



FY 2015 Cote d'Ivoire Country 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 Cote d'Ivoire.

- 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.”

Côte d'Ivoire

Country Operational Plan 2015

Strategic Direction Summary

Revised

September 17, 2015

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Goal Statement

The PEPFAR program in Côte d'Ivoire will contribute to achieving the UNAIDS 90:90:90 goals embraced by the Ivoirian government and multilateral stakeholders by increasing coverage of quality combination prevention services feeding into the clinical cascade. The two-year vision established in COP 2014 guides COP 2015 toward reaching 80% saturation of adult treatment and 40 percent coverage of pediatric treatment in select high-impact geographic areas based on current Ivoirian treatment guidelines with a ≤ 350 CD4 threshold. The program is currently focused in 14 of 20 health regions that represent approximately 80 percent of people living with HIV (PLHIV). Further epidemiologic, demographic, and program data analysis, combined with budget considerations and discussions of “core, near-core, and non-core” activities, have led to targeting 39 districts for scale-up to reach 90:90:90: 16 “saturation” (by FY 2017) districts, and 23 “aggressive scale-up districts. The “saturation” districts represent 42% of the estimated disease burden in country, have the largest current patient cohorts, and are among areas most likely to be sources of new infections. Bolstering pediatric treatment services is also central to the COP 2015 approach, furthering the goal established in COP 2014 to attain 40% coverage.

In the 23 “aggressive scale-up” districts the program will continue to make new diagnoses of PLHIV and increase linkages into the clinical cascade, efforts initiated in COP 2013 to improve quality of service delivery and retention of patients on treatment.

The remaining 40 districts will be considered “sustained” districts (note that clinical services in the remaining three districts in country are being supported by the Global Fund to fight AIDS, Tuberculosis and Malaria [GF, or “the Global Fund”]) where the primary shift will be virtual elimination of service demand creation, no new sites, and increased reliance on systems and services provided by the Ivoirian government’s health infrastructure. Patients currently being served through higher-yield PMTCT and ART sites will be maintained on pre-ART and treatment, and the minimum package of care for orphans and vulnerable children (OVC) will continue in these regions throughout COP 2015 implementation. In line with OGAC guidance, routine testing services for PMTCT at sites in sustained districts will no longer be PEPFAR-supported, but women testing positive will access prophylaxis, ART and care services with PEPFAR support. Eliminating demand creation efforts will substantially reduce targets across program areas in these regions and will contribute to a shift in funding to high impact areas. The refined high-yield testing strategy will result in increased efficiencies, reducing the number of tests provided, but identifying and retaining a higher proportion of HIV positive individuals.

PEPFAR and the Ivoirian government are finalizing transition plans for low-yield and no-yield HTC and PMTCT sites at the ≤ 4 threshold (four or fewer PLHIV identified in the previous reporting year) during COP 2014, and are discussing further refinement of this strategic shift informed by available yield, costing data and absorptive capacity of GOCl and other stakeholders/funders. This discussion over the next year will also include a determination of the threshold for “low-volume” ART sites and development of an approach to better serve populations currently in a low-volume site. Hub-and-spoke and centers of excellence models are under consideration for the transfer of clients to more effective higher volume clinics in their area. PEPFAR has supported conversations between the Ambassador and

key members of the Ivorian government, including the Prime Minister, regarding resource needs of the national HIV response, which will lead to identification of logical and feasible shifts in program responsibility from the U.S. Government (USG) to the Ivorian government leading up to 2020.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

According to 2014 census results, Côte d'Ivoire has a total population of 22,848,945, of which males account for 51.7% (11,716,826) and females 48.3% (10,954,505). The 2014 UNAIDS report on Côte d'Ivoire¹ estimates HIV prevalence at 2.7%, compared to the 3.7% national prevalence figure published in the DHS. Much higher rates among sex workers (SW) and men who have sex with men (MSM) have been estimated through recent studies (11.4%² and 18%³ respectively). The Ivorian population under 15 years of age is estimated to be 8,780,535, or 38%. With a prevalence of 0.8%, approximately 70,000 children are infected with HIV. According to UNAIDS, the estimated total number of people living with HIV (PLHIV) is 370,000; the number of orphans and vulnerable children (OVC) is approximately 400,000, and the number of pregnant women needing ARVs is 50,937. There are approximately 19,000 new HIV infections and 28,000 deaths from AIDS each year in Côte d'Ivoire.

Substantial progress has been made in Côte d'Ivoire towards controlling the HIV epidemic over the past ten years. With a total PEPFAR investment of over \$1.1 billion dollars, a Global Fund investment of \$93 million disbursed to date, and local efforts, the prevalence of HIV has dropped significantly from an estimated prevalence rate of 10% in 2000 to 2.7% in 2014 (UNAIDS). About 37% of PLHIV (137,630) have been put on HIV care services, and over 133,000 on ART.

In spite of the tremendous progress made, major gaps still exist in achieving HIV epidemic control. Retention on treatment in general is a major problem and even greater gaps exist in enrolling and retaining children on treatment. The national response would benefit from focused testing to increase HIV-positive yield; increased linkages between community and clinical services to improve retention on care and treatment services; and greater linkages between TB and HIV programs for improved services for co-infected people. The Ivorian government has placed a priority on economic growth and infrastructure to the detriment of investments in health. Competing priorities in the health sector have also contributed to governmental investment and support that is currently inadequate for HIV control. Delays in adoption of policies known to better enrollment and retention on HIV treatment and care have impeded progress.

¹ <http://www.unaids.org/sites/default/files/epidocuments/CIV.pdf>

² Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côte d'Ivoire, 2014."

³ Study on HIV Prevalence and Associated Risk Factors among Men Who Have Sex with Men in Abidjan, Côte d'Ivoire (SHARM-CI): "HIV and Associated Risk Factors among MSM in Abidjan, Côte d'Ivoire" (FHI 360 Report, January 22, 2013).

According to 2013 World Bank data, the gross national income per capita for Côte d'Ivoire is \$1,450.⁴ The Ivorian national strategic health plan seeks to improve the health and well-being of the population and reduce morbidity and mortality. The national annual health budget, however, is only 594 billion FCFA (approximately \$100 million), or 5.36% of the national budget. This is well below the pledged level of 15% in the Abuja Declaration. The public health budget is insufficient to fulfill the stated needs and policies of the national health plans, and the allocation of resources is infrequently aligned with the strategic priorities. Despite efforts to provide free services for specific groups in need, many of the poorest continue to have to pay out of pocket for health care.

⁴ <http://data.worldbank.org/country/cote-divoire>

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		<15				15+				Source, Year
			Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	
Total Population	22,848,945	100%	4,353,342	19,02%	4,427,196	19,37%	6,933,115	30,34%	7,135,292	31,30%	Côte d'Ivoire 2014 Census. Total male: 11,716,826 (51, 7%); total female 10,954,505 (48, 3%);
Prevalence (%)		2,7 ⁰ % ⁵		Data Not available		Data Not available		4.6%		2.7%	UNAIDS report 2014 (2013 Data) and Cote d'Ivoire DHS+ 2011-2012
AIDS Deaths (per year)	28,000		Data Not available		Data Not available		Data Not available		Data Not available		UNAIDS report 2014 (2013 Data)
PLHIV	370,000		40,000		30,000		170,000		130,000		UNAIDS report 2014 (2013 Data)
Incidence Rate (Yr)		Data Not available		Data Not available		Data Not available		Data Not available		Data Not available	
New Infections (Yr)	19,000										UNAIDS report 2014 (2013 Data)
Annual births	1,221,815	5%									National Program against HIV/AIDS
% >= 1 ANC visit	Data Not available	85%	Data Not available	Data Not available			Data Not available	Data Not available			MICS Survey 2006
Pregnant women needing ARVs	50,937	4,30%									Plan D'élimination de la transmission Mère-Enfant du VIH de la Côte d'Ivoire, (2012-2015)
Orphans (maternal, paternal, double)	400,000		Data Not available		Data Not available		Data Not available		Data Not available		
TB cases (Yr)	25299		0.11%		Data Not available		Data Not available		Data Not available		National TB Program routine data, 2013

⁵ Note: The discrepancy in prevalence and prevalence disaggregated by sex is due to the use of two different data sources: the population-level prevalence cited is based on modeling published in the 2014 UNAIDS report; prevalence disaggregated by sex comes from the 2011-2012 DHS. The population-level prevalence in the DHS+ was 3.7%.

TB/HIV Co-infection	5551	25%	Data not available	National TB Program routine data, 2013							
Males Circumcised	Data Not available	Data Not available			Data Not available	Data Not available			Data Not available	Data Not available	
Key Populations											
Total MSM*	Data Not available	Data Not available									
MSM HIV Prevalence	Data Not available	18.8%									Risk behaviors and vulnerability for HIV among MSM survey in Abidjan, 2011-2012
Total FSW											
FSW HIV Prevalence	Data Not available	11.4%									Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côté d'Ivoire, 2014."
Total PWID	Data Not available	Data Not available									
PWID HIV Prevalence	Data Not available	Data Not available									
Priority Populations (MILITARY)	40,000	3,4%	Data Not available	SABERS 2014							
Priority Populations Prevalence (Adolescent girls and young women 15-24 years)		0,8%	Data Not available								

Table 1.1.2 Cascade of HIV diagnosis, care and treatment (12 months)										
				HIV Care and Treatment ***				HIV Testing and Linkage to ART ***		
	* 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	22,848,945	2.7%	370,000	137,630	129,993	16,058	data not available	1,610,102	66,628	28,236
Population less than 15 years	8,780,535	0.8%	70,000	8,462	6,408	1,036	data not available	105,096	data not available	645
Pregnant Women	1,142,447	data not available	data not available	data not available	16,131	data not available	data not available	605,172	12,393	1,543
MSM	data not available	18.8%	data not available	data not available	data not available	data not available	data not available	data not available	data not available	data not available
FSW	data not available	11.4%	data not available	data not available	data not available	data not available	data not available	data not available	data not available	data not available
PWID	data not available	data not available	data not available	data not available	data not available	data not available	data not available	data not available	data not available	data not available
Adolescent girls and young women (15-24)		0.8%								
Military	40,000	3.4%	1,360	data not available	650	data not available	data not available	data not available	data not available	data not available

* RGPB 2014

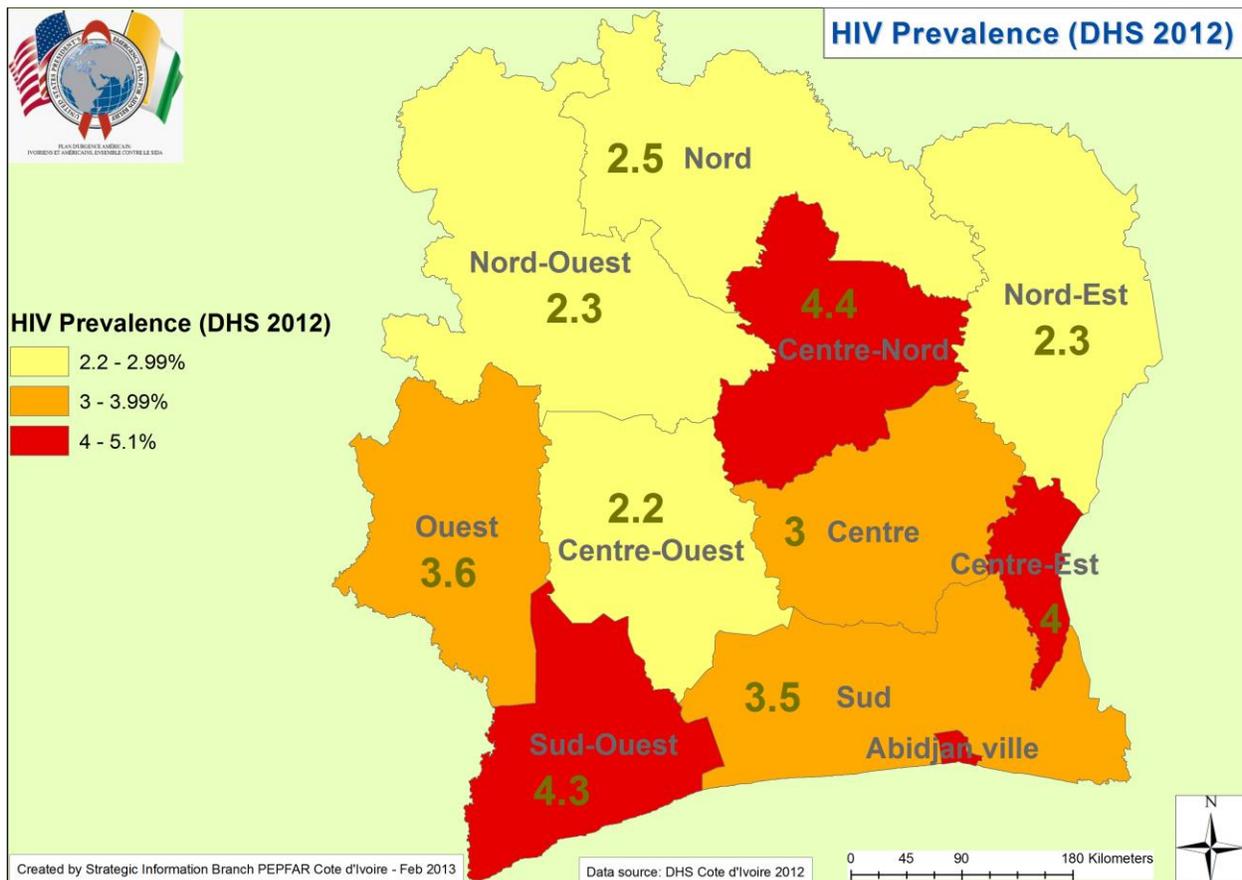
** UNAIDS 2014

*** PEPFAR CI APR2014

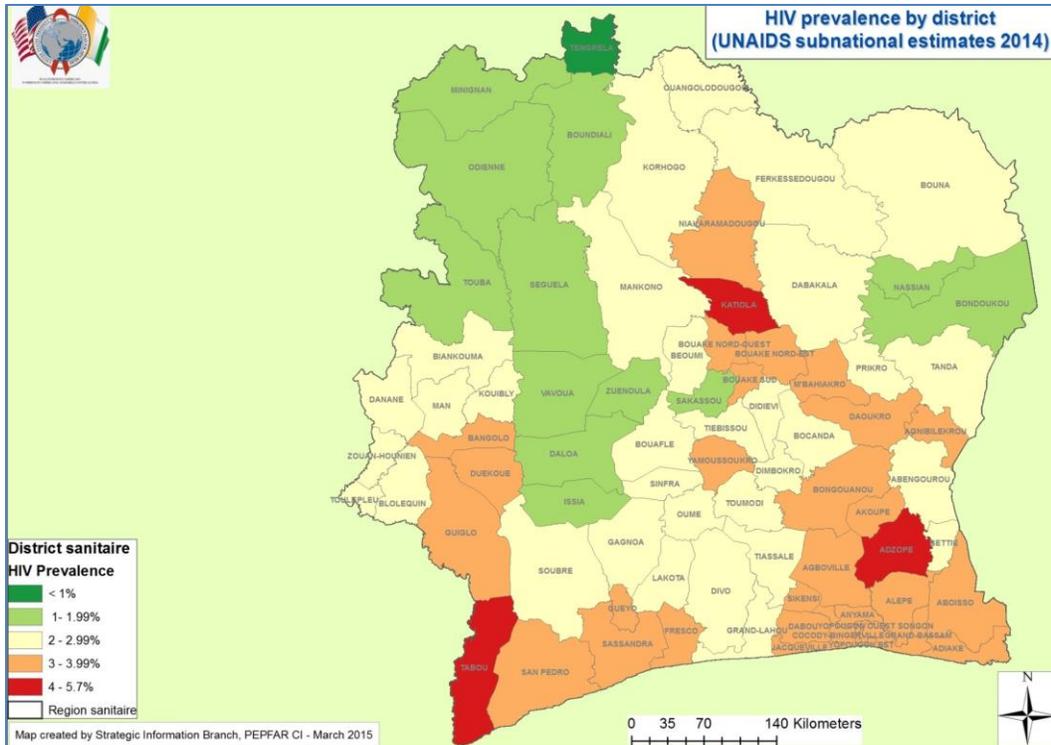
As described in Table 1.1.1, the burden of HIV is evident among female sex workers (FSW) and men who have sex with men (MSM). According to 2014 SABERS data, men in the military have a higher rate of prevalence, and in particular locations prevalence was found to be considerably higher than the military average. As described in section 4.2, adolescent girls and young women have a prevalence of 0.8% according to the 2011-12 DHS, which is eight times higher than their male peers. Programmatic data shows 5.5% prevalence among adults seeking care and 25% prevalence among TB patients. Certain other sub-populations show elevated prevalence, such as widows and widowers, and older men with higher educational and socioeconomic status.

Geographically, the burden of disease is broken down into eleven areas that do not correspond exactly to Côte d'Ivoire's regions. The burden of prevalence is concentrated in Abidjan (5.1%), the 'center-north' (4.4%), 'southwest' (4.3%), and 'center-east' (4.0%), with prevalence lower than the DHS national average of 3.7% in the 'west,' 'south,' 'center,' 'north,' 'northeast,' and 'center-west.'

Fig. 1.1.1: HIV prevalence by geographic area

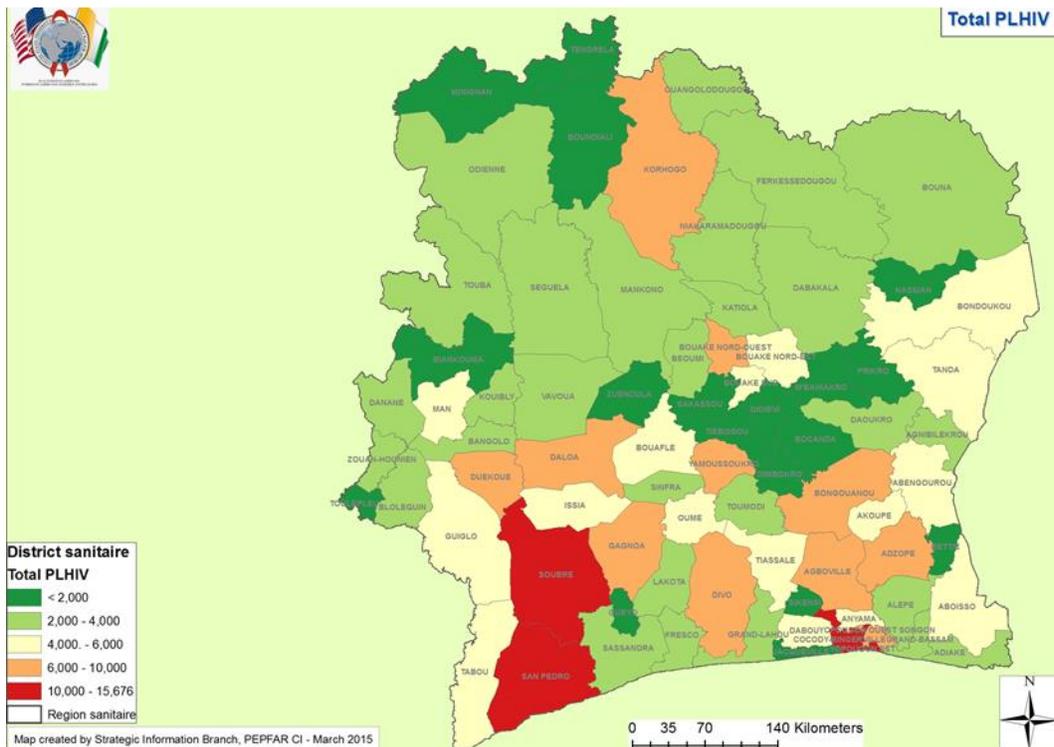


In 2015, UNAIDS released health district-level modeling based on the above 2012 DHS data, which, despite limitations in reliability, provides a more nuanced geographic picture of the epidemic (below).



On the map below (Fig. 1.1.2), estimates of PLHIV by district show 6,000 or more PLHIV in the orange and red districts.

Fig. 1.1.2: Total people living with HIV by health district



1.2 Investment Profile

Currently, PEPFAR is funding over 75% of the national HIV response. According to the new GF requirement that the country provide a match and indication of “willingness to pay,” or a commitment to increasing resources over time, the Ivoirian government (GOCI) has committed approximately \$13.1 million to HIV in FY 2016 (7%). The contribution of GF to the HIV response in Côte d’Ivoire under the current grant award (phase 2 of Round 9) is just under \$125,000,000 over five years, or about \$25,000,000 per year, including a €14 million (approximately \$15 million) commitment to ARV procurements on a national level in 2016. The PEPFAR contribution has remained relatively stable over the past three years and is anticipated to continue at this level. Over the next year, the GOCI will draft a new five-year prioritized and costed national strategic plan for HIV, which will inform a number of planning processes, including the Country Coordinating Mechanism’s (CCM) concept note development for the next allocation of the new funding model (NFM) for HIV (2017-2019). PEPFAR’s commitment to supporting the response, in particular the national supply of ARVs, will largely depend on a renewed negotiation with GF during this process. If the GF contribution remains stable or increases, PEPFAR will have the flexibility to further increase service provision or support other important program areas; however, if the GF tranche were to decrease, PEPFAR’s programming and budget would be considerably affected beginning in FY 2017, barring a substantial increase in resource commitment from the GOCI. While the USG anticipates a relatively transparent and calm election process in October 2015, the PEPFAR team is aware of the potential for post-election fallout affecting the program’s ability to implement and for the national response to achieve its objectives. The competing priorities of the MSLS pose an ongoing challenge as well for achievements, sustainability, and plans to transition pieces of the PEPFAR program to GOCI responsibility.

Table 1.2.1 Investment Profile by Program Area⁶

Program Area	Total Expenditure	% PEPFAR*	% GF	% GRP	% Other
Clinical care, treatment and support	\$92,206,243	74	17	6	3
Community-based care	\$ 2,876,354	56	38	5	2
PMTCT	\$10,510,627	87	2	7	3
HTC	\$10,348,310	80	10	7	3
VMMC	\$0	0	0	0	0
Priority population prevention	\$ 6,548,911	66	26	6	3
Key population prevention	\$10,018,458	85	4	7	3
OVC	\$13,661,822	89	0	8	3
Laboratory	\$ 9,419,512	89	0	8	3
SI, Surveys and Surveillance	\$ 9,911,643	75	16	6	3
HSS	\$16,977,396	74	17	6	3
Total	\$182,479,274	77	14	7	3

⁶ GRP, National AIDS Spending Assessment , 2012.

Table 1.2.2 Procurement Profile for Key Commodities, January – December 2014*

Commodity Category	Total				%
	Expenditure	% PEPFAR	% GF	% GRP	
ARVs	\$26,349,703	65%	34%	1%	
Rapid test kits	\$3,146,387	63%	37%		
Other drugs: CTX	\$899,846	68%	29%	2%	
Other drugs: STI treatment	\$38,691		100%		
Male Condoms	\$724,891	81%			19%
Female Condoms	\$318,646	74%			26%
Other commodities: Lab reagents	\$7,135,210	88%	12%		
Other commodities: Lubricant	\$57,679	100%			
Total	\$38,671,053	70%	30%	<1%	<1%

(* based on actual deliveries occurred during calendar year 2014.

