

Approved



Cameroon

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

I. Country Context

Cameroon is a lower-middle-income country with a population of 22 million representing more than 275 ethnic groups. Politically stable, Cameroon achieved economic growth of 4.9% in 2013. The country's epidemiological profile is dominated by communicable diseases such as malaria and HIV and an increasing prevalence of non-communicable diseases such as diabetes and cardiovascular disease. Maternal mortality is 782 per 100,000 live births; under-5 mortality is 127 per 1,000 live births. Funding for health is about 5% of the Government of Cameroon (GRC) 2013 budget. In 2010, private spending accounted for 70.4% of health expenditures; 13.2% came from external resources and 16.4% from GRC funds (World Bank 2012). The provision of basic services, including HIV/AIDS services, remains a challenge for the government, especially from the regional to the district levels. HIV/AIDS is low on a long list of priorities for the GRC, whose 2014 budget focuses heavily on non-health items.

Epidemiology of the HIV epidemic

Despite a decrease in HIV prevalence from 5.6% in 2004 to 4.3% (DHS 2011), Cameroon is one of the highest-prevalence countries in Central Africa. Prevalence is high among men who have sex with men (MSM) (37%), female sex workers (FSW) (36%), and pregnant women (7.6%). Other at-risk sub-populations include sero-discordant couples, the uniformed services, long-distance truck drivers (LDTD), economically vulnerable women and girls, migrants, prisoners, and orphans and vulnerable children (OVC). There are marked disparities in HIV rates between women (5.6%) and men (2.9%), with prevalence five times higher among women ages 15-24 than among their male counterparts. Prevalence peaks at 10% among women ages 35-39 and at 6.3% among men ages 45-48. Geographically, prevalence ranges from 1.2% in the far North to 7.2% in the South. Prevalence is higher among urban, employed, and wealthier men and women (DHS 2011). An estimated 5.9% of couples are sero-discordant. About 46% of women and 58% of men have never received an HIV test result. About 542,000 adults (>15 years) and 58,600 children (0-14) are living with HIV, including 275,600 who need antiretroviral therapy (ART) (UNAIDS 2013). There are about 43,000 new infections per year and 333,000 orphans (ages 0-17) due to AIDS. About 31% (7,908/25,360) of TB patients tested for HIV are HIV/TB co-infected, according to the National AIDS Control (NACC) 2012 report, and TB is the leading cause of AIDS-related deaths.

The NACC estimates that HIV infections are principally driven by sexual intercourse (88%), including early sexual debut, multiple concurrent sexual partnerships, and transactional and inter-generational sex; mother-to-child transmission (14%); and transfusion of unsafe blood. Women's risk is heightened by low socio-economic status, gender inequality, and harmful socio-cultural practices. Stigma and discrimination



have marginalized people living with HIV/AIDS (PLWHA) and key populations (KPs), especially MSM.

Status of the national response

Cameroon's national response to the HIV/AIDS epidemic is led by the inter-ministerial NACC, which coordinates implementation of the recently revised National HIV/AIDS Strategic Plan (NSP) 2014-2017. While this plan targets most major HIV/AIDS program areas, GRC funding has focused mostly on procurement of ARVs, with commitments amounting to more than 60% of national needs. PEPFAR funded 6% of the national HIV/AIDS response in 2012, with 45% of funding coming from the GRC; 44% from the Global Fund for AIDS, Tuberculosis and Malaria (GFATM); and modest contributions from the Clinton Health Access Initiative (CHAI), World Bank, European Union, French Cooperation, UNICEF, and the corporate sector.

HIV prevention and testing services have been integrated into all national, regional, and district hospitals in all 10 regions. The NACC estimates the number of ART patients at 130,778 as of December 2013, representing 47.4% coverage. Despite significant progress, the national response is built on a public health system that is under-resourced [REDACTED]. Uptake of PMTCT and other gateway services remains insufficient, particularly in rural areas, and only 42% of pregnant women attend antenatal care (ANC) services. The lost-to-follow-up (LTFU) rate among ART patients after one year is about 38% (GARP 2012).

The government's capacity to mobilize funds for HIV/AIDS remains a major challenge, and with new GFATM funding still in the planning stages and CHAI ending its ARV procurements, uncertain funding horizons and weaknesses in strategic information and supply-chain management continue to haunt program implementation with the specter of ARV stock-outs.

USG role in the national response

PEPFAR funding and technical assistance (TA) are designed to strengthen Cameroon's health structures and systems at national and local levels, to integrate HIV services, and to build country ownership. PEPFAR support prioritizes four of Cameroon's 10 regions (Northwest, Southwest, Littoral, and Center) that contain 74% of adults and 80% of children in need of ART. Programmatically, PEPFAR has played an effective leadership role in PMTCT, prevention for KPs, and systems strengthening for laboratory and blood safety.

