United States Department of State

Washington, D.C. 20520

UNCLASSIFIED January 13th, 2021

INFORMATION MEMO FOR AMBASSADOR RICHARD K. BELL, CÔTE D'IVOIRE

FROM: SGAC Chair Teeb Al-Samarrai and PPM Ann Sangthong

THROUGH: Ambassador Deborah L. Birx, MD

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Richard K. Bell/Charge Joann M. Lockard,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. As the threat of COVID-19 has impacted PEPFAR countries, PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR implementation over the past year has shown tremendous effort to maintain clients on treatment, initiating and accelerating client centered service delivery adaptations, while doing what was possible in HIV prevention programs deeply affected by COVID-19 shutdowns. The following themes have emerged across all of PEPFAR-supported countries; As the economic impact of COVID continues to be seen at both national and community levels, it is more important than ever to use granular data and expand what is working in specific SNUs for viral load coverage and suppression. We saw differential progress in this area independent of the impact of COVID19. Focus groups and deep analytics of client returning to care to ensure we are addressing the critical persistent and new structural barriers. Focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade and identifying challenges by district and country for clear and actionable plans. In addition, leverage OVC, DREAMS and other resources for clear accountability to work with mothers and improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies to reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, DREAMS, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program areas level, along with the work teams have done, to build relationships and co-planning with your partner government, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities as well as understanding COVID relief and other potential funding available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not and these funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic also laid bare the depth and breadth of inequities still across the globe and clear evidence that when constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present, and are now fully exposed, as these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all of our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, a number of countries have shown a level of resiliency were achieving epidemic control of HIV, and others are on the brink of epidemic control. With continued implementation, most PEPFAR countries are on a path to achieving program coverage goals. With that in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period, and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are very excited about your progress in:

- **Policy Changes**: The Government of Côte d'Ivoire rapidly implemented and scaled-up multi-month dispensing for adult PLHIV in the setting of the COVID-19 pandemic and coordinated management of ARVs. Accelerating the TLD transition in the setting of COVID-19 for adult men has resulted in improved viral load suppression (VLS) among men across all age groups.
- **Patient-Centered Care:** The PEPFAR team and IPs implemented various site- and system-level adaptations to ensure access to ARVs, support adherence, and improve viral load coverage (VLC)/VLS. These adaptations included: home and community delivery of medications, evening and weekend hours for viral load (VL) testing, expanded use of dried blood spots (DBS), SMS appointment reminders, and expanded access to VL Champions, social workers, and community counselors.
- **Data-driven site management**: The PEPFAR team's data-driven interventions improved VLC and VLS among children and adolescents.

Together with the Government of Côte d'Ivoire and civil society leadership we have made tremendous progress together. Côte d'Ivoire should be proud of the progress made over the past 18 years of PEPFAR

implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue and we again highlight 5 overarching issues we see across PEPFAR.

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))
4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed [net new on treatment and treatment current growth, (retention surrogate)]
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following specific key challenges in PEPFAR Côte d'Ivoire:

- TLD transition among women and children continues to lag behind and is reflected in poor VLS rates.
- Ongoing challenges in scale up of effective case finding, including index testing and targeted community testing.
- Need to scale and standardize best practices across the program and strengthen oversight of partner performance and coordination across partners. Inconsistencies are reflected in the decline in linkage and poor performance by partners.
- Challenges related to data integrity and ensuring PLHIV initiated on treatment remain on treatment.

A full set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 21 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016, PEPFAR and the Global Fund resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Côte d'Ivoire has not achieved the 2020 goals and is on not on track to achieve 2030 goals early which means sustaining the amazing gains will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Côte d'Ivoire is **$100,750,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program direction provided below must be met. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team, in collaboration with the Government of Côte d'Ivoire and civil society of Côte d'Ivoire, believes is critical for the country's progress towards controlling the pandemic and maintaining control.

We are hoping this approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Chair Teeb Al-Samarrai, PPM Ann Sangthong, PEPFAR Country Coordinator Bibola Ngalamulume**

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

1 **Policy Changes**: Successful switch from TLE orders to TLD. TLD uptake increased from 11% in October 2019 to 43% in September 2020 at all PEPFAR supported ART sites. Significant acceleration of MMD across all age groups with 91% stable patients and 78% of patients overall on at least 3-month dispensing of ARV (3MMD). As of September 2020, 53% of ART stable patients were receiving 3MMD and the remaining 47% patients were receiving 6MMD.
2 **Patient-Centered Care:** Since Q4 of 2019, trends in VLC and particularly VLS among men across all age groups have steadily increased, likely a reflection of accelerated TLD transition in the setting of COVID-19.
3 **Data-driven site management**: The team's data-driven and integrated approach to increasing VLC and VLS among children and adolescents at the worst performing sites through case management and alignment across community, facility, OVC, lab, and supply chain SMEs provides an excellent example of interagency and cross-sector collaborations.

Challenges:

1 Côte d'Ivoire needs to accelerate TLD transition among women and children. As of September 2020, the proportion of women (37%) and children (13%) on TLD has progressed slowly in comparison to men (74%). As of FY20 Q4, although overall VLS rates for adult men and women reached 87%, VLC/VLS rates for certain age groups such as young men and women 15-24 years of age were ≤80% and VLS among children (ages 1-14) ranged from 54-71% well below the goal of 90%.
2 Inefficient modalities hinder achievements in targeted testing. Case finding only achieved 47% of the HTS_POS target, despite over-testing by 126%. Index testing was not scaled up significantly across most partners. An estimated 50% of IPs achieved the expected index testing yield of 20%. Clinical IPs achieved an average of 42% of their HTS_POS targets as compared to community IPs (72%). Partners will need to leverage and build upon best practices from ICAP and IRC to successfully scale up targeted testing.
3 The program linkage to treatment rate dropped from 99% (FY Q1) to 84% (FY20 Q4), despite reports from both community and clinical IPs recording linkage rates of >96%. Further DQAs confirmed data integrity issues in four districts. COVID-19 management in FY20 Q3 also halted HIV activities in Abidjan, where the LTFU rates were highest (71%) in comparison to other regions (58%). Partners will need to scale and standardize best practices across the program, such as ICAP's SMS appointment reminder notifications to patients. Partners will also need to monitor and address deficiencies in practices and data integrity through a well-defined Data Integrity TWG in collaboration with the MOH and other stakeholders.
4 Côte d'Ivoire's absence of a national unique patient identification (UPID) system continued to perpetuate risks with data integrity, illustrated by DQA results in FY20 Q4 that confirmed two districts duplicated ARV codes for reported positives. The implemented UPID will also aide difficulties retaining patients and preventing IIT. The average number of weekly interruptions declined from 14,000 (FY19 Q4) to 8,000 (FY20 Q4). The UPID could help reduce missed appointments, missed medications, and track patients that relocate to other regions. PEPFAR

Côte d'Ivoire needs to accelerate UPID implementation, starting with all high and moderate impact sites.

