

Approved



Côte d'Ivoire
Country Operational Plan
FY 2014

Note: Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.



Operating Unit Overview

OU Executive Summary

Country Context

Côte d'Ivoire (CI) will hold presidential election in 2015. President Ouattara is running for reelection and has indicated his determination to reestablish the country's leadership role in the region. After more than a decade of political and military crises, the country is slowly healing divisions, addressing poverty, and rebuilding decimated government service capacity. Political tensions remain high, however, with former President Gbagbo awaiting trial for war crimes and the task of reconciliation unfinished. Nonetheless, the country's economic rebound has been impressive and provided a strong basis for further progress. The International Monetary Fund (IMF) estimates that CI's economic growth rate reached 8.5% in 2013, following a 9.8% increase in 2012, and will remain at this level for the medium term. This strong performance needs to be translated into investments in human development. The country's literacy rate was estimated at 56.9% in 2011, with the literacy rate among females at only 47.6%.

Providing basic services, including health care and HIV/AIDS treatment, continues to challenge the Government of Côte d'Ivoire (GoCI), especially outside of Abidjan. The infant mortality rate in CI is 68 deaths per 1,000 live births, with neonatal mortality of 38 per 1,000 live births; more than half of infant mortality occurs during the first month of life. The maternal mortality rate is estimated at 614 deaths per 100,000 live births. According to Save the Children's 2013 State of the World's Mothers Report, which evaluates countries according to the well-being of mothers and children, CI is ranked 167 out of 176 on the Mothers Index.

Epidemiology of HIV and AIDS in CI

CI has the highest HIV prevalence in West Africa at 3.7% (DHS, 2011-2012). When compared with the results of the 2005 AIDS Indicators Survey (AIS), it is clear that CI is experiencing a mixed epidemic that has become feminized. Changes in key data may be attributed to the impact of demographic and economic shifts during the crisis years. The mediocre rates of retention in antiretroviral therapy (ART) services (due to lack of patient follow-up or death) may have contributed to the overall drop in HIV prevalence noted between the last two DHS surveys. Women ages 15-39 have a higher prevalence than men in each five-year age group ranges, and women of all age groups, from 15-49, have a prevalence of 4.6% compared to 2.7% in men. Female HIV prevalence declined from 6.4% in 2005 to 4.6% in 2012, yet remains higher than male HIV prevalence, which was almost unchanged at 2.7%. Prevalence dropped dramatically among women ages 30-34 (from 14.9% to 6.8%) and increased significantly among older



men (from 5.9% to 7.8% for ages 40-49, reaching 9% for ages 50-59). While the gender gap is alarming among ages 15-29 (7-8 times higher prevalence among females), there is little difference between women and men above age 35.

Abidjan, the economic capital with the highest concentration of people in the country, has the highest prevalence overall (5.1%). The largest gender disparity in prevalence is in the North Central region, with female prevalence reaching 6.7% and male prevalence at 2.2%. There are significant disparities in other regions as well. Several high-prevalence regions were affected by civil and ethnic conflict which displaced populations, disrupted social networks, and increased rates of gender-based violence (GBV), including rape. Prevalence also increased notably from 1.7% to 2.3% in the Northwest. In general, urban prevalence is higher than in rural areas.

Other available data suggest that the epidemic is driven by early-age sexual activity, multiple/concurrent sexual partnerships, transactional/inter-generational sex, poor knowledge about HIV, and low condom use (DHS, STARR study 2012, transactional study at Yamoussoukro). Key populations (KPs) include sex workers and men who have sex with men (MSM); data from a recent study of MSM in Abidjan (SHARM 2012) indicate an HIV prevalence of 18%. Other at-risk sub-populations include sero-discordant couples, uniformed services, economically vulnerable women and girls, transportation workers, prisoners, and orphans and vulnerable children (OVC). Gender inequality and GBV also heighten HIV risk across all socio-economic and cultural backgrounds.

Status of the National Response

In 2011, two former ministries were fused into a single Ministry of Health and the Fight against AIDS (MSLS). Two General Directorates are charged with planning, budgeting and coordinating the national response to HIV (DGLS) and with oversight and coordination of health services at all levels (DGS). PEPFAR engages directly at the central level, coordinating regularly with DGS, DGLS, and other key personnel. PEPFAR also works through its implementing partners (IPs) at the regional and district levels and holds regular technical and strategic meetings with Directorates and other entities involved in the national HIV response. It is uncertain how much attention HIV will garner from the GoCI in the upcoming year during election preparations, but PEPFAR is moving forward to engage with the Prime Minister on the future of the national response with a focus on increasing domestic funding and leadership. Although progress toward adopting key WHO recommendations has been slow, Option B+ and task-sharing recommendations are moving through the GoCI approval process.

