FRPS-Nord Ouest	-	-
Fontem	30	20
Foumban	-	-
Foumbot	-	-
Fundong	253	162
Galim	-	-
Garoua 1	-	-
GAROUA 2	-	-
Garoua Boulai	-	-

**Cameroon COP15 Targets by District:
Tuberculosis (TB)**

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Gaschiga	-	-
Gazawa	-	-
Golombe	-	-
Gouffey	-	-
Guere	-	-
Guider	-	-
Guidiguis	-	-
Hina	-	-
Japoma	-	-
Kaele	-	-
Kar Hay	-	-
Kekem	-	-
Kette	-	-
Kolofata	-	-
Konye	-	-
Kouoptamo	-	-
Kousseri	-	-
Koza	-	-
Kribi	-	-
Kumba	-	-
Kumbo East	134	110
Kumbo West	158	117
Lagdo	-	-
Limbe	213	137
Logbaba	14	6
Lolodorf	-	-
Lomie	-	-
Loum	-	-
Mada	-	-
Maga	-	-
Makary	-	-
Malentouen	-	-
Mamfe	36	7
Manjo	-	-
Manoka	-	-
Maroua 1	-	-
Maroua 2	-	-
Maroua 3	-	-
Massangam	-	-
Mayo Oulo	-	-
Mbalmayo	137	-
Mbandjock	89	44
Mbang	-	-
Mbanga	-	-
Mbangué	-	-
Mbankomo	-	-
Mbengwi	28	18
Mbonge	-	-
Mbouda	-	-
Meiganga	-	-
Melong	-	-
Meri	-	-
Messamena	-	-
Meyomessala	-	-
Mfou	82	53
Mifi	-	-
Mindif	-	-
Mogode	-	-
Mokolo	-	-
Moloundou	-	-
Monatele	48	9
Mora	-	-
Moulvoudaye	-	-
Moutourwa	-	-
Mundemba	-	-
Muyuka	80	31
Mvangan	-	-
Nanga Eboko	56	39
Ndelele	-	-
Ndikinimeki	22	14

**Cameroon COP15 Targets by District:
Tuberculosis (TB)**

	Number of registered new and relapsed TB cases with documented HIV status	The number of registered TB cases with documented HIV-positive status who start or continue ART
Ndom	-	-
Ndop	48	22
Ndu	37	30
New Bell	3	-
Ngambe	-	-
Ngaoundal	-	-
Ngaoundere Rural	-	-
Ngaoundere Urbain	-	-
Ngog Mapubi	42	17
Ngong	-	-
Ngoumou	72	46
Nguelemendouka	-	-
Nguti	-	-
Njikwa	-	-
Njombe Penja	111	64
Nkambe	80	60
Nkolbisson	-	-
Nkolndongo	-	-
Nkondjock	-	-
Nkongsamba	-	-
Ntui	18	11
Nwa	-	-
Nylon	4	-
Obala	145	72
Okola	122	22
Oku	-	-
Olamze	-	-
Penka Michel	-	-
Pette	-	-
Pitua	-	-
Poli	-	-
Pouma	51	17
Rey Boubou	-	-
Roua	-	-
Saa	45	12
Sangmelima	-	-
Santa	-	-
Santchou	-	-
Soa	27	13
Tchollire	-	-
Tibati	-	-
Tignere	-	-
Tiko	273	136
Tokombere	-	-
Tombel	26	14
Touboro	-	-
Tubah	-	-
Vele	-	-
Wabane	-	-
Wum	75	50
Yabassi	9	4
Yagoua	-	-
Yokadouma	-	-
Yoko	-	-
Zoetele	-	-
Other_ Cameroon	340	107
Total	8,464	2,692



HIV/AIDS Sustainability Index and Dashboard

To assist PEPFAR and government partners in better understanding each country's sustainability landscape and making informed investment decisions, PEPFAR teams and stakeholders completed the inaugural **Sustainability Index and Dashboard (SID)** during COP 2015. This new tool assesses the current state of sustainability of national HIV/AIDS responses across 15 critical elements, scores for which are displayed on a color-coded dashboard. As the SID is completed over time, it will allow stakeholders to track progress across these components of sustainability. On the pages that follow, you will find the 2015 country dashboard as well as the questionnaire responses that determined the scores. The legend for the colors depicted on the dashboard is below.

Dark Green Score (17-20 pts) (sustainable and requires no additional investment at this time)
Light Green Score (13-16.9 pts) (approaching sustainability and requires little or no investment)
Yellow Score (7-12.9 pts) (emerging sustainability and needs some investment)
Red Score (0-6.9 pts) (unsustainable and requires significant investment)

Sustainability Analysis for Epidemic Control: CAMEROON

Epidemic Type: Generalized
Income Level: Low Middle
PEPFAR Categorization: Long Term Strategy
COP 15 Planning Level:

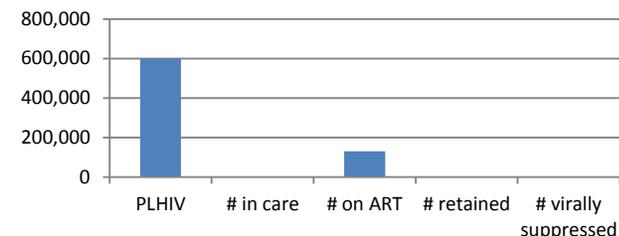


SUSTAINABILITY DOMAINS AND ELEMENTS

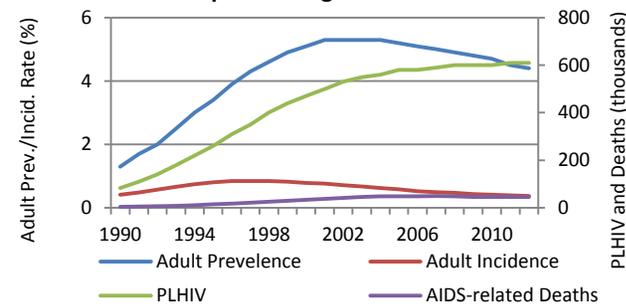
Institutionalized Data Availability		Score
1. Epidemiological and Health Data	Yellow	7.7
2. Financial/Expenditure Data	Light Green	14.0
3. Performance Data	Light Green	16.0
Domestic Program and Service Delivery		
4. Access and Demand	Yellow	10.2
5. Human Resources for Health	Yellow	11.2
6. Commodity Security and Supply Chain	Yellow	7.1
7. Quality Management	Red	4.0
Health Financing and Strategic Investments		
8. DRM: Resource Generation	Light Green	14.0
9. DRM: Resource Commitments	Red	6.0
10. Allocative Efficiency	Red	4.0
11. Technical Efficiency	Yellow	9.5
Accountability and Transparency		
12. Public Access to Information	Red	5.0
13. Oversight and Stewardship	Yellow	9.0
Enabling Environment		
14. Policies, Laws, and Regulations	Light Green	13.0
15. Planning and Coordination	Light Green	14.0

