

CAMEROON
Country Operational Plan
COP 2018
Strategic Direction Summary
March 15, 2018



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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
ASQ:	Ages and Stages Questionnaire
CAD	Community ART Dispensation
CAMPHIA:	Cameroon Population HIV Impact Assessment
CBO:	Community-Based Organization
CCM	Country Coordinating Mechanism
CCP:	Central Contraceptive Procurement
CDC:	Centers for Disease Control and Prevention
CENAME:	Central Medical Store
CHW:	Community Health Workers
CMS:	Central Medical Store
CODB:	Cost of Doing Business
COP:	Country Operational Plan
CQI:	Continuous Quality Improvement
CSO:	Civil Society Organization
DHIS ₂ :	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
EID:	Early Infant Diagnosis
EPP	Estimation and Projection Package
EMR:	Electronic Medical Record
FBO:	Faith-Based Organization
FSN:	Foreign Service National
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
HIS:	Health Information System
HIV:	Human Immunodeficiency Virus
HKID:	Orphans and Vulnerable Children (budget code)
HLAB:	Laboratory Infrastructure (budget code)
HMBL:	Blood Safety (budget code)
HOP:	Headquarters Operational Plan
HSS:	Health System Strengthening
HTC:	HIV Testing & Counseling
HTS:	HIV Testing Services
HTXD:	ARV Drugs
HTXS:	Adult Treatment (budget code)
HVCT:	HIV Testing and Counseling (budget code)
HVMS:	Management and Operations (budget code)
HVOP:	Sexual Prevention – Other Sexual Prevention (budget code)
HVSI:	Strategic Information (budget code)
HVTB:	TB/HIV (budget code)
IBBS:	Integrated Bio-Behavioral Survey
IM:	Implementing Mechanism
INH:	Isoniazid
IP:	Implementing Partner
IPT	Isoniazid Preventive Therapy
IT:	Information Technology
KP:	Key Population(s)
LCM	Linkage Case Management
LE	Locally-engaged
LPV/r	Lopinavir/ritonavir
LRA	Linkage and Retention Agent
LTFU:	Lost to Follow-Up
M&E:	Monitoring and Evaluation
MCH:	Maternal and Child Health
MDR	Multi-Drug Resistance
MER	Monitoring, Evaluation, and Reporting
MMP:	Multi-Month Prescription
MoPH:	Ministry of Health
MSM:	Men who have Sex with Men

MTCT:	Prevention of Mother to Child Transmission (budget code)
NACC:	National AIDS Control Committee
NASA:	National AIDS Spending Assessment
NTD:	Neglected Tropical Disease
OGAC:	Office of the Global AIDS Coordinator
OHSS:	Health System Strengthening (budget code)
OVC:	Orphans and Vulnerable Children
PBFW:	Pregnant and Breastfeeding Women
PCR:	Polymerase Chain Reaction
PDCS:	Pediatric Care and Support (budget code)
PDTX:	Pediatric Treatment (budget code)
PE:	Peer Educator
PEPFAR:	United States President's Emergency Plan for AIDS Relief
PITC:	Provider-Initiated HIV Testing and Counseling
PL:	Peer Leader
PLHIV:	People Living with HIV
PMTCT:	Prevention Mother to Child Transmission
PN:	Peer Navigator
POART:	PEPFAR Oversight Accountability and Review Team
PR:	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PT:	Proficiency Testing
PWID:	People Who Inject Drugs
Q:	Quarter
QA:	Quality Assurance
QI:	Quality Improvement
QIC:	Quality Improvement Collaborative
QMS:	Quality Management System
RBF	Results Based Financing
RTK:	HIV Rapid Test Kit
SABERS:	HIV Seroprevalence and Behavioral Epidemiology Risk Survey
SI:	Strategic Information
SID:	Sustainability Index and Dashboard
SIMS:	Site Improvement through Monitoring System
SMS:	Short Message Service
SNU:	Sub-National Unit
SOP:	Standard Operating Procedure
SQA:	Service Quality Assessment

SLIPTA:	Stepwise Laboratory Improvement Process Towards Accreditation
STI:	Sexually Transmitted Infection
TA:	Technical Assistance
TB:	Tuberculosis
TLD	Tenofovir/Lamivudine/Dolutegravir
UN:	United Nations
UNAIDS:	Joint United Nations Program on HIV/AIDS
USAID:	United States Agency for International Development
UNFPA:	United Nations Populations Fund
USG:	United States Government
VCT:	Voluntary Counseling and Testing
VL:	Viral Load
VMMC:	Voluntary Medical Male Circumcision
WHO:	World Health Organization

1.0 Goal Statement

The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) will build on existing partnerships with the Government of the Republic Cameroon (GRC), local and international stakeholders to reach epidemic control by 2020 through targeted and strategic approaches detailed in this Country Operational Plan (COP) 2018. As of December 2017, 253,343 people living with HIV (PLHIV) were on treatment nationally of which 71% were located in PEPFAR scale-up clusters of Yaoundé and Douala; and sustained health districts in the Center, Littoral, Northwest, and Southwest regions. Revised Spectrum analysis estimates a 16.6% drop in the disease burden to 517,482 PLHIV, among which 67.8 % reside in PEPFAR scale-up and sustained health districts. Nationally, it is expected that 322,477 PLHIV will be on antiretroviral treatment (ART) by the end of 2019 (representing 62% of all PLHIV).

In COP18, PEPFAR will test 1,351,307 Cameroonians (858,979 adults, 318,951 children, and 164,479 pregnant women); initiate 64,865 on ART; and maintain 254,103 PLHIV on treatment including supporting 124,916 to access viral load testing. Additionally, 7,541 men who have sex with men (MSM) and 14,438 female sex workers (FSW) will be reached with prevention activities, among which 13,194 will be tested for HIV. Finally, PEPFAR Cameroon will reach 12,611 adolescent girls and young women (AGYW) with DREAMS-like programming and provide a core package of services to 18,839 orphans and vulnerable children (OVC).

PEPFAR Cameroon analyzed site level data disaggregated by sex and age to identify where we are finding PLHIV and who we are missing. In addition to using targeted screening tools to identify at-risk populations, COP18 will also continue supporting the following interventions: after-school, weekend, and night clinic hours; differentiated models – same-day initiation, community ART initiation, and dispensation; health facility “retention committees” to address retention and resistance issues; and social network testing of MSM, FSW, and partners and clients of FSW.

PEPFAR Cameroon has intensified partner management in order to improve decision-making based on real-time data and prompt corrective actions. This includes weekly/monthly reviews of site level data, service provider performance, and financial outlays. Quarterly Site Improvement Monitoring System (SIMS) visits and routine Data Quality Assessments (DQA) enables implementing partners (IP) to identify and scale up best practices. Intensive partner management has resulted in greater ownership of data and outcomes, as individual staff at service provider, IP, and U.S. Government (USG) level are held accountable for performance.

PEPFAR utilizes all platforms to gather and share information with relevant stakeholders. This includes regular meetings with the Ministry of Public Health (MoPH), National AIDS Control Committee (NACC), bi-lateral and multi-lateral partners, and civil society. Collaboration with the Global Fund and Joint United Nations Program on HIV/AIDS (UNAIDS) is strong; the USG also utilizes the Health Technical and Financial Partners' Forum for further outreach. Through targeted efforts and strong partnerships across all stakeholders, Cameroon will make great strides in reaching the 95/95/95 goal and ending HIV as a public health threat by 2030.

Pregnant women needing ARVs	31,040														2017 SPECTRUM projection
AIDS Orphans (maternal, paternal, double)	254,251														2017 SPECTRUM projection
Notified TB cases (Yr.)	25,975														WHO 2016, Global Tuberculosis Report 2017
% of TB cases that are HIV infected	8,264	34%													WHO 2016,
% of Males Circumcised	NA	93.9%													DHS 2011
Estimated Population Size of MSM*	66,842	1.38%													Papworth, 2014
MSM HIV Prevalence		20.7%													2016 IBBS report
Estimated Population Size of FSW	112,580	1.96%													World Bank, 2016
FSW HIV Prevalence		24.3%													2016 IBBS report
Estimated Population Size of PWID	NA	NA													N/A
PWID HIV Prevalence	NA	NA													N/A
Estimated Size of Priority	36,000										3600	10%	32,400	90%	SABERS 2011

2.1 Summary Statistics, Disease Burden & Country Profile

Cameroon's HIV/AIDS epidemic is mixed (i.e. one or more concentrated epidemics within a generalized epidemic). While overall adult HIV prevalence is steadily decreasing (5.5% in 2004 to 3.8% in 2016); prevalence among women is twice that of men (5.1% vs. 2.5%, UNAIDS 2016). HIV prevalence is highest among women between 35-39 years of age (10%); and over 7% among women aged 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 than 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. HIV prevalence remains high among key populations (KP) at 24.3% for FSWs and 20.7% for MSM.

In Cameroon, HIV/AIDS is more prevalent in urban areas, which are home to slightly more than 50% of the population. From the DHS 2011, the economic capital, Douala, and the political capital, Yaoundé, together have an overall HIV prevalence 5.5% with 7.7% among women and 3.1% among men. Other cities combined have an overall HIV prevalence of 4.3% with a 5.5% among women and 3.0% among men, while rural areas have HIV prevalence 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, with prevalence above 6%. However, when considering population size, Cameroon's disease burden is highest in the Center (including Yaoundé), Littoral (including Douala), Northwest, and Southwest regions, where PEPFAR scale-up and sustained health districts are located. The greatest disease burden is in the scale-up clusters of Yaoundé and Douala.

KP overall present with significantly higher HIV prevalence compared to the national average. Amongst these sub populations, an understanding of how the epidemic differs by population type and by age group is essential for effective programming. Disparities in prevalence amongst FSWs vary significantly by age (IBBS 2016). Though they represent a significant majority of FSWs, those below the age of 30 (20-24: 8.7%, 25-29: 16.1%) have lower prevalence compared to those above the age of 30 (30-34: 33.8%, 35-39: 42.2%, 40-44: 46.3%, 45-49: 48.8%, 50-54: 40.0% and 55+: 26.3%). Similarly, amongst MSM, HIV prevalence is higher amongst older MSMs (20-24: 15.2%, 25-29: 29.4%, 30-34: 33%, 35-39: 40%, 40-44: 45% and 45+: 57.1%). Cameroon's Gross National Income (GNI) per capita in 2017 was \$1,400 (World Bank, Atlas Method). Wealthier and middle-class Cameroonians have higher HIV prevalence (5.1% and higher in the first and second wealthiest quintiles and 4.4% in the third quintile) compared to those in the fourth (4.2%) and fifth (2.0%) quintiles. It is important to note, however, that most Cameroonians in the two poorest quintiles live in rural areas, where prevalence rates are lower.

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression

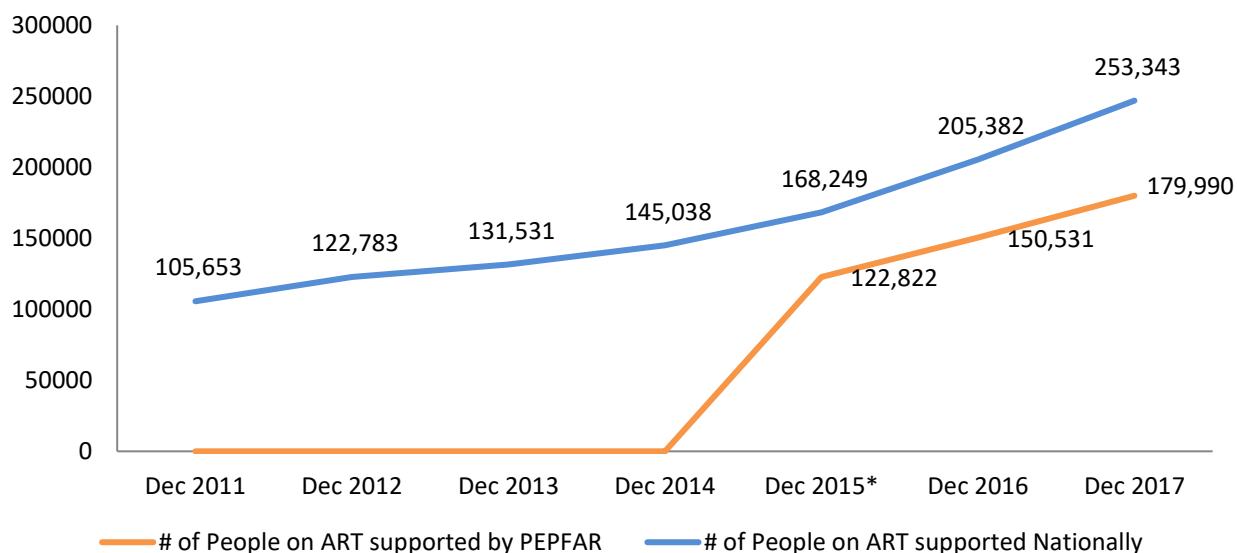
*Epidemiologic Data					**HIV Treatment and Viral Suppression			**HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate	HIV Prevalence	Estimated Total PLHIV	PLHIV diagnosed	On ART	ART Coverage	Viral Suppression*	Tested for HIV	Diagnosed HIV Positive	Initiated on ART
	(#)	(%)	(#)	(#)	(#)	(%)	(%)	(#)	(#)	(#)
Total population	23,476,618	3.8%	517,485	380,000	253,343	49%	81%	2,591,437	103,476	77,217
Population less than 15 years	10,012,613		41,234		8,574	21%	60%	113,772	1,947	1,677
15-24 year olds	4,628,668	1.37%	65,375		17,557	27%	69%	751,617	16,332	10,981
25+ year olds	8,835,337	3.54%	410,876		220,815	54%	83%	1,726,048	85,197	64,559
***MSM	66,842	20.70%	13,836	8,890	8,571	62%	NA	4,609	511	345
***FSW	112,580	24.30%	27,357	16,774	13,445	49%	NA	8,584	1,033	740
PWID +Priority Pop (Military)	36,000	6.00%	2,160	1,296	641	30%	85%	NA	NA	NA

*Data source is Spectrum 2017 **Data source is DHIS2 National Data for 2017

***Data Source is IBBS World Bank Report 2016 + SABERS 2011 and PEPFAR APR results 2017

Overall, HIV prevalence has dropped in the country from 4.3% (UNAIDS 2013) to 3.8% (UNAIDS 2016). 73% of PLHIV have been diagnosed by end of 2017, with 44% actively on treatment. The Military (30%) and PLHIV less than 15 (23%) have the lowest ART coverage as of 2017 results. Viral suppression is lowest in pediatrics (60%) and adolescents and young adults (69%). FSW have a lower ART coverage (49%) compared to MSM (62%).

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment

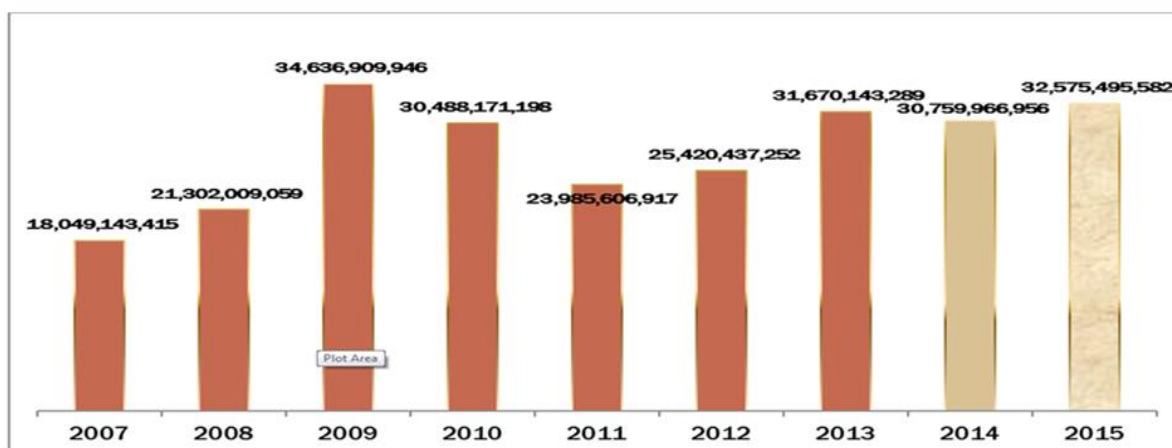


* Dec 2015 data reflects September 2015 data, for PEPFAR supported patients only

2.2 Investment Profile

The national expenditures data shown on Figure 1 and on Table 2.2.1 are based on the National AIDS Spending Assessment (NASA) for 2014-2015, released in 2017. In order to align with the 2015 national expenditure report, PEPFAR Cameroon used data from Expenditure Analysis (EA) 2015 to complete the table. National HIV/AIDS expenditures have increased from \$40 million in 2011, \$42.4 million in 2012, to \$55.1 million in 2013. In 2014, the total expenditure was estimated at 30,759,966,956 FCFA and 32,575,495,582 FCFA in 2015, showing a marked increase of 5.6% between the two years. As illustrated by Figure 1 below, HIV expenditures have been fluctuating annually since 2007.

Figure 1: Fluctuations in HIV/AIDS Spending, 2007-2015 in FCFA (Source: Cameroon NASA 2014-2015)



Significant donor funding of the national HIV/AIDS response continue through PEPFAR at \$44,213,185 in FY19 and through the Global Fund for AIDS, Malaria and Tuberculosis (GFATM) – estimated at €105 million for 2018-2020 with matching catalytic funds for KP, AGYW and Human Rights programming. As in previous years, the bulk of investment will focus on care and treatment, particularly procurement of antiretrovirals (ARVs). With 66% of GFATM grant focused on procurement of HIV/AIDS commodities, the HIV/AIDS national response will rely on PEPFAR COP18 FY19 investments to ensure availability and quality within service delivery.

Table 2.2.1: Annual Investment Profile by Program Area (2015)

Program Area	Total Expenditure	% PEPFAR	% GFATM	% Host Country	% Other
Clinical care, treatment and support	\$15,127,917	13.8%	27.5%	55.6%	3.1%
Community-based care, treatment, and support	\$1,059,436	0.0%	89.4%	0.0%	10.6%
PMTCT	\$9,698,433	78.8%	7.7%	6.1%	7.5%
HTS	\$1,822,743	25.2%**	25.2%	32.7%	5.8%
VMMC	\$0	-	-	-	-
Priority population prevention	\$4,161,276	3.1%	3.1%	3.2%	92.8%
Key population prevention	\$769,559	53.5%	53.5%	0.0%	0.2%
AGYW Prevention	\$124,913	0.0%	0.0%	0.0%	100.0%
OVC	\$709,679	61.6%**	38.4%	0.0%	0.0%
Laboratory	\$3,247,185	9.7%**	55.6%	34.5%	0.2%
SI, Surveys and Surveillance	\$2,514,046	61.6%	19.2%	2.8%	16.4%
HSS	\$3,277,038	26.9%	30.1%	33.0%	10.0%
Other	\$3,277,038	90.5%	1.9%	0.0%	7.6%
Total	\$53,924,174	35.4%	24.0%	27.2%	13.4%

(1 USD= 604, 09818081 FCFA in 2015)

* (GRC, National AIDS Spending Assessment, 2015), all amounts in 2015 USD. Exchange rate applied (\$1=604, 09818081 FCFA) based on Treasury Reporting Rates of Exchange as of December 31, 2015 (www.irs.gov). Expenditures reported in this table for Host country and Other (GFATM, bilateral donors, UN agencies, and international organizations) partners are based on the 2015 NASA. In order to align with NASA 2015 report, PEPFAR expenditures reported in this table are based on FY2015 EA data. Total expenditures match 2015 NASA, however, methodology used to allocate percentages consists of: (1) host country percentage allocation from the 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; (4) In 2015, priority population prevention activities were funded by the German Cooperation; (5) AGYW prevention was covered through UNICEF.

**According to 2015 NASA, Host country (public, private and household) contributed towards 27.2% of expenditures while other international partners contributed towards 13.4%; PEPFAR contributed 61.6% for OVC activities; while other international partners contributed 100% in AGYW.

Table 2.2.2: Annual Procurement Profile for Key Commodities (2015)

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% Host Country
ARVs	\$26,648,204	5%	82%	13%
Rapid test kits	\$1,019,916	14%	86%	0
Other drugs	\$447,736	0	100%	0
Lab reagents	\$2,171,821	33%	67%	0
Condoms	\$160,417	100%	0	0
Viral Load commodities	\$108	0	100%	0
Other commodities	\$1,898,379	75%	25%	0
Total	\$32,346,581	12%	77%	11%

Source: PEPFAR investments: FY2015 EA and remaining ACT funds, CCP/condoms investments not included, GFATM: Approved 2015 orders from principal recipients based on HIV grant reprogramming (NACC) and Cameroon National Association for Family Welfare, 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 PMI	\$20,000,000	\$2,800,000	1	\$1,543,655	\$20 million represents annual funding to reduce the burden of malaria, prioritizing pregnant women, children 0-5, and populations living in zones with intense seasonal transmission (North and Far North regions) including \$2,800,000 for supply chain strengthening. FY2018
Family Planning/	\$650,000	\$0	\$0	\$0	Demographic and Health Survey (DHS). Data collection will occur in 2018 and final

DHS					report available in 2019.
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, strengthen national and local response capacities, and educate at-risk populations on how to prevent exposure to dangerous pathogens. FY15 – FY19.
USAID (NTD)	\$4,500,000	\$0	\$0	\$0	Annual support to Government of Cameroon in eliminating neglected tropical diseases such as lymphatic filariasis, trachoma, onchocerciasis.
CDC Global Health Security	\$16,082,073	\$0	\$0	\$0	\$16,082,073 represents funds allocated in FY 15 through FY18. Previously, focus was on programs including Ebola and Global Health Security. In FY18, focus was on strengthening Workforce Development (Field Epidemiology Training Program), Laboratory, Emergency Management and Surveillance, Immunization. FY19 funds have not yet been released.
Total	\$64,232,073	\$2,800,000	1	\$1,543,655	

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	0	0	0	0	0	
VMMC – Central Funds	0	0	0	0	0	
Other PEPFAR Central Initiatives	0	0	0	0	0	
Other Public Private Partnership	0	0	0	0	0	
Total	0	0	0	0	0	

2.3 National Sustainability Profile Update

SID Process

PEPFAR Cameroon completed the Sustainability Index and Dashboard (SID 3.0) in the first quarter of FY18 – two years after completion of SID 2.0 – through a collaborative process with full

participation from the PEPFAR country team and relevant partners. PEPFAR Cameroon began the SID 3.0 process by undertaking a desk review of all required documentation with follow-up consultations of the various constituencies. It met with external stakeholders from different PEPFAR supported regions and collected information to feed the SID 3.0 from civil society representatives, private sector entities, health committee parliamentarians, UNAIDS, USG and the GRC-NACC. The NACC convened a final review session with stakeholders in early FY18, with participants reviewing the completed tool, further discussing findings, identifying priorities and providing additional input. The next SID process will take place in early FY20.

Sustainability Strengths

Technical and Allocative Efficiencies (9.33 – dark green) is the strongest sustainability element. This element scored 9.33 from 6.15 in two years. Efficiency improvements were made with the introduction of Test and Start and differentiated service delivery models along with integrated TB/HIV services and HIV/maternal and child health (MCH) services.

Public Access to Information (9.00 – dark green): Even though it saw a slight decrease from 10.00 in SID 2.0; all input remains the same from both 2.0 and 3.0. An additional question in the 3.0 slightly alters the scoring in question 5.2.

Planning and Coordination (8.95 – dark green): The GRC asserts a strong leadership role in the national HIV response. This leadership has resulted in the adoption of best practices and global technical policies. Though Cameroon saw a slight dip from the SID 2.0 in its capacity to plan and coordinate, it still maintains a dark green scoring.

Private Sector Engagement (8.67 – light green): With an upward turn from 5.58 points in SID 2.0, Cameroon made significant strides in engaging the private sector in the national HIV/AIDS response, although private sector investment is slanted towards private health facility providers and larger corporations.

Civil Society Engagement (7.58 – light green): Cameroon has an ‘approaching sustainability’ scoring of 7.58 in SID 3.0, which is a slight increase from SID 2.0. Some efforts required to ensure full integration of civil society organizations (CSO) in national planning and monitoring of services by the NACC.