In the past, the USG has provided limited support for HIV/AIDS care and (except for emergency orders of ARVs) no direct support for treatment services, which are provided by public, private, and faith-based health facilities with support from the GRC and GFATM.

II. PEPFAR focus in FY 2014

Drawing on a) recommendations from a PEPFAR portfolio review and HQ TA and diplomatic visits, b) national priorities and programmatic gaps, and c) OGAC priorities in the funding letter, the PEPFAR



Cameroon team will focus COP 2014 efforts on improving the quality of its prevention and systems strengthening programs; and launching activities in two new program areas: ARV procurement and support for HIV/AIDS treatment and care. Concentrating on its four high-prevalence regions, the USG's top priorities are:

1. Support the GRC to implement and scale up PMTCT and Option B+ with a high-quality approach that can serve as a model for rest of the country.
2. Building from this PMTCT platform, begin support for ART and care through ARV procurement and TA.
3. Improve the quality and extend the reach of prevention and care programming for KPs (FSW and MSM) and other vulnerable populations (PLWHA, military personnel and their communities, OVC).
4. Strengthen linkages among facility-based prevention, care, and treatment services and between facility- and community-based services (including care and support for OVC) to ensure a functioning continuum of response (CoR).
5. Strengthen the supply chain at the national, regional, divisional, and district levels to build capacity and ensure reliable supplies, timely deliveries, and more efficient stock management.
6. Strengthen the laboratory system through establishment of a National Public Health Laboratory (NPHL), lab accreditation, and quality assurance (QA).
7. Continue to support GRC initiatives to ensure a safe and reliable blood-supply system.
8. Support the GRC to establish a functioning health management information system (HMIS).

These priorities align closely with the priorities outlined in OGAC's funding letter, which include support for PMTCT scale-up and care/treatment (addressed in priorities 1 and 2 above); improved planning and coordination to ensure that scale-up plans align with available resources and that ARV supplies are adequate to keep patients on ART (priorities 5 and 8); strengthened supply chain capacities (priorities 5 and 8); increased focus on KPs (Priority 3); targeting to areas with high concentrations of people in need of ART (priorities 1, 2, and 4); and improved community-facility linkages (Priority 4).

The USG team's priorities, discussed in detail in the "Program Overview" section below, justify budget-code shifts in COP 2014, with substantial increases in HTXD (\$10 million earmarked for ARVs), HTXS, PDTX, HBHC, PDCS, and HVTB, together moving from 4.7% of the total budget in COP 2013 to 40.3% in COP 2014.

COP 2014 planning reflects interagency consensus involving all in-country agencies (CDC, USAID, DOD, Peace Corps, and DOS) as well as consultation with the Ministry of Health (MoH), other donors, and civil society organizations (CSOs). An interagency portfolio review in December 2013 focused on IP performance, pipelines, strategic alignment, and transition plans and allowed the definition of impact priorities and barriers in each program area. TA visits for PMTCT and ART added to HQ support received in 2013. Top-down budgeting assigned allocations to reflect identified priorities. Pipeline was analyzed for each IP and agency and, where appropriate, applied to COP 2014 new funding requests. Results of the program's first Expenditure Analysis were considered in setting budget amounts and targets, although



data quality will need to be improved next year to make this information more useful. Overall, COP 2014 implementation will be supported by [REDACTED] \$36,250,000 in new funding. One-time central funding of up to \$9,000,000 will be programmed outside the COP to support Option B+ implementation and PMTCT/ART integration.

III. Progress and Future

Although PEPFAR Cameroon has no Partnership Framework or approved country strategy, all investments are designed to strengthen the country's capacity to lead, sustainably manage, and increasingly finance an effective national response. This includes promoting:

- a) Political ownership and stewardship, with USG advocacy for increased GRC health-sector spending and timely realization of the GRC's significant financial contributions for HIV/AIDS
- b) Mutual accountability, with USG encouragement of CSOs that play a constructive role in advocacy and monitoring
- c) Capacity building, with extensive USG support for training and mentoring
- d) Institutional and community ownership, including prioritizing work with Cameroonian partners.

During the current implementation period, Cameroonian organizations account for 56.4% of program funds. In all planning, the NSP helps guide the USG's selection of priorities. Joint USG-GRC planning and decision making, while still nascent, are being strengthened through MoH participation in PEPFAR's portfolio review and COP development. Ongoing GRC dialogue with the private sector on innovative and sustainable ARV financing represents enormous potential for the national HIV/AIDS response and for future PEPFAR engagement. PEPFAR is working to increase collaboration with civil society and other donors (see respective narratives). These steps will be consolidated in a Sustainability Plan in 2014.

