

CAMEROON

Country Operational Plan

(COP/ROP) 2019

Strategic Direction Summary

May 10, 2019



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ACRONYMS

| | |
|-------------------|--|
| 3PL | Third Party Logistics |
| AGYW | Adolescent Girls and Young Women |
| AIDS | Acquired Immune Deficiency Syndrome |
| ANC | Antenatal Care |
| APR | Annual Performance Report |
| ART | Antiretroviral Therapy |
| ARV | Antiretroviral |
| CAD | Community ART Dispensation |
| CAMPHIA | Cameroon Population HIV Impact Assessment |
| CBA | Childbearing age |
| CBO | Community-Based Organization |
| CCM | Country Coordinating Mechanism |
| CDC | Centers for Disease Control and Prevention |
| CHW | Community Health Workers |
| CLHIV | Children Living with HIV |
| CODB | Cost of Doing Business |
| COP | Country Operational Plan |
| CSO | Civil Society Organization |
| DHIS ₂ | District Health Information System |
| DHS | Demographic and Health Survey |
| DIC | Drop-in Center |
| DoD | Department of Defense |
| DQA | Data Quality Assessment |
| DREAMS | Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative for young girls |
| DSD | Direct Service Delivery |
| DTC | Diagnosis and Treatment Centers |
| DTG | Dolutegravir |
| EA | Expenditure Analysis |
| ECD | Early Childhood Development |
| EGPAF | Elizabeth Glaser Pediatric AIDS Foundation |
| EID | Early Infant Diagnosis |
| EMR | Electronic Medical Record |
| FSW | Female Sex Workers |
| FY | Fiscal Year |
| GBV | Gender-Based Violence |
| GFATM | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GSM | Granular Site Management |
| GRC | Government of the Republic of Cameroon |

| | |
|--------|---|
| HBHC | Adult Care and Support (budget code) |
| HCW | Healthcare Workers |
| HEI | HIV-Exposed Infants |
| HIS | Health Information System |
| HIV | Human Immunodeficiency Virus |
| HKID | Orphans and Vulnerable Children (budget code) |
| HLAB | Laboratory Infrastructure (budget code) |
| HMBL | Blood Safety (budget code) |
| HSS | Health System Strengthening |
| HTC | HIV Testing & Counseling |
| HTS | HIV Testing Services |
| HTXD | ARV Drugs |
| HTXS | Adult Treatment (budget code) |
| HVCT | HIV Testing and Counseling (budget code) |
| HVMS | Management and Operations (budget code) |
| HVOP | Sexual Prevention – Other Sexual Prevention (budget code) |
| HVSI | Strategic Information (budget code) |
| HVTB | TB/HIV (budget code) |
| IBBS | Integrated Bio-Behavioral Survey |
| IDP | Internally Displaced Persons |
| IP | Implementing Partner |
| IPT | Isoniazid Preventive Therapy |
| KP | Key Population(s) |
| KPLHIV | Key Population (s) living with HIV |
| LCM | Linkage Case Management |
| LDTD | Long Distance Truck Drivers |
| LE | Locally-engaged |
| LPV/r | Lopinavir/ritonavir |
| LRA | Linkage and Retention Agent |
| LTFU | Lost to Follow-Up |
| LTWG | Laboratory Technical Working Group |
| M&E | Monitoring and Evaluation |
| MCH | Maternal and Child Health |
| MDR | Multi-Drug Resistance |
| MER | Monitoring, Evaluation, and Reporting |
| MMP | Multi-Month Prescription |
| MoPH | Ministry of Health |
| MSM | Men who have Sex with Men |
| MTCT | Prevention of Mother to Child Transmission (budget |

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

| | |
|--------|--|
| SOP | Standard Operating Procedure |
| SQA | Service Quality Assessment |
| STI | Sexually Transmitted Infection |
| TA | Technical Assistance |
| TAT | Turnaround Time |
| TAW | Treatment Access Watch |
| TB | Tuberculosis |
| TBIC | TB Infection Prevention and Control |
| TLD | Tenofovir/Lamivudine/Dolutegravir |
| TLD | Tenofovir/Lamivudine/Dolutegravir |
| TPT | TB preventive treatment |
| UNAIDS | Joint United Nations Program on HIV/AIDS |
| USAID | United States Agency for International Development |
| USG | United States Government |
| VCT | Voluntary Counseling and Testing |
| VL | Viral Load |
| WHO | World Health Organization |

1.0 Goal Statement

In close partnership with the Government of the Republic of Cameroon (GRC), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) will implement more strategic approaches and expand to all ten regions of the country to achieve HIV epidemic control. The Cameroon Population-Based HIV Impact Assessment (CAMPHIA), concluded in 2018, revealed HIV prevalence decreased from 4.3% in 2011 to 3.4% among adults ages 15-49 and Cameroon has achieved 56%-93%-80% of the Joint United Nations Programme on HIV/AIDS (UNAIDS) 95-95-95 goals. With better understanding of the epidemic and the gaps to reach these goals, national policy changes and strategic prioritizations have been made in order to achieve epidemic control by 2021.

Formal and informal user fees contribute to the financing of Cameroon's health sector and account for approximately 70% - 80% of facility operational budgets. However, out-of-pocket expenses create an undue financial burden for people living with HIV (PLHIV) and are a significant barrier to HIV prevention, care and treatment for the poor and vulnerable. Understanding that achieving epidemic control will be difficult if fees for HIV services remain in place, the GRC made a breakthrough policy decision in April 2019 to eliminate informal HIV user fees in the public sector immediately and all formal user fees for HIV services by January 2020. PEPFAR will support the GRC in meeting required milestones, recognizing the significance of this action in the country's national HIV response. Cameroon has an estimated 528,490 PLHIV. As of December 2018, 299,961 PLHIV were on treatment nationally and it is expected that 322,477 will be on antiretroviral treatment (ART) nationally by the end of 2019. In the 2019 Country Operational Plan (COP), PEPFAR will implement a scale up program at 298 high-volume clinical sites and 21 military clinical sites in all ten regions - grouped into four strategic zones, and will add 180,965 people to treatment over the next two years. To achieve this, PEPFAR will move aggressively, with 70% of the target (127,935) achieved in COP19, and the remaining 30% (53,030) in COP 20. PEPFAR Cameroon will also improve access to viral load (VL) testing to reach 85% of PLHIV. Additionally, 71,661 key and priority populations including men who have sex with men (MSM), female sex workers (FSW), and injection drug users will be reached with prevention activities, among whom 42,496 will be tested for HIV. Finally, PEPFAR will provide a core package of services to 54,413 orphans and vulnerable children (OVC), including 9,330 children living with HIV (CLHIV). Strategies will be tailored to address key gaps, including scale-up of same-day ART, Dolutegravir (DTG)-based regimens, VL monitoring, and differentiated service delivery models.

To accelerate achievement of these ambitious targets, PEPFAR will intensify partner management down to the site level and implement real-time corrective actions as needed. Regular engagement and close coordination with government, civil society, and bi-lateral and multi-lateral partners is critical to ensure the success of this scale up and reaching the 95-95-95 goals. PEPFAR is deeply committed to supporting GRC in achieving HIV epidemic control by 2021.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Cameroon's HIV/AIDS epidemic is mixed (i.e., one or more concentrated epidemics within a generalized epidemic). National HIV incidence is 0.27% among the population aged 15-64. Four out of five new infections are among women aged 15-64. While overall adult HIV prevalence is steadily decreasing (3.7% in 2017 to 3.4% in 2018); prevalence among women is more than twice that of men (4.8% vs. 2.0%, CAMPHIA 2018). HIV prevalence is highest among women between 40-44 years of age (9.3%); and over 8% among women aged 35-39 and 45-49. For men, HIV prevalence is highest in the 50-54 age range (6.0%), and over 5.3% among men in the age group 40-44. In previous COPs, the highest prevalence was among women between 35-39 and men 45-49; it suggests that this same population are older and age bands with the highest prevalence are adjusted accordingly. Adolescent girls and young women (AGYW) are more affected than their male counterpart: 1.2% vs. 0.2% in the 15-19 age range, and 2.9% vs. 0.6% in the 20-24 age range. HIV prevalence remains high among key populations (KP) at 24.3% for FSWs and 20.7% for MSM.

From CAMPHIA 2018, the economic capital, Douala, and the political capital, Yaoundé, together have an overall HIV prevalence of 3.4% with 5.2% among women and 1.7% among men. Other cities combined have an overall HIV prevalence of 3.7% with a 5.3% among women and 2.1% among men, while rural areas have HIV prevalence of 4.3% among women and 2.1% among men. The regions with prevalence above 5% are the three southeastern regions of the country (South, East, and Center), with prevalence of 6.3%, 5.9% and 5.8% respectively and the Northwest region, with a prevalence of 5.1%.

KP overall present with significantly higher HIV prevalence compared to the national average. Amongst KP sub-populations, understanding of how the epidemic differs by population type and age group is essential for effective programming. Disparities in prevalence amongst FSWs vary significantly by age according to the 2016 Integrated Bio-Behavioral Survey (IBBS). Though they represent a significant majority of FSWs, those below the age of 30 (20-24: 8.7%, 25-29: 16.1%) have a lower prevalence compared to those above the age of 30 (30-34: 33.8%, 35-39: 42.2%, 40-44: 46.3%, 45-49: 48.8%, 50-54: 40.0% and 55+: 26.3%). Similarly, amongst MSM, HIV prevalence is higher amongst older MSMs (20-24: 15.2%, 25-29: 29.4%, 30-34: 33%, 35-39: 40%, 40-44: 45% and 45+: 57.1%).

Table 2.1.2: 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*

| Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression* | | | | | | | | | | |
|---|-------------------------------------|----------------------|----------------------------|-------------------------------------|---------------|------------------|---|--------------------|----------------------------|----------------------|
| Epidemiologic Data | | | | HIV Treatment and Viral Suppression | | | HIV Testing and Linkage to ART Within the Last Year | | | |
| | *Total Population Size Estimate (#) | **HIV Prevalence (%) | *Estimated Total PLHIV (#) | PLHIV diagnosed (#) | ***On ART (#) | ART Coverage (%) | **Viral Suppression (%) | Tested for HIV (#) | Diagnosed HIV Positive (#) | Initiated on ART (#) |
| Total population | 24,764,836 | 3.4% | 528,467 | 323,231 | 278,366 | 53% | 44.7% | 2,722,045 | 89,566 | 71,942 |
| Population <15 years | 10,240,422 | | 42,182 | 23,622 | 10,169 | 24% | | 332,609 | 3,415 | 3,062 |
| Men 15-24 years | 2,355,779 | | 15,622 | 8,748 | 4,002 | 26% | | 219,575 | 2,616 | 1,608 |
| Men 25+ years | 4,541,880 | | 147,770 | 82,751 | 73,332 | 50% | | 603,388 | 27,081 | 20,174 |
| Women 15-24 years | 2,355,779 | | 40,680 | 22,781 | 16,543 | 41% | | 567,596 | 11,203 | 9,013 |
| Women 25+ years | 4,631,949 | | 282,236 | 185,329 | 174,320 | 62% | | 998,877 | 45,251 | 38,085 |
| +MSM | 66,842 | 20.7% | 13,836 | | | | | 5,057 | 747 | 710 |
| +FSW | 112,580 | 24.3% | 27,357 | | | | | 9,241 | 1,359 | 1,267 |
| PWID | | | | | | | | | | |
| ++Priority Pop (specify) | 50,000 | 3.3% | 1,650 | 990 | 884 | 54% | 39% | 7,081 | 362 | 213 |

*Data source is Spectrum 2018 **Data source is CAMPHIA 2018 ***Data source is DHIS2 National Data for 2018

+ Data Source is IBBS World Bank Report 2016 ++ SABERS 2018 and PEPFAR APR results 2018

Overall, HIV prevalence has dropped in the country from 3.7% (UNAIDS 2017) to 3.4% (CAMPHIA 2018). 56% of PLHIV have been diagnosed by end of 2018, with 53% actively on treatment. PLHIV less than 15 (24%) and aged from 15 to 24 (26%) have the lowest ART coverage as of 2018 results. Overall viral suppression is 44.7%, nationally, and 39% among militaries.

Figure 2.1.3 National and PEPFAR Trend for Individuals currently on Treatment

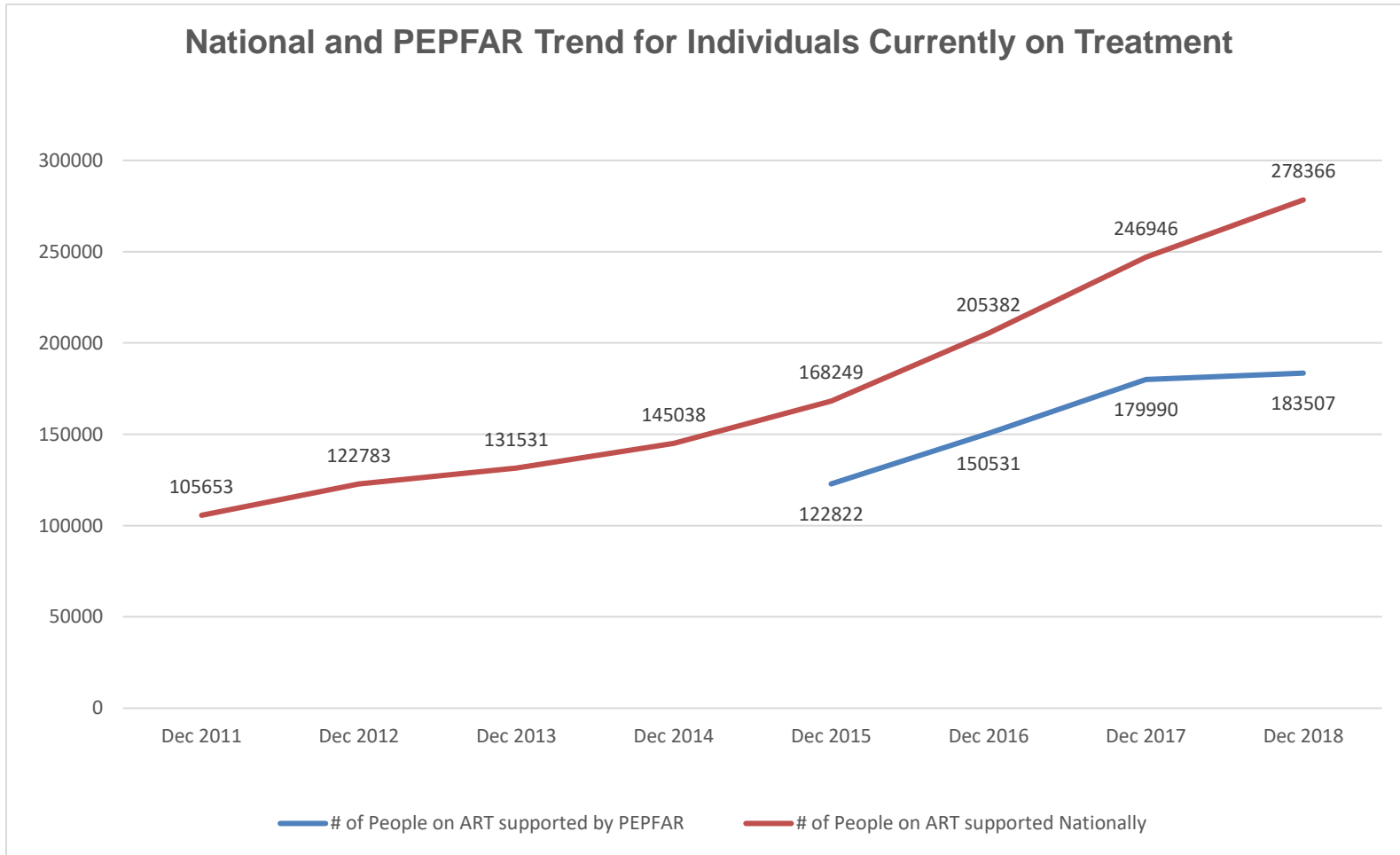
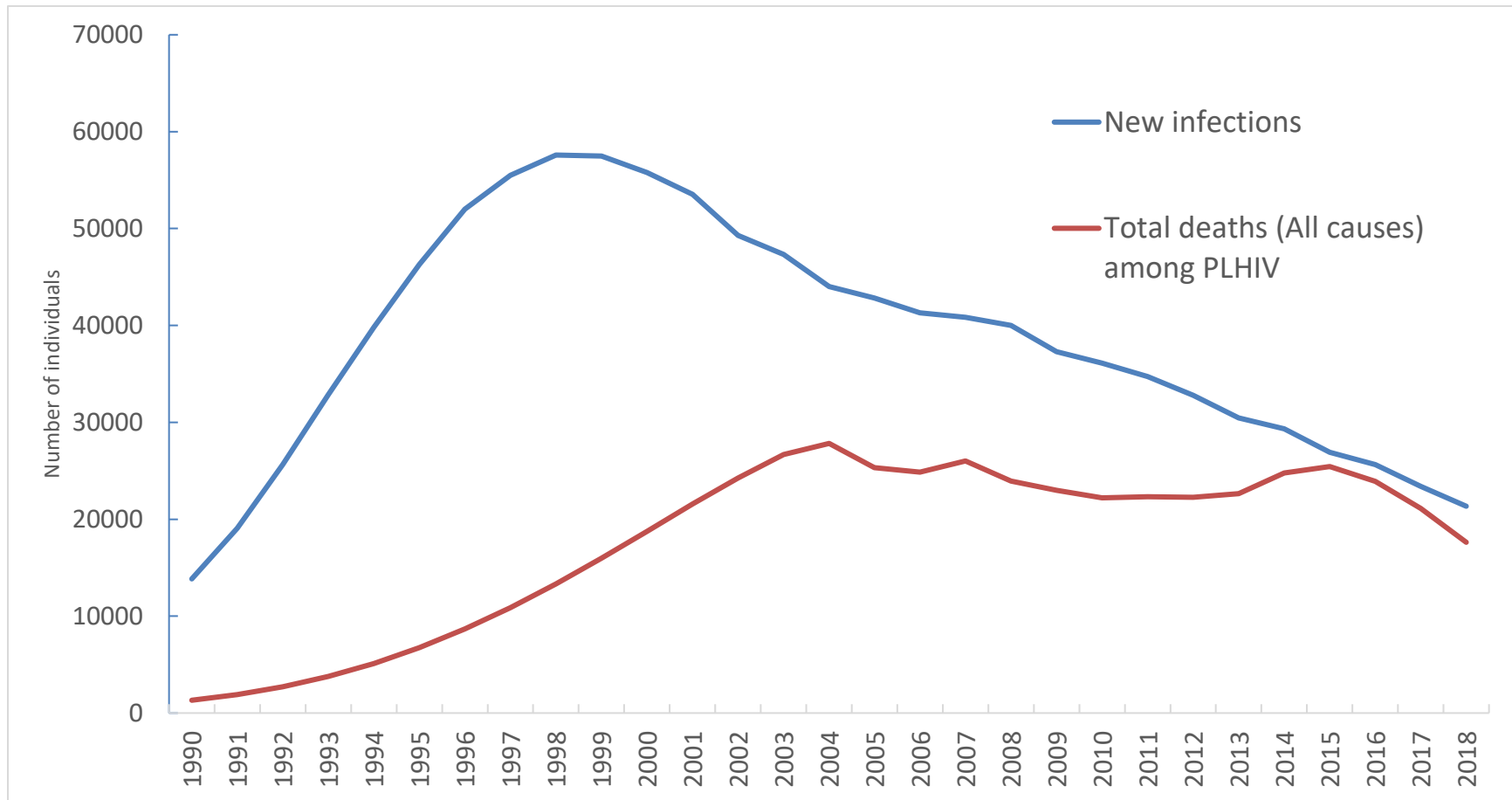


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV

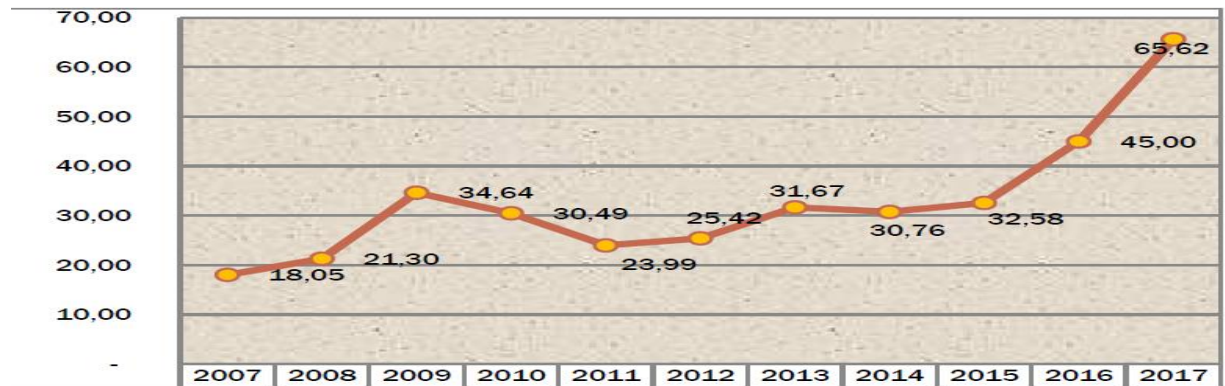


2.2 Investment Profile

The national and external expenditures data shown in Figure 2.2. 1 are based on the National AIDS Spending Assessment (NASA) for 2016-2017, released in 2017. In order to align with the 2016-2017 national expenditure report, PEPFAR Cameroon used data from the 2017 Expenditure Analysis (EA) to complete the table. National HIV/AIDS expenditures increased by 45.8% between 2016 and 2017, from \$74,999,460 to \$109,367,233 respectively.

Expenditures have been fluctuating annually since 2007 with an increase between 2007 and 2009 but a significant decrease of 30.7% between 2010 and 2011, due to the global economic crisis. As shown below, spending then increased 32% from 2011 to 2013. The implementation of Round 10 activities of the Global Fund for AIDS, TB, and Malaria (GFATM) and the growing involvement of bilateral partners such as PEPFAR, contributed to this increase in HIV expenditure. Under the New Funding Model (NFM) of the GFATM, funds allocated for the three-year funding cycle (2015-2017) were expended in the last two years (2016-2017); with the first half of 2016 devoted to preparatory work; hence the concentration of expenditures in 2017.

Figure 2.2.1: HIV/AIDS Spending, 2007-2017 in FCFA



(Source: Cameroon 2016-2017 NASA/REDES report)

The comparative analysis of the 2016-2017 expenditures and the projected budget in the 2014-2017 National Strategic Plan (NSP), shows that these funds represent 40% and 53.6%, in 2016 and in 2017 respectively, of the national HIV needs. The national HIV/AIDS response continues to rely heavily on donor funding. In 2016 and 2017, these funds accounted for more than 80% of all HIV expenses in the country.

Table 2.2.1: Annual Investment Profile by Program Area¹

| Table 2.2.1 Annual Investment Profile by Program Area ² | | | | | |
|--|-------------------|------------|--------------|----------------|-------------|
| Program Area | Total Expenditure | % PEPFAR | % GF | % Host Country | % Other |
| Clinical care, treatment and support | | 32.5% | 44.0% | 19.6% | 2.9% |
| Community-based care, treatment, and support | | | | | |
| HIV Testing Services (HTS) | | | | | |
| Laboratory | | | | | |
| OVC | \$69,364,341 | 99.6% | 0.0% | 0.0% | 0.4% |
| Prevention | \$922,034 | 27.4% | 56% | 2% | 8% |
| Strategic Information (SI), Surveys and Surveillance | \$23,279,327 | 34.5% | 60.9% | 0.3% | 0.2% |
| Health Systems Strengthening (HSS), clinical research & human rights | \$15,149,082 | 0.0% | 23.5% | 7.7% | 0.0% |
| Total | \$652,449 | 32% | 48.3% | 13% | 3.6% |

Source: 2016–2017 NASA/REDES report) Original report in FCFA, exchange rate used was 600 FCFA to 1 USD

Table 2.2.2: Annual Procurement Profile for Key Commodities

| Table 2.2.2 Annual Procurement Profile for Key Commodities in USD | | | | | |
|---|-------------------------|--------------|---------------|----------------|-------------|
| Commodity Category | Total Expenditure | % PEPFAR | % GF | % Host Country | % Other |
| Antiretroviral (ARVs) | 29,168,471.19 | 5.2 % | 81.4% | 13.4% | 0% |
| Rapid test kits | 5,855,721.06 | 6.4% | 74.1% | 19.5% | 0% |
| Other drugs | 1,554,273.26 | | 99.5% | 0.5% | 0% |
| Early Infant Diagnosis (EID) | 4,203,212.93 | 45.8% | 51.3% | 0% | 3% |
| Point of Care (POC) Viral Load | | | | | |
| Viral Load commodities | | | | | |
| POC EID | | | | | |
| Condoms | 166,666.67 | 0% | 0% | 100% | |
| Other commodities | 536,749.83 | 0% | 100% | 536,749.83 | |
| Total | \$ 41,485,094.94 | 9.24% | 77.89% | 12.59% | .03% |

Source: PEPFAR investments (Global Health Supply Chain (GHSC) program, EA 2017); National AIDS Control Committee, GFATM, and Central Medical Store Expenditure Incurred; Expertise France Expenditure 2017

Table 2.2.3: Annual USG Non-PEPFAR Funded Investments and Integration

| Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration | | | | | |
|--|--------------------------------|--|-----------------|------------------------------------|---|
| Funding Source | Total USG Non-PEPFAR Resources | Non-PEPFAR Resources Co-Funding PEPFAR IMs | # Co-Funded IMs | PEPFAR COP Co-Funding Contribution | Objectives |
| President's Malaria Initiative | \$22,500,000 | \$9,450,000 | 1 | \$2,280,596 | Through 18195, Procurement of health commodities (insecticide treated nets, rapid diagnostic tests, malaria drugs) focusing on the North and Far North regions. USAID also provides technical assistance (TA) focused on strengthening pharmaceutical management systems in the North, Far North, Littoral, Center, Northwest, and Southwest regions through support for regional pharmaceutical advisors, training of warehouse staff, upgrades to the Logistics Management and Information System and supportive supervision. |
| Global Health Security (CDC) | \$6,828,091 | \$700,000 | 0 | \$0 | The \$700,000 was for the GHSA Flagship Program. |
| Global Health Security (USAID) | \$4,000,000 | \$0 | 0 | \$0 | Focused on detecting viruses with pandemic potential, improving laboratory capacity to support surveillance, strengthening national and local response capacities, and educating at-risk populations on how to prevent exposure to dangerous pathogens. |
| USAID (NTD) | \$4,085,000 | \$0 | 0 | \$0 | Strengthening national neglected tropical diseases (NTD) program to control or eliminate trachoma, lymphatic filariasis, onchocerciasis, schistosomiasis, and soil-transmitted helminths. |
| Total | \$37,413,091 | \$10,150,000 | | \$2,280,596 | |

Table 2.2.4: N/A

2.3 National Sustainability Profile Update

PEPFAR Cameroon completed the Sustainability Index and Dashboard (SID 3.0) in the first quarter of FY18 through a collaborative process with full participation from the PEPFAR country team and

relevant partners. Included were external stakeholders from different PEPFAR supported regions and information was collected and fed into the SID 3.0 from civil society representatives, private sector entities, health committee parliamentarians, UNAIDS, United States Government (USG) and the GRC (through National AIDS Control Committee-NACC). The NACC convened a final review session with stakeholders in early FY18, with participants reviewing the completed tool, further discussing findings, identifying priorities and providing additional input. The next SID process will take place in late 2019.

Sustainability Vulnerabilities

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

Commodity Security and Supply Chain (5.43 - yellow): Weak procurement and supply chain management of HIV/AIDS-related commodities continues to negatively affect the attainment of the 95-95-95 goals. There is insufficient warehouse and inventory level optimization, insufficient institutional capacity to use HIV pharmacy information for decision making (fragmentation between logistics and strategic information, tools, and reports), and an inadequate supply of commodities to meet demand for new strategies such as provider-initiated HIV testing and counselling (PITC), retesting for verification, and proficiency testing (PT) panels. There is a national committee for the quantification of all health products and a sub-committee for quantifying and monitoring the supply of HIV products.

This notwithstanding, progress from last year has been the effective functioning of the high level technical working group with multi- sectoral ministerial members, members from development partners notably GFATM, PEPFAR, UNITAID, the private sector and the civil society; created to provide a complete transformation plan of the supply chain. In addition, with TA from the PEPFAR Cameroon's supply chain partner, Cameroon's operational plan on multi-month scripting has been finalized and is being implemented.

Policies and Governance (5.98, yellow): The overall policy environment has improved from last year with significant strides in removing barriers to accessing HIV services by PLHIV. The country has recently declared that there will be elimination of all HIV formal and informal user fees, effective by January 2020. In addition, progress have been made with policies, which were adopted in the 2018-2022 NSP and planned to be implemented within NFM 2.

Laboratory (5.83 - yellow): Cameroon has developed a NSP for the Development of Cameroon Laboratories 2016-2020. Additionally, a National Public Health Laboratory was built and Cameroon now has four ISO-15189 accredited laboratories (National EID Reference Laboratory Mutengene, Buea Regional Hospital Laboratory, Bamenda Regional Hospital Laboratory and the TB Reference Laboratory Bamenda).

A Laboratory Technical Working Group (LTWG) was created last year to improve coordination across the different laboratories; in view of avoiding activity over-lap and optimizing the resources of concerned stakeholders. To further lessen stock outs, commodity expiration and service disruptions, PEPFAR customizes well-adapted performance tracking tools, to strengthen national quantification and procurement of reagents and supplies for rapid testing, EID and VL.

Quality Management (5.76 – yellow): A Quality Assurance/Quality Improvement (QA/QI) technical working group has been created with the objective of building capacity of trainers to roll-out Cameroon's Quality Improvement Program. However, sites have not yet routinely incorporated ongoing evaluation of the quality of services offered.

In COP 18, PEPFAR Cameroon prioritized Commodity Security and Supply Chain, Policies and Governance, Laboratory, and Quality Management as above-site activities; with interventions to strengthen laboratory quality management systems (QMS) and to reinforce the Ministry of Public Health's (MoPH) health information system, intensify coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies. Furthermore, PEPFAR continues to provide TA to improve in-country logistics for effective and efficient delivery of health commodities to service delivery points, strengthening the capacity of leadership and governance structures to prioritize, and coordinate supply chain activities and improving visibility and the use of accurate and reliable data to drive informed decisions.

By the end of COP 19, the MoPH will have led the enforcement of the elimination of all HIV formal and informal user fees by the newly created Inspector generals' task force; as well as the implementation of the TLD³ plan. PEPFAR Cameroon will support VL/EID laboratories to ensure timely stock monitoring of VL commodities and anticipate any increase in VL commodity demand. Moreover, it will pursue adequate labeling and packaging of larger pack-sizes of ARVs of 90-count and 180-count bottles in its procurement and continue to improve on inventory management and ordering tools, as well as pharmacy management guidance to facilitate the implementation of multi-month scripting (MMS). If laboratory quality manuals and tools on VL have been finalized by the end of COP 19, the NACC will supervise and coordinate the implementation phase. This will improve coordination along sample referral network.

PEPFAR will advocate with the GFATM for an aligned increase in the next funding cycle. Currently, over 60% of GFATM funds is allocated to commodity procurement with limited funding to service delivery. To complement GFATM funding, PEPFAR has steadily increased funding to direct service delivery to improve on the quality of care provided to PLHIV.

To sustain epidemic control, PEPFAR Cameroon will intensify efforts to directly fund Cameroonian structures including local non-profit and GRC structures. CDC's current prime implementing partner (IP) is a local partner, and has been since the start of PEPFAR programming in Cameroon. DOD will begin the process of transitioning to a local partner in COP19 with the objective of having

³ Tenofovir/Lamivudine/Dolutegravir

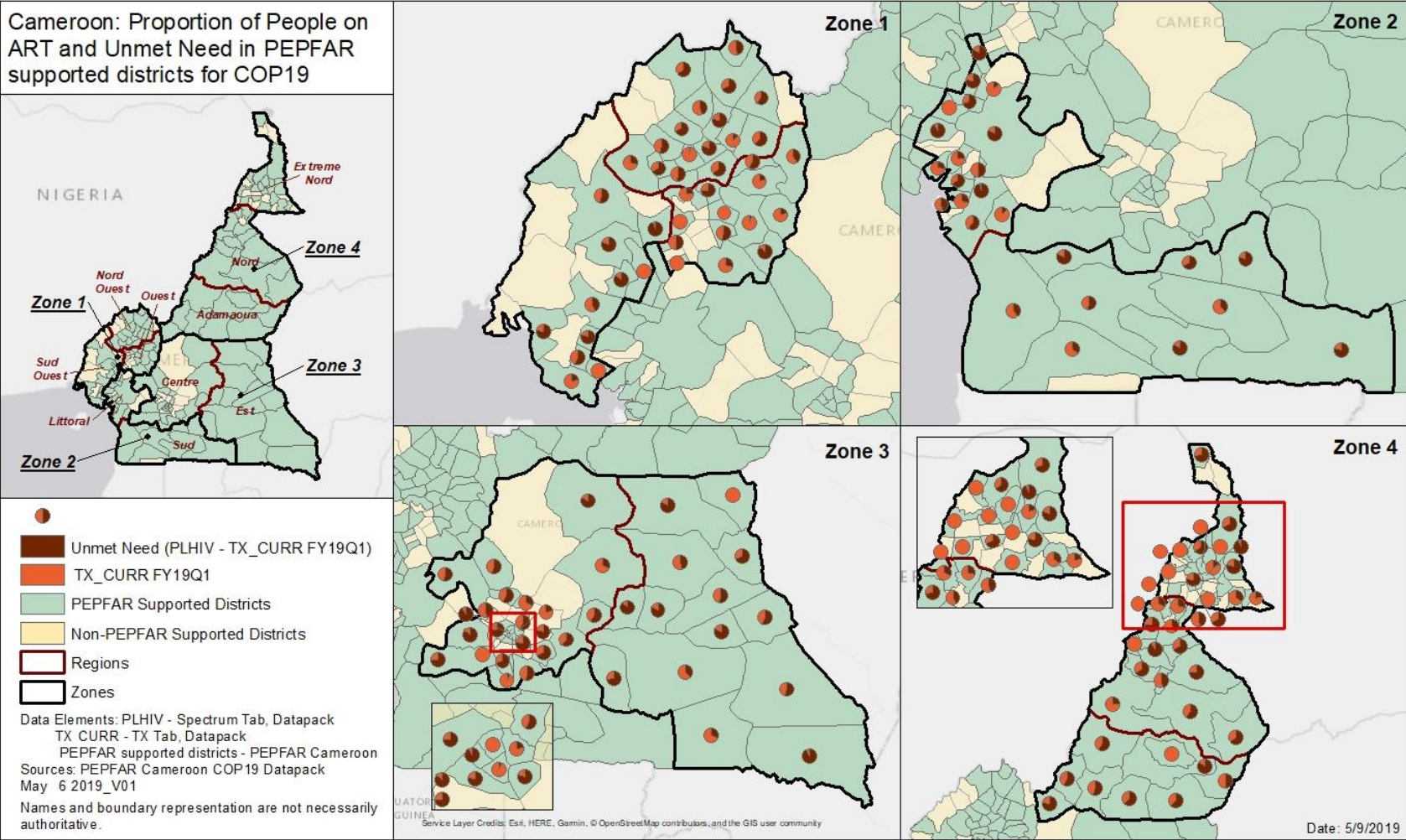
a local prime IP in COP20. USAID has also begun a process to transform its procurement and partnering approaches by prioritizing transition awards for all new procurements, including ensuring current international IPs develop the capacity of local organizations to become stronger and more mature entities that will enable them to become eligible to receive direct awards from the USG or other donors in the future. In COP19, USAID will directly support a local CSO to oversee the user fees elimination policy.

2.4 Alignment of PEPFAR investments geographically to disease burden

The map and inserts presented in figure 2.4.1 show areas where PEPFAR will provide support in FY2020, with focus on 144 health districts across all the 10 regions of Cameroon. All PEPFAR supported health districts have been distributed in 4 zones. Zone 1 is targeting West, South West and North West regions; Zone 2 Littoral and South regions; Zone 3 Center and East regions and Zone 4 the northern regions of Cameroon (Adamaoua, North and Far North). The map helps visualize not only the large unmet need in terms of PLHIV on ART in some of the new targeted districts, but also that ART coverage exceeds 80% in some districts such as the previous clustered ones (Cité Verte, Djoungolo, Deido, Mbangue, New Bell, etc) and in new targeted districts in the northern regions of Cameroon, as well as North West.

Beginning FY20, the type of support provided by PEPFAR to selected sites will be all Direct Service Delivery (DSD), such as same same-day ART initiation, multi-month scripting, community ART dispensation and differentiated schedules or flexible hours at health facilities. There will no longer be a sustained package. All interventions will be focused on rapid acceleration towards epidemic control in 298 scale-up health facilities and 21 military sites.

Figure 2.4.1 : ART coverage of PLHIV by SNU



2.5 Stakeholder Engagement

PEPFAR Cameroon has been building and maintaining strong coordination and collaboration with all relevant stakeholders including the GRC, Civil Society Organizations (CSO) core groups and other stakeholders. All relevant stakeholders are involved in the COP process beginning at the release of COP guidance through to the approval process and then through implementation. PEPFAR has been addressing HIV user fees up to the highest levels of government. During the COP19 Regional Program Meeting in Johannesburg, South Africa, the GRC representatives advocated to the new Minister of Public Health for the elimination of HIV user fees and the official decision was signed on April 4th, 2019 with elimination beginning on January 1st, 2020. PEPFAR and other stakeholders will support the GRC in meeting milestones throughout the year to ensure that timely implementation. Specifically, ensuring that funding is allocated to cover HIV user fees during the 2020 government budget negotiations that take place between October and November.

Collaborating with key stakeholders including community organizations to help enforce user fee elimination policy as well as generate demand, support adherence and retention efforts and strengthen linkages and referrals is crucial if epidemic control is to be attained. While PEPFAR support is guided by the 2018-2022 Cameroon National Strategic Plan, PEPFAR gives importance to the different perspectives on what will be considered credible evidence of outcomes and impact from all stakeholders. In that light, PEPFAR kicked-off the COP 19 planning process with a retreat in Yaounde with representatives from MoH-NACC, CSOs, multilateral organizations (UNAIDS, WHO), the CCM and Implementing partners; who were convened to provide sound recommendations for COP19.

Prior to the retreat, PEPFAR shared the COP 17 Annual Performance Report (APR), with the stakeholders to ensure the formulation of informed and meaningful recommendations for COP 19. CSO representatives present at the retreat underlined the importance of further broadening partnerships with all non-profit organisations as the fight against HIV/AIDS shifts in response to changing HIV policies in order to reach epidemic control by 2021. A CSO representative was present at both the Regional Program Meeting and the follow on meeting in Washington, DC to ensure that a CSO perspective was heard and incorporated into the COP19 development.

PEPFAR Cameroon has strong coordination with the GFATM to ensure there is no program duplication and address procurement and commodities challenges and to ensure that key and priority populations have improved access to HIV prevention, care, and treatment. A mapping of GFATM and PEPFAR investment in AGYW (a new focus for the GFATM) has been undertaken to avoid any duplication of effort. Additionally, the existing MOU between PEPFAR and GFATM partners will be revised to reflect updates in COP19.

PEPFAR Cameroon sits on the Health Sector Partners group which brings together all of the large donors engaged in the health sector to coordinate programming, encourage collaboration and avoid duplication; as well as exchange information on any issues or initiatives coming from the government.

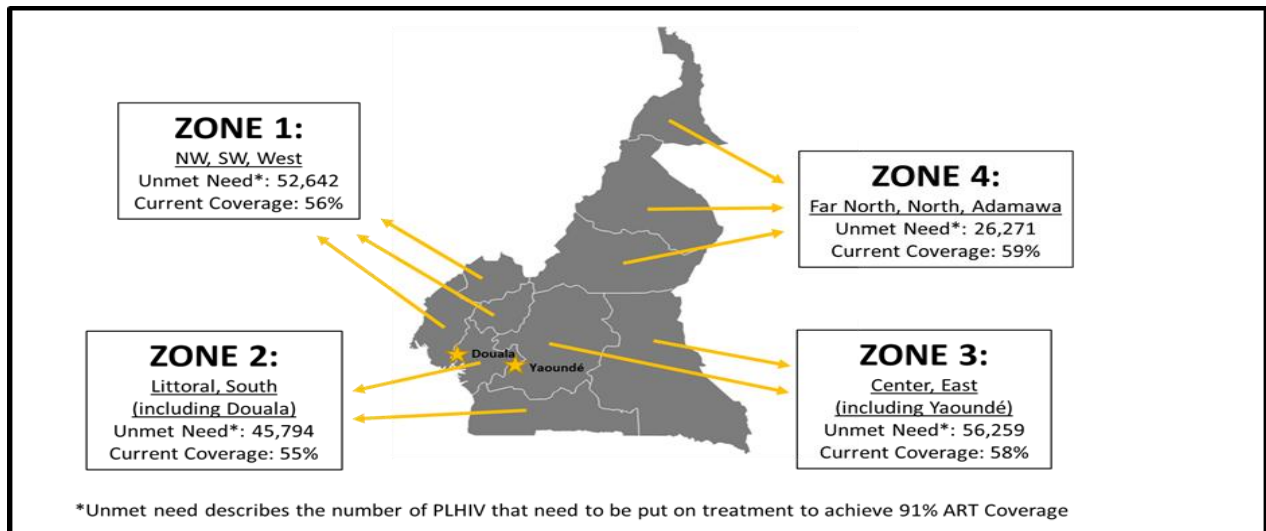
3.0 Geographic and Population Prioritization

In COP19, PEPFAR will increase its geographic coverage in Cameroon from four regions (Center, Littoral, North West & South West) to ten regions, implementing a scale-up package at the 298 highest volume clinical sites across the country to achieve 91% ART coverage nationwide by 2020. COP18 activities are implemented in 56 scale-up sites in Yaoundé and Douala clusters and 292 sustained sites in 58 districts across four regions.

The CAMPHIA, conducted from 2017 to 2018, provided information on national and regional progress toward control of the HIV epidemic. The survey showed a prevalence of 3.4% among adults ages 15-49, with regional variation ranging from 6.3% in the South Region to 1.5% in the Far North Region. The survey also revealed Cameroon’s progress toward achieving the UNAIDS 95-95-95 goals and indicate that 56% of PLHIV in Cameroon are aware of their HIV status, 93% of diagnosed PLHIV are on treatment, and 80% of those on ART are virally suppressed.

Over the next two years, PEPFAR Cameroon will add 180,965 patients on ART by moving aggressively in COP19 to achieve 70% of this target (127,935) and the remaining 30% (53,030) by the end of COP20 (FY 2021). PEPFAR has grouped the ten regions into four strategic zones: Zone 1 (Western Zone) will include the Northwest, Southwest, and West regions; Zone 2 (Southern Zone) will include the Littoral and South regions; Zone 3 (Eastern Zone) will include the Center and East regions; and Zone 4 (Northern Zone) will include the North, Far North, and Adamawa regions. Clinical partners will implement COP19 activities in each of the four zones in the different program areas. Above-site and community-based activities will be supported by other implementing partners. The current ART coverage and unmet need for each Zone are reflected in figure 3.1.

Figure 3.1: Current status of ART coverage and unmet need in achieving 91% ART coverage



To reach 91% coverage, PEPFAR Cameroon will support 298 sites in the four zones: 79 sites in Zone 1 (Western Zone), 72 in Zone 2 (Southern Zone), 73 in Zone 3 (Eastern Zone), and 74 in Zone 4 (Northern Zone). PEPFAR Cameroon will also support 21 military sites.

Table 3.1: TX_CURR and treatment population coverage by zones

| Zone | TX_CURR | Number of selected sites | TX_CURR at selected Sites | % of Treatment Population at selected Sites |
|---|----------------|--------------------------|---------------------------|---|
| Zone 1 (Western Zone): NW, SW, West | 83,990 | 79 | 76,173 | 91% |
| Zone 2 (Southern Zone): Littoral, South | 71,032 | 72 | 64,416 | 91% |
| Zone 3 (Eastern Zone): Center, East | 97,647 | 73 | 82,309 | 84% |
| Zone 4 (Northern Zone): North, Extreme North, Adamawa | 47,292 | 74 | 42,622 | 90% |
| Total | 299,961 | 298 | 265, 520 | 91% |

The top 298 sites will be divided into tiers based on the number of patients currently on ART (TX_CURR) at each site in order to ensure adequate HIV care and services and human resource alignment.

| |
|--|
| <p>Tier System: TIER 1: Sites with TX_CURR > 2,000 TIER 2: Sites with TX_CURR 1,001 – 2,000 TIER 3: Sites with TX_CURR 500 – 1,000 TIER 4: Sites with TX_CURR < 500</p> |
|--|

ART services will be scaled up for the general population (children, adolescents, young adults, men, and women), KP, other priority populations (PP), and the military.

Table 3.2: Current Status of ART saturation

| Table 3.2 Current Status of ART saturation | | | | |
|--|--------------------------------------|-------------------------|-----------------------|-----------------------|
| Prioritization Area | Total PLHIV/% of all PLHIV for COP19 | # Current on ART (FY18) | # of SNU COP18 (FY19) | # of SNU COP19 (FY20) |
| Attained | - | - | - | - |
| Scale-up Saturation | 489,515/92.6% | 297,627 | 12 | 144 |
| Scale-up Aggressive | - | - | - | - |
| Sustained | - | - | 46 | - |
| Central Support | 38,975/7.4% | 4,474 | 33 | 45 |

In COP19, PEPFAR Cameroon will expand its geographic coverage to all 10 regions, providing a scale up package of HIV prevention, care and treatment services to the highest volume clinical sites in order to reach epidemic control. PEPFAR Cameroon will continue to focus on current priority and key populations (KP), with an increased focus on reaching men including clients and regular non-

buyer partners of female sex workers (FSW) through the “Sex, Test & Treat” strategy using prevention education, self-test kits, and referrals to testing where available.

PEPFAR Cameroon will continue to prioritize KP, including FSW and MSM in Yaoundé, Douala and Bamenda, with an expansion to three new cities, Bafoussam, Bertoua and Ngaoundéré. In addition, the program will increase outreach, begun in FY19 (COP18), to injection drug users and transgender women, although the numbers are expected to remain small. Programmatic data alongside the most recent IBBS population size estimates demonstrates that the program may be close to saturation for some KP, especially FSW in Yaoundé and Douala. Given this potential saturation, there was a need to look to other locations for new case finding while continuing to offer prevention services to HIV-negative beneficiaries as well as adherence and retention packages to KP living with HIV (KPLHIV) within the Douala and Yaoundé clusters. This has led to an expansion of the PEPFAR KP program to three new cities, Bafoussam, Bertoua and Ngaoundéré.

The geographic focus targets the six largest and highest burden cities nationally, several of which include large universities which have proven to be an emerging area for case finding among MSM and AGYW engaging in transactional sex or seasonal sex work. The presence of major sex work hotspots along key transport corridors was also a prioritization criteria, in addition to the presence of refugees, Internal Displaced Persons (IDPs) and the associated humanitarian response (Bertoua and Bafoussam) that can increase vulnerability and sex work. In addition, coordination with the Cameroon National Association for Family Welfare (GFATM KP community Principal Recipient) helped determine areas with existing programmatic gaps.

Throughout COP18, average yields of approximately 14% were recorded for FSW and MSM and improvement over the previous year due to improved risk screening and scale up of index testing. Yields for those age 30 and above remain consistently higher and strategies are in place to target more older KP. Based on this and the geographic expansion to new cities, it is expected that yields will slightly increase in FY20 through improved focus on index testing and targeted testing of older KP.

With regard to OVC, the PEPFAR program will expand from 13 to 39 health districts to align with the expansion of the clinical program. Geographic prioritization is based on the residential location of beneficiaries with a focus on health districts rather than sites; thereby enabling the program to cover all CLHIV residing in a target health district irrespective of ART sites (including tier 2-4). The program will consist of prevention and case finding activities for OVC as well as ensuring community support for linkage to care and retention among children and adolescents living with HIV. Primary target beneficiaries include CLHIV and their families, HIV-positive pregnant and breastfeeding women (PBFW), and HIV-exposed infants (HEI). In addition, through its KP project, PEPFAR Cameroon will continue to offer an enhanced package of services to adolescent daughters of FSW in FY20 in the cities covered by the project. In recognition of the extreme vulnerability, regular exposure to violence, and the high risk of entering sex work for this subpopulation, resources will be focused on risk avoidance, risk reduction, gender-based violence (GBV) prevention and response, care, and support.

In alignment with COP 19 acceleration implementation, Peace Corps will strategically scale up Volunteer placement and community engagement across six (South, Adamawa, West, East, Littoral and Center) of the ten districts. Peace Corps Volunteer placements will be prioritized at ART facilities and CSOs working across tier 1 and 2 sites where Volunteers will work providing community and household level adherence support to adolescents living with HIV, PLHIV and their households. At the community level, OVCs – particularly older OVCs in the 10-18 years range will be reached through Peace Corps with a comprehensive package of layered interventions through DSD. GBV prevention will be systematically integrated into interventions. Similarly, Peace Corps Volunteers will expand their DREAMS-like approach by strategically partnering with OVC focused IPs and schools in priority health districts to maximize opportunities to reach AGYW and boys to provide age appropriate primary prevention with in and out of school AGYW.

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 ensuring viral suppression

CAMPHIA showed the HIV prevalence for populations ages 0-14, 15-49, 15-64 are 0.2%, 3.4% and 3.7%, respectively. Among adult ages 15-64 years, the HIV prevalence varies by region, ranging from 1.5% in the Far North Region to 6.3% in the South Region. The survey also revealed that 56% of PLHIV in Cameroon are aware of their HIV status, 93% of whom are on treatment and 80% of whom are virally suppressed. Age disaggregation shows an increase for higher age bands across the three 90s: Among the 15-29, 30-49 and 50-64 age groups, the 1st 90 was 29%, 61% and 69% respectively; the 2nd 90 was 92%, 92% and 97% respectively; and the 3rd 90 was 74%, 78% and 89% respectively.

Further disaggregation by sex shows higher awareness of HIV status among females in the 15-29, 30-49 and 50-64 age groups (31%, 63%, and 75% respectively) relative to males in the same age groups (22%, 55%, and 61% respectively). For the 2nd 90, we observe better trends among males (100%, 93%, and 97% respectively) compared to females (90%, 91%, and 97% respectively). For the 3rd 90, viral suppression among females on ART are 76%, 78%, and 85% respectively for the age groups, and 67%, 76%, and 96% respectively for males.

Of the 528,490 estimated PLHIV from CAMPHIA, only 57% (299,961) are currently on ART, resulting in an unmet need of 180,965 to reach 91% ART coverage in Cameroon. The ART gap to reach epidemic control varies from region to region as seen on the table below.

Table 4.1.1: Cameroon HIV burden and unmet need by region (CAMPHIA)

| Region | PLHIV* | Current on Treatment | Current Coverage | Gap to 100% Coverage | Gap to 91% Coverage |
|--------------|----------------|----------------------|------------------|----------------------|---------------------|
| Adamawa | 23,043 | 14,174 | 62% | 8,869 | 6,795 |
| Centre | 133,157 | 77,149 | 58% | 56,008 | 44,024 |
| East | 35,971 | 20,498 | 57% | 15,473 | 12,236 |
| Far North | 27,979 | 16,882 | 60% | 11,097 | 8,579 |
| Littoral | 101,529 | 57,772 | 57% | 43,757 | 34,619 |
| North | 29,816 | 16,236 | 54% | 13,580 | 10,897 |
| North West | 62,661 | 36,626 | 58% | 26,035 | 20,396 |
| South | 26,851 | 13,260 | 49% | 13,591 | 11,174 |
| South West | 60,590 | 25,289 | 42% | 35,301 | 29,848 |
| West*** | 26,893 | 22,075 | 82% | 4,818 | 2,398 |
| Total | 528,490 | 299,961 | 57% | 228,529 | 180,965 |

In order to reach epidemic control by FY21, PEPFAR Cameroon will expand the clinical program to cover 298 high volume sites to achieve 91% ART coverage across the 10 regions.

Spectrum 2018 estimates also identify population gaps by age group and sex, which need to be addressed in order to achieve HIV epidemic control. Table 4.1.2 shows major gaps in reaching all subpopulations, especially children, AGYW, and men. Strategies to address these gaps are detailed in ensuing paragraphs.

Table 4.1.2: Who Are We Missing – By Age and Gender (Spectrum 2018 estimates)

| Distribution by Age | Estimated PLHIV | | PLHIV currently on ART | | Current ART | | Remaining PLHIV that | |
|---------------------|-----------------|----------------|------------------------|---------------|-------------|------------|----------------------|---------------|
| | Female | Male | Female | Male | Female | Male | Female | Male |
| <1 | 1,222 | 1,269 | 295 | 318 | 24% | 25% | 695 | 710 |
| 1-4 | 4,890 | 5,077 | 1,178 | 1,273 | 24% | 25% | 2,783 | 2,839 |
| 5-9 | 7,495 | 7,738 | 1,880 | 2,006 | 25% | 26% | 4,191 | 4,262 |
| 10-14 | 7,154 | 7,320 | 1,491 | 1,551 | 21% | 21% | 4,304 | 4,378 |
| 15-19 | 13,139 | 6,323 | 4,534 | 2,479 | 35% | 39% | 6,109 | 2,643 |
| 20-24 | 27,538 | 9,297 | 10,483 | 2,699 | 38% | 29% | 11,823 | 4,832 |
| 25-29 | 42,234 | 17,256 | 18,926 | 4,946 | 45% | 29% | 15,284 | 9,031 |
| 30-34 | 53,857 | 25,617 | 28,159 | 8,825 | 52% | 34% | 15,465 | 11,925 |
| 35-39 | 57,526 | 29,590 | 34,278 | 12,478 | 60% | 42% | 12,318 | 11,490 |
| 40-44 | 46,090 | 27,113 | 29,713 | 13,489 | 64% | 50% | 7,620 | 8,473 |
| 45-49 | 30,305 | 20,221 | 20,439 | 11,359 | 67% | 56% | 4,108 | 5,020 |
| 50+ | 52,218 | 27,977 | 36,914 | 17,660 | 71% | 63% | 5,383 | 5,001 |
| Total | 343,668 | 184,799 | 188,290 | 79,084 | 55% | 43% | 90,081 | 70,603 |

In COP17 (FY18), PEPFAR Cameroon provided HTS to 1,108,767 clients, compared to a target of 958,361 clients, with an HIV positive yield of 3.6%. There were 39,853 HIV positive clients identified of the target of 50,588. 65.4% of the PLHIV were females and 34.6% were males. Age disaggregation showed that 73% of PLHIV were within the 25-49 age group, 14% were in the >50 age group, 9.4%

in the 20-24 age group, and 3.6% were below 19 years of age. The yield (1%) in the 0-14 age group was higher than the result shown by CAMPHIA (0.2%).

Outstanding gaps

The data indicate some progress has been made in case finding from 60.5% in FY17 to 78.8% in FY18 against targets set for the first 90. Nonetheless, achievement is still suboptimal especially among children, adolescent girls & young women (AGYW), and men. HIV case identification is a key step in the clinical cascade in achieving epidemic control, therefore strategies and approaches are needed to address this gap.

Strategies to improve HIV case finding

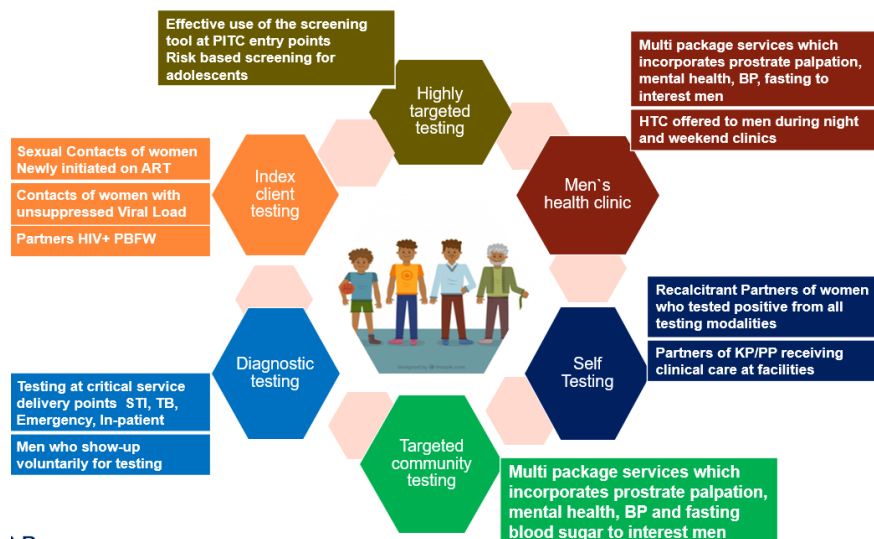
Based on analysis of PEPFAR's FY18 performance described above, PEPFAR Cameroon will expand high yield testing strategies to the six new regions (Adamaoua, East, Far North, North, South & West). PEPFAR Cameroon will also prioritize HTS for the following populations in the initial PEPFAR supported regions (Center, Littoral, North West & South West): children at risk for HIV, adolescents aged 10-19 who meet defined risk criteria, men (particularly in the 15-34 age groups), and women in the 15 -25 age group. In order to address these gaps, PEPFAR Cameroon will scale up approaches proven to improve case finding such as quality index testing and will discontinue non-targeted testing. PITC will occur at all high yield entry points such as TB clinics, In-patient services, Emergency, Malnutrition, Pediatric, PMTCT & VCT including mobile testing for clients of FSWs (yield of 4.5%). Index testing will target sexual partners of adult index cases, parents of pediatric index cases at ART/TB services (yield 43%) and also children exposed to HIV in facilities and Drop-In Centers (yield 16%). Index testing will be systematically offered to sexual partners of all newly initiated ART clients and old ART patients who are not virally suppressed, biological children of clients who are high risk for HIV through use of a screening tool to identify those children at risk of MTCT, and parents of all newly-diagnosed pediatric patients. Health care providers and IPs will be trained or retrained on identifying sexual contacts, biological children and parents of index cases for testing. PEPFAR will ensure the availability of various models of index testing such as self-testing in the KP program, partner to partner notification, and provider to partner notification. Targeted PITC using a screening tool to identify at-risk adults, adolescents and children will be offered at low yield entry points, including the community. Self-testing will continue in FY20 to reach partners of KP who refuse other testing modalities or are unwilling to come to the health facilities, drop-in centers (DICs) or KP community events.

To improve the quality of testing, mentorship and site supervision will be intensified at all sites. For all target populations and geographical areas, PEPFAR Cameroon will continue to use site level data by age and sex, and begin tracking performance at the site level by modality to identify high, medium, and low performing sites. Weekly data collection and reporting will be strengthened. IPs will work with high performing sites to identify and adapt best practices to mentor and support low performing sites to improve performance.

Strategies to reach men

In COP19, PEPFAR Cameroon will use index testing to reach husbands and sexual partners of HIV-positive women, sexual partners of MSM, clients and regular non-transactional partners of FSWs. Other strategies will include highly targeted testing in health facilities and community settings and self-testing for partners of pregnant women, partners of index cases and clients and non-transactional partners of FSWs who do not wish to access HTS in health facilities & DICs. In military settings, targets for self-testing will include non-commissioned officers, index partners who are military but do not wish to come to health facilities, and officers returning from deployments longer than six months. Diagnostic testing will also be implemented at critical service delivery entry points and VCT. HIV testing counselors will be extended to the new PEPFAR sites and will be responsible for counseling, testing and linkage of HIV positive clients at various entry points.

Figure 4.1.1: COP 19 Strategies to Identify Men 15+



For men in the 15-24 age groups, PEPFAR Cameroon will support health facilities to extend clinic hours and provide weekend services to accommodate working men and young men in school. Out-of-school young men will be targeted and mobilized for HIV prevention, care and treatment through youth associations and the use of social and print media such as “Amongst the Youth” and “100% Jeunes” magazines. HIV testing for adolescents and young men will be highly targeted based on risk mapping and behavioral analysis with the effective use of the screening tool at facility and community levels. Index testing will be offered to sexual contacts of adolescents and young men who are newly diagnosed with HIV or virally unsuppressed. Diagnostic testing will also be offered to adolescents and young men at high yield service delivery entry points and VCT. PEPFAR Cameroon will also identify “adolescent champions” to mobilize their peers and link them to adolescent-friendly HTS services.

Men aged >25 years will be reached through a package of modalities including index testing for sexual contacts of women newly initiated on ART, contacts of women with unsuppressed VL, partners of HIV-positive PBFW and partners of KPs. Men who are biological parents of HIV-positive children, will also be reached through index testing in all clinical settings. Options for HIVself-testing will be offered to partners of KPs receiving care at the community level. Targeted PITC will be offered to men with the effective use of the screening tool to assess risk and diagnostic testing at key service delivery entry points (sexually transmitted infections - STI, TB, emergency, in-patient) and VCT. Male-friendly services will be scaled up to reach military and civilian men with a multi-service package including prostate palpation, mental health evaluation, blood pressure screening, fasting blood sugar assessment, in addition to HTS on men's health clinic days. Extended clinic hours including night and weekend shifts will provide an opportunity to offer HTS to more men. Health education and literacy materials tailored to men's health will be scaled up to reach men aged 25 years and above in facilities and communities. The military program will provide health messaging (including the importance of testing at least once a year) and information on availability and location of HTS during morning assembly of military personnel. HIV testing information and health messaging will also be promoted on social media, social events and drop-in centers for KPs and for men accompanying their families to facilities. Outreach activities to find high-risk men in communities, especially during events that attract men (drinking spots, sporting events, resting spots for truck drivers, KP chill-ins, officers' mess halls, training centers for non-commissioned officers) will be used as opportunities to offer testing. PEPFAR Cameroon will continue reaching regular partners and non-transactional partners of FSW through a voucher referral system and self-testing.

Strategies to reach women

PEPFAR Cameroon will offer index testing to wives and partners of HIV-positive men and mothers of HIV-positive biological children in clinic settings. Targeted testing will be offered to at-risk women based on risk assessment with the effective use of the screening tool to achieve higher HIV yields. Routine HTS will be offered to all PBFW at antenatal care (ANC) services. Retesting of pregnant women who initially tested negative at first ANC visit and retesting for verification within the context of the test and start strategy will be offered. Diagnostic testing will be offered to women at critical high yield service delivery entry points (STI, TB, emergency, in-patient) and VCT. For all pregnant women, PEPFAR Cameroon will extend the 'Catch-Up Strategy' to reach pregnant women in hard-to-reach localities for ANC and PMTCT services in all PEPFAR-supported sites in the 10 regions, as this is the second highest modality through which HIV positive women are identified.

Figure 4.1.2: Strategies for Achieving Epidemic Control among AGYW



Self-testing will be offered to female partners of HIV-positive MSM. HIV testing among FSW will be prioritized and outreach testing for widows will be intensified within existing informal associations and gatherings of widows. PEPFAR Cameroon will also offer index testing to partners of HIV-positive AGYW and teenage PBFW. Targeted testing will be offered to at-risk out-of-school AGYW including teenage mothers based on risk mapping and behavioral analysis with the effective use of the screening tool at facility and community level. Diagnostic testing will also be available for AGYW at all high yield entry points. Out-of-school AGYW will also be targeted and mobilized for HIV prevention, treatment and care through youth associations and social and print media. Community testing opportunities will be made available for AGYW. Routine HTS and re-testing will be offered to AGYW who previously tested negative at first ANC visit. Post-GBV care package including HTS will be offered to AGYW who are victims of violence. PEPFAR Cameroon will also identify “AGYW and teenage mother champions” to mobilize their peers and link them to adolescent-friendly services to ease access to prevention materials, reproductive health care and HIV services. Service delivery will be adapted for AGYW working or in school to include extended working hours and weekends. PEPFAR Cameroon will apply a screening tool to identify and offer HTS to at-risk AGYW, particularly those who are already sexually active (including teenage mothers); those living in or around sex work settings; adolescent daughters of FSWs, those living in or around military barracks, AGYW who are widows, and presumptive TB cases.

PEPFAR Cameroon will support minor repairs and rearrangement of counseling space to ensure privacy and confidentiality for clients. Monitoring and supervision will be intensified to ensure improved quality of services and linkage to treatment for clients.

4.1.2 Getting PLHIV on treatment

Based on CAMPHIA and 2018 Spectrum estimates, 54% of PLHIV in Cameroon were on treatment at the end of December 2018, leaving a gap of 46%. Age and sex disaggregation further shows disparity of treatment coverage, with only 24% of PLHIV aged 10-19, 30% of 20-24 year olds, 47% of 25-49 year olds, and 57% of PLHIV above 50 years estimated to be on treatment. PEPFAR FY18 data show that of the 39,849 patients who tested positive, 37,213 were initiated on ART, reflecting an overall linkage rate of 93.3%. Age and sex disaggregation of the data revealed that among the 37,213 patients linked to treatment, 69.6% were females and 30.4% were males. Linkage rates among all PLHIV identified were 98% for children <15 years, 86% for adolescents aged 15-19, 85% for young adults aged 20-24, 95% for adults aged 25-49, and 92% for adults above 50. PEPFAR Cameroon evaluates site level linkage data by age, sex, priority population and testing modality on a weekly basis at each site, and will expand this routine evaluation to all supported sites across the 10 regions. PEPFAR Cameroon in FY19 provided technical assistance to MOPH in the development of the TLD Transition Plan and quantification. PEPFAR supply chain TA partner and clinical IPs will provide support to MOPH to begin TLD Transition in August 2019.

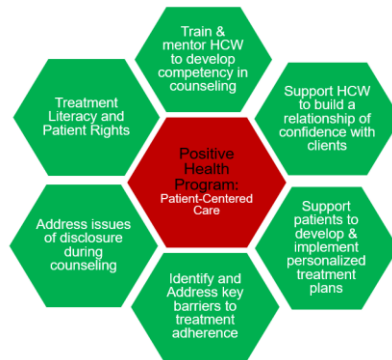
Outstanding gaps

Programmatic results show marked progress has been made in linkage of newly identified positives from 83% in FY17 to 93.3% in FY18. However, there are still gaps in linkage rates across some age groups, especially among adolescent 15-19 years (86%) young adults aged 20-24 (85%), whom there are also lower linkage rates for males relative to females. Linking PLHIV to treatment is a key step in achieving epidemic control, therefore strategies and approaches are needed to address these gaps. Other challenges identified during the return to care campaign (RTC) included denial of HIV status, limited patient HIV and general health knowledge, and stigma and discrimination.

Strategies to improve linkage to care and treatment

PEPFAR Cameroon will implement a patient-centered care initiative by rolling out a 'Positive Health Program' across the 10 regions. This initiative will include training and mentoring healthcare workers (HCWs) to develop competency in counseling, supporting HCWs (doctors, nurses, case managers, index tracers, testing counselors) to build a relationship of confidence with their clients, accompanying patients to develop and implement personalized treatment plans, identifying and addressing key barriers to treatment adherence, addressing issues of disclosure during counseling, and addressing patient rights. Patient literacy resources including posters, flyers, positive health booklets, etc. will be developed and used for patient education on their treatment and care. In FY20, PEPFAR Cameroon will support MOH in the roll out of TLD in all ten regions through training and mentorship of HCW, provision of SOPs, data collection tools for documentation and reporting and ensure the availability of commodities at site level.

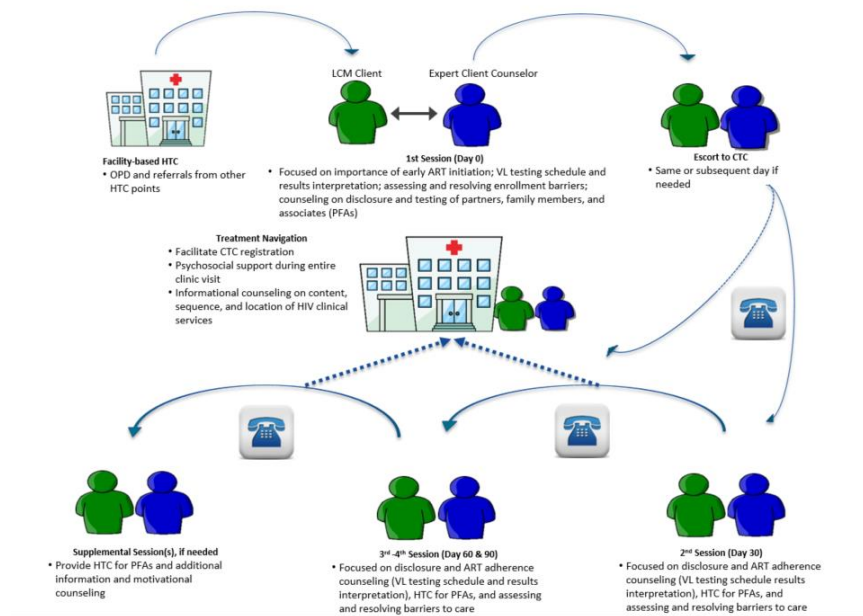
Figure 4.1.2.1: Positive Health Program



PEPFAR Cameroon will scale up same-day ART initiation while ensuring adequate patient preparedness through therapeutic education. Age-appropriate therapeutic classes for adolescents and young adults will also be intensified. The linkage agent model currently implemented across PEPFAR-supported scale-up clusters helped improve linkage rates for FY18 (93.3%). This model will be scaled up in all 298 PEPFAR-supported sites in the 10 regions. PEPFAR Cameroon will strengthen the existing linkage agent model with highly experienced expert client counselors to enhance linkage and retention through ‘CamLink’ a PEPFAR-solutions linkage and case management (LCM) strategy tailored to Cameroon.

Figure 4.1.2.2: Facility-Based LCM Model

Facility-Based LCM Model: CamLink



This model will reinforce accompanied referrals through peer linkage agents who are expert client counselors to target young people, adolescents and men. PEPFAR will continue to support

Cameroon government's decentralization of ART to PMTCT, TB, and HTS stand-alone sites to accommodate men and children through task shifting and promote the family care model.

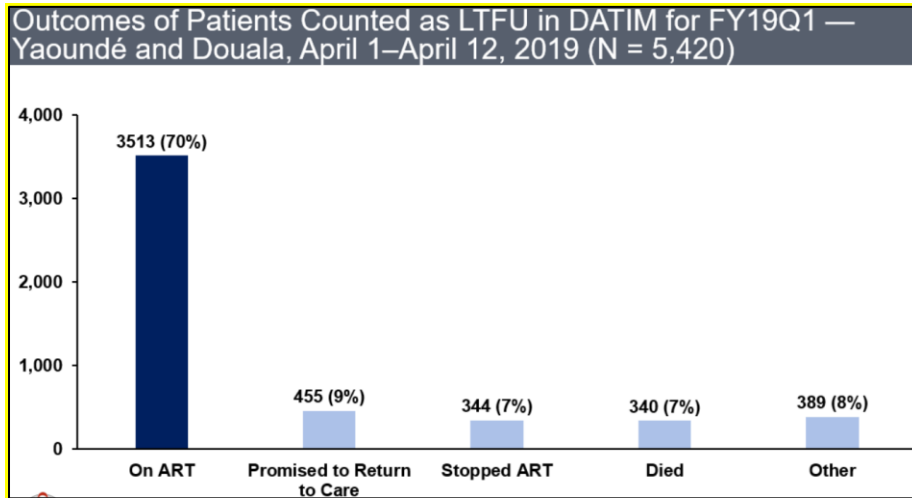
PEPFAR Cameroon will provide training and mentoring of HCWs to provide high quality HIV services to KP and PP who prefer to receive care and treatment in clinical facilities. This training package will include identification, monitoring, preventing stigma and discrimination, patient rights, diversity and service quality. While KP linkage rates have improved considerably in FY18, peer navigators will continue to connect newly identified HIV-positive KP clients to facility linkage and retention case managers through the hand shake model. Training of healthcare providers and setting up KP-friendly services will be intensified in the PEPFAR-supported sites, and community-focused strategies for KPs will be established in concert with existing civil society organizations.

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

4.1.3 Ensuring Retention & Viral Load suppression

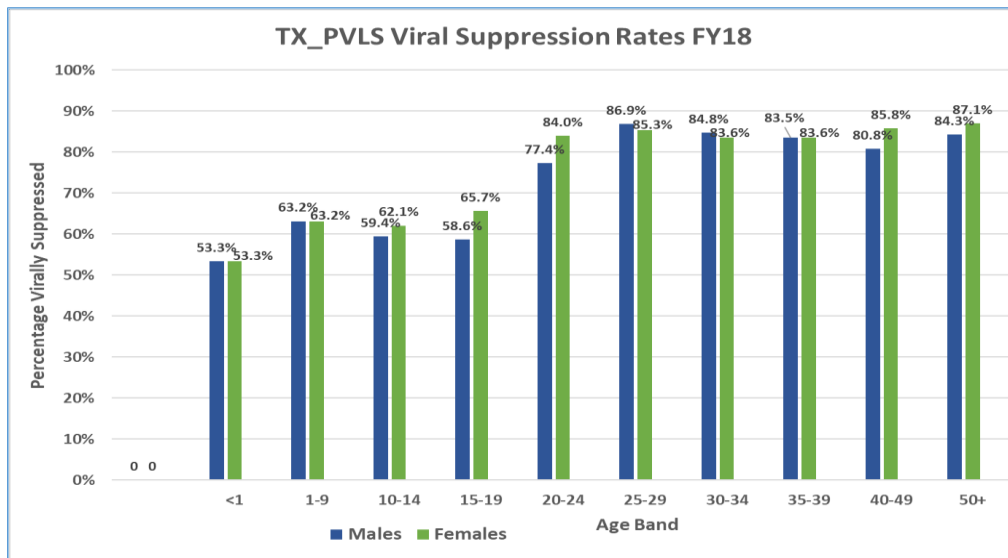
PEPFAR Cameroon FY18 results on PLHIV identification, treatment and retention over a 12-month period, revealed that only 46% of the PLHIV cohort (12,039) was still on treatment, down from 72% (37,646) reported in FY17. This result is well-below the 90% global target and showed substantial variations in retention rates across the age groups: 5% (309) among <15 year olds, 52% (7,817) among females >15 and 11% (3,913) among males >15 year-olds. Given the lower than expected retention rates across age bands, PEPFAR Cameroon organized a RTC campaign in Yaoundé and Douala clusters to determine outcomes of patients presumed lost to follow up in FY19 Q1 and facilitate their return to care. The rapid patient tracking effort revealed that 70% (3,513/5,420) of PLHIV unaccounted for were on treatment, but not properly documented, and a smaller proportion of patients were truly lost to follow-up (LTFU) or had discontinued treatment. PEPFAR Cameroon is applying lessons learned from the campaign to design effective Cameroon-specific strategies to address the challenges identified and strengthen patient retention in care across all age groups.

Figure 4.1.3.1: Outcomes of patients LTFU during RTC Campaign



PEPFAR Cameroon FY18 results on VL coverage was approximately 31% (58,419) of 188,979 PLHIV on ART. The overall suppression rate was 82% (48,102/58,419) – 81% for males and 84% for females, and age and sex disaggregation shows variations across the age groups.

Figure 4.1.3.2: Viral Load Suppression by Age and Sex, FY18 APR

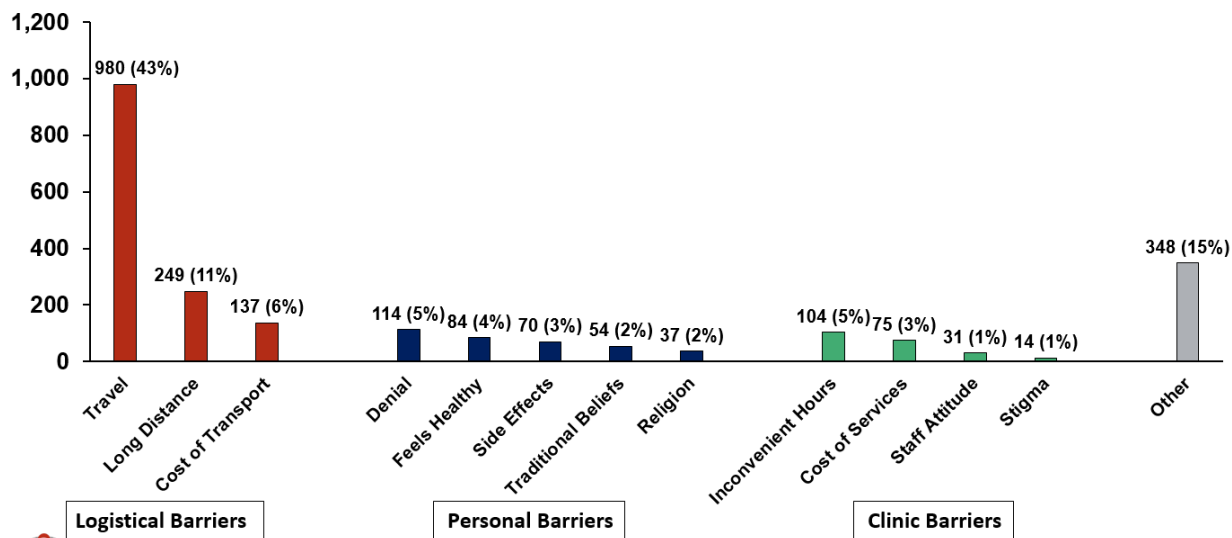


Outstanding gaps

FY18 results showed low retention rates (<90%) across all age groups. Children <15 years and adult men had lower retention rates. The RTC campaign also provided information on factors impacting retention such as clinical (inconvenient hours, cost of services, staff attitude, stigma), personal (denial, side effects, feeling healthy, traditional/religious beliefs), and logistical (travel, long distance to facility, cost of transportation) barriers, see Figure 4.1.3.3.

Figure 4.1.3.3: Factors Impacting Patient Retention

Documented Reasons for LTFU Among Patients in Yaoundé and Douala (N = 2,297 Documented Reasons)



Programmatic results also demonstrated suboptimal suppression rate of 82% overall and across various age groups and sex. VL suppression is significantly lower in age groups <24 and particularly for males within the 10-24 age group. The VL scorecard assessment of laboratory and facility readiness to scale up VL done in FY18 also highlighted key gaps affecting efficient VL scale up such as frequent stock out of VL reagents, inadequate systems for sample transport and return of results, low demand creation, poor monitoring of patients with high VL and lack of standardized tools and systems for the test request, and data collection and reporting.

Strategies to improve retention and VL suppression

To reach the FY20 treatment targets and maintain 100% of PLHIV on treatment, PEPFAR Cameroon will ensure all PLHIV initiated on ART benefit from a patient-centered care through the ‘Positive Health Program’ as previously described. This will consist of assessing patient readiness and preparing them for treatment through proper therapeutic education and effective counseling before ART initiation. Expert clients will accompany newly initiated patients to provide assistance with practical issues related to ARV medications during the first six months of ART, strengthen relationship with patients and therefore enhance retention in care. As part of the linkage and case management retention strategy (CamLink), HIV Case managers will identify and link patients to their preferred facility for ART treatment initiation and management. IPs will support health facilities to set up counseling space for therapeutic education and enhanced adherence counselling.

Differentiated service delivery models such as MMS will be provided for patients who are stable with suppressed VL to enhance adherence and retention. PEPFAR Cameroon will continue to advocate to GRC and MOPH for patient eligibility criteria for MMS to be reduced from 1 year to 6 months, and for MMS of up to 6 months for patients who have been stable on the current three MMS for at least a year. The program will also advocate for 6 months ART prescriptions for mobile patients and for men who identify challenges coming to the clinic for ART pickups. Community ART dispensation (CAD) for stable patients and task shifting will be strengthened and expanded. PEPFAR Cameroon will develop training materials on advanced disease patient management and will train HIV care providers to identify and manage advanced disease cases to reduce their high risk of morbidity and mortality. Retention tools standard operating procedures, registers, diaries, etc.) will be harmonized and checklists for patient retention will be developed for HIV case managers. In addition, training materials, roles and responsibilities for all site retention staff will be harmonized.

PEPFAR Cameroon will continue RTC efforts to ensure rapid tracking of defaulters and patients LTFU. Cohorts of patients will be assigned to linkage and retention case managers who will be responsible for monitoring patient appointments in harmonized logbooks, ensuring timely ART pick-up as scheduled, identifying defaulters and encouraging their return through phone calls, short message services (SMS), home visits, etc. PEPFAR Cameroon will also continue supporting PLHIV support groups and community adherence clubs including adapting group meetings at clinics to coincide with drug pickup and other clinical assessments. Support groups for patients newly initiated on ART and for those not virally suppressed will be created to improve adherence, retention and VL suppression.

PEPFAR Cameroon will improve access to VL testing to reach 85% of PLHIV (90% for those already on treatment and 75% for those newly initiated), including KP on treatment. Strategies include strengthening the sample transport system, ensuring availability of VL commodities, increasing VL demand creation, intensifying and enhancing adherence counseling for patients with unsuppressed VL using Undetectable = Untransmittable (U=U) messages, monitoring testing outcomes towards implementation of U=U, making available tools for monitoring patients with high VL, and ensuring adequate documentation and reporting. PEPFAR Cameroon will ensure improved management and monitoring of patients with high VL to increase number of patients eligible for MMS and CAD once virally suppressed and thereby ensuring improved adherence to treatment and increased retention. The reward for performance scheme to improve uptake of VL will be expanded to the other PEPFAR-supported sites. VL registers harmonized in FY18 will be produced and made available at sites for monitoring of patients by HCWs.

PEPFAR Cameroon will engage regional delegations of health and district health services to provide TA through mentorship and supervision to support prevention, care and treatment interventions in all 10 regions, including availability of commodities, documentation, and reporting to ensure quality HIV services to PLHIV. PEPFAR Cameroon together and IPs will conduct regular focus group discussions among PLHIV with emphasis on clients of priority and harder to reach

populations (such as men, AGYW, KP, youth) in order to continue to identify barriers to care, receive feedback on service quality, and continuously improve services that will increase access to HIV care and treatment.

PEPFAR Cameroon will work with IPs to ensure oversight of patient management and quality service delivery following the national standard operating procedures (SOP). Support will be provided to GRC to update existing SOPs and other job aides to successfully implement and monitor care and treatment activities. PEPFAR Cameroon will continue supporting health facility ‘retention committees’ to address issues related to retention and resistance. The program will support revision of ART tools to ensure documentation of ART side effects. Site mentorship will be intensified to improve quality of service delivery. This mentorship model will consist of onsite training, mentoring provided by expert physicians, nurses, expert client counselors, linkage and retention case managers from high performing ART sites to support low performing sites. Facilitative supervision will also be reinforced through the scale up of Granular Site Management (GSM), Site Improvement through Monitoring Systems (SIMS version 4.0), ongoing supervision and Continuous Quality Improvement initiatives to identify and address gaps in a timely manner.

PEPFAR Cameroon will assign clinical program staff to each clinical zone and specific sites to closely monitoring site level performance on a weekly basis by tracking missed appointments and accounting for site level retention. IPs will support sites to develop systems in place for daily data triangulation and use. Data use will be enhanced at sites to improve quality of service delivery. IPs will work with facilities to track retention in care by service delivery model, sex, and age, and will improve strategies to track, document and report LTFU outcomes more accurately. Best practices reported at top performing sites will be promoted and adapted at low performing sites. IPs will closely monitor use and report on facility charges of HIV user fees to ensure elimination of financial barriers to HIV care and treatment.

Strategies to improve retention among men

PEPFAR Cameroon implemented strategies in FY18 to improve retention among men, including adapted hours, weekend clinics and night clinic shifts to accommodate busy and working men. These strategies will be intensified and expanded to all PEPFAR-supported sites. MMS and CAD will be made available to stable male patients, with continued advocacy to GRC and MoPH for 6 months ART prescription for men who are mobile.

Fast Track mechanisms will be put in place to ensure men who attend clinics only for pickups are served in a timely manner. Improved documentation of MMS and CAD through DICs and other community-based organizations (CBOs) will be ensured to avoid misclassification of some patients as LTFU. This includes military on deployment who sometimes receive 6-month ART packs or are served in the community and are misclassified as LTFU. Health education and literacy materials tailored to men’s health will be developed and made available to all men including KP and PP, with peer linkage and retention agents available to address male, KP, and PP specific issues. Peer support groups and male-friendly clinics will be scaled up in all PEPFAR-supported sites.

Strategies to improve retention among children and adolescents

Since FY17, PEPFAR Cameroon implements a bi-directional referral system for CLHIV between clinical sites and the OVC program. The clinical service providers receive OVCs at health facilities and provide HIV prevention, treatment and care services, while the OVC service providers conduct monthly home visits to provide community-based care and support and other wraparound services in core areas identified in individual case plans of HIV-positive children and adolescents (see section 4.1.5 and 4.2 for description of OVC program). PEPFAR Cameroon will expand this strategy across the 10 regions to enhance uptake of HIV services and retention of children in care.

PEPFAR Cameroon will support IPs to reinforce the alignment of drug pick-ups for children with appointments for vaccination, mother's drug pick-up or support group activities. Adolescents' drug pick-up times will be adapted to fit school schedules. PEPFAR Cameroon will continue supporting adolescent treatment support groups and train providers and case managers to assist them with disclosure, build their capacity on life skills, provide information on sexual and reproductive health, counseling on treatment adherence and proper transition to adulthood. PEPFAR Cameroon will also support the identification of "adolescent champions" to lead age-appropriate therapeutic education and foster retention. The "Enhanced Adherence Counseling" program will be implemented in clinical settings, which includes provision of tailored messaging to caregivers of children and adolescents, and establishing a system for timely return and management of high VL results in pediatric clinics.

Clinical Service Delivery in Conflict zones

Over the past four years, Cameroon has been affected by Boko Haram activity in the Northern regions and armed conflict in the North West and South West regions, leading to massive internal displacement and movement of populations from the affected areas across the border into neighboring countries. The situation is particularly worse in the North West and South West, with the ongoing 'Anglophone crisis'. The health sector has been significantly affected by the conflict, with service interruptions due to closure of some health facilities, arson and destruction of health facilities and other infrastructures, and attacks on health personnel. In addition, there has been difficulties in transporting ARVs, vaccines, other drugs and commodities from the regional stores to the health facilities. The theft or destruction of motorcycles and vehicles and restricted movements in the areas, referred to as 'ghost towns', limits healthcare access and affects reporting from health facilities in the conflict areas. There is increased risk of HIV transmission among affected populations because of behavioral changes due to interruption of social networks and economic vulnerability (particularly among women and adolescents) as well as sexual violence and disruption of health services. In FY18, most of the health districts in the PEPFAR-supported North West and South West regions were impacted by the ongoing armed conflict.

where traveling back and forth is safer; 6-month MMS for displaced and hard to reach clients, and use of clients who can get to facilities to distribute ART to other clients.

Outstanding Gaps

FY18 results across the quarters showed a decline in HTS_POS, TX_NEW, and TX_CURR. These results are also reflected in the PMTCT, Pediatric and TB cascades. Populations affected by humanitarian emergencies and armed conflict are often at increased risk of HIV due to insecurity and other vulnerabilities. Refugees and IDPs are not often included in national HIV strategic plans, so may not receive prevention and treatment services. PLHIV are particularly vulnerable to the effects of instability associated with conflicts as they have difficulty accessing health services for treatment and care. Traditional service delivery packages at health facilities are ineffective and follow up of patients on ART in these areas has been challenging.

Strategies to improve HIV services in the conflict zones

PEPFAR Cameroon will expand HIV services in the conflict-affected areas and health care providers will be trained and mentored on provision of HIV and TB prevention, care and treatment services in conflict settings. In COP19, the program will focus testing support on targeted HIV testing services using mobile community clinics working in hideouts and bushes, index testing through facilities. The use of continuous care cards and displaced clients registers will be scaled up across the country. HIV service delivery will be extended using mobile community clinics working in hideouts and bushes. The capacity of health care providers will be strengthened to offer improved GBV service delivery, including post-exposure prophylaxis and HTS for victims of sexual violence. PEPFAR will advocate to the GRC to increase access of displaced persons to six-month drug supplies and improving drug availability. In collaboration with GRC, PEPFAR Cameroon will ensure availability of condoms to displaced populations in the conflict regions. The reward for performance scheme to improve uptake of VL for displaced clients will be expanded and the use of a hotline to provide information for displaced clients will be explored. The use of clients who can get to facilities to distribute ART to other clients will be scaled up.

PEPFAR Cameroon will also target and provide support to reach TB/HIV co-infected patients through the mobile clinics. To decrease the burden of TB among PLHIV, clinical IPs will intensify case finding for TB among PLHIV, and provide Isoniazid Preventive Therapy (IPT) to PLHIV who screen negative for TB. To decrease the burden of HIV among TB patients, clinical IPs will include HIV testing and counseling for presumptive and confirmed TB cases, ensure linkage to ART for those diagnosed with HIV, and decentralize TB case finding and management through facility or community outreach strategies. Data collection tools will be adapted and made available for proper documentation, data collection and reporting.

4.1.4 PMTCT

In February 2018, GRC released a decision memo to decentralize ART to all PMTCT, HTS, and TB stand-alone sites for a more holistic family approach. PEPFAR Cameroon supported GRC's decentralization policy and expanded ART services to PMTCT, HTS, and TB stand-alone sites in PEPFAR-supported regions. This strategy resulted in an increase in the number of sites providing ART to all populations from 254 in 2017 to over 3,300 by December 2018 across the country. To improve on the ANC coverage gap identified in FY17, PEPFAR Cameroon implemented a catch-up strategy to reach pregnant women with PMTCT services in hard-to-reach populations. This improved the coverage for pregnant women accessing ANC and PMTCT services. In addition, cohort monitoring for PBFW on ART was implemented in FY18 to improve retention to care and reduce mother to child transmission of HIV. Index testing was also scaled up for partners of HIV-positive PBFW.

Results and achievements

PEPFAR Cameroon received 194,772 of an expected 262,196 pregnant women at ANC in PEPFAR-supported sites in FY18, representing 74.3% coverage. The program did not achieve the 90% target for ANC coverage; however, this was an improvement compared to 52% in FY17. Of all pregnant women who attended ANC, 187,250 (96%) were tested for HIV, among whom 8,630 tested positive, representing 54.2% of the expected target of 15,920, with a yield of 5% for both known and new and 2% (3,198) for the newly tested positives. Of the 8,630 pregnant women who tested positive, 8,339 (97%) received ART. PEPFAR Cameroon regularly analyzes the clinical cascade for pregnant women to inform program improvement strategies. Additionally, IPs continue to work with facilities to identify and address key barriers to PMTCT uptake such as decentralizing PMTCT services to informal health facilities that are providing limited HIV services to PBFW with no documentation or reporting.

Outstanding gaps

Although progress has been made to improve ANC coverage from 52% in FY17 to 74.3% in FY18, substantial efforts still have to be made to reach the 90% target for ANC coverage with focus on PBFW who are IDPs in the conflict-affected regions, those in hard to reach communities, and AGYW. HIV user fees have resulted in missed opportunities to offer PMTCT services and impacted retention on ART for PBFW. Stock outs of test kits remain a challenge, and VL coverage for PBFW is suboptimal (12%).

Strategies to improve PMTCT Uptake

To increase ANC coverage in COP19, PEPFAR Cameroon will expand implementation of integrated community interventions through the Catch-up strategy by Community Health Workers (CHWs) to find pregnant women in hard-to-reach populations who have difficulties accessing health care, with active linkage to health facilities using the dialogue structures. IPs will work with district health services to map out areas with low ANC uptake to provide targeted community outreach services. Routine HTS will be offered to all PBFW at ANC services. Retesting of pregnant women

who initially tested negative at first ANC visit and retesting for verification within the context of the test and start strategy will be offered. PEPFAR Cameroon will institutionalize comprehensive family HIV prevention, care and treatment programming by supporting decentralization of ART to PMTCT stand-alone sites and intensifying same day ART initiation for pregnant women who test positive.

PEPFAR Cameroon will support GRC to ensure effective implementation of the decision to eliminate user fees for ANC. PEPFAR Cameroon will also implement a reward for performance scheme in priority districts to find pregnant women in the community and link them to the facility. CHWs will empower women through home visits and community-based action groups to improve their awareness of ANC services and facilitate trust in health care workers. Mobile health technologies, SMS reminders and encouraging messages through social and print media will be used to increase community mobilization for ANC services. The mother-mentor program will be rolled out in all PEPFAR-supported sites. Community-facility linkage through CHWs will be expanded across the 10 regions. Partner notification will be scaled up for partners of HIV-positive PBFW. Site level performance data across the clinical cascade for PMTCT will be monitored and used for performance improvement.

Strategies to improve retention of pregnant and breastfeeding women on ART

PEPFAR Cameroon will expand the implementation of the ANC and postpartum care package during the ANC and postnatal period, which includes vaccination, ART, VL, and family planning services for PBFW to improve retention in the PMTCT program. PMTCT cohort monitoring, which was implemented in FY18 to improve retention of PBFW on ART, will be expanded to all PEPFAR-supported sites in the 10 regions. Cohort monitoring tools and SOPs will be produced to monitor outcomes for HEIs and the mother-baby pair on ART and service providers trained on their use. Linkage and retention case managers will strengthen community-facility linkages through active defaulter tracking programs, home visits, and psychosocial support group programs. Support group activities for PBFW will be expanded and PBFW who consent will be provided TLD to improve their retention on treatment.

PEPFAR Cameroon will engage regional delegations of health and district health services to support ANC and PMTCT interventions and reporting in informal health facilities to ensure provision of quality ANC and PMTCT interventions in line with national guidelines, access to PMTCT commodities, linkage of HIV-positive PBFW to established health facilities for continuum of care as needed, and documentation and reporting on PMTCT interventions. PEPFAR will work with IPs to ensure continuum of care to IDPs by using case managers to reach out to PBFW and their partners with HIV services. PEPFAR Cameroon will continue to support GRC to adopt a VL algorithm for PBFW to ensure appropriate follow up and VL suppression. VL testing for PBFW will be scaled up and expanded to the new PEPAR-supported sites to monitor viral suppression, with training and mentorship of HCWs to ensure effective implementation.

4.1.5 Pediatrics

Cameroon has further decentralized point of care EID for HEI to a number of reference, regional, and district hospitals to reduce turnaround time and accelerate early management of children infected with HIV. In 2017, this strategy was implemented in 58 sites in the four PEPFAR-supported regions through Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), with support from UNITAID, which contributed to improved EID uptake for HEI. Prophylactic ART coverage for HEI within 2 months increased from 76% in 2016 to 90% in 2017 (NACC Annual Report, 2017). This performance could be attributed to the improved availability of commodities for EID and the availability of pediatric psychosocial support agents to ensure tracking and documentation of defaulters.

The identification and management of HIV-positive children and adolescents remains suboptimal. Coverage for HIV-positive children and adolescents increased from 18.4% in 2016 to 56.7% in 2017.

In FY18, PEPFAR Cameroon supported the implementation of several strategies to improve uptake of HIV services for pediatric populations, including decentralization of pediatric ART in health facilities through task shifting. Service providers were trained to offer quality ART services to children and adolescents, PITC was offered at all pediatric entry points in health facilities and in the community, index testing of biological children of adult index cases was rolled out and reported as the highest yield in identifying children, and cohort monitoring for HEI was implemented in all scale up sites and contributed to improved EID for HEI. Bi-directional referral of children and adolescents between the OVC and clinical programs was reinforced, HTS is offered free for children <15 and testing for adolescents 15-19 years old will be free of charge from January 2020. VL testing was adopted and is currently being implemented for monitoring of patients, including children on ART, but scale up remains a major challenge. Monitoring of children on ART was also reinforced with the hiring of psychosocial support staff specifically for linking and retaining children in care.

Results and achievements

In 2017, Cameroon registered 15,105 HIV exposed infants born to HIV-positive pregnant mothers who underwent polymerase chain reaction (PCR) testing, among whom 753 tested positive – giving a yield of 5%. In FY18, PEPFAR Cameroon reported 8,889 HEI who had a PCR test at two months, representing 103% coverage (8889/8630) and 59% of the country coverage, with a yield of 5%. 83% (262/317) of HIV-positive infants <1 year old were enrolled on ART.

At the end of FY18, PEPFAR Cameroon provided ART to 7,493 CLHIV <15, accounting for 55.2% of PEPFAR FY18 pediatric target (13,568). This represents 76.3% (7,493/9,824) of the total number of children on ART nationwide (MOPH report, 2017). Of the 39,849 individuals diagnosed with HIV in FY18, 18.8% were children and adolescents <15 years, and the linkage rate was 98%. VL suppression for children and adolescents linked to ART was 62%. PEPFAR routinely evaluates site level linkage and retention data for adolescents and children.

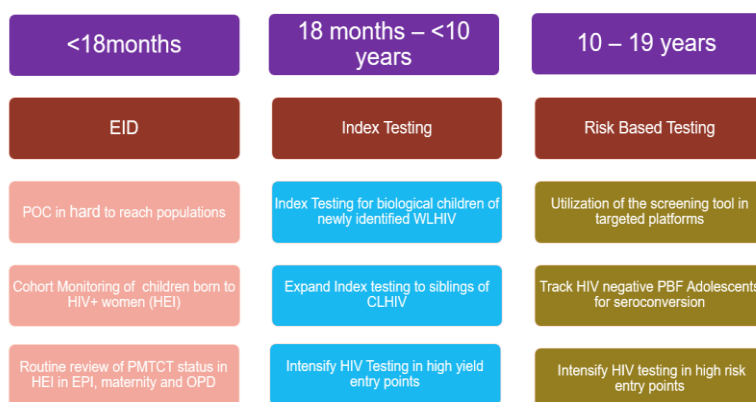
Outstanding gaps

Despite the progress made, there remain a number of challenges, including suboptimal case finding in pediatric and adolescent populations. The implementation of strategies to improve case findings for pediatric and adolescent populations resulted in the excessive testing of children but a low yield. The linkage rate was suboptimal (86%) for adolescents aged 15-19 years, with low retention and VL uptake among HIV-positive children and adolescents on ART. VL suppression rates for children were also low (62%), possibly as a result of suboptimal availability of the preferred ARV formulations for children, socioeconomic factors that contribute to poor adherence and poor ART clinic attendance, and parent or caregiver reticence to disclose HIV status to children and adolescents. There was also limited support for HIV-positive children receiving care in facilities from the available PEPFAR OVC package due to limited resources.

PEPFAR Cameroon will expand cohort monitoring for the mother-baby pair to improve EID uptake for all HEI to all 298 sites across the 10 regions. PEPFAR will support linking of EID services for HEI to a standard package of ANC and postpartum care for mothers and infants. Linkage and retention case managers posted to postnatal services will capture all mothers on ART who deliver and enroll the mother-baby pair in the cohort register for monitoring until 18 months postpartum when the final HIV status of the HEI is known. The program will advocate and support the expansion of Point Of Care for EID nationwide and will continue to ensure the creation of networks of health facilities around existing point of care to maximize use and enhance uptake of EID for HEI. PEPFAR Cameroon will leverage the OVC program to help link PBFW and HEI who are defaulters in the community to EID services.

Linkage and retention case managers will also ensure linkage of infants who test positive for HIV and provide comprehensive counseling and support to the mother or caregiver to ensure the infant stays in care. IPs will work with facilities to monitor EID uptake, HEI tracking, and testing turnaround time (TAT). Sample transport system will be strengthened to support EID and VL uptake and TAT through the use of bikers. IPs will work with facilities to share best practices from high performing sites with low performing sites. Routine review of PMTCT status among HEI in EPI, maternity and OPD will be ensured.

Figure 4.1.5.1: Finding pediatric & adolescent populations through tailored strategies



Strategies to reach children and adolescents

PEPFAR Cameroon will expand the pediatric package of services and support GRC to complete the rollout of Test and Treat for pediatric and adolescents in the 10 regions.

In COP19, PEPFAR Cameroon will expand key strategies to improve pediatric and adolescent HIV prevention, care and treatment to all the 298 sites in the 10 regions. Pediatric ART will be decentralized to all PEPFAR supported sites. PITC at entry points in facilities and the community will use the screening tool to assess risk for children and adolescents. Index testing will be offered to biological children of newly tested HIV-positive women or to men who test positive but the wife's status is unknown or died of an unknown cause, who are deemed to be at high risk for HIV. HIV testing will be offered to children with malnutrition, presumptive or confirmed TB, emergency patients, and inpatient for those with unknown status at admission and are at high risk for HIV.

PEPFAR Cameroon will use pediatric linkage case management experts to accompany children and adolescent who test positive at facility and community levels for ART initiation. Health care providers will be trained and mentored on counseling, testing, pediatric care and treatment, including adherence counseling and retention to provide quality HIV services to children and adolescents. PEPFAR will support IPs to ensure the availability of dosing charts at sites, the appropriate prescription of pediatric ART, and the availability and timely request of pediatric ARV drugs. The bidirectional referral of children and adolescents between the OVC program and other CBOs will also be scaled up. The capacity of HCWs will be strengthened to facilitate disclosure, transitioning to adult ART and to receive adolescents transitioned from other pediatric services. Tools adapted for pediatric counselling and disclosure developed in FY18 will be produced and used at all PEPFAR-supported sites. Support group activities for children, adolescents and their parents will be intensified and sites will be strengthened to use these sessions to provide integrated services. VL testing will also be scaled up for children and adolescents living with HIV. Health care providers will be trained and mentored to increase VL prescription and interpretation of results for monitoring of children and adolescents on ART per national guidelines.

In the new PEPFAR-supported regions, high performing clinical sites will be identified and supported to mentor low performing sites. IPs will be supported to ensure availability of data collection tools and appropriate documentation and reporting. Weekly data program review meetings involving all technical staff will be organized to ensure harmonization and appropriate reporting.

As previously mentioned, the OVC program will also play a key role in ensuring community support for linkage to care, retention, and adherence among children and adolescents living with HIV. More specifically, the program will provide the following services to target beneficiaries:

- CLHIV and their families. Trained case workers will carry out monthly home visits to provide early childhood development (ECD) for children below 8 years of age focused on positive parenting interventions and early stimulation; adherence counselling; age and stage appropriate disclosure support, education progress monitoring; nutritional

assessment and counselling; violence screening; transportation support to access health services and medical coverage for other health conditions; and other services as needs arise. Additional services for adolescents living with HIV will include screening for drug, alcohol, and sexual risk behavior and providing counselling to reduce identified risk practices. The program will strengthen bidirectional referral between community-based organizations and health facilities including organizing case conferencing, and monthly coordination meetings.

- HIV-positive PBFW and children living in their care. Trained case workers will conduct monthly home visits to provide ECD focused on positive parenting and early stimulation; adherence monitoring; and accompanied referrals to health facilities to ensure confirmatory testing among HEI.
- Other children at risk (children of female sex workers, GBV cases reported to the program, AGYW in or at risk of entering sex work, internally displaced children/adolescents). See section 4.2 for primary prevention program targeting AGYW and OVC.

The OVC program will provide wrap-around services such as household economic strengthening activities and education support for formal schooling and vocational training to help mitigate the negative impact of HIV on households. Finally, the program will seek to leverage existing programs such as USAID's Food for Peace program (targeting refugees and IDPs), President's Malaria Initiative (in health districts in the North and Far North regions), and the World Bank's Social Safety Net program to improve the living conditions of OVC and their families.

Cross-cutting strategies

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

4.1.6 TB/HIV Summary

Cameroon is one of 30 countries with the highest burden of TB/HIV co-infection. In 2017, the estimated number of new TB cases expected was 47,000, of which only 24,905 (52%) cases were notified. TB incidence rate was 103/100,000 population, with treatment coverage of 52%. Among all TB cases notified in 2017, the majority (59%) were males and 5.5% were children, with the detection rate among children, less than the 7-12% expected target. Therapeutic success rate for new and relapsed TB cases was 85% in 2017 and 79% for HIV-positive TB cases, less than the 90% target. In 2017, only 176 of an estimated 273 multidrug-resistant (MDR)/rifampicin resistant (RR) TB patients were diagnosed and treated (National TB Control Program report, 2017). GRC is focusing efforts to increase TB case detection and cure rate for both drug sensitive and multi-drug resistance TB (MDR-TB).

Cameroon has adhered to the Sustainable Development Goals and the World Health Organization (WHO)'s Strategy to END-TB and has implemented various short and long-term TB and HIV strategic plans to reduce the burden of TB. Despite being preventable and curable, TB remains the leading cause of infectious disease morbidity and mortality for PLHIV, with the urban cities of Yaoundé (15.4%) and Douala (17.6%) accounting for one third (33%) of all TB patients in Cameroon (National TB Control Program, 2017). In 2017, 95% of TB patients were tested for HIV, with 31% TB/HIV co-infection. Among all HIV/TB co-infected cases identified, 96% were linked to ART. The incidence of TB was 1.5% among PLHIV on ART and 11.3% among PLHIV not on ART. Although the MoPH recommends the provision of IPT to PLHIV without active TB, implementation of this policy is still limited.

To support GRC in the scale up of IPT, CDC started a new Cooperative Agreement with Cameroon's National TB Control Program (NTCP) in FY18 to 'Decrease the TB/HIV Burden and Develop Systems to Achieve and Sustain TB/HIV Epidemic Control in Cameroon under the President's Emergency Plan for AIDS Relief (PEPFAR)'. This award will contribute to strengthening prevention, diagnosis and treatment of TB in PLHIV through screening and case identification; TB infection prevention and control; HIV testing, monitoring and clinical care for TB clients; and health system strengthening.

PEPFAR clinical IPs continue to support HIV clinical units through capacity building to offer quality TB screening using basic signs and symptoms, refer suspected cases for TB diagnostic evaluation, and provide preventive treatment for PLHIV without active TB, and curative treatment to confirmed TB cases. TB clinical units are also strengthened to offer systematic HIV testing to all TB patients and refer positive cases for ART initiation. Capacity building to offer integrated TB/HIV services using a one-stop shop model is still ongoing, as only a few sites are currently providing integrated TB/HIV services. In addition to existing national TB registers, harmonized stools for reporting across the cascade will be produced and made available at sites to ensure full functionality.

Results and achievements

In FY18, PEPFAR Cameroon provided 10,000 Gene-Xpert cartridges to improve confirmatory TB diagnostics for presumptive TB cases. Clinical facilities were supported to develop and implement infection prevention and control plans. At PEPFAR supported sites, 96% (10,670/11,142) of new and relapsed TB cases knew their HIV status, 37% (3,896) of TB patients were co-infected with HIV, and 94% (3,676) of HIV-positive TB cases were initiated on ART in FY18. In ART clinics, only 84% (154,276/183,473) of all PLHIV were screened for TB, and 2% had a positive TB symptom screen – a lower achievement than the 5% expected target. Eighty seven percent of specimens were sent to the laboratory for confirmation, up from 66% in FY17. PEPFAR continues to provide support for the integration of TB and HIV services at facility level with focus on in-service capacity building for service providers to provide quality HIV/TB services to co-infected patients.

Outstanding gaps

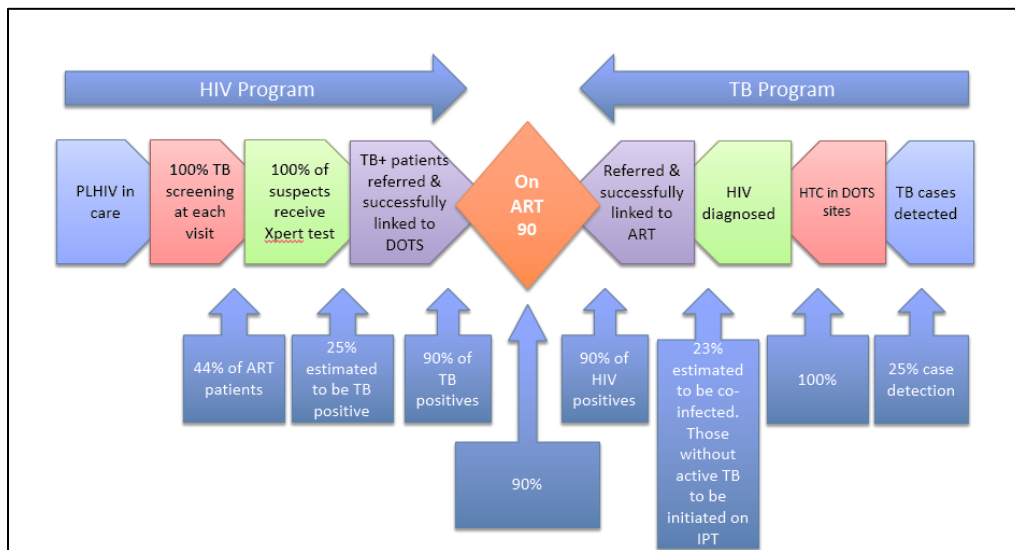
Despite implementation of TB/HIV integrated activities in Cameroon, TB/HIV prevalence remains high at 31%. TB case finding, diagnosis and treatment remains suboptimal, especially among children. TB diagnosis continues to rely on microscopy for the majority of diagnosed cases despite increased roll out of molecular technology (GeneXpert, TB Lamp). The number of Diagnosis and Treatment Centers (DTCs) increased from 220 in 2011 to 256 in 2018, but not all DTCs offer microscopy. IPT implementation is limited by drug availability, staff capacity, and tools for data capture and reporting. The diagnosis of TB patients remains a challenge especially in the two big cities of Yaoundé (15%) and Douala (68.5%), with only about 40% of all TB patients notified coupled, and the sample transport system is not yet well established. Several DTCs do not offer TB diagnostic tests to patient's onsite and instead refer patients to other facilities for testing due to unavailability of personnel, inappropriate space, and unavailability of microscopes; however patients may be lost to follow up between the referral and the testing sites. The TB diagnostic capacity for PLHIV, prisoners, children, contacts of confirmed Pulmonary Bacteriological TB and other at-risk populations remains suboptimal. There is limited integration of ART and TB services in health facilities, poor coordination at all levels of the health sector, and limited sharing of TB and HIV data.

Strategies to expand uptake of TB/HIV services

The new TB award will build the National TB Control Program's capacity to decrease the burden of TB/HIV and develop systems to achieve and sustain TB/HIV epidemic control in Cameroon. In COP19, PEPFAR Cameroon will expand TB/HIV services to all PEPFAR-supported sites in the 10 regions. PEPFAR will provide TB screening to all 299,961 PLHIV on ART, presumptive TB cases will be referred for diagnostic evaluation, and all PLHIV who test positive for TB will be linked to TB treatment. HIV testing services will be offered to all TB patients, ART provided for all TB patients diagnosed with HIV, and IPT will be provided to 151,875 PLHIV without active TB, including military and all other vulnerable populations. To reach the COP19 targets and decrease the burden of TB among PLHIV, the coinfection package of services will include intensifying case finding for TB among PLHIV, providing IPT to new and old PLHIV without active TB, and implementing infection

prevention and control measures. To decrease the burden of HIV among TB patients, the service delivery package will include HIV testing and counseling for presumptive or confirmed TB cases, and linkage to ART for TB patients diagnosed with HIV.

Figure 4.1.6.1: PEPFAR Cameroon TB/HIV Cascade



PEPFAR Cameroon will continue to strengthen TB/HIV integration in facilities, with effective decentralization of HIV testing and ART initiation in TB clinics, while decentralizing TB case finding and management in pediatric clinics.

To strengthen prevention, diagnosis and treatment of TB among PLHIV, PEPFAR Cameroon will build the capacity of health care providers to actively screen for TB among PLHIV, diagnose and provide TB treatment to positive cases, and generate demand in all high volume sites across the 10 regions. The capacity of the laboratory network will be strengthened to link 100% of sites for testing (microscopy, GeneXpert, TB lamp) of PLHIV with TB symptoms. IPT will be provided to PLHIV who screen negative for TB in all PEPFAR-supported sites. Active TB case finding will be implemented at various facility entry points and the community. Case finding, diagnosis and treatment of TB in children and adolescents will be decentralized and strengthened. PEPFAR Cameroon will continue to support GRC to produce and make available data collection tools for IPT and train/mentor service providers in the 10 regions to provide IPT to PLHIV without active TB and document services offered in the registers.

To strengthen TB infection prevention and control (TBIC) procedures in health facilities in the 10 regions, PEPFAR Cameroon will build the capacity of HCWs and auxiliary staff on basic infection prevention, control strategies and biosafety, support districts/health facilities to develop and implement TBIC plans, and implement systematic TB screening of health and related staff in all the sites according to national guidelines. To strengthen HIV testing, monitoring and clinical care for

TB clients, PEPFAR Cameroon will build the capacity and mentor DTCs to provide HIV testing for presumptive and confirmed TB cases, link positive cases to ARV, provide clinical mentorship to improve TB screening, diagnosis and TB treatment to PLHIV.

In COP19, PEPFAR Cameroon will continue to support revisions of national guidelines, TB/HIV data review meetings, TB/HIV coordinating body meetings, and technical support through mentoring of health care providers in all PEPFAR-supported facilities. Mentorship, supervision, monitoring and evaluation will be strengthened through TA, site visits, and partner management and monitoring. PEPFAR Cameroon will increase the capacity to track TB screening documentation at site level and across sex and age groups, as well as the capacity to monitor management of HIV/TB patients and the clinical cascade. PEPFAR Cameroon will strengthen health systems by building monitoring and evaluation (M&E) capacity through implementation of an online data service for the management of network communications, reinforce the capacity of NTCP central and regional level staff to get real time data on TB and TB/HIV, and digitalize data collection, transmission, and analysis by integration and harmonization in the District Health Information System (DHIS2). The program will also support coordination efforts and provide TA, mentorship and supervision in all the sites.

4.2 Prevention, specifically detailing programs for priority programming

HIV prevention for AGYW and children

In COP19, PEPFAR Cameroon will continue providing age-appropriate services to beneficiaries between the ages of 9 and 24 years at household, school, and community level. Prevention activities will focus around the principal areas of life skills education; sexual and reproductive health (SRH) education; gender norms and equity; GBV prevention and response; condom education, promotion, and skills-building; and referrals to clinical services for uptake. Trained caseworkers will conduct risk assessments and deliver key messages on SRH and GBV prevention during home visits to OVC households. The program will also work with adult and peer mentors to deliver key messages on HIV and violence prevention through secondary school health and gender clubs. At community level, the program will continue working with young people to identify safe spaces (homes, community halls, etc.) where they can receive messages on HIV, GBV prevention and response, and SRH (including condom education). These activities coupled with education support to both girls and boys at risk of HIV and household economic strengthening activities will contribute to reducing the risk of new infections among children and young people (with a focus on AGYW) in target health districts.

Program activities will focus primarily on risk prevention and delaying sexual debut for children 9-14 years; and risk reduction for older adolescents, 15-19 years. In the past two years, the program has utilized several evidence-informed modules – “My Changing Body (Body Literacy and Fertility Awareness for Young People)”, “Go Girls”, “Grassroot Soccer Skillz”, and “Peace Corps Life Skill Manual” – in order to teach girls and boys below the age of 18 about puberty, self-confidence, and good health practices that will contribute to their future sexual and reproductive health. In line with COP19 technical guidance, PEPFAR Cameroon will also incorporate three evidence-informed

modules in its current program that expand on the topics of healthy relationships, making healthy decisions about sex, and sexual consent. Activities targeting children aged 15-19 or children that present HIV risk factors will include condom promotion and skills-building. The program will refer all children presenting HIV risk factors to health facilities for HTS.

In addition to supporting children and young people with essential health information and services, PEPFAR Cameroon will also implement positive parenting programs focused on strengthening parent/caregiver's relationships with children in their care. In COP18, trainers from Clowns without Borders South Africa supported the OVC program to adapt the "Parenting for Lifelong Health (PLH) for Parents and Teens" manual to the Cameroonian context, including training caseworkers on content and facilitation skills. This manual seeks to establish nurturing caregiver-child (9 to 17 years) relationships and reduce the risk of violence against children in and outside the home. PEPFAR Cameroon will continue to offer services using the PLH manual at home and in community group settings.

According to CAMPHIA, annual incidence of HIV among adult's ages 15-64 years in Cameroon is 0.27% with Prevalence of HIV among adult's ages 15-64 years in Cameroon is 3.7%. HIV prevalence peaks at 9.3% among females ages 40-44, as compared to a peak of 6.0% among males ages 50-54. As the PEPFAR Cameroon program scales up services across the country, provision of targeted key prevention messages to primary populations at the community level will be required. PEPFAR Cameroon will leverage Peace Corps Volunteers who will partner with community based organizations and counterparts by building community capacity to provide HIV and sexual violence prevention targeted messages to at risk individuals and families. In addition, Volunteers will also work with adult and peer mentors to engage men and boys using Men As Partners curriculum as they are essential toward reducing new infections. Emphasis will focus on risk reduction behavior change communication messages and approaches that will contribute to reducing risk of new infections and linking older priority population to prevention and testing services. Peace Corps Volunteer placements will be leveraged to strengthen community and household interventions that provide primary prevention education, reinforce treatment adherence and treatment literacy particularly through ART groups and linkages to care and support services.

Reaching AGYW with GBV clinical services

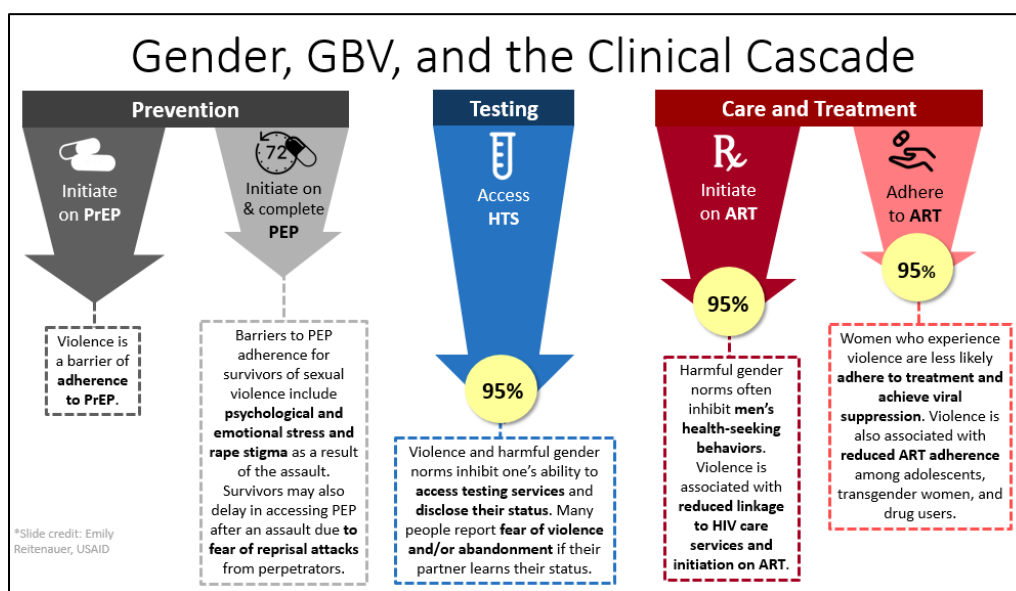
Cameroon faces many challenges related to GBV and high risk of HIV for adolescents aged 15-19 years. In 2011, the Demographic and Health Survey (DHS IV) indicated that over half (55%) of women age 15 and above reported experiencing some form of violence. Twenty percent of the first sexual intercourse for women of reproductive age was forced and 30% of those who had sex before the age of 15 were forced. CAMPHIA data also revealed an HIV prevalence of 1.2% among adolescents (2% among girls, 0.4% among boys) and HIV rates for females 15-19 years were six times higher than males in the same age group.

Table 4.2.1: Vulnerable to Violence Among Women (DHS, 2011)

| Percentage of women currently in union or out of union who have undergone physical, emotional or sexual abuse by their current or most recent husband/partner, according to certain sociodemographic characteristics, Cameroon DHS 2011 | | | | | | | |
|---|-----------|----------|--------|--------------------|--------------------------------|---------------------|---------------------------------|
| Age | Emotional | Physical | Sexual | Physical or sexual | Emotional, physical, or sexual | Physical and sexual | Emotional, physical, and sexual |
| 15-19 | 35.1 | 38.3 | 23.8 | 47.9 | 54.3 | 14.2 | 12.9 |
| 20-24 | 38.5 | 44.4 | 23 | 53.3 | 60.5 | 14.1 | 11.5 |
| 25-29 | 44.5 | 50.2 | 20.9 | 55.5 | 64.2 | 15.6 | 11.9 |
| 30-39 | 43.7 | 44.2 | 18.8 | 49.9 | 60.5 | 13.1 | 11.4 |
| 40-49 | 42.3 | 42.8 | 17.7 | 47.5 | 56.9 | 13.0 | 10.8 |

Violence is often associated with an increased risk for HIV, as it limits the ability to negotiate safe sexual practices, interferes with the ability to disclose HIV status, and interferes with the ability to access health care services. PLHIV are often vulnerable to violence and have increased exposure to physical, sexual, emotional, and economic abuse. GBV impacts the HIV clinical cascade.

Figure 4.2.1: GBV and the 95-95-95 Clinical Cascade



Healthcare facilities are an entry point for survivors of violence. In collaboration with GRC and other stakeholders, the program will continue to strengthen the capacity of health facilities and HCWs to provide post-GBV clinical care to survivors.

FY18 GBV program results and achievements

In FY18, PEPFAR Cameroon supported a GBV clinical pilot program in six health facilities in Yaoundé and Douala clusters. During the implementation of this initiative, GBV programmatic tools were developed and used to train health care providers on the clinical and psychological management of GBV and on the provision of first line support to GBV survivors. The GBV program also developed indicators and registers that were used as the main source of data collection and reporting. Data clerks were also trained to document and report on quality data. In FY18, 212 GBV patients were received, of a target of 150 (141%) in the six facilities. Sexual violence represented 107% (90/84) with a high incidence for children <15 (46/12) and for females (89/90). The turnaround time of case reporting was 60% (54/90) for cases of sexual violence within 72 hours of the incident, while the provision of PEP to victims of sexual violence was 79% (43/54) reported within the same period. Among all GBV cases received, 89% (190/212) had an unknown HIV status, of whom 74% (141/190) were tested for HIV and 1.4% (2/141) were diagnosed with HIV and linked to treatment.

Outstanding gaps

The GBV program was piloted in only six PEPFAR-supported sites of 56 scale-up sites in FY18. The uptake of GBV activities was high and resulted in increased awareness and demand at the facilities but resource allocation was limited.

Strategies to improve services to GBV Victims

In COP19, PEPFAR Cameroon will advocate for the integration of GBV interventions and indicators in the national HIV guidelines & DHIS2, and for increased collaboration with law enforcement to support GBV activities. GBV guidelines, tools and SOPs developed in FY18 will be produced, rolled out and used to train health care providers in all GBV sites. The program will work with other stakeholders (United Nations Population Fund, United Nations Children’s Fund, UNAIDS, WHO, GRC, etc.) to make available post-GBV care kits including rapid test kit nationwide. PEPFAR Cameroon will expand GBV services to at least one high volume facility per district in all the 10 regions, with referral networks around each GBV operational site/district. Community operational sites will be created to respond to GBV in conflict regions. GBV services will be integrated into OVC, PMTCT, adolescent and adult prevention and treatment programs. PEPFAR Cameroon will create awareness and build referral networks by working with community IPs to strengthen bidirectional referral of GBV cases, and building capacity and supporting health care providers in identifying and providing assistance to women who fear violence as a result of testing and disclosure of HIV status to partners. Children, adolescents and women living with HIV will be routinely sensitized on GBV during clinical visits.

Key Populations

HIV prevalence remains high among KP (24.3% in FSW and 20.7% in MSM, IBBS 2016) with the burden of the epidemic concentrated in urban cities. Therefore, KP prevention efforts will remain focused in the current implementation areas of Yaoundé, Douala, Bamenda and expand to three

additional cities, Bertoua, Bafoussam, and Ngaoundéré. These cities were selected in coordination with the GFATM community principal recipient (PR) and civil society and the choice was based on HIV burden. Together, the six urban centers covered are those with the highest burden of KPLHIV based on the best available size estimates. In addition, the cities cover the major national and international transport corridors, major university towns, and communities hosting large concentrations of internally displaced persons and refugees. In these cities, PEPFAR will continue to scale up targeted community interventions focused on preventing new HIV infections, strengthening case finding, linkage to treatment, ART adherence and retention support. In addition, differentiated models of service delivery like community based dispensing will be reinforced.

FY18 Results and achievements

FY 18 data reveal that 30,430 KP were reached with prevention messages and materials and 14,298 tested for HIV. Of the 47% who were tested for HIV, 2,082 were diagnosed HIV-positive (15%) and 1,977 were linked to treatment (95%). In order to better target and test those beneficiaries most likely to be HIV-positive, index testing was expanded after FY18Q2. In addition, innovative approaches to differentiated index testing through social events and other avenues introduced last year were scaled up in all CBO.

Regarding clients of FSW, the program continued to implement the Sex, Test & Treat approach where FSW counsel their clients and provide them with a coupon for free testing at DICs or participating health centers. Under that strategy, the program recorded a yield of 8% (83/997) in those clients, nearly four times the national prevalence for adult men.

In addition, PEPFAR Cameroon has been working with GRC, GFATM, UNAIDS, and other partners to update national policies, tools and standardized approaches for KP programming to include new prevention activities like Pre-exposure prophylaxis (PrEP) and HIV self-testing. This work will continue and will engage stakeholders beyond the health sector such as local authorities, law enforcement, and the judiciary to create an enabling environment for FSW and MSM free from stigma, discrimination, or fear of violence.

Outstanding gaps

FY18 program data reveal that the majority of KP reached last year were less than 30 years old (79% of MSM and 60% of FSW) and yields are consistently lower in this age group than in older KP; additional efforts to reach older KP who are more likely to be HIV-positive are being implemented in FY19 and will be scaled up in FY20. In addition, FY18 yields for MSM and FSW (14% and 15% respectively) were similar to the IBBS 2016 prevalence for those newly tested with yield trends following the same pattern as noted in the study. For KP aged 30 and above, average yield (28% in FY18 Q4 data) was almost triple that of the younger age bands (8% 7% in FY18 Q4 data) and this situation is seen in the two sub populations.

Program strategies for COP 19 will be tailored to each geographic area and sub-population with a focus on retention to treatment for KPLHIV and scaling up differentiated index testing activities with fidelity.

Strategies to improve cases finding, linkage and retention in the continuum of care

KP services begin at the community level with prevention activities and case finding. Under the Enhanced Peer Education and Mobilization model, outreach and prevention messaging as well as distribution of male and female condoms and lubricants are provided by trained Peer Educators (PE) and Peers Leaders (PL). Prevention efforts in COP19 will increasingly target their focus to younger KP who have historically shown lower yields and KP who have previously tested HIV negative. New interventions like PrEP will continue to be offered to KP as an additional prevention choice and routinely to the HIV-negative partner in sero-discordant couples for the first six months that the HIV-positive partner is on treatment. Online-mediated strategy and outreach mobilization will be used and emphasized to reach more KP.

With regard to testing, cumulative FY18 results show testing at DICs generally produces higher yields than mobile testing with HIV prevalence increasing with age. For that reason, sexual network mapping of older MSM and social network mapping of older FSW will be emphasized in FY20. In addition, regular hotspot mapping by PLs will continue identifying new and old hotspots with high yield to strengthen targeted testing. Through a performance-based approach, PLs or PE will receive incentives for the number of clients referred and tested at the DIC. Systematic index testing will continue and be scaled up in new cities. Index testing will focus on sexual partners of MSM, regular, non-paying sexual partners of FSW, and children of FSW.

Clients of FSW will continue to be reached by the innovative coupon system known as Sex, Test & Treat and with emphasis on Long Distance Truck Drivers (LDTD). Under the Sex, Test & Treat strategy, FSW provide HIV prevention education to their clients and provide them with a coupon for free testing at DICs or participating health centers. The FSW then receives a small incentive payment of about \$1 for each completed referral. LDTD will be tracked and offered prevention services along transport corridors as well as access to ART in the site that is most convenient for them in coordination with PEPFAR clinical partners.

For those cases in which MSM in particular are fearful of direct contact notification, indirect methods such as the social gatherings known as “Grins” or “Chill-ins” which anonymously bring together partners of HIV-positive MSM for a social event where testing is conducted will continue in COP19. For other hard to reach partners such as MSM who do not identify as part of the lesbian, gay, bisexual, or transgender community, female partners of MSM who do not know their partners are bisexual, and those regular, non-buying sexual partners of FSW who refuse to come in to the DIC, self-test kits will be distributed to the HIV-positive KP to encourage their partners to test. PL and PE will provide counseling to KP partners and information for those who return for confirmatory tests. Those who test positive on self-tests will be referred to a local facility for a confirmatory test and supported by PLs and PEs within the community.

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

After enrollment on ART, the PN continues to support the client, focusing on the Positive Health, Dignity, and Prevention model and assisting with access to needed services, including psychosocial support, nutritional counseling as well as clinical services such as treatment for STIs, VL testing, SRH services, and post-GBV care, which is partially supported by GFATM. FY18 programmatic data revealed that 72% (202/281) of KP presenting with STIs were FSW. Systematic STI screening, as well as sexual and reproductive health services, will be provided to all KP reached (with a targeted approach for FSW). Once found positive and linked to a health facility, PN provide clients with routine adherence counseling and retention support during home visits and frequent calls. They actively work to avoid defaulters to treatment and bring back any clients lost-to-follow-up. The PN will assist in contact tracing to ensure that the index patient approach is successfully applied to each new case diagnosed and that prevention messages reach those most at-risk. The PN program will continue in FY19 and continue to be monitored through monthly stakeholder meetings including representatives from local health facilities, the community and local government.

Almost all DICs in Yaoundé, Douala and Bamenda are dispensing ARV as part of the community ART dispensation program and currently, treatment initiation is available onsite at one DIC. In COP 19, at least half of the DICs in the mentioned cities will offer treatment services under mentorship of health facilities as a part of differentiated models of care and task shifting to improve access to care for PLHIV.

Almost all DICs in Yaoundé, Douala and Bamenda are dispensing ARV as part of the community ART dispensation program and currently, treatment initiation is available onsite at one DIC in collaboration with a mentoring clinical facility. In COP 19, at least half of the DICs in the mentioned cities will offer treatment services under this type of mentorship arrangement as a part of differentiated models of care and task shifting to improve access to care for PLHIV.

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

underscore the importance of long-term community-based care and support for HIV-positive KP adherence and retention.

The program uses SIMS data and site level analysis of KP cascade data to inform KP strategies, manage partners, identify sites where HIV-positive KP are being found, tailor differentiated programming to fill gaps and target high yield sites as well as ensure program quality. PEPFAR Cameroon staff will continue to use data for decision making through bi-monthly data reviews and monthly partner management meetings. Further data collection will include an increase in the number of SIMS assessments as well as the number of site visits to both hotspots and DICs. Since FY18, partner performance has improved and shown considerable initiative in utilizing lessons learned to expand reach, maximize impact in testing and increase linkage to treatment, such lessons learned will continue to be used to improve PEPFAR KP programming.

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

Policy/guideline changes that will impact the program area are found in Appendix D.

Program directives for COP19

In FY18, PEPFAR Cameroon noted suboptimal performance across the clinical cascade. The program reported overtesting with low yields, low achievement of initiation targets, low retention of patients on ART and poor VL coverage. In addition, high yield strategies such as index testing were not sufficiently scaled up. Formal and informal user fees limit access of patients to HIV services.

Immediate actions were taken to address the challenges. A RTC campaign was organized in Yaoundé and Douala clusters to track all patients in the 56 scale-up sites that were unaccounted for in FY19 Q1, determine patient outcomes and facilitate their return to care. The rapid patient tracking effort revealed that the majority of patients were still on treatment but not properly documented. The clinical program also implemented weekly data reporting by the clinical IP to monitor performance and intensified partner management.

During COP19 planning and finalization meetings, Cameroon was given the following recommendations from the U.S. Office of the Global AIDS Coordinator (OGAC):

- Continue rapid tracking and assessment of practices at the site level to understand retention problems
- Improve data quality at sites, especially around retention and human resources for health (HRH). Retrain data capturers and other relevant staff at sites and partner offices as necessary.
- Continue planning for a scale up of MMS and community distribution models which are currently only available in limited areas.
- Index testers must be retrained and processes revised to implement with fidelity. Virally suppressed patients should not be used as index clients. Children should be screened for risk.

- Support enforcement of informal user fee elimination in clinics in conjunction with GRC and community partners.
- Plan transition to a service delivery model. Reassign staff as needed and re-evaluate non-service delivery expenses.
- Continue assignments of team to sites and team member accountability for each site's retention.
- Engage community partner for enforcement of user fee elimination at the sites.

Management of Implementing Partners

To align with PEPFAR program strategies and improve partner performance in an ongoing and timely manner, PEPFAR Cameroon will:

- Implement weekly, biweekly or monthly site level data review by age and sex with IPs.
- Implement quarterly mini-PEPFAR Oversight Accountability and Review Team (POART) sessions where IPs use data to evaluate performance and review strategy with the program staff.
- Provide high quality TA to IPs at least monthly from Yaounde and HQ targeting program areas of highest priority and impact.
- Conduct SIMS visits with on-site feedback and TA plus monthly feedback to IP and integrate SIMS into IP site visits.
- Implement monthly management meetings to review of results vs financial outlays, with site level performance versus outlays forthcoming.
- Scale up GSM in high volume clinical facilities.
- Collaborate with teams from MoPH at national, regional and district level and IPs to provide TA to sites specific to site performance and need.
- Conduct routine data quality assessments (DQA) by agency and by IP at site level and jointly with MoPH, including chart review.
- Provide feedback on IP action plan developed to improve data quality at site level.

Effective partner management will lead to improved site level performance, a better targeted TA at site level and improved collaboration in site management.

Innovative, evidence-based solutions in COP19 to reach epidemic control

- Expansion of the clinical program to the ten regions in Cameroon to reach epidemic control
- Alignment of human resources for health based on site assessment and recommendations from OGAC. Above-site and non-service delivery roles that are currently in the scale-up districts in COP18 will be limited in COP19.
- Increasing access to and coverage of EID and VL testing for PBFW using POC testing

- To improve on HTS yield, index testing, targeted testing based on risk assessment using the screening tool and diagnostic testing in critical entry points including VCT will be scaled up in all PEPFAR supported regions.
- Bidirectional referral of OVCs between CBOs and clinical services will be reinforced and scaled up.
- Tracking tools will be harmonized and used at sites to reinforce patient tracking
- Optimization of pediatric ARVs and reinforce prescription of highly efficient protocols to pediatric patients.
- Adolescents and young PLHIV will be empowered to take control of their health.
- Data collection tools and SOPs will be harmonized to restructure the site level M&E system for improved data collection, synchronization, reporting and use.
- The VL lab and facility score card will be used to identify gaps and scale up efficiencies in VL testing and monitor quality improvement in service delivery.
- Community outreach strategies in addition to cohort monitoring will be implemented to improve ANC coverage and enhance uptake of EID for HEIs and retention of PBFW in care.
- Partner management will be intensified, with CDC/PEPFAR clinical program staff assigned to each zone and high-volume sites to improve performance.
- PEPFAR Cameroon will support GRC to intensify mentoring and supervision to ensure total elimination of informal and formal user fees following.
- Regular focus group discussions will with beneficiaries to identify challenges to care and improve on retention and viral suppression.

Scale up of index testing in COP19

Index testing currently accounts for 15% of positives and is being scaled-up to the target of 30%. To reach epidemic control in Cameroon, this modality will be expanded to all PEPFAR-supported sites, targeting sexual partners and biological children of patients newly diagnosed with HIV and those not virally suppressed, and parents of children living with HIV. Training for health care providers will be intensified to ensure quality counseling in alignment with the five Cs essential for HTS: consent, confidentiality, counseling, correct test results, and connection to HIV prevention, care and treatment. PEPFAR Cameroon will ensure the availability of index testing strategies such as self-testing, partner-to-partner notification and service provider to partner notification. All partners of index cases newly diagnosed with HIV will also become index cases and HIV testing will be offered to their other sexual partners including their biological children at high risk for HIV.

4.4 Commodities

PEPFAR Cameroon's commodity budget has increased from \$864,941 in COP 18 to \$ 12,900,400 in COP19 of which \$9,659 will be invested in procurement of HIV self-test kits for key populations, \$11,094 for PrEP, \$ 850,020 for IPT, \$5,570,075 for ARV and \$6,359,593 for VL testing commodities. In COP18 the program focused primarily on buffer stocks of HTS and VL commodities as Global Fund commitments for ART and other key inputs were sufficient to meet expected treatment

targets. With the dramatic increase in treatment targets in COP19, Global Fund investments would not be able to cover all patients expected to be newly enrolled, so a corresponding increase in PEPFAR commodity investments is necessary to close the gap. The 2018-2020 GFATM HIV budget allocation has decreased from \$99.3 million over two years (2016-2017) to \$93.5 million over three years (2018-2020), and other stakeholders such as the World Bank and the French Development Agency have ceased their commodity investments entirely. Additionally, the timing of GRC HIV commodities procurement funds disbursement is uncertain and highly variable, leading to a delayed start of the procurement cycle. Given the length of the procurement cycle, any delays in procurement initiation create an atmosphere of uncertainty in the system and can result in system-wide stock outs.

Based on the last commodities quantification exercise of March 19, 2019, the NACC has projected funding gaps during 2020 for rapid test kits (RTK) (96%) and VL commodities (48%). These projections may be further exacerbated by current financial gaps for RTK (90%) and VL (90%) in 2018.

The reliance on GRC financial uncertainties and GFATM PR performance coupled with current public health supply chain maturity level will continue to influence commodities shortages and risks in FY20. Reasons for stock-outs at the health clinics include problems in procurement, forecasting, and requisitioning by the regions; tardiness in ordering or poor forecasting by the clinics; and a burdensome number of bureaucratic steps required to obtain approvals on stock allocation decisions at any stage in the system as well as lack of consumption data availability.

In addition, there is often fragmentation of responsibility and governance between the MoPH, the PR, the Central and Regional Medical Stores, and health staff at clinics. This undermines accountability at each level and further exacerbates the risks in distribution, contributing to stock outs.

PEPFAR Cameroon is working with GRC, GFATM, and other stakeholders to plan for transition to TLD during COP19. The PEPFAR team is heavily engaged in country planning through the TLD technical working group convened by the government and helped to develop the country TLD transition plan. The plan includes different phases of TLD transition implementation with targeted populations, packaging size of products that will enable multi moth dispensing, and phase-out of Nevirapine based regimens. The tentative timeline for TLD transition is presented in Figure 4.4.1 below.

| Table 4.4.1 TLD Transition Timeline | | |
|--|--------------------------|---|
| Phases | Key dates | Activity |
| Phase 1 | July 2019-December 2019 | <ul style="list-style-type: none"> Begin patient transition at first wave of sites for all naive patients initiated on ARV except pregnant women |
| Phase 2 | January 2020 – June 2020 | <ul style="list-style-type: none"> implementation of TLD to existing 1st line patients except pregnant women |

| | | |
|-----|-----------|----------------------------|
| End | July 2020 | • TLD transition completed |
|-----|-----------|----------------------------|

4.5 Collaboration, Integration and Monitoring

In COP19, PEPFAR Cameroon will leverage technical strengths and competencies across all agencies to ensure efficiencies in addressing gaps identified in COP18 and development of COP19 in order to meet the program goals of achieving epidemic control by sex and across different age groups by 2021. To address these gaps, the team, through a collaborative effort, will build on their technical strengths to guide implementation of innovative strategies for achieving epidemic control among children, OVCs, AGYW, KPs, adolescents, adult women and men. Agencies will continue to collaborate in conducting SIMs and supporting community outreach programs as required. PEPFAR Cameroon agencies will collaborate in implementing a single model of Self Testing as an innovative strategy for finding men and will also leverage on this collaborative effort and their different clinical, pharmaceutical and supply chain expertise to guide the government through an effective TLD Transitioning that will start taking place during COP18 implementation.

To address specific gaps identified in COP18, PEPFAR Cameroon’s key interventions in COP19 towards attaining epidemic control across the ten regions of the country will focus on knowing who to target, where to find PLHIV, finding those we are missing and improving on strategies to link and retain patients in treatment. To ensure success and sustainability, PEPFAR Cameroon will continue to leverage and strengthen existing collaboration with the GRC and other key stakeholders such as GFATM, UNAIDS, Unitaid, and the WHO.

PEPFAR Cameroon has intensified partner management by investing in new approaches and continue to implement those that improved efficiencies of partner performance in COP18. Across all PEPFAR Cameroon agencies, these include weekly, biweekly or monthly meetings and site visits for performance reviews, monthly review and reporting of activities by budget code and by site with immediate follow-up on required corrective actions, routine DQA by agency and by IP at site level, trainings on PEPFAR’s Monitoring, Evaluation, and Reporting (MER) system and indicators, and monthly SIMS visits. Additionally, biannual portfolio implementation reviews and reviewing work plans to ensure that COP strategies are accurately captured with activities that are appropriately aligned to PEPFAR objectives. Documentation of partner performance including new tools to allow for deeper assessment of partner performance and facilitation of timely interventions will improve performance and impact within a short time frame.

4.6 Targets for scale-up locations and populations

Based on geographic and population prioritization decisions made for COP19, PEPFAR Cameroon used national and PEPFAR program data on current treatment coverage to calculate the total number of additional PLHIV to be initiated on treatment in all ten regions by the end of FY20. A total of 121,551 net new PLHIV need to be placed on treatment by APR FY20 in order to achieve the COP19 goal. The targets for the following three tables were generated from DATIM.

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

| 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 (APR FY20) HTS_TST | Newly Identified Positive (APR FY20) HTS_TST_POS | Newly Initiated on ART (APR FY 20) TX_NEW |
| Total Men | 468,758 | 46,415 | 42,632 |
| Total Women | 1,506,933 | 101,764 | 79,656 |
| Total Children (<15) | 58,778 | 5,412 | 5,647 |
| Total from Index Testing | 201,625 | 40,299 | 38,220 |
| Adults | | | |
| TB Patients | 27,632 | 841 | 841 |
| Pregnant Women | 653,297 | 865 | 847 |
| Key populations | 39,996 | 6,399 | 5,534 |
| Priority Populations | 22,254 | 2,678 | 2,062 |
| Other Testing | 1,232,512 | 137,396 | 113,004 |
| Pediatrics (<15) | | | |
| HIV Exposed Infants | 16,344 | 316 | 300 |
| Other pediatric testing | 42,434 | 5,096 | 5,347 |

Both linkages and positivity yield are expected to improve in FY20, given plans to scale up index testing modalities, linkage, and retention activities, and intensive screening for people at risk. The military health facilities will test 22,254 individuals (military and civilians) with an expectation of finding 2,678 positives and linking 2,062 individuals to treatment.

In order to set targets for KP, PEPFAR used size estimation proportions from 2016 IBBS report, other data sources such as the World Bank's FSW study, and routine program data. Based on these estimations, FY19 Q1 and Q2 achievements, and calculations based on net new cases, PEPFAR set ambitious but attainable targets for FY20 for KPs reached and tested for HIV.

Table 4.6.3: Target Populations for Prevention Interventions to Facilitate Epidemic Control

| Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control | | | |
|---|---|--------------------------------|--------------------|
| Target Populations | Population Size Estimate (scale-up SNUs) | Coverage Goal (in FY20) | FY20 Target |
| FSW | 70,487 | 65% | 45,765 |
| MSM | | | 20,497 |
| Clients of FSW | | | 4,217 |
| OVC | | | 54,317 |
| AGYW | | | 31,435 |
| TOTAL | | | 156,231 |

For OVC, PEPFAR Cameroon considered past performance, CLHIV, HEI, and other at-risk children (e.g. children of FSWs) size estimations in new clinical health sites and KP hotspots and the estimated number of children that will exit at the end of the FY19 in order to establish targets. Based on these calculations, PEPFAR Cameroon will continue to implement activities in Yaoundé, Douala, Bamenda and new health districts with the target of reaching 37,998 OVC and caregivers with DSD services. Peace Corps shifted service delivery type and implementation sites in FY19 and will link Volunteers to the new expanded geographical locations in COP19.

Table 4.6.4: Targets for OVC and Linkages to HIV Services

| Table 4.6.4 Targets for OVC and Linkages to HIV Services | | | |
|---|---|---|--|
| SNU | Estimated # of Orphans and Vulnerable Children | Target # of active OVC (FY20Target) OVC_SERV | Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC* |
| Bamenda | | 2,519 | 2,393 |
| Buea | | 390 | 370 |
| Limbe | | 624 | 593 |
| Tiko | | 879 | 835 |
| Bonassama | | 1,027 | 976 |
| Cite des Palmiers | | 844 | 802 |
| Deido | | 3,564 | 3,386 |
| Japoma | | 109 | 103 |
| Logbaba | | 353 | 335 |
| Mbangue | | 270 | 256 |
| New Bell | | 1,397 | 1,327 |
| Nylon | | 1,432 | 1,360 |
| Nkongsamba | | 309 | 294 |
| Njombe Penja | | 226 | 215 |
| Biyem Assi | | 1,364 | 1,296 |
| Cite Verte | | 5,560 | 5,282 |
| Djoungolo | | 3,485 | 3,311 |
| Efoulan | | 848 | 806 |
| Nkolbisson | | 58 | 55 |
| Nkolndongo | | 852 | 810 |
| Bafia | | 329 | 312 |
| Obala | | 250 | 237 |
| Bertoua | | 1,609 | 1,529 |
| Abong Mbang | | 441 | 419 |
| Garoua Boulai | | 803 | 762 |
| Mifi | | 1,650 | 1,567 |
| Dschang | | 902 | 857 |
| Garoua 1 | | 1,452 | 1,379 |
| Maroua 2 | | 1,025 | 974 |
| Yagoua | | 563 | 535 |
| Mokolo | | 730 | 694 |
| Ngaoundere Urbain | | 1,553 | 1,475 |

| | | | |
|----------|--|--------|--------|
| Meiganga | | 581 | 552 |
| TOTAL | | 37,998 | 36,097 |

4.7 Cervical Cancer Program Plans

N/A

4.8 Viral Load and Early Infant Diagnosis Optimization

ART coverage for HIV-positive children and adolescents increased from 18.4% in 2016 to 56.7% in 2017; however, identification and management of HIV infection among this population remains weak, often compounded by other challenges such as frequent stock out of commodities and prolonged turnaround times for return of results to caregiver of over 30-60 days, well above the WHO recommended standard of a maximum of 30 days. In FY17, viral suppression among pregnant women in the PEPFAR-supported sites was significantly low at 77% and in FY18, VL coverage for PBFW in Cameroon was also suboptimal (12%). Frequent stock out of reagents and user fees were key challenges contributing to this gap, resulting in missed opportunities to offer quality PMTCT services as well as low retention on ART for pregnant and breastfeeding women. The recent ministerial circular released in April 2019 announcing elimination of user fees for HIV services by January 2020 will enhance successful implementation and scale up of POC VL for PBFW. Cameroon has a high burden of TB/HIV co-infection and TB remains the leading cause of infectious disease morbidity and mortality for PLHIV (National TB Control Program, 2017). In 2017, TB/HIV co-infection was 34%, with TB incidence of 1.5% among PLHIV on ART and 11.3% among PLHIV not on ART. TB diagnosis still remains a challenge, due in part to a lack of well-established and appropriate sample transport systems, easy access to efficient diagnostic capacity and inadequate infrastructure to support quality processes in TB diagnosis. Some facilities resort to referring patients to other sites for testing, resulting in patients being lost along the TB/HIV testing cascade.

In FY16, Cameroon initiated a decentralized phased approach for introducing and integrating near POC and POC testing to improve efficiencies in EID for HEI and VL testing for PBFW into HIV and/or TB laboratory-clinical facility network. These POCs include the two WHO prequalified platforms for decentralized HIV infant testing and VL testing: the m-PIMA POC (previously Alere q) and the GeneXpert near POC, which were introduced in country by Clinton Health Access Initiative, EGPAF, and United Nations Children’s Fund in a UNITAID-supported project. Initial introduction was in a few reference, regional, and district hospitals, but has since been expanded to 162 sites across all 10 regions and the number of platforms have also increased from 8 in 2017 to 43 in 2019 and include 25 m-PIMAs and 18 GeneXperts. The use of POC platforms improved turnaround time for return of results which reduced to same day, hence more children living with HIV being quickly identified and immediately put on treatment by clinicians. POC implementation in the PEPFAR-supported sites has demonstrated overwhelmingly positive results as shown in the table below:

Table 4.8.1: POC EID for PEPFAR-Supported Sites

| | 2016 | 2017 | 2018 | 2019 | Total |
|---|------|-------|-------|------|--------|
| Number of Platforms (20 m-PIMA; 13 GeneXpert) | 5 | 8 | 20 | 0 | 33 |
| Number of Tests Performed | 0 | 2,544 | 7,716 | 606 | 10,866 |
| Number of HIV Positive children identified | 0 | 191 | 312 | 22 | 525 |
| Number of Positive Children Initiated on ART | 0 | 176 | 272 | 16 | 464 |

POC testing has proven to be an impactful intervention to achieve the first and second 90 for HEIs, and the 2017 NACC annual report indicated an increase in the prophylactic ART coverage for HEI within 2 months from 76% in 2016 to 90% in 2017. Of the 43 POC platforms spread across 162 sites in the 10 regions, 14 of these platforms are currently being used for integrated TB/HIV (EID) testing and from 2017-2018, CHAI has been able to provide 1,451 POC VL testing for PBFW within the six non-PEPFAR supported regions.

In COP19, PEPFAR Cameroon will leverage existing conventional and POC platforms for VL, EID and TB to strategically scale up and expand POC VL testing for PBFW in hard-to-reach sites and populations in all PEPFAR-supported zones. This will ensure efficient and impactful use of POC instruments to support VL testing among PBFW and EID testing for HEIs. As part of the strategy to enhance TB/HIV integration and optimization of both conventional and POC instrument capacities, PEPFAR Cameroon will invest in strengthening coordination of the network of health facilities around existing point of care hubs to maximize use and enhance uptake of EID and POC VL for PBFW. In 2017, PEPFAR collaborated with GRC, GFATM and other partners to lead the effort on conventional and POC EID and VL platform mapping and instrument capacity utilization which is being used to identify appropriate networks for platform integration based on geographical location, type of platforms and volume of tests required. PEPFAR Cameroon will continue to coordinate with GFATM, GRC, and other partners to define efficient strategies to monitor and address supply chain challenges such as harmonizing the cost of EID and VL testing commodities and improving quantification systems to prevent frequent stock outs. This collaboration continues to be strengthened over the years and as a result, the country now benefits from a significant reduction in the cost of VL test kits from \$56 to \$16 and negotiations are ongoing for further reductions which will include equipment maintenance as part of the package. This will also ensure that the same costs are applicable to GRC, GFATM, and all other stakeholders in country.

Once finalized, this will enable PEPFAR Cameroon to leverage commodities from GFATM and other partners to increase coverage for EID and VL testing for PBFW in 2020. PEPFAR Cameroon is also working with GRC to support implementation of MoPH directives against unauthorized costs for ANC services and to eliminate patient fees for VL testing that serve as a barrier to other care and treatment services. PEPFAR Cameroon will leverage support from the UNITAID POC project for platform distribution and will support efforts to strengthen sample transportation within the network of facilities to continue to improve access to EID and POC VL for PBFW. In the same light, PEPFAR Cameroon will collaborate with and leverage GFATM-funded TB program to facilitate network optimization of polyvalent platforms at all levels using existing and new

platforms. PEPFAR will also provide TA to encourage coordination of platform mapping and continuous networking through the existing EID and VL technical working group.

Projected new sites or geographic areas in FY20 for EID and VL among PBFW only and funds allocated in the FAST; (including commodity procurement, trainings or TA etc.)

PEPFAR will prioritize support to expand POC EID and VL for PBFW in hard-to-reach regions within Zone 4 (Northern Zone) as well as well as conflict-affected regions within Zone 1 (Western Zone). Although the unmet need within Zone 4 (Northern Zone) is significantly lower than within Zones 1 (Western), 2 (Southern) and 3 (Eastern), HEIs and PBFW remain a vulnerable population in these regions, added to the challenges with access to facilities and sample transport. PEPFAR funding has been allocated in the FAST to support External Quality Assessment for the different assays and testers, trainings required to support near POC implementation, strengthening sample transport, and TA to support waste management especially for the GeneXpert platforms. PEPFAR funds will also support implementation of QIC, which has been successfully implemented in Cameroon and will be used to enhance POC EID and POC VL for PBFW uptake through improved sample collection and reduced turnaround time for getting results back to patients. QIC will focus on EID and linkage of infants to treatment services, VL testing for PBFW and their children, and increasing ANC attendance for pregnant women.

Transition arrangements for existing POC platforms owned by other stakeholders and located within PEPFAR supported sites

As previously mentioned, the UNITAID Point-of-Care Diagnosis of HIV Project was launched in nine sub-Saharan African countries in August 2015 and will be completed in July 2019. In collaboration with the MOPH, relevant national TWGs and key partners, the Unitaid POC EID Project has procured and placed POC EID technologies at strategically selected health facilities, and developed capacity at national, sub-national and facility levels to ensure uninterrupted, high-quality and sustainable POC EID/VL testing services. The UNITAID implementing partners supported the project through forecasting, procurement and distribution of POC platforms, test cartridges, and associated supplies as well as the development or strengthening of systems, process and tools needed to select, enrol and operate POC sites. The gradual, phased implementation model ensured local leadership and ownership of project decision-making, with the MoPH and/or relevant national authority taking full responsibility for specific aspects of the project, in order to enable smooth transition of POC EID activities to the MoPH by the end of the project. The process of developing this transition plan was coordinated by the Ministry of Public Health through the Department for Control of Diseases, Epidemics and Pandemics that has the mandate for the health response in the fight against HIV, STIs, Viral Hepatitis and TB. In addition, the contributions of other GRC stakeholders in the control of HIV were taken into consideration, including other partners involved in the drive towards HIV epidemic control. The process lasted nine months and took place in four phases:

- In April 2018, a desktop literature review on transition plans of POC EID was carried out as well as a situational analysis of what is done in the area of POC EID/VL.
- Between June and August 2018, joint coordination and consultation meetings were held on the importance of POC EID/VL.
- In September 2018, a team composed of EGPAF personnel shared with all stakeholders the draft of the transition plan that had been developed, which briefly summarized the various parts of the plan.
- In November 2018, a workshop for finalization, validation and translation of the plan was organized with all stakeholders.

What will be transitioned?

1. Leadership and governance for POC EID/TB/VL.
2. Financing of POC EID/TB/VL.
3. Procurement, ownership, and management of POC EID/TB/VL commodities.
4. Orientation, training, mentoring and supervision for POC EID/TB/VL.
5. Information systems for POC EID/TB/VL.
6. POC EID/TB/VL service delivery, including QA and post-market surveillance.
7. Demand creation and civil society mobilization.
8. Biosafety and biosecurity.

PEPFAR will support GRC and partners with the following planned core activities to ensure GRC ownership and sustainability of POC platforms:

- Complete a stakeholder mapping in order to identify the partners who are supporting pediatric HIV activities in country, including partners who may support future POC EID operations.
- Assemble information about the results achieved by the project and the level of financial and technical support needed to sustain and expand access to POC testing for EID/TB and VL.
- Share with key stakeholders information about the project achievements and projected future needs (financial and technical), and advocate for their support to sustain POC EID/TB/VL procurement and operations.
- Advocate for the integration of POC testing into domestic budgets and donor funding proposals, such as PEPFAR COP's CDC continuation applications, and GFATM proposals, as well as into the reprogramming of budgets for existing GFATM grants.
- Build MoPH and/or partner capacity to support and sustain POC EID/VL operations and linkage.
- Identify and prepare partner(s) to take over responsibility for POC EID procurement, customs clearance, warehousing and distribution.
- Complete an EID network strategy and/or map for the integration of POC EID/TB/VL into the current conventional EID/VL laboratory network.
- Transfer ownership of POC assets, including service and maintenance agreements, to the government and/or appropriate partners.

- Support the implementation and roll out of the VL/EID dashboard for efficient monitoring and evaluation and program coordination.
- Complete and share a project transition report.

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

Cameroon does not have attained or sustained locations and populations in COP19.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

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

To ensure that investments continue to support effective changes in the barriers identified in COP18 and through GSM, SIMS and the SID 3.0, PEPFAR Cameroon made some adjustments and changes to activities to meet the required above-site and site level investments. These changes took into consideration program orientation and achievements to re-align new and improved strategies in accordance with the pivot from the cluster approach to a national coverage, prioritizing high volume facilities and focusing on addressing the sex and age variations identified in the different geographic locations. PEPFAR Cameroon will continue to invest in strategies that focus on addressing structural barriers to care which were identified in COP18 by ensuring improved service and data quality across the country, improved identification and linkage of beneficiaries, measuring progress toward attaining the 95-95-95 targets, ensuring uninterrupted access to HIV and TB commodities, and reinforcing the healthcare system through strategic service models that bridge clinical and community-based services. The interagency team will continue to focus its site level and above site-level program support in COP19 to address the identified programmatic gaps in Cameroon.

The SID 3.0 showed the following gaps in service delivery and the national health system, which directly affect attainment of the three 95s.

Procurement and supply chain management of commodities

Commodity security and supply chain (SID 3.0 element score of 5.43) remains one of the major areas in need of critical investment in order to achieve epidemic control in Cameroon. In order to successfully scale the clinical treatment program nationwide, a mature supply chain system must be in place to assure an uninterrupted supply of commodities. Key systems barriers that need to be addressed in order for the country to reach maturity include: insufficient warehouse and inventory level optimization; insufficient leadership and governance structures to facilitate prioritization, coordination, and accountability; and challenges in logistics data quality which lead to inaccurate forecasting, distribution, and chronic over/understock at service delivery points.

Currently, the U.S. government through PEPFAR and the President Malaria Initiative (PMI) is the only donor with significant investments in TA for national procurement and distribution of essential medicines in Cameroon. Due to a significant reduction in COP19 resources to support TA activities in COP19, PEPFAR Cameroon's supply chain program will focus interventions in the following areas:

- **Data visibility:** improving timeliness and accuracy of data to react quickly to avoid impending stock outs or expiries. PEPFAR Cameroon's ability to foresee and avoid under-/over-stock or expiries across the country depends heavily on the availability of data. PEPFAR Cameroon will strengthen the logistics management information system by supporting 10 regional warehouses and VL reference labs to submit monthly procurement plans and monitoring reports (which includes stock status of ARVs, RTKs, TB preventive treatment (TPT), and VL reagents). Due to limited resources, the program will also support tier 1 health facilities in 2 high burden health districts each in the Littoral, Center, North and Far North regions to identify bottlenecks and address root causes that could affect data visibility. If additional resources become available, the supply chain partner can extend this practice to all tier 1 health facilities, thereby strengthening PEPFAR Cameroon's ability to influence data quality and timeliness at site level.

- **Rationalization and reverse logistics:** rapidly redeploying stocks where they are needed. National level stock-outs or expiries are increasingly rare due to improvements in forecasting and quantification but site level stock outs and over-stock remain a problem. The current system is designed only to push drugs and commodities out to facilities; there is no reverse logistics mechanism to pull them back and redeploy. The supply chain program will introduce reverse logistics systems including third party logistics (3PL) transport to rationalize stocks, moving overstock at risk of expiry to sites experiencing or at risk of stock-out. The program currently uses 3PL to move PMI-funded commodities within the North and Far North regions – this is a viable option to cope with limited availability of vehicles for distribution of medicines and introduce competitive pressure for regional medical stores through performance improvement incentives. Additionally, the program will support VL reference labs in timely stock monitoring and continue to support regional warehouses to properly store and coordinate an integrated last-mile distribution of all PEPFAR commodities. The goal is of this support is to build internal capacity within these intitutions

such that they will be able to maintain these standards when PEPFAR eventually transitions out.

- **Last-mile distribution in complex contexts.** Nationwide expansion of the clinical program will present unique logistical challenges that are very different from current PEPFAR supported regions. These include inadequate and impassable roads and the need to operate in conflict affected zones. The supply chain program will employ lessons learned from distributing PMI-supported commodities in the North and Far North regions to encourage the use 3PL sub-contractors to distribute PEPFAR-funded commodities ensure accountability and minimize risk.
- **Support for national supply chain transformation process.** The supply chain implementing mechanism (18195) is a key TA provider in the national supply chain transformation process led by the Director of Cooperation at the MoPH. This process aims to radically reimagine the national supply chain from the central medical store down to the service delivery point. In COP19, PEPFAR Cameroon will continue supporting this process including promoting government uptake of innovative solutions (e.g. public-private 3PL partnerships). Other national level support will include updating the national quantification and supply plans to integrate all sources of commodities; closely monitoring actual consumption trends versus targets; and updating pharmacy management guidance to facilitate the implementation of MMS and other key policy changes.

Significant unmet needs in laboratory and Quality Management Systems

A strong laboratory QMS is critical in ensuring the quality of testing, as a weak QMS may result in laboratory errors that can lead to over and under diagnosis. PEPFAR Cameroon has changed the laboratory landscape in Cameroon considerably. Through PEPFAR support, 17 laboratories are enrolled in the “Stepwise Laboratory Improvement Process Towards Accreditation” process, nine have at least one star and three are ISO 15189 accredited. All laboratories in scale-up sites are enrolled in the HIV dried-tube specimen PT scheme with a participation rate of 100% and a PT pass rate of 97.8% (May 2018 session). More testing sites have been added within the nine hundred and thirty one facilities trained on laboratory QA to expand testing to all entry points. PEPFAR Cameroon is a major partner in supporting laboratory quality assurance programs, especially the PT program.

Despite the improvements made, there is still a significant gap to attain sustainability. With reduced funding and concomitant expansion for PEPFAR supported laboratory activities in Cameroon, the laboratory program had to improve efficiencies through reduction in the cost of doing business by maintaining one implementing partner in COP19 and to leverage support from other stakeholders such as GFATM. PEPFAR continues to advocate for MoPH and other stakeholders to provide support for complimentary laboratory programs. To align with required site level reporting, PEPFAR Cameroon laboratory support reduced its above site funding to focus

more at site level where activities are implemented with direct impact on the beneficiaries. For the next two years as outlined on Table 6, laboratory-strengthening activities will focus on providing support to MoPH to finalize and implement laboratory quality manuals and tools on VL and HIV RT. Policy, planning, management and coordination activities will include support to the LTWG, roll out of the revised national curriculum for training of laboratory personnel, and disseminate and implement the National Laboratory Strategic Plan.

Challenges for Strategic Information

SI is critical in determining the effect of health systems strengthening interventions on service delivery targets and overall system goals – health information systems (HIS) such as Electronic Medical Record (EMR) and DHIS₂, are critical to program monitoring and performance improvement planning. Despite progress made, there is still a need for high-level involvement, coordination and utilization of data generated by different stakeholders. During data review meetings, the SIMS, MER and other data sources have revealed discrepancies that need to be addressed. PEPFAR Cameroon is working with NACC to reinforce MoPH's HIS by developing and strengthening SI system tools, establishing systems and intensifying coordination, mentorship and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies. PEPFAR Cameroon is also working with the government around issues of data governance, confidentiality, access, and use. PEPFAR Cameroon will also organize national conferences to share best practices, challenges and lessons learnt to come up with recommendations to be adopted nationally. Through NACC, PEPFAR will continue to support GRC in training, coordination and harmonization of data to ensure the scale up of new prevention, treatment and care strategies.

PEPFAR Cameroon has made significant progress towards addressing some of the systems barriers identified, but MER, SIMS, and the recent HIS assessment show there are still challenges particularly with the collection and use of data, standards, and governance. In COP₁₉, PEPFAR Cameroon will continue to make critical systems investment to close gaps and support activities to meet the well-defined benchmarks. Each benchmark will be monitored over a set timeline with measurement and outcome indicators clearly defined; however, progress made will be reported during the quarterly POART calls. PEPFAR will support the GRC to conduct DQA and/or service quality assessments at both regional and district levels with the involvement of high-level MoPH staff. The policies, tools, SOPs and guidelines developed will also be used to monitor progress made. The impact of these activities will lead to better-harmonized data with fewer discrepancies, improved transport and referral system, and reduced turn-around-time for commodities, samples and patient results.

Universal access to HIV treatment and care

Cameroon faces the unique challenge of using user fees to finance health services including HIV and TB services (testing, VL, TB testing, and consultation fees). Many health facilities also charge informal user fees not approved by the government. Following advocacy from key stakeholders

including the U.S. Office of the Global AIDS Coordinator, on April 5, 2019, the Cameroonian government made public a Ministerial Decision and Circular on the immediate elimination of informal HIV user fees and the elimination of all formal fees for HIV services by January 2020. In preparation for the January 2020 milestone, PEPFAR Cameroon, UNAIDS, and other stakeholders will support the government to put in place measures to improve working conditions within health facilities that do not involve the recovery of costs from end users at the point of service delivery.

Recognizing the important role of civil society in holding the GRC to account for commitments made, beginning in COP18 and continuing in COP19, PEPFAR Cameroon will support Treatment Access Watch (TAW), a well-respected national watchdog to scale up its monitoring of health facilities through “secret shoppers” and a hotline and mobile app for actual patients. PEPFAR will also build the capacity of the organization to improve their reporting of health facilities not in compliance with the new government policy and facilitate coordination between TAW and the GRC to ensure appropriate actions are taken to sanction those who violate the policy.

Over the longer term, the U.S. government (through USAID) is using non-PEPFAR resources to support the GRC in the elaboration and implementation of its sustainable health financing strategy. Since 2016, the GRC has embarked on the process of defining and developing a new health financing strategy with the goal of ensuring access to high quality healthcare services for the population while decreasing household health expenditures and avoiding catastrophic expenses. The process has benefitted from broad and well-coordinated donor support with participation by the WHO, UNAIDS, the World Bank, the International Labor Organization, the French and German bilateral cooperations, and various national and international NGOs. The strategy aims to achieve universal health coverage by building on existing structures such as the World Bank’s performance-based financing and the French and German supported Project Cheque-Sante, and introducing new insurance mechanisms to eliminate all point-of-service fees for covered health services including HIV/AIDS.

7.0 Staffing Plan

The PEPFAR Cameroon team conducted a staffing analysis to improve programmatic alignment of staff to facilitate and sustain HIV epidemic control and successfully implement the national programmatic scale up. Core activities required increased focus of staff time and skill sets on specific program components such as intensified programmatic management and strategic information analysis and meeting SIMS targets. For COP19, there are proposed changes by USAID, Peace Corps and CDC to the staffing footprint. There are 55 recorded positions with 44 positions funded under PEPFAR.

CDC

In COP16, CDC Cameroon went through a reduction in force, which was later followed by a request to repurpose five locally engaged (LE) staff positions. These positions were repurposed for the following: HIV/TB Public Health Specialist, Key and Priority Populations Public Health Specialist, HTC/Linkages Specialist, HIV Surveillance Public Health Specialist, and Partner Management and Finance Public Health Administrative Specialist to better align the staffing footprint with PEPFAR programmatic investment. Hiring for these positions were delayed by the long Department of State HR position classification process and by the U.S. government-hiring freeze.

During COP19 planning, CDC Cameroon received guidance from OGAC to expand the clinical program from 56 scale-up sites in four regions to 298 scale-up sites in 10 regions across the entire country. Due to PEPFAR's expansion to cover the entire country and CDC implementing the clinical portfolio in Cameroon, CDC is planning to fill all vacant positions and realigning its staffing to meet current program priorities.

In December 2017, CDC submitted an exemption request to the hiring freeze to recruit and hire staff for the five positions. The exemption was approved in January 2018. Two of the positions have been filled, the Key and Priority Populations Public Health Specialist is currently in classification, and the remaining positions will be filled by the end of FY2019.

CDC Cameroon is currently operating at 70 percent staffing capacity. With the expansion in geographical coverage, additional staffing is essential to meet program goals. CDC requested three additional LES technical staff to provide close site supervision and partner management and oversight, and TA to all 298 sites across the 10 regions in Cameroon. When all the vacant positions will have been filled, CDC will be operating at a full staffing level but will still be stretching its staffing capacity in order for the program to achieve epidemic control by 2021.

In the COP19 Budget, CDC is approved for \$593,698 of funding for a Global Health Security Agenda (GHSA) position. This position will take on the GHSA Program responsibilities currently covered by the Country Director and Deputy Country Director, and enable them to focus on the PEPFAR program and achievement of HIV Epidemic control in Cameroon.

DOD

DOD program will be expanding from six to ten regions and from 17 to 21 sites from Cop 18 to COP19. The staffing and CODB will remain the same as COP 18 levels, that is, two LES and a budget of \$237,000.

Peace Corps

Peace Corps will add an additional two LE staff to their CODB, bringing the total to three.

State

The PEPFAR Coordination Office staffing levels remain constant with one Direct Hire and two LES.

USAID

With concurrence from Management and the Front Office, USAID has been authorized to add two additional LE staff in order to intensify its partner management strategy and build the capacity of Cameroonian partners to eventually receive direct grants from the U.S government, in line with PEPFAR's goal of transitioning HIV services to local partners.

- One Financial Analyst (Risk Management) will provide much needed analyses and advice on financial and accountability issues relating to planning, achieving results and evaluating partner performance. The incumbent will also support current local sub-grantees by assessing their financial capabilities and providing necessary support and training in order to increase capacity, strengthen accountability, and prepare them to receive direct funding from USAID.
- One Monitoring, Evaluation, and Learning Specialist will support USAID's SI Advisor to monitor data for results and its impact on USAID's programs. The incumbent will also support USAID and partners in implementing learning agendas to guide performance management and increasing USAID's contributions to the PEPFAR Solutions Platform. As USAID seeks to increasingly work directly with local partners, the incumbent will play a key role in supporting local partners to improve their M&E capacity in order to facilitate effective reporting and results-based management.

CODB

The PEPFAR Cameroon CODB has increased from \$7,818,254 in COP 2018 to \$8,676,566 in COP 2019, indicating an 11% increase. The difference of \$753,698 was approved to fund USAID LES and a CDC position (\$160,000 and \$593,698) respectively. PEPFAR Cameroon has made efficiencies in staff to meeting programmatic priorities.

APPENDIX A -- PRIORITIZATION

Table A.1 SNU Prioritization to Reach Epidemic Control

| Organization unit | Period | Prioritization | <15 | 15+ | | Overall Coverage |
|-------------------|--------|---------------------|------|--------|------|------------------|
| | | | Peds | Female | Male | |
| Akonolinga | COP15 | Sustained | 9% | 147% | 35% | 69% |
| | COP16 | Sustained | 5% | 52% | 9% | 23% |
| | COP17 | Sustained | 210% | 51% | 19% | 44% |
| | COP18 | Sustained | 19% | 98% | 21% | 45% |
| | COP19 | Scale-up Saturation | 29% | 54% | 56% | 46% |
| Ayos | COP15 | Sustained | 8% | 42% | 6% | 18% |
| | COP16 | Sustained | 11% | 54% | 9% | 23% |
| | COP17 | Sustained | 175% | 43% | 16% | 37% |
| | COP18 | Sustained | 18% | 88% | 19% | 41% |
| | COP19 | Scale-up Saturation | 31% | 57% | 57% | 48% |
| Bafia | COP15 | Sustained | 12% | 51% | 9% | 23% |
| | COP16 | Sustained | 12% | 74% | 12% | 32% |
| | COP17 | Sustained | 404% | 99% | 36% | 85% |
| | COP18 | Sustained | 19% | 154% | 33% | 70% |
| | COP19 | Scale-up Saturation | 32% | 62% | 62% | 52% |
| Biyem Assi | COP15 | Sustained | 18% | 124% | 23% | 55% |
| | COP16 | Sustained | 20% | 134% | 27% | 61% |
| | COP17 | Scale-up Saturation | 472% | 116% | 51% | 104% |
| | COP18 | Scale-up Saturation | 78% | 92% | 70% | 80% |
| | COP19 | Scale-up Saturation | 65% | 130% | 131% | 109% |
| Cité Verte | COP15 | Sustained | 95% | 177% | 36% | 86% |
| | COP16 | Sustained | 93% | 212% | 44% | 101% |
| | COP17 | Scale-up Saturation | 629% | 154% | 65% | 138% |
| | COP18 | Scale-up Saturation | 91% | 97% | 74% | 87% |
| | COP19 | Scale-up Saturation | 73% | 150% | 151% | 125% |
| Djougolo | COP15 | Scale-up Saturation | 31% | 165% | 42% | 81% |
| | COP16 | Scale-up Saturation | 40% | 243% | 52% | 112% |
| | COP17 | Scale-up Saturation | 987% | 242% | 105% | 217% |
| | COP18 | Scale-up Saturation | 70% | 133% | 101% | 101% |
| | COP19 | Scale-up Saturation | 53% | 109% | 110% | 91% |
| Efoulan | COP15 | Sustained | 2% | 34% | 4% | 14% |
| | COP16 | Sustained | 5% | 45% | 6% | 18% |
| | COP17 | Scale-up Saturation | 72% | 18% | 8% | 16% |
| | COP18 | Scale-up Saturation | 3% | 20% | 15% | 12% |
| | COP19 | Scale-up Saturation | 20% | 39% | 39% | 32% |
| Eseka | COP15 | Sustained | 1% | 4% | 1% | 2% |
| | COP16 | Sustained | 4% | 22% | 4% | 10% |
| | COP17 | Sustained | 216% | 53% | 19% | 45% |

| | | | | | | |
|-------------|-------|---------------------|------|------|-----|-----|
| | COP18 | Sustained | 10% | 98% | 21% | 45% |
| | COP19 | Scale-up Saturation | 23% | 34% | 34% | 30% |
| Mbalmayo | COP15 | Sustained | 11% | 84% | 16% | 37% |
| | COP16 | Sustained | 16% | 103% | 20% | 46% |
| | COP17 | Sustained | 402% | 98% | 39% | 86% |
| | COP18 | Sustained | 0% | 158% | 34% | 71% |
| | COP19 | Scale-up Saturation | 35% | 66% | 66% | 56% |
| Mfou | COP15 | Sustained | 4% | 54% | 14% | 26% |
| | COP16 | Sustained | 4% | 62% | 15% | 29% |
| | COP17 | Sustained | 313% | 76% | 30% | 67% |
| | COP18 | Sustained | 0% | 130% | 28% | 58% |
| | COP19 | Scale-up Saturation | 25% | 44% | 45% | 38% |
| Monatele | COP15 | Sustained | 7% | 40% | 7% | 17% |
| | COP16 | Sustained | 11% | 55% | 9% | 24% |
| | COP17 | Sustained | 304% | 75% | 29% | 65% |
| | COP18 | Sustained | 0% | 127% | 27% | 57% |
| | COP19 | Scale-up Saturation | 41% | 72% | 73% | 62% |
| Nanga Eboko | COP15 | Sustained | 15% | 57% | 19% | 31% |
| | COP16 | Sustained | 12% | 65% | 10% | 28% |
| | COP17 | Sustained | 140% | 34% | 14% | 30% |
| | COP18 | Sustained | 0% | 78% | 17% | 35% |
| | COP19 | Scale-up Saturation | 56% | 95% | 95% | 82% |
| Ndikinimeki | COP15 | Sustained | 7% | 55% | 5% | 21% |
| | COP16 | Sustained | 10% | 37% | 6% | 16% |
| | COP17 | Sustained | 196% | 48% | 19% | 42% |
| | COP18 | Sustained | 0% | 95% | 20% | 43% |
| | COP19 | Scale-up Saturation | 36% | 64% | 65% | 55% |
| Ngog Mapubi | COP15 | Sustained | 1% | 13% | 2% | 5% |
| | COP16 | Sustained | 2% | 11% | 2% | 5% |
| | COP17 | Sustained | 142% | 35% | 13% | 30% |
| | COP18 | Sustained | 4% | 78% | 17% | 35% |
| | COP19 | Scale-up Saturation | 14% | 20% | 20% | 18% |
| Ngoumou | COP15 | Sustained | 2% | 19% | 4% | 8% |
| | COP16 | Sustained | 16% | 74% | 14% | 33% |
| | COP17 | Sustained | 363% | 89% | 32% | 76% |
| | COP18 | Sustained | 38% | 142% | 30% | 66% |
| | COP19 | Scale-up Saturation | 24% | 44% | 44% | 37% |
| Nkolndongo | COP15 | Sustained | 1% | 24% | 3% | 10% |
| | COP16 | Sustained | 4% | 36% | 6% | 15% |
| | COP17 | Scale-up Saturation | 255% | 62% | 24% | 54% |
| | COP18 | Scale-up Saturation | 21% | 55% | 42% | 39% |

| | | | | | | |
|-------------------|-------|---------------------|------|------|------|------|
| | COP19 | Scale-up Saturation | 15% | 28% | 28% | 24% |
| Ntui | COP15 | Sustained | 3% | 19% | 3% | 8% |
| | COP16 | Sustained | 4% | 25% | 5% | 11% |
| | COP17 | Sustained | 274% | 67% | 26% | 58% |
| | COP18 | Sustained | 2% | 118% | 25% | 53% |
| | COP19 | Scale-up Saturation | 14% | 24% | 24% | 21% |
| Obala | COP15 | Sustained | 15% | 78% | 14% | 35% |
| | COP16 | Sustained | 16% | 97% | 18% | 43% |
| | COP17 | Sustained | 402% | 98% | 38% | 86% |
| | COP18 | Sustained | 0% | 157% | 34% | 70% |
| | COP19 | Scale-up Saturation | 50% | 95% | 96% | 80% |
| Okola | COP15 | Sustained | 0% | 7% | 1% | 3% |
| | COP16 | Sustained | 0% | 17% | 3% | 7% |
| | COP17 | Sustained | 231% | 57% | 23% | 50% |
| | COP18 | Sustained | 0% | 106% | 23% | 47% |
| | COP19 | Scale-up Saturation | 20% | 34% | 34% | 30% |
| Saa | COP15 | Sustained | 6% | 36% | 8% | 17% |
| | COP16 | Sustained | 7% | 34% | 8% | 16% |
| | COP17 | Sustained | 261% | 64% | 26% | 56% |
| | COP18 | Sustained | 0% | 116% | 25% | 52% |
| | COP19 | Scale-up Saturation | 38% | 63% | 64% | 55% |
| Soa | COP15 | Sustained | 6% | 55% | 10% | 24% |
| | COP16 | Sustained | 6% | 76% | 13% | 32% |
| | COP17 | Sustained | 322% | 79% | 29% | 68% |
| | COP18 | Sustained | 0% | 131% | 28% | 59% |
| | COP19 | Scale-up Saturation | 38% | 61% | 60% | 53% |
| Bonassama | COP15 | Sustained | 24% | 135% | 24% | 60% |
| | COP16 | Sustained | 22% | 142% | 26% | 62% |
| | COP17 | Scale-up Aggressive | 490% | 119% | 51% | 107% |
| | COP18 | Scale-up Saturation | 58% | 75% | 57% | 63% |
| | COP19 | Scale-up Saturation | 52% | 105% | 106% | 88% |
| Cité Des Palmiers | COP15 | Sustained | 17% | 80% | 16% | 37% |
| | COP16 | Sustained | 21% | 98% | 21% | 45% |
| | COP17 | Scale-up Aggressive | 361% | 88% | 33% | 76% |
| | COP18 | Scale-up Saturation | 41% | 55% | 42% | 46% |
| | COP19 | Scale-up Saturation | 37% | 72% | 73% | 61% |
| Deido | COP15 | Scale-up Aggressive | 33% | 112% | 25% | 54% |
| | COP16 | Scale-up Aggressive | 42% | 188% | 45% | 90% |
| | COP17 | Scale-up Aggressive | 735% | 179% | 78% | 161% |
| | COP18 | Scale-up Saturation | 77% | 111% | 84% | 91% |
| | COP19 | Scale-up Saturation | 51% | 106% | 106% | 88% |

| | | | | | | |
|------------|-------|---------------------|-------|------|------|------|
| Edea | COP15 | Sustained | 11% | 56% | 12% | 26% |
| | COP16 | Sustained | 18% | 69% | 15% | 33% |
| | COP17 | Sustained | 308% | 75% | 29% | 65% |
| | COP18 | Sustained | 23% | 142% | 30% | 65% |
| | COP19 | Scale-up Saturation | 30% | 55% | 56% | 47% |
| Logbaba | COP15 | Sustained | 15% | 79% | 15% | 35% |
| | COP16 | Sustained | 9% | 90% | 14% | 38% |
| | COP17 | Scale-up Aggressive | 298% | 72% | 28% | 63% |
| | COP18 | Scale-up Saturation | 27% | 44% | 33% | 35% |
| | COP19 | Scale-up Saturation | 24% | 46% | 46% | 39% |
| Mbangue | COP15 | Sustained | 23% | 132% | 20% | 56% |
| | COP16 | Sustained | 29% | 201% | 35% | 88% |
| | COP17 | Scale-up Aggressive | 2151% | 520% | 221% | 466% |
| | COP18 | Scale-up Saturation | 32% | 40% | 30% | 34% |
| | COP19 | Scale-up Saturation | 47% | 87% | 87% | 74% |
| New Bell | COP15 | Sustained | 30% | 168% | 29% | 73% |
| | COP16 | Sustained | 33% | 199% | 37% | 88% |
| | COP17 | Scale-up Aggressive | 166% | 40% | 18% | 36% |
| | COP18 | Scale-up Saturation | 55% | 71% | 54% | 60% |
| | COP19 | Scale-up Saturation | 49% | 99% | 99% | 82% |
| Nkongsamba | COP15 | Sustained | 18% | 102% | 16% | 44% |
| | COP16 | Sustained | 20% | 111% | 17% | 47% |
| | COP17 | Sustained | 0% | 254% | 100% | 141% |
| | COP18 | Sustained | 0% | 315% | 68% | 141% |
| | COP19 | Scale-up Saturation | 63% | 122% | 124% | 103% |
| Nylon | COP15 | Sustained | 20% | 140% | 26% | 62% |
| | COP16 | Sustained | 31% | 181% | 33% | 80% |
| | COP17 | Scale-up Aggressive | 181% | 44% | 17% | 38% |
| | COP18 | Scale-up Saturation | 48% | 70% | 53% | 57% |
| | COP19 | Scale-up Saturation | 39% | 76% | 77% | 64% |
| Pouma | COP15 | Sustained | 14% | 88% | 16% | 39% |
| | COP16 | Sustained | 19% | 108% | 23% | 50% |
| | COP17 | Sustained | 0% | 10% | 4% | 5% |
| | COP18 | Sustained | 0% | 47% | 10% | 21% |
| | COP19 | Scale-up Saturation | 58% | 111% | 166% | 112% |
| Yabassi | COP15 | Sustained | 4% | 25% | 7% | 13% |
| | COP16 | Sustained | 8% | 32% | 8% | 15% |
| | COP17 | Sustained | 0% | 38% | 13% | 20% |
| | COP18 | Sustained | 0% | 80% | 17% | 36% |
| | COP19 | Scale-up Saturation | 11% | 26% | 26% | 21% |
| Bafut | COP15 | Sustained | 13% | 44% | 10% | 21% |

| | | | | | | |
|------------|-------|---------------------|------|------|------|------|
| | COP16 | Sustained | 30% | 62% | 14% | 31% |
| | COP17 | Sustained | 162% | 41% | 17% | 37% |
| | COP18 | Sustained | 15% | 88% | 19% | 41% |
| | COP19 | Scale-up Saturation | 28% | 45% | 44% | 39% |
| Bali | COP15 | Sustained | 17% | 71% | 13% | 31% |
| | COP16 | Sustained | 25% | 88% | 16% | 40% |
| | COP17 | Sustained | 189% | 48% | 24% | 45% |
| | COP18 | Sustained | 29% | 102% | 22% | 48% |
| | COP19 | Scale-up Saturation | 21% | 47% | 47% | 38% |
| Bamenda | COP15 | Sustained | 53% | 162% | 33% | 76% |
| | COP16 | Sustained | 62% | 182% | 38% | 86% |
| | COP17 | Sustained | 466% | 119% | 51% | 107% |
| | COP18 | Sustained | 170% | 185% | 40% | 96% |
| | COP19 | Scale-up Saturation | 67% | 137% | 138% | 114% |
| Batibo | COP15 | Sustained | 27% | 132% | 20% | 56% |
| | COP16 | Sustained | 36% | 160% | 27% | 70% |
| | COP17 | Sustained | 456% | 116% | 45% | 101% |
| | COP18 | Sustained | 44% | 178% | 38% | 83% |
| | COP19 | Scale-up Saturation | 54% | 98% | 98% | 83% |
| Fundong | COP15 | Sustained | 43% | 115% | 21% | 53% |
| | COP16 | Sustained | 49% | 126% | 24% | 59% |
| | COP17 | Sustained | 429% | 110% | 46% | 98% |
| | COP18 | Sustained | 133% | 180% | 39% | 91% |
| | COP19 | Scale-up Saturation | 40% | 76% | 77% | 64% |
| Kumbo East | COP15 | Sustained | 23% | 86% | 20% | 41% |
| | COP16 | Sustained | 29% | 91% | 23% | 45% |
| | COP17 | Sustained | 418% | 107% | 45% | 95% |
| | COP18 | Sustained | 118% | 171% | 37% | 86% |
| | COP19 | Scale-up Saturation | 27% | 52% | 52% | 44% |
| Kumbo West | COP15 | Sustained | 78% | 161% | 38% | 80% |
| | COP16 | Sustained | 91% | 187% | 52% | 98% |
| | COP17 | Sustained | 370% | 94% | 61% | 97% |
| | COP18 | Sustained | 224% | 173% | 37% | 95% |
| | COP19 | Scale-up Saturation | 62% | 121% | 122% | 102% |
| Mbengwi | COP15 | Sustained | 40% | 125% | 23% | 57% |
| | COP16 | Sustained | 42% | 141% | 27% | 64% |
| | COP17 | Sustained | 452% | 115% | 40% | 97% |
| | COP18 | Sustained | 44% | 171% | 37% | 80% |
| | COP19 | Scale-up Saturation | 41% | 64% | 65% | 57% |
| Ndop | COP15 | Sustained | 26% | 89% | 13% | 38% |
| | COP16 | Sustained | 37% | 104% | 16% | 46% |

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|-------------|-------|---------------------|------|------|------|------|
| | COP17 | Sustained | 358% | 91% | 37% | 80% |
| | COP18 | Sustained | 94% | 163% | 35% | 80% |
| | COP19 | Scale-up Saturation | 26% | 50% | 50% | 42% |
| Ndu | COP15 | Sustained | 31% | 72% | 6% | 29% |
| | COP16 | Sustained | 41% | 96% | 19% | 45% |
| | COP17 | Sustained | 310% | 79% | 41% | 75% |
| | COP18 | Sustained | 34% | 147% | 31% | 68% |
| | COP19 | Scale-up Saturation | 29% | 54% | 55% | 46% |
| Nkambe | COP15 | Sustained | 26% | 83% | 11% | 35% |
| | COP16 | Sustained | 41% | 108% | 18% | 48% |
| | COP17 | Sustained | 300% | 77% | 30% | 67% |
| | COP18 | Sustained | 97% | 141% | 30% | 71% |
| | COP19 | Scale-up Saturation | 23% | 47% | 47% | 39% |
| Wum | COP15 | Sustained | 19% | 57% | 10% | 25% |
| | COP16 | Sustained | 23% | 78% | 13% | 35% |
| | COP17 | Sustained | 291% | 74% | 28% | 64% |
| | COP18 | Sustained | 37% | 126% | 27% | 59% |
| | COP19 | Scale-up Saturation | 27% | 52% | 52% | 44% |
| Bangem | COP15 | Sustained | 19% | 25% | 38% | 32% |
| | COP16 | Sustained | 17% | 82% | 14% | 36% |
| | COP17 | Sustained | 410% | 99% | 35% | 85% |
| | COP18 | Sustained | 31% | 118% | 25% | 55% |
| | COP19 | Scale-up Saturation | 150% | 616% | 585% | 451% |
| Buea | COP15 | Sustained | 22% | 103% | 19% | 46% |
| | COP16 | Sustained | 27% | 128% | 25% | 58% |
| | COP17 | Sustained | 438% | 106% | 36% | 90% |
| | COP18 | Sustained | 52% | 156% | 33% | 74% |
| | COP19 | Scale-up Saturation | 30% | 60% | 61% | 50% |
| Ekondo Titi | COP15 | Sustained | 15% | 37% | 9% | 18% |
| | COP16 | Sustained | 12% | 44% | 11% | 22% |
| | COP17 | Sustained | 214% | 52% | 18% | 44% |
| | COP18 | Sustained | 17% | 96% | 21% | 45% |
| | COP19 | Scale-up Saturation | 19% | 32% | 32% | 28% |
| Fontem | COP15 | Sustained | 17% | 41% | 10% | 20% |
| | COP16 | Sustained | 19% | 42% | 10% | 21% |
| | COP17 | Sustained | 393% | 96% | 34% | 81% |
| | COP18 | Sustained | 24% | 149% | 32% | 69% |
| | COP19 | Scale-up Saturation | 7% | 9% | 9% | 8% |
| Kumba | COP15 | Sustained | 26% | 96% | 23% | 47% |
| | COP16 | Sustained | 29% | 139% | 29% | 64% |
| | COP17 | Sustained | 495% | 120% | 42% | 102% |

| | | | | | | |
|-------------|-------|---------------------|------|------|------|------|
| | COP18 | Sustained | 71% | 178% | 38% | 86% |
| | COP19 | Scale-up Saturation | 41% | 83% | 83% | 69% |
| Limbe | COP15 | Sustained | 19% | 117% | 26% | 54% |
| | COP16 | Sustained | 30% | 136% | 31% | 64% |
| | COP17 | Sustained | 555% | 135% | 45% | 113% |
| | COP18 | Sustained | 60% | 191% | 41% | 90% |
| | COP19 | Scale-up Saturation | 56% | 110% | 110% | 92% |
| Mamfe | COP15 | Sustained | 41% | 201% | 40% | 92% |
| | COP16 | Sustained | 89% | 207% | 48% | 102% |
| | COP17 | Sustained | 981% | 239% | 85% | 204% |
| | COP18 | Sustained | 0% | 284% | 61% | 127% |
| | COP19 | Scale-up Saturation | 30% | 64% | 64% | 53% |
| Muyuka | COP15 | Sustained | 14% | 65% | 10% | 28% |
| | COP16 | Sustained | 10% | 65% | 8% | 26% |
| | COP17 | Sustained | | 76% | 27% | 40% |
| | COP18 | Sustained | 0% | 125% | 27% | 56% |
| | COP19 | Scale-up Saturation | 17% | 28% | 28% | 24% |
| Nguti | COP16 | Sustained | 56% | 147% | 31% | 70% |
| | COP17 | Sustained | | | | |
| | COP18 | | | | | |
| | COP19 | Scale-up Saturation | 13% | 27% | 28% | 23% |
| Tiko | COP15 | Sustained | 38% | 137% | 29% | 64% |
| | COP16 | Sustained | 40% | 163% | 35% | 76% |
| | COP17 | Sustained | | 108% | 38% | 57% |
| | COP18 | Sustained | 67% | 163% | 35% | 78% |
| | COP19 | Scale-up Saturation | 69% | 142% | 143% | 118% |
| Tombel | COP15 | Sustained | 19% | 58% | 11% | 26% |
| | COP16 | Sustained | 27% | 76% | 16% | 36% |
| | COP17 | Sustained | | 98% | 35% | 52% |
| | COP18 | Sustained | 0% | 152% | 33% | 68% |
| | COP19 | Scale-up Saturation | 13% | 21% | 21% | 18% |
| Abong Mbang | COP19 | Scale-up Saturation | 49% | 90% | 91% | 77% |
| Ako | COP19 | Scale-up Saturation | 56% | 71% | 73% | 67% |
| Ambam | COP19 | Scale-up Saturation | 44% | 90% | 91% | 75% |
| Bafang | COP19 | Scale-up Saturation | 78% | 147% | 149% | 125% |
| Bandjoun | COP19 | Scale-up Saturation | 42% | 65% | 65% | 57% |
| Bangangte | COP19 | Scale-up Saturation | 54% | 98% | 98% | 83% |
| Bangourain | COP19 | Scale-up Saturation | 41% | 63% | 63% | 56% |
| Bankim | COP19 | Scale-up Saturation | 22% | 33% | 34% | 30% |
| Banyo | COP19 | Scale-up Saturation | 39% | 58% | 57% | 51% |
| Batouri | COP19 | Scale-up Saturation | 35% | 66% | 66% | 56% |

| | | | | | | |
|---------------|-------|---------------------|------|------|------|------|
| Bertoua | COP19 | Scale-up Saturation | 38% | 77% | 78% | 65% |
| Betare Oya | COP19 | Scale-up Saturation | 13% | 23% | 23% | 20% |
| Bibemi | COP19 | Scale-up Saturation | 43% | 46% | 45% | 45% |
| Bogo | COP19 | Scale-up Saturation | 62% | 113% | 116% | 97% |
| Bourha | COP19 | Scale-up Saturation | 150% | 376% | 402% | 309% |
| Djohong | COP19 | Scale-up Saturation | 46% | 68% | 81% | 65% |
| Djoum | COP19 | Scale-up Saturation | 19% | 29% | 30% | 26% |
| Doume | COP19 | Scale-up Saturation | 17% | 27% | 28% | 24% |
| Dschang | COP19 | Scale-up Saturation | 85% | 159% | 160% | 135% |
| Ebolowa | COP19 | Scale-up Saturation | 34% | 65% | 65% | 55% |
| Figuil | COP19 | Scale-up Saturation | 46% | 75% | 79% | 67% |
| Foumban | COP19 | Scale-up Saturation | 61% | 112% | 114% | 96% |
| Foumbot | COP19 | Scale-up Saturation | 72% | 136% | 137% | 115% |
| Galim | COP19 | Scale-up Saturation | 30% | 37% | 36% | 35% |
| Garoua Boulai | COP19 | Scale-up Saturation | 92% | 172% | 174% | 146% |
| Garoua I | COP19 | Scale-up Saturation | 73% | 141% | 142% | 119% |
| Garoua II | COP19 | Scale-up Saturation | 10% | 13% | 13% | 12% |
| Gaschiga | COP19 | Scale-up Saturation | 27% | 38% | 38% | 35% |
| Guider | COP19 | Scale-up Saturation | 59% | 100% | 101% | 86% |
| Hina | COP19 | Scale-up Saturation | 250% | 555% | 592% | 466% |
| Japoma | COP19 | Scale-up Saturation | 5% | 8% | 8% | 7% |
| Kaele | COP19 | Scale-up Saturation | 107% | 178% | 181% | 155% |
| Kar Hay | COP19 | Scale-up Saturation | 67% | 92% | 91% | 83% |
| Kette | COP19 | Scale-up Saturation | 29% | 50% | 49% | 42% |
| Kolofata | COP19 | Scale-up Saturation | 98% | 145% | 145% | 129% |
| Kouoptamo | COP19 | Scale-up Saturation | 18% | 21% | 20% | 20% |
| Kousseri | COP19 | Scale-up Saturation | 33% | 45% | 45% | 41% |
| Kribi | COP19 | Scale-up Saturation | 45% | 86% | 87% | 72% |
| Lagdo | COP19 | Scale-up Saturation | 49% | 73% | 72% | 65% |
| Lolodorf | COP19 | Scale-up Saturation | 10% | 26% | 27% | 21% |
| Lomie | COP19 | Scale-up Saturation | 43% | 95% | 98% | 79% |
| Loum | COP19 | Scale-up Saturation | 32% | 44% | 44% | 40% |
| Mada | COP19 | Scale-up Saturation | 30% | 38% | 39% | 35% |
| Maga | COP19 | Scale-up Saturation | 28% | 29% | 29% | 29% |
| Malantouen | COP19 | Scale-up Saturation | 47% | 83% | 83% | 71% |
| Manjo | COP19 | Scale-up Saturation | 11% | 33% | 32% | 25% |
| Maroua 1 | COP19 | Scale-up Saturation | 32% | 45% | 45% | 41% |
| Maroua 2 | COP19 | Scale-up Saturation | 110% | 214% | 215% | 180% |
| Maroua 3 | COP19 | Scale-up Saturation | 15% | 9% | 8% | 11% |
| Massangam | COP19 | Scale-up Saturation | 69% | 113% | 112% | 98% |
| Mayo Oulo | COP19 | Scale-up Saturation | 56% | 96% | 97% | 83% |

| | | | | | | |
|-------------------|-------|---------------------|------|------|------|------|
| Mbang | COP19 | Scale-up Saturation | 11% | 25% | 26% | 21% |
| Mbanga | COP19 | Scale-up Saturation | 10% | 15% | 15% | 14% |
| Mbouda | COP19 | Scale-up Saturation | 61% | 107% | 107% | 91% |
| Meiganga | COP19 | Scale-up Saturation | 32% | 54% | 54% | 46% |
| Melong | COP19 | Scale-up Saturation | 18% | 26% | 26% | 23% |
| Messamena | COP19 | Scale-up Saturation | 15% | 39% | 40% | 31% |
| Meyomessala | COP19 | Scale-up Saturation | 17% | 31% | 31% | 26% |
| Mifi | COP19 | Scale-up Saturation | 80% | 155% | 155% | 130% |
| Mokolo | COP19 | Scale-up Saturation | 149% | 248% | 249% | 215% |
| Moloundou | COP19 | Scale-up Saturation | 10% | 13% | 13% | 12% |
| Mora | COP19 | Scale-up Saturation | 44% | 50% | 50% | 48% |
| Moulvoudaye | COP19 | Scale-up Saturation | 61% | 33% | 29% | 41% |
| Mvangan | COP19 | Scale-up Saturation | 6% | 24% | 26% | 19% |
| Ndelele | COP19 | Scale-up Saturation | 37% | 61% | 61% | 53% |
| Ngaoundal | COP19 | Scale-up Saturation | 34% | 55% | 55% | 48% |
| Ngaoundere Rural | COP19 | Scale-up Saturation | 15% | 21% | 22% | 19% |
| Ngaoundere Urbain | COP19 | Scale-up Saturation | 73% | 142% | 142% | 119% |
| Ngong | COP19 | Scale-up Saturation | 33% | 49% | 49% | 44% |
| Nguelemendouka | COP19 | Scale-up Saturation | 7% | 18% | 18% | 14% |
| Njombe Penja | COP19 | Scale-up Saturation | 121% | 226% | 226% | 191% |
| Nkolbisson | COP19 | Scale-up Saturation | 8% | 11% | 11% | 10% |
| Oku | COP19 | Scale-up Saturation | 20% | 30% | 32% | 27% |
| Pette | COP19 | Scale-up Saturation | 375% | 938% | 955% | 756% |
| Pitua | COP19 | Scale-up Saturation | 61% | 83% | 84% | 76% |
| Poli | COP19 | Scale-up Saturation | 65% | 104% | 107% | 92% |
| Rey Bouba | COP19 | Scale-up Saturation | 33% | 36% | 37% | 35% |
| Sangmelima | COP19 | Scale-up Saturation | 43% | 86% | 88% | 72% |
| Santa | COP19 | Scale-up Saturation | 36% | 67% | 66% | 57% |
| Santchou | COP19 | Scale-up Saturation | 18% | 75% | 70% | 54% |
| Tchollire | COP19 | Scale-up Saturation | 37% | 56% | 57% | 50% |
| Tibati | COP19 | Scale-up Saturation | 38% | 63% | 62% | 54% |
| Tignere | COP19 | Scale-up Saturation | 33% | 57% | 59% | 50% |
| Tokombere | COP19 | Scale-up Saturation | 145% | 175% | 176% | 165% |
| Touboro | COP19 | Scale-up Saturation | 33% | 51% | 51% | 45% |
| Tubah | COP19 | Scale-up Saturation | 18% | 27% | 27% | 24% |
| Yagoua | COP19 | Scale-up Saturation | 61% | 110% | 111% | 94% |
| Yokadouma | COP19 | Scale-up Saturation | 36% | 64% | 63% | 54% |
| Zoetele | COP19 | Scale-up Saturation | 26% | 47% | 47% | 40% |

Table A.2 ART Targets by Prioritization for Epidemic Control

| Prioritization Area | Total PLHIV | Expected current on ART (APR FY19) | Additional patients required for 80% ART coverage | Target current on ART (APR FY20) TX_CURR | Newly initiated (APR FY20) TX_NEW | ART Coverage (APR 20) |
|--|--------------------|---|--|---|--|------------------------------|
| Attained | | | | | | |
| Scale-Up Saturation | 489,515 | 271,393 | 110,193 | 381,592 | 127,935 | 92.60% |
| Scale-Up Aggressive | | | | | | |
| Sustained | | | | | | |
| Central Support | 38,975 | | | | | |
| Commodities (if not included in previous categories) | | | | | | |
| Total | 528,490 | | | | | |

APPENDIX B – Budget Profile and Resource Projections

B1. COP 19 Planned Spending

Table B.1.1 COP19 Budget by Program Area

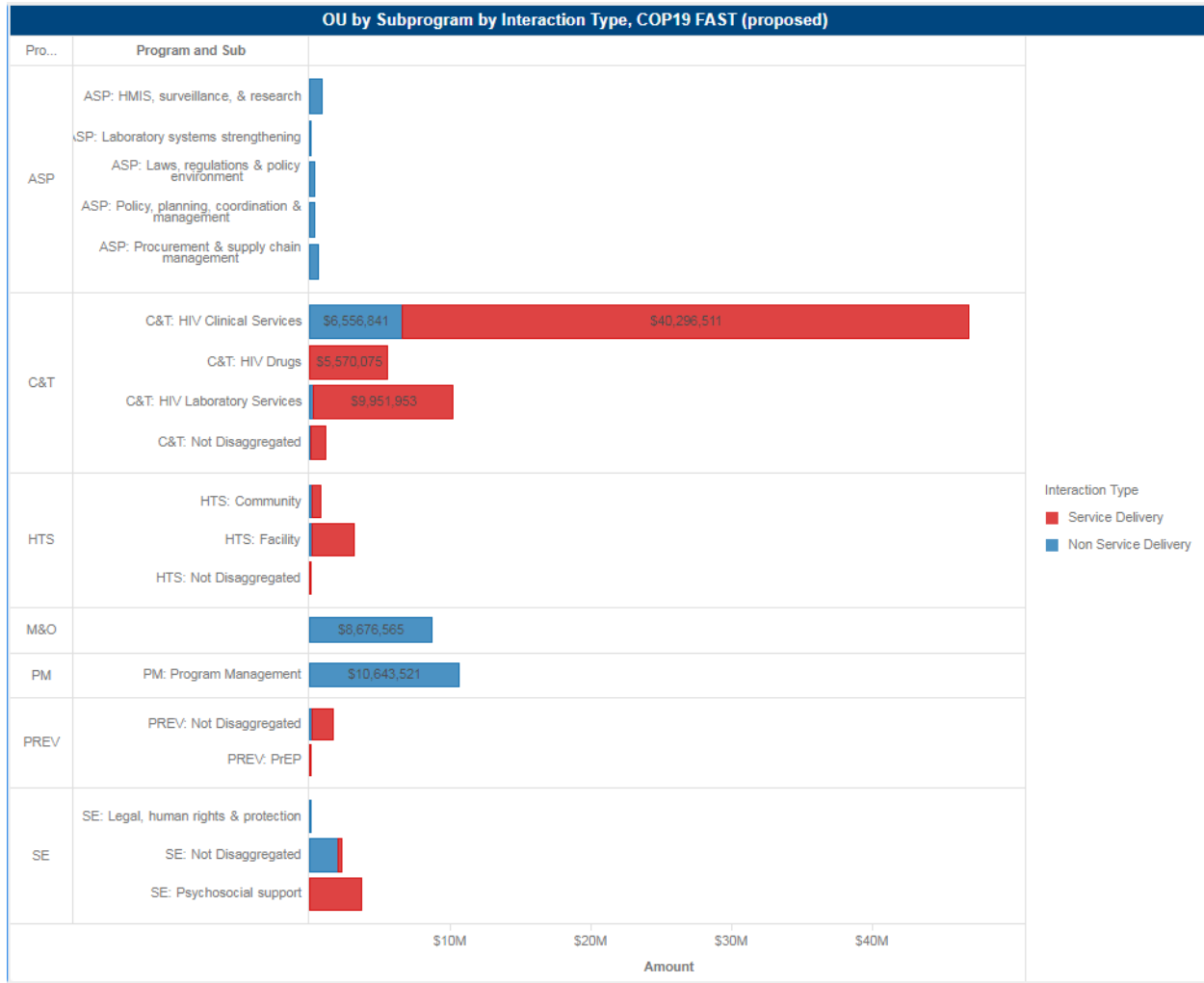


Table B.1.2 COP19 Total Planning Level

| Applied Pipeline | New Funding | Total Spend |
|------------------|-----------------|-----------------|
| \$US 10,450,779 | \$US 86,732,008 | \$US 97,182,787 |

*Data included in Table B.1.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Agency” report.

| Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only) | |
|---|-------------------------|
| PEPFAR Budget Code | Amount Allocated |
| CIRC | \$0 |
| HBHC | \$6,253,678 |
| HKID | \$5,900,438 |
| HLAB | \$135,041 |
| HMBL | \$0 |
| HMIN | \$0 |
| HTXD | \$5,618,595 |
| HTXS | \$33,299,181 |
| HVAB | \$0 |
| HVCT | \$5,231,750 |
| HVMS | \$2,216,416 |
| HVOP | \$1,927,027 |
| HVSI | \$1,162,903 |
| HVTB | \$10,045,823 |
| IDUP | \$0 |
| MTCT | \$4,103,927 |
| OHSS | \$1,290,576 |
| PDCS | \$3,466,225 |
| PDTX | \$6,080,426 |

*Data included in Table B.2.2 should match FACTS Info records, and can be double-checked by running the “Summary of Planned Funding by Budget Code” report

B.2 Resource Projections

COP19 budget was developed based on the priorities outlined in Cameroon’s COP19 planning letter and subsequent acceleration funds. In addition to allocating resources based on HIV incidence and prevalence among target populations, PEPFAR Cameroon considered the actual costs of funding various approaches using historic data in order to determine resource projections.

Care & Treatment (66%)

The bulk of COP19 activities are focused on this program area. Nine percent of this budget will support the procurement of commodities – PrEP, VL reagents and consumables, TPT, and ARVs.

Activities under this program area take into account actual costs of maintaining beneficiaries on treatment in clinical facilities, through community dispensation and other community-based care and support activities. Key cost inputs include salaries (of service delivery staff at clinical facilities, drop-in center personnel, OVC service provider personnel, etc.), general costs associated with running drop-in centers and/or local organizations (rent, utilities, etc.), activities essential to

service delivery to patients at clinical facilities, transportation support to beneficiaries to access health facilities, payment of medical bills for other health conditions, and travel costs associated with providing onsite supervision and mentoring. The care and treatment budget was developed by prioritizing the most cost efficient strategies being implemented by existing clinical facilities, drop-in centers and OVC service providers and also projected start-up costs (using historical information) for opening new sites across the country.

HTS (4% of total funding)

Activities under this program area take into account actual costs for identifying, testing, counselling, and linking beneficiaries to treatment. Key cost inputs include salaries, general office costs, travel, and transportation associated with providing onsite supervision and mentoring. This budget also includes the cost of procuring HIV self-test kits for the KP program.

SE (6% of total funding)

Socioeconomic activities primarily target KP and OVC. KP activities under this program include costs associated with organizing activities (e.g. sensitizing law enforcement, health personnel, etc.) to create a more enabling environment for KP to live in safety and dignity. These are activities are primarily non-service delivery and delivered directly by the implementing partners. Cost inputs include staff salaries, travel and transportation, and logistics costs associated with organizing meetings or trainings.

The OVC program's budget was developed taking into account the actual cost of providing community-based services to OVC in current health districts and projecting start-up costs (using historical information) of expanding this program across the country. The program also took into account specificities of each zone (e.g. poverty index; CLHIV burden, significant population of refugees and internally displaced persons, etc.) in order to determine the service package that may be best suited to each context and the projected number of children and families that may benefit from each service. Finally, the program used historical data to project the cost of providing training and TA for new OVC service providers (including the cost of short-term TA and other costs related to organizing training workshops); travel for monthly data verification and quality improvement visits; and monthly coordination meetings.

PREV (2% of total funding)

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

ASP (2% of total funding)

The HSS budget supports lab, strategic information, supply chain activities, and a new activity focused on strengthening civil society engagement in addressing user fee barriers.

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

APPENDIX D– Minimum Program Requirements

| Policy and Implementation Status of Minimum Requirements | | | |
|--|---|--|--|
| Issue | Policy Status | Implementation Status COP18 - # of sites, districts by population, partner | Implementation Status COP19 - # of sites, districts by population, partner |
| 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups. | GRC adopted Test and Start in May 2016 and field implementation began in 2017 across all health facilities. PEPFAR/WHO provided support to GRC to develop the strategic document to facilitate the implementation of Test and Start. This strategic document provides policy guidance on HIV testing and retesting for verification in facilities and communities; differentiated service delivery models, including for different subpopulations; and multi-month scripting for stable patients, including community dispensation and LTFU strategies. The strategy also decentralized PMTCT, HTC and TB standalone sites to full ART sites through the enforcement of the task shifting policy. | Test and start implemented in most PEPFAR supported sites. 56 DSD sites and 180 sustained sites) | Test and start will be scaled up to all 298 PEPFAR-supported scale-up sites and 21 military sites. |
| 2. Adoption and implementation of differentiated service delivery models, including six month multi-month scripting (MMS) and delivery models to improve identification and ARV coverage of men and adolescents. | National policy states that differentiated service delivery models be available at all health facilities. Current DSD models include same day ART initiation, multi-month scripting and community ART dispensation by CBOs. However, MMS is not uniform across facilities due to a lack of SOP's. Additionally, the supply chain system is weak and even though there aren't stock-outs, the availability of MMS at health facilities remains a challenge (forecasting, delivery). Some patients prefer to receive MMS at health facilities rather than through CBOs. A new approach currently being piloted is to move | Same day ART initiation, multi-month scripting and community ART dispensation are currently implemented in most PEPFAR supported sites. MMS for 3 months is implemented for stable patients in all the ART sites | Same day ART initiation, multi-month scripting and community ART dispensation will be fully scaled up in all PEPFAR supported sites. Advocacy is ongoing for 6 MMS to be integrated to the ART guidelines for stable patients who have been on 3 MMS for 12 months |

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| | toward Community ART Refill Groups, which will be mentored by community workers for clients who prefer not to come to the DIC. | | |
| 3. Completion of TLD transition, including consideration for women of childbearing potential and adolescents, and removal of nevirapine-based regimens. | <ul style="list-style-type: none"> • The TLD transition document was finalized with the starting phase planned for July 19 (nationwide). • The order of TLD will be placed the NACC through the GFATM. • Phase I (starting phase) 6 months : All new patients adults males and women plus TB/HIV patients • Phase II (scaling up): all patients of ART on preferred first line treatment or alternate (including TB/HIV) • Registration of TLD in country to occur for a good implementation. Waiver in process while waiting to avoid delays in the start up phase . <p>How the country is addressing women of childbearing age (CBA).</p> <ul style="list-style-type: none"> • Ongoing discussion for women of CBA with effective contraception and not intending to get pregnant are considered to receive TLD • Waiting for WHO guidelines to support the assumptions <p>Plan to use TLE 600 or TLE400 and for what targeted population.</p> <ul style="list-style-type: none"> • TLE 600 to be used for pregnant women and those of CBA • Plan to transition from TLE 600 to TLE 400 • TLE 400 to be registered and included in essential medical drugs list in country for procurement <p>Draw-down plan for nevirapine-based formulations</p> <ul style="list-style-type: none"> • All patients on nevirapine-based formula will be transitioned to TLD | TLD plan is available and will be implemented starting July 2019 | TLD will be scaled up according to the TLD transition plan |

| | | | |
|--|--|--|---|
| | <ul style="list-style-type: none"> All children on nevirapine-based formulation will be transitioned to other regimens for peds. | | |
| 4. Scale up of Index testing and self-testing, and enhanced pediatric and adolescent case finding, ensuring consent procedures and confidentiality are protected and monitoring of intimate partner violence (IPV) is established. | PEPFAR Cameroon is advocating for the integration of index testing in the National HIV Guidelines which is currently under review. Policy development for self-testing is under approval and implementation will begin in 2019 | Index testing is currently being scaled up in all PEPFAR supported sites. Self testing will begin implementation in 2019 | Index testing will be scaled up with Fidelity Health Care providers will be retrained Prioritizing newly diagnose patients initiated on ART and virally unsuppressed Old patients |
| 5. TPT for all PLHIVs must be scaled-up as an integral and routine part of the HIV clinical care package. | The policy is nation-wide but implementation has only been rolled out in select health facilities such as tertiary district hospitals. | IPT is implemented for newly initiated patients on ART in PEPFAR supported sites | IPT will be scaled up to all PLHIV screened negative for TB in PEPFAR supported sites |
| 6. Direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups. | Test and start implemented in most PEPFAR supported sites | Same day ART initiation is implemented nation wide | We plan to retrain staff on counselling and therapeutic education including enhanced adherence counselling, implement linkage case management model using expert clients |
| 7. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and related services, such as ANC and TB services, affecting access to HIV testing and treatment and prevention. | The USG and other stakeholders have advocated to the GRC for elimination of user fees to the highest level of government. On April 4 th , the Minister of Health signed a Decision Memo eliminating all HIV user fees starting in January 2020. The USG and other partners, will be following up with the GRC to ensure that all milestones are met - funding is included in the government budget sessions and parliamentary | HIV fees as per the policy from various circular letters. Voucher system implemented at PEPFAR supported DSD sites | Elimination of all HIV user fees by January 2020 |

| | | | |
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| | approval in late 2019 and that implementation of the user fee status begin in January 2020. | | |
| 8. Completion of VL/EID optimization activities and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups. | Included in the VL Policy that was approved in 2017. | Optimization activities were completed in COP17. Ongoing monitoring how optimization levels are improving. | Ongoing monitoring. |
| 9. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | Programming for case based surveillance | Cohort monitoring for PMTCT and HEI outcomes were initiated in COP18. | Scaled up in all PEPFAR supported sites. |
| 10. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support. | The current OVC and ART guidelines are under review and will be available by end of FY19. | Implementation is aligned with scale-up health districts. The 10 – 14 age group is increasing and the number of children reached in Q1 is higher than all of COP17. We have also begun to proportionally increase the number of CLHIV that are benefitting from OVC services through improved partnership with the clinical program. | The OVC program is aligned with the clinical program. |
| 11. Evidence of resource commitments by host | According to the World Bank Public Expenditure Review of Cameroon, a lower middle-income country, the public spending on health remains one of the lowest in Africa. To date, Cameroon has spent between 4 – 5% annually on | | |

| | | | |
|---|---|--|--|
| governments with year after year increases. | total health expenditure as a share of GDP. Household out-of-pocket payments are the main source of health financing. The USG Front Office regularly calls on the GRC for increased national health expenditure. | | |
| 12. Clear evidence of agency progress toward local, indigenous partner prime funding. | | In COP18, CDC was the agency with indigenous prime partners. However, mid COP18, a new international partner will begin programming along with the initial prime partner under the clinical program. | USAID's two new procurements will be transition awards for COP19 (international to national partner); USAID will also directly fund TAW (a Cameroonian CSO). |
| 13. Scale up of unique identifier for patients across all sites. | There is a UIC for patients on ART and also for KP's. The two systems are not linked yet but work is in progress on linking these platforms. In addition, clients often get new unique IDs when they change treatment sites and the capability to link patients across sites does not exist for the general clinical program. | No funding has been allocated for UIC under COP18. | Planned for COP20 pending funding allocation' |
| Issue | Policy or implementation status change | | |
| VL management: Country policy updated. | Policy is being updated to include the algorithm for PBFW. VL testing will be free for all HIV patients starting in January 2020. | | |
| Screen better and test smarter: Stop over-testing. | Differentiated testing models document has been developed in country with a focus on more targeted testing using screening tools and index-testing. | | |

Tables and Systems Investments for Section 6.o

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|--|--|-------------------------------------|-----------------|--|---|--------------------|------------------|---|
| USAID | Chemionics International, Inc. | ASP: Procurement & supply chain management | Non-Targeted Pop: Not disaggregated | \$ 138,606.00 | Supply chain infrastructure | Insufficient warehouse and inventory level optimization | COP18 | COP20 | 80% |
| USAID | Chemionics International, Inc. | ASP: Procurement & supply chain management | Non-Targeted Pop: Not disaggregated | \$ 120,528.00 | Forecasting, supply chain plan, budget, and implementation | Ineffective leadership and governance structures to facilitate prioritization, coordination and accountability within the supply chain activities | COP19 | COP20 | 15% |
| USAID | Chemionics International, Inc. | ASP: Procurement & supply chain management | Non-Targeted Pop: Not disaggregated | \$ 343,504.00 | Supply chain infrastructure | Lack of accurate and reliable logistics data to drive informed decision making | COP18 | COP20 | 70% |
| HHS/CDC | NATIONAL AIDS CONTROL COMMITTEE | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 83,990.00 | Program and data quality management | Weak strategic information systems and management | COP18 | COP20 | 50% |
| HHS/CDC | NATIONAL AIDS CONTROL COMMITTEE | ASP: Policy, planning, coordination & management | Non-Targeted Pop: Not disaggregated | \$ 215,973.00 | Clinical guidelines, policies for service delivery | Weak national health system and service delivery | COP18 | COP20 | 40% |
| HHS/CDC | Global Health Systems Solutions | ASP: Policy, planning, coordination & management | Non-Targeted Pop: Not disaggregated | \$ 81,400.00 | Lab quality improvement and assurance | Weak national health system and service delivery | COP18 | COP20 | Develop at least 50% of tools and guidelines needed |
| HHS/CDC | Global Health Systems Solutions | ASP: Laboratory systems strengthening | Non-Targeted Pop: Not disaggregated | \$ 93,028.00 | Lab policy, budgets, and strategic plans | Weak national health system and service delivery | COP18 | COP20 | LTWG meetings with attendance sheets and minutes documented, Monitor implementation of the new curriculum in a laboratory training school |
| HHS/CDC | Cameroon Baptist Convention Health Board | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 66,894.00 | HMIS systems | Weak strategic information systems and management | COP18 | COP20 | 50% |
| HHS/CDC | NATIONAL TUBERCULOSIS CONTROL PROGRAM | ASP: Laboratory systems strengthening | Non-Targeted Pop: Not disaggregated | \$ 3,000.00 | Training in laboratory systems strengthening | Weak national health system and service delivery | COP18 | COP20 | 50% |

Table 6-E (Entry of Above Site Programs Activities)

| Funding Agency | PrimePartner | COP19 Program Area | COP19 Beneficiary | Activity Budget | COP19 Activity Category | Key Systems Barrier | Intervention Start | Intervention End | COP19 Benchmark |
|----------------|--|-------------------------------------|-------------------------------------|-----------------|-------------------------|---|--------------------|------------------|-----------------|
| HHS/CDC | Elizabeth Glaser Pediatric Aids Foundation | ASP: HMIS, surveillance, & research | Non-Targeted Pop: Not disaggregated | \$ 135,869.00 | HMIS systems | Weak strategic information systems and management | COP18 | COP20 | 50% |