Data source: SCMS/Cdi, HIV/Commodities Technical Working Notes; <http://www.myaccessrh.org>

Expenses for laboratory equipment not included in this table (estimated at \$2.5million in calendar year 2014)

Table 1.2.3 Non-PEPFAR Funded Investments and Integration and PEPFAR Central Initiatives:
N/A

1.3 National Sustainability Profile

IDENTIFIED ISSUES

The Sustainability Index and Dashboard (SID) process identified weaknesses in the six domains. Service delivery in particular requires substantial effort to reach and sustain the 90-90-90 goal. Notably, data availability suffers from the absence of HIV incidence, viral load (VL), and supply chain assessment information. Domestic ARV funding and stock capacity should be improved and the overall system needs increased participation in HIV services using current staff, fortified with an improved quality assurance approach.

The GOCI can improve the sustainability of HIV interventions by increasing the domestic health budget to at least 15%, as agreed in the Abuja Declaration, disaggregating the budget to allow expenditure monitoring per population type. In addition, an information platform should be used to share HIV-related documents and information, specifically audits. Increased participation from the GOCI should include intervention mapping, more acceptances of civil society programmatic and technical contributions, and a law protecting key populations' access to services.

NON-PEPFAR SOLUTIONS

Solutions to problems identified above may come from the host government, multilateral organizations, and several donors. Although the GOCI is increasing the proportion of human resources devoted to

HIV/AIDS services with a large recruitment and deployment program supported by the French Development Agency (AFD) and the World Bank (WB), continued support is needed from these donors to increase health staff's performance and accountability for HIV services.

Multilateral and bilateral organizations are combining their efforts with those of the host government for improved sustainability; notably, the Global Fund (GF) contributes to HIV commodities; the World Health Organization (WHO) advocates for local health budget funding increases (to 15% or more), UNAIDS advocates for policy change, and the WB for intervention mapping. ESTHER, funded by the French government, is providing technical assistance and 10,000 VL tests at PEPFAR-supported ART sites. The International Monetary Fund, WB, and Paris Club creditors have allowed Côte d'Ivoire to direct more funds towards poverty reduction priorities such as the purchase of ARVs within the framework of debt relief.

PEPFAR SOLUTIONS

In COP 2015, PEPFAR Côte d'Ivoire will continue to press for increased local governmental funding at senior levels. We will address the need for incidence and viral load data through support for GOCI HIV incidence data collection efforts. We will deploy a laboratory information system and decentralize VL testing and quality improvement initiatives.

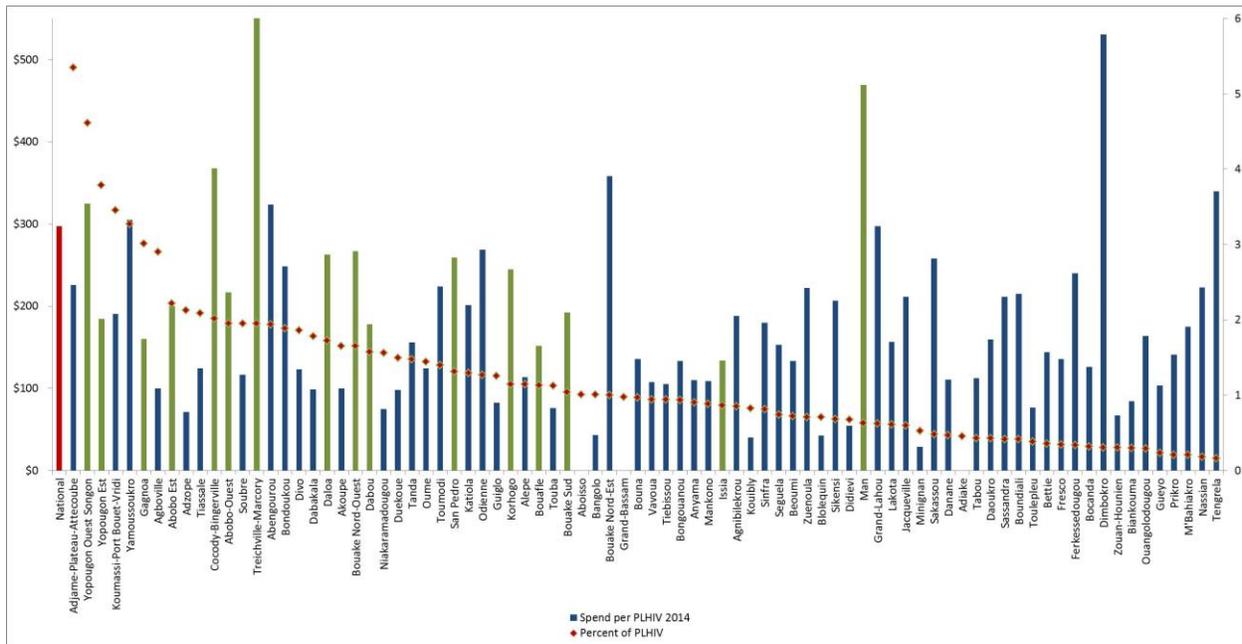
The USG will make investments to increase health staff's performance and accountability for HIV services through the development and implementation of a national quality approach for HIV health services, and evidence-based planning and budgeting for HIV. Further, the PEPFAR investments will support the implementation of the national strategy for performance based financing (PBF), focusing on the 15 scale-up districts.

The PEPFAR USG team, in collaboration with other stakeholders, will work to increase the participation of civil society at the programmatic and technical decision-making levels and advocate for launching the National Health Financing Committee with membership from the MSLS, the Ministry of Economy and Finance, and the Ministry of Budget.

1.4 Alignment of PEPFAR investments geographically to disease burden

The expenditure analysis information is useful for the COP planning exercise as a means of drawing attention to outliers and determining some unit costs. Calculations of prevalence and therefore burden used for COP 2015 strategic planning, however, have been informed by UNAIDS prevalence data, which is more current than the DHS data set which informed the EA. Therefore, some shifts in the rank order of districts by burden of modeled PLHIV used for COP planning will not align with the EA analysis recommendations.

Fig. 1.4.1: Expenditure and percent of PLHIV by district



As demonstrated in Fig. 1.4.1, expenditure per PLHIV is on average \$297 and ranged between \$17 and \$1,140. Upper limit outliers seem to be related to an inaccurate repartition of national and regional spending among districts. The districts that host the university hospitals, which are the national reference centers for care and treatment, have the highest expenditures per PLHIV, as do districts that host regional hospitals, regional directorates of health, and PEPFAR IP offices. Another element explaining the non-alignment of expenditure to disease burden is patient migration toward sites/districts perceived to provide better care and treatment, whether justified or not.

Lower limit outliers are potentially hiding missed opportunities. Four districts in the top third according to disease burden are obviously underfunded, at three times less than the national average. The effectiveness of interventions in those four districts (Gagnoa, Agboville, Adzopé, and Tiassale) needs scrutiny, as they host more than 7% of the national HIV burden and could be good targets for reinvestment of funds saved during the recent transitions. One of these districts (Adzopé) is a “scale-up to saturation” district, and the other three will see continuing investments as “aggressive scale-up” districts.

The EA tools and site expenditure assessment tool (SEAT) demonstrate that some reinvestments can be realized from the transition away from low yield HTC and PMTCT sites, but that the final dollar value of these shifts is a small fraction of the funds needed for overall expansion of the initiatives planned in scale-up districts for priority populations.

Analysis of sub categories of expenditures shows similar trends. The apparent overinvestment in Treichville is clearer when viewed through the lens of pediatric expenditure by district, and by the fact that the reference clinics serve a much larger population than just the local community, making the denominator incorrect. Two care and treatment partners are outliers for different reasons: one is an

international partner with a history of high cost, while the second is just starting and may need additional time before reaching its full efficiency. Finally, the EA has confirmed that the cost of finding positive patients through facility-based testing is largely lower than the cost of finding positive individuals with community-based partners.

Figure 1.4.2 Total expenditure, PLHIV, and Expenditure per PLHIV by district

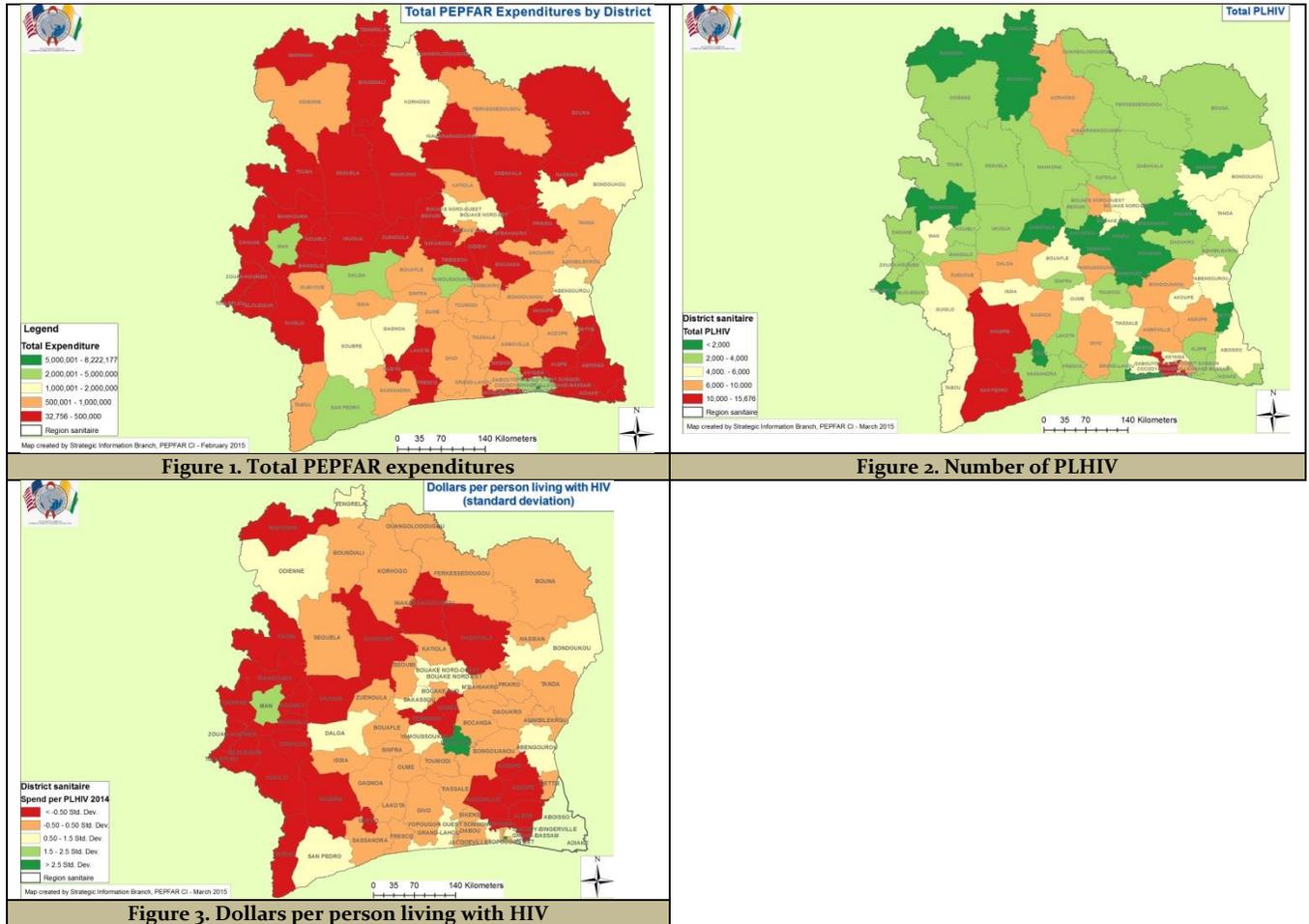


Figure 1. Total PEPFAR expenditures

Figure 2. Number of PLHIV

Figure 3. Dollars per person living with HIV

1.5 Stakeholder Engagement

The USG has a strong relationship with the GOCI, including frequent technical meetings and a regular standing meeting for PEPFAR leadership with the Director General for Health (DGS) and his executive team. Since September 2014, the USG has been communicating and negotiating the PEPFAR pivot and related strategic shifts in programming, including changes resulting from core/near-core/non-core discussions as well as program area targets. While deriving much of the strategic approach from assessments of data and program need, the PEPFAR team has presented COP 2015 approaches to counterparts within the MSLS, civil society and health sector donors. The close engagement with UNAIDS and the GOCI leadership throughout the SID development workshop also helped ensure buy-in and exchange on priorities for complementary investment.

Engagement with the Global Fund is primarily through the Country Coordinating Mechanism, or CCM (HIV committee, TB committee, Executive Bureau, and General Assembly). The recent addition of a GF Liaison to the PEPFAR team is helping to ensure better programmatic and strategic coordination, and the efforts continue to ensure complementarity of investment and effort in supply chain and policy issues, including advocacy for increased national resource allocations. Strategic shifts in PEPFAR programming have been shared through the HIV committee and Executive Bureau meetings. COP strategies, targets and budgets have been discussed with these groups, and their contributions are informing the pace and scope of the planned transitions.

The USG is committed to reinforcing inclusion of civil society in COP planning and advocacy efforts, building on regular engagement through national planning processes and technical discussions, as well as specific PEPFAR outreach efforts. To this end, we held a series of meetings to share PEPFAR's strategic shifts. Civil society networks also regularly participate in Global Fund CCM.

Private sector investments are an underutilized resource for expanding the national HIV response. While a range of enterprises are on the Global Fund CCM, neither PEPFAR nor the Government of Côte d'Ivoire has yet fully developed this partnership opportunity. The advocacy platform created by the development of the next five year strategic health strategy offers one means to bolster this effort.

COP 2015 efforts that will lay the groundwork for a future Country Health Partnership (CHP) include continued multi-stakeholder discussions regarding HIV financing. The Prime Minister asked the USG to participate in a joint committee on health financing, which has yet to be convened. This committee would establish processes and structures for joint decision-making on PEPFAR resource allocation as well as increase the Ministry of Health and the Fight Against AIDS's (MSLS) ability to gather and collate data across donors. The USG goal is to identify an HIV budget line and a growing commitment of domestic resources in addition to the mandatory match and "willingness to pay" contribution associated with the GF grants.

The PEPFAR costing studies, particularly for clinical services for pediatric and adult patients, and increased engagement on issues around health economics and finance will help identify potential cost efficiencies and resource mobilization plans by the GOCI. PEPFAR has been working in coordination with the Global Fund and UNAIDS to encourage better budget negotiations by the MSLS for the national HIV response and overall health care financing. The review of the current national plan and the development of a costed new five year strategic plan will allow PEPFAR to further advocate for accountability and transparency of budget decisions and expenditures in line with the priority needs.

2.0 Core, Near-Core and Non-Core Activities

During the COP 2014 process, the PEPFAR-CI team reviewed the entire portfolio and classified activities as Core, Near Core, or Non-Core. During COP 2015, the focus will remain on Core activities while transition planning will be focused on Near Core activities.

Activities classified as Non-Core were stopped during COP 2014, and are not part of this COP 2015 request, notably, for OVC: Life Skills in schools, renovations, and shelter; for prevention: school-based interventions, blood donor mobilization and hemovigilance committee support. General population HIV VCT and procurement of reagents for TB control are also no longer being funded. Some health system strengthening (HSS) activities were also scheduled to be completed during COP 2014: health and HIV financing studies, pre-service curriculum development for lab technicians, support to the laboratory accreditation program, and surveillance capacity building. Certain aspects of supply chain supports, including subcontracts for trucking/distribution routes, will be successfully transitioned by the end of COP 2014. HIV and family planning integration will be maintained through HIV service delivery points but not through family planning specific service delivery points.

Activities that were identified as Near Core-T have already been transitioned or are in the process of being transitioned. Cervical cancer screening transfer to the MSLS will be complete by September 2015, and the decentralized district health systems strengthening pilot program was adopted by GF. Hematology and biochemistry tests for patients in care will be transitioned to the MSLS.

While the earlier categorization of core/near core/non-core had listed technical assistance supports to the Global Fund mechanisms as an activity to be transitioned, the PEPFAR team continues to receive requests for assistance and to identify strategic areas of weaknesses which merit an extension of this aspect of the PEPFAR program. Global Fund TA therefore has been reclassified as Near Core.

3.0 Geographic and Population Prioritization

To achieve epidemic control, the PEPFAR program has prioritized geographically and by population group. Through a targeted case-finding strategy, PEPFAR will prioritize key populations (MSM and FSW), the military, adolescent girls and young women, TB patients, and the highest risk groups in the general population (e.g., clients of CSWs; women 15-24 years of age; higher risk adult men 35-49+ years of age) for HTC. OVC and children seeking clinical care will be targeted for pediatric case finding. Beginning in COP 2014, the PEPFAR program shifted its geographic emphasis to 14 focus regions based on prevalence and population density. For COP 2015, the team analyzed program data, surveys, new census data and district level modeling of prevalence rates as derived from UNAIDS reports, and will target those areas of highest HIV burden. Of the 79 health districts currently supported by PEPFAR in Côte d'Ivoire (the remaining three receive support from the Global Fund for clinical activities), , thirty-nine districts will be prioritized for scale-up, leading to 80% saturation for 16 districts by FY2017. With a highly focused and efficient strategy, PEPFAR aims to enroll 35,455 adults and 9,380 children on ART in COP 2015 for a total of 44,835 new enrollees and 166,712 total patients on ART (153,346 adults and 13,366 children). Coverage will increase significantly from COP 2014, but a gap to achieving epidemic control still exists. PEPFAR has estimated the annual cost of achieving the UNAIDS 90/90/90 goals by 2020 to be \$305 million, while current investments are less than \$200 million per year. However, the prioritization decisions the team is now making aim to narrow this gap by increasing efficiencies, while the team advocates for the GOCI to take on a greater portion of the national HIV cost.

4.0 Program Activities for Epidemic Control in Priority Locations and Populations

4.1 Targets for priority locations and populations

There are 20 health regions and 82 health districts in Côte d'Ivoire. In COP 2014, 14 focus regions were selected, with 64 districts and an estimated 301,204 PLHIV (81% of national total). PEPFAR's five maintenance regions with 15 districts have an estimated 61,076 PLHIV (17%). The remaining three-district region is supported by Global Fund, accounting for 7,720 PLHIV (2%).

For COP 2015, selection of priority locations was based on a finer geographic prioritization, based on an analysis of district-level population, number of PLHIV and prevalence data. Districts were ranked based on their total number of PLHIV. We also ranked districts by the most recent UNAIDS HIV prevalence estimates at the subnational level.

PEPFAR will scale up, aiming for saturation, in fifteen high-burden districts. Current coverage levels in some of these districts will be a limitation when considering the volume of additional net new patients needed for saturation in this time frame, but the projected rate of enrollment in these districts will increase two- to three-fold.

In 24 districts new enrollments will continue to increase by approximately 15%, which is the current calculated yearly progression rate. Combined across the scale-up districts, sixteen districts will have achieved the 80% coverage target by FY2017. In the forty sustained districts, passive enrollment will reduce by 50% the current progression rate. A total of 44,835 PLHIV will be newly enrolled on ART in FY 2016 (as reference: 28,148 in FY 2014).

Efforts to identify HIV positive people and link them into services will be augmented in the fifteen scale-up districts. Implementing partners (IPs) will reinforce community efforts to ensure as many PLHIV as possible are identified and enrolled into the clinical cascade. A task-sharing policy has recently been adopted and plans are being developed to train providers, which will increase the capacity in existing sites to serve a larger patient cohort. Tradeoffs include dramatically reduced support for broader population-based messaging, prevention, and testing as well as postponement or reconsideration of some HSS initiatives. The resources needed to support targets were based on unit expenditures by program area across the clinical cascade and systems strengthening activities needed for these districts, including laboratory, SI and supply chain management. Finally, the program will gain cost savings by reducing investments in the forty sustained districts and transitioning low yield PMTCT and HTC sites. These savings have been fed back into the clinical cascade to support higher targets in the scale-up districts.

As of FY2014, PEPFAR was supporting 129,993 patients on ART. This target will increase by 28% to 166,712 by the end of FY 2016, representing a projected net increase of 36,712 patients from APR 2014 to APR 2016.

In COP 2015, PEPFAR will continue to enroll patients currently in care at an accelerated rate, anticipating the rollout of ≤ 500 CD4 threshold (WHO 2013 recommendations) prior to the end of COP 2014 implementation. Testing sick adults and children will remain a high priority through PITC. With a prevalence of 25% among TB patients, the program aims to test all TB patients and enroll 90% of those identified as HIV-positive into care. HTC will be focused on key populations and priority populations, including females aged 15-24 and high-risk males aged 35-49 including military. For key populations, size estimations are underway, allowing more efficient targeting. Regarding PMTCT, elimination of support to no-yield and low-yield testing sites will be completed in COP 2014; following analysis to determine whether any warrant sustained of support for routine testing due to above-average prevalence to ensure this important population is still receiving services where necessary until further transition can be negotiated.

The 44,835 patients that will be newly initiated on ART include:

- 10,883 adults (TB patients, sick patients, adolescent girls, key and priority population)
- 5,412 children
- 5,653 pregnant women
- 22,549 pre-ART patients receiving clinical care who will be switched on ART due to the implementation of the WHO 2013 guidelines
- 338 infants from EID entry stream

The assumptions used in the clinical cascade were based on the current performance of the program and adjusted unit expenditures from the expenditure analysis (EA) that take into account anticipated additional programmatic efforts needed to reach saturation in the scale-up districts. Applying these unit expenditures to the defined targets resulted in costing out the clinical cascade; the budget meets the treatment earmark and supports the scale-up scenario in the priority high-burden districts.

Challenges in meeting the targets include: 1) efficiently rolling out the ≤ 500 CD4 threshold for ART; 2) locating hot spots of key populations; 3) ensuring testing amongst a minimum percentage of the populations; and 4) providing adequate support for testing and enrollment into care. Additionally, PEPFAR-funded clinical IPs have gone through significant shifts in strategies and footprint over the past two years, including a geographic rationalization, addressing low 12-month retention rates on ART, increasing coverage of pediatric ART, addressing low uptake and coverage of TB/HIV services, and supporting sites that were transitioned from the Global Fund. Moreover, IPs and PEPFAR do not have full control over site-level service provision because government-owned public health care centers face systemic challenges beyond HIV. These challenges include lack of motivated staff, limited access for remote populations, insufficient capacity of sites to continue enrolling patients, weak linkages between facility and community-based services for continuum of care, and the competing priorities and vision of health equity of the MSLS.

Availability of population data at subnational level is a challenge. Population data used in country is based on estimates and projections from the National Institute of Statistics based on the 1998 census. The 2014 census results are not yet available. UNAIDS subnational estimates do not always geographically align with other national data. For key populations, no national size estimates are available. PEPFAR is working with MSLS and other partners to consolidate data sets and for several size estimation surveys.

Proposed efficiency gains have been modeled using the clinical cascade tool. In the forty sustained districts, the enrollment rate will be at a minimum, with approximately 2,944 new enrollees beginning ART in FY 2016, representing about 50% of the current enrollment rate (APR 2014). The revised testing approach will allow for at least a 50% reduction in testing outside of PITC and reorientation of approximately \$5.1 million (compared to the COP 2014 planned HCT spending level) to other key areas in the clinical cascade, including adult and pediatric care and treatment activities.