PEPFAR is continuing to scale up the number of people receiving HIV services in high impact regions and improving the quality of services provided. ART enrollment follows national guidance, aligned with the



World Health Organization (WHO) 2010 guidelines: patients with a CD4 count <350 are eligible to initiate ART. According to the PEPFAR 2014 semi-annual report, 115,414 PEPFAR-supported patients received ART, representing 93% of total patients supported by PEPFAR and the Global Fund to fight AIDS, Tuberculosis and Malaria (GF) (123,692). The number of eligible adults and children provided with a minimum of one-care service, including OVC services, increased by 25%. The country is preparing to simplify enrollment of the mother-child pair on ART. Subsequently, through adoption of WHO 2013 guidelines on prevention of mother-to-child transmission (PMTCT) Option B, and the eventual transition to Option B+, all pregnant women and children under-fives who test positive will be initiated on ART.

Service coverage remains insufficient: of the 3,257 infants born to HIV-positive pregnant women in the first half of FY 2014, a total of 3,198 (98%) received an HIV test within 12 months of birth. However, this represents only 37% of the 8,621 HIV-positive pregnant women identified in the reporting period. Although national guidelines and tools are in place to ensure a continuum of response, implementation remains a challenge. The attrition rate 12 months after ART initiation was high at 33% in 2013. Following a thorough assessment of the structural and patient-level barriers, the program is continuing to improve the 12-month retention rate of patients on ART from 60% in FY 2012 to 67% in FY 2013.

U.S. Government's Role in the National Response

PEPFAR is the largest partner in the national HIV response, currently financing the majority of ARV and laboratory equipment procurements in country. The GoCI turns to PEPFAR for direct assistance when HIV commodity shortages occur. Due to PEPFAR interventions, stock-outs at ART sites of at least one of eight tracer commodities were reduced from between 67-91% in FY 2013 to 13% six months into project implementation. PEPFAR's expertise contributes to all areas of the national HIV response, through technical assistance (TA) and a focus on the integration of HIV/AIDS services into national health and social structures. This strategy of TA and reinforcement of national structures is implemented largely through PEPFAR's 40 IPs and over 200 sub-partners, and ensures that all activities include a systems-strengthening component.

Currently PEPFAR funds 509 ART sites and 706 PMTCT sites, as well as the national blood safety and infectious waste management programs. Supported sites and activities have been carefully evaluated and refined for COP 2014, as detailed below, to focus resources more efficiently and eliminate no-yield and low-yield sites. CDC/Retro-CI, with PEPFAR support, serves as a regional reference laboratory for quality control, training, capacity building and accreditation. This combination of ART and PMTCT service delivery, health-systems strengthening for laboratory and supply chain, and coordination with local organizations for integrated prevention and community care programs allows PEPFAR to improve the continuum of response for HIV/AIDS prevention, care, and treatment services.



Other Donor Contributions and Coordination

As a major bilateral donor, the PEPFAR team collaborates with the other bilateral and multilateral health donors in developing common approaches and on advocacy with the GoCI on policy issues such as task sharing, strategic planning and mobilization of resources for health. PEPFAR liaises with other stakeholders through the forum for technical and financial partners (PTF) in health, and through GF's Country Coordinating Mechanism (CCM), UNAIDS, and independent engagement with bilateral and multilateral partners. GF Principal Recipients (PRs) are implementing Phase 2 of their Round 9 HIV grant that provides clinical services in the region of Sud-Comoë, and community services in 25 districts across the country that are geographically and programmatically coordinated to avoid overlap with PEPFAR implementation. This year (COP 2013), PEPFAR has taken over clinical services for approximately 15,000 patients formerly covered by the GF PRs. In exchange, the GF has agreed to procure over \$15 million in antiretroviral drugs, which reduces the anticipated commodity burden on PEPFAR and enables the country program to support decentralized service delivery in a more targeted manner.

Collaborations with and contributions from other donors include:

The GF (in addition to programming mentioned above): PEPFAR continues to provide coordination, TA and support for the concept paper development for the new funding model and is recruiting a GF Liaison (GFL).

UNAIDS: Development of an 'Investment Case for CI' is under discussion with GF and PEPFAR. PEPFAR would contribute TA to this process and would leverage results to lobby for complementary funding from other sources.

ESTHER: Provides support for viral load monitoring and for HIV and TB services for prison populations.