Trajectory

In Cameroon, PEPFAR arrived relatively late (2009-10) and with comparatively modest funding. While this allows the program to apply lessons learned the hard (and expensive) way in other countries, it also means that the country has not benefited from a decade of fast-rising budgets and technical support. As a result, even compared to other Long-Term Strategy countries, Cameroon may still need certain external investments and activities to go through initial and scale-up phases before transitioning to Cameroonian entities. This is important to keep in view, even as the USG team accesses some additional funding and plans with transition in mind. Areas in which increased or sustained efforts will be needed for the foreseeable future include:

PMTCT and ART: As an eMTCT country where PEPFAR has been a catalyst for quality PMTCT and Option B+ phase-in, Cameroon will require sustained support to consolidate and extend its gains, with PMTCT serving as a platform to strengthen adult and pediatric treatment programs.

KPs: The USG is a driving force behind services and an enabling environment for KPs, which are only just



beginning to break through walls of silence, stigma, discrimination, and in some cases legal prosecution and violence.

OVC: PEPFAR's program is just beginning, in a landscape devoid of national leadership and coordinated local initiative.

Strategic information: Given weaknesses throughout national information systems, this area will require years of sustained investment to achieve a unified and functional national system.

Supply chain: Milestones on a lengthy transition path include the GRC's commitment to funding a substantial proportion of ARV needs and the existence of a functional national supply chain.

In some other areas, programs are farther advanced along the trajectory toward transition:

Blood Safety: Starting from Ground Zero (no blood safety program) just two years ago, PEPFAR engagement has produced remarkable results, including establishment of a National Blood Transfusion Program and an MoH sub-directorate for blood safety and laboratories, acquisition of vital blood bank equipment, and introduction of a line item in the country's budget.

Laboratory Strengthening: Transition is clearly underway, with the GRC taking over the CDC lab, four labs on the way to accreditation (compared to 0 a year ago), establishment of a NPHL, and advances in QA.

IV. Program Overview

ARV Drugs (\$10,000,000, 31.1% of program budget)

Since 2012, the costs of ARVs have been primarily supported by the GRC, GFATM, and CHAI (UNITAID). Due to delays in fulfilling GFATM Round 10 conditions, Cameroon experienced stock-outs of first-line ARVs in 2012 and 2013. The GRC mobilized support and funding from PEPFAR on two occasions through the Emergency Commodity Fund as well as funding from the GFATM, World Bank, the French Government, and the Office of the Cameroon President to address the immediate crisis and ensure coverage through 2014.

The revised NSP estimates the costs of first-line ARVs and pre-ART and ART tests for 2014-2017 at \$196 million (\$49 million/year) and costs of PMTCT (B+) at \$25.8 million (\$6.4 million/year). The GFATM has committed \$20 million (from \$81 million in indicative funding under the New Funding Model) for the purchase of ARVs, and the GRC commitment for ARVs in its public investment budget is \$20 million. However, given uncertainties in GRC and GFATM timelines for releasing funds, continued financial gaps for ARVs appear likely.

To contribute towards the prevention of ARV stock-outs, PEPFAR will program \$10 million for the procurement of ARVs to support PMTCT implementation (\$4.4 million) and provide buffer stock for other ART patients (\$5.6 million) in its four high-burden regions. PEPFAR will also work with the GRC, GFATM, and other stakeholders to improve forecasting, procurement, stock management and distribution systems. In response to face-to-face discussions with the Minister of Health and his staff, as well as PEPFAR's written explanation of the conditions for accessing the \$10 million, the Minister has sent a letter approving this plan. (Please see supplemental documents for more details.)



Prevention (\$12,913,850, 38.9% of program budget)

As discussed in the "Epidemiology" section, Cameroon's generalized epidemic shows significant variations across genders, ages, regions and urban-rural locations, and population groups. Most new HIV infections in general populations occur due to risky sexual behavior and high prevalence of other sexually transmitted infections (STIs). Lack of male circumcision and injection drug use are not significant factors.

The NSP defines priority groups as KPs (MSM and FSWs), general population in the 15-24 age range, uniformed services, mobile populations (particularly LDTD), and pregnant women. With population size estimates of 69,000 MSM and 92,000 FSWs (JHU/R2P 2013), 17% of HIV-positive men (15-49 age range) are MSM, and 13% of HIV-positive women are FSWs.

Among adults with multiple sexual partners, only 43% of men and 37% of women reported using a condom with their most recent partner. Consistent use of condoms by MSM is reported at 33.1% with a female partner and 53.3% with a male partner. FSWs report an average of 109.5 clients a month, and only 13.1% use condoms with non-paying partners all the time.