Sustainability Vulnerabilities

Unlike SID 2.0, Cameroon did not achieve red scores in SID 3.0. However, within the nine elements that scored yellow, five were in the National Health System and Service Delivery domains, showing that health systems building remains a challenging area and requires further strengthening to support HIV critical services.

Commodity Security and Supply Chain (5.43 – yellow): Weak procurement and supply chain management of HIV/AIDS-related commodities continues to negatively impact attainment of the

90-90-90 goals. There is 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 provider-initiated testing and counselling (PITC), retesting for verification, and proficiency testing (PT) panels. There is a national committee for the quantification of all health products and a sub-committee for quantifying and monitoring the supply of HIV products. PEPFAR Cameroon's supply chain partner is developing technical guidance on implementation of multi-month scripting.

Policies and Governance (5.98, yellow): The overall policy environment needs further improvement, particularly in the areas that focus on KP. Cameroon also needs to review auditing practices and would benefit from regular audits with real-time implementation of recommended findings. Cameroon adopted multiple policies since the SID 2.0 such as strengthening task shifting, implementing Test and Start in facilities and communities, differentiated service delivery models, including for different subpopulations; multi-month scripting for stable patients including community based ART dispensation and lost-to-follow-up (LTFU) strategies.

Laboratory (5.83 - yellow): This scoring went from 3.01 to 5.83 over the past two years, a significant improvement. Cameroon has developed a National Strategic Plan for the Development of Cameroon Laboratories 2016-2020. Additionally, a National Public Health Laboratory was built and Cameroon now has three ISO-15189 accredited laboratories. In spite of the reduced cost for viral load (VL) testing from 21,000 FCFA (about \$33) to 5,000 FCFA (about \$8), VL testing still remains a barrier for many patients. Reaching the third 90 will continue to be difficult with minimal funding for VL testing. 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 further reduce prices, gaps in stock outs and service disruptions. However, stock outs remain a major challenge in the HIV response.

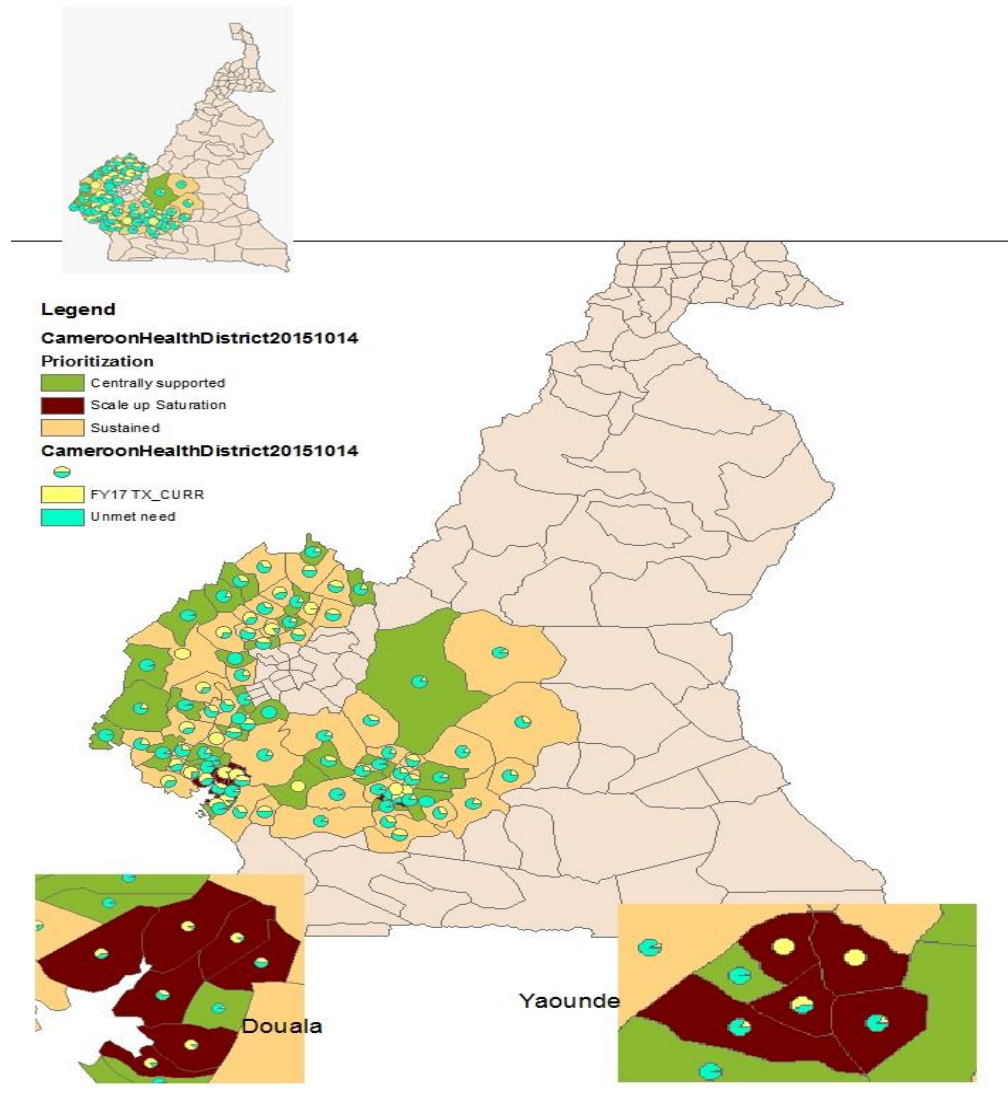
Quality Management (5.76 - yellow): Great strides were made in this element as it was the lowest performing in SID 2.0 at a 2.19, rising to its current 5.76 scoring. A Quality Assurance/Quality Improvement (QA/QI) technical working group has been created with the objective of building capacity of trainers to roll-out Cameroon's Quality Improvement Program (CAQIP). However, sites have not yet routinely incorporated ongoing evaluation of the quality of services offered.

Following a review of SID 3.0 findings, Commodity Security and Supply Chain, Policies and Governance, Laboratory, and Quality Management, have become prioritized above-site activities in COP18. PEPFAR Cameroon will seek to strengthen laboratory quality management systems (QMS) for efficient health service delivery; reinforce MoPH health information system by developing and strengthening strategic information systems; intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies. PEPFAR will support the development of updated clinical

guidelines to meet international standards for transitioning to a Tenofovir/Lamivudine/Dolutegravir (TLD)-based regimen. Additionally, focus will be put on improving in-country logistics including effective and efficient delivery of health commodities to service sites; and strengthening information systems to ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and continuous quality improvement teams. The supply chain program will also strengthen the capacity of leadership and governance structures to prioritize and coordinate supply chain activities; and improve visibility and use of accurate and reliable data to drive informed decisions.

2.4 Alignment of PEPFAR investments geographically to disease burden

Figure 2.4.1 COP18 unmet need and district prioritization



The map and inserts presented in figure 2.4.1 show areas where PEPFAR is providing support with focus on the two urban clusters of Yaoundé and Douala. The Yaoundé cluster includes the health districts of Djoungolo, Nkolndongo, Biyem Assi, Cité Verte, and Efoulan. The Douala cluster includes the health districts of Deido, Cité des Palmiers, Nylon, Bonnassama, New Bell, Logbaba, and Mbangue. The lower left hand insert shows a large-scale version of the Douala cluster, and the lower right shows a large-scale version of Yaoundé. The insert maps help visualize not only the large unmet need in terms of PLHIV on ART in these two urban areas (Efoulan and Nkolndongo for Yaoundé cluster and Cité des Palmiers and Logbaba for Douala cluster), but also that ART coverage exceeds 80% in some districts (Cité Verte and Djoungolo for Yaoundé cluster and Deido, Mbangue and New Bell for Douala cluster). PEPFAR Cameroon will continue working in the clusters of Yaoundé and Douala, as opposed to individual health districts, taking into account geographic proximity of health districts and client mobility (i.e. crossing district lines to receive access HIV Testing Services and treatment).

Five sites previously classified as centrally supported will transition to sustained, while 11 sites will move from sustained to scale-up. Twenty-six low volume health facilities (ten or fewer positives and 11 or fewer currently on ART) have been identified and will be transitioned to central support in collaboration with 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.

2.5 Stakeholder Engagement

Supporting the GRC in a national unified HIV response, PEPFAR Cameroon maintains strong coordination and collaboration 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 COP18, PEPFAR collaborated with the host government, multilaterals, and CSOs to ensure a shared understanding of the COP18 strategic direction and programmatic challenges. PEPFAR Cameroon emphasized the prioritizing of strong partnerships with GRC and GFATM to reach sustained epidemic control. With the support of the UNAIDS, PEPFAR held meetings with CSOs in Douala and Yaoundé in early FY18, in order to disseminate the COP 16 Annual Performance Report (APR), as well as COP17 Q1 results and receive recommendations for COP18. The recommendation which stood out from these meetings is the need to further involve the CSOs in the follow-up of newly treated PLHIV by use of those currently on treatment within the community dispensation context.

PEPFAR Cameroon works with UNAIDS to convene quarterly meetings with CSOs for the dissemination of PEPFAR quarterly data. Representatives from organizations of PLHIV, KP, AGYW, OVC, 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.

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 in AGYW (a new focus for the GFATM) will be undertaken to avoid any duplication of effort. Additionally, the existing MOU between PEPFAR and GF partners will be revisited to reflect updates in the COP18.

PEPFAR Cameroon holds permanent membership in the GFATM Country Coordinating Mechanism (CCM) and its oversight committee. PEPFAR continues to follow up on the conditions of the CCM eligibility after the Eligibility and Performance Assessment and a Performance Improvement Plan were conducted in FY16. A roadmap was developed for this follow-up to ensure that the CCM stays eligible for GFATM funding. PEPFAR is the lead of a subcommittee for the development of a training program for the FY18 newly appointed CCM

members to improve their ability to carry out oversight supervision of Principal Recipients (PRs), understand the national HIV response and its actors, and improve new CCM members' knowledge 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.

3.0 Geographic and Population

For COP18, PEPFAR Cameroon will continue its geographic prioritization of Douala and Yaoundé. Following the COP16 programmatic pivot to scale-up in the urban health districts of Deido (in Douala) and Djoungolo (in Yaoundé), PEPFAR Cameroon conducted an analysis of where patients access ART facilities in relation to 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. One example from the 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 surrounding districts. In response to this analysis, in COP17, a cluster strategy provided a logical expansion of ART coverage from the Deido and Djoungolo health districts to move Cameroon towards epidemic control. In light of its success, this cluster strategy will continue throughout COP18 to increase ART coverage and to increase progress towards epidemic control in Cameroon's two largest urban centers, Yaoundé and Douala.

Forty-four percent of all PLHIV in the four PEPFAR-supported regions are concentrated in the urban clusters in the metropolitan areas of Yaoundé and Douala. The Yaoundé metropolitan area (Center region), including Djoungolo, Nkolndongo, Biyem Assi, Cité Verte and Efoulan districts, contains 58% (80,381) of the PLHIV residing in the two urban clusters. The Douala metropolitan area (Littoral region), including Deido, Cité de Palmiers, Bonnassama, Logbaba, Mbangue, New Bell and Nylon districts, contains 42% (59,296) of the PLHIV residing in the two urban clusters. To reach the PEPFAR Cameroon target of 93% ART coverage in 12 districts within Douala and Yaoundé clusters by the end of FY19, PEPFAR Cameroon will scale up its efforts in 56 health facilities to move these facilities towards saturation. The following table demonstrates the estimated PLHIV burden across the PEPFAR Cameroon program.

Table 3.1: Current status of ART saturation and progress towards 95/95/95 across all SNUs

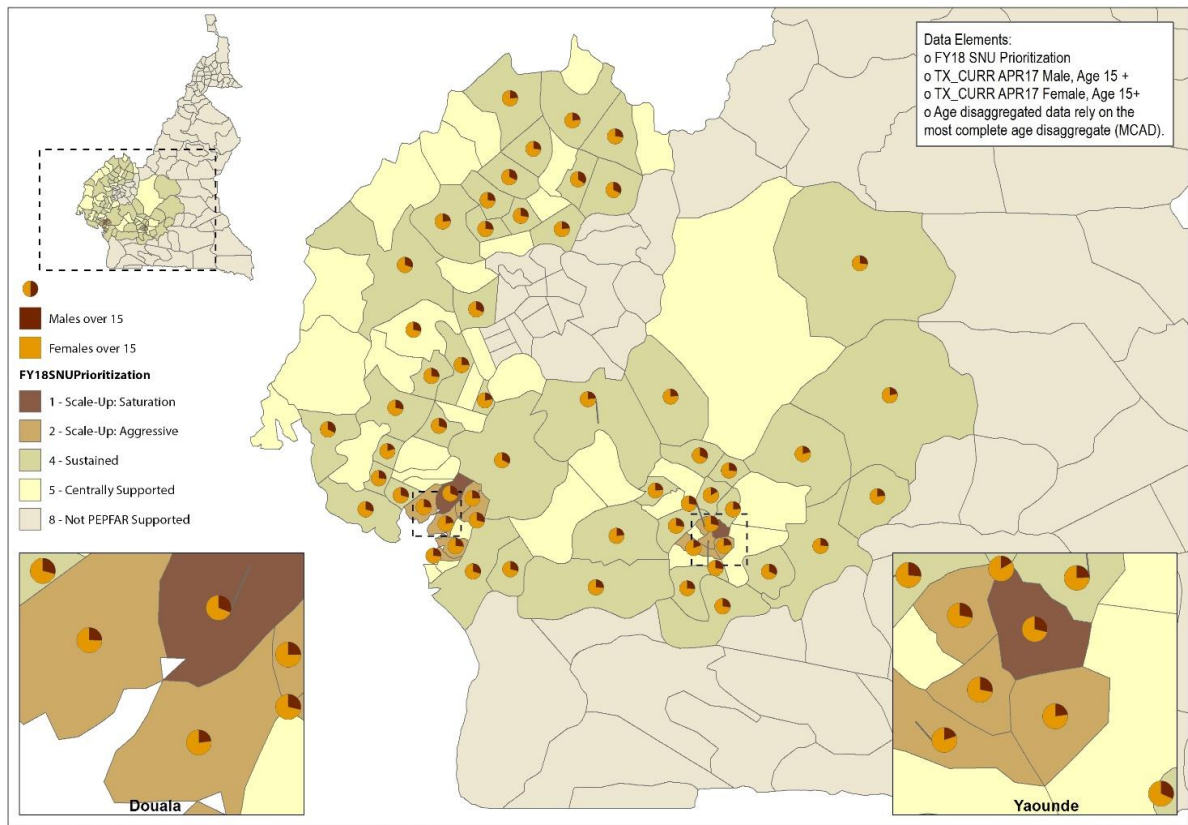
Prioritization Area	Total PLHIV/% of all PLHIV for COP18	# Current on ART (FY17)	# of SNU COP17 (FY18)	# of SNU COP18 (FY19)
Attained	0	0	0	0
Scale-up Saturation	138,450 / 39%	92,232	5	12
Scale-up Aggressive	0	0	7	0
Sustained	173,555 / 49%	80,053	46	46
Central Support	38,684 / 11%		33	33

* Data derived from Data Pack tool and 2017 revised Spectrum PLHIV estimates

For COP18, PEPFAR Cameroon will continue to focus on current priority and key populations, with an increased focus on reaching children of FSW and men including clients and regular non-buyer partners of FSW. Within Cameroon, identifying and retaining men is a challenge as men have the tendency to be identified at later stages of HIV illness than women and are less likely to come to a facility for HIV testing than women. According to the most recent Spectrum estimates, 35.8% of the PLHIV in Cameroon are male; however, looking at Figure 3.2 below, it is clear that many sites are falling short of reaching men based on an expected proportion. In COP18, specific strategies to target men by age group will be implemented to increase case finding, linkage, and retention for men across age groups in scale-up sites. In addition, more support will be given to index testing in sustained sites to increase case finding among male sexual partners of PLHIV. PEPFAR Cameroon will, in particular, target clients and regular non-buyer partners of FSW through the “Sex and Test” strategy using prevention education, self-test kits, and referrals to testing where available.

Figure 3.2: Proportion of men and women at PEPFAR sites

Cameroon: Proportion of Males and Females Age 15 and Over on PEPFAR-supported ART (FY17) and District Prioritization FY18



Names and boundary representation are not necessarily authoritative.

Source: ICPI_FactView_PSNU_20171222_v2_1

February 8, 2017

PEPFAR Cameroon will continue to prioritize KP, including FSW and MSM in 11 hotspots, 10 of which are in the Yaoundé and Douala scale-up clusters and one in the sustained district of Bamenda. Following the geographic pivot for clinical sites in FY18, these hotspots are aligned to the districts covered by clinical treatment partners. Throughout COP17, average yields of approximately 12% were recorded for FSW and MSM.

While this does represent a decrease in yield compared to previous years, yields for those age 30 and above remain consistently higher. Based on this, it is expected that yields will increase in FY19 through improved focus on index testing and targeted testing of older KP. Programmatic data alongside of the most recent Integrated Bio-Behavioral Survey (IBBS) population size estimates demonstrate that the program may be close to saturation for some KP, especially FSW in Yaoundé and Douala. Given this potential saturation, there may be a need in the near future to look to other locations for new case finding while continuing to offer prevention services to HIV-negative beneficiaries as well as adherence and retention packages within the Douala and Yaoundé clusters.

PEPFAR Cameroon will continue to focus on the military and AGYW. The last HIV Seroprevalence and Behavioral Epidemiology Risk Survey (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 FY17 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 are being further examined through an ongoing SABERS study being implemented during COP17. 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.

With regard to AGYW, PEPFAR Cameroon will continue to leverage military, OVC, and KP program, including the presence of Peace Corps Volunteers to provide a DREAMS-like package of services in scale-up clusters and sustained sub-national units (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, behavior change interventions focusing on risk avoidance and risk reduction will remain a priority. To ensure that AGYW's risks are comprehensively addressed, engagement of key influencing populations, such as adolescent girls' parents, community leaders, men and sex partners will be reinforced using appropriate age/sex curricula delivered in a culturally appropriate manner. In addition, gender equitable principles and norms will continuously be integrated into all interventions in a consistent manner, and GBV prevention incorporated into the prevention package of services provided.

In addition, through its KP project, PEPFAR Cameroon is offering an enhanced package of services to adolescent daughters of FSW in FY18 and will continue in FY19. In recognition of the extreme vulnerability, regular exposure to violence, and the high risk of entering sex work for this subpopulation, resources will be focused on risk avoidance, risk reduction, gender-based violence (GBV) prevention, care, and support. At the community level in sustained SNUs, OVCs – particularly older OVCs in the 10-18 years range will be reached through Peace Corps with a comprehensive package of layered interventions through Direct Service Delivery (DSD). GBV prevention will be systematically integrated into interventions.

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

4.1 Finding the missing, getting PLHIV on treatment, and ensuring retention

UNAIDS Spectrum Estimation and Projection Package (EPP Spectrum) indicate that less than 50% of Cameroonians 15 – 49 years are aware of their serostatus. HIV prevalence in Cameroon shows an upward trend among age groups from birth through the age of 49, and a steady decline after the age of 50. These results are consistent with PEPFAR Cameroon 2017 programmatic data; however, yields in the 10-19 age group were significantly lower than expected.

In 2017, PEPFAR Cameroon provided HIV Testing Services (HTS) to 1,154,782 clients, compared to a set target of 1,050,915 clients, with an HIV positive yield of 4.6%. There were 52,336 HIV positive clients identified of the set target of 86,449. Age disaggregation showed that 68.9% of PLHIV were within the 25-49 age group (comparable to EPP spectrum estimates of 66.6%), 12.8% were above the age of 50 (comparable to EPP spectrum estimates of 13%), and 11% were in the 20-24 age group (comparable to EPP spectrum estimates of 10%). Yields in the 10-19 age group were significantly lower than in the expected group, accounting for 3.9% of the PLHIV burden compared to EPP spectrum estimates of 6.6%.

Sex disaggregation of PEPFAR data shows higher HIV prevalence among females relative to males. Females account for 57.3% of PLHIV compared to 42.7% for males in the 25-49 year age group. This result is comparable to EPP spectrum estimates of a 2:1 ratio of HIV positive women to men within this age group. Females also account for 60% of PLHIV in the 20-24 year age group and 58.7% of PLHIV in the 10-19 age group. In order to take a closer look at gaps in case-finding, site level, modality, sex, age, and geographic data on testing and testing yield for FY17 and FY18Q1 were triangulated with preliminary Cameroon Population HIV Impact Assessment (CAMPHIA) data on PLHIV awareness of status.

Outstanding gaps

This data indicates suboptimal case finding (60.5%) of the set target for first 90 in FY17, especially among adolescents, young adults, and men. Identifying PLHIV is a key step in achieving epidemic control, therefore strategies and approaches are needed to address this gap.

Strategies to improve HIV case finding

Based on analysis of PEPFAR's FY17 and FY18Q1 performance described above, PEPFAR Cameroon has prioritized HTS for the following populations: HIV positive adolescents, aged 10-19 who meet defined risk criteria; HIV-positive men (particularly in the 20-35 age groups); and HIV-positive women in the 15 -25 age group. In order to address these gaps, PEPFAR Cameroon will continue approaches proven to improve case finding such as index testing (yield 15-22%) and will discontinue non-targeted PITC. Targeted PITC (yield 5-11%) will occur at all priority high yield entry points, including testing partners of adult index cases or parents of pediatric index cases at

ART and TB services (yield 39%), testing exposed children of HIV-infected parents in facilities and KP in drop-in centers (yield 16%), as well as engaging men through partner testing and contact tracing. At the community level, targeted mobile testing will continue, particularly for clients of FSWs (yield of 4.5%). Self-testing will be introduced in FY19 to reach partners of KP unwilling to come to drop-in centers (DICs) or KP community events. PEPFAR Cameroon will undertake demand creation activities at scale-up sites and use of screening tools (within facility and community settings) to identify at-risk populations.

For all target populations and geographical areas, PEPFAR Cameroon will continue to use site level data by age and sex, and begin tracking performance at site level by modality, to identify high, medium, and low performing sites. Implementing partners (IPs) will work with high performing sites to identify successful strategies in addition to mentoring and supporting lower performing sites by adapting successful strategies to improve performance.

Strategies to reach men

In COP18, PEPFAR Cameroon will use index testing to reach husbands and sexual partners of HIV-positive women; sexual partners of MSM; clients and regular non-buyer partners of FSWs. Strategies will include targeted testing in health facilities and community settings, and self-testing for clients and regular non-buying partners of FSWs who do not wish to access HTS in DIC settings. In military settings, targets for self-testing include noncommissioned officers, index partners who are military but do not wish to come to health facilities, and officers returning from long deployments of more than six months. Targeted PITC will also be implemented at TB entry points and all entry points in facilities and communities as strategies to reach men.

Table 4.1.1: Strategies for Achieving Epidemic Control among Adult Men

Age Group	Index	Targeted	Self	TB	Dx	Strategies		Projected Data:	
						Modality	% Pos Men		
15-19	✓	✓	✓			After-school clinic hours and focus on out-of-school kids	<ul style="list-style-type: none"> Cell phone mobilization <ul style="list-style-type: none"> -G-Reporting -Whatsapp Age related linkage agents 	<ul style="list-style-type: none"> Social network testing MSM; Partners and clients of FSW Differentiated models – same-day initiation, MMP, community ART initiation and dispensation Support health facility “retention committees” to address issues related to retention and resistance Screening tools in facility and community settings 	Facility Index 18% Com Index 3% Inpatient 10% Targeted Mobile 5% Other PITC 40% TB Clinic 5% VCT 13% Community-based VCT 5%
20-24	✓	✓	✓			Weekend and night clinic hours			
25-49	✓	✓	✓	✓	✓	Information on testing availability: <ul style="list-style-type: none"> Military morning assembling, KP grins and DIC Men accompanying their families to facilities 	Multi Disease approach MIL and other men		
>50	✓	✓	✓	✓	✓				

For men in the 15-24 age groups, PEPFAR-supported health facilities will extend clinic hours to accommodate working men and young men in school. Young men will be mobilized via social media strategies using WhatsApp and U-Reporting. PEPFAR Cameroon will also employ “adolescent champions” to mobilize their peers and link them to adolescent-friendly HTS services. Primary HTS modalities will include index testing, targeted testing, and self-testing.

