Côte d'Ivoire

Country Operational Plan

(COP/ROP) 2019

Strategic Direction Summary

May 31, 2019

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Table of Contents

1.0 Goal Statement

2.0 Epidemic, Response, and Program Context
- 2.1 Summary statistics, disease burden and country profile
- 2.2 Investment profile
- 2.3 National sustainability profile update
- 2.4 Alignment of PEPFAR investments geographically to disease burden
- 2.5 Stakeholder engagement

3.0 Geographic and population prioritization

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations
- 4.1 Finding the missing, getting them on treatment, and retaining them
- 4.2 Prevention, specifically detailing programs for priority programming
- 4.3 Additional country-specific priorities listed in the planning level letter
- 4.4 Commodities
- 4.5 Collaboration, Integration and Monitoring
- 4.6 Targets for scale-up locations and populations

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations
- 5.1 COP19 programmatic priorities
- 5.2 Targets for attained and sustained locations and populations
- 5.3 Establishing service packages to meet targets in attained and sustained districts

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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

Appendix A - Prioritization

Appendix B- Budget Profile and Resource Projections

Appendix C- Tables and Systems Investments for Section 6.0

Appendix D – Minimum Program Requirements

1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) program in Côte d'Ivoire's (PEPFAR-CI) vision for the Fiscal Year (FY) 2020 is focused on addressing systemic barriers and ensuring that at least 95% of individuals initiated on treatment are retained in treatment services and receive high quality services, and that key policies are implemented to achieve the Joint United Nations Program on HIV/AIDS (UNAIDS) 90:90:90 goals. Under the leadership of the Government of Côte d'Ivoire (GoCI), PEPFAR-CI and stakeholders have adopted these goals to address specific gaps in the program:

1. Immediate, full adoption of policies, including: TLD for all patients, 6 month dispensing for stable patients, and elimination of user fees for HIV services
2. Joint monitoring with the Ministere de la Santé et l'Hygienne Publique (MSHP), Civil Society Organizations, and local governors to ensure health policies and work practices of health care providers are being implemented and enforced
3. Geographic prioritization to focus resources in 60 districts (instead of 86) and prioritize the 140 highest volume sites for maximum impact
4. Regionalization of implementing partners for improved coordination
5. New joint evaluation of clinical and community partners at the site level to ensure closer collaboration in case finding, linkage and retention, and intensive partner monitoring
6. Human resources for health (HRH) redistribution based on site volume and prioritization
7. Patient-centered approach to address barriers preventing access to HIV health services, including reduced number of visits to the health facility and improved patient clinical flow

In FY2020, PEPFAR-CI will focus on 140 priority sites representing approximately 70% of individuals on treatment with intensified efforts to ensure linkage of > 95% and retention of > 95% in all ages and sex bands. Intensive joint site level monitoring by USG, MSHP, and clinical and community partners will continue at the 140 sites while limiting testing to ensure retention challenges are resolved before sites scale up case finding. The implementation of the unique patient identifier for HIV services and increased use of the EMR will improve tracking of patients, data reporting, and monitoring.

PEPFAR-CI and MSHP leadership will implement a new collaborative framework for community-clinical linkages, to ensure that services are centered around the needs of patients at the site level along the continuum of HIV services. Additional focus on increasing viral load (VL) coverage from 78% to 92% and suppression from 78% to 90% in FY2020 is essential to monitoring the impact of the response and reaching epidemic control. Populations with low prevalence but high vulnerabilities - Orphans and Vulnerable Children (OVC) and adolescent girls and young women (AGYW) - will benefit from primary prevention services. The continued implementation of targeted pre-exposure prophylaxis (PrEP) among high-risk groups (AGYW, key populations, and sero-discordant couples) remains a critical element in FY2020 for averting new infections.

The program is addressing the high AIDS-related mortality by increasing opportunities for early HIV diagnosis with index and self-testing, increasing access to early infant diagnosis (EID), ensuring continued same day ART initiation, and addressing comorbidities by introducing testing and treatment for cryptococcal meningitis, TB urinary (LAM) testing, and scaling up TB preventive therapy.

PEPFAR-CI is re-engaging with GoCI leadership to improve monitoring and program performance, leveraging multi-level engagement with stakeholders and the Embassy Front Office.

2.0 Epidemic, Response, and Program Context

Côte d'Ivoire has an estimated total population of 25,097,521 in 2018 (National Institute of Statistics - INS) of which males account for 51% (12,796,311) and females 49% (12,301,201). The estimated Ivoirian population under 15 years of age is 10,026,419, representing 40% of the total population. The 2017/2018 population based HIV Impact Assessment (PHIA) found an HIV prevalence of 2.9% for 15 to 64 year olds. PHIA also found a prevalence of 2.5% among the 15 to 49 years old population, which is much lower than the 3.7% reported in the 2011/2-12 DHS for the same age group. Much higher estimates exist among female sex workers (FSW) and men who have sex with men (MSM) (11.4%[1] and 12.33% respectively). The 2019 UNAIDS Spectrum estimates, using the PHIA results, noted a total PLHIV of 458,434, including 32,000 children living with HIV, and approximately 32,000 OVC and 19,000 pregnant women needing ARVs. Annually, there are approximately 18,000 new HIV infections (2,700 among children) and 15,000 AIDS-related deaths in Côte d'Ivoire.

Côte d'Ivoire has made substantial progress towards reaching HIV epidemic control over the past ten years. With a total PEPFAR-CI investment of almost $1.6 billion, an investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) of $164.7 million to date, and increasing GoCI financial contributions and efforts, the number of PLHIV on antiretroviral therapy (ART) has increased from 4,536 in 2004 to 248,195 in 2018. The success of Option B+ is specifically contributing to the achievement of the first 90 goal, specifically for women, of the Joint United Nations Program on HIV/AIDS (UNAIDS) 90:90:90 goals.

[1] 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."

Despite advances, the country still faces obstacles in achieving epidemic control. Major retention and linkage issues have been identified and considerable gaps still exist in identifying HIV-infected men and children, and linking them to treatment services. Viral suppression remains low among children 0-14 years old (54%), with varying rates among finer age bands (approximately 50-90%). Gaps along the clinical cascade are significantly greater for men, where most HIV-positive young and adolescent men remain unidentified and most men 25+ who are diagnosed are not linked to treatment.

Recent measures by the Government of Côte d'Ivoire and intensified PEPFAR-CI efforts will have positive impact on these deficits. Beginning in January 2017, President Alassane Ouattara has demonstrated more attention on the health sector, which has historically seen less public investment than infrastructure, education, and other sectors contributing to strong economic growth. The national response now aligns with PEPFAR-CI's strategy on focused testing to increase HIV-positivity yield, with written guidance distributed in October 2017. The nationwide adoption of Test and Start, multi-month scripting, and implementation of the circular to abolish all user fees in public health facilities, are contributing to better enrollment in treatment services. As of March 2018, 100% of PEPFAR-supported ART sites were implementing Test and Start. FY2019 also continues to place increased attention on addressing the programmatic and systems gaps in retention, case identification, linkage to services for children, KP, AGYW 15-24 years of age, and men, also on expanding access to and uptake of VL testing nationwide. Progress in these areas will significantly accelerate the country's achievement of the 90:90:90 goals.

Table 2.1.1

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	25,097,512		4,962,373	19.8%	5,064,047	20.2%	2,339,859	9.3%	2,414,014	9.6%	4,998,969	19.9%	5,318,250	21.2%	Spectrum 2019
HIV Prevalence (%)		2.9		0.2%		0.2%		0.9%		0.3%					CIPHIA 2017-2018
AIDS Deaths (per year)	15,756		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Spectrum 2019
# PLHIV	458,434		15,442		15,989		29,271		14,275		231,318		152,138		Spectrum 2019
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)	18,579														Spectrum 2019
Annual births	1,221,815														National program
% of Pregnant Women with at least one ANC visit		85	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			MICS Survey 2016
Pregnant women needing ARVs	19,166														Spectrum 2019
Orphans (maternal, paternal, double)	230,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		UNAIDS report 2018
Notified TB cases (Yr)	25,299		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data

% of TB cases that are HIV infected	5,551		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data
% 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	
Estimated Population Size of MSM*	31,348														Program Estimates 2019
MSM HIV Prevalence		11.6													IBBS 2015-2016
Estimated Population Size of FSW	51,058														Program Estimates 2019
FSW HIV Prevalence		11.4													IBBS 2014
Estimated Population Size of PWID	Data N/A	Data N/A													
PWID HIV Prevalence	Data N/A	Data N/A													
Estimated Size of Priority Populations (Military)	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	SABERS 2014
Estimated Size of Priority Populations Prevalence (specify)															

Table 2.1.2

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	25,097,512	2.9	458,434	271,616	255,612	56%	78%	2,300,758	76,276	61,346
Population <15 years	10,026,419		31,431		10,269	33%	54%	306,288	3,171	2,762
Men 15-24 years	2,414,014		14,275		4,204	29%	57%	110,126	1,889	960
Men 25+ years	5,318,250		152,138		61,563	40%	79%	391,944	23,354	17,326
Women 15-24 years	2,339,859		29,271		13,493	46%	68%	555,238	7,678	5,393
Women 25+ years	4,998,969		231,318		166,082	72%	80%	937,162	40,184	34,905
MSM	31348	11.6						13,824	1,439	1,255
FSW	51058	11.4						42,904	3,620	2,635
PWID										
Priority Pop (specify)										

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

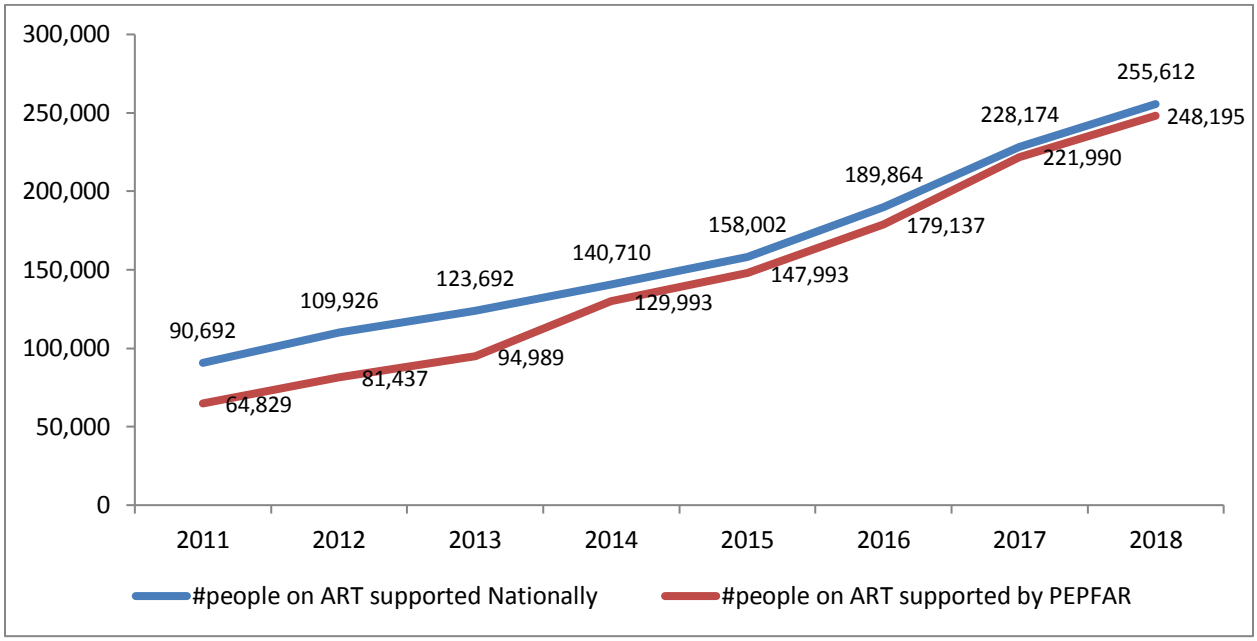
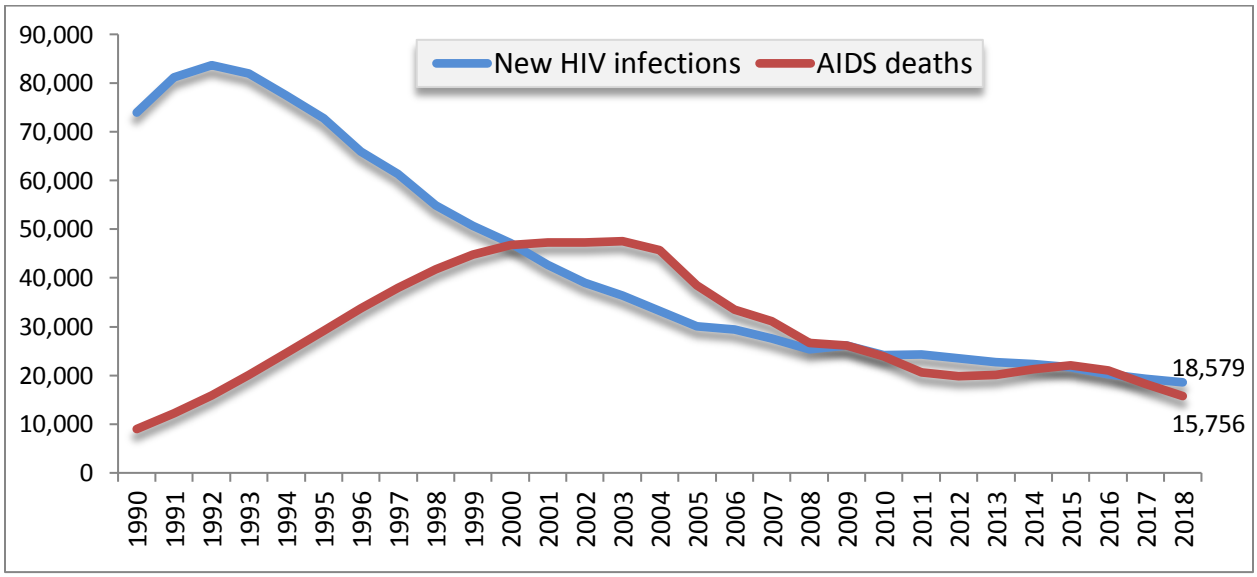


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV



2.2 Investment Profile

The government is committed to ensuring equitable access to quality health services for all Ivoirians. This commitment is iterated in the 2016-2020 National Health Development Plan (PNDS). The GoCI recently signed up for the Global Financing Facility (GFF), a country-led and innovative approach to financing, which will help significantly increase investments in health. As a catalyst for a health investment platform, the GFF supported the development of the investment case to prioritize high-impact interventions required to achieve the goals set in the health development plan. The PNDS was presented during the first ever 3-day, April 15-18, 2019, National Dialogue on Health Financing chaired by the Vice-President of the Republic of Côte d'Ivoire.

As stated in the 2020-2023 Investment Case for Health launched during the National Dialogue on Health Financing, the health budget represents 6% of the national total budget. This is very low despite the continuous economic growth that Côte d'Ivoire has experienced during the past seven years. Household payments and foreign investments cover 60% of the total health expenditures. This high dependency on external resources is a serious threat to continuity of funding for health services.

An analysis of the investments in the health sector from 2016-2018 suggests that the U.S. government was the largest foreign contributor to health, accounting for 15% of heath investments, second to the GoCI with 62.05%.

The most recent National AIDS spending assessment for Côte d'Ivoire was conducted in 2012; therefore Table 2.2.1 is not included. Instead, below is a table which illustrates the most recent financial information on heath investments in Côte d'Ivoire.

Funding Source	**Total 2016-2018**	**%**
MSHP	$1,456,828,886	62.05%
USG	$353,801,567	15.07%
The Global Fund	$266,620,304	11.36%
GAVI	$73,834,785	3.14%
WFP	$51,860,650	2.21%
World Bank	$47,258,734	2.01%
French Development Agency (AFD)	$26,114,742	1.11%
UNFPA, KOIKA, Muskoka	$23,181,236	0.99%
KFW	$21,381,619	0.91%
UNICEF	$8,619,123	0.37%
Others	$18,472,727	0.79%
Total	$2,347,974,372	

Source: Adapted from 2020-2023 Investment Case for Côte d'Ivoire, April 2019 (1$ to 550 CFA)

Table 2.2.2

Table 2.2.2 Procurement Profile of Key Commodities (Jan. -Dec. 2018*)									
Commodity Category	**Total Expenditures**	**PEPFAR**	**% PEPFAR**	**GF**	**%GF**	**GoCI**	**% GoCI**	**UNITAID**	**% UNITAID**
ARVs	$27,836,829	$7,510,690	27%	$12,409,719	45%	$7,916,420	28%		0%
Rapid test kits	$3,924,005	$47,000	1%	$3,179,732	81%	$697,273	18%		0%
Other drugs (CTx, STI kits)	$1,083,699	$7,037	1%	$0	0%	$1,076,662	99%		0%
Lab reagents	$2,201,389	$638,591	29%	$1,067,888	49%	$494,910	22%		0%
Viral Load reagents	$5,157,500	$3,293,289	64%	$624,341	12%	$970,683	19%	$269,187	5%
TB(Genexpert) commodity	$152,173	$0	0%	$152,173	100%		0%		0%
Condoms	$731,508	$731,508	100%		0%		0%		0%
Other supplies	$324,824	$171,507	53%		0%	$153,317	47%		0%
Total	**$41,411,926**	**$12,399,621**	**30%**	**$17,433,853**	**42%**	**$11,309,265**	**27%**	**$269,187**	**1%**

Table 2.2.3

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**
USAID MCH	$2,000,000	$0	0	$0
USAID TB	$0	$0	0	$0
USAID Malaria	$25,000,000	$4,959,080	3	$29,959,080
Family Planning	$2,000,000	$0	0	$0
NIH	$0	$0	0	$0
CDC (Global Health Security)	$1,527,680	$0	0	$0
Peace Corps	$0	$0	0	$0
DOD Ebola	$0	$0	0	$0
MCC	$0	$0	0	$0
Total	**$30,527,680**	**$4,959,080**	**3**	**$29,959,080**

Table 2.2.4

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP					
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**
DREAMS Innovation	$0	$0	$0	0	$0
VMMC – Central Funds	$0	$0	$0	0	$0
Other PEPFAR Central Initiatives	$0	$0	$0	0	$0
Other Public Private Partnership	$0	$0	$0	0	$0

Total	$0	$0	$0	0	$0

2.3 National Sustainability Profile Update

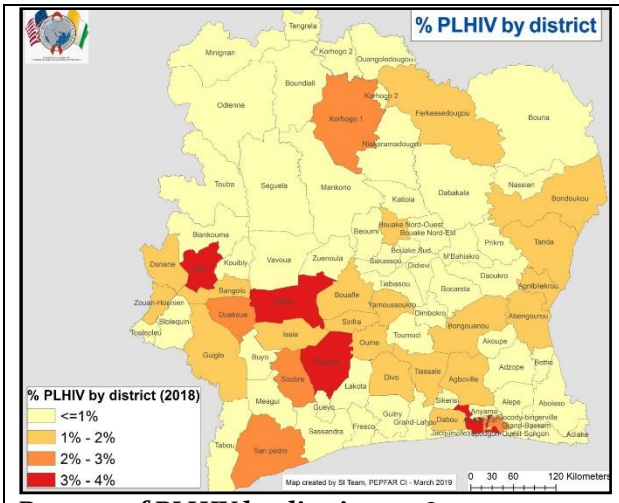
In general, Côte d'Ivoire has made progress on the majority of the sustainability elements. Despite this notable progress, the program is still struggling in some areas with persistent vulnerabilities. Such elements include policies and governance, technical and allocative efficiencies, and epidemiological and health data. In COP19, PEPFAR-CI will partake in a number of above-site interventions aiming to improve the score for sustainability elements with very low scores. PEPFAR-CI is also collaborating with the MSHP and other health sector donors to continue oversight on sustainability elements with good scores.

Sustainability Elements	SID 2.0 (2015)	SID 3.0 (2017)	Change between 2015 and 2017
1. Planning and Coordination	6.50	9.50	3.00
2. Policies and Governance	3.95	4.56	0.61
3. Civil Society Engagement	5.93	6.46	0.53
4. Private Sector Engagement	6.02	6.50	0.48
5. Public Access to Information	8.00	8.00	-
6. Service Delivery	7.04	6.48	(0.56)
7. Human Resources for Health	7.92	7.20	(0.72)
8. Commodity Security and Supply Chain	4.24	5.61	1.37
9. Quality Management	4.43	5.57	1.14
10. Laboratory	4.49	6.00	1.51
11. Domestic Resource Mobilization	4.72	6.79	2.07
12. Technical and Allocative Efficiencies	3.63	5.06	1.43
13. Epidemiological and Health Data	5.95	5.48	(0.47)
14. Financial/Expenditure Data	5.93	6.67	0.74
15. Performance Data	7.00	7.40	0.40

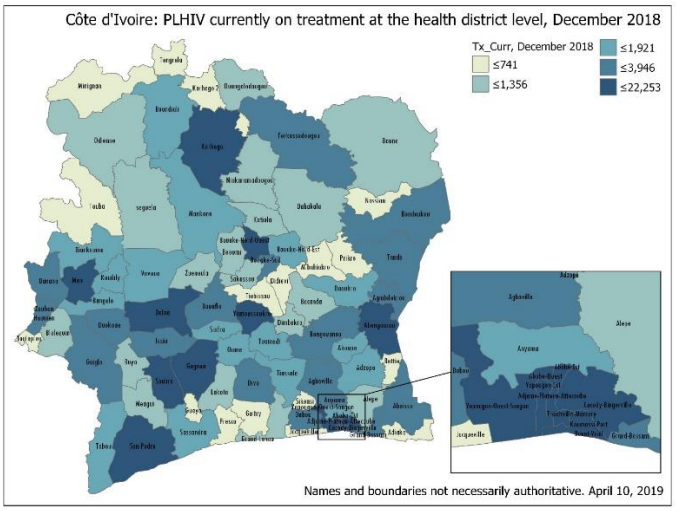
2.4 Alignment of PEPFAR investments geographically to disease burden

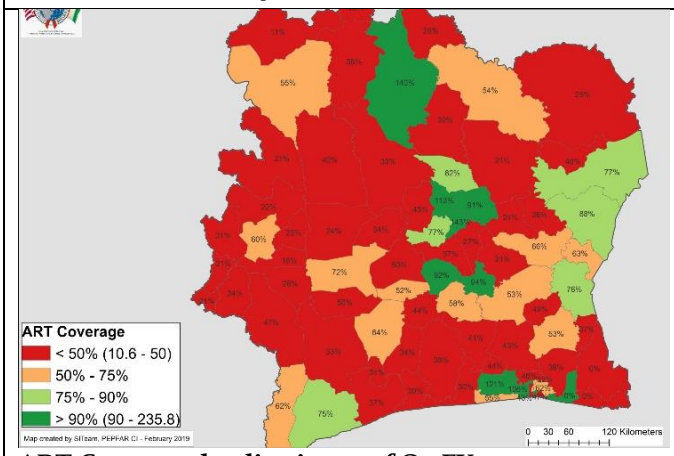
In COP19, PEPFAR investments will support 60 of the 86 districts in Côte d'Ivoire, with the majority of investment provided to 140 priority sites, which account for 70% of people on HIV treatment (as of December 2018). Additional details are provided in Section 3.0. General community support will be concentrated at the 140 priority sites, with no PEPFAR investments in general community programming in districts with no priority sites. OVC programming will focus in 58 of the 60 priority districts, KP programming will focus in 42 districts based on KP population density and hot-spots, and DREAMS will remain in the same 4 districts as COP18. While there will be investments at the facility level in the 795 sustained sites, PEPFAR support and investments will be provided with less intensity. Additional details are provided in Section 5.3 (see Figure 2.4.1 for COP19 PEPFAR geographic presence).

Figure 2.4.1 Number of PLHIV, Treatment Coverage and Viral Load Testing Coverage

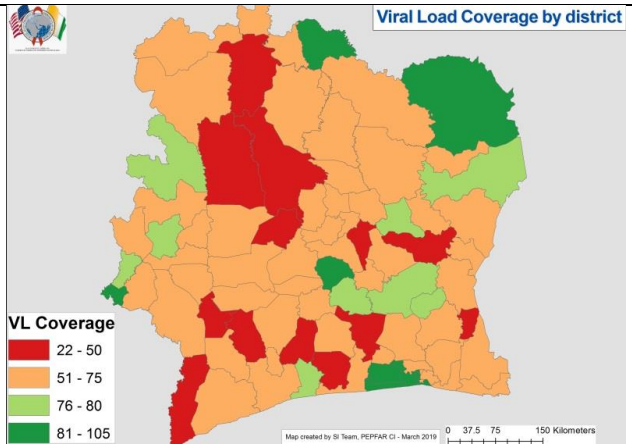


Percent of PLHIV by district, 2018





ART Coverage by district as of Q2 FY2019



Viral Load Coverage by district as of Q2 FY2019

2.5 Stakeholder Engagement

From the beginning of the COP19 process, PEPFAR-CI has engaged many critical stakeholders including: the Government of Côte d'Ivoire (GoCI) - Minister of Health, Director General of Health (DGS), and the National AIDS Control Program (PNLS); Civil Society Organizations (CSOs); and bilateral and multilateral partners such as UNAIDS, WHO, GF, and the French Embassy. The PNLS and CSOs have been engaged in the review of COP implementation throughout the year, notably through the quarterly and day-long pre- or post-PEPFAR Oversight and Accountability Results Team (POART) meetings organized by the PEPFAR Coordination Office (PCO). Documents outlining recommendations from these meetings have been shared with all partners on a regular basis.

Notable examples of Côte d'Ivoire's high-level engagement in the COP19 process include the following:

- The President of Côte d'Ivoire recently hosted Festus Mogae, former president of Botswana and Chair of Champions for an AIDS-Free Generation. This meeting focused on increasing GoCI domestic resources in the health sector and abolishing user fees for HIV-related patients in Côte d'Ivoire.
- For the first time the Minister of Health participated in the COP19 approval meeting held in Washington, DC April 24-26, 2019, and the GoCI was represented by the DGS in Johannesburg, South Africa for the Regional Planning Meeting (RPM).
- A Circular was signed during the RPM where the GoCI took formal action to remove all user fees in public health facilities and support the 6 months ARV prescription for stable patients.

The stakeholder engagement calendar below provides a detailed overview of how PEPFAR-CI engaged these stakeholders and involved them in the development of COP19.

