

Côte d'Ivoire
Country Operational Plan
(COP) 2017
Strategic Direction Summary
March 2017



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1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) program in Côte d'Ivoire will contribute to achieving the UNAIDS 90:90:90 goals embraced by the Ivorian government and multilateral stakeholders, by increasing access to quality combination prevention services, improving antiretroviral therapy (ART) coverage, and scaling up Viral Load (VL) testing services. COP17 intensifies the vision of reaching 80% global coverage of adult treatment and 80% of pediatric treatment in select high-impact geographic areas by 2020, prioritizing 19 Scale-Up to Saturation Districts and 20 Aggressive Scale-Up Districts. In addition, PEPFAR Côte d'Ivoire (PEPFAR-CI) has a more aggressive package of services in four Scale-up to Saturation Districts to ensure they reach Attained Status by the end of fiscal year 2018 (FY18), whereby 81% of all HIV-infected women, men, children, and adults will be receiving anti-retroviral treatment (ART). The Saturation Districts have the largest current patient cohorts, are among areas most likely to be sources of new infections, and represent 35% of the estimated disease burden in the country. The Aggressive Scale-Up districts represent an additional 41% 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, pediatric cases, and Key Populations (KPs), while increasing linkages along the clinical cascade. With the upcoming Population-based HIV Impact Assessment (PHIA), there will be an opportunity to better assess progress towards the 90:90:90 goals and fine tune the HIV response.

In the 40 Sustained Districts, with 24% of the estimated number of PLHIV, COP15 began transitioning service demand and maintenance towards the Ivorian government's health infrastructure, with no new sites established by PEPFAR. Patients currently served through higher-yield PMTCT and ART sites will continue to receive treatment at PEPFAR-supported sites, and the minimum package of care for orphans and vulnerable children (OVC) will continue in Sustained Districts throughout COP16. PEPFAR support for direct service delivery to OVC and their households will completely transition out of the Sustained Districts by the end of FY17.

PEPFAR-CI has been supporting the Ivorian government since COP15 to put in place policy measures and tools to implement Test and Start, which the Government of Côte d'Ivoire (GOCI) officially adopted with the release of a "circular" (*note circulaire*) for nationwide application in February 2017. Accompanying this policy directive, Côte d'Ivoire began nationwide implementation of differentiated models of care between stable and unstable patients, including a formalization for multi-month scripting. The National HIV Strategic Plan for 2016-2020 (PSN) takes into account a Test and Start approach in order to reach the country's five-year goal of reaching 90:90:90 globally and for the pediatric population. In COP16, PEPFAR-CI is beginning advocacy that would pave the way for small-scale implementation in COP17 of community-based ARV distribution in select areas, self-testing for men and KPs, and adoption of Isoniazid Preventive Therapy (IPT) policy in two tertiary hospitals.

The Executive Office of the U.S. Embassy in Abidjan continues to engage actively in Health Diplomacy with key members of GOCI, including the Prime Minister and the Minister of Health and Public Hygiene. The primary discussion topic has been resource needs of the national HIV response to prepare for a substantive shift in program responsibility from the U.S. Government (USG) to the Ivorian government, an area that has seen much success over the past year.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden, and epidemic profile

According to the 2014 census results, Côte d'Ivoire has a total population of 22,671,331, of which males account for 52% (11,789,092) and females 48% (10,882,239). The 2016 UNAIDS report on Côte d'Ivoire¹ estimates HIV prevalence at 3.2%, compared to the 3.7% national prevalence figure published in the Demographic and Health Survey (DHS). Much higher rates among female sex workers (FSW) and men who have sex with men (MSM) have been estimated through recent studies (11.4%² and 18%³ respectively). The Ivorian population under 15 years of age is estimated to be 8,780,535, or 38%. According to UNAIDS, the estimated total number of people living with HIV (PLHIV) is 460,000; the number of OVC is approximately 230,000, and the number of pregnant women needing antiretroviral medication (ARVs) is 22,000. There are approximately 25,000 new HIV infections, encompassing 4,700 new infections in children (0-14 years) and 22,000 deaths, from AIDS each year in Côte d'Ivoire.

Côte d'Ivoire has made substantial progress towards controlling the HIV epidemic over the past ten years. With a total PEPFAR investment of almost \$1.2 billion, an investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) of \$129 million to date, and increasing GOCI financial contributions and efforts, the HIV prevalence has dropped significantly from an estimated prevalence rate of 10% in 2000 to 3.2% in 2016¹. The number of PLHIV on antiretroviral therapy (ART) has increased up from 4,536 in 2004 to 183,211 PLHIV in 2016. The success of Option B+ implementation will lead to the achievement of the first 90 among women by FY17.

In spite of these tremendous advances, the country still faces obstacles achieving HIV epidemic control. Major gaps exist in identifying HIV-infected men and children, and linking them to treatment services, although these cohorts exhibit high rates of retention once enrolled. Viral suppression remains well below 72% among all age and sex bands. The scale of gaps along the clinical cascade is significantly greater for MSMs and FSWs.

Recent measures by the Ivorian government and intensified PEPFAR efforts will have positive impacts on these deficits. Beginning in January 2017, the second term of President Alassane Dramane Ouattara has demonstrated more attention on the health sector, which has historically seen less public investment than infrastructure, education, and other factors contributing to strong economic growth. In alignment with PEPFAR strategy, the national response has agreed on focused testing to increase HIV-positivity yield. The nationwide adoption of Test and Start as well as multi-month scripting will lead to better enrollment in, linkage to, and retention in treatment services. COP17 also continues to place increased attention on addressing the programmatic and systems gaps in case identification and linkage to services for children, Key Populations (KPs), adolescent girls and young women (AGYW, 15-24 years of age), and men above

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

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

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

25 years of age, and on expanding access to VL testing nationwide. Progress in these areas will significantly accelerate the country's achievement of the 90:90:90 goals.

Table 2.1.1 Host Country Government Results

	Total		<15				15-24				25+			
			Female		Male		Female*		Male		Female		Male*	
	N	%	N	%	N	%	N	%	N	%	N	%	N	%
Total Population ¹	22,671,331	100	4,679,147	20.64	4,751,499	20.96	2,267,891	10.00	2,273,419	10.02	4,016,049	17.71	4,683,326	20.66
HIV Prevalence (%) ^{2,3}		3.2 ²		Data N/A		Data N/A	15-19: 965 ³ 20-24: 903 ³	15-19: 0.8 ³ 20-24: 3.6 ³	15-19: 789 ³ 20-24: 761 ³	15-19: 0.1 ³ 20-24: 0.5 ³	2,641 ³	6.56 ³	2501 ³	4.88 ³
AIDS Deaths (per year) ⁴	22,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
# PLHIV ⁴	460,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
Incidence Rate (Yr)		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A
New Infections (Yr) ²	25,004		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
Annual births ⁵	1,221,815	5												
% of Pregnant Women with at least one ANC visit ⁶	Data N/A	85	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A		
Pregnant women needing ARVs ⁷	22,000	4.30												
Orphans (maternal, paternal, double)	230,000		Data N/A		Data N/A									
Notified TB cases (Yr) ⁸	25,299		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
% of TB cases that are HIV infected ⁸	5,551	25	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	Data N/A	Data N/A
% of Males Circumcised	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	Data N/A	Data N/A	Data N/A	Data N/A
Estimated Population (Pop) Size of MSM	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	Data N/A	Data N/A	Data N/A	Data N/A
MSM HIV Prevalence ⁹		11.20		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A
Estimated Pop Size of FSW ²	59,040		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
FSW HIV Prevalence ¹⁰		11.40		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A
Estimated Pop Size of 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	Data N/A	Data N/A	Data N/A	Data N/A
PWID HIV Prevalence ²	Data	5.30	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	Data N/A	Data N/A
Estimated Size of Priority Pop (military) ¹¹	40,000	3.4	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A

* Priority Populations

1 Cote d'Ivoire Census Final Report 2014

2 AIDSinfo Online Database (2015 Data)

3 Cote d'Ivoire DHS+ 2011-2012

4 UNAIDS report 2014 (2013 Data)

5 National Program against HIV/AIDS, Cote d'Ivoire

6 MICS Survey 2006

7 Plan D'élimination de la transmission Mère-Enfant du VIH de la Côte d'Ivoire, (2012-2015)

8 National TB Program routine data, 2013

9 Risk behaviors and vulnerability for HIV among MSM survey in Abidjan, 2011-2012

10 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."

11 SABERS 2014

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment, and viral suppression

Epidemiologic Data					HIV Treatment and Viral Suppression ²			HIV Testing and Linkage to ART Within the Last Year ⁶		
	Total Population Size Estimate ¹	HIV Prevalence	Estimated Total PLHIV ²	PLHIV diagnosed ⁶	On ART	ART Coverage	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
Total population	22,671,331	3.2% ²	460,000	313,143	183,211	40%	29%	1,614,356	55,055	45,255
Population less than 15 years	9,430,646	0.42% ²	29,000	15,954	8,906	31%	22%	304,927	3,137	2,817
15-24 year olds	4,541,310	1.35% ⁴	38,360	77,694	16,121	42%	31%	345,838	5,148	3,832
25+ year olds	8,699,375	5.76% ⁴	392,640	219,495	158,184	40%	29%	963,434	46,805	38,606
MSM	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
FSW	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
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
AGYW (15-24)	2,267,891	2.2% ⁴	18,143	Data N/A	3,489	Data N/A	Data N/A	149,597	3,051	1,484
Men (25-49)	3,213,568	4.9% ⁴	157,465	Data N/A	19,260	Data N/A	Data N/A	544,224	25,449	6,048
Men (50+)	1,469,758	9% ⁴	132,278	Data N/A	8,563	Data N/A	Data N/A	22,878	1,822	1,685
Military ⁵	40,000	3.4%	1,360	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A

¹ Côte d'Ivoire Census Final Report 2014

² PEPFAR-CI DataPack COP16

³ PEPFAR-CI APR15

⁴ DHS-CI 2011-2012

⁵ SABERS 2014

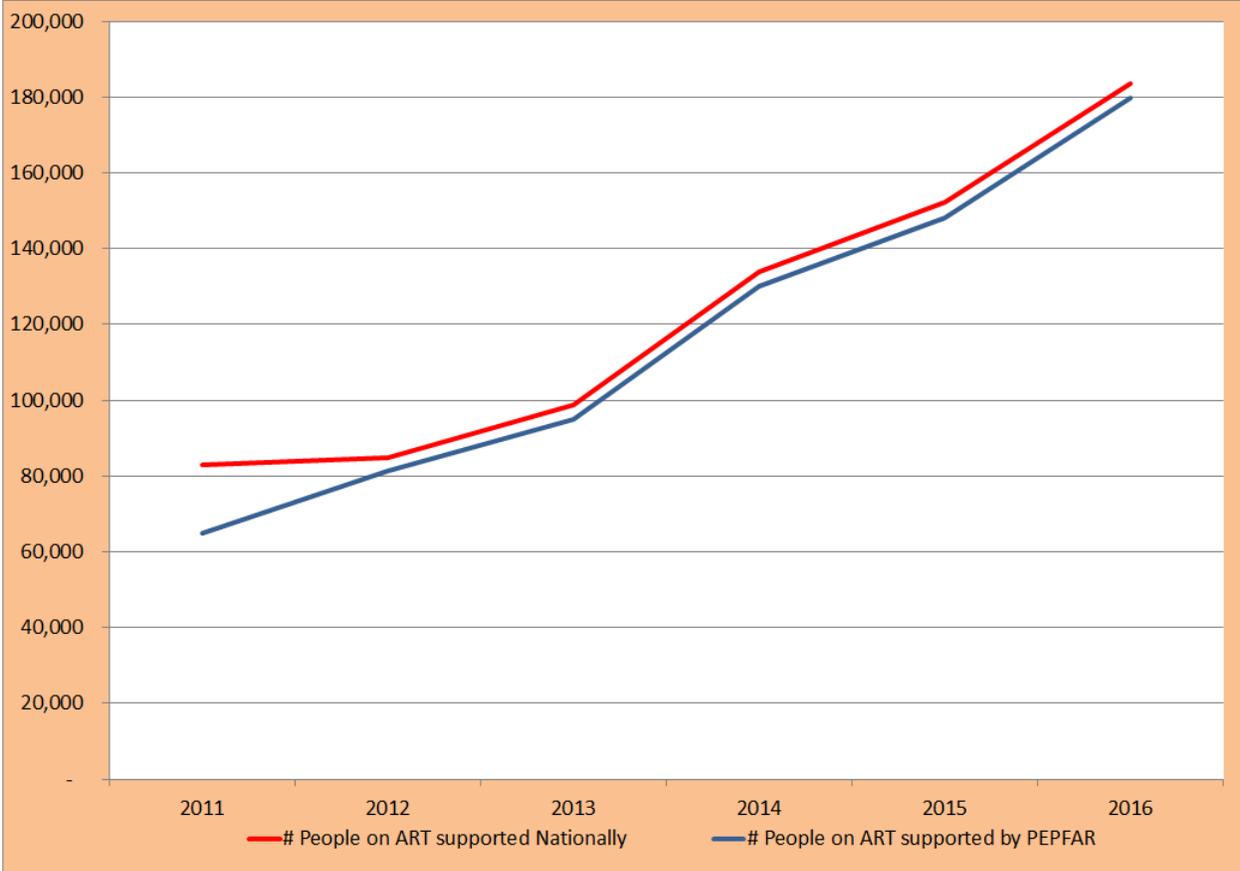
⁶ PEPFAR-CI APR16

While men in the military have an HIV prevalence rate of 3.4% as shown in the Table above, some hot spots show prevalence ranging from 5 to 8%⁴. Prevalence among AGYW (2.2%) is seven times

⁴ SABERS 2014

higher than their male peers, and even more elevated among men aged 25-49 (4.9%) and 50+ (9%). The prevalence among adults seeking care is 5.76%, but 25% amongst TB patients according to program data. The HIV burden is evident among FSWs and MSMs, according to recent studies⁵. Critical data from the upcoming PHIA beginning in July 2017, funded primarily through CDC central funds, will be available to estimate the size of KPs and consequently better assess progress towards epidemic control, guide the national HIV response, and ensure optimal investments. The PHIA will measure, among other key indicators, prevalence of detectable ARVs, transmitted HIV drug resistance, uptake of and access to HIV-related services, and common HIV co-morbidities.

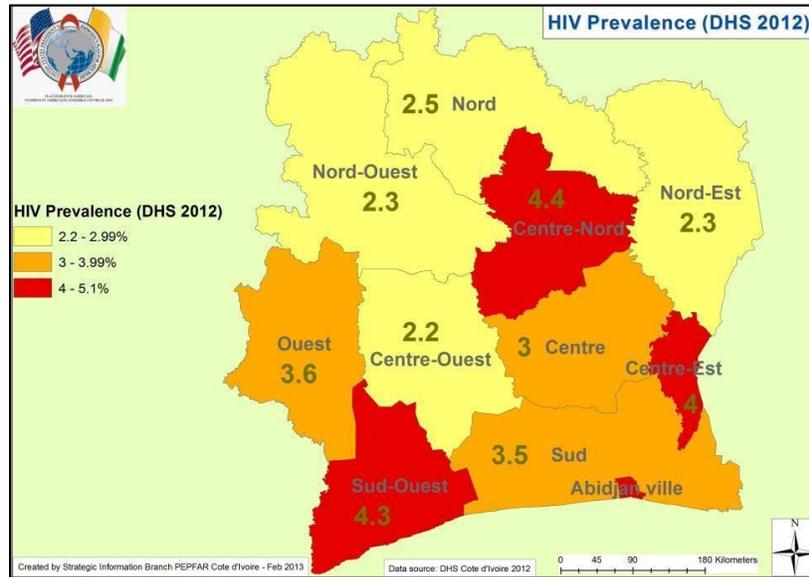
Figure 2.1.1 National and PEPFAR Trend for Individuals Currently on Treatment



⁵ Enda Santé, 2014; SHARM-CI, 2012

Geographically, the disease burden is broken down into eleven areas (Fig 2.1.2), 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.

Figure 2.1.2: HIV prevalence by geographic area (DHS 2012)



In 2015, UNAIDS released health district-level modeling based on 2012 DHS data (Fig 2.1.2), which, despite limitations in reliability, provides a more nuanced picture of the epidemic (below).

Figure 2.1.3: HIV prevalence by geographic area (UNAIDS sub-national estimates 2015)

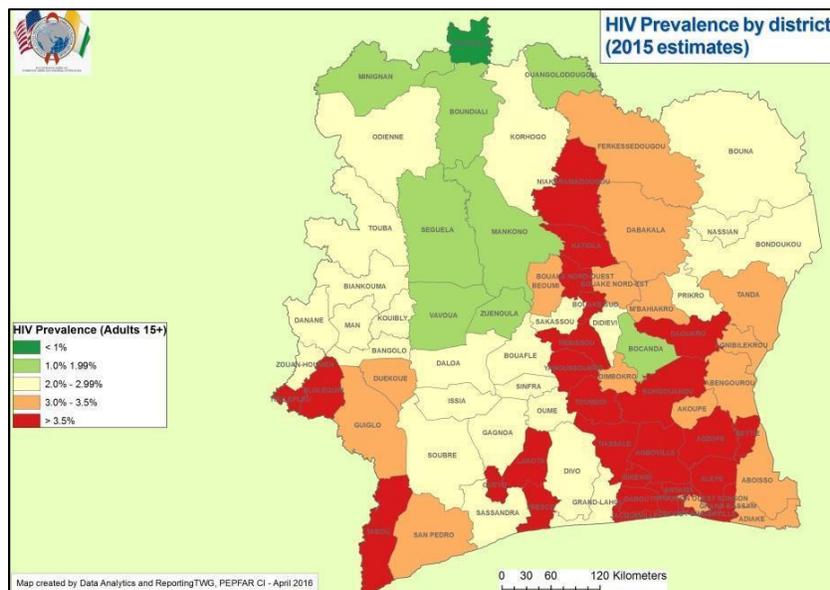
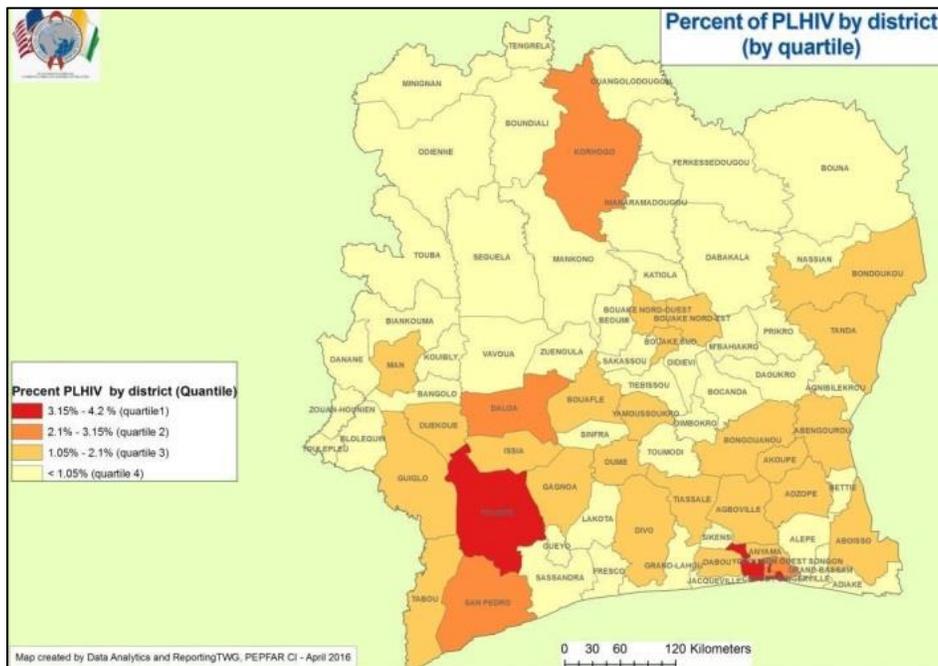
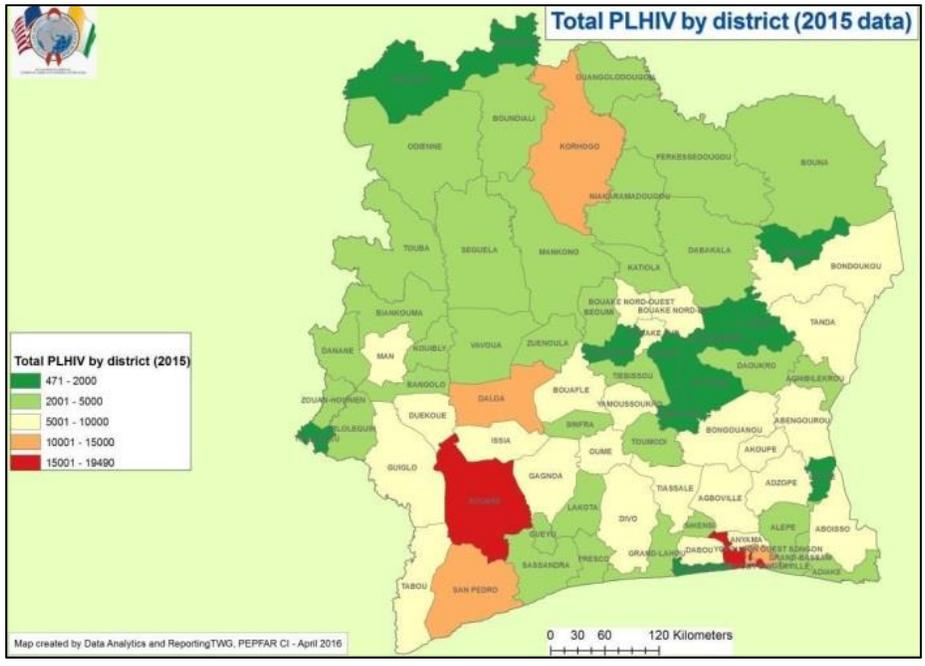


Figure 2.1.4 Total and percent of people living with HIV by health district



2.2 Investment Profile

The gross national income per capita for Côte d'Ivoire is \$1,450⁶, according to 2013 World Bank data. Since 2012, the country has consistently maintained real growth around 8% annually, among the fastest in Africa if not the world. The 2017 health budget for Côte d'Ivoire is \$808 million, an 11.5% rise from the 2016 budget level, and the GOCI continues to honor its commitment to increase domestic investments for the HIV response. The budget notification for 2017 includes \$35 million for HIV-related commodities over two years: \$7 million will go toward the 2017 commodities supply plan, with the remaining \$28 million toward the 2018 supply plan that coincides with COP17. This investment represents a 300% increase from the COP16 period. PEPFAR-CI's efforts to advocate for increased domestic resources for health, supported by high-level interventions through the Executive Office of the U.S. Embassy, are contributors to this increased commitment. The team finds it very promising that the Vice President pledged at the annual meeting of the National Committee to fight AIDS in February 2017, to continue this level of investment into the future. Along with the planned roll-out of universal health coverage in January 2018, it is hopeful that those in need will have better access to healthcare services.