Men aged 25 years and above will be reached through a package of modalities including index testing, self-testing, targeted PITC, diagnostic testing and the use of TB entry points (data show 65% of TB cases are men within this age group). Health education and literacy materials tailored to men’s health will be developed and used to reach men in this age group. The military program will provide health messaging (including importance of testing at least once a year) and information on availability and location of HTC facilities during morning assembly of military personnel. HIV testing information and health messaging will also be promoted at social events and drop-in centers for key populations and for men accompanying their families to facilities. Scale up of male-friendly services with a multi-disease package of activities will be offered to military and civilian men. Outreach activities to find high-risk men in communities especially during events that attract men (KP chill-ins, Officers’ mess halls, training centers for non-commissioned officers) will be used as opportunities to offer testing. PEPFAR Cameroon will continue reaching regular partners and non-buying sexual partners of FSW through a voucher system and self-testing. A large number of adult men will be reached through index testing and partner notification services being offered to all female PLHIV at scale-up sites, including index testing modalities that include a self-testing approach. Men, who are parents, will also be reached through index testing of HIV positive biological children in all clinical settings.

Strategies to reach women

Table 4.1.2: Strategies for Achieving Epidemic Control among Adult Women

Age Group	Index	Targeted	Self-Tes	TB	DX	Strategies		APR FY17 Data	
						Modality	% Pos FEM		
15-19	☑	☑	☑			<ul style="list-style-type: none"> Adolescents-friendly services in facilities (extend work hours and weekends, ease access to prevention materials) Age-specific peer linkage agents Testing in hotspots settings for children of FSW and their peers Enhanced therapeutic education 	<ul style="list-style-type: none"> Support MOH Inspector General’s Office and regional delegates to enforce circular letters addressing user fees in clinics 	Facility Index Inpatient	16% 5%
20-24	☑	☑	☑			<ul style="list-style-type: none"> Age-specific peer linkage agents 	<ul style="list-style-type: none"> Support health facility “retention committees” to address issues related to retention and resistance 	Targeted Mobile Other PITC	5% 5%
25-49	☑	☑	☑	☑	☑	<ul style="list-style-type: none"> Index testing: Men on ART, clients of FSW Package of postpartum care intervention from ANC, postnatal period and through transfer to ART program Align women support group meetings and drug pickup in health facilities with other clinical services Adapt adult VL algorithm for pregnant and breastfeeding women 	<ul style="list-style-type: none"> Screening tools in facility and community settings VL testing 3 months post-ART initiation among pregnant women 	TB Clinic VCT Community-based VCT	25% 7% 24%
>50	☑	☑	☑	☑	☑	<ul style="list-style-type: none"> Outreach testing at widow meeting groups 			

PEPFAR Cameroon will offer index testing to wives of HIV-positive men and mothers of their HIV positive biological children in clinic settings, through targeted testing and self-testing for female sexual partners of HIV-positive MSM and military staff as well as prevention of mother-to-child (PMTCT) services at ANC, diagnostic testing, and testing at TB sites. The partners of index cases will be given the opportunity to choose where to be tested either in facility or community based settings. HIV testing among FSW will continue to be a focus and outreach testing for widows will be intensified within existing informal associations and gatherings of widows. The use of screening tools will be scaled up in facility and community settings to allow for a more targeted testing approach to achieve higher HIV yields.

PEPFAR Cameroon will apply a screening tool to identify at-risk AGYW, particularly those who are already sexually active (including teenage mothers); those living in or around sex work settings; adolescent daughters of FSWs, those living in or around military barracks as well as AGYW who are widows, and cases with presumptive TB. AGYW will also be mobilized via social media using WhatsApp and U-Report, and “adolescent champions.” Adolescent-friendly services in facilities will include extended work hours and weekends to ease access to prevention materials, reproductive health care and HIV services.

For pregnant women across the age ranges, PEPFAR Cameroon will scale up postpartum follow-up of the mother-baby pair from ANC through the postnatal period and successful transfer to ART programs. The ‘Catch-Up Strategy’ to reach pregnant women in hard to reach localities for ANC and PMTCT services will be scaled up, as this is the second highest modality through which HIV positive women are identified. PEPFAR Cameroon will support minor repairs and rearrangement of space in counseling units to ensure confidentiality, monitoring and supervision, and strengthen linkage to treatment via linkage and retention agents. PEPFAR Cameroon will scale up retesting of pregnant women who initially tested negative at first ANC visit and retesting for verification within the context of the test and start strategy.

4.1.2 Getting PLHIV on treatment

Based on EPP Spectrum estimates, 44% of PLHIV in Cameroon were on treatment at the end of FY17, leaving a gap of 56%. Only 24% of PLHIV aged 10-19, 30% of 20-24 year olds, 47% of 25-49 year olds, and 57% of PLHIV above 50 years are estimated to be on treatment, showing wide disparity in treatment coverage across the various age groups.

PEPFAR FY17 data show that of the 52,336 patients who tested positive, 43,394 were initiated on ART, reflecting an overall linkage rate of 83%. Age and sex disaggregation of the data revealed that among the 43,394 patients linked to treatment, 65.5% were females and 34.5% were males, reflecting higher losses among males along the linkage chain. Within the age groups, 76.6% of adolescents aged 10-19 that were diagnosed with HIV in FY17 were linked to treatment, 67.1% of young adults aged 20-24, 85.8% of PLHIV aged 25-49, and 86.3% of PLHIV above the age of 50

were linked to treatment. PEPFAR routinely evaluates site level linkage data by age and sex, and will expand to more closely look at linkage data by age, sex, priority population, and testing modality on a weekly basis at each scale-up site.

Outstanding gaps

There is suboptimal linkage to treatment overall (83%), with greatest linkage challenges among adolescents (76.6%) and young adult groups (67.1%), among whom there are also lower linkage rates for males relative to females. FY18Q1 data also shows low linkage rates (74%) for males >50. Effective strategies are needed to address these gaps.

Strategies to improve linkage to care and treatment

PEPFAR Cameroon will scale up differentiated service delivery models by intensifying same-day ART initiation and age-appropriate therapeutic classes for adolescents and young adults. PEPFAR Cameroon will also adapt the Linkage Case Management (LCM) model, which successfully linked people across age and sex groups in Bukoba, Tanzania (as described on the PEPFAR Solutions website). In addition to the comprehensive linkage agent model currently implemented across PEPFAR-supported scale-up clusters and adoption of the LCM model, PEPFAR Cameroon will scale up accompanied referrals through peer linkage agents to target younger males. PEPFAR will support Cameroon government's decentralization of PMTCT/TB/HTC standalone sites to accommodate men through task shifting and promote the family care model. While KP linkages rates have improved considerably through FY17 and early FY18, peer navigators will connect newly identified HIV-positive KP clients to facility linkage and retention agents. Training of healthcare providers and setting up KP-friendly services will be intensified in the clusters. For KP who continue to be reluctant to go to health facilities, or those who prefer to be treated at the DIC, on-site treatment initiation will be scaled-up from one DIC in FY18 to at least half of all DICs in FY19.

PEPFAR Cameroon will scale up adolescent friendly ART and reproductive health services through training of health care providers on how to approach and attract adolescents as well as how to address their specific health needs. Health facilities will designate spaces for provision of age-appropriate services to adolescents. PEPFAR Cameroon will also strengthen bi-directional referrals between health facilities and OVC service providers to ensure comprehensive follow-up of HIV-positive children and adolescents.

4.1.3 Ensuring Retention

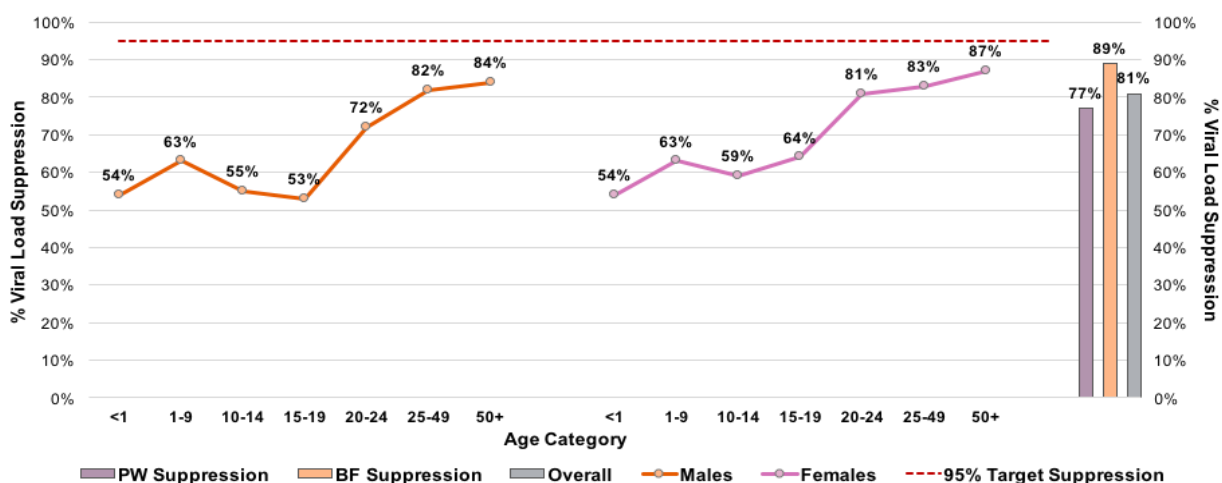
In FY17 PEPFAR Cameroon monitored a cohort of PLHIV on ART across all age groups over a 12-month period, at the end of which only 72% of the cohort (37,646) was still on treatment. Though this was well-below the 90% global target, PEPFAR's results were above the overall national rate of 65%. There are substantial variations in retention rates across the age groups: 41% among <1, 69% among 15-19, 62% among 20-24 year-olds, which are below the overall retention rate in FY17. Retention rates ranged from 73% to 77% for the following age groups: 74% among 1-9, 77% among 10-14, 73% among 25-49, and 74% for >50 year olds. Given below 90% retention across age bands,

PEPFAR Cameroon will continue implementing strategies to improve retention rates across all age groups. PEPFAR Cameroon routinely looks at site level retention by age and sex, as well as VL suppression by age and sex to monitor performance and inform program planning.

Outstanding gaps

There are low retention rates below the 90% target across all age groups and among males and females. The adolescent and young adult groups had the lowest retention challenges, with generally lower retention rates for males. Additionally, while no age group has achieved 90% VL suppression, Figure 4.1 shows that VL suppression is significantly lower in age groups under 20.

Figure 4.1.3: Viral Load Suppression by Age and Sex, FY17 APR



Strategies to improve retention in care and treatment

To reach the FY19 treatment targets and maintain PLHIV on treatment, PEPFAR Cameroon will ensure all PLHIV initiated on treatment benefit from enhanced therapeutic education and counseling for retention in care. Differentiated service models such as multi-month prescription (MMP), community ART initiation and/or dispensation for stable patients, and task shifting will continue. In addition, a differentiated service delivery model for PLHIV with advanced HIV disease will be implemented to reduce their high risk of morbidity and mortality. PEPFAR Cameroon will improve access to viral load testing for PLHIV on treatment by strengthening the sample day transport system, ensuring availability of viral load commodities and subsidies/voucher schemes to enhance uptake of MMP for patients whose viral load are suppressed and therefore qualify for community or multi-month dispensation. Management of patients with high viral load will be closely monitored and enhanced adherence counselling will continue to ensure improved adherence to treatment and retention. A number of voucher schemes will be adopted to reduce user fee barriers to client retention in care, as described in 4.3.

PEPFAR Cameroon will expand ongoing LTFU campaigns, including assigning a cohort of patients to each linkage and retention agent who will be responsible for monitoring on time ART

pick-up as scheduled in appointment logbooks, identifying defaulters and encouraging their return through phone calls, short message service (SMS) messages, home visits, etc. PEPFAR Cameroon will also continue supporting PLHIV support groups and community adherence clubs including adapting group meetings at clinics to coincide with drug pickup and other clinical assessment.

All KP DICs are currently operating as community ART dispensation sites and PEPFAR will continue to advocate for revision of the national directives on defining what a “stable patient” is so that patients who wish to receive their treatment at the community level can do so. While DICs are intended to serve KP specifically, they also welcome stable patients from the general population who wish to receive their treatment there.

PEPFAR Cameroon will conduct facilitative supervision and on-site mentorship to improve quality of service delivery. This mentorship model will consist of onsite training, mentoring provided by expert physicians, nurses and linkage relay agents (LRA) from larger and more experienced ART sites to support smaller satellite sites. IPs support facility and community staff in conducting informal discussion groups among clients of priority and harder to reach groups (such as men, AGYW, KP, youth) in order to continue to identify barriers to care, receive feedback on service quality, and continuously improve services that will increase access to HIV care and treatment.

Above site support will include updating existing Standard Operating Procedures (SOP) and other job aides to successfully implement and monitor scale up. PEPFAR Cameroon will also continue supporting health facility “retention committees” to address issues related to retention and resistance, and will continue to enhance GRC’s knowledge to adapt adult VL algorithm for pregnant and breastfeeding women to VL testing three months post-ART initiation.

PEPFAR Cameroon will continue to monitor site level performance on a weekly basis by tracking missed appointments (and using LRA to follow up). IPs will closely monitor use and implementation of voucher schemes at each site to reduce financial barriers to receiving HIV care and treatment. IPs will work with facilities to track retention in care by service delivery model, sex, and age, and will improve strategies to report LTFU outcomes and more accurately identify true LTFU versus transfer. Strategies and models used at top performing sites will be promoted and supported for adaptation at lower performing sites.

Strategies to improve retention among men

Specific health education and literacy materials tailored to men’s health will be developed and made available to all men living with HIV on ART with peer linkage agents available to address male-specific issues. Adapted hours and clinic times including weekends and night clinic shifts will accommodate busy and working men on ART. Improved documentation of MMP will be ensured to avoid considering some stable patients, for example military on deployment who sometimes receive six-month ART packs, as considered LTFU.

Strategies to improve retention among children and adolescents

PEPFAR Cameroon will implement the “Enhanced Adherence Counselling” program in clinical settings, which includes providing tailored messaging to caregivers of children and adolescents, and establish a system for timely return and management of high viral load results to clinics. Drug pick-ups for children will be aligned with appointments for vaccination and mother’s drug pick-up. Adolescents’ drug pick-up times will be adapted to fit school schedules. PEPFAR Cameroon will continue supporting adolescent treatment support groups which provide messaging on life skills, sexual and reproductive health, and counseling on treatment adherence and transition to adulthood.

A bi-directional referral system between clinical sites and OVC service providers will be scaled up. OVC service providers will conduct monthly home visits to provide services in core areas identified in individual case plans of HIV-positive children and adolescents including psychosocial counseling and adherence monitoring using the pill-count method. Monthly home visits will also include nutritional assessments, using the Mid-Upper Arm Circumference and counseling. All moderate to severe cases of malnutrition will be referred to nutrition clinics for treatment. The OVC program will use the Ages and Stages Questionnaire (ASQ-3) to identify and provide early interventions that will lead to good development of HIV-positive children below the age of 5.

4.1.4 PMTCT

Cameroon recently upgraded all PMTCT standalone sites to ART sites and further decentralized point of care early infant diagnosis (EID) to reference, regional, and some district hospitals to reduce turnaround time and accelerate early management of children infected with HIV. This strategy has been conclusive in four major regional towns, including Douala and Yaoundé, through Elizabeth Glaser Pediatric AIDS Foundation (EGPAF) with support from Unitaid.

Results and achievements

In FY17, 180,961 of an expected 348,439 pregnant women attended ANC in PEPFAR-supported sites, representing 52% coverage. Of all pregnant women who attended ANC, 172,874 (96%) were tested for HIV. Among pregnant women tested for HIV at ANC, 9,212 tested positive, representing 47% of the expected target of 19,870, with a yield of 5%. Of the 9,212 pregnant women who tested positive, 8,802 (96%) received ART, of which 8,544 HIV-Exposed Infants (HEI) benefited from a polymerase chain reaction (PCR) test at two months, representing 93% coverage (and 70% of the overall expected target of 12,260). Only 70% (8,544/12,280) of HEI had a DNA PCR test done by two months of birth, while 65% (275/424) of HIV infected infants <1 year-old enrolled on ART. Viral load suppression for pregnant and breastfeeding women is 78% and 89% respectively. PEPFAR Cameroon regularly analyzes the clinical cascade for pregnant women to inform program improvement strategies. Additionally, IPs have worked to identify barriers to PMTCT and

collected data to help address the issue, including documenting ANC service costs at scale-up sites.

Outstanding gaps

There is low (52%) ANC attendance due to a number of factors, including user fees. This has resulted in missed opportunities to offer PMTCT services to pregnant women, and low retention on ART for pregnant and breastfeeding women. There are also stock outs of test kits and ART commodities, and low (65%) linkage of infants to ART treatment services.

Strategies to improve PMTCT Uptake

In FY19, PEPFAR Cameroon will support implementation of integrated community interventions through the Catch-up strategy by Community Health workers (CHWs) to find pregnant women in hard to reach communities who have difficulty accessing health care or who cannot afford ANC services. CHWs will empower women and improve their experience in ANC centers, incorporating trust and respect in ANC services. CHWs will engage women through the Group ANC model (ongoing in Nigeria, Uganda and Kenya), home visits, community-based action groups and increase community awareness of ANC by leveraging m-health technologies and SMS-reminders and encouraging messages. The congregational-based intervention (baby shower program), which has been proven to increase couples/male partner ANC attendance, will be scaled up in high volume priority districts. PEPFAR Cameroon will support GRC to standardize user fees for ANC, implement voucher programs for indigents and engage the inspector general's office to support enforcement of circular letters addressing user fees. PEPFAR Cameroon will also implement performance based financing in priority districts to find pregnant women in the community. PEPFAR Cameroon will institutionalize comprehensive family HIV prevention, care and treatment programming, strengthen HIV retesting for pregnant women who tested negative at first ANC, and intensify same day ART initiation for pregnant women who test positive. Community-facility linkage through CHWs will be scaled up. Site level performance data across the clinical cascade for PMTCT, including use of voucher systems, will be monitored and used for performance improvement as previously described for the clinical cascade.

Strategies to improve uptake of EID and ART for HIV infected infants

PEPFAR Cameroon will rollout cohort monitoring for the mother-baby pair to improve EID uptake for all HIV Exposed Infants (HEI) in PEPFAR-supported regions and create a network of health facilities around existing point of care to maximize use and enhance uptake of EID for HEIs. PEPFAR Cameroon will leverage OVC program to scale up EID using ANC clinics as entry points to prevent LTFU of the mother-baby pair and promote integrated child wellness. Linkage and retention agents will be posted to the postnatal services to capture all mothers on ART who deliver and enroll the mother-baby pair in the cohort register for monitoring until 18 months postpartum when the pair graduate from PMTCT services, at which point the final HIV status of the HEI will be documented. PEPFAR will support linking of EID services for HEI to a standard package of ANC and postpartum care for mothers and infants. Linkage and retention agents will also deliver an LCM model to infants who test positive for HIV, providing comprehensive

counseling and support to the mother or care giver to ensure the infant stays in HIV care. IPs will work with facilities to monitor EID uptake, HEI tracking, and testing turnaround time. IPs will work with facilities to transfer best practices from high performing facilities to lower performing sites.

Strategies to improve retention of pregnant and breastfeeding women on ART

PEPFAR Cameroon will implement a package of postpartum care interventions from ANC, postnatal period and through transfer to ART program, including family planning (see annex). PEPFAR Cameroon will also scale up implementation of PMTCT cohort monitoring to priority and sustained support districts, with development of SOPs and training tools. The PMTCT/HEI cohort register will be scaled up to monitor outcomes for HEIs and the mother-baby pair on ART. A viral load algorithm will be adopted for pregnant women to ensure viral load testing three months after initiation on ART, and scale up of VL testing for pregnant and breastfeeding women (PBFW) with training and site oversight. PEPFAR Cameroon will scale up systematic referrals of mother-baby pair to OVC service providers for community based retention. LRA's will strengthen community-facility linkages through active defaulter tracing programs, home visits, and psychosocial support group programs. Partner notification will be scaled up for partners of HIV-positive PBFW. Site level performance will be monitored and managed as previously described for retention of women.

Cross-cutting strategies

Quality Improvement Collaborative (QIC), which has been successfully implemented in Cameroon, will be used to improve EID performance. QIC will focus on EID and linkage of infants to treatment services, viral load testing for pregnant and breastfeeding women and their children, and increasing ANC attendance for pregnant women. PEPFAR Cameroon will implement the mentorship model, where mentors from high performing sites mentor other smaller sites. In-service training, monthly mentorship, and supportive supervision visits will also be part of the package.

4.1.5 Pediatrics

Cameroon has an estimated 41,234 children living with HIV (National Report on HIV Projection, 2017); with a national pediatric ART coverage of 23.9% (MOPH 2017). Of children in Cameroon on ART, 73% are in PEPFAR-supported districts. Implementation of Test and Start, adopted for children in 2013 and for the general population including older children and adolescents in 2016, is ongoing nationwide. Provider-initiated testing is offered at all pediatric entry points in health facilities and in the community. Viral Load testing was adopted and is currently being implemented for monitoring of patients, including children on ART, but scale up remains a major challenge. Monitoring of children on ART was reinforced with the hiring of psychosocial support staff specifically for children. Decentralization of EID Point of Care to reference, regional and some district hospitals was implemented to reduce turnaround time and accelerate early management of children infected with HIV. HTS is offered free for children <15 and PEPFAR Cameroon continues to advocate with GRC to provide free testing for adolescents 15-19 years old.

PEPFAR will continue supporting decentralization of pediatric antiretroviral services through task shifting at all levels of the health pyramid to accelerate pediatric HIV response in Cameroon.

Results and achievements

At the end of FY17, PEPFAR Cameroon provided ART to 7,228 PLHIV <15, accounting for 18.9% of PEPFAR FY17 target. This represents 75.4% of the total number of children on ART nationwide (MOPH report, 2017). Of the overall 52,336 individuals who tested HIV positive in FY17, only 7.3% were children and adolescents. Viral suppression for children and adolescents linked to ART was 57%. PEPFAR routinely evaluates site level linkage and retention data for adolescents and children.

Outstanding gaps

Despite the progress made, there remain a number of challenges. Suboptimal case finding in pediatric populations is due to a number of factors such as parents' refusal to bring children to health facilities for HTS due to perceived stigma and discrimination as well as previous approaches not focusing on identifying adolescents with risk factors. Low ART coverage among HIV-positive children and adolescents are likely due to centralized pediatric ART services that may result in long-distance referral and poor linkage. Low retention among HIV-positive children and adolescents on ART and low viral suppression may be a result of sub-optimal availability of the preferred ARV formulations for children <3 years; socio-economic factors that contribute to poor adherence and poor ART clinic attendance and parent/service provider reticence to disclose HIV status to children and adolescents.