Date	**Objective**	**Outcomes**	**Next steps**	**Comments**
Before COP19 Submission				
01/23/2019	PEPFAR-CI share with stakeholders: The COP19 development process, the PLL COP19 overview	Stakeholders understand the COP process Stakeholders understand the timeline for the next steps of the COP19.	Plan the next meeting. Share the documentation.	Meeting was held at Embassy office and led by Heather Watts
01/31/2019 In – Country retreat	Discuss COP19 guidance /orientation	Stakeholder feedback was shared	Continue discussion via phone and email to ensure stakeholder inputs are taken into account for specially the need to support CSO watchdogs	

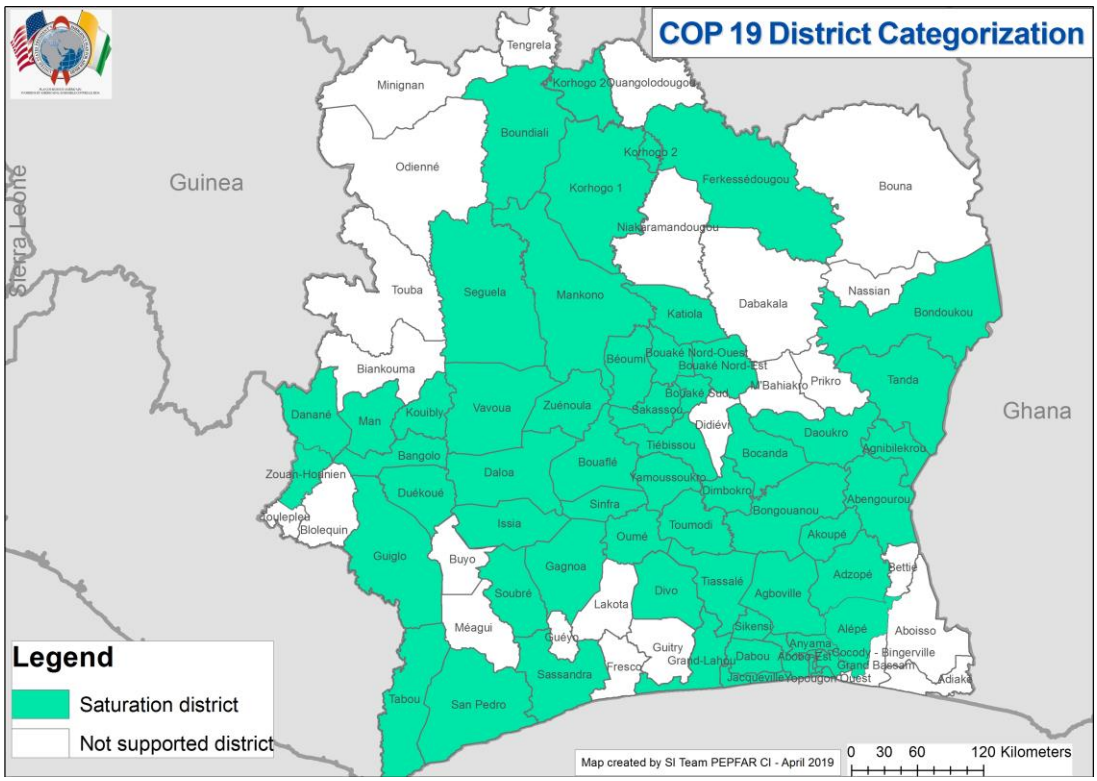
	COP19 expectations from stakeholders, timelines for future steps Receive input from stakeholders on the COP19 strategy for CI.		activities and stigma/discrimination intervention	
03/07/2019	Additional conversation with CSO on 13 Minimum requirements (especially TLD transition , 6 MMS and Retention barriers /user fees and others)			
04/02/2019	PEPFAR-CI debrief on RPM meeting's outcomes to UN organization groups (called SNU)	SNU understand COP19 CI Reboot country implications. Specific priorities (in term of geo-prioritization and packages) Issues with Linkage and Retention to be fixed ASAP	Continue to share any updates available	
05/09/2019	IPs' FY2019 Q1&Q2 results shared by OGAC/Heather Watts Under MSHP /DGS leadership With participation of : CSO; WHO,UNAIDS,GF ,PNLS and all DRs (regional directors)	Opportunity for IPs to share their achievement /challenges and way moving forward (from Q3) to improve performance and fix the retention issues and all of that in presence of all DRs for in-country ownership of this reboot process	Monthly monitoring meeting at the regional level under DR leadership to review all IPs achievement CSOs representatives to participate and report any issues found at the site/community level	
05/28/2019	Draft COP19 SDS shared with stakeholders			Draft SDS was shared via email with CSO and all stakeholders (English version)
05/29/2019	Meeting with PEPFAR-CI to answer/clarify any concerns regarding the SDS with stakeholders	PEPFAR-CI will convene a follow-up meeting to provide details regarding the COP19 contents. Go over CSO 'IMs in COP19 (focus on retention barriers through Observatoire and Stigma & Discrimination)		Focus of the meeting on COP19 footprint and services packages by types of sites CSO COP19 activities

05/31/2019	Final SDS to be shared with CSOs and other stakeholders			
After COP19 Submission				
06/25/2019	PEPFAR-CI to explain how stakeholder feedback was incorporated in COP19 planning and how PEPFAR will continue to engage them throughout the year	Stakeholders understand how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP19, what was not, and why these decisions were made.	Share the redacted COP19 when available and approved.	A redacted version of the approved COP19 will be shared by email. Hard copies will be available upon request.

3.0 Geographic and Population Prioritization

PEPFAR-CI prioritizes investments, both geographically and demographically, to achieve epidemic control. Of the 86 health districts in Côte d'Ivoire, PEPFAR-CI will provide intensified support to 60 districts for clinical service delivery and community services. These 60 districts are prioritized for targeted programming to higher-risk populations, with a 90% forecast of ART coverage by FY2020. Three districts have already met the second 90 target at the end of FY2017: Yopougon-Ouest-Songon, Treichville-Marcory, and Bouake-Nord-Ouest. PEPFAR-CI anticipates achieving 90% treatment saturation in an additional 6 districts by the end of FY2019, and 51 districts by the end of FY2020. The CIPHIA results have been used to assess ART coverage, site level retention data, and refocus interventions to address gaps. The ongoing cluster analysis will also provide an opportunity to determine patient movement across sites and districts and whether certain districts should be prioritized based on demand.

Figure 3.1



To achieve the 90:90:90 targets, the PEPFAR-CI program is intensifying targeted case finding and ART enrollment strategies for priority districts and populations. Implementing partners (IPs) are readjusting their technical assistance (TA) and coaching approaches to increase their site-level presence and provide direct support (including HRH) to facility-based providers, particularly at low-performing sites with the capacity for significantly higher volume. Site level and district-level data shows consistent issues with linkage and retention and varying degrees of success in case

identification. Consequently, PEPFAR-CI is directing its partners on aggressive actions to fix retention and linkage issues at the site level. They are described in detail in section 4.

Table 3.1

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP19**	**# Current on ART (FY2018)**	**# of SNU COP18 (FY2019)**	**# of SNU COP19 (FY2020)**
Scale-up Saturation	405,679	128,276	19	60
Scale-up Aggressive		79,760	21	
Sustained		38,993	40	
Not PEPFAR Supported	52,754		3	26

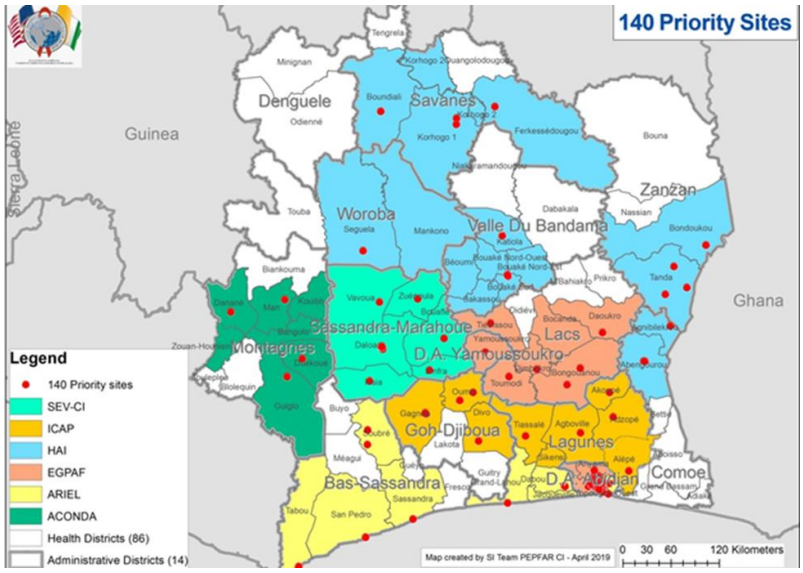
4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 – 4.3 COP19 Programmatic Priorities for Epidemic Control

4.1 Finding the missing, getting them on treatment, and retaining them ensuring viral suppression

PEPFAR-CI aims to treat 357,702 PLHIV by the end of FY2019. In order to achieve 95% treatment coverage by FY2020, PEPFAR-CI is prioritizing its efforts in 140 sites located in 60 districts covering 70% of PLHIV in Côte d'Ivoire (involving 63% of PEPFAR TX-Curr). Half of the 140 sites are located in the greater Abidjan area. Strong efforts will be applied to achieve 95% in both linkage and retention in the 140 priority sites.

Figure 4.1.1: 140 priority sites for COP19



Direct Service Delivery (DSD) approach and shifts in FY2020:

A key barrier in Côte d'Ivoire HIV/AIDS response is the limited capacity to consistently deliver core clinical services at an acceptable standard of care. PEPFAR-CI-supported clinical services are implemented primarily in the public sector health facilities through an integration of HIV services with other diseases and delivery by the Ministry of Health (MSHP) clinicians, including doctors, nurses, midwives, pharmacists, laboratory staff, and data managers.

PEPFAR-CI, with mutual agreement from the MSHP, has paused general HIV testing and has limited this service at the facility level for asymptomatic clients and at the community level, except for index testing and the PMTCT, OVC, DREAMS, and KP programs. In addition, PEPFAR will work closely with MSHP and CSOs to monitor the full implementation of the new national guidelines on the implementation of TLD, elimination of user fees, and the implementation of differentiated models of service delivery including multi-month dispensing of ARVs. As such, all stakeholders will perform joint site visits in the 140 priority sites on a monthly basis. Following preliminary discussions, PEPFAR-CI will benefit from HQ-based technical support to operationalize the model agreed upon with the MSHP with a more detailed direct service deliver (DSD) strategy that outlines: i) service packages, ii) roles and responsibilities of facility-based versus community care providers, iii) human and financial resource allocations to address the needs of specific sites and sub-populations, and iv) a monitoring plan. The next steps will include the transition from the existing to the new model during COP18 implementation, which will include a review of implementing partner (IP) work plans and a reallocation of resources to align with site-level targets for case finding, linkage to treatment services, and patient retention.

In preparation for FY2020, a rapid assessment of human resources is being conducted at the 140 priority sites. The gaps identified by cadre and by site will be covered by MSHP first and, if additional assistance is needed, by PEPFAR through its implementing partners.

Strong collaboration and consultation with GoCI, international stakeholders, and professional associations will be critical in continuously reassessing the most efficient model for PEPFAR support and to design an appropriate transition plan for sustainability and build on successes to achieve and maintain epidemic control. PEPFAR-CI will achieve this through monthly and quarterly meetings, under DGS leadership, with all stakeholders involved in the HIV response and through joint monitoring of the COP process.

Quality management:

Quality management (QM) is critical for identifying underperforming sites for real time course correction. QM will be extended to all the 140 priority sites in 60 districts in FY2020 to ensure that HIV services are being offered with a goal of achieving increasingly higher quality and consistent standards of care.

Targeted SIMS visits will be conducted at all 140 priority sites to improve service delivery and above site level visits will ensure that implementing partners, district health management teams and other

central and decentralized entities have the capacity to provide effective support to sites. Facility and community site level data will be collected and aggregated to produce regional and national benchmarking reports. Selected "non-SIMS" granular site management visits will also be conducted by PEPFAR-CI to ensure that new guidelines and technical recommendations are implemented appropriately. Each of the 140 sites will receive a monthly visit beginning in FY2019Q3 and will continue at each site until the sites achieve a standard benchmark to reinitiate active case finding.

Partner management is done at three levels: (i) Activity Managers (AM) will conduct weekly and monthly progress reviews and course correction of deficiencies, in addition to monthly and quarterly partner meetings and financial reviews; (ii) the Interagency team will conduct site visits and data review of key indicators on a monthly basis; and (iii) the National Program will conduct quarterly program results reviews led by the PNLS with the participation of PEPFAR-CI, IPs, and stakeholders. Implementing partner performance will be assessed and, after analysis of root causes, underperforming IPs will be placed on a 6 month improvement plan. If they don't show improvement, they will be considered for target and associated budget reduction.

Community-Facility Linkage:

Strengthening community and facility linkages is a critical component of PEPFAR-CI's strategy to increase case finding and linkage to ART, and retain patients on treatment. Starting in COP19, PEPFAR-CI will rationalize the geographic distribution of clinical and community partners, pairing each clinical IP with a community IP to increase efficiency. Memoranda of understanding (MOUs) were created to formalize this collaboration, delineating roles and responsibilities of each partner in upholding services across the clinical cascade. Starting in Q4 of FY2018 and into FY2019, PEPFAR-CI will review existing MOUs and perform quarterly monitoring to monitor benchmarks of success in addressing coverage gaps across populations and age bands. Each IP will have a clear scope of work and standard operating procedures (SOP)s for monthly tracking of referrals/counter-referrals and patients lost to follow-up who have been found in the community and returned to a health facility to continue treatment. The newly distributed MSHP national referral and counter-referral tool will facilitate consistent tracking of patients.

Community IPs are responsible for the following community interventions: (1) index testing of sexual partners and partner notification in the community and index testing of children of PLHIV identified in clinical facilities, (2) support for self-testing, (3) active referral for ART initiation for those identified in the community to increase treatment coverage and reduce mortality, (4) Reinforcing adherence counseling for ART (5) Community ART distribution, (6) implementation of differentiated care models, (7) establishing and implementing support groups including "patient buddy systems" (8) screening for opportunistic infections such as TB and active referral for treatment, and (9) home visit tracking of PLHIV who are lost to follow-up and identify barriers to seeking treatment and reasons for lost to follow-up. This community-to-facility bidirectional referral is important for both IPs to achieve their targets as well as keep clients engaged across the continuum of care. Clinical IPs will also be responsible for linking clients back to community IPs for appropriate, relevant community-based interventions, such as supportive services that increase

retention (including adherence support) and improve viral suppression. Community and clinical IP work plans will reflect their integrated roles in client care and shared accountability for site-level targets. Community and clinical IPs will be monitored monthly and receive a score based on site-level performance. At underperforming sites, both IPs will be placed on 6 month improvement plans. If site performance doesn't improve, the site will be considered for target and associated budget reduction.

The clinical-community collaboration will ensure a smooth continuum of care for patients and support full implementation of differentiated service delivery models. HIV-infected individuals identified in a clinical facility will receive care and treatment services in the facility and additional community-based support as needed until declared stable, at which point, they become eligible for community ART distribution and referred to a community-based counselor or a peer who ensures that the patient remains linked to the facility for treatment and laboratory services. Those identified in the community as HIV-infected are referred and escorted by community counselors or peers to the facility for same day ART initiation. In the context of index case testing and partner notification, counselors and providers ensure that gender-based violence risk assessment is completed, that sexual partners have the option of getting tested in the community or in a facility but will be escorted by the community counselor to the clinical facility for treatment if found to be HIV-infected. Also, HIV-infected children and exposed infant are linked with OVC platforms as priority beneficiaries.

Community counselors from the facility and the community will hold weekly coordination meetings to ensure that; referred patients received same day or prompt ART initiation, patients lost to follow-up are tracked and traced, transfers out are documented, and patients' social needs are addressed promptly. Monthly multidisciplinary team meetings at sites and quarterly district coordination meetings will be reinforced to ensure a good linkage between community and clinical settings.

Human Resources for Health:

Human Resources for Health (HRH) remain a significant barrier to high-quality service delivery required for HIV epidemic control. Specific challenges include: (i) lack of an accurate assessment of the total number of health providers required to provide HIV/AIDS services and other basic health services; (ii) MSHP budgetary constraints limiting the recruitment of sufficient staff; and (iii) the imbalanced distribution of health care workers across the country. A rapid assessment of HRH gaps by IPs in March 2018 showed similar findings for various cadres (physicians, nurses, midwives and community lay counselors) needed to reach FY2018 and proposed FY2019 targets. Moreover, there are other HR-related barriers impeding the replication of good practices with fidelity: (i) demotivated health care providers who expect incentives to implement HIV services including data collection activities because they require additional work, (ii) targeted testing not well accepted by some care providers who continue to do broad based PITC.

The program will therefore engage with the MSHP for a broader national HRH strategy. The continued provision of lay counselors through local organizations is critical to preserve client engagement across the continuum of care. In the priority 140 sites, the USG team will also work with the district government for effective targeted supervision/mentoring and coaching of care providers on targeted testing and other policies, HRH performance review, providers motivational strategies, service quality management, data quality management and use of data for decision making on a monthly basis.

Index Case Testing:

Côte d'Ivoire adopted index case testing in FY2019 as its main approach to address its most critical gap of case identification observed across all populations and age groups and is scaling up this approach urgently now and into FY2020 to be able to reach epidemic control by 2020. The program anticipates increasing the percent of positives coming from index case testing from 27.5% of, as of FY2019 Q2, to 34% for FY2020.

All positive cases identified through clinical services and in community settings will systematically serve as index cases with active tracking of all sexual network partners for testing. Following a partner elicitation interview, a routine listing of the sexual partners of all newly identified patients and those currently on ART will be done. This listing is updated each time the patient comes to the health center. The index case will be given the option for an assisted or unassisted disclosure to their sexual contacts and offer them a HIV self-test for selected target groups for COP19 (partners of FSW & MSM, military personnel aged 40+ and sexual partners of HIV positive women, and male partners of HIV positive pregnant women who do not accept testing through standard testing platforms). A standardized tracking system will ensure follow-up with index case clients to strengthen case identification and linkage to treatment. A risk assessment of gender based violence will be conducted prior to partner notification. In the context of self-testing, counselors will be available to accompany patients tested positives in the community for confirmatory testing and ART initiation at the facility and support will be provided for HIV status disclosure at both the community and facility levels.

Overall, this level of scale up will require tight monitoring of partner performance to ensure full roll out with fidelity in FY2019. PEPFAR-CI will continue to conduct weekly partner monitoring for the large volume sites to monitor the implementation of index case testing. Based on PEPFAR-CI partner level analysis of best practices in index testing, successful strategies are being replicated at 140 priority sites and selected lower volume sites. Additional lay workers, community counselors will be recruited for proper implemented this strategy in the priority sites.

An analysis of testing modalities shows that high positive volumes are expected in ANC and PITC, which will all be feeding index case testing. Facilities will offer multiple approaches within PITC and ANC:

- Options for index client to return with partner or refer in for PITC

- Option for outreach via community partner to follow-up on identified partners. This will be facilitated by strong coordinating platforms between clinical and community partners.
- Establish both anonymous and disclosure options for partner notification. For those not willing to disclose, the former could be leveraged. These may include non-specific targeted messaging around risk and testing, etc.

In addition, female PLHIV on treatment at facilities and those attending antenatal clinics will be prioritized as index cases in order to reach their male counterparts for HIV testing.

Family testing limited to the biological children of HIV-infected women and FSW will be scaled up while clearly differentiating from sexual partner testing. HIV-infected children will be linked to OVC services as appropriate. Training will also be provided for index testing with fidelity in the pediatric context in addition to training on correct reporting and monitoring to track progress and implement real time corrective action.

The OVC program will contribute to case finding. Specifically OVC implementing partners will fully roll out a risk assessment tool to all sites, by October 2019, for OVCs with unknown HIV status, and provide testing services as needed. A list of sexual partners of all HIV positive adults and sexually active adolescents in OVC households will be updated monthly. The program will then provide HIV testing services to sexual partners with unknown or undisclosed HIV status. All partners who test positive will be actively referred to care and treatment, long term treatment adherence support, retention on treatment support platforms.

KP programmatic results from FY2019 Q1 show a yield of 23% through index testing and it is expected that the addition of self-testing will allow better reach of the most hidden MSM as well as stable partners of FSW. Implementing partners will monitor consistent scale-up of these strategies across all KP sites.

Private Sector:

Based on the fact that PEPFAR will no longer fund private sector activities, 70 private sites, with 6,306 PLHIV on ART as of FY2019 Q2, will be transitioned to the MSHP by the end of FY2019.

Reaching Men:

Socio-cultural norms like disease stigma and fear of discrimination can discourage people from accessing HIV services. Men are more likely to access testing services as part of a multi-disease package, which is the approach within which PEPFAR-CI embeds HIV services such as HTS.

In terms of volume, APR18 results showed that PEPFAR-CI identified 25,243 men (out of 502,070 tested) through other provider-initiated testing and counseling/PITC for HIV. While the yield was 5%, the program will evaluate the "other" PITC entry point data to identify the specific testing modalities representing the major yield and volume drivers (by age) for men, and to assess their capacity for greater volume. In order to optimize the PITC, a screening tool used in high yield sites, which includes sexual risk factors, STIs and other symptomatology is being implemented in some

high yield sites and will be scale-up with fidelity in FY2020 to improve HIV case identification in low yield sites. The TB screening tool/algorithm developed by ICAP will be used in all 246 supported TB clinics to propose HIV testing to TB presumptive clients during FY2019 and scale-up to non-TB clinics in FY2020.

Moreover, the program will couple index case testing with targeted testing optimization at the facilities. Positive cases identified through clinical services and in the community will systematically serve as index cases with tracking of all (main or casual) sexual network partners for HTS. Routine listing of sexual partners of all newly identified women and those currently on ART will be systematic. Psychosocial support for partner notification and/or partner testing (any modality) including self-testing, will be provided. The active tracking of sexual male partners will be scaled up during FY2019 and sustained in FY2020 with the goal to identify 50% of the new HIV+ through index networks in the 140 priority sites.

Index testing in both community and facility settings will incorporate self-testing. The option will be provider-initiated and offered to the index cases for their sexual partners. Providers will also give guidance on how to approach self-testing and partner notification. The health provider will give the index case the option to provide either an assisted or an unassisted test to the sexual contact.

Based on the mandate set by OGAC in the COP19 PPL, community-based testing is paused, with the exception of index testing and the PMTCT, OVC, DREAMS, and KP programs. IPs are currently implementing this approach, which has allowed successful tracing of sexual networks in the community and it will be scaled up in the community for all ages and reinforced in Q3 and Q4. For adolescent and young men (aged 15-24), IPs will reinforce age-appropriate sexual risk reduction counseling and linkage to care and treatment services. Additionally, men will be reached through other platforms like DREAMS: the male partners of AGYW will be identified and targeted for HTS and linked to prevention and care and treatment services as appropriate.

PEPFAR-CI program will work in coordination with Alliance Côte d'Ivoire (Global Fund PR) to increase the community outreach to non-PEPFAR sites within certain priority districts to ensure maximum complementarity.

Case finding:

Interventions at facilities:

- Systematic index testing through facility-based testing entry points (PMTCT, Internal medicine, TB and STI)
- Targeted testing
- OPD modality: informational sessions followed by provider initiated testing expanded to general and regional hospitals
- Extended hours and men-dedicated staff at HIV dedicated clinics, primary care private for non-profit centers (FSU Com and CSU Com), faith-based health centers.

Interventions in the community:

- Scale-up of index testing using a multi disease integrated approach for sexual network tracing and by expanding the approach to other PEPFAR platforms such as OVC and DREAMS

ART Initiation, Linkage and Retention:

Interventions at facilities:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Accompaniment to ART initiation
    - Ensure weekly monitoring of linkages as QI measure at all 140 priority sites
- ART Adherence support through:
    - Enrollment in age-appropriate support groups
    - Fast track at facility
    - Multi-month scripting for stable patients (6 months)
    - Facility-based community ART distribution (hybrid model)
- Better monitoring through roll-out of electronic ART registers and extended hours (after hours, weekend refills, workplace etc.)

Interventions in the community:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Accompaniment to ART initiation
    - Ensure weekly monitoring of linkages as QI measure at all 140 priority sites
- ART Adherence support through:
    - Age-appropriate treatment literacy materials and approaches
    - Enrollment in age-appropriate support groups
    - Community based ART distribution at community-based adherence clubs and community ART groups

In addition to the above-mentioned interventions, age-specific ones are described in table below.

Table 4.1.5 Case finding and ART Initiation and Retention Strategies to Reach Men by age band

Age	Case Finding	ART Initiation and Retention
15-19	**Interventions in community:** - Linkage through youth prevention to provide information about prevention, OVC/DREAMS programs. - School health programs	**Interventions in community:** - ART Adherence support through: o Enrollment in adolescent support group o Psychosocial support for caregivers
20-24	**Interventions at facilities:** - Provided initiated Self-testing **Interventions in community:** - Embedded testing as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at work places, unions, male oriented gatherings Grins - Self-testing - Mobile testing	**Interventions at facilities:** - Improved linkage to ART through: - Expansion of ART services in universities and workplace health centers with high yield HIV testing **Interventions in community:** - ART Adherence support through: o Psychosocial support for caregivers
25+	**Interventions at facilities:** - Other PITC reporting modality unpacked to optimize high yield entry points - Systematic index testing through facility-based testing entry points (Internal medicine, TB and STI) and referral to preventive health services and counselors - Replication of best practices found at high volume and high yield sites - Self-testing **Interventions in community:** - Index testing embedded as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at work places, unions, male oriented gatherings - Self-testing	**Interventions at facilities:** - Active linkage to ART through: o Expand ART services in workplace health centers with high testing yield o Focus on districts with high volume of positive cases identified low adult men ART coverage and tailor DSD services accordingly by age - ART Adherence support through: o Expand multi-month prescriptions for stable patients **Interventions in community:** - Expand multi-month prescriptions for stable patients

Reaching Children and Adolescents

The number of children receiving ART nationwide increased by 18% between 2014 and 2017, with children under 15 years old accounting for approximately 5% of the treatment cohort. National data show that pediatric ART coverage is proportionately lower at 34%, compared to 48% adult coverage in Côte d'Ivoire. As a result, PEPFAR-CI is working closely with the GoCI and other stakeholders to fast track the pediatric HIV response and rapidly scale up pediatric ART coverage

in the 140 priority sites. The program expects that 90% of children will be on ART in FY2020, with a 50% reduction in mortality rates.

