CAMEROON

Country Operational Plan

COP 2017

Strategic Direction Summary

April 17, 2017

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ACRONYMS

ACT:	Accelerating Children's HIV/AIDS Treatment Initiative
AGYW:	Adolescent Girls and Young Women
AIDS:	Acquired Immune Deficiency Syndrome
ANC:	Antenatal Care
APR:	Annual Progress Report
ART:	Antiretroviral Therapy
ARV:	Antiretroviral
ASLM :	African Society for Laboratory Medicine
C&T:	Care and Treatment
CBCTS:	Community-Based Care and Treatment Services
CBTC:	Community-Based Testing and Counseling
CBO:	Community-Based Organization
CDC:	Centers for Disease Control and Prevention
CENAME:	Central Medical Store
CHAI:	Clinton Health Access Initiative
CHW:	Community Health Workers
CoAg:	Cooperative Agreement
COP:	Country Operational Plan
CoPT:	Combination of HIV/AIDS Prevention and Treatment
CQI:	Continuous Quality Improvement
CSO:	Civil Society Organization
CTX:	Cotrimoxazole
DataNav:	Data Navigation (Tool)
DHIS2:	District Health Information System
DHS:	Demographic and Health Survey
DIC:	Drop-In Center
DoD:	Department of Defense
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative for young girls
DSD:	Direct Service Delivery
DQA:	Data Quality Assessment
EA:	Expenditure Analysis
ECD:	Early Childhood Development
EID:	Early Infant Diagnosis
EQA:	External Quality Assessment
EMR:	Electronic Medical Record
FBCTS:	Facility-Based Care and Treatment Services
FBO:	Faith-Based Organization
FP:	Family Planning
FSW:	Female Sex Workers

FTE:	Full-Time Equivalent
FY:	Fiscal Year
GBV:	Gender-Based Violence
GFATM:	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRC:	Government of the Republic of Cameroon
HBHC:	Adult Care and Support (budget code)
HEI:	HIV-Exposed Infants
HHS:	United States Department of Health and Human Services
HIV:	Human Immunodeficiency Virus
HLAB:	Laboratory Infrastructure (budget code)
HMBL:	Blood Safety (budget code)
HOP:	Headquarters Operational Plan
HQ:	Headquarters
HRH:	Human Resources for Health
HSS:	Health System Strengthening
HTC:	HIV Testing & Counseling
HTS:	HIV Testing Services
HTXS:	Adult Treatment (budget code)
HVSI:	Strategic Information (budget code)
HVTB:	TB/HIV (budget code)
IBBS:	Integrated Bio-Behavioral Survey
ICAP:	International Center for AIDS Care and Treatment Programs (Columbia University)
ICF:	Intensified Case Finding
IM:	Implementing Mechanism
IP:	Implementing Partner
IRB:	Institutional Review Board
IT:	Information Technology
KP:	Key Population(s)
LCI:	Local Capacity Initiative
LES:	Locally Employed Staff
LMIS:	Logistics Management Information System
LTFU:	Lost to Follow-Up
M&E:	Monitoring and Evaluation
M&O:	Management and Operations
MAT:	Medication-Assisted Treatment
MCH:	Maternal and Child Health
MNCH:	Maternal, Newborn, and Child Health
MOH:	Ministry of Health
MOU:	Memorandum of Understanding
MSM:	Men who have Sex with Men
MTB:	Mycobacterium tuberculosis

NACC:	National AIDS Control Committee
NASA:	National AIDS Spending Assessment
NGO:	Non-governmental Organization
NFM:	New Funding Model
NPHL:	National Public Health Laboratory
OGAC:	Office of the Global AIDS Coordinator
OHSS:	Health System Strengthening (budget code)
OI:	Opportunistic Infection
OSPSIDA:	HIV/AIDS Commodity Management Tracking Tool for West Africa
OVC:	Orphans and Vulnerable Children
PBF:	Performance-Based Financing
PCV:	Peace Corps Volunteer
PDCS:	Pediatric Care and Support (budget code)
PDTX:	Pediatric Treatment (budget code)
PEPFAR:	United States President's Emergency Plan for AIDS Relief
PITC:	Provider-Initiated HIV Testing and Counseling
PLHIV:	People Living with HIV
PMTCT:	Prevention Mother to Child Transmission
PT:	Proficiency Testing
PWID:	People Who Inject Drugs
Q:	Quarter
QA:	Quality Assurance
QC:	Quality Control
Q-Corps:	Quality-Corps
QI:	Quality Improvement
QM:	Quality Management
QMS:	Quality Management System
RT-Corps:	Rapid Test- Quality Corps
RTK:	HIV Rapid Test Kit
RT-QII:	Rapid Test Quality Improvement Initiative
SABERS:	HIV Seroprevalence and Behavioral Epidemiology Risk Survey
SBOR:	Systems and Budget Optimization Review
SI:	Strategic Information
SID:	Sustainability Index and Dashboard
SILC:	Savings and Internal Lending Community
SIMS:	Site Improvement through Monitoring System
SMS:	Short Message Service
SNU:	Sub-National Unit
SOP:	Standard Operating Procedure
SOW:	Scope (or Statement) of Work

SQA:	Service Quality Assessment
SLIPTA:	Stepwise Laboratory Improvement Process Towards Accreditation
SLMTA:	Strengthening Laboratory Management Towards Accreditation
STI:	Sexually Transmitted Infection
TA:	Technical Assistance
TAT:	Turnaround Time
TA-SDI:	Technical Assistance – Service Delivery Improvement
TB:	Tuberculosis
ToT:	Training of Trainers
UE:	Unit Expenditure
UIC:	Unique Identifier Code
UN:	United Nations
UNAIDS:	Joint United Nations Program on HIV/AIDS
UNICEF:	United Nations Children's Fund
USAID:	United States Agency for International Development
USG:	United States Government
VCT:	Voluntary Counseling and Testing
VL:	Viral Load
VMMC:	Voluntary Medical Male Circumcision
WB:	World Bank
WHO:	World Health Organization

1.0 Goal Statement

PEPFAR Cameroon, in partnership with the Government of the Republic of Cameroon (GRC), will work toward the goal of reaching epidemic control in Cameroon by 2020. The COP17 Strategic Direction Summary (SDS) delineates the strategies that will be followed in fiscal year 2018 (FY18) to reach this goal. Novel strategies include a better geographic alignment to achieve epidemic control in two urban clusters surrounding the cities of Douala and Yaounde, which together are home to 26% of people living with HIV (PLHIV) in Cameroon. PEPFAR Cameroon will implement evidence-based programming and activities to reach targeted populations in these two scale-up clusters and key and priority population sites in sustained districts. PEPFAR Cameroon expects to achieve 60% saturation in the scale-up districts by the end of FY18, and 80% saturation by the end of FY19. Activities will be concentrated in 45 scale-up clinical health facilities and 10 key population drop-in centers (DICs) in the two clusters to reach the greatest number of PLHIV, including adults, children, and their families.

Preliminary reports for FY17 Q1 indicate an overall 78% linkage rate from testing to treatment (9811/12521), but show persistent differences across genders and ages, and depending on key or priority population status. PEPFAR Cameroon recognizes that additional targeted efforts will be needed to ensure 80% coverage of all sex and age disaggregations by the end of FY19, and to achieve epidemic control. The team will use proven strategies to achieve success including intensive demand creation and identification of PLHIV (1st 90); improved linkage, enrollment and initiation on treatment using Test and Start (2nd 90); and more effective adherence and retention services to achieve viral suppression (3rd 90). PEPFAR Cameroon will initiate or scale up the following strategies: Index-Patient contact tracing; Family Model; Enhanced Peer Navigation for Key Populations (KP); targeted programs for adolescent girls and young women (AGYW), orphans and vulnerable children (OVC), and the military; and targeted provider-initiated HIV testing and counseling (PITC) focusing on the highest yield services including tuberculosis treatment sites, antenatal care (ANC), and adult and pediatric inpatient/outpatient wards.

The PEPFAR Cameroon team will work with GRC counterparts to support dissemination and full implementation of national Test and Start guidelines and to address structural barriers including fees for services. PEPFAR, along with the National AIDS Control Council (NACC), will work toward ensuring same day ART initiation and transferring stable patients to multi-month scripting and community-based distribution. The USG will support policy development and implementation of health services, ensuring a broader enabling environment for KP and other vulnerable groups.

PEPFAR Cameroon will engage with civil society organizations (CSOs) and multilateral organizations. UNAIDS is a key partner in GFATM and CSO engagement, hosting discussions on program implementation, geographic expansion and commodities challenges. CSO stakeholders' meetings will continue on a quarterly basis and the USG plans to increase engagement by conducting site visits to CSOs to strengthen existing relationships. Staff traveling to field sites will discuss quarterly results with Regional Delegates and district and site level authorities.

2.0 Epidemics, Response, and Program Context

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	22,734,198		4,750,970	20.9%	4,911,065	21.6%	2,516,789	11.1%	2,304,934	10.1%	4,237,556	18.6%	4,012,890	17.7%	National Bureau of census, population projections, 2010
HIV Prevalence (%)		4.30%					1.43%								UNAIDS,2013
AIDS Deaths (per year)	26,743														2016 SPECTRUM projection
# PLHIV	639,812		16,755	3%	17,437	3%	43,132	7%	24,731	4%	317,665	50%	220,092	34%	2016 SPECTRUM projection
Incidence Rate (Yr)		0.3													UNAIDS, 2013
New Infections (Yr)	38,595														2016 SPECTRUM projection
Annual births	839,935														2016 SPECTRUM projection
% of Pregnant Women with at least one ANC visit		84.50%													DHS, 2011
Pregnant women needing ARVs	33,192														2016 SPECTRUM projection

Orphans (maternal, paternal, double)	316,335														Estimations et projections sur le sida au Cameroun Periode 2010 - 2020
Notified TB cases (Yr)	26,117														National TB Control Program, 2015
% of TB cases that are HIV infected	9,663	37%													National TB Control Program, 2015
% of Males Circumcised	NA	94%													DHS 2012
Estimated Population Size of MSM*	66,842	1.38%													Papworth, 2014
MSM HIV Prevalence		37.2%													UNAIDS 2014 estimate based on 2012 IBBS report
Estimated Population Size of FSW	115,562	1.96%													World Bank, 2016
FSW HIV Prevalence		36.00%													IBBS report, 2009
Estimated Population Size of PWID	NA	NA													N/A
PWID HIV Prevalence	NA	NA													N/A
Estimated Size of Priority Populations (Military)	36,000										3600	10%	32,400	90%	SABERS 2011

2.1 Summary Statistics, Disease Burden & Country Profile

Cameroon's HIV/AIDS epidemic is mixed generalized/concentrated: Adult HIV prevalence in the general population has fallen consistently (7.7% in 1999 to 4.3% in 2013), but has remained high among female sex workers (FSW), with an estimated prevalence of 36%. HIV prevalence among men who have sex with men (MSM) is currently estimated at 37.2%. According to the DHS 2011, the HIV prevalence rate for women is nearly twice that for men (5.6% vs. 2.9%), due in part to women's natural greater vulnerability to infection, as well as Cameroon's almost universal (94%) circumcision rate. HIV prevalence is highest among women between 35-39 years of age, but is over 7% among women from 25-35 and 40-44. For men, HIV prevalence is highest in the 45-49 age range (6.3%), but also over 5% among men between the ages of 30 and 39. Among youth, females are more affected then males: 2.0% vs. 0.4%, in the 15-19 age range, and 3.4% vs. 0.6% in the 20-25 age range. Divorced and widowed women (15.7% and 17.9%) and men (5.1% and 10.6%) also have high HIV prevalence rates.

In Cameroon, HIV/AIDS is more prevalent in urban areas, which are home to slightly more than 50% of the population. In particular, the economic capital, Douala, and the political capital, Yaounde, together have HIV prevalence rates of 7.7% among women and 3.1% among men. Other cities combined have HIV prevalence rates of 5.5% among women and 3.0% among men, while rural areas have HIV prevalence rates of 4.6% among women and 2.7% among men. The regions with the highest prevalence are the three southeastern regions of the country (South, East, and Center) and the Northwest region, all of which have higher than 6% HIV prevalence rates. However, due to absolute population size and the tendency for Cameroon's epidemic to be concentrated in urban areas, the burden of disease is highest in the PEPFAR-supported regions: Center (including Yaounde), Littoral (including Douala), Northwest, and Southwest. The greatest disease burden is in the district clusters encompassing Yaounde and Douala.

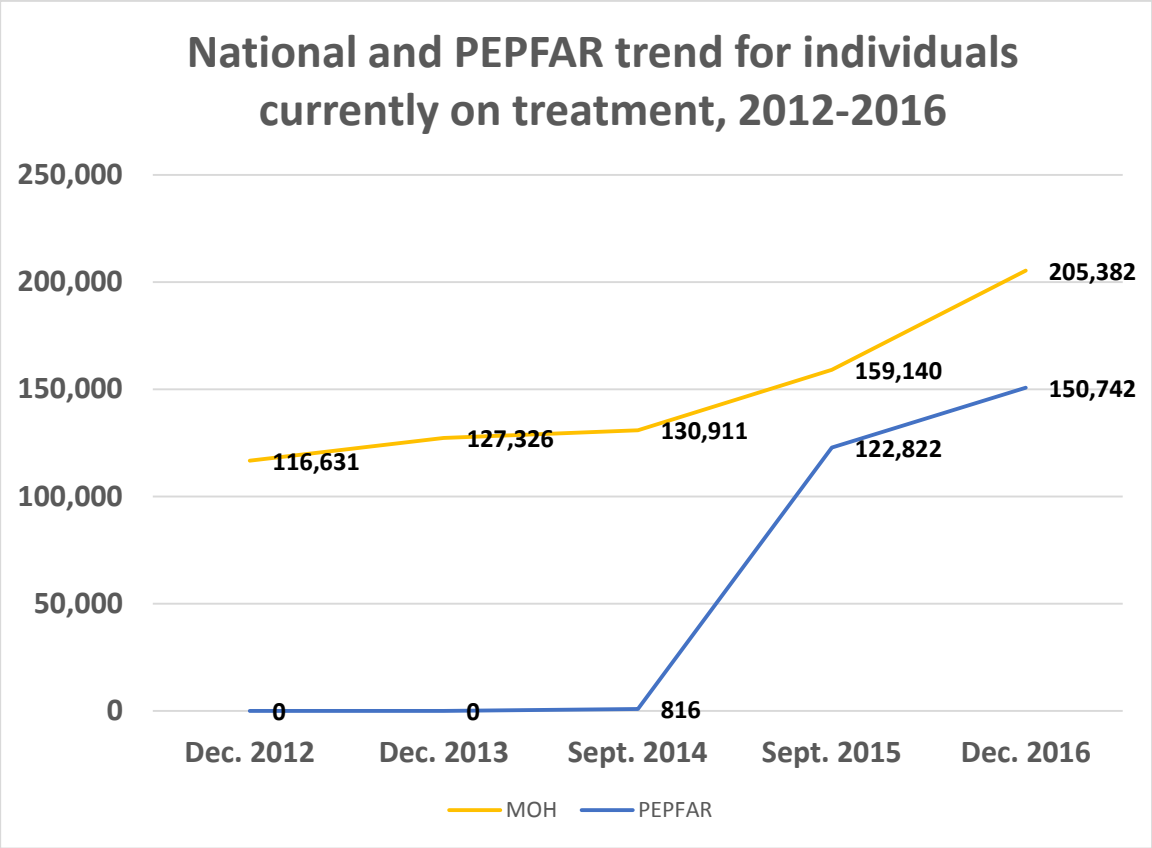
Cameroon's GNI per capita in 2015, the most recent year for which data are available, was USD $1,230 (World Bank, Atlas Method). Wealthier and middle-class Cameroonians have higher HIV prevalence rates (5.1% and higher in the two wealthier economic quintiles and 4.4% in the middle quintile) than poorer Cameroonians (4.2% in the fourth richest and 2.0% in the poorest). It is important to note, however, that most Cameroonians in the two poorest quintiles live in rural areas.

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression										
	Epidemiologic Data				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV	PLHIV diagnosed	On ART	ART Coverage	Viral Suppression	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(%)	(%)	(#)	(#)	(#)
Total population	22,734,198	4.30%	639,812		205,359	32%	NA	1,689,696	93,216	65,205
Population less than 15 years	9,662,035		34,192		8,486	25%		244,689	5,106	3,178
15-24 year olds	4,821,723	1.43%	67,863		18,832	28%		533,073	15,001	NA
25+ year olds	8,250,446		537,757		178,041	33%		1,044,937	73,112	NA
MSM	66,842	37.2%	24,865	2,080*	214	10.29%	NA	1,710	379	188
FSW	115,562	36.0%	41,602	1,979	556	28.09%	NA	4,908	948	275
PWID										
Priority Pop (Military)	36,000	6.00%	2,160	1,296	400	18.00%	80.00%	1,423	77	55

* MSM and FSW diagnosed based on PEPFAR data only, as national level data are unavailable.

Table 2.1.2 shows Cameroon's 90-90-90 cascade. Cameroon currently has an estimated ART coverage of 32%, with 205,359 PLHIV on ART. ART coverage is lowest for children and adolescents living with HIV (25%) and highest for PLHIV 25 and older (33%). ART coverage is also lower among MSM, with only about 10% of HIV positive MSM on ART and FSW with coverage at approximately 28% in PEPFAR supported sites. Last year 1,689,696 people were tested for HIV, and 93,216 (5.5%) tested positive. Of the positives, 65,205 (70%) were initiated on ART. However, among children, FSW, and MSM, the proportion of positives initiated on ART is lower than the overall proportion (62.2%, 49.6%, and 29.0% respectively), highlighting current challenges. This is despite higher testing yields among MSM and FSW (22% and 19.3% respectively) than in the overall population. Figure 2.1.3 shows the increasing number of PLHIV on ART since 2012, including the increasing numbers of those supported by PEPFAR on ART, which was 150,742 through FY17 quarter 1.

Figure 2.1.3 National and PEPFAR Trend for individuals currently on treatment, 2012-2016



GRC adopted Test and Start in May 2016 and field implementation subsequently began in some sites. PEPFAR/WHO provided support to GRC to develop the strategic document to facilitate the implementation of Test and Start which has been finalized and is in the process of validation. This strategic document provides policy guidance on HIV testing and retesting for verification in facilities and communities; differentiated service delivery models, including for different subpopulations; and multi-month scripting for stable patients, including community dispensation and loss to follow up (LTFU) strategies. The strategy also promotes the decentralization of ART down to PMTCT, HTC and TB standalone sites through the enforcement of the task shifting policy. A routine viral load (VL) operational plan has also been developed and VL is currently being scaled up in country.

Following the implementation of Test and Start, several steps have been taken to ensure a smooth roll out of multi-month scripting, which will decongest the limited number of ART sites and increase adherence to treatment. GRC has updated drug prescription forms; PEPFAR and WHO supported GRC to develop standard operating procedures (SOPs), job aids, and tools that clearly define stable patients eligible for multi-month scripting, the number of months of ART to be provided, and procurement management and monitoring systems at various levels. Final versions of those materials will be distributed to care givers during FY17. Additional ART sites

established in FY17 will receive these materials and staff will be trained in their application. By the end of FY17, all health care workers (HCWs), doctors, and nurses responsible for ART dispensation at ART sites within the Yaounde and Douala clusters will have been trained on the identification of eligible stable patients, and full application of the multi-month scripting policy is expected in late FY17 or early FY18. PEPFAR Cameroon continues to support GRC to develop community dispensation models, which are currently being piloted by selected community based organizations (CBOs), including in KP DICs. A planned evaluation of the effect of multi month scripting on adherence to treatment is still inscribed in PEPFAR Cameroons agenda and mid FY18 will make the results available.

The major programmatic gaps and barriers identified through the 2016 Sustainability Index and Dashboard (SID) and included in COP16 remain largely the same. These barriers include quality management for linkage and adherence and laboratory services, and supply chain management. PEPFAR Cameroon will maintain systems investments in these areas to continue addressing structural barriers to care. These investments will ensure improved service and data quality within the two scale-up clusters; improved identification and linkage of beneficiaries; better measurement of progress toward attaining the 90-90-90 targets; uninterrupted access to HIV/AIDS commodities; and a healthcare system reinforced through strategic service models that bridge clinical and community-based services. Specific investments are described in greater detail in Section 6.0.

2.2 Investment Profile

The National AIDS Spending Assessment (NASA) for 2014/2015 has not been officially released by the GRC. National expenditures data shown in Table 2.2.1 are based on the 2013 NASA. In order to align with the 2013 national expenditure report, PEPFAR Cameroon used data from EA 2013[1] to complete the table. National HIV/AIDS expenditures have increased from $40 million in 2011 to $42.4 million in 2012 to $55.1 million in 2013. The national HIV/AIDS response is heavily funded by external sources, representing 70% of total expenditures incurred in 2013 – 29% of HIV/AIDS expenditures were incurred by domestic actors (GRC, private sector, out-of-pocket expenditures); 22% by GFATM, 23% by PEPFAR, and 26% by other bilateral (French and German governments), multilateral (UN agencies), and international NGOs.

Technical areas with the highest expenditures in 2013 were care and treatment (46.3% of total budget), with the bulk of expenditures focused on procurement of antiretroviral (ARV) medications; prevention (25%) with expenditures for KP programming making up 1.9% of total expenditures; Health System Strengthening and program management expenditures (22.2%). Areas with the lowest investments are social protection (0.12%), OVC (0.89%), and SI (1.3%).

[1] 2013 NASA indicates PEPFAR expenditure of $10.2 million; meanwhile PEPFAR 2013 EA exercise indicates expenditure of $12.5 million.

Significant funders of the national HIV/AIDS response continue through PEPFAR at $46,605,485 in FY18 and the GFATM-GRC Concept Note, which is estimated at 90 million Euros for 2018 - 2020. As in previous years, the bulk of investment will focus on care and treatment, particularly procurement of ARVs (approximately 73% of concept note budget will focus on procurement). With substantial focus on commodities, the HIV/AIDS national response will rely on PEPFAR COP FY2017 and 2018 investments to ensure availability and quality within service delivery.

Table 2.2.1 Annual Investment Profile by Program Area, 2013*

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
Clinical care, treatment and support	$30,797,364.17	3%		54%	43%
Community-based care, treatment, and support	$240,121	6%		23%	70%
PMTCT	$8,591,391	59%		5%	36%
HTS	$362,933	(336%)**		98%	2%
VMMC	$0				
Priority population prevention	$1,261,035	0%		15%	85%
Key population prevention	$1,243,643	85%		0%	15%
Prevention (General)	$4,169,607	8%		41%	51%
OVC	$593,472	(100%)**		0%	100%
Laboratory	$0	(100%)**		0%	0%
SI, Surveys and Surveillance	$4,632,386	13%		12%	75%
HSS	$13,043,752	10%		5%	85%
Total	$64,935,704				

* (GRC, National AIDS Spending Assessment, 2013), all amounts in 2013 USD. Exchange rate applied ($1=476.54 CFA) based on Treasury Reporting Rates of Exchange as at December 31, 2013 (www.irs.gov). Expenditures reported in this table for Host country and Other (GF, bilateral donors, UN agencies, and international organizations) partners are based on the 2013 NASA, which does not break down donor expenditures by program area. Expenditure breakdown specifically for GFATM was not available. The 2014 and 2015 NASA is awaiting official release by the GRC. In order to align with NASA 2013 report, PEPFAR expenditures reported in this table are based on FY2013 EA exercise in order to align with national expenditure data. Total expenditures match 2013 NASA, however, methodology used to allocate percentages consists of: (1) host country percentage allocation comes from NASA; (2) PEPFAR percentage allocation is based on EA expenditure divided by total expenditure for category in NASA; (3) Other percentage allocation generated by calculating balance after subtracting host country and PEPFAR percentage allocations (with exception of HTC program area).