More than two-thirds of youth and adolescents have inadequate knowledge about HIV/STIs, have never been tested, and don't consistently use condoms. Girls ages 15-24 have 5.4 times higher prevalence than boys in the same age range (DHS 2011). Among military populations, despite a decrease in prevalence from 11.2% in 2004 to 6% in 2011, the HIV burden remains higher than in the general population. There is no current data on mobile populations; prevalence among LDTD was estimated at 16.2% in 2004. There are about 81,000 HIV-positive pregnant women annually. FSW access to PMTCT is poor. A review in 2013 identified weaknesses in Cameroon's prevention program, including insufficient resources for outreach, lack of condoms and lubricants, and limited integration of HIV/AIDS and sexual/reproductive health (S/RH).

With COP 2014 funding, PEPFAR will support the GRC to achieve the following interlinked results: scale-up of PMTCT, increased coverage of prevention with KPs, and enhanced GRC capacity to ensure safe blood transfusions. Because of regional disparities in HIV burden and associated response, PEPFAR support will continue to target its four regions with high HIV prevalence, where joint agency resources will be leveraged for better outcomes. In addition, the KP program will continue to target commercial centers of the South and East regions, where PEPFAR has established drop-in centers, and expand to the Adamaoua region, which registers the highest HIV prevalence among FSW (48.4%) and has no sustained HIV/AIDS prevention interventions. Geographic targets for the KP program are well-aligned with the military program, which has military camps in all target regions. The PEPFAR Cameroon strategy is implementing the Blueprint strategy of smart investment by targeting interventions in the regions and among populations where the majority of HIV acquisition and transmission occurs.

PMTCT

Cameroon is one of 22 priority countries for PMTCT. PMTCT has been a priority intervention in



successive NSPs and is PEPFAR Cameroon's largest program, with \$15 million earmarked for PMTCT and related activities.

A 2012 sentinel site survey found HIV prevalence among pregnant women of 7.6%. ANC services were being provided at 2,999/3,500 health facilities (85%), but only 42% of pregnant women reported for first ANC (NACC 2012). Only 33.6% of expected pregnant women were tested for HIV, and 21.4% of expected HIV+ pregnant women received ARV prophylaxis. Nearly 50% of the estimated 1,019,341 pregnant women in the country were expected in the four PEPFAR-supported regions, as were 73.1% of the 17,386 women who received ARVs for PMTCT.

Follow-up of HIV-exposed infants was weak countrywide, with only 15% of those expected receiving prophylactic ARVs, 8% cotrimoxazole (CTX) prophylaxis, and 12% PCR HIV testing at 6 weeks (8.4% HIV-infected).

Since 2011, the USG has supported the GRC to improve coverage and quality. Efforts to improve PMTCT with maternal, neonatal and child health (MNCH) resulted in the creation of a PMTCT technical working group (TWG); development of an integrated PMTCT/MNCH training curriculum, supervision guide, check lists, registers, and an integrated service-delivery model; and staff capacity building. PEPFAR-supported PMTCT services in the Northwest and Southwest regions led to increases from 2011 to 2012 in the number of women attending ANC (28% more), the number of PMTCT sites (20%), and the proportion of pregnant women tested for HIV (from 95% to 99.3%).

As of January 2014, PEPFAR implementing partners (IPs) were supporting 628 PMTCT service-delivery sites (out of >3,000 sites nationwide).

In 2013, PEPFAR also supported the MoH to develop an operational plan to shift from Option A to Option B+, with a phased-in approach through 2017. A national document for task shifting was validated in 2013; implementation is expected to be accelerated alongside Option B+.

With COP 2014 funding and up to \$9 million in central funding (still to be programmed), PEPFAR will support the GRC to move toward its goal of eliminating MTCT and keeping mothers alive by extending the coverage and improving the quality of PMTCT services. Working in four regions, PEPFAR will use COP 2014 funds to:

1. Strengthen PMTCT/MNCH integration and coordination through regular PMTCT/pediatric care and treatment TWG meetings, training, a national system for staff mentoring and supervision, and regular site program coordination meetings.
2. Support the roll-out of Option B+ starting with co-located ART/PMTCT sites.
3. Support implementation of comprehensive family-centered PMTCT services, including expanded early infant diagnosis (EID), with stronger linkages to community care (including OVC care). Our modestly increased PMTCT targets reflect 1) our concern that growth not outpace ARV supplies available at the facility level and 2) our guidance to IPs and their community liaisons, who will also begin supporting ART services, to redirect some resources from demand creation toward adherence/retention support.
4. Strengthen linkages with care and treatment services along with intensive pediatric HIV case



finding, HIV testing and counseling (HTC) for partners and children, effective referral/counter-referral systems, and community-based follow-up for retention.

