

Côte d'Ivoire

Country Operational Plan (COP) 2016

Strategic Direction Summary

April 21, 2016

Table of Contents

Goal Statement

1.0 Epidemic, Response, and Program Context

- 1.1 Summary statistics, disease burden and epidemic profile
- 1.2 Investment profile
- 1.3 Sustainability Profile
- 1.4 Alignment of PEPFAR investments geographically to burden of disease
- 1.5 Stakeholder engagement

2.0 Core, near-core and non-core activities for operating cycle

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

- 4.1 Targets for scale-up locations and populations
- 4.2 Priority population prevention
- 4.3 Preventing mother-to-child transmission (PMTCT)
- 4.4 HIV testing services (HTS)
- 4.5 Facility and community-based care and support
- 4.6 TB/HIV
- 4.7 Adult treatment
- 4.8 Pediatric Treatment
- 4.9 OVC
- 4.10 Laboratory

5.0 Program Activities in Sustained Support Locations and Populations

- 5.1 Package of services and expected volume in sustained support locations and populations
- 5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

- 6.1 Critical systems investments for achieving key programmatic gaps
- 6.2 Critical systems investments for achieving priority policies
- 6.3 Proposed system investments outside of programmatic gaps and priority policies

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

Appendix A- Core, Near-core, Non-core Matrix

Appendix B- Budget Profile and Resource Projections

Appendix C- Systems Investments for Section 6.0

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. COP16 accelerates the vision of reaching 80% coverage of adult treatment and 40% of pediatric treatment in select high-impact geographic areas, targeting 16 Scale-Up to Saturation Districts and 23 Aggressive Scale-Up Districts. The Saturation Districts represent 34% of the estimated disease burden in the country, have the largest current patient cohorts, and are among areas most likely to be sources of new infections. The Aggressive Scale-Up districts represent an additional 40% of the estimated disease burden. In both areas, the program will intensify outreach for positive case identification of people living with HIV (PLHIV), especially among older men, adolescent young girls and women, and pediatric cases, while increasing linkages along the clinical cascade.

In the 40 Sustained Districts, with 23% of the estimated number of PLHIV, COP15 has begun transitioning service demand and maintenance towards the Ivoirian government's health infrastructure, with no new sites established by PEPFAR. Patients currently served through higher-yield PMTCT and ART sites will be maintained on treatment at PEPFAR-supported sites, and the minimum package of care for orphans and vulnerable children (OVC) will continue in these regions, with complete transition of OVC families occurring by FY17. Routine testing services for PMTCT at sites in Sustained Districts are no longer PEPFAR-supported, but women testing positive continue to access prophylaxis, ART and care services with PEPFAR support.

PEPFAR has been supporting the Ivoirian government since COP15 to put in place policy measures and tools to implement Test and Start, a major policy accomplishment. It is expected that the Government of Côte d'Ivoire (GOCI) will release a "circular" (*circulaire*) for nationwide application of a Test and Start approach for all PLHIV before the end of FY16. The National HIV Strategic Plan for 2016-2020, currently near validation at the time of COP16 submission, takes into account a Test and Start approach in order to reach the country's five-year goal of reaching 90:90:90. PEPFAR-CI is advocating the adoption of alternative service delivery models in COP16 to accompany the policy revisions, such as differentiated care guidelines for stable patients, alternative methods of ARV distribution, and the progressive withdrawal of support for CD4 monitoring and scale up of viral load testing.

COP15 continues the transition to the Ivoirian government of low-yield and no-yield HIV testing sites identified at APR14, with joint monitoring on the progress of transition and the quality of services through a combined PEPFAR, government, and implementing partner committee. PEPFAR-CI is performing this analysis of low/no-yield sites on an annual basis, while also deliberating further how to better serve populations in low-volume sites located in high-burden areas. The U.S. Ambassador to Côte d'Ivoire continues to engage actively with key members of the Ivoirian government, including the Prime Minister and the Minister of Health, regarding resource needs of the national HIV response in order to encourage a progressive but substantive

shift in program responsibility from the U.S. Government (USG) to the Ivoirian government leading up to 2020, an area that has seen success over the past year.

1.0 Epidemic, Response, and Program Context

1.1 Summary statistics, disease burden and country or regional profile

According to 2014 census results, Cote 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 2015 UNAIDS report on Côte d'Ivoire¹ estimates HIV prevalence at 3.5%, 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 Ivoirian population under 15 years of age is estimated to be 8,780,535, or 38%. According to UNAIDS, the estimated total number of people living with HIV (PLHIV) is 460,000; the number of orphans and vulnerable children (OVC) is approximately 230,000, and the number of pregnant women needing ARVs is 50,937. There are approximately 25,000 new HIV infections and 22,000 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 3.5% in 2015 (UNAIDS). About 42% of PLHIV (195,755) have been put on HIV care services, and over 150,000 on ART.

In spite of the tremendous progress made, major gaps still exist in achieving HIV epidemic control. Retention on treatment in general has improved, but still remains below 80%, and even major 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. COP16 places increased attention on addressing the programmatic and systems gaps in case identification and linkage to services of children, Key Populations (KPs), and the priority population of men above 35 years of age, as well as on increasing access to viral load testing nationwide. Progress in these areas will significantly accelerate the country toward the 90:90:90 goals. The USG is optimistic that President Ouattara's second term will focus more attention on health and education, sectors that have seen less investment than economic growth and infrastructure. Competing priorities in the health sector have also contributed to government

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 Côté 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).

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.

According to 2013 World Bank data, the gross national income per capita for Côte d'Ivoire is \$1,450.⁴ The country is experiencing robust economic growth with a 8.5% GDP increase in 2015. Though the GOCI budget for health has impressively doubled over the past four years, going from \$361 million in 2013 to \$725 million in 2016, these investments represent respectively only 4.8% and 6.2% of the its overall annual 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	22,671,331	100%	4,679,147	20.64%	4,751,499	20.96%	6,283,940	27.72%	6,956,745	30.69%	Côte d'Ivoire 2014 Census. Total male: 11,716,826 (51, 7%); total female 10,954,505 (48, 3%);
HIV Prevalence (%)		3.5% ⁵		Data N/A		Data N/A		4.6%		2.7%	UNAIDS report 2015 (2013 Data) and Cote d'Ivoire DHS+ 2011-2012
AIDS Deaths (per year)	22,000		Data N/A		Data N/A		Data N/A		Data N/A		UNAIDS report 2014 (2013 Data)
# PLHIV	460,000						250,000		170,000		UNAIDS report 2014 (2013 Data)
Incidence Rate (Yr)		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
New Infections (Yr)	25,000										UNAIDS report 2014 (2013 Data)
Annual births	1,221,815	5%									National Program against HIV/AIDS
% of Pregnant Women with at least one ANC visit	Data N/A	85%	Data N/A	Data N/A			Data N/A	Data N/A			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)	230,000		Data N/A		Data N/A		Data N/A		Data N/A		
Notified TB cases (Yr)	25,299		0.11%		Data N/A		Data N/A		Data N/A		National TB Program routine data, 2013
% of TB cases that are HIV infected	5,551	25%	Data N/A	Data N/A	National TB Program routine data, 2013						
% of Males Circumcised	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A	
Estimated Population Size of MSM	Data N/A	Data N/A									
MSM HIV	Data	18.0%									Risk behaviors and vulnerability for HIV among MSM survey in Abidjan,

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 2015 UNAIDS report; prevalence disaggregated by sex comes from the 2011-2012 DHS. The population-level prevalence in the DHS+ was 3.7%.

Table 1.1.1 Key National Demographic and Epidemiological Data												
	Total		<15				15+				Source, Year	
	N	%	Female		Male		Female		Male			
			N	%	N	%	N	%	N	%		
Prevalence	N/A											2011-2012
Estimated Population Size of FSW	Data N/A	Data N/A										
FSW HIV Prevalence	Data N/A	11.4%										JHU, 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."
Estimated Population Size of PWID	Data N/A	Data N/A										
PWID HIV Prevalence	Data N/A	Data N/A										
Estimated Size of Priority Pop (military)	40,000	3.4%	Data N/A	SABERS 2014								
Estimated Size of Priority Pop (AGYW 15-24 years)		0.8%	Data N/A									
Estimated size of Priority Pop (Men 25-49)	3,213,568											
Estimated size of Priority Pop (Men 49+)	1,469,758											

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	22,671,331	3.5%	460,000	195,755	147,947	147,947	Data N/A	1,865,353	65,245	28,336
Population less than 15 years	9430646	0.42%**	40,000	10,090	7,268	7,268	Data N/A	105,096	data not available	645
Pregnant Women	1,142,447	1.7% ***	10,675	data not available	16,332	16,332	Data N/A	625,921	10,675	1,543
MSM	Data N/A	18.8%	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A
FSW	Data N/A	11.4%	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A
PWID	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A
Adolescent girls and young women (15-24)	2,267,891	0.8% ***	18,143	9,677	3,489	3,489	Data N/A	149,597	3,051	1,484
Men (25-49)	3,213,568	4.9%****	157,465	36,607	19,260	19,260	Data N/A	544,224	25,449	6,048
Men 50+	1,469,758	9%****	132,278	11,465	8,563	8,563	Data N/A	22,878	1,822	1,685
Military	40,000	3.4%	1,360	Data N/A	650	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A

* RGPH 2014

** UNAIDS Report 2015

*** PEPFAR-CI APR2015

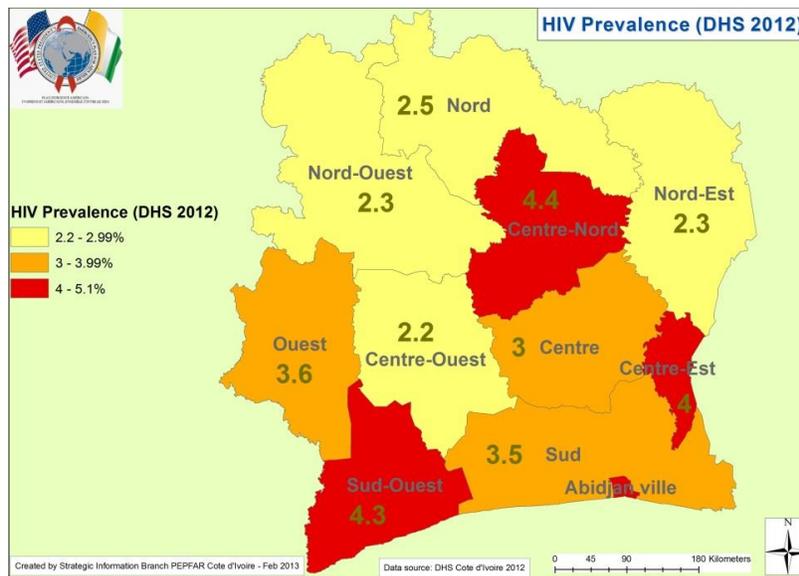
**** DHS-CI 2011-2012

***** SABERS 2014

As described in Table 1.1.1, the HIV burden is evident among female sex workers (FSW) and men who have sex with men (MSM). While men in the military have a prevalence rate of 3.4%, some hotspots show prevalence ranging from 5 to 8%. Prevalence among AGYW is eight times higher than their male peers (0.8%) while much more elevated among men aged 25-49 (4.9%) and 50+ (9%). The prevalence among adults seeking care is 5.5%, and 25% amongst TB patients.

Geographically, the disease burden is broken down into eleven areas (Fig 1.1.1). The burden is concentrated in Abidjan (5.1%), the ‘center-north’ (4.4%), ‘southwest’ (4.3%), and ‘center-east’ (4.0%), with a lower prevalence (less than 3.7%) in the remaining areas.

Fig. 1.1.1: HIV prevalence by geographic area (DHS2012)



In 2015, UNAIDS released health district-level modeling based on 2012 DHS data (Fig 1.1.2), which, despite limitations in reliability, provides a more nuanced picture of the epidemic (below).

Fig. 1.1.2: HIV prevalence by geographic area (UNAIDS subnational estimates 2015)

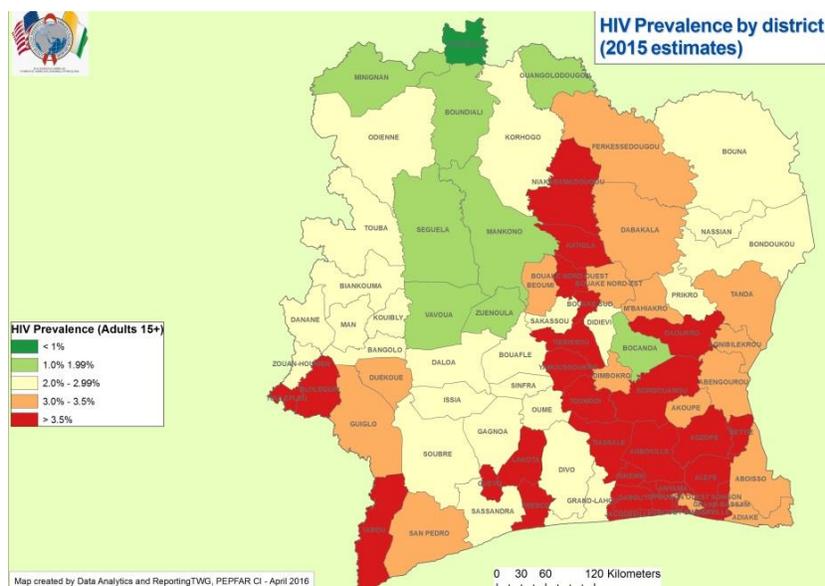
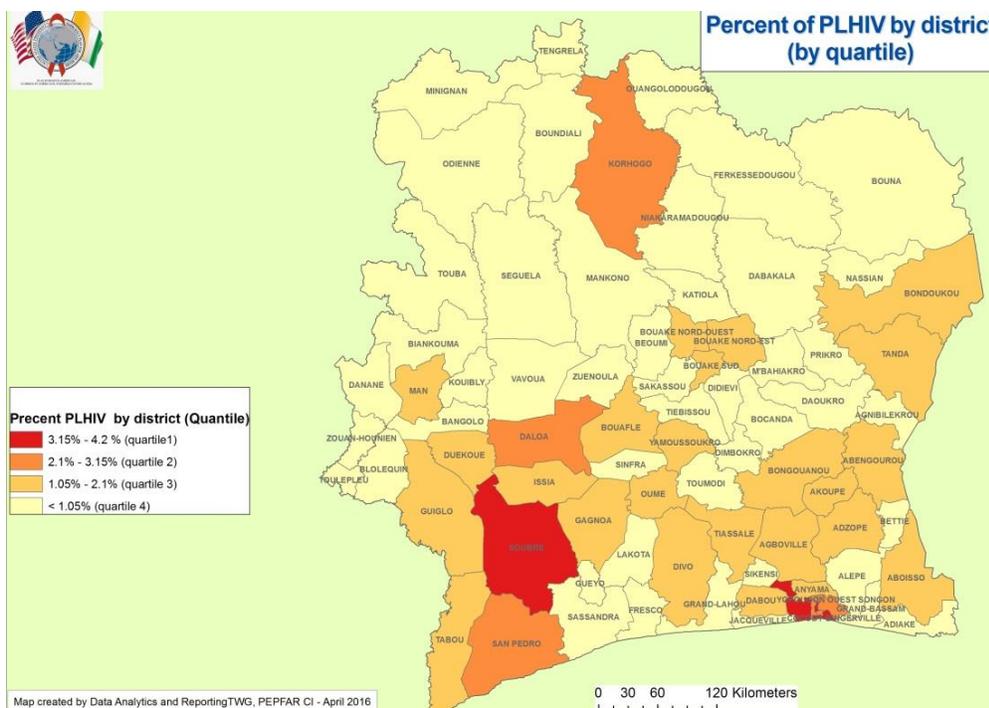
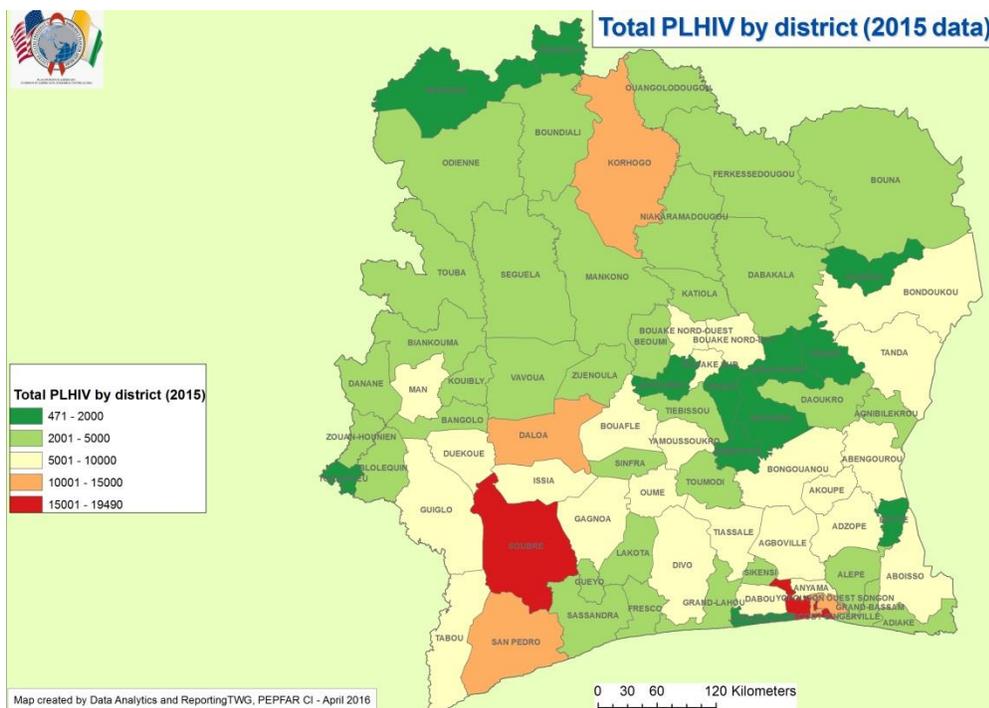


Fig. 1.1.3 shows district estimates of PLHIV, with 6,000 or more PLHIV in the orange and red districts.

