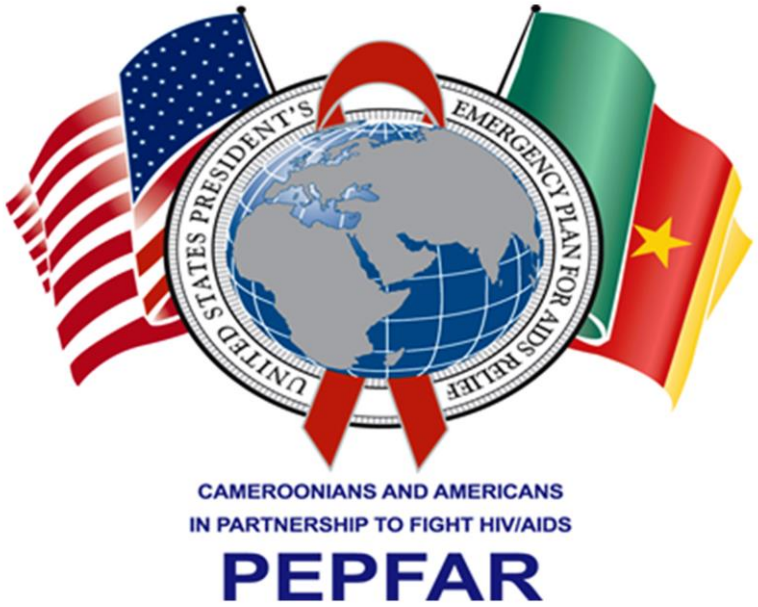


Cameroon Country Operational Plan
COP 2022
Strategic Direction Summary
5 MAY 2022

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 OU's 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.

Acronyms

3PL	Third Party Logistics
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent Girls and Young Women
AHD	Advanced HIV Disease
AIDS	Acquired Immune Deficiency Syndrome
ALHIV	Adolescents Living with HIV
ANC	Antenatal Care
APR	Annual Performance Report
APS	Accompagnateurs Psycho Sociaux (fr.), Psychosocial Guides/Agents (en.)
ARPA	American Rescue Plan Act
ART	Antiretroviral Therapy
ARV	Antiretroviral
C&T	Care and Treatment
CAD	Community ART Dispensation/Dispensing
CALHIV	Children and Adolescents Living with HIV
CAMPHIA	Cameroon Population HIV Impact Assessment
CBA	Childbearing age
CBO	Community-Based Organization
CCM	Country Coordinating Mechanism
CDC	U.S. Centers for Disease Control and Prevention
CFA	Central African Franc
CFSW	Clients of Female Sex Workers
CHW	Community Health Workers
CLHIV	Children Living with HIV
CODB	Cost of Doing Business
COP	Country Operational Plan

C19RM	COVID19 Response Mechanism
CSO	Civil Society Organization
DHIS2	District Health Information System
DHS	Demographic and Health Survey
DIC	Drop-in Center
DNO	Diagnostic Network Optimization
DoD	Department of Defense
DQA	Data Quality Assessment
DREAMS	Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe initiative for AGYW
DSD	Direct Service Delivery, or Differentiated Service Delivery
DTC	Diagnosis and Treatment Centers
DTG	Dolutegravir
e-MTCT	Elimination of Mother to Child Transmission
EA	Expenditure Analysis
EAC	Enhanced Adherence Counseling
ECD	Early Childhood Development
EGPAF	Elizabeth Glaser Pediatric AIDS Foundation
EID	Early Infant Diagnosis
eLMIS	Electronic Logistics Management Information System
EMR	Electronic Medical Record
EPI	Expanded Programme of Immunization
FP	Family Planning
FSW	Female Sex Workers
FY	Fiscal Year
GBV	Gender-Based Violence
GHSA	Global Health Security Agenda
GSM	Granular Site Management

GRC	Government of the Republic of Cameroon
HCW	Healthcare Workers
HEI	HIV-Exposed Infants
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HIVST	HIV Self-Testing
HSS	Health System Strengthening
HTC	HIV Testing and Counseling
HTS	HIV Testing Services
HVL	High Viral Load
IBBS	Integrated Bio-Behavioral Survey
ICT	Index Case Testing
IDP	Internally Displaced Persons
IIT	Interruptions in Treatment
IP	Implementing Partner
IPT	Isoniazid Preventive Therapy
IPV	Intimate Partner Violence
KP	Key Population(s)
KPLHIV	Key Population(s) living with HIV
LCM	Linkage Case Management
LDTD	Long Distance Truck Drivers
LE	Locally engaged
LPV/r	Lopinavir/ritonavir
LRA	Linkage and Retention Agent
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MDR	Multi-Drug Resistance

MER	Monitoring, Evaluation, and Reporting
MMD	Multi-Month Dispensation/Dispensing
MOH	Ministry of Health
MOU	Memorandum of Understanding
MSM	Men who have Sex with Men
MTCT	Mother to Child Transmission
NACC	National AIDS Control Committee
NASA	National AIDS Spending Assessment
NFM	New Funding Model
NTCP	National Tuberculosis Control Program
NTD	Neglected Tropical Disease
OI	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PBF	Pregnant and Breastfeeding
PBFW	Pregnant and Breastfeeding Women
PCR	Polymerase Chain Reaction
pDTG	Pediatric Dolutegravir
PE	Peer Educator
PEP	Post-Exposure Prophylaxis
PEPFAR	United States President's Emergency Plan for AIDS Relief
PITC	Provider-Initiated HIV Testing and Counseling
PL	Peer Leader
PLH	Parenting for Lifelong Health
PLHIV	People Living with HIV
PLH	Parenting for Lifelong Health
PMTCT	Prevention Mother to Child Transmission
PN	Peer Navigator

PNC	Post-natal Care
POART	PEPFAR Oversight Accountability and Review Team
POC	Point of Care
PR	Principal Recipient
PrEP	Pre-Exposure Prophylaxis
PT	Proficiency Testing
PWID	People Who Inject Drugs
QA	Quality Assurance
QI	Quality Improvement
QIC	Quality Improvement Collaborative
QMS	Quality Management System
RTC	Return to Care
RTK	HIV Rapid Test Kit
SABERS	HIV Seroprevalence and Behavioral Epidemiology Risk Survey
SGAC	Department of State's Office of the Global AIDS Coordinator
SGBV	Sexual and Gender-Based Violence
SI	Strategic Information
SID	Sustainability Index and Dashboard
SIMS	Site Improvement through Monitoring System
SMS	Short Message Service
SNS	Social Network Strategy
SNU	Sub-National Unit
SOP	Standard Operating Procedure
SQA	Service Quality Assessment
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TA	Technical Assistance

TAT	Turnaround Time
TAW	Treatment Access Watch
TB	Tuberculosis
TBIC	TB Infection Prevention and Control
TLD	Tenofovir/Lamivudine/Dolutegravir
TLE	Tenofovir/Lamivudine/Efavirenz
TPT	TB preventive treatment
UIC	Unique Identifier Code
UNAIDS	Joint United Nations Program on HIV/AIDS
USAID	United States Agency for International Development
USG	United States Government
VCT	Voluntary Counseling and Testing
VL	Viral Load
WHO	World Health Organization

1.0 Vision and Goal Statement

In Fiscal Year 2022 Country Operational Plan (COP21), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) team in Cameroon is implementing new and innovative strategies to support the Government of Cameroon (GRC) in responding to the HIV epidemic, as well as to maintain PEPFAR program gains in the context of the COVID-19 pandemic. This submission of the FY23 COP (COP22) plan, details the strategies and programming that the U.S. Government (USG) will implement in the COP22 cycle, which will support Cameroon in reaching epidemic control of HIV by the end of 2023.

Cameroon has an estimated 494,476 People Living with HIV (PLHIV), according to the 2022 UNAIDS Spectrum model estimates. As of December 2021, 388,354 PLHIV were receiving antiretroviral treatment (ART) nationally, and national targets aim for 442,328 to be on ART by the end of COP22. Indeed, a critical achievement of COP22 planning has been the alignment of PEPFAR targets with national and NFM3 (Global Fund) targets, with a now common goal of achieving epidemic control in COP22 by placing 442,328 individuals on treatment, which represents 90% treatment coverage of all individuals living with HIV in Cameroon and is in line with the 95-95-95 UNAIDS treatment goals. COP22 is planned with the COVID-19 pandemic in mind, which has impacted health facilities and PEPFAR programming in Cameroon since COP19. As of April 11, 2022, there have been 119,799 confirmed cases of COVID-19 in Cameroon, including 1,927 deaths, with 1,821,131,824 vaccine doses administered and 1,163,960 persons fully vaccinated, as of April 13 (MOH, WHO). While COVID-19 will continue to impact programming in COP22, the COP22 plan will build on the achievements and innovations made in COP20 and COP21 to adapt to COVID-19 and advance towards epidemic control. Through an allocation of $80.4 million, COP22 will intensify strategies on:

- **Ensuring access to optimal treatment regimens,** specifically that all adults living with HIV weighing at least 30kg are offered TLD for treatment, and all children who are at least 4 weeks of age and weigh at least 3 kg are offered DTG-10 for treatment
- **Improving pediatric performance** across the cascade spectrum, prioritizing early infant diagnosis (EID) coverage at 2 months, transitioning all children to dolutegravir, and increasing MMD and viral load suppression and coverage in children
- **Differentiated testing and service delivery,** to customize case-finding approaches for different geographic and population needs, and provide person-centered care that includes multi-month and decentralized drug dispensation, and other population-focused strategies
- **Accelerating population-tailored prevention strategies, especially scaling up Pre-Exposure Prophylaxis (PrEP)** and working to expand access to PrEP to all at-risk populations, including all Key Populations, Adolescent Girls and Young Women (AGYW), pregnant and breastfeeding women, and sero-discordant couples
- **Improving supply chain management** and commodities procurement, stock management, and distribution coordination

In COP22, PEPFAR will add an additional 40,008 people to treatment (TX_NEW). Cameroon will improve and prioritize EID to reach 95% (6,428) of HIV-exposed infants (HEI) by the 2-month

mark. Additionally, 96,786 key populations (KP), including men who have sex with men (MSM), female sex workers (FSW), prisoners, and people who inject drugs (PWID), will be reached with prevention activities, among whom all will be tested for HIV if not already known to be positive. A focus on prevention and expanding access to Pre-Exposure Prophylaxis (PrEP) will lead to 8,725 newly enrolled individuals on oral PrEP. PEPFAR will provide a comprehensive package of services to 65,321 orphans and vulnerable children (OVC) and offer enrollment to 90% of the children and adolescents living with HIV (CALHIV) through PEPFAR-supported health facilities in areas of implementation of the OVC program.

The PEPFAR program in Cameroon will continue to build off the success of the breakthrough policy decision to remove user-fee implementation in COP19 and ensure the continued implementation of this policy decision through community-led monitoring (CLM). PEPFAR Cameroon aims to strengthen its CLM activities by focusing on the quality of KP services in COP22 and improving participation of civil society in health programming by engaging independent, local civil society organizations (CSO) and KP-led organizations to implement CLM activities. The PEPFAR team will also engage in regular coordination and planning sessions with CSOs throughout the COP22 year, to ensure that CSO feedback is incorporated into programming in an on-going and interactive manner.

Regular engagement and close coordination with the GRC, CSOs, and bilateral and multilateral partners have been critical to the continued success of the PEPFAR Cameroon program and reaching the 95-95-95 goals. This COP submission responds to the directives of the Planning Level Letter as well as to the input of our stakeholders, as received through our COP planning meetings, and reflects PEPFAR's shared commitment to achieving HIV epidemic control in Cameroon by 2023.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

As of May 2022, Cameroon's total population was estimated at 27,874,766 people, with a total projected number of PLHIV for 2022 at 494,476 (Spectrum, 2022). Cameroon has a mixed HIV/AIDS epidemic (i.e., one or more concentrated epidemics within a generalized epidemic). National HIV incidence is 0.27% among the population aged 15-64. Four out of five new infections are among women aged 15-64. Overall, adult HIV prevalence has continually decreased in the past 15+ years, moving from 5.4% in 2004 (DHS, 2004) to 4.3% in 2011 (DHS, 2011), 3.4% in 2017 (CAMPHIA, 2017) and recently 2.7% in 2018 (DHS, 2018).

The most recent population-based HIV impact assessment (PHIA) in Cameroon was done in 2017, and much progress has been made in the years since. The results from the PHIA indicated that 56% of people living with HIV were aware of their status, 93% of those aware of their status were on treatment, and 80% of those on treatment were virally suppressed. Though without another PHIA, the current values for these three metrics can only be estimated with program data, currently, the program estimates that 85% of individuals living with HIV know their status, 92% of those who know their status are on treatment, and 94% of those on treatment are virally suppressed. These estimates correspond to the current number of people living with HIV who

are on antiretroviral treatment nationally, which was 388,358 in December 2021, representing 78.5% treatment coverage (the proportion of those who are HIV positive who are also on treatment), nationally.

HIV prevalence is highest among women between 35-39 years of age (6.5%), and 40-44 years of age (6.4%); and close to 5% among women aged 45-49 and 50-64. For men, HIV prevalence is highest in the 35-39 age range (5.1%), and over 4.8% among men in the age group 40-44. AGYW are equally affected as their male counterparts in the 15-19 age range (0.8%) but have a higher burden in the 20-24 age range (2.4% vs. 1.5%). From DHS 2018, prevalence is higher in urban areas (2.9%) compared to rural areas (2.4%). The economic capital, Douala, and the political capital, Yaoundé, both have a 2.4% prevalence, with 3.2% among women and 1.5% among men. Other urban areas have an overall HIV prevalence of 3.4% with 4.3% among women and 2.3% among men. The South and East Regions have the highest prevalence (5.8% and 5.6%, respectively), with the lowest prevalence regions being the Far North (1.1%), West (1.6%) and North (1.7%). While prevalence among women is overall nearly twice that of men (3.4% vs. 1.9%, DHS 2018), the ratio between women and men shows different patterns from one Region to another. Prevalence among women is 3.6 and 3.5 times higher than men (North-West and Littoral respectively), while the South is the one Region where men have a higher prevalence than women (5.5% among women versus 6.1% for men).

KP overall presents with significantly higher HIV prevalence compared to the national average, 24.3% among FSWs and 29.7% among MSMs (IBBS, 2016). Disparities in prevalence amongst FSWs vary significantly by age, according to the 2016 Integrated Bio-Behavioral Survey (IBBS). Though they represent a significant majority of FSWs, those below the age of 30 (20-24: 8.7%, 25-29: 16.1%) have a lower prevalence compared to those above the age of 30 (30-34: 33.8%, 35-39: 42.2%, 40-44: 46.3%, 45-49: 48.8%, 50-54:40.0% and 55+: 26.3%). Similarly, amongst MSM, HIV prevalence is lower amongst younger MSMs (20-24: 15.2%, 25-29: 29.4%, 30-34: 33%, 35-39: 40%, 40-44: 45% and 45+:57.1%).

Standard Table 2.1.1

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				
			Female		Male		Female		Male		Female		Male		Source, Year
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	27,874,766	100%	5,709,707	20.5%	5,812,075	20.9%	2,783,755	10.0%	2,810,144	10.1%	5,430,263	19.5%	5,328,822	19.1%	2022 Spectrum Estimates
HIV Prevalence (%)		2.7%		0.10%		0.30%		1.10%		0.90%		4.70%		2.20%	DHS 2018, CAMPHIA 2018 Spectrum 2021
AIDS Deaths (Per year)	10,709		1,391		1,427		462		358		3,918		3,153		2022 Spectrum estimates
# PLHIV	494,476		14,389		14,734		34,138		21,261		282,349		127,605		2022 Spectrum Estimates
Incidence Rate (Yr)		0.04%		0.02%		0.02%		0.09%		0.03%		0.06%		0.03%	2022 Spectrum Estimates
New Infections (Yr)	10,636		1,082		1,118		2,627		710		3,445		1,654		2022 Spectrum Estimates
Annual births	901,742														2022 Spectrum estimates
% Of Pregnant Women with at least one ANC visit		87%													DHS 2018
Pregnant women needing ARVs	24,999														2020 Spectrum estimates
AIDS Orphans (maternal, paternal, double)	456,554														2021 Spectrum estimates
Notified TB cases (Yr)	22,740														WHO 2021, Global Tuberculosis Report
% Of TB cases that are HIV infected	6,359	10%													WHO 2021, Global Tuberculosis Report
% Of Males Circumcised		93%													DHS 2018
Estimated Population Size of MSM*	66,842														Papworth, 2014
MSM HIV Prevalence		20.70%													2016 IBBS report
Estimated Population Size of FSW	112,580														World Bank, 2016
FSW HIV Prevalence		24.30%													2016 IBBS report
Estimated Population Size of PWID	N/A														N/A
PWID HIV Prevalence	N/A														N/A
Estimated Size of Priority Populations (Military)	50,000														SABERS 2018
Estimated Size of Priority Populations Prevalence (specify)		3.30%													SABERS 2018

