Côte d'Ivoire

Country Operational Plan

COP 2018

Strategic Direction Summary

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1.0 Goal Statement

The President's Emergency Plan for AIDS Relief (PEPFAR) program in Côte d'Ivoire (PEPFAR-CI) is advancing efforts in the Fiscal Year (FY) 2018 Country Operational Plan (FY19) to achieve the Joint United Nations Program on HIV/AIDS' (UNAIDS) 90:90:90 goals. With buy-in from the Government of Côte d'Ivoire (GOCI) stakeholders, our shared goal is HIV epidemic control with the vision of reaching 90% global coverage of adult treatment and 90% of pediatric treatment in select high-impact geographic areas by 2019. The four pillars of PEPFAR's vision are to:

1. Increase antiretroviral (ARV) coverage to 90% in all age and sex bands by 2020
2. Reduce HIV-related mortality rates by 50% by 2020
3. Reduce HIV incidence among most vulnerable populations
4. Strengthen the enabling environment to support effective, quality service delivery.

FY19 continues to prioritize 19 Scale-Up to Saturation Districts, four of which will reach Attained Status by the end of FY18, and 21 Aggressive Scale-Up Districts. The Saturation Districts represent 49% of the estimated disease burden, with an additional 33% of the burden in Aggressive Scale Up districts.

In these priority areas, the program will intensify evidence-based approaches for case identification of people living with HIV (PLHIV), with a heightened focus on men, children, and key populations (KP). PEPFAR-CI will reinforce a collaborative framework for community-clinical linkages, to ensure targeted client support along the continuum of HIV services. Additional focus on increasing viral load (VL) coverage from 61% to 94% in FY19 is essential to monitoring the impact of the response. Populations with low prevalence but high vulnerabilities - Orphans and Vulnerable Children (OVC) and adolescent girls and young women (AGYW) - will benefit from intensified prevention efforts, focused on risk avoidance and violence prevention. The introduction of targeted pre-exposure prophylaxis (PrEP) among high-risk groups (sex workers, men who have sex with men and sero-discordant couples) is another critical element in FY19 for averting new infections. FY19 PrEP target is 7,961, including 5,768 sero-discordant couples, 1,176 MSM, and 1,017 SW. The intervention among sero-discordant couples will be implemented in three high prevalence districts in Abidjan regions whereas for KP, the approach will be nationwide, targeting high risk sero-negative MSM and SW.

The program is implementing specific strategies to address the continued high AIDS-related mortality by increasing opportunities for early HIV diagnosis in the community and in the facility with index and self-testing and increasing access to early infant diagnosis (EID), ensuring good ART coverage by reinforcing task shifting and same day ART initiation, and addressing comorbidities with scale up of HIV testing of presumptive TB patients.

There are three major shifts required to reach the ambitious goals of FY19:

1. The design and implementation of age-differentiated strategies, tailored to address age-specific barriers within male, pediatric, and KP sub-populations. OVC and AGYW will also benefit from age-differentiated approaches for outreach and service uptake.
2. Concentrated strategies in areas with the most unmet need to achieve maximum impact. Our analysis shows seven districts across Côte d'Ivoire represent the largest gaps in case finding and linkage among men and children.

3. Renewed engagement of GOCI in monitoring the HIV epidemic and continuously adjusting the response. Key inputs include (a) central level coordination, reflecting increased leadership and accountability for the response (b) heightened engagement of regional- and district-level leadership who will assist in ensuring timely program implementation with fidelity at all the sites in accordance national policies.

PEPFAR-CI will mirror this increased accountability through intensified management and oversight of its implementing partners (IPs). Continued weekly monitoring of key indicators along the clinical cascade will supplement monthly reviews of interagency program results. An algorithm for partner performance that matches PEPFAR Monitoring, Evaluation and Reporting (MER) achievement against financial management measurements is a new addition to the partner management framework, aimed at improving performance with cost efficiencies.

PEPFAR-CI will sustain stakeholder engagement with shared accountability and more action-oriented deliverables that commit participants to (a) replicate or scale up identified best practices and (b) abandon low-impact, inefficient interventions.

Utilizing multi-level health diplomacy, the Executive Office of the U.S. Mission in Abidjan continues to engage key members of GOCI, including the Prime Minister and the Minister of Health and Public Hygiene. Sustainable financing, increased demand creation for HIV services, and stronger central leadership remain the key points of advocacy for both the U.S. Mission and fellow technical and financial partners in the HIV response.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Country Profile

The 2014 Côte d'Ivoire census placed the total population at 22,671,331, of which males account for 52% (11,789,092) and females 48% (10,882,239). The estimated Ivorian population under 15 years of age is 8,780,535, or 38%. The 2017 UNAIDS estimate for HIV prevalence was 2.7%[1], compared to 3.7% as reported in the 2011/2012 Demographic and Health Survey. Much higher estimates exist among female sex workers (FSW) and men who have sex with men (MSM) (11.4%[2] and 18%[3] respectively). The UNAIDS PLHIV estimate is 475,000, with approximately 320,000 OVC and 22,000 pregnant women needing ARVs. Annually, there are approximately 20,000 new HIV infections (3,300 among children) and 25,000 AIDS-related deaths in Côte d'Ivoire.

Côte d'Ivoire has made substantial progress towards controlling the HIV epidemic over the past ten years. With a total PEPFAR investment of almost $1.2 billion, an investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) of $164.7 million to date, and increasing GOCI financial contributions and efforts, the number of PLHIV on antiretroviral therapy (ART) has increased from 4,536 in 2004 to 228,174 PLHIV in 2017. The success of Option B+ is contributing to the achievement of the first 90 among women (90% of the women who are HIV infected know their status) by the end of FY18.

Despite advances, the country still faces obstacles achieving epidemic control. Major gaps exist in identifying HIV-infected men and children, and linking them to treatment services, although these cohorts exhibit high rates of retention once enrolled. Viral suppression remains low among children 0-14 years old (54%), with varying rates among finer age bands. Gaps along the clinical cascade are significantly greater for men, where most HIV-positive young and adolescent men remain unidentified and most men 25+ are diagnosed but not linked to treatment.

Recent measures by the GOCI and intensified PEPFAR efforts will have positive impact on these deficits. Beginning in January 2017, the second term of President Alassane Ouattara has demonstrated more attention on the health sector, which has historically seen less public investment than infrastructure, education, and other sectors contributing to strong economic growth. The national response now aligns with PEPFAR strategy on focused testing to increase HIV-positivity yield, with written guidance distributed in October 2017. The nationwide adoption of Test and Start as well as multi-month scripting are showing better enrollment in treatment services. As of March 2018, 100% of PEPFAR-supported ART sites are implementing "Test and Start". FY19 also continues to place increased attention on addressing the programmatic and systems gaps in case identification and linkage to services for children, KP, AGYW 15-24 years of age, and men, also on expanding access to and uptake of VL testing nationwide. Progress in these areas will significantly accelerate the country's achievement of the 90:90:90 goals.

[1] http://www.unaids.org/sites/default/files/epidocuments/CIV.pdf

[2] Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côte d'Ivoire, 2014."

[3] Study on HIV Prevalence and Associated Risk Factors among Men Who Have Sex with Men in Abidjan, Côte d'Ivoire (SHARM-CI): "HIV and Associated Risk Factors among MSM in Abidjan, Côte d'Ivoire" (FHI 360 Report, January 22, 2013).

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	24,920,088		4,679,147	20.64	4,751,499	20.96	2,267,891	10	2,273,419	10.02	4,016,049	17.71	4,683,326	20.66	Census, 2014
HIV Prevalence (%)		2.51		1.1		0.5		3.5		1.8		3.5		1.8	Spectrum 2018
AIDS Deaths (per year)	24,175		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Spectrum 2018
# PLHIV	474,488		19642		14,325		86184		64,975		164976		124386		Spectrum 2018
Incidence Rate (Yr)		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
New Infections (Yr)	26,009														Spectrum 2018
Annual births	1,221,815														National program
% of Pregnant Women with at least one ANC visit		85	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			MICS Survey 2016
Pregnant women needing ARVs	19,982														Spectrum 2018

Orphans (maternal, paternal, double)	230,000		Data N/A		Data N/A										
Notified TB cases (Yr)	25,299		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014. National TB Program routine data
% of TB cases that are HIV infected	5,551		Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	2014. National TB Program routine data
% of Males Circumcised	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A	
Estimated Population Size of MSM*	9211														GAM 2016; 2014 est. ; Ville d'Abidjan
MSM HIV Prevalence		11													GAM 2016; 2014 est. ; Ville d'Abidjan
Estimated Population Size of FSW	59 040														2015, Data provided through GAM 2015

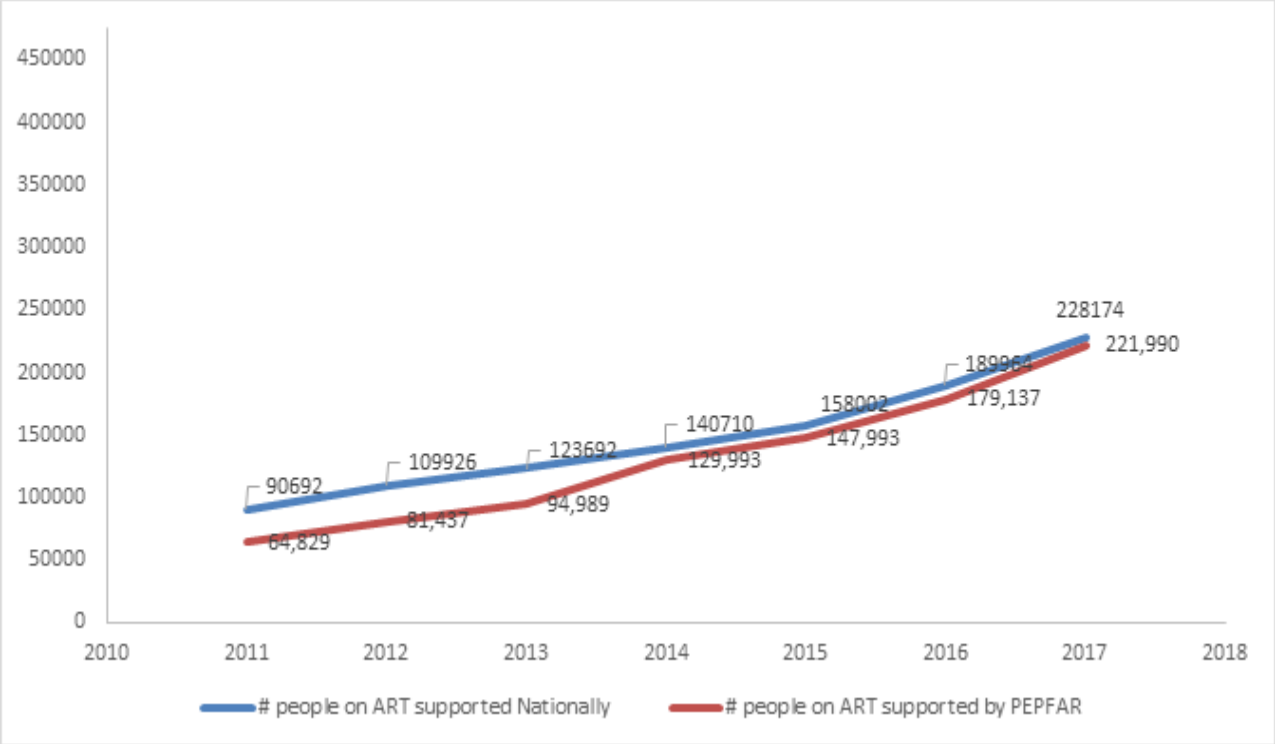
FSW HIV Prevalence		11.2													2015, Data provided through GAM 2015
Estimated Population Size of PWID	Data N/A	Data N/A													
PWID HIV Prevalence	Data N/A	Data N/A													
Estimated Size of Priority Populations (Military)	40,000	3,4	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	SABERS 2014
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression[4]										
Epidemiologic Data					**HIV Treatment and Viral Suppression**			**HIV Testing and Linkage to ART Within the Last Year**		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	22,671,331	2.5%	472,823	340,491	228,174	48.3%	77%	1,854,908	54,512	53,923
Population <15 years	9,430,646		32,300	20,610	10,608	32.8%	54%	322,738	2,549	2,622
Men 15-24 years	2,273,419		64,930	19,377	3,055	4.7%	78%	84,593	1,231	597
Men 25+ years	4,683,326		124,297	68,949	54,804	44.1%	78%	266,941	14,199	12,934
Women 15-24 years	2,267,891		86,232	74,744	11,838	13.7%	78%	200,052	4,518	4,517
Women 25+ years	4,016,049		165,065	156,812	147,868	89.6%	78%	417,076	24,899	33,253
MSM	31,333	11.6%						10,702	1,062	100
FSW	51,058	11.4%						33,678	2,577	125

[4] National data as of September 2017

While men in the military have an HIV prevalence rate of 3.4%, as shown in the Table above, some hot spots show prevalence ranging from 5% to 8%. Prevalence among AGYW (2.2%) is seven times higher than their male peers, and even more elevated among men aged 25-49 (4.9%) and 50+ (9%). The prevalence among adults seeking care is 5.76%, but 21% amongst tuberculosis (TB) patients, according to program data. The HIV burden is evident among FSWs and MSMs, according to recent studies[5]. PEPFAR-CI will be able to use critical data from the Côte d'Ivoire Population-Based HIV Impact Assessment (CIPHIA) to estimate the size of KP via the network scale-up method (NSUM) and consequently better assess progress towards epidemic control among them, guide the national HIV response, and ensure optimal investments. NSUM facilitates the estimation of CIPHIA participants' personal network size, including KP. The CIPHIA is also measuring, among other key indicators, prevalence of detectable ARVs, transmitted HIV drug resistance, uptake of and access to HIV-related services, viral suppression and common HIV co-morbidities.

Figure 2.1.3 National and PEPFAR Trends for Individuals Currently on Treatment



Geographically, the disease burden is broken down into 11 areas (Fig 2.1.2), concentrated in Abidjan (5.1%), the Center-North (4.4%), Southwest (4.3%), and Center-East (4.0%), with a lower prevalence (less than 3.7%) in the remaining areas.

[5] Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côte d'Ivoire, 2014." Study on HIV Prevalence and Associated Risk Factors among Men Who Have Sex with Men in Abidjan, Côte d'Ivoire (SHARM-CI): "HIV and Associated Risk Factors among MSM in Abidjan, Côte d'Ivoire" (FHI 360 Report, January 22, 2013).

2.1.1. Current progress towards epidemic control, including national coverage of key interventions (HTS, ART, adult and pediatric, PMTCT, coverage of KP)

Despite a challenging policy environment and financial constraints, Côte d'Ivoire continues to make progress toward epidemic control especially for adult women. Overall, PLHIV Spectrum modeling shows that HIV incidence and AIDS-related mortality trends remain stable across all age groups over time during these past five years. However, finer age disaggregation analysis shows downward trends for both new infections and AIDS-related deaths among children (0-14 years old) but an increase of deaths among adult men (15+).

The analysis of the clinical cascade by sex and age shows that as of the end of FY17, the country has diagnosed 80% of the estimated 460,000 PLHIV. This coverage was higher for females (98%) and adults (81%), than for males (55%), and children (64%). Concerning the second 90, 49% of PLHIV are receiving life-saving ART, or 228,000 patients including Sud Comoe where PEPFAR does not support clinical services. This rate was higher for females (61%) than males (32%). Similarly, treatment coverage is higher for adults (50%) than for children (29%). When considering programmatic performance, 61% of the diagnosed PLHIV were receiving ART, with achievement higher among adults (61%) and females (62%) than in males (57%) and children (56%). Finally, regarding the third 90, programmatic data show 77% of patients on ART with viral suppression, with approximately 78% among adults, male and female, but 56% among children.

The FY17 PEPFAR Annual Program Results (APR17) shows that PEPFAR efforts are reaching most areas with higher estimated populations of MSM and FSW. 79% of FSWs were tested for HIV, with 65% of those identified HIV-positive linked to ART. Rates were slightly higher among MSM, with 85% coverage for HIV testing services (HTS) and 85% linkage to ART.

The preliminary analysis of the clinical cascade of the three 90s by SNU prioritization across all ages and sexes shows that the largest gaps occur in seven main districts: Yopougon Est, Abobo Est, Cocody-Bingerville, Koumassi-Port Bouet-Vridi, Adjame-Plateau-Attecoubé, San Pedro and Soubré. The first five are located in Abidjan and are mostly urban areas, while the last two are agricultural areas located in the southwest of the country and have a large presence of mobile populations (particularly men and KP) in the harvest season. The program will intensify monitoring efforts by both increasing the frequency and changing some parameters in the monitoring tools to address site and above site issues (volume, yield, fidelity of strategy/policy implementation) in these districts starting in Q3 FY18. Timely assessments and interventions will result in maximizing the impact of the program toward epidemic control by 2020. Based on human resource for health (HRH) needs assessment done in March 2018, it was determined that there insufficient health care providers at the facility level as one of root causes for highest gaps in case identification and initiation of treatment. IPs are adjusting their work plans starting in Q3 FY18 to implement changes no later than Q4 to urgently address the HRH gap. There is an ongoing cluster analysis to provide a better understanding of patient movements across districts to assess other contributing factors.

2.1.4. Implementation of key policies

With support from PEPFAR, Côte d'Ivoire continues to make progress towards the adoption of international guidelines that are critical for the implementation of evidence-based strategies to reach ambitious prevention, treatment, and care targets. Côte d'Ivoire nationally implemented policies on Test and Start and same day ART initiation policy in February 2017; by the end of FY18,

the country will have rolled-out the policies at all PEPFAR-supported ART sites due to the scale-up of task-shifting and routine coaching of service providers by IPs.

To date, ART patients classified as stable are receiving reduced clinical and laboratory visits, and a three-month supply of ARVs per the February 2017 policy mentioned above. However, not all sites have fully implemented this facility-based differentiated care model due to challenges such as weak capacity at sites to re-adjust their stock levels of ARVs to reflect the demand patterns multi-month scripting. Another barrier to implementation is the low uptake of Viral Load Testing in some of ART sites. PEPFAR-CI continues to monitor the nationwide implementation of the differentiated care model and will add forecasting and monitoring trainings at the site level.

Community ART distribution continues to be an area of strong advocacy for which, as a first step, the Ministry of Health and Public Hygiene (MSHP) has agreed to implement a small scale hybrid facility-community worker distribution of ARVs project at 24 clinics for an anticipated 6,000 stable adults ART patients in FY18. The approach accepted by the PNLS is based on a facility-based adherence club model that has found success in other countries, as documented by UNAIDS and MSF in 2014, whereby community counselors and/or peers dispense ARV drugs in the facility during clinical visits or support group sessions. To date, approximately 1,711 stable patients are participating in this project. For the National AIDS Control Program (PNLS), this intermediate step is crucial to ensure a smooth transition from an exclusive facility distribution model to a community one. In this way, the PNLS will assess the needs and capacities of the sites and community health workers, in addition to the components for proper oversight and management of the drugs before developing tools and SOPs to scale-up drug dispensation at the community. Additionally, the success of this project in the remainder of FY18 implementation will support our already successful advocacy efforts by presenting the evidence piece requested by the Ministry of Health. Consequently, both drug dispensation at the community level and the facility-based adherence club model with fidelity in high volume ART sites will be scaled-up nationwide in FY19. An additional area of advocacy with MSPH and international stakeholders is support for the integration of community health workers (CHWs) in the health system similar to other African countries.

Community ARV Distribution

In COP 18, a community ARV distribution model will be rolled out as part of a broader community ART program. This model seeks to decongest health facilities, address bottlenecks associated with PLHIV regular visits to health facilities, reduce stigma, and improve adherence to treatment at the community level, reduce risk of treatment interruption, improve patient satisfaction based on this patient-centered strategy. The model uses community support group sessions organized by community-based counselors and peers to provide treatment counseling, psychosocial support, and referral in case of ARVs side effects, dispense ARVs to stable PLHIVs, address stigma/discrimination cases. To be enrolled in the Community ART program, PLHIVs must first be initiated on treatment in a health facility and declared stable as outlined in national treatment protocols and standards. Eligible stable PLHIVs receive three-month refills of ARV drugs in the community from the community-based counselors and peers who also provide peer-to-peer psychosocial support and adherence counseling to ensure that PLHIVs comply with their periodic medical appointments at the facility as needed. As a stock and adverse event monitoring measure, community-based counselors and peers will complete basic inventory management and reporting tools for ARVs distributed as part of the community ARVs logistics system. They also will monitor PLHIVs for any

reportable adverse events. The community inventory management and adverse events reports will form part of the logistics management and supply chain reporting system.

Self-Testing

The MSHP cited HIV self-testing (HIVST) in 2016 in the national HIV Testing and Counseling Policy Document and Guidelines as an additional tool to increase testing uptake and yield among targeted high risk and/or hard-to-reach populations, including men, KP, and sexual partners of HIV-infected women. The implementation details (who, where, how) of the HIVST strategy was not detailed in this policy. In FY18, the MSHP created a multilateral technical working group (TWG) on HIVST in charge of developing implementation guidelines and procedures based on a small-scale intervention, which aims to validate the test format, by the end of Q3. Besides PEPFAR and the GF financial support, UNITAID is also providing support for self-testing in Côte d'Ivoire. In FY19, selective HIVST will be integrated in the index case testing strategy. The service provider offering the self-test to targeted populations (at the facility or the community level) will also be responsible for follow up with the military client >40 years old, the male client, the index or sexual partner (partner of HIV-infected pregnant women, stable partner of FSW and MSM, military partner of HIV-infected women). Regular follow up will continue until the client or the sexual partner has tested him/herself, has received a confirmatory testing at the facility or the community level if tested positive, and has enrolled into a treatment program at the facility level. The expansion of HIVST throughout districts with a large unmet need will address more proactively the case finding gap in different hard-to-reach sub populations (men, military 40+, and KPs). In October 2017, the country officially adopted targeted testing and distributed guidance to all clinical sites.

TB Prevention Therapy for PLHIV (TPT)

The MSHP approved the implementation of a phased TPT project in October 2017 for HIV-infected patients receiving care and treatment services at seven sites, created a TWG that is currently developing the plan and tools, and forecasting drug needs for TPT implementation. In FY19, this intervention will scale up to 70 sites selected in districts with high TB/HIV co-infection rates for about 69,000 HIV-infected adults and children on ART.

Test and Start in the Military

Testing and treatment of new military recruits is an untapped approach to address the testing and ART coverage gap for men. In FY18, PEPFAR will continue to advocate with the Ministry of Defense to revise the 2014 military HIV policy to include Test and Start and status notification for all new military recruits, with the intention of full-scale implementation in FY19.

2.2 Investment Profile

Since 2012, the country has consistently maintained real growth around 8% annually, among the fastest in Africa if not the world. The 2018 health budget for Côte d'Ivoire is $827 million, which represents 6.12%[6] of the national total budget, and a 2.3% rise from the 2017 health budget level. For 2018 compared to 2017, the final finance law envisaged a reduction of 52.7% ($44,337,063 to $20,990,000) of the investment expenditure concerning the HIV response. PEPFAR-CI continues

[6] Percentage based on exchange rate of 500 FCFa = 1 USD, applied to the overall government 2018 budget of 6.724 billion FCFA

its efforts to advocate for increased domestic resources for health, supported by high-level interventions through the Executive Office of the U.S. Embassy. The MSHP has commissioned a modeling study on the epidemiological and economic consequences of varying the sources of funding; final results are expected before October 2018 which can contribute to advocacy for increased domestic resources for HIV response. The contribution of the GF to the HIV response in Côte d'Ivoire is approximately $81 million for the 2018-2020 grant period, a reduction in allocation of about 40% over the previous three-year period but similar to the recent spending rate on the HIV grant. Available HIV expenditure data by program area and by major donors in Côte d'Ivoire comes from the UNAIDS-supported National AIDS Spending Assessment conducted 2012.

Table 2.2.1a: Annual Investment Profile (2012 National AIDS Spending Assessment)

Program Area	Total Expenditure	% PEPFAR	% GF	% GOCI	% Other
Clinical care, treatment and support	$92,206,243	74%	17%	6%	3%
Community-based care	$2,876,354	56%	38%	6%	2%
PMTCT	$10,510,627	87%	2%	8%	3%
HTS	$10,348,310	80%	10%	7%	3%
Priority population prevention	$6,548,911	66%	26%	5%	3%
Key population prevention	$10,018,458	85%	4%	8%	3%
OVC	$13,661,822	89%	0%	8%	3%
Laboratory	$9,419,512	89%	0%	8%	3%
SI, Surveys and Surveillance	$9,911,643	75%	16%	6%	3%
HSS	$16,977,396	74%	17%	6%	3%
Total	**$182,479,274**	77%	14%	6%	3%

More recent data from the 2015 National Health Accounts exist, but do not disaggregate by program area.

Table 2.2.1b: Annual Investment Profile (2015 National Health Accounts)

Program Area	2015 Total Expenditure	% PEPFAR	% GF	% GOCI	% Other
Clinical care, treatment and support	$92,750,180	37%	48%	13%	2%
Community-based care, treatment, and support	$111,962,540	58.37%	32.87%	3.57%	5.20%
Other	$1,307,340	0%	0%	3%	97%
Total	$206,020,060	48%	40%	8%	4%

Females	$120,006,880	49%	40%	8%	4%
Males	$86,013,200	48%	39%	8%	5%
<5 years	$41,428,140	43%	48%	7%	0%
≥5 years	$1,535,360	88%	0%	10%	2%
15-49 years	$143,365,340	53%	43%	2%	2%
Non-specified age/Other age	$19,691,240	24%	0%	49%	27%

Table 2.2.2.a illustrates the total amount spent per commodities type during calendar year 2017, by funding source. The actual domestic expenditures toward purchase of HIV commodities has significantly increased to reach 26% in calendar year 2017.

Table 2.2.2.a Procurement Profile of Key Commodities (January - December 2017)7

Commodity Category	Total Expenditures	PEPFAR		GF		UNITAID		GOCI	
		USD	%	USD	%	USD	$	USD	$
ARVs	$29,714,719	$10,150,096	34%	$10,457,369	35%	n/a	n/a	$9,107,254	31%
Rapid test kits	$5,156,582	$2,978,950	57.8%	$1,230,840	24%	n/a	n/a	$946,792	18%
Other drugs (CTX, STI kits)	$2,353,081	$644,370	27%		0%	n/a	n/a	$1,708,711	73%
Lab reagents	$8,074,572	$2,425,177	30%	$4,593,528	57%	n/a	n/a	$1,055,867	13%
Viral Load reagents	$2,804,344	$2,173,001	77.49%		0%	$631,343	23%	$0	0%
TB(Genexpert) commodity	$0				0%	n/a	n/a	$0	0%
Condoms	$957,168	$957,168	100%		0%	n/a	n/a		0%
Other supplies	$156,257	$156,257	100%		0%	n/a	n/a	$0	0%
Total	$49,216,723	$19,485,020	40%	$16,281,737	33%	$631,343	1%	$12,818,624	26%

PEPFAR-CI, with input from the PNLS, estimates the national HIV commodities needs for FY19 period as $58.25 million. This total budget breaks down between the GOCI (39%), GF (23%), UNITAID (2%), and PEPFAR (36%). PEPFAR-CI's contribution will be used mainly to procure first line ARV drugs including tenofovir, lamivudine, and dolutegravir (TLD), VL and EID reagents, and HIV rapid test kits. PEPFAR-CI will also procure 45,000 HIV1/2 self-tests.

[7] Based on actual deliveries occurred during calendar year 2017. Data source: GHSC-PSM ARTMIS, Pipeline, NPSP

The total need for condoms in FY19 consist of 20 million male condoms, 500,000 female condoms and 500,000 sachets of personal lubricant for a total value estimate of $920,000. The USAID Commodity Fund will support the procurement of these quantities.

The Table 2.2.2.b below provides a summary of HIV commodities funding contribution (in million USD) by funding source for FY19.