FY2020 goals are to (1) ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, with risk assessments conducted for 100% of OVCs to identify those in need of HTS, through strong collaboration between facilities and community settings, and (2) to start and retain on ART all infected children regardless of age. Key priorities for pediatric and adolescent care and treatment in FY2020 include increasing ART and VL testing coverage and suppression rates, improving TB screening, expanding nutritional assessment counseling and support (NACS), and increasing systematic and routine HTS of all children, through a family-centered approach in the index testing context, and same day initiation of ART for those positive, especially:

- Index testing:
    - If child is the family HIV index, then all his/her biological siblings and parents would be tested
    - If mother is the family HIV index, then all her biological children would be tested
- Children in inpatient settings
- Children in outpatient settings, identified through screening tool (Bandason, et. al.)
- Children presenting with suggestive signs and symptoms of immune deficiency
- OVC identified through HIV risk screening tool
- Biological children of FSW
- Children diagnosed as malnourished
- Children with TB or suspected TB

Strategy for achieving Epidemic Control among Children and Adolescents includes:

- Increase PMTCT_STAT_POS 2 month coverage and PMTCT_FO to ≥ 80%
- Scale-up POC EID platforms and integrate EID/TB testing on Gene Xpert
- Improve mother-infant pair retention throughout pregnancy and breastfeeding by using the cohort registry
- Enhanced tracking of HEIs not enrolled in care after birth, systematic screening of HEI at routine MCH visits, and optimized ANC counselling messages
- Enhanced case management: Enroll HEIs in OVC programs and provide peer support for mothers
- Improve availability and use of postnatal infant prophylaxis
- Implement POC for viral load monitoring for 40% pregnant and breastfeeding women to identify exposed infants who may need intensified postnatal prophylaxis
- Levegare OVC program to provide treatment education and adherence counseling to improve retention and achieve viral load suppression among chidren and adolescents

For FY2020, the program will focus effort on select acceleration sites that will scale with fidelity practices such as the provision of dedicated pediatric staff (healthcare workers and lay counselors),

Lopinavir/ritonavir formulation (pellets for children <3 years), TLD for adolescents ≥10 years and ≥ 35 kg through Pediatric ART optimization plan, to reach epidemic control among HIV infected children and adolescents.

Aligning with the task-shifting policy, PEPFAR-CI, through monthly site visits and IP monitoring, will continue to build the capacity of general practitioners, nurses, and midwives to effectively initiate pediatric HIV care and treatment, and ensure that training of staff on the most recent ART guidelines. Additionally, the program will create a network of pediatric care and treatment providers that will go hand in hand with the establishment of a mentoring system implemented at 140 priority sites.

PEPFAR-CI will also support differentiated service delivery models for children and adolescents meeting the definition of "stable" patients, including six-month (instead of monthly) ARV prescriptions and twice a year (instead of monthly) clinic consultation visits, as well as community ART distribution or facility pick-up for stable patient.

PEPFAR-CI is now monitoring site level achievement monthly, and working to collect and analyze testing yield and linkage to ART data from identified pediatric testing entry points on a weekly basis. The generation of a monthly listing of newly tested positive children has led to increased pediatric case finding and treatment; the program will scale up this practice across all IPs to facilitate the monitoring of pediatric enrollment in and adherence to treatment. PEPFAR-CI will strengthen collaboration and cross-referral between clinical HIV programs, social welfare/community-based support systems, and OVC services to support clinic-based linkage and retention efforts. Linkages between HIV testing and prevention programs will focus on at-risk adolescents and young women. Section 4.2 provides more details on the implementation of DREAMS programming for girls and young women, ages 10-19.

The program has the objective of ensuring 95% suppression among all children on ART. To facilitate early identification of treatment failure in infants, PEPFAR-CI will use VL testing as the only routine biological monitoring test in all supported sites. Each laboratory is generating a weekly list of children with unsuppressed VL to provide to facilities, which in turn conduct active follow-up for supplementary patient education and enhanced adherence counseling support on a monthly basis. As per national guidelines, children receive a VL test every six months; but those with unsuppressed VL will receive a second test after three months. Testing for infants in remote sites, with no available VL testing services, will use Dried Blood Spot (DBS) samples. Each of the pediatric sites will have a focal point for follow-up of children with unsuppressed VL, linked to the laboratory focal point to ensure effective continuum of service to children.

SIMS visits will continue with the version 4.0 for improving the quality of pediatric care and treatment services. PEPFAR-CI will improve the linkages between clinical and community services for active follow-up in the community through involvement of both social and community workers and the development and dissemination of a mapping of community organizations working around health facilities. PEPFAR-CI will support IPs as well as facility staff to utilize quality improvement

approaches and systematically apply data analysis to make meaningful, real-time program improvements to programmatic gaps identified through MER and SIMS analysis.

Common Interventions Across all Ages

Although significantly large gaps in positive case finding lie among three priority districts, coverage is low for the first and second 90s across almost all the Scale-up Districts. Besides the recruitment of additional lay counselors and health providers trained in pediatric HIV management, who will intervene for all ages and services along the three 90s, and in all districts, especially at high volume sites, each pediatric age band will benefit from the following scaled-up approaches.

ART Initiation and Linkage:

- Weekly monitoring of linkage to ART initiation
- Task-shifting for ART initiation and monitoring

Viral Suppression:

- Scale up of VL Dashboard
- Implementation of mother and adolescent peer support groups to enhance medication adherence and viral suppression
    - LVP/r pellets
    - TLD for peds and adolescents >10 yrs (and >35 kgs)
- HIV genotyping targeting children with multiple treatment failure

Furthermore, PEPFAR-CI will implement age-differentiated strategies along the continuum of needs for children and adolescents, as indicated in the table below.

Table 4.1.7 Case finding and ART Initiation and Retention Strategies to Reach the Pediatric Population by age band

Age	Testing	Treatment	Adherence and Viral Suppression
<1	- Coaching on and supervision of mother-child health booklet documentation and use - Active tracking of positive pregnant mothers to ensure preventive care and EID services for newborn - Expansion of EID POC in high volume sites		
1-9	- Family index testing - Coaching on and supervision optimized PITC at key entry points - Linkage with OVC and KP programs		

10-14	- Coaching on and supervision optimized PITC at key entry points - Family index testing	- Sexual and reproductive health services - Support for disclosure	
15-19	- Sexual index testing - Risk assessment tool		- Teen Clubs for adolescent peer support - PHDP package

Reaching Tuberculosis/HIV co-infected individuals

TB is the number one cause of death among PLHIV: the death rate for TB/HIV co-infected patients in 2018 was 20% nationally, reducing the retention rate among PLHIV on ART. Adequate case management among this cohort will significantly affect progress in viral suppression and reduce mortality. In FY2020, PEPFAR-CI will support coordination of TB/HIV collaborative activities by MSHP and national regional and district levels and will support 230 TB clinics, in 60 Districts supported by PEPFAR in the public sector, including a TB strategic package of services designed to provide maximum support for the health of PLHIV and TB/HIV co-infected patients:

- HIV testing for all presumptive TB patients and all TB patients in TB clinics, and rapidly start ART for TB negative HIV positive patients and TB/HIV co-infected patients according to national guidance
- ART provision for TB/HIV co-infected patients in all TB clinics
- Effective TB case finding by TB screening of PLHIV in care
- Lipoarabinomannan (LAM) test for HIV patients with advanced disease
- TPT for eligible PLHIV

HIV testing for patients with presumptive TB will continue as an integral part of services offered in TB and HIV clinics. The International Center for AIDS Care and Treatment Program (ICAP) started implementing this activity in FY2016, showing consistent increase in case finding for both female and male clients. PEPFAR-CI is scaling this practice among all clinical IPs, starting in the highest burden areas, and closely monitoring the activity on a quarterly basis.

PEPFAR-CI recognizes that the TB entry point has limited volume, but the addition of the presumptive TB strategy could double the number of HIV cases identified through this modality. Additionally, the program will continue to implement the “Engage TB Strategy” using a family approach to reach the missing TB cases.

Clinical evaluation of contact of patients with TB diseases will be strengthened to increase TB case finding, this routine household contact tracing will be extended to patients cured for TB.

Children living with a TB contact will be screened and referred to a TB clinic for TB diagnosis. If the TB screening is positive children under 5 will received TPT (activity supported by Global Fund).

Index testing among TB/HIV co-infected patient will be implemented to increase HIV case finding to reach the first 95 goal.

TB prevention will be strengthened in FY2020.

At the national level 72 HCW were diagnosed with TB, and most of them did not work in TB clinics. NTP started coaching on TBIC in sites where a HCW contracted TB and put in place local committee for TBIC. TB infection control is therefore a major challenge in health centers in general. All TBIC measures will be implemented in PEPFAR supported districts. National policy and technical guidance are already available at the national level. The national strategic plan of TBIC expired in 2016. A new national strategic plan will be developed and the operational plans will be rolled out at the district level. A local committee will be established for implementation of all TBIC measures:

- Environmental and administrative control measures:

- Window opened in waiting room or build appatam (shelter) if there is no ventilated waiting room in facilities
- Rapid screening to separate coughing patients from other patients. Hand hygiene with suitable equipment for sites without running water nor those equipment;
- Cough hygiene education to coughing patients: as posters showing cough hygiene already available in TB clinics, those posters will be placed on the walls of the waiting room in HIV clinics

- Facility level measures coordinated by NTP in terms of policy, guidelines and monitoring and evaluations

- Personnel equipment for anti-tuberculosis centers in charge of MDR TB cases and other personnel protective equipment for all facilities

With PEPFAR support, the MSHP will scale up TPT from seven to 70 HIV clinics located in SNUs with high TB/HIV co-infection rates in FY2019, after the evaluation of the six sites from the initial phase. The approach will use GeneXpert as the diagnostic tool to screen for TB infections among PLHIV and determine the eligibility for TPT. Starting in April 2018, Expertise France is providing technical assistance to develop the national guidance for TPT. For COP19, USAID will support drug provision of TPT extension. The roll out of TPT in 2019 is a great example of collaboration amongst stakeholders; with the additional contribution of the National TB Control Program (PNLT) which will procure the drugs through the next Global Fund concept note (the current concept note does not include funding for TPT).

In FY2020, PEPFAR-CI is working with the PNLT on the rapid diagnosis of TB and MDR-TB among PLHIV. Toward this end, GeneXpert-based TB and MDR-TB diagnosis will expand from 11 sites to

36 sites, encompassing Anti-Tuberculosis Centers (CATs), central labs, and HIV clinics, for the integration of EID and TB diagnosis and a reliable transport system. PEPFAR-CI support to the PNLT and IPs will also reinforce the sample referral system from HIV clinics to CATs and sites equipped with the GeneXpert, in order to reach a target of 45,000 PLHIV with presumptive TB tested. Quality assurance of TB smear microscopy diagnosis at 27 CATs and 250 CDTs will occur through the implementation of an External Quality Assessment Scheme coordinated by the PNLT with the technical support of the National TB reference laboratory. The continuation of the WHO/AFRO accreditation program, starting at 10 CATs in FY2019 to cover at least 20 CATs in FY2020, will also progressively improve the overall quality management system.

Above-site investments in TB management focus on strengthening the coordination of HIV and TB/HIV activities at central and decentralized levels, as well as coordination by national institutions for the implementation of laboratory activities related to maintenance, testing and Laboratory Information Systems (LIS) quality. 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. The 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.

4.2 Prevention, specifically detailing programs for priority programming:

a. *HIV prevention for AGYW and children*

The OVC program will continue to provide a robust community platform that contributes to the path to HIV epidemic control by linking HIV-positive OVC to treatment sites, PMTCT, and pediatric services. In COP19 an emphasis is placed on: primary prevention of sexual violence and HIV infection for boys and girls (9-17 years old) enrolled in OVC program, and for girls aged 9--19 in the DREAMS program.

The OVC program is implemented in 58 out of 60 new PEPFAR priority districts. A new geographic distribution among OVC implementing partners is meant to increase efficiency in the program and better coordinate interventions. Only three implementing partners will be providing OVC services in COP19 vice six in COP18. Technical assistance (TA) targets will no longer be reported under OVC activities through the National OVC program (PNOEV). Emphasis is put on providing direct service delivery to the most vulnerable children in order to mitigate the impact of HIV in their lives and to promote a new generation without HIV. PEPFAR-CI's partners will continue to implement and routinely monitor the OVC case management plan, as well as assess the achievement of graduation benchmarks for OVC households in order to graduate those reaching the self-sufficient stage.

The total target of beneficiaries under 18 years old is maintained from COP18 to COP19 and a ratio of four children to one caregiver is reflected in the target to ensure that children under 18 are the

focus of the program. The primary caregiver in the OVC household will be served by the program in addition of all vulnerable children under 18 living in that household, though the "non-essential" adults in the household will no longer receive support from PEPFAR. Due to the recent success in DREAMS sites, the OVC program is integrating parenting programs and the primary prevention of sexual violence and HIV for boys and girls module in intensification sites. The main goal of introducing these programs is to reduce the impact of HIV on children and prevent HIV infection among the young generation.

HIV risk assessments will be done for 100% of children to ensure that those in need of HIV testing are referred and linked to ART as applicable. Those found to be HIV negative or ineligible for testing will receive the primary prevention of sexual violence and HIV module.

PEPFAR-CI's OVC program continues to improve targeted approaches to identify and enroll the most at-risk OVC sub-populations. The goal is to increase the proportion of enrolled OVC who are HIV-positive, HIV-exposed children, adolescent girls at high risk of HIV infection, as well as other high-risk OVC sub-populations. Since at least 98% of HIV-positive children enrolled in OVC programs are under treatment, the OVC program demonstrates an opportunity to identify infected children in the community and start them on treatment, as well as to reinforce adherence and retention of those already on ART. In close collaboration with health facilities, OVC IPs will collect the viral load data of children on treatment to show the contribution of community support to reach the third 90 goal.

A Memorandum of Understanding (MOU) signed during COP18 between clinical and OVC IPs, health facility staff, and NGOs was an opportunity to strengthen the entire program. The close linkage between health and OVC systems has helped identify and mitigate any gaps in services between HIV-positive children enrolled in both pediatric and OVC programs.

The PEPFAR-CI OVC program will continue to leverage the DREAMS program when possible. In the four DREAMS districts, at least 30% of AGYW aged 9-17 in OVC programs will benefit from complementary, DREAMS packages and receive the standard parenting and primary prevention of sexual violence and HIV module that is used in both programs. The approach for preventing sexual violence and HIV risk among girls 9-14 years will include: reinforcement of community awareness, case identification and reporting by community and school GBV standby committees; improving violence risk screening through active and early detection of girls facing GBV, especially rape, in their family or community; improving access to post-GBV care by widely spreading information on available post exposure care services after rape among OVC and DREAMS beneficiaries; and ensuring systematic referral from community to health facility and assistance to victims for non-medical support such as police, judicial, psychosocial support with family involvement. Mentor-led clubs and community mobilization for norms change will continue in DREAMS districts.

PEPFAR-CI started DREAMS interventions in COP17 when indicators reflected high vulnerability of AGYW to HIV infection. In COP19, the four DREAMS districts, Cocody-Bingerville, Abobo-Est,

Man, and Daloa, remain the same as in COP18, with a slight shift in targets to increase the number of beneficiaries per district and focus on the 9-14 age bands. In COP19, the 9-14 age bands will represent 60% of DREAMS beneficiaries. COP19 will pursue the emphasis on primary prevention for 9-14 year olds and risk reduction for 15 to 19 year olds by offering a strong curriculum on primary sexual violence and HIV prevention with social assets building and referrals for SRH services and other relevant services as applicable. Caregivers will participate in positive parenting specific for adolescents which will promote norms changes, especially around violence prevention, through an evidence-based curriculum. These interventions will reinforce the creation of a safe environment for girls inside their family and in their community.

DREAMS interventions will leverage existing platforms such as OVC programs, HTS, sexual and reproductive health, ANC, and other prevention programs. Through a mentoring system for AGYW and family and community interventions, DREAMS activities will increase awareness and skills to prevent and respond to GBV for girls. PEPFAR-CI team will continue to conduct routine technical visits to the sites (at least quarterly) to improve the quality of services related to OVC and AGYW. PEPFAR-CI also plans to do an internal quality assessment of services provided by the OVC/DREAMS IPs.

PEPFAR-CI's OVC and DREAMS approaches align with government guidelines for child protection and complement activities from other actors or donors, including the Global Fund and UNICEF.

b. Key Populations

In COP19, the KP program will experience significant changes at the strategic, programmatic and geographical levels based on COP19 PEPFAR guidelines.

In alignment with PEPFAR's objective of sustainable HIV epidemic control and achieving 70% funding to local partners by FY2020, PEPFAR-CI will begin to transition KP HIV services to local partners. This transition is a key component of the PEPFAR program and is essential to achieving sustainable epidemic control. It is critical that the full range of HIV prevention and treatment services are owned and implemented by local institutions, governments, and organizations regardless of current ARV coverage levels. The intent of transitioning to local partners is to increase the delivery of direct HIV services, along with indirect services provided at the site, and establish sufficient capacity, capability, and sustainability of local partners to ensure successful, long-term local partner engagement and impact.

PEPFAR-CI recognizes the increasing contribution of local partners to the achievement of the KP program and intends to make direct awards to two local organizations in COP19. The two local NGOs will provide the full package of KP services (prevention, testing, linkage to treatment and community care to support retention and adherence) in 26 districts. One international partner will continue service delivery in another 16 districts and will provide technical assistance to strengthen the capacity of the local NGOs.

KP interventions will continue targeting MSM, FSW, and transgender individuals (TG), focusing on 42 districts to target high volume KP populations and underserved areas. PEPFAR-CI used KP size estimation results of the Integrated Behavioral and Biological Survey (IBBS) funded by Global fund/ ENDA Santé in 2014, which shows an HIV prevalence of 11.4% among FSW. Programmatic mapping and size estimation using PLACE methodology was also done in April 2017 which found a prevalence of 12.33% among MSM.

Based on the KP size estimates, a gap exists in reaching HIV-positive KPs. FY2018 PEPFAR program data analysis showed the following key challenges to achieving epidemic control among these populations: Low case finding (8.4% for FSW and 10.4% for MSM), low volume of older FSW (over forty years old) found, low linkage of KPs to ART (72% for FSW and 94% for MSM), inability to properly track highly mobile FSW, limited access to viral load services among KPs on ART (28%), low viral load suppression among those with access to services (63%), and a weak community-clinical continuum of care.

According to FY2018 results, 80% (70,986) of KP reached have been tested, which is still short in reaching the program objective of 95%. In COP19, PEPFAR will implement targeted testing interventions for KPs by reinforcing social network strategies to reach most at risk and most hidden KPs, intensifying peer education (improve the skills level of peer educators specifically for FSW), testing at-risk FSW, MSM, TG, and index testing of stable partners and biological children of FSW. Self-testing will be scaled up among MSM, FSW, TG and their stable partners. The overall expected yield for KPs is 13.5 % (12.5% for FSW and 15% for MSM).

In FY2019 the PEPFAR-CI KP program will target FSW who are hard to reach and were underserved in previous implementation periods, particularly those who work in secluded areas in big towns. The KP program will also continue to increase the engagement of 'maquis' (local restaurants) and hotel managers, pimps and 'queen mothers' of FSW by involving them in the program by sensitizing them and providing condoms and lubricants to promote contraceptive use by FSW.

Optimized KP approaches developed since FY2018 such as risk assessment tools, the Enhanced Peer Outreach Approach (EPOA), and index testing will be scaled across all KP sites. This will be achieved by implementing new approaches such as self-testing in order to reach the goal of increasing case finding among KPs. PEPFAR-CI's program will also combine traditional peer outreach approaches with impactful, innovative approaches such as EPOA, a performance-based incentive that employs peer mobilizers to reach peers in their social and sexual networks and encourage them to get tested and linked to treatment. IPs's work plans will incorporate EPOA as a routine activity to efficiently increase case finding. The implementation of the risk assessment tool will contribute to minimizing retesting of KPs while increasing positive yield.

FY2019 Q1 results showed a yield of 23.1% through index testing and IPs will monitor the scale-up of this effective strategy with fidelity across all KP sites. The program will couple index testing with

self-testing to reach the hard to find FSW, MSM, as well as their sexual partners, through peer navigators. Peer navigators are trained on the national guidelines on self-testing and on post-distribution key messages about the availability and accessibility of KP-friendly services.

The implementation of self-test will start in Q4 of FY2019 in 2 cities, Abidjan and Yamoussoukro. In COP19, the approach will be scaled to include all KP sites, both community and clinical, and through NGOs, CBOs, Drop in Centers (DIC), and hot spots.

Historically, more than 10% of KPs reached declined testing for a number of reasons: some knew their status and did not want to disclose it to the community tester (peer educator), others preferred to be tested in health facilities, or some were just afraid of a positive test result. The KP program will improve counselling to reduce the declination rate.

In COP19, the implementation of PrEP will be done in selected KP sites with a focus on FSWs with large number of clients, KPs with repetitive STI, KPs with high risk sexual behavior such as irregular use of condoms, and sero-discordant couples. The PEPFAR-CI program will also intensify distribution of condoms and lubricants.

National guidelines for PrEP were adopted in March 2019 with high stakeholder engagement (government, civil society, technical partners, etc.). The full implementation of PrEP will be based on the preliminary results of PrEP acceptability and feasibility studies focusing on a FSW and MSM cohort (ANRS/PACCI and Espace Confiance). Beginning in COP18, KP implementing partners will increase PrEP literacy among providers and create demand for PrEP among providers and beneficiaries. National training modules have already been validated and health care providers and community providers will be trained in FY2019Q4 for full implementation in COP19 to target the 1,586 KPs who tested negative but are at high risk of HIV infection.

In order to maximize the rate of linkage to treatment among FSW and address issues related to their high mobility, PEPFAR-CI is currently working with the Ministry of Health to set up a unique identifier code system based on the National Electronic Medical Records (EMR) - SIGDEP2. The MSHP adopted the concept of implementing a unique patient identifier in 2018 and created a technical working group which developed a concept note and is developing the tools/software and systems. A pilot will be done in COP18 and, if all goes well, the system will be scaled-up in COP19.
During COP19, PEPFAR-CI will continue to support the GoCI in addressing human rights issues and institutional barriers in KP programming by extending training on stigma free service provision to health care workers and social workers in public health facilities. The KP sensitivity training will reinforce the capacity of health care workers in public health facilities and social workers to better provide KP-friendly services. The SMS2/LINK tool for client satisfaction will also be used to monitor stigma and discrimination at the community and facility levels. Furthermore, Stigma Index Assessment 2.0 will be conducted in FY2020, which will be led by CSOs and technical support will be provided by UNAIDS and GNP (Global Network of People Living with HIV).

The KP program will improve accessibility of viral load services to KPs through health care worker training in facilities, support sample transportation, and development of custom indicators for retention at 1 & 3 months. Community workers will reinforce Undetectable = Untransmittable (U=U) messaging and viral load literacy to improve KP awareness in the community. Post counselling, PLHIV support groups to improve adherence to treatment and a tracking system tool for KPs on ART will be emphasized in COP19.

4.3 Additional country-specific priorities listed in the planning level letter

Côte d'Ivoire specific priorities listed in the letter were addressed with the renewed and demonstrated commitment of the MSHP. The Test and Start implementation across all geographies, age, sex and risk groups is ongoing and will be fully implemented at the end of FY2018. The six month MMS began in April 2019 in some sites and will be rolled out across other sites throughout FY2018. The MSHP signed one circular note to reinforce the message about no user fees and one to adopt a policy to transition all HIV patients to TLD beyond newly initiating men by FY2020. Advocacy toward the Global Fund and other multilateral organization is continuing to achieve a broad TLD transition.

Regarding PEPFAR-CI's testing strategy, community and implementing partners have been instructed to pause testing. PEPFAR-CI, with mutual agreement from MSHP, has paused general HIV testing and has limited this service at the facility level for asymptomatic clients and at the community level, except for index testing and the PMTCT, OVC, DREAMS, and KP programs. Community IPs will no longer provide active testing in the community except for index case identification from newly identified positives at facilities, and testing of key populations. A plan for scale-up of TPT at all treatment sites will be developed and implemented as part of a quality treatment strategy in FY2020.

The user fees impact was assessed and through the leadership of the MSHP, all user fees have been removed from public health facilities. The PEPFAR-CI team is monitoring MSHP's commitment at every level, through regular, unannounced site visits, specifically at PEPFAR-supported facilities, to ensure that PLHIV don't pay for any fees for treatment or other services relative to their status and also through civil society watchdog network that will be funded on the COP19. An intensive interagency and interdisciplinary site visit effort started in March 2019 to understand the reasons for high number of "lost to follow-up" patients and to help bring these patients back to care and reinstate ART. A new strategy was developed to be implemented immediately and continue in COP19 to promote accountability and foster collaboration between clinical and community partners. This strategy is the basis for finding lost to follow-up patients, bringing them back to care, and ensuring that at least 90% of PLHIV are retained in care to also ensure viral suppression. Another important factor addressed in the site visits was ensuring the timely return of viral load results through a strong laboratory platform system.

PEPFAR-CI's OVC program refocused investments on prevention for 9-17 year olds. Additionally, the program will ensure that all OVC know their HIV status and that all HIV+ OVC are on ART.

The COP18-19 implementation is aligning with the updated OVC_SERV indicator, including minimum graduation benchmark requirements. A national graduation tool is used by IPs and the graduation rate expected for COP19 is 10% of OVC household.

All agencies are continuing to make efforts to increase the level of PEPFAR funding to local partners.

