**United States Department of State**

***Washington, D.C. 20520***

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

**INFORMATION MEMO FOR AMBASSADOR BARLERIN, CAMEROON**

**SUBJECT: Fiscal Year (FY) 2020 PEPFAR Planned Allocation and Strategic Direction**

With input from the field teams through the quarterly POARTS and from Headquarters Country Accountability and Support Teams, we have thoroughly reviewed progress of the program in your country over time and specifically the end of year results of the Country Operational Plan (COP) 2018 and current COP 2019 implementation as we plan for COP 2020. We have noted the following key successes and specific areas of concern:

Key Successes:

- User Fees elimination and preparation for the implementation of this policy change
- The scale up of viral load testing to improve viral load coverage among PLHIV
- Implementation of Test and Start as seen through consistently strong linkage numbers

Areas of Concern:

- Weak and ineffective supply chain and commodities procurement and distribution mechanisms from the national to the site level
- Underperformance on case finding and testing, including declining testing yields, weak index testing implementation and ineffective screening methods
- Inadequate policies and implementation of the minimum program requirements related to client-centered service delivery, including:
  - ART Optimization for both adult and pediatric regimens
  - Multi month dispensation and differentiated service delivery models
  - Host country response and co-financing

## SECTION 1: COP/ROP 2020 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2019 (EOFY) tool, and performance data, the total COP/ROP 2020 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency.

### Table 1. COP/ROP 2020 Total Budget including Applied Pipeline

TABLE 1: All COP 2020 Funding by Fiscal Year

| OU Total | Bilateral | | | | Central | TOTAL |
|---|---|---|---|---|---|---|
| | FY20 | FY19* | FY17 | Unspecified | Unspecified | TOTAL |
| Total New Funding | $ 38,191,666 | $ - | $ - | | | $ 38,191,666 |
| GHP-State | $ 37,616,547 | $ - | $ - | | | $ 37,616,547 |
| GHP-USAID | $ - | $ - | $ - | | | $ - |
| GAP | $ 575,119 | $ - | $ - | | | $ 575,119 |
| Total Applied Pipeline | | $ 53,570,911 | | $ 308,334 | $ - | $ 53,879,245 |
| DOD | | $ 632,586 | | | $ - | $ 632,586 |
| HHS/CDC | | $ 36,255,024 | | | $ - | $ 36,255,024 |
| HHS/HRSA | | | | $ - | $ - | $ - |
| PC | | $ 258,725 | | $ 58,985 | $ - | $ 317,710 |
| State | | | | $ - | $ - | $ - |
| USAID | | $ 16,424,576 | | $ 249,349 | $ - | $ 16,673,925 |
| TOTAL FUNDING | $ 38,191,666 | $ 53,570,911 | $ - | $ 308,334 | $ - | $ 92,070,911 |

*FY 2019 Bilateral Pipeline consists of Year 2 Acceleration Funds from COP19 already at agencies.

## SECTION 2: COP/ROP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS

### Table 2. COP/ROP 2020 Earmarks

TABLE 2: COP 2020 Earmarks by Fiscal Year

| Earmarks | COP 2020 Planning Level | | | |
|---|---|---|---|---|
| | FY20 | FY19 | FY17 | Total |
| C&T | $ 20,000,000 | $ - | $ - | **$ 20,000,000** |
| OVC | $ 1,800,000 | $ - | $ - | **$ 1,800,000** |
| GBV | $ 100,000 | $ - | $ - | **$ 100,000** |
| Water | $ 125,000 | $ - | $ - | **$ 125,000** |

** Countries should be programming to levels outlined in Part 1 of the COP 2020 Planning Level Letter. These earmark controls above represent the minimum amounts that must be programmed in the given appropriation year.*
*See Appendix 1 for detailed budgetary requirements