CONTEXTUAL DATA

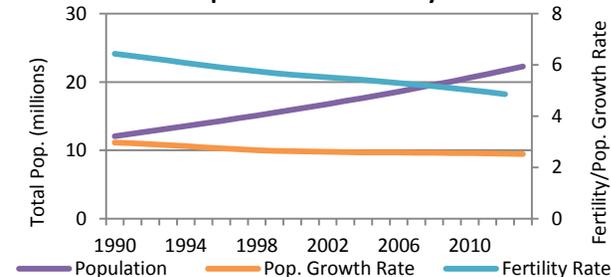
Care and Treatment Cascade



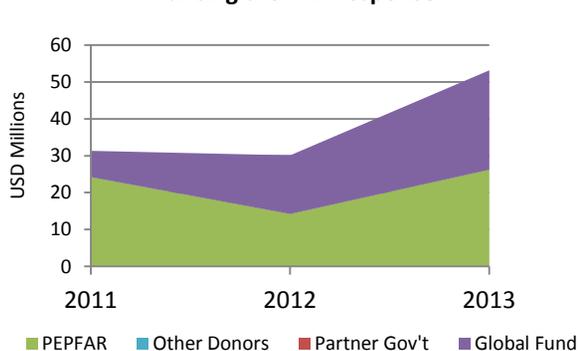
Epidemiological Data



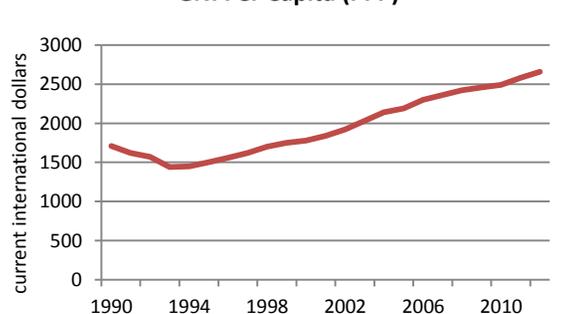
Population and Fertility



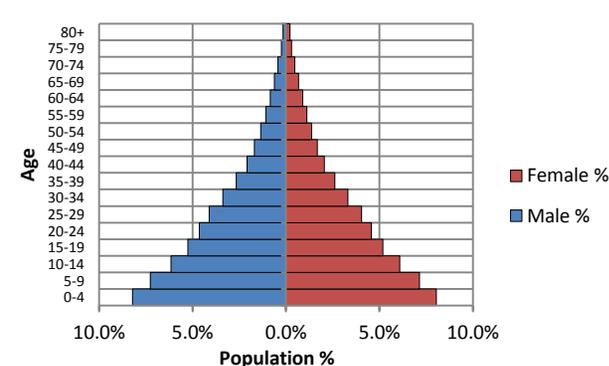
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



CONTEXTUAL DATA

Domain A: Institutionalized Data Availability

What Success Looks Like: Using local and national systems, the Host Country Government collects and makes available timely, comprehensive, and quality HIV/AIDS data (including epidemiological, economic/financial, and performance data) that can be used to inform policy, program and funding decisions.

1. Epidemiological and Health data: Host Country Government routinely collects, analyzes and makes available data on the HIV/AIDS epidemic and its effects on health outcomes. HIV/AIDS epidemiological and health data include size estimates of key populations, PLHIV and OVC, HIV incidence, HIV prevalence, viral load, AIDS-related mortality rates, and co-infection rates.

			Source of data	Notes/Comments
<p>Q1. Who leads: Who leads/manages the planning and implementation of HIV/AIDS epidemiological surveys and/ or surveillance (convenes all parties and makes key decisions)?</p>	<p><input checked="" type="radio"/> A. Host Country Government/other domestic institution</p> <p><input type="radio"/> B. External agency with host country government</p> <p><input type="radio"/> C. External agency, organization or institution</p> <p><input type="radio"/> D. Not conducted</p>	4.5		Decision reached in the interagency, GRC and stakeholder meeting for the SID completion at NACC.
<p>Q2. Who finances: Within the last three years, what proportion of the latest HIV/AIDS epidemiological data survey did the host country government fund?</p>	<p><input type="radio"/> A. 80-100% of the total cost of latest survey was financed by Host Country Government</p> <p><input type="radio"/> B. 60-79% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> C. 40-59% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> D. 20-39% of the total cost of latest survey financed by Host Country Government</p> <p><input checked="" type="radio"/> E. 10-19% of the total cost of latest survey financed by Host Country Government</p> <p><input type="radio"/> F. 0-9% of the total cost of latest survey financed by Host Country Government</p>	1		NACC Annual Report; PEPFAR COP data; UNAIDS and GFATM data
<p>Q3. Comprehensiveness of Prevalence and Incidence Data: Does Host Country Government collect HIV prevalence and or incidence data?</p>	<p><input type="radio"/> No, the government does not collect HIV prevalence or incidence data</p> <p><input checked="" type="radio"/> Yes, the government collects (check all that apply):</p> <p><input checked="" type="checkbox"/> A. HIV prevalence</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input checked="" type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input checked="" type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input checked="" type="checkbox"/> Data analyzed for trends <input checked="" type="checkbox"/> Data made publicly available <p><input type="checkbox"/> B. HIV incidence</p> <ul style="list-style-type: none"> <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed for trends 	2.2		Most recent country prevalence and incidence reports: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".

	<input type="checkbox"/> Data made publicly available			
Q4. Comprehensiveness of Viral Load Data: Does Host Country Government collect viral load data?	<input checked="" type="radio"/> No, the government does not collect viral load data <input type="radio"/> Yes, the government collects viral load data (check all that apply): <input type="checkbox"/> Collected by age <input type="checkbox"/> Collected for children <input type="checkbox"/> Collected by sex <input type="checkbox"/> Collected by key population <input type="checkbox"/> Sub-national data <input type="checkbox"/> Collected every 3 years <input type="checkbox"/> Data analyzed to understand trends	0	In country source such as government report: Not Applicable.	This data is collected, however the interagency and stakeholder teams were unable to come to a consensus on why the data is collected and for what purpose. Is it strategically collected for program planning? Or is it collected as an after thought on medical forms and not for programmatic purposes?
Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations?	<input checked="" type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input type="checkbox"/> Men who have sex with men (MSM) <input type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input type="checkbox"/> Government leads and manages the size estimation studies	0	In country source such as government report: Not Applicable.	This information is collected by USG and other bilateral and multilateral agencies. UNAIDS stated that the GRC does conduct size estimations for FSW, and MSM, and that the GRC leads and manages these estimates.
Epidemiological and Health Data Score:		7.7		

2. Financial/Expenditure data: Government collects, tracks and analyzes financial data related to HIV/AIDS, including the financing and spending on HIV/AIDS from all financing sources, costing, and economic evaluation for cost-effectiveness.		Source of data	Notes/Comments
Q1. Expenditure Tracking: Does the host country government have a nationally agreed upon expenditure tracking system to collect HIV/AIDS expenditure data?	<input type="radio"/> No, it does not have a national HIV/AIDS expenditure tracking system <input checked="" type="radio"/> Yes, the government has a system to collect HIV/AIDS expenditure data (check all that applies): <input checked="" type="checkbox"/> A. Collected by source of financing, i.e. domestic public, domestic private, out-of-pocket, Global Fund, PEPFAR, others <input checked="" type="checkbox"/> B. Collected by expenditures per program area, such as prevention, care, treatment, and health systems strengthening <input type="checkbox"/> C. Collected sub-nationally <input checked="" type="checkbox"/> D. Collected annually <input checked="" type="checkbox"/> E. Data is made publicly available	4 In country source, such as government HIV/AIDS expenditure tracking policy, strategy or SOP: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".	Completed annually with availability of funding. Otherwise completed bi-annually.