European Union: Provides overall support in health contributing to the implementation of national surveys, such as the 2011-2012 DHS.

French Development Agency: Provides support for pre-service training at the National School of Nurses and Midwives (INFAS) and reform of the national public health pharmacy (PSP).

World Bank: Is considering support for universal health coverage (a GoCI initiative); results-based financing with the GoCI matching funds for a portion of the country; development of the health management information system; and rehabilitation of emergency infrastructure.

UNICEF: Support for the Violence against Children Survey (VACS), planned to begin in COP 2014.

Building on an assessment of the role of the private sector in provision of HIV services in CI, the team is exploring ways to partner with private sector health clinics and examining how this model can be expanded in national programming.

PEPFAR Focus in FY 2014



Following consultations in DC, PEPFAR has refined its strategy to control the epidemic in country, focusing on saving lives and preventing new infections through a multi-pronged approach.

1. Increasing efficiencies throughout the program

The program has identified no-yield and low-yield testing and PMTCT sites across the country that will be phased out to ensure resources are directed toward high-yield and high-impact sites. Low-volume ART sites will also be phased out in conjunction with a transition plan to ensure current patient needs are covered by a larger local service delivery point. No-yield and low-yield sites account for 39% of HTC sites and 65% of PMTCT sites; 23% of ART sites are considered low-volume.

The program has also reviewed expenditure analysis data and historic program data to refine cost estimates across program areas, in particular those associated with service delivery (testing, laboratory support, clinical care, and treatment). These revisions represent a substantial cost savings and are reflected in the budget and target modifications.

2. Geographic focus

To increase the impact of limited funds and control the epidemic, the PEPFAR program will support saturation of combination prevention services in the 14 health regions that represent 93% of the national HIV need. One other health region is covered by GF. In the remaining five health regions, PEPFAR will continue to support MSLS-managed sites with a limited maintenance package.

80/40 Goal: In the 14 focus regions, the PEPFAR program will continue to bolster efforts to increase retention and coverage of ART for adults and children. The goal is to reach 80% coverage of adults in need of ART and 40% coverage of children in need of ART by the end of COP 2015 (based on 2010 WHO guidelines, the current official national policy).

3. Combination Prevention

PEPFAR/CI will implement combination prevention (ART for Prevention, PMTCT, Condoms, and HTC) in the areas of highest need based on HIV prevalence and population density, reducing incidence in these focused areas. IPs will strengthen demand for HTC. Prevention services for priority populations will include condoms, active referrals and accompaniment to HTC and PMTCT (including a focus on couples), and sexual prevention. The nationally validated minimum package of services (diagnosis and treatment of sexually transmitted infections (STI) and opportunistic infections (OIs), HTC, condoms, sexual prevention, ART and care, family planning (FP) services) for MSM and commercial sex workers (CSW) will continue to be supported and implemented.

4. High-yield testing strategy

To ensure efficient use of resources and identify as many HIV-infected individuals as possible and include them in the clinical cascade, PEPFAR has refined its testing strategy. Testing in the general population has been phased out to refocus on key and priority populations, especially pregnant women, with other high prevalence populations contributing to the total testing burden. These other populations include



CSW, MSM, TB patients, OVC, ill adults and children, and their families.

With COP 2014 funds, PEPFAR will consolidate results gained in Abidjan while scaling up quality and quantity of HIV services in the other focus health regions. Clinical, supply-chain, and other health-system-strengthening (HSS) partners will address priorities by reinforcing the decentralized or regional aspects of their programs to build quality throughout the health care pyramid.

USG Top Priorities in FY 2014

1. Treatment and PMTCT: Continue increasing enrollment and retention of patients in ART and PMTCT services through intensified site-level support, including roll-out of Option B+.
2. Pediatric enrollment in care and treatment, including early infant diagnostics (EID): Implement community and health care facility strategies to improve EID, universal treatment of all children under five, and early treatment initiation in infants to increase coverage.
3. Decentralized supply-chain strengthening: As part of a comprehensive strategy including quantification of national commodity needs, efficiency, and quality of HIV related commodities, extend PEPFAR decentralized supply chain system support down the chain to the final beneficiary through district and regional coordination.
4. Prevention: See #3 in "PEPFAR Focus in FY 2014" above.
5. Support for policy reform including task sharing and adoption of Option B+.

Changes and Developments

To maximize use of resources and gain epidemic control, PEPFAR strategically assessed all funded activities to determine which were core, near core, near core-transitional, and non-core. These programmatic distinctions (as discussed in DC during the COP 2014 Reverse TDY) allowed the team to prioritize activities with the greatest impact on HIV prevention, care, and treatment to control the epidemic faster and more efficiently.

