United States Department of State

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COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR Bell, Côte d'Ivoire

SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction

With input from the field team through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the PEPFAR Côte d'Ivoire program over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Côte d'Ivoire's Key Successes

1. Côte d'Ivoire has successfully eliminated informal non-HIV user fees on HIV services in FY2019
2. The Prevention of Mother to Child Transmission (PMTCT) program continues to do well with 99% coverage of HIV testing in antenatal clinics and proxy ART coverage of 99% of HIV positive pregnant women receiving treatment
3. Rapid acceleration and increase in multi-month drug dispensing for PLHIV on ART

Côte d'Ivoire's Key Challenges

1. Lack of progress in finding new HIV infected persons through targeted index testing and linkage from testing into care, especially among men, adolescents, and children.
2. Unacceptably high rates of lost to follow-up across all implementing partners, particularly among populations under 40 years of age, and low viral load coverage and suppression rates across all IPs, particularly among men, adolescents, and children.
3. Lack of a robust and universal quality management practices in both prevention and treatment at the service delivery level and need for rigorous monitoring and oversight of implementing partner performance and financial monitoring.
4. Failure to sufficiently scale TLD transition and limited progress in implementing key policy reforms such as community ARV distribution.

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SECTION 1: COP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows. Note that all pipeline numbers were provided and confirmed by your agency.

TABLE 1 : All COP 2020 Funding by Fiscal Year

OU Total	Bilateral				Central	TOTAL
	FY20	**FY19**	**FY17**	**Unspecified**	**Unspecified**	**TOTAL**
Total New Funding	**$ 98,455,876**	**$ -**	**$ -**			**$ 98,455,876**
GHP- State	$ 96,680,876	$ -	$ -			**$ 96,680,876**
GHP- USAID	$ -	$ -	$ -			**$ -**
GAP	$ 1,775,000	$ -	$ -			**$ 1,775,000**
Total Applied Pipeline				**$ 14,547,145**	**$ 1,716,979**	**$ 16,264,124**
DOD				$ -	$ -	**$ -**
HHS/CDC				$ 9,017,616	$ -	**$ 9,017,616**
HHS/HRSA				$ -	$ -	**$ -**
PC				$ -	$ -	**$ -**
State				$ -	$ -	**$ -**
USAID				$ 5,529,529	$ 1,716,979	**$ 7,246,508**
TOTAL FUNDING	**$ 98,455,876**	**$ -**	**$ -**	**$ 14,547,145**	**$ 1,716,979**	**$ 114,720,000**

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SECTION 2: COP 2020 BUDGETARY REQUIREMENTS

Countries should plan for the full Care and Treatment (C&T) level of $79,100,000 and the full Orphans and Vulnerable Children (OVC) level of $22,850,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

TABLE 2 : COP 2020 Earmarks by Fiscal Year *

Earmarks	COP 2020 Planning Level			
	FY20	**FY19**	**FY17**	**Total**
C&T	$ 62,000,000	$ -	$ -	**$ 62,000,000**
OVC	$ 14,600,000	$ -	$ -	**$ 14,600,000**
GBV	$ 1,305,075	$ -	$ -	**$ 1,305,075**
Water	$ 205,750	$ -	$ -	**$ 205,750**

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.*

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TABLE 3 : All COP 2020 Initiative Controls

	COP 20 Total
Total Funding	**$ 23,600,000**
VMMC	$ -
Cervical Cancer	$ -
DREAMS	$ 16,000,000
HBCU Tx	$ -
COP 19 Performance	$ -
HKID Requirement	$ 7,600,000

***See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review

Table 4. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	263,855	357,702
VMMC among males 15 years or older	NA	NA
DREAMS (AGYW completing at least the primary package)	24,962 (96.6% of total AGYW reached)	NA
Cervical Cancer	NA	NA
PrEP	0	1,810
TB Preventive Therapy	201	81,179

Table 5. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP/ROP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
DOD	$3,488,142	$1,607,182	$(1,880,960)
HHS/CDC	$84,876,733	$82,374,494	$(2,502,239)
HHS/HRSA	$150,000	$147,723	$(2,277)
State	$414,930	$326,414	$(88,516)
USAID	$51,578,796	$42,615,252	$(8,963,544)
Grand Total	**$140,508,601**	**$127,120,512**	**$(13,418,089)**

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Table 6 provides greater detail of the mechanisms that underoutlayed or overoutlayed and didn't meet targets.