<p>Q2. Quality of Expenditure Tracking: Is the Host Country Government tracking expenditures based on international standards? What type of expenditure data are available in the country, i.e. NHA, NASA, others:</p>	<p><input type="radio"/> No, they are not using any international standards for tracking expenditures</p> <p><input checked="" type="radio"/> Yes, the national government is using international standards such as WHO National Health Accounts (NHA), National AIDS Spending Assessment (NASA), and/or methodology comparable to PEPFAR Expenditure Analysis or the Global Fund new funding tracking model.</p>	5	NASA	
<p>Q3. Transparency of Expenditure Data: Does the host country government make HIV/AIDS expenditure data (or at a minimum a summary of the data) available to the public?</p>	<p><input type="radio"/> No, they do not make expenditure data available to the public</p> <p>Yes, check the one that applies:</p> <p><input checked="" type="radio"/> A. Annually</p> <p><input type="radio"/> B. Bi-annually</p> <p><input type="radio"/> C. Every three or more years</p>	5	In country source of latest expenditure data made available to the public: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014"	
<p>Q4. Economic Studies: Does the Host Country Government conduct special health economic studies or analyses for HIV/AIDS, i.e. costing, cost-effectiveness, efficiency?</p>	<p><input checked="" type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input type="radio"/> Yes, check all that apply:</p> <p><input type="checkbox"/> A. Costing studies or analyses</p> <p><input type="checkbox"/> B. Cost-effectiveness studies or analyses</p> <p><input type="checkbox"/> C. Efficiency studies or analyses</p> <p><input type="checkbox"/> D. Cost-benefit studies or analyses</p>	0	In country reports: Not Applicable.	

Financial/Expenditure Data Score: 14

<p>3. Performance data: Government collects, analyzes and makes available HIV/AIDS service delivery data. Service delivery data is analyzed to track program performance, i.e. coverage of key interventions, results against targets, and the continuum of care and treatment cascade, including adherence and retention.</p>		Source of data		
<p>Q1. Collection of service delivery data: Does the host country government have a system to routinely collect/report HIV/AIDS service delivery data?</p>	<p><input type="radio"/> No, the government does not have an HIV/AIDS service delivery data collection system</p> <p><input checked="" type="radio"/> Yes, service delivery data are collected/reported for (check all that apply):</p> <p><input checked="" type="checkbox"/> A. For HIV Testing</p> <p><input checked="" type="checkbox"/> B. For PMTCT</p> <p><input checked="" type="checkbox"/> C. For Adult Care and Support</p> <p><input checked="" type="checkbox"/> D. For Adult Treatment</p> <p><input type="checkbox"/> E. For Pediatric Care and Support</p> <p><input checked="" type="checkbox"/> F. For Pediatric Treatment</p> <p><input type="checkbox"/> G. For AIDS-related mortality</p>	5	HIV/AIDS service delivery HMIS policy/SOP and latest report citation: ANC Registers (provided by ICAP) and "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".	
<p>Q2. Analysis of service delivery data: Does the Host Country Government routinely analyze service delivery data to measure Program performance? i.e. continuum of care cascade, coverage, retention, AIDS-related mortality rates?</p>	<p><input type="radio"/> No, the government does not routinely analyze service delivery data to measure performance</p> <p><input checked="" type="radio"/> Yes, service delivery data are being analyzed to measure (check all that apply):</p> <p><input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence</p> <p><input checked="" type="checkbox"/> B. Results against targets</p> <p><input checked="" type="checkbox"/> C. Coverage</p>	4	For each check, in-country source of latest data: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".	Retention and AIDS-related death rates are not routinely collected as indicators. Additional comments from Global Fund were that option "E. AIDS-related death rates" also takes place.

	<input checked="" type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input type="checkbox"/> E. AIDS-related death rates			
Q3. Comprehensiveness of service delivery data: Does the host country government collect HIV/AIDS service delivery data in a manner that is timely, accurate and comprehensive?	<input type="radio"/> No <input checked="" type="radio"/> Yes, service delivery data are being: (check all that apply): <input checked="" type="checkbox"/> A. Collected at least quarterly <input checked="" type="checkbox"/> B. Collected by age <input checked="" type="checkbox"/> C. Collected by sex <input checked="" type="checkbox"/> D. Collected from all clinical sites <input type="checkbox"/> E. Collected from all community sites <input checked="" type="checkbox"/> F. Data quality checks are conducted at least once a year	5	"RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".	
Q4. Transparency of service delivery data: Does the host country government make HIV/AIDS program performance and service delivery data (or at a minimum a summary of the results) available to the public routinely?	<input type="radio"/> No, they do not make program performance data available to the public Yes, check the one that applies: <input checked="" type="radio"/> A. At least annually <input type="radio"/> B. Bi-annually <input type="radio"/> C. Every three or more years	2	In country source of where HIV/AIDS service delivery data are available to public, such as a website: NACC website	When the annual progress report is generated.
Performance Data Score:		16		

THIS CONCLUDES THE SET OF QUESTIONS ON THE INSTITUTIONALIZING DATA AVAILABILITY DOMAIN

Domain B. Domestic Program and Service Delivery

What Success Looks Like: Host country institutions (inclusive of government, NGOs, civil society, and the private sector), the domestic workforce, and local health systems constitute the primary vehicles through which HIV/AIDS programs and services are managed and delivered. Optimally, national, sub-national and local governments have achieved high and appropriate coverage of a range of quality, life-saving HIV/AIDS prevention, care and treatment services and interventions. There is a high demand for HIV/AIDS services, which accessible and affordable to poor and vulnerable populations at risk of infection (i.e. key populations, discordant couples, exposed infants), are infected and or are affected by the HIV/AIDS epidemic.

4. Access and Demand: There is a high uptake of HIV/AIDS prevention, care and treatment services and programs among key populations and individuals infected and affected by HIV/AIDS, especially among those in the lowest socio-economic quintiles.		Source of data	Notes/Comments
<p>Q1. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing ART.</p> <p><input type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing ART.</p>	<p>Q1 Score: 4</p>	<p>In country source, i.e., SIMS, readiness assessments: NACC (National AIDS Control Committee) data.</p>
<p>Q2. Access to PMTCT: What percent of facilities in high prevalence/burden locations are providing PMTCT (Option B+)?</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. More than 80% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> B. 50-79% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input type="radio"/> C. 21-49% of facilities in high prevalence/burden locations are providing Option B+.</p> <p><input checked="" type="radio"/> D. 20% or less of facilities in high prevalence/burden locations are providing Option B+.</p>	<p>Q2 Score: 0</p>	<p>In country source, i.e., readiness assessments: PMTCT Progress Report (NACC)</p>
<p>Q3. Who is delivering HIV/AIDS services: What percent of Care and Treatment clients are treated at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. 80% or more of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of HIV/AIDS care and treatment clients are treated at public service delivery sites</p>	<p>Q3 Score: 3</p>	<p>In country source, i.e. MOH report: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".</p>
<p>Q4. Access to ART: What percent of facilities in high prevalence/burden locations are provided ART prescription and client management services?</p>	<p><input checked="" type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p>	<p>Q4 Score: 0</p>	