The contribution of the GF to the HIV response in Côte d'Ivoire under the current grant award (Phase 2 of Round 9) is \$29 million for 2017, with approximately \$16.9 million committed for HIV-related commodities. The allocation for Côte d'Ivoire for the next three year Round (2018-2020) is \$69.6 million, which is a reduction in allocation of about 40% over the previous three-year period but similar to the recent spending rate on the GF HIV grant.

At the date of COP approval, the country was in the process of proposal preparation for the GF grant period January 2018 – December 2020, which included joint situational analyses between Ministry of Health and Public Hygiene (MSHP), GF and PEPFAR. During these proposal discussions, the two donors, along with the country Principal Recipients (PRs), agreed that PEPFAR would budget HIV commodities support in COP17 based on a projected GF contribution of \$10 million.

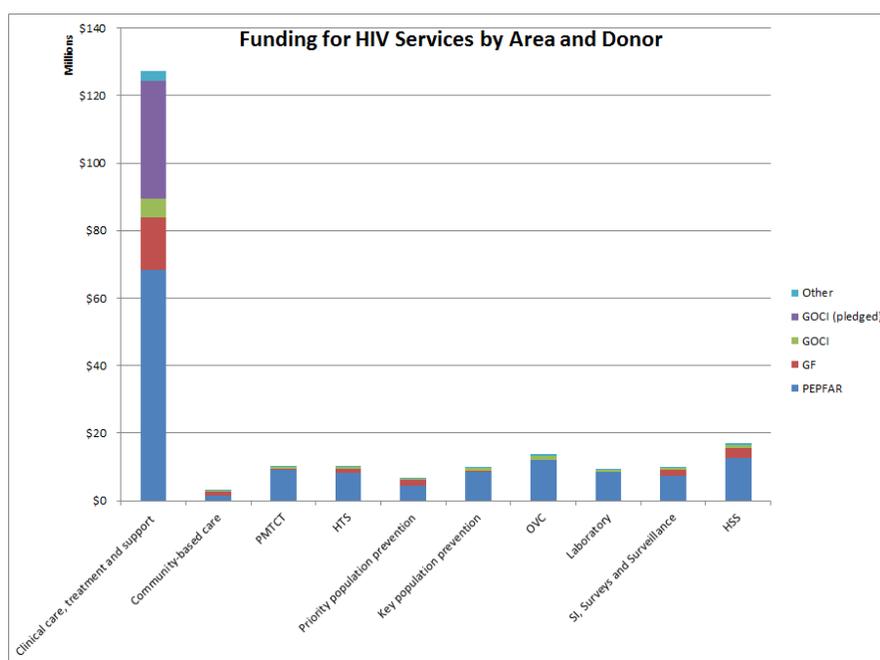
Table 2.2.1 Annual Investment Profile by Program Area (2012)⁷

Program Area	Total Expenditure	% PEPFAR	% GF	% GOCI	% Other
Clinical care, treatment and support	\$92,206,243	74	17	6	3
Community-based care	\$2,876,354	56	38	6	2
PMTCT	\$10,510,627	87	2	8	3
HTS	\$10,348,310	80	10	7	3
Priority population prevention	\$6,548,911	66	26	5	3
Key population prevention	\$10,018,458	85	4	8	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	6	3

⁶ <http://data.worldbank.org/country/cote-divoire>

⁷ GOCI, National AIDS Spending Assessment, 2012 (most recent complete assessment available)

Figure 2.2.1 Investment Profile by Program Area (2012)⁸



The projected national HIV Commodities needs during COP17 are estimated at \$58.9 million, split between the GOCI (57.4%), the GF (17.0%); and PEPFAR (25.6%). PEPFAR contributions for commodities in COP17 will be used mostly to fund 30% percent of the first-line ARVs for adults, 60-63% of VL and Early Infant Diagnosis (EID) tests, and 40% of HIV rapid tests kits. The GOCI and the GF will cover the remainder of HIV commodities needed for the COP17 period. Table 2.2.2, below, provides details on the proportions of commodities supported by funding source.

The estimated condom need for COP17 includes 15 million male condoms, 450,000 female condoms and 500,000 lubricants. The USAID Commodity Fund will cover the estimated \$900,000 for the procurement of these quantities.

Table 2.2.2 Annual Procurement Profile for Key Commodities in COP17

Commodity Type	Total Need	PEPFAR	% PEPFAR	Global Fund	% Global Fund	GOCI	% GOCI
ARVs Adults (1st line)	\$30,731,002	\$9,147,826	29.8%	\$6,886,818	22.4%	\$14,696,358	47.8%
ARVs Adults (2 nd line)	\$1,911,993	\$0	0.0%	\$0	0.0%	\$1,911,993	100.0%
ARVs Peds (1st line)	\$5,984,651	\$0	0.0%	\$2,083,483	34.8%	\$3,901,167	65.2%
ARVs Peds (2ndline)	\$314,513	\$0	0.0%	\$314,513	100.0%	\$0	0.0%
ARVs Adults & Peds (3rd line)	\$800,000	\$0	0.0%	\$0	0.0%	\$800,000	100.0%
EID reagents	\$193,596	\$116,158	60%	\$0	0.0%	\$77,439	40.0%
VL reagents	\$5,088,706	\$3,205,885	63.0%	\$661,532	13.0%	\$1,221,289	24.0%
CD4, hematology,	\$5,117,239	\$0	0.0%	\$0	0.0%	\$5,117,239	100.0%

⁸GOCI, National AIDS Spending Assessment, 2012, most recent complete assessment available

Commodity Type	Total Need	PEPFAR	% PEPFAR	Global Fund	% Global Fund	GOCI	% GOCI
biochemistry reagents							
Other Lab Supplies	\$1,929,279	\$1,119,330	58.0%	\$0	0.0%	\$809,950	42.0%
OI Drugs, STI Kits and Therapeutic food	\$3,040,550		0.0%	\$52,752	1.7%	\$2,987,798	98.3%
Rapid test kits	\$3,773,584	\$1,509,433	40.0%	\$0	0.0%	\$2,264,150	60.0%
Total	\$58,885,112	\$15,098,632	25.6%	\$9,999,098	17.0%	\$33,787,382	57.4%

Table 2.2.3 Annual 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 (GHS) Peace Corps DOD Ebola MCC				N/A	
Total					

Table 2.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	PEPFAR COP Co-Funding Contribution	Total Non-PEPFAR Resources	# Co-Funded IMs	Total Non-COP Co-funding PEPFAR IMs	Objectives
DREAMS	\$10,000,000	\$17,346,259	N/A	5	0	Reduce incidence of HIV among girls and young women 10-19, maximizing OVC platform and prevention program
ACT DREAMS Innovation DREAMS Test & Start-Men VMMC Viral Load Other PEPFAR Central Initiatives Other PPP					N/A	
Total	\$10,000,000	\$17,346,259	0	5	0	

2.3 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-sectoral PEPFAR.

The resulting 2016 Sustainability Index Dashboard (SID) showed strengths in three out of the four domains, specifically in the elements of Public Access to Information, Human Resources for Health (HRH), Service Delivery, and Data Related to Performance.

The most evident vulnerability to sustainability touched upon laboratory services, quality management of services at health facilities, domestic mobilization of funds, and allocative efficiency. PEPFAR-CI is implementing a five-year plan with the MSHP to strengthen the national laboratory network and to increase sustainable laboratory capacity. Meanwhile, the scale-up of VL testing along with supervision and coaching for improved quality, will continue in COP17. COP17 will also continue technical assistance on resource allocation begun in COP15, along with advocacy for domestic resource mobilization, an area that saw success with aforementioned increased government contribution to HIV-related commodities. Efforts to increase domestic resource mobilization are especially critical given the government's adoption of "Test and Start" and the expected costs to support additional patients. PEPFAR continues to work in coordination with other technical/financial partners to encourage better budget negotiations by the MSHP for the national HIV response and for overall health care financing, especially as a co-lead with the World Bank of the Technical Working Group on Health Financing, an entity newly created by the health donors.

Two additional areas of lesser 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 COP17. 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 physical and human resource capacity of the central warehouse system.

Overall, the investment climate in Côte d'Ivoire is very positive for donors as well as the private sector. Multilateral and bilateral organizations in addition to the GF are combining their efforts with those of the host government for improved sustainability. WHO, UNAIDS, and the French Cooperation advocate for policy changes based on normative guidance. The World Bank has been contributing to improving the health financing climate, including interventions in performance-based financing and universal health coverage. Expertise France, funded by the French government, is providing technical assistance collaboration with PEPFAR-CI on VL testing, while PEPFAR-CI coordinates its strategies for PMTCT, pediatrics, and adolescents with UNICEF investments. The Millennium Challenge Corporation is expected to agree on a Compact with the GOCI in late 2017, which will offer multiple areas of potential collaboration with PEPFAR-CI in girls' empowerment and HIV sensitization.

2.4 Stakeholder Engagement

The PEPFAR Coordination Office in Abidjan takes the lead in coordinating engagement with external stakeholders, which include GOCI agencies, the Country Coordinating Mechanism (CCM), civil society, technical and financial partners, as well as PEPFAR Implementing Partners (IPs). The primary fora for these interactions are day-long stakeholder meetings that take place every two or three months, particularly prior to each quarterly analysis (POART) call. Each consultation opens with presentations of PEPFAR results to date and PEPFAR programmatic updates, followed by exchanges with stakeholders on their reactions to the presentations. The format for stakeholder meetings recently began to include small working groups to flesh out common approaches to observed programmatic challenges. The results assist PEPFAR-CI in applying at least mid-year course corrections to ensure that beneficiaries are optimally accessing PEPFAR services and that IPs are reaching their targets. These stakeholders actively participated in the COP17 retreat, contributing to the development of targets and technical service packages in the domains of HIV testing services (HTS), priority and KP prevention, adult and pediatric treatment, TB, PMTCT, OVC, and laboratory.

The PEPFAR Coordination Office additionally organizes consultations exclusively with representatives of civil society organizations every quarter, to receive information at the community level about on-going challenges and opportunities with the national HIV program. PEPFAR-CI is committed to reinforcing the capacity of civil society to participate in national and PEPFAR planning processes and technical discussions. The civil society-only meetings allow this group of stakeholders more time for exchange on issues that may not be as relevant to the operational concerns of IPs or technical/financial partners. The CCM, of which civil society networks are members, provides an additional platform for engagement in which PEPFAR has been actively participating.

Since September 2014, PEPFAR-CI has been communicating to and negotiating with the GOCI regarding the PEPFAR pivots, as well as accompanying data analysis and related strategic shifts in programming. This has entailed frequent technical meetings with the National AIDS Control Program (PNLS) and the National OVC Program (PNOEV). Higher level meetings have also occurred regularly between the Executive Office of the U.S. Embassy and the Minister of Health, and between PEPFAR leadership and the Director General for Health (DGS) and his executive team. Meetings with GOCI leadership in addition to regular programmatic discussions helped ensure appropriate exchange on aligned priorities and investments. This was crucial for the adoption of WHO-recommended strategies on which are based both the PSN 2016-2020 and PEPFAR-CI programming to rapidly progress toward epidemic control.

PEPFAR-CI regularly engages with the GF through weekly calls with the Fund Portfolio Manager and through the CCM (HIV committee, TB committee, Executive Bureau, and General Assembly). Continuous communication on programmatic issues, including on-going priorities in PEPFAR programming and COP-specific planning of targets and budgets, has ensured comprehensive community and clinical approaches as well as complementarity of investment and efforts in supply chain and policy issues. In addition, PEPFAR conducts technical meetings with the HIV PRs (PNLS and Alliance CI) to discuss the optimal programmatic strategies for the country, maximizing investments from donors at both 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.

Private sector investments are an underutilized resource for expanding the national HIV response. A range of private sector partners are members of the CCM, a partnership opportunity that PEPFAR and the GOICI are just beginning to develop. PEPFAR extended an invitation to the COP17 retreat, for the first time, to the Coalition of Ivorian companies against AIDS, also a member of the CCM, and intends to continue engagement with the private sector, especially in its “Men’s strategy”.

3.0 Geographic and Population Prioritization

To achieve epidemic control, the PEPFAR-CI program began prioritizing investments 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 GF for clinical service delivery), 39 districts are prioritized for concentrated outreach to populations at greatest risk of HIV acquisition and transmission, which will lead to 81% coverage of ART for four districts by FY18 and an additional 15 by FY20. To reach these targets, PEPFAR-CI is intensifying targeted case-finding strategies for those populations at greatest risk or need, notably KPs, pediatrics, AGYW, and men (including the military). Section 4.4 provides more details on the PEPFAR-CI approach for case identification in COP17.

Côte d’Ivoire is on track to achieve its saturation goals with the proposed targets for new treatment enrollees in the next few years. However, significant efforts to increase and manage capacity both at the facility and in the community are necessary to absorb and retain an accelerating number of new patients. Besides a growth in the number of facility- and community-based health care workers, PEPFAR-CI will also encourage scaled-up implementation of differentiated models of care and greater engagement of community health workers (CHWs) for retention support and improved efficiencies to sustain epidemic control.

Table 3.1 Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Scale-up Saturation	155,749 (35%)	106,251	16	19
Scale-up Aggressive	184,673 (41%)	46,564	23	20
Sustained	105,040 (24%)	26,230	40	40
TOTAL	445,462	179,045	79	79

Figure 3.1: Current ART Coverage by SNU

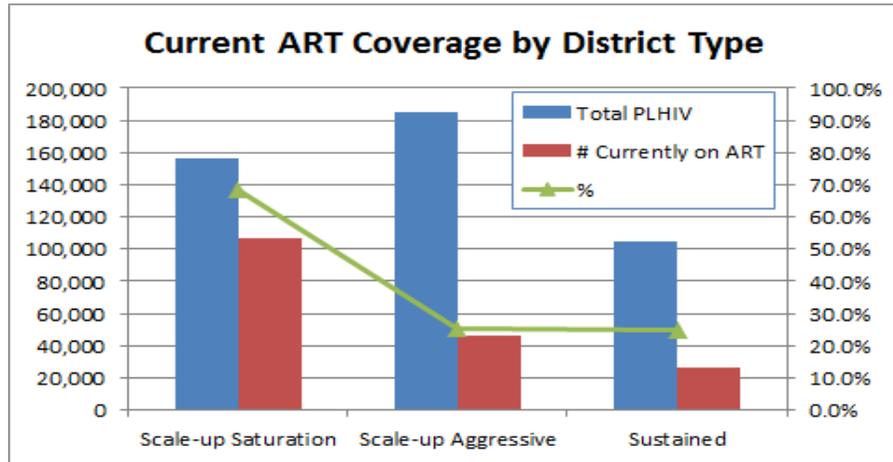
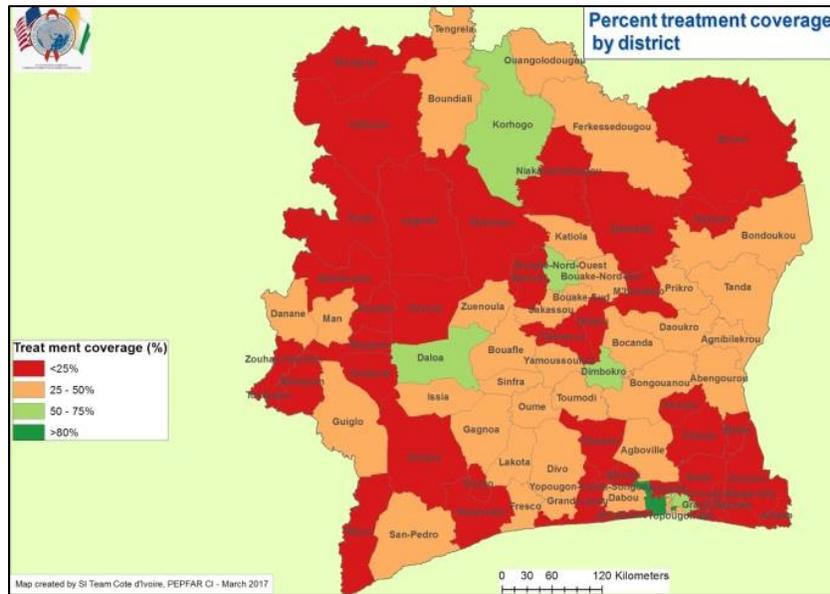


Figure 3.2: Percent treatment coverage by district



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. COP17 maintains the Scale-Up Districts determined in COP16, based on an analysis and validation of district-level population, number of PLHIV and prevalence data, using the most recent UNAIDS estimates at the sub-national level (2016). PEPFAR-CI supported 147,947 patients on ART in FY15 and 179,045 in FY16. This target will increase by 71% to 306,241 by the end of FY18, representing a projected

net increase of 127,196 patients from APR16 to APR18.

Additional Impact Funds for Cote d'Ivoire will contribute to accelerating programs in 19 Scale-Up to Saturation districts to achieve 80% saturation by the end of COP17. PEPFAR-CI will use the supplemental funding to increase case identification among high-yield populations and at entry points in prioritized districts and to strengthen treatment strategies. Many of the Scale-Up to Saturation districts already have high coverage levels and are nearing saturation. In the 23 Aggressive Scale-Up Districts representing 37.2% of the PLHIV, new enrollments will increase by approximately 5.43 fold, a significantly increased progression rate compared to the current calculated yearly progression rate of 10%. In the 40 Sustained Districts, passive enrollment will increase by 4.44 fold from COP16. With Impact Funds in COP17, the program is increasing its total target of new enrollments on ART by more than 60%, aiming to reach a total of 129,690 new ART patients: 36% in Scale-Up to Saturation Districts, 45% in Aggressive Scale-Up, and 19% in Sustained Districts. This represents 67% treatment coverage at APR18 or a coverage gap of 17% in order to reach 80% saturation, with a remaining total gap of 33%. As of December 2016, the country has identified 69.8% of PLHIV, placed 40% (183,211 total on ART) on treatment, and achieved viral suppression in 73.4% (134,477 virally suppressed). PEPFAR-CI expects to support a total of 306,241 people on treatment in COP17.