Table 6. COP/ROP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY 19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP/ROP18 Budget $)
17496	Population Services International	DOD	$563,730	$1,399,691	$(835,961)
18292	Sante Espoir Vie Côte d'Ivoire	HHS/CDC	$2,652,027	$2,952,027	$(300,000)
81613	FHI360 Development LLC	USAID	$30,000	$49,447	$(19,447)
70038	Population Services International	DOD	$2,664,412	$888,000	$2,664,412

* This PSI mechanism allocations were delayed therefore only in operation for Q3 and Q4

Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	2,120,369	**2,419,474**	114.1%	HTS	$14,165,618	66%
	HTS_TST_POS	102,886	**54,310**	52.8%			
	TX_NEW	120,655	**52,105**	43.2%	C&T	$28,714,608	56%
	TX_CURR	401,341	**253,777**	63.2%			
	VMMC_CIRC	NA	NA	NA		$5,784,682	56%
	OVC_SERV	177,136	139,271	78.6%	SE for OVC		
DOD*	HTS_TST	21524	**10,028**	46.6%	HTS	$66,798	12%
	HTS_TST_POS	1667	**704**	42.2%			
	TX_NEW	1269	**706**	55.6%	C&T	$395,251	25%
	TX_CURR	9497	**5223**	62%			

	VMMC_CIRC	NA	NA	NA		NA	
	OVC_SERV	NA	NA	NA			
USAID	**HTS_TST**	126,331	**119,084**	95.1%	HTS	$4,137,108	91%
	HTS_TST_POS	8743	**7280**	83.3%			
	TX_NEW	6983	**2957**	42.3%	C&T	$19,567,486	87%
	TX_CURR	14,609	**6853**	46.9%			
	VMMC_CIRC	NA	**NA**	NA			
	OVC_SERV	88,110	**88,110**	106.6%	SE for OVC	$3,372,500	100%
				Above Site Programs		$11, 888,737	
				Program Management		$22,957,081	

*****DOD Implementing Partners only operated in Q1, Q3, and Q4
Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.

COP/ROP 2018 | FY 2019 Analysis of Performance

Successes in COP 2018 implementation are:

- Elimination of formal and informal user fees with no reports of user fees after MOH circular was disseminated
- Significant increase in multi-month dispensing for eligible PLHIV on ART
- PMTCT program continues with 99% coverage of HIV testing in ANC and proxy ART coverage of 99% of HIV positive pregnant women receiving treatment
- To address challenges in pediatrics care and treatment, Côte d'Ivoire convened a meeting focused on children and adolescents in Fall 2019 and have implemented a variety of initiatives to improve pediatric care,
- Overall, Côte d'Ivoire is doing well in ensuring that each AGYW in DREAMS is receiving a layered package of services across the 10-14 and 15-19 age bands.

However, there are significant and ongoing challenges:

90-90-90 Cascade Case Finding

- UNAIDS 2019 data shows significant gaps in the 1st 90 (53%), 2nd 90 (39%), and 3rd 90 (29%) among males 15+ years in Côte d'Ivoire.
- Case finding of men, particularly young men, continues to be a challenge across IPs.

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- There was wide-spread under-achievement of HIV case finding targets despite ongoing over-testing by CDC clinical implementing partners: 126% (ACONDA), 189% (SEV-CI), 252% (ARIEL), 260% (HAI), EGPAF (235%), and 330% (ICAP) with no partner achieving their HTS_TST_POS targets and overall HTS_TST_POS yield country-wide at 2.4%-- lower than estimated prevalence. Despite this, all clinical partners except for DOD's partner PSI outlayed at least 95% of their budgets.
- CDC community implementing partners also continued to over-test, however achieved better yields than facility partners with 4%: (EGPAF-Keneya Dougou), 4% (IRC), 6% (SEV-CI), 7% (Heartland Alliance), and 18% (JHPIEGO).
- Index-testing yields averaged 10% across the country, however high-volume sites continue to have poor index testing elicitation and cascade yields.
- Elicitation and testing of children of HIV positive mothers is poor across partners.