Strategies to reach children and adolescents

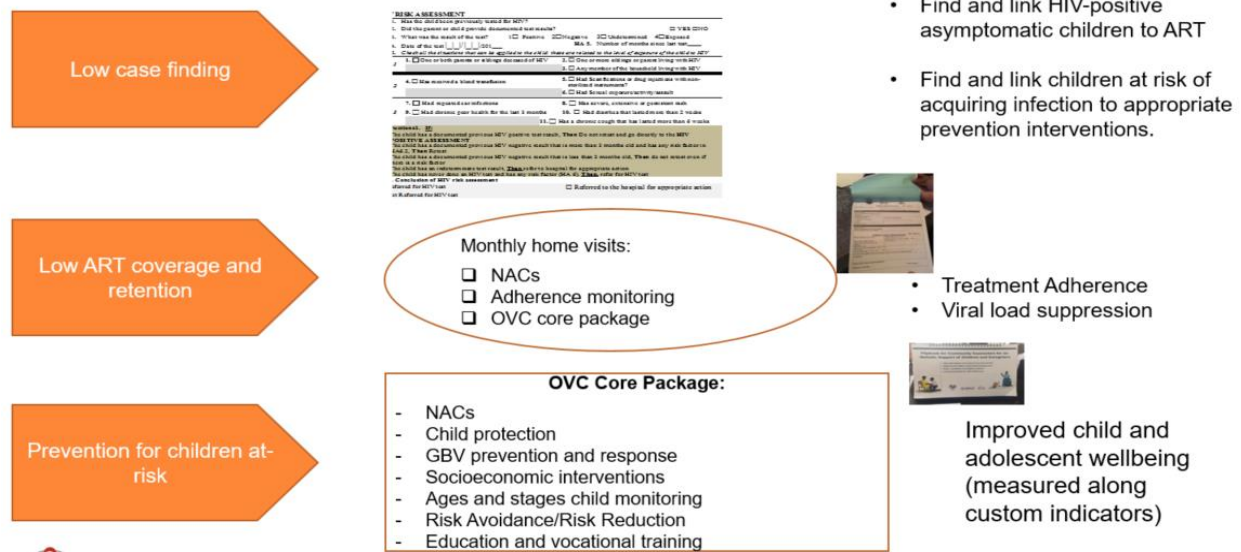
To reach the 90-90-90 goals, PEPFAR Cameroon will scale up the pediatric package of services and support GRC to complete the roll-out of Test and Start, further decentralize pediatric treatment and care, as well as reduce user fees to help improve linkages from identification to treatment initiation and retention among children and adolescents. PEPFAR Cameroon will also intensify case finding for children to improve ART coverage rates, retention, and viral suppression rates for pediatric and adolescent populations.

Table 4.1.3: Strategies for Achieving Epidemic Control among Pediatrics

Age Group	Case Finding				Strategies
	EID	Index	Targeted PITC	TB	
<1	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<ul style="list-style-type: none"> Intensified case finding through: <ul style="list-style-type: none"> Mother-infant pair screening and monitoring Improve service uptake through POC diagnostics Integrate targeted HIV testing at immunizations, malnutrition & TB HIV testing screening tools in facility and community settings Bidirectional referrals between OVC and Clinical service delivery points Decentralization of pediatric care
1-9		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
10-14		<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	

To improve pediatric and adolescent case finding in FY19, PEPFAR Cameroon will scale up index testing of biological children of HIV-positive women or to men who test positive but the wives status is unknown or died of an unknown cause, provide targeted PITC to children in high-prevalence entry points such as outpatient department, TB, malnutrition, immunization, emergency and inpatient setting. Additional strategies include generating demand for pediatric HTS through community outreach education to parents and caregivers (in savings and internal lending groups, faith-based communities, etc.), rollout of cohort monitoring for the mother-baby pair to improve EID uptake for all HEI in the PEPFAR supported regions, and creation of network of health facilities around points-of-care to maximize use and enhance uptake of EID for HEIs. PEPFAR will also continue to screen children in appropriate adolescent settings, including use of an optimized screening tool.

Table 4.1.4: Strategies for Achieving Epidemic Control among OVC



PEPFAR Cameroon will continue to leverage the OVC platform in order to address low case finding among children and adolescents and low ART coverage and retention among HIV-positive children and adolescents. The program will reach 18,8369 OVC and their caregivers (87% of whom are below the age of 18 years) with DSD interventions in scale-up clusters and 13 sustained sites. Children living with HIV will make up about 20% of <18 OVC_SERV result. The OVC program uses a case management cycle to deliver home-based services focused on the following core areas: child protection, GBV prevention and response, socioeconomic interventions, ages and stages child monitoring, age-appropriate risk avoidance or risk reduction interventions, education support and vocational training. The OVC program will administer screening tools to improve identification of HIV-exposed infants and linkage of asymptomatic HIV-positive children and adolescents to ART. The OVC program will also collaborate with ART sites to enroll HIV-positive pregnant women in its Ages and Stages child monitoring intervention. Using the Ages and Stages Questionnaire version 3 (ASQ-3) tool, the OVC program will identify and provide early interventions (including positive parenting counselling) to track mother-baby pairs through the end of exposure to minimize risks of HIV transmission. Testing in KP hotspot settings will continue to be promoted for children of FSW and their peers. PEPFAR Cameroon will also scale up systematic referrals of mother-baby pair to OVC service providers for community-based retention, and decentralize TB case finding in pediatric clinics to enhance HIV testing for presumptive and TB confirmed cases. Youth “champions” from adolescent-friendly clinics trained on life skills and behavioral analysis will reach out to high risk peers to invite them to facilities or through adolescent social networks for testing. There will be a review and harmonization of HIV screening tools in facility and community settings.

To improve ART coverage, PEPFAR Cameroon will build the capacity of all ART sites to be able to initiate children and adolescents on treatment, and increase the availability of pediatric ARVs and trained staff from clinicians to nurses through task shifting. PEPFAR Cameroon will ensure the

availability of pediatric age-specific peer linkage agents to find and link every HIV positive infant, child and adolescent identified to ART. Bidirectional referrals between clinical and OVC services will be strengthened to ensure children and adolescents are not lost to follow-up during the early initiation stage. Efforts will also be focused on decentralizing pediatric care and treatment using specialized facilities to provide supervision and mentorship to other ART sites.

To improve on retention and viral suppression for children and adolescents, PEPFAR Cameroon will have to address three key challenges: a) Sub-optimal availability of preferred ARV formulations for children <3 years. PEPFAR Cameroon will support the availability of pediatric formulations, especially the lopinavir/ritonavir (LPV/r)-based regimen ensuring IPs monitor guideline implementation for appropriate dosing /administration and the systematic assessment of nutritional status at every visit for dose adaptation; b) Socio-economic factors that contribute to poor adherence and ART clinic attendance. PEPFAR Cameroon will improve access to existing social services that can improve adherence and ART clinic attendance by promoting bidirectional referrals between clinical and OVC service providers to address social vulnerabilities that contribute to non-adherence; c) Parent/service provider reticence to disclose status to children and adolescents, which affects ART adherence. PEPFAR Cameroon will strengthen counseling skills on age-appropriate disclosure by lay counsellors and age-specific peer linkage and retention agents. Positive parenting counseling sessions will reinforce messaging to parents and caregivers on the importance of disclosure. Adolescent-friendly programs with peer support groups for treatment and care of children and adolescents, including adapted friendly hours will be scaled up to provide age-appropriate therapeutic classes and enhanced adherence counseling sessions to attain viral suppression. Monthly home visits and intense psychosocial support will be supported whenever required. PEPFAR Cameroon will subsidize user fees for VL to enhance monitoring and early decision making in cases of poor adherence to treatment and poor VL suppression, and continue to scale up the family treatment model and support transitioning from pediatric to adult ART. Site level analyses used for performance management of pediatric programs was previously described in the clinical cascade narrative.

4.1.6 TB/HIV Summary

Cameroon is one of 30 countries with the highest burden of TB/HIV co-infection worldwide. World Health Organization (WHO) estimates that there were 48,319 new TB cases in 2016. Of these, only 25,975 (54%) were notified, with an incidence rate of 105/100,000 population and a treatment coverage of 55%. The majority of TB cases notified were predominantly males with about 65% of cases between the ages of 15 to 44 years old and 5.5% were children detected out of the 10% expected target. TB/HIV co-infection was 34% in 2016, with an incidence of TB among people living with HIV (PLHIV) on ART of 1.5% and 11.3% among PLHIV not on ART. Yaoundé and Douala accounted for one third of all TB/HIV co-infected patients in Cameroon. Cameroon MoPH recommends the provision of Isoniazid Preventive Therapy (IPT) to PLHIV without TB infection; however, implementation of this policy is still very limited.

In 2016, 93% of TB patients were tested for HIV test, with an HIV positive yield of 34% in new and relapsed TB cases, among whom 92% of co-infected cases were initiated on antiretroviral therapy.

In the same year, 176 patients were diagnosed with multi-drug resistant/rifampicin resistant TB (MDR/RR-TB), and were treated. The therapeutic success rate for new and relapsed TB cases has increased from 80% in 2011 to 84% in 2015 and 81% for HIV positive TB cases. More efforts are needed to reach the planned target of 85%.

FY17 Results and achievements

In PEPFAR-supported sites, 96% of new and relapsed TB cases knew their HIV status, 38% of TB patients were co-infected with HIV and 89% of HIV-positive TB cases were initiated on ART in FY17. In HIV management units, only 74% of all PLHIV were screened for TB, and the 2.9% that screened positive was a lower proportion than the 5% expected. Only 66% of specimens were sent to the laboratory for confirmation. PEPFAR continues to provide support for the integration of TB & HIV programs at facility level with focus on in-service capacity building for service providers in the four PEPFAR-supported regions. HIV management units receive support to offer TB screening using basic signs and symptoms, referral of suspected cases for TB diagnostic evaluation, and treatment of confirmed cases. TB management units offer systematic HIV testing to all TB patients and refer positive cases for ART initiation. Service providers in the TB clinics are trained to offer ART; however, few TB sites received support and few are currently providing integrated TB/HIV services. Other sites have yet to receive tools and ART to ensure full functionality. Gene-Xpert cartridges were also provided to facilitate TB diagnosis among presumptive cases.

Outstanding gaps

Despite the support and progress made, TB case finding and diagnosis remains suboptimal. The prevalence of HIV among TB patients remains high, with challenges providing integrated ART services in TB clinics. TB diagnostic capacity for PLHIV, prisoners, and other at risk populations is still limited to the cities of Yaoundé and Douala. IPT implementation is also limited by the availability of drugs and tools for data capture and reporting. There is suboptimal TB case finding and management among children, and there is also evidence suggesting patients with presumptive TB who cannot afford confirmatory testing delay enrollment in care for TB and HIV.

Strategies to expand uptake of TB/HIV services

In FY19, PEPFAR Cameroon will expand focus on TB/HIV services from the two initial scale-up health districts (Deido and Djoungolo) to the Yaoundé and Douala clusters. PEPFAR will provide TB screening to 203,283 PLHIV on ART, HTS to 11,789 TB patients, increase ART coverage to 4,636 HIV-TB co-infected adults and children, and provide Isoniazid (INH) to 10,777 PLHIV – including the military and all other vulnerable populations. To reach the FY19 targets, the scale-up package of services includes intensifying case finding for TB among PLHIV, providing IPT, and implementing infection control measures. For TB patients, scale-up package of services provides HIV testing for presumptive and confirmed TB cases, provides ART, and decentralizes pediatric TB case finding and management.

Table 4.1.5: Strategies for Improving TB/HIV Coverage

Age Group	Among PLHIV			Among TB Patients		
	Scale up of Xpert* for TB diagnostic evaluation among PLHIV	Scale up provision of Isoniazid Preventive Therapy**	Scale up of TB Infection Control	HIV testing among presumptive and confirmed TB cases	Provision of ART** to TB patients	Decentralize pediatric TB case finding and management
0-14	☑	☑	☑	☑	☑	☑
15+	☑	☑	☑	☑	☑	

PEPFAR Cameroon will continue to strengthen TB/HIV integration in facilities with effective decentralization of HIV testing and ART initiation in TB clinics while decentralizing TB case finding and management in pediatric clinics. PEPFAR Cameroon will continue to support HIV testing among TB patients as well as presumptive TB cases and their contacts and strengthen TB screening as well as improved case detection among PLHIV. PEPFAR Cameroon will learn lessons from the current support to scale up Xpert for TB diagnostic evaluation among PLHIV in the two clusters of Yaoundé and Douala with the highest TB/HIV burden. Gene Xpert cartridges made available will facilitate diagnostic evaluation of TB among PLHIV with TB symptoms. PLHIV who cannot afford necessary TB diagnostic testing will receive services through a voucher program to reduce the user fee barrier. PEPFAR Cameroon will support CHWs to trace contacts of people suspected of having TB and confirmed cases then conduct TB screening and HIV testing around the index cases at community level. The Global Fund supports 100 community agents for TB case finding in Yaoundé; this is an opportunity to leverage synergies. People suspected of having TB and HIV contacts will be referred to facilities for confirmation of TB diagnosis and HIV testing. PEPFAR Cameroon will ensure ART initiation for all TB and HIV patients within two to eight weeks of initiating TB treatment, and prioritize timely initiation and completion of TB treatment including MDR TB treatment among PLHIV. Site level linkage and retention staff (psychosocial support workers) and CHWs will ensure linkages from all clinical and community entry points for treatment and care.

PEPFAR Cameroon will scale up the provision of Isoniazid Preventive Therapy, building on lessons learned from the pilot implementation in 50 high volume ART sites in Cameroon. PEPFAR Cameroon will support MoPH to develop data collection tools for IPT and train service providers to provide INH to PLHIV without TB symptoms and effectively document services offered in the registers. PEPFAR Cameroon will strengthen laboratory capacity to use the most sensitive and specific screening and diagnostic algorithms at the facility and community levels. PEPFAR

Cameroon, in collaboration with the GFATM, will support the MOPH to roll out IPT for PLHIV nationwide.

PEPFAR Cameroon will support activities for TB infection prevention and control to minimize the risk of TB transmission within the scale-up clusters in order to provide a safe environment in which to seek health services. Guidelines for infection prevention and control developed with support from PEPFAR Cameroon will guide the implementation of infection control plans developed at facility level in the clusters. Activities will include improvement of quality management for TB/HIV services, support for TB health care providers and minor renovations for TB infection control.

In FY19, PEPFAR Cameroon will strengthen Cameroon's National TB Control program to decrease the TB/HIV burden and develop systems to achieve and sustain TB/HIV epidemic control in Cameroon. In support of the MOPH, 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. Mentorship, supervision, monitoring and evaluation will be strengthened through TA, site visits, and partner management and monitoring.

PEPFAR Cameroon will increase capacity to track TB screening documentation at site level and across sex and age groups, as well capacity to monitor co-infection management of HIV/TB patients and the clinical cascade. Data use for program improvement is described under the clinical cascade.

4.2 Prevention, specifically detailing programs for priority programming

In COP18, PEPFAR will continue to focus its prevention efforts on key and priority populations including MSM, FSW, AGYW and the Military. Prevention activities targeting children of FSW (cFSW) and those living within hotspots will also continue. New prevention interventions such as Pre-exposure Prophylaxis (PrEP) will be introduced to those KP most at risk. To improve targeted testing especially of men, self-testing will be introduced and HIV testing services for clients and regular non-buyer partners of FSW will be increased.

HIV prevention and risk avoidance for AGYW and OVC

Cameroon remains among the countries with the highest burden of HIV in Central Africa even though there is a slight decrease of deaths in recent UNAIDS estimations. The consequence is that OVC numbers remains important in country with 254,251 infants orphaned or made vulnerable by HIV according to EPP SPECTRUM 2017. Since mid-FY 17, PEPFAR OVC activities have aligned with clinical services prioritization in the two clusters of Douala and Yaoundé plus Bamenda, and this geographic location will continue in FY 19.

FY17 Results and achievements

In FY 17, a new beneficiary enrollment strategy based on assessing beneficiary needs with new PBF incentives and adjustments was implemented in all 11 CSOs leading to the achievement of more

than 100% of targets with 12,467 OVC served. Among those OVC, 10,699 were children <18 years (among whom 52.4% are girls and 25% aged 5 to 9 years); and 1,768 adults. Adolescents 10-17 years constituted 40.2% of the total children <18 years, 92.4% of whom accessed HIV testing and services (HTS) in FY17. Case monitoring plans were developed for each active beneficiary. Apart from HTS and SILC, other services included early childhood development (ECD), Sexual and Reproductive Health (SRH) education, educational support, nutritional counseling and support, and referrals.

Introduction of targeted testing using an HIV risk assessment tool since July 2017, has improved identification of positive cases with 413 HIV-positive beneficiaries identified in FY 17 of which 181 were new cases and 232 self-reported. Overall, 714 HIV-positive beneficiaries have been identified to date, with 694 (97%) successfully linked and on treatment. In addition, case management of HIV-positive children was intensified leading to the attainment of 93% adherence to treatment

Outstanding gaps

Despite strong program results and shifts in ensuring that beneficiaries enrolled in the program are receiving high quality services in all the program sites, there are gaps to address. The number of children receiving multiple services is low and there are disproportions in services offered. Also, with active beneficiaries representing less than 30% of total OVC served (3 396 in FY17), there are improvements needed in the coming fiscal year related to the recent change that occurred with the PEPFAR OVC_SERV indicator. In addition, among beneficiaries served, 85% were children and in FY19, PEPFAR aims to increase this percentage such that almost all 87% of active beneficiaries are children and adolescents. Furthermore, the number of HIV-positive children referred to the OVC project by health facilities was insignificant and emphasis will be made, beginning in FY18 and continuing into in FY19, to strengthen the bidirectional referral system for those OVC first identified in clinical settings.

Strategies to improve services to OVC

PEPFAR Cameroon's HIV prevention and OVC program will reach 18,836 (OVC_SERV target) OVC (among which 87% are under the age of 18) and caregivers with services in the core areas of child protection, GBV prevention and response, socioeconomic interventions, Ages and Stages child monitoring, risk avoidance or risk reduction interventions, education support, and vocational training. More specifically, PEPFAR Cameroon will leverage OVC, KP, and military programs to provide a DREAMS-like package of services to 12,611 (OVC_SERV and PP_PREV target) AGYW. The target populations includes AGYW living within and around military barracks, adolescent daughters of FSWs, and AGYW living in or near sex work hotspots or otherwise identified as at-risk of entering sex work. PEPFAR Cameroon employs a range of approaches for reducing sexual risk behaviors among vulnerable adolescents and young people at individual, household, and community level.

Table 4.1.6: Strategies for Achieving Epidemic Control among Adolescent Girls and Young Women

Age Group	Body Literacy & Fertility Awareness	Risk Avoidance	Parenting & Caregiver Programs	Educational Support	GBV Prevention & Education	HTS Screening, Referral, Linkage to Care & Support	Risk Reduction, Condom Education, Distribution	Economic Strengthening	Linkages to SRH Programming
10-14	✓	✓	✓	✓	✓	✓			
15-17			✓	✓	✓	✓	✓	✓	
18-24				✓	✓	✓	✓	✓	✓
Leverage existing OVC, military, key populations with comprehensive prevention interventions to reach 21,107 adolescent girls and young women (OVC_SERV and PP_PREV indicators)									

At the individual level, PEPFAR Cameroon identifies at-risk youth (particularly children in the 10-17 age range) using a vulnerability assessment tool that screens for sexual risk behavior and use of alcohol and other drugs. A personalized case plan is developed for at-risk youth which may include individual risk avoidance or risk reduction counselling (including condom education); referrals for HTS and linkage to ART; education support/vocational training (targeting AGYW); GBV prevention and post-rape care; and positive parenting counselling for teenage parents and/or caregivers of at-risk youth. Services are provided within safe spaces identified by the individual to create an enabling environment for one-on-one support.

PEPFAR Cameroon recognizes the importance of addressing financial vulnerability as a necessary platform for promoting the efficacy of individual-level interventions. At the household level, PEPFAR Cameroon provides grants and skills-building support to develop income generating activities, enrolls youth (15 and above) and adult caregivers in savings and internal lending communities, and provides financial literacy courses focused on overcoming financial barriers that place youth (particularly AGYW) at risk of acquiring HIV infection.

At the community level, PEPFAR Cameroon interventions target school-based and out-of-school youth. School-based interventions are provided through health or gender clubs/camps using peers to deliver curriculum-based (e.g. “My Changing Body: Body Literacy and Fertility Awareness for Young People”) sexuality education and life skills approaches to improve sexual and reproductive health. Interventions targeting out-of-school youth include community film screenings about teenage pregnancy and GBV; working with schools, community leaders, men’s groups, curriculum-based trainings on gender equity and GBV including promoting “Thursdays

in Black”(i.e. wearing black or a pin each Thursday to declare you are part of a global movement resisting attitudes and practices that permit rape and violence).

The program uses SIMS data and site level analysis of OVC cascade data (including OVC_SERV and OVC_HIVSTAT indicators) to manage partners, identify sites where HIV-positive OVC are being found, and verify quality of the package of services.

HIV prevention and risk avoidance for Key Populations

Based on the latest IBBS, HIV prevalence remains high among KPs (24.3% in FSW and 20.7% in MSM) with the burden of the epidemic being concentrated in urban cities targeted by PEPFAR. Therefore, KP prevention efforts will remain focused on 11 hotspots, 10 of which are in the two scale-up clusters of Yaoundé and Douala and one hotspot in the sustained district of Bamenda. In these hotspots, PEPFAR will continue to scale up targeted community interventions focused on preventing new HIV infections, strengthening case finding, linkage to treatment and ART adherence support. Work begun in FY17 to ensure KP-friendly service delivery will be scaled up and reinforced in PEPFAR-supported health facilities with differentiated models of service delivery. This includes community-based dispensing and community initiation of ART.

Table 4.1.7: Strategies for Achieving Epidemic Control among Key Populations

Age Group	FSW			MSM			CROSS CUTTING STRATEGIES
	index	targeted social network	Self testing	index	targeted social network	Self testing	
15-19		✓	✓	✓	✓	✓	<ul style="list-style-type: none"> • Home visits to find KPLHIV lost to follow up • Scale up onsite ART initiation in more DIC • Improve analyze and use of program data at all level
20-24	✓	✓	✓	✓	✓	✓	
25-49	✓	✓	✓	✓	✓	✓	
>50	✓	✓	✓	✓	✓	✓	

FY17 Results and achievements

FY 17 data reveal that 21,577 KPs were reached with prevention messages and materials and 13,193 tested for HIV. Of the 61% who were tested for HIV, 1,544 were diagnosed HIV-positive (12%) and 1,085 were linked to treatment (70%).

In order to better target and test those beneficiaries most likely to be HIV-positive, one innovative approach introduced has been testing conducted in MSM “Grins” or “Chill-ins” implemented by one MSM CBO in Yaoundé and another in Douala. These MSM social events serve as a strategy for indirect index testing when the index patient is reluctant to accept direct partner notification for

fear of violence or recrimination. Instead of DIC staff reaching out directly to the partners, the index case himself will invite his partner or partners to a social event, during which they will be offered prevention messages and services as well as HIV testing. In this way, the project is able to reach the index partners without them knowing they have been specifically targeted because of their partner's status. This strategy is proving highly successful with an 18% yield in FY 18 Q1 and will be scaled up to other CBOs through the remainder of FY 18.

Regarding clients of FSW, the program has implemented a new approach called Sex & Test where FSWs counsel their clients and provide them with a coupon for free testing at DICs or participating health centers. Under that strategy, 7 641 of those clients have been reached with prevention activities, 4 001 (52%) tested for HIV with 180 testing positive, a yield of 4.5%, nearly twice the national prevalence for adult men.

In addition, PEPFAR Cameroon has been working with GRC, GFATM, UNAIDS, and other partners to update national policies, tools and standardized approaches for KP programming including monitoring and evaluation. This work will continue and will engage stakeholders beyond the health sector such as local authorities, law enforcement, and the judiciary to create an enabling environment for FSW and MSM free from stigma, discrimination, or fear of violence.

Outstanding gaps

FY17 program data reveal a slight gap in KP prevention activities with 21,577 beneficiaries reached (89% targets achievement). Most of those KPs reached were less than 30 years of age (79% in MSM and 60% FSW) and yields are consistently lower in this age group than in older KP; additional efforts are needed to reach older KP who are more likely to be HIV-positive.

In addition, FY17 data shows gaps in identification of new beneficiaries with a decline in yields over all quarters and performance disparities by population and sites (appendix D). FY17 yields for MSM and FSW (11% and 12% respectively) were close to the IBBS 2016 prevalence for those newly tested with yield trends following the same pattern as noted in the study. For KP aged 30 and above, average yield (22% in IBBS 2016 and in FY17 Q4 data) was almost double that of the younger age bands (10% IBBS 2016 and 7% in FY17 Q4 data) and this situation is seen in the two sub populations.

Program strategies for FY 19 will focus in prevention activities for younger groups and increased cases findings among the elders.