5. Enhance community mobilization through trained community leaders, workers, and organizations, and PLWHA associations, who will also work to ensure treatment adherence, LTFU tracing, and linkages to community (including OVC) services.
6. Extend PMTCT coverage to target military communities and expand services to target adolescent girls and FSWs through community linkages.
7. Strengthen the PMTCT monitoring and evaluation (M&E) system through training in the use of new PMTCT/MNCH registers and roll-out of District Health Information System (DHIS2) software.
8. Enhance quality in the PMTCT, care, and ART service delivery system through a national mentoring system (including tools and training), support for regular staff mentoring and formative supervision visits, and updating of norms and standards for PMTCT, care, and ART.
9. Strengthen the site system of care through mentor support for designing an appropriate patient flow and organizing site-level multidisciplinary teams to institute a system for service quality assessment and improvement.
10. Strengthen the PMTCT/MNCH commodities system through ARV procurement and support to improve forecasting, procurement, management, and distribution of HIV drugs and commodities.

Key populations

Based on the NACC 2012 report, less than 5% of KPs in Cameroon have been reached with prevention and care services. In an environment where people are prosecuted for consensual same-sex conduct more aggressively than in any other country in the world (Human Rights Watch), the most important achievement to date of PEPFAR's KP investment is that KP issues have been brought into the open with key stakeholder engagement. GRC technical staff have started meeting with LGBT groups to discuss KP data and programs. This is a foundation for an enabling environment and increased service coverage.

For the next two years, the PEPFAR strategy will continue to support the continuum of prevention, care, and treatment for KPs in the major cities of five regions (Littoral/Douala; Center/Yaoundé; Northwest/Bamenda; East/Bertoua; and South/Kribi). Activities will be expanded as appropriate to the largest urban areas with high concentrations of target populations. Building on mapping of hotspots/KP venues, PEPFAR will strengthen and expand interventions through drop-in centers and mobile outreach services targeting MSM, FSWs, and their clients (including LDTDs) and families. Community case managers will help ensure that clients benefit from the full range of prevention services and referrals, as needed.

PEPFAR support for HTC will prioritize key and other vulnerable populations. While national stock-outs of HIV test kits have occurred in the past, NACC projections indicate that supplies will be adequate for 2014 and 2015. Male and female condoms and gel lubricants will be procured through the PEPFAR central mechanism and by other partners (German Development Bank (KfW), GFATM, and UNFPA). Condoms will be made available for sale at 600 KP-friendly distribution points and for free through CBO networks.



Other commodities (HIV and CD4 test kits, STI/opportunistic infection drugs) will be supported by the GRC and GFATM.

PEPFAR will also invest in improving the enabling environment, supporting the NACC to increase sensitivity and understanding among policy-makers and health and social workers. To address high levels of HIV-related stigma, PEPFAR will continue to promote stigma-reduction interventions and the creation of PLWHA groups. PEPFAR will also support development of an HIV strategy within the military and will continue to work at military bases and health facilities. Prevention services will be integrated or linked to PMTCT and OVC services.

PEPFAR plans to conduct a second FSW IBBS and a second MSM IBBS in 2015.

Blood Safety

Cameroon's blood safety program collects only 20% of national blood needs. Most donated blood is tested for HIV, but only 90% is tested for hepatitis B and syphilis, and just 50% is tested for hepatitis C. Building on major gains (see "Trajectory" above) to address continuing challenges, USG support will strengthen 10 regional new blood centers, train staff, help establish a quality system working toward accreditation and proficiency testing, and help develop a communications package to increase voluntary non-remunerated blood donations.

New procurements:

1. PMTCT, ART, and care support in two regions (replacing current sub-partner arrangement) (CDC)
2. Prevention and care for KPs (USAID)
3. Follow-on for prevention and testing targeting military populations (DoD)
4. Follow-on for PMTCT and lab strengthening (DoD)

Treatment Services (\$2,288,093, 6.9% of program budget)

The NSP proposes to increase ART coverage to 60% and the number of ART patients to 248,079 by December 2017. In early 2014, the MoH adopted the 2013 WHO recommendations for ART eligibility at CD4 <500 for adults and for all HIV-positive children under age 5 years regardless of CD4 level. Implementation will be gradual. The MoH plans to develop consolidated guidelines for PMTCT, HIV management for adults and children, and TB/HIV co-infection by June 2014.

A critical weakness of Cameroon's ART program is its high LTFU rate, with retention rates of only 61.5% at 12 months and 25.6% at 60 months (GARP 2012). There is no national plan to promote quality improvement in clinical services, and supervision by the MoH Directorate of Disease Control (DLM) is limited. A pharmaco-vigilance system and reporting tools exist, but side effects of ARVs and other drugs are rarely reported by care providers.