Linkage, ARV Coverage

- See Table 8 below which demonstrates that case finding and linkage to treatment continues to be a significant challenge, particularly among men, adolescents, and children.
- Limited implementation of TLD transition with MOH policies that are inconsistent with WHO Guidelines and PEPFAR recommendations and require double contraception for women of reproductive age and written consent prior to initiation or transition to TLD
- TLD Transition has been extremely slow and as of December 31, 2019, only ~20,000 PLHIV are on TLD (<8% of TX_CURR).
- Linkage rates among children are <90%.
- As of December 2019, 69% of eligible PLHIV on ART are on 3-6 month dispensing with only 32% on 6MMD.

Viral Load Testing & Suppression

- Only 8 of 19 regions achieved viral load coverage at or greater than 80% (not including military sites) and only 1 region achieved viral load coverage > 90%.
- VL suppression, particularly among men, children, and adolescents continues to be unacceptably low.
- There are significant gaps and poor performance across partners in achieving viral load coverage and retention with little improvement quarter on quarter.

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Table 8. Clinical Cascade by gender and fine-age band

Female							Male						
Age	**PLHIV**	**On Treatment**	**VL Tested (den)**	**VL Suppressed**	**% On Treatment**	**% VL Suppressed**	**Age**	**PLHIV**	**On Treatment**	**VL Tested (den)**	**VL Suppressed**	**% On Treatment**	**% VL Suppressed**
<01	903	262	52	29	29%	56%	<01	946	212	49	18	22%	37%
01-04	3622	1,323	961	543	37%	57%	01-04	3762	1,264	887	489	34%	55%
05-09	5550	2,009	1,959	1,289	36%	66%	05-09	5746	1,966	1,900	1,109	34%	58%
10-14	5366	1,948	2,080	1,267	36%	61%	10-14	5546	1,888	2,014	1,102	34%	55%
15-19	9581	3,202	2,180	1,363	33%	63%	15-19	6006	1,499	1,544	924	25%	60%
20-24	19687	9,082	5,266	3,983	46%	76%	20-24	8272	1,506	1,039	698	18%	67%
25-29	29133	20,747	11,990	9,421	71%	79%	25-29	12596	3,585	1,550	1,177	28%	76%
30-34	34514	28,314	20,777	16,475	82%	79%	30-34	16054	5,726	3,236	2,477	36%	77%
35-39	38645	34,379	26,966	21,602	89%	80%	35-39	18907	9,427	6,019	4,665	50%	78%
40-44	40219	29,814	26,741	21,957	74%	82%	40-44	20902	12,251	9,710	7,634	59%	79%
45-49	33791	22,431	17,805	14,955	66%	84%	45-49	21778	12,345	9,053	7,307	57%	81%
50+	55015	34,564	28,945	25,139	63%	87%	50+	61892	24,194	18,677	15,730	39%	84%