Fig. 1.1.3: Total and percent of people living with HIV by health district



1.2 Investment Profile

PEPFAR is currently funding over 75% of the national HIV response. The GOCI has committed approximately \$13.1 million to HIV in FY16 (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. The GOCI has nearly completed 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 HIV allocation from the Global Fund (2017-2019). The plan is budgeted for a Test and Start model to be implemented on a national scale. 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 FY17, barring a substantial increase in resource commitment from the GOCI.

After holding a peaceful presidential election and realizing robust economic growth, the Ivoirian context for increased investments in health and poverty-reducing development activities is very positive. PEPFAR efforts to encourage increases in domestic resource mobilization for health have seen some success. In COP15, the national commitment increased to \$5 million, a ten-fold increase from 2014. The PEPFAR team anticipates an \$8.5 million commitment for HIV commodities. However, the competing priorities of the Ministry of Health and Public Hygiene (MSHP) pose an ongoing challenge as well for achieving ambitious targets, sustaining gains, and transitioning 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
HTS	\$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

Table 1.2.1 reflects the information as of FY2015. At the date of COP submission, the Global Fund Principal Recipients (PRs) were in the process of finalizing their cost extension proposals covering the period Oct 2016 – Dec 2017, which overlaps with COP16 implementation. During the proposal drafting discussions, of which the Global Fund country team has received updates, PEPFAR and the PRs came to an agreement that PEPFAR would budget ARV support in COP16 with the

⁶ GRP, National AIDS Spending Assessment , 2012.

assumption that Global Fund would contribute at least €15 Million, although this figure represents less than the 45% of the national need that had been committed in the current grant.

Table 1.2.2 below summarizes the value of key HIV commodities procured in calendar year 2015.

Commodity Category	Total Expenditures	PEPFAR	% PEPFAR	GF	% GF	GOCI	% GOCI
ARVs	\$20,798,047	\$10,980,197	52.79	\$9,265,155	44.55	\$552,695	2.66
Rapid test kits	\$4,158,243	\$3,426,725	82.41	\$0	0.00	\$731,518	17.59
Other drugs (CTx, STI Kits)	\$903,034	\$903,034	100.00	\$0	0.00	\$0	0.00
Lab reagents	\$12,819,288	\$7,092,811	55.33	\$5,726,477	44.67	\$0	0.00
Viral Load reagents	\$395,536	\$395,536	100.00	\$0	0.00	\$0	0.00
TB (Genexpert) commodity	\$109,301	\$109,301	100.00	\$0	0.00	\$0	0.00
Condoms	\$505,402	\$300,000	59.36	\$160,402	31.74	\$45,000	8.90
Other supplies	\$128,196	\$128,196	100.00	\$0	0.00	\$0	0.00
Total	\$39,817,047	\$23,335,800	58.61	\$15,152,033	38.05	\$1,329,213	3.34

(* based on actual deliveries occurred during calendar year 2015.

Data source: , RetroCI; ASM; SCMS/CDI, Alliance Cote d'Ivoire; UNFPA; HIV/Commodities Technical Working Notes;

<http://www.myaccessrh.org>

Table 1.2.3 USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH					
USAID TB					
USAID Malaria					
Family Planning					
NIH					
CDC NCD				N/A	
Peace Corps					
DOD Ebola					
MCC					
Total					

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
ACT						
DREAMS						
DREAMS Innovation						
DREAMS Test & Start-Men						
VMMC				N/A		
Viral Load						
Other PEPFAR Central Initiatives						
Other Public Private Partnership						
Total						

1.3 National Sustainability Profile

In February 2016, PEPFAR-CI, UNAIDS and the MSHP jointly organized a one-day workshop on the Sustainability Index, bringing together 36 representatives from multiple ministries, multilateral organizations, civil society, the private sector, and other development partners, in addition to the interagency, multi-sectorial PEPFAR. Based on their areas of expertise, participants were divided into four subgroups, one for each Sustainability Domain, to complete the SID questions. The four groups gathered at the end of the day to present the summary results.

The 2016 Sustainability Index Dashboard (SID) showed strengths in three out of the four domains, specifically Public Access to Information, HRH, Service Delivery, and Data related to performance. The most evident vulnerability to sustainability touches upon laboratory services and quality management of services at health facilities, which, of course, impact IV services. Also of note as a very important vulnerability is the domestic mobilization of funds and allocation of resources. HIV budgets allocated to the various central health institutions of GOCI are generally not linked to planning based on results and effective strategies. As a result, the Ministry of Economy and Finance (MEF) cannot align the budget allocations to the specific HIV-related needs. In addition, HIV-specific budget proposals/projects are not always linked to the implementation of high-impact, scientifically-proven strategies/activities. The MSHP recognizes the need for technical assistance to build budget procedures that are better linked to programming results and needs, and PEPFAR has provided technical support to the National HIV Strategic Plan to budget for Test and Start. After promising results in COP15, PEPFAR continues to advocate at multiple levels for an increase in domestic resources allocated the HIV response, particularly for commodity procurement. PEPFAR will also advocate for an increase in the government contribution to sustain the response by investing in domestic resources in the mobilization, training, and retention of community-level staff. The increased focus on community models of service delivery, outreach to PHLIV and support to retention, all corollaries

of a “Test and Start” approach, necessitate serious investment in human resources at the community health staffing levels.

Two additional areas of vulnerability to sustainability include: policy and governance and supply chain management. These are both areas where PEPFAR support has been active in previous years and will continue in COP16. Technical assistance for improvement in supply chain management will address commodity stock outs at decentralized levels and also extend to increasing capacity for laboratory commodity management. A redesigned procurement mechanism will allow for cohesive, integrated supply chain support and build the capacity of the central warehouse system.

In COP16, PEPFAR-CI at senior levels will continue to press for increased local governmental funding. Support for HIV incidence data collection efforts by the GOCI and completion of the Population-based HIV Impact Assessment will address the need for incidence and viral load data. The program will be seeing an scale-up of viral load testing to ensure viral suppression; support quality improvement for all HIV services, which contributes to the three 90’s; and, as integral part of these efforts, deploy a laboratory information system and enhanced sample transport logistics.

COP16 will make investments to increase health staff 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, 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 MSHP, the MEF, and the Ministry of Budget.

Solutions to problems identified above may come from the host government, multilateral organizations, and several donors. Regular HIV Committee meetings and stakeholder engagement which have increased in COP15 have enhanced the PEPFAR’s ability to understand common investments in these areas. 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.

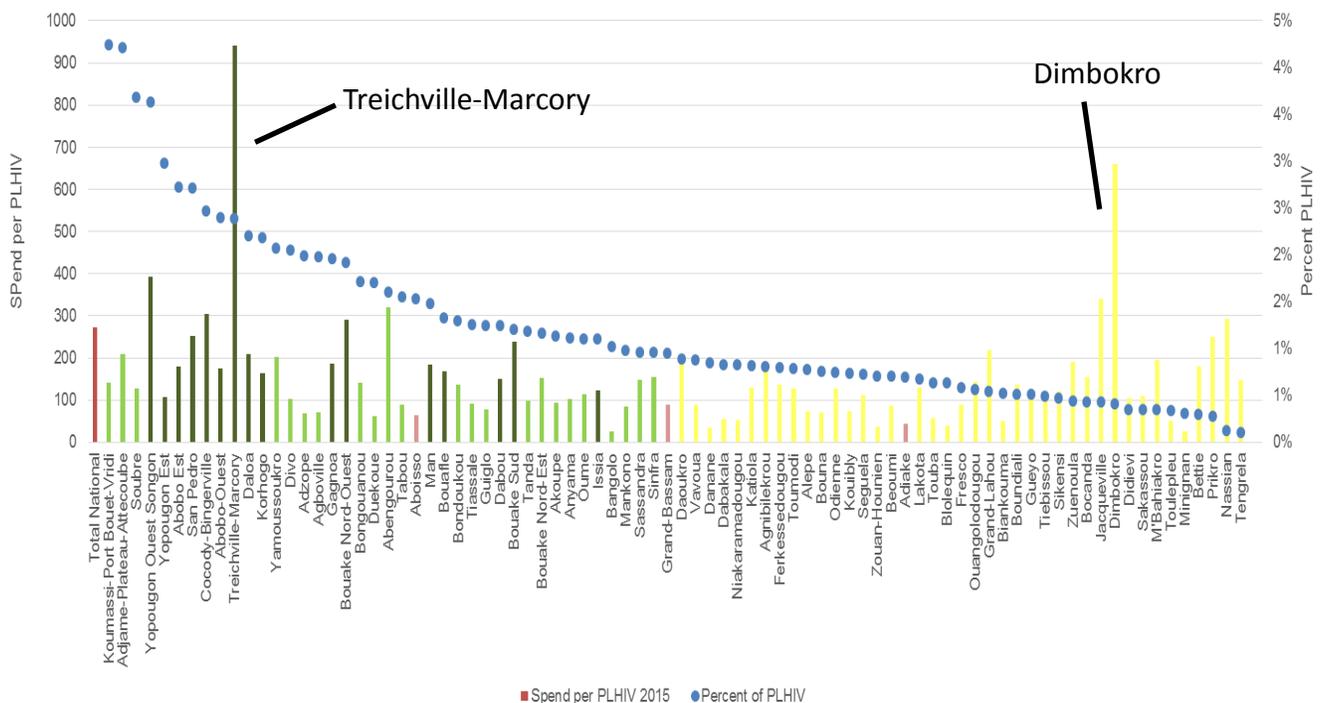
Overall, the investment climate in Côte d’Ivoire is very positive for donors as well as the private sector. Multilateral and bilateral organizations are combining their efforts with those of the host government for improved sustainability; notably, the Global Fund contributes to the procurement of HIV commodities; the World Health Organization (WHO) advocates for local health budget funding increases (to 15% or more) and uptake of new clinical guidelines, UNAIDS advocates for policy change, and the WB for key population intervention mapping. ESTHER, funded by the French government, is providing technical assistance and conducting 10,000 VL tests each at PEPFAR-supported ART sites. UNICEF provides support for the implementation of Option B+ as

well as of task-shifting in 12 districts. 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. The Millennium Challenge Corporation found Côte d'Ivoire eligible for a Compact in December 2015. Ongoing work developing that program could bring significant additional resources to Ivoirian development efforts.

1.4 Alignment of PEPFAR investments geographically to disease burden

The expenditure analysis (EA) information has been 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 COP16 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 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 \$272 and ranged between \$25 (Minignan) and \$940 (Treichville-Marcory). The data does not reflect COP15 pivots - it illustrates the direction towards better control of the epidemic as per COP 2014 wave meeting decisions. This graph shows that in FY15, PEPFAR expenditures by Sub-National Unit (SNU) followed the trend of the disease burden: in FY 2014, 65% of SNUs were not in alignment as opposed to 13% in FY15.

Investments for certain SNUs like Bouake Nord-Ouest, Bouake and Nord-Est and Man drastically dropped from extreme upper values in FY14 to aligned values in FY15. In Dimbokro, the high investment includes operating costs of a major partner assigned to this location, which the team will seek to address. Apparent overinvestment in Treichville is due primarily to one facility that houses several reference clinics serving a much larger population than just the local community, making the denominator inaccurate. In this SNU, furthermore, a new care and treatment partner started HIV service provision in private sector health facilities only in the last month of FY14. This mechanism is an extreme outlier in a number of cost categories. The team has developed a mitigation plan with the partner, which aims at cutting program costs while also increasing results. It is expected that the unit expenditures for this project would decrease significantly and reach many more beneficiaries by the end of FY16, as the program becomes fully and effectively operational.

Finally, the EA has confirmed that the cost of finding positive patients through facility-based testing is far lower than the cost of finding positive individuals through community-based testing. These cost differentials are driven by differences in the model; more salary and facility costs must be borne by the community-based partners, which are saved by the facility partners operating in the public sector, GOCI-supported sites.

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

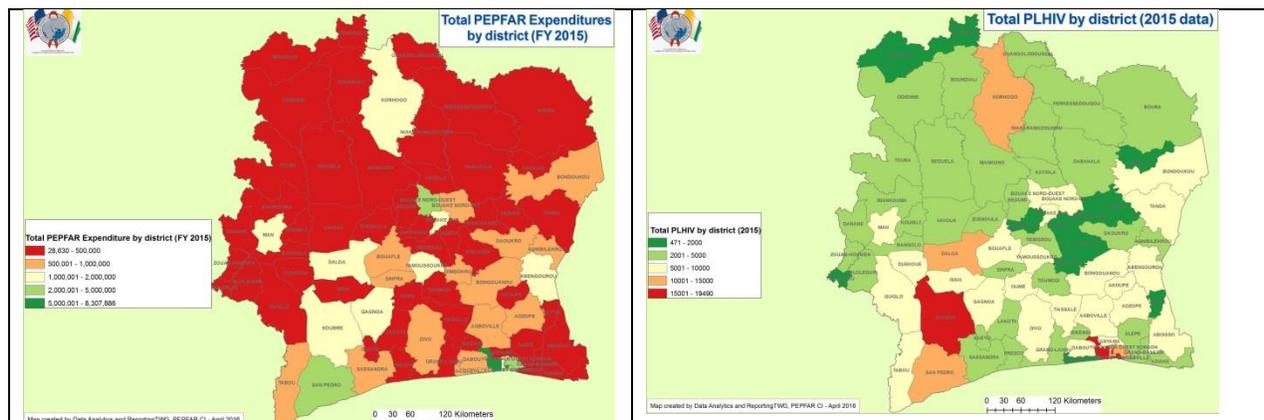


Figure 1. Total PEPFAR expenditures

Figure 2. Number of PLHIV

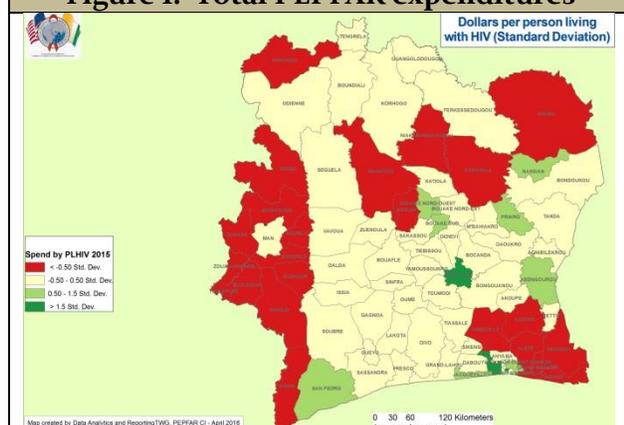


Figure 3. Dollars per person living with HIV

1.5 Stakeholder Engagement

PEPFAR-CI has a strong and long lasting relationship with the GOCI. This includes frequent technical meetings and a biweekly 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. PEPFAR-CI derives the strategic approach for each year from assessments, programmatic data analysis and program needs. The GOCI leadership and the close engagement with UNAIDS throughout the SID development, in addition to regular programmatic discussions, helped ensure appropriate exchange on priorities for complementary investment. This was crucial to allow a broad understanding and buy-in for the COP16 strategies that the PEPFAR presented in several sessions counterparts within the MSHP, civil society and health sector donors.

PEPFAR-CI has a newly dedicated technical working group for External Stakeholder Engagement that addresses challenges, solutions, and opportunities for regular engagement throughout the year. The team developed a calendar of stakeholder and civil society engagement that is widely distributed and posted on the PEPFAR-CI/Embassy webpage. These meetings include:

- Biweekly bilateral meetings with the DGS;
- Monthly meetings with DGS, stakeholders and civil society representatives;
- Quarterly meetings, before each POART call, with the entities above as well as PEPFAR implementing partners;
- Quarterly meetings focused on representatives of civil society organizations, their networks and platforms;
- Meetings and visits every six weeks to a selected individual civil society organization.