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

	Scale-up to reach 90:90:90 - saturation districts
	Scale-up to reach 90:90:90 - aggressive districts
	Sustained districts

District	Estimated number of PLHIV (hyp: constant)	Expected Current on ART FY15	# additional patients required for 80% coverage	Expected Newly initiated on ART FY16	Expected Current on ART FY16
Treichville-Marcory	8837	18,194	-	2503	18498
Yopougon-Ouest-Songon	13433	11,365	-	979	10862
Abobo-Est	10052	5,610	2,431	2105	6833
Cocody-Bingerville	9124	5,820	1,480	1499	6518
Abobo-Ouest	8855	5,876	-	1351	6435
Daloa	8143	5,285	-	1299	5862
Yopougon-Est	11022	4,035	4,783	2120	5632
Korhogo	8049	4,157	-	1900	5358
Bouake-Nord-Ouest	7068	4,384	1,270	1300	5051
San-Pedro	10032	3,724	4,302	1898	4969
Gagnoa	7218	3,082	2,692	2100	4560
Issia	4063	2,607	-	700	2939
Bouaflé	4903	1,846	2,076	1499	2935
Man	5453	1,981	-	1020	2649
Dabou	4582	1,564	2,102	1501	2682
Bouake-Sud	4441	2,174	1,378	868	2437
Koumassi-Port Bouet-Vridi	15677	5,779	6,763	3997	8599

Adjame-Plateau-Attecoube	15579	6,009	6,454	3000	7960
Soubre	13620	2,454	8,442	2000	3907
Yamoussoukro	7642	2,694	3,420	1088	3354
Divo	7579	1,991	4,072	506	2265
Adzope	7357	1,098	4,788	663	1552
Agboville	7316	1,912	3,941	386	2049
Bongouanou	6342	1,729	3,345	505	1986
Duekoue	6287	889	4,141	319	1071
Abengourou	5926	2,319	2,422	546	2544
Tabou	5738	623	3,967	239	838
Bondoukou	4792	2,038	1,796	549	2301
Tiassale	4649	709	3,011	311	903
Guiglo	4584	987	2,680	232	1085
Tanda	4374	1,630	1,870	526	1914
Bouake-Nord-Est	4291	750	2,683	392	1265
Akoupe	4166	757	2,577	214	863
Anyama	4097	991	2,287	339	1179
Oume	4074	1,507	1,752	388	1687
Bangolo	3757	381	2,625	115	440
Mankono	3629	664	2,239	249	809
Sassandra	3535	904	1,925	272	970
Sinfra	3527	1,446	1,376	422	1660
Daoukro	3264	1,238	1,373	167	1257
Vavoua	3250	732	1,867	76	724
Danane	3123	1,148	1,350	185	1190
Dabakala	3051	565	1,877	86	582
Niakara	3044	427	2,008	64	439
Katiola	2996	685	1,712	100	701
Agnibilekrou	2967	1,447	927	151	1431
Ferkessedougou	2945	1,274	-	164	1287
Toumodi	2888	1,141	1,169	110	1122
Alepe	2874	549	1,750	77	559
Bouna	2771	527	1,690	63	528
Odiene	2748	632	1,566	117	669
Kouibly	2717	321	1,853	35	319
Seguela	2677	643	1,498	101	665
Zouhan Hounien	2609	445	1,642	101	488
Beoumi	2578	438	1,624	75	456
Lakota	2484	844	1,143	89	791
Touba	2337	89	1,781	40	113
Bolequin	2323	174	1,684	34	185

Fresco	2158	548	1,179	76	559
Ouangolodougou	2051	523	1,118	48	511
Grand-Lahou	2000	387	1,213	38	381
Biankouma	1910	399	1,129	67	416
Boundiali	1880	904	600	103	902
Gueyo	1865	156	1,336	31	166
Tiebissou	1801	366	1,074	78	396
Sikensi	1719	163	1,212	29	172
Zuenoula	1633	862	444	113	872
Bocanda	1567	445	809	56	448
Jacqueville	1559	206	1,041	37	217
Dimbokro	1513	992	-	128	1001
Didievi	1290	89	944	19	96
Sakassou	1271	519	498	95	548
M'bahiakro	1265	218	794	25	218
Toulepleu	1253	79	924	14	83
Minignan	1140	73	839	18	81
Bettie	1096	151	726	25	157
Prikro	1027	274	548	53	291
Nassian	462	96	274	17	100
Tengrela	379	157	146	31	168

Table 4.1.2 Entry Streams for ART Enrollment (FY 2016)

Entry Streams for ART Enrollment	Tested for HIV (in FY16)	Identified Positive (in FY16)	Enrolled on ART (in FY16)
Targeted Testing			
Adults	240,304	18,604	10,883
Sick patients	240,304	9,972	5,833
Military	6,000	252	147
Adolescent girls	10,000	80	47
TB diagnosed patients	23,000	5,750	3,364
MSM	5,000	900	527
FSW	15,000	1,650	965
Children	136,542	9,397	5,413
Malnourished	11,800	708	408
In-patient/hospitalized	3,644	364	210
TB diagnosed patients	500	75	43
TB suspects	2,000	200	115
Other out-patients	47,930	2,397	1,380
OVC	70,668	5,653	3,256
Pregnant Women	350,000	7,000	5,653
HIV-positive Patients on clinical care			
Adults (57,333)			22,549
Children (4,536)			18,920
			3,629
EID	10,300	450	338
Total	737,146	35,452	44,835

Table 4.1.3: N/A (Voluntary Medical Male Circumcision)

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNUs)	Coverage Goal (in FY 2016)	FY 2016 Target
Men who have sex with men (MSM)	23,687	60%	14,212
Female sex workers (FSW)	88,792	60%	53,275
Females 15-24	2,266,123	5.6%	128,171
Men 35-49	3,077,199	1.5%	45,029
Military	40,000	6.9%	2,750
Total	4,462,329	5.3%	243,437

Table 4.1.5 Targets for OVC and Linkage to HIV Testing, Care and Treatment

Regions and Districts	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
Abidjan 1 Grands Ponts	8,489	30,084	15,069	18,570	1,328
Adjamé-Plateau-Attécoubé	2,762	15,124	7,572	8,263	378
Dabou	812	2,701	1,354	2,912	130
Grand-Lahou	307	879	444	210	18
Jacqueville	266	976	492	226	10
Yopougon-Est	1,957	6,346	3,175	4,542	270
Yopougon-Ouest-Songon	2,384	4,058	2,032	2,417	522
Abidjan 2	11,192	39,980	20,023	27,438	2,306
Abobo-Est	1,986	4,567	2,287	4,274	324
Abobo-Ouest	1,749	4,023	2,015	3,026	311
Anyama	809	1,482	745	840	58
Cocody-Bingerville	1,804	7,957	3,986	4,155	307
Koumassi-Port Bouet-Vridi	3,098	14,244	7,130	9,568	414
Treichville-Marcory	1,746	7,707	3,860	5,575	892
Agneby-Tiassa-Me	4,826	18,061	9,046	6,970	292
Adzopé	1,371	3,342	1,674	1,831	74
Agboville	1,234	6,330	3,168	2,208	100
Akoupé	703	3,605	1,806	1,247	42
Alépé	485			10	28
Sikensi	290	762	383	175	8
Tiassalé	744	4,022	2,015	1,499	40
Bélier	2,155	3,472	1,738	2,506	233
Didiévi	192			0	6
Tiébissou	267			4	19
Toumodi	447			6	54
Yamousoukro	1,250	3,472	1,738	2,496	154
Bounkani-Gontougo	2,161	13,900	6,962	4,065	226
Bondoukou	811	4,738	2,371	1,638	109
Bouna	490	3,528	1,767	614	20
Nassian	78	1,512	759	263	6
Tanda	782	4,122	2,065	1,550	91
Cavally-Guemon	3,886	10,889	5,453	3,870	146
Bangolo	713	2,246	1,126	765	23
Bloléquin	427			1,604	8
Duekoué	1,223	6,029	3,018	1,159	51
Guiglo	865	2,614	1,309	338	47

Kouibly	499			4	15
Toulepleu	160			0	2
Gbeke	3,794	20,640	10,336	9,255	459
Béoumi	485	1,515	761	412	22
Bouaké-Nord-Est	839	3,713	1,860	1,349	40
Bouaké-Nord-Ouest	1,383	10,774	5,390	4,822	240
Bouaké-Sud	868	3,842	1,925	2,461	131
Sakassou	219	796	400	211	26
Gbokle-Nawa-San Pedro	7,408	17,491	8,756	10,897	526
Gueyo	398			2	8
San-Pedro	2,126	8,048	4,027	4,829	241
Sassandra	757	1,284	643	735	46
Soubré	2,859	6,499	3,253	4,636	188
Tabou	1,269	1,660	833	695	43
Gôh	1,907	6,099	3,056	5,275	297
Gagnoa	1,193	5,077	2,542	4,438	222
Oumé	715	1,022	514	837	75
Hambol	1,366	5,307	2,660	1,266	78
Dabakala	421	1,890	949	330	27
Katiola	489	3,417	1,711	934	32
Niakara	456			2	19
Haut Sassandra	3,030	6,069	3,039	4,763	456
Daloa	1,618	4,271	2,138	3,242	273
Issia	808	1,798	901	1,511	147
Vavoua	604			10	36
Indenie-Djuablin	1,818	4,056	2,034	1,918	194
Abengourou	1,067	2,692	1,347	1,556	121
Agnibilékrou	554	1,178	592	312	65
Bettié	197	186	95	50	8
Kabadougou-Bafing-Folon	977			10	36
Minignan	180				2
Odienné	435			6	28
Touba	362			4	6
Loh Djiboua	2,393	7,949	3,979	2,580	167
Divo	1,465	7,119	3,563	2,379	104
Fresco	447			2	27
Lakota	480	830	416	199	36
Marahoue	1,916	2,564	1,293	3,521	271
Bouaflé	960	1,245	628	2,534	146
Sinfra	691	774	390	833	81
Zuenoula	265	545	275	154	44
N'Zi-Ifou	3,109	16,702	8,364	5,110	249
Bocanda	315	3,718	1,862	968	18
Bongouanou	1,329	5,488	2,746	2,166	97

Daoukro	693	1,731	868	463	61
Dimbokro	303	2,993	1,499	788	49
M'bahiakro	263	2,772	1,389	723	10
Prikro	206			2	14
Poro-Tchologo-Bagoue	3,193	23,124	11,576	9,062	392
Boundiali	372	4,198	2,103	1,141	44
Ferkessedougou	633	3,271	1,638	894	59
Korhogo	1,695	14,776	7,391	6,784	256
Ouangolodougou	432	879	444	241	25
Tengrela	62			2	8
Sud-Comoé	2,389				
Aboisso	1,154				
Adiaké	522				
Grand-Bassam	713				
Tonkpi	2,782	2,734	1,371	2,240	227
Biankouma	398			4	19
Danané	653			14	57
Man	1,171	2,734	1,371	2,218	128
Zouhan Hounien	561			4	23
Worodougou-Bere	1,208	1,820	912	856	67
Mankono	704	1,820	912	852	34
Séguéla	504			4	33
Total	70,000	230,941	115,667	120,172	7,950

As mentioned in section 5.0, approximately 39,000 OVC will receive continuing services in sustained districts in COP 2015; Global Fund partner Alliance supports 10,000 OVC nationally.

4.2 Priority Population Prevention

PEPFAR will implement combination prevention (ART for Prevention, PMTCT, Condoms, and HTC) in the areas of highest need based on HIV prevalence and population density, reducing incidence in these focus areas. PEPFAR strategically assessed all funded activities in the COP 2014 process and prioritized them to ensure the greatest impact.

Priority populations will include key populations (KP) (Men who have Sex with Men [MSM], Commercial Sex Workers [CSW]), military, and the highest risk groups in the general population (e.g., clients of CSWs; women 15-24 years; higher risk adult men 35-49+ years). Populations outside of these high-risk groups will no longer be served in an effort to achieve impact and control the epidemic. Prevention IPs will focus on condoms, active referrals to HTC and PMTCT, and evidence based sexual prevention programs. The nationally validated minimum package of services (e.g. sexually transmitted infections [STIs] and opportunistic infections [OIs] diagnosis and treatment, HTC, condoms, sexual prevention, ART and care, family planning [FP] services) for MSM and CSW will continue to be supported. In COP 2015, prevention programs will focus on creating demand for HTC for all key and priority populations, and

increasing the HTC rates among KPs to 44% or more. For the KPs, stronger emphasis is also being placed on the clinical cascade and ensuring that those who test positive receive care and treatment, including increased access to viral load testing.

Significant changes in the prevention portfolio will include substantial geographical and population shifts. PEPFAR IPs conducted a mapping exercise in June 2014, with an aim to reducing incidence in priority and key populations within higher burden geographical areas. COP 2015 will narrow the focus down to highest burden districts within those regions. Priority population prevention programs will be clustered around clinical services in these districts to strengthen linkages to HTC and PMTCT and to ensure HIV positive individuals receive care and treatment. For KPs, strategic information on micro hotspot mapping, size estimation, and HIV prevalence will be utilized for effective targeting. For the military, program implementation will focus on areas of highest HIV prevalence based on the 2014 Seroprevalence and Behavioral Epidemiology Risk Survey (SABERS) study.

Condom programming is a critical gap in the Côte d'Ivoire program for both Prevention and Care and Treatment partners. A new condom program to address this gap is underway. A standard operating procedure document has been drafted for all IPs. There is currently a large supply of condoms (both male and female) and lubricants at the national warehouse. The critical gap is demand and the distribution of condoms by the individual IPs to their beneficiaries. Recent awareness-raising among PEPFAR staff and renewed emphasis on condom programming within IPs should help to focus resources and energy in this vital prevention area.

In COP 2014, PEPFAR strategically assessed all funded activities within each IP to determine which were core, near core, near core-transitional, and non-core. Partners shifted activities to the fourteen focus regions and to populations of higher risk and/or prevalence. Geographic areas (e.g., Hambol and Loh-Djiboua) and populations (e.g., young boys, parents, families of uniformed services personnel) outside of those domains are no longer supported, and partners were asked to withdraw from these areas by quarter two in FY 2015. However, geographic intervention areas will be revised in light of COP 2015 decisions.

SIMS visits revealed gaps in the referral and counter-referral systems between community and clinical partners, and between reproductive health and PMTCT services. Gender programming and condom access were also identified as challenges. Improvements are needed in performance management, policy and practice, and service quality. Individual IP improvement plans are now being implemented.

4.3 Prevention of mother to child transmission (PMTCT)

From 2004 to September 2014, with support from PEPFAR, the coverage of PMTCT services has increased from 26 sites in 3 health regions to 868 sites in 20 health regions, providing HIV testing and counselling services to 605,172 pregnant women, and reaching 16,122 HIV positive clients with ARV prophylaxis. The neonate infectivity rate is currently at 3% for newly-enrolled women, and 2% for women who used ART prior to becoming pregnant, which is below the current e-MTCT goal of 5%.

Since 2012, PEPFAR has supported the GOCI in adopting the e-MTCT initiative. Through the central PMTCT/ART integration funds, Côte d'Ivoire is making the transition from PMTCT Option B to B+ through development of materials, procedures, tools, and systems for quality program implementation. With this funding, implementation of PMTCT Option B+ formally starts in April 2015.

The COP 2015 PMTCT strategy is aligned with the e-MTCT goal to reduce MTCT to less than 5% by 2015, place 95% of HIV positive pregnant women on ART by 2015, and provide early infant diagnosis (EID) to 70% of exposed infants. COP 2015 strategies will include the following:

- 1) Geographic prioritization to focus on high yield sites (more than 4 HIV positive pregnant women per year)
- 2) Operationalization of the B+ M&E system (M&E Framework)
- 3) Involvement of 50% of PMTCT sites in the Rapid Test Quality Improvement Initiative (RTQII) and CD4 testing using point-of-care equipment
- 4) Integration of PMTCT with family planning services Sustainability planning
- 5) Reduction and redirection of PEPFAR support from 868 PMTCT sites to 466 higher yield sites located in 39 scale-up districts.

All PEPFAR sites will be supported to use the B+ M&E Framework. PMTCT registers and forms are being updated to meet PEPFAR specifications and will be scaled up in 2015. SIMS data in the PMTCT domain show that ART in labor and delivery, EID, and enrollment of HIV-infected infants in care and treatment services need to be improved, with 43.9% of services surveyed receiving either red or yellow scores. Emphasis will be placed on the provision of a full package of support including focused capacity building, mentorship, data quality assurance, and reporting support in these districts.

Fifty percent of PMTCT B+ sites will participate in the national RTQII. The PMTCT team will work closely with the laboratory team to scale up to all sites in FY 2017. To support FP integration goals, the PEPFAR team will advocate that PMTCT sites be prioritized as the GOCI scales-up availability of family planning across health platforms. The national target is that 100 percent of health sites will provide FP services; current coverage is only 75%. Robust referrals to high quality FP sites will be emphasized and PEPFAR will prioritize the scale-up of integrated family planning into MNCH programs at 40% of PMTCT sites in FY 2016. Supported sites will align with the USG regulations on FP compliance.

In Côte d'Ivoire, PEPFAR supports PMTCT services by providing critical support to the sites (ARVs and other commodities, salaries for critical health care workers) and routine technical visits to the sites (at least quarterly for all sites, regardless of district type). PEPFAR-CI is collaborating with other donors to support implementation of PMTCT Option B+, working with UNICEF and the GF on issues of coordination, monitoring, community engagement and commodities.

The role of community is important when addressing ANC uptake and retention. PEPFAR is advocating for a national community health workers cadre strategy, including the use of community and lay counselors in facilities and the community setting for a strong continuum of care. Peer support groups

for mothers will also be used. A holistic model of support for the needs of pregnant and breastfeeding women, including family planning, nutrition, and links to OVC and community care platforms are critical to achieving COP 2015 PMTCT strategies and targets.

4.4 HIV Testing and Counseling

Clinics will continue to provide provider-initiated testing and counseling (PITC) for symptomatic adults and children (including TB patients and OVC). PITC will account for about 72% of the HTC targets, and the remaining 28% will be dedicated to community-based testing focusing on MSM, CSW, family members of index cases (including discordant couples), and priority populations (e.g., , young women aged 15-24 years, OVC, military, and higher-risk men aged 35-49+ years).

In COP 2014, general population testing has been phased out, as has stand-alone voluntary counseling and testing centers, to refocus on key and priority populations and PITC in health care settings to achieve a higher yield. Community partners both create demand for HTC and provide linkages to HTC and other care and treatment services. To improve traceability, the referral and counter-referral systems among all services need to be improved and are a priority. Pregnant women will comprise the bulk of people tested, with other high prevalence populations contributing to the total number. The HTC program will improve targeted testing of pediatric and adolescent cases through inpatient and outpatient services (e.g., TB, nutrition programs, OVC services) to increase children's access to treatment services.

A 2014 national law will require premarital HIV tests, prohibits discrimination against individuals who are HIV positive and mandates HIV status disclosure for sexual partners. Implementation and enforcement has yet to be seen, although the National Assembly is taking steps to publicize the law among constituency groups. To date, it has not resulted in any programmatic shifts or implications. The large strategic shifts in global PEPFAR priorities resulted in significant modifications to implementing partner HTC activities. The largest shifts in COP 2014 were the phasing out of low- and no-yield HTC sites based on APR 2014 results. The definition of "no-yield" is 0 HIV+ individuals identified over a 12-month period (70 sites), and "low yield" is defined as identifying 4 or fewer HIV+ individuals over a 12-month period (268 sites). Based on this threshold in COP 2014, PEPFAR/CI is transitioning out of 334 HTC sites which represent about 37% of the total 916 HTC sites. Transition plans were developed with the MSLS and IPs and implementation began in December 2014.

In COP 2015, PEPFAR will provide full support, including training, coaching, minor rehabilitation, routine site visits, laboratory support, and commodities, to the remaining higher-yield HTC sites in the scale up districts. Assessments of these HTC transition efforts show the program will realize modest cost savings, which will be reinvested in higher-yield sites to improve the identification of HIV-positive individuals, particularly children and adolescents, and linking them to care and treatment.

The PEPFAR lab team will support about 1,200 HIV testing points, , including community, military, PMTCT, and laboratory, to strengthen quality assurance methods and provide proficiency testing panels.

The quality assurance program will include two phases of the rapid test quality improvement training package (RTQII) for all HTC sites, which includes a training package on HIV quality assurance, quality assurance tools, monitoring site performance, and assessing the impact of the RTQII. PEPFAR will support the sustainability of HTC by strengthening human resource capacity and building linkages between community and facility services, especially for effective counter-referral.

The first round of SIMS was implemented in September 2014 and included nine HTC sites (six in health care settings and three community-based sites). Common challenges included: 1) quality assurance issues in 71% of sites; 2) lack of HIV patients who were adequately referred to CD4 tests and other care and treatment services; and 3) site level HIV proficiency testing with three sites having scored >50% in the HTC SIMS tool. The PEPFAR team developed individual IP improvement plans based on SIMS visits and will review them in subsequent visits.

4.5 Facility and Community-Based Care and Support

In alignment with Côte d'Ivoire's strategy and priorities for achieving treatment saturation and quality health outcomes, PEPFAR will support a strategic package of core and near-core care and support services in scale-up districts. The package of care and support services includes as Core: Index case-based family testing, TB testing, MER data collection, analysis, and reporting, data quality assurance (DQA), and program evaluation, SIMS and DATIM, TB screening, referral, and infection control, FP counseling and referral for HIV+ women, home-based continuum of care to improve retention, PHDP, GBV/HIV referral networks (specifically through social centers) and social worker accompaniment to clinical, post-rape care, PEP, and community sensitization for ANC uptake. Near Core: nutritional assessment and counseling, laboratory screening for blood transfusion, injection safety, coordination of national GBV/TWG, coordination of social services response for OVC, targeted mobile testing in scale-up districts, ART services in low volume sites, periodic surveys and surveillance: AIS, ANC, monitoring and evaluation capacity building, data analysis and data management systems (HMIS, LMIS), support to the central medical store, support the GF implementation, support for implementation of task sharing, hematology, STI and biochemistry for ART in sustained districts, laboratory equipment maintenance and repair and biosafety, and in-service training (LIS), and point-of-care (POC) evaluation. Activities related to cervical cancer prevention will be transitioned by September 2015.

As of APR 2014, 99% of HIV patients over 15 years of age were reached with a minimum package of positive health, dignity, and prevention (PHDP) interventions; 91% of patients (adults and children) with advanced infection were newly enrolled on ART (28,236); 129,993 adults and children with advanced infection received ART representing a 104% target achievement, while 186,159 out of 186,477 (99.8%) HIV positive adults and children were provided with a minimum of one care service. Of all PLHIV, 93,302 (83%) received cotrimoxazole (CTX) prophylaxis.

Based on the APR 2014, the 12 month adult ART retention rate is 70% compared with a 75% target. Improving retention in care for both ART and pre-ART patients remains a high priority, and community-based platforms are essential to achieving this goal. Robust community-based programs will aim to

facilitate continuity of services for PLHIV and their families, ensuring a linked continuum of response from clinic to household, with the social centers as critical service delivery points. Interventions include community-based PLHIV support groups, community distribution models for ARVs, demand creation and service promotion within the community, matched and peer mother approaches to PMTCT, and PHDP services both at sites and at the community level, as well as other innovative strategies to keep people in care and ensure that they initiate ART when eligibility criteria are met. Initial SIMS visits have shown that improvement is needed in facilitating linkages between facility and community-based services; PEPFAR is working with the MSLS to reinforce the existing national guidelines and tools for tracking linkages between services through active referral and counter-referral. Efforts are also in place to improve linkages from HTC to care and care to community-based services.