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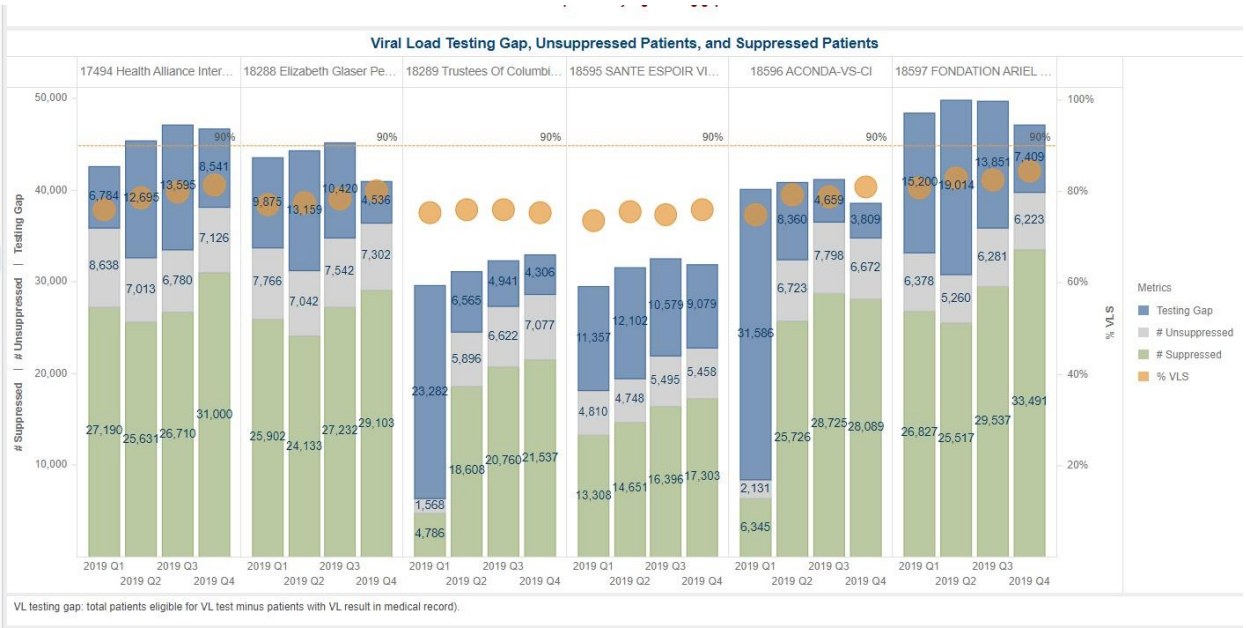
Figure 1. Viral Load Testing Gaps, Suppressed, Unsuppressed, and Percentage Viral Load Suppression Across Implementing Partners, FY19 Q1-Q4



Retention

- Retention continues to be an ongoing challenge, particularly among men and women PLHIV <40 years of age. This was true for EGPAF, ICAP, SEV-CI, ACONDA, and Fondation ARIEL which are responsible for the majority of PLHIV, and to a much lesser extent for HAI and PSI.
- Between FY18Q4 and FY19Q4, the percentage of males 15+ years on treatment in Côte d'Ivoire increased by only 9%.
- In FY19, most of the percentage increase was in the 50+ year old age band with a decrease in percentage of males on treatment in the 25-29 years age band and no significant percentage change in the 30-34 year old age band.

Prevention and other services

- The OVC program performance in FY19 did not improve from FY18. The OVC_SERV achievement for OVC beneficiaries < 18 years of age was 76% in Côte d'Ivoire for FY19 (65% for CDC, 103% for USAID). The OVC_HIVSTAT known status proxy for FY19 in Côte d'Ivoire was 87% (80% for CDC, 98% for USAID) with significant underperformance by EGPAF (64%) and JHPEIGO (58.1%). OVC graduation rates for IRC and SEV-CI were only 4% and 8%, respectively. OVC_HIVSTAT underperformance (87% known status proxy) reflects challenges with facility/community collaboration.
- PrEP availability is predominantly to FSW with minimal impact on MSM or distribution to high-risk AGYW or pregnant/breastfeeding women.
- TB symptom screening of PLHIV on ART was 91% in FY19 and only 201 PLHIV on

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ART were started on TPT.

Partner Management

- Ongoing lack of rigorous monitoring and oversight of implementing partner performance and financial monitoring. As well as lack of systematic partner management processes to ensure effective facility/community collaboration.
- FY19 expenditure reporting shows high program management costs contributing nearly 20% of total expenditures with wide variation by IP. Partners with >30% program management include: Family Health International (57%), Heartland Alliance International (44%), Population Services International (39%), JHPIEGO Corporation (37%), Abt Associates (35%), JSI Research and Training Institute, Inc. (35%), and AIMAS (35%).
- There were extensive obligations as a result of close-out and reductions of budgets from both CDC and USAID, resulting in ~$3M in obligations that were not budgeted for in COP18.

Government Policies

- TLD policies not consistent with WHO guidelines.
- Community ARV and DSD models not included in current MOH policies.
- Lack of data-driven quality management practices at the service delivery level for both.

Above Site

- Significant challenges related to poor general population literacy, stigma & discrimination, as well as PLHIV literacy, and health care worker HIV treatment literacy.
- Data systems: Slow implementation of unique identifiers and lack of collection of mortality data.
- Need to strengthen supply chain management and end-to-end visibility for commodities.
- Laboratory investments need to be reconsidered and realigned in order to align with current and projected ARV coverage levels. Historically high PEPFAR lab investments have not impacted viral load testing and suppression levels primarily due to poor case finding performance.