PEPFAR-CI has also increased engagement with the Global Fund primarily through the CCM (HIV committee, TB committee, Executive Bureau, and General Assembly) and with weekly calls with the Fund Portfolio Manager. The recent addition of a GF Liaison to the PEPFAR ensures better programmatic and strategic coordination and supports the strategic follow up of the HIV GF grant. Efforts continue to ensure comprehensive community and clinical approaches as well as complementarity of investment and efforts in supply chain and policy issues, which included advocacy for increased domestic resource mobilization and allocations. Strategic shifts in PEPFAR programming have been shared through the CCM HIV committee and Executive Bureau meetings. In addition, the GF Liaison has been facilitating technical meetings between PEPFAR and both Global HIV PRs (the National AIDS Control Program and Alliance CI) to discuss the best programmatic strategies for the country, maximizing investments from both donors at clinical and community levels. These efforts include integrated mapping of community activities for both PEPFAR and the GF and agreements on contributions to cover the national HIV drug needs. A set of maps showing the coordination of Global Fund- and PEPFAR-supported community efforts is among the supplemental documents for COP 2106. COP strategies, targets and budgets have been discussed with these groups, and their contributions are informing the pace and scope of the

planned transitions, and are contributing to the development of the Cost Extension proposals for the Phase 2 of Round 9.

The CCM has also been added to the regular PEPFAR stakeholder engagement agenda, as referenced above.

PEPFAR-CI 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, PEPFAR-CI held a series of meetings specifically for CSOs 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. A range of private sector partners are members of Global Fund CCM, but neither PEPFAR nor the GOCI have yet fully developed this partnership opportunity. The advocacy platform created by the development of the National HIV Strategic Plan 2016-2020 offers the opportunity to bolster this effort.

Following successful advocacy efforts led by the U.S. Ambassador to Côte d'Ivoire, the GOCI significantly increased domestic resources towards the HIV response. The USG goal is for the GOCI to identify a budget line for HIV and to increase its commitment of domestic resources in addition to the mandatory match and "willingness to pay" contribution associated with the Global Fund grants. Through advocacy efforts and technical support, the PEPFAR investment is showing results. These efforts will intensify in COP16, with economic modeling aimed to further the case for additional domestic spending.

Efforts to increase domestic resource mobilization are especially critical given the Government's adoption of "Test and Start." Additional resources will be critical to cover the cost of additional patients. PEPFAR has been working in coordination with the Global Fund, UNAIDS and the French Embassy to encourage better budget negotiations by the MSHP for the national HIV response and overall health care financing. Review of the current national health plan and development of the National HIV Strategic Plan 2016-2020 (costed for Test and Start), will allow PEPFAR to further advocate for resource mobilization, accountability and transparency of budget decisions and expenditures in line with the priority needs to reach the 90:90:90 by 2020.

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 COP15, the team determined that appropriate shifts had been made and non-core activities had appropriately ended. This progress continues in COP16, where the focus will remain on Core activities while transition planning will be focused on Near Core activities.

Activities classified as Non-Core in COP15 are not part of COP16 request. Notably, for OVC, these activities include life skills in schools, renovations, and shelter; for prevention, these include school-based interventions, blood donor mobilization and support for hemovigilance. 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 laboratory technicians, support for the laboratory accreditation program, and surveillance capacity building. Certain aspects of supply chain management, including subcontracts for trucking/distribution routes, will be successfully transitioned by the end of FY16. HIV and family planning integration will be maintained through HIV service delivery points but not through family planning specific service delivery points.

Transition to the MSHP of hematology and biochemistry tests for patients in care (with the exception of pregnant women) will begin in COP16, particularly as the country adopts the “Test and Start” policy which eliminates the “care” component, moving patients straight to treatment. OVC support in Sustained Districts will also undergo rapid transition. A full determination of Core, Near Core, and Non-Core is included in Appendix A.

3.0 Geographic and Population Prioritization

To achieve epidemic control, the PEPFAR program prioritized geographically and by population group: districts with over 1% of the total national PLHIV were classified as Scale-Up Districts, while those with less demand and less than 1% of the national PLHIV were designated as Sustained. Of the 79 health districts currently supported by PEPFAR in Côte d’Ivoire (the remaining three receiving support from the Global Fund for clinical activities), 39 districts have been prioritized for scale-up, which will lead to 80% saturation for 16 districts by FY2017. This highly focused and efficient strategy is demonstrating results and PEPFAR is on track to reach the ambitious targets as of FY 16 Q1.

Through a targeted case-finding strategy in COP16, PEPFAR intensify strategies to find and link KPs (Men who have sex with men, MSM, and Female sex workers, FSW), the military (95% of whom are male), AGYW, TB patients, and the highest risk groups in the general population to HIV testing services. Given that men are missing throughout the cascade, the COP16 PEPFAR game changer will focus on male engagement and retention. OVC and children seeking clinical care will be more intensively targeted for pediatric case finding.

While Côte d’Ivoire is already on track with the proposed targets for new enrollees on treatment in the next few years to achieve 80% ARV coverage, significant efforts need to be made in terms of the capacity to absorb and retain these new patients into the system. These will include efforts at health facilities but even more at the community level that must achieve the needed dimension and sustainability to grant long life retention of HIV patients on treatment within the context of a developing country. The prioritization decisions the team made in order to address the gap are: increased focus on men, adoption of new service delivery models and differentiated models of patient care, expansion of test and start to all populations, increased engagement of community health workers (CHWs) for retention support. These actions have contributed to narrow the gap by increasing efficiencies, while the team keeps advocating for increasing domestic resource mobilization to cover the national HIV cost.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for scale-up locations and populations

There are 20 health regions and 82 health districts in Côte d'Ivoire. COP16 maintains the Scale-Up Districts determined in COP15, based on an analysis and validation of district-level population, number of PLHIV and prevalence data. Districts were ranked based on their total number of PLHIV, using the most recent UNAIDS HIV prevalence estimates at the subnational level (2015).

PEPFAR supported 129,993 patients on ART in FY2014 and 147,947 in FY2015. This target will increase by 39% to 206,354 by the end of FY17, representing a projected net increase of 36,712 patients from APR15 58,407 to APR16.

PEPFAR will scale up programs in 16 high-burden districts to achieve 80% saturation by the end of COP16. Many of these districts already have high coverage levels and are nearing saturation. In the 23 Aggressive Scale-Up Districts representing 40% of the PLHIV, new enrollments will continue to increase by approximately 15%, an increased progression rate compared to the current calculated yearly progression rate of 10%. In the 40 Sustained Districts, passive enrollment will reduce by 50% the current progression rate. A total of 44,835 PLHIV will be newly enrolled on ART at APR16 (a significant increase from 28,336 in APR15). For COP16, the program aims to reach 78,385 new enrollments on ART, leading to 45% treatment coverage at APR17, or 56% coverage for 80% saturation with a remaining gap of 24%. Currently, the country has identified 56% of PLHIV (257,971 positives identified out of the estimated 460,000 PLHIV), placed 58% (151,422 total on ART) on treatment and achieved viral suppression in 72% (108,614 virally suppressed). In COP15, and with a good prognostic from FY16 Q1 results, PEPFAR-CI expects to reach a total of 206,354 people on treatment in COP16.

In COP16, the 78,385 patients newly initiated on ART include:

- 61,311 (TB patients, sick patients, adolescent girls, men, key and priority populations)
- 8,202 children
- 8,878 pregnant women
- 22,651 pre-ART patients receiving clinical care who will be switched on ART due to the implementation of the WHO 2015 guidelines
- 560 infants from EID entry stream
- 941 PLHIV identified by the DoD/Military program (478 military, 303 CSW that have military clients, and 133 index case family members)

Challenges in meeting targets include locating hot spots of KPs, ensuring linkage into and retention on treatment, efficiently implementing “Test and Start” along with new service delivery models, and ensuring testing update among priority populations. 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, aligning with COP15 and COP16 geographic pivots, and supporting sites that were transitioned from the Global Fund. These shifts have helped the program achieve promising results. More programmatic shifts are coming as PEPFAR adopts new service delivery models along with the national “Test and Start” policy. However, 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 MSHP.

Availability of population data at a 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 KPs, no national size estimates are available. PEPFAR is working with the MSHP and other partners to consolidate data sets and for several size estimation surveys.

However, the PEPFAR is confident in the program’s capacity to perform. The GOCI has demonstrated its commitment to ending the HIV epidemic through adoption of “Test and Start.” The pivots made in COP15 produced expected results at FY16 Q1. PEPFAR is significantly intensifying efforts to identify HIV positive people and link them into services in the 16 Scale-Up Districts in COP15. Implementing partners are reinforcing community efforts to ensure as many PLHIV as possible are identified and enrolled into the clinical cascade. These efforts will continue, along with an enhanced focus on men, who too frequently fall out of the clinical cascade. The recently adopted task-sharing policy and plans to train providers are essential to rolling out the new service delivery models for ARV distribution, as these models will increase the capacity in existing sites to serve a larger patient cohort.

The program will utilize an efficient testing model with better case finding strategies in order to test fewer people, but find more individuals testing positive. Targeted testing of sick adults and children will remain a high priority through provider-initiated testing and counseling (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. HTS will be focused on key and targeted testing among priority populations, including females aged 15-24 and high-risk males aged 25-49, including military. For KPs, size estimations are underway, allowing for more efficient targeting.

The assumptions used in the clinical cascade were based on the current performance of the program and adjusted unit expenditures from the FY15 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 high-burden districts.

COP16 investments center on how to support three main programmatic gaps (case identification of pediatric cases, outreach to KPs and priority populations, and viral load scale up) and two priority policies (Test and Start, and new service delivery models). Reduced investments in the 40 Sustained Districts, the transitioned low yield PMTCT and HTS sites, and the elimination of stand-alone “care” investments with the expected movement to Test and Start have allowed savings to feed back into the clinical cascade for higher targets in the Scale-Up Districts.

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

	Saturation Districts: 80% ART coverage by 2017
	Aggressive Scale-Up Districts: 80% ART coverage by 2020
	Sustained Districts

District	Estimated number of PLHIV (hyp: constant)	Expected Current on ART FY16	# additional patients required for 80% coverage	Expected Newly initiated on ART FY17	Expected Current on ART FY17	ART Coverage (APR 17)
Yopougon-Ouest-Songon	16,701	11,079	2,282	5,244	13,360	80%
Yopougon-Est	13,703	5,415	5,547	6,943	10,961	80%
Abobo-Est	12,497	6,833	3,165	4,611	9,996	80%
San-Pedro	12,473	4,969	5,009	5,936	9,978	80%
Cocody-Bingerville	11,344	6,518	2,557	4,340	9,075	80%
Abobo-Ouest	11,009	6,435	2,372	3,963	8,806	80%
Treichville-Marcory	10,987	18,498		3,806	18,498	168%
Daloa	10,123	5,795	2,303	3,484	8,032	79%
Korhogo	10,006	5,358	2,647	3,701	8,005	80%
Gagnoa	8,974	4,560	2,619	3,640	7,179	80%
Bouake-Nord-Ouest	8,788	5,051	1,979	3,297	7,030	80%
Man	6,780	2,649	2,775	3,622	5,424	80%
Bouafle	6,095	2,935	1,941	2,553	4,875	80%
Dabou	5,697	2,682	1,876	2,885	4,557	80%
Bouake-Sud	5,521	2,437	1,980	2,453	4,047	73%
Issia	5,051	3,006	1,035	1,770	4,041	80%
Koumassi-Port Bouet-Vridi	19,490	8,599	6,993	1,616	8,599	44%
Adjame-Plateau-Attécoubé	19,369	7,960	7,535	1,479	7,960	41%
Soubre	16,933	3,907	9,639	535	3,907	23%
Yamoussoukro	9,501	3,354	4,247	796	3,354	35%
Divo	9,423	2,216	5,322	632	2,216	24%
Adzope	9,147	1,552	5,766	261	1,552	17%
Agboville	9,096	2,049	5,228	329	2,049	23%
Bongouanou	7,885	1,986	4,322	578	1,986	25%
Duekoué	7,816	1,071	5,182	570	1,071	14%
Abengourou	7,368	2,544	3,350	460	2,544	35%
Tabou	7,133	740	4,966	104	740	10%
Bondoukou	5,958	2,301	2,465	548	2,301	39%
Tiassalé	5,780	903	3,721	214	903	16%

District	Estimated number of PLHIV (hyp: constant)	Expected Current on ART FY16	# additional patients required for 80% coverage	Expected Newly initiated on ART FY17	Expected Current on ART FY17	ART Coverage (APR 17)
Guiglo	5,699	1,085	3,474	247	1,085	19%
Tanda	5,438	1,914	2,436	386	1,914	35%
Bouake-Nord-Est	5,335	1,265	3,003	353	1,265	24%
Akoupe	5,180	863	3,281	160	863	17%
Anyama	5,094	1,179	2,896	102	1,179	23%
Oume	5,065	1,687	2,365	325	1,687	33%
Bangolo	4,671	440	3,297	230	440	9%
Mankono	4,512	809	2,801	204	809	18%
Sassandra	4,395	1,068	2,448	190	1,068	24%
Sinfra	4,385	1,660	1,848	342	1,660	38%
Daoukro	4,058	1,257	1,989	276	1,257	31%
Vavoua	4,040	724	2,508	150	724	18%
Danane	3,883	1,190	1,916	292	1,190	31%
Dabakala	3,794	582	2,453	100	582	15%
Niakaramadougou	3,785	439	2,589	114	439	12%
Katiola	3,725	701	2,279	161	701	19%
Agnibilekrou	3,689	1,431	1,520	223	1,431	39%
Ferkessedougou	3,661	1,287	1,642	553	1,287	35%
Toumodi	3,590	1,122	1,750	185	1,122	31%
Alepe	3,573	559	2,299	177	559	16%
Bouna	3,445	528	2,228	128	528	15%
Odienne	3,417	669	2,065	264	669	20%
Kouibly	3,378	319	2,383	103	319	9%
seguela	3,328	665	1,997	169	665	20%
Zouhan Hounien	3,244	488	2,107	167	488	15%
Beoumi	3,205	456	2,108	188	456	14%
Lakota	3,088	840	1,630	308	840	27%
Touba	2,905	113	2,211	42	113	4%
Bolequin	2,888	185	2,125	49	185	6%
Fresco	2,683	559	1,587	200	559	21%
Ouangolodougou	2,550	511	1,529	88	511	20%
Grand-Lahou	2,487	381	1,609	56	381	15%
Biankouma	2,375	416	1,484	73	416	18%
Boundiali	2,337	902	968	285	902	39%
Gueyo	2,319	166	1,689	21	166	7%
Tiebissou	2,239	396	1,395	80	396	18%
Sikensi	2,137	172	1,538	47	172	8%
Zuenoula	2,030	872	752	270	872	43%
Bocanda	1,948	448	1,110	97	448	23%
Jacqueville	1,939	217	1,334	24	217	11%
Dimbokro	1,882	1,001	505	133	1,001	53%
Didievi	1,604	96	1,187	12	96	6%
Sakassou	1,580	548	716	161	548	35%

District	Estimated number of PLHIV (hyp: constant)	Expected Current on ART FY16	# additional patients required for 80% coverage	Expected Newly initiated on ART FY17	Expected Current on ART FY17	ART Coverage (APR 17)
M'bahiakro	1,573	218	1,040	93	218	14%
Toulepleu	1,558	83	1,163	28	83	5%
Minignan	1,417	81	1,053	36	81	6%
Bettie	1,363	157	933	34	157	12%
Prikro	1,277	291	731	57	291	23%
Nassian	575	100	360	35	100	17%
Tengrela	471	168	209	-	168	36%

Table 4.1.2 Entry Streams for ART Enrollment (FY 2017)

Entry Streams for ART Enrollment	Tested for HIV (in FY 17)	Identified Positive (in FY 17)	Enrolled on ART (in FY 17)
Targeted Testing			
Adults	637,107	40,411	37,083
Sick patients	473,301	26,032	23,888
Uniformed Service Personnel	7,000	294	270
Adolescent girls	26,877	215	197
Priority Pop. Women (20-29 old)	30,881	1,421	1,304
Priority Pop. Other Men (35 + old)	29,193	1,985	1,822
TB diagnosed patients	22,000	4,620	4,240
MSM	8,297	1,493	1,370
FSW	39,559	4,351	3,993
Children	168,348	9,287	7,782
Malnourished	10,000	600	503
In-patient/hospitalized	26,500	1060	888
TB diagnosed patients	600	90	75
TB suspects	5,000	500	419
Other out-patients	53,770	2,689	2,253
OVC	72,478	4,349	3,644
Pregnant Women	509,294	9,346	8,645
HIV-positive Patients on clinical care			24,455
Adults (40,449)			24,455
Children (0)			0
EID	12,986	561	420
Total	1,314,749	59,605	78,385

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

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (priority SNU's)	Coverage Goal (in FY17)	FY17 Targets
Men who have sex with men (MSM)	23,687	56%	13,200
Female sex workers (FSW)	88,792	62%	55,464
Transgender (TG)	NA		50
Male 25-49	1,575,061	5.1%	80,449
Male 50+	720,323	3.7%	26,309
Female 15-19	609,136	6.5%	39,364
Female 20-24	520,551	7.0%	36,625
Total	3,537,550	7.11%	251,461