Standard Table 2.1.2

Table 2.1.2 95-95-95 cascade: HIV diagnosis, Treatment, and Viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	*Total Population Size Estimate (#)	**HIV Prevalence (%)	*Est Total PLHIV (#)	*PLHIV diagnosed (#)	*On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	27,874,766	2.70%	494,476	422,181	388,358	78.5%	84.5%	3,110,397	84,449	70,860
Population <15 years	11,521,782	0.25%	29,123	12,769	11,531	39.6%	68%	194,145	2,679	1,958
Men 15-24 years	2,810,144	0.90%	21,261	13,825	6,285	29.6%	77%	269,710	2,766	2,005
Men 25+ years	5,328,822	2.20%	127,605	114,569	106,913	83.8%	88%	734,487	25,921	22,035
Women 15-24 years	2,783,755	1.10%	34,138	25,496	21,220	62.2%	81%	719,959	11,325	9,164
Women 25+ years	5,430,263	4.70%	282,349	255,522	242,409	85.9%	99%	1,190,096	41,758	*35,698*
+MSM	66,842	20.7%**	13,836	-	-	-	-	16,025	1,474	*889*
+FSW	112,580	24.3%**	27,357	-	-	-	-	22,437	1,677	*708*
PWID	-	-	-	-	-	-	-	1,567	74	*27*
++Priority Pop	50,000	3.3%	1,650	-	-	-	-	10,006	-	-

Figure 2.1.1 Updated National and PEPFAR New Trend for Individuals Currently on Treatment

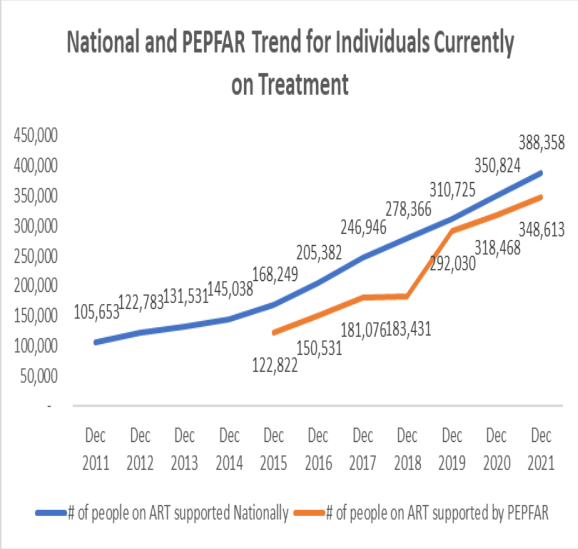


Figure 2.1.2 Updated Trend of Infections and All-Cause Mortality among PLHIV

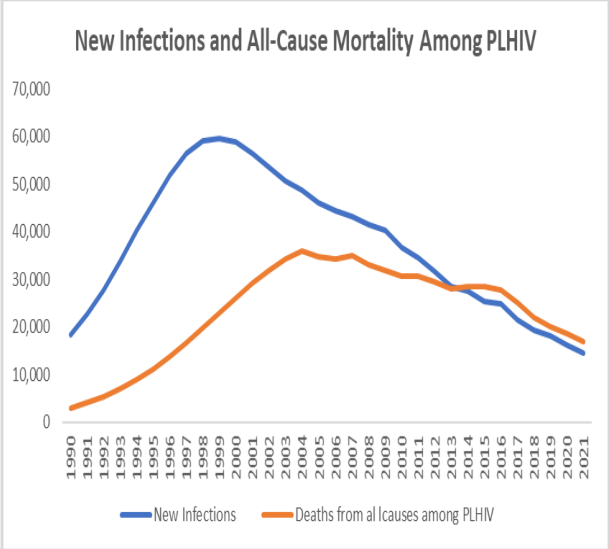


Figure 2.1.3 Assessment of ART program growth in FY21

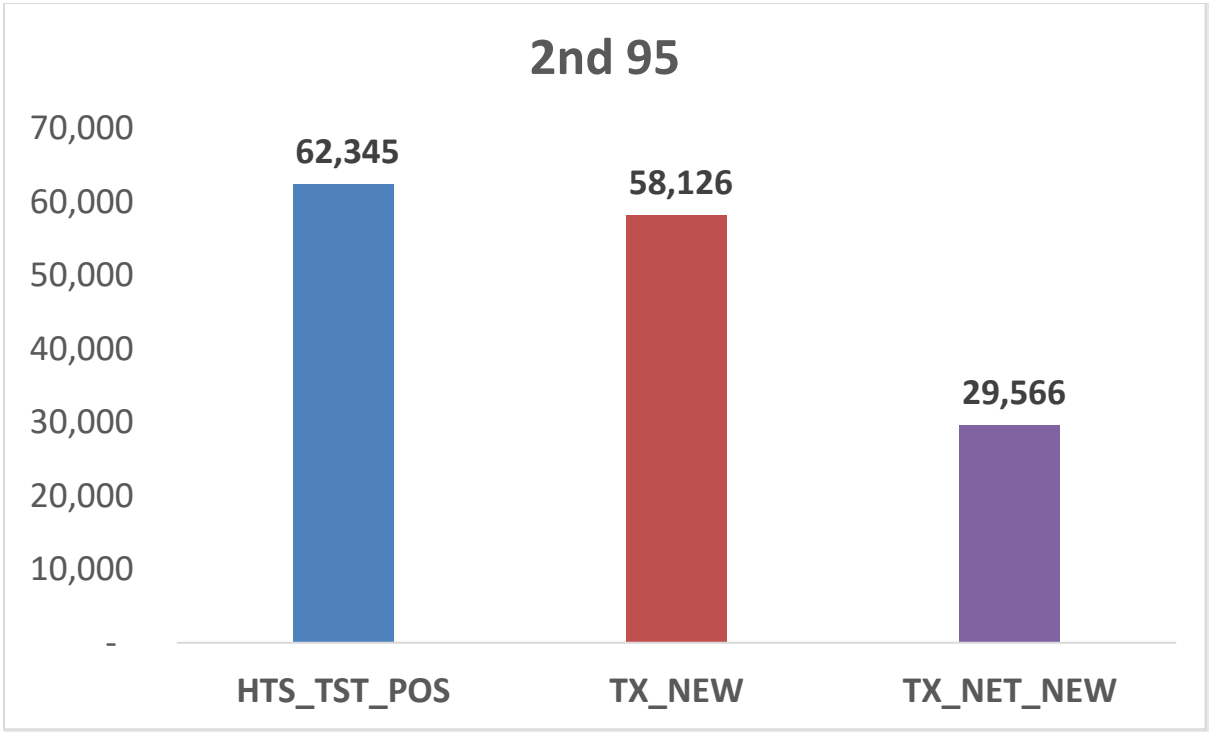


Figure 2.1.4 Clients Gained/Lost from ART by Age/Sex, Q1FY21 to Q4FY21

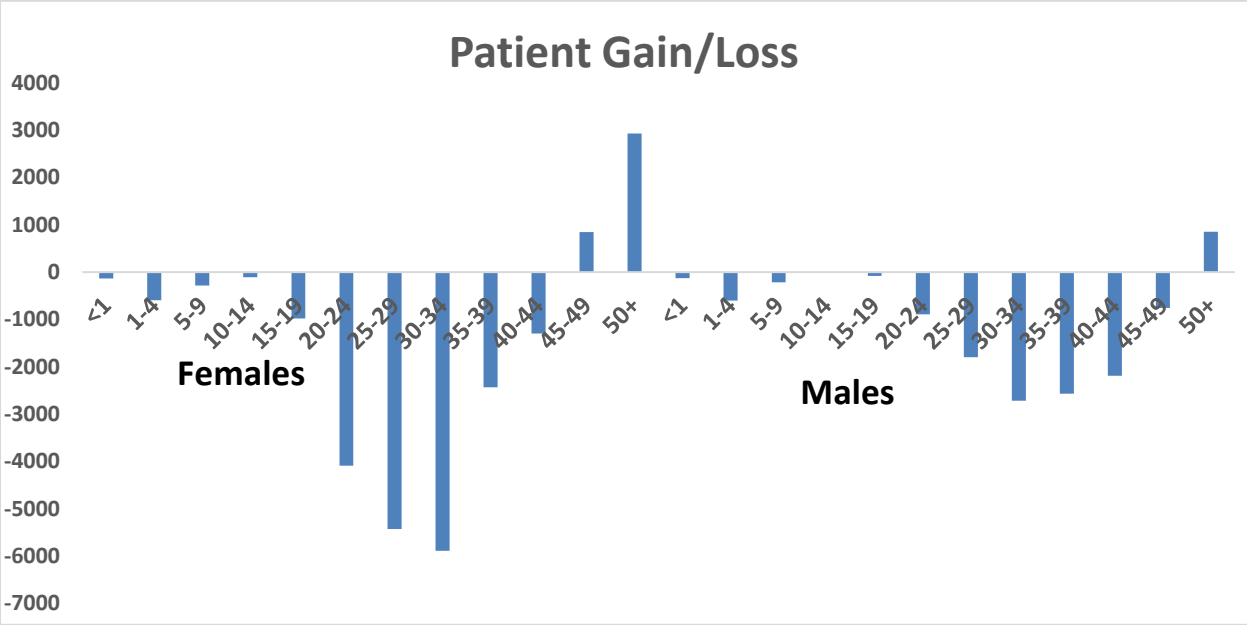


Figure 2.1.5 Epidemiologic Trends and Program Response for Cameroon

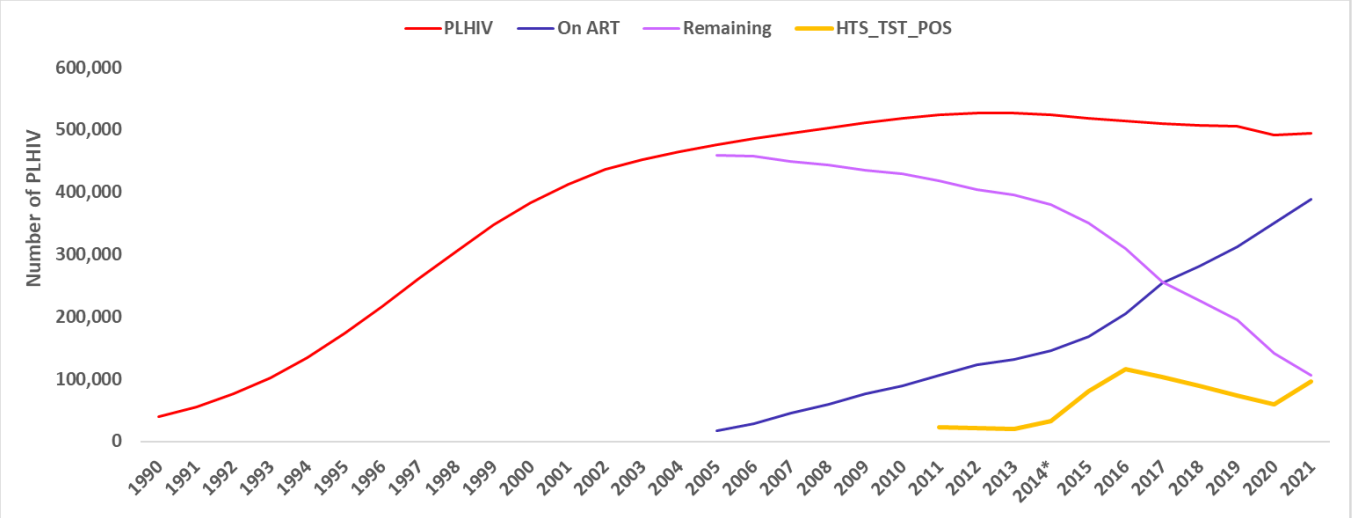


Figure 2.1.6 Net change in HIV treatment by sex and age bands 2021 Q1 to 2021 Q4

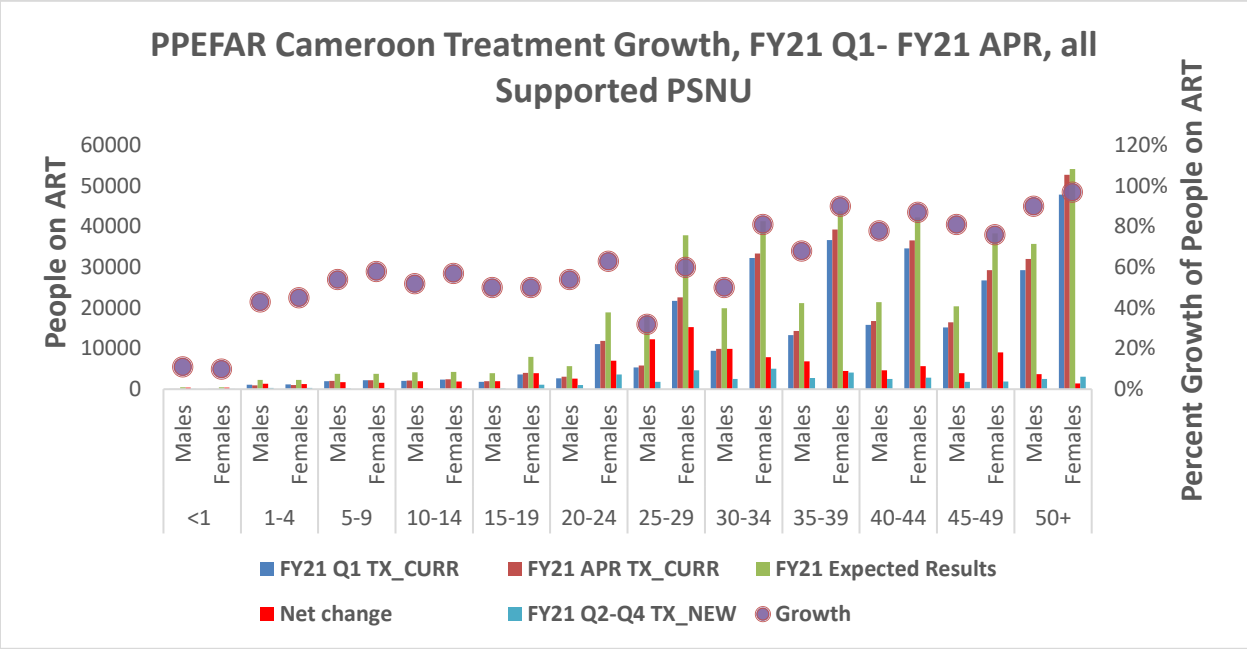


Figure 2.1.6 highlights the continued need for interventions to increase the HIV treatment program among children and adolescents living with HIV, especially infants and males between the 25–34-year-old age range.

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

In COP22, to optimize ART for children and adolescents living with HIV (CALHIV) and reduce morbidity and mortality in this sub-population, PEPFAR Cameroon plans to decentralize pediatric and adolescent HIV care through the creation of pediatric training centers and a mentorship program to cover at least 50% of the sites, up from the current 21% under the leadership of the National AIDS Control Committee (NACC). High-volume pediatric clinics will be identified according to standard criteria and strengthened to serve as “hubs” that offer high quality HIV care and treatment services to children and adolescents. PEPFAR Cameroon will conduct a baseline assessment for these sites to identify gaps that clinical Implementing Partners (IPs) will address throughout COP22. Site Mentors will have their capacities strengthened to train and mentor smaller “spoke” facilities to offer a minimum package of age and gender appropriate services to all CALHIV. A competency-based harmonized training curriculum developed by the Ministry of Health (MOH) in collaboration with its partners will serve to guide the implementation of pediatric training centers of excellence. PEPFAR Cameroon will contribute to develop additional tools, standard operating procedures (SOPs), job aids and registers to strengthen monitoring and evaluation of the project.

HIV Prevention, Care and Treatment Services for Pregnant and Breastfeeding (PBF) AGYW will be implemented within the Prevention of Mother to Child Transmission (PMTCT) program. PBF AGYW are a vulnerable population as they are less likely to engage in Antenatal care (ANC) and Post-natal care (PNC), have higher maternal mortality and stillbirths, and experience high stigma and Gender-Based Violence (GBV). They are also less likely to know their HIV status before

pregnancy, or to enroll in and adhere to ART, putting them at greater risk of MTCT of HIV. PEPFAR Cameroon will implement and scale-up "Age-appropriate risk and vulnerability screening interventions to address disparities" for PBF AGYW in all PEPFAR supported sites. Services offered for this target population will include active screening at multiple care points (i.e., infant immunization visits, family planning (FP) visits) of young mothers for risk factors and seroconversion, adolescent-friendly PMTCT services such as peer-led activities, flexible ANC schedules and health care providers trained in adolescent- and youth-friendly care. Adolescent champions will be identified among PBF AGYW at ANC and will have their capacities strengthened to provide adolescent- and youth-friendly services. Other services will include prevention and risk reduction counselling, treatment literacy through mother mentors and peer support, partner testing and disclosure, child well health services and positive parenting, sexual and reproductive health (SRH) services including FP, capacity-building on leadership, and life skills while ensuring referrals and linkages to OVC/AGYW and other support services. Services for the prevention and case finding among pregnant and breastfeeding women (PBFW) through the provision of HTS and PrEP to vulnerable populations will be made available, as well as the rollout of HIV prevention services, including PrEP, with a focus on reaching AGYW, pregnant and breastfeeding women, and other high-risk groups, in high HIV prevalence settings.

Additionally, PEPFAR Cameroon will continue to support the implementation of outreach interventions in the community such as "*Chefferie* testing" to improve case finding. (See the subsection on Community Case-Finding Strategies for a detailed explanation of the *Chefferie* approach.) More attention will be paid to identifying and addressing stigma and discrimination in all PEPFAR supported sites. FY21 program and DHIS2 data shows that some regions are approaching epidemic control, hence the need to introduce recency testing to better understand epidemiologic trends of recent infections and better target case-finding efforts to reach those communities with increasing new transmissions in these regions. To ensure continuity of treatment among all PLHIV, the program will continue to scale up the implementation of multi-month dispensation (MMD) for all eligible PLHIV, with a focus on 3-5 and 6+ months pending on drug availability, and the rollout of decentralized drug distribution via satellite sites and other differentiated service delivery models across the 10 regions. To reduce morbidity and mortality among PLHIV, PEPFAR Cameroon will continue to offer a minimum package of services for advanced HIV disease (AHD) and to support capacity-building of health care providers to identify and manage AHD. Lastly, the program will collaborate with the MOH to set up a free e-learning platform on HIV and TB care and treatment to strengthen health care worker (HCW) capacity.