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SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP/ROP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP/ROP 2020, the failure to meet any of these requirements will result in reductions to the Côte d'Ivoire budget. (See Section 2.2. of COP Guidance)

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Table 9. COP/ROP 2020 (FY 2021) Minimum Program Requirements

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	**Partially Complete** Adoption of Test and Start with >100% linkage among adults however <90% linkage for children.	Stigma and discrimination are an ongoing barrier to linkage. Many PLHIV deny their diagnosis.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	**NOT COMPLETED** MOH recently agreed to transition all adolescent and adult men with PLHIV on ART as well as women ≥55 years to TLD. WHO in Côte d'Ivoire has proposed revised guidelines recommending TLD for all (without any condition) to MOH that are currently under review. MOH plans to release the revised guidelines on January 2020. PEPFAR Team is providing ongoing support to PNLS to redesign and update training. MOH-PNLS is conducting ongoing training and coaching of providers at high-volume sites.	MOH policy inconsistent with WHO Guidelines and PEPFAR Recommendations. MOH guidelines require women of child-bearing age to have two forms of contraception and folic acid supplements prior to transition to TLD. MOH consent forms misrepresent risks of TLD to women of child-bearing age. Inappropriate and inadequate trainings of HCW.

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1 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

2 Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

		The Global Fund has agreed to replace procurement of TLE with TLD.	Adverse event monitoring systems not in place Stock outs and stock management challenges.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi- month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	**NOT COMPLETED** MMD policies adopted in 2017 with significant progress in implementation and scale-up of MMD in FY19. Stable adult ART patients have clinical visits twice a year, 6MMD and VL testing annually. Stable pediatric ART patients receive quarterly clinical visits, 6MMS, and VL testing twice a year. WHO and PEPFAR will support MOH to pilot and implement a small-scale community distribution of ARVs in two high burden but hard-to-reach zones to inform policy decision.	Modest decrease in MMD as PLHIV being transitioned to TLD. No DSD models or national policy for community ARV distribution in place, pilot project of community ARV being discussed.
	4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by end of COP20, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	**NOT COMPLETED** Very limited TPT initiation and completion among PLHIV thus far though services are offered to patients at no fee. PEPFAR advocated to remove policy barriers related to CD4 and chest X-ray. MOH removed CD4 barrier accepted to provide X-ray free for PLHIV. Initial pilot completed at 7 sites in 2019 and will be expanded to 60 sites by end of 2020.	Several barriers to TPT implementation, including national policies that until recently required CD4 count and chest x-ray for PLHIV to be eligible for TPT. Uncertainty regarding availability of GeneXpert. Need for updated policies and coordinated scale-up plan.
	5. Completion of Diagnostic Network	**NOT COMPLETED**	Poor planning and implementation of

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[3] Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

	Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Only 8 of 19 regions achieved viral load coverage at or greater 80% (not including military sites) and only 1 region achieved viral load coverage > 90%.	laboratory optimization nationally. VL specimen transportation challenges have been reported.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	**Partially Complete** Index-testing yields average 10% across the OU however high-volume sites continue to have poor index testing cascade yields. Pediatric Index Testing also continues to be suboptimal across most IPs with elicitation of pediatric contacts being <1 for most. Self-testing policies were implemented in 2018 and as of the end of July 2019, a total of 5,047 self-tests have been issued to clients. They are offered directly to high-risk clients or to partners as part of index testing services. The HIV Self-test services targeted men who have sex with men (MSM), sexual partners of index cases who refused routine testing, and hard-to-reach men.	Poor roll-out, inadequate training and oversight by IPs, lack of appropriate HRH capacity of HCW. Challenges in facility-clinical collaboration. Limited MOH engagement in promoting index testing practices.

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[5] Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing- guidelines/en/

Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre- exposure prophylaxis (PrEP), to HIV- negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV- negative partners of index cases, key populations and adult men engaged in high- risk sex practices)[6]	**NOT COMPLETED** Policy has been adopted, and guidelines developed. Training of trainers sessions were conducted in August 2019, however service providers have not yet been trained on new PrEP guidelines.	Delays with training for service providers and community health workers on PrEP guidelines. The challenges include correct target setting, tracking the continuum of PrEP delivery, lack of training of health providers, and other site- level implementation challenges. Current MOH PrEP guidelines do not include PBFW.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case	**Partially Complete** Performance was unchanged in FY19. Ongoing need to increase coverage, particularly to reach OVC <18 years of age and C/ALHIV.	OVC_HIVSTAT underperformance reflects challenges with clinic/community collaboration.