PEPFAR is strengthening programmatic coordination and capacity building efforts through the creation of regional offices in targeted intervention areas; in certain circumstances, IPs have been able to negotiate for co-location with Regional Health Directorate offices, further enhancing the partnership. For example, SCMS has five regional sub-offices and has convinced the GoCI to hire 20 regional pharmacists to bolster availability of HIV commodities.

Funding-Level Letter Priorities and COP 2014

These priorities, discussed in detail in the "Program Overview" section below, are in alignment with COP



2014 guidance and subsequent feedback received from the S/GAC-led 2014 interagency COP review, revised COP 2014 guidance, and the reverse TDY COP determinations made in DC. Priorities are also continuations of steps taken in FY 2013-14 to address recommendations made by the OGAC Care and Treatment TWG based on its 2013 and 2014 TDYs, as well as from multiple Prevention TDYs, a TB assessment, an economic strengthening TDY, and availability of new and emerging data from the DHS and the SABERS study of HIV prevalence and behavior among the military population.

Interagency Budget Approach

PEPFAR conducted interagency strategic planning sessions, including reviews of strategy, comparative advantage and long term vision, past performances and the need to design new initiatives as programs plan for closeout. During COP development, the team built a consensus for the distribution of the overall budget into budget codes, using innovative modeling tools and detailed costing data to ensure a fully funded implementation plan to achieve 80/40 treatment coverage and meet the care and treatment earmark as well as other programmatic needs in the clinical cascade and beyond. The team carefully considered pipeline calculations and, as relevant, some expenditure analysis data. Several meetings were organized to propose budget division among mechanisms across budget codes in line with priorities and targets.

The COP 2014 budget aligns with the revised split across the \$140 million planning level of \$116,280,308 in new funding and \$23.9 million in pipeline use, meeting the Care and Treatment Earmark at 54% and exceeding the OVC earmark at 18% of programmatic funds. Negotiated increases in GF contributions on commodities funding and careful planning allow supply chain procurements to continue while also supporting decentralized system strengthening.

Progress and Future

Country Strategy

The team has articulated a bold vision for epidemic control, reaching 40% treatment coverage for pediatrics and 80% coverage for adults by the end of COP 2015, while maintaining a strong focus on quality and retention. The PEPFAR team will continue to support reorganization of the drug distribution system, improving quality of care at public health facilities through task sharing and other measures, and supporting the GoCI in holding health workers accountable. The 14 focus health regions encompass 93% of the HIV need in country and the revised program strategy aims to reach saturation at fewer but higher impact sites to make progress toward controlling the epidemic. This strategic approach aligns with the National Strategic Plan on HIV/AIDS (NSP-HIV/AIDS) 2012-2015 and supports the GoCI, civil society, and the private sector to reduce new infections and save lives through implementation of the high-yield



testing strategy, saturation of services through combination prevention and retention efforts, and alignment of community and clinical programs in the geographic focus area. There is some concern that competing and emerging health priorities and the pending presidential election could preclude a greater political and financial engagement of GoCI at a critical juncture in the realignment of the PEPFAR strategy.

Country Ownership

All PEPFAR investments are designed to strengthen the capacity of the GoCI, civil society, and private sector to plan, implement, and monitor the continuum of responses that are essential for quality HIV and AIDS services, improved health outcomes, and eventual control of the epidemic. In all planning, the NSP-HIV/AIDS guides the selection of priorities. During the past year of COP development, PEPFAR has been engaged directly with the GoCI, working with key ministries, technical leaders, and TWGs to address policy questions and priorities. The PEPFAR team has also held meetings with fellow donors and representatives of civil society to ensure collaboration and joint planning, particularly with and for the end beneficiaries. The impact of these engagement efforts has been a growing understanding of PEPFAR by the other stakeholders and more joint decision-making about major strategic issues.

PEPFAR will assist the GoCI with the development of a new five-year plan to replace the current NSP-HIV/AIDS, and will participate in building a new HIV surveillance plan, to better understand the country's HIV epidemic. To achieve these goals, PEPFAR will actively seek the participation of civil society and local organizations, thus ensuring that participation extends beyond the centralized level, while at the same time making sure that real programmatic needs are addressed in the new five-year plan.

Finally, PEPFAR will participate in developing the country's GF concept notes, and work with the CCM to ensure their activities are complementary to PEPFAR funded activities. The addition of a health economist to the PEPFAR country technical team and increased attention to cost efficiencies and expenditure rates, along with engagement in the long-awaited UNAIDS-initiated Investment Case development with other donors should increase this aspect of advocacy for broader resource mobilizations from the GoCI and private sector.