4.4 Commodities

In April 2019, the MSHP adopted and rolled out policy on Tenofovir+Lamivudine+Dolutegravir (TLD) treatment for all HIV-positive adults and children (>35 kg) that are newly initiating antiretroviral treatment (ART). Women of childbearing potential are eligible to receive DTG but the decision should be taken after informed consent of the woman on the advantages and potiential risk (sides effects). The prescription of DTG to women of childbearing potential will be systematically associated with double contraception and a supplement of folic acid. The transition of all adult men, women of childbearing potential, and children (>35 kg) already on ART who are stable (with suppressed VL) will start in July 2019. PEPFAR provided support to the MSHP to develop a TLD supply plan which is aimed at ensuring continuous availability of TLD at service delivery. The National Standard Treatment Guidelines (STGs) for ART were recently revised to include TLD. According to the new STGs, patients that are already on TLE will be switched to TLD after their 2nd measure of VL, with a result below 1,000 copies /mL. The full implementation of TLD transition is expected for early 2020.

MSHP, in April 2019, issued a "Note Circulaire" updating the multi-month scripting (MMS) policy. The implementation of MMS with dispensation of 6-month equivalent of drugs to "stable" patients is effectively being implemented. It is expected that by the end of FY2020, the number of adult patients enrolled on MMS will represent 40-50% of total PLHIV on treatment.

PEPFAR-CI's COP19 total of $5.9M for commodities budget has been developed under a number of assumptions: the GF contribution for HIV commodities will be around $11M based on GF's Year 3 budget for its HIV program in Côte d'Ivoire; and the Ivoirian government will contribute approximately $22.3 million for procurement of HIV commodities based on its 2020 HIV commodities supply plan. If all these pledges are met, the 2020 supply for HIV commodities will be totally funded. Due to COP17 and COP18, treatment uptake and retention, S/GAC anticipates cost savings that would safe guard if these assumptions are not met.

Procurement of TLD as the preferred first-line drug for ART: On a programmatic level, PEPFAR-CI's budget for commodities will be used primarily to partially fund procurement of 1st line ARV drugs for adults (TLD). Pending orders of TLE in the FY2019 procurement plan have been converted into TLD orders. Côte d'Ivoire will also prioritize procurement of 180-count and 90-count bottles of TLD in order facilitate uptake of MMS.

Optimization of Pediatric ART: All new patients weighing 20-29.9kg will be transitioned to DTG. For PI based regimens for all eligible patients, we will begin a more aggressive transition ensuring all new and existing eligible patients are on LPV/r syrup, pellets, or tablets.

All the formulations/products that are needed for the optimization including DTG 50mg and LPV/r pellets have already been registered in the country. CI has already received the first shipment of pellets. An implementation plan and roll out of a protease inhibitors (PI) based regiment is expected to begin with 5,479 patients in the 5-14kg weight band.

Procurement of Embiciytabine/ Tenofovir for PrEP: During FY2020, PEPFAR-CI will support procurement of approximatively 21,000 doses of ART for PrEP. These quantities will be primarily used to serve 3,600 clients among KPs to reduced post exposure risks to HIV infections.

Procurement of drugs for treatment of cryptococcal meningitis: PEPFAR-CI investments will also support the procurement of treatment for cryptococcal meningitis for approximately 634 patients (10% of TX_NEW, then 5% CrAg positive). The treatment will be made available at regional hospitals. The proposed treatment algorithm includes the following: oral fluconazole 1,200 mg/day and flucytosine 100 mg/kg/day for two weeks or amphotericin/fluconazole as below if flucytosine not available followed by fluconazole 800 mg/day for 8 weeks, then 200 mg/day maintenance.

Procurement of condoms and lubricants: PEPFAR-CI investments in FY2020 will be used to fund procurement and distribution of 10 million male condoms, 200,000 female condoms, and 100,000 units of lubricants. These quantities represent half of the estimated PEPFAR-supported country needs for FY2020. The other half has been budgeted using the FY2020 Condom Procurement Fund.

The majority of COP19 commodities have been budgeted for procurement through the GHSC-Procurement Programs, except for a very small amount attributing to very specific lab items which have been budgeted under the CDC-RETROCI procurement mechanism.

4.5 Collaboration, Integration and Monitoring

a. Strengthening cross technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MSHP;

PEPFAR-CI is committed to active collaboration with all key stakeholders especially, GFATM, WHO, UNAIDS, MSHP and Ministry of Defense (MOD) on all technical aspects of program implementation and results achievement. Through these engagements, the USG team has stimulated broad participation in the COP19 planning process, including representation from several multilateral organizations, local and international non-governmental organizations, and CSOs. PEPFAR-CI will continue this close collaboration and engagement with these stakeholders through joint planning, policy enforcement, site visits, and periodic review of performance.

In view of the 90-90-90 goals, the DGS is setting up a coordination mechanism to improve the overall performance of the national AIDS program (PNLS) as well as to increase the involvement of

health regions health districts in site monitoring. PEPFAR-CI will support this Joint Monitoring Plan, which will involve three levels:

- National- under the leadership of the DGS
- Decentralized level- through active oversight of Regional Health Directors and Health District Directors as well as strong collaboration with decentralized authorities (regions and autonomous districts) as a way to ensure participation of communities.
- Site level- through collegial accountability of health facilities and community actors, with CSO playing active role in monitoring implementations of policies.

PEPFAR-CI will support the implementation of this plan, specifically through weekly monitoring, monthly performance data reviews led by the DGS, quarterly performance reviews led by minister in person, regular field supervision, and semi-annual review of performance, in the presence of all stakeholders.

Whenever necessary, the PEPFAR-CI team will also support the MSHP in the development of specific policy documents, guidelines, ministerial orders or other types of formalized agreements to address implementation challenges.

b. Strengthening IP management and monitoring, and the implementation evidence-based strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods;

Based on the performance gaps identified during the COP18 implementation period, PEPFAR-CI has put in place immediate remediation/surge plans by IPs to reduce LTFU and improve linkage and retention.

In COP19, all USG agencies will prioritize partner management for achieving results. There will be – at a minimum -- monthly monitoring of priority sites by USG, IPs, and MSHP, focusing on critical issues including retention, lost to follow-up, data quality, as well as monitoring of policy roll out (TLD, MMD and elimination of user fees) to ensure immediate implementation. The USG team will hold weekly reviews of site level data and monthly reviews to identify high performing sites where best practices can be rapidly identified and scaled and problems can be rapidly addressed. A new interagency dashboard will be developed and is expected to facilitate rapid and standardized review of key indicators (both MER and custom indicators) across the cascade and related expenditures to ensure that PEPFAR investments are resulting to impact.

PEPFAR-CI will actively support GoCI engagement for a new Joint Monitoring Plan, including Performance-Based Funding (PBF) at the regional level, as a result of Ambassador Birx's agreement to apply $4M in additional PEPFAR funding. This will improve coordination and oversight of HIV service delivery, ensure engagement of MSHP staff, and share accountability of results.

The role of civil society organizations will be strengthened by establishing a "watchdog" system to alert PEPFAR and MSHP on issues related to quality service delivery and roll out of policies (e.g., elimination of user fees).

In collaboration with the MSHP, PEPFAR-CI will continue granular site management (GSM) to help improve and sustain performance at the priority sites. Weekly targets will be set for each site and reviewed jointly by the USG team, MSHP, and regional health authorities. Consistently underperforming sites will be subject to focused monitoring by the site management team (MSHP and USG staff), to fix performance gaps rapidly.

PEPFAR-CI will continue to hold monthly oversight and accountability meetings with all IPs in order to discuss and resolve implementation challenges, especially at the above site and/or policy level, and also to share evidence-based successful solutions for rapid replication.

Laboratory:

Despite a strong laboratory network, Côte d'Ivoire's PEPFAR program still has weakness in coverage and a low VL suppression rate. To mitigate these issues the team has developed an innovative approach for program and clinical IP management.

In order to achieve epidemic control by reaching 90% coverage and 90% suppression by September 2019, PEPFAR-CI will focus on 140 clinical sites for improvement. These sites under the surge plan have defined indicators across the clinical cascade. Weekly target for VL coverage and suppression were set by partners for the 140 clinical sites such as number of blood samples to collect and number of patients to enroll into the EAC. CDC through I-Tech developed and implemented an electronic tool to monitor VL appointment and follow-up of unsuppressed patients and enroll them in enhanced adherence counseling. The electronic tool will help clinical IPs to generate weekly reports for CDC to review.

In addition, strategies such as extended operating hours will be implemented at clinical sites for consultation and blood drawing during weekends and evenings after work. Home blood draws and transportation will also be provided for patients with physical disabilities. To reduce time spent at the clinic, appointments for drug collection will coincide with blood drawing, and children and PBFW will be prioritized. Clinical IPs are implementing dedicated VL testing days with fast track patient circuits at the facility or nearest satellite lab and additional HR for VL sample management will be available during weekends. Another strategy is the call center established by a clinical partner that will be implemented at all 140 sites. This center will remind patients of their appointment, collect any relevant information that will help improve patients' adherence to treatment and reduce lost to follow-up, and the list of non-reachable patients will be shared with community IPs to initiate home visits. These strategies will be scaled with fidelity at all 140 sites and will be monitored every week using the VL/EAC electronic tools. IPs will be monitored on a weekly basis with emails sent to poor performers, requests for explanation, visits and coaching to sites with the poorest performance with PNLS and district health team, and close monitoring to improve indicators. IPs with poor performance after 3 months of implementation of the surge plan

will be put on performance improvement plans. The 140 sites have been set a goal to reach 90% coverage by the end of June 2019, and to improve VL suppression to 90% by September 2019.

c. Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade;

The PEPFAR-CI HRH strategy in COP19 aims to provide support for human resources for health to ensure implementation along the clinical cascade, particularly with resources allotted to improved clinical service delivery package and outreach into the community, and monitoring of task-shifting for care and treatment.

PEPFAR-CI will provide salary support to staff primarily at the 140 priority facilities and communities as needed to ensure services are provided with a patient-centered approach.

Community cadres will be responsible for community-based index tracing, ensuring all patients found positive are properly counseled and linked to treatment, tracing all defaulters, and making sure patients who are eligible for viral load testing return to the clinic for their tests.

Additionally, these CHWs will be the cornerstone for implementation of the DSD models highlighted in section 4.5.4. The deployment of these additional community staff will be assigned to the 140 priority sites.

HRH reviews will be incorporated into routine site monitoring so that sites that need increased HRH support or optimized HRH are identified and supported promptly.

PEPFAR-CI is currently conducting modeling and analysis of workforce requirements for the maintenance of HIV services in consultation with implementing partners. The results of this exercise will serve as the basis for formal dialogue with the MSHP and other stakeholders on greater shared responsibility of HRH requirements and as part of domestic resource mobilization efforts for HIV.

PEPFAR-CI is working assiduously with the MSHP on the definition and standardization of responsibilities and remuneration for community health workers within the framework of the National HIV response and the National Health Development Plan (PNDS 2016-2020).

To address challenges with the third 90 of the clinical cascade, PEPFAR-CI is introducing numerous measures to drastically improve access, uptake and increase viral suppression rates. Focus will be on children, adolescents, pregnant and breastfeeding women where gap have been observed. These changes/interventions include training 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; effective utilization of VL testing dashboards to fast track unsuppressed VL with emphasis on children and adolescents and to document clinical site and laboratory performance; improving the laboratory information system to collect data on VL uptake and real time data analysis. Programs and district health teams will be in charge of developing and implementing effective policies, planning, HRH and real time

monitoring of patient data. Packages of activities are defined for implementing partners to support the district heath teams, provide resources for registers, training materials, transportation and improve turnaround time for results. Case based ECHO long distance training platform and lab mapping to optimize VL lab network and improve laboratory clinical interface will continue. Facility and community IPs will receive adequate resources and staff for optimal management of patients to improve VL suppression, reduce mortality, and reduce lost to follow-up.

d. Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites;

Providing a patient-centered service delivery model to ensure linkage, retention, and achieve viral suppression will be a core pillar in COP19 programming. COP19 evidence-based approaches will focus on the "Link Me, Keep me, and Bring Me Back" approach that encompasses targeted interventions for newly diagnosed or established patients not engaged in care and treatment or lost to follow-up. Specific activities will include:

- Scale up community distribution of ARVs
- Expand flexible hours at facilities and streamline the flow of patients at the facility to reduce waiting times
- Identification of linkage and retention agents who will be working in the community to trace patients who miss appointments or are lost to follow-up (LTFU) and bring them back to care
- Identification of a clinic patient navigator who will be responsible for fast tracking the patient across the different service delivery points
- Identification of a treatment buddy who will support service providers in case management
- Implementation with fidelity of the revised standard operating procedures (SOPs) for management of appointments to prevent patients to become LTFU

COP19 will also focus on strengthening community-facility collaboration. Specific activities include:

- New packages of service delivery that streamline responsibilities of community and facility lay workers across the clinical cascade
- Weekly meeting of community and facility staff at the site for ongoing management, course correction, and facilitate collaborative case management
- Monthly meetings of community and facility IPs for ongoing review and management of site level collaboration, evaluate results, and course correct
- IP work plans including community-facility collaboration and shared indicators
- USG and MSHP monitoring that includes community-facility shared indicators

Also in COP19, weekly monitoring of site level data will be done to more rapidly identify and scale up best practices and course-correct issues. Additionally, TA will be provided by the IP, JHPIEGO,

to strengthen community-facility interface and improve active case management using a tablet based system.

e. Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control.

After reviewing MER indicator results, the Sustainability Index and Dashboard (SID 3.0), SIMS visit findings for the last three fiscal years, and conducting other trend analyses from granular site-level data, PEPFAR-CI consulted with the MSHP to identify key system barriers and determine above service delivery interventions that can help improve and sustain retention on ART.

In COP19, PEPFAR-CI will spend $8 Million on above service delivery interventions. The table below provides a mapping identified key barriers to measurable outcomes related to above service delivery interventions. Please refer to Table 6 (Appendix C) for more details.

Key Systems Barrier	Expected Outcome
1. Misalignment of OVC and DREAMS databases/reporting systems to inform layering and comprehensive services packages delivered to beneficiaries' sub-groups (OVC, DREAMS, and OVC & DREAMS).	Improved availability of quality and timely OVC and DREAMS data to inform decision making
2. Insufficient ART coverage and retention for men, women and adolescents due to slow adoption and low implementation of policies (differentiated service delivery models, including six month multi-month scripting, free user fees)	Increased on-ART Retention
3. Delayed implementation of TLD transition plan and adoption of optimal ART regimens	Côte d'Ivoire will transition patients to TLD beyond newly initiating men by FY2020. Without a comprehensive TLD transition plan and progress toward transition, PEPFAR cannot be successful in Côte d'Ivoire
4. Inconsistent implementation of high yield HIV screening and testing approaches including pediatric and adolescent case finding	Improved accuracy of HIV case finding at facility level
5. Limited coverage of TB preventive treatment (TPT) for PLHIVs (i.e. TPT not part of integral and routine part of the HIV clinical care package)*	Reduced HIV morbidity and mortality among TB coo-infected patients
6. Weak on-ART linkage of clients from testing to treatment across age, sex, and risk groups	Increased on-ART linkage and retention
7. Persistence of stigma and discrimination against people infected and affected by HIV/AIDS	Increased on-ART linkage and retention
8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	At least 90% of PLHIV are retained in care and are virally suppressed.

9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveillance, M&E, HIMS, unique identifier)	Improved data quality and timeliness for better programmatic decisions
10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	Scale up capacities local indigenous partners to own HIV response

*Please note that barrier 5 will be monitored and supported without specific funding from Table 6.

f. Use of unique identifiers across sites and programs in clinical settings

Côte d'Ivoire program linkage, retention, and data quality issues reflected in the COP19 Planning letter, motivated the following directive: *"Outline a plan to expedite the development and implementation of a unique identifier system to help facilitate linkage and improve data quality."* To handle those issues, PEPFAR-CI needs to implement a program level identifier, i.e. a unique patient ID for all PLHIVs and TB patients, regardless the program they are using (HTC, ART, PMTCT, Lab, etc.) and will need to facilitate linkage between HTC, ART, LAB and other services records, through efficient data exchange.

Expected Outcomes

- Use of unique patient level data for HIV program monitoring, evidence-based decision-making, disease surveillance and public health response
- Use of health information exchange between lab results, including VL and EMR, to improve turn-around time, data quality and use for clinical decision-making
- Use of combined longitudinal ART patient data coming from various sources, such as HTC, ART, Lab, and case notification, for improved service quality at facility level, for more comprehensive and accurate data analysis

4.6 Targets for scale-up locations and populations –SKIPPED- AWAITING DATIM INPUT

Standard Table 4.6.1

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts			
Entry Streams for ART Enrollment	**Tested for HIV (APR FY20) *HTS_TST***	**Newly Identified Positive (APR FY20) *HTS_TST_POS***	**Newly Initiated on ART (APR FY 20) *TX_NEW***
Total Men	**166,680**	**21,126**	**20,144**
Total Women	**879,899**	**54,147**	**51,649**
Total Children (<15)	**57,055**	**3,474**	**3,622**
Total from Index Testing	**135,150**	**28,123**	**NA**
Adults			
TB Patients	**15,504**	**1,332**	**1,385**
Pregnant Women	**454,102**	**4,366**	**4,106**
VMMC clients			

Key populations	23,748	3,128	NA
Priority Populations	NA	NA	NA
Other Testing	NA	NA	NA
Previously diagnosed and/or in care	NA	NA	NA
Pediatrics (<15)			
HIV Exposed Infants	9,699	268	268
Other pediatric testing	7,400	148	148
Previously diagnosed and/or in care			

Standard Table 4.6.3 is required; however, the rows for prioritized populations may be different for each country.

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY20)**	**FY20 Target**
PP_PREV	**229,565**	**65%**	**149,210**
KP_PREV	**62,666**	**52%**	**32,320**
TOTAL	**292,231**	**62%**	**181,530**

Standard Table 4.6.4 is required, except for countries with no OVC investments or targets.

Table 4.6.4 Targets for OVC and Linkages to HIV Services				
SNU	**Estimated # of Orphans and Vulnerable Children <18**	**Target # of active OVC (FY20Target) <18** OVC_SERV	**Target # of active OVC (FY20Target) <18 and 18+** OVC_SERV	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target)** OVC*
Abengourou	**5,951**	**2,072**	**2,593**	**2,307**
Abobo-Est	**14,913**	**14,595**	**18,372**	**16,213**
Abobo-Ouest	**4,444**	**3,178**	**3,975**	**3,531**
Adjame-Plateau-Attecoube	**11,286**	**9,410**	**11,768**	**10,455**
Adzope	**4,598**	**1,710**	**2,138**	**1,899**
Agboville	**7,975**	**2,912**	**3,643**	**3,238**
Akoupe	**3,542**	**1,591**	**1,990**	**1,770**
Anyama	**2,194**	**2,130**	**2,664**	**2,368**
Bangolo	**10,296**	**2,077**	**2,598**	**2,311**
Bondoukou	**8,074**	**4,619**	**5,776**	**5,130**
Bongouanou	**6,402**	**4,338**	**5,426**	**4,819**

Bouafle	7,106	2,276	2,846	2,531
Bouake-Nord-Est	4,213	3,021	3,778	3,357
Bouake-Nord-Ouest	8,371	5,118	6,399	5,687
Bouake-Sud	4,840	2,933	3,668	3,259
Cocody-Bingerville	12,586	12,183	15,427	13,534
Dabou	5,522	1,847	2,309	2,051
Daloa	13,783	11,245	13,968	12,493
Divo	9,273	7,207	9,015	8,009
Duekoue	13,200	4,335	5,421	4,816
Gagnoa	16,214	3,958	4,950	4,397
Guiglo	8,415	3,190	3,989	3,543
Issia	4,752	1,584	1,980	1,761
Korhogo 1	9,295	6,729	8,434	7,476
Koumassi-Port Bouet-Vridi	10,186	8,484	10,610	9,428
Man	19,987	6,653	8,367	7,394
Mankono	8,833	413	506	413
Oume	5,214	2,021	2,528	2,249
San-Pedro	12,045	3,613	4,519	4,014
Sinfra	4,653	2,481	3,103	2,756
Soubre	12,661	3,136	3,923	3,487
Tabou	2,772	439	538	439
Tanda	6,457	4,740	5,928	5,268
Tiassale	5,445	2,863	3,580	3,180
Treichville-Marcory	6,644	3,285	4,109	3,651
Yamoussoukro	7,931	2,433	3,043	2,704
Yopougon-Est	9,405	3,799	4,752	4,224
Yopougon-Ouest-Songon	12,474	2,633	3,293	2,927
TOTAL	321,952	161,251	201,926	179,089

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

5.1 COP19 Programmatic Priorities

PEPFAR-CI will reduce investment in clinical services at sustained sites. Targeted KP programming will continue based on hot spots and OVC programming will continue in 58 out of the 60 prioritized geographic districts. The focus will remain reaching at least 95% retention for all ages and sex bands in the 140 priority sites. PEPFAR-CI will conduct limited facility testing and community-based index testing around the positive identified in the facility for populations outside of KP and OVC.

Ensuring at least 95% linkage is a priority as well as ensuring good VL coverage and suppression for individuals receiving treatment. PEPFAR-CI will continue to provide commodities while lab sample transport will be limited to select sites.

The differences in the package of services for clinical services between priority and sustained sites are intensity of efforts, HRH investment, and frequency of site visits. Community services for the general population are limited only to priority sites.

5.2 Targets for attained and sustained locations and populations- SKIPPED – AWAITING DATIM

Standard Table 5.2.1 is required.

Table 5.2.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Saturation Support Districts*			
Saturation Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing (all populations)	*HTS_TST*	**915,696**	**1,103,634**
HIV positives (all populations)	*HTS_TST_POS*	**53,064**	**78,747**
Treatment new	*TX_NEW*	**114,787**	**75,415**
Current on ART	*TX_CURR*	**208,843**	**357,702**
OVC	*OVC_SERV*	**291,497**	**224,269**
Key populations	*KP_PREV*	**64,926**	**32,320**

*Calculations for targets for clinical services should be based on maintaining 80% ART coverage levels in the Attained districts. [Current Retention + (Passive HTC_POS * Linkage)]/PLHIV = 80% ART Coverage

Standard Table 5.2.2 is required.

Table 5.2.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts			
Sustained Support Volume by Group		**Expected result APR 19**	**Expected result APR 20**
HIV testing in PMTCT sites	*PMTCT_STAT*	**205,013**	-
HTS (only sustained ART sites in FY18)	*HTS_TST/HTS_TST_POS*	**48,0895 / 18,038**	-
Current on ART	*TX_CURR*	**66,595**	-
OVC	*OVC_SERV*	**11,403**	-

5.3 Establishing service packages to meet targets in attained and sustained districts

Patient category	Cadre	Activity/Task	Children	Adolescents	Women 15+	Men 15+	KP
undiagnosed	Facility lay worker	• Ensure Index testing implementation with fidelity and active referral (escort for treatment initiation to facilities) with documentation of successful ART initiation (patient unique ART identification code) • Handover of partner notification to the community after 2 weeks	x	x	x	x	
		• Ensure complete contact information with all PLHIV at each visit • Documentation of the index testing cascade (captured in the linkage register)	x	x	x	x	x
		** HIV negative and vulnerable AGYW, diagnosed in facility, Referral to DREAMS		x	x		
		• Children of HIV+ parents referred to OVC program	x				
		• HIV negative clients provided with prevention package (including PrEP for sero-discordant couples)		x	x	x	x
	Health care worker/lay worker	• Targeted facility based testing (PITC , pregnant & breastfeeding women, TB, key populations, EID)	x	x	x	x	
	Community worker	• Ensure Index testing/partner notification implementation with fidelity, active referral and documentation of treatment uptake	x	x	x	x	x
		• Support self-testing for specific populations				x	x

		• Ensure complete contact information with all PLHIV at each visit • documentation of the Index Testing cascade (captured in linkage register)	x	x	x	x	x
		• Testing of eligible OVC	x	x			
		• ** HIV negative and vulnerable, diagnosed in community, Referral to DREAMS		x	x		
		• Children of HIV+ parents referred to OVC program					
		• HIV negative clients provided with prevention package (including PrEP referral for sero-discordant couples)		x	x	x	x
Diagnosed, not linked	Facility lay worker	• Referral of OVC to OVC community program, share list with OVC case manager weekly	x	x			
		Post-test counseling including: • Treatment literacy and VL literacy • ART readiness assessment • Psychosocial support • Referral to support groups	x	x	x	x	x
		• Link new PLHIV with facilitator/ retention agents	x	x	x	x	x
		• Pre-visit reminder 48 hours before scheduled appointment • Call patients who do not initiate same day ART. After a minimum of 3 attempts within 1 week, hand over to community worker.	x	x	x	x	
	Community worker	• OVC case manager: follow-up with OVC and guardian • Strengthen linkage between OVC and facility	x	x			
		• Escort and hand off positives diagnosed in community to facility	x	x	x	x	x

		lay worker/health care worker • Documentation of successful ART initiation (for those tested in the community) linked to UIC (once available)					
		Post-test counseling including: • Treatment literacy and VL literacy • ART readiness assessment • Psychosocial support • Referral to support groups	x	x	x	x	x
		• *Home visits for patients who do not initiate Tx after 1 week at facility after calling 3 times *(including TB suspects, and TB treatment)*	x	x	x	x	
	Health care worker	• Community ART initiation (approved for KP, other populations pending policy update)	x	x	x	x	x
Started ART, LTFU, or stopped ART	Facility worker	• Call newly initiated patients to check in one week after initiation (tracking side effects etc.)	x	x	x	x	x
		• Treatment coaching Pre-visit reminder 48 hours in advance	x	x	x	x	x
		• Scale up VL testing services and ensure utilization of VL results for patient management	x	x	x	x	x
		• Strengthen tracking and adherence support of LTFU patients in collaboration with the community worker (aided by MOU)	x	x	x	x	x
		• Call/ tracking of missed appointments up to 1 week (3 calls), then refer to community lay worker for community tracking	x	x	x	x	x
		• Document reasons for defaulting/stopping ART	x	x	x	x	x
		• Ensure client is paired with treatment buddy	x	X (adolescent	x	x	x

		for reinforced adherence		support services)			
		• Ensure DSD for eligible patients (based on lists of eligible patients)	X	X	x	x	x
		• Ensure scale up of TLD for eligible patients	X	x	x	x	x
		• Start TPT for eligible patients	x	x	x	x	x
	Community	• Home visits for LTFU after 1 week • Document reasons for defaulting/stopping ART to tailor programs	x	x	x	x	x
		• Referral to support groups • and strengthen community adherence support groups and "expert patients"	x	X (adolescent support services)	x	x	x
		• Ensure client is paired with treatment buddy for strengthening adherence	x	x	x	x	x
ART, not suppressed (Unstable)	Facility	• Index testing for high viremic patients. Handover of partner notification to community after 2 weeks.		x	x	x	x
		• Enhanced adherence counselling and repeat VL monitoring • Population specific support groups (including pediatric and adolescent support groups/package of services) • Appointment reminders 48 hours in advance	x	x	x	x	x
		• Support for TLD transition	x	x	x	x	x
		• Support implementation of Advanced disease package for those with CD4 <200 or clinical stage III/IV or children <5 years (including TB, CM)	x	x	x	x	x
		• Strengthen VL literacy education and continue throughout course of treatment	x	x	x	x	x
		• Scale up VL testing services and ensure	x	x	x	x	x

		utilization of VL results for patient management					
	Community	• Support Index testing for sexual partners of high viremic patients		x	x	x	x
		• Strengthen and continued adherence counseling and VL literacy education	x	x	x	x	x
		• Support facility lay worker in tracking patients who have not returned for VL after 1 week	x	x	x	x	x
		• Population specific support groups (including pediatric and adolescent support groups/package of services)	x	x	x	x	x
Stable patients on DSD (> 6 months	Facility	• Pre-visit/appointment reminders 48 hours in advance including VL once a year	x	x	x	x	x
		• Support MMS (graduation to 6 month scripting, bulk pill dispensation) and • Support Fast track with pharmacy pick-ups	x	x	x	x	x
		• Population specific support groups (including pediatric and adolescent support groups/package of services)	x	x	x	x	x
		• F/u community ARV distribution to ensure documentation aligns with M& E	x	x	x	x	x
		• Phone screening of opportunistic infections for stable patients (every quarter)	x	x	x	x	x
	Community	• Supervise Community ARV distribution and share lists with facility Lay worker	x	x	x	x	
		• Assess and strengthen VL literacy and	x	x	x	x	

		education including U=U messaging, as needed					
		• Call for MMD patient for check-in monthly and document accordingly	x	x	x	x	x
		• Population specific support groups (including pediatric and adolescent support groups/package of services)	x	x	x	x	x
Cross-cutting elements		• Ensure training and continued mentorship of existing and recruited CHWs, peer educators, peer navigators to support all populations	x	x	x	x	x
		• Continuous quality improvement	x	x	x	x	x
		• Ensure data quality and reporting	x	x	x	x	x
		• Weekly meetings between facility and community lay workers to strengthen case management	x	x	x	x	x