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6 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

	management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9- 14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.		
Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	**Partially Complete** The Community Observatory on Treatment (OCT) did not identify any reports of any formal or informal user fees in public health facilities for care related to HIV infection including ANC, TB, and routine clinical services (between Jan- June 2019). A rapid user fee survey conducted by HSSA and RIP + included a pre-test carried out in December 2019 on two sites in Abidjan, one of which was public. This survey found that HIV-related services at the public hospital were free however HIV services (except for ARVs) were associated with a fee at the private site. Currently Cervical cancer services are not free for HIV-infected women. No specific communication has been made on the management of cervical cancer. **Other related updates**: MOH circular notes issued on March 19, 2019 and April 2019 removed user fees in the public sector for: access to all direct HIV services and medication	The Health System Strengthening Accelerator (HSSA) team is working with CSO to conduct a rapid user fees assessment. The goal is to identify any types of payment linked to HIV services in public facilities in Côte d'Ivoire.

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[7] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

		(consultation, health booklet, HIV testing and treatment, laboratory monitoring tests, ARV drugs, CTX prophylaxis, routine clinical services); ANC, HIV testing for children <15 MOH is conducting site visits from Dec 2019 to March 2020 at 140 priority sites by the office on Inspectors to enforce the implementation of the policies Cervical cancer: PEPFAR transitioned cervical cancer screening and treatment of pre-cancerous lesions with LEP to the National Cancer Program in 2015.	
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	**NOT COMPLETED** Clinical partners are strengthening CQI as part of standardized site support, with a focus on retention, stigma, and patient-centered care. PEPFAR teams have begun to identify gaps at sites through routine data review, site visits (SIMS, GSM, Drop by) for quality improvement with staff on-site, IPs and MOH. PEPFAR team is working with IPs to improve oversight and management of sites.	Historically limited IP and PEPFAR team oversight of sites. MOH has not had a functioning national CQI teams at many sites. Lack of SOPs or SOPs not being adhered to.
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general	**NOT COMPLETED** For updated messages to reduce stigma and discrimination, messages have been elaborated for the Test and Start Campaign and used by PNLS during World AIDS Day Campaign. During COP19, 3 partners received funding to provide activities that will include VL literacy and U=U messaging (Jhpiego, John Hopkins and FHI360).	Limited host country leadership activities focused on HIV messaging for the general population.

8 Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

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	population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Economic behavior study was conducted in 5 health centers to evaluate physicians' behavior through human centered design. Results were used to design job aids to improve interactions, communication between clients and providers. TA is planned from HQ to assess current online activity and results of the assessment will be used to train new online peer educator leaders (PEL) and to refresh old online PEL. ECHO platform was also funded as a strategy to promote U=U activities and the goal is for this to be implemented in early 2020. A Technical Assistant was hired to develop a concept note for the Lab ECHO program and coordinate development of the Lab ECHO program with ASLM and the national aids program due mid-Jan 2020 ASLM to facilitate 12 bimonthly HIV viral load scale up ECHO sessions over 6 months, starting in April 2020.	
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	**NOT COMPLETED**	
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	**NOT COMPLETED**	GoCI contribution decrease from COP17 funding of $27.7M to $11.3M in COP19.
	14. Monitoring and reporting of	**NOT COMPLETED**	

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	morbidity and mortality outcomes including infectious and non-infectious morbidity.		
	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	**NOT COMPLETED** MOH adopted a unique identifier implementation plan in 2018 and established a Unique Identifier TWG. A pilot at 10 sites in Abidjan started in late 2019 with the determination to use fingerprints as the unique identifier. The TWG has developed and validated the Client / patient flows by entry point (PMTCT, CT, EID, etc.) in the health facility. The TWG also developed and validated HIV case notification and reporting form and finally organized a workshop to assess the integration of fingerprint solution with SIGDEP 2 (National EMR).	Project management challenges have resulted in unexpected delays in development and implementation. Delays in delineating scope of work (SOW) as well as delays in COP19 funds may contribute to further delays.