A TB/HIV committee is mandated to develop strategic plans, mobilize resources, build capacity, and implement and monitor TB/HIV activities. According to the NACC 2012 report, 82% (20,810/25,360) of



reported TB cases were tested for HIV; CTX and ART were provided to 85% and 60% of TB/HIV patients, respectively. However, implementation of the 3I's (infection control, intensified case finding, isoniazid preventive therapy (IPT)) is weak. Only 11,951 PLWHA had a documented TB screening in 2012. IPT is not implemented except for children under 5 years whose parents have TB.

Of the 130,778 people on ART in 2012, 5,631 (4.3%) were children under age 15 years, representing just 15% of the country's pediatric ART needs (under old guidelines). LTFU for mother-infant pairs at 6 weeks was 35% (GARP 2012). Only 18% of PMTCT sites in the country offer PCR-DBS testing. OVC programs have no formal or effective links with facility-based HIV services.

Besides emergency ARV procurements, PEPFAR support to the ART program has focused on TA for strengthening the supply chain, elaboration of policy documents, and support for the creation of PMTCT/Peds and ART TWGs and an ongoing nationwide audit of the number of ART patients.

With COP 2014 funding, PEPFAR will leverage its PMTCT platform to expand its support to the ART program through ARV procurement and TA aimed at improving linkages, retention, and quality of ART services. This TA will cover all 98 ART sites in the four PEPFAR focus regions (all co-located with PMTCT sites, and all providing both adult and pediatric ART). Priority activities will include:

1. ARV procurement (see above)
2. TA for revision of ART guidelines
3. Expanded site monitoring, mentoring, and supportive supervision by PEPFAR and the DLM, as a base for development of a National Quality Plan
4. Strengthening adherence counseling and patient tracking, with capacity building for community health workers (CHWs)
5. Strengthened laboratory capacity in HIV diagnosis and biological monitoring
6. Advocacy for introduction of a pharmaco-vigilance reporting tool in the ART consolidated guidelines
7. Support for the MoH to integrate KP-friendly services in the training curriculum of health care workers
8. Training, supervision, and development of policies, tools, and job aids that ensure screening and documentation of TB among PLWHA, and advocacy for IPT and infection control
9. Activities strengthening lab and strategic information capacities, described below

Specific activities to improve pediatric ART will include:

1. Training in pediatric HIV care
2. Expanded EID coverage in four regions to at least 30% by 2016 through training, commodities, and lab analysis support
3. An active search strategy for pediatric HIV/AIDS using HIV-infected parents or siblings as entry points
4. Strong linkages between OVC and pediatric ART/care services
5. Revised M&E tools



6. Development of pediatric HIV care normative documents.

Based on OGAC advice, the Cameroon team's treatment targets consist of Option B+ women for FY 2014 and of TA-only for all ART patients at supported sites for FY 2015.

Care and Support (\$3,030,339, 9.1% of program budget)

Lack of access to care and support was a major shortcoming of the national HIV/AIDS response highlighted in a mid-term evaluation of the NSP. For PEPFAR's facility-based program, care has not been a major focus, consisting mainly of helping to ensure 1) linkage to care and receipt of GRC-funded CTX for HIV-positive pregnant women and their babies (77% combined in FY 2013) and 2) EID for HIV-exposed infants (66% in FY 2013).

At the community level, the PEPFAR IP's leveraging of GFATM Round 10 funds has been instrumental in establishing a continuum-of-care approach linking beneficiaries to health facilities and to resources in the community. PEPFAR has supported GRC-recognized community relay agents as well as NGO-supported CHWs to conduct routine client intake needs assessments, provide appropriate services using standardized forms, and conduct client follow-up. Targets of the community approach have primarily been FSWs, MSM, and PMTCT clients.

Given the importance of care in an effective CoR, and in conjunction with its new support for ART, COP 2014 places a stronger emphasis on adult and pediatric care and support, with an 83% increase in the HBHC/PDCS budget and definition of a package of services to be supported at facility and community levels.

In setting its priorities for the care portfolio, the USG team considered the strength of evidence supporting each intervention. Adult care and support in PMTCT and KP settings will prioritize ensuring CTX preventive therapy, CD4 testing, basic screening for TB, promotion of malaria prevention, provision of water-purification products, screening and referral for STIs, nutritional assessment and counseling, FP/RH counseling, treatment adherence counseling, psychosocial support, and routine use of CHWs to support ART retention and linkages to OVC services. In addition, pediatric care and support will prioritize increasing country capacity to provide EID with linkages to HIV services, including OVC services. These care interventions will be implemented at all supported PMTCT and ART sites (including military sites) in the four regions as well as KP drop-in centers and other community sites. An expanded and focused Peace Corps PEPFAR program will prioritize care and prevention activities, with volunteers helping to ensure effective linkages with other USG interventions.