<u>Package for 140 priority sites</u>

- Implement the above service package by population in both facility and community
- Conduct at least monthly site visit by partners and joint USG/MSHP/CSO to assess quality of services and/or provide coaching/mentoring to facility staff
- Ensure weekly reporting of custom indicators to monitor retention
- Implement all policies (TLD, no user fees, DSD, TPT, etc.), and monitor implementation
- Ensure adequate HRH allocation based on the gaps but the bottom line is that PEPFAR will be supporting:
  - Lay workers in the facility and community (# TBD based on patient volume)
  - Data manager at each site
  - Clinical and clinical support staff (Doctors, Nurses, Midwives, Laboratory Technicians, Pharmacists and/or Assistant Pharmacists) based on the gaps and in alignment with the MSHP's vision to utilize its staff where available
  - Hire social workers (as needed) and link them to social centers so they can coach and supervise lay workers and provide additional support counseling
- Ensure SIGDEP2 is available

<u>Package for sustained sites</u>

- Implementation of the above service package by population in facility only – OVC and KP community IPs also have MOUs with applicable sites

- Conduct quarterly site visits
- Conduct quarterly data analysis
- Implement policies (TLD, no user fees, DSD, TPT, etc.)
- Ensure HRH reallocation
    - Transition all facility-based lay workers that PEPFAR currently supports to MSHP and ensure that MSHP provides adequate resources to support sites based on patient volume
    - PEPFAR will continue to fund data managers at sites, including sharing data managers across smaller sites as needed.
    - Transition support for all clinical staff (doctors, nurses and midwives) currently supported by PEPFAR to MSHP in the public sector sustained sites. In these sites, ensure MSHP-staff engagement in the service provision of activities.
    - In FBOs/NGO facilities, PEPFAR will continue to support clinical staff based on a case-by-case analysis to determine need and depending on patient volume.
- Service package (testing, treatment, VL) should not differ from sustained and priority sites

5.4 HRH allocation

PEPFAR-CI will focus on providing HRH support for the 140 priority sites. Working with the MSHP and implementing partners, it will be determined how many staff are currently at each site per cadre. Level of effort required for each cadre will be calculated to determine, per site, how many staff are needed based on patient volume. If additional staff are needed, PEPFAR-CI will work with the MSHP and implementing partners to redistribute resources to the appropriate sites. If additional clinical staff and clinical support staff are needed, priority will be given to provide performance-based financing to MSHP staff, and PEPFAR supported staff will be prioritized for management, social workers, lay workers, and other cadres, per the suggestion of the MSHP. In addition, PEPFAR-CI will work with implementing partners to ensure that resources are available for staff to provide the appropriate services. As previously mentioned, community lay workers will be assigned to each of the priority sites. As part of the April 2019 circulaire signed by the MSHP, monitoring at facilities has begun to ensure that employees report to work as expected and outlined specific repercussions for absenteeism.

Similar to the priority sites, in the 795 sustained sites, PEPFAR-CI will work with the MSHP and implementing partners to determine how many staff are currently at each site per cadre. Level of effort will be calculated to determine how many staff per cadre are needed.

Since the 140 priority sites are PEPFAR-CI's focus, their staffing needs will be assessed and addressed accordingly, which may include providing direct HRH support. For the 795 sustained sites, however, the MSHP will have to fill the staffing gaps as PEPFAR-CI will only provide data HRH assistance. PEPFAR-CI will support data managers, sharing data managers across multiple sites or programs depending on the size and location of the site. PEPFAR-CI is currently working

to determine if the MSHP will provide facility lay workers to the sustained sites. Community lay workers will not be assigned to sustained sites.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Through SID 3.0, MER, SIMS and Granular Site Management visits, PEPFAR-CI has identified ten (10) key system barriers that prevent it from fully achieving its objectives. To address these barriers, the majority of the systems level investments in Table 6 support activities to strengthen and enable an environment for quality service delivery.

The vast majority of proposed activities are related to SID 3.0 elements with the objectives to i) improve availability of quality and timely OVC and DREAMS, ii) increase VL coverage and suppression rate, iii) increase on ART linkage and Retention, iv) transition all PLHIV to TLD, v) decrease HIV morbidity and mortality, and vi) reduce HIV-related stigma and discrimination against KP and PLHIV.

These objectives and their corresponding above-site activities provide the foundation for the site-level, service delivery interventions supporting PEPFAR-CI. All planned activities work together toward sustained epidemic control.

The benchmarks and outcomes identified by the PEPFAR-CI team are measurable and reasonable, with the intention of monitoring progress on a quarterly basis.

a. Laboratory

During FY2020, PEPFAR-CI will focus on addressing the challenges and weaknesses identified during FY2018:

- Weak clinical and laboratory interface
- Weak VL literacy among laboratory, clinical and community providers
- Delays in sample processing to weak human resources and infrastructure
- Long turnaround time
- Insufficient laboratory and clinical interface.

In FY2018, 17 VL labs supported by PEPFAR were functional and strategically located throughout the country. All laboratories will be operating to increase their testing capacities and optimizing the VL equipment utilization. The use of DBS for better uptake in remote sites will be strengthened. PEPFAR-CI through this increased capacity for VL testing and the utilization of DBS for sample collection, expects a coverage of 92% by FY2019.

The program will strategically place POC EID machines to increase 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 program within 50 laboratories and 3000 HIV testing points that have received proficiency testing panels for HIV. PEPFAR-CI is contributing to decentralizing microbiological testing to diagnose STIs and HIV opportunistic infections to ten regional laboratories, and will provide about 10,000 of these tests to HIV-infected KP.

PEPFAR-CI plans to fully transition RETRO-CI to the MSHP over a 5-year period. Details can be found in Annex E.

b. Supply chain

Supply chain strengthening interventions in FY2020 will continue to contribute to bolstering health systems for quality control, monitoring and real-time response.

Building on the prior year achievements in this area, PEPFAR-CI investments focus on support for improved: monitoring of inventory management at the lower levels of the health system supply chain; real-time availability of stock and reliable supply chain; logistics data to inform supply plan management and decision-making; forecasting and quantification, planning, and implementation of the TLD transition. Improved management of lab commodities at the central and subnational levels of the health systems; and assuring an effective national logistics system for a community-based distribution of ARVs. Table 6 includes detailed interventions. Concurrently, these activities will also assure improved coordination among stakeholders and increased ownership of local institutions of supply chain processes.

7.0 Staffing Plan

Staffing analysis

CDC completed an office restructuring exercise by June 2019 to ensure that the office will be adequately staffed for program performance and that S/GAC increasing demands for site level monitoring and closer partner management could be appropriately accomplished. As part of this process, positions were selected for abolishment and repurposing, and several vacancies were abolished in COP18 with a plan for continued reassessment of staff performance to ensure that highly skilled staff with multiple competencies were retained or recruited to better support PEPAR strategic goals and objectives. Following the planned reductions in the COP19 planning letter, additional changes were made to meet the budgetary restrictions, resulting in plans for staffing reduction and additional repurposing of existing and vacant positions.

DOD has two local positions to cover program performance needs and will continue to use ICASS to limit the number of staff and to optimize administrative and other support cost sharing.

PCO is reducing staffing by two positions in COP19. PCO will share administration responsibilities with CDC and USAID; furthermore, the media coordination responsibilities will be handled by the State Department, Public Affairs Section (PAS) to reduce duplication.

USAID conducted an analysis to ensure adequate staffing levels to execute the required number of increased site visits and also the transition to local partners for the key populations program. USAID has received approval to hire two additional local staff to support staffing needs outside the COP19 PPL budget.

The overall USG footprint for all agencies was reassessed to maximize efficiencies and reduce any duplication. Interagency program staff will be actively engaged in SIMS and granular site management visits with occasional support from non-PEPFAR program staff.

Long Term Vacant Positions

CDC has three vacant positions at different stages of the hiring process. Recruitment of a local-hire Biostatistician was delayed due to the requirement to reclassify the position, a task assigned to the Department of State regional classification center, which was understaffed due to the previous hiring freeze and affected other agencies' ability to recruit. Classification is completed and recruitment should be done by mid July 2019. As a recognized expert on advanced methods of statistical analysis, the incumbent provides expert technical assistance to both CDC and PEPFAR teams, and partners to plan and implement data quality and information use strategies. He/she provides support in all phases of PEPFAR program data collection (target setting, SIMS, EA, Q/S/APR, etc), data quality, and information use assurance. Temporary and remote assistance was provided intermittently from Atlanta to address this gap. It is expected that the recruitment of the HIV Clinical Advisor (repurposed Associate Director of Science) and the Deputy Country Director will be completed by the end of August 2019.

USAID currently has two vacancies, though one is for the PEPFAR Coordinator's Office. The agency has completed the recruitment process for both vacancies and is expecting a start date of July 2019.

DOD has one vacant local hire position, the Strategic Information Specialist. All documentation was approved by the Embassy's Management section and was sent to the Regional Classifier for position classification. It is expected that the recruitment will be completed by the end of September 2019.

PCO There are currently no State funded PCO vacancies

Proposed New Positions for COP19

CDC has no new positions proposed for COP19.

USAID received approval to add two new positions. Considering the need to support the overall large-scale transition from international implementing partners to local partners, USAID intends to recruit 2 technical staff: one Technical Programmatic specialist and one Management Specialist. The new staff will help build capacity of new local partners to ensure they meet USG financial management requirements and comply with USAID acquisition and assistance regulations and processes, while maintaining high quality service delivery. All the new staff will be

local hire Foreign Service Nationals who will be based in the USAID office and spend between 50%-75% of their time with local partners working on site level data and information. The capacity building approach will involve hand-on mentorship and coaching with an emphasis on community-level interactions and feedback systems.

DOD has no new positions proposed for COP19

PCO has no new positions proposed for COP19.

Major changes to CODB

CDC will have a significant reduction in CODB due to staffing reductions and travel expenses may increase depending on the required site visit requirements for COP19.

USAID has reduced its CODB by 9.6% compared with COP18 levels. This change is due to reductions in the ICASS, professional development, and IT budgets.

DOD has no major changes to CODB.

PCO has a slightly higher CODB than COP18 funding levels due to the staff layoff packages, which will be paid out during COP19. The benefits of PCO staff reduction will be realized during COP20 and beyond.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

District	COP	prioritization	Results Reported	Attained: 909-90-90 (81%) by Each Age and Sex Band to Reach 95-95-95 (90%) Overall																							
				Treatment Coverage at APR by Age and Sex																							
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Abengourou	COP15	Agg	APR 16	8%	6%	13%	13%	18%	19%	21%	21%	5%	3%	18%	4%	58%	15%	79%	21%	105%	37%	153%	87%	153%	87%	49%	47%
	COP16	Agg	APR 17	13%	11%	21%	24%	29%	34%	35%	38%	6%	4%	21%	4%	68%	18%	93%	25%	123%	44%	180%	103%	180%	103%	57%	55%
	COP17	Satur	APR 18	26%	37%	26%	37%	26%	37%	26%	37%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%
	COP18	Satur	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	86%	97%	86%	97%	86%	97%	86%	97%	86%	97%	86%	97%	86%	97%	86%	97%
	COP19	Satur	APR 20	72%	77%	51%	140%	53%	53%	67%	59%	33%	68%	60%	94%	105%	150%	98%	139%	100%	127%	81%	99%	60%	94%	44%	73%
Abobo-Est	COP15	Satur	APR 16	14%	14%	23%	30%	32%	43%	38%	48%	7%	3%	26%	4%	84%	15%	116%	21%	153%	37%	223%	89%	223%	89%	71%	47%
	COP16	Satur	APR 17	17%	15%	29%	31%	40%	44%	47%	50%	9%	4%	30%	4%	97%	18%	133%	25%	176%	44%	258%	105%	258%	105%	82%	56%
	COP17	Satur	APR 18	106%	137%	106%	137%	106%	137%	106%	137%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%
	COP18	Satur	APR 19	109%	135%	109%	135%	109%	135%	109%	135%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%
	COP19	Satur	APR 20	177%	226%	235%	311%	97%	102%	48%	50%	15%	55%	26%	132%	49%	230%	82%	249%	94%	149%	83%	77%	50%	46%	28%	30%
Abobo-Ouest	COP15	Satur	APR 16	20%	18%	33%	38%	46%	56%	55%	62%	8%	4%	28%	5%	92%	21%	126%	28%	166%	50%	244%	119%	244%	119%	78%	64%
	COP16	Satur	APR 17	20%	16%	34%	33%	47%	48%	55%	53%	9%	4%	32%	5%	105%	21%	144%	29%	190%	52%	278%	122%	278%	122%	89%	65%
	COP17	Satur	APR 18	138%	145%	138%	145%	138%	145%	138%	145%	152%	66%	152%	66%	152%	66%	152%	66%	152%	66%	152%	66%	152%	66%	152%	66%
	COP18	Satur	APR 19	136%	168%	136%	168%	136%	168%	136%	168%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%
	COP19	Satur	APR 20	289%	224%	413%	336%	339%	275%	211%	236%	155%	150%	128%	219%	143%	400%	169%	543%	198%	407%	262%	278%	164%	212%	134%	173%
Adjame-Plateau-Attecoube	COP15	Agg	APR 16	5%	4%	8%	9%	11%	12%	13%	14%	5%	3%	16%	4%	51%	15%	70%	21%	93%	37%	135%	87%	135%	87%	43%	47%
	COP16	Agg	APR 17	6%	5%	10%	10%	15%	15%	17%	17%	5%	4%	19%	4%	62%	18%	84%	24%	111%	43%	163%	101%	163%	101%	52%	54%
	COP17	Agg	APR 18	45%	35%	45%	35%	45%	35%	45%	35%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%
	COP18	Agg	APR 19	82%	101%	82%	101%	82%	101%	82%	101%	83%	89%	83%	89%	83%	89%	83%	89%	83%	89%	83%	89%	83%	89%	83%	89%

	COP19	Satur	APR 20	57%	35%	77%	84%	49%	56%	29%	39%	14%	40%	22%	61%	33%	121%	66%	150%	75%	143%	92%	90%	75%	62%	54%	53%
Adzope	COP15	Agg	APR 16	6%	4%	10%	8%	13%	11%	16%	12%	2%	1%	6%	1%	19%	6%	26%	8%	34%	13%	50%	32%	50%	32%	16%	17%
	COP16	Agg	APR 17	10%	6%	16%	13%	23%	19%	27%	22%	2%	1%	6%	2%	20%	7%	28%	9%	36%	17%	53%	39%	53%	39%	17%	21%
	COP17	Agg	APR 18	32%	22%	32%	22%	32%	22%	32%	22%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	107%	122%	107%	122%	107%	122%	107%	122%	107%	122%	107%	122%	107%	122%	107%	122%
	COP19	Satur	APR 20	52%	22%	75%	81%	54%	56%	14%	36%	10%	42%	27%	73%	34%	95%	34%	89%	77%	106%	71%	67%	67%	55%	55%	59%
Agboville	COP15	Agg	APR 16	9%	7%	15%	15%	21%	21%	24%	24%	3%	2%	10%	2%	34%	9%	46%	13%	61%	23%	89%	53%	89%	53%	28%	29%
	COP16	Agg	APR 17	12%	8%	19%	17%	27%	25%	32%	28%	3%	2%	11%	2%	35%	9%	48%	12%	63%	22%	93%	52%	93%	52%	30%	28%
	COP17	Agg	APR 18	30%	27%	30%	27%	30%	27%	30%	27%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	101%	115%	101%	115%	101%	115%	101%	115%	101%	115%	101%	115%	101%	115%	101%	115%
	COP19	Satur	APR 20	47%	68%	44%	60%	31%	34%	18%	17%	11%	22%	14%	39%	19%	59%	25%	56%	42%	68%	43%	43%	41%	44%	32%	38%
Agnibilekrou	COP15	Sust	APR 16	11%	9%	18%	18%	26%	26%	30%	29%	5%	3%	18%	4%	60%	17%	82%	23%	109%	40%	159%	95%	159%	95%	51%	51%
	COP16	Sust	APR 17	9%	7%	14%	15%	20%	22%	24%	25%	6%	3%	20%	4%	65%	16%	88%	22%	117%	39%	171%	92%	171%	92%	55%	50%
	COP17	Sust	APR 18	29%	27%	29%	27%	29%	27%	29%	27%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%
	COP18	Sust	APR 19	57%	76%	57%	76%	57%	76%	57%	76%	77%	87%	77%	87%	77%	87%	77%	87%	77%	87%	77%	87%	77%	87%	77%	87%
	COP19	Satur	APR 20	90%	96%	77%	110%	53%	29%	31%	22%	15%	41%	9%	46%	61%	84%	48%	91%	71%	88%	55%	66%	63%	91%	19%	44%
Akoupe	COP15	Agg	APR 16	9%	5%	15%	10%	20%	15%	24%	17%	2%	2%	7%	2%	24%	9%	32%	13%	43%	23%	63%	54%	63%	54%	20%	29%
	COP16	Agg	APR 17	12%	8%	19%	16%	27%	24%	32%	26%	4%	3%	13%	3%	43%	13%	59%	17%	78%	31%	115%	72%	115%	72%	37%	39%
	COP17	Agg	APR 18	33%	17%	33%	17%	33%	17%	33%	17%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%
	COP19	Satur	APR 20	107%	111%	117%	87%	42%	61%	29%	33%	7%	39%	13%	77%	29%	82%	45%	93%	67%	147%	67%	67%	88%	97%	46%	57%
Alepe	COP15	Sust	APR 16	10%	4%	16%	9%	22%	13%	26%	15%	2%	1%	7%	2%	25%	7%	34%	10%	45%	17%	65%	41%	65%	41%	21%	22%

	COP16	Sust	APR 17	13%	6%	22%	13%	31%	19%	37%	21%	2%	2%	7%	2%	23%	10%	32%	14%	42%	24%	62%	57%	62%	57%	20%	31%
	COP17	Sust	APR 18	35%	21%	35%	21%	35%	21%	35%	21%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%
	COP18	Sust	APR 19	63%	83%	63%	83%	63%	83%	63%	83%	66%	75%	66%	75%	66%	75%	66%	75%	66%	75%	66%	75%	66%	75%	66%	75%
	COP19	Satur	APR 20	77%	241%	87%	241%	87%	63%	39%	40%	25%	18%	8%	72%	46%	116%	50%	140%	120%	196%	135%	155%	122%	169%	98%	150%
Anyama	COP15	Agg	APR 16	6%	4%	11%	8%	15%	12%	17%	13%	3%	1%	10%	2%	33%	7%	45%	10%	60%	18%	87%	42%	87%	42%	28%	22%
	COP16	Agg	APR 17	7%	6%	11%	12%	15%	17%	18%	19%	4%	2%	13%	2%	44%	9%	60%	12%	79%	22%	115%	52%	115%	52%	37%	28%
	COP17	Agg	APR 18	33%	27%	33%	27%	33%	27%	33%	27%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%
	COP18	Agg	APR 19	82%	101%	82%	101%	82%	101%	82%	101%	88%	93%	88%	93%	88%	93%	88%	93%	88%	93%	88%	93%	88%	93%	88%	93%
	COP19	Satur	APR 20	324%	234%	284%	146%	119%	164%	79%	126%	56%	64%	65%	139%	75%	190%	94%	245%	110%	209%	111%	128%	113%	151%	78%	111%
Bangolo	COP15	Agg	APR 16	2%	1%	3%	2%	5%	3%	6%	3%	1%	1%	5%	1%	15%	4%	21%	5%	28%	9%	41%	22%	41%	22%	13%	12%
	COP16	Agg	APR 17	2%	1%	3%	3%	4%	4%	4%	4%	2%	1%	6%	1%	21%	6%	29%	8%	38%	14%	56%	32%	56%	32%	18%	17%
	COP17	Agg	APR 18	75%	65%	75%	65%	75%	65%	75%	65%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%
	COP18	Agg	APR 19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%
	COP19	Satur	APR 20	6%	6%	2%	2%	3%	5%	3%	4%	6%	5%	14%	7%	12%	12%	7%	13%	11%	17%	17%	18%	12%	19%	6%	22%
Beoumi	COP15	Sust	APR 16	4%	3%	7%	7%	9%	10%	11%	11%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	19%	20%
	COP16	Sust	APR 17	6%	3%	9%	7%	13%	10%	15%	12%	3%	2%	10%	2%	33%	9%	45%	12%	59%	22%	86%	51%	86%	51%	27%	27%
	COP17	Sust	APR 18	20%	22%	20%	22%	20%	22%	20%	22%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%
	COP18	Sust	APR 19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%
	COP19	Satur	APR 20	115%	121%	10%	81%	39%	24%	20%	34%	19%	57%	26%	70%	27%	138%	66%	106%	69%	86%	57%	79%	79%	104%	82%	125%
Bettie	COP15	Sust	APR 16	3%	6%	6%	13%	8%	18%	9%	20%	2%	1%	7%	2%	21%	6%	29%	9%	39%	15%	57%	36%	57%	36%	18%	19%
	COP16	Sust	APR 17	5%	5%	8%	10%	11%	15%	13%	17%	2%	1%	7%	1%	22%	6%	31%	8%	40%	15%	59%	35%	59%	35%	19%	19%
	COP17	Sust	APR 18	10%	20%	10%	20%	10%	20%	10%	20%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%

	COP18	Sust	APR 19	63%	83%	63%	83%	63%	83%	63%	83%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Biankouma	**COP15**	Sust	APR 16	1%	1%	1%	1%	2%	2%	2%	2%	3%	2%	9%	2%	30%	8%	42%	11%	55%	19%	80%	44%	80%	44%	26%	24%
	COP16	Sust	APR 17	1%	2%	2%	4%	3%	6%	4%	6%	4%	2%	13%	3%	43%	10%	59%	14%	78%	25%	115%	60%	115%	60%	37%	32%
	COP17	Sust	APR 18	11%	11%	11%	11%	11%	11%	11%	11%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%
	COP18	Sust	APR 19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Blolequin	**COP15**	Sust	APR 16	2%	2%	4%	5%	5%	7%	6%	7%	1%	1%	5%	1%	16%	3%	21%	4%	28%	6%	41%	15%	41%	15%	13%	8%
	COP16	Sust	APR 17	3%	2%	5%	5%	6%	7%	7%	7%	2%	1%	6%	1%	20%	4%	27%	6%	35%	11%	52%	25%	52%	25%	16%	14%
	COP17	Sust	APR 18	9%	11%	9%	11%	9%	11%	9%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%
	COP18	Sust	APR 19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Bocanda	**COP15**	Sust	APR 16	7%	8%	11%	16%	16%	23%	19%	26%	3%	2%	12%	2%	39%	10%	53%	13%	70%	23%	102%	55%	102%	55%	33%	29%
	COP16	Sust	APR 17	7%	5%	11%	11%	16%	16%	19%	19%	4%	2%	12%	2%	41%	10%	56%	14%	74%	25%	108%	58%	108%	58%	35%	31%
	COP17	Sust	APR 18	12%	14%	12%	14%	12%	14%	12%	14%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%
	COP18	Sust	APR 19	56%	78%	56%	78%	56%	78%	56%	78%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%
	COP19	Satur	APR 20	71%	261%	35%	65%	25%	37%	30%	50%	10%	23%	14%	16%	83%	113%	29%	49%	38%	61%	22%	37%	34%	50%	59%	116%
Bondoukou	**COP15**	Agg	APR 16	10%	9%	17%	20%	24%	28%	29%	32%	5%	2%	17%	3%	56%	12%	76%	16%	101%	29%	148%	68%	148%	68%	47%	36%
	COP16	Agg	APR 17	16%	13%	26%	27%	37%	39%	43%	44%	7%	3%	24%	4%	80%	17%	109%	23%	144%	40%	211%	95%	211%	95%	67%	51%
	COP17	Satur	APR 18	93%	104%	93%	104%	93%	104%	93%	104%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%
	COP18	Satur	APR 19	77%	111%	77%	111%	77%	111%	77%	111%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%
	COP19	Satur	APR 20	101%	76%	94%	66%	45%	56%	70%	70%	50%	74%	47%	109%	56%	138%	74%	160%	96%	151%	112%	126%	109%	130%	64%	98%