The Government of Côte d'Ivoire is adopting a policy framework more conducive to achieving the ambitious COP goals. The recent recommendations related to treatment of all HIV-infected children less than 10 years of age regardless of CD4 count, the tasks shifting/sharing policy, the PMTCT/ART integration activities, and the implementation of the recommendation to initiate ART for all patients with $CD4 \leq 500$ will be implemented over the coming two years. A large proportion of the COP 2014 treatment targets will be reached by enrolling newly eligible patients currently in care and PMTCT services, the team is confident that additional beneficiaries will be enrolled in care and pre-ART services during COP 2015 at an accelerated rate due to some of these policy shifts. Community-based promotion of services and interventions for retention within services will be critical for this success.

PEPFAR will also prioritize access to ART for key and priority populations through targeted testing and treatment of those infected and by reinforcing strong linkages between demand creation and service promotion, outreach prevention, targeted, community-based and mobile testing, and clinical care and treatment services.

4.6 Tuberculosis and HIV co-infection (TB/HIV)

According to the World Health Organization (WHO), the 2012 TB incidence was 172 cases per 100,000 inhabitants. In 2013, 25,299 TB cases were reported, and of these, 24% were co-infected TB/HIV; 54% received ART and 77% received cotrimoxazole (CTX).

The FY 2014 APR data indicates that only 64% of PLHIV were screened for TB, including 1% of children at PEPFAR-supported sites. Recent policy shifts will help redress these challenges. First, PEPFAR will move to a TB/HIV integrated care model at 177 TB clinics currently providing ART to HIV/TB co-infected patients. PEPFAR IPs will organize in-service trainings for all nurses working in all TB clinics where ART is currently provided to TB/HIV co-infected patients by referral. These trainings will enable the nurses to provide ART to eligible patients without the necessity of seeing a doctor. Furthermore, PITC will be provided for 90% of TB and all presumptive TB patients across the country as well as maintaining at least 80% of TB/HIV patients on ART. PEPFAR CI's TB approach is not delineated by district type due to TB's status as the primary cause of death among adults infected with HIV in CI.

SIMS results show that there are still many challenges around TB/HIV activities, with low marks for TB screening among PLHIV and TB infection control. Reports and recommendations were sent to IPs and HCW coaching will be reinforced at sites to address these challenges.

PEPFAR IPs will strengthen TB screening among PLHIV, reinforcing coaching of HCWs in HIV clinics, and extending this activity to HIV positive pregnant women as an integral part of the MCNH comprehensive package. IPs will also support intensified TB screening among HIV positive children, taking all opportunities to reach HIV positive children health system entry points. PEPFAR CI's target is to reach 80% of PLWHA who received at least one clinical care service with TB screening.

As a near-core activity, IPs will continue TB infection control activities to prevent TB transmission to HCW and other patients. Non-core activities, like commodity supply for TB infection control, have been successfully transitioned to the Global Fund.

PEPFAR will continue support to PEPFAR IPs for the coordination, implementation, and expansion of MDR-TB detection, and continued support to the regional reference laboratory network for decentralization of opportunistic infection diagnosis capacity. PEPFAR will provide support to build capacity within the national laboratory network with the intention that PEPFAR IPs, the TB laboratory network, and at least 14 regional hospitals will be able to deliver quality laboratory diagnostics of HIV/AIDS related opportunistic infections, particularly TB and STIs. The award should directly contribute to the improvement and availability of quality laboratory testing in the country, improve TB, STI, and other HIV-related opportunistic infection surveillance, improve the quality of laboratory data, and strengthen infrastructure and capacities in microbiology.

As part of the coordination planning among stakeholders, PEPFAR works on care and support, PHDP and retention and adherence to ART with TB/HIV co-infected patients. Global Fund works on DOTS strategy for TB control and sputum transport while French programs support HIV testing for incarcerated TB patients.

4.7 Adult Treatment

PEPFAR will continue to support a standard package of ART services in 39 scale-up districts, including sites with TB/HIV co-infected patients and HIV-positive pregnant women. In these districts, the program will increase the total number of patients on ART in Côte d'Ivoire to 166,712 by the end of COP 2015. This strategy will yield 80% or higher treatment coverage in two districts in FY 2016 and 16 districts in FY 2017, funds permitting. Patients in sustained districts will continue to receive the same ART services with a focus on retention. PEPFAR will transition support to low volume ART sites (fewer than 25 patients currently on ART), linking patients to the nearest high volume ART site, fully transitioning low volume ART sites to MSLS in COP 2017.

PEPFAR continues to assist the National HIV/AIDS Care and Treatment Program (PNLS) to expand implementation of the revised national ART guidelines and to reduce the number of ART protocols and

regimens to the strict minimum. Procurement and distribution of ARV drugs and laboratory commodities have improved in FY 2014 with reduced stock-outs at the central pharmacy and site level. PEPFAR improved reporting from sites and districts and supported extension of a revised electronic patient medical record software that includes a functioning pharmacy module. Quality-improvement efforts continue to focus on the program's family-centered treatment approach and PEPFAR will support the implementation of the WHO 2013 ART guidelines adopted in FY 2015. The service delivery package for adult ART includes routine clinic visits, ARV drug, laboratory monitoring (CD4, hematology, biochemistry and VL), and active patient tracking for improved retention, PEP, and support for sample transportation.

As of September 2014 (APR 2014), 28,236 patients, both adult and pediatric, with advanced infection were newly enrolled on ART (91% of FY14 target); 129,993 adults and children with advanced infection received ART representing 104% target achievement. The percentage of adults and children known to be alive and on treatment 12 months after initiation of ART was 70%, below the FY 2014 retention target of 75%. Improving patient retention on ART remains a high priority. High retention rates are observed among some partners due to large investments in capacity and human resources at the site level. PEPFAR IPs are utilizing community support groups and other innovative strategies (e.g. keeping desk diaries to monitor daily patients' appointments, conducting monthly cohort analysis and monitoring for patients six and twelve months after ART initiation, and automated reminders) to actively track and keep people on ART.

SIMS visits have shown that patient tracking and a linkage between ART services and community services needs improvement. The testing cascade between the number of clients testing positive and number of patients currently on ART is concerning; based on partial data from APR14, almost 33% of positive patients did not have a baseline CD4 count to assess their eligibility to ART because of inefficiencies in the referrals system. The program will continue to work to harmonize care and treatment activities at ART sites between clinical and community-based partners. To that end, clinical IPs are revisiting standard operating procedures and making sure patients who need ART are receiving effective treatment. Moreover, partners are working on strengthening the linkages between facility and community-based services and are sharing best practices. Community counselors will be used for testing as well as follow-up of ART patients in the community. In alignment with the UNAIDS's goal of achieving viral suppression for patients receiving ART, PEPFAR will continue to assist MSLS in scaling-up access to VL.

The 2013 WHO treatment recommendations will result in up to 48% of patients currently in pre-ART becoming treatment-eligible, a cohort of over 20,000. Task sharing will be implemented nationwide with a focus in TB clinics where nurses already provide TB drugs to patients.

Building on lessons learned from the PEPFAR-supported pilot ART service provision within private medical clinics, a policy of expanding access to ART services will be adopted and guide expansion of ART in other private-for-profit clinics in high burden districts. This aspect of our work will increase service coverage and contribute to the sustainability of the national response.

4.8 Pediatric Treatment

PEPFAR will increase pediatric case finding, improve adherence and retention, and advocate for policy change. A national process to adopt new guidelines to initiate ART for all children under ten years and for those 10-14 years old with CD4 < 500 is underway. PEPFAR has worked closely with key stakeholders to define innovative strategies to increase pediatric care and treatment coverage. Although Côte d'Ivoire is not a recipient of Accelerating Children's Treatment (ACT) funding, the ACT technical approaches and objectives are evident in COP 2015 strategies to reinforce linkages between the community OVC program and key entry points at the health facility level. As part of the policy priorities, PEPFAR is working on a task shifting plan focused on training nurses and midwives to initiate HIV care and treatment and on ensuring that clinical staff are trained on the latest ART guidelines.

The number of children receiving ART nationwide has increased by 18% from 5,620 (2013) to 6,610 (2014), with children under 15 years old accounting for approximately 5% of the total of number of people on ART. However, current pediatric ART coverage is disproportionately low at 8% compared to 36% adult ART coverage (2014 UNAIDS GAP Report). PEPFAR will continue to scale up pediatric ART coverage in support of epidemic control in high burden districts. Key priorities for pediatric and adolescent care and treatment for COP 2015 include increasing ART coverage, improving TB screening, NACS, and increasing systematic and routine HIV testing of all children, including:

- 1) Children of adults receiving HIV services (including PMTCT and TB/HIV),
- 2) Children in hospital/inpatient settings,
- 3) OVC beneficiaries,
- 4) Malnourished children,
- 5) Children with TB

The COP 2015 goal is to ensure that the majority of high-yield HTC and PMTCT sites offer testing for children and adolescents and systematically treat (and retain) all infected children under 10 years old. Ensuring systematic testing for at least 75% (70,668) OVC through strong collaboration between facilities and community settings is a priority intervention. PEPFAR is also working with its IPs to routinely collect and analyze testing yield data from each of these identified pediatric testing points.

Collaborations and cross-referrals between clinical HIV programs and national social welfare/community based support systems will be strengthened. Linkages between HIV testing and prevention programs will focus on at-risk adolescents and young women. PEPFAR will push for adoption and implementation of DREAMS strategies such as condom promotion and provision, HIV testing and counseling, post violence care, and improved access to sexual/reproductive health services.

The PEPFAR program will support GOCI to define and roll out a standardized adolescent package of care, including adolescent-friendly health services covering issues related to school, adherence, disclosure, sexuality/reproductive health, and stigma. PEPFAR will continue to reinforce clinical partners' family-centered approach.

To facilitate early identification of treatment failure and address the issue of sample transportation, viral load testing (VL) will be prioritized. PEPFAR will prioritize decentralization of VL access in scale-up districts by opening two new laboratories for a total of eight PEPFAR-supported regional VL laboratories. It is anticipated that 75% of children on ART will receive VL tests in FY 2016. Other donors have planned the purchase of additional four VL machines.

PEPFAR is conducting studies on the cost of HIV treatment in Côte d'Ivoire and pediatric outcome evaluation, with results expected in Q4 of FY 2015. During COP 2015, PEPFAR will use pediatric and adult treatment costing data to advocate with GOCI for national budget allocation and strategic investments for future programming.

PEPFAR is working with MSLS and other key stakeholders to address pediatric bottlenecks including case identification and linkage to care and treatment services through joint target setting, formalized linkages, referral networks, leveraging community contributions, and coordinated messaging. Initial SIMS visits have shown that improvement is needed in the dissemination of job aids, implementing procedures, documentation of linkages between health facilities and community services, and development of a family centered approach to build parental and caregiver capacity to care for children living with HIV.

4.9 Orphans and Vulnerable Children (OVC)

The OVC program has strategically made geographic shifts to maximize synergies and linkages with other PEPFAR-supported HIV and AIDS services. By aligning to the highest burden districts, the OVC program will work with PMTCT, HCT, pediatrics, and adolescent prevention programs to ensure a robust community platform to respond to the socioeconomic, health and psychosocial needs of children infected and affected by HIV/AIDS. A critical component of this strategy is ensuring HIV positive children and adolescents are referred to OVC services and given additional retention and adherence support. In sustained districts, PEPFAR will ensure that currently enrolled OVC continue to receive integrated high-quality intervention packages, while working on transition plans with the GOCI and other donors. PEPFAR will transition support for these programs no later than the end of FY 2017, as mandated by OGAC.

The GOCI adopted several new OVC-related policies, including a new social protection policy, a child protection policy, and school-based campaigns to reduce teenage pregnancies and violence in school. These national strategies and PEPFAR guidance for the ACT and Determined, Resilient, Empowered, AIDS-free, Mentored and Safe lives (DREAMS) initiatives have informed COP 2015 approaches towards ensuring complementary holistic, family and child-focused programming. For example, while scaling up pediatric care and support, OVC health needs will be prioritized and

community-clinical linkages reinforced. Similarly, the OVC platform will target adolescent girls for prevention, care, and treatment services, as well as for GBV prevention and education, mentoring, and economic strengthening.

OVC programs, due to their extensive household and community-based activities, have an important role to play in identifying children at risk and supporting their access to HCT. Community-based partners will emphasize OVC-linked testing strategies, using social center platforms and index case testing with OVC families. Because a community-based approach to supporting children affected by HIV and AIDS rooted in sound community development principles is essential, PEPFAR will continue to build capacity of social centers as critical service delivery points for OVC interventions. These community-based strategies emphasize inclusion and social protection for the most vulnerable members of communities.

The PEPFAR-CI OVC program prioritizes family-centered, age-appropriate models of care and support. Community-based health, psychosocial, and socioeconomic services are essential to the success of the PEPFAR-CI strategy, as is expanding coverage and reach and facilitating continuity of services for PLHIV and their families. The program builds the capacity of the social welfare workforce through systems capacity investments to ensure psychosocial support for OVC and their families. PEPFAR provides block grants to ensure enrollment and retention in school, especially for girls, and household economic strengthening activities to improve families' abilities to support OVC health, nutrition, and education needs. Non-core OVC activities (shelter, life skills in school, emergency one-off feedings) have stopped; activities that continue are core (healthcare referrals, legal and social protection, HES & education for OVC and families, nutrition – coordination of NACs, positive parenting and psychosocial support) and near-core (coordination of social service response), in line with COP 2015 review guidance.

The SIMS visits identified challenges in the OVC portfolio, particularly with regard to facilities (100% red), because early childhood development is monitored through the mother-child health card rather than from patients' charts, making progress difficult to judge. The community-based OVC program scored: Red: 62.5%; Yellow: 25%; Light Green: 7.5% and Green: 5%. Common issues include lack of available written procedures for some standards and lack of documented active referrals between clinical and community platforms. New strategies focus on gender-sensitive strategies and referrals for gender-based violence. Pilot approaches with social centers to reinforce community-clinical linkages through an OVC task force will be dedicated to this purpose. Block grants and mentoring programs for adolescent girls to ensure retention in school, and scaled up economic strengthening programs targeting OVC caregivers and PLHIV will further this agenda. Data from internal and external impact evaluations of current programs, including forthcoming economic strengthening data, will inform programmatic direction.

Alongside care and treatment scale up, the OVC program intends to increase its reach in COP 2015 from 200,000 to 263,556 (including 32,615 TA) beneficiaries served through high-quality intervention packages. To achieve these ambitious OVC goals, PEPFAR must continue to strengthen the link between the national health and social welfare systems. These comprehensive strategies will work across sectors to mitigate the long-term health, socioeconomic, and socio-emotional impact of HIV and AIDS on

children, families, and communities. The OVC program will also support the pediatric care and treatment programs through case identification, adherence and retention through home visits.

5.0 Program Activities to Maintain Support for Other Locations and Populations

5.1 Maintenance package of services in other locations and populations

PEPFAR will provide the same HTC and care & treatment services in scale-up and sustained districts for key populations, TB/HIV and OVC programs. However, PEPFAR will no longer support prevention activities for key population in sustained districts in COP 2015.

In line with the MSLS directives and guidelines, PEPFAR-CI will maintain most core packages of services for ART, PMTCT, and OVC in the forty sustained districts with the exclusion of:

- Active demand creation (including routine testing for PMTCT);
- Broad PITC;
- Community-based testing for non-key/priority populations;
- Non-essential laboratory services for management of PLWHA in care (such as hematology, electrolytes, and liver function tests, except at baseline and as clinically indicated);
- Deployment of new health information systems electronic tools and infrastructure;
- FP integration;
- Implementation of task-sharing activities;
- Pharmacovigilance\HIV drug resistance surveys; and
- Minor renovations.

In sustained districts, no new sites will be supported and PEPFAR staff support will not increase. The maintenance package will include quarterly supervision visits and:

- HTC: diagnostic HTC, linkages/referrals to care and treatment, and commodity supply chain support;
- Care Services: community-based retention/ continuum of care/ linkages, CTX, TB screening, PHDP package including condoms, CD4 monitoring, NACS for children, and commodity supply chain support;
- ART services: ARVs, lab monitoring (CD4, HIV, hematology, biochemistry and VL), commodity supply chain support, active retention activities, and post-exposure prophylaxis (PEP);
- PMTCT: ARV prophylaxis/ART (Option B/B+), lab monitoring (CD4, HIV, hematology, biochemistry, VL, EID), CTX, TB screening, linkages to care and treatment, and active retention activities;

- OVC: Household economic and food security, access to HTC and linkage to services, growth monitoring, early childhood development activities, improving child and family relationships, and keeping children in family, NACS, support to the national OVC agency to perform quarterly supervision and TA to social centers and the OVC platform;
- Laboratory: essential laboratory testing for the management of PLWHA on ART (CD4, HIV, hematology, biochemistry and VL), quality management systems, maintenance of lab equipment and existing laboratory information systems, and lab reagents supply chain support;
- Waste Management: provision of plastic bags and biosafety boxes, and maintenance of existing incinerators;
- SI/M&E: provision of paper-based data collection tools, support of existing electronic LIS, and quarterly data validation visits.

The main assumption used to determine expected volume in sustained districts was passive enrolment of new patients on ART. This includes transitioning PMTCT routine testing to the MSLS and minimizing other HTC efforts. PEPFAR will continue to maintain a minimum quality of care and treatment services to ensure retention of patients on ART. Despite these efforts, a higher loss-to-follow-up (LTFU) rate of patients in care and treatment is anticipated in sustained districts. The unit expenditures for care and treatment by budget codes used to estimate the required resources in sustained areas were based on FY 2014 EA data and are aligned with cost savings gained from reducing investments in trainings, coaching, staffing, minor renovations/rehabilitation, and outreach community mobilization to increase retention. As such, the average unit expenditures were \$175.81 (adult Pre-ART care); \$160.98 (pediatric Pre-ART care); \$182.54 (adult ART without ARVs); \$187.44 (pediatric ART without ARVs).

Maintenance Volume by Group	Expected result APR 15	Expected result APR 16	Percent increase (decrease)
HIV testing in PMTCT sites	75,532	0	(100%)
HTC (only sustained ART sites in FY 2014)	247,859	0	(100%)
Current on care (not yet initiated on ART)	29,763	27,127	(8.85%)
Current on ART	24,535	21,289	(13.2%)
OVC	38,882	37,031	(5%)

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

A total of 76 HTC and 258 PMTCT low-yield sites are being transitioning to the MSLS. While the USG has negotiated with MSLS for a smooth transition, the Ivorian government and other stakeholders are not receptive to the “quality vs. equity” argument, particularly in the context of upcoming elections. The timeline of transitions between COP 2014-2016 is a challenge due to non-alignment of planning cycles and difficulty for the MSLS to gain traction on HIV funding requirements in the face of competing health and other GOCI priorities. PEPFAR is committed to continuing this work in close collaboration with the GOCI to ensure continuity of care for these affected patients. In COP 2015, PEPFAR-supported sites that have 25 or fewer patients receiving ART will begin to be transitioned following identification of

appropriate strategies. One proposed strategy is that treatment patients will be connected to the nearest high volume ART site in a hub and spoke model. To minimize loss-to-follow-up, health care providers from high volume sites will rotate periodically in low volume sites to continue service provision rather than moving the patients to the reference site. PEPFAR will continue to discuss with MSLS and other donors for full transition of these sites in a two-year timeframe. Cost saving gained from transitioning services in low yield/volume sites will be used to scale up services in high burden districts and populations.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Laboratory strengthening

In COP 2014, key laboratory program strategies and results include support to national institutions for coordination and to the clinical IPs for service delivery to HIV positive patients. Quality management systems (QMS) were implemented in 56 labs, and an equipment maintenance program in all labs. In addition, GeneXpert machines were installed in seven TB and HIV clinics, microbiological testing (including STIs) was decentralized at six regional labs and EID/VL at three regional labs. A total of 240 labs including 128 POC/CD4 sites and 112 clinical labs, are providing services, and more than 100 laboratories have a lab information system. SIMS visits at 17 laboratories have shown challenges on 5 out of 6 elements assessed. Quality management systems were scored 83% in red, as were 50% for quality of testing, 50% for information systems, 33% for availability of standard operating procedures, and 16% for stock out of lab reagents.

The laboratory strategy is designed to address the weaknesses noted during SIMS: improved and continuous quality, stronger human and systems capacities, greater efficiency, better coordination, and evidence-based deployment and expansion of laboratory equipment. Option B+ rollout and the new care and treatment strategies require scale-up of laboratory capacity at a decentralized level that will improve access to VL to 75% of pregnant women and children testing positive, and 50% of adults including priority populations.

