CÔTE D'IVOIRE

Country Operational Plan

(COP/ROP) 2022

Strategic Direction Summary

6 May 2022

PEPFAR

U.S. President's Emergency Plan for AIDS Relief

Contents

***Military PSNU data are non-public**

A portion of PEPFAR data relates to foreign military sites, such as bases, barracks, or military hospitals. Data originating at these sites are aggregated to each respective operating unit (OU) Military PSNU and are non-public. When developing graphics for the SDS, do not include the Military PSNU, which you can find in PSNU dropdowns in

Panorama. These services may be funded through a variety of implementing agencies or mechanisms, so the Military PSNU designation is not equivalent to DOD as an implementing agency.

1.0 Vision and Goal Statement

The President's Emergency Plan for AIDS Relief program in Côte d'Ivoire's (PEPFAR-CI) vision for the Fiscal Year (FY) 2023 is to close gaps among critical sub-populations, improve quality and efficiency of interventions, and continue to build sustainable systems to achieve the Joint United Nations Program on HIV/AIDS (UNAIDS) 95:95:95 goals. Under the leadership of the Government of Côte d'Ivoire (GoCI), PEPFAR-CI and stakeholders have adopted these goals to build on successes and address specific remaining gaps in the program in order to:

1. Maintain and continue significant improvements to patient-centered care in the era of COVID-19: differentiated service delivery; tenofovir, lamivudine, and dolutegravir (TLD) as the mainstay of antiretroviral therapy (ART); multi-month dispensation (MMD), and TB preventive therapy (TPT)
2. Reduce new infections among at-risk populations by expanding access and reducing barriers to pre-exposure prophylaxis (PrEP) services
3. Reduce morbidity & mortality, particularly among children and adolescents: implement novel models of differentiated service delivery to improve case management and viral load suppression (VLS)
4. Simplify and integrate HIV service delivery for sustainability within the primary health care system
5. Find missing TB cases among people living with HIV (PLHIV) and scale up TPT at national level
6. Improve both service delivery and data quality through increasingly integrated patient-level data systems
7. Reduce stigma & discrimination and increase community engagement through community-led monitoring, the faith and community initiative (FCI), increased collaboration with key population (KP) groups and other civil society partners
8. Strengthen the nation's supply chain system from the central level to last-mile delivery closely partnering with GoCI to continue progressively transition commodity procurement to the government
9. Increase government capacity and sustainability of HIV investments through direct support to the Ministry of Women, Family and Children (MFFE) as well as continued support to the Ministry of Public Health, Hygiene, and Universal Health Coverage and the Ministry of Defense

In FY23, PEPFAR-CI will focus on supporting 515 strategic facilities and their respective surrounding communities within 79 districts in addition to the military PNSU, representing 83% of all ART patients in the country. These sites will deliver a package of services that addresses specific programmatic gaps (e.g., targeted case-finding, key population (KP) and men-friendly services, improved pediatric case-management, reducing treatment interruption, and improving viral load coverage and suppression), and calibrated by patient needs. This approach will allow clinical and community implementing partners (IPs) to prioritize improving quality in the areas of greatest need.

Thanks to strong partnership and collaborative efforts with the National AIDS Control Program (PNLS) and Ministry of Health (MSHP), PEPFAR-CI has made tremendous progress transitioning over 90% of ART patients to TLD, ensuring 90% of these patients are on MMD, ensuring nearly 100% of CLHIV are on DTG-based regimens, and increasing TPT initiations ten-fold for two consecutive fiscal years. Policy shifts have, therefore, translated into site-level service delivery for critical life-saving interventions. A major focus of the PEPFAR-CI program in FY23 will be to accelerate PrEP initiation among all those at elevated risk of HIV acquisition. This acceleration will rely on further policy modifications to which GoCI is already in favor of to increase eligibility and remove barriers to uptake.

PEPFAR's supply chain investments are aligned to support these priorities. In COP22, oversight and capacity building interventions will be strengthened at the decentralized level to ensure sufficient supply for TLD scale up and other life-saving HIV services, for priority districts and sites in need. PEPFAR-CI will continue to strengthen local and government capacity by supporting high-functioning procurement and logistics systems at the national level to ensure safe, secure, reliable, and sustainable HIV commodities throughout the country. PEPFAR-CI will continue working in collaboration with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and GoCI to ensure timely and sufficient procurement of high-quality HIV commodities aligned with FY23 needs.

To improve the sustainability, quality and efficiency of HIV service delivery, PEFPAR-CI will move towards increasingly comprehensive models across the clinical and community continuum. This approach will allow for streamlined person-centered care, improved individual data management, and simpler communication and coordination with sub-national MSHP counterparts. Progressively, more consolidated, and comprehensive service delivery will be seen in the 10 districts of Abidjan and over half of the 79 PEPFAR-supported districts across the country. PEPFAR-CI's COP22 human resources for health (HRH) investments are efficient and integrated based on differentiated service delivery models and an increasing number of PLHIV who are stable on ART. COP22 targets are ambitious, with the program aiming to reach viral load coverage (VLC) of 94%, VLS among ART patients of 95%, and population (among all PLHIV) VLS of 77%.

Key populations (KP) remain critical beneficiaries given the importance and severity of HIV among this subgroup and their vital dynamic in Côte d'Ivoire's achievement of epidemic control. COP22 addresses KPs unique needs through a tailored, comprehensive package of services, encompassing the HIV continuum, from primary prevention to VLS.

Similarly, youth are an important subgroup given that a significant portion of the Ivorian population is under the age of 15 (~42%)[1]. Achieving VLS, reducing HIV-related death, interrupting transmission, and implementing quality primary prevention activities are critical to ensure that Côte d'Ivoire achieves epidemic control and avoids a resurgence of HIV among young people in the coming years. For populations with low prevalence but high vulnerability, orphans, and vulnerable children (OVC) and DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) funding accounts for 14% of the PEFPAR-CI program, and these investments will be better calibrated in COP22 to accelerate efforts towards epidemic

control. The resumption of limited direct support to MFFE will build capacity and promote greater ownership of OVC and DREAMS programming. Beginning in COP22, PEPFAR-CI will collaborate with MSHP to introduce recent infection surveillance, allowing the national program to lay the foundation for future identification of geographic and demographic areas of ongoing transmission.

Among Côte d'Ivoire's most pressing challenges is HIV-related mortality, with the UNAIDS 2022 SPECTRUM Estimates reporting approximately 8,356 annual AIDS-related deaths. This is corroborated by program data from PEPFAR implementing partners. PEPFAR-CI is addressing this situation by increasing opportunities for early HIV diagnosis with index-, self-, and targeted-testing; expanding the continuous quality improvement program; increasing access to early infant diagnosis (EID); ensuring same day ART initiation; implementing an advanced HIV disease package in 60 of 172 high impact sites; and further scale up of TPT. Moreover, facility and community-based interventions (including community health posts) will reduce HIV-related mortality among men through accelerated case finding and reduced treatment interruption. Among these interventions will be partnership with faith-based institutions to disseminate Undetectable=Untransmittable (i.e., U=U) and stigma-reduction messaging; the importance of early diagnosis; and the promising reality of a healthy, productive life on ART. Implementing a peer-led model to support children and young people living with HIV (CAYPLHIV) will improve VLS and survival, while decreasing onward transmission among this vulnerable population. Finally, expanding the community-led monitoring program will broaden PEPFAR-CI's civil society engagement, focusing on KP voices to inform programmatic decision-making.

PEPFAR-CI has made tremendous progress towards HIV epidemic control, thanks to consistent support and encouragement from the Front Office, robust civil society engagement, diligent partner management, close coordination with multilateral partners, and sincere collaboration with government counterparts. These relationships and an increasing focus on efficiency will help ensure the sustainability of USG investments to end the HIV epidemic.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Preliminary results of Côte d'Ivoire's recent 2021 census estimated a population of 28,096,651 permanent residents with a growth rate of 2.9% between 2014 and 2021 (National Institute of Statistics – INS, 2021 Census). Most of the population resides in cities with 15,152,232 (53.9%) people living in cities compared to 12,944,419 (46.1%) in rural areas. Rapid urbanization continues in Côte d'Ivoire, with the urban population in 2021 being seven times higher than in 1975. Abidjan has over a fifth of the total population (21.7%) with a density 30 times higher than the national average. The census confirmed the percent of males (52.2%, 14,669,207) is higher than females (47.8%, 13,427,444). The estimated Ivorian population under age 15 is 11,271,234, or 42.2%.

The 2017/2018 population-based HIV Impact Assessment (PHIA) found an HIV prevalence of 2.9% among 15 to 64-year-olds. PHIA also found a prevalence of 2.5% among the 15 to 49-

year-old population, which is much lower than the 3.7% reported in the 2011/2012 DHS for the same age group. Much higher estimates exist among female sex workers (FSW) and men who have sex with men (MSM) (11.4% and 12.3% respectively). The preliminary 2022 UNAIDS Spectrum model estimates that in 2021 a total of 374,290 PLHIV, including 15,936 children living with HIV (CLHIV) and approximately 15,000 pregnant who women need ARVs. An estimated 292,252 PLHIV (78%) are on treatment, resulting in an ART coverage gap of 82,038 PLHIV. The annual incidence of HIV is 0.023%, resulting in 5,995 new HIV infections in 2021 (619 among children). An estimated 8,356 AIDS-related deaths occurred in 2021 in Côte d'Ivoire (509 among children).

Côte d'Ivoire has worked steadily towards reaching HIV epidemic control over the past eighteen years. With a total PEPFAR-CI investment of almost $1.7 billion from 2004 to date, an investment from GFATM of $390 million from 2004 to date, and increasing GoCI financial contributions and efforts, the number of PLHIV on ART has increased from 4,536 in 2004 to 292,252 in 2021. Of these, 241,406 PLHIV (83%) as of FY22 Q1 are receiving care at 516 ART facilities and the military PSNU supported by PEFPAR. While the success of Option B+ is contributing to progress towards achievement of the first 95 of the Joint United Nations Program on HIV/AIDS (UNAIDS) 95:95:95 goals among women living with HIV (85.5% know their status; largest remaining gaps among 40 years and older), significant gaps remain in the first 95 among children living with HIV (only 65.9% know their status) and men living with HIV (72.2% know their status). In PEPFAR-supported sites which account for 80% of all CLHIV on ART, over 98% of all CLHIV are on DTG-based regimens. This has resulted in a significant but still suboptimal improvement in viral load suppression among children from 66% in FY21 Q1 to 80% in FY22 Q1 at PEPFAR-supported sites, driving an increase in national VLS among children from 66% in CY 2020 to 72% in CY 2021. Côte d'Ivoire has now achieved overall 96.5% for the second 95.

Adolescent girls and young women (AGYW) continue to face unique risks of HIV infection and barriers to services, including high rates of violence with one in five females (19.2%) experiencing sexual violence before the age of 18. In FY21, while the program surpassed the KP prevention target (156%), there are still gaps for this population across the clinical cascade. HIV testing coverage among KP remains insufficient with 25% of eligible KP reached by prevention services declining HIV testing, although KP decline testing for a variety of reasons including wanting to receive prevention services separate from testing and being PLHIV. In FY22 Q1, HIV testing yield among KP was suboptimal at 7.9% [FSW: 7.3%; MSM: 9.4%; transgender (TG): 2.3%] due to challenges in targeting new hotspots and lack of systematic use of risk assessment tools by providers. Despite 96% linkage to ART, approximately 50% of KP newly tested positive at PEPFAR-supported sites choose to be initiated on ART at non PEPFAR-supported sites. Better understanding is needed of the issues around access to and quality of services at PEPFAR-supported KP sites, which are funded to be competent and KP friendly, including reinforcement of communication and coordination between community and clinical sites. The retention among KP (93%) is below the target of 98% due to insufficient number of peer navigators, lack of systematic implementation of procedures to prevent and track treatment interruption. Similarly, VLC and VLS among KP remain sub-optimal at 69% and 87%, respectively in FY21 Q4 due to impact of COVID-19, high mobility of the target population, need for continued demand creation among providers and beneficiaries, and extended stockout

of VL reagents leading to long turn-around-time for VL results. The high stigma and discrimination environment particularly towards KP is a key contributor to the challenges just described.

Côte d'Ivoire has made significant progress in adopting an enabling policy and systems environment that supports progress towards epidemic control, especially over the last two years. However, varying degrees of challenges remain with the implementation of 15 of the 16 minimum program requirements (MPR), with some needing significant attention and focus (please see appendix D). Recent measures by GoCI and intensified PEPFAR-CI efforts are addressing these deficits. Beginning in January 2017, President Alassane Ouattara has focused more attention on the health sector, though this sector has historically seen less public investment than infrastructure, education, and other sectors contributing to strong economic growth. In 2018, the Ivorian authorities launched the rehabilitation and upgrading of three regional hospital centers (RHC) and five general hospitals (GH) at a cost of around $180 million. In addition, in 2020 the Ivorian Ministry of Health adopted a project for the construction and rehabilitation of 500 first-contact health facilities across the country. The project-based investment is approximately $316 million. National policies generally align with PEPFAR-CI's strategy on focused testing to increase effectiveness of case finding and linkage to treatment, with written guidance distributed in October 2017. A February 2020 circular reiterated the importance of rapid transition to TLD, differentiated service delivery (e.g. 3-6 MMD for stable patients, community ART dispensation) and TB preventive treatment (TPT) for all eligible ART patients. In October 2020, the Ministry of Health (MoH) issued a notice recommending 6-MMD for all adult PLHIV (stable and unstable) and reinforcing the provisions related to TLD transition, TPT and community ARV distribution as part of the *Programme Nationale de Lutte Contre SIDA* (PNLS) COVID-19 contingency plan. These policies laid the foundation for the rapid exponential growth in TLD coverage among adults (from 48% in FY21 Q1 to 94% in FY22 Q1) with quasi-complete closure of the gap in TLD coverage between men and women (from 40 percentage points in FY21 Q1 to just 4 percentage points in FY22 Q1). Coverage for DTG-based regimens for children under 15 years has jumped from 40% in FY21 Q1 to 98% in FY22 Q1. Finally, 89% percent of all PLHIV on ART are on multi-month dispensing (3-5 MMD: 42%; 6MMD: 47%) at the end of FY22 Q1.

To partner to achieve the 95:95:95 goals in Côte d'Ivoire, PEPFAR programming in FY23 will continue to focus on addressing critical programmatic and systems gaps in the following areas:

Table 2.1.1: Areas and Populations of Focus for COP22/FY23

Populations of Urgency/Concern	1st 95 – Case finding	2nd 95 – Continuity of Treatment	3rd 95 – Improving Long-Term VLS	Cross-cutting
Men	X	X	X	HIS and Lab systems
Children/Adolescents	X		X	
Women >40	X			
Young women		X	X	

Table 2.1.2: Host Country Government Results

Table 2.1.2 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	27,959,387		5,764,745	20.6%	5,826,547	20.8%	2,853,097	10.2%	2,850,977	10.2%	5,283,364	18.9%	5,380,657	19.2%	National estimates; 2021 Census data not available for Spectrum 2022
HIV Prevalence (%)		1.3%		0.1%		0.1%		0.7%		0.4%		4.1%		1.9%	CIPHIA 2017-2018
AIDS Deaths (per year)	8,841		318		324		356		405		3,524		3,914		Spectrum 2022 for 2021
# PLHIV	366,174		6,889		7,017		21,330		12,729		216,575		101,634		Spectrum 2022, Naomi subnational model projection for Sep 2022
Incidence Rate (Yr)		0.19%		0.06%		0.06%		0.38%		0.06%		0.38%		0.25%	
New Infections (Yr)	5,995														Spectrum 2022 for 2021
Annual births	1,221,815														National program
% of Pregnant Women with at least one ANC visit[1]		85%	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			MICS Survey 2016
Pregnant women needing ARVs	16,039														Spectrum 2022

[1] Data from the national program about pregnant women who have at least one ANC visit do not include age disaggregation.

Table 2.1.2 Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Orphans (maternal, paternal, double)[2]	230,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		UNAIDS report 2019
Notified TB cases (2021)	20,749		616		616		1,362		1,967		5,121		11,047		National TB Program routine data, 2021
% of TB cases that are HIV infected[3]	13%		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		National TB Program routine data, 2021
% of Males Circumcised[4]	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A	
Estimated Population Size of MSM	35,198	34.7%													Program Estimates 2022
MSM HIV Prevalence	4,083	11.6%													IBBS 2015-2016
Estimated Population Size of FSW	55,681	55.0%													Program Estimates 2022
FSW HIV Prevalence	6,348	11.4%													IBBS 2014
Estimated Population Size of PWID[5]	Data N/A	Data N/A													
PWID HIV Prevalence[5]	Data N/A	Data N/A													

[2] Data on orphans are not disaggregated by age and sex.

[3] The national program for TB does not have annual disaggregated data available.

[4] There is no voluntary medical male circumcision (VMMC) program in Côte d'Ivoire.

[5] There are no size estimates available for PWID in Côte d'Ivoire.

Table 2.1.2 Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Estimated Size of Priority Populations (Military)[6]	40,000	3.4	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	SABERS 2014
Estimated Size of Priority Populations Prevalence (specify)															

[6] SABERS 2014 study does not include age and sex disaggregation.

Table 2.1.3 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression

Table 2.1.3 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	27,959,387	1.3	366,174	310,565	292,242	80%	91%	1,177,367	33,478	30,931
Population <15 years	11,591,292	0.1%	13,906	9,768	10,487	75%	77%	118,533	1,100	1,209
Men 15-24 years	2,850,977	0.4%	12,729	9,084	7,626	81%	74%	47,781	1,057	919
Men 25+ years	5,380,657	1.9%	101,634	81,938	70,041	69%	93%	196,371	9,821	8,936
Women 15-24 years	2,853,097	0.7%	21,330	17,846	18,423	86%	80%	297,371	2,776	2,567
Women 25+ years	5,283,364	4.1%	216,575	191,929	185,665	86%	92%	517,311	18,724	17,300
MSM	35198	11.6%	4,083					11,181	1,395	944
FSW	55681	11.4%	6,348					20,649	1,816	596
PWID										
Priority Pop (specify)										

Sources: Spectrum 2022 (Total Population Size Estimate, HIV Prevalence, Estimated Total PLHIV, PLHIV diagnosed)*;* MoH data 2021 (On ART, ART Coverage, Viral Suppression); PEPFAR Data 2021 (Tested for HIV, Diagnosed HIV Positive, Initiated on ART)

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

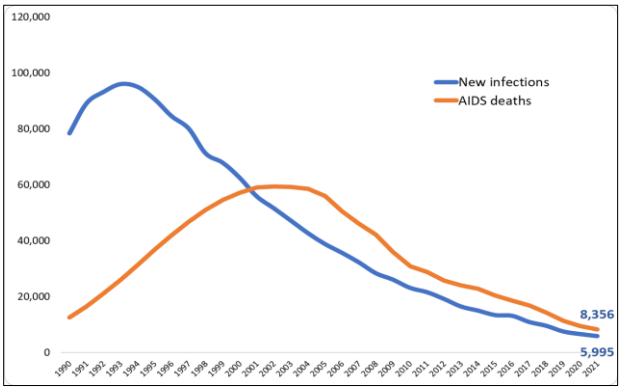
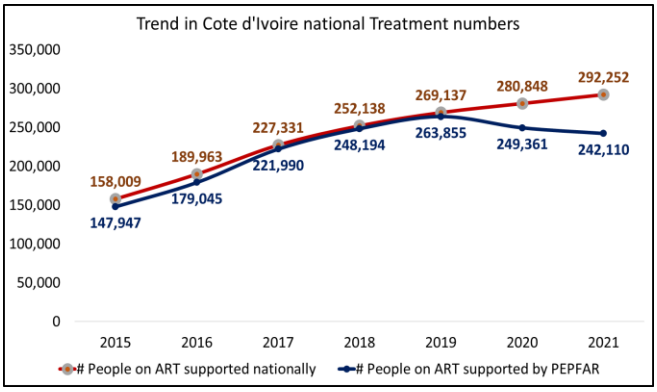
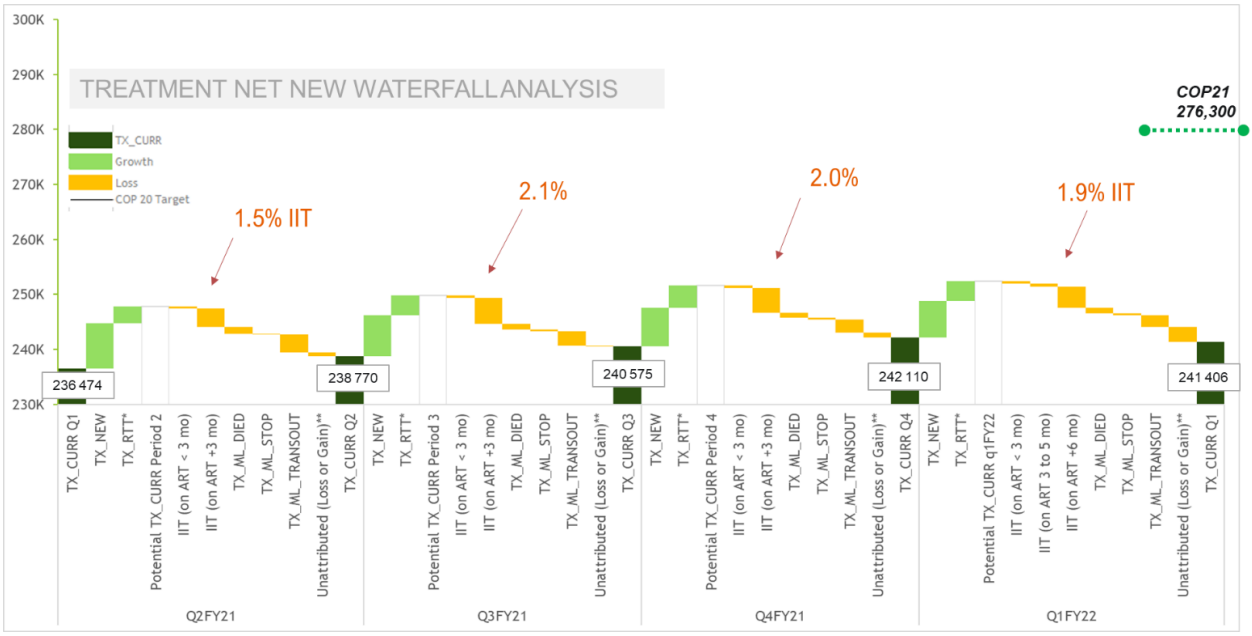


Figure 2.1.5 Updated National and PEPFAR Trend for Individuals currently on Treatment



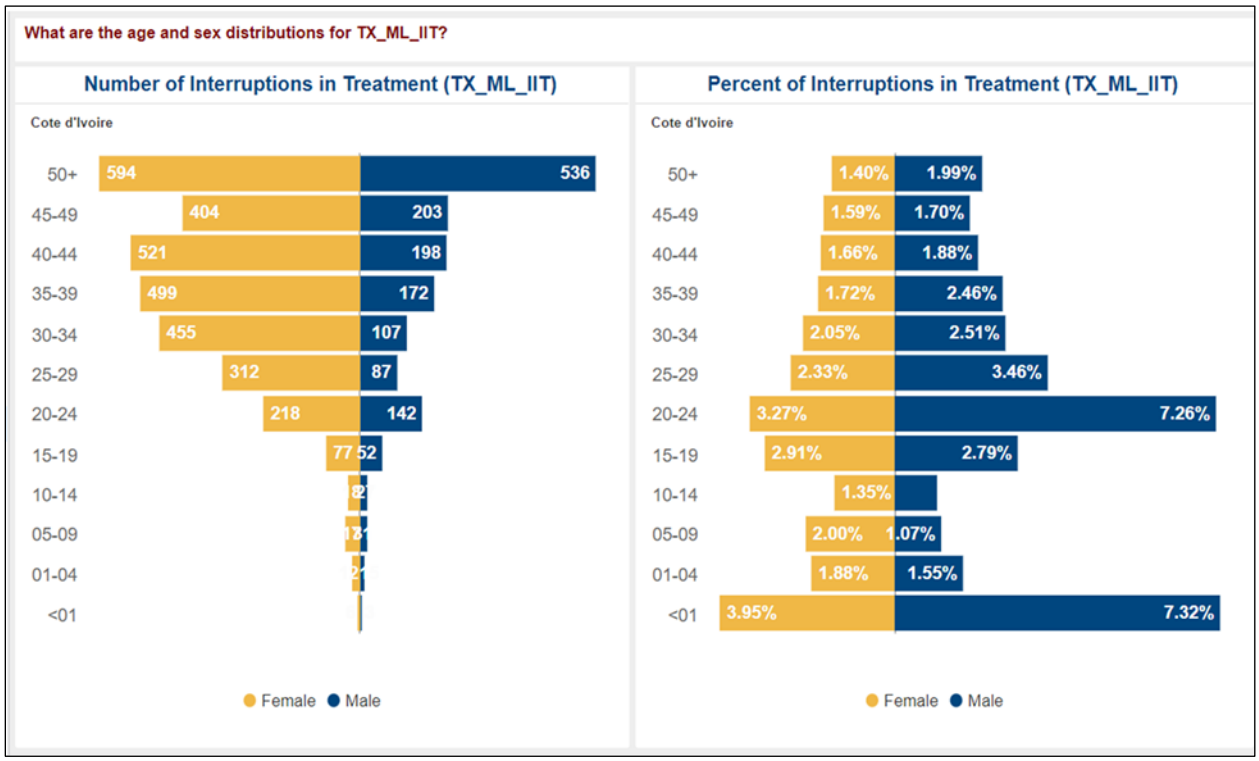
In FY2020 (COP19), PEPFAR transitioned out of 420 sites in Côte d'Ivoire that were in 23 low HIV burden districts, sites with low volume on ART, or private sites no longer receiving PEPFAR support. These transitioned sites supported approximately 30,000 PLHIV on ART (10% of PEPFAR ART cohort). Again in FY2021 (COP20), PEPFAR transitioned an additional 409 low volume sites to MSHP, representing approximately 20,000 PLHIV on ART (another 10% of PEPFAR supported ART cohort).

Figure 2.1.6 Assessment of PEPFAR ART Program Growth in FY21



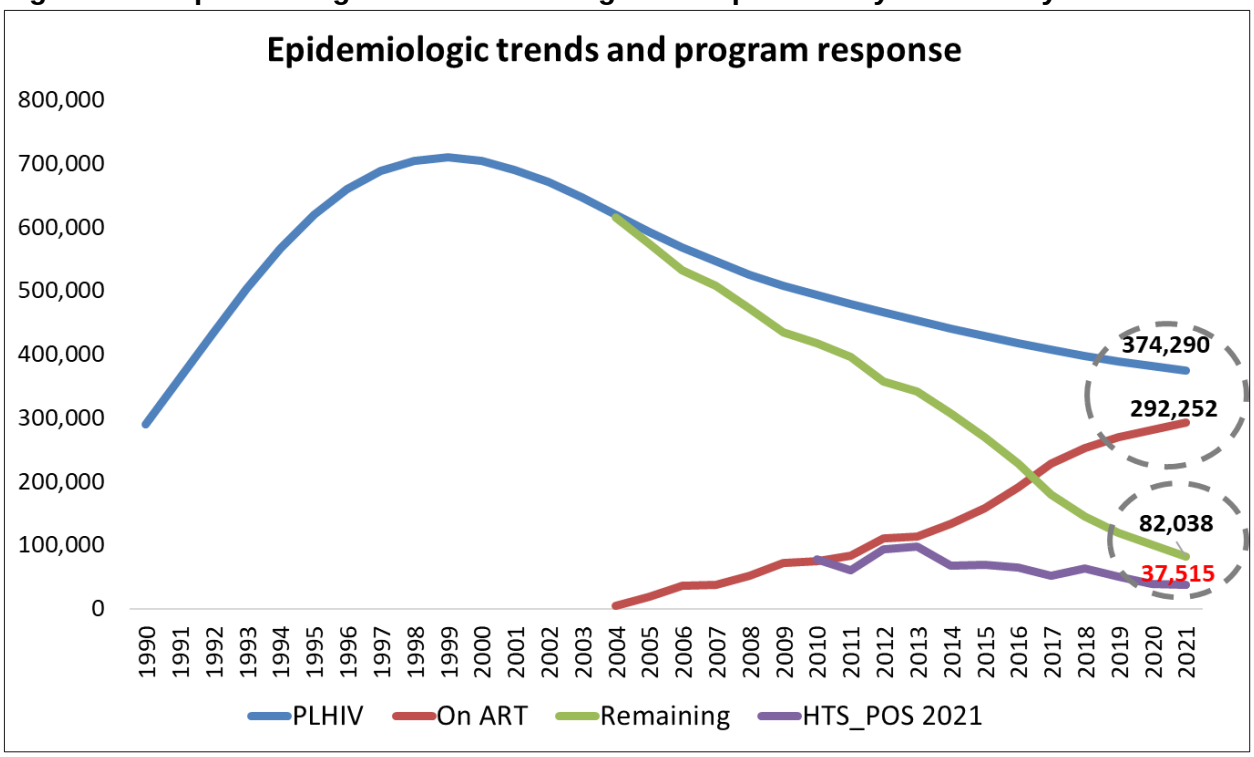
See Section 4.2 for more information on improving program growth and continuity in treatment.

Figure 2.1.7 Clients Gained/Lost from ART by Age/Sex, FY21 Q4



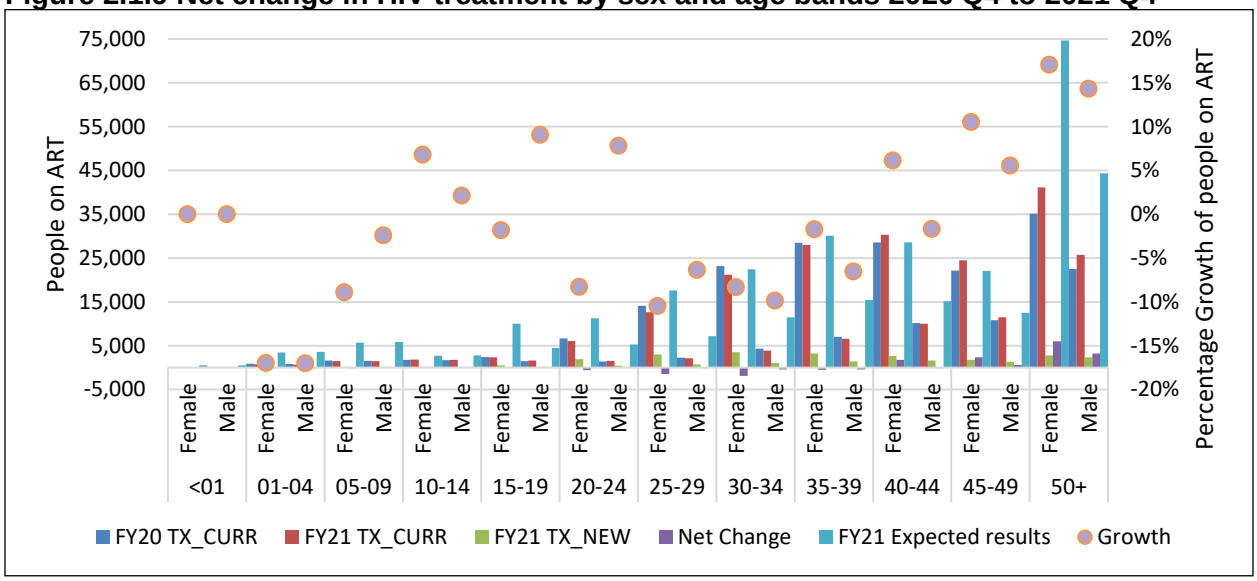
The number of interruptions in treatment (IIT) increases in older age groups and among women – a reflection of the ART cohort. Younger adults (15-39) and children under one year, however, have the highest rates of IIT. See Section 4.2 for more information on IIT and activities aimed to improve continuity in treatment.

Figure 2.1.8 Epidemiologic Trends and Program Response for your Country



Gaps in the number of PLHIV remaining find and initiate on ART decreases each year; however, case finding rate (HTS_POS) is also declining. To close remaining gaps, strategies will need to adjust and adapt to find those not yet identified as well as swiftly identify those newly infected.

Figure 2.1.9 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4



Overall, largest growth (+5%) observed among Females 10-14 and 40+ and Males 15-24 and 45+. Note that the growth rate compares FY2021 results with FY2020, which had an additional 409 low volume sites and approximately 20,000 PLHIV on ART that have since transitioned to

MSHP. FY2021's expected results (targets) also were based on previous 2020 PLHIV estimates that have since significantly decreased in more recent models.

2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART Continuity

The majority of program activities proposed in COP22 will continue, be refined and/or accelerate ongoing COP21 activities including:

Activities to Continue:

- Reinforcement of age-based case finding for men and expansion of male-friendly services to link men to care and maintain them on treatment including continued investment in the Circle of Hope model in one key district with the largest gaps for men.
- Maintenance of improvements to patient-centered care in the era of COVID-19: TLD, MMD, TPT and differentiated service delivery (DSD).
- Maintenance of strong clinical and community support for children and adolescents by providing additional dedicated staff and intensified case management to improve VLC and VLS at selected high-volume pediatric sites.
- Maintenance of advanced HIV disease package of services at 60 high volume and military sites, targeting adults and children to reduce mortality among clients with advanced disease.
- Maintenance of a site-level HIS package including SIGDEP3.0 ® (patient electronic medical record), Unique Patient Identity (UPID), OpenELIS (lab information management system) and "*Plateforme Electronique du Suivi du Patient (PESP)*" (a tablet-based, patient-level case management system) that supports continuity of treatment at all 172 high impact sites.
- Partnership with faith communities to reduce stigma and strengthen HIV and treatment literacy for improved HIV outcomes across the clinical cascade.

Activities to be Refined:

- Implementation of safe and ethical index testing, including monitoring of intimate partner violence (IPV), with fidelity at scale as a key approach for case finding.
- Strengthening program implementation approaches to prevent IIT as well as to boost return to care when IIT does occur with a particular focus on PLHIV newly initiated on ARV (<3months) and male and female adolescents and young adults 15 - 39 years.
- Consolidation and standardization of community ARV distribution, building on COVID-19 adaptations.
- Reduction of morbidity & mortality, particularly among children and adolescents through the implementation of novel models of differentiated service delivery to improve case management and VLS as part of a comprehensive approach to pediatric care and treatment.

Activities to Intensify and/or Accelerate:

- Reduction of new infections among at-risk populations by expanding access to pre-exposure prophylaxis (PrEP) services.

- Reinforcement of comprehensive services for KP including differentiated clinical services at targeted sites and support for government-recommended HRH ratios to deliver the minimum package of services within the community.
- Expansion of community-led monitoring.
- Strengthening of the Gender Based Violence (GBV) response.
- Reinforcement and expansion of continuous quality improvement (CQI) to cover all high impact sites in Abidjan.
- Supplemental investments to improve both service delivery and data quality through patient-level data systems by supporting site-level interoperability of SIGDEP3.0, UPID and OpenELIS at all 172 high impact sites as well as piloting site-level de-duplication of patient records at 10 sites.

New Activities to be Introduced in COP22

- Improvement of government capacity and sustainability of prevention investments through direct support to the Ministry of Women, Family and Children (MFFE).

2.3 Investment Profile

The Government of Côte d'Ivoire is committed to ensuring equitable access to quality health services for all Ivorians as outlined in the 2021-2025 National Health Development Plan (PNDS). In 2022[7], domestic financing from GoCI for Côte d'Ivoire's HIV/AIDS response accounts for 28%, or $50 million of the overall budget. The remainder is donor funded. The United States Government (USG)—which has consistently made the largest contribution—is supporting 56% ($101 million) of the Côte d'Ivoire HIV/AIDS budget and GFATM dedicating 16% ($28 million). GoCI's proportion of funding has increased in the past six years, while GFATM funding has remained relatively consistent (except for an additional $7 million in 2023). Accordingly, PEPFAR's proportion of funding has decreased since 2018.

Because of its large contribution to the national HIV response, PEPFAR provides the majority of support to all program areas. GoCI does not provide any direct funding to HIV testing services, socio-economic (including OVC) services, or above-site programs. However, in 2022, GoCI was the largest contributor of funding for HIV/AIDS commodities (52% of the $42 million budget), with PEPFAR supporting 17%. Tables 2.3.1 and 2.3.2 provide additional details on the distribution of funding allocation in 2022 across the three funders.

[7] Since GoCI and GFATM's fiscal year aligns with the calendar year, for GoCI and GFATM's budget contributions, 2022 refers to January – December 2022. Because PEPFAR's fiscal year is distinct, 2022 refers to PEPFAR's support for COP22 or October 2021 – September 2022.

Table 2.3.1: Investment Profile (Funding Landscape) for HIV Programs

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Care and Treatment	$114,073,276	42%	13%	45%	0%	
HIV Care and Clinical Services	$46,155,452	0%	31%	69%	0%	
Laboratory Services incl. Treatment Monitoring	$8,336,297	0%	3%	97%	0%	
Care and Treatment (Not Disaggregated)	$59,581,527	80%	1%	20%	0%	
HIV Testing Services	$8,359,740	0%	3%	97%	0%	
Facility-Based Testing	$4,098,626	0%	5%	95%	0%	
Community-Based Testing	$3,873,175	0%	2%	98%	0%	
HIV Testing Services (Not Disaggregated)	$387,939	0%	0%	100%	0%	
Prevention	$12,582,734	10%	32%	59%	0%	
Community mobilization, behavior and norms change	$5,429,127	0%	28%	72%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$478,078	0%	2%	98%	0%	
Condom and Lubricant Programming	$1,249,203	0%	40%	60%	0%	
Opioid Substitution Therapy	$61,966	0%	100%	0%	0%	
Primary Prevention of HIV & Sexual Violence	$3,230,548	0%	35%	65%	0%	
Prevention (Not Disaggregated)	$2,133,812	57%	36%	7%	0%	
Socio-economic (incl. OVC)	$13,929,624	0%	15%	85%	0%	
Case Management	$806,581	0%	12%	88%	0%	
Economic Strengthening	$2,171,390	0%	0%	100%	0%	
Education Assistance	$3,441,955	0%	0%	100%	0%	
Psychosocial Support	$2,271,832	0%	34%	66%	0%	
Legal, Human Rights, and Protection	$1,262,859	0%	84%	16%	0%	
Socio-economic (Not Disaggregated)	$3,975,007	0%	5%	95%	0%	
Above Site Programs	$6,038,348	0%	32%	68%	0%	
HRH Systems	$260,479	0%	0%	100%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$885,000	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$2,369,218	0%	49%	51%	0%	
Laboratory Systems Strengthening	$272,820	0%	0%	100%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$1,845,831	0%	43%	57%	0%	
Laws, Regulations and Policy Environment	$405,000	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$0					
Program Management	$25,096,714	6%	20%	74%	0%	
Implementation Level	$25,096,714	6%	20%	74%	0%	
Total (incl. Commodities)	**$180,080,436**	**28%**	**16%**	**56%**	**0%**	
Commodities Only	**$42,031,144**	**52%**	**31%**	**17%**	**0%**	
% of Total Budget	*23%*					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.2: Investment Profile (Funding Landscape) for HIV Commodities

Table S2. Investment Profile (Budget Allocation) for HIV Commodities, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2022
Antiretroviral Drugs	$30,111,440	70%	21%	10%	0%	
Laboratory Supplies and Reagents	$3,687,655	0%	57%	43%	0%	
CD4	$25,207	0%	0%	100%	0%	
Viral Load	$1,465,173	0%	0%	100%	0%	
Other Laboratory Supplies and Reagents	$2,197,274	0%	96%	4%	0%	
Laboratory (Not Disaggregated)	$0					
Medicines	$514,391	0%	59%	41%	0%	
Essential Medicines	$313,949	0%	33%	67%	0%	
Tuberculosis Medicines	$153,540	0%	100%	0%	0%	
Other Medicines	$46,902	0%	100%	0%	0%	
Consumables	$2,603,456	4%	55%	41%	0%	
Condoms and Lubricants	$895,642	0%	50%	50%	0%	
Rapid Test Kits	$1,581,248	0%	61%	39%	0%	
VMMC Kits and Supplies	$0					
Other Consumables	$126,566	77%	23%	0%	0%	
Health Equipment	$1,408,591	53%	47%	0%	0%	
Health Equipment	$1,160,255	64%	35%	0%	0%	
Service and Maintenance	$248,336	0%	100%	0%	0%	
PSM Costs	$3,705,612	0%	58%	42%	0%	
Total Commodities Only	**$42,031,144**	**52%**	**31%**	**17%**	**0%**	

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.3 below details annual USG non-PEPFAR funded investments of almost $40 million, none of which are co-funded with PEPFAR IMs.

Table 2.3.3: Annual USG Non-PEPFAR Funded Investments and Integration, 2022

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**
USAID Maternal and Child Health	$5,500,000	$0	0	$0	Ensure that all women and children have the same chance of a healthy life
USAID TB	$0	$0	0	$0	
USAID Malaria	$24,000,000	$0	0	$0	Reduce malaria-related morbidity and mortality
Family Planning	$7,500,000	$0	0	$0	Reduce maternal mortality and save children's lives
NIH	$0	$0	0	$0	
CDC (Global Health Security)	$2,800,000	$0	0	$0	Respond to infectious disease outbreaks
DOD	$0	$0	0	$0	
MCC	$0	$0	0	$0	
Total	**$39,800,000**	**$0**	**0**	**$0**	

2.4 National Sustainability Profile Update

In September 2021, working in collaboration with UNAIDS, MSHP, through the Directeur Générale de la Santé (DGS), PNLS, civil society, private sector, and other key stakeholders, PEPFAR completed the biennial 2021 Sustainability Index and Dashboard (SID) and Responsibility Matrix (RM). In the Defense sector, the Military Sustainability Index and

Dashboard (MILSID) is conducted on a yearly basis, and results guide evidence-based decisions on PEPFAR's above-site investments.

Sustainability Strengths

In general, since 2015, Côte d'Ivoire has made progress on the majority of the sustainability elements as measured through the Sustainability Index Dashboard (SID) and Responsibility Matrix (RM). The SID 2021 observed Côte d'Ivoire's improved quality management, as a result of GoCI's institutionalizing quality management systems, plans, workforce capacities and other key inputs to ensure that modern quality improvement methodologies are applied to managing and providing HIV/AIDS services across the country. Market openness increased slightly because of GoCI and donor policies, which did not negatively distort the market for HIV services by reducing participation and/or competition. In addition, there are no restrictions on the provision of any one aspect of HIV prevention, testing, counseling, or treatment services to a single entity nor are there policies limiting the ability of licensed, local providers to provide certain direct clinical services. There is freedom for innovation, advertisement and all HIV service providers are held to the same standards of service quality.

Planning and Coordination also performed strong, although it observed a decrease from 9.50 in SID 2019 to 8.50 in 2021. But GoCI continues to have a multi-year and costed National Strategic Plan for HIV along with strategic plans for other health and social matters that impact HIV programs (ex: lab, OVC and pharmaceutical activities). These plans are inclusive, participative, and implemented in coordination with most stakeholders. Although progress has been made in the coordination of National HIV Implementation through funding provided to the DGS in COP19, additional support was allocated in COP20 and COP21 to sustain this progress and empower the government to ensure program oversight and improve coordination of HIV service delivery and ensure efficient district level empowerment and leadership.

There have been improvements in the score of performance data compared to 2019. However, two elements scored low including the reliance on an external partner for technical assistance of service delivery data and GoCI providing some funding (approx. 10-49%) to the routine collection of service delivery data. However, the timeliness of service delivery data is a strength with the HIV/AIDS service delivery data now collected on a quarterly basis to inform analysis of program performance, which is a welcome improvement compared to 2019.

The laboratory continues to score high at 7.59. GoCI ensures adequate funds, policies, and regulations to ensure laboratory capacity (workforce, equipment, reagents, quality) matches the services required for PLHIV. A national laboratory strategic plan exists, and although it has a limited budget, there is a national office with specific authority to manage laboratory services (including plan, monitor, purchase, and provide guidance) at the regional and district level across all sectors. GoCI has an adequate number of qualified laboratory personnel (human resources [HR]) in the public sector, to sustain key functions to meet the needs of PLHIV for diagnosis, monitoring treatment and viral load suppression. The viral load infrastructure is there to test for viral load to reach sustained epidemic control although adequate specimen transport and results return capacity is limited.

Civil Society Engagement maintained a high score of 7.50 in the 2021 SID. The country has formal channels or opportunities for diverse civil society groups to engage and provide feedback on its HIV/AIDS policies, programs, and services (not including GFATM CCM civil society engagement requirements). Since 2019, the civil society has been empowered through engagement with the DGS to ensure active participation in various fora to ensure that their voices, concerns, and feedback are translated into action to improve service delivery for all PLHIV. The civil society has substantially increased active engagement to impact policy, programming, and budget decisions related to HIV/AIDS.

Sustainability Vulnerabilities

Despite the notable progress above, the program is still struggling in some areas with persistent vulnerabilities and saw a decrease in the scoring of some elements since 2019's assessment. Policies and Governance saw a decrease from 7.51 in 2019 to 6.04 in 2021. While GoCI had made significant progress in terms of policy change through several Circular Notes signed during the past two years, the country still has improvement to do, more in terms of the speed between the national technical work force teams decisions and the circulars to be signed, and more of the policy to be rolled out in the entire country.

Human Resources for Health also remains a vulnerability and saw a decrease of 21% since 2019. Ongoing significant challenges in quality service delivery affect efforts to achieve epidemic control. Specific challenges include: (i) lack of an accurate assessment of the total number of health providers required to provide HIV/AIDS services and other basic health services; (ii) MSHP budgetary constraints limiting the recruitment and retention of sufficient staff; and (iii) the misallocation of health care workers and human resources in health (HRH) across the country. Despite the challenges, PEPFAR has made significant contributions in establishing flexible hours in numerous health facilities to increase access to care.

Domestic Resource Mobilization (DRM) continues to remain a vulnerability to sustainability in Côte d'Ivoire. GoCI committed to significantly increase its financial contribution as President Alassane Ouattara publicly pledged to increase the budget for HIV at the National AIDS Council in both 2016 and 2017. Indeed, the budget doubled from 2015 to 2016 with a strong focus on the procurement of ARVs and laboratory inputs. However, the budget for these items decreased from 2016 to 2017. The USG team, under the leadership of the U.S. Ambassador, is committed to continuing to support the Ivorian Government's efforts to mobilize domestic resources through both technical assistance and policy advocacy. At this point GoCI dedicates approximately 6% of its annual budget to health which is still far from the 15% pledged in the Abuja Declaration.

Public Access to Information reported a significant decrease in scoring from 2019 to 2021, from 7.11 to 5.33. Significant improvement is still needed in this area due to the weak government education system, responsible for providing scientifically accurate education to the public about HIV/AIDS, as well as procurement transparency procedures that are not fully in place.
The 2019 SID added element of Data for Decision–Making Ecosystem saw an improvement but still scored low due to the lack of operational civil registration and vital statistics systems in

place that record births and deaths across the country; in addition to the absence of a Unique identifier system to track the delivery of services for HIV/AIDS or others health services. Service Delivery continues to be a vulnerability, scoring less than in 2019 (6.01 vs. 5.06). However, despite the policy changes being recent, the model of differentiated service delivery continues to be scaled up with the 6 MMD and TLD transition, including improvement between community and clinical partners.

While significant improvement was documented since SID 2015, commodity security and supply chain still remain major challenges. The bigger bottlenecks surround poor communication and coordination between the central and periphery medical stores and lack of dedicated human resources, which affects the last mile distribution and commodities availability. Procurement and distribution of lab reagents and commodities have faced challenges both at national and peripheral levels.

Figure 2.4.1 Sustainability Index Dashboard

Sustainability Analysis for Epidemic Control: Côte d'Ivoire

Epidemic Type:	Generalized
Income Level:	Lower middle income $100,750,00
PEPFAR COP21 Planning Level:	0

SUSTAINABILITY DOMAINS and ELEMENTS	2015 (SID 2.0)	2017 (SID 3.0)	2019 (SID 4.0)	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	6.50	9.50	9.50	8.50
2. Policies and Governance	3.95	4.56	7.51	6.04
3. Civil Society Engagement	5.93	6.46	7.50	7.50
4. Private Sector Engagement	6.02	6.50	6.03	4.13
5. Public Access to Information	8.00	8.00	7.11	5.33
National Health System and Service Delivery				
6. Service Delivery	7.04	6.48	6.01	5.06
7. Human Resources for Health	7.92	7.20	7.66	6.09
8. Commodity Security and Supply Chain	4.24	5.61	6.34	6.76
9. Quality Management	4.43	5.57	9.33	9.14
10. Laboratory	4.49	6.00	7.56	7.59
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	4.72	6.79	8.10	5.52
12. Technical and Allocative Efficiencies	3.63	5.06	6.78	5.00
13. Market Openness	N/A	N/A	8.44	8.68
Strategic Information				
14. Epidemiological and Health Data	5.95	5.48	5.62	7.00
15. Financial/Expenditure Data	5.83	6.67	7.50	6.67
16. Performance Data	7.00	7.40	5.90	8.00
17. Data for Decision-Making Ecosystem	N/A	N/A	4.00	5.00

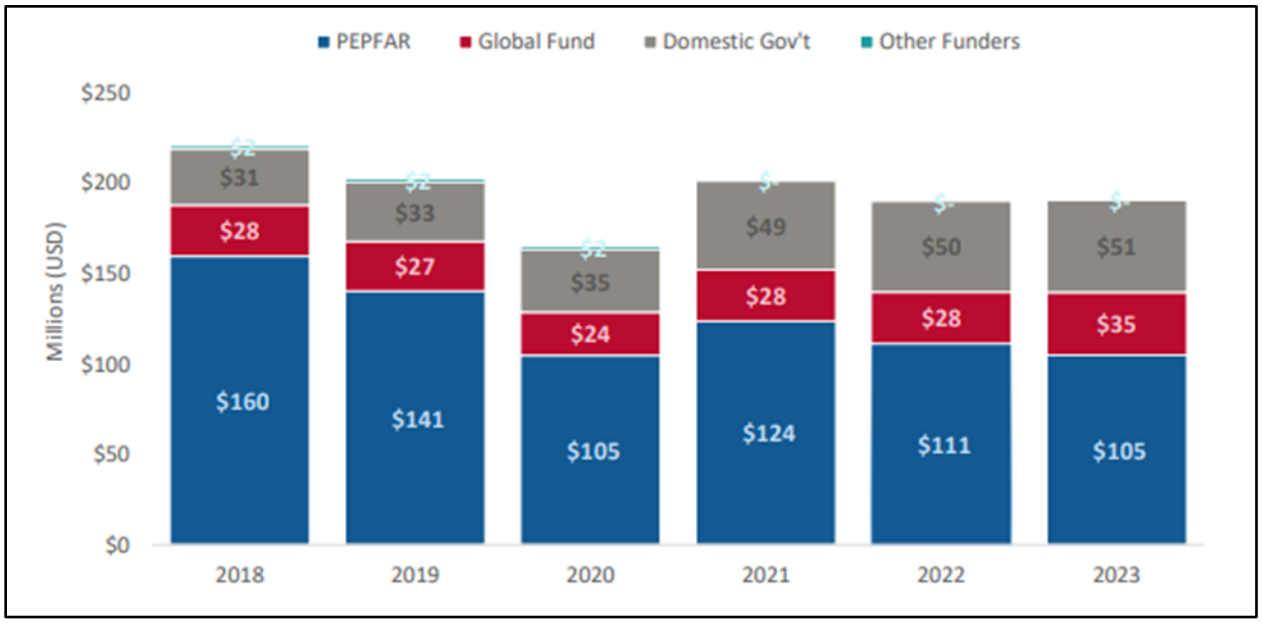
In COP22, PEPFAR-CI will focus on several above-site and site level interventions aiming to improve the score for sustainability elements, in particular those that have a low score: policies and governance, public access to information, service delivery, human resources for health, commodity security and supply chain, and technical and allocative efficiencies. COP21 funding levels for these activities are maintained in COP22 with additional funding targeting pre-service education for health workers and funding for local civil society organizations. In addition, in COP22, additional funding is designated to assist in the transition to the Ministry of Defense (MoD), and the training of health authorities and leaders of the MoD and military-led NGOs.

PEPFAR-CI is also collaborating with the MSHP and other health sector donors to continue oversight on sustainability elements with good scores.

Donor Support

As described in Section 2.3 and shown in Figure 2.4.2 below, the U.S. Government continues to provide the majority of funding for the HIV response in CI although their proportion of funding has decreased over the past six years. In 2023, PEPFAR-CI plans to contribute 55% of the total HIV/AIDS funding ($105 million), with GoCI providing $51 million (27%), and GFATM financing $35 million (18%).

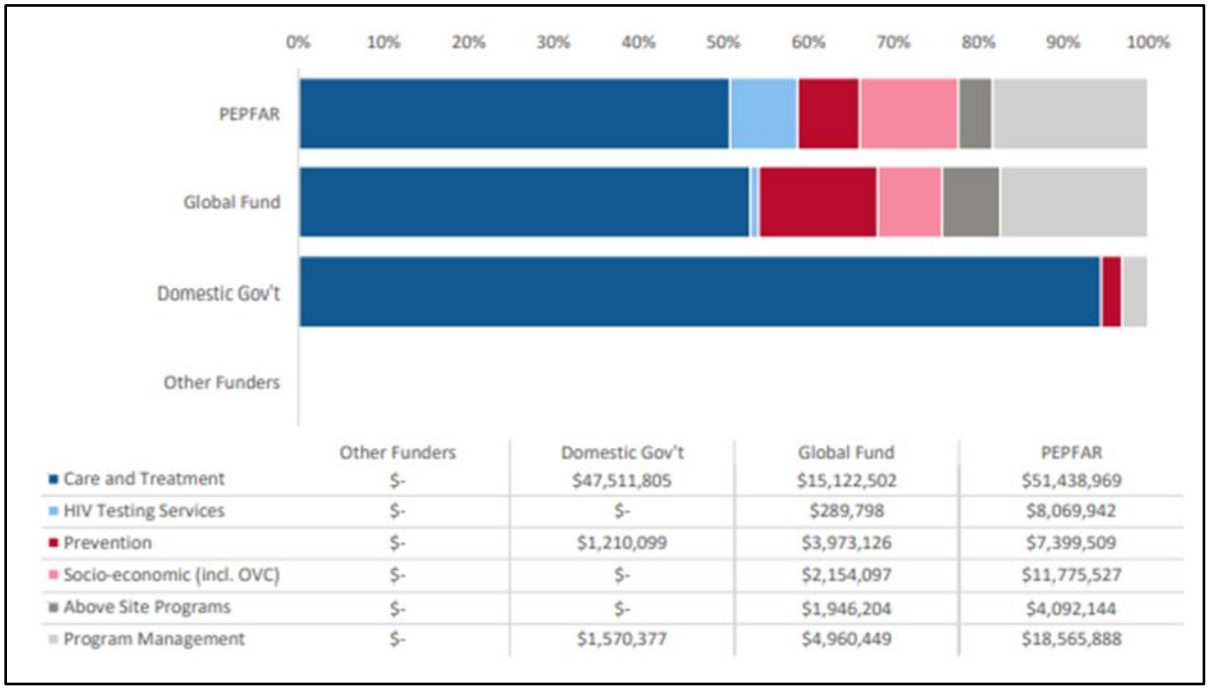
Figure 2.4.2: Trend in Total Budget by Funder, 2018 - 2023[8]



Excluding USG M&O, in 2022, funding from all three sources was mostly provided to programs (versus partner program management and above-site support). However, there is variation with the proportion of a funder's budget that is allocated to certain program areas. For example, as shown in Figure 2.4.3, 78% ($78.7 million) of PEPFAR's 2022 budget was allocated to programs, while 97% of GoCI's budget or $48.7 million was designated for program implementation. Within programs, in 2022, PEPFAR directed 51% ($51.4 million) of their budget to care and treatment, while GoCI directed $47.5 million or 94% of their budget to care and treatment and GFATM – 53% ($15 million).

[8] 2018 – 2022 PEPFAR USG Management and Operations is included in Figure 2.4.2. PEPFAR 2023 is topline budget pending approval and includes USG M&O.

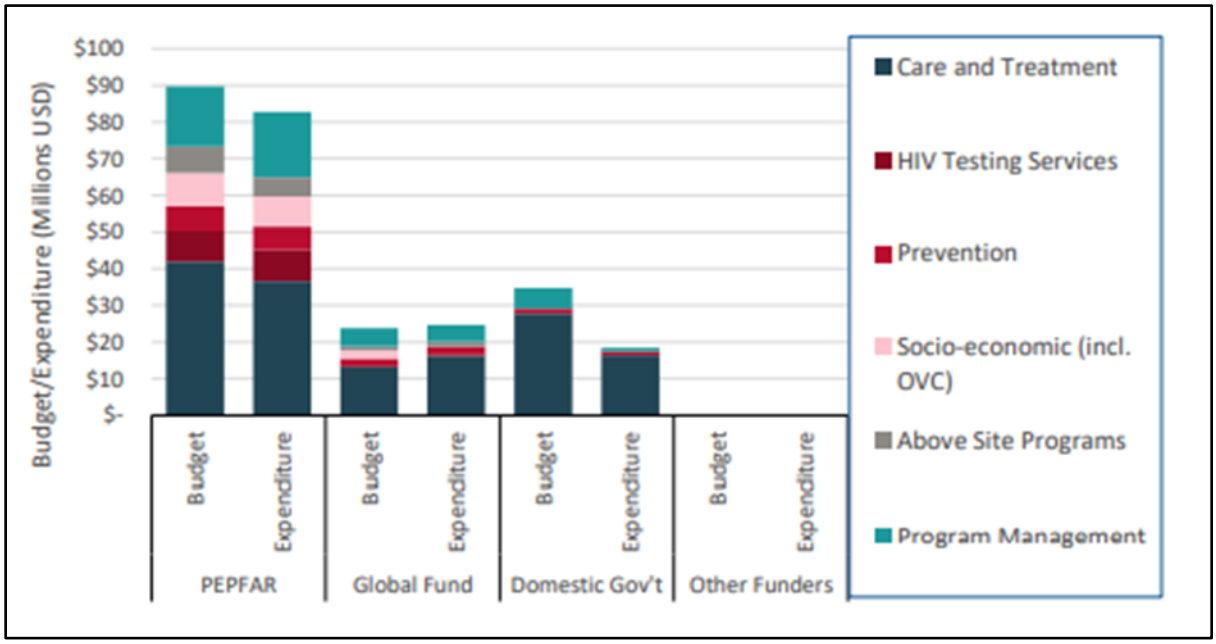
Figure 2.4.3: Budget Allocation by Funder, 2022



	Other Funders	Domestic Gov't	Global Fund	PEPFAR
Care and Treatment	$-	$47,511,805	$15,122,502	$51,438,969
HIV Testing Services	$-	$-	$289,798	$8,069,942
Prevention	$-	$1,210,099	$3,973,126	$7,399,509
Socio-economic (incl. OVC)	$-	$-	$2,154,097	$11,775,527
Above Site Programs	$-	$-	$1,946,204	$4,092,144
Program Management	$-	$1,570,377	$4,960,449	$18,565,888

As shown in Figure 2.4.4, expenditure across the different funders stratified by program area illustrates similar distributions to the budget with all funders spending a majority of their expenditure on care and treatment.

Figure 2.4.4: Total Detailed Budget Allocation versus Expenditure by Funder, 2020



Funding to Indigenous Partners

Côte d'Ivoire has shown progress in terms of transitioning to local partners. Tables 2.4.1 and 2.4.2 show that in COP19, 71% of the $76.6 million for IPs were allocated to international prime

partners, while 29% were local. In COP21, the proportion of funding to international partners decreased to 62% (out of $87.4 million), and 38% to local partners. Currently, in COP22, only $47.6 million is apportioned to IPs continuing into COP22, but 54% are allocated to international with 46% to local partners.