In COP22, at least 90% of eligible CALHIV in PEPFAR-supported Sub-national Units (SNUs) will be offered enrollment in the OVC program to increase access to health, social, legal, and economic support and to support their continuity in treatment and viral load suppression. These OVC-supported SNUs encompass clients on treatment in high burden PEPFAR-supported clinical sites, as well as those receiving treatment in smaller, non-PEPFAR sites co-located in the same health district. OVC programs will focus on the key challenges for children in the epidemic, specifically: continued transmission of HIV from mother to child, the pediatric treatment gap, advanced disease, low virologic suppression rates, the high rate of sexual violence against adolescent girls, and the risk to children of losing a caregiver due to adult interruption in treatment and poor viral suppression rates. Community and clinical partners will continue to strengthen

their collaboration based on agreement through Memoranda of Understanding (MOUs) signed in COP21. Through these MOUs, the community and clinical partners will continue to improve bi-directional referrals and case conferencing, and conduct joint data reviews, monthly coordination meetings, and joint site visits in order to strengthen the collaboration platform.

2.3 Investment Profile

This investment profile reflects the latest approved national and external expenditure data from 2018-2019. To align with the 2018-2019 national expenditure report, PEPFAR Cameroon used data from the 2018 Expenditure Reporting for analysis. PEPFAR Cameroon is working with government and other stakeholders to ensure access to more up to date information as this data has not been updated recently enough to provide a clear investment profile for 2022.

According to these sources, national HIV/AIDS outlays slightly increased by 7% between 2018 and 2019, from 48,839,658,551 FCFA to 52,340,515,482 FCFA respectively ($78.6 million USD to $84.2 million USD). Even with this increase, domestic spending remained low at 12.0% in 2018 and 10.4% in 2019, leaving the national HIV response heavily reliant on external funding: 88.0% in 2018 and 89.6% in 2019. Again, this data is out of date and must be updated to understand the current context, though it is expected that current funding continues to reflect a dependence on external funding for the HIV response.

Although HIV/AIDS expenditures showed a general upward trend between 2007 and 2019, progression has been uneven, as seen in Figure 2.3.1 below. Between 2007 and 2009, allocated resources increased, but then declined in 2010 and 2011 due to the global economic and financial crisis. Funding then experienced an increase of 32% between 2011 and 2013, from 23.99 billion FCFA to 31.67 billion FCFA due to the implementation of the R10 program of the Global Fund, with 2013 representing a pivotal year and the growing involvement of bilateral partners such as the USG through the PEPFAR program. A steady rise in funding for HIV from 2014 onwards reflects the continued support of the Global Fund through the new funding model and the increasing funding from the USG to Cameroon.

Figure 2.3.1: Trends in HIV/AIDS spending between 2007 and 2019 in Cameroon

Source: 2018-2019 NASA/REDES report

Standard Table 2.3.1: Investment Profile for HIV Program

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2021						
	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	$	%	%	%	%	2018-2021
Care and Treatment	$93,222,551	0%	44%	56%	0%	
HIV Care and Clinical Services	$83,135,471	0%	46%	54%	0%	
Laboratory Services incl. Treatment Monitoring	$7,902,955	0%	2%	98%	0%	
Care and Treatment (Not Disaggregated)	$2,184,125	0%	95%	5%	0%	
HIV Testing Services	$9,940,270	0%	26%	74%	0%	
Facility-Based Testing	$5,525,986	0%	14%	86%	0%	
Community-Based Testing	$1,891,868	0%	56%	44%	0%	
HIV Testing Services (Not Disaggregated)	$2,522,416	0%	29%	71%	0%	
Prevention	$5,278,638	0%	48%	52%	0%	
Community mobilization, behavior and norms change	$1,874,859	0%	89%	11%	0%	
Voluntary Medical Male Circumcision	$0					
Pre-Exposure Prophylaxis	$937,962	0%	3%	97%	0%	
Condom and Lubricant Programming	$639,567	0%	100%	0%	0%	
Opioid Substitution Therapy	$33,748	0%	100%	0%	0%	
Primary Prevention of HIV & Sexual Violence	$108,583	0%	100%	0%	0%	
Prevention (Not Disaggregated)	$1,683,919	0%	5%	95%	0%	
Orphans and Vulnerable Children	$6,780,032	0%	23%	77%	0%	
Case Management	$0					
Economic Strengthening	$0					
Education Assistance	$0					
Psychosocial Support	$0					
Legal, Human Rights, and Protection	$1,401,326	0%	83%	17%	0%	
OVC (Not Disaggregated)	$5,378,706	0%	8%	92%	0%	
Above Site Programs	$74,877,898	0%	22%	78%	0%	
Human Resources for Health	$2,788,271	0%	100%	0%	0%	
Institutional Prevention	$0					
Procurement and Supply Chain Management	$2,651,659	0%	35%	65%	0%	
Health Mgmt Info Systems, Surveillance, and Research	$3,050,325	0%	68%	32%	0%	
Laboratory Systems Strengthening	$245,578	0%	31%	69%	0%	
Public Financial Management Strengthening	$0					
Policy, Planning, Coordination and Management of Disease Ctrl Programs	$55,756,826	0%	2%	98%	0%	
Laws, Regulations and Policy Environment	$543,000	0%	0%	100%	0%	
Above Site Programs (Not Disaggregated)	$9,842,239	0%	95%	5%	0%	
Program Management	$18,808,937	0%	27%	73%	0%	
Implementation Level	$18,808,937	0%	27%	73%	0%	
Total (incl. Commodities)	**$208,908,326**	**0%**	**33%**	**67%**	**0%**	
Commodities Only	**$55,178,543**	**0%**	**90%**	**10%**	**0%**	
% of Total Budget	26%					

Source: HIV Resource Alignment

Standard Table 2.3.2: Investment Profile for HIV Commodities

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**
NIH	-	-	-	-	-
USAID Malaria	$21,940,600	$11,412,780 (malaria supply chain TA and commodities procurement)	1 (Through two task orders for HIV/AIDS and malaria)	$7,694,828 (FY21; HIV/AIDS supply chain TA and commodities procurement)	Engage in malaria service delivery (distribution of nets, seasonal malaria chemoprevention, treatment) and health systems strengthening (strategic information, supply chain systems strengthening, human resources for health).
USAID Global Health Security Agenda (GHSA)	$6,381,597	$0	0	$0	Provide COVID-19 technical assistance for vaccine delivery and country readiness. Prevent and control emerging zoonotic diseases of significant public health concern. Bolster workforce capacity and disease surveillance and response. Enhance pharmaceutical services. Risk communication and community engagement.
USAID Neglected Tropical Diseases	$4,118,000	$0	0	$0	Support the Ministry of Public Health to eliminate, address public health problems and/or sustain treatment for NTDs.
USAID Polio	$171,054	$0	0	$0	Support country team readiness
USAID other HIV/AIDS	$630,000	$380,000	1 (However, different scope for COP-funded activities).	$0 (FY21); $240,000 (COP22 – however, different scope)	Support the city of Yaoundé to accelerate local HIV, TB, and viral hepatitis response. Conduct assessment on feasibility of implementing decentralized distribution of antiretroviral therapy in Cameroon
USAID other HSS	$22,500	$0	0	$0	Build the supply chain capacity of Presbyterian Health Services' Central Pharmacy and Cameroon Baptist Convention Health Service Central Pharmacy.
USAID (Humanitarian Assistance)	$2,381,500	$0	0	$0	Provide health and nutrition assistance to refugees, internally displaced person, and host community
CDC (Global Health Security)	$ 1,000,000	-	-	-	Support activities to strengthen laboratory capacity; prepare for, detect and respond to emergencies. Improve disease surveillance capacity. Develop a public health workforce through the Cameroon Field Epidemiology Training Program. Provide technical assistance for immunizations and zoonotic diseases. Respond to the COVID-19 pandemic
Peace Corps	-	-	-	-	-
DOD Ebola	-	-	-	-	-
MCC	-	-	-	-	-
Other (specify)	-	-	-	-	-
Total	**$ 36,645,251**	**-**	**-**	**-**	**-**

2.4 National Sustainability Profile Update

Cameroon Country Overview

The Government of the Republic of Cameroon (GRC), in partnership with PEPFAR Cameroon, other multilateral donors, civil society and the private sector, has made significant progress towards the goal of reaching epidemic control of HIV. From Spectrum data as of December 2021, Cameroon's estimated status is 85/92/94, showing positive trends for incidence and mortality. Estimated HIV prevalence, per the 2018 DHS, stands at 2.7% among adults aged 15 - 49.

During the Sustainability Index Dashboard (SID) timeframe of 2020-2021, Cameroon maintained program gains during the beginning of the COVID-19 pandemic through innovative strategies to sustain HIV services. As of April 11, 2022, Cameroon had 119,799 COVID-19 cumulative confirmed cases, including 1,927 deaths (1.6% fatality rate) and 117,792 recoveries (98.3% recovery rate). Over 3.4 million doses of Sinopharm, AstraZeneca, J&J and Pfizer COVID-19 vaccines have been received through various sources, with over 1 million people receiving at least one dose of the vaccines, resulting in 8.5% of the target population fully vaccinated. 781 pregnant women were infected with COVID-19, leading to seven 7 deaths. As of April 11, the country had a severity rate of 0.0% with no reported active cases and no in-patients to date. The country sustained four waves that all have made negative impacts on the HIV program, which has nonetheless adapted various mitigation strategies. (Source: Ministry of Public Health)

The major programmatic gaps and barriers identified through the SID 2021 remain largely the same; with most of the elements remaining similar to SID 4.0. Only two elements fell below SID 4.0 levels, however this decrease was minimal across all two. The weakest elements remain the Laboratory under National Health System and Service Delivery and Data for Decision Making Ecosystem under Strategic Information, however, the increasing trend has remained over the last few SIDS.

The dashboard demonstrates that even though gains have been made or sustained in most investment domains, Cameroon continues to need support in investments in HIV and the health sector to reach its potential for reaching epidemic control and sustaining the national response. In a climate of uncertain global HIV funding, the SID process will remain critical in supporting the GRC and partners in understanding where investments have made sufficient impact over the years and where investments might need to be more appropriately targeted to reach national sustainability.

In addition to these weaker elements above, Supply Chain and Laboratory remain vulnerable with a yellow score, making smaller gains starting from SID 2.0 in 2015. To mitigate and support investment, the USG continues to work closely with NACC and other stakeholders to proactively identify stock tension, raise red flag on supply disruption risks, redistribute stock as needed between regions/labs, expedite import waiver process and orders to minimize impact on programming. Limited national procurement levels continue to undermine the supply strategy.

SID Process

PEPFAR Cameroon began the SID 2021 process by undertaking a desk review of all required documentation with follow up consultations of the various constituencies. Through virtual and in-person meetings, PEPFAR staff met with external stakeholders from the different PEPFAR supported regions to facilitate the SID 2021 process; input was gathered from civil society representatives, private sector entities, UNAIDS, WHO, the Global Fund, USG and the GRC. A final review session with stakeholders was convened in October 2021, with participants reviewing the completed tool, further discussing the findings, identifying priorities, and providing additional input.

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	9.17	8.95	10.00	9.50
2. Policies and Governance	4.35	5.98	6.18	7.11
3. Civil Society Engagement	7.00	7.58	7.58	7.92
4. Private Sector Engagement	5.58	8.11	8.89	9.24
5. Public Access to Information	10.00	9.00	9.00	9.00
National Health System and Service Delivery				
6. Service Delivery	4.40	5.88	6.17	6.17
7. Human Resources for Health	6.17	6.71	7.54	7.54
8. Commodity Security and Supply Chain	4.11	5.43	5.57	6.18
9. Quality Management	2.19	5.76	6.76	7.14
10. Laboratory	3.01	5.83	6.56	5.71
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	6.11	5.62	6.31	6.31
12. Technical and Allocative Efficiencies	6.15	8.83	9.36	8.60
13. Market Openness	N/A	N/A	9.64	9.67
Strategic Information				
14. Epidemiological and Health Data	4.78	5.54	6.22	6.18
15. Financial/Expenditure Data	8.33	8.33	8.33	8.33
16. Performance Data	6.17	6.19	6.09	6.96
17. Data for Decision-Making Ecosystem	N/A	N/A	3.67	5.36

Sustainability Strengths:

- **Planning and coordination (9.5– dark green):** The Government of Cameroon continues to perform a strong leadership role in the national HIV response. This leadership has resulted in the adoption of best practices and global technical policies. Cameroon saw a slight dip from the SID 4.0 in its capacity to plan and coordinate but still maintains a high dark green scoring. The government will need to maintain this to ensure consistent progress towards 95-95-95. With PEPFAR support, the Government is taking the lead in coordinating all HIV stakeholders in-country through an annual coordination meeting in view of eliminating programs overlaps and optimizing programs efficiency and impact.
- **Private Sector Engagement (9.24 – dark green):** Cameroon made significant strides from the SID 2.0 in further engaging the private sector in the national HIV/AIDS response, but the private sector remains slanted more towards private and faith-based health facility providers and larger corporations.
- **Technical and Allocative Efficiencies (8.6 – dark green):** This element saw a slight decrease from 2019 but has gained significantly since 2015, starting with a score of 6.15. Efficiency improvements were made with the introduction of the elimination of the HIV user fees across the country in January 2020 and with multi-month scripting, among other differentiated service delivery.

Sustainability Vulnerabilities

Cameroon has not scored any unsustainable/red level elements since SID 2.0 in 2015. However, within seven yellow elements scored, four continue in the National Health System and Service Delivery domain, showing that health systems remain an emerging sustainability priority and continue to need strengthening to support HIV critical services.

- **Commodity Security and Supply Chain (6.18 - yellow):** The scoring in this element increased slightly from 5.57. A 2022-2026 National Strategic Plan to Strengthen the Supply Chain Management of Health Products was released in April 2022. It has 9 key priorities: (1) Selection of products and quantification of demand; (2) Supply plan; (3) Transport and distribution (LMD); (4) Storage and management of expiries; (5) Inventory control and Quality Assurance; (6) Financing; (7) Logistics Management Information System; (8) Network Governance and Collaboration: coordination with donors and partners; (9) Organization, personnel, training, and organizational support for logistics.

However, insufficient funding for procurement and supply chain management of HIV/AIDS-related commodities continues to negatively affect supply chain performance and the attainment of the 95-95-95 goals. Cameroon experiences insufficient funding for capacity-building of warehouse and inventory level optimization, insufficient institutional capacity to use HIV pharmacy information for decision making and persistent funding gaps caused by GRC inability to meet financing commitments. For example, multi-month dispensing (MMD) has been progressively rolled out, but at a rate lower than anticipated due to the funding gap of commodities.

Frequent misalignment between National Guidance on clinical implementation and site-level operational realities also leads to aggravated stock tensions which constrain PEPFAR's ability to implement and accelerate new strategies such as provider-initiated HIV testing and counselling (PITC), index case testing, retesting for verification, and proficiency testing (PT) panels.

Under priority 1, a national committee for the quantification of all health products and a sub-committee for quantifying and monitoring the supply of HIV products exists but needs to be formalized. PEPFAR will strengthen the role of this committee and advocate for the adoption of the Quantification Analytic Tool to streamline forecasting and supply planning processes.

At the level of regional and last mile supply chain support, PEPFAR developed and piloted an online ordering tool in two regions including the Centre and Littoral (West regions was also enrolled) to improve facility ordering submission and on time submission rates, as well as to streamline order validation and distribution planning. In COP22, PEPFAR plans to scale-up and fully operationalize this online ordering tool to the remaining regions. PEPFAR will also amend its Last Mile Delivery strategy to include insertion of the regional funds in the LMD mechanism.
More so, PEPFAR will strengthen the central supply chain mechanism through CENAME for the storage of health commodities.

- **Laboratory (5.71 - yellow):** This scoring went from 3.01 in 2015, a significant improvement, but saw a small decrease from 2019. The 2019-2021 operational plan of the National Strategic Plan for the Development of Laboratories 2016-2022 is still awaiting

implementation. Challenges remain with Human Resources and pre- and in-service trainings. In COP22, PEPFAR will continue to support the coordination of laboratory activities in Cameroon by providing technical assistance to the Ministry of Public Health for all quality management activities, supporting the creation of a Laboratory Technical Working Group, supporting the implementation of the national laboratory policy document, and supporting the implementation of the National Strategic Plan for Laboratories.

Due to COVID-19 related challenges, PEPFAR was unable to fully support the country in implementing the National Strategic Plan for the Development of Cameroon Laboratories 2016-2022 and the Operational Plan for Laboratory Network 2019-2021, but the pandemic also gave PEPFAR an opportunity to identify gaps within the lab systems which must be addressed to meet testing gaps within the clinical cascade and to plan mitigation strategies to address possible challenges during the pandemic. In view of this, diagnostic laboratory optimization will continue to be prioritized and extended in COP22 to avoid activity overlap and to leverage existing platforms and Point of Care resources from other stakeholders.

The use of multiplex assays will continue to be considered to Improve VL Testing. Cameroon now has six ISO-15189 accredited laboratories, including the National EID Reference Laboratory in Mutengene, the Buea Regional Hospital Laboratory, the Bamenda Regional Hospital Laboratory, and the TB Reference Laboratory Bamenda, the Limbe Regional Hospital Laboratory and “Centre Pasteur du Cameroun”. ECHO platforms were used for remote mentoring and supervisions during this COVID-19 related era, and will be continued, especially in supporting the VL/EID reference laboratories. PEPFAR will continue to support these laboratories for quality testing for HIV, EID, VL and TB, ensuring engagement and continuous participation in External Quality Assessments; as well as site and personnel certification for all reference laboratories and facility testing laboratories or sites. Recency testing will be implemented in COP22, and the laboratory will also support proficiency testing for recency testing and viral load to ensure quality testing practices for across facilities.