Bongouanou	**COP15**	Agg	APR 16	8%	5%	13%	11%	18%	16%	22%	18%	4%	2%	14%	2%	45%	10%	62%	14%	81%	25%	119%	58%	119%	58%	38%	31%
	COP16	Agg	APR 17	9%	7%	15%	15%	21%	22%	25%	25%	5%	3%	17%	3%	55%	14%	76%	19%	100%	33%	146%	78%	146%	78%	47%	42%
	COP17	Agg	APR 18	39%	33%	39%	33%	39%	33%	39%	33%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%
	COP18	Agg	APR 19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%
	COP19	Satur	APR 20	98%	68%	57%	60%	51%	61%	54%	56%	20%	31%	11%	53%	103%	193%	40%	83%	49%	77%	60%	79%	67%	98%	89%	185%
Bouafle	**COP15**	Satur	APR 16	12%	10%	20%	20%	28%	29%	33%	33%	4%	2%	14%	3%	47%	12%	64%	16%	85%	28%	124%	67%	124%	67%	40%	36%
	COP16	Satur	APR 17	15%	13%	25%	28%	35%	40%	42%	45%	6%	4%	22%	4%	72%	17%	98%	24%	129%	42%	189%	100%	189%	100%	60%	54%
	COP17	Satur	APR 18	164%	161%	164%	161%	164%	161%	164%	161%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%
	COP18	Satur	APR 19	112%	144%	112%	144%	112%	144%	112%	144%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%
	COP19	Satur	APR 20	73%	96%	35%	48%	42%	60%	42%	47%	40%	34%	28%	85%	34%	93%	44%	103%	58%	105%	52%	89%	59%	84%	28%	76%
Bouake-Nord-Est	**COP15**	Agg	APR 16	6%	4%	10%	8%	14%	11%	17%	13%	4%	2%	12%	2%	40%	8%	54%	11%	72%	20%	105%	48%	105%	48%	34%	26%
	COP16	Agg	APR 17	7%	6%	12%	12%	16%	18%	20%	20%	5%	2%	15%	3%	51%	11%	70%	15%	92%	27%	135%	65%	135%	65%	43%	35%
	COP17	Agg	APR 18	43%	28%	43%	28%	43%	28%	43%	28%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%
	COP18	Agg	APR 19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%
	COP19	Satur	APR 20	49%	104%	37%	69%	42%	50%	38%	38%	13%	45%	16%	75%	21%	107%	29%	112%	58%	84%	59%	58%	56%	52%	37%	58%
Bouake-Nord-Ouest	**COP15**	Satur	APR 16	21%	20%	35%	42%	49%	61%	58%	68%	7%	4%	24%	5%	78%	21%	107%	29%	141%	51%	207%	120%	207%	120%	66%	64%
	COP16	Satur	APR 17	27%	21%	44%	43%	62%	62%	73%	70%	8%	5%	27%	6%	90%	24%	124%	33%	163%	59%	239%	140%	239%	140%	76%	75%
	COP17	Satur	APR 18	121%	166%	121%	166%	121%	166%	121%	166%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%
	COP18	Satur	APR 19	113%	156%	113%	156%	113%	156%	113%	156%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%
	COP19	Satur	APR 20	50%	96%	156%	162%	101%	117%	132%	145%	100%	82%	41%	98%	46%	151%	70%	193%	119%	152%	139%	146%	125%	159%	137%	197%
Bouake-Sud	**COP15**	Satur	APR 16	10%	7%	17%	15%	24%	22%	28%	25%	6%	3%	20%	4%	67%	16%	92%	22%	121%	38%	177%	91%	177%	91%	56%	49%
	COP16	Satur	APR 17	13%	8%	22%	18%	31%	25%	36%	29%	7%	4%	25%	4%	82%	18%	112%	25%	148%	44%	217%	104%	217%	104%	69%	56%
	COP17	Satur	APR 18	133%	88%	133%	88%	133%	88%	133%	88%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%

	COP18	Satur	APR 19	83%	115%	83%	115%	83%	115%	83%	115%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%
	COP19	Satur	APR 20	86%	106%	54%	79%	70%	74%	56%	94%	58%	105%	67%	142%	82%	204%	94%	245%	106%	224%	152%	175%	169%	181%	148%	211%
Bouna	COP15	Sust	APR 16	5%	5%	8%	10%	12%	15%	14%	16%	2%	1%	7%	2%	25%	7%	34%	10%	44%	17%	65%	40%	65%	40%	21%	21%
	COP16	Sust	APR 17	6%	5%	9%	10%	13%	15%	15%	17%	3%	2%	9%	2%	30%	9%	42%	12%	55%	21%	80%	50%	80%	50%	26%	27%
	COP17	Sust	APR 18	14%	17%	14%	17%	14%	17%	14%	17%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%
	COP18	Sust	APR 19	55%	80%	55%	80%	55%	80%	55%	80%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Boundiali	COP15	Sust	APR 16	11%	12%	19%	24%	26%	35%	31%	40%	5%	4%	17%	5%	57%	19%	79%	26%	104%	46%	152%	109%	152%	109%	48%	58%
	COP16	Sust	APR 17	17%	14%	27%	29%	38%	42%	45%	47%	7%	5%	24%	5%	78%	22%	107%	31%	141%	54%	206%	129%	206%	129%	66%	69%
	COP17	Sust	APR 18	25%	26%	25%	26%	25%	26%	25%	26%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%
	COP18	Sust	APR 19	60%	89%	60%	89%	60%	89%	60%	89%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%
	COP19	Satur	APR 20	26%	27%	91%	77%	58%	68%	40%	47%	16%	45%	21%	103%	23%	140%	71%	136%	88%	161%	114%	136%	116%	69%	31%	36%
Cocody-Bingerville	COP15	Satur	APR 16	34%	26%	56%	55%	78%	79%	92%	89%	8%	5%	27%	5%	89%	22%	121%	31%	160%	54%	234%	128%	234%	128%	75%	69%
	COP16	Satur	APR 17	36%	29%	60%	62%	83%	89%	99%	100%	10%	6%	34%	7%	112%	28%	154%	39%	203%	69%	297%	164%	297%	164%	95%	88%
	COP17	Satur	APR 18	162%	162%	162%	162%	162%	162%	162%	162%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%
	COP18	Satur	APR 19	109%	135%	109%	135%	109%	135%	109%	135%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%
	COP19	Satur	APR 20	384%	504%	349%	367%	130%	97%	57%	53%	35%	74%	48%	170%	92%	267%	131%	275%	162%	191%	125%	95%	80%	66%	52%	44%
Dabakala	COP15	Sust	APR 16	7%	5%	12%	11%	17%	16%	21%	18%	2%	1%	7%	1%	22%	5%	30%	7%	40%	12%	59%	29%	59%	29%	19%	16%
	COP16	Sust	APR 17	13%	10%	21%	21%	30%	30%	35%	33%	3%	2%	10%	2%	32%	8%	44%	10%	58%	18%	84%	44%	84%	44%	27%	23%
	COP17	Sust	APR 18	17%	15%	17%	15%	17%	15%	17%	15%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%
	COP18	Sust	APR 19	66%	54%	66%	54%	66%	54%	66%	54%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Dabou	**COP15**	Satur	APR 16	13%	9%	21%	19%	29%	27%	35%	30%	5%	3%	18%	3%	60%	14%	82%	19%	109%	33%	159%	78%	159%	78%	51%	42%
	COP16	Satur	APR 17	16%	13%	26%	26%	36%	38%	43%	43%	7%	4%	24%	5%	79%	20%	108%	27%	143%	48%	209%	114%	209%	114%	67%	61%
	COP17	Satur	APR 18	109%	97%	109%	97%	109%	97%	109%	97%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%
	COP18	Satur	APR 19	85%	112%	85%	112%	85%	112%	85%	112%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%
	COP19	Satur	APR 20	17%	54%	37%	76%	51%	64%	59%	91%	59%	31%	19%	62%	29%	75%	31%	98%	58%	112%	171%	254%	98%	134%	99%	122%
Daloa	**COP15**	Satur	APR 16	12%	7%	19%	14%	27%	21%	32%	24%	6%	4%	21%	5%	68%	19%	93%	25%	123%	45%	180%	107%	180%	107%	58%	57%
	COP16	Satur	APR 17	19%	15%	31%	31%	44%	45%	52%	50%	9%	6%	32%	7%	104%	28%	143%	38%	189%	68%	276%	161%	276%	161%	88%	86%
	COP17	Satur	APR 18	155%	70%	155%	70%	155%	70%	155%	70%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%
	COP18	Satur	APR 19	89%	106%	89%	106%	89%	106%	89%	106%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%
	COP19	Satur	APR 20	60%	82%	60%	42%	41%	80%	35%	54%	25%	65%	35%	104%	57%	138%	77%	137%	87%	142%	73%	100%	79%	98%	29%	77%
Danane	**COP15**	Sust	APR 16	3%	3%	5%	7%	6%	10%	8%	12%	4%	2%	12%	2%	41%	10%	56%	13%	74%	24%	108%	56%	108%	56%	35%	30%
	COP16	Sust	APR 17	5%	4%	8%	8%	11%	12%	13%	13%	4%	3%	15%	3%	50%	13%	69%	17%	91%	31%	132%	73%	132%	73%	42%	39%
	COP17	Sust	APR 18	16%	25%	16%	25%	16%	25%	16%	25%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%
	COP18	Sust	APR 19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP19	Satur	APR 20	10%	10%	8%	14%	11%	8%	13%	10%	6%	19%	5%	33%	14%	32%	19%	41%	29%	41%	27%	51%	28%	84%	19%	73%
Daoukro	**COP15**	Sust	APR 16	9%	6%	15%	13%	21%	19%	25%	21%	4%	3%	15%	3%	49%	12%	67%	17%	88%	30%	129%	71%	129%	71%	41%	38%
	COP16	Sust	APR 17	7%	6%	11%	13%	16%	18%	18%	21%	5%	3%	16%	3%	52%	13%	72%	18%	95%	32%	138%	76%	138%	76%	44%	41%
	COP17	Sust	APR 18	33%	22%	33%	22%	33%	22%	33%	22%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%
	COP18	Sust	APR 19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%
	COP19	Satur	APR 20	56%	59%	70%	81%	65%	77%	51%	92%	19%	29%	28%	65%	166%	299%	30%	81%	54%	94%	70%	89%	88%	111%	132%	201%
Didievi	**COP15**	Sust	APR 16	3%	3%	4%	7%	6%	10%	7%	12%	1%	1%	5%	1%	15%	5%	21%	7%	27%	12%	40%	28%	40%	28%	13%	15%
	COP16	Sust	APR 17	2%	2%	4%	5%	5%	7%	6%	8%	2%	1%	6%	1%	20%	5%	28%	7%	36%	12%	53%	29%	53%	29%	17%	15%
	COP17	Sust	APR 18	13%	20%	13%	20%	13%	20%	13%	20%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%

	COP18	Sust	APR 19	30%	42%	30%	42%	30%	42%	30%	42%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Dimbokro	**COP15**	Sust	APR 16	15%	12%	25%	25%	34%	37%	40%	41%	7%	4%	26%	5%	84%	19%	115%	25%	152%	45%	223%	106%	223%	106%	71%	57%
	COP16	Sust	APR 17	15%	9%	25%	19%	35%	27%	41%	30%	8%	4%	28%	5%	92%	19%	126%	26%	167%	47%	244%	110%	244%	110%	78%	59%
	COP17	Sust	APR 18	46%	40%	46%	40%	46%	40%	46%	40%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%
	COP18	Sust	APR 19	65%	90%	65%	90%	65%	90%	65%	90%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%
	COP19	Satur	APR 20	40%	42%	79%	31%	76%	75%	76%	100%	31%	41%	30%	74%	46%	137%	37%	122%	81%	154%	88%	155%	93%	170%	136%	310%
Divo	**COP15**	Agg	APR 16	8%	8%	13%	17%	18%	24%	21%	27%	3%	2%	12%	3%	39%	11%	53%	14%	70%	26%	102%	60%	102%	60%	33%	32%
	COP16	Agg	APR 17	10%	9%	17%	18%	23%	26%	27%	29%	4%	3%	15%	3%	49%	13%	67%	18%	89%	32%	130%	76%	130%	76%	41%	41%
	COP17	Agg	APR 18	19%	31%	19%	31%	19%	31%	19%	31%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%
	COP19	Satur	APR 20	67%	80%	52%	52%	29%	33%	22%	21%	16%	23%	7%	42%	23%	64%	28%	76%	42%	80%	61%	66%	58%	53%	45%	45%
Duekoue	**COP15**	Agg	APR 16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	7%	2%	22%	9%	30%	12%	39%	21%	57%	50%	57%	50%	18%	27%
	COP16	Agg	APR 17	6%	4%	10%	8%	14%	11%	16%	13%	3%	2%	10%	3%	32%	12%	44%	16%	58%	29%	85%	69%	85%	69%	27%	37%
	COP17	Agg	APR 18	26%	34%	26%	34%	26%	34%	26%	34%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%
	COP18	Agg	APR 19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%
	COP19	Satur	APR 20	5%	5%	6%	11%	15%	21%	9%	8%	11%	20%	7%	30%	13%	27%	18%	35%	20%	38%	29%	39%	28%	45%	15%	44%
Ferkessedougou	**COP15**	Sust	APR 16	8%	8%	13%	17%	18%	25%	22%	28%	5%	5%	17%	5%	56%	22%	76%	31%	100%	54%	147%	129%	147%	129%	47%	69%
	COP16	Sust	APR 17	13%	9%	21%	19%	29%	28%	34%	31%	6%	5%	22%	6%	72%	26%	98%	35%	130%	62%	189%	147%	189%	147%	61%	79%
	COP17	Sust	APR 18	19%	33%	19%	33%	19%	33%	19%	33%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%
	COP18	Sust	APR 19	60%	89%	60%	89%	60%	89%	60%	89%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%
	COP19	Satur	APR 20	19%	29%	33%	41%	50%	40%	50%	25%	23%	38%	18%	87%	53%	118%	61%	107%	67%	112%	62%	55%	78%	89%	34%	53%
Fresco	**COP15**	Sust	APR 16	7%	6%	12%	13%	17%	19%	20%	21%	3%	2%	10%	3%	33%	12%	45%	16%	59%	28%	87%	67%	87%	67%	28%	36%

	COP16	Sust	APR 17	7%	7%	12%	15%	17%	22%	20%	25%	3%	3%	11%	3%	36%	12%	50%	17%	65%	30%	96%	70%	96%	70%	31%	38%
	COP17	Sust	APR 18	16%	12%	16%	12%	16%	12%	16%	12%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%
	COP18	Sust	APR 19	63%	83%	63%	83%	63%	83%	63%	83%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gagnoa	COP15	Satur	APR 16	13%	9%	21%	19%	30%	28%	35%	31%	5%	3%	16%	4%	52%	14%	71%	20%	94%	35%	138%	83%	138%	83%	44%	44%
	COP16	Satur	APR 17	18%	14%	30%	29%	42%	42%	50%	48%	7%	5%	24%	6%	80%	23%	110%	32%	145%	56%	212%	133%	212%	133%	68%	71%
	COP17	Satur	APR 18	98%	130%	98%	130%	98%	130%	98%	130%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%
	COP18	Satur	APR 19	89%	106%	89%	106%	89%	106%	89%	106%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%
	COP19	Satur	APR 20	43%	28%	34%	36%	37%	37%	25%	24%	15%	29%	18%	59%	35%	75%	40%	90%	50%	88%	49%	68%	55%	69%	26%	57%
Grand-Lahou	COP15	Sust	APR 16	5%	7%	8%	14%	11%	21%	13%	23%	3%	2%	9%	2%	29%	9%	40%	13%	53%	23%	78%	54%	78%	54%	25%	29%
	COP16	Sust	APR 17	9%	8%	15%	17%	21%	24%	24%	27%	4%	3%	13%	3%	41%	12%	57%	17%	75%	30%	110%	71%	110%	71%	35%	38%
	COP17	Sust	APR 18	16%	28%	16%	28%	16%	28%	16%	28%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%
	COP18	Sust	APR 19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%
	COP19	Satur	APR 20	91%	111%	23%	40%	50%	19%	25%	18%	15%	14%	9%	31%	9%	36%	17%	51%	36%	67%	58%	64%	51%	51%	50%	51%
Gueyo	COP15	Sust	APR 16	6%	3%	10%	7%	14%	10%	16%	11%	1%	1%	5%	1%	16%	4%	22%	5%	29%	9%	43%	20%	43%	20%	14%	11%
	COP16	Sust	APR 17	6%	4%	9%	9%	13%	13%	15%	14%	2%	1%	6%	1%	18%	4%	25%	6%	33%	11%	49%	25%	49%	25%	16%	13%
	COP17	Sust	APR 18	5%	5%	5%	5%	5%	5%	5%	5%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%
	COP18	Sust	APR 19	39%	41%	39%	41%	39%	41%	39%	41%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Guiglo	COP15	Agg	APR 16	5%	4%	8%	9%	11%	12%	13%	14%	3%	2%	11%	3%	36%	11%	50%	15%	66%	27%	96%	64%	96%	64%	31%	34%
	COP16	Agg	APR 17	6%	4%	10%	9%	14%	13%	16%	15%	3%	2%	11%	3%	37%	12%	51%	16%	67%	28%	99%	67%	99%	67%	32%	36%
	COP17	Agg	APR 18	35%	29%	35%	29%	35%	29%	35%	29%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%
	COP18	Agg	APR 19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%

	COP19	Satur	APR 20	4%	4%	17%	14%	16%	17%	23%	20%	4%	21%	15%	39%	25%	46%	39%	66%	24%	61%	41%	61%	37%	52%	24%	85%
Guitry	COP15																										
	COP16																										
	COP17																										
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Issia	COP15	Satur	APR 16	7%	7%	12%	16%	16%	23%	19%	26%	5%	3%	16%	3%	52%	14%	72%	19%	95%	34%	138%	81%	138%	81%	44%	43%
	COP16	Satur	APR 17	14%	10%	23%	21%	33%	31%	39%	35%	7%	4%	24%	5%	80%	21%	109%	28%	145%	50%	211%	119%	211%	119%	68%	64%
	COP17	Satur	APR 18	95%	123%	95%	123%	95%	123%	95%	123%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%
	COP18	Satur	APR 19	103%	132%	103%	132%	103%	132%	103%	132%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%
	COP19	Satur	APR 20	82%	86%	30%	36%	66%	48%	16%	32%	36%	40%	27%	94%	43%	115%	62%	137%	83%	128%	72%	108%	83%	105%	38%	75%
Jacqueville	COP15	Sust	APR 16	7%	4%	11%	8%	16%	12%	19%	13%	2%	1%	6%	1%	20%	5%	27%	7%	36%	12%	53%	29%	53%	29%	17%	16%
	COP16	Sust	APR 17	10%	6%	16%	12%	22%	17%	26%	19%	3%	2%	10%	2%	33%	9%	45%	13%	60%	23%	88%	54%	88%	54%	28%	29%
	COP17	Sust	APR 18	20%	11%	20%	11%	20%	11%	20%	11%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%
	COP18	Sust	APR 19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%
	COP19	Satur	APR 20	24%	25%	12%	12%	45%	26%	24%	20%	4%	15%	5%	30%	13%	41%	22%	48%	34%	56%	45%	55%	37%	39%	41%	47%
Katiola	COP15	Sust	APR 16	12%	6%	20%	12%	28%	18%	33%	20%	4%	2%	12%	2%	40%	8%	55%	11%	73%	20%	107%	47%	107%	47%	34%	25%
	COP16	Sust	APR 17	14%	7%	23%	15%	32%	21%	38%	24%	4%	2%	15%	3%	48%	11%	66%	14%	87%	26%	127%	61%	127%	61%	40%	32%
	COP17	Sust	APR 18	21%	17%	21%	17%	21%	17%	21%	17%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%
	COP18	Sust	APR 19	72%	59%	72%	59%	72%	59%	72%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%
	COP19	Satur	APR 20	117%	124%	68%	57%	92%	64%	63%	181%	44%	55%	25%	66%	34%	56%	32%	59%	38%	85%	73%	126%	73%	195%	26%	103%
Korhogo	COP15	Satur	APR 16	13%	10%	21%	22%	30%	32%	35%	35%	6%	4%	22%	4%	73%	18%	100%	24%	132%	43%	192%	103%	192%	103%	61%	55%
	COP16	Satur	APR 17	16%	13%	26%	27%	36%	40%	43%	45%	8%	5%	27%	5%	89%	22%	122%	30%	161%	54%	236%	128%	236%	128%	75%	68%
	COP17	Satur	APR 18	126%	111%	126%	111%	126%	111%	126%	111%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%

	COP18	Satur	APR 19	89 %	131 %	89 %	131 %	89 %	131 %	89 %	131 %	116 %	141 %	116 %	141 %	116 %	141 %	116 %	141 %	116 %	141 %	116 %	141 %	116 %	141 %	116 %	141 %
	COP19		APR 20																								
Korhogo 1	COP19	Satur	APR 20	132 %	113 %	105 %	108 %	78 %	86 %	83 %	71 %	61 %	116 %	44 %	233 %	197 %	306 %	186 %	286 %	159 %	209 %	138 %	123 %	114 %	97 %	40 %	70 %
Kouibly	COP15	Sust	APR 16	2%	1%	3%	2%	5%	3%	5%	4%	2%	1%	6%	1%	19 %	5%	26 %	7%	34 %	12 %	50 %	28 %	50 %	28 %	16 %	15 %
	COP16	Sust	APR 17	3%	2%	5%	5%	7%	7%	8%	8%	2%	1%	8%	2%	25 %	7%	34 %	9%	45 %	17 %	66 %	40 %	66 %	40 %	21 %	21 %
	COP17	Sust	APR 18	8%	6%	8%	6%	8%	6%	8%	6%	38 %	18 %	38 %	18 %	38 %	18 %	38 %	18 %	38 %	18 %	38 %	18 %	38 %	18 %	38 %	18 %
	COP18	Sust	APR 19	35 %	48 %	35 %	48 %	35 %	48 %	35 %	48 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %
	COP19	Satur	APR 20	8%	9%	6%	6%	19 %	11 %	12 %	12 %	3%	13 %	2%	14 %	6%	26 %	17 %	31 %	24 %	40 %	30 %	40 %	30 %	51 %	21 %	68 %
Koumassi-Port Bouet-Vridi	COP15	Agg	APR 16	11 %	7%	18 %	15 %	25 %	22 %	29 %	24 %	5%	3%	18 %	3%	60 %	12 %	82 %	17 %	109 %	30 %	159 %	71 %	159 %	71 %	51 %	38 %
	COP16	Agg	APR 17	12 %	9%	21 %	20 %	29 %	28 %	34 %	32 %	7%	3%	23 %	4%	74 %	16 %	102 %	22 %	135 %	39 %	197 %	91 %	197 %	91 %	63 %	49 %
	COP17	Agg	APR 18	48 %	38 %	48 %	38 %	48 %	38 %	48 %	38 %	104 %	46 %	104 %	46 %	104 %	46 %	104 %	46 %	104 %	46 %	104 %	46 %	104 %	46 %	104 %	46 %
	COP18	Agg	APR 19	82 %	101 %	82 %	101 %	82 %	101 %	82 %	101 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %
	COP19	Satur	APR 20	135 %	98 %	184 %	249 %	114 %	159 %	86 %	105 %	43 %	57 %	47 %	136 %	48 %	224 %	91 %	289 %	121 %	227 %	134 %	144 %	102 %	103 %	68 %	82 %
Lakota	COP15	Sust	APR 16	11 %	9%	18 %	20 %	25 %	28 %	29 %	32 %	4%	3%	14 %	3%	46 %	14 %	62 %	19 %	82 %	35 %	121 %	82 %	121 %	82 %	39 %	44 %
	COP16	Sust	APR 17	14 %	11 %	24 %	22 %	33 %	32 %	39 %	36 %	5%	4%	17 %	5%	57 %	18 %	78 %	25 %	103 %	45 %	150 %	106 %	150 %	106 %	48 %	57 %
	COP17	Sust	APR 18	21 %	26 %	21 %	26 %	21 %	26 %	21 %	26 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %
	COP18	Sust	APR 19	63 %	83 %	63 %	83 %	63 %	83 %	63 %	83 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Man	COP15	Satur	APR 16	7%	4%	12 %	9%	16 %	13 %	19 %	14 %	5%	3%	16 %	3%	52 %	14 %	71 %	19 %	94 %	33 %	137 %	79 %	137 %	79 %	44 %	42 %
	COP16	Satur	APR 17	9%	6%	15 %	13 %	21 %	18 %	25 %	21 %	6%	4%	21 %	5%	70 %	20 %	97 %	27 %	127 %	48 %	187 %	115 %	187 %	115 %	60 %	62 %
	COP17	Satur	APR 18	149 %	73 %	149 %	73 %	149 %	73 %	149 %	73 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %
	COP18	Satur	APR 19	84 %	114 %	84 %	114 %	84 %	114 %	84 %	114 %	103 %	115 %	103 %	115 %	103 %	115 %	103 %	115 %	103 %	115 %	103 %	115 %	103 %	115 %	103 %	115 %