### Table 3. Total COP/ROP 20 Initiative Funding

TABLE 3 : All COP 2020 Initiative Controls

| | COP 20 Total |
|---|---|
| Total Funding | **$ 1,800,000** |
| VMMC | $ - |
| Cervical Cancer | $ - |
| DREAMS | $ - |
| HBCU Tx | $ - |
| COP 19 Performance | $ - |
| HKID Requirement | $ 1,800,000 |
| | |
| | |
| | |

**SECTION 3: PAST PERFORMANCE – COP/ROP 2018 Review**

**Table 4. COP/ROP OU Level FY19 Program Results (COP18) and FY20 Targets (COP19)**

| Indicator | FY19 result (COP18) | FY20 target (COP19) |
|---|---|---|
| **TX Current Adults** | **192,716** | **365,015** |
| **VMMC among males 15 years or older** | **N/A** | **N/A** |
| **DREAMS** | **N/A** | **N/A** |
| **Cervical Cancer** | **N/A** | **N/A** |
| **TB Preventive Therapy (N)** | **10,560** | **151,875** |
| **PrEP** | **312** | **1,851** |

**Table 5. COP/ROP 2018 | FY 2019 Agency-level Outlays versus Approved Budget**

| OU/Agency | Sum of Approved COP/ROP 2018 Planning Level | Sum of Total FY 2019 Outlays | Sum of Over/Under Outlays |
|---|---|---|---|
| **Cameroon** | | | |
| DOD | $ 1,551,969 | $ 1,065,827 | $ 486,142 |
| HHS/CDC | $ 30,755,047 | $ 29,372,720 | $ 1,382,327 |
| PC | $ 974,290 | $ 827,299 | $ 146,991 |
| USAID | $ 10,301,879 | $ 9,753,252 | $ 548,627 |
| **Grand Total** | **$ 43,583,185** | **$ 41,019,098** | **Under outlay: $ 2,564,087** |

**Table 6. COP/ROP 2018 | FY 2019 Partner-level Outlays vs Approved Budget**

| Mechanism ID | Partner Name | Funding Agency | COP 18 Planned Funding | Total Outlays FY 19 | Outlay Delta Check | Outlay Justification |
|---|---|---|---|---|---|---|
| 17364 | PSI | DOD | - | 818 | (818) | Closeout costs |
| 14118 | African Society for Laboratory Medicine | HHS/CDC | - | 100,000 | (100,000) | HQ centrally managed award last funded by Cameroon in COP 17. IP did not implement any COP18 activities for this OU. Partner self-reported FY19 outlay data, collected by CDC HQ, indicates that actual FY19 outlays are $0 |
| 17336 | Columbia University | HHS/CDC | - | 574,113 | (574,113) | HQ centrally managed award with no country control over how draws affect CANs. Partner self-reported FY19 outlay data, collected by CDC HQ, indicates that actual FY19 outlays are $14,973 |
| 14127 | WHO/AFRO | HHS/CDC | - | 12,728 | (12,728) | HQ centrally managed award with no country control over how draws affect CANs |
| 16816 | Elizabeth Glaser Pediatric AIDS Foundation | HHS/CDC | - | 256,739 | (256,739) | HQ centrally managed award with no country control over how draws affect CANs. Partner self-reported FY19 outlay data, collected by CDC HQ, indicates that actual FY19 outlays are $0 |
| 16744 | Catholic Relief Services | USAID | 2,169,228 | 2,665,815 | (496,587) | Outlays exceed COP18 planning level due to delayed disbursement from FY18 (which were processed in FY19Q1). |

**Table 7. COP/ROP 2018 | FY 2019 Results & Expenditures**

| Agency | Indicator | FY19 Target | FY19 Result | % Achievement | Program Classification | FY19 Expenditure | % Service Delivery |
|---|---|---|---|---|---|---|---|
| HHS/CDC | HTS_TST | 935,244 | 1,210,466 | 77% | HTS Program Area | $4,680,637 | 89% |
| | HTS_TST_POS | 28,623 | 61,294 | 47% | | | |
| | TX_NEW | 28,155 | 63,253 | 45% | C&T Program Area | $15,682,041 | 76% |
| | TX_CURR | 192,685 | 246,119 | 78% | | | |
| VMMC_CIRC | | N/A | N/A | N/A | VMMC Subprogram | N/A | N/A |
| | OVC_SERV | N/A | N/A | N/A | OVC Beneficiary | N/A | N/A |
| DOD | HTS_TST | 28,305 | 30,226 | 94% | HTS Program Area | $168,530 | 88% |
| | HTS_TST_POS | 1,976 | 2,249 | 88% | | | |
| | TX_NEW | 1,697 | 2,167 | 78% | C&T Program Area | $680,118 | 82% |
| | TX_CURR | 6,889 | 7,895 | 87% | | | |
| | VMMC_CIRC | N/A | N/A | N/A | VMMC Subprogram | N/A | N/A |
| | OVC_SERV | N/A | N/A | N/A | OVC Beneficiary | N/A | N/A |
| USAID | HTS_TST | 19,849 | 21,436 | 93% | HTS Program Area | $673,813 | 66% |
| | HTS_TST_POS | 2,955 | 2,153 | 137% | | | |
| | TX_NEW | N/A | N/A | N/A | C&T Program Area | $3,464,474 | 79% |
| | TX_CURR | N/A | N/A | N/A | | | |
| | VMMC_CIRC | N/A | N/A | N/A | VMMC Subprogram | N/A | N/A |
| | OVC_SERV | 18,377 | 15,728 | 117% | OVC Beneficiary | $1,807,371 | 52% |

**COP/ROP 2018 | FY 2019 Analysis of Performance**

Analysis of case finding results in COP18 reveals that case finding is one of the areas with the greatest need for improvement for the program. Case finding nationally fell dramatically short of targets with only 51.7% achievement for the HTS_TST_POS indicator for the year. While we acknowledge that during the latter half of the year most sites were experiencing shortages or stock outs of rapid test kits, we also know that performance in the first two quarters was also weak, and only slightly better than in Q3 and Q4 for HTS_TST_POS achievement.
Additionally, one of the most concerning aspects of Cameroon's case finding performance was testing yields, which should not be impacted by commodity shortages.

Case finding yields have continued to trend downward over time, with declines in all four SNUs over the past twelve quarters, and the current yield very close to the national prevalence. Yields in the Centre region were stronger overall than the other three regions, however we believe this to be driven by the higher prevalence in that region, not necessarily by comparatively better testing strategies. Overall, the downward trend in testing yields was driven by OtherPITC yields among young men and women ages 0-24, and especially men. This downward trend over the last twelve quarters is especially concerning given that during this time period, index testing was implemented in Cameroon, including at the KP partner. This highlights the problem that index testing has both not been scaled to the extent it needs to be-both in the clinical and the KP program- and also that where implemented, yields were not sufficient and the number of contacts elicited were not enough to drive a successful result for overall case finding. Additionally, this yield trend highlights that the mix of testing modalities also continues to be inefficient, with far too much OtherPITC testing in all regions, except for the military, where OtherPITC performance has been impressively strong due to a highly effective screening tool, which should be used as a model for the clinical program.

Analysis of COP18 performance for Care and Treatment reveals some improvements over COP17, but still major gaps to treatment coverage across most SNUs. Though retention continued to be a problem in COP18, there were signs that retention was improving in the latter quarters of COP18, especially in the Centre region where the Cameroon Baptist Convention Health Board was working. In spite of these improvements, retention among young adult cohorts (especially ages 20-24, 25-29 and 30-34), for both men and women, is a persistent challenge for both clinical partners (CBCHB and EGPAF) in all regions.

Linkage, though perpetually a point of strength in Cameroon, did show some fluctuations in COP18, though CBCHB showed strong performance in the Centre region and SW regions. CBCHB could improve linkage in the NW, and EGPAF could improve in Littoral, though EGPAF showed signs of improving in Q4 in the Littoral region. Viral load coverage was an area of success for all partners and regions in COP18, as we saw the voucher program drive an uptick of viral load coverage in all SNUs towards the end of COP18. While viral load suppression continues to hover below 90% overall, we did see some improvement in viral load suppression, especially in the Littoral region in Q3 and Q4. We commend these achievements on the 3rd 90 and encourage teams to continue to

message U=U and the importance of viral load testing.

Thus, in spite of some successes in care and treatment and viral load coverage and linkage, target achievement for TX_NEW was at 45.6% for the year. This was driven by weak performance in case finding, as discussed above, but must improve in COP19 and COP20. It is especially important to note the gaps in the treatment program related to men. Specifically, between FY18Q4 and FY19Q4, the percentage of males 15+ years on treatment in the program increased by only 9%. In FY19, most of the percentage increase was in the 50+ year old age band with 8% increase of males on treatment in the 25-29 year age band and no significant percentage change in the 30-34 year old age band. In addition, in the first three quarters of FY19, the program put half the number of males than females 15+ years on treatment.

For the OVC portfolio, the OVC_SERV achievement for OVC beneficiaries under age 18 was 83% in Cameroon for FY19 (88% USAID, 47% Peace Corps). All agencies and implementing partners should work to improve the OVC_SERV achievement to 90% or higher. In FY19, 16.4% of OVC beneficiaries in Cameroon exited without graduation (17% USAID, 0.2% Peace Corps), reflecting program quality issues. The percentage of OVC beneficiaries that exit the OVC program without graduation should be 10% or lower across agencies and implementing partners.

Finally, perhaps the other most critical program challenge in COP18 was with the Supply Chain and commodity procurement. Weaknesses here caused nationwide stockouts and low stocks in RTKs, ARVs, TPT, and Viral Load Reagents in COP18. The PEPFAR team, including diplomatic engagement by the Front Office, and partners made a great effort to identify the weaknesses in the supply chain, concluding with a post-COP18 TDY to summarize and align on the diagnosis of where the needs are. The main findings from this TDY which must be addressed in COP20 are the following:

- Delays in custom clearance of program commodities and long waiver process
- Critical lack of information data (supply chain) and visibility of stocks on-hand, consumption data, procurement data, and pipeline data at the facility level and below
- Lack of an efficient distribution system and insufficient coordination at different levels of distribution process, from the national to the regional and regional to the site level
- Lack of an effective cold chain that functions nation-wide for the transportation of viral load commodities
- Lack of a concrete and practical supply chain transformation plan for Cameroon exacerbated by weak governance structures to drive supply chain transformation
- Poor warehousing practices where products are improperly stored and quantities not tracked in a transparent and optimal manner
- Understaffed and inadequately capacitated personnel managing ordering and distribution, especially at the regional and site level.

## SECTION 4: COP/ROP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP/ROP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

For COP/ROP 2020, the failure to meet any of these requirements will result in reductions to the Cameroon budget. (See Section 2.2. of COP Guidance)

**Table 8. COP/ROP 2020 (FY 2021) Minimum Program Requirements**

| | Minimum Program Requirement | Status | Outstanding Issues Hindering Implementation |
|---|---|---|---|
| **Care and Treatment** | 1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1] | The adoption on Test and Start has been a success in Cameroon. Linkage has shown to be continually strong, with some weaker performance in Littoral region. | No outstanding policy or implementation challenges remaining, we simply encourage the continued effective implementation through strong partner management. |
| | 2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including | TLD transition was delayed due to a number of policy and commodity/supply chain issues. Procurement planning | All children must be transitioned to optimal non-NVP regimens and that changes must be |

1 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization, September 2015

| | | | |
|---|---|---|---|
| | adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2] | indicates a move toward TLD, but the amount of NVP formulations, especially for pediatrics, is concerning as are the government's guidelines around TLD implementation, which may overemphasize the risk to women of childbearing age. | communicated and implemented at the site level. Guidelines for WCBA must reflect true risks associated with TLD, and not overstate risk to fetus. |
| | 3. Adoption and implementation of differentiated service delivery models, including six-month multi-month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3] | The adoption of multi-month dispensation has been slow and continues to constitute a minority of the treatment population. Six month dispensing has not been implemented and must be scaled up. | Policies requiring that patients demonstrate a suppressed viral load before becoming eligible for MMD should be reconsidered. All patients should receive multimonth dispensation, and six months of treatment where possible. |
| | 4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4] | TPT was not prioritized prior to COP19, however, in COP19, funding was provided to initiate a country-wide scale up. Commodities issues have prevented this from taking full effect so far in COP19, but there is still an intention to progress towards this goal during COP19 implementation. | Supply chain and commodity issues have prevented a complete roll out of TB preventive treatment. Supply chain issues must be prioritized and addressed, with a priority on TPT coverage. |
| | 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 | Viral load coverage has improved and will continue to scale up as user fee elimination goes into effect. | The ability of the national supply chain to support the efficient transportation of viral load commodities between labs and sites is limited and requires improvement. |



2 Update of recommendations on first- and second-line antiretroviral regimens. Geneva: World Health Organization, July 2019

3 Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection. Geneva: World Health Organization, 2016

| | | | |
|---|---|---|---|
| | caregiver within 4 weeks. | | |
| **Case Finding** | 6. Scale up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[4] | Index testing has not been scaled with fidelity. Self-testing has not been implemented outside of the KP program, and even there in limited quantities. | There is a fundamental need to retrain index case workers in proper implementation and contact solicitation practices. Yields have shown slight improvement, but are still not acceptable, and index coverage, and number of contacts elicited remain a hindrance to effective implementation. |
| **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)[5] | PrEP has not been funded by the PEPFAR program historically, except for in very limited quantities in the KP program. | Any regulations requiring that a minor (individual under 19) receive consent from a parent, guardian or other adult to access PrEP should be removed. |
| | 8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and 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) | The implementation of OVC alignment to the clinical program began in rigor in COP19. This scale-up mirrored the clinical program scale up into all 10 regions of Cameroon. The team has effectively chosen site locations that complement the location and geographies of clinical sites. | No outstanding barriers, continue to scale-up per COP19. |



4 Guidelines on HIV self-testing and partner notification. Supplement to consolidated guidelines on HIV testing services. Geneva: World Health Organization, 2016 https://www.who.int/hiv/pub/self-testing/hiv-self-testing-guidelines/en/

5 Guideline on when to start antiretroviral therapy and on pre-exposure prophylaxis for HIV. Geneva: World Health Organization; 2015 (http://www.who.int/hiv/pub/guidelines/earlyrelease-arv/en).

| | | | |
|---|---|---|---|
| | providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. | | |
| **Policy & Public Health Systems Support** | 9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[6] | The elimination of all formal and informal user fees for HIV services went into effect on January 1, 2020. The government of Cameroon should be commended for its efforts both in making this policy change, and in planning rigorously and funding its implementation. | We expect the first year of implementation to provide useful information on any challenges of implementing this new policy at the site level. We will work to monitor the implementation, including the new financing mechanisms used to fund the sites directly (rather than funding them through user fees), and will support adjustments as deemed necessary. CSO-led monitoring at the site level to ensure effective elimination of user fees should continue. |
| | 10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[7] | SIMS data indicates that the weakest area of performance is around patient tracking and data reporting. The rapid patient tracking conducted by the team in the spring of 2019 supports this conclusion. | A lack of EMR and a unique ID for patients makes patient tracking and retention monitoring challenging. Lessons learned from the rapid tracking exercise are important, but lack of networked, electronic systems, will continue to pose a challenge. |
| | 11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country | The scale up of viral load testing in COP18 is encouraging. Uptake has been strong and the demand for viral load testing has been encouraging. | There is a need for an improved supply chain, specifically around viral load sample collection and transport, to support the successful implementation of |



[6] The practice of charging user fees at the point of service delivery for HIV/AIDS treatment and care. Geneva: World Health Organization, December 2005

[7] Technical Brief: Maintaining and improving Quality of Care within HIV Clinical Services. Geneva: WHO, July 2019

| | | | |
|---|---|---|---|
| | 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. | | country-wide viral load coverage. |
| | 12. Clear evidence of agency progress toward local, indigenous partner prime funding. | Due to underperformance, we reduced funding in COP18 for the local partner, the Cameroon Baptist Convention Health Board. To support the scale up in COP19, three new clinical partners were engaged, all International. | We continue to work with the CBC to improve performance, and have seen improvements in the latter quarters of COP18. Local KP and OVC partners have been engaged for transitioning over the next few years, but the transition was incomplete as of COP18 due to a lack of preparedness. There is an opportunity to increase local partners through CSO-led monitoring through Ambassadors small grants. |
| | 13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended. | The GoC showed a strong commitment to user fee elimination by funding as a line item in the national budget and also providing additional funding through presidential decree. However, this came after years of co-financing payments that were not made to support HIV programming, which resulted in nation-wide stock outs in 2019 and 2020. | In addition to funding the user fee elimination, the government must continue to honor its Global Fund commitment and participate in closing any commodities gaps that are identified in the move towards epidemic control. |
| | 14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity. | As a continuation of systems level investments started in COP18, systems to monitor morbidity and mortality should be prioritized. | No major barriers are identified; we encourage teams to continue with implementation. |
| | 15. Scale-up of case-based surveillance and unique identifiers for patients across all sites. | These activities have not been prioritized in Cameroon, given a still large treatment coverage gap. Unique identifiers exist for KPs and for ART treatment, but for ART, they are not linked to a | Health information systems are not currently in place in a robust way to enable case- based surveillance. |

| | | | |
|---|---|---|---|
| | | network that is accessed by all sites. | |

In addition to meeting the minimum requirements outlined above, it is expected that Cameroon will:

**Table 9. Cameroon COP/ROP 2020 (FY 2021) Technical Directives**

| **OU –Specific Directives** |
|---|
| **Supply Chain/Commodities** |
| 1. Supply chain partner must engage 3PL providers to do last mile distribution of commodities to clinical sites. |
| 2. Supply chain partner must engage personnel to assist in the customs clearance and waiver process at the point of entry in country. |
| 3. Supply chain partner must provide support for warehousing, inventory and distribution management at the national level at CENAME and at regional level via the "point focal." |
| 4. Clinical partners must engage pharmacy staff at sites to ensure proper ordering of optimal regimens is done, and to support proper storage practices, as well as support data collection of consumption and stock on hand at sites to inform optimal ordering. |
| 5. Supply chain transformation plan must be completed in COP20 in coordination with Global Fund, with plans to address lack of data visibility, distribution optimization, cold chain and warehousing challenges, and other key issues identified above. |
| **Case Finding** |
| 1. Index testing must be scaled with fidelity in all regions, with index testing counselors identified and retrained for all sites and with targets given to all index testers around number of contacts elicited and yields achieved. In COP19, all KP index testing should be stopped until further notice. |
| 2. OtherPITC must decline dramatically as a proportion of HTS_TST targets in COP20. |
| 3. Where Other PITC testing is done at clinical sites, the screening tool from the military partner must be used, with special attention paid to screening younger cohorts, whose yields have declined dramatically. |
| **Care & Treatment** |
| 1. Viral load testing must continue to scale up to achieve 90% coverage. |
| 2. Viral load suppression must improve to above 90%. This change should be driven by improved retention models for young people, TLD scale up, MMD and community dispensation. |
| 3. Retention strategies for young adults must be devised and implemented at the site level. |
| **Minimum Program Requirements** |

| |
|---|
| 1. A review of TLD guidelines must be done to ensure that the risk posed to WCBA by TLD is not overstated. |
| 2. Optimal ART Regimens for pediatrics must be implemented at all sites. Clinical partners must engage with staff prescribing and ordering pediatric ART regimens to ensure optimal regimens are provided. |
| 3. Multi-month dispensation must be scaled up dramatically in COP20. Partner level data must be collected on the proportion of the treatment population on MMD and reported to SGAC once each month. |
| 4. Community dispensation must also be scaled up. Partner level data must be collected on the proportion of the treatment population receiving community dispensation and reported to SGAC once each month. |
| 5. Opportunity to increase local partners and monitoring of user fee elimination through CSO-led monitoring through Ambassadors small grants. |
| **OVC** |
| 1. In COP20, OVC and clinical implementing partners in Cameroon must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program. |
| 2. OVC_SERV target achievement for beneficiaries under the age of 18 must increase to 90% or higher. |
| 3. Explore ways that Peace Corps can collaborate with Global Fund to support their investment in DREAMS-like programming for adolescent girls and young women. |
| **PrEP** |
| 1. Propose expansion of PrEP in populations with the greatest need. |
| **TB** |
| 1. Scale up of TB preventive therapies must continue with programs available to all PLHIV on treatment by the end of COP20. |

**COP/ROP 2020 Technical Priorities**

Client Centered Treatment Services

COP20 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site- level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services.

Community-led Monitoring

In COP 20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

Groups to be prioritized for PrEP include those testing negative in index testing but remaining at increased risk of HIV acquisition by virtue of unprotected exposure to a PLHIV with unsuppressed viral load, key populations including sex workers, men who have sex with men, transgender persons, people who use drugs, adolescent girls and young women, including pregnant and breastfeeding women, in areas with high HIV incidence or with high risk partners, and other identified serodiscordant couples. PEPFAR Cameroon should allocate $800,000 for PrEP in COP20.

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets should be set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows. PEPFAR Cameroon should allocate $1,000,000 for TB Prevention and TPT commodities in COP20.

OVC

To support the Minimum Program Requirement described above, in COP 20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi- disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

PLHIV Stigma Index 2.0

PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP 20, whether supported by PEPFAR or other resources.

**COP/ROP 2020 Stakeholder Engagement** (see section 2.5.3 of COP Guidance)

Sustained control of the HIV/AIDS epidemic necessitates that PEPFAR teams actively and routinely coordinate and communicate with all partners, including local, regional and international civil society and community stakeholders, multilateral partners and the host country government. With your leadership, PEPFAR is leading the way in facilitating transparent processes and in sharing data and results. Continued meaningful engagement with these groups throughout the development and implementation of COP/ROP 2020 remains a requirement for all PEPFAR programs, and as such the COP/ROP 2020 process will engage with stakeholders early and frequently. This engagement specifically includes the sharing of FY 2019 Q4 and FY 2019 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2020 in order to introduce and discuss all COP/ROP 2020 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2020. It is critical that meaningful involvement of civil society and community input is solicited and incorporated in every step of the process. In alignment with sustained control of the epidemic, the intentional outreach and inclusion throughout this process of civil society and community organizations that directly work with key and priority populations should be a priority of the PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2020, PEPFAR will convene in-person meetings in Johannesburg, South Africa, Bangkok, Thailand, and Atlanta, GA where outstanding decisions will be discussed and finalized. In addition to host-country representatives, the meetings will also include representatives from local and international civil society and community organizations and multilateral partners. Specific guidance for the 2020 meeting delegations have been provided elsewhere. Engagement with all stakeholders is required beyond the meetings and throughout the COP/ROP 2020 development and finalization process. As in COP/ROP 2019, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with stakeholders for their input and comments at least 72 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2020 Guidance for a full list of requirements and engagement timelines.

## APPENDIX 1: Detailed Budgetary Requirements

### Table 10. COP/ROP 2020 New Funding Detailed Controls by Initiative

| | COP 2020 Planning Level | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| | FY20 | | | FY19 | | | FY17 | | | COP 20 Total |
| | GHP-State | GHP-USAID | GAP | GHP-State | GHP-USAID | GAP | GHP-State | GHP-USAID | GAP | |
| Total New Funding | **$ 37,616,547** | **$ -** | **$ 575,119** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ -** | **$ 38,191,666** |
| Core Program | $ 35,816,547 | $ - | $ 575,119 | | | | | | | **$ 36,391,666** |
| COP 19 Performance | $ - | | | | | | | | | **$ -** |
| HKID Requirement ++ | $ 1,800,000 | | | | | | | | | **$ 1,800,000** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |
| | | | | | | | | | | **$ -** |

*++DREAMS countries with GHP-USAID funding can use FY20 GHP-USAID funding to meet their FY20 HKID Requirement. These countries include: Kenya; Nigeria; South Africa; Tanzania; Uganda; and Zambia*

### Table 11. COP/ROP 2020 Acceleration 20*

| | COP 20 |
|---|---|
| Total | **$ 53,570,911** |

***These funds are FY2019 appropriation funds that were transferred to USG Agencies during COP 2019 planning.*

*Care and Treatment: If there is no adjustment to the COP/ROP 2020 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment amount from Part 1 of the planning level letter across all funding sources. Additionally, due to Congressional earmarks, some of the care and treatment requirement must be programmed from specific funding sources, as indicated above in Table 2. Your care and treatment requirement for the purposes of Congressional earmarks is calculated as the sum of total new FY 2020 funding programmed to the HTXS, HTXD, HVTB, HBHC, PDTX, PDCS, HLAB budget codes, 80% of the total funding programmed to the MTCT budget code, and 50% of the total funding programmed to the HVCT budget code.*

*Orphans and Vulnerable Children (OVC): Countries must program to the full OVC amount from Part 1 of the planning across all funding sources. Your OVC requirement is made up of the HKID Requirement (see details below) and 85% of the DREAMS non-HKID programmed funds for all new FY 2020 funds. Additionally, due to Congressional earmarks, some of the OVC requirement must be programmed from specific funding sources, as indicated above in Table 2. The COP 2020 planned level of new funds for the OVC earmark can be above this amount; however, it cannot fall below it.*

*HKID Requirement: OU's COP/ROP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP/ROP 2020 HKID requirement is derived based upon the approved COP/ROP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The*

*COP/ROP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.*

*Gender Based Violence (GBV): OU's COP/ROP 2020 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total* ***new FY 2020*** *funding programmed to the GBV cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 GBV earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for GBV can be above this amount; however, it cannot fall below it.*

*Water: OU's COP/ROP 2020 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total* ***new FY 2020 funding*** *programmed to the water cross-cutting code. Your COP/ROP 2020 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2020 planned level of new FY 2020 funds for water can be above this amount; however, it cannot fall below it.*

*Transitioning HIV Services to Local Partners: To sustain epidemic control, it is critical that the full range of HIV prevention and treatment services are owned and operated by local institutions, governments, and organizations – regardless of current ARV coverage levels. The intent of the transitioning to local partners is to increase the delivery of direct HIV services, along with non-direct services provided at the site, and establish sufficient capacity, capability, and durability of these local partners to ensure successful, long-term local partner engagement and impact. This action is a priority for all OUs, Regional Programs and Country Pairs.*
*PEPFAR has set a 70% goal* ***by agency*** *by the end of FY20 and must meet 40% by FY19. Each country has to contribute to this goal based on the context of the local partner mix and types of public and private partners available to provide essential services. Therefore, each OU agency should work with their respective agency HQ in determining their contribution in meeting the agency level local partner requirement for FY20 as appropriate through their COP/ROP 2019 submission.*

**COP/ROP 2020 Applied Pipeline (**See Section 9.1.2 Applied Pipeline of COP Guidance)

*All agencies in Cameroon should hold a 3 month pipeline at the end of COP/ROP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP/ROP 2019 implementation (end of FY 2020) with a pipeline in excess of 3 months is required to apply this excessive pipeline to COP/ROP 2020, decreasing the new funding amount to stay within the planning level.*