The main goals of this community-based program are 1) to demonstrate positive health outcomes for PLWHA and 2) to strengthen the USG program's clinical and community linkages to address high LTFU rates. Providing results in these areas will meet client needs holistically and present a strong case to advocate for acceptance of a CoR model at the national level, perhaps enabling care interventions in PEPFAR focus regions to be adapted and applied throughout the country.

A major challenge in Cameroon is the lack of national guidelines on the provision of care services for adults,



adolescents, and children. The USG will request TA from the HQ Care and Support TWG and work with the GRC to develop national care guidelines.

Building on the PEPFAR program's PMTCT platform will allow care and treatment support to be implemented with minimal additional up-front costs. Thoughtful collaborative planning by USG agencies will maximize efficiencies in building a CoR, e.g. connecting CDC and DoD activities in PMTCT/ART clinical facilities with community-based prevention and care (including FP and OVC care services) supported by USAID and Peace Corps.

Coverage of EID is still low, with 429 health-care facilities collecting dried blood spot (DBS) specimens to perform DNA PCR testing. Challenges include sample transportation issues, LTFU, high turnaround times for test results, and poor service uptake. PEPFAR support has strengthened the EID program in four regions (299 of 429 sites). The CDC laboratory in the Southwest region is one of two reference labs providing EID testing and building EID capacity. The lab is being transitioned to the MoH with CDC oversight.

PEPFAR will continue to support EID capacity building by expanding the collection of DBS to all PMTCT sites in five regions (Southwest, Northwest, Littoral, West, and Center). The GRC and PEPFAR IPs will implement a national sample transportation plan in 2014-15.

With its involvement in Option B+ and treatment, PEPFAR will begin providing support for TB/HIV activities by incorporating lab QA for TB testing and requesting TA from HQ to assist the GRC in developing/updating national infection control guidelines.

The Cameroon team will launch its first OVC program in 2014, with the goal of strengthening capacities of the GRC, community networks, and families to deliver sustainable, high-quality care and support to OVC and their families. Activities will support the development of standard procedures and quality improvement approaches for OVC care and support, identify and strengthen networks of community providers, and support economic-strengthening activities. Where possible, OVC care and support will wrap around other USG activities (PMTCT, ART, drop-in centers, etc.) for maximum efficiency and impact. OVC are also a priority population for the Peace Corps, which will increase its activities in seven regions (including the four PEPFAR focus regions).

New procurement: OVC care and support (USAID)

Health Systems Strengthening (HSS) (\$4,945,674, 14.9% of program budget)

PEPFAR's goal is to reach sustainable impact with a strong country-owned HIV/AIDS response leading toward an AIDS-free generation. Among many systems that require strengthening, PEPFAR will focus on critical weaknesses that must be addressed in order for PEPFAR-funded interventions targeting national priorities to succeed. More robust USG efforts to improve supply chain management, laboratory systems, strategic information, and human resources for health (HRH, described in various technical areas) are designed to produce strategic and sustainable improvements in Cameroon's HIV/AIDS and health sectors.



Supply Chain

PEPFAR Cameroon has been strengthening the logistics management information system (LMIS) for the past two years and has succeeded in creating clear procedures and guidelines for quantification, projection, and warehouse storage. The implementer has focused on the central level as well as six regional distribution centers and has supported training and supervision in 34 facilities.

Compared to the size and needs of the country, this is a modest beginning. In anticipation of more USG-purchased health commodities in FY 2014, the PEPFAR team will shift its focus to establishing a clear distribution system from the central to regional to district levels. More support will be given to regional and district-level staff to provide accurate data that will be used by all donors and the NACC. PEPFAR will continue to coordinate with all HIV donors at the central level in the areas of ARV quantification, use of the Central Medical Stores, and avoiding stock-outs in 2014-2015. PEPFAR will also add a logistics/supply chain adviser to its staff to guide and monitor these efforts.

Strategic Information (SI)

[REDACTED]. The National M&E Plan is being updated to support the revised NSP for HIV/AIDS. With TA from PEPFAR, the NACC has drafted paper-based M&E tools for selected NSP indicators, but these tools are yet to be fully deployed, and end-users have not yet been trained.

For the next two years, PEPFAR SI priorities are:

- Development, piloting and implementation of standardized M&E forms for PMTCT/ART as a step toward a national M&E system
- Improvement of data quality through training, supervision, and data quality assessments (DQAs)
- Enhancement of data use for planning, policy-making, and improved coordination of HIV/AIDS activities

With HQ support, the USG will lead a service quality assessment / DQA on PMTCT and KP activities. Financial and technical support will strengthen the M&E TWG in the collection and use of information. District Health Information System (DHIS2) software and hardware will be rolled out to support reporting for the national PMTCT, key population, and ART programs, with emphasis on the four PEPFAR focus regions to provide a model for the rest of the country.