<p>Q4. Services to key populations: What percent of key population HIV/AIDS prevention program clients receive services at public service delivery sites? These can include government-supported or accredited domestic private, civil society, or faith-based operated services. (i.e. those sites that receive commodities from the government and/or follow government protocols).</p>	<p><input type="radio"/> A. 80% or more of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> B. 50-79% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> C. 20-49% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p> <p><input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites</p>			
<p>Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%</p>	<p><input type="radio"/> This information is not available</p> <p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. 80% or more of PLHIV are currently receiving ART</p> <p><input type="radio"/> B. 50-79% of PLHIV are currently receiving ART</p> <p><input checked="" type="radio"/> C. 20-49% of PLHIV are currently receiving ART</p> <p><input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART</p>	<p>Q5 Score 2</p>	<p>In country source, i.e. government annual HIV/AIDS report: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".</p>	
<p>Q6. Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, key populations, and those who may access HIV services about these rights?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations.</p> <p><input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply):</p> <p><input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services</p> <p><input type="checkbox"/> educates key populations about their legal rights in terms of access to</p> <p><input type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS</p> <p><input checked="" type="checkbox"/> national law exists regarding health care privacy and confidentiality protections</p> <p><input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found</p>	<p>Q6 Score 1.2</p>	<p>In country source, i.e., government strategy/plan/SOP, HIV/AIDS Human Rights assessment report: "UNAIDS Legal Assessment Report".</p>	

Access and Demand Score

10.2

5. Human Resources for Health: HRH staffing decisions for those working on HIV/AIDS are based on use of HR data and are aligned with national plans. Host country has sufficient numbers and categories of competent health care workers and volunteers to provide quality HIV/AIDS prevention, care and treatment services in health facilities and in the community. Host country trains, deploys and compensates health workers providing HIV/AIDS services through local public and/or private resources and systems. Host country has a strategy or plan for transitioning staff funded by donors.

Source of data

Notes/Comments

Check the one answer that best describes the current situation:

This information is not available

Q1 Score: 0

In country HRH assessments; HRIS data; in country training assessments; SIMS Above site SF tool "HRH Staffing CEE" SOURCE: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN

<p>Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?</p>	<p><input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand</p> <p><input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply)</p> <p><input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand</p> <p><input type="checkbox"/> HIV community-based service sites have adequate numbers of staff to meet the HIV patient demand, and CHWs have appropriate linkages to high HIV burden/ volume community and facility sites</p>		<p>LE VIH/SIDA ET LES STI AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".</p>	
<p>Q2. HRH Transition: What is the status of transitioning PEPFAR and other donor supported HIV/AIDS health worker salaries to local financing/compensation?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. There is no inventory or plan for transition of donor-supported health workers</p> <p><input type="radio"/> B. There is an inventory and plan for transition of donor-supported workers but it has not been implemented to date</p> <p><input type="radio"/> C. There is an inventory and plan for transition of donor-supported workers, but it has been only partially implemented to date.</p> <p><input type="radio"/> D. There is an inventory and plan for donor-supported workers to be transitioned, and staff are being transitioned according to this plan</p> <p><input type="radio"/> E. No plan is necessary because all HIV/AIDS health worker salaries are already locally financed/compensated</p>	<p>Q2 Score: 0</p>	<p>In country PEPFAR HRH transition plan and documentation: Unknown Source/Mising source/dissent recorded from stakeholders</p>	
<p>Q3. HRH Financial reform: Has financial reform been undertaken in the last 5 years to address government financing of health workers?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No financial reform has been undertaken in the last 5 years to address government financing of health workers</p> <p><input checked="" type="radio"/> B. Financial reforms have been undertaken in the last 5 years to address government financing of health workers (check all that apply):</p> <p><input checked="" type="checkbox"/> Wage reform to increase salaries and or benefits of health workers</p> <p><input type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 1</p>	<p>In country source, i.e. report on HRH reform or civil service reform: The sources were NACC and discussions in stakeholders meetings to discuss the SID and complete it. Stakeholders present included NACC, PEPFAR Interagency team, CSO's, UNAIDS and the French Embassy. Additionally, the Global Fund contributed virtually.</p>	
<p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. HIV/AIDS content used by pre-service institutions is out of date (has not been updated within the last 3 years) - For example, an average national score of RED in SIMS AS-SF "Pre-Service Education" CEE</p> <p><input checked="" type="radio"/> B. Pre-service institutions have updated HIV/AIDS content within the last three years (check all that apply):</p> <p><input checked="" type="checkbox"/> content updated for all HIV/AIDS services</p>	<p>Q4 Score: 2.2</p>	<p>SIMS Above Site-SF Tool, "Pre-Service Education" CEE or if other country team knowledge: NACC policy and NACC confirmed at stakeholders SID meeting.</p>	

<p>HIV/AIDS services include HIV content that has been updated in last three years?</p>	<p><input checked="" type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input type="checkbox"/> updated curriculum is problem based/competency based</p> <p><input checked="" type="checkbox"/> updated curriculum includes practicums at high volume clinical/ social services sites</p> <p><input type="checkbox"/> institutions that track students after graduation</p>			
<p>Q5. In-Service: To what extent is the country institutionalizing PEPFAR/other donor supported HIV/AIDS in-service training (IST) into local training systems?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input checked="" type="radio"/> A. National IST curricula institutionalizes PEPFAR/other donor-supported HIV/AIDS training.</p> <p><input type="radio"/> B. There is a strategy for institutionalizing PEPFAR/other donor-supported IST training and it is being implemented.</p> <p><input type="radio"/> C. There is a strategy in place for institutionalizing PEPFAR supported IST training but it is not being fully implemented to date.</p> <p><input type="radio"/> D. There is not a strategy in place for institutionalizing PEPFAR/other donor supported IST training.</p>	<p>Q5 Score: 3</p>	<p>Country Team Knowledge, with NACC confirmation at stakeholders SID meeting.</p>	<p>PMTCT and Pediatric Care (PEPFAR); Adult Care (ESTHER).</p>
<p>Q6. HRIS: Does the government have a functional Human Resource Information System (HRIS) for the health sector?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> A. No, there is no HRIS</p> <p><input checked="" type="radio"/> B. Yes, the government does have a HRIS (check all that apply)</p> <p><input checked="" type="checkbox"/> The HRIS is primarily funded by host country institutions</p> <p><input type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input type="checkbox"/> The government produces HR data from the HRIS at least annually</p> <p><input checked="" type="checkbox"/> The government uses data from the HRIS for HR planning and management</p>	<p>Q6 Score: 1</p>	<p>National HRIS document</p>	<p>Support is needed to include a better monitoring of new skills/competences acquisition by health workers as well as their involvement in specific programs like HIV/AIDS.</p>
<p>Q7. Domestic funding for HRH: What proportion of health worker (doctors, nurses, midwives, and CHW) salaries are funded with domestic resources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. Less than 20%</p> <p><input type="radio"/> B. 20-49%</p> <p><input type="radio"/> C. 50-79%</p> <p><input checked="" type="radio"/> D. 80% or more</p>	<p>Q7 Score: 4</p>	<p>"RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".</p>	<p>Most health workers are put on payroll. Community health workers are not considered health personnel.</p>