Table 2.2.2.b Detailed COP 18 summary of HIV commodities (in million USD)

Items	**PEPFAR**	**GF**	**GOCI**	**UNITAID**	**Total**	%o of item
ARVs Adults (1st line)	$12.68	$8.00	$9.40	$0.00	**$30.08**	*52%*
ARVs Adults (2nd line)	$0.00	$0.00	$5.70	$0.00	**$5.70**	*10%*
ARVs Ped (1st line)	$3.41	$2.60	$1.10	$0.00	**$7.11**	*12%*
ARVs Ped (2nd line)	$0.00	$0.40	$0.20	$0.00	**$0.60**	*1%*
Lab supplies (hemato and biochemistry)	$0.00	$0.00	$0.90	$0.00	**$0.90**	*2%*
EID	$0.09	$0.00	$0.00	$0.00	**$0.09**	*0%*
VL reagents	$3.82	$1.20	$1.20	$1.16	**$7.38**	*13%*
CD4 reagents	$0.00	$0.00	$0.30	$0.00	**$0.30**	*1%*
Other Lab Supplies	$0.10	$0.10	$0.20	$0.00	**$0.40**	*1%*
OI Drugs	$0.10	$0.40	$1.90	$0.00	**$2.40**	*4%*
Rapid test kits	$0.67	$0.80	$1.50	$0.19	**$3.16**	*5%*
Other Lab Equipment	$0.13	$0.00	$0.00	$0.00	**$0.13**	*0%*
Total expected contribution	**$21.00**	**$13.50**	**$22.40**	**$1.35**	**$58.25**	
Total proportion	36%	23%	38%	2%		*100%*

Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration					
Funding Source	**Total USG Non-PEPFAR Resources (US $)**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs (US $)**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution (US $)**	**Objectives**
USAID Malaria	25,000,000	6,116,635	3	8,378,020	Contribute to reduction of malaria related morbidity and mortality
USAID Global Health Security Agenda	1,100,000	1,100,00	3	8,033,539	Strengthen national capacity to predict, detect and respond to emerging pandemic threats.
CDC Global Health Security Agenda	3,233,467	0	0	1,633,333	Strengthen national capacity to predict, detect and respond to emerging pandemic threats.
MCC	57,040,000	TBD[8]	TBD	TBD	Poverty reduction through education and infrastructure projects.
TOTAL	**86,373,467**	**7,216,635**	**6**	**18,045,092**	

2.3 National Sustainability Profile Update

The MSHP, UNAIDS, and PEPFAR-CI jointly organized a one-day workshop to complete the third version of the sustainability index dashboard (SID 3.0) Participants came from MSHP leadership, Civil Society Organizations (CSO), bilateral and multilateral stakeholders, IPs, and the PEPFAR-CI country team.

Prior to the workshop, participants received the SID 2.0 dashboard and summary, along with a pre-populated version of the SID 3.0 with preliminary responses from PEPFAR-CI that workshop participants validated. The PEPFAR-CI country team also assisted HQ in updating the French language version of the tool for worldwide distribution.

The SID 3.0 tool identified data availability and public access to information as the main strengths moving towards the sustainability of the Ivorian response against the HIV epidemic. The next areas of strength were the adoption of new health policies for service delivery, human resources for health (with some exceptions like in the area of pediatrics), domestic resources mobilization, quality management and access to laboratory services via decentralization.

Despite the above-mentioned strengths and the ongoing efforts of Côte d'Ivoire to control the HIV epidemic through ARV treatment saturation, the tool identified a number of challenges that remain unattended. The effectiveness of technical support and allocation of resources was identified as the main weakness with a score of 2.20. In general, neither budget planning nor allocations for the HIV program are based on the analysis of successful interventions and their cost. Likewise, policy and governance, security and supply chain of critical products at the subnational level, and the lack of a quality management system for health services, were identified as weaknesses.

The MSHP recognizes the need for technical assistance (TA) to build budget proposals that are data driven, with a focus on linking investments to achievements, accurately costing successful interventions that address needs, and projecting long- and short-term costs. Table 6 includes interventions to address this weakness in FY18 and FY19, while the PEPFAR-CI team has begun

[8]The MCC Compact is currently in development, and the implementing partners remain to be determined.

exchanges with the Office of Technical Assistance in the Department of Treasury to explore the possibility of having a point of contact at the central level.

Table 6 activities and direct assistance from PEPFAR-CI will support the MSHP on the development of a framework, adoption and systematization of quality control approaches to improve the delivery services. This support will continue for programs on quality assurance of HIV rapid testing and VL testing as well on quality improvement of laboratory services. PEPFAR-CI will also continue its support to strengthen supply chain management, in coordination with the GF, to assure adequate planning, ordering systems, distribution, and reporting, including communications between central and peripheral levels, eliminate stock-outs in health facilities. There is a commitment from relevant stakeholders to improve coordination and collaboration for supply chain management.

PEPFAR-CI has begun designing an approach to assess and address the human resources gap for pediatrics and men in terms of both the number and skill set of trained personnel, and will continue to support implementation of a national strategy for community workers that can assure sustainability of the HIV response.

PEPFAR has been supporting the Ministry of Family, Child Protection and Solidarity (MFPES) in reducing the social impact HIV among the most vulnerable children. To that end, the MFPES revised the national OVC policy document and 5 years national strategic plan including capacity-building plan to sustain OVC programs/services. PEPFAR transitioned OVC support services to MFPES in sustained districts in September 2017.

The Government of Côte d'Ivoire is highly committed to improving the national health response but is still facing challenges in increasing its domestic funding for HIV. In this context, the need for coordinated investments by donors is crucial. PEPFAR, the GF, and other multilateral and bilateral organizations are combining their efforts with those of the host government for improved sustainability. This includes special attention to health system strengthening, with more tangible and better-tracked interventions (reflected through PEPFAR efforts in Table 6 and the SID to assure impactful interventions, and through the GF with a specific grant on HSS). World Health Organization (WHO), UNAIDS, and the French Cooperation advocate for policy changes based on normative guidance. The World Bank has been contributing to improving the health-financing climate, including large-scale projects on performance-based financing and universal health coverage. Expertise France, funded by the French government and the GF, is providing TA on VL testing and training of health care and community workers on VL literacy, in collaboration with PEPFAR-CI, which coordinates its strategies for PMTCT, pediatrics, and adolescents with the United Nations Children's Fund (UNICEF) investments. The Millennium Challenge Corporation finalized its Compact with the GOCI in late 2017, offering multiple areas of potential collaboration with PEPFAR-CI like the Data Collaborative for Local Impact, girls' empowerment and HIV sensitization.

Table 2.3.1 SID 3.0 Workshop Participant Organizations		
Bilateral and multilateral organizations	**Local Government**	**CSOs, IPs, Other**
United Nations Programme on HIV/AIDS (UNAIDS)	Ministry of Health	Central Coordinating Mechanism (CCM)
United Nations Population Fund (UNFPA)	National HIV Aids Program (PNLS)	National Institute of Statistics
United Nations Children's Fund (UNICEF)	Ministry of Budget	Ivorian Network of Organizations of Persons Living with HIV-AIDS
World Health Organization	Ministry of Women and Child Protection	John Hopkins University
Embassy of France	Ministry of Justice	Abt Associates
African Development Bank	Ministry of Planning	Population Service International
Office for the Coordination of Humanitarian Affairs (OCHA)	Ministry of Defense	Family Health International 360
World Food Programme (WFA)	NPSP (New Pharmacy Stores)	Save the Children
	Ministry of State, Ministry of Employment, Social Affairs and Vocational Training (MEMEAS-FP)	Civil society Platform
	National Program of Pharmaceutical Activity (PNDAP)	The Council of HIV /AIDS NGOs in Côte d'Ivoire (COS-CI)
	NASA/NHA	Program PAC-CI
	National HIV/AIDS Alliance (ANSCI)	ESTHER Alliance for Global Health Partnerships (ESTHER-FR)
		COF Plus CI
		Alliance of Religious against Aids and other Pandemics (ARSIP)
		ICAP
		Elisabeth Glazer Pediatric Aids Foundation (EGPAF)
		HAI (Heartland Alliance)

The U.S. Department of Defense (DoD) conducted the second version of a similar assessment for the military sector, the MILSID 2.0, with a high involvement of all military departments along with IPs. The main strength, with a score of 6.5, lay in access to information. The MILSID 2.0 reflected increasing vulnerabilities in the areas of planning and coordination, policies and governance, service delivery, military healthcare staffing quality, epidemiological and health data, and performance data. The MILSID 2.0 tool identified laboratory, technical and allocative efficiencies, commodity security and supply plan, resources mobilizations and financial/expenditure data as the most significant Achilles heels in the military HIV response sustainability. Under FY19, there are three specific issues to address, policies and governance, laboratory, and financial/expenditure data.

Table 6 activities will support the mobilization of more internal resources for the military sector, the update of the military HIV policies to enable an effective environment for high yielding testing approaches and high linkage rate into treatment, and aggressive stigma and discrimination reduction. Above-site activities for sustainability of the military response also include strengthening the VL testing coverage for the military and the neighboring populations, and the improvement of the system for data quality management at all levels of the military health pyramid.

The optimization of the local capacities to reach a sustainable HIV response will be monitored through the annual update of the sustainability index dashboard (SID) at the country level. All elements passing the 8.0 scoring threshold will be considered for transition to the GOCI with a specific plan to ensure proper appropriation and monitoring of sustainability consistency. The other elements below the score of 8.0 will be addressed in an agreed upon plan with the MSHP to identify the resource mobilization mechanisms to fund the necessary improvements and the specific timeline for each element to reach the score of 8.0.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

This year again, the expenditure analysis (EA) information proved useful for the COP planning exercise as a means of drawing attention to outliers and determining some unit costs. The PNLS in collaboration with UNAIDS and PEPFAR recently conducted the latest estimates of the number of people living with HIV in Côte d'Ivoire and their distribution by health district. Therefore, some shifts in the rank order of districts by burden of PLHIV used for FY19 planning will not align with the EA analysis recommendations.

As demonstrated in Fig. 2.4.1, expenditure per PLHIV is on average $116 and ranged between $2 (Adiaké) and $434 (Bétié). This is a drop from the FY17 unit expenditure, with an average of $272 and a range between $25 (Minignan) and $940 (Treichville-Marcory).

According to the graph, PEPFAR expenditures in FY17 did not strictly follow the trend of the disease burden by SNU. Investments at certain SNUs like Bétié, and Katiola dramatically increased from lower values in FY15. Treichville continues to misrepresent an overinvestment due to HIV referral services at the University Hospital Center, making the denominator inaccurate.

Finally, the EA17 results confirmed that the cost of finding positive patients through facility-based testing continues to be far lower than the cost of finding them through community-based testing, with the cost of finding positives in the private sector dropping considerably from FY15.

Figure 2.4.1 Expenditure and percent of PLHIV by district

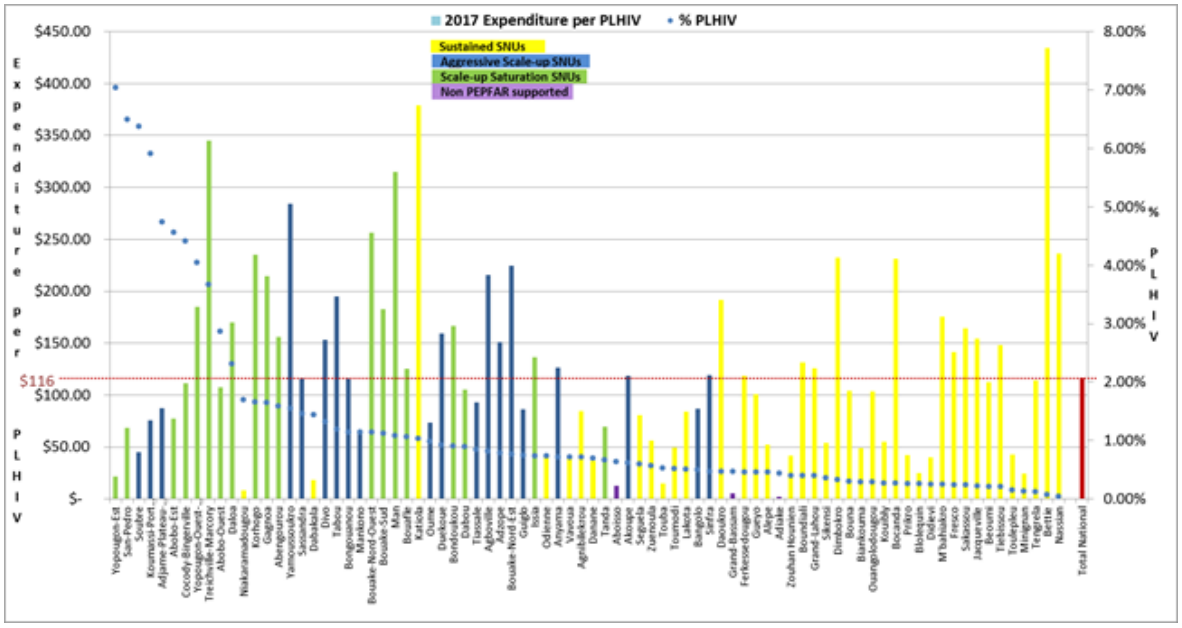
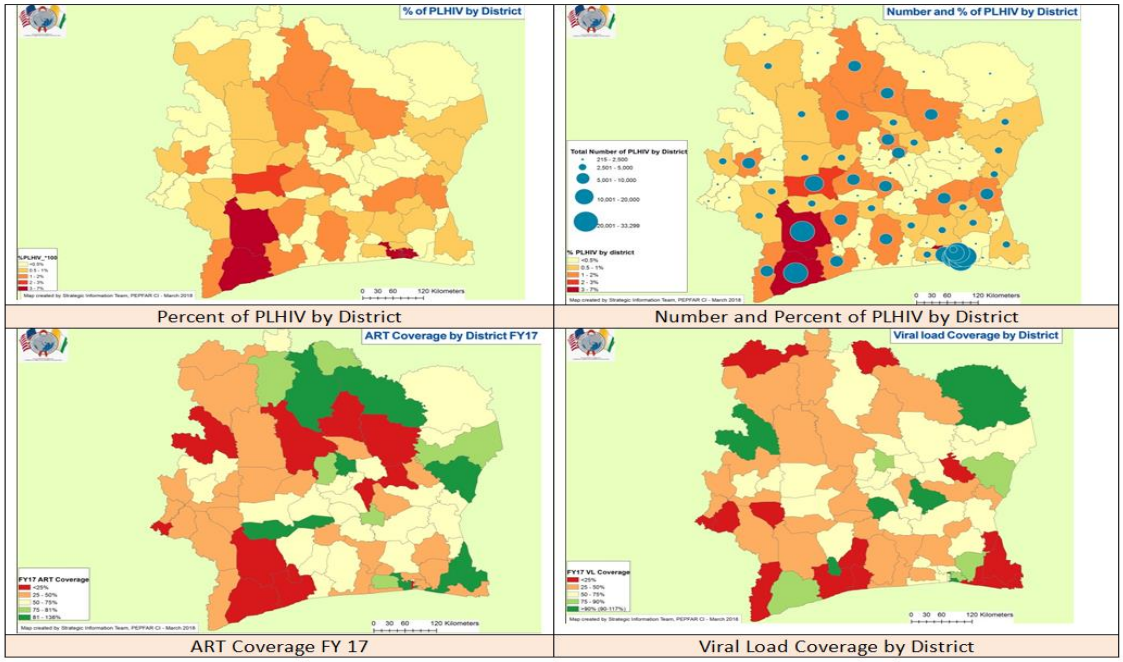


Figure 2.4.2 Number of PLHIV, Treatment Coverage and Viral Load Testing Coverage



2.5 Stakeholder Engagement

Stakeholders, encompassing the GOCI, CSOs, and technical/financial, bilateral/multilateral partners (PTFs), engage in the review of COP implementation throughout the year, notably through the quarterly daylong, pre- or post-PEPFAR Oversight and Accountability Results Team (POART) process meetings organized by the PEPFAR Coordination Office (PCO). Opportunities to share and use PEPFAR data and results with external stakeholders occur in other sponsored platforms such

as UNAIDS- or WHO-led PTF consultations and the National AIDS Control Program (PNLS) coordination meetings. Each quarterly POART-related consultation usually opens with presentations of PEPFAR results to date and PEPFAR programmatic updates. In FY17, meetings began to include small working groups to flesh out common approaches to observed programmatic challenges; reaching men, children, and KP have been recurrent topics. The conclusions assist PEPFAR-CI in applying mid-year course corrections to ensure that beneficiaries are optimally accessing PEPFAR services and that IPs are reaching their targets.

Stakeholder engagement for FY19 planning began in the middle of January 2018 with a meeting between the PCO and a contingent of 13 representatives from indigenous organizations working in multiple areas of the national HIV response. The CSOs used the consultation as a forum to make the following specific programming requests for FY19, many of which the PEPFAR-CI team addressed during the subsequent planning period:

1. Increased attention to HIV prevention
2. ARV stock-out warning system
3. PrEP
4. Community-based ARV distribution
5. Capacity building opportunities for CSOs
6. Programs for people who use drugs

FY19 development itself began with a Temporary Duty (TDY) visit at the end of January 2018 of HQ-based representatives of all PEPFAR Implementing Agencies active in Côte d'Ivoire (Centers for Disease Control and Prevention/CDC, Department of Defense/DOD, State Office of the Global AIDS Coordinator/SGAC, USAID). A major component of this visit included consultations with the IPs, PNLS of the MSHP, and the PTFs active in the national HIV response, as well a site visits. The objective was to set the stage to stakeholders for COP planning by providing an orientation of new approaches and tools, and conducting a preliminary exchange on major gaps, root causes, solutions and strategies that demonstrated success.

A weeklong FY19 strategic planning retreat followed the TDY. Participants included:

- all PEPFAR IPs, both service delivery and TA partners
- representatives from multiple government agencies involved in the national HIV response (PNLS, National OVC Program/PN-OEV, Ministry of Defense, Ministry of Education)
- PTFs (UNAIDS, WHO, UNICEF, United Nations Population Fund/UNFPA)[9]
- CSO representatives of indigenous PLHIV and KP organizations

Members of the PEPFAR-CI team led small group work with participants toward two objectives:

- Defining target setting assumptions
- Developing decision trees to identify key activities to address major problem statements for specific programs (testing and treatment for men; pediatrics; KP; pregnant women; OVC; health systems strengthening) towards epidemic control acceleration.

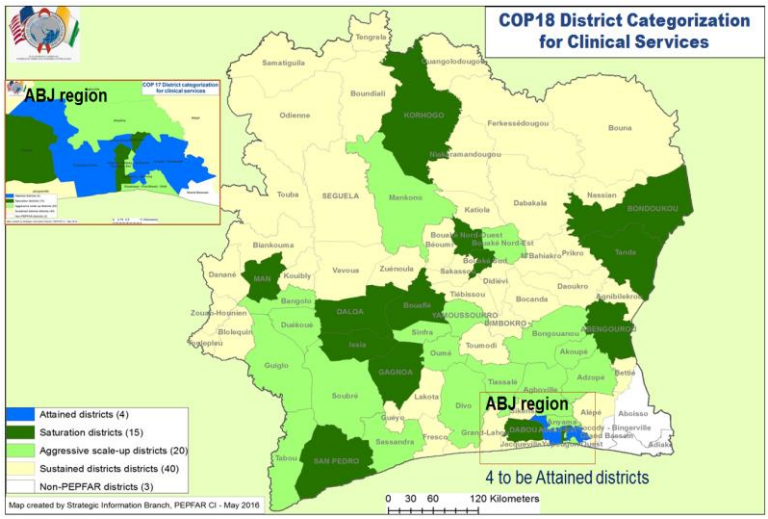
[9] The Embassy of France, World Bank, the Global Fund Country team based in Geneva, and the Global Fund community Principal Recipient were not able to send representatives, although they received advance invitations to the retreat.

Additionally, some IPs provided information on successful practices across the different groups. For instance, in the men's group, amongst the best practices identified at the meeting were: HIV diagnosis on all presumptive TB cases, index testing at high yield PMTC sites, demand creation at men friendly places (restaurants/*maquis*, sport bars) and modification of screening tool for the private sector. All these practices will be scaled-up in FY19. Furthermore, the need of strengthen clinical and community collaboration/partnership for case finding and linkage to ART was identified at this meeting.

PEPFAR-CI members also engaged with stakeholders outside of the strategic planning retreat to develop the TLD transition plan; the commodities investment profile; the TPT expansion; and the laboratory optimization plan. These and other programmatic discussions between PEPFAR-CI and stakeholders - specifically the PNLS, GF in Geneva, WHO, UNAIDS, and CSOs - continued at the FY19 Regional Planning Meeting (RPM) in February 2018. The CSO representatives at the RPM had also taken part in the consultation with the PCO in January 2018; one of their remarks after hearing the overview of the FY19 strategies was an affirmation that the PEPFAR priorities had incorporated their concerns and priorities. Stakeholders were particularly active in providing input for the analysis and development of strategies for reaching men, for finalizing the TLD transition and for identifying areas of complementarity to avoid duplication of efforts and strengthen synergies for gaps coverage. Their engagement continued through to COP submission through participation in conference calls with HQ and review of the Strategic Direction Summary.

3.0 Geographic and Population Prioritization

PEPFAR-CI prioritizes investments geographically and demographically to achieve epidemic control. Of the 79 health districts currently supported by PEPFAR-CI for clinical service delivery, 39 are prioritized for targeted programming to higher-risk populations, with 90% forecasted ART coverage by FY19. Three districts have already met the second 90 target at the end of FY17: Yopougon-Ouest-Songon, Treichville-Marcory, and Bouake-Nord-Ouest. PEPFAR-CI anticipates saturating an additional 4 by the end of FY18, and 53 by the end of FY19. The upcoming CIPHIA data will be used to assess if ART coverage assumptions are valid and where resources should be refocused in addressing gaps. The ongoing cluster analysis will also provide an opportunity to determine patient movement across sites and districts and whether certain districts should be prioritized based on demand.



To achieve these targets, the program is intensifying targeted case finding and ART enrollment strategies for priority districts and populations. IPs are readjusting their TA and coaching approach to increase their site-level presence and provide direct support (including human resources for health) to facility-based providers, particularly at low-performing sites with the capacity for significantly higher volume. Age- and sex-disaggregated analyses show that men and children have the greatest ART coverage gaps (with coverage currently at 32% and 29%, respectively). District-level data shows varying degrees of success in case identification and ART linkage in Scale-Up districts. Consequently, PEPFAR-CI is directing its partners on scaling-up successful strategies tailored by age- and sex-specific for both case identification and ART linkage. They are described in detail in section 4.

Closing the male and pediatric gaps in the seven districts with greatest unmet need will accelerate progress towards the second 90. Five of these districts represent the largest age- and sex-disaggregated gaps, suggesting infrastructural or environmental barriers that require above-site interventions with crosscutting and more sustained impact for epidemic control.

Table 3.1 Current Status of ART saturation

Prioritization Area	Total PLHIV (FY19)	Current on ART (FY17)	# of SNU (FY18)	# of SNU (FY19)
Scale-up Saturation	226,503	129,371	19	19
Scale-up Aggressive	156,088	59,152	21	21
Sustained	82,925	33,467	40	40

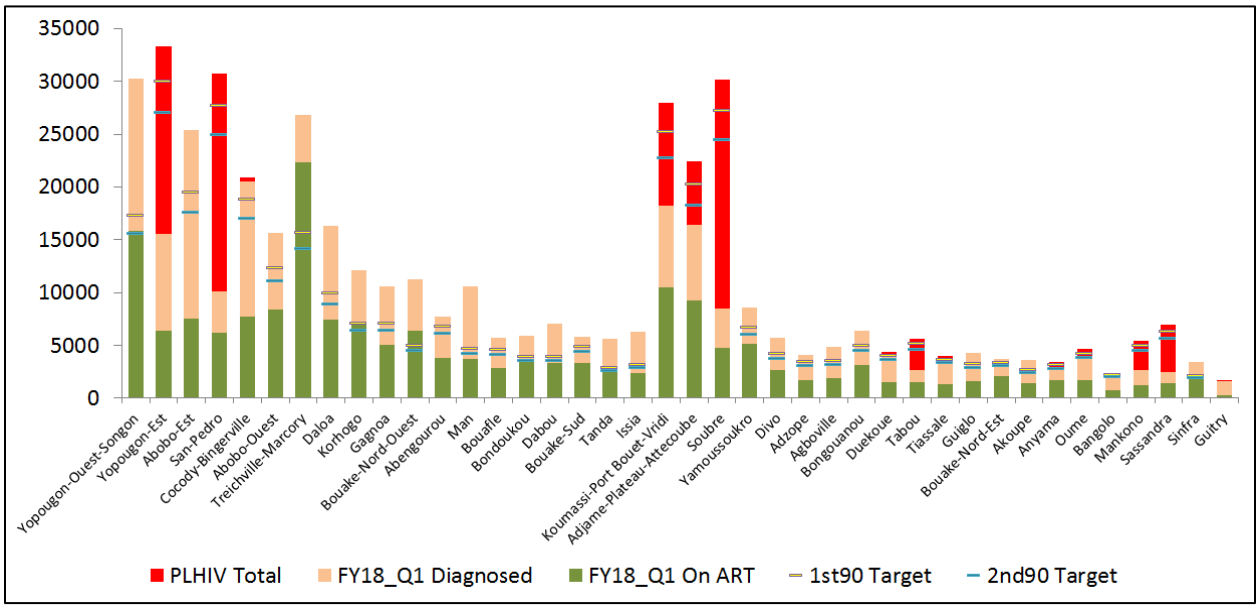
4.0 Program Activities for Epidemic Control in Scale-Up Locations and Populations

4.1 Finding the missing, getting them on treatment, and retaining them

PEPFAR-CI aims to treat 308,714 by the end of FY18. In order to arrive at 90% treatment coverage at FY19, PEPFAR-CI is prioritizing ART initiation at a national level of 59,340 men (with an emphasis among the 25-49 and 50+ age bands where the largest gaps occur), 11,402 children, and 6,231 KP. As of December 2017, 80% of the estimated number of PLHIV (425,300 out of the estimated 465,516) in PEPFAR-supported districts knew their status; 48% were placed on treatment and 77% of them have achieved viral suppression. PEPFAR-CI expects to support 421,161 people on treatment in FY19. Based on FY17 and preliminary Q2FY18 results, case identification is the major bottle neck to ART coverage. The program aims to tackle this issue by 1) expanding index testing, 2) ART distribution to the community setting, moving away from an exclusive facility model and, 3) turning all exclusive testing sites into testing/treatment sites

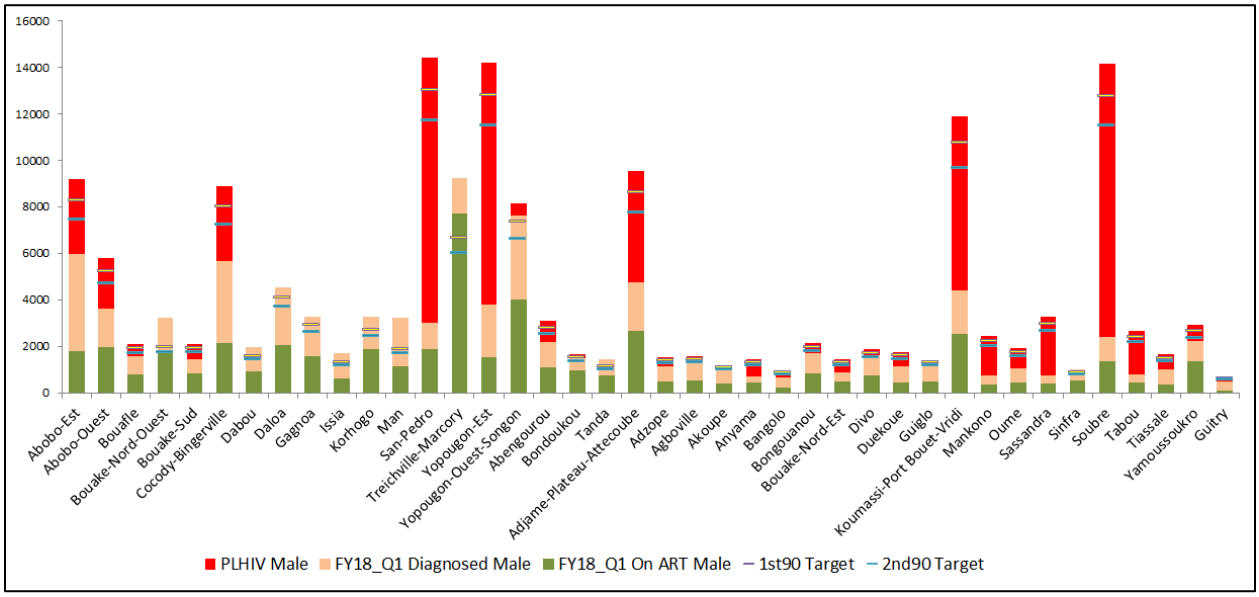
Geographically, PEPFAR-CI will focus its efforts in seven districts: San Pedro, Soubre, Yopougon Est, Koumassi-vridi, Adjame-Plateau for all populations; and Abobo Est and Cocody-Bingerville which show a large gap in men mainly. The first five districts represent 53% of the case-finding gap for all populations included in the 39 scale up districts as shown in red the figure below:

Figure 4.1.1 Clinical Cascade in Scale-up Districts Including all Populations and Ages



Moreover, as previously mentioned the graph below shows the additional gap for men in the two extra districts. These seven districts account for 75% of the case finding gap in men and 51% of the treatment gap overall.

Figure 4.1.2 Men Clinical Cascade in Scale-up Districts



Direct Service Delivery (DSD) approach and shifts in FY19

A key barrier in CI's HIV/AIDS response is the limited capacity to consistently deliver core clinical services at an acceptable standard of care. PEPFAR-CI-supported clinical services are implemented primarily in the public sector health care system through an integration of HIV services with other diseases and delivery by MSHP clinicians, including doctors, nurses, midwives, pharmacists, laboratory staff and data managers.