2015 and Beyond

By the end of COP 2014 implementation, more than half of the cooperative agreements/grants to PEPFAR partners will end. PEPFAR will be evaluating the current programs to build on successes and design subsequent investments to further align with the PEPFAR Blueprint and AIDS-Free Generation principles. New program procurement design will build on ten years of PEPFAR experience in CI and successful strategies and tactics from other countries' programs to transform PEPFAR into the most



highly performing program possible. The program will be approaching the “80/40” treatment coverage goal by the end of COP 2015 and will be reassessing progress to establish a new ambitious goal for the next COP cycle.

Although drug availability at the central level has improved substantially over the past four years, site level shortages remain problematic. SCMS will prioritize the decentralized supply chain, thereby reinforcing drug availability at all levels. Historically, care and treatment IPs tested and provided results to more than 99% of pregnant women presenting at PEPFAR sites, while testing only 46% of infants born to HIV-positive women. New programs for both health facility and community-based IPs will be designed with the longstanding need to bridge this gap in mind. The 12-month ART retention rate, which was rarely monitored by IPs and public health facilities, will be considered a main performance indicator for any care and treatment IP as recommended by the MERS strategy. Finally, PEPFAR is strongly encouraging the GoCI to follow the international standard practice of adopting and implementing task sharing policies and defining mutual commitments for the coming period, including broader consideration of data emerging from the Ivoirian program.

Program Overview

Care

Relevant Data

UNAIDS estimates from 2012 show that about 450,000 Ivoirians are living with HIV. There are an estimated 440,000 HIV-related OVC, including 63,000 children living with HIV. About 24% of TB patients tested for HIV are TB/HIV co-infected (National TB Program, 2010), and TB is the leading cause of AIDS-related deaths. The number of eligible adults and children provided with a minimum of one care service increased from 265,872 in FY 2012 to 353,296 in FY 2013, which includes 141,954 OVC, 40% of the total estimated children in need.

Priority Interventions

A key priority for the next two years is to improve linkages between facility and community-based services and between pediatric care, treatment, and other services including Positive Health, Dignity and Prevention (PHDP), community home-based care and treatment services. All PEPFAR-supported ART, PMTCT, and TB/HIV IPs hire community counselors (CCs) at their sites to provide a comprehensive package of HIV prevention interventions and effective support for all clients. In FY 2014, PHDP services will be extended to reach 90% of PLHIV receiving clinical care at PEPFAR-supported sites. PEPFAR will continue supporting clinical IPs to integrate HIV testing, care and treatment at 12 new TB centers to reach 154 sites. PEPFAR will support the national TB program (PNLT) in comprehensive TB/HIV



co-management and decentralized multi-drug resistant TB treatment in 16 TB centers, and will improve TB diagnostics among PLHIV by providing five GeneXpert machines to TB clinics.

PEPFAR IPs will support the PNLT to implement TB infection control both in TB centers and HIV clinics by scaling up routine opt-out testing and counseling at all TB clinics, providing HIV testing for all new patients in TB clinics. In addition, IPs will work with PNLT to incorporate and implement the clinical TB symptom screening tool for HIV-infected adults and children into the national HIV patient encounter form. Pre-ARV patients will be provided with improved cotrimoxazole prophylaxis, and diagnosis and treatment of OIs. TB infection control will be transitioned to the national TB control program for further scale-up with financial support from GF or other government or donor funds.

Improving the nutritional status of PLHIV is a proven intervention to increase retention in care and treatment. PEPFAR, the World Food Program and the National Nutrition Program will provide food and nutritional education and support to eligible adults and children through PMTCT, treatment, and community-based programs. The nutrition services package includes: 1) nutritional assessment and counseling for PLHIV; 2) therapeutic or supplementary food provision for malnourished patients receiving ART; and 3) dietary and household food security assessments and support as the continuum of care for PLHIV and their families. Finally, the feminization of the epidemic in CI requires greater gender awareness in all aspects of care and prevention, including disclosure of HIV status. PEPFAR strategies to address gender will include reaching more girls in care and treatment services, positive-prevention interventions for young girls infected with HIV, and stigma-reduction campaigns with an expanded role for peer support and peer advocacy. Integration of FP services is another priority for improvement in the year ahead. GBV programming and access to post-exposure prophylaxis are critical needs to address drivers of the epidemic, and PEPFAR will continue to address these needs directly and through advocacy with GoCI.