**According to 2013 NASA, Host country (public and private) contributed towards 98% of expenditures while international partners contributed towards 2%; international partners contributed 100% for OVC activities; and there were no expenditures in lab (these expenditures may be covered under HSS). It is not possible to align PEPFAR data with these program areas as expenditures reported in EA 2013 exceed total expenditures reported in NASA for these program areas.

Table 2.2.2 Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$42,037,438	4.81	65.37	29.82	
Rapid test kits	$4,202,021	24.99	66.30	8.71	
Other drugs	$2,093,709	0	93.88	6.12	
Lab reagents	$340,168	0	100.00	0	
Condoms and lubricants	$2,897,621		42.67	5.57	51.77
Viral Load commodities	$8,599,099	22.52	77.48	0	
MAT					
Other commodities					
Total	$60,170,056	8.32	67.26	21.92	2.49

Source: PEPFAR investments: COP 16 and remaining ACT funds, CCP/condoms investments not included, GF: Approved 2017 orders from principal recipients based on HIV grant reprogramming (NACC) and CAMNFAW, GRC: CENAME and NACC (expenditures incurred), Other (UNFPA): Family planning quantification report.

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID NTD	$4,536,034	$0	$0	$0	Support to Government of Cameroon in eliminating neglected tropical diseases such as lymphatic filariasis, trachoma, onchocerciasis, etc.
Family Planning	$2,948,220	$0	0	$0	Resources include: - (a) DCA focused on increasing private sector lending to health enterprises, particularly facilities that offer family planning and SRH service; (b) procurement of condoms and lubricants to support PEPFAR programming; (c) Demographic and Health Survey (DHS) 2017.
USAID (Global Health Security)	$23,000,000	$0	0	$0	$23 million represents multi-year budget to detect viruses with pandemic potential, improve laboratory capacity to support surveillance, respond in an appropriate and timely manner, strengthen national and local response capacities, and educate at-risk populations on how to prevent exposure to dangerous pathogens.
CDC Global Health Security	$3,302,333	$0	$0	$0	Other Non-PEPFAR programs including Ebola and Global Health Security
Peace Corps	$45,900	$0	$0	$0	West African Food Security Funds (from USAID) that support food security projects. Beneficiaries are small scale farmers (for improving farming systems for higher productivity and food transformation), and women of child bearing age including children 0-5 years.
DOD	$0	$0	$0	$0	DOD only has PEPFAR Funds
Total	**$33,832,487**	**$0**	**$0**	**$)**	

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
DREAMS Innovation	N/A	N/A	N/A	N/A	N/A	N/A
VMMC – Central Funds	N/A	N/A	N/A	N/A	N/A	N/A
LCI	N/A	N/A	N/A	N/A	N/A	N/A
Other PEPFAR Central Initiatives 1. Impact Fund 2. Performance Funding 3. Health Information Systems	$3,000,000	N/A	N/A	N/A	N/A	N/A
Other Public Private Partnership	N/A	N/A	N/A	N/A	N/A	N/A
Total	**$3,000,000**					

2.3 National Sustainability Profile Update

The Sustainability Index and Dashboard (SID 2.0) was completed in late 2015 through a collaborative process with full engagement from PEPFAR (Cameroon field team and remote support from Headquarters), the GRC, GFATM, CSOs, and UNAIDS. SIDs are now requested every 2 years in order to better capture progress, given that most indicators won't demonstrate progress on an annual time frame. The next SID process will take place in early FY18.

Sustainability Strengths

As identified in SID 2.0, planning and coordination is the strongest sustainability element, followed by financial/expenditure data and civil society engagement. In SID2.0, all stakeholders recommended that planning and coordination would require continued support to ensure that Cameroon is successful in implementation of Test and Start. The GRC has started preparations for the GFATM concept note (2018 – 2020) to support the national TB and HIV programs as well as for the National Strategic Plan 2018 – 2022. PEPFAR and GFATM will continue support for the continuum of care for the general population and KPs. PEPFAR and GFATM coordinate to avoid overlap and are standardizing approaches used in community strengthening.

Sustainability Vulnerabilities

Quality management and laboratory were identified as the weakest elements from the SID 2.0.

Cameroon still needs support in laboratory governance within the health structure and in laboratory quality management systems that meet international standards. Cameroon continues to have poor lab infrastructure. These vulnerabilities have implications across reaching and maintaining the 1st, 2nd, and 3rd 90s.

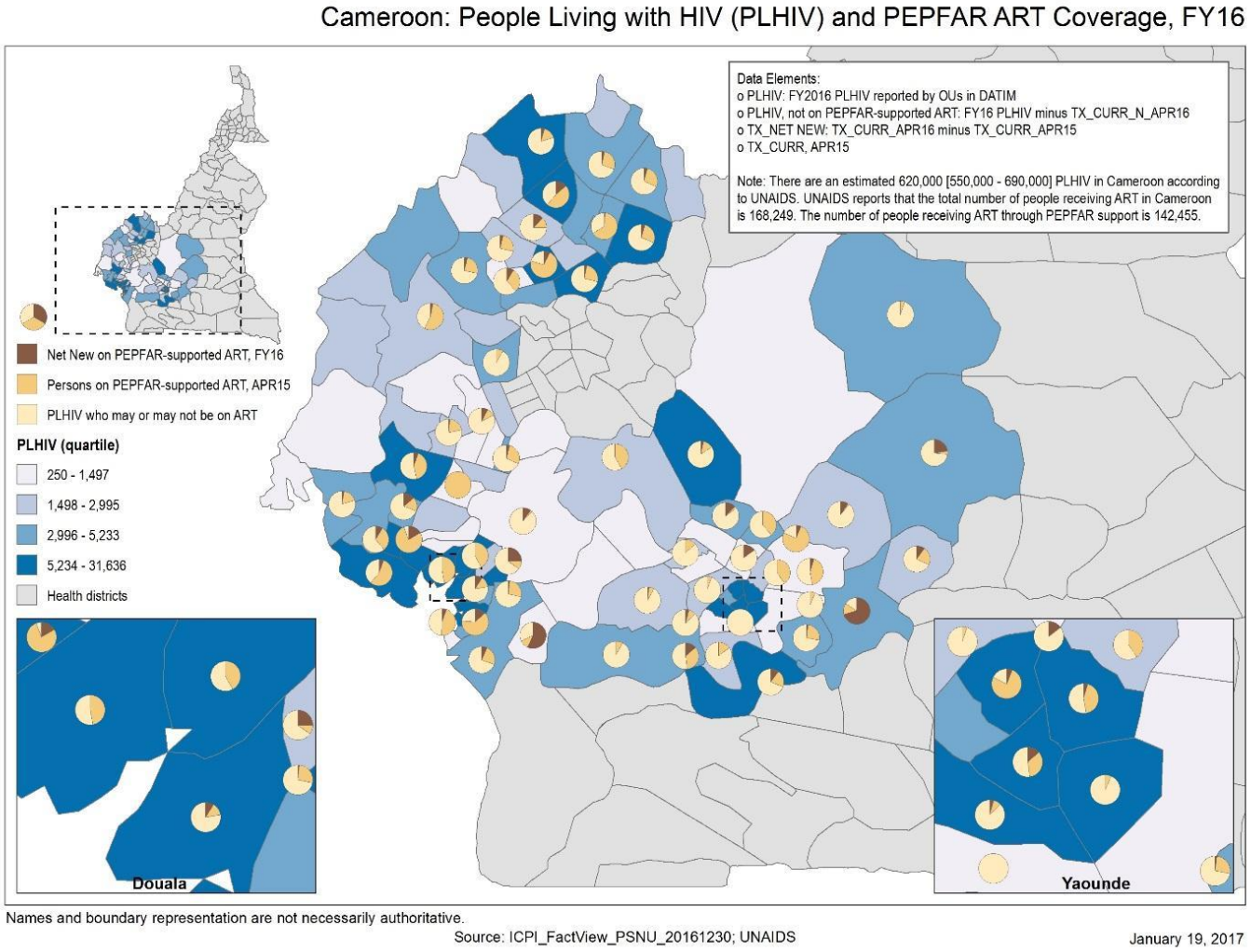
Policies and Governance was highlighted as a sustainability vulnerability, but the GRC has made great strides to address this element since SID 2.0. The strategic document for the Test and Start strategy has been finalized, which includes: HIV testing and retesting for verification both in facilities and communities; differentiated service delivery models, including for different subpopulations; and multi-month scripting for stable patients, including community dispensation and LTFU strategies. PEPFAR has supported Cameroon in the implementation of Test and Start by improving the quality of services provided and by providing significant technical assistance in scale-up districts, sites with high yields, and KP hotspots. At the health facility level, multi-month scripting has been implemented, but not necessarily systematically (depending on the decision of the prescriber, the level of adherence by the patient, and the availability of ARVs). In early FY17, a ministerial circular was issued that addresses cost barriers, specifically on the distribution of free patient charts, which eliminates the fees for patients to open their files. PEPFAR Cameroon will continue to engage with GRC towards developing a national policy and guidelines for KPs.

A National Strategic Plan for Laboratories has been finalized, costed, and translated into English. An operational plan on routine viral load has been developed and viral load is currently being scaled up in country and the previous package of laboratory follow-up tests for PLHIV has been reduced to VL or CD4 count only, thus reducing the VL costs from 21000 CFA (about $33) to 5000 CFA (about $8). However, the reduced cost remains a barrier for many patients. Reaching the 3rd 90 will continue to be difficult with minimal funding for VL. PEPFAR has actively engaged with GFATM to strategize on strengthening national quantification and procurement of reagents and supplies for rapid testing, EID and viral load to reduce the gaps in stock outs and service disruptions. However, some stock outs have been reported.

Weak procurement and supply chain management of HIV/AIDS-related commodities, which affects reaching the 1st, 2nd, and 3rd 90s, has remained a vulnerability with insufficient warehouse and inventory level optimization, insufficient institutional capacity to use HIV pharmacy information for decision making (fragmentation between logistics and strategic information, tools, and reports), and an inadequate supply of commodities to meet demand for new strategies such as PITC, retesting for verification, and proficiency testing (PT) panels. GRC supply chain staff have not yet been trained at the national, regional or district facility level. Clinical partners have trained staff on supply chain at the facility level. The supply chain partner is developing technical guidance to countries on how to implement multi-month scripting.

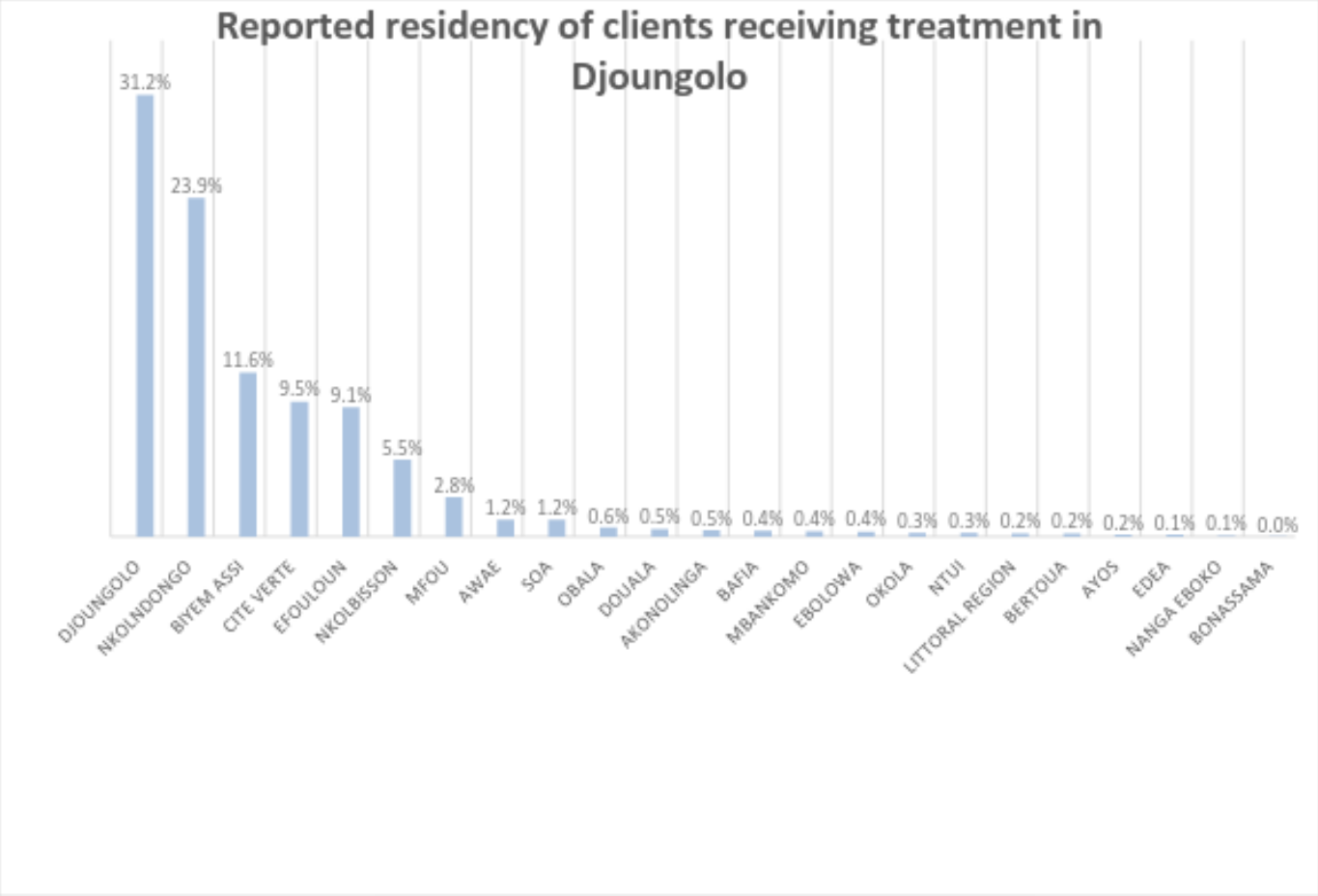
2.4 Alignment of PEPFAR investments geographically to disease burden

Figure 2.4.1, Cameroon: PLHIV and PEPFAR ART Coverage, FY16



The map and insets presented in figure 2.4.1 show that the greatest burden of PLHIV remains in the clusters of districts around Cameroon's two urban centers: Yaounde and Doula. The Yaounde cluster will expand beyond the scale-up district of Djoungolo to include Nkolndongo, Biyem Assi, Cite Verte, and Efoulan. The Douala cluster will expand beyond the scale-up district of Deido to also include Cite des Palmiers, Nylon, Bonnassama, New Bell, Logbaba, and Mbangue. The lower left hand inset shows a large-scale version of the Douala cluster, and the lower right shows a large-scale version of Yaounde. The inset maps help visualize not only the large number of PLHIV living in these two urban areas, but also that the number of persons not on PEPFAR-supported ART (and possibly not receiving any treatment) exceeds 50% in most of the Douala and Yaounde clusters.

Figure 2.4.2 Reported Residency of Clients Receiving Treatment in Djoungolo District (Yaounde)



For COP16, PEPFAR Cameroon had selected Deido, one district of Douala, and Djoungolo, one district of Yaounde, to be targeted for scale up. However, as demonstrated in Figure 2.4.2 within the Yaounde cluster, clients often cross district barriers to receive their HIV diagnosis and treatment. As an example, only 31.2% of Djoungolo clients receiving treatment in Djoungolo report residing in Djoungolo, while the remainder comes from neighboring districts to receive treatment. Likewise, it was found that Djoungolo clients also often cross district boundaries to receive HIV diagnosis and treatment. The same phenomenon impacts Douala, making it impossible to reach epidemic control by scaling up only one district at a time due to the movement to seek care. In order to address both the great HIV burden and the movement across districts for care and treatment, PEPFAR Cameroon is expanding geographic focus to cover both urban centers, which will make it possible to achieve epidemic control. This geographic realignment should cover nearly all clients moving across districts in the two urban centers.

In COP 2015, facility-based care and treatment services (FBCTS) activities were initiated in clinics with a high yield of HIV-positive patients within the priority and sustained districts. In COP 2016, PEPFAR Cameroon continued to focus FBCTS activities in clinical sites with the highest number of HIV patients (11 and above) and/or PMTCT sites with more than 5 HIV positive patients. The redirection of PEPFAR investments away from PMTCT clinics with no and/or low yield, which started in COP 2015 when 1,247 PMTCT clinics were transitioned to the GRC, continued in COP16 with an additional 255 PMTCT clinics transitioned to GRC and those resources redirected to high yield ART and/or PMTCT sites. For COP17, an additional 74 sites with ten or fewer ART clients and four or fewer positives per year will be transitioned to GRC. PEPFAR investments from sites with no and low yield will be redirected to scaling up care and treatment for newly initiated patients on ART in the scale-up clusters.

Figure 2.4.3 Expenditure by SNU, FY16

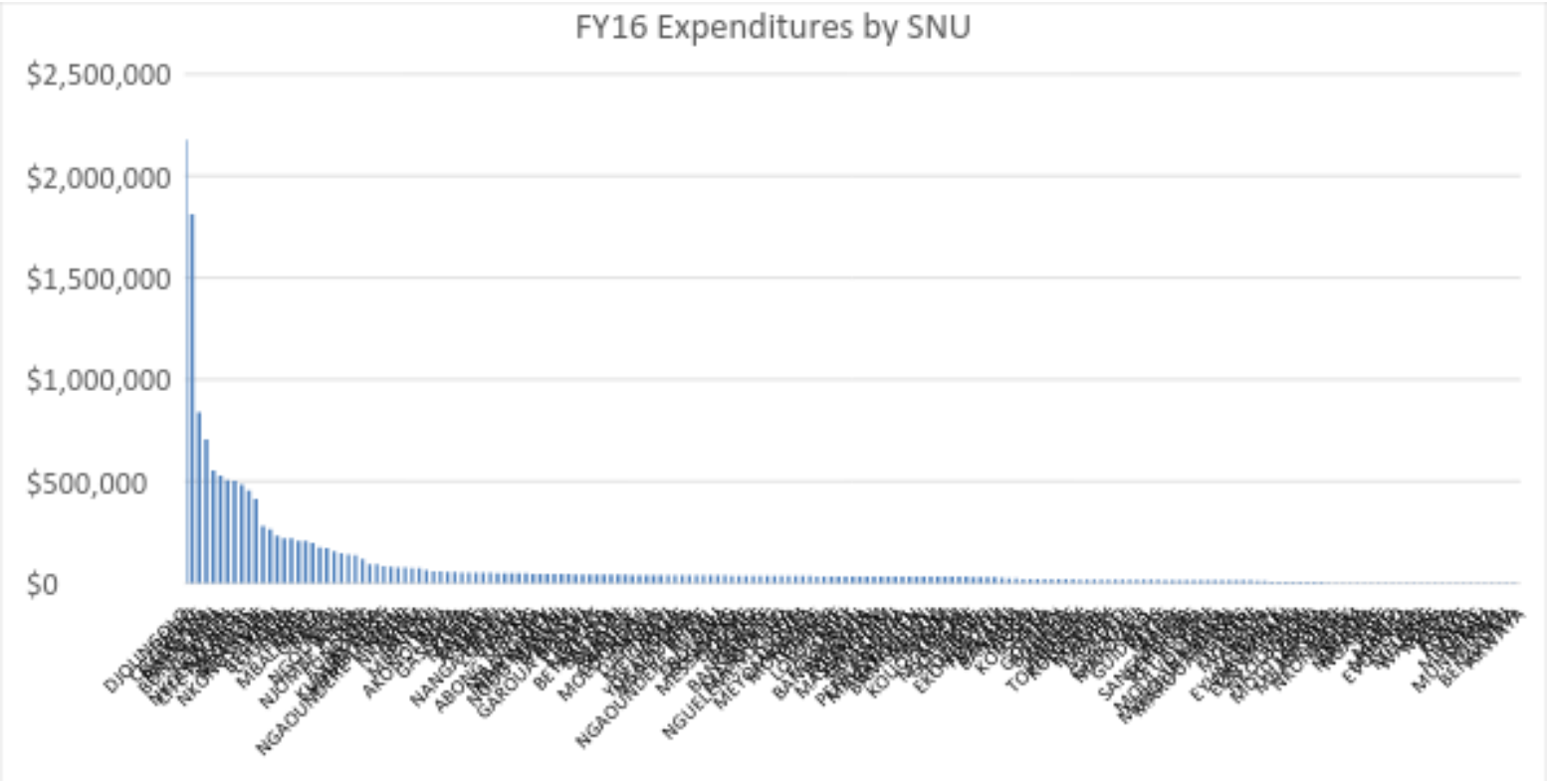


Figure 2.4.3 shows FY16 expenditure by SNU. The COP program pivoted between FY16 and FY17 and is pivoting again for FY18, so this figure does not fully reflect the pivot made for FY17, where the scale up regions are Deido and Djoungolo. Likewise, in FY18, we will expect the see more funding around the Yaounde and Douala clusters. The Yaounde cluster has been receiving a high proportion of funds (including Djoungolo, Cite Verte, Biyem Assi, Nkolndongo, and Efoulan, which are five of the top six funded SNUs). The Douala cluster will receive an increasing proportion of funds in FY18, beginning with a concentration on Deido as a scale-up SNU for FY17.

2.5 Stakeholder Engagement

Supporting the GRC in a national unified HIV response, PEPFAR Cameroon has coordinated and continues to coordinate with all relevant stakeholders. PEPFAR Cameroon meets with government stakeholders on a quarterly basis to brief them on program status and updates as well as to discuss policy development and implementation. In the development of COP 2017, PEPFAR collaborated with the host government, multi-laterals and CSOs to ensure a shared understanding of the COP17 strategic direction, geographic expansion to the cluster model, and programmatic challenges. PEPFAR Cameroon reiterated the prioritizing of strong partnerships with GRC and GFATM to reach sustained epidemic control.

PEPFAR Cameroon works with UNAIDS to convene quarterly meetings with CSOs for dissemination of PEPFAR quarterly data. Representatives from organizations of PLHIV, KP, AGYW, OVC, PMTCT and faith-based organizations (FBO) participate in the meetings. Additionally, to strengthen existing and to build new partnerships with CSOs, PEPFAR Cameroon will conduct office and site visits to local CSOs while undertaking field visits such as SIMS. It is expected that this approach will foster a more inclusive environment between PEPFAR and CSOs.

PEPFAR Cameroon has strong coordination with the GFATM to address potential program overlaps, procurement and commodities challenges and to ensure that key and priority populations have improved access to HIV prevention, care, and treatment. A mapping of GFATM and PEPFAR investment will be undertaken to eliminate duplication of effort.

PEPFAR is strategically placed to provide substantial support to the development of GFATM's new funding model grants in 2017. Additionally, PEPFAR Cameroon holds a permanent membership in the Country Coordinating Mechanism (CCM) and participates in all CCM meetings, ordinary and extraordinary, and is a member of the Oversight Committee. PEPFAR continues to follow-up on the conditions of the CCM eligibility after the Eligibility and Performance Assessment (EPA), and a Performance Improvement Plan (PIP) were conducted in FY16. A roadmap was developed for this follow-up to ensure that the CCM stays eligible for GF funding, given that the three disease programs will develop their respective Requests for Funding for the period 2018-2020 in FY17. PEPFAR chairs a subcommittee for the development of a communication strategy to improve their transparency, visibility and governance, particularly with civil society, as required by the GFATM CCM Guidelines.

PEPFAR Cameroon sits on the Health Sector Partners group which brings together all of the large donors intervening in the health sector to coordinate programming, encourage collaboration and avoid duplication as well as exchange information on any issues or initiatives coming from the government. The group is chaired by the WHO Representative and includes senior representation from other UN agencies including UNAIDS, UNICEF, and UNFPA, other international organizations such as the World Bank, representatives of bilateral missions notably the French and Germans, and INGOs such as CHAI. The group meets monthly and the USG is represented by agency leads for USAID and CDC.