In addition to meeting the minimum requirements outlined above, it is expected that Côte d'Ivoire will:

Table 10. COP/ROP 2020 (FY 2021) Technical Directives

Côte d'Ivoire –Specific Directives
HIV Treatment
1. In COP20, the Côte d'Ivoire program should continue focusing on finding and reaching HIV+ men (specifically within the 25-34 year age band), adding them to treatment, and attaining viral suppression among this group. Scale index testing with fidelity, including for 100% of biological children of HIV-positive mothers.
2. Meeting clients where they are with what they need at each stage of the treatment cascade will be critical to advancing life-long continuity of ART. This requires a better understanding of client needs in order to remove barriers to treatment. Leveraging the insights garnered through MenStar, PEPFAR Côte d'Ivoire should implement a core package of services that meet men where they are with what they need. Please see the newly released MenStar Guidance Document and Compendium for recommended strategies, interventions, and examples**.**

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3. Continued efforts to address gaps in retention and viral load suppression are critical and tailored approaches are needed for different population groups (e.g. adolescents, men, pregnant and breastfeeding women). It's critical that the underlying reasons for retention challenges are addressed along with ensuring that information systems are effective and community-facility collaborations are in place to identify and track PLHIV who are lost to follow- up so that they can be traced and returned to care promptly.
4. Need to optimize viral load testing and early identification of PLHIV who are failing treatment.
5. Ensure transition of all eligible CLHIV to lopinavir/ritonavir pellets or TLD to achieve >90% VL suppression among CLHIV.
6. Implement child, adolescent, and family-centered care and differentiated service delivery models and community ARV models.
7. Diagnostic Network Optimization activities need to be appropriately managed and completed.
HIV Prevention
1. Maintain and improve key population (KP) prevention and treatment programming while improving quality of services for KP by routine assessment of the quality of services using SIMS or other CQI efforts.
2. Ensure training of service providers and address barriers to implementation. PrEP availability and distribution should ensure availability to all eligible populations, including MSM and high-risk AGYW, pregnant and breastfeeding women. PrEP should also be available to HIV-negative partners to index clients.
3. Rapid scale-up of TPT to all sites in COP20.
4. In COP20, OVC and clinical implementing partners in Côte d'Ivoire must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program. Partner management needs to increase to ensure quality implementation, including appropriate targeting and enrollment strategies in line with COP guidance.
5. In COP20, all OVC implementing partners and agencies must ensure that 90% or more of OVC beneficiaries under age 18 have a known HIV status or are deemed not to need a test based on a standard HIV risk assessment.
6. All agencies and implementing partners should work to improve the OVC_SERV achievement to 90% or higher.
7. Cervical Cancer services should be available and free for all HIV positive women.
8. COP19 DREAMS funding was designated for AGYW PrEP implementation. Scale up is needed.
Partner and Financial management