Significant Changes

The program has just undertaken an extensive programmatic and geographic prioritization process to map out PEPFAR's 14-region increased coverage implementation zone and the intended package of successful interventions for these regions as well as the five maintenance regions. As all OVC IPs reach the end of their awards in 2014 and 2015, the team will evaluate current programs and use data to inform consolidation of previously geographically dispersed awards into high-impact intervention zones, reaching more OVC and PLHIV with similar investment levels. Based on evidence from the DHS, OVC beneficiaries will include children of widows, widowers, and divorcees, in addition to those linked through known HIV status of parents or caregivers. PEPFAR will continue to prioritize family-centered, age appropriate models of care and support, tailored to individual children's needs. IPs will emphasize community mobilization for testing, using OVC as an entry point for family-based approaches to clinical



services, including the full package of PHDP for PLHIV households. A key programmatic emphasis will be ensuring the link into health care services for OVC.

Treatment

Relevant Data

UNAIDS 2012 estimates show that 190,000 adults and 35,000 children are in need of ART based on a CD4 count <350. The NSP-HIV/AIDS has set a goal of providing ART to at least 80% of adults and 95% of children in need of ART by the end of 2015. Based on these overarching goals, the National HIV Care and Treatment Program (PNPEC) has set annual national targets of 138,500 and 152,000 patients receiving ART by the end of 2014 and 2015, respectively. At the end of FY 2013, the total number of ART patients supported by PEPFAR and GF was 112,721. All health districts have at least one site offering ART, and nationally 529 ART sites (482 PEPFAR-supported) were offering ART, resulting in coverage rate of 55% and 16% for adults and children, respectively. PEPFAR will phase out support of ART sites with 25 or fewer current ART patients (23% of all PEPFAR supported ART sites), ensuring patients are referred to a larger local hub and increasing their access to high quality services.

Priority Interventions

PEPFAR will continue to deploy a site-focused strategy to increase ART retention at 12 months. As part of this strategy, PEPFAR clinical IPs will increase the regularity and intensity of site visits, including support to high-impact sites within the 14 focus regions, some of which were previously supported by GF, to reach the 80/40 treatment goal. Clinical and quality improvement IPs will continue to provide TA to MSLS and treatment IPs in development and implementation of quality standards, approaches and indicators based on ART program findings and recommendations from relevant studies. Treatment failure will be assessed clinically, immunologically, and with viral load (VL) testing. PEPFAR will continue to provide VL testing for adult patients with suspicion of clinical and/or immunological failure, and two VL tests annually for children on ART for early detection of treatment failure. In addition, USG will prioritize VL tests as a monitoring tool to assess the success of ART for all HIV-positive pregnant women receiving ARVs to reduce MTCT, and key populations such as MSM and CSW in achieving viral suppression to prevent HIV transmission. PEPFAR will support MSLS to conduct ARV drug resistance surveillance.

One of the highest priorities of PEPFAR for FY 2014 is to scale up pediatric enrollment in care and treatment, including EID. To do this, IPs will continue a gradual expansion of services targeting HIV-infected children and adolescents at high-impact sites in focus regions and extend access to lower levels of the health pyramid. A combination of community and health facility strategies will be used to improve EID, universal treatment of all children under five, and early treatment initiation in infants. The September 2015 target is to provide ART to 143,591 people including 9,844 children, having enrolled



38,163 new people on ART including 4,510 children. Early identification of HIV exposure and infection status among HIV-exposed children and children attending outpatient and in-patient facilities for any health issue will be increased through improved tracking and provider-initiated testing and counseling. Finally, all IPs will continue to foster strong linkages between facilities and community-based services involved in pediatric care and treatment to ensure testing is provided at all pediatric entry points and that appropriate HIV prevention, care and treatment services are provided.

As mentioned above, the GF allocated approximately \$15 million for ARV purchases; PEPFAR proposes to contribute an additional \$18.6 million, which together will provide enough ARVs to cover the FY 2015 treatment target. With support from IPs, PEPFAR will continue to improve efficiency in ARV drug purchases by providing support to MSLS in accelerating registration of generic ARV drugs, and by procuring more approved generic and fixed-dose combination (FDC) formulas for children. More than 95% of ARV drugs to be procured will be FDCs. In FY 2014, the USG will continue to build the capacity of PSP/MSLS and decentralized-level district and site pharmacies for a functioning logistics management information system, including improved timeliness and completeness of reporting. PEPFAR and IPs will emphasize data analysis and use for decision making at central and decentralized levels using data collected from SIGARV and SIGLab, two local data collection tools. PEPFAR and IPs will also continue to assist the PSP in scaling up SIGLab.