Strategies to improve cases findings, linkage and retention in the continuum of Care

KP services begin at the community level with prevention activities and case finding. Under the Enhanced Peer Education and Mobilization model, outreach and prevention messaging as well as distribution of male and female condoms and lubricants are provided by trained Peer Educators (PE) and Peers Leaders (PL). Prevention efforts in FY19 will increasingly target their focus to younger KPs who have historically shown lower yields and KPs who have previously tested HIV negative. Beginning in FY19, PrEP will be offered to KPs in Douala and Yaoundé as an additional

prevention choice and routinely to the HIV-negative partner in sero-discordant couples for the first six months that the HIV-positive partner is on treatment.

With regard to testing, FY18Q1 results show testing at DICs generally produces higher yields than mobile testing with HIV prevalence increasing with age. For that reason, sexual network mapping of older MSM and social network mapping of older FSW will be emphasized in FY19. Regular hotspot mapping by PLs will continue identifying new and old hotspots with high yield to strengthen targeted testing. Through a performance-based approach, PLs or PEs will receive incentives for the number of clients referred and tested at the DIC. Systematic index testing will be scaled up beginning in FY18 and continuing into FY19. Index testing will focus on sexual partners of MSM, regular, non-paying sexual partners of FSW, and children of FSW.

Clients of FSW will continue to be reached by the innovative coupon system known as Sex & Test. Under the Sex & Test strategy, FSWs provide HIV prevention education to their clients and provide them with a coupon for free testing at DICs or participating health centers. The FSW then receives a small incentive payment of about \$1 for each completed referral.

For those cases in which MSM in particular are fearful of direct contact notification, indirect methods such as the social gatherings known as “Grins” or “Chill-ins” which anonymously bring together partners of HIV-positive MSM for a social event where testing is conducted will continue in FY19. For other hard to reach partners such as MSM who do not identify as part of the lesbian, gay, bisexual, or transgender (LGBT) community, female partners of MSM who do not know their partners are bisexual, and those regular, non-buying sexual partners of FSW who refuse to come in to the DIC, self-test kits will be distributed to the HIV-positive KPs to encourage their partners to test. PLs and PEs will provide counseling to KP partners and information for those who return for confirmatory tests. Those who test positive on self-tests will be referred to a local facility for a confirmatory test and supported by PLs and PEs within the community.

Once tested positive for HIV, KPs are assigned a Peer Navigator (PN). Those PN are normally PLs or PEs who are identified as living successfully with HIV/AIDS and have been recruited and given additional training in order to provide counseling services including client treatment and adherence support. PNs will physically accompany their clients to health facilities and present them to the designated KP-friendly provider in what is known as the “handshake” between the community and facility provider.

After enrollment on ART, the PN continues to support the client, focusing on the Positive Health, Dignity, and Prevention model and assisting with access to needed services, including psychosocial support, nutritional counseling as well as clinical services such as treatment for sexually transmitted infections (STIs), VL testing, sexual and reproductive health services, and post-GBV care, which is partially supported by GFATM. FY18Q1 programmatic data revealed that 95% (121) of KPs presenting with STIs were FSWs. As a continued response, systematic STI screening as well as sexual and reproductive health services will be provided to all KPs reached with a targeted approach for FSWs. Once found positive and linked to a health facility, PNs

provide clients with routine adherence counseling and actively work to bring back any clients lost-to-follow-up. The PN will 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. The PN program will continue in FY19 and continue to be monitored through monthly stakeholder meetings including representatives from local health facilities, the community and local government.

All DICs in Yaoundé and Douala clusters are already dispensing ARV as part of the community ART dispensation program. Currently, treatment is available onsite at one DIC and plans are being made to ensure at least half of the DICs offer treatment services by end of FY19, as a part of differentiated models of care and task shifting to improve access to care for PLHIV.

In order to create a more favorable legal environment for KPs in Cameroon, PEPFAR and partners continue to play a lead role in advocating for the rights of key populations and intervening when those rights are violated. By leveraging GFATM efforts, PEPFAR and its partners continue to actively work to sensitize police and military personnel on issues of gender identity and sexual orientation and to ensure that the moratorium on KP criminalization is respected. In cases where the moratorium has not been respected and arbitrary arrests have occurred, the U.S. Embassy Front Office and Regional Security Office have sought to mitigate the consequences. To develop community ownership of policy activities for KPs, PEPFAR continues to provide support to Community-based Organizations (CBOs) to build a GBV task force to improve GBV reporting and documentation of GBV cases. Although PEPFAR is working to ensure protection for KPs, 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 HIV-positive KP adherence and retention.

The program uses SIMS data and site level analysis of KP cascade data to inform KP strategies, manage partners, identify sites where HIV-positive KPs are being found, tailor differentiated programming to fill gaps and target high yield sites as well as ensure program quality. PEPFAR Cameroon staff will continue to use data for decision making through bi-monthly data reviews and monthly partner management meetings. Further data collection will include an increase in the number of SIMS assessments as well as the number of site visits to both hotspots and DICs. Since FY17Q4, partner performance has improved and shown considerable initiative in utilizing lessons learned to expand reach, maximize impact in testing and increase linkage to treatment. Such lessons learned will continue to be used to improve PEPFAR KP programming.

Priority Populations

In Cameroon, the military has one of the highest HIV incidence rates with 0% HIV+ at recruitment and 6% HIV+ by the 5th year of service (SABERS 2011). Priority prevention focuses on averting infections in new military recruits and consists of a five-activity prevention package that will be offered to 4,990 active duty military and other priority populations (AYGW target for FY 19 is 1,511) who live around military barracks.

In FY 17, the PP_PREV target was 3,000. At the end of the implementation period, 2,307 active duty military and 726 AYGW were reached, giving an overall achievement of 3,033 (101%). In FY18, the military plans to reach out to 5,648 new military recruits and those going for deployment in a package of activities entitled “Ready for Deployment”. The increase in targets for FY18 is due to the rise in military recruitments within the context of political instability in specific parts of the country. The clearance process for a new IP to take over this activity has just been finalized; implementation will begin in full scale in Q3 of FY 18. As such this activity has not yet started in FY 18 and no achievements have been recorded as of Q2 FY 18.

In FY19, the military will reach 4,990 active duty military that have been deployed for not more than three years; by using a screening tool, emphasis will focus on knowledge of HIV status. Those who do not present a high risk for HIV exposure will be reeducated on risk avoidance and condom use. In agreement with Military Command, this training will be conducted and repeated at all military educational sessions.

Community Relay Agents trained in community activities will ensure that those who test HIV positive will receive continuous post-test counselling and accompanied to ART services to ensure linkage to treatment and adherence counselling after initiating ART. Active duty military that test positive are encouraged to join support groups that meet their specific needs (age, sex, and military rank in cases of barracks with large troops).

The prevention package for AGYW includes another module on Life Skills and enhanced education on risk reduction and risk avoidance methods. AYGW clubs will be created around the military barracks where all the prevention activities will be carried out.

4.3 Additional country-specific priorities listed in the planning level letter

Utilize PEPFAR financial resources to reduce the clients’ financial barriers to HIV, ANC, and PMTCT services due to user fees while continuing dialogues and defining solutions with the Government of Cameroon for the elimination of all user fees

Cameroon faces the unique challenge of using user fees to finance health services including HIV and TB services (testing, viral load, TB testing and consultation fees). Some health facilities are able to charge informal user fees not approved by the government. A PEPFAR IP collected data on the user fees charged at facilities supported by PEPFAR and found a large range of service fees around ANC services, testing, consultations, and lab. These fees have been identified as barriers to pregnant women to access HTS; and PLHIV with presumptive TB to access ART or TB treatment because they cannot afford to pay the out-of-pocket costs related to TB tests, and/or to enroll in HIV care or initiate ART. In addition, since VL test results are needed to categorize a patient as stable or unstable, inability to pay for VL testing leads to a lack of VL results, which prevents people who would most benefit from MMP and community ART services as well as increasing visits and high costs for the HIV program. In COP18, PEPFAR will invest in short-, medium-, and long-term strategies to address financial barriers to HIV services from user fees while continuing to identify and implement solutions to address the supply side barriers.

To immediately address demand-side financial barriers to HIV services, PEPFAR IPs will implement several voucher systems for PLHIV in need to support removing user fee barriers in order to achieve epidemic control, without upsetting health financing structures at site level. These voucher schemes will mainly be implemented in scale-up clusters, as the resources going to sustained sites are not sufficient for voucher program implementation at scale. Case-identification, linkage, and treatment initiation will be promoted using an index testing package that includes free testing and enrollment in care for sex partners and biological children of diagnosed PLHIV. VL testing vouchers will be offered to children, adults, pregnant women, and KP with identified need. Support for VL testing will increase the number of eligible stable patients who can receive multi-month scripting and community ART delivery. PLHIV with presumptive TB will be supported for TB confirmatory tests when they do not have the means to immediately pay for testing, which will increase linkage rates and shorten time to receiving ART, while improving patient outcomes. Vouchers for clinical consultations will be available on a limited basis to vulnerable and priority groups, including adolescents, children, vulnerable women, and other identified groups with need. Finally, a limited number of ANC packages will be provided free of charge to women identified in the community who have not attended ANC for financial reasons. Needs will be identified through contacts with linkage and retention agents trained in case management, and IPs will work with community leaders and CBOs to help identify people with financial barriers, and voucher reimbursements to facilities will be based on approved and published government rates for services. For underfunded facilities with a large financially constrained client base, other results-based financing models for HIV services will be considered. It is important to note that the current model of performance-based financing (PBF) in Cameroon aims to address performance issues, and is not currently a model that directly addresses user fee barriers. PEPFAR Cameroon will aim to inform the longer term health financing strategy (described below) by using lessons learned from current PBF activities, including the effectiveness of tested HIV indicators.

PEPFAR will support GRC, through NACC, to provide more oversight to ensure that only government-approved user fees are charged at government sites. PEPFAR will also work with the highest levels of the MOPH to look for ways to support reduction in user fees until the longer term strategy described below is in place.

Over the longer term, PEPFAR Cameroon will provide targeted TA to the GRC in the elaboration and implementation of its sustainable health financing strategy. Since 2016, the GRC has embarked on the process of defining and developing a new health financing strategy with the goal of ensuring access to high quality healthcare services for the population while decreasing household health expenditures and avoiding catastrophic expenses. This strategy will incorporate results-based financing (RBF) to eliminate all point-of-service fees, including HIV/AIDS services, enabling PLHIV to access HIV care and treatment as well as other medical services to improve their overall health. The strategy takes into account existing PBF activities funded by the World Bank and relevant pilot projects such as the *Cheque Santé*, an innovative maternal and neonatal insurance scheme, funded by the French and German cooperations. The process has benefitted

from broad and well-coordinated donor support with participation by the WHO, UNAIDS, the World Bank, the International Labor Organization, the French and German bilateral cooperations, and various national and international NGOs. The USG health team, using non-COP funds, has been supporting this effort since late 2016. Technical assistance activities in FY17 and FY18 have included the elaboration and costing of the proposed service delivery package, training and capacity building of MOH staff on costing and budgeting tools, and developing of a communications strategy. Proposed COP funded TA deliverables in FY19 include continued development of communications tools and deployment of the strategy developed in FY18, elaboration of a manual of standard operating procedures for accreditation of health facilities and RBF modalities, and training of healthcare providers on the transition from a fee-for-service to RBF payment system.

Use the most recent epidemiologic data to ensure PEPFAR program aligns with unmet need for testing and treatment (by age and sex)

The most recent available Spectrum data was used for COP18 planning. In addition, a first look at preliminary, unofficial CAMPHIA data was used to help inform planning. The CAMPHIA team (including GRC) is working on an accelerated timeline to finalize the completed national data set and ensure validated data is available for local and national planning as soon as possible. Official release of the summary sheet has advanced to July 2018. PEPFAR team members are heavily engaged in CAMPHIA analysis and will also facilitate data use for program planning among GRC, implementing partners, and other stakeholders in Cameroon. This will include at least one workshop for PEPFAR IPs, including GRC to review data cleared for release. This workshop will include in-depth discussions of data interpretation and implications, as well as facilitated discussion on recommendations for shifts in program priorities and strategies to address the HIV epidemic based on the most current population-based data.

Ensure implementation, management and resource allocation of the PEPFAR program is geographically focused in the priority high burden areas around Yaoundé and Douala

Continuing in COP18, all clinical scale-up sites are located in the Douala and Yaoundé clusters. Additionally, the number of scale-up sites in the clusters is increasing from 45 in COP17 to 56 in COP18, expanding efforts to reach epidemic control in the priority, high burden clusters. The clusters account for the largest share of resources allocated, and are the focus of the most comprehensive packages of services across population groups and along the clinical cascade. Implementation of PEPFAR programs in the Yaoundé and Douala clusters is also the focus of a proportionally high level of time spent on partner management and capacity building.

Prioritization of increasing multi-month scripting to six months

Current policy allows for three months of drug scripting in country for stable HIV patients. However, there are existing challenges that need to be addressed for many patients to access multi-month scripting. In order to be defined as a stable patient in Cameroon, VL testing results are needed and carry a fee of 5,000 FCFA, or about \$9.50, which can be a barrier to clients' ability to take advantage of multi-month scripting to reduce the financial and time burden of HIV care and treatment. In order to move towards six month scripting, PEPFAR will support the

government to change policy to allow for six months of ART. In addition, PEPFAR will support strategies that remove VL testing as a barrier to achieving the stable patient designation necessary to receive multi-month scripting. Finally, PEPFAR will need to support facilities and supply chain to manage ART supplies in a way that facilitates adequate supply and space for multi-month scripting. In addition, clinical IPs will support and mentor sites to increase the number of clients receiving multi-month scripting. PEPFAR will monitor the numbers of clients receiving multi-month script at least quarterly.

Increase community ART dispensation to all populations living in high-burden areas in Yaoundé and Douala

Community ART dispensation continues to increase in scale, with the number of community ART clients in Douala increasing from 1,124 in the first quarter of FY18 to 1,682 by the middle of the second quarter. Likewise, Yaoundé saw an increase from 740 at the end of the fourth quarter in FY17 to 1,605 by the end of the first quarter of FY18. While the number of PLHIV receiving community ART dispensation will continue to increase during COP17, eligibility for community ART dispensation is hampered by the need and cost of VL testing to be classified as a stable patient, an eligibility requirement according to national guidelines to receive the service.

Table 4.3.1: Scale-up plan for Community ART Dispensation

Community ART Dispensation (CAD) Scale-Up Plan (March 2018 – September 2019)						
Timeline	# of CAD sites	# of clinical sites linked to a CAD site (% of total)	# of clinical sites	# of PLHIV eligible for CAD	# of PLHIC enrolled in CAD	% of eligible PLHIV enrolled in CAD
March 2018						
Yaoundé Cluster	18	6 (24%)	25	39,258	1,605	4%
Douala Cluster	21	12 (60%)	20	34,528	1,682	5%
September 2018						
Yaoundé Cluster	-	15 (60%)	25	47,974	4,797	10%
Douala Cluster	-	20 (100%)	20	34,528	3,453	10%
March 2019						
Yaoundé Cluster	-	25 (78%)	32	53,889	8,083	15%
Douala Cluster	-	24 (100%)	24	39,332	5,900	15%
September 2019						
Yaoundé Cluster	-	32 (100%)	32	59,803	11,961	20%
Douala Cluster	-	24 (100%)	24	44,116	8,823	20%

Scale up of the number of CAD sites is dependent upon approval by the MOH *Caveat: Clients eligibility criteria for CAD enrollment requires viral load results; currently the cost of a viral load test remains a barrier for many clients, therefore CAD scale-up will be limited †FY17, FY18, or FY19 TX_CURR x 0.80; assumptions: 80% of all PLHIV on ART are eligible for CAD enrollment and FY18 and FY19 TX_CURR targets are met ‡60% of PLHIV who are eligible for CAD enrollment will choose to enroll

For COP18, PEPFAR Cameroon will simultaneously work to remove the VL testing access barrier while further increasing access to community ART delivery for PLHIV. (See table 4.3.1 for Community ART Dispensation scale-up plan). Additionally, PEPFAR Cameroon will leverage both

existing and newly created platforms to deliver community ART, including CBOs (for the general population, KPs, Peds/Adolescents and the Military), ART support and adherence groups, DICs, and other community programs. Facility-community linkages will continue to be supported to expand community ART services.

Eliminate excessive testing in populations (across age and sex) in favor of targeted testing HIV testing based on selection of a pre-approved screening tool and including scale-up of index testing

At the time of writing, the current national guideline in Cameroon remains universal testing for the general population. GFATM supports targeted testing and the new Global Fund concept note put forward by the government also includes plans for targeted testing. PEPFAR is working with GRC and GFATM to ensure that the testing policy change is documented in the guidelines and communicated to all facilities. PEPFAR will continue to support use of an approved screening tool (and will support government adoption of a high quality, approved screening tool) for modalities with low yield, including PITC. However, the screening tool will not be used in high yield modalities and discretion may be used in modalities with general low yield which also reach priority populations (such as men and adolescents). Index testing for newly identified PLHIV at facilities has been increasing since COP16 and is currently scaling rapidly in COP17 with higher than population average yields for biological children and sexual partners of the index case. In COP18, index testing will be offered to all new and continuing clients at scale-up sites, and will be supported in sustained sites. See Table 4.3.2 for a Scale-Up Plan of Index Case Testing in Scale-up to saturation clinical sites.

Table 4.3.2: Scale-up plan or Index Case Testing

Index Case Testing (ICT) Scale-Up Plan (March 2018–September 2019)				
Timeline	# of clinical sites performing ICT (% of total)	# of clinical sites	% of TX_CURR with completed ICT (≥15 years)	% of TX_CURR with completed ICT (<15 years)
March 2018	Yaoundé cluster	25	5%	5%
	Douala cluster	20	5%	5%
September 2018	Yaoundé cluster	25	40%	40%
	Douala cluster	20	40%	40%
March 2019	Yaoundé cluster	32	75%	75%
	Douala cluster	24	75%	75%
September 2019	32 (100%)	32	90%	90%

Yaoundé cluster	24 (100%)	24	90%	90%
Douala cluster				

In FY19, case finding will be emphasized in the 25+ age bands of KPs as program and IBBS data revealed higher yields in those age groups. Strategies such as support from older DIC staff to mobilize social networks and, scaled-up indirect index testing through social events known as “Grins” and “Chill-ins” for those fearing the repercussions of direct partner notification will be implemented to ensure targeted testing to those most likely to be HIV positive. In addition, social and sexual network mapping of KPs diagnosed HIV-positive will be emphasized and conducted by PN in the community in order to reach more index patients. Household identification of every HIV-positive FSW enrolled in the program will be conducted by leveraging the efforts of OVC case managers and this will help improve testing of index children and regular non buyer sexual partners of those FSW, as well as other AGYW living within hotspots. At the DIC, each case manager will provide enhanced counseling on partner notification and status disclosure to HIV-positive clients in order to ensure more of their sexual partners come to test for HIV and progress will be monitored weekly. Younger KPs and those previously testing negative will be screened and only tested/retested if they meet risk criteria. While coupons for testing of FSW clients under the Sex & Test strategy will continue to be given out by both HIV positive and HIV negative FSW to avoid stigma, additional focus will be placed on ensuring that the majority of participants are HIV positive FSW.

Improve linkage to treatment and retention service delivery models in priority areas for all populations; with enhanced focus on those with unmet need (pediatrics, adult men, KP)

In COP18, clinical IPs will implement a LCM, similar to the Bukoba, Tanzania model presented on the PEPFAR Solutions website. The LCM model data from Tanzania shows high acceptance and good linkage to care for adult men and women. The program is designed to identify barriers to care and work with clients to address them. For pediatrics, the LCM model will include caregiver support and for adolescents and young people, peer matching will be used as much as possible to ensure clients have an LCM manager they are comfortable with.

Additionally, index testing modalities, including partner notification, index testing of biological children, and targeted self-testing will include the option to accept case management using the LCM model to link newly diagnosed PLHIV to care. Presented earlier on addressing user fee barriers, the index testing model includes a package that allows for clients to be tested, linked, and enrolled in care without user fees charged to the client. See table 4.3.3 for a timeline Same-Day ART Initiation Scale-Up.

Table 4.3.3: Scale-plan for Same-Day ART initiation

Same-Day ART Initiation (SADI) Scale-Up Plan (March 2018–September 2019)		
Timeline	# of clinical sites offering SADI (% of total)	# of clinical sites
March 2018		
Yaoundé cluster including Mil Sites	25 (100%)	25
Douala cluster including mil	20 (100%)	20
September 2018		
Yaoundé cluster	25 (100%)	25
Douala cluster	20 (100%)	20
March 2019		
Yaoundé cluster	32 (100%)	32
Douala cluster	32 (100%)	24
September 2019		
Yaoundé cluster	32 (100%)	32
Douala cluster	24 (100%)	24

The active linkage model involving PNs who accompany KPs to health facilities for treatment will continue in FY19 as it has proven to improve the linkage to treatment of KPs (83% and 86% linkage rate respectively for FSW and MSM in FY18Q1). For KPs not willing to attend general population clinics for their treatment, onsite initiation of ART at DIC will be scaled up in at least half of the DICs in FY19.

The “Sex & Test” strategy, an innovative approach recognized by Epidemic Control Team 4 as a best practice in reaching more men, will be scaled up in FY19 in community settings. While the program was conceived primarily as an entry point for testing, results on linkage have been surprisingly strong with 71% of men known to be linked to treatment.

Reinforce and continue recent successes in continuous tracking of patients who enroll but fall out of treatment, especially in Yaoundé and Douala, to ensure all are retained

Tremendous progress has been made in tracking clients falling out of treatment, particularly through loss to follow-up campaigns beginning in COP16 and continuing into COP17, alongside site level numbers being tracked and followed up at least weekly in scale-up sites and ongoing logging outcomes for clients successfully traced. Despite this, there is still growing evidence that clients are transferring between sites without sufficient tracking. The linkage and retention agent cadre will continue to trace clients lost to follow up and the IPs will implement a case management and support model, which could include user fee vouchers, additional counseling, and transport assistance as found necessary by the case manager to facilitate staying in HIV care. Social support, adherence clubs and groups will also be leveraged to encourage members to

support and follow up with group members who miss a meeting or leave care. Immediate follow-up beginning with a missed appointment will be offered for all clients at scale-up sites, and follow-up will be supported for clients at sustained sites. IPs will also increase capacity to present data that accounts for transfers who left a facility but are still in care.

Laboratory Optimization

PEPFAR IPs collaborated with GRC and other stakeholders to conduct a national lab mapping and instrument optimization exercise. This was undertaken to address concerns around current country capacity to accommodate increase in access to and uptake of VL testing as a result of user fees subsidization (described above) and to ensure optimum and sustainable VL testing Results from the instrument optimization and mapping exercise shows that the country currently has an unutilized instrument capacity of 90% for conventional and 89% for POC VL testing and a well mapped out national instrument capacity distribution right down to facility level. Using these findings, PEPFAR Cameroon will continue to collaborate with MOH and will leverage on GF support and resources to strengthen the laboratory and sample referral network, including human resource capacity building critically needed to maximize utilization of these platforms and improve scale-up of viral load testing. To further improve on efficiencies in VL testing, PEPFAR Cameroon will continue to support the country in standardizing the use and maintenance of these platforms and coordinating testing efforts through a VL Laboratory Network. PEPFAR Cameroon will also invest in strengthening laboratory Quality Management Systems (QMS) through Continuous Quality Improvement (CQI) activities for efficient and quality service delivery across laboratory facilities and sites within both clusters.

4.4 Commodities

PEPFAR Cameroon's commodity budget has been reduced annually from a peak of \$10 million in COP 14 to \$864,941 in COP18, of which \$128,000 will be invested in procurement of HIV self-test kits, \$50,176 for PrEP, and \$686,765 for VL testing commodities. Despite the continued growth of the country's HIV prevention, care and treatment targets, the 2018-2020 GFATM HIV budget allocation has decreased from \$99.3 million over two years (2016-2017) to \$93.5 million over three years (2018-2020), and other stakeholders such as the World Bank and the French Development Agency have ceased their commodity investments entirely. 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 can result in system-wide stock outs.