In COP17, the 129,690 patients projected to be newly initiated on ART in all districts include:

- 113,504 high-risk individuals (TB patients, sick patients, men, sexual partners of index cases, MSM, and FSW) and AGYW
- 6,092 children
- 9,411 pregnant women
- 226 infants through EID
- 457 PLHIV identified through the Department of Defense/Military Program

Among the 129,609 patients newly initiating on ART nationally, 105,378 will come from Scale-Up Districts.

As part of the implementation of the Test and Start policy, PEPFAR-CI will work to enroll all pre-ART patients receiving care in FY16 and those identified in FY17 on ART by the end FY17. IPs will continue to track pre-ART patients identified in FY16 not yet initiated on ART by the end of FY17, through outreach by community counselors and community health workers. The data manager at each site will generate the monthly listing of pre-ART patients for the community counselors who will then actively call patients to set up appointments for ART initiation, based on site capacity. Children (less than 15 years old) and adults with a CD4 count close to 500/mm³ will be prioritized for ART initiation, regardless of the site's capacity. In order to enroll all pre-ART patients by the end of FY17, any other pre-ART patients with scheduled appointments more than three months into the future will be re-scheduled to initiate ART within the two months following the production of the monthly pre-ART listing. Reinforcement of treatment preparedness counseling at the site and through outreach media campaigns in the community will complement this active patient tracking. IPs will also work with a local CSO, RIP+ (*Réseau Ivoirien des organisations de personnes vivant avec le VIH*, the Ivorian Network of PLHIV organizations) to relay the message to their peers and strengthen adherence and retention counseling. PEPFAR-CI will furthermore monitor progress of ART initiation of pre-ART patients through the monthly ART enrollment report submitted by clinical IPs.

Availability of population data at a sub-national level continues to be 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 sub-national estimates do not always geographically align with other national data. A five-year collaboration plan with UNAIDS that will continue in COP17 will strengthen the country's strategic information system capacity to enable better collection of data at the sub-national level and identification of new pockets of infections to guide the national response. For KPs, no national size estimates are available, but the upcoming PHIA and ongoing surveillance and micro-mapping will produce results to inform better KP outreach in COP16 and COP17. PEPFAR works on an on-going basis with the MSHP and other partners to consolidate data sets and produce several size estimation surveys.

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY18) TX_NEW
Adults (>15)			
TB Patients	20,870	4,383	4,383
Pregnant Women	441,253	6,619	6,613
Key populations	69,763	4,814	4,332
Priority Populations	227,395	11,370	10,167
Other Testing	1,908,341	81,209	73,088
Total Adults	2,667,622	108,394	98,589
Pediatrics (<15)			
HIV Exposed Infants	11,533	636	636
Other pediatric testing	328,616	7,413	6,153
Total Pediatrics	340,149	8,049	6,789
TOTAL	3,007,771	116,443	105,378

Table 4.1.2: N/A (Voluntary Medical Male Circumcision) (N/A)

Table 4.1.3 Targets for OVC and Linkage to HIV Services

Scale-Up Districts	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18 Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC_KNOWNSTAT
Abidjan 1-Grands Ponts	77,823	16,557	11,590
Adjame-Plateau-Attécoubé	48,001	9,208	6,446
Dabou	4,706	1,745	1,222
Yopougon-Est	11,320	3,192	2,234
Yopougon-Ouest-Songon	13,796	2,411	1,688
Abidjan 2	92,722	41,439	29,007

Scale-Up Districts	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC_KNOWNSTAT
Abobo-Est	10,324	15,192 ⁹	8,559
Abobo-Ouest	9,095	3,190	2,233
Anyama	4,208	2,130	1,491
Cocody-Bingerville	18,742	18,810 ⁹	7,319
Koumassi-Port Bouet-Vridi	32,201	10,169	7,118
Treichville-Marcory	18,152	3,267	2,287
Agneby-Tiassa-Me	24,123	9,987	6,991
Adzope	7,556	1,832	1,282
Agboville	7,514	3,270	2,289
Akoupe	4,279	1,677	1,174
Tiassale	4,774	3,209	2,246
Belier	7,848	2,534	1,774
Yamoussoukro	7,848	2,534	1,774
Bounkani-gontougo	0	9,043	6,330
Bondoukou	0	4,310	3,017
Tanda	0	4,733	3,313
Cavally-Guemon	15,024	9,374	6,561
Bangolo	3,859	2,053	1,437
Duekoue	6,457	4,256	2,979
Guiglo	4,708	3,064	2,145
Gbeke	16,227	11,489	8,043
Bouake-Nord-Est	4,407	3,179	2,225
Bouake-Nord-Ouest	7,259	5,058	3,541
Bouake-Sud	4,561	3,253	2,277
Gbokle-Nawa-San Pedro	33,815	9,586	6,711
San-Pedro	10,303	3,286	2,300
Sassandra	3,631	1,128	790
Soubre	13,988	2,991	2,094
Tabou	5,893	2,181	1,527
Goh	11,597	5,755	4,028
Gagnoa	7,413	3,868	2,707
Oume	4,184	1,888	1,321
Haut-Sassandra	12,535	10,015	7,010
Daloa	8,363	16,019 ¹⁰	5,947
Issia	4,172	1,519	1,063
Indenie-Djuablin	6,087	2,268	1,587

⁹ This target is higher than the estimated number of OVC in the previous column for two reasons: it includes OVC and their family members and it accounts for additional DREAMS targets that would not be reached through the OVC programs.

¹⁰ This target is higher than the estimated number of OVC in the previous column for two reasons: it includes OVC and their family members and it accounts for additional DREAMS targets that would not be reached through the OVC programs.

Scale-Up Districts	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target) OVC_KNOWNSTAT
Abengourou	6,087	2,268	1,587
Loh-Djiboua	0	6,719	4,703
Divo	0	6,719	4,703
Marahoue	8,658	4,657	3,260
Bouafle	5,035	2,210	1,547
Sinfra	3,623	2,447	1,713
N'zi-ifou	6,514	4,927	3,449
Bongouanou	6,514	4,927	3,449
Porotchologo-Bagoue	8,266	6,531	4,572
Korhogo	8,266	6,531	4,572
Tonkpi	5,601	5,430	3,801
Man	5,601	10,130 ⁱⁱ	3,801
Worodougou-Bere	0	2,167	1,517
Mankono	0	2,167	1,517
Total	326,840	159,630	111,741

Table 4.1.4 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate	Coverage Goal (in FY18)	FY18 Targets
Men who have sex with men (MSM)	23,687	64.1%	15,180
Female sex workers (FSW)	88,792	71.9%	63,784
Transgender (TG)	NA		58
Male 25-49	2,269,030	6%	136,869
Male 50+	1,037,743	0.3%	3,531
Female 15-19	866,441	8%	68,640
Female 20-24	740,435	13.9%	102,960
Total	4,913,643	6.3%	312,000

4.2 Priority and Key Population Prevention

In COP17, prevention interventions will continue to target MSM, FSW, and Transgender Individuals. PEPFAR-CI will conduct a situational analysis of persons who inject drugs and persons in prisons for potential future interventions for these populations, if a significant need is identified. The following priority populations will also be targeted in COP17: AGYW (15-24 years), higher risk men aged 25+ years, military and uniformed personnel, OVC (especially children of FSW), and high-risk groups in the general population, such as index cases (family

ⁱⁱ This target is higher than the estimated number of OVC in the previous column for two reasons: it includes OVC and their family members and it accounts for additional DREAMS targets that would not be reached through the OVC programs.

members and stable sexual partners) of FSW. The program concentrates more on stable rather than non-stable (clients) of FSW, as tracking up the clients of FSW poses a challenge because they since are mobile and not based at a regular “site”; thus, the follow-up of clients is irregular if at all possible.

PEPFAR-CI is optimizing implementation of a combination prevention approach to reach the goal of reduced HIV incidence among priority and KPs, including HIV risk avoidance. This approach, aligning with the national HIV program, includes targeted HTS, testing and management of sexually transmitted infections (STIs), ART for prevention, PMTCT, and promotion and distribution of condoms and lubricant gels. Prevention programs will be clustered around clinical services to strengthen active linkages (referrals and counter-referrals) to HTS and PMTCT, including services for family planning, post-gender-based violence (GBV) care, TB screening and treatment, hepatitis and genital cancer diagnosis, post-exposure prophylaxis (PEP), and HIV care and treatment. PEPFAR-CI will reinforce advocacy for pre-exposure prophylaxis (PrEP) while scaling up PEP. The program will introduce condom vending machines, and also disseminate updated information related to the availability and localization of other condom outlets. In this way, target populations will have knowledge of where to find condoms independently, and not need to rely entirely on IP outreach sessions to access them, IPs will continue to apply the existing condom standard operating procedure through social marketing of condom and lubricant gels, and promotion and distribution among key and priority populations. More details on the HTS strategies follow in section 4.4 on HTS

During COP17, PEPFAR-CI will also support the GOCI to (i) update the Minimum Package of Activities for KPs by addressing human rights issues and institutional barriers against KPs (laws and policies reducing stigma and discrimination), (ii) implement strategies as part of a package of health services and practices for men, segmented by relevant age groups, and (iii) define and operationalize a national package of health services and guidance for AGYW in collaboration with other partners. In addition, IPs will conduct awareness campaigns (mass/“middle” media, social media, and capacity building of community-based organizations) to destigmatize health services with the objective of augmenting uptake by KPs and men.

Training for health care workers and other site staff to deliver KP-friendly/competent services will continue under the leadership of the PNLS. This will improve access to and uptake of services, and build better relations between KP clients and health workers that can lead to successful index case testing as well as retention strategies. For COP17, PEPFAR-CI will develop other key clinical service delivery elements to make access to ART easier, more acceptable, and more efficient, and to support adherence and retention. These elements will include same day ART initiation, decentralized ART services to select community sites, and increased access to Drop-In Centers. IPs will strengthen the Peer Navigator program for fast-track clinical services to improve follow-up for KPs tested negative, and to improve community adherence in care and treatment services for KPs tested positive. Prevention and treatment services especially need to be tailored and targeted to older MSM who have been hard to reach and underserved. Prevention and treatment services for FSW need to reach those new to sex work and likely to be at higher risk for HIV acquisition due to low condom use and/or high STI levels. The PEPFAR-CI program will link those involved in sex work below the age of 18 to programs addressing GBV, particularly in the context of USG policy which defines this cohort as trafficked persons. PEPFAR-CI is supporting a Violence against Children Survey (VACS) that is expected to provide national population-based estimates in COP17 which describe the magnitude and nature of violence against children, as well as the epidemiologic patterns of risk and protective factors of violence experienced by children for

the purpose of developing and implementing effective prevention strategies.

In addition to MSMs, FSWs, and TGs, COP16 HIV prevention activities prioritized highly vulnerable groups in Scale-Up districts. These included men aged 25 and above, with a focus on linking this group to HTC, and care and treatment services including growth points where men have limited access to HIV services. Men were identified as a critical game changer for epidemic control, based on epidemiological and programmatic data showing a dramatic increase in HIV prevalence among men starting age 35+, reaching the highest prevalence (9%) among men over age 50 (DHS-2012, APR15). Regardless of age, men are not regularly accessing health services in general and HIV services in particular, waiting until they become very sick before seeking care, evidenced by lower CD4 counts upon initiation.

With COP17 funding, PEPFAR-CI will intensify its efforts to “find the men” and link them into facility-based services through a much more structured approach. PEPFAR-CI’s “Men’s strategy” builds upon (i) findings from qualitative research identifying barriers and facilitators for men accessing services along three domains of interventions: the individual, the service delivery, and the societal level, (ii) an Implementing Partner Consultation in December 2016 that resulted in best practices such as wellness programs for men, incentive approaches through PMTCT venues, and Husbands’ Schools, and (iii) existing PEPFAR efforts (e.g., Brothers for Life and Chronic Care model).

PEPFAR-CI has clustered the interventions covered under the Men’s strategy along the three domains mentioned above. At the individual level, this relates to targeting men who match a country-defined profile of “high risk” to ensure a high positivity yield. Targeted outreach may also require considering urgent care and outpatient sections where men are more likely to seek care, in addition to outreach into the community where they commonly congregate socially (workplaces, bars, sports events, clubs). COP17 investments will be exploring innovations that attract men, such as self-testing and mHealth for mapping, communications, and linkages.

At the service delivery level, PEPFAR-CI will work toward creating a more enabling environment to welcome men at sites, such as after-work or evening hours and dedicated only clinical spaces where they can engage with their peers. COP17 efforts will also expand engagement of the private sector, where men – especially HIV-positive men – are more likely to seek care. PEPFAR-CI will continue to link its prevention activities for military personnel to HTS scale-up in higher prevalence areas, identified in the 2014 SABERS, and to prevention education in community settings and within military training academies.

Finally, at the societal level, COP17 efforts focus on reducing social stigma that impede men from seeking health services. PEPFAR-CI will continue to support the development and scale-up of a chronic care platform for men to encourage them to frequent health services in general - and HTS in particular- as a wellness practice, building off experiences of multi-service health services fairs/events in other countries to support the promotion of health and wellness days for men. It will be critical to conduct messaging to men in general that change their association that health facilities equal sickness, women, children, and the stigma carried by HIV. Toward this end, PEPFAR-CI seeks to adapt success stories of other African countries such as the Baby Shower approach in Nigeria, Husbands’ schools in Niger, and the Community Mobilization and Norms Change program in Lesotho

In COP17, PEPFAR-CI will enhance its prevention approach for AGYW with the introduction of DREAMS-like activities to work toward risk avoidance and reduction. The DREAMS-like package will build upon the existing strong OVC platform, and is described in more detail in section 4.10 on the OVC program.

PEPFAR-CI will address social level HIV stigma among the general population, impacting especially KPs and men, by mainstreaming stigma reduction in HIV/AIDS policies, and working to dispel the myths and stereotypes about HIV/AIDS. This would include sharing accurate information on modes of HIV transmission, enforcing the importance of confidential and anonymous HIV testing, and disseminating knowledge about treatment options to community and opinion leaders. To increase community awareness and encourage proactive discussions, IPs will conduct advocacy sessions with community leaders as well as interpersonal outreach with the family members, social networks, and colleagues of PLHIV regarding HIV/AIDS prevention and access to early treatment. These efforts seek to strengthen communities to keep open diverse lines of communication in order to tear down social stigma barriers and break isolation and fear.

PEPFAR-CI relies on data from Site Improvement through Monitoring System (SIMS) visits to monitor implementing partner performance on a regular basis, with a specific focus on gaps and opportunities in referral and counter-referral systems between community and clinical partners, and between reproductive health, key and priority population prevention, and PMTCT services.

4.3 Prevention of mother to child transmission (PMTCT)

The MSHP, with support from PEPFAR-CI, completed the scale-up of Option B+ in July 2016, having formally started in November 2015. PEPFAR-CI programmatic data shows a reduction in the MTCT transmission rate from 3.5% to 3% in 2016, for which the goal in the PSN 2016-2020 is under 2% by 2020. Furthermore, SIMS data show that ART in labor and delivery, EID, and the enrollment of HIV-infected infants in care and treatment have improved, with an average of only 12% of services surveyed receiving either red or yellow scores. Building off of these achievements, PEPFAR-CI will continue in COP17 to align with the national Test and Start strategy, the PSN 2016-2020, and UNAIDS goals to ensure that pregnant and breastfeeding women have access to PMTCT programs and are provided with lifelong ART within HIV care and treatment programs, and that their children have access to necessary services. The PMTCT strategy is guided by geographic prioritization to focus on high yield sites (> 4 HIV-positive pregnant women per year), strengthened facility-based services complemented by community support, and enhanced monitoring and evaluation.

The PMTCT package in scale-up districts will include support for demand creation activities and PITC at all entry points for pregnant and breastfeeding mothers, HIV testing with same day ART initiation, HTS for their children including EID among HIV-exposed infants (HEI), and linkage into pediatric care and treatment when necessary. All-supported PMTCT sites will participate in the national RTQII in FY18. Critical site-level support for the facility will continue, such as for ARVs and other commodities, health care worker salaries, and focused capacity building, including monthly mentorship, supportive supervision visits, and assistance with full operationalization of the Option B+ M&E Framework, data quality assurance, and reporting.

A holistic model of support for the needs of pregnant and breastfeeding women and their children is also essential to achieving PMTCT strategies and targets. PEPFAR-CI will continue advocacy

for national recognition and standardized, adequate compensation for CHWs and lay counselors in facility and community settings, as they are essential for an effective continuum of care, including encouraging ANC uptake and ART retention. Other community-based interventions will include peer support groups for mothers and their sexual partners, the Baby Shower approach, and linkages with OVC for HIV-infected children.

To support family planning (FP) integration goals, PEPFAR-CI will advocate that the GOCI prioritize PMTCT sites in the scale-up of FP across health platforms. The national target is to increase coverage of FP services from its current level of 54% to 100% of PMTCT settings. PEPFAR-CI will emphasize robust referrals to high quality FP at PMTCT service delivery points while also prioritizing the integration of FP into maternal, newborn, and child health programs at all PMTCT sites, which will align with the USG regulations on FP compliance.

4.4 HIV Testing Services (HTS)

The COP17 approach for the aggressive scale-up of HTS aims to reach 80% HTS coverage in Scale-up to Saturation districts by FY18, in line with the PSN 2016-2020 objective of identifying 90% of all PLHIV by 2020.

PEPFAR-CI adjusted its strategy and package through detailed analyses on yield and epidemiologic data to redefine need by modality and by target sub-populations in order to feed into the treatment objectives.

The HTS package for COP17 will include:

- Quality HIV testing and counseling services, especially in high burden areas, through a combination of delivering to both community-based and facility-based approaches
- Community linkages/systems to ensure earlier diagnosis of HIV patients
- Active linkages to treatment, care, and support in all settings
- Quality Assurance/Quality Improvement (QA/QI) systems for HIV rapid testing.

The military prevention program will continue to focus on the highest HIV prevalence areas which align to Scale-Up Districts.

In clinical settings, PEPFAR-CI will continue to enhance provider-initiated HTS (PITC), targeting symptomatic in- and out-patients with specific packages for high-risk adults and children. Targeted entry points for adults include: malnourished patients, TB/TB-suspect cases, and sexual partners of index patients. Targeted entry points for children will also include malnourished individuals, TB/TB-suspect cases, and family index cases of FSWs, while also paying special attention to OVC and HEI. Antenatal clinics will continue to provide HTS to support the Option B+ package including EID for 100% of exposed infants.

At community-based entry points, PEPFAR-CI will combine HTS with education and community mobilization program with the aim of increasing HTS uptake and positivity yield. IPs will improve the identification of peer educators (PE) and work to raise the ratio of PEs from 1:92 FSW and 1:60 MSM to 1:40-60 FSW and 1:30-40 MSM. Additional interventions will include capacity-building for KP-led community-based organizations and community engagement, and the promotion of social and sexual network strategies to increase case identification and community-based support.

Based on SIMS findings revealing inadequate referrals of HIV-diagnosed individuals to care and treatment services, community IPs will explore innovations and best practices to strengthen linkages between HTS and between these services. PEPFAR-CI is prioritizing the improvement of referral and counter-referral systems among all services to improve traceability. Referral books have been set up at the site level, pending the validation by the PNLs of a national register for referral monitoring that has already undergone pre-testing.

COP17 places special emphasis on enhanced service delivery to high yield hard-to-reach and hidden populations such as MSM/TG, men 25+, and index cases of family network and sexual partners. Proposed activities to address these gaps encompass:

- Routine testing of sexual partners' network of index cases
- Innovations to increase HTS among men 25+, such as wellness programs, mHealth, Husbands' Schools, and Baby Shower approaches
- Small scale implementation of self-testing directed towards MSM and men
- Utilization of data from hotspot micro-mapping, IBBS, size estimation work, PHIA, and IP reports for more effective KP targeting.

In addition, PEPFAR-CI is instituting weekly testing yield reviews and monthly clinical cascade reviews with IPs, sub-partners and, and sites, along with training for better data use, to better understand the progress of outreach and improve the clinical cascade among peers, clinicians, and program managers. The PEPFAR-CI will continue to support QA/QI systems for HIV rapid testing through the Rapid Testing Quality Improvement Initiative (RTQII). PEPFAR-CI will continue to provide support to all 2,500 (2,300 testing posts and 200 laboratories) HIV community and clinical testing points to strengthen quality assurance methods and furnish proficiency testing (PT) panels. The COP17 RTQII program includes the following: training package on HIV quality assurance; use and analysis of HIV rapid test log book; and enrollment of 1000 HTS testing sites in the certification program, with a goal to certify 50% of them and for at least 75% of the certified sites to be located in high-yield districts. All PEPFAR supported testing posts will conduct an evaluation of HIV misdiagnosis data to ensure accuracy of results, with the goal that 80% of participating posts will achieve the required PT panel score of 100%.