Significant Changes

MSLS is considering adopting 2013 WHO recommendations to treat all HIV-infected children under five, regardless of CD4 count, and moving from Option B to B+, which involves lifelong ART for all HIV-positive pregnant women, to be rolled out in 2015. MSLS has shown some interest in adopting the recommendation to initiate ART for all patients with a CD4 count less than 500. However, given the current gap in coverage for existing eligible adults at a CD4 count of less than 350, cost, and capacity limitations, this is as yet still in preliminary discussions. The 80/40 treatment vision projects coverage at the 2010 WHO recommendations. PEPFAR is engaging at a number of levels to advise and advocate for adoption of these policies.

Prevention

Relevant Data

Data from the DHS described CI as a mixed epidemic country marked by significant geographic and population heterogeneity. In-depth knowledge of HIV is lacking; only 25% of males and 14% of females aged 15-49 years have a complete knowledge of HIV. Only about 8% of females and 16% of males hold non-stigmatizing attitudes towards people living with the virus. The current DHS reported sexual debut by age 15 as 20% among females and 14% among males; by age 18 it increases to 69% of females and



48% of males. Among women who had sex with two or more partners in the past 12 months, only 30% reported the use of a condom during their last sexual intercourse. Among men, the figure is only 33%. The highest levels of condom use were observed among those who were unmarried (59%). About 32% of married men reported having two or more partners in the last year compared to 24.5% of single men. HTC services are not being used by the majority of the population: 62% of women and 75% of men have never tested for HIV. Studies among female CSW during their first clinical visit have consistently reported a 20% prevalence rate. A recent study reported an 18% prevalence level among MSM in Abidjan, nearly five times higher than the general population. There are a number of current and planned studies that will explore biological and behavioral aspects of populations at risk (e.g. MSM, CSW, vulnerable women, military). Results will enable the GoCI and PEPFAR to reorient the portfolio to ensure greater impact.

Priority Interventions

The prevention program will focus on achieving saturation of combination prevention in areas of highest need based on HIV prevalence and population density. PEPFAR IPs conducted a mapping exercise in June 2014, which started the conversation on how IPs could better meet the national HIV needs; however, additional geographical shifts will be necessary based on the new PEPFAR vision defined in August 2014. Prevention IPs will be geographically focused where clinical services are located to guarantee better linkages to HTC and PMTCT. Pairing of prevention with treatment and care IPs will also strengthen linkages between HTC and PMTCT to care and ART services.

IPs will deliver prevention services for priority populations including condoms, active referrals and accompaniment to HTC and PMTCT (including a focus on couples), and sexual prevention. The nationally validated minimum package of services (STI, HTC, Condoms, Sexual Prevention, ART and Care, OI, FP) for MSM and CSW will continue to be supported and implemented. A condom strategy is being developed which will address methods to better target priority groups, distribute condoms, create demand, and increase uptake. The Blood Safety program will focus on laboratory screening to prevent infections transmitted through blood transfusions. The Injection Safety program will focus on medical waste management at high volume treatment sites.

Significant Changes

Significant changes in the prevention portfolio will include substantial geographical shifts in where prevention IPs are implementing. Future programs will focus on areas of highest HIV prevalence and population density as well as clustering around clinical services to strengthen linkages and retention and adherence to ART. Priority populations will include key populations (MSM, CSW) and the highest risk groups in the general population (e.g. women 15-24 years, adult men 35-49 years, truckers, seasonal workers). Populations outside of these high-risk groups will no longer be served in an effort to achieve impact and control the epidemic in CI. Certain activities in the Blood Safety and Injection Safety programs



will be transitioned to the GoCI or other donors over a 4 to 18 month timeline.

Governance and Systems

Relevant Data

As a result of a significant funding disparity and the disparity of the quality of services at the two largest levels of the Ivorian health system (community based health facilities and general/regional hospitals), the majority of the population who seek services in the public sector does so at the teaching hospitals, thereby overburdening this level, and interrupting the flow of services from the two larger levels. According to analysis of data from the National Health Information System, the public health care system is underutilized, with only 18% of the population accessing at least one service per year. CI has a dynamic private health sector that consists of nearly 1,200 clinics and private practices and more than 650 pharmacies.