The NACC has projected funding gaps during 2019 for rapid test kits (RTK) (84%) and VL commodities (32%). These projections may be further exacerbated by current financial gaps for RTK (46%), ARV (49%) and VL (90%) in 2018.

Recent GFATM-supported in-country supply chain diagnostics conducted by Deloitte show the health product supply chain in Cameroon recommended a structural transformation, executed in three waves to ensure viability and sustainability. The reliance on GRC financial uncertainties and GFATM PR performance coupled with current public health supply chain maturity level will continue to influence commodities shortages and risks in FY19.

The GRC implements a distribution model through which the government procures drugs and distributes them using a publicly run Central Medical Store (CMS) and a government-owned transport fleet. The model inhibits CMS hiring of qualified personnel due to low wages and limited incentives. Reasons for stock-outs at the health clinics include problems in procurement, forecasting, and requisitioning by the regions; tardiness in ordering or poor forecasting by the clinics; and a burdensome number of bureaucratic steps required to obtain approvals on stock allocation decisions at any stage in the system.

There is often fragmentation of responsibility and governance between the MOPH, the PR, the Central and Regional Medical Stores, and health staff at clinics. This undermines accountability at each level and further exacerbates the risks in distribution, contributing to stockouts.

PEPFAR Cameroon is working with GRC, Global Fund, and other stakeholders to plan for transition to TLD during COP18. The PEPFAR team is heavily engaged in country planning through the TLD technical working group convened by the government. The tentative timeline for TLD transition is presented in Figure 4.4.1 below.

Key dates	Activity
January 2018	<ul style="list-style-type: none"> • TLD transition working group convened by GRC to begin planning
April – August 2018	<ul style="list-style-type: none"> • Begin formal process to update national treatment guidelines • Updated national guidelines released including TLD • Finalize training materials and job aids
May-June 2019	<ul style="list-style-type: none"> • First wave of training on updated clinical guidelines
July 2018	<ul style="list-style-type: none"> • Quantification completed • Official launch to be held
October 2018	<ul style="list-style-type: none"> • Global Fund order to be placed
July 2019	<ul style="list-style-type: none"> • Begin patient transition at first wave of sites
August 2019–December 2020	<ul style="list-style-type: none"> • Implementation of all phases of TLD transition
January 2021	<ul style="list-style-type: none"> • TLD transition complete

4.5 Collaboration, Integration and Monitoring

In COP18, PEPFAR Cameroon will leverage technical strengths and competencies across all agencies to ensure efficiencies in addressing gaps identified in COP17 in order to meet the program goals of achieving epidemic control by sex and across different age groups by 2020. To address these gaps, the team, through a collaborative effort, will build on their technical strengths to guide implementation of innovative strategies for achieving epidemic control among children, OVCs, AGYW, KPs, adolescents, adult Women and men. Agencies will continue to collaborate in conducting SIMs and supporting community outreach programs as required. PEPFAR Cameroon agencies will collaborate in implementing a single model of Self Testing as an innovative strategy for finding men and will also leverage on this collaborative effort and their different clinical, pharmaceutical and supply chain expertise to guide the government through an effective TLD Transitioning. The inter-agency will continue to work with GRC in building MOPH capacity as well as supporting trainings on Continuous Quality Improvement and KP-friendly approaches to improve management and monitoring of KP beneficiaries in care and treatment centers.

To further address specific gaps identified through COP17 performance data, PEPFAR Cameroon's key interventions in COP18 towards attaining epidemic control within the Yaoundé and Douala clusters will focus on knowing who to target and where to find PLHIV, finding those we are missing and improving on our strategies to link and retain them in treatment. PEPFAR Cameroon plans to meet these program goals by scaling up strategies that have worked in Cameroon and using other new and innovative strategies that have been shown to work in other countries. To ensure success and sustainability, PEPFAR Cameroon will need to leverage and strengthen existing collaboration with the GRC and other key stakeholders such as GFATM, UNAIDS, Unitaid, and the World Health Organization (WHO).

In COP18, PEPFAR Cameroon will coordinate with GFATM, MOPH, and other partners to define efficient strategies to address supply chain challenges such as the cost of EID and VL testing commodities. This collaboration recently resulted in a significant reduction in the cost of VL test kits from \$56.00 to \$18.56 and negotiations are ongoing for further reductions which will include equipment maintenance as part of the package and also ensure that the same costs will be applicable to GRC, GFATM, and all other stakeholders in country. Once finalized, this will enable PEPFAR Cameroon to leverage commodities from GFATM and other partners to increase coverage for EID and VL testing in 2019. PEPFAR Cameroon is also working with GRC to support implementation of MOPH directives against unauthorized costs for ANC services and to eliminate patient fees for VL testing that serve as a barrier to other care and treatment services. PEPFAR Cameroon will leverage support from the Unitaid POC project to improve access to EID for HEI and improve turn-around-time for returning results and putting more infants on treatment. In the same light, PEPFAR Cameroon will collaborate with and leverage on GFATM-funded TB program to roll out IPT in high volume sites within the Yaoundé and Douala clusters. PEPFAR Cameroon will also support GRC and collaborate with WHO to develop tools, guidelines and job aids for an efficient TLD transition process.

In COP17, PEPFAR Cameroon engaged and invested in monitoring partner performance at above site and site levels across the clinical cascade through SIMS and regular partner management, as well as Quarterly IP mini-PEPFAR Oversight and Accountability Review Teams (POART) for program and data review and analysis. Although this reinforced follow-up resulted in significant improvement in IP implementation, data analysis and reporting, there are still unmet challenges with documentation, daily follow-up and data collection and analysis that are critical to finding our missing PLHIV, linking and retaining them in treatment to ensure viral suppression. To address these challenges in COP18, PEPFAR Cameroon will intensify partner management by investing in new approaches and continue to implement those that improved efficiencies of partner performance in COP17. Across all PEPFAR Cameroon agencies, these will include weekly, biweekly or monthly meetings and site visits for performance reviews, monthly review and reporting of activities by budget code and by site with immediate follow-up on required corrective actions, routine DQA by agency and by IP at site level, trainings on PEPFAR's Monitoring, Evaluation, and Reporting (MER) system and indicators, and monthly SIMS visits, biannual portfolio implementation reviews, monthly tripartite meetings between agency, IP and beneficiary including biweekly SABERS coordination calls, reviewing work plans to ensure that COP strategies are accurately captured with activities that are appropriately aligned to PEPFAR objectives, documentation of partner performance including new tools to allow for deeper assessment of partner performance and to facilitate timely interventions that will improve performance and impact within a short time frame. These tools will support partner management and elaboration of performance reports that will also be shared with the GRC.

To strengthen systems across the clinical cascade, PEPFAR Cameroon will collaborate with GRC to ensure that standardized monitoring and evaluation (M&E) tools, guidelines, and new policies and strategies are integrated, aligned with the national strategy, and appropriately implemented by IPs and other stakeholders. To build systems that will enhance uptake and scale up of VL testing across the cascade, PEPFAR Cameroon will collaborate with MOPH and work with IPs 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 tracking eligible and non-suppressed patients within both clusters. An 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 PEPFAR will continue to collaborate with GRC to ensure integration into the national HIMS for use by both MOPH and GFATM within the entire health system. With 90% of unutilized instrument capacity for conventional VL testing, PEPFAR Cameroon will collaborate with MOPH as well as leverage GFATM support to strengthen the laboratory, sample referral network, human resource capacity and improve scale up of viral load testing. PEPFAR Cameroon will also invest in strengthening laboratory QMS through Continuous Quality Improvement (CQI) and rapid test-continuous quality improvement (RT-CQI) across laboratory facilities and sites within both clusters. To address frequent supply chain issues with recurrent stock-outs of commodities for EID, VL testing, and RTKs, PEPFAR Cameroon will continue to work with GRC and GFATM to improve in-country inventory management practices, distribution planning, logistics operations and governance.

PEPFAR Cameroon has made significant investments not only in identifying strategies that improve efficiencies in addressing implementation gaps across different populations, but also in ensuring improvement in the quality of services delivered at both community and facility levels to reach target populations. PEPFAR Cameroon's improved models of care delivery include the use of screening tools in both facility and community settings, supporting health facility committees to improve retention and monitor resistance, supporting VL testing at 3 months post-ART initiation for pregnant women, bidirectional referrals between OVC and clinical service delivery points, social network testing and home visits to find HIV-positive KP who are lost to follow-up, mother-infant pair screening, after school clinic hours with focus on out-of-school kids, targeted educational support, community ART initiation and dispensation, same-day initiation and multi-month prescription. To enhance efficiencies of these service delivery models, PEPFAR will ensure that these models are in alignment with the national strategy and will invest in strengthening capacity of GRC staff at central and regional levels to enforce circular letters and guidelines that support implementation of new or revised care models. GRC will also be supported to conduct routine supervision and build skills that would improve on the analysis and use of data at all levels to inform policy and program decisions.

Significant progress towards bridging some of the system barriers have been identified, but MER and SIMS data show there are still challenges, particularly with the collection and use of data and governance. In COP18, PEPFAR Cameroon will continue to make critical systems investment to close gaps and support service delivery activities that clearly address the key barriers identified with clearly defined outcome indicators that will monitor progress towards attaining epidemic control. Progress made will also be reported during the quarterly POART calls and to improve efficiencies and save costs, activities will be dropped or modified based on their effectiveness in addressing the barriers identified. PEPFAR will engage the GRC to conduct DQAs or service quality assessments (SQA) at both regional and district levels with the involvement of high-level MOPH staff to ensure sustainability of improved service quality and efficiencies achieved.

4.6 Targets for scale-up locations and populations

Based on geographic and population prioritization decisions made for COP18, 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 93% ART coverage in the Douala and Yaoundé scale-up clusters by the end of FY19. A total of 49,676 net new PLHIV need to be placed on treatment by APR FY18 in order to achieve the 2019 goal. In FY19, PEPFAR Cameroon will initiate 28,840 new patients on treatment in the scale-up clusters (Table 4.6.1). 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 (34% in 2016), high rates of TB-related mortality among PLHIV, and their ability to access existing PEPFAR-supported care programs and GRC-supported TB clinics, PEPFAR increased the target number of TB/HIV co-infected patients identified and the percentage initiated on ART to 100% by the end of FY18, which will continue in

FY19. 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 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly Initiated on ART (APR FY19)
	(APR FY19) <i>HTS_TST</i>	(APR FY19) <i>HTS_TST_POS</i>	<i>TX_NEW</i>
Total Men	199,965	10,073	11,059
Total Women	347,536	16,189	16,049
Total Children (<15)	248,730	1,757	1,732
Adults			
TB Patients	5,423	853	833*
Pregnant Women	97,232	2,015	2,219
VMMC clients	0	0	0
Key populations	13,195	1,544	
Priority Populations (Mil)	30,226	2,249	2,167
Other Testing	0	0	0
Previously diagnosed and/or in care	0	0	1486
Pediatrics (<15)			
HIV Exposed Infants	4,441	303*	289
Other pediatric testing	16,822	164	1553*
Previously diagnosed and/or in care	0	0	88

Both linkages and positivity yield are expected to improve in FY19, given 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).

The military health facilities will test 33,900 individuals (military and civilians) with an expectation of finding 2,079 positives and linking 2,167 individuals to treatment.

PP_PREV will be offered to 6,501 military personnel with the expected outcome that offering PP_PREV to this group will enhance their knowledge on how to remain HIV negative. AGYW 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.

In order to set targets for KP, PEPFAR used size estimation proportions from 2016 IBBS report. Based on these estimations, FY17 and FY18 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 FY19 for KPs reached and tested for HIV.

Table 4.6.3 Target Populations for Prevention Interventions

Target Populations	Population Size Estimate (scale-up SNU)	Coverage Goal (in FY18)	FY19 Target
AGYW			12,611
Military	36,000	13%	6,501
KP_PREV (MSM)	11,065	58%	9,773
KP_PREV (FSW)	22,287	60%	19,547
TOTAL	69,352		48,432

* Data derived from Data Pack tool

For OVC, PEPFAR Cameroon considered past performance (12,414 OVC_SERV DSD in FY17); OVC size estimations in health districts that fall within the Yaoundé 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 exit at the end of the FY18 in order to establish targets. Based on these calculations, PEPFAR Cameroon will continue to implement activities in Yaoundé Cluster, Douala Cluster, Bamenda and others health districts with the target of reaching 18,836 OVC and caregivers with DSD services. Peace Corps will shift in service delivery type and implementation sites in FY19. As of FY19, Peace Corps will essentially provide DSD services and will move to nine new sustained districts and one centrally supported district, while maintaining activities in two FY18 geographic locations in sustained districts.

Table 4.6.4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY19Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target)
Yaoundé Cluster	80,136	8,307	7,248
Douala Cluster	43,913	3,669	3,201
Bamenda	2,717	3,437	2,998
Other sustained SNU	73,069	3,053	-
TOTAL	199,835	18,466	13,447

* Data derived from Data Pack tool. Source of OVC estimates: National Institute of Statistics, "Tableau de Bord Social" (2009)

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

5.1 COP18 Programmatic Priorities

COP18 programmatic priorities for sustained districts include support for HIV index testing based on risk factors, support for linkage, counseling and retention services, and ongoing support to laboratory quality and sample transport services. Additionally, TLD transition activities will be supported at sites being transitioned during COP18. HIV testing support will include targeted PITC and index testing of sexual partners and biological children of PLHIV to increase case finding. PEPFAR will continue to support using bikers for health for lab sample transportation.

5.2 Targets for attained and sustained locations and populations

While some health districts have achieved 80% coverage, no district has reached saturation in all age and sex disaggregation's, thus no district has reached attained status. In sustained locations, clients on ART will be maintained in HIV care and treatment services through FY19 in both ART and PMTCT sites. In FY19, PEPFAR Cameroon will increase the 96,653 patients on treatment in FY18 to 123,480 in the sustained districts (Table 5.2.2).

Table 5.2.2: Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group			Expected result APR 18
HIV testing in PMTCT sites	PMTCT_STAT	189,777	52,367
HTS (only sustained ART sites in FY17)	HTS_TST/HTS_TST_POS	567,466 / 33,007	570,726 / 35,232
Current on ART	TX_CURR	96,653	123,480
OVC	OVC_SERV	11,206	6,490

* Data derived from Data Pack tool

5.3 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 FY19 in both ART and PMTCT sites in the sustained districts. Based on available data and decentralization, five sites are moving from centrally supported to sustained, while 11 sites moved from sustained to scale-up. Twenty-six low volume health facilities (ten or fewer positives and 11 or fewer currently on ART) have been identified and will be transitioned to central support in collaboration with GRC. Clients attending sustained sites within scale-up and sustained districts will be provided a minimum package of HIV case identification, care and treatment services and PMTCT provided by GRC with mentoring and supportive supervision visits and limited support (as described below) by PEPFAR IPs. The PEPFAR supported package at sustained sites includes:

- Targeted testing, including index testing services to sexual partners and biological children of PLHIV;

- 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;
- Supportive supervision and mentorship to ensure quality;
- EID for HEI;
- Support to 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 and potentially EMR (depending on roll-out schedule);
- TLD transition support;
- Strengthening supply chain management

The GRC will provide doctors and nurses at these sites. Additionally, ARVs, RTKs, VL, and Cotrimoxazole will be provided through GFATM and GRC via the national supply chain system. IPs will supplement phone credit and transportation to support index testing using existing facility staff, and to support existing CHWs in their linking and tracing activities. Any patient who presents for services will receive them, so if a person presents for PMTCT services, requests HIV testing or presents with an opportunistic infection, HIV testing and treatment will be provided as needed. There will be limited demand generation for testing for high risk, exposed groups. Otherwise, limited 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. Targeted testing, with a focus on index testing of sexual partners and biological children will supported to ensure limited resources are best used to find positives among children and adults with the highest risk. TLD transition will also be supported at sustained sites. Transition is expected to begin in the second half of COP18 implementation.

While Bamenda health district is considered a sustained SNU for general population, it is a scale-up site for KP programming and will receive the same level intervention as detailed in section 4.2.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR Cameroon has attuned its systems investments shifting towards areas with identified barriers to program implementation and leveraging on support from government and other stakeholders to address gaps identified in the areas of quality management, laboratory system strengthening, supply chain management, and data quality. PEPFAR Cameroon considered progress made over the last three years, the program pivot to clusters, and the current level of investment by PEPFAR and other donors to continue focusing on addressing these critical systems barriers and allow for sufficient time for these investments to affect target achievement.

In order to ensure that investments continue to support effective changes in the barriers identified in COP17 and through SIMS and the SID 3.0, PEPFAR Cameroon made some adjustments and changes to activities to meet the required above site and site level investments. These changes took into consideration program orientation and achievements to re-align new and improved strategies in accordance with the pivot from the district approach to the cluster approach whilst focusing on addressing the sex and age variations identified per the different geographic locations. PEPFAR Cameroon will continue to invest in the approaches and strategies that focus on addressing the structural barriers to care which were identified in COP17 by ensuring improved service and data quality within the two scale-up clusters; improved identification and linkage of beneficiaries; measuring progress toward attaining the 90-90-90 targets; ensuring uninterrupted access to HIV/AIDS commodities; and reinforcing the healthcare system through strategic service models that bridge clinical and community-based services. The interagency team will continue to focus its site level and above site-level program support in COP18 to address the identified programmatic gaps in Cameroon.

The SID 3.0 showed the following gaps in service delivery and the national health system, which directly affect attainment of the three 90s.

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

Following completion of SID 3.0, although the element score for commodity security and supply chain has improved from 4.11 to 5.43, this element is one of the major areas in need of critical investments in order to achieve epidemic control in Cameroon. Findings from the GFATM-funded assessment of in-country supply chain maturity support this need for investment. Currently, the U.S. government through PEPFAR and the President Malaria Initiative (PMI), is the only donor with significant investments in TA for national procurement and distribution of essential medicines in Cameroon.

The PEPFAR Cameroon Team, through review of the SID 3.0 and SIMS data, have identified key sustainability vulnerabilities for supply chain such as (a) severe uncertainties on timeliness and disbursements for 10-40% of needs supported by the host country government (procurement financing); (b) poor visibility of stock and use of distribution data (stock);(c) in-country logistics funding constraints (supply chain financing); (d) use of outdated standard operating procedures coupled with bureaucratic processes (supply chain plan and assessment) and weak

supervision/monitoring system for HIV commodities and lack of use of to drive informed decision (core essential elements A_10.04[493], A_10.05[494], A_10.09[498] and A_10.10[499]).

In response to these vulnerabilities, PEPFAR Cameroon supply chain investments will: (i) expand regional and district-led supportive supervision systems and continuous quality improvement teams, (ii) integrate lean management & benchmarking within distribution centers and the central medical store to help address challenges with late deliveries and congested warehouses, (iii) increase deliveries to last mile through partnerships with the private sector (including GRC-commodities). PEPFAR Cameroon will also support key governance activities such as data driven government-led technical working groups, forecasting and supply planning as well as data visualization and analytics initiatives at central and regional levels to increase data visibility, enable better inventory management, and improve overall delivery.

PEPFAR Cameroon's supply chain partner will work closely with the two GFATM HIV PRs and 4 of the 10 regional stores to strengthen inventory management and distribution skills. Investments will improve supply chain planning data in order to create supply processes that 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.

Based on recent audit findings, PEPFAR Cameroon 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. PEPFAR Cameroon will 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.

Significant unmet challenges in laboratory and Quality Management Systems

PEPFAR Cameroon has changed the laboratory landscape in Cameroon considerably. Through PEPFAR support, 14 laboratories are enrolled in the "Stepwise Laboratory Improvement Process Towards Accreditation (SLIPTA)" process, nine have at least one star and three are ISO 15189 accredited. All laboratories in scale-up sites are enrolled in the HIV dried-tube specimen PT scheme with a participation rate of 100% and a PT pass rate of 99% (June 2017 session). Nine hundred and thirty one other facilities have also been trained on laboratory QA leading to a significant improvement in the SID score from 3.01 in SID2.0 to 5.83 in SID3.0. PEPFAR Cameroon is a major partner in supporting laboratory quality assurance programs especially PT program. Despite the improvement made, there is still a huge gap to attain sustainability. With reduced funding for PEPFAR supported laboratory activities in Cameroon, the laboratory program had to improve efficiencies through reduction in the cost of doing business by using one implementing partner in COP18 instead of three. To align with required site/facility level reporting, PEPFAR Cameroon laboratory support reduced its above site funding to focus more at site/facility level where activities are implemented with direct impact on the beneficiaries. Discussions are already ongoing with MOPH, GFATM, Unitaaid and other stakeholders to leverage support for

implementing complimentary laboratory programs. For the next three years as outlined on Table 6, laboratory-strengthening activities will focus on supporting certification of both sites and personnel for HIV point of care and conventional testing and on CQI to ensure accurate and reliable results for HIV, EID and VL. Laboratory systems support activities will include improved laboratory network systems to reinforce the sample transport, referral systems and support equipment maintenance and standardization.

Challenges for Strategic Information

Strategic Information (SI) is critical in determining the effect of health systems strengthening interventions on service delivery targets and overall system goals – health information systems (HIS) such as Electronic Medical Record (EMR) and District Health Information System (DHIS₂), are critical to program monitoring and performance improvement planning. Despite progress made, there is still a need for high-level involvement, coordination and utilization of data generated by different stakeholders. During data review meetings, the SIMS, MER and other data sources have revealed discrepancies that need to be addressed. PEPFAR Cameroon will work with NACC to reinforce MOPH's HIS by developing and strengthening SI systems tools and establishing systems and intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies. PEPFAR will also work with the government around issues of data governance, confidentiality, access, and use.

PEPFAR Cameroon will equally organize national conferences to share best practices, challenges and lessons learnt to come up with recommendations that could be adopted nationally. Through NACC, PEPFAR will continue to support the GRC in training, coordination and harmonization of data to ensure the scale up of new prevention, treatment and care strategies.

PEPFAR Cameroon has made significant progress towards bridging some of the systems barriers identified, but MER, SIMS, and the recent HIS assessment show there are still challenges particularly with the collection and use of data, standards, and governance. In COP₁₈, PEPFAR Cameroon will continue to make critical systems investment to close gaps and support activities to meet the well-defined benchmarks. Each benchmark will be monitored over a set timeline with measurement and outcome indicators clearly defined; however, progress made will be reported during the quarterly POART calls. PEPFAR will support the GRC to conduct DQA/SQA at both regional and district levels with the involvement of high-level MOPH staff. The policies, tools, SOPs and guidelines developed will also be used to monitor progress made. The impact of these activities will lead to better-harmonized data with fewer discrepancies, improved transport and referral system, reduced turn-around-time for commodities, samples and patient results.

7.0 Staffing Plan

For COP₁₇, the PEPFAR Cameroon team conducted an extensive staffing analysis to improve programmatic alignment of staff to facilitate and sustain HIV epidemic control and successfully implement the programmatic pivot to the two scale-up geographic clusters within Douala and

Yaoundé. Core activities required increased focus of staff time and skill sets on specific program components such as intensified programmatic management and strategic information analysis and meeting SIMS targets. For COP18, there is only one proposed change by U.S. Agency for International Development (USAID) to the staffing footprint.

The total number of staff on record is 53 recorded positions. Of these 53 recorded positions, 35 are fully funded by PEPFAR, three USAID positions are partially funded between PEPFAR and PMI, four are funded by the State Department and eleven are funded by the Peace Corps.

Long-term Vacant Positions

In 1998, the U.S. Centers for Disease Control and Prevention (CDC) Cameroon Office was inaugurated as an HIV/AIDS research-based laboratory program, and its mission, geographic focus, technical assistance role, and funding have expanded over the past few years. CDC Cameroon's mission includes provision of direct support and technical assistance to the Government of Cameroon, Ministry of Health (MOPH), and partners to implement HIV/AIDS activities under PEPFAR.

The work that began as a laboratory research program has expanded over time, with many activities that have resulted in numerous accomplishments. However, the staffing pattern since its inception has not evolved as rapidly. CDC Cameroon was flagged during COP15 negotiations to realign its staffing to better reflect a PEPFAR-funded care and treatment program. In COP17 development, the CDC Cameroon office was directed by the Office of the Global AIDS Coordinator (OGAC) to pivot to more effectively address the HIV epidemic in Cameroon, and revisions in the staffing pattern were needed to align with the HIV/AIDS treatment investment.