Given your country's status of epidemic control, the following priority strategic and integrated changes are recommended:

1 **Develop a Comprehensive Quality Improvement Strategy** to scale and implement best practices with fidelity and create an environment that fosters the strategic use of data and adoption of innovative solutions and sharing across sites, IPs, and districts. Site and District level CQI strategies must be tied to specific metrics and have clear, time-bound goals.

2 **Optimize Human Resources for Health** (HRH) through a comparative analysis of the staff on high performing sites compared to low performing sites, on testing, treatment and VLS with the intent to adjust low performing sites' staffing mix to improve optimal resource allocation tied to performance. Local context and other factors such as COVID-19, or supply chains challenges (HIV testing kits or ARV stock out) should also be included in the analysis of sites.

3 **Accelerate scale-up of client-centered policies and strategies to close gaps across the cascade**: this includes individual patient identifiers to facilitate continuity of care and address data integrity challenges; expanding community ARV distribution, MMD, and completing TLD transition in FY21; strengthen community and facility collaboration to address case finding, continuity of treatment, and VLC/VLS gaps.

SECTION 1: COP/ROP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP/ROP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. These planning levels do not include $4.9 million that was set aside in COP20 as a State/SGAC TBD. S/GAC will consider proposals to utilize some of this funding in COP21 instead of in COP20 if that is better from a programmatic standpoint. Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP21, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	$ 95,842,199	$ -	$ -	$ -	$ 750,000	$ -	$ -	$ -	$ 96,592,199
GHP-State	$ 94,067,199	$ -	$ -		$ -	$ -	$ -		$ 94,067,199
GHP-USAID	$ -				$ 750,000				$ 750,000
GAP	$ 1,775,000				$ -				$ 1,775,000
Total Applied Pipeline	$ -	$ -	$ -	$ 4,157,801	$ -	$ -	$ -	$ -	$ 4,157,801
DOD				$ 864,040				$ -	$ 864,040
HHS/CDC				$ 358,439				$ -	$ 358,439
HHS/HRSA				$ -				$ -	$ -
PC				$ -				$ -	$ -
USAID				$ 2,720,000				$ -	$ 2,720,000
USAID/WCF				$ 215,322				$ -	$ 215,322
State				$ -				$ -	$ -
State/AF				$ -				$ -	$ -
State/EAP				$ -				$ -	$ -
State/EUR				$ -				$ -	$ -
State/PRM				$ -				$ -	$ -
State/SCA				$ -				$ -	$ -
State/SGAC				$ -				$ -	$ -
State/WHA				$ -				$ -	$ -
TOTAL FUNDING	$ 95,842,199	$ -	$ -	$ 4,157,801	$ 750,000	$ -	$ -	$ -	$ 100,750,000

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Countries should plan for the full Care and Treatment (C&T) level of $62,000,000 and the full Orphans and Vulnerable Children (OVC) level of $14,600,000 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$62,000,000	$-	$-	**$62,000,000**
OVC	$14,600,000	$-	$-	**$14,600,000**
GBV	$1,300,000	$-	$-	**$1,300,000**
Water	$205,750	$-	$-	**$205,750**

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks.*
***Only GHP-State will count towards the GBV and Water earmarks.*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL
Total Funding	**$100,000,000**	**$750,000**	**$100,750,000**
Core Program	$84,000,000	$-	**$84,000,000**
Cervical Cancer	$-	$-	**$-**
Community-Led Monitoring	$-	$-	**$-**
Condoms (GHP-USAID Central Funding)	$-	$750,000	**$750,000**
DREAMS	$16,000,000	$-	**$16,000,000**
HBCU Tx	$-	$-	**$-**
One-time Conditional Funding	$-	$-	**$-**

Surveillance and Public Health Response	$-	$-	**$-**
VMMC	$-	$-	**$-**

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	**FY20**	**FY19**	**Unspecified**
ICASS	$-	$-	$-	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

Table 5. COP/ROP OU Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	**9,507**	**25,267**
TX Current >15	**239,854**	**332,578**
VMMC >15	**N/A**	**N/A**
DREAMS (AGYW PREV)	**28,727**	**N/A**
Cervical Cancer Screening	**N/A**	**N/A**
TB Preventive Therapy	**335**	**72,271**

Table 6. COP/ROP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	3,254,827	1,707,615	1,547,212
HHS/CDC	58,113,003	55,861,773	2,251,230
HHS/HRSA	185,606	185,606	0
State	521,555	500,195	21,360
USAID	42,750,782	37,328,706	5,422,076
Grand Total	**104,825,773**	**95,583,895**	**9,241,878**

These figures include only bilateral figures at present.

Table 7. COP/ROP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
9419	American Society For Microbiology	HHS/CDC	$623,731	$1,299,335	($675,604)
70057	Results For Development Institute, Inc.	USAID	$320,000	$820,000	($500,000)
18382	Chemonics International, Inc.	USAID	$1,717,693	$2,088,515	($370,822)
18595	SANTE ESPOIR VIE COTE D'IVOIRE	HHS/CDC	$2,461,952	$2,761,952	($300,000)
18377	NOUVELLE PHARMACIE DE LA SANTE PUBLIQUE DE COTE D'IVOIRE	USAID	$517,216	$630,215	($112,999)

These figures include only bilateral figures at present.