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1. In FY2021 PEPFAR Côte d'Ivoire needs to tightly monitor partner financial performance and ensure partners are outlaying and expending within approved levels. Any and all adjustments to approved spending levels must be agreed upon by the interagency team and submitted to S/GAC as an OPU. S/GAC reserves the right to restrict funding to any partners if they fail to outlay or expend within approved COP20 levels during FY 2020.
2. COP2020 budgets must include any potential close out costs that may be incurred during FY2021.
3. Integration, expansion, and increased training of community health care workforce across sites.
4. Planning must begin to transition to local, indigenous partners for PRIME Funding.
5. Implementing Partners must be held responsible and accountable for ensuring that SOPs are available, updated, and adhered to across sites.
Other Government Policy or Programming Changes Needed
1. TLD Implementation: TLD should be available to HIV positive women of reproductive age without any contraceptive requirements. No consent forms should be required for women to sign prior to initiation or transition to TLD. TLD should also be available to PLHIV who are not virally suppressed and children with HIV >20kg.
2. TPT policies—CXR, even if offered for free may still be a barrier to TPT initiation and should not be used to in place of molecular diagnostic testing. Molecular diagnostic testing (e.g. GeneXpert) should be available for TB diagnosis.
3. Immediate implementation of comprehensive continuous quality improvement (CQI) policies to strengthen site-level CQI capacity as well as oversight by IPs and Regional Health Officers to ensure standard operating procedure are in place, adhered to, and updated as needed.
4. Cervical Cancer services should be available and free for all HIV positive women.
5. Leverage electronic stock management software (mSupply) for on-time inventory management and transactions tracking.
6. PEPFAR investment will support decentralization of the supply chain health system, focusing on strengthening human resource capacity to increase accountability of supply chain management functions at sub-national level of health system and availability of commodities at sites.
7. Design and implement a comprehensive Decentralized Drug Delivery Models which prioritize (a) community-based ARVs distribution; (b) increase capacity for and outsourced last mile delivery of ARVs and other HIV commodities and (c) develop a model for alternative pick-up points for ARVs using a market segmentation for a client-centered approach.
8. PEPFAR investments should advance NPSP capabilities to support end-to-end visibility on distribution of ARVs and other HIV commodities at subnational level. A performance-based programming approach will be used to set up an optimized last mile delivery model between health districts depot and services delivery points.
9. PEPFAR should reallocate funds from lab to better support first and second 90's of the clinical cascade. Laboratory QM needs to be shifted to the MOH fully in COP2020 as well as any other laboratory training and supervisory responsibilities historically supported by

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PEPFAR.
10. Leverage Monthly PNLS-Regional Health Director meetings to develop data-driven processes for continuous quality improvement of services, identify cross-cutting challenges, share and scale best practices across sites and implementing partners, and encourage local innovation.

COP/ROP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Côte d'Ivoire must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with

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unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. (Groups will be tailored to country context).

TB Preventive Treatment (TPT)
TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3HP) as supply allows.

DREAMS
DREAMS funding is allocated within your COP 2020 planning level and must be used exclusively for the goal of HIV Prevention among adolescent girls and young women (AGYW) in DREAMS SNUs in accordance with all DREAMS and COP 2020 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP20 DREAMS implementation include: systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition, improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR), and accelerating PrEP uptake for AGYW.

DREAMS is receiving an increase in new funding which should be used for the following:

- Expand into the 20-24 age group in all districts.
- PrEP: Significantly scale-up PrEP for AGYW in all DREAMS districts.
- Minimum Requirements for new funds: To receive additional funds, Côte d'Ivoire must present a strategy and a timeline at the COP meeting for the following:
    - Hire a dedicated DREAMS Coordinator (100% LOE)
    - Hire a DREAMS ambassador for each district to support DREAMS coordination and oversight
    - Implement approved, evidence-based curricula in line with the current DREAMS Guidance
    - Ensure a fully operable layering database with unique IDs across IPs and SNUs
    - Ensure a full geographic footprint in all districts
    - Address challenges and ensure DREAMS implementation in all districts with fidelity

In addition, DREAMS Côte d'Ivoire should focus on the following:

- Layering: A recent interagency TDY revealed that there are challenges with the DREAMS layering database which PNOEV is now managing. Resolving these issues and ensuring database management and full functionality for all IPs is a priority. This is a good example of what should be prioritized with new funds.

OVC
To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case

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conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

Cervical Cancer Screening and Treatment:
Funding for cervical cancer screening and treatment of pre-invasive lesions. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

COP/ROP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

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In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

TABLE 11 : New Funding Detailed Initiative Controls

	COP 2020 Planning Level			
	FY20			**COP 20 Total**
	GHP-State	**GHP-USAID**	**GAP**	
Total New Funding	**$ 96,680,876**	**$ -**	**$ 1,775,000**	**$ 98,455,876**
Core Program	$ 89,080,876	$ -	$ 1,775,000	**$ 90,855,876**
COP 19 Performance	$ -			**$ -**
HKID Requirement ++	$ 7,600,000			**$ 7,600,000**

++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia

<u>Care and Treatment</u>: If there is no adjustment to the COP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.

<u>Orphans and Vulnerable Children (OVC)</u>: Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the

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HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.

HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total ***new FY 2020*** *funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total ***new FY 2020 funding*** *programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs. PEPFAR has set a 70% goal ***by agency*** *by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.*

COP/ROP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Côte d'Ivoire should hold a 3 month pipeline at the end of COP/ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.

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