Table 2.4.1: Funding Distribution to Indigenous Partners as Prime Partner, by Funder

Table 2.4.1 Funding Distribution to Indigenous Partners as Prime Partner, by Funder																
Fiscal Year	COP19				COP20				COP21				COP22			
Funding Agency	International		Local		International		Local		International		Local		International		Local	
DOD	$2,994,827	100%			$3,111,787	100%			$2,999,231	100%			$3,138,563	100%		
HHS/CDC	$27,908,640	58%	$19,845,748	42%	$28,363,855	59%	$20,055,889	41%	$23,716,991	46%	$27,928,365	54%	$1,331,511	6%	$20,668,630	94%
HHS/HRSA	$185,606	100%			$603,700	100%			$1,119,240	100%			$1,183,876	100%		
USAID	$23,530,865	94%	$2,142,942	6%	$30,022,033	91%	$4,569,665	9%	$26,430,486	86%	$5,195,153	14%	$21,816,165	84%	$4,271,954	16%
Côte d'Ivoire	$54,619,938	71%	$21,988,690	29%	$62,101,375	72%	$24,625,554	28%	$54,265,948	62%	$33,123,518	38%	$27,470,115	52%	$24,940,584	48%

Table 2.4.2: Percent of Budget Distribution to Indigenous Partners as Prime Partner, by Funder

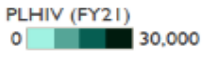
Table 2.4.2 Percent of Budget Distribution to Indigenous Partners as Prime Partner, by Funder								
	COP19		COP20		COP21		COP22	
Funding Agency	International	Local	International	Local	International	Local	International	Local
DOD	100%		100%		100%		100%	
HHS/CDC	58%	42%	59%	41%	46%	54%	7%	93%
HHS/HRSA	100%		100%		100%		100%	
USAID	92%	8%	87%	13%	84%	16%	84%	16%
Côte d'Ivoire	71%	29%	72%	28%	62%	38%	54%	46%

2.5 Alignment of PEPFAR investments geographically to disease burden

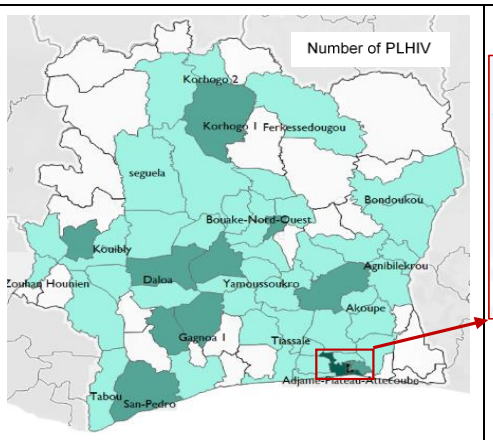
In COP22, PEPFAR will continue to invest in the same geographic areas as in COP21—i.e., in 79 out of 113 health districts that account for approximately 90% of the total PLHIV burden in Côte d'Ivoire. While the overall PEPFAR footprint in COP22 is unchanged compared to COP21, PEPFAR will rationalize the geographic scope for implementing partners between CDC and USAID to maximize efficiency. As per guidance from S/GAC, Abidjan regions are rationalized with Abidjan 1 under CDC (5 districts) and Abidjan 2 under USAID (5 districts). Review of the 2022 Spectrum estimates, as well as recent PEPFAR-CI and national program data, reaffirmed that the 79 supported health districts will continue to account for the highest disease burden and the largest gaps in ART coverage, case finding, continuity of treatment, and pediatric VLS. They are also home to the majority of KP and other priority populations as well as the largest number of facilities where these populations are served.

Figure 2.5.1: People Living with HIV (PLHIV), Treatment Coverage, and Viral Load Testing Coverage

Figure 1: Number of PLHIV by district



Source:
PLHIV UNAIDS Spectrum estimates 2021



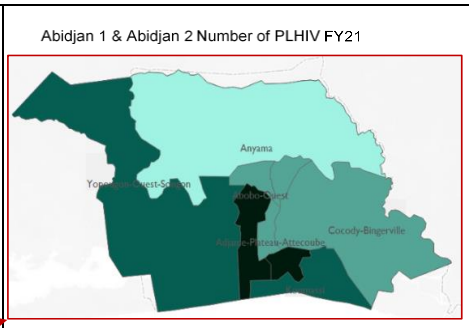
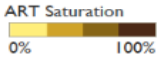
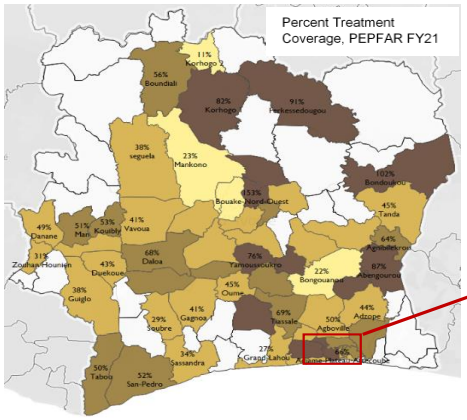


Figure 2: Percent treatment coverage



PEPFAR contributes ~90% of national TX_CURR in respective districts

Data sources:
TX_CURR: PEPFAR FY21 Q4
PLHIV data from DATIM (2021)
OU: Cote d'Ivoire



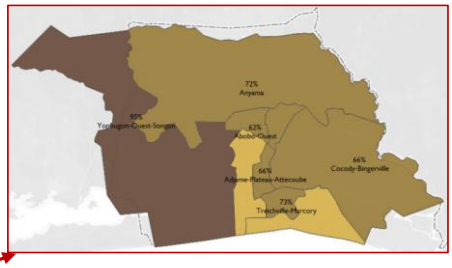
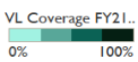
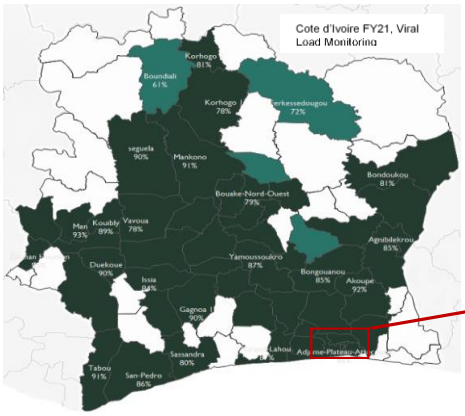
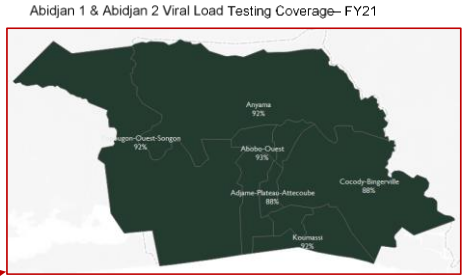


Figure 3: Viral load testing coverage



Data sources:
TX_CURR: PEPFAR FY21 Q4
PLHIV data from DATIM (2021)
OU: Cote d'Ivoire





2.6 Stakeholder Engagement

Throughout COP21 planning and implementation and during the COP22 planning process, PEPFAR-CI engaged and continues to engage critical stakeholders including: GoCI [Minister of Health, Director General of Health (DGS)], the PNLS and PNLT (National TB program); the Minister of Women, Family and Children through the PNOEV (National Program for OVC); CSOs; and private sector and bilateral and multilateral partners such as UNAIDS, WHO, and

GFATM. The PNLS and CSOs have been engaged in the review of COP21 implementation throughout the year, notably through the quarterly and day-long virtual pre- or post-PEPFAR Oversight and Accountability Results Team (POART) meetings organized by the PEPFAR Coordination Office (PCO). In COP21 all POART meetings were hybrid (i.e., virtual and in person) to better allow CSOs to participate. GoCI and other stakeholder engagement is also strengthened through the PEPFAR-supported monthly coordination meetings and quarterly review meetings that encompass results, successes and challenges in all regions and districts of Côte d'Ivoire. The more frequent opportunities for in-depth exchange further strengthen the PEPFAR-GoCI partnership. In addition, even though the implementation of the COP20-CLM program was delayed due to administrative constraints and grantees received funding only in April 2022, to date, three meetings have taken place which have included CSOs, to identify sharing of best practices for quality delivery of HIV services to PLHIV regardless GFATM or PEPFAR presence in the area.

Notable examples of Côte d'Ivoire's high-level stakeholder engagement in the COP22 process include the following:

- As previously mentioned in Section 2.4, during the SID exercise, PEPFAR-CI engaged the private sector, which provided an opportunity for various stakeholders to discuss the strengths and vulnerabilities of the HIV response, which helped spearhead discussions in the COP22 planning process.
- PCO facilitated preparatory meetings to ensure that CSOs were well-versed of all COP materials and are continually in dialogue t receive sufficient information from PEPFAR-CI.
- During COP21 implementation PEPFAR-CI is engaging key stakeholders in multiple fora, including monthly high-level HIV meetings to exchange on the HIV response with multilateral partners (GFATM, WHO, UNAIDS) under MoH leadership. These meetings help to quickly resolve issues and anticipate key actions.
- PEPFAR-CI engaged with CSOs and KP organizations to guarantee high quality support and services to KPs and to better understand specific CSO concerns. On April 26, 2022, the Minister of Health; the Minister of Women, Children and Family; the DGS; and the U.S. Ambassador will participate in the COP22 approval meeting in Abidjan, Côte d'Ivoire.

The stakeholder engagement calendar below provides a detailed overview of how PEPFAR-CI included these stakeholders and involved them in the development of COP22.

Table 2.6.1: PEPFAR-CI COP22 Activities

Table 2.6.1: PEPFAR-CI COP22 Activities with Stakeholders				
Date	**Objective**	**Outcomes**	**Next steps**	**Comments**
Before COP22 Submission				
12/06/2021	Stakeholder Meetings COP20 APR results review with participation of CSOs, WHO, IPs, private sector, UNAIDS, GFATM and PNLS	Allowed PEPFAR to share achievements /challenges identifying opportunities with stakeholders to improve performance and identify solutions related to retention, PrEP, and other WHO recommendations		
11/9/2021	Provided the link to the Draft COP22 guidance for online public feedback	Stakeholders provided online feedback	S/GAC to release the Guidance	The process was challenging and limited CSO and GoCI involvement as the document was in English
01/24/2022	COP22 PLL in French was shared with all stakeholders	Stakeholders understand the COP22 priorities and timeline for the next steps of COP22.		
01/25/2022	CSO consultation on CSO's COP22 expectation	PEPFAR funding was explained to CSO; CSO shared their 3 – 5-year vision	CSO to share with PEPFAR CSO's top priorities for COP22 implementation.	UNAIDS facilitated and hosted the meeting
02/3-4/2022 In-country retreat	PEPFAR-CI retreat with stakeholders discussing timelines for COP22 steps and strategies	Stakeholders provided feedback on COP22 strategy	To continue discussion via phone and email to ensure stakeholder inputs are incorporated into COP22 strategy, in particular the support for stigma and discrimination, and human rights focused on KPs	UNAIDS hosted the two-day retreat
03/10/2022	PEPFAR-CI shared all tools for input and feedback before the COP22 planning meeting with S/GAC	Virtual meeting was held with CSOs to review the COP22 proposed strategies by program area	CSO members reviewed the proposed strategies and prepared responses	Draft strategic plans were shared via email to CSO
3/14-16/2022	COP22 virtual planning meeting with CSO participation. The meeting was led by S/GAC with participation from stakeholders including the MSHP, PNLS and multilateral stakeholders.	Stakeholders participated in person and virtually in the planning meeting sharing priorities to be considered for COP22 implementation.		UNAIDS hosted the meeting

Table 2.6.1: PEPFAR-CI COP22 Activities with Stakeholders				
Date	**Objective**	**Outcomes**	**Next steps**	**Comments**
During March and early April	Multiples email exchanges with CSO and stakeholders to review their concerns about the COP22 tools shared	Virtual meetings were held with CSOs to obtain feedback on the COP22 proposed strategies by program area and request for CSOs to be engaged in program implementation.	PEPFAR-CI to integrate CSO feedback in subsequent revisions of the strategic plan and COP22 proposal.	PEPFAR-CI faced multiple issues with tools that delayed the delivery of tools to stakeholders
04/19/2022	Summary of COP22 proposal (DataPack summary, FAST and strategic vision) shared with stakeholders	Virtual meeting was held with civil society members to review the FAST summary and DataPack flatpack, addressing any concerns prior to the COP22 approval meeting		
05/16/2022	COP22 SDS to be shared with stakeholders and meeting held with CSOs to review feedback integrated into the budget and DataPack	Meeting with CSOs was conducted virtually and led by PCO		Draft SDS was shared via email with CSO and all stakeholders (English version)
After COP22 Submission				
5/16/2022	Final SDS to be shared with CSOs and other stakeholders			English and French version
05/23/2022	PEPFAR-CI to explain how stakeholder feedback was incorporated in COP22 planning and how PEPFAR will continue to engage them throughout the year	Stakeholders understand how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP22, what was not, and why these decisions were made.	Share the redacted COP22 when available and approved.	A redacted version of the approved COP22 will be shared by email. Hard copies will be available upon request.

2.7 Stigma and Discrimination

Stigma and discrimination (S&D) are a major challenge impeding access to quality services for key and other vulnerable populations, including PLHIV in Côte d'Ivoire. A baseline assessment conducted by GFATM in 2018 found the following human rights related barriers to access HIV services: stigmatizing attitudes and discriminatory practices against PLHIV and key populations; the lack of knowledge on human rights and medical ethics related to HIV among personnel of the health sector; lack of training and awareness on rights of key populations and on HIV/AIDS among law enforcement agents; low level of legal literacy among key populations resulting in lack of knowledge and tools to stand up for their rights; problematic laws and policies included in articles of the 2014 HIV law where transmission can be criminalized, disclosure of status to a third party is allowed in certain non-medical circumstances, and parental consent is required for testing of minors. The Index Stigma 2.0 assessment provided similar findings.

To overcome these barriers several activities are currently being implemented or planned in the near term. These include the organization of a National Multisectoral Consultation on Human Rights, HIV and TB which resulted in the development of a Human Rights, HIV and TB Five-Year plan (2021-2025); the promotion of an enabling policy environment in the National HIV, AIDS and STI Strategic Plan (2021-2025); the inclusion of human rights activities in the application to GFATM (NFM3); the subscription of Côte d'Ivoire as a member of the International Coalition within the Global Partnership along with the development of an action plan; and the creation of a national working group on human rights, HIV and tuberculosis chaired by the Ministry of Justice.

COP22 proposed activities will build and leverage on existing efforts and resources with the goal to foster an enabling environment to overcome barriers to accessing quality prevention, and address stigma for equitable care for PLHIV, KP and other vulnerable populations. Specific strategies/advocacy actions will be aligned with the national priorities highlighted in the national road map/action plan and which focus on:

- Reducing self-stigma and its consequences on access to HIV care and treatment for PLHIV and KP;
- Reducing stigma and discrimination from health care and community providers;
- Increasing access to legal/services for victims of human rights violation; and
- Developing strategic partnership with the media and increasing the role of Civil Society Organizations (CSOs) to help address S&D.

The details and specifics for the activities that PEPFAR will receive PEPFAR support will be agreed upon with the national stakeholders and included in the scope of the community-led monitoring (CLM) program. Finally, PEPFAR Côte d'Ivoire will leverage the New Global Stigma and Discrimination component within the existing CDC-UNAIDS central support cooperative agreement for 2021-2026 for which Côte d'Ivoire is among the selected countries, to provide technical orientation for the development and implementation of the activities.

3.0 Geographic and Population Prioritization

PEPFAR-CI prioritizes investments, both geographically and demographically, to achieve 95:95:95 and reach epidemic control. In COP22, PEPFAR-CI will continue to support clinical service delivery and community services in 79 of 113 health districts in Côte d'Ivoire (see Figure 3.1 for a map of the 79 districts). These 79 districts are prioritized for targeted PEPFAR programming to reach higher-risk populations, supporting approximately 90% of the national PLHIV burden (see Table 3.1.1 for the current status of ART saturation in these districts). According to HIV estimates for 2021, 24 of 113 health districts in Côte d'Ivoire have over 90% of PLHIV on ART. PEPFAR-CI supports 22 of these districts, which include: Abengourou, Akoupe, Arrah, Bondoukou, Bouake-Nord-Ouest, Bouake-Sud, Boundiali, Cocody-Bingerville, Dabou, Ferkessedougou, Gagnoa 1, Guiglo, Grand-Bassam, Katiola, Korhogo 1, Koun-Fao, Man, Sakassou, Tanda, Toulepleu, Treichville-Marcory, Yamoussoukro, Yopougon-Ouest-Songon, and Zuenoula.

Table 3.1 Current Status of ART Saturation

Table 3.1 Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP22**	**# Current on ART (FY21)**	**# of SNU COP21 (FY22)**	**# of SNU COP22 (FY23)**
Attained	-	-	0	0
Scale-up Saturation	326,297 89% of 366,174 PLHIV est.	242,110 (PEPFAR) 270,037 (MSHP, including PEPFAR)	79	79
Scale-up Aggressive	-	-	0	0
Sustained	-	-	0	0
Central Support	-	-	0	0
Not PEPFAR Supported	39,877 11% of 366,174 PLHIV est.	22,205 (MSHP)	34	34

Source: Spectrum 2022 HIV Estimates, including NAOMI Subnational Model Estimates, as of Jan 2022, and PEPFAR FY21 reported results.

National projections estimate an additional 5 health districts, all supported by PEPFAR, will reach 90% of PLHIV on ART by the end of FY22 (Sep 2022). These districts include: Agnibilekrou, Alepe, Dimbokro, Tabou, and Transua. Figure 3.2 highlights currently saturated districts as well as those projected to be saturated in COP22.

See Appendix A for a complete table on the continuous SNU Prioritization to reach epidemic control, including 2021 ART coverage for each health district by age and sex groups.

Figure 3.1: COP22 PEPFAR geographic presence

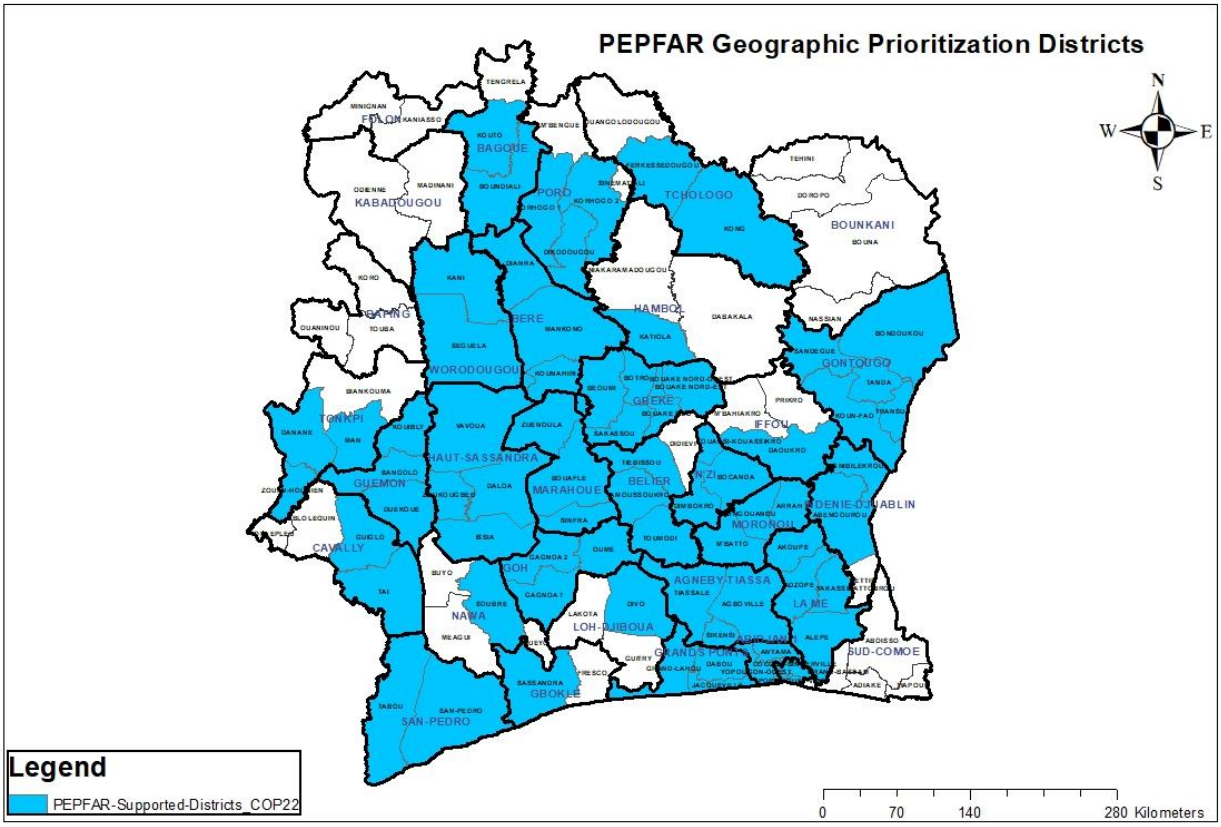
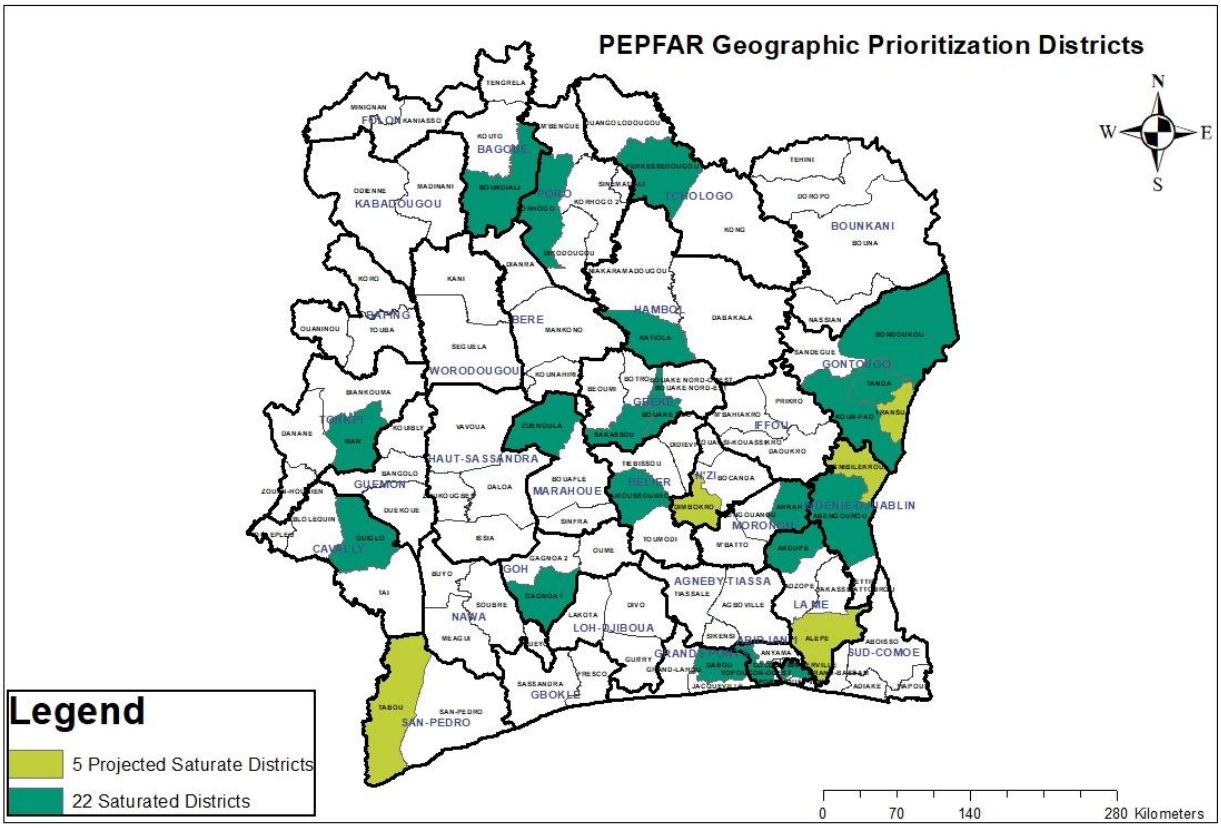
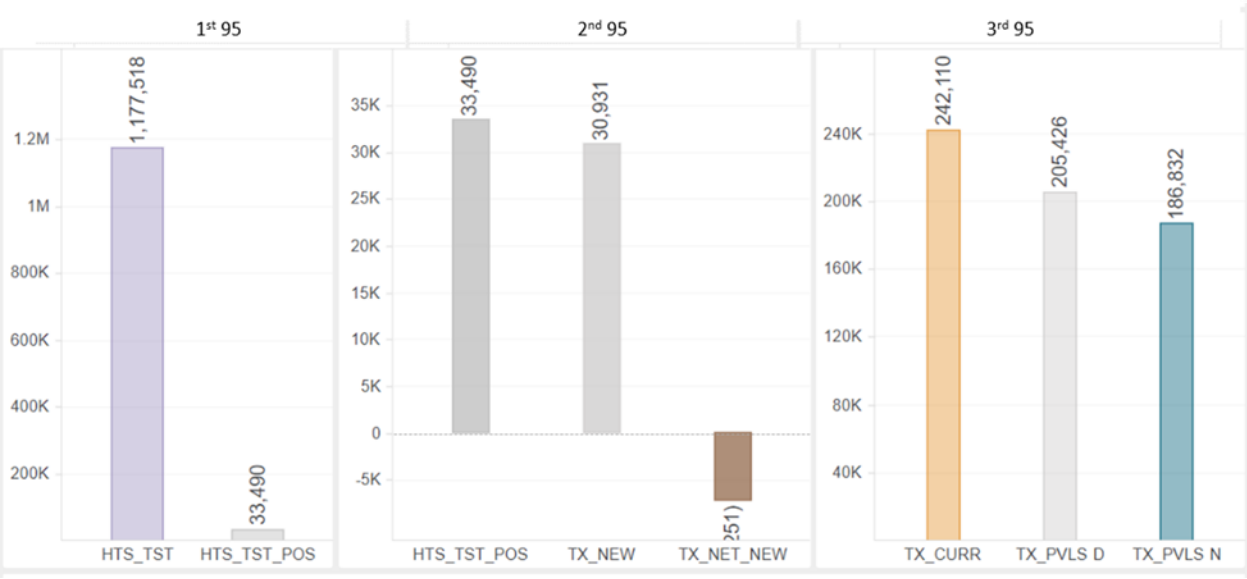


Figure 3.2: COP22 PEPFAR geographic prioritization and ART coverage saturation



4.0 Client-Centered Program Activities for Epidemic Control

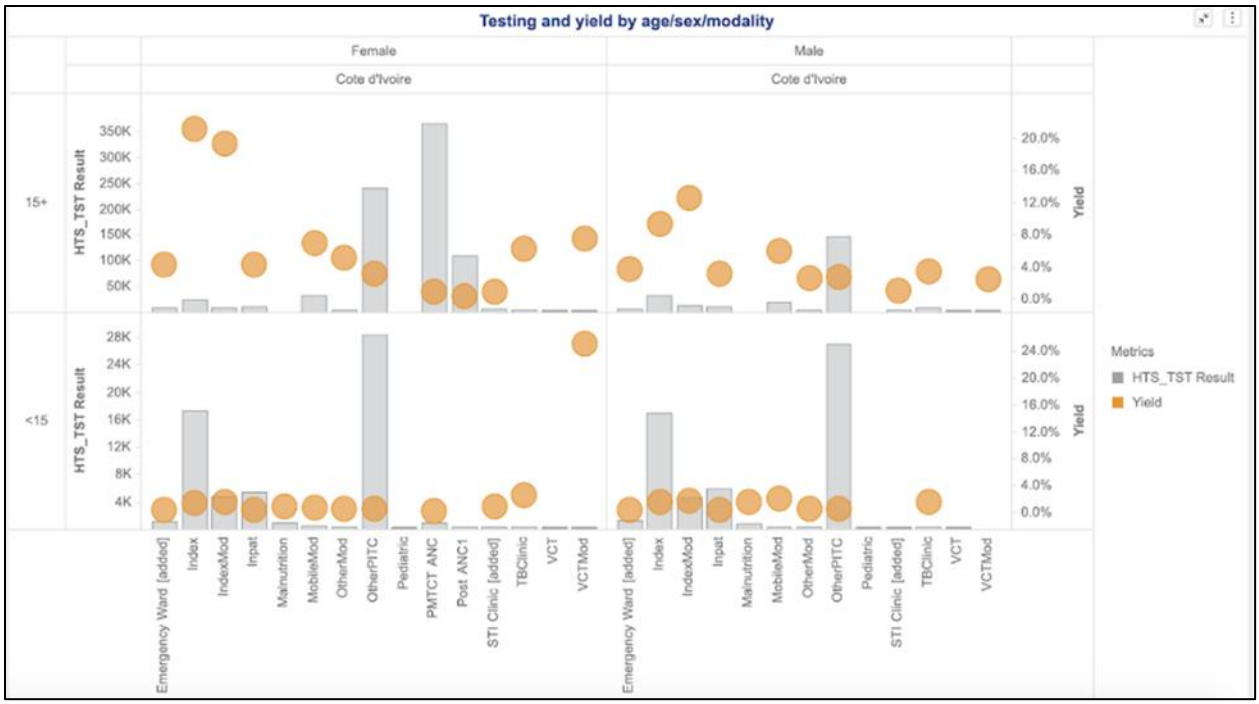
Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



4.1 Finding people with undiagnosed HIV and getting them started on treatment

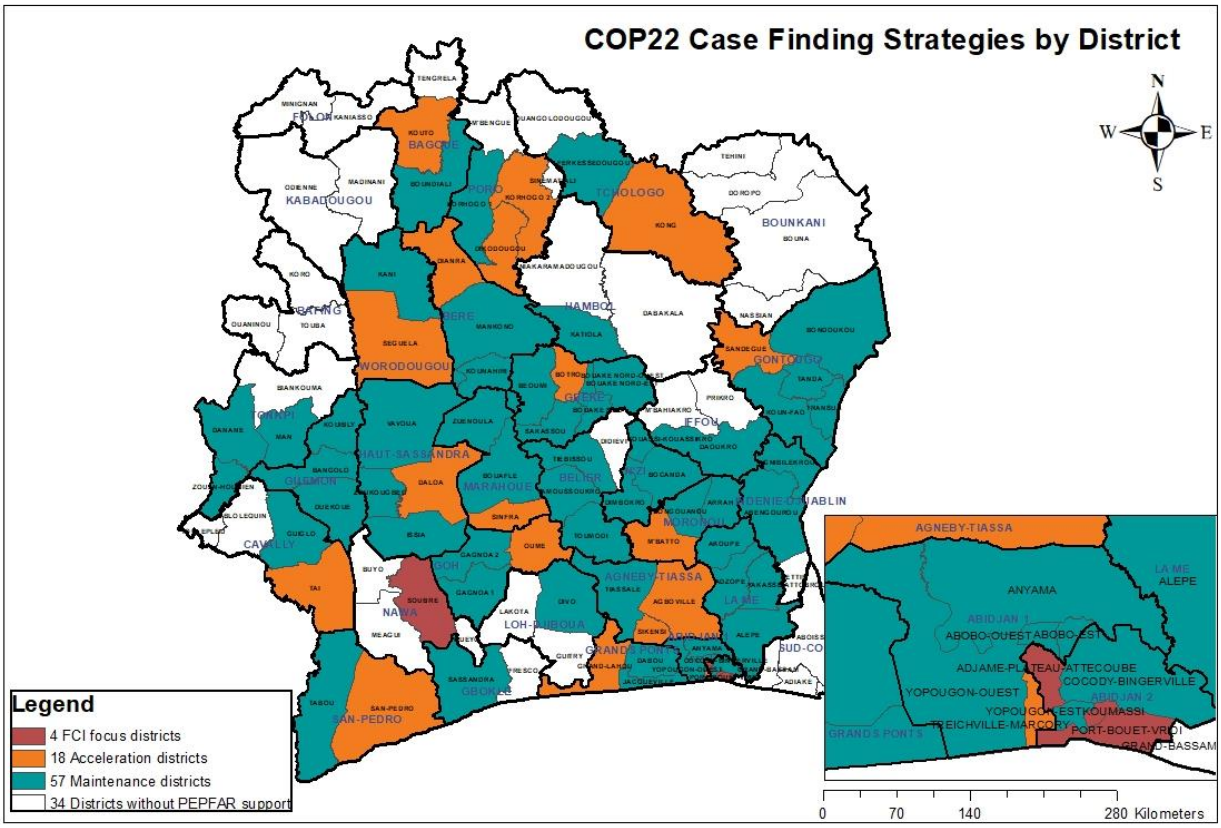
The COP22 case finding strategy will ensure a targeted approach with a focus case finding among subpopulations with the largest gaps, including women 40 years and older, men of all ages, and children and adolescents. HIV testing services (HTS) modalities, including facility-based provider-initiated testing and counseling (PITC), index testing, and community-mobile testing, will be prioritized and scaled in accordance with the demographic gaps in each geographic region.

Figure 4.1.1 Testing Volume and Yield by Modality and Age/Sex, FY21



As shown in Figure 4.1.2, three districts in Abidjan and one district outside Abidjan (Soubre) have been identified as Faith and Community Initiative (FCI) districts, as they had the largest case finding gaps in men and children in FY21 and will continue FCI activities to focus on closing gaps in these specific populations in COP22 using the Côte d'Ivoire national FCI coalition, which was launched in June 2020 under the leadership of the PNLS in collaboration with UNAIDS and PEPFAR. The goal of FCI is to address the gap in the clinical cascade for marginalized populations, including men, adolescents, and children. Through this initiative, PEPFAR intends to reinforce the capacity of the Alliance of Religious against AIDS and other Pandemic (ARSIP) to help reduce stigma and discrimination around HIV, especially for men. This will result in increased coverage of HIV testing among men living with HIV, ensure optimum linkage and treatment continuity in order to achieve viral suppression.

Figure 4.1.2: Stratification of PEPFAR-supported districts for tailored case finding strategies



Created by CDC Strategic Information Branch - April 2022

PEPFAR-funded FCI Activities started in COP21 and focus on the four FCI-targeted districts: Adjame-Plateau-Attecoube, Koumassi, Port-Bouet-Vridi and Soubre. Activities include the creation of a national steering committee responsible to oversee and monitor the implementation, the development and dissemination of new “messages of hope” through the faith alliances and inter-faith structures, and the implementation of the Circle of Hope model in one of the four districts. As of March 2022, PEPFAR and its FCI-implementing partners had: engaged with national stakeholders under leadership of MoH and ARSIP; developed and validated 13 new messages of hope addressing testing, treatment, and viral load suppression; and engaged with community leaders to map men’s hotspots in the Circle of Hope district to establish static community outposts. COP22 activities will build on achievements made in COP21 and reinforce the scope of the project. The program will continue to collaborate with the relevant stakeholders to implement the currently approved activities in the existing 4 targeted districts and create 3 new community outposts in the target district of Adjame-Plateau-Attecoube.

An additional 18 districts need to accelerate case finding to identify between 100 and 655 more HIV positive individuals to close district- or regional-level gaps (see Appendix F for a detailed table of each district and the case-finding gaps). COP22 (FY23) case finding targets (HTS_TST_POS) were allocated following a regional and district-level review of programmatic

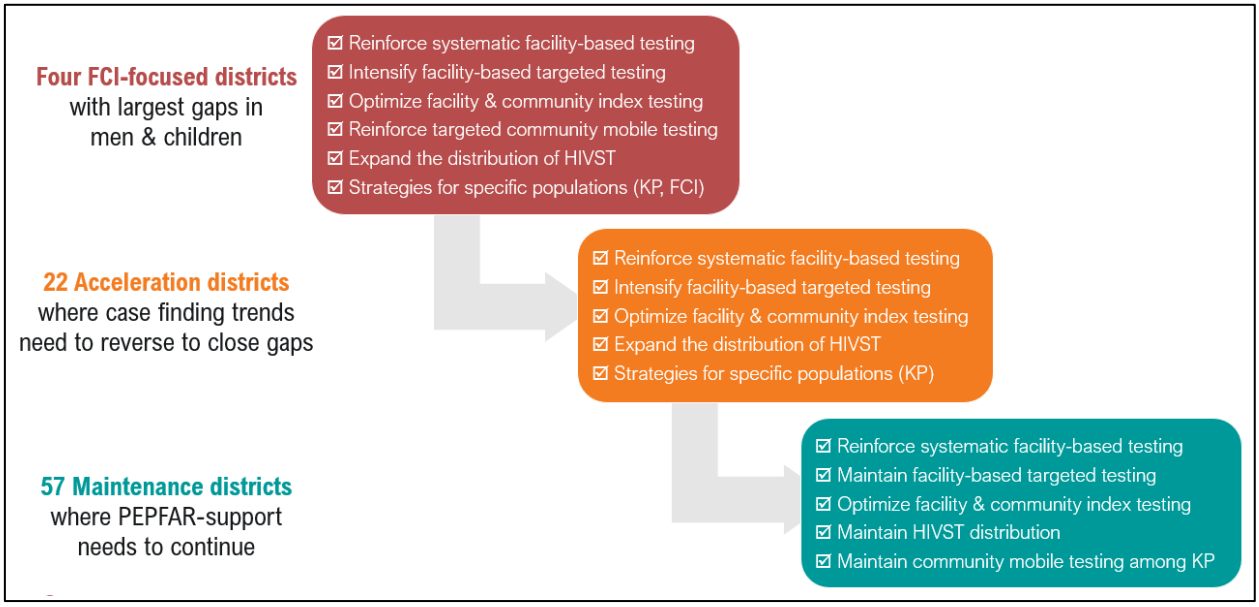
trends and subnational estimated ART gaps. Areas with largest remaining gaps, yet stagnant or declining case finding trends will receive concerted support from PEPFAR to ensure adequate human and financial resources, appropriate training/coaching of providers, and regular monitoring of site performance to accelerate case finding. The program will implement the following case finding strategies:

- Reinforce systematic facility-based testing at priority entry point [TB, sexually transmitted infection (STI), in-patient and malnutrition]
- Intensify facility-based targeted testing using the nationally approved screening tool (OPD and Emergency Ward)
- Optimize facility and community index testing among newly tested positive and viremic patients, with specific focus on male sexual partners of index women, and biological children of infected mothers
- Reinforce targeted community-based testing using the screening tool during mobile or event-based testing
- Expand the primary and secondary distribution of HIV self-testing as part of index and mobile testing for hard-to-reach individuals
- Implement specific strategies to reach KP, including social network strategies (SNS) and the enhanced peer outreach approach (EPOA)

The 4 FCI-focus and 18 acceleration districts together have approximately 50% of all case finding (HTS_TST_POS) targets for COP22 (FY23). Achievement of COP22 targets rests in the ability of these districts to expand and adapt successful case finding activities to reverse trends.

The remaining 57 districts will maintain community mobile testing among KP, existing HIVST distribution, facility-based targeted testing, reinforce systematic facility-based testing, and optimize index testing services.

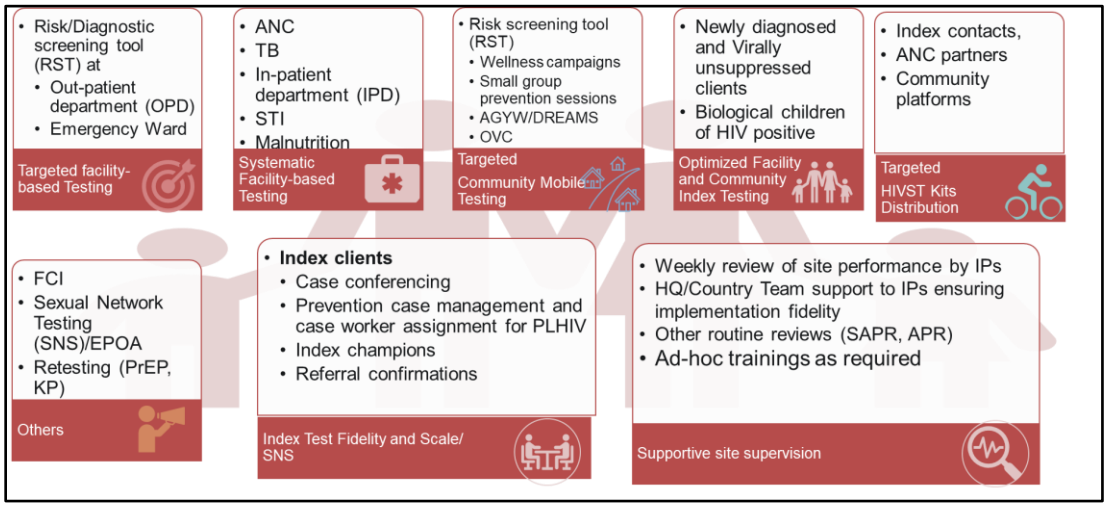
Figure 4.1.3: Specific strategies by type of PEPFAR-supported districts



PEFPAR-CI's case finding modalities are explained below and in Figure 4.1.4:

- Targeted facility-based testing (PITC) using a validated risk screening tool for patients seen in OPD and emergency wards
- Systematic PITC for patients in antenatal clinic (ANC), TB, inpatient, STI and malnutrition wards. Given the program's gaps in pediatric case-finding, and ongoing challenges with HIV-related mortality, systematic PITC will be prioritized to avoid missed opportunities in inpatient settings and all entry points where children are seen. Systematic PITC will also be offered to pregnant and breastfeeding women not tested during ANC at labor and delivery rooms and postnatal care.
- Targeted community-based testing using a risk screening tool during wellness/multi-disease approach and small group prevention sessions for priority populations (DREAMS, OVC, Men 25+)
- Facility and community-based index testing for sexual contacts of newly diagnosed and virally unsuppressed clients, and all biological children of positive women
- HIV self-testing (HIVST) distribution for contacts of index cases, sexual partners of positive ANC women and community platforms as needed

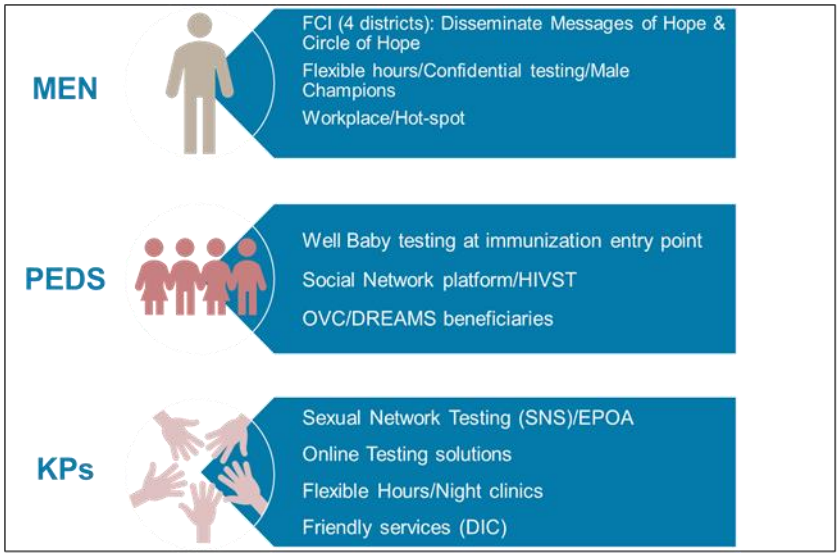
Figure 4.1.4: HTS modalities: implementation details



Innovative strategies for specific sub-populations (Figure 4.1.5) are described below:

- Men: collaboration with faith leaders (FCI) initiative to accelerate HTS through community posts and HIVST; flexible hours and male champions at facility level; workplace and hotspot testing in the community, especially within the KP program
- KP/high-risk: Sexual Network Testing; interval HTS for PrEP clients; intensified support at KP-predominant facilities; flexible hours for clients
- Children/adolescents: index testing and HIVST via Zvandiri peer-led model
- Mother-baby dyads: integrated HTS services in well-child visits and immunization clinics/outreach

Figure 4.1.5: Additional Strategies by Population with the Largest Gaps



PEPFAR-CI will continue to address cross-cutting issues that impact case finding and linkage services. They have been mentioned in each section above and are summarized as follows: i) implementation of standard operating procedures (SOPs) with fidelity, ii) scaling up safe and ethical index testing; iii) assessment and capacity building to meet the standards, including TB services; iv) assessing and providing HRH support as needed for different strategies; v) ensuring data quality and integrity of HTS services; vi) developing a dashboard and expansion of CommCare to monitor the collaboration between clinical and community partners on HTS and linkage. Key barriers at the community-level, including stigma and out of date HIV-knowledge, will be reduced through Messages of Hope and prevention activities to strengthen demand for testing among at-risk individuals. Finally, community-clinic collaboration and data management will be improved as PEPFAR-CI gradually moves towards comprehensive service delivery through consolidation of the IP landscape. This will be seen in Abidjan and more than half of the 79 PEPFAR-supported districts in FY 23.

Adaptations to COVID-19

During the early period of the COVID-19 pandemic, PEPFAR IPs developed contingency plans to adapt to a changing and more restricted environment. Currently program implementation has returned to baseline, but these strategies can be resumed if COVID transmission rebounds and necessitates preventive measures.

Linkage Strategies

PEPFAR-CI will continue to increase the frequency and intensity of partner management to ensure data quality, integrity, and transparency of positive cases reported and linked to treatment. Community-based HTS activities will follow PEPFAR's geographic footprint, focusing on the catchment areas surrounding PEPFAR-supported facilities, whereas other areas have been transitioned to MSHP support. Moreover, linkage will be facilitated through comprehensive service delivery by a single IP responsible for both facility and community-based activities. In areas where facility and community-based IPs are distinct, SOPs will be respected, including

escorting community-identified positives to facilities for ART initiation. CQI interventions will focus on strengthening this process, and utilization of the patient-level CommCare tool by both facility and community-based lay workers will improve the accuracy of linkage tracking. Details of linkage strategies are described in Figure 4.1.6 below.

Figure 4.1.6: Linkage to ART & Early Engagement: Strategies designed to best serve clients newly diagnosed with HIV

Populations	Linkage Approaches	Linkage Outcomes
MEN Young & Older	▪ Immediate ART, offered as multi-month starter pack ▪ Escorted linkage and navigation that is discrete and empathetic ▪ Friendly clinics (days / time or with dedicated space); expedited services (i.e., fast-tracking) for those working or in school, including after-hours, weekends, etc. ▪ Access to in-person counseling	▪ > 95% linkage rates in all cases where HIVST outcomes have been ascertained ▪ An accountable staff member designated to confirm successful linkage and early engagement ▪ Decentralized drug delivery linkage
WOMEN PMTCT patients & Older	▪ Immediate ART, offered as multi-month starter pack; ▪ Escorted linkage and navigation that is discrete and empathetic ▪ Access to in person counseling and remote psychosocial support (SMS, phone calls, or community workers)	
CHILDREN/ ADOLESCENTS	▪ Immediate ART ▪ Reinforce family-centered approach with focus on mothers and caregivers ▪ Expand point-of-care EID to accelerate treatment initiation ▪ Strengthen bi-directional collaboration between OVC and pediatric care and treatment programs ▪ Support friendly services for children and adolescents, including roll out of the Community Adolescent Treatment Supporters Program (CATS) in 2 districts in Abidjan	

4.2 Ensuring viral suppression and ART continuity

Viral load coverage (VLC) and viral load suppression (VLS) at PEPFAR-supported sites has improved over the years from 67% in FY17 to 86% in FY22 Q1, and from 70% in FY17 to 92% in FY22 Q1, respectively. Figures 4.2.1 and 4.2.2 illustrate viral load coverage and suppression by sex and age bands at the end of FY21 Q1.

Figure 4.2.1: VLC by age and sex, FY22 Q1

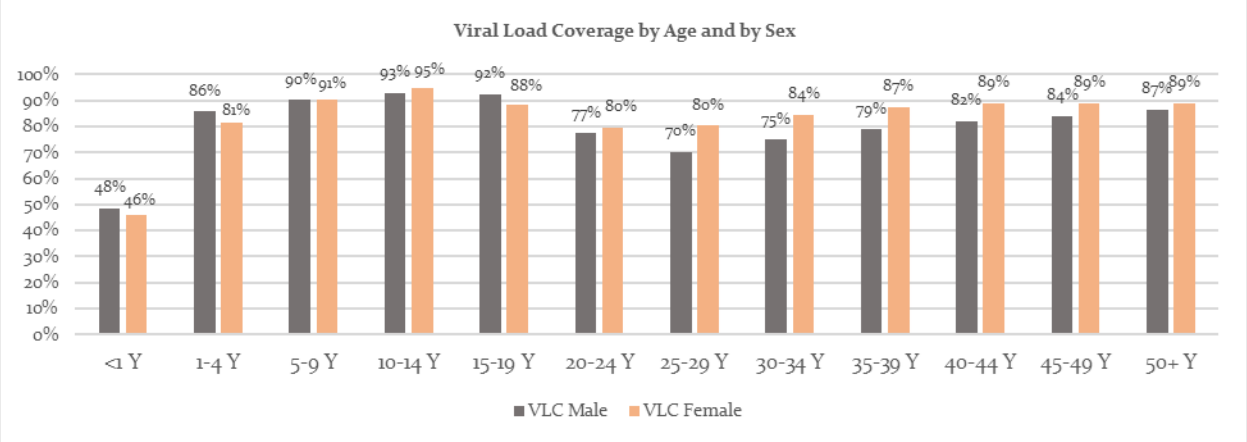
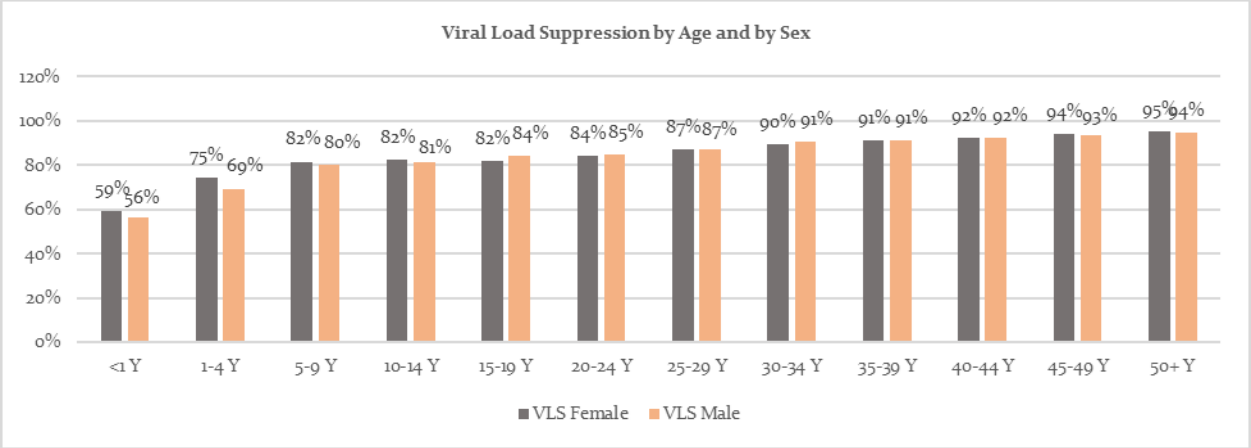


Figure 4.2.1: VLS by age and sex, FY22 Q1



Despite this overall improvement, the program still has suboptimal VLC (<80%) in 15 of the 79 prioritized districts. Detailed analysis of VLC and VLS continue to show gaps in sub populations including KP, pregnant and breastfeeding women (PBFW), young adults aged 20-34 years, and children aged 0-4 years.

To address these gaps during COP22, PEPFAR will continue to implement and expand strategies and practices that have been demonstrated to improve VLC and VLS at 455 high impact and moderate impact clinical sites, including at least 100 pediatric sites with CLHIV cohorts of >10 patients. The low impact sites receiving PEPFAR support will have a technical assistance model with no additional human resource support. However, these sites will be linked to nearby high impact and moderate impact sites, thereby benefiting from those investments. These strategies include extended operating hours at clinical sites for consultation and blood draws during weekends and evenings after work; home blood draws and transportation for patients with physical disabilities; improved patient flow by combining appointments for ARV pick up with VL testing; and prioritization of children and PBFW by maximizing opportunities for VL testing at routine visits, and by proactively tracking these cohorts, alerting patients and providers when tests are due, and following up on results for decision-making. Additional strategies for improving VLC will include dedicated VL testing days with fast-track patient circuits at the facility or nearest satellite lab, and additional HRH for VL collection. Dedicated clinical and community lay counselors will be recruited and strategically placed at key sites based on demonstrated gaps and patient needs. Their roles are to remind patients of appointments, collect any relevant information that will help improve patients' adherence to treatment and reduce interruption in treatment, and share the list of non-reachable patients with community IPs to initiate home visits.

For hard-to-reach sub populations such as KP, children, PBFW and clients living in remote locations, PEPFAR-CI will continue to maximize the use of dried blood spot (DBS) testing and introduce and progressively transition to plasma separation cards (PSC). DBS would account for approximately 20% of all planned viral load tests and PSC would account for about 50% of the planned DBS tests. Community lay counselors will be trained on both DBS and PSC sample collection.

Finally, the direct SMS patient notification system from OpenELIS would be expanded to all viral load labs in FY23 and would be configured to alert patients with unsuppressed viral load of their results. This would improve the turnaround time for results among all PLHIV and particularly hard-to-reach populations as well as boost overall efforts to improve VLC and VLS.
These strategies will be implemented at the maximum possible number of PEPFAR-supported sites, calibrated to their specific needs and within existing budget constraints. Progress will be monitored every week using the VL/EAC electronic tools. IPs will be monitored on a weekly basis with coaching and visits to sites with the poorest performance by PNLS and district health teams, and close monitoring to improve indicators. IPs with poor performance after 3 months of implementation of the surge plan will be put on performance improvement plans. The goal for PEPFAR-supported sites will be to reach 95% coverage and 95% suppression by September 2023.

The key underlying challenges for linkage to care include but are not limited to double testing of patients already on ART, suboptimal application of established procedures to ensure effective active referral and confirmation of ART treatment initiation for positives identified, data quality and integrity challenges, and referral of positives to non-PEPFAR supported sites when community HTS is happening outside of PEFPAR's geographic footprint. Linkage continues to be >95% for positives identified in the facility setting, and PEPFAR-supported HRH will continue to implement the following successful interventions:

- Enhanced post-test counseling
- Patient navigation to ART initiation
- Weekly monitoring of linkage as a QI measure at 173 high impact ART sites

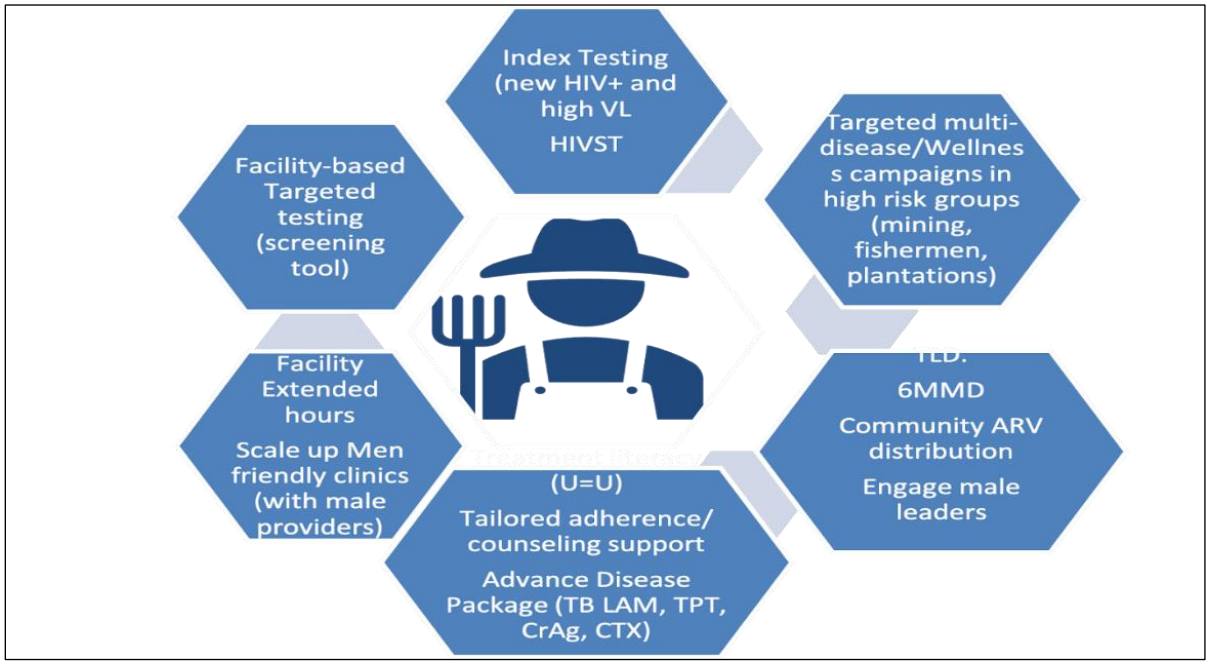
Linkage of positives identified in the community represents a more significant challenge and will be addressed as mentioned in Section 4.1 above. Despite significant case-finding efforts, PEPFAR-CI has struggled to increase its TX CURR at the desired pace, for a number of key reasons: interruptions in treatment (IIT), HIV-related mortality, and data quality issues pending the nationwide implementation of patient-level data systems. At the end of FY22Q1, only 70% of adolescents aged 20-24 and young men aged 25-29 years that interrupted treatment were returned to care.

PEPFAR-CI, in collaboration with MSHP and implementing partners, has developed a set of SOPs, guidelines, tools and materials on ART adherence counseling, tracking, and managing of routine patient appointments, and return to care for IIT patients. Implementing partners and PEPFAR staff provide training and mentorship to providers, community lay workers and other relevant stakeholders to ensure implementation with fidelity of those tools and materials. COP22 planning is based upon optimal HRH to patient ratios and intensified partner management such that sites have adequate and qualified HRH to deliver quality services throughout the cascade. In addition, the COP22 HRH ratios consider the widespread implementation of MMD, and reduced visit frequency for established patients, thereby achieving significant efficiencies.

Continuity of treatment among men

Given the disproportionately low VLS rates and clinical outcomes among men, continuity of treatment strategies needs to be patient-centered and implemented immediately. As illustrated in the graphic below (Figure 4.2.5), reinforcing and expanding where applicable, the implementation of extended hours, differentiated service delivery models for established patients, integration of HIV services into broader wellness approaches, and designation of men's champions will be reinforced and expanded, where applicable, rendering services more accessible and attractive in COP22. Counseling messages would be updated and improved, to emphasize accurate risk perception and HTS, early ART initiation, and U=U.

Figure 4.2.3: Continuity of treatment services for men



For men referred to community services, peer navigators will focus on self-efficacy, treatment literacy around TLD and awareness-raising around DSD options to ensure initiation of treatment even in the absence of symptoms. In all cases, coping potential and self-efficacy will be addressed per MenStar recommendations. Additional detail on services targeting men is illustrated in Table 4.1.6.

Continuity of treatment for children and adolescents

In order to improve continuity of treatment, adherence to ART, and long-term VLS among children and adolescents, PEPFAR-CI will be implementing the Zvandiri CATS model as highlighted in the PEPFAR Solutions platform and COP22 Guidance. Through this model, implementing partners in two high-burden districts in Abidjan will recruit, train, and deploy peer counselors known as community adherence treatment supporters (CATS) to provide post-test counseling and linkage to ART at facility-level, as well as adherence support for CAYPLHIV and caregivers at community-level. In addition, CATS provide mentorship to clinical providers on child/adolescent-friendly communication and HIV status disclosure, as well as facilitating adherence groups. This initial year of implementation will also include significant engagement

with MSHP and civil society partners, as successful implementation of the model across several sub-Saharan African countries has illustrated the need for CATS to be integrated into multidisciplinary health teams at facility-level. In the community setting, the CATS play a critical role in changing attitudes and combating stigma and discrimination, and as important representatives of PLHIV engaged in the response.

Continuous Quality Improvement (CQI) and Community Led Monitoring (CLM)

Building on COP21 achievements, PEPFAR-CI will expand Continuous Quality Improvement (CQI) activities with site-level QI coaching to encompass all high-impact sites in Abidjan, where treatment continuity gaps are largest. Technical assistance will be provided to clinical-community IPs to improve standardization of packages of services, and address data and service-delivery quality across PEPFAR indicators, especially case finding, continuity of care, and VLS. Coaching will leverage previous and current DQA work and scale-up of weekly data quality reporting tools. Intensive site level coaching activities will include training of CSOs, training of trainers (TOTs), and SOP development, conducted in partnership with IPs. In addition, CQI activities include robust engagement with civil society, using evidenced-based strategies for capturing clients' experiences including anonymous comment boxes, telephone hotlines, journey mapping, client surveys, and community advisory boards.

Community engagement is key to understanding priorities for improving care, ensuring continuity, and reducing stigma among PLHIV. Building on activities in COP20 and COP21, PEPFAR-CI will implement the CLM project with a specific focus on smaller and marginalized CSOs representing key populations. CLM support will include direct funding support for the monitoring itself, as well as organizational capacity building to render these smaller CSOs more competitive for future funding opportunities.