Human Resources for Health Score

11.2

6. Commodity Security and Supply Chain: The National HIV/AIDS response ensures a secure, reliable and adequate supply and distribution of quality products, including drugs, lab and medical supplies, health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment. Host country efficiently manages product selection, forecasting and supply planning, procurement, warehousing and inventory management, transportation, dispensing and waste management reducing costs while maintaining quality.		Source of data	Notes/Comments
<p>Q1. ARV domestic financing: What is the estimated obligated funding for ARV procurement from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input checked="" type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	<p>Q1 Score: 2</p>	<p>Data from NASA.</p> <p>Cameroon located in the 35%-45% bracket.</p>
<p>Q2. Test Kit domestic financing: What is the estimated obligated funding for Rapid Test Kits from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input checked="" type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	<p>Q2 Score: 2</p>	<p>Same as above.</p>
<p>Q3. Condom domestic financing: What is the estimated obligated funding for condoms from domestic public revenue (not donor) sources?</p>	<p>Check the one answer that best describes the current situation:</p> <p><input type="radio"/> This information is not known</p> <p><input checked="" type="radio"/> A. 0-9% obligated from domestic public sources</p> <p><input type="radio"/> B. 10-29% obligated from domestic public sources</p> <p><input type="radio"/> C. 30-79% obligated from domestic public sources</p> <p><input type="radio"/> D. 80% or more obligated from domestic public sources</p>	<p>Q3 Score: 0</p>	<p>In country source, i.e., NHA, MOH, Condom assessment report: PEPFAR/GFATM Data and "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014".</p>
<p>Q4. Supply Chain Plan: Does the country have an agreed-upon national supply chain plan with an implementation plan or a thorough annually-reviewed supply chain SOP?</p>	<p><input type="radio"/> A. No, there is no plan or thoroughly annually reviewed supply chain SOP</p> <p><input checked="" type="radio"/> B. Yes, there is a Plan/SOP. It includes these components: (check all that apply)</p> <p><input checked="" type="checkbox"/> Human resources</p> <p><input type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input type="checkbox"/> Reverse Logistics</p> <p><input type="checkbox"/> Waste management</p> <p><input checked="" type="checkbox"/> Information system</p> <p><input checked="" type="checkbox"/> Procurement</p> <p><input checked="" type="checkbox"/> Forecasting</p> <p><input checked="" type="checkbox"/> Supply planning and supervision</p>	<p>Q4 Score: 3.1</p>	<p>"RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
	<p><input checked="" type="radio"/> A. No, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) less than 90% of the time</p>	<p>Q5 Score: 0</p>	<p>In country source, i.e., supply chain assessment report, LMIS data: Not Applicable.</p>

<p>Q5. Stock: Do Public and Private Sector Storage facilities (Central and intermediate level) report having HIV and AIDS commodities stocked according to plan (above the minimum and below the maximum stock level) 90% of the time?</p>	<p><input type="radio"/> B. Yes, storage facilities report having commodities stocked according to plan (above the minimum and below the maximum stock level) 90% or more of the time</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at central level</p> <p><input type="checkbox"/> Both public and (if they exist in the country) private storage facilities at intermediate level</p>			
<p>Q6. Assessment: Was an overall score of above 80% achieved on the SCMS National Supply Chain Assessment?</p> <p>(If a different credible assessment of the national supply chain has been conducted, you may use this as the basis for response. Note the details and date of the assessment in the "source of data" column.)</p>	<p><input checked="" type="radio"/> A. No assessment has been conducted nor do they have a system to oversee the supply chain</p> <p><input type="radio"/> B. Yes, an assessment was conducted but they received below 80%</p> <p><input type="radio"/> C. No assessment was conducted, but they have a system to oversee the supply chain that reviews:</p> <p><input type="checkbox"/> Commodity requirements</p> <p><input type="checkbox"/> Commodity consumption</p> <p><input type="checkbox"/> Coordinates procurements</p> <p><input type="checkbox"/> Delivery schedules</p> <p><input type="radio"/> D. Yes, an assessment was conducted and they received a score that was 80% or higher</p>	<p>Q6 Score: 0</p>	<p>In country Assessment Report: Not Applicable.</p>	

Commodity Security and Supply Chain Score

7.1

7. Quality Management: Host country ensures that HIV/AIDS services are managed and provided in accordance with established national/global standards and are effective in achieving positive health outcomes (reduced AIDS-related deaths, reduced incidence, and improved viral load/adherence). Host country has institutionalized quality management approaches in its HIV/AIDS Program that ensure continued quality during and following donor to government transitions.

			Source of data	Notes/Comments
<p>Q1. Existence of System: Does the government have a functional Quality Management/Quality Improvement (QM/QI) infrastructure?</p>	<p><input checked="" type="radio"/> A. No, there is no QM/QI infrastructure within national HIV/AIDS program or MOH</p> <p><input type="radio"/> Yes, there is a QM/QI infrastructure within national HIV/AIDS program or MOH. The infrastructure (check all that apply):</p> <p><input type="checkbox"/> Routinely reviews national HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Routinely reviews district/regional HIV/AIDS performance and clinical outcome data</p> <p><input type="checkbox"/> Prioritizes areas for improvement</p>	<p>Q1 Score: 0</p>	<p>In country sources, i.e., QM/QI strategic plan/SOP, QM/QI Assessment Report: DQA/SQA PEPFAR Cameroon/CDC.</p>	<p>For HIV related LAB this does exist.</p>
	<p><input checked="" type="radio"/> No, there is no HIV/AIDS-related QM/Q strategy</p>	<p>Q2 Score: 0</p>	<p>QM/QI Strategy document: DQA/SQA PEPFAR</p>	<p>For HIV related LAB this does exist.</p>

<p>Q2. Strategy: Is there a current (updated within the last 2 years) national QM/QI strategy that is either HIV/AIDS program-specific or includes HIV/AIDS program-specific elements?</p>	<p><input type="radio"/> B. Yes, there is a QM/QI strategy that includes HIV/AIDS but it is not current (updated within the last 2 years)</p> <p><input type="radio"/> C. Yes, there is a current QM/QI strategy that includes HIV/AIDS program specific elements</p> <p><input type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>		Cameroon/CDC.	
<p>Q3. Guidelines: Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p>	<p><input type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input checked="" type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input checked="" type="checkbox"/> PMTCT (option B+)</p> <p><input checked="" type="checkbox"/> Adult ART</p> <p><input checked="" type="checkbox"/> Pediatric ART</p> <p><input checked="" type="checkbox"/> Adolescent ART</p> <p><input checked="" type="checkbox"/> Test and treat for specific populations</p>	Q3 Score: 4	Current GRC (aka WHO) SOP/technical guidelines for PMTCT and ART.	New guidelines were recently adopted to reflect test and treat perspectives, respecting the WHO 2013 guidelines.
<p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p>	<p><input checked="" type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input type="checkbox"/> Use of data to determine quality of program or services</p> <p><input type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	Q4 Score: 0	In country sources, i.e., report, presentation, or annual plan indicating use of data for quality improvement: N/A	Global Fund agrees with the indicated response but UNAIDS dissents, indicating a Yes to this question and also checking the second box. (use of data to determine quality of programs and services)
<p>Q5. Post-transition: Does the host country government monitor whether the quality of HIV/AIDS service outcome is maintained at sites where PEPFAR/other donors have transitioned from a direct implementation role?</p>	<p><input checked="" type="radio"/> A. No, there is no quality monitoring at sites post-transition</p> <p><input type="radio"/> B. Yes, there is quality monitoring at transition sites. Monitoring includes:</p> <p><input type="checkbox"/> All transition sites</p> <p><input type="checkbox"/> Review of service outcomes</p> <p><input type="checkbox"/> Client feedback on changes in quality</p> <p><input type="checkbox"/> Quality improvement action plan</p> <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	Q5 Score: 0	In country sources, i.e., post-transition report or documentation: Not Applicable. There have been no transitioned sites	Does not apply, as no sites have been transitioned as of yet.
Quality Management Score			4	

THIS CONCLUDES THE SET OF QUESTIONS ON THE DOMESTIC PROGRAM AND SERVICE DELIVERY DOMAIN

Domain C. Health Financing and Strategic Investment

What Success Looks Like: Host country government is aware of the financial resources required to effectively and efficiently meet its national HIV/AIDS prevention, care and treatment targets. HCG actively seeks, solicits and/or generates the necessary financial resources, ensures sufficient resource commitments, and uses data to strategically allocate funding and maximize investments.