In July 2017, the CDC Cameroon office had a reduction in force to better align staff with PEPFAR programmatic investment and repurpose these positions for five new job categories: HIV/TB Public Health Specialist, Priority Populations Public Health Specialist, HTC/Linkages Specialist, HIV/AIDS Surveillance Public Health Specialist and a Partner Management and Finance Public Health Administrative Specialist.

As CDC Cameroon began to work on creating these positions, the hiring freeze limited efforts. These positions are to realign our staffing pattern and were previously approved by the interagency PEPFAR team in country during the COP17 planning period. As a direct result of the hiring freeze, CDC was unable to fill these positions to expeditiously pursue the recommended transition. These are existing full-time equivalent (FTE) positions that have been repurposed to align with our programmatic investments to reflect the needs of our care and treatment program.

This staffing realignment is a critical strategic transition of personnel and programmatic resources. In December 2017, CDC submitted an exemption request to the hiring freeze to recruit and hire staff for the five local-engaged staff positions. This will permit CDC to more effectively plan and execute the OGAC directed transition to classify and recruit staff for the above positions.

The exemption was approved in January 2018 and the positions are currently going through classification and should be filled by the end of FY 2019.

Proposed New Positions

With concurrence from Management, USAID is requesting a cost-neutral addition of one FSN staff. Based on recommendations from the OGAC-led inter-agency mission to Cameroon in July 2017, USAID's PEPFAR team has greatly intensified its partner management strategy and the currently staffing level is proving inadequate. USAID requests to add one additional foreign service national (FSN) position, specifically an HIV Prevention Specialist. The HIV Prevention Specialist would provide high level expertise to inform HIV prevention activities across the USAID/PEPFAR portfolio including KP, clients and children of FSWs, and OVC, including vulnerable AGYW. At present, there is no one on the inter-agency team with a specific prevention remit so the incumbent will also serve as a technical resource to the inter-agency team on prevention among the general population and other priority populations such as the military and AGYW as requested. The new position would be complementary to the existing HIV Specialist, allowing that position to focus entirely on community based care and treatment including linkage to treatment, community-based dispensation, and retention. Increasing the technical and managerial capacity of the team will directly contribute to improving results across the KP and OVC cascade. The addition of this FSN position will be covered entirely by savings generated from split funding the Supply Chain Governance Advisor between PEPFAR and PMI. Moving that position from 100% PEPFAR funding to a 70% PEPFAR/30% PMI split makes sense programmatically to ensure an integrated approach to supply chain technical assistance and will generate additional savings to PEPFAR.

Changes to Cost of Doing Business (CODB)

The PEPFAR Cameroon CODB budget has increased from \$7,780,197 in COP 2017 to \$7,818,254 in COP 2018 indicating a 0.5% increase. The difference of \$38,057 was due to fully funding the PEPFAR Coordinator LNA position and the addition of a new staffing position within the Department of Defense (DOD). The shifts within agency level budgets are as follows:

- DOD: Full staff costs associated with the DOD Program Manager and Program Assistant.
- State: Full costs associated with the PEPFAR Coordinator, SI Technical Advisor and partial costs for the Global Fund Liaison.

PEPFAR Cameroon's CODB is 17.7% of its total PEPFAR budget, up from 16.7% in COP17. While the staffing footprint largely stayed the same, the higher percentage costs of the CODB are due to a lower budget envelope for COP18. 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 -- PRIORITIZATION

SNU Prioritization Table A.1

Organization unit	Period	Prioritization	<15	15+		Overall Coverage
			Peds	Female	Male	
Akonolinga	COP15	Sustained	9%	147%	35%	69%
	COP16	Sustained	5%	52%	9%	23%
	COP17	Sustained	210%	51%	19%	44%
	COP18	Sustained	19%	98%	21%	45%
Ayos	COP15	Sustained	8%	42%	6%	18%
	COP16	Sustained	11%	54%	9%	23%
	COP17	Sustained	175%	43%	16%	37%
	COP18	Sustained	18%	88%	19%	41%
Bafia	COP15	Sustained	12%	51%	9%	23%
	COP16	Sustained	12%	74%	12%	32%
	COP17	Sustained	404%	99%	36%	85%
	COP18	Sustained	19%	154%	33%	70%
Biyem Assi	COP15	Sustained	18%	124%	23%	55%
	COP16	Sustained	20%	134%	27%	61%
	COP17	Scale-up Saturation	472%	116%	51%	104%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Cité Verte	COP15	Sustained	95%	177%	36%	86%
	COP16	Sustained	93%	212%	44%	101%
	COP17	Scale-up Saturation	629%	154%	65%	138%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Djoungolo	COP15	Scale-up Saturation	31%	165%	42%	81%
	COP16	Scale-up Saturation	40%	243%	52%	112%
	COP17	Scale-up Saturation	987%	242%	105%	217%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Ebebda	COP15	Sustained	12%	62%	7%	25%
	COP16	Sustained	2%	66%	7%	25%
	COP17	Sustained	282%	69%	24%	58%
	COP18	Sustained	25%	116%	25%	54%
Efoulan	COP15	Sustained	2%	34%	4%	14%
	COP16	Sustained	5%	45%	6%	18%
	COP17	Scale-up Saturation	72%	18%	8%	16%
	COP18	Scale-up Saturation	0%	0%	0%	0%

Eseka	COP15	Sustained	1%	4%	1%	2%
	COP16	Sustained	4%	22%	4%	10%
	COP17	Sustained	216%	53%	19%	45%
	COP18	Sustained	10%	98%	21%	45%
Mbalmayo	COP15	Sustained	11%	84%	16%	37%
	COP16	Sustained	16%	103%	20%	46%
	COP17	Sustained	402%	98%	39%	86%
	COP18	Sustained	0%	158%	34%	71%
Mbandjock	COP15	Sustained	4%	36%	7%	16%
	COP16	Sustained	2%	33%	5%	14%
	COP17	Sustained	378%	93%	36%	81%
	COP18	Sustained	0%	150%	32%	67%
Mfou	COP15	Sustained	4%	54%	14%	26%
	COP16	Sustained	4%	62%	15%	29%
	COP17	Sustained	313%	76%	30%	67%
	COP18	Sustained	0%	130%	28%	58%
Monatele	COP15	Sustained	7%	40%	7%	17%
	COP16	Sustained	11%	55%	9%	24%
	COP17	Sustained	304%	75%	29%	65%
	COP18	Sustained	0%	127%	27%	57%
Nanga Eboko	COP15	Sustained	15%	57%	19%	31%
	COP16	Sustained	12%	65%	10%	28%
	COP17	Sustained	140%	34%	14%	30%
	COP18	Sustained	0%	78%	17%	35%
Ndikinimeki	COP15	Sustained	7%	55%	5%	21%
	COP16	Sustained	10%	37%	6%	16%
	COP17	Sustained	196%	48%	19%	42%
	COP18	Sustained	0%	95%	20%	43%
Ngog Mapubi	COP15	Sustained	1%	13%	2%	5%
	COP16	Sustained	2%	11%	2%	5%
	COP17	Sustained	142%	35%	13%	30%
	COP18	Sustained	4%	78%	17%	35%
Ngoumou	COP15	Sustained	2%	19%	4%	8%
	COP16	Sustained	16%	74%	14%	33%
	COP17	Sustained	363%	89%	32%	76%
	COP18	Sustained	38%	142%	30%	66%
Nkolndongo	COP15	Sustained	1%	24%	3%	10%
	COP16	Sustained	4%	36%	6%	15%
	COP17	Scale-up Saturation	255%	62%	24%	54%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Ntui	COP15	Sustained	3%	19%	3%	8%
	COP16	Sustained	4%	25%	5%	11%
	COP17	Sustained	274%	67%	26%	58%
	COP18	Sustained	2%	118%	25%	53%
Obala	COP15	Sustained	15%	78%	14%	35%
	COP16	Sustained	16%	97%	18%	43%
	COP17	Sustained	402%	98%	38%	86%

	COP18	Sustained	0%	157%	34%	70%
Okola	COP15	Sustained	0%	7%	1%	3%
	COP16	Sustained	0%	17%	3%	7%
	COP17	Sustained	231%	57%	23%	50%
	COP18	Sustained	0%	106%	23%	47%
Saa	COP15	Sustained	6%	36%	8%	17%
	COP16	Sustained	7%	34%	8%	16%
	COP17	Sustained	261%	64%	26%	56%
	COP18	Sustained	0%	116%	25%	52%
Soa	COP15	Sustained	6%	55%	10%	24%
	COP16	Sustained	6%	76%	13%	32%
	COP17	Sustained	322%	79%	29%	68%
	COP18	Sustained	0%	131%	28%	59%
Bonassama	COP15	Sustained	24%	135%	24%	60%
	COP16	Sustained	22%	142%	26%	62%
	COP17	Scale-up Aggressive	490%	119%	51%	107%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Cité Des Palmiers	COP15	Sustained	17%	80%	16%	37%
	COP16	Sustained	21%	98%	21%	45%
	COP17	Scale-up Aggressive	361%	88%	33%	76%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Deido	COP15	Scale-up Aggressive	33%	112%	25%	54%
	COP16	Scale-up Aggressive	42%	188%	45%	90%
	COP17	Scale-up Aggressive	735%	179%	78%	161%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Edea	COP15	Sustained	11%	56%	12%	26%
	COP16	Sustained	18%	69%	15%	33%
	COP17	Sustained	308%	75%	29%	65%
	COP18	Sustained	23%	142%	30%	65%
Logbaba	COP15	Sustained	15%	79%	15%	35%
	COP16	Sustained	9%	90%	14%	38%
	COP17	Scale-up Aggressive	298%	72%	28%	63%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Mbangue	COP15	Sustained	23%	132%	20%	56%
	COP16	Sustained	29%	201%	35%	88%
	COP17	Scale-up Aggressive	2151%	520%	221%	466%
	COP18	Scale-up Saturation	0%	0%	0%	0%
New Bell	COP15	Sustained	30%	168%	29%	73%
	COP16	Sustained	33%	199%	37%	88%
	COP17	Scale-up Aggressive	166%	40%	18%	36%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Njombe Penja	COP15	Sustained	69%	282%	69%	137%
	COP16	Sustained	64%	321%	73%	152%
	COP17	Sustained	1065%	257%	114%	233%
	COP18	Sustained	12%	336%	72%	152%
Nkongsamba	COP15	Sustained	18%	102%	16%	44%
	COP16	Sustained	20%	111%	17%	47%

	COP17	Sustained	0%	254%	100%	141%
	COP18	Sustained	0%	315%	68%	141%
Nylon	COP15	Sustained	20%	140%	26%	62%
	COP16	Sustained	31%	181%	33%	80%
	COP17	Scale-up Aggressive	181%	44%	17%	38%
	COP18	Scale-up Saturation	0%	0%	0%	0%
Pouma	COP15	Sustained	14%	88%	16%	39%
	COP16	Sustained	19%	108%	23%	50%
	COP17	Sustained	0%	10%	4%	5%
	COP18	Sustained	0%	47%	10%	21%
Yabassi	COP15	Sustained	4%	25%	7%	13%
	COP16	Sustained	8%	32%	8%	15%
	COP17	Sustained	0%	38%	13%	20%
	COP18	Sustained	0%	80%	17%	36%
Bafut	COP15	Sustained	13%	44%	10%	21%
	COP16	Sustained	30%	62%	14%	31%
	COP17	Sustained	162%	41%	17%	37%
	COP18	Sustained	15%	88%	19%	41%
Bali	COP15	Sustained	17%	71%	13%	31%
	COP16	Sustained	25%	88%	16%	40%
	COP17	Sustained	189%	48%	24%	45%
	COP18	Sustained	29%	102%	22%	48%
Bamenda	COP15	Sustained	53%	162%	33%	76%
	COP16	Sustained	62%	182%	38%	86%
	COP17	Sustained	466%	119%	51%	107%
	COP18	Sustained	170%	185%	40%	96%
Batibo	COP15	Sustained	27%	132%	20%	56%
	COP16	Sustained	36%	160%	27%	70%
	COP17	Sustained	456%	116%	45%	101%
	COP18	Sustained	44%	178%	38%	83%
Fundong	COP15	Sustained	43%	115%	21%	53%
	COP16	Sustained	49%	126%	24%	59%
	COP17	Sustained	429%	110%	46%	98%
	COP18	Sustained	133%	180%	39%	91%
Kumbo East	COP15	Sustained	23%	86%	20%	41%
	COP16	Sustained	29%	91%	23%	45%
	COP17	Sustained	418%	107%	45%	95%
	COP18	Sustained	118%	171%	37%	86%
Kumbo West	COP15	Sustained	78%	161%	38%	80%
	COP16	Sustained	91%	187%	52%	98%
	COP17	Sustained	370%	94%	61%	97%
	COP18	Sustained	224%	173%	37%	95%
Mbengwi	COP15	Sustained	40%	125%	23%	57%
	COP16	Sustained	42%	141%	27%	64%
	COP17	Sustained	452%	115%	40%	97%
	COP18	Sustained	44%	171%	37%	80%
Ndop	COP15	Sustained	26%	89%	13%	38%

	COP16	Sustained	37%	104%	16%	46%
	COP17	Sustained	358%	91%	37%	80%
	COP18	Sustained	94%	163%	35%	80%
Ndu	COP15	Sustained	31%	72%	6%	29%
	COP16	Sustained	41%	96%	19%	45%
	COP17	Sustained	310%	79%	41%	75%
	COP18	Sustained	34%	147%	31%	68%
Nkambe	COP15	Sustained	26%	83%	11%	35%
	COP16	Sustained	41%	108%	18%	48%
	COP17	Sustained	300%	77%	30%	67%
	COP18	Sustained	97%	141%	30%	71%
Wum	COP15	Sustained	19%	57%	10%	25%
	COP16	Sustained	23%	78%	13%	35%
	COP17	Sustained	291%	74%	28%	64%
	COP18	Sustained	37%	126%	27%	59%
Bangem	COP15	Sustained	19%	25%	38%	32%
	COP16	Sustained	17%	82%	14%	36%
	COP17	Sustained	410%	99%	35%	85%
	COP18	Sustained	31%	118%	25%	55%
Buea	COP15	Sustained	22%	103%	19%	46%
	COP16	Sustained	27%	128%	25%	58%
	COP17	Sustained	438%	106%	36%	90%
	COP18	Sustained	52%	156%	33%	74%
Ekondo Titi	COP15	Sustained	15%	37%	9%	18%
	COP16	Sustained	12%	44%	11%	22%
	COP17	Sustained	214%	52%	18%	44%
	COP18	Sustained	17%	96%	21%	45%
Fontem	COP15	Sustained	17%	41%	10%	20%
	COP16	Sustained	19%	42%	10%	21%
	COP17	Sustained	393%	96%	34%	81%
	COP18	Sustained	24%	149%	32%	69%
Kumba	COP15	Sustained	26%	96%	23%	47%
	COP16	Sustained	29%	139%	29%	64%
	COP17	Sustained	495%	120%	42%	102%
	COP18	Sustained	71%	178%	38%	86%
Limbe	COP15	Sustained	19%	117%	26%	54%
	COP16	Sustained	30%	136%	31%	64%
	COP17	Sustained	555%	135%	45%	113%
	COP18	Sustained	60%	191%	41%	90%
Mamfe	COP15	Sustained	41%	201%	40%	92%
	COP16	Sustained	89%	207%	48%	102%
	COP17	Sustained	981%	239%	85%	204%
	COP18	Sustained	0%	284%	61%	127%
Muyuka	COP15	Sustained	14%	65%	10%	28%
	COP16	Sustained	10%	65%	8%	26%
	COP17	Sustained		76%	27%	40%
	COP18	Sustained	0%	125%	27%	56%

Nguti	COP16	Sustained	56%	147%	31%	70%
	COP17	Sustained				
Tiko	COP15	Sustained	38%	137%	29%	64%
	COP16	Sustained	40%	163%	35%	76%
	COP17	Sustained		108%	38%	57%
	COP18	Sustained	67%	163%	35%	78%
Tombel	COP15	Sustained	19%	58%	11%	26%
	COP16	Sustained	27%	76%	16%	36%
	COP17	Sustained		98%	35%	52%
	COP18	Sustained	0%	152%	33%	68%

*The main data source used for PLHIV estimates by SNU, sex and age is Spectrum which only provide SNU, sex and coarse age disaggregates (<15 M, <15 F, >15 M, >15F). SNU PLHIV estimates by sex and fine age disaggregation are not available from COP15 to COP18. The numerator is based on PEPFAR APR results. Despite the availability of <15 SNU PLHIV estimates by sex, <15 M and <15F treatment coverage could not be estimated because <10 treatment results are not broken down by sex

Prioritization Area	Total PLHIV	Expected current on ART (APR FY18)	Additional patients required for 80% ART coverage	Target current on ART (APR FY19) TX_CURR	Newly initiated (APR FY19) TX_NEW	ART Coverage (APR 19)
Attained	N/A	N/A	N/A	N/A	N/A	N/A
Scale-Up Saturation	138,450	100,828	10,914	122,639	27,691	93%
Scale-Up Aggressive	N/A	N/A	N/A	N/A	N/A	N/A
Sustained	173,555	96,653	43,421	123,480	35,562	71%
Military	N/A	5,639	N/A	7,895	2,167	
Central Support	38,684	0	31,222	0	0	0
Commodities (if not included in previous categories)	N/A	N/A	N/A	N/A	N/A	N/A
Total	350,689	203,120	85,557	254,014	65,420	72%

APPENDIX B – Budget Profile and Resource Projections

B1. COP18 Planned Spending

Table B.1.1 COP18 Budget by Approach and Program Area

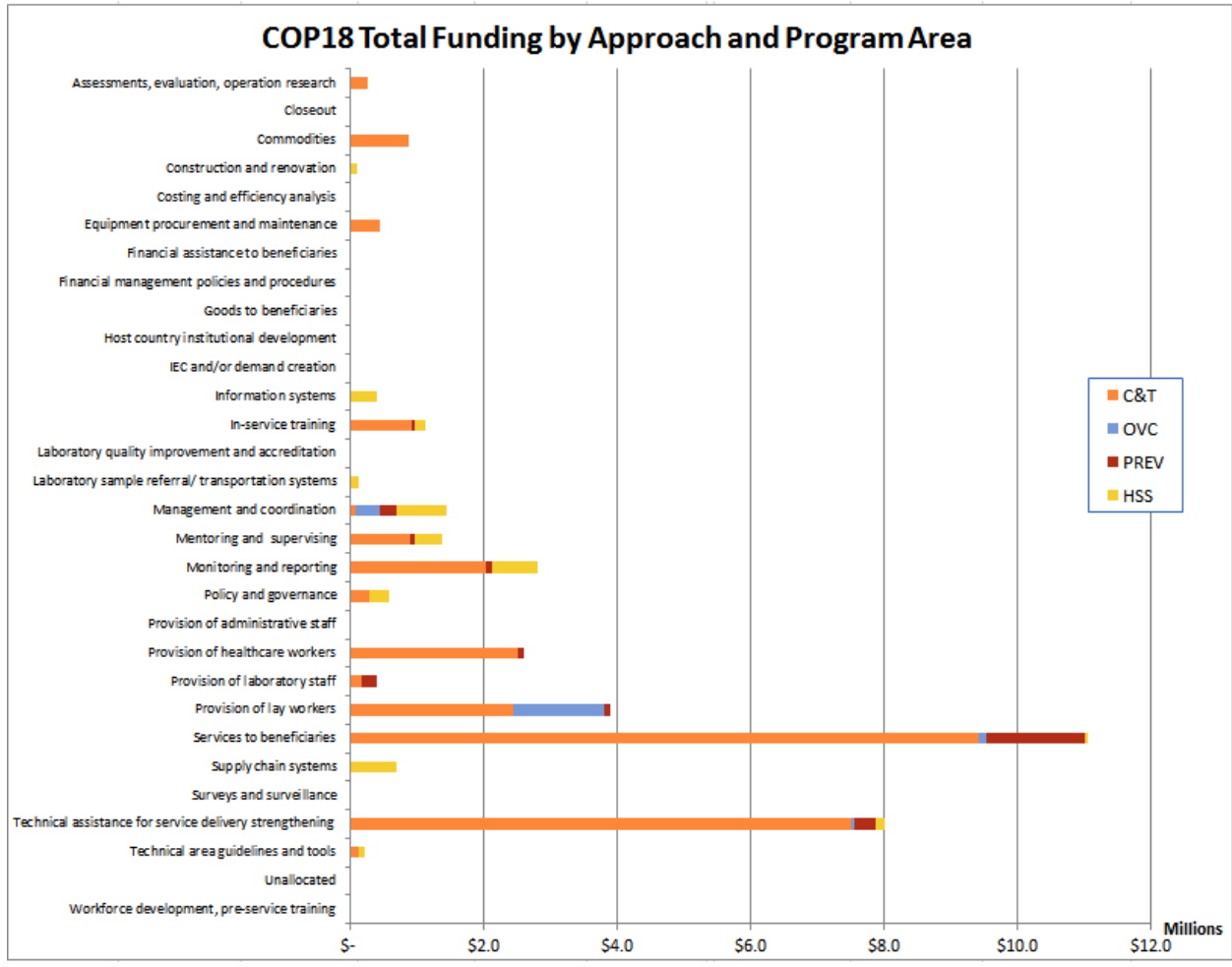


Table B.1.2 COP18 Total Planning Level

Applied Pipeline	New Funding	Total Spend
\$2,346,955	\$41,866,230	\$US44,213,185

*Data included in Table B.1.2 matches FACTS Info records

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	\$1,046,094
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$0
HVOP	Other Sexual Prevention	\$1,481,638
IDUP	Injecting and Non-Injecting Drug Use	\$0
HMBL	Blood Safety	\$0
HMIN	Injection Safety	\$0
CIRC	Male Circumcision	\$0
HVCT	Counseling and Testing	\$3,595,901
HBHC	Adult Care and Support	\$4,163,295
PDCS	Pediatric Care and Support	\$1,114,410
HKID	Orphans and Vulnerable Children	\$1,825,576
HTXS	Adult Treatment	\$17,622,057
HTXD	ARV Drugs	\$166,318
PDTX	Pediatric Treatment	\$1,790,935
HVTB	TB/HIV Care	\$523,407
HLAB	Lab	\$1,472,057
HVSI	Strategic Information	\$1,136,078
OHSS	Health Systems Strengthening	\$1,303,495
HVMS	Management and Operations	\$4,624,969
TOTAL		\$41,866,230

B.2 Resource Projections

COP 2018 budget was developed based on the priorities outlined in Cameroon’s COP18 planning letter. In addition to allocating resources based on HIV incidence and prevalence among target populations, PEPFAR Cameroon considered the actual costs of funding various approaches using historic data in order to determine resource projections. As with previous years, sites with low volume and/or low yield were assessed and decisions made to shift resources to higher volume sites. Finally, all interventions were assessed and resources shifted from low performing intervention (e.g. mass testing) to high impact interventions (e.g. targeted testing). Seventy-three percent of total funding will be incurred at site level.

Care and Treatment (65% of total funding)

The budget for case-finding takes into account reduced numbers of PITC through targeted testing while supporting costs for an increased number of index testing. This includes the costs to

PEPFAR for testing, counseling, and linkage services, including supporting personnel, transport, and mentoring, supervision, and oversight at facility-level for optimizing site level case-finding.

The care and treatment budget was developed by prioritizing the most effective strategies, and using historical and projected costs of delivering these strategies. This includes cost of the site level staff at scale up sites, program management, oversight, TA, and mentorship costs, costs of developing strategies, procedures, job aids, and other materials needed to implement a particular strategy, and site and community level implementation costs of the strategies. It also includes voucher and program management costs to reduce financial barriers to service uptake.

The TB costs include prioritization of activities with the highest potential for impact, and costing of personnel, program management, and activity implementation for selected activities. Costs associated with developing TB/HIV tools and guidelines are also included. Includes site level costs for infection control measures and active case finding for presumptive TB at community level.