Figure 4.2.4 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY21

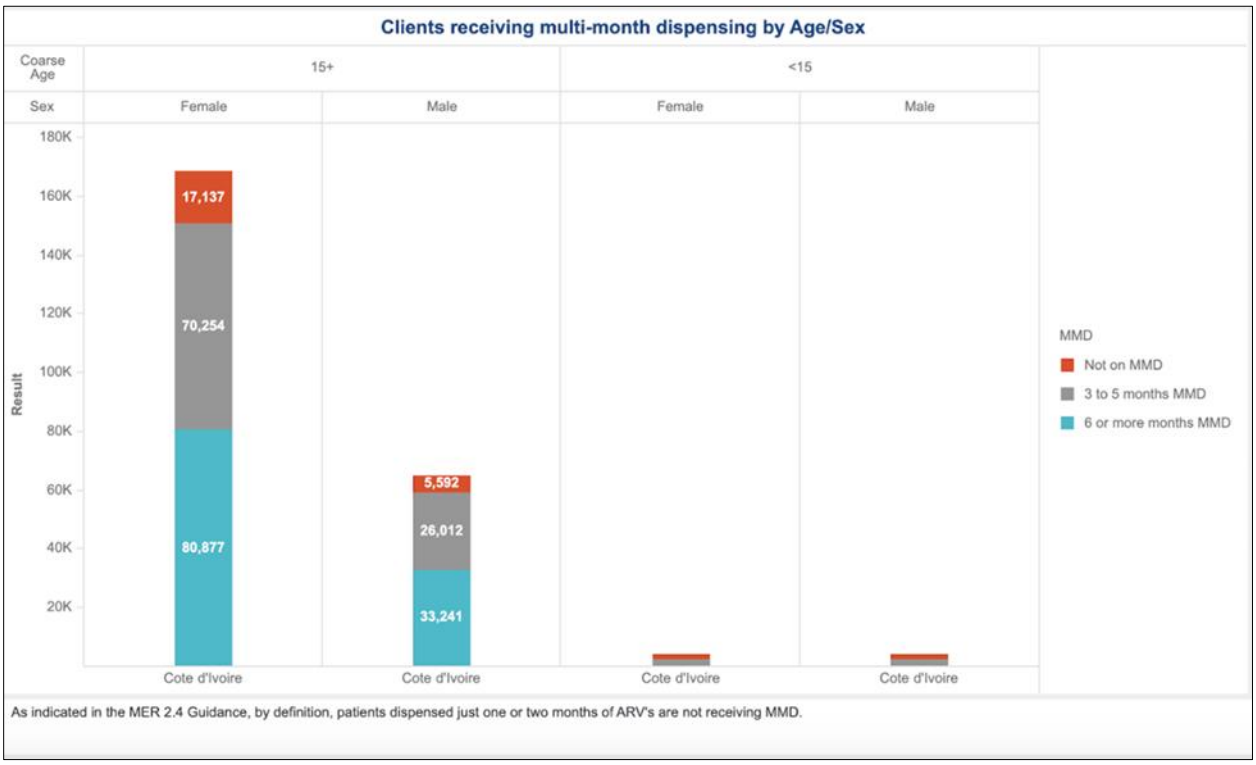
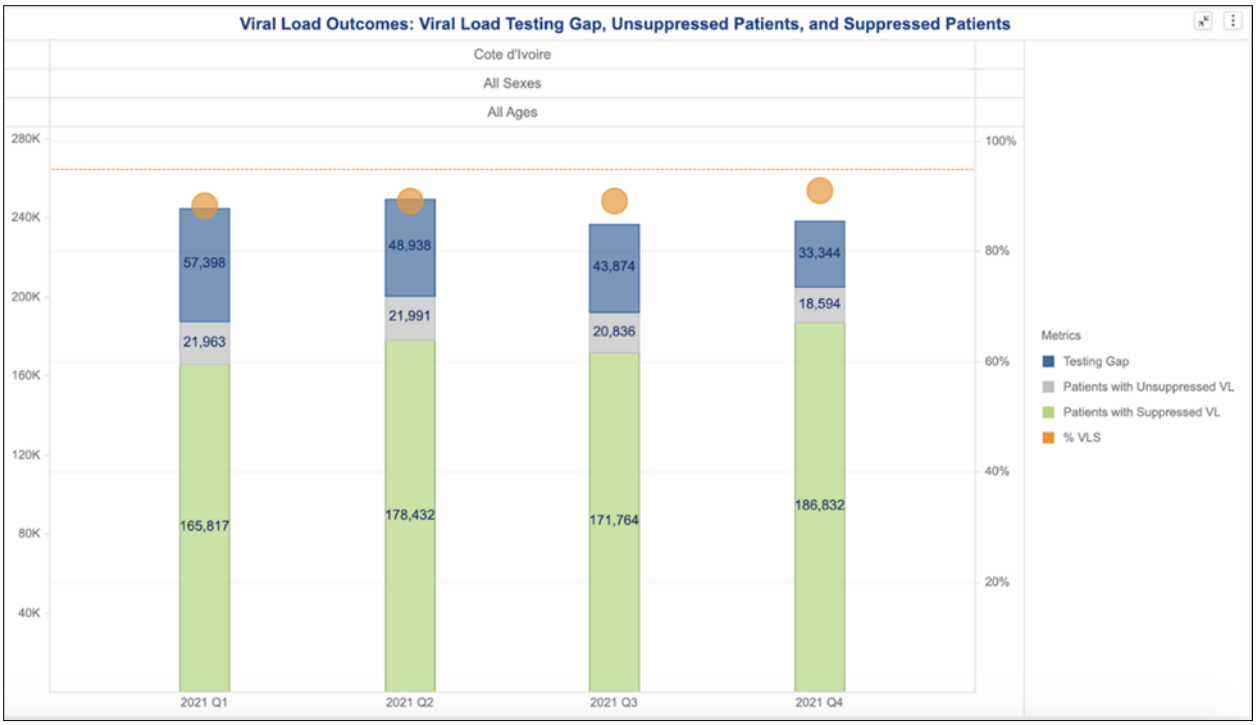


Figure 4.2.5 Viral Load Outcomes, FY21



4.3 Prevention, specifically detailing programs for priority programming

During COP22, PEPFAR Côte d'Ivoire will continue to refocus prevention activities for better epidemiologic alignment, including data-driven geographic prioritization and greater programmatic integration between OVC, DREAMS, and KP activities. Coordination with health facilities will be reinforced to support strong linkage and retention in care and treatment. In addition, COP22 will enable the Ministry of Women, Family and Child (MFFE), through the National program for Orphans and Vulnerable Children (PN-OEV), to strengthen the coordination and monitoring-data at the national level for the implementation with fidelity of the OVC, DREAMS, and GBV programs.

a. HTS:
   The program will continue to offer pre- and post-test counseling to all persons willing to be tested. All persons tested negative are given messages and tips for the prevention of HIV. Persons tested negative, especially contacts of index clients and those at high-risk of HIV transmission are offered condoms including lubricants for key populations and promptly referred to PrEP services.

   The program will ensure that persons receiving PrEP are tested every three months for HIV according to the national HTS algorithm. HIV self-testing (HIVST) will only be used in the absence of RTKs or due to COVID-19-related restrictions. Currently, Côte d'Ivoire is not offering blood based HIVST, which is more sensitive than the oral test. If HIV seroconversion is detected among an individual taking PrEP, the individual will be actively referred and linked to treatment services.

   The program will test serodiscordant couples at least once a year if the negative person has risk factors and/or the index is virally unsuppressed.
   The OVC program will continue to assess and identify persons at high-risk of HIV infection and test them or refer for testing. All biological children under 19 years of age are being tested. Self-test kits will be given to parents or caregivers to test children older than 2 years old if needed.

   The program will scale up adolescent friendly HTS services, which is part of the DREAMS core package of interventions. AGYW will be reached through mobile HTS, after-hours services in health facilities, HTS delivered in Safe Spaces/Girls Clubs, and HIV self-testing. HTS will also be offered to the male sex partners of DREAMS participants.

   The program will continue to provide systematic testing to ANC1 and post ANC1 women but will not support retesting of negative ANC women during the third trimester because of low HIV prevalence among pregnant women.

b. DREAMS:

The HIV epidemic in sub-Saharan Africa affects women and girls disproportionately relative to men and boys. In 2019, women and girls accounted for 59% of the new infections, 24% of which were among AGYW aged 15-24. In Western and Central Africa, specifically, 48,000 AGYW aged 15-24 acquired HIV in 2019, accounting for nearly 70% of all new cases in this age group[9]. These gender disparities also exist in Côte d'Ivoire.

According to the most recent estimates available, AGYW aged 15-24 in Côte d'Ivoire account for approximately 25% of new HIV infections in the country. Despite representing 50% of adolescents and young people aged 10–24[10], AGYW represent 86% of new HIV infections, 61% of PLHIV, among the population. The HIV incidence among AGYW aged 10-24 is triple that of adolescent boys and young men of the same age (0.00024 vs. 0.00008, respectively)[11].

Drivers of HIV among young women and girls in Côte d'Ivoire include a wide range of gender inequalities such as early and forced marriage, gender-based violence (GBV), unequal access to information including sexual health knowledge, limited negotiating power and lack of economic autonomy. The deep and profound HIV-related gender disparities in the country are further driven by broader structural issues that perpetuate young women and girls' vulnerability, including harmful cultural and gender norms, food insecurity, marginalization and systemic oppression, human trafficking, humanitarian crises and COVID-19 repercussions.

Changing the trajectory of new HIV infections in Côte d'Ivoire to reduce gender disparities requires investments and strategies that will comprehensively address the HIV prevention needs of KP and the risks and vulnerabilities of AGYW aged 15-24. Given the mixed nature of Côte d'Ivoire's HIV epidemic, the ability to target the highest risk adolescents at highest risk of HIV is a critical determinant of effective programming.

HIV prevention program planning in Côte d'Ivoire must consider the aforementioned context-specific, social, and structural determinants that increase HIV risk among young women and girls. It must be guided by the DREAMS evidence base, DREAMS Theory of Change program results, and/or evidence of impact on HIV incidence while also considering the local epidemiology. Programmatic review of age disaggregated national, subnational, and local data on HIV among young women and girls is imperative to obtain more granular profiles of those at the highest risk of HIV and/or STI acquisition in the prioritized localities. Moreover, addressing HIV infections among young women and girls in Côte d'Ivoire requires harmonization with prevention interventions among their male sexual partners in addition to the highest-impact elements of prevention: long-term VLS among known PLHIV and PrEP.

[9] 2020 Global AIDS Report
[10] National Stats Institute
[11] Spectrum 2022

The PEPFAR Determined, Resilient, Empowered, AIDS-Free, Mentored and Safe (DREAMS) Partnership addresses key HIV risk and vulnerability factors among AGYW through an evidence-based, age-informed, comprehensive, and multi-sectoral package of biomedical, behavioral, and structural interventions. Since COP19, PEPFAR-CI has been implementing the DREAMS program in four SNUs: Abobo-Est, Cocody-Bingerville, Man and Daloa. The PEPFAR-CI DREAMS comprehensive package of services was developed using PEPFAR approved curriculum, including: Parenting for Lifelong Health (typically called Sinovoyu or Ahoundjoue in Ivorian local language); SASA!; and “Complete Sexual Education,” a country-specific curriculum. The Complete Sexual Education curriculum includes the three HIV and violence prevention modules.

Table 4.3.1 shows the layering services offered by age band broken down by primary, secondary and contextual interventions.

Table 4.3.1 DREAMS Interventions by Age Groups

Table 4.3.1: DREAMS Interventions by Age Groups				
		10-14	15-19	20-24

INDIVIDUAL	**Primary Individual Interventions**	• Prevention of sexual violence and HIV at school or in the community
		  ○ Social assets building
		  ○ Psychosocial support
		  ○ HIV assessment
		  ○ Financial Literacy		

	Secondary Individual Interventions	• Educational Support / Literacy • Access to condoms* • Mixed contraception • HIV counseling, testing, and active referral for ART • Post-violence care • Social protection • Food security and nutrition	• Educational Support / Literacy • Access to condoms • Mixed contraception • HIV counseling, testing, and active referral for ART • Post-violence care • Social protection • Food security and nutrition • Testing and active referral for PrEP • Socio-economic strengthening	• Educational Support / Literacy • Access to condoms • Mixed contraception • HIV counseling, testing, and active referral for ART • Post-violence care • Food security and nutrition • Testing and active referral for PrEP • Socio-economic strengthening
CONTEXTUAL	**Contextual Level Interventions**	• Parenting/Caregiver Programming (AHOUNDJOUÊ)^ • Community mobilization/ community norms change • Household economic strengthening^		

*Only for AGYW who are sexually active; ^ Only for parents of AGYW aged 10-19 old

Through implementation of the aforementioned curricula with AGYW, parents, and community leaders, PEPFAR-CI achieved 100% of the annual target in COP20 and COP21. A total of 50,975 AGYW completed the DREAMS program at the end of FY21, and program data projections estimate that at the end of FY22, the number of AGYW completing DREAMS will grow to 87,158. This projection represents a total completion rate of 33% among the 267,739 AGYW at high risk across all 4 DREAMS SNUs. Cocody-Bingerville and Daloa are projected to achieve 29% and 34% (of 7,704 and 9,604 AGYW, respectively). And in the Man and Abobo-Est DREAMS districts, completion rates are projected to be particularly impressive among AGYW in the 10–14-year age band (79% and 61% of 11,567 and 14,858, respectively).

Despite these achievements and projections, the PEPFAR-CI DREAMS program continues to experience challenges with reaching and supporting AGYW, especially those who are the most vulnerable to HIV. To ensure the most hard-to-reach AGYW are identified, the DREAMS program will continue to leverage existing platforms such as OVC, HTS, sexual and reproductive health, ANC, STI, and KP. The program will continue to strengthen linkages with the OVC platform for eligible DREAMS beneficiaries to guarantee access to integrated HIV and violence primary prevention services for all eligible adolescent girls ages 10-14 and for those ages 10-17 who may require family-based support and case management. The program will also continue to use the Girls Roster methodology to systematically identify the most vulnerable AGYW based on risks factors such as pregnancy, extreme poverty, drug or alcohol use, early school drop-out, and high-risk sexual behavior.

To identify AGYW most at risk, PEPFAR-CI will also implement new and innovative strategies to fill programming gaps. Specific strategies planned for COP22 include:

- Enrollment analysis (i.e., comprehensive cohort profiles) to better reach young women identified as selling sex, never schooled, and other AGYW most vulnerable to HIV
- Collaboration with KP IPS and KP national networks (i.e., ROPC-CI)
- Social network strategies, economic strengthening strategies, and support for gainful employment to increase enrollment of AGYW aged 20-24

PEPFAR-CI's DREAMS programming is well accepted in the community and the commitment of AGYW, and their parents facilitates the creation of a pool of DREAMS Ambassadors at the national, regional and site level. DREAMS Ambassadors reinforce messages around the benefits of DREAMS, advocate with political and administrative authorities, and promote DREAMS across the SNUs. In COP22, DREAMS Ambassadors will also play an important role in demand creation among the 20–24-year age band to increase representation in the program.

To address the challenge of low availability and access to PrEP, advocacy for community-based PrEP initiation is ongoing and will be complemented in COP22 with a programmatic review of current PrEP uptake by AGYW at the site level to identify best

practices and opportunities for scale-up. By advocating for enabling environments and adopting a demand creation approach, PEPFAR-CI aims to overcome social and structural barriers and increase the number of AGYW on PrEP.

Finally, AGYW-centered programming in Côte d'Ivoire is also lacking clearly defined pathways and journey maps that describe how girls and young women 'move' through the system to access the most critical services in a timely manner, at the most intense periods of risk and in between. PEPFAR Côte d'Ivoire DREAMS districts lack robust quality improvement systems that systematically use data to support program improvement beyond routine monitoring and reporting. The program's coordination mechanisms are multi-sectoral, but a good number lack a specific mandate to oversee AGYW programming. Most IPs engage AGYW in program planning but fail to engage them during program implementation and evaluation. To address these gaps, PEPFAR-CI will leverage the continuous quality improvement (CQI) approach to improve DREAMS programming.

PEPFAR-CI's commitment to AGYW is demonstrated by its expanding DREAMS investment, which has grown from $9,633,020 (9%) of the COP19 budget to $16,000,000 (15%) of the COP22 budget despite a steadily shrinking envelope. To maximize efficiency, PEPFAR-CI has refined and standardized package costs across all USG agencies and PEPFAR implementing partners based on IP expenditures, results, targets, and package content. The financial data analysis used to inform the current budget considered economies of scale for both variable and fixed costs of services.

The cost of secondary clinical services provided to DREAMS beneficiaries was similarly calculated based upon historical expenditures and indicated that a total of $316,950 will cover clinical needs for AGYW in the 4 districts. This cost allows the allocation of a specific budget to the clinical IP in each of these districts to cover their expenses with AGYW referred from the DREAMS program. This budgeting method is expected to maximize PEPFAR's financial investments by allocating to each IP the budget necessary to serve the number of AGYW allocated to it, considering economies of scale for various service components (e.g., HRH, training, etc.) that can be achieved while increasing the population volume.

In COP22, all IPs will continue to use an operable layering tool to ensure completion of at least the full primary package of interventions, monitor the referral and counter-referral system of active AGYW, and report the AGYW_PREV indicator among DREAMS beneficiaries with greater fidelity in accordance with their age and needs. To ensure the most vulnerable girls are identified, all partners will conduct a vulnerability assessment to screen and to offer enrollment in DREAMS services. Once enrolled in the program, AGYW will be offered a specific package of services based on individual needs.

c. OVC:

In Côte d'Ivoire, 476,391[12] children aged 0-17 are affected by HIV, including 27,542 children and adolescents aged 0-19 who are living with HIV. To address the needs of OVC[13], PEPFAR-CI delivers an OVC package of services in 38 of Côte d'Ivoire's 79 PEPFAR-supported districts; the program, which targets children aged 0-17 and their caregivers, has been part of the PEPFAR-CI portfolio from its inception.

In COP22, five implementing partners (Save the Children, two local partners, IRC, and SEV-CI) will continue to deliver OVC services in the existing 38 OVC districts. PEPFAR-CI will offer a comprehensive package of services to eligible OVC beneficiaries through intensive family-based case management and a range of services addressing household vulnerability over longer periods of time. The program will employ existing enrollment tools from the HIV-Sensitive Community Case Management package to identify children aged <18 who are HIV-positive, survivors of sexual violence, HIV exposed infants (HEI) of mothers who interrupted treatment at PMTCT sites, biological children of HIV-positive mothers, children of FSW, double orphans, children living in child-headed households, and/or pregnant adolescents/adolescent mothers. These priority OVC sub-populations will be offered a comprehensive package of services to ensure they are healthy, stable, safe, and schooled. In COP22, the main entry points for selection and enrollment of OVC for this service package will be pediatric services, ART enrollment points within health facilities, mother-to-child-transmission (MTCT) services, community-based HIV testing platforms, GBV service points, KP dedicated services, and other relevant community- or facility-based referral points.

All children with unknown HIV status who are enrolled in the OVC program will receive HIV risk assessments to ensure those in need of HIV testing are tested or referred and linked to ART if positive. Those found to be HIV-negative or ineligible for testing will receive the primary prevention package, including an evidence-based sexual violence and HIV prevention intervention. In COP20, 148,728 of 152,105 of beneficiaries aged <18 receiving comprehensive services had their HIV status reported to OVC IPs, representing 98% proxy knowledge of HIV status. Moreover, among the 6,828 OVC known to be HIV-positive, all (100%) were on ART. In COP22, the OVC program aims to offer enrollment at least 90% of C/ALHIV on ART in OVC districts, in alignment with COP guidance. The OVC program will also continue providing age-appropriate disclosure support to C/ALHIV and their caregivers and help to improve index testing for all biological children and siblings (aged <19 with unknown HIV status) of HIV-positive mothers.

[12] Plan Strategique National, PNOEV 2016-2020

[13] PEFPAR defines orphans and vulnerable children (OVC) as children and/or orphans infected with or affected by HIV. The latter category includes children with HIV-positive parents or household members, and children with significant risk factors for HIV acquisition, including sexual violence and parents who are KP.

When appropriate, the PEPFAR-CI OVC program will continue to leverage the DREAMS program to improve synergy and efficiency while ensuring complementarity of OVC and DREAMS investments. In alignment with PEPFAR guidance, IPs across the 4 DREAMS districts will refer/counter-refer AGYW aged 10-19 from the OVC program for complementary DREAMS services, should they require more intensive HIV prevention support. To improve coordination of OVC services nationwide, the PEPFAR-CI OVC program will provide PNOEV with ongoing support for the OVC database as well as the revision and printing of tools. As communicated in the COP22 planning letter, Côte d'Ivoire's OVC non-DREAMS initiative control is $4,673,200, while the DREAMS initiative control, including some OVC budget is at $16,000.000. The OVC and DREAMS programs include specific and distinct packages of services and separate budgets are developed accordingly. For COP22, budgets were developed based on analysis of each program's package of services, previous years expenditures and appropriate tiers of targets. It is important to note that there is no overlap in the budgeting exercise. The Côte d'Ivoire country team ensured that beneficiaries of both programs were not double counted in the budgeting process.

Côte d'Ivoire's OVC Preventive program, started in COP19, will identify boys and girls aged 10-14 who do not fall into the OVC comprehensive category, but who live within the high-burden catchment areas of the program. These children should be eligible for sexual violence and/or HIV prevention interventions and will be systematically recruited and enrolled in educational sessions that use evidence-based curricula—such as the parenting for Lifelong Health programs implemented under the DREAMS program (see DREAMS section)—to address HIV risk vulnerabilities. The main entry points for these OVC will be community platforms, in coordination with community school councils, community child protection committees, and community health workers. If a child discloses other risks during the session's implementation, such as sexual assault, rape, or living in a HIV household, an appropriate referral will be made to respond to identified needs, including for potential enrollment in the OVC Comprehensive program.

PEPFAR-CI's OVC program has a strong track record of success. In COP22, the 3 OVC IPs achieved 113% of their OVC_SERV target (232,325). The overall achievement ranged from 103% to 139% across IPs, and the target includes beneficiaries from the OVC comprehensive, OVC preventive and DREAMS programs. A total of 213,063 beneficiaries aged <18 were served, representing 112% of the COP20 annual target (190,128); 14,526 beneficiaries graduated from the program, representing 93% of the graduation target (15,619). PEPFAR-CI has made significant progress in improving the ratio of adult-to-child beneficiaries of the program. Currently, adults represent 17% and children represent 83% of all beneficiaries. For reference, while there is no official PEPFAR target, generally is a caregiver to child ratio of 4:1 is deemed to be acceptable. Furthermore, in COP20, 95% (19,325) of the 15,568 targeted adult beneficiaries and children graduated from the program. The CQI program platform will be leveraged to further strengthen the OVC program and improve outcomes for its beneficiaries. Accelerating household graduation based on the achievement of PEPFAR OVC

graduation benchmarks will allow enrollment of other eligible children, especially those living with HIV who are not yet receiving OVC services.

Another recent success has been the improved collaboration between the PEPFAR-CI OVC program and clinical facilities. In COP22, OVC IPs will continue to triangulate data with their clinical counterparts to ensure close VLC and VLS monitoring among C/ALHIV on ART and continued implementation of adherence support groups. The program will continue to update and strengthen the operationalization of existing MOUs between clinical and OVC IPs, health facility staff, and NGOs where necessary to improve and standardize HTS and to systematically screen all beneficiaries to increase index testing for improved case-finding. Children and adolescent beneficiaries will be referred to facility-based nutrition programs in cases of moderate or severe malnutrition.

In COP22, along with the rest of the PEPFAR-CI portfolio, the OVC program will be rationalized in the 10 Abidjan districts, where one agency each will be responsible for comprehensive services (care and treatment, prevention, KP) in Abidjan's 2 health regions. A transition plan has been developed in the interagency space to ensure a smooth transition and continuity of services without disruption to beneficiaries.

d. Primary prevention of HIV and sexual violence among 10–14-year-olds:

OVC Preventive Program
The OVC program will identify boys and girls aged 10-14 who do not fall into the OVC_Comprehensive category, but who live within high burden catchment areas of the program. These children should be eligible for sexual violence prevention activities and/or HIV prevention activities. These at-risk adolescents will be systematically recruited and enrolled in educational sessions that use evidence-based curricula, the Parenting for Lifelong Health programs (Sinovuyo or "Ahoundjoue," locally) used under the DREAMS program, to address vulnerability to HIV acquisition. The main entry points for these OVC will be community platforms, in coordination with community school councils, community child protection committees, and community health workers. During the sessions' implementation, if a child discloses other risks such as: sexual assault, rape, or living in a HIV household, the appropriate referral will be done to respond to his specific need, including potential enrollment in the OVC Comprehensive program.

Priority Population Program (PP_PREV)
During COP21, the PEPFAR-CI program faced the following key challenges with respect to sexual prevention activities:

- Significant proportion of enrolled individuals with no risk
- The number of individuals newly tested or referred for testing remained almost constant from COP19 to COP20

In COP22, the PEPFAR Côte d'Ivoire program will continue to target priority populations, including children aged 10-14 years at risk, AGYW aged 15-24 years, adult men aged

25+ years; adolescent boys and young men as sexual partners of AGYW. A particular focus will be on at-risk men through innovative and aggressive community strategies (flexible hour activities, peer education, multi-diseases campaign, workplace prevention program, etc.)

To address the key challenges above, Côte d'Ivoire PP_PREV will implement the following strategies during COP22:

Table 4.3.2 Priority Population Prevention Strategies

Table 4.3.2: Priority Population Prevention Strategies	
Key Gaps	**COP22 strategies**
Targeting of high number of individuals with no risk	• Identify individuals that are most vulnerable to HIV acquisition to provide sexual prevention minimum package by using risk tools assessment with fidelity. • Continue/Develop innovative and aggressive community strategies (flexible hour activities, peer education, multi-diseases campaign, workplace prevention program, etc.) to reach men most at risk of contracting HIV infection • Enhance primary prevention of sexual violence and HIV for adolescent girls in high HIV-burden areas and for 10–14-year-old girls and boys
Low linkage and enrollment of eligible clients for PrEP	• Scale PrEP in priority populations including key populations, men and AGYW with innovative and aggressive community strategies • Improve bi-directional linkage with clinical IPs for the enrollment of most vulnerable individuals.

e. Pre-Exposure Prophylaxis (PrEP)

During COP22, PEPFAR Côte d'Ivoire will expand PrEP roll out and scale-up and continue offering PrEP for key populations, serodiscordant couples, adolescents, and young women at substantial risk 15-24 y/o and will include other populations at substantial risk such as men, PBFW. PrEP screening tools will be used to identify those eligible for PrEP among targeted population groups; clients who tested HIV negative and who meet clinical criteria (e.g., HIV-negative, free of kidney complications) will be offered PrEP services. PrEP-specific screening and counseling will be fully incorporated into HIV post-test counseling for multiple testing modalities, including community and facility-based index case contact testing, ANC, and community-based KP testing. Wherever couples are found to be discordant, efforts will be made to ensure that the HIV-negative partner can make an informed decision about starting PrEP, including referrals to nearby PrEP initiation sites.

PEPFAR Côte d'Ivoire will work with PNLS/MoH to support the revision of national guidelines for PrEP implementation to align with WHO 2022 normative guidance on PrEP. The approved information, education, and communication (IEC) materials and demand creation tools are available and will be disseminated to support the consolidation of national rollout.

During COP22, with WHO updates on PrEP implementation, the following policy barriers including the requirement of baseline biological eligibility assessment for PrEP initiation (Hepatitis B testing and Kidney function), the restriction of PrEP prescription to medical doctors despite a task-shifting policy in place for ART, the limitation of the term "Target population for PrEP" to include only KP, Serodiscordant couples and vulnerable AGYW and the limitation of PrEP provision out of the clinical space, will be removed. In addition, in COP22, the specific strategies below based on key challenges and by targeted populations, will be implemented or continue to be implemented:

Table 4.3.3 PrEP COP22 Strategies

Table 4.3.3 PrEP COP22 Strategies		
Target Populations	**Key challenges**	**Key COP22 Strategies**
AGYW	• Low enrolment of AGYW for PrEP services • Low PrEP demand	• Improve availability of AGYW friendly services • Scale-up the PrEP demand creation for AGYW • Review current PrEP use by AGYW at site level to identify best practices for uptake and effective use • Strengthen collaboration with KP IPs for identification of AGYW's most at risk • Ensure active referral of all eligible AGYW to PrEP designated sites • Raise PrEP awareness with specific messages tailored to AGYW (PrEP sites, the importance of using PrEP…) • Promote PrEP in youth-dedicated services such as SSU-SAJ
KP	• Low enrolment of KP for PrEP services • Unavailability of PrEP at some sites • Lack of KP friendly services at some dedicated PrEP sites	• Improve the use of KP navigators and peer educators to address PrEP awareness • Scale-up PrEP services at all designated KP sites • Ensure that Client-centered approaches include stigma and discrimination reduction education for PrEP providers. • Strengthen collaboration with dedicated KP sites to increase awareness of sites designated to provide PrEP (mapping)
Serodiscordant couples	• HIV status disclosure among serodiscordant couples	• Organize sessions on the importance of HIV status disclosure and benefits of PrEP (support group)
Overall target populations	• Designation of "targeted populations" in the guidelines limit access to all population at high risk • Complaints about the size of PrEP tablets	• Expand PrEP services in the community and target all vulnerable populations such as PBFW and other identified populations at risk (men, boys, etc.) • Improve awareness of PrEP services at community level and at HIV services delivery points such as HTS, ART clinics, ANC/PMTCT, DREAMS settings, and KP services • Advocate integrating PrEP information into post-test counseling • Advocacy to explore new PrEP products [*Dapivirine vaginal ring; Long-acting cabotegravir (CAB-LA)*] to improve adherence, PrEP demand, and uptake • Develop messages tailored to each target population to be used when offering services such as index testing, self-support group, etc.) • Where feasible, allocate resources, including human resources for health for PrEP scale-up • Advocacy to GoCI for buy-in to PrEP provision out of the clinical space

For COP22, the strategic vision for PrEP is continued to be based primarily on 3 key priorities including increasing demand creation, improving PrEP uptake, and supporting PrEP effective use. PEPFAR-CI will intensify community-engagement and community-mobilization strategies to accelerate demand creation; strengthen collaboration and referral between PrEP sites, community providers, and other non-PrEP facilities. PrEP sites are identified using the following criteria: HIV disease burden and growth at the district level, TX CURR and growth at district level, and size and growth of the KP population at both district and site-level. Furthermore, PEPFAR-CI will further sensitize facility-based clinicians on PrEP initiation for eligible clients, as civil society has clearly indicated that there is existing demand among their constituents which is not currently being met. PEPFAR-CI will also ensure that all clients who initiate on PrEP are asked about experience of violence, provided first-line support, and linked to appropriate violence response services.

PEPFAR-CI will also continue advocacy with GFATM to support MoH to maintain laboratory equipment needed for the PrEP initiation workup and availability of some commodities related to PrEP offer.

f. Gender-Based Violence (GBV)

Throughout COP22, PEPFAR Côte d'Ivoire partners are expected to continue providing high quality post-GBV care services and integrate post-GBV services into the PEPFAR Côte d'Ivoire clinical cascade, to address GBV as a risk factor for HIV infection and poor adherence to HIV treatment. Additionally, to improve identification of GBV survivors and referrals to post-GBV services. To support service implementation PEPFAR Côte d'Ivoire partners are expected to do the following at:

- Establish post-GBV care services and allocate the recommended post-rape kits
- Ensure availability of the most updated GBV algorithms and drugs for children, adolescents, and adults in line with national GBV guidelines
- Ensure that there is a staff member responsible for the GBV program that is familiar with the GBV multisectoral procedures and the points of contact for referrals to psycho-social support, police, social welfare services, forensic and legal services within the health facility, and/or the district
- Identify and properly train healthcare workers responsible for the provision of post-GBV services to offer quality services and accurately report and complete forms and registers
- Ensure facility and community providers responsible for providing support to GBV survivors are adequately trained in LIVES support
- Provide regular mentoring and supervision to ensure quality counseling and services
- Sensitize health facility staff (HCW/Auxiliary staff) regarding post-GBV care services to ensure their involvement in the referral processes
- Ensure that the locations where post-GBV services will be provided within health facility are defined (ex: PrEP, PMTCT, HTS, etc.)

- Support implementation of GBV quality assurance (QA); monitoring and evaluation (M&E) and the GBV screening tool as per MoH guidelines
- Provide post-GBV care services as part of KP prevention package in all sites that offer services for KPs
- Report on GBV progress at every IP monthly meeting and through periodic PEPFAR Côte d'Ivoire reporting
- Reproduce and distribute the national GBV register, GBV IEC and other materials
- Reinforce demand creation to promote GBV prevention and response at community and facility level
- Train all community providers in GBV LIVES (1st Line of Support) such as OVC, DREAMS, KP case managers and mentors in supporting age-appropriate, gender-sensitive disclosure of GBV.
- Scaling Parenting for Lifelong Health and SASA to address knowledge gaps and change negative gender norms among parents and community members
- Increase the number of GBV Awakening Committees
- Ensuring no service charges or user fees of any kind, including for clinical services, transportation fees, fees for filling out, filing, or copying forms.

g. Children / PMTCT

Côte d'Ivoire's PMTCT program continues to be strong with 98% coverage and 100% of HIV positive women receiving treatment. The COP221 PMTCT package will be implemented at all high, moderate, and low-impact sites in all 79 PEPFAR-supported districts to scale up access of HIV services to pregnant and breastfeeding women (PBFW) in high burden and underserved settings. To increase HIV case finding for PGBW, HIV testing will be provided to PGBW going to non-PEPFAR supported sites in PEPFAR-supported districts where we have site supported by PEPAR The strategies for PBFW will include support for demand creation activities and PITC at all mother and child entry points. The PMTCT package will provide HIV testing with same day ART initiation, friendly PMTCT services for adolescents, VL testing among pregnant women, early infant diagnosis (EID) for HIV-exposed infants (HEI), and linkage into pediatric care and treatment when necessary. To ensure high HTS coverage in ANC, all PMTCT sites will offer index testing with fidelity targeting partners and sexual networks of HIV-positive women, biological children, and adolescents. Self- test kits will be provided for hard-to-reach sexual contacts including the establishment of tracking procedures for the return of self-test results.

To reach 95% 2-month EID coverage, ensure timely return of results (4 weeks or less) and optimal ART linkage, the COP221 program will continue to expand the following strategies: (1) Active tracking of mother & baby pairs; (2) Monitoring of clinical/community collaboration through weekly meeting between clinical and community actors to verify whether HEI have effectively been tested, and (3) Daily monitoring of the mother and infant pair registers to create a weekly listing of HEI

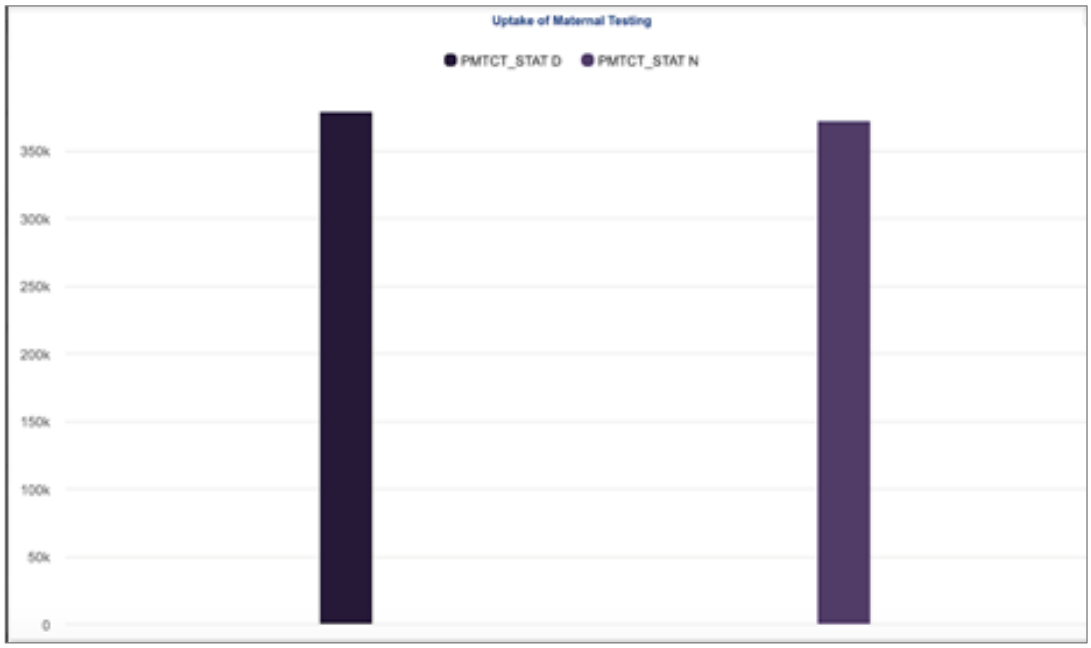
needing EID and follow up of EID appointment by phone calls/home visits. In addition, PEPFAR will encourage systematic referral of all C/ALHIV as well as HEI and their mothers to the OVC program where available.

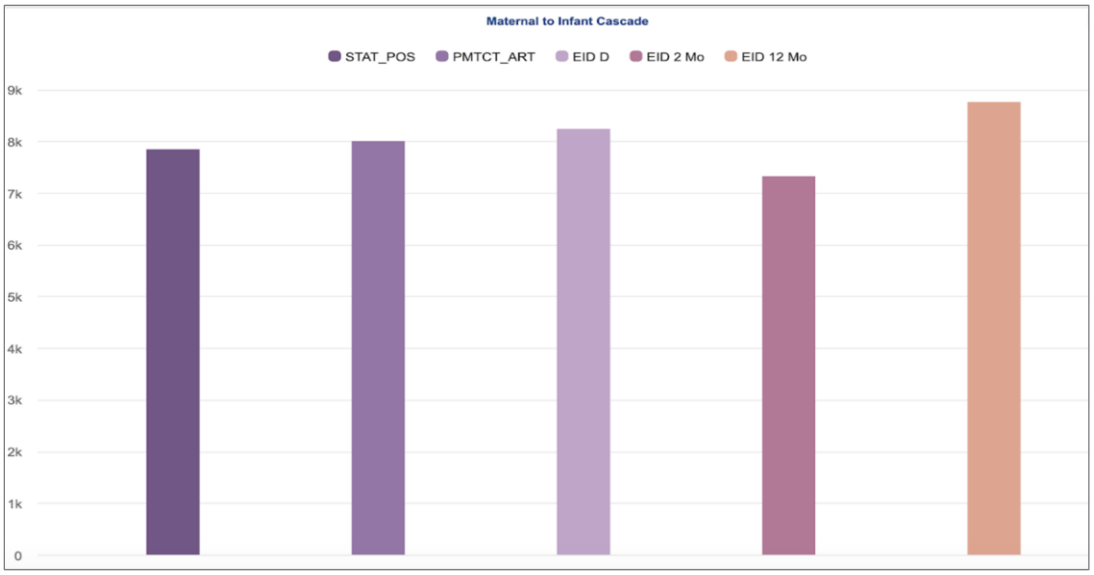
In COP22, PEPFAR will continue to implement and scale up the following strategies already in place in COP21 to increase access of pregnant and breastfeeding HIV+ women to viral load testing. PEPFAR-CI will provide HRH support (e.g., VL champions) to follow this cohort at site level, as described above for children. Chart review, follow up, and improved documentation will ensure that prenatal and post-partum visits are leveraged for VL sample collection. Dedicated VL champions will also follow up on VL results, ensure results are available to providers and explained to patients, and support treatment literacy. Counseling and support messages will be reinforced to include U=U strategy. Best practices for continuity of treatment and VLC/VLS will be shared among providers and across sites and IPs through the ECHO platform. Finally, expanding access to TLD will be critical to improving VLS rates. In addition to the afore mentioned strategies to boost viral load coverage and viral load suppression in PBFW, Optimization of the use of 60 point of care (POC) for VL testing on all PMTCT sites for PBFW and their children will help to close remaining GAP in VLC and VLS.

PEPFAR-CI will also use Mentor Mothers at high volume PMTCT sites to ensure linkage and continuity of treatment of PBFW and HEI. PEPFAR-CI will also deploy POC machines to 33 additional high volume and geographically hard-to-reach sites (for a total of 60 sites) as well as use DBS for VL sample collection for hard-to-reach PBFW and children. The goal in COP22 is for 60% of all EID samples to be run on POC machines for rapid turnaround time and initiation on ART for exposed infants who are HIV-positive. This may help to close the gap in the number of HIV-exposed infants not tested at two months, which was over 500 in FY21, per Figure 4.3.1

At present, PrEP and MMD for PBFW are not included in national PMTCT guidelines. PEPFAR-CI will continue to advocate through coordination meetings with MSHP and multilateral stakeholders and regular interactions with civil society organizations, for inclusion of PrEP and MMD for PBFW into the national PMTCT guidelines. PrEP will be scale up in MNCH and FP settings for HIV negative client at high risk such as PBFW, AGYW, and FSW.

Figure 4.3.1 PMTCT Cascade





Source: PEPFAR Panorama: PMTCT-HEI: Single OU dossier; Overview page; PMTCT and HEI Cascade

h. Key Populations

Key populations are a critical subgroup in Côte d'Ivoire's aim to achieve epidemic control due to the severity of HIV among this population and their vital and dynamic position in the country's ongoing HIV epidemic. According to a UNAIDS 2021 report, 19% of new HIV infections in the country occur among sex workers (most of whom are female sex workers), 21% among MSM, and 27% among clients and partners of all KP.

Côte d'Ivoire's first two national strategic plans to fight HIV and STIs (2002-2004 and 2006-2010) recommended focusing activities on a number of "key populations".

However, in practice, these KP included vast segments of the overall population with varying degrees of vulnerability to HIV acquisition and transmission. Of note, MSM were identified as KP in the strategic plan beginning in 2006. And in 2011, the 2011-2015 strategic plan re-centered prevention activities to focus on what the country considered to be the most vulnerable KP (i.e., FSW, MSM, young people).

In 2020, PNLS conducted a population size estimate (PSE) that estimated a total of 90,879 KP in Côte d'Ivoire. Among respondents, 61% (55,681) identified as FSW and 39% (35,198) as MSM. Most respondents (34% vs. 66%) were residents of Abidjan. The PSE found HIV prevalence among KP was higher than that of the general population at 4.8% among FSW, 7.7% among MSM, and 3.4% among TG. Notably, prevalence was highest among MSM residing in the city of Abidjan (29%). The following reflects PEPFAR-CI's FY22 Q1 HTS results among KPs:

Table 4.3.4 PEPFAR-CI's FY22 Q1 HTS Results among KPs

Table 4.3.4 PEPFAR-CI's FY22 Q1 HTS Results among KPs			
KP Group	Total Tested	Positivity Yield	# Linked to ART
FSW	4,890	7.26%	355
MSM	2,442	9.38%	229
TG	43	2.33%	1

Various risk factors and vulnerabilities cause KP to be particularly susceptible to HIV, including diminished access to care, stigma, and discrimination. FSW experience intersectional vulnerabilities that further increase susceptibility to sexual and physical violence: 32% of FSW PSE respondents reported experiencing sexual violence (55% of whom reported violence in direct connection with sex work), and the same proportion reported experiencing physical violence (62% of whom reported violence in connection with sex work)[14].

PEPFAR-CI includes FSW, MSM and TG among the program's primary KP beneficiaries and has prioritized KP investments to ensure tailored and comprehensive packages of services that reduce risk and vulnerabilities among these subgroups. Following a slight decrease from $4,875,342 in COP20 to $4,544,910 in COP21, the program's COP22 KP budget will increase significantly to $6,428,081, a total representing approximately 6% of the total PEPFAR annual budget.

The KP program includes an overall package of services for KP across the cascade with tailored approaches to meet the specific needs of FSW, MSM and TG beneficiaries. The program is comprehensive and managed in a way that ensures underserved KP populations receive person-centered care in line with WHO Normative Guidance on the provision of services to these populations. KP differentiated care includes prevention and case finding modalities such as social network testing and referrals; index testing; HIV self-testing; integrated PrEP screening and enrollment; active linkage referrals and

[14] IBBS 2014

treatment initiation; and specialized case management, including viral load tracking and follow-up.

PEPFAR-CI conducts routine analysis of KP data disaggregated by KP type and engages in continuous quality improvement to meet specific needs of MSM, FSW and TG beneficiaries. Additional strategies include drop-in centers in Cocody, Attecoube, Bouake and Yopougon East; recruitment of peer educators and navigators with ties to MSM, FSW, and TG community networks; online outreach strategies with specific approaches to reach hidden high-risk individuals and social networks, especially MSM; and human rights and GBV response activities appropriate to the specific needs of MSM, FSW, TG communities. Additionally, a package of services is provided to KP survivors of GBV, including legal, psychosocial and transportation support.

KP program successes are reflected in recent PEPFAR-CI program data that show improvements in KP prevention and treatment outcomes. In COP20, the number of KP sensitized to the program (i.e., KP_PREV) was 52,889, a 14% increase compared to the previous fiscal year. This growth is explained by escalation of approaches that use frequent programmatic mapping to identify new sites and KP networks, a best practice that has been carried forward in COP21 and will continue in COP22. From COP18 to COP20, KP TX_CURR increased by 58% and the KP TX_NEW increased by 74%. Linkage to treatment among KP was 96% owing to active referral by community workers, strengthening of index testing, and diversified care and treatment services.

Notwithstanding recent achievements, the Côte d'Ivoire KP program is still navigating certain challenges. In COP20, one key challenge was testing effectiveness. Specifically, the program's HTS positivity yields for KP (10% overall; 8.8% for FSW; and 12.6% for MSM) were lower than anticipated, though this would be expected if prevention efforts are having their intended impact.

There were also challenges across retention and VLC and VLS. While the overall COP20 retention rate was 93% among all 23 sites offering PEPFAR-CI's KP service packages, there was considerable site-level variation, and Abidjan had the highest number of losses. However, COP21 Q1 program results show improvements in some KP sites in Abidjan due to joint monitoring of patients by social worker and peer navigator pairs and tracking of LTFU patients through KP social networks. In COP20, viral load coverage remained low at 69% and suppression was suboptimal at 87%. Major challenges included mobility of patients, inadequate numbers, and training of clinical staff at certain sites, and slow VL result turnaround times due to reagent and equipment challenges related to COVID-19. However, VLC improved from COP20 Q4 (69%) to COP21 Q1(72%) owing primarily to the use of DBS for VL, placement of VL champions track results, and training of health care workers on VL case management. These practices will continue in COP22.

In COP22 PEPFAR-CI refined its standard KP packages of services in line with MSHP guidance. Because KP populations' needs differ across the cascade of HIV services, requiring different programmatic approaches with different associated costs, and often provided by different IPs, PEPFAR-CI defined four different KP service packages to allow for standardized programming and more efficient budget allocations:

1. KP care and treatment at KP-friendly health facilities.
2. KP testing at KP-friendly health facilities, disaggregated into the different facility entry points including index testing, PMTCT and post ANC, systematic testing entry points (TB, STI, malnutrition and inpatient), emergency ward and other PITC
3. KP community comprehensive package, including adherence support, return to care, prevention activities and PrEP
4. KP testing in the community, including the Community wellness approach (to diagnose KP) and community index testing for HIV-positive KP

To maximize efficiencies, PEPFAR-CI defined the cost of these different packages based on expenditures across the different IPs providing such services and the volume of beneficiaries they were serving. Programmatic data was used to determine the standard of care for each of the services. This approach allowed the program to tailor the budget to the nuances of the program interventions, saving where there are efficiencies while investing more where needed. The exercise led to 2 tiers for KP care and treatment based on the type of facility and level of adaptation to KP, rather than on the facility's patient volume. KP HRH ratios were also adjusted to meet national standards to ensure optimal quality of services and improved programmatic results such as retention in care.

Due to the nature of the comprehensive services, the KP_PREV indicator was used to indicate the volume of beneficiaries for the community KP comprehensive package. The program was revised after establishing the correlation between the expenditures and the beneficiaries served, because of currently substandard ratios of peer educators and peer navigators causing implementation challenges. HRH assumptions were adjusted to allow for the recommended ratios based on national community health guidelines and the recommended ratios.
This budgeting methodology is expected to maximize financial investments, as it considers actual expenditures and results, while correcting the gap in HRH to improve programmatic results and quality in COP22.

PEPFAR-CI's COP22 KP program strategy aims to reinforce KP friendly training & oversight among service providers to ensure KP friendly services across the full cascade and to oversee the 4 existing drop-in centers. SOPs are in place for active linkage of HIV-positive KP via qualified peer navigators using referral and counter-referral forms. FY21 data has raised questions about the very low linkage rate of KP individuals to

PEPFAR-supported sites. There are several possible explanations, and the interagency team will utilize DQA, joint site visits, and the CQI platform to identify gaps and address them immediately.

PEPFAR-CI will continue to implement targeted testing interventions for KPs by reinforcing social network strategies to reach the most at-risk and most hidden KPs, including intensifying peer education. Self-testing will be scaled up among MSM, FSW, TG and their stable partners. Index testing will continue to be implemented also with fidelity and in line with PEPFAR S/GAC index testing guidance to conform to minimum ethical and safety standards for all community members, including implementing IPV risk assessment and service provision.

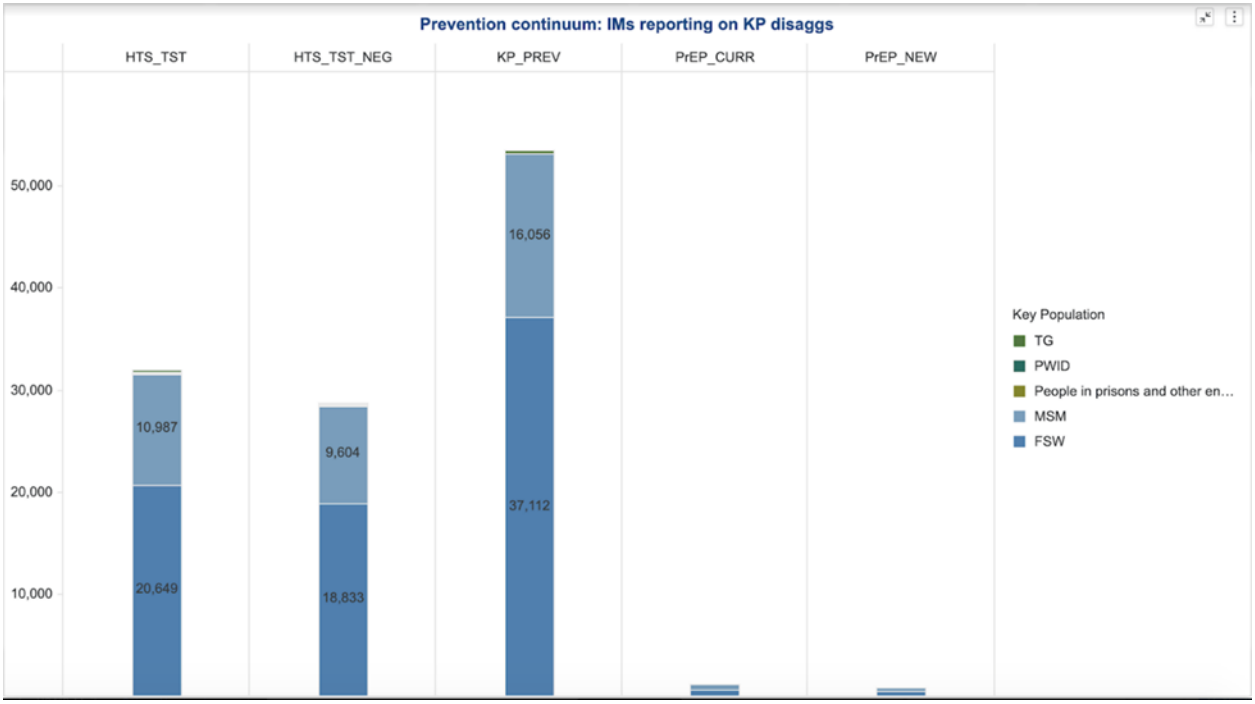
The program will couple index testing with self-testing to reach the hard-to-find FSW, MSM, as well as their sexual partners, through peer navigators. Self-test achievement will be improved by training more peer navigators on the national guidelines on self-testing and on key messages about the availability and accessibility of KP-friendly services to overcome access-related barriers and strengthen demand for services. Demand for self-testing will be created through standard outreach/SBCC messaging, online outreach, support groups, and home visits to KP living with HIV by peer educators and navigators.

In COP22, PEPFAR-CI will emphasize further engagement with KP communities, whose insights will help the program to further improve the uptake and effectiveness of community-based interventions such as HIVST, index testing, and PrEP. PEPFAR-CI will also provide technical and organizational support to PLHIV and KP networks and KP-led groups who will in turn be better positioned to prevent and respond to incidents of violence, address stigma and discrimination, and provide legal literacy training across KP communities.

Some KP continue to decline community HIV testing, for several key reasons—e.g., knowledge of status and unwillingness to disclose it to the community tester (peer educator), preference to be tested in health facilities, fear of a positive HIV test result, etc. In COP22, the Côte d'Ivoire KP program will improve counseling through training and ongoing mentoring to reduce the HIV testing refusal rate. Self-testing will continue to be offered to those refusing "traditional testing." Training and mentoring will include WHO HIV testing standards to ensure the "5Cs" are observed (i.e., consent, confidentiality, counseling, correct test results and connection to HIV prevention, treatment, and care), and Intimate Partner Violence screening and referrals will be implemented as standard practice. Additionally, counseling will include routine use of risk assessments that identify KP with high-risk factors for HIV exposure and provide education on the benefits of testing and treatment, including U=U messaging. Finally, testing hesitancy among KP underscores the importance of ongoing efforts towards stigma reduction at facilities and throughout the community. In COP22, the expected testing yields for FSW, MSM, and TG are 9%, 13%, and 6%, respectively. These targets

are consistent with COP20 results. However, if prevention efforts are having the anticipated impact and reducing incidence, these positivity yields may not be achieved.

Figure 4.3.2 Prevention Continuum by Key Population Group



Source: PEPFAR Panorama: Prevention: Singe OU dossier; All Prevention chapter; Prevention Continuum by KP

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

The priorities listed in the planning level letter and the relevant strategies and approaches put in place to address those priorities in COP22 are listed below.

1. ***Revisit and refine overall testing strategy with sub-strategies for specific populations – in particular for men and pediatrics.***

   The PEPFAR-CI testing strategy has been refined and calibrated with sub-strategies addressing men and children as recommended by the PLL. The overall case finding strategy including specific approaches for men and children is addressed in detail in section 4.1.

2. ***Scale PrEP in priority populations (key populations, men, AGYW).***

   The PEPFAR-CI PrEP scale up plan including policy barriers and specific approaches for KP, AGYW and men is described in detail in section 4.3.e.

3. Focus on reducing TB morbidity and mortality among HIV treatment cohort with approaches to testing and offer of TPT.

TB is the leading cause of death among PLHIV in Côte d'Ivoire. In 2021, the mortality rate for TB/HIV co-infected patients was 20%. In Côte d'Ivoire, PEPFAR and implementing partners support the National AIDS Control Program (PNLS) and the National TB Control Program (PNLT) to provide comprehensive and integrated TB/HIV diagnosis as well as care and treatment services at the national, regional and district levels in 79 Districts. During FY21 HIV services were fully integrated in 100% of TB clinics, 100% of new and relapsed TB cases knew their HIV status and 97% of the 2,323 HIV positive TB cases received ART.

Integration of TB screening, diagnosis and TB prevention in ART clinics remains suboptimal. During FY21, while 97% of PLHIV on ART were reported to be screened for TB, only 0.5% were positive for TB symptoms – a significantly lower achievement than the expected 5% to 10% screen positivity rates among PLHIV. The use of GeneXpert for TB diagnosis among PLHIV increased significantly from 35% (FY20) to 76% (FY21). TB treatment among PLHIV who are confirmed positive for TB is optimal due to strong referral and counter-referral systems between ART sites and TB treatment centers.

PEPFAR, WHO and GFATM advocated and supported the PNLS/PNLT to lift major policy barriers to improve the management of TB/HIV and accelerate the scale up of TPT. A series of national guidelines and policy updates as well as official notices were issued in this regard at the beginning of COP21 effectively paving the way for significant scale of priority TB/HIV interventions in COP21. However, TB preventive therapy (TPT) coverage among PLHIV who screened negative for TB was still significantly low (4%) at the end of FY21 despite a 10-fold increase in the total number of PLHIV who started TPT from 1,192 (FY20) to 10,012 (FY21). Since then, thanks to intensive partner management and ongoing site support, the initiation of TPT has grown exponentially at PEPFAR sites as demonstrated by preliminary FY22Q1 data showing that about 89,000 PLHIV on ART (36% of TX_CURR) who screened negative for TB have initiated TPT. This rapid acceleration was slowed down by insufficient stock of drugs which resulted in the prioritization of patients who have already initiated TPT to complete their treatment. Orders have been placed for supplemental stocks of INH using Global Fund cost savings and the program will relaunch intensive scale up of TPT as soon as enough drugs arrive in country. The country should consider and implement 3HP for TPT as more effective, less side effects and with high completion rate for eligible ART patients and recommended by WHO.

The persistent challenges of TB/HIV program include:

- Low TPT initiation rate among PLHIV who screened negative for TB
- Suboptimal completion rate among PLHIV who initiate TPT
- Suboptimal TB screen positivity among PLHIV
- Suboptimal TB diagnosis among children living with HIV (CLHIV)

- Lack of implementation of TB/HIV activities among KP
- Delay in the roll out of Advanced HIV Disease package of services
- Non-alignment of TB diagnosis among PLHIV with the latest WHO guidelines
- Suboptimal TB/HIV decentralization, community-based services and alignment with ART services.

In COP22, PEPFAR-CI will continue to work with MoH, WHO, the GFATM to address these barriers and improve the coverage and quality of TB/HIV services. The key priorities for TB/HIV and Advanced HIV Disease in COP22 include:

- Increased TPT initiation and completion rate among PLHIV among PLHIV who initiate TPT by
  - Building capacity of providers
  - Securing enough medication to support scale up
  - Scaling up the roll out of 3-HP based on the availability of medication beginning with patients newly initiated on ART
- Increased TB screen positivity rate among PLHIV by
  - Building capacity of providers on the appropriate use of screening questions and data reporting tools
  - Reintroducing the use of X-ray to augment screening questions for patients who screen positive for symptoms other than cough.
- Increased TB screening and diagnosis among children living with HIV by revising the algorithm, training, and coaching providers, ensuring available specimen collection supplies, and testing reagents specific to children
- Scale up the implementation of TB/HIV activities among KP by building capacity of health care workers on KP competency
- Maintenance of implementation of the AHD package at the current 60 high impact sites and ensure procurement of key commodities (CrAg, TB-LAM, Fluconazole, Flucytosine, Xpert cartridge, and other laboratory supplies)
- Continue to support MoH (PNLS/PNLT) to update the national TPT scale up plan and national TB diagnosis guidelines for PLHIV to:
  - Reintroduce X-ray (CAD) for TB screening
  - Include LF-LAM for AHD
  - Incorporate new WHO-recommended POC molecular diagnostics, (such as Truenat), and
  - Develop a specific testing algorithm for children, which consider stool-based TB screening and diagnostic for children using GeneXpert

4. Close the treatment gap in men.

The PEPFAR-CI COP22 strategy to ensure that men who are diagnosed with HIV are effectively linked and retained in care as well as strategies to successfully return those interrupt treatment is described in detail in sections 4.1 and 4.2.

5. ***Refine and/or develop a comprehensive approach to pediatric care and treatment.***
In response to the PLL, PEPFAR-CI has defined a strategy that provides a comprehensive approach to pediatric care and treatment including refined and intensified case finding strategies (Section 4.1), adoption and funding of the evidence-based Zvandiri CATS model to improve continuity of treatment, adherence to ART, and long-term VLS among children and adolescents (Section 4.2), continuation of successful approaches for boosting VLC, VLS and EID via a surge plan at selected sites (Section 4.2, 4.10), and reinforced collaboration between the clinical and OVC programs for adherence support, status disclosure preparation and improved VLS.

6. ***Increased attention to comprehensive programming for key populations and AGYW.***

Key Populations
A detailed description of the PPFAR-CI KP program strategy and approach including the cascade for linkage and treatment continuity is provided in section 4.3.h.

DREAMS
A comprehensive description of the DREAMS program including its focus on prevention of HIV and sexual violence at the community level and increase support for education and comprehensive economic strengthening is provided in Section 4.3.b.

7. ***Support efficient patient-centered care within GoCI health delivery architecture and management.***
A key barrier in Côte d'Ivoire's HIV/AIDS response is the limited capacity to consistently deliver efficient patient-centered care in clinical settings. This issue is due to ineffective integration of HIV program into the routine health care system. HIV services are still considered to be an additional workload by health care workers, many of whom are not engaged in the delivery of HIV services. HIV care and treatment services are heavily concentrated in clinical setting with non-congruent collaboration between clinical and community actors. Providers complain about the number of data collection tools and reporting systems. There are insufficient policies allowing the implementation of differentiated service delivery models across the clinical cascade along with mistrust of patients' capacity to take care of themselves. These challenges overburden health care centers which creates long waiting time, workflow not adapted to the needs of the patients, and limited involvement of the patients in the decision-making process toward improved the quality of services.