4.5 Facility and Community-Based Care and Support

PEPFAR-CI's package of care and support services necessary to fast-track and retain patients in treatment services supports the GOCI's policy of Test and Start and the treatment goals of the PSN 2016-2020. The core service package includes the following elements:

- Index case-based sexual partner testing
- TB screening and referral for testing and/or treatment
- Linkages from fixed and mobile HTS to treatment through community-based services
- Home-based continuum of care to improve treatment literacy and retention
- Positive health, dignity, and prevention (PHDP) interventions, including FP counseling and referral
- Provision of cotrimoxazole prophylaxis
- WASH interventions (e.g. communication and M&E tools, Counseling...)
- GBV/HIV referral networks (specifically through social centers and PLHIV organizations) and CHW and social worker linkage to clinical, post-rape care, and PEP services

- Community sensitization for ANC uptake and HIV prevention among AGYW
- Nutritional assessment, counseling, and support (NACS)
- Referral of PLHIV and OVCs to social services based on specific needs
- Referral of patients from low volume sites to ART service hubs
- ART dispensing by community health workers in selected sites
- Laboratory services for patient monitoring
- M&E tools and trained human resources for quality data collection, management and reporting.

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. While PEPFAR-CI mainly supports facility-based services through the public sector, the program will strengthen services in the private for-profit sector to increase ART coverage in Scale-up to Saturation Districts. Program data has demonstrated potential to “find the men”, including HIV-positive men. COP17 investments in private for-profit clinics will include: (i) support for clinical service delivery (training, coaching, ARV drugs and HIV test kit procurement, rapid access to VL testing, and M&E), and (ii) capacity-building of the association of network of private clinics for sustainability of the HIV response.

APR16 showed a 12-month ART retention rate of 81% compared with an 85% target. This achievement is a result of intensive technical assistance from IPs to service delivery sites, including implementation of standard operating procedures (SOP) and tools to monitor patients’ appointments on a daily basis (diaries, registers, pharmacy logs, EMR), triangulate various data sources to identify patients who missed appointments or are lost-to-follow-up, and conduct active follow-up to retrieve and maintain them on ART as well as document outcomes in registers at all supported-sites. While this represents significant improvement from 2013, when the country was only two years out of a decade of civil conflict, improving retention in ART will continue to be among the highest priorities. Community-based platforms are essential to support this effort.

SIMS results have shown that despite efforts, improvement is still needed in facilitating linkages between facility and community-based services. This is especially the case for referrals from clinics to community sites, representing a systems barrier in two of PEPFAR-CI’s programmatic gaps. PEPFAR-CI will intensify community-based programs in COP17 to facilitate the continuity of services for PLHIV and their families. Interventions include community-based PLHIV support groups, community ARVs distribution models in select areas, demand creation and service promotion within the community, matched and peer mother approaches to PMTCT, and PHDP services both at clinic and community levels, as well as other innovative community-based strategies to initiate people and keep them on ART. Social centers will be critical service delivery points, especially with the expansion of alternative service delivery models. National recognition of CHWs, discussed in section 4.3, and the development of clearer terms of reference for their work, including those affected by task-shifting/sharing, are key steps in optimizing their impact of the continuum of care. At the above-site level, PEPFAR-CI will continue to support the MSHP to update national care and treatment guidelines and policies as well as develop a national tool for tracking linkages between services through active referral and counter-referral.

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

TB is the largest cause of death among PLHIV, and adequate case management among this cohort

will significantly affect progress in viral suppression in Côte d'Ivoire. In COP17, there will be a 32% increase in the number of TB clinics (from 180 to 237) receiving PEPFAR-CI support to offer TB patients a comprehensive package of TB/HIV services regardless of the geographic location of the point of service. This package includes:

- HIV testing for new and relapsed TB patients
- ART provision for TB/HIV co-infected patients
- TB screening of PLHIV in care

PEPFAR-CI support includes monitoring of TB/HIV activities at both HIV and TB clinics through SIMS 3.0. The program will also provide TA to revise technical guidance on integrating HIV testing for TB suspects in TB clinics, redefining patient flow and coaching health care workers in TB clinics on HTS. Since medical doctors lead only 24 out of 246 TB clinics (about 10%), PEPFAR-CI will also implement multiple measures to increase ART provision for TB/HIV co-infected patients. These include training on task-sharing for TB clinic nurses who lead 90% of TB clinics, and support to the National TB Program (PNLT) to move these nurse-led TB clinics to a TB/HIV integrated care model under a “One Stop Shop” approach. Presumptive TB patients who test positive for HIV but do not have TB will be referred to HIV clinics to be initiated as early as possible on ART, which will also have a positive impact in preventing TB transmission.

TB screening in COP17 will extend to HIV positive pregnant women as part of the comprehensive maternal, newborn, and child health package, while continuing to be strengthened for other PLHIV, including children. The program will implement the WHO “Engage TB strategy” to intensify TB case finding, using a family approach to reach missing TB cases. PEPFAR-CI will advocate in COP16 for the adoption of the Isoniazid Preventive Therapy (IPT) policy in Côte d'Ivoire, implementing this intervention in COP17 in two tertiary hospitals, and perform TB diagnosis using urinary testing for a select group of PLHIV with advanced disease.

To allow for rapid confirmation of TB cases, PEPFAR-CI will coordinate implementation of GeneXpert platforms at TB regional treatment clinics (CATs), including the purchase of three additional machines to supplement the 13 GeneXpert CATs currently operational nationwide. A total of 237 peripheral TB diagnosis and treatment centers (CDTs) offer sputum smear microscopy, along with a PT panel program. The TB program will also provide TA to the PNLT to (i) organize a sample referral system from HIV clinics to CATs, and (ii) revise the national testing algorithm according to GeneXpert capacity, both of which will also lead to faster case confirmation.

Additional above-site interventions include training and coaching for health care workers and HIV focal points on infection control, and continued support for the coordination, implementation, and expansion of MDR-TB detection. This latter entails assistance to the regional reference laboratory network to decentralize the capacity for opportunistic infection diagnosis. 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 opportunistic infections, particularly TB and STIs. Furthermore, PEPFAR will support the expansion of the External Quality Assessment Scheme for TB smear microscopy from 46 TB participating laboratories to all 196 TB laboratories performing TB smear microscopy.

4.7 Adult Treatment

In COP17, PEPFAR-CI will continue to support a standard package of ART services in 39 priority Districts, including sites with TB/HIV co-infected patients and HIV-positive pregnant women. Districts will receive tailored packages to reflect efforts needed to close the gaps in ART coverage, especially in priority districts. IPs will implement the package most aggressively in Scale-Up to Saturation Districts, with additional efforts to ensure 80% saturation by sex and age in four districts targeted to be Attained by the end of FY18, while implementing at a slightly reduced pace in Aggressive Scale-Up Districts, and passively in Sustained Districts. Interventions include:

- Establishment of support protocols in new sites
- Recruitment and training of new health care providers
- New training/mentoring technologies for providers (ECHO distance learning program and e-Learning)
- Targeted demand creation and HTS among high yield populations and entry points to match 80% treatment coverage, including counseling on awareness of early treatment availability and benefits
- Ongoing treatment literacy for existing and newly tested positive patients receiving ART
- Active linkages from testing to treatment services
- Aggressive scale-up of task-sharing
- Performance-based financing
- Provision of ARVs and PEP
- Adolescent-friendly services for adolescent-specific care and treatment
- Community-based services to improve retention
- Supply chain management support
- Active patient tracking, with new technologies to improve retention on ART (mHealth and COMCARE mobile phone app for patient tracking)
- Access to VL testing
- Laboratory services
- Monitoring and evaluation

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, as covered in the previous section 4.5. Section 4.5 also provides detail on expanded interventions on retention, such as community support groups and innovative strategies to actively track and keep people on ART, an area that improved over the years due to large site-level investments in capacity and human resources.

Meanwhile, PEPFAR-CI is working closely with the MSHP to implement 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, and engaging community counselors to perform HTS and follow-up of ART patients. PEPFAR-CI is applying Impact Funds to monitor and follow up with full implementation of Test and Start nationally, including continued capacity-building for HCWs to initiate immediate treatment for any individual testing positive, which will contribute to improving the cascade from testing to treatment.

Retention is also expected to increase with continued assistance to the PNLs to implement differentiated service delivery models for stable and unstable patients on ART, coinciding with the implementation of Test and Start. Stable patients on ART will receive:

- Reduced clinical visits (from four to two per year)
- Reduced biological monitoring (from twice to once a year)
- Multi-month ARV drugs supply (from one to three months)
- Reduced laboratory monitoring tests
- VL testing, transitioning from CD4 monitoring

Unstable patients 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 savings along the clinical cascade.

The procurement and distribution of drugs and laboratory commodities improved in FY16 with reduced stock-outs at the central and site levels. PEPFAR-CI contributed to increasing the storage capacity of the NPSP and renovating 15 District Pharmacies as well as improving reporting (at site and district levels) and supporting extension of a revised electronic patient medical record software that includes a functioning pharmacy module. Supply chain management support in COP17 will build on these achievements to focus on ensuring adequate stock in line with Test and Start, multi-month scripting, and community ARV distribution in select sites.

In COP17, PEPFAR-CI will begin a hub-and-spoke model to link patients at ART sites in Scale-up Districts with less than 100 patients currently on ART (new definition of low volume, up from 25 patients) to the nearest high volume ART site, if analysis demonstrates the site's low potential for growth and/or for contribution to the goal of 80% saturation in the district.

SIMS visits showed a significant improvement in the quality of adult care and treatment services, with 24% red and yellow scores in FY16. However, incomplete documentation of the patient management tools represents a major challenge. Quality improvement will continue to focus on the program's family-centered treatment approach.

4.8 Pediatric Treatment

The number of children receiving ART nationwide has increased by 18% between 2014 and 2016, with children under 15 years old accounting for approximately 5% of the total of number of people on ART. However, national data shows that pediatric ART coverage is still proportionately lower at 30% compared to 40% adult coverage in Côte d'Ivoire, and for the first time in the history of the HIV epidemic, new infections among children 0-14 years in the West/Central Africa region are the highest worldwide. PEPFAR-CI will work closely with the GOCI and partners to fast track the pediatric HIV response in Cote d'Ivoire and continue to scale-up pediatric ART coverage in high burden districts, applying recommendations that the team developed with PEPFAR HQ technical assistance throughout FY16 and FY17. A key step includes enhanced partner management with frequent results monitoring to ensure that IPs are effectively and fully implementing appropriate strategies to reach the much more ambitious targets for FY18.

COP17 goals are to ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, with systematic testing for at least 75% of OVCs through strong collaboration between facilities and community settings, and to start and retain on ART all infected children regardless of age. Although the age of consent for HIV testing in Côte d'Ivoire is 16 years, the HIV law from 2014 also indicates that the best interest of the child should always prevail if the child must undergo testing. It is a measure that seeks to address resistance from the

parent or guardian by providing the provider with some authority to exercise clinical judgment to request a HIV test. Key priorities for pediatric and adolescent care and treatment in COP17 include increasing ART and VL testing coverage, improving TB screening, expanding NACS, and increasing systematic and routine HTS of all children, especially the entry points below.

Targeted entry point	FY18 Target
Children with TB or suspected TB	1520
Children presenting suggestive symptoms	900
Malnourished children	870
Children of Adults receiving HIV services	850
OVC identified through screening tool	700
Children in inpatient settings	560
Index testing (PITC): HIV index client family tree (genealogy form/tree)	240
Outpatients identified through screening tool (Bandason, et al.)	226
Early infant diagnosis	226

PEPFAR-CI has worked closely with key stakeholders to address pediatric bottlenecks and define innovative strategies to increase pediatric case identification and care and treatment coverage. Although PEPFAR-CI is not the recipient of Accelerating Children’s Treatment (ACT) funding, the program will implement ACT-like technical approaches and objectives in COP17, to reinforce linkages between community OVC programs and key entry points at health facilities. Aligning with the task-shifting policy, PEPFAR-CI will continue training general practitioners, nurses, and midwives to initiate pediatric HIV care and treatment, and ensure training on the most recent ART guidelines. This will be accompanied by the creation of a network of pediatric care and treatment providers and the establishment of a mentoring system at selected sites in Scale-Up Districts.

PEPFAR-CI will also support differentiated service delivery models for children as for adults. Stable children receiving ART will have clinical visits 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 with monthly visits.

PEPFAR-CI is monitoring site level achievement quarterly, and working to routinely collect and analyze testing yield data from identified pediatric testing points weekly. Pediatric case finding will increase through the creation of a monthly listing of newly tested positive children, to be able to monitor their enrollment in treatment and improve adherence and retention. PEPFAR-CI will strengthen collaboration and cross-referral between clinical HIV programs, social welfare/ community-based support systems, and OVC services. Linkages between HIV testing and prevention programs will focus on at-risk adolescents and young women. Section 4.9 provides more details on the implementation of DREAMS-like strategies for girls and young women, ages 10-19.

To facilitate early identification of treatment failure in infants, PEPFAR-CI will use VL testing as the only biological monitoring test in all supported regions. Decentralization of VL access will occur with the opening of a total of 15 new laboratories operating in all Scale-up Districts. The program expects that 100% of children will be on ART in the Scale-up Districts in FY18. Testing for infants in remote sites, with no available VL testing services, will use DBS samples.

SIMS visits have shown significant improvement in quality of pediatric care and treatment services with 23% red and yellow scores in FY16. 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 the development, dissemination and mapping of community organizations working around health facilities.

4.9 Orphans and Vulnerable Children (OVC)

The OVC program of PEPFAR-CI seeks to address the needs of the most vulnerable children, while reinforcing the household capacity for self-sufficiency. The Most vulnerable children include those who are (i) exposed to, infected by, or affected by HIV, (ii) are children of diagnosed PLHIVs or FSW, (iii) regularly absent from school, or (iv) identified as sick and/or malnourished. PEPFAR-CI's approaches align with government guidelines for child protection and complement activities from other donors, including GF and UNICEF. By aligning also to the high burden priority districts, OVC programming links transversally to PMTCT, HTS, prevention, and care and treatment programs to provide a robust community platform that can respond to the socio-economic, health, educational, legal, and psychosocial needs of children and families infected and affected by HIV. Interventions range from educational support and economic skills-building to psychosocial programs and referrals to clinical services. In COP17, PEPFAR-CI will expand this package of services to more OVCs and their families, while also strengthening the coordination by the National Program for Orphans and Vulnerable Children (PN-OEV). PEPFAR-CI will also rely on the OVC framework to optimize reach to children living with HIV, children of KPs, and girls and young women.

PEPFAR-CI will extend OVC programming to almost 10% more OVCs than last year to assist the GOCI in meeting 90% of the PSN 2016-2020 goals for OVC and their families. To achieve these objectives, PEPFAR-CI will continue strengthening the link between national health and social welfare systems, as well as build the capacity of the social welfare workforce. This comprehensive approach and fundamental systems investment across sectors will mitigate long-term health, economic, and psycho-socio-emotional impact of HIV and AIDS on children, families, and communities.

In Côte d'Ivoire, OVC services are available through government social centers and PEPFAR community IPs, both of which perform needs assessments, case management, referrals when needed, and monitoring and evaluation in their standard care package. The PN-OEV, under the Ministry of Solidarity, Women, and Child Protection (MSFPE), is the central entity that oversees the coordination of these interventions. The PN-OEV also provides technical assistance to implementing NGOs, MSFPE regional offices, and social centers which, in addition to offering direct service delivery, coordinate the local OVC platforms that bring together multi-sectoral actors at the decentralized level. PEPFAR-CI support in COP17 will reinforce the capacity of the PN-OEV to strengthen the human resources at social centers and provide supportive supervision through the regional offices, as well as reinforce the capacities of the social centers and civil society organizations for service delivery.

The COP17 strategy will focus on layering the OVC and pediatric programs, using the OVC platform for targeted HTS referrals and index case testing, and linking positively diagnosed pediatric clients into the OVC program. Community- and household-based interventions for

HIV-infected OVC and their families will continue to include nutritional support, regular home visits, links to robust educational support, health card verification for appointments missed, pill counts, facilitated support groups for adult and adolescent PLHIVs, and household economic strengthening (e.g. savings groups), all with a view to heightening focus on retention, adherence, and referrals to health facilities.

A particular priority in COP17 will be linkage into the OVC program for the children of KPs, especially FSWs, with consideration of pediatric testing integrated into KP programs. PEPFAR-CI will pay specific attention to avoid stigmatization and discrimination while providing services to these children.

Under the OVC program, PEPFAR-CI will expand prevention and active identification of GBV cases among children. An OVC task force will consider approaches for the social centers to reinforce the community-clinic linkages, in response to recommendations from the 2016 Gender Analysis for focused effort on gender-sensitive strategies and referrals for GBV. Upcoming VACS findings will also provide relevant data to address violence through the OVC program.

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-CI IPs target more girls, who represent almost 60% of the OVC targets. In COP17, PEPFAR-CI will rely more on the OVC program as an entry point for HIV prevention activities for AGYW. In addition to the OVC services mentioned above, this target sub-population in four Scale-up to Saturation Districts will have access to DREAMS-like prevention packages, with the main objectives of improving risk avoidance and strengthening GBV prevention and post-GBV care.

The DREAMS-like approach, targeting AGYW ages 10-19, will institute secondary educational support, a mentoring system, and interventions that increase awareness and skills to prevent and respond to GBV for the girls, plus parenting skills-building and support for their parents. PEPFAR-CI will also open twelve safe spaces in all four districts, with activities in empowerment, team-building, leadership, and sports along with linkages to HIV and health services districts. DREAMS beneficiaries who are sexually active will be advised to refer their male sex partners to the DREAMS community counselor, with the objective of linking the partner to other services such as HIV, or GBV prevention/response programs.

The package of interventions for girls 10-14 will have a heavier emphasis on risk avoidance and risk reduction, while the package for girls age 15-19 will include supplementary services for youth-friendly sexual and reproductive health care services. IPs will also engage in differentiated recruitment and retention strategies to respond to the particular needs and interests of the two cohorts.

PEPFAR-CI selected the districts of Cocody-Bingerville, Abobo-Est, Man, and Daloa for DREAMS-like implementation, based on the following criteria:

1. Highest GBV prevalence (4.4% - 8.3%)
2. Highest HIV prevalence among AGYW (2.2% - 5.1%)
3. Highest adolescent pregnancy rate (22.65% - 29.1%)
4. Lowest school attendance rate for AGYW ages 10-18 (7.4% - 41.3%)
5. Lowest AGYW Family Planning use (14.5% - 29.2%).

PEPFAR-CI will create a girls' roster to better target their location within these districts. Though some but not all participants will be introduced to the DREAMS package through the OVC program, the existing national OVC database will provide unique tracking identifiers for all DREAMS beneficiaries while distinguishing between those who are only in the OVC program, those who are only in the DREAMS program, and those who participate in both. The program will also draw upon VACS data on transactional sex behavior by AGYW and on male sex partners. Prevention IPs in the same areas are implementing complementary approaches directed to older men, thus reinforcing the collaboration between the OVC and prevention programs to enable a comprehensively safe environment for girls and young women.

4.10 Laboratory

During COP17, PEPFAR-CI will focus on addressing the challenges and weaknesses identified through the electronic dashboard reporting system during COP15 in the VL testing scale-up phase in three regions (San Pedro, Bouake, Abengourou). The lab program will specifically address the following issues: low VL coverage (10%), delays in sample processing, long turnaround time, poor data reporting and analysis, and weak laboratory capacity and clinician literacy.