8. Domestic Resource Mobilization: Resource Generation: The host-country government costs its national HIV/AIDS response, solicits and generates revenue (including but not limited to tax revenues, public sector user fees, insurance, loans, private sector and other strategic partnerships, and/or other innovative sources of financing) and allocates resources to meet the national budget for HIV/AIDS.		Source of data	Notes/Comments
<p>Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?</p>	<p><input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget</p> <p><input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget</p> <p><input checked="" type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries</p> <p><input type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators</p>	<p>Q1 Score: 4</p>	<p>In country source, i.e. national budget, budget summary or report for 2014: National Budget, "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
<p>Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?</p>	<p><input type="radio"/> A. No</p> <p><input type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program</p> <p><input checked="" type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program</p>	<p>Q2 Score: 6</p>	<p>In country source, i.e. national budget, budget summary or report for 2014: National Budget, "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and other stakeholders.</p>
<p>Q3. Fiscal Policy: Does the country pass the MCC scorecard indicator for fiscal policy? (Countries without an MCC scorecard: Is general government net lending/borrowing as a percent of GDP averaged across 2011-2013 greater than (i.e. more positive than) -3.1 percent?)</p>	<p><input checked="" type="radio"/> Yes</p> <p><input type="radio"/> No</p>	<p>Q3 Score: 4</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>derived from: http://www.mcc.gov/pages/selectio n/scorecards</p>
<p>Q4. Domestic public revenue: What was annual domestic government revenue as a percent of GDP in the most recent year available? (domestic</p>	<p>Check the appropriate box for your country's income category:</p> <p><u>FOR LOW INCOME</u></p> <p><input type="radio"/> A. More than 16.4% (i.e. surpasses category mean)</p> <p><input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean)</p> <p><input type="radio"/> C. Less than 14.8%, (less than 90% of category mean)</p> <p><u>FOR LOW MIDDLE INCOME</u></p> <p><input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p>	<p>Q4 Score: 0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Original Source: IMF Government Finance Statistics.</p>

revenue excludes external grants)	<input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean) <input checked="" type="radio"/> F. Less than 20.1% (less than 90% of category mean)		
	FOR UPPER MIDDLE INCOME <input type="radio"/> G. More than 27.8% (i.e. surpasses category mean) <input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean) <input type="radio"/> I. Less than 25.0% (less than 90% of category mean)		

Score for Domestic Resource Mobilization: Resource Generation:	14
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9. Domestic Resource Mobilization: Resource Commitments: Host country government makes adequate multiyear resource commitments to achieve national HIV/AIDS goals for epidemic control and in line with the available fiscal space. These commitments for the national HIV/AIDS program ensure a well-trained and appropriately deployed workforce, functioning health systems, sufficient commodities and drugs, and local institutions at all levels able to perform activities and carry out responsibilities.		Source of data	Notes/Comments
Q1. Benchmarks for health spending: African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)? Non-African countries: Is government health expenditure at least 3 percent of GDP?	<input type="radio"/> A. Yes <input checked="" type="radio"/> B. No	Q1 Score: 0	OGAC-provided data sheet (follows tab E) Original sources: WHO and World Bank.
Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%	<input type="radio"/> A. Less than 10% <input type="radio"/> B. 10-24% <input checked="" type="radio"/> C. 25-49% <input type="radio"/> D. 50-74% <input type="radio"/> E. 75% or Greater	Q2 Score: 5	NASA or NHA data: NASA and NHA.
Q3. Key population spending: What percent of key population-specific interventions are financed with domestic public and domestic private sector funding (excluding out of pocket expenditure)?	<input type="radio"/> A. None or information is not available <input checked="" type="radio"/> B. 1-9% <input type="radio"/> 10-24% <input type="radio"/> 25-49%	Q3 Score: 1	In country source, i.e., NASA data, national expenditure analysis report: NASA, USAID KP knowledge

Expenditure:	<input type="radio"/> 50-74% <input type="radio"/> 75% or Greater		
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Score for Domestic Resource Mobilization: Resource Commitments:	6
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		Source of data	Notes/Comments
<p>10. Allocative Efficiency: The host country analyzes and uses relevant HIV/AIDS epidemiological, health, health workforce, and economic data to inform HIV/AIDS investment decisions. For maximizing impact, data are used to choose which high impact program services and interventions are to be implemented, where resources should be allocated, and what populations demonstrate the highest need and should be targeted (i.e. the right thing at the right place and at the right time).</p>			
<p>Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<input type="radio"/> A. No, data are not used annually <input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply: <input type="checkbox"/> Epidemiological data are used <input checked="" type="checkbox"/> Health/service delivery data are used <input type="checkbox"/> Financial data are used <input type="checkbox"/> There is integrated analysis across data streams <input type="checkbox"/> Multiple data streams are used to model scenarios	<p>Q1 Score: 2</p>	<p>In country documentation of strategic plan or annual planning, "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
<p>Q2. Geographic allocation: Does the host country government use data to determine the appropriate number and location of HIV/AIDS service sites (proportional to yield or burden data)?</p>	<input checked="" type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites <input type="radio"/> B. Less than 20% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients <input type="radio"/> E. 80% or more of HIV/AIDS service delivery sites yield 80% or more of new positive HIV test results or ART clients	<p>Q2 Score: 0</p>	<p>In country government source, i.e., presentation, GIS data, planning document: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
	<input type="radio"/> A. No, there is no system for funding cycle reprogramming	<p>Q3 Score: 2</p>	<p>In country source: policy/SOP: "RAPPORT ANNUEL 2013 DE LUTTE</p>

<p>Q3.Data driven reprogramming: Do host country government policies/systems allow for reprogramming investments based on new or updated program data during the government funding cycle?</p>	<p><input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used</p> <p><input checked="" type="radio"/> C. Yes, there is a system that allows for funding cycle reprogramming and reprogramming is done as per the policy but not based on data</p> <p><input type="radio"/> D. Yes, there is a policy/system that allows for funding cycle reprogramming and reprogramming is done as per the policy and is based on data</p>	<p>CON IRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
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Allocative Efficiency Score: 4

11. Technical Efficiency: Through enhanced processes, economies of scale, elimination of waste, prevention of new infections, expenditure analysis, strategic targeting, and other technical improvements, the host country is able to achieve improved HIV/AIDS outcomes within the available resource envelope (or achieves comparable outcomes with fewer resources). Thus, maximizing investments to attain epidemic control.