Within that framework, PEPFAR clinical partners have supported the scale up of HIV service delivery by providing technical assistance both at above site and site level. Above site technical assistance included support for policy and guidelines development, capacity building of regional and district level staff to plan, supervision, monitoring and evaluation of service delivery activities and ensuring their alignment with national/PEPFAR standards. Site-level direct services support to patients include: (i) mentoring and coaching of providers, (ii) quality improvement of services, (iii) provision of supplies and equipment to sites, (iv) salary support for staff, (v) provision of tools and SOPs, (vi) minor rehabilitation, (vii) support for sample transportation, and (viii) funding to local NGO or sub-grantees for direct service to patients (e.g. HTS services, telephone fees, home visit transportation fees, support group sessions etc.) Given the GOCI ambitions to control the epidemic through the 90-90-90, and the current programmatic gaps especially in reaching and treating men and children, PEPFAR-CI is repositioning its support from a focused technical assistance to a comprehensive direct service delivery model, effective Q3 of FY 18.

The new direct service delivery strategy aims to support the provision of quality HIV testing and treatment services to an increasing number of patients by aligning resource allocations with site-

level gaps and ensure a solid continuum of care between facilities and community-based interventions.

The development of this new model will be done during FY18 Q3 and Q4, in a phased approach. In the weeks following the April in-person approval meeting, PEPFAR-CI will continue consultations with the MSHP to analyze root causes of site underperformance, define a framework, and clarify roles and expectations for this new model in both HR and non-HR related aspects. Following these preliminary discussions, PEPFAR-CI will benefit from HQ-based technical support to operationalize the model agreed upon with the MSHP with a more detailed DSD strategy that outlines: i) service packages, ii) roles of facility-based versus community care providers, iii) human and financial resource allocations to address the needs of specific sites and sub-populations, and iv) a monitoring plan. The subsequent step will be the transition from the existing to the new model, which will include a review of IP work plans and a reallocation of resources as necessary, to align with site-level targets for case finding and treatment.

In preparation for FY19, a rapid assessment of health care personnel was conducted at the PEPFAR-supported high-burden districts. The gaps identified by cadre and by site were then used to estimate the overall cost of human resources needed and to allocate funding to partners assigned to districts with large programmatic gaps due to human resources challenges. In addition, a root cause analysis is ongoing at several districts to determine other factors contributing to the programmatic gaps besides HRH such as the extent of regional and district level engagement needed for better accountability at the site level and for implementation of case identification strategies.

Starting in Q3FY18, based on the initial HRH analysis, IPs supporting the 7 districts with the highest gaps for men and pediatrics are reassessing root causes contributing to gaps. In cases where insufficient staffing is identified as the main root cause for programmatic gaps, staff will be repurposed or recruited in consultation with district leadership. Sites will also be assessed for practices that are not yielding results which will be discontinued to make resources available for more pressing needs. Staff recruited may include counselors for index testing and tracking loss to follow up, data clerks to free up providers and counselors to focus on patients, newly graduated doctors and nurses to provide same day ART initiation to an increasing patient management load with Test and Start, and community workers for bidirectional referral between the community and the facility. Despite task shifting, many providers without pediatric specialty or experience are frequently referring HIV-infected infants to other facilities for treatment and not providing same day ART initiation. Placing health providers with pediatric experience at high volume sites to provide coaching and mentoring to midwives and nurses and to provide prompt ART initiation to infants will be essential to decrease the mortality in this age group.

Recruited staff may be part of the current surge effort to reach epidemic control while PEPFAR-CI continues to engage with the GOCI on how to transition them to other structures after epidemic control is achieved at the district level. There is an existing model of using interns to work in PEPFAR supported laboratories to support HR needs which has been effective in addressing laboratory gaps.

In addition, PEPFAR-CI will provide training and supervision support to MSHP staff at regional and district health levels so that they can provide direct supervision to site staff and provide support to strengthen the HR performance review process conducted by the district level. This is an essential

component of supporting the new MSPH reform of the district health system to improve health outcomes of various health indicators including HIV.

Strong collaboration and consultation with GOCI, international stakeholders, and professional associations will be critical in continuously reassessing the most efficient model for PEPFAR support and to design an appropriate transition plan for sustainability and to retain successes to maintain epidemic control once it is reached.

Quality management

Quality management (QM) is critical for identifying underperforming sites for real time course correction. QM will be extended to all sites in Scale Up to Saturation and Aggressive Scale Up districts in FY18 and sustained districts in FY19 to ensure that HIV services are being offered with a goal of increasingly higher-quality and consistent standards of care.

Targeted SIMS visits will be conducted at all high volume and select low volume sites to improve service delivery and above site level visits will ensure that Implementing partners, health district management teams and other central and decentralized entities have the capacity to provide effective support to sites. Facility and community site level data will be collected and aggregated to produce regional and national benchmarking reports. Selected "non SIMS" visits will also be conducted by PEPFAR-CI USG to ensure that new guidelines and TDY recommendations are being implemented appropriately.

Partner management is done at 3 levels: (i) Activity Manager conducts weekly and monthly progress reviews and course correction in addition to monthly and quarterly partner meetings and financial reviews; (ii) the Interagency conducts monthly data reviews of key indicators; and (iii) the National Program will conduct quarterly program results reviews led by PNLS with the participation of PEPFAR-CI, IPs, and stakeholders. IP performance is assessed and, after analysis of root causes, underperforming IPs will be placed on a 6 month improvement plan and if don't show improvement will be considered for targets and associated budget reduction to be transitioned to another IP, to the GOCI, or to other donors in consultation with appropriate national stakeholders and S/GAC.

Community-Facility Linkage

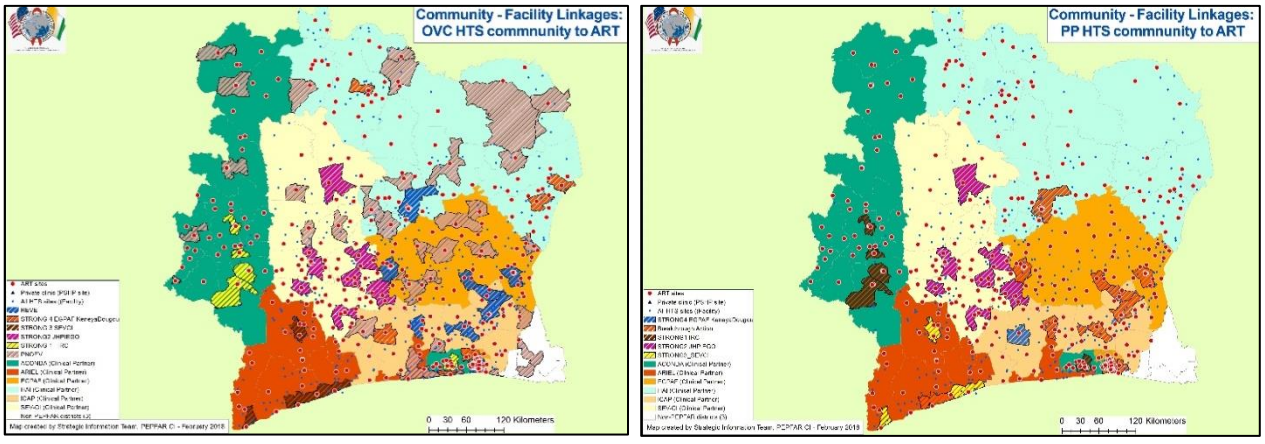
Strengthening community and facility linkages is a critical component of PEPFAR-CI strategy to increase case finding and linkage to ART, and to maintain retention in treatment and care services. Since FY16, PEPFAR-CI has rationalized the geographic distribution of clinical and community partners, pairing each clinical IP with a community IP to increase efficiency. Memoranda of understanding (MOUs) formalize this collaboration, delineating roles and responsibilities of each partner in upholding services across the clinical cascade. Starting in Q4 FY18 and into FY19, PEPFAR-CI will review existing MOUs and perform quarterly monitoring to define and monitor benchmarks of success in addressing coverage gaps across populations and age bands. Each IP will be responsible for a clear scope of work and SOPs for monthly tracking of referrals/counter-referrals and the loss-to-follow-up found in the community and linked back to a health facility. The newly distributed MSPH national referral and counter-referral tool will provide a consistent tracking system of patients.

Community IPs are responsible for contributing to demand creation for HIV testing services in facilities to enable earlier diagnosis for PLHIV. This is a critical component of increasing treatment coverage and reducing mortality rates, typically spiked by late-stage diagnoses. This community-to-facility bidirectional referral is key in order for clinical IPs to achieve their case finding targets as well as to keep clients engaged across the continuum of care. Clinical IPs will also be responsible for linking clients to community IPs for appropriate, relevant community-based interventions, such as supportive services that increase retention (including adherence support) and enable viral suppression. Community and clinical IP work plans will reflect their integrated roles in client care and shared accountability for facility-based HTS targets.

This partnership will ensure a smooth continuum care for patients and support full implementation of differentiated service delivery models. Individuals identified as HIV-infected inside a facility will receive care and treatment services in the facility and additional community-based support as needed until determined to be stable, at which point, they become eligible for community ART distribution and referred to a community-based counselor or a peer who ensures that the patient remains linked to the facility for treatment and laboratory services. Those identified in the community as HIV-infected are referred and escorted to the facility for same day ART initiation by community counselors or peers. In the context of index case testing and partner notification, counselors and providers ensure that gender-based violence risk assessment is completed, that sexual partners have the option of getting tested in the community or in a facility but will be escorted by the community counselor to the facility for treatment if found to be HIV-infected. Also, HIV-infected children and exposed infant are linked with OVC platforms.

Community counselors from the facility and the community hold weekly coordination meetings to ensure that referred patients received same day or prompt ART initiation, that loss of follow up are listed and updated for tracking, transfers are documented, and patient social needs are addressed. Monthly multidisciplinary team meetings at sites and quarterly district coordination meetings will be reinforced to ensure a good linkage between community and clinical settings. Figure 2.1.4 shows the geographic coverage of testing and ART sites by community and clinical partners.

Figure 2.1.4 Community –Facility Geographic Coverage for Priority Populations and OVC



Human Resources for Health

Human Resources for Health (HRH) remain a significant barrier to high-quality service delivery required for HIV epidemic control. Specific challenges include: (i) lack of an accurate assessment of the total number of health providers required to provide HIV/AIDS services and other basic health services; (ii) budgetary restraints limiting the recruitment of sufficient staff; and (iii) the imbalanced distribution of health care workers across the country. A rapid assessment of HRH gaps by IPs in March 2018 showed similar findings for various cadres (physicians, nurses, midwives and community lay counselors) needed to reach FY18 and proposed FY19 targets. Moreover, there are other HR-related barriers impeding the replication of good practices with fidelity: (i) demotivated health care providers who expect incentives to do HIV related data collection activities because they require additional work, (ii) targeted testing not well accepted by some care providers who continue to do broad based PITC, (iii) insufficient coverage of testing within nonpublic health centers, outdated community HIV knowledge, lack of sensitive screening strategies for men, and high cost to patients in nonpublic health centers. On the other hand, there is also insufficient office space for consultation in some hospitals. Consequently, patients are referred to hospitals outside their districts, i.e. patients from Yopougon Est are sent to Yopougon Ouest due to lack of a referral hospital within the district.

In response to these gaps, PEPFAR-CI will operationalize an aggressive HRH plan in the seven districts with the largest coverage gaps in FY19. Key inputs include the recruitment of 409 healthcare workers (116 physicians, 146 nurses, and 147 midwives) placed at 20% of the sites providing treatment to 80% of patients in these seven priority districts. PEPFAR-CI will support the salary of these health care workers through the clinical IPs in their respective districts, aligning the MSHP's salary scale to facilitate transition. At an above-site level, PEPFAR-CI will leverage the Government-to-Government agreement with MSHP to place HRH assets for the management of pediatric and men programs as well as monitoring and evaluation resources. PEPFAR-CI is exploring options with MSHP to designate facility-based healthcare workers exclusively for male clients as well as increasing the number of healthcare workers with specialized training for pediatric clients.

Furthermore, the program will also engage with the MSHP for a broader national HRH strategy. The continued provision of lay counselors through local indigenous organizations is critical to preserve client engagement across the continuum of care. In priority districts, the USG team will also work with the District Government for effective targeted supervision/mentoring and coaching of care providers on targeted testing and other policies, HRH performance review, providers motivational strategies, service quality management, data quality management and use of data for decision making.

Index Case Testing

Côte d'Ivoire has adopted index case testing in FY18 as its main approach to address its most critical gap of case identification observed across all populations and age groups and is scaling up this approach urgently now and into FY19 to be able to reach epidemic control by 2020. The program is moving from 8% of positives coming from index case testing as of Q2FY18 to plans to increase to 30% for FY19.

To fully scale up index partner testing, IPs as well as site level service providers will receive adequate, prompt assistance including training, coaching, mentoring and supervision based on the ongoing gap analysis, especially for new and low performing sites with high volume potential. All

positive cases identified through clinical services and in community settings will systematically serve as index cases with active tracking of all sexual network partners for testing. Following a partner elicitation interview, a routine listing of the sexual partners of all newly identified patients and those currently on ART will be done. This listing is updated each time the patient comes to the health center. The index case will be given the option for an assisted or unassisted disclosure to their sexual contacts and offer them a HIV self-test for selected target groups for COP18 (partners of FSW & MSM, military sexual partners of HIV positive women, and male partners of HIV positive pregnant women who do not accept testing through standard testing platforms). A standardized tracking system will ensure follow up with index case clients to strengthen case identification and linkage to treatment. A risk assessment of gender based violence will be conducted prior to partner notification. In the context of self-testing, counselors will be available to accompany patients tested positives in the community for confirmatory testing and ART initiation at the facility and support will be provided for HIV status disclosure at both the community and facility levels.

Overall, this level of scale up will require tight monitoring of partner performance to ensure full roll out with fidelity in FY18. PEPFAR-CI will continue to conduct weekly partner monitoring for the large volume sites to monitor the implementation of index case testing. Based on PEPFAR-CI partner level analysis of best practices in index testing, successful strategies are being replicated at high volume sites and selected lower volume sites. Additional lay workers, community counselors will be recruited for proper implemented of this strategy.

An analysis of testing modalities shows that high positive volumes are expected in ANC and PITC, which will all be feeding index case testing. Facilities will offer multiple approaches within PITC and ANC:

- Options for index client to return with partner or refer in for PITC
- Option for outreach via community partner to follow up on identified partners. This will be facilitated by strong coordinating platforms between clinical and community partners.
- Establish both anonymous and disclosure options for partner notification. For those not willing to disclose, the former could be leveraged. These may include non-specific targeted messaging around risk and testing, etc.

In addition, female PLHIV on treatment at facilities and those attending antenatal clinics will be prioritized as index cases in order to reach their male counterparts for HIV testing. As part of the new male focused program, male partners will be referred to male-oriented settings.

Family testing limited to the biological children of HIV-infected women and FSW will be scaled up while clearly differentiating from sexual partner testing. HIV-infected children will be linked to OVC services as appropriate. Training will also be provided for index testing with fidelity in the pediatric context in addition to training on correct reporting and monitoring to track progress and implement real time corrective action.

The OVC program will contribute to case finding. Specifically OVC implementing partners will fully roll out a risk assessment tool to all sites for OVCs with unknown HIV status, and provide testing services as needed. A list of sexual partners of all HIV positive adults and sexually active adolescents in OVC households will be updated monthly. The program will then provide HIV testing services to sexual partners with unknown or undisclosed HIV status. All partners who test positive will be

actively referred to care and treatment, long term treatment adherence support, retention on treatment support platforms.

KP programmatic results from FY18 Q1 show a yield of 17% through index testing and it is expected that that the addition of self-testing will allow better reach of the most hidden MSM as well as stable partners of FSW. Implementing partners will monitor consistent scale-up of these strategies across all KP sites.

In the military program, the projection is to increase the ratio of HIV positives identified through index testing to 30% in FY19. The additional community mediators to be recruited will be trained to support military health providers (doctors and nurses) to have a regular contact with the patients for sexual partners' identification and testing, even if the mediator needs to go in the community to offer testing services.

Private Sector

It is important to note that private sector health facilities deliver half of health services in Côte d'Ivoire[10]. The Private Sector Health Project (PSHP) has demonstrated consistently over time its ability to find a high yield (7%) of hard to reach, positive adult men, and increasingly adult women outside of PMTCT. While volume was initially low, PSHP has consistently increased volume over time (from 273 in FY15 to 2,636 patients currently on ART in FY18 Q1) while maintaining a high yield of 7%, above the national average of 3.5%. The Private sector is an important entry point to find HIV positive clients and link them to treatment, but tight targeting to ensure a significant contribution to epidemic control is critical. In refining its strategic focus, PSHP will, as of Q3 of FY18 Q3:

- Transition sites with a low number of clients on treatment (25 patients or less) and low yield (5% or less)
- Geographically reduce the number of districts from 24 to 14 with an emphasis on the seven districts with the highest gap in case finding for men and women;
- Reduce the number of overall sites from 150 planned for FY18 to 70 sites; and
- Scale up current successful practices like:
    - Optimized PITC at the internal medicine and dermatology departments.
    - Modified Screening tool to fast track male patients
    - Demand creation at places heavily visited by men (maquis, sport events)

In FY19, with a budget reduction of 37%, PSHP has right-sized targets based on historical performance. Moving into FY19, stringent site selection criteria include geographic location, population type (with an emphasis on men 25+), disease burden, performance and proximity to workplace health services. This strategic focus will allow the project to scale up its demonstrated best practices by concentrating reduced resources in sites with the capacity for higher volume.

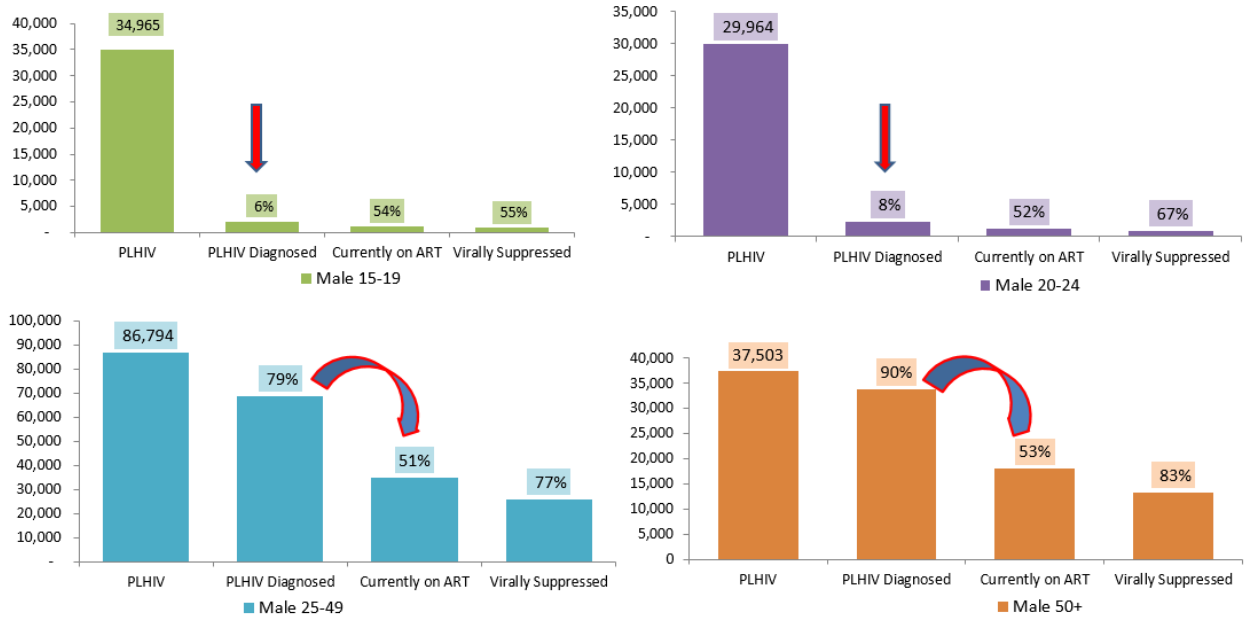
[10] Barnes, Jeffrey, Desiré Boko, Mamadou Koné, Alphonse Kouakou, Thierry Uwamahoro, and James White. 2013. Ivory Coast Private Health Sector Assessment. Bethesda, MD: Strengthening Health Outcomes through the Private Sector Project, Abt Associates

In addition to its unique niche in direct service delivery, PSHP fills an important gap by helping to strengthen transparency, accountability, and, ultimately government oversight of the private sector.

Reaching Men

Case finding and ART linkage among men is sub-optimal in Côte d'Ivoire. PEPFAR-CI will improve and optimize these areas by leveraging facility-to-community integration, rapidly scaling best practices, and filling outstanding gaps identified through formative research with men and programmatic experience. In FY19, PEPFAR-CI will increase male uptake of HIV services across the HIV cascade through a balance of demand creation interventions and improvements at the service level to render services more men-friendly (accommodating surroundings, provider sensitization, and expanded clinic hours). This strategy includes recruitment of dedicated health providers and lay counselors, and training and coaching on index case testing with a multi-disease integrated approach. At the end of FY18 Q1, the program had identified a total of 102,687 men, leaving 42% undiagnosed for all ages ,with the largest gaps in the 15-19 and 20-24 age ranges (94% and 92% respectively). As illustrated in the graphic below, the testing gaps among 25-49 and 50+ are 21% (17,912 individuals) and 10% (3,698 individuals) respectively. While the testing gaps among the 25-49 and 50+ age ranges are the smallest, the linkage to treatment gaps are the largest, with 49% (33,828) and 47% (15,796) unlinked, respectively.

Figure 4.1.3 Men Clinical Cascade by Age as of FY18 Q1

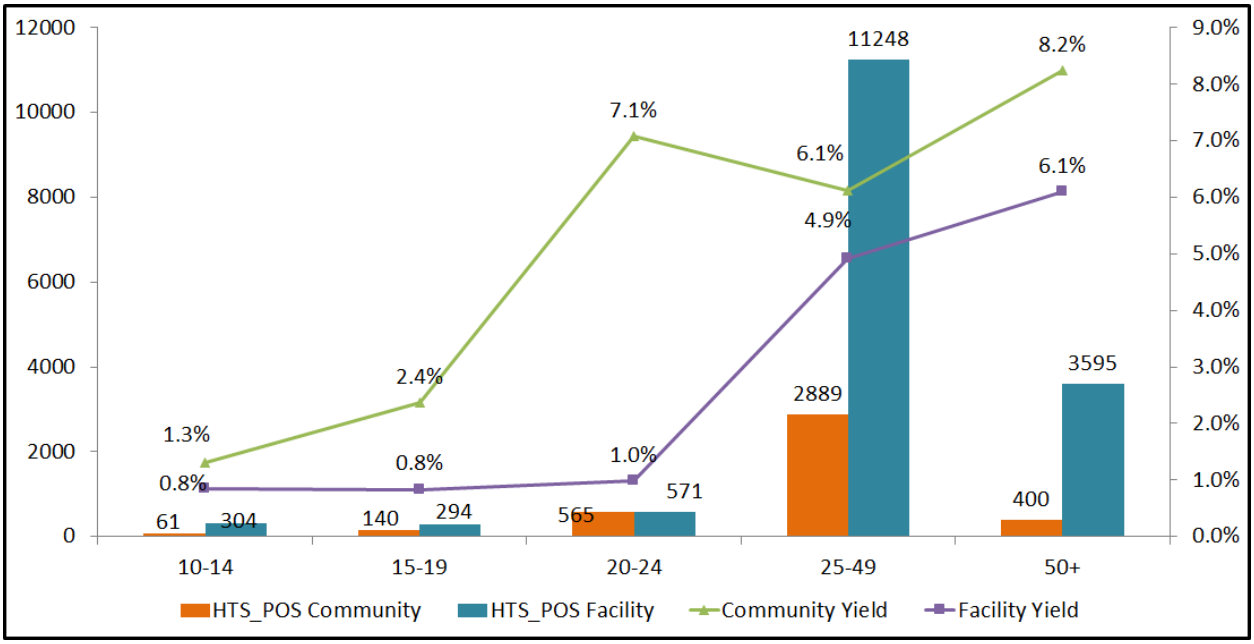


Given this differentiation across ages, the program will intensify case finding strategies for men under 25 and linkage to treatment for men 25+. Best practices include those found in country and from Lesotho (men-friendly services, self-testing, Outpatient Department/OPD modality) and Mozambique (Optimized PITC monitoring), which will be further explained in the strategies section depicted by age. Some of the practices like community ART distribution, multi-month prescription and the use of an ART unique identifier are also linked to an increased ART uptake

and adherence among men in Lesotho. These practices are currently implemented in Côte d'Ivoire; however, they are at an early stage and at a small scale. Therefore, it is not possible to conclude that these practices are helping the program link more men to treatment. However, given the experiences from other countries, the program anticipates the success of these practices and therefore closely monitor by sex and age-bands for smooth expansion in FY19.

Socio-cultural norms like disease stigma and fear of discrimination can negatively affect uptake of HIV services. Men are more likely to access testing services as part of a multi-disease package, which is the approach within which PEPFAR-CI embeds HIV services such as HTS. Added data from community testing entry points reveal higher yields for the young ages when compared to all facility testing entry points (see figure below) with index testing (through a multi-disease integrated approach) as the main yield and volume driver in the community.

Figure 4.1.4 Men Cases Identified by Age at all Facility entry Points vs. Community Entry Points in FY17



In terms of volume, APR17 results showed that PEPFAR-CI identified 11,112 men (out of 303,861 tested) through other provider-initiated testing and counseling/PITC for HIV at the facilities. While the yield was only 3.7%, the program will evaluate the "other" PITC entry point data to identify the specific testing modalities representing the major yield and volume drivers (by age) for men, and to assess their capacity for greater volume. In order to optimize the PITC, a screening tool used in high yield sites, which includes sexual risk factors, STIs and other symptomatology is being implemented in some high yield sites and will be scale-up with fidelity in FY19 to improve HIV case identification in low yield sites. The TB screening tool/algorithm developed by ICAP will be used in all 246 supported TB clinics to propose HIV testing to TB presumptive clients during FY18 and scale-up to non-TB clinics in FY19.

The program has not yet fully optimized index testing in terms of both yield and volume given some data reporting issues such as misreporting (misclassification) of index case testing, especially

at the facilities. A meeting with all IPs took place at the end of FY16 to address those issues, so the program can have a better estimation of the real amounts of index testing.

Moreover, the program will couple index case testing with PITC optimization at the facilities. Positive cases identified through clinical services and in the community will systematically serve as index cases with tracking of all (main or casual) sexual network partners for HTS. Routine listing of sexual partners of all newly identified women and those currently on ART will be systematic. Psychosocial support for partner notification and/or partner testing (any modality) including self-testing, will be provided. The active tracking of sexual male partners will be scaled up during FY18 and sustained in FY19 with the goal to identify 30% of the new HIV+ through index networks in the priority districts.

Index testing in both community and facility settings will incorporate self-testing. The option will be provider-initiated and offered to the index cases for their sexual partners. Providers will also give guidance on how to approach self-testing and partner notification. The health provider will give the index case the option to provide either an assisted or an unassisted test to the sexual contact.

Also in the community, a testing approach with great success is the one embedded in a multi-disease platform where eligible men access HIV testing along with other services for malaria, blood pressure and diabetes with "no fear". The eligibility to HIV testing is assessed by using a screening tool which includes sexual risk factors, STI, TB and other symptomatology. IPs are currently implementing this approach, which has allowed successful tracing of sexual networks in the community and it will be scaled up in the community for all ages. For adolescent and young men (aged 15-24), IPs will reinforce age-appropriate sexual risk reduction counseling including risk avoidance for those aged 15-19 and linkage to care and treatment services. Additionally, men will be reached through other platforms like DREAMS: the male partners of AGYW will be identified and targeted for HTS and linked to prevention and care and treatment services as appropriate.

PEPFAR CI program will work in coordination with Alliance (Global Fund PR) to increase the community outreach to non-PEPFAR sites within certain priority districts to ensure maximum complementarity.

Sites located in areas with the largest unmet need will be monitored weekly for volume and yield in the first two quarters while other sites will be monitored monthly. Once the sites demonstrate good results, they could be transitioned to monthly monitoring. Sites with high volume potential and low yield will also be monitored weekly for a six-month period in order to increase the yield.

Improving access to treatment has been the program's main goal and one of the main advocacy topics with the host country government since PEPFAR started in Côte d'Ivoire. Successful practices from other PEPFAR countries have showed that the decentralization of treatment services, significantly increased ART access and adherence. Some of these practices such as multi-month prescription, treatment availability at schools and workplaces, task-shifting, active referral and treatment accompaniment, fast track and same day ART initiation, were already adopted in Côte d'Ivoire and will be scaled up this year. Twelve schools and university health centers have already integrated ART services, serving 377 PLHIV currently on ART (as of FY18Q1). ART services will extend to 20 during FY18 the current fiscal year and to 30 during FY19. ART is available in 14 workplace health centers, for a 1,090 patients currently on ART, with plans to extend to 20 in FY18

and reinforced activities in FY19. Additionally, PEPFAR-CI continues to advocate for rapid scale-up of community ART distribution to increase ART coverage and retention.

Program data demonstrates that the key practices associated with improving linkage and retention are those that closely monitor and guide the client throughout the cascade, such as accompaniment for ART initiation, flexible hours, fast track to reduce waiting time, and dedicated providers for male friendly services. These approaches improve the perception of accessing services and consequently increase access. These approaches are implemented through a synergy between clinical and community partners.

The linkage between facility and community is done through the establishment of a robust referral/counter referral system including tools and quality improvement committees regular meeting that will be reinforced during FY18 and sustained in FY19.

Common Interventions Across all Ages

The strategies will be aggressively implemented and monitored in the seven priority districts for all ages. Though, given the gap in the 20-24 age band, the program will expand the strategy to three high burden districts (Abobo Ouest, Yopougon Ouest and Treichville) in addition to self-testing for the 25+ age bands.

Case finding:

Interventions at facilities:

- Systematic index testing through facility-based testing entry points (PMTCT, Internal medicine, TB and STI)
- OPD modality: informational sessions followed by provider initiated testing expanded to general and regional hospitals
- Extended hours and men-dedicated staff at HIV dedicated clinics, primary care private for non-profit centers (FSU Com and CSU Com), faith-based health centers.

Interventions in community:

- Scale-up of index testing using a multi disease integrated approach for sexual network tracing and by expanding the approach to other PEPFAR platforms such as OVC and DREAMS
- Mobile testing campaigns in heavily male dominated sectors, e.g. carpentry, plantations, neighborhood associations, labor unions
- School/workplace health programs

ART Initiation, Linkage and Retention:

Interventions at facilities:

- Active linkage to ART through:
  - Enhanced post-test counseling
  - Accompaniment to ART service
  - Expanded availability of ART services in school, university,work place health centers
- ART Adherence support through:
  - Enrollment in age-appropriate support groups

    - Fast track at facility
    - Facility-based community ART distribution (hybrid model)
- Better monitoring through roll-out of electronic ART registers and extended hours (after hours, weekend refills, workplace etc.)

Interventions in community:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Accompaniment to ART service
    - Ensure weekly monitoring of linkages as QI measure at all sites in priority districts
- ART Adherence support through:
    - Age-appropriate treatment literacy materials and approaches
    - Enrollment in age-appropriate support groups
    - Community based ART distribution at community-based adherence clubs and community ART groups

In addition to the above-mentioned interventions, age-specific ones are described in table below.

Table 4.1.5 Case finding and ART Initiation and Retention Strategies to Reach Men by Age band

Age	Case Finding	ART Initiation and Retention
15-19	**Interventions in community:** - Linkage through Youth prevention to provide information about avoid risk , OVC/DREAMS programs in Abobo East, Cocody Bingerville - School health programs	**Interventions in community:** - ART Adherence support through: o Enrollment in adolescent support group o Psychosocial support for caregivers
20-24	**Interventions at facilities:** - Provided initiated Self-testing **Interventions in community:** - Embedded testing as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at work places, unions, male oriented gatherings Grins - Self-testing - Mobile testing	**Interventions at facilities:** - Improved linkage to ART through: - Expansion of ART services in universities and workplace health centers with high yield HIV testing **Interventions in community:** - ART Adherence support through: o Psychosocial support for caregivers
25+	**Interventions at facilities:** - Other PITC reporting modality unpacked to optimize high yield entry points - Systematic index testing through facility-based testing entry points (Internal medicine, TB and STI) and referral to preventive health services and counselors - Replication of best practices found at high volume and high yield sites - Self-testing	**Interventions at facilities:** - Active linkage to ART through: o Expand ART services in workplace health centers with high testing yield o Focus on districts with high volume of positive cases identified low adult men ART coverage and tailor DSD services accordingly by age

	Interventions in community: - Index testing embedded as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at work places, unions, male oriented gatherings - Self-testing	- ART Adherence support through: o Expand multi-month prescriptions for stable patients **Interventions in community:** - Expand multi-month prescriptions for stable patients
Mil_	**Shifts in FY18:** - Significant reduction in mobile testing (sites with low yield ++) - Optimized testing at the facility level with fidelity - Optimized mobilization for mobile testing based on a risk assessment grid (before mobile units visits) - Increase of community mediators dedicated to index patients' sexual network testing at both military facility and community levels - Stop of active testing for military aged 20-24 (yield <1%) **Additional priorities for FY19:** - Self testing distribution to all military population aged 40+, in the facilities or in the workplaces - Self tests to positive women for their military spouses and other sexual partners - Close follow up with clients receiving self tests by community mediators to increase effective use and provide adequate timely assistance - Index patients' sexual network testing - Additional entry points (emergency rooms, psychiatry, dermatology, presumptive TB)	**Shifts in FY18:** - Integration of ARVs prescribers in mobile testing units to increase same day initiation rate, reduce LTFU and improve ARV coverage **Additional priorities for FY19:** - Training of military nurses for treatment task-shifting and increased men-dedicated staff - Aggressive stigma and discrimination reduction environment through military hierarchy, military troops (community level) and military health service providers (facility level) - Community based ART distribution – Enrollment in ART military support groups - Multi-month scripting for stable patients

Reaching Children and Adolescents

The number of children receiving ART nationwide has increased by 18% between 2014 and 2017, with children under 15 years old accounting for approximately 5% of the treatment cohort. National data show that pediatric ART coverage is proportionately lower at 34% compared to 48% adult coverage in Côte d'Ivoire, and for the first time in the history of the HIV epidemic, new infections among children 0-14 years in the West/Central Africa region are the second highest worldwide. As a result, PEPFAR-CI is working closely with the GOCI and other stakeholders to fast track the pediatric HIV response in Côte d'Ivoire and rapidly scale up pediatric ART coverage in high burden

districts. The program expects that 90% of children will be on ART in FY19, with a 50% reduction in mortality rates.

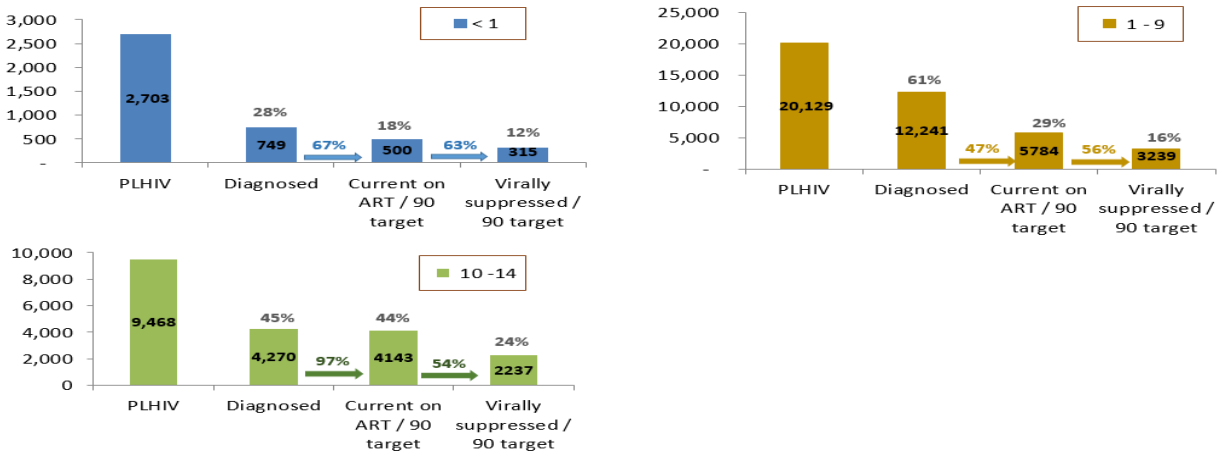
FY19 goals are to (1) ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, with risk assessments conducted for 100% of OVCs to identify those in need of HTS, through strong collaboration between facilities and community settings, and (2) to start and retain on ART all infected children regardless of age. Key priorities for pediatric and adolescent care and treatment in FY19 include increasing ART and VL testing coverage and suppression rates, improving TB screening, expanding nutritional assessment counseling and support (NACS), and increasing systematic and routine HTS of all children, through a family-centered approach, and same day initiation of ART for those positive, especially:

- Index testing:
  - If child is the family HIV index, then all his/her biological siblings would be tested
  - If mother is the family HIV index, then all her biological children would be tested
- Children in inpatient settings
- Children in outpatient settings, identified through screening tool (Bandason, et. al.)
- Children presenting with suggestive signs and symptoms of immune deficiency
- OVC identified through HIV risk screening tool
- Biological children of FSW
- Children diagnosed as malnourished
- Children with TB or suspected TB

FY17 and FY18 Q1 data showed diverse needs by age group throughout the clinical cascade among HIV-infected children and adolescents.

Across the three nineties, the biggest gap was in case identification, especially for the <1 year-old (28% coverage) and 15-19 age groups (6% coverage). Linkage to ART was an issue for all age groups, except for the 10-14 age group, which reflected a 97% of linkage of diagnosed children enrolled on ART. Case finding and linkage to treatment gaps for children and adolescents occurred in almost all Scale-Up Districts. Low viral suppression is a common challenge across all age groups and the lowest for 1-9 year olds (16%).

Figure 4.1.6 Pediatric clinical Cascade by Age as of FY18 Q1



For FY19, PEPFAR-CI has worked closely with key stakeholders to analyze the root causes impeding performance across the pediatric clinical cascade and identify solutions by age group based on best practices implemented at high performing sites to increase pediatric case identification and treatment coverage in order to achieve sustained viral suppression. The program will focus effort on select acceleration sites that will scale with fidelity practices such as the provision of dedicated pediatric staff (healthcare workers and lay counselors), Lopinavir/ritonavir formulation (pellets for children <3 years), TLD for adolescents ≥10 years and ≥ 30 kgs, to reach epidemic control among HIV infected children and adolescents.

Aligning with the task-shifting policy, PEPFAR-CI will continue to build the capacity of general practitioners, nurses, and midwives to effectively initiate pediatric HIV care and treatment, and ensure that training of staff on the most recent ART guidelines. Additionally, the program will create a network of pediatric care and treatment providers that will go hand in hand with establishment of a mentoring system implemented at selected sites in Scale-Up Districts. The criteria used to select those sites was: Good results across the cascade, High Peds Volume, Capacity to absorb additional patients, Advantageous geographic distribution, Opportunity to link with different community partners, Opportunity to link with VL lab.

PEPFAR-CI will also support differentiated service delivery models for children and adolescents meeting the definition of "stable" patients, including three-month (instead of monthly) ARV prescriptions and twice a year (instead of monthly) clinic consultation visits, as well as community ART distribution or facility pick-up for stable patient.

PEPFAR-CI is now monitoring site level achievement monthly, and working to collect and analyze testing yield and linkage to ART data from identified pediatric testing entry points on a weekly basis. The generation of a monthly listing of newly tested positive children has led to increased pediatric case finding and treatment; the program will scale up this practice across all IPs to facilitate the monitoring of pediatric enrollment in and adherence to treatment. PEPFAR-CI will strengthen collaboration and cross-referral between clinical HIV programs, social welfare/community-based support systems, and OVC services to support clinic-based linkage and retention efforts. Linkages between HIV testing and prevention programs will focus on at-risk adolescents and young women. Section 4.2 provides more details on the implementation of DREAMS-like programming for girls and young women, ages 10-19.

The program has the objective of ensuring 85% suppression among all children on ART. To facilitate early identification of treatment failure in infants, PEPFAR-CI will use VL testing as the only routine biological monitoring test in all supported regions. Each laboratory is generating a weekly list of children with unsuppressed VL to provide to facilities, which in turn conduct active follow-up for supplementary patient education and enhanced adherence counseling support on a monthly basis. As per national guidelines, children receive a VL test every six months; but those with unsuppressed VL will receive a second test after three months. Testing for infants in remote sites, with no available VL testing services, will use Dried Blood Spot (DBS) samples. Each of the pediatric sites will have a focal point for follow-up of children with unsuppressed VL, linked to the laboratory focal point to ensure effective continuum of service to children.

SIMS visits have shown significant improvement in the quality of pediatric care and treatment services, with 23% red and yellow scores in FY17. PEPFAR-CI will improve the linkages between clinical and community services for active follow-up in the community through involvement of

both social and community workers and the development and dissemination of a mapping of community organizations working around health facilities. PEPFAR-CI will support IPs as well as facility staff to utilize quality improvement approaches and systematically apply data analysis to make meaningful, real-time program improvements to programmatic gaps identified through MER and SIMS analysis.

Common Interventions Across all Ages

Although significantly large gaps in positive case finding lie among three priority districts, coverage is low for the first and second 90s across almost all the Scale-up Districts. Besides the recruitment of additional lay counselors and health providers trained in pediatric HIV management, who will intervene for all ages and services along the three 90s, and in all districts, especially at high volume sites, each pediatric age band will benefit from the following scaled-up approaches.

ART Initiation and Linkage:

- Weekly monitoring of linkage to ART initiation
- Task-shifting for ART initiation and monitoring

Viral Suppression:

- Scale up of VL Dashboard
- Implementation of mother and adolescent peer support groups to enhance medication adherence and viral suppression
    - LVP/r pellets
    - TLD for peds and adolescents >10 yrs (and >30 kgs)
- HIV genotyping targeting children with multiple treatment failure

Furthermore, PEPFAR-CI will implement age-differentiated strategies along the continuum of needs for children and adolescents, as indicated in the table below.

Table 4.1.7 Case finding and ART Initiation and Retention Strategies to Reach the Pediatric Population by Age band

Age	Testing	Treatment	Adherence and Viral Suppression
<1	- Coaching on and supervision of mother-child health booklet documentation and use - Active tracking of positive pregnant mothers to ensure preventive care and EID services for newborn - Expansion of EID POC in high volume sites		

1-9	- Family index testing - Coaching on and supervision optimized PITC at key entry points - Linkage with OVC and KP programs		
10-14	- Coaching on and supervision optimized PITC at key entry points - Family index testing	- Sexual and reproductive health services - Support for disclosure	
15-19	- Sexual index testing - Risk assessment tool		- Teen Clubs for adolescent peer support - PHDP package

Reaching Tuberculosis/HIV co-infected individuals

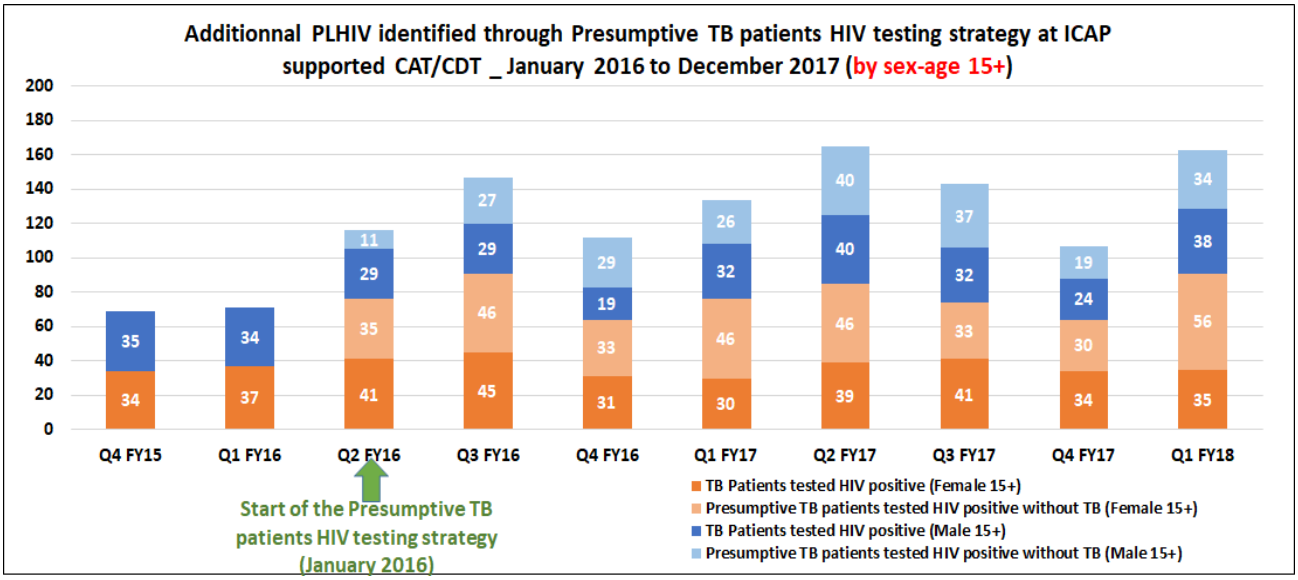
TB is the number one cause of death among PLHIV: the death rate for TB/HIV co-infected patients in 2017 was 21% at the national level, reducing the cure rate to 72% for TB/HIV co-infected patients against 83% for non-TB/HIV patients. The adequate case management among this cohort will significantly affect progress in viral suppression in Côte d'Ivoire and reduce mortality. In FY19, PEPFAR-CI will support 246 TB clinics, both in the public and private sector, including a TB strategic package of services designed to provide maximum support for the health of TB/HIV co-infected patients:

- HIV testing for all presumptive cases and relapsed TB patients
- ART provision for TB/HIV co-infected patients
- TB screening of PLHIV in care
- Lipoarabinomannan (LAM) test for HIV patients with advanced disease

FY18 includes support for the LAM test, which will continue FY18in FY19 for approximately 1,000 PLHIV with advanced disease.

Furthermore, for FY19, HIV testing for patients with presumptive TB will be an integral part of services offered in TB and HIV clinics. The International Center for AIDS Care and Treatment Program (ICAP) started implementing this activity in FY16, showing consistent increment in case finding for both female and male clients. PEPFAR-CI is scaling this practice among all clinical IPs, starting in the highest burden areas, and closely monitoring the activity on a quarterly basis.

Figure 4.1.8 Presumptive TB Cases Diagnosed for HIV as Compared to Confirmed TB by Age and Sex



PEPFAR-CI recognizes that the TB entry point has limited volume, but the addition of the presumptive TB strategy could potentially double the number of HIV cases identified through this modality. Additionally, the program will continue to implement the "Engage TB Strategy" using a family approach to reach the missing TB cases.

With PEPFAR support, the MSHP will scale up TPT from seven to 70 HIV clinics located in SNUs with high TB/HIV co-infection rates in FY19. The approach will use GeneXpert as the diagnostic tool to screen for TB infections among PLHIV and determine the eligibility for TPT. Starting in April 2018, Expertise France is providing technical assistance to develop the national guidance for TPT. The roll out of TPT in 2021 is a great example of collaboration amongst stakeholders, with the additional contribution of the National TB Control Program (PNLT) who will be procuring the drugs through the next Global Fund concept note (the current concept note does not include funding for TPT).

In FY19, PEPFAR-CI is working with the PNLT on the rapid diagnosis of TB and MDR-TB among PLHIV. Toward this end, GeneXpert-based TB and MDR-TB diagnosis will expand from 11 sites to 36 sites, encompassing Anti-Tuberculosis Centers (CATs), central labs, and HIV clinics, for the integration of EID and TB diagnosis and a reliable transport system. PEPFAR-CI support to the PNLT and IPs will also reinforce the sample referral system from HIV clinics to CATs and sites equipped with the GeneXpert, in order to reach a target of 45,000 PLHIV with presumptive TB tested. Quality assurance of TB smear microscopy diagnosis at 27 CATs and 250 CDTs will occur through the implementation of an External Quality Assessment Scheme coordinated by the PNLT with the technical support of the National TB reference laboratory. The continuation of the WHO/AFRO accreditation program, starting at 10 CATs in FY18 to cover at least 20 CATs in FY19, will also progressively improve the overall quality management system.

Above-site investments in TB management focus on strengthening the coordination of HIV and TB/HIV activities at central and decentralized levels, as well as coordination by national institutions

for the implementation of laboratory activities related to maintenance, testing and Laboratory Information Systems (LIS) quality. Additional above-site interventions include training and coaching for health care workers and HIV focal points on infection control, and continued support for the coordination, implementation, and expansion of MDR-TB detection. The latter entails assistance to the regional reference laboratory network to decentralize the capacity for opportunistic infection diagnosis. Capacity-building efforts within the national laboratory network will assist IPs, the TB laboratory network, and at least 14 regional hospitals in delivering quality laboratory diagnostics of HIV-related opportunistic infections, particularly TB and STIs.

4.2 Prevention, specifically detailing programs for priority programming

HIV prevention, mitigation, and risk avoidance for OVC and AGYW

The OVC program provides a robust community platform that contributes to HIV testing for children and adolescents at high risk as well as treatment initiation, long-term care, adherence support, and viral suppression. The program addresses the needs of the most vulnerable, HIV-affected children, while reinforcing caregiver and family capacity for self-sufficiency. Toward this end, it links transversally to pediatrics, PMTCT, HTS, prevention, and care and treatment programs in priority zones to support the GOCI in reaching epidemic control. PEPFAR-CI's approaches align with government guidelines for child protection and complement activities from other OVC actors, including the Global Fund and UNICEF. The final goal of the OVC Core Program Areas is to ensure that children and their families are "Healthy, Schooled, Stable and Safe", with improved child and family well-being.

To support this goal, the program direction in FY19 based on performance data includes:

- Providing services to vulnerable children at high risk of HIV infection, with a focus on adolescent girls
- Ensuring active referral of all HIV-exposed and HIV-positive infants in care to OVC programs through linkage by Community Counselors (CCs) at the health facility level with CCs in the community
- Reinforcing testing of biological children of HIV-positive women and of sexual partners of index cases identified in OVC households, with active linkage to care and treatment for all HIV-positive individuals
- Screening for HIV of most vulnerable OVC to increase testing yield, and finding those hard to reach positives in the key decisions made on program direction bullets
- Reinforcing operational collaboration between OVC programs and health facilities
- Targeting support to the principal caregiver in the household in order to reduce the number of 18+ age beneficiaries
- Developing and implementing graduation benchmarks for self-sufficient OVC households
- Ensuring bidirectional referrals and counter-referrals of infected children through monthly meetings involving OVC staff and health facility staff

PEPFAR-CI's OVC program seeks to improve targeting approaches to identify and enroll the most at risk OVC sub-populations. The goal is to increase the proportion of enrolled OVC who are HIV-positive, HIV-exposed children, adolescent girls at high risk of HIV infection, as well as other high-risk OVC sub-populations. The program prioritizes enrollment of children defined as most vulnerable through one or more of the following criteria:

- Children infected with HIV
- Children of parents or siblings infected with HIV
- Orphans due to HIV/AIDS
- Children of Female Sex Worker (FSW)
- Children outside family care
- Children who have experienced violence, including gender based violence (GBV)
- Children with disabilities
- Adolescent girls living in an area with a high HIV prevalence or with an elevated risk for HIV infection.

FY17 data shows an average gap of 60% between the enrollment of HIV positive children in pediatric treatment and those enrolled in OVC programs, with different trends across SNUs. Recognizing that not all OVCs meet the definition of "most vulnerable," the OVC program has a significant pool of unserved HIV-positive children who can benefit from OVC services. Since at least 98% of HIV-positive children enrolled in OVC programs are under treatment, the OVC program demonstrates an opportunity to identify infected children in the community and start them on treatment, as well as to reinforce adherence and retention of those already on ART.

Toward this end, the program will strengthen regional coordination meetings between health and community stakeholders, under the leadership of the PN-OEV. This will include regular HIV case conferencing through collaboration between case managers and health facility staff. PEPFAR-CI, in collaboration with the PN-OEV, is developing a case management plan and tools for HIV-infected children to harmonize across community and health facility actors who will have clearly defined roles. The OVC program will also strengthen operational collaborative frameworks involving clinical and community IPs, health facility staff, and NGOs, that the health and social regional directors will be monitoring and coordinating. The close linkage between health and community systems will help smooth any gaps in services between HIV-positive children enrolled in both pediatric and OVC programs.

In FY19, the OVC program will increase the proportion of children (under 18) versus adults (18+). FY19 has a notable shift in the 18+ target from 40% to 29% of all beneficiaries, while the proportion of beneficiaries under 18 years old will increase from 60% to 71%. Regular program monitoring is tracking that IPs are not over-serving beneficiaries 18+ and are also accurately counting those that are legitimately receiving services. Moreover, given the high HIV risk for adolescent girls, the OVC program will re-orient itself to serve more girls than boys, with 60% of the under 18 targets for FY19 designated for girls. Best practices show that where a specific package of services is available for adolescent girls, more adolescent girls are likely to enroll in and benefit from OVC program. With the support of PNOEV, PEPFAR implementing partners will replicate a specific package of service for girls, to include items like life skills, girls mentoring, and female OVC support groups.

PEPFAR-CI will continue reinforcing the connection between the national health and social welfare systems, in addition to build the capacity of the social welfare workforce. This holistic approach and fundamental systems investment across sectors will mitigate the long-term health, economic, and psycho-socio-emotional impact of HIV and AIDS on children, families, and communities.

The COP18 strategy will focus on layering the OVC and pediatric programs, using the OVC platform for targeted HTS referrals and index case testing, and linking positively diagnosed pediatric clients into the OVC program. A critical component of this strategy is the use of the OVC HIV Risk

Screening Tool to improve effective HIV case identification among children and adolescent. The program will pursue the implementation of the risk screening tool for all (100%) vulnerable children and adolescents with an unknown HIV status, and provide HIV testing if needed. Community and household-based interventions for HIV-infected OVC and their families will continue to include: nutritional support, regular home visits, links to robust educational support, health card verification for missed appointments, pill counts, and facilitated support groups for caregiver and adolescent PLHIV, age-appropriate disclosure support for children or adolescents living with HIV, and household economic strengthening. The primary objective of this package is to heighten greater well-being, provide the conditions for children to thrive and focus on retention, adherence, and viral load suppression.

In coordination with DREAMS-like implementation, OVC programs will strengthen violence prevention and response, including for GBV. The approach for preventing sexual violence and HIV risk among girls 9-14 years will include: reinforcement of community awareness, case identification and reporting by the community and school GBV committees; improving violence risk screening through active and early detection of girls facing GBV, especially rape; improving access to post-GBV care by raising awareness of available post-exposure care services among DREAMS beneficiaries; ensuring systematic referral from community to health facility and providing non-medical assistance to victims such as police or psychosocial support; increasing coverage of educational support; increasing parenting support and household economic strengthening. The program is collaborating with the MFPES, GF and UNICEF to strengthen community structures. Mentor-led clubs and community mobilization for norms change will continue in DREAMS-like implementation areas.

OVC programs have evolved over time and now incorporate economic strengthening of the household as a key element to build coping and care capacities of caregivers of children affected by HIV/AIDS. PEPFAR-CI will use a graduation approach with two main strategies. The first strategy will focus self-sufficiency of the household by involving caregivers in Village Loan and Saving Association (VLSA). VLSA has shown to be a sustainable approach in the PEPFAR-CI program. Most of VLSA created in FY17 are still functioning without external assistance. VSLA members save and invest enough money to allow beneficiaries themselves to provide care to their children and adolescent girls. The second graduation approach employs a capacity building or skills transfer approach. The program will place emphasis on transferring parenting skills to OVC parents/caregivers and improving their economic status for self-sufficiency.

PEPFAR-CI's partners will continue to implement and routinely monitor the OVC case management plan, as well as assess the achievement of graduation benchmarks for enrolled OVC and families, in order to graduate self-sufficient households. A specific exit plan will be developed for each OVC and their household based on their context and needs. Graduation benchmarks and the logic model developed by PEPFAR-CI will be adapted and implemented at national level under PNOEV. A map of interventions from GOCI or others donors, targeting vulnerable children will be conducted to support systematic referrals. In COP 18 the rate of graduated OVC and family is expected to increase to 12%.

PEPFAR-CI will continue to build the capacity of social centers and community-based partners as critical service delivery points for OVC interventions. These efforts will include the harmonization of eligibility criteria and tools and the development of partnerships with the different gateways to identify and include highly vulnerable children and adolescents in OVC programs identified above.

The PN-OEV, under the Ministry of Solidarity, Women, and Child Protection (MSFPE), is the central entity that oversees the coordination of OVC interventions. In close collaboration with the PEPFAR-CI team, the PN-OEV will organize regular coordination meetings to share new guidance, best practices, and harmonized tools and strategies with IPs and to monitor results and evaluate the quality of services provided. A quarterly data analysis will take place with IPs, the national program, and the PEPFAR-CI team, with a focus on data use for decision-making. At the regional level, coordination will include health facilities and community stakeholders to ensure implementation of an optimal package of services to respond to the needs of beneficiaries.

PEPFAR-CI started DREAMS-like interventions in FY18 in four districts, Cocody-Bingerville, Abobo Est, Man, and Daloa, selected based on indicators reflecting high HIV vulnerability among AGYW:

- Highest GBV prevalence (4.4% - 8.3%)
- Highest HIV prevalence among AGYW (2.2% - 5.1%)
- Highest adolescent pregnancy rate (22.65% - 29.1%)
- Lowest school attendance rate for AGYW ages 10-18 (7.4% - 41.3%)
- Lowest AGYW Family Planning use (14.5% - 29.2%)

In FY19, DREAMS-like districts and targets remain the same as in FY18, with a slight shift of targets to increase the proportion of the 9-14 age bands. FY19 will feature an emphasis on risk avoidance for 9-14 year olds and risk reduction for 15 to 19 year olds, with a strong curriculum on sexual education with-social assets building and age-specific prevention messaging and referrals for SRH services as needed. Caregivers will participate in positive parenting specific for adolescents, and community partners will promote norms change, especially around violence prevention, through an evidence-based curriculum. These interventions will reinforce the creation of a safe environment for girls inside their family and in their community. DREAMS-like interventions will leverage existing platforms such as OVC programs, HTS, sexual and reproductive health, ANC, and other prevention programs. Through a mentoring system for AGYW and family and community interventions, DREAMS-like activities will increase awareness and skills to prevent and respond to GBV for girls.

Both the OVC and DREAMS-like programs will draw upon data from the Violence Against Children Survey (VACS), on the prevalence of physical, emotional, and sexual violence among AGYW as well as the factors that protect and place AGYW at risk for GBV. Preliminary results, expected at the end of the calendar year 2018, will also contribute to defining the main factors of vulnerability in Côte d'Ivoire as well as identifying and addressing gaps in GBV screening and post-GBV care. The Post-VACS data-to-action workshops will take place during FY19. Data-to-action workshops help support the GOCI by working through a multi-sector task force to bring key leaders from a wide range of government ministries, CSOs, and global organizations together to help link VACS data to the INSPIRE technical package. INSPIRE is a collection of strategies that have shown success in reducing violence against children in various contexts. The main domains of the INSPIRE package consist of: implementation and enforcement of laws; norms and values; safe environments; parent and caregiver support; income and economic strengthening; response and support services; and education and life skills.

The multi-sector task force will lead the development of a comprehensive, national plan to prevent violence against children. After the development and validation of the national plan, partners will continue to work together to implement and monitor stated activities and expand prevention

efforts. Turning data into action require efforts from many stakeholders. The VACS Data to Action (D2A) Tool offers a bridge between collecting VACS data and acting on it. It draws on the INSPIRE technical package to reinforce caregiver and family capacity for self-sufficiency. Toward this end, it links transversally to PMTCT, HTS, prevention, and care and treatment programs in priority zones to support the GOCI in reaching epidemic control. PEPFAR-CI's approaches align with government guidelines for child protection and complement activities from other OVC actors, including the GF and UNICEF. The final goal of the OVC Core Program Areas is to ensure that children and their families are "Healthy, Schooled, Stable and Safe", with improved child and family well-being.

Key and Populations

In FY19, KP interventions will continue to target MSM, FSW, and Transgender Individuals, with an expansion from 49 to 54 sites to reach more underserved areas. The KP program is aligned with the sites containing the highest estimated KP populations and HIV prevalence. PEPFAR-CI will use the results of CIPHIA, expected in December 2018 with preliminary results in June 2018, to adjust interventions and locations for these populations.

A gap remains in terms of reaching HIV-positive KP. FY17 PEPFAR program data analysis shows that the following key challenges remain to achieve epidemic control among these populations:

- Low case finding (8% for FSW, 10% for MSM), particularly among age bands over forty years old
- Low linkage to ART treatment (65 % for FSW and 85 % for MSM)
- High mobility of FSW, especially in areas with high economic activity (eg, cocoa plantations, mines)

The KP program will contribute to reaching epidemic control through aggressive and evidenced-based strategies to better reach those most hidden. The program is tailoring prevention and HIV testing services for MSM and FSW over 40 years old among whom only 1.2% of FSW are enrolled on ART. Of the estimated 12,444 KP,[11] 5,173 have tested positive since FY15 through PEPFAR-supported programs. Previous strategies have faced challenges with finding positive cases, with only 71.6% of MSM and 59% of FSW tested in FY18 compared to targets

FY19 will target FSW who have been hard to reach and underserved in previous implementation periods, particularly those who work in brothels. The KP programs will also increase the engagement of brothel managers (pimps and queen mothers) and the bodyguards of FSW by involving them in the program through sensitization and providing condoms and lubricants. This will allow the KP program to access the FSW who work in brothels, which the program does not currently reach.

Optimized KP approaches developed since FY17 such as risk assessment tools, the Enhanced Peer Outreach Approach (EPOA), and index testing will be combined, replicated and/or scaled across all KP sites with new approaches in FY18, notably self-testing, to reach the goal of increasing case finding among KP. IP work plans will incorporate the EPOA as a routine activity.

[11] PEPFAR programmatic data, Mid-term Evaluation Heartland Alliance Project, 2016

To efficiently increase case finding, IPs are systematically assessing the HIV risk of all KP program beneficiaries before proposing HIV testing to them and their sexual partners. The implementation of the risk assessment tool in some sites in FY17 showed success in decreasing the total volume of HTS among KP (minimizing unnecessary retesting of KP) while increasing positive yield.

PEPFAR-CI's KP program will combine traditional peer outreach approaches with impactful, innovative approaches such as the EPOA, a performance-based incentive that employs peer mobilizers to reach peers in their social and sexual networks, and encourage them to get tested and linked to treatment. In FY17, PEPFAR-CI conducted the EPOA strategy in 14 FSW sites and eight MSM underperforming sites; the intervention resulted in a positive yield of approximately 22% for both populations.

FY18 Q1 results show a yield of 17% through index testing, of which IPs will monitor the scale-up with fidelity across all KP sites. The program will couple index testing with self-testing to reach the most hidden MSM as well as stable partners of FSW. Peer navigators will give self-test kits to HIV-infected FSWs for distribution to their stable partners, and to HIV-infected MSM for their most hidden partners. Peer navigators will receive training on the self-testing protocol and on post-distribution key messages about the availability and accessibility of KP-friendly services for self-test kits beneficiaries.

The implementation of self-testing is starting in FY18 Q3 in 14 Scale-up to Saturation Districts; PEPFAR-CI will scale up the approach in all remaining districts with KP programming at the beginning of FY19, in both facility and community settings through NGOs/CBOs, Drop In Centers, and hot spots. Since the last revision of the national HTS guidelines in 2016, the MSHP has adopted self-testing and is currently developing standardized guidelines to handout to service delivery providers. The national HTS TWG is also proceeding to validate the WHO-recommended OraQuick as the preferred self-test kit.

In FY19, PEPFAR-CI will introduce point-of-care recency testing among KP newly diagnosed with HIV infection in Abidjan, and will expand the recent infection surveillance system nationally to all newly diagnosed PLHIV over the following years. PEPFAR-CI will continue to look for opportunities to expand recency testing, particularly to include recency testing for men and other priority populations in COP19.

FY19 will intensify routine training and coaching of community testing providers to ensure linkage of all positively tested KP to treatment services, and strengthen site level supervision to monitor successful active referral and same day initiation for treatment.

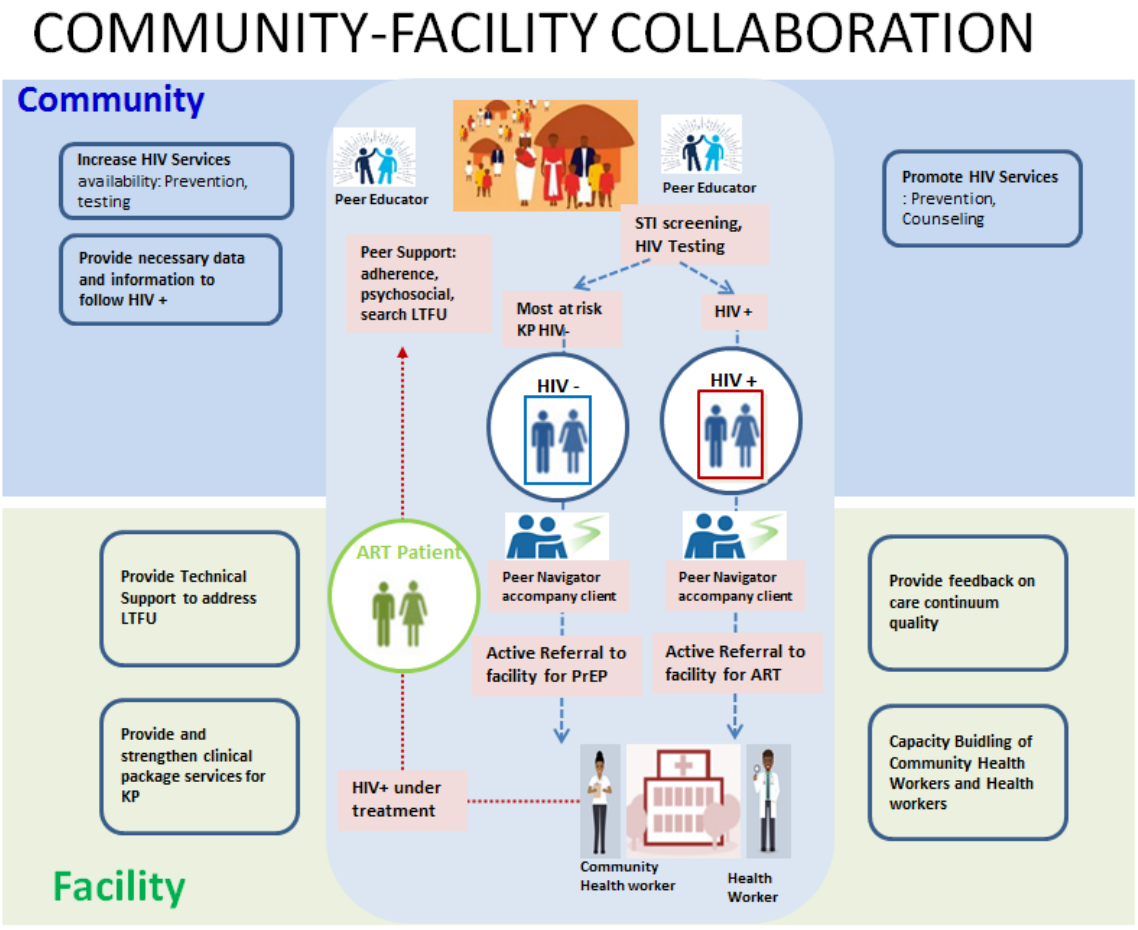
Another recent change in national approach is the MSHP endorsement of pre-exposure prophylaxis (PrEP) in February 2018. IPs are pre-testing PrEP acceptability among FSW and MSM during FY18 by increasing PrEP literacy among providers, initiation of PrEP demand creation for both providers and beneficiaries while assessing PrEP acceptability.

Lessons learned from this pre-test will help to design the strategy (implementing areas, methods, targets, and supply chain) for expanded implementation in FY19. The program will prioritize PrEP for 1,176 MSM and 1,017 FSW who are HIV-negative and most at risk, such as those who are not systematically using condoms.

To improve the low linkage rate of 60% among FSW and address FSW mobility, PEPFAR-CI will assist the MSHP to set up the unique identifier code system based on the National Electronic Medical Records (EMR) (SIGDEP2). The number of peer navigators will also increase to align to the national ratio as defined in the national KP cascade assessment in 2017 (from 1/64 currently to the national ratio of 1/40 FSW peer navigators, and from 1/49 to 1/30 MSM peer navigators).

During FY19, PEPFAR-CI will also support the GOCI to address human rights issues and institutional barriers against KP by extending training on stigma free service provision to health care workers and social workers in public health facilities, and will provide training on KP-friendly services to reduce stigma and discrimination. The KP sensitivity training will reinforce the capacity of health care workers in public health facilities and social workers providing KP friendly services. The SMS2/Rapid Pro online tool for client satisfaction and stigma monitoring will help to adapt the training curricula as described in the HIV/AIDS Epidemic Control Solutions platform. The Legal Environment Assessment has been completed, with a stakeholder validation workshop expected in May 2018.

PEPFAR-CI is also reinforcing coordination and collaboration between community and clinical IPs by developing MOUs, supporting regular meetings, supporting health facility-based peer educators dedicated to linkage activities, and integrating KP indicators into tools used in clinical settings. The MOU between clinical and community IPs ensure that clinical staff from KP-friendly health centers are trained on stigma-free (KP-sensitive) HIV management, and are able to provide HIV services adapted to KP needs. Regular information sharing (for example. list and contact information of lost to follow up patient) and decision-making meetings bring together health care providers and community health organization staff in order to operationalize and routinize the collaboration. The schema below demonstrates the community-facility flow of services available to the KP client.



Community engagement to support KP outreach can also benefit from increased collaboration with indigenous organizations that work outside of HIV; the CSO platforms and umbrella organizations in Côte d'Ivoire with whom PEPFAR-CI has quarterly exchanges include those that focus on HIV as well as those that intervene in other health and disease programs, presenting an opportunity for extended reach beyond HIV-specific indigenous groups.

Prevention of mother to child transmission (PMTCT)

PEPFAR-CI's PMTCT program continues to be strong with 96% coverage of HIV services among pregnant and breastfeeding women. The program is in line to achieving the National Strategic Plan (PSN) of a MTCT transmission rate of 2% by 2020.

Outstanding gaps in the program include low coverage of EID at two months of age, low uptake of VL testing among pregnant and breastfeeding women, lack of a specific program for adolescent pregnant women and low yield PMTCT health facilities.

To improve access to EID services in FY19, PEPFAR-CI will supplement the current UNITAID point-of-care (POC) DNA PCR testing in 167 PMTCT facilities with support to an additional 90 large-

volume PMTCT facilities in the Scale-Up Districts with POC DNA PCR testing. PEPFAR-CI will also support the implementation of a defined package of care for HIV-positive postpartum women and their infants. This package will integrate maternal and infant services, align HIV-related services with immunization services, and ensure follow-up or tracking of mother-infant pairs by CHWs.

To improve retention and viral suppression for pregnant and breastfeeding HIV-positive women, PEPFAR-CI will expand the use of the enhanced PMTCT monitoring indicators to involve more health facilities from the current 28 reporting sites. Working through the Ministry of Health (PNLS), PEPFAR-CI will train and incorporate the use of enhanced PMTCT monitoring indicators in high volume PMTCT sites in scale-up priority districts. The PMTCT monitoring indicators will be collected monthly at site level by IPs, and in collaboration with health district teams will analyze data to identify gaps and challenges, and provide feedback to the site. PEPFAR -CI will develop and scale-up a specific VL algorithm for pregnant and breastfeeding women.

In alignment with age-specific programming occurring in other technical areas, PEPFAR-CI will develop approaches to address the needs of adolescent pregnant and breastfeeding women by setting up adolescent specific services in MCH services thus, reinforcing healthcare providers' capacity to provide sexual and reproductive health services to adolescents. The PMTCT program will also link these beneficiaries to OVC and/or DREAMS-like interventions. Facility/community PMTCT programs will also be selectively co-located with OVC programs to influence and enhance social support services for HIV-exposed and infected children.

PEPFAR-CI is reviewing barriers to low uptake and retention in ANC/PMTCT programs in scale-up districts, and is exploring the replication of mobile phone use and CHW home visits, congregational-based intervention (baby shower program), and community-based action group which have shown to be impactful. PEPFAR-CI will continue to support CHWs and lay counselors in facility and community settings to encourage increased participation in ANC. PEPFAR-CI will increase the "advanced strategy" approach of ANC whereby health workers extend outreach deeper into the community, and couple it with services for vaccination, nutrition, and curative consultations. FY19 will also support efforts to execute a training manual for community actors on the socio-cultural barriers to PMCT as well as conduct training of providers on the psychosocial needs of patients. In FY19, the program will strengthen support for peer support groups among mothers and adolescents to ensure that they are function in all high-volume PMTCT facilities in scale-up districts. PEPFAR-CI initiated the baby shower program in FY18 to support ANC uptake and male partner involvement, and will continue to monitor whether this intervention merits rapid replication.

4.3 Implementing Partner Management

In FY17, PEPFAR-CI initiated steps towards a robust and more real-time monitoring of IPs. The program began collecting monthly results on the number of HIV-positive individuals identified and the number of HIV-positive individuals linked to ART among men, children, and KP, for interagency program reviews.

In order to ensure alignment with evolving program strategies for optimal success of the national HIV program, PEPFAR-CI will continue quarterly meetings with IPs in FY18 to share data on current program coverage gaps by target population and geographic location, and include discussion on alignment of technical achievement, financial performance and quality (SIMS) data with each IP.

The first discussion on FY18 Q2 results will include the required program and budget changes in current FY18 work plans and agreement on expected performance levels for FY18 Q3-Q4 in order to set the path for a successful FY19.

These revised FY18 work plans are the starting point to develop FY19 work plans based on new strategic objectives, geographic priorities, and target distribution. At a minimum, both FY18 and FY19 work plans will incorporate, as appropriate to the scope of work of each IP, the key approaches identified for each priority program area along the clinical cascade, and for each priority sub-population. The IPs will consistently apply these strategies, with fidelity, across their sites and in line with approved budget parameters.

PEPFAR-CI team is also developing a performance review calendar with actions to verify that each IP has started implementing the new agreed upon strategies and approaches identified to achieve the intended results.

While quarterly partner performance management lies with an interagency team, each USG agency is responsible for managing its respective awards to ensure optimal success of the program. At present, PEPFAR monitoring primarily relies on data and other reports provided by the IPs themselves without a national data quality process and without sufficient site-level reality by the country team. Since FY17, PEPFAR-CI is assisting the MSPH in elaborating a national data quality assurance protocol, which will be implemented nationally starting in June 2018. Effective FY18 Q3, the PEPFAR-CI team will implement a new model of monitoring which includes:

- Optimized site-level presence both for quality assurance and accountability
- Real time progress monitoring and decision making for corrective action, using benchmarks to measure outlays against technical achievement
- Reallocation of resources to respond to program challenges as needed
- Routine analysis of root causes of underperformance

SIMS, newly initiated targeted site supervision visits, and financial monitoring visits to IPs by the PEPFAR-CI team will help improve site-level performance and ensure proper financial investments.

In order to track and report on progress in implementing these strategies, the project team will meet monthly to review IP outcomes by site and suggest revisions/updates to IP work plan as necessary to catch-up on performance gaps. When necessary, PEPFAR-CI will organize ad hoc site visits jointly with PNLS to follow up on specific issues identified during the routine reviews and have corrective actions ready for reporting during the following POART.

When partner performance is of concern, PEPFAR CI management teams will increase the frequency of the review of results to weekly remediation actions, utilizing frequent benchmarks to monitor progress. Lessons learned from other successful partners as well any strategic technical shifts will be included in the remediation strategy. Over-spending will neither be approved nor accepted. If spending is outpacing target achievement or monthly burn rate toward the approved annual budget, a financial remediation plan will be enacted.

In cases of prolonged underperformance by a partner, agencies will be responsible for enforcing time bound (no more than 90 day) performance improvement plans using their agency-specific standardized procedures.

There may be situations, either epidemiological or related to partner performance, that require shifting funds from one partner to another or from a site to another. In this case, PEPFAR CI plans to submit reprogramming requests in the hopes to make these adjustments in a timely manner.

Another key element of success for COP implementation is the need for strong coordination by the MSHP at central and regional/district levels. POART calls will include the PNLS, which will be taking a more active part in the periodic assessment of progress and decision-making of corrective action. PEPFAR-CI technical advisors will schedule regular in-person presence with their technical homologues at the MSHP to ensure real-time communication on implementation challenges and provide TA as needed.

The PEPFAR-CI team also fully engages in regular coordination meetings - either through actual presence or through financial and logistical support as reflected in Table 6 - between the MSHP, PNLS, and IPs. The MSHP itself, through the Director General of Health and the PNLS, have started convening stakeholder meetings to review regional level results with the PTFs and IPs, as of March 2018.

The PTFs and PEPFAR-CI have been advocating for greater accountability to program outcomes among regional and district health officers. PEPFAR-CI is working with the MSHP and other stakeholders to ensure that all health regional and district teams understand the newly adopted strategies and include them in their supervision plans. PEPFAR-CI will join the PTFs in providing technical and financial support for the training of district health officers, as part of the planned health district reform led by MSPH.

4.4 Commodities

Starting in October 2018, the MSHP will implement a plan to transition patients on to TLD as the preferred first-line ART regimen in the National HIV Guidelines. The transition plan prioritizes TLD for all HIV-positive adults and children (>30 kg) newly initiating ART, and all existing adults and children (>30 kg) already on ART with suppressed VL. It is expected that 87% of ART patients will be on TLD by the end of FY19. In the event that the first TLD shipment does not arrive in country before September 2018, PEPFAR-CI in collaboration has developed a contingency TLD transition plan, which reflects a later arrival of TLD stock in the country with a start date of Q3FY19.

FY19 commodities budget accounts for the TLD Transition Plan and supports PEFAR-CI's programmatic strategy. It includes other new commodities: HIV recency testing, isoniazid and pyridoxine for TB patients, and Geenius HIV tests to improve the diagnosis of HIV2 patients. Based on the announced pledged levels of the major donors reflected in Table 2.2.2.b and the expectation of minimal disruption during the execution of the national supply plan, PEPFAR-CI does not anticipates no funding gaps nor any national commodities stock-outs or shortages during FY19.

During FY17, delayed funds disbursements by the GOCI prevented the procurement entity for the MSHP, the National Medical Stores, from adhering to the validated supply plan schedule. The joint quantification and supply plan technical working group made several adjustments in the supply plan to avoid disruptions in commodity delivery and availability. The new commodities profile imposes the need for a robust coordination of procurements and a rigorous monitoring of supply plans. PEPFAR-CI will continue to strengthen the capacity of National Coordinating Committee for

the Procurement of Medication and Biological Products, to provide adequate oversight of quantifications and supply planning process.

4.5 Collaboration, Integration and Monitoring

PEPFAR-CI has put in place multiple mechanisms to address challenges across the entire clinical cascade.

PEPFAR-CI regularly tracks progress of the clinical cascade, down to the level of SNU and IP, with special attention paid to Scale-Up Districts; starting in FY18, during this FY19 period the program will place more focus on five districts with the major gaps on the first and second 90 for men and children. The internal interagency sub-structure underwent a reorientation in August 2017 from programmatically focused TWGs to population-based TWGs, especially for men, pediatrics and pregnant women, OVC and AGYW, and KP. These groups now have an explicit monthly task to conduct program reviews based on monthly partner results and discussions across the cascade (prevention, HTS, linkage, treatment, adherence, as applicable) for each of these groups. Weekly strategy meetings with the technical branch/team leads and heads of the four implementing agencies in Côte d'Ivoire provide a platform for TWGs to present analysis for a higher level of discussion that might lead to changes in program direction.

IPs engaging in HTS activities, both at the facility and in the community, are additionally receiving PEPFAR weekly support to follow up on yield results. PEPFAR-CI will base this exercise on a dashboard developed by CDC Atlanta, which triangulates yield with expenditure data. Quarterly data submissions and the subsequent POART reviews provide a further opportunity every quarter to monitor SNU and partner-level achievement against targets, and also reassess the cascade of testing and treatment by SNU and by partner. This quarterly implementation review is enhanced by quality results from required Site Improvement Monitoring System visits, which are particularly concentrated in Scale-Up Districts where prioritized high volume sites are located.

Cross-technical collaboration with external stakeholders - notably the PNLS, PN-OEV, and MOD as the key government interlocutors, and the GF as the other principal donor to HIV - occur regularly throughout the month and year. In addition to program-specific coordination meetings led by the PNLS, the MSHP will institute in calendar year 2018, routine cross-program reviews through a newly created Technical Committee for the Fight Against AIDS (CTLS). The CTLS will meet every two to three months, and is comprised of technical experts from multiple line ministries, CSOs, and PTFs. Actions and decisions resulting from CTLS consultations move upward to a Coordinating Committee for the Fight Against AIDS (CCLS), chaired by the Minister of Health, which engages a higher level of decision-makers such as Chiefs of Mission and government agency directors. PEPFAR-CI will be an active, regular member of the CTLS, and will encourage the Front Office to be an equally active participant in the CCLS. This new schema came into being partly from continuous advocacy by PEPFAR-CI, the GF, and the United Nations family for increased effort by the GOCI to pull together all the contributors to the national HIV response for routine, joint programmatic monitoring and discussion.

PEPFAR-CI also conducts technical meetings directly with the GF Principal Recipients (PNLS and Alliance-CI) to discuss the optimal programmatic strategies for the country, maximizing investments from donors at both clinical and community levels. These efforts have included integrated mapping of community activities of both donors, and agreements on contributions to

cover the national HIV drug needs. Continuous communication on programmatic issues, including ongoing priorities in PEPFAR programming and COP-specific planning of targets and budgets, has ensured comprehensive community and clinical approaches as well as complementarity of investment and efforts in supply chain and policy issues.

To prepare for the GF HIV grant proposal for the 2018-2020 grant period, the MSHP, PEPFAR, and the GF conducted joint situational (data and programmatic) analyses. These exercises utilized programmatic findings that fed into the preparation of the PSN 2016-2020 and harmonized data sources and target-setting. One of the results was the projected clinical cascade for FY18 that serves as the basis for both FY18 and the GF 2018-2020 propsosal.

In FY19, PEPFAR-CI will continue to provide support for human resources for health to ensure implementation along the clinical cascade. The program has allocated resources to improve adherence and outreach into the community, and monitoring of task-shifting for care and treatment. To address challenges with the final phase of the clinical cascade, and building on the last year success, PEPFAR-CI will continue to work along with the MSHP to address access and uptake of VL testing, with emphasis on practices that have yielded good results on increasing VL testing coverage. These include: 24 hour shifts at laboratories; VL scorecards, dashboards and focal points at each clinical site in addition to increased lab staff at both clinical and lab sites; and monthly site-level lab data reporting and monitoring. The establishment of lab hubs for pre-analytic work will reduce turnaround time and substantially increase VL testing access in Scale-Up Districts, especially for women and pediatrics.

4.6 Targets for scale-up locations and populations

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 (APR19) *HTS_TST***	**Newly Identified Positive (APR19) *HTS_TST_POS***	**Newly Initiated on ART (APR19) *TX_NEW***
Total Men	571,911	44,853	54,704
Total Women	879,421	41,773	43,956
Total Children (<15)	347,071	9,231	9,747
Adults			
TB Patients	19,469	1,468	1,361
Pregnant Women	434,131	5,560	5,446
VMMC clients	n/a	n/a	n/a
Key Populations	40,545	6,023	5,722
Priority Populations (including OVC)	100,237	4,114	3,908
Other Testing	1,217,934	78,951	75,003
Previously diagnosed and/or in care	n/a	n/a	14,799
Pediatrics (<15)			
HIV Exposed Infants	10,632	1,024	978
Other pediatric testing	265,750	9,231	9,747
Previously diagnosed and/or in care	n/a	n/a	1,462

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate** (scale-up **SNUs**)	**Coverage Goal (in FY18)**	**FY19 Target**
Females 15-24	1,606,876	10.1%	38,600
Females 25+	2,845,450	0.0%	37,957
Males 15-24	1,605,181	0.0%	24,888
Males 25+	3,306,773	4.0%	84,161
Total PP_PREV	**9,364,280**	**3.2%**	**185,606**
MSM	22,800	65.0%	23,698
TG	NA	NA	263
FSW	37,171	159.4%	36,459
TOTAL KP_PREV	**59,971**	**123.3%**	**60,420**

Table 4.6.4 Targets for OVC and Linkages to HIV Services (All Districts, Including New Saturation)			
SNU	**Estimated # of OVC**	**Target # of Active OVC (FY19 Target) OVC_SERV (<18 and >18)**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC_HIVSTAT (<18 only)**
Not Defined	**15,058**	**3,508**	**2,728**
Aboisso	7,278	2,434	1,893
Adiake	3,292	0	0
Grand-Bassam	4,488	1,074	835
Scale-Up Agg	**171,822**	**114,527**	**89,077**
Adjame-Plateau-Attecoube	20,059	16,097	12,520
Adzope	9,473	2,873	2,235
Agboville	9,420	4,678	3,638
Akoupe	5,364	2,535	1,972
Anyama	5,275	3,390	2,637
Bangolo	4,838	3,359	2,613
Bongouanou	8,166	6,904	5,370
Bouake-Nord-Est	5,525	6,401	4,979
Divo	7,124	8,964	6,972
Duekoue	8,095	7,063	5,493
Guiglo	5,902	5,695	4,430
Guitry	2,635	790	614
Koumassi-Port Bouet-Vridi	20,185	14,401	11,201
Mankono	4,673	3,511	2,730
Oume	5,245	3,887	3,023
Sassandra	4,552	1,873	1,456
Sinfra	4,542	4,073	3,168
Soubre	17,537	5,036	3,917
Tabou	7,388	3,721	2,894
Tiassale	5,985	4,775	3,714
Yamoussoukro	9,839	4,501	3,501
Scale-Up Sat	180,729	132,060	115,146
Abengourou	7,630	3,310	2,574
Abobo-Est	12,942	9,112	11,749
Abobo-Ouest	11,402	5,055	3,932
Bondoukou	6,170	9,035	7,027
Bouafle	6,312	3,622	2,817
Bouake-Nord-Ouest	9,101	8,144	6,334
Bouake-Sud	5,717	4,668	3,631
Cocody-Bingerville	11,748	11,711	11,595
Dabou	5,900	3,296	2,563
Daloa	10,484	7,651	9,292
Gagnoa	9,293	6,448	5,015
Issia	5,231	2,625	2,041
Korhogo	10,363	17,113	13,310
Man	7,021	6,059	6,655
San-Pedro	12,917	6,686	5,200
Tanda	5,632	7,542	5,866
Treichville-Marcory	11,378	7,104	5,525
Yopougon-Est	14,191	8,684	6,754

Table 4.6.4 Targets for OVC and Linkages to HIV Services (All Districts, Including New Saturation)			
SNU	**Estimated # of OVC**	**Target # of Active OVC (FY19 Target) OVC_SERV (<18 and >18)**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC_HIVSTAT (<18 only)**
Yopougon-Ouest-Songon	17,296	4,195	3,263
Sustained	**108,782**	**7,775**	**6,048**
Agnibilekrou	3,820	196	153
Alepe	3,701	0	0
Beoumi	3,320	0	0
Bettie	1,411	0	0
Biankouma	2,460	0	0
Blolequin	2,991	0	0
Bocanda	2,017	0	0
Bouna	3,568	1,391	1,082
Boundiali	2,421	0	0
Dabakala	3,929	132	103
Danane	4,021	462	359
Daoukro	4,202	0	0
Didievi	1,662	24	19
Dimbokro	1,949	1,667	1,296
Ferkessedougou	3,792	0	0
Fresco	2,779	0	0
Grand-Lahou	2,575	0	0
Gueyo	2,402	0	0
Jacqueville	2,008	534	415
Katiola	3,858	0	0
Kouibly	3,498	0	0
Lakota	3,198	45	35
M'bahiakro	1,629	993	772
Minignan	1,467	0	0
Nassian	595	0	0
Niakaramadougou	3,920	0	0
Odienne	3,538	610	475
Ouangolodougou	2,641	0	0
Prikro	1,322	212	165
Sakassou	1,636	0	0
seguela	3,446	285	222
Sikensi	2,213	0	0
Tengrela	488	0	0
Tiebissou	2,319	0	0
Touba	3,008	1,224	952
Toulepleu	1,614	0	0
Toumodi	3,718	0	0
Vavoua	4,184	0	0
Zouhan Hounien	3,359	0	0
Zuenoula	2,103	0	0
Total	**476,391**	**257,870**	**212,999**

Table 4.6.4 Targets for OVC and Linkages to HIV Services (Scale-Up Districts Only, Including New Saturation)			
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of Active OVC (FY19 Target) OVC_SERV (<18 and >18)**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY19 Target) OVC_HIVSTAT (<18 only)**
Scale-Up Agg	**171,822**	**114,527**	**89,077**
Adjame-Plateau-Attecoube	20,059	16,097	12,520
Adzope	9,473	2,873	2,235
Agboville	9,420	4,678	3,638
Akoupe	5,364	2,535	1,972
Anyama	5,275	3,390	2,637
Bangolo	4,838	3,359	2,613
Bongouanou	8,166	6,904	5,370
Bouake-Nord-Est	5,525	6,401	4,979
Divo	7,124	8,964	6,972
Duekoue	8,095	7,063	5,493
Guiglo	5,902	5,695	4,430
Guitry	2,635	790	614
Koumassi-Port Bouet-Vridi	20,185	14,401	11,201
Mankono	4,673	3,511	2,730
Oume	5,245	3,887	3,023
Sassandra	4,552	1,873	1,456
Sinfra	4,542	4,073	3,168
Soubre	17,537	5,036	3,917
Tabou	7,388	3,721	2,894
Tiassale	5,985	4,775	3,714
Yamoussoukro	9,839	4,501	3,501
Scale-Up Sat	**180,729**	**132,060**	**115,146**
Abengourou	7,630	3,310	2,574
Abobo-Est	12,942	9,112	11,749
Abobo-Ouest	11,402	5,055	3,932
Bondoukou	6,170	9,035	7,027
Bouafle	6,312	3,622	2,817
Bouake-Nord-Ouest	9,101	8,144	6,334
Bouake-Sud	5,717	4,668	3,631
Cocody-Bingerville	11,748	11,711	11,595
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Issia	5,231	2,625	2,041
Korhogo	10,363	17,113	13,310
Man	7,021	6,059	6,655
San-Pedro	12,917	6,686	5,200
Tanda	5,632	7,542	5,866
Treichville-Marcory	11,378	7,104	5,525
Yopougon-Est	14,191	8,684	6,754
Yopougon-Ouest-Songon	17,296	4,195	3,263
Total	**352,551**	**246,587**	**204,223**

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

5.1 FY19 Programmatic Priorities in attained and sustained districts and populations

As the volume of HIV-positive individuals expected in Sustained Districts is significantly lower per district, PEPFAR-CI has a reduced effort in case finding in these locations except for KP hotspots. Community-based HTS does not take place in Sustained Districts, except for KP in those select areas. While KP prevention activities continue in targeted areas in Sustained Districts, there are no other prevention activities for any other population.

However, Sustained Districts still have HIV-positive individuals, so the program continues to ensure strong linkage of those individuals to care, treatment, and retention interventions, and to provide VL testing access to monitor their suppression. Corresponding lab and supply chain strengthening occurs in Sustained locations as in Scale-up locations in order to adequately serve patients on ART.

At the end of FY17, PEPFAR-CI completed its transition to the PN-OEV of OVC direct service delivery in Sustained Districts. Beginning in FY18 and continuing into FY19, PEPFAR is exclusively supporting a TA approach for the OVC program in Sustained Districts

5.2 Targets for attained and sustained locations and populations

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

Sustained Support Volume by Group		**Expected result APR18**	**Expected result APR19**
HIV testing in PMTCT sites	*PMTCT_STAT*	**131,690**	**197,564**
HTS (only sustained ART sites in FY17)	*HTS_TST/HTS_TST_POS*	**351,789/27,955**	**459,046/19,565**
Current on ART	*TX_CURR*	**46,585**	**62,844**
OVC	*OVC_SERV*	**55,953**	**8,638**

5.3 Establishing service packages to meet targets in attained and sustained districts

PEPFAR-CI will continue to maintain the minimum package of quality of care and treatment services to ensure the retention of patients on ART in Sustained Districts as well as the four targeted to be Attained by the end of FY18, with the same care and treatment services in all districts for PLHIV, KP, TB/HIV co-infected individuals while limiting prevention activities and HTS. PEPFAR-CI's support for existing facility-based staffing will not increase nor will the program extend into new clinical or community sites in these areas.

In addition to quarterly supervision visits from IPs, the maintenance package in Sustained and Attained Districts will encompass support for the following:

- HTS: targeted HTS for KP in hot spots; index testing targeting HIV infected sexual partners, biological children of HIV infected mothers and siblings of HIV infected children; HTS for patients with AIDS symptoms; linkages and referrals to care and treatment; commodity supply chain support
- ART: ARV prescription and provision; clinical monitoring; commodity supply chain support; task-sharing support; active retention activities; adolescent peer support groups
- Care Services: community-based retention/continuum of care linkages; cotrimoxazole; TB screening; Positive Health, Dignity, Prevention package including condoms; NACS for children; commodity supply chain support
- PMTCT: all interventions under ART and Care services at high yield sites only (>4 HIV-positive pregnant women diagnosed per year); family planning integration; testing of sexual partners and children of HIV-infected pregnant and breastfeeding women
- Laboratory: CD_4 at baseline, hematology, VL testing referrals, quality management systems; maintenance of lab equipment and existing laboratory information systems; lab reagents supply chain support
- SI/M&E: strengthening of the national surveillance system for HIV case notification; provision of paper-based data collection tools; support of existing electronic laboratory information system; quarterly data validation visits

The main assumption used to determine expected volume in Sustained Districts was the passive enrollment of new patients on ART. Adjustments to the strategic objective cost for care and treatment by budget codes factored in reduced investments in training, coaching, staffing, minor renovations/ rehabilitation, and community outreach and mobilization. OVC interventions in Sustained Districts will be limited to the support to the PN-OEV for quarterly supervision and TA to social centers and OVC platforms.

In the Attained Districts, PEPFAR-CI will place special emphasis in outreach and demand creation for target sub-groups that may continue to face gaps across the clinical cascade. This includes continued outreach, prevention, and HTS for KP. Support for surveillance, program monitoring, and laboratory systems will continue in order to assess that the epidemic remains under control for all saturated age and sex groups.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

The majority of the systems level investments in Table 6 support the strategic objectives under the fourth pillar of PEPFAR-CI's vision for FY19 to strengthen an enabling environment for quality service delivery:

- 4.1: Enhance national capacity for governance for sustained leadership and ownership and effective health policy adoption
- 4.2:- Accelerate policy implementation through direct diplomatic engagement with the government at the national and sub-national levels
- 4.3: Bolster health systems strengthening for quality control, monitoring and real-time response
- 4.4: Aggressively reduce HIV-related stigma and discrimination as well as stigma and discrimination against KP and PLHIV that impede uptake of services across the continuum

These objectives and their corresponding above-site activities provide the foundation for the site-level, service delivery interventions supporting the three other pillars. As mentioned in the Goal Statement, all four pillars work together toward sustained epidemic control.

All Table 6 investments correspond to gaps identified through root cause analyses by PEPFAR-CI team members with stakeholders, beginning in the FY19 Strategic Planning Retreat. The vast majority of proposed activities are related to SID 3.0 elements with scores lower than six (yellow). Activities addressing weaknesses in service delivery concentrate on increasing uptake or prevention and testing among the highest risk groups, addressing barriers to service uptake among KP, and improving access and management of service delivery in the military program.

PEPFAR-CI has identified benchmarks and outcomes that are measurable and reasonable, with the intention of monitoring progress on a quarterly basis.

Laboratory

During FY19, PEPFAR-CI will focus on addressing the challenges and weaknesses identified during FY17 through the lab weekly dashboard reporting system. The lab program will specifically address the following areas that the reporting system highlighted:

- Delays in sample processing to weak human resources and infrastructure
- Long turnaround time
- Insufficient laboratory and clinical interface
- Weak clinician literacy on VL results reporting, interpretation and patient management
- Limited access of private sector clinics to VL laboratories

The PEPFAR-CI laboratory strategy of increasing access to and coverage of VL testing to 73% in FY17 was effective with operationalization of a total of 16 VL reference laboratories strategically located throughout the country in scale-up and saturation districts. High-level engagement of the MSHP resulted in an equipment placement contract to install up to 19 VL testing machine, in

addition to collaboration with the GF and the French Cooperation. These developments were key for PEPFAR-CI's ability to increase VL access and coverage from 10% to 60% of patients on ART in almost one year of implementation.

The testing capacity of the RETRO-CI lab operated by the CDC, which serves as a backup for all laboratories in the country, increased to perform about 1,000 VL tests per day. RETRO-CI has trained personnel from nine regional laboratories and established the use of DBS for better uptake in remote sites and minimization of stock-outs of VL and EID reagents. All laboratories will be operating 24 hours a day, thereby doubling their testing capacities and optimizing the VL equipment utilization. Through this increased capacity for VL testing and the transition to exclusive VL testing and utilization of DBS for sample collection, PEPFAR-CI expects a coverage of 94% by FY19.

PEPFAR-CI is addressing delays in sample processing and long turnaround times by operationalizing 50 PEPFAR-supported laboratory hubs located around the regional reference laboratories, to increase and improve laboratory pre-analytic processes. The program is rectifying insufficient access of the private sector clinics by introducing indicators in the lab weekly monitoring dashboard indicator to track access by those clinics.

Additional interventions responding to above-mentioned weaknesses include: training for health care and community health workers, with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based compensation to improve lab staff retention; effective utilization of VL testing dashboards to fast track patients with unsuppressed VL, with an emphasis on children and adolescents, and to document clinical site and laboratory performance; and laboratory information system enhancements to collect data on VL testing uptake and-real time data analysis. The program will strategically place POC EID machines to increase coverage, with the goal of increasing EID among babies aged zero to two months from 74% to 85%.

PEPFAR-CI will continue the implementation of the quality management systems program within 50 laboratories and 3000 HIV testing points that have received proficiency testing panels for HIV. PEPFAR-CI is contributing to decentralizing microbiological testing to diagnose STIs and HIV opportunistic infections to ten regional laboratories, and will provide about 10,000 of these tests to HIV-infected KP.

Supply chain

Supply chain strengthening interventions in FY19 will continue to contribute to bolstering health systems strengthening for quality control, monitoring and real-time response in Côte d'Ivoire.

Building on the prior year achievements in this area, PEPFAR-CI investments focus on support for: improved monitoring of inventory management at the lower levels of the supply chain/health system; availability of real-time and reliable supply chain/logistics data to inform ordering, stock placement, and supply chain decision-making; forecasting, planning, and implementation of the TLD transition; improved management of lab commodities at the central and subnational levels of the health/lab systems; and an effective national logistics system for assuring community-based distribution of ARVs. Table 6 includes detailed interventions. Concurrently, these activities will also assure improved coordination among stakeholders and increased ownership of local institutions of supply chain processes.

7.0 USG Management, Operations and Staffing Plan to Achieve Stated Goals

7.1 Staffing assessment

The interagency PEPFAR-CI team performed a staffing assessment in 2015 that confirmed the adequacy of the team's footprint to respond to program oversight and monitoring demands. The current PEPFAR leadership validated this determination as part of the staff planning for FY19. The main change that occurred in 2015 was the establishment of interagency TWGs across technical areas, a structure that recently underwent another reform in August 2017, where teams were divided by targeted subpopulations. Therefore, there are currently technical working groups: OVC/DREAMS, Adult cascade with focus on men, pediatric cascade, KPs; and three support groups: strategic information, health systems strengthening and financial teams. Two co-chairs (one per agency) were selected by agency heads to lead the TWGs.

7.2 Vacancies

CDC has nine vacant positions at different stages of the hiring process. The delays stem primarily from the requirement to reclassify the positions, a task assigned to the Department of State regional classification center, which was understaffed due to the hiring freeze. Key positions have recently been prioritized for processing while support to the team is being provided with TDY and remote assistance from Atlanta. It is estimated that the positions will be posted within the next few months and filled by July 2018.

[REDACTED]

USAID currently has two vacancies. The agency has completed the recruitment process for one vacancy and, pending security clearance, is expecting a start date of June 2018. The second position became vacant only two months ago; it will be posted in April 2018 with an anticipated start date in October 2018.

The PCO has one position that became vacant in December 2017, and another that will be vacant in May 2018. The first will be potentially advertised in May 2018, with an anticipated start date in December 2018. The second position has already been advertised and should be filled in the next few months.

7.3 New Positions

[REDACTED]

7.4 Major changes to the Cost of Doing Business

The overall Cost of Doing Business (CODB) in FY19 has increased by less than $72,000 from FY18. Each implementing agency underwent different internal changes. CDC maintains the same CODB level in FY19 despite converting a Locally Employed Staff position to a U.S. Direct Hire position and increasing up country travel for site supervisory visits. CODB for DOD and the PCO rise significantly, due largely to staffing changes: support for additional staff member for DOD, salary and International Cooperative Administrative Support Services (ICASS) adjustments to reflect actual expenditures for State. USAID has reduced its CODB, due also to an ICASS downward adjustment, which offsets the increases above.

APPENDIX A – Prioritization

SNU Prioritization

Table A.1: Treatment Coverage at APR17 by Age and Sex

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Military Cote d'Ivoire	COP17	Mil						
	COP18	Mil						
Abengourou	COP15	Scale-Up Agg	APR16	16%	17%	58%	29%	43%
	COP16	Scale-Up Agg	APR17	27%	30%	68%	34%	51%
	COP17	Scale-Up Sat	APR18	26%	37%	93%	47%	71%
	COP18	Scale-Up Sat	APR19	79%	105%	86%	97%	90%
Abobo-Est	COP15	Scale-Up Sat	APR16	29%	38%	84%	29%	59%
	COP16	Scale-Up Sat	APR17	36%	39%	97%	35%	68%
	COP17	Scale-Up Sat	APR18	106%	137%	131%	57%	102%
	COP18	Scale-Up Sat	APR19	109%	135%	88%	90%	90%
Abobo-Ouest	COP15	Scale-Up Sat	APR16	42%	49%	92%	39%	67%
	COP16	Scale-Up Sat	APR17	43%	42%	105%	40%	74%
	COP17	Scale-Up Sat	APR18	138%	145%	152%	66%	118%
	COP18	Scale-Up Sat	APR19	136%	168%	92%	94%	95%
Aboisso	COP15	Not Defined	APR16	0%	0%	0%	0%	0%
	COP16	Not Defined	APR17	0%	0%	0%	0%	0%
	COP17	Not Defined	APR18	0%	0%	0%	0%	0%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Not Defined	APR19	0%	0%	0%	0%	0%
Adiake	COP15	Not Defined	APR16	0%	0%	0%	0%	0%
	COP16	Not Defined	APR17	0%	0%	0%	0%	0%
	COP17	Not Defined	APR18	0%	0%	0%	0%	0%
	COP18	Not Defined	APR19	0%	0%	0%	0%	0%
Adjame-Plateau-Attecoube	COP15	Scale-Up Agg	APR16	10%	11%	51%	29%	39%
	COP16	Scale-Up Agg	APR17	13%	13%	61%	33%	47%
	COP17	Scale-Up Agg	APR18	45%	35%	72%	58%	65%
	COP18	Scale-Up Agg	APR19	82%	101%	83%	89%	86%
Adzope	COP15	Scale-Up Agg	APR16	12%	10%	19%	10%	15%
	COP16	Scale-Up Agg	APR17	21%	17%	20%	13%	17%
	COP17	Scale-Up Agg	APR18	32%	22%	56%	32%	45%
	COP18	Scale-Up Agg	APR19	79%	105%	107%	122%	111%
Agboville	COP15	Scale-Up Agg	APR16	19%	18%	33%	18%	26%
	COP16	Scale-Up Agg	APR17	25%	22%	35%	17%	27%
	COP17	Scale-Up Agg	APR18	30%	27%	57%	30%	45%
	COP18	Scale-Up Agg	APR19	79%	105%	101%	115%	105%
Agnibilekrou	COP15	Sustained	APR16	23%	23%	60%	31%	46%
	COP16	Sustained	APR17	18%	20%	64%	30%	47%
	COP17	Sustained	APR18	29%	27%	85%	44%	65%
	COP18	Sustained	APR19	57%	76%	77%	87%	80%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Akoupe	COP15	Scale-Up Agg	APR16	18%	13%	24%	18%	21%
	COP16	Scale-Up Agg	APR17	25%	21%	43%	24%	34%
	COP17	Scale-Up Agg	APR18	33%	17%	48%	36%	42%
	COP18	Scale-Up Agg	APR19	79%	105 %	85%	97%	90%
Alepe	COP15	Sustained	APR16	20%	12%	25%	14%	20%
	COP16	Sustained	APR17	28%	17%	23%	19%	21%
	COP17	Sustained	APR18	35%	21%	30%	16%	24%
	COP18	Sustained	APR19	63%	83%	66%	75%	70%
Anyama	COP15	Scale-Up Agg	APR16	13%	10%	33%	14%	24%
	COP16	Scale-Up Agg	APR17	14%	15%	43%	17%	31%
	COP17	Scale-Up Agg	APR18	33%	27%	73%	30%	53%
	COP18	Scale-Up Agg	APR19	82%	101 %	88%	93%	90%
Bangolo	COP15	Scale-Up Agg	APR16	4%	2%	15%	7%	11%
	COP16	Scale-Up Agg	APR17	3%	3%	21%	11%	16%
	COP17	Scale-Up Agg	APR18	75%	65%	48%	20%	38%
	COP18	Scale-Up Agg	APR19	78%	107 %	85%	99%	90%
Beoumi	COP15	Sustained	APR16	9%	9%	22%	13%	17%
	COP16	Sustained	APR17	12%	9%	32%	17%	24%
	COP17	Sustained	APR18	20%	22%	39%	23%	32%
	COP18	Sustained	APR19	61%	85%	101 %	120 %	105%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Bettie	COP15	Sustained	APR16	7%	16%	21%	12%	17%
	COP16	Sustained	APR17	10%	13%	22%	11%	17%
	COP17	Sustained	APR18	10%	20%	37%	21%	29%
	COP18	Sustained	APR19	63%	83%	119%	134%	120%
Biankouma	COP15	Sustained	APR16	2%	2%	30%	15%	22%
	COP16	Sustained	APR17	3%	5%	43%	20%	30%
	COP17	Sustained	APR18	11%	11%	49%	24%	37%
	COP18	Sustained	APR19	35%	48%	75%	88%	75%
Blolequin	COP15	Sustained	APR16	5%	6%	15%	5%	11%
	COP16	Sustained	APR17	6%	6%	19%	8%	14%
	COP17	Sustained	APR18	9%	11%	34%	11%	24%
	COP18	Sustained	APR19	35%	48%	75%	88%	75%
Bocanda	COP15	Sustained	APR16	14%	20%	39%	18%	29%
	COP16	Sustained	APR17	14%	14%	41%	19%	30%
	COP17	Sustained	APR18	12%	14%	60%	28%	45%
	COP18	Sustained	APR19	56%	78%	71%	84%	75%
Bondoukou	COP15	Scale-Up Agg	APR16	22%	25%	56%	22%	40%
	COP16	Scale-Up Agg	APR17	33%	34%	79%	31%	57%
	COP17	Scale-Up Sat	APR18	93%	104%	104%	40%	79%
	COP18	Scale-Up Sat	APR19	77%	111%	103%	128%	110%
Bongouanou	COP15	Scale-Up Agg	APR16	17%	14%	45%	19%	32%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP16	Scale-Up Agg	APR17	19%	19%	55%	26%	40%
	COP17	Scale-Up Agg	APR18	39%	33%	86%	37%	63%
	COP18	Scale-Up Agg	APR19	78%	108 %	84%	100 %	90%
Bouafle	COP15	Scale-Up Sat	APR16	25%	26%	47%	22%	35%
	COP16	Scale-Up Sat	APR17	32%	35%	71%	33%	53%
	COP17	Scale-Up Sat	APR18	164 %	161 %	98%	42%	80%
	COP18	Scale-Up Sat	APR19	112 %	144 %	92%	98%	97%
Bouake-Nord-Est	COP15	Scale-Up Agg	APR16	13%	10%	39%	16%	28%
	COP16	Scale-Up Agg	APR17	15%	15%	51%	21%	36%
	COP17	Scale-Up Agg	APR18	43%	28%	78%	31%	56%
	COP18	Scale-Up Agg	APR19	78%	108 %	84%	100 %	90%
Bouake-Nord-Ouest	COP15	Scale-Up Sat	APR16	45%	53%	78%	40%	61%
	COP16	Scale-Up Sat	APR17	56%	55%	90%	46%	70%
	COP17	Scale-Up Sat	APR18	121 %	166 %	104 %	49%	85%
	COP18	Scale-Up Sat	APR19	113 %	156 %	127 %	145 %	134%
Bouake-Sud	COP15	Scale-Up Sat	APR16	22%	19%	67%	30%	48%
	COP16	Scale-Up Sat	APR17	28%	22%	82%	34%	58%
	COP17	Scale-Up Sat	APR18	133 %	88%	105 %	51%	84%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Scale-Up Sat	APR19	83%	115 %	85%	97%	90%
Bouna	COP15	Sustained	APR16	11%	13%	24%	13%	19%
	COP16	Sustained	APR17	12%	13%	30%	16%	23%
	COP17	Sustained	APR18	14%	17%	37%	20%	29%
	COP18	Sustained	APR19	55%	80%	70%	87%	75%
Boundiali	COP15	Sustained	APR16	24%	31%	57%	36%	46%
	COP16	Sustained	APR17	35%	37%	78%	42%	60%
	COP17	Sustained	APR18	25%	26%	65%	41%	53%
	COP18	Sustained	APR19	60%	89%	69%	87%	75%
Cocody-Bingerville	COP15	Scale-Up Sat	APR16	71%	70%	88%	42%	69%
	COP16	Scale-Up Sat	APR17	76%	78%	112 %	54%	87%
	COP17	Scale-Up Sat	APR18	162 %	162 %	117 %	57%	96%
	COP18	Scale-Up Sat	APR19	109 %	135 %	88%	90%	90%
Dabakala	COP15	Sustained	APR16	16%	14%	22%	10%	17%
	COP16	Sustained	APR17	27%	26%	32%	14%	25%
	COP17	Sustained	APR18	17%	15%	42%	19%	32%
	COP18	Sustained	APR19	66%	54%	90%	63%	75%
Dabou	COP15	Scale-Up Sat	APR16	27%	24%	60%	26%	44%
	COP16	Scale-Up Sat	APR17	33%	34%	79%	38%	59%
	COP17	Scale-Up Sat	APR18	109 %	97%	103 %	44%	80%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Scale-Up Sat	APR19	85%	112%	104%	114%	107%
Daloa	COP15	Scale-Up Sat	APR16	24%	18%	68%	35%	51%
	COP16	Scale-Up Sat	APR17	40%	39%	104%	53%	79%
	COP17	Scale-Up Sat	APR18	155%	70%	122%	64%	98%
	COP18	Scale-Up Sat	APR19	89%	106%	91%	89%	91%
Danane	COP15	Sustained	APR16	6%	9%	41%	18%	29%
	COP16	Sustained	APR17	10%	10%	50%	24%	36%
	COP17	Sustained	APR18	16%	25%	82%	37%	60%
	COP18	Sustained	APR19	35%	48%	75%	88%	75%
Daoukro	COP15	Sustained	APR16	19%	17%	49%	23%	36%
	COP16	Sustained	APR17	14%	16%	52%	25%	38%
	COP17	Sustained	APR18	33%	22%	72%	35%	54%
	COP18	Sustained	APR19	61%	85%	101%	120%	105%
Didievi	COP15	Sustained	APR16	5%	9%	15%	9%	12%
	COP16	Sustained	APR17	5%	6%	20%	9%	15%
	COP17	Sustained	APR18	13%	20%	27%	16%	22%
	COP18	Sustained	APR19	30%	42%	63%	75%	65%
Dimbokro	COP15	Sustained	APR16	31%	32%	84%	35%	60%
	COP16	Sustained	APR17	32%	24%	92%	36%	65%
	COP17	Sustained	APR18	46%	40%	92%	39%	68%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Sustained	APR19	65%	90%	85%	101%	90%
Divo	COP15	Scale-Up Agg	APR16	16%	21%	38%	20%	30%
	COP16	Scale-Up Agg	APR17	21%	23%	49%	25%	37%
	COP17	Scale-Up Agg	APR18	19%	31%	65%	33%	50%
	COP18	Scale-Up Agg	APR19	79%	105%	99%	112%	103%
Duekoue	COP15	Scale-Up Agg	APR16	7%	8%	21%	17%	18%
	COP16	Scale-Up Agg	APR17	12%	10%	32%	23%	27%
	COP17	Scale-Up Agg	APR18	26%	34%	48%	37%	42%
	COP18	Scale-Up Agg	APR19	78%	107%	85%	99%	90%
Ferkessedougou	COP15	Sustained	APR16	17%	22%	55%	42%	47%
	COP16	Sustained	APR17	27%	24%	71%	48%	58%
	COP17	Sustained	APR18	19%	33%	69%	47%	58%
	COP18	Sustained	APR19	60%	89%	104%	132%	110%
Fresco	COP15	Sustained	APR16	16%	16%	33%	22%	27%
	COP16	Sustained	APR17	16%	20%	36%	23%	29%
	COP17	Sustained	APR18	16%	12%	35%	26%	30%
	COP18	Sustained	APR19	63%	83%	82%	93%	85%
Gagnoa	COP15	Scale-Up Sat	APR16	27%	24%	52%	27%	40%
	COP16	Scale-Up Sat	APR17	38%	37%	80%	44%	63%
	COP17	Scale-Up Sat	APR18	98%	130%	103%	55%	84%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Scale-Up Sat	APR19	89%	106%	98%	95%	97%
Grand-Bassam	COP15	Not Defined	APR16	0%	0%	0%	0%	0%
	COP16	Not Defined	APR17	0%	0%	0%	0%	0%
	COP17	Not Defined	APR18	0%	0%	0%	0%	0%
	COP18	Not Defined	APR19	0%	0%	0%	0%	0%
Grand-Lahou	COP15	Sustained	APR16	10%	18%	29%	18%	24%
	COP16	Sustained	APR17	19%	21%	41%	23%	33%
	COP17	Sustained	APR18	16%	28%	44%	27%	36%
	COP18	Sustained	APR19	57%	76%	77%	88%	80%
Gueyo	COP15	Sustained	APR16	12%	9%	16%	7%	12%
	COP16	Sustained	APR17	12%	11%	18%	8%	14%
	COP17	Sustained	APR18	5%	5%	30%	12%	21%
	COP18	Sustained	APR19	39%	41%	54%	48%	50%
Guiglo	COP15	Scale-Up Agg	APR16	10%	11%	36%	21%	28%
	COP16	Scale-Up Agg	APR17	13%	12%	37%	22%	29%
	COP17	Scale-Up Agg	APR18	35%	29%	57%	33%	46%
	COP18	Scale-Up Agg	APR19	78%	107%	85%	99%	90%
Guitry	COP15	Scale-Up Agg	APR16					
	COP16	Scale-Up Agg	APR17					
	COP17	Scale-Up Agg	APR18					
	COP18	Scale-Up Agg	APR19	79%	105%	75%	85%	80%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Issia	COP15	Scale-Up Sat	APR16	15%	20%	52%	27%	39%
	COP16	Scale-Up Sat	APR17	30%	27%	80%	39%	59%
	COP17	Scale-Up Sat	APR18	95%	123%	97%	52%	80%
	COP18	Scale-Up Sat	APR19	103%	132%	113%	120%	116%
Jacqueville	COP15	Sustained	APR16	14%	11%	20%	10%	15%
	COP16	Sustained	APR17	20%	15%	33%	18%	26%
	COP17	Sustained	APR18	20%	11%	32%	16%	25%
	COP18	Sustained	APR19	57%	76%	77%	88%	80%
Katiola	COP15	Sustained	APR16	26%	16%	40%	15%	29%
	COP16	Sustained	APR17	29%	19%	48%	20%	35%
	COP17	Sustained	APR18	21%	17%	49%	19%	35%
	COP18	Sustained	APR19	72%	59%	83%	59%	70%
Korhogo	COP15	Scale-Up Sat	APR16	27%	28%	72%	34%	53%
	COP16	Scale-Up Sat	APR17	33%	35%	89%	42%	66%
	COP17	Scale-Up Sat	APR18	126%	111%	122%	58%	97%
	COP18	Scale-Up Sat	APR19	89%	131%	116%	141%	123%
Kouibly	COP15	Sustained	APR16	4%	3%	19%	9%	14%
	COP16	Sustained	APR17	6%	6%	25%	13%	19%
	COP17	Sustained	APR18	8%	6%	38%	18%	28%
	COP18	Sustained	APR19	35%	48%	81%	94%	80%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Koumassi-Port Bouet-Vridi	COP15	Scale-Up Agg	APR16	22%	19%	60%	23%	42%
	COP16	Scale-Up Agg	APR17	26%	25%	74%	30%	53%
	COP17	Scale-Up Agg	APR18	48%	38%	104 %	46%	77%
	COP18	Scale-Up Agg	APR19	82%	101 %	77%	82%	80%
Lakota	COP15	Sustained	APR16	23%	25%	45%	27%	36%
	COP16	Sustained	APR17	30%	28%	56%	35%	46%
	COP17	Sustained	APR18	21%	26%	61%	37%	49%
	COP18	Sustained	APR19	63%	83%	72%	81%	75%
Man	COP15	Scale-Up Sat	APR16	15%	11%	52%	26%	38%
	COP16	Scale-Up Sat	APR17	19%	16%	70%	38%	53%
	COP17	Scale-Up Sat	APR18	149 %	73%	97%	51%	80%
	COP18	Scale-Up Sat	APR19	84%	114 %	103 %	115 %	106%
Mankono	COP15	Scale-Up Agg	APR16	13%	16%	24%	13%	19%
	COP16	Scale-Up Agg	APR17	16%	17%	37%	21%	29%
	COP17	Scale-Up Agg	APR18	33%	27%	59%	34%	47%
	COP18	Scale-Up Agg	APR19	85%	96%	86%	83%	85%
M'bahiakro	COP15	Sustained	APR16	9%	0%	20%	11%	15%
	COP16	Sustained	APR17	9%	6%	24%	14%	18%
	COP17	Sustained	APR18	18%	15%	27%	15%	21%
	COP18	Sustained	APR19	52%	72%	66%	79%	70%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Minignan	COP15	Sustained	APR16	2%	4%	11%	6%	9%
	COP16	Sustained	APR17	4%	10%	17%	13%	15%
	COP17	Sustained	APR18	0%	0%	21%	11%	16%
	COP18	Sustained	APR19	71%	80%	76%	73%	75%
Nassian	COP15	Sustained	APR16	0%	9%	28%	14%	21%
	COP16	Sustained	APR17	11%	11%	36%	13%	25%
	COP17	Sustained	APR18	31%	6%	43%	22%	33%
	COP18	Sustained	APR19	52%	75%	91%	112%	95%
Niakaramadougou	COP15	Sustained	APR16	16%	13%	22%	11%	17%
	COP16	Sustained	APR17	16%	16%	26%	11%	20%
	COP17	Sustained	APR18	32%	25%	28%	14%	23%
	COP18	Sustained	APR19	44%	36%	73%	51%	60%
Odienne	COP15	Sustained	APR16	19%	25%	29%	15%	23%
	COP16	Sustained	APR17	27%	27%	43%	20%	33%
	COP17	Sustained	APR18	17%	20%	57%	28%	44%
	COP18	Sustained	APR19	47%	53%	73%	70%	70%
Ouangolodougou	COP15	Sustained	APR16	11%	24%	39%	25%	32%
	COP16	Sustained	APR17	20%	25%	51%	31%	40%
	COP17	Sustained	APR18	8%	19%	43%	27%	34%
	COP18	Sustained	APR19	60%	89%	79%	100%	85%
Oume	COP15	Scale-Up Agg	APR16	11%	11%	34%	20%	27%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP16	Scale-Up Agg	APR17	16%	18%	51%	25%	38%
	COP17	Scale-Up Agg	APR18	34%	26%	75%	43%	60%
	COP18	Scale-Up Agg	APR19	80%	104 %	86%	95%	90%
Prikro	COP15	Sustained	APR16	10%	12%	39%	19%	29%
	COP16	Sustained	APR17	14%	22%	48%	21%	35%
	COP17	Sustained	APR18	14%	23%	71%	36%	54%
	COP18	Sustained	APR19	52%	72%	66%	79%	70%
Sakassou	COP15	Sustained	APR16	29%	32%	44%	24%	35%
	COP16	Sustained	APR17	34%	36%	64%	30%	49%
	COP17	Sustained	APR18	26%	26%	76%	43%	60%
	COP18	Sustained	APR19	61%	85%	91%	108 %	95%
San-Pedro	COP15	Scale-Up Sat	APR16	17%	18%	49%	28%	38%
	COP16	Scale-Up Sat	APR17	20%	20%	63%	35%	48%
	COP17	Scale-Up Sat	APR18	120 %	118 %	92%	57%	80%
	COP18	Scale-Up Sat	APR19	95%	97%	96%	82%	90%
Sassandra	COP15	Scale-Up Agg	APR16	12%	10%	28%	18%	22%
	COP16	Scale-Up Agg	APR17	15%	15%	39%	20%	30%
	COP17	Scale-Up Agg	APR18	31%	29%	67%	44%	55%
	COP18	Scale-Up Agg	APR19	88%	92%	78%	69%	75%
seguela	COP15	Sustained	APR16	6%	10%	26%	14%	20%
	COP16	Sustained	APR17	16%	20%	44%	25%	35%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP17	Sustained	APR18	10%	18%	64%	34%	49%
	COP18	Sustained	APR19	62%	69%	72%	69%	70%
Sikensi	COP15	Sustained	APR16	10%	8%	19%	7%	13%
	COP16	Sustained	APR17	18%	18%	34%	16%	25%
	COP17	Sustained	APR18	8%	3%	34%	13%	24%
	COP18	Sustained	APR19	57%	76%	56%	64%	60%
Sinfra	COP15	Scale-Up Agg	APR16	20%	32%	40%	21%	31%
	COP16	Scale-Up Agg	APR17	34%	33%	54%	28%	42%
	COP17	Scale-Up Agg	APR18	50%	61%	125 %	67%	97%
	COP18	Scale-Up Agg	APR19	80%	104 %	201 %	222 %	200%
Soubre	COP15	Scale-Up Agg	APR16	10%	10%	26%	14%	20%
	COP16	Scale-Up Agg	APR17	12%	12%	35%	18%	26%
	COP17	Scale-Up Agg	APR18	29%	31%	69%	38%	54%
	COP18	Scale-Up Agg	APR19	88%	92%	62%	55%	61%
Tabou	COP15	Scale-Up Agg	APR16	6%	5%	17%	10%	13%
	COP16	Scale-Up Agg	APR17	7%	6%	26%	16%	20%
	COP17	Scale-Up Agg	APR18	33%	24%	56%	34%	45%
	COP18	Scale-Up Agg	APR19	88%	92%	80%	71%	77%
Tanda	COP15	Scale-Up Agg	APR16	25%	25%	55%	24%	41%
	COP16	Scale-Up Agg	APR17	33%	30%	67%	30%	50%
	COP17	Scale-Up Sat	APR18	163 %	66%	93%	44%	75%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP18	Scale-Up Sat	APR19	77%	111%	122%	152%	129%
Tengrela	COP15	Sustained	APR16	45%	6%	61%	27%	45%
	COP16	Sustained	APR17	56%	34%	87%	42%	66%
	COP17	Sustained	APR18	39%	8%	66%	30%	49%
	COP18	Sustained	APR19	55%	81%	59%	75%	65%
Tiassale	COP15	Scale-Up Agg	APR16	14%	16%	23%	12%	18%
	COP16	Scale-Up Agg	APR17	23%	21%	39%	19%	30%
	COP17	Scale-Up Agg	APR18	34%	38%	55%	28%	44%
	COP18	Scale-Up Agg	APR19	79%	105%	80%	91%	85%
Tiebissou	COP15	Sustained	APR16	17%	20%	29%	12%	22%
	COP16	Sustained	APR17	16%	18%	34%	15%	25%
	COP17	Sustained	APR18	25%	29%	53%	23%	40%
	COP18	Sustained	APR19	61%	85%	91%	108%	95%
Touba	COP15	Sustained	APR16	4%	6%	14%	9%	11%
	COP16	Sustained	APR17	8%	8%	22%	13%	17%
	COP17	Sustained	APR18	3%	4%	26%	16%	21%
	COP18	Sustained	APR19	43%	48%	68%	65%	65%
Toulepleu	COP15	Sustained	APR16	11%	2%	11%	7%	9%
	COP16	Sustained	APR17	10%	8%	15%	8%	12%
	COP17	Sustained	APR18	0%	0%	20%	12%	16%
	COP18	Sustained	APR19	57%	77%	61%	71%	65%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
Toumodi	COP15	Sustained	APR16	13%	24%	44%	20%	33%
	COP16	Sustained	APR17	14%	20%	49%	24%	37%
	COP17	Sustained	APR18	22%	28%	80%	36%	60%
	COP18	Sustained	APR19	56%	78%	93%	111%	97%
Treichville-Marcory	COP15	Scale-Up Sat	APR16	88%	92%	220%	158%	185%
	COP16	Scale-Up Sat	APR17	93%	90%	241%	170%	200%
	COP17	Scale-Up Sat	APR18	103%	105%	237%	180%	206%
	COP18	Scale-Up Sat	APR19	115%	142%	125%	127%	126%
Vavoua	COP15	Sustained	APR16	12%	12%	22%	13%	18%
	COP16	Sustained	APR17	21%	24%	44%	25%	35%
	COP17	Sustained	APR18	13%	15%	48%	29%	39%
	COP18	Sustained	APR19	58%	75%	78%	86%	80%
Yamoussoukro	COP15	Scale-Up Agg	APR16	18%	20%	57%	29%	43%
	COP16	Scale-Up Agg	APR17	22%	23%	71%	32%	52%
	COP17	Scale-Up Agg	APR18	39%	51%	86%	45%	67%
	COP18	Scale-Up Agg	APR19	78%	108%	84%	100%	90%
Yopougon-Est	COP15	Scale-Up Sat	APR16	12%	15%	57%	30%	43%
	COP16	Scale-Up Sat	APR17	14%	14%	68%	30%	49%

SNU	COP	Prioritization	Results Reported	<15		15+		Overall TX Coverage
				F	M	F	M	
	COP17	Scale-Up Sat	APR18	107 %	114 %	100 %	48%	80%
	COP18	Scale-Up Sat	APR19	89%	110 %	90%	92%	91%
Yopougon-Ouest-Songon	COP15	Scale-Up Sat	APR16	58%	60%	111 %	47%	82%
	COP16	Scale-Up Sat	APR17	60%	59%	127 %	53%	93%
	COP17	Scale-Up Sat	APR18	158 %	141 %	148 %	62%	114%
	COP18	Scale-Up Sat	APR19	105 %	129 %	96%	98%	98%
Zouhan Hounien	COP15	Sustained	APR16	7%	7%	28%	15%	21%
	COP16	Sustained	APR17	7%	9%	33%	18%	25%
	COP17	Sustained	APR18	8%	6%	50%	29%	38%
	COP18	Sustained	APR19	35%	48%	75%	88%	75%
Zuenoula	COP15	Sustained	APR16	16%	21%	46%	28%	37%
	COP16	Sustained	APR17	38%	44%	72%	41%	58%
	COP17	Sustained	APR18	31%	38%	83%	50%	67%
	COP18	Sustained	APR19	58%	75%	73%	80%	75%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Number of PLHIV, end of FY17	FY18 Expected TX_CURR Result	Additional Patients required for 80% ART (APR18)	Target Current on ART (APR19) TX_CURR	Newly initiated (APR19)	ART Coverage (APR19)
Scale-Up Saturation	226,503	171,128	10,074	223,117	63,145	99%
Scale-Up Aggressive	156,088	91,212	33,659	129,711	44,985	83%

Sustained	82,925	46,585	19,755	62,844	19,401	76%
Total	**465,516**	**308,925**	**63,488**	**415,672**	**127,531**	**89%**

APPENDIX B – Budget Profile and Resource Projections

B1. FY19 Planned Spending

Below is a visualization of PEPFAR-CI's FY19 investments by approach and program area.

Table B.1.1 FY19 Budget by Approach and Program Area

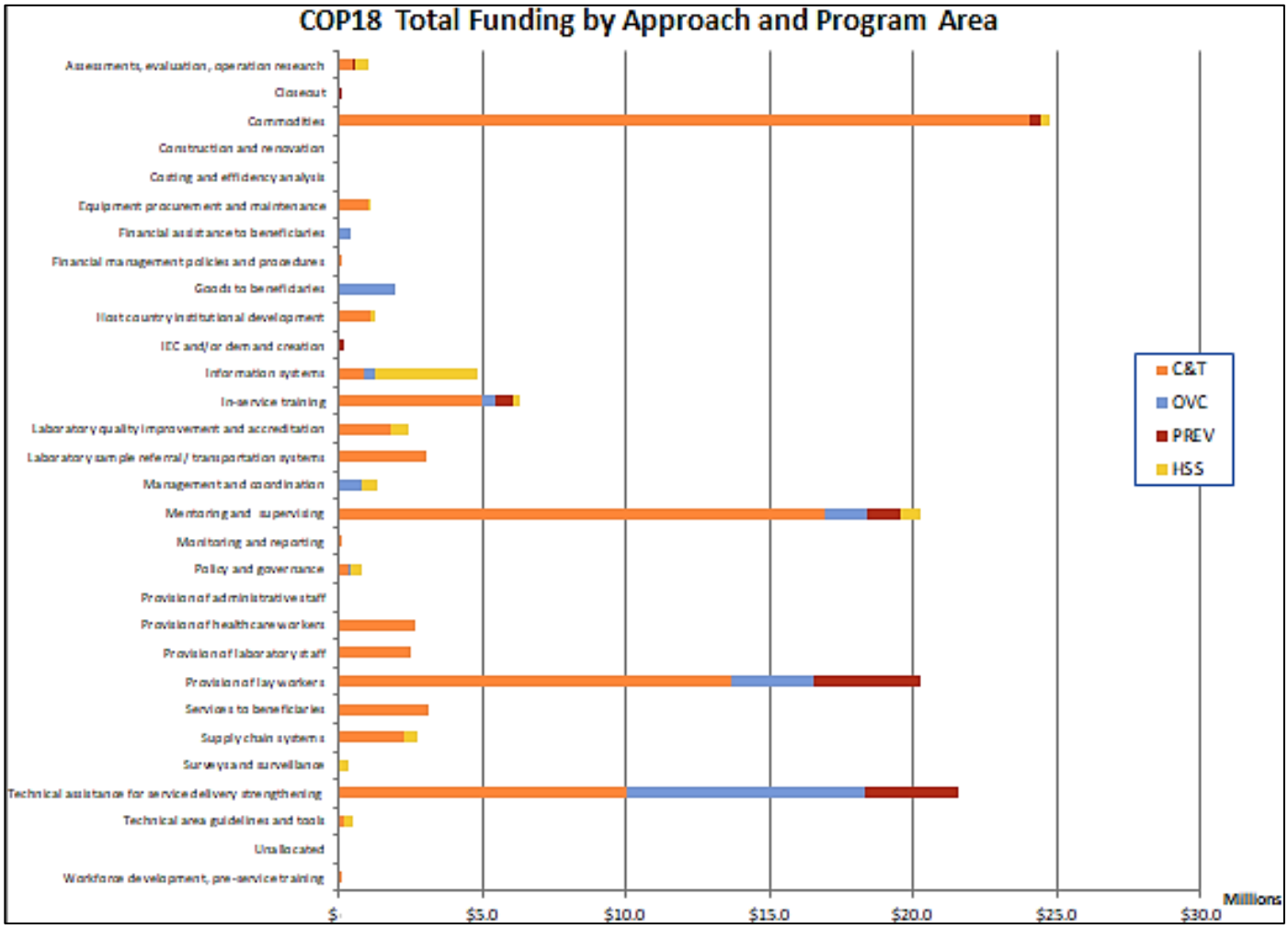

Table B.1.2 FY19 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$ 31 857 517	**$ 31 857 517**	**$140 508 601**

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	$2 891 588
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$2 040 495
HVOP	Other Sexual Prevention	$3 892 204
IDUP	Injecting and Non-Injecting Drug Use	-
HMBL	Blood Safety	-
HMIN	Injection Safety	-
CIRC	Male Circumcision	-
HVCT	Counseling and Testing	$11 196 423
HBHC	Adult Care and Support	$6 914 043
PDCS	Pediatric Care and Support	$4 908 964
HKID	Orphans and Vulnerable Children	$16 588 258
HTXS	Adult Treatment	$36 675 770
HTXD	ARV Drugs	$202 449
PDTX	Pediatric Treatment	$3 704 795
HVTB	TB/HIV Care	$5 298 694
HLAB	Lab	$1 995 001
HVSI	Strategic Information	$3 021 738
OHSS	Health Systems Strengthening	$1 248 003
HVMS	Management and Operations	$8 072 659
TOTAL		**$ 108,651,084**

B.2 Resource Projections

PEPFAR-CI applied an incremental, program-based budgeting approach to ascertain the appropriate budget per implementing mechanism. This entailed a review of the implementing mechanism's expected scope of work and, if applicable, targets, and included an assessment of its capacity based on previous achievement as well as on geographic gaps.

APPENDIX C –Systems Investments for Section 6.0

Please find attached separately.

APPENDIX D – List of Acronyms

AGYW	Adolescent girls and young women
ANC	Antenatal care
APR	Annual Program Results
ART	Antiretroviral therapy
ARV	Antiretroviral medication
CATs	Anti-Tuberculosis Centers
CC	Community Counselors
CCLS	Coordinating Committee for the Fight Against AIDS
CCM	Country Coordinating Mechanism
CDC	Centers for Disease Control and Prevention
CHW	Community health worker
CIPHIA	Côte d'Ivoire Population-Based HIV Impact Assessment
CNCAM	National Coordinating Committee for the Procurement of Medication and Biological Products
COP	Country Operational Plan
CSO	Civil society organization
CTLS	Technical Committee for the Fight Against AIDS
CTX	Cotrimaxozole
DBS	Dried Blood Spot
DHS	Demographic and Health Survey
DNA PCR	Deoxyribonucleic acid polymerase chain reaction
DOD	Department of Defense
EID	Early infant diagnosis
EMR	Electronic medical records
EPOA	Enhanced Peer Outreach Approach
FP	Family Planning
FSW	Female sex workers
FY	Fiscal year
GBV	Gender based violence
GF	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHSA	Global Health Security Agenda
GNI	Gross national income
GOCI	Government of Côte d'Ivoire
HEI	HIV-exposed infants
HIVST	HIV self-testing
HSS	Health systems strengthening
HTS	HIV testing services
ICAP	International Center for AIDS Care and Treatment Program
ICASS	International Cooperative Administrative Support Services
IPs	Implementing partners

KP	Key Populations
LIS	Laboratory Information Systems
MER	PEPFAR Monitoring, Evaluation and Reporting
MOD	Ministry of Defense
MSFPE	Ministry of Solidarity, Women, and Child Protection
MSHP	Ministry of Health and Public Hygiene
MSM	Men who have sex with men
NACS	Nutritional assessment counseling and support
NPSP	National Medical Stores
OPD	Outpatient department
OVC	Orphans and vulnerable children
PCO	PEPFAR Coordination Office
PEPFAR	President's Emergency Plan for AIDS Relief
PEPFAR-CI	PEPFAR Côte d'Ivoire
PITC	Provider initiated testing and counseling
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child HIV transmission
PNLS	National AIDS Control Program
PNLT	National TB Control Program
PN-OEV	National OVC Program
POART	PEPFAR Oversight and Accountability Results Team
POC	Point-of-care
PR	Principal Recipient
PrEP	Pre-exposure prophylaxis
PSN	National HIV Strategic Plan
PTFs	Bilateral/multilateral partners
RPM	Regional Planning Meeting
SDS	Strategic Direction Summary
SGAC	State Office of the Global AIDS Coordinator
SID	Sustainability Index Dashboard
SNU	Sub-national unit
STI	Sexually transmitted infection
TA	Technical assistance
TB	Tuberculosis
TB/HIV	Tuberculosis and HIV co-infection
TDY	Temporary duty
TLD	Tenofovir disoproxil fumarate, lamivudine, and dolutegravir
TPT	Tuberculosis preventive therapy
TWG	Technical working group
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USDH	US Direct Hire
VACS	Violence Against Children Survey
VL	Viral Load
WHO	World Health Organization

Table 6 Attachment

	Agency	Name	Implementing Mechanisms Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
1	HHS/CDC	CDC-RETRO-CI GHAI	U.S. Department of Health and Human	11491	HSS	To strengthen the national coordination and HIV	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Surveys and surveillance Approach not listed in EAST	Assessment of acquired resistance of PLHIV on 1st and 2nd line ART in Cote d'Ivoire using CIPHIA data	Limited data on 1st and 2nd line ART acquired resistance
2	USAID	Sustainable Condoms Solutions Project	AIMAS	14073	HSS	Increase Availability and accessibility of condoms and	3.1 - Focus/target/customize early prevention programming and testing to	Management and coordination.	a) Maintain stock and distribution of free condoms and lubricants at AIMAS regional offices;	Low condom accessibility across the country
3	USAID	Sustainable Condoms Solutions Project	AIMAS	14073	HSS	Strengthen sustainable systems for condom and	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Policy and governance	a) Support implementation of the national Comprehensive Condom Programming (CCP);	Weak institutional policy in condom programming
4	USAID	Sustainable Condoms Solutions Project	AIMAS	14073	PREV	Build demand for, and correct and consistent use of condoms	3.1 - Focus/target/customize early prevention programming and testing to	IEC and/or demand creation	a) Conduct market surveys on condom & lubricant use and collect sex disaggregated data on key populations;	Lack of national data on condom use to inform stakeholders and to support decision making;
5	HHS/CDC	FHI360_ Surveillance and Program Evaluation	FHI 360	17014	C&T	To evaluate CDC/PEPFAR partners' projects	3.3 - Accelerate integration of biomedical interventions (PrEP + PEP) into prevention services	Assessments, evaluation, operation research	Planning activity for PrEP implementatio evaluation (protocol development, validatio workshop, clearance, data	No data on HIV self testing
6	HHS/CDC	FHI360_ Surveillance and Program Evaluation	FHI 360	17014	C&T	To evaluate CDC/PEPFAR partners' projects	2.2 - Reinforce full implementation of standardized referral/counter referral	Assessments, evaluation, operation research	Evaluation of the implementation of community distribution of ARVs; Evaluation of the national implementation	No data on community ART distribution
7	HHS/CDC	FHI360_ Surveillance and Program Evaluation	FHI 360	17014	C&T	To evaluate CDC/PEPFAR partners' projects	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Assessments, evaluation, operation research	Evaluation of the effectiveness of Tenofovir/Lamivudine/Dolutegravir (TLD); measurement of	No data on TLD implementation
8	HHS/CDC	HAI coag2015	Health Alliance International	17494	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample transportation for biological	Weak linkage between health facilities, social centers and community service
9	DOD	PSI Cote d'Ivoire	Population Services International	17496	HSS	2. Increase commitment of military leadership to	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Laboratory quality improvement and	Address gaps identified during the SLMTA accreditation process for 8 military laboratories	Insufficient compliance with WHO laboratory quality standards
10	DOD	PSI Cote d'Ivoire	Population Services International	17496	C&T	0	1.3 - Rapidly expand successful treatment and retention strategies at all sites based on a robust	Laboratory sample referral/ transportation	Support viral load samples transportation to satellite and viral load testing laboratories	Insufficient coverage with viral load testing laboratories

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
1	13. Epidemiological and Health Data	5.48	Data on ART acquired resistance is obtained and serves as baseline before TLD implementation	1 year	Final report on characterization of ART acquired resistance is disseminated	Data limited to select patients with failed ART, and no data on general prevalence of acquired	Data collection completed and final report disseminated	
2	6. Service Delivery	6.48	Condoms are adequately stocked and accessible	3 years	Condom stock reports	71% availability of condoms at distribution points across the country	Increase to 80% availability of condoms at distribution points across the country	
3	6. Service Delivery	6.48	CCP Programming is fully implemented; Price policy and cost-	1 year	CCP management report	National Comprehensive Condom Programming (CCP) report developed but not implemented;	Effective implementation of the national Comprehensive Condom Programming (CCP);	
4	6. Service Delivery	6.48	Increased demand and uptake for condoms among priority populations;	3 years	Market survey report, reporting tool	70% of young people used a condom during sex.	Dashboard for condom demand is available and used; At least 90% of young people	
5	13. Epidemiological and Health Data	5.48	Self testing is scaled up and uptake by men and key pops is addressing the 1st 90 gap.	2 years	eLMIS reporting rate; eLMIS Completeness.	No data	Approved Protocol and beginning of data collection	
6	13. Epidemiological and Health Data	5.48	ART distribution at the community level is implemented effectively and scaled up, and the 2nd 90 gap	2 years	Final report on evaluation of ART distribution is disseminated	No data	Approved Protocol and beginning of data collection	
7	13. Epidemiological and Health Data	5.48	TLD is implemented as 2nd line ART in Cote d'Ivoire, and ART optimization is attained for PLHIV: 2nd and 3rd 90	2 years	Final report on TLD implementation evaluation is disseminated	No data	Approved Protocol and beginning of data collection	
8	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No Data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
9	10. Laboratory	6.00 (SID 3.0) 2.30 (MILSID 2.0)	8 military laboratories with 4 stars	1 year	External laboratory audit report	3 miliatry laboratories with 4 stars and 5 military laboratories with 3 stars	8 military laboratories with 4 stars	
10	10. Laboratory	6.00 (SID 3.0) 2.30 (MILSID 2.0)	90% of patients on ART on military sites have access to viral load testing for biological monitoring	1 year	MER indicator	No data	Viral load testing results documented for 90% of patients	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
1	Activity completed	K3	Activity completed	
2	Increase to 90% availability of condoms at distribution points across the country		Increase to 95% availability of condoms at distribution points across the country	
3	Activity completed		Activity completed	
4	At least 85% of young people will use a condom during sex		At least 90% of young people will use a condom during sex	
5	Final report disseminated			
6	Final report disseminated			
7	Final report disseminated			
8	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
9				
10				

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
11	DOD	PSI Cote d'Ivoire	Population Services International	17496	PREV	0	3.1 - Focus/target/customize early prevention programming and testing to	IEC and/or demand creation	Support phone-based promotion of test & start advantages and available free care and treatment services through the	Insufficient HTS services uptake by military population
12	USAID	REVE Reducing Vulnerability in Children	Save The Children Federation Inc	17515	C&T	Increased capacity of local governments and	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Host country institutional development	(a) Provide technical assistance to social centers to strengthen their technical and organizational capacities for the	Insufficient coordination of system results in duplicate HIV testing results in the data set
13	USAID	Measure Evaluation Phase IV	University of North Carolina at Chapel Hill	17583	C&T	Technical assistance to improve in-country use of	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	(a) Support the deployment of EMR (SIGDEP2) at site level (clinic and pharmacy modules) in collaboration with clinical	Lack of integrated electronic patient information system for patient monitoring
14	USAID	Measure Evaluation Phase IV	University of North Carolina at Chapel Hill	17583	OVC	Technical assistance to improve in-country use of	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	(a) Support the improvement of the National OVC database and the implementation of a user support system to improve	Weak national OVC information system and lack of data for DREAMS related interventions
15	USAID	Measure Evaluation Phase IV	University of North Carolina at Chapel Hill	17583	C&T	Technical Assistance to the MOH to support	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	(a) Implement interoperability between data systems; (b) Support MoH to improve	Lack of an interoperable national health information system with the different existing
16	USAID	Linkages	FHI 360	17763	C&T		1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Information Systems	a) Use the SMS 2 tool to gather patient feedback on their experience to better evaluate stigmatization reduction, in the	Fear of being stigmatized against by HCW is causing patients to avoid seeking treatment
17	USAID	Global Health Supply Chain Quality Assurance	Global Health Supply Chain	17872	HSS	Provide independent, essential; comprehensive	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Technical area guidelines and tools	a) Provide TA to develop multi-year strategic plan for LNSP; b) Develop standard operating	Weak in-country capacity to maintain drug quality
18	HHS/CDC	LABQUASY - Itech/University of washington CoAg	ITECH	17914	C&T	Implement QMS in the entire laboratory network /	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Policy and governance	To facilitate earlier HIV diagnosis through a reliable, high quality HIV rapid test algorithm through the reproduction and	Weak national quality management systems for HIV screening in facility and Community
19	HHS/CDC	LABQUASY - Itech/University of washington CoAg	ITECH	17914	C&T	Implement QMS in the entire laboratory network /	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Laboratory quality improvement and	Certify 750 HIV testing sites and 250 Human Resources providing HIV testing	Weak national quality management systems for HIV screening in facility and Community
20	HHS/CDC	LABQUASY - Itech/University of washington CoAg	ITECH	17914	C&T	Implement QMS in the entire laboratory network /	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory quality improvement and	Implement the PT program in at 3000 testing sites/points including Blood transfusion laboratories, to increase the	Weak national quality management systems for HIV screening in facility and Community

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
11	6. Service Delivery	6.48 (SID 3.0) 4.43 (MILSID 2.0)	2.5% increase in number of men using HTS services	1 year	MER indicator	DATIM targets	2.5% increase in number of men using HTS services	
12	1. Planning and Coordination	9.5	Improved coordination, supervision, reporting and monitoring of 12 social centers	2 years	75% of social centers are reinforced using SBMR standard quality	3 social centers are coordinating their HIV data collection and reporting;	9 social centers effectively coordinate HIV data collection and reporting;	
13	13. Epidemiological and Health data	5.48	Electronic Medical Record system available and working at all treatment sites and compiled reports available at	1 year	National health information system assessment report	National health information system assessment report 2017. As of March 2018 only	80% of ART sites use SIGDEP2 EMR	
14	13. Epidemiological and Health data	5.48	Robust national OVC database, increased data use for decision-making, Girls roster and data collection	1 year	Field assessment	National OVC report. Although currently deployed at all 57 social centers, less than 10% of	80% of social centers and OVC platforms report quality data on time using the newly developed tools	
15	13. Epidemiological and Health data	5.48	100% of districts, 100% of regions and national level use data triangulated from the different health information	1 year	National health information system assessment report	National health information system assessment report 2017. DHIS2 is currently	80% of districts, 80% of regions and national level effectively use data triangulated from the	
16	6. Service Delivery	6.48	HCW and social workers from 22 public health facilities are trained to avoid stigmatizing their HIV patients, thus	1 year	Programmatic IP's report	22 HCW trained on KP sensitivity training to create	Extend KP sensitivity training to nurses, social workers,	
17	8. Commodity Security and Supply chain	5.61	Quality of health commodities is monitored and in-country quality management system is	1 year	Quality Assurance Report; LNSP Strategic Plan.	a) Outdated SOPs b) 0 Capacity to test efavirenz quality	a) Standards Operation procedures developed for Quality Control;	
18	10. Laboratory	6	HIV Rapid Testing Quality Improvement Initiative (RTQII) is fully implemented at all HIV testing point in the	2 years	number of guidelines printed and disseminated	HTC guidelines; HTC training modules; Quality Manual	70% of reproduced guidelines disseminated to high volume testing sites in the seven priority districts	
19	10. Laboratory	6	HIV Rapid Testing Quality Improvement Initiative (RTQII) is fully implemented at all HIV testing point in the	3 years	National RTQII database	100 service providers and 50 sites will be certified	750 HIV testing sites and 250 Human Resources providing HIV testing certified	
20	10. Laboratory	6	HIV Rapid Testing Quality Improvement Initiative (RTQII) is fully implemented at all HIV testing point in the	3 years	National RTQII database	PT implemented in 2500 testing points	3000 testing points implement PT	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
11				
12	All 12 social centers effectively coordinate HIV data collection and reporting;		Activity completed	
13				
14				
15				
16				
17				
18	Guidelines include revisions for recency testing and self-testing policies for nationwide distribution			
19	1000 HIV testing sites and 500 Human Resources providing HIV testing certified		Certify 750 HIV testing sites and 250 Human Resources providing HIV testing	
20	continious implementation of HIV PT pannel program at about 3000 testing points		continious implementation of HIV PT pannel program at about 3000 testing points	

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
21	HHS/CDC	LABQUASY - Itech/University of washington CoAg	ITECH	17914	HSS	Improve coordination of laboratory efforts by	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	Implement Viral Load/EID Dashboard in scale-up districts and upgrade of OpenLIS including interoperability with	Poor laboratory data collection system
22	USAID	PRIVATE SECTOR HEALTH PROJECT	Abt Associates	17942	HSS	Strengthened enabling environment for provision of	4.2 - Accelerate policy implementation through direct diplomatic engagement with the	Host country institutional development	Provide support to: a) MOH for the regulation of accreditation of private clinics	Some populations, including many men, do not regularly access public clinics; but the
23	USAID	PRIVATE SECTOR HEALTH PROJECT	Abt Associates	17942	C&T	Strengthened enabling environment for provision of	2.2 - Reinforce full implementation of standardized referral/counter referral	Laboratory sample referral/ transportation	Support private clinics to participate in bidirectional referral system including sample transportation for biological	Insufficient coverage with viral load testing laboratories
24	HHS/CDC	EGPAF Djasso	EGPAF Djasso	18288	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample	Weak linkage between health facilities, social centers and community service
25	HHS/CDC	Columbia University - ICAP - Follow-on	Columbia University - ICAP - Follow-on	18289	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample	Weak linkage between health facilities, social centers and community service
26	HHS/CDC	STRONG 2 - JHPIEGO	JHPIEGO	18291	OVC	Provide comprehensive HIV prevention, care and	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Policy and governance	JHPIEGO will provide technical assistance to PNOEV and OVC partners to Implement Quality and Performance Based	a) Lack of performance standard for the implementation of OVC-centered activities b)
27	HHS/CDC	IPCI-Follow on-Pasteur Institute of Cote d'Ivoire	Pasteur Institute of Ivory Coast	18294	C&T	Strengthen tuberculosis (TB) diagnostics capacity and facilitate decentralization of diagnostic for	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Technical area guidelines and tools	Organize annual review meeting with regional laboratories and DAVs; Validate the technical manual for the safe transportation of sputum; Strengthen the supervisory capacity at the district level and	Weak QMS at TB diagnosis laboratories (Central, Regional, peripheral)
28	HHS/CDC	Ministry of Health - Follow-on	Ministry of Health and Public Hygiene	18295	HSS	Coordinate and supervise health sector AIDS and TB response at	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Policy and governance	LNSP will coordinate development of laboratory national policies and guidelines.	Low access to VL
29	HHS/CDC	Ministry of Health - Follow-on	Ministry of Health and Public Hygiene	18295	HSS	Coordinate and supervise health sector AIDS and TB response at	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Management and Coordination	Support quarterly and annual Coordination meetings, policy development workshops, development of annual training	Low commitment from the Regional / District health Team

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
21	13. Epidemiological and Health Data	5.48	Improved accuracy and availability of HIV viral load data in the context of epidemic control	3 years	MER indicators (TX_PVLS) by sex and age	FY17Q4 TX_PVLS data	Implement Viral Load/EID Dashboard in scale-up districts and upgrade of OpenLIS including	
22	2. Policies and Governance	4.56	All clinics of network accredited	3 years	a)Number of private clinics enrolled in accreditation process;	63 private clinics	150 private clinics	
23	6. Service Delivery	6.48	Increased knowledge of VL status among patients using private clinics	1 year	VL coverage among private clinic patients	7% of patients using private clinics know their VL status	At least 80% of patients using private clinics know their VL status	
24	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
25	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
26	1.3 Coordination of National HIV Implementation	2	a) Reduce HIV impact on OVCs and their families; b) Have stronger Regional	2 years	Social Regional Entities and Regional OVC platforms effectively develop and supervise the	No Data	Development and effective dissemination of performance standards	
27	10. Laboratory	6	Effective decentralization with region offering full service and participating to surveillance at decentralized level	3 years	Number of annual review meeting	Annual meeting report for COP17	At least one annual review meeting held	
28	10. Laboratory	6	90% of patients on ART in Abidjan and area, while 75% of ART patients in others districts have access to Viral	3 years	lab policies and guidelines available	Some national lab guidelines exist	At least one guideline is developed to support the improvement of laboratory activities and HIV/AIDS	
29	1.3 Coordination of National HIV Implementation	2	Effective coordination meetings held regularly at Regional and Districts levels for effective delivery of	2 years	Number of meeting held per year	No data	One meeting held at district level every quarter	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
21	Viral Load EID Dashboard implemented at CDC RETROCI reference labs and at 16 VL labs in scale-up districts and upgrade of OpenLIS including		Viral Load EID Dashboard implemented at CDC RETROCI reference labs and at all VL labs in scale-up districts and upgrade of OpenLIS including interoperability with SIGDEP2 and ELMIS	
22	Regulation and accreditation process for private clinics is in place, Workbook for private clinics taking HIV services in account is available		All the private clinics of the network are accredited	
23	At least 95% of clients using private clinics knows their VL status			
24	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
25	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
26	Secure Openlis version is fully functional on the remain 50% of clinical site with Openlis			
27	At least one annual review meeting held		At least one annual review meeting held	
28	At least 50% of guidelines are developed to support the improvement of laboratory activities and HIV/AIDS service delivery		At least 80% of laborarories meet laboratory quality standards	
29	FY20 national HIV report dissemintated		FY21 national HIV report dissemintated	

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
30	HHS/CDC	Ministry of Health - Follow-on	Ministry of Health and Public Hygiene	18295	HSS	To strengthen the national coordination and HIV	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	Purchase lab reagents for the ANC Surveillance survey Among Pregnant Women and strengthen capacity of MOH	Lack of recent HIV ANC surveillance data. Last survey occurred in 2008
31	HHS/CDC	Ministry of Health - Follow-on	Ministry of Health and Public Hygiene	18295	C&T	To strengthen the national coordination and HIV	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Technical area guidelines and tools	Development and reproduction of the new national HIV surveillance strategic plan for 2020 - 2024	Need for new strategic plan for the national surveillance system
32	USAID	*[REDACTED]*	TBD	18377	HSS	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	a) Use logistics data to inform decision making; b) Oversee implementation and	Lack of in-country ownership on actual purchases of health program commodities;
33	USAID	TBD - GHSCTA - Global Health Supply Chain Technical	TBD - IHSCTA	18382	C&T	Continue to strengthen end to end supply chain system	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Supply chain systems	Provide institutional support to Government institutions and local organizations (CNCAM; NPSP) to strengthen supply chain	Weak capacity at NPSP and CNCAM to coordinate and oversee supply chain functions;
34	USAID	TBD - GHSCTA - Global Health Supply Chain Technical	TBD - IHSCTA	18382	HSS	collect, analyze and use quality date for planning	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	a) Strengthen last mile distribution system for ARVs and lab commodities;	Lack of real-time reliable logistics data to inform decision making
35	USAID	TBD - GHSCTA - Global Health Supply Chain Technical	TBD - IHSCTA	18382	HSS	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Supply chain systems	a) Provide support to Health Programs, regions and health districts to conduct regular revisions of quantification of	Inadequate monitoring of supply chain activities and inventory management at
36	USAID	TBD - GHSCTA - Global Health Supply Chain Technical	TBD - IHSCTA	18382	C&T	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Supply chain systems	a) Provide institutional support to Government institutions and local organizations (CNCAM; NPSP) to strengthen supply chain	Weak inventory management and forecasting
37	USAID	TBD - GHSCTA - Global Health Supply Chain Technical	TBD - IHSCTA	18382	C&T	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Laboratory sample referral/ transportation	a) Provide technical support for implementation of the national biological sample transportation system	Inadequate national supply chain (central and sub-national level) adapted to new services
38	HHS/CDC	CDC UNAIDS Central Mechanism	UNAIDS II	18431	HSS	Support countries to develop effective and	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	Scale up implementation and use of “Situation Room and M-TEW platform” at national level; Continue support for the	Lack of real time reporting system and data driven decision making process at
39	HHS/CDC	CDC UNAIDS Central Mechanism	UNAIDS II	18431	HSS	Support countries to develop effective and	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Surveys and surveillance	Establishment of the national surveillance system for HIV case notification, incidence and mortality of PLHIV	Lack of HIV incidence and mortality data in cote d'ivoire. HIV individual Case notification is

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
30	13. Epidemiological and Health Data	5.48	HIV prevalence among pregnant women is determined and used for HIV estimations	2 years	Final ANC surveillance report disseminated	The latest ANC Survey among pregnant women conducted in 2008: urban HIV prevalence = 5.6%	ANC report, availability of data tools, DQA reports, HIV reports, acutare and up to date	
31	13. Epidemiological and Health Data	5.48	New Surveillance Strategic Plan for 2020-2024 is developed	2 years	Final version of the Surveillance strategic Plan for 2020-2024 disseminated	The current surveillance strategic plan is for 2015-2019; this plan will end next	Surveillance strategic plan for 2020-2024 validated by all stakeholders	
32	8. Commodity Security and Supply chain	5.61	Effective national logistics system is designed and implemented for community-based distribution of ARVs	3 years	eLMIS Reporting Rate: Percentage of Health facilities using eLMIS to submit report and orders	80% completion rate of reporting; Data use of subnational	100% completion of reporting rate; Data use of subnational level	
33	8. Commodity Security and Supply chain	5.61	Improved coordination among stakeholders; increased ownership of local institutions of supply chain	3 years	Level of country counterpart ownership demonstrated in quantification and supply	Country counterpart ownership estimated at 60%	Country counterpart ownership increased to 75%	
34	8. Commodity Security and Supply chain	5.61	Storage standards are fully complied with at both central and sub-national levels of the system. Implementation of	3 years	Percentage of storerooms with health commodities stocked according to plan (within min and max	Percentage of storerooms within health commodities stocked according to plan (within	Achieve at least 80% for all indicators including: - Percentage of storerooms	
35	8. Commodity Security and Supply chain	5.61	Effective national logistics system is designed and implemented for community-based distribution of ARVs	3 years	eLMIS reporting rate; eLMIS completeness.	Stockout rates (5%); Order fulfillment rates (83.5%);	a) Computer-based inventory management tool rolled-out to 82 health district depots;	
36	8. Commodity Security and Supply chain	5.61	Strengthen supply chain forecasting; Build capacity of inventory	3 years	Supply chain performance dashboard	Stockout rates (5%); Order fulfillment rates (83.5%);	a) Computer-based inventory management tool roll-out to 82 health district depots;	
37	8. Commodity Security and Supply chain	5.61	Optimum management of lab commodities both at central and subnational level of health systems	3 years	Stockout rates; Order fulfillment rates;	Stockout rates (5%); Order fulfillment rates (83.5%);	a) Computer-based inventory management tool roll-out to 82 health district depots;	
38	13. Epidemiological and Health Data	5.48	Improved data timeliness at central level for decision making	2 years	Situation Room report disseminated	No data	50% of health districts and connected and use the "Situation Room"	
39	13. Epidemiological and Health Data	5.48	HIV incidence and mortality surveillance systems among people living with HIV is established	3 years	HIV incidence and mortality surveillance systems established and operational	Cote d'Ivoire has neither conducted HIV incidence survey; needs to put in place a HIV incidence	Approved and validated Protocol, data collection tools and SOPs by all relevant committees	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
30	ANC report, availability of data tools, DQA reports, HIV reports, acutare and up to date			
31	Surveillance strategic plan for 2020-2024 printed and disseminated			
32	100% completion of reporting rate; Data use of subnational level is at least 90%;		100% completion of reporting rate; 100% Data use of subnational level is	
33	Country counterpart ownership increased to 90%		Country counterpart ownership increased to 100%	
34	Achieve at least 80% for all indicators including: - Percentage of storerooms with health		Achieve at least 100% for all indicators including: - Percentage of storerooms with health commodities stocked according to plan (within min	
35	a) National transportation system for biological sample is rolled out to 90% of the ART sites		a) National transportation system for biological sample is rolled out to 100% of the ART sites b) 100% of Health personel involved in lab	
36	a) Annual quantification and forecasting exercises generate an forecast accuracy rate of 90%		a) Annual quantification and forecasting exercises generate an forecast accuracy rate of 95% b) 100% of staff at central and peripheral level at	
37	a) National transportation system for biological sample is rolled out to 90% of the ART sites		a) National transportation system for biological sample is rolled out to 100% of the ART sites b) 100% of Health personel involved in lab	
38	100% of health districts and connected and use the "Situation Room"			
39	Incidence system established and data collected		Annual Incidence reports disseminated and mortality survey data published	

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
40	HHS/CDC	ACONDA VS-Follow-on	ACONDA VS - Follow-on TBD	18595	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample	Weak linkage between health facilities, social centers and community service
41	HHS/CDC	SEV CI- Follow - on TBD	SEV CI - Follow-on TBD	18596	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample	Weak linkage between health facilities, social centers and community service
42	HHS/CDC	Fondation ARIEL-Follow-on TBD	Fondation ARIEL - Follow-on TBD	18597	C&T	Improve identification, initiation, and retention of	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory sample referral/ transportation	Support health centers to participate in bidirectional referral system including sample	Weak linkage between health facilities, social centers and community service
43	USAID	Breakthrough Action (HC3 follow on)	JHUCCP	18606	C&T	Increase the practice of key HIV prevention behaviors, risk	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Assessments, evaluation, operation research	Analysis and dissemination of data collected during COP17 on men's knowledge and attitudes towards self-testing	Lack of data to inform self-testing programming for men
44	HHS/HRSA	Global Initiative Health Workforce for HIV	JHPIEGO	18639	C&T	Develop a CHW Training Package	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Workforce development, pre-service training	Support the early roll-out of the CHW cadre and identify and correct any challenge in their deployment	Suboptimal identification, linkage, and retention of PLHIV and in particular men and youths
45	HHS/HRSA	Global Initiative Health Workforce for HIV	JHPIEGO	18639	C&T	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Host country institutional development	Train the District Health Management team on providing adequate oversight and supportive supervision	Limited capacity of DHMT to provide supportive supervision to CHW teams
46	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	PREV	0	3.1 - Focus/target/customize early prevention programming and testing to	Assessments, evaluation, operation research	Assess barriers for testing services uptake among military personnel	Insufficient HTS services uptake by military population
47	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	PREV	0	3.1 - Focus/target/customize early prevention programming and testing to	IEC and/or demand creation	Support phone-based promotion of test & start advantages and available free care and treatment services through the	Insufficient HTS services uptake by military population
48	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	C&T	0	2.1 - Drastically increase early stage HIV diagnosis through optimized case finding, high risk assessment	Workforce development, pre-service training	Update training modules of the Military Health pre-service Training Center (CISSA) to include optimized testing at the	Limited pre-service training modules
49	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	C&T	0	1.3 - Rapidly expand successful treatment and retention strategies at all sites based on a robust	Laboratory sample referral/ transportation	Support viral load samples transportation to satellite and viral load testing laboratories	Insufficient coverage with viral load testing laboratories

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
40	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
41	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
42	1. Planning and coordination	9.5	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	2 years	Mer indicator Tx-PVLS	No data	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression	
43	13. Epidemiological and Health data	5.48	Contribute to finalized national self test policy and strengthen targeted programming/implementatio	1 year	Assessment reports	n/a	Data collection completed and final result disseminated	
44	7	7.2	Every large HIV facilities in priority SNUs are linked to a team of CHW	2 years	Percentage of large volume sites linked to a CHW team	5%	33%	
45	1. Planning and coordination	9.5	DHMT in every priority SNUs independantly provide supportive supervision to CHW teams	3 years	Percentage of priority SNUs DHMT independantly providing supportive supervision to	0%	25%	
46	6. Service Delivery	6.48 (SID 3.0) 4.43 (MILSID 2.0)	One qualitative survey among military population's report available	1 year	APR Narrative	No assessment available	One qualitative survey among military population's report available	
47	6. Service Delivery	6.48 (SID 3.0) 4.43 (MILSID 2.0)	27.5% increase in number of men using HTS services	3 years	MER indicator	DATIM targets	7.5% increase in number of men using HTS services	
48	Human Resources for Health	7.20 (SID 3.0) 4.37 (MILSID 2.0)	Updated CISSA training modules available	1 year	APR Narrative	No pre-service training modules on optimized testing at the facility level, index testing for	Updated CISSA training modules available	
49	10. Laboratory	6.00 (SID 3.0) 2.30 (MILSID 2.0)	95% of patients on ART on military sites have access to viral load testing for biological monitoring	3 years	MER indicator	No data	Viral load testing results documented for 90% of patients	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
40	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
41	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
42	95% of HIV+ patient have access to Viral Load test with 95% of Viral load suppression			
43	Activity completed		Activity completed	
44	95% of large volume sites in priority districts linked to CHW team.			
45	66% of priority SNU DHMTs provide independent supportive supervision to CHW teams.		100% of priority SNU DHMTs provide independent supportive supervision to CHW teams.	
46				
47	10% increase in number of men using HTS services		10% increase in number of men using HTS services	
48				
49	Viral load testing results documented for 92.5% of patients		Viral load testing results documented for 95% of patients	

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
50	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	HSS	0	3.1 - Focus/target/customize early prevention programming and testing to	Assessments, evaluation, operation research	Conduct an HIV Seroprevalence and Behavioral Epidemiology Risk Surveys (SABERS) among military populations, following	Lack of updated prevalence among military personnel by region, age and rank and
51	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	HSS	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Equipment procurement and maintenance	Strengthen capacities of the Ministry of Defense's HIV Sectoral Committee - CSLS - to lead high quality coordination	Insufficient capacity of the Ministry of Defense's Health system to provide quality HIV-related
52	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	HSS	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Host country institutional development	a)- Review status of 2018-2022 Military HIV Strategic Plan's yearly implementation including financial reporting, and support	Insufficient capacity of the Ministry of Defense's Health system to provide quality HIV-related
53	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	C&T	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	a)- Support CSLS and the military health system to implement at scale an electronic data management system for patients	Insufficient real time quality data availability
54	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	C&T	0	1.2 - Enhance capacity of sites to deliver tailored, high-quality HIV services at a high standard of care for priority	Laboratory quality improvement and	Support lab refurbishment work for VL testing services delivery	Insufficient adequacy of existing laboratories to offer VL related testing services
55	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	HSS	0	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Laboratory quality improvement and	Address gaps identified during the SLMTA accreditation process for 8 military laboratories	Insufficient compliance with WHO laboratory quality standards
56	DOD	DOD-FACI partnership program for sustainable HIV	TBD	70038	C&T	0	2.1 - Drastically increase early stage HIV diagnosis through optimized case finding, high risk assessment	Policy and governance	Update Ministry of Defense's HIV policies to integrate new priorities and describe their modalities of application; offer	Lack of up-to-date policies to support HIV response in the military sector
57	USAID	*[REDACTED]*	TBD	70057	HSS	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Financial management policies and procedures	a) DRM: Provide support to MOH to improve domestic resource mobilization and allocation for sustainable	Limited financial resources to close coverage gap
58	USAID	*[REDACTED]*	TBD	70057	HSS	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Policy and governance	Monitor progress of health account institutionalization building on the key indicators used by WHO	Limited financial resources to close coverage gap
59	USAID	*[REDACTED]*	TBD	70057	HSS	0	4.1 - Enhance national capacity for governance for sustained leadership and ownership and effective	Host country institutional development	a) Strengthen capacity of FNLS on leadership and resource mobilization techniques;	Insufficient domestic resources fighting HIV/AIDS

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
50	13. Epidemiological and Health Data	5.48 (SID 3.0) 5.48 (MILSID 2.0)	One SABERS report for military population available	2 years	APR Narrative	SABERS 2014	SABERS's protocol approved	
51	a)- Planning and Coordination	a)- 9.50 (SID 3.0) 5.15 (MILSID 2.0)	Ministry of Defense's CSLS and CISSA equipped	1 year	APR report	Ministry of Defense's CSLS and CISSA inventory lists	Ministry of Defense's CSLS and CISSA equipped	
52	a)- Service Delivery b)- Domestic	a)- 6.48 (SID 3.0) 4.43 (MILSID 2.0) b)- 6.79 (SID3.0)	a)-2018-2022 Military HIV Strategic Plan's yearly implementation reviewed; following years budgeted	3 years	APR Report	2018-2022 Military HIV Strategic Plan	a)-2018-2022 Military HIV Strategic Plan's year 1 implementation reviewed; year 2 budgeted operational	
53	a)- Performance Data b)- Laboratory	a)- 7.40 (SID 3.0) 3.18 (MILSID 2.0) b)- 6.00 (SID 3.0)	a)- 100% of military health centers with electronic data management system for patients records (EMR)	3 years	APR Narrative EMR at sites	a)- Not existing b)- Not existing	a)- SOPs developed; 75% of military health centers with electronic data management system for patients records	
54	10. Laboratory	6.00 (SID 3.0) 2.30 (MILSID 2.0)	1 military VL testing laboratory and 3 military satellite laboratories refurbished	1 year	APR Narrative	Existing 4 military laboratories, to receive VL testing satellite laboratory services	1 military VL testing laboratory and 3 military satellite laboratories refurbished	
55	10. Laboratory	6.00 (SID 3.0) 2.30 (MILSID 2.0)	3 military laboratories accredited (5 stars) and 5 other military laboratories with 4 stars	1 year	External laboratory audit report	8 military laboratories with 4 stars	3 military laboratories accredited (5 stars) and 5 other military laboratories with 4 stars	
56	2. Policies and Governance	4.56 (SID 3.0) 4.87 (MILSID 2.0)	Updated Ministry of Defense's HIV policies available	1 year	APR Narrative	2014 Ministry of Defense's HIV policies	Updated Ministry of Defense's HIV policies available	
57	12.Technical and Allocative Efficiencies	5.06	Increased national resources for HIV response; Establishment of a	3 years	Country investment profile; Domestic commitments	Modeling study on "Invest now in the fight against HIV / AIDS in Côte d'Ivoire or pay later?"	2019 GoCI National budget (National Finance Act); Baseline assessment report	
58	12.Technical and Allocative Efficiencies	5.06	Analysis of 2017 National health account produced to serve as DRM advocacy element	1 year	2017 National Health Accounts Report	2016 National Health Accounts Report; GoCI budget for health is	2017 National Health Accounts Report	
59	11. Domestic Resource Mobilization	6.79	AIDS control Funds (FNLS) receives pledges from various institutions to support HIV response	3 years	Amount of non-traditional resources mobilized for HIV response	25% of annual purchases of HIV commodities funded by GoCI	50% of annual purchases of HIV commodities funded by GoCI;	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
50	SABERS's final report available			
51				
52	a)-2018-2022 Military HIV Strategic Plan's year 2 implementation reviewed; year 3 budgeted operational plan produced		a)-2018-2022 Military HIV Strategic Plan's year 3 implementation reviewed; year 4 budgeted operational plan produced	
53	a)- 100% of military health centers with electronic data management system for patients records (EMR) operational;			
54				
55	6 military laboratories accredited (5 stars) and 2 other military laboratories with 4 stars		8 military laboratories accreditated	
56				
57	2020 GoCI National budget (National Finance Act) for Healthshows increase to 6.5% ;		2021 GoCI National budget (National Finance Act) for Healthshows increase to 6.8% ; At least 95% of GoCI funds for HIV commodities	
58	COP 2018 is Year One; activity is not continuing into COP 2019			
59	FNLS resoures mobilization plan developped; National Financial Strategy for HIV		Increased participation of non-traditional actors to HIV financing (Private sector institutions; Corporates, National philanthropists; etc..)	

	Agency	Name	Implementing Mechanims Name	Mechanism ID	Program Area	COP17 Strategic Objective	COP18 Strategic Objective	Approach	COP18 Activity (above-site, above-service delivery)	Key Systems Barrier
60	USAID	*[REDACTED]*	TBD	70060	OVC	Technical assistance to improve in-country use of	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	(a) Support the improvement of the National OVC database and the implementation of a user support system to improve	Weak national OVC information system and lack of data for DREAMS related interventions
61	USAID	*[REDACTED]*	TBD	70060	HSS	Technical Assistance to the MOH to support	4.3 - Bolster health systems strengthening for quality control, monitoring and real-time response	Information Systems	(a) Implement interoperability between data systems; (b) Support MoH to improve	Lack of an interoperable national health information system with the different existing
62	USAID	OPTIMIZE	ICAP	70062	C&T	0	4.2 - Accelerate policy implementation through direct diplomatic engagement with the	Technical area guidelines and tools	a) Creation of enabling environment: share up-to-date evidence, guidance and lessons learned from other country	Lack of inclusion of optimal new ARVs in national guidelines

	Related SID 3.0 Element	SID 3.0 Element Score	Expected Outcome	Expected Timeline for Achievement of Outcome (1,	Relevant Indicator or Measurement Tool	COP18 Baseline Data	Year One (COP18) Annual Benchmark (Planned)	Note: FY19 Q2 and K3Q4results will be
60	13. Epidemiological and Health data	5.48	Robust national OVC database, increased data use for decision-making, Girls roster and data collection	1 year	Field assessment	National OVC report. Although currently deployed at all 57 social centers, less than 10% of	80% of social centers and OVC platforms report quality data on time using the newly developed tools	
61	13. Epidemiological and Health data	5.48	100% of districts, 100% of regions and national level use data triangulated from the different health information	1 year	National health information system assessment report	National health information system assessment report 2017. DHIS2 is currently	80% of districts, 80% of regions and national level effectively use data triangulated from the	
62	2. Policies and Governance	4.56	TLD transition is completed. 90% of patients are transitioned to TLD. National treatment guidance is	2 years	% of ART clients on TLD; Execution of TLD Transition Plan	7% of adult ART clients on TLD	a)TLD transition plan endorsed and fully executed both at Central and subnational levels;	

	Year Two (COP19) Annual Benchmark	Note: FY20 Q2 and Q4results will be	Year Three (COP20) Annual Benchmark	Note: FY21 Q2 and Q4results will be
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62	a) Progress report on execution of TLD transition b) Assessment report on implemention		COP 2019 is Year Two; activity is not continuing into COP 2020	