One of the main results of the PEPFAR-CI laboratory strategy in FY17 will be an effective decentralization of access to VL and EID tests at eight regional reference laboratories¹² and three additional ones in Abidjan¹³ to complement the existing four VL laboratories in Abidjan. High level engagement of the MSHP with their signature of a three-year leasing contract to install up to 30 VL testing machine will result in the installation of 18 machines in these 15 PEPFAR-supported labs by the end of FY17, including high volume machines capable of performing up to 1,000 tests per day. The testing capacity of the CDC Retro-CI lab, which serves as a backup for all laboratories and the sole processing lab for all DBS samples in the country, will also be increased to perform about 1,000 VL tests per day. PEPFAR-CI will encourage the use of Dried Blood Spot (DBS) for better uptake in remote sites and minimization of stock-outs of VL and EID reagents. The eight regional laboratories will operate 24 hours a day, thereby doubling their testing capacities. PEPFAR-CI will also be working in collaboration with its IPs and the PNL3 three-year plan to shift all patient monitoring from CD4 to VL testing by FY18. Through this increased capacity for VL testing and the transition to exclusive VL testing, PEPFAR-CI expects the following coverage by FY18:

- 80% of patients in Scale-up to Saturation Districts, with 100% coverage in four districts¹⁴
- 75% of patients in Aggressive Scale-up Districts
- 50% of patients in Sustained Districts
- 100% of patients in Military sites
- 100% of patients in the private sector

This includes VL testing access to 100% of pregnant women and children in all the Scale-Up Districts. At the date of COP approval, the VL testing coverage in the three GF-supported districts remained to be determined.

¹² San Pedro, Bouake, Abengourou, Yamoussoukro, Man, Korhogo, Gagnoa and Soubre

¹³ INSP; Abobo-Sud and CEPREF

¹⁴ Abobo-Ouest; Cocody-Bingerville; Yopougon-Songon-Ouest; Treichville-Marcory

Delays in sample processing and long turnaround times for results will also be rectified with the opening of 15 PEPFAR-supported laboratory hubs located around the regional reference laboratories, to increase and improve laboratory pre-analytic processes.

Additional interventions responding to above-mentioned weaknesses include: roll-out of the integrated biological sample transportation system; training for health care and community health workers, with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based financing to improve lab staff retention; implementation of VL testing dashboards and scorecards at each laboratory and care and treatment sites to document performance; and establishment of a laboratory information system to collect data on VL uptake and viral suppression at more than 100 laboratories. PEPFAR-CI will develop a specific dashboard to monitor EID coverage, with the goal of increasing EID among babies aged zero to two months from 74% to 85%.

PEPFAR-CI will continue the implementation of the quality management systems (QMS) program within 51 laboratories and HIV testing points that have received PT panels for HIV. PEPFAR-CI The program has contributed to decentralizing microbiological testing to diagnose STIs and HIV opportunistic infections to ten regional laboratories, and will provide about 10,000 tests to HIV-infected KPs.

4.11 Commodities

No funding gaps are projected for FY18, and PEPFAR-CI does not anticipate any national commodities stock-outs or shortages during COP17. However, the new separation of procurement and management responsibilities for HIV commodities entails a shift in the approach of PEPFAR's supply chain technical assistance to Côte d'Ivoire. While reducing country dependence on external funding is commendable, it increases supply chain risks, giving rise to the challenges generally associated with host government funding the procurement of health commodities, as seen in other countries. Such challenges include: long procurement timelines, delays in the disbursement of funds, and low procurement performance. In order to mitigate these risks, PEPFAR-CI will increase its participation in coordination efforts, in order to avoid disruption in the implementation of the joint national supply plan for health commodities. The team will coordinate with all relevant stakeholders through the National Coordinating Committee for the Procurement of Medication and Biological Products (CNCAM), to ensure that supplies of HIV commodities imported into the country arrive in a timely manner and that technical support to increase the CNCAM's ability to better coordinate national forecasting and supply planning of HIV commodities is made available. More specific details on supply chain interventions are included in Appendix C.

4.12 Collaboration, Integration, and Monitoring

PEPFAR-CI ensures cross-technical collaboration and implementation across agencies to address challenges along the clinical cascade, through weekly strategy and programming meetings that involve participation of the technical branch leads and agency heads of the four implementing agencies in Côte d'Ivoire. In addition, technical collaboration with external stakeholders on the clinical cascade became particularly prominent in the development of the PSN 2016-2020, continuing through the preparation of the GF Phase 2 Round 9 Cost Extension and into COP17 planning.

To prepare for the GF proposal for the 2018-2020 grant period, the MSHP, PEPFAR, and the GF conducted joint situational (data and programmatic) analyses. These exercises utilized programmatic findings that fed into the preparation of the PSN 2016-2020 and harmonized data sources and target-setting. One of the results was the projected clinical cascade for FY18 that serves as the basis for both COP17 and the GF 2018-2020 proposal.

PEPFAR-CI regularly tracks progress of the clinical cascade, down to the level of SNU and implementing partner, with special attention paid to Scale-Up Districts. Beginning in COP16 and continuing with the same level of intensity in COP17, PEPFAR-CI is instituting monthly reviews of partner results on prevention, treatment, and linkage specific to KPs, as an added focus on bolstering the KP clinical cascade. Implementing partners engaging in HTS activities, both at the facility and in the community, are additionally receiving PEPFAR weekly support to follow up on yield results. PEPFAR-CI will base this exercise on a dashboard developed by CDC Atlanta which triangulates yield with expenditure data. Quarterly data submissions and the subsequent POART reviews provide a further opportunity every quarter to monitor SNU and partner level achievement against targets, and also reassess the cascade of testing and treatment by SNU and by partner. This quarterly implementation review is enhanced by quality results from required Site Improvement Monitoring System visits, which are particularly concentrated in Scale-Up Districts where prioritized high volume sites are located.

In COP17, PEPFAR-CI will continue to provide support for human resources for health to ensure implementation along the clinical cascade, particularly with resources allotted to improved adherence and outreach into the community, and monitoring of task-shifting for care and treatment. To address challenges with the final phase of the clinical cascade, PEPFAR-CI is introducing numerous measures to address access and uptake of VL testing in COP16, which will continue to scale-up in COP17. These innovations, described in more detail in the laboratory section above, include: 24 hour shifts at laboratories; introduction of VL scorecards, dashboards and focal points at each clinical site in addition to increased lab staff at both clinical and lab sites; monthly site-level lab data reporting and monitoring by the IP; and establishment of lab hubs for pre-analytic work that will reduce turnaround time and substantially increase VL testing access in Scale-up Districts, especially for women and pediatrics.

5.0 Program Activities for Epidemic Control Sustained Locations and Populations

5.1 Targets for sustained locations and populations

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites	PMTCT_STAT	117,170	131,886
HTS (only sustained ART sites in FY 17)	HTC_TST/HTS_POS	9,297	19,113
Current on ART	TX_CURR	21,338	41,543

Table 5.1.2 Targets for OVC and Linkage to HIV Services for Sustained Districts

Regions and Districts	Estimated # of Orphans and Vulnerable Children	FY18 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 (FY18 Target) OVC_KNOWNSTAT
Abidjan 1-Grands Ponts	3,655	714	499
Grand-Lahou	2,054	683	478
Jacqueville	1,601	31	21
Agneby-Tiassa-Me	4,718	678	474
Alepe	2,952	0	0
Sikensi	1,766	678	474
Belier	4,816	1,007	705
Didievi	0	134	94
Tiebissou	1,850	0	0
Toumodi	2,966	872	611
Bounkani-gontougo	0	4,855	3,398
Bouna	0	2,427	1,699
Nassian	0	2,427	1,699
Cavally-Guemon	6,463	2,300	1,610
Bolequin	2,386	0	0
Kouibly	2,790	0	0
Toulepleu	1,287	2,300	1,610
Gbeke	3,953	16,791	11,754
Beoumi	2,648	8,395	5,877
Sakassou	1,305	8,395	5,877
Gbokle-Nawa-San Pedro	1,916	0	0
Gueyo	1,916	0	0
Hambol	0	119	83
Dabakala	0	44	31
Katiola	0	74	52
Niakaramadougou	0	0	0
Haut-Sassandra	3,338	1,846	1,292
Vavoua	3,338	1,846	1,292
Indenie-Djuablin	4,173	360	251
Agnibilekrou	3,047	192	134
Bettie	1,126	168	117
Kabadougou-Bafing-Folon	0	9,226	6,458
Minignan	0	4,191	2,934
Odienne	0	3,225	2,258
Touba	0	1,809	1,266
Loh-Djiboua	0	60	42
Fresco	0	0	0
Lakota	0	60	42
Marahoue	1,677	205	143
Zuenoula	1,677	205	143
N'zi-ifou	7,814	6,964	4,876
Bocanda	1,609	1,455	1,019
Daoukro	3,352	1,455	1,019
Dimbokro	1,554	2,483	1,738
M'bahiakro	1,299	1,455	1,019

Regions and Districts	Estimated # of Orphans and Vulnerable Children	FY18 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 (FY18 Target) OVC_KNOWNSTAT
Prikro	0	116	81
Poro-Tchologo-Bagoue	7,452	10,282	7,197
Boundiali	1,931	3,427	2,399
Ferkessedougou	3,025	3,427	2,399
Ouangolodougou	2,107	3,427	2,399
Tengrela	389	0	0
Tonkpi	7,849	525	367
Biankouma	1,962	0	0
Danane	3,207	525	367
Zouhan Hounien	2,680	0	0
Worodougou-Bere	0	27	19
Seguela	0	27	19
Total	57,824	55,957	39,168

5.2 Package of services in sustained support locations and populations

PEPFAR-CI will continue to maintain minimum quality of care and treatment services to ensure the retention of patients on ART in Sustained Districts, with the same care and treatment services in all districts for PLHIV, KPs, TB/HIV co-infected individuals, and OVCs, as described in the previous section, while limiting prevention activities and HTS. PEPFAR-CI support for existing facility-based staffing will not increase nor will the program extend into new clinical or community sites.

In addition to quarterly supervision visits, the maintenance package in the Sustained Districts will encompass support for the following:

- **HTS:** diagnostic HTS, targeted HTS for KPs in hot spots; HTS for sexual partners of index cases; HIV index case-based family tree to identify HIV-infected children; linkages and referrals to care and treatment; commodity supply chain support
- **ART:** ARV prescription and provision; clinical monitoring; commodity supply chain support; task-sharing support; active retention activities; adolescent peer support groups
- **Care Services:** community-based retention/continuum of care linkages; CTX; TB screening; PHDP package including condoms; NACS for children; commodity supply chain support
- **PMTCT:** all interventions under ART and Care services at high yield sites only (> 4 HIV-positive pregnant women diagnosed per year); family planning integration; testing of sexual partners and children of HIV-infected pregnant and breastfeeding women
- **OVC:** support to the national OVC agency to perform quarterly supervision and TA to social centers and OVC platforms
- **Laboratory:** CD4 at baseline, hematology, VL testing referrals, quality management systems; maintenance of lab equipment and existing laboratory information systems; lab reagents supply chain support
- **SI/M&E:** provision of paper-based data collection tools; support of existing electronic laboratory information system; quarterly data validation visits

The main assumption used to determine expected volume in Sustained Districts was the passive enrollment of new patients on ART. Adjustments to the unit expenditures for care and treatment by budget codes factored in reduced investments in training, coaching, staffing, minor renovations/rehabilitation, and outreach community mobilization.

In COP17, PEPFAR-CI will begin transitioning support to the MSHP of low-volume ART sites in Sustained Districts (newly defined as sites with less than 100 patients currently on ART).

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

The interagency team will continue to focus its site level and above site level program support in COP17 to address three programmatic gaps to achieving the 90:90:90 goals in Côte d'Ivoire, identified in COP16:

1. Low national coverage of pediatric care and treatment
2. Low outreach to and coverage of Key Populations (KPs) and Priority Populations (PPs)
3. Low access to VL testing

While retention among pediatric cases is satisfactory, national pediatrics coverage remains 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 the health care workforce to address the pediatric population

Case identification also remains low among KPs and PPs, particularly evident among men aged 25+. These are sub-populations for which the country faces challenges in welcoming them to a facility for services in HIV prevention, care, and treatment but also for general health and well-being. 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 impede 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 limited in Côte d'Ivoire, based on the following barriers:

- 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

PEPFAR-CI is on track with implementing previously identified activities to overcome these barriers and arrive at outcomes by FY19 that contribute to sustained epidemic control. The interagency team has added activities to advance progress toward those outcomes, subsequent to

needs and opportunities recognized during FY16 POART analyses. For the pediatric approach, additional activities to identify malnourished children, a cohort that has demonstrated high yield for HIV positivity, and to address the special needs of adolescents living with HIV are being implemented. Additional activities to support the expected outcomes for coverage of PPs are linked to an improved strategy to reach men. Finally, new activities related to VL testing coverage indicated in Table 6 in Appendix C provide more details on the scale-up plan which began in COP16.

6.2 Critical Systems Investments for Achieving Priority Policies

After more than a year of preparation with PEPFAR-CI support, the GOCI formally adopted Test and Start for all populations living with HIV and alternative models of service delivery in February 2017, two priority policies with which PEPFAR aligns its systems investments. COP17 will continue site level and above site level interventions to overcome barriers to lead to successful scale-up of the treatment cascade and continued smooth implementation of these policies. The major systems barriers for Test and Start relate to:

- Lack of enabling policies to place all individuals testing positive on ART
- Limited financial resources to close the 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

The main barriers for carrying out differentiated service delivery models pertain to the lack of a supply chain management system that can adequately monitor activities and inventory management at decentralized levels of the health system.

With the formal adoption of national policies in COP16, COP17 activities will no longer relate to the dissemination of new guidelines or the development of SOPs, though there are additional activities that explicitly support the incorporation of Test and Start in the military health system. Activities related to supply chain management that originally appeared in Table 6.2 are now found in Table 6.3, to show a more comprehensive and concise picture of the transversal support that these activities provide.

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

Besides the programmatic gaps and priority policies, systems investments in COP17 relate to one of three areas:

- Supply chain management
- Laboratory network strengthening
- Strategic information (SI)

PEPFAR-CI is on track to implement previously identified activities to overcome these barriers, and arrive at outcomes by FY19 that contribute to the achievement of the 90:90:90 objectives as well as sustained epidemic control, with a few SI activities coming to fruition before COP17 begins.

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

7.1 Staffing assessment

The interagency PEPFAR-CI team performed a staffing assessment in 2015 that confirmed the adequacy of the team's footprint to respond to program oversight and monitoring demands. The current PEPFAR leadership validated this determination as part of the staff planning for COP17. The main change that occurred in 2015 was the establishment of interagency technical working groups across technical areas.

After a year of implementation, the PEPFAR Coordination Office surveyed the interagency team members to solicit feedback on the challenges and success of the new TWG structure, the results of which identified the need to redefine the TWGs and develop a procedures manual. In COP17, PEPFAR-CI will continue to adapt to this revised interagency governance structure.

7.2 Vacancies

The Department of State (DoS) and Department of Defense have filled all their vacancies and will not request any new positions for COP17. A Small Grants Coordinator was part of the DoS staffing request in COP16. This position is no longer required, and the responsibilities were divided amongst the current staff in the PEPFAR Coordination Office. A Federal hiring freeze beginning in January 2017 and continuing for non-locally employed staff positions at the date of the COP17 submission, delayed and put on hold HR processes, thus preventing USAID and CDC from advancing on filling vacancies.

The CDC has ten vacant positions at different hiring stages that will be filled by the end of the federal hiring freeze. The positions range from recruitment to reclassification and to interviews. Changes in country leadership, the Federal hiring freeze, a need for a staff assessment resulting in the planned reorganization of some branches affected the CDC's ability to fill these positions. It is expected that the agency will fill all the vacancies once the hiring freeze is lifted if not by the start of COP 17.

USAID filled all vacancies from COP16 but faces two others at the date of the COP17 submission, one starting in November 2016 and the second expected in mid-March 2017.

7.3 New Positions

CDC is requesting a new position, agreed upon by the interagency PEPFAR team and of which the Executive Office of the U.S. Embassy in Abidjan was informed. [REDACTED]

7.4 Major changes to the Cost of Doing Business

The Cost of Doing Business in COP17 has increased by less than half a million USD (\$415,711) from COP16 (all cost categories included), due to the addition of one overseas hire mentioned above for

the CDC and the associated ICASS and administrative costs; increased travel for SIMS visits for CDC and USAID; and increased professional development needs for all agencies. Downward staffing needs for the DoS slightly offset these upward changes.

APPENDIX A - Prioritization

Table A.1

SNU	COP15 prioritization	APR 16 ART Coverage	COP16 prioritization	Expected ART Coverage APR17	COP17 prioritization	Expected ART Coverage APR 18
Abengourou	Aggressive scale-up	43%	Aggressive scale-up	35%	Scale-up to saturation	80%
Abobo-Est	Scale-up to saturation	59%	Scale-up to saturation	80%	Scale-up to saturation	95%
Abobo-Ouest*	Scale-up to saturation	67%	Scale-up to saturation	80%	Scale-up to saturation	114%
Bondoukou	Aggressive scale-up	40%	Aggressive scale-up	39%	Scale-up to saturation	80%
Bouafle	Scale-up to saturation	35%	Scale-up to saturation	80%	Scale-up to saturation	80%
Bouake-Nord-Ouest	Scale-up to saturation	61%	Scale-up to saturation	80%	Scale-up to saturation	88%
Bouake-Sud	Scale-up to saturation	48%	Scale-up to saturation	73%	Scale-up to saturation	80%
Cocody-Bingerville*	Scale-up to saturation	69%	Scale-up to saturation	80%	Scale-up to saturation	96%
Dabou	Scale-up to saturation	44%	Scale-up to saturation	80%	Scale-up to saturation	80%
Daloa	Scale-up to saturation	51%	Scale-up to saturation	79%	Scale-up to saturation	99%
Gagnoa	Scale-up to saturation	40%	Scale-up to saturation	80%	Scale-up to saturation	83%
Issia	Scale-up to saturation	39%	Scale-up to saturation	80%	Scale-up to saturation	80%
Korhogo	Scale-up to saturation	53%	Scale-up to saturation	80%	Scale-up to saturation	96%
Man	Scale-up to saturation	38%	Scale-up to saturation	80%	Scale-up to saturation	80%
San-Pedro	Scale-up to saturation	38%	Scale-up to saturation	80%	Scale-up to saturation	80%
Tanda	Aggressive scale-up	41%	Aggressive scale-up	35%	Scale-up to saturation	80%
Treichville-Marcory*	Scale-up to saturation	185%	Scale-up to saturation	168%	Scale-up to saturation	222%
Yopougon-Est	Scale-up to saturation	43%	Scale-up to saturation	80%	Scale-up to saturation	80%
Yopougon-Ouest-Songon*	Scale-up to saturation	82%	Scale-up to saturation	80%	Scale-up to saturation	116%
Adjame-Plateau-Attecoube	Aggressive scale-up	39%	Aggressive scale-up	41%	Aggressive scale-up	65%
Adzope	Aggressive scale-up	15%	Aggressive scale-up	17%	Aggressive scale-up	45%
Agboville	Aggressive scale-up	26%	Aggressive scale-up	23%	Aggressive scale-up	50%
Akoupe	Aggressive scale-up	21%	Aggressive scale-up	17%	Aggressive scale-up	46%
Anyama	Aggressive scale-up	24%	Aggressive scale-up	23%	Aggressive scale-up	55%
Bangolo	Aggressive scale-up	11%	Aggressive scale-up	9%	Aggressive scale-up	40%
Bongouanou	Aggressive scale-up	32%	Aggressive scale-up	25%	Aggressive scale-up	70%
Bouake-Nord-Est	Aggressive scale-up	28%	Aggressive scale-up	24%	Aggressive scale-up	60%
Divo	Aggressive scale-up	33%	Aggressive scale-up	24%	Aggressive scale-up	65%
Duekoue	Aggressive scale-up	18%	Aggressive scale-up	14%	Aggressive scale-up	47%
Guiglo	Aggressive scale-up	28%	Aggressive scale-up	19%	Aggressive scale-up	55%