Priorities for COP 2015 include:

1. Improve coordination of lab activities, increase human resource quality, and monitor lab equipment maintenance
2. Develop and implement a comprehensive EQA program for 1,517 HIV point of testing and clinical lab sites, including phases 1 and 2 of the rapid test quality improvement training package (RTQII) for all VCT sites
3. Continue decentralization of EID/VL in two new scale-up districts and provision of more point-of-care VL to increase access in the community

4. Ensure HIV+ patient access to laboratory services at all PEPFAR supported care and treatment sites and provision of quality HIV tests at all VCT and PITC sites. Procure laboratory equipment as needed in new laboratory supported sites in scale-up districts
5. Continue implementation of a laboratory information system and build capacity for its use ; continued implementation of and technical assistance for a laboratory supplies management system, eLMIS
6. Continue support for deployment of GeneXpert machines, with the intention to evaluate their impact on TB case detection among HIV-infected patients and detection of MDR-TB
7. Carry out laboratory quality management systems activities and streamline blood transfusion lab activities into one consortium which will implement QMS at all PEPFAR supported labs

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
Support RETROCI Laboratories providing services to HIV+ patients											
Participate in international external quality assurance programs	Procure EQA panels	Procure EQA panels		HLAB 90,000	11491 CDC RETROCI	1.Epi and health data (Yellow)	X	X	X		X
Support the implementation of the EQA program by National Public health lab	Training of key central lab personal	Training of key central lab personal		HLAB 100,000	11491 CDC RETROCI	1.Epi and health data (Yellow)	X	X	X		X
Provide technical assistance to the lab network through coaching supervision, on site training	Supervision and coaching of sites	Supervision and coaching of sites		HLAB 100,000	11491 CDC RETROCI	1.Epi and health data (Yellow)	X	X	X		X
Support operation of RETROCI for lab services	Renovations, maintenance contract and procurement of new lab equipment to support accreditation	Renovations, maintenance contract and procurement of new lab equipment to support accreditation		HLAB 672,000	11491 CDC RETROCI	7.Quality Management System (Yellow)	X	X	X		X
Quality Assurance for HIV testing											
Implement a quality assurance (QA) program RTQII countrywide	Develop a national QA policy and revise the 5 years strategic plan. Implement RTQII in 300 labs and 1,217 HIV testing sites.	Adopt and implement QA policy strategies and extend RTQII to additional 1,000 HIV testing sites		HLAB 100,000	New Lab partner (TBD)	1.Epi and health data (Yellow)	X	X	X	X	
	Customize the CDC generic logbook/ HTC register and the SPI-POCT checklist for testing site and POC and implement at 300 labs and 1,217 sites	Adopt and Implement the logbook and SPI-POCT at additional 1000 sites		HLAB 231,000	New Lab partner (TBD)	1.Epi and health data (Yellow)	X	X	X	X	

	Train about 500 persons on the RTQII and 20 TOT on the SPI/POCT checklist	Train additional 500 persons on the RTQII and 20 TOT on the SPI/POCT checklist		HLAB 270,000	New Lab partner (TBD)	1.Epi and health data (Yellow)	X	X	X	X	
	Procure reagents for PT panels development, panels transport and logbooks and checklist for 1300 sites	Procure reagents for PT panels development, panels transport and logbooks and checklist for additional 7 sites		HLAB 275,000	New Lab partner (TBD)	1.Epi and health data (Yellow)	X	X	X	X	
	Distribute PT panels to 1300 testing sites	Distribute PT panels to 2000 testing sites		HLAB 400,000	New Lab partner (TBD)	1.Epi and health data (Yellow)	X	X	X	X	
Point-of-Care diagnostics											
Evaluation strategies to assess the impact of POC CD4 on pediatric and PMTCT programs	Develop and implement evaluation study on numbers of PIMA and FACSpresto sites to assess their impact on the pediatric and PMTCT programs			HLAB 200,000	New Lab partner (TBD)	4.Performanc e data(green)	X	X		X	X
Support for Viral Load Monitoring											
Decentralization of viral load and EID services to patients at 7 regions	Procure and install two CML labs and renovate 4 regional labs to ensure services to about 6000 exposed infant and 12,000 adults	Maintain 8 regional CMLs		HLAB850,000	9419 CDC Lab coalition-ASM	1.Epi and health data (Yellow)		X	X	X	X
	Procure 12,000 viral load and 6000 EID tests to complement the lysing contract services of the MSLS with private companies	Procure 12,000 viral load and 6000 EID tests to complement the lysing contract services of the MSLS with private companies		407,820 (HTXS+PDCS)		1.Epi and health data (Yellow)		X	X	X	X
	Training and coaching of 30 lab personnel to provide VL and EID services at decentralized laboratories	Training and coaching of 30 lab personnel to provide VL and EID services at decentralized laboratories		HLAB 150,000	11491 CDC RETROCI	1.Epi and health data (Yellow)		X	X	X	X

Laboratory Systems: Quality Management Systems											
Implementation of QMS to ensure access to quality clinical monitoring for HIV, Viral load, EID, CD4 and opportunistic infection including TB	Implementation of SLMTA training for 13 labs	Implementation of SLMTA training for 15		HLAB 400,000	ASM	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	X
	Implementation of SLIPTA and coaching of 66 labs on the 110 supported clinical labs	Implementation of SLIPTA and coaching of 81 labs on the 110 supported clinical labs		HLAB 362,000	ASM	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	X
	Implementation of SLMTA and SLIPTA, coaching and supervision at 2 MOD laboratories	Implementation of SLMTA and SLIPTA, coaching and supervision at additional MOD laboratories		HLAB 150,000	DOD (TBD)	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	X
Laboratory Systems: Training and retention											
Support INFAS (lab technicians pre-service school) for the implementation of pre-service SLMTA curriculum	Support the lab technicians pre-service school operation	Support the lab technicians pre-service school operation		HLAB 50,000	12673 MSLS	5. Human resource for Health (light green)		X		X	X
	Support workshop to introduce the pre-service SLMTA curriculum at INFAS	Support workshop to introduce the pre-service SLMTA curriculum at INFAS		HLAB 50,000	12673 MSLS	5. Human resource for Health (light green)		X		X	X
Laboratory Systems: Biomedical Equipment Maintenance Systems											
Management of biomedical equipment maintenance in all PEPFAR supported laboratory and incinerators	Support the operation of the MSLS institution in charge coordination of maintenance activities	Support the operation of the MSLS institution in charge coordination of maintenance activities		HLAB 100,000	12673 MSLS	3.Performanc e data (green) 6.commodity supply chain (red)		X		X	X

	Procure lab maintenance contract	Procure lab maintenance contract		1,200,000 (HTXS, HBHC)	12673MSLS	3.Performance data (green) 6.commodity supply chain (red)		X		X	X
Laboratory Systems: Biosafety											
Implementation of Biosafety and biosecurity program in Cote d'Ivoire	Evaluation of biomedical laboratories			HLAB 100,000	New Lab partner (TBD)		X	X		X	X
	Develop a national strategic document of biosafety of Biomedical laboratories			HLAB 100,000	New Lab partner (TBD)	14.Policies, laws and regulation (light green)	X	X		X	X
Laboratory Systems: Laboratory Information Systems											
Support the implementation of specific software for laboratory management and equipment management	Support the development and implementation of OPENLIS and BLISS at about 100 clinical labs			400,000 (HVSI)	13966 UWash I-Tech	3.Performance data (green)	X	X	X	X	X
	Support the development and implementation of resource MAP at 10 sites			100,000 (HVSI)	13966 UWash I-Tech	3.Performance data (green)	X	X	X	X	X
Laboratory Systems: Sample Referral Systems											
Support the development of a national sample referral system	Situation analysis			HLAB 100,000	New Lab partner (TBD)	3.Performance data (green) 4.Access and demand (yellow)	X	X	X	X	X

	Development of a national strategy for sample referral			HLAB 100,000	New Lab partner (TBD)	3.Performance data (green) 4.Access and demand (yellow)	X	X	X	X	X
Laboratory Institutions											
Support the national public health laboratory to coordination lab interventions	Coordinate national effort for EQA and PMS for HIV RTK	Coordinate national effort for EQA and PMS for HIV RTK		HLAB 100,000	12673 MSLS	15.Planning and coordination (yellow)	X	X	X	X	X
	Coordinate national efforts for clinical laboratory supervision and implementation of QMS	Coordinate national efforts for clinical laboratory supervision and implementation of QMS		HLAB 100,000	12673 MSLS	15.Planning and coordination (yellow)	X	X	X	X	X
Blood Safety											
Support laboratory related blood safety intervention for safe blood access, waste management and accreditation of blood bank labs	Procurement of laboratory reagents for blood product screening			HLAB 1,100,000	New Lab partner (TBD)	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	
	Implementation of quality management systems at 3 blood banks labs and at 24 blood collection units			HLAB 200,000	New Lab partner (TBD)	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	
	Training and procurement of tools to insure proper linkage of HIV+ blood donors to ART laboratory services			HLAB 100,000	New Lab partner (TBD)	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	

	1.Assessment of 10 years PEPFAR support to blood bank based on expected outcomes 2. Assessment of reductions of PEPFAR fund to blood safety programs on availability of blood product in CI			HLAB 100,000	New Lab partner (TBD)	4.Access and demand (yellow) 7.Quality Management System (Yellow)	X	X		X	
Operational Research											
Support ISPEC for the implementation of an evaluation of HIV-2/ HVB prevalence in newly HIV+ diagnose patients seeking CD4 staging	Procure lab reagents to support the study			HLAB 100,000	17014 FHI360	1.Epi and health data (Yellow)	X	X	X	X	X
Evaluate new laboratory methods and technic	Procure reagents and IRB fees			HLAB 50,000	11491 CDC RETROCI	1.Epi and health data (Yellow) 6.commodity supply chain (red)	X	X	X	X	X
Procurement of laboratory equipment											
Procure new laboratory equipment	Procure 4 equipment to replace old equipment in PEPFAR supported labs			HLAB 857,176	9396 SCMS	6.commodity supply chain (red)	X	X	X	X	X
TOTAL HLAB = \$7,625,787											

6.2 Strategic information (SI)

PEPFAR provides support to strengthen the national M&E, Health Information Systems (HIS), and Surveillance and Surveys.

Following the review of the national HIS system and adaptation of District Health Information System 2 (DHIS2) as the new national health data reporting system, PEPFAR and other donors (such as GF, World Bank and UNFPA) will support the deployment of DHIS2 to the remaining scale-up districts where DHIS2 is not yet in use. PEPFAR is also supporting the implementation of an electronic logistics management information system (eLMIS), an improved electronic patient records management system, a national OVC database and a laboratory information system (OpenELIS) for key laboratories in the country. PEPFAR will also support the improvement and maintenance of the master facility list, required for the new MER strategy. PEPFAR will continue to support the development of Data Quality Assurance (DQA) and data use strategies.

To assess HIV services coverage and impact, PEPFAR will continue to support the MSLS to conduct biological and behavioral surveys including size estimation among key populations (MSM, CSW), HIV drug resistance surveillance, and data quality audit for routine PMTCT data as well as ANC surveillance. The HIV Impact Assessment planned in COP 2014 will commence during the last quarter of FY 2015 and provide data on coverage and impact of key HIV services. As PEPFAR shifts its support from low burden to high burden areas this type of surveillance system will help us refocus geographically if necessary.

Following the revision of HIV tools for inclusion of the PEPFAR Monitoring, Evaluation and Reporting (MER) indicators, the team will focus on adapting or revising existing paper-based and electronic data collection and reporting tools, and training providers at site level on the new indicators, and how to collect and report on them.

PEPFAR continues to promote sustainability by building the capacity of Ivoirian government agencies and organizations to mobilize resources and implement evidence-based programs, including the capacity to collect, process, analyze, and use data effectively.

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
HIS											
Technical Assistance to support the rollout out of DHIS 2	Rollout completed in 8 focus regions	Rollout completed in all high burden districts	HVSI 200,000	HVSI 200,000	Measure Evaluation IM 17583	1.3 Performance Data (Score= 2.4 Quality Management 4.1 Public Transparency 4.2 Oversight & Stewardship			X	X	
Technical assistance for the implementation of a new EMR (SIGDEP2/OpenMRS)	Pilot tested completed	Deployment completed in 50% of ART sites	HVSI 100,000	HVSI 150,000	Measure Evaluation IM 17583	1.3 Performance Data 2.4 Quality Management 4.1 Public Transparency 4.2 Oversight & Stewardship		X	X	X	X
Technical Assistance for the implementation of eLMIS	Pilot test completed in 50 sites	Deployment completed in 80% of ART and PMTCT sites	HVSI 150,000	HVSI 100,000	Measure Evaluation IM 17583	1.3 Performance Data 2.4 Quality Management 4.1 Public Transparency 4.2 Oversight & Stewardship			X		
Technical assistance for the deployment of OpenElis (Laboratory information system)	Deployment completed in 5 regional laboratories	Deployment to all key laboratories completed and transition plan to MOH in place	HVSI 500,000	HVSI 600,000	U- Washington ITECH IM 13966	1.3 Performance Data 2.4 Quality Management 4.1 Public Transparency 4.2 Oversight & Stewardship			X		X

M&E											
Adapting and revision of existing paper-based and electronic data collection and reporting tools	All identified changes processed and incorporated in national tools	Tools adaptation completed; reproduction and distribution to all sites completed	HVSI 100,000	HVSI 200,000	Measure Evaluation IM 17583	1.1 Epi & Health Data			X		
Training of providers at sites on the new indicators and on updated data collection tools	Training plans completed	All sites trained on new tools	HVSI 100,000	HVSI 150,000	Measure Evaluation IM 17583	1.1 Epi & Health Data			X		
Data quality audit for routine PMTCT data	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 100,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data			X		
Surveillance and Surveys											
HIV Impact Assessment	Survey protocol completed	Data collection and draft results produced	HVSI 1,600,000	HVSI 1,600,000	Columbia University ICAP IM 13616	1.1 Epi & Health Data 3.4 Technical Efficiency	X		X		X
ANC surveillance survey	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 100,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X		X		X
Biological and behavioral survey and size estimation among key populations (MSM, CSW)	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 100,000	ISPEC (Improving HIV/AIDS Surveillance and Program Evaluation in Côte d'Ivoire) FHI 360 – IM 17014	1.1 Epi & Health Data	X	X	X		X
HIV drug resistance surveillance	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 50,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X	X	X	X	X

Pharmacovigilance activities	Training tools completed; training of health completed	Implementation of Electronic tools for case notification completed	HVSI 50,000	HVSI 50,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X	X	X	X	X
ARV Treatment outcome study	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 300,000		ISPEC (Improving HIV/AIDS Surveillance and Program Evaluation in Cote d'Ivoire) FHI 360 – IM 17014	1.1 Epi & Health Data	X	X	X	X	X
HIV incidence survey using DBS specimens from ANC	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 100,000		Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X	X	X	X	X
HIV sentinel survey among pregnant women and PMTCT routine Data Quality Audit survey	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 100,000	HVSI 50,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X	X	X	X	X
Early Warning Indicators survey	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 50,000	Ministry of Health 2010 CoAg IM 12673	1.1 Epi & Health Data	X	X	X	X	X
Biological and behavioral survey among military	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 100,000	DOD IM	1.1 Epi & Health Data	X	X	X	X	X
OVC program outcomes evaluation	Protocol completed	Data collection, Data analysis, and Report completed	HVSI 50,000	HVSI 100,000	ISPEC (Improving HIV/AIDS Surveillance and Program Evaluation in Cote d'Ivoire) FHI 360 – IM 17014	1.1 Epi & Health Data	X	X	X	X	X

6.3 Health System Strengthening (HSS)

Activities budgeted under the HSS codes are aligned to the vision of achieving epidemic control by feeding into the PEPFAR clinical cascade. Agreement on phasing out of a set of HSS activities was reached during the COP14 review. The phase out of both near-core transition and non-core activities will be completed by August 2015. PEPFAR's investments in the LMG decentralized pilot are being picked up by Global Fund. Health financing studies have been transferred to World Bank. Proposed supply chain investments complement investments by Global Fund, EU and French bilateral cooperation.

Activities proposed for COP 2015 are in line with the recommendations made during multi stakeholder SID workshop in Abidjan in February 2015. In addition we took into account OGAC guidance (including the new HRH policy) and recommendations from TWG members. In FY 2016, HSS investments will support:

Commodity Security and Health supply chain Strengthening

- Provision of technical assistance to improve leadership and governance of the Central National Medical Store (NPSP)
- National quantification and coordination of supply planning of HIV/AIDS commodities including antiretroviral drugs, HIV rapid test kits and laboratory equipment;
- Strengthen the supply chain system in order to ensure last-mile distribution of HIV commodities and improve data visibility for logistics.
- Monitoring quality of HIV commodities

Human Resources for Health

- Assessment of HRH capacity at high impact sites
- Increase supply of HRH at high impact sites
- Interventions to recruit, deploy and retain HRH at high impact sites
- Absorption of PEPFAR project staff by Ministry of Public Service

Policy, Governance and Leveraging Resources

- Advocacy and support for HSS policies development, especially for implementation of task sharing and WHO 2013 recommendations;
- Technical and financial assistance to government ministries and agencies responsible for ensuring delivery of comprehensive HIV services ;
- Support for regulatory bodies and associations responsible for HIV/AIDS-related registration and credentials.
- Policy and regulatory work for effective HIV service delivery in the private health sector
- Support evidence-based costing of national AIDS plan using results from ART costing exercise
- Advocacy for domestic resource mobilization for HIV/AIDS response
- Leveraging Global Fund investments in Côte d'Ivoire.

Quality of HIV care and treatment services

- Work with MSLS to support implementation of national quality assurance (QA)/Quality Improvement (QI) standards for HIV care and treatment

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 (COP15)	4. 2015	5. 2016 (COP15)			8. HIV Testing	9. Linkage to Care (LTC)	10. ART uptake	11.*Other Combination prevention	12. Viral suppression
Supply Chain Management											
Decentralized (end to end) SCM	Stockout rates of HIV tracer commodities at HIV sites reduced from 10 to 4%	Stockout rates of HIV tracer commodities at HIV sites reduced from 4 to 1%	2,400,000 HSS	900,000 HSS	Supply Chain Management System IM 9396	6 Commodity Security and Supply Chain (red)	X	X	X	X	X
Quality of HIV commodities	N/A (New in COP 15)	Quality of HIV commodities at selected service delivery points is consistent with international standards	0	500,000 HSS	Supply Chain for Quality Assurance IM 17872	7 Quality Management (red)	X		X	X	X
HRH											
<u>Assessment of HRH capacity at sites in focus districts in high burden regions</u>	2014-2015 HRH Strategic Plan	National 2016-2020 HRH Strategic Plan finalized based on HRH analysis using OneHealthTool and workload analysis	150,000 HSS	150,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)	X	X	X	X	X
	N/A (New in COP 15)	PEPFAR high yield sites: HRH gap analysis report completed	0	250,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)	X	X	X	X	X
<u>Increase supply of HRH for PEPFAR supported high impact sites</u>	Task shifting curriculum developed and implemented in 3 nurse training schools	Task shifting curriculum implemented in additional 2 nurse training schools. 1,750 new graduates trained (nurses and midwives) and assigned as	350,000 HSS	910,000 HSS	Health Finance and Governance IM 16685, HRSA Columbia Global Nurse Capacity Building Program 2013 IM 17003 and Emory University_Suppo	5 Human Resources for Health (light green)	X	X	X	X	X

		needed to PEPFAR high yield sites. Pilot with CHW to increase enrollment and retention of ART.			rt to Nurses_ ASPH - CoAg #5U36E000002-02 IM 17903						
	HRH retention strategy drafted	Career profiles and national HRH retention strategy finalized	100,000 HSS	100,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)	X	X	X	X	X
	N/A (New in COP 15)	Health worker career profiles implemented that allocate more experienced clinicians to PEPFAR high yield sites	0	100,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)	X	X	X	X	X
<u>Recruitment, deployment and retention at PEPFAR supported high impact sites</u>	PBF national policy developed and launched	HIV indicators finalized as part of national Performance Based Financing (PBF) strategy	100,000 HSS	100,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)					
	N/A – new in COP15 (policy not yet in place)	The PBF approach will support provision of incentives to motivate staff with priority to the 15 scale-up districts	0	174,050 HTXD	EGPAF international CDC CoAg 2011-Djidja IM 13651, Fondation Ariel CDC CoAg 2011 IM 13631	5 Human Resources for Health (light green)	X	X	X	X	X
	HRH retention strategy and Performance Management System developed	Implementation of HRH retention strategy and Performance Management System	100,000 HSS	375,000 HSS	Health Finance and Governance IM 16685 and U-Washington ITECH IM 13966	5 Human Resources for Health (light green)	X	X	X	X	X
<u>Sustainable HRH financing</u>	Profiles for data managers and CHW validated by MOH	Absorption of PEPFAR project staff (data managers and CHW) by Ministry	175,000 HSS	200,000 HSS	Health Finance and Governance IM 16685	5 Human Resources for Health (light green)	X	X	X	X	X

		of Public Service									
Policy, Governance and Leveraging Resources											
TA to independent National Medical Stores (Governance and Management)	Improved governance, strengthened leadership capacity, construction of new warehouse (WiB) completed	National Medical Stores transformed in a credible institution which progressively starts local procurement of selected HIV commodities (non- ARV)	1,500,000 HSS	500,000 HSS	Supply Chain Management System IM 9396	13 Oversight and Stewardship (light green)	X		X	X	
National level TA and support: policies and technical guidelines, management support, program coordination, TWGs supervision, etc	GOCI line ministries effectively manage, coordinate and supervise the national HIV response	GOCI line ministries effectively manage, coordinate and supervise the national HIV response	800,000 HSS	245,000 HSS	Ministry of Health 2010 CoAg IM 12673, Contraceptive Commodities Fund IM 7383, USAID Condoms Management IM 14073	13 Oversight and Stewardship (light green)	X	X	X	X	X
Leveraging Global Fund investments in Cote d'Ivoire (CCM support)	PEPFAR and Global Fund investments are well aligned	PEPFAR and Global Fund investments are well aligned	900,000 HSS	900,000 HSS	Leadership, Management and Governance Project (LMG) IM 13602	15 Planning and Coordination (yellow)	X	X	X	X	X
Increase host country funding for HIV/AIDS response	TA to National AIDS Program on mobilizing domestic funding to support HIV response	Domestic funding for health and HIV commodities increased from 1 to 10% of national needs	200,000 HSS	700,000 HSS	Health Finance and Governance IM 16685	9 Domestic Resource Mobilization (red)	X	X	X	X	X
Policy and regulatory work for effective HIV service delivery in the private health	MOH effectively regulates delivery of quality HIV care and treatment in	MOH effectively regulates delivery of quality HIV care and treatment in private health	150,000 HSS	150,000 HSS	SHOPS Abt Follow on IM 16689	4 Access and Demand (yellow)	X	X	X	X	X

sector	private health sector	sector										
Evaluations	Protocols drafted and IRB approvals obtained for several evaluations	MSM size estimation survey at national level, Biological and behavioral survey among key populations (MSM, CSW), SCMS end of contract evaluation	641,000 HSS	250,000 HSS	ISPEC (Improving HIV/AIDS Surveillance and Program Evaluation in Cote d'Ivoire) FHI 360 – IM 17014, Evidence for Development (E4D) IM 17871	3 Performance data (dark green)						
Quality of HIV care and treatment services												
Establish and support implementation of national QA/QI standards for HIV care and treatment	National Quality Improvement policies and standards drafted	National Quality Improvement policies and standards established and used by Clinical Partners	400,000 HSS	500,000 HSS	ASSIST (Applying Science to Strengthen and Improve Systems) IM 16861	7 Quality Management (red)	X	X	X	X	X	
Quality improvement for HTC and data	N/A (New in COP 15)	Military HIV staff trained and in control of their HIV data	0	145,740 HSS	DOD TBD	7 Quality Management (red)	X	X	X			

7.0 Staffing Plan

Direction from OGAC is influencing the allocation of staff resources, particularly as the team shifts to support the new data and reporting mandates. The team has made shifts to ensure the appropriate mix of staff, but is still anticipating an external staffing review. As the team composition and integral nature of the PEPFAR programming continue to change in line with the evolving strategies, comparative advantages, and challenges, the team is working across agencies and with close engagement of Mission leadership to preserve the tight working relationships while creating cleaner lines of authority and accountability. The team is establishing Technical Working Groups (TWGs) to maintain and improve technical collaboration, while moving from an integrated functional structure to a more traditional model in which agencies operate independently and collaborate through the TWGs and leadership structures (e.g., Executive Team, Strategy and Policy Team). We are also investing in a more robust PEPFAR Coordination Office suited to the expanding mandate for external coordination and for reporting requirements from Washington.

The alignment of the portfolio to the core/near core and non-core determinations is having minimal impact on the staffing composition this year, but it is fostering increased collaboration across technical branches to ensure that activities are smoothly transitioned and the integrated efforts across programs and partners are well aligned with the program strategy.

The broader context of Côte d'Ivoire, and the expectation of additional health resources linked with the Ebola response and the Global Health Security Agenda, as well as overall growth in bilateral and regional health initiatives are influencing the longer term planning for all the Agencies at post. As additional (non-PEPFAR) bilateral funds may be allocated in coming years, positions will be reviewed to identify opportunities for redistributions of costs for staff in line with additional responsibilities; the current proposal reflects costs in line with expected budgets and levels of effort as shown in the staffing charts.

With the increasing demand for data and analysis, and the additional volumes of data required for quarterly assessments, SIMS, and EA, the Côte d'Ivoire team needs data management support to centralize the various data management activities, and ensure data quality and accessibility and timeliness of the SIMS process and related activities. To better coordinate these efforts, the operational platform (including supports for ICASS, drivers and travel coordination) as well as careful planning for assessment missions and follow-up, will require additional resources in the coming year. All agencies have reflected these costs in their respective SIMS plans as well as in the Management and Operations budgets. We have also proposed additional staff to support these efforts, as noted in the agency specific sections.