- **Epidemiological and Health Data (6.18 – yellow):** Saw a slight decrease from 2019. Minimal funding is provided by the Government of Cameroon for surveys and surveillance; majority of funding is provided through donors.

- **Data for Decision Making Ecosystem (5.36 – yellow):** Great strides were made in this element as it was the lowest performing in SID 4.0, with a score of 3.67. However, the country still lacks a national Unique Identification Code (UIC). A UIC is in its pilot phase in some selected facilities and is being used for prevention and the management of STIs in programs funded by donors.

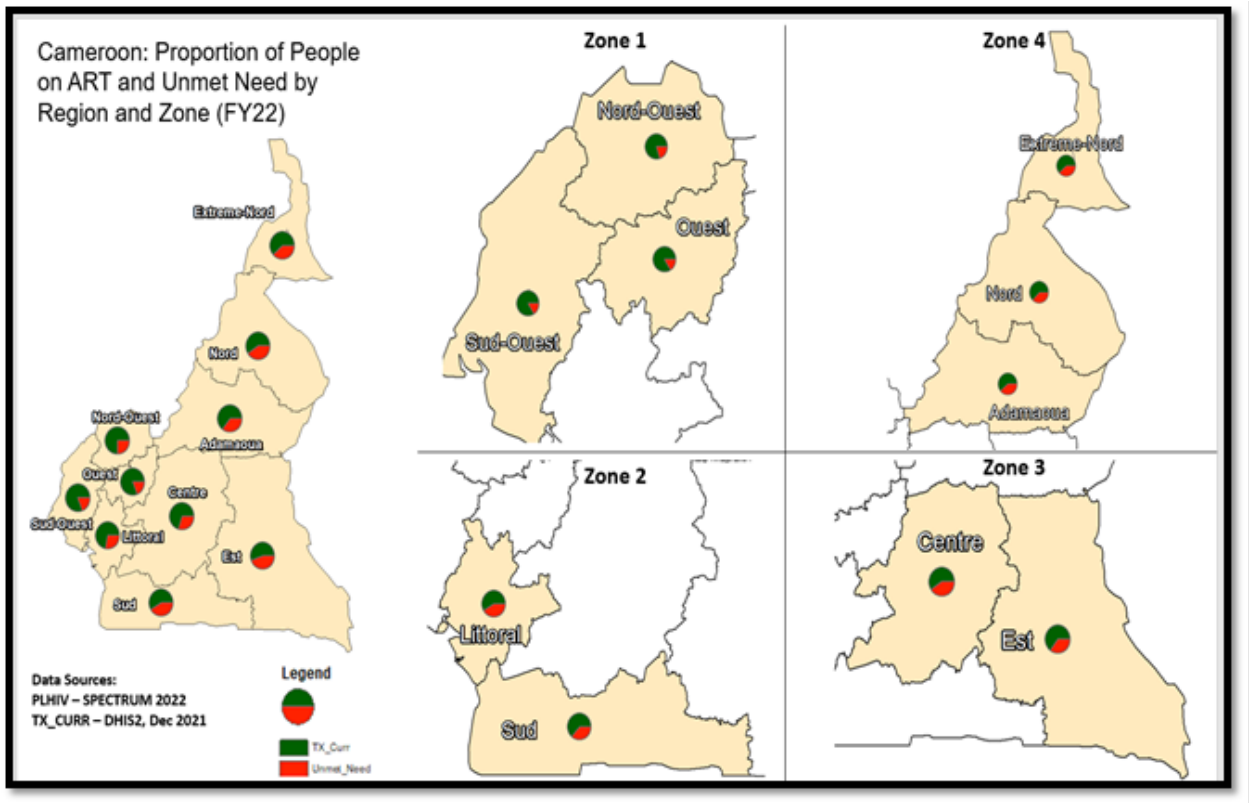
The light green elements including policies and governance, civil society engagement and quality management with moderate gradings, underscores the need to continue to invest in efforts and resources to further improve on their sustainability and their ability to strengthen the health systems in-country.

2.5 Alignment of PEPFAR investments geographically to disease burden

The map and inserts presented in figure 2.5.1 show areas where PEPFAR will provide support in FY2023, with focus on 157 health districts across all 10 Regions of Cameroon. All PEPFAR supported health districts have been distributed into four Zones: Zone 1 includes the West (Ouest), South-West (Sud Ouest), and North-West (Nord-Ouest) Regions; Zone 2 the Littoral and South (Sud) regions; Zone 3 the Center (Centre) and East (Est) regions and Zone 4 the northern regions of Cameroon (Adamawa (Adamaoua), North (Nord) and Far North (Extreme Nord)).

All support provided by PEPFAR to selected sites will be use Differentiated Service Delivery (DSD) models, such as MMD, Community ART Dispensation (CAD), and differentiated schedules or flexible hours at health facilities. All interventions will be focused on rapid acceleration towards epidemic control in 308 scale-up health facilities and 21 military sites.

Figure 2.5.1



2.6 Stakeholder Engagement

PEPFAR Cameroon has been building and maintaining strong coordination and collaboration with all key stakeholders including the GRC, CSO core groups, and other key stakeholders in the HIV/AIDS response. All key stakeholders are involved in strategic discussions from the COP retreat through the COP planning and approval. They also provide resources where needed and guidance to support implementation and accelerating the response towards HIV epidemic control in Cameroon. PEPFAR has been following up on the elimination of all formal and informal HIV user fees in line with the ministerial decision that was signed and released on April 4th, 2019, instituting HIV user fees elimination beginning on January 1st, 2020. This decision is the result of

strong advocacy by PEPFAR at the highest level of government during COP19 planning. PEPFAR supported the workshop led by MOH Department of Disease, Epidemics, and Pandemics Control and NACC in November 2020, in Douala to assess the evolution of HIV user fees elimination implementation across the country. Specifically, during this workshop, challenges in user fees elimination were discussed and solutions commonly found; reports on supervision and lessons learned in the first year of implementation; budget and fund recovery flow; the role of community-based organizations (CBOs) in user fees elimination; clarifications provided on user fees elimination and universal health coverage; and the role of partners in the implementation of the user fees elimination policy. PEPFAR has been very active in the supervision task force across the country to oversee the implementation of this policy. In an effort to eliminate HIV program overlaps and optimize efficiency and impact, PEPFAR is supporting the Government to coordinate an all-HIV intervention mapping through intense engagement and collaboration with all HIV stakeholders in-country.

2.7 Stigma and Discrimination

Laws in Cameroon still criminalize same sex, sex work, possession of certain drugs for personal use, as well as attempted homosexuality and outraging public decency (frequent for transgender people). This legal framework, in turn, makes KP highly vulnerable to violence. The 2016 key populations IBBS results revealed that FSW persistently face violence, with the most recurrent issues being blackmail (45%), arrest on charges related to sex work (34%) and being forced to have sex against one's will (33%). Similarly, for MSM, the study documented recurrent blackmail (23%), rape (17%) and being forced to homosexuality (15%). A 2018 baseline assessment report commissioned by the Global Fund noted that rigid gender norms in Cameroon were driving sexual and physical violence and abuse against KPs. In one recent instance, on February 8, 2021, two transgender women were arrested at a restaurant in Douala for wearing typically female clothing. They were held in custody for three months (May 11, 2021) before being sentenced to five years in prison and issued fines of 200,000 CFA (USD $370) on the grounds of "attempted homosexuality". In a mixed-method study by NACC and WHO in 2022, it was found that all surveyed Key populations reported some form of stigma and discrimination when receiving health services. The study also found a high level of self-stigmatization among KPs.

A multi-country pilot of the Stigma Index 2.0 Survey documented continued high levels of stigma and discrimination experienced by PLHIV in Cameroon, including internalized stigma, high rates of stigma and violence against KPLHIV, and stigma-related delays in seeking testing and engaging in care. In addition, the 2018 DHS found that 39% of women and 49% of men have discriminatory attitudes against PLHIV. Since a few years, discrimination against PLHIV in health facilities are seemingly reducing but stigma persists in some areas such as lodging, education and work.

Drug users also are a highly stigmatized group with limited access to services. Efforts have been made in the past years to ameliorate their access to services, for instance: the Ministerial decree in 2015 supporting the creation of care, follow-up, and addiction prevention. Nevertheless, the package of services to PWID is still to be adapted to their specific needs by the Government of Cameroon.

A study conducted by the Clinton Health Access Initiative (CHAI) in 2019 on stigma in Douala showed that 21% of TB patients are worried about stigma linked to disclosing their health condition

to family members whenever they are asked to bring along family members for TB screening. TB-related stigma hampers community contact tracing but motivates patients to accept IPT for their children.

Stigma and discrimination related to HIV has an impact on the first 95 by leading to refusal of HIV testing services or denial of HIV-positive status. Negative attitudes against HIV equally impact the second and third 95 with non-disclosure of HIV-positive status, low adherence, interruption in treatment, poor retention, and low viral load suppression. KPLHIV face a more challenging situation with double stigma against their sexual orientation/practice and their HIV status. The 2016 key populations IBBS revealed that key population subgroups experience discriminatory remarks by family members in relation to their sexual orientation or sex work (FSW 12%, MSM 14%), feel afraid seeking health services (FSW 6%, MSM 14%), or avoid seeking health services (FSW 5%, MSM 14%). The annual report on violence against sexual and gender minorities published by LGBT organizations under the umbrella of the Unity Platform shows that 4,116 cases of violence occurred in 2021 alone, the majority being cases of psychological (71%) and physical (16%) violence. While 42.5% of cases were perpetrated by individuals in the immediate environment of survivors (family, partners, landlords, neighbors), and 46,0% by individuals whose nature remained unknown/unreported, only 1% of cases occurred in the health setting (n=28). An A new IBBS was conducted in 2021-2022, and the results should be available later in 2022. This new survey will shed light on the current size of different key population groups in Cameroon, and their experiences in the health care system.

Cameroon's 2021-2023 National HIV strategic plan in alignment with WHO consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations and UNAIDS Aids Global Strategy 2021-2026 “End inequalities. End Aids” has ambitions to reduce by 50% the HIV-related stigma and discrimination of PLHIV and key and vulnerable populations by the end of 2023, including MSM, FSW, PWID, and TG. The country has developed a Five-Year Plan 2020-2024 for the global response to human rights-related barriers to access to HIV and TB. The FYP provides a comprehensive set of interventions, including reducing stigma and discrimination in community, health, justice, and emergency settings, increasing legal literacy and access to health services for key populations, law and policy reforms, and reducing harmful norms and gender-based violence. Despite the availability of intermittent surveys, the national HIV program has difficulties monitoring the progress towards this objective and, as a result, does not effectively adjust program implementation accordingly.

In COP22, the PEPFAR program will continue to align with the 2021-2023 National HIV Strategic Plan and the 2020-2024 Five-Year Plan, and it will support the national program to provide stigma-free HIV services at service delivery points of health clinics, drop-in-centers, and other community settings. This will be done through both supply-side and demand-side interventions.

On the supply side, the PEPFAR program will:

- Make sure that all healthcare workers and community health workers are trained and retrained to provide person-centered and friendly stigma-free HIV services at all service delivery points.
- Confirm that all service delivery points have adequate space to improve privacy and confidentiality.

- Verify that both HIV service providers and patients/beneficiaries are educated on patients' rights, including age-appropriate education.
- Reinforce that all sites have systems/procedures in place to collect, address, and incorporate the feedback of beneficiaries into their program planning, implementation, and monitoring.
- Ensure all PEPFAR supported community and facility sites collaborate frankly during data collection, feedback meetings on community-led monitoring activities and be open and available to make changes to curb stigma and discrimination of users.
- Ensure that all PEPFAR-supported facilities and community-based service providers meet and maintain the minimum standards of safe and ethical index testing with special considerations for key and priority populations to limit coercion and potential intimate partner violence.
- Assist clients with partner notification and disclosure of HIV status. Provide age-appropriate education to CALHIV and support family-centered disclosure to minimize stigma and discrimination.
- Support MOH-led communication to limit stigma and discrimination, including the U=U messaging.
- Discourage care models that place clients in different socio-economic classes like the "VIP" model. Ensure all facilities providing HTS respect the WHO 5Cs (counseling, consent, confidentiality, correct test results and connection to treatment).
- Implement DSD models for HIV testing, care, and treatment so that the patient receives care where and when it is most convenient. PEPFAR will continue to scale-up MMD to reduce the number of facility visits, as well as incorporate a family model, support groups, CAD, extended hours and weekend services that conform better to client situations. These services shall be effective, efficient, confidential and client centered.
- Continue to advocate for the one-stop-shop model at the drop-in-centers for key populations.
- Work with KP coalition to reduce stigma and discrimination in the health settings: KP-friendly training of FMO (Police force), lawyers, journalists, and other stakeholders; provide safe spaces for KP at risk of violence; income-generating interventions for most at-risk populations including KP groups; and the implementation of the stigma index 2.0 survey.

On the demand side, the PEPFAR program will expand its support to build and leverage community-led monitoring (CLM) as a tool to empower communities and civil society to learn about their rights, and to collect structured data on beneficiaries' feedback on the cost barriers to access to HIV services, quality of HIV services, as well as stigma and discrimination. Through CLM initiatives, the PEPFAR program will assist the National program with filling the gap of program data to inform program implementation adjustments as well as policy development to reduce stigma and discrimination and improve quality of services. In addition, CLM data and processes will enable civil society organizations to conduct evidence-based advocacy to further

advance the rights of patients to benefit from stigma-free and quality HIV services at all service delivery points.

3.0 Geographic and Population Prioritization

In COP22, PEPFAR geographic coverage in Cameroon continues in all ten regions, implementing a scale-up package at the 347 highest volume clinical sites and 21 military clinical sites across the country to achieve 95% ART coverage nationwide by 2023.

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

In the West Region (Zone 1) where the ART coverage is the highest (94%) and unmet need the lowest, case finding strategy will prioritize index testing, focusing on newly initiated on ART and old patients on ART who are virally unsuppressed and Key Populations as indexes cases. We will also be focusing on improving retention to make sure we do not lose patients who are in care. For the North-West and the South-West regions that have been greatly affected by the crisis, systems will be adapted to respond to the increasing number of internally displaced persons (IDPs). Multidisciplinary teams will be put in place to reach out with HIV prevention, care and treatment services to locations where IDPs are found. For the South-West region, we shall also be especially focusing on reaching out to AGYW to improve ANC attendance.

Zone 2 (Littoral and South) and Zone 3 (Center and East) have similar ART coverages (76% in Zone 2 and 78% in Zone 3) and both zones represent 58% of the total unmet need. While the Littoral and Center regions that have been receiving PEPFAR support will continue to focus on intensifying different strategies for case finding, linkage and retention in different sub-populations, the East and South regions that just started receiving PEPFAR support to scale up these strategies.

Zone 4 (North, Far North and Adamawa) has the lowest ART coverage (70%) and represents 27.5% of the total ART gap. This situation is similar in all three regions and across age and sex. This Zone has a peculiarity that health seeking behaviors are not pronounced. Focus will first be on sensitization of the importance of getting to health facilities to seek health care in addition to providing a full package of differentiated services for different sub-populations (children, adolescents, young men, young women and men and adults) across the entire cascade.

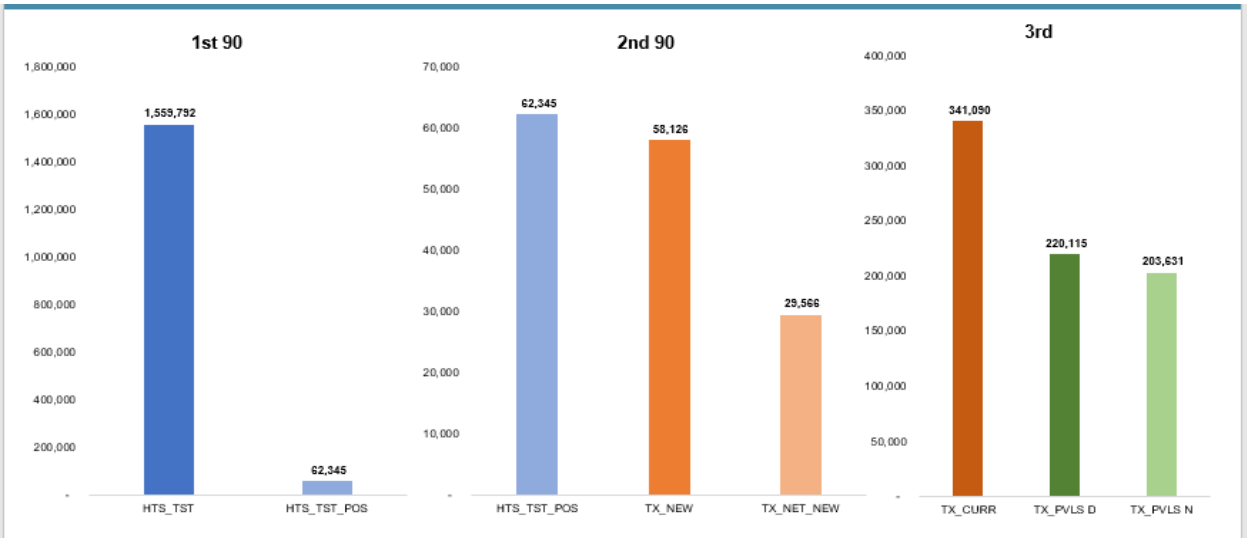
PEPFAR Cameroon will add 20,201 patients on ART by the end of COP22 (FY 2023). Clinical and Community Partners will implement COP22 activities in each of the four zones in the different program areas. Above-site activities will be supported by other implementing partners. The current ART coverage is reflected in Table 3.1.

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

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP22**	**# Current on ART (FY21)**	**# of SNU COP21 (FY22)**	**# of SNU COP22 (FY23)**
Attained	-	-	-	-
Scale-up Saturation	469,187/95%	361,893	146	154
Scale-up Aggressive	-	-	-	-
Sustained	-	-	-	-
Central Support	25,289/5%	-	-	-

4.0 Person-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 90/90/90 Cascade, FY21



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

CAMPHIA results in July 2017 showed the HIV prevalence for populations ages 0-14, 15-49, 50-64 is 0.2%, 3.4% and 3.7%, respectively. Among adults aged 15-64 years, HIV prevalence varies widely by region, ranging from 1.5% in the Far North Region to 6.3% in the South Region. The survey also revealed that 56% of PLHIV in Cameroon were aware of their HIV status, 93% of whom are on treatment, and 80% of those on treatment were virally suppressed. Disaggregated data shows higher coverage among older age groups towards achieving the three 95's: Among the 15-29, 30-49 and 50-64 age groups, the 1st 90 was 29%, 61% and 69% respectively; the 2nd 90 was 92%, 92% and 97% respectively; and the 3rd 90 was 74%, 78% and 89% respectively.

Further disaggregation by sex shows higher awareness of HIV status among females in the 15-29, 30-49 and 50-64 age groups (31%, 63%, and 75% respectively) relative to males in the same age groups (22%, 55%, and 61% respectively). For the 2nd 95, better trends are observed among males (100%, 93%, and 97% respectively) compared to females (90%, 91%, and 97% respectively). For the 3rd 95, viral suppression among females on ART are 76%, 78%, and 85% respectively for the above age groups, and 67%, 76%, and 96% respectively for males.

The Cameroon FY22 Q1 clinical cascade using both Spectrum and program data as of December 2021 shows that the Country has made significant progress compared to CAMPHIA results. Based on Spectrum and programmatic estimates, 85% of PLHIV in Cameroon are aware of their HIV status, of whom 92% are on treatment and, of whom 94% are virally suppressed.

Spectrum 2022 estimates identify population gaps by age group and sex, which need to be addressed to achieve HIV epidemic control. Table 4.1.3 below shows more detail on the major gaps in reaching subpopulations, especially children, AGYW, and men. Strategies to address these gaps are detailed in the following paragraphs.

FY21 Performance and Achievements

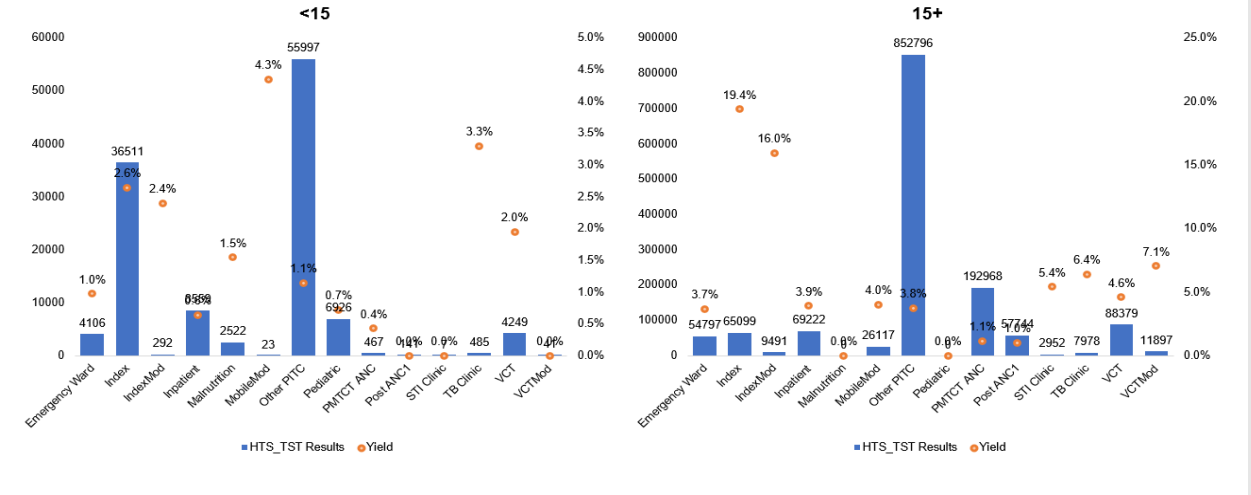
In COP20 (FY21), PEPFAR Cameroon provided HTS to 1,559,727 clients, compared to a target of 1,376,157 clients, giving an achievement of 113.3%. There were 62,340 HIV positive clients identified of the target of 88,687 representing 70.3% targets achievement at 4% yield. 62.2% of the newly diagnosed PLHIV were females and 37.8% were males. Achievement is still suboptimal, especially among children, adolescent girls and young women (AGYW), and men. Age disaggregation of FY21 results showed that 6.4% of PLHIV were below 19 years of age, 11.3% in the 20-24 age group, 70.5% were within the 25-49 age group and 11.8% were in the >50 age group.

The number of HIV positive clients identified through other PITC modality has consistently increased across the quarters in FY21. All PEPFAR supported facilities are currently using the register form of the screening tool and efforts are in place to further optimize other PITC using the risk-based screening tool to further target testing and increase yields.

We observe growing positives trends from ICT over the past 4 quarters (3,218 in Q1FY21 to 4,125 in Q4FY21) and yields from ICT have remained high (13.0% in Q1FY21, 14.0% in Q4FY21) and above 20% in the KP program. This has been achieved by scaling ICT innovative strategies such as anonymous elicitation where index clients anonymously list contacts, 1 by 2 strategy includes confidentially providing HIV testing to the contacts as well as their neighboring household and pairing of testers with experienced peers/Doctors and nurses while supervising closely through virtual GSM, SIMS and other onsite QA/QI actions.

In the KP programs, PEPFAR Cameroon identified more than 3,805 (being 6.1% of overall OU positives) new HIV positive KPs in FY21. Increased community and facility collaboration has ensured improved quality in the reported numbers for both community and clinical programs. The continuous implementation of a differentiated approach to ICT in the community KP program and routine monitoring for IPV risk has ensure ICT remains the main entry point/modality for finding positives amongst most of the different KP groups.

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



As seen in Figure 4.1.1 above, the highest volume of people tested took place through other PITC. The number of HIV positive individuals identified through the other PITC modality has consistently increased across the quarters in FY21. All PEPFAR supported facilities are currently using the register form of the screening tool and efforts are in place to further optimize other PITC using the risk-based screening tool to further target testing and increase testing efficiency.

HIV positive case finding trends from ICT have increased over the past four quarters (3,218 in Q1FY21 to 4,125 in Q4FY21) and yields from ICT have remained high (13.0% in Q1FY21, 14.0% in Q4FY21), reaching above 20% in the KP program. This has been achieved by scaling innovative ICT strategies such as anonymous elicitation where index clients anonymously list contacts; 1 by 2 strategy, which involves confidentially providing HIV testing to the contacts as well as their neighboring household and pairing of testers with experienced peers/doctors and nurses while supervising closely through virtual Granular Site Management (GSM); Site Improvement through Monitoring Systems (SIMS) and other onsite Quality Assurance/Quality Improvement (QA/QI) actions. However, the program is not yet where it intends to be in terms of index testing, and efforts are being strengthened to get there.

Outstanding Gaps and Challenges

Table 4.1.1 Finding the missing by age and sex and getting them on treatment (Spectrum 2022)

Age	PLHIV		DIAGNOSED		% DIAGNOSED		GAP	
	Female	Male	Female	Male	Female	Male	Female	Male
<01	629	505	140	104	22%	21%	489	401
01-04	3,173	2,524	1,143	892	36%	35%	2,030	1,632
05-09	4,613	4,954	1,739	1,843	38%	37%	2,874	3,111
10-14	6,630	7,428	2,671	2,977	40%	40%	3,959	4,451
15-19	9,982	10,929	6,858	6,536	69%	60%	3,124	4,393
20-24	20,951	14,032	15,723	9,370	75%	67%	5,228	4,662
25-29	31,236	19,374	26,121	15,113	84%	78%	5,115	4,261
30-34	37,283	22,137	33,588	18,982	90%	86%	3,695	3,155
35-39	39,339	22,448	35,913	19,540	91%	87%	3,426	2,908
40-44	34,168	19,358	31,553	17,288	92%	89%	2,615	2,070
45-49	22,577	12,374	20,753	11,046	92%	89%	1,824	1,328
50+	116,864	27,459	99,889	24,008	85%	87%	16,975	3,451
Grand Total	**327,445**	**163,522**	**276,091**	**127,699**	84%	78%	**51,354**	**35,823**

In Table 4.1.1 above, Spectrum estimates show that 84% of female and 78% of male PLHIV have been diagnosed. However, we observe significant gaps in the first 95 in the pediatric and adolescent ages for both males and females. For all age groups less than 14 years, there was less than 50% coverage, with coverage being the lowest in those <1 year (21%). This is significantly lower compared to populations >30 years, with diagnoses approaching 100%. Overall, data shows higher gaps in case finding for men compared to their female counterparts. These gaps have been analyzed and lead to strategies outlined below to address the gaps.

Table 4.1.2 Finding the missing and getting them on treatment by Region (Spectrum 2022)

REGION	PLHIV		DIAGNOSED		% DIAGNOSED		GAP	
	Female	Male	Female	Male	Female	Male	Female	Male
Adamaoua	16,896	8,800	13,797	6,689	82%	76%	3,099	2,111
Centre	75,225	37,592	66,321	30,954	88%	82%	8,904	6,638
Est	24,356	11,652	20,541	9,219	84%	79%	3,815	2,433
Extreme Nord	25,712	14,058	19,124	9,807	74%	70%	6,588	4,251
Littoral	55,516	26,605	48,159	21,688	87%	82%	7,357	4,917
Nord	26,674	13,748	20,499	9,600	77%	70%	6,175	4,148
Nord Ouest	33,525	15,480	29,814	12,787	89%	83%	3,711	2,693
Ouest	21,339	10,060	18,847	8,124	88%	81%	2,492	1,936
Sud	16,997	8,622	13,823	6,279	81%	73%	3,174	2,343
Sud Ouest	31,205	16,905	25,166	12,552	81%	74%	6,039	4,353
Grand Total	**327,445**	**163,522**	**276,091**	**127,699**	84%	78%	**51,354**	**35,823**

Table 4.1.2 of case finding progress by sex and region shows the highest gaps among both females and males in Far North (Extreme Nord), and North (Nord). The Centre and Littoral Regions, with the highest number of PLHIV, are closing the gaps in diagnosing PLHIV and have

among the highest rates of case identification for both sexes. Nevertheless, much still needs to be done across the country to close the remaining gaps in case finding.

HIV testing services represent an essential pathway to identifying two important subgroups of individuals: 1) Persons living with HIV in need of initial linkage or re-engagement to treatment, and 2) individuals who are HIV negative, yet at high-risk, and would benefit from evidence-based prevention interventions. It remains imperative to apply a person-centered approach with every person who receives HIV testing services. Individuals at risk for HIV should receive positive, consistent counseling on the benefits of timely HIV testing, treatment, and prevention services.

As seen above, the PEPFAR Cameroon program continues to experience various challenges in case finding among certain age groups and regions. Furthermore, COVID-19 continued to impact case finding in Q1FY22 with the spread of the Delta variant and the third wave of the pandemic in Cameroon. The PEPFAR Cameroon program suffered challenges with providing access to HTS in conflict-affected areas such as the ongoing socio-political anglophone crisis in the North-West and South-West Regions and the Boko-Haram terrorist insurgency in the Far North Region. Challenges with ensuring access to services also occurred in remote and hard-to-reach populations in many Regions like the East, South, North, Far North and Adamawa. Furthermore, limited stocks and periodic stock out of RTKs and HIV self-test kits restricted case finding progress. Early infant diagnosis also experienced a stockout of EID sample collection material and test kits, with equally low access to EID point-of-care (POC) diagnostics in some regions.

Fig 4.1.2 Undiagnosed Children Living with HIV (CLHIV)

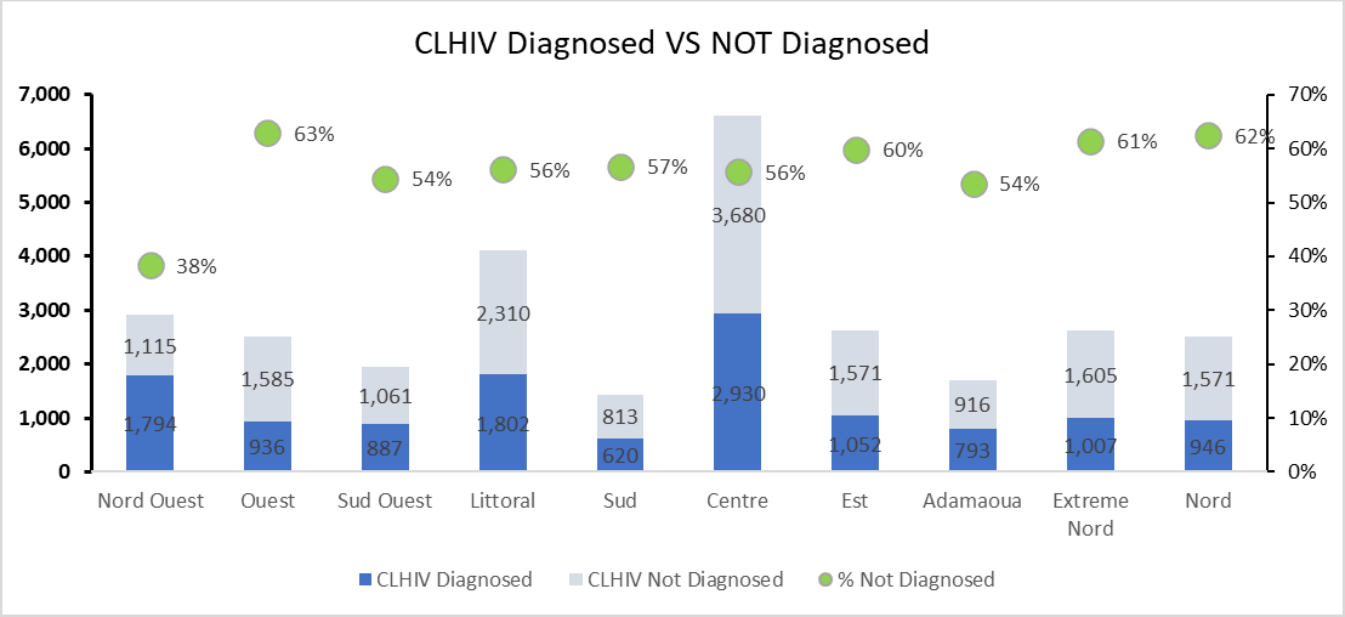


Figure 4.1.2 above shows significant gaps in undiagnosed CLHIV across all the regions, ranging from 38% to 63%. Notably, the West (Ouest) has the highest gap of 63% of CLHIV not yet diagnosed, with the Far North (Extreme Nord) and North (Nord) Regions not far behind, with gaps of 61% and 62% respectively.

Fig 4.1.3 Undiagnosed Adults Living with HIV (ALHIV)

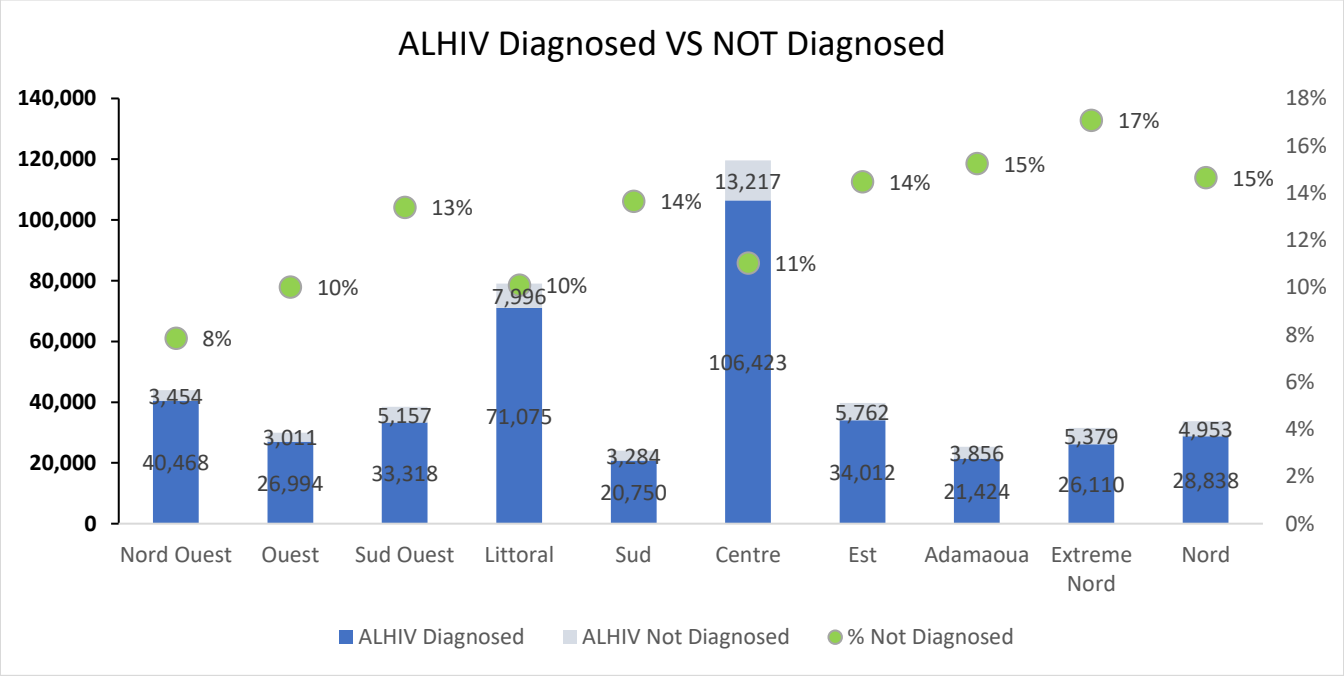


Figure 4.1.3 above shows significant gaps in undiagnosed adult PLHIV in the Centre and Littoral Regions, where there are the largest estimated populations of PLHIV. The highest percentage gaps are in the three northern Regions that make up Zone 4, with Far North (Extreme Nord) at 17%, North (Nord) and Adamawa (Adamoua) both at 15%. The South-West (Sud Ouest), South (Sud) and East (Est) Regions also show significant gaps between 13% and 14% of undiagnosed ALHIV.

4.1.1 Strategies to improve HIV case finding

Based on analysis of FY21 performance described above, PEPFAR Cameroon will continue to scale up innovative case finding strategies. PEPFAR Cameroon will continue to prioritize HTS for the following populations who showed significant gaps in case finding:

- children at risk for HIV
- adolescents aged 10-19 who meet defined risk criteria
- Men, particularly in the 15-34 age group, and
- women in the 15 -25 age group.

PEPFAR Cameroon will focus on the following key entry points for case finding: index case testing (facility and community), optimized provider-initiated counseling and testing (PITC) using the validated screening tool, and voluntary counseling and testing. The program shall continue to offer systematic testing at high yield entry points such as TB, STI, and in the maternity services, including ANC as well as diagnostic testing to people with signs/symptoms suggestive of HIV. HIV self-testing will be brought to scale. Given the challenges of access to HTS due to distance, the IPs shall continue to implement community testing strategies to meet and test clients where they live and work. PEPFAR Cameroon will scale up approaches proven to improve case finding

such as quality index testing and will discontinue non-targeted testing. Social Network Strategy (SNS) was reported as a separate modality in COP21 and will be optimized in COP22. PEPFAR Cameroon will continue to implement zone-specific and population-specific approaches, as well as recency testing to fine-tune prevention and case finding and guide informed decision making.

Scale-up of Index Testing at both Facility and Community levels

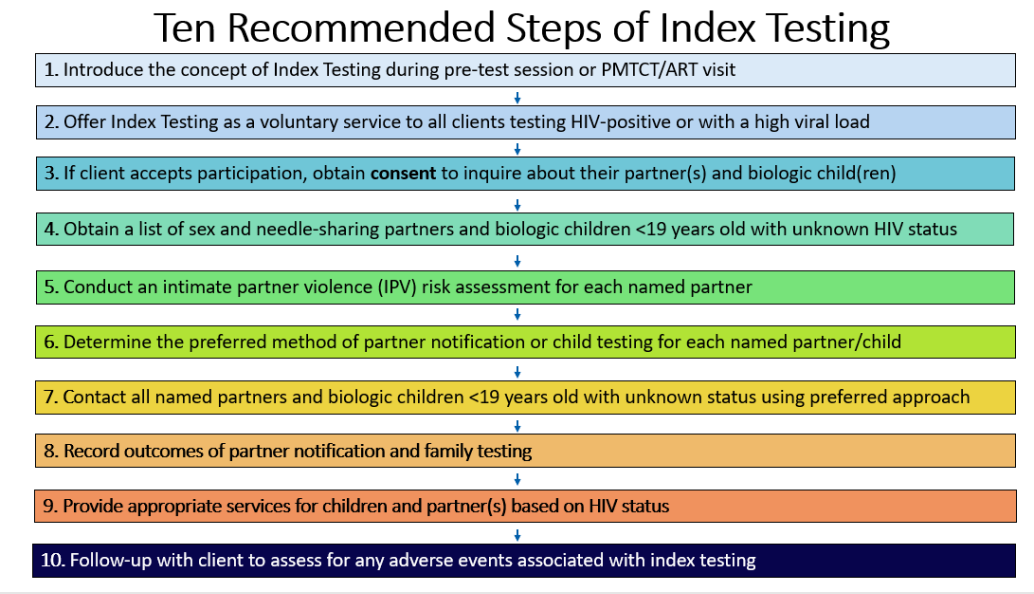
Index testing (also referred to as contact tracing, or partner notification, or partner services) is a case-finding approach that focuses on eliciting the sexual or needle-sharing partners and biological children and parents of individuals living with HIV and offering them HIV testing services. In COP22, index testing will target sexual partners of adult index cases, parents of pediatric index cases and children exposed to HIV, in facilities and in the community. Index testing will also be systematically and routinely offered to all persons living with HIV, including children and adolescents, who are either newly diagnosed or attending ART/PMTCT services. Health care providers and IPs will be trained or retrained on eliciting and testing sexual contacts, biological children, and parents of index cases.

Index testing services shall be integrated into complementary and synergistic HTS approaches to maximize the number of contacts who are reached with HTS. These approaches include PITC, HIV self-testing (HIVST), and SNS.

Detailed documentation of index testing services by contact type down to treatment initiation shall continue in COP22. The index testing cascade will be comprehensively and continuously reviewed to close gaps and identify areas for improvement. This helps to refocus interventions, monitor yields per contact type and redirect efforts in case finding.

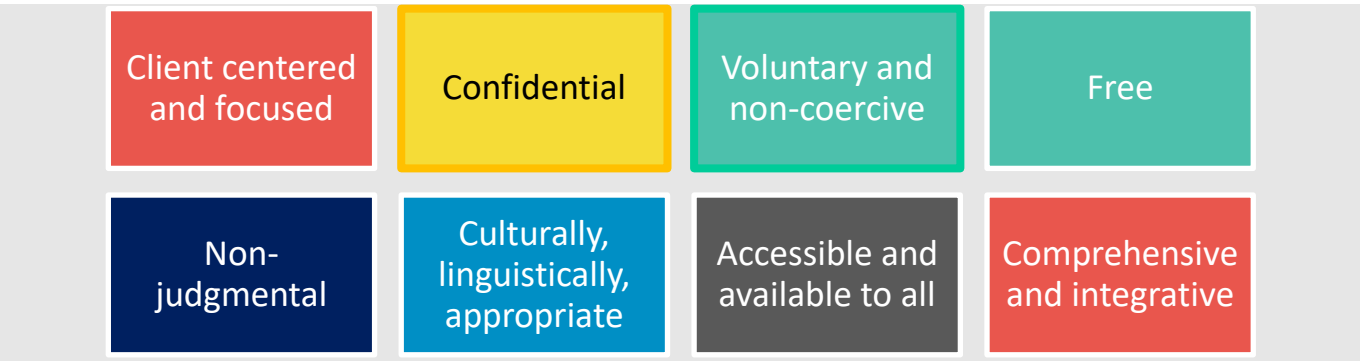
The program will intensify the use of the 10-8-4 approach to implement index testing services, following ten steps, eight principles, and four notification strategies, as described in Figures 4.1.4, 4.1.5 and 4.1.6 below.

Fig 4.1.4: Ten Recommended Steps of Index Testing



While following the ten recommend steps described in Figure 4.1.4 above, building trust and rapport between the index testing provider and client is key. It has been observed in multiple countries that clients may, at first, only share information about one partner at the time of diagnosis. However, when the experience with the first partner goes smoothly and their trust with their provider grows, clients often become more willing to share information about any additional partners. To increase the relationship of trust, elicitation of contacts should be considered as an ongoing process rather than a one-time intervention. More experienced counselors appear to have better results than those who are newer to working with index cases. These experienced counselors can be called upon to peer mentor newer providers. PEPFAR Cameroon provides supportive supervision visits to index testing providers at least quarterly to provide additional support and capacity-building. In addition to peer mentors and supportive supervision, the program also implements case conferences, where index testing providers are brought together to discuss strategies for addressing difficult cases, to allow providers the opportunity to learn from each other.

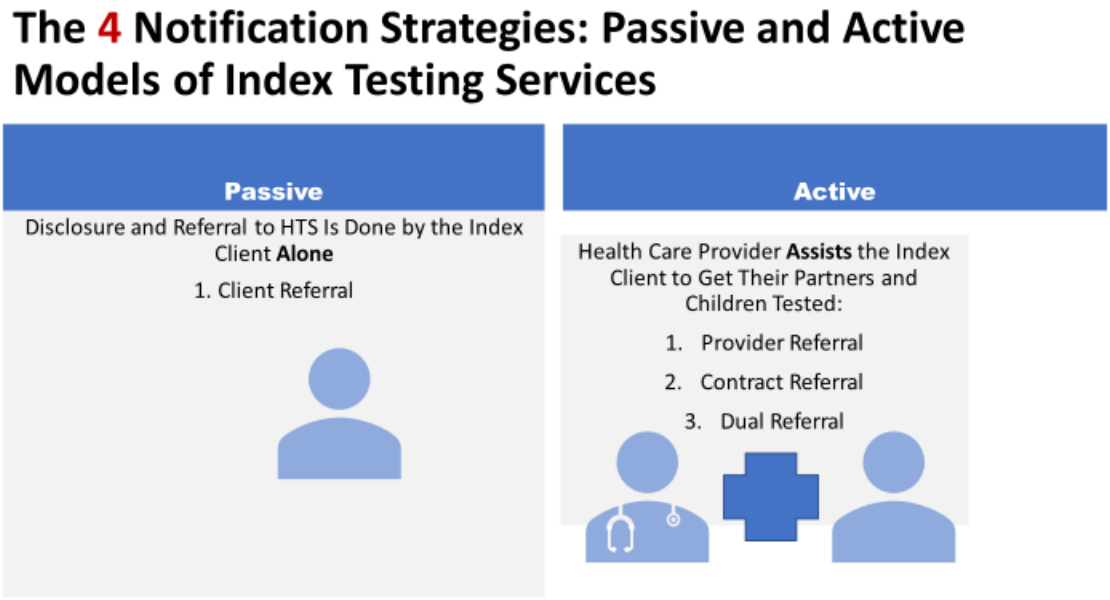
Fig 4.1.5 Eight Principles of Index Testing



All index testing providers will adhere to eight principles, whereby index testing services should be:

1. Client centered and client focused: focused on the needs and safety of the index client and their partner(s) and child(ren). Different person-centered models of index testing will be provided such as self-testing, facility-based or community testing. The contacts will be offered HIV testing services where they are most convenient, be it at homes, offices, facilities, etc.
2. Confidential: maintained at all times for the index client as well as all named partners and children. The identity of the index client should not be revealed and no information about partners should be conveyed back to the index client (unless explicit consent from all parties is obtained).
3. Voluntary and non-coercive. Mandatory or coercive approaches are never justified.
4. Free, at no cost to either the client or their contacts.
5. Offered in a non-judgmental manner.
6. Culturally and linguistically appropriate to the local context
7. Accessible and available to all index clients.
8. Integrative or linked to other services such as HIV treatment for contacts testing positive and prevention for contacts testing negative.

Fig 4.1.6 The 4 Notification Strategies of Index Testing



The final aspect of PEPFAR's approach to index testing offers the four notification strategies indicated in Figure 4.1.6. PEPFAR will ensure the availability of all these models, while also screening all named partners for IPV and refer for services.

In addition, the program will pair index testers with nurses and doctors to improve partner elicitation and testing. PEPFAR will identify other best practices from different zones to roll out to other zones. One such practice is anonymous contact elicitation in which index clients who do not feel comfortable sharing sexual contact information with the counselor or index tester are given the opportunity to anonymously submit the information in a box.

Minimum Standards for Conducting Safe and Ethical Index Testing Services,
PEPFAR Cameroon will continue to ensure that all PEPFAR supported facilities meet and maintain index testing minimum standards and WHO 5Cs:

1. Counseling
2. Informed consent
3. Confidentiality
4. Connection to Services
5. Intimate Partner Violence Risk Assessment
6. Training and Supportive Supervision
7. Adverse Events Monitoring and Response.

PEPFAR Cameroon relies on the SIMS Standards for index testing for quality assurance in all PEPFAR-supported facilities. PEPFAR conducted an assessment of index testing services in all PEPFAR-supported facilities using the REDCap tool. Sites that were determined to not meet the minimum standards for safe and ethical index testing were provided with time-bound and

actionable corrective action plans and PEPFAR IPs oversaw the implementation of the plans at the site level. All PEPFAR supported sites currently meet the minimum standards for safe and ethical ICT. The PEPFAR team shall continue to technically support them to maintain these standards.

Effective index testing requires collaboration and cooperation between community and facility programs. Facility programs share contact lists and information for partner(s)/child(ren) in need of assisted partner notification approaches with community implementing partners. These community partners then trace partner(s) and children, offer them HTS, and link newly diagnosed persons living with HIV to ART services at the facility. In COP22, the program will continue jointly engaging facility and community partners through sharing of findings and collaboratively seeking solutions, while taking into account specific needs of KP and Young People.

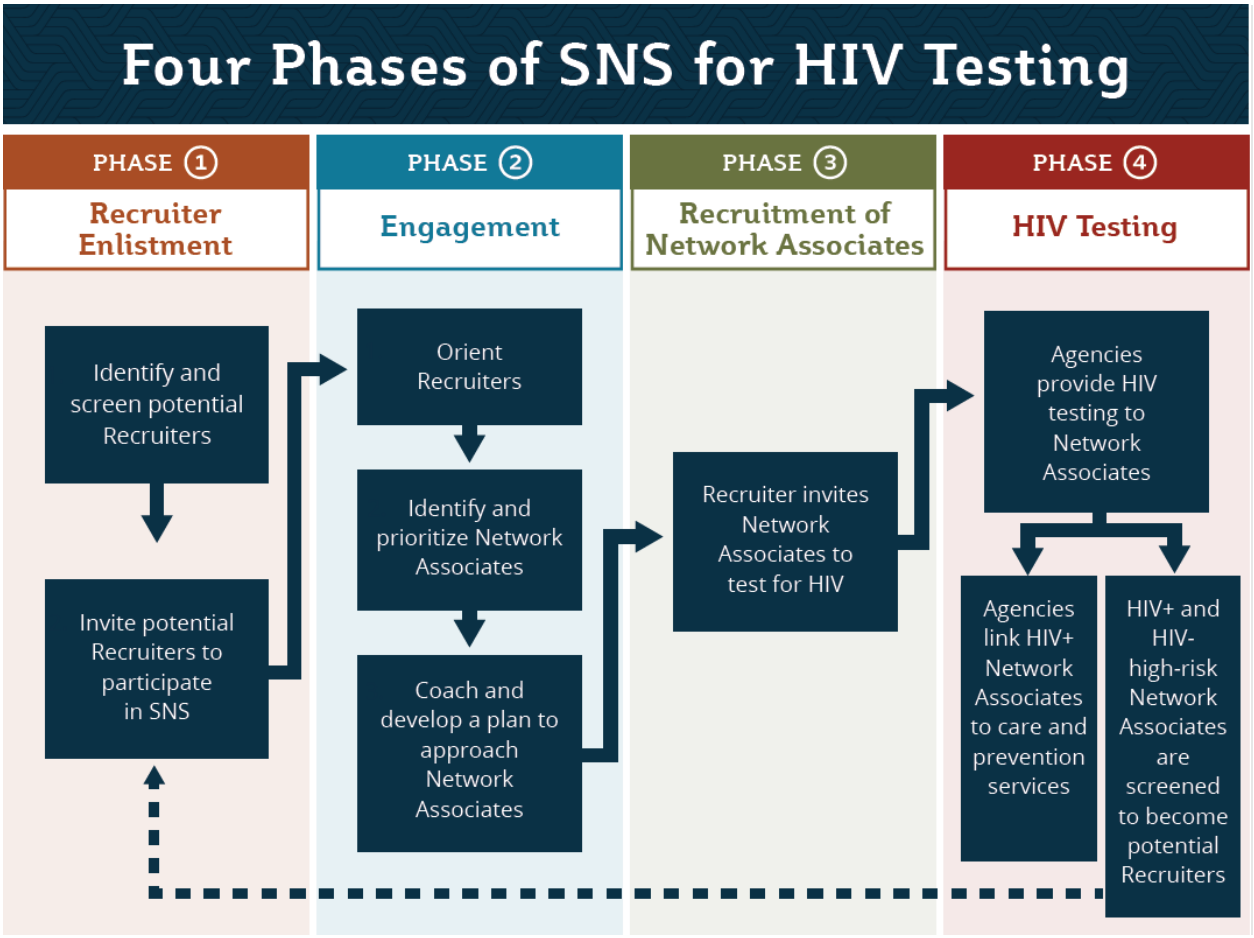
The program will continue its work to sign Collaboration framework documents, including data sharing and confidentiality agreements between the clinical and community programs, to optimize index testing.

Social Network Strategy (SNS)

The Social Network Strategy for HIV Testing Recruitment is an evidence-supported approach to recruiting persons at high risk for HIV infection. SNS is based on the underlying principles that people in the same social network share similar risks and risk behaviors for HIV, and that people in the same social network can exert influence on each other because they know and trust each other. The approach begins with identifying clients or peers who are HIV positive or at high risk for HIV and enlisting them to become Recruiters. Recruiters serve a short-term role and receive coaching to identify, engage, and direct Network Associates (NA), people in the Recruiter's social network at risk for HIV, to HIV testing services.

The implementation of SNS takes place through the four phases indicated in Figure 4.1.7.

Fig 4.1.7 Four Phases of Social Network Strategy



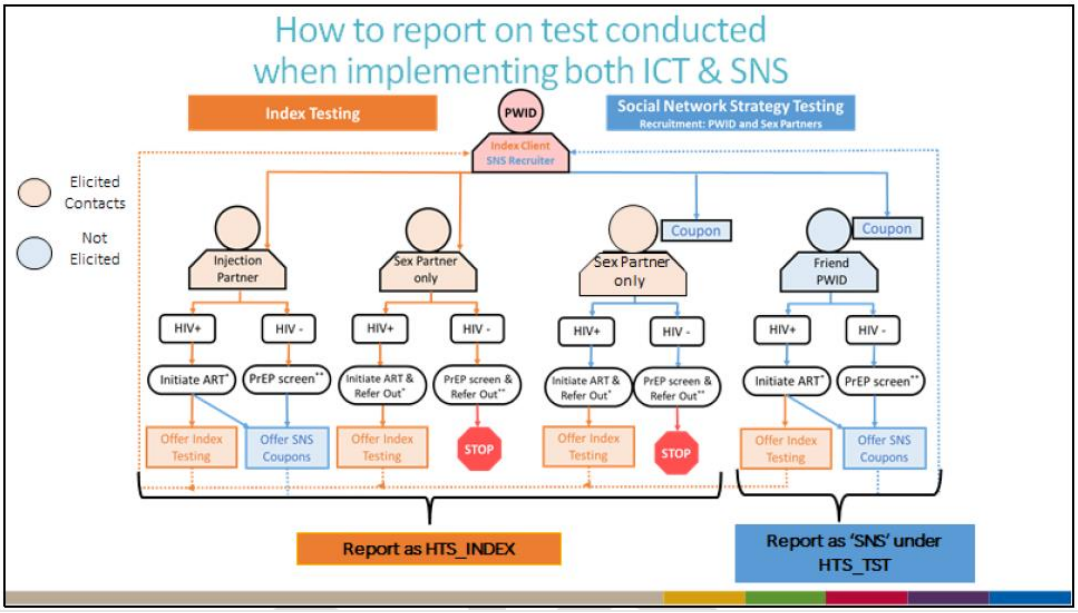
This process is circular, creating chains of referral that can penetrate hidden networks. Regular identification and recruitment of potential Recruiters will be conducted to make a successful SNS program. Previous Network Associates serve as good sources of potential Recruiters because they understand the program and may tap deeper into the social networks of the Recruiter who initially identified them. PEPFAR Cameroon considers and approaches each Network Associate as a potential Recruiter if they fit the target population and risk profile and meet the desired Recruiter characteristics.

In COP22, SNS complements index testing in two ways:

1. There may be contacts that the index client does not disclose during the elicitation process but who should be tested for HIV. Asking clients to identify other individuals in their social network who may be at high risk for HIV and in need of an HIV test allows index clients to name these contacts without necessarily revealing that they are a sex or needle-sharing partner. Similarly, providing recruitment coupons to an index client allows the individual to safely recruit their undisclosed contacts for testing.
2. Index clients may have contacts that they would like to notify and refer on their own (e.g., the client referral approach). Providing recruitment coupons to the index client provides an alternative, less direct way for them to encourage their partner(s) to receive HTS

without the need to directly tell the partner that they have been exposed to HIV and need to get tested. This allows clients to recruit additional contacts without revealing that they are a sex or needle-sharing partner and does not require PLHIV to name — or even know the names of — their contacts to make referrals. Similarly, they do not have to share personal details of their contacts, which index testing requires.

Fig 4.1.8 Reporting schema for joint ICT and SNS



PEPFAR Cameroon reported SNS for the first time as a separate HTS modality in COP21. In COP22, the program intends to strengthen data collection and monitoring of SNS, with weekly and monthly reviews to understand more immediately what is working and what is not working. IPs will continue to ensure the availability of reporting tools for SNS.

Optimized Provider Initiated Testing and Counseling (PITC)

PITC remains the leading contributor to HIV case finding in the PEPFAR Cameroon program at about 50%, with yields around 4% in COP20. A balanced and informed consideration is required to determine the right mix of HTS strategies required to achieve progress, even amid COVID-19-related constraints. PITC remains one of the least costly cases finding strategies available and remains appropriate in Cameroon's epidemic context.

The program will implement three strategies in PITC:

The first strategy is diagnostic testing, the testing of individuals who present with signs or symptoms suggestive of HIV, including signs or symptoms of TB. For women, diagnostic testing will be offered to any mother of a child born with HIV or with unexplained illness who died before age 2 years.

Targeted testing is a second approach and comprises the testing of subpopulations of increased risk as identified by behavioral, clinical, or demographic characteristics, or a combination of these. Targeted PITC using the register form of the screening tool to identify at-risk adults, adolescents and children will be offered at low yield entry points, including the community. On February 19th, 2020, the Minister of Health of the Government of Cameroon signed a circular giving directives on the correct use of the HIV screening tool in all facilities to ensure effective implementation and scale up of targeted testing.

Universal testing is the third testing approach, the testing of individuals presenting for medical attention regardless of presenting complaint. All people presenting for care in the following settings are considered at risk and will be tested for HIV: Antenatal Care Clinics, TB clinics, STI clinics, malnutrition clinics (for children), medication-assisted therapy clinics, and harm reduction sites. All hospitalized patients, including children in inpatient wards, and clients showing up at the facility for VCT shall be systematically offered HIV testing Services.

To improve other PITC yield in COP22, PEPFAR Cameroon will cease supporting strategies with low or almost no yield, such as testing at ear/nose/throat or radiology departments and testing of caregivers. The program shall train and mentor consultants/providers on the use of the screening tool, document testing coverage at high yield entry points, monitor yields, monitor the use of the screening tool and continuously mentor health facility staff on using targeted testing registers. All entry points shall be saturated with APS testers to ensure the screening tool is effectively used.

HIV Self-testing (HIVST)

WHO defines HIVST as a process in which a person collects their own specimen (oral fluid or blood), performs a rapid HIV test, and interprets the result, where and when they want. HIVST is an effective tool for expanding access to individuals at risk who may not otherwise actively seek out HIV testing services, and to individuals at ongoing risk who may need to test frequently.

In COP21, the PEPFAR Cameroon program distributed 18,568 HIV Self-test kits achieving 64% of annual targets. Implementation faced challenges of stockout of kits and low results return rates. HIV Self-testing in COP22 will continue to be accelerated in the groups authorized by MOH, which include KPs, partners of key populations, partners of PLHIV (screening around index cases) above the age of 18, young women above the age of 18 in vulnerable situations, men in vulnerable situations and partners of HIV+ pregnant women. Many of these groups refuse other testing modalities or are unwilling to come to the health facilities, drop-in centers (DICs), or community events where HTS is offered. Meanwhile, PEPFAR will also continue advocacy with MOH to extend access to HIVST to at-risk AGYW/ABYM below 18 years of age.

There are two main methods of offering HIVST: directly assisted HIVST and unassisted HIVST. Directly assisted HIVST refers to when individuals who are self-testing for HIV receive tailored, translated or pictorial instructions for use with additional support such as a local telephone hotline, virtual real-time support or supervision through online platforms, an in person or video-based instruction or as part of a large group (e.g., waiting room) from a trained provider or peer before distribution of the HIVST kit, with instructions on how to perform a self-test and how to interpret the self-test result. This assistance is provided in addition to the manufacturer-supplied instructions for use. Directly assisted HIVST does not mean that the test must be performed in

the presence of a provider. Unassisted HIVST refers to the distribution of HIVST kits with the manufacturer-supplied instructions, but without additional instruction or assistance.

The directly assisted strategy shall be prioritized and the unassisted strategy shall be used for clients not reached directly. Distribution shall be done by care providers and community health workers at both facility and community levels. Indirect distribution shall be done through sexual contacts in index testing and in KP and GP social networks.

Importantly, HIVST is a screening test and should not be used to provide a definitive HIV diagnosis. All positive self-tests require a confirmatory test done by a healthcare worker for treatment initiation to occur. However, distribution of HIVST kits may help reach individuals who otherwise would be unable or reluctant to go to a facility and is an especially important option during the COIVD-19 pandemic. Among the PEPFAR IPs offering self-testing, self-test kit distribution will be maximized outside of the clinic setting - including providing self-tests through decentralized distribution approaches such as peer home delivery, private or community pharmacies, etc. - which will help reduce COVID-19 transmission by decongesting facilities and reducing the frequency and/or duration of client-provider interactions. PEPFAR IPs will continue to ensure HIVST registers are available in all facilities and will continue to strengthen the M&E process for HIVST.

Follow-up of beneficiaries

All distribution approaches of self-tests shall be accompanied by active follow-up of beneficiaries by appointments for beneficiaries to bring results, by phone, home visits etc. to provide support before, during and after conducting the HIV self-test. Clients with reported reactive results shall be followed up actively by APS or other clinical and community health staff and linked to confirmatory testing and treatment. Those with negative results shall be provided preventive services like health education on adopting risk reduction behaviors, condoms, and PrEP.

It is important to note that under current MOH policy, self-testing is not available to all population groups. PEPFAR Cameroon will advocate to expand access to all populations, and especially to at-risk adolescent and young girls and boys below 18 years of age.

Community Case Finding Strategies

Community-based testing services are HIV testing services offered within a community, outside of a health facility. WHO recommends community-based testing, especially to reach men, key populations and their partners, young people, and other vulnerable populations who may be less likely to be seen or tested in facilities. However, these more targeted approaches to community-based testing have the potential to reinforce stigma by differentiating specific populations. Given the potential for unintended reinforcement of stigma, careful planning and implementation of stigma mitigation strategies is an essential component of targeted community-based testing services. PEPFAR Cameroon also ensures strong linkage systems to confirmatory diagnosis, care and treatment, or prevention services in all its community HIV testing strategies.

Targeted community case finding strategies shall be implemented in homes, offices, gold mines, carpentry/tailoring workshops etc. where clients are most conveniently located. Approaches to community case finding in COP22 include:

- Testing at Satellite Sites: IPs shall continue putting testers at satellite health facilities, small facilities which are not full-fledged HIV testing and treatment sites, to screen clients who consult there. Those screened reactive will be actively linked to PEPFAR-supported sites for confirmatory diagnosis and treatment initiation.
- The “1 by 2” strategy: PEPFAR will intensify the suspect strategy to provide HTS to index contacts and suspected cases through CHW and APS in the community as their neighboring households to avoid stigma.
- Testing at gold mines in the East
- KP-specific strategies: COP22 will intensify testing at DICs, hotspots, and chill-ins, and use of SNS and social media. Please see the section below for more details on HTS outreach for KPs.

Location-based Testing Strategies

Leveraging the organized establishment of the highly respected traditional authority, PEPFAR Cameroon will also scale up *Chefferie* Testing in COP22 to boost case-finding. This is a community strategy that was successfully implemented in COP21 exclusively in the Northern Zone to respond to: low health facility attendance rate, long distances to facilities, insecurity due the Boko-Haram insurgency, geographic inaccessibility in the rainy season, gender inequities with health care access, and fear of IPV which impacts Index Testing. In this strategy, the Traditional Authority (the Chefferie) mobilizes the population to benefit from an integrated package of services that includes but is not limited to targeted HTS, blood pressure monitoring, blood sugar and STI screening. Clients identified as HIV positive are confidentially linked to facilities for ART enrollment.

4.1.2 Population-based testing strategies

PEPFAR Cameroon tailors its HIV testing services to the various sub-populations:

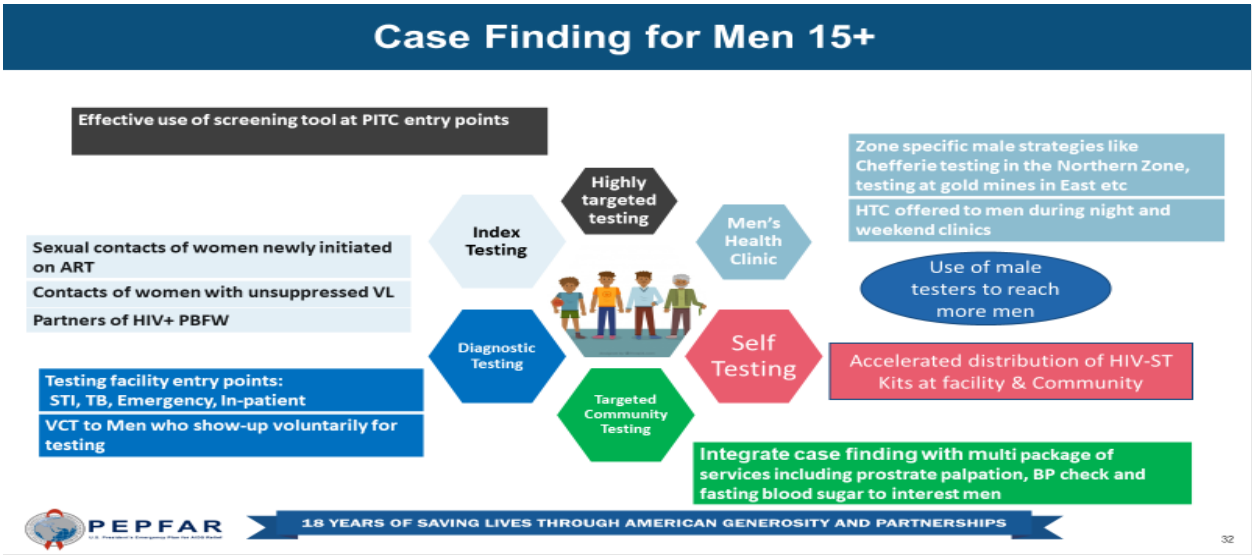
- The KPs reached for comprehensive and combined prevention services at health facilities, hotspots, drop-in-centers, and prisons will systematically benefit from an HIV risk assessment and be tested for HIV accordingly. The beneficiaries enrolled into the PrEP program, including FSW, MSM, PWID, and TG, will be offered HIV testing on a quarterly basis and linked to ART in the event of seroconversion. Depending on the entry point (health facility or community), eligible KP will receive HIVST kits to distribute to their hard-to-reach contacts.
- The HIV status of each OVC will be monitored as well as that of their caregivers. OVC with unknown status will be linked to testing at the health facility or community-level. The OVC program will continue to strengthen index case testing in close collaboration with the clinical program to ensure eligible family members are reached with testing services.
- Adolescents and young people reached through prevention services will be screened and offered HTS services when eligible.
- Pregnant women are systematically tested in Cameroon, but additional efforts will be made to reach the partners of PBFW with HIV testing services, including offering HIVST.
- Heterosexual sero-discordant couples will be offered prevention services.

To ensure the quality of testing services for the above-mentioned populations, the PEPFAR program will continue to train and where fitting, provide refresher training on key topics including targeted HTS, SNS, HIVST. Age-appropriate screening tools will be updated and validated jointly with relevant stakeholders. Details on population-specific strategies follow.

Strategies to reach men

In COP22, PEPFAR Cameroon will use index testing to reach husbands and sexual partners of HIV-positive women, sexual partners of MSM, clients and regular non-transactional partners of FSWs. Other strategies will include highly targeted testing in health facilities and community settings and self-testing for partners of pregnant women, partners of index cases and clients and non-transactional partners of FSWs who do not wish to access HTS in health facilities and DICs. In military settings, targets for self-testing will include non-commissioned officers, index partners who are military but do not wish to come to health facilities, and officers returning from deployments longer than six months. Diagnostic testing will also be implemented at critical service delivery entry points and VCT. The program shall have more male testers to reach the men and implement an integrated package of services such as BP, diabetes and STI screening to attract the men. The program will implement extended hours and weekend testing to accommodate men who work and those in school. We will continue to implement and adapt Zone specific and client centered strategies to find more men like with Chefferie testing, index testing to partners of positive women, targeted testing, and other community strategies. The social network strategy will be brought to scale for men who share sexual, social and drug injecting risk.

Figure 4.1.9: COP22 Strategies to Identify Men 15+



For men in the 15-24 age group, PEPFAR Cameroon will support health facilities to extend clinic hours and provide weekend services to accommodate working men and young men in school. Out-of-school young men will be targeted and mobilized for HIV prevention, care and treatment through youth associations, among IDPs, through support groups of ALHIV and PLHIV (parents) and the use of social and print media such as WhatsApp, Facebook, Instagram, Tik-Tok etc. HIV testing for adolescents and young men will be highly targeted based on risk mapping and behavioral analysis with the effective use of the screening tool at facility and community levels.

Index testing will be offered to sexual contacts of adolescent young boys and men who are newly diagnosed with HIV or virally unsuppressed. Diagnostic testing will also be offered to adolescent boys and young men at high yield service delivery entry points and VCT. PEPFAR Cameroon will also identify “adolescent champions” to mobilize their peers and link them to adolescent friendly HTS services.