To overcome these challenges, PEPFAR has been supporting the MoH to adopt enabling policies to support efficient patient-centered care within the GoCI health delivery architecture and management. In COP22, PEPFAR's facility-based service delivery support will continue to complement MSHP clinicians with lay workers and social workers dedicated to addressing critical programmatic gaps. This will include dedicated personnel to ensure high-quality, patient-centered index testing, monitoring

and case management of the pediatric ART cohort, support to caregivers for pediatric ART administration, viral load monitoring, integrated services to improve case-finding among men, and increase PrEP uptake.

PEPFAR will continue to support MoH to adopt and implement differentiated service delivery models (DSDM) across the clinical cascade for each priority population. As a concrete step towards the simplification of the service delivery models, PEPFAR-CI will advocate for and support the update of national guidelines to evolve from old definitions of patient stability to current WHO standards of established and non-established patients as well to reduce the number of required clinical visits for all patients. This will reduce the frequency of visits in health facilities and give enough time to providers to focus on difficult cases whereas the established patients will become more autonomous in managing their disease supported by community actors. PEPFAR will build on lessons learned from COVID-19 adaptions to continue to increase 6-month ARV dispensation and community distribution of ARV through expansion of community peer support groups to reduce treatment interruption and increase viral load suppression. An emphasis will be put on children and adolescents by piloting the Zvandiri Community Adolescent Treatment Supporter (CATS) program in two districts. DSDM will also target other populations such as PBFW, children <5 years old (guidelines currently being updated to allow MMD from 2 years), the mother-infant pair, patients with AHD, and KP.

8. Strengthen systems and approaches in efficient program delivery and partner management

As mentioned above in Section 2.5, Abidjan regions will be rationalized with Abidjan 1 under CDC (5 districts) and Abidjan 2 under USAID (5 districts). The implementing partners in these regions will deliver comprehensive HIV prevention, treatment, and care to the general population, KP and other priority populations. The rationalization of partner programmatic and geographic portfolio has been extended by CDC to zones outside Abidjan where they fund the full clinical-community continuum by consolidating the general population prevention, care, and treatment services to a single IP by district to further alleviate inefficiencies in the collaboration between clinical and community partners. USAID will continue to work with specialized community partners outside of Abidjan, reinforcing established MOUs for consistent and quality linkage to care. PEPFAR will continue to improve partner management by conducting:

- Weekly partner check-in calls
- Monthly partners performance reviews (PPR)
- Quarterly program reviews
- Site Improvement Monitoring System (SIMS), granular site management (GSM), data quality audits (DQA) and rapid data quality checks (RDQC) visits
- These forums will also be used to shared lessons learned and best practices across program areas and partners
- Leveraging HQ TA as needed

9. Health information systems activities should continue to advance aligned with and under the leadership of GoCI.

PEPFAR-CI established an Interagency Health Information System (HIS) Technical Working Group (TWG) in December 2021 with a mission to continue supporting the MSHP to develop and implement a sustainable national HIS that provides timely and high-quality data to inform health decisions at all levels of the national health pyramid. PEPFAR-CI's HIS TWG primary goal has been to develop a harmonized interagency vision for the next 3 years. This vision is based on existing national HIS, MSHP priorities and strategic plans, as well as advances prior PEPFAR HIS investments (See Fig 4.4.1 for a depicted landscape).

To develop a shared vision, including defining the HIS activities for COP22, PEPFAR-CI's HIS TWG assessed current National HIS Systems and PEPFAR HIS Investments and consolidated a mapping of all PEPFAR-supported HIS activities and plans and is producing a Strategic Plan document. One key finding, also raised in the PLL, is the need for an interoperable layer. Currently, Côte d'Ivoire's HIV HIS is fragmented with isolated applications or systems requiring direct information exchange that involve developing both applications to be interoperable. The Strategic Plan comes to respond to the interoperability challenge and encompasses plans for further system (i.e., applications and tools) development activities, including addressing interoperability, and deployment as well as plans for policy and governance, capacity development, infrastructure needs, and budget projections. PEPFAR-CI used this plan to determine COP22 priorities (See Fig 4.4.2 for a depiction of activities) and will continue to use it to guide future years' activities.

PEPFAR-CI's vision is to support Côte d'Ivoire to have a durable, interoperable HIS capable of enabling:

1. Person-centric care and case-base surveillance from point of testing for HIV through VLS
2. Case management of OVC and tracking of OVC/DREAMS prevention activities
3. Systemic tracking of commodities and supply chain management
4. Timely, accessible, and high-quality data are available to make decisions across all levels of the health pyramid, from patients and providers to districts and national levels
5. Enabling rapid data exchange and sharing to facilitate public health surveillance and data-driven decision-making

This HIS will be built under the guiding principles reflected in Côte d'Ivoire's National HIS Strategic Plan: Simplicity, Harmonization, Sustainability, Scalability, Information sharing, Traceability, Respect/Confidentiality, Economy, and Integrity. The HIS will rely on the use of international information technology (IT) standards, including standards-based health information exchange (HIE), and will transition to or build on free, opensource software and/or that have source available and are nonproprietary software. The HIS will continue to encompass one national electronic medical record system (EMR; SIGDEP),

one electronic lab information system (ELIS; OpenELIS); one logistics management system for supply chain (LMIS; E-SIGL); and one electronic OVC/DREAMS information systems (OVC/DREAMS DB) with electronic dashboards –all built on opensource software– that constitute a simple and sustainable landscape.

Figure 4.4.1: Diagram of PEPFAR-CI HIV HIS Landscape Vision

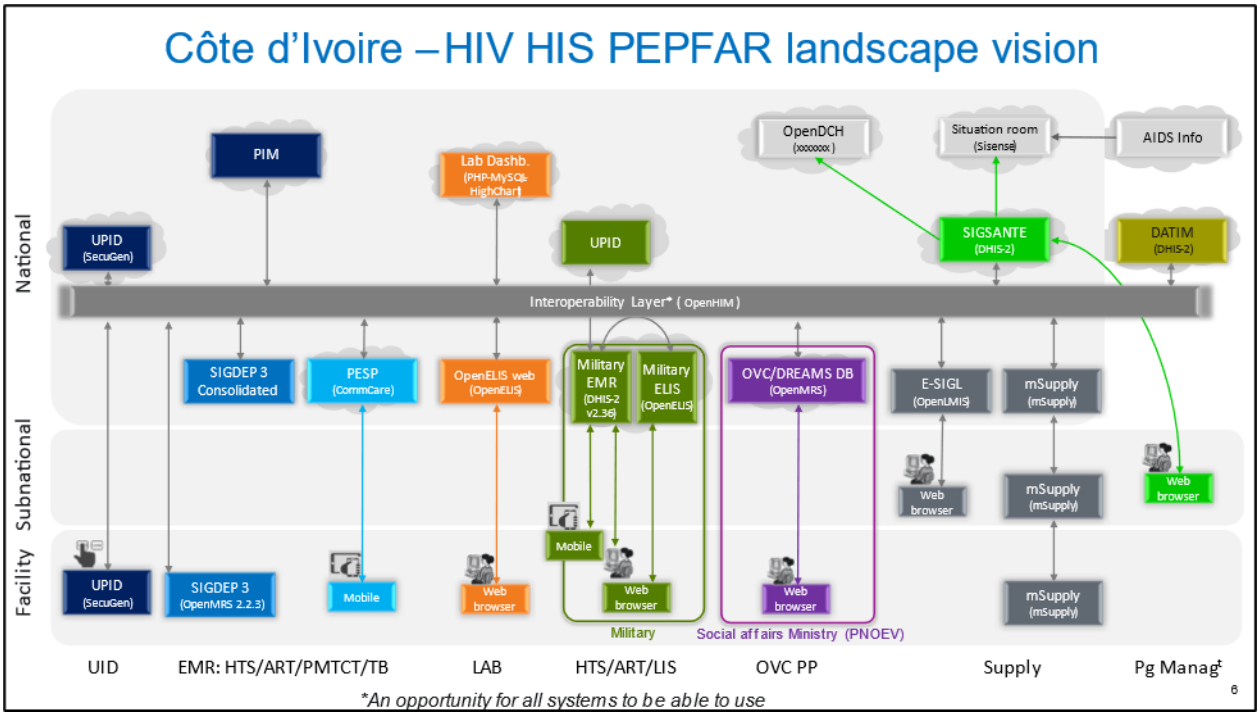
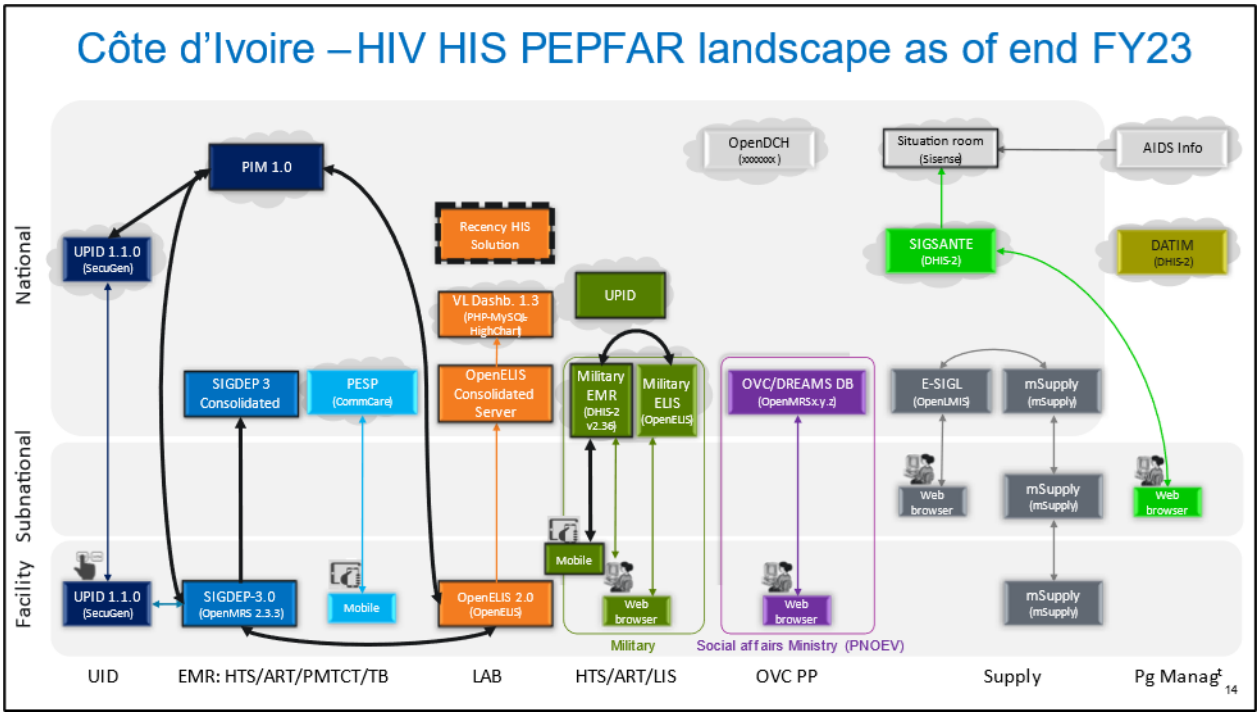


Figure 4.4.2: Diagram of PEPFAR-CI HIV HIS Landscape at the end of FY23 (COP22 activities in black)



4.5 Additional Program Priorities

Between the time of COP21 planning last year until date, there have been three major policy/guideline changes (all signed on June 09, 2021) that impact the program. These changes were all achieved thanks to significant advocacy and technical input and support from PEPFAR-CI. They include:

1. **Official notice revising the national definition of the threshold for interruption in treatment (IIT) from 90 days to 28 days.**

   This notice officially aligned MoH definition of IIT with current WHO and PEPFAR guidance. The change is fully implemented at all PEPFAR sites with hard copies of the guidance shared with all providers, relevant paper and electronic data collection and reporting systems adequately updated to reflect the change, and recurring PEPFAR-funded training, refreshers, and supportive supervision for appropriate implementation ongoing. The intended impact is to align data collection and reporting practices for key indicators and to support efforts to improve continuity of treatment for all PLHIV on ART. This guideline addresses MPR #1 (Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.)

2. ***Revision of the national PMTCT guidelines with updates on***:
    - Guidelines for VL testing in PBFW
    - Management of HIV-exposed infants (HEI) including risk stratification criteria and guidelines for ARV prophylaxis
    - National algorithm for EID in HEI

    This policy is fully implemented at all PEPFAR sites with hard copies of the guidance shared with all providers and recurring PEPFAR-funded training, refreshers, and supportive supervision for appropriate implementation ongoing. The intended impact is to improve VLC among PBFW and HEI as well as to further reduce risk of vertical transmission of HIV in accordance with current WHO guidelines. This guideline addresses MPR #1 (Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.)

3. ***Update to national pediatric ART guidelines making DTG-based regimens the first line option and recommending the transition of all children to DTG-based regimens.***

    This policy is fully implemented at all PEPFAR sites with hard copies of the guidance shared with all providers and recurring PEPFAR-funded training, refreshers, and supportive supervision for appropriate implementation ongoing. The intended impact of this policy/guideline update is to ensure the transition of all CLHIV on ART to optimized DTG-based regimens and to boost adherence and viral load suppression among children. This guideline addresses MPR #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 who are >4 weeks of age and weigh >3 kg, and removal of all NVP- and EFV-based ART regimens)

    The PEPFAR-supported HTS program has made significant progress in scaling up safe and ethical index testing. At the end of FY21Q4, 100% of sites offering index testing services had been assessed for RedCap or SIMS standards for intimate partner violence (IPV) monitoring and support was provided for remediation. Despite this progress, there is insufficient coverage of index testing among biological children of HIV-infected women and male sexual contacts of female index cases. The program is addressing these challenges by recruiting/identifying index testing champions, strengthening the clinical and community interface for improved index case management, and ensuring that 100% of sites and providers comply with the safe and ethical index testing standards. The implementation of safe and ethical index testing services is an ongoing activity as new providers are recruited at supported sites, and sites are routinely assessed for compliance with the standards. The plan for ongoing monitoring, action, and accountability to ensure compliance with the guidance include refresher and/or new training of providers, routine coaching and supportive supervision, regular assessment of

the standards through the RedCap tool and/or SIMS standards and ensuring that IPV/LIVES related SOPs and reporting tools are available.

As described elsewhere, PEPFAR-CI implementation in COP22 will feature increasingly comprehensive and consolidated service delivery, in Abidjan and the majority of PEPFAR-supported districts outside Abidjan where funding for the clinical-community continuum is assured by a single USG agency. This shift will allow for more sustainable, efficient, and patient-centered care across both facility and community settings. One major factor in this decision was the ongoing challenge of community HTS and linkage data quality observed over several years of PEPFAR-CI implementation, along with challenges in data management among IPs for the purpose of index HTS and support for treatment continuity. The decision to prioritize an innovative model for pediatric and adolescent support was driven by ongoing challenges in improving VLS and reducing mortality in this sub-population. Similar challenges in case finding among men underscored the need to implement innovative strategies partnering with faith leaders and improving the male-friendliness of health facilities. Finally, results from the last 5 quarters indicating progress on key priorities, and towards epidemic control, highlighted the need to ensure that the program is well-positioned to sustain its impact. Consequently, PEPFAR-CI will work with MSHP/PNLS to introduce recent infection surveillance and further accelerate progress on funding local/indigenous IPs.

PEPFAR-CI partner management is done at three levels: (i) Activity Managers (AM) will conduct weekly and monthly progress reviews and course correction of deficiencies, in addition to monthly and quarterly partner meetings and financial reviews; (ii) the Interagency team will conduct site visits on an as-needed basis to address issues impacting multiple IPs, and monthly data review of key indicators; and (iii) the National Program will conduct quarterly program results reviews led by the PNLS with the participation of PEPFAR-CI, IPs, and stakeholders. Continued engagement with all stakeholders, including civil society and community members, multilateral partners, and bilateral partners, is to continue throughout COP2022 implementation. Core to this critical engagement is the sharing of and discussion surrounding quarterly results and achievement and findings from community-led monitoring. This continued engagement will ensure all parties' understanding of Côte d'Ivoire's progress and help identify any strategic changes to be made to reach epidemic control more efficiently and effectively.

Agreements made during COP22 discussions, including those regarding geographic focus, targets, budgets, SIMS, use of pipeline, partner implementation and partner management will be monitored and evaluated on a regular basis via both ad hoc check-ins and discussions as well as the joint HQ and country team POART discussions. It is expected that teams closely monitor partner performance and engage with each implementing partner on a regular basis to ensure achievement of targets, outcomes, and impact in a manner consistent with the approval memo, approved SDS, budgets and targets as finalized in PEPFAR systems. Any partner with EITHER (1) <15 percent of target achievement at 3 months or (2) less than 30% of target achievement at 6 months

on key indicators must have a complete review of performance data (including trends in performance) and expenditures to date by program area, implement remediation, and conduct intensive follow-up. Biannual data reporting is acceptable for programs that do not report on a quarterly basis (e.g., OVC program). In the HIV treatment program, most clients are continuing treatment year after year and current on treatment (TX_CURR) performance should be between 98% and 100% of the target. This can be adjusted in country context where HIV treatment services are still scaling up and the treatment new target is greater than 10% of treatment current. OVC programs are also similar in that there are active clients continuing services from the previous year; if the IP achieves less than 80% of their target at Q2, performance review should be triggered.

For key populations programming, per MER Guidance and program requirements, HIV testing is a required element of the KP_PREV indicator. HIV testing services (HTS) or referring an individual to HTS is required to be offered (at least once during the reporting period and/or in accordance with WHO/national guidance) unless the individual had previously been tested positive for HIV. HIV prevention services must be tailored to individual risks. If the individual is self-identified as HIV positive, then HTS provision or referral to HTS will not be a required element of this indicator. Workplans for IPs should reflect these HTS requirements for key populations programming. Additionally, where referral to HTS is made, IP workplans and program design should incorporate measures to follow through on HTS with KP clients to ensure referral completion. These elements (i.e., review, remediation, and follow-up) should be incorporated into the existing IP work plans. A second quarter of consistently poor performance by the IP should also result in implementation of a documented Performance Improvement Plan (PIP) or Correction Action Plan (CAP), in accordance with implementing agency policy. PIP indicators should reflect the core issue. If the issue is linkage of test positive to treatment the indicator measured should be test positive to new in treatment of greater than 85 percent. If the issue is retention, it should be net new on treatment equal to 90 percent of new on treatment. After two quarters of intensive oversight and remediation for underperformance, partners should be close to full achievement of targets expected at quarter three. With a third quarter of consistently poor performance by the IP, implementing agencies should notify S/GAC the options the agency is implementing to address partner non-performance. including options for a shift to new partners. The country team should notify the S/GAC Chair and PPM immediately of the improvement plan.

Through the community led monitoring (CLM) initiative, PEPFAR-CI will provide funds to 2-3 sentinel CSOs in key districts to monitor monthly, the availability of, and access to HIV prevention and treatment services for KP (sex workers, MSM, people who inject drugs, transgender people), AGYW, and men over 25. PEPFAR-CI will build the advocacy /engagement capacity of key CLM stakeholders and provide technical assistance to MNSC and their partners (DIIS, DSC, PNLS, PNLT) in definition of key CLM indicators on HIV prevention and treatment services as well as the design of a system to track CLM indicators and incorporation of data in DHIS2. Data collected at

selected PEPFAR supported sites through the oversight of the CSOs will be analyzed to capture actionable insights about equity, stigma, and discrimination for KP, PLHIV, and other vulnerable population. Findings will be disseminated to all key stakeholders to come up with a consensual corrective action plan including advocacy items for change in policies and practices to improve equity, reduce stigma and discrimination and promote human rights to improve treatment outcomes for KP, PLHIV and other vulnerable populations.

4.6 Commodities

The COVID-19 pandemic continued to hinder supply chain operations worldwide, creating national level stock tensions and occasional site level stock-outs. The most affected commodities are lab commodities, and in particular viral load (VL) reagents. Shipment lead time and freight cost have both increased, stretching commodities availability and budgets. In COP21, mitigation measures were implemented to minimize the impact of COVID-19 on HIV service delivery. Such mitigation measures included the use of USAID central American Rescue Plan Act (ARPA) funds for the procurement of 62,232 VL tests and 6,720 Early Infant Diagnosis (EID) tests, to compensate for the commodity gap caused by the increased freight costs. This procurement, which allowed clearing of the reagent-delay-induced VL sample backlog - has allowed the PEPFAR-CI program to maintain VL and EID coverage. The transition plan to replace the VL Cobas CAP/CTM machines with Cobas 4800 new platforms has also taken longer than initially planned, which contributed to interruptions of testing and sample backlogs. Careful donor coordination is needed in COP22 to address supply chain risks related to COVID-19 and other global developments.

As part of transitioning to an all-inclusive pricing model, GoCI has already signed a memorandum of understanding (MOU) with Roche for the provision of VL and EID platforms. Through this MOU, Roche has provided the equipment and is committed to ensuring its maintenance, while GoCI and its partners, including PEPFAR-CI, have committed to buying the testing reagents and consumables. A similar MOU has been signed with Abbott Alere for the mPIMA POC machines. Abbott has provided 33 machines, to add to the already existing 27 machines, for which GoCI, along with its key donors, has committed to procure reagents and consumables.

PEPFAR-CI and GFATM continue to be the main external donors for the COP22/FY 23 HIV commodity funding landscape, while GoCI continues to increase its contribution. To avoid duplication in resource allocations, GoCI, GFATM, PEPFAR-CI, WHO, and UNAIDS continue to fully coordinate their planning processes, through the annual national quantification, the quarterly supply planning exercises, and the monthly stock analysis. In COP22, PEPFAR-CI will continue to procure commodities to address and support the PLL Minimum Program Requirements (MPR), including optimized ART regimens: TLD in multi-month distribution (MMD) bottles for adults; DTG-based regimens for children <20 kgs; RTKs; VL and EID reagents and consumables; and TB & Advanced HIV Disease diagnostics and medicines. PEPFAR-CI's $10M commodity budget for COP22 has been developed in an inclusive and tightly coordinated manner, with GoCI, the GFATM and all other major stakeholders to align with

both the national commodities plan for 2023 and the PEPFAR priorities and guidelines. In this successful process, key assumptions were agreed upon:

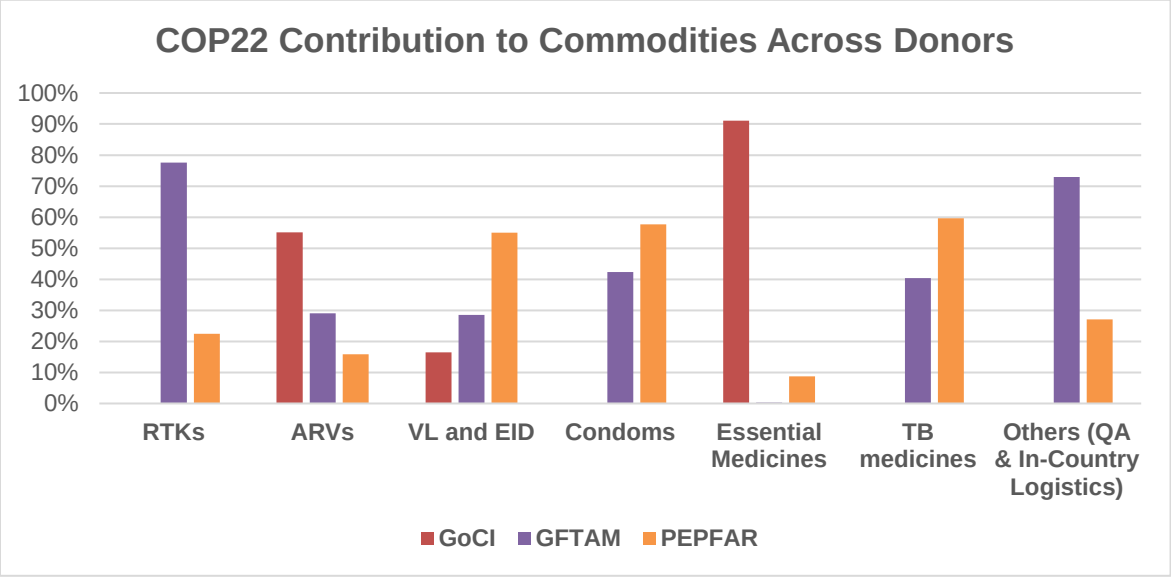
1. The GFATM contribution for HIV commodities will be around $15.4M based on GFATM's New Funding Model (NFM3);
2. GoCI will cover the remaining gap of approximately $20M based on its 2023 HIV commodities supply plan;
3. GoCI will reduce their procurement of TLD 30 count bottles and, instead, increase procurement of TLD 90 count bottles, which are cheaper and more aligned with the MMD policy;
4. GoCI will convert their planned procurement of LPV/r 200/50 mg into procurement of TLD and other DTG based regimens.

This optimization effort is expected to generate savings estimated at $5M that will serve to cover what would be a potential funding gap in key commodities such as ARVs, self-test kits and VL reagents and consumables. Furthermore, it will allow PEPFAR to continue focus on TLD MMD bottles to support and boost the MMD policy in Côte d'Ivoire, and the pediatric optimized ARV, DTG-10, to improve VL Suppression (VLS) outcome in children.

During COP21, PEPFAR-CI has adapted its procurement plan to include the appropriate reagents and consumables for the newly introduced Abbott mPIMA VL and EID POC machines, aiming to improve VL and EID coverage among positive mothers and their babies at PMTCT sites. In addition, during COP21, PEPFAR-CI is transitioning the Roche VL platforms, from the legacy Cobas CAP/CTM machines - for which Roche will stop manufacturing reagents and consumables- to the newer and more robust Cobas 4800 machines. The supply plan for COP22 was developed in line with this VL and EID platform shift. Considering the need to update the national laboratory policy for PLHIV monitoring, PEPFAR-CI has initiated a dialogue with the National HIV/AIDS Program (PNLS) and an agreement was made to revise the existing policy in FY 22. The PEPFAR team is drafting terms of reference (TORs) to support this revision exercise.

The COP22 commodities budget was developed to complement the national needs, contributing to the national common basket for HIV health supplies. Figure 4.6.1 below summarizes the proposed budget allocation by commodities category and by funding sources.

Figure 4.6.1: Percent Contribution to Commodities by Funding Source in FY23



Similarly to COP21, in COP22, PEPFAR-CI will procure commodities primarily through the Global Health Supply Chain (GHSC) procurement mechanism, with a small portion of select lab commodities budgeted for procurement through the Local Health Supply Procurement and Logistic Activity (LHSPLA), Côte d'Ivoire's Local Procurement and Supply Chain TA provider mechanism: procurement through LHSPLA, implemented by the NPSP, supports the strengthening of a Local Partner mechanism and better access to specific lab commodities available locally.

Optimization of TLD and DTG-based regimens for adults and pediatrics

PEPFAR-CI's COP22 commodities budget will primarily focus on the procurement of optimized ART regimens. PEPFAR will continue to procure TLD, the preferred first line regimen for adults, and DTG-based regimens for CLHIV.

Despite the quasi-complete transition to TLD, the country still procures small quantities of TLE-400 for patients who cannot tolerate and/or are considered ineligible for DTG based regimens. PEPFAR-CI and relevant stakeholders will continue to dialogue with GoCI to ensure that GoCI only orders the absolute minimum required quantities of TLE400 and instead prioritizes procurement of TLD to support full and rapid transition of patients to preferred TLD regimens. PEPFAR-CI will also continue engaging with GoCI and relevant stakeholders in monitoring and limiting orders of pediatric LPV/r to the minimum necessary, instead prioritizing the full transition of CLHIV to DTG-based regimens.

In-country discussions about Multi Month Dispensation (MMD) policy continue among stakeholders, GoCI and Civil Society Organizations (CSOs): CSOs have expressed concerns regarding dispensation of TLD 180 count packs, despite the lack of evidence-based risk of potential instability of the TLD in 180 count packs. While continuing the dialogue with CSOs, PEPFAR-CI is prioritizing for COP22 the procurement of TLD 90 count bottles, continuing to

support MMD through this regimen, and allocating a smaller amount to procure 180-count TLD bottles.

During COP20, PEPFAR-CI successfully introduced DTG 10mg for children <20 kg. The first 7,700 bottles of DTG-10 were received in CÔTE D'IVOIRE in April 2021. PEPFAR-CI has committed to procure 100% of the DTG-10 needed to ensure implementation of pediatric optimized regimens is completed by September 30th, 2022. The goal was to transition all children on DTG-10, starting with those on NNIRT (NVP and EFV). The initial target was to switch 90% of pediatrics on DTG-10, but preliminary program data at the end of FY22 Q2 shows that more than 90% of eligible children have already been transitioned. To ensure that sufficient stock is available to support this rapid transition, PEPFAR-CI has placed an additional order of 65,000 bottles of DTG 10 mg. From these, 32,500 bottles were already delivered in November 2021 and the remaining quantity is scheduled to arrive in September 2022, as planned. The PEPFAR-CI team is monitoring closely to make sure that enough stock is continuously available at site level. PEPFAR-CI has also ordered 58,000 bottles of ABC/3TCF 120/60 mg, the backbone of the DTG-based regimen, to close a potential gap due to the rapid transition to the pediatric DTG-based ART. For COP22, PEPFAR-CI plans to continue procuring 100% of DTG-10mg needs, while the ABC/3TCF 120/60 mg and DTG-50 mg needs will be shared between PEPFAR-CI and GFATM at 50/50.

Procurement of Tenofovir/Lamivudine for PrEP

In COP22, PEPFAR-CI plans to procure 50,217 bottles of Tenofovir/Lamivudine 300/300mg for PrEP. These will complement the existing quantities previously procured, and current pending orders by the GFATM.

Procurement of drugs for treatment of cryptococcal meningitis

In COP22, PEPFAR-CI will not procure medicines for cryptococcal meningitis because existing stocks are sufficient to cover the FY 23 needs. PEPFAR-CI will procure Cryptococcus Antigen (CrAg) test kits for diagnosis.

Procurement of TB diagnostics and TPT

In COPn22, PEPFAR-CI will procure diagnostic tests and treatment commodities for both TB and Advanced HIV Disease. These will complement existing orders placed by the GFATM through NFM3. The TPT scale-up implementation has been faster than expected and resulted in a potential shortage in commodities during FY 22. PEPFAR-CI initiated discussions with the GFATM and GoCI on how this gap would be closed and it was agreed that a part of savings from NFM3 implementation will be used to cover any COP21 gaps in TPT commodities, as well as any uncovered needs in COP22.

Procurement of condoms and lubricants

In COP22, PEPFAR-CI investments will support procurement and distribution of 10,350,000 male condoms, 250,000 female condoms, and 655,000 units of personal lubricants. This will be achieved with support from COP22 Condom Procurement Fund. Condoms will be stored at the central medical store (NPSP) and distributed through the district-level approach to local NGOs.

PEPFAR IPs submit their consumption report, work plans, and condom needs to the health districts. The health districts compile all needs and submit monthly requests to NPSP which send the condoms down to the health district to supply the IPs. This process is the same for routine distribution or any campaigns or special activities.

Supply Chain Management

Supply chain strengthening interventions in FY2023 will continue bolstering health systems for quality control, monitoring, and real-time response. Given funding limitations, PEPFAR-CI will work closely with GFATM, who is also providing funding support for last mile distribution.

Building on the prior year's investments and achievements, PEPFAR-CI will:

1. Continue working with GoCI, GFATM, and other key donors to support coordination and advocacy for the extension of mSupply;
2. Reinforce the existing eLMIS tool for a more robust data visibility system, including supporting interoperability with mSupply;
3. Provide institutional support to GoCI and local organizations (CNCAM and NPSP) for the national health commodities quantification, forecasting and supply planning;
4. Ensure PEPFAR-CI supported health districts routinely collect, review, and provide feedback on logistics data, taking timely and appropriate actions to address stock imbalances;
5. Continue supporting the scale-up of optimized treatments, specifically TLD and other DTG-based regimens for adults and pediatrics;
6. Support PPMR-HIV, TLD and MMD data collection, in compliance with PEPFAR data requirements, to inform decision making;
7. Improve inventory management system at central level (NPSP) as well as inventory and order management at site level to reduce stockout risks and improve quality management systems for decentralized logistics;

In COP22, PEPFAR-CI will continue to work on a small scale, some of the key challenges of last mile distribution in Côte d'Ivoire. Recent national supply chain assessments, MCKINSEY (2018) and Global Fund (2021) have clearly described and documented last mile distribution challenges in the Côte d'Ivoire health pyramid. Some are weaknesses in order and inventory management at site and district level, inadequacy of dedicated HRH, timely data collection and visibility, etc. These often compromise drug and test availability at site level, are highlighted in the Côte d'Ivoire COP22 PLL and are therefore a priority for the PEPFAR-CI team.

In COP22, PEPFAR-CI will continue to support Côte d'Ivoire through the Project Last Mile (PLM). This support will include a set of above site activities as well as package of site level and health district interventions.

Above-site level support will include sustaining and scale LMD strategic recommendations from the COP21 pilot. This will consist of sustaining procedures implemented at central level such as: (a) continue providing strategic advisory guidance on design of last mile distribution model to NPSP and DAP; (b) refine national strategy for order management, inventory management, and

performance management processes using private sector best practices; (c) develop national scale up plan with NPSP and DAP to leverage existing infrastructure and enable scale up of agreed last mile delivery model; and (d) build capacity of the DAP, NPSP and other above-site personnel required to enable optimal performance of the last mile delivery model.

At site level, PEPFAR-CI will focus on sustaining the last mile delivery service package implemented in 43 facilities (3 Health Districts) during COP21, and, if possible, expand to some additional health facilities in other health districts. PEPFAR-CI through the PLM project will support existing infrastructure from DAP, NPSP and other implementing partners to provide a site level service package that includes (a) new inventory management routines and processes to respond to gaps in the capability of staff responsible for inventory management at health facilities; (b) new order management processes that enable facilities to improve effectiveness of managing order flows; (c) performance management processes to improve inventory management and order management practices within health facilities across districts; (d) capacity-building and training PGPs to implement inventory, order, and performance management processes across health facilities in the current and, if possible, any new health districts; (e) and provide coaching to staff at health facilities.

4.7 Collaboration, Integration and Monitoring

1. ***Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MoH***

   PEPFAR-CI's strategic vision is to help align PEPFAR and all other bilateral and multilateral support behind a national strategy led by the Government of Côte d'Ivoire (GoCI). Throughout FY22 thus far, PEPFAR-CI has successfully maintained and strengthened effective collaboration with all key stakeholders, including the Ministry of Health and Public Hygiene (MSHP), the Ministry of Defense (MOD), the GFATM, WHO, UNAIDS, and CSOs on all aspects of program implementation and results achievement. This fruitful collaboration has permitted major policy shifts to improve program quality, including the rapid transition to TLD, DTG for children, and the scale-up of MMD and TPT. In addition, non-PEPFAR stakeholders play an increasingly substantial role in the COP planning process. PEPFAR-CI intends to continue this close and effective collaboration through quarterly sharing and review of performance data, including best practices and programmatic challenges, joint planning and sites visits, and joint monitoring of policy implementation. As mentioned in section 4.1, a key element of this coordination will be ensuring that PEPFAR investments are focused on the program's geographic footprint, with the remaining districts and communes supported by non-PEPFAR actors. In addition, PEPFAR will expand its engagement with CSOs and faith leaders through the existing CLM, CQI and FCI initiatives, respectively. The MoH General Directorate (DGS) will continue to lead coordination efforts in collaboration with the PNLS and the National OVC Program (PNOEV). This approach will contribute to the MSHP's overall vision to ensure the sustainability of the national HIV/AIDS response by generating synergies, including decentralized authorities (elected or appointed) who will be held increasingly accountable for the oversight of HIV/AIDS activities at regional and

district levels. In COP22, PEPFAR will resume limited direct funding to MFFE for capacity building and coordination of DREAMS and OVC interventions. Both MSHP and MFFE will be progressively positioned to assume increasing responsibility for service delivery interventions in line with sustainability planning.

Since COP19, PEPFAR-CI has been supporting a Joint Monitoring Plan, under the leadership of the DGS and technical oversight of the PNLS. The plan brings together all key stakeholders including donors, CSOs, Region Presidents, Préfets, Sous-Préfets, and regional and district health officials under a joint framework for planning and program review. This plan has helped raise awareness at decentralized levels with more accountability from region and district health directors on program performance, which has in turn led to site level implementation of policy shifts on TLD, DTG, MMD, and TPT. PEPFAR-CI will continue to support this Joint Monitoring Plan at three levels:

- At the national level, program review is done on a quarterly basis under the leadership of the DGS, and with the active involvement of all regional directors. Continuous data review and program adjustment occur through field supervision and mentorship visits throughout the implementation period, led by district and regional directors. The PEPFAR-CI team supports the MSHP in the development of policy documents, guidelines, and standard operating procedures to accelerate progress towards the 95-95-95 goals.
- At regional and district levels, PEPFAR IPs and USG staff regularly engage with Regional Health Directors and District Health Directors for both ad hoc and regularly scheduled program oversight (e.g., SIMS, GSM, and other site visits). Regional and District health leadership will also be engaged by PEPFAR IPs, USG staff, and CSOs in reviewing and responding to CLM and CQI findings.
- At site level, PEPFAR IPs are embedded within ministry structures at facility and community level. PNLS and PEPFAR-CI are in the process of finalizing a code of conduct for all IPs (funded by PEPFAR and others) to encompass ethics, data integrity, quality of care and coordination. In COP22, PEPFAR-CI will continue to strengthen community-facility collaboration using the “Collaborative Monitoring Matrix” developed in COP20, though as mentioned, increasing consolidation of IPs for comprehensive service delivery will obviate much of this need. PEPFAR-CI, GFATM and other key partners will also continue to support the MSHP in the systematic review and triangulation of patient level care and treatment outcomes.

The goal of these multi-level collaboration efforts is to help improve data use for program performance and to boost the MSHP capacity for data governance in the national HIV response.

2. ***Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods***

In COP22, all USG agencies will continue to strengthen partner management for achieving results, with a focus on case finding among critical sub-populations, continuity of treatment and VLS, data quality and completeness, and patient-centered care (i.e., safe, ethical index HTS; KP-competent and friendly services, male and adolescent-friendly accommodations). The USG team will continue to monitor weekly data to rapidly course-correct where necessary. PCO-led interagency site-visits will continue as needed, to address data issues with community HTS and linkage to care. Interagency technical working groups (TWG) will continue to facilitate rapid and standardized review of key indicators (both MER and custom indicators) across the cascade; the increasing granularity of COP planning based on service packages and HRH assumptions will strengthen partner oversight, linking HRH investments to program results per the MER definition of direct service delivery. IPs will leverage and build upon best practices to scale up priority interventions, benefiting from PCO-led quarterly reviews around each POART.

PEPFAR-CI will support appropriate increase of human resources within GoCI to implement joint monitoring, complementing the Performance-Based Funding (PBF) resources from the World Bank to help address critical gaps at district level through site-level recognition and improve oversight and quality of HIV service delivery with a special focus on TA sites. This is a critical step towards increasing MSHP ownership of HIV service delivery and its integration into the existing primary health care system. Consistently underperforming areas (facility and community) will receive focused monitoring by the site management team (MSHP, CSO and USG staff), to rapidly assess whether HRH deployments have occurred as planned and budgeted, and whether facility/community leadership is appropriately engaged in HIV service delivery.

Through the expansion of CLM, increasing KP representation and engagement will allow for better monitoring of stigma and discrimination, and to provide IPs with valuable insight. Innovations like Circle of Hope community posts and the Zvandiri CATS model will help IPs to improve results across the cascade for critical sub-populations like men, children, and adolescents. All three of these (CLM, FCI, Zvandiri) also represent examples of PEPFAR IPs' increasing collaboration with civil society for lasting impact.

3. ***Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade***

The PEPFAR-CI HRH strategy in COP22 aims to continue to provide support for human resources for health to strengthen implementation along the clinical cascade, at both facility and community levels. PEPFAR-CI will continue to support staff at high impact and moderate impact facilities and surrounding catchment communities as needed to

ensure high-quality, patient-centered services. PEPFAR-CI has begun monitoring the allocation, productivity, and impact of HRH by linking staffing changes to relevant facility and community performance, and this data was foundational in developing budget assumptions for COP22. The increased rigor and granularity introduced in COP21 planning has allowed the USG team to identify efficiencies and improve standardization of service delivery costs across PEPFAR IPs. This evolving process will continue to benefit PEPFAR-CI's programming in the years to come.

Community cadres will be responsible for community-based case finding, ensuring all patients found positive are properly counseled and linked to treatment, tracing all defaulters, supporting patients who are at risk of missing an appointment, and making sure patients who are eligible for viral load testing return to the clinic for their tests. PEPFAR-CI is constantly analyzing workforce requirements for the maintenance of HIV services in consultation with implementing partners. In COP22, PEPFAR-CI is working towards increased integration and 'one-stop' service delivery for mother-baby dyads by deploying HRH to immunization and well-child entry points. This will improve case finding among children as well as increasing convenience for patients to receive HIV services without having to move to a different entry point. Importantly, this integration does not require a net increase in HRH, given the efficiencies identified through MMD and reduced visit frequency for established patients.

To address challenges with the third 95 of the clinical cascade, PEPFAR-CI has introduced numerous measures to significantly improve VL uptake and increase viral suppression rates. These changes/interventions include training health care and community health workers with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based financing to improve lab staff continuity of treatment; effective utilization of VL testing dashboards to fast track unsuppressed VL with emphasis on children, adolescents and men and to document clinical site and laboratory performance; improving the laboratory information system to collect data on VL uptake and real time data analysis; strengthening capacity for OVC staff to track VLC/VLS for beneficiaries; and clinical HRH support (VL champions). These interventions have led directly to improvements in both VLC and VLS. Programs and district health teams will be responsible for developing and implementing effective policies, planning, HRH, and real time monitoring of patient data. Packages of activities are defined for IPs to support the district heath teams, provide resources for registers, training materials, transportation and improve turnaround time for VL results. Lab mapping to optimize VL lab network and improve laboratory clinical interface will continue in COP22, building on the DNO work which began in COP21. Interoperability and integration of clinical and laboratory data between the eLIS and SIGDEP (EHR) systems will improve individual patient care and program monitoring.

4. ***Improving integration of quality and efficiencies in service delivery through improved models of care delivery across community and facility sites***

Community-facility collaboration has been described extensively in previous sections, with clearly defined roles and responsibilities for each throughout the cascade. MOUs and monitoring frameworks will continue to be utilized as described. In COP22, the program has identified significant efficiencies by calibrating HRH assumptions with an increasingly established ART population, and through differentiated service delivery models. Improvements in data management (UPID, SIGDEP upgrades/expansion, and CommCare) will also contribute to efficiency by reducing data duplication and irregularities, while comprehensive service delivery through a consolidated IP landscape will increase efficiencies in HRH needs and data management, while improving patient-centered care.

5. ***Supporting community-led monitoring of treatment services with minimum quarterly meetings to review reported observations and recommendations with representatives and follow up as needed***

   In partnership with UNAIDS, PEPFAR-CI will continue to support CLM in COP22 with a specific focus on greater representation of marginalized KP groups. CLM findings will be integrated into quarterly coordination meetings to highlight challenges and best practices in terms of high-quality, person-centered care. The USG-UNAIDS team will continue to improve CLM methodology and indicators in an iterative and collaborative process with CSOs. Finally, CLM funding will also support organizational capacity building among recipient organizations.

6. ***Ensuring above-site program activities are mapped to key barriers and measurable outcomes related to reaching epidemic control; and monitored in an ongoing manner***

   Above site program activities, as detailed in Section 5.0, speak to specific cross-cutting barriers such as stigma and discrimination and strengthening of foundational systems in laboratory, supply chain, and health information management: gaps in each of these areas have direct impact upon the clinical cascade results. The introduction of recent infection surveillance represents an important initiative for the national program as Côte d'Ivoire approaches epidemic control and tracking of ongoing viral transmission becomes increasingly important. In line with PEPFAR guidance, all above-site activities are linked to annual benchmarks, SID and MILSID elements.

7. ***Use of unique identifiers across sites and programs in clinical settings for monitoring***

   In COP18 (FY2019), PEPFAR-CI collaborated with MSHP to approve the concept to use securely encrypted numeric code (based on fingerprint) to constitute a unique patient identification code (UPID) to be used for all PLHIVs and TB patients across all programs (e.g., HTS, ART, PMTCT, Lab) to address Côte d'Ivoire's systemic program linkage, interruptions to treatment, and data quality issues. In COP19 (FY2020), the UPID was

fully integrated into Côte d'Ivoire's HIS architecture and the site-level solution was developed and tested with the national EMR (SIGDEP2). The initial rollout phase, however, was delayed in FY2020 due to COVID 19 health restrictions.

In COP21, through ARPA and Ambition funds, PEPFAR Côte d'Ivoire is supporting UPID implementation along with an updated EMR (SIGDEP3) at all 172 high impact sites, which support approximately 70% of active patients on treatment. In addition, a national-level UPID system requires a central Patient Identity Management solution to deduplicate and manage patients across individual sites and eventually all testing locations. In COP22, PEPFAR will support MSHP in implementing a Patient Identity Management system at 10 initial sites. This system will use the UPID to deduplicate integrated data from SIGDEP 3.0 and eLIS: as such, accurate, individual patient-level clinical and VL data will be available at site level. In COP22, an assessment will be conducted to identify how the UPID system can start deployment in the military program, considering specific military constraints.

4.8 Targets by population

Below are COP22 targets by population.

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART (APR FY22)**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY23) *TX_CURR***	**Newly initiated (APR FY23) *TX_NEW***	**ART Coverage (APR 23)**
Attained						
Scale-Up Saturation	**366,174**	**302,127**	**0**	**278,023**	**31,706**	**76%**
Scale-Up Aggressive						
Sustained						
Central Support						
Commodities (if not included in previous categories)						
TOTAL	**366,174**	**302,127**	**0**	**278,023**	**31,706**	**76%**

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY23)**	**Expected Coverage (in FY23)**
N/A	[Specify age bands for focus]	**N/A**	**N/A**	**N/A**	**N/A**
N/A	**Total/Average**	**N/A**	**N/A**	**N/A**	**N/A**

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate* (SNUs)**	**Disease Burden***	**FY23 Target**
AGYW at risk of HIV acquisition (*AGYW_PREV)*	**273,515**	**0.7%**	**42,700**
Female sex workers (*KP_PREV/FSW)*	**55,681**	**N/A**	**28,933**
Men Having Sex with Men (*KP_PREV/MSM)*	**35,198**	**N/A**	**12,697**
Priority population (P*P_PREV)*	**968,770**	**1.3%**	**149,232**
TOTAL	**1,333,164**	**N/A**	**233,562**

Table 4.8.4 Targets for OVC and Linkages to HIV Services

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target) OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target) OVC_SERV Preventative**	**Target # of active OVC (FY23 Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC***
Abengourou	14,337	2,651	168	0	2,094
Abobo-Est	25,960	10,352	956	6,470	6,841
Abobo-Ouest	29,692	4,487	1,152	0	3,511
Adjame-Plateau-Attecoube	36,880	10,328	1,068	0	8,157
Adzope	6,007	2,037	84	0	1,611
Agboville	9,480	3,252	140	0	2,571

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Akoupe	3,667	1,832	56	0	1,449
Anyama	6,251	2,319	84	0	1,837
Arrah	3,379	32	56	0	20
Bangolo	13,250	2,185	140	0	1,734
Bondoukou	15,790	5,383	168	0	4,258
Bongouanou	6,942	4,605	84	0	3,663
Bouafle	13,599	2,819	196	0	2,192
Bouake-Nord-Est	7,548	3,387	84	0	2,682
Bouake-Nord-Ouest	16,432	6,013	196	0	4,784
Bouake-Sud	11,638	3,685	140	0	2,915
Cocody-Bingerville	30,404	10,872	984	5,580	7,853
Dabou	8,877	2,270	140	0	1,797
Daloa	20,493	8,912	928	6,640	6,413
Divo	10,293	7,734	168	0	6,142
Duekoue	10,920	4,727	168	0	3,746
Gagnoa 1	11,412	4,769	168	0	3,754
Guiglo	4,708	3,583	56	0	2,826
Issia	10,060	1,979	140	0	1,550
Korhogo 1	19,418	7,664	872	0	6,068
Koumassi	20,621	3,656	900	0	2,840
Koun-Fao	5,016	101	56	0	76
Man	26,948	5,422	900	4,070	3,814
Mankono	5,561	685	84	0	541
M'Batto	3,818	93	56	0	67
Oume	11,279	2,375	140	0	1,873
Port-Bouet-Vridi	21,635	6,605	900	0	5,195
Sandegue	2,271	52	28	0	42
San-Pedro	23,073	4,652	984	0	3,633

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
SNU	**Estimated # of Orphans and Vulnerable Children**	**Target # of active OVC (FY23 Target) OVC_SERV Comprehensive**	**Target # of OVC (FY23 Target) OVC_SERV Preventative**	**Target # of active OVC (FY23 Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC***
Sinfra	9,829	2,835	140	0	2,243
Soubre	13,438	3,756	224	0	2,953
Tabou	4,205	667	56	0	517
Tanda	3,596	4,960	56	0	3,953
Tiassale	7,656	3,236	112	0	2,558
Transua	3,775	58	56	0	44
Treichville-Marcory	36,660	5,850	1,068	0	4,653
Yamoussoukro	13,874	3,235	196	0	2,536
Yopougon-Est	42,538	4,668	1,264	0	3,622
Yopougon-Ouest-Songon	33,557	5,363	956	0	4,175
TOTAL	**636,787**	**176,146**	**16,572**	**22,760**	**135,803**

4.9 Viral Load and Early Infant Diagnosis Optimization

In continuation of activities that were initiated in COP21 using funds from the ARPA, PEPFAR-CI will demonstrate its strong commitment to the completion of a comprehensive Diagnostic Network Optimization (DNO) exercise in collaboration with GFATM and GoCI by providing funds for the following:

- Development of a prioritized strategy within the operational plan at Q4 FY 22 and incorporation of the integrated sample referral system design
- Support for VL and other molecular test waste reduction and disposal
- Recommendation of short-, medium- and long-term strategies for the continued support of HIV/TB services by assessing system barriers
- Assistance for MoH to develop and validate policy and guidelines related to the optimization plan

Based on analysis of costs associated with equipment maintenance in previous COP cycles, PEPFAR-CI has adopted the innovative strategy of all-inclusive pricing and has been a primary advisor to MoH to transition to reagent rental agreements for cost savings and better coordination of vendor support. Several departments of the MoH including the National Public Health

Laboratory (LNSP), the PNLS, the national medical warehouse (NPSP), the DIEM, the CRIEM and other laboratories have been capacitated by PEPFAR and are engaged in the development and revision of reagent rental agreements towards all-inclusive pricing models. With the scale up of VL testing, PEPFAR has worked closely with MoH to adopt equipment placement strategies to reduce costs associated with laboratory equipment procurement and maintenance and used the cost savings to procure more reagents and associated consumables to boost program performance. Despite this progress the program still faces significant challenges with unstable electricity supply for equipment (requiring provision of stabilizers and support for functioning of standby generators) as well as maintenance needs for small support equipment required for the smooth functioning of the lab program such as freezers and air conditioners. The savings from the rental agreements will allow the program to continue to support these critical needs in COP22. Another challenge is that while the HIV program (PNLS) supports instrument placement, the TB program (PNLT) continues to purchase instruments requiring significant equipment maintenance resources provided through the GFATM portfolio. PEPFAR-CI will continue to advocate with the GFATM and PNLT for transition to all-inclusive pricing agreements like the PNLS.

Thanks to PEPFAR-CI working closely with MoH to develop a national VL/EID POC testing policy, an updated rental agreement was established with Abbott for the placement of 33 additional mPIMA machines in FY21 bringing the national total to 60 mPIMA POC machines. These machines are strategically placed at 60 high volume PMTCT sites with the goal of covering 60% of EID and 25 % of VL needs for PBFW with POC testing, using a hub and spoke model. Additional strategies such as community EID testing and testing at other entry points such as vaccination and nutrition centers will help improve VL and EID coverage for mother-baby dyads. In FY23, PMTCT optimization of the network will continue through community VL/EID testing with the goal of reducing TAT to 24 hours or less.

Regarding TB/HIV diagnostic integration, multiplexing and use of data systems to alert patients of the availability of their test results, PEPFAR-CI will extend the existing Lab Information System (LIS) OpenELIS to the TB diagnostic laboratory network. This should result in reducing laboratory results TAT and improve the laboratory-clinical interface. Required annual security upgrades of OpenELIS will also be implemented to comply with international guidelines to enable a secure access to the system and protect patient records. In addition, OpenELIS will be upgraded to improve the interface between patients' medical records and the VL, EID and TB lab as well as to allow for direct SMS patient notification to alert patients with unsuppressed viral load of their results at all viral load labs. Additional upgrades will be made to the LIS for interoperability with the patients' electronic medical record (EMR) SIGDEP. PEPFAR-CI will also continue to support lab staff capacity building as well as targeted strategic support for lab equipment maintenance not covered by warranties. The Laboratory program through Pasteur Institute, will also support efforts for the implementation of the AHD package of services at selected PEPFAR-supported clinical sites including access to CD4 testing by patients with advanced HIV disease presenting to these clinics.

Finally, PEPFAR-CI will continue to advocate with MoH and Global Fund for the development of an integrated sample transport system as well as to provide funding for TA and development of SOPs for the system.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

PEPFAR-CI above-site investments in COP22 are focused on SID and MILSID elements that speak directly to cross-cutting challenges impeding the optimal achievement of program results. These include availability and utilization of epidemiological and program data; human resources for health; commodity security/supply chain; laboratory systems; civil society engagement, domestic resource mobilization, and technical/allocative efficiency. Half of these areas scored yellow in the 2021 SID exercise. All Table 6 investments have annual benchmarks and implementation timelines per COP guidance, and the overarching goal of these investments is to work with GoCI, multilateral stakeholders, and civil society to create service delivery and information systems that are high-impact, patient-centered, and sustainable in the Ivorian environment.

- Most of the Table 6 activities address gaps in health information systems, both in the public and military sectors. These include interoperability among electronic health records (EHR) and laboratory information systems, as well as unique identifier solutions to facilitate de-duplicated patient-level data tracking. Following years of PEPFAR investment in development and implementation, the *"Plateforme Electronique de Suivi du Patient"* (built using the CommCare ® system) and the OVC/DREAMS database are being transitioned to host country responsibility (MSHP and MFFE, respectively) in line with sustainability planning. Finally, UPID and Patient Identity Management systems are developed in a manner that allows integration with GoCI's broader vision for an electronic national health ID system, though the latter's development is not imminent. PEPFAR-CI is in constant communication with GFATM to maximize harmonization and synergy of HIS investments, to ensure synergistic advancement of GoCI priorities.
- HRH recruitment and retention investments include human resource information systems (HRIS) investments for the military, pre-service training to help integrate HIV service delivery into primary health care, and support for critical positions within MSHP that maintain the program's focus on epidemic control.
- Supply chain investments are focused on improving sub-national level data tracking to avoid site-level stockouts and improving central stock management systems to improve distribution. PEPFAR-CI continues to coordinate closely with GFATM in this area, as both commodity procurement and last mile delivery are areas of overlap that require significant investment beyond what PEPFAR alone can provide.
- Above-site investments will support PrEP demand creation for KP and AGYW groups receiving key and vulnerable populations programming. These investments address the technical directives and minimum program requirements regarding PrEP to prevent new infections. In addition, KP CSOs will be the focus of COP22 CLM investments, which contain both site-level and above-site components.

- Capacity building investments in both the civilian and military sectors will advance PEPFAR-CI's efforts towards sustainability, serving KP-led organizations, the MoD and military-affiliated PLHIV organizations, MSHP, and MFFE. These investments are critical to facilitate increasingly local responsibility for program implementation
- Investments to strengthen laboratory systems will continue to ensure consistent, high-quality, and accurate HIV diagnostic outputs and are complementary to GFATM investments in this sector. The DNO exercise, in partnership with GFATM, is critical to maximize efficiency of equipment procurement, specimen transport, and reagent forecasting.
- Recent infection surveillance will be initiated in COP22, representing a critical surveillance activity for countries approaching epidemic control. Initial investments will be in training; establishment of data collection, interpretation, and visualization systems; and pilot implementation at 10 sites. As a lab-based activity, additional site-level investments are not anticipated among service providers. In subsequent years, the system will be expanded to allow the national program to identify demographic and geographic areas of ongoing viral transmission. The RIS system will be developed in close collaboration with host country laboratory and surveillance personnel, and PEPFAR-CI will invest in building MSHP capacity for ultimate responsibility.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Staffing Analysis

The PEPFAR Côte d'Ivoire team is improving its staffing footprint to improve human resources programmatic alignment to facilitate and sustain HIV epidemic control, and to successfully support the national program. A partial interagency Management and Operations (M&O) review of the program was conducted prior to COP21 implementation to ensure that the program has the appropriate distribution of technical staff to ensure the provision of high-quality services and rigorous partner management. During COP21, agencies are capitalizing on the current staffing footprint to improve efficiencies. For example, CDC has included DREAMS activities under the current HIV Prevention Support, Youth & GBV Advisor position as the target populations' scopes are closely aligned. In addition, the interagency team agreed to shift the Data Analyst for Cost Effectiveness from an agency specific position to the PEPFAR Coordination Office (PCO) to better serve the interagency needs.

The PEPFAR-CI team works to balance interagency and intra-agency activities throughout the COP implementation period through biweekly interagency technical working group (TWG) meetings, which include representation from all PEPFAR agencies. Intra-agency partner management activities include weekly IP check-ins, monthly partner performance reviews (PPRs), interagency data quality audits (DQAs), and other ad-hoc meetings scheduled around planned interagency TWG meetings. To meet SIMS requirements coupled with other program activities, staff from various branches (strategic information, program managers and technical

specialists) will continue to support SIMS and other site visits in small groups on a rotating basis to ensure regular coverage of sites while minimizing disruption of ongoing programming. IP program performance in areas such as linkage and retention as well as client-centered services are reviewed to ensure appropriate recommendations provided depending on gaps identified. Other program monitoring tools include SIMS and granular site management (GSM) visits to improve quality of services (service and non-service delivery) at facility and community sites. PEPFAR-CI interagency and intra-agency scheduled, and ad-hoc site visits are frequent, and always include central and/or sub-national representation from MSHP. This helps to ensure that partner oversight and coordination are truly a collective responsibility shared by USG agencies and MSHP and have been a critical factor in the rapid national progress on key priorities like TLD/DTG transition, TPT, and MMD.

In COP21, CDC is working with UNAIDS to provide direct funding to between three and six civil society organizations (CSOs) to build their capacity to collect qualitative and quantitative data about services that PLHIV and KPs receive at PEPAR-supported sites to inform policy change. A joint, CDC-UNAIDS multidisciplinary team is in frequent communication overseeing this process, which was kicked off with an interagency sensitization launch addressing a broad range of CSOs and PNLS. CDC-UNAIDS leadership holds biweekly calls to oversee progress. The team is on track to roll-out CLM implementation in FY23Q3 and Q4, and the process will be simpler in COP22, building on current experience.

Looking to COP22 implementation and maximizing staffing, USAID is amid a Health Team restructuring to better align staff with the evolving portfolio (PEPFAR and beyond). The exercise includes a review of positions, alignment of positions and teams with the new portfolio, and an annual training plan (per staff member and for the team) to address skills and competencies that would benefit from additional training. Similarly, CDC identified the need for a Key Populations Technical Advisor. The functions of this position were previously covered by the Prevention, Care, and Treatment (PCT) Deputy, who coincidentally was a KP expert but retired in August 2021. Recruitment of this position is currently underway.

For more details about specific M&O for each agency for PEPFAR-CI, please see below.

CDC

CDC and PEPFAR-CI have been providing technical and financial support to the Côte d'Ivoire MSHP to establish and continuously improve quality HIV/AIDS services at health facility and community levels within the framework of the National HIV Strategic Plan (PSN), and in collaboration with the PNLS.

As Côte d'Ivoire approaches the 95/95/95 benchmarks and based on COP22 guidance and overall programmatic needs for the country, CDC aims to ensure efficient and sustainable implementation of HIV services to deliver an AIDS-free generation in a manner that is transparent, accountable, and impactful. To support these efforts, CDC plans to recruit for a vacant Key Populations (KP) technical advisor position in FY23/COP22. The functions of this

position were previously performed by the former Prevention, Care, and Treatment (PCT) Deputy Branch Chief, who was a renowned KP expert but has since retired. The KP position will provide technical support to CDC/PEPFAR in KP program implementation.