SNU	COP15 prioritization	APR 16 ART Coverage	COP16 prioritization	Expected ART Coverage APR17	COP17 prioritization	Expected ART Coverage APR 18
Koumassi-Port Bouet-Vridi	Aggressive scale-up	42%	Aggressive scale-up	44%	Aggressive scale-up	77%
Mankono	Aggressive scale-up	21%	Aggressive scale-up	18%	Aggressive scale-up	50%
Oume	Aggressive scale-up	27%	Aggressive scale-up	33%	Aggressive scale-up	60%
Sassandra	Aggressive scale-up	22%	Aggressive scale-up	24%	Aggressive scale-up	55%
Sinfra	Aggressive scale-up	31%	Aggressive scale-up	38%	Aggressive scale-up	60%
Soubre	Aggressive scale-up	20%	Aggressive scale-up	23%	Aggressive scale-up	55%
Tabou	Aggressive scale-up	13%	Aggressive scale-up	10%	Aggressive scale-up	48%
Tiassale	Aggressive scale-up	18%	Aggressive scale-up	16%	Aggressive scale-up	46%
Yamoussoukro	Aggressive scale-up	43%	Aggressive scale-up	35%	Aggressive scale-up	75%
Agnibilekrou	Sustained	46%	Sustained	39%	Sustained	74%
Alepe	Sustained	20%	Sustained	16%	Sustained	28%
Beoumi	Sustained	17%	Sustained	14%	Sustained	34%
Bettie	Sustained	17%	Sustained	12%	Sustained	35%
Biankouma	Sustained	22%	Sustained	18%	Sustained	41%
Blolequin	Sustained	11%	Sustained	6%	Sustained	28%
Bocanda	Sustained	29%	Sustained	23%	Sustained	50%
Bouna	Sustained	19%	Sustained	15%	Sustained	33%
Boundiali	Sustained	46%	Sustained	39%	Sustained	61%
Dabakala	Sustained	17%	Sustained	15%	Sustained	32%
Danane	Sustained	29%	Sustained	31%	Sustained	60%
Daoukro	Sustained	36%	Sustained	31%	Sustained	60%
Didievi	Sustained	12%	Sustained	6%	Sustained	28%
Dimbokro	Sustained	60%	Sustained	53%	Sustained	75%
Ferkessedougou	Sustained	47%	Sustained	35%	Sustained	72%
Fresco	Sustained	27%	Sustained	21%	Sustained	36%
Grand-Lahou	Sustained	24%	Sustained	15%	Sustained	44%
Gueyo	Sustained	12%	Sustained	7%	Sustained	26%
Jacquerville	Sustained	15%	Sustained	11%	Sustained	29%
Katiola	Sustained	29%	Sustained	19%	Sustained	46%
Kouibly	Sustained	14%	Sustained	9%	Sustained	33%
Lakota	Sustained	36%	Sustained	27%	Sustained	58%
M'bahiakro	Sustained	15%	Sustained	14%	Sustained	23%
Minignan	Sustained	9%	Sustained	6%	Sustained	19%
Nassian	Sustained	21%	Sustained	17%	Sustained	37%
Niakaramadougou	Sustained	17%	Sustained	12%	Sustained	28%

SNU	COP15 prioritization	APR 16 ART Coverage	COP16 prioritization	Expected ART Coverage APR17	COP17 prioritization	Expected ART Coverage APR 18
Odienne	Sustained	23%	Sustained	20%	Sustained	47%
Ouangolodougou	Sustained	32%	Sustained	20%	Sustained	46%
Prikro	Sustained	29%	Sustained	23%	Sustained	59%
Sakassou	Sustained	35%	Sustained	35%	Sustained	61%
seguela	Sustained	18%	Sustained	20%	Sustained	51%
Sikensi	Sustained	13%	Sustained	8%	Sustained	29%
Tengrela	Sustained	45%	Sustained	36%	Sustained	60%
Tiebissou	Sustained	22%	Sustained	18%	Sustained	44%
Touba	Sustained	11%	Sustained	4%	Sustained	28%
Toulepleu	Sustained	9%	Sustained	5%	Sustained	20%
Toumodi	Sustained	33%	Sustained	31%	Sustained	62%
Vavoua	Sustained	18%	Sustained	18%	Sustained	39%
Zouhan Hounien	Sustained	21%	Sustained	15%	Sustained	44%
Zuenoula	Sustained	37%	Sustained	43%	Sustained	67%

*Districts targeted to reach Attained status by FY18

Table A2. ART Targets by Prioritization 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 FY17	# additional patients required for 80% coverage	Expected Newly initiated on ART FY18	Expected Current on ART FY18	ART Coverage (APR 18)
Abengourou	7,368	2,544	3,350	3,176	5,264	80%
Abobo-Est	12,497	10,001	(3)	3,086	11,855	95%
Abobo-Ouest*	11,009	8,801	6	5,063	12,518	114%
Bondoukou	5,958	2,301	2,465	2,971	4,671	80%
Bouafle	6,095	4,875	1	489	4,876	80%
Bouake-Nord-Ouest	8,788	7,030	0	1,507	7,726	88%
Bouake-Sud	5,521	4,047	370	821	4,417	80%
Cocody-Bingerville*	11,344	9,075	(0)	2,962	10,901	96%
Dabou	5,697	4,557	0	456	4,557	80%
Daloa	10,123	8,032	67	2,844	9,975	99%
Gagnoa	8,974	7,179	(0)	1,016	7,444	83%
Issia	5,051	4,041	(0)	404	4,041	80%
Korhogo	10,006	8,005	0	2,524	9,646	96%
Man	6,780	5,424	(0)	542	5,424	80%
San-Pedro	12,473	9,952	26	1,025	9,978	80%
Tanda	5,438	1,914	2,437	2,604	4,058	80%
Treichville-Marcory*	10,987	18,498	(9,709)	6,462	22,597	222%
Yopougon-Est	13,703	10,935	27	1,125	10,962	80%
Yopougon-Ouest-Songon*	16,701	13,386	(26)	7,962	19,115	116%
Adjame-Plateau-Attecoube	19,369	7,944	7,551	6,023	12,590	65%
Adzope	9,147	1,552	5,765	2,976	4,116	45%
Agboville	9,096	2,049	5,227	2,595	4,222	50%
Akoupe	5,180	863	3,281	1,561	2,174	46%
Anyama	5,094	1,179	2,896	1,796	2,778	55%
Bangolo	4,671	440	3,297	1,589	1,783	40%
Bongouanou	7,885	1,986	4,322	3,328	4,967	70%
Bouake-Nord-Est	5,335	1,265	3,003	2,054	2,978	60%
Divo	9,423	2,216	5,322	3,611	5,228	65%
Duekoue	7,816	1,071	5,182	2,462	3,314	47%
Guiglo	5,699	1,085	3,475	1,879	2,617	55%
Koumassi-Port Bouet-Vridi	19,490	8,599	6,993	7,742	15,007	77%
Mankono	4,512	809	2,801	1,473	2,135	50%
Oume	5,065	1,687	2,365	1,690	3,039	60%
Sassandra	4,395	1,068	2,448	1,524	2,417	55%
Soubre	16,933	3,907	9,640	6,067	9,313	55%

District	Estimated number of PLHIV (hyp: constant)	Expected Current on ART FY17	# additional patients required for 80% coverage	Expected Newly initiated on ART FY18	Expected Current on ART FY18	ART Coverage (APR 18)
Tabou	7,133	740	4,967	2,874	3,228	48%
Tiassale	5,780	903	3,721	1,936	2,500	46%
Yamoussoukro	9,501	3,354	4,246	3,515	6,382	75%
Agnibilekrou	3,689	1,431	1,520	1,277	2,487	74%
Alepe	3,573	559	2,300	396	868	28%
Beoumi	3,205	456	2,108	670	1,011	34%
Bettie	1,363	157	933	288	399	35%
Biankouma	2,375	416	1,484	551	868	41%
Bolequin	2,888	185	2,125	550	680	28%
Bocanda	1,948	448	1,110	485	867	50%
Bouna	3,445	528	2,228	571	999	33%
Boundiali	2,337	902	968	489	1,247	61%
Dabakala	3,794	582	2,453	680	1,174	32%
Danane	3,883	1,190	1,916	1,432	2,326	60%
Daoukro	4,058	1,257	1,989	1,153	2,213	60%
Didievi	1,604	96	1,187	303	357	28%
Dimbokro	1,882	1,001	504	389	1,276	75%
Ferkessedougou	3,661	1,287	1,642	1,106	2,197	72%
Fresco	2,683	559	1,588	317	803	36%
Grand-Lahou	2,487	381	1,608	620	898	44%
Gueyo	2,319	166	1,689	368	493	26%
Jacqueville	1,939	217	1,334	294	476	29%
Katiola	3,725	701	2,279	710	1,310	46%
Kouibly	3,378	319	2,383	739	962	33%
Lakota	3,088	840	1,631	866	1,517	58%
M'bahiakro	1,573	218	1,040	153	338	23%
Minignan	1,417	81	1,052	159	225	19%
Nassian	575	100	360	102	192	37%
Niakaramadougou	3,785	439	2,589	492	856	28%
Odienne	3,417	669	2,064	967	1,487	47%
Ouangolodougou	2,550	511	1,529	445	878	46%
Prikro	1,277	291	731	483	683	59%
Sakassou	1,580	548	716	503	955	61%
seguela	3,328	665	1,997	1,238	1,684	51%
Sikensi	2,137	172	1,538	376	514	29%
Tengrela	471	168	209	85	236	60%
Tiebissou	2,239	396	1,395	580	887	44%
Touba	2,905	113	2,211	575	601	28%
Toulepleu	1,558	83	1,163	188	246	20%
Toumodi	3,590	1,122	1,750	1,221	2,155	62%
Vavoua	4,040	724	2,508	980	1,569	39%
Zouhan Hounien	3,244	488	2,107	876	1,240	44%
Zuenoula	2,030	872	752	635	1,370	67%

*Districts targeted to reach Attained status by FY18

APPENDIX B – Budget Profile and Resource Projections

B.1 Planned Spending in COP17

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
\$45,393,451	\$114,786,857	\$160,180,308

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
CIRC	Male Circumcision	\$0
HBHC	Adult Care and Support	\$7,893,908
HKID	Orphans and Vulnerable Children	\$17,851,022
HLAB	Lab	\$7,097,097
HTXS	Adult Treatment	\$45,779,671
HTXD	ARV Drugs	\$9,356,673
HVCT	Counseling and Testing	\$27,784,744
HVMS	Management & Operations	\$13,206,547
HVOP	Other Sexual Prevention	\$6,935,254
HVSI	Strategic Information	\$3,040,422
HVTB	TB/HIV Care	\$4,473,391
IDUP	Injecting and Non-Injecting Drug Use	\$0
MTCT	Mother to Child Transmission	\$3,179,263
OHSS	Health Systems Strengthening	\$2,122,705
PDCS	Pediatric Care and Support	\$5,168,260
PDTX	Pediatric Treatment	\$4,383,450
HMBL	Blood Safety	\$19,496
HMIN	Injection Safety	\$0
HVAB	Abstinence/Be Faithful	\$1,888,405
TOTAL		\$160,180,308

B.2 Resource Projections

The process for resource projections for COP17 took into account minimum support needed for the targets and commodities contributing to the clinical cascade, additional site- and above-site level support activities, and management and staffing.

PEPFAR-CI updated the clinical cascade by focusing on enrolling almost 130,000 new patients on ART. This process encompassed the following steps:

1. Identifying the main entry streams for HTS based on program traits and performance.
2. Defining assumptions for the clinical cascade, including:
 - a. Variable HIV prevalence or expected positivity of the main entry streams for HTS
 - b. ART enrollment rates, depending upon SNU
 - c. Retention rates by ART enrollees (new vs. old cohort) and by SNU
 - d. Assessments of the feasibility of expansion and absorptive capacity of IPs and sites.

The interagency team examined FY16 EA data and made adjustments in the component cost

categories of the relevant unit expenditures to reflect changes in services and management for COP17. Adjustments that led to the final unit budgets for each target ranged from increases to accommodate the recruitment of additional staff and more frequent travel needs related to outreach and supervision, to decreases to account for economies of scale in program management and SI support. Where appropriate, different SNUs received different unit budgets due to geographic distinctions in service delivery.

The team calculated the requisite commodity needs support the resulting testing and treatment targets, as well as the minimum management and staffing efforts needed to operate the program.

The final piece of this exercise related to the identification and budgeting of the additional site- and above-site level activities that contribute to advancing toward the 90:90:90 goals, including those in Section 6. The financial data sources for this planning included FY16 EA reports and implementing partner program data.

APPENDIX C – Tables and Systems Investments for Section 6.o

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

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
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	Print and disseminate 510,000 revised mother and child health booklet	350,000 mother and child health booklets printed 36% of providers used the mother and child booklet	14% of providers use the mother and child booklet in scale-up districts	Survey, SIMS	PDCS	[REDACTED]	Ministry of Health - Follow-on	6. Service delivery
	Improved data for pediatric case identification	Provide technical assistance to PNN to reinforce case identification for malnourished children and link them systematically to HIV services (jobs aid, supervision, data collection...)	Malnutrition Job-aids, guidances are validated and 100 tools printed	Conduct at least 4 supervisions/mentoring in supported districts . Organize at least 4 workshops for nutrition data validation. 100% of nutrition data are collected and analyzed for decision making	reference and counter reference tool	PDCS	[REDACTED]	FANTA3	6. Service delivery
						HBHC	[REDACTED]	FANTA3	6. Service delivery

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
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.	Organize a national workshop to validate the harmonized counter-referral tool between facility, social and community	National workshop to validate the harmonized counter-referral tool between facility, social and community	n/a	Partner report			Ministry of Health - Follow-on	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	Print, disseminate and provide technical assistance on use of harmonized counter-referral tool between facility, social centers and community	1500 harmonized referral and counter-referral tool printed and disseminated At least one tool available per site	1500 harmonized referral and counter-referral tool printed and disseminated At least one tool available per site	SIMS	PDCS	[REDACTED]	Ministry of Health - Follow-on	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	Print and disseminate mapping of community organizations working around health facilities to reinforce and optimize pediatric referrals	All mapping documents/materials are printed and disseminated in all community organizations working around health facilities to reinforce and optimize pediatric referrals (2 posters and 10 leaflets per sites)	Updated mapping documents/materials are printed and disseminated in all community organizations working around health facilities to reinforce and optimize pediatric referrals (2 posters and 10 leaflets per sites)	SIMS / MER 2.0	PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
	Support a Regional/District collaboration framework between Regional/District	At least two Regional / District collaboration meetings between Regional/District Chief of Health	At least two Regional / District collaboration meetings between Regional/District Chief of Health (MSHP) and Chief of Community	SIMS / MER 2.0	PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
					PDCS	[REDACTED]	[REDACTED]	6. Service delivery	
PDCS					[REDACTED]	[REDACTED]	6. Service delivery		

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		Chief of Health (MSHP) and Chief of Community (under MPFFPE, MEPS) in Scale-Up to Saturation and Aggressive Districts	(MSHP) and Chief of Community (under MPFFPE, MEPS) in Scale-Up to Saturation Districts are held annually	(under MPFFPE, MEPS) in Scale-Up to Saturation Districts are held annually		PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
3. Limited capacity of health care workforce to address pediatric populations	80% of children and adolescents who test positive are enrolled into and retained in care Scale-Up to Saturation and Aggressive Scale-Up Districts	Provide technical and financial support to district level leadership to establish a network of providers (including military) who engage in pediatric care and treatment	Pediatric Job-aids, guidances are validated, /Advocacy meeting is completed and providers (including military) who engage in pediatric care and treatment are identified in supported districts	Pediatric Job-aids, guidances are printed and disseminated /Advocacy meeting is completed and providers (including military) who engage in pediatric care and treatment are identified in supported districts (10 job aids per site, 10 guidance per site, 4 quarterly meetings)	MER 2.0	PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
						PDCS	[REDACTED]	[REDACTED]	6. Service delivery
		PDCS	[REDACTED]	PSI	6. Service delivery				
		Development of a toolkit for scale-up of adolescent-friendly health services for adolescents living with HIV	Current capacity of healthcare workers and other cadres is evaluated	Written package of services and a training plan is developed Evaluation plan to evaluate roll-out of services and quality of service provision is developed	Availability of a toolkit of AFHS Evaluation report	PDCS	[REDACTED]	[REDACTED]	6. Service delivery
TOTAL							\$521,002		

Table 6.1.2 Key Programmatic Gap #1: Low coverage of Key and Priority Populations

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
KP-unfriendly environment for case identification and clinical services	Two fully functional drop-in centers in each of the 4 Attained districts and 8 scale up to saturation districts	Establish drop-in centers (DIC) in all districts, with a focus on young MSMs	Two drop in centers	Five drop in centers	Field visit report, DIC activity report, Mapping of functional drop in centers	HVOP/ HVCT/ HTXS/ HBHC	[REDACTED]	Linkages	6. Service delivery
	Number of FSWs, MSMs, and TGs using drop-in centers increases by 50% annually		Two drop in centers	Five drop in centers		HVOP/ HVCT/ HTXS/ HBHC	[REDACTED]	PROTECT	6. Service delivery
	Train at least 10 Health providers in each of the scale up districts to provide KP-friendly and stigma-free services	Train community health workers to provide KP-friendly and stigma-free services	At least 80% of health workers are trained to provide KP friendly, clinical and stigma/discrimination services free services	All health sites in each selected district provided KP-friendly, clinical and stigma/discrimination services free services (respectful, non-judgmental with good clinical skills)	Site visit Final report disseminated Advocacy guidelines disseminated at all levels	HVCT/ HTXS	[REDACTED]	PROTECT	7. HRH
						HVCT/ HTXS	[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	Update and harmonize the national unique identifying codes (UIC) for tracking system	n/a	Conduct workshops and meetings with stakeholders, eg PNLs, DPPEIS, CBOs, service providers	Annual report	HVOP	[REDACTED]	MOH	6. Service delivery
	At least 80% of all community and health	Train health and community workers on the	Validation and dissemination of the referral/counter	Training of health workers at high volume sites	Annual report	HVAB	[REDACTED]	[REDACTED]	7. HRH
						HVCT/	[REDACTED]	PROTECT	7. HRH

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score	
	workers are trained on the process and implementation of newly finalized referral/counter-referral system in each PEPFAR-supported site	newly finalized referral/counter-referral system/procedures	referral tool			HTXS/ HBHC	[CTED]			
						HVCT/ HTXS/ HBHC	[REDACTED]	Linkages	7. HRH	
						HVCT/ HTXS/ HBHC	[REDACTED]	STRONG 1	7. HRH	
						HVCT/ HTXS/ HBHC	[REDACTED]	STRONG 2	7. HRH	
						HVCT/ HTXS/ HBHC	[REDACTED]	STRONG 3	7. HRH	
						HVCT/ HTXS/ HBHC	[REDACTED]	STRONG 4	7. HRH	
Social and Gender norms impeding KPs and PPs from seeking HIV services, especially AGYW and men 25+	At least 65% of targeted men and AGYW within priority and key (MSM) populations in each of the 4 Attained, 15 scale up to saturation, and 20 aggressive scale up districts use care and treatment services	Conduct pro-KP friendly advocacy at all levels (community, clinic, policy/central) to address stigma and discrimination and GBV against KPs	N/A	All stakeholders reached at all levels are aware of the strategies needed to address stigma/discrimination and GBV against KPs	Final report	HVOP	[REDACTED]	PROTECT	3. Civil Society Engagement	
						HVOP	[REDACTED]	Linkages	3. Civil Society Engagement	
		Operationalize a national package of health services	Define and operationalize a package of health services and practices for men, segmented by relevant age groups (eg. 25-49, 50+)	Definition and validation of package of services	Training of staff on package of services in 4 Attained and 15 Scale up to Saturation districts	Annual report	HVOP/ HVCT/ HTXS/ HBHC	[REDACTED]	[REDACTED]	6. Service delivery
			Operationalize a national package of health services	Adaptation of package of services to local contexts	Training of staff on package of services in 4 Attained and 15 Scale	Annual report	HVOP/ HVCT/ PDCS/	[REDACTED]	STRONG 1	6. Service delivery

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		and guidance for AGYW, segmented by relevant age groups		up to Saturation districts		PDTX			
						HVOP/HVCT/PDCS/PDTX	[REDACTED]	STRONG 2	6. Service delivery
						HVOP/HVCT/PDCS/PDTX	[REDACTED]	STRONG 3	6. Service delivery
						HVOP/HVCT/PDCS/PDTX	[REDACTED]	STRONG 4	6. Service delivery
						HVOP/HVCT/PDCS/PDTX	[REDACTED]	[REDACTED]	6. Service delivery
	Conduct awareness campaigns to destigmatize health service uptake by men (mass media, social media)	Dissemination and analysis of results of formative research on men to develop content	Implement content from analysis of results of formative research on men	Annual report	HVOP/HVCT/HTXS/HBHC	[REDACTED]	[REDACTED]	6. Service delivery	
					HVOP/HVCT/HTXS/HBHC	[REDACTED]	STRONG 1	6. Service delivery	
					HVOP/HVCT/HTXS/HBHC	[REDACTED]	STRONG 2	6. Service delivery	
					HVOP/HVCT/HTXS/HBHC	[REDACTED]	STRONG 3	6. Service delivery	
					HVOP/HVCT/HTXS/HBHC	[REDACTED]	STRONG 4	6. Service delivery	