Table 4.1.5 Targets for OVC and Linkage to HIV Services

Regions and Districts	Estimated # of Orphans and Vulnerable Children	FY17 Target # of active OVC (<18 OVC_SERV)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY17 Target) OVC_KNOWNSTAT*
Abidjan 1-Grands Ponts	67,683	18,373	N/A
Adjame-Plateau-Attecoube	48,001	10,326	N/A
Dabou	4,706	2,463	N/A
Grand-Lahou	2,054	450	N/A
Jacqueville	1,601	630	N/A
Yopougon-Est	11,320	4,504	N/A
Abidjan 2	106,517	32,794	N/A
Abobo-Est	10,324	4,221	N/A
Abobo-Ouest	9,095	2,950	N/A
Anyama	4,208	758	N/A
Cocody-Bingerville	18,742	5,696	N/A
Koumassi-Port Bouet-Vridi	32,201	11,841	N/A
Treichville-Marcory	18,152	5,253	N/A
Yopougon-Ouest-Songon	13,796	2,075	N/A
Agneby-Tiassa-Me	28,840	13,336	N/A
Adzope	7,556	2,537	N/A
Agboville	7,514	4,642	N/A
Akoupe	4,279	2,644	N/A
Alepe	2,952	0	N/A
Sikensi	1,766	389	N/A
Tiassale	4,774	3,124	N/A
Belier	12,664	2,888	N/A
Didievi	NA	42	N/A
Tiebissou	1,850	0	N/A
Toumodi	2,966	0	N/A
Yamoussoukro	7,848	2,846	N/A
Bounkani-gontougo	NA	10,996	N/A
Bondoukou	NA	3,902	N/A
Bouna	NA	2,745	N/A
Nassian	NA	1,059	N/A
Tanda	NA	3,290	N/A
Cavally-Guemon	21,487	9,386	N/A
Bangolo	3,859	1,574	N/A
Blolequin	2,386		N/A
Duekoue	6,457	5,330	N/A
Guiglo	4,708	2,482	N/A
Kouibly	2,790	0	N/A

Toulepleu	1,287	0	N/A
Gbeke	20,180	15,508	N/A
Beoumi	2,648	856	N/A
Bouake-Nord-Est	4,407	5,207	N/A
Bouake-Nord-Ouest	7,259	6,092	N/A
Bouake-Sud	4,561	2,817	N/A
Sakassou	1,305	536	N/A
Gbokle-Nawa-San Pedro	35,731	12,230	N/A
Gueyo	1,916	0	N/A
San-Pedro	10,303	5,737	N/A
Sassandra	3,631	657	N/A
Soubre	13,988	4,904	N/A
Tabou	5,893	932	N/A
Goh	11,597	4,487	N/A
Gagnoa	7,413	3,759	N/A
Oume	4,184	728	N/A
Hambol	NA	3,659	N/A
Dabakala	NA	1,727	N/A
Katiola	NA	1,932	N/A
Niakaramadougou	NA	0	N/A
Haut-Sassandra	15,873	6,346	N/A
Daloa	8,363	4,913	N/A
Issia	4,172	1,433	N/A
Vavoua	3,338	0	N/A
Indenie-Djuablin	10,259	3,355	N/A
Abengourou	6,087	2,436	N/A
Agnibilekrou	3,047	793	N/A
Bettie	1,126	126	N/A
Kabadougou-Bafing-Folon	NA	822	N/A
Minignan	NA	0	N/A
Odienne	NA	627	N/A
Touba	NA	195	N/A
Loh-Djiboua	NA	4,464	N/A
Divo	NA	3,918	N/A
Fresco	NA	0	N/A
Lakota	NA	546	N/A
Marahoue	10,335	2,129	N/A
Bouafle	5,035	994	N/A
Sinfra	3,623	753	N/A
Zuenoula	1,677	382	N/A
N'zi-ifou	14,329	13,324	N/A
Bocanda	1,609	2,503	N/A

Bongouanou	6,514	5,003	N/A
Daoukro	3,352	1,165	N/A
Dimbokro	1,554	2,486	N/A
M'bahiakro	1,299	2,167	N/A
Prikro	NA	0	N/A
Poro-Tchologo-Bagoue	15,717	15,510	N/A
Boundiali	1,931	2,373	N/A
Ferkessedougou	3,025	1,849	N/A
Korhogo	8,266	10,791	N/A
Ouangolodougou	2,107	497	N/A
Tengrela	389	0	N/A
Sud-Comoe	NA	0	N/A
Aboisso	NA	0	N/A
Grand-Bassam	NA	0	N/A
Tonkpi	13,450	4,064	N/A
Biankouma	1,962	0	N/A
Danane	3,207	1,110	N/A
Man	5,601	2,954	N/A
Zouhan Hounien	2,680	0	N/A
Worodougou-Bere	NA	1,401	N/A
Mankono	NA	1,275	N/A
seguela	NA	126	N/A
Total	384,663	175,072	N/A

Approximately 39,000 OVC will receive continuing services in Sustained Districts in COP16; Global Fund-supported Alliance CI supports 10,000 OVC nationally.

4.2 Priority Population Prevention

One PEPFAR goal is to reduce incidence among priority populations. PEPFAR-CI is optimizing implementation of a combination prevention approach to reach this goal, including targeted HIV testing services (HTS), ART for prevention, PMTCT, and procurement and distribution of condoms and lubricant gels. Focus on reaching KPs will also extend to hot spots identified in the Sustained Districts. Proposed priorities for COP16 rely on a dynamic and strategic assessment of achievements to date, salient programmatic gaps, and are aligned with the national HIV program.

In COP16, priority populations include the key populations of MSM, FSW, transgender women; AGYW 15-24 years; higher risk men aged 25+ years; military and uniformed personnel; OVC and other high risk groups in the general population, such as family members of index patients and clients of FSW. Men are a new priority population for COP16, to ensure they are and remain enrolled in the clinical cascade. Prevention IPs will focus on condom promotion and distribution, active referrals to HTS and PMTCT, and evidence-based sexual prevention programs, with a focus

on gender norms. In support of the Test and Start policy expected to be adopted in Côte d'Ivoire, the program will increasingly target KPs and PPs to improve HIV case identification and HIV yield among those tested. HTS achievement will increase to have at least 75% of KPs and 50% of PPs in Scale-Up Districts tested and aware of their sero-status.

Based on analysis of service statistics and programmatic data, PEPFAR-CI notes exponential increase in HIV prevalence among men starting age 35+, reaching the highest prevalence (9%) among men over age 50 (DHS-2012, APR15). However, it is also amply evident that regardless of age, men do not access HIV services in particular, access fewer health services in general, and that they wait until become very sick (evidenced by lower CD4 counts upon initiation) before they actually come to a health facility. PEPFAR-CI will therefore increase focus on reaching adult men as a critical game changer for epidemic control. The program can able to build on existing PEPFAR efforts (e.g. with Brothers for Life, military and other male dominated uniformed services), and also leverage other USG efforts targeting men, such as the Regional Security Office which is training police forces, to construct a robust program to reach men with differentiated interventions, including those addressing gender-based violence (GBV). The new overall approach will place more effort in going out to seek where men are most likely to be found, but also to increase efforts to link them to where they seek services. At the facility level, this often means going beyond the PMTCT and ANC wards to outpatient sections where there are sick people. As health centers and institutions increasingly target and serve women and children, PEPFAR-CI will explore approaches that are more “men-friendly”, for example by creating “safe spaces” within the facilities where men can be with other men and access educational and promotional information including HIV services.

Given that the majority of men do not come to health facilities, the program will also implement outreach approaches to reach them where they commonly congregate: workplaces, bars, sports events and clubs by using selection criteria to reach the most at risk. For both facility and community settings, the program will support development of a wellness platform for men to prompt them to care for themselves, including HIV testing as a wellness practice. PEPFAR-CI will build on experiences of other countries with multi-health service campaigns to support the organization of health and wellness days for men, for instance around workplaces and other sites that likely attract men who engage in high risk sexual behaviors. Although the program is targeting higher risk men to ensure a high positivity yield, it will be critical to reach men with health promoting activities, practices, and services, beginning to change the association they have that health facilities equal sickness, women, and children, and the stigma carried by HIV.

Prevention programs for other priority population will be clustered around clinical services to strengthen linkages to HTS and PMTCT, and ensure HIV-positive individuals receive care and treatment. PEPFAR-CI will utilize data from hotspot micro-mapping, size estimation and HIV prevalence for effective KP targeting. For the military, the program will continue to focus on the highest HIV prevalence areas which align to Scale-Up Districts.

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 under procurement, with planned award for May 2016. A condom standard operating procedure has been drafted for all IPs. Critical gaps remain in condom demand and distribution by 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.

Despite progress made thus far, SIMS visits continue to identify gaps in referral and counter-referral systems between community and clinical partners, and between reproductive health, key population prevention, and PMTCT services. Gender programming and condoms were also identified as challenges. Improvements are needed in performance management, policy and practice, and service quality. IP improvement plans are being carefully examined.

4.3 Prevention of mother to child transmission (PMTCT)

From 2004 to September 2015, with PEPFAR support, PMTCT coverage has increased from 26 sites in 3 health regions to 687 sites in 19 health regions providing HTS to 625,921 pregnant women, and reaching 16,332 HIV positive clients with ARV prophylaxis. Neonate infectivity rate is currently 3.5% for newly-enrolled women, and 2% for women who used ART prior to pregnancy, which is below the current e-MTCT goal of 5%. PEPFAR program data shows current average rate transmission through breastfeeding period to be 3.5%.

Since 2012, PEPFAR supported the GOCI in adopting the e-MTCT initiative. Through the central PMTCT/ART integration funds, Côte d'Ivoire transitioned from PMTCT Option B to B+, developing materials, procedures, tools, and systems for quality program implementation. PEPFAR/GOCI started Option B+ formally in FY16 and will complete implementation roll-out to all Scale-Up Districts by April 2016.

COP16 PMTCT strategy is aligned with the e-MTCT goal to reduce MTCT to less than 5% by 2016, place 95% of HIV positive pregnant women on ART by 2016, and provide early infant diagnosis (EID) to 70% of exposed infants. Strategies include the following:

- 1) Geographic prioritization to focus on high yield sites (> 4 HIV positive pregnant women per year)
- 2) Operationalization of Option B+ M&E system (M&E Framework)
- 3) Involvement of 50% of PMTCT sites in Rapid Test Quality Improvement Initiative (RTQII)
- 4) Integration of PMTCT with family planning services sustainability planning
- 5) Redirection of PEPFAR support from 687 PMTCT sites to 861 higher yield sites, both in Scale-Up and Sustained Districts, to allow EID to HIV-exposed infant in Sustained Districts.
- 6) Improve couples testing to reach more male partners in PMTCT sites

All PEPFAR sites will be supported to use the B+ M&E Framework, using updated forms developed in COP15. PMTCT SIMS data shows that ART in labor and delivery, EID, and enrollment of HIV-infected infants in care and treatment need improvement, with 43.9% of services surveyed receiving either red or yellow scores. Emphasis will be placed on provision of a full package of support, including focused capacity building, mentorship, data quality assurance, and reporting support in these districts. This includes critical site-level support such as ARVs and other commodities, salaries for critical health care workers, and routine technical and SIMS visits (minimum quarterly for all sites, regardless of district type). PEPFAR-CI is collaborating with other donors to support effective implementation of Option B+, working with UNICEF and Global Fund on issues of coordination, monitoring, community engagement and commodities.

50% of PMTCT sites will participate in the national RTQII. The PMTCT team will work closely with the laboratory team to scale up RTQII to all sites in FY17. To support FP integration goals, PEPFAR will advocate that PMTCT sites are prioritized as the GOCI scales up availability of family planning across health platforms. National target is that 100% of health sites will provide FP services; current coverage is 75%. Robust referrals to high quality FP sites will be emphasized and PEPFAR will prioritize scale-up of integrated FP into maternal, newborn and child health programs at 40% of PMTCT sites in FY17. Supported sites will align with the USG regulations on FP compliance.

The role of CHWs is important when addressing ANC uptake and retention. While a national CHW cadre strategy exists, PEPFAR will continue advocacy for national recognition and standardized, adequate compensation for CHW and lay counselors in facility and community settings, as they are essential for an effective continuum of care. Peer support groups for mothers and their sexual partners will also be used. A holistic model of support for needs of pregnant and breastfeeding women, including FP, nutrition, and links to OVC and community care platforms, are critical to achieving COP16 PMTCT strategies and targets.

4.4 HIV Testing Services (HTS)

Country is already implementing Test and Start for selected populations, and plans (process is well advanced) to implement this policy nationally for all individuals testing positive still in FY16. This impacts the COP16 HTS package. PEPFAR will support this policy, ensuring that all new HIV patients have immediate linkage to treatment services.

Clinics will continue to provide PITC for symptomatic adults and children (including TB patients and OVC). PITC will account for about 82% of the HTS targets, the remaining 18% will focus on community-based testing for MSM, CSW, TG women, family members of index cases (including discordant couples), and priority populations (see 4.2).

In COP16, PEPFAR is providing full support, including training, coaching, minor rehabilitation, routine site visits, laboratory support, and commodities, to higher-yield HTS sites in Scale-Up Districts. Modest cost savings from assessments of HTS transition efforts were reinvested in

higher-yield sites to improve the identification of HIV-positive individuals, particularly children and adolescents, linking them to care and treatment.

PEPFAR lab team supported about 1,000 HIV testing points (community and clinical) to strengthen quality assurance methods and provide proficiency testing panels. The RTQII program included two phases of for all HTS sites: a training package on HIV quality assurance; and impact assessment of the RTQII. PEPFAR also supported sustainability of HTS by strengthening human resource capacity and building linkages between community and facility services, especially for effective counter-referral.

Common challenges identified during SIMS visits included: 1) QA issues in 71% of sites; 2) inadequate referrals of HIV patients to care and treatment services; and 3) only three sites scoring >50% in HIV proficiency testing. The team has started in COP15 to address problems on testing quality and patient referrals, with individual IP improvement plans developed that will be reviewed in subsequent visits. Overall, 2,000 testing posts will eventually be enrolled in HIV proficiency testing.

In clinical settings, PEPFAR-CI will continue to enhance PITC, targeting symptomatic in- and out-patients with specific packages for adults, children and TB patients. Antenatal clinics will provide HTS to support Option B+ package including EID for exposed infants. The HTS approach will continue targeted testing of pediatric and adolescent cases through in-patient and out-patient services to increase children's access to treatment services.

Community partners will create demand and provide linkages to HTS and other care and treatment services. PEPFAR is prioritizing the improvement of referral and counter-referral systems among all services to improve traceability. Low case identification among older men has been newly identified as a major programmatic gap, as aforementioned. In COP16, the program will focus on targeting these men to access HTS, including the development of male-friendly HTS packages for clinical and community services, with continued focus on the military, and on older men who have not been previously tested.

4.5 Facility and Community-Based Care and Support

PEPFAR-CI will assist the GOCI to implement Test and Start as part of a strategic package of core and near-core care and support services necessary to fast-track and retain patients in treatment services in PEPFAR supported districts. While Facility-based services will be available mainly through the public sector, PEPFAR will also strengthen services in private for profit sector to increase ART coverage in Scale-up to Saturation Districts. Although about 40% of health care services are provided in private for profit clinics, this sector has not been significantly engaged in the provision of HIV clinical services>PEPFAR investments in private for profit clinics in COP16 will continue to include: i) support for HIV clinical service delivery (training, coaching, ARV drugs and HIV test kit supply, rapid access to viral load testing, M&E), and ii) capacity building of the association of network of private clinics (ACPCI) for sustainability of the response.

The package of care and support services and approaches includes the following Core elements:

- Index case-based family testing,
- TB testing, TB screening, referral, and infection control,
- FP counseling and referral for HIV+ women including FSW,
- Home-based continuum of care to improve treatment literacy, retention;
- Positive health, dignity and prevention (PHDP) interventions;
- GBV/HIV referral networks (specifically through social centers, PLHIV organizations) and CHW and social worker accompaniment to clinical, post-rape care, and PEP
- Community sensitization for ANC uptake and HIV prevention among AGYW.

Near Core interventions that continue but eventually transition over time, include:

- nutritional assessment and counseling,
- laboratory screening for blood transfusion,
- coordination of social services response for OVC,
- targeted mobile testing in Scale-Up Districts,
- ART services in low volume sites (less than 25 PLHIV),
- periodic surveys and surveillance: AIS, ANC,
- capacity building for monitoring and evaluation, data analysis and management systems ,
- support the central medical store,
- support for implementation of task sharing,
- laboratory equipment maintenance, repair, biosafety, and in-service training for LIS,
- point-of-care evaluation.

In APR15, the program exceeded its target to reach HIV patients over 15 years old that were reached with a minimum package of PHDP interventions. APR15 shows a 12 month adult ART retention rate of 76% compared with an 80% target. While this represents significant improvement from 2013, when the country was only two years after a decade of civil conflict, improving retention in ART will be among the highest priorities, and community-based platforms are essential to support this effort and Test and Start implementation. Robust community-based programs will aim to facilitate continuity of services for PLHIV and their families, ensuring a linked continuum response from clinic to household. Social centers will be critical service delivery points, including implementing new services delivery models. Interventions include community-based PLHIV support groups, community ARVs distribution models, demand creation and service promotion within the community, matched and peer mother approaches to PMTCT, and PHDP services both at sites and community level, as well as other innovative strategies to initiate people and keep them on ART.