Currently, CDC has two institutional contractors funded under a central contracting mechanism in Atlanta. With the current shift in program priorities and focus on sustainability towards host country program ownership, CDC will split the two contractional functions by placing one of these functions under a personal services contract (PSC) mechanism to serve as the CDC Health Systems Strengthening and Sustainability Advisor for HIV impact. The position will be responsible for long-term planning and strategic direction of CDC support to the MSHP, including health financing, human resources for health, human capacity development, system governance, and integrated service delivery. This contract requires an NSDD-38, for which CDC was previously approved in 2019. The request to fill this NSDD-38 was also included in the Embassy Abidjan's Mission Resource Request (MRR) for FY23 in February 2021. The remaining contractual functions will stay with the headquarters' central contracting mechanism. CDC will continue to provide technical guidance and financial oversight of clinical and community partners, with a focus on cost efficiencies throughout the portfolio. Overall, CDC's Cost of Doing Business will decrease from $10,024,055 in FY22/COP21 to $9,968,052 in FY23/COP22 (all cost categories included). In FY23, CDC will have a net reduction of two positions to our staffing footprint with filling the vacant KP Technical Advisor position and the retirement of three (3) Retro-CI staff, which is in line with current Retro-CI transition plan.

USAID

USAID continues to support the Government of Côte d'Ivoire in their goal of achieving sustained HIV epidemic control through PEPFAR-supported implementation activities as well as capacity strengthening support through direct USAID technical assistance. With an emphasis on sustainability, key areas of support are strategic information and health systems strengthening including supply chain/commodities management and health financing/domestic resource mobilization.

USAID has a lean staffing footprint of 19 PEPFAR supported staff in COP21: 14 Foreign Service nationals (FSNs), 2 Third Country Nationals (TCNs), and 3 US Personal Service Contractors (US/PSC). Following an efficient management model where activity managers are also technical advisors, the USAID PEPFAR team is comprised of 3 branches that are led by a newly approved HIV Team Lead (US/PSC) position: Integrated Service Delivery (1 US/PSC and 5 FSNs), Health Systems Strengthening (1 US/PSC, 1 TCN, and 4 FSNs), and Strategic Information (4 FSNs). The team is also assisted by three support staff for administrative, financial, and contract support. A combined team of SI and program management/technical staff ensure that SIMS and other quality assurance site visits are conducted regularly, according to schedule and based on emerging needs.

USAID currently has three vacancies: two new positions and one replacement position. Recruitment of the new positions (AGYW/DREAMS Program Management Support position and

the HIV Team Lead position) are both underway and expected to be filled before the end of the fiscal year (FY22). The SI Team Lead position was unexpectedly vacated in late March, and the recruitment process has begun.

In April 2018, PEPFAR announced a goal to direct 70 percent of USAID/PEPFAR funds to local partners through direct prime awards in order to achieve country ownership of the HIV response. To make progress toward this goal, local partners must be appropriately supported to assure programmatic and operational integrity and to continue the arch of progress that PEPFAR has achieved to-date. For COP22, USAID and SGAC recognized that missions need staff who can invest dedicated levels of effort to local partner transition; additive funding was thus dedicated for 71 new local staff positions at select missions around the world in COP22 and COP23, with half receiving initial funding in COP22. Côte d'Ivoire received approval to add two new locally employed positions (FSN-10s) in COP22 as a part of this agreement, and a third locally employed position is expected to be approved in COP23. Utilizing standard position descriptions, USAID plans to add 1 position in the Office of Financial Management, 1 position in the Office of Acquisition and Assistance and 1 AOR/program manager. These positions will help PEPFAR-CI continue to transition successfully to local partners.

USAID continuously assesses program management needs to ensure the staffing footprint is aligned with the evolving PEPFAR portfolio and enables robust partner management. Thus, USAID also proposes adding a HIV Clinical Advisor (FSN-12) to for sufficient oversight and robust management of USAID's expanding clinical portfolio.

HRSA

For COP22, recruitment is ongoing for a direct-hire agency lead position based in Abidjan. This position will not be COP-funded and will be supported by HRSA's central funds. Pending selection and eventual security clearance, the direct hire is expected to onboard in FY23 Q1. HRSA continues to use ICASS to limit the number of staff and to optimize administrative and other support cost-sharing.

DOD

For COP22, DOD has two local positions to cover program performance needs and will continue to use ICASS to limit the number of staff and to optimize administrative and other support cost sharing. The Strategic Information Specialist onboarded in FY22 Q2. DOD has no new positions proposed for COP22. Small increase has been made from COP21 to update ICASS to actual costs.

PCO

Currently, the PCO office currently consists of 5 employees: the PEPFAR Country Coordinator, Assistant Program Coordinator, Global Fund Liaison Advisor, Program Assistant, and Data Analyst for Cost Effectiveness, the latter of which is funded by CDC in COP21, however, it will be funded by State starting in COP22. Two additional positions have applicants selected but

onboarding has yet to commence. These include the Monitoring & Reporting Coordinator position which has been vacant since FY21Q1 and the candidate is pending security clearance, and the DREAMS Coordinator position who will start in FY22Q3.

APPENDIX A -- PRIORITIZATION

Continuous Nature of SNU Prioritization to Reach Epidemic Control

Table A.1

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
_Military Côte d'Ivoire	COP20	Military	APR21	N/A: No target required																								
	COP21	Military	APR22																									
	COP22	Military	APR23																									
Abengourou	COP15	Scale-Up: Agg	APR16	8%	6%	13%	13%	18%	19%	21%	21%	5%	3%	18%	4%	58%	15%	79%	21%	105%	37%	153%	87%	153%	87%	49%	47%	43%
	COP16	Scale-Up: Agg	APR17	13%	11%	21%	24%	29%	34%	35%	38%	6%	4%	21%	4%	68%	18%	93%	25%	123%	44%	180%	103%	180%	103%	57%	55%	54%
	COP17	Scale-Up: Satur	APR18	26%	37%	26%	37%	26%	37%	26%	37%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	93%	47%	57%
	COP18	Scale-Up: Satur	APR19	8%	17%	20%	36%	27%	34%	83%	72%	35%	38%	25%	54%	38%	87%	47%	107%	55%	101%	65%	105%	85%	112%	58%	57%	57%
	COP19	Scale-Up: Satur	APR20	72%	77%	51%	140%	53%	53%	67%	59%	33%	68%	60%	94%	105%	150%	98%	139%	100%	127%	81%	99%	60%	94%	44%	73%	83%
	COP20	Scale-Up: Satur	APR21	15%	0%	25%	38%	29%	34%	75%	70%	36%	24%	41%	74%	49%	99%	56%	123%	65%	116%	79%	114%	112%	128%	67%	67%	64%
	COP21	Scale-Up: Satur	APR22	20%	20%	50%	94%	88%	102%	86%	89%	31%	35%	43%	86%	90%	112%	136%	126%	116%	108%	99%	89%	95%	84%	80%	85%	82%
	COP22	Scale-Up: Satur	APR23	33%	33%	153%	219%	141%	178%	119%	136%	45%	29%	60%	97%	110%	171%	159%	187%	96%	165%	101%	128%	117%	148%	104%	73%	117%
Abobo-Est	COP15	Scale-Up: Satur	APR16	14%	14%	23%	30%	32%	43%	38%	48%	7%	3%	26%	4%	84%	15%	116%	21%	153%	37%	223%	89%	223%	89%	71%	47%	60%
	COP16	Scale-Up: Satur	APR17	17%	15%	29%	31%	40%	44%	47%	50%	9%	4%	30%	4%	97%	18%	133%	25%	176%	44%	258%	105%	258%	105%	82%	56%	70%
	COP17	Scale-Up: Satur	APR18	106%	137%	106%	137%	106%	137%	106%	137%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	131%	57%	103%
	COP18	Scale-Up: Satur	APR19	5%	5%	22%	29%	29%	35%	74%	88%	43%	20%	21%	36%	21%	60%	22%	89%	39%	93%	56%	94%	77%	94%	42%	36%	47%
	COP19	Scale-Up: Satur	APR20	177%	226%	235%	311%	97%	102%	48%	50%	15%	55%	26%	132%	49%	230%	82%	249%	94%	149%	83%	77%	50%	46%	28%	30%	110%
	COP20	Scale-Up: Satur	APR21	10%	0%	18%	27%	34%	38%	88%	94%	52%	23%	28%	40%	23%	63%	26%	92%	38%	95%	59%	101%	83%	102%	48%	41%	51%
	COP21	Scale-Up: Satur	APR22	11%	11%	41%	78%	103%	127%	91%	96%	56%	55%	42%	65%	46%	85%	65%	111%	79%	105%	93%	94%	89%	76%	68%	64%	73%
	COP22	Scale-Up: Satur	APR23	67%	67%	82%	126%	107%	130%	137%	149%	95%	60%	55%	70%	57%	120%	56%	153%	76%	151%	86%	149%	128%	141%	107%	57%	101%
Abobo-Ouest	COP15	Scale-Up: Satur	APR16	20%	18%	33%	38%	46%	56%	55%	62%	8%	4%	28%	5%	92%	21%	126%	28%	166%	50%	244%	119%	244%	119%	78%	64%	72%
	COP16	Scale-Up: Satur	APR17	20%	16%	34%	33%	47%	48%	55%	53%	9%	4%	32%	5%	105%	21%	144%	29%	190%	52%	278%	122%	278%	122%	89%	65%	77%
	COP17	Scale-Up: Satur	APR18	13%	22%	28%	32%	46%	38%	99%	90%	49%	31%	22%	39%	23%	65%	27%	94%	34%	96%	63%	93%	77%	95%	43%	37%	52%
	COP18	Scale-Up: Satur	APR19	136%	168%	136%	168%	136%	168%	136%	168%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	92%	94%	113%
	COP19	Scale-Up: Satur	APR20	289%	224%	413%	336%	339%	275%	211%	236%	155%	150%	128%	219%	143%	400%	169%	543%	198%	407%	262%	278%	164%	212%	134%	173%	252%
	COP20	Scale-Up: Satur	APR21	4%	35%	26%	20%	45%	38%	105%	94%	49%	21%	31%	35%	28%	63%	29%	93%	34%	92%	64%	99%	79%	99%	47%	42%	53%
	COP21	Scale-Up: Satur	APR22	20%	20%	68%	49%	144%	134%	110%	106%	82%	59%	73%	60%	66%	91%	97%	113%	93%	111%	107%	99%	100%	80%	87%	72%	85%
	COP22	Scale-Up: Satur	APR23	33%	33%	90%	93%	118%	93%	188%	168%	77%	55%	71%	56%	53%	91%	51%	121%	56%	133%	94%	116%	133%	118%	92%	51%	91%
Aboisso	COP15	Not Supported		N/A: No target required																								
	COP16	Not Supported																										
	COP17	Not Supported																										
	COP18	Not Supported																										
	COP19	Not Supported																										

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F			
	COP20	Not Supported																												
	COP21	Not Supported																												
	COP22	Not Supported																												
Adiake	COP15	Not Supported																												
	COP16	Not Supported																												
	COP17	Not Supported																												
	COP18	Not Supported																												
	COP19	Not Supported																												
	COP20	Not Supported																												
	COP21	Not Supported																												
	COP22	Not Supported																												
				N/A: No target required																										
Adjame-Plateau-Attecoube	COP15	Scale-Up: Agg	APR16	5%	4%	8%	9%	11%	12%	13%	14%	5%	3%	16%	4%	51%	15%	70%	21%	93%	37%	135%	87%	135%	87%	43%	47%	39%		
	COP16	Scale-Up: Agg	APR17	6%	5%	10%	10%	15%	15%	17%	17%	5%	4%	19%	4%	62%	18%	84%	24%	111%	43%	163%	101%	163%	101%	52%	54%	46%		
	COP17	Scale-Up: Agg	APR18	45%	35%	45%	35%	45%	35%	45%	35%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	72%	58%	57%		
	COP18	Scale-Up: Agg	APR19	13%	5%	16%	16%	21%	27%	30%	41%	15%	17%	14%	33%	20%	67%	35%	99%	34%	102%	78%	102%	86%	91%	49%	41%	44%		
	COP19	Scale-Up: Satur	APR20	57%	35%	77%	84%	49%	56%	29%	39%	14%	40%	22%	61%	33%	121%	66%	150%	75%	143%	92%	90%	75%	62%	54%	53%	66%		
	COP20	Scale-Up: Satur	APR21	17%	27%	16%	16%	22%	27%	34%	47%	20%	16%	27%	36%	25%	64%	32%	98%	40%	104%	74%	115%	97%	101%	57%	46%	48%		
	COP21	Scale-Up: Satur	APR22	20%	20%	57%	51%	91%	107%	46%	66%	24%	21%	40%	43%	41%	69%	49%	95%	56%	95%	71%	87%	67%	61%	56%	60%	58%		
	COP22	Scale-Up: Satur	APR23	50%	50%	63%	38%	57%	54%	42%	70%	29%	26%	45%	41%	34%	73%	37%	98%	43%	117%	56%	102%	90%	98%	72%	44%	60%		
Adzope	COP15	Scale-Up: Agg	APR16	6%	4%	10%	8%	13%	11%	16%	12%	2%	1%	6%	1%	19%	6%	26%	8%	34%	13%	50%	32%	50%	32%	16%	17%	16%		
	COP16	Scale-Up: Agg	APR17	10%	6%	16%	13%	23%	19%	27%	22%	2%	1%	6%	2%	20%	7%	28%	9%	36%	17%	53%	39%	53%	39%	17%	21%	20%		
	COP17	Scale-Up: Agg	APR18	32%	22%	32%	22%	32%	22%	32%	22%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	56%	32%	38%		
	COP18	Scale-Up: Agg	APR19	40%	43%	45%	48%	29%	32%	22%	59%	11%	37%	29%	71%	30%	101%	47%	110%	48%	80%	72%	58%	69%	71%	33%	25%	50%		
	COP19	Scale-Up: Satur	APR20	52%	22%	75%	81%	54%	56%	14%	36%	10%	42%	27%	73%	34%	95%	34%	89%	77%	106%	71%	67%	67%	55%	55%	59%	56%		
	COP20	Scale-Up: Satur	APR21	43%	29%	43%	59%	29%	30%	21%	45%	24%	31%	33%	79%	30%	101%	47%	109%	58%	81%	73%	64%	69%	72%	33%	26%	51%		
	COP21	Scale-Up: Satur	APR22	50%	50%	143%	129%	111%	144%	33%	46%	28%	44%	41%	95%	43%	114%	95%	116%	122%	87%	100%	66%	80%	59%	51%	38%	78%		
	COP22	Scale-Up: Satur	APR23	0%	0%	33%	117%	165%	150%	73%	120%	44%	43%	51%	57%	54%	83%	44%	111%	45%	107%	70%	107%	94%	129%	108%	59%	78%		
Agboville	COP15	Scale-Up: Agg	APR16	9%	7%	15%	15%	21%	21%	24%	24%	3%	2%	10%	2%	34%	9%	46%	13%	61%	23%	89%	53%	89%	53%	28%	29%	28%		
	COP16	Scale-Up: Agg	APR17	12%	8%	19%	17%	27%	25%	32%	28%	3%	2%	11%	2%	35%	9%	48%	12%	63%	22%	93%	52%	93%	52%	30%	28%	30%		
	COP17	Scale-Up: Agg	APR18	30%	27%	30%	27%	30%	27%	30%	27%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	57%	30%	39%		
	COP18	Scale-Up: Agg	APR19	89%	162%	42%	57%	31%	35%	35%	43%	19%	25%	34%	75%	37%	115%	44%	110%	71%	109%	67%	66%	62%	60%	34%	26%	60%		
	COP19	Scale-Up: Satur	APR20	47%	68%	44%	60%	31%	34%	18%	17%	11%	22%	14%	39%	19%	59%	25%	56%	42%	68%	43%	43%	41%	44%	32%	38%	38%		
	COP20	Scale-Up: Satur	APR21	100%	186%	38%	52%	31%	24%	38%	42%	23%	36%	39%	84%	48%	128%	58%	119%	59%	95%	75%	73%	73%	67%	38%	28%	65%		
	COP21	Scale-Up: Satur	APR22	33%	33%	91%	122%	72%	74%	34%	52%	21%	64%	34%	93%	50%	121%	91%	119%	108%	88%	95%	66%	80%	46%	47%	38%	70%		
	COP22	Scale-Up: Satur	APR23	50%	50%	33%	73%	85%	87%	85%	96%	36%	30%	31%	43%	36%	87%	36%	99%	57%	103%	55%	95%	106%	103%	90%	51%	67%		
Agnibilekrou	COP15	Sustained	APR16	11%	9%	18%	18%	26%	26%	30%	29%	5%	3%	18%	4%	60%	17%	82%	23%	109%	40%	159%	95%	159%	95%	51%	51%	47%		
	COP16	Sustained	APR17	9%	7%	14%	15%	20%	22%	24%	25%	6%	3%	20%	4%	65%	16%	88%	22%	117%	39%	171%	92%	171%	92%	55%	50%	48%		
	COP17	Sustained	APR18	29%	27%	29%	27%	29%	27%	29%	27%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	52%		
	COP18	Sustained	APR19	0%	0%	22%	32%	18%	23%	64%	34%	26%	20%	20%	35%	27%	59%	24%	84%	44%	71%	53%	71%	93%	92%	44%	46%	42%		
	COP19	Scale-Up: Satur	APR20	90%	96%	77%	110%	53%	29%	31%	22%	15%	41%	9%	46%	61%	84%	48%	91%	71%	88%	55%	66%	63%	91%	19%	44%	58%		

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP20	Scale-Up: Satur	APR21	0%	0%	30%	18%	25%	25%	68%	41%	24%	20%	19%	41%	14%	51%	16%	85%	38%	81%	63%	89%	104%	91%	55%	55%	44%
	COP21	Scale-Up: Satur	APR22	0%	0%	94%	50%	95%	91%	94%	74%	27%	41%	19%	54%	18%	72%	32%	105%	73%	95%	95%	91%	121%	78%	89%	98%	67%
	COP22	Scale-Up: Satur	APR23	100%	100%	78%	233%	147%	210%	121%	117%	50%	34%	25%	72%	13%	79%	29%	109%	60%	121%	87%	96%	138%	128%	99%	66%	96%
Akoupe	COP15	Scale-Up: Agg	APR16	9%	5%	15%	10%	20%	15%	24%	17%	2%	2%	7%	2%	24%	9%	32%	13%	43%	23%	63%	54%	63%	54%	20%	29%	23%
	COP16	Scale-Up: Agg	APR17	12%	8%	19%	16%	27%	24%	32%	26%	4%	3%	13%	3%	43%	13%	59%	17%	78%	31%	115%	72%	115%	72%	37%	39%	37%
	COP17	Scale-Up: Agg	APR18	33%	17%	33%	17%	33%	17%	33%	17%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	36%
	COP18	Scale-Up: Agg	APR19	167%	248%	159%	131%	43%	75%	62%	81%	5%	44%	48%	158%	83%	211%	103%	216%	123%	243%	120%	122%	132%	113%	71%	47%	117%
	COP19	Scale-Up: Satur	APR20	107%	111%	117%	87%	42%	61%	29%	33%	7%	39%	13%	77%	29%	82%	45%	93%	67%	147%	67%	67%	88%	97%	46%	57%	67%
	COP20	Scale-Up: Satur	APR21	133%	200%	118%	100%	36%	63%	38%	75%	10%	54%	28%	135%	38%	188%	89%	214%	107%	153%	116%	123%	140%	121%	69%	39%	99%
	COP21	Scale-Up: Satur	APR22	0%	0%	189%	144%	91%	127%	33%	52%	3%	55%	13%	101%	26%	131%	96%	170%	121%	120%	103%	77%	106%	73%	82%	50%	82%
	COP22	Scale-Up: Satur	APR23	0%	0%	100%	25%	133%	167%	267%	200%	46%	97%	7%	56%	12%	119%	49%	131%	102%	155%	106%	164%	164%	199%	174%	80%	106%
Alepe	COP15	Sustained	APR16	10%	4%	16%	9%	22%	13%	26%	15%	2%	1%	7%	2%	25%	7%	34%	10%	45%	17%	65%	41%	65%	41%	21%	22%	22%
	COP16	Sustained	APR17	13%	6%	22%	13%	31%	19%	37%	21%	2%	2%	7%	2%	23%	10%	32%	14%	42%	24%	62%	57%	62%	57%	20%	31%	25%
	COP17	Sustained	APR18	35%	21%	35%	21%	35%	21%	35%	21%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	25%
	COP18	Sustained	APR19	162%	177%	57%	125%	35%	23%	28%	61%	6%	24%	23%	73%	50%	113%	61%	121%	74%	97%	81%	106%	96%	125%	50%	47%	76%
	COP19	Scale-Up: Satur	APR20	77%	241%	87%	241%	87%	63%	39%	40%	25%	18%	8%	72%	46%	116%	50%	140%	120%	196%	135%	155%	122%	169%	98%	150%	104%
	COP20	Scale-Up: Satur	APR21	250%	200%	50%	131%	39%	29%	36%	60%	6%	26%	38%	79%	54%	110%	64%	125%	79%	105%	78%	118%	100%	132%	53%	49%	84%
	COP21	Scale-Up: Satur	APR22	0%	0%	100%	175%	91%	118%	47%	53%	4%	27%	50%	87%	66%	73%	86%	116%	119%	90%	78%	93%	103%	73%	58%	74%	74%
	COP22	Scale-Up: Satur	APR23	100%	100%	50%	50%	86%	86%	100%	138%	15%	58%	39%	34%	33%	35%	28%	81%	48%	75%	54%	90%	105%	130%	110%	92%	72%
Anyama	COP15	Scale-Up: Agg	APR16	6%	4%	11%	8%	15%	12%	17%	13%	3%	1%	10%	2%	33%	7%	45%	10%	60%	18%	87%	42%	87%	42%	28%	22%	24%
	COP16	Scale-Up: Agg	APR17	7%	6%	11%	12%	15%	17%	18%	19%	4%	2%	13%	2%	44%	9%	60%	12%	79%	22%	115%	52%	115%	52%	37%	28%	31%
	COP17	Scale-Up: Agg	APR18	33%	27%	33%	27%	33%	27%	33%	27%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	44%
	COP18	Scale-Up: Agg	APR19	21%	44%	49%	31%	58%	61%	75%	132%	33%	59%	21%	40%	38%	80%	35%	117%	45%	91%	55%	115%	80%	102%	54%	48%	62%
	COP19	Scale-Up: Satur	APR20	324%	234%	284%	146%	119%	164%	79%	126%	56%	64%	65%	139%	75%	190%	94%	245%	110%	209%	111%	128%	113%	151%	78%	111%	142%
	COP20	Scale-Up: Satur	APR21	0%	0%	62%	31%	49%	44%	95%	135%	24%	17%	77%	53%	62%	98%	33%	121%	59%	100%	63%	121%	86%	114%	56%	56%	65%
	COP21	Scale-Up: Satur	APR22	0%	0%	106%	73%	90%	100%	94%	91%	34%	21%	108%	44%	76%	55%	44%	101%	92%	76%	68%	82%	76%	62%	66%	66%	68%
	COP22	Scale-Up: Satur	APR23	0%	0%	214%	171%	113%	135%	131%	163%	71%	44%	126%	57%	89%	85%	65%	126%	54%	130%	79%	118%	107%	128%	116%	54%	99%
Arrah	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	100%	100%	38%	43%	70%	100%	75%	119%	42%	42%	21%	43%	68%	59%	46%	84%	81%	90%	91%	87%	100%	93%	96%	128%	76%
	COP22	Scale-Up: Satur	APR23	0%	0%	100%	100%	46%	62%	133%	200%	32%	52%	32%	48%	80%	108%	51%	124%	70%	126%	108%	140%	149%	155%	120%	106%	89%
Bangolo	COP15	Scale-Up: Agg	APR16	2%	1%	3%	2%	5%	3%	6%	3%	1%	1%	5%	1%	15%	4%	21%	5%	28%	9%	41%	22%	41%	22%	13%	12%	11%
	COP16	Scale-Up: Agg	APR17	2%	1%	3%	3%	4%	4%	4%	4%	2%	1%	6%	1%	21%	6%	29%	8%	38%	14%	56%	32%	56%	32%	18%	17%	15%
	COP17	Scale-Up: Agg	APR18	75%	65%	75%	65%	75%	65%	75%	65%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	46%
	COP18	Scale-Up: Agg	APR19	0%	0%	8%	6%	3%	11%	10%	59%	4%	7%	4%	34%	17%	50%	19%	53%	26%	41%	42%	41%	38%	33%	15%	21%	23%
	COP19	Scale-Up: Satur	APR20	6%	6%	2%	2%	3%	5%	3%	4%	6%	5%	14%	7%	12%	12%	7%	13%	11%	17%	17%	18%	12%	19%	6%	22%	10%
	COP20	Scale-Up: Satur	APR21	0%	0%	5%	3%	5%	11%	7%	12%	6%	11%	7%	47%	19%	45%	18%	59%	29%	44%	45%	43%	41%	34%	18%	24%	22%
	COP21	Scale-Up: Satur	APR22	0%	0%	47%	21%	41%	100%	34%	51%	11%	24%	16%	84%	43%	73%	61%	80%	98%	63%	89%	49%	72%	34%	45%	48%	49%
	COP22	Scale-Up: Satur	APR23	0%	0%	27%	27%	4%	11%	6%	10%	5%	3%	2%	26%	5%	37%	16%	40%	25%	40%	30%	37%	29%	32%	13%	22%	19%
Beoumi	COP15	Sustained	APR16	4%	3%	7%	7%	9%	10%	11%	11%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	19%	20%	18%
	COP16	Sustained	APR17	6%	3%	9%	7%	13%	10%	15%	12%	3%	2%	10%	2%	33%	9%	45%	12%	59%	22%	86%	51%	86%	51%	27%	27%	25%

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP17	Sustained	APR18	20%	22%	20%	22%	20%	22%	20%	22%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	28%
	COP18	Sustained	APR19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	98%
	COP19	Scale-Up: Satur	APR20	115%	121%	10%	81%	39%	24%	20%	34%	19%	57%	26%	70%	27%	138%	66%	106%	69%	86%	57%	79%	79%	104%	82%	125%	68%
	COP20	Scale-Up: Satur	APR21	0%	0%	36%	18%	19%	27%	65%	47%	50%	66%	30%	48%	66%	128%	59%	72%	54%	84%	57%	52%	108%	109%	41%	50%	54%
	COP21	Scale-Up: Satur	APR22	0%	0%	113%	63%	64%	82%	65%	47%	32%	103%	26%	70%	94%	135%	111%	56%	84%	78%	52%	42%	78%	57%	51%	67%	65%
	COP22	Scale-Up: Satur	APR23	0%	0%	75%	75%	107%	27%	44%	44%	4%	13%	19%	31%	24%	38%	33%	40%	16%	36%	34%	50%	46%	50%	67%	42%	38%
Bettie	COP15	Sustained	APR16	3%	6%	6%	13%	8%	18%	9%	20%	2%	1%	7%	2%	21%	6%	29%	9%	39%	15%	57%	36%	57%	36%	18%	19%	18%
	COP16	Sustained	APR17	5%	5%	8%	10%	11%	15%	13%	17%	2%	1%	7%	1%	22%	6%	31%	8%	40%	15%	59%	35%	59%	35%	19%	19%	18%
	COP17	Sustained	APR18	10%	20%	10%	20%	10%	20%	10%	20%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	24%
	COP18	Sustained	APR19	63%	83%	63%	83%	63%	83%	63%	83%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	119%	134%	109%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Biankouma	COP15	Sustained	APR16	1%	1%	1%	1%	2%	2%	2%	2%	3%	2%	9%	2%	30%	8%	42%	11%	55%	19%	80%	44%	80%	44%	26%	24%	20%
	COP16	Sustained	APR17	1%	2%	2%	4%	3%	6%	4%	6%	4%	2%	13%	3%	43%	10%	59%	14%	78%	25%	115%	60%	115%	60%	37%	32%	29%
	COP17	Sustained	APR18	11%	11%	11%	11%	11%	11%	11%	11%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	28%
	COP18	Sustained	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	68%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Blolequin	COP15	Sustained	APR16	2%	2%	4%	5%	5%	7%	6%	7%	1%	1%	5%	1%	16%	3%	21%	4%	28%	6%	41%	15%	41%	15%	13%	8%	11%
	COP16	Sustained	APR17	3%	2%	5%	5%	6%	7%	7%	7%	2%	1%	6%	1%	20%	4%	27%	6%	35%	11%	52%	25%	52%	25%	16%	14%	14%
	COP17	Sustained	APR18	9%	11%	9%	11%	9%	11%	9%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	34%	11%	18%
	COP18	Sustained	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	68%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Bocanda	COP15	Sustained	APR16	7%	8%	11%	16%	16%	23%	19%	26%	3%	2%	12%	2%	39%	10%	53%	13%	70%	23%	102%	55%	102%	55%	33%	29%	30%
	COP16	Sustained	APR17	7%	5%	11%	11%	16%	16%	19%	19%	4%	2%	12%	2%	41%	10%	56%	14%	74%	25%	108%	58%	108%	58%	35%	31%	31%
	COP17	Sustained	APR18	12%	14%	12%	14%	12%	14%	12%	14%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	60%	28%	34%
	COP18	Sustained	APR19	56%	78%	56%	78%	56%	78%	56%	78%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	71%	84%	74%
	COP19	Scale-Up: Satur	APR20	71%	261%	35%	65%	25%	37%	30%	50%	10%	23%	14%	16%	83%	113%	29%	49%	38%	61%	22%	37%	34%	50%	59%	116%	55%
	COP20	Scale-Up: Satur	APR21	0%	0%	6%	11%	11%	23%	38%	36%	19%	6%	20%	18%	94%	115%	23%	47%	28%	46%	27%	42%	34%	55%	37%	55%	33%
	COP21	Scale-Up: Satur	APR22	0%	0%	22%	50%	92%	100%	53%	84%	25%	14%	18%	27%	84%	93%	62%	54%	60%	53%	43%	38%	46%	49%	63%	80%	50%
	COP22	Scale-Up: Satur	APR23	200%	200%	80%	60%	81%	56%	50%	80%	19%	29%	23%	31%	71%	97%	29%	48%	32%	68%	34%	49%	34%	64%	70%	56%	65%
Bondoukou	COP15	Scale-Up: Agg	APR16	10%	9%	17%	20%	24%	28%	29%	32%	5%	2%	17%	3%	56%	12%	76%	16%	101%	29%	148%	68%	148%	68%	47%	36%	42%
	COP16	Scale-Up: Agg	APR17	16%	13%	26%	27%	37%	39%	43%	44%	7%	3%	24%	4%	80%	17%	109%	23%	144%	40%	211%	95%	211%	95%	67%	51%	59%

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP17	Scale-Up: Satur	APR18	93%	104%	93%	104%	93%	104%	93%	104%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	104%	40%	81%
	COP18	Scale-Up: Satur	APR19	77%	111%	77%	111%	77%	111%	77%	111%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	103%	128%	108%
	COP19	Scale-Up: Satur	APR20	101%	76%	94%	66%	45%	56%	70%	70%	50%	74%	47%	109%	56%	138%	74%	160%	96%	151%	112%	126%	109%	130%	64%	98%	91%		
	COP20	Scale-Up: Satur	APR21	18%	50%	54%	53%	42%	45%	77%	102%	51%	41%	53%	120%	83%	171%	104%	174%	93%	131%	113%	124%	125%	127%	62%	52%	86%		
	COP21	Scale-Up: Satur	APR22	40%	50%	106%	113%	126%	122%	65%	97%	43%	55%	53%	133%	128%	185%	181%	173%	138%	137%	136%	111%	121%	98%	82%	87%	108%		
	COP22	Scale-Up: Satur	APR23	75%	75%	170%	100%	67%	79%	70%	98%	25%	35%	32%	77%	43%	126%	90%	145%	77%	129%	90%	107%	122%	116%	88%	59%	87%		
Bongouanou	COP15	Scale-Up: Agg	APR16	8%	5%	13%	11%	18%	16%	22%	18%	4%	2%	14%	2%	45%	10%	62%	14%	81%	25%	119%	58%	119%	58%	38%	31%	33%		
	COP16	Scale-Up: Agg	APR17	9%	7%	15%	15%	21%	22%	25%	25%	5%	3%	17%	3%	55%	14%	76%	19%	100%	33%	146%	78%	146%	78%	47%	42%	42%		
	COP17	Scale-Up: Agg	APR18	39%	33%	39%	33%	39%	33%	39%	33%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	86%	37%	53%		
	COP18	Scale-Up: Agg	APR19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	92%		
	COP19	Scale-Up: Satur	APR20	98%	68%	57%	60%	51%	61%	54%	56%	20%	31%	11%	53%	103%	193%	40%	83%	49%	77%	60%	79%	67%	98%	89%	185%	73%		
	COP20	Scale-Up: Satur	APR21	13%	7%	12%	6%	11%	16%	19%	24%	9%	6%	4%	15%	21%	39%	12%	19%	13%	23%	13%	25%	26%	29%	18%	25%	17%		
	COP21	Scale-Up: Satur	APR22	50%	50%	63%	40%	115%	160%	67%	76%	27%	45%	25%	61%	120%	124%	85%	74%	69%	74%	65%	71%	93%	58%	89%	105%	75%		
	COP22	Scale-Up: Satur	APR23	50%	50%	113%	75%	96%	81%	83%	147%	29%	35%	46%	49%	81%	101%	48%	63%	46%	95%	40%	84%	103%	88%	87%	69%	73%		
Botro	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	0%	0%	100%	100%	63%	150%	46%	67%	22%	38%	43%	46%	28%	58%	64%	75%	81%	79%	67%	70%	85%	66%	77%	114%	64%		
	COP22	Scale-Up: Satur	APR23	0%	0%	50%	25%	38%	154%	50%	88%	50%	33%	29%	43%	37%	73%	29%	79%	40%	95%	78%	96%	83%	91%	85%	68%	59%		
Bouafle	COP15	Scale-Up: Satur	APR16	12%	10%	20%	20%	28%	29%	33%	33%	4%	2%	14%	3%	47%	12%	64%	16%	85%	28%	124%	67%	124%	67%	40%	36%	38%		
	COP16	Scale-Up: Satur	APR17	15%	13%	25%	28%	35%	40%	42%	45%	6%	4%	22%	4%	72%	17%	98%	24%	129%	42%	189%	100%	189%	100%	60%	54%	56%		
	COP17	Scale-Up: Satur	APR18	164%	161%	164%	161%	164%	161%	164%	161%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	98%	42%	101%		
	COP18	Scale-Up: Satur	APR19	112%	144%	112%	144%	112%	144%	112%	144%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	92%	98%	106%		
	COP19	Scale-Up: Satur	APR20	73%	96%	35%	48%	42%	60%	42%	47%	40%	34%	28%	85%	34%	93%	44%	103%	58%	105%	52%	89%	59%	84%	28%	76%	61%		
	COP20	Scale-Up: Satur	APR21	14%	42%	21%	23%	17%	35%	38%	34%	26%	22%	31%	56%	16%	82%	29%	99%	44%	82%	50%	75%	78%	78%	45%	38%	45%		
	COP21	Scale-Up: Satur	APR22	25%	25%	87%	83%	70%	110%	78%	56%	41%	51%	49%	65%	40%	91%	86%	122%	101%	104%	82%	77%	88%	73%	81%	69%	73%		
	COP22	Scale-Up: Satur	APR23	75%	75%	83%	89%	61%	84%	97%	83%	33%	45%	37%	64%	31%	103%	58%	116%	63%	124%	74%	92%	102%	89%	89%	48%	76%		
Bouake-Nord-Est	COP15	Scale-Up: Agg	APR16	6%	4%	10%	8%	14%	11%	17%	13%	4%	2%	12%	2%	40%	8%	54%	11%	72%	20%	105%	48%	105%	48%	34%	26%	28%		
	COP16	Scale-Up: Agg	APR17	7%	6%	12%	12%	16%	18%	20%	20%	5%	2%	15%	3%	51%	11%	70%	15%	92%	27%	135%	65%	135%	65%	43%	35%	37%		
	COP17	Scale-Up: Agg	APR18	43%	28%	43%	28%	43%	28%	43%	28%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	78%	31%	48%		
	COP18	Scale-Up: Agg	APR19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	92%		
	COP19	Scale-Up: Satur	APR20	49%	104%	37%	69%	42%	50%	38%	38%	13%	45%	16%	75%	21%	107%	29%	112%	58%	84%	59%	58%	56%	52%	37%	58%	54%		
	COP20	Scale-Up: Satur	APR21	0%	11%	12%	20%	23%	25%	42%	61%	24%	22%	12%	48%	33%	65%	24%	73%	30%	54%	43%	47%	51%	46%	32%	23%	34%		
	COP21	Scale-Up: Satur	APR22	50%	50%	153%	93%	111%	117%	66%	81%	49%	70%	51%	106%	71%	107%	78%	136%	87%	110%	92%	73%	97%	58%	68%	58%	85%		
	COP22	Scale-Up: Satur	APR23	50%	50%	156%	175%	65%	132%	124%	147%	44%	65%	43%	92%	44%	137%	68%	156%	57%	124%	85%	87%	121%	89%	77%	39%	93%		
Bouake-Nord-Ouest	COP15	Scale-Up: Satur	APR16	21%	20%	35%	42%	49%	61%	58%	68%	7%	4%	24%	5%	78%	21%	107%	29%	141%	51%	207%	120%	207%	120%	66%	64%	67%		
	COP16	Scale-Up: Satur	APR17	27%	21%	44%	43%	62%	62%	73%	70%	8%	5%	27%	6%	90%	24%	124%	33%	163%	59%	239%	140%	239%	140%	76%	75%	77%		
	COP17	Scale-Up: Satur	APR18	121%	166%	121%	166%	121%	166%	121%	166%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	104%	49%	99%		
	COP18	Scale-Up: Satur	APR19	113%	156%	113%	156%	113%	156%	113%	156%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	127%	145%	136%		
	COP19	Scale-Up: Satur	APR20	50%	96%	156%	162%	101%	117%	132%	145%	100%	82%	41%	98%	46%	151%	70%	193%	119%	152%	139%	146%	125%	159%	137%	197%	121%		
	COP20	Scale-Up: Satur	APR21	63%	63%	116%	104%	108%	106%	271%	295%	170%	85%	89%	139%	93%	204%	86%	274%	152%	246%	174%	247%	224%	256%	126%	125%	159%		
	COP21	Scale-Up: Satur	APR22	20%	20%	147%	158%	193%	200%	127%	155%	98%	81%	84%	92%	70%	121%	84%	172%	139%	149%	124%	127%	133%	109%	102%	108%	117%		

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP22	Scale-Up: Satur	APR23	50%	50%	100%	122%	100%	91%	195%	220%	84%	80%	74%	64%	59%	87%	48%	119%	58%	139%	88%	129%	127%	140%	105%	75%	100%
Bouake-Sud	COP15	Scale-Up: Satur	APR16	10%	7%	17%	15%	24%	22%	28%	25%	6%	3%	20%	4%	67%	16%	92%	22%	121%	38%	177%	91%	177%	91%	56%	49%	49%
	COP16	Scale-Up: Satur	APR17	13%	8%	22%	18%	31%	25%	36%	29%	7%	4%	25%	4%	82%	18%	112%	25%	148%	44%	217%	104%	217%	104%	69%	56%	59%
	COP17	Scale-Up: Satur	APR18	133%	88%	133%	88%	133%	88%	133%	88%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	105%	51%	89%
	COP18	Scale-Up: Satur	APR19	83%	115%	83%	115%	83%	115%	83%	115%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	85%	97%	94%
	COP19	Scale-Up: Satur	APR20	86%	106%	54%	79%	70%	74%	56%	94%	58%	105%	67%	142%	82%	204%	94%	245%	106%	224%	152%	175%	169%	181%	148%	211%	124%
	COP20	Scale-Up: Satur	APR21	14%	21%	24%	28%	22%	29%	53%	65%	36%	42%	53%	69%	69%	94%	50%	114%	47%	94%	76%	89%	98%	102%	57%	46%	58%
	COP21	Scale-Up: Satur	APR22	0%	0%	92%	124%	97%	125%	89%	109%	57%	81%	71%	130%	108%	145%	99%	184%	96%	145%	129%	122%	121%	110%	96%	100%	101%
	COP22	Scale-Up: Satur	APR23	33%	33%	131%	123%	76%	80%	93%	119%	36%	38%	78%	82%	73%	122%	46%	144%	63%	163%	88%	149%	146%	145%	116%	71%	94%
Bouna	COP15	Sustained	APR16	5%	5%	8%	10%	12%	15%	14%	16%	2%	1%	7%	2%	25%	7%	34%	10%	44%	17%	65%	40%	65%	40%	21%	21%	20%
	COP16	Sustained	APR17	6%	5%	9%	10%	13%	15%	15%	17%	3%	2%	9%	2%	30%	9%	42%	12%	55%	21%	80%	50%	80%	50%	26%	27%	25%
	COP17	Sustained	APR18	14%	17%	14%	17%	14%	17%	14%	17%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	37%	20%	24%
	COP18	Sustained	APR19	55%	80%	55%	80%	55%	80%	55%	80%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	70%	87%	75%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Boundiali	COP15	Sustained	APR16	11%	12%	19%	24%	26%	35%	31%	40%	5%	4%	17%	5%	57%	19%	79%	26%	104%	46%	152%	109%	152%	109%	48%	58%	50%
	COP16	Sustained	APR17	17%	14%	27%	29%	38%	42%	45%	47%	7%	5%	24%	5%	78%	22%	107%	31%	141%	54%	206%	129%	206%	129%	66%	69%	64%
	COP17	Sustained	APR18	25%	26%	25%	26%	25%	26%	25%	26%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	65%	41%	44%
	COP18	Sustained	APR19	60%	89%	60%	89%	60%	89%	60%	89%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	69%	87%	77%
	COP19	Scale-Up: Satur	APR20	26%	27%	91%	77%	58%	68%	40%	47%	16%	45%	21%	103%	23%	140%	71%	136%	88%	161%	114%	136%	116%	69%	31%	36%	73%
	COP20	Scale-Up: Satur	APR21	80%	40%	21%	54%	23%	35%	50%	36%	14%	22%	14%	92%	17%	146%	47%	144%	68%	123%	101%	114%	155%	65%	38%	18%	63%
	COP21	Scale-Up: Satur	APR22	100%	100%	80%	167%	100%	158%	95%	80%	23%	66%	19%	133%	39%	230%	117%	197%	190%	181%	170%	134%	253%	68%	95%	46%	118%
	COP22	Scale-Up: Satur	APR23	0%	0%	225%	175%	43%	64%	156%	133%	17%	13%	7%	100%	26%	159%	58%	169%	84%	163%	117%	124%	128%	103%	77%	50%	91%
Buyo	Not Supported		N/A: No target required																									
Cocody-Bingerville	COP15	Scale-Up: Satur	APR16	34%	26%	56%	55%	78%	79%	92%	89%	8%	5%	27%	5%	89%	22%	121%	31%	160%	54%	234%	128%	234%	128%	75%	69%	79%
	COP16	Scale-Up: Satur	APR17	36%	29%	60%	62%	83%	89%	99%	100%	10%	6%	34%	7%	112%	28%	154%	39%	203%	69%	297%	164%	297%	164%	95%	88%	97%
	COP17	Scale-Up: Satur	APR18	162%	162%	162%	162%	162%	162%	162%	162%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	117%	57%	112%
	COP18	Scale-Up: Satur	APR19	109%	135%	109%	135%	109%	135%	109%	135%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	88%	90%	100%
	COP19	Scale-Up: Satur	APR20	384%	504%	349%	367%	130%	97%	57%	53%	35%	74%	48%	170%	92%	267%	131%	275%	162%	191%	125%	95%	80%	66%	52%	44%	160%
	COP20	Scale-Up: Satur	APR21	8%	15%	19%	25%	27%	27%	88%	59%	52%	26%	63%	51%	77%	81%	52%	108%	54%	105%	66%	115%	86%	96%	50%	41%	58%
	COP21	Scale-Up: Satur	APR22	25%	25%	53%	87%	110%	133%	95%	79%	56%	52%	82%	74%	115%	103%	99%	120%	96%	118%	83%	103%	86%	70%	69%	64%	83%
	COP22	Scale-Up: Satur	APR23	60%	60%	96%	104%	62%	88%	125%	114%	82%	39%	131%	60%	92%	100%	75%	120%	71%	131%	95%	118%	124%	105%	78%	44%	91%
Dabakala	COP15	Sustained	APR16	7%	5%	12%	11%	17%	16%	21%	18%	2%	1%	7%	1%	22%	5%	30%	7%	40%	12%	59%	29%	59%	29%	19%	16%	19%
	COP16	Sustained	APR17	13%	10%	21%	21%	30%	30%	35%	33%	3%	2%	10%	2%	32%	8%	44%	10%	58%	18%	84%	44%	84%	44%	27%	23%	29%
	COP17	Sustained	APR18	17%	15%	17%	15%	17%	15%	17%	15%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	42%	19%	26%
	COP18	Sustained	APR19	66%	54%	66%	54%	66%	54%	66%	54%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	90%	63%	71%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP21	Not Supported																										
	COP22	Not Supported																										
Dabou	COP15	Scale-Up: Satur	APR16	13%	9%	21%	19%	29%	27%	35%	30%	5%	3%	18%	3%	60%	14%	82%	19%	109%	33%	159%	78%	159%	78%	51%	42%	46%
	COP16	Scale-Up: Satur	APR17	16%	13%	26%	26%	36%	38%	43%	43%	7%	4%	24%	5%	79%	20%	108%	27%	143%	48%	209%	114%	209%	114%	67%	61%	62%
	COP17	Scale-Up: Satur	APR18	109%	97%	109%	97%	109%	97%	109%	97%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	103%	44%	83%
	COP18	Scale-Up: Satur	APR19	85%	112%	85%	112%	85%	112%	85%	112%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	104%	114%	106%
	COP19	Scale-Up: Satur	APR20	17%	54%	37%	76%	51%	64%	59%	91%	59%	31%	19%	62%	29%	75%	31%	98%	58%	112%	171%	254%	98%	134%	99%	122%	79%
	COP20	Scale-Up: Satur	APR21	0%	0%	38%	23%	35%	45%	104%	138%	55%	46%	43%	84%	100%	120%	46%	129%	62%	134%	99%	143%	147%	189%	106%	108%	83%
	COP21	Scale-Up: Satur	APR22	0%	0%	35%	43%	63%	97%	88%	104%	35%	43%	26%	40%	43%	53%	31%	61%	62%	79%	75%	72%	82%	75%	85%	92%	58%
	COP22	Scale-Up: Satur	APR23	0%	0%	70%	60%	59%	85%	88%	104%	37%	44%	35%	49%	27%	67%	32%	77%	39%	107%	55%	97%	112%	122%	100%	80%	64%
Daloa	COP15	Scale-Up: Satur	APR16	12%	7%	19%	14%	27%	21%	32%	24%	6%	4%	21%	5%	68%	19%	93%	25%	123%	45%	180%	107%	180%	107%	58%	57%	52%
	COP16	Scale-Up: Satur	APR17	19%	15%	31%	31%	44%	45%	52%	50%	9%	6%	32%	7%	104%	28%	143%	38%	189%	68%	276%	161%	276%	161%	88%	86%	82%
	COP17	Scale-Up: Satur	APR18	155%	70%	155%	70%	155%	70%	155%	70%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	122%	64%	100%
	COP18	Scale-Up: Satur	APR19	89%	106%	89%	106%	89%	106%	89%	106%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	91%	89%	89%	91%	93%
	COP19	Scale-Up: Satur	APR20	60%	82%	60%	42%	41%	80%	35%	54%	25%	65%	35%	104%	57%	138%	77%	137%	87%	142%	73%	100%	79%	98%	29%	77%	74%
	COP20	Scale-Up: Satur	APR21	6%	6%	21%	20%	31%	44%	60%	94%	27%	31%	29%	81%	27%	115%	42%	132%	50%	114%	80%	107%	101%	111%	54%	49%	60%
	COP21	Scale-Up: Satur	APR22	14%	14%	54%	43%	94%	102%	61%	83%	37%	45%	38%	81%	38%	102%	65%	117%	85%	107%	102%	86%	98%	71%	74%	66%	70%
	COP22	Scale-Up: Satur	APR23	60%	60%	142%	96%	132%	103%	123%	171%	49%	64%	60%	96%	40%	141%	51%	150%	67%	149%	93%	126%	142%	124%	111%	57%	100%
Danane	COP15	Sustained	APR16	3%	3%	5%	7%	6%	10%	8%	12%	4%	2%	12%	2%	41%	10%	56%	13%	74%	24%	108%	56%	108%	56%	35%	30%	29%
	COP16	Sustained	APR17	5%	4%	8%	8%	11%	12%	13%	13%	4%	3%	15%	3%	50%	13%	69%	17%	91%	31%	132%	73%	132%	73%	42%	39%	36%
	COP17	Sustained	APR18	16%	25%	16%	25%	16%	25%	16%	25%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	47%
	COP18	Sustained	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	68%
	COP19	Scale-Up: Satur	APR20	10%	10%	8%	14%	11%	8%	13%	10%	6%	19%	5%	33%	14%	32%	19%	41%	29%	41%	27%	51%	28%	84%	19%	73%	25%
	COP20	Scale-Up: Satur	APR21	25%	0%	29%	18%	10%	20%	29%	35%	11%	23%	6%	48%	16%	70%	39%	75%	41%	60%	52%	58%	52%	62%	30%	38%	35%
	COP21	Scale-Up: Satur	APR22	33%	33%	105%	121%	77%	100%	90%	95%	16%	46%	9%	96%	40%	115%	109%	99%	106%	81%	103%	60%	72%	54%	57%	70%	75%
	COP22	Scale-Up: Satur	APR23	100%	100%	117%	75%	42%	60%	50%	24%	20%	53%	5%	97%	21%	137%	55%	117%	65%	122%	86%	81%	71%	91%	46%	52%	70%
Daoukro	COP15	Sustained	APR16	9%	6%	15%	13%	21%	19%	25%	21%	4%	3%	15%	3%	49%	12%	67%	17%	88%	30%	129%	71%	129%	71%	41%	38%	37%
	COP16	Sustained	APR17	7%	6%	11%	13%	16%	18%	18%	21%	5%	3%	16%	3%	52%	13%	72%	18%	95%	32%	138%	76%	138%	76%	44%	41%	39%
	COP17	Sustained	APR18	33%	22%	33%	22%	33%	22%	33%	22%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	45%
	COP18	Sustained	APR19	61%	85%	61%	85%	61%	85%	61%	85%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	101%	120%	98%
	COP19	Scale-Up: Satur	APR20	56%	59%	70%	81%	65%	77%	51%	92%	19%	29%	28%	65%	166%	299%	30%	81%	54%	94%	70%	89%	88%	111%	132%	201%	88%
	COP20	Scale-Up: Satur	APR21	0%	20%	24%	19%	28%	31%	52%	50%	22%	19%	6%	34%	85%	167%	11%	45%	22%	43%	45%	52%	54%	71%	52%	57%	42%
	COP21	Scale-Up: Satur	APR22	50%	50%	57%	107%	111%	100%	72%	47%	23%	43%	5%	49%	48%	87%	46%	56%	46%	54%	73%	49%	74%	55%	77%	81%	61%
	COP22	Scale-Up: Satur	APR23	100%	100%	100%	100%	130%	127%	93%	67%	40%	46%	11%	44%	59%	131%	35%	70%	36%	77%	58%	76%	99%	102%	96%	64%	78%
Dianra	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	100%	100%	40%	100%	167%	83%	130%	0%	0%	44%	0%	88%	10%	91%	114%	100%	79%	75%	81%	51%	43%	28%	40%	25%	66%
	COP22	Scale-Up: Satur	APR23	100%	100%	200%	133%	92%	33%	57%	0%	28%	22%	0%	55%	19%	94%	53%	100%	55%	74%	78%	53%	35%	42%	31%	8%	61%
Didievi	COP15	Sustained	APR16	3%	3%	4%	7%	6%	10%	7%	12%	1%	1%	5%	1%	15%	5%	21%	7%	27%	12%	40%	28%	40%	28%	13%	15%	13%
	COP16	Sustained	APR17	2%	2%	4%	5%	5%	7%	6%	8%	2%	1%	6%	1%	20%	5%	28%	7%	36%	12%	53%	29%	53%	29%	17%	15%	15%
	COP17	Sustained	APR18	13%	20%	13%	20%	13%	20%	13%	20%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	20%

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP18	Sustained	APR19	30%	42%	30%	42%	30%	42%	30%	42%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	58%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Dikodougou	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	0%	0%	140%	60%	57%	57%	64%	0%	27%	44%	32%	74%	45%	130%	83%	175%	110%	99%	89%	79%	100%	74%	51%	62%	69%
	COP22	Scale-Up: Satur	APR23	0%	0%	67%	0%	67%	67%	57%	14%	29%	32%	25%	23%	20%	100%	84%	86%	63%	88%	65%	78%	69%	76%	57%	35%	50%
Dimbokro	COP15	Sustained	APR16	15%	12%	25%	25%	34%	37%	40%	41%	7%	4%	26%	5%	84%	19%	115%	25%	152%	45%	223%	106%	223%	106%	71%	57%	62%
	COP16	Sustained	APR17	15%	9%	25%	19%	35%	27%	41%	30%	8%	4%	28%	5%	92%	19%	126%	26%	167%	47%	244%	110%	244%	110%	78%	59%	65%
	COP17	Sustained	APR18	46%	40%	46%	40%	46%	40%	46%	40%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	58%
	COP18	Sustained	APR19	65%	90%	65%	90%	65%	90%	65%	90%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	85%	101%	88%
	COP19	Scale-Up: Satur	APR20	40%	42%	79%	31%	76%	75%	76%	100%	31%	41%	30%	74%	46%	137%	37%	122%	81%	154%	88%	155%	93%	170%	136%	310%	93%
	COP20	Scale-Up: Satur	APR21	33%	0%	44%	56%	35%	35%	92%	108%	45%	14%	29%	55%	31%	86%	28%	84%	41%	89%	67%	104%	89%	128%	74%	100%	61%
	COP21	Scale-Up: Satur	APR22	0%	0%	67%	38%	140%	100%	53%	83%	36%	41%	24%	63%	22%	41%	38%	74%	58%	85%	69%	80%	97%	88%	89%	117%	63%
	COP22	Scale-Up: Satur	APR23	100%	100%	50%	100%	93%	54%	100%	130%	32%	47%	21%	64%	8%	66%	15%	81%	40%	107%	74%	101%	88%	136%	85%	84%	74%
Divo	COP15	Scale-Up: Agg	APR16	8%	8%	13%	17%	18%	24%	21%	27%	3%	2%	12%	3%	39%	11%	53%	14%	70%	26%	102%	60%	102%	60%	33%	32%	32%
	COP16	Scale-Up: Agg	APR17	10%	9%	17%	18%	23%	26%	27%	29%	4%	3%	15%	3%	49%	13%	67%	18%	89%	32%	130%	76%	130%	76%	41%	41%	39%
	COP17	Scale-Up: Agg	APR18	19%	31%	19%	31%	19%	31%	19%	31%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	41%
	COP18	Scale-Up: Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	99%	112%	101%
	COP19	Scale-Up: Satur	APR20	67%	80%	52%	52%	29%	33%	22%	21%	16%	23%	7%	42%	23%	64%	28%	76%	42%	80%	61%	66%	58%	53%	45%	45%	45%
	COP20	Scale-Up: Satur	APR21	138%	138%	72%	73%	27%	25%	56%	77%	30%	44%	21%	128%	52%	224%	76%	209%	72%	152%	105%	113%	86%	93%	45%	37%	87%
	COP21	Scale-Up: Satur	APR22	25%	25%	129%	126%	76%	103%	70%	78%	24%	55%	35%	99%	54%	159%	99%	141%	101%	117%	114%	78%	83%	51%	63%	45%	81%
	COP22	Scale-Up: Satur	APR23	0%	0%	200%	250%	198%	145%	93%	123%	58%	43%	41%	94%	46%	125%	56%	140%	62%	148%	76%	135%	125%	122%	114%	62%	102%
Doropo	New health district established in 2020																											
	COP21	Not Supported	N/A: No target required																									
	COP22	Not Supported																										
Duekoue	COP15	Scale-Up: Agg	APR16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	7%	2%	22%	9%	30%	12%	39%	21%	57%	50%	57%	50%	18%	27%	19%
	COP16	Scale-Up: Agg	APR17	6%	4%	10%	8%	14%	11%	16%	13%	3%	2%	10%	3%	32%	12%	44%	16%	58%	29%	85%	69%	85%	69%	27%	37%	28%
	COP17	Scale-Up: Agg	APR18	26%	34%	26%	34%	26%	34%	26%	34%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	38%
	COP18	Scale-Up: Agg	APR19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	92%
	COP19	Scale-Up: Satur	APR20	5%	5%	6%	11%	15%	21%	9%	8%	11%	20%	7%	30%	13%	27%	18%	35%	20%	38%	29%	39%	28%	45%	15%	44%	21%
	COP20	Scale-Up: Satur	APR21	0%	0%	7%	35%	20%	17%	23%	35%	10%	21%	12%	59%	13%	82%	29%	91%	30%	62%	52%	68%	57%	57%	25%	30%	35%
	COP21	Scale-Up: Satur	APR22	25%	25%	48%	100%	69%	95%	63%	62%	26%	78%	24%	117%	20%	113%	93%	117%	83%	87%	103%	71%	93%	51%	61%	54%	70%
	COP22	Scale-Up: Satur	APR23	0%	0%	50%	120%	61%	39%	31%	66%	25%	52%	18%	62%	26%	78%	43%	88%	43%	77%	56%	68%	72%	68%	48%	30%	51%
Ferkessedougou	COP15	Sustained	APR16	8%	8%	13%	17%	18%	25%	22%	28%	5%	5%	17%	5%	56%	22%	76%	31%	100%	54%	147%	129%	147%	129%	47%	69%	49%
	COP16	Sustained	APR17	13%	9%	21%	19%	29%	28%	34%	31%	6%	5%	22%	6%	72%	26%	98%	35%	130%	62%	189%	147%	189%	147%	61%	79%	61%
	COP17	Sustained	APR18	19%	33%	19%	33%	19%	33%	19%	33%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	47%
	COP18	Sustained	APR19	60%	89%	60%	89%	60%	89%	60%	89%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%	132%	104%
	COP19	Scale-Up: Satur	APR20	19%	29%	33%	41%	50%	40%	50%	25%	23%	38%	18%	87%	53%	118%	61%	107%	67%	112%	62%	55%	78%	89%	34%	53%	56%