	COP19	Satur	APR 20	6%	5%	9%	14%	12%	18%	16%	12%	9%	17%	7%	31%	15%	30%	21%	41%	28%	46%	33%	47%	31%	58%	18%	70%
Mankono	COP15	Agg	APR 16	6%	6%	11%	13%	15%	19%	17%	21%	2%	1%	7%	2%	24%	7%	33%	10%	44%	17%	64%	40%	64%	40%	20%	22%
	COP16	Agg	APR 17	8%	7%	13%	14%	18%	20%	21%	22%	3%	2%	11%	3%	38%	11%	52%	15%	68%	27%	100%	63%	100%	63%	32%	34%
	COP17	Agg	APR 18	33%	27%	33%	27%	33%	27%	33%	27%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%
	COP18	Agg	APR 19	85%	96%	85%	96%	85%	96%	85%	96%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%
	COP19	Satur	APR 20	8%	12%	20%	24%	14%	18%	23%	16%	7%	25%	7%	61%	41%	75%	45%	106%	58%	99%	54%	68%	67%	64%	29%	47%
M'bahiakro	COP15	Sust	APR 16	4%	0%	7%	0%	10%	0%	12%	0%	2%	1%	6%	1%	20%	6%	28%	8%	37%	14%	54%	34%	54%	34%	17%	18%
	COP16	Sust	APR 17	4%	2%	7%	5%	10%	7%	11%	8%	2%	2%	7%	2%	24%	7%	33%	10%	43%	18%	63%	42%	63%	42%	20%	23%
	COP17	Sust	APR 18	18%	15%	18%	15%	18%	15%	18%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%
	COP18	Sust	APR 19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%
	COP19	Satur	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Minignan	COP15	Sust	APR 16	1%	1%	2%	3%	2%	4%	3%	5%	1%	1%	3%	1%	11%	3%	16%	4%	21%	7%	30%	18%	30%	18%	10%	9%
	COP16	Sust	APR 17	2%	4%	3%	8%	4%	11%	5%	12%	2%	1%	5%	2%	18%	7%	24%	9%	32%	16%	46%	38%	46%	38%	15%	20%
	COP17	Sust	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%
	COP18	Sust	APR 19	71%	80%	71%	80%	71%	80%	71%	80%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nassian	COP15	Sust	APR 16	0%	3%	0%	7%	0%	10%	0%	11%	3%	2%	9%	2%	28%	7%	39%	10%	51%	18%	75%	42%	75%	42%	24%	23%
	COP16	Sust	APR 17	5%	4%	9%	9%	12%	13%	15%	14%	3%	1%	11%	2%	36%	7%	50%	9%	66%	16%	96%	38%	96%	38%	31%	21%
	COP17	Sust	APR 18	31%	6%	31%	6%	31%	6%	31%	6%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%
	COP18	Sust	APR 19	52%	75%	52%	75%	52%	75%	52%	75%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Niakarama dougou	COP15	Sust	APR 16	8%	5%	13%	10%	18%	15%	21%	17%	2%	1%	7%	1%	22%	6%	30%	8%	40%	14%	59%	33%	59%	33%	19%	18%
	COP16	Sust	APR 17	7%	6%	12%	13%	17%	19%	20%	21%	2%	1%	8%	1%	26%	6%	36%	8%	47%	14%	69%	34%	69%	34%	22%	18%

	COP17	Sust	APR 18	32%	25%	32%	25%	32%	25%	32%	25%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%
	COP18	Sust	APR 19	44%	36%	44%	36%	44%	36%	44%	36%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Odienne	**COP15**	Sust	APR 16	9%	9%	15%	20%	21%	28%	25%	32%	3%	2%	9%	2%	29%	8%	40%	11%	53%	19%	78%	45%	78%	45%	25%	24%
	COP16	Sust	APR 17	13%	10%	21%	22%	29%	31%	35%	35%	4%	2%	13%	3%	44%	11%	60%	15%	79%	26%	115%	61%	115%	61%	37%	33%
	COP17	Sust	APR 18	17%	20%	17%	20%	17%	20%	17%	20%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%
	COP18	Sust	APR 19	47%	53%	47%	53%	47%	53%	47%	53%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Ouangolodougou	**COP15**	Sust	APR 16	5%	9%	9%	19%	12%	27%	15%	30%	3%	3%	12%	3%	39%	13%	54%	18%	71%	32%	104%	75%	104%	75%	33%	40%
	COP16	Sust	APR 17	9%	9%	16%	19%	22%	28%	26%	32%	5%	3%	15%	4%	51%	16%	70%	22%	92%	39%	135%	93%	135%	93%	43%	50%
	COP17	Sust	APR 18	8%	19%	8%	19%	8%	19%	8%	19%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%
	COP18	Sust	APR 19	60%	89%	60%	89%	60%	89%	60%	89%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Oume	**COP15**	Agg	APR 16	5%	4%	9%	9%	12%	13%	15%	14%	3%	2%	10%	3%	34%	11%	47%	14%	62%	26%	90%	60%	90%	60%	29%	32%
	COP16	Agg	APR 17	8%	7%	13%	14%	17%	21%	21%	23%	4%	3%	15%	3%	51%	13%	70%	18%	92%	32%	134%	76%	134%	76%	43%	41%
	COP17	Agg	APR 18	34%	26%	34%	26%	34%	26%	34%	26%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%
	COP18	Agg	APR 19	80%	104%	80%	104%	80%	104%	80%	104%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%
	COP19	Satur	APR 20	83%	70%	50%	48%	20%	48%	29%	58%	19%	58%	12%	85%	15%	96%	34%	113%	61%	86%	53%	68%	60%	66%	27%	59%
Prikro	**COP15**	Sust	APR 16	5%	4%	8%	9%	11%	14%	13%	15%	3%	2%	12%	2%	39%	10%	53%	14%	70%	25%	102%	58%	102%	58%	33%	31%
	COP16	Sust	APR 17	6%	8%	11%	17%	15%	25%	18%	28%	4%	2%	15%	3%	49%	11%	67%	15%	88%	26%	128%	62%	128%	62%	41%	33%
	COP17	Sust	APR 18	14%	23%	14%	23%	14%	23%	14%	23%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%
	COP18	Sust	APR 19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%

	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sakassou	**COP15**	Sust	APR 16	14 %	12 %	23 %	25 %	32 %	36 %	37 %	41 %	4%	3%	13 %	3%	44 %	13 %	60 %	17 %	79 %	31 %	116 %	72 %	116 %	72 %	37 %	39 %
	COP16	Sust	APR 17	16 %	13 %	27 %	28 %	38 %	41 %	45 %	46 %	6%	3%	20 %	4%	65 %	16 %	89 %	22 %	117 %	38 %	171 %	91 %	171 %	91 %	55 %	49 %
	COP17	Sust	APR 18	26 %	26 %	26 %	26 %	26 %	26 %	26 %	26 %	76 %	43 %	76 %	43 %	76 %	43 %	76 %	43 %	76 %	43 %	76 %	43 %	76 %	43 %	76 %	43 %
	COP18	Sust	APR 19	61 %	85 %	61 %	85 %	61 %	85 %	61 %	85 %	91 %	108 %	91 %	108 %	91 %	108 %	91 %	108 %	91 %	108 %	91 %	108 %	91 %	108 %	91 %	108 %
	COP19	Satur	APR 20	217 %	114 %	149 %	43 %	77 %	51 %	92 %	113 %	59 %	53 %	33 %	76 %	20 %	127 %	54 %	144 %	80 %	134 %	101 %	139 %	135 %	156 %	146 %	258 %
San-Pedro	**COP15**	Satur	APR 16	8%	7%	14 %	14 %	19 %	20 %	23 %	23 %	4%	3%	15 %	4%	49 %	15 %	67 %	20 %	88 %	36 %	129 %	85 %	129 %	85 %	41 %	46 %
	COP16	Satur	APR 17	10 %	8%	16 %	16 %	22 %	23 %	27 %	26 %	6%	4%	19 %	5%	64 %	18 %	87 %	25 %	115 %	45 %	168 %	106 %	168 %	106 %	54 %	57 %
	COP17	Satur	APR 18	120 %	118 %	120 %	118 %	120 %	118 %	120 %	118 %	92 %	57 %	92 %	57 %	92 %	57 %	92 %	57 %	92 %	57 %	92 %	57 %	92 %	57 %	92 %	57 %
	COP18	Satur	APR 19	95 %	97 %	95 %	97 %	95 %	97 %	95 %	97 %	96 %	82 %	96 %	82 %	96 %	82 %	96 %	82 %	96 %	82 %	96 %	82 %	96 %	82 %	96 %	82 %
	COP19	Satur	APR 20	37 %	59 %	39 %	41 %	50 %	58 %	38 %	40 %	23 %	44 %	18 %	49 %	51 %	121 %	49 %	121 %	64 %	128 %	77 %	104 %	83 %	87 %	94 %	79 %
Sassandra	**COP15**	Agg	APR 16	6%	4%	9%	8%	13 %	12 %	16 %	13 %	2%	2%	8%	2%	28 %	10 %	38 %	13 %	50 %	23 %	73 %	55 %	73 %	55 %	23 %	30 %
	COP16	Agg	APR 17	7%	6%	12 %	12 %	17 %	17 %	20 %	19 %	3%	2%	12 %	3%	39 %	11 %	54 %	15 %	71 %	26 %	104 %	62 %	104 %	62 %	33 %	33 %
	COP17	Agg	APR 18	31 %	29 %	31 %	29 %	31 %	29 %	31 %	29 %	67 %	44 %	67 %	44 %	67 %	44 %	67 %	44 %	67 %	44 %	67 %	44 %	67 %	44 %	67 %	44 %
	COP18	Agg	APR 19	88 %	92 %	88 %	92 %	88 %	92 %	88 %	92 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %
	COP19	Satur	APR 20	62 %	66 %	94 %	76 %	41 %	74 %	42 %	41 %	17 %	58 %	20 %	59 %	36 %	90 %	54 %	115 %	89 %	121 %	104 %	104 %	103 %	98 %	97 %	111 %
seguela	**COP15**	Sust	APR 16	3%	4%	4%	8%	6%	11 %	7%	12 %	2%	1%	8%	2%	26 %	7%	36 %	10 %	47 %	18 %	69 %	42 %	69 %	42 %	22 %	22 %
	COP16	Sust	APR 17	7%	7%	12 %	16 %	17 %	23 %	20 %	25 %	4%	3%	14 %	3%	45 %	13 %	61 %	18 %	81 %	32 %	118 %	76 %	118 %	76 %	38 %	41 %
	COP17	Sust	APR 18	10 %	18 %	10 %	18 %	10 %	18 %	10 %	18 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %
	COP18	Sust	APR 19	62 %	69 %	62 %	69 %	62 %	69 %	62 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %
	COP19	Satur	APR 20	33 %	53 %	25 %	24 %	14 %	11 %	9%	4%	11 %	29 %	15 %	79 %	87 %	133 %	85 %	160 %	78 %	124 %	58 %	75 %	59 %	74 %	46 %	54 %
Sikensi	**COP15**	Sust	APR 16	5%	3%	8%	7%	11 %	10 %	13 %	11 %	2%	1%	6%	1%	19 %	4%	25 %	5%	34 %	9%	49 %	22 %	49 %	22 %	16 %	12 %

	COP16	Sust	APR 17	9%	7%	14%	14%	20%	21%	24%	23%	3%	2%	10%	2%	34%	8%	46%	11%	61%	20%	89%	47%	89%	47%	28%	25%
	COP17	Sust	APR 18	8%	3%	8%	3%	8%	3%	8%	3%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%
	COP18	Sust	APR 19	57%	76%	57%	76%	57%	76%	57%	76%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%
	COP19	Satur	APR 20	84%	87%	47%	22%	33%	42%	17%	15%	3%	19%	2%	22%	7%	33%	23%	52%	40%	55%	48%	49%	40%	37%	28%	28%
Sinfra	COP15	Agg	APR 16	10%	12%	16%	26%	22%	37%	26%	42%	4%	2%	12%	3%	40%	11%	54%	15%	72%	26%	105%	62%	105%	62%	34%	33%
	COP16	Agg	APR 17	16%	12%	27%	26%	37%	37%	44%	42%	5%	3%	16%	4%	54%	15%	74%	20%	98%	36%	144%	85%	144%	85%	46%	46%
	COP17	Agg	APR 18	50%	61%	50%	61%	50%	61%	50%	61%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%
	COP18	Agg	APR 19	80%	104%	80%	104%	80%	104%	80%	104%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%
	COP19	Satur	APR 20	47%	78%	37%	32%	79%	54%	62%	42%	24%	34%	16%	51%	16%	72%	25%	93%	53%	101%	52%	73%	60%	72%	29%	72%
Soubre	COP15	Agg	APR 16	5%	4%	8%	8%	11%	12%	13%	13%	2%	2%	8%	2%	26%	7%	36%	10%	47%	18%	69%	42%	69%	42%	22%	23%
	COP16	Agg	APR 17	6%	5%	9%	10%	13%	14%	16%	16%	3%	2%	11%	2%	35%	10%	48%	13%	63%	24%	92%	56%	92%	56%	30%	30%
	COP17	Agg	APR 18	29%	31%	29%	31%	29%	31%	29%	31%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%
	COP18	Agg	APR 19	88%	92%	88%	92%	88%	92%	88%	92%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%
	COP19	Satur	APR 20	13%	28%	33%	39%	29%	32%	20%	18%	14%	31%	14%	45%	33%	76%	42%	99%	67%	98%	87%	68%	94%	60%	88%	56%
Tabou	COP15	Agg	APR 16	3%	2%	5%	4%	7%	6%	8%	6%	1%	1%	5%	1%	17%	5%	23%	7%	30%	13%	45%	31%	45%	31%	14%	16%
	COP16	Agg	APR 17	4%	2%	6%	4%	8%	6%	10%	7%	2%	2%	8%	2%	26%	8%	35%	11%	46%	20%	68%	47%	68%	47%	22%	25%
	COP17	Agg	APR 18	33%	24%	33%	24%	33%	24%	33%	24%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%
	COP18	Agg	APR 19	88%	92%	88%	92%	88%	92%	88%	92%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%
	COP19	Satur	APR 20	41%	43%	41%	27%	46%	60%	28%	35%	2%	38%	8%	63%	18%	114%	46%	102%	73%	111%	98%	107%	154%	107%	94%	103%
Tanda	COP15	Agg	APR 16	12%	9%	20%	19%	28%	28%	33%	32%	5%	3%	17%	3%	55%	13%	75%	18%	99%	31%	145%	74%	145%	74%	46%	40%
	COP16	Agg	APR 17	16%	11%	26%	24%	36%	34%	43%	39%	6%	3%	20%	4%	67%	16%	92%	22%	122%	39%	178%	91%	178%	91%	57%	49%
	COP17	Satur	APR 18	163%	66%	163%	66%	163%	66%	163%	66%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%
	COP18	Satur	APR 19	77%	111%	77%	111%	77%	111%	77%	111%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%

	COP19	Satur	APR 20	35%	73%	58%	66%	70%	73%	56%	51%	43%	36%	11%	68%	23%	99%	49%	147%	98%	174%	124%	160%	128%	169%	87%	167%
Tengrela	COP15	Sust	APR 16	21%	2%	36%	4%	49%	6%	59%	7%	5%	3%	19%	4%	62%	14%	84%	20%	111%	35%	163%	83%	163%	83%	52%	45%
	COP16	Sust	APR 17	27%	13%	44%	27%	62%	38%	73%	43%	8%	5%	27%	5%	88%	22%	120%	30%	159%	53%	232%	126%	232%	126%	74%	68%
	COP17	Sust	APR 18	39%	8%	39%	8%	39%	8%	39%	8%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%
	COP18	Sust	APR 19	55%	81%	55%	81%	55%	81%	55%	81%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Tiassale	COP15	Agg	APR 16	7%	6%	11%	12%	15%	18%	18%	20%	2%	1%	7%	2%	24%	6%	32%	9%	43%	15%	62%	37%	62%	37%	20%	20%
	COP16	Agg	APR 17	11%	8%	18%	17%	25%	24%	30%	27%	3%	2%	12%	2%	39%	10%	54%	14%	71%	25%	104%	58%	104%	58%	33%	31%
	COP17	Agg	APR 18	34%	38%	34%	38%	34%	38%	34%	38%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%
	COP18	Agg	APR 19	79%	105%	79%	105%	79%	105%	79%	105%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%
	COP19	Satur	APR 20	96%	63%	46%	57%	38%	33%	23%	21%	10%	25%	10%	39%	16%	49%	28%	78%	51%	65%	52%	53%	58%	41%	34%	38%
Tiebissou	COP15	Sust	APR 16	8%	7%	13%	16%	19%	22%	22%	25%	3%	1%	9%	2%	29%	6%	39%	9%	52%	16%	76%	37%	76%	37%	24%	20%
	COP16	Sust	APR 17	7%	7%	12%	14%	17%	21%	20%	23%	3%	2%	10%	2%	34%	8%	47%	11%	62%	19%	91%	45%	91%	45%	29%	24%
	COP17	Sust	APR 18	25%	29%	25%	29%	25%	29%	25%	29%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%
	COP18	Sust	APR 19	61%	85%	61%	85%	61%	85%	61%	85%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%
	COP19	Satur	APR 20	116%	122%	29%	107%	41%	61%	111%	76%	28%	49%	9%	24%	55%	129%	20%	71%	28%	100%	63%	108%	76%	106%	93%	201%
Touba	COP15	Sust	APR 16	2%	2%	3%	5%	4%	7%	5%	7%	1%	1%	4%	1%	14%	5%	20%	6%	26%	11%	38%	27%	38%	27%	12%	14%
	COP16	Sust	APR 17	4%	3%	6%	6%	8%	9%	10%	10%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	18%	20%
	COP17	Sust	APR 18	3%	4%	3%	4%	3%	4%	3%	4%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%
	COP18	Sust	APR 19	43%	48%	43%	48%	43%	48%	43%	48%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Toulepleu	COP15	Sust	APR 16	5%	1%	9%	2%	12%	2%	14%	3%	1%	1%	3%	1%	11%	4%	15%	5%	20%	9%	29%	20%	29%	20%	9%	11%

	COP16	Sust	APR 17	5%	3%	8%	6%	11%	9%	13%	10%	1%	1%	4%	1%	15%	4%	20%	6%	27%	10%	39%	23%	39%	23%	12%	12%
	COP17	Sust	APR 18	0%	0%	0%	0%	0%	0%	0%	0%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%
	COP18	Sust	APR 19	57%	77%	57%	77%	57%	77%	57%	77%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%
	COP19	Not Supp	APR 20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Toumodi	COP15	Sust	APR 16	6%	9%	10%	19%	14%	28%	16%	31%	4%	2%	13%	3%	44%	11%	61%	15%	80%	26%	117%	61%	117%	61%	37%	33%
	COP16	Sust	APR 17	7%	7%	11%	15%	15%	22%	18%	25%	4%	3%	15%	3%	49%	13%	67%	18%	89%	31%	130%	74%	130%	74%	41%	40%
	COP17	Sust	APR 18	22%	28%	22%	28%	22%	28%	22%	28%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%
	COP18	Sust	APR 19	56%	78%	56%	78%	56%	78%	56%	78%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%
	COP19	Satur	APR 20	57%	60%	35%	7%	52%	27%	75%	44%	22%	33%	13%	50%	23%	85%	41%	97%	78%	129%	89%	135%	87%	138%	122%	190%
Treichville-Marcory	COP15	Satur	APR 16	42%	34%	70%	72%	97%	105%	115%	117%	20%	17%	67%	20%	221%	84%	303%	114%	399%	203%	584%	480%	584%	480%	187%	258%
	COP16	Satur	APR 17	44%	34%	74%	71%	102%	103%	121%	116%	21%	18%	74%	22%	242%	90%	332%	123%	438%	218%	641%	515%	641%	515%	205%	276%
	COP17	Satur	APR 18	103%	105%	103%	105%	103%	105%	103%	105%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%
	COP18	Satur	APR 19	115%	142%	115%	142%	115%	142%	115%	142%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%
	COP19	Satur	APR 20	165%	239%	248%	321%	266%	381%	331%	486%	223%	188%	196%	139%	252%	296%	288%	485%	270%	483%	376%	385%	398%	330%	383%	311%
Vavoua	COP15	Sust	APR 16	5%	5%	9%	10%	13%	14%	15%	16%	2%	1%	7%	2%	22%	7%	31%	10%	40%	17%	59%	41%	59%	41%	19%	22%
	COP16	Sust	APR 17	10%	9%	17%	19%	23%	27%	27%	31%	4%	3%	13%	3%	44%	13%	61%	18%	80%	32%	117%	76%	117%	76%	37%	41%
	COP17	Sust	APR 18	13%	15%	13%	15%	13%	15%	13%	15%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%
	COP18	Sust	APR 19	58%	75%	58%	75%	58%	75%	58%	75%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%
	COP19	Satur	APR 20	35%	110%	58%	24%	52%	55%	23%	24%	20%	47%	22%	109%	48%	92%	55%	138%	87%	115%	48%	57%	57%	53%	22%	46%
Yamoussoukro	COP15	Agg	APR 16	8%	8%	14%	16%	20%	23%	23%	26%	5%	3%	17%	4%	57%	15%	78%	21%	103%	37%	151%	87%	151%	87%	48%	47%
	COP16	Agg	APR 17	10%	9%	17%	18%	24%	26%	29%	29%	6%	3%	22%	4%	71%	17%	97%	23%	129%	41%	188%	96%	188%	96%	60%	52%
	COP17	Agg	APR 18	39%	51%	39%	51%	39%	51%	39%	51%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%

	COP18	Agg	APR 19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%
	COP19	Satur	APR 20	26%	37%	39%	55%	35%	49%	83%	82%	60%	35%	33%	71%	81%	176%	40%	123%	59%	144%	77%	138%	88%	133%	125%	185%
Yopougon-Est	**COP15**	Satur	APR 16	6%	6%	10%	12%	14%	17%	16%	19%	5%	3%	17%	4%	58%	16%	79%	21%	104%	38%	152%	90%	152%	90%	49%	48%
	COP16	Satur	APR 17	7%	5%	11%	11%	16%	15%	18%	17%	6%	3%	21%	4%	68%	16%	93%	22%	123%	39%	180%	91%	180%	91%	57%	49%
	COP17	Satur	APR 18	107%	114%	107%	114%	107%	114%	107%	114%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%
	COP18	Satur	APR 19	89%	110%	89%	110%	89%	110%	89%	110%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%
	COP19	Satur	APR 20	78%	74%	119%	103%	44%	57%	39%	34%	34%	36%	27%	91%	47%	135%	72%	190%	83%	159%	79%	95%	67%	68%	41%	53%
Yopougon-Ouest-Songon	**COP15**	Satur	APR 16	28%	22%	46%	47%	64%	68%	76%	76%	10%	5%	34%	6%	111%	25%	152%	34%	201%	60%	294%	142%	294%	142%	94%	76%
	COP16	Satur	APR 17	28%	22%	47%	47%	65%	68%	77%	76%	11%	6%	39%	7%	127%	28%	175%	38%	231%	68%	337%	161%	337%	161%	108%	86%
	COP17	Satur	APR 18	158%	141%	158%	141%	158%	141%	158%	141%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%
	COP18	Satur	APR 19	105%	129%	105%	129%	105%	129%	105%	129%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%
	COP19	Satur	APR 20	140%	168%	199%	192%	140%	149%	161%	180%	130%	151%	78%	155%	94%	272%	104%	267%	138%	291%	246%	277%	66%	66%	74%	87%
Zouhan Hounien	**COP15**	Sust	APR 16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	8%	2%	28%	8%	38%	11%	50%	20%	73%	47%	73%	47%	23%	25%
	COP16	Sust	APR 17	4%	4%	6%	7%	8%	11%	10%	12%	3%	2%	10%	2%	33%	10%	45%	13%	60%	23%	87%	55%	87%	55%	28%	30%
	COP17	Sust	APR 18	8%	6%	8%	6%	8%	6%	8%	6%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%
	COP18	Sust	APR 19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP19	Satur	APR 20	5%	5%	3%	9%	7%	7%	9%	5%	9%	12%	4%	19%	8%	24%	12%	26%	11%	22%	17%	30%	18%	37%	12%	34%
Zuenoula	**COP15**	Sust	APR 16	8%	8%	12%	17%	17%	24%	21%	27%	4%	3%	14%	4%	46%	15%	64%	20%	84%	36%	123%	84%	123%	84%	39%	45%
	COP16	Sust	APR 17	18%	16%	30%	34%	42%	50%	50%	56%	6%	4%	22%	5%	72%	22%	99%	30%	131%	53%	191%	125%	191%	125%	61%	67%
	COP17	Sust	APR 18	31%	38%	31%	38%	31%	38%	31%	38%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%
	COP18	Sust	APR 19	58%	75%	58%	75%	58%	75%	58%	75%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%
	COP19	Satur	APR 20	115%	75%	43%	41%	7%	31%	25%	27%	36%	73%	12%	63%	35%	67%	43%	89%	38%	78%	54%	66%	59%	70%	28%	65%

Table A.2

Table A.2 ART Targets by Prioritization for Epidemic Control						
		COP 18	Treatment Gap	COP 19		
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY19)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY20) *TX_CURR***	**Newly initiated (APR FY20) *TX_NEW***	**ART Coverage (APR 20)**
Scale-Up Saturation	**405,687**	**208,843**	**115,707**	**357,702**	**75,415**	**88%**
Not Supported	**52,746**					
Scale-Up Aggressive (COP 18)		***140,512***				
Sustained (COP 18)		***66,595***				
Total	**458,433**	**415,950**		**357,702**	**75,415**	**78%**

APPENDIX B – Budget Profile and Resource Projections

B1. COP19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

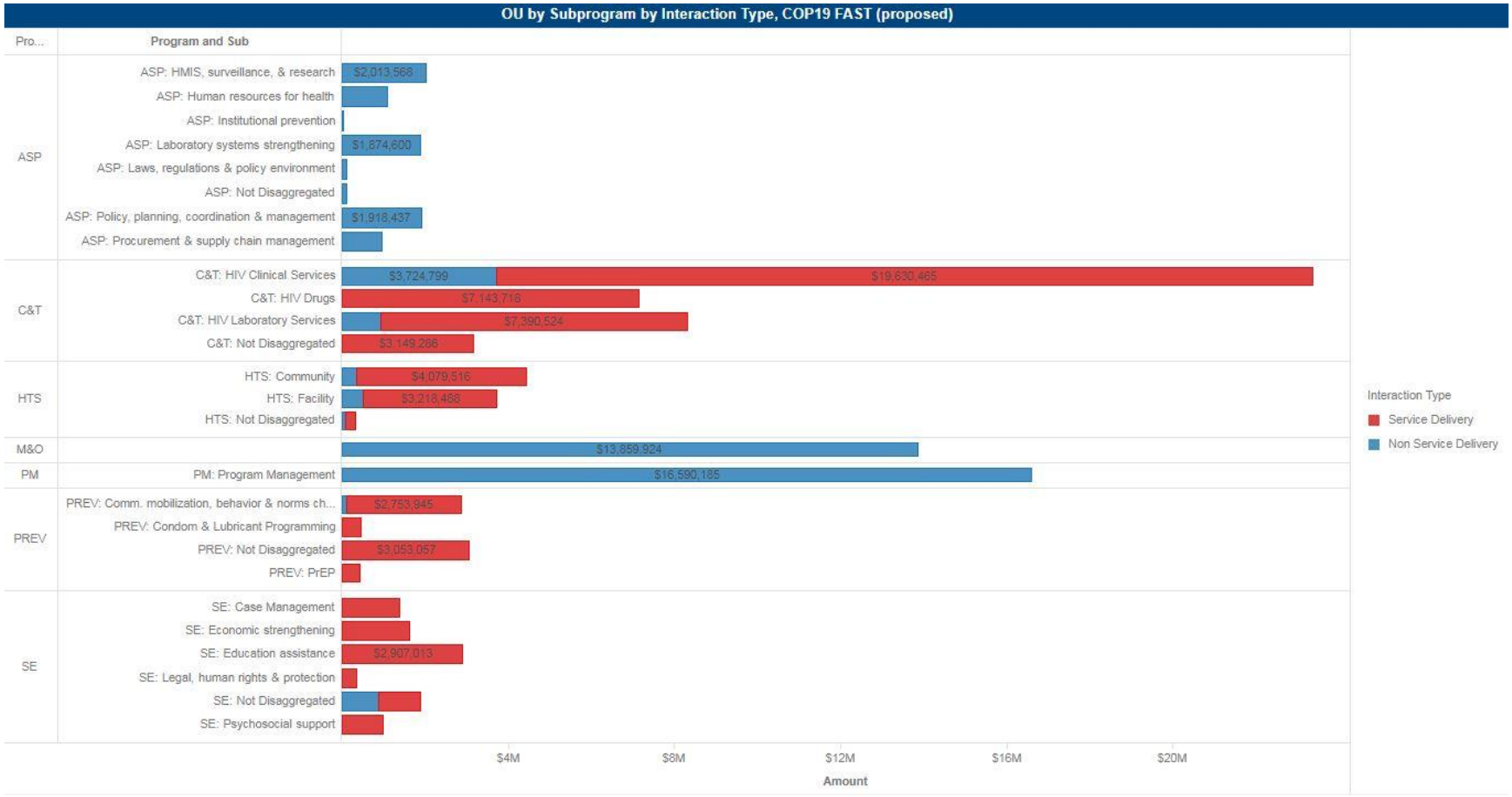


Table B.1.2.1 COP19 Budget by Agency

Initiative Type	Fiscal Year	2020
	Funding Agency	**Amount**
Planning Level	DOD	$3,254,827
	HHS/CDC	$58,113,003
	HHS/HRSA	$185,606
	State	$521,556
	USAID	$42,750,783

Table B.1.2.2 COP19 Budget – Bilateral 19 Pipeline vs. New Funding

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$US 54,421,337	**$US 50,404,436**	**$US 104,825,773**

Table B.1.2.3 COP19 Budget by Resource Allocation

Initiative Type	Fiscal Year	2020
	Budget Code	**Amount**
Planning Level	APPLIED PIPELINE	$54,421,337
	CIRC	$0
	HBHC	$6,636,214
	HKID	$7,683,628
	HLAB	$697,997
	HMBL	$0
	HMIN	$0
	HTXD	$6,384,464
	HTXS	$9,262,523
	HVAB	$3,047,891
	HVCT	$4,107,374
	HVMS	$3,271,438
	HVOP	$2,373,164
	HVSI	$1,898,533
	HVTB	$98,783
	IDUP	$0
	MTCT	$661,836
	OHSS	$1,480,712
	PDCS	$1,180,267
	PDTX	$1,619,614

B.2 Resource Projections

For COP19 resource projections, PEPFAR-CI used an incremental budget methodology using the COP18 budget as a basis for continuing IMs, consistent with S/GAC guidance and the FAST process.

Prior to allocating COP19 resources, PEPFAR-CI conducted multiple in-depth reviews of the country program's performance by geography and by population, as of FY2019 Q2. Based on the major findings, the USG team engaged in robust dialogue with key stakeholders, including MSHP, PNLS, UN System Agencies, and CSOs to determine the key programmatic gaps and agree on technical priorities to address these gaps and "reboot" the country program.

In an effort to invest COP19 funding in the most efficient way and to ensure that these investments would lead toward epidemic control, the USG team engaged in a geographic prioritization exercise by refocusing PEPFAR investments on 60 health districts (out of 86) and more specifically, on 140 priority sites within those districts. These 140 sites account for 70% of people on HIV treatment as of December 2018. The remaining 795 sustained sites will receive PEPFAR support and investments but with less intensity.

Commodities were estimated to account for patients to be tested and expected to be put on ART with respect to the on-going TLD transition and 6 month MMS. As for Table 6 interventions, they were identified to address key policy barriers and funded accordingly.

Final COP19 budget adjustments were made at the IM level, based on programmatic shifts and geographic redistribution to implement the "Reboot." Budget decisions were made by first agreeing on allocations for M&O, closing costs, above-site activities, KP programming, commodities, and laboratory. DREAMS funding allocation for DREAMS IMs was based on DREAMS targets and HKID allocation for OVC IMs was based on <18 OVC_SERV targets. The remaining budget envelope was allocated to clinical and community IMs based on district-level TX_CURR targets in which clinical IMs received 75% of the funding and community IMs received 25%.

For all IMs, "Program Management" costs were capped at 23% of total IM funding to ensure most of the funding goes to field program interventions.

APPENDIX D– Minimum Program Requirements

Thanks to PEPFAR advocacy, Côte d'Ivoire has made significant progress in meeting the 13 minimum requirements.

1. Côte d'Ivoire adopted the Test and Start policy along with Differentiated Service Delivery Models (DSDM) for stable patients in February 2017. Currently, Test and Start is implemented in all PEPFAR-supported sites across all age, sex and risk groups. DSDM is adopted and being implemented.
2. On February 2019, the MSHP adopted 6 multi-month scripting for stable patients on ART and this policy is currently being scale-up at all sites.
3. The MSHP adopted the transition to TLD on February 2019 with 2-phased implementation approach. The policy was emphasized by a circular note on April 19, 2019 providing additional guidance for the implementation. The initial phase targeting adults and children (>35 kg or 10+ years old) newly initiated on ART started in April 2019 with training of providers at more than 100 high volume ART sites along with dispensation of the drug. The second phase that will include patients already on treatment and women with childbearing potential will start in July 2019. Nevirapine-based regimen has been phased out in treatment protocols.
4. Since FY2018, Côte d'Ivoire has scaled up index testing at supported sites through clinical and community partners. The COP19 priority will limit index testing to newly tested positive and patients already on treatment with unsuppressed viral load at all PEPFAR-supported sites. Index patients will primarily be identified in facilities by the clinical partners who will do partner notification and contact tracing. Clinical partners will handover contact tracing to the community if the index has not been able to refer his contacts to the facility for testing after two weeks. Index testing indicators are included in the routine program monitoring to allow review of performance across the cascade.
5. The MSHP adopted Tuberculosis Preventive Therapy (TPT) as part of the routine HIV care package in October 2018 with a phased scale-up approach. The initial phase targeting patients newly initiated on ART is currently being implemented in six high volume ART sites with a goal to cover 70 sites in 34 districts by end FY2019. The plan for COP19 is to continue the implementation of TPT in the high volume sites and include patients already on treatment. The protocol is INH and Pyridoxine for 6 months.
6. The Test and Start policy adopted in 2017 recommends treatment initiation without delay, which will contribute to improved linkage to treatment. To improve linkage and reach 95% in COP19, PEPFAR-CI will address linkage within facility testing and treatment service delivery points and linkage from the community to the facility. Specific activities at the facility include strengthening post-test counseling to ensure age-appropriate treatment and viral load literacy, conducting ART readiness assessment, providing psychosocial support, linking newly identified HIV positive patients with a facilitator, and calling patients who do not initiate ART the same day. Similar activities will be conducted in the

community with an escort to hand off of newly tested positive diagnosed in the community to a facility. Linkage to ART will be monitored on a weekly basis to ensure that the program is on track to meet the target of 95%. Implementation of the unique identifier will also assist in accurately assessing true linkage performance.

7. The MSHP has taken a firm stand on eliminating user fees. In April 2019, the MSHP issued a circular note removing all formal and informal user fees for HIV patients and pregnant women attending facilities. PEPFAR-CI, MSHP and Civil Society Organizations (CSO) are monitoring the implementation during site visits.
8. The National VL/EID scale-up plan was developed in 2018 and is being currently implemented. PEPFAR-CI has established a strong laboratory network of 17 reference laboratories with a capacity of 400,000 VL/EID test/year. The CDC Retro-CI laboratory included in the network also serves as backup for all laboratories in the country. Its capacity was increased to perform about 1,000 VL tests per day. All the PEPFAR-supported districts and sites have access to VL/EID services. In COP19, all the reference laboratories will operate with a shift mode of 24 hours, thereby doubling their testing capacities and optimizing the VL equipment utilization. This will reduce the turn-around-time (TAT) to a maximum of two weeks to ensure proper patient management. Through this increased capacity for VL/EID testing PEPFAR-CI expects a coverage of 90% by FY2020. There will 20% of DBS target to increase VL uptake in remote sites.
9. Monitoring of morbidity and mortality among patient receiving care and treatment services is critical in the context of low retention. Since FY2019, PEPFAR is implementing the mortality and morbidity (TX_ML) required indicator at all supported sites and across all populations. Data will be analyzed on a quarterly basis to inform the program. In addition, in COP19, PEPFAR plans to support the implementation of LAM assay and Cryotoccocal Antigen test to diagnose co-morbidities for patients with advanced disease in 10 reference sites.
10. COP19 OVC interventions align with highest burden areas. OVC_SERV targets reflect focus on areas with the highest treatment gaps. Staring in FY2019, PEPFAR will increase services for OVC under 18 with a ratio of 4:1.
11. The GoCI has increased its contribution to the response to HIV over these past years. Currently its contribution to the purchase of HIV commodities is about 22% while the annual health sector budget is at approximately 5.6%. Most recently, the President announced an additional 10 million in funding for HIV response.
12. Country ownership of the response is the vision of the GoCI. In FY2019 26% of PEPFAR budget was allocated to local indigenous organizations. Each agency is working with its headquarters to reach the global program requirement.
13. MSHP adopted the concept of implementing a unique patient identifier in 2018 and created a technical working group which developed a concept note and is developing the tools/software and systems. A pilot will be done in COP18 and, if all goes well, the system will be scaled-up in COP19.

APPENDIX E– RETRO-CI Transition Plan

RETRO-CI started in 1988, as a research project and is located at the Centre National Hospitalier Universitaire (CHU) of Treichville. It is the result of an implementation agreement between the U.S. Department of Health and Human Services (DHHS)/CDC and the Ministry of Health and Public Hygiene (MSHP) of Côte d'Ivoire, signed in 1988 and renewed in April 2013 by the Minister of Health and Public Hygiene, and the Assistant Secretary for Global Affairs, the US DHHS. In 2004, when the PEPFAR-CI program started, research activities were phased out along with the transition of several RETRO-CI staff to MSHP.

For COP19, PEPFAR-CI is proposing to start transferring certain laboratory testing and system strengthening activities and associated personnel from RETRO-CI to the MSHP. More specifically, the transition of RETRO-CI will consist of MSHP gradually taking over laboratory baseline testing and system strengthening activities currently performed by the RETRO-CI, including technical and support staff and operating costs, over a period of 5 years. The transition plan has two specific objectives: (1) To transfer all baseline serology, clinical biology, VL, EID , HIV DR testing and STI testing to MSHP, and (2) To maintain RETRO-CI in a role of technical assistance, quality assurance, and training center as well as being a back-up for the network of VL/EID laboratories supported by PEPFAR-CI. Discussions are ongoing with the MSHP to develop a detailed calendar and agree on key modalities for the transition. At the end of the transition, a total of 21 staff will be moved under the MSHP payroll, while 9 staff directly involved in PEPFAR-CI laboratory program implementation and lab data management will remain with PEPFAR/CDC-CI based at the US embassy. The COP19 budget is 1.8 million for procurement, travel and supervision coaching without staff salaries. Cost of Infrastructure and utilities such as electricity and water, sample storage, external facility maintenance, and trash pickup are under the GoCI since the beginning of the project

The table below illustrates the proposed timeline as well as the respective roles of CDC/PEPFAR and the MSHP during the 5-year process.

TIMING / FUNCTIONS TO TRANSFER	YEAR 1 Jan-Dec 2020	YEAR 2 Jan-Dec 2021	YEAR 3 Jan-Dec 2022	YEAR 4 Jan-Dec 2023	YEAR 5 Jan-Dec 2024
Facilities Maintenance : biological hazard cleaning, grounds keeping, custodial work	100 %	100 %	100 %	100 %	100 %
Laboratory Technicians (T= 13)	23 % (3) 77% (10)	38 % (5) 62% (8)	54 % (7) 46% (6)	70 % (9) 30% (4)	100 % (13)
Support Staff (T= 8)	38% (3) 62% (5)	50% (4) 50% (4)	62% (5) 38% (3)	100% (8)	100% (8)
Clinical Biology Testing	100 %	100 %	100 %	100 %	100 %
EQA program for Serology	100%	30 % 70 %	80 % 20%	100 %	100 %
Competencies and training in VL/EID	100 %	30 % 70 %	80 % 20 %	100 %	100 %
CQI VL/EID	100 %	30 % 70 %	50 % 50 %	80 % 20 %	100 %
STI Testing	100 %	50 % 50 %	80 % 20 %	100 %	100 %

MSHP CDC/PEPFAR

Yearly key milestones and tentative budget trend is as below:

By year 5, RETRO-CI lab technicians and support staff salaries is $0 contribution from PEPFAR

Key milestones at year 5 are:

1. RETRO-CI governance structure fully established and functional with MSHP taking full ownership of the lab, all salaries of lab technicians and support staff, and with the capacity to carry all core functions of the lab.

2. CDC provides technical assistance for PEPFAR laboratory program

3. Additional non-PEPFAR funding source available at country level

The table below illustrates the PEPFAR and GoCI contribution for operating cost and salaries

YEAR 1 Jan-Dec 2020	**YEAR 2 Jan-Dec 2021**	**YEAR 3 Jan-Dec 2022**	**YEAR 4 Jan-Dec 2023**	**YEAR 5 Jan-Dec 2024**
PEPFAR Budget: $ 1.8 M operating cost and $1,031,280 salaries	PEPFAR Budget: $1.5 M operating costs and $1,041,204 salaries	PEPFAR Budget: $1.2M operating costs and $780,768 salaries	PEPFAR Budget: $ 1.0 M operating cost and $520,512 salaries	PEPFAR Budget: $0 operating cost and $0 salaries
GoCI budget: Salaries for 6 staff and facility maintenance and utilities	GoCI budget: Salaries for 9 staff and facility maintenance and utilities	GoCI budget: Salaries for 12 staff and facility maintenance and utilities	GoCI budget: Salaries for 17 staff and facility maintenance and utilities	GoCI budget: Salaries for 21 staff and facility maintenance and utilities

Operating cost include procurement for reference test, maintenance contract for PEPFAR equipment and for reference testing, proficiency testing, lab information system and measurement tools.

This proposed operating budget is to be considered as tentative depending on OGAC stated priorities for PEPFAR-CI.

Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	AIMAS	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 150,000	National strategic plans, operational plans and budgets	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP17	COP20	Increase to 90% availability of condoms at distribution points across the country
USAID	AIMAS	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 145,000	Oversight, technical assistance, and supervision to subnational levels	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP18	COP20	Year 1 operational plan executed.
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 300,000	Forecasting, supply chain plan, budget, and implementation	6. Weak on-ART linkage of clients from testing to treatment across age, sex, and risk groups	COP17	COP21	Country counterpart ownership increased to 90%
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 450,000	Supply chain infrastructure	2. Insufficient ART coverage and retention for men, women and adolescents due to slow adoption and low implementation of policies (differentiated service delivery models, including six month multi-month scripting, free user fees)	COP17	COP21	Achieve at least 90% for all indicators including: - Percentage of storerooms with health commodities stocked according to plan (within min and max levels); - Percentage of storerooms that meet appropriate storage conditions;
USAID	WITS HEALTH CONSORTIUM (PTY) LTD	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 50,000	Clinical guidelines, policies for service delivery	3. Delayed implementation of TLD transition plan and adoption of optimal ART regimens	COP18	COP19	TLD Transition Plan fully implemented
USAID	[Placeholder]	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 245,000	HMIS systems	1. Missalignment of OVC and DREAMS databases/reporting systems to inform layering and comprehensive services packages delivered to beneficiairies sub-groups (OVC, DREAMS, OVC&DREAMS).	COP17	COP20	100% of social centers and OVC and DREAMS platforms report quality data on time using the newly developed tools

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	[Placeholder]	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 255,000	Program and data quality management	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP18	COP20	100% of districts, 100% of regions and national level effectively use data triangulated from the different health information system modules
USAID	Johns Hopkins University, The	ASP: Laws, regulations & policy environment	Key Pops: Not disaggregated	$ 15,000	Information and sensitization for public and government officials	6. Weak on-ART linkage of clients from testing to treatment across age, sex, and risk groups	COP19	COP19	"www. Jai le controle" is redesigned with features forkey populations
USAID	Johns Hopkins University, The	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 20,000	Clinical guidelines, policies for service delivery	6. Weak on-ART linkage of clients from testing to treatment across age, sex, and risk groups	COP19	COP19	80 % of providers (in BA-supported centers) are using job-aids;
USAID	FHI Development 360 LLC	ASP: Institutional prevention	Key Pops: Not disaggregated	$ 20,000	Training in institutional prevention programs	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP19	COP19	95% of clients who visit website have accepted HIV screening
USAID	NOUVELLE PHARMACIE DE LA SANTE PUBLIQUE DE COTE D'IVOIRE	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 150,000	Supply chain infrastructure	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP18	COP20	90 % eLMIS features available; Compatibity error rate below 35%

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	NOUVELLE PHARMACIE DE LA SANTE PUBLIQUE DE COTE D'IVOIRE	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 50,000	Training in supply chain systems	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP18	COP19	Significant reduction of Lab commodities and VL reagents processing errors (less than 2%)
DOD	Population Services International	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 20,000	Evaluations	7. Persistence of stigma and discremination against people infected and affected by HIV/AIDS	COP19	COP19	1) Assessment tools developed and approved by the military leadership and institution review board as necessary; 2) Conduct baseline assessment; 3) Analyze baseline data to inform programmatic interventions. Time frame for activity is 1 month at the beginning of the year.
DOD	Population Services International	ASP: Laws, regulations & policy environment	Priority Pops: Military & other uniformed services	$ 35,000	Information and sensitization for public and government officials	7. Persistence of stigma and discremination against people infected and affected by HIV/AIDS	COP19	COP20	1) Workshop delivered; 2) Code of Conduct and Action Plan developed; 3) Plan for follow-on sessions conducted by master facilitators developed
DOD	Population Services International	ASP: Laws, regulations & policy environment	Priority Pops: Military & other uniformed services	$ 40,000	Information and sensitization for public and government officials	7. Persistence of stigma and discremination against people infected and affected by HIV/AIDS	COP19	COP21	1) Military Hotline respondants trained. 2) Military HIV Hotline functional.
DOD	Population Services International	ASP: Laws, regulations & policy environment	Priority Pops: Military & other uniformed services	$ 5,000	Assessing impact of policies and regulations on HIV	7. Persistence of stigma and discremination against people infected and affected by HIV/AIDS	COP19	COP20	1) Policy development committee formed; 2) Draft policy created or existing policy revised; 3) Meetings with key military leadership held.
DOD	Population Services International	ASP: Human resources for health	Priority Pops: Military & other uniformed services	$ 6,000	Pre-service training	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP19	COP19	Updated CISSA training modules available: 1) TLD transition, 2) TB Preventive Treatment (TPT), 3) Linkage and Retention, 4) Viral Load management, 5) Mortality and Morbidity reporting, 6) new MER indicators, 7) stigma and discrimination at the facility level

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
DOD	Population Services International	ASP: Human resources for health	Priority Pops: Military & other uniformed services	$ 40,200.00	HRH recruitment and retention	6. Weak on-ART linkage of clients from testing to treatment across age, sex, and risk groups	COP19	COP19	1) Military HRHIS installed and functional. 2) Policy development committee formed with at least the FACI Chief of Staff Representatives, the Ministry of Defense's Health Directorate and Human Resources Directorate. 3) Military HRH policies developped. 4) Military HRH recruitemnt plan developped.
DOD	Population Services International	ASP: Laboratory systems strengthening	Priority Pops: Military & other uniformed services	$ 71,600	Lab accreditation	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP18	COP20	6 military laboratories accredited (5 stars) and 2 other military laboratories with 4 stars
DOD	Population Services International	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 76,800	Program and data quality management	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP18	COP20	1) 100% of military health centers with electronic data management system for patients records (EMR) operational. 2) 100% of military laboratories in the military lab network with electronic data management system operational. 3) 100% military sites with data collection tools
DOD	Population Services International	ASP: Policy, planning, coordination & management	Priority Pops: Military & other uniformed services	$ 78,350	Oversight, technical assistance, and supervision to subnational levels	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP19	COP19	All military health facilities equipped with functional webinar equipment
DOD	Population Services International	ASP: Policy, planning, coordination & management	Priority Pops: Military & other uniformed services	$ 12,000	Oversight, technical assistance, and supervision to subnational levels	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP18	COP19	100% of the Regional Quality Management Offices created
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 50,000	Clinical guidelines, policies for service delivery	4. Inconsistent implementation of high yield HIV screening and testing approaches including pediatric and adolescent case finding	COP17	COP20	National Guidelines for HIV diagnosis available at 90% of HIV testing sites

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 250,000	Lab quality improvement and assurance	4. Inconsistent implementation of high yield HIV screening and testing approaches including pediatric and adolescent case finding	COP17	COP21	850 HIV testing sites and 400 Human Resources providing HIV testing certified
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 75,000	Lab policy, budgets, and strategic plans	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP18	COP19	OPENLIS, integrated in the DHIS2 and is fully operational
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 100,000	Lab quality improvement and assurance	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP16	COP21	Viral Load EID LIS implemented at CDC RETROCI reference labs and at 17 VL labs in scale-up districts and 50 VL hubs
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 150,000	Lab policy, budgets, and strategic plans	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP17	COP19	The LIS installed at all labs complies with the international security systems
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 375,000	Lab accreditation	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP17	COP21	VL/EID 17 VL labs fully accredited
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 125,000	Lab quality improvement and assurance	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP19	COP20	The Openelis modules for TB is developped and installed at 27 sites. 60 users trained on the new modules.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	[Placeholder]	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 84,000	Lab quality improvement and assurance	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP19	COP21	The POCT are installed in PMTCT sites and 90% of women and children have access to VL and IED tests.
HHS/CDC	PASTEUR INSTITUTE OF IVORY COAST	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 100,000	Lab quality improvement and assurance	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP16	COP20	5000 clients served in the 10 regional labs
HHS/CDC	PASTEUR INSTITUTE OF IVORY COAST	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 100,000	Lab quality improvement and assurance	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP17	COP20	75% of the labs are enrolled in the EQA
HHS/CDC	PASTEUR INSTITUTE OF IVORY COAST	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 100,000	Lab accreditation	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP19	COP21	2 central labs and 5 biggest TB laboratories are accredited
HHS/CDC	INTERNATIONAL RESCUE COMMITTEE, INC.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 100,000	Clinical guidelines, policies for service delivery	1. Missalignment of OVC and DREAMS databases/reporting systems to inform layering and comprehensive services packages delivered to beneficiairies sub-groups (OVC, DREAMS, OVC&DREAMS).	COP18	COP19	OVC services is supervised in the 57 OVC platforms by social regional directors

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 1,173,087	Oversight, technical assistance, and supervision to subnational levels	2. Insufficient ART coverage and retention for men, women and adolescents due to slow adoption and low implementation of policies (differentiated service delivery models, including six month multi-month scripting, free user fees)	COP17	COP21	4 coordination meetings 12 supervisions and one annual coordination meeting conduted
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 901,239	HMIS systems	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP19	COP20	Maintenance of unique identifier system in all PEPFAR supported sites FY 19 national HIV report available Updated data collection tool available with new MER indicators Updated electronic tools deployed in all PEPFAR supported sites
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 260,000	Lab policy, budgets, and strategic plans	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP16	COP20	QMS fully implemented in the 17 VL labs and the 3500 testing points HIV Post marketing surveillance activity implemented
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 150,000	Program and data quality management	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP16	COP20	Second situation room report disseminated 2019 National and small area HIV estimates available
DOD	Population Services International	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 170,029	Evaluations	9. Insufficient monitoring and reporting of morbidity/mortality outcomes including infectious/non-infectious morbidity (Surveilance, M&E, HIMS, unique identifier)	COP18	COP19	1) SABERS's protocol approved by Cote d'Ivoire and US-based ethical committees. 2) Data collection completed. 3) Final report produced with key conclusions and recommendations. 4) Final report disseminated.

Table 6-E (Entry of Above Site Programs Activities)									
Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	COP19 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/HRSA	JHPIEGO CORPORATION	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 84,000	Lab quality improvement and assurance	8. Limited access to VL/EID testing services and delayed availability of results for clients management (to achieve more than 90% retention rate across age, sex, and risk groups)	COP19	COP21	Lab Echo is implemented in 17 VL labs, 50 VL hubs and 40 clinical and 40 community sites
USAID	Results For Development Institute, Inc.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 240,000	Information and sensitization for public and government officials	2. Insufficient ART coverage and retention for men, women and adolescents due to slow adoption and low implementation of policies (differentiated service delivery models, including six month multi-month scripting, free user fees)	COP20	COP20	75% of priority sites visited
USAID	Results For Development Institute, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 80,000	Surveillance	7. Persistence of stigma and discremination against people infected and affected by HIV/AIDS	COP19	COP19	Improved understanding of stigma related barriers to accessing HIV services for PLHIV including key populations
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	$ 964,330	HRH recruitment and retention	10. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; indigenous partners; CSOs…)	COP19	COP19	Number of priority sites implementing Performance-Based Funding (PBF) initiative to address critical HRH gaps.
HHS/HRSA	JHPIEGO CORPORATION	ASP: Human resources for health	Non-Targeted Pop: Not disaggregated	$ 71,606	Institutionalization of in-service training	2. Insufficient ART coverage and retention for men, women and adolescents due to slow adoption and low implementation of policies (differentiated service delivery models, including six month multi-month scripting, free user fees)	COP19	COP19	280 CHW/Lay counselors trained on retention at 140 priority sites