Priority Interventions

Priority interventions are organized according to the WHO Health Systems framework, which consists of six “building blocks:” health workforce, financing, governance, service delivery, medicines, and information. In the health workforce, PEPFAR works with the GoCI and other stakeholders to formalize the policy of task-sharing among health workers. Task-sharing, which empowers nurses and midwives to fulfill service delivery tasks previously reserved for doctors (such as prescription of ARV drugs) or lab technicians (such as CD4 testing), is particularly important to ensure scale-up of ART services.

PEPFAR has selected two regions in which IPs will improve health service delivery and health outcomes through HSS and creating leaders motivated with strong skills in governance, leadership, and management at the Regional Health Directorates and the Departmental Health Directorates. The project will improve the health regions’ overall management capacity and functioning with respect to planning, oversight, coordination, and integration of HIV and other health services, both clinical and community. The package spans most of the building blocks of the health system, from human resources to commodities to health information, with the aim of improving key health indicators, including coverage and retention in ART services.

PEPFAR will continue to support national institutions such as the PNPEC, the National Public Health Reference Laboratory, INFAS, Institut Pasteur-CI and the Directorate for Medical Equipment Infrastructure. PEPFAR will support a platform for training of lab professionals to evaluate new point-of-care equipment for VL and CD4 testing and for routine rapid testing for HIV. In support of PEPFAR FY 2014 priorities, laboratory IPs will implement decentralization of EID and VL at three regions with highest HIV prevalence and will develop a comprehensive external quality assessment program for



HIV rapid testing, CD4 count, biochemistry, and hematology. Quality assurance efforts and a process of lab accreditation are also being supported.

A greater emphasis is being put on improving the supply chain workforce, especially at the periphery of the health care system. In 2013 SCMS opened five sub-offices staffed with a team of logisticians. Their primary role is capacity building of health workers and commodities managers at the peripheral level. The recent deployment of 20 regional pharmacists is another positive step, after the PSP reform, towards consolidating the transfer of roles and supply chain responsibilities to partner government counterparts.

Significant Changes

The HSS branch in PEPFAR was established in 2012 and became fully operational in 2013. The governance and system portfolio will be fully deployed during this implementation period, with more support for health economics and engagements with the private sector.

GHI, Program Integration, Central Initiative, and Other Considerations

PEPFAR has not completed a Global Health Initiative (GHI) strategy in CI, but several GHI principles are addressed in COP 2014.

Focus on Women, Girls, and Gender Equality: Given above-mentioned DHS data regarding GBV, it is clear that gender disparities and experience of violence among girls and women must be more directly addressed. Adolescent girls and young women are of particular focus in the programmatic strategy. Further emphasis is needed on training clinicians to recognize GBV and provide care and treatment and on communications to circulate essential information regarding timeliness of rape survivors seeking medical care. More focus is needed on legal and judicial solutions and in ensuring access to PEP. Additional data will come through the VACS, planned in collaboration with UNICEF. Prevention and clinical services IPs have been asked to emphasize GBV social and health sector referral systems linkages for case identification, HIV testing, care and treatment, and FP integration.

Encourage country ownership and invest in country-led plans: PEPFAR works with GoCI on many levels, including coordination, and technical meetings and workshops. The PEPFAR program fits within the framework of the NSP-HIV/AIDS and other related strategies, such as human resources for health. PEPFAR anticipates engagement during COP 2014 for the development of the next phase (2016-2020) of NSP.

Strengthen and leverage other key multilateral organizations, global health partnerships, and private sector engagement: See page 4 of the Executive Summary for a description of PEPFAR activities addressing this principle.



Build sustainability through health systems strengthening and public-private partnerships: A number of HSS efforts are under way and planned for COP 2014, including a focus on decentralization. The program also allows for enhanced supply chain management and district level supportive supervision in two regions of the country. The team also plans for greater engagement with the private health care sector.

PEPFAR's engagement strategy with the GF Secretariat: The team's strategy includes regular coordination and exchange through ongoing teleconference and in-person meetings with the Fund Portfolio Manager (FPM), based in Geneva; representing the Financial and Technical Partners (PTF, health donor group) on the Bureau of CCM; and leadership participation in the HIV Committee to the CCM. PEPFAR also funds two Management Sciences for Health projects (Leadership Management and Governance and Grants Management Solutions) to build capacity of the GF Secretariat, PRs and Sub-Recipients. The FPM and PEPFAR will continue to engage with UNAIDS through regular meetings to advance policy and advocacy agendas. Expected outcomes of these interactions include better anticipation of and response to TA and funding needs; better program coordination and complementarity of PEPFAR IPs and the GF PRs to reduce duplication and increase efficiencies; and establishing a common policy agenda and collectively advocating w/ the GoCI. The recruitment of a GFL will strengthen these efforts.