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP20	Scale-Up: Satur	APR21	20%	50%	35%	28%	44%	38%	105%	80%	39%	30%	15%	91%	56%	164%	44%	166%	70%	189%	106%	148%	184%	156%	76%	63%	83%
	COP21	Scale-Up: Satur	APR22	0%	0%	60%	100%	105%	86%	97%	77%	37%	44%	12%	93%	62%	165%	76%	157%	107%	182%	122%	122%	154%	111%	97%	96%	90%
	COP22	Scale-Up: Satur	APR23	100%	100%	140%	140%	129%	94%	170%	170%	65%	50%	15%	102%	33%	195%	51%	195%	71%	227%	116%	177%	213%	180%	121%	87%	123%
Fresco	COP15	Sustained	APR16	7%	6%	12%	13%	17%	19%	20%	21%	3%	2%	10%	3%	33%	12%	45%	16%	59%	28%	87%	67%	87%	67%	28%	36%	29%
	COP16	Sustained	APR17	7%	7%	12%	15%	17%	22%	20%	25%	3%	3%	11%	3%	36%	12%	50%	17%	65%	30%	96%	70%	96%	70%	31%	38%	32%
	COP17	Sustained	APR18	16%	12%	16%	12%	16%	12%	16%	12%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	25%
	COP18	Sustained	APR19	63%	83%	63%	83%	63%	83%	63%	83%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	82%	93%	83%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Gagnoa (COP15 to COP19) Gagnoa 1 (COP20 onward)	COP15	Scale-Up: Satur	APR16	13%	9%	21%	19%	30%	28%	35%	31%	5%	3%	16%	4%	52%	14%	71%	20%	94%	35%	138%	83%	138%	83%	44%	44%	43%
	COP16	Scale-Up: Satur	APR17	18%	14%	30%	29%	42%	42%	50%	48%	7%	5%	24%	6%	80%	23%	110%	32%	145%	56%	212%	133%	212%	133%	68%	71%	66%
	COP17	Scale-Up: Satur	APR18	98%	130%	98%	130%	98%	130%	98%	130%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	103%	55%	91%
	COP18	Scale-Up: Satur	APR19	89%	106%	89%	106%	89%	106%	89%	106%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	98%	95%	97%
	COP19	Scale-Up: Satur	APR20	43%	28%	34%	36%	37%	37%	25%	24%	15%	29%	18%	59%	35%	75%	40%	90%	50%	88%	49%	68%	55%	69%	26%	57%	45%
	COP20	Scale-Up: Satur	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP21	Scale-Up: Satur	APR22	0%	0%	176%	142%	100%	87%	41%	53%	16%	41%	15%	88%	58%	119%	86%	146%	107%	112%	101%	76%	84%	54%	58%	51%	75%
	COP22	Scale-Up: Satur	APR23	33%	33%	250%	250%	210%	238%	174%	157%	34%	50%	45%	109%	60%	128%	74%	175%	64%	159%	112%	179%	137%	155%	134%	69%	126%
Gagnoa 2	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	0%	0%	88%	88%	67%	96%	27%	17%	4%	59%	15%	70%	33%	61%	51%	72%	83%	48%	72%	38%	53%	33%	28%	26%	47%
	COP22	Scale-Up: Satur	APR23	0%	0%	36%	36%	30%	22%	30%	41%	4%	12%	3%	33%	5%	33%	9%	50%	21%	40%	31%	35%	48%	41%	35%	23%	26%
Grand-Lahou	COP15	Sustained	APR16	5%	7%	8%	14%	11%	21%	13%	23%	3%	2%	9%	2%	29%	9%	40%	13%	53%	23%	78%	54%	78%	54%	25%	29%	25%
	COP16	Sustained	APR17	9%	8%	15%	17%	21%	24%	24%	27%	4%	3%	13%	3%	41%	12%	57%	17%	75%	30%	110%	71%	110%	71%	35%	38%	35%
	COP17	Sustained	APR18	16%	28%	16%	28%	16%	28%	16%	28%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	44%	27%	31%
	COP18	Sustained	APR19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%
	COP19	Scale-Up: Satur	APR20	91%	111%	23%	40%	50%	19%	25%	18%	15%	14%	9%	31%	9%	36%	17%	51%	36%	67%	58%	64%	51%	51%	50%	51%	41%
	COP20	Scale-Up: Satur	APR21	25%	25%	28%	27%	24%	22%	47%	24%	13%	27%	19%	36%	18%	63%	21%	71%	23%	68%	43%	70%	61%	61%	36%	35%	37%
	COP21	Scale-Up: Satur	APR22	0%	0%	58%	33%	82%	63%	65%	12%	14%	40%	13%	37%	22%	44%	38%	60%	61%	56%	53%	46%	50%	39%	53%	38%	41%
	COP22	Scale-Up: Satur	APR23	200%	200%	133%	17%	86%	77%	62%	23%	15%	23%	11%	31%	28%	55%	19%	75%	34%	72%	47%	70%	75%	69%	63%	31%	63%
Grand-Bassam	Not Supp		N/A: No target required																									
Gueyo	COP15	Sustained	APR16	6%	3%	10%	7%	14%	10%	16%	11%	1%	1%	5%	1%	16%	4%	22%	5%	29%	9%	43%	20%	43%	20%	14%	11%	13%
	COP16	Sustained	APR17	6%	4%	9%	9%	13%	13%	15%	14%	2%	1%	6%	1%	18%	4%	25%	6%	33%	11%	49%	25%	49%	25%	16%	13%	15%
	COP17	Sustained	APR18	5%	5%	5%	5%	5%	5%	5%	5%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	30%	12%	16%
	COP18	Sustained	APR19	39%	41%	39%	41%	39%	41%	39%	41%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	54%	48%	47%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Guiglo	COP15	Scale-Up: Agg	APR16	5%	4%	8%	9%	11%	12%	13%	14%	3%	2%	11%	3%	36%	11%	50%	15%	66%	27%	96%	64%	96%	64%	31%	34%	29%

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP16	Scale-Up: Agg	APR17	6%	4%	10%	9%	14%	13%	16%	15%	3%	2%	11%	3%	37%	12%	51%	16%	67%	28%	99%	67%	99%	67%	32%	36%	30%
	COP17	Scale-Up: Agg	APR18	35%	29%	35%	29%	35%	29%	35%	29%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	57%	33%	41%
	COP18	Scale-Up: Agg	APR19	78%	107%	78%	107%	78%	107%	78%	107%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	92%
	COP19	Scale-Up: Satur	APR20	4%	4%	17%	14%	16%	17%	23%	20%	4%	21%	15%	39%	25%	46%	39%	66%	24%	61%	41%	61%	37%	52%	24%	85%	31%
	COP20	Scale-Up: Satur	APR21	0%	14%	7%	15%	9%	12%	29%	37%	7%	12%	10%	48%	19%	59%	32%	69%	32%	60%	38%	49%	53%	45%	23%	25%	29%
	COP21	Scale-Up: Satur	APR22	50%	50%	36%	71%	74%	84%	79%	86%	12%	57%	23%	113%	64%	113%	116%	137%	112%	130%	83%	78%	95%	58%	58%	66%	77%
	COP22	Scale-Up: Satur	APR23	100%	100%	67%	117%	52%	108%	60%	60%	23%	58%	2%	108%	36%	144%	62%	153%	77%	174%	101%	135%	108%	106%	70%	73%	87%
Guitry	Not Supp		N/A: No target required																									
	COP18	Scale-Up: Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	75%	85%	84%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Issia	COP15	Scale-Up: Satur	APR16	7%	7%	12%	16%	16%	23%	19%	26%	5%	3%	16%	3%	52%	14%	72%	19%	95%	34%	138%	81%	138%	81%	44%	43%	40%
	COP16	Scale-Up: Satur	APR17	14%	10%	23%	21%	33%	31%	39%	35%	7%	4%	24%	5%	80%	21%	109%	28%	145%	50%	211%	119%	211%	119%	68%	64%	61%
	COP17	Scale-Up: Satur	APR18	95%	123%	95%	123%	95%	123%	95%	123%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	97%	52%	86%
	COP18	Scale-Up: Satur	APR19	103%	132%	103%	132%	103%	132%	103%	132%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	113%	120%	117%
	COP19	Scale-Up: Satur	APR20	82%	86%	30%	36%	66%	48%	16%	32%	36%	40%	27%	94%	43%	115%	62%	137%	83%	128%	72%	108%	83%	105%	38%	75%	68%
	COP20	Scale-Up: Satur	APR21	10%	0%	21%	24%	34%	21%	33%	39%	14%	24%	19%	74%	22%	106%	47%	134%	62%	107%	74%	92%	99%	95%	53%	42%	52%
	COP21	Scale-Up: Satur	APR22	33%	33%	91%	70%	106%	77%	58%	69%	18%	57%	17%	99%	36%	117%	85%	149%	119%	128%	113%	84%	104%	79%	89%	70%	79%
	COP22	Scale-Up: Satur	APR23	33%	33%	185%	115%	127%	75%	57%	63%	19%	33%	17%	107%	26%	108%	41%	136%	66%	141%	103%	107%	117%	109%	92%	49%	82%
Jacqueville	COP15	Sustained	APR16	7%	4%	11%	8%	16%	12%	19%	13%	2%	1%	6%	1%	20%	5%	27%	7%	36%	12%	53%	29%	53%	29%	17%	16%	17%
	COP16	Sustained	APR17	10%	6%	16%	12%	22%	17%	26%	19%	3%	2%	10%	2%	33%	9%	45%	13%	60%	23%	88%	54%	88%	54%	28%	29%	28%
	COP17	Sustained	APR18	20%	11%	20%	11%	20%	11%	20%	11%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	32%	16%	21%
	COP18	Sustained	APR19	57%	76%	57%	76%	57%	76%	57%	76%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%	88%	77%
	COP19	Scale-Up: Satur	APR20	24%	25%	12%	12%	45%	26%	24%	20%	4%	15%	5%	30%	13%	41%	22%	48%	34%	56%	45%	55%	37%	39%	41%	47%	30%
	COP20	Scale-Up: Satur	APR21	0%	0%	100%	25%	29%	29%	43%	100%	18%	43%	15%	100%	59%	85%	56%	152%	60%	107%	103%	123%	93%	112%	74%	64%	66%
	COP21	Scale-Up: Satur	APR22	0%	0%	20%	20%	57%	86%	50%	64%	18%	25%	5%	37%	23%	38%	44%	69%	30%	50%	56%	40%	31%	43%	42%	50%	37%
	COP22	Scale-Up: Satur	APR23	0%	0%	0%	100%	44%	33%	100%	67%	13%	16%	18%	42%	10%	55%	31%	78%	25%	59%	35%	57%	41%	59%	55%	36%	41%
Kani	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	100%	100%	167%	133%	22%	78%	67%	125%	11%	14%	9%	108%	42%	133%	93%	131%	114%	95%	114%	41%	64%	22%	52%	27%	78%
	COP22	Scale-Up: Satur	APR23	0%	0%	133%	133%	33%	36%	33%	117%	13%	21%	0%	90%	27%	146%	89%	143%	92%	151%	98%	71%	112%	41%	57%	21%	69%
Katiola	COP15	Sustained	APR16	12%	6%	20%	12%	28%	18%	33%	20%	4%	2%	12%	2%	40%	8%	55%	11%	73%	20%	107%	47%	107%	47%	34%	25%	31%
	COP16	Sustained	APR17	14%	7%	23%	15%	32%	21%	38%	24%	4%	2%	15%	3%	48%	11%	66%	14%	87%	26%	127%	61%	127%	61%	40%	32%	37%
	COP17	Sustained	APR18	21%	17%	21%	17%	21%	17%	21%	17%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	49%	19%	29%
	COP18	Sustained	APR19	72%	59%	72%	59%	72%	59%	72%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	83%	59%	69%
	COP19	Scale-Up: Satur	APR20	117%	124%	68%	57%	92%	64%	63%	181%	44%	55%	25%	66%	34%	56%	32%	59%	38%	85%	73%	126%	73%	195%	26%	103%	77%
	COP20	Scale-Up: Satur	APR21	25%	25%	32%	20%	51%	44%	106%	156%	41%	53%	31%	78%	44%	117%	54%	138%	83%	119%	116%	128%	186%	178%	80%	85%	83%

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+			
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP21	Scale-Up: Satur	APR22	0%	0%	50%	64%	127%	153%	100%	117%	34%	93%	49%	95%	74%	117%	89%	116%	117%	111%	122%	103%	145%	122%	91%	112%	92%
	COP22	Scale-Up: Satur	APR23	0%	0%	140%	100%	76%	94%	120%	210%	35%	74%	27%	103%	62%	181%	69%	194%	100%	191%	134%	146%	193%	175%	104%	100%	109%
Kong	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	0%	0%	0%	0%	86%	57%	0%	89%	0%	0%	0%	70%	100%	98%	95%	69%	81%	54%	44%	44%	61%	26%	33%	14%	42%
	COP22	Scale-Up: Satur	APR23	0%	0%	0%	0%	0%	136%	67%	67%	0%	50%	0%	45%	175%	78%	12%	53%	18%	43%	11%	31%	27%	53%	40%	15%	38%
Korhogo (COP15 to COP18) Korhogo 1 (COP19 onward)	COP15	Scale-Up: Satur	APR16	13%	10%	21%	22%	30%	32%	35%	35%	6%	4%	22%	4%	73%	18%	100%	24%	132%	43%	192%	103%	192%	103%	61%	55%	55%
	COP16	Scale-Up: Satur	APR17	16%	13%	26%	27%	36%	40%	43%	45%	8%	5%	27%	5%	89%	22%	122%	30%	161%	54%	236%	128%	236%	128%	75%	68%	68%
	COP17	Scale-Up: Satur	APR18	126%	111%	126%	111%	126%	111%	126%	111%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	122%	58%	100%
	COP18	Scale-Up: Satur	APR19	89%	131%	89%	131%	89%	131%	89%	131%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	116%	141%	122%
	COP19	Scale-Up: Satur	APR20	132%	113%	105%	108%	78%	86%	83%	71%	61%	116%	44%	233%	197%	306%	186%	286%	159%	209%	138%	123%	114%	97%	40%	70%	131%
	COP20	Scale-Up: Satur	APR21	38%	31%	51%	70%	33%	36%	104%	74%	38%	39%	25%	86%	76%	162%	93%	183%	86%	142%	103%	128%	122%	136%	63%	55%	82%
	COP21	Scale-Up: Satur	APR22	29%	33%	129%	175%	115%	122%	104%	79%	44%	73%	23%	102%	94%	181%	148%	198%	130%	162%	129%	119%	115%	105%	86%	87%	108%
	COP22	Scale-Up: Satur	APR23	0%	0%	170%	161%	78%	103%	127%	136%	44%	42%	30%	84%	29%	131%	63%	168%	84%	171%	105%	139%	128%	117%	77%	50%	93%
Korhogo 2	New health district established in 2020																													
	COP20	Scale-Up: Satur	APR21	0%	50%	36%	55%	5%	16%	11%	11%	7%	10%	0%	69%	30%	100%	28%	61%	33%	53%	34%	22%	21%	30%	21%	7%	30%
	COP21	Scale-Up: Satur	APR22	0%	0%	67%	133%	25%	75%	29%	0%	20%	17%	0%	77%	64%	87%	94%	61%	30%	60%	36%	13%	23%	18%	31%	14%	41%
	COP22	Scale-Up: Satur	APR23	0%	0%	0%	67%	18%	100%	57%	50%	25%	48%	0%	29%	13%	58%	45%	64%	33%	80%	41%	16%	28%	21%	22%	14%	34%
Koro	New health district established in 2020																													
	COP21	Not Supported	N/A: No target required																											
	COP22	Not Supported																												
Kouassikouassikro	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	0%	0%	0%	0%	150%	150%	100%	100%	0%	0%	80%	50%	217%	300%	86%	72%	44%	43%	18%	8%	18%	0%	78%	108%	68%
	COP22	Scale-Up: Satur	APR23			0%	100%	0%	50%	400%	200%	25%	20%	50%	22%	260%	382%	29%	107%	11%	12%	0%	9%	13%	18%	196%	120%	92%
Kouibly	COP15	Sustained	APR16	2%	1%	3%	2%	5%	3%	5%	4%	2%	1%	6%	1%	19%	5%	26%	7%	34%	12%	50%	28%	50%	28%	16%	15%	14%
	COP16	Sustained	APR17	3%	2%	5%	5%	7%	7%	8%	8%	2%	1%	8%	2%	25%	7%	34%	9%	45%	17%	66%	40%	66%	40%	21%	21%	19%
	COP17	Sustained	APR18	8%	6%	8%	6%	8%	6%	8%	6%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	38%	18%	21%
	COP18	Sustained	APR19	35%	48%	35%	48%	35%	48%	35%	48%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	81%	94%	72%
	COP19	Scale-Up: Satur	APR20	8%	9%	6%	6%	19%	11%	12%	12%	3%	13%	2%	14%	6%	26%	17%	31%	24%	40%	30%	40%	30%	51%	21%	68%	21%
	COP20	Scale-Up: Satur	APR21	0%	0%	11%	13%	20%	28%	21%	8%	0%	12%	4%	45%	8%	56%	29%	78%	43%	65%	67%	67%	62%	78%	42%	40%	33%
	COP21	Scale-Up: Satur	APR22	0%	0%	55%	55%	93%	120%	64%	23%	0%	46%	5%	62%	19%	71%	67%	72%	70%	63%	82%	50%	60%	48%	62%	52%	52%
	COP22	Scale-Up: Satur	APR23	0%	0%	29%	29%	13%	11%	9%	5%	0%	11%	1%	29%	5%	34%	9%	50%	21%	48%	40%	42%	27%	37%	19%	23%	20%
Koumassi-Port Bouet-Vridi (COP15 to COP20) Koumassi (COP20 onward)	COP15	Scale-Up: Agg	APR16	11%	7%	18%	15%	25%	22%	29%	24%	5%	3%	18%	3%	60%	12%	82%	17%	109%	30%	159%	71%	159%	71%	51%	38%	43%
	COP16	Scale-Up: Agg	APR17	12%	9%	21%	20%	29%	28%	34%	32%	7%	3%	23%	4%	74%	16%	102%	22%	135%	39%	197%	91%	197%	91%	63%	49%	54%
	COP17	Scale-Up: Agg	APR18	48%	38%	48%	38%	48%	38%	48%	38%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	104%	46%	64%
	COP18	Scale-Up: Agg	APR19	82%	101%	82%	101%	82%	101%	82%	101%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	77%	82%	84%
	COP19	Scale-Up: Satur	APR20	135%	98%	184%	249%	114%	159%	86%	105%	43%	57%	47%	136%	48%	224%	91%	289%	121%	227%	134%	144%	102%	103%	68%	82%	127%
	COP20	Scale-Up: Satur	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP21	Scale-Up: Satur	APR22	17%	17%	51%	95%	115%	112%	96%	94%	56%	44%	55%	54%	44%	77%	72%	101%	72%	109%	89%	96%	88%	77%	65%	66%	73%
	COP22	Scale-Up: Satur	APR23	75%	75%	115%	100%	103%	100%	121%	146%	56%	46%	57%	59%	37%	98%	52%	123%	58%	152%	80%	129%	127%	128%	87%	52%	91%
Kounahiri	New health district established in 2020																													

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP21	Scale-Up: Satur	APR22	0%	0%	80%	0%	29%	71%	110%	30%	0%	41%	0%	66%	33%	136%	29%	125%	104%	103%	118%	43%	83%	36%	53%	49%	56%
	COP22	Scale-Up: Satur	APR23	0%	0%	100%	0%	36%	73%	100%	50%	23%	24%	7%	54%	21%	171%	13%	143%	69%	120%	60%	68%	110%	49%	62%	33%	58%
Koun-Fao	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	0%	0%	27%	36%	120%	129%	43%	87%	32%	46%	17%	60%	17%	75%	58%	91%	69%	92%	95%	107%	102%	94%	71%	102%	65%
	COP22	Scale-Up: Satur	APR23	0%	0%	33%	33%	74%	121%	92%	83%	43%	33%	22%	63%	18%	111%	53%	110%	68%	128%	86%	132%	154%	158%	89%	79%	74%
Kouto	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	0%	0%	33%	83%	100%	122%	23%	69%	0%	39%	22%	88%	28%	119%	125%	131%	114%	103%	107%	86%	65%	40%	36%	20%	65%
	COP22	Scale-Up: Satur	APR23	0%	0%	75%	100%	31%	77%	88%	100%	0%	39%	43%	66%	46%	172%	94%	107%	68%	156%	76%	82%	78%	59%	43%	17%	67%
Lakota	COP15	Sustained	APR16	11%	9%	18%	20%	25%	28%	29%	32%	4%	3%	14%	3%	46%	14%	62%	19%	82%	35%	121%	82%	121%	82%	39%	44%	39%
	COP16	Sustained	APR17	14%	11%	24%	22%	33%	32%	39%	36%	5%	4%	17%	5%	57%	18%	78%	25%	103%	45%	150%	106%	150%	106%	48%	57%	49%
	COP17	Sustained	APR18	21%	26%	21%	26%	21%	26%	21%	26%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	61%	37%	41%
	COP18	Sustained	APR19	63%	83%	63%	83%	63%	83%	63%	83%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	72%	81%	75%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
M'bahiakro	COP15	Sustained	APR16	4%	0%	7%	0%	10%	0%	12%	0%	2%	1%	6%	1%	20%	6%	28%	8%	37%	14%	54%	34%	54%	34%	17%	18%	15%
	COP16	Sustained	APR17	4%	2%	7%	5%	10%	7%	11%	8%	2%	2%	7%	2%	24%	7%	33%	10%	43%	18%	63%	42%	63%	42%	20%	23%	19%
	COP17	Sustained	APR18	18%	15%	18%	15%	18%	15%	18%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	27%	15%	20%
	COP18	Sustained	APR19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	69%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
M'Batto	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	100%	100%	78%	111%	108%	73%	90%	53%	17%	57%	6%	41%	85%	135%	77%	75%	72%	58%	81%	56%	58%	47%	77%	87%	73%
	COP22	Scale-Up: Satur	APR23	100%	100%	100%	200%	79%	79%	200%	78%	40%	39%	14%	68%	89%	192%	58%	84%	50%	70%	62%	74%	85%	86%	83%	69%	87%
M'Bengue	New health district established in 2020																											
	COP21	Not Supported	N/A: No target required																									
	COP22	Not Supported																										
Madinani	New health district established in 2020																											
	COP21	Not Supported	N/A: No target required																									
	COP22	Not Supported																										
Man	COP15	Scale-Up: Satur	APR16	7%	4%	12%	9%	16%	13%	19%	14%	5%	3%	16%	3%	52%	14%	71%	19%	94%	33%	137%	79%	137%	79%	44%	42%	38%
	COP16	Scale-Up: Satur	APR17	9%	6%	15%	13%	21%	18%	25%	21%	6%	4%	21%	5%	70%	20%	97%	27%	127%	48%	187%	115%	187%	115%	60%	62%	53%
	COP17	Scale-Up: Satur	APR18	149%	73%	149%	73%	149%	73%	149%	73%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	97%	51%	86%
	COP18	Scale-Up: Satur	APR19	84%	114%	84%	114%	84%	114%	84%	114%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	103%	115%	106%
	COP19	Scale-Up: Satur	APR20	6%	5%	9%	14%	12%	18%	16%	12%	9%	17%	7%	31%	15%	30%	21%	41%	28%	46%	33%	47%	31%	58%	18%	70%	25%
	COP20	Scale-Up: Satur	APR21	17%	6%	19%	28%	17%	25%	28%	30%	18%	15%	11%	51%	16%	67%	30%	83%	36%	70%	52%	63%	69%	65%	32%	36%	37%
	COP21	Scale-Up: Satur	APR22	20%	20%	106%	112%	85%	118%	53%	59%	28%	41%	24%	101%	38%	103%	86%	121%	93%	93%	99%	69%	93%	62%	63%	69%	73%

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP22	Scale-Up: Satur	APR23	14%	14%	86%	76%	46%	57%	66%	65%	23%	29%	12%	40%	20%	58%	51%	67%	60%	76%	74%	48%	91%	55%	61%	34%	51%
Mankono	COP15	Scale-Up: Agg	APR16	6%	6%	11%	13%	15%	19%	17%	21%	2%	1%	7%	2%	24%	7%	33%	10%	44%	17%	64%	40%	64%	40%	20%	22%	21%
	COP16	Scale-Up: Agg	APR17	8%	7%	13%	14%	18%	20%	21%	22%	3%	2%	11%	3%	38%	11%	52%	15%	68%	27%	100%	63%	100%	63%	32%	34%	31%
	COP17	Scale-Up: Agg	APR18	33%	27%	33%	27%	33%	27%	33%	27%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	59%	34%	41%
	COP18	Scale-Up: Agg	APR19	85%	96%	85%	96%	85%	96%	85%	96%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	86%	83%	87%
	COP19	Scale-Up: Satur	APR20	8%	12%	20%	24%	14%	18%	23%	16%	7%	25%	7%	61%	41%	75%	45%	106%	58%	99%	54%	68%	67%	64%	29%	47%	41%
	COP20	Scale-Up: Satur	APR21	0%	10%	10%	12%	11%	19%	26%	27%	10%	13%	3%	24%	18%	38%	23%	54%	19%	40%	26%	38%	32%	28%	14%	13%	21%
	COP21	Scale-Up: Satur	APR22	0%	0%	92%	69%	95%	139%	82%	126%	23%	29%	18%	69%	67%	105%	80%	135%	91%	106%	90%	85%	77%	51%	57%	47%	72%
	COP22	Scale-Up: Satur	APR23	0%	0%	88%	50%	61%	79%	75%	113%	21%	30%	33%	58%	27%	109%	55%	132%	67%	129%	69%	99%	92%	71%	62%	30%	64%
Minignan	COP15	Sustained	APR16	1%	1%	2%	3%	2%	4%	3%	5%	1%	1%	3%	1%	11%	3%	16%	4%	21%	7%	30%	18%	30%	18%	10%	9%	9%
	COP16	Sustained	APR17	2%	4%	3%	8%	4%	11%	5%	12%	2%	1%	5%	2%	18%	7%	24%	9%	32%	16%	46%	38%	46%	38%	15%	20%	15%
	COP17	Sustained	APR18	0%	0%	0%	0%	0%	0%	0%	0%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	21%	11%	11%
	COP18	Sustained	APR19	71%	80%	71%	80%	71%	80%	71%	80%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	76%	73%	75%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Nassian	COP15	Sustained	APR16	0%	3%	0%	7%	0%	10%	0%	11%	3%	2%	9%	2%	28%	7%	39%	10%	51%	18%	75%	42%	75%	42%	24%	23%	20%
	COP16	Sustained	APR17	5%	4%	9%	9%	12%	13%	15%	14%	3%	1%	11%	2%	36%	7%	50%	9%	66%	16%	96%	38%	96%	38%	31%	21%	25%
	COP17	Sustained	APR18	31%	6%	31%	6%	31%	6%	31%	6%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	43%	22%	28%
	COP18	Sustained	APR19	52%	75%	52%	75%	52%	75%	52%	75%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	91%	112%	89%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Niakaramadougou	COP15	Sustained	APR16	8%	5%	13%	10%	18%	15%	21%	17%	2%	1%	7%	1%	22%	6%	30%	8%	40%	14%	59%	33%	59%	33%	19%	18%	19%
	COP16	Sustained	APR17	7%	6%	12%	13%	17%	19%	20%	21%	2%	1%	8%	1%	26%	6%	36%	8%	47%	14%	69%	34%	69%	34%	22%	18%	21%
	COP17	Sustained	APR18	32%	25%	32%	25%	32%	25%	32%	25%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	28%	14%	24%
	COP18	Sustained	APR19	44%	36%	44%	36%	44%	36%	44%	36%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	73%	51%	55%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Odienne	COP15	Sustained	APR16	9%	9%	15%	20%	21%	28%	25%	32%	3%	2%	9%	2%	29%	8%	40%	11%	53%	19%	78%	45%	78%	45%	25%	24%	26%
	COP16	Sustained	APR17	13%	10%	21%	22%	29%	31%	35%	35%	4%	2%	13%	3%	44%	11%	60%	15%	79%	26%	115%	61%	115%	61%	37%	33%	36%
	COP17	Sustained	APR18	17%	20%	17%	20%	17%	20%	17%	20%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	57%	28%	35%
	COP18	Sustained	APR19	47%	53%	47%	53%	47%	53%	47%	53%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	73%	70%	64%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										

District (psnu)	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 at APR by Age and Sex																								
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP22	Not Supported																										
Ouangolodougou	COP15	Sustained	APR16	5%	9%	9%	19%	12%	27%	15%	30%	3%	3%	12%	3%	39%	13%	54%	18%	71%	32%	104%	75%	104%	75%	33%	40%	34%
	COP16	Sustained	APR17	9%	9%	16%	19%	22%	28%	26%	32%	5%	3%	15%	4%	51%	16%	70%	22%	92%	39%	135%	93%	135%	93%	43%	50%	43%
	COP17	Sustained	APR18	8%	19%	8%	19%	8%	19%	8%	19%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	43%	27%	28%
	COP18	Sustained	APR19	60%	89%	60%	89%	60%	89%	60%	89%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	79%	100%	85%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Ouaninou	New health district established in 2020																											
	COP21	Not Supported	N/A: No target required																									
	COP22	Not Supported																										
Oume	COP15	Scale-Up: Agg	APR16	5%	4%	9%	9%	12%	13%	15%	14%	3%	2%	10%	3%	34%	11%	47%	14%	62%	26%	90%	60%	90%	60%	29%	32%	27%
	COP16	Scale-Up: Agg	APR17	8%	7%	13%	14%	17%	21%	21%	23%	4%	3%	15%	3%	51%	13%	70%	18%	92%	32%	134%	76%	134%	76%	43%	41%	39%
	COP17	Scale-Up: Agg	APR18	34%	26%	34%	26%	34%	26%	34%	26%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	75%	43%	49%
	COP18	Scale-Up: Agg	APR19	80%	104%	80%	104%	80%	104%	80%	104%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	86%	95%	91%
	COP19	Scale-Up: Satur	APR20	83%	70%	50%	48%	20%	48%	29%	58%	19%	58%	12%	85%	15%	96%	34%	113%	61%	86%	53%	68%	60%	66%	27%	59%	55%
	COP20	Scale-Up: Satur	APR21	111%	88%	27%	43%	19%	18%	34%	37%	8%	20%	11%	62%	48%	110%	32%	90%	46%	90%	63%	53%	61%	51%	30%	25%	49%
	COP21	Scale-Up: Satur	APR22	0%	0%	65%	127%	100%	80%	58%	47%	11%	43%	13%	112%	71%	118%	82%	108%	99%	105%	101%	53%	80%	40%	52%	42%	67%
	COP22	Scale-Up: Satur	APR23	33%	33%	129%	138%	85%	53%	47%	55%	17%	16%	8%	65%	20%	64%	31%	86%	36%	88%	54%	92%	95%	79%	82%	40%	60%
Port-Bouet-Vridi	New health district established in 2020																											
	COP21	Scale-Up: Satur	APR22	33%	33%	49%	80%	120%	116%	87%	89%	34%	51%	28%	74%	28%	101%	71%	117%	83%	126%	106%	99%	103%	71%	69%	57%	76%
	COP22	Scale-Up: Satur	APR23	75%	75%	125%	121%	103%	103%	98%	124%	37%	53%	32%	76%	35%	106%	52%	132%	61%	150%	97%	124%	144%	115%	87%	44%	90%
Prikro	COP15	Sustained	APR16	5%	4%	8%	9%	11%	14%	13%	15%	3%	2%	12%	2%	39%	10%	53%	14%	70%	25%	102%	58%	102%	58%	33%	31%	29%
	COP16	Sustained	APR17	6%	8%	11%	17%	15%	25%	18%	28%	4%	2%	15%	3%	49%	11%	67%	15%	88%	26%	128%	62%	128%	62%	41%	33%	36%
	COP17	Sustained	APR18	14%	23%	14%	23%	14%	23%	14%	23%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	71%	36%	42%
	COP18	Sustained	APR19	52%	72%	52%	72%	52%	72%	52%	72%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	66%	79%	69%
	COP19	Not Supported	N/A: No target required																									
	COP20	Not Supported																										
	COP21	Not Supported																										
	COP22	Not Supported																										
Sakassou	COP15	Sustained	APR16	14%	12%	23%	25%	32%	36%	37%	41%	4%	3%	13%	3%	44%	13%	60%	17%	79%	31%	116%	72%	116%	72%	37%	39%	39%
	COP16	Sustained	APR17	16%	16%	16%	13%	27%	28%	38%	41%	45%	46%	6%	3%	20%	4%	65%	16%	89%	22%	117%	38%	171%	91%	55%	49%	43%
	COP17	Sustained	APR18	69%	69%	69%	58%	69%	58%	69%	58%	69%	58%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%	96%	46%	68%
	COP18	Sustained	APR19	52%	52%	52%	112%	52%	112%	52%	112%	52%	112%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%	5%	11%	36%
	COP19	Scale-Up: Satur	APR20	217%	114%	149%	43%	77%	51%	92%	113%	59%	53%	33%	76%	20%	127%	54%	144%	80%	134%	101%	139%	135%	156%	146%	258%	107%
	COP20	Scale-Up: Satur	APR21	0%	0%	87%	36%	29%	42%	64%	155%	89%	41%	73%	67%	60%	68%	66%	90%	53%	79%	98%	102%	167%	149%	95%	91%	75%
	COP21	Scale-Up: Satur	APR22	0%	0%	114%	143%	67%	78%	62%	85%	65%	48%	42%	55%	42%	40%	55%	70%	67%	60%	88%	81%	102%	84%	94%	122%	69%
	COP22	Scale-Up: Satur	APR23	0%	0%	200%	25%	31%	50%	63%	63%	89%	28%	14%	27%	7%	44%	21%	64%	28%	46%	44%	63%	55%	89%	89%	79%	51%
Sandegue	New health district established in 2020																											

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+			
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
	COP21	Scale-Up: Satur	APR22	100%	100%	240%	120%	143%	100%	50%	70%	47%	50%	0%	65%	45%	68%	77%	87%	124%	104%	108%	73%	103%	51%	44%	25%	83%
	COP22	Scale-Up: Satur	APR23	0%	0%	200%	133%	282%	191%	71%	133%	56%	40%	16%	54%	13%	98%	66%	126%	56%	160%	90%	180%	106%	106%	110%	39%	97%
San-Pedro	COP15	Scale-Up: Satur	APR16	8%	7%	14%	14%	19%	20%	23%	23%	4%	3%	15%	4%	49%	15%	67%	20%	88%	36%	129%	85%	129%	85%	41%	46%	39%
	COP16	Scale-Up: Satur	APR17	10%	8%	16%	16%	22%	23%	27%	26%	6%	4%	19%	5%	64%	18%	87%	25%	115%	45%	168%	106%	168%	106%	54%	57%	50%
	COP17	Scale-Up: Satur	APR18	28%	28%	28%	29%	28%	29%	28%	29%	28%	29%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	66%	38%	42%
	COP18	Scale-Up: Satur	APR19	14%	14%	14%	15%	14%	15%	14%	15%	14%	15%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	7%
	COP19	Scale-Up: Satur	APR20	37%	59%	39%	41%	50%	58%	38%	40%	23%	44%	18%	49%	51%	121%	49%	121%	64%	128%	77%	104%	83%	87%	94%	79%	65%
	COP20	Scale-Up: Satur	APR21	23%	25%	22%	25%	29%	22%	48%	61%	25%	26%	10%	54%	29%	88%	34%	111%	43%	93%	74%	93%	83%	87%	48%	31%	49%
	COP21	Scale-Up: Satur	APR22	25%	25%	57%	83%	100%	73%	71%	97%	29%	41%	17%	73%	44%	88%	62%	116%	85%	103%	102%	88%	95%	66%	74%	50%	69%
	COP22	Scale-Up: Satur	APR23	57%	67%	100%	103%	94%	69%	86%	88%	32%	39%	25%	70%	25%	105%	43%	131%	49%	128%	74%	115%	103%	106%	85%	36%	76%
Sassandra	COP15	Scale-Up: Agg	APR16	6%	4%	9%	8%	13%	12%	16%	13%	2%	2%	8%	2%	28%	10%	38%	13%	50%	23%	73%	55%	73%	55%	23%	30%	24%
	COP16	Scale-Up: Agg	APR17	7%	6%	12%	12%	17%	17%	20%	19%	3%	2%	12%	3%	39%	11%	54%	15%	71%	26%	104%	62%	104%	62%	33%	33%	31%
	COP17	Scale-Up: Agg	APR18	21%	21%	21%	21%	21%	21%	21%	21%	21%	21%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%	45%	29%	30%
	COP18	Scale-Up: Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	78%	69%	79%
	COP19	Scale-Up: Satur	APR20	62%	66%	94%	76%	41%	74%	42%	41%	17%	58%	20%	59%	36%	90%	54%	115%	89%	121%	104%	104%	103%	98%	97%	111%	74%
	COP20	Scale-Up: Satur	APR21	0%	0%	18%	21%	26%	46%	36%	79%	17%	12%	14%	58%	32%	92%	33%	113%	69%	95%	83%	85%	80%	87%	44%	42%	49%
	COP21	Scale-Up: Satur	APR22	0%	0%	21%	29%	52%	76%	52%	83%	16%	10%	9%	44%	22%	61%	58%	88%	56%	65%	58%	50%	48%	39%	43%	41%	43%
	COP22	Scale-Up: Satur	APR23	100%	100%	38%	50%	64%	82%	31%	125%	8%	6%	11%	31%	17%	56%	13%	74%	42%	80%	47%	60%	58%	58%	48%	31%	51%
seguela	COP15	Sustained	APR16	3%	4%	4%	8%	6%	11%	7%	12%	2%	1%	8%	2%	26%	7%	36%	10%	47%	18%	69%	42%	69%	42%	22%	22%	20%
	COP16	Sustained	APR17	7%	7%	12%	16%	17%	23%	20%	25%	4%	3%	14%	3%	45%	13%	61%	18%	81%	32%	118%	76%	118%	76%	38%	41%	36%
	COP17	Sustained	APR18	10%	18%	10%	18%	10%	18%	10%	18%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	64%	34%	37%
	COP18	Sustained	APR19	62%	69%	62%	69%	62%	69%	62%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	72%	69%	69%
	COP19	Scale-Up: Satur	APR20	33%	53%	25%	24%	14%	11%	9%	4%	11%	29%	15%	79%	87%	133%	85%	160%	78%	124%	58%	75%	59%	74%	46%	54%	56%
	COP20	Scale-Up: Satur	APR21	29%	0%	22%	36%	24%	7%	31%	31%	15%	69%	18%	88%	20%	94%	45%	111%	54%	76%	54%	69%	65%	47%	25%	17%	44%
	COP21	Scale-Up: Satur	APR22	0%	0%	62%	100%	116%	26%	62%	46%	22%	124%	35%	91%	25%	107%	105%	126%	140%	95%	96%	69%	99%	40%	52%	32%	70%
	COP22	Scale-Up: Satur	APR23	50%	50%	38%	86%	143%	61%	35%	25%	23%	20%	21%	114%	44%	124%	99%	190%	101%	117%	89%	111%	102%	81%	72%	29%	76%
Sikensi	COP15	Sustained	APR16	5%	3%	8%	7%	11%	10%	13%	11%	2%	1%	6%	1%	19%	4%	25%	5%	34%	9%	49%	22%	49%	22%	16%	12%	14%
	COP16	Sustained	APR17	9%	7%	14%	14%	20%	21%	24%	23%	3%	2%	10%	2%	34%	8%	46%	11%	61%	20%	89%	47%	89%	47%	28%	25%	27%
	COP17	Sustained	APR18	8%	3%	8%	3%	8%	3%	8%	3%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	34%	13%	18%
	COP18	Sustained	APR19	57%	76%	57%	76%	57%	76%	57%	76%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	56%	64%	62%
	COP19	Scale-Up: Satur	APR20	84%	87%	47%	22%	33%	42%	17%	15%	3%	19%	2%	22%	7%	33%	23%	52%	40%	55%	48%	49%	40%	37%	28%	28%	35%
	COP20	Scale-Up: Satur	APR21	150%	200%	36%	38%	22%	32%	9%	70%	0%	14%	0%	56%	25%	83%	43%	117%	63%	93%	76%	63%	75%	103%	27%	26%	59%
	COP21	Scale-Up: Satur	APR22	0%	0%	100%	200%	80%	100%	33%	88%	0%	31%	0%	56%	34%	85%	79%	96%	92%	86%	128%	44%	85%	53%	41%	33%	64%
	COP22	Scale-Up: Satur	APR23	0%	0%	200%	150%	62%	69%	67%	100%	22%	32%	4%	24%	16%	69%	60%	80%	43%	100%	71%	91%	88%	102%	89%	49%	66%
Sinematiali	New health district established in 2020																											
	COP21	Not Supported																										
	COP22	Not Supported		N/A: No target required																								
Sinfra	COP15	Scale-Up: Agg	APR16	10%	12%	16%	26%	22%	37%	26%	42%	4%	2%	12%	3%	40%	11%	54%	15%	72%	26%	105%	62%	105%	62%	34%	33%	35%
	COP16	Scale-Up: Agg	APR17	16%	12%	27%	26%	37%	37%	44%	42%	5%	3%	16%	4%	54%	15%	74%	20%	98%	36%	144%	85%	144%	85%	46%	46%	47%
	COP17	Scale-Up: Agg	APR18	50%	61%	50%	61%	50%	61%	50%	61%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	125%	67%	83%

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP18	Scale-Up: Agg	APR19	80%	104%	80%	104%	80%	104%	80%	104%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	201%	222%	172%
	COP19	Scale-Up: Satur	APR20	47%	78%	37%	32%	79%	54%	62%	42%	24%	34%	16%	51%	16%	72%	25%	93%	53%	101%	52%	73%	60%	72%	29%	72%	53%		
	COP20	Scale-Up: Satur	APR21	14%	14%	24%	28%	33%	20%	81%	57%	13%	16%	16%	45%	18%	64%	28%	88%	39%	87%	62%	86%	90%	80%	49%	45%	46%		
	COP21	Scale-Up: Satur	APR22	133%	133%	55%	76%	93%	48%	91%	69%	17%	36%	16%	54%	36%	90%	58%	96%	71%	89%	91%	76%	93%	61%	79%	66%	72%		
	COP22	Scale-Up: Satur	APR23	0%	0%	138%	85%	76%	57%	115%	115%	30%	28%	32%	74%	27%	83%	40%	112%	50%	113%	68%	107%	114%	89%	97%	54%	71%		
Soubre	COP15	Scale-Up: Agg	APR16	5%	4%	8%	8%	11%	12%	13%	13%	2%	2%	8%	2%	26%	7%	36%	10%	47%	18%	69%	42%	69%	42%	22%	23%	21%		
	COP16	Scale-Up: Agg	APR17	6%	5%	9%	10%	13%	14%	16%	16%	3%	2%	11%	2%	35%	10%	48%	13%	63%	24%	92%	56%	92%	56%	30%	30%	27%		
	COP17	Scale-Up: Agg	APR18	29%	31%	29%	31%	29%	31%	29%	31%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	69%	38%	46%		
	COP18	Scale-Up: Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	62%	55%	69%		
	COP19	Scale-Up: Satur	APR20	13%	28%	33%	39%	29%	32%	20%	18%	14%	31%	14%	45%	33%	76%	42%	99%	67%	98%	87%	68%	94%	60%	88%	56%	49%		
	COP20	Scale-Up: Satur	APR21	0%	6%	5%	11%	15%	11%	29%	21%	9%	15%	8%	32%	9%	51%	15%	80%	22%	62%	36%	55%	39%	54%	24%	26%	26%		
	COP21	Scale-Up: Satur	APR22	17%	17%	44%	60%	109%	70%	89%	56%	18%	34%	14%	47%	13%	67%	44%	88%	63%	72%	78%	52%	64%	40%	56%	41%	52%		
	COP22	Scale-Up: Satur	APR23	50%	50%	112%	124%	102%	95%	91%	71%	24%	37%	9%	56%	14%	75%	31%	110%	51%	100%	66%	83%	79%	80%	67%	35%	67%		
Tabou	COP15	Scale-Up: Agg	APR16	3%	2%	5%	4%	7%	6%	8%	6%	1%	1%	5%	1%	17%	5%	23%	7%	30%	13%	45%	31%	45%	31%	14%	16%	14%		
	COP16	Scale-Up: Agg	APR17	4%	2%	6%	4%	8%	6%	10%	7%	2%	2%	8%	2%	26%	8%	35%	11%	46%	20%	68%	47%	68%	47%	22%	25%	20%		
	COP17	Scale-Up: Agg	APR18	33%	24%	33%	24%	33%	24%	33%	24%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	40%		
	COP18	Scale-Up: Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%		
	COP19	Scale-Up: Satur	APR20	41%	43%	41%	27%	46%	60%	28%	35%	2%	38%	8%	63%	18%	114%	46%	102%	73%	111%	98%	107%	154%	107%	94%	103%	65%		
	COP20	Scale-Up: Satur	APR21	20%	25%	11%	18%	27%	26%	48%	67%	9%	15%	8%	73%	24%	125%	38%	127%	59%	109%	79%	92%	115%	102%	51%	46%	55%		
	COP21	Scale-Up: Satur	APR22	0%	0%	21%	38%	40%	65%	47%	76%	19%	22%	12%	60%	25%	69%	44%	80%	67%	70%	71%	51%	79%	44%	52%	48%	46%		
	COP22	Scale-Up: Satur	APR23	0%	0%	17%	50%	141%	68%	115%	208%	19%	45%	9%	79%	9%	69%	45%	115%	77%	108%	77%	95%	109%	102%	78%	46%	70%		
Tai	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	0%	0%	117%	50%	100%	63%	31%	58%	11%	18%	9%	92%	25%	96%	63%	123%	69%	63%	86%	27%	87%	20%	42%	40%	54%		
	COP22	Scale-Up: Satur	APR23	0%	0%	100%	200%	167%	50%	71%	100%	0%	62%	0%	144%	22%	98%	47%	168%	60%	87%	64%	53%	108%	40%	50%	33%	72%		
Tanda	COP15	Scale-Up: Agg	APR16	12%	9%	20%	19%	28%	28%	33%	32%	5%	3%	17%	3%	55%	13%	75%	18%	99%	31%	145%	74%	145%	74%	46%	40%	43%		
	COP16	Scale-Up: Agg	APR17	16%	11%	26%	24%	36%	34%	43%	39%	6%	3%	20%	4%	67%	16%	92%	22%	122%	39%	178%	91%	178%	91%	57%	49%	53%		
	COP17	Scale-Up: Satur	APR18	163%	66%	163%	66%	163%	66%	163%	66%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	84%		
	COP18	Scale-Up: Satur	APR19	77%	111%	77%	111%	77%	111%	77%	111%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	122%	152%	123%		
	COP19	Scale-Up: Satur	APR20	35%	73%	58%	66%	70%	73%	56%	51%	43%	36%	11%	68%	23%	99%	49%	147%	98%	174%	124%	160%	128%	169%	87%	167%	86%		
	COP20	Scale-Up: Satur	APR21	22%	22%	8%	24%	21%	19%	58%	51%	11%	10%	9%	29%	9%	50%	19%	73%	27%	58%	52%	69%	63%	68%	39%	35%	35%		
	COP21	Scale-Up: Satur	APR22	0%	0%	100%	150%	123%	154%	122%	100%	32%	33%	26%	92%	62%	124%	90%	156%	91%	136%	150%	141%	135%	112%	124%	120%	99%		
	COP22	Scale-Up: Satur	APR23	100%	100%	50%	275%	67%	117%	256%	289%	39%	42%	30%	96%	39%	177%	52%	239%	82%	233%	160%	214%	224%	261%	167%	113%	143%		
Tehini	New health district established in 2020																													
	COP21	Not Supported	N/A: No target required																											
	COP22	Not Supported																												
Tengrela	COP15	Sustained	APR16	21%	2%	36%	4%	49%	6%	59%	7%	5%	3%	19%	4%	62%	14%	84%	20%	111%	35%	163%	83%	163%	83%	52%	45%	47%		
	COP16	Sustained	APR17	27%	13%	44%	27%	62%	38%	73%	43%	8%	5%	27%	5%	88%	22%	120%	30%	159%	53%	232%	126%	232%	126%	74%	68%	71%		
	COP17	Sustained	APR18	39%	8%	39%	8%	39%	8%	39%	8%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	40%		
	COP18	Sustained	APR19	55%	81%	55%	81%	55%	81%	55%	81%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	67%		
	COP19	Not Supported	N/A: No target required																											

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F			
	COP20	Not Supported																												
	COP21	Not Supported																												
	COP22	Not Supported																												
Tiapoum	New health district established in 2020																													
	COP21	Not Supported	N/A: No target required																											
	COP22	Not Supported																												
Tiassale	COP15	Scale-Up: Agg	APR16	7%	6%	11%	12%	15%	18%	18%	20%	2%	1%	7%	2%	24%	6%	32%	9%	43%	15%	62%	37%	62%	37%	20%	20%	20%
	COP16	Scale-Up: Agg	APR17	11%	8%	18%	17%	25%	24%	30%	27%	3%	2%	12%	2%	39%	10%	54%	14%	71%	25%	104%	58%	104%	58%	33%	31%	33%
	COP17	Scale-Up: Agg	APR18	34%	38%	34%	38%	34%	38%	34%	38%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	40%
	COP18	Scale-Up: Agg	APR19	79%	105%	79%	105%	79%	105%	79%	105%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	88%
	COP19	Scale-Up: Satur	APR20	96%	63%	46%	57%	38%	33%	23%	21%	10%	25%	10%	39%	16%	49%	28%	78%	51%	65%	52%	53%	58%	41%	34%	38%	43%
	COP20	Scale-Up: Satur	APR21	200%	225%	55%	88%	33%	45%	43%	58%	18%	46%	34%	122%	45%	175%	60%	210%	80%	127%	98%	97%	118%	83%	40%	39%	89%
	COP21	Scale-Up: Satur	APR22	33%	33%	100%	144%	75%	96%	34%	35%	15%	61%	26%	119%	49%	123%	74%	148%	86%	94%	99%	60%	88%	37%	45%	45%	72%
	COP22	Scale-Up: Satur	APR23	0%	0%	144%	100%	76%	72%	95%	126%	31%	22%	33%	85%	28%	96%	40%	105%	49%	111%	63%	82%	106%	102%	77%	37%	70%
Tiebissou	COP15	Sustained	APR16	8%	7%	13%	16%	19%	22%	22%	25%	3%	1%	9%	2%	29%	6%	39%	9%	52%	16%	76%	37%	76%	37%	24%	20%	24%
	COP16	Sustained	APR17	7%	7%	12%	14%	17%	21%	20%	23%	3%	2%	10%	2%	34%	8%	47%	11%	62%	19%	91%	45%	91%	45%	29%	24%	27%
	COP17	Sustained	APR18	25%	29%	25%	29%	25%	29%	25%	29%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	53%	23%	34%
	COP18	Sustained	APR19	61%	85%	61%	85%	61%	85%	61%	85%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%	108%	91%
	COP19	Scale-Up: Satur	APR20	116%	122%	29%	107%	41%	61%	111%	76%	28%	49%	9%	24%	55%	129%	20%	71%	28%	100%	63%	108%	76%	106%	93%	201%	76%
	COP20	Scale-Up: Satur	APR21	0%	33%	13%	50%	13%	17%	73%	55%	32%	28%	0%	13%	40%	71%	17%	43%	18%	42%	30%	63%	32%	57%	38%	44%	34%
	COP21	Scale-Up: Satur	APR22	0%	0%	0%	100%	33%	56%	93%	73%	45%	41%	0%	22%	7%	35%	35%	46%	30%	48%	47%	63%	46%	46%	64%	63%	41%
	COP22	Scale-Up: Satur	APR23	0%	0%	0%	25%	31%	54%	56%	75%	38%	28%	20%	30%	0%	33%	20%	46%	15%	53%	25%	56%	45%	68%	53%	39%	34%
Touba	COP15	Sustained	APR16	2%	2%	3%	5%	4%	7%	5%	7%	1%	1%	4%	1%	14%	5%	20%	6%	26%	11%	38%	27%	38%	27%	12%	14%	12%
	COP16	Sustained	APR17	4%	3%	6%	6%	8%	9%	10%	10%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	18%	20%	18%
	COP17	Sustained	APR18	3%	4%	3%	4%	3%	4%	3%	4%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	15%
	COP18	Sustained	APR19	43%	48%	43%	48%	43%	48%	43%	48%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	60%
	COP19	Not Supported	N/A: No target required																											
	COP20	Not Supported																												
	COP21	Not Supported																												
	COP22	Not Supported																												
Toulepleu	COP15	Sustained	APR16	5%	1%	9%	2%	12%	2%	14%	3%	1%	1%	3%	1%	11%	4%	15%	5%	20%	9%	29%	20%	29%	20%	9%	11%	10%
	COP16	Sustained	APR17	5%	3%	8%	6%	11%	9%	13%	10%	1%	1%	4%	1%	15%	4%	20%	6%	27%	10%	39%	23%	39%	23%	12%	12%	13%
	COP17	Sustained	APR18	0%	0%	0%	0%	0%	0%	0%	0%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	11%
	COP18	Sustained	APR19	57%	77%	57%	77%	57%	77%	57%	77%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	66%
	COP19	Not Supported	N/A: No target required																											
	COP20	Not Supported																												
	COP21	Not Supported																												
	COP22	Not Supported																												
Toumodi	COP15	Sustained	APR16	6%	9%	10%	19%	14%	28%	16%	31%	4%	2%	13%	3%	44%	11%	61%	15%	80%	26%	117%	61%	117%	61%	37%	33%	34%
	COP16	Sustained	APR17	7%	7%	11%	15%	15%	22%	18%	25%	4%	3%	15%	3%	49%	13%	67%	18%	89%	31%	130%	74%	130%	74%	41%	40%	38%

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+			
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
	COP17	Sustained	APR18	22%	28%	22%	28%	22%	28%	22%	28%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	80%	36%	47%
	COP18	Sustained	APR19	56%	78%	56%	78%	56%	78%	56%	78%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	93%	111%	90%
	COP19	Scale-Up: Satur	APR20	57%	60%	35%	7%	52%	27%	75%	44%	22%	33%	13%	50%	23%	85%	41%	97%	78%	129%	89%	135%	87%	138%	122%	190%	70%		
	COP20	Scale-Up: Satur	APR21	0%	0%	22%	12%	32%	14%	80%	45%	35%	29%	18%	42%	57%	85%	27%	79%	34%	74%	54%	77%	69%	88%	61%	61%	46%		
	COP21	Scale-Up: Satur	APR22	0%	0%	54%	33%	125%	44%	93%	59%	37%	55%	18%	58%	76%	96%	71%	77%	70%	97%	81%	76%	85%	71%	96%	98%	65%		
	COP22	Scale-Up: Satur	APR23	100%	100%	186%	100%	127%	77%	147%	53%	29%	49%	32%	68%	37%	70%	36%	81%	75%	114%	71%	103%	132%	105%	110%	66%	86%		
Transua	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	0%	0%	125%	100%	90%	130%	82%	35%	12%	17%	0%	34%	15%	63%	62%	112%	71%	124%	113%	113%	106%	75%	89%	83%	69%		
	COP22	Scale-Up: Satur	APR23	100%	100%	80%	120%	106%	63%	73%	70%	8%	18%	3%	36%	18%	69%	35%	98%	44%	134%	90%	115%	112%	117%	82%	51%	73%		
Treichville-Marcory	COP15	Scale-Up: Satur	APR16	42%	34%	70%	72%	97%	105%	115%	117%	20%	17%	67%	20%	221%	84%	303%	114%	399%	203%	584%	480%	584%	480%	187%	258%	195%		
	COP16	Scale-Up: Satur	APR17	44%	34%	74%	71%	102%	103%	121%	116%	21%	18%	74%	22%	242%	90%	332%	123%	438%	218%	641%	515%	641%	515%	205%	276%	210%		
	COP17	Scale-Up: Satur	APR18	103%	105%	103%	105%	103%	105%	103%	105%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	237%	180%	174%		
	COP18	Scale-Up: Satur	APR19	115%	142%	115%	142%	115%	142%	115%	142%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	125%	127%	127%		
	COP19	Scale-Up: Satur	APR20	165%	239%	248%	321%	266%	381%	331%	486%	223%	188%	196%	139%	252%	296%	288%	485%	270%	483%	376%	385%	398%	330%	383%	311%	310%		
	COP20	Scale-Up: Satur	APR21	3%	2%	9%	8%	14%	13%	56%	51%	33%	18%	39%	17%	29%	30%	25%	55%	32%	79%	61%	113%	107%	134%	78%	64%	44%		
	COP21	Scale-Up: Satur	APR22	8%	8%	38%	38%	92%	86%	81%	80%	38%	40%	56%	36%	44%	50%	54%	82%	59%	120%	90%	144%	119%	144%	121%	135%	74%		
	COP22	Scale-Up: Satur	APR23	33%	33%	107%	124%	199%	200%	206%	207%	91%	79%	109%	57%	90%	75%	78%	111%	68%	181%	101%	222%	200%	283%	234%	147%	135%		
Vavoua	COP15	Sustained	APR16	5%	5%	9%	10%	13%	14%	15%	16%	2%	1%	7%	2%	22%	7%	31%	10%	40%	17%	59%	41%	59%	41%	19%	22%	19%		
	COP16	Sustained	APR17	10%	9%	17%	19%	23%	27%	27%	31%	4%	3%	13%	3%	44%	13%	61%	18%	80%	32%	117%	76%	117%	76%	37%	41%	37%		
	COP17	Sustained	APR18	13%	15%	13%	15%	13%	15%	13%	15%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	48%	29%	30%		
	COP18	Sustained	APR19	58%	75%	58%	75%	58%	75%	58%	75%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	78%	86%	77%		
	COP19	Scale-Up: Satur	APR20	35%	110%	58%	24%	52%	55%	23%	24%	20%	47%	22%	109%	48%	92%	55%	138%	87%	115%	48%	57%	57%	53%	22%	46%	58%		
	COP20	Scale-Up: Satur	APR21	14%	17%	33%	50%	39%	27%	47%	42%	14%	26%	10%	83%	32%	114%	58%	141%	72%	108%	73%	80%	66%	59%	38%	32%	53%		
	COP21	Scale-Up: Satur	APR22	33%	33%	105%	110%	117%	71%	52%	51%	17%	36%	9%	71%	28%	94%	99%	107%	87%	88%	88%	53%	62%	37%	55%	45%	65%		
	COP22	Scale-Up: Satur	APR23	0%	0%	117%	109%	52%	52%	88%	54%	14%	18%	12%	58%	12%	88%	57%	98%	54%	102%	61%	60%	68%	51%	47%	26%	54%		
Yakasse-Attobrou	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	0%	0%	175%	100%	67%	100%	33%	0%	14%	65%	18%	70%	37%	114%	110%	100%	86%	71%	100%	40%	71%	25%	38%	29%	61%		
	COP22	Scale-Up: Satur	APR23			200%	50%	57%	43%	60%	60%	15%	12%	0%	48%	47%	51%	35%	88%	28%	107%	58%	49%	104%	61%	62%	26%	57%		
Yamoussoukro	COP15	Scale-Up: Agg	APR16	8%	8%	14%	16%	20%	23%	23%	26%	5%	3%	17%	4%	57%	15%	78%	21%	103%	37%	151%	87%	151%	87%	48%	47%	44%		
	COP16	Scale-Up: Agg	APR17	10%	9%	17%	18%	24%	26%	29%	29%	6%	3%	22%	4%	71%	17%	97%	23%	129%	41%	188%	96%	188%	96%	60%	52%	52%		
	COP17	Scale-Up: Agg	APR18	39%	51%	39%	51%	39%	51%	39%	51%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	86%	45%	59%		
	COP18	Scale-Up: Agg	APR19	78%	108%	78%	108%	78%	108%	78%	108%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	84%	100%	92%		
	COP19	Scale-Up: Satur	APR20	26%	37%	39%	55%	35%	49%	83%	82%	60%	35%	33%	71%	81%	176%	40%	123%	59%	144%	77%	138%	88%	133%	125%	185%	82%		
	COP20	Scale-Up: Satur	APR21	42%	18%	20%	21%	20%	25%	108%	119%	57%	27%	38%	40%	58%	116%	27%	90%	35%	94%	68%	109%	90%	127%	78%	72%	62%		
	COP21	Scale-Up: Satur	APR22	20%	25%	39%	53%	70%	78%	97%	101%	55%	43%	30%	58%	48%	87%	53%	94%	53%	95%	83%	94%	83%	89%	92%	97%	68%		
	COP22	Scale-Up: Satur	APR23	33%	33%	200%	162%	190%	178%	200%	184%	85%	63%	58%	64%	50%	80%	57%	120%	58%	140%	79%	132%	134%	150%	147%	81%	112%		
Yopougon-Est	COP15	Scale-Up: Satur	APR16	6%	6%	10%	12%	14%	17%	16%	19%	5%	3%	17%	4%	58%	16%	79%	21%	104%	38%	152%	90%	152%	90%	49%	48%	43%		
	COP16	Scale-Up: Satur	APR17	7%	5%	11%	11%	16%	15%	18%	17%	6%	3%	21%	4%	68%	16%	93%	22%	123%	39%	180%	91%	180%	91%	57%	49%	48%		
	COP17	Scale-Up: Satur	APR18	107%	114%	107%	114%	107%	114%	107%	114%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	100%	48%	86%		
	COP18	Scale-Up: Satur	APR19	89%	110%	89%	110%	89%	110%	89%	110%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	90%	92%	94%		