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 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		Provide TA to PEPFAR clinical partners and AIMAS to reach men with mHealth approach	N/A	Completion of two pilot activities (at ports and agriculture areas) to reach men	baseline and post-intervention quantitative/qualitative reports	OHSS/HVCT/HTXS/	[REDACTED]	[REDACTED]	6. Service delivery
		Provide small grants to local CSOs for community based sensitization activities to increase uptake of services	Select first round of grantees	Select second round of applicants	Signature of grants	HVOP/ HBHC	[REDACTED]	Small Grants	3. Civil Society Engagement
TOTAL							\$1,700,000		

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
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	Assessment and design National biological sample transportation system	Assessment reports available and sample transportation system design completed and tools available		Number of HIV patients on ART with at least one VL results per year and documented in the laboratory information system			[REDACTED]IHS C-TA	10. Laboratory
		Pilot the designed system in five districts	All labs of the 5 pilot Districts are using the sample transportation	All laboratories and treatment sites in the attain and saturation districts are effectively using the sample transportation system			[REDACTED]IHS C-TA	10. Laboratory	
		Use DBS for viral load testing in remote and difficult-to-access geographic areas	All labs in difficult-to-access areas of the 5 pilot Districts are using DBS for VL test	All laboratories and treatment sites in the attain and saturation districts are effectively using the sample transportation system		HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory
		Use innovative approach (drones) for samples transportation	Drones are effectively used in relevant areas of the 5 pilot Districts for the sample transportation	All laboratories and treatment sites in the attain and saturation districts are effectively using the sample transportation system		HTXS/PDTX	[REDACTED]	CDC Lab Coalition	10. Laboratory
2. Limited human resource capacity on viral load testing performance and Viral load literacy for health providers		Conduct-Coordinate in-service training of health and non health staff on VL, QMS, biological sample management and transportation)	Training Curriculum for VL ; QMS; biological sample transportation are available	Revised training curriculum for VL; QMS; biological sample transportation are available	Number of HIV patients on ART with at least one VL results per year and documented in the laboratory information system	HTXS	[REDACTED]	Ministry of Health - Follow-on	10. Laboratory
		Train Health care providers and	700 Health providers are	1400 trained are trained (clinicians, Lab					

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score	
		community health workers on VL literacy	trained (clinicians, Lab technicians and community)	technicians and community)	ART with at least one VL results per year and documented in the laboratory information system	HTXS/PDTX	[REDACTED]	HAI	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
		Ensure effective deployment of 120 Lab Technician; trained staff to VL testing	32 technicians trained covering 9 labs in scale-up districts (one training station)	60 Technicians trained (3 training stations)	Report on the number of Lab technicians deployed to selected areas	HTXS/PDTX	[REDACTED]	RETROCI	10. Laboratory	
		Ensure retention of laboratory staff through performance based financing linked to VL testing	90% of lab staff are retained through the PBF scheme in 10 labs	90% of lab staff are retained through the PBF scheme at all PEPFAR supported VL labs	Report on the percentage of lab technicians retained	HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
		3. Weak Monitoring of VL and EID commodities	Implement a national electronic Dashboard at MOH to monitor viral suppression in 100% of	Report of the requirement gathering to establish an electronic systems to monitor VL is available	Report of the requirement gathering to establish an electronic systems to monitor VL is available	VL dashboard indicators and Availability of Dashboard at all laboratories and clinical sites	HTXS/PDTX	[REDACTED]	CDC I-TECH	10. Laboratory

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		sites in saturation and aggressive scale-up districts							
		Identify indicators for the matrix of the dashboard				HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Establish central data base				HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Procure tool for collection of data and transmission (tablet)				HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Train health care workers on data entry and data quality check				HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Routine data collection at lab, clinical sites and Community sites level and analysis	Determine the number of sites and geographical distribution for year 1 and perform data collection in those sites	Determine the number of sites and geographical distribution for year 2 and perform data collection in those sites		HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Conduct data management and maintenance of data base	Maintenance/update of database for year 1	Maintenance /update of database for year 2		HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Create a national weblink for sharing of indicators info (ex of Kenya and Uganda)	Creation of the national weblink and collection of feedback	Maintenance of the national weblink with adjustments based on feedback from year 1		HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory
		Adapt and implement a VL and EID paper-based dashboard	25% of Lab and care and treatment sites effectively utilized the VL & EID	50% of Lab and care and treatment sites in total effectively utilized the VL & EID paper-		HTXS/PD TX	[REDACTED]	CDC I-TECH	10. Laboratory

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		at all labs and care and treatment sites	paper-based dashboard.	based dashboard.					
		Nominate and train VL focal point at each care and treatment and lab site (Laboratory and clinical interface)	25% of site implementing VL have designated VL focal points (lab, clinical and community) who organize regular coordination of multidisciplinary meetings on VL management (including dashboard monitoring)	50% of site implementing VL have designated VL focal points (lab, clinical and community) who organize regular coordination of multidisciplinary meetings on VL management (including dashboard monitoring)		HTXS/PDTX	[REDACTED]	CDC I-TECH	10. Laboratory
		Establish system to fast-track patients with non suppressed VL results (more than 1000 copies) and management of patients	50% of site implementing VL have effective SOPs in order to fast-track patients with non suppressed VL results (more than 1000 copies);	100% of site implementing VL have effective SOPs in order to fast-track patients with non suppressed VL results (under 1000 copies);		HTXS/PDTX	[REDACTED]	CDC I-TECH	10. Laboratory
		Conduct a gap analysis to prepare care and treatment sites to implement VL/EID scorecard	50% of sites are using the score-cards	100% of sites are using the score-cards		HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory
						HTXS/PDTX	[REDACTED]	HAI	10. Laboratory
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
						HTXS/PDTX	[REDACTED]	[REDACTED]	10. Laboratory	
			Establish HR expertise at national medical stores for specialized lab commodities through recruitment and training	100% of commodity technical working group members, key staff of the CNCAM and 25% of NPSP staff dedicated to the management of VL commodities are effectively trained	Trained commodity technical working group and the CNCAM and NPSP staff at MOH	Stock-out reports	HTXS	[REDACTED]	[REDACTED]IHS C-TA	10. Laboratory
			Develop SOPs and provide training on SOPs for management of lab commodities (at central and district levels)	Draft SOPs are developed and submitted for review	SOPs are approved by MoH and all staff are trained on the SOPs and the SOPs are effectively used in all attain and scale-up districts.		HTXS	[REDACTED]	[REDACTED]IHS C-TA	10. Laboratory
			Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	[REDACTED]	7. HRH
			Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	HAI	7. HRH
			Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	[REDACTED]	7. HRH

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	[REDACTED]	7. HRH
		Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	[REDACTED]	7. HRH
		Provide training on SOPs for management of lab commodities at site level				HTXS	[REDACTED]	[REDACTED]	7. HRH
5. Limited access to viral load testing for TB/HIV 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	Provide TA to the National TB Control Program and the National TB reference Laboratory to develop a comprehensive workplan for TB smear microscopy EQAs	PEPFAR/GF integrated workplan is available	PEPFAR/GF integrated workplan is available.	National Integrated TB/HIV workplan	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory
		Reinforce HR capacity to implement TB smear microscopy EQAS at 100% of TB laboratories	25% of TB Diagnosis/treatment centers' staff are trained on TB smear microscopy EQAS	50% of TB Diagnosis/treatment centers' staff are trained on TB smear microscopy EQAS	Training report	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory
		Provide mentorship program to monitor and sustain TB smear microscopy EQAs	25% of TB Diagnosis/treatment centers participate into the mentorship program and sustain TB	50% of TB Diagnosis/treatment centers participate into the mentorship program to monitor and sustain TB smear	Mentorship reports	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory

Table 6.1.3 Key Programmatic Gap #1: Low access to Viral Load (VL) testing									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
			smear microscopy EQAs	microscopy EQAS					
		Support through a mentorship program the implementation of WHO/AFRO accreditation scheme at two central labs and 10 CATs	two central labs and 10 TB treatment centers enrolled in WHO/AFRP scheme	2 central and 50% of TB treatment centers reach 3 stars	Number of lab WHO accredited	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory
		Sustain early TB diagnosis and MDR-TB detection using GeneXpert among TB/HIV co-infected patients and patients at risk for MDR-TB	Eight CATs equipped with GeneXpert and able to provide MDR-TB detection services to all TB/HIV co-infected patients	Eight CATs maintained with GeneXpert equipment and able to provide MDR-TB detection services to all TB/HIV co-infected patients	Number of site equipped with GeneXpert	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory
		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 in additional CATs	Procurement of GeneXpert to equip three additional CATs	Three additional CATs equipped with GeneXpert and provide MDR-TB detection services to all TB/HIV co-infected patients	Number of site equipped with GeneXpert	HVTB	[REDACTED]	CDC Lab Coalition	10. Laboratory
TOTAL							\$2,950,000		

Table 6.2.1 Test and Start

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
1. Lack of enabling policies for all tested positive to start on ART	Full implementation of SOP for clinical service sites.	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) workshop	Revised SOP and validated available for test and start		Number of clinical sites who realize test and start (Quarterly Report)			Ministry of Health - Follow-on	6. Service delivery
	MOH effectively manage, coordinate and supervise the national HIV response	Support monitoring, coordination meetings, site visits, supervision, participation in PEPFAR key events	1- Monthly, At least 50% quarterly coordination meeting; site visit ; supervision are held. Management capacity is built and trainings conducted	at least 75% of Monthly, quarterly and annual Coordination meetings, sites visits, supervisions are held	Number of coordination meeting and site visit reports available	HBHC/ HLAB/ HTXS/ HVSI/ HVTB/ OHSS/ PDCS/ PDTX	[REDACTED]	Ministry of Health - Follow-on	2. Policies and Governance
	Inclusion of Military Health Infrastructure in national Test and Start policy and implementation.	Support the development of CSLS/D strategic plan for the years 2018 to 2023 including test and start. Work together with the military leadership including the Director of DSASA, the military health chiefs, the Director of the military health school, the	N/A	The 2018-2023 CSLS/D strategic plan is developed with the contribution of all key partners under the leadership of the military high level hierarchy.	Availability of the new 2018-2023 CSLS/D Strategic Plan		OHSS	[REDACTED]	PSI

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		laboratory chiefs and others stakeholders.							
		Facilitate quarterly meetings between the CSLS/D and the Ministry of Health. This will include the health directors of each military branch and the DSASA.	N/A	Quarterly meeting effectively held	Quarterly meeting reports	OHSS	[REDACTED]	PSI	2. Policies and Governance
2. Limited financial resources to close coverage gap	Completion of costing reports for use by the MOH.	Conduct budgetisation of revised 2017 operational plan for HIV/AIDS (OHT (one health tool) consultancy plus 2 workshops of 25 attendees)	The budgetisation of the PSN will be done during this FY (taking in account Test and Start strategy)		Partner report			Abt/HFG	11. Domestic Resource Mobilization
	Host government contribution to fight against HIV/AIDS increases from \$12 million (2016) to \$40 million (2020)	Support MoH to develop an advocacy plan for DRM increase for HIV/AIDS program	A matrix for the implementation of the 2017 action plan for the mobilization of internal resources has been developed	Activity 2.3: Support MoH to develop an advocacy plan for DRM increase for HIV/AIDS program (HFG)	DRM is increased	OHSS	[REDACTED]	Abt/HFG	11. Domestic Resource Mobilization
		Conduct advocacy efforts (workshops/meetings) to get buy-in from other health sector donors (e.g. UNAIDS, WB,	GOCI contribution towards HIV/AIDS increases by \$7 million at least	GOCI contribution towards HIV/AIDS increase by \$7 million at least		the budget increase rate	OHSS	[REDACTED]	Ministry of Health - Follow-on

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		GF, French Cooperation etc.) and civil society for the request to increase GoCI contribution towards HIV/AIDS (donor round table, publications, conference, etc)							
	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)	Provide TA to MOH to effectively track accurate information on expenditure in HIV sector (HIV sub account of National Health Accounts)	MOH expenditure analysis report available (REDES)	MOH expenditure analysis report available (REDES)	REDES; National Aids Spending Assessment reports (NASA); SDS Table 2.2.2	OHSS	[REDACTED]	Abt/HFG	14. Financial and Economic Data
						OHSS	[REDACTED]	Ministry of Health - Follow-on	
3. Insufficient number of adequately trained HIV services providers at clinical and community levels	In-service training: training modules are updated and pool of national trainers updated in new training materials	Revise national training modules to reflect policy changes (test and start, new service delivery modules, task shifting, Key Pop, role of CHW, etc)	Training modules are updated to reflect Test and Start and Differentiated Care Models	Revised training modules are printed and disseminated	training on test and start and new service delivery model conducted with a pool of trainers updated	PDTX	[REDACTED]	Ministry of Health - Follow-on	7 HRH
		Train a pool of 150 national/regional trainers on revised policies (6 sessions of 3-day	50 Trainers are trained on revised policy	50 Trainers are trained on revised policy		PDTX	[REDACTED]	Ministry of Health - Follow-on	7 HRH

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		workshop of 25 people each)							
		Develop national in-service training plan to train MOH staff	COP16 Training plan available	COP17 Training plan is available				Ministry of Health - Follow-on	7 HRH
	Staff working at HIV care and treatment sites in districts targeted for ART saturation is motivated (PBF pilot jointly with World Bank and Global Fund)	Support implementation of PBF pilot phase in saturation and aggressive scale up districts (in collaboration with Global Fund and World Bank)	PBF is effectively implemented in all relevant sites	PBF is effectively implemented in all relevant sites (HFG)	DATIM	HTXS	[REDACTED]	[REDACTED]	7. HRH
						PDTX	[REDACTED]	[REDACTED]	7. HRH
						HTXS	[REDACTED]	HAI	7. HRH
						PDTX	[REDACTED]	HAI	7. HRH
						HTXS	[REDACTED]	[REDACTED]	7. HRH
						PDTX	[REDACTED]	[REDACTED]	7. HRH
						HTXS	[REDACTED]	[REDACTED]	7. HRH
						PDTX	[REDACTED]	[REDACTED]	7. HRH
						HTXS	[REDACTED]	[REDACTED]	7. HRH
						PDTX	[REDACTED]	[REDACTED]	7. HRH
						HTXS	[REDACTED]	[REDACTED]	7. HRH
						PDTX	[REDACTED]	[REDACTED]	7. HRH
	Community Health Workers (CHWs) are nationally	Build an advocacy case and obtain buy in from other health	Produce, share and agreed on a n evidence based report showing	Present case to the relevant GOCI authorities at different levels and across	Final report	OHSS	[REDACTED]	Abt/ HFG	7 HRH

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
	recognized as an essential cadre needed to reach HIV and health goals	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 (donor round table, publications, conference, etc)	different successful approaches using CHWs in conjunction with other donors and stakeholders	technical capacities (MOH, Ministry of finance)					
		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	Study tour organized and get MOH staff buy-in		Formal recognition of CHW in the national health system by the MOH			Ministry of Health - Follow-on	7. HRH
		Provide TA to MOH and national training institution resulting in standardized training package and recruitment process for CHWs	Standardized training package is adopted by the pre-service training institution	Advocacy for the recruitment of the CHWs		PDTX	[REDACTED]	HRSA ICAP Follow On	7. HRH
4. Inadequate national supply chain (central	uninterrupted availability of	Support 4 in-service training	90 percent of HIV commodities are	95 percent of HIV commodities are	eLMIS	HTXS/ HBHC	[REDACTED]	[REDACTED]	8 Commodity

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
and sub-national level) adapted to new service delivery models, Test and Start HIV Rapid Test Kits and consumables and VL testing scale-up	HIV commodities of good quality and at the right price at HIV service delivery points and Inventory management at district depots and health facility level are improved to prevent stockouts.	sessions for 500 Health personnel including district 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)	available at central level. At service delivery points stockout rates decrease from 10 percent to 5 percent.	available at central level. At service delivery points stockout rates decrease from 5 percent to 2 percent.				IHSC-TA	Security and Supply Chain
		Build capacity at NPSP in order to increase management capacities for lab commodities (VL; EID controls and reagents)	100 percent of commercial staff at NPSP are trained on standard management of lab commodities	Reinforcement and extension of training using lessons learned and what is most applicable for different settings	Training curricula; Training activity reports	HTXS/ HBHC	[REDACTED]	[REDACTED] IHSC-TA	8 Commodity Security and Supply Chain
		Support computer based Inventory management system at all PEPFAR supported districts and health facility level	35% of PEPFAR supported Districts Pharmacies	35% of PEPFAR supported Districts Pharmacies and health facilities at attained and scale-up Districts are using a computer based inventory system	Software-edited inventory reports at sites	OHSS	[REDACTED]	[REDACTED] IHSC-TA	8 Commodity Security and Supply Chain
		Support the revision of national Standard Operation Procedures for	Revised SOPs for effective quantification and forecasting which reflects test and			SOPs			Ministry of Health - Follow-on

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		quantification and forecasting which reflects T&S policy and new service delivery models	start and new service delivery are available						
		Support MoH in using LMIS data to inform decision making (procurement; emergency delivery, etc...)	Effective utilization of LMIS data by the MOH (400 sites)		LMIS Reports			Ministry of Health - Follow-on	8. Commodity Security and Supply Chain
		Support workshop to develop SOPs for HIV/AIDS commodities management within the context of new treatment policy	Procurement system is integrated and coordinated for HIV/AIDS commodities		CNCAM Activity Reports			[REDACTED] IHSC-TA	8. Commodity Security and Supply Chain
		Support revision and implementation of LMIS (paper-based and electronic) which reflect test and start, and VL testing and lab commodities	Improved quantification and forecasting capacity of HIV/AIDS commodities at country level both national and subnational		Quantification Reports			[REDACTED] IHSC-TA	8. Commodity Security and Supply Chain
		Provide support to Health Regions and health districts to conduct regular revisions of quantification of HIV/AIDS	Information shared; stock level balance shared among actors at regions		LMIS Feedback Reports			[REDACTED] IHSC-TA	8. Commodity Security and Supply Chain

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		commodities							
		Support the NPSP to review transport and distribution plan which reflects the changes imposed by T&S and new service delivery model.	Product Delivery Lead time are shortened from one month to two weeks	SOP developed, printed and disseminated Supervision visits conducted	Delivery schedule; Supply chain dashboard (order turnaround time)	HTXS/ HBHC/ PDCS/ PDTX	[REDACTED]	[REDACTED]	8. Commodity Security and Supply Chain
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	Develop, revise, reproduce and disseminate national HIV rapid test guidelines needed for the implementation of RTQII including misdiagnosis surveillance	HTC guidelines developed HTC integrated modules developed ; Quality manual for PT, certification and PMS developed	print and disseminate the documents	HTC guidelines; HTC training modules; Quality Manual	HLAB/ HVCT	[REDACTED]	CDC I-TECH	9. Quality Management
		Certify 1000 (50%) HIV testing sites and 250 Human Resources providing HIV testing	A pool of trained HIV testing certification assessors is created Regulatory documents and selection criteria for sites and human resources are developed	50 HIV testing sites certified 100 HIV testers certified	National RTQII database	HLAB/ HVCT	[REDACTED]	CDC I-TECH	9. Quality Management
		Implement post-marketing surveillance for HIV rapid tests at central (1) and key decentralize pharmacists (50)	Guidelines and SOP have been developed	PMS for HIV Rapid test conducted at the central lab and central pharmacy	PMS Database	HLAB/ HVCT	[REDACTED]	CDC I-TECH	9. Quality Management
		Implement the	PT program	PT program conducted	National RTQII	HLAB/	[REDACTED]	CDC	9. Quality

Table 6.2.1 Test and Start

Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		PT program in at 2000 testing sites/points including Blood transfusion laboratories	conducted in 2500 testing sites	in 2500 testing sites	database	HVCT	[CTED]	I-TECH	Management
		Print and distribute and analyze 1000 HIV Rapid Test log books and registers at 50% of testing posts	HIV testing registers are available at 50% of HIV testing sites	HIV testing registers are available at 100% of HIV testing sites	HIV testing Registers indicator reports	HLAB/ HVCT	[REDACTED]	CDC I-TECH	9. Quality Management
		Subcontract with laboratory technician and other health workers professional associations (midwives, nurses) for coaching supervision and certification of HIV testers	2 professional associations assessed	2 professional associations are involved in the certification process of 250 sites and 500 human resources	Reports of site and testers certifications	HLAB/ HVCT	[REDACTED]	CDC I-TECH	9. Quality Management
		Implement Step-wise Laboratory Quality Improvement Process Towards Accreditation (SLIPTA) in 50 laboratories located in 49 scale-up and sustained districts	conduct a LQMS training at 25 labs including 3 NBTS abs	conduct a LQMS training at additional 25 labs conduct a mentoring in 25 labs	Number of Lab technicians trained	HLAB	[REDACTED]	I CDC I-TECH	9. Quality Management
		Implement and sustain	conduct a LQMS training at all	conduct a LQMS training at all attained,	Number of sites enrolled	HLAB	[REDACTED]	CDC I-TECH	9. Quality Management