With HQ funding, the USG will support two implementation science studies on HIV drug resistance among 1) children and mothers in PMTCT programs and 2) ART-naïve patients at urban and rural ART centers.

Laboratory Strengthening

To strengthen sustainable laboratory capacity to respond to the HIV/AIDS epidemic, PEPFAR's efforts over the next two years will focus on completing a National Laboratory Strategic Plan (NLSP) and policies, setting up a Lab TWG, operationalizing the National Public Health Laboratory (NPHL), and improving access to and quality of lab services.



PEPFAR will support the establishment of a national External Quality Assessment (EQA) center that will build capacity for QA programs, including proficiency testing (PT) and certification.

To sustain these efforts, PEPFAR will support the WHO/AFRO SLIPTA accreditation process, which will help develop capacity for laboratory quality management systems. A Basic Laboratory Information System (BLIS) that has been implemented in four labs will gradually be expanded.

PEPFAR will support equipment listing and standardization as well as development of pre-service and in-service curricula and training for engineers on equipment calibration and maintenance. PEPFAR will also support in-service training for lab staff.

Strengthening sample referral linkages will be another key focus, along with the piloting of new technologies, such as point-of-care diagnostics.

A lab policy (in draft) developed with PEPFAR support will provide a roadmap for improving lab services across the tiered system.

PEPFAR supports implementation of a national PT program for HIV and CD4 testing, including training and implementation of national guidelines. PEPFAR will also support the SLIPTA process for accreditation of 12 labs over the next two years.

The use of dried tube specimen (DTS) technology and standardized HIV logbooks has been successful in monitoring the quality of testing in more than 300 facilities, and PEPFAR will support the GRC to scale up these efforts to 500 new sites and initiate PT programs for TB support and patient monitoring.

Emphasizing sustainability and the integration of lab services for major diseases, PEPFAR will work to improve pre-service training curricula in lab diagnosis and monitoring of diseases. Pre-service training support will benefit 300 graduates yearly, and 30 lecturers will be trained as trainers.

V. GHI, Program Integration, Central Initiatives, and other considerations

USG Cameroon's 2012 Global Health Initiative (GHI) Strategy seeks to improve the health of Cameroonians by reducing the incidence of HIV and other communicable diseases, decreasing child and maternal mortality rates through PMTCT, and strengthening health systems. As described above, PEPFAR interventions align with GHI principles – including a focus on women and girls in PMTCT and FSW services, integration of services in a functional CoR, capacity building across all program areas, and collaboration with the GRC and other donors – and PEPFAR results contribute directly to GHI targets. PEPFAR will leverage other programs contributing to GHI results, including CDC's Central African Field Epidemiology and Laboratory Training Program and USAID's Emerging Pandemic Threats and Neglected Tropical Disease Control programs.

PEPFAR supports all coordination efforts, including national TWGs; consults on a regular basis with key donors; and participates in the GFATM Country Coordinating Mechanism (CCM) and its technical oversight committee. The PEPFAR team conducts bi-weekly information-sharing calls with the GFATM and UNAIDS. Starting in 2014, the USG and WHO will co-chair the Technical and Financial Partners' Forum. The USG provides financial support and TA for the development of key documents for GFATM concept

Approved



note development, including a mid-term evaluation and revision of the NSP and an assessment of the number of patients on ART nationwide, funded jointly with the GRC, GFATM, and the French 5% Initiative. As part of a coordination committee for concept note development, the USG will participate in development of a UNAIDS Investment Approach (planned for April-May 2014) and continue to support the CCM to submit a joint HIV/AIDS-TB concept note by June 2014.

PEPFAR Cameroon is using \$1,058,000 in Country Collaboration Initiative funds to strengthen the implementation capacity of the GFATM Round 10 principal recipients and the oversight capacity of the CCM through financial and/or technical support for a new TWG that is developing a package of services for KPs, the recent NSP revision, the assessment of the number of ART patients, and the CCM secretariat. The 2012 National Health Account exercise, also financed with CCI funds, will contribute to an improved understanding of HIV/AIDS financial gaps within Cameroon's overall health program, while financial support to finalize the 2012 NASA will provide an overview of HIV/AIDS financing and donor mapping. To enhance country ownership, PEPFAR is supporting a proposal by a faith-based CSO to use Local Capacity Initiative funds to build the capacities of rural councils and health district management teams.

Program Contacts:

Gregory Thome, State Department (ThomeGD@state.gov)

Catherine Akom, State Department (AkomCA@state.gov)

Bolu Omotayo, CDC (obb3@cdc.gov)

Peter Wondergem, USAID (pwondergem@usaid.gov)

Mark Orlic, Peace Corps (MOrlic@peacecorps.gov)

Grace Dion, DoD (DionNguteGA@state.gov)

Time Frame: FY 2014: October 2013 – September 2014