District (psnu)	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 at APR by Age and Sex																										
				<1		0-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+				
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
	COP19	Scale-Up: Satur	APR20	78%	74%	119%	103%	44%	57%	39%	34%	34%	36%	27%	91%	47%	135%	72%	190%	83%	159%	79%	95%	67%	68%	41%	53%	76%
	COP20	Scale-Up: Satur	APR21	5%	10%	8%	11%	9%	9%	30%	22%	13%	9%	18%	20%	21%	37%	24%	47%	26%	48%	34%	54%	43%	47%	26%	21%	25%
	COP21	Scale-Up: Satur	APR22	18%	18%	74%	96%	77%	96%	99%	75%	23%	35%	38%	61%	50%	93%	88%	99%	78%	94%	78%	84%	70%	59%	58%	54%	67%
	COP22	Scale-Up: Satur	APR23	38%	38%	80%	95%	54%	75%	76%	61%	22%	26%	34%	50%	42%	85%	51%	105%	48%	108%	56%	93%	78%	91%	57%	36%	62%
Yopougon-Ouest-Songon	COP15	Scale-Up: Satur	APR16	28%	22%	46%	47%	64%	68%	76%	76%	10%	5%	34%	6%	111%	25%	152%	34%	201%	60%	294%	142%	294%	142%	94%	76%	88%
	COP16	Scale-Up: Satur	APR17	28%	22%	47%	47%	65%	68%	77%	76%	11%	6%	39%	7%	127%	28%	175%	38%	231%	68%	337%	161%	337%	161%	108%	86%	98%
	COP17	Scale-Up: Satur	APR18	158%	141%	158%	141%	158%	141%	158%	141%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	148%	62%	120%
	COP18	Scale-Up: Satur	APR19	105%	129%	105%	129%	105%	129%	105%	129%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	96%	98%	104%
	COP19	Scale-Up: Satur	APR20	140%	168%	199%	192%	140%	149%	161%	180%	130%	151%	78%	155%	94%	272%	104%	267%	138%	291%	246%	277%	66%	66%	74%	87%	159%
	COP20	Scale-Up: Satur	APR21	14%	10%	19%	25%	42%	38%	105%	113%	99%	44%	55%	61%	37%	90%	38%	131%	41%	139%	80%	161%	110%	184%	70%	77%	74%
	COP21	Scale-Up: Satur	APR22	9%	9%	52%	78%	137%	133%	106%	113%	94%	69%	64%	69%	55%	84%	72%	121%	72%	126%	109%	120%	106%	116%	94%	99%	88%
	COP22	Scale-Up: Satur	APR23	29%	29%	100%	109%	168%	188%	144%	200%	143%	78%	130%	79%	71%	103%	79%	138%	75%	177%	125%	167%	184%	193%	162%	87%	123%
Zouhan Hounien	COP15	Sustained	APR16	3%	3%	5%	6%	8%	9%	9%	10%	2%	2%	8%	2%	28%	8%	38%	11%	50%	20%	73%	47%	73%	47%	23%	25%	21%
	COP16	Sustained	APR17	4%	4%	6%	7%	8%	11%	10%	12%	3%	2%	10%	2%	33%	10%	45%	13%	60%	23%	87%	55%	87%	55%	28%	30%	25%
	COP17	Sustained	APR18	8%	6%	8%	6%	8%	6%	8%	6%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	50%	29%	29%
	COP18	Sustained	APR19	35%	48%	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	68%
	COP19	Scale-Up: Satur	APR20	5%	5%	3%	9%	7%	7%	9%	5%	9%	12%	4%	19%	8%	24%	12%	26%	11%	22%	17%	30%	18%	37%	12%	34%	14%
	COP20	Scale-Up: Satur	APR21	0%	0%	14%	22%	11%	18%	19%	24%	11%	8%	10%	32%	23%	47%	26%	55%	32%	39%	32%	36%	36%	46%	23%	20%	24%
	COP21	Scale-Up: Satur	APR22	0%	0%	87%	64%	50%	95%	58%	74%	17%	29%	14%	61%	39%	58%	69%	66%	72%	51%	56%	30%	53%	36%	39%	34%	48%
	COP22	Scale-Up: Satur	APR23	50%	50%	113%	100%	42%	80%	37%	37%	18%	25%	18%	45%	23%	79%	34%	97%	50%	65%	43%	48%	43%	64%	38%	28%	51%
Zoukougbeu	New health district established in 2020																													
	COP21	Scale-Up: Satur	APR22	100%	100%	113%	0%	27%	91%	89%	100%	19%	6%	0%	77%	82%	110%	123%	128%	90%	108%	130%	67%	95%	58%	63%	65%	77%
	COP22	Scale-Up: Satur	APR23	200%	200%	60%	20%	71%	24%	40%	40%	32%	30%	27%	69%	19%	76%	60%	118%	55%	119%	75%	76%	84%	65%	48%	38%	69%
Zuenoula	COP15	Sustained	APR16	8%	8%	12%	17%	17%	24%	21%	27%	4%	3%	14%	4%	46%	15%	64%	20%	84%	36%	123%	84%	123%	84%	39%	45%	38%
	COP16	Sustained	APR17	18%	16%	30%	34%	42%	50%	50%	56%	6%	4%	22%	5%	72%	22%	99%	30%	131%	53%	191%	125%	191%	125%	61%	67%	63%
	COP17	Sustained	APR18	31%	38%	31%	38%	31%	38%	31%	38%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	83%	50%	56%
	COP18	Sustained	APR19	58%	75%	58%	75%	58%	75%	58%	75%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%	80%	73%
	COP19	Scale-Up: Satur	APR20	115%	75%	43%	41%	7%	31%	25%	27%	36%	73%	12%	63%	35%	67%	43%	89%	38%	78%	54%	66%	59%	70%	28%	65%	52%
	COP20	Scale-Up: Satur	APR21	0%	25%	32%	35%	19%	24%	53%	25%	11%	33%	24%	119%	24%	114%	45%	134%	60%	117%	70%	99%	84%	112%	59%	60%	57%
	COP21	Scale-Up: Satur	APR22	0%	0%	83%	42%	53%	65%	85%	38%	13%	23%	15%	90%	18%	73%	70%	94%	55%	66%	67%	54%	59%	47%	60%	58%	51%
	COP22	Scale-Up: Satur	APR23	0%	0%	71%	100%	29%	30%	57%	21%	24%	29%	21%	51%	12%	65%	22%	68%	33%	54%	28%	55%	69%	55%	50%	37%	41%

APPENDIX B – Budget Profile and Resource Projections

B.1 COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area

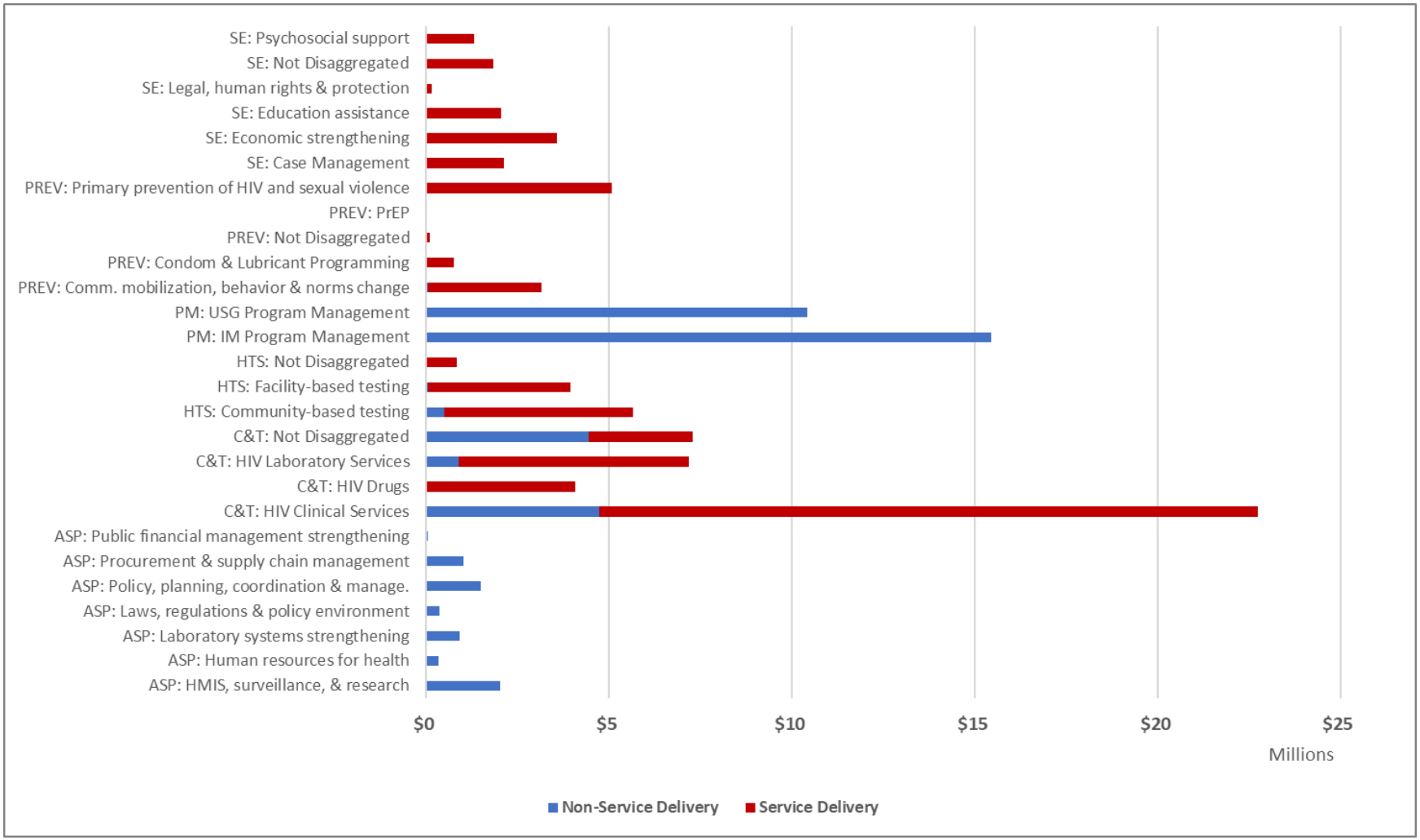


Table B.1.2 COP22 Budget by Program Area

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
	Sub-Program	Non Service Delivery	Service Delivery	Total	Non Service Delivery	Service Delivery	Total
Total		**$42,747,467**	**$62,525,533**	**$105,273,000**	**41%**	**59%**	**100%**
C&T	**Total**	**$10,067,664**	**$31,212,749**	**$41,280,413**	**24%**	**76%**	**100%**
	HIV Clinical Services	$4,738,517	$18,020,691	**$22,759,208**	21%	79%	**100%**
	HIV Drugs		$4,064,484	**$4,064,484**		100%	**100%**
	HIV Laboratory Services	$889,920	$6,285,326	**$7,175,246**	12%	88%	**100%**
	Not Disaggregated	$4,439,227	$2,842,248	**$7,281,475**	61%	39%	**100%**
HTS	**Total**	**$540,653**	**$9,874,381**	**$10,415,034**	**5%**	**95%**	**100%**
	Community-based testing	$503,390	$5,153,380	**$5,656,770**	9%	91%	**100%**
	Facility-based testing	$37,263	$3,898,840	**$3,936,103**	1%	99%	**100%**
	Not Disaggregated		$822,161	**$822,161**		100%	**100%**
PREV	**Total**	**$56,702**	**$10,415,056**	**$10,471,758**	**1%**	**99%**	**100%**
	Comm. mobilization, behavior & norms change	$42,734	$3,119,906	**$3,162,640**	1%	99%	**100%**
	Condom & Lubricant Programming		$750,000	**$750,000**		100%	**100%**
	Not Disaggregated		$100,000	**$100,000**		100%	**100%**
	PrEP	$13,968	$1,364,131	**$1,378,099**	1%	99%	**100%**
	Primary prevention of HIV and sexual violence		$5,081,019	**$5,081,019**		100%	**100%**
SE	**Total**		**$11,023,347**	**$11,023,347**		**100%**	**100%**
	Case Management		$2,116,620	**$2,116,620**		100%	**100%**
	Economic strengthening		$3,577,016	**$3,577,016**		100%	**100%**
	Education assistance		$2,043,721	**$2,043,721**		100%	**100%**
	Legal, human rights & protection		$137,851	**$137,851**		100%	**100%**
	Not Disaggregated		$1,836,959	**$1,836,959**		100%	**100%**
	Psychosocial support		$1,311,180	**$1,311,180**		100%	**100%**
ASP	**Total**	**$6,223,245**		**$6,223,245**	**100%**		**100%**
	HMIS, surveillance, & research	$2,022,517		**$2,022,517**	100%		**100%**
	Human resources for health	$346,929		**$346,929**	100%		**100%**
	Laboratory systems strengthening	$916,267		**$916,267**	100%		**100%**
	Laws, regulations & policy environment	$365,000		**$365,000**	100%		**100%**
	Policy, planning, coordination & management of disease control programs	$1,503,511		**$1,503,511**	100%		**100%**
	Procurement & supply chain management	$1,032,213		**$1,032,213**	100%		**100%**
	Public financial management strengthening	$36,808		**$36,808**	100%		**100%**
PM	**Total**	**$25,859,203**		**$25,859,203**	**100%**		**100%**
	IM Program Management	$15,446,425		**$15,446,425**	100%		**100%**
	USG Program Management	$10,412,778		**$10,412,778**	100%		**100%**

Metrics	Amount			Percent to Total by Rows (Amount)		
Program and Sub	Non-Service Delivery	Service Delivery	Total	Non-Service Delivery	Service Delivery	Total
	$42,747,467	**$62,525,533**	**$105,273,000**	**41%**	**59%**	**100%**
C&T: HIV Clinical Services	$4,738,517	$18,020,691	**$22,759,208**	21%	79%	**100%**
PM: IM Program Management	$15,446,425		**$15,446,425**	100%		**100%**
PM: USG Program Management	$10,412,778		**$10,412,778**	100%		**100%**
C&T: Not Disaggregated	$4,439,227	$2,842,248	**$7,281,475**	61%	39%	**100%**
C&T: HIV Laboratory Services	$889,920	$6,285,326	**$7,175,246**	12%	88%	**100%**
HTS: Community-based testing	$503,390	$5,153,380	**$5,656,770**	9%	91%	**100%**
PREV: Primary prevention of HIV and sexual violence		$5,081,019	**$5,081,019**		100%	**100%**
C&T: HIV Drugs		$4,064,484	**$4,064,484**		100%	**100%**
HTS: Facility-based testing	$37,263	$3,898,840	**$3,936,103**	1%	99%	**100%**
SE: Economic strengthening		$3,577,016	**$3,577,016**		100%	**100%**
PREV: Comm. mobilization, behavior & norms change	$42,734	$3,119,906	**$3,162,640**	1%	99%	**100%**
SE: Case Management		$2,116,620	**$2,116,620**		100%	**100%**
SE: Education assistance		$2,043,721	**$2,043,721**		100%	**100%**
ASP: HMIS, surveillance, & research	$2,022,517		**$2,022,517**	100%		**100%**
SE: Not Disaggregated		$1,836,959	**$1,836,959**		100%	**100%**
ASP: Policy, planning, coordination & management of disease control programs	$1,503,511		**$1,503,511**	100%		**100%**
PREV: PrEP	$13,968	$1,364,131	**$1,378,099**	1%	99%	**100%**
SE: Psychosocial support		$1,311,180	**$1,311,180**		100%	**100%**
ASP: Procurement & supply chain management	$1,032,213		**$1,032,213**	100%		**100%**
ASP: Laboratory systems strengthening	$916,267		**$916,267**	100%		**100%**
HTS: Not Disaggregated		$822,161	**$822,161**		100%	**100%**
PREV: Condom & Lubricant Programming		$750,000	**$750,000**		100%	**100%**
ASP: Laws, regulations & policy environment	$365,000		**$365,000**	100%		**100%**
ASP: Human resources for health	$346,929		**$346,929**	100%		**100%**
SE: Legal, human rights & protection		$137,851	**$137,851**		100%	**100%**
PREV: Not Disaggregated		$100,000	**$100,000**		100%	**100%**
ASP: Public financial management strengthening	$36,808		**$36,808**	100%		**100%**

Table B.1.3 COP22 Total Planning Level

Metrics	Proposed COP22 Budget	Proposed COP22 Budget	Proposed COP22 Budget
Operating Unit	**Applied Pipeline**	**New**	**Total**
Total	**$5,366,101**	**$99,906,899**	**$105,273,000**
Côte d'Ivoire	$5,366,101	$99,906,899	**$105,273,000**

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

	Proposed COP22 Budget												
Program	**C&T**		**HTS**		**PREV**		**SE**		**ASP**		**PM**		
Beneficiary	**Proposed COP22 Budget**	**Percent to Total**	**Proposed COP22 Budget**	**Percent to Total**	**Proposed COP22 Budget**	**Percent to Total**	**Proposed COP22 Budget**	**Percent to Total**	**Proposed COP22 Budget**	**Percent to Total**	**Proposed COP22 Budget**	**Percent to Total**	**Total**
Total	**$41,280,413**	**100%**	**$10,415,034**	**100%**	**$10,471,758**	**100%**	**$11,023,347**	**100%**	**$6,223,245**	**100%**	**$25,859,203**	**100%**	**$105,273,000**
Females	$285,256	1%			$5,826,478	56%	$6,701,865	61%	$685,000	11%	$1,916,373	7%	**$15,414,972**
Key Pops	$2,186,263	5%	$1,815,348	17%	$1,687,276	16%			$305,000	5%	$434,194	2%	**$6,428,081**
Males			$792,088	8%	$562,815	5%							**$1,354,903**
Non-Targeted Pop	$36,599,000	89%	$5,932,777	57%	$1,900,353	18%			$4,701,783	76%	$23,047,438	89%	**$72,181,351**
OVC			$385,980	4%	$303,270	3%	$4,321,482	39%	$250,000	4%	$461,198	2%	**$5,721,930**
Pregnant & Breastfeeding Women			$1,205,803	12%									**$1,205,803**
Priority Pops	$2,209,894	5%	$283,038	3%	$191,566	2%			$281,462	5%			**$2,965,960**

B.2 Resource Projections

For COP22 resource projections, PEPFAR-CI used an incremental budget methodology using COP20 expenditures and COP21 budgets as a basis for continuing IMs, consistent with S/GAC guidance and the FAST process. PEPFAR-CI conducted a high-level budget review of achievements in comparison to spend at the OU level, broken down by program area, and then budget execution by IM versus target achievement. After completing the data review, the PLL was reviewed taking into consideration the earmark allocations for care and treatment and OVC, and how the proposed interventions for COP22 would meet these mandatory budget amounts. In addition, the USG team engaged in

robust dialogue with key stakeholders, including MSHP, PNLS, UN System Agencies, and CSOs to identify key programmatic gaps and agree on technical priorities to address these gaps and support the country program.

Prior to allocating COP22 resources, PEPFAR-CI created an interagency budget team and conducted multiple in-depth reviews of the program's financial and performance data from all IPs for a given service package. The USG interagency team selected an agreed-upon average, removing outliers, and split programs into tiers by target size (where relevant) to align with an economies of scale budget plan. The team applied an incremental approach for each package of services based on quantitative and qualitative data related to the strategies proposed, and finalized costs of the services packages by tiers, as applicable, remaining abreast to the overall COP22 strategy and budget envelopes. Each package of services considered HRH needs based on rigorous site level HRH analyses, review of further program efficiencies, and synergies between facility and community-based activities. For HTS, PEPFAR-CI worked with IPs to estimate COP20 expenditures by HTS modality, in which outliers were removed from the analyses and certain facility HTS modalities with shared HRH were combined. Program efficiencies were considered to ensure that the HTS COP22 budget aligned with the overall reduced PEPFAR-CI budget envelope.
Final COP22 budget adjustments were made at the IM level, based on programmatic shifts given 6-MMD and the current stage of the epidemic in Côte d'Ivoire, prioritizing populations with additional resource needs (e.g., MSM, FSW, C/ALHIV, unstable patients), and rebuilding program costs with a focus on site-level service delivery interventions. Budget decisions were made by first allocating for M&O, commodities, DREAMS, OVC, KP programming, and above-site activities. DREAMS and OVC funding allocation first removed country-wide activities and the remaining funding was split by IM-based on DREAMS targets. OVC funding allocation for OVC IMs was based on <18 OVC_SERV targets. Some DREAMS funding was allocated to clinical IPs to provide secondary services to AGYW within the four DREAMS districts.

Commodities were estimated to account for patients to be tested and expected to be put on ART with respect to the on-going TLD transition and push towards 6-MMD for all adult PLHIV. As for above-site level interventions, they were identified to address key policy barriers and funded accordingly. Specific examples of the detailed budget process applied can be found in Section 4 above.

APPENDIX C – Tables and Systems Investments for Section 6.0

Key Systems Barriers-E

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)						Cote D'Ivoire
Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
11. Domestic Resource Mobilization	5.5	Increased GOCI budget for the national HIV response, with adequate resource commitments and expenditures to achieve national HIV goals for epidemic control in line with the country's financial ability.	Lack of Financial Resources	The proportion of funds that go to the health sector from GOCI is inadequate, i.e only less than 15% of the national budget is allocated to health sector and only less than 10% of the HIV spend is from domestic resources.	10+ years	The expectation is an steady increase year to year from the GOCI to the health sector. SID2021 score of 5.52
3. Civil Society Engagement	7.5	Local civil society is an active partner and key stakeholder in the national HIV/AIDS response.	Lack of Financial Resources	Limited domestic resources for HIV-related civil society organizations. No laws or policies that permit CSOs to be funded from a government budget through open competition.	4-5 years	SID2021 score of 7.50
8. Commodity Security and Supply Chain	6.8	Consistent stock availability at service delivery points	Lack of technical capacity	The GOCI has inadequate technical capacity to support implementation of supply chain activities, including last mile distribution.	4-5 years	New to optimize use of health workforce. SID2021 score of 6.76
10. Laboratory	7.6	Well staffed, cooordinated, functional and sustainable laboratory services that provide high quality, accurate, reliable and timely test results to support clinical patient care and public health programs	Lack of technical capacity	Lack of adequate local technical capacity in terms of HR and other resources to implement/manage and sustain specilised lab activities like quality management systems Open eLIS that are currently supported by PEPFAR.	4-5 years	SID2021 score of 7.59
14. Epidemiological and Health Data	7.0	Increased availability of quality surveillance and program data including KP to understand the epidemic and inform programmatic response to achieve and maintain epi control. Developed systems to produce these data.	Legal, policy or regulatory constraint	Some KP behaviors are criminalized, human rights often not protected nor acknowledged	10+ years	
14. Epidemiological and Health Data	7.0	Government is staffed and trained to fully manage the EMR system/HIS and lead technical studies and surveys on various populations.	Lack of technical capacity	The GOCI relies mostly on external partners for technical capacity and implementation of the HIS and key population surveys.	10+ years	
7. Human Resources for Health	6.1	Adequate health workforce with appropriate skills mix to attain and maintain epidemic control	Lack of Financial Resources	The GOCI has limited resources to hire health workers, including those currently supported by PEPFAR and other donors	4-5 years	SID2021 score of 6.09
8. Commodity Security and Supply Chain	6.8	Consistent stock availability at service delivery points	Lack of Financial Resources	The GOCI has a challenge in providing adequate resources for required commodities and last mile delivery. Often, committed funds have been inefficient and do not match allocated actuals. This leaves large funding gaps that often become emergency or unplanned funding requests.	10+ years	SID2021 score of 7.76
7. Human Resources for Health	6.1	Adequate health workforce with appropriate skills mix to attain and maintain epidemic control	Lack of technical capacity	Limited techncial capacity resulting in suboptimal use of HR for HIS decision-maling at decentralized level.	4-5 years	SID2021 score of 6.09
10. Laboratory	7.6	Well staffed, cooordinated, functional and sustainable laboratory services that provide high quality, accurate, reliable and timely test results to support clinical patient care and public health programs	Lack of Financial Resources	Limited GOCI funding for critical lab commodities, infrastructure, diagnostic platforms and ancillary lab equipment, biosafety equipment and transportation to support courrier systems. Much of the financing of the lab system has been supported by PEPFAR/CI is not visible to GoCI and therefore the GOCI is not able to fully comprehend the long term sustainability costs.	4-5 years	Increase GOCI funding to MOH & Lab. SID2021 score of 5.00
11. Domestic Resource Mobilization	5.5	Increased GOCI budget for the national HIV response, with adequate resource commitments and expenditures to achieve national HIV goals for epidemic control in line with the country's financial ability.	Lack of managerial capacity	The health sector lacks capacity to effectively advocate for more revenue collection and allocation to HIV.	10+ years	SID2021 score of 5.52
1. Planning and Coordination	8.5	Increased accountability of site staff toward reaching program targets or outcomes	Other	Ensuring site level MoH staff have the capacity to provide quality HIV services to clients.	10+ years	Lack of technical capacity, resources, managerial capacity
14. Epidemiological and Health Data	7	Increased availability of quality surveillance and program data (including KP) to understand the epidemic and inform programmatic response to achieve and maintain epi control. Developed systems to produce these data.	Lack of Financial Resources	The GOCI does not have the financial resources to fully fund the EMR, HIS and SI systems and associated staffing needs. Also, substantial proprotion of KP activities, including surveys and size estimates, are funded by external sources.	4-5 years	SID2021 score of 7.00

Key Systems Barriers-E (continued)

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)						Cote D'Ivoire
Step 1: Select SID element	SID score (autopopulated)	Step 2 - What is the outcome expected from investing in this element? (may duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments
2. Policies and Governance	6	Strengthened Local Civil Society Organizations to voice existing challenges and barriers and facilitate HIV services delivery.	Lack of managerial capacity	The GOCI has inadequate capacity to manage HIV programs and contribute to epidemic control in a sustainable manner	2-3 years	
5. Public Access to Information	5.3	Improved PrEP scale-up. Decrease policy and implementation barriers that create significant challenges to offering PrEP and acceptance by populations whom could benefit from this prevention intervention.	Legal, policy or regulatory constraint	Policy challenges exists hindering services access and uptake.	2-3 years	
6. Service Delivery	5.1	Strengthened quality KP programming by providing technical assistance to KP local partners, supporting them in program and project management, implenemtation of KP trageted community activities, build administrative and financial capacity, share best practices for monitoring and evaluation to collect and analyse results, reach targets and get overall expected results for all KP indicators;	Lack of managerial capacity	The GOCI has inadequate capacity to provide managerial oversight including financial, monitoring and evaluation as well as technical assistance to KP Local Partners (CSO)	2-3 years	
16. Performance Data	8	The GOCI has the ability to collect, analyze and use HIV/AIDS service delivery data by population, program and geographic area	Lack of Financial Resources	The GOCI has inadequate financial resources to fully fund the monitoring and evaluation activities, and capacity building of staff to support a strong national OVC/DREAMS/GBV M&E system	4-5 years	
17. Data for Decision-Making Ecosystem	5	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Lack of technical capacity	The GOCI has inadequate capacity to fully utilize all administrative and HIV/AIDS data and other relevant administrative data in an integrated manner for analysis across diseases and conditions	4-5 years	

Table 6-E

Table 6-E (Entry of Above Site Programs Activities)
Please note that for this tab to function properly, data must have already been pasted in the FAST-P tab.

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$110,225	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	The Ministry of Defense of Cote d'Ivoire's HIS Central Department is fully capable to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance with no external support/assistance.	Lack of Financial Resources	Lack of technical capacity		1) Provision of technical assistance for: a) Upgrade of DHIS2 to version 2.36. b) Maintenance of the DHIS2 system and automatic reminder SMS sending to patients. c) Use of DHIS2's GIS module for patient geolocation using tablets during community-based activities d) Development of interoperability between DHIS2 and Open ELIS. 2) Supply of IT equipment to the Ministry of Defense's HIS Central Department. 3) Duplication and dissemination of data collection tools. 4) Training of the Ministry of Defense's new HIS Central Department staff in M&E.	COP18	COP25	The Ministry of Defense has no financial resources to support costs associated with maintaining and improving the quality and the performance of a robust HIS for data-based decision making processes.	* EMR scaled up at 100% sites * DHIS2 upgraded to version 2.33 * SOPs updated * Comprehensive and quality reporting on TX_ML functional * Data quality improved * Data collection tools duplicated and disseminated	Yes	* EMR functional on 100% sites * DHIS2 version 2.33 functional * Comprehensive and quality TX_ML data available * Data quality improved * No stock out of updated data collection tools at 100% sites	1) a) DHIS2 upgraded to version 2.36 by December 2022. 100% staff working on DHIS2 on version 2.36 trained by March 2023 b) Two security certificates installed for DHIS2 system maintenance by March 2023. 100% DHIS2's malfunctioning incidents resolved within 24 hours. 50% patients receive automatic SMS reminder for appointments by September 2023. c) DHIS2's GIS module functional and 100% patients receiving households visits geolocated by September 2023 d) DHIS2 and Open ELIS interoperable by September 2023 2) Ministry of Defense's HIS Central Department equipped based on IT need assessment by March 2023 3) Data collection tools duplicated and disseminated to 100% military sites by September 2023 4) 100% Ministry of Defense's new HIS Central Department staff trained in M&E by September 2023	1) a) Availability and functionality of DHIS2 version 2.36 on the Ministry of Defense' server. Proportion of staff working on DHIS2 trained. b) Number of security certificates installed. Proportion of DHIS2's malfunctioning incidents resolved within 24 hours. Proportion of patients receiving automatic SMS reminders c) Proportion of patients receiving households visits geolocated and geolocation information attached to their EMR in DHIS2. Number of service providers trained to enter patients' geolocation data in DHIS2 d) Number of IT devices supplied to the Ministry of Defense's HIS Central Department 3) Number of data collection tools duplicated. Proportion of sites with no stock out of data collection tools 4) Proportion of Ministry of Defense's new HIS Central Department staff trained in M&E.	Yes	The MILSID2021 score is 7.01
$107,500	ASP: HMIS, surveillance, & research-NSD	Priority Pops: Military & other uniformed services	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	The Ministry of Defense of Cote d'Ivoire is able to prevent HIV retesting for HIV positive people and duplication of patients on ART in collaboration with the national database using the UPID system	Lack of Financial Resources			1) Finalization of diagnostic and analyses of the environment specific needs 2) Conception and deployment of the unique patient identifier (UPI) web based application with interoperability with DHIS2	COP22	COP24	N/A	N/A	Not applicable	No unique patient identifier system available in the Ministry of Defense	1) Diagnostic and analyses of the environment specific needs fully completed and report available by July 2023 2) Conception and deployment of the unique patient identifier (UPI) at 25% of military sites by September 2023	1) Report of diagnostic and analyses available 2) Report of conception and deployment available	Yes	The MILSID2021 score is 7.01 These activities address MPR #16
$36,808	ASP: Public financial management strengthening-NSD	Priority Pops: Military & other uniformed services	Domestic resource mobilization	11. Domestic Resource Mobilization	8.10	5.52	11.6 Domestic Spending: What percent of the annual national HIV response is financed with domestic public and domestic private sector HIV funding? (Domestic funding excludes out-of-pocket, Global Fund grants, and other donor resources)?	The annual HIV response in the Cote d'Ivoire Defense sector is fully financed with domestic public HIV funding	Lack of Financial Resources			1) Local responsibility workshop for short-, mid- and long-term transition of the PEPFAR-supported military program to the Ministry of Defense 2) Advocacy workshop for internal resources mobilization 3) Feasibility review of Performance-based Strategic Orders in the Defense sector's HIV program	COP22	COP25	N/A	N/A	Not applicable	1) 2022-2025 Military HIV Strategic Plan developed and budgeted 2) Technical assistance provided for HIV financial data tracking at the Ministry of Defense level 3) FY22 HIV expenditures financial report available at the Ministry of Defense.	1) One local responsibility workshop for short-, mid- and long-term transition of the PEPFAR-supported military program to the Ministry of Defense organized by March 2023. 2) One advocacy workshop for internal resources mobilization organized by June 2023. 3) One feasibility review of Performance-based Strategic Orders in the Defense sector's HIV program completed by March 2023	1) Local responsibility workshop report available 2) Advocacy report available 3) Feasibility report available	Yes	The MILSID2021 score is 3.75
$25,111	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.01	5.06	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	The national military health authorities, the leaders from the Military PLHIV-led NGO and from the Militaries' Wives led NGO have the capacity to effectively plan and manage HIV programs	Lack of managerial capacity	Lack of Financial Resources		Training of health authorities and leaders of the Ministry of Defense of Cote d'Ivoire, the Military PLHIV-led NGO and the Militaries' Wives-led NGO in HIV program management	COP22	COP22	N/A	N/A	Not applicable	Existing military health authorities and leaders of the Military PLHIV-led NGO and the Militaries' Wives-led NGO with lack in HIV program management abilities	1) Ten military health authorities trained in HIV program management by March 2023. 2) Ten leaders from the Military PLHIV-led NGO and the Military Wives-led NGO trained in HIV program management by March 2023.	1) Training report available 2) Training report available	No	The MILSID2021 score is 5.81
$1,818	ASP: Human resources for health-NSD	Priority Pops: Military & other uniformed services	HRH recruitment and retention	7. Human Resources for Health	7.66	6.09	7.7 HR Data Collection and Use: Does the country systematically collect and use health workforce data, such as through a Human Resource Information Systems (HRIS), for HIV/AIDS services and/or health workforce planning and management?	The Ministry of Defense of Cote d'Ivoire has an electronic Human Resource Information Systems (HRIS), functional and maintained for HIV/AIDS services and/or health workforce planning and management	Lack of Financial Resources	Lack of technical capacity		Maintenance and upgrade of the electronic Human Resource for Health Information Systems (HRHIS) developed and deployed in FY22	COP21	COP22	The Ministry of Defense has no budget nor technical expertise to support maintenance and upgrade of the system.	* Military Human Resources for Health Information System (MHRHIS) acquired, installed and functional. * Military staff trained on the MHRHIS use * Military HRH management policy reviewed	Not applicable	* Military Human Resources for Health Electronic Information System (MHRHIS) fully functional. * Military staff trained on the MHRHIS use * Military HRH management policy reviewed	100% staff in charge of Military Human Resources for Health Electronic Information System (MHRHIS) management trained on system updates by March 2023. 100% MHRHIS's malfunctioning incidents resolved within 72 hours by September 2023. 4 quarterly MHRHIS database quality review by September 2023.	Proportion of staff in charge of MHRHIS management trained on system updates. Proportion of malfunctioning incidents resolved within 24 hours. Number of quarterly MHRHIS database quality review conducted.	No	The MILSID2021 score is 3.61
$180,000	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.01	5.06	3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	Strengthened quality KP programming by providing technical assistance to KP local partners, supporting them in program and project management, implementation of KP targeted community activities, build administrative and financial capacity, share best practices for monitoring and evaluation to collect and analyze results, reach targets and get overall expected results for all KP indicators;	Lack of managerial capacity	Lack of technical capacity	Legal, policy or regulatory constraint	To strengthen quality of KP programing: 1) Improve and support project management, planning and delivery through the development and dissemination of Program Management standards, processes, management tools, and learning solutions using local experience and cross-learning exchanges. 2) Provide programmatic, financial and monitoring and evaluation technical assistance to KP Local Partners (CSO), strengthen their programmatic and administrative capacity promoting KP led HIV community service delivery. 3)Promote and support technical and PM quality and knowledge-sharing among partners what they do well; scale-up, what they do need improvement on, close coaching/mentoring in order to get there; what they are not good at, seek for additional support or find other ways to get going; 4) Provide PM technical assistance and short-term support to staff and project teams (through Daily Situation Room Meeting where data are analyzed on a daily basis and motivate them to go further using the granular data analysis, coaching on specific item such as Finance, Direct Costs vs. Indirect Costs, support their policies and trainings, capacity building virtual and in person, bring TDYers to train them EPIC will share best practices through virtual training, ready-to-teach training materials on all key technical interventions and approaches, cross-learning from partners who do well, Partner presentation of their results, key challenges, recommendations, and way forward using local experience and local solutions. Training will be provided to the local partners, both virtual and in person trainings. Epic will monitor CSOs progress towards becoming self-sufficient through assessments before, during, and after the trainings, reviewing work plans and remediation plans developed by the local partners, follow-up of SIMS visits, RDQA, DQA and Finance reviews.	COP21	COP24	Financial resources and technical capacity building are needed to progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses. PLL, Structural barriers for KP: COP 22 plans should prioritize and	Capacity Development of 2 KP local partners. Financial and programmatic assistance is currently done through coaching on the preparation of budgets, financial reports and verification of financial data as well as work plans, monitoring and evaluation and data collection on a quarterly basis. Specific steps to address CSOs program and administrative management skills to provide KP-led and KP-competent differentiated HIV services.	Partial	KP CSOs working as prime partners of USAID, managing USG funds and implementing KP community services, decreasing the impact of the structural barriers that limit KP differentiated HIV services.	Quality of KP services programming by the 2 local Partners (CSOs) improved; management tools in place timely reporting with improved quality, Local partners achieve good results on KP indicators;	Monthly Supervision Weekly data meeting Quarterly site visit regular Meeting /coaching to share best practices Monthly Report analysis; Routine evaluation of Local Partner's programmatic and financial performance	Yes	Support will be phased out progressively as the CSOs increase their capacity of managing the HIV services they are providing and have solid institutional management procedures working.
$750,963	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	6.34	6.76	8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all sectors? Select only ONE answer.	Commodity stock management and transparency challenges to program delivery decrease leading to decreased with risks to viral load reagent and ARV security. Timely procurement, maintenance, and service level agreement support for commodities. Site-level stock availability and adequate management. More reliable procurement forecasting contributing to the common basket approach. Strengthened capacity of local partner.	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Support PEPFAR-supported health districts to routinely collect, review and provide feedback on logistics data, and take appropriate actions to address stock imbalances. Support the scale of optimized treatments, specifically TLD and other DTG-based regimens for adults and pediatrics. Support PPMR-HIV, TLD and MMD data collection, in compliance with PEPFAR data requirements, to inform data driven decision making. Reinforce the existing eLMIS tool for a more robust data visibility system, including supporting interoperability with mSupply. Improve the logistics data analysis and visualization system for decision-making. Improve the inventory management system at NPSP to reduce stockout risks.	COP19	Post COP25	Continue strengthening the national pharmacy (NPSP), local partner, up to international standards.	Improve data visibility. Increased ownership and improved management of national supply chain with reduced stockouts and faster response to emergency situations.	Partial	Stockouts reported at site level. Currently 10% of stockouts at national level. NPSP faces space limitations to receive the volume of orders for the national supply chain, being the only institution warehousing health commodities for all country. NPSP does not have enough HRH to sustain continuous supply chain management operations during physical inventories and while entering stock data on new deliveries. NPSP faces financial challenges due to the payment system used by the GoCI - which led to a current debt of approximately 21 million USD to the NPSP;	NPSP has staff members assigned to keep basic operations (incoming orders and outgoing deliveries) during physical inventories. Decreased intervention and technical assistance of USAID Supply Chain advisors in national supply chain problem solving - meaning stronger local partner, the NPSP. Increased domestic funding for commodities procured through NPSP. (Response to question: Under this agreement, NPSP continues efforts for domestic resource mobilization - NPSP has a contract with MoH and is the entity responsible for procurement and distribution to the regional level of all medical commodities in country (including USG procured commodities). NPSP is part of the voices advocating with GoCI for an increased domestic (GoCI) investment on health commodities - this common effort has led to increased contributions by GoCI to the commodities landscape which allowed PEPFAR to slowly reduce its proportional contributions over the past 10 years.) Reduce the level of national stockouts to 5%. Continue increasing data visibility.	(a) Monthly reports (TLD, MMD, PPMR-HIV, Stock review) (b) Quarterly, Semi-Annual and Annual reports (c) Site visits (d) Tools available (e) monitor reports by clinical partners on stock risks, stockouts and/or expiration;	Yes	Progressive phasing out of support as local partner becomes more autonomy.
$281,250	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	6.34	6.76	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Reduced risks for commodity stock management to critical items specifically viral load reagents and ARV security. Improved commodity stock management and transparency: weakness has presented challenges to program delivery, Improved site-level stock availability and management; 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. Overcome delays in scale up in TB/HIV treatment and TB preventative therapy and policy barriers to implementation of PrEP in all target populations. Additional financial resources and related training, human resources, necessary to successfully establish across all sites.	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	Sustaining LMD strategic recommendations from COP21 pilot: - sustain activities in 43 Health Facilities in the 3 Health Districts from COP21. Provide strategic advisory guidance on design of last mile delivery model to NPSP and DAP at a national level including ongoing routine meetings with key stakeholders, including workshops and associated costs, to gain buy-in and alignment at national, regional and district levels. Refine national strategy for order management, inventory management, and performance management processes using private sector best practices: requires routine check-ins with NPSP/DAP and other implementing partners, including workshops to develop and share refined strategies and gain alignment, including regional and district level delegates (associated travel and other workshops related costs). Develop national scale up plan with NPSP and DAP to leverage existing infrastructure to enable scale up of agreed last mile delivery model: ongoing routine meetings with key stakeholders, this activity could also includes workshops and associated costs to gain buy-in and alignment at national, regional and district levels. Special emphasis will be placed on building performance capacity of the PGP's, training up to 30 PGPs (figure subject to change based on current reality on the ground) Build capacity of the DAP, NPSP and other above-site personnel required to enable optimal performance of the last mile delivery model This activity will require the role out of trainings to personnel. PLM will focus on leveraging existing resources and infrastructure for the trainings. Assuming around 5 (an estimate at this time) above site personnel per district, PLM estimates training around 30 above-site personnel.	COP21	Post COP25	As highlighted in our PLL, site level stockouts represent a significant risk to the PEPFAR program in CdI. Support the country extending the best practices and training of health facilities on the model that will be implemented through PLM in COP21 to other districts is key to develop capacity at both central and site levels. The activities implemented in COP21 in 3 Health Districts (43 health facilities) will be sustained by PLM.	Pilot model for site level stock and inventory management completed and best practices acquired by the DAP and NPSP will be available to the country to share and implement in other HD.	Partial	Improved stock and inventory management in 3 HD (43 HF). Best practices will become available to be shared and implemented by the MoH in the different HD with the above site technical and logistical coordination between DAP, NPSP, the PNLS and the Health Districts.	Best practices in order and inventory management national procedures, from central to district level and vice-versa, with improved coordination through the health pyramid.	(a) Monthly stock inventory) (b) Site visits (c) Tools available (d) Monthly reports (TLD, MMD, PPMR-HIV, Stock review) (e) Quarterly, Semi-Annual and Annual reports Commodities availability at facilities. Proper and timely inventory management and orders at site level; Documentation of stock-outs;		To support MoH extending to all HD and improve site level stock and inventory management nationwide.
$60,000	ASP: Laws, regulations & policy environment-NSD	Females: Young women & adolescent females	Information and sensitization for public and government officials	5. Public Access to Information	7.11	5.33	N/A	Improve PrEP scale-up. Decrease policy and implementation barriers that create significant challenges to offering PrEP and acceptance by populations whom could benefit from this prevention intervention. PrEP new achievement was 33% and - PLL guidance to demand creation strategies and materials to normalize PrEP.	Legal, policy or regulatory constraint	Lack of technical capacity		During COP 21, AIMAS has developed PrEP material for demand creation for AGYW (video capsule, sketch audio, posters and pamphlets) and will hand them over to PNLS. In COP 22, BA will ensure/follow up on the use of the communication tools during project implementation with AGYW in DREAMS districts. In that regards, BA will: Train DREAMS IPS on the use of these communication tools in collaboration with PNLS Organize 6 Coaching session for DREAMS IPs' on the use of PrEP demand creation materials during DREAMS session Coordination meeting with DREAMS IPs to follow-up on tools dissemination and PrEP uptake. 2 Joint supervisions (every 6 months) on demand creation activities and identification of Issues and best practices Conduct focus group to assess behavior change after 10 months of roll out.	COP22	COP24	Not Applicable	Under COP21, some activities under another IP have improved PrEP uptake from 29% to 33%.	Not applicable	PrEP current achievement 33%.	Increased PrEP demand Creation among AGYW leading to a 15% increase in PrEP uptake.	Proportion of AGYW who adopt PrEP availability and use of materials; recommendations from supervisions and documented best practices shared behavior change assessment results Quarterly Reports	No	
$125,000	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Information and sensitization for public and government officials	5. Public Access to Information	7.11	5.33	N/A		Legal, policy or regulatory constraint	Lack of technical capacity		Tools used for demand creation at the national level is not adapted to KPs. BA, will develop messages and tools to increase PrEP uptake and adherence among KPs. (These are not the same activities as above for AGYW. For KP BA will develop messages and tools to increase PrEP uptake and adherence among KPs, currently to the tools used for demand creation at the national level are not adapted to KPs. Conduct an rapid assessment to evaluate the level of acceptability and use of PrEP among KPs Focus group with FSW and MSM to undertake conception of messages 2 workshops of 3 days for the conception of specific messages for KP for demand creation among FSW, MSM Production of maquettes/Pre test of messages and materials Production and Dissemination of SBCC materials and tools ($60 K) (Pamphlets, IT materials, social media…) Orientation of KPs' IPs on demand creation tools elaborated. Join supervision of demand creation activities and identification of Issues and best practices conduct follow-up assessment on behavior change after 10 months of roll out.	COP22	COP24	Not Applicable	Under COP21, some activities under another IP have improved PrEP uptake from 29% to 33%.	Not applicable	PrEP current achievement 33%.	Increased PrEP demand creation among KP, leading to a 15% increase in PrEP uptake.. Note: Both for KP and AGYW we expect same level of increase in uptake, but not because the activities are the same - demand creation activities will be specific for each population, and different. At this point in country the uptake of PrEP is still low and with disseminating specific AGWY messages, and developing and using KP specific messages we estimate an equivalent increase in uptake in both populations)	Proportion of KPs who adopt PrEP demand creation messages and SBCC materials available; behavior change assessment results available Best practices and issues documented and shared	No	
$325,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Vital registration systems	17. Data for Decision-Making Ecosystem	4.00	5.00	17.3 Interoperability of National Administrative Data: To fully utilize all administrative data, are HIV/AIDS data and other relevant administrative data sources integrated in a data warehouse where they are joined for analysis across diseases and conditions?	Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Lack of technical capacity	Lack of sufficient HRH		1. Migration of OVC/DREAMS database systems to newly developed OpenMRS platform and transition to PNOEV: 2. Support full migration of OVC/DREAMS database systems to newly developed OpenMRS platform 3. Complete historical data migration to new platform 4. Support full deployment and use of the new platform for social centers, local NGOs and DREAMS implementing partners. 5. Capacity building for users of the database systems, system administrators on maintenance of the new platform and network security within the datacenter 6. Support to the datacenter and Internet Connectivity for Social Centers during transitional phase	COP20	COP22	Complete the transition. Challenges during COP21 implementation, including the hiring of staff with the technical profile to manage the database, led to the need to continue/finalize this intervention's transition in COP22.	Increased accessibility of the DREAMS and OVC systems, facilitating PEPFAR partners and MFPES use; Increased capacity of stakeholders to use the OVC/DREAMS databases for monitoring and evaluation, promote and support data analysis; OVC/DREAMS primary tools developed and disseminated	Partial	System transition to PNOEV has begun. Database and server housed at PNOEV and operational.	Complete full migration of the two databases (OVC and DREAMs) in the new enhanced and unique OVC/DREAMS database and transition to PNOEV; Finalization (Technical Assistance) of the deployment at all social centers and eligible IPs; Design and implementation of a helpdesk for the new OVC/DREAMS database;	% of social centers reporting trough OVC & DREAMS Platforms on time; Accurate reporting on OVC and DREAMS packages; AGYW_PREV disaggregates. Percent of social centers reporting through OVC and DREAMS platforms	No	
$800,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	9.50	8.50	1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	Strong engagement of MOH at the central and decentralized-level in program oversight and monitoring through regular coordination and data review meetings and supervision will result in increased accountability of site staff toward reaching program targets or outcomes % of patients on TLD % of patients on 6MMD % of patients TPT % of clients on PrEP Linkage proxy Retention proxy	Lack of Financial Resources			1) DGS to organize high-level monthly meetings with PNLS, PEPFAR team, UNAIDS, WHO, GF to advance policies and address emerging national level HIV program challenges (a) 2) DGS and PNLS to hold monthly review of district-level performance with Regional Health Directors, bilateral and multilateral partners and CSOs (based on WETMOT, SIMS, GSM data). Agenda will include policies, quality initiatives, underserved beneficiaries; followed by collective decision to address specific gaps (a) 3) Following each POART, the DGS and PNLS will convene a meeting with PEPFAR and Implementing Partners to review program performance and decide on corrective measures to address challenges/gaps (a) 4) Each Regional Health Director to hold quarterly data review by Regional AIDS Committees (CRLS) including decentralized governments, préfets, mayors, community leaders, CSOs; discussion of progress/impact of policy implementation and collective decision to address key challenges (TB, stigma and discrimination, LTFU, GBV, nutrition of PLHIV, etc.) (b) 5) Targeted district- and site-level mentorship visits by Regional Health Directors, to address critical performance gaps and monitor best practice replication. (a) 6) District Health Management Team (DHMT) to actively track district-level progress using the framework metrics, district level roadmaps and conduct quarterly supervision/coaching (a) 7) Quarterly supervision by Inspector General office to monitor implementation of key policies and provide hands-on support to district health officers on HRH and other administrative challenges (b) 8) DGS to ensure effective implementation of community-facility MOU as well as involvement of CSO in addressing emerging challenges, through periodic reinforcement and/or problem solving site visits (a) 9) PNLS to conduct periodic data reviews to monitor the impact of community-level HIV/AIDS message dissemination on uptake of services across the clinical cascade as well as ANC attendance (a) 10) In order to ensure sustainability of quality assurance and Continuous Quality Improvement (CQI) approaches, the MOH will revise and integrate CQI into central, regional and district level supervision and data reviews (b)	COP19	COP24	Continuous need for strong and systematic engagement of MOH at the central and decentralized levels in program oversight and monitoring, including through regular coordination and data review meetings and supervision	Strong engagement of MOH at the central and decentralized-level in program oversight and monitoring through regular coordination and data review meetings and supervision will result in increased accountability of site staff toward reaching program targets or outcomes: at least 90 % of patients on TLD at least 90 % of patients on 6MMD 220,730 patients on TPT 1,053 clients on PrEP Linkage proxy= 95% Retention proxy = 98%	Yes	Strong engagement of MOH at the central and decentralized-level in program oversight and monitoring through regular coordination and data review meetings and supervision will result in increased accountability of site staff toward reaching program targets or outcomes: at least 90 % of patients on TLD at least 90 % of patients on 6MMD 220,730 patients on TPT 1,053 clients on PrEP Linkage proxy= 95% Retention proxy = 98%	Strong engagement of MOH at central and decentralized levels in program oversight and monitoring through regular coordination and data review meetings and supervision, as demonstrated by the regular organization of planned meetings with documentation of key decisions and follow-up plans	National HIV reports; National policies and guidelines; Supervision reports; Periodic DQA reports	Yes	

Table 6-E (continued)

Table 6-E (Entry of Above Site Programs Activities)
Please note that for this tab to function properly, data must have already been pasted in the FAST-P tab.

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	SID component the activity is expected to impact	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	Barrier to Local Responsibility this activity addresses-2 (optional)	Barrier to Local Responsibility this activity addresses-3 (optional)	COP22 Activity Description	Intervention Start	Intervention End	If ongoing from a previous year, please provide rationale for continued spending	Benchmark from COP21 (if activity existed in COP21)	Met benchmark past 2 years?	COP22 Baseline	COP22 Benchmark	Indicator/Measurement Tool	Will the activity be continued once all benchmarks have been achieved?	Notes
$200,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	7.56	7.59	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (if exact or approximate percentage known, please note in Comments column)	Ensure the quality of lab tests performed (VL, HIV tests, CD4…) and that accurate results are given to patients	It is not included in local HIV response plans	It is not included in local HIV response plans	It is not included in local HIV response plans	Coordination of lab activities and Continuous quality improvement implementation on 200 Sites. Remaining sites to be covered by Global Fund	COP18	COP25	We need to ensure continuous quality of lab tests performed (VL, HIV tests, CD4…) and that accurate results are given to patients, at PEPFAR supported sites	100% of supported laboratories received PT Panel and 03 Viral Load laboratories were accredited	Partial	Laboratories : PT Panel : 170/200 enrolled, 140 participated and 121 passed 1VL laboratory accredited over 6 Audited POCT HIV testing: PT Panel 2235 Clinical POCT and 396 Community POCT participated, 1674 clinical and 362 community participated and 1658 clinical and 343 community passed 1131 POCT HIV certified 450 Testers certified	Laboratories 200 Laboratories enrolled , participate and pass the PT panel program 4 Laboratories accredited over 6 Audited POCT HIV testing : 2000 POCT enrolled, participate and pass the PT panel program 1131 POCT maintained certificate 450 testers maintained certificate	MER Indicators	Yes	Continuous quality improvement must be maintained even beyond achievement of all benchmarks
$200,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	7.66	6.09	7.8 Management and Monitoring of Health Workforce Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for health workforce activities in HIV service delivery sites, including training, supervision, deployments, quality assurance, and others across all sectors. Select only ONE answer.	Improved program performance	Lack of Financial Resources			HR: Continue providing support the following key positions: -HIV/AIDS Senior Advisor (DGS), -3 Data manager at DGS, PNLS and DIIS) Support MOH in the implementation of "Initiative d'Achat Strategique" (IAS): Implementation of IAS at selected priority sites to cover critical gaps: case finding, retention and viral load suppression for adolescents and children; case finding for men and women; retention of young adults	COP19	COP24	Continued need for HR at central level for data monitoring and effective coordination of the national response; Delayed implementation of IAS which only began in COP 21	HRH: 1 Senior HIV Advisor and 5 Data Managers contracted and located at MOH/DGS; IAS (performance-based incentive) implemented at selected priority sites in 3 health regions	Partial	HRH: 1 Senior HIV Advisor and 5 Data Managers contracted and located at MOH/DGS; IAS (performance-based incentive) implemented at selected priority sites in 3 health regions	HRH: 1 Senior HIV Advisor and 5 Data Managers contracted and located at MOH/DGS; IAS (performance-based incentive) implemented at selected priority sites in 8 health regions	HR: numbers of contracts renewals; IAS: number of Health regions and priority sites implementing IAS	Yes	Adequate staffing of MOH/DGS will help improve the monitoring of Regional Health authorities in service quality improvement and data monitoring for decision making. IAS incentive scheme will help address HRH challenges and result in improved quality and program achievements across the clinical cascade
$420,264	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	MOH technical capacity on HMIS systems is strengthened and they effectively supervise implementation of existing HMIS systems and development and rollout of new systems.	Lack of Financial Resources	Lack of technical capacity		-Maintenance, administration fees and internet connection for the SIGDEP 3.0 consolidated central database; -Maintenance and resting AWS server for 12 months for the UPID system; -Maintenance of PESP/CommCare system; -Provide oversight on interoperability process between OpenLIS and SIGDEP 3.0 consolidated central database; -Development of SIGDEP 3.0 new interface using OpenMRS core module; -Development of the SIGDEP 3.0 Consolidated Central Database; -Start data collection and reporting tools digitalization process; -Support MOH/DIIS/PNLS routine activities to improve data quality and date use; -Supervision of Patient Identify Management (PIM) system development	Prior to COP 18	COP23	Development and maintenance of adequate health information systems is critical to support program service delivery and monitor performance against targets with quality data (completeness, consistency, data integrity, timeliness, deduplicated). This activity supports the availability and use of national data collection tools and reporting forms; availability and use of an EMR aligned with current tools and reporting requirements as well as interoperable with eLIS; availability of use of the UPID Solution identified by MoH to manage unique patients across HIS; and implements routine data quality activities	MOH technical capacity on HMIS systems is strengthened and they effectively supervise implementation of existing HMIS systems and development and rollout of new systems.	Yes	MOH technical capacity on HMIS systems is strengthened and they effectively supervise implementation of existing HMIS systems and development and rollout of new systems.	MOH technical capacity on HMIS systems is strengthened and they effectively supervise implementation of existing HMIS systems and development and rollout of new systems.	Activity will be coordinated with MoH through the National HIS TWG including CDC, USAID, clinical Ips, Global Funds, WHO, UNAIDS, NPSP. Activity will be tracked and monitored through HIS TWG sessions and workshop reports, availability of Patient Identity Management listings, availability of data security and confidentiality policy and SOPs	Yes	
$100,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy (or a national surveillance and survey strategy with specifics for HIV)?	Timeliness of Epi and surveillance data Access and use of data for decision making	Lack of technical capacity			-Provide technical assistance to MOH to develop accurate national and sub national HIV estimates for COP23 and national HIV plans -Continue the improvement and expanding the use of the Situation Room for decision making at all levels of the health pyramid	Prior to COP 18	COP24	National HIV estimates are conducted on annual basis	-Development of annual 2021 HIV estimates; -Use of Situation Room to monitor the performance of programs against 95-95-95 targets		Availability of national HIV estimates for 2021 Availability of Situation Room reports on program performance against 95-95-95 targets	Development of annual 2022 HIV estimates; Situation Room used by National program to monitor performance and progress towards National targets of achieving 95-95-95 by 2030 (Initial Spectrum 2022 estimates for 2021: 80-97-84)	National HIV estimates reports; Periodic Situation Room reports	Yes	National HIV estimates are required every year for program planning
$53,511	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Civil society engagement	3. Civil Society Engagement	7.50	7.50	3.3 Impact of Civil Society Engagement: Does civil society engagement substantively impact policy, programming, and budget decisions related to HIV/AIDS?	Access and use of data for decision making	Legal, policy or regulatory constraint			-Continue support to CLM above sites activities (-Build the advocacy and engagement capacity of key CLM stakeholders -Conduct district level accountability meetings to present and discuss barriers and challenges of service delivery and quality -Support the organization of coordination meetings between different CLM stakeholders to strengthen the synergy between CLM initiatives supported by various partners	COP19	COP24	Continuous need for improved coordination and strong CSO engagement in the national HIV/AIDS response	Provide funding to 2 to 3 CSOs in key districts to monitor access to HIV prevention and treatment services for key populations and PLHIV; Build advocacy and engagement capacity of key CLM stakeholders ; Conduct district-level accountability meeting to present and discuss barriers and challenges of service delivery and quality; Provide TA to the MOH in the definition of key CLM indicators and develop and dashboard	Partial	Funding provided to 2 to 3 CSOs in key districts to monitor access to HIV prevention and treatment services for key populations and PLHIV; Improved advocacy and engagement capacity of key CLM stakeholders; District-level accountability meetings held to present and discuss barriers and challenges of service delivery and quality; Provision of TA to the MOH in the definition of key CLM indicators and develop and dashboard	•Build the advocacy and engagement capacity of key CLM stakeholders •Conduct district level accountability meetings to present and discuss barriers and challenges of service delivery and quality •Support the organization of coordination meetings between different CLM stakeholders to strengthen the synergy between CLM initiatives supported by various partners •Collect data at PEPFAR supported sites, conduct analysis, triangulate, and capture actionable insights about equity, stigma and discrimination for KP, PLHIV, and other vulnerable population •Disseminate findings, agree upon corrective action and advocate for change in policies and practices to improve equity, reduce stigma and discrimination and promote human rights to improve treatment outcomes for KP, PLHIV and other vulnerable populations •Support the functioning of the dashboard to track and publish the state of service delivery	Number of small grants to CSOs; Dashboard reports; Coordination meeting reports	Yes	
$586,267	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.7 Comprehensiveness of Viral Load Data: To what extent does the host country government collect/report viral load data according to relevant disaggregations and across all PLHIV? (if exact or approximate percentage known, please note in Comments column)	The TB program will give us accurate data for TB test perform on sites with Genexpert to monitor the TB algorithm used on sites and reduce mortality The interoperability of the LIS with EMR will improve real time data and lab result access by clinician, improve the lab result TAT, improve data quality including deduplication of patients Increased VL and LIS data available for monitoring and program goal achievement at site, district, and central levels Improved pediatric clinical cascade outcomes: Index testing, Retention, VL coverage, VL suppression	Lack of Financial Resources			-Include TB data in OPENLIS to produce TB report for decision making and to reduce sample TAT -Implement required annual security upgrade of the Laboratory Information System (OpenELIS) to comply with international guidelines to enable a secure access to the system and protect patient records -Connect OpenELIS with POC machines for VL, EID, and TB and with Abbott system -Upgrade the PCM Tool to a web-based format to cover all peds focused sites and routine maintenance -Provide informatic support for SMS notifications to patients with unsuppressed viral load -IT materials maintenance	COP19	COP25		-Establish interoperability between OPENLIS and SIDGEP, pilot at two clinical sites; -Implement VL results by SMS for 3000 patients at high impact PEFAR supported sites	Yes	-Establish interoperability between OPENLIS and SIDGEP, pilot at two clinical sites; -Implement VL results by SMS for 3000 patients at high impact PEFAR supported sites	-Interoperability between OPENLIS and SIGDEP3 extended at all high impact sites -SMS Notification to 3500 patients/month from 18 VL laboratories -OPENLIS connectivity established with 60 POC EID/VL and 27 TB laboratories -PCM Tool upgraded for email and SMS alert, MER indicator to integrate	Number of clinical sites with interconnectivity between SIGDEP and OPENLIS; Number of patients effectively receiving SMS notification for VL results per month; Number of site data POC EID Viral and TB integrated into the OPENLIS database; Number of email and SMS alerts received at pediatric clinical and community sites per month;	Yes	The level of funding was not sufficient to implement the activity in the number of PEPFAR supported sites. So implementation will be done in a phased approach in 3 more years. After benchmarks have been met, PEPFAR support will focus on maintenance and modernization of systems.
$130,000	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab policy, budgets, and strategic plans	10. Laboratory	7.56	7.59	10.5 Viral Load Infrastructure: Does the host country have sufficient infrastructure to test for viral load to reach sustained epidemic control?	DNO: Barriers to Laboratory optimization are identified and addressed, including policies, sample transportation system, equipment, human resources, etc. Policies and guidelines are developed	Lack of Financial Resources	Legal, policy or regulatory constraint		DNO: Support MOH in the implementation of short-, medium, and long-term recommendations of DNO results. Develop policies and guidelines	COP21	COP22		Baseline assessment of the laboratory network (VL, CD4, etc.) including equipment, human resources and infrastructure	Yes	Identification of preferred DNO scenarios and operational plans for their implementation : the following activities are implemented 1-Refine and rerun scenarios based on stakeholders feedback on priorities, and practical feasibility 2-Prepare implementation plan for selected outputs including activities, timelines, resources and responsibilities	• Implementation of a Recommended DNO model to improve coordination, timeliness and reduce costs by consolidating various routes into one integrated system and ensuring consistent service to each location • Integrated sample transportation to be incorporated into the existing MOH structures using an adequate approach, managed through MOH structures movement to optimize efficiencies	Adequate number of VL laboratories	No	Successful implementation of DNO will largely depend on MOH engagement and proactiveness in adopting and enforcing policies and other regulatory measures
$550,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	5.62	7.00	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau/s, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	National Patient Identify Management system, capable of routinely deduplicating and managing unique patient IDs MOH capacity to maintain and supervise implementation of system Initial small scale rollout of system at 10 sites System deployed to all 172 high impact sites Master patient list for patients across all high impact	Lack of Financial Resources	Lack of technical capacity		-Small-scale (10 sites) deployment of the system, including: installation, training and coaching of users, evaluation, joint supervision of deployment with MSHP/DIIS, establish help desk, address bugs and implement improvements to system suggested by users following initial rollout, develop plan for additional deployment -Hosting of the system -Maintenance and support of the system -Train MSHP to manage / administrate / support the system -Implement data exchange between the Patient Identity Management system (SIGDEP3.0, UPID, OpenELIS) and assess the possibility to use a Health Information Exchange (HIE) architecture to support these data exchange and with other systems	COP21	COP23		Establishment of Patient Identity Management system based on standards	Not applicable	Establishment of Patient Identity Management system based on standards	National Patient Identify Management system deployed at 10 initial sites and capable of deduplication and managing unique IDs MOH capacity to maintain and supervise implementation of system	Activity will be coordinated with MSHP through the National HMIS TWG including CDC, USAID, Clinical IPs, Global Fund, WHO, UNAIDS, NPSP. Activity will be tracked and monitored through HMIS TWG sessions and workshop reports, availability of Patient Identity Management listings, availability of data security and confidentiality policy and SOPs	No	Rationale for continuing spending: To begin effective rollout of deduplication of patient records at the site level.
$250,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	OVC: Not disaggregated	National strategic plans, operational plans and budgets	1. Planning and Coordination	9.50	8.50	1.3 Coordination of National HIV Implementation: To what extent does the host country government coordinate all HIV/AIDS activities implemented in the country, including those funded or implemented by CSOs, private sector, and donor implementing partners?	OVC support, HIV prevention for adolescent girls and young women (AGYW), and GBV national reference policy documents aligned with the latest internationally recognized policies and guidelines toward the control of the HIV epidemic including the national response plan for VACS. Improved quality of OVC, HIV prevention, DREAMS, and GBV services through supervision; Improved coordination of OVC, HIV prevention, DREAMS, and GBV services with key stakeholders .	Lack of Financial Resources			1. Align OVC support, HIV prevention for adolescent girls and young women (AGYW), and GBV national reference policy documents with the latest internationally recognized policies and guidelines toward the control of the HIV epidemic including the national response plan for VACS. 2. Conduct routine supervision of OVC, HIV prevention, DREAMS, and GBV services to ensure that they are aligned with national standards and monitor CQI activities. 3. Support quarterly coordination meetings to improve OVC, HIV prevention, DREAMS, and GBV services with key stakeholders . 4. Support key positions for the management of the CoAg	COP22	Post COP25		N/A	Not applicable	Activity starting in COP 22	OVC support, HIV prevention for adolescent girls and young women (AGYW), and GBV national reference policy documents aligned with the latest internationally recognized policies and guidelines toward the control of the HIV epidemic including the national response plan for VACS. Improved quality of OVC, HIV prevention, DREAMS, and GBV services through supervision; Improved coordination of OVC, HIV prevention, DREAMS, and GBV services with key stakeholders .	National OVC, HIV prevention, DREAMS, and GBV policies and guidelines; National reports on OVC, HIV prevention, DREAMS, and GBV services	Yes	
$300,000	ASP: HMIS, surveillance, & research-NSD	Females: Young women & adolescent females	Program and data quality management	16. Performance Data	5.90	8.00	16.3 Comprehensiveness of Service Delivery Data: To what extent does the host country government collect HIV/AIDS service delivery data by population, program and geographic area? (Note: Full score possible without selecting all disaggregates.)	II. Monitoring and evaluation 1. Analyze the current data/activities to evaluate the effectiveness, efficiency and coherence, of OVC, DREAMS, and GBV activities to inform the development of policy and system . 2. Strengthen national OVC/DREAMS/GBV M&E system a) Develop/Revise M&E procedures for OVC, DREAMS, and GBV programs. b) Print and disseminate national data collection and reporting tools for OVC, DREAMS, and GBV programs. c) Strengthen the capacity of M&E staff at the district level including the platform within the social centers (training/capacity building to monitor program implementation) d) Conduct DQA and supervision to improve OVC, DREAMS, and GBV data quality 3. OVC/DREAMS database: a) Support the transition of the database from DataFI to the MFFE b) Support improvement and maintenance of the OVC/DREAMS database after the transition.	Lack of Financial Resources			-Maintenance of the system (server room, applications, power supply, day to day administration of the system, -Purchase strong firewalls to ensure security of the system (12 months license) -Organization of workshops for the development of security and confidentiality guidelines of the system	COP22	Post COP25	N/A	N/A	Not applicable	Activity starting in COP 22	Improved accuracy of OVC, DREAMS, and GBV activities to inform the development of policy and systems; National OVC/DREAMS/GBV M&E systems strengthened M&E procedures and data collection tools for OVC, DREAMS and GBV programs are printed and disseminated; . Improved capacity of M&E staff at the district level, including the platform within the social centers ; Improved quality of OVC, DREAMS, and GBV data Effective maintenance of the OVC/DREAMS database system, including adequate security features and appropriate licensing;	National reports on OVC, HIV prevention, DREAMS, and GBV;	Yes	
$120,000	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	7. Human Resources for Health	7.66	6.09	7.5 Pre-service: Do current pre-service education curricula for any health workers providing HIV/AIDS services include HIV content that has been updated in last three years? Note: List applicable cadres in the comments column.	Accurate, up to date HIV content cascaded to nursing and midwifery training institutions; Confidence to manage HIV patients imbued in final – year students	Lack of technical capacity			Strengthened student rural clinical rotation to achieve 95-95-95; Specialized health professionals to strengthen health service delivery in high volume sites in Abidjan	COP22	COP23		N/A	N/A	Institutional Assessment Activity starts in COP 22	Develop a robust student rural rotation plan in the high volume sites around Abidjan and collaborate closely with training institution for medical, nursing $ Midwifery students - Numbers trained - 561 over 5 months (100-150)	- Number of students trained - Number of STRIPE modules taught - Number of students and faculty accessing and using the LMS - Number of grant reports written/ prepared and correctly submitted	Yes	TBD is for QISSEC UCSF that needs to be added as a new mechanism for COP22
$150,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	16. Performance Data	5.90	8.00	16.5 Analysis of Service Delivery Data: To what extent does the host country government routinely analyze service delivery data to measure program performance (i.e., continuum of care cascade, coverage, retention, AIDS-related mortality rates)?	Technical capacity on Health care providers improved/strengthened, reinforcement/ implementation of the current competence-based Approach(LMS) in all existing institutions.	Lack of technical capacity			Document and address policy/ site-level HRH barriers to achieving 95:95:95 targets; Strengthen the Nursing Association/Council to provide requisite regulatory services	COP22	COP25		N/A	N/A	Activity starting in COP 22	Implement protocol for evaluating the improvement of HRH barriers to achieving 95:95:95 targets; Provide ongoing technical assistance for human resources for health (HRH) HIV Capacity at the National and Provincial nursing council	Customized indicators to measure the number of cadres trained – nurses, midwives, doctors, field supervisors, medical laboratory sciences, environmental health sciences, dental therapy, pharmacy technology	Yes	This is new activity that will roll out across different institutions across the country to build the next-generation of health professionals
$63,140	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	5.62	7.00	14.10 Quality of Surveillance and Survey Data: To what extent does the host country government define and implement policies, procedures and governance structures that assure quality of HIV/AIDS surveillance and survey data?	-National recency protocol developed and pilot implemented at 10 sites; -Recency dashboard developed	Legal, policy or regulatory constraint			-Development of a national recency protocol; -Small-scale implementation at 10 sites; -Development of a recency dashboard.	COP22	COP25	N/A	N/A	Not applicable	Activity starting in COP 22	-National recency protocol developed and pilot implemented at 10 sites; -Recency dashboard developed	-Availability of national recency protocol -Recency data from the 10 sites available on the dashboard	Yes	This is a laboratory-based surveillance activity that must be implemented as a routine activity to provide key information on HIV recent infections for program decision making.
$250,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Internal controls and accounting standards	2. Policies and Governance	7.51	6.04	2.9 Rights to Access Services: Recognizing the right to nondiscriminatory access to HIV services and support, does the government have efforts in place to educate and ensure the rights of PLHIV, all epidemiologically significant key populations, and those who may access HIV services about these rights?	Strengthening Local Civil Society Organizations to voice existing challenges and barriers and facilitate HIV services delivery.	Lack of managerial capacity			Strengthen institutional and organizational performance by local entities and CSOs to improve their ability to manage HIV programs and contribute to epidemic control in a sustainable manner.	COP22	COP25			Not applicable	Not Applicable	Improved capacity of 5 local partners based on COP21 capacity development score gaps	Monthly and quarterly reports. Institutional and organizational documentation available and being used at the local partners. Quality management systems functioning at local partners.	No	Support full transition of HIV services to local partners.