Table 8. COP/ROP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/ CDC	HTS_TST	1,039,652	1,323,289	127%	HTS	$5,282,945	108%
	HTS_TST_POS	69,087	29,825	43%			
	TX_NEW	73,600	32,010	43%	C&T	$21,025,193	85%
	TX_CURR	351,961	245,243	70%			
	VMMC_CIRC	N/A	N/A	N/A	N/A	N/A	N/A
	OVC_SERV	51,252	66,960	131%	OVC	$5,335,924	75%
DOD	HTS_TST	16,187	11,059	68%	HTS	$328,756	81%
	HTS_TST_POS	1,899	1,234	65%			
	TX_NEW	1,815	1,035	57%	C&T	$1,370,413	85%
	TX_CURR	5,741	4,118	72%			
	VMMC_CIRC	N/A	N/A	N/A	N/A	N/A	N/A
	OVC_SERV	N/A	N/A	N/A	N/A	N/A	N/A
USAID	HTS_TST	47,795	61,779	129%	HTS	$2,765,445	98%
	HTS_TST_POS	7,761	6,054	78%			
	TX_NEW	N/A	N/A	N/A	N/A	$14,135,757	97%
	TX_CURR	N/A	N/A	N/A	N/A		
	VMMC_CIRC	N/A	N/A	N/A	N/A	N/A	N/A
	OVC_SERV	173,017	177,447	103%	OVC	$13,809,551	85%
					Above Site Programs		5,260,402
					Program Management		17,785,129

COP/ROP 2019 | FY 2020 Analysis of Performance

OU/PSNU Levels

Case finding & Linkage

- Overall improvement in test optimization shown by increased yield from 2.5% to 3.2% over the past four quarters and overall testing volumes (HTS_TST) that have declined by nearly 50% between FY19 and FY20. (1) Rapport achieved through MOH level policy engagement and partnership with district level health authorities (2) Increased testing yield within PITC and index testing (3) a consistent increase of the contribution of index in the total cases that were identified now reaching 36% which surpassed the target of 30% for FY20 (4) improvements in mobile community testing, (4) roll out of the risk screener may have contributed to this trend. Quarterly OU-level case finding did not change significantly and overall FY20 achievement was less than 50%.
- There has been target achievement or near achievement for case finding among young men ages 20-24 (136%) 25-29 (97%) and women ages 15-19 (88%) and 20-24 (91%) however case finding targets for women 25+ and men 35+ were <65% and as low as 32% for women 40+ despite testing yields of 6-7% (Figure 1, Figure 2).

Figure 1. Case finding achievements by gender and age group among adults

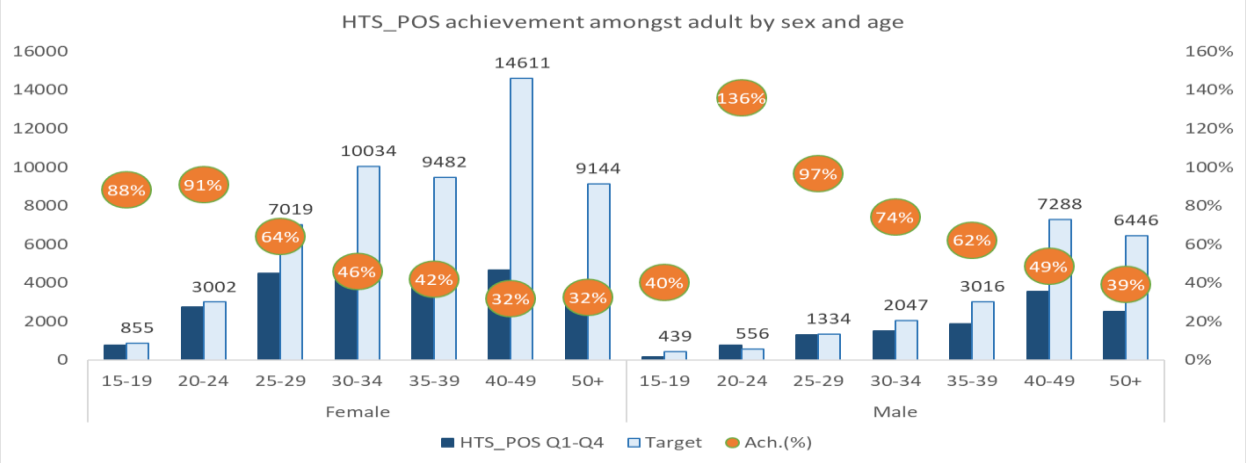
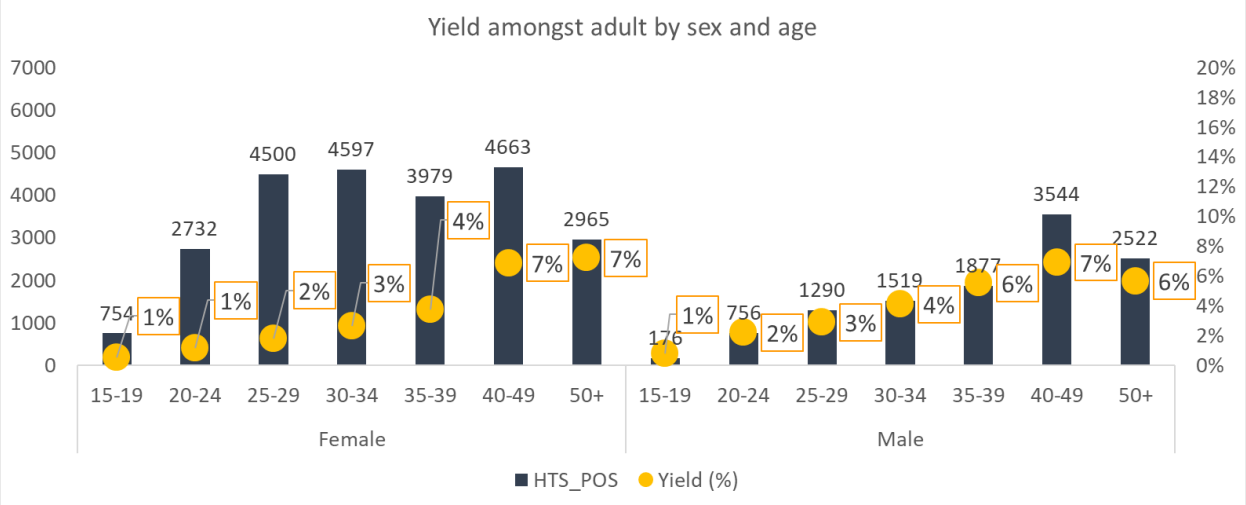