A PEPFAR Coordination Office (PCO) is being staffed with two previously approved positions: Assistant Coordinator and Media Outreach Coordinator. The team proposes to hire a reporting/monitoring coordinator, to address SIMS and POART quarterly reporting, coordination with the GOCl and other

stakeholders, as well as PEPFAR collaboration in various national planning processes. As agencies shift from an integrated organizational chart to individual entities, an administrative assistant will be hired to support the PCO.

CDC is not requesting any new positions. Instead, two recently vacated positions will change in scope to enhance the Strategic Information capacity, especially for Monitoring and Evaluation to guide program intervention planning and decision making. CDC is proceeding with filling the vacant positions of 'Associate Director for Programs' and 'Operations Manager' that were approved in COP 2013 but were not filled. CDC is also filling the vacant positions of a Biostatistician, Budget Analyst and a chauffeur. CDC abolished four positions during the last fiscal year - an Assistant Biologist; two Administrative Assistants, and a Chauffeur.

In addition to the 17 full and partial staff supporting USAID's PEPFAR portfolio in country, and to the continuing administrative support for the PEPFAR Coordinator until the position can be transitioned to the State LNA mechanism, USAID is proposing two new staffing actions in support of COP 2015. The data management demands, particularly for SIMS and DATIM activities, require the creation of a new data management assistant position, to serve as a host country national member of the strategic information team. The team is also proposing repurposing a previously approved vacant position (private sector advisor) to become a health communications advisor, reflecting the need to strengthen the engagement of key and priority populations in prevention, community health promotion and OVC related activities in line with the new strategies. Given USAID's growth in Côte d'Ivoire, the Health Team will need more contractual, communications and executive office support locally, as noted in the budget. The team reviews skills, responsibilities and portfolios to ensure high quality technical and administrative oversight of the full breadth of the portfolio, including assessing the need for scope revisions to align with a consolidated USAID office structure and expanding need for integrated health programming across initiatives.

DHAPP/DOD filled the Program Manager position in COP14. There are no plans for additional staffing in COP 2015. The Program Manager will manage SIMS visits using motor pool vehicles with no major additional costs planned for COP 2015 timeframe.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP 2015

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
Site level	<ol style="list-style-type: none"> 1- Condoms for All Higher-Risk Groups (e.g. KP & PLWHA, Priority Populations) 2- HTC in PMTCT; 3- Health care referrals for OVC; 4- ARV Prophylaxis /ART for PMTCT, EID, CTX for PMTCT; 5- Laboratory Biological Monitoring for PMTCT, ART and care, (Hematology, Biochemistry, Viral load, EID, TB and CD4) 6- Support capacity building for continuous quality improvement at PEPFAR supported laboratories for accreditation 7- Support implementation of LIS at labs (BLISS) 8- Implementation of lab EQA and RTQII 9- 6- Drugs and Commodities for ART, and PMTCT, 10- PEP; 11- PITC for Adults and Peds, 12- Index case-based family testing; 13- TB testing; 14- Commodities for testing; 15- Clinical Monitoring for PMTCT, ART and Care; 16- MER data collection, analysis and reporting; 17- DQA and Program Evaluation. 1- Laboratory monitoring (EID, CD4, hematology, biochemistry, VL) for children and adult on ART, 18- Combination Prevention—ART for Prevention, Condoms, PMTCT, HTC for KP and PPs 19- Key Populations: Nationally Validated Minimum Package of Services (STI, HTC, ART, Sexual Prevention, Condoms) 20- GBV/HIV referral networks (e.g. social centers, PEP) 21- Linkages and referrals from community to clinical services for KP and PP including OVC and their families; 	<ol style="list-style-type: none"> 1- Implement a public health evaluation of the impact of the project on patient monitoring within two of the six regions 2- Community sensitization for ANC uptake in scale-up districts 3- FP counseling and referral for HIV+ women; 4- Safe injection practices; 6- Couple testing; 5- Home-based continuum of care to improve retention; 6- TB screening, referral and infection control; 7- NACS for pediatrics in scale-up districts; 8- Chronic care model pilot (pilot in two regions after which follow-on policy work with MSLS and implementation framework 2 years); 9- 	<ol style="list-style-type: none"> 1- Non-HIV related GBV activities, 2- For sustained districts identified by cut-off criteria in COP 2015: will not conduct active recruitment of new HIV+, no new sites; 3- Package of prevention services for low prevalence populations (e.g. spouses of uniformed services, youth >14 years, males aged 10-24 years) 4- NACS in sustained districts; 5- Targeted hemovigilance for blood tracing (PMTCT, Anemia) 6- Blood bags and tubes (transition based on ministry budgeting 2-3 of funds reduction)(By end of FY 2016), 7- Home-based care; 8- Services to low prevalence and low yield sites, 9- Renovation and Shelter for OVCs, 10- Emergency one-off feedings for OVCs

- 22- PHDP
- 23- HTC services for priority and key populations: Military, Partners of FSW & MSM; Young Women 15-24 years old (OVC, ANC, higher-risk younger women), Men 35-49 years old (higher socio-economic status, higher education, workplaces)
- 24- Commodity supply.
- 25- Child protection, legal protection and social protection for OVCs;
- 26- Household economic strengthening for OVCs and families;
- 27- Education and nutrition including NACS support for OVCs and families

Sub-national level			
National level			
1. MSM and FSW micro-mapping and size estimation located in urban hot spots; Biological and behavioral survey among key Populations	1- 2- 3- 4- 5- 6- 7- 8- 9- 10-	Mentor the lab technician association (AIBT) by assisting to establish solid links between the association and members TA and targeted funding to MSLS to improve coordination of the health sector response to HIV epidemic; PERIODIC RECURRING : National revision of HIV indicators for the implementation of the MER; Medical waste management at high volume treatment sites (integrate with treatment partners with treatment work, ANC survey among pregnant women and PMTCT routine data quality audit for HIV surveillance. (By end of FY 2015), Coordination of the social sector response to HIV epidemic; Coordinate national GBV TWG; HIV-2 and HBV co-infection routine service delivery and surveillance to ensure appropriate patient treatment; populations (MSM, CSW); Program and Impact Evaluation	1- 2- 3- 4- 5- 6- 7- 8-
			ASLM to build laboratory capacity in CRESAC ASCP support to school of lab technicians (INFAS) (By end of FY 2015), Medical waste management, Safe injection practices, Surveillance capacity building for the Ministry of Health Safe injection practices among hospitals and within clinical services (in routine package with treatment partners), Policy development, Coordinate GBV TWG, Non-HIV related GBV activities, Pre-Service training; Surveillance capacity development.

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP 2015

	Core Activities	Near-core Activities	Non-core Activities
HTC	<ul style="list-style-type: none"> 1. HTC in PMTCT 2. Testing key and priority populations (MSM & FSW, women 20-24 years, military and adult men 35-49 years) 	<ul style="list-style-type: none"> 1. Couples testing 	<ul style="list-style-type: none"> 1. Stand-alone VCTs 2. Voluntary testing and counseling for the general population 3. population

4. Provider initiated counseling and testing for sick and at risk adults and children (including TB patients)
5. HTC commodities

4. Home-based testing for non-index based cases

Care and Treatment	<p>Core Activities</p> <ol style="list-style-type: none"> 1. Condom services for KP, PLWHA, & Priority Populations, 2. ARV Prophylaxis /ART for PMTCT, EID 3. CTX for PMTCT 4. Biological Monitoring for PMTCT, ART and care 5. Drugs and Commodities for ART, and PMTCT 6. PITC for Adults and Peds 7. Index case-based family testing 8. TB testing 9. Commodities for testing; 10. Clinical Monitoring for PMTCT, ART and Care. Community sensitization for ANC uptake 11. Home-based continuum of care to improve retention; 	<p>Near-core Activities</p> <ol style="list-style-type: none"> 1. Support Capacity building for continuous quality improvement at PEPFAR supported laboratories for accreditation 2. FP counseling and referral for HIV+ women; 3. Safe injection practices; 4. TB Screening, referral and infection control 5. NACS for pediatrics in focus regions; 6. PHDP. 	<p>Non-core Activities</p> <ol style="list-style-type: none"> 1. Cervical Cancer Screening 2. For sustained districts identified by cut-off criteria in COP 2015, no active recruitment of new HIV+, no new sites, quarterly quality and reporting sites, commodity supply, active linkage to testing and care and treatment services regardless of region for key pops and TB patients (by end of March FY 2016)
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Prevention	<p>Core Activities</p> <ol style="list-style-type: none"> 1- Combination Prevention—ART for Prevention, Condoms, PMTCT, HTC for KPs and PPs 2- Key Populations: Nationally Validated Minimum Package of Services (STI, HTC, ART, Sexual Prevention, Condoms) 3- Condoms for All Higher-Risk Groups (e.g. KP, PPs, & PLWHA) 4- Linkages and referrals from community to clinical services for KP and PP; 5- Providing Active Follow-Up and Tracking of ART patients to increase adherence and retention for KPs 6- HTC services for PPs & KPs; 7- PEP; 8- GBV/HIV referral networks (e.g. social centers, and accompaniment to clinical, post rape care and PEP) 9 Package of Prevention Services for Partners of FSW & MSM; Young Women 15-24 years old; higher risk men 35-49 years old , military 	<p>Near-core Activities</p> <ol style="list-style-type: none"> 1- Laboratory screening to prevent infections transmitted through blood transfusions,- 2- Safe injection practices 	<p>Non-core Activities</p> <ol style="list-style-type: none"> 1- Activities in low prevalence and low yield sites 2- Package of Prevention Services and testing for spouses of uniformed services, male youth >14 years, males aged 10-34 years in the general population 3- Targeted hemovigilance for blood tracing (PMTCT, Anemia) 4- Procurement of blood bags and tubes (By end of FY 2016)
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1- OVC Program/sy stem	<p>Core Activities</p> <ol style="list-style-type: none"> 1- Health Care Referrals for OVC 2- Family-based testing around index cases 3- Child protection, legal protection and social 	<p>Near-core Activities</p> <ol style="list-style-type: none"> 1- Coordinate national GBV TWG 2- Policy development for PEP, HIV testing, and post rape services 	<p>Non-core Activities</p> <ol style="list-style-type: none"> 1- Renovation and Shelter for OVCs One-off emergency feedings
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support	2-	protection for OVCs	3-	Coordination of the social sector response to HIV epidemic
	4-	Household economic strengthening for OVC and their families		
	5-	Education and nutrition support for OVCs and families		
Laboratory	Core Activities		Near-core Activities	
	1-	Routine lab monitoring test (HIV, EID, TB, CD4, VL, hematology, biochemistry, STI)	1-	Mentor the lab technician association (AIBT) by assisting to establish solid links between the association and members
	2-	Quality management systems (EQA panels and RTQII)	2-	Development and implementation of training curricula for lab management at INFAS and at Medical and Pharmacy faculties.
	3-	Laboratory information system I-Tech to Support Implementation of LIS at labs (OPENLIS and BLISS)	3-	Implement a public health evaluation of the impact of the project on patient monitoring within two of the six regions
	4-	ASM: 1- Technical assistance for the implementation of a national external quality assurance (EQA) to ensure quality of laboratory test with emphasis on HIV rapid test results		
	5-	Procurement, small repair (containerized lab, minor repairs) and technical assistance for decentralization EID and viral load at four regions		
	6-	Technical assistance to the national reference lab and TB program for TB and other Opportunistic Infections including STIs to ensure appropriate service delivery to HIV+ patients. Procurement of GeneXpert to TB MDR diagnostic and VL in TB treatment centers		
	7-	Technical assistance for continuous quality improvement at PEPFAR supported laboratories		
	8-	LABQuasy to provide support and expertise to expand the SLMTA program and continue to support labs in scale-up districts		
	9-	IPCI: Capacity building for TB and other Opportunistic Infections including STIs to ensure appropriate service delivery to HIV+ patients, TBMDR diagnosis (in 10 regional labs)		
	10-	Validation and implementation of national policies on Biosafety and sample transportation.		
	11-	Renovation of 3 regional labs to implement microbiology testing.		
	12-	CDC RETROCI: 1-Implementation of a national external quality assurance program (EQA) for HIV, CD4, PCR (EID) viral load, hematology, and biochemistry to ensure quality of laboratory test with emphasis on rapid test results		

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP 2015	Estimated Funding in COP 2016	# of IMs	Transition End date	Notes
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Cervical Cancer screening	Phasing out	0	0	6	Sept 2015	
PMTCT in low yield sites	Transition to Government	0	0	7	Feb 2015	268 sites transitioned to MSLS management
HCT in low yield sites	Transition to Government	0	0	7	Feb 2015	76 HTC sites transitioned to MSLS management
ART low volume sites: PEPFAR-supported sites that have 25 or fewer patients receiving ART	Transition to Government	\$266,000	TBC	6	Sep 2016	PEPFAR-CI will continue to discuss with MSLS and other donors for full transition of these sites in a two-year time frame
Transition of hematology and biochemistry to MSLS for patients in care	Transition to Government	\$347,739	\$347,739	1	Sep 2016	
Blood bags and tubes	Transition to Government			1	Sep 2016	Discussions to increase MSLS budgeting for this line item will continue
Injection Safety and Waste Management within PEPFAR clinical partners				6	Sep 2016	
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$US	\$US	\$US
Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$3,372,186
HVAB	Abstinence/Be Faithful Prevention	\$1,205,625
HVOP	Other Sexual Prevention	\$8,089,230
HMBL	Blood Safety	\$5,625
HMIN	Injection Safety	\$121,715
HVCT	Counseling and Testing	\$2,444,947
HBHC	Adult Care and Support	\$11,589,283
PDCS	Pediatric Care and Support	\$5,934,933
HKID	Orphans and Vulnerable Children	\$12,015,295
HTXS	Adult Treatment	\$31,870,468
HTXD	ARV Drugs	\$17,779,414
PDTX	Pediatric Treatment	\$4,428,181
HVTB	TB/HIV Care	\$3,666,060
HLAB	Lab	\$7,625,787
HVSI	Strategic Information	\$5,796,787
OHSS	Health Systems Strengthening	\$7,217,595
HVMS	Management and Operations	\$17,017,177
TOTAL		\$140,180,308

B.2 Resource Projections

The clinical cascade is the main tool used for projecting resources required for COP 15 implementation, including carrying costs and plans for scale-up and saturation. The cascade is also designed to support achievement of the program goal for FY16, as it provides a means of calculating the requisite inputs (commodities and services) at each step of the progression of a patient from testing through to treatment using unit costs, programmatic data and epidemiologic calculations. The process encompasses the following steps:

1. Identify the main entry streams for HIV testing based on program characteristics and performance. The tool can then be run through adjusting targets at each phase of the cascade to test varied strategies of intensity and resources.
2. Define key parameters and assumptions for the clinical cascade. Parameters used in the models:
 - a. Variable HIV prevalence within sub-group of people identified for testing - based on actual data for priority populations (MSM, FSWs, young girls, military, etc.)
 - b. Targets for testing developed based on the COP guidance and current programmatic data
 - c. Distinct services (care, ART) enrollment rate used, depending upon geography (passive enrollment rate in sustained districts vs. active enrolment in scale-up districts, etc.)
 - d. Models of retention rates by ART enrollees (new vs. old cohort) and by geography (scale-up districts vs. sustained districts)
 - e. Assessments of the feasibility of expansion and absorptive capacity of partners and sites
3. Explore variable unit cost of services and supplies based on FY14 expenditures analysis results and realism for the program, including potential cost savings through leveraged resources from other donors, etc.

An interagency team of technical leaders then runs the model and derives several options for strategic consideration by the broader team and agency leadership. Modifications can be calculated through review of the cost estimates, adjustments to targets, review of attrition rates at each phase of clinical and programmatic progression, and realism of targets and affordability.

Once the aggregate national program targets are set for the key areas of testing, care and treatment, including the linked sub-categories of PMTCT, adult and pediatric services and TB/HIV integration, have been determined, the next phase of budgeting program reviews and negotiations for the cross sectorial areas of HSS, prevention, lab, SI and OVC. Each area is budgeted in line with program priorities, impact and partner performance.

Additional elements of budget development include opportunities for counterpart funds leveraging, pipelines, partner performance, priority opportunities for expansion or innovation, and earmarks.

Cote d'Ivoire 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)
Abengourou	15,199	493	4,337	546	2,544
Abobo-Est	29,245	1,342	15,927	2,105	6,833
Abobo-Ouest	24,433	969	8,509	1,351	6,435
Aboisso	-	-	-	-	-
Adiake	-	-	-	-	-
Adjame-Plateau-Attecoube	47,750	1,105	6,092	3,000	7,960
Adzope	11,201	241	1,629	663	1,552
Agboville	12,803	200	2,862	386	2,049
Agnibilekrou	469	164	1,666	151	1,431
Akoupe	8,012	183	1,493	214	863
Alepe	198	115	633	77	559
Anyama	4,746	160	1,930	339	1,179
Bangolo	3,777	165	657	115	440
Beoumi	156	84	467	75	456
Bettie	86	36	211	25	157
Biankouma	73	77	628	67	416
Bloléquin	38	74	323	34	185
Bocanda	1,616	54	624	56	448
Bondoukou	11,116	568	3,344	549	2,301
Bongouanou	11,524	351	3,127	505	1,986
Bouaflé	20,816	441	2,884	1,499	2,935
Bouake-Nord-Est	7,748	346	2,233	392	1,265
Bouake-Nord-Ouest	19,600	707	6,656	1,300	5,051
Bouake-Sud	12,384	281	2,551	868	2,437
Bouna	763	72	634	63	528
Boundiali	397	114	1,024	103	902
Cocody-Bingerville	26,642	1,148	10,348	1,499	6,518
Dabakala	436	74	930	86	582
Dabou	14,924	535	4,192	1,501	2,682
Daloa	30,566	1,210	5,431	1,284	5,795
Danane	270	124	1,454	185	1,190
Daoukro	785	302	1,735	167	1,257
Didievi	19	29	158	19	96
Dimbokro	1,117	131	1,326	128	1,001
Divo	18,264	530	3,254	500	2,216
Duekoué	6,309	143	1,588	319	1,071
Ferkessedougou	187	185	1,384	164	1,287
Fresco	38	74	609	76	559
Gagnoa	28,613	905	3,837	2,100	4,560
Grand-Bassam	-	-	-	-	-
Grand-Lahou	342	69	515	38	381
Gueyo	26	63	206	31	166
Guiglo	5,220	355	1,690	232	1,085
Issia	15,424	444	2,562	715	3,006
Jacquerville	296	34	107	37	217
Katiola	540	113	899	100	701
Korhogo	40,114	1,309	6,300	1,900	5,358
Kouibly	90	85	605	35	319
Koumassi-Port Bouet-Vridi	47,402	1,397	7,908	3,997	8,599
Lakota	366	164	1,009	95	840
M'bahiakro	878	36	283	25	218
Man	11,295	575	4,506	1,020	2,649
Mankono	8,448	206	971	249	809
Minignan	-	30	173	18	81
Nassian	318	30	149	17	100
Niakaramadougou	37	5	587	64	439
Odiéne	130	129	1,007	117	669
Ouangolodougou	34	65	649	48	511
Oumé	9,588	272	1,537	388	1,687
Prikro	29	21	81	53	291
Sakassou	320	141	605	95	548
San-Pedro	34,101	696	4,053	1,898	4,969
Sassandra	10,365	139	770	300	1,068
Seguela	83	217	747	101	665
Sikensi	208	67	291	29	172
Sinfra	8,983	249	1,364	422	1,660
Soubre	38,030	665	3,388	2,000	3,907
Tabou	8,098	153	696	211	740

Cote d'Ivoire 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)
Tanda	8,556	380	2,597	526	1,914
Tengrele	22	48	173	31	168
Tiassale	8,778	242	1,177	311	903
Tiebissou	75	79	445	78	396
Touba	73	90	625	40	113
Toulepleu	9	37	198	14	83
Toumodi	126	192	1,209	110	1,122
Treichville-Marcory	28,935	2,198	20,395	2,503	18,498
Vavoua	185	111	1,028	76	724
Yamoussoukro	14,957	568	4,041	1,088	3,354
Yopougon-Est	26,886	2,038	8,895	2,100	5,415
Yopougon-Ouest-Songon	19,424	2,433	19,052	999	11,079
Zouhan Hounien	69	149	827	101	488
Zoukougbeu	-	-	-	-	-
Zuenoula	344	185	903	113	872
Other_ Cote d'Ivoire	6,000	-	-	-	-
Total	727,524	30,211	211,910	44,836	166,710

**Cote d'Ivoire 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
Abengourou	-	860	3,717
Abobo-Est	7,110	1,880	5,875
Abobo-Ouest	7,108	1,873	4,023
Aboisso	-	-	-
Adiake	-	-	-
Adjame-Plateau-Attecoubé	24,157	4,798	14,777
Adzopé	4,611	297	3,471
Agboville	-	66	6,330
Agnibilekrou	-	-	1,434
Akoupe	-	47	3,605
Alepe	-	-	-
Anyama	-	560	1,082
Bangolo	-	341	2,246
Beoumi	-	-	1,760
Bettie	-	-	186
Biankouma	-	-	-
Bloléquin	-	-	-
Bocanda	-	-	7,118
Bondoukou	-	155	5,611
Bongouanou	-	309	12,055
Bouaflé	-	1,271	1,426
Bouake-Nord-Est	-	1,476	7,441
Bouake-Nord-Ouest	-	1,476	8,568
Bouake-Sud	-	1,477	3,842
Bouna	-	-	3,938
Boundiali	-	-	2,578
Cocody-Bingerville	6,138	1,185	7,988
Dabakala	-	-	2,495
Dabou	-	850	3,553
Daloa	19,369	3,616	6,438
Danane	-	-	1,665
Daoukro	-	-	3,996
Didievi	-	-	63
Dimbokro	-	-	7,665
Divo	8,515	2,750	5,612
Duekoué	-	798	7,687
Ferkessedougou	-	-	3,360
Fresco	-	-	-
Gagnoa	-	1,090	5,380
Grand-Bassam	-	-	-
Grand-Lahou	-	-	642
Gueyo	-	-	-
Guiglo	-	978	3,587
Issia	-	344	2,057
Jacquerville	-	-	908
Katiola	-	-	2,978
Korhogo	23,418	2,183	14,843
Kouibiyé	-	-	-
Koumassi-Port Bouët-Vridi	23,227	2,399	16,341
Lakota	-	-	787
M'bahiakro	-	-	3,222
Man	-	1,124	4,291
Mankono	-	266	1,820
Minignan	-	-	-
Nassian	-	-	1,512
Niakaramadougou	-	-	-
Odiénne	-	-	941
Ouangolodougou	-	-	900
Oumé	-	1,181	1,040
Priko	-	-	-
Sakassou	-	-	796
San-Pedro	9,009	5,626	8,216
Sassandra	-	81	937
Seguela	-	-	189
Sikensi	-	-	556
Sinfra	-	1,181	1,091
Soubre	14,048	2,438	7,018
Tabou	-	446	1,337

**Cote d'Ivoire 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
Tanda	-	155	4,696
Tengrela	-	-	-
Tiassale	-	44	4,284
Tiebissou	-	-	-
Touba	-	-	293
Toulepleu	-	-	-
Toumodi	-	-	-
Treichville-Marcory	5,637	6,830	7,339
Vavoua	-	-	-
Yamoussoukro	6,304	2,677	3,922
Yopougon-Est	6,236	3,568	6,521
Yopougon-Ouest-Songon	8,313	3,569	2,962
Zouhan Hounien	-	-	-
Zoukougbeu	-	-	-
Zuenoula	-	-	545
Other_ Cote d'Ivoire	2,750	-	-
Total	175,950	62,265	263,556

**Cote d'Ivoire 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
Abengourou	10,820	381
Abobo-Est	14,632	513
Abobo-Ouest	14,555	506
Aboisso	-	-
Adiake	-	-
Adjame-Plateau-Attecoube	18,096	635
Adzope	6,122	215
Agboville	8,588	297
Agnibilekrou	-	-
Akoupe	5,657	201
Alepe	-	-
Anyama	2,094	72
Bangolo	2,275	79
Beoumi	-	-
Bettie	-	-
Biankouma	-	-
Bloulequin	-	-
Bocanda	495	18
Bondoukou	6,844	237
Bongouanou	6,707	233
Bouafle	11,033	382
Bouake-Nord-Est	4,610	162
Bouake-Nord-Ouest	6,079	211
Bouake-Sud	4,732	166
Bouna	-	-
Boundiali	-	-
Cocody-Bingerville	14,175	497
Dabakala	-	-
Dabou	4,758	166
Daloa	16,469	572
Danane	-	-
Daoukro	-	-
Didievi	-	-
Dimbokro	-	-
Divo	10,446	363
Duekoue	2,322	81
Ferkessedougou	-	-
Fresco	-	-
Gagnoa	13,996	490
Grand-Bassam	-	-
Grand-Lahou	-	-
Gueyo	-	-
Guiglo	2,697	92
Issia	10,589	372
Jacquerville	-	-
Katiola	-	-
Korhogo	15,682	546
Kouibly	-	-
Koumassi-Port Bouet-Vridi	18,252	642
Lakota	-	-
M'bahiakro	-	-
Man	3,883	138
Mankono	6,325	220
Minignan	-	-
Nassian	-	-
Niakaramadougou	-	-
Odienne	-	-
Ouangolodougou	-	-
Oume	6,596	232
Prikro	-	-
Sakassou	-	-
San-Pedro	17,623	616
Sassandra	7,579	265
seguela	-	-
Sikensi	-	-
Sinfra	5,857	207
Soubre	20,308	713

**Cote d'Ivoire 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
Tabou	6,371	222
Tanda	4,453	156
Tengrela	-	-
Tiassale	5,708	197
Tiebissou	-	-
Touba	-	-
Toulepleu	-	-
Toumodi	-	-
Treichville-Marcory	8,637	305
Vavoua	-	-
Yamoussoukro	6,502	232
Yopougon-Est	9,718	339
Yopougon-Ouest-Songon	11,242	392
Zouhan Hounien	-	-
Zoukougbeu	-	-
Zuenoula	-	-
Other_ Cote d'Ivoire	-	-
Total	353,527	12,363

**Cote d'Ivoire 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
Abengourou	302	56
Abobo-Est	904	168
Abobo-Ouest	984	181
Aboisso	-	-
Adiake	-	-
Adjame-Plateau-Attecoube	3,089	569
Adzope	217	40
Agboville	267	49
Agnibilekrou	109	20
Akoupe	84	15
Alepe	198	37
Anyama	243	45
Bangolo	137	26
Beoumi	56	10
Bettie	30	6
Biankouma	86	15
Bolequin	38	7
Bocanda	51	10
Bondoukou	198	37
Bongouanou	274	51
Bouafle	256	47
Bouake-Nord-Est	65	12
Bouake-Nord-Ouest	896	166
Bouake-Sud	31	6
Bouna	43	8
Boundiali	47	8
Cocody-Bingerville	565	104
Dabakala	50	10
Dabou	277	51
Daloa	769	141
Danane	270	50
Daoukro	255	47
Didievi	19	3
Dimbokro	202	38
Divo	427	78
Duekoue	193	35
Ferkessedougou	140	26
Fresco	38	7
Gagnoa	492	90
Grand-Bassam	-	-
Grand-Lahou	102	18
Gueyo	26	5
Guiglo	205	38
Issia	243	44
Jacquerville	30	6
Katiola	101	18
Korhogo	377	69
Kouibly	90	17
Koumassi-Port Bouet-Vridi	1,635	301
Lakota	147	28
M'bahiakro	30	6
Man	394	72
Mankono	84	15
Minignan	-	-
Nassian	9	2
Niakaramadougou	37	6
Odiene	130	25
Ouangolodougou	26	5
Oume	130	24
Prikro	29	6
Sakassou	77	14
San-Pedro	569	104
Sassandra	118	24
seguela	83	15
Sikensi	-	-
Sinfra	185	35
Soubre	463	85
Tabou	108	23

**Cote d'Ivoire 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
Tanda	203	37
Tengrela	22	4
Tiassale	330	60
Tiebissou	75	14
Touba	73	14
Toulepleu	9	2
Toumodi	126	23
Treichville-Marcory	1,568	288
Vavoua	185	34
Yamoussoukro	441	81
Yopougon-Est	878	162
Yopougon-Ouest-Songon	1,640	301
Zouhan Hounien	69	13
Zoukougbeu	-	-
Zuenoula	172	32
Other_ Cote d'Ivoire	-	-
Total	23,521	4,339



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: COTE d'IVOIRE

Epidemic Type: Generalized
Income Level: Low Middle
PEPFAR Categorization: Long Term Strategy
COP 15 Planning Level: \$140,180,308

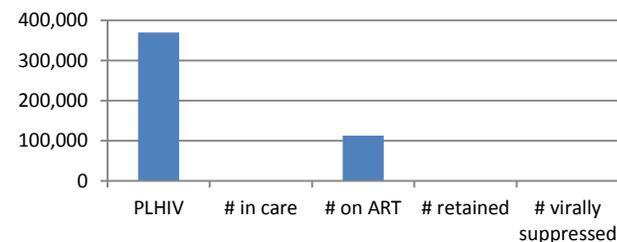


SUSTAINABILITY DOMAINS AND ELEMENTS

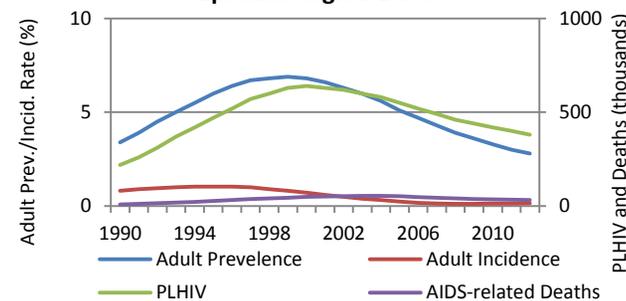
Category	Score
Institutionalized Data Availability	
1. Epidemiological and Health Data	9.4
2. Financial/Expenditure Data	16.5
3. Performance Data	17.0
Domestic Program and Service Delivery	
4. Access and Demand	11.4
5. Human Resources for Health	15.6
6. Commodity Security and Supply Chain	4.0
7. Quality Management	8.0
Health Financing and Strategic Investments	
8. DRM: Resource Generation	16.0
9. DRM: Resource Commitments	2.0
10. Allocative Efficiency	16.0
11. Technical Efficiency	18.0
Accountability and Transparency	
12. Public Access to Information	8.0
13. Oversight and Stewardship	13.5
Enabling Environment	
14. Policies, Laws, and Regulations	14.0
15. Planning and Coordination	9.0

CONTEXTUAL DATA

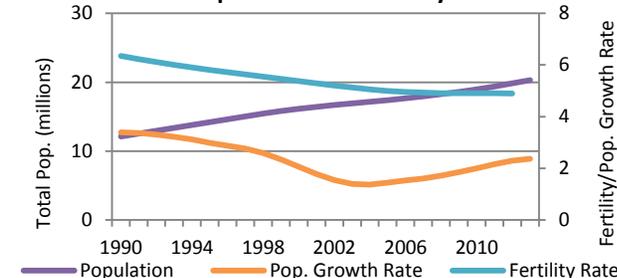
Care and Treatment Cascade



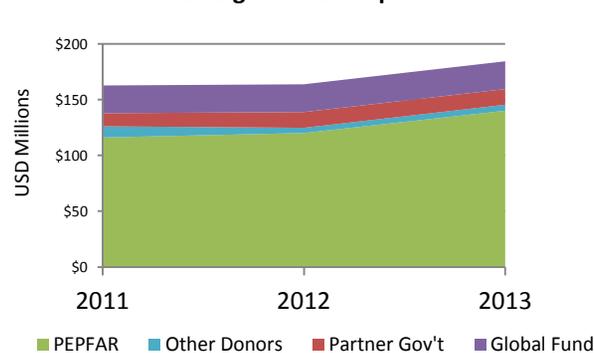
Epidemiological Data



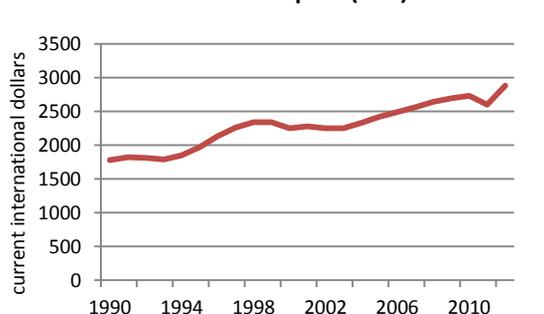
Population and Fertility



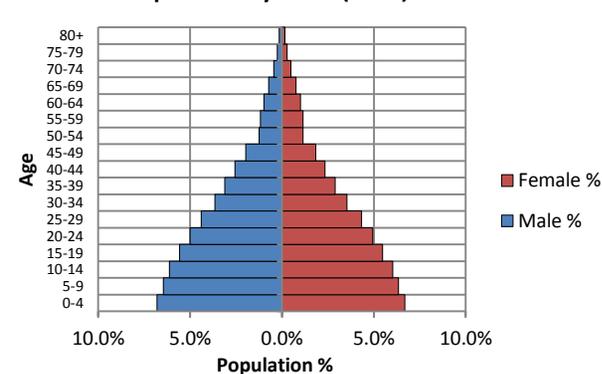
Financing the HIV Response



GNI Per Capita (PPP)



Population Pyramid (2014)



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	<p>DHS Report 2011-2012 Decree No. 2011-426 of November 30, 2011 providing for the organization of the MSLS National Health Policy DOCUMENT</p>	
<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	<p>DHS Report 2011-2012. DHS 2011-2012 Budget</p>	
<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> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data analyzed for trends</p> <p style="margin-left: 20px;"><input checked="" type="checkbox"/> Data made publicly available</p> <p><input type="checkbox"/> B. HIV incidence</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by age</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected for children</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by sex</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected by key population</p> <p style="margin-left: 20px;"><input type="checkbox"/> Sub-national data</p> <p style="margin-left: 20px;"><input type="checkbox"/> Collected every 3 years</p> <p style="margin-left: 20px;"><input type="checkbox"/> Data analyzed for trends</p>	2.3	<p>DHS Report 2011-2012, AIS 2005 National HIV Report 2013 GARP Report 2014 IBBS Report 2014 SHARM Report 2012</p>	

	<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	Viral load is only done for HIV patients at ART Sites but not institutionalized
Q5. Key Populations: Does the Host Country Government conduct size estimation studies for key populations?	<input type="radio"/> No, the host country government does not conduct size estimation studies for key populations <input checked="" type="radio"/> Yes, the government conducts key population size estimates (check all that apply): <input checked="" type="checkbox"/> Men who have sex with men (MSM) <input checked="" type="checkbox"/> Female sex workers <input type="checkbox"/> Transgender <input checked="" type="checkbox"/> People who inject drugs (PWID) <input type="checkbox"/> Government finances at least 50% of the size estimation studies <input checked="" type="checkbox"/> Government leads and manages the size estimation studies	1.6	. Mapping and Size estimations for Key Populations most at risk of HIV Transmission . IBBS Report 2014 . Health Report for drug users in Abidjan, Cote d'Ivoire: Prevalence and risk practice for HIV, Viral Hepatitis and other infections 2014 . SHARM Report 2012 . CAPTURE RECAPTURE Reports, FHI ENSEA 2008 2009 2010

Epidemiological and Health Data Score: 9.4

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	. NHA, NASA Input Year . Annual Health Status Report (RASS) . REDES Report

<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	<p>. NHA, NASA . REDES Report 2010</p>	
<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	<p>. NHA, NASA . REDES Report 2010</p>	
<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 type="radio"/> No, they are not conducting special health economic studies for HIV/AIDS</p> <p><input checked="" type="radio"/> Yes, check all that apply:</p> <p><input checked="" type="checkbox"/> A. Costing studies or analyses</p> <p><input checked="" 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>	2.5	<p>. HIV AIDS services sustainability analysis, MoH/PEPFAR, October 2009; . CSW and MSM HIV minimum package unit costing, January 2013; . Costing of HIV services in Public Health sector, October 2008. . Adult and Pediatric ART Costing Study 2015 . NHA</p>	

Financial/Expenditure Data Score: 16.5

<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	Notes/Comments	
<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 checked="" 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>	6	<p>. Annual Health Sector HIV Indicators Report in Cote d'Ivoire 2013 . National HIV Report 2010</p>	
<p>Q2. Analysis of service delivery data: Does</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>	3	<p>. Annual Health Sector HIV Indicators Report in Cote d'Ivoire 2013 . NSP review Report 2006 - 2010</p>	

<p>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>	<input checked="" type="checkbox"/> A. Continuum of care cascade, including testing, care, treatment, retention and adherence <input checked="" type="checkbox"/> B. Results against targets <input checked="" type="checkbox"/> C. Coverage <input type="checkbox"/> D. Site specific yield for HIV testing (HTC and or PMTCT) <input type="checkbox"/> E. AIDS-related death rates			
<p>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?</p>	<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 checked="" type="checkbox"/> E. Collected from all community sites <input checked="" type="checkbox"/> F. Data quality checks are conducted at least once a year		<p>6 . National Reporting System . National HIV Report 2010</p>	
<p>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?</p>	<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		<p>2 Annual Health Sector HIV Indicators Report in Cote d'Ivoire 2013</p>	
<p>Performance Data Score:</p>			<p>17.0</p>	

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.

			Source of data	Notes/Comments
<p>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.</p>				
<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 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 checked="" 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: 1</p>	<p>DIPE Report 2013 (32% of Health facilities deliver ARV services) DHS CI 2011-2012 provides prevalences per Health Region PNLS database 2013 provides the numbers of health facilities that deliver ARV services</p>	<p>This indicator is not completed by the DPPEIS DPPEIS report should take this into account</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>PEPFAR Annual Report 2014</p>	<p>This indicator is not completed by the DPPEIS The activity is performed in pilot in 19 regions out of 20</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>Annual Health Sector HIV Indicators Report (DIPE 2013)</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"/> 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 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>Q4 Score: 3</p>	<p>PEPFAR Annual Report 2014</p>	<p>This indicator is not completed by the DPPEIS DPPEIS report should take this into account</p>

	<input type="radio"/> D. Less than 20% of key population HIV/AIDS prevention program clients receive services at public service delivery sites			
Q5. Uptake of services: What percent of PLHIV are currently receiving ART? _____%	<input type="radio"/> This information is not available Check the one answer that best describes the current situation: <input type="radio"/> A. 80% or more of PLHIV are currently receiving ART <input type="radio"/> B. 50-79% of PLHIV are currently receiving ART <input checked="" type="radio"/> C. 20-49% of PLHIV are currently receiving ART <input type="radio"/> D. Less than 20% of PLHIV are currently receiving ART	Q5 Score	2	2014 UNAIDS Report Recommendations: Clinical partners addressing the: 1. Increased geographic access to ART in high impact regions 2. Increased access to ART for people living with HIV to reach the 90:90:90 goals Note: With the new shifts in geographic coverage, PEPFAR and its clinical partners are well placed to address these gaps with MSLs overtime. Global Fund can also assist with the region of Sud-Comoé.
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?	Check the one answer that best describes the current situation: <input type="radio"/> No, the government does not recognize a right to nondiscriminatory access to HIV services for all populations. <input checked="" type="radio"/> Yes, there are efforts by the government (check all that apply): <input checked="" type="checkbox"/> educates PLHIV about their legal rights in terms of access to HIV services <input checked="" type="checkbox"/> educates key populations about their legal rights in terms of access to <input checked="" type="checkbox"/> National policy exists for de-stigmatization in the context of HIV/AIDS <input type="checkbox"/> national law exists regarding health care privacy and confidentiality protections <input type="checkbox"/> government provides financial support to enable access to legal services if someone experiences discrimination, including redress where a violation is found	Q6 Score	2.4	CI HIV Law Passed 2014, National Policy and Guidelines Documents Strengthen awareness about and dissemination of the law, Strengthen financial support for access to legal services
Access and Demand Score			11.4	

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	
Q1. HRH Sufficiency: Does the country have sufficient numbers of health workers trained in HIV/AIDS to meet the HIV service delivery needs?	Check the one answer that best describes the current situation: <input type="radio"/> This information is not available <input checked="" type="radio"/> A. No, HIV service sites do not have adequate numbers of staff to meet the HIV positive patient demand <input type="radio"/> B. Yes, HIV service sites do have adequate numbers of staff to meet the HIV patient demand (check all that apply) <input type="checkbox"/> HIV facility-based service sites have adequate numbers of staff to meet the HIV patient demand <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	Q1 Score:	0	HRH Interim Development Plan 2015-2015 Low involvement of staff in HIV service delivery due to insufficient incentive. Carry out staff incentive determinants assessment Recommendations: 3. Develop an incentive policy scheme for HR that takes into account urban and rural specificities 4. Disseminate data related to HR (deployment, performance evaluation) Note: PEPFAR via Abt. Associates seems also well positioned to assist the government in addressing this issue on the policy side. However, contribution from other donors such as the World Bank, French Cooperation (C2D), and others can help in addressing the motivation piece and HR shortage if any.

<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 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 checked="" 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: 2</p>	<p>Level 1 and Level 2 employment directory, reference document and codification of the health pyramid in Côte d'Ivoire Memorandum of Understanding between HRO and partners</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 checked="" type="checkbox"/> Increase in budget allocation for salaries for health workers</p>	<p>Q3 Score: 2</p>	<p>HRH Interim Development Plan 2015-2015 p. 30</p>	<p>Disseminate HRH Interim Development Plan 2015-2015</p>
<p>Q4. Pre-Service: Does current pre-service education curricula for health workers providing HIV/AIDS services include HIV content that has been updated in last three years?</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><input checked="" type="checkbox"/> updated content reflects national standards of practice for cadres offering HIV/AIDS-related services</p> <p><input checked="" 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>Q4 Score: 2.6</p>	<p>INFAS, INFS and UFR des Sciences Medicales Maquettes Syllabus Document</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>Training Curricula in Management and Leadership, monitoring evaluation, prevention and care and treatment</p>	<p>DFRS, INSP, PNLS, PNDAP, are organizing trainings (M/E, etc)</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 checked="" type="checkbox"/> There is a national interoperability strategy for the HRIS</p> <p><input checked="" 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: 2</p>	<p>HRH Interim Development Plan 2014-2015 p. 27 HRO Report</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>HRH Interim Development Plan 2015-2015 p. 27</p>	<p>Community health providers and community counselors are not supported by the government. Include Community health provider, community counselors, data manager positions in the public service job classification</p>

Human Resources for Health Score 15.6

<p>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.</p>		<p>Source of data</p>	<p>Notes/Comments</p>
<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 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>Q1 Score: 0</p>	<p>ARV logistics management technical committee meeting reports : "Rapport Technique de la Quantification des ARVs et Cotrimoxazole, 1-5 Sept 2014" by SCMS.</p> <p>Domestic public income are limited for 3rd line ARV funding, especially for Rategravir and Darunavir</p> <p>Recommendations: 5. Increase government contribution to the purchase of ARV drugs and commodities (Test kits and Condom, applies to questions below)</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 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>Q2 Score: 0</p>	<p>ARV logistics management technical committee meeting reports : "Rapport Technique de la Quantification des ARVs et Cotrimoxazole, 1-5 Sept 2014" by SCMS.</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>ARV logistics management technical committee meeting reports : "Rapport Technique de la Quantification des ARVs et Cotrimoxazole, 1-5 Sept 2014" by SCMS.</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 checked="" type="checkbox"/> Training</p> <p><input checked="" type="checkbox"/> Warehousing</p> <p><input checked="" type="checkbox"/> Distribution</p> <p><input checked="" type="checkbox"/> Reverse Logistics</p> <p><input checked="" 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: 4</p>	<p>National Supply Chain Strategic Plan 2012-2015; GAS Plan 2014-2015, Decentralized level Supply Chain Building Project SOP (Standard Procedure for unusable pharmaceuticals management, pharmacy organization standard, supervision procedure, standard procedure for logistics information management system).</p>	<p>A Technical Working Group on HIV/AIDS consumable supply plan to review forecasts and the supply plan for the country needs. With PEPFAR support, the country has developed a policy document/standard operating procedure for unusable health consumables management. The big challenge was the capacity of the government to mobilizing sufficient fund for the effective destruction of expired drugs. Develop a policy for unusable pharmaceuticals destruction. Develop and implement the SIGL automation project. Build product dissemination capacity from districts</p> <p>Recommendations: 6. Operationalize and automate the logistic information and management system (SIGL) to improve reporting</p> <p>Note: PEPFAR again should continue to provide technical support to improve operationalization and functioning of the SIGL but significant contribution from other donors such as the GF and EU is really needed to fill the gap. As regard to the financing of ARV drugs and laboratory commodities, given that GF budget for commodities is not increasing, PEPFAR should definitely advocate for increased contribution from GoCI.</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 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><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>Q5 Score: 0</p>	<p>ARV Logistics Quantification and Management Technical Committee Report</p>	<p>Consumables are stored on public sites only. The pharmaceutical storage center (NPSP) and the 76 operational intermediate storage sites (of the 82 health districts) have 90% HIV/AIDS commodities storage level. Reference: SCMS Quaterly Report (July -Sept 2014).</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>The HIV/AIDS Commodities working group holds bi-monthly meetings to coordinate supply chain related activities and update supply plans. A national Supply chain Assessment exercise is under design. An agenda for the exercise is available and include the following timeline: Training (February 16th); Start of data collection (Feb. 23rd) End of data collection(March 13th). Data analysis and report drafting: April 2015.</p>	<p>The current first situation analysis of national supply chains, that takes place from February to March 2015</p>

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"/> B. 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>No Data available</p>	<p>Facilities exist, but are not operational (Quality Directorate, CRESAC,)</p> <p>Recommendations: 7. Develop a national integrated quality management system for HIV/AIDS services</p> <p>Note: PEPFAR through URC is well positioned to assist with that but this is also an area of support for WHO, UNAIDS and UNICEF. PEPFAR should request MSLS to identify a national body with who we should interact and build capacity.</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"/> A. No, there is no HIV/AIDS-related QM/Q strategy</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 checked="" type="radio"/> D. Yes, there is a current HIV/AIDS program specific QM/QI strategy</p>	<p>Q2 Score: 4</p>	<p>Prevention standard documents for Peer Education,</p> <p>National reference document for care and treatment for people living with HIV-1: HEALTH FACILITIES</p> <p>National reference document for care and treatment for people living with HIV-2: COMMUNITY FACILITIES</p>	
<p>Q3. Guidelines: Does national HIV/AIDS technical practice follow current WHO guidelines for PMTCT and ART?</p> <p><input checked="" type="radio"/> A. No, the national practice does not follow current WHO guidelines for PMTCT or ART</p> <p><input type="radio"/> B. Yes, the national practice does follow current WHO guidelines for:</p> <p><input type="checkbox"/> PMTCT (option B+)</p> <p><input type="checkbox"/> Adult ART</p> <p><input type="checkbox"/> Pediatric ART</p> <p><input type="checkbox"/> Adolescent ART</p> <p><input type="checkbox"/> Test and treat for specific populations</p>	<p>Q3 Score: 0</p>	<p>National guidelines document 2012 (that takes into account WHO Guidelines 2010)</p>	<p>Adaptation of WHO guidelines 2013 in progress</p>
<p>Q4. QI Data use: Does the host country government monitor and use data for HIV/AIDS quality improvement?</p> <p><input type="radio"/> A. No, there is no monitoring for HIV/AIDS quality improvement</p> <p><input checked="" type="radio"/> B. Yes, there is monitoring for HIV/AIDS quality improvement. Monitoring includes:</p> <p><input type="checkbox"/> All sites</p> <p><input checked="" type="checkbox"/> Use of data to determine quality of program or services</p> <p><input checked="" type="checkbox"/> Making recommendations and action plan for mid-course corrections</p>	<p>Q4 Score: 4</p>	<p>Meeting notes from Clinical Partners. Quarterly data review and validation meeting. ARV logistics management technical group report</p>	

<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> <ul style="list-style-type: none"> <input type="checkbox"/> All transition sites <input type="checkbox"/> Review of service outcomes <input type="checkbox"/> Client feedback on changes in quality <input type="checkbox"/> Quality improvement action plan <p><input type="radio"/> C. PEPFAR/other donors have never supported direct service delivery in the country</p>	<p>Q5 Score: 0</p>	<p>In country sources, i.e., post-transition report or documentation:</p>	<p>Non applicable question</p>
<p style="text-align: right;">Quality Management Score</p>		<p>8</p>		

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
Q1. Domestic budget: Is there a budget line item for HIV/AIDS in the national budget?	<input type="radio"/> A. No, there is no budget line item for HIV/AIDS in the national budget <input type="radio"/> B. Yes, there is an HIV/AIDS budget line item under the Health budget <input type="radio"/> C. Yes, there is an HIV/AIDS program-based budget across ministries <input checked="" type="radio"/> D. Yes, there is an HIV/AIDS program-based budget across ministries and the budget contains HIV/AIDS program indicators	Q1 Score: 6	MoH Budget, Ministry of Education Budget, Ministry of Defense Budget, General Direction of Budget/Ministry of Finance Yes there is a budget line item for HIV in the national budget, that is an aggregation of HIV budgets of different ministries
Q2. Budgetary Framework: Does the country's budgeting process utilize a Medium-Term Expenditure Framework (MTEF) or Medium-Term Fiscal Framework (MTFF)?	<input type="radio"/> A. No <input type="radio"/> B. Yes, but it does not include a separate costing of the national HIV/AIDS strategy or program <input checked="" type="radio"/> C. Yes, and it includes a separate costing of the national HIV/AIDS strategy or program	Q2 Score: 6	2012-2015 MULTIANNUAL PROGRAMMING DOCUMENT OF EXPENDITURES AND ANNUAL PERFORMANCDE PROJECT DOCUMENT (CDMT)
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?)	<input type="radio"/> Yes <input checked="" type="radio"/> No	Q3 Score: 0	OGAC-provided data sheet (follows tab E) derived from: http://www.mcc.gov/pages/election/scorecards
Q4. Domestic public revenue: What was annual domestic government revenue as a percent of	Check the appropriate box for your country's income category: <u>FOR LOW INCOME</u> <input checked="" type="radio"/> A. More than 16.4% (i.e. surpasses category mean) <input type="radio"/> B. 14.8%-16.4%, (i.e. 90-100% of category mean) <input type="radio"/> C. Less than 14.8%, (less than 90% of category mean) <u>FOR LOW MIDDLE INCOME</u>	Q4 Score: 4	OGAC-provided data sheet (follows tab E) Original Source: IMF Government Finance Statistics

<p>GDP in the most recent year available? (domestic revenue excludes external grants)</p>	<p><input type="radio"/> D. More than 22.3% (i.e. surpasses category mean)</p> <p><input type="radio"/> E. 20.1-22.3% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> F. Less than 20.1% (less than 90% of category mean)</p> <p>FOR UPPER MIDDLE INCOME</p> <p><input type="radio"/> G. More than 27.8% (i.e. surpasses category mean)</p> <p><input type="radio"/> H. 25.0%-27.8% (i.e. 90-100% of category mean)</p> <p><input type="radio"/> I. Less than 25.0% (less than 90% of category mean)</p>			
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Score for Domestic Resource Mobilization: Resource Generation: 16

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
<p>Q1. Benchmarks for health spending:</p> <p>African countries: Is the government meeting the Abuja commitment for government health expenditure (at least 15% of General Government Expenditure)?</p> <p>Non-African countries: Is government health expenditure at least 3 percent of GDP?</p>	<p><input type="radio"/> A. Yes</p> <p><input checked="" type="radio"/> B. No</p>	<p>Q1 Score: 0</p>	<p>2012-2015 National Health Plan: table 1, Page 48</p>	<p>Recommendation: MoH budget is at least 15% of GoCI budget</p>
<p>Q2. Domestic spending: What proportion of the annual national HIV response are domestic HIV expenditures financing (excluding out-of-pocket)? _____%</p>	<p><input type="radio"/> A. Less than 10%</p> <p><input checked="" type="radio"/> B. 10-24%</p> <p><input type="radio"/> C. 25-49%</p> <p><input type="radio"/> D. 50-74%</p> <p><input type="radio"/> E. 75% or Greater</p>	<p>Q2 Score: 2</p>	<p>NASA or NHA data: 2010-2011 NASA, Chart 2, page 31</p>	<p>NASA report 2014 will allow for rate update</p>
<p>Q3. Key population spending: What percent of</p>	<p><input checked="" type="radio"/> A. None or information is not available</p> <p><input type="radio"/> B. 1-9%</p>	<p>Q3 Score: 0</p>	<p>No report is available</p>	<p>Disaggregate HIV/AIDS budget line per population type (key population)</p>

<p>Q9. 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)?</p>	<p><input type="radio"/> 10-24%</p> <p><input type="radio"/> 25-49%</p> <p><input type="radio"/> 50-74%</p> <p><input type="radio"/> 75% or Greater</p>			<p>Recommendation: HIV budget line to be disaggregated by types of PLHIV</p>
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<p>Score for Domestic Resource Mobilization: Resource Commitments:</p>	<p>2</p>
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<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>Source of data</p>	<p>Notes/Comments</p>
<p>Q1. Data-driven allocation: Does the host country government routinely use existing data to drive annual HIV/AIDS program investment decisions?</p>	<p><input type="radio"/> A. No, data are not used annually</p> <p><input checked="" type="radio"/> B. Yes, data are used annually. Check all that apply:</p> <p><input checked="" type="checkbox"/> Epidemiological data are used</p> <p><input checked="" type="checkbox"/> Health/service delivery data are used</p> <p><input checked="" type="checkbox"/> Financial data are used</p> <p><input type="checkbox"/> There is integrated analysis across data streams</p> <p><input checked="" type="checkbox"/> Multiple data streams are used to model scenarios</p>	<p>Q1 Score: 8</p>	<p>2011-2015 HIV AIDS National Strategic Plan, 2011-2014 Health Information Strategic Plan (ex DIPE, now DPPEIS)</p> <p>All data are used for planning processes. But funding decisions are informed by policy priorities under fiscal constraints.</p> <p>Recommendation: Advocacy for a better evidence-based HIV plan financing</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>	<p><input type="radio"/> A. The government does not consider yield or burden when deciding on the number and location of HIV/AIDS service sites</p> <p><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</p> <p><input type="radio"/> C. 20-49% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p> <p><input checked="" type="radio"/> D. 50-79% of HIV/AIDS service delivery sites yield 80% or more of positive HIV test results or ART clients</p>	<p>Q2 Score: 5</p>	<p>The Government uses the principle of horizontal equity in health service delivery including HIV AIDS care and treatment</p> <p>Based on the principle of horizontal equity (to provide health services to every Ivorian across the nation), the Government takes responsibility to build and renovate health facilities.</p>

	<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			
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?	<input type="radio"/> A. No, there is no system for funding cycle reprogramming <input type="radio"/> B. Yes, there is a policy/system that allows for funding cycle reprogramming but it is seldom used <input 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 <input checked="" 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	Q3 Score: 3	Ministry of Finance's Budget extension allocation process	The process is called "Budgetary Extension" and is initiated by the Ministry of Finance in Q2 of the given year. Based on the current operational plan, budget proposal and semi-annual results, MoH Directors can advocate for additional funding (if they received 100% funds they asked for) or remaining funding (if they didn't receive all funds they requested).

Allocative Efficiency Score:		16
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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
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Q1. Unit costs: Does the Host Country Government use expenditure data or cost analysis to estimate unit costs of HIV/AIDS services? (note: full score of five points can be achieved without checking all disaggregate boxes).	<input type="radio"/> A. No <input checked="" type="radio"/> B. Yes (check all that apply): <input type="checkbox"/> Annually <input checked="" type="checkbox"/> For HIV Testing <input checked="" type="checkbox"/> For Care and Support <input checked="" type="checkbox"/> For ART <input checked="" type="checkbox"/> For PMTCT <input type="checkbox"/> For VMMC <input checked="" type="checkbox"/> For OVC Service Package <input checked="" type="checkbox"/> For Key population Interventions	Q1 Score: 5	Adult and Pediatric ART Costing Study 2015 BNETD and MEF reference document of prices HIV harmonized unit costs matrix	Recommendation: Advocacy for more expenditure/cost analysis
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<p>Q2. Improving efficiency: Which of the following actions is the Host Country Government taking to improve technical efficiencies?</p>	<p>Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> Using findings from cost-effectiveness or efficiency studies to modify operations or interventions <input checked="" type="checkbox"/> Streamlining management to reduce overhead costs <input checked="" type="checkbox"/> each ti <input checked="" type="checkbox"/> Improving procurement competition <input checked="" type="checkbox"/> Integration of HIV/AIDS into national or subnational insurance schemes (private or public) <input checked="" type="checkbox"/> Scaling up evidence-based, high impact interventions and reducing interventions without evidence of impact <input checked="" type="checkbox"/> Geographic targeting in high burden/high yield sites to increase impact <input checked="" type="checkbox"/> Analysis of expenditure data to establish appropriate range of unit costs 	<p>Q2 Score: 4</p>	<p>Pool procurement of HIV/AIDS commodities (ARVS) and Rapid test kits through PEPFAR implementing mechanism (SCMS) and strong coordination with Global Fund.</p>	<p>Each time it needed, MoH public health specialists conduct evidence based literature reviews and write technical notes in order to publish best practices.</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 type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>Q3 Score: 3</p>	<p>NASA, NHA</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> <ul style="list-style-type: none"> <input type="checkbox"/> They are not paying for any ARVs <input type="checkbox"/> They are not paying for any test kits <input type="checkbox"/> They are paying no more than 5% above the international benchmark price for first line ARVs <input checked="" type="checkbox"/> They are paying no more than 5% above the international benchmark price for test kits 	<p>Q4 Score: 2</p>	<p>http://apps.who.int/hiv/amds/price/hdd/Default.aspx</p>	<p>Recommendation: Advocacy for an increase of GoCI contribution in ARVs financing</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><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes</p>	<p>4</p>	<p>WHO, Global Price Reporting Mechanism - http://apps.who.int/hiv/amds/price/hdd/</p>	

Current unit cost: \$ _____				
Technical Efficiency Score:				18

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 style="text-align: center;">Q1 Score: 6.0</p> <ul style="list-style-type: none"> <input type="radio"/> A. Extensive Information (OBI Score 81-100; or PEFA score of A- or better on element PI-10) <input type="radio"/> B. Significant Information (OBI Scores 61-80; or PEFA score of B or B+ on element PI-10) <input checked="" type="radio"/> C. Some Information (OBI Score 41-60; or PEFA score of B-, C or C+ on element PI-10) <input type="radio"/> D. Minimal Information (OBI Score 21-40; or PEFA score of C- or D+ on element PI-10) <input type="radio"/> E. Scant or No Information (OBI Score 0-20; or PEFA score of D or below on element PI-10) <input type="radio"/> F. There is neither Open Budget Index score nor a PEFA assessment to assess the transparency of government budget 	<p>OGAC-provided data sheet (follows tab E)</p> <p>Data derived from Open Budget Index 2013 Results finalized but not yet published</p> <p>(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 style="text-align: center;">Q2 Score: 2.0</p> <ul style="list-style-type: none"> <input type="radio"/> A. No, the national HIV/AIDS program progress report or presentation of results is not made public <input checked="" type="radio"/> B. Yes, the national HIV/AIDS program progress report and/or results are made publically available (Check all that apply): <ul style="list-style-type: none"> <input type="checkbox"/> On Website <input type="checkbox"/> Through any type of media <input checked="" type="checkbox"/> Disseminate print report or presentation of results 	<p>Annual HIV Report 2013. Find Exact source Rapport annuel des indicateurs VIH du secteur sante en Cote d'Ivoire, 2013, Rapport annuel VIH 2013</p>
<p>Q3. Audit transparency: Does the host country government make an annual national HIV/AIDS</p>	<p style="text-align: center;">Q3 Score: 0.0</p> <ul style="list-style-type: none"> <input checked="" type="radio"/> A. No audit is conducted of the National HIV/AIDS program, or the audit report is not made available publically <input type="radio"/> B. Yes, the national HIV/AIDS program audit report is made public. Check all that apply: 	<p>There are public expenses reviews, audits have been instituted, but there is no delegated legislation</p>

<p>Government make an annual national HIV/AIDS program audit report publically available?</p>	<input type="checkbox"/> On website <input type="checkbox"/> Through any type of media <input type="checkbox"/> Disseminate print report			<p>Registration</p>
Public Access to Information Score: 8				

<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 type="radio"/> A. PEFA assessment never conducted, or data unavailable <input checked="" type="radio"/> B. PEFA was conducted and score was below C <input type="radio"/> C. PEFA was conducted and score was C <input type="radio"/> D. PEFA was conducted and score was B <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) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org)</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 type="radio"/> A. PEFA assessment never conducted, or data unavailable <input checked="" type="radio"/> B. PEFA was conducted and score was C or higher for: </p> <p> <input checked="" type="checkbox"/> (i) Completeness of the financial statements <input type="checkbox"/> (ii) Timeliness of submission of the financial statements <input checked="" type="checkbox"/> (iii) Accounting standards used </p>	<p>Q2 Score: 4.0</p>	<p>OGAC-provided data sheet (follows tab E) Data derived from Public Expenditure and Financial Accountability Framework (www.pefa.org) Annual HIV Report 2013. Find Exact source Rapport annuel des indicateurs VIH du secteur sante en Cote d'Ivoire, 2013, Rapport annuel VIH 2013</p>
	<p>Check A, B, or C; if C checked, select appropriate disaggregates:</p> <p> <input type="radio"/> A. No, there are no formal channels or opportunities <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>Q3 Score: 5.5</p>	<p>To Be Added Based on meeting notes; Attendance list, reports strategic documents (NSP, National Strategic Plan for TB, malaria, PMTCT, RS, Nutrition, etc.)</p>
	<p>Decree of DD Order 400 of the Minister of health Dec. 18, 2007</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 checked="" type="radio"/> C. Yes, there are formal channels and opportunities for civil society engagement and feedback. Check all that apply:</p> <ul style="list-style-type: none"> <input checked="" type="checkbox"/> During strategic and annual planning <input checked="" type="checkbox"/> In joint annual program reviews <input checked="" type="checkbox"/> For policy development <input checked="" type="checkbox"/> As members of technical working groups <input type="checkbox"/> Involvement on evaluation teams <input checked="" type="checkbox"/> Giving feedback through social media <input checked="" type="checkbox"/> Involvement in surveys/studies <input checked="" type="checkbox"/> Collecting and reporting on client feedback 			
<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>	<ul style="list-style-type: none"> <input type="radio"/> A. EEI score of 0-0.38; or if no EEI score, there are laws or polices that restrict civil society playing an oversight role <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 <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>Q4 Score: 4.0</p>	<p>OGAC-provided data sheet (follow tab E) Order 400 MSHP/CAB, 18 Dec, 2007 - chapter 2 article 9 on health district senior teams functioning; directory of health sector NGOs; direct grants to NGOs Data derived from Civicus Enabling Environment Index (civicus.org/eei/)</p>	<p>Civil society involved and grant, but this collaboration needs to be formalized</p>
<p>Oversight and Stewardship Score:</p>		<p>13.5</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.

	Source of data	Notes/Comments
<p>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.</p>		
<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 <input checked="" type="radio"/> B. Yes, there are such laws, regulations or policies. Check all that apply (each check box reduces score): </p> <p> <input 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 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>	<p>Q1 Score: 4.0</p>	<p>CI LAW. Cf. article of the penal code relating to prostitution; cf article 335 and 336, section 4, chapter 9: "Harm to human health, to public morality and hygiene". Act 88686 of 22 July 1988 on the suppression of illicit traffic and use of narcotic drugs, of psychotropic substances and poisonous substances.</p> <p>There is a legislative gap regarding homosexuality. Steering (street prostitution) is prohibited</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>Q2 Score: 4.0</p>	<p>cf. HIV/AIDS Act (enacted 14 July 2014); General HIV/AIDS Policy Letter in Cote d'Ivoire (Dec. 2003) Nation STI/HIV/AIDS Strategic Plan. HIV/AIDS Guidelines within the ministry of Defense (Nov. 2013); National AIDS Policy for highly vulnerable populations (Oct. 2012)</p> <p>Ministry of Defense AIDS policy document includes the gender-based violence issue. The organization chart of the Ministry of Health and the Fight against AIDS has created a section in charge of highly vulnerable people (female sex workers, MSM, drug users, prisoners). This demonstrates government commitment to focussing especially these vulnerables groups. Likewise, the National AIDS Strategic Plan takes these groups into account.</p> <p>RECOMMENDATIONS: The general HIV/AIDS Policy letter is very obsolete and does no longer tally with the actual context of vulnerable populations in Cote d'Ivoire. It is expedient for the government to renew this commitment toward vulnerable populations taking into account the current epidemiological context, that include strengthening the protection of people's rights regardless of their sexual orientation.</p>

<p>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?</p>	<p><input type="radio"/> A. No, there are no special provisions or advantages for CSOs</p> <p><input checked="" type="radio"/> B. Yes, there are special provisions and advantages for CSOs. Check all that apply:</p> <p><input type="checkbox"/> Significant tax deductions for business or individual contributions to not-for-profit CSOs</p> <p><input checked="" type="checkbox"/> Significant tax exemptions for not-for-profit CSOs</p> <p><input type="checkbox"/> Open competition among CSOs to provide government-funded services</p> <p><input checked="" type="checkbox"/> Freedom for CSOs to advocate for policy, legal and programmatic change</p>	<p>Q3 Score: 2.0</p>	<p>No formal data, but in-country knowledge and acknowledgement of this question was addressed during the workshop.</p>	<p>Yes. Privileges and exemptions are granted to civil society organizations at their request on a case-by-case basis. (Ex., RIP+ doesn't have a formal document notifying the exemption scheme that is applied to its case. However, RIP+ benefits from tax advantages and other exemptions upon request).</p>
<p>Q4. Enabling legislation: Are there policies or legislation that govern HIV/AIDS service delivery?</p>	<p><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> B. Yes, there are. Check all below that are included:</p> <p><input checked="" type="checkbox"/> A national public health services act that includes the control of HIV</p> <p><input checked="" type="checkbox"/> A task-shifting policy that allows mid-level providers to provide key HIV/AIDS services</p>	<p>Q4 Score: 4.0</p>	<p>cf. HIV/AIDS Act (enacted on 14 July 2014); Order on delegation of tasks. News release of the Council of Ministers of October 1, 2014. (item 11) http://www.presidence.ci/presentation-detail/449/communiqued-conseil-des-ministres-du-mercredi-01-10-2014</p>	<p>A Communication at a Council of Ministers approving the implementation of task delegation</p>
Policies, Laws, and Regulations Score:		14		

<p>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.</p>		Source of data	Notes/Comments	
<p>Q1. National Strategy: Does the country have a multi-year, costed national strategy to respond to HIV?</p>	<p><input type="radio"/> A. No, there is no national strategy for HIV/AIDS</p> <p><input checked="" type="radio"/> B. Yes, there is a national strategy. Check all that apply:</p> <p><input checked="" type="checkbox"/> It is multiyear</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>Q1 Score: 4.0</p>	<p>National HIV/AIDS Strategic Plan 2011-2015</p>	<p>The elaboration of the strategic plan covering the period of 2016-2020 is underway</p>
<p>Q2. Data driven prioritization: Did the host</p>	<p><input type="radio"/> A. No data-driven prioritization approach was used</p>	<p>Q2 Score: 2</p>	<p>National HIV/AIDS Strategic Plan 2011-2015</p>	<p>An investment framework will be developed during the upcoming strategic planning exercise 2016-2020.</p>

<p>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 checked="" type="radio"/> B. Yes, a data-driven prioritization approach was used but it did not</p> <p><input type="radio"/> C. Yes, a data-driven prioritization approach was used that coordinated the investments of multiple funding sources</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 checked="" type="radio"/> B. Yes, with conditions</p> <p><input type="radio"/> C. Yes</p>	<p>Q3 Score: 1</p>	<p>Global Fund 2014 eligibility list. Cf. CCM Cote d'Ivoire evaluation report 2014</p>	<p>AFRICASO organization was committed to assisting CCM in integrating global fund recommendations related to the representation of key populations within the bureau of CCM. (Now there is a seat for key population representatives).</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 checked="" type="radio"/> A. No, it does not track or map all HIV/AIDS activities</p> <p><input 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 type="checkbox"/> Activities are tracked or mapped</p> <p><input type="checkbox"/> Duplications and gaps are addressed</p> <p><input type="checkbox"/> Joint operational plans are developed that include key activities of all implementing agencies</p>	<p>Q4 Score: 0.0</p>	<p>MOH Report</p>	<p>The government does not have a clear visibility of all the intervention of civil society stakeholders. the government is making coordination efforts as part of the multisectoral approach of the fight against HIV/AIDS. Joint site visits with donors and the ministry are arranged interventions monitoring improvement. RECOMMENDATION: Revitalize the various coordination instances of the response of the fight against HIV/AIDS. Intervention mapping should be updated.</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><input type="radio"/> A. No</p> <p><input checked="" type="radio"/> 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> <p><input checked="" type="checkbox"/> In advocacy</p> <p><input type="checkbox"/> In programmatic decision-making</p> <p><input type="checkbox"/> In technical decision-making</p> <p><input checked="" type="checkbox"/> In service delivery</p>	<p>Q5 Score: 2.0</p>	<p>Civil Society networks. RIP+ COSCI</p>	<p>The Civil Society is more active in the service delivery and advocacy than in taking actual decisions. Not always they are involved in the technical or programmatic decision taking.</p>

Planning and Coordination Score:

9

THIS CONCLUDES THE SET OF QUESTIONS ON THE ENABLING ENVIRONMENT DOMAIN