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		laboratory Quality Management System (QMS) at operational levels (districts and health facilities).	saturation districts	and remaining saturation and scale up for saturation districts	in the LQMS				
		Develop national policies, regulatory documents, guidelines and SOPs for biosafety and biosecurity	regulatory documents, SOP are developed	Biosafety procedures and measures implemented in 50% of PEPFAR implemented labs with all staff trained on the measures and labs equipped accordingly	Report on Biosafety assessment of the labs	HLAB	[REDACTED]	CDC I-TECH	9. Quality Management
		Strengthen the national laboratory and laboratorian network	Formalize a national laboratory task force Develop national policies, regulatory documents and guidelines Ministry technical working group established and responsible for coordination of laboratory efforts nationally	Sensitize lab professionals, MOH stakeholders National policies and procedures reviewed and updated Improved competency in the use of national policies, procedures and comprehensive plan for resource allocation Increased the efficiency in the use of strategic documents and laboratory resources for planning	Meeting reports	HLAB	[REDACTED]	CDC I-TECH	9. Quality Management
		Train 75% of members of laboratorian's professional association in QMS	2 laboratorians association are sensitized on the QMS	2 laboratorians associations are involved in QMS activities	Meeting reports	HLAB	[REDACTED]	CDC I-TECH	9. Quality Management
		Support NBTS to	10 lab workers	20 lab workers trained	Increased	HLAB	[REDACTED]	CDC	9. Quality

Table 6.2.1 Test and Start									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		develop procedures for HIV tests evaluation	trained		quality service availability of NBTS laboratories		<i>[CTED]</i>	I-TECH	Management
		Provide TA to NBTS program to improve commodities management	Procurement of 25% of lab reagents for HIV and hepatitis B and C and small supplies and equipment maintenance	Procurement of 25% of lab reagents for HIV and hepatitis B and C and small supplies and equipment maintenance		HLAB	<i>[REDACTED]</i>	CDC I-TECH	9. Quality Management
	HIV Misdiagnosis surveillance is implemented on the routine basis at all HIV testing sites	Conduct TOT and training of Health workers	Sites selection criteria are defined		Increased knowledge and skills of laboratory and other health facility personnel on biosafety and biosecurity	HLAB/HVCT	<i>[REDACTED]</i>	CDC I-TECH	9. Quality Management
		Implement misdiagnosis activity incrementally to reach 50% of testing posts at the end of the fiscal year	5% of testing points are assessed for accuracy of HIV tests results at their reference laboratories	5% of testing points are assessed for accuracy of HIV tests results at their reference laboratories		HLAB	<i>[REDACTED]</i>	CDC I-TECH	9. Quality Management
TOTAL						\$4,881,500			

Table 6.1.1 New Services Delivery Models

Table 6.1.1 New Services Delivery Models									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
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.	Support GOCI to revise national guidelines to reflect Test and Start and New Service Delivery models (2-3 day event, 25 people)	revised guidelines and validated available for test and start and new service delivery model		number of clinical sites who implement guidelines of new service delivery models			Ministry of Health - Follow-on	2. Policies and Governance
	Circular and other official documents are developed and disseminated to all service providers to implement Test and Start	Print and disseminate the revised guidelines (2,000 copies)	2000 copies of Revised guidelines disseminated in all clinical and community sites				Ministry of Health - Follow-on	2. Policies and Governance	
2. Inadequate monitoring of supply chain activities and inventory management at decentralized level of health system	Effective national logistics system is designed and implemented for community-based distribution of ARVs	Support design of community-ART distribution of HIV commodities	advocacy for community ART distribution	Community based logistic system is designed, including tools for CHWs	partner report	HTXS	[REDACTED]	[REDACTED]IHSC-TA	8 Commodity Security and Supply Chain
		Support small scale community-ART distribution of HIV commodities	n/a	CHWs deployed in one district for community ART distribution	partner report	HTXS	[REDACTED]	[REDACTED]	

Table 6.1.1 New Services Delivery Models									
Key Systems Barrier	Outcomes expected after 3 years of investment	Proposed COP 2017 activity	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	BC	Amount	IM	Relevant SID Element and Score
		Support training of CHWs on management and reporting on ART distribution	n/a	CHW oriented on logistics principles and commodities management	partner report	HTXS	[REDACTED]	[REDACTED]IHSC-TA	
		Support update of SOPs and LMIS to include community-ART distribution	n/a	Needs assessment conducted	partner report	HTXS	[REDACTED]	[REDACTED]IHSC-TA	
TOTAL							\$155,000		

Table 6.3 Other Proposed Systems Investments

Table 6.3 Other Proposed Systems Investments									
Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
Supply Chain Management	Oversee implementation of Maintain eLMIS system for health commodities	Sustained Epi Control	Commodities are stored in a good conditions, in order to maintain quality across the system.	eLMIS is deployed in 400 sites	eLMIS is deployed in 800 sites	eLMIS report	[REDACTED]	OHSS	[REDACTED]
							[REDACTED]	HVSI	[REDACTED]
	Implement eLMIS system across the supply chain system	Sustained Epi Control				Supply chain performance dashboard	[REDACTED]	HTXS/HVCT/PDTX	[REDACTED]IHSC-TA
	Use logistics data to inform decision making	Sustained Epi Control			framework of data analytics is developed	logistics information system is routinely reported	Data analytics framework	[REDACTED]	OHSS
						[REDACTED]	HVSI	[REDACTED]	
	Provide institutional support to Government institutions and locals organizations (CNCAM; NPSP) to strengthen supply chain	Sustained Epi Control		CNCAM is operational; NPSP has adequate competences to monitor	quarterly quantification workshops bi-annual	Supply chain performance dashboard	[REDACTED]	OHSS	[REDACTED]IHSC-TA

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
	functions, with a focus on quantification, forecasting and supply planning of health commodities (eg, quantification exercises, supply plan reviews)			commodities supply plan	forecasting workshops				
	Strengthen last mile distribution system for ARVs and lab commodities	Sustained Epi Control		last mile logistics system is designed between health districts depots and services delivery points	cars purchased	Supply chain performance dashboard	[REDACTED]	HTXS/OHSS	[REDACTED]IHSC-TA
	Support refurbishing and improvement of storage capacity of 45 health district depots.	Second 90; Third 90		15 of 45 health district depots are refurbished	8 additional health district depots are refurbished (@ \$100k each)	Completion report; Storage conditions check-list	[REDACTED]	OHSS/HTXS/HBHC/PDCS/PDTX/HVCT	[REDACTED]IHSC-TA
	Support improved storage and inventory management of health commodities at peripheral level of health system	Sustained Epi Control		Trained staff in 40 health districts on inventory management	Staff supported for 4 sub-offices that manage 82 districts	Supply chain performance dashboard	[REDACTED]	HTXS/HBHC/PDCS/PDTX/HVCT	[REDACTED]IHSC-TA
	Support design and implementation of efficient reverse logistics for health commodities	Sustained Epi Control		Reverse logistic system for health commodities is designed	Reversed logistics system in implemented between Health Districts and central medical stores	Report on unusable health commodities	[REDACTED]	OHSS/HTXS/HVCT	[REDACTED]IHSC-TA
	Provide independent, essential, comprehensive quality assurance/control services covering the different health elements. Examples include but is 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	Sustained Epi Control	Quality of health commodities is monitored and in-country quality management system is improved.	QA needs assessment conducted at LNSP and NPSP	Lab infrastructure and Equipment improved for quality control of ARVs at LNSP; Quality Assurance System at NPSP is re-designed.	Quality assurance report	[REDACTED]	HTXS/PDCS/PDTX/HVCT/HLAB	GHSC QA

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
	drug regulatory authority responsible for in-country supply chains.								
Institutional/ Organizational Development	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	CCM received TA for the use of GF dashboard, for site visit	Continue the CCM support activity in COP 17	GF proposals (quality and timeliness of submissions)	[REDACT ED]	OHSS	[REDACT ED]
	Provide TA to MOH for development and implementation of national policies in priority areas, such as quality improvement, private sector services, youth services, etc.	First 90; Second 90;	GoCI has a national quality assessment / improvement policy and technical guidelines which is being implemented by the clinical partners	National quality improvement framework and operational plan for health services is finalized and validated.	Technical guidelines for QI disseminated and implemented at site level.	GoCI documents and technical guidelines.	[REDACT ED]	OHSS	ASSIST
	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 SNUs where PEPFAR supports HIV care and treatment services in private sector	PP platform is in place under the lead of the health district in SNUs where PEPFAR supports HIV care and treatment services in private sector	This activity need to be continued	Meeting notes; Reports; Memorandum of Understanding.	[REDACT ED]	OHSS	Abt/PSHP
	Provide TA for nutritional service delivery system strengthening	Sustained Epi Control	Improved skills of districts, health and community providers to address quality issue in nutrition interventions	Extend in Attained districts	pursue extension in scale up districts	reports of training and supervision	[REDACT ED]	OHSS	FANTA ₃
			Nutrition behavior change communication strategies widely disseminated.	Nutrition behavior change communication strategies integrated at attained district sites.	Nutrition behavior change communication strategies integrated at aggressive scale-up districts at community and health facility	Copy of BCC strategy on sites quarterly meeting report	[REDACT ED]	PDCS	FANTA ₃

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
					levels.				
			Reinforced data collection system, analysis and coordination by the PNN	n/a	PNN prepares and holds quarterly meetings with partners to analyze results based on data collected at sites.		[REDACTED]	MTCT	FANTA ₃
							[REDACTED]	PDCS	FANTA ₃
Laboratory strengthening	Procure EQA panels for laboratory monitoring tests in order to enroll all PEPFAR supported laboratories into an international external quality assurance programs and support EQA related activities	First 90; Third 90;	All PEPFAR supporter laboratories are enrolled and pass EQA for HIV testing, VL, EID, TB and clinical tests	80% of PEPFAR supported laboratories are enrolled and pass EQA for HIV testing, VL, EID, TB and clinical tests	90% of PEPFAR supported laboratories are enrolled and pass EQA for HIV testing, VL, EID, TB and clinical tests	EQA reports available	[REDACTED]	HLAB	RETROCI
	Provide TA to the lab network through coaching supervision, on site training for VL, EID, SIMS visit, and lab related activities	First 90; Third 90;	All PEPFAR supported laboratories have improved laboratory processes and provide accurate and timely HIV RT and HIV monitoring test	25% of PEPFAR supported laboratories are coached through regular site supervision and have improved processes (accurate and timely results)	50% of PEPFAR supported laboratories are coached through regular site supervision and have improved processes (accurate and timely results)	Availability of coaching and supervision reports and SIMS dashboard	[REDACTED]	HLAB	RETROCI
	Evaluate new HIV related laboratory methods and techniques to improve testing capacities of the National HIV program (including self-testing)	First 90; Third 90;	Periodic Revision HIV RT and HIV monitoring test algorithm	Number of HIV testing and HIV monitoring test algorithm revised according to evaluation reports including new POC, HIV rapid test, HIV self-testing	Number of HIV testing and HIV monitoring test algorithm revised according to evaluation reports including new POC, HIV rapid test, HIV self-testing	Report summarizing Number of POC, New techniques and HIV RT evaluated	[REDACTED]	HLAB	RETROCI
	Provide TA to Institut Pasteur to improve STI and TB related diagnostics at central labs, 10 regional labs and at all TB diagnosis centers	Third 90; Sustained Epi Control	Improve TB, STI diagnosis and increase access to STI diagnosis at PEPFAR supported laboratories	50% of laboratories provides timely and accurate STI testing; 50% of TB treatment centers have improved diagnosis	80% of laboratories provides timely and accurate STI testing; 80% of TB treatment centers have improved diagnosis	Site supervision reports and EQA reports	[REDACTED]	HVTB	ASM

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
	Train staff from 5 military labs of the labs on preventative maintenance of equipment, and management of lab inputs, and help them to develop 200 quality related tools.	First 90; Third 90; Sustained Epi Control	5 labs will have achieved 5 stars in SLMTA scoring	n/a	Corrective action and increase in star level of 5 labs	SLMTA scoring	[REDACTED]	HLAB	PSI
	Coordinate PEPFAR-supported lab activities on a quarterly basis	First 90; Third 90; Sustained Epi Control	Effective coordination of PEPFAR laboratory activities by MOH	Implementation of quarterly coordination meetings by the National Public Health Laboratory	Implementation of quarterly coordination meetings by the National Public Health Laboratory	Quarterly coordination meetings reports	[REDACTED]	HLAB	Ministry of Health - Follow-on
	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	50% of laboratories provides timely and accurate OIs testing; 50% of TB treatment centers have improved diagnosis	80% of laboratories provides timely and accurate OIs testing; 80% of TB treatment centers have improved diagnosis	Site supervision reports and EQA reports	[REDACTED]	HVTB	IPCI Follow On
	Strengthen Human Resource capacity at central and at 10 regional labs for TB and OIs diagnosis	First 90; Second 90; Third 90; Sustained Epi Control		50% of laboratories are adequately staffed to provide timely and accurate results for OIs and TB testing;	80% of laboratories are adequately staffed to provide timely and accurate results for OIs and TB testing;	Number of person trained on TB and OIs diagnosis	[REDACTED]	HVTB	IPCI Follow On
	Enroll all TB and OIS laboratories in a national and international EQA program.	Third 90; Sustained Epi Control		Enroll all TB and OIs laboratories in a national and international EQA program.	Enroll all TB and OIS laboratories in a national and international EQA program.	EQA reports	[REDACTED]	HVTB	IPCI Follow On
	Organize hubs around regional labs for high laboratory impact in collaboration with the new international lab partner.	Third 90; Sustained Epi Control		50% of laboratories provides timely and accurate OIs testing; 50% of TB treatment centers have improved diagnosis	80% of laboratories provides timely and accurate OIs testing; 80% of TB treatment centers have improved diagnosis	Site supervision reports and EQA reports	[REDACTED]	HVTB	IPCI Follow On

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
Strategic Information	Support CSLS and the military health system to improve their reporting through the use of the DHIS2 MIS system.	First 90; Second 90; Sustained Epi Control	Capacity developed among the CSLS and the military health system to use nationally adopted MIS data management systems	Provision of equipment, training, follow up and supervision	Military treatment sites have access to paper-based and well maintained electronic tools.	Quarterly reports	[REDACTED]	HTXS HVCT HVSI PDTX	PSI
	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. All treatment sites in priority districts have access to electronic tools. Real time data available in saturation and aggressive scale-up districts.	Electronic tools are deployed and interoperability between the tools is in progress.	Interoperability between electronic tools functional	- Field Assessment - Availability of real-time data	[REDACTED]	HVSI	Measure Evaluation
	Improve data use at central, regional and district levels	Sustained Epi Control	Development of data use SOPs for all districts, systems dashboards, monthly data use report by districts, regions and at central level	- Monthly Report by districts are based on SOPs - National Data use workshop	Data use is integrated in MoH routine reporting activities.	Dissemination of SOPs at central, regional and districts levels.	[REDACTED]	HVSI	Measure Evaluation
	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	- Deployment planning of the tools (SIGDEP2) - Electronic tools are deployed	Electronic tools (eLMIS, SIGDEP2 EMR and OVC database) are used routinely by all sites, districts and central levels Improved quality of patient tracking and retention in	EMR indicator Field Assessment	[REDACTED]	HKID HTXS HVSI MTCT PDTX	Measure Evaluation

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
					treatment with mhealth tools				
	Conduct OVC program outcomes evaluation (EGPAF Kenya & HOPE-CL Project evaluation)	First 90; Third 90; Sustained Epi Control	Collection of OVC essential survey indicators that address the HIV status, protection, education and wellbeing.	Data collection and dissemination of final results		Final report disseminated			FH1360/ ISPEC
	Reproduce revised 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	Data collection tools available in all the sites	Data collection tools available in all the sites	Data Collection tools stock assessment	[REDACT ED]	HTXS HVCT HVSI MTCT HVTB PDTX	Ministry of Health - Follow-on
	Conduct supervision, assess performance of the RHIS, Quarterly data validation workshops; deploy paper - based and electronic tools and maintenance; Strengthen security and confidentiality at site and central level	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.	Availability of preliminary reports (RHIS Report, HIV Report, deployment of paper-based and electronic tools)	Availability of preliminary reports (RHIS Report, HIV Report, deployment of paper-based and electronic tools)	Final Reports Dissemination	[REDACT ED]	HVSI	Ministry of Health - Follow-on
	Ensure data quality improvement (Data quality audit for ART, OVC, PMTCT and HTC, Routine checks along the data flow process)	Sustained Epi Control	Improved data quality and program monitoring across technical areas at sites level.	Availability of data quality strategy including data quality assurance, data flow analysis, M&E procedures.	Data quality audit preliminary findings results	Data quality audit final report	[REDACT ED]	MTCT	UCSF TA
[REDACT ED]							HTXS	UCSF TA	
[REDACT ED]							HKID	UCSF TA	
[REDACT ED]							HVCT	UCSF TA	
	Deploy and maintain OPENLIS and OPENLIS Basic on ART sites	First 90; Second 90; Sustained Epi Control	Improved lab quality patient records and patient clinical outcomes	Deployment and maintenance of OPENLIS in 6 regional labs and OPENLIS Basic in 45 districts lab	Deployment and maintenance of OPENLIS in 14 regional labs and OPENLIS Basic in 95 labs districts	- Deployment plan and monitoring report - Sites supportive visit report	[REDACT ED]	HVSI	CDC I-TECH
	Conduct Violence Against	Sustained Epi	Frequencies and types	Approved and	Data collection and	Final report	[REDACT ED]	HKID	MSFFPE

Table 6.3 Other Proposed Systems Investments

Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
	Children Study (VACS)	Control	of violence against children are known and this information is being used to change policies and programming	validated protocol by all relevant Ethics Committees	dissemination of final results	disseminated	ED]		CoAg
	Conduct HIV and associated risk factors among MSM (SHARM) in San Pedro		HIV prevalence among MSM related sexual behaviors within largest urban centers (San Pedro)	Data collection and dissemination of final results		Final report disseminated			FHI360/ ISPEC
	Conduct biological and behavior survey among KPs (FSWs) including mapping and size estimation	First 90; Second 90; Sustained Epi Control	Data on HIV prevalence among KP, KP related sexual behaviors within largest urban centers (San Pedro, Guiglo, Korhogo, Man)	Approved and validated protocol by all relevant Ethics Committees	Data collection and dissemination of final results	Final report disseminated	[REDACT ED]	HVOP	FHI360/ ISPEC
	Conduct biological and behavior survey among stable partners of FSWs	First 90; Second 90; Sustained Epi Control	Data on HIV prevalence among stable partners-related sexual behaviors in Abidjan	Approved and validated protocol by all relevant Ethics Committees	Data collection and dissemination of final results	Final report disseminated	[REDACT ED]	HVOP	FHI360/ ISPEC
	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	Approved and validated protocol by all relevant Ethics Committees	Data collection and dissemination of final results	Final report disseminated	[REDACT ED]	HVSI/MT CT	Ministry of Health - Follow-on
	Conduct HIV Drug Resistance Early Warning Indicators	Sustained Epi Control	PEPFAR Program effectiveness monitoring, patient monitoring, retention, ARV drugs availability to avoid occurrence of ART drug resistance	Approved and validated protocol by all relevant Ethics Committees	Data collection and dissemination of final results	Final report disseminated	[REDACT ED]	HVSI	Ministry of Health - Follow-on
	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	Staff are trained and small area estimates are available		Small area estimates are disseminated			CDC-UNAIDS Central mechanism

Table 6.3 Other Proposed Systems Investments									
Systems Category	Activity	Impact	Outcomes expected after 3 years of investment	Year One annual benchmark (COP 2016)	Year Two annual benchmark (COP 2017)	Measurement Tool	Amount	BC	IM
			(PLHIV estimation, prevalence,)						
	Assess the clinical and immunological outcomes of adult PLHIV on ART	First 90; Second 90; Sustained Epi Control	Availability of adults data on HIV prevalence, Retention of patients on treatment, LTFU, mortality, adherence	Data collection and dissemination of final results		Final report disseminated			FH1360/ ISPEC
Total							7,239,177		