SRE Tool-SaSR

COP22 Program Area	COP22 Beneficiary	COP22 Activity Budget	Activity Description	Filter Here - Select Surveillance and Research	Activity Type	Country	Award number of the implementing mechanism associated with the activity	DUNS of implementing partner responsible for the activity	Total budget planned for the activity (across all COP years)	Planned start date of data collection	Expected end date of data collection	Budget planned for the closeout year of the activity	Activity Title	Name of USG Agency POC for this activity	USG Agency POC Official email address (typically ending in .gov/.mil) of the USG Agency POC for this activity. Please do not enter personal email addresses in this field	PI Name (s)	PI Official email address (typically associated with the affiliated organization) of the principal investigator or project lead POC for this project. Please do not enter personal email addresses in this field	Primary evaluation or study questions	Activity objectives	Activity's primary study population	Additional populations studied	Planned activity sample size	Planned sampling methodology	HIV biomarkers to be assessed as part of protocol	COP or HOP funded?	Activity Start COP/FY Year	Activity End COP/FY Year	Current Stage of activity (as of COP22)	COP22 Baseline Status (major)	COP22 Baseline Status (detail)	How does this activity advance COP priorities?
ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	$ 63,140	-Development of a national recency protocol; -Small-scale implementation at 10 sites; -Development of a recency dashboard.	Surveillance	HIV recency surveillance	Cote d'Ivoire	GH2349	851746505	1180000	April 2023	September 2023	N/A	HIV Recent Infection Surveillance	Shirish Balachandra	ymx1@cdc.gov	Audrey Luxenburg	mnw0@cdc.gov	Prevalence of recent infection in high risk population and by geography	1. Monitor trends in the proportion testing recent on RITA among newly diagnosed PLHIV by select demographic and HIV risk variables. 2. Identify geographic locations associated with testing recent on the RITA to inform geographic prioritization of HIV prevention interventions.	>= 16 years, Pregnant women, and key population newly diagnosed with HIV	N/A	500-5000	TBD	TBD	COP	COP22/FY23	COP26/FY27 or after	Newly Commencing	Protocol_Scope	Under development	Programs should establish recent infection surveillance to monitor recent infections, long-term infections, as well as retesting to identify gaps in programs and inform data-driven decisions that can be more dynamic, targeted, and effective as programs reach and maintain epidemic control.

SRE Tool-Eval

There are no above-site level evaluation activities proposed for COP22.

APPENDIX D– Minimum Program Requirements

Care and Treatment	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	**Completed.** Côte d'Ivoire adopted Test and Start policy in February 2017. Currently, Test and Start is implemented in 100% of PEPFAR-supported 517 ART sites across all age, sex, and risk groups. Despite this achievement, FY22Q1 linkage rate at PEPFAR-supported sites was 94% mainly due the referral of some patients newly tested positive to non PEPFAR-supported sites for ART initiation. These patients are not accounted for in PEPFAR-reported TX_NEW number. DQA/RDQC confirmed 97% linkage considering these patients. PEPFAR will continue to monitor linkage to ART, especially for newly tested positive in the community and for high mobile populations.
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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	**In progress *(on track)*:** MoH adopted TLD policy in 2019 that was reinforced in 2020. The policy is currently implemented in 100% of 517 PEPFAR-supported ART sites. As of FY22Q1 the coverage of DTG-based regimen among females (15+), males (15+) and children were 92%, 96% and 98%, respectively. PEPFAR will continue to support efforts to increase TLD coverage for PBFW currently at 78% and in 5 of 28 PEPFAR-supported regions with a coverage <90%. This will be done by conducting high-level advocacy with MoH for TLD-favorable policy for PBFW, ongoing training/coaching of providers, sensitization of patients/women about the benefits of TLD and ensuring sufficient supply of TLD.
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	**In-progress *(acceptable progress made but needs continued significant attention to maintain progress and attain completion)***. DSDM policy was adopted in February 2017 along with Test and Start. The policy was reinforced on 15 October 2020 as part of the contingency plan to mitigate the impact of COVID-19 on HIV services recommending rapid scale-up of 6MMD (for all stable and non-stable patients) along with community distribution of ARV. As of FY22Q1, 90% of adults on ART at 516 PEPFAR-supported sites were receiving 3+MMD. despite this remarkable achievement, 8/28 PEPFAR-supported regions have MMD coverage<80%. Children <5 years old, PBFW, and patients with Advanced HIV Disease (AHD) are excluded in the current guidelines. PEPFAR will continue to support scale up of DSDM, including 6MMD among adults and children through advocacy to include populations that are currently excluded, improve site level implementation of policies/guidelines (training/coaching of providers), and ensure sufficient supply of TLD or DTG-based regimens.

Care and Treatment (continued)	
4) All eligible PLHIV, including children and adolescents, -should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	**In progress *(acceptable progress made but needs continued significant attention to maintain progress and attain completion)*:** Lot of progress was made on the policy front for TPT. TPT policy was adopted in 2017 with lot of restrictions hindering rapid scale-up. Thanks to PEPFAR advocacy, the policy was revised on February 14, 2020, allowing TPT for all PLHIV (newly and already on ART) along with updated algorithms/SOPs for TB diagnosis among PLHIV, and the development of a road map for scale-up. Despite a low uptake of TPT in FY21 (4% coverage of TX_CURR), PEPFAR implementing partners accelerated the scale up of TPT and in FY22Q1, 59% (305/516) of PEPFAR ART sites were reinforced to offer TPT, resulting in about 89,000 patients (36% of TX_CURR) who screened negative for TB being initiated on TPT. The persistent challenges are operational and include sub-optimal involvement of health care providers, insufficient drug availability (delaying enrolment of new patients on TPT), length of treatment with IHN and high tablet load for patients, lack of alignment of TPT drug dispensation and ARV, and delay in the delivery of 3-HP despite approval of this protocol since June 2021. PEPFAR will continue to address these challenges by building capacity of providers, work with MoH and the GFATM to secure enough medication to support scale up, work with MoH to update the national scale up plan and align testing guidelines with WHO latest recommendations.
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.	**In Progress *(acceptable progress made but needs continued significant attention to maintain progress and attain completion)***: Diagnostic Network Optimization (DNO) activities were on hold until COP21 funding was confirmed through ARPA funding. Since then, PEPFAR is collaborating with the Ministry of Health (MoH) and GFATM to conduct a mapping of the equipment network that will inform the development of a DNO package to be implemented in COP22. To that end a contract has already been signed with FIND to develop the DNO package.
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 should be offered testing for HIV.	**In progress *(on track)***: While the clinical cascade performance is sub-optimal for the 1st 95, and notably for males and children, PEPFAR-support HTS program has made significant progress in scaling up safe and ethical index testing and self-testing services. In FY21, 100% of sites offering index testing services were assessed for RedCap or SIMS standards for intimate partner violence (IPV) monitoring and support was provided for remediation. Despite this progress, there is insufficient coverage of index testing services among biological children of HIV-infected women and male sexual contacts of women index cases. The program is addressing these challenges by recruiting/identifying index testing champions, strengthening clinical and community interface for improved index case management, and ensuring that 100% of sites and providers comply with the safe and ethical index testing standards.

Prevention and OVC	
7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (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, key populations and adult men engaged in high-risk sex practices)	**In progress *(behind on implementation, needs major focus)*:** PrEP is currently among the top challenging interventions for PEPFAR Côte d'Ivoire. Since the adoption of PrEP policy (November 2019), the scale up of PrEP faced multiple policy and implementation barriers. Despite these challenges the performance is slowly improving. In FY22Q1, 1,349 clients were initiated on PrEP, representing 18% of FY22 target of 7,465 surpassing FY21Q1 result of 76. PrEP services are currently available in 72% (51/79) of PEPFAR-supported districts. Regarding policy barriers, the current national guidelines require baseline biological eligibility assessment (creatinine and Hepatis B surface antigen tests), limit the prescription of PrEP to trained physicians despite task-shifting policy in place since 2015, and limit the prescription of PrEP to heath care centers. With respect to implementation challenges, there is low demand creation for PrEP services at both facility and community levels due to lack of sensitization, insufficient number of providers/sites trained to offer PrEP, and weak referrals of eligible clients from the community to PrEP sites. To overcome these barriers, PEPFAR and WHO are currently supporting the MoH to align national policy with the WHO latest guidelines, including new protocols to improve retention on PrEP and de-medicalization of PrEP prescription to allow paramedical to initiate and follow patients.
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 children at risk of HIV infection, 2) facilitating linkage to treatment and 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 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	**In progress *(on track)*:** In FY21, most PEPFAR-supported districts had at least 90% enrollment of children/adolescents living with HIV (C/ALHIV) enrolled in an OVC program. Only 7/79 districts had a coverage <90% needing special attention. The program will continue to strengthen the collaboration between the clinical and OVC programs, ensure that OVC case managers systematically screen all beneficiaries for HIV testing, reinforce linkage with PMTCT program to ensure early enrolment of HIV-infected pregnant and breastfeeding adolescents, and provide family-centered care model for enrolled households with multiple PLHIV/C/ALHIV.
Policy & Public Health Systems Support	
9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.	**In progress *(behind on implementation, needs major focus)***: With a relatively low HIV prevalence, stigma and discrimination is key barriers to accessing quality HIV services to PLHIV and other vulnerable populations. The challenges include self-stigmatization of patients, stigmatization by health providers, and poor knowledge of patients' rights. COP22 has prioritized tackling stigma and discrimination (S&D) through different angles, including community-led monitoring to collect relevant data for action, build capacity of CSOs for advocacy toward policy change for enabling environment, ensure that key CSOs including, PLHIV and KP organizations are engaged in any action, and collaborate with other partners/donors to develop strategies to address S&D and promote human rights.

Policy & Public Health Systems Support (continued)	
10) 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.	**Completed:** in 2019, the MoH issued a circular not recommending free services for PLHIV in the public sector facilities. Since COP20, there had not been any report of user-fees by CSO, however, the program will continue to collect data through CLM and/or other systems to ensure that free policies are implemented with fidelity.
11) OUs assure program and site standards, including infection prevention & control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.	**In progress *(on track)*:** QA/CQI is core program for PEPFAR Côte d'Ivoire. A few challenges exist at the national and decentralized levels, including remobilization of national QI TWG, ensuing functioning of site-level QI teams, improve documentation of data collection tools, improve M&E processes for both facility and community activities, provide support to improve site-level analysis for data-driven decision, and improve quality of district-level facility and community data. Best practices to address specific challenges such as on viral load suppression are being scale up nationwide.
12) Evidence of treatment literacy 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.	**In progress *(on track)*:** The National AIDS Control Program (PNLS) is continuing to support treatment and viral load literacy activities for PLHIV and health care providers along, including dissemination of messages around U=U. The treatment adherence and viral load counseling materials have been aligned to the ICAP-developed U=U toolkits for adults, adolescents, and children. These messages are disseminated to the public using various channels (radio, TV, billboard). As part of FCI project, PEPFAR supported the development of new "messages of hope" that highlight the benefits of treatment. These messages are being disseminated through the religious organization networks to help reduce stigma around HIV and improve adherence on treatment to achieve viral load suppression.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	**In progress *(on track)***: PEPFAR Côte d'Ivoire continues to make progress toward provide local partner direct funding, including funding to KP-led and women-led organizations in support of Global AIDS strategy targets related to community-KP and women-led responses. From COP19 to COP21, the percentage of PEPFAR budget allocated to local indigenous partners increased from 42% to 54% for CDC and 6% to 14% for USAID. While CDC has primarily funded general population local indigenous organizations, USAID focused on KP-led organizations. The trend will be sustained in COP22 and future planning.

Policy & Public Health Systems Support (continued)	
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	**In progress *(on track)*:** While GoCI has increased its contribution to the purchase of ARVs, OI drugs and commodities over time reaching 62% and 44% of the total contribution, respectively in COP21, the SID21 shows that domestic resource mobilization to assume greater responsibility of the HIV response remains a challenge as scored in yellow on the dashboard. Therefore, advocacy for increased domestic resources mobilization is an ongoing effort that will continue to be supported by PEPFAR and other donors on a yearly basis during the national budget negotiation. In addition, PEPFAR will work to ensure that GoCI fulfill its commitment and deliver drugs and commodities timely to prevent any disruption in service delivery.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	**In progress *(behind on implementation, needs major focus)*:** Mortality remains one of the major causes of attrition among patients on ART at PEPFAR-supported sites. The lack of reliable systems to report on morbidity and mortality outcomes among PLHIV makes it difficult to accurately estimate the magnitude of the problem and provide adequate response. PEPFAR planned to conduct a comprehensive mortuary study to determine the causes of death among PLHIV, but it was not approved by the national ethics committee due to socio-cultural concerns around autopsies. PEPFAR will reinforce support for correct and systematic usage of data collection tools and triangulation of data from various sources (charts, patient trackers, appointment registers, tracing logs, etc.) to improve the reporting on mortality and morbidity including reporting of the TX_ML indicator. In addition, PEPFAR will repurpose the mortuary study to an evaluation study of patients who died or are lost-to-follow to better understand final outcomes and cause of death among PLHIV as well as to improve reporting.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	**In progress *(on track)*:** The UPID was piloted in 10 sites in COP20. The tool is being scaled up and as of December 2021, it was deployed in 50 high impact sites. The goal is to cover the 172 PEPFAR-supported high impact sites in by end of fiscal year 2022. Case surveillance will be implemented in future COP as part of the upgrade of SIGDEP3.

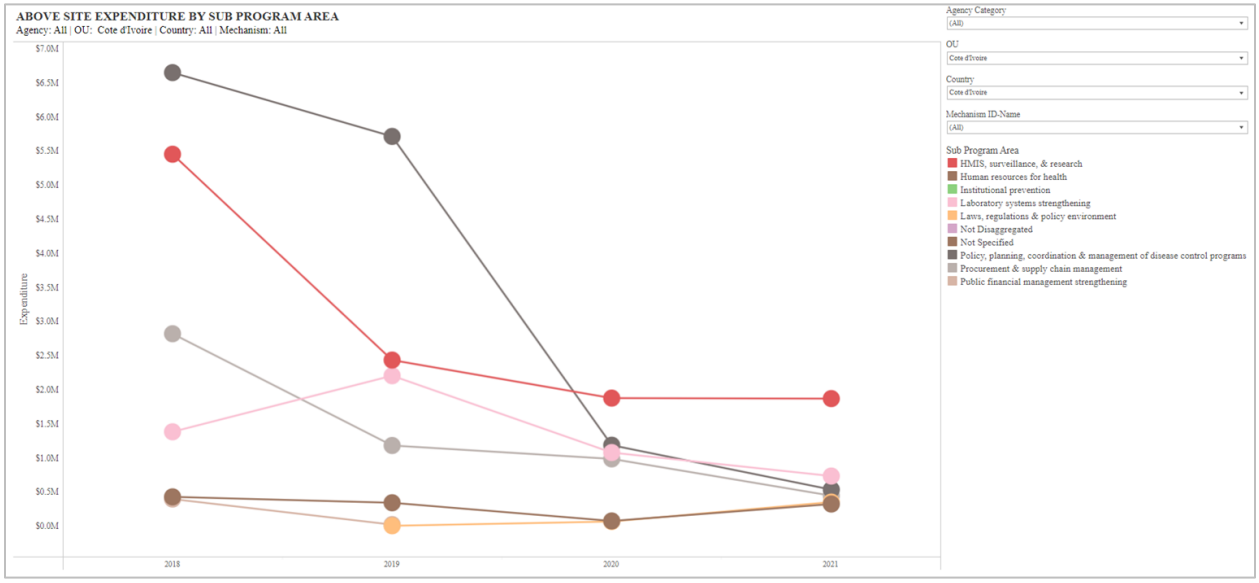
APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

1. Misalignments between Investments and Outcomes

Figures E.1.1. Trends in Investments and SID Scores for System-Related Elements

SID

Domain	SID Element	FY2017	FY2019	FY2021	Score Over Time
	Sum of SIDweighted_answer				
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.50	9.50	8.50	
	2. Policies and Governance Score:	4.56	7.51	6.04	
	3. Civil Society Engagement Score:	6.46	7.50	7.50	
	4. Private Sector Engagement Score:	6.50	6.03	4.13	
	5. Public Access to Information Score:	8.00	7.11	5.33	
National Health System & Service Delivery	6. Service Delivery Score:	6.48	6.01	5.06	
	7. Health Workforce Score:	7.20	7.66	6.09	
	8. Commodity Security and Supply Chain Score:	5.61	6.34	6.76	
	9. Quality Management Score:	5.57	9.33	9.14	
	10. Laboratory Score:	6.00	7.56	7.59	
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	6.79	8.10	5.52	
	12. Technical and Allocative Efficiencies Score:	5.06	6.78	5.00	
	13. Market Openness Score:		8.44	8.68	
Strategic Information	14. Epidemiological and Health data Score:	5.48	5.62	7.00	
	15. Financial/Expenditure data Score:	6.67	7.50	6.67	
	16. Performance Data Score:	7.40	5.90	8.00	
	17. Data for Decision-Making Ecosystem Score:		4.00	5.00	
SID element scoring criteria		< 3.50	3.50-6.99	7.00-8.49	8.50-10.00

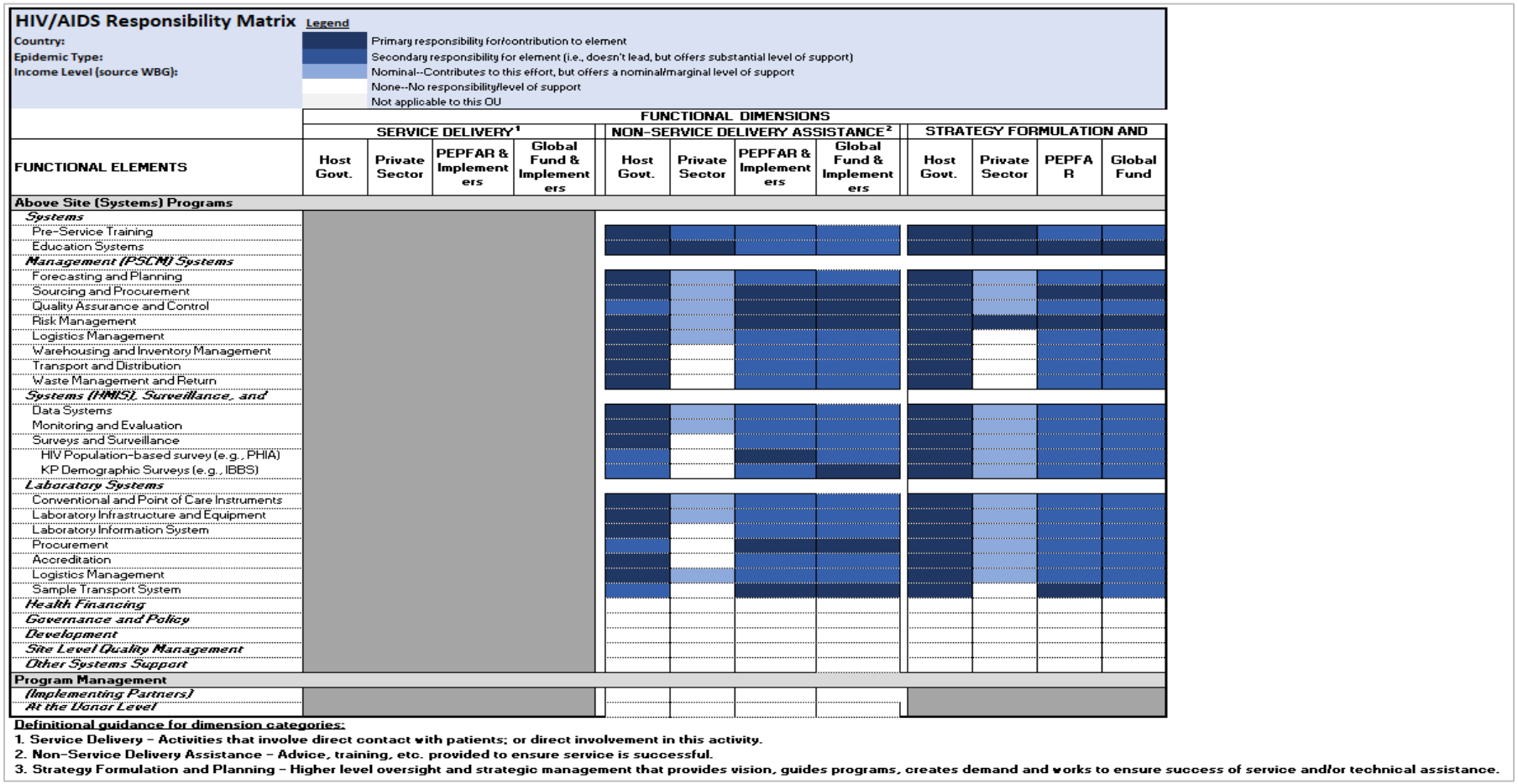


Above Site Investments and Activities Reported in COP Table 6

SID Scores					Above Site Activities and Budget Reported in Table 6					
SID Score						COP18	COP19		COP20	
Domain	SID Elements	2017	2019	2021	SID Budget Activity	Activities	Activities	Budget	Activities	Budget
Governance, Leadership & Accountability	1. Planning and Coordination Score:	9.50	9.50	8.50	Planning and Coordination	9			1	$40,000
	2. Policies and Governance Score:	4.56	7.51	6.04	Policies and Governance	3	5	$1,984,693		
	3. Civil Society Engagement Score:	6.46	7.50	7.50	Civil Society Engagement				2	$280,000
	4. Private Sector Engagement Score:	6.50	6.03	4.13	Public Access to Information				3	$530,000
	5. Public Access to Information Score:	8.00	7.11	5.33	Service Delivery	9	13	$1,200,200	2	$900,000
National Health System & Service Delivery	6. Service Delivery Score:	6.48	6.01	5.06	Human Resources for Health	2			2	$405,000
	7. Health Workforce Score:	7.20	7.66	6.09	Human Resources for Health		6	$1,435,330		
	8. Commodity Security and Supply Chain Score:	5.61	6.34	6.76	Commodity Security and Supply Chain	7			1	$735,000
	9. Quality Management Score:	5.57	9.33	9.14	Laboratory	10	10	$1,349,600	1	$250,000
	10. Laboratory Score:	6.00	7.56	7.59	Domestic Resource Mobilization	1				
Strategic Financing & Market Openness	11. Domestic Resource Mobilization Score:	6.79	8.10	5.52	Technical and Allocative Efficiencies	2				
	12. Technical and Allocative Efficiencies Score:	5.06	6.78	5.00	Epidemiological and Health Data	15	11	$2,083,918	3	$1,315,000
	13. Market Openness Score:		8.44	8.68	Performance Data	1			3	$739,000
Strategic Information	14. Epidemiological and Health data Score:	5.48	5.62	7.00						
	15. Financial/Expenditure data Score:	6.67	7.50	6.67						
	16. Performance Data Score:	7.40	5.90	8.00						
	17. Data for Decision-Making Ecosystem Score:		4.00	5.00						

*Above site activities without either a SID element or budget were excluded from this analysis
**COP 18 Above Site budgets were not inlcuded in Table 6 and therefore not in this tool
***COP activities were linked to the first SID element listed in Table 6 and for COP19 mapped to SID Elements by Key Systems Barriers
****(blank) indicates activities were not assigned to SID elements

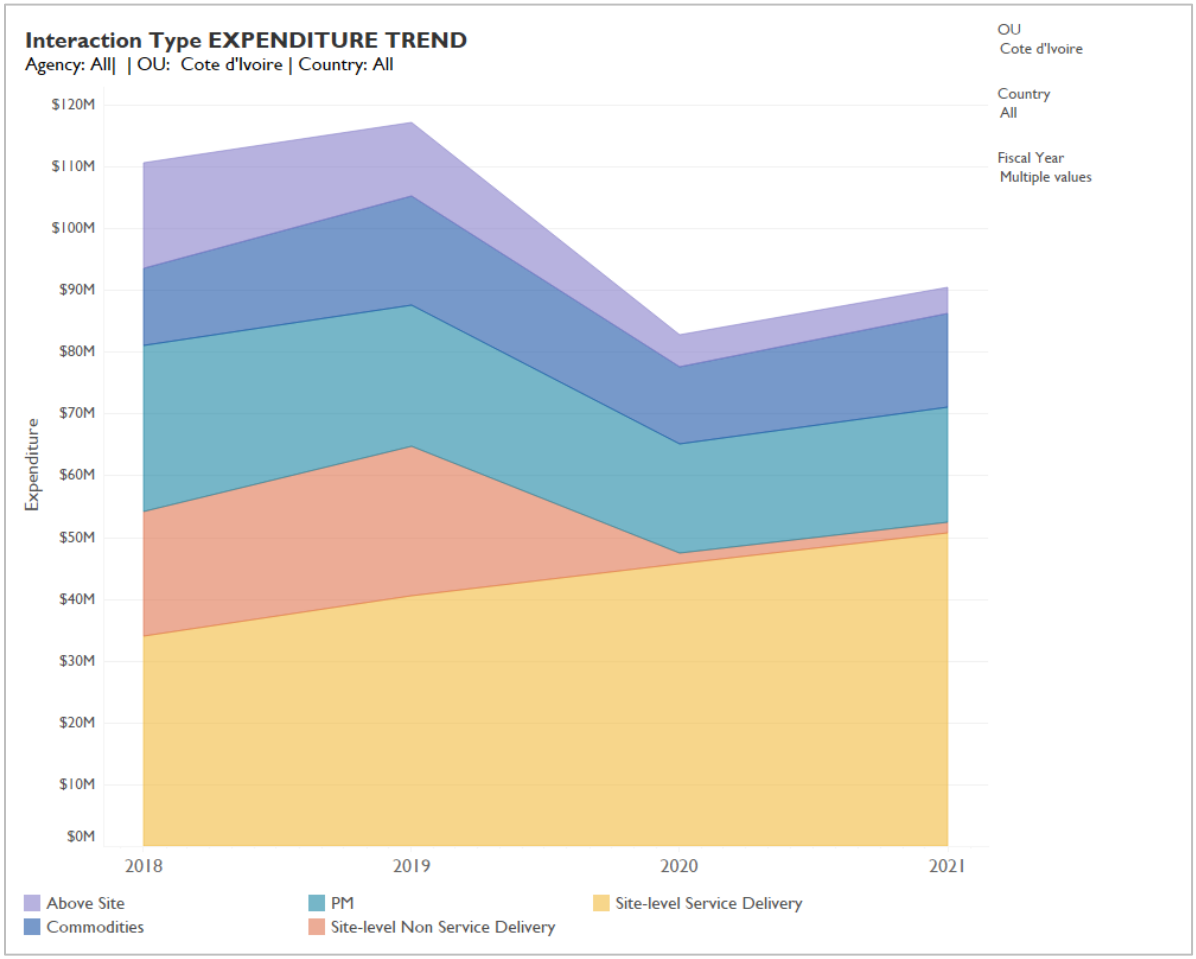
Figure E.1.2 Percent Primary Responsibility Ratings from Responsibility Matrix

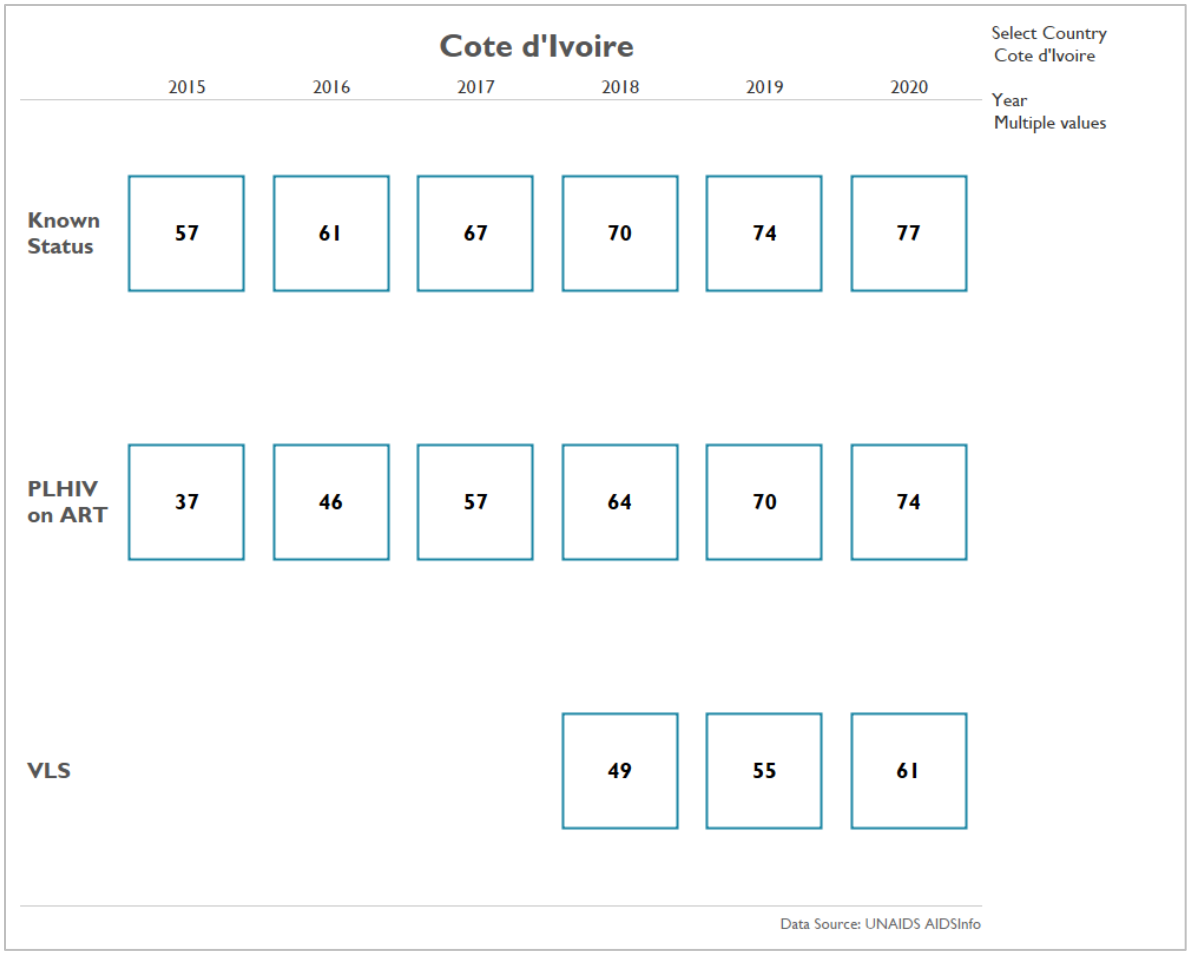


Source: PEPFAR Côte d'Ivoire Responsibility Matrix, 2021

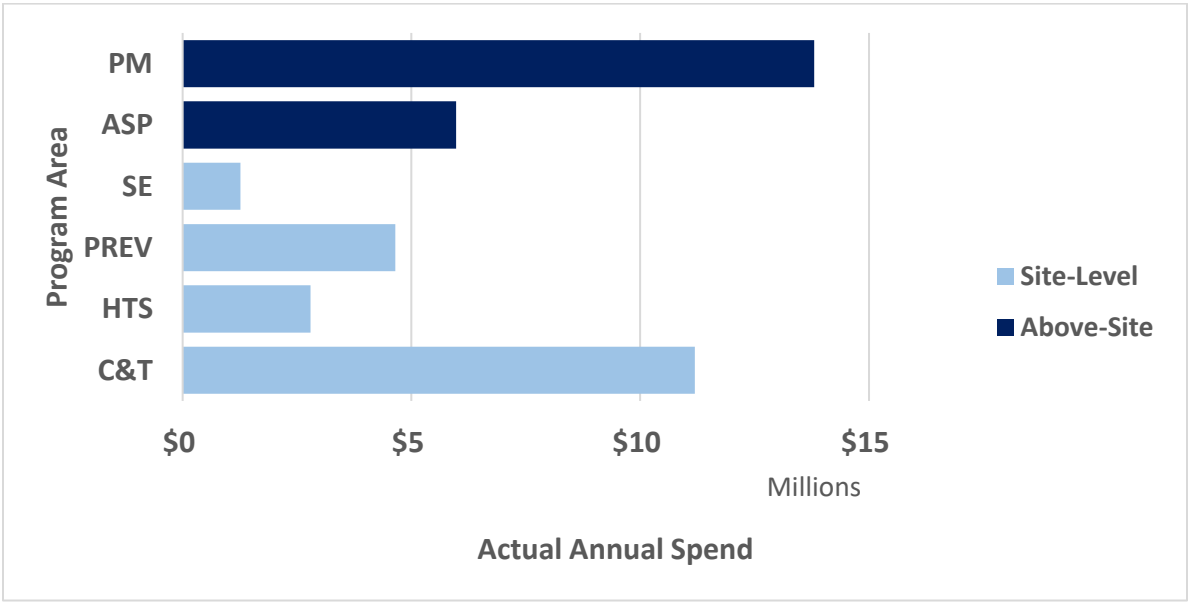
The national HIV program is primarily implemented in MSHP facilities with GoCI providing the primary responsibility for above-site programs, including pre-service training, financial management systems and health information systems. GoCI also leads strategy formulation and planning processes with some support from PEPFAR and GFATM.

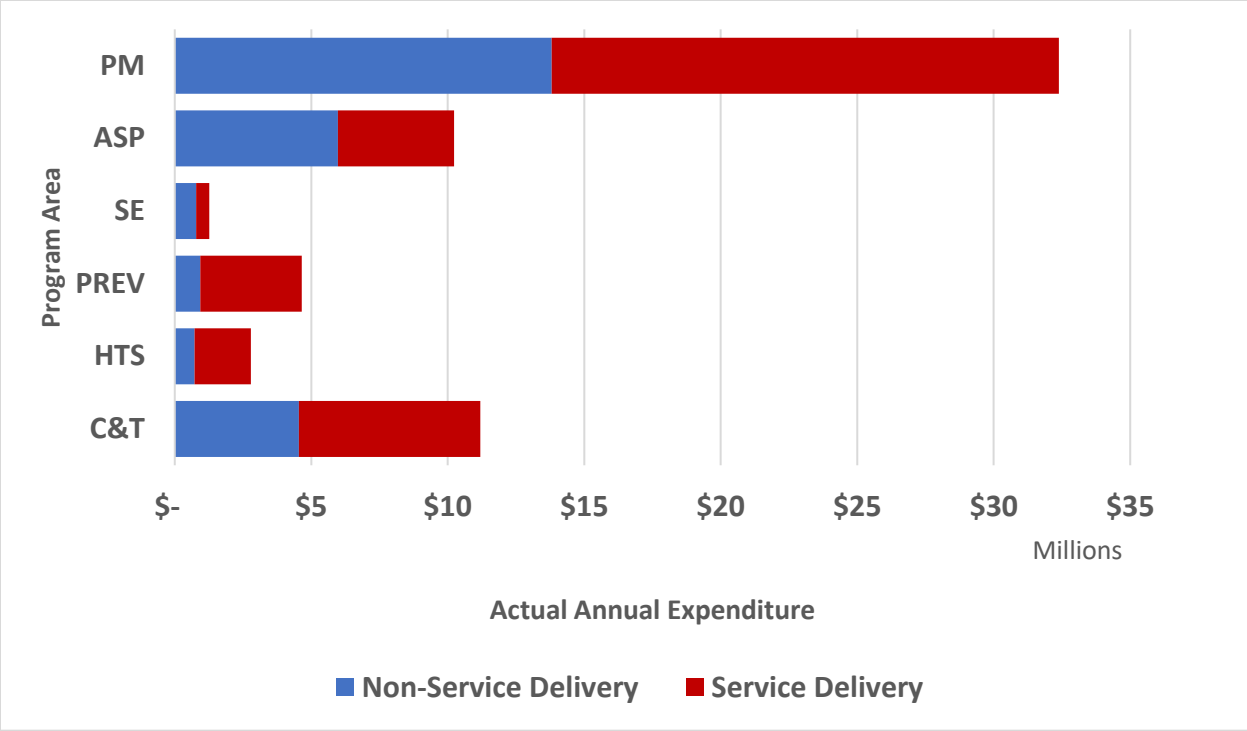
Figures E.1.3 Assessing Côte d'Ivoire's PEPFAR Expenditure Trends by Interaction Type and Epidemic Control Status





Figures E.1.4 HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery





In COP20, PEPFAR-CI supported 9,012 HCWs (5,610 full-time equivalent (FTE)) at a total annual spend of $32,962,270 without fringe. A total of $10,918,043 (33%) was spent on service delivery staff (6,302 individuals or 3,779 FTEs) compared to $22,044,226 on non-service delivery staff (2,710 individuals or 1,831 FTEs). In addition, 49% ($16,235,147) of COP20 HRH annual expenditure is at above-site level, followed by 21% expenditure ($6,872,909) for facility-based staff, 20% ($6,659,623) for community, and 10% ($3,193,590) for roving staff. However, when looking at FTEs, PEPFAR-CI supports more community (2,220) and facility-based staff (2,046) than above-site (1,042 FTE), which indicates that above-site level staff cost more than service delivery staff. This aligns with the GoCI HIV response given that HIV services are provided in mostly MSHP supported facilities and PEPFAR-CI provides more technical support and oversight with direct service delivery in the community.

2. Areas for Transition

Areas in which GoCI can take on greater responsibility in the short-term include:

Procurement of key commodities

GoCI is the largest contributor to the purchase of commodities related to the HIV response accounting for 52% of total contributions towards overall HIV commodities in 2022 (COP21), see Section 2.3, Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities. However, the relative proportion of their contribution to core commodities such pediatric DTG regimens (0%), TPT drugs (0%) and viral load/EID reagents (11%) is still suboptimal.

The rationale for the selection of commodities as a transition area lies in the importance of these core commodities towards the long-term success of the HIV response itself. The government already possesses the necessary financial and technical competencies in this area and there is

a favorable political, economic, and regulatory context for a progressive transition. The transition being proposed here is not related to an ask for supplemental financial resources beyond what the government is already providing, which would be a much harder and longer-term proposition, but rather an optimization of existing resources in favor of these key commodities aligning with international guidelines. As part of the COP22 planning process, PEPFAR-CI was able to successfully negotiate the redirection of over $5 million of GoCI resources initially earmarked for obsolete non-optimal ARV regimens towards key commodities. PEPFAR-CI will continue to engage GoCI in this area ensuring that the significant resources being put in by the government are used to optimal effect.

Risks with this transition lie around the uncertainties related to the actual amount of GoCI's financial contributions for HIV commodities every year, in an environment where GoCI is still contributing only 6% of its annual budget for health, far below the 15% pledged at the Abuja Declaration. In addition, the timeline for the allocation and availability of these resources, even after they are approved, is variable and the delivery calendar for GoCI procured commodities is uncertain, with frequent significant delays, posing a real risk of stock out on key commodities and thus to the continuity of services. To mitigate these risks, PEPFAR and GFATM will continue to front load their orders while advocating for greater efficiency and timeliness in GoCI orders.

Ownership and management of the OVC/DREAMS database and the PESP/CommCare patient follow-up application as well as greater autonomy in the technical management and implementation and maintenance of HIS investments.

In the area of HIS investments, two long standing projects developed and implemented by PEPFAR IPs (PESP/CommCare and the OVC/DREAMS database) are slated to be fully transitioned to the MSHP and MFFE, respectively in COP22. The government already possesses the requisite financial and technical competencies in this area and there is a favorable political, economic, and regulatory context for this transition. While some additional financial and technical support continues in COP22 for the final elements of the transition, it is expected that from COP23 onward any additional funding will be minimal and through the G2G agreements with these ministries.

The main risks to the proposed transition include the availability of stable financial resources as well as qualified personnel (high turnover) to ensure maintenance of the systems. To mitigate these risks PEPFAR has and continues to invest in open-source systems requiring the least possible financial resources and in the training of a core cadre of local technical experts on all supported systems. Previous experience in the HIS arena, such as with the transition of DHIS2, will be leveraged to ensure smooth transition, local ownership, and maintenance of function.

Establishment of an internship program for laboratory graduates and placement of civil servants at the RetroCI Laboratory.

As part of the ongoing transition plan for the RetroCI laboratory to full government ownership, PEPFAR is proposing, for COP22, the establishment of an internship program for laboratory

graduates to allow for capacity building as well as the eventual placement of civil servants at Retro-CI. In the long term, this will create a sustainable and GoCI-supported RetroCI workforce, capable of maintaining Retro-CI continuous and accredited services. Even though there is a favorable political and regulatory context for this transition, there are significant questions about GoCI's financial and technical capacity to take over this and greater responsibility for the lab in the near term. To mitigate these risks, the PEPFAR team continues to invest in quality management systems and is in constant communication with MSHP leadership and technical experts on gradual handover of various functions without compromising the institution's world-class standards and accreditation.

3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response

The USG team will continue the ongoing discussions with regards to the clinical workforce and its involvement in HIV service delivery. Under a PEPFAR funded G2G agreement, MSHP is implementing a performance-based financing model akin to, but more efficient and targeted than the broader one currently supported by World Bank funding. This is an important opportunity to accelerate program results and can be done in an ethical and transparent manner as demonstrated in other PEPFAR OUs. In COP22, as the PEPFAR-CI team will be introducing new initiatives such as the Zvandiri CATS model for comprehensive child/adolescent support, and recent infection surveillance to identify areas of ongoing viral transmission, all planning and initial implementation will be carried out together with MSHP leadership and based on its vision. This is critical for the success and eventual transition of these programs. Capacity building with the MFFE will also better position that ministry for eventual service delivery responsibilities in the OVC and DREAMS sectors. Furthermore, and more broadly, the PEPFAR-CI program is moving towards increasingly consolidated, simplified, and comprehensive service delivery. This model allows for more efficient HRH deployment, patient-centered care across facility and community settings, and streamlined collaboration with sub-national MSHP leadership. In this manner, in COP22 most PEPFAR-supported districts will feature increasingly sustainable service delivery models.

Strengthening local partner capacity and the ability to function as prime implementing partners is another critical element in the pathway toward full country ownership of a sustainable HIV response. Sustainable community interventions depend on a solid pool of highly competent local partners that represent and support vulnerable populations in the communities they serve. This includes key beneficiaries of HIV services such as key populations and orphans and vulnerable children. The local partners' preparedness and wherewithal depends not only on their technical competency but also their administrative, financial management and fundraising abilities. Similarly, the role of civil society is a vital element of a sustainable HIV response ensuring the voices and interests of the beneficiaries themselves are adequately represented. In COP22, PEPFAR will continue to expand and strengthen local partner and civil society capacity and support them on their journey to self-reliance. Key population local partners will continue to serve as primes and will increase in number and geographic coverage. OVC local partners will also be brought on as prime PEPFAR implementing partners in COP22. Tailored support will be provided, based on individual IP needs assessments, to ensure a successful transition as primes. Support will include administrative and financial management skills and

systems strengthening as well as technical mentoring to ensure a successful transition and long-term self-reliance.

Along the same lines, the military program, DOD will organize a workshop with the Ministry of Defense and other key stakeholders to discuss local responsibility and identify short-, mid- and long-term steps towards an HIV response in the Defense sector that is fully supported and funded by domestic public HIV funding, This will be an opportunity for the Ministry of Defense to understand the costs of the packages and the program needs including but not limited to human resources for health, capacity building, systems maintenance and strengthening, etc. Another workshop for internal resources mobilization will be held in FY23 to identify funding sources and mechanisms that will progressively replace PEPFAR investments as we are getting closer to epidemic control. In this process, performance-based strategic orders (or performance-based financing) will be envisaged as an option and a review of the opportunities, requirements, and constraints specific to the Ministry of Defense will be conducted to assess its feasibility for the military program.

4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).

PEPFAR Côte d'Ivoire continues to support MSHP and, in COP22, will also reengage with MFFE to generate, manage, and use high-quality public health-related data.
MSHP is finalizing its National HIS Strategic Plan (*Plan Stratégique du Système National d'Information Sanitaire* (PSSNIS) 2021-2025), which has selected "Strengthening Governance" as one of its key goals and outlines the following guiding principles: Simplicity, Harmonization, Sustainability, Scalability, Information sharing, Traceability, Respect/Confidentiality, Economy, and Integrity. PEPFAR-CI is aligning a three-year strategic plan for with the PSSNIS, which includes a plan to support MSHP to customize Data Access, Sharing and Use guidelines for CI (HIS strategic plan chap. 3.1.3.2).

PEPFAR-CI collaborates closely with MSHP's National Program against HIV (PNLS) and the Directorate of Health Informatics (DIIS) on data use and data quality through National TWGs (HMIS, M&E and Surveillance) activities, routine and targeted data quality assessments (DQAs), the annual national HIV estimates exercise, the annual PEPFAR-Ministry data alignment exercise, the introduction of recent infection surveillance in COP22, and other data sharing needs (Key Population program data and estimates data, Viral Load results, etc.). Activities planned with MFFE will encompass data collection and management, data quality assessment database management, data analysis and use of DREAMS and OVC data for program improvement, including capacity building, training workshops, and review meetings. For the military program, all efforts are conducted under the leadership and technical ownership of the Ministry of Defense's Health Directorate, their HIV Sectoral Committee, and their Strategic Information Department. The vision is to have the three digital health investments (DHIS2 for EMR, OpenELIS and UPID) fully interoperable by COP24 and continuously use for data-based decision making.

APPENDIX F – Case Finding Gaps by District

Case Finding Gaps by District[15]

Region		District	Region		79 PEPFAR-Supported Districts			
			PLHIV Est (Sep 2022)	ART Cov Gap	ART Cov Gap	HTS POS (FY21 Results)	HTS POS (COP22 Target)	Change FY21-23
Abidjan 1		Yopougon-Est	17,607	10,365	8,165	1,630	2,234	604
		Abobo-Ouest			2,010	1,146	1,209	63
		Abobo-Est			2,250	1,502	1,516	14
		Anyama			377	349	352	3
		Yopougon-Ouest-Songon			(2,437)	1,767	1,513	(254)
Abidjan 2		Adjame-Plateau-Attecoube	15,362	6,182	5,640	1,350	1,536	186
		Port-Bouet-Vridi			2,408	1,181	1,365	184
		Koumassi			2,224	847	970	123
		Treichville-Marcory			(3,813)	1,422	1,457	35
		Cocody-Bingerville			(277)	1,130	1,039	(91)
Agneby-Tiassa		Agboville	8,555	2,444	1,259	362	593	231
		Sikensi			582	123	286	163
		Tiassale			603	381	168	(213)
Bagoue		Kouto	2,498	266	443	81	220	139
		Boundiali			(177)	247	26	(221)
Belier		Tiebissou	9,684	606	605	63	49	(14)
		Yamoussoukro			(379)	664	628	(36)
		Toumodi			380	332	268	(64)
Bere		Dianra	4,213	1,844	683	41	145	104
		Kounahiri			256	56	24	(32)
		Mankono			905	304	168	(136)
Cavally		Tai	2,986	357	343	39	151	112
		Guiglo			14	404	110	(294)
Gbeke		Botro	18,916	1,713	467	68	223	155
		Bouake-Nord-Est			894	378	439	61
		Beoumi			360	92	78	(14)
		Sakassou			62	61	38	(23)
		Bouake-Sud			(157)	520	74	(446)

[15] Red = FCI-focused + Acceleration district (4)
Orange = Acceleration district (18)
Blank = Maintenance district (57)

Region	District	Region		79 PEPFAR-Supported Districts			
		PLHIV Est (Sep 2022)	ART Cov Gap	ART Cov Gap	HTS POS (FY21 Results)	HTS POS (COP22 Target)	Change FY21-23
	Bouake-Nord-Ouest			87	763	310	(453)
Gbokle	Sassandra	2,305	575	575	153	183	30
Goh	Oume	12,917	3,101	1,897	494	596	102
	Gagnoa 2			1,856	84	116	32
	Gagnoa 1			(652)	855	859	4
Gontougo	Sandegue	12,728	(166)	629	14	530	516
	Transua			111	88	91	3
	Koun-Fao			48	150	81	(69)
	Tanda			(122)	293	36	(257)
	Bondoukou			(832)	762	103	(659)
Grand Ponts	Grand-Lahou	6,533	1,426	1,025	103	401	298
	Jacqueville			163	43	22	(21)
	Dabou			238	310	130	(180)
Guemon	Bangolo	14,203	9,184	5,008	214	148	(66)
	Kouibly			2,500	132	57	(75)
	Duekoue			1,676	434	244	(190)
Hambol	Katiola	1,624	(389)	(389)	277	27	(250)
Haut-Sassandra	Daloa	17,705	5,802	1,819	987	1,201	214
	Issia			1,323	412	496	84
	Vavoua			1,983	211	255	44
	Zoukougbeu			677	106	127	21
Iffou	Daoukro	2,562	531	531	242	243	1
Indenie-Djuablin	Agnibilekrou	8,988	476	286	218	251	33
	Abengourou			190	839	565	(274)
Loh-Djiboua	Divo	4,296	450	450	562	559	(3)
Marahoue	Sinfra	11,997	3,068	1,840	369	975	606
	Bouafle			1,590	729	584	(145)
	Zuenoula			(362)	196	17	(179)
Me	Akoupe	6,063	562	(203)	187	189	2
	Adzope			358	200	200	-
	Yakasse-Attobrou			286	39	37	(2)
	Alepe			121	112	72	(40)
Moronou	M'Batto	5,891	1,385	607	134	287	153
	Bongouanou			768	233	257	24

Region	District	Region		79 PEPFAR-Supported Districts			
		PLHIV Est (Sep 2022)	ART Cov Gap	ART Cov Gap	HTS POS (FY21 Results)	HTS POS (COP22 Target)	Change FY21-23
	Arrah			10	204	80	(124)
Nawa	Soubre	5,611	1,958	1,958	508	766	258
N'zi	Bocanda	3,636	892	681	88	171	83
	Kouassikouassikro			95	30	75	45
	Dimbokro			116	150	66	(84)
Poro	Korhogo 2	10,090	985	739	13	221	208
	Dikodougou			416	71	178	107
	Korhogo 1			(170)	968	170	(798)
San-Pedro	San-Pedro	11,473	3,479	3,375	640	1,295	655
	Tabou			104	172	151	(21)
Tchologo	Kong	2,333	169	670	16	246	230
	Ferkessedougou			(501)	244	26	(218)
Tonkpi	Zouhan Hounien	17,463	(11,023)	2,207	203	267	64
	Danane			840	372	288	(84)
	Man			(14,070)	1,081	655	(426)
Worodougou	Seguela	3,228	1,553	1,394	264	535	271
	Kani			159	76	16	(60)