The care and treatment budget was developed taking into account the actual cost (based on historical expenditure data) of providing community-based services to identify and link HIV-positive KP, children, and adolescents to ART treatment sites as well as the costs of providing community-based dispensation on-site for stable patients. The budget also includes the cost of procuring commodities for PrEP, HTS, and self-testing.

Key inputs include the cost of providing lay workers (OVC case managers, KP peer leaders, etc.) to implement high impact strategies focused on finding new positives in the community and linking them to HTS services; salaries and benefits of key site level staff providing HTS at drop-in centers; and costs associated with running community drop-in centers including rent, utilities.

Care and treatment resource projects take into account costs associated with providing community-based services to HIV-positive KP, children and adolescents such as monthly home visits, salaries and benefits of onsite staff responsible for community ART initiation/dispensation; accompanied referrals and transportation assistance to beneficiaries to access health services; and cost of providing medical care, etc. Primary inputs include the cost of providing lay workers, transportation assistance to beneficiaries from homes to health facilities; costs associated with providing medical care (e.g. purchase of ready-to-use therapeutic foods; lab tests, etc.).

Above service delivery activities have been budgeted using historic data for the cost of providing in-service training (consultants, development and printing materials, etc.); onsite mentoring and supportive supervision; and holding strategic planning meetings with health facilities to address bottlenecks that hinder access to services.

OVC (4% of total funding)

The HKID budget was developed taking into account the actual cost of providing community-based services to orphans and vulnerable children. The OVC program uses a performance-based model which includes a “price list” associated with each service provided. PEPFAR Cameroon considered the cost of providing each service and the projected number of children to receive each service in order to estimate the cost of providing direct services to beneficiaries. The HKID budget code also used historic expenditure data to project the cost of providing training and technical assistance for OVC service providers, including the cost of short-term technical assistance and other costs related to organizing training workshops; travel for monthly data verification and quality improvement visits; and monthly coordination meetings.

Prevention (6% of total funding)

Prevention resource projections take into account cost of running a key populations drop-in center to provide a range of prevention services to key populations. Primary inputs include site level personnel salaries and benefits, fuel and vehicle maintenance, travel and transportation, building rental and office supplies. The budget also takes into account project management costs which include onsite supportive supervision and routine financial and program monitoring.

For prevention of maternal to child transmission, available resources were limited by the treatment earmark. Interventions and activities were prioritized based on past and expected program impact. Other costs include CHWs and other personnel to support MTCT, project management costs, program supervision costs, and costs to support MTCT interventions.

HSS (9% of total funding)

The HSS budget supports lab, strategic information, and government work to strengthen the health system. For lab and SI, the proposed activities were prioritized and selected based on importance to the PEPFAR program and expected impact. For strategic information, costs include the personnel, infrastructure, travel, and additional support and capacity building costs for DHIS2 and EMR. For laboratory, the costs include personnel, and costs for activities and travel to support lab systems through mentorship, supportive supervision, technical assistance, and limited training. Costs for PT and DQA are also included. Personnel and associated activity costs of coordinating TLD transition and oversight to user fee implementation are also included.

The HSS budget also leverages other funding including the GFATM and PMI to strengthen PEPFAR investments in service delivery strengthening. The budget allocation has prioritized key supply chain activities that address HIV-specific bottlenecks using historic expenditure data. Primary inputs include operational costs (staff salaries and benefits, building rental, etc.); costs of holding coordination and data review meetings; HIV commodities storage and distribution to last mile, and district-led supportive supervision systems.

Changes in the Clinical Budget Code Funding Levels Between COP17 and COP18

The reduction in the HTXS budget from COP17 to COP18 is the result of reallocation of funds to other clinical budget codes which were not reflected in COP 17. These include HBHC, HVTB (for scale up of TB case finding among PLHIV and other TB/HIV strategies), and PDTX (to address gaps such as lower VL suppression among the pediatric population). The increases in these four clinical budget codes are more than the decrease in HTXS as reflected in the table below, showing an overall increase from COP17 to COP18 across clinical budget codes.

HTXS Reduction from COP 17 to COP18	\$3,044,290
Clinical budget code budget increases from COP17 to COP 18	
HBHC	\$2,282,035
PDCS	\$712,721
PDTX	\$348,248
HVTB	\$483,867
TOTAL	\$3,826,871

APPENDIX C – Clinical Cascades Over Time by Site for Men, Women, and Children [REDACTED]

[REDACTED]

Table 6 Attachment

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
1	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	C&T	Improve in-country logistics including effective and efficient delivery of health commodities to service sites	Supply chain systems
2	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve in-country logistics including effective and efficient delivery of health commodities to service sites	Supply chain systems
3	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve in-country logistics including effective and efficient delivery of health commodities to service sites	Supply chain systems
4	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve in-country logistics including effective and efficient delivery of health commodities to service sites	Supply chain systems
5	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and continuous quality improvement teams	Management and Coordination for HSS
6	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and continuous quality improvement teams	Management and Coordination for HSS
7	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and continuous quality improvement teams	Management and Coordination for HSS
8	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and	Management and Coordination for HSS

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
1	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.	Insufficient warehouse and inventory level optimization	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV supply chain responsiveness through fast replenishment of inventory	3 years
2	Support CENAME and selected regional stores to improve inventory management practices and distribution planning (Conduct monthly review of key performance indicators of regional funds, identify and implement priority corrective actions.)	Insufficient warehouse and inventory level optimization	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV supply chain responsiveness through fast replenishment of inventory	3 years
3	Leverage private transport companies for efficient and reliable last mile distribution of GROC-procured commodities (Support GRC-funded commodities in-country operating costs to deliver the medicines from central to patient level)	Insufficient warehouse and inventory level optimization	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV supply chain responsiveness through fast replenishment of inventory	3 years
4	Support district managers and regional stakeholders on reverse logistics implementation	Insufficient warehouse and inventory level optimization	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV supply chain responsiveness through fast replenishment of inventory	3 years
5	Train districts teams in data visualization and analysis, root cause analysis and continuous improvement process	Inadequate human resource for service delivery and supply chain management	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV commodity availability within PEPFAR-supported districts	3 years
6	Enhance local and regional capacity building stewardship (leadership, change management and meeting effectiveness)	Inadequate human resource for service delivery and supply chain management	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV commodity availability within PEPFAR-supported districts	3 years
7	Conduct monthly data-driven logistics supportive supervision visits within priority districts including feedback meetings	Inadequate human resource for service delivery and supply chain management	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV commodity availability within PEPFAR-supported districts	3 years
8	Conduct quarterly logistics supportive supervision visits within sustained support districts	Inadequate human resource for service delivery and supply chain management	<i>Commodity Security & Supply Chain</i>	5.43	Improved HIV commodity availability within PEPFAR-supported districts	3 years

#	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and Q4 results will be recorded here for monitoring.	Year Two (COP/ ROP19) Annual Benchmark	Note: FY20 Q2 and Q4 results will be recorded here for monitoring.	Year Three (COP/ ROP20) Annual Benchmark
1	Warehouse Order Processing Time (days)	30	21		15		10
2	Inventory Accuracy Rate	53%	65%		80%		90%
3	Stock Wastage due to Expiration or Damage	15%	10%		7%		5%
4	Percent of facilities that experienced a stockout at any point during the last 3 months	21%	15%		10%		7%
5	On-time reporting Rate	23%	50%		70%		80%
6	Availability of documented schedule for logistics supervision	0%	70%		85%		95%
7	HF Inventory Accuracy Rate	36%	60%		75%		85%
8	Accuracy of inventory records	24%	45%		50%		60%

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
9	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Ensure continued accuracy of stock management, timely ordering and reliable data reporting through district-led supportive supervision system and continuous quality improvement teams	Management and Coordination for HSS
10	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities	Supply chain systems
11	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities	Supply chain systems
12	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities	Supply chain systems
13	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities	Supply chain systems
14	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Improve leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities	Supply chain systems
15	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems
16	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems
17	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems
18	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems
19	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems
20	USAID	Global Health Supply Chain Program	Global Health Supply Chain Program	18905	HSS	Strengthen visibility and use of accurate and reliable data to drive informed decision	Information Systems

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
9	Revise and disseminate logistics job aids and reference materials	Inadequate human resource for service delivery and supply chain management	Commodity Security & Supply Chain	5.43	Improved HIV commodity availability within PEPFAR-supported districts	3 years
10	Support supply chain management coordination committees at central level and regional PEPFAR-supported regions	Ineffective leadership and governance structures to facilitate prioritization,	Commodity Security & Supply Chain	5.43	Improved accountability and transparency in HIV supply chains	3 years
11	Develop and /or revise the Commodity Security and Supply Plan	Ineffective leadership and governance structures to facilitate prioritization,	Commodity Security & Supply Chain	5.43	Improved accountability and transparency in HIV supply chains	3 years
12	Support NACC and MOH to develop and implement a phased-transition TLD plan including time-bound targets (Support National Essential Medicines list revision including TLD; Support National Medicines Regulatory	Ineffective leadership and governance structures to facilitate prioritization,	Commodity Security & Supply Chain	5.43	Improved accountability and transparency in HIV supply chains	2 years
13	Support key stakeholders to review logistics parameters and policies	Ineffective leadership and governance structures to facilitate prioritization,	Commodity Security & Supply Chain	5.43	Improved accountability and transparency in HIV supply chains	3 years
14	Provide technical assistance to GF Principal Recipient to improve procurement practices	Ineffective leadership and governance structures to	Commodity Security & Supply Chain	5.43	Improved accountability and transparency in HIV supply chains	3 years
15	Conduct logistics data quality assessments in selected high-volume sites and districts	Lack of accurate and reliable logistics data to drive informed decision making	Commodity Security & Supply Chain	5.43	Improved HIV logistics data accuracy and use for decision	3 years
16	Establish sub-contracts with local civil society organizations as stock-outs watchdog on a monthly basis within scale-up districts	Lack of accurate and reliable logistics data to drive informed decision making	Commodity Security & Supply Chain	5.43	Improved HIV logistics data accuracy and use for decision	3 years
17	Support an eLMIS landscape and interoperability analysis	Lack of accurate and reliable logistics data to drive informed	Commodity Security &	5.43	Improved HIV logistics data accuracy and use for decision	2 years
18	Support development of logistics data visualization, analytics and use for decision-making at regional and central levels	Lack of accurate and reliable logistics data to drive informed decision making	Commodity Security & Supply Chain	5.43	Improved HIV logistics data accuracy and use for decision	3 years
19	Conduct Logistics Systems Assessment within selected regions	Lack of accurate and reliable logistics data to drive informed	Commodity Security &	5.43	Improved HIV logistics data accuracy and use for decision	3 years
20	Support regional Supply Chain teams on data monitoring, aggregation, and analysis	Lack of accurate and reliable logistics data to drive informed decision making	Commodity Security & Supply Chain	5.43	Improved HIV logistics data accuracy and use for decision	3 years

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9	Availability of stock management tools, written procedures and guidelines	23%	75%		85%		95%
10	Order Lead Time (days)	38	21		14		10
11	Quarterly Supply Plan Updates	1	3		4		4
12	Percentage of Procured Products that meet stringent regulatory authority or WHO	95%	97%		100%		
13	Availability of stock management tools, written procedures and guidelines	23%	75%		85%		95%
14	On-Time Delivery	40%	60%		70%		80%
15	LMIS Data Quality	10%	40%		55%		65%
16	Stock-out Rate	21%	15%		10%		7%
17	Facility Reporting rate	37%	55%		75%		85%
18	Stocked according to plan facility Level (TLE and/or TLD)	56%	70%		80%		90%
19	LMIS Data Quality	10%	40%		55%		65%
20	On-time Reporting Rate	23%	50%		70%		80%

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
21	USAID	<Placeholder>	<Placeholder>	70037	HSS	Support the Government of Cameroon to eliminate user fees through the development and implementation of a sustainable health financing strategy.	Policy and Governance
22	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Construction and renovation
23	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Laboratory sample referral and transportation system
24	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Management and Coordination for HSS
25	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Management and Coordination for HSS

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
21	Provide technical assistance to the Government of Cameroon to support development and implementation of a sustainable health financing strategy which addresses user fees and expands access to HIV treatment and other primary health services.	User Fees	Policies and Governance	5.98	Elimination of user fees for HIV care and treatment services.	3 years
22	Continually train and mentor health facilities/staff in QA and biosafety	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
23	Reinforce EID/VL specimen transport system to support PT transport	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
24	Support MOH to finalize and implement lab policies, guidelines, and tools on Viral Load and quality HIV RT	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
25	Support GOV in the creation of a Laboratory Board	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years

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21							
22	Number of health facilities/staff mentored	All scale up sites trained on QA but continuous mentorship is ongoing	Train about 25% of staff at the cluster sites on QA and enroll them in the PT program		Train about 50% of staff at the cluster sites on QA and enroll them in the PT program		Train about 75% of staff at the cluster sites on QA and enroll them in the PT program
23	Reduced TAT for EID/VL/PT samples shipped	PT sample referrals on-going	Reduce TAT for sample referral to 25%		Reduce TAT for sample referral to 50%		Reduce TAT for sample referral to 75%
24	Number of tools adopted, disseminated and in use at health facilities	Some tools and guidelines waiting adoption and validation (re-testing for verification, National Laboratory Strategic Plan (NLSP) document and policy, guidelines for site/personnel certification.	Adoption of tools and guidelines which are pending and assessment of tools needed in the provision of quality services to all HIV patients		Develop atleast 25% of SOPs and guidelines needed	Develop atleast 25% of SOPs and guidelines needed	Develop atleast 50% of SOPs and guidelines needed
25	Creation of a laboratory board	Some tools and guidelines waiting adoption and validation (re-testing for verification, National Laboratory Strategic Plan (NLSP) document and policy, guidelines for site/personnel certification.	Documents submitted to hierarchy for authorization to create a lab board		Approval for the creation of a lab board		Presence of a functional laboratory board

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
26	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Management and Coordination for HSS
27	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Management and Coordination for HSS
28	CDC	Global Health Systems Solutions (GHSS)	Global Health Systems Solutions (GHSS)	18230	HSS	Strengthen laboratory quality management systems (QMS) for efficient health service delivery	Management and Coordination for HSS
29	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	HSS	Reinforce MOH health information system by developing and strengthening strategic information systems tools and establishing systems	Information Systems

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
26	Provide support to the National Laboratory Technical Working Group	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
27	Roll out the revised National Curriculum for training of laboratory personnel	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
28	Disseminate and implement National Laboratory Strategic Plan	Weak Health Systems and Service Delivery	Laboratory	5.83	Improved laboratory systems to support quality health services	3 years
29	Develop, print and distribute SOPs on data collection and reporting at site level	Weak Strategic Information systems and management	Epidemiological and Health Data	5.54	Availability and usage of data to improve decision making	3 years

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26	Number of LTWG meetings held	Some tools and guidelines waiting adoption and validation (re-testing for verification, National Laboratory Strategic Plan (NLSP) document and policy, guidelines for site/personnel certification.	Regular LTWG meetings with attendance sheets and minutes documented		Regular LTWG meetings with attendance sheets and minutes documented		Regular LTWG meetings with attendance sheets and minutes documented
27	New laboratory curriculum adopted and disseminated	Some tools and guidelines waiting adoption and validation (re-testing for verification, National Laboratory Strategic Plan (NLSP) document and policy, guidelines for site/personnel certification.	Adoption and dissemination of new laboratory curriculum		Pilot the laboratory training curriculum to some schools		Roll out of new laboratory training curriculum to lab training schools
28	National Laboratory Strategic Plan printed and adopted.	Some tools and guidelines waiting adoption and validation (re-testing for verification, National Laboratory Strategic Plan (NLSP) document and policy, guidelines for site/personnel certification.	Availability of the NLSP document and policy		Support the implementation of some activities listed in the NLSP		National Laboratory Strategic Plan Implemented
29	Availability of standardized tools and SOPS	DQA/SQA reports available	Quarterly DQA/SQA activities conducted		Quarterly DQA/SQA activities conducted	Quarterly DQA/SQA activities conducted	Quarterly DQA/SQA activities conducted

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
30	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	HSS	Reinforce MOH health information system by developing and strengthening strategic information systems tools and establishing systems	Information Systems
31	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	HSS	Reinforce MOH health information system by developing and strengthening strategic information systems tools and establishing systems	Management and coordination
32	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	HSS	Reinforce MOH health information system by developing and strengthening strategic information systems tools and establishing systems	Information Systems
33	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	HSS	Reinforce MOH health information system by developing and strengthening strategic information systems tools and establishing systems	Management and Coordination for HSS
34	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
30	Print and distribute M&E tools at all facilities;	Weak Strategic Information systems and management	Epidemiological and Health Data	5.54	Availability and usage of data to improve decision making	3 years
31	Quarterly data review/validation meetings at district and regional level	Weak Strategic Information systems and management	Epidemiological and Health Data	5.54	Availability and usage of data to improve decision making	3 years
32	Improve DHIS2 Capabilities by adding more functionalities (dashboard, etc)	Weak Strategic Information systems and management	Epidemiological and Health Data	5.54	Availability and usage of data to improve decision making	3 years
33	Train service providers and decision makers on data use through DHIS2	Weak Strategic Information systems and management	Epidemiological and Health Data	5.54	Availability and usage of data to improve decision making	3 years
34	Identify national supervisors including Inspector Generals and train them on integrated HIV supervision, DQA and SQI	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years

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30	Availability of standardized tools and SOPS	M& E tools available	Availability of M&E tools	Availability of M&E tools	Availability of M&E tools	Availability of M&E tools	Availability of M&E tools
31	Availability of standardized tools and SOPS	Basic DHIS2 functional	Improved functionality on the DHIS2 system	Improved functionality on the DHIS2 system	Improved functionality on the DHIS2 system	Improved functionality on the DHIS2 system	Improved functionality on the DHIS2 system
32	Availability of standardized tools and SOPS	Data coordination meeting reports available	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with
33	Availability of standardized tools and SOPS	Data coordination meeting reports available	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with	Quarterly Data TG meetings held with
34	National supervisors appointed	Reports and M&E tools available	Reports of quarterly meetings	Reports of quarterly meetings	Reports of quarterly meetings	Reports of quarterly meetings	Reports of quarterly meetings

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
35	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance
36	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance
37	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Technical area guidelines and tools
38	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance
39	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
35	Conduct quarterly joint integrated supervision with USG at national level	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years
36	Disseminate findings on supervision during joint quarterly coordination meetings with USG with MOH/Sites.	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years
37	Develop a national mentorship guidelines, produce and disseminate	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years
38	Identify national mentors according to subject matter expert and train them on mentorship and service quality improvement	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years
39	Support national QI collaborative and QI initiatives and initiate an Award of Excellence Program in the clusters	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years

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35	Reports of quaterly meetings	Reports and M&E tools available	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings
36	Reports of quaterly meetings	Reports and M&E tools available	National supervisors appointed	National supervisors appointed	National supervisors appointed	National supervisors appointed	National supervisors appointed
37	National supervisors appointed	Reports and M&E tools available	National supervisors appointed	National supervisors appointed	National supervisors appointed	National supervisors appointed	National supervisors appointed
38	National supervisors appointed	Reports and M&E tools available	QI projects developed best practices shared	QI projects developed best practices shared	QI projects developed best practices shared	QI projects developed best practices shared	QI projects developed best practices shared
39	QI projects developed best practices shared	Reports and M&E tools available	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
40	CDC	National AIDS Control Committee (NACC)	National AIDS Control Committee (NACC)	18229	C&T	Intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies	Policy and Governance
41	CDC	Cameroon Baptist Convention Health Services	CBCHS CE/LIT	17361	C&T	Identify HIV+ through high quality and targeted HTS services and increase ART and Viral Load coverage for pediatrics, adolescents and adults living with HIV.	Assessments, evaluation, operation research
42	CDC	Cameroon Baptist Convention Health Services	CBCHS CE/LIT	17361	C&T	Identify HIV+ through high quality and targeted HTS services and increase ART and Viral Load coverage for pediatrics, adolescents and adults living with HIV.	Assessments, evaluation, operation research
43	CDC	UNICEF	UNICEF	70030	C&T	Organize the second national conference on eMTCT and Pediatric/adolescent HIV care and treatment	Policy and governance
44	CDC	UNICEF	UNICEF	70030	C&T	Organize the second national conference on eMTCT and Pediatric/adolescent HIV care and treatment	Policy and governance
45	CDC	UNICEF	UNICEF	70030	C&T	Organize the second national conference on eMTCT and Pediatric/adolescent HIV care and treatment	Policy and governance
46	CDC	UNICEF	UNICEF	70030	C&T	Organize the second national conference on eMTCT and Pediatric/adolescent HIV care and treatment	Policy and governance

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
40	Organize Quarterly coordination meetings for all PEPFAR implementing partners (RTG/HIV, RDPH, district clusters etc) and organize biannual National Coordination meetings with all Implementing partners and Donors	Weak national health system and service delivery	Service Delivery & Quality Management	5.88 & 5.76 respectively	Improved quality of service	3 years
41	Develop protocol	Weak Strategic Information systems and management	Performance data	6.19	Evaluation reports	2 years
42	Data Collection/analysis and dissemination	Weak Strategic Information systems and management	Performance data	6.19	Evaluation reports	3 years
43	Sharing of best practices/challenges from sites	Weak governance, leadership and accountability	Policies and Governance	5.98	Improved policies and governance around eMTCT pediatric/adolescent HIV care and treatment	1 year
44	Recommendations towards policy review	Weak governance, leadership and accountability	Policies and Governance	5.98	Improved policies and governance around eMTCT pediatric/adolescent HIV care and treatment	1 year
45	Review of policies	Weak governance, leadership and accountability	Policies and Governance	5.98	Improved policies and governance around eMTCT pediatric/adolescent HIV care and treatment	1 year
46	Adoption & dissemination	Weak governance, leadership and accountability	Policies and Governance	5.98	Improved policies and governance around eMTCT pediatric/adolescent HIV care and treatment	1 year

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40	Reports of quaterly meetings	Reports and M&E tools available	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings	Reports of quaterly meetings
41	Evaluation report	Not applicable	Preliminary report		Complete evaluation report and result dissemination		
42	Evaluation report	Not applicable	Preliminary report		Complete evaluation report and result dissemination		
43	Meeting report and policies available	Meeting report and policies available	Meeting report and policies available				
44	Meeting report and policies available	Meeting report and policies available	Meeting report and policies available				
45	Meeting report and policies available	Meeting report and policies available	Meeting report and policies available				
46	Meeting report and policies available	Meeting report and policies available	Meeting report and policies available				

#	Funding Agency	Implementing Mechanism Name	Prime Partner	Mechanism ID	Program Area	COP18 Strategic Objective	Approach
47	CDC	WHO-TBD	WHO-TBD	70029	C&T	Clinical guidelines updated to international standards to support TLD transition	Technical area guidelines and tools
48	CDC	WHO-TBD	WHO-TBD	70029	C&T	Clinical guidelines updated to international standards to support TLD transition	Technical area guidelines and tools
49	CDC	TB-TBD	TB-TBD	70028	C&T	Strengthen prevention and treatment of tuberculosis in PLHIV through screening, case identification and referral of TB clients for HIV testing and monitoring and clinical care	Policy and Governance

#	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1, 2, or 3 years)
47	Support change in national guidelines to include TLD as first line treatment	Weak Health Systems and Service Delivery	Service Delivery	5.88	Clinical guidelines updated to support TLD transition	1 year
48	Develop tools and job aids	Weak Health Systems and Service Delivery	Service Delivery	5.88	Clinical guidelines updated to support TLD transition	1 year
49	Develop tools, SOPS and job aids to support INH implementation and infection control	Weak Health Systems and Service Delivery	Service Delivery	5.88	Tools for implementation of INH and infection control measures	3 years

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47	Approval to transition to TLD	Not applicable	Availability of national TLD tools and guidelines at ste level.				
48	Approval to transition to TLD	Not applicable	Availability of national TLD tools and guidelines at ste level.				
49	Availability of tools/SOPS and guidelines	Availability of tools/SOPS and guidelines	Availability of tools/SOPS and guidelines		Availability of tools, SOPs and guidelines at both Central level and PEPFAR supported sites		Dissemination of tools and guidelines nationally