			Source of data	Notes/Comments
<p>Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services?</p> <p>(note: full score of five points can be achieved without checking all disaggregate boxes).</p>	<p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes (check all that apply):</p> <p><input type="checkbox"/> Annually</p> <p><input type="checkbox"/> For HIV Testing</p> <p><input type="checkbox"/> For Care and Support</p> <p><input type="checkbox"/> For ART</p> <p><input type="checkbox"/> For PMTCT</p> <p><input type="checkbox"/> For VMMC</p> <p><input type="checkbox"/> For OVC Service Package</p> <p><input type="checkbox"/> For Key population Interventions</p>	<p>Q1 Score: 0</p>	<p>In country source, i.e., government document, report or presentation: Meeting at NACC, and NACC confirmed a "NO" answer to this question.</p>	
	<p>Check all that apply:</p> <p><input type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions</p> <p><input type="checkbox"/> Streamlining management to reduce overhead costs</p>	<p>Q2 Score: 1.5</p>	<p>In country sources for each checked: PMTCT bottle neck analysis.</p>	

<p>Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p><input type="checkbox"/> Reducing fragmentation to lower unit costs, i.e. pooled procurement, resource pooling</p> <p><input checked="" type="checkbox"/> Improving procurement competition</p> <p><input type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public)</p> <p><input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact</p> <p><input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact</p> <p><input type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs</p>			
<p>Q3. Loss ratio: Does host country government have a system to measure the proportion of domestic public HIV/AIDS spending that supports direct service delivery (not administrative/overhead costs)?</p>	<p><input checked="" type="radio"/> A. No</p> <p><input type="radio"/> B. Yes</p>	<p>Q3 Score: 0</p>	<p>NACC confirmed that the response is "NO" to this question.</p>	
<p>Q4. Benchmark prices: Are prices paid by the government for first-line ARVs and Test Kits within 5% variance of international benchmark prices (UNAIDS Investment Case)?</p>	<p>Check boxes that apply:</p> <p><input type="checkbox"/> They are not paying for any ARVs</p> <p><input type="checkbox"/> They are not paying for any test kits</p> <p><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs</p> <p><input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits</p>	<p>Q4 Score: 4</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	<p>In 2013 and 2014, Cameroon paid a higher percentage due to an urgent procurement because of emergency ARV stock-outs.</p>
<p>Q5. ART unit costs: Have average unit costs for providing ART in the country reduced within the last two years?</p> <p>Unit cost 2 years ago: \$ _____</p> <p>Current unit cost: \$ _____</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>		<p>WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</p>	
<p>Technical Efficiency Score:</p>		<p>9.5</p>		

THIS CONCLUDES THE SET OF QUESTIONS ON THE HEALTH FINANCING AND STRATEGIC INVESTMENT DOMAIN

Domain D. Accountability and Transparency

What Success Looks Like: Host government upholds a transparent and accountable resolve to be responsible to its citizens and international stakeholders (donors) for achieving planned HIV/AIDS results, is a good steward of HIV/AIDS finances, widely disseminates program progress and results, and provides mechanisms for eliciting feedback.

12. Public Access to Information: Host government widely disseminates timely and reliable information on the implementation of HIV/AIDS policies and programs, including goals, progress and challenges towards achieving HIV/AIDS targets, as well as fiscal information (public revenues, budgets, expenditures, large contract awards, etc.) related to HIV/AIDS. Program and audit reports are published publically.	Source of data	Notes/Comments
<p>Q1. OBI: What is the country's "Open Budget Index" score? (Alternative for countries lacking an OBI score: What was the country's score on the most recent Public Expenditure and Financial Accountability Assessment (PEFA) for PI-10: "Public Access to Fiscal Information"?)</p>	<p>Q1 Score: 1.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index (http://survey.internationalbudget.org/) and PEFA data (www.pefa.org).</p>
<p>Q2. National program report transparency: Does the host country government make an annual national HIV/AIDS program progress report and or results publically available?</p>	<p>Q2 Score: 4.0</p>	<p>"RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>
<p>Q3. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically</p>	<p>Q3 Score: 0.0</p>	<p>RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS</p>

<p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS program audit report publically available?</p>	<p><input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply:</p> <p><input type="checkbox"/> On website</p> <p><input type="checkbox"/> Through any type of media</p> <p><input type="checkbox"/> Disseminate print report</p>		<p>Yaoundé Avril 2014, Consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders</p>	
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Public Access to Information Score: 5

<p>13. Oversight and Stewardship: Government institutions are held accountable for the use of HIV/AIDS funds and for the results of their actions by the electorate and by the legislature and judiciary. Public employees are required to account for administrative decisions, use of resources, and results obtained. There is timely and accurate accounting and fiscal reporting, including timely audit of public accounts and effective arrangements for follow-up. There are mechanisms for citizens and key stakeholders to review and provide feedback regarding public programs, services and fiscal management.</p>		<p>Source of data</p>	<p>Notes/Comments</p>	
<p>Q1. Availability of Information on Resources Received by Service Delivery Units. PEFA score on PI-23 was C or higher in most recent assessment.</p>	<p><input checked="" type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was below C</p> <p><input type="radio"/> C. PEFA was conducted and score was C</p> <p><input type="radio"/> D. PEFA was conducted and score was B</p> <p><input type="radio"/> E. PEFA was conducted and score was A</p>	<p>Q1 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org).</p>	<p>No data available.</p>
<p>Q2. Quality and timeliness of annual financial statements. PEFA score for element PI-25 was C or higher in most recent assessment.</p> <p>Actual scores are ____</p>	<p>Check A or B; if B checked, select appropriate disaggregates:</p> <p><input checked="" type="radio"/> A. PEFA assessment never conducted, or data unavailable</p> <p><input type="radio"/> B. PEFA was conducted and score was C or higher for:</p> <p><input type="checkbox"/> (i) Completeness of the financial statements</p> <p><input type="checkbox"/> (ii) Timeliness of submission of the financial statements</p> <p><input type="checkbox"/> (iii) Accounting standards used</p>	<p>Q2 Score: 0.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org).</p>	<p>No data available.</p>
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p>		<p>"RAPPORT ANNUEL 2013 DE LUTTE</p>	

<p>Q3. Government Channels and Opportunities for Civil Society Engagement: Does host country government have formal channels and opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services?</p>	<p><input type="radio"/> A. No, there are no formal channels or opportunities</p> <p><input type="radio"/> B. No, there are no formal channels or opportunities but civil society is called upon in an ad hoc manner to provide inputs and feedback</p> <p><input checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <p><input checked="" type="checkbox"/> During strategic and annual planning</p> <p><input checked="" type="checkbox"/> In joint annual program reviews</p> <p><input checked="" type="checkbox"/> For policy development</p> <p><input checked="" type="checkbox"/> As members of technical working groups</p> <p><input checked="" type="checkbox"/> Involvement on evaluation teams</p> <p><input type="checkbox"/> Giving feedback through social media</p> <p><input checked="" type="checkbox"/> Involvement in surveys/studies</p> <p><input type="checkbox"/> Collecting and reporting on client feedback</p>	<p>Q3 Score: 5.0</p>	<p>CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFAT M, NACC and stakeholders.</p>	
<p>Q4. Civil society Enabling Environment: What score did your country receive on the 2013 Civicus Enabling Environment Index (EEI), which measure the socio-cultural, socio-economic and governance environments for civil society?</p> <p>If your country is not included in the EEI, are there any laws or policies that prevent a full range of civil society organizations from providing oversight into the government's HIV/AIDS response?</p>	<p><input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or policies that restrict civil society playing an oversight role</p> <p><input type="radio"/> B. EEI score of 0.39-0.50; or there are no laws that restrict civil society playing a role in providing oversight of the HIV/AIDS response but in practice, it is not accepted by government</p> <p><input checked="" type="radio"/> C. EEI score of 0.51 - 0.76; or there are no laws or policies that prevent civil society from playing a role in providing oversight of the HIV/AIDS response and civil society is very actively engaged in providing oversight</p>	<p>Q4 Score: 4.0</p>	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Civicus Enabling Environment Index (civicus.org/eei/).</p>	<p>No EEI data available. However, there are no laws restricting civil society on this matter.</p>
<p>Oversight and Stewardship Score:</p>			<p>9</p>	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ACCOUNTABILITY AND TRANSPARENCY DOMAIN

Domain E. Enabling Environment

What Success Looks Like: Relevant government entities demonstrate transparent resolve and take actions to create an enabling policy and legal environment, and provide technical and political leadership to coordinate an effective national HIV/AIDS response.