Figure 2. Yield by Gender and Age Group among Adults

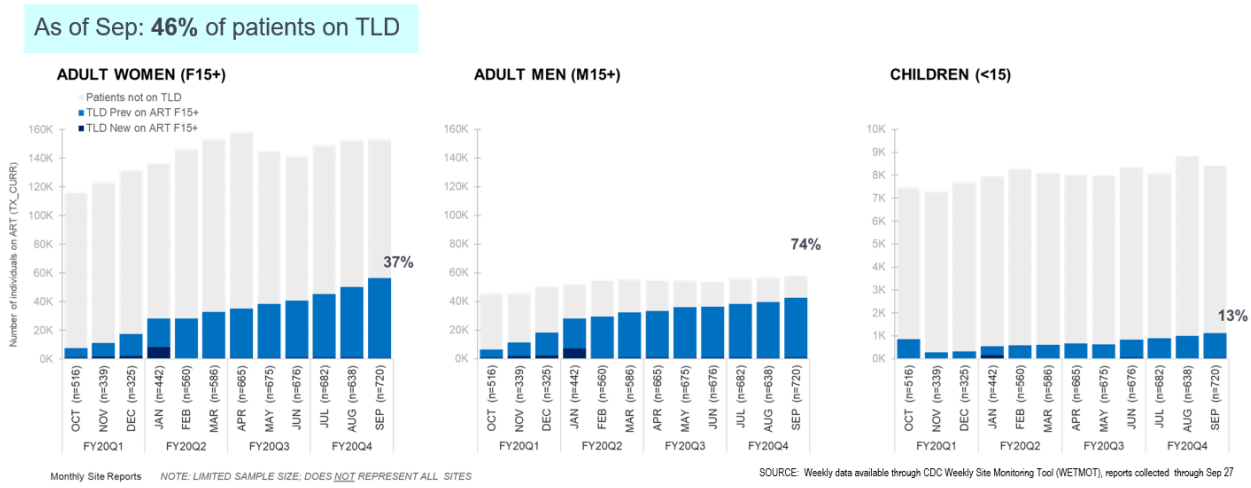


- Pediatric target achievement overall was only 36% overall with the largest volume in the 1-9 years old (854). Index testing accounts for 50% of case finding and needs to be scaled with fidelity.
- While FY20 TX_Net_New is similar to FY19 achievements, it is notable that there have been fewer unexplained losses.
- There was significant OU-level drop in linkage in FY20Q3 and Q4 of 83% and 84% respectively which is concerning and undergoing investigation. We commend the team's integrated approach to analyzing linkage rates by district and partner and clinical-community dyads to address gaps in community-facility collaboration.
- Côte d'Ivoire expanded index testing of biological children such that 51.7% of all positive children came from index modality compared to 46.8% during FY19 APR. The NNT of index modality is 57 at FY20 Q4 compared to 62 PEPFAR average during the same reporting period. Beginning 2018 Q4, Côte d'Ivoire has had quarterly upward trends on pediatric linkage to treatment. This was the case in FY20 despite a transient decrease in linkage in FY20 Q3. Côte d'Ivoire is one of the few PEPFAR programs with a high quarterly pediatric VLC rate of >80% (better than the adults VLC rate). The high pediatric VLC rates are seen across almost all SNUs during FY20 Q3 and Q4 respectively.

Care & Treatment

- 74% of adult male PLHIV on TLD regimens however only 37% of adult women PLHIV and 13% of children on DTG-based regimens (Figure 3).
- Pediatrics: Côte d'Ivoire has successfully phased out NVP use, ongoing challenges related to LPV/r administration continue to be a challenge and being addressed through case management, caregiver training, and linkage with OVC programs. GoCI plans to transition to pediatric DTG10mg once available.

Figure 3. Continued Progress in TLD transitions by Month

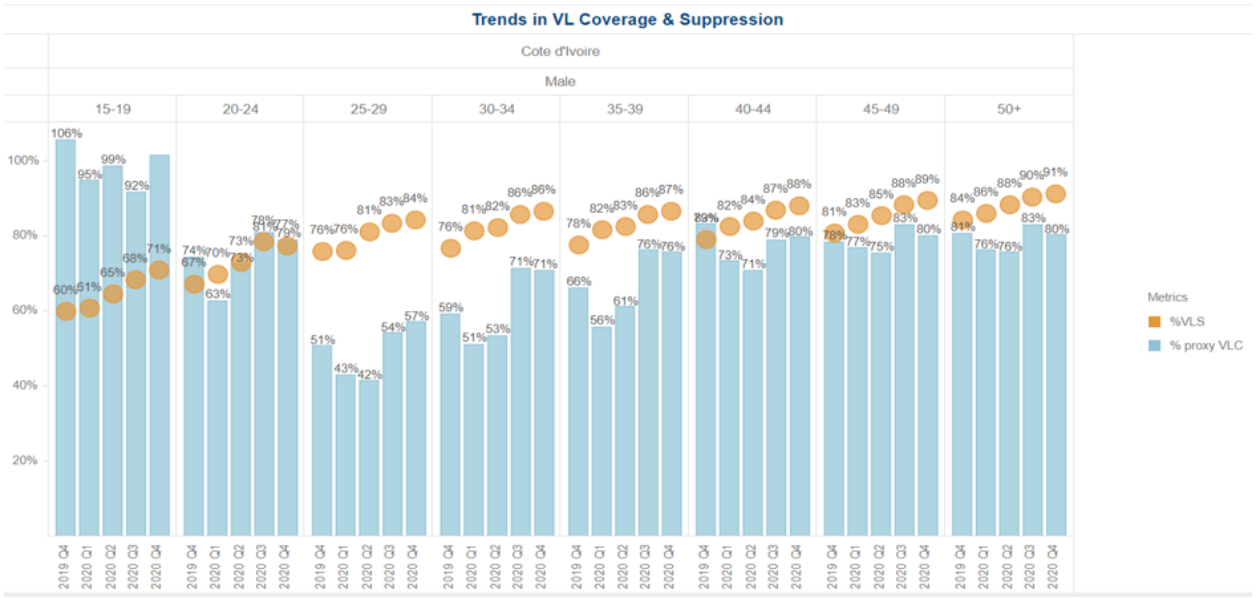


Continuity of Treatment

- HAI in collaboration with IRC (1), BTA (2), and HAI (&) improved retaining 99.5% of TX_CURR at 10 health districts in FY20 Q4.
- ACONDA, in collaboration with IRC, improved retaining 99.5% of TX_CURR at 6 health districts in FY20 Q4.
- Best practices to improve retention from EGPAF and ICAP should be shared among all community and clinical IPs. Best practices include the verification of missed appointments, harmonizing VL and ART appointments, and developing a personalized follow-up template for each case.

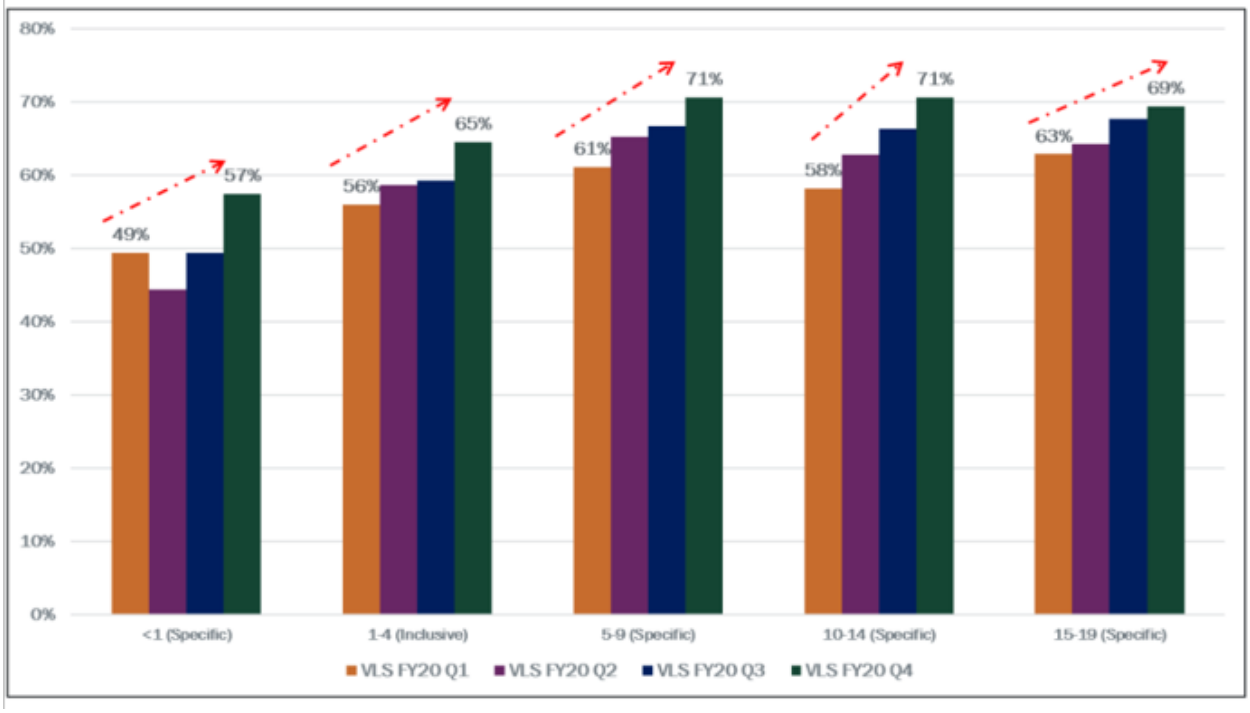
- 30 of 60 districts achieved quarterly retention rates of >96% with the majority achieving rates >99.5% however overall unexplained losses were 17,535 reiterating the need for increased attention on continuity in treatment efforts.
- Overall OU treatment interruptions are declining from a weekly average of 1197 in FY20 Q1 to a weekly average of 838 in FY20 Q4 and the majority of interruptions in treatment are among adult women and PLHIV on ART treatment for >12 months suggesting the need for ongoing efforts for client centered treatment approaches to keep patients engaged in care. Of note, 8 districts: Soubre, Bouake-Nord-Ouest, Ferkessedougou, Korhogo 1, Man, Abobo-Ouest, Divo, and Daloa accounted for three-quarters of overall loss. From an IP perspective, ARIEL and EGPAF continue to account for the highest numbers of clients LTFU.
- VLC and VLS achieved or exceeded 84 and 80%, respectively at all clinical IPs except for SEVCI which achieved VLC of 77% as of FY20Q4 (still an improvement from 68% in FY20Q1). VLS improved across all clinical IPs with the most significant improvements at ICAP (76 to 84%) and SEVCI (78 to 84%) between FY20Q1 and FY20Q4.
- VLC and VLS improved among men across all age bands (Figure 4) however VLC remains <80% among men ages 20-39 years of age.

Figure 4. Trends in VLC and VLS among Men by Fine Age Band, FY19Q4-FY20Q4



- VLC and VLS remain suboptimal in pregnant and breastfeeding women with wide variation among implementing partners. Strategies to improve testing and high VL should be implemented including tracking of mother-infant pairs, ART optimization, and AGYW appropriate services.
- VLC/VLS: Significant increase in EID Coverage at 2 months (over 95%) for two consecutive quarters due to improvement in the use of longitudinal register and SOPs to transport samples to the reference sites in case POC devices are not functioning.
- VLS increased through a coordinated, data-driven effort for 4,555 children in an effort focused on the 95 clinical sites with the worst pediatric VLC/VLS performance (Figure 5). This approach coordinated efforts across clinical, laboratory, OVC, and supply chain. Best practices included training of HCWs, using pediatric tools for follow-up, referral to OVC programs, and consistent use of a weekly monitoring tool.

Figure 5. Increase of VLS among Children and Adolescents FY20 Q1-FY20 Q4



- **DREAMS** programming continues to exceed targets with strong achievement across age bands and SNUs with an overall OU achievement of 111%. In comparison to FY19, DREAMS in FY20 has reached an additional 2,806 AGYW and drastically increased completion by over 4,000 AGYW.
- A national EMR, based on the OpenMRS opensource, has been put in place with interagency support. The standalone version used by 375+ facilities, represents 80% of active ART patients at all PEPFAR facilities and 70% nationally. Development of a consolidated-server version is complete and initial deployment planned for FY21. The operational standalone version will be upgraded to a new version of OpenMRS, allowing for interoperability with the LIS. A VL dashboard is now fully operational. It allows decision makers to access to useful info, such as VL suppression per regimen. It is fed by the opensource laboratory information system OpenELIS, itself rolled-out in 100+ lab (including 18 VL labs).

Partner and Financial Performance

- The majority of PEPFAR Côte d'Ivoire implementing partners demonstrated improvements in some areas however no partner consistently performed well across multiple program metrics. Several IPs were put on performance improvement plans in FY20.
- Partners with limited programmatic targets and results continued to execute funding at the constant rate irrespective of performance. PEPFAR Côte d'Ivoire should proactively ensure active partner management strategies and policies are in place (in accordance with COP Guidance) to ensure corrective actions are implemented in a timely manner. Remediation plans should include time-limited performance benchmarks and provisions to adjust funding levels based on performance.

- Care & Treatment: C&T partners ICAP and PSI expended less budget but performed better in target achievement, with ICAP 60% TX_NEW and 74% TX_CURR, and PSI 57% TX_NEW and 72% TX_CURR. C&T partners EGPAF and Fondation Ariel underperformed, while spending more than 50% or nearly all their budget. PEPFAR Côte d'Ivoire may consider the reduction in their C&T budget and/or shift targets for COP21.
- OVC: OVC partners performed well with respect to target achievement. However, there are needs for improvement with respect to budget compliance. IRC exceeded target achievement for OVC_SERV % but spent over 100% of their C&T budget. SEVCI exceeded target achievement also, with 139% OVC_SERV% and 106% of the C&T budget expended.
- HTS: HTS budget was fully expended by TBD-Reve, EGPAF, ICAP, SEV-CI, and ARIEL. However, only HTS_TEST % target achievement ranged from 90% to 126% suggested over testing. There were successful strides in HTS_Self achievement at 87%. All other HTS indicators underperformed with HTS_TST_POS falling under 50% target achievement. FHI and IRC exceeded HTS target achievements and spent nearly all/full budget. EGPAF, ICAP, SEVCI, and Fondation Ariel had high expenditures and a variation of indicator performance. EGPAF spent 133% of their HTS budget, but only met 25% HTS_TST_POS indicator target achievements. ICAP exceeded 75% HTS_TST_POS indicator target achievement, but overspent HTS budget by 605%. SEVCI exceeded 75% HTS_TST_POS indicator target achievement but overspent 126%. Fondation Ariel achieved 39% of HTS_TST_POS target but spent 100% of their HTS budget. PEPFAR Côte d'Ivoire needs to review case finding strategies across the program and conduct activity-based costing strategies review to ensure expenditures maximize results.
- Local, indigenous partner funding: Côte d'Ivoire has failed to achieve 70% of the budget allocated to local partners at the total OU (29%), CDC (42%), or USAID (13%) levels.

SECTION 4: COP/ROP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)

All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP20 implementation (FY2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). 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.

All PEPFAR programs are expected to meet all of the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR OU team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the OU budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	Adoption of Test and Start with >95 linkage across all age, sex and risk groups in all supported sites and districts. The COVID-19 pandemic reduced clinic visits, demonstrated by reduced linkage 85% in Q3.
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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Policy was adopted for all population groups, including women of childbearing age and children ≥ 20 kg at all PEPFAR supported sites and districts however implementation is ongoing. Awaiting DTG 10mg supply to transition eligible CLHIV. Proportion of women (37%) and children (13%) on TLD or DTG-based regimens remain far behind men (74%).
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	MMD implementation and scale-up is progressing and was accelerated by COVID-19 adaptations. Necessity to scale-up community ARV distribution model to more districts.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT initiations and completions did not meet targets (e.g. Q1-Q4 TB_PREV_D total of 1,192 and target was 96,500). Initial reluctance from the MOH to authorize initiation of TPT with INH without vitamin B6 caused delay, as well as major delays in the arrival of PEPFAR-funded TPT drugs. Data collection tools and screening questions were also outdated.
5. Completion of Diagnostic Network 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	VLC is improving and program has leveraged DBS to expand access.

EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Diagnostic Network Optimization plan was developed but has not been completed. Ongoing TA required and there are needs to address and streamline specimen transport challenges. Exercise conducted with PNLS in July 2020 confirmed estimated number of tests to be performed and estimated utilization rate among all VL labs. Significant issues were identified, including the stockout of reagents, instrument breakdown and delayed replacement, limited # of POC, and delayed policy change to GeneXpert as the first line diagnostic test for TB/HIV.
Testing	
1. 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 should be offered testing for HIV.	Ongoing scale-up and expansion of HIV self-testing and implementation of Safe and Ethical Index Testing Guidance and Assessments. Ongoing need to ensure all index testing counselors are trained according to Safe and Ethical Index Testing Guidance to make appropriate referrals and assessments, sites are staffed appropriately, and performance reviews are done at site and district levels. Challenges with monitoring self-test kit distribution usage and results. The COVID-19 pandemic impacted the patient's trust to use HIV self-tests.
Prevention and OVC	
1. 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*)*	PrEP policies in place however limited scale up thus far. Need for demand generation among all priority populations.
2. 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	Ongoing effort and OVC-clinical collaborations are being strengthened, including between linking pregnant women with HIV to OVC.

facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case 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	Need to leverage OVC to strengthen pediatric case finding as well as index testing of biological children of women with HIV.
Policy & Systems	
1. 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.	Need to continue discussions with CSOs to ensure policies are implemented with fidelity.
2. 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.	The national CQI policy document and virtual platforms to coordinate national, regional, and district coordination were developed. Commitment of MOH/DGS demonstrated through their leadership in monthly coordination meetings with Regional Health Directors. IPs have established functional CQI teams at supported sites (routine data reviews to address to address challenges) at high impact sites and districts. There are interagency Quality Improvement Collaboratives planned in select sites to review data for decision making around improvement of low performing key indicators (i.e., retention, index testing, EID, etc.). Travel restrictions due to COVID-19 hindered progression. Challenges in selection of sites and need for support of site virtually.
3. 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 population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	PEPFAR is working with MOH leadership to develop and disseminate new HIV messaging taking into account the latest evidence on prevention, treatment, and care for the general population. Partners continue to adjust the counseling message at 100% sites and health districts.

4. Clear evidence of agency progress toward local, indigenous partner direct funding.	No significant progress between FY19-FY21. Overall, 29% of OU funding is directly to local partners; CDC: 42% local IP and USAID: 13%. Weaknesses have been identified in local/indigenous partners particularly in six areas including legal structure, financial management and internal control, procurements system, and human resources and organizational sustainability which must be addressed to ensure transition.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Significant increase in GoCI's expenditures for HIV commodities: $11.3M in CY2018 to $24.9 M in CY2019. GoCI planned investments for commodities during COP19 implementation period was $19.68M, an 11% decrease from prior year investments ($22.3M committed in COP18). Increase in GoCI health budget from FCFA 376 billion (5.2% of total budget) in CY 2019 to FCFA 446 billion (5.5% of total budget) in CY 2020. Increase in HIV budget from FCFA 18.4 billion in CY 2019 to FCFA 24.7 billion in CY 2020. GoCI anticipates a slowdown in growth and sharp fall in imports due to the COVID-19 crisis. This will affect tax revenues (48.8% of total revenues) and generate a shortfall of around 1 percentage point of GDP.
6. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	TX_ML reporting reviewed and identified needs for improvements through refresher training of IPs. Activities could not be implemented due to a one-year delay in the procurement of commodities TB LAM and CrAg, GeneXpert cartridges.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	MSHP developed client/patient flows by entry point (PMTCT, Counseling and testing, EID, etc.) at health facilities. An assessment was conducted at all COP19

	prioritized high volume sites. Small-scale implementation ("Phase I") has been initiated at 10 sites in Abidjan, includes: acquisition of fingerprint reader devices, upgrading informatics equipment at the sites, training, reproduction and distribution paper tools and SOPs, and installation of the biometric system at central and site level. Resource constraints have halted further scale up of the UID solution in COP20 to expand to remaining ART sites in PEPFAR-supported districts. Master patient index (MPI; client register) must be developed

In addition to meeting the minimum requirements outlined above, it is expected that Côte d'Ivoire will consider all the following technical directives and priorities:

Table 10. COP/ROP 2021 (FY 2022) Technical Directives

OU –Specific Directives
HIV Treatment
1. Scale up of TLD to ALL PLHIV, including women and children, must be completed before FY2022. Continue to optimize pediatric regimens and develop strategy to accelerate transition to DTG 10mg for eligible children when available.
2. Sustain and scale up targeted case finding strategies and index testing with fidelity and in accordance with Safe and Ethical Index Testing Guidance. Consider South-South TA with other PEPFAR programs that have effectively scaled-up case finding.
3. The program should implement a core basic package of services that meet men where they are with what they need. The team should integrate MenStar strategies and interventions with routine case finding and other services. Please see https://pepfar.sharepoint.com/sites/MenStar for Operational Guidance, recommended strategies, interventions, and examples.
4. To improve VLS among children, the program must intensify and expand efforts to support health care workers to ensure caregivers administer LPVr pellets correctly, support adherence counseling, and switch regimen when indicated in case of treatment failure, transition to DTG/TLD and leveraging OVC and . More intensive monitoring of mentorship and supportive supervision of providers by IPs is crucial, family centered-care, ensuring all high impact pediatric sites establish functional viremia clinic, IPs to conduct disclosure training to HCWs and age-appropriate disclosure support to caregivers and adolescents, and adaptation of Operation Triple zero model at PEPFAR-supported sites. Supply chain team to ensure availability of optimal pediatric ARV drugs.
5. Expand and rapidly scale client-centered service delivery, including expanding access to decentralized distribution models for ARVs such as community ARV distribution and other DSD models.
6. Scale DBS for VLC in rural areas and other areas or for priority populations with poor VLC related to access.

HIV Prevention
1. GBV services and support are lacking as found through the Safe and Ethical Index Testing evaluations. Program review also demonstrated unacceptably low GEND_GBV achievements within DREAMS districts for AGYW. Recommend mapping and measuring quality and availability of GBV services, including AGYW-friendly GBV services, to identify gaps. Partners should have more aggressive targets for AGYW and work to improve bidirectional linkages.
2. PrEP achievements are minimal across the priority groups and are nonexistent for AGYW in DREAMS SNUs. Rapidly scale access, demand, and utilization for AGYW and PBFW. Strong focus should go into the DREAMS PrEP program to create demand, address stigma within the community and by parents/caregivers and increase options for community-based delivery to enable successful PrEP uptake.
3. The PrEP program should work closely with MOH/PNLS to revise guidelines to expand PrEP access beyond the initial 28 pilot sites, ensuring at a minimum that all KP testing sites are included. Likewise, the program can consider adopting and expanding additional innovations, such as clients testing negative as part of EPOA/RNR and index testing campaigns. The program can likewise increase PrEP demand creation via peer outreach, collaboration with CSOs, and train additional providers to increase PrEP literacy.
4. The KP program did not meet TG targets in FY20. The program should improve targeting of TG and other KPs, including incorporating findings of recent Global Fund-supported size estimation exercise, and work with KP CSOs to provide services dedicated to and led by the TG and KP community. The program can furthermore work to align the TG service package and geographical division with that being proposed in the new Global Fund concept note. The program should also develop strategies to leverage online and virtual outreach strategies.
5. Continue to improve OVC coverage of TX_CURR<15y/o by accelerating C/ALHIV enrollment in high volume districts and/or those which have <50% coverage as of FY20 Q4. Address the underachievement of 27% for the OVC_SERV <1 year-age band, with a focus on accelerating enrollment of HIV-exposed infants (HEI) and pregnant women with HIV. Continue to prioritize HIV+ PBFW and adolescent PBFW. It is recommended that the OVC program prioritize HEI enrollment in districts with lowest EID at 2 months results and help track and support all mother-baby pairs through Final Outcome results.
6. TB/HIV: Improve quality of TB symptom screening to ensure patients with TB are not missed(expect 10% to 15% screen positive for TB symptoms). Maximize usage of 27 GeneXperts in country across the OU and ensure GeneXpert is the first line of diagnosis for PLHIV with TB symptoms: only 35% specimen sent to Xpert Lab and this should reach at least 80% before FY2022.
7. The quality of TB screening in children should be reviewed to improve TB case identification in children, especially in children newly initiated on ART and children with malnutrition. For TB diagnostics, increase the use of alternative sample types and diagnostic testing. To improve TPT initiation and completion, address clinical and supply chain barriers to pediatric TPT, including diagnostic testing or availability of pediatric formulations of TB or TPT medications/FDC.
Other Government Policy or Programming Changes Needed
1. In partnership with GF, MOH, and other partners support capacity building to strengthen data-driven decision making and CQI.
2. Pediatric and Adolescent-Centered Services: The program should continue to scale up pediatric index testing across all SNUs. Moreover, HIV screening and testing should be strengthened at malnutrition and TB entry through focused HRH investments. - Offer HIV testing to 100% of infants and children with signs or symptoms TB, malnutrition, or those hospitalized in inpatient wards - Offer HIV testing to 100% of biological children and adolescents of according to index testing criteria

3. Expand use of pediatric HIV risk screening tool (RST) to all clinical sites in key entry points where PITC is implemented. This will help further improve pediatric testing efficiency and increase identification of HIV positive children and adolescents who may otherwise be missed.
4. Laboratory Network Optimization: In collaboration with the MOH, Global Fund, and other donors, and to ensure long term and sustainable laboratory diagnostic systems to support continued VL, EID, TB and other diseases of public health importance, including COVID-19, country program should develop and implement a national laboratory Diagnostic Network Optimization (DNO) that addresses: a) complementary use of point of care (POC) and centralized instruments, b) TB/HIV diagnostic integration, c) multiplexing, d) integrated sample transport system, and e) data systems to include SMS to alert patients of the availability of their test results. Also, need to enhance further engagement in supporting joint negotiations in expanding PEPFAR VL/EID all-inclusive approach to standard pricing and SLAs terms with GF and MOH.
5. Advanced HIV Disease: Improved screening and management of advanced HIV disease is needed for both newly diagnosed children as well as children already on ART. Quantification for commodities for advanced disease, such as CD4, LF-LAM, and prophylactic medications, should include children and adolescents, and pediatric formulations of cotrimoxazole and TPT should be procured in coordination with GF and MOH.
DREAMS: 6. Some concern that very high completion of primary and secondary services within 6 months means that AGYW are not getting the full benefits of the program. The team should review completion criteria for each intervention as well as the timeline for program completion to ensure AGYW are maintained in the program for an appropriate amount of time. Based on DREAMS completion and saturation estimates, consider expansion per COP DREAMS Guidance. 7. Expand economic strengthening activities as a core component of programming. Please explore opportunities for training DREAMS recipients to support PEPFAR programmatic priorities whether as data managers, CHW, or peer advocates.
8. All CLHIV should be referred to OVC and where possible, family-centered DSD and MMD models should be implemented. Maximize the OVC platform to help improve index testing for all biological children <19 years of HIV+ mothers, through the application of complementary index testing SOPs for OVC and clinical IPs. Further align OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on actively facilitating testing for all children at risk of HIV infection. In addition, and OVC IPs should be actively tracking VL results for beneficiaries and adapting support to ensure long-term VLS.
9. Human Resources for Health (HRH) and Sustainability: PEPFAR Côte d'Ivoire needs to complete HRH Inventory tool or similar HRH inventory assessment and alignment activities prior to COP21 planning meeting. Consider using the HRH Needs and Optimization Solution to identify gaps between currently supported PEPFAR staff and the recommended staffing level and composition needed to deliver services.
10. Supply Chain: Develop a supply chain transformation plan to be completed in COP21 in coordination with Global Fund, PNLS, NPSP, and partners, with plans to address data visibility challenges (at the facility level, laboratory, subnational, national levels), distribution optimization, cold chain and warehousing challenges, oversight, procurement activities, and other key issues, across all stakeholders. Strengthen capacity at facility, district, and national level capacity for data-driven decision-making.
11. Health Information Systems: Continue to support efforts to integrate information management systems, exploring opportunities to collaborate with other donors and GoCI.

12. Continue to support efforts to accelerate implementation of Unique Patient Identification System in partnership with GoCI and other donors.
13. As part of CQI efforts, PEPFAR Côte d'Ivoire should develop protocols for conducting virtual SIMS visits (as appropriate given COVID-19 restrictions) and expand the number of facilities reviewed. SIMS data reviews should be integrated into ongoing CQI efforts.
14. PEPFAR Côte d'Ivoire should consider supporting advancement of a CHW dispensing policy. This policy might facilitate MMD expansion and could remove dispensing workload from doctors, nurses, and pharmacists. WHO ARV guidelines recommend that CHWs be authorized to dispense ART.
15. Strengthen capacity of local/indigenous partners, particularly in six areas including legal structure, financial management and internal control, procurements system, and human resources and organizational sustainability, to support transition. Sustainability workplans with performance metrics should be developed and monitored.
16. Partners will need to scale and standardize best practices across the program. Partners will also need to monitor and address deficiencies in practices and data integrity through a well-defined Data Integrity TWG in collaboration with the MOH and other stakeholders.

COP/ROP 2021 Technical Priorities

Client Centered Treatment Services

COP21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is 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 free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality, clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

Community-led Monitoring

In COP 21, 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)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be routinely screened for TB and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptoccal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

DREAMS

DREAMS funding is allocated within your COP 2021 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 2021 Guidance. In addition to ensuring that all DREAMS beneficiaries complete the core package of relevant services, priorities for COP21 DREAMS implementation include systematically identifying and engaging AGYW that are most vulnerable to HIV acquisition; particularly pregnant AGYW and those who are mothers; improving the package of economic strengthening services offered to AGYW (including exploring potential job opportunities through PEPFAR); ensuring evidence-based curricula are implemented with quality and fidelity; enhancing mentoring selection, training, compensation and supportive supervision processes; and accelerating PrEP uptake for AGYW in DREAMS SNUs.

OVC

To support the Minimum Program Requirement described above, in COP 21 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, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. 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.

Condoms and Lubricants

Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues This funding is in addition to funds allocated for condom programming and additional condom/lubricant procurement in each country from COP21 country funding as determined during the COP planning process.

Côte d'Ivoire will have access to **$750,000** from the Condom Fund in COP21/FY22, contingent upon adequate justification of need. Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP21 guidance. Among other items, this justification should include an outline of how Côte d'Ivoire will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV 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 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR Côte d'Ivoire should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)

Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact", OUs with continuing FCI investments should continue implementing best practices in accordance with FCI and COP21 Guidance. Priorities for COP21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices

There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP/ROP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. 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.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings. .

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2021. The PEPFAR investments to support the national response

must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings 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, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2021 development, finalization, and implementation. As in COP/ROP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): OU's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): OU's COP/ROP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: **community mobilization, behavior, and norms change** (all populations)

+

50 % Prevention: **Not disaggregated** (all populations)

Gender Based Violence (GBV): OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 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 FY21, and must meet 40% by FY20.

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 FY21 as appropriate through their COP/ROP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP/ROP 2021 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 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain a 3-month buffer. Any agency that anticipates ending COP/ROP 2020 implementation (end of FY 2021) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2021, decreasing the new funding amount to stay within the planning level.