3.0 Geographic and Population Prioritization

Following the COP16 programmatic pivot to scale up in the urban health districts of Deido (in Douala) and in Djoungolo (in Yaounde) in order to reach the greatest number of PLHIV, PEPFAR Cameroon conducted an analysis of where patients access ART facilities vs. their place of residence. It became clear that, in many cases, patients were receiving services in one of the scale-up districts then returning to their residence in a neighboring district. Specifically, an analysis of patients accessing services in the Djoungolo health district showed that 31.2% of patients served were residents of Djoungolo, while 54.1% were residents of four peripheral districts. Using a cluster approach to expand out from the Deido and Djoungolo health districts enables logical expansion of ART coverage to move Cameroon to epidemic control.

45% of all PLHIV in the four PEPFAR supported regions are concentrated in the urban clusters in the metropolitan areas of Yaoundé and Douala. The Yaounde metropolitan area (Centre region), including Djoungolo, Nkolndongo, Biyem Assi, Cite Verte and Efoulan districts, contains 59.5% (99,947) of the PLHIV residing in the two urban clusters. Conversely, the Douala metropolitan area (Littoral region), including Deido, Cite de Palmiers, Bonnassama, Logbaba, Mbangue, New Bell and Nylon districts, contains 40.5% (68,100) of the PLHIV residing in the two urban clusters. To reach both populations, PEPFAR Cameroon will concentrate its efforts in 45 health facilities classified as aggressive scale-up in order to reach the ambitious target of 60% ART coverage in the 12 districts within the Douala and Yaounde clusters by the end of FY18. In order to reach this goal, treatment new targets in the two clusters are set for 39,372 in FY16; 88,722 in FY17; and 51,882 in FY18. Substantial effort will be required, particularly in FY17, but PEPFAR Cameroon expects to reach these targets. The following table demonstrates the estimated PLHIV burden in the cluster districts.

In addition to the urban cluster focus, PEPFAR Cameroon will continue to prioritize KP, including female sex workers (FSW) and men who have sex with men (MSM) in 11 hotspots, 10 of which are in the Yaounde and Douala scale-up clusters. The new cluster approach improves alignment with KP activities by ensuring that the health facilities nearest the hotspots are all now considered scale-up facilities. One additional hot spot is in Bamenda, which is considered sustained for adults, but scale-up for children, KP and OVC. Yields across these 11 sites remained consistently high in FY16, averaging approximately 19% for FSW and 22% for MSM, and it is expected that these yields will be sustained or even increase through FY17 with full scale-up of the Enhanced Peer Navigation (EPN) model. Of 22,701 new adult positives identified in PEPFAR scale-up sites in FY16, 1,862 (8%) of these were diagnosed in KP drop-in centers. Based on targets set for COP 17, KP sites will contribute 3,015 (15%) new positives in FY18.

PEPFAR Cameroon will also continue to focus on two priority populations, the military and AGYW. The last SABERS study, conducted in 2011, showed 6% HIV prevalence among military service members, compared to 4.3% prevalence in the general population (DHS 2011). Programmatic data from FY16 shows higher prevalence in military personnel who have been in service for more than five years, suggesting an increased incidence in this subpopulation, all of whom were seronegative for HIV

on recruitment. These preliminary findings will be further examined through a new SABERS study planned in COP 17. This study is expected to confirm the need to continue focusing on this population group to stem the tide of new infections and reach epidemic control. Stigma and discrimination continue to hamper efforts of military personnel to seek ART services and remain on treatment. To address this, PEPFAR will focus on outreach to increase the high military command's understanding of the need for military personnel of all ranks to know their HIV status and that early initiation of ART contributes to a healthy military force. This outreach includes sensitizing the high command to the urgent need to address stigma and discrimination and incorporating lessons on stigma and discrimination in all PEPFAR trainings addressing the Cameroonian Armed Forces (CAF).

With regard to AGYW, Peace Corps Volunteers will continue providing TA using a DREAMS-like community-based HIV prevention package of services in 21 sustained SNUs. HIV prevalence remains three to four times higher among AGYW than among the male population of the same age group (DHS, 2011); it is clear that unprotected sex with adult men is a major factor responsible for such disparity in prevalence rates. As a result, risk avoidance and reduction using behavior change interventions will remain a top priority. To ensure that AGYW's risks are comprehensively addressed, engagement of key influencing populations such as adolescent girls' parents, guardians and partners will be reinforced using appropriate age/sex curriculums delivered in a culturally appropriate manner.

In addition, beginning in FY17, through its KP project, PEPFAR Cameroon began offering an enhanced package of services to adolescent daughters of FSW, which will continue in FY18. In recognition of the extreme vulnerability, regular exposure to violence, and high risk of entering sex work of this subpopulation, resources will be focused on risk avoidance, risk reduction and gender-based violence (GBV) prevention, care, and support. Children of FSW are expected to contribute 129 new positives toward pediatric targets for epidemic control.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	0	0	0	
Scale-up Saturation	0	70,919	1	12
Scale-up Aggressive	168,047/40%	0	1	0
Sustained	203,937/48%	71,536	56	45
Central Support	48,512/12%		33	34

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

4.1 Targets for scale-up locations and populations

Based on geographic and population prioritization decisions made for COP 17, PEPFAR Cameroon used national and PEPFAR program data on current treatment coverage to calculate the total number of additional PLHIV to be initiated on treatment in order to reach 80% ART coverage in the Douala and Yaounde scale-up clusters by the end of FY19. A total of 9,415 net new PLHIV need to be placed on treatment by APR FY18 in order to achieve the 2019 goal. In FY18, PEPFAR Cameroon will initiate 19,498 new patients on treatment in the scale-up clusters (Table 4.1.1). Using the cascade approach to setting HIV testing targets, PEPFAR Cameroon considered several critical program streams to more efficiently identify HIV positives and effectively link them to C&T. Given the high burden of TB/HIV co-infection (29-44%), high rates of TB-related mortality among PLHIV, and their ability to access existing PEPFAR-supported care programs and GRC-supported TB clinics, PEPFAR has increased the number of TB/HIV co-infected patients identified and the percentage initiated on ART to 100% by the end of FY17, which will continue in FY18. The remaining required to meet the target for PLHIV newly initiated on ART in scale-up districts will be identified and linked to treatment via provider-initiated, voluntary, and mobile counseling and testing models targeted to KP and priority populations (Section 4.5).

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY18) HTS TST	Newly Identified Positive (APR FY18) HTS TST POS	Newly initiated on ART (APR FY18) *TX_NEW*
Adults			
TB Patients	***2,067***	**535**	**535**
Pregnant Women	***136,189***	**4,424**	**4,556**
VMMC clients	***0***	**0**	**0**
Key populations	***12,855***	**3,015**	**2,714**
Priority Populations	***9,913***	**818**	**682**
Other Testing	***118,635***	**8,405**	**7,457**
Previously diagnosed and/or in care		**2,925**	**2,925**
Total Adults	**279,659**	**20,122**	**18,869**
Pediatrics (<15)			
HIV Exposed Infants	***7,281***	**113**	**107**
Other pediatric testing	***30,428***	**580**	**428**
Previously diagnosed and/or in care		**94**	**94**
Total Pediatrics	***37,710***	**788**	**629**
TOTAL	**317,369**	**20,910**	**19,498**

*Data derived from Data Pack tool

Both linkages and positivity yield are expected to improve in FY18, given the plans to scale up index testing modalities, linkage and retention activities, and screening for people at risk from certain settings (such as adolescent friendly health services and venue-based testing). Additionally, though the ACT initiative ended in FY16, PEPFAR Cameroon plans to continue to improve pediatric yields with family index testing and a pediatric screening tool. Introduction of the family model for HIV clinical services and adolescent friendly HIV services should continue to improve pediatric program performance.

The military health facilities will test 33,479 individuals (military and civilians) with an expectation of finding 2,402 positives and linking 2,162 individuals to treatment. Of the 33,479 people to be tested, 9,913 will be active duty military personnel resulting in the likelihood of 818 positives and linking 682 to treatment.

PP_PREV will be offered to 5,648 military personnel, of whom 2,648 will be new recruits who had recently tested negative on recruitment and have known status. Offering PP_PREV to this group will enhance their knowledge on how to remain HIV negative. 400 AYGW aged 15 – 30, who live within military barracks, will be targeted in a bid to prevent new infections and empower them with positive life skills and adoption of seeking medical services to know their HIV status or other health related issues. For those to whom the PP_PREV package will be offered, 47% will be tested during the mobile campaigns offered by the military community IP. This 47% represents active duty military personnel who have been in service for more than 5 years. Given the programmatic 6% yield in active military personnel who have served for more than 5 years, the DoD Community IP will actively test this group and ensure linkage to treatment services. The new military recruits, as well as the AYGW, will be encouraged and provided with HIV testing referral slips, if their last HIV result dates older than 6 months.

In order to set targets for KP, as in previous years, PEPFAR applied size estimation proportions from Papworth, 2014 (MSM and children of FSW), and the World Bank, 2016 (FSW) to the age-appropriate male/female census information for the 11 KP hotspot districts. Based on these estimations, FY16 and FY17 Q1 achievements, and calculations based on net new cases needed to achieve 60% coverage in the two scale-up clusters, PEPFAR set ambitious but attainable targets for FY18 for KPs reached and tested for HIV. Based on past performance and expectations of improved targeting with the EPM model, yield was set at 25% for FSW and 20% for MSM. For children of FSW, targets were set based on preliminary data for FY17 as this was a new activity. FSW were estimated to have on average 1.5 children per mother living at home, so the FY18 target for reach was set at 1.5 times the number of expected HIV-positive FSW. The projected yield is based on the 5.6% recorded in Q1 of FY17.

Table 4.1.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY18 Target
AGYW	0	0	0
FSW Clients	**0**	0	**0**
KP_PREV(MSM)	**11,216**	**56%**	**7,750**
KP_PREV(FSW)	**14,928**	**75%**	**17,250**
Total	**26,144**		**25,000**

*Data derived from Data Pack tool

For OVC, PEPFAR Cameroon considered past performance (13,830 OVC_SERV DSD in FY16); OVC size estimations; estimated number of children added in implementation year 2017 (7,539) in health districts that fall within the Yaounde and Douala clusters/KP hotspots (Djoungolo, Nkolndongo, and Deido), and Bamenda health district which is a KP hotspot; and the estimated number of children that will age out at the end of the FY18 in order to establish targets. Based on these calculations, PEPFAR Cameroon will expand geographic coverage within the Yaounde and Douala clusters and continue activities in Bamenda health district with the target of reaching 22,282 OVC and caregivers with DSD and TA-SDI services. Additional OVC targets for sustained districts covered by Peace Corps will be detailed in Section 5.

Table 4.1.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target)
		OVC_SERV	OVC*
Yaounde Cluster	**265,456**	**9,688**	**9,289**
Douala Cluster	**164,461**	**4,279**	**4,111**
Bamenda	**30,026**	**5,207**	**5,139**
Other sustained SNU	**3,108**	**3,108**	**2,360**
Total	**463,051**	**22,282**	**20,899**

*Data derived from Data Pack tool

Uncertainties regarding population estimates, as well as program data and data quality, continue to be limitations in assessing the HIV epidemic. PEPFAR Cameroon will continue to work with UNAIDS to improve estimates, as well as work closely with partners to improve quality of program data.

4.2 Priority and Key Population Prevention Summary

In COP 17, PEPFAR will continue to focus its prevention efforts on key and priority populations including MSM, FSW, AGYW and the Military. In addition, PEPFAR will continue to scale up work began in COP 16 to expand a comprehensive dreams-inspired prevention approach to children of FSW (cFSW) and those living within hotspots.

KP prevention efforts will remain focused on 11 hotspots, 10 of which now fall into the newly defined scale-up clusters of Yaounde and Douala and one in Bamenda, considered sustained for the general population but scale-up for KP. In these hotspots, PEPFAR will continue to scale up targeted community interventions focused on preventing new HIV infections and strengthening identification and linkage to treatment for those who are already HIV positive. Support for national condom and lubricant forecasting and procurement will continue in FY18, largely tailored to priority populations and KP. Work begun in FY17 to ensure KP-friendly service delivery in PEPFAR supported health facilities and differentiated models of service delivery including community-based dispensing of ART will be scaled up and reinforced.

<u>Key Populations</u>

Since 2014, PEPFAR Cameroon has served as an example of technical leadership and innovation in the national KP response. As part of its sustainability agenda, PEPFAR will work with GRC, GF, UNAIDS, and other partners to develop and update national policies, tools and standardized approaches for KP programming and monitoring and evaluation. PEPFAR will also continue to engage with other stakeholders beyond the health sector such as local authorities, police, and the military to create an enabling environment in which FSW and MSM are able to access health services free from stigma, discrimination, or fear of violence.

KP service delivery begins at the community level and for those testing positive for HIV, includes a continuum of services provided both within the community and at the health facility. Under the Enhanced Peer Education and Mobilization (EPM or EPEM) model, outreach and prevention messaging, as well as distribution of male and female condoms and lubricant, are conducted by trained peer educators. Within the EPEM model, index case testing using social networks of KPs will be done to reach children of FSW and other KPs. The EPEM model also uses sexual networks for clients and regular partners of FSW and partners of MSM. Peer educators (PE), sometimes known as Peer Leaders (PL) are members of the KP community who conduct group trainings around HIV prevention, testing and service availability as well as distribution of prevention commodities. Systematic STI screening is done for all KPs reached. FY 17 Q1 programmatic data revealed that of the

4.3% of KPs presenting with STIs, 62% (132) were FSW. Both MSM and FSW have expressed a preference for testing at Drop-in Centers (DIC) over mobile testing, peer educators/leaders have played an increasing role in driving KP testing activities. PL or PE are paid a base remuneration and then operate on a performance-based incentives approach for the number of clients who are received and tested at the DIC.

Once a KP is tested positive for HIV, he or she will be assigned a Peer Navigator (PN). PN are normally PL or PE who are identified as living successfully with HIV/AIDS and have been recruited and given additional training. Their job is to accompany HIV+ clients throughout the process from diagnosis to enrollment on ART and beyond to long-term adherence support. Beginning at diagnosis, PN provide counseling services to ensure that clients accept their results and are willing to go on treatment. If treatment is provided onsite at the DIC (currently only one DIC is offering this service) the client can begin treatment immediately. In other cases, the PN will physically accompany the client to the health facility and present them to the designated KP-friendly provider in what is known as the "handshake" between the community and facility provider. Beginning in FY17, PEPFAR is working to ensure that this handshake takes place directly following diagnosis to enable same day initiation at the health facility.

After enrollment on ART, the PN continues to follow the client, focusing on the Positive Health and Dignity model and assisting with access to psychosocial, nutritional and other services, including other clinical services such as STI treatment and post-GBV care supported by the Global Fund. The PN provides routine adherence counseling and actively works to bring back any clients lost to follow up. PN or PE/PL may also assist in contact tracing to ensure that the index patient approach is successfully applied to each new case diagnosed and that prevention messages reach those most at risk.

Due to relatively low yields noted in FY16, clients and partners of FSW have not been retained as a priority population and thus no targets have been set. That said, they will continue to benefit from some prevention activities. FSW peer mobilizers (PM) will continue to provide sensitization on HIV prevention and encourage their clients and regular partners to seek testing at DICs or health centers.

In terms of partner management, PEPFAR staff will continue monthly data review meetings begun in FY17 and increase the number of non-SIMS site visits to both hotspots and DICs. Overall, partner performance has been satisfactory and the partner has shown considerable initiative in introducing and evaluating new strategies to expand reach and maximize impact.

With regard to creating a more favorable legal environment for KPs in Cameroon, PEPFAR and the Embassy continue to play a leading role in advocating for LGBT rights and intervening when those rights are violated. *[REDACTED]* That said, the continuing existence of KP stigma and the lack of adequate legal protections underscore the importance of long-term community-based care and support for adherence and retention well beyond the handshake with the clinical facility.

Priority Populations

In FY18, PEPFAR Cameroon will continue to provide high quality prevention and other services to AGYW and the military. PEPFAR will also scale-up activities aimed at children of FSW, which began in FY17.

AGYW

The majority of AGYW will be served directly by Peace Corps Volunteers in sustained districts and will be discussed in Section 5.2. Adolescent daughters of FSW will also be reached at all 11 KP hotspots in Yaounde, Douala, and Bamenda. In FY17, PEPFAR began offering systematic HIV testing to all children of HIV positive FSW. In FY18, this will be scaled-up to reach all children of FSW, regardless of the mother's HIV status, who meet risk criteria including sexual activity or GBV as well as those children living within hotspots. Children testing positive will be immediately accompanied to treatment sites and all children will be referred for OVC services focusing on risk avoidance, school enrollment and household economic strengthening. Given their particular vulnerabilities with regard to GBV and the risk of entering sex work, adolescent daughters of FSW will be offered an enhanced DREAMS-inspired package which includes the basic OVC package but places additional emphasis on GBV prevention and post-GBV care and, for older adolescents, access to the full complement of family planning services. An AGYW package of tailored services will be delivered at the health facilities when an AGYW is referred or identified at the facilities.

Military

In COP 17, PEPFAR will continue to offer a combined prevention package including promotion of testing to military service personnel in order to promote awareness and avert new infections. The PP_PREV package will include continuous sensitization on HIV, referral to HIV testing services and enhanced education for participants to encourage them to seek medical attention in health facilities. Education on correct condom use and distribution of condoms will be made available to all military personnel especially those going on deployment. The use of mobile testing targeting barracks situated near commercial sex work hot spots or during training of some military groups will be used to better target those to be tested. Alcohol and substance abuse use will be also included in training modules as well as gender equality. Those military personnel who test positive will be given a modified PP_PREV package focusing on PHDP. For those presenting with symptoms of TB or STI, referrals will be made to health facilities. Linkage agents in communities will actively link those tested positive to facilities using the triplicate linkage forms developed by PEPFAR Cameroon. In communities as well as in facilities, adherence education, psychosocial support, nutritional counseling, and family planning counseling will be carried out by lay counselors to improve treatment adherence and retention. LTFU campaigns that started in FY16 will continue as well as SMS reminders two days before ART pick up. Testing of families or sexual partners of index case will be used at different entry points.

4.3 VMMC Summary

PEPFAR Cameroon does not implement VMMC programming.

4.4 PMTCT Summary

Cameroon updated its National ART Guidelines in 2016, expanding the implementation of Test and Start for all HIV-positive individuals including pregnant women, in lieu of the previous Option B+ policy. In FY18, PEPFAR Cameroon will align with the national Test and Start strategy to ensure complete decentralization of ART in PMTCT standalone programs and institutionalization of a comprehensive family HIV care and treatment program.

2017 Spectrum data show that an estimated 845,048 pregnant women will attend ANC, and about 34,028 HIV positive pregnant women will need PMTCT services (HIV positivity rate of 4.0%), compared to 33,192 projected in 2016. The GRC has noticed a downward trend in the national HIV seropositivity rate for pregnant women from 6.3% in 2014 to 4.7% in 2016 (MOH, 2016) and a seroconversion rate of 5% for pregnant women who tested negative at first ANC. The MOH is emphasizing the retesting of all HIV negative pregnant women at ANC and in labor and breastfeeding.

Cameroon's mother to child HIV transmission rate is 5.6 % at six weeks (MOH, 2015) and 25% by 18 months, contributing roughly 7,300 of 9,500 newly infected children annually (UNAIDS, 2014). Only 65% of HIV Exposed Infants (HEI) had a DNA PCR test done by two months of birth while 84% of HIV-exposed and infected infants <1-year-old enrolled on ART (MOH, 2015). The 2016 NACC annual report revealed some successes in the PMTCT program. These include an increase in ANC attendance from 69.5% in 2014 to 78% in 2016 and up to 635,178 (97%) of pregnant women receiving an HIV test, with 29,693 (4.8%) identified HIV-positive and 19,940 (67%) positives initiated on ART nationwide.

In FY18, PEPFAR Cameroon's PMTCT strategy will support the pivot to epidemic control in the two scale-up clusters. This strategy will include decentralization of ART to PMTCT standalone using a family treatment approach, strengthening HIV retesting and the same day ART initiation model, enhancing infant virological testing (IVT), community-facility linkage through community health workers (CHW), and scale-up of PMTCT cohort monitoring for the mother-infant pair. PMTCT implementation will be sustained across 306 health facilities (HF) and scaled up in 45 HF in the two scale-up clusters. A total of 74 HF with low HIV yield (≤ four positive pregnant women per annum) out of the 425 HF in the four PEPFAR-supported regions in FY17 will be transitioned to GRC and GFATM in FY18.

The FY18 PMTCT package in scale-up clusters will include demand creation and PITC at all entry points for pregnant and breastfeeding mothers. Partner notification through family testing, HIV retesting, same-day ART initiation, intra-facility and inter-facility linkages using appointment and linkage logbooks, SMS reminders on ART pick up, in-service training, monthly mentorship, and supportive supervision visits will also be part of the package. The scale-up clusters will also benefit

from VL testing during pregnancy and annually thereafter for stable patients and the use of "Bikers for Health" for HIV sample transport. The PMTCT Cohort register will be scaled up to monitor outcomes for HEIs and the mother-infant pair on ART. Furthermore, retention agents will strengthen community-facility linkages through active defaulter tracing programs and home visits, and in psychosocial support group programs. The Nigerian church-based baby shower program will be adapted to the context of Cameroon and scaled up and linked to PMTCT and ART programs. PEPFAR Cameroon will continue to support the implementation of FP integration in the PMTCT and HIV C&T programs, which was scaled up in FY17 in the Yaounde and Douala clusters. Program implementation will be in compliance with USG legislation and will integrate a mix of methods (short and long term FP methods) in HIV C&T. UNFPA Cameroon and other stakeholders will supply FP commodities.

All PEPFAR sites will continue to use the upgraded PEPFAR/GRC specified Option B+ M&E Framework and tools produced with the PMTCT/ART integration funds and will be integrated into the patient electronic management records (EMR) once EMR are piloted. SIMS re-visits will be prioritized to sites that score red during initial visits.

Currently, partner management and monitoring activities undertaken by PEPFAR Cameroon include monthly activity management meetings using an existing reporting tool to check on implementation of work plans; check on achievements on reaching targets in relation to spending; and discuss and verify site visits conducted. PEPFAR Cameroon also conducts quarterly data reviews with partners to check data collection and quality and provide feedback on previous quarters' data. PEPFAR Cameroon also undertakes SIMS visits which provide valuable input for follow up with partners to improve service quality. In Q4 of FY16, PEPFAR started visiting selected sites to address performance based on Panorama results, sometimes in conjunction with SIMS visits ("SIMS plus").

In FY18, PEPFAR Cameroon will reinforce the ongoing partner management and monitoring activities to show more visibility and better assist the partners. PEPFAR Cameroon will closely manage implementing partners to improve performance in the clusters through monthly meetings, regular site visits by USG staff and bi-weekly reporting. The Tanzania partner management model that utilizes more elaborate monitoring tools will be adapted for use by USG staff to conduct partner performance monitoring. This model allows for planning; implementing and reporting; analysis; interpretation and decision making; and feedback and remediation. All these phases are needed to inform new strategic planning and funding allocation.

Finally, PEPFAR Cameroon will implement the mentorship model, where mentors from high performing sites mentor other smaller sites.

4.5 HTC Summary

GRC's policy for HIV testing, released in January 2016, required provider initiated testing and counseling (PITC) for all individuals attending any health facility to seek any medical attention. In 2016, GRC provided HTC services to 1,689,696 clients, compared to 882,639 clients in 2015 with an HIV

positive yield of 6.0% (NACC 2015). This motivated PEPFAR partners, early in FY16, to support widespread HIV testing across all entry points, testing 800,229 clients, and achieving more than twice (212%) the set target of 378,357 clients, with an HIV positive yield of 6.4%. However, the achievement of HIV positive targets following widespread testing was very low, particularly in the scale-up to saturation district of Djoungolo (5.3%). A lower (<6%) than expected HIV positive yield was also observed in this district.

The GRC has traditionally sponsored free mass HIV testing across the country during certain time periods, such as the month leading up to World AIDS Day. During the remainder of the year though, payment for testing is still required for the general adult population, and current policy prohibits HIV testing for minors (under 15 years) without parental consent. The PEPFAR Cameroon team has engaged in discussions with the MOH to consider targeted testing in order to improve on testing yield and maximize resources. This will be facilitated by implementing screening tools to increase yield on HIV testing via better targeted use of test kits. Retesting for verification has been approved within the test and start guidelines and PEPFAR Cameroon will be scaling up this activity in COP17.

FY18 Targets for HTC have been calculated based on the cascade analysis to meet the 60% treatment coverage target in Yaounde and Douala. To reach this coverage in FY18, FY16 APR HIV program positivity rates were used to determine HTC and linkage to treatment, as well as estimates of a 90% retention rate for new and old ART patients. SIMS results were also used to address deficiencies in the quality of service, which has led to the improvement in key low-scoring program domains.

In FY18, PEPFAR Cameroon will continue to prioritize facility and community-based HIV testing to identify PLHIV and link them to treatment, care, and support programs; facilitate stand-alone HTC sites in priority high yield entry points including TB clinics, adult clinics (inpatient/outpatient), KP DICs, pediatric clinics, OVC services, STI services, and military recruits. Specifically, PEPFAR Cameroon will reinforce its HTC program to ensure that HIV testing and identification of HIV infected individuals follows the best use of resources. PEPFAR will implement screening tools to increase the yield of HIV testing for children (modeled after the tool piloted in Zimbabwe) and adults via better targeting of test kits. The service delivery package for HTC will include provision of counselors (psychosocial workers), as needed, renovation of counseling units to ensure confidentiality, monitoring and supervision, and strengthening linkages to treatment via linkage and retention agents. At the facility level in the Yaounde and Douala clusters, PEPFAR Cameroon will undertake demand creation in scale-up sites in order to scale up PITC in all priority high yield entry points (yield 5-12%), including testing clients of index cases at ART and TB services (yield 39%), testing children of HIV infected parents within a family index testing model (yield 16%), and engaging men through partner testing and contact tracing especially for women attending ANC and HTC services. Testing will include venue-based testing also targeting adult males, adolescents, children and those aged below 30 years. At the community level, men will be targeted at non-facility based venues; advocacy is in place for self-testing as an opportunity to reach men who would not usually come to the facility. Targeted mobile testing in hotspots and particular moments (nights) by DICs and CBOs will be continued,

followed by linkages to treatment; special emphasis will be made in ensuring the "handshake" between the community linkage navigators and the clinical linkage and retention (CLR) agents as well as outreach approaches using CBOs and CHWs to encourage referral for HIV testing. Social/network testing of the index case will be used as an additional strategy for testing Key Populations, as well as for the general population.

In FY18, PEPFAR Cameroon will reach 15,162 key and priority populations (representing approximately 56% of KP_PREV as well as 100% of children of HIV-positive FSWs) with emphasis in HTS provided within drop-in centers (DIC). PEPFAR Cameroon has supported the establishment of laboratory capacity within all DICs, enabling them to provide HTS onsite. All DICs are enrolled in a PEPFAR-supported proficiency testing program and receive weekly supervision/mentorship visits from a health facility and PEPFAR-funded lab partner. PEPFAR Cameroon will continue to scale-up the enhanced peer navigation (EPN) model - an adaptation of the respondent-driven sampling method - for targeted community mobilization. EPN is based on the assumption that while overall outreach will decrease, clients recruited via the EPN model are more likely to get tested, more likely to be HIV-positive, and more likely to initiate treatment. At the same time, a significant portion of clients reached through this method may already know their HIV status. No solid data on the percentage of KP with known status exists at present but discussions with community-based partners led to adoption of an initial assumption of 30%. Of the 70% remaining, 80% are expected to accept testing, leading to the 56% target. This assumption may be revised as program data on those with known status becomes available. At each DIC, a skilled psychosocial counselor provides pre- and post-test counseling, and is also responsible for ensuring linkage to treatment for clients diagnosed HIV-positive via community–clinical facility referral and counter referral, known as the "hand shake". HIV-positive FSWs will be encouraged to have their children tested for HIV in addition to children living within hotspots. This will be a joint effort between KP and OVC service providers to ensure all children of FSW and those living in hotspots (irrespective of parent's status) are screened for HIV risk, tested if they meet risk criteria, and referred to the OVC program for comprehensive services. DICs will no longer conduct mobile testing for clients of sex workers due to demonstrated low yields. Nevertheless, clients will continue to be reached with prevention services and FSWs will be encouraged to bring their partners/clients to DICs for HTS.

PEPFAR Cameroon overall will provide HIV testing to 279,659 adults (142,408 in Yaounde and 137,251 in Douala) to newly identify 17,197 PLHIV (9,551 in Yaounde and 7,646 in Douala) and test 37,710 children (18,281 in Yaounde and 19,629 in Douala) to identify 788 CLHIV (447 in Yaounde and 246 in Douala) by focusing and scaling up HTC in the two clusters. PEPFAR Cameroon will reinvest cost savings in HTC from centrally supported sites to scale-up districts in high priority districts with harder-to-reach PLHIV and improve linkage and enrollment to C&T.

In FY18, PEPFAR Cameroon will reinforce the ongoing partner management and monitoring activities to show more visibility and better assist the partners as described in section 4.4 on page 33.

4.6. Facility- and Community-based Care and Support Summary

There are no longer pre-ART steps required by GRC's national ART guidelines but fees associated with establishing a patient file and certain lab tests remain challenges to enrolling and retaining patients in services and achieving viral suppression. Patients surveyed also reported transport costs incurred to access the health facility as a major barrier. To address these challenges, PEPFAR Cameroon will continue to support rapid extension of Test and Start for all populations and scale-up differentiated care models, including multi-month scripting and community dispensation, to minimize transport and other associated costs. The enhanced linkage and retention agent program at the facility level will include stronger client education and counseling to improve retention and adherence. A facility-initiated support group model will also be scaled up to facilitate ongoing support to clients and act as a platform for community ART delivery. In addition, beginning in FY17, PEPFAR will pilot PBF to evaluate its feasibility as an innovative mechanism to reduce or eliminate patient fees, and reinforce the retention and treatment failure committee, which replaced the therapeutic treatment committee. Based on results, PBF will be scaled-up in FY18.

PEPFAR will help the NACC to produce and disseminate the operational plan of the test and start strategy. PEPFAR will also train CBOs in scale-up and sustained districts while working with NACC to accelerate training plans in non PEPFAR supported districts and sites. PEPFAR will support NACC to disseminate community data collection tools and train providers on their use by September 2017.

PEPFAR will provide a comprehensive package of care and support services within the two scale-up clusters as well as KP hotspots, and military sites. The package will improve linkage and decrease the time from diagnosis to treatment, promote adherence, track patients LTFU, support disclosure of HIV status to partners and families and index-patient testing, screen for STIs and other OI, and provide referrals and counseling on good nutrition.

Linkage and retention agents will be in place in all PEPFAR supported facilities and the "handshake" approach will be reinforced, ensuring a seamless transition between community and facility service providers. Adherence activities will include: scale up of same day ART initiation; multi month dispensation of ARVs and community dispensation; trainings for CHWs and peer educators; development of job aids and print materials; and development of tracking log books. CHWs, CSOs, and peer educators will use testing mobilization and tracking tools to track patients within community settings and relink patients LTFU to treatment.

At the community level, DICs and other structures will continue to provide a comprehensive community care package focusing on positive health and dignity for KP, AGYW and the Military. This will include counseling PLHIV on disclosure and the importance of bringing partners and children in for testing, condom use, family planning, alcohol and other drug use reduction. Community support groups will continue to play a strong role in enhancing adherence to treatment. Community tracking efforts will be evaluated by the number of patients brought back into care on a monthly basis, as well as the number of patients referred from communities to facilities. Community-based structures will

also play a key role in preventing GBV and supporting survivors and providing nutritional counseling and in some cases, nutritional support to those who meet clinical criteria.

Ongoing partner management and monitoring of activities to show more visibility and better assist the partners is described in section 4.4 on page 33.

In addition, PEPFAR Cameroon instituted quarterly review meetings FY16 to share field results with military high command. Weekly reporting on key indicators was instituted to assess field performance and make timely decisions. Only HTC, yields, and linkage were addressed in this initial weekly performance reporting, but moving forward PEPFAR Cameroon will increase monthly tracking of no-shows for ART pickups and institute LTFU campaigns. Lastly, PEPFAR Cameroon intends to classify sites by performance and give awards to sites keeping up good performance in a sustained manner.

4.7 TB/HIV Summary

Cameroon has a high incidence of tuberculosis (TB). WHO estimates there were 49,000 (212/100,000) new TB cases in 2015, 6,900 deaths due to TB alone, and 6,200 due to TB/HIV. The National TB program reported 26,117 new TB cases in 2015 (114/100,000) and about 53% TB treatment coverage. National guidelines allow for systematic HIV testing for TB patients, ART for TB/HIV clients and IPT for children 0-5 years old and for all PLHIV. In 2015, 92% of TB patients had an HIV test result with an HIV positive yield of 36% in all forms of TB. In the same year, 122 patients were diagnosed with MDR-TB, and were treated. Pulmonary TB rates reported in prisons are on average close to 10 times higher than in the comparable civilian population. Therapeutic success rate has increased from 72% in 2003 to 80% in 2011, but more efforts are needed to reach the planned target of 85%.

GRC has a network of 238 accessible and functional TB diagnostic and treatment centers (CDTs) corresponding to an average of one CDT per 90,000 inhabitants, and is continuing efforts to further decentralize services to ensure provision of TB and HIV services in the same locations by the same staff. CDTs also provide TB treatment free of charge, routine HIV testing among TB patients and detection of drug resistant TB. Nevertheless, the country still faces some challenges, including improving low TB treatment coverage, ensuring a regular supply of medicines, improving the cure rate in major cities and in certain regions, strengthening laboratory diagnostic capacities, systematizing TB detection in PLHIV and management of MRTB, increasing involvement of civil society (CS) and private clinics, improving quality of service delivery and human resources at all levels, and ensuring effective program management at all levels.

Since FY15, PEPFAR Cameroon support for the integration of TB and HIV programs has focused on in-service capacity building for clinicians in TB, PMTCT, and ART clinics in the four PEPFAR-supported regions. These efforts are to ensure that TB screening (basic signs and symptoms) and referral of suspected cases for TB diagnosis and treatment services are in place. It constitutes a core package to increase ART coverage of TB/HIV co-infected individuals and to accelerate planning and implementation of collaborative TB/HIV activities. GRC is offering IPT routinely to children 0-5 years old. In FY16, the MOH, through PEPFAR / Global Fund, began preparations to pilot INH for adults in

50 approved sites over a period of 6 months. The pilot implementation has not yet become operational; only about 02 sites are functional.

In FY18, PEPFAR Cameroon will continue to strengthen HIV integration in TB settings, including HIV testing and ART initiation for HIV positive individuals. PEPFAR Cameroon will continue HIV testing among persons with TB as well as presumptive TB and their contacts and strengthen TB screening among PLHIV. PEPFAR Cameroon will strengthen contact tracing and offer HIV testing and TB screening to contacts of people with TB and household members of PLHIV. ART initiation will be ensured for all TB and HIV patients within 2-8 weeks of initiating TB treatment. Gene Xpert cartridges will be provided to improve timely identification and diagnosis of all PLHIV with TB through improved screening and case detection. The team will work on strengthening active case finding at all entry points among PLHIV, especially among targeted risk groups such as pregnant women, children, and prisoners, using the most sensitive and specific screening and diagnostic algorithms at the facility and community levels. PEPFAR Cameroon will prioritize timely initiation and completion of TB treatment including MDR TB treatment among PLHIV. PEPFAR Cameroon will support site level linkage staff (psychosocial support workers) and CHWs to ensure linkages from all clinical entry points to treatment and care.

PEPFAR Cameroon, in collaboration with the GFATM, will support the MOH to roll out TB preventive therapy (IPT) for PLHIV nationwide. PEPFAR Cameroon will use lessons learned from the scale up IPT pilot for all PLHIV without active TB disease in the scale up clusters.

TB infection prevention and control activities to minimize the risk of TB transmission will continue in scale-up clusters in order to provide a safe health-seeking environment, including improvement of quality management for TB/HIV service. This will also include support for TB monitoring nurses and TB-adapted renovation (infection control / ventilation), cabinets, and minor equipment.

In support of the MOH, PEPFAR will support revisions of National Guidelines, TB/HIV data review meetings, TB/HIV coordinating body meetings, and technical support through mentoring of health care providers in scale up clusters.

Partner management and monitoring of activities is defined in section 4.4 on page 33.

4.8 Adult Treatment Summary

GRC's MOH sent out a missive approving "Test and Start" as an MOH practice in May 2016 and launched the official policy in June 2016. The National Test and Start Guidelines will be fully implemented during FY17. Included in the guidelines are same day ART initiation and community dispensation, which PEPFAR Cameroon will be scaling up to curb service costs incurred by clients and to improve retention. Despite many efforts, service fees still constitute a barrier, particularly for viral load testing. PEPFAR Cameroon will continue to work with the MOH in its efforts to secure Ministry of Finance approval for the reduction/elimination of fees in order to facilitate access to treatment and enable measurement of viral suppression. USG partners also support GRC to work on a unique

identifier system for better tracking of patients.

In 2016, GRC provided ART services to 65,205 new clients, bringing the total number of clients receiving ART to 205,359 clients, compared to 168,249 clients in 2015 (NACC 2015). PEPFAR Cameroon supported 39,372 new clients in FY16 bringing the total number of clients receiving ART in the PEPFAR supported regions to 142,455. In FY18, PEPFAR Cameroon will expand focus on treatment from the two initial scale-up health districts (Deido and Djoungolo) to the Yaounde and Douala clusters and continue to increase ART coverage for adults, children, patients with TB/HIV co-infection, pregnant women and their partners, KPs, less than 30 years old, AGYW, STI patients, and military recruits.

To reach the FY18 treatment targets, the scale-up package of services includes: 1) demand creation and PITC at all entry points; 2) linkage of HIV infected individuals to ART initiation through a comprehensive linkage agent model; 3) initiation of HIV positive individuals to ART with the scale up of same-day initiation; 4) activities to ensure viral load demand creation for clinicians and patients, as well as viral suppression including ARV refill and counseling for retention in care with multi-month scripting; and 5) adherence counseling and viral load monitoring. Within this context, PEPFAR Cameroon will expand the ongoing loss-to-follow up (LTFU) campaign that has shown some benefits in 10 facilities (bringing back 91% of contacted LTFU cases) and is currently being rolled out. The expanded campaign will implement a comprehensive linkage-retention agent (LRA) model that will entail realignment of current implementing partner staffing to put more linkage agents and qualified linkage staff that can provide psychosocial counseling at the facilities, physically linking clients to services and coordinating retention and support group activities. The LRA will expand upon the existing MOH funded psychosocial staff at the health facilities in order to allow an appropriate amount of clients per LRA. PEPFAR Cameroon will expand the Family Treatment Model in conjunction with the Family Testing Model already being successfully implemented (with a yield of 16%) in five facilities to address the challenges of children not receiving care in the same place as their parents. Adolescent, under 30, and male friendly service delivery models will be promoted within the context of peer matching. The partner notification (PN) and contact tracing (CT) approach has also been successfully implemented in nine facilities with an encouraging yield (39%). These two approaches will be expanded in all scale-up sites in the clusters. The contract tracing and family treatment models will be utilized to enable more men to be reached and retained into treatment. Within the linkage agent model, the KP peer mobilizer model and support group packages, emphasis will be put on encouraging involvement of men. Linkage agents will facilitate access to treatment by providing information, psychosocial support and regular reminders. Varied clinic hours are also being implemented to facilitate treatment access, particularly for men who are unable to access facilities during the week. For example, Saturday clinic hours for ART collection along with dispensation through MOH approved CBO's. Worksite VCT and linkage to treatment is also being considered. PEPFAR Cameroon will scale up same day ART initiation, multi-month scripting, community service delivery in line with NACC's policy, and support group models. The KP model will also be expanded in the health facilities to ensure the "handshake" as the community linkage navigator hands over the KP client to the facility LRA, training of healthcare providers and setting up KP-friendly services.

Monitoring for quality service delivery will be ensured through supervision and mentoring; support will be provided to physicians, nurses and LRA at sites; buffer stock for RTKs, VL, ARVs, CTX, and EID reagents will be made available; and minor renovations, cabinets, and minor equipment will be supplied to improve the quality of services.

The hub and spoke model proposed by PEPFAR Cameroon in COP16 has been revised to a mentorship model taking into account the country context as MOH is scaling up decentralization of facility capacity to deliver ART services in smaller facilities such as Option B+ facilities. PEPFAR Cameroon will implement the mentorship model where larger and more experienced ART sites will provide mentorship support to smaller satellite sites for continuous staff capacity building, providing supervision and mentoring to smaller sites.

Following SIMS visits there is an improvement in the FY16 results for Adult Treatment, with only 15.4% of sites scoring red and 23.1% yellow, compared to 70% red scores in FY15. Sites with red scores are prioritized for mentorship and supportive supervision to address facility based issues.

PEPFAR Cameroon will initiate 19,498 adults and children living with HIV to ART (10,678 in Yaounde and 8,820 in Douala) and support 100,828 PLHIV currently receiving ART (59,968 in Yaounde and 40,860 in Doula) by focusing and scaling up HIV testing and linkages in the two Yaounde and Douala clusters. PEPFAR Cameroon will reinvest cost savings in treatment from centrally supported sites to cluster districts in high priority harder-to-reach PLHIV districts and improve linkage and enrollment to C&T.

PEPFAR Cameroon will reinforce the ongoing partner management and monitoring activities to show more visibility and better assist the partners as described in section 4.4 on page 33.

4.9 Pediatric Treatment Summary

Cameroon has an estimated 34,192 children living with HIV in 2016 (National Report on HIV Projection, 2016), with a national pediatric ART coverage 25% (MOH 2016), compared to 24% in PEPFAR-supported districts. In 2013, Cameroon adopted treatment for all HIV-positive children <5 years of age or with TB. In 2016, Test and Start was adopted for the general population including older children and adolescents. Absolute parental consent for HIV testing had been reduced from 18 years to 15 years with free HTC for adolescents <15; PEPFAR Cameroon is recommending to the GRC to provide free HTC for adolescents 15-19 years old.

PEPFAR Cameroon's pediatric treatment program began in FY15 with PEPFAR Accelerating Children's Treatment (ACT) Initiative. At the end of FY16, PEPFAR Cameroon provided ART to 6,008 children <15 living with HIV and a 2381 adolescents 15-19 years old; although short of the overall <20 ACT target of 11,260, this represents substantial progress given the nascent pediatric ART program. During ACT, pediatric tools and standard operating procedures were developed and piloted and are now available to enhance data collection for children across all sites. In addition, 4 Pediatric Centers of Excellence

(COEs) have been well established in each of the PEPFAR-supported regions and currently provide onsite training and mentorship to expand pediatric treatment and care to the broader network of PEPFAR-supported pediatric treatment sites.

In FY17, PEPFAR Cameroon aligned the former 34 ACT sites with the PEPFAR geographic prioritization and in FY18, will further align with the COP 17 pivot by scaling-up pediatric treatment and care in the two geographic clusters of Yaounde and Douala. The two Pediatric COEs in regions outside of Yaounde and Douala will continue providing mentorship support pediatric treatment sites in the sustained districts.

In FY17, PEPFAR supported GRC to roll out a standardized package of treatment and care at all pediatric treatment sites designed to create demand for pediatric services, scale-up of PITC at all entry points including HIV testing of children of index cases, and link CLHIV to HIV care and treatment that includes TB screening. No pediatric ARV stock outs were reported, age-disaggregated data collection tools were used at sites, and age-disaggregated HTC and treatment data were reported. Despite these programmatic successes, some challenges persist, especially in case-finding, linkage, and retention; preventing full scale-up of pediatric care and treatment. Active pediatric and adolescent HIV case-finding, strengthening linkages between HIV testing and treatment, improving retention and coordination between clinical and community service providers will be continued areas of focus in FY18 to aggressively enhance pediatric scale-up in Cameroon.

For FY18, PEPFAR Cameroon's <15 HIV pediatric treatment target (TX_CURR) is 13,568 (6,286 in scale-up clusters and 7,282 in sustained) with a retention rate at 90%. To reach the 90/90/90 goals, the scale-up package of services will include continued support to GRC to fully roll-out Test and Start, as well as reduction of user fees to help improve linkages from identification to treatment initiation and retention among children and adolescents.

To reach pediatric and adolescent treatment targets in FY18, family index testing, PITC in high prevalence entry points and targeted testing using screening tools in lower prevalence entry points such as outpatient department and community settings will be used to increase efficiency and testing yield in the two clusters. Furthermore, cohort monitoring activities piloted in FY17 to improve EID for HEI even after weaning and to monitor and track CLHIV on ART over time, will be rolled out in the cluster districts. Communication with parents around pediatric care and treatment, EID, viral load including the importance of follow-up visits will be improved.

Child friendly corners and adolescent friendly hours as well as health care delivery models to address the HTC and ART needs for adolescents will be strengthened. Peer matched LRA and/or peers will be used for adolescents; support groups and counseling on sexual risk reduction will be part of the adolescent package. In addition, educational programs for caregivers including standard operating procedures and data collection tools on transition from pediatric to adult ART will be developed and piloted in the two clusters. Innovative treatment models such as the family treatment model or the one stop shop service delivery model for the mother-baby pair will be promoted at facilities. Also,

increased collaboration between facilities and community services and OVC programs will be strengthened through a "hand shake" to ensure successful bi-directional referral and linkage of children and adolescents including children of FSWs, OVC, HIV-exposed infants/mother pairs.

In FY18, sites identified as poorly performing through routine site visits, shall be prioritized for mentorship and supportive supervision to address facility based issues.

Please see section 4.4 on page 33 for partner management and monitoring.

4.10 OVC Summary

In FY16, PEPFAR Cameroon reached 13,830 OVC and their caregivers with DSD interventions, 81 percent (11,210) of which were below the age of 18. A standard package of services was offered to OVC in the scale-up clusters of Yaounde (Djoungolo and Nkolndongo health districts) and Douala (Deido health district); and sustained health district of Bamenda - which is also considered a hot spot for KP and OVC. Primary activities included initiating case management for CLHIV and ALHIV; facilitating access to health services including HTS and linkage to treatment; provision of community based care and treatment services; and household economic strengthening.

In FY17, PEPFAR Cameroon introduced age-appropriate layered interventions, focused on addressing overlapping vulnerabilities faced by OVC sub-populations. This included rolling out a community-based screening tool to identify and prioritize at-risk OVC for HTS referrals and establishing protocols for routine testing of sexually active OVC. In FY17 Q1, PEPFAR Cameroon screened 3,506 children, with a positivity rate of 4 percent – it is also worth noting that of this number, 142 children of HIV-positive FSWs were screened, with a positivity rate of 5.6 percent. Other interventions include case conferencing, sexual and reproductive health education and service linkages particularly for adolescent girls and young women (AGYW), early childhood development integrated into HIV clinical care, nutrition, and education support (via school block grants and scholarships), with a focus on girls' primary school completion and transition to secondary. In the course of the year, PEPFAR Cameroon leveraged OVC Plus-Up funds to begin addressing gaps in provision of GBV prevention interventions and post-GBV care focusing on adolescent girls and young women, particularly children of HIV-positive female sex workers. At community level, PEPFAR Cameroon introduced an enhanced package for adolescent daughters of FSWs (who have an elevated risk of abuse and entry into sex work) focused on risk avoidance and prevention of gender-based violence (GBV) as well as comprehensive post-violence care. Other interventions included: development of national guidelines and standard operating procedures (SOPs) for provision of post-GBV clinical services; assessments of health facilities and provision of basic equipment for clinical examination, basic surgical procedures, and laboratory services; training and mentoring of health care providers in post rape care; and provision of post-GBV clinical care for at least 50 active beneficiaries.

In FY18, PEPFAR Cameroon will expand coverage of the DSD interventions described above to reach 22,282 OVC and their caregivers. PEPFAR Cameroon will leverage the OVC platform to: (a) improve pediatric HIV testing and case identification through targeted community screenings; (b) improve

pediatric care and treatment through Memoranda of Understanding between OVC service providers and ART sites for bi-directional referrals; (c) improve pediatric retention via case conferencing, home visits, active case finding, and household economic strengthening (promotes resilience by strengthening household capacity to access medical care, healthy nutrition, etc.); and (d) expand a care and support package for children of FSWs. PEPFAR Cameroon will continue provision of post-GBV clinical services to children who have witnessed or experienced sexual violence including screening and counseling for gender-based violence (GBV) within HIV/AIDS prevention, care, and treatment programs; strengthening post-rape care services including referrals (intra-hospital and community-clinical referrals); and ongoing mentorship and training of healthcare providers.

PEPFAR Cameroon will strengthen and improve data management and service delivery quality through the use and monitoring of standardized case management/referral tools; technical capacity building of service providers using international and national curricula on pediatric and adolescent care and support; and use of evidence-informed approaches for integrating core HIV prevention and risk reduction interventions for AGYW.

PEPFAR Cameroon will expand geographic coverage for comprehensive DSD interventions (currently in four health districts) to include all KP hotspots within the scale-up clusters of Yaounde and Douala and continue activities in the sustained health district of Bamenda which is also considered a KP hot spot in order to improve linkages to HTS, care, and treatment among children of FSWs. Section 5.10 provides additional information on PEPFAR Cameroon's OVC approach in other sustained sites.

Program Area 4.11: Addressing COP17 Technical Considerations

PEPFAR Cameroon has worked in partnership with all relevant stakeholders to address the COP17 technical considerations across the UNAIDS 90-90-90 goals and in cross-cutting areas such as prevention, health systems strengthening, and community engagement and has sought efficiencies where possible.

To reach the 1st 90, PEPFAR Cameroon will reinforce its HTC program to ensure that HIV testing and identification of HIV infected individuals follows the best use of resources. PEPFAR will implement screening tools to increase the yield on HIV testing for children, AGYW, and young adults under 30 via better targeting of test kits. At the facility level, in the Yaounde and Douala clusters, PEPFAR Cameroon will undertake demand creation in scale-up sites to scale up PITC in all priority high yield entry points (yield 5-12%), including testing clients of index cases at ART and TB services (yield 39%), testing children of HIV infected parents within a family index testing model (yield 16%), and engaging men through partner testing and contact tracing. Testing will include venue-based testing also targeting adolescents, children and those aged below 30 years. PEPFAR Cameroon is also strengthening testing for key and priority populations through expanded capacity of KP DICs. Laboratory capacity to allow on-site HTS has been established in DICs, and all DICs are enrolled in a PEPFAR-supported proficiency testing program and receive weekly supervision/mentorship visits from a health facility and PEPFAR-funded lab partner. PEPFAR Cameroon will continue to scale-up the

enhanced peer mobilizer (EPM) model - an adaptation of the respondent-driven sampling method - for targeted community mobilization. At each DIC, a skilled psychosocial counselor provides pre- and post-test counseling, and is also responsible for ensuring linkage to treatment for clients diagnosed HIV-positive via community–clinical joint case tracking, known as the "hand shake" between community agents and health care providers. HIV-positive FSWs will be supported to have their children tested for HIV and KP and OVC service providers will collaborate to ensure all children of FSW and those living in hotspots (irrespective of parent's status) are screened for HIV risk, tested if they meet risk criteria, and referred to the OVC program for comprehensive services.

For the 2nd 90, PEPFAR Cameroon will implement the following scale-up service package: 1) demand creation and PITC at all entry points; 2) linkage of HIV infected individuals to ART initiation through a comprehensive linkage agent model; 3) initiation of HIV positive individuals to ART with the scale up of same day initiation; 4) activities to ensure viral load suppression including ARV refill, counseling for retention in care with multi-month scripting; and 5) adherence counseling and viral load monitoring. Within this context, PEPFAR Cameroon will expand the ongoing loss-to-follow up (LTFU) campaign that has shown some benefits in 10 facilities (bringing back 91% of contacted LTFU cases) and is currently being rolled out. A comprehensive linkage-retention agent (LRA) model will place more linkage agents and qualified psychosocial counselors at the facilities, physically linking clients to services and coordinating retention and support group activities. PEPFAR Cameroon will expand a family treatment model in conjunction with the family testing model already being successfully implemented (with a yield of 16%) in 5 facilities to address the challenges of children not receiving care in the same place as their parents. Adolescent, under 30, and male friendly models, will be promoted within the context of peer matching. The partner notification (PN) and contact tracing (CT) approach, which has been successfully implemented in 9 facilities with an encouraging yield (39%), will be expanded in all scale-up sites in the clusters. The family treatment model combined with PN and CT will help in finding more HIV infected men and link them into treatment and care.

The GRC adopted Test and Start in May 2016 and field implementation has begun in some sites. Subsequently, PEPFAR and WHO worked with GRC to develop a strategic document that describes a policy for HIV testing and retesting for verification both in facilities and communities, differentiated service delivery models including for different subpopulations, Multi-month scripting for stable patients including community dispensation and loss to follow up (LTFU) strategies. PEPFAR Cameroon will scale up same day ART initiation, multi-month scripting, community service delivery in line with this policy and support group models. The KP model will also be expanded in the health facilities to ensure a "handshake" as the community linkage navigator hands over the KP client to the facility LRA, training of healthcare providers and implementation of KP-friendly services. PEPFAR Cameroon will also maximize testing efficiencies through support for Continuous Quality Improvement (CQI) in testing services, including rolling out the Rapid Test Quality Improvement Initiative (RT-QII) and Proficiency Testing (PT) to all sites within both clusters and also implement site and personnel certification for HIV rapid testing in support of retesting for verification and optimize the quality of testing services to support Test and Start.

For the 3rd 90, PEPFAR Cameroon will support GRC to test for viral load and monitor trends in viral suppression for 20% of clients on ART in all scale-up sites within both clusters. To address barriers to ART retention in all scale-up sites within both clusters, particularly among children<5years, adolescents, young adults and men, PEPFAR Cameroon will fully scale-up a family treatment model, implement differentiated service delivery packages such as Multi-month scripting and community dispensation; support a comprehensive active linkage agent model using peer matching and implement the support group strategy for ART delivery. The engagement and full coordination among PEPFAR, the GFATM, the GRC and other partners is critical in achieving the 3rd 90. PEPFAR has engaged discussions with GRC and Global Fund on cost reduction strategies for viral load commodities to improve testing uptake and is currently working with GRC towards patient fee elimination for viral load to ensure increased and efficient uptake and retention in scale-up sites within both clusters. The USG commodity team at global level has succeeded in working with the leading vendor of viral load commodities to reduce pricing from $56 to $31, but this cost does not include the 25% service charge for shipping and delivery. The team in Cameroon will work with the GRC and the vendor to further reduce this price to support COP17 targets and the MOH has agreed to sign a volume commitment for at least three years that could lead to a further reduction of the negotiated price from $31 to $16.50.

Building on the experiences and achievements from FY16, PEPFAR Cameroon will continue to work with the GRC to foster collaborations with other partners like the GFATM and CHAI and leverage their support in providing commodities for viral load testing while PEPFAR continues to strengthen quality systems in testing and monitoring to accommodate improved efficiencies in treatment and retention. PEPFAR will continue to strengthen systems along the viral load testing cascade to provide a robust sample transport system that covers all scale-up sites within the clusters, support reduction in turn-around–time for results return through electronic systems (SMS printers) which will be installed in all labs or testing sites in scale-up facilities within the clusters. PEPFAR will continue systems investments to support standardization of tools, SOPs and protocols for viral load implementation and ensure enrollment of at least 4 viral load reference laboratories in an External Quality Assessment (EQA) program. PEPFAR will also support implementation of a robust M&E system and the use of a dashboard for tracking quality systems across the viral load testing cascade, including viral suppression. To ensure improved efficiencies in viral load testing and to maximize scale-up, PEPFAR will also support roll out of use of DBS for viral load testing in both clusters in accordance with the national viral load strategy. PEPFAR will strengthen Quality Management Systems across the testing cascade by supporting specialized training for at least 6 biomedical engineers on repair of viral load platforms and associated equipment such as freezers, heating blocks, centrifuges, pipets and timers. PEPFAR will also support trainings on quality assured DBS sample collection, packaging and shipping and provide in-service Quality Assurance trainings for laboratory technicians to sustain Continuous Quality Improvement in laboratory testing. In-Service trainings will also be provided for clinicians and nurses to improve requisition, uptake and interpretation of viral load results as well as effective management of patients with positive or negative viral load results. PEPFAR will also support robust patient education to increase demand and uptake for VL and will also provide technical guidance to the newly established Viral Load Technical Working Group as they seek to harmonize and coordinate

activities between MOH and partners whilst ensuring adherence to national testing policies, strategy and guidelines.

In addition to activities targeted to address each of three 90s, PEPFAR Cameroon will support expanded prevention and care services for OVCs and under 30 year olds. Through existing KP programming, community-based drop-in centers have begun offering targeted youth friendly services to adolescent children of FSWs focused on prevention, reproductive health, HIV testing, and linkage to treatment. At the health facility level, adolescent and young adult friendly services are being established, including "one-stop shops" for testing and counseling and intra- and inter-facility linkages for adolescents and young adults. In FY18, the linkage and retention model will be implemented to scale and linkage agents will be designated specifically for adolescents and young adults, to help them navigate barriers to early and rapid ART initiation, fast track ARV refills for stable youths and provide adherence counseling and support that addresses the specific needs of adolescents and young adults. In FY17, PEPFAR began offering an enhanced prevention package to adolescent daughters of HIV-positive FSW. In addition to the risk avoidance and GBV prevention services offered to all OVC, older adolescents and young women are also able to access a full range of reproductive health and family planning services. In FY18, this will be scaled up to adolescent daughters of all FSW, regardless of the mother's HIV status, and those living in hotspots. Changes have also been made within the OVC package to ensure closer alignment with the DREAMS model. In particular, more emphasis will be placed on risk avoidance, GBV prevention and layering of services to maximize the impact of resources within the existing budget.

Finally, PEPFAR Cameroon is implementing crosscutting activities focused on strengthening the health system and community engagement. In FY17, PEPFAR Cameroon will pilot a performance-based financing (PBF) study in two clinical facilities in Douala, layering on ongoing World Bank-funded PBF activities. Based on the outcome of this study, this initiative will be mainstreamed in FY18. PEPFAR Cameroon is also working with the HRH technical working group (TWG) to assist in conducting a rapid site level workforce assessment of facilities using an HRH assessment tool. This assessment will take place in FY17 and the findings will inform COP17 implementation, particularly in health worker allocation/deployment and alignment of HRH with clinical cascade. The ongoing LTFU campaign, the comprehensive LRA model, and the KP "Handshake" model, all detailed above, are expected to strengthen community engagement.

Program Area 4.12: Commodities

PEPFAR Cameroon's commodity budget has dropped from $10,000,000 in COP 14 to $1,164,192 in COP 17, of which $300,000 will be invested in procurement of HIV rapid diagnostic kits and $864,192 in viral load commodities. Despite the continued growth of the country's HIV prevention, care and treatment targets, the GFATM HIV budget allocation has decreased from $99,274,507 (2015-2017) to $93,469,489 for the next three years (2018-2020), and other stakeholders such as the World Bank and the French Development Agency (AFD) have ceased their commodity investments entirely. This situation is exacerbated by the persistent financial uncertainties surrounding GRC commitments including

counterpart funding. Furthermore, recent GFATM audit findings rated the National AIDS Council's controls over supply chain processes and the GFATM Secretariat's assurance mechanisms as ineffective (July 2016)[2]. The absolute reliance on GFATM principal recipient's (PR) performance and system strengthening efforts will continue to carry commodities shortages risks in fiscal year 2018. The recent audit (2016) highlighted the status quo on previous outstanding recommendations regarding procurement and supply chain management identified in 2009. Major supply chain risks include inefficient procurement and continual emergency orders resulting from poor engagement and communication between PRs and GFATM's pool procurement mechanism; inadequate storage, distribution and inventory management at central and regional medical stores; and a lack of stock monitoring by PRs.

The GRC implements a distribution model where the government procures drugs and distributes them using a publicly run Central Medical Store (CMS) and a government-owned transport fleet. This model provides limited flexibility for the CMS to hire people with supply chain experience and skills because of poor wages and incentive systems in the public sector.

Additionally, the timing of GRC HIV commodities procurement funds disbursement is uncertain and highly variable, leading to a delayed start of the procurement cycle. Given the length of the procurement cycle, any delays in procurement initiation create an atmosphere of uncertainty in the system and result in system-wide stock outs.

Finally, the root causes of stock-outs at the health clinics may be due to problems in procurement, forecasting and requisitioning by the regions; tardiness in ordering or poor forecasting by the clinics; or the burdensome amount of bureaucratic steps required to obtain approvals on stock allocation decisions at any stage in the system. However, the underlying cause of many of these problems is the lack of an accountability structure. There is often fragmentation of responsibility and governance between the Ministry of Health, the PR, the Central and Regional Medical Stores, and health staff at clinics. This creates a system of diffuse accountability where each actor can attribute the underperformance of the supply chain to other actors in the system. Such overall lack of accountability exacerbates the risks in distribution.

PEPFAR's supply chain partner will work closely with the two HIV PRs and four of the ten regional stores to strengthen inventory management and distribution skills. Investments will improve supply chain planning data in order to create supply processes that can guarantee the highest level of service and minimize stock-outs. Supply chain coordination committees will be supported and information sharing strengthened to enhance the continuous feedback that is required for supply chain planning in the four regions. Promoting good governance and creating greater transparency of product flow information in the public sector supply chain is an important prerequisite for many of the technical solutions described above.

[2] GF-OIG (2016). Audit Report Global Fund Grants to the Republic of Cameroon: Procurement and Supply Chain Management

Based on recent findings, PEPFAR will work with the GFATM's PRs and CMS to decentralize the distribution model towards a hub-and-spoke logistic system to gain efficiencies in distribution of HIV commodities, provide financial support for outsourced third party transport providers to cope with availability of vehicles for distribution of medicines, and introduce competitive pressure for regional medical stores through performance improvement incentives.

Program Area 4.13: Collaboration, Integration and Monitoring

The PEPFAR Cameroon program recently pivoted from a district approach to a cluster approach, increasing coverage and the need to quickly address challenges at different points of the clinical cascade that would impact reaching targets for all three 90s. PEPFAR Cameroon's key areas of focus to attain the three 90s in the Yaounde and Douala clusters include: (a) supporting targeted testing to improve testing yield; (b) strengthening linkage systems to achieve 90% retention within the Yaounde and Douala clusters, with a special emphasis on infants, children, AGYW, young adults (<30), KPs and men; (c) implementing cost reduction strategies for EID and viral load commodities; and (d) working with GRC to eliminate patient fees for VL testing. In order to achieve these goals, PEPFAR Cameroon coordinates with GFATM, MOH and other partners to define efficient strategies to address supply chain challenges such as the cost of commodities. This collaboration recently resulted in a significant reduction in the cost of viral load test kits from $56 to $31. PEPFAR Cameroon and GFATM are also engaged in discussions with MOH to provide guidance to eliminate patient fees VL testing to ensure efficient uptake and retention in all population groups. In order to improve linkage to treatment for KPs and the military, USAID, CDC and DOD collaborate in implementing the "handshake" approach to foster collaboration between clinical and community partners. PEPFAR Cameroon and GFATM agreed to have regular monthly meetings in the interest of more effective coordination.

PEPFAR Cameroon conducts regular SIMS visits and COAG follow-up site visits to monitor partner activities. PEPFAR Cameroon has also developed a quarterly rapid assessment checklist as a supplement to the SIMS tool to allow for deeper assessment of partner performance and to facilitate timely interventions that will improve performance and impact within a short time frame. This tool supports partner management and partner performance reports are shared with the MOH. PEPFAR Cameroon ensures that standardized M&E tools, guidelines, and new policies and strategies are implemented across partners and collaborates with MOH to ensure these are integrated and aligned with the national strategy. To strengthen scale-up of VL testing across the cascade, PEPFAR Cameroon collaborates with MOH to support in-service trainings and task shifting to realign new program strategies such as the use of linkage and relay agents (LRA) to improve efficiency in retention and uptake in scale-up sites within the clusters. The M&E Dashboard for tracking quality systems across the viral load testing cascade as well as viral suppression will be used to support implementation by all PEPFAR IPs and also integrated into the national system for use by both MOH and GFATM within the entire health system. Through an effective PEPFAR Cameroon inter-agency collaboration, CDC IPs support quality assurance training for DIC staff to promote efficiencies in HIV

rapid testing.

All PEPFAR implementing partners will concentrate on supportive supervision and mentorship to improve efficiency of innovative and differentiated service delivery models and will work in collaboration with and train MOH staff to ensure integration and standardization of tools and services across the board. To improve efficiency within the clusters, PEPFAR Cameroon will support implementation of other services such as multi-month scripting; community dispensation and the support group strategy for ART delivery. These service models are all approved and appear in the MOH strategic plan for care and treatment.

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

5.1 Targets for attained and sustained locations and populations

While some health districts have achieved 80% saturation, no district has reached saturation in all age and sex disaggregations, thus no district has reached attained status. In sustained locations, clients on ART will be maintained in HIV care and treatment services through FY18 in both ART and PMTCT sites. PEPFAR Cameroon expects to test 564,083 in PMTCT sites in FY18 and 33,724 in sustained ART sites. In FY18, PEPFAR Cameroon will maintain 96,653 current patients on treatment in the sustained districts (Table 5.1.2).

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		Expected result APR 17	Expected result APR 18
HIV testing in PMTCT sites	*PMTCT_STAT*	**285,634**	**564,083**
HTS (only sustained ART sites in FY17)	*HTC_TST/HTS_POS*	**58,829**	**33,724**
Current on ART	*TX_CURR*	**126,428**	**96,653**
OVC	*OVC_SERV*	**6,163**	**8,315**

*Data derived from Data Pack tool

5.2: Priority and Key Population Prevention Summary

In this section, "priority populations" refers to AGYW, including those living with HIV. Military and key population site, including the KP hotspot in Bamenda, are considered scale-up sites, even if they are located within sustained districts. Service packages for these populations are described in Section 4.2.

In FY16, PEPFAR Cameroon provided core HIV prevention interventions to 17,734 individuals, 32.3 % (5,728) of whom were AGYW. The core HIV prevention package is focused mainly on capacity strengthening and includes: transmission and risk reduction information; curriculum-based, age

appropriate prevention skills and sexuality education; information and mobilization for HTC, adult/community engagement, demand creation to access care and treatment services, condom promotion, and gender equity promotion.

There are no Q1 FY17 results reported for AGYW, as Peace Corps Volunteers are the principal providers of TA services, and their trimestral reporting cycle does not align with PEPFAR's quarterly reporting cycle. Through its Volunteers, Peace Corps will continue providing TA using a DREAMS–tailored, community-based HIV prevention package of services in 21 sustained SNUs. HIV prevalence remains three to four times higher in AGYW compared to the male population of the same age group (DHS, 2011) and unprotected sex with adult men is a major factor responsible for the disparity in prevalence rates. As a result, risk avoidance and reduction using behavioral change interventions will remain a priority in FY18. To ensure that AGYW's risks are comprehensively addressed, engagement of key influencing populations such as adolescent girls' parents, guardians and partners will be reinforced using appropriate age/sex curriculums delivered using culturally appropriate methodologies. By the end of FY18, 65% of the total individuals reached with DREAMS-tailored prevention interventions will be AGYW.

Evidence of program impact – specifically risk reduction through positive behavior change - will be documented in the best possible manner. The existing HTS referral tool used by implementing partners, where possible, will be reviewed and adapted for use by Volunteers. This will improve program quality, ensuring that AGYW are more actively linked to HTS.

5.3 **VMMC Summary**

PEPFAR Cameroon does not implement VMMC programming.

5.4 Preventing mother-to-child transmission (PMTCT)

In sustained districts and health facilities, PEPFAR will not promote demand creation, conduct extensive trainings, nor provide staff. PEPFAR will ensure quarterly supportive supervision and mentorship visits for on the job training and QA, continued support for women newly initiating ART and those on treatment after pregnancy, breastfeeding in existing ART sites, and use of "Bikers for Health" for sample pick up. PITC for pregnant women at ANC will be provided through GRC support. GRC and GFATM will provide ARVs, RTKs, CTX, and TB treatment at sustained sites. Finally, M&E systems and tools will be strengthened to address linkages and tracking of LTFU of mother-infant pairs in all sustained and scale-up sites, including establishing a birth cohort monitoring system starting with a pilot to track infants, assigning CHWs to follow infected mothers throughout the antenatal and postnatal period, developing peer support groups, implementing SMS reminders, and training ANC staff to ensure that they provide respectful care and effective counseling. PEPFAR will continue to enhance education of the regional technical working groups to address the gaps in ART sites to reach attained status in all sex and age groups in specific sustained districts that are not yet attained, i.e. Mbengwi, Yabassi, and Bamenda.

5.5 HTC Summary

GRC's national policy for HIV testing released in January 2016 required provider initiated testing and counseling (PITC) for all individuals who attended any health facility to seek any medical attention. In 2016, GRC provided HTC services to 1,689,696 clients, compared to 882,639 clients in 2015, with an HIV positive yield of 6.0% (NACC 2015). This also motivated PEPFAR partners in FY16 to support widespread HIV testing across all entry points, testing 800,229 clients, more than twice (212%) of the set target of 378,357 clients, with an HIV positive yield of 6.4%. The GRC encourages free mass HIV testing across the country during specific periods, such as the month leading up to World AIDS Day. However, payment for testing is still required during the remainder of the year for the general adult population, and current policy prohibits HIV testing for minors (under 15 years) without parental consent. The PEPFAR Cameroon team has engaged in discussions with MOH to consider future targeted testing to improve testing yield and maximize resources. This will be facilitated by implementing screening tools to increase yield on HIV testing through better targeted use of test kits. Retesting for verification has been approved within the test and start guidelines and PEPFAR Cameroon will be scaling up this activity in COP17.

FY18 Targets for HTC have been calculated based on cascade analysis assuming a treatment growth rate of 10% of the current number of individuals receiving ART in the sustained districts. To reach this coverage in FY18, FY16 APR HIV program positivity rates were used to determine HTC and linkage to treatment, as well as estimates of retention rate at 90% for new and old ART patients. SIMS results were also used to address deficiencies in the quality of service, which has led to improvement in key low-scoring program domains.

In sustained districts/sites, demand creation will not be carried out but PEPFAR Cameroon will continue to provide linkages and retention support for clients who are currently on treatment. The GRC supports RTKs and staffing, and provision of HTC will continue according to national guidelines.

In the sustained sites, PEPFAR Cameroon will provide HIV testing support for 534,131 individuals to identify 45,855 PLHIV. PEPFAR Cameroon will reinvest cost savings in HTC from centrally supported sites to scale-up districts in high priority harder-to-reach PLHIV districts and improve linkage and enrollment to C&T.

PEPFAR Cameroon will continue to reinforce the ongoing partner management and monitoring activities in sustained sites, as described in section 4.4 on page 33.

5.6 Facility and Community Based Care and Support

PEPFAR Cameroon's implementing partners will support a "light touch" package of services in sustained districts through quarterly technical assistance visits meant to improve linkage and retention of patients, resulting in community VL suppression. The simplified treatment package will include adherence counseling and VL referrals when necessary and screening for TB and other OIs in

PLHIV. GRC-funded CHWs and CSOs already working in communities will continue to provide tracking of patients LTFU. Standard documents and SOP for linkage and documentation of LTFU will be provided to the GFATM and GRC for use at all treatment sites in Cameroon. GRC and GFATM will provide all ARVs, RTKs, and some CD4 and VL reagents.

5.7 TB/HIV Summary

The package of TB/HIV services in the sustained districts will include quarterly supportive supervision and mentorship visits for QA, support for TB screening, linkages of patients from all clinical entry points to treatment and care for ART or TB initiation, tracking, and retention. Additionally, onsite training will be made available for health clinical staff, pharmacists, data managers, and CHWs. Demand creation will be provided by GRC. GRC and GFATM will provide ARVs, INH and TB treatment. While PEPFAR TB/HIV activities will be focused in the two scale-up clusters, the sustained districts will benefit from screening and prevention of TB through the national GRC basic package of services across all regions of Cameroon.

5.8 Adult treatment

In 2016, GRC provided ART services to 65,205 new clients, bringing the total number of clients receiving ART to 205,359 clients compared to 168,249 clients in 2015 (NACC 2015). PEPFAR Cameroon supported 39,372 new clients in FY16 bringing the total number of clients receiving ART in the PEPFAR supported regions to 142,455. PEPFAR Cameroon will identify 33,414 PLHIV in the sustained sites. Using EA data by mechanism and district, the team determined that the 2016 average expenditure per individual treated in the sustained sites was $24.32 (Appendix B).

Within the sustained sites, PEPFAR Cameroon will support activities to ensure linkages and retention without promoting demand creation. PEPFAR Cameroon will continue to use community systems, through reduced numbers of linkage agents to support adherence, linkages, and retention activities, while monitoring compliance through supportive supervision (Appendix A). The package of services in sustained districts will include provision of quarterly supportive supervision and mentorship visits for QA, support for linkages of patients from all clinical entry points to treatment and care for prescription initiation, plus TB screening, tracking, and retention; nutritional assessment and counseling as well as providing TA for VL testing and using GFATM VL supplies. Demand creation and PITC will be provided by GRC. GRC and GFATM will also provide ARVs, RTKs, CTX, and TB treatment. GFATM absorbed PEPFAR sites transitioned in FY16

PEPFAR Cameroon will initiate 32,384 PLHIV into ART in the sustained sites and provide support to 96,653 PLHIV who are currently on ART.

Please refer to section 4.4 on page 33 for partner management.

5.9 Pediatric Treatment

The package of services in sustained districts for pediatric care and treatment will include provision of

quarterly supportive supervision and mentorship visits for QA, support for linkages of patients from all pediatric clinical entry points including PMTCT to treatment and care for ART initiation, plus TB screening, tracking, and retention; nutritional assessment and counseling; and onsite training for "Bikers for Health" clinical staff, pharmacists, data managers, and CHWs. Demand creation and PITC will be provided by GRC. GRC and GFATM will provide ARVs, RTKs, CTX, and TB treatment. Negotiations will be ongoing for GFATM to absorb PEPFAR sites transitioned in FY18.

5.10: OVC Narrative Sustained Sites

In FY16, PEPFAR Cameroon supported TA interventions for 3,180 OVC and their caregivers with TA interventions, 45 % (1,409) of who were below the age of 18. The following package of services was offered to OVCs in 10 community sites of sustained districts: a curriculum-based, age appropriate HIV prevention package for older OVCs, OVC education and linkage to HTS, the core HIV prevention package, positive parenting focused on parent-child SRH education, nutrition education and meal planning skills (specifically for care givers of younger OVCs 0-9 year), and financial literacy and IGA skills development for older OVCs.

There are no AGYW FY17 results reported for Q1, as Peace Corps Volunteers are the principal providers of TA services, and their trimestral reporting cycle does not align with PEPFAR's quarterly reporting cycle.

In FY18, PEPFAR Cameroon will continue to implement comprehensive OVC TA interventions in 15 sustained districts. In order to maximize opportunities to reach orphaned and vulnerable adolescent girls with services, the OVC TA platform will be leveraged using evidence-based approaches to integrate core HIV prevention and risk reduction interventions as described in section 5.2. The existing HTS referral tool used by implementing partners will be reviewed and adapted for use by Volunteers where possible. This is a measure to improve program quality, ensuring that adolescent OVCs are actively linked to HTS.

5.11: Establishing service packages to meet targets in attained and sustained districts

Current clients on ART will be maintained in HIV care and treatment services through FY18 in both ART and PMTCT sites in the sustained districts. Low volume health facilities (four or fewer HIV+ yield in PMTCT and HTC or ten or fewer HIV+ clients receiving treatment in ART sites) have been identified and will be transitioned to central support in collaboration with GRC. Seventy-four of 380 FY16 sustained sites will be transitioned based on these criteria. Clients attending sustained sites within scale-up and sustained districts (see site classification in Supplemental Documents) will also be provided a minimum package of HIV care and treatment services and PMTCT provided by GRC with mentoring and supportive supervision visits by PEPFAR IPs. The PEPFAR supported package at sustained sites includes:

- Basic linkage to care services;
- Routine laboratory quality assurance systems and capacity building for VL testing and use of electronic and paper-based systems to monitor quality;
- "Light touch" supportive supervision and mentorship to ensure quality;
- EID for HEI;
- Use of existing CHW systems to:
    - Provide counseling and referral;
    - Follow up and track defaulters;
- Use of bikers for health to pick up and drop off samples, results, and data; and
- Monitoring and evaluation support for systems and processes around data collection, including using DHIS2.

GRC will provide doctors and nurses at these sites. Additionally, ARVs, RTKs, VL, and CTX will be provided through GFATM and GRC via the national supply chain system. IPs will supplement phone credit to support existing CHWs in their linking and tracing activities. Passive enrollment in HIV care and treatment will occur in these districts. No patient will be denied HIV treatment, so if a person presents for PMTCT services, requests HIV testing or presents with an OI, HIV testing and treatment will be provided as needed. There will be no demand generation for testing and no active scale-up of HIV care and treatment or PMTCT services in these districts and at sustained sites, some increase is expected due to natural growth. Implementing partners will ensure patients receive ARVs provided by GRC through GFATM. Pregnant and breastfeeding women newly initiated on treatment will be provided with support related to clinical and laboratory monitoring, EID, and adherence and retention.

Outside of ANC and passive testing and linkage to care in PMTCT and ART sites, PEPFAR support for HTC is minimal, but the GRC will likely continue testing at these sites.

Program Area 5.12: Commodities

Please refer to Program Area 4.12.

Program Area 5.13: Collaboration, Integration and Monitoring

PEPFAR Cameroon will maintain a light touch approach for collaboration, integration, and monitoring in the sustained districts, but GFATM, other partners and GRC will continue active support. Although PEPFAR Cameroon will not engage in any demand creation within these sites, patients who require testing and care and treatment services will be attended to. Coordination with GFATM, MOH and other partners to define efficient strategies to address supply chain challenges such as cost of

commodities will enable GRC and GF to fully support these sites. This collaboration recently resulted in a significant reduction in the cost of viral load test kits from $56 to $31. The outcome of discussions between PEPFAR Cameroon, GFATM, and MOH to eliminate patient fees VL testing to ensure efficient uptake and retention will also support sustained sites covered by GRC and GFATM.

PEPFAR implementing partners conduct quarterly site visits to monitor services in sustained sites and ensure that M&E tools, guidelines, and new policies and strategies are implemented across partners, and collaborate with MOH to ensure they are aligned with the national strategy. The M&E Dashboard for tracking quality systems across the VL testing cascade and viral suppression will be used by both MOH and GFATM to support sustained sites as required within the entire health system.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

6.1 Critical Systems Investments for Achieving Key Programmatic Gaps

PEPFAR Cameroon will maintain its systems investments in the areas of quality management, laboratory, and supply chain management to continue addressing the structural barriers to care identified in COP 16 by ensuring improved service and data quality within the two scale-up clusters; ensuring improved identification and linkage of beneficiaries; measuring progress toward attaining the 90-90-90 targets; ensuring uninterrupted access to HIV/AIDS commodities; and re-enforcing the healthcare system through strategic service models that bridge clinical and community-based services. PEPFAR Cameroon considered progress made from year one investments, the program pivot to clusters, and the current level of investment by PEPFAR and other donors to continue focusing on addressing these systems barriers and allow for sufficient time for these investments to impact target achievement. In order to ensure that investments continue to support effective changes in the barriers identified in COP 16 and through the Sustainability Index and Dashboard (SID), PEPFAR Cameroon made some adjustments and changes to activities in order to meet the required year 2 benchmarks. Changes made also took into consideration program orientation and year one benchmark achievements to re-align new and improved strategies in accordance with the pivot from the district approach to the cluster approach.

The interagency team will continue to focus its site level and above site level program support in COP17 to address the identified programmatic gaps in Cameroon:

1. Low coverage and quality of facility and community ART services leads to poor linkages, adherence and retention (2nd and 3rd 90s) in priority health districts.

Most of Table 6.1.1 (poor linkages, adherence, and retention) activities will be discontinued in COP 17

due to insufficient funds for ICAP (IM 17336); remaining available funds will be re-allocated to NACC (IM 18229) to continue supporting SI activities to address barrier 3 (weak SI management). Above site support will focus on increasing data collection, reporting and dissemination as well as a military prevalence survey.

2. Weak procurement and supply chain management of HIV/AIDS related commodities (1st, 2nd, 3rd 90s).

PEPFAR Cameroon is the only donor with significant investment in technical assistance for national procurement and management of HIV/AIDS-related commodities. Following recent GFATM audit findings on Cameroonian supply chain system and risk management workshop and the recruitment of an international long-term advisor, new insights have emerged to tackle supply chain system's key barriers. Overall, most of COP 16 expected benchmarks are on track despite delays in start-up on the new supply chain mechanism.

3. Weak laboratory quality management systems (1st, 2nd, 3rd 90s).

Funds were also allocated to NACC for laboratory support, as seen in table 6.1.3 (weak laboratory quality management). These activities address a new barrier (absence of a laboratory liaison within NACC) identified based on data from COP16 and the need to reinforce strategies in order to meet the first, second and third 90s. A GRC laboratory liaison seated in NACC will manage policies and provide coordination and guidance to all partners to ensure that data generated from the different EID and VL reference testing laboratories are made available in a timely manner and managed efficiently. Following delays experienced with release of new program policies, strategies and guidelines that have slowed program implementation with significant impact on reaching PEPFAR targets, these new activities will address this barrier by providing policy guidance to the laboratory TWG and supporting the timely adoption and validation of guidelines in relation to test and start and EID/VL monitoring, thus strengthening weak linkage and retention systems.

6.2 Critical Systems Investments for Achieving Priority Policies

Stronger investments will be made in HIV/TB co-infection activities, which have produced the highest testing yield despite limited investment. SIMS data show very poor infection control measures within the PEPFAR supported sites and across health facilities in Cameroon, further necessitating additional investment.

PEPFAR Cameroon has observed limited progress toward closing some systems barriers due to misalignment of funding availability with program cycles, and because some partners have not had sufficient time to re-align to the second program pivot (district approach). However, these systems barriers identified remain critical to closing the identified programmatic gaps and the planned COP17 activities appropriately support meeting the benchmarks.

7.0 Staffing Plan

The PEPFAR Cameroon team conducted an extensive staffing analysis to improve programmatic alignment of staff to facilitate and sustain HIV epidemic control, successfully implement the programmatic pivot to two geographic clusters (Douala and Yaounde) and the PEPFAR business model, which began in COP15. Core activities requiring increased focus of staff time and skill set include:

- Intensified strategic information (SI) for data driven decision making;
- Complete the roll out of Test and Start, with a particular focus on adult men, AGYW, pediatric patients and TB clients;
- Strengthened detection, linkages and retention activities in the two scale up clusters and across all priority population groups;
- Achievement of the 90:90:90 goals from testing through VL suppression with adequate above-site investments in laboratory and supply chain management systems;
- Strengthen external consultation and community strengthening;
- Completing SIMS visits in a timely manner; and
- Improving costing projections and tracking expenditures for better resource projections.

Following are the results of the above-mentioned exercise:

1. Overall staffing situation: The total number of staff on record remained the same from COP 2016 through COP 2017 at 45 recorded positions. Of these 45 recorded positions, 38 are fully funded by PEPFAR, one is partially funded by PEPFAR, one is centrally funded by PEPFAR, and four are funded by the State Department.
2. Vacancy positions: Of the 11 vacancies in COP 2016, 9 have been filled and two (DOD's Program Assistant and State's SI Technical Advisor) are in the process of recruitment.
3. New positions: PEPFAR Cameroon is not requesting for any new positions.
4. Other positions: In COP 2017 submission, CDC Cameroon is proposing to repurpose five positions to better align with the technical demands to achieve HIV epidemic control and intensify management and monitoring of its implementing partners. The proposed positions to be repurposed are (also reflected in the CDC Agency Organization Chart) are as follows:
    a. Repurpose a Laboratory Technician to an Adult HIV Treatment Advisor,
    b. Repurpose a second Laboratory Technician to an Priority Populations Treatment Advisor,
    c. Repurpose the ADS Science Specialist to a Linkages/Retention Senior Program Officer,
    d. Repurpose the Associate Director for Programs to an HIV/TB Clinical Team Lead,
    e. Repurpose a Driver to a second Cooperative Agreement Specialist.
5. Distribution of technical staff: Overall, distribution of staff along technical categories aligns with the pivot and new business model. Approximately 63% of the 100% PEPFAR funded staff fall under technical leadership and programmatic oversight (24 serve as subject matter

experts). PEPFAR Cameroon also acknowledges that only 1 FTE program budget specialist is insufficient and will consider further repurposing of positions to hire health economist(s) to support the interagency team to improve systems in capturing financial and programmatic data, including aligning investments with the pivot across the board.

6. Future plans: PEPFAR Cameroon acknowledges that more can be done on staffing to further improve current alignment. The team will continue to review current position descriptions by agency and skill sets to improve its staffing-for-results.

Major changes to CODB:

The PEPFAR Cameroon CODB budget has increased from $6,794,271 in COP 2016 to $7,780,197 in COP 2017 indicating a 14.51% increase. The difference of $985,926 was due mainly to increases in the local compensation plan, increases in ICASS, fully costing all positions (as opposite to the prorated costs in COP 2016) and the repurposed positions from lower grades to higher grades. The largest shifts within agency level budgets are as follows:

- HHS: Increased costs due to the proposed repurposed positions;
- USAID: Costing reflects achievement of full staffing in COP17 compared to COP16 when salaries, benefits and support costs were pro-rated;
- State: Full costs associated with the PEPFAR Coordinator, SI Technical Advisor and partial costs for the Global Fund Liaison.

Excluding the centrally funded $3,000,000 for HIS activities, PEPFAR Cameroon's CODB is 16.7% of its total PEPFAR budget (down from 18.8% in COP 2016) which is higher than most countries. PEPFAR Cameroon will continue to explore ways to reduce the budget but any further cuts will result in negative programmatic outcomes including staff reductions, limited SIMS visits and limited travel for programmatic field support essential training.

APPENDIX A

SNU Prioritization

Table A.1

SNU	COP15 Prioritization	APR16 Achievement	COP16 Prioritization	Expected Achievement by APR17	COP17 Prioritization	COP17 Target: (APR18)	FY18 ART coverage
Yaounde Cluster		39%		40%	Scale-up Saturation	59968	60%
Doula Cluster		41%		55%	Scale-up Saturation	40860	60%
Kumba	Sustained	36%	Sustained	34%	Sustained	7314	47%
Bamenda	Sustained	91%	Sustained	133%	Sustained	12364	100%
Kumbo East	Sustained	25%	Sustained	15%	Sustained	3983	23%
Ndop	Sustained	27%	Sustained	42%	Sustained	3920	63%
Bafia	Sustained	0%	Sustained	14%	Sustained	3196	34%
Limbe	Sustained	47%	Sustained	60%	Sustained	5115	76%
Mbalmayo	Sustained	10%	Sustained	9%	Sustained	3065	33%
Buea	Sustained	29%	Sustained	54%	Sustained	2885	67%
Tiko	Sustained	72%	Sustained	102%	Sustained	5155	91%
Wum	Sustained	15%	Sustained	28%	Sustained	1859	45%
Nkambe	Sustained	24%	Sustained	26%	Sustained	2312	34%
Fundong	Sustained	48%	Sustained	24%	Sustained	4652	32%
Ntui	Sustained	3%	Sustained	6%	Sustained	1212	33%
Akonolinga	Sustained	15%	Sustained	25%	Sustained	1464	43%
Muyuka	Sustained	24%	Sustained	27%	Sustained	1757	35%
Kumbo West	Sustained	53%	Sustained	77%	Sustained	2802	74%
Nkongsamba	Sustained	33%	Sustained	41%	Sustained	5153	100%
Edea	Sustained	33%	Sustained	32%	Sustained	2465	46%
Nanga Eboko	Sustained	17%	Sustained	40%	Sustained	557	27%
Ndu	Sustained	29%	Sustained	24%	Sustained	1997	34%
Ngoumou	Sustained	21%	Sustained	37%	Sustained	1306	48%
Obala	Sustained	36%	Sustained	26%	Sustained	2363	39%
Eseka	Sustained	9%	Sustained	6%	Sustained	1292	21%
Mbandjock	Sustained	9%	Sustained	11%	Sustained	820	30%
Ekondo Titi	Sustained	22%	Sustained	33%	Sustained	1015	49%

Batibo	Sustained	35%	Sustained	108%	Sustained	1165	100%
Mfou	Sustained	33%	Sustained	27%	Sustained	1384	40%
Ayos	Sustained	24%	Sustained	31%	Sustained	876	40%
Ngog Mapubi	Sustained	8%	Sustained	4%	Sustained	931	18%
Saa	Sustained	0%	Sustained	0%	Sustained	987	39%
Okola	Sustained	5%	Sustained	4%	Sustained	953	35%
Tombel	Sustained	27%	Sustained	18%	Sustained	1074	29%
Bafut	Sustained	31%	Sustained	43%	Sustained	804	44%
Mamfe	Sustained	69%	Sustained	39%	Sustained	2162	51%
Fontem	Sustained	16%	Sustained	11%	Sustained	910	27%
Ndikinimeki	Sustained	12%	Sustained	8%	Sustained	797	23%
Mbengwi	Sustained	36%	Sustained	273%	Sustained	750	100%
Monatele	Sustained	17%	Sustained	27%	Sustained	531	46%
Njombe Penja	Sustained	98%	Sustained	83%	Sustained	1516	79%
Soa	Sustained	17%	Sustained	26%	Sustained	476	44%
Bali	Sustained	45%	Sustained	84%	Sustained	553	79%
Ebebda	Sustained	16%	Sustained	20%	Sustained	281	33%
Bangem	Sustained	17%	Sustained	22%	Sustained	300	37%
Yabassi	Sustained	14%	Sustained	14%	Sustained	125	20%
Pouma	Sustained	14%	Sustained	14%	Sustained	54	9%
Nguti	Sustained	50%	Sustained	43%	Centrally Supported		

Table A.2 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY17)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY18) *TX_CURR***	**Newly initiated (APR FY18) *TX_NEW***	**% ART Coverage (APR 18) TX_CURR**
Attained						
Scale-Up Saturation						
Scale-Up Aggressive	**168,047**	**91,413**	**43,025**	**100,828**	**19,498**	**60%**
Sustained	**203,937**	**78,191**	**84,959**	**96,653**	**32,384**	**47.39%**
Central Support	**48,512**	**400**	**38,410**	**0**	**0**	
Commodities (if not included in previous categories)						
Total	**420,496**	**170,004**	**166,394**	**197,481**	**51,882**	

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level		
Applied Pipeline	New Funding	Total Spend
$US 6,965,148	**$US 39,640,337**	**$US 46,605,485**

Table B.1.2 Resource Allocation by PEPFAR Budget Code

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$US 2,231,070
HVAB	Abstinence/Be Faithful Prevention	$US 0
HVOP	Other Sexual Prevention	$US 2,343,609
IDUP	Injecting and Non-Injecting Drug Use	$US 0
HMBL	Blood Safety	$US 0
HMIN	Injection Safety	$US 0
CIRC	Male Circumcision	$US 0
HVCT	Counseling and Testing	$US 4,013,037
HBHC	Adult Care and Support	$US 1,905,259
PDCS	Pediatric Care and Support	$US 401,689
HKID	Orphans and Vulnerable Children	$US 1,804,211
HTXS	Adult Treatment	$US 21,595,061
HTXD	ARV Drugs	$US 27,160
PDTX	Pediatric Treatment	$US 1,442,687
HVTB	TB/HIV Care	$US 493,410
HLAB	Lab	$US 1,532,660
HVSI	Strategic Information	$US 1,182,289
OHSS	Health Systems Strengthening	$US 1,133,495
HVMS	Management and Operations	$US 6,499,848
TOTAL		**$49,605,485**

B.2 Resource Projections

PEPFAR unit expenditures (UE) from the most recent Expenditure Analysis (EA 2016) data and the PEPFAR Budget Allocation Calculator (PBAC) were used to calculate the required resources to support targets for HTC, care and treatment, PMTCT, priority and KP prevention, and OVC. Adjustments to UEs were made to account for anticipated changes in the programmatic package of services in the coming implementation year due to changes to the geographic pivot from scale-up districts to scale-up

clusters, and the need to significantly improve linkage and retention rates. It should be noted that, for the first time in COP17, UEs do not include program management and routine strategic information costs.

HTC

The HTC modalities for the HTC UE utilized included PITC, VCT and CBTC UEs with differing UEs for military sites, scale-up sites, and sustained sites.

- PITC: The HTC UE of $3.44 was applied to PITC for military FBCTS, while an adjusted PITC UE of $14.16 was applied for civilian FBCTS in scale-up sites, accounting for renovations in counseling booths in 77 sites and family-centered testing and venue-based models. In sustained districts, a UE of $0.53 was applied.
- VCT: In COP17, VCT services will target KP and military populations. With regards to KP, VCT will be offered within KP DICs that provide services across eleven hot spots. Since there is no historical expenditure data for provision of HTS within DICs, an adjusted VCT UE of $24.96 is calculated based on 2016 EA data adjusted for outliers and health districts no longer supported by the program (e.g. Kribi and Bertoua). The HTC UE of $12.95 was applied to VCT for the military.
- CBTC: In COP17, PEPFAR will only supported CBCT through the military's implementing partner with an HTC UE of $12.95 applied.

Care, Treatment, and Support

PEPFAR Cameroon began supporting care and treatment services in April 2016. Due to the timing of this roll out in relation to the two pivots PEPFAR Cameroon has/is undergoing, the EA 2016 UE was not used, but was instead built based on planned activities for COP 17.

- Adult/Pediatric Treatment – No ARV (TX_CURR): Due to Infants on care no longer having its own UE, these costs were rolled into the Pediatric FBCTS UE. The Adult and Pediatric UEs are the same at $160.32 and were based on a planned aggressive scale up retention model that will include retention agents, increased travel/transport, and the roll out of viral load testing. For the sustained districts, the UE of $24.32 was applied. The military program will apply a UE of $117.13 for their sites based on calculations from EA 2016 results representing the sole military IP. The package of services reflected in the UEs mentioned above do not include TB/HIV (in both scale-up and

sustained districts) as this is a new service so a UE could not be confidently determined.

PMTCT

- PMTCT: PEPFAR started in Cameroon as a PMTCT program so has the longest and most reliable associated UEs. PEPFAR Cameroon used the EA 2016 Pregnant Women on Care PMTCT_ARV UE (without the cost of ARV) of $81.92 for both scale up sites and the military. In sustained sites, a PMTCT_ARV UE of $54.36 was applied. The packages of services reflected in the UEs mentioned above do not include TB/HIV (in both scale-up and sustained sites) nor viral load (in scale-up sites) as these are new services and are reflected as a lump sum until UEs can be confidently determined. Regarding Pregnant Women Tested PMTCT_STAT, the EA 2016 UE applied was $1.00 for scale up sites and the military while a UE of $0.63 was applied for sustained sites. For infants tested, PEPFAR Cameroon used the EA 2016 Infants Tested PMTCT_EID of $49.75 for scale-up and military sites. For sustained sites, the PMTCT_EID UE applied was $24.74.

OVC

- PEPFAR Cameroon applied an adjusted UE of $92.02 in OVC_SERV DSD sites (2 scale-up clusters and Bamenda health district), while Peace Corps applied a lower UE of $18.31 for OVC_SERV TA-SDI activities. The adjusted UE of $92.02 is a weighted average taking into account standard OVC package (calculated taking into account EA 2016 data under OVC_All Care and unit cost of new activities introduced in FY17) and a specific package of services (provided by KP partner) for children of FSWs.

PP_PREV

- PEPFAR Cameroon applied the EA 2016 PP_PREV UE of $18.37 for the military while Peace Corps applied a lower UE of $14.96.

KP: FSW

- PEPFAR Cameroon applied an adjusted KP_FSW UE of $121.42 taking into account EA 2016 data, new prevention activities introduced in FY2017, and EA 2016 expenditures associated with provision of community-based care and treatment services to HIV-positive FSWs.

KP: MSM

- PEPFAR Cameroon applied an adjusted KP_MSM UE of $123.00 taking into account EA 2016 data (adjusted for outlier in Efoulan), new prevention activities introduced in FY17, and EA 2016 expenditures association with provision of community-based care and treatment services to HIV-positive MSM.

Table of UEs:

Program Area	**Agency**	**COP 2017 Final Applied Unit Budget (UE)**	**Notes on Minimum Package of Services**
FBTCS (Adult, Pediatric, Infant-on-care Treatment Package)	DOD Military	$117.13	The Military UE is $117.13 ($285.69 without PM of 59%) from Data Nav as the package of services remains the same going into COP 17
	CDC Scale Up Sites	$160.32	Implement differentiated Models of Service Delivery to include the following facility-based packages: Family model, Pediatric model, Community support groups that incorporates ART dispensation model, AGYW package, KP package, young adults (under 30) package and older men package. This UE was built as new. The CBCHB UE is $149.05 (without PM/SI). Infants-on-care no longer has its own UE so was also rolled into this UE. UE was based on following calculations and adjustments: a) implement aggressive scaled up retention model by modifying cadre of Retention Agents (share costs with linkage agents – above) at sites ($300/month salary: 40 high, 20 medium, 8 low); b) increase travel and transport (x3) (currently in $533,570x3=$1,600,710); c) Social Support Group Package (important for differentiated service models); o Staffing (One Coordinator @ high and medium); o $500/month; Training $6,000/year; running costs; o Introduce tool kits for various priority groups; o Costing: XX/# of sites; d) Viral Load Roll Out: o Training of health workers at site level (no additional cost); o Tools dissemination for health workers (tools have been harmonized but not disseminated); o VL education materials for patients (above site cost); o Scale up and strengthen sample transportation (and transport lab supplies as well) to include VL (current system is for EID – bikers program) (57 total bikers is $19,314 – 5 months May-Sept 2016); Add 10 more bikers to total 67
	CDC Sustained Sites	$24.32	Same package as last year.

PMTCT_STAT, PMTCT_STAT Known Pos (Pregnant Women Tested and Receiving Results)	DOD Military	$1.00	UE for sustained site does not exist for MIL
	CDC Scale Up Sites	$1.00	Same package as last year
	CDC Sustained Sites	$0.63	Same package as last year
PMTCT_ARV (Pregnant Women on ART)	DOD Military	$81.92	UE is $XXX ($XX without PM of 56%), UE for sustained site does not exist for MIL
	CDC Scale Up Sites	$81.92	
	CDC Sustained Sites	$54.36	
PMTCT_EID (Infants Tested)	DOD Military	$49.75	
	CDC Scale Up Sites	$49.75	
	CDC Sustained Sites	$24.74	UE for sustained sites does not exist for the Military
OVC	USAID	$92.02	EA 2016 expenditures based on following services: referrals for HTS; economic strengthening; expenditures associated with care and support to cLHIV; psychosocial support, and case management. **New activities** in FY2017 (which did not occur in 2016) include education support, early childhood development for children, SRH, post-GBV community care package, procurement and distribution of RUTF for clinically malnourished cLHIV; identification and HTS of children of HIV-positive FSWs; enhanced package of services to children of FSWs including distribution of condoms and lubricants, and psychosocial counseling to children who have experienced and/or witnessed (sexual) violence.
	Peace Corps		Same package as COP 2016. Total Peace Corps Budget is: HVMS=$632,082; HKID= $58,217; HVOP=$145,543; HBHC=$119,669. UE calculated as: target = 3,108; $58,217/ 3,108= $18.31
PP_PREV	DOD Military	$18.37	
	Peace Corps	$14.96	Peace Corps: Target = 17,734 (UE = [$145,543+119,669]/17,734 = $14.96) • AGYW remain PC's priority target population. Package of services include: Transmission and Risk reduction education • Curriculum based, age appropriate prevention skills and sexuality education including life skills • Information on and mobilization for HTC • Adult/community engagement in HIV prevention • Condom Promotion • Gender equitable principles promotion • Treatment literacy and adherence support to people

			living with HIV
FSW	USAID	$121.42	Package of services in 2016 included staff LoE for community outreach, peer outreach, and linkage to various services available at drop-in center; condom and lubricant promotion and distribution; engagement with GRC and CAMNAFAW (Global Fund) to create enabling environment; services provided at DIC (nutrition education, small group sessions, STI screening and syndromic management, etc.); continuous prevention and linkage to HTS for HIV-negative beneficiaries; post-GBV community care package. **New activities** introduced in FY2017 include (1) enhanced peer mobilizer model. This is now the primary strategy (adapted from RDS approach) for reaching and recruiting more FSWs for HTS and other services provided at DIC. Additional cost of $4.17 takes into account hiring of community-based peer leaders (no longer called peer educators) who are given a salary (and transport costs, communications credit, etc.) and an expanded role in identifying and managing beneficiaries.
MSM	USAID	$123.00	Package of services in 2016 included staff LoE for community outreach, peer outreach, and linkage to various services available at drop-in center; condom and lubricant promotion and distribution; engagement with GRC and CAMNAFAW (Global Fund) to create enabling environment; services provided at DIC (nutrition education, small group sessions, STI screening and syndromic management, etc.); continuous prevention and linkage to HTS for HIV-negative beneficiaries; post-GBV community care package. UE for provision of services to MSM higher than for FSW taking into account the extra effort required to identify MSM (due to stigma and discrimination). **New activities** introduced in FY2017 include (1) enhanced peer mobilizer model. This is now the primary strategy (adapted from RDS approach) for reaching and recruiting more FSWs for HTS and other services provided at DIC. Additional cost of $4.6 takes into account hiring of community-based peer leaders (no longer called peer educators) who are given a salary (and transport costs, communications credit, etc.) and an expanded role in identifying and managing beneficiaries.

APPENDIX C

See attached Excel table.

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Table 6.1.1 Key Programmatic Gap #1: Low coverage and quality of facility and community ART services leads to poor linkages, adherence and retention (2nd and 3rd 90s) in priority health districts									
1. Shortage of adequately trained health and community workers to increase ART uptake in priority districts	75% increase in number of health and community workers trained in priority districts.	100 health and community workers in priority health districts trained.	N/A (Not entered because activity discontinued for COP17)	# of health and community workers trained in priority districts	~~Activity 1.1: ICAP will support MoPH to implement training of trainers (ToT) for faculty at 16 Nursing/Midwifery schools (in Yaoundé and Douala) on the topics of Test and Start and Quality Improvement Methodology.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS**		$ -		
	Increase coverage and retention of ART in priority districts from 26.1% & 60% respectively to 80%	Implementation of test and start at 45 health facilities in PEPFAR scale-up sites	N/A (Not entered because activity discontinued for COP17)	# of health facilities with Test and Start implemented	~~Activity 1.2: TA through supportive supervision will be provided by ICAP and will include 16 5-day supportive supervision visits on PMTCT/ART tools completion in the PEPFAR regions. Participants will include District trained staff, data managers from the regional delegation of the Public Health office, M&E staff from the DFH/MOPH~~ **NOT FUNDED COP17 DUE TO LACK OF FUNDS**		$ -		
2. Insufficient capacity of health and community based systems to support uptake, linkage and retention	100% linkage to care and treatment; and < 20% loss to follow-up in priority health districts.	Implementation of test and start at 45 health facilities in PEPFAR scale-up sites.	All facilities in the 02 clusters in Yaounde and Douala are implementing the national SOPs on linkage and retention		~~Activity 2.1: Provide extended advisory support for both PEPFAR and Global Fund financed partners to strengthen their capacity to ensure program oversight meets international best practice standards for key population guidance, quality monitoring, and oversight.~~ **ACTIVITY NOT FUNDED IN COP17; WILL BE FUNDED USING USAID HOP $$**	~~OHSS~~	$ -	~~18049~~	~~Quality Management~~

3. Weak strategic information management	75% increase in data collection, reporting, and dissemination	PMTCT/option B+, M&E tools printed and distributed in 189 health districts	N/A (Not entered because activity discontinued for COP17)	NACC quaterly report	~~Activity 3.1: PEPFAR/Cameroon will support MoPH to print and distribute PMTCT/option B+ M&E tools (including registers, monthly reporting forms and job aids) across the country including 6 non-PEPFAR regions in order to ensure availability of standardized tools across the country.~~ **MOVED FROM BARRIER 1, WILL NOT BE FUNDED IN COP 17**	~~HTXS~~	~~$ -~~	~~17336~~	~~Quality Management~~	
	75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	NACC quaterly report	Activity 3.1: PEPFAR/Cameroon will continue to work with NACC to strengthen implementation of SQA/DQA across the country. NACC is responsible for supervising implementation of SQA/DQA activities in six non-PEPFAR regions.	HVSI	$ 21,993	18229	Quality Management	Above site
	75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	NACC quaterly report	Activity 3.2: NACC will conduct quarterly regional DQA activities in collaboration with NACC SI Unit in the four PEPFAR regions.	HVSI	$ 43,726	18229	Quality Management	Above site
	75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	NACC quaterly report	Activity 3.3: NACC will coordinate Monitoring and Evaluation technical working group meetings focused on addressing critical issues related to data collection on treatment and care; and developing guidance for nationwide implementation. PEPFAR funds will support technical working group meetings and also production and dissemination of the HIV/AIDS annual report for NACC to all regions	HVSI	$ 7,308	18229	Quaity Management	Above site

75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	NACC quaterly report	Activity 3.4: NACC will coordinate nationwide implementation of DHIS2 while also making sure non-PEPFAR regions report their data via DHIS2 in order to have the same data quality standard across the country. DHIS2 review meetings will ensure gaps are identified and actions to remediate or mitigate errors addressed.	HVSI	$ 25,617	18229	Quality Management	Above site
75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	# of facilities with standardized registers	Activity 3.5: PEPFAR/Cameroon will support NACC to ensure overall coordination of all data quality and reporting across the country for HIV/AIDS-related indicators. This includes performing supportive supervision for ART and Option B+ sites in six non-PEPFAR regions.	HVSI	$ 19,399	18229	Quality Management	Above site
75% increase in data collection, reporting, and dissemination	National DHIS User Guide developed, printed and made available in 189 health districts	Availability of NACC annual report At least four NACC quarterly reports provide evidence on assessments performed and performed and mitigation plans	Real time data from DHIS	Activity 3.6: In order to improve on coordination and also the ability to collect and analyze real-time data, PEPFAR funds will also support internet connectivity at NACC and its 10 Regional offices. Internet access will facilitate reporting including shortening lead time for dissemination of reports site level reports.	HVSI	$ 22,467	18229	Quality Management	Above site
75% increase in data collection, reporting, and dissemination	Recruit data manager	Continue to support data manager	Presence of Data Manager	Activity 3.7: In order to assure data security, PEPFAR/Cameroon will support NACC to recruit an IT/Data Manager to strengthen site level capacity in record keeping.	HVSI	$ 11,423	18229	Quality Management	Above site
75% increase in data collection, reporting, and dissemination	At least 50% (95) trainings conducted	N/A (Not entered because activity discontinued for COP17)	Number of trainings conducted	~~Activity 3.8: In COP 2016, PEPFAR/Cameroon, through ICAP, will support trainings in all 189 health districts in Cameroon.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDING; ACTIVITY MOVED TO DIFFERENT IM**	~~HVSI~~	~~$ -~~	~~17336~~	~~Quality Management~~	
75% increase in data collection, reporting, and dissemination	Equipment procured for 10 regional NACC offices	N/A (Not entered because activity discontinued for COP17)	Number of offices with DHIS equipment procured	~~Activity 3.9: ICAP will support NACC in implementation of DHIS2 through procurement of equipment (desktop, uninterrupted power supply, surge protector strip, printer, toner, cartridge and external hard drive) for ten regional NACC offices. Estimated cost per package is $3,451 based on previous ICAP purchase.~~ **NOT FUNDED IN COP17 BECAUSE ACTIVITY COMPLETED**	~~HVSI~~	~~$ -~~	~~17336~~	~~Quality Management~~	

75% increase in data collection, reporting, and dissemination	16 solar electricity devices procured	N/A (Not entered because activity discontinued for COP17)	Number of solar panels procured	~~Activity 3.10: ICAP will also support procurement of 16 solar electricity devices for 16 health districts locates in non-PEPFAR regions which do not have any access to electricity.~~ **NOT FUNDED IN COP17 BECAUSE ACTIVITY COMPLETED**	~~HVSI~~	~~$ -~~	~~17336~~	~~Quality Management~~	
75% increase in data collection, reporting, and dissemination	500 DHIS user guides printed and distributed	N/A (Not entered because activity discontinued for COP17)	Number of user guides distributed in the 189 districts	~~Activity 3.11: ICAP will support the printing of and distribution of 500 DHIS user guides to each of the 189 districts and 35 regional and central hospitals. Unit costs per user guide have been estimated at $20.~~ **NOT FUNDED IN COP17 BECAUSE ACTIVITY COMPLETED**	~~HVSI~~	~~$ -~~	~~17336~~	~~Quality Management~~	
75% increase in data collection, reporting, and dissemination	45 desktop computers procured and installed for the 2 scale-up districts	45 desktop computers procured and installed in the new cluster districts (Douala cluster and Yaounde cluster)	EMR in reference hospitals, regional hospital and some district hospitals	Activity 3.12: NACC will roll out an Electronic Medical Record (EMR) – Openmrs or DHIS2 – system in reference hospitals, regional hospitals, some districts hospitals and other big facility across the country 45 desktop computers and other accessories for the scale-up sites in the cluster districts (Douala and Yaounde). Engagement with other partners will also be key for success.	HVSI	$ 400,000	18229	Quality Management	Above site
75% increase in data collection, reporting, and dissemination	Internet connectivity in all 189 health districts Electronic, real-time transmission of DHIS2 results from all 189 health districts	N/A (Not entered because activity discontinued for COP17)	~~Number of internet equipement purchased~~	~~Activity 3.13: In addition to equipment procurement, ICAP will also support internet connectivity at 189 health districts ($50 per month for 12 months for 189 health districts, 13 regional staff).~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDING; ACTIVITY MOVED TO DIFFERENT IM**	~~HVSI~~	~~$ -~~	~~17336~~	~~Quality Management~~	
75% increase in data collection, reporting, and dissemination	Quarterly visits in all regions conducted and reports made available	Quarterly visits in all regions conducted and reports made available	Frequency of conducted visits and number of reports available	Activity 3.15:PEPFAR/Cameroon will support NACC to meet its supportive supervision responsibilities including supporting site visits to newly-created HIV/AIDS treatment and care sites to monitor service and data quality	HTXS	$ 36,857	18229	Quality Management	Above site

	75% increase in data collection, reporting, and dissemination	4 trainings conducted for data clerks	4 trainings conducted for data clerks	Data clerks producing quality data on HIV/TB including Option B+	Activity 3.16: PEPFAR/Cameroon will support trainings of data clerks on the use of data collection tools and its management will contribute in strengthening the capacity of the M&E system to generate quality strategic information on TB/HIV treatment and care and option B+ for decision making.	HVTB	$ 37,489	18229	Quality Management	Above site
	Seroprevalence among millitary updated and published **NEW OUTCOME FOR COP 17**	IRB Approval of HIV SABERS	Field data collection and analysis begins	HIV incidence and prevalence among military after 5yrs of service	Activity 3.14: Key activities in FY 2017 will include development and IRB approval of protocol for military prevalence study and other activities related to preparing for implementation of the study in FY 2018.	HVSI	$ 250,000	17365	Quality Management	
TOTAL							**$ 876,279**			

Table 6.1.2 Key Programmatic Gap #2: Weak Procurement and Supply Chain Management of HIV/AIDS-related commodities (1st, 2nd, and 3rd 90s)

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score	
1. Insufficient warehouse and inventory level optimization	100% (4) PEPFAR-supported Regional Medical Stores (RMS) maintain appropriate min-max levels 70% of the time for annual reporting periods	100% of stock records at RMS and 80% of stock records at health facilities correspond with physical counts for a set of indicator drugs in RMS	80% of scale-up sites maintain appropriate min-max stocks of HIV commodities tracers	MER: SC_STOCK (Stocked According to Plan)	1.1 Collaboration across the regional, district and site levels to develop procedures and tools for regional supply plans and monitor performance; and improve regional management of medicines including quantification of HIV/AIDS-related commodities. Collaboration across the regional, district, and site levels will focus on strengthening data sharing and flows of information. Clinical IPs will report on site-level stock data.	OHSS	$134,000	18195	Commodity Security and Supply Chain	Above site
						HLAB	$43,343	18195		Above site
						HTXS	$177,657	18195		Above site
	Storage capacity at 100% (4) regional warehouses capable of maintaining 3-6 months of stock in order to meet new test and treat requirements	Minor infrastructure upgrades to storage spaces at regional warehouses completed. Health facility infrastructure upgrades were completed by clinical IPs	Fewer than 20% Red or Yellow for facility level supply chain reliability CEEs	SIMS Facility module Supply Chain Reliability CEE results	1.2 Optimize and rationalize storage spaces available for the HIV program at central and regional warehouses and streamline warehouse space in order to optimize in- and outflows of drugs.	OHSS	$100,000	18195	Commodity Security and Supply Chain	Above site
	50% of pharmacy attendants at PEPFAR-funded health facilities have received training on good dispensing practices	Revised guidelines on management (including dispensing procedures) of HIV/AIDS commodities developed	Fewer than 20% Red or Yellow for facility level supply chain management and medication dispensing CEEs	SIMS Facility module Supply Chain Management and medication dispensing CEE results	**ACTIVITY NO LONGER APPROPRIATE** ~~Develop national regulations for appointment, training, ongoing coaching, and retention of pharmacy attendants including specific considerations for HIV and other disease specific programs~~ 1.3 Strengthen the national level working group, including clinical IPs, the supply chain partner, and the GRC to develop and disseminate inventory management tools, job aides and standard operating procedures on long-term HIV commodities forecasting, taking into account existing tools and international best practices. **[new COP17 activity]**	HTXS	$60,547	18195	Commodity Security and Supply Chain	Above site
						MTCT	$29,193	18195		Above site
						HBHC	$60,260	18195		Above site

2. Insufficient institutional capacity to use HIV pharmacy information for decision making	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores	Health Facility Reporting Rates	**ACTIVITY NO LONGER APPROPRIATE** ~~Conduct a feasibility study to create interfaces between DHIS/OSPSIDA in order to improve data migration and optimization of IT tools and participate in GRC donor initiative to automatize Logistics Management Information System~~ 2.1 Pilot an electronic Logistic Management information System at high burden sites within scale-up clusters in collaboration with ongoing processes being implemented by other partners, including clinical IPs. **[new COP17 activity]**	HTXS	$25,000	18195	Commodity Security and Supply Chain	
						MTCT	$20,000	18195		Above site
						HBHC	$20,000	18195		Above site
	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores	Health Facility Reporting Rates	2.2 Support civil society organizations to collect key supply chain performance indicators on a monthly basis	OHSS	$38,000	18195	Commodity Security and Supply Chain	Above site
	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores	Health Facility Reporting Rates	**ACTIVITY NO LONGER APPROPRIATE** 2.3 ~~Support GRC to include key pharmaceutical management indicators in routine program management~~.		$0	18195	Commodity Security and Supply Chain	Above site
	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Coordinated procurement plan for commodities developed and implemented on annual basis.	Percentage of HIV commodities for which a country supply plan was developed during the last year and updated every six months	2.4 Develop an annual Commodity Security and Supply Plan based on targets, objectives and M&E plan.	OHSS	$72,000	18195	Commodity Security and Supply Chain	Above site
						HLAB	$12,000	18195		Above site
	Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities				**ACTIVITY NO LONGER APPROPRIATE** 2.5 ~~Develop guidelines for condom and lubricant importation and quality assurance~~		$0		Commodity Security and Supply Chain	Above site

Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities				**ACTIVITY NO LONGER APPROPRIATE** 2.6 ~~Develop a stock monitoring tool for lab commodities to be used at warehouse and facility level that can assist to accurately track utilization and stock levels of reagents, and inform procurement and distribution decision making~~		$0		Commodity Security and Supply Chain	Above site
Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Coordinated procurement plan for commodities developed and implemented on annual basis.	Percentage of facilities that received SCM/logistics supervision visits according to schedule	2.7 Conduct regional and/or district quarterly feedback meetings involving health facilities (ART managers), local health authorities, regional warehouses, and clinical IPs to review supervision indicators and build management skills to improve oversight performance of HIV commodities management.	HTXS	$50,000	18195	Commodity Security and Supply Chain	Above site
					MTCT	$10,000	18195		Above site
					HBHC	$25,000	18195		Above site
Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Coordinated procurement plan for commodities developed and implemented on annual basis.	Percentage of facilities that received SCM/logistics supervision visits according to schedule	2.8 Developing tablet-based supervision tools to automatize supervision scores and information gathering; conduct joint supervision with district and/or regional NACC coordinators; and review reports submitted by health facilities to customize supervision and onsite technical assistance during visits; collaborate with clinical IPs to monitor health facility stocks of ARVs, RTKs, condoms, CTX, lab reagents; and liaise with Regional Medical Stores when required to avoid stock outs.	OHSS	$67,921	18195	Commodity Security and Supply Chain	Above site
					HLAB	$67,730	18195		Above site
					HTXS	$203,000	18195		Above site
Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.	Coordinated procurement plan for commodities developed and implemented on annual basis.	Percentage of facilities that received SCM/logistics supervision visits according to schedule	2.9 Develop a joint plan with the NACC regional coordinator, the Regional Medical Stores and District Medical Officers to progressively graduate good performing health facilities, and transfer pharmacy supervision responsibilities to the government	OHSS	$40,934	18195	Commodity Security and Supply Chain	Above site
Quarterly stock monitoring reviews are conducted using reports from 100% of regional stores and from 50% of health facilities	Availability of complete monthly reports per region submitted to OSPSIDA or existing LMIS system for the past six months.		Percentage of facilities that received SCM/logistics supervision visits according to schedule	**ACTIVITY NO LONGER APPROPRIATE** 2.10 ~~Support NACC to develop a national training curriculum, job descriptions and coaching plan for all HIV Regional Supply Chain Advisers; including technical meeting reviews to discuss consistency and harmonization of approaches across regions and to share strategic logistics information~~		$0		Commodity Security and Supply Chain	Above site

	GRC's GF audit rating improved from ineffective to partially effective **NEW OUTCOME**	Revised guidelines on management (including dispensing procedures) of HIV/AIDS commodities developed	Fewer than 40% Red or Yellow for Supporting Fonctions Commodities set	SIMS Above-site module Commodities set results	3.1 Technical assistance to improve implementation of complementary distribution and dispensing strategies including standard distribution through the public sector, distribution through the private sector and community base distribution	HTXS	$37,751	18195	Commodity Security and Supply Chain	Above site
						MTCT	$5,000	18195		Above site
						HBHC	$30,025	18195		Above site
	GRC's GF audit rating improved from ineffective to partially effective **NEW OUTCOME**	Revised guidelines on management (including dispensing procedures) of HIV/AIDS commodities developed	Fewer than 40% Red or Yellow for Supporting Fonctions Commodities set	SIMS Above-site module Commodities set results	**NEW ACTIVITY [COP17]** 3.2 Strengthen supply chain management coordination committees at central level, PEPFAR-supported regions and 12 scale-up districts	OHSS	$73,544	18195	Commodity Security and Supply Chain	Above site
						HLAB	$11,456	18195		Above site
3. Poor governance of pharmaceutical and lab management sector at all levels	GRC's GF audit rating improved from ineffective to partially effective **NEW OUTCOME**	Revised guidelines on management (including dispensing procedures) of HIV/AIDS commodities developed	Fewer than 40% Red or Yellow for Supporting Fonctions Commodities set	SIMS Above-site module Commodities set results	**ACTIVITY NO LONGER VALID** ~~Develop dispensing procedures and patients appointment management tools for pharmacy attendants and pharmacists in the public, community and private sectors, to allow multiple months' supply of ARVs and CTX, as per PEPFAR guidelines come July 2016~~ 3.3 Support district managers and regional stakeholders on reverse logistics implementation **[new COP17 activity]**	MTCT	$16,900	18195	Commodity Security and Supply Chain	Above site
						HTXS	$13,695	18195		Above site
						HBHC	$26,900	18195		Above site
	GRC's GF audit rating improved from ineffective to partially effective **NEW OUTCOME**	Revised guidelines on management (including dispensing procedures) of HIV/AIDS commodities developed	Fewer than 40% Red or Yellow for Supporting Fonctions Commodities set	SIMS Above-site module Commodities set results	**ACTIVITY MODIFIED** ~~TA to NACC to troubleshoot supply chain management challenges, prepare supply chain procurement and distribution plan, and as need be, respond to Global Fund conditions precedent to disbursement of funds for procurement of commodities.~~ 3.4 Provide technical support to GF's principal recipients (NAC and CAMNAFAW) and their subrecipients to strengthen procurement and supply chain controls	OHSS	$122,343	18195	Commodity Security and Supply Chain	Above site
						HLAB	$27,657	18195		Above site
TOTAL							**$1,621,856**			

Table 6.1.3 Key Programmatic Gap #3: Weak laboratory quality management systems (1st, 2nd, 3rd 90s)										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**	
1. Weak Laboratory Governance within the health structure	An operational National Public Health Laboratory with an EQA coordination center.	An operational National Public Health Laboratory	EQA coordination center set-up.	1. LTWG established 2. 50% of sites within the cluster districts enrolled and participating in the EQA program	1.1**:** Set-up of EQA center at NPHL and provide in-service training	HLAB	$200,000	18230	10.Laboratory	Above site
	An operational National Public Health Laboratory with an EQA coordination center.	An operational National Public Health Laboratory	EQA coordination center set-up.	1. LTWG established 2. 50% of sites within the cluster districts enrolled and participating in the EQA program	1.2: Set-up PT panel production unit for HIV and TB at the NPHL **MODIFIED FROM COP16**					
	An operational National Public Health Laboratory	Lab policy and strategic plan developed	National Laboratory policy and strategic Plan adopted and implemented.	Availability of the NLSP and policy documents at both regional and district levels in both clusters	1.3: Printing and dissemination of lab policy and strategic plan to all sites within both clusters.					
	National Laboratory polices and strategic Plan are developed, adopted and implemented.	National Laboratory policy and strategic Plan developed and translated, pending adoption and dissemination.	National Laboratory policy and strategic Plan adopted and implemented. Laboratory Technical Working Group established and functioning.	Availability of the NLSP and policy documents at both regional and district levels in both clusters	1.4: ASLM will provide technical assistance to the Laboratory Technical Working Group that will guide adherence to the laboratory policy and strategic plan within the framework of the Medical Laboratory Board.	HLAB	$15,000	14118	10. Laboratory	**Above site**

2. No accredited laboratories (i.e. labs that meet international standard for quality) in tiered system	Laboratory staff in all labs within scale-up districts trained on quality management system (QMS)	Lab staff in all facilities at scale-up districts trained on QMS.	Train at least 50% of lab staff in facilities or testing sites in both clusters on QMS	Number of lab staff and laboratories or testing sites trained and certified for HIV testing.	2.1: IP will roll out External Quality Assessment (EQA) programs for HIV , EID, Viral load and CD4 testing and also start implementing EQA for TB in scale-up sites within both clusters to minimize misinterpretation and misclassification of results. Support certification of laboratories and lab staff engaged in HIV testing.				
	Laboratory staff in all labs within scale-up districts trained on quality management system (QMS)	Lab staff in all facilities at scale-up districts trained on QMS.	Train at least 50% of lab staff in facilities or testing sites in both clusters on QMS	Number of lab staff and laboratories or testing sites trained and certified for HIV testing.	2.2: Support certification of laboratories and lab staff engaged in HIV testing - (please move to section 2.1 above)				
	Laboratory staff in all labs within scale-up districts trained on quality management system (QMS)	Lab staff in all facilities at scale-up districts trained on QMS.	Train at least 50% of lab staff in facilities or testing sites in both clusters on QMS	Number of lab staff and laboratories or testing sites trained and certified for HIV testing.	2.3: Train all sites on re-testing for verification to support test and start. Provide job aids, SOPs, and algorithms for verification testing				
	100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	1. All labs (44) in scale up districts enrolled in CQI programs. 2. 10 facilities in scale-up districts (22%) engaged in site certification for quality testing.	CQI scaled-up in at least 80 testing sites in both clusters and 75% (212) of Lab staff in all facilities within both clusters trained on QMS.	Number of facilities enrolled and participating in CQI	2.4: IP will support roll out of the Rapid Test Quality Improvement Initiative (RT-QII) to all sites within both clusters.				
	100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	All labs (44) in scale up districts enrolled in CQI programs.	CQI scaled-up in at least 80 testing sites in both clusters and 75% (212) of Lab staff in all facilities within both clusters trained on QMS.	Number of facilities enrolled and participating in CQI	2.5: Implement Logbooks in all testing sites to capture testing data, monitor staff competency and adherence to testing policy and guidelines				

100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	1. All labs (44) in scale up districts enrolled in CQI programs. 2. 10 facilities in scale-up districts (22%) engaged in site certification for quality testing.	Train at least 50% of lab staff in facilities or testing sites in both clusters on QMS CQI scaled-up in at least 80 testing sites in both clusters and 75% (212) of Lab staff in all facilities within both clusters trained on QMS.	Number of lab staff and laboratories or testing sites trained and certified for HIV testing.	2.6 Train Q-Corps and roll-out RT-QII	HLAB	$300,000	18230	10.Laboratory	Site level
100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	All labs (44) in scale up districts enrolled in CQI programs.	CQI scaled-up in at least 80 testing sites in both clusters and 75% (212) of Lab staff in all facilities within both clusters trained on QMS.	Number of sites supervised and reports made available	2.7: Conduct site supervision and corrective actions					
100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	All labs (44) in scale up districts enrolled in CQI programs.	All EID / Viral Load reference labs enrolled in EQA for EID / Viral load testing.	Number of facilities enrolled and participating in CQI	2.8:Scale-up EQA for EID and Viral load testing in all reference labs providing testing services to sites within both clusters.(this aligns with benchmark #3 in column D)					
100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	All labs (44) in scale up districts enrolled in CQI programs.	All EID / Viral Load reference labs enrolled in EQA for EID / Viral load testing.	Number of facilities enrolled and participating in CQI	2.9: IP will support embedded laboratory mentorship in accordance with the CQI process to enhance sustainability of the quality testing services for optimum patient care.					
100% of laboratories in PEPFAR supported districts enrolled in continuous quality improvement (CQI) programs (e.g. Proficiency testing)	All labs (44) in scale up districts enrolled in CQI programs.	All EID / Viral Load reference labs enrolled in EQA for EID / Viral load testing.	Number of facilities enrolled and participating in CQI	2.10: IP will train on and support implementation and roll out of Basic Laboratory Information System (BLIS) and provide technical assistance to directly link the lab to the clinician using BLIS					
All labs within the scale up sites enrolled in the SLIPTA process.	Train using the SLMTA toolkit and conduct lab assessments in 50% of labs within the sustain sites	50% of labs within the cluster attain one star with the SLIPTA checklist	Number of labs with one atleast one star or more using the SLIPTA checklist	2.11: IP will develop SOPs and Job aids to train on reagent and supplies management within the laboratory; and conduct trainings using the SLMTA toolkit					

	Revise lab staff pre-service training curriculum to include QMS processes	1. Supplies and instruments required for pre-service training provided 2. Revised training curriculum for lab staff Piloted in at least 2 pre-service training institutions.	Revised pre-service training curriculum adopted and implemented in at least 3 lab training institutions.	Training curriculum endorsed by all stakeholders Training laboratory operationalized	2.12: ASLM will support printing and dissemination of the revised curriculum	HLAB	$65,000	14118	10.Laboratory	Above site
	At least 2 accredited labs in tiered system supporting patient testing and monitoring.	One lab achieved ISO 15189 accreditation	50% of labs within the cluster attain ISO 15189 accreditation	Number of accredited labs within the cluster	2.13: ASLM will Support accreditation for 4 SLIPTA labs 2 of which are within the clusters (1 lab already got ISO 15189 accreditation in July 2016)	HLAB	$20,000	14118	10. Laboratory	Above site
3. Poor Lab Infrastructure	All trained laboratory staff are implementing biosafety standards in priority sites.	75% of laboratory staff in scale-up districts are trained to implement biosafety standards	25% of labortoyr staff in new cluster scale-up districts are trained to implement biosafety standards	Number of biosafety officers within the clusters and number of biosafety manuals available	3.1: Support minor infrastructural upgrades to enhance biosafety and quality testing processes. Develop guidelines and SOPs for laboratory biosafety **NEW ACTIVITY**					
	Increase in number of trained biomedical engineers from 21 to 50.	~~50 biomedical engineers trained~~ **BENCHMARK ACHIEVED**	25% of engineers in cluster districts trained	Number of engineers trained	3.2: Training of biomedical engineers **NEW ACTIVITY**					
	Laboratory equipment for EID and viral load testing standardized.	All EID reference labs enrolled in EQA for EID testing.	2. Tools for viral load implementation available and routinely used in at least 80% of all sites in both clusters 3. Equipment maintenance contracts established and available in at least 4 EID/VL reference labs.	1. Number of sites in EQA for EID and VL testing. 2. % of sites with standardized VL implementation tools available	3.3: Inadequate sample collection, storage and transportation is a major barrier for provision of quality testing. IP will provide training on quality assured sample collection to strengthen uptake of viral load and EID testing, and reduce TAT for returning EID and viral load results nationally.	HLAB	$450,000	18230	10. Laboratory	
	Institutionalized sample referral system as part of national lab network.	National sample transport system for EID, VL, and proficiency panels (for all PEPFAR supported health districts)	1. SMS printers installed in all scale-up sites to reduce TAT of results to facilities in both PEPFAR supported clusters	# of SMS printers installed	3.4: IP will also support establishment of a sample transport system for EID, Viral load and Proficiency panels to cover all all sites within both clusters. Training in this area will also strengthen the lab workforce and improve efficiency in service delivery to meet the increasing					Site level

4. Absence of laboratory liaison within the NACC NEW BARRIER	Strengthen National Laboratory capacity and implementation of national Laboratory strategic plan	N/A	A designated lab/NACC liaison hired	Availability of a national database for monitoring virologic assays	4.1: PEPFAR will support NACC to develop a national database for EID to effectively monitor EID and Viral load data. **NEW ACTIVITY**	HLAB	$77,472	18229	Quality Management	Above site
	Strengthen National Laboratory capacity and implementation of national Laboratory strategic plan	N/A	LTWG established	Number of LTWG meetings held	4.2: PEPFAR will support NACC to coordinate laboratory technical working group meetings focused on addressing critical issues related to laboratory quality practices. **NEW ACTIVITY**	HLAB	$35,863	18229	Quality Management	Above site
	Strengthen National Laboratory capacity and implementation of national Laboratory strategic plan	N/A	Viral load dashboard available at atleast 50% of the facilities within the cluster	Number of tools and SOPS available	4.3: In order to meet the 90% of target on viral load PEPFAR/Cameroon will support NACC to develop standardize tools, SOPs and protocols and implement dashboard for tracking viral suppression. **NEW ACTIVITY**	HLAB	$35,381	18229	Quality Management	Above site
	Strengthen National Laboratory capacity and implementation of national Laboratory strategic plan	N/A	Supportive supervision reports available with documnetation on corrective actions	Supportive supervision tools developed	4.4: PEPFAR/Cameroon will support NACC to ensure overall coordination of all data quality and reporting across the country for viral load indicators. This includes performing supportive supervision for 08 viral load reference laboratories. This will contribute in strengthening the capacity of the M&E system to generate quality strategic information on viral load. **NEW ACTIVITY**	HLAB	$36,012	18229	Quality Management	Above site
TOTAL							**$1,234,728**			

Table 6.2.1: Test and START									
Key Systems Barrie	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
1. Absence of policy document on Test and Start	Policy document developed and published	Policy Document on Test and Start Developed and Disseminated (available at least, in all 45 PEPFAR-funded health facilities)	N/A	Is there a document? (Y/N)	1.1: Continuous engagement with the MoPH to translate discussions into policy, for the reduction of service fees and eliminate use of therapeutic committees for initiation of ART. ALL circular letters reducing patient fees and number of laboratory test before ART initiation will be disseminated to all care givers.	N/A	$0	N/A	
2. Absence of updated guidelines and SOPs for Test and Start implementation	Addendum to guidelines, SOPs and Algorithms available for distribution	Policy Document on Test and Start Developed and Disseminated (available at least, in all 45 PEPFAR-funded health facilities)	N/A	Has document been drafted and distributed? (Y/N)	2.1 Update guidelines and SOPs National ART and HTC guidelines, Algorithms for Lab monitoring (VL/CD4). Re-Test HIV positives before initiating ART Workshop with HQ support to harmonize strategies on hub and spoke as well as test and start.	N/A	$0	N/A	
3. Absence of implementation and M&E plan for Test and Start	Implementation /M&E plans available	Implementation /M&E plans available	N/A	Plans available (Y/N)	3.1 Develop implementation/M&E plans	N/A	$0	N/A	
4. Patient Fees for HIV-related Services	Patients do not pay for HIV/AIDS-related services.				4.1 PEPFAR/Cameroon is currently in negotiation with GRC, WB, and other technical and financial partners to buy into an ongoing PBF scheme focused on reducing service charges incurred by HIV-positive patients. PEPFAR/Cameroon will use CDC/HOP funds in a PBF pilot. This initiative will determine its effectiveness in reducing HIV patient fees	N/A	$0	N/A	
	All patients tested positive immediately put on treatment.	75% of patients tested immediately put on treament	100% of patients tested immediately put on treatment	SIMS 2.0					
	Lost to follow-up between testing and treatment is zeroed out.	NACC Annual report shows 10% reduction in LTFU.	NACC Annual report shows 30% reduction in LTFU	NACC Annual Report					
	Viral Load testing fully implemented and scaled up	NACC Annual report shows 45% VL coverage	NACC Annual report shows 85% VL coverage	NACC Annual Report					
~~5. Therapeutic Committee Approval for ART initiation~~ **BARRIER ELIMINATED**	~~Therapeutic Committee Approval for ART Initiation eliminated~~ **OUTCOME ACHIEVED**	N/A	N/A	N/A	N/A	N/A	N/A	N/A	

6. Absence of community engagement	Develop community dispensation models	Develop community dispensation models				N/A	$0	N/A		
TOTAL							$0			

Table 6.2.2 New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)	
1. Poor coverage of patients on ART and TB treatment	Increase coverage and retention of ART in priority districts from 26.1% & 60% respectively to 80%	Implementation of test and start at 45 health facilities in PEPFAR scale-up sites	Scale up the implementation of TB/HIV and test and start in the 2 cluster scale-up districts in PEPFAR supported regions	Number of facilities implementing a QI and TB infection control plan	Activity 1.1: PEPFAR will support the national program to develop, produce and disseminate national guidelines on quality management and also infection control and implement an infection control plan which will contribute in setting standards and reduce hospital infection during service delivery. **MOVED TO TB/HIV SECTION**	HVTB	$ 108,857	18229	Quality Management	Above site
	Increase coverage of adults and children on ART to about 80% by 2018	Implementation of test and start at 45 health facilities in PEPFAR scale-up sites.	Reach at least 25% proposed 2018 coverage	Number of new TB cases notified and tested for HIV from the community and other facility entry points	~~Activity 1.2: PEPFAR/Cameroon will support counselors for active case finding of TB suspects and PLHIV and cotnact tracing to ensure linkage to care and treatment and retention~~ **DUPLICATIVE OF ACTIVITY 1.3, NOT FUNDED IN COP17**					
	Increase coverage of adults and children on ART to about 80% by 2018	Implementation of test and start at 45 health facilities in PEPFAR scale-up sites.	Reach at least 25% proposed 2018 coverage	Number of new TB cases notified and tested for HIV from the community and other facility entry points	Activity 1.3: PEPFAR/Cameroon will strengthen the capacity of services providers to implement active case finding for HIV/TB at various entry points, including contact tracing, in selected high volume treatment and care health facilities including in the community.	HVTB	$44,185	18229	Human Resources for Health	Above site
	Increase coverage of adults and children (KPs) on ART to about 80% by 2018	5 DIC serves as community dispensation sites	N/A no funding	# of DICs serving as community dispensation sites	~~Activity 1.4: Produce country-specific treatment literacy information (including "test and start" guidance) for PLHIV and KPs and disseminate to priority populations.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS; WILL BE FUNDED THROUGH USAID HOP $$**					

2. Inadequate HIV services	Increased the number of functional ART sites offering quality HIV / TB care and treatment to patients, including for children, to about 189 by 2018	28 two-week trainings completed in COP16	N/A no funding	# of trainings completed	~~Activity 2.1: PEPFAR/Cameroon will organize 20 two weeks didactic and practical training sessions on pediatric HIV care and treatment for groups of 12 individuals from four districts hospitals in the four PEPFAR supported regions. Furthermore PEPFAR/Cameroon will organize 8 two week didactic and practical training sessions on pediatric HIV care and treatment for groups of 12 individuals from districts hospitals in the six non PEPFAR supported regions.~~ **NOT FUNDED FOR COP17 DUE TO LACK OF FUNDS; INTEGRATED IN CLINICAL IP ACTIVITIES**		$0			
	Increase the number of functional ART sites offering quality HIV / TB care and treatment to patients, including for children, to about 189 by 2018	All PLHIV TB suspects to be tested for TB in the two scale-up districts (Deido and Djoungolo)	Scale-up the implementation of TB/HIV testing in the 02 cluster scale up district	Number of PLHIV cases diagnosed for TB using the Gene Xpert	Activity 2.2: PEPFAR/Cameroon will continue to provide 10,000 cartridges for the Gene X-pert machines to enhance HIV/TB testing, facilitate patient follow-up and ensure positive cases are linked to treatment and care.	HVTB	$108,297	18229	Quality Management	Above site
	Increase the number of functional ART sites offering quality HIV / TB care and treatment to patients, including for children, to about 189 by 2018	NACC hired a HIV/TB care and treatment expert	Continue to support the HIV/TB Care and Treatment Expert.	TB/HIV Expert on board and fully overseeing the integration of TB/HIV implementation at facilities	Activity 2.3: PEPFAR/Cameroon will support the TB/HIV Care and Treatment Expert to continue ensuring the effective integration and implementation of TB/HIV activities both at national and facility level and also ensure data entry and reporting for TB/HIV interventions.	HVTB	$46,185	18229	Quality Management	Above site
	Increase the number of functional DIC offering quality HTS and adherence services to KPs, including for children, to about 07 by 2018	5 DICs offered HTS to KPs	N/A no funding	# of DICs offering HTS to KPs	~~Activity 2.4: Conduct research study among KP CSOs to estimate viral load for KPs and provide trainings and materials for government facilities to disaggregate cascade data to KPs, particularly for viral load.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS; WILL BE FUNDED THROUGH USAID HOP $$**					
	Increase the number of functional ART sites offering quality HIV / TB care and treatment to patients, including for children, to about 189 by 2018	Facility-based infection and QI plan developed and implememented in 45 facilities 2 scale-up districts (Deido and Djoungolo)	Facility-based infection and QI plan developed and implememented in 45 facilities in the 2 scaleup clusters (Douala and Yaounde)	Number of facilities implementing infection control measures	Activity 2.5: PEPFAR will support the national program to develop a facility based infection control plan and quality improvement management plan for the Clustered Districts and ensure their implementation according to national norms and standards	HVTB	108,857	18229	Quality Management	Above site

	Increase the number of health facilities linked with DICs which are providing services for KPs	05 Health faciltities are KP friendly		# Health facilties that are KP firendly **measurement:** CHAMP annual report	~~Activity 2.6: Administration of the key populations (KP) stigma index at identified health facilities providing ARVs to KPs and provision of TA for trainings to health care workers for KP inclusive~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS; WILL BE FUNDED THROUGH USAID HOP $$**				

3. Absence of an organized system in place to ensure linkages, adherence and retention of patients on ART	Increase to 80% the proportion of pregnant women, breastfeeding mothers and children retained in treat and care by 2018	Cohort monitoring tools developed and organize services to monitor cohort up to 18 months	N/A	N/A	~~Activity 3.1: Organize Post-natal services and implement Cohort monitoring to strengthen the linkage and retention of HIV positive pregnant & breastfeeding mothers to treatment & care and ensure HIV Exposed infants are Tested (EID, HTC) and children tested positive linked and retained in treatment and care. The HEI cohort monitoring will also enable us determine the outcome of children exposed to HIV after 18 months~~. **ACTIVITY NOT FUNDED IN COP17 DUE TO LACK OF FUNDS; INTEGRATED IN CLINICAL IPS**				
	Increase to 90% the proportion of KPs HIV+ linked to care and treatment	National KP UIC developed			~~Activity 3.2: Develop unique identifier code (UIC) system for KP. Key activities will focus on linking UIC to national system, provision of quality control and monitoring tools, and establishing additional staff training or conducting ongoing audits to ensure compliance.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS; WILL BE FUNDED THROUGH USAID HOP $$**				
TOTAL							**$ 416,381**		

Table 6.3 Other Proposed Systems Investments										
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**	
Inst & Org Development										
	Increased appropriation of the HIV/AIDS response and improved quality of reporting for policy making by 2018	Two national and regional coordination meetings occur and results disseminated		1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	PEPFAR will support NACC to effectively ensure coordination of the national HIV response through the organization of National and Regional joint coordination meetings for the fight against HIV	HVSI	$26,861	18229	Planning & Coordination	Above site
	~~Increased harmonization of blood safety practices in blood banks by 2018~~ **OUTCOME ACHIEVED**	~~Four quarter supervision visits conducted.~~	N/A	1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	~~PEPFAR will support NACC to organize semestrial Coordination meetings for the Blood safety program and carryout Quarterly supportive supervision of blood safety activities while ensuring all patients testing positive in the blood banks are referred for treatment and care.~~ **NOT FUNDED IN COP17 DUE TO LACK OF FUNDS**					
	Improved Coordination and monitoring of the HIV Program by 2018	Full-time staff at both national HIV/AIDS and TB programs focused on strengthening management of joint HIV/AIDS and TB programs.		1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.	PEPFAR will provide support to NACC and the TB programs to effectively manage and coordinate the national program	HVMS	$162,324	18229	Planning & Coordination	Above site
Strategic Information										
	~~Improved Coordination and monitoring of the HIV Program by 2018~~	~~N/A~~		~~1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.~~	~~PEPFAR/Cameroon will support management and operations costs to assure effective program management by ICAP.~~					
TOTAL							**$189,185**			
GRAND TOTAL							**$4,338,429**			

Summary Budget

Table 6.1.1	**$876,279**
Table 6.1.2	**$1,621,856**
Table 6.1.3	**$1,234,728**
Table 6.2.2	**$ 416,381**
Table 6.3	**$189,185**
TOTAL	**$4,338,429**