14. Policies, Laws, and Regulations: Host country develops, implements, and oversees a wide range of policies, laws, and regulations that will achieve coverage of high impact interventions, ensure social and legal protection and equity for those accessing HIV/AIDS services, eliminate stigma and discrimination, and sustain epidemic control within the national HIV/AIDS response.

		Source of data	Notes/Comments
<p>Q1. Structural obstacles: Does the country have laws, regulations or policies that present obstacles to effective HIV prevention, treatment, care and support?</p>	<p><input type="radio"/> A. No, there are no such laws or policies</p> <p><input checked="" type="radio"/> B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score):</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Criminalization of HIV transmission <input type="checkbox"/> HIV testing disclosure policies or age requirements <input type="checkbox"/> Non-disclosure of HIV status laws <input checked="" type="checkbox"/> Anti-homosexuality laws <input checked="" type="checkbox"/> Anti-prostitution legislation <input checked="" type="checkbox"/> Laws that criminalize drug use, methadone use or needle exchange 	<p>Q1 Score: 2.0</p>	<p>In country source, i.e., name of law or policy: See comments section.</p> <p>Criminalization of HIV transmission is under the law that condemns voluntary transmission of STI. Global Fund and UNAIDS believed that the second box option "HIV testing disclosure policies or age requirements" should also be checked.</p>
<p>Q2. Access protection: Is there a National HIV/AIDS Policy or set of policies and laws that creates a legal and policy environment that ensures non-discriminatory and safe access to HIV/AIDS services, providing social and legal protection where those rights are violated?</p> <p>(note: full score of six points possible without checking all boxes)</p>	<p><input type="radio"/> A. No, there are no such policies or laws</p> <p><input checked="" type="radio"/> B. Yes, there are such policies and laws. Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> For people living with HIV <input checked="" type="checkbox"/> For men who have sex with men <input checked="" type="checkbox"/> For transgendered persons <input checked="" type="checkbox"/> For sex workers <input checked="" type="checkbox"/> For people who inject drugs <input checked="" type="checkbox"/> For children orphaned or affected by HIV/AIDS 	<p>Q2 Score: 6.0</p>	<p>In country source, i.e., the name of laws and policies: "RAPPORT ANNUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>

	<input checked="" type="checkbox"/> For young girls and women vulnerable to HIV <input checked="" type="checkbox"/> For survivors of gender-based violence			
Q3. Civil society sustainability: Does the legislative and regulatory framework make special provisions for the needs of Civil Society Organizations (CSOs) or give not-for-profit organizations special advantages?	<input type="radio"/> A. No, there are no special provisions or advantages for CSOs <input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply: <input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs <input type="checkbox"/> Significant tax exemptions for not-for-profit CSOs <input type="checkbox"/> Open competition among CSOs to provide government-funded services <input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change	Q3 Score: 1.0	In country source, name of legislation: Cameroon Health Sector Partnership Strategy 2009.	
Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes, there are. Check all below that are included: <input checked="" type="checkbox"/> A national public health services act that includes the control of HIV <input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services	Q4 Score: 4.0	In country source, name of legislation or policy: "RAPPORT ANNUUEL 2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS, Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.	
Policies, Laws, and Regulations Score:		13		
15. Planning and Coordination: Senior policy makers prioritize health and the HIV/AIDS response. Host country develops, implements, and oversees a multiyear national strategy and serves as the preeminent architect and convener of a coordinated HIV/AIDS response in the country across all levels of government and key stakeholders, civil society and the private sector. National plans are aligned to national priorities to achieve planned targets and results, with full costing estimates and plans incorporated.			Source of data	Notes/Comments
Q1. National Strategy: Does the country have a	<input type="radio"/> A. No, there is no national strategy for HIV/AIDS <input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply: <input checked="" type="checkbox"/> It is multiyear	Q1 Score: 4.0	In country source, name of current strategy: HIV/AIDS National Strategic Plan 2014-2017.	

<p>multi-year, costed national strategy to respond to HIV?</p>	<p><input checked="" type="checkbox"/> It is costed</p> <p><input checked="" type="checkbox"/> Its development was led by the host country government</p> <p><input checked="" type="checkbox"/> Civil society actively participated in the development of the strategy</p>			
<p>Q2. Data driven prioritization: Did the host country government develop the strategy using a data-driven prioritization approach, which coordinates the investment of multiple sources of funding, i.e. Investment Case?</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p> <p><input checked="" type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not coordinate the investment of multiple funding sources</p> <p><input type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</p>	<p>Q2 Score: 2</p>	<p>In country source, i.e., data analysis government used:</p>	
<p>Q3. CCM criteria: Has the country met the minimum criteria that all CCMs must meet in order to be eligible for funding by the Global Fund?</p>	<p><input type="radio"/> A. No or there is no CCM</p> <p><input type="radio"/> B. Yes, with conditions</p> <p><input checked="" type="radio"/> C. Yes</p>	<p>Q3 Score: 2</p>	<p>Global Fund Eligibility List 2014</p>	
<p>Q4. Coordination of national response: Does the host country government coordinate (track and map) all HIV/AIDS activities in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners, to avoid duplication and gaps?</p>	<p><input type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input checked="" type="radio"/> B. the host country government coordinates all HIV/AIDS activities. Check all that apply:</p> <p><input type="checkbox"/> Of Civil Society Organizations</p> <p><input type="checkbox"/> Of private sector</p> <p><input type="checkbox"/> Of donor implementing partners</p> <p><input checked="" type="checkbox"/> Activities are tracked or mapped</p> <p><input checked="" type="checkbox"/> Duplications and gaps are addressed</p> <p><input checked="" type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies</p>	<p>Q4 Score: 3.0</p>	<p>In country source, i.e., Coordination data or reports: See comments, and consensus was reached during inter-stakeholder meeting to complete the SID.</p>	
	<p><input type="radio"/> A. No</p>	<p>Q5 Score: 3.0</p>	<p>In country source for each checked: "RAPPORT ANNUEL</p>	

<p>Q5. Civil society engagement: Is there active engagement of diverse non-governmental organizations in HIV/AIDS advocacy, decision-making and service delivery in the national HIV/AIDS response?</p>	<p>B. Yes, civil society (such as community-based organizations, non-governmental organizations and faith-based organizations, local leaders and/or networks representing affected populations) are actively engaged. Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> In advocacy <input checked="" type="checkbox"/> In programmatic decision-making <input type="checkbox"/> In technical decision-making <input checked="" type="checkbox"/> In service delivery 		<p>2013 DE LUTTE CONTRE LE VIH/SIDA ET LES IST AU CAMEROUN (NACC) GTC-CNLS Yaoundé Avril 2014", and consensus reached at meeting with PEPFAR/UNAIDS/GFATM, NACC and stakeholders.</p>	
Planning and Coordination Score:			14	

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN