CAMEROON Country Operational Plan

COP 2020

Strategic Direction Summary

March 23, 2020

Table of Contents

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	U.S. 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
DHIS2	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 and 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
MandE	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

The Government of the Republic of Cameroon (GRC) made a breakthrough policy decision in April 2019 to immediately eliminate informal HIV user fees in the public sector and all formal user fees for HIV and HIV related services as of January 1st, 2020. A highly coordinated process was undertaken by the USG and multi-lateral partners to support the government in costing the user fee elimination, developing payment mechanisms and ensuring communication and monitoring strategies are in place throughout all health facilities. Elimination of this main barrier will support Cameroon in achieving epidemic control of HIV by 2021.

In Country Operational Plan (COP)19, the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) implemented more strategic approaches and expanded to all ten regions of the country and this scale up will continue throughout COP20. Key successes noted were the elimination of HIV user fees and policy preparation, the scale up of viral load testing and consistent implementation of Test and Start resulting in strong linkage to initiating patients on treatment. **COP20 will intensify strategies on**:

- **Improving supply chain** and commodities procurement and distribution
- **Implementing case finding and testing with fidelity**, specifically addressing declining testing yields
- **Policy requirements and implementation** - ART optimization, multi-month dispensation and host country financing.

Cameroon has an estimated 504,472 People Living with HIV (PLHIV). As of December 2019, 312,214 PLHIV were on treatment nationally and it is expected that 381,023 will be on antiretroviral treatment (ART) nationally by the end of COP19. In COP19, PEPFAR implemented a scale up program at 298 high-volume clinical sites and 21 military clinical sites in all ten regions and will add 94,516 additional people to treatment in COP20. PEPFAR Cameroon will also improve access to viral load (VL) testing to reach 78% of PLHIV. Additionally, 77,022 key populations, including men who have sex with men (MSM), female sex workers (FSW), prisoners and injection drug users (IDU), will be reached with prevention activities, among whom 48,471 will be tested for HIV. Prevention activities will also target 45,689 priority populations, specifically adolescent girls and young women (AGYW), adolescent boys and young men (ABYM), clients of sex workers, IDPs and military personnel. Finally, PEPFAR will provide a core package of services to 67,675 orphans and vulnerable children (OVC), including 15,014 children and adolescents living with HIV (CLHIV/ALHIV).

To ensure achievement of these ambitious targets in COP19 and COP20, PEPFAR intensified partner management down to the site level and implements real-time corrective actions as needed. Regular engagement and close coordination with government, civil society organizations (CSO) and bi-lateral and multi-lateral partners has been critical to ensure the success of this scale up and

reaching the 95-95-95 goals. PEPFAR remains committed to supporting the 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 total population was estimated at 25,527,242 by the National Institute of Statistics in 2019 and the total projected number of PLHIV for 2020 is 504,472 (Spectrum, 2019). 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. Overall adult HIV prevalence continues to decrease, moving from 5.4% in 2004 (DHS, 2004) to 4.3% in 2011 (DHS, 2011), 3.4% in 2017 (CAMPHIA, 2017) and recently 2.7% in 2018 (DHS, 2018). Prevalence among women is nearly twice that of men (3.4% vs. 1.9%, DHS 2018).

HIV prevalence is highest among women between 35-39 years of age (6.5%), and 40-44 years of age (6.4%); and close to 5% among women aged 45-49 and 50-64. For men, HIV prevalence is highest in the 35-39 age range (5.1%), and over 4.8% among men in the age group 40-44. Adolescent girls and young women (AGYW) are equally affected compared to their male counterparts in the 15-19 age range (0.8%) but have a higher burden in the 20-24 age range (2.4% vs. 1.5%). HIV prevalence remains high among key populations (KP) at 24.3% for FSWs and 20.7% for MSM (IBBS, 2016).

From DHS 2018, prevalence is higher in urban areas (2.9%) compared to rural areas (2.4%). The South and East regions remain the highest prevalence ones with 5.8% and 5.6% prevalence respectively, and the lowest prevalence regions are the Far North (1.1%), West (1.6%) and North (1.7%). The HIV prevalence ratio between women and men shows different patterns from one region to another, with only one region in which men have a higher prevalence than women (South, 5.5% among women versus 6.1% for men), and other regions where women are 3.6 and 3.5 times more infected than men (North West and Littoral respectively). The economic capital, Douala, and the political capital, Yaounde, have a 2.4% prevalence, with 3.2% among women and 1.5% among men. Others cities combined have an overall HIV prevalence of 3.4% with 4.3% among women and 2.3% among men.

KP overall present with significantly higher HIV prevalence compared to the national average. 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%).

The number of People Living with HIV on antiretroviral treatment was 312,214 in December 2019, representing 62% coverage, nationally.

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	26,639,498	100	5,537,105	20.8	5,635,844	21.2	2,638,537	9.9	2,661,866	10	5,138,099	19.3	5,028,047	18.9	2020 Spectrum estimates
HIV Prevalence (%)		3.4%		0.20%		0.30%		1.34%		0.56%		5.50%		4.80%	CAMPHIA 2017, SPECTRUM 2020
AIDS Deaths (per year)	12,696		1,182		1,186		484		384		5,287		4,173		2020 Spectrum estimates
# PLHIV	504,281		13,696		14,232		34,658		14,766		285,057		242,872		2020 Spectrum estimates
Incidence Rate (Yr)		0.59						0.15		0.05					CAMPHIA 2018
New Infections (Yr)	14,596		1,000		1,029		3,769		1,275		4,465		3,058		2020 Spectrum estimates
Annual births	845,468														2020 Spectrum estimates
% of Pregnant Women with at least one ANC visit	3,924	87													DHS 2018
Pregnant women needing ARVs	23,249														2020 Spectrum estimates
AIDS Orphans (maternal, paternal, double)	402,891														2020 Spectrum estimates
Notified TB cases (Yr)	23,757														WHO 2019, Global Tuberculosis Report
% of TB cases that are HIV infected	13,000	31%													WHO 2019, Global Tuberculosis Report
% of Males Circumcised		93.90%													DHS 2011
Estimated Population Size of MSM*	66,842														Papworth, 2014
MSM HIV Prevalence		20.70%													2016 IBBS report
Estimated Population Size of FSW	112,580														World Bank, 2016
FSW HIV Prevalence		24.30%													2016 IBBS report
Estimated Population Size of PWID	N/A														N/A
PWID HIV Prevalence	N/A														N/A
Estimated Size of Priority Populations (Military)	50,000														SABERS 2018
Estimated Size of Priority Populations Prevalence (specify)		3.30%													SABERS 2018

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	26,639,498	2.7%*	504,281	391,253	312,214	62%	53%	2,546,337	78,143	58,473
Population <15 years	11,172,949		27,928	10,031	10,391	37%	25%	237,995	2,812	2,082
Men 15-24 years	2,661,866	1.1%*	14,766	11,217	4,624	31%	27%	205,509	2,209	1,544
Men 25+ years	5,028,047		141,872	107,815	83,510	59%	51%	596,039	23,672	17,440
Women 15-24 years	2,638,537	1.5%*	34,658	28,435	17,335	50%	43%	532,898	9,617	7,196
Women 25+ years	5,138,099		285,057	233,755	196,166	69%	59%	973,896	39,833	30,211
+MSM	66,842	20.7%**	13,836					6,092	819	790
+FSW	112,580	24.3%**	27,357					10,695	1,777	1,668
PWID										
++Priority Pop	50,000	3.3%	1650		1,290	78%	67%	3,039	143	152

*Data source is Spectrum 2019 **Data source is DHS 2018 ***Data source is DHIS2 National Data for 2019
+ Data Source is IBBS World Bank Report 2016 and PEPFAR APR results 2019
++ Data Source is SABERS Report 2018 and PEPFAR APR results 2019

Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment

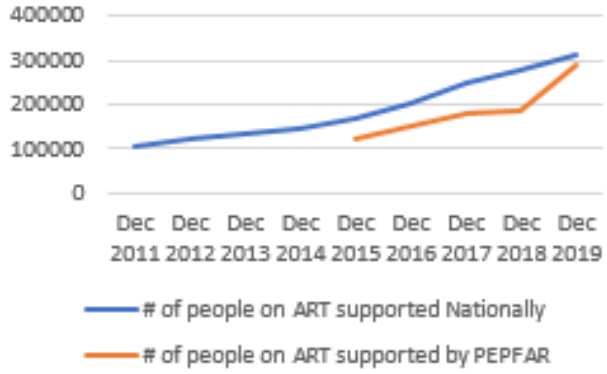


Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV

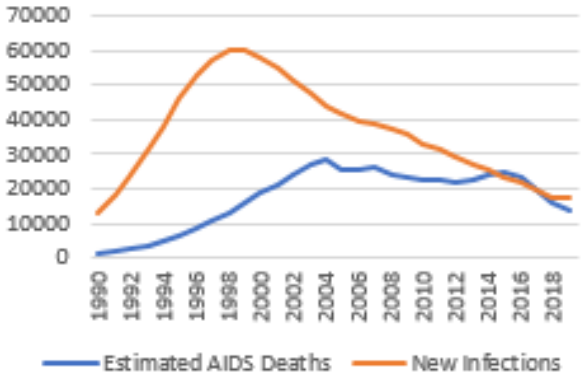


Figure 2.1.5 Progress retaining individuals In lifelong ART in FY19

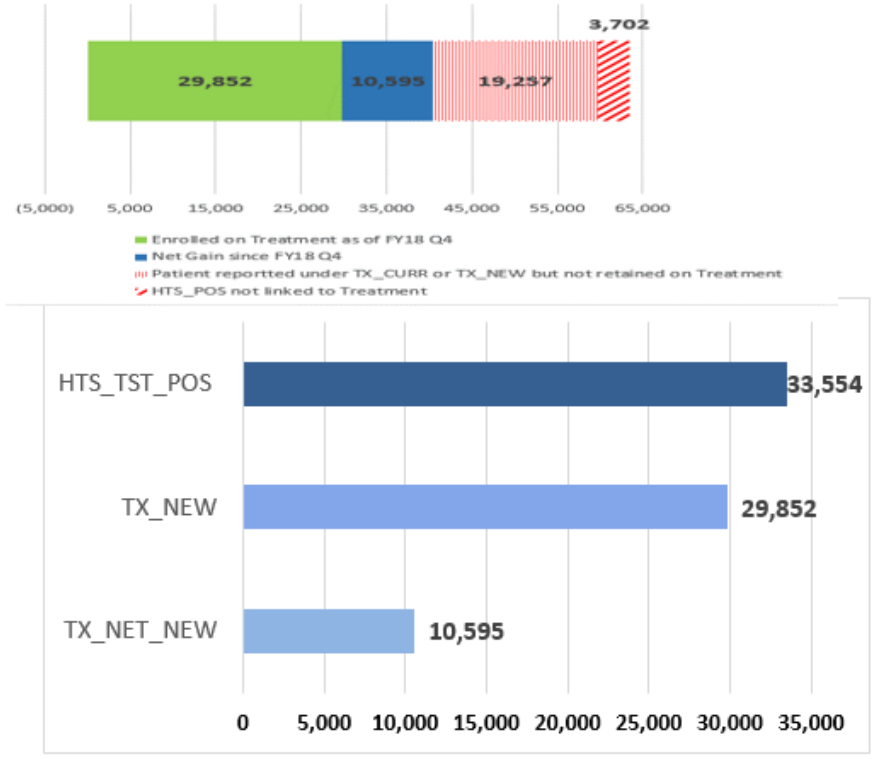


Figure 2.1.6 Proportion of clients lost in lifelong ART in FY19

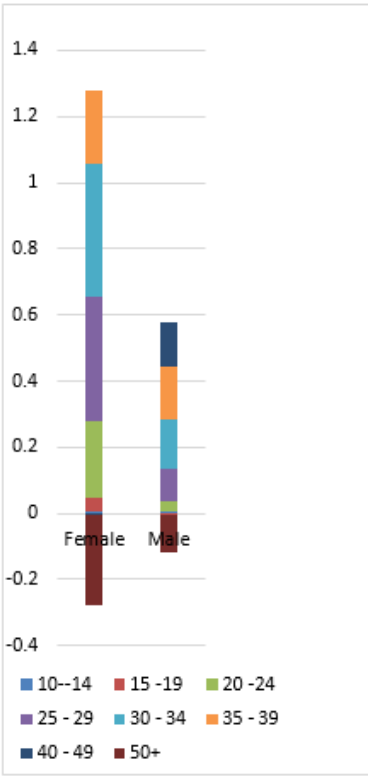
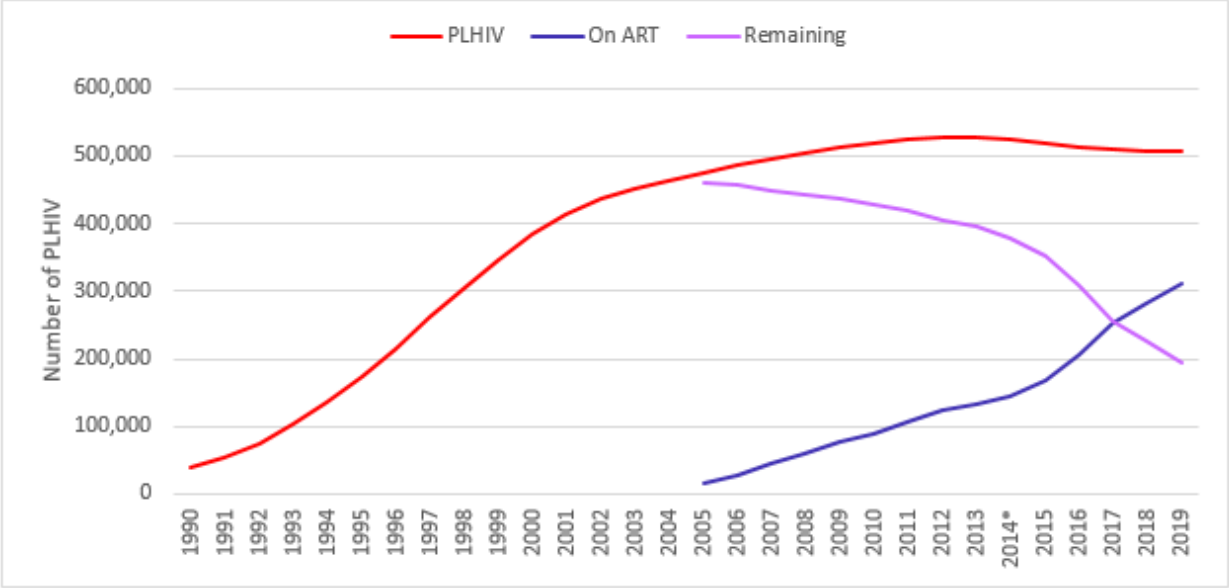


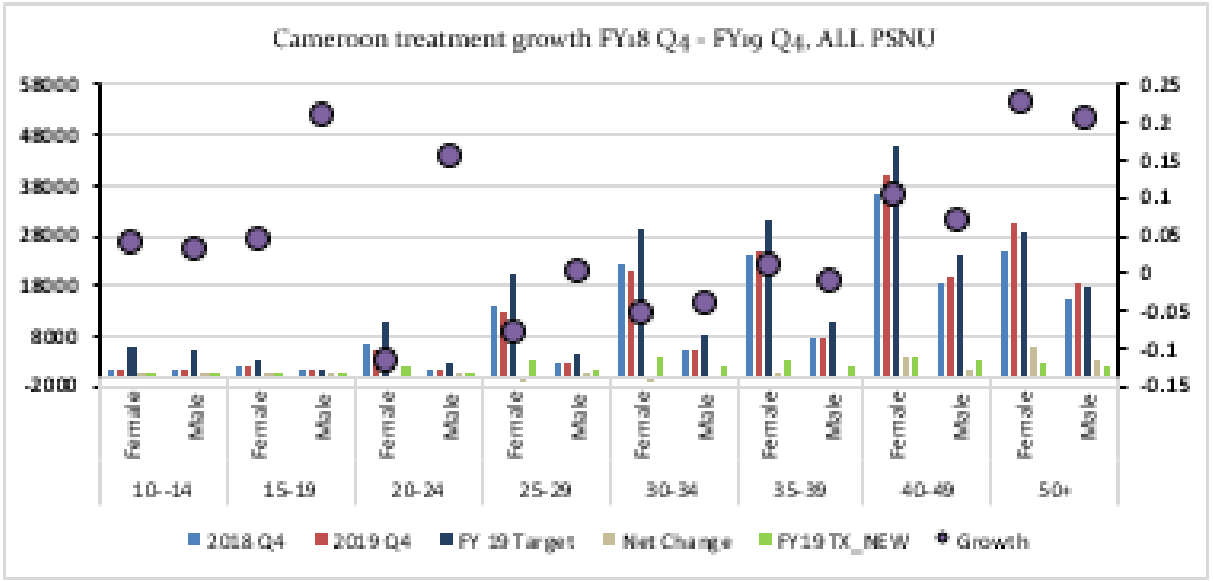
Figure 2.1.7 Epidemiologic Trends and Program Response



* Before 2014, only the total number of newly identified positive was reported by the MOH

Figure 2.1.8 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population.

Figure 2.1.8 Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4



2.2 New Activities and Areas of Focus for COP20, Including Focus on Client Retention

In COP 20, at least 90% of Adolescents and Children Living with HIV (A/CLHIV) followed in health facilities will benefit from the PEPFAR OVC-supported program to improve their retention to care and viral load suppression. As the OVC program is unable to cover all PEPFAR supported clinical sites within the available resource envelope, priority has been given to the highest burden health districts in all ten regions. These OVC-supported SNU's encompass patients on treatment at the highest burden PEPFAR supported clinical sites as well as those receiving treatment in smaller, non-PEPFAR sites co-located in the same health district. Community and clinical partners will continue monthly coordination meetings and joint site visits in order to strengthen the collaboration platform that began in the last quarter of FY19.

2.3 Investment Profile

The 2018 – 2019 National AIDS Spending Assessment (NASA) has not been finalized and approved by the Government of Cameroon as of the development of COP20. This investment profile will focus on the last approved national and external expenditure data for 2016 – 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 fluctuated 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 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.

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.

Table 2.3.1: Annual Investment Profile by Program Area[1]

Table 2.3.1 Annual Investment Profile by Program Area[2]					
Program Area	**Total Expenditure**	**% PEPFAR**	**% GF**	**% Host Country**	**% Other**
Clinical care, treatment and support					
Community-based care, treatment, and support					
HIV Testing Services (HTS)		32.5%	44.0%	19.6%	2.9%
Laboratory	**$69,364,341**				
OVC	**$922,034**	99.6%	0.0%	0.0%	0.4%
Prevention	**$23,279,327**	27.4%	56%	2%	8%
Strategic Information (SI), Surveys and Surveillance	**$15,149,082**	34.5%	60.9%	0.3%	0.2%
Health Systems Strengthening (HSS), clinical research and human rights	**$652,449**	0.0%	23.5%	7.7%	0.0%
Total	**$109,367,233**	**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 2.3.2: Annual Procurement Profile for Key Commodities

Table 2.3.2 Annual Procurement Profile for Key Commodities in USD 2017					
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 2.3.3: Annual USG Non-PEPFAR Funded Investments and Integration

Table 2.3.3 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**
CDC and USAID (President's Malaria Initiative)	$22,500,000	$2,600,000*	1	$750,000	Non-PEPFAR resources support the following supply chain TA activities (IM 18195): (1) support to manage distribution of ($7.5 million worth) commodities in two regions from the port of entry to the regional warehouses; (2) strengthening of the supply chain management system with a focus on improving warehousing as well as logistics data availability, accuracy, and use centrally and in the North and Far North regions; (3) implement a semi-annual EUV survey at the national level to monitor the availability of key malaria control commodities at health facilities and regional warehouses on a national scale.
USAID (Global Health Security Agenda)	TBD	$0	-	$0	Implementation of GHSA Phase 1 roadmap ended in September 2019. Cameroon is partner country for phase II (GHSA 2024) but has not yet received FY20 appropriation.
Peace Corps	$34,783	$0	$0	$0	Training of Peace Corps volunteers and provision of smalls grants for promotion of malaria prevention and care seeking.
CDC (Global Health Security)	$1,500,000	$0	0	$593,698	Funding for GHSA Program Director (USDH position)
Total	**$24,034,783**	**$2,600,000**		**$1,343,698**	

2.4 National Sustainability Profile Update

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. According to the latest National AIDS Spending Assessment (NASA) in 2017, the analysis of the expenditures for 2016 and 2017 represent 40% and 53.6%, respectively, of the national HIV needs. The national HIV/AIDS response continues to rely heavily on donor funding and the GRC has difficulty in meeting Global Fund co-financing obligations. Like many West and Central African countries, Cameroon also faced the challenge of historically charging user fees to finance health services including HIV and TB services, creating a

barrier for people to access HIV services. 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 supported the government to raise awareness about elimination of fees for HIV services, put in place measures to eliminate HIV user fees at the point of service delivery and also support the government in the monitoring of health facilities on compliance with the new directive. As of January 1, 2020, the HIV user fee elimination went into effect and roll out across health facilities in country has been impressive.

SID Process: PEPFAR Cameroon began the SID 2019 process by undertaking a desk review of all required documentation with follow up consultations of the various constituencies. PEPFAR staff met with internal and external stakeholders to facilitate the SID 2019 tool development; input was gathered from civil society representatives, private sector entities, parliamentarians, multi-lateral partners, USG and the GRC. A final review session was cohosted by the USG and UNAIDS with stakeholders on September 4th and 5th, 2019, with participants providing consensus on the final review, further discussing the findings and identified priorities and providing any additional input.

Sustainability Strengths: Out of the 17 elements counted, Cameroon counted four dark green and four light green scores, an increase in both scores from the SID 3.0. The strongest elements were found in the Governance, Leadership and Accountability Domain.

> **Planning and coordination (10.00 – dark green):** The Government of Cameroon performs a strong leadership role in the process of development and policy guidelines. This leadership has resulted in the adoption of best practices and global technical policies. The processes are inclusive and well-structured in terms of shared responsibility and accountability, accounting for the diversity and comparative advantage of key stakeholders in the country. It was noted that more focus should be given to further engaging the private sector in the national response.
>
> **Market Openness (9.67 – dark green):** This was a new element introduced in the SID 2019. Cameroon scored quite high in this area, showing that Cameroon and donor policies do not negatively distort the market for HIV services by reducing participation and/or competition.

Sustainability Vulnerabilities: Cameroon did not achieve any red scores in SID 2019. However, within the nine elements that scored yellow, four were in the National Health System and Service Delivery domains, down from five in the SID 3.0.

Commodity Security and Supply Chain (5.57 - 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, 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. In 2018, a 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 was created to develop a complete transformation plan of the supply chain.

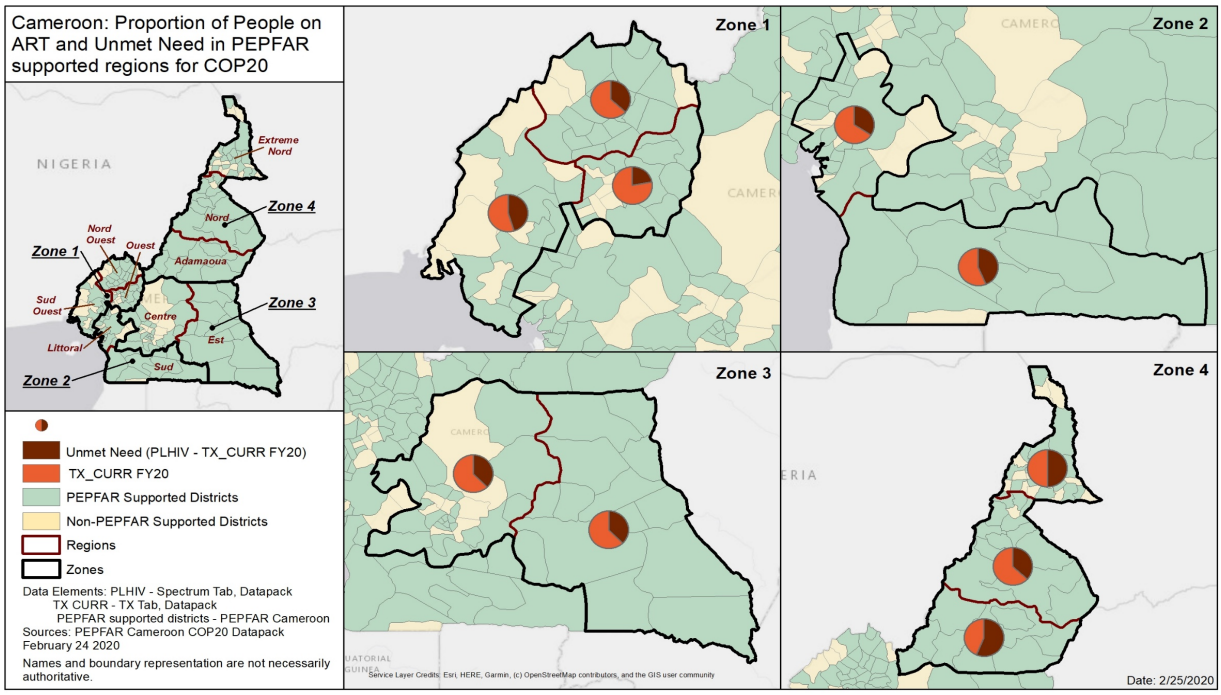
Laboratory (6.29 - yellow): Cameroon has developed an NSP for the Development of Cameroon Laboratories 2016-2020. Additionally, a National Public Health Laboratory was built, and Cameroon now has four ISO-15189 accredited laboratories (National EID Reference Laboratory Mutengene, Buea Regional Hospital Laboratory, Bamenda Regional Hospital Laboratory and the TB Reference Laboratory Bamenda). A Laboratory Technical Working Group (LTWG) was created in 2018 to improve coordination across the different laboratories; in view of avoiding activity overlap and optimizing the resources of concerned stakeholders.

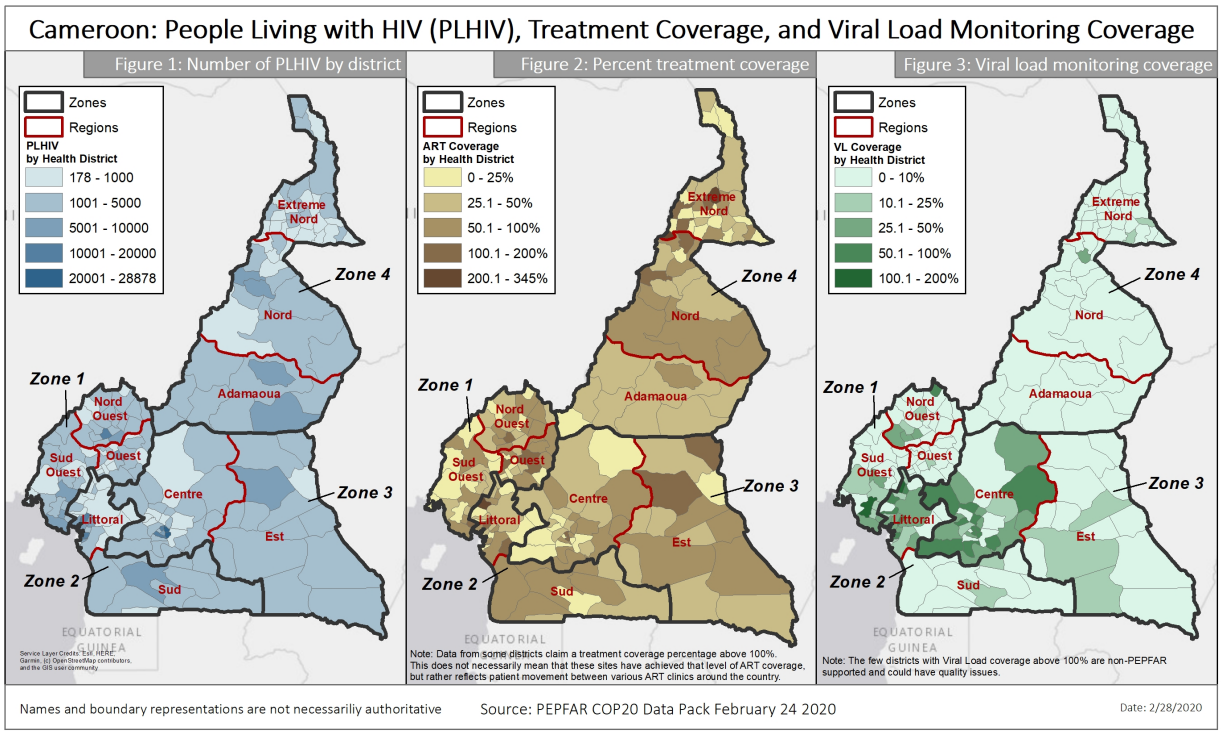
2.5 Alignment of PEPFAR investments geographically to disease burden

The map and inserts presented in figure 2.5.1 show areas where PEPFAR will provide support in FY2021, with focus on 144 health districts across all 10 regions of Cameroon. All PEPFAR supported health districts have been distributed into 4 zones. Zone 1 is targeting the West, South West and North West regions; Zone 2 the Littoral and South regions; Zone 3 the 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.

Since FY20, all support provided by PEPFAR to selected sites is 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. All interventions are focused on rapid acceleration towards epidemic control in 298 scale-up health facilities and 21 military sites.

Figure 2.5.1; Total PLHIV, Coverage of total PLHIV with ART, and viral load coverage in PEPFAR supported regions.





2.6 Stakeholder Engagement

PEPFAR Cameroon has been building and maintaining strong coordination and collaboration with all key stakeholders including the GRC, Civil Society Organizations (CSO) core groups, and other key stakeholders. All key stakeholders are involved in strategic discussions from the pre-COP process through COP planning and approval. They also provide resources where needed and guidance to support implementation and accelerating the response towards HIV epidemic control in Cameroon. PEPFAR has been following up on the elimination of all formal and informal HIV user fees in line with the Ministerial decision that was signed and released on April 4th, 2019 instituting HIV user fees elimination beginning on January 1st, 2020. This decision is the result of strong advocacy by PEPFAR at the highest level of government during COP19. A PEPFAR supported meeting led by MOH-NACC was held in March 2019, in Douala to evaluate the unit cost of each HIV services to have an estimated budget and plan for reimbursement at the level of the health facilities to ensure the smooth implementation of the HIV user fee elimination policy. PEPFAR and other stakeholders will continue to support the GRC in meeting milestones and ensuring implementation and adequate controls. Throughout 2019, PEPFAR and the US Embassy Front Office engaged in extensive advocacy to ensure that sufficient funding was allocated in the 2020 national budget to cover health facility reimbursements. During the RPM 2020 in Johannesburg, South Africa, the permanent Secretary of MOH-National AIDS Control Committee presented the GRC's engagement and planned approach to the HIV user fees process.

PEPFAR has played a key role in the update of the national ART treatment guidelines including the TLD transition process with consideration for women of childbearing age and adolescents, and removal of nevirapine-based regimens. As per the updated national ART guidelines, women of childbearing Age will be offered TLD after informed consent. PEPFAR will also ensure printing and distribution of the updated national ART treatment guidelines, at the health facilities. A training of trainers on ART Optimization and TLD roll out was conducted in August 2019 in Douala and this training has been cascaded down to all 10 regions.

Collaborating with key stakeholders including CSOs is crucial to help reinforce the implementation of the user fee elimination policy as well as create demand and improve uptake of HIV services across all age bands, sex and populations, support adherence and retention efforts and strengthen referrals and linkages to rapid ART initiation, viral load monitoring. While PEPFAR support is guided by the 2018-2022 Cameroon National Strategic Plan and the revised ART Treatment guidelines, PEPFAR gives importance to the different perspectives on what will be considered credible evidence of outcomes and impact from all key stakeholders. In that light, PEPFAR began the COP 20 planning process with a retreat in Douala Jan 27th to Jan 31st, 2020 with representatives from the MoH-NACC-NTCP, CSOs, multilateral organizations (UNAIDS, WHO, GIZ, UNFPA, UNICEF, Islamic Development Bank), CAMNAFAW, the CCM and PEPFAR implementing partners; who were convened to provide sound recommendations for COP20.

Prior to the retreat, PEPFAR shared the COP18 (FY19) Annual Performance Report (APR) with the stakeholders to ensure the formulation of informed and meaningful recommendations for COP 20.

During the COP20 retreat in Douala there were presentations from the GRC-NACC-NTCP-DPML, Civil Society Organizations (CSO) groups, CAMNAFAW, PEPFAR agencies and other key stakeholders for a better understanding, to avoid duplication and strengthen collaborative efforts towards reaching epidemic control by September 2021. Representatives of GRC, CSO core groups, and other key stakeholders were also present at the Regional Program Meeting Feb 17th -21st in Johannesburg, South Africa.

PEPFAR Cameroon has strong collaboration and coordination with the GFATM to avoid duplication, address procurement and commodities challenges, and ensure that key and priority populations have improved access to quality patient-centered HIV prevention, care, and treatment services. A mapping of GFATM and PEPFAR investments in AGYW (a new focus for the GFATM) has been done to avoid any duplication of effort.

PEPFAR Cameroon sits on the Health Sector Partners group which brings together all major 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

For COP20, PEPFAR Cameroon will continue its geographic prioritization of four zones started in COP19. Following the COP19 programmatic pivot to scale-up in the four zones covering the 10 regions and 298 clinical sites and 21 Military sites in Cameroon, PEPFAR Cameroon conducted an analysis of ART Gap by zone, region, age and sex and the data shows that all the zones are not at the same level in terms of ART coverage and unmet needs.

The ART gap is very low (Less than 60% ART coverage) for children, adolescents and young boys and girls and males in general across all regions except for the West. So, our case finding, linkage and retention strategies on these sub-populations will be scaled up and intensified and will be the same for all the zones and regions except the West region in zone 1.

In the West region (Zone 1) where the ART coverage is the highest (78%) and unmet need the lowest, case finding strategy will prioritize Index testing, focusing on newly initiated on ART and Old patients on ART who are virally unsuppressed and Key Population as index; we will also be focusing on improving retention to make sure we don't lose patient who are in care. For the North West and the South West regions that have been greatly affected by the crisis, systems will be adapted to respond to the increasing number of IDPs. Multidisciplinary teams will be put in place to reach out with HIV prevention, care and treatment services to locations were IDPs are found. For the Southwest region, we shall also be focusing on reaching out to AGYW especially to improve on the ANC attendance.

Zone 2 (Littoral and South) and Zone 3 (Center and East) have similar ART coverages (64% in zone 2 and 62% in zone 3) and both zones represents 53% of the total unmet need. While Littoral and Center regions that have been receiving PEPFAR support would be focusing on intensifying the different strategies for different sub-populations in terms of case finding, linkage and retention, the East and South regions that are just starting to receive PEPFAR support would be scaling up these strategies.

Zone 4 (North, Far North and Adamawa) has the lowest ART coverage (52%) and represents 23% of the total ART gap. This situation is similar in all three regions and across age and sex. This zone has a peculiarity that health seeking behaviors is not pronounced. Here, focus will first be on sensitization on the importance of getting to health facilities to seek for health care in addition to providing a full package of differentiated services for different sub-populations (children, adolescents, young men, young women and men and adults) across the entire cascade.

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

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP20**	**# Current on ART (FY19)**	**# of SNU COP19 (FY20)**	**# of SNU COP20 (FY21)**
Attained	-	-	-	-
Scale-up Saturation	465,733/92%	306,705	144	144
Scale-up Aggressive	-	-	-	-
Sustained	-	-	-	-
Central Support	38,548/8%	5,321	45	46

Table 3.2: ART coverage and unmet need by region (Spectrum 2020 estimates)

Regions	**Estimated PLHIV**		**Current on ART**		**ART Coverage**		**ART Gap**	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Adamawa	19,891	9,891	9,542	4,440	48%	45%	10,349	5,451
Centre	86,785	45,860	54,533	23,073	63%	50%	32,252	22,787
East	21,451	11,310	14,855	6,717	69%	59%	6,596	4,593
Far North	23,232	12,022	12,504	6,512	54%	54%	10,728	5,510
Littoral	56,870	29,882	41,170	17,004	72%	57%	15,700	12,878
North	19,027	9,656	13,127	5,791	69%	60%	5,900	3,865
North West	37,880	17,493	25,585	10,262	68%	59%	12,295	7,231
South	16,856	9,388	11,180	4,658	66%	50%	5,676	4,730
South West	30,814	16,161	19,300	7,776	63%	48%	11,514	8,385
West	20,605	9,207	17,284	6,901	84%	75%	3,321	2,306
Grand Total	333,411	170,870	219,080	93,134	66%	55%	114,331	77,736

Table 3.3: ART Coverage and unmet need by Zone (Spectrum 2020 estimates)

Zones	Estimated PLHIV		Current on ART		ART Coverage		ART Gap	
	Female	Male	Female	Male	Female	Male	Female	Male
Zone 1	89,299	42,861	62,169	24,939	70%	58%	27,130	17,922
Zone 2	73,726	39,270	52,350	21,662	71%	55%	21,376	17,608
Zone 3	108,236	57,170	69,388	29,790	64%	52%	38,848	27,380
Zone 4	62,150	31,569	35,173	16,743	57%	53%	26,977	14,826
Grand Total	**333,411**	**170,870**	**219,080**	**93,134**	**66%**	**55%**	**114,331**	**77,736**

Key and Priority Populations

PEPFAR Cameroon will continue to focus on current priority and key populations, with an increased focus on reaching men including clients and regular non-buyer partners of FSW through the "Sex, Test and Treat" strategy using prevention education, self-test kits, and referrals to testing where available. Overall, in the absence of reliable population size estimates, PEPFAR Cameroon's program data shows consistent upward trends in the number of KP reached. PEPFAR will collaborate with other partners for an integrated bio-behavioral surveillance (IBBS) to be conducted for the KP and the Priority Population.

PEPFAR Cameroon will continue to prioritize KP, including FSW and MSM in six cities (Yaoundé, Douala, Bamenda, Bertoua, Bafoussam, and Ngaoundere), with an expansion in COP20 to one new city (Kribi). In addition, the program will continue emphasizing outreach to injection drug users and transgender women that began in COP18, although the numbers are expected to remain small.

The geographic focus targets the seven 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. Prioritization criteria also included the presence of Kribi (a beach resort and sea port) and major sex work hotspots along key transport corridors, as well as the presence of refugees, Internally 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 (CAMNAFAW), the GFATM KP community Principal Recipient, helped determine and address existing geographic and programmatic gaps.

Throughout COP18, despite a stock out of RTKs, average yields of approximately 14% were recorded for FSW and MSM, due to improved risk screening and scale up of index testing; this trend continued into COP19. 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, it is expected that yields will slightly increase in FY21 through improved focus on differentiated index testing, social network-based testing and targeted testing of older KP.

Orphans and Vulnerable Children

Regarding OVC, the PEPFAR program will expand from 31 to 40 health districts in 10 regions to align with the clinical program and achieve directives laid out in the PLL. Geographic prioritization is based on the residential location of beneficiaries with a focus on health districts thereby enabling the program to cover all A/CLHIV and their families residing in a target health district irrespective of location of ART site. 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 A/CLHIV and treatment literacy for them and their caregivers. Primary target beneficiaries include A/CLHIV and their families, children of PLHIV, HIV-positive pregnant and breastfeeding women (PBFW) and HIV-exposed infants (HEI), adolescent boys and girls.

PEPFAR Cameroon will leverage the OVC and Peace Corps platforms to provide a comprehensive primary prevention package to OVCs 9-14 years. Additional prevention interventions for children and adolescents between the age of 9 and 17 years will focus on risk avoidance, risk reduction, and gender-based violence (GBV) prevention and response. Illustrative activities include school scholarships, vocational training, SRH education and referrals to other high impact services, household economic strengthening, etc. Peace Corps has scaled up volunteers' placement and community engagement across six (South, Adamawa, West, East, Littoral and Center) of the ten regions. This will continue in COP 20 with priority given to PEPFAR Supported ART facilities and CSOs. In these facilities, their role will be focused on providing treatment literacy and adherence education and primary prevention services to ALHIV where possible. In the community they'll provide 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 primary prevention interventions through DSD. Sexual and GBV prevention will be systematically integrated into interventions. Similarly, Peace Corps Volunteers will expand their DREAMS[2]-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 in and out-of-school AGYW.

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

4.1 Finding the missing and getting them on treatment

CAMPHIA showed the HIV prevalence for populations ages 0-14, 15-49, 15-64 are 0.2%, 3.4% and 3.7%, respectively. Among adults age 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 were aware of their HIV status, 93% of whom are on treatment and 80% of whom were 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.

In order to reach epidemic control by FY21, PEPFAR Cameroon has expanded the clinical and military programs to cover 319 high volume sites to achieve 91% ART coverage across the 10 regions.

Spectrum 2020 estimates also identify population gaps by age group and sex, which need to be addressed in order to achieve HIV epidemic control. Table 4.1.3 shows major gaps in reaching all subpopulations, especially children, AGYW, and men. Strategies to address these gaps are detailed in following paragraphs.

Table 4.1.1: Who Are We Missing – By Age and Gender (*Spectrum 2020 estimates*)

Age groups	Estimated PLHIV		Current on ART		ART Coverage		ART Gap	
	Female	Male	Female	Male	Female	Male	Female	Male
<01	619	659	183	174	30%	26%	436	485
01-04	2,669	2,804	1,184	1,101	44%	39%	1,485	1,703
05-09	4,485	4,672	1,903	1,832	42%	39%	2,582	2,840
10-14	5,923	6,097	2,151	1,877	36%	31%	3,772	4,220
15-19	11,433	6,263	4,232	1,720	37%	27%	7,201	4,543
20-24	23,225	8,503	13,119	2,908	56%	34%	10,106	5,595
25-29	36,061	14,037	30,721	11,585	85%	83%	5,340	2,452
30-34	48,047	21,279	30,721	11,585	64%	54%	17,326	9,694
35-39	56,052	26,432	30,721	11,585	55%	44%	25,331	14,847
40-44	50,672	26,524	30,721	11,585	61%	44%	19,951	14,939
45-49	35,793	21,833	30,721	11,585	86%	53%	5,072	10,248
50+	58,432	31,767	42,705	25,598	73%	81%	15,727	6,169
Grand Total	**333,411**	**170,870**	**219,080**	**93,134**	**66%**	**55%**	**114,331**	**77,736**

In COP18 (FY19), PEPFAR Cameroon provided HTS to 983,398 clients, compared to a target of 1,262,128 clients, with an HIV positive yield of 3.4%. There were 33,554 HIV positive clients identified of the target of 64,803. 63.7% of the newly diagnosed PLHIV were females and 36.3% were males. Age disaggregation showed that 6.4% of PLHIV were below 19 years of age, 9.8% in the 20-24 age group, 70.9% were within the 25-49 age group and 13.0% were in the >50 age group.

Outstanding gaps

The data for FY19 indicate achievement of 77.8% of testing targets and 51.8% of case finding targets. Achievement is still suboptimal especially among children, adolescent girls and 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.

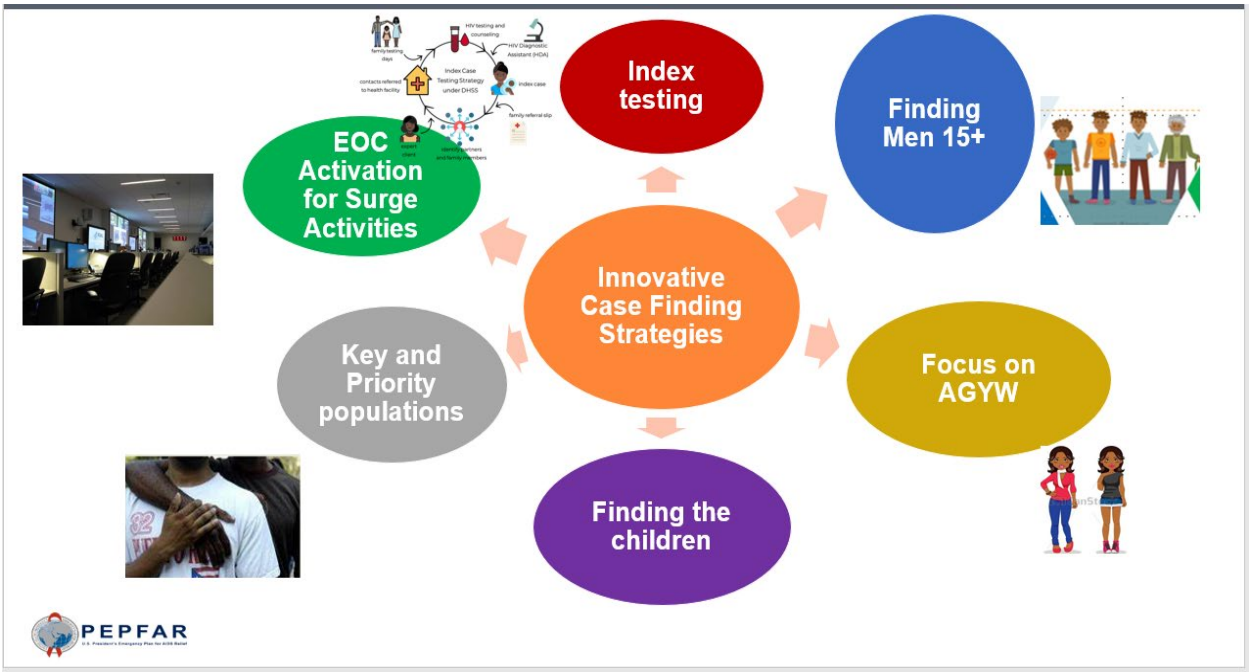
Strategies to improve HIV case finding

Based on analysis of PEPFAR's FY19 performance described above, PEPFAR Cameroon will continue to scale up case finding strategies along with innovative strategies. PEPFAR Cameroon will continue to prioritize HTS for the following populations which showed remarkable gaps in case finding; 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. Using the calculation of the number of adults or infants needed to test to identify one positive, the keys entry points the program will focus on will be Index Case Testing (facility and community), Voluntary Counseling and Testing and TB clinics. 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 and VCT including mobile testing for clients of FSWs including long distance truck drivers. Index testing will target sexual partners of adult index cases, parents of pediatric index cases and also children exposed to HIV in facilities and in the community. 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 at 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 eliciting sexual contacts, biological children and parents of index cases for testing. PEPFAR will ensure the availability of various models of partner notification such as client, provider, contract, and dual notifications and will screen all named partners for intimate partner violence (IPV) and refer for services. Different client-centered models of index testing will be provided such as self-testing, facility based or community testing. 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. On February 19 2020, the Minister of Health of the Government of Cameroon signed a circular note giving directives on the correct use of the HIV screening tool in all facilities to ensure effective implementation and scale up of targeted testing. Self-testing will continue in FY21 to reach partners of KPs who refuse other testing modalities or are unwilling to come to the health facilities, drop-in centers (DICs) or KP community events. In addition, the program will implement "targeted testing in index case testing" and also pairing index testers with nurses and doctors to improve partner elicitation and testing.

To improve other PITC yield among those reached by the program, PEPFAR Cameroon will close down non-productive entry points such as ENT consults and radiology, train and mentor providers on the use of the screening tool, especially in the new clinical sites, document testing coverage at high yield entry points, monitor the adoption of the screening tool as a prerequisite for reimbursement of user fees for HTS, incorporate the screening tool into the testing register, with printing and disseminating to all sites and continuous mentorship of health facility staff on using targeted testing register.

To improve the quality of testing, mentorship and site supervision will be intensified at all sites. The laboratory and clinic interface will be strengthened by reinforced collaboration between the lab partner (GHSS) and the clinical partners to ensure quality HIV testing. For all target populations and geographical areas, PEPFAR Cameroon will continue to use site level data by age and sex and continue tracking performance at the site level by modality to identify high, medium, and low performing sites. Weekly data collection and reporting of program indicators and test kits 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.

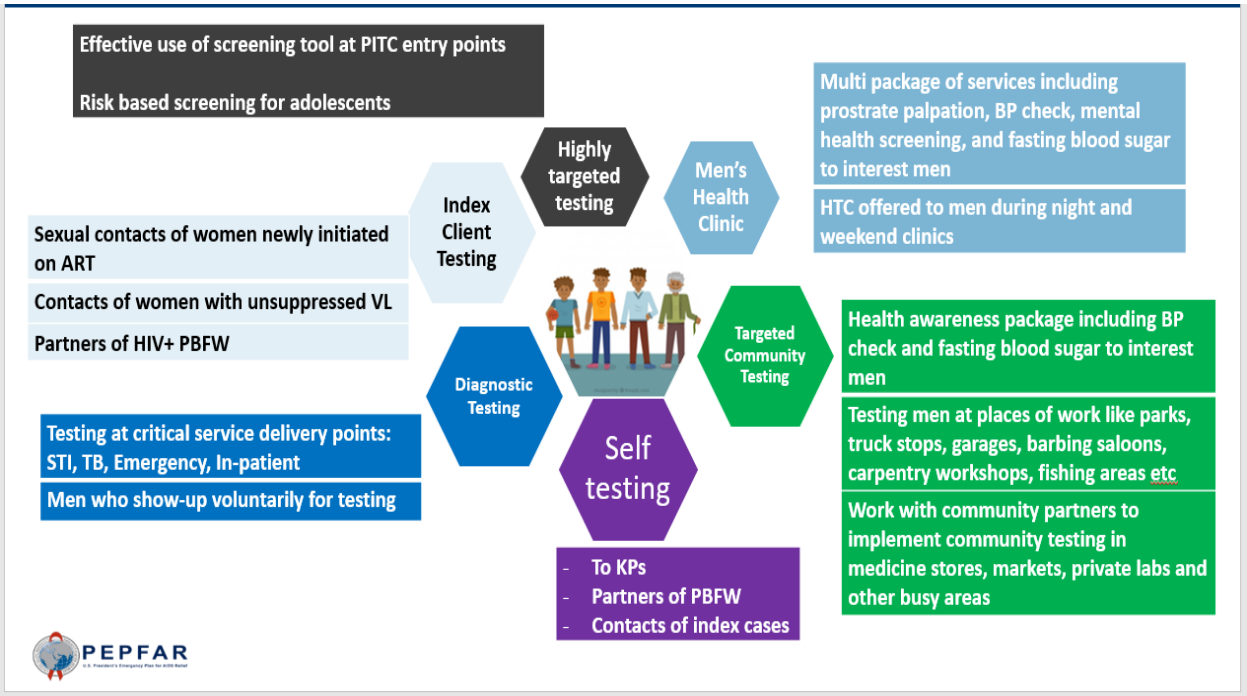
Figure 4.1.1: Innovative solutions for Case Finding in COP20



Strategies to reach men

In COP20, 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 and 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 4.1.2: COP20 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, among internally displaced persons (IDP), support groups of ALHIV and PLHIV (parents) 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 adolescent young boys and men who are newly diagnosed with HIV or virally unsuppressed. Diagnostic testing will also be offered to adolescent boys 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.

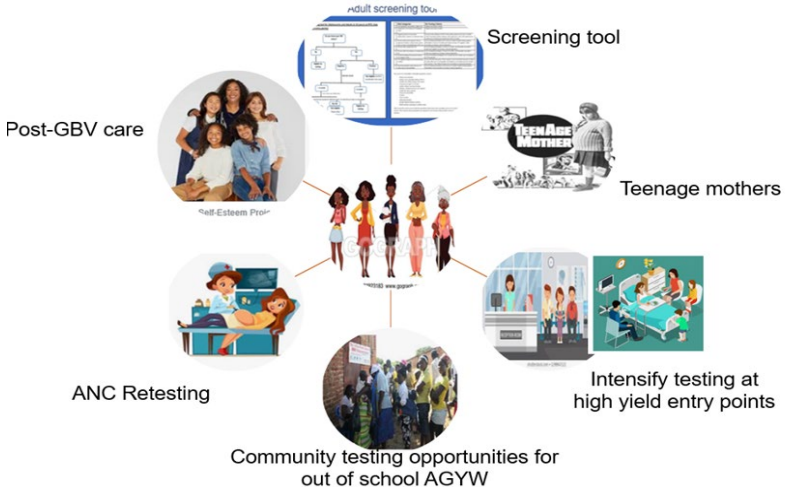
Men aged >25 years will be reached through a package of modalities including index testing for sexual contacts of women newly initiated on ART, contacts of women with unsuppressed VL, partners of HIV-positive PBFW and partners of KPs. Men who are biological parents of HIV-positive children, will also be reached through index testing in all clinical settings. Options for HIV self-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. HIV self-test kits will also be proposed to harder-to-reach men (KPs, partners of PBFW and index contacts) who will not be reached through traditional approaches either at facility or community levels. 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, barber saloons, carpentry workshops, fishing areas, KP chill-ins, officers' mess halls, training centers for non-commissioned officers) will be used as opportunities to offer testing. Other innovative approaches to find men will be through targeted community testing activities in collaboration with community partners to include testing in medicine stores, markets, private laboratories and other busy areas. PEPFAR Cameroon will continue reaching regular partners and non-transactional partners of FSW through a voucher referral system and self-testing. PEPFAR Cameroon will also make use of trained male expert clients to reach and link their peers to male-friendly HIV testing services.

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 pregnant and breastfeeding women (PBFW) at antenatal care (ANC) services and to PBFW during delivery in case they did not attend ANC in the course of their pregnancy. 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. 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.

Figure 4.1.3: Strategies for Achieving Epidemic Control among AGYW



PEPFAR Cameroon will offer index testing to AGYW who are sexual partners of HIV-positive men, AGYW who are biological children of index parents and AGYW who are teenage mothers of index children. 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 material, 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.

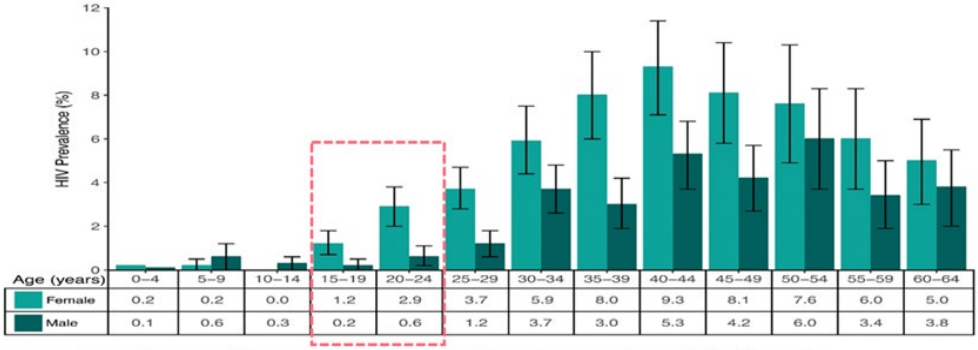
PEPFAR Cameroon will support minor repairs and rearrangement of counseling space to ensure privacy and confidentiality for clients. Monitoring and supervision will be intensified to ensure improved quality of services and linkage to treatment for clients.

AGYW face significant barriers in accessing health services or protecting their own health. Lack of access to comprehensive and accurate information on sexual and reproductive health means that adolescent girls and young women are not equipped to manage their sexual health or to reduce potential health risks. Furthermore, AGYW are less able to negotiate condom use, have limited

access to HIV testing, modern contraception and family planning and are less able to adhere to HIV treatment.

Low risk perception (about 45% awareness), early sexual debut, age-disparate partnerships drive sexual transmission hence the need to reach men. Violence against women in the context of HIV, low retention rates and low rates of viral load suppression among all HIV-positive AGYW are some of the key factors that have affected the HIV cascade among AGYW. Sustained efforts to prevent and to diagnose HIV infection in AGYW as early as possible and to ensure rapid initiation of ART should help achieve epidemic control. CAMPHIA 2018 data showed higher HIV prevalence rates among the 15-19 and 20-24 age groups compared to their male counterparts.

Figure 4.1.4 show AGYW are Vulnerable to HIV (CAMPHIA, 2018)



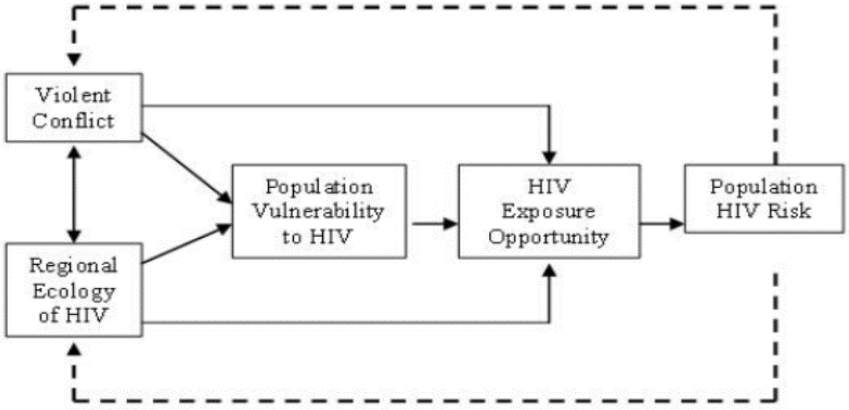
Age (years)	0–4	5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64
Female	0.2	0.2	0.0	1.2	2.9	3.7	5.9	8.0	9.3	8.1	7.6	6.0	5.0
Male	0.1	0.6	0.3	0.2	0.6	1.2	3.7	3.0	5.3	4.2	6.0	3.4	3.8

- **Females aged 15-19 years have HIV rates 6x that of their male counterparts**
- **Females aged 20-24 years have HIV rates nearly 5x that of their male counterparts**

PEPFAR FY19 GBV data showed 93% of all report victims of GBV were females among whom 48% were victims of sexual violence. In FY19, PEPFAR Cameroon PMTCT data showed that 38% of all pregnant women received and tested in PEPFAR supported health facilities were AGYW aged 10-24 years. This population constituted 20% of all the HIV positive pregnant women identified; in the 10-14 age band, all positives were newly initiated on ART showing recent infections in this age group. FY19 PEPFAR data also show low case finding results, low retention rates, low viral load uptake and low suppression rates among adolescents and young people.

The sociopolitical crisis in the North West and South West regions has resulted in the displacement of over 650,000 Cameroonians to other urban cities and neighboring countries among whom the majority are women and children. AGYW have been subjected to human rights abuses including sexual violence and are left in conditions that interrupt social networks and increase economic vulnerability; poverty has forced young people to use commercial sex to survive. This conflict and displacement have been associated with increased risk of HIV transmission as reported in the Bonnassama Health District where HIV yields of 10% among the displaced populations are seen.

Figure 4.1.5: Conceptual Framework of Principal Causes of HIV Risk in Conflict-Affected Populations



Strategies to reach AGYW and ABYW with HIV prevention and risk avoidance

At the facility level, PEPFAR Cameroon will target adolescents and young people living with HIV aged 10-24, IDPs, GBV survivors, teenage mothers, partners of AGYW, ABYM and AGYW seen through ICT. Prevention activities will focus around the principal areas of risk and vulnerability mapping, life skills building; sexual and reproductive health (SRH) education; contraception, condom education, promotion, risk reduction education and counselling, positive parenting, treatment literacy and adherence for Adolescents Living with HIV (ALHIV). PEPFAR Cameroon will also identify "AGYW and teenage mother champions" through peer education 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 in and out of school to include extended working hours and weekends.

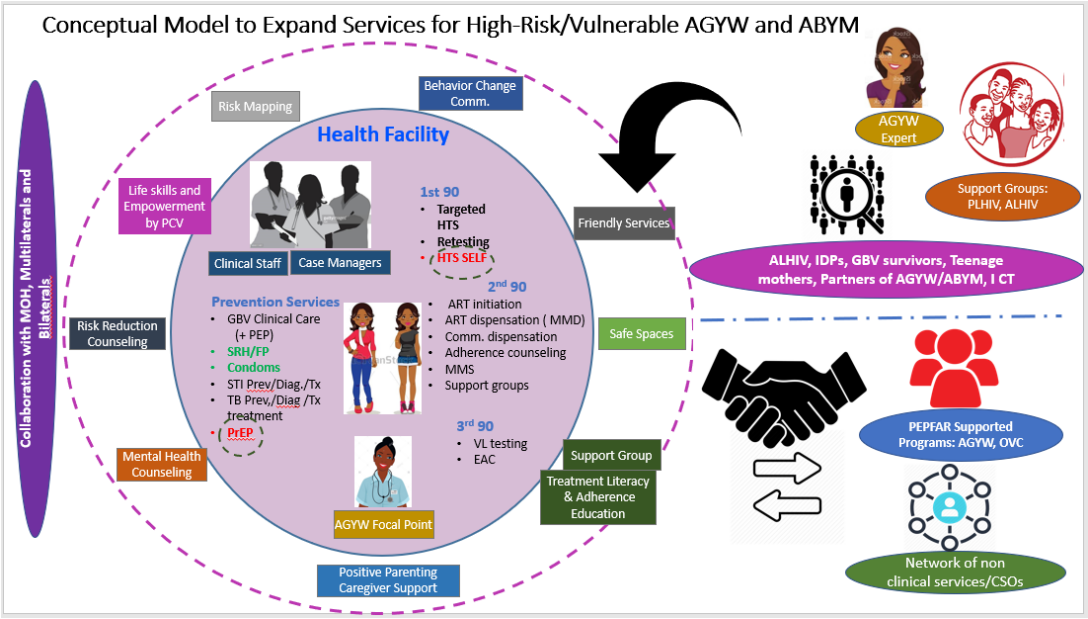
HIV self-test kits will be made available to at-risk hard-to-reach AGYW who might face geographical, security-related or socio-cultural barriers in accessing HIV testing services. Diagnostic testing will also be available for AGYW at all high yield entry points. Out-of-school AGYW will also be targeted and mobilized for HIV prevention, treatment and care through youth associations, among internally displaced persons (IDP), support groups of ALHIV and PLHIV (their adolescent daughters), and social and print media. Community testing opportunities will be made available for AGYW.

The post-GBV clinical care package including counseling and testing, PEP, diagnosis and management of STIs contraception and referral to other support services will be offered to AGYW who are survivors of violence.

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, positive living and how to address their specific health needs. Health facilities will designate safe space for provision of age-appropriate services to adolescents and young people. PEPFAR Cameroon will also

strengthen bi-directional referrals between health facilities and community AGYW and OVC service providers to ensure effective linkage to treatment and a comprehensive follow-up of HIV-positive children and adolescents in need. To improve linkage to care and treatment among AGYW and ABYM, expert clients (AGYW/ABYM focal point) in this sub-population will be identified, trained and recruited to ensure active linkage and retention of newly identified HIV positive peers to treatment and care.

Figure 4.1.6: Conceptual Model to expand services for high-risk AGYW and ABYM



Strategies to reach Key Populations

The PEPFAR KP program will continue to expand targeted community and facility based HTS to KPs. Community strategies such as peer-to-peer referrals, peer testing for triage using the rapid finger prick test, third party including medicine vendors in hotspots and referrals of harder-to-reach KPs reached online and through social media will continuously be used. HTS will be provided at the community – DICs, hotspots or KP meeting and sex work venues. PEPFAR Cameroon will principally use risk/social network mapping to provide testing to key populations including MSM and FSW as a differentiated testing approach. HTS will be mainstreamed during MSM community social events (chill-ins, grins).

PEPFAR Cameroon will strengthen health facilities to provide KP-friendly services (stigma free, nonjudgmental, and extended and weekend hours) to KPs who prefer to seek HTS at the health facility - walk-ins or initially referred from community activities. FSW will additionally be reached in the facilities during ANC and post-natal services for PBFW. HIV self-tests will be used as a tool to improve access to HTS among KPs that are harder-to-reach including MSM and FSW.

Index testing and social network-based HIV testing will be used to reach husbands and sexual partners of HIV-positive women, sexual partners of MSM, clients and regular non-transactional partners of FSWs. Index testing will be implemented in a manner that takes into account human right concerns and consistently assesses and addresses the risk of intimate partner violence (IPV). To that effect, amongst KPs, PEPFAR programs will routinely screen for IPV risk prior to offering index testing services and use a differentiated approach to testing that includes distribution of self-test kits or social network approaches such as organizing community events where partner can be tested without partner disclosure/notification. 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 and 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. In addition to screening for IPV risk, PEPFAR supported community and clinical sites will also ensure provision or referral to GBV services for victims or potential victims.

Prisoners will be reached with targeted testing services within the prisons. Systematic HTS services using the screening tool will be offered to incoming (new) prisoners. Incarcerated persons accessing the prison's health facility for other medical conditions, including presumptive TB cases will be offered risk-based HTS.

Strategies to reach Orphans and Vulnerable Children (OVC)

PEPFAR Cameroon will expand the pediatric package of services and support the GRC to complete the rollout of Test and Treat for pediatric cases.

The OVC program plays 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:

- A/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, as well community adolescent clubs for treatment literacy and support. The program will strengthen bidirectional referral between community-based organizations and health

facilities, including MOU for referral and counter referral with supported facilities, organizing case conferencing, and monthly coordination meetings. In addition, the program will leverage other donors and governmental institutions investments by referring beneficiaries to access services PEPFAR is unable to provide.

- 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 4.3 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), German Corporation for International Cooperation GmbH (GIZ) programs in the North and the World Bank's Social Safety Net program to improve the living conditions of OVC and their families.

4.1 Retaining clients on treatment and ensuring viral suppression

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 show disparities in treatment coverage, with only 24% of PLHIV aged 10-19, 30% of 20-24-year-old, 47% of 25-49-year-old, and 57% of PLHIV above 50 years estimated to be on treatment. PEPFAR FY19 data show that of the 33,554 patients who tested positive, 29,852 were initiated on ART, reflecting an overall linkage rate of 89%. Age and sex disaggregation of the data revealed that among the 29,852 patients linked to treatment, 66% were females and 54% were males. Linkage rates among all PLHIV identified were 101.1% for children <15 years and 88.5% for adolescents and adults above 15 years old. 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. In COP20, PEPFAR Cameroon, through the supply chain TA partner and clinical IP's, will provide technical assistance to MOPH in the implementation and scale up of the TLD Transition Plan nationwide, which began in January 2020.

Outstanding gaps

Programmatic results show a linkage rate around 90% in FY19. However, there are still gaps in linkage rates across some age groups, especially among adolescent males 15-19 years (64%) and young adults aged 20-29 (85%); there are 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 was the low linkage rate during index case testing strategies mainly for sexual partners of index cases and specially for same day ART initiation (SDAI). The linkage for pediatrics is also due to the small number of sites, which can provide pediatric HIV care, and treatment (21%) resultant to missed opportunities due to referral and the weak mother and infant cohort monitoring.

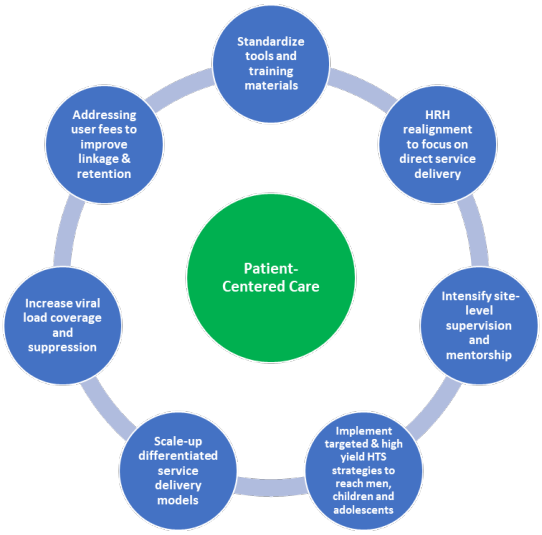
Strategies to improve linkage to care and treatment

PEPFAR Cameroon will continue to implement a patient-centered care approach across the 10 regions. This includes the human resource realignment to focus on direct service delivery; standardized tools and training materials, implementing targeted and high yield testing strategies to reach men, children and adolescents; addressing user fees to improve linkage and retention; increasing VL coverage and suppression; scaling up differentiated service delivery models through continuous quality improvement activities and intensified site level mentorship and supervision.

In COP 20, PEPFAR Cameroon will reinforce the linkage rate among positive patients identified during ICT strategies, PMTCT/HEI cohort monitoring and pediatric care by using expert clients, by accelerating decentralization of pediatric HIV care and treatment and by rolling out cohort monitoring for positives mothers and HIV exposed infants.

PEPFAR Cameroon is supporting the 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 ensuring the availability of commodities at site level. To ensure full transition to TLD for all eligible clients, a training of trainers was conducted and cascaded to all ten regions. This transition started in all regions for newly initiated patients and patients on NVP-based regimens and will progressively include all patients with a focus on women of childbearing age who choose to be on this regimen and children >20 kg for DTG regimen >30 kg for TLD regimen.

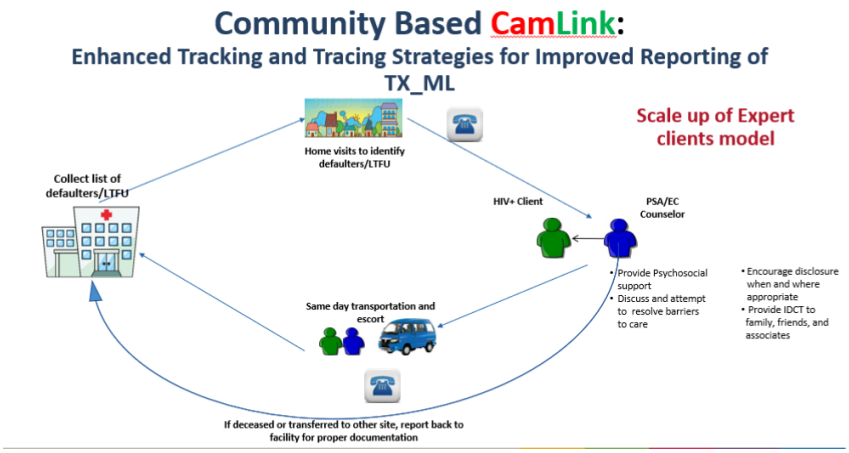
Figure 4.2.1. Patient Center Care Approach



PEPFAR Cameroon will scale up active linkage of patients through the use of peer navigator programs based on an existing linkage agent model with highly experienced expert client counselors and case managers to enhance linkage and retention. 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. The active tracking of defaulters and LTFU patients through the national patient tracking tool will be scale up in all the 10 regions. The expansion in all 298 clinical sites and 21 military-supported sites of extended hours/weekend hours for ARVs refill, the differentiated service delivery model options (same day ART initiation, community ART dispensation and multi-month dispensation for 6 months) and the advanced disease management for adults and pediatrics.

This facility-based linkage 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 the GRC'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. In COP20, PEPFAR Cameroon will provide support to expand the community-based linkage model in association with civil society organizations (CSO) in all ten regions. This will entail a strong collaboration between the facility and the community with the use of referral and counter referral of patients from the facility to the community and vice versa. The expert client/counselors will work closely with the community relay agent to undertake home visits and actively escort patients to the facility when needed.

Figure 4.2.2: Community based linkage 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

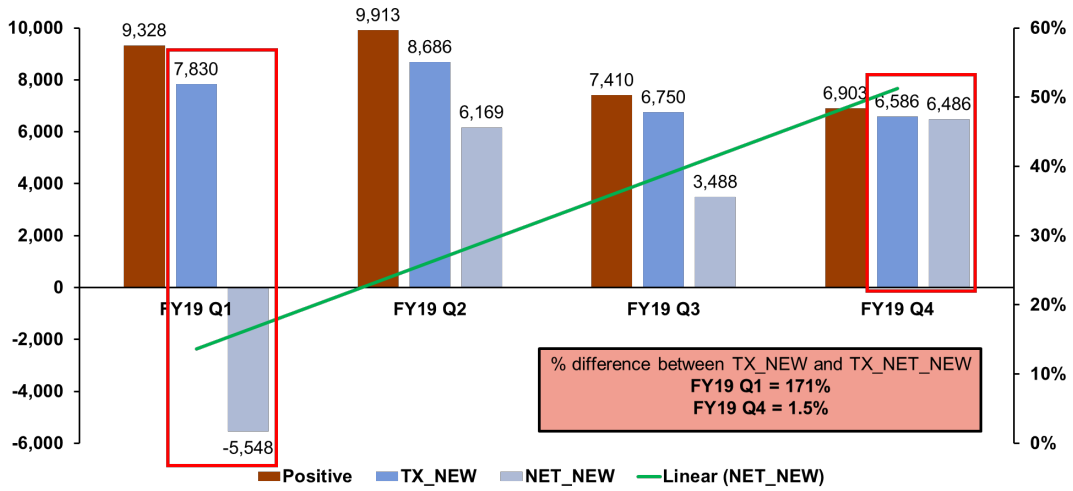
package will include identification, monitoring, preventing stigma and discrimination, patient rights, diversity and service quality. While KP linkage rates have improved considerably in FY18, peer navigators will continue to connect newly identified HIV-positive KP clients to facility linkage and retention case managers through the handshake model. Extended and weekend hours to meet KPs' needs will be brought to scale across PEPFAR supported health facilities, especially facilities that are closer to hotpots and KP meeting venues. There will be an on-call physician at the facility level to facilitate linkage to treatment of newly tested positive KPs. Training of healthcare providers and setting up KP-friendly services will be intensified in the supported sites, and community-focused strategies for KPs will be established in concert with existing CSO's.

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.

Ensuring Retention and Viral Load suppression

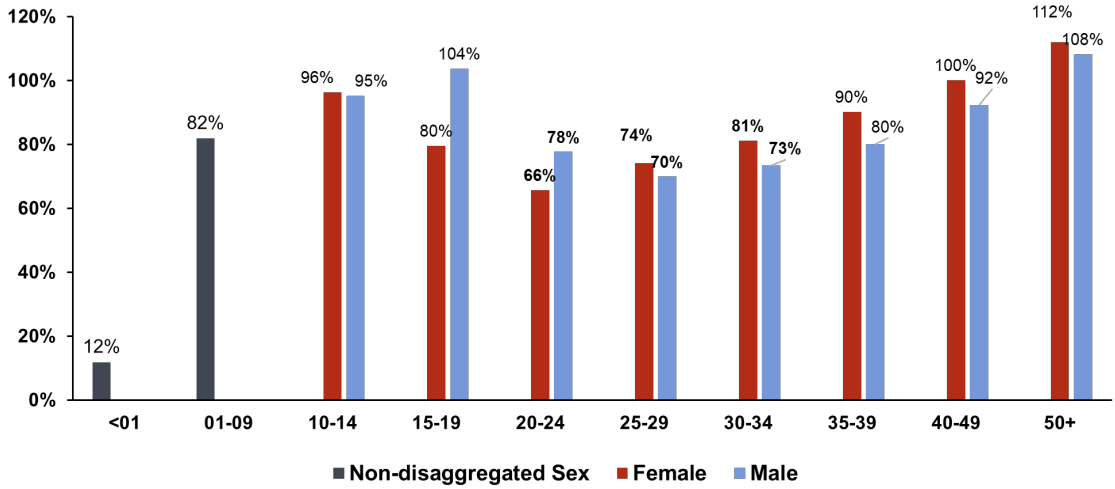
PEPFAR Cameroon FY19 results on PLHIV identification, treatment and retention over a 12-month period, shows an increase trend of TX_NET_NEW quarter by quarter since FY19Q2 with a percentage difference between TX_NEW and TX_NET_NEW of 1.5% at end of FY19 Q4. This result is based on the lessons learned from the return to care (RTC) campaign held after FY19Q1 to rapidly track and bring back to care all patients who were unaccounted for their ART in the DSD PEPFAR supported sites in FY19. PEPFAR Cameroon will continue to implement the patient tracking activities such as health care providers training, mentoring, tools and SOPs in all the ten regions.

Figure 4.2.3: Patients Gain and loss throughout FY19 (OU)



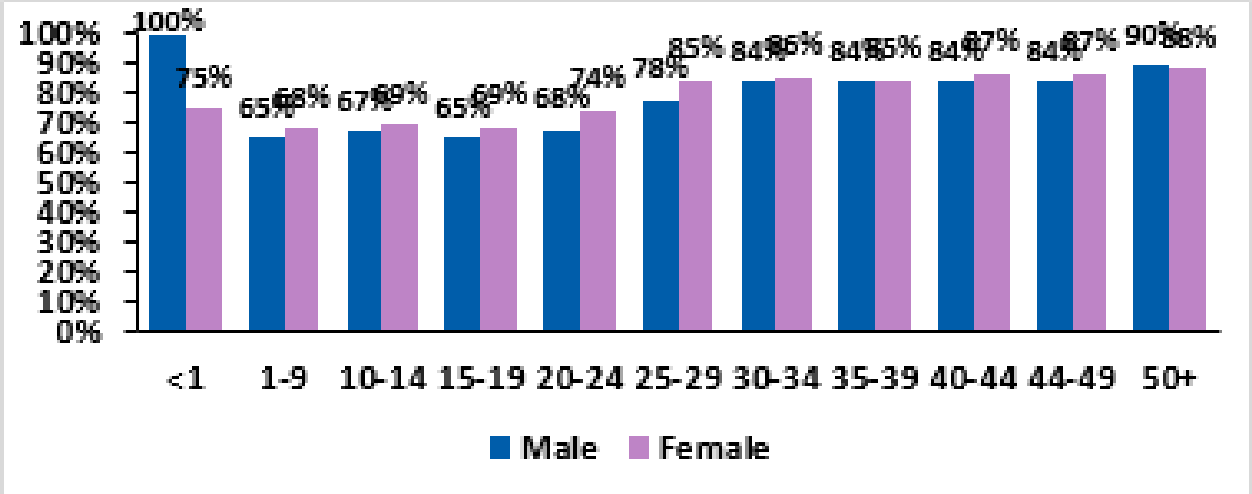
The retention rate is well-below the 90% global target across some specific age and sex. Although we have seen significant improvements in retention and decreased LTFU rates we have challenges with retention among some key age and sex categories. As seen below, males and females among the age categories 20-34 represent the age-sex category where there is need to intensify efforts to improve on retention.

Figure 4.2.4: FY19 Retention by age and sex



PEPFAR Cameroon FY19 VL coverage was approximately 49% of 183,324 PLHIV on ART. The overall suppression rate was 85% – 80% for males and 82.6% for females, and age and sex disaggregation show variations across the age groups.

Figure 4.2.5: FY19 Viral Load Suppression by Age and Sex



Outstanding gaps

FY19 results showed low retention rates (<90%) across male and female aged 20-34 years. In FY19, The RTC campaign 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.

Programmatic results also demonstrated a 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 follow-up VL scorecard assessment of laboratory and facility readiness to scale up VL done in FY19 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 FY21 treatment targets and maintain 95% of PLHIV on treatment, PEPFAR Cameroon will ensure all PLHIV initiated on ART benefit from a patient-centered care approach 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 MMD will be provided for patients who are stable with suppressed VL to enhance adherence and retention. PEPFAR Cameroon will implement MMD of up to 6 months for patients who have been stable on the current three MMD for at least a year pending the availability of ARVs**.** The program will also provide support 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 low level viremia and ensuring adequate documentation and reporting using a national EID/VL data system and dashboard. PEPFAR Cameroon will ensure improved management and monitoring of patients with high VL to increase number of patients eligible for MMD and CAD once virally suppressed and thereby ensuring improved adherence to treatment and increased retention. The use of viral load champions in health facilities to improve uptake of VL will be expanded to all PEPFAR-supported sites in the 10 regions. VL registers harmonized in FY19 will be produced and made available at sites for monitoring of patients by HCWs. Given the regional and zonal specificities of the country, Government of Cameroon recently set up a decentralized transport system to meet the sample referral needs of the population. PEPFAR will leverage this opportunity to optimize the sample referral system and improve turn-around-time for viral load and EID results. PEPFAR will also implement patient-centered approaches like positive parenting to improve VL coverage and retention for children and adolescents and will monitor the quality of testing services by ensuring all VL reference labs are enrolled in a quality assurance program towards accreditation.

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. With IPs, the program 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 joint granular site Management (GSM)/Site Improvement through Monitoring Systems (SIMS), ongoing supervision and continuous quality improvement initiatives to identify and address gaps in a timely manner.

PEPFAR Cameroon will maintain the assignment of clinical program staff to each clinical zone and specific sites to closely monitor 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

In COP 20, PEPFAR Cameroon will implement various strategies to improve retention among men, including expedited services/fast-tracking for working men, after-hours and community-based ART distribution; integrated HIV testing and treatment services packaged with other services such as STD, TB; male-friendly clinic services, with sensitized staff and male-only clinics. These strategies will be intensified and expanded to all PEPFAR-supported sites. PEPFAR will also train LRA to provide support for disclosure, to identify barriers to HIV care, to address challenges, intensify post-test counselling and education and ensure the availability of immediate ART, which will be offered as a starter pack upon testing.

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 MMD 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. The Defense Forces activities will be implemented to address retention issues resulting from stigma and discrimination.

Strategies to improve retention among children and adolescents

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 OVC program section). PEPFAR Cameroon will expand this strategy across the 10 regions to enhance uptake of HIV services and retention of children in care.

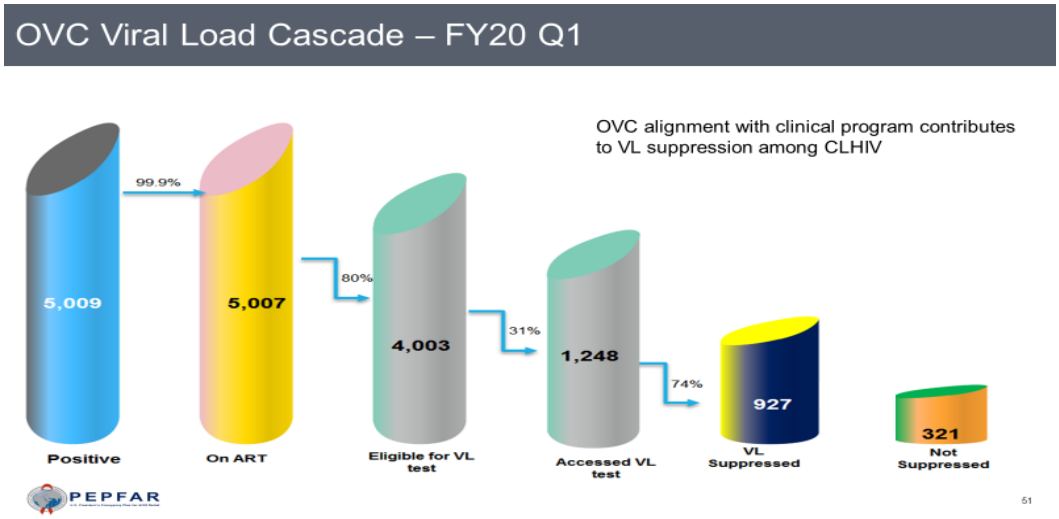
PEPFAR Cameroon will support IPs to reinforce the alignment of drug pick-ups for children with appointments for vaccination, mother's drug pick-up or support group activities. Adolescents' drug pick-up times will be adapted to fit school schedules. PEPFAR Cameroon will continue supporting adolescent 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.

To improve retention among younger cohorts such as children <15 and adolescents and young adults 10-24, PEPFAR Cameroon will strengthen the patient tracking system linking the facilities and the communities through peer educators and regular drug and commodities supply system. For children <15 years, the program will scale up differentiated service delivery models (DSD) such as multi-month dispensation (MMD) for all stable children, age appropriate disclosure and home-based visits. Regularly, health care providers will ensure TB screenings, adherence counseling, viral load testing, and documentation of weight at last visit and prescription of co-trimoxazole for opportunistic infections. In addition, the program will strengthen the community-based interventions (OVC) through bi-directional referrals and collaboration with health facilities. For adolescents and young adults 10-24, PEPFAR Cameroon will provide support to scale up adolescent and youth friendly services, patient navigators, peer support and linkages to community-based social services and family support, screening for and responding to violence. The program will also support the implementation of a comprehensive and prevention package provided by community partners (OVC and PC), a community adherence support by OVC partners and CAC and the linkage to other social services based on the needs.

Currently in COP19, the OVC program is supporting A/CLHIV with community adherence and tracking their outcomes to see treatment efficacy. At least once a month, case managers trained on treatment literacy conduct home visits to provide therapeutic education and adherence counseling to A/CLHIV as well as viral load reminders.

In COP 20, those activities will be expanded and strengthened and almost all A/CLHIV in PEPFAR supported health facilities in the OVC-supported SNU will be linked to the OVC program to benefit from that community adherence package. Also, treatment regimens and reasons for poor adherence among those with unsuppressed viral load will be identified and solutions found to address them with clinical partners during monthly stakeholders' meetings. OVC case managers will monitor for poor adherence and treatment failure in children on ART and notify clinical partners immediately if this should occur.

Figure 4.2.6: OVC VL cascade



In COP20, PEPFAR Cameroon will continue providing age-appropriate services to beneficiaries between the ages of 9 and 24 years at household, school, and community level. Primary 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)", "Doorways I and II community training manual", "Grassroots Soccer

(Skillz Program)", and "Peace Corps Life Skills 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 COP20 technical guidance, PEPFAR Cameroon has incorporated three evidence-informed modules in its current program that expand on the topics of healthy relationships, making healthy decisions about sex, and sexual consent although the focus of the program will be on the comprehensive program area, due to the size of the program and epidemiological context as elicited by the COP20 guidance. 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 COP 20, PEPFAR Cameroon will continue to offer services at home and in community group settings using the Parenting for Lifelong Health (PLH) for Parents and Teens" manual adapted to the Cameroonian context with the support from trainers from Clowns without Borders South Africa. 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. Efforts to reach more men with HTS will continue to be intensified through the Men as Partners programs and outreach interventions in households' settings.

PMTCT/Pediatrics

In FY19, PEPFAR Cameroon saw an improvement in the overall PMTCT coverage up from 60% in FY18 to 84%. The implementation of the catch-up strategy to reach pregnant women with PMTCT services in hard-to-reach populations contributed to improving the coverage for pregnant women accessing ANC and PMTCT services. There was increased improvement in the quality of PMTCT services offered to pregnant women as 96% of those received at PEPFAR supported facilities knew their status and 96% of those who were positive were also linked to treatment. In addition, cohort monitoring for PBFW on ART was implemented in FY19 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. In the new PEPFAR supported regions, the program will continue to support the GRC decision memo to decentralize ART to all PMTCT, HTS, and TB stand-alone sites for a more holistic family approach. In FY19, following advocacy by the PEPFAR Cameroon team, the GRC approved a new viral load testing algorithm for pregnant and breastfeed women in the new HIV management guidelines.

Results and achievements

PEPFAR Cameroon received 168,505 of an expected 177,911 pregnant women at ANC in PEPFAR-supported sites in FY19, representing 84% coverage. The program did not achieve the 90% target for ANC coverage; however, this was an improvement compared to 60% in FY18. Of all pregnant women who attended ANC, 161,071 (96%) were tested for HIV, among whom 7,060 tested positive, representing 78.7% of the expected positive target of 8,974, with a yield of 4% for both known and new and 1% (2,364) for the newly tested positives. 38% of all pregnant women received and tested were adolescent girls and young women 10-24 years of age. Of the 7,060 known and new positive

pregnant women, 6,785 (96%) received ART among whom 20% were AGYW. 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 60% in FY18 to 84% in FY19, 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. Stock outs of test kits remain a challenge, and VL coverage for PBFW is suboptimal (9%) with 87% suppression rates.

Strategies to improve PMTCT Uptake

To increase ANC coverage in COP20, 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 in all PEPFAR supported sites in the ten regions. IPs will work with district health services to map out areas with low ANC uptake and provide targeted community outreach services. Routine HTS will be offered to all PBFW at ANC services. All pregnant women who initially tested negative at first ANC visit will be retested and retesting for verification within the context of the test and start strategy will be offered according to national guidelines. 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 the GRC to ensure effective implementation of the decision to eliminate user fees for ANC. PEPFAR Cameroon will continue to implement the catch-up strategy in priority districts in the ten regions 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 FY19 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 and made available to all health facilities 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 a continuum of care to IDPs by using multidisciplinary teams, case managers and CBOs to reach out to PBFW and their partners with HIV services. PEPFAR Cameroon will scale up and expand viral load testing for pregnant and breastfeeding women following the new VL algorithm and improve on the documentation of viral load testing and viral suppression for PBFW in all PEPAR-supported sites to ensure appropriate monitoring, with training and mentorship of HCWs to ensure effective implementation.

In 2018, GRC signed a ministerial decision reorganizing the ART management structures in Cameroon with the goal of decentralizing ART services to 5th and 6th category health facilities that initially provided standalone prevention of mother to child transmission of HIV (PMTCT) services to pregnant and breastfeeding women including their HIV exposed infants (HEI) but operationalization remains a challenge. 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. The EID coverage for HEI in PEPFAR supported sites is quite good, >80% at 2-months and 110% at 12 months. In 2019, 16,638 HIV exposed infants benefited from EID testing through the existing POC network put in place through Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), CHAI and UNICEF, with support from UNITAID representing 79% of the national target (21,077). (NACC Annual Report 2018). Prophylactic ART coverage for HEI within 6 weeks is 83,53% in 2018 (NACC Annual Report, 2018).

In FY19, 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 being implemented in

about 50% of sites and contributed to the improved EID for HEI. Bi-directional referral of children and adolescents between the OVC and clinical programs is being reinforced, HTS is offered free for children and adolescents since January 2020. VL testing is currently being scaled up for monitoring of patients, including children and adolescents on ART, but scale up remains a major challenge. Monitoring of children on ART was also reinforced with the hiring of pediatric psychosocial support staff specifically for linking and retaining children in care.

Results and achievements

In 2018, Cameroon registered 16,638 HEI born to HIV-positive pregnant mothers who underwent polymerase chain reaction (PCR) testing, among whom 958 tested positive – giving a yield of 5.8%. In FY19, PEPFAR Cameroon reported 8,030 HEI who had a PCR test at twelve months, representing 110% of all HIV positive pregnant who delivered during the reporting period at PEPFAR supported sites (8,030/7,322) and 48.3% of the country coverage, with a yield of 3%. Seventy eight percent (183/234) of HIV-positive infants <1-year-old were enrolled on ART down from 83% (262/317) in FY18. At the end of FY19, PEPFAR Cameroon provided ART to 6,736 CLHIV <15, accounting for 45.7% of PEPFAR FY19 pediatric target (14,753). Only 54% of the expected HIV positive children were identified (1,063/1,964) with a linkage rate of 102% (1,063/1,089) and a TX-NEW of 51% (1,089/2,137). The retention rate was low (9%) showing the program identified new positive children but lost (649) more than the number of children enrolled (7,368-8,017). VL coverage for children and adolescents is 42% and the suppression rate for children and adolescents linked to ART was 71.75%. PEPFAR routinely evaluates site level linkage and retention data for adolescents and children.

Outstanding gaps

Only 21% (848/3984) of facilities providing ART services offer comprehensive pediatric care to children and adolescents and 79% provide PMTCT only. Despite the progress made, there remain a number of challenges, including suboptimal case finding in pediatric and adolescent populations. Low access to EID POC due to poor distribution of EID/POC platforms coupled with inadequate sample transport systems to transport EID/VL samples to the reference laboratories and frequent stock outs of EID commodities. There is suboptimal use of the pediatric screening tool resulting in the excessive testing of children with very low yields. Inconsistent availability of optimized pediatric ART regimens, poor adjustment of pediatric ART dosage with weight and age according to guidelines, and increased death rates of up to 17.9 for children <5 years due to poor identification and management of children with advanced HIV disease in pediatric services remain obstacles. The linkage rates for the adolescent subpopulation 15-19 years especially the males was suboptimal (64%), with low retention rates across the pediatric cascade (i.e. 12% among the < 1 year old) and VL coverage (42%) among HIV-positive children and adolescents on ART. VL suppression rates for children were also low (71.75%), possibly as a result of suboptimal availability of optimized 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 through the bidirectional

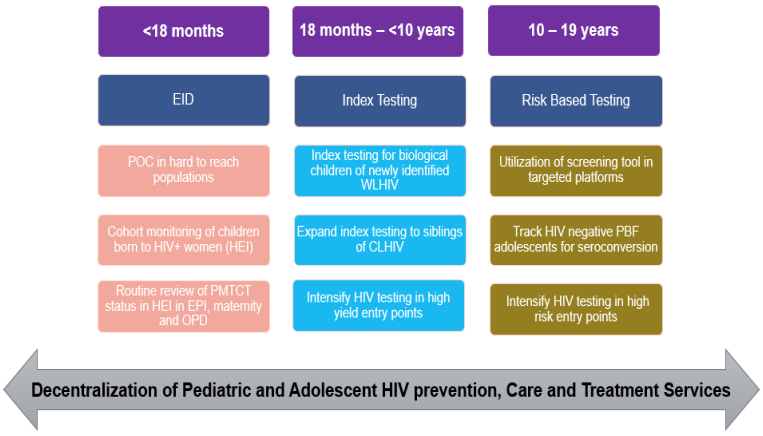
referrals for CLHIV between the PEPFAR clinical and OVC package of services to help improve on outcomes for children and adolescents prior to the COP19 scale up.

Strategies to reach children and adolescents

In COP20, PEPFAR Cameroon will expand key strategies to improve pediatric and adolescent HIV prevention, care and treatment to all 319 sites in the ten regions. PEPFAR Cameroon will support the decentralization of pediatric and adolescent HIV services to PMTCT standalone sites to improve on case finding, linkage of positive HIV children identified through PMTCT and the family centered care.

PEPFAR Cameroon will continue to advocate and support the expansion of point of care for EID in hard to reach districts and will continue to ensure the creation of networks of health facilities around existing point of care machines to maximize use and enhance uptake of EID for HEI while ensuring the availability of EID test kits. Sample transport systems will be set up and/or strengthened to support EID and VL uptake and testing turnaround time (TAT) through the use of bikers. 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. Cohort monitoring for HEI will be expanded for the mother-baby pair to enhance EID uptake for all HEI across all 10 regions. IPs will work with facilities to monitor EID uptake, HEI tracking, and TAT. Community partners will be empowered to actively search for HEI in the community and link them to the facilities for EID services. PEPFAR Cameroon will leverage the OVC program to help link PBFW and HEI who are defaulters in the community to EID services. PEPFAR will support linking of EID services for HEI to a standard package of ANC and postpartum care for mothers and infants. Pediatric 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 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 4.3.1: Finding pediatric and adolescent populations through tailored strategies



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. PITC will be reestablished at all high yield pediatric and adolescent entry points in facilities with availability of rapid test kits. Targeted testing will be intensified using the screening tool to assess for risk and identify the most at risk and vulnerable adolescents for testing at both facility and community levels. Index case testing for biological children will be expanded to all sites in the new regions. 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 adolescents who test positive at facility and community levels for ART initiation. Health care providers will be trained and mentored on pediatric HIV management including counseling and testing, pediatric ART optimization, VL, advanced HIV disease and enhanced 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 optimized pediatric ART, and the availability and timely request of pediatric ARV drugs. Appropriate weight and height scales will be provided to ensure weight appropriate ART prescriptions.

VL testing will be scaled up for children and adolescents living with HIV. To improve on viral load coverage, health care providers will be mentored to line list all children eligible for viral load testing and ensure VL prescriptions are provided with samples collected and referred to the reference laboratories for VL testing. The results once available will be presented for interpretation and decision making according to national guidelines. Enhanced adherence counseling will be intensified through mentorship for children and adolescents with high viral load to improve on viral suppression. Child friendly corners and support groups for children will also be implemented. The capacity of HCWs will be strengthened to facilitate disclosure, transitioning of adolescents to adult ART services and for the adult health care providers to receive adolescents transitioned from other pediatric services. Tools adapted for pediatric counselling and disclosure in use since FY18 will be produced and made available 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.

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. However, children will have to be brought to the facility at least once in a quarter for anthropometric measurement in order to adjust ART dosage if necessary. Providers and case managers will also be trained to provide parenting caregiver support. 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.

The bidirectional referral of children and adolescents between the Clinical and OVC program will be strengthened. The clinical service providers will receive OVCs at health facilities and provide them with HIV prevention, treatment and care services, while the OVC program will 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.

TB/HIV

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. GRC is focusing efforts to increase TB case detection and cure rate for both drug sensitive and multi-drug resistance TB (MDR-TB).

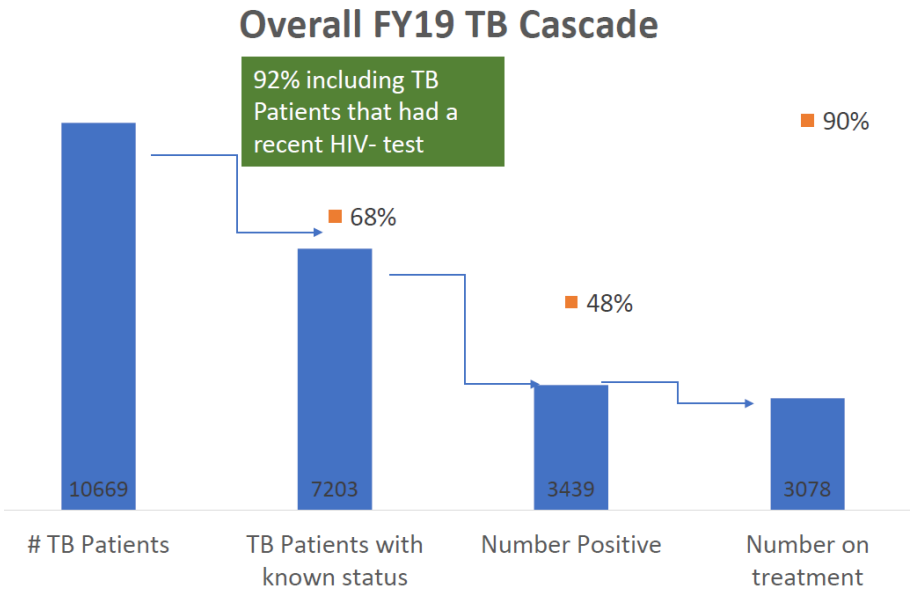
Cameroon has adhered to the Sustainable Development Goals and the World Health Organization (WHO)'s Strategy to END-TB and has implemented various short and long-term TB and HIV strategic plans to reduce the burden of TB. Despite being preventable and curable, TB remains the leading cause of infectious 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 TB prevention and treatment, CDC implemented a 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.

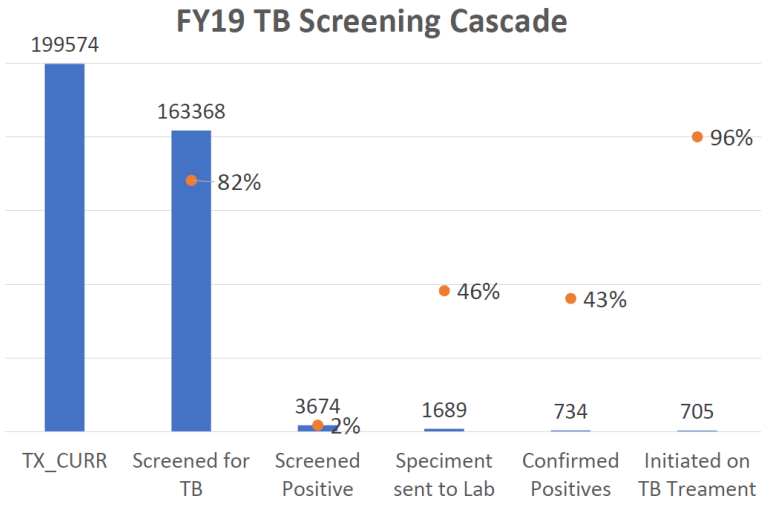
PEPFAR clinical IPs continue to support HIV clinical units through capacity building to offer quality TB screening using basic signs and symptoms, refer suspected cases for TB diagnostic evaluation, and provide preventive treatment for PLHIV without active TB, and curative treatment to confirmed TB cases. 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 tools for reporting across the cascade have been produced and will be made available at all sites to ensure full functionality.

Results and achievements

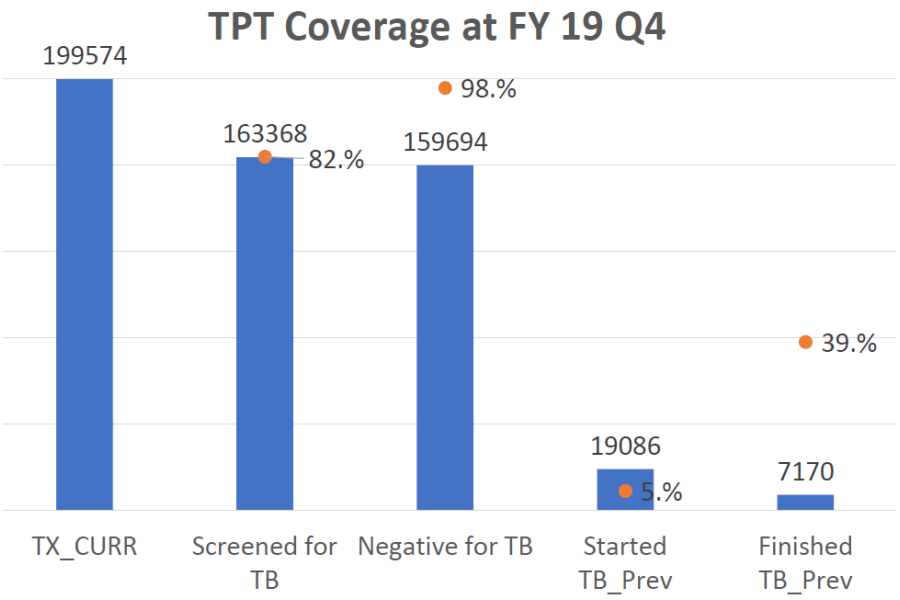
In FY18, PEPFAR Cameroon provided 10,000 Gene-Xpert cartridges to improve confirmatory TB diagnostics for presumptive TB cases. Clinical facilities were supported to develop and implement infection prevention and control plans. At PEPFAR supported sites, 92% of new and relapsed TB cases knew their HIV status, 48% of TB patients were co-infected with HIV, and 90% of HIV-positive TB cases were initiated on ART in FY19.



In ART clinics, only 82% of all PLHIV were screened for TB, and 2% had a positive TB symptom screen – a lower achievement than the 5% expected target. Forty six percent of specimens were sent to the laboratory for confirmation and 43% were confirmed positive, of which 96% were initiated on treatment. 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.



Among 82% of PLHIV screened for TB in FY19, 98% had a negative TB symptom screen, of which 5% were initiated on TB preventive therapy.



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 most 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 Cooperative agreement with the National TB Control Program will strengthen the program's capacity to decrease the burden of TB/HIV and develop systems to achieve and sustain TB/HIV epidemic control in Cameroon. In COP20, PEPFAR Cameroon will continue expanded TB/HIV

service provision in all PEPFAR-supported sites in the 10 regions. Clinical IPs will provide TB screening to all 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 PLHIV without active TB, including military and all other vulnerable populations. To reach the COP20 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 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.

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 of 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 COP20, 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 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 clinical sites.

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, Bertoua, Bafoussam, and Ngaoundéré. In COP20, an expansion to a new city (Kribi) will be made in order to reach additional beneficiaries in need. These cities were selected based on HIV burden, in coordination with the GFATM community principal recipient (PR) and civil society. Together, the seven 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, tourist attractions, 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.

In COP 20, PEPFAR Cameroon will develop and distribute health education and treatment literacy materials tailored to KPs and PPs' health will be developed with peer linkage and retention agents (KP/PP focal points) available to address KP and PP specific issues. KP-friendly clinics (stigma free, non-judgmental, extended/weekend hours) will be scaled up in all PEPFAR-supported sites, especially clinics around DICs, hotspots and KP meeting venues. KP peer support groups hosted by facilities initiated during FY20 will be supported and brought to scale during COP20. Multi-month scripting and MMD will be done for KPs on ART who have become stable. Community ART dispensation will also be proposed as an option to stable KPs who can choose to pick up ART at the level of the DIC.

At community level through DICs, KPs will continuously receive adherence counseling and support from community case managers and peer navigators. Viral load sample collection will also be done at DICs to continuously improve KP/PP access to VL testing. The peer navigator and KP focal point at the facility will work together through a handshake model to track VL test results. Peer navigator or expert client will provide guidance on results interpretation and provide enhanced adherence counseling to virally unsuppressed KP/PP.

FY19 Results and achievements

FY19 data reveal that 38,457 KP were reached with prevention messages and materials and 21,436 tested for HIV. Of the 47% who were tested for HIV, 2,956 were diagnosed HIV-positive (15%) and 2,478 were linked to treatment (95%). In order to better target and test those beneficiaries most

likely to be HIV-positive, index testing was expanded in FY19. In addition, innovative approaches to differentiated index testing through social events and other avenues introduced last year were scaled up in all CBO to minimize the risk of intimate partner violence.

Regarding clients of FSW, the program continued to implement the Sex, Test and 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, in FY19 the program recorded a yield of 12% (163/1393) in those clients, more than six 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. Those policy documents are now available and PrEP and HIV self-testing activities began in the last quarter of FY19. In COP20, PEPFAR will continue to work alongside with the GRC and key stakeholders to update policies and programmatic tools for PrEP implementation and to expand this program nationwide and to other populations in need, including partners of pregnant women and partners of sero-discordant couples. PEPFAR will also continue and programs will engage stakeholders beyond the health sector such as local authorities, law enforcement, and the judiciary to create a more enabling environment for FSW and MSM free from stigma, discrimination, or fear of violence.

Outstanding gaps

FY19 program data show 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, FY19 yields for MSM and FSW (14% for both populations) were similar to the IBBS 2016 prevalence for those newly tested with yield trends following the same pattern as noted in the study. In the KP program, those aged 30 and above, average yield (24% in FY19 Q4 data) was double that of the younger age bands (12% in FY19 Q4 data). Program strategies for COP 20 will be tailored to each geographic area and sub-population with a focus on PrEP initiation and adherence, retention to treatment for KPLHIV, and scaling up differentiated index testing activities with fidelity.

Strategies to improve KP 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 COP20 will increasingly target their focus to younger KP who have historically shown lower yields and KP who have previously tested HIV negative.

PrEP interventions 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. To improve on PrEP uptake, adequate communication strategies to address misinformation within the KP community, motivational interviewing skills and adjusting counseling and IEC approaches will be implemented and expanded. Small-group sessions for experience sharing among PrEP users, online-mediated strategy and outreach mobilization will be used and emphasized to reach more KP and keep on PrEP those who have made the choice to start the PrEP.

Regarding testing, cumulative FY19 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 FY21. 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. Differentiated index testing will continue and be scaled up in new cities in a manner that guarantees human rights and minimizes risk of IPV. That index testing approach will focus on sexual partners of MSM, regular, non-paying sexual partners of FSW, and children of FSW.

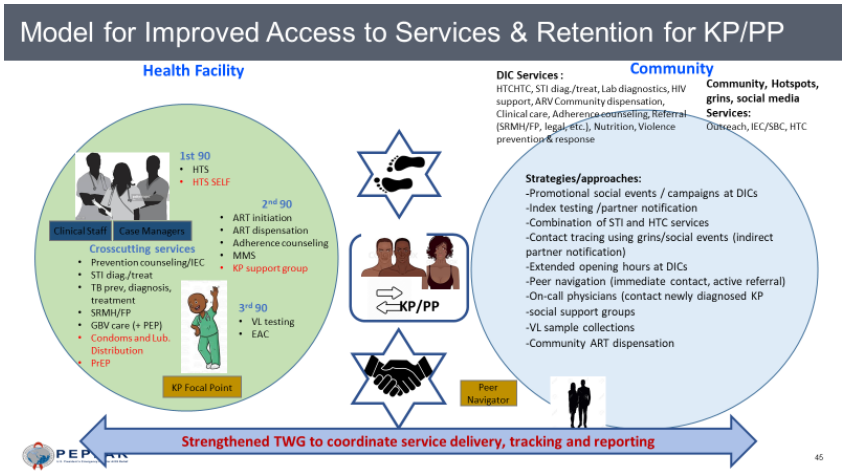
Clients of FSW will continue to be reached by the innovative coupon system known as Sex, Test and Treat and with an emphasis on Long Distance Truck Drivers (LDTD). Under the Sex, Test and Treat strategy, FSW provide HIV prevention education to their clients and provide them with a coupon for free testing 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 to be expanded in COP20. 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. Systematic STI screening, as well as sexual and reproductive health services, will continue to be provided to all KP reached (with a targeted approach for FSW) in collaboration with CAMNAFAW. 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.

Figure 4.3.2: Model for improved access to services and retention for KP



Almost all DICs in Yaoundé, Douala and Bamenda are dispensing ARV as part of the community ART dispensation program and this will be scaled to the new cities added in FY20 and FY21.

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.

Strategies to improve HIV services in host and refugee communities

PEPFAR Cameroon will ensure that regions that are principally hosting internally displaced persons (IDPs) and refugees will be equipped to provide tailored HIV prevention, care and treatment services to meet IDPs' needs. The regions involved include the Adamawa, Centre, East, Littoral and West regions. IPs covering these regions will build a strong collaboration with the District Health Services with high IDP and refugees' burden through Regional Delegations of Public Health and the Regional Technical Working Groups to reach out to IDP/refugee communities through an integrated community (outreach) service delivery approach. Community health workers (including members from IDP/refugee communities) at the level of the districts will be trained on basic HIV and AIDS, targeted social and behavior change communication, community mobilization in favor of uptake of HIV prevention, care and treatment services.

Based on this collaboration, HIV services across all three 90's will be integrated in routine and periodic outreach activities for other primary health care programs organized by the District Health Services. These can include vaccination, ANC catch-up, mother/child health and nutrition actions, bed nets distribution, mass drug administration (neglected tropical diseases). HIV services package that can be integrated during such community outreach activities include facility-led counseling, testing, HIV self-test, condom distribution, treatment initiation, ART dispensation, adherence counseling, VL sample collection and TB screening.

During COP20, IPs will liaise and coordinate with other key emergency response actors or organizations (UNFPA, OCHA) to ensure HIV services (testing, PEP, treatment, VL testing) are included in the minimum initial service package (MISP) in conflict affected areas and IDP host communities and refugee camps.

Comprehensive, Integrated, Resilient ART System (CIRAS) and Cameroon Surge:

PEPFAR Cameroon scaled up its geographical coverage to all ten regions in FY20 to support the MOH to reach HIV epidemic control by September 2021. This translates into increasing ART

coverage from 57% in 2019 to 91% by 2021 through finding and enrolling 180,965 PLHIV on treatment.

In COP19, PEPFAR Cameroon plans to activate the national and ten regional Emergency Operations Centers (EOC) towards achieving HIV epidemic control in COP20, leveraging CDC's Global Health Security Agenda investment in establishing the EOC. The objective of the surge is to accelerate progress towards epidemic control in the 10 regions of the country, across the entire HIV prevention, care and treatment cascade. The goal is to increase the number of PLHIV receiving antiretroviral treatment (TX_CURR) by 180,965 from October 2019 (TX_CURR 299,961) to September 2021 (TX_CURR 480,926). The activation will be at national and regional level starting at a high level of activation for approximately 3 months and will move to a lower level of activation, thereafter, based on performance during initial months of activation. To increase the number of PLHIV on ART, the program needs to act quickly to meet target, to prioritize all ICS/EOC activities and to use a pragmatic stepwise implementation strategy.

Cross-cutting strategies

In all 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. Quality Improvement Collaborative (QIC), which has been successfully implemented in Cameroon, will be used to improve on the clinical program performance. The QIC will focus on EID, case finding and linkage of infants to treatment services, VL testing and suppression for PBFW, children and adolescents, increasing ANC attendance for pregnant women, and linkage and retention for the general population. PEPFAR Cameroon will expand the implementation of 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.

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

In COP18, one of the most critical program challenges was supply chain and commodity procurement. Failure of the GRC to mobilize counterpart funding and place commodity orders on time resulted in nationwide stockouts and low stocks in RTKs, ARVs, TPT, and viral load and EID Reagents. The PEPFAR team, including diplomatic engagement by the Front Office, and partners made a great effort to identify the weaknesses in the supply chain, concluding with a post-COP18 inter-agency TDY, which found delays in custom clearance, a lack of data and visibility of stocks on hand, a lack of efficient distribution systems and insufficient coordination at various levels, a lack of effective nationwide cold chain and warehousing systems, and understaffed personnel managing ordering and distribution.

Analysis of case finding results in COP18 reveals that case finding is another area with great need for improvement within the program. Due largely to shortages or stock outs of rapid test kits, case

finding nationally fell dramatically short of targets. Testing yields also staggered behind and index testing was not sufficiently scaled up.

Lastly, analysis of COP18 performance for care and treatment reveals some improvements over COP17, but there are still major gaps to treatment coverage across most SNUs. Retention among young adult cohorts for both men and women, is a persistent challenge. Viral load suppression continues to hover below 90% with significant gaps in viral load coverage.

During COP20 planning and finalization meetings, other priorities outlined by OGAC for Cameroon were:

- A review of TLD guidelines for the women of childbearing age population
    - The National guidelines of the Ministry of Public Health have been updated with directives on the implementation of TLD rollout. During trainings on ARVs optimization and TLD rollout, health care providers will be trained on these updates and implementation strategies. During counseling, the providers will adequately communicate to women of childbearing potential to give the advantages of TLD and the possible side effects in order to obtain their informed choice.
- Engage local partners in monitoring of user fee elimination at the sites
    - Implementing Partners monitor progress on user fee elimination at site level on a daily basis and provide weekly reports on progress made and challenges encountered. CSOs are also engaged in monitoring this process.
- Collaboration between Peace Corps and Global Fund to support investment in DREAMS-like programming for adolescent girls and young women

Supply Chain Transformation

- Supply chain partner must engage 3PL providers for last mile distribution of commodities to clinical sites.
- Supply chain partner must engage personnel to assist in the customs clearance and waiver process at the point of entry in country.
- Supply chain partner must provide support for warehousing, inventory, and distribution management at the national and regional levels.
- Clinical partners must engage pharmacy staff at sites to ensure proper ordering of optimal regimens and to support proper storage practices, as well as support data collection of consumption and stock at sites for optimal ordering.
- Supply chain transformation plan must be completed in COP20 in coordination with Global Fund.

Improved Case-Finding

- Scale up of index testing with fidelity in all regions.
- Index testing counselors identified and retrained for all sites.
- Decrease Other PITC testing dramatically as a proportion of HTS_TST targets in COP20.
- Use of screening tool where Other PITC testing is done at clinical sites.

Client Centered Service Delivery

- Implementation of optimal ART regiments for pediatrics at all sites.
- Dramatic scale-up of multi-month dispensation with partner level data collected on the proportion of the treatment population on MMD.
- Community dispensation must also be scaled up with partner level data collected on the proportion of the treatment population receiving community dispensation.
- Implement retention strategies for young adults at the site level.
- 90% or more of children and adolescents on ART with PEPFAR support should be offered the opportunity to enroll in the comprehensive OVC program.
- 90% or higher OVC_SERV target achievement for beneficiaries under the age of 18.
- Continued scale up of viral load testing to achieve 90% coverage.
- Improve viral load suppression to above 90% through improved retention models for young people, TLD scale up, multi-month dispensation, and community dispensation.
- Expansion of PrEP in populations with the greatest need.
- Continued scale up of TB preventive therapies.

4.5 Commodities

After experiencing a period of stock tensions, the Cameroon supply chain outlook is promising. At the central, regional, district and health facility level, antiretroviral treatment, rapid test kit, viral load reagent and consumable stock levels are stabilizing, and occurrence rates of stock outs are declining. In order to maintain the trend and ensure a responsive supply chain that can sustainably serve patients in need of commodities, PEPFAR is investing in innovative supply chain strategies that will contribute in the short, medium and long term to ensuring the establishment of a resilient supply chain for health commodities. In COP20, PEPFAR will also invest in commodities procurement, contributing $5,995,000 for the acquisition of rapid test kits Determine and KHB Shanghai ($1,579 518), viral load reagents and consumables ($2,920,482), commodities for PreP ($495,086) and Isoniazid ($999,999) for tuberculosis prevention among people living with HIV.

COP20, PEPFAR will also align its supply chain strategies to Government of Cameroon priorities and will leverage other supply chain resources from other in-country partners such as the Global Fund. Synergies among partners will eliminate duplication and support the country's efforts to achieve HIV epidemic control (see section 5.0).

The total national cost of commodities procurement in FY21 is estimated at $48,167,788, including antiretrovirals, viral load reagents and rapid test kits. The implementation of COP 19 has been hampered by delays in procurement and delivery of commodity orders occasioned by the delayed

materialization of counterpart funding by the Government of Cameroon, resulting in commodity shortages and stock out. While this situation is currently improving, PEPFAR Cameroon will continue to monitor consumption data for risk of stock out and will request early release of COP 20 funding to ensure reception of shipments of key commodities by October 2020. It is important to note that the PEPFAR Cameroon program will focus its procurement on ensuring adequate RTK stock and contributing to VL coverage but will still rely on the Government of Cameroon and the Global Fund for ARVs and other commodities. Any delays on the part of the Government of Cameroon to execute orders for ARVs may affect the program's ability to meet its treatment targets.

To ensure proper ordering of optimal regimens, the capacity of pharmacy staff will be strengthened. Clinical Implementing Partners will also continue to provide support at the site level to ensure proper commodity inventory monitoring and storage practices (including the use of stock cards). Furthermore, the clinical program will provide verification when commodities are received, and send notifications when stocks are low at the facilities. Because facility-level information on consumption and service provision is critical for national quantification, clinical partners will strengthen data collection practices at sites, and ensure that this information is transmitted from sites to regional and central levels.

4.6 Collaboration, Integration and Monitoring

In COP20, PEPFAR Cameroon will improve collaboration and leverage technical strengths and competencies across all agencies to ensure efficiencies in addressing gaps identified in COP18/19 and development of COP20 in order to meet the program goals of achieving epidemic control by sex and across different age groups and populations by Sept 2021. To address these gaps, the team through a collaborative effort, will build on their technical strengths and expertise to guide implementation of innovative strategies for achieving epidemic control among children, OVCs, AGYW, KPs, adolescents, adult women and men in all four zones across the national territory. Agencies will continue to collaborate in conducting GSM/SIMS/DAQ/SQA, implementing CQI activities and supporting CSOs and other community outreach programs to ensure the provision of quality patient-centered HIV/TB services. 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 support the GRC to complete the TLD transition process which started during COP19 implementation. PEPFAR Cameroon agencies will implement PrEP for key and priority populations and sero-discordant couples and reinforce the U=U messaging. PEPFAR Cameroon agencies will improve collaboration with CSOs.

To address specific gaps identified in COP18/COP19 , PEPFAR Cameroon's key interventions in COP20 towards achieving epidemic control in all four zones across the ten regions of the country will focus on knowing who to target, where and how to find PLHIV, finding those we are missing (men and adolescents), finding the drivers of the epidemic (AGYW) and improving on strategies to link positives to rapid ART initiation, retain patients in ART treatment, improve viral load coverage and keep them virally suppressed. To ensure success and sustainability, PEPFAR Cameroon will

continue to leverage and strengthen existing collaboration with the GRC, CSOs and other key stakeholders such as GFATM, UNAIDS, Unitaid, GIZ, UNICEF and WHO. In COP20, PEPFAR Cameroon will fund UNAIDS to support the GRC in coordinating efforts towards ensuring the availability of HIV data at district, regional and national level for decision making.

PEPFAR Cameroon has intensified partner management by investing in new approaches like GSM/SIMS integrated site visits to enhance site level granular management coupled with CQI activities, implementation of the remediation tracker and will continue to implement those that improved efficiencies of partner/site performance in COP18/COP19. Across all PEPFAR Cameroon agencies, improved strategies include weekly data reporting by the IPs, and the provision of review/feedback on data reported by USG staff. The frequency of site visits either weekly, biweekly or monthly for program performance reviews depends on the gap identified. This review and reporting of activities are done by budget code and by site with immediate follow-up on required corrective actions for remediation. Routine DQA and corrective action by agency and by IP at site level, trainings on the most recent version of PEPFAR's Monitoring, Evaluation and Reporting (MER) guidance and indicators. Regular Check-In at site level to track progress with the implementation of the remediation tracker following each site visit and ensuring remediation is not just a change in color code but a reflection in the site performance with respect to their targets.

The PEPFAR Cameroon program conducts quarterly mini-POART with the IPs to review data for oversight, accountability, performance and corrective actions for overall program quality improvements. Additionally, the program holds quarterly portfolio implementation reviews and reviews IP work plans to ensure that COP strategies are accurately captured with activities that are appropriately aligned to PEPFAR objectives. Additionally, strategies which have proven to improve program performance will be replicated across the four zones throughout the national territory. The program also plans to implement peer review meetings as CQI activities to exchange challenges and share best practices within the zones and across program areas are rolled out.

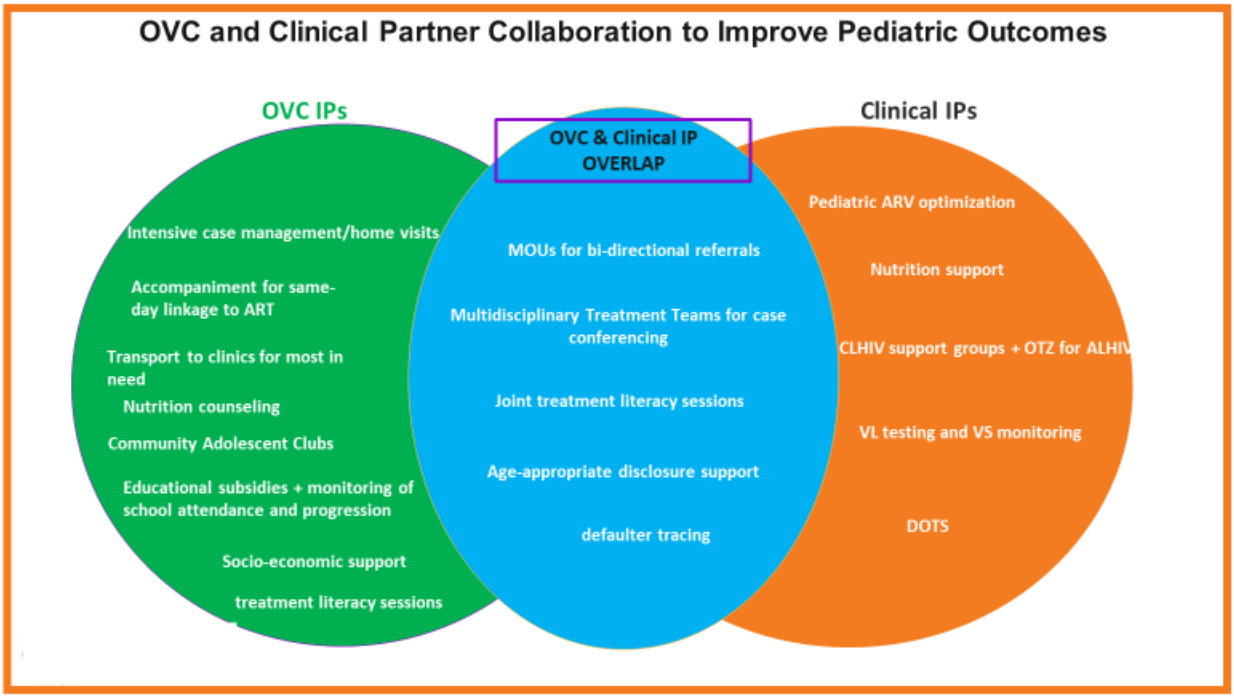
The Minister of Health signed a service note on March 2, 2020 on activation of the EOC and implementation of the Cameroon surge activities in COP19 in collaboration with MOH-NACC, DGHP and the implementing partners to accelerate progress towards epidemic control by Sept 2021. Surge tools and systems are being put in place at facility level pending official activation by the Minister of Health.

Activation of the EOC and implementation of the Cameroon surge activities in COP19 in collaboration with MOH-NACC, DGHP and the implementing partners beginning March 1st, 2020 will accelerate progress towards epidemic control by Sept 2021.

Concerning KP activities, a TWG within the PEPFAR inter-agency will be instituted and meetings hold at least every month to discuss site implementation and areas of improvement. In addition, monthly meetings will be conducted between PEPFAR community and clinical IPs to share ART

unique identifier codes (UIC) and community UIC of clients reached to avoid double counting when reporting in DATIM. Ongoing collaboration between PEPFAR KP community partners and the Global Fund community PR (CAMNAFAW) will continue with each partner leveraging another's resources, ad hoc and monthly meetings held at central and regional levels.

To improve on pediatric outcomes, an inter-agency PEPFAR TWG on A/CLHIV-OVC will discuss on a monthly basis all related issues about strengthening collaboration of the various programs in the field. Also, a strong collaboration platform will be instituted among clinical and OVC partners. MOU defining roles and responsibilities of each party will be signed by OVC partners and PEPFAR supported sites for referral and counter referral of children on ART. Monthly meetings will take place at the district level involving community, clinical partners and health facilities to review all data and address gaps identified by either community actors or clinicians. At the national level, bimonthly meetings will be convened by the MOH (NACC) to follow up on the integration of the community and clinical case management model that will have been adopted.



In order to monitor access to services in health facilities, PEPFAR Cameroon will continue to support community-led monitoring systems. Reports generated by CBOs reporting on access to and quality of services provided at health facilities will continue to be shared through weekly scorecards and other avenues bringing together government, partners and community actors (see section 5.0). At the national level, quarterly review of the findings of community actors, IPs and MOH Inspectors generals will be presented and remediation plans adopted to improve access to care of beneficiaries.

4.7 Targets by population

Table 4.7.1 ART Targets by Prioritization for Epidemic Control

Table 4.7.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY20) ±	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) *TX_CURR*	Newly initiated (APR FY21) *TX_NEW*	ART Coverage (APR 21)
Attained						
Scale-Up Saturation	465,733	381,592	-	452,367	94,516	97%
Scale-Up Aggressive						
Sustained						
Central Support	38,548	-	-	-	-	-
Commodities (if not included in previous categories)						
Total	504,281	-	-	452,367	94,516	91%*

* Including the 5,321 PLHIV currently on ART in centrally supported SNUs
± Cameroon Ministry of Health only plan targets at national and regional levels. Health district level targets are not available

Standard Table 4.7.2: VMMC – N/A for Cameroon

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY21)	FY21 Target
PP_PREV (CFSW, AGYW, ABYM)	-	-	45,689
KP_PREV (FSW)	-	-	50,047
KP_PREV (MSM)	-	-	22,274
KP_PREV (People in prisons and other enclosed settings)	-	-	4,000
KP_PREV (PWID)	-	-	701
TOTAL	-	-	122,711

Table 4.7.4 Targets for OVC and Linkages to HIV Services

Table 4.7.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Adamaoua	-	5,323	4,253
Centre	-	21,634	14,570
Est	-	5,547	4,092
Extreme Nord	-	3,696	2,417
Littoral	-	15,505	10,442
Nord	-	2,276	1,523
Nord Ouest	-	3,945	2,634
Ouest	-	5,097	3,774
Sud	-	1,785	1,545
Sud Ouest	-	2,968	1,978
TOTAL	-	67,776	47,228

4.8 Cervical Cancer Program Plans

N/A for Cameroon

4.9 Viral Load and Early Infant Diagnosis Optimization

ART coverage for HIV-positive children and adolescents was at 36% in 2019 however, identification and management of HIV infection among this population remains weak, often compounded by other challenges such as frequent stock out of ARVs, ART related-commodities and prolonged turnaround times for return of DNA/RNA PCR 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 VL 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 (especially for breastfeeding women who are usually LTFU post-partum). The recent ministerial circular released in April 2019 announcing elimination of user fees for HIV services beginning January 2020 will enhance successful implementation, improve demand creation 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). The NACC 2018 national annual report indicates that as of December 31st, 2018 on an active file of 281083, TB screening was done in 218799 giving a 77.84%, 23741 cases were diagnosed for TB amongst which 22550 were tested for HIV given a 95% coverage. Amongst the 22550 tested, 6457

were infected with HI given a 28,63% TB/HIV co-infection rate which is less than 30.7% reported in 2017. TB diagnosis remains a challenge, due in part to a lack of well-established and appropriate sample referral and 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. There is also the need to strengthen systems in place for the follow-up of presumptive TB cases through the TB evaluation cascade to determine and document outcome.

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 (within 2hours), 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 4.9.1: POC EID for PEPFAR-Supported Sites

	2016	2017	2018	2019	Total
Number of Platforms (25 m-PIMA; 18GeneXpert	5	8	20	10	43
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 2018 NACC national annual report shows that as of December 31st, 2018 17214 HEIs were documented born if HIV positive pregnant women, 14378 of these HEIs were given nevirapine for prophylaxis given a coverage rate of 83.53%. 96.65% (16638/17214) were tested for HIV amongst which 958 (5.8%) of them tested HIV positive and 55.94% (536/958) were initiated on ART.

Of the 70 POC platforms distributed across the 10 regions, 14 of these platforms are currently being used for integrated TB/HIV (EID) testing.

In COP20, 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 availability of commodities, 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 optimize 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 2021. PEPFAR Cameroon is currently working with GRC to support implementation of MoPH directives on the elimination of user fees for HIV services (e.g. VL testing) and against unauthorized ANC service fees and other malpractices which serve as a barrier to accessing 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 FY21 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 CQI 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. CQI will focus

on EID and linkage of infants to ART 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 uniterrrupted, high-quality and sustainable POC EID/VL testing services. The UNITAID implementing partners supported the project through forecasting, procurement and distribuiton 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 0 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 EQA and post-market surveillance.
7. Demand creation, community and civil society mobilization.

8. Biosafety, biosecurity and waste management.

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 commodities 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.
- Rollout EQA for POC EID/TB and VL
- Complete and share a project transition report.

For Viral load reagents and commodities, PEPFAR Cameroon will engage with a 3PL to ensure transportation down to the testing laboratories and will also engage with Abbott to benefit from the negotiated all-inclusive price per test for viral load reagents and commodities.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Improving supply chain systems

Improved governance and a sense of supply chain ownership and accountability are gaining momentum and the Government of Cameroon is currently investing in strengthening the supply chain coordination for health commodities. A supply chain coordination unit has been established within the Directorate of Pharmacy, Medicines and Laboratories to lead on all supply chain initiatives under the leadership of the Supply Chain Steering Committee, chaired by the Minister of Public Health. The Ministry of Public Health has released an ambitious agenda for the transformation of the health sector, and it stresses the need to reinforce the supply chain and develop a national strategic plan. The Global Fund is ready to increase funding for supply chain strengthening, including the development of a national strategic plan for supply chain. The GF is also working on reinforcing data reporting, collaborating with the UNFPA on developing an electronic logistics management information system that will ensure a strong linkage between regional warehouses and the central level.

In COP 20, PEPFAR supply chain strategies are built on the planning level letter directives and the recommendations of the multilateral supply chain visit.

No.	Strategic Directive	Key Activities
1	Engaging Third Party Logistics to ensure last mile distribution of commodities to clinical sites	• Two Regional Funds for Health Promotion (Regional Warehouses) in the Center and Littoral regions are supported and empowered to directly manage a 3PL to transport commodities to all PEPFAR supported health facilities. • 3PL solutions for transportation of non-cold chain health commodities from the remaining 8 Regional Funds for Health Promotion (Regional Warehouses) to supported health facilities are managed by the supply chain TA partner • A 3PL is contracted and managed directly by USAID to transport Viral Load cold chain commodities from the central level storage facility to accredited testing laboratories
2	Engage personnel to assist in the customs clearance and waiver process at the point of entry in country	• Place procurement orders and inform all stakeholders on procurement planning • Track all placed orders and manage freight forwarder so that status of placed orders is known, and freight forwarders provide regular updates on status of incoming shipments • Collaborate with the Ministry of Finance, Customs, the Ministry of Health and the DPML • Engage with customs • Confirm deliveries
3	Provide support for warehousing, inventory and distribution management at the national level at CENAME and at regional level via the "point focal	Dedicated personnel who make sure medicines move from the Regional Warehouse to health facilities A continuous assessment of warehouse and storage best practices to safeguard medicines integrity • Continuously assess warehouse storage capacity against expected shipment volumes to spot optimization opportunities: Run 5 S (Sort, Set, Shine, Standardize, Sustain)Generate, capture, use and transmit data on how medicines and other commodities are being used at the regional level • Ensure accurate and timely counting and reporting the total number of usable and unusable commodity items available in the warehouse Receive health facility reports on medicines stock levels and usage rates • Analyze orders submitted by the health facilities and draft distribution plans

		• Submit work orders (approved distribution plans) to 3PL for implementation Transport medicines from the regional warehouse to health facilities • Receive a distribution plan from the Regional Technical Group • Inform the 3PL on the availability of the plan and monitor its implementation • Analyze 3PL performance against Key Performance Metrics
4	Clinical partners must engage pharmacy staff at sites to ensure proper ordering of optimal regimens is done, and to support proper storage practices, as well as support data collection of consumption and stock on hand at sites to inform optimal ordering	To ensure proper ordering of optimal regimens, the capacity of pharmacy staff will be strengthened. Clinical Implementing Partners will also continue to provide support at the site level to ensure proper commodity inventory monitoring and storage practices (including the use of stock cards). Furthermore, the clinical program will provide verification when commodities are received, and send notifications when stocks are low at the facilities. Because facility-level information on consumption and service provision is critical for national quantification, clinical partners will strengthen data collection practices at sites, and ensure that this information is transmitted from sites to regional and central levels. Monthly meetings between supply chain and clinical IP supply chain focal points will also be conducted to review site level data including: • Consumption data • Stock on hand • Return and reverse logistics • Patient numbers per regimen
5	Supply chain coordination with Global Fund: transformation plan must be completed in COP20 in coordination with GF, with plans to address lack of data visibility, distribution optimization, cold chain and warehousing challenges, and other key issues identified above	• Support the supply chain steering committee in supply chain leadership, governance and resource mobilization • Re-energize the quantification committee and ensure quarterly supply plan review meetings • Establish the Procurement, Shipping, Customs and Warehousing as well as the Distribution, Transportation and3PL committees. Develop and reinforce standard operating procedures for all committee • Support the LMO to improve supply chain coordination and governance of the integrated national supply chain system • Support the elaboration of a costed national strategic plan for supply chain system • Improve data use: reinforce data generation, capture, reporting and use for decision making

PEPFAR Cameroon will continue working with GRC, GFATM, and other stakeholders to scale up TLD use in all health facilities. Supply chain TA will contribute to the minimum program requirements through ensuring availability of MMD friendly commodities and ensuring quantification and procurement of optimal antiretroviral formulations such as TLD for all patients including women of childbearing age and disposing NVP regimen will continue in COP 20. For pediatrics, availability of DTG for children weighing between 30kg and 20kg will also be prioritized.

Improving health service delivery through community monitoring

PEPFAR Cameroon will continue strengthening community engagement in health service delivery in recognition of the important role of civil society in holding governments to account for commitments made. Through existing civil society organizations that implement PEPFAR-funded programs as sub-partners and clinical IPs, PEPFAR Cameroon will continue collecting data on client experience accessing HIV services at health facilities, including barriers that could affect health outcomes (e.g. application of user fees, availability of service, quality of service, etc.). PEPFAR Cameroon will also continue supporting the national civil society watchdog, Treatment Access Watch (TAW), to gather data along key indicators that measure access to and quality of services provided at health facilities for both HIV and TB interventions. This data will be collated into scorecards that are disseminated on a weekly basis to support decision-making processes. In addition, PEPFAR Cameroon will use the Ambassador's small grants to reinforce community led monitoring of quality of services, user fee elimination practices and accessibility of services. These grants will ensure monitoring of key elements of access to services by CBOs allowing for a vast triangulation of information that will help NACC and its inspector generals to ensure adequate service delivery within public facilities. Finally, PEPFAR Cameroon will fund the NACC under an existing cooperative agreement with HHS/CDC and the Inspector General for health's office to ensure they can respond to findings from their own site visits and reports/findings from CSOs and Implementing partners.

Supporting the sustainability of user fee elimination on the path toward UHC

To ensure that the elimination of user fees for HIV/AIDS services is sustained and that HIV remains a focus as Cameroon seeks to expand access and move toward universal health coverage (UHC), PEPFAR Cameroon will continue to provide targeted technical assistance to the Ministry of Health in the development of its UHC service package. Key elements of this assistance will include supporting the development of systems for classification and enrollment of patients into potential insurance mechanisms and the application of robust financial and data management systems to ensure timely and accurate reimbursements to health facilities and minimize the risks of fraud and abuse. PEPFAR Cameroon support will also focus on coordinated advocacy, involving the Ministry of Health, the US Embassy, and other bilateral and multilateral donors, to the highest levels of the Government of Cameroon for increased domestic revenue allocations to the health sector to ensure that Cameroon is able to develop and implement a sustainable health financing strategy. This work addresses issues around Policies and Governance (SID 2019 score of 6.18) specifically contributing to the following key systems barriers: user fees charged at health service delivery points impede

ART uptake and retention, and host country government has not developed a long-term financing strategy for HIV/AIDS.

Improving 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 five are ISO 15189 accredited. All laboratories in historic 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. 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.

Improving Strategic Information

SI is critical in determining the effect of health systems strengthening interventions on service delivery targets and overall system goals. Updating regional and district HIV estimates will provide an accurate picture of Cameroon's progress toward HIV Epidemic control. 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 under an existing cooperative agreement with CDC 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 COP20, 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.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR Cameroon team conducted a staffing analysis for COP19 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. There are 55 recorded positions with 44 positions funded under PEPFAR.

CDC

In COP19 planning, CDC Cameroon was guided by S/GAC to expand the clinical program from 56 scale up sites in four regions to 298 scale up sites in ten regions across the entire country. Despite more than a doubling of the program's geographic coverage and oversight responsibilities, no additional staffing was approved in COP19. This staffing level was also maintained in COP20. There are two current vacancies in the process of recruitment in FY20. Compared to other countries, CDC Cameroon has a lower percentage of the budget devoted to CODB. This means current staff are stretched to provide close oversight, site supervision and partner management in order to meet programmatic goals.

In COP20, CDC is approved to continue funding the Global Health Security Agenda (GHSA) Program Director position. This position is under recruitment and it is expected to be filled before the end of FY20.

DOD

DOD program will maintain its footprint in the ten regions and in 21 sites from Cop 19 to COP20. The staffing will remain the same as COP19 levels that is two LES.

Peace Corps

The hiring process is ongoing for two LE Staff approved in Peace Corp's COP 19 CODB. Therefore, Peace Corp will be operating at a full staffing level in COP20. As a result, additional staff won't be requested in COP20.

State

The PEPFAR Coordination Office staffing levels remain constant with one Direct Hire and two LES. CODB remains the same as COP19.

USAID

While USAID's staffing level remains the same, the 22% increase in CODB reflects: (1) fully loaded cost of two USAID LES positions approved in COP19; (2) grade promotions and step increase of current staff; and (3) increased travel budget due to nationwide expansion including travel to geographic areas that require additional coordination with the Regional Security Office.

USAID will repurpose the roles and responsibilities of the existing Program Management Assistant position to support the implementation of its supply chain improvement strategy. Section 5.0 of the SDS proposes private sector solutions to address challenges associated with transporting commodities. USAID will establish direct agreements with three local (two parastatal and one private) structures to outsource transport for distribution of HIV commodities to health facilities and reference laboratories.

USAID will realign the roles and responsibilities of the current Program Management Assistant to address the workload demand of managing three direct partnership agreements. The incumbent's position title has been revised from Program Management Assistant to Private Sector Engagement (PSE) Coordinator in order to reflect the increase in scope. As PSE Coordinator, the incumbent will support USAID's Supply Chain Governance Advisor to maintain effective partnership and communication with local partners including building work plans and evaluating partner performance. The PSE Coordinator will also identify challenges and liaise with existing supply chain field support mechanisms to address capacity building needs of parastatal partners.

APPENDIX A -- PRIORITIZATION

Table A.1. Continuous Nature of SNU Prioritization to Reach Epidemic Control

SNU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Coverage
				Treatment Coverage by APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Abong Mbang	COP19	Scale-up Saturation	APR20	60%	60%	70%	67%	62%	59%	45%	43%	42%	34%	57%	42%	90%	114%	73%	82%	65%	68%	72%	68%	100%	81%	78%	98%	75%
Abong Mbang	COP20	Scale-up Saturation	APR21	80%	80%	90%	86%	86%	82%	82%	76%	77%	74%	80%	73%	90%	114%	86%	88%	86%	84%	90%	85%	100%	91%	91%	98%	89%
Ako	COP19	Scale-up Saturation	APR20	100%	100%	25%	20%	38%	38%	30%	30%	21%	30%	31%	20%	41%	56%	33%	40%	31%	36%	38%	40%	55%	48%	42%	59%	39%
Ako	COP20	Scale-up Saturation	APR21	100%	100%	50%	40%	63%	50%	50%	40%	42%	40%	48%	27%	54%	60%	48%	46%	48%	41%	53%	46%	67%	55%	57%	63%	52%
Akonolinga	COP18	Sustained	APR19			33%	40%	35%	29%	17%	27%	30%	13%	54%	17%	51%	26%	44%	23%	35%	44%	35%	38%	70%	63%	83%	73%	54%
Akonolinga	COP19	Scale-up Saturation	APR20	67%	50%	53%	53%	54%	50%	39%	38%	36%	33%	49%	38%	71%	92%	57%	67%	56%	62%	69%	67%	93%	78%	84%	73%	63%
Akonolinga	COP20	Scale-up Saturation	APR21	100%	75%	73%	73%	77%	75%	69%	68%	63%	64%	69%	63%	82%	92%	75%	78%	76%	77%	84%	81%	93%	87%	76%	85%	79%
Ambam	COP19	Scale-up Saturation	APR20	33%	25%	79%	73%	71%	63%	50%	45%	60%	42%	82%	54%	110%	130%	77%	83%	66%	67%	76%	69%	106%	82%	71%	85%	79%
Ambam	COP20	Scale-up Saturation	APR21	100%	75%	93%	87%	88%	85%	82%	82%	83%	79%	89%	80%	110%	130%	88%	89%	86%	84%	91%	87%	106%	93%	89%	94%	92%
Ayos	COP18	Sustained	APR19		33%	110%	73%	32%	60%	15%	33%	39%	21%	62%	17%	54%	39%	48%	36%	56%	48%	73%	48%	94%	55%	87%	69%	59%
Ayos	COP19	Scale-up Saturation	APR20	100%	67%	80%	73%	74%	70%	54%	52%	51%	39%	68%	50%	99%	125%	81%	92%	80%	85%	99%	94%	134%	108%	78%	101%	88%
Ayos	COP20	Scale-up Saturation	APR21	100%	67%	80%	73%	74%	70%	54%	52%	51%	39%	68%	50%	99%	125%	81%	92%	80%	85%	99%	94%	134%	108%	78%	101%	88%
Bafang	COP19	Scale-up Saturation	APR20	100%	100%	89%	89%	65%	68%	50%	54%	53%	50%	68%	60%	101%	132%	93%	129%	111%	142%	147%	167%	185%	179%	99%	130%	112%
Bafang	COP20	Scale-up Saturation	APR21	100%	100%	89%	89%	65%	68%	50%	54%	53%	50%	68%	60%	101%	132%	93%	129%	111%	142%	147%	167%	185%	179%	99%	130%	112%
Bafia	COP18	Sustained	APR19			76%	61%	74%	30%	24%	32%	37%	11%	48%	11%	62%	25%	66%	38%	66%	47%	77%	63%	85%	65%	121%	85%	69%
Bafia	COP19	Scale-up Saturation	APR20	50%	50%	65%	61%	55%	52%	40%	39%	39%	33%	52%	39%	73%	95%	58%	69%	57%	62%	68%	68%	91%	78%	96%	73%	64%
Bafia	COP20	Scale-up Saturation	APR21	75%	75%	82%	78%	77%	73%	71%	68%	63%	64%	71%	64%	82%	95%	75%	79%	76%	76%	83%	81%	91%	88%	76%	85%	79%
Bafut	COP18	Sustained	APR19			36%	18%	50%	56%	33%	26%	17%	17%	14%	9%	23%	5%	41%	14%	43%	41%	51%	65%	57%	95%	66%	79%	44%
Bafut	COP19	Scale-up Saturation	APR20	100%	67%	55%	55%	56%	56%	42%	43%	39%	35%	48%	38%	65%	91%	54%	66%	53%	60%	65%	66%	93%	82%	70%	100%	65%
Bafut	COP20	Scale-up Saturation	APR21	100%	67%	64%	64%	67%	61%	58%	52%	54%	43%	59%	44%	72%	91%	64%	69%	64%	64%	73%	69%	93%	83%	77%	100%	70%
Bali	COP18	Sustained	APR19			50%	29%	45%	36%	20%	57%	15%	36%	26%	5%	36%	61%	51%	20%	77%	40%	79%	69%	92%	79%	132%	119%	63%
Bali	COP19	Scale-up Saturation	APR20			67%	57%	64%	64%	47%	50%	48%	43%	52%	40%	74%	106%	59%	78%	58%	72%	72%	78%	103%	97%	78%	110%	73%
Bali	COP20	Scale-up Saturation	APR21			83%	71%	73%	73%	60%	57%	63%	50%	64%	45%	79%	106%	67%	80%	67%	74%	78%	80%	103%	97%	83%	110%	78%
Bamenda	COP18	Sustained	APR19	13%	18%	49%	45%	93%	92%	109%	97%	60%	85%	47%	35%	67%	30%	95%	44%	123%	72%	160%	121%	174%	170%	166%	216%	115%
Bamenda	COP19	Scale-up Saturation	APR20	69%	65%	132%	128%	118%	122%	89%	94%	94%	84%	111%	90%	152%	219%	124%	158%	121%	143%	148%	136%	212%	192%	159%	225%	149%
Bamenda	COP20	Scale-up Saturation	APR21	69%	65%	132%	128%	118%	122%	89%	94%	94%	84%	111%	90%	152%	219%	124%	158%	121%	143%	148%	136%	212%	192%	159%	225%	149%
Bandjoun	COP19	Scale-up Saturation	APR20	50%	50%	43%	43%	25%	27%	19%	21%	19%	17%	27%	24%	39%	53%	35%	48%	42%	32%	56%	62%	70%	68%	36%	54%	42%
Bandjoun	COP20	Scale-up Saturation	APR21	100%	50%	86%	43%	69%	27%	67%	21%	64%	17%	64%	24%	68%	53%	66%	48%	71%	32%	80%	62%	87%	68%	70%	54%	64%
Bangangte	COP19	Scale-up Saturation	APR20	100%	100%	89%	89%	65%	68%	50%	54%	51%	48%	65%	55%	97%	144%	90%	122%	108%	135%	143%	159%	179%	174%	96%	145%	108%

NU	COP	Prioritization	Result to Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Cover age
				Treatment Coverage by APR by Age and Sex																								
				<01		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Bangangte	COP20	Scale-up Saturation	APR21	100%	100%	89%	89%	65%	68%	90%	84%	91%	48%	63%	55%	97%	144%	90%	122%	108%	135%	143%	159%	179%	174%	96%	145%	108%
Bangem	COP18	Sustained	APR19									33%		58%	20%	49%	24%	49%	12%	34%	18%	31%	36%	56%	43%	60%	37%	38%
Bangem	COP19	Scale-up Saturation	APR20			33%	33%	75%	60%	60%	90%	33%	17%	42%	30%	61%	76%	49%	30%	40%	39%	42%	38%	80%	46%	56%	71%	49%
Bangem	COP20	Scale-up Saturation	APR21			100%	100%	100%	100%	120%	100%	83%	100%	85%	80%	88%	88%	89%	88%	90%	85%	92%	91%	96%	93%	94%	97%	91%
Bangourain	COP19	Scale-up Saturation	APR20	100%	100%	33%	33%	14%	17%	11%	13%	25%	13%	30%	27%	42%	65%	39%	32%	47%	58%	62%	69%	75%	73%	44%	66%	47%
Bangourain	COP20	Scale-up Saturation	APR21	100%	100%	100%	33%	71%	17%	67%	13%	89%	13%	67%	27%	72%	65%	70%	52%	76%	58%	85%	69%	93%	73%	76%	66%	69%
Bankim	COP19	Scale-up Saturation	APR20	33%	33%	25%	25%	19%	19%	15%	15%	13%	10%	18%	15%	27%	36%	22%	27%	20%	23%	23%	24%	33%	30%	27%	36%	25%
Bankim	COP20	Scale-up Saturation	APR21	67%	67%	75%	67%	71%	71%	74%	67%	66%	66%	67%	63%	70%	70%	70%	66%	72%	66%	75%	69%	78%	71%	75%	75%	70%
Banyo	COP19	Scale-up Saturation	APR20	100%	100%	46%	46%	45%	43%	34%	34%	30%	26%	40%	33%	60%	79%	49%	39%	48%	50%	51%	52%	74%	65%	63%	87%	55%
Banyo	COP20	Scale-up Saturation	APR21	100%	100%	85%	85%	86%	78%	79%	76%	74%	74%	76%	72%	85%	87%	82%	80%	82%	78%	86%	82%	93%	87%	88%	96%	85%
Batiba	COP18	Sustained	APR19			30%	10%		19%	9%		15%	10%	15%		17%	61%	14%	5%	22%	14%	28%	18%	21%	32%	26%	20%	18%
Batiba	COP19	Scale-up Saturation	APR20	100%	100%	70%	70%	76%	86%	99%	62%	58%	52%	67%	57%	93%	131%	76%	96%	74%	86%	89%	93%	128%	117%	96%	136%	91%
Batiba	COP20	Scale-up Saturation	APR21	100%	100%	80%	70%	82%	86%	73%	62%	70%	52%	75%	57%	93%	131%	82%	96%	80%	86%	92%	93%	128%	117%	96%	136%	93%
Batoufari	COP19	Scale-up Saturation	APR20	67%	50%	71%	67%	56%	52%	41%	39%	38%	33%	51%	38%	82%	106%	66%	76%	58%	63%	64%	63%	88%	74%	71%	92%	68%
Batoufari	COP20	Scale-up Saturation	APR21	100%	75%	93%	87%	88%	85%	85%	83%	79%	80%	78%	75%	89%	106%	85%	87%	85%	85%	88%	87%	97%	93%	90%	92%	88%
Bertoua	COP19	Scale-up Saturation	APR20	60%	55%	89%	83%	76%	72%	55%	52%	52%	43%	73%	53%	116%	144%	93%	103%	82%	85%	58%	85%	125%	100%	100%	123%	94%
Bertoua	COP20	Scale-up Saturation	APR21	60%	55%	89%	83%	76%	72%	55%	52%	52%	43%	73%	53%	116%	144%	93%	103%	82%	85%	58%	85%	125%	100%	100%	123%	94%
Betare Oya	COP19	Scale-up Saturation	APR20	33%	25%	29%	27%	22%	26%	21%	19%	17%	13%	22%	15%	36%	46%	29%	33%	26%	27%	28%	27%	39%	32%	31%	39%	30%
Betare Oya	COP20	Scale-up Saturation	APR21	100%	75%	71%	73%	76%	74%	76%	72%	84%	68%	86%	63%	71%	73%	71%	69%	72%	69%	74%	71%	78%	75%	75%	77%	72%
Bibemi	COP19	Scale-up Saturation	APR20	100%	100%	13%	13%	20%	19%	16%	15%	16%	14%	20%	15%	31%	38%	26%	26%	22%	22%	24%	21%	34%	26%	31%	36%	26%
Bibemi	COP20	Scale-up Saturation	APR21	100%	100%	63%	63%	87%	96%	63%	55%	55%	57%	56%	52%	62%	60%	60%	56%	61%	55%	63%	56%	67%	59%	65%	65%	61%
Biyem Assi	COP18	Scale-up Saturation	APR19	30%		56%	42%	90%	77%	71%	65%	55%	60%	67%	45%	122%	54%	138%	60%	120%	69%	110%	93%	111%	103%	132%	147%	106%
Biyem Assi	COP19	Scale-up Saturation	APR20	90%	82%	133%	127%	153%	144%	113%	107%	116%	92%	155%	110%	207%	251%	130%	138%	93%	95%	98%	91%	146%	113%	147%	177%	125%
Biyem Assi	COP20	Scale-up Saturation	APR21	90%	82%	133%	127%	153%	144%	113%	107%	116%	92%	155%	110%	207%	251%	130%	138%	93%	95%	98%	91%	146%	113%	147%	177%	125%
Bogo	COP19	Scale-up Saturation	APR20	100%	100%	80%	80%	60%	60%	46%	46%	42%	43%	63%	44%	103%	131%	92%	109%	89%	97%	99%	97%	140%	121%	115%	143%	97%
Bogo	COP20	Scale-up Saturation	APR21	100%	100%	80%	80%	60%	60%	46%	46%	42%	43%	63%	44%	103%	131%	92%	109%	89%	97%	99%	97%	140%	121%	115%	143%	97%
Bonassama	COP18	Scale-up Saturation	APR19	27%	9%	39%	27%	41%	44%	68%	39%	43%	30%	51%	29%	82%	41%	85%	38%	73%	49%	70%	54%	63%	60%	73%	80%	65%
Bonassama	COP19	Scale-up Saturation	APR20	55%	55%	89%	84%	112%	94%	76%	71%	82%	62%	106%	76%	139%	173%	87%	94%	62%	64%	62%	59%	88%	71%	83%	103%	82%
Bonassama	COP20	Scale-up Saturation	APR21	64%	64%	89%	84%	112%	94%	80%	73%	84%	66%	106%	78%	139%	173%	87%	94%	65%	66%	66%	61%	89%	73%	85%	103%	84%
Bourha	COP19	Scale-up Saturation	APR20			40 0%	40 0%	30 0%	30 0%	20 0%	20 0%	183%	20 0%	273%	20 0%	42 0%	533%	40 61%	423%	382%	378%	433%	378%	591%	48 61%	483%	543%	402%
Bourha	COP20	Scale-up Saturation	APR21			40 0%	40 0%	30 0%	30 0%	20 0%	20 0%	183%	20 0%	273%	20 0%	42 0%	533%	40 61%	423%	382%	378%	433%	378%	591%	48 61%	483%	543%	402%
Buea	COP18	Sustained	APR19	13%	22%	25%	26%	30%	32%	28%	38%	26%	22%	34%	16%	31%	33%	58%	24%	53%	29%	49%	44%	54%	31%	63%	61%	47%
Buea	COP19	Scale-up Saturation	APR20	36%	33%	30%	47%	57%	53%	44%	41%	39%	38%	49%	35%	67%	84%	50%	55%	41%	43%	44%	47%	63%	50%	60%	75%	52%

NU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								
				Treatment Coverage by APR by Age and Sex																								Overall TX Coverage
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Bura	COP20	Scale-up Saturation	APR21	88%	89%	86%	87%	91%	89%	91%	90%	88%	91%	87%	88%	89%	84%	88%	87%	89%	86%	91%	88%	94%	90%	92%	94%	90%
Cité Des Palmiers	COP18	Scale-up Saturation	APR19	10%		34%	32%	43%	36%	39%	37%	30%	37%	37%	21%	60%	27%	65%	27%	47%	33%	53%	44%	57%	49%	67%	86%	52%
Cité Des Palmiers	COP19	Scale-up Saturation	APR20	50%	50%	78%	73%	91%	84%	67%	63%	72%	56%	94%	69%	122%	153%	76%	84%	54%	57%	55%	53%	77%	63%	74%	93%	73%
Cité Des Palmiers	COP20	Scale-up Saturation	APR21	60%	60%	80%	75%	91%	85%	71%	67%	75%	59%	94%	72%	122%	153%	78%	84%	59%	60%	60%	56%	80%	66%	76%	93%	76%
Cité Verte	COP18	Scale-up Saturation	APR19	31%	57%	187%	196%	258%	233%	242%	179%	116%	165%	92%	73%	135%	63%	148%	78%	130%	88%	132%	109%	191%	132%	233%	263%	147%
Cité Verte	COP19	Scale-up Saturation	APR20	108%	100%	189%	176%	224%	208%	168%	155%	159%	133%	210%	155%	281%	357%	176%	198%	127%	157%	134%	131%	200%	167%	200%	257%	180%
Cité Verte	COP20	Scale-up Saturation	APR21	108%	100%	189%	176%	224%	208%	168%	155%	159%	133%	210%	155%	281%	357%	176%	198%	127%	157%	134%	131%	200%	167%	200%	257%	180%
Deido	COP18	Scale-up Saturation	APR19	28%	25%	63%	65%	134%	108%	198%	105%	109%	127%	84%	113%	135%	101%	132%	87%	123%	75%	127%	92%	128%	113%	164%	194%	126%
Deido	COP19	Scale-up Saturation	APR20	100%	92%	182%	172%	214%	197%	199%	149%	167%	133%	220%	199%	288%	356%	178%	195%	126%	133%	127%	121%	179%	146%	171%	212%	170%
Deido	COP20	Scale-up Saturation	APR21	100%	92%	182%	172%	214%	197%	199%	149%	167%	133%	220%	199%	288%	356%	178%	195%	126%	133%	127%	121%	179%	146%	171%	212%	170%
Djohong	COP19	Scale-up Saturation	APR20	100%	100%	50%	50%	55%	55%	43%	43%	34%	27%	43%	33%	65%	88%	54%	67%	49%	58%	30%	112%	82%	75%	71%	93%	61%
Djohong	COP20	Scale-up Saturation	APR21	100%	100%	100%	83%	91%	82%	86%	79%	76%	73%	76%	71%	89%	88%	82%	82%	82%	81%	79%	112%	96%	90%	91%	93%	85%
Djoum	COP19	Scale-up Saturation	APR20	50%	50%	38%	33%	31%	27%	21%	19%	20%	14%	30%	23%	40%	50%	28%	32%	24%	26%	28%	27%	39%	32%	26%	34%	30%
Djoum	COP20	Scale-up Saturation	APR21	100%	100%	75%	78%	77%	80%	79%	81%	71%	76%	75%	73%	79%	78%	76%	74%	78%	74%	80%	76%	84%	80%	79%	80%	78%
Djoungolo	COP18	Scale-up Saturation	APR19	18%	17%	29%	40%	57%	38%	40%	33%	43%	40%	67%	75%	92%	65%	88%	53%	75%	55%	77%	66%	90%	76%	127%	142%	82%
Djoungolo	COP19	Scale-up Saturation	APR20	58%	54%	105%	100%	123%	114%	92%	85%	92%	73%	121%	88%	162%	200%	101%	110%	73%	76%	78%	73%	115%	92%	115%	142%	102%
Djoungolo	COP20	Scale-up Saturation	APR21	58%	54%	105%	100%	123%	114%	92%	85%	92%	73%	121%	88%	162%	200%	101%	110%	73%	76%	78%	73%	115%	92%	115%	142%	102%
Doume	COP19	Scale-up Saturation	APR20	50%	33%	27%	27%	21%	20%	15%	15%	15%	13%	20%	16%	31%	41%	25%	30%	22%	25%	25%	25%	34%	29%	26%	36%	26%
Doume	COP20	Scale-up Saturation	APR21	100%	67%	73%	73%	74%	70%	73%	74%	65%	70%	66%	66%	71%	72%	70%	69%	71%	70%	74%	71%	78%	74%	73%	77%	72%
Dschang	COP19	Scale-up Saturation	APR20	100%	100%	111%	111%	82%	89%	63%	69%	66%	64%	86%	74%	125%	187%	115%	157%	137%	171%	181%	202%	224%	218%	122%	185%	138%
Dschang	COP20	Scale-up Saturation	APR21	100%	100%	111%	111%	82%	89%	63%	69%	66%	64%	86%	74%	125%	187%	115%	157%	137%	171%	181%	202%	224%	218%	122%	185%	138%
Ebolowa	COP19	Scale-up Saturation	APR20	56%	50%	63%	58%	61%	54%	42%	38%	45%	33%	63%	43%	85%	101%	61%	64%	53%	52%	60%	54%	84%	65%	56%	68%	62%
Ebolowa	COP20	Scale-up Saturation	APR21	89%	80%	85%	81%	89%	86%	86%	83%	79%	79%	83%	78%	85%	101%	85%	83%	85%	81%	89%	84%	96%	89%	87%	90%	87%
Edea	COP18	Sustained	APR19	52%	23%	39%	59%	57%	44%	28%	17%	23%	12%	47%	11%	61%	23%	67%	36%	69%	53%	77%	59%	71%	68%	72%	73%	61%
Edea	COP19	Scale-up Saturation	APR20	50%	40%	83%	79%	77%	72%	58%	55%	52%	43%	66%	48%	89%	112%	69%	79%	67%	71%	75%	72%	96%	79%	59%	76%	73%
Edea	COP20	Scale-up Saturation	APR21	75%	60%	89%	84%	80%	75%	65%	60%	58%	50%	70%	52%	89%	112%	73%	80%	71%	73%	79%	74%	96%	81%	64%	78%	76%
Efoulan	COP18	Scale-up Saturation	APR19		15%	46%	26%	27%	21%	16%	8%	16%	5%	49%	14%	66%	30%	56%	31%	40%	28%	30%	25%	29%	24%	38%	33%	35%
Efoulan	COP19	Scale-up Saturation	APR20	23%	23%	44%	42%	50%	46%	37%	35%	39%	31%	50%	36%	67%	83%	42%	46%	30%	31%	32%	30%	47%	38%	47%	59%	42%
Efoulan	COP20	Scale-up Saturation	APR21	54%	54%	67%	65%	73%	69%	68%	64%	66%	63%	71%	64%	80%	89%	67%	67%	62%	60%	63%	60%	72%	65%	71%	76%	67%
Ekondo Titi	COP18	Sustained	APR19			30%	9%	25%	18%	10%	19%	21%	17%	14%	5%	15%	10%	23%	12%	23%	14%	26%	23%	37%	34%	74%	47%	29%
Ekondo Titi	COP19	Scale-up Saturation	APR20	50%	33%	30%	27%	38%	35%	30%	29%	24%	17%	30%	19%	41%	52%	31%	34%	25%	26%	27%	25%	38%	31%	38%	47%	32%
Ekondo Titi	COP20	Scale-up Saturation	APR21	100%	67%	90%	82%	88%	88%	90%	95%	83%	87%	83%	83%	85%	83%	85%	84%	87%	83%	89%	86%	91%	89%	90%	91%	87%

NU	COP	Prioritization	Result to Report	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Cover age
				Treatment Coverage by APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Ezeku	COP18	Sustained	APR19			23%	7%	13%		22%	3%	10%	9%	18%	2%	16%	10%	25%	10%	24%	18%	23%	33%	32%	17%	28%	26%	22%
Ezeku	COP19	Scale-up Saturation	APR20	33%	33%	23%	21%	25%	24%	19%	18%	16%	11%	20%	13%	27%	36%	23%	26%	22%	24%	27%	26%	36%	30%	22%	28%	25%
Ezeku	COP21	Scale-up Saturation	APR21	67%	67%	62%	57%	63%	60%	59%	56%	53%	51%	53%	51%	57%	60%	56%	53%	57%	53%	61%	57%	67%	61%	58%	60%	58%
Figuil	COP19	Scale-up Saturation	APR20	100%	100%	100%	100%	86%	75%	67%	67%	58%	60%	81%	62%	129%	168%	103%	126%	89%	103%	95%	100%	134%	121%	126%	167%	109%
Figuil	COP21	Scale-up Saturation	APR21	100%	100%	100%	100%	86%	75%	67%	67%	58%	60%	81%	62%	129%	168%	103%	126%	89%	103%	95%	100%	134%	121%	126%	167%	109%
Fontem	COP18	Sustained	APR19						20%	9%	8%	8%	8%	10%		6%	5%	7%	4%	10%	10%	12%	10%	14%	32%	13%	20%	11%
Fontem	COP19	Scale-up Saturation	APR20	100%	50%	17%	14%	33%	30%	27%	25%	17%	23%	24%	14%	33%	40%	24%	26%	19%	20%	20%	19%	28%	23%	28%	36%	25%
Fontem	COP21	Scale-up Saturation	APR21	100%	50%	100%	86%	89%	80%	50%	92%	83%	92%	81%	81%	83%	83%	82%	81%	84%	83%	87%	84%	88%	85%	87%	88%	85%
Foumban	COP19	Scale-up Saturation	APR20	80%	80%	77%	77%	58%	62%	45%	49%	46%	44%	61%	51%	89%	132%	82%	112%	98%	124%	130%	147%	162%	158%	88%	133%	99%
Foumban	COP21	Scale-up Saturation	APR21	80%	80%	77%	77%	58%	62%	45%	49%	46%	44%	61%	51%	89%	132%	82%	112%	98%	124%	130%	147%	162%	158%	88%	133%	99%
Foumbot	COP19	Scale-up Saturation	APR20	67%	67%	108%	108%	74%	80%	57%	63%	60%	57%	77%	66%	114%	164%	106%	141%	127%	157%	168%	188%	211%	202%	113%	167%	127%
Foumbot	COP21	Scale-up Saturation	APR21	67%	67%	108%	108%	74%	80%	57%	63%	60%	57%	77%	66%	114%	164%	106%	141%	127%	157%	168%	188%	211%	202%	113%	167%	127%
Fundong	COP18	Sustained	APR19			72%	42%	103%	79%	78%	78%	57%	50%	21%	11%	35%	15%	36%	24%	82%	46%	114%	79%	115%	108%	110%	140%	74%
Fundong	COP19	Scale-up Saturation	APR20	67%	67%	92%	88%	86%	88%	64%	67%	61%	57%	73%	60%	108%	145%	83%	107%	82%	99%	106%	108%	144%	134%	109%	156%	101%
Fundong	COP21	Scale-up Saturation	APR21	67%	67%	92%	88%	86%	88%	64%	67%	61%	57%	73%	60%	108%	145%	83%	107%	82%	99%	106%	108%	144%	134%	109%	156%	101%
Gafim	COP19	Scale-up Saturation	APR20	100%	100%	17%	17%	23%	25%	18%	20%	13%	7%	18%	13%	27%	41%	25%	34%	30%	37%	40%	45%	50%	48%	27%	41%	30%
Gafim	COP21	Scale-up Saturation	APR21	100%	100%	67%	17%	69%	25%	63%	20%	57%	7%	50%	13%	63%	41%	62%	34%	66%	37%	73%	45%	78%	48%	67%	41%	36%
Garoua Boulai	COP19	Scale-up Saturation	APR20	150%	150%	140%	127%	128%	121%	92%	88%	81%	69%	114%	84%	162%	223%	147%	162%	130%	135%	144%	133%	138%	156%	136%	134%	149%
Garoua Boulai	COP21	Scale-up Saturation	APR21	150%	150%	140%	127%	128%	121%	92%	88%	81%	69%	114%	84%	162%	223%	147%	162%	130%	135%	144%	133%	138%	156%	136%	134%	149%
Garoua I	COP19	Scale-up Saturation	APR20	100%	100%	128%	121%	107%	103%	84%	82%	84%	69%	114%	87%	162%	244%	146%	172%	126%	140%	136%	137%	134%	168%	178%	233%	132%
Garoua I	COP21	Scale-up Saturation	APR21	100%	100%	128%	121%	107%	103%	84%	82%	84%	69%	114%	87%	162%	244%	146%	172%	126%	140%	136%	137%	134%	168%	178%	233%	132%
Garoua II	COP19	Scale-up Saturation	APR20	38%	38%	9%	9%	10%	9%	8%	7%	7%	6%	11%	7%	17%	22%	14%	16%	12%	13%	13%	13%	18%	16%	17%	21%	14%
Garoua II	COP21	Scale-up Saturation	APR21	75%	63%	55%	46%	54%	49%	36%	49%	30%	49%	51%	46%	55%	52%	54%	50%	53%	49%	57%	51%	60%	53%	58%	56%	54%
Gaschiga	COP19	Scale-up Saturation	APR20	100%	50%	17%	17%	25%	25%	21%	20%	21%	20%	25%	20%	41%	52%	32%	36%	28%	29%	30%	28%	42%	34%	39%	52%	33%
Gaschiga	COP21	Scale-up Saturation	APR21	100%	50%	67%	67%	67%	67%	64%	60%	59%	60%	60%	55%	67%	72%	64%	62%	63%	60%	65%	59%	71%	64%	70%	74%	65%
Guider	COP19	Scale-up Saturation	APR20	150%	150%	80%	73%	74%	74%	61%	58%	59%	52%	81%	63%	127%	170%	101%	121%	86%	98%	92%	94%	132%	115%	122%	162%	105%
Guider	COP21	Scale-up Saturation	APR21	150%	150%	80%	73%	74%	74%	61%	58%	59%	52%	81%	63%	127%	170%	101%	121%	86%	98%	92%	94%	132%	115%	122%	162%	105%
Hina	COP19	Scale-up Saturation	APR20	200%	200%	133%	133%	100%	100%	75%	75%	73%	75%	107%	73%	176%	225%	157%	175%	153%	159%	169%	159%	244%	194%	196%	233%	164%
Hina	COP21	Scale-up Saturation	APR21	200%	200%	133%	133%	100%	100%	75%	75%	73%	75%	107%	73%	176%	225%	157%	175%	153%	159%	169%	159%	244%	194%	196%	233%	164%
Japoma	COP19	Scale-up Saturation	APR20	25%	20%	18%	13%	12%	11%	9%	8%	10%	8%	13%	8%	18%	22%	11%	12%	8%	8%	8%	8%	11%	9%	11%	14%	11%
Japoma	COP21	Scale-up Saturation	APR21	50%	40%	26%	25%	23%	21%	21%	16%	22%	16%	25%	16%	27%	29%	21%	20%	19%	16%	19%	16%	22%	17%	21%	21%	20%
Kaele	COP19	Scale-up Saturation	APR20	200%	100%	100%	86%	62%	62%	50%	47%	52%	44%	71%	54%	120%	155%	108%	124%	103%	113%	113%	113%	164%	141%	130%	168%	112%
Kaele	COP21	Scale-up Saturation	APR21	200%	100%	100%	86%	62%	62%	50%	47%	52%	44%	71%	54%	120%	155%	108%	124%	103%	113%	113%	113%	164%	141%	130%	168%	112%

NU	COP	Prioritization	Result Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																						Overall TX Coverage
				Treatment Coverage by APR by Age and Sex																						
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Kar Hay	COP19	Scale-up Saturation	APR20	103%	103%	25%	20%	33%	30%	25%	25%	17%	8%	25%	18%	46%	54%	41%	47%	40%	41%	44%	42%	63%	52%	46%	81%	42%
Kar Hay	COP20	Scale-up Saturation	APR21	103%	103%	100%	80%	89%	90%	92%	83%	78%	85%	80%	76%	83%	85%	83%	83%	87%	82%	90%	88%	93%	89%	90%	93%	88%
Kette	COP19	Scale-up Saturation	APR20	103%	103%	20%	20%	38%	33%	27%	25%	25%	23%	33%	24%	58%	69%	46%	49%	40%	41%	44%	40%	60%	47%	47%	60%	45%
Kette	COP20	Scale-up Saturation	APR21	103%	103%	60%	80%	88%	78%	82%	75%	71%	77%	70%	71%	82%	85%	78%	78%	77%	77%	82%	78%	87%	82%	82%	86%	79%
Kolofata	COP19	Scale-up Saturation	APR20	91%	91%	43%	43%	29%	27%	22%	21%	19%	16%	20%	15%	43%	56%	41%	46%	39%	41%	44%	42%	62%	51%	48%	81%	42%
Kolofata	COP20	Scale-up Saturation	APR21	103%	91%	100%	100%	93%	87%	89%	84%	81%	84%	81%	77%	84%	85%	85%	80%	88%	82%	91%	86%	94%	90%	92%	92%	89%
Kousseri	COP19	Scale-up Saturation	APR20	91%	91%	11%	11%	16%	17%	12%	13%	9%	5%	12%	10%	19%	27%	18%	25%	22%	27%	29%	33%	36%	36%	19%	29%	22%
Kousseri	COP20	Scale-up Saturation	APR21	103%	91%	56%	11%	63%	17%	60%	13%	38%	5%	37%	10%	60%	27%	39%	25%	62%	27%	69%	33%	72%	36%	63%	29%	50%
Kousseri	COP19	Scale-up Saturation	APR20	83%	71%	27%	25%	21%	20%	16%	16%	17%	14%	22%	17%	38%	48%	34%	39%	33%	36%	37%	36%	53%	44%	41%	54%	36%
Kousseri	COP20	Scale-up Saturation	APR21	103%	86%	83%	79%	87%	82%	87%	83%	78%	82%	78%	76%	82%	80%	83%	79%	85%	81%	89%	84%	91%	86%	89%	90%	84%
Kribi	COP19	Scale-up Saturation	APR20	60%	60%	81%	74%	77%	69%	54%	49%	38%	42%	80%	55%	106%	126%	74%	80%	64%	65%	73%	67%	101%	80%	68%	82%	76%
Kribi	COP20	Scale-up Saturation	APR21	80%	103%	93%	87%	94%	90%	90%	87%	85%	84%	90%	84%	106%	126%	89%	89%	88%	86%	93%	88%	101%	94%	91%	95%	93%
Kumba	COP18	Sustained	APR19	11%	10%	46%	41%	70%	74%	62%	70%	44%	39%	53%	33%	93%	34%	119%	56%	110%	73%	110%	94%	110%	96%	136%	134%	98%
Kumba	COP19	Scale-up Saturation	APR20	67%	60%	115%	110%	126%	118%	99%	94%	94%	72%	110%	78%	150%	130%	110%	123%	89%	94%	93%	89%	133%	109%	123%	162%	114%
Kumba	COP20	Scale-up Saturation	APR21	67%	60%	115%	110%	126%	118%	99%	94%	94%	72%	110%	78%	150%	130%	110%	123%	89%	94%	93%	89%	133%	109%	123%	162%	114%
Kumba East	COP18	Sustained	APR19			33%	29%	50%	54%	63%	50%	33%	43%	17%	13%	25%	7%	36%	22%	54%	30%	56%	63%	96%	99%	78%	104%	55%
Kumba East	COP19	Scale-up Saturation	APR20	60%	60%	71%	71%	67%	69%	50%	52%	51%	46%	60%	52%	82%	120%	67%	87%	63%	79%	79%	87%	114%	106%	86%	125%	81%
Kumba East	COP20	Scale-up Saturation	APR21	80%	60%	81%	71%	75%	69%	63%	52%	63%	46%	69%	52%	85%	120%	73%	87%	73%	79%	84%	87%	114%	106%	89%	125%	85%
Kumba West	COP18	Sustained	APR19	33%	67%	136%	67%	124%	79%	109%	100%	44%	100%	20%	20%	28%	28%	56%	39%	100%	80%	126%	141%	159%	174%	95%	165%	89%
Kumba West	COP19	Scale-up Saturation	APR20	103%	103%	121%	113%	108%	113%	82%	87%	82%	75%	90%	80%	134%	132%	109%	142%	108%	123%	123%	141%	186%	174%	141%	201%	132%
Kumba West	COP20	Scale-up Saturation	APR21	103%	103%	121%	113%	108%	113%	82%	87%	82%	75%	90%	80%	134%	132%	109%	142%	108%	123%	123%	141%	186%	174%	141%	201%	132%
Lagdo	COP19	Scale-up Saturation	APR20	150%	150%	67%	60%	59%	59%	48%	45%	42%	35%	62%	47%	97%	125%	78%	90%	68%	74%	72%	71%	103%	88%	95%	127%	81%
Lagdo	COP20	Scale-up Saturation	APR21	150%	150%	89%	70%	82%	76%	86%	64%	70%	57%	78%	63%	97%	125%	88%	90%	83%	82%	87%	80%	103%	92%	95%	127%	90%
Limbe	COP18	Sustained	APR19		22%	20%	31%	54%	38%	56%	54%	33%	53%	39%	20%	68%	37%	83%	41%	77%	53%	89%	63%	86%	74%	106%	113%	73%
Limbe	COP19	Scale-up Saturation	APR20	63%	56%	89%	84%	92%	87%	73%	68%	68%	56%	82%	58%	113%	141%	84%	92%	69%	71%	73%	68%	105%	84%	100%	124%	88%
Limbe	COP20	Scale-up Saturation	APR21	88%	56%	89%	84%	92%	87%	94%	68%	90%	56%	92%	58%	113%	141%	93%	92%	90%	71%	94%	68%	105%	84%	100%	124%	94%
Logbaba	COP18	Scale-up Saturation	APR19	68%		50%	42%	28%	37%	12%	15%	20%	9%	62%	13%	103%	24%	50%	43%	58%	28%	59%	32%	28%	22%	36%	38%	43%
Logbaba	COP19	Scale-up Saturation	APR20	33%	33%	56%	54%	66%	60%	49%	45%	31%	39%	67%	48%	87%	110%	54%	60%	39%	41%	39%	37%	55%	45%	52%	66%	52%
Logbaba	COP20	Scale-up Saturation	APR21	90%	90%	63%	56%	72%	66%	56%	51%	58%	46%	71%	52%	87%	110%	59%	63%	46%	46%	46%	43%	60%	50%	56%	69%	57%
Lolodorf	COP19	Scale-up Saturation	APR20			20%	20%	38%	33%	25%	23%	29%	23%	34%	25%	47%	59%	33%	37%	28%	30%	32%	31%	44%	37%	31%	38%	34%
Lolodorf	COP20	Scale-up Saturation	APR21			80%	80%	88%	89%	83%	83%	76%	83%	76%	75%	79%	83%	77%	78%	78%	75%	81%	78%	83%	83%	81%	84%	80%
Lomie	COP19	Scale-up Saturation	APR20			67%	67%	60%	60%	46%	43%	38%	40%	55%	40%	82%	117%	66%	79%	58%	67%	64%	67%	88%	79%	72%	92%	69%
Lomie	COP20	Scale-up Saturation	APR21			83%	83%	80%	90%	85%	79%	72%	80%	78%	75%	88%	117%	83%	88%	83%	84%	86%	86%	94%	93%	88%	92%	88%

NU	CDP	Prioritization	Result to Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Coverage
				Treatment Coverage by APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Loum	CDP19	Scale-up Saturation	APR20	100%	100%	75%	60%	43%	36%	33%	30%	39%	30%	45%	29%	60%	77%	46%	53%	44%	47%	49%	48%	62%	53%	39%	30%	48%
Loum	CDP20	Scale-up Saturation	APR21	100%	100%	100%	80%	57%	50%	44%	40%	50%	40%	53%	36%	65%	82%	52%	58%	51%	51%	55%	52%	67%	56%	46%	55%	55%
Makk	CDP19	Scale-up Saturation	APR20	67%	67%	23%	23%	24%	22%	19%	18%	15%	11%	29%	15%	33%	46%	29%	37%	28%	33%	31%	33%	45%	41%	30%	46%	32%
Makk	CDP20	Scale-up Saturation	APR21	100%	100%	85%	85%	88%	82%	88%	85%	79%	85%	79%	77%	82%	80%	83%	79%	85%	82%	89%	85%	91%	86%	89%	88%	85%
Mago	CDP19	Scale-up Saturation	APR20	100%	100%	11%	11%	17%	16%	14%	13%	13%	12%	15%	12%	27%	33%	24%	26%	23%	23%	26%	23%	37%	29%	28%	36%	25%
Mago	CDP20	Scale-up Saturation	APR21	100%	100%	78%	78%	83%	79%	91%	83%	74%	80%	76%	73%	79%	76%	80%	76%	83%	78%	86%	80%	88%	83%	86%	86%	81%
Malantouan	CDP19	Scale-up Saturation	APR20	100%	100%	36%	36%	30%	33%	23%	26%	26%	27%	38%	28%	31%	72%	48%	64%	37%	71%	75%	85%	93%	90%	31%	75%	57%
Malantouan	CDP20	Scale-up Saturation	APR21	100%	100%	73%	36%	70%	33%	67%	26%	63%	27%	66%	28%	73%	72%	72%	64%	78%	71%	89%	85%	93%	90%	77%	75%	71%
Manfe	CDP18	Sustained	APR19			33%	40%	69%	29%	19%	35%	23%	32%	40%	37%	31%	24%	69%	25%	61%	48%	85%	74%	97%	89%	190%	178%	82%
Manfe	CDP19	Scale-up Saturation	APR20	91%	91%	122%	110%	131%	121%	106%	100%	91%	79%	110%	80%	131%	134%	113%	129%	91%	99%	97%	95%	138%	117%	132%	172%	113%
Manfe	CDP20	Scale-up Saturation	APR21	91%	91%	122%	110%	131%	121%	106%	100%	91%	79%	110%	80%	131%	134%	113%	129%	91%	99%	97%	95%	138%	117%	132%	172%	113%
Manjo	CDP19	Scale-up Saturation	APR20			33%	33%	20%	20%	14%	14%	23%	14%	25%	27%	37%	42%	28%	30%	27%	27%	30%	27%	38%	30%	24%	33%	29%
Manjo	CDP20	Scale-up Saturation	APR21			67%	67%	40%	40%	29%	29%	38%	29%	36%	36%	46%	47%	36%	37%	36%	33%	39%	33%	47%	37%	33%	41%	38%
Marwa 1	CDP19	Scale-up Saturation	APR20	60%	60%	30%	29%	24%	23%	19%	19%	17%	14%	24%	17%	42%	50%	38%	42%	37%	38%	41%	38%	59%	47%	46%	56%	39%
Marwa 1	CDP20	Scale-up Saturation	APR21	80%	80%	80%	76%	85%	82%	88%	83%	77%	82%	77%	75%	82%	80%	82%	79%	85%	82%	88%	84%	91%	87%	88%	90%	84%
Marwa 2	CDP19	Scale-up Saturation	APR20	167%	167%	207%	193%	157%	147%	122%	119%	112%	103%	153%	111%	258%	333%	235%	277%	227%	250%	253%	252%	361%	311%	228%	377%	247%
Marwa 2	CDP20	Scale-up Saturation	APR21	167%	167%	207%	193%	157%	147%	122%	119%	112%	103%	153%	111%	258%	333%	235%	277%	227%	250%	253%	252%	361%	311%	228%	377%	247%
Marwa 3	CDP19	Scale-up Saturation	APR20	100%	67%			5%	4%	4%	4%	2%	3%	6%	3%	9%	11%	8%	9%	8%	8%	9%	8%	13%	10%	10%	12%	8%
Marwa 3	CDP20	Scale-up Saturation	APR21	100%	67%			86%	74%	83%	82%	74%	77%	74%	73%	76%	70%	77%	71%	80%	73%	83%	78%	83%	77%	83%	79%	77%
Massangam	CDP19	Scale-up Saturation	APR20			90%	90%	75%	75%	90%	80%	80%	80%	70%	57%	100%	130%	94%	115%	111%	125%	148%	130%	182%	167%	98%	130%	111%
Massangam	CDP20	Scale-up Saturation	APR21			90%	90%	75%	75%	90%	80%	80%	80%	70%	57%	100%	130%	94%	115%	111%	125%	148%	130%	182%	167%	98%	130%	111%
Mayo Oulo	CDP19	Scale-up Saturation	APR20	100%	100%	25%	25%	38%	38%	33%	30%	30%	30%	45%	29%	71%	90%	58%	69%	51%	57%	54%	56%	78%	69%	72%	92%	60%
Mayo Oulo	CDP20	Scale-up Saturation	APR21	100%	100%	75%	75%	75%	75%	89%	70%	70%	80%	74%	64%	87%	95%	82%	86%	80%	80%	83%	81%	96%	90%	91%	103%	84%
Mbalmayo	CDP18	Sustained	APR19	90%	90%	54%	46%	33%	33%	18%	16%	28%	10%	59%	12%	59%	34%	71%	42%	73%	50%	73%	67%	76%	63%	82%	79%	63%
Mbalmayo	CDP19	Scale-up Saturation	APR20	90%	90%	54%	50%	46%	45%	35%	34%	34%	29%	46%	34%	66%	83%	54%	61%	53%	56%	65%	61%	87%	71%	91%	66%	58%
Mbalmayo	CDP20	Scale-up Saturation	APR21	67%	83%	73%	68%	73%	69%	66%	63%	62%	82%	67%	61%	78%	83%	72%	74%	73%	72%	82%	77%	93%	83%	73%	82%	75%
Mbang	CDP19	Scale-up Saturation	APR20			17%	14%	27%	25%	19%	18%	12%	17%	21%	13%	32%	39%	26%	28%	23%	23%	26%	23%	35%	27%	29%	36%	26%
Mbang	CDP20	Scale-up Saturation	APR21			83%	71%	82%	75%	75%	71%	69%	72%	65%	67%	71%	69%	69%	70%	71%	68%	73%	70%	77%	73%	73%	76%	72%
Mbango	CDP19	Scale-up Saturation	APR20	50%	33%	50%	27%	18%	17%	14%	13%	16%	12%	18%	11%	25%	31%	20%	22%	19%	20%	21%	20%	27%	22%	17%	21%	21%
Mbango	CDP20	Scale-up Saturation	APR21	100%	67%	40%	36%	23%	22%	27%	21%	27%	20%	28%	19%	33%	38%	29%	29%	28%	27%	31%	27%	37%	29%	27%	28%	29%
Mbangue	CDP18	Scale-up Saturation	APR19	11%	13%	13%	17%	16%	25%	24%	11%	18%	11%	41%	23%	70%	28%	58%	23%	42%	32%	28%	33%	38%	25%	36%	37%	37%
Mbangue	CDP19	Scale-up Saturation	APR20	57%	57%	75%	70%	82%	76%	68%	57%	59%	50%	79%	60%	104%	131%	84%	72%	46%	49%	46%	45%	64%	54%	62%	80%	62%
Mbangue	CDP20	Scale-up Saturation	APR21	71%	71%	79%	73%	84%	78%	67%	61%	63%	56%	80%	64%	104%	131%	88%	74%	52%	53%	52%	49%	69%	58%	66%	82%	66%

NU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Cover 09e
				Treatment Coverage by APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Mbengwi	COP18	Sustained	APR19			25%		54%	92%	44%	38%	26%	29%	20%		24%	27%	37%	22%	36%	25%	30%	37%	77%	71%	93%	89%	49%
Mbengwi	COP19	Scale-up Saturation	APR20	90%	90%	38%	38%	46%	46%	33%	38%	32%	24%	38%	29%	90%	76%	40%	53%	39%	48%	48%	53%	69%	65%	54%	74%	50%
Mbengwi	COP20	Scale-up Saturation	APR21	100%	100%	90%	90%	62%	54%	90%	41%	50%	35%	54%	38%	66%	78%	54%	57%	53%	53%	60%	56%	77%	69%	65%	76%	60%
Mbouda	COP19	Scale-up Saturation	APR20	80%	80%	74%	74%	55%	56%	42%	46%	46%	43%	38%	48%	85%	125%	78%	106%	94%	117%	125%	139%	253%	148%	83%	126%	94%
Mbouda	COP20	Scale-up Saturation	APR21	80%	80%	84%	74%	74%	98%	65%	46%	66%	43%	72%	48%	89%	125%	85%	106%	94%	117%	125%	139%	253%	148%	90%	126%	98%
Meiganga	COP19	Scale-up Saturation	APR20	43%	43%	34%	32%	31%	30%	24%	24%	21%	18%	28%	21%	44%	56%	36%	41%	33%	36%	39%	38%	56%	47%	48%	61%	40%
Meiganga	COP20	Scale-up Saturation	APR21	86%	71%	76%	68%	78%	71%	76%	70%	66%	67%	68%	63%	75%	74%	73%	70%	75%	70%	76%	72%	84%	77%	82%	84%	73%
Melong	COP19	Scale-up Saturation	APR20	100%	100%	20%	20%	38%	38%	30%	27%	30%	27%	33%	25%	43%	54%	33%	37%	31%	32%	35%	33%	44%	36%	28%	37%	33%
Melong	COP20	Scale-up Saturation	APR21	100%	100%	40%	40%	50%	50%	40%	36%	40%	36%	42%	38%	50%	61%	41%	44%	40%	38%	44%	39%	51%	43%	37%	43%	43%
Messamena	COP19	Scale-up Saturation	APR20			90%	90%	36%	36%	27%	27%	25%	24%	33%	32%	80%	82%	49%	53%	44%	49%	49%	49%	68%	57%	53%	70%	50%
Messamena	COP20	Scale-up Saturation	APR21			83%	83%	82%	82%	80%	80%	69%	76%	74%	73%	83%	88%	79%	83%	80%	80%	82%	82%	90%	85%	84%	90%	82%
Meyomessala	COP19	Scale-up Saturation	APR20			43%	42%	42%	38%	30%	27%	28%	17%	40%	28%	53%	63%	39%	39%	33%	32%	36%	33%	53%	40%	36%	43%	39%
Meyomessala	COP20	Scale-up Saturation	APR21			82%	83%	84%	82%	82%	80%	76%	80%	77%	78%	82%	83%	79%	77%	80%	78%	83%	79%	87%	83%	82%	84%	81%
Mfou	COP18	Sustained	APR19					14%	10%	10%	4%	10%	4%	19%	11%	26%	14%	38%	24%	41%	29%	48%	38%	59%	42%	55%	39%	35%
Mfou	COP19	Scale-up Saturation	APR20	40%	40%	40%	38%	35%	33%	27%	25%	26%	21%	32%	24%	47%	59%	38%	44%	36%	40%	46%	44%	62%	51%	56%	47%	41%
Mfou	COP20	Scale-up Saturation	APR21	60%	60%	63%	62%	63%	62%	62%	56%	56%	57%	59%	54%	67%	73%	63%	64%	64%	63%	70%	66%	79%	71%	63%	69%	66%
Mfou	COP21	Scale-up Saturation	APR22	113%	113%	133%	133%	103%	111%	79%	87%	85%	78%	110%	93%	136%	238%	146%	101%	174%	221%	230%	263%	287%	281%	196%	236%	176%
Mfou	COP22	Scale-up Saturation	APR23	113%	113%	133%	133%	103%	111%	79%	87%	85%	78%	110%	93%	136%	238%	146%	101%	174%	221%	230%	263%	287%	281%	196%	236%	176%
Makolo	COP19	Scale-up Saturation	APR20	20 0%	20 0%	136%	136%	113%	113%	90%	86%	88%	82%	122%	89%	20 4%	263%	283%	202%	176%	193%	194%	193%	278%	233%	209%	287%	131%
Makolo	COP20	Scale-up Saturation	APR21	20 0%	20 0%	136%	136%	113%	113%	90%	86%	88%	82%	122%	89%	20 4%	263%	283%	202%	176%	193%	194%	193%	278%	233%	209%	287%	131%
Makoumdou	COP19	Scale-up Saturation	APR20	90%	90%	14%	14%	25%	23%	18%	17%	11%	16%	19%	12%	29%	37%	23%	28%	20%	22%	22%	22%	31%	25%	25%	33%	24%
Makoumdou	COP20	Scale-up Saturation	APR21	100%	90%	71%	71%	75%	77%	76%	72%	64%	74%	67%	64%	70%	71%	69%	69%	70%	68%	73%	71%	76%	73%	73%	76%	71%
Manatele	COP18	Sustained	APR19			100%		100%		90%	31%	50%		33%	24%	37%	14%	37%	29%	69%	29%	49%	44%	49%	50%	102%	65%	50%
Manatele	COP19	Scale-up Saturation	APR20	100%	100%	80%	80%	44%	40%	33%	31%	38%	31%	50%	38%	70%	86%	55%	66%	54%	60%	63%	66%	86%	75%	90%	67%	60%
Manatele	COP20	Scale-up Saturation	APR21	100%	100%	80%	80%	78%	70%	67%	62%	65%	62%	70%	63%	86%	86%	73%	78%	74%	76%	86%	80%	93%	86%	73%	82%	77%
Mara	COP19	Scale-up Saturation	APR20	133%	100%	27%	25%	23%	22%	18%	18%	18%	15%	25%	18%	41%	53%	37%	43%	36%	39%	40%	39%	57%	48%	45%	58%	39%
Mara	COP20	Scale-up Saturation	APR21	133%	100%	87%	86%	87%	86%	89%	83%	78%	83%	78%	76%	83%	86%	84%	82%	86%	82%	90%	86%	92%	89%	90%	91%	85%
Mouhvoudaye	COP19	Scale-up Saturation	APR20	20 0%	20 0%	25%	20%	11%	10%	8%	8%	13%	8%	16%	6%	29%	33%	26%	27%	25%	24%	28%	24%	40%	30%	32%	37%	26%
Mouhvoudaye	COP20	Scale-up Saturation	APR21	20 0%	20 0%	100%	80%	89%	80%	83%	83%	75%	83%	73%	71%	78%	73%	80%	77%	82%	76%	83%	82%	86%	82%	83%	83%	81%
Mayuku	COP18	Sustained	APR19	25%		13%	6%	21%	31%	23%	12%	14%	17%	21%	6%	26%	12%	34%	17%	33%	22%	39%	25%	34%	30%	62%	40%	32%
Mayuku	COP19	Scale-up Saturation	APR20	90%	90%	38%	35%	42%	38%	32%	30%	27%	23%	33%	24%	46%	58%	34%	38%	28%	29%	29%	28%	42%	34%	41%	52%	36%
Mayuku	COP20	Scale-up Saturation	APR21	75%	100%	88%	88%	88%	88%	90%	88%	84%	89%	84%	83%	85%	86%	85%	82%	87%	83%	89%	85%	90%	86%	89%	90%	87%
Mvangan	COP19	Scale-up Saturation	APR20					13%	11%	8%	8%	5%	8%	15%	6%	20%	21%	14%	13%	6%	23%	14%	11%	19%	13%	13%	14%	13%

NU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																						Overall TX Cover age
				Treatment Coverage by APR by Age and Sex																						
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Mvangan	COP21	Scale-up Saturation	APR21					88 %	78 %	73 %	77 %	78 %	77 %	72 %	73 %	73 %	71 %	73 %	71 %	72 %	73 %	76 %	74 %	78 %	78 %	76 %	76 %	74%
Nanga Eboko	COP18	Sustained	APR19			63 %	78 %	67 %	88 %	25 %	33 %	33 %	33 %	53 %	24 %	67 %	31 %	63 %	42 %	59 %	47 %	89 %	43 %	86 %	71 %	102 %	103 %	69%
Nanga Eboko	COP19	Scale-up Saturation	APR20	100 %	100 %	88 %	78 %	67 %	63 %	90 %	48 %	51 %	48 %	86 %	48 %	94 %	121 %	73 %	88 %	73 %	82 %	89 %	88 %	119 %	102 %	71 %	97 %	82%
Nanga Eboko	COP21	Scale-up Saturation	APR21	100 %	100 %	100 %	89 %	80 %	75 %	73 %	71 %	72 %	71 %	77 %	66 %	94 %	121 %	83 %	88 %	83 %	86 %	89 %	93 %	119 %	102 %	84 %	97 %	89%
Ndelele	COP19	Scale-up Saturation	APR20	90 %	90 %	38 %	38 %	29 %	27 %	20 %	19 %	29 %	17 %	29 %	20 %	45 %	56 %	36 %	39 %	32 %	32 %	33 %	32 %	46 %	36 %	36 %	47 %	36%
Ndelele	COP21	Scale-up Saturation	APR21	100 %	100 %	88 %	88 %	79 %	73 %	80 %	76 %	67 %	74 %	70 %	67 %	75 %	80 %	74 %	73 %	75 %	73 %	76 %	75 %	83 %	76 %	78 %	82 %	76%
Ndikiri mobi	COP18	Sustained	APR19			14 %		50 %	50 %	22 %	21 %	17 %	10 %	30 %		32 %	37%	41 %	27 %	48 %	60 %	49 %	44 %	71 %	55 %	63 %	48 %	44%
Ndikiri mobi	COP19	Scale-up Saturation	APR20	90 %	90 %	57 %	50 %	43 %	43 %	33 %	32 %	31 %	30 %	42 %	30 %	59 %	76 %	46 %	58 %	47 %	51 %	57 %	56 %	78 %	64 %	47 %	59 %	52%
Ndikiri mobi	COP21	Scale-up Saturation	APR21	100 %	100 %	86 %	75 %	71 %	71 %	67 %	63 %	58 %	63 %	63 %	56 %	74 %	82 %	69 %	71 %	70 %	70 %	77 %	74 %	88 %	79 %	71 %	77 %	73%
Ndip	COP18	Sustained	APR19	11%	11%	53 %	38 %	51 %	52 %	38 %	54 %	28 %	25 %	32 %	8%	36 %	20 %	51 %	26 %	57 %	34 %	52 %	48 %	54 %	46 %	62 %	48 %	46%
Ndip	COP19	Scale-up Saturation	APR20	33 %	33 %	53 %	51 %	46 %	48 %	35 %	37 %	37 %	34 %	46 %	36 %	62 %	88 %	50 %	63 %	49 %	57 %	59 %	62 %	85 %	76 %	64 %	89 %	60%
Ndip	COP21	Scale-up Saturation	APR21	96 %	44 %	63 %	56 %	60 %	52 %	52 %	43 %	54 %	41 %	59 %	42 %	70 %	88 %	62 %	66 %	62 %	60 %	69 %	65 %	89 %	78 %	73 %	90 %	68%
Ndu	COP18	Sustained	APR19	25 %	25 %	42 %	58 %	100 %	50 %	44 %	41 %	24 %	29 %	12 %	8%	26 %	15 %	48 %	20 %	56 %	39 %	63 %	60 %	71 %	62 %	56 %	69 %	47%
Ndu	COP19	Scale-up Saturation	APR20	50 %	50 %	53 %	53 %	45 %	47 %	35 %	37 %	35 %	32 %	42 %	33 %	57 %	82 %	46 %	61 %	46 %	55 %	56 %	62 %	82 %	75 %	62 %	82 %	57%
Ndu	COP21	Scale-up Saturation	APR21	75 %	75 %	63 %	56 %	61 %	53 %	53 %	44 %	51 %	39 %	55 %	42 %	66 %	84 %	59 %	63 %	59 %	59 %	67 %	65 %	86 %	76 %	71 %	89 %	66%
New Bell	COP18	Scale-up Saturation	APR19	9%	17 %	49 %	28 %	74 %	55 %	55 %	56 %	63 %	51 %	79 %	52 %	190 %	57 %	145 %	73 %	116 %	83 %	90 %	91 %	133 %	76 %	97 %	100 %	98%
New Bell	COP19	Scale-up Saturation	APR20	50 %	83 %	140 %	132 %	169 %	157 %	127 %	118 %	128 %	106 %	164 %	125 %	215 %	282 %	159 %	156 %	96 %	107 %	97 %	98 %	137 %	118 %	123 %	173 %	130%
New Bell	COP21	Scale-up Saturation	APR21	50 %	83 %	140 %	132 %	169 %	157 %	127 %	118 %	128 %	106 %	164 %	125 %	215 %	282 %	159 %	156 %	96 %	107 %	97 %	98 %	137 %	118 %	123 %	173 %	130%
Ngaoundal	COP19	Scale-up Saturation	APR20	90 %	90 %	38 %	33 %	26 %	25 %	20 %	20 %	18 %	16 %	25 %	19 %	30 %	53 %	33 %	39 %	30 %	33 %	33 %	35 %	51 %	44 %	43 %	57 %	36%
Ngaoundal	COP21	Scale-up Saturation	APR21	100 %	100 %	76 %	72 %	74 %	69 %	75 %	70 %	69 %	67 %	69 %	64 %	75 %	76 %	73 %	71 %	75 %	69 %	78 %	72 %	83 %	77 %	80 %	83 %	75%
Ngaoundere Rural	COP19	Scale-up Saturation	APR20	75 %	75 %	18 %	17 %	13 %	13 %	10 %	10 %	9%	9%	14 %	11%	22 %	29 %	18 %	21 %	16 %	18 %	18 %	19 %	27 %	23 %	23 %	31 %	20%
Ngaoundere Rural	COP21	Scale-up Saturation	APR21	100 %	100 %	71 %	67 %	74 %	66 %	73 %	66 %	63 %	66 %	65 %	60 %	89 %	86 %	68 %	63 %	70 %	64 %	73 %	66 %	75 %	69 %	74 %	73 %	69%
Ngaoundere Urbain	COP19	Scale-up Saturation	APR20	67 %	67 %	98 %	94 %	89 %	87 %	70 %	69 %	62 %	55 %	81 %	64 %	125 %	169 %	112 %	123 %	94 %	106 %	108 %	110 %	156 %	136 %	132 %	182 %	114%
Ngaoundere Urbain	COP21	Scale-up Saturation	APR21	67 %	67 %	98 %	94 %	89 %	87 %	70 %	69 %	62 %	55 %	81 %	64 %	125 %	169 %	112 %	123 %	94 %	106 %	108 %	110 %	156 %	136 %	132 %	182 %	114%
Ngog Mapubi	COP18	Sustained	APR19			20 %	20 %	16%	16%		4%	4%		22 %	5%	15 %	11%	15 %	16%	19 %	21 %	21 %	19 %	27 %	15 %	24 %	19 %	17%
Ngog Mapubi	COP19	Scale-up Saturation	APR20	50 %	50 %	10 %	10 %	18 %	17 %	13 %	12 %	13 %	12 %	15 %	12 %	22 %	27 %	18 %	22 %	18 %	20 %	21 %	22 %	29 %	25 %	17 %	22 %	20%
Ngog Mapubi	COP21	Scale-up Saturation	APR21	100 %	100 %	50 %	50 %	59 %	56 %	54 %	52 %	53 %	52 %	52 %	52 %	55 %	55 %	54 %	53 %	55 %	53 %	56 %	55 %	62 %	56 %	55 %	57 %	55%
Ngong	COP19	Scale-up Saturation	APR20	100 %	100 %	50 %	46 %	43 %	42 %	34 %	34 %	31 %	26 %	44 %	33 %	72 %	93 %	57 %	67 %	49 %	54 %	52 %	53 %	74 %	64 %	69 %	92 %	59%
Ngong	COP21	Scale-up Saturation	APR21	100 %	100 %	83 %	69 %	74 %	71 %	69 %	69 %	64 %	65 %	68 %	65 %	83 %	93 %	76 %	80 %	74 %	73 %	77 %	75 %	87 %	82 %	84 %	92 %	78%
Nguamou	COP18	Sustained	APR19			22 %	33 %	63 %	56 %	52 %	52 %	20 %	13 %	30 %	27 %	49 %	22 %	63 %	24 %	54 %	50 %	84 %	52 %	89 %	63 %	112 %	86 %	64%
Nguamou	COP19	Scale-up Saturation	APR20	100 %	100 %	89 %	89 %	81 %	81 %	62 %	59 %	59 %	48 %	77 %	60 %	114 %	143 %	92 %	107 %	90 %	99 %	111 %	109 %	131 %	125 %	87 %	116 %	100%
Nguamou	COP21	Scale-up Saturation	APR21	100 %	100 %	89 %	89 %	81 %	81 %	62 %	59 %	59 %	48 %	77 %	60 %	114 %	143 %	92 %	107 %	90 %	99 %	111 %	109 %	131 %	125 %	87 %	116 %	100%

MU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Coverage
				Treatment Coverage by APR by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Nyankumaouke	COP19	Scale-up Saturation	APR20			27 %	25 %	19 %	18 %	14 %	13 %	14 %	12 %	21 %	14 %	33 %	40 %	27 %	28 %	24 %	24 %	27 %	24 %	38 %	29 %	29 %	36 %	27%
Nyankumaouke	COP20	Scale-up Saturation	APR21			73 %	78 %	76 %	73 %	72 %	71 %	66 %	70 %	67 %	64 %	72 %	73 %	70 %	69 %	72 %	69 %	75 %	71 %	79 %	74 %	74 %	77 %	72%
Nyarri	COP18	Sustained	APR19			60 %	20 %	85 %	43 %	63 %	33 %	17 %	10 %	20 %	18%	19 %	41%	35 %	15 %	30 %	18 %	38 %	31 %	58 %	30 %	74 %	57 %	37%
Nyarri	COP19	Scale-up Saturation	APR20			60 %	60 %	67 %	57 %	50 %	44 %	39 %	30 %	30 %	40 %	70 %	92 %	52 %	59 %	42 %	46 %	44 %	44 %	64 %	55 %	58 %	77 %	54%
Nyarri	COP20	Scale-up Saturation	APR21			80 %	80 %	100 %	100 %	100 %	100 %	83 %	90 %	85 %	87 %	89 %	92 %	88 %	85 %	89 %	84 %	91 %	88 %	96 %	90 %	92 %	94 %	90%
Njombe Penja	COP18	Sustained	APR19	100 %		200 %	150 %	133 %	91 %	113 %	163 %	73 %	125 %	47 %	56 %	106 %	29 %	183 %	103 %	258 %	166 %	287 %	206 %	353 %	472 %	297 %	24 8%	220%
Njombe Penja	COP19	Scale-up Saturation	APR20	20 0%	20 0%	275 %	275 %	91 0%	91 0%	225 %	225 %	227 %	188 %	27 8%	20 0%	361 %	479 %	274 %	326 %	259 %	289 %	29 0%	289 %	372 %	316 %	232 %	30 0%	290%
Njombe Penja	COP20	Scale-up Saturation	APR21	20 0%	20 0%	275 %	275 %	91 0%	91 0%	225 %	225 %	227 %	188 %	27 8%	20 0%	361 %	479 %	274 %	326 %	259 %	289 %	29 0%	289 %	372 %	316 %	232 %	30 0%	290%
Nkambe	COP18	Sustained	APR19		17 %	75 %	64 %	79 %	68 %	61 %	57 %	38 %	26 %	33 %	11%	93 %	24 %	58 %	26 %	60 %	40 %	64 %	62 %	74 %	64 %	66 %	61 %	54%
Nkambe	COP19	Scale-up Saturation	APR20	33 %	33 %	84 %	82 %	48 %	49 %	56 %	56 %	38 %	33 %	42 %	38 %	59 %	85 %	49 %	63 %	48 %	58 %	59 %	64 %	84 %	79 %	63 %	92 %	59%
Nkambe	COP20	Scale-up Saturation	APR21	50 %	50 %	67 %	56 %	62 %	59 %	52 %	43 %	51 %	41 %	33 %	41 %	68 %	85 %	60 %	66 %	60 %	61 %	69 %	67 %	88 %	81 %	72 %	92 %	67%
Nkalbissan	COP19	Scale-up Saturation	APR20	20 %	17 %	13 %	13 %	13 %	12 %	10 %	9%	8%	7%	11%	6%	14 %	18 %	9%	10 %	7%	7%	7%	7%	11%	9%	10 %	13 %	9%
Nkalbissan	COP20	Scale-up Saturation	APR21	60 %	50 %	52 %	50 %	55 %	53 %	55 %	51 %	48 %	50 %	49 %	46 %	51 %	51 %	50 %	48 %	50 %	47 %	51 %	48 %	53 %	49 %	52 %	52 %	50%
Nkolndongo	COP18	Scale-up Saturation	APR19		7%	21 %	17 %	22 %	14 %	13 %	9%	18 %	7%	39 %	19 %	56 %	25 %	43 %	24 %	28 %	20 %	21 %	19 %	19 %	16 %	20 %	23 %	26%
Nkolndongo	COP19	Scale-up Saturation	APR20	30 %	28 %	30 %	29 %	34 %	32 %	25 %	24 %	24 %	20 %	32 %	25 %	43 %	54 %	27 %	30 %	20 %	21 %	21 %	20 %	31 %	25 %	31 %	39 %	28%
Nkolndongo	COP20	Scale-up Saturation	APR21	59 %	55 %	59 %	57 %	64 %	62 %	61 %	58 %	56 %	56 %	61 %	55 %	66 %	70 %	58 %	58 %	56 %	53 %	57 %	54 %	62 %	57 %	62 %	65 %	59%
Nkongsamba	COP18	Sustained	APR19		100 %	133 %	91 %	80 %	91 %	70 %	43 %	25 %	55 %	42 %	13 %	46 %	23 %	47 %	17 %	100 %	44 %	120 %	76 %	146 %	94 %	149 %	121 %	88%
Nkongsamba	COP19	Scale-up Saturation	APR20	100 %	100 %	122 %	110 %	120 %	113 %	90 %	86 %	83 %	73 %	110 %	82 %	144 %	184 %	111 %	130 %	108 %	117 %	119 %	118 %	152 %	130 %	94 %	125 %	117%
Nkongsamba	COP20	Scale-up Saturation	APR21	100 %	100 %	122 %	110 %	120 %	113 %	90 %	86 %	83 %	73 %	110 %	82 %	144 %	184 %	111 %	130 %	108 %	117 %	119 %	118 %	152 %	130 %	94 %	125 %	117%
Ntui	COP18	Sustained	APR19		25 %	39 %	16 %		24 %	20%	9%	21 %	4%	33 %	9%	33 %	20 %	24 %	26 %	27 %	19 %	25 %	25 %	30 %	25 %	25 %	23 %	24%
Ntui	COP19	Scale-up Saturation	APR20	25 %	25 %	17 %	16 %	13 %	12 %	9%	9%	9%	9%	14 %	9%	18 %	24 %	15 %	17 %	14 %	16 %	18 %	17 %	24 %	20 %	14 %	19 %	16%
Ntui	COP20	Scale-up Saturation	APR21	75 %	75 %	90 %	53 %	53 %	52 %	51 %	49 %	47 %	49 %	49 %	45 %	52 %	52 %	51 %	49 %	52 %	50 %	55 %	52 %	59 %	54 %	53 %	59 %	52%
Nylon	COP18	Scale-up Saturation	APR19	43 %	42 %	51 %	44 %	76 %	58 %	67 %	44 %	35 %	49 %	66 %	33 %	96 %	58 %	108 %	44 %	94 %	52 %	93 %	66 %	93 %	77 %	101 %	112 %	84%
Nylon	COP19	Scale-up Saturation	APR20	91 %	83 %	114 %	108 %	142 %	131 %	106 %	99 %	109 %	84 %	142 %	104 %	184 %	231 %	114 %	127 %	81 %	87 %	82 %	79 %	113 %	95 %	110 %	139 %	111%
Nylon	COP20	Scale-up Saturation	APR21	91 %	83 %	114 %	108 %	142 %	131 %	106 %	99 %	109 %	84 %	142 %	104 %	184 %	231 %	114 %	127 %	81 %	87 %	82 %	79 %	113 %	95 %	110 %	139 %	111%
Obala	COP18	Sustained	APR19	25 %	25 %	91 %	68 %	41 %	18 %	21 %	27 %	31 %	11%	36 %	10 %	62 %	25 %	67 %	45 %	73 %	54 %	87 %	77 %	92 %	80 %	103 %	100 %	70%
Obala	COP19	Scale-up Saturation	APR20	75 %	75 %	78 %	74 %	75 %	71 %	56 %	53 %	52 %	46 %	70 %	52 %	99 %	127 %	79 %	90 %	77 %	84 %	93 %	92 %	125 %	106 %	72 %	100 %	88%
Obala	COP20	Scale-up Saturation	APR21	100 %	75 %	89 %	74 %	88 %	71 %	77 %	53 %	71 %	46 %	80 %	52 %	99 %	127 %	86 %	92 %	86 %	84 %	93 %	92 %	125 %	106 %	86 %	100 %	91%
Okola	COP18	Sustained	APR19					33 %		67%		13 %	67%	42 %	8%	39 %	10 %	41 %	27 %	26 %	31 %	42 %	41 %	49 %	33 %	41 %	31 %	33%
Okola	COP19	Scale-up Saturation	APR20	50 %	50 %	14 %	14 %	25 %	23 %	18 %	18 %	29 %	17 %	23 %	17 %	39 %	43 %	27 %	30 %	26 %	28 %	32 %	30 %	43 %	33 %	25 %	32 %	25%
Okola	COP20	Scale-up Saturation	APR21	50 %	50 %	57 %	57 %	67 %	62 %	59 %	59 %	56 %	56 %	56 %	54 %	62 %	65 %	57 %	57 %	58 %	57 %	64 %	61 %	70 %	63 %	62 %	62 %	60%
Oku	COP19	Scale-up Saturation	APR20	33 %	33 %	23 %	23 %	18 %	19 %	14 %	15 %	13 %	15 %	28 %	15 %	23 %	34 %	19 %	25 %	18 %	23 %	22 %	25 %	32 %	31 %	24 %	36 %	25%

NU	CO P	Prioritization	Result to Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Cover age
				Treatment Coverage by API by Age and Sex																								
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Oku	CO Pa2	Scale-up Saturation	API22	67 %	67 %	46 %	31 %	41 %	29 %	36 %	22 %	35 %	26 %	38 %	23 %	41 %	40 %	36 %	32 %	38 %	30 %	42 %	31 %	49 %	37 %	42 %	41 %	38%
Penn	CO P19	Scale-up Saturation	API20	20 0%	20 0%	300 %	333 %	30 0%	30 0%	290 %	229 %	293 %	20 0%	322 %	233 %	531 %	665 %	478 %	556 %	46 5%	49 4%	501 6%	49 4%	74 8%	636 %	578 %	735 %	499%
Penn	CO Pa2	Scale-up Saturation	API22	20 0%	20 0%	300 %	333 %	30 0%	30 0%	290 %	229 %	293 %	20 0%	322 %	233 %	531 %	665 %	478 %	556 %	46 5%	49 4%	501 6%	49 4%	74 8%	636 %	578 %	735 %	499%
Pinn	CO P19	Scale-up Saturation	API20	20 0%	20 0%	67 %	67 %	70 %	64 %	59 %	59 %	46 %	43 %	62 %	42 %	101 %	136 %	83 %	97 %	72 %	79 %	77 %	78 %	110 %	95 %	99 %	132 %	86%
Pinn	CO Pa2	Scale-up Saturation	API22	20 0%	20 0%	83 %	67 %	90 %	64 %	85 %	59 %	68 %	43 %	77 %	42 %	101 %	136 %	89 %	97 %	83 %	79 %	89 %	78 %	110 %	95 %	99 %	132 %	90%
Puli	CO P19	Scale-up Saturation	API20	100 %	100 %	60 %	60 %	44 %	40 %	33 %	33 %	33 %	33 %	53 %	44 %	84 %	113 %	67 %	82 %	58 %	67 %	62 %	65 %	87 %	80 %	82 %	111 %	70%
Puli	CO Pa2	Scale-up Saturation	API22	100 %	100 %	100 %	80 %	78 %	70 %	75 %	67 %	67 %	67 %	76 %	69 %	90 %	113 %	84 %	91 %	80 %	82 %	84 %	82 %	95 %	91 %	93 %	111 %	86%
Puuma	CO Pa8	Sustained	API19			190 %	190 %	75 %	125 %	110 %	40 %	110 %		73 %		61 %	33 %	126 %	33 %	126 %	65 %	140 %	127 %	138 %	130 %	162 %	136 %	111%
Puuma	CO P19	Scale-up Saturation	API20			190 %	190 %	190 %	190 %	120 %	120 %	100 %	67 %	32 %	323 %	196 %	200 %	122 %	143 %	64 %	243 %	133 %	136 %	175 %	190 %	108 %	136 %	139%
Puuma	CO Pa2	Scale-up Saturation	API22			190 %	190 %	190 %	190 %	120 %	120 %	100 %	67 %	32 %	323 %	196 %	200 %	122 %	143 %	64 %	243 %	133 %	136 %	175 %	190 %	108 %	136 %	139%
Rey Bouba	CO P19	Scale-up Saturation	API20	67 %	67 %	27 %	25 %	19 %	18 %	15 %	15 %	13 %	11%	20 %	17 %	32 %	43 %	25 %	30 %	22 %	24 %	24 %	23 %	34 %	29 %	29 %	39 %	26%
Rey Bouba	CO Pa2	Scale-up Saturation	API22	67 %	67 %	73 %	56 %	62 %	59 %	62 %	56 %	56 %	54 %	58 %	53 %	63 %	67 %	61 %	60 %	61 %	57 %	63 %	56 %	68 %	61 %	63 %	68 %	62%
Sea	CO Pa8	Sustained	API19		90 %	44 %	33 %	25 %	12 %	10 %	23 %	15 %	4%	22 %	7%	23 %	61%	37 %	18 %	46 %	24 %	56 %	31 %	63 %	60 %	54 %	67 %	41%
Sea	CO P19	Scale-up Saturation	API20	100 %	100 %	67 %	67 %	50 %	47 %	36 %	36 %	43 %	30 %	54 %	43 %	77 %	98 %	61 %	72 %	59 %	63 %	72 %	71 %	96 %	82 %	98 %	76 %	66%
Sea	CO Pa2	Scale-up Saturation	API22	100 %	100 %	78 %	78 %	73 %	71 %	71 %	64 %	68 %	61 %	72 %	67 %	84 %	98 %	76 %	80 %	77 %	78 %	83 %	82 %	96 %	90 %	77 %	86 %	81%
Sangmelima	CO P19	Scale-up Saturation	API20	91 %	91 %	100 %	94 %	104 %	93 %	71 %	64 %	73 %	62 %	104 %	71 %	139 %	167 %	98 %	108 %	84 %	88 %	97 %	91 %	135 %	109 %	91 %	114 %	102%
Sangmelima	CO Pa2	Scale-up Saturation	API22	91 %	91 %	100 %	94 %	104 %	93 %	71 %	64 %	73 %	62 %	104 %	71 %	139 %	167 %	98 %	108 %	84 %	88 %	97 %	91 %	135 %	109 %	91 %	114 %	102%
Santa	CO P19	Scale-up Saturation	API20	67 %	67 %	50 %	50 %	46 %	48 %	34 %	37 %	40 %	33 %	43 %	30 %	62 %	87 %	50 %	63 %	49 %	57 %	59 %	63 %	83 %	77 %	64 %	92 %	60%
Santa	CO Pa2	Scale-up Saturation	API22	100 %	100 %	64 %	57 %	56 %	52 %	53 %	43 %	55 %	40 %	57 %	41 %	70 %	87 %	60 %	66 %	60 %	61 %	69 %	67 %	88 %	79 %	72 %	92 %	68%
Santchou	CO P19	Scale-up Saturation	API20			50 %	50 %	20 %	20 %	14 %	17 %	33 %	17 %	42 %	38 %	62 %	83 %	60 %	73 %	71 %	79 %	92 %	92 %	114 %	100 %	62 %	96 %	67%
Santchou	CO Pa2	Scale-up Saturation	API22			100 %	50 %	80 %	20 %	71 %	17 %	67 %	17 %	71 %	38 %	76 %	83 %	78 %	73 %	83 %	79 %	92 %	92 %	114 %	100 %	82 %	96 %	82%
Soa	CO Pa8	Sustained	API19	100 %		33 %	17 %		18 %		7%	42 %		69 %	25 %	75 %	52 %	66 %	39 %	53 %	90 %	50 %	52 %	43 %	38 %	44 %	47 %	49%
Soa	CO P19	Scale-up Saturation	API20	100 %	100 %	50 %	50 %	40 %	36 %	29 %	29 %	31 %	27 %	40 %	30 %	59 %	73 %	47 %	52 %	46 %	48 %	56 %	52 %	74 %	60 %	44 %	57 %	50%
Soa	CO Pa2	Scale-up Saturation	API22	100 %	100 %	67 %	67 %	70 %	64 %	64 %	64 %	62 %	60 %	65 %	60 %	75 %	82 %	70 %	70 %	70 %	70 %	77 %	74 %	86 %	78 %	70 %	77 %	72%
Tchollire	CO P19	Scale-up Saturation	API20	133 %	133 %	55 %	55 %	33 %	33 %	27 %	27 %	32 %	25 %	43 %	36 %	72 %	96 %	59 %	68 %	51 %	56 %	55 %	55 %	78 %	67 %	71 %	95 %	61%
Tchollire	CO Pa2	Scale-up Saturation	API22	133 %	133 %	82 %	82 %	75 %	67 %	69 %	65 %	64 %	61 %	70 %	64 %	83 %	96 %	77 %	82 %	76 %	75 %	79 %	76 %	90 %	83 %	86 %	95 %	80%
Tibati	CO P19	Scale-up Saturation	API20	50 %	50 %	33 %	32 %	30 %	30 %	24 %	24 %	21 %	18 %	28 %	22 %	44 %	55 %	36 %	41 %	33 %	35 %	36 %	37 %	56 %	46 %	47 %	62 %	40%
Tibati	CO Pa2	Scale-up Saturation	API22	100 %	100 %	78 %	68 %	76 %	73 %	76 %	71 %	69 %	69 %	71 %	65 %	76 %	76 %	75 %	71 %	76 %	70 %	80 %	73 %	83 %	77 %	82 %	84 %	76%
Tignere	CO P19	Scale-up Saturation	API20	33 %	33 %	45 %	42 %	30 %	29 %	23 %	23 %	22 %	21 %	27 %	20 %	40 %	52 %	33 %	41 %	30 %	35 %	35 %	36 %	50 %	43 %	43 %	56 %	37%
Tignere	CO Pa2	Scale-up Saturation	API22	67 %	100 %	50 %	38 %	80 %	71 %	82 %	75 %	71 %	71 %	71 %	65 %	76 %	75 %	76 %	72 %	76 %	71 %	80 %	74 %	85 %	79 %	82 %	85 %	77%
Tiko	CO Pa8	Sustained	API19		17 %	56 %	48 %	124 %	95 %	233 %	138 %	59 %	42 %	49 %	33 %	100 %	40 %	173 %	67 %	184 %	109 %	233 %	138 %	255 %	162 %	238 %	172 %	133%
Tiko	CO P19	Scale-up Saturation	API20	100 %	100 %	164 %	152 %	170 %	158 %	234 %	126 %	129 %	102 %	152 %	111 %	201 %	271 %	196 %	177 %	126 %	233 %	234 %	129 %	192 %	159 %	184 %	234 %	165%
Tiko	CO Pa2	Scale-up Saturation	API22	100 %	100 %	164 %	152 %	170 %	158 %	234 %	126 %	129 %	102 %	152 %	111 %	201 %	271 %	196 %	177 %	126 %	233 %	234 %	129 %	192 %	159 %	184 %	234 %	165%

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP20 Budget by Program Area

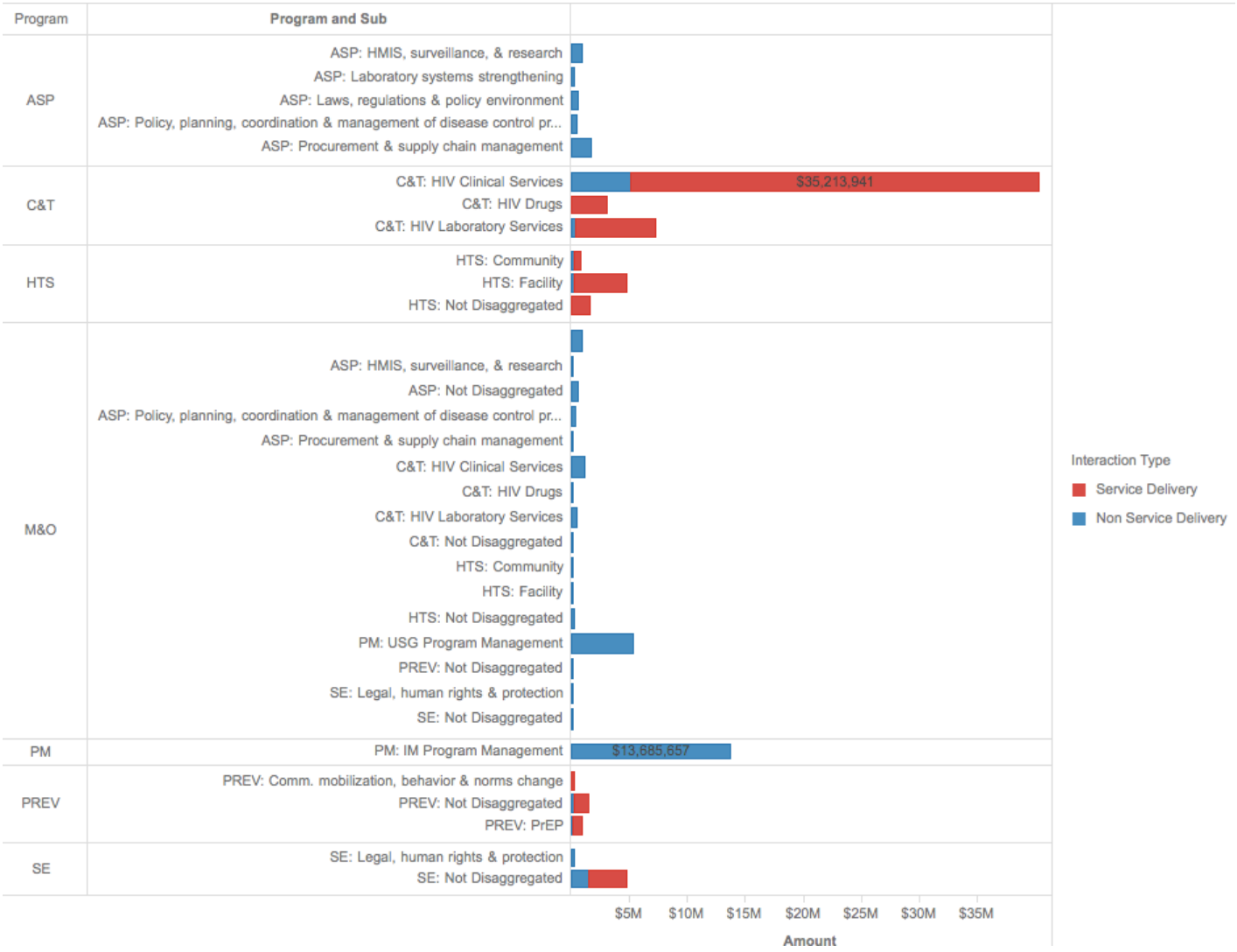


Table B.1.2 COP20 Total Planning Level

Applied Pipeline	New Funding	Total Spend
$US53,879,245	$US 38,463,053	$US92,342,298

*Data included in Table B.1.2 should match FACTS Info records and total applied pipeline amount required in PLL guidance.

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$1,206,850
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$0
HVOP	Other Sexual Prevention	$252,149
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$3,216,533
HBHC	Adult Care and Support	$1,275,266
PDCS	Pediatric Care and Support	$1,580,677
HKID	Orphans and Vulnerable Children	$2,020,729
HTXS	Adult Treatment	$18,359,271
HTXD	ARV Drugs	$1,351,972
PDTX	Pediatric Treatment	$1,206,850
HVTB	TB/HIV Care	$700,000
HLAB	Lab	
HVSI	Strategic Information	$69,905
OHSS	Health Systems Strengthening	$1,000,082
HVMS	Management and Operations	$6,222,778
TOTAL		**$92,342,298**

*Data included in Table B.2.2 should match FACTS Info records.

B.2 Resource Projections

The COP20 budget considers priorities outlined in Cameroon's planning level letter and historic expenditure trends.

Care and Treatment (55%)

The commodities budget is a result of agreement between PEPFAR Cameroon, GRC, and the Global Fund for AIDS, TB, and Malaria during the COP20 Regional Planning Meeting (February 17-21, 2020). PEPFAR Cameroon will fund the National TB Control Program to procure INH ($699,984) under CDC's cooperative agreement with the NTCP and VL reagents and consumables ($2,920,482). The data source for unit prices is the 2020 product e-catalogue produced by USAID's Global Health Supply Chain – Procurement Supply Management (GHSC-PSM) implementing mechanism.

Furthermore, global freight estimates, in-country logistics, etc. are based on GHSC-PSM's previous experience procuring commodities for the Cameroon operating unit.

PEPFAR Cameroon will also implement a third-party logistics (3PL) model for direct delivery of VL/EID reagents to 12 VL/EID reference laboratories, and for delivery of ARVs and other HIV from regional warehouses to PEPFAR-supported health facilities. The program considered USAID's experience implementing 3PL with PMI funding to estimateresources required to implement a similar model in the HIV sector.

Costs associated with community-based care and support use historic expenditure data from the key populations and OVC programs to project resource needs for COP20. The KP program's (IM#16743) investment in the care and treatment program area remains steady from COP19 through COP20. For the first time, the OVC program (IM#16744) has allocated resources within the care and treatment program area based on the estimated resources required to provide services that are specifically focused on HIV-positive pregnant and breastfeeding women, children and adolescents living with HIV within its portfolio. This includes adherence monitoring, age-appropriate disclosure, prevention with positives, comprehensive risk reduction interventions for adolescents living with HIV, etc. Budgeting takes into account the projected number of HIV-positive beneficiaries that will be supported by the program, staff salaries and benefits (including estimating human resource needs based on number of HIV-positive beneficiaries), medical coverage for treatment of noncommunicable and other infectious diseases that are not covered under the user fee policy, transportation support to health facilities, etc. Activities targeting HIV-positive OVC represent 20% of all activities targeting OVC in PEPFAR Cameroon's COP20 budget.

HTS (8%)

Costs associated with community-based testing reflect the actual costs incurred by the key populations program to identify, test, counsel, and link those diagnosed HIV-positive to treatment. The budget includes costs associated with offering HTS at drop-in centers and hot spots, counselling and distribution of self-test kits, assisted administration of self-test kits, follow-up of unassisted HIV self-testing, and accompanied referrals to health facilities to access HTS and/or to link those diagnosed HIV-positive to treatment. Key cost inputs include partial to full salaries/stipends of staff providing HTS such as laboratory technicians, counselors, peer leaders, etc. Other inputs include travel and transportation associated with providing onsite supervision and mentoring.

PEPFAR Cameroon will procure Rapid test kits ($1,079,518). The data source for unit prices is the 2020 product e-catalogue produced by USAID's Global Health Supply Chain – Procurement Supply Management (GHSC-PSM) implementing mechanism. Global freight estimates, in-country logistics, etc. are based on GHSC-PSM's previous experience procuring commodities for the Cameroon operating unit.

The HTS budget also includes resource projections for implementing the 3PL model for direct delivery of RTKs procured by both PEPFAR and the Global Fund for AIDS, TB, and Malaria to PEPFAR-support health facilities.

SE (5% of total funding)
Socioeconomic activities target key populations, OVC and their caregivers. KP activities are primarily focused on creating an enabling environment (e.g. sensitizing law enforcement, health personnel, etc.). Key inputs include staff salaries, travel and transportation, and logistics costs associated with organizing meetings or training.

Activities targeting OVC and their caregivers considers the actual cost of providing community-based services to OVC across the country using FY20 Q1 and partial Q2 expenditure data. As FY20Q1 was primarily focused on expansion and startup at new sites, the program used expenditure data from existing sites to project resource estimates required to implement the program nationwide while also considering specificities of each zone (e.g. target, poverty index; projected household size; distance from household to OVC service provider's location, nearest health facility and other high impact services; significant population of refugees and internally displaced persons; existence of other high impact programs; etc.). Key inputs include personnel salaries and benefits, travel and transportation, projected direct financial support to beneficiaries (through education grants, transportation, and startup capital), legal services, etc. The program also used historical data to project resources required to implement NSD activities including staff salaries and benefits; historic costs of travel for monthly data verification and quality improvement visits; monthly coordination meetings; cost of refresher training, cost associated with placement of Peace Corps volunteers, etc.

PREV (3% of total funding)
Prevention activities target key and priority populations, particularly adolescents and young people. Resource projections consider historic costs 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/stipends and benefits, production of IEC materials, travel and transportation, etc.

Clinical implementing partners will procure PrEP for key, priority and at-risk populations in COP20. GHSC-PSM will procure PrEP ($159,089) on behalf of the key populations program. The data source for unit prices is the 2020 product e-catalogue produced by USAID's Global Health Supply Chain – Procurement Supply Management (GHSC-PSM) implementing mechanism. Global freight estimates, in-country logistics, etc. are based on GHSC-PSM's previous experience procuring commodities for the Cameroon operating unit.

Resource projections under the Prevention program area also consider the cost of providing primary prevention services to adolescents and young people through Peace Corps volunteers and the OVC platform. Key cost inputs include costs associated with Peace Corps volunteer placement, staff salaries and benefits at implementing partner and sub-partner level, production of IEC

materials, refreshments during group activities, transportation support (as needed) to beneficiaries, etc.

ASP (4% of total funding)
The ASP budget supports lab, strategic information, supply chain TA, and interventions focused on achieving universal health coverage.

The supply chain budget leverages other funding from the PMI program to strengthen PEPFAR investments in service delivery strengthening across the country. PMI-funded TA is implemented at national level and in two regions while PEPFAR-funded TA is country-wide. Primary inputs include operational costs associated with placing regional advisors at each warehouse; salaries and benefits of staff supporting central level systems and structures; costs of holding coordination meetings; estimated costs of trainings (including international consultants providing short-term technical assistance); district-led supportive supervision visits to health facilities; and regional travel for general supervision.

Resource projections for ASP activities focused on universal health coverage consider historic expenditures incurred by field support mechanism and local partner. ASP activities focused on supporting GRC (70037) implement its universal health coverage strategy include the following key inputs: costs associated with logistics for in-country trainings, production and dissemination of materials, and costs associated with hiring international consultants to provide short-term technical assistance. The current implementing partner (IM# 70037) previously used non-COP funds to provide similar services to GRC.

Resource projections for ASP activities focused on supporting community monitoring of health service delivery (IM# 81586) includes the following inputs: salaries and benefits of personnel, stipends to community animators and secret shoppers, costs associated with maintaining/updating mobile app, logistics to organize training of community animators and secret shoppers, logistics to organize sensitization meetings with PLHIV associations, and development of IEC materials. The resource projections have been developed through the co-creation process which essentially involves working directly with the local partner to estimate resource needs.

APPENDIX C – Tables and Systems Investments for Section 6.0
TABLE 6

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Poor warehousing practices where products are improperly stored, and quantities not tracked in a transparent and optimal manner	COP19	COP22	inventory accuracy (100%); on-time deliveries (100%)
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	Lack of a concrete and practical supply chain transformation plan for Cameroon exacerbated by weak governance structures to drive supply chain transformation	COP19	COP21	10%
HHS/CDC	Cameroon Baptist Convention Health Board	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	100% in zone 1
HHS/CDC	Cardno Emerging Markets Usa, Ltd.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP20	COP22	75%
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	90%
HHS/CDC	Georgetown University (the)	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	90%

HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	90%
HHS/CDC	NATIONAL AIDS CONTROL COMMITTEE	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	90%
HHS/CDC	World Health Organization	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	Weak strategic information for Epidemiological, Health and Performance Data for Decision Making	COP19	COP22	90%
HHS/CDC	Global Health Systems Solutions	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	Insufficient National Health Systems and Service Delivery	COP18	COP22	90%
HHS/CDC	NATIONAL TUBERCULOSIS CONTROL PROGRAM	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Training in laboratory systems strengthening	Insufficient National Health Systems and Service Delivery	COP19	COP21	90%
HHS/CDC	Global Health Systems Solutions	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Sub-optimal Implementation of Policies and Governance	COP18	COP21	90%
HHS/CDC	NATIONAL AIDS CONTROL COMMITTEE	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	Sub-optimal Implementation of Policies and Governance	COP19	COP22	90%
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	Sub-optimal Implementation of Policies and Governance	COP19	COP22	90%

APPENDIX D– Minimum Program Requirements

	Minimum Program Requirements	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	The adoption on Test and Start has been a success in Cameroon. Linkage has shown to be continually strong, with some weaker performance in Littoral region. • Same Day Initiation is offered at all clinical sites historically supported by PEPFAR. A few of the new clinical sites were not offering SDI.	No outstanding policy or implementation challenges remaining, we simply encourage the continued effective implementation through strong partner management. • Clinical IPs are currently working with the new supported sites to ensured 100% of sites are offering SDI.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.	TLD transition was delayed due to a number of policy and commodity/supply chain issues. Procurement planning indicates a move toward TLD, but the amount of NVP formulations, especially for pediatrics, is concerning as are the government's guidelines around TLD implementation, which may overemphasize the risk to WCBA. • The new national HIV guidelines state that women of CB potential are eligible for TLD if they are on effective contraception. The guidelines state that children >30kg are eligible for TLD and children between 20 kg and	All children must be transitioned to optimal non-NVP regimens and that changes must be communicated and implemented at the site level. Guidelines for WCBA must reflect true risks associated with TLD and not overstate the risk to the fetus. • The new national HIV guidelines state all children and adults should be transitioned off NVP-based regimens.

		30kg are eligible for DTG based regimens.	
	3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.	The adoption of multi-month dispensation has been slow and continues to constitute a minority of the treatment population. Six-month dispensing has not been implemented and must be scaled up. • Patients in conflict-affected NW and SW regions and deployed military are provided with 6-month scripts.	Policies requiring that patients demonstrate a suppressed viral load before becoming eligible for MMD should be reconsidered. All patients should receive MMD, and six months of treatment where possible. • VL suppression remains a criterion for MMD eligibility. • PEPFAR continues to advocate for all patients to be eligible for 6-month MMD; however, policy decisions are also impacted by consistent availability of commodities (ARVs).
	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT was not prioritized prior to COP19, however, in COP19, funding was provided to initiate a country-wide scale up. Commodities issues have prevented this from taking full effect so far in COP19, but there is still an intention to progress towards this goal during COP19 implementation. • Current policy states all patients who screen negative for TB are eligible for TPT.	Supply chain and commodity issues have prevented a complete roll out of TB preventive treatment. Supply chain issues must be prioritized and addressed, with a priority on TPT coverage. • TPT scale up has been limited nationwide due to limited availability of IPT, especially in the new clinical sites. Clinical IPs are training staff at new sites and

	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Viral load coverage has improved and will continue to scale up as user fee elimination goes into effect. • COP20 provides more robust TA to the national supply chain • All clinical IPs have developed and are updating line lists of all clients eligible for VL testing to ensure improved VL coverage in COP19 pending availability of commodities.	The ability of the national supply chain to support the efficient transportation of viral load commodities between labs and sites is limited and requires improvement. • The VL/EID network optimization is progressing with the mapping of each health care facility to a laboratory (with a designated back up laboratory when there are VL sample backlogs). This includes ensuring human resources match the volume of work, a VL reagent redistribution plan is implemented, and a sample/result delivery network based upon the local geography to ensure improved TAT for both VL and EID results.
Case Finding	6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.	Index testing has not been scaled with fidelity. Self-testing has not been implemented outside of the KP program, and even there in limited quantities. • Case finding is the top priority in COP19, with an intensification of ICT. The planned national Emergency Operations Center (EOC) activation is aimed at coordinating efforts and ensuring adequate support for case	There is a need to retrain index case workers in proper implementation and contact solicitation practices. Yields have shown slight improvement, and index coverage, and number of contacts elicited remain a hindrance to effective implementation. • Concurrent with the EOC activation, clinical IPs are training/retraining psychosocial workers on ICT, especially in the new clinical sites supported by PEPFAR.

		• Case finding is the top priority in COP19, with an intensification of ICT. The planned national Emergency Operations Center (EOC) activation is aimed at coordinating efforts and ensuring adequate support for case finding activities in all sites receiving PEPFAR support.	• Concurrent with the EOC activation, clinical IPs are training/retraining psychosocial workers on ICT, especially in the new clinical sites supported by PEPFAR.
Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including PrEP, to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, KP's and adult men engaged in high-risk sex practices)	PrEP has not been funded by the PEPFAR program historically, except for in very limited quantities in the KP program. • Current policy states PrEP use is allowed for KPs >21 years (i.e., FSWs and MSM). • COP20 has provisions for PREP procurement in both the community and clinical settings. The PEPFAR clinical program is developing a comprehensive plan for prevention services in COP20, including PrEP expansion for HIV-negative clients found through testing in populations at high risk of HIV acquisition.	Any regulations requiring that a minor (individual under 19) receive consent from a parent, guardian or other adult to access PrEP should be removed. • Advocacy for a conducive policy environment is ongoing with the MoH. • Proposed populations include serodiscordant couples and high-risk populations (e.g., AGYW, prisoners, etc.)
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all	The implementation of OVC alignment to the clinical program began in rigor in COP19. This scale-up mirrored the clinical program scale up into all 10 regions of Cameroon. The team has effectively chosen site locations that complement the location and geographies of clinical sites.	No outstanding barriers continue to scale-up per COP19.

	children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	• The OVC scale-up is currently in 9 regions and adding the 10th by the beginning of COP20. The locations chose to maximize CLHIV coverage by focusing on the highest burden districts within each region.	
Policy and Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.	The elimination of all formal and informal user fees for HIV services went into effect on January 1, 2020. The government of Cameroon should be commended for its efforts both in making this policy change, and in planning rigorously and funding its implementation. • PEPFAR will continue to work with the government of Cameroon to monitor and report to ensure that full elimination of HIV user fees has taken place and continues. Multiple strategies have been deployed to ensure continued elimination.	We expect the first year of implementation to provide useful information on any challenges of implementing this new policy at the site level. We will work to monitor the implementation, including the new financing mechanisms used to fund the sites directly (rather than funding them through user fees), and will support adjustments as deemed necessary. CSO monitoring at the site level to ensure effective elimination of user fees should continue. • Clinical and Community IPs are monitoring implementation of no user fees in health facilities receiving PEPFAR support and community IPs are monitoring user fee elimination at CBOs. • Additional efforts will be made in COP20 to ensure that the HIV care and treatment services are

	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.	SIMS data indicates that the weakest area of performance is around patient tracking and data reporting. The rapid patient tracking conducted by the team in the spring of 2019 supports this conclusion. • An integrated SIMS/Granular Site Management (GSM) structure is being developed to ensure a greater focus on improvement of quality HIV care and treatment services at the site level. Custom indicators have been developed and are being used at a number of sites to determine the effectiveness of the SIMS/GSM integration and remediation plans resulting from the site assessments.	A lack of EMR and a unique ID for patients makes patient tracking and retention monitoring challenging. Lessons learned from the rapid tracking exercise are important, but lack of networked, electronic systems, will continue to pose a challenge. • Although EMR availability is currently limited, EMR modules related to HIV care and treatment have been developed and are being used for improved patient care and tracking at a few sites, with plans for eventual scale-up pending resources.
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	The scale up of viral load testing in COP18 is encouraging. Uptake has been strong and the demand for viral load testing has been encouraging. • All clinical IPs are updating line lists of patients eligible for VL at their supported sites. A systematic approach is being used to ensure VL testing is ordered and samples are collected for all eligible patients. • An enhanced communication and messaging package is being developed	There is a need for an improved supply chain, specifically around viral load sample collection and transport, to support the successful implementation of country-wide viral load coverage. • The VL/EID network optimization is progressing with the mapping of each health care facility to a laboratory (with a designated back up laboratory when there are VL sample backlogs). This includes ensuring human resources match the volume of work, a VL reagent

		for all sites to ensure patients are receiving "messages of hope". Part of this package for HIV-infected and non-infected individuals is regarding the benefits of durable VL suppression and U=U.	redistribution plan is implemented, and an established sample/result delivery network based upon the local geography.
	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	To support the scale up in COP19, three new clinical partners were engaged, all International. • The local clinical partner has made significant improvements over the last three quarters. Performance of the three international partners has been suboptimal in FY20 Q1, especially the new IPs –related to a slow transition to their respective zones and the continued unavailability/limited availability of commodities. • The COP20 plan for 3PL solutions for supply chain also includes provision for three new local partners.	We continue to improve performance and have seen improvements in the latter quarters of COP18. Local KP and OVC partners have been engaged for transitioning over the next three years. The use of 3PL service providers to conduct last mile delivery of HIV commodities also offers an opportunity for local partner funding. In two regions, the Regional Funds for Health Promotion will be supported directly to engage 3PL contractors. In the remaining eight regions, 3PL contractors will be engaged by the supply chain IP with the goal of transitioning additional regions to direct funding in subsequent years. There is an opportunity to increase local partners through CSO-led monitoring through Ambassadors small grants.

			There is an opportunity to increase local partners through CSO-led monitoring through Ambassadors small grants.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	The GRC showed a strong commitment to user fee elimination by funding as a line item in the national budget and also providing additional funding through presidential decree. This came after co-financing payments that were not made, which resulted in nation-wide stock outs in 2019 and 2020. • With the elimination of HIV user fees, the GRC has contributed an additional $8.5 million to the HIV response in 2020.	In addition to funding the user fee elimination, the government must continue to honor its Global Fund commitment and participate in closing any commodities gaps that are identified in the move towards epidemic control.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	As a continuation of systems level investments started in COP18, systems to monitor morbidity and mortality should be prioritized. • There are ongoing collaborations with the various stakeholders and the MoH to advocate for all clinical IPs and sites to adopt and implement DAMA into their monitoring and reporting systems. • Although EMR availability is currently limited, the EMR modules related to HIV care and treatment have been	No major barriers are identified; we encourage teams to continue with implementation. • Additional resources will be needed to take EMR to scale throughout the country.

	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	These activities have not been prioritized in Cameroon, given a still large treatment coverage gap. Unique identifiers exist for KPs and for ART treatment, but for ART, they are not linked to a network that is accessed by all sites.	Health information systems are not currently in place in a robust way to enable case-based surveillance. • With additional funding the current small-scale EMR system with development of patient unique IDs could be scale up nationwide ensuring a case-based surveillance system is in place for enhanced patient monitoring.