SIMS visits have shown that despite efforts, improvement is still needed in facilitating linkages between facility and community-based services, especially for referrals from clinics to community sites, being a systems barrier in two of PEPFAR-CI's programmatic gaps. PEPFAR supports the MSHP to update national care and treatment guidelines and policies as well as to develop a

national tool for tracking linkages between services through active referral and counter-referral. Efforts are also in place to improve linkages from HTS to treatment through community-based services. PEPFAR-CI team will continue to support this area, which is a critical component Test and Start strategy.

The task-shifting/sharing and PMTCT/ART integration activities (Option B+) are official policies being implemented. 32% of the COP16 treatment targets will come from patients currently in pre-ART and PMTCT services that became eligible with the new policy. PEPFAR-CI believes that the rate of enrollment of additional beneficiaries in treatment upon knowledge of their sero-status can be accelerated as policy shifts such as task-shifting/sharing are being rolled out. In addition, community-based promotion of services and interventions for ART retention will be a critical investment for this success. Therefore, the official recognition of the CHWs and development of more clear terms of reference will be a key health diplomacy effort to help overcome a barrier and optimizing the continuum of care for PLHIVs.

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

PEPFAR will continue to support 177 TB clinics, with all TB patients receiving a comprehensive package of TB/HIV services regardless of the geographic location of the point of service (Scale-Up or Sustained Districts). TB is the largest cause of death among PLHIV, and adequate case management among this cohort will significantly affect progress in viral suppression nationally.

In COP16, PEPFAR plans to provide HIV testing to 22,600 new and relapse TB patients (93% of expected TB cases), who will have test results recorded in TB registers. PEPFAR will provide TA to revise technical guidance, integrating HIV testing for TB suspects in TB clinics, redefining patient flow and coaching health care workers in TB clinics. The program will implement the WHO “Engage TB strategy” to intensify TB case finding, by reaching missing TB cases using a family approach.

Furthermore, PEPFAR expects to provide ART to 95% of the 4,710 expected TB/HIV co-infected patients. Currently, only 17 TB clinics are led by medical doctors who can provide ART to TB/HIV co-infected patients, the other 160 led by nurses who refer all TB/HIV co-infected patients. PEPFAR will support these National TB Program (PNLT) to move these nurse-led TB clinics to a TB/HIV integrated care model, allowing all the 177 TB clinics to provide ART to HIV/TB co-infected patients under a “One Stop Shop Model”. PEPFAR-supported training of TB clinic nurses on task-sharing will contribute to these efforts.

APR15 shows that more than 80% of the PLHIV in care was screened for TB. In COP16, PEPFAR plans to strengthen TB screening among PLHIV, including children, and extend this activity to HIV positive pregnant women as part of the MCNH comprehensive package, in order to raise this coverage of TB screening to 90% of PLHIV on ART.

PEPFAR will coordinate implementing GeneXpert platforms at TB regional treatment clinics (CATs) to allow for rapid confirmation of TB cases. The program will also provide TA to the

PNLT to organize a sample referral system from HIV clinics to CATs, and to revise the national testing algorithm according to GeneXpert capacity, both of which will also lead to faster case confirmation. There are currently a total of 14 operational GeneXpert CATs nationwide. Implementing GeneXpert platforms will also contribute for better HIV viral load monitoring of TB/HIV co-infected patients and HIV patients around TB clinics, as the equipment enables both TB diagnosis and HIV viral load test using the same platform.

SIMS results show challenges with TB infection control (IC) in HIV clinics, because TB/HIV activities are led by PNLT who started implementing IC in TB clinics but not yet in HIV clinics. HCWs and HIV focal points will receive training and coaching in IC, and PEPFAR will monitor progress through coordination meetings and site visits.

PEPFAR will continue support coordination, implementation, and expansion of MDR-TB detection, and support to the regional reference laboratory network for decentralization of opportunistic infection diagnosis capacity. Capacity-building efforts within the national laboratory network will assist IPs, the TB laboratory network, and at least 14 regional hospitals in delivering quality laboratory diagnostics of HIV-related OIs, particularly TB and STIs.

4.7 Adult Treatment

PEPFAR supported the National AIDS Control Program (PNLS) to implement the WHO 2013 ART guidelines that were adopted in September 2015. These guidelines included Test and Start, for pregnant women, TB/HIV and Hep/HIV co-infected patients, KPs, children under 10, and HIV-infected partner within sero-discordant couples, and a CD4 500 eligibility for the remaining PLHIV. The MSHP is currently finalizing the National HIV Strategic Plan (PSN) 2016-2020 which goal includes the 90:90:90 Fast Track strategy, to control the HIV epidemic by 2020. In alignment with newly released WHO treatment guidelines, the MSHP is now including the Test and Start for all PLHIV policy, and expects to apply Test and Start for all PLHIV nationwide by the end of FY16.

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. The PEPFAR package of ART services will be provided aggressively in the Scale-Up for Saturation Districts, at a reduced pace in Aggressive Scale-Up Districts, and passively in the Sustained Districts; with the following interventions:

- aggressive demand creation to reach 80% ART coverage
- targeted HTS among high yield populations,
- establishment of support in new sites
- recruitment and training of new health care providers
- aggressive implementation of task-sharing
- reinforcing linkages from testing to treatment services
- strengthening community-based services to improve retention
- support supply chain management

- performance-based financing (PBF)
- monitoring and evaluation
- laboratory services

The PEPFAR program will increase the number of patients on ART to 206,263 by APR17, leading to saturation in all the 16 Saturation Districts. Sustained Districts will continue to receive the same ART services, focusing on retention. PEPFAR-CI will begin transitioning to the MSHP support of low-volume ART sites (≤ 25 patients currently on ART), linking patients to the nearest high volume ART site (hub-and-spoke model). The program will take special considerations for low-volume ART sites in Scale-Up districts, which will undergo further analysis to assess their potential for growth and for their contribution to the goal of 80% saturation in the district.

PEPFAR-CI will assist the PNLs to implement differentiated service delivery models for stable patients on ART, accompanying the implementation of Test and Start. This include advocacy for stable patients on ART to receive reduced clinical visits (from four to two per year), reduced biological monitoring (from twice to once a year), three-month ARV drugs supply (from monthly), reduced laboratory monitoring tests, and the transition from CD4 monitoring to VL testing. Patients not considered stable or those with suspicion of clinical failure will continue to be monitored as currently scheduled (every three and six months for clinical and laboratory visits, respectively). These changes result in efficiencies and cost saving along the clinical cascade.

Procurement and distribution of drugs and laboratory commodities have improved in FY15 with reduced stock-outs at the central pharmacy and site level. PEPFAR improved reporting (at site and district levels), and supported extension of a revised electronic patient medical record software that includes a functioning pharmacy module. Quality improvement continues to focus on the program's family-centered treatment approach. The service delivery ART package for adults will include differentiated clinic visits, ARV drugs, VL testing, and active patient tracking for improved retention, PEP, and support transportation of lab samples. APR15 showed 28,346 adults and children newly enrolled on ART in FY15. Through Test and Start, beginning at the end of FY16, PEPFAR-CI expects to reach 78,385 patients newly enrolled on ART by APR17. Retention has improved due to large site level investments in capacity and human resources. PEPFAR will sustain and expand these investments, including community support groups and other innovative strategies to actively track and keep people on ART.

SIMS visits show that patient tracking and linkages between ART and community services need improvement. The cascade is challenging due to poor access to CD4 count to assess eligibility, and weak linkages. Test and Start will support overcome this challenge and the program will continue to harmonize care and treatment activities between clinical and community-based partners. PEPFAR will specifically target men, to keep them retained in care and treatment programs. Meanwhile, PEPFAR is working closely with the MSHP to develop new strategies to improve the clinical cascade. These include strengthening post-test counseling, keeping a list of newly tested HIV positive patients at each site, designing and implementing SOPs to fast track enrollment in care and treatment. In addition, we are improving tracking of patients in pre-ART

by creating a monthly list and fast-tracking enrollment in ART. Community counselors will be performing testing as well as follow-up of ART patients.

Aligned with UNAIDS's goal of achieving viral suppression for 90% of patients receiving ART, PEPFAR-CI will continue support scaling-up access to VL testing, a major programmatic gaps, by establishing and operationalizing 13 regional laboratories.

PEPFAR-CI will continue to support the expansion of ART services in private, for-profit medical clinics in high burden districts, contributing to national ART coverage and sustainability of the national response.

4.8 Pediatric Treatment

PEPFAR-CI has worked closely with key stakeholders to define innovative strategies to increase pediatric care and treatment coverage. Although PEPFAR-CI is not the recipient of Accelerating Children's Treatment (ACT) funding, the program will implement ACT technical approaches and objectives in COP16, to reinforce linkages between community OVC program and key entry points at health facility. Following the task-shifting policy, PEPFAR-CI will continue training general practitioners, nurses and midwives to initiate pediatric HIV care and treatment, and ensuring training on latest ART guidelines.

The number of children receiving ART nationwide has increased by 18% from 2014 to 2015, with children under 15 years old accounting for approximately 5% of the total of number of people on ART. However, pediatric ART coverage is disproportionately low at 18% compared to 34% adult coverage (2015 UNAIDS Report). PEPFAR will continue to scale up pediatric ART coverage in high burden districts. Key priorities for pediatric and adolescent care and treatment in COP16 include increasing ART coverage, improving TB screening, NACS, and increasing systematic and routine HIV testing of all children, especially:

- Children of adults receiving HIV services
- Children in inpatient settings
- OVC
- Malnourished children
- Children with TB
- Children presenting suggestive symptoms.

The COP16 goal is to ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, as well as start and retain on ART all infected children regardless of age. PEPFAR-CI will support creation of a network of pediatric care and treatment providers and establish a mentoring system at selected sites in Scale-Up Districts. PEPFAR will also support differentiated service delivery models for children as for adults. Stable children receiving ART will have clinical visit twice a year and receive three-month ARV supplies through a community distribution system or facility pick up. Children who do not fit the definition of "stable" will

continue monthly visits. A priority intervention is ensuring systematic testing for at least 75% of OVCs through strong collaboration between facilities and community settings.

PEPFAR-CI is monitoring site level achievement quarterly, working to routinely collect and analyze testing yield data from identified pediatric testing points. PEPFAR-CI will increase pediatric case finding, improve adherence and retention by improving tracking of children in pre-ART through creation of a monthly listing to fast-track enrollment in treatment. Collaboration and cross-referral between clinical HIV programs and 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-CI will support adoption and implementation of DREAMS strategies such as packages including condom promotion and provision, HTS, post-violence care, and improved access to sexual/reproductive health services. PEPFAR-CI will also support to define and roll out a standardized adolescent care package, including adolescent-friendly health services covering issues related to school, adherence, disclosure, sexuality/reproductive health and stigma, and will continue to reinforce clinical partners' family-centered approach.

To facilitate early identification of treatment failure in infants, VL testing will be used as the only biological monitoring test, for regions where it is available. Decentralization of VL access in Scale-Up Districts will occur with the opening of two new laboratories, for a total of eight PEPFAR-supported regional VL laboratories. The program expects that 100% of children on ART in Abidjan, and 75% of children in others regions will receive two VL tests per year in FY16. Infants in remote sites, with no available VL test, will be monitored with CD4 count.

PEPFAR-CI is working with the MSHP and key stakeholders to address pediatric bottlenecks, including case identification and linkage to care and treatment, through joint target setting, formalized linkages, referral networks, leveraging community contributions, and coordinated messaging. PEPFAR will reach out to the Ivoirian First Lady, appointed by UNAIDS as Special Ambassador for Pediatric AIDS, in a "know your status, know your child's status" campaign.

SIMS visits have shown that improvement is needed in dissemination of job aids, implementing procedures, linkages documentation 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. PEPFAR-CI will improve linkages between clinical and community services for active follow-up in the community, through involvement of both social and community workers, and development, dissemination and mapping of community organizations working around health facilities.

4.9 Orphans and Vulnerable Children (OVC)

PEPFAR-supported OVC programs align geographically with pediatric care and treatment and prevention programs for AGYW in Scale-Up Districts. The OVC program also aligns with government guidelines for child protection and complements with donor partners. PEPFAR-CI

focuses on identifying the most vulnerable children, such as those who have missed school regularly, are sick and/or malnourished at community and facility levels, and whose parents are known PLHIVs. Thus, the OVC program will work with PMTCT, HTS, pediatrics, nutrition, and adolescent prevention programs to ensure a robust community platform that can respond to socioeconomic, health, social and psychosocial needs of children and families infected and affected by HIV and AIDS.

A critical component of this strategy is to improve HIV case identification among children and adolescents, and immediately link them to treatment services. This linkage is of critical importance with a Test and Start approach. Furthermore, PEPFAR will continue to have a heightened focus on maintaining OVCs in treatment by strengthening retention and adherence support through OVC interventions in communities and households, including nutrition support, regular home visits, links to robust education support, health card verification for appointments missed, pill counts, and facilitated support groups for adult and adolescent PLHIVs.

Community-based partners will emphasize OVC-linked testing strategies, using social center platforms and index case testing with OVC families. Community-based approaches to support children affected by HIV and AIDS rooted in sound community development principles are essential. Therefore, PEPFAR will continue to build the 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.

OVC targets for COP16 remain close to the COP15 target, reflecting the 2015 UNAIDS OVC estimates and programmatic realities. To achieve these goals, PEPFAR must continue strengthening the link between national health and social welfare systems. These comprehensive strategies will work across sectors to mitigate long-term health, socio-economic and socio-emotional impact of HIV and AIDS on children, families, and communities. In COP 16, the program will build the capacity of the social welfare workforce through systems capacity investments to ensure psychosocial support for OVC and their families.

Results from the gender analysis show the need for new efforts focus on gender-sensitive strategies and referrals for GBV. Approaches with social centers to reinforce community-clinical linkages through an OVC task force will be dedicated to this purpose. Data from internal and external impact evaluations of current programs, including economic strengthening data, informed this programmatic direction.

OVC programs are an entry point for PEPFAR to identify AGYW who are HIV negative, provide them with prevention counseling and refer them to prevention and reproductive health services. Based on routine data and evidence showing that AGYW are more at risk of HIV infection compared to boys and young men in the same age groups, PEPFAR-supported OVC partners target more girls, which represent up to 60% of the OVC targets. OVC and prevention programs will use approaches from the DREAMS initiative through comprehensive prevention approaches tailored for AGYW. This will include 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.

PEPFAR-CI will continue its support for the development of coordination and service delivery by the PNOEV, social centers, and indigenous NGOs . PEPFAR-CI uses case management to regularly assess child/family improvement to determine case closure according to the national policy and PEPFAR guidance. Based on these assessments, approximately 5% of children will age out of the OVC program during COP16. PEPFAR-CI has been working closely with the Global Fund community principal recipient to transition 10,000 OVC in Sustained Districts to Global Fund support. Refer to Section 5.2 for more details on the transition of OVC programs in Sustained Districts.

4.10 Laboratory

One of the main results of the PEPFAR-CI laboratory program in FY16 will be an effective decentralization of access to VL load and EID test at four regional reference laboratories, with the goal to have six regional platforms. This was made possible by the support of national institutions which coordinate laboratory activities and clinical IPs who conduct VL and EID service delivery. The program will continue the implementation of the quality management systems (QMS) program within 51 labs and HIV testing point who received proficiency testing panel for HIV, hematology and biochemistry test. PEPFAR-CI will continue to support the national program under a maintenance contract to provide uninterrupted laboratory service to HIV positive patients. GeneXpert machines were installed in four TB regional CATs to attain 14 operational centers nationwide, eight of which are directly supported by PEPFAR, while sputum smear microscopy is offered in a total of 185 peripheral TB diagnosis and treatment centers (CDTs). Microbiological testing including for STIs to diagnose HIV OIs has been decentralized to six regional labs. A total of 300 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 24 laboratories have shown improvement in three out of six areas evaluated: information management, QMS and quality test monitoring who scored 62%, 17% and 15% green respectively instead of 100% red in previous year. This improvement happened after PEPFAR IPs and Retro-CI lab staff provided coaching to lab personnel. A continuing effort is needed to improve the six laboratory elements identified in SIMS.

In FY17, the laboratory strategy is designed to continue: increasing access to VL testing and EID laboratory service coverage, with a total of 13 functional VL and EID platforms countrywide; supporting Option B+ rollout and the new care and treatment service delivery models; and providing quality HIV testing. This will be possible by addressing each of the barriers identified for VL and EID testing access, such as designing and implementing an integrated biological sample transportation system, training and maintaining through performance-based financing at least four lab personnel at each of the six regional VL and EID laboratories, and reducing stock-outs of VL reagents and commodities. The program will work closely with central laboratories, Retro-CI, LabQuasy and the PNLs on a three-year transition plan to shift patient monitoring frp,

CD4 to exclusive VL testing of by FY18. Through this shift, PEPFAR-CI expects that 100% of ART patients located in Abidjan and 75% of ART patients located in the Scale-Up Districts will have access to at least one VL test per year by FY17, and that all patients will be monitored through VL testing by FY18. About 6,000 TB/HIV co-infected patients will also access VL testing in the 11 TB treatment centers equipped with GeneXpert. The EID coverage will increase from 58% to 65% due to POC testing combined with decentralized laboratory services in the community.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of services in sustained support locations and populations

PEPFAR will provide the same HTS, care, and treatment services in all districts for KPs, TB/HIV and OVC programs. PEPFAR supports limited prevention activities for KPs and PPs in identified hot spots in Sustained Districts in COP16.

In line with the MSHP directives and guidelines, PEPFAR-CI will maintain most core services for ART, PMTCT, and OVC in the 40 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 PLHIV 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;
- Family planning integration;
- Pharmacovigilance/HIV drug resistance surveys;
- 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 HTS, and targeted community-based HTS for key population in hot-spots, 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, phasing out CD4 monitoring, NACS for children, and commodity supply chain support;
- ART services: ARVs, lab monitoring (progressively transitioning CD4 for VL, HIV, creatinine as a biochemistry test for patients receiving TDF-containing regimen and VL), commodity supply chain support, active retention activities, and post-exposure prophylaxis (PEP);

- PMTCT: ARV prophylaxis/ART (Option B/B+), lab monitoring (transitioning CD4, HIV, hematology, creatinine, VL, EID), CTX, TB screening, linkages to care and treatment, and active retention activities;
- OVC: Household economic and food security, access to HTS 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; OVC activities will be transitioned by the end of COP16.
- Laboratory: essential laboratory testing for the management of PLHIV 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 enrollment of new patients on ART. Unlike in COP2015, PEPFAR plans to support PMTCT services in high yield sites in sustain districts to scale-up Option + nationwide and contribute to elimination of mother-to-child transmission regardless of SNU category. 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 FY15 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 \$134.86 (adult Pre-ART care); \$186.70 (adult ART without ARVs); \$226.73 (pediatric ART without ARVs).

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

Sustained Support Volume by Group	Expected result APR 16	Expected result APR 17	Percent increase (decrease)
HIV testing in PMTCT sites	464	915	97%
HTS (only maintenance ART sites in FY 17)	824*	1192**	45%
Current on ART	482	740	54%
OVC	104	77	-26%

*Includes 727 facilities and 97 communes

**Includes 1103 facilities and 89 communes

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

PEPFAR participates in a joint working group created by the GOCI that includes contributions from implementing partners, to monitor the progress of the transition to GOCI of previously PEPFAR-supported low- and no-yield sites identified in APR 2014 (67 HTC and 115 PMTCT). PEPFAR performs this analysis of site yield on an annual basis, but is responsibly ensuring through the working group that the GOCI is able to maintain the quality of services in the transitioned sites before being presented with additional sites.

In COP15, PEPFAR-supported sites that have 25 or fewer patients receiving ART will begin to be transitioned following identification of appropriate strategies and this will continue in COP2016. 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-CI has made a determination to continue supporting low-volume ART sites in Scale-Up Districts to reach the goal of 80% saturation. These sites will also be used “spoke” sites to accommodate the higher patient load resulting from Test and Start, and to bring sites closer to patients. Based on APR15, and this criterion, a total of 19 low-volume ART sites will be transitioned to MOH in COP2015. PEPFAR will continue to discuss with the MSHP 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.

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 to shift support by the end of FY17. PEPFAR-CI shared the vision of this pivot and its impact on geographic focus shift to ensure better coordination with GOCI and others donors for the transition in Sustained Districts. The transition was discussed and agreed upon with key Ministries involved in HIV and pediatric care and treatment, particularly the MSHP and the Ministry for the Promotion of Women, Family and the Protection of Children, through a collaborative approach bringing together various key stakeholders under the leadership of the National OVC program (PNOEV). The discussion focused on sustainability and the shift to other donors (Global Funds, UNICEF) and national counterparts (National Fund to fight AIDS/MEF, PNOEV, etc.). Through these consultations, Alliance Cote d'Ivoire, the Global Fund community PR will take over support of 10,000 OVC 9 in Sustained Districts) out of the total 42,975 OVC. The remaining 32,975 OVC will continue to be supported by the National Fund to stable families to take care of their own children. The PEPFAR-Ci anticipates more than 60% of families will graduate, and be able to support OVCs in Sustained Districts by the end of FY17.

In Sustained Districts, the OVC program is assisting partners, families and the National OVC program to put in place a transition plan for OVC families. The package of services was defined with a strong focus on economic strengthening activities to increase family strengthening in taking care of their children. In each zone, implementing partners are promoting and closely

monitoring the savings group approach to ensure success of activities and developing plans that include mapping of existing resources. In Sustained Districts, partners will no longer be enrolling new cases. The COP16 funds will be used to position PNOEV as the lead of for a strong transition plan. Our primary goal is to ensure that services will continue in some capacity to families previously supported by PEPFAR and that the transition is ethically planned and carried out with full transparency and community involvement.

The existing OVC files, already maintained by the PNOEV, via social centers established in each zone, will be used carefully monitor the transition of service delivery to these families with local, national or other international donors. The families will be transitioned during a three-month close out process before the end of FY17,

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

The interagency team identified the following three programmatic gaps to achieving the 90:90:90 goals in Côte d'Ivoire:

1. Low national coverage of pediatric care and treatment
2. Low coverage outreach to and coverage of KPs and PPs
3. Low access to VL testing

For all programmatic gaps, PEPFAR-CI identified interventions in COP16 that will occur both at site level in service delivery and at the sub-national and national level through systems support.

While retention among pediatric cases is satisfactory, national pediatrics coverage is extremely low and the capacity to find pediatric cases to enroll into treatment has been limiting. The key systems barriers for coverage of pediatrics include:

- Insufficient data for pediatric case identification at high yield entry points
- Weak linkage between health facilities, social centers and community services
- Limited capacity of health care workforce to address pediatric population

Case identification is also low among KPs and PPs, particularly evident among older men in the 25-29 age band. These are sub-populations for which the country faces challenges in welcoming to the facility for services in HIV prevention, care and treatment but also for general health and well-being. These are also sub-populations with significantly higher HIV prevalence and whose behaviors lead to higher risk of transmission. The barriers for this gap include:

- Non-operational Referral/Counter-referral system
- K/PP-unfriendly environment for case identification and clinical services
- Social and Gender norms that discourage uptake of HIV services among KPs and PPs

Lastly, expanding access and utilization of VL testing is crucial to monitoring progress toward the third 90, but VL testing access is currently very limited in Côte d'Ivoire, based on the following:

- Lack of an integrated national biological sample transportation system
- Limited human resource capacity on VL testing
- Weak management of VL commodities
- Limited access to VL testing for TB/VHI co-infected patients

Table 6.1.1 Key Programmatic Gap #1: Low national coverage of pediatric care and treatment

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount (\$)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Insufficient data for pediatric case identification at high yield entry points	The revised mother and child health booklet is used for pediatric case identification at high yield entry points is known by at least 50% of providers (facility, community) in scale up to saturation district and aggressive district	Activity 1.1: Print and disseminate 510,000 revised mother and child health booklet	PDCS	[REDACTED]	MSHP CoAg	6. Service delivery
2. Weak linkage between health facilities, social centers and community services	A standardized referral/counter-referral system between facility and community services is established in all districts.	Activity 2.1: Organize a national workshop to validate the harmonized counter referral tool between facility, social and community	PDCS	[REDACTED]	MSHP CoAg	2. Policies and Governance
	A standardized referral/counter-referral system between facility and community services is functional in Scale-Up to Saturation and Aggressive Scale-Up Districts	Activity 2.2: Print, disseminate and provide technical assistance on use of harmonized counter referral tool between facility, social centers and community	PDCS	[REDACTED]	MSHP CoAg	6. Service delivery
	80% of children and adolescents who test positive are enrolled into and retained in care Scale-Up to Saturation and Aggressive Scale-Up Districts	Activity 2.3: Print and disseminate mapping of community organizations working around health facilities to reinforce and optimize pediatric referrals	PDCS	[REDACTED]	MSHP CoAg	6. Service delivery
		Activity 2.4: Support a Regional/District collaboration framework between Regional/District Chief of Health (MSHP) and Chief of Community (under MPFFPE, MEPS) in Scale-Up to Saturation Districts	PDCS	[REDACTED]	clinical partners	6. Service delivery
3. Limited capacity of health care workforce to address pediatric populations	Quarterly meetings are organized in all Scale-Up to Saturation and Aggressive Scale-Up Districts for providers to discuss problems and issues, and find common solutions in pediatric care and treatment	Activity 3.1: Provide technical and financial support to district level leadership to establish a network of providers who engage in pediatric care and treatment	PDCS	[REDACTED]	clinical partners	6. Service delivery
TOTAL				\$628,000		

Table 6.1.2 Key Programmatic Gap #1: Low coverage of Key and Priority Populations							
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)	
KP-unfriendly environment for case identification and clinical services	Two fully functional drop-in centers in each of the 16 scale up to saturation districts	Establish drop-in centers in sample of scale up to Saturation Districts	HVOP	[REDACTED]	Linkages	6. Service delivery	
	Number of FSWs using drop-in centers increases by 50% annually	Train CHWs to provide KP-friendly and stigma-free services	HVOP	[REDACTED]	Linkages	6. Service delivery	
	Number of MSMs using drop-in centers increases by 50% annually		HVOP	[REDACTED]	PROTECT	6. Service delivery	
	Number of TGs using drop-in centers increases by 50% annually	Train at least 10 Health providers in each of the scale up districts to provide KP-friendly and stigma-free services	HVOP	[REDACTED]	PROTECT	7. HRH	
	Train at least 10 Health providers in each of the scale up districts to provide KP-friendly and stigma-free services		HVOP	[REDACTED]	Linkages	7. HRH	
Non-operational Referral/Counter-referral system (KP and PP)	Annual Increase in number of completed referral of KPs and PPs who receive the services in all PEPFAR -supported districts	Organize friendly-competition to recognize the best performing site for referrals twice a year	HVOP	[REDACTED]	PROTECT	6. Service delivery	
			HVOP	[REDACTED]	Linkages		
			HVAB	[REDACTED]	STRONG		
			HVAB	[REDACTED]	JHU HC3		
	At least 80% of all community and health workers are trained on the process and implementation of newly finalized	Train health and community workers on the newly finalized referral/counter referral system/procedures	Provide small grants to local CSOs for community-based sensitization activities to increase uptake of services	HVOP	[REDACTED]	Small Grants	3. Civil Society Engagement
			Train health and community workers on the newly finalized referral/counter referral system/procedures	HVAB	[REDACTED]	HC3	7. HRH
				HVOP	[REDACTED]	PROTECT	
			HVOP	[REDACTED]	Linkages		

Table 6.1.2 Key Programmatic Gap #1: Low coverage of Key and Priority Populations						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
	referral/counter-referral system in each PEPFAR-supported site		HVAB	[REDACTED]	STRONG	
Social and Gender norms discouraging KPs and PPs especially men 25+ from seeking HIV services	At least 65% of targeted men within priority and key (MSM) populations in each of the 39 scale up districts use care and treatment services	Conduct community outreach to sensitize on pro-KP friendly advocacy and support, including addressing stigma and discrimination and GBV against KPs	HVOP	[REDACTED]	PROTECT	3. Civil Society Engagement
			HVOP	[REDACTED]	Linkages	
		Promote positive gender norms to increase service uptake and reduce risk behaviors.	HVOP	[REDACTED]	PROTECT	3. Civil Society Engagement
			HVOP	[REDACTED]	Linkages	
			HVAB	[REDACTED]	STRONG	
		Define and operationalize a package of health services and practices segmented by relevant age groups (Eg. 25-49, 50+)	HVAB	[REDACTED]	JHU HC3	6. Service delivery
		TOTAL				600,000

Table 6.1.3 Key Programmatic Gap #3: Low access to VL testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Activities Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Lack of an integrated national biological sample transportation system (Whole Blood-Plasma-DBS-Sputum)	90% of patients on ART in Abidjan and area, while 75% of ART patients in others districts have access to Viral Load for biological monitoring by FY17	Activity 1.1: Assessment and design National biological sample transportation system	HLAB	[REDACTED]	[REDACTED]	10. Laboratory
		Activity 1.2: Pilot the system in five districts	HLAB	[REDACTED]	[REDACTED]	10. Laboratory
		Activity 1.3: Establish 50 satellite Labs at District linked to reference laboratories (HR, equipment, training, SOPs)	HLAB	[REDACTED]	ASM	10. Laboratory
2. Limited human resource capacity on viral load testing		Activity 2.1 Technical assistance to the MSHP for Expansion of capacity to monitor viral suppression in 100% of sites in saturation and aggressive Scale-Up Districts	HVSI	[REDACTED]	[REDACTED]	10. Laboratory
		Activity 2.2: Conduct in-service training of health and non-health staff on Test and Start, VL, QMS, biological sample management and transportation)	HLAB	[REDACTED]	MSHP CoAg	10. Laboratory
		Activity 2.3: Increase capacity at RETROCI-CI for in service training and plan transfer to the MSHP	HLAB	[REDACTED]	RETROCI	10. Laboratory
		Activity 2.4: Ensure effective deployment of dedicated staff for VL testing	HLAB	[REDACTED]	RETROCI	10. Laboratory
		Activity 2.5: Ensure retention of laboratory staff through performance based financing linked to VL testing	HLAB	[REDACTED]	CDC Clinical partners	10. Laboratory
		Activity 3.1: Establish HR expertise at national medical stores for specialized lab commodities through recruitment and training	HLAB	[REDACTED]	[REDACTED]	10. Laboratory
3. Weak management of Viral Load commodities		Activity 3.2: Develop and provide training on SOPs for management of lab commodities (at central, district and site levels)	HLAB	[REDACTED]	[REDACTED]	10. Laboratory
		Activity 4.1 Procure laboratory reagents and supplies to support delivery of HIV Viral Load GeneXpert Tests to TB/HIV co-infected patients in Scale-Up Districts	HVTB	[REDACTED]	RETROCI	10. Laboratory
4. Limited access to viral load testing for TB/VHI co-infected patients	90% of TB/MDR TB case detection and ensure Viral suppression among both TB/HIV co-infected patients in scale-up districts	Activity 4.2 Provide technical assistance to the National TB Control Program and the National TB reference Laboratory to develop a comprehensive workplan for TB smear microscopy EQAs		[REDACTED]	ASM	10. Laboratory

Table 6.1.3 Key Programmatic Gap #3: Low access to VL testing						
Key Systems Barrier	Outcomes expected after 3 years of investment	Activities Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
		Activity 4.3 Reinforce human resource capacity to support implementation of TB smear microscopy EQAS at 100% of TB laboratories		[REDACTED]	ASM	10. Laboratory
		Activity 4.4 Provide mentorship program to monitor and sustain TB smear microscopy EQAS		[REDACTED]	ASM	10. Laboratory
		Activity 4.5 Support through a mentorship program the implementation of WHO/AFRO accreditation scheme at two central laboratories and 10 CATs		[REDACTED]	ASM	10. Laboratory
		Activity 4.6 Sustain early TB diagnosis and MDR-TB detection using GenExpert among both TB/HIV co-infected patients and patients at risk for MDR-TB at eight CATs		[REDACTED]	ASM	10. Laboratory
		Activity 4.7 Extend early TB diagnosis and MDR-TB detection using GenExpert among both TB/HIV co-infected patients and among patients at risk for MDR-TB at 3 additional CATs		[REDACTED]	ASM	10. Laboratory
TOTAL				1,800,000		

6.2 Critical Systems Investments for Achieving Priority Policies

PEPFAR-CI has been working with the PNLs on an implementation plan for the national implementation of Test and Start, and the team has identified the major systems barriers that could be addressed through PEPFAR-supported interventions in COP 2106. The major systems barriers for successful implementation include:

- Lack of enabling policies to place all individuals testing positive on ART
- Limited financial resources to close coverage gap
- Insufficient number of adequately trained HIV services providers at clinical and community levels
- Inadequately adapted national supply chain system
- Weak national quality management systems for laboratory HIV screening and retesting prior to ART initiation, at both the facility and community levels

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)
1. Lack of enabling policies for all tested positive to start on ART	Full implementation of SOP for clinical service sites.	Activity 1.3: Revise SOPs for HIV delivery both at facility and community services to reflect Test and Start and New Service Delivery Models (2 session of 3-day workshop of 25 people)	OHSS	[REDACTED]	MSHP CoAg	6. Service delivery
	MOH effectively manage, coordinate and supervise the national HIV response	Activity 1.4: Support monitoring, coordination meetings, site visits, supervision, participation in PEPFAR key events	OHSS	[REDACTED]	MSHP CoAg	6. Service delivery
2. Limited financial resources to close coverage gap	The 2017 budget of the national strategic plan for HIV/AIDS is revised based on new directives (service delivery models and programmatic realities). A modeling study on the economic benefits of investing in HIV/AIDS is conducted by an academic institution. The results of the study are used by the US Embassy (Front Office)	Activity 2.1: Conduct budgetization of revised 2017 operational plan for HIV/AIDS (OHT (one health tool) consultancy plus 2 workshops of 25 attendees)	OHSS	[REDACTED]	Abt/HFG	11. Domestic Resource Mobilization
		Activity 2.2: Support modeling study to assess health and economic benefits (including future savings) expected from increased GOCI HIV funding (in collaboration with university or research institute)				

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)
3. Insufficient number of adequately trained HIV services providers at clinical and community levels	and MOH to lobby for increased domestic government investments in HIV/AIDS.					
	Host government contribution to fight against HIV/AIDS increases from \$12 million (2016) to \$40 million (2020)	Activity 2.3: Support the MSHP to develop an advocacy plan for DRM increase for HIV/AIDS program	OHSS	[REDACTED]	Abt/HFG	11. Domestic Resource Mobilization
		Activity 2.4: Conduct advocacy efforts to get buy-in from other health sector donors (e.g. UNAIDS, WB, GF, French Cooperation etc.) and civil society for request to increase GOCI contribution towards HIV/AIDS (eg, donor round table, publications, conference)		[REDACTED]	MSHP CoAg	
	At least 80% of GOCI funds is used to procure ARV drugs and laboratory commodities. At least 10% of GOCI funds is used to support salary / financial incentives for Community Health Workers (CHWs)	Activity 2.5: Provide TA to the MSHP to effectively track accurate information on expenditure in HIV sector (HIV sub account of National Health Accounts)	OHSS	[REDACTED]	Abt/HFG	14. Financial and Economic Data
		Activity 2.6: Provide TA to NPSP and CNCAM-CI (National Coordination Commission for the Strategic Procurement of Essential Drugs and Health Supplies) to track effective spending of GOCI funding on procurement of HIV commodities		[REDACTED]	MSHP CoAg	
	In-service training: training modules are updated and pool of national trainers updated in new training materials	Activity 3.1: Revise national training modules to reflect policy changes (test and start, new service delivery modules, task shifting, role of CHW, etc.)	PDTX	[REDACTED]	MSHP CoAg	7. HRH
		Activity 3.2 Train a pool of 150 national/regional trainers on revised policies (6 sessions of 3-day workshop of 25 people each)				
		Activity 3.3 National in-service training plan developed				
	900 Staff trained in HIV service delivery is deployed to districts targeted for ART saturation	Activity 3.4: the MSHP/DHR deploys at least 60% of newly recruited nurses / midwives trained on task shifting in ART Saturation Districts; and prioritizes HIV Saturation Districts when rotating staff that has been trained	OHSS	[REDACTED]	Abt/HFG	7. HRH
	Agreement reached between PEPFAR and	Activity 3.5: Support implementation and evaluation of PBF pilot phase and ensure	OHSS	[REDACTED]	Abt/HFG	

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)
	Global Fund to fund a PBF pilot in 2 to 5 scale up to saturation districts. PEPFAR will support the HIV indicators and GF will support the non HIV indicators.	that HIV continues to be centrally positioned in the national scale up of PBF				
		Activity 3.6: Support implementation of PBF pilot phase in saturation and Aggressive Scale-Up Districts (in collaboration with GF and WB)	HTXS PDTX	[REDACTED]	Clinical Partner	
	Community Health Workers (CHWs) are essentially recognized as an essential cadre needed to reach HIV and health goals. The training package and incentives (financial and others) for CHWs is standardised	Activity 3.7: Build an advocacy case and obtain buy in from other health sector donors (e.g. UNAIDS, WB, GF, French Cooperation, UNICEF) and civil society which will result in formalization of the role that CHWs play in the health / HIV sector (eg, donor round table, publications, conference)	OHSS PDTX	[REDACTED]	Abt/HFG	7. HRH
		Activity 3.7 GOCI and partners standardize financial incentives for CHWs (with standardized pay scale or contract status with standardized financial incentive)				
		Activity 3.8 Facilitate study tour for a group of GOCI representatives (inter- ministerial) to learn from best practices in selected African countries focusing on CHW policy and curriculum development				
Activity 3.9 TA to the MSHP and national training institution resulting in standardized training package and recruitment process for CHWs	[REDACTED]	MSHP CoAg				
[REDACTED]	[REDACTED]	ICAP				
4. Inadequate national supply chain (central and sub-national level) adapted to new service delivery models, Test and Start, and VL testing scale-up	Training completed of 500 districts pharmacists, store managers, nurses, midwives, lab personnel, and CHWs/CCs on commodities management, and community-based distribution of HIV commodities (including ARVs, VL and EID reagents). National Medical Stores (NPSP) creates and recruits laboratory	Activity 4.1: Support 4 in-service training sessions for 500 districts pharmacists, store managers, nurses, midwives, lab personnel, and CHWs/CCs on commodities management, and community-based distribution of HIV commodities (including ARVs, VL and EID reagents)	OHSS	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain
		Activity 4.2: Build capacity at NPSP in order to increase management capacities for lab commodities (VL; EID controls and reagents)	OHSS			
		Activity 4.3: Support refurbishing and improvement of storage capacity of 15	OHSS			

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)	
	products specialist or team. TA is provided to build expertise of laboratory team at NPSP. Stock out of HIV tracer commodities (including ARVs, VL and EID reagents) is reduced from 4% to 1%. 15 district pharmacies are rehabilitated to bring them in line with acceptable storage conditions for ARV drugs and HIV commodities (WHO). Timely submission of LMIS reports by increases from 80% to 100% (year 3). 75% of district pharmacies are stocked according to plan for HIV commodities (4 months plus 2 months security stock)	health district depots.				8. Commodity Security and Supply Chain	
		Activity 4.4: Support computer based Inventory management system at districts and health facility level	OHSS				
		Activity 4.5: Support the revision of national Standard Operation Procedures for quantification and forecasting which reflects T&S policy and new service delivery models	OHSS	[REDACTED]	MSHP CoAg		
		Activity 4.6: Support the MSHP in using LMIS data to inform decision making (eg, procurement; emergency delivery)	OHSS				
	Technical assistance to national quantification and forecasting committee (CNCAM) resulting in annual procurement plan for HIV commodities that takes into account the switch to test and start and innovative service delivery models.	Activity 4.7: Support workshop to develop SOPs for HIV/AIDS commodities management within the context of new treatment policy	OHSS	[REDACTED]	[REDACTED]		
	LMIS (paper-based and electronic) is revised to reflect test and start and VL testing. CNCAM is strengthened to provide TA to regional and district level for quantification and forecasting exercises for HIV commodities	Activity 4.8: Support revision and implementation of LMIS (paper-based and electronic) which reflect test and start, and VL testing	OHSS	[REDACTED]	[REDACTED]		
		Activity 4.9: Provide support to Health Regions and Districts to conduct regular revisions of quantification of HIV/AIDS commodities	OHSS		[REDACTED]		
		TA to National Medical	Activity 4.10: Support the NPSP to review	OHSS			[REDACTED]

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)
	Stores (NPSP) to revise transport and distribution system for HIV commodities (to address changes that will come with the introduction of test and start and new service models)	transport and distribution plan which reflects the changes imposed by T&S and new service delivery model.				
5. Weak national quality management systems for laboratory HIV screening and retesting prior ART initiation (facility and Community)	HIV Rapid Testing Quality Improvement Initiative (RTQII) is fully implemented at all HIV testing point in the Scale-Up Districts	Activity 5.1: Develop, revise, reproduce and disseminate national HIV rapid test guidelines needed for the implementation of RTQII including misdiagnosis surveillance	HLAB	[REDACTED]	[REDACTED]	9. Quality Management
		Activity 5.2: Certify 1000 (50%) HIV testing sites	HLAB	[REDACTED]		9. Quality Management
		Activity 5.3 Implement post-marketing surveillance at central (1) and key decentralize pharmacists (50)	HLAB	[REDACTED]		9. Quality Management
		Activity 5.4: Implement the PT program in at 2000 testing sites/points including Blood transfusion laboratories	HLAB	[REDACTED]		9. Quality Management
		Activity 5.5: Print and distribute 1000 HIV Rapid Test log books and registers at 50% of testing posts	HLAB	[REDACTED]		9. Quality Management
		Activity 5.6: Subcontract with laboratory technician associations for coaching supervision and certification of HIV testers	HLAB	[REDACTED]		9. Quality Management
		Activity 5.7: Implement Step-wise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) in 50 laboratories located in 49 scale-up and Sustained Districts	HLAB	[REDACTED]		9. Quality Management
		Activity 5.8: Implement and sustain laboratory Quality Management System (QMS) at operational levels (districts and health facilities).	HLAB	[REDACTED]		9. Quality Management
		Activity 5.9: Develop national policies, regulatory documents, guidelines and SOPs for biosafety and biosecurity	HLAB	[REDACTED]		9. Quality Management
		Activity 5.10: Develop SOPs for biosafety and biosecurity	HLAB	[REDACTED]		9. Quality Management
		Activity 5.11: Strengthen the national	HLAB	[REDACTED]		9. Quality

Table 6.2.1 Test and Start						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if app)
		laboratory and laboratorian network				Management
		Activity 5.12: Train 75% of members of laboratorian's professional association in QMS	HLAB	[REDACTED]		9. Quality Management
		Activity 5.13: Support NBTS to develop procedures for HIV tests evaluation	HLAB	[REDACTED]		9. Quality Management
		Activity 5.14: Provide TA to NBTS program to improve commodities management				9. Quality Management
	HIV Misdiagnosis surveillance is implemented on the routine basis at all HIV testing sites	Activity 5.15: Conduct TOT and training of Health workers	HLAB	[REDACTED]		9. Quality Management
		Activity 5.16: Implement misdiagnosis activity incrementally to reach 50 % of testing posts at the end of the fiscal year	HLAB	[REDACTED]		9. Quality Management
TOTAL				8,583,916		

The institution of new service delivery models can facilitate the implementation of Test and Start in order to mitigate the challenges at the facility and in the community in managing a larger cohort of patients on ART. The main barriers are programmatically driven with the primary systems-related barrier pertaining to the lack of a supply chain management system that can adequately monitor activities and inventory management at decentralized levels of the health system.

Table 6.2.2 New Services Delivery Models						
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP/ROP16	Budget Code(s)	Activity Budget Amount (\$)	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
1. Lack of enabling policies for all tested positive to start on ART	GOCI revises national guidelines to reflect test and start policy for all HIV-positive individuals.	Activity 1.1: Support GOCI to revise national guidelines to reflect implementation of Test and Start and New Service Delivery models (2 sessions of 3-day workshop of 25 people)	OHSS	[REDACTED]	MOH CoAg	2. Policies and Governance
	Circular and other official documents are developed and disseminated to all service providers to implement test and start.	Activity 1.2: Print and disseminate the revised guidelines (2,000 copies)	OHSS	[REDACTED]	MOH CoAg	2. Policies and Governance
2. Inadequate monitoring of supply chain activities and inventory management at decentralized level of health system	Proposal for transfer of responsibility for ARVs and HIV commodities is developed and endorsed by MOH. Training of community based distributors of HIV commodities (Yr1: Scale-Up to Saturation Districts; Yr2 Aggressive Scale-Up Districts; Yr3: Sustained Districts). SOP and LMIS are revised to account for community distribution of HIV commodities. Effective national logistics system is designed and implemented for community-based ARV distribution. Adequate equipment is provided for community based storage of HIV commodities.	Activity 2.1: Support design and implementation of community-based distribution of HIV commodities	OHSS	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain
		Activity 2.2: Support training of community workers on management and reporting on distribution of ARVs				
		Activity 2.3: Support update of SOPs and LMIS to include community-based distribution of ARVs				
TOTAL				591,350		

6.3 Proposed system investments outside of programmatic gaps and priority policies.

The table below encapsulates cross-cutting system investments proposed for COP16 that affect multiple technical areas, including those identified as the primary programmatic gaps. The interagency team has prioritized activities that have the greatest impact in reaching the 90:90:90 goals and in assisting the country in achieving a sustainable national HIV response.

Table 6.3 Other Proposed Systems Investments						
Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
Supply Chain Management						
1. Capacity building of central medial stores	Activity 1.1: Oversee implementation of eLMIS system for health commodities	Sustained Epi Control	Real time data on supplies is available at all 83 direct clients of National Medical Stores (NPSP) and all orders are processed based on eLMIS. National quantification and forecast exercises are based on real life logistics data. MPSP maintains adequate amount (9 months) of stock of HIV supplies (6 months plus 3 months security stock).	[REDACTED]	OHSS HVSI	[REDACTED]
	Activity 1.2: Using logistics data to make to make decision	Sustained Epi Control		[REDACTED]	OHSS HVSI	[REDACTED]
2. Supply chain system strengthening	Activity 2.1: Provide supply chain related systems strengthening technical assistance encompassing the different elements of a comprehensive supply chain (e.g. quantification/forecasting, procurement transportation, warehousing, and information systems).	Sustained Epi Control	Stock out of HIV tracer commodities is reduced from 4% to 1%. 15 district pharmacies are rehabilitated to bring them in line with acceptable storage conditions for ARV drugs (WHO). Timely submission of logistic management information (LMIS) reports increases from 80% to 100% (by year 3). 70% of district pharmacies are stocked according to plan for HIV commodities (4 months plus 2 months security stock)	[REDACTED]	HTXS OHSS	[REDACTED]
	Activity 2.2: Provide technical assistance to improve the availability of health commodities at decentralized level of health system.	Sustained Epi Control			OHSS HLAB	
	Activity 2.3: Provide institutional support to Government institutions and locals entities (CNCAM; NPSP) to strengthen supply chain functions, esp. quantification, forecasting planning of health commodities	Sustained Epi Control			OHSS	
	Activity 2.4: Strengthen last mile distribution system for ARVs and lab	Sustained Epi Control			HTXS OHSS	

Table 6.3 Other Proposed Systems Investments						
Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
	commodities					
	Activity 2.5: Support improved storage and inventory management of health commodities at peripheral level of health system	Sustained Epi Control			HTXS OHSS	
	Activity 2.6: Support design and implementation of efficient reverse logistics for health commodities	Sustained Epi Control			HTXS OHSS	
	Activity 2.7: Support establishment of a reliable system to improve data visibility and use of data for decision making	Sustained Epi Control			OHSS HVSII	
	Activity 2.8: Design and implement efficient capacity building system to maintain a robust workforce for logistics and supply chain system across all level of health system in the public.	Sustained Epi Control			OHSS	
3. Supply Chain Quality Assurance	Activity 3.1: Provide independent, essential, comprehensive quality assurance/control services covering the different health elements. Examples include but are not limited to: a) TA on proper sampling and testing, and pre-shipment inspections required as part of overall product quality process; b) TA to national drug regulatory authority responsible for in-country supply chains.	Sustained Epi Control	75% of the batches of HIV commodities in CI are undergoing quality control in WHO certified laboratories. TA is provided to national laboratory for quality resulting in certification by WHO (3 year output).	[REDACTE D]	OHSS	GHSC-GA
Institutional/Organizational Development						
4. Leveraging of funding	Activity 4.1: Support CCM and Principal Recipients for HIV and TB with the goal to ensure well aligned PEPFAR and Global Fund investments	Sustained Epi Control	PEPFAR and Global Fund investments are well aligned. The Cote d'Ivoire Global Fund Country Coordinating Mechanism (CCM) and the Global Fund Principal Recipients (PRs) fulfill the critical functions of a CCM, using data for decision making and oversight and have leadership, management, and financial skills strengthened and demonstrated	[REDACTE D]	OHSS	MSH/LMG

Table 6.3 Other Proposed Systems Investments						
Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
			capacity to implement, monitor, and evaluate HIV and TB programs.			
5. Improved quality of services	Activity 5.1: Provide TA to national quality improvement unit and to Clinical Partners	First 90; Second 90;	GoCI has a national quality assessment / improvement policy and technical guidelines which is being implemented by the clinical partners (100% of sites in scale up to saturation and aggressive scale up district implement the national quality improvement policy and guideline)	[REDACTED]	OHSS	URC/ASSIST
	Activity 5.2: Support public-private collaborative platform to improve services in the private sector	First 90; Second 90;	Coordination, reporting, monitoring and supervision of health services are harmonized across public and private health sector in SNU's where PEPFAR supports HIV care and treatment services in private sector.	[REDACTED]	OHSS	Abt/PSHP
	Activity 5.3: Provide TA for nutritional service delivery system strengthening	Sustained Epi Control	Improved adherence, retention of HIV positive children and their parents	[REDACTED]	OHSS	FHI360/Fanta
Laboratory						
6. Laboratory system strengthening	Activity 6.1: Participate in international external quality assurance programs and support EQA related activities	First 90; Third 90;	National public health laboratory enrolls public health lab in the national EQA program	[REDACTED]	HLAB	RETROCI
	Activity 6.2: Provide TA to the lab network through coaching supervision, onsite training for VL, EID and lab related activities	First 90; Third 90;	National public health laboratory coordinates a program of coaching and supervision of national lab networks	[REDACTED]	HLAB	RETROCI

Table 6.3 Other Proposed Systems Investments						
Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
	Activity 6.3: Assess new laboratory methods and techniques	First 90; Third 90;	Competency transferred to the National public health laboratory	[REDACTED]	HLAB	RETROCI
	Activity 6.4: Provide TA to Institut Pasteur for STI and TB related activities	Third 90; Sustained Epi Control		[REDACTED]	HVTB	ASM
	Activity 6.5: Provide biosafety and quality control materials to DOD laboratories, and implement quality management systems and train key staff to provide reliable laboratory results to military	First 90; Third 90; Sustained Epi Control		[REDACTED]	HLAB	DOD Military partner
	Activity 6.6: Support national coordination of laboratory activities	First 90; Third 90; Sustained Epi Control	Effective coordination as a result of Directorate in charge of Laboratory	[REDACTED]	HLAB	MSHP CoAg
	Activity 6.7: Strengthen TB and OIs diagnosis at central and 10 regional labs	Third 90; Sustained Epi Control	Effective decentralization with region offering full service and participating to surveillance at decentralized level	[REDACTED]	HLAB	Institut Pasteur
	Activity 6.8: Ensure training and activities in HR development.	First 90; Second 90; Third 90; Sustained Epi Control		[REDACTED]	HVTB	Institut Pasteur
	Activity 6.9: Strengthen QAQC program.					
Activity 6.10: Organize hubs around regional labs for high laboratory impact in collaboration with the new international lab partner.						
Strategic Information						
7. Monitoring and Evaluation	Activity 7.1: Continue the development of the information system in MOD and linked to the MSHP system	First 90; Second 90; Sustained Epi Control	Established an effective information system. Adapt current MOH tools for national reporting with disaggregate information between civilian and military pops) to capture military specific health information to take informed decisions for Military	[REDACTED]	HVSI	DOD Military partner
	Activity 7.2: Support interoperability between the data systems	Second 90	Data system integration. Improvement in quality of: patient records, patient tracking system, and retention in treatment monitoring at all facilities. 100% of treatment sites	[REDACTED]	HVSI	Measure Evaluation

Table 6.3 Other Proposed Systems Investments

Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
			in saturation and aggressive scale-up districts have access to electronic tools. Real time data available in saturation and aggressive scale-up districts.			
	Activity 7.3: Improve data use at central, regional and district levels	Sustained Epi Control	SOPs are developed and used by 100% of treatment sites in priority districts (systems dashboards, monthly data use report by districts, regions and at central level)	[REDACTED]	HVSI	Measure Evaluation
	Activity 7.4: Deploy electronic tools (DHIS2, OpenMRS /SIGDEP2 EMR, eLMIS, OVC database)	First 90; Second 90; Sustained Epi Control	Improved quality of : patient records, patient tracking system, retention in treatment monitoring, All treatment sites in saturation and aggressive scale-up districts have access to electronic tools	[REDACTED]	HVSI	Measure Evaluation
	Activity 7.6: Conduct OVC program outcomes evaluation (EGPAF Keneya & HOPE-CI Project evaluation)	First 90; Third 90; Sustained Epi Control	Collection of OVC essential survey indicators that address the HIV status, protection, education and wellbeing.	[REDACTED]	HKID	FHI360/ISPEC
	Activity 7.7: Reproduce paper-based data collection tools	First 90; Sustained Epi Control	Availability of patient records, registers in all sites. Improved reporting in saturation and Aggressive Scale-Up Districts	[REDACTED]	HVSI	MSHP CoAg
	Activity 7.8: Conduct supervision, assess performance of the RHIS, conduct data validation workshops, deploy paper-based and electronic tools and maintenance	Sustained Epi Control	Improved quality of patient level data and RHIS performance. All treatment sites and districts have access to paper-based and well maintained electronic tools.	[REDACTED]	HVSI	MSHP CoAg
	Activity 7.9: Ensure data quality improvement (Data quality audit for ART, OVC, PMTCT and HTC, Routine checks along the data flow process)	Sustained Epi Control	Improved quality of patient level data and RHIS performance. All treatment sites and districts have access to paper-based and well maintained electronic tools.	[REDACTED]	MTCT HTXS HKID HVCT	UCSF TA

Table 6.3 Other Proposed Systems Investments						
Systems Category*	Activity	Indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control	Outcomes expected after 3 years of investment	Budget Amount	Budget Code(s)	Associated Implementing Mechanism ID
8. Surveys	Activity 8.1 Conduct Violence Against Children Study (VACS)	Sustained Epi Control	Frequencies and types of violence against children are known and this information is being used to change policies and programming	[REDACTED]	HKID	UNICEF
	Activity 8.2: Conduct biological and behavioral survey among KPs (MSM, CSW)	First 90; Sustained Epi Control	HIV prevalence among KP, KP related sexual behaviors within largest urban centers (Abidjan, Bouake, San Pedro, Gagnoa, Daloa)	[REDACTED]	HVSI	FHI360/ISPEC
9. Surveillance	Activity 9.1: Assess PMTCT program data quality for HIV surveillance among pregnant women in Cote d'Ivoire	First 90; Sustained Epi Control	HIV prevalence among pregnant women, PMTCT routine data quality assessed, PLHIV estimates	[REDACTED]	HVSI	MSHP CoAg
	Activity 9.2: Conduct Early Warning Indicators survey	Sustained Epi Control	PEPFAR Program effectiveness monitoring, patient monitoring, retention, ARV drugs availability	[REDACTED]	HVSI	MSHP CoAg
	Activity 9.3: Train and support decentralized level to develop district/region level estimates and projections	First 90; Second 90; Third 90; Sustained Epi Control	Improved availability and use of small area estimates for adequate HIV responses at district/region levels (PLHIV estimation, prevalence)	[REDACTED]	HVSI	CDC-UNAIDS Central mechanism
10. Operations Research	Activity 10.1: Conduct ARV Treatment outcome study	First 90; Second 90; Sustained Epi Control	Availability of data on HIV prevalence, Retention of patients on treatment, LTFU, mortality, adherence	[REDACTED]	HTXS	FHI360/ISPEC
TOTAL				9,315,010		

7.0 Staffing Plan

7.1 Staffing assessment

In July 2015, PEPFAR-CI engaged PricewaterhouseCoopers (PwC) to perform a staffing assessment by reviewing staff responsibilities and the distribution of effort to respond to program oversight and monitoring demands. An interagency HQ team made subsequent trips to provide TA on analyzing the PwC deliverables and implementing any recommendations, specifically within the framework of helping PEPFAR-CI meet the 90:90:90 targets through improved organizational efficiency and effectiveness.

After conclusion of the staffing assessment exercise, the PEPFAR-CI leadership determined that the existing staffing structure with regard to the number and type of positions of each of the agency teams (including those not yet filled) corresponded to the new requirements for technical leadership, program management, site monitoring, reporting requirements and maintenance of strong relationships with external stakeholders. Two significant changes did occur, however:

First, the previously integrated structure of PEPFAR-CI whereby co-located staff collaborated on programming and partner planning without concern for agency designations, evolved into distinct agency spaces with separate agency-specific technical staff. Co-location had previously led to challenges and sensitivities with regard to staff supervision and partner oversight across agencies.

Secondly, this division of technical staff by agency necessitated a new model of interagency technical collaboration. Consequently, in October 2015, interagency Technical Working Groups (TWGs) were created. A staffing retreat in January 2016 led to the development of terms of reference for each TWG.

In COP16, PEPFAR-CI will continue to adapt to and solidify this new interagency governance structure.

7.2 Vacancies

The CDC has four vacancies that have exceeded more than six months. The Operations Manager position is currently going through the Human Resources office procedures and is expected to be filled by June 2016. [REDACTED]

The one USAID vacancy exceeding six months of Deputy Health Office Director will be filled in June 2016. A long-term consultant coupled with TDY support has provided interim coverage of this position in the months before the Foreign Service Officer assigned to the position could assume post.

[REDACTED]

7.3 New Positions

[REDACTED]

7.4 Major changes to the Cost of Doing Business

The Cost of Doing Business in COP16 has diminished by more than \$1M from COP16 in multiple areas, which offsets a few increases in other areas. The DOD budget in program travel has risen to due expected increase in travel for SIMS and other monitoring, while the budget for non-ICASS administrative costs have decreased. The PEPFAR Coordination Office has requested a budget increase [REDACTED]; support for increased number of interagency partner meetings and trainings to better engage with external stakeholders as well as to train implementing partners on ever evolving PEPFAR guidance.

In contrast, the M&O budget planning for CDC in COP15 was for 15 months as opposed to 12 months for COP16, which reduces the cost of doing business. USAID administrative costs and instructional contractor support have stayed mostly stable.

APPENDIX A

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

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 & PLHIV, Priority Populations) 2- HTS 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- 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- Combination Prevention—ART for Prevention, Condoms, PMTCT, HTS for KP and PPs 18- Key Populations: Nationally Validated Minimum Package of Services (STI, HTS, ART, Sexual Prevention, Condoms) 19- GBV/HIV referral networks (e.g. social centers, PEP) 20- Linkages and referrals from community to clinical services for KP and PP including OVC and their families; 21- PHDP 22- HTS 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 	<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; 5- Couples testing; 6- Home-based continuum of care to improve retention; 7- TB screening, referral and infection control; 8- NACS for pediatrics in Scale-Up Districts; 9- Chronic care model pilot (pilot in two regions after which follow-on policy work with the MSHP and implementation framework 2 years); 10- CD4 monitoring 11- Community-based testing in Sustained Districts for OVC 12- DQA and Program Evaluation. Laboratory monitoring (EID, CD4, hematology, biochemistry, VL) for children and adult on ART, 13- 	<ol style="list-style-type: none"> 1- Services to low prevalence and low yield sites, 2- Hematology and biochemistry for HIV negative pregnant women 3- General population testing 4- Demand creation in Sustained Districts

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	Core Activities	Near-core Activities	Non-core Activities
	(higher socio-economic status, higher education, workplaces)		
	23- Commodity supply.		
	24- Child protection, legal protection and social protection for OVCs;		
	25- Household economic strengthening for OVCs and families;		
	26- Education and nutrition including NACS support for OVCs and families		
Sub-national level			
1.	1- MSM and FSW micro-mapping and size estimation located in urban hot spots; Biological and behavioral survey among key Populations	1- Mentoring lab technician association (AIBT) by assisting to establish solid links between the association and members	
	2- Advocacy for domestic resource mobilization tools and models	2- TA and targeted funding to MLSL to improve coordination of the health sector response to HIV epidemic;	
	3- Policy support for Test and Start and new service delivery models	3- PERIODIC RECURRING : National revision of HIV indicators for the implementation of the MER;	
	4- Technical support for supply chain management	4- Medical waste management at high volume treatment sites (integrate with treatment partners with treatment work,	
		5- ANC survey among pregnant women and PMTCT routine data quality audit for HIV surveillance.	
		6- (By end of FY15), Coordination of the social sector response to HIV epidemic;	
		7- Coordinate national GBV TWG;	
		8- HIV-2 and HBV co-infection routine service delivery and surveillance to ensure appropriate patient treatment;	
		9- populations (MSM, CSW);	
		10- Program and Impact Evaluation	

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP16

HTS	Core Activities	Near-core Activities	Non-core Activities
	<ol style="list-style-type: none"> 1. HTS in PMTCT 2. Testing key and priority populations (MSM, FSW, women 20-24 years, military and adult men 35-49 years) 3. Provider initiated counseling and testing for sick and at risk adults and children (including TB patients) 4. HTS commodities 	<ol style="list-style-type: none"> 1. Couples testing 	<ol style="list-style-type: none"> 1. Voluntary testing and counseling for the general population
Care and Treatment	<ol style="list-style-type: none"> 1. Condom services for KP, PLHIV, & Priority Populations 2. ARV Prophylaxis/ART for PMTCT, EID 3. Care and treatment 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. 11. Community sensitization for ANC uptake. 12. Home-based continuum of care to improve retention; 	<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. TB screening, referral and infection control 4. NACS for pediatrics in focus regions; 5. PHDP. 	<ol style="list-style-type: none"> 1. For Sustained Districts identified by cut-off criteria in COP16, 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 FY16)
Prevention	<ol style="list-style-type: none"> 1- Combination Prevention—ART for Prevention, Condoms, PMTCT, HTS for KPs and PPs 2- Key Populations services: Nationally Validated Minimum Package of Services (STI, HTS, ART, Sexual Prevention, Condoms) 3- Condoms for All Higher-Risk Groups (e.g. KP, PPs, & PLHIV) 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- HTS 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. 	<ol style="list-style-type: none"> 1- Laboratory screening to prevent infections transmitted through blood transfusions- 	<ol style="list-style-type: none"> 1- Activities in low prevalence and low yield sites (annually reviewed) 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

	Core Activities	Near-core Activities	Non-core Activities
OVC Program/ system support	<ul 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 protection for OVCs 4- Household economic strengthening for OVC and their families 5- Education and nutrition support for OVCs and families 	<ul style="list-style-type: none"> 1- Coordinate national GBV TWG 2- Policy development for PEP, HIV testing, and post rape services 3- Coordination of the social sector response to HIV epidemic 	
Laboratory	<p>Core Activities</p> <ul style="list-style-type: none"> 1. Routine lab monitoring test (HIV, EID, TB, CD4, VL, hematology, biochemistry, STI) 1- Quality management systems (EQA panels and RTQII) 2- Laboratory information system I-Tech to Support Implementation of LIS at labs (OPENLIS and BLISS) 3- 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 4- Procurement, small repair (containerized lab, minor repairs) and technical assistance for decentralization EID and viral load at four regions 5- 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. 6- 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, MDR-TB diagnosis (in 10 regional labs) 10- Validation and implementation of national policies on Biosafety and sample transportation. 11- CDC RETROCI: 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 	<p>Near-core Activities</p> <ul style="list-style-type: none"> 1. Implementation of training curricula for lab management at INFAS and at Medical and Pharmacy faculties. 2. Renovation of 3 regional labs to implement microbiology testing. 	<p>Non-core Activities</p> <ul style="list-style-type: none"> 1- Mentor the lab technician association (AIBT) by assisting to establish solid links between the association and members 2- Implement a public health evaluation of the impact of the project on patient monitoring within two of the six regions

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP17	# of IMs	Transition End date	Notes
PMTCT & HCT in low yield sites	Transitioned to Government	0	0	7	July 2016	115 sites transitioning to the MSHP management. This is an annual exercise
HCT in low yield sites	Transition to Government	0	0	7	July 2016	67 HTC sites transitioning to the MSHP management. This is an annual exercise
Transition of hematology and biochemistry to the MSHP for patients in care	Transition to Government	\$347,739	\$347,739	1	Sep 2016	
OVC support in sustained sites	Transition to GF-support Alliance	\$1,360,519	0	6	Sept 2017	All 6 OVC IMs will still be in Sustained Districts through COP16

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
\$11,983,584	\$128,266,724	\$140,180,308

Table B.1.2 Resource Allocation by PEPFAR Budget Code		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$4,079,674
HVAB	Abstinence/Be Faithful Prevention	\$295,665
HVOP	Other Sexual Prevention	\$5,378,475
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	0
HMIN	Injection Safety	0
CIRC	Male Circumcision	0
HVCT	Counseling and Testing	\$8,242,894
HBHC	Adult Care and Support	\$8,526,290
PDCS	Pediatric Care and Support	\$3,336,836
HKID	Orphans and Vulnerable Children	\$11,672,119
HTXS	Adult Treatment	\$39,411,832
HTXD	ARV Drugs	\$16,941,822
PDTX	Pediatric Treatment	\$3,396,047
HVTB	TB/HIV Care	\$3,614,567
HLAB	Lab	\$8,050,000
HVSI	Strategic Information	\$3,354,372
OHSS	Health Systems Strengthening	\$7,966,128
HVMS	Management and Operations	\$15,913,587
TOTAL		\$140,180,308

B.2 Resource Projections

As in the previous years, the clinical cascade is the main tool used for projecting resources required for COP16 implementation, including carrying costs and plans for scale-up, saturation, and a Test and Start approach. The cascade is also designed to support achievement of the program goal for FY17, 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 (eg, MSM, FSW, pediatrics young girls, men 25-49)
 - 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 (eg, active enrollment in Scale-Up Districts vs passive enrollment rate in Sustained Districts)
 - 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 FY15 EA results and for the program, including potential cost savings through leveraged resources from other donors and projected changes in the package of services.

A sub-group of interagency, multi-sectorial staff 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 and treatment have been determined including the linked sub-categories of PMTCT, adult and pediatric services and TB/HIV integration, the next phase of budgeting reviewed the program support activities in the cross-sectorial areas of HSS, prevention, lab, SI and OVC. All technical areas with non-target driven activities is budgeted in line with program priorities, impact and partner performance, prioritizing activities support the programmatic gaps, the priority policies, and above all, the Goal Statement of PEPFAR-CI to reach 80% coverage in the Saturation Districts by FY17.

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