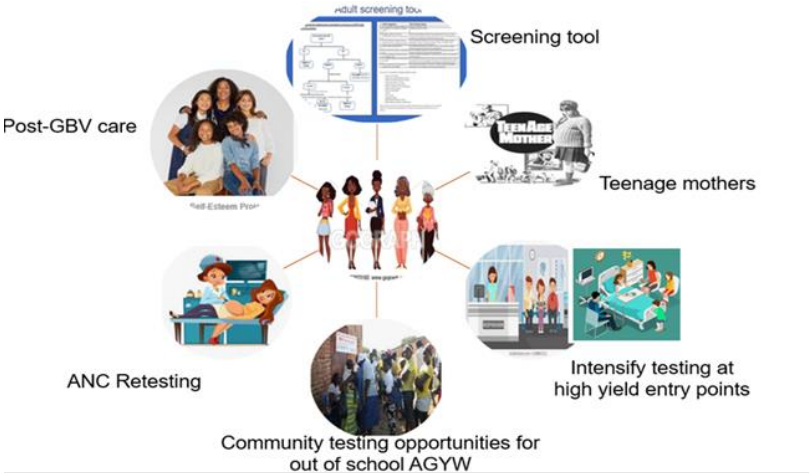
Men aged >25 years will be reached through a package of modalities including index testing for sexual contacts of women newly initiated on ART, contacts of women with unsuppressed VL, partners of HIV-positive PBFW, and partners of KPs. Men who are biological parents of HIV-positive children, will also be reached through index testing in all clinical settings. Options for HIV self-testing will be offered to partners of KPs receiving care at the facility and community level. Targeted PITC will be offered to men with the effective use of the screening tool to assess risk and diagnostic testing at key service delivery entry points (sexually transmitted infections - STI, TB, emergency, in-patient) and VCT. HIV self-test kits will also be proposed for harder-to-reach men (KPs, partners of PBFW and index contacts) who will not be reached through traditional approaches either at facility or community levels. In addition to HTS on men’s health clinic days, male-friendly services will be scaled up to reach military and civilian men with a multi-service package including prostate palpation, mental health evaluation, blood pressure screening, and fasting blood sugar assessment. Extended clinic hours including night and weekend shifts will provide an opportunity to offer HTS to more men at their convenience. Health education and literacy materials tailored to men’s health will be scaled up to reach men aged 25 years and above in facilities and communities. The military program will provide health messaging (including the importance of testing at least once a year) and information on availability and location of HTS during morning assembly of military personnel. HIV testing information and health messaging will also be promoted on social media, at social events at drop-in centers for KPs and for men accompanying their families to facilities. Outreach activities to find high-risk men in communities, especially during events that attract men (drinking spots, sporting events, resting spots for truck drivers, barber salons, carpentry workshops, gold mines, fishing areas, KP chill-ins, officers’ mess halls, training centers for non-commissioned officers) will be used as opportunities to offer testing. Other innovative approaches to find men will be through targeted community testing activities in collaboration with community partners to include testing in medicine stores, markets, satellite sites, private laboratories, and other busy areas. PEPFAR Cameroon will continue reaching regular partners and non-transactional partners of FSW through a voucher referral system and self-testing. PEPFAR Cameroon will also make use of trained male expert clients to reach and link their peers to male-friendly HIV testing services.

Strategies to reach women

PEPFAR Cameroon will offer index testing to wives and partners of HIV-positive men and mothers of HIV-positive biological children in clinic settings. Targeted testing will be offered to at-risk women based on risk assessments with the effective use of the screening tool to achieve higher HIV yields. Routine HTS will be offered to all PBFW at ANC services and to PBFW during delivery, in case they did not attend ANC in the course of their pregnancy. Retesting of pregnant women who initially tested negative at their first ANC visit and retesting for verification within the context of the test and start strategy will be offered. Diagnostic testing will be offered to women at critical high yield service delivery entry points (STI, TB, emergency, in-patient) and VCT. For all pregnant

women, PEPFAR Cameroon will extend the 'Catch-Up Strategy" to reach pregnant women in hard-to-reach localities for ANC and PMTCT services in all PEPFAR-supported sites in the 10 regions, as this is the second highest modality through which HIV positive women are identified. Self-testing will be offered to female partners of HIV-positive men. HIV testing among FSW will be prioritized and outreach testing for widows will be intensified within existing informal associations and gatherings of widows.

Fig 4.1.10: Strategies for Achieving Epidemic Control among AGYW



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

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

Strategies to improve retention of pregnant and breastfeeding women on ART

PEPFAR Cameroon will expand the implementation of the ANC and postpartum care package during the ANC and postnatal period, which includes vaccination, ART, VL, and FP services for PBFW to improve retention in the PMTCT program. PEPFAR Cameroon will ensure women know their status, start ART and are virally suppressed prior to conception at PMTCT service, ART Clinics and the community. The program will strengthen adherence and retention in care for viral suppression among PBFW and their HIV+ partners on ARVs. This will be achieved through strengthening the capacity of facilities for viral load testing, improving adherence and retention for HIV+ PBFW on ARVs in care and optimizing cohort monitoring for the mother-baby pair at PMTCT. DSD models such as TLD transitioning, 3-6 MMD for stable PBFW, Mother-to-mother Mentoring program, treatment literacy leveraging on the U=U messaging to attain viral load suppression and near zero risk of MTCT will be scaled up in all PEPFAR supported sites. Women's access to FP will also be scaled up by ensuring all WLHIV have access to voluntary contraception, and safer conception education and counseling.

PEPFAR Cameroon will scale up and expand viral load testing for PBFW following the new VL algorithm and improve on documentation of viral load testing and viral suppression for PBFW in all PEPAR-supported sites. The program will ensure appropriate monitoring, with training and mentorship of HCWs to ensure effective implementation. Viral Load coverage for PBFW will also be improved through intensified patient education, demand creation and service provision.

Follow-up of the HIV+ mother-baby pair until the end of the exposure period of 24 months will be strengthened through Cohort monitoring. Monitoring of the mothers and babies will be reinforced to ensure mothers and infants are better retained in care and ensure reporting on the Final Outcome (FO). Cohort monitoring tools and SOPs will be produced and made available to all health facilities and community settings to monitor outcomes for HEIs and the mother-baby pair on ART and service providers trained on their use. Linkage and retention case managers and community health workers will strengthen community-facility linkages through active defaulter tracking programs, home visits, and psychosocial support group programs. Support group activities for PBFW will be expanded to improve their retention in care. Appropriate documentation will be encouraged and sharing of experiences and good practices will be promoted with continuous quality improvement projects implemented in facilities with gaps.

Strategies to reach Key Populations

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

Considering that current program results show testing at DICs generally produces higher yields than mobile testing with HIV prevalence increasing with age, sexual network mapping of older MSM and social network mapping of older FSW will be emphasized in FY23. In addition, regular hotspot mapping by Peer Leaders (PL) will continue identifying new and old hotspots with high yield to strengthen targeted testing.

Clients of FSW will continue to be reached by innovative approaches including analysis of risk social networks and with emphasis on Long Distance Truck Drivers (LDTD). LDTD will be tracked and offered prevention services along transport corridors as well as access to ART in the site that is most convenient for them in coordination with PEPFAR clinical partners.

PEPFAR Cameroon will strengthen health facilities to provide KP-friendly services (stigma free, nonjudgmental, extended and weekend hours) to KPs who prefer to seek HTS at the health facility. HTS will be provided based on results of a risk assessment tool that will systematically be used. Additionally, through a facility-led outreach approach, health care providers will reach, recruit and test KPs in underserved communities (in the absence of a KP community program). FSW will also be reached in the facilities during ANC and post-natal services for PBFW. HIV self-test distribution will be brought to scale as a tool to improve access to HTS among KPs that are harder-to-reach including MSM and FSW.

Index testing and social/sexual network-based HIV testing will be used to reach husbands and sexual partners of HIV-positive women, sexual partners of MSM, clients and regular non-transactional partners of FSWs. Index testing will be implemented in a manner that takes into account human rights concerns and consistently assesses and addresses IPV risk. To that effect, amongst KPs, PEPFAR programs will routinely screen for IPV risk prior to offering index testing services and use a differentiated approach to testing that includes distribution of self-test kits or social/sexual network approaches such as organizing community events where partner can be tested without partner disclosure/notification. For those cases in which MSM are fearful of direct contact notification, indirect methods such as the social gatherings known as “Grins” or “Chill-ins” which anonymously bring together partners of HIV-positive MSM for a social event where testing is conducted will continue in COP22. For other hard to reach partners such as MSM who do not identify as part of the lesbian, gay, bisexual, or transgender community, female partners of MSM who do not know their partners are MSM, and those regular, non-buying sexual partners of FSW who refuse to come in to the DIC, self-test kits will be distributed to the HIV-positive KP to encourage their partners to test. PL and PE will provide counseling to KP partners and information for those who return for confirmatory tests. Those who test positive on self-tests will be referred to a local facility for a confirmatory test and supported by PLs and PEs within the community.

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

and will be responsible for counseling, testing and linkage of HIV positive clients at various entry points. In addition to screening for IPV risk, PEPFAR supported community and clinical sites will also ensure provision or referral to GBV services for victims or potential victims.

Prisoners will be reached with targeted testing services within the prisons. During COP22, PEPFAR Cameroon will scale up training of prison peer educators to offer routine tests for triage to their peers (existing inmates). Systematic HTS services using the screening tool will be offered to incoming (new) prisoners. Incarcerated persons accessing the prison's health facility for other medical conditions, including presumptive TB cases will be offered risk-based HTS.

The PEPFAR KP program will provide technical assistance to the Global Fund community prime recipient on community-based HIV testing and linkage services as well on the monitoring of the HTS cascade. An MOU will be signed between the PEPFAR community and the Global Fund community programs to align the services and reporting as well as limit deduplication in the reporting of KP services.

Strategies to reach Orphans and Vulnerable Children (OVC)

The OVC program plays a key role in ensuring community support for HIV services for children and adolescents living with HIV, including case-finding. Through the OVC program in COP22, trained case workers will carry out monthly home visits to provide a variety of support services, among them screening and referrals for HTS among CALHIV and their families and accompanied referrals to health facilities to ensure confirmatory testing for HEI, along with transport support to access health services.

Furthermore, at the facility level, PSS in collaboration with OVC partners will offer community outreach testing to OVCs and their household based on risk assessments. PEPFAR Cameroon will ensure adequate follow-up of children and adolescents diagnosed as positive for HIV by continuing to strengthen collaboration between community-based organizations and health facilities through MOUs for referrals/counter-referrals, case conferencing, and monthly coordination meetings.

Children and Adolescents.

According to Spectrum 2020 estimates, the number of PLHIV in Cameroon was estimated at 506,432 people in 2019, of whom 33,289 (6.5%) were children under 15 years of age. There was a drop of 48% in new infections since 2010 (33,183 in 2010 versus 17,113 in 2019), giving an incidence rate of 0.69%, the 15-24 age group accounted for > 30% of new infections, with the 0-14 age group accounting for about 20% (3,308), mainly due to mother-to-child transmission (MTCT). The drop in the incidence rate were mainly outcomes relating to the implementation of prevention of mother-to-child transmission (PMTCT) programs, combined prevention packages for key and vulnerable populations and, of course, the expansion of access to care including antiretrovirals (ARVs). In the 10-19 age group, there were around six times as many new infections in young girls (2,097) as young boys (351), a differential observed since 2004, while in the 15-24 age group the ratio was reduced to one boy for every three girls. The very significant difference between boys and girls in the 10-19 age group (sex ratio of 1:6) is explained by early and disproportionate infection obtained through sexual transmission among 15-19-year-old girls. This could be due to the frequency of intergenerational sex, especially transactional sex; earlier

age of sexual activity and low condom use in this age group. Only 50% of girls in this age group reported regular condom use, compared to 72 percent of boys (Demographic and Health Survey 2018).

According to Spectrum 2020, the total number of children infected through MTCT was 3,308 in 2019, which means that the estimated transmission rate (including residual transmission through breastfeeding) is still high, at 14.2%. MTCT of HIV remains the main cause of HIV infection among children in Cameroon with the largest numbers of pediatric infections acquired through MTCT coming especially from women lost to follow-up and those who did not receive ART during pregnancy. Mapping carried out in 2018 estimated that there were 201,653 young people and adolescents in vulnerable situations [155,615-247,691] in the country mainly those who have dropped out of school and who usually frequent hotspots or live with a partner from a key population. The Littoral, Center and West Regions had the largest number of participants, at 37,442 (29,015 - 45,828), 32,917 (26,901-38,932), and 24,472 (18,332-30,613), respectively. Douala and Yaoundé had the highest number of adolescents and young people vulnerable to HIV, at 26,431 (20,819-32,043) and 19,612 (16,046-23,177), respectively.

Children, especially those under five years of age, are also a vulnerable population. They are often victims of TB transmission from adults. In addition, the management of pediatric TB is one of the weak links in the TB Control program, especially since children under five years of age can develop severe TB rapidly and mortality is high when they are diagnosed late. The proportion of reported pediatric cases under 15 years of age was only 5.5% in 2019, whereas the standard recommends at least 10-12% of all cases notified in country and < 2 % in children under five years of age. In 2019, 2,933 children under five years of age were put on isoniazid preventive therapy (IPT). In the 15- 24 years age bracket we observe increasing notification rates of 8.7% for males and 6.8% for females.

Care and treatment of children and adolescents (C/A) remain the weak link in the HIV response despite strategies adopted such as free ARVs in 2005, early infant diagnosis in 2007, health vouchers and elimination of user fee for HIV services in 2020. Despite a decline in the number of children living with HIV since 2010, ARV coverage remains low at 37.0% among children 0 14 years in 2021, ranging from 25.1% (FN) to 54.8% (North) and 39.5% for Adolescents 15- 19 years of age compared to 84.4% for adults 25 years and older. The impact of ARV drug resistance on HIV management among children and adolescents remains a growing concern, particularly in Sub Saharan Africa (SSA) and in Cameroon. Children and adolescents are at high risk of ART failure.

According to Spectrum 2020, there were 14,058 HIV-related deaths in 2019 [11,773-16,105], down from 37% in 2010 (22,244). Of these deaths, 2,515 [1,608-3,496], or about 18%, were among children <15 years of age in 2019, with no difference between males and females.
(Profile of HIV estimates and projections for Cameroon for the period 2019-2025).

In 2018, GRC signed a ministerial decision reorganizing the ART management structures in Cameroon with the goal of decentralizing ART services to the 5th and 6th category health facilities that initially provided standalone PMTCT services to PBFW, including their HEI, but

operationalization remained a challenge. Decentralization trends had been relatively very slow for pediatric care with only 21% of ART sites offering services to children.

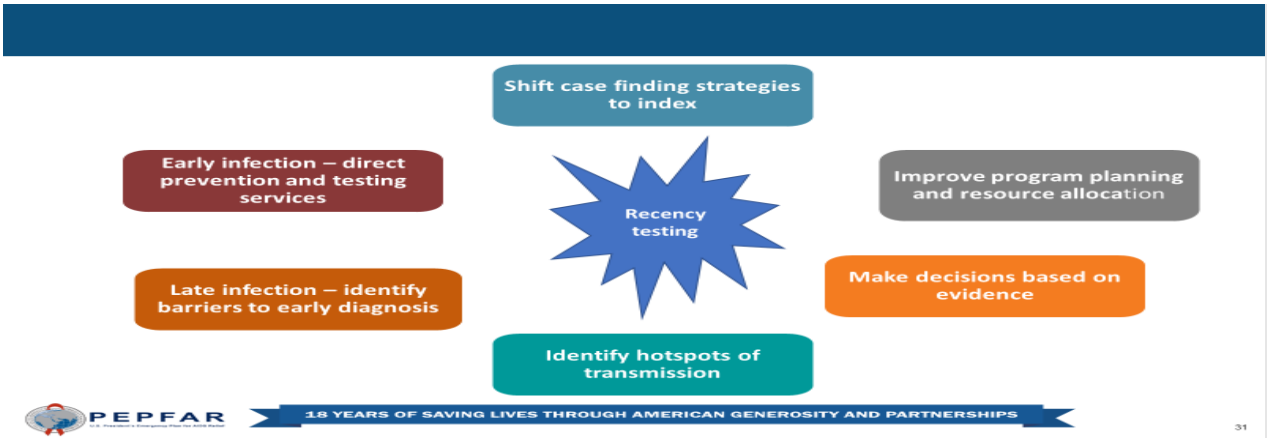
Cameroon has further decentralized EID POC for HEI to several reference, regional, and district hospitals to reduce turnaround time (TAT) and accelerate early management of children infected with HIV but ensuring continuous availability of commodities remain the biggest challenge. In 2019, out of the 15,172 HEI identified, only 68.4% received an EID-PCR test at 12 months through the existing national POC network put in place through Elizabeth Glaser Pediatric AIDS Foundation (EGPAF), Clinton Health Access Initiative (CHAI) and UNICEF, with support from a global health initiative that invests in new ways to prevent, diagnose, and treat HIV/AIDS and TB quickly, cheaply and effectively (UNITAID). In FY20, PEPFAR Cameroon had a low EID coverage of 50% at 2 months with an increase to 94.7% at 12 months, representing 60% of the national target (15,172). Prophylactic ART coverage for HEI within 6 weeks was 87% in 2019 (NACC Annual Report, 2019).
Cameroon has recently developed a scale up plan for pediatric care with main objectives being to ensure; all HIV exposed children receive e-MTCT prophylaxis (nevirapine, cotrimoxazole), ensure all HIV exposed children receive HIV diagnostic tests (PCR from the 6th week of life, 9 months, and serology at 18 months) and ensure all identified HIV-positive children are placed on ART.

In FY21, PEPFAR Cameroon supported the implementation of several strategies to improve uptake of HIV services for the pediatric and adolescent populations, including decentralization of pediatric ART in health facilities through task shifting which remained slow. Service providers were trained to offer optimized ART services to children and adolescents, PITC was offered at all pediatric entry points in health facilities and in the community, index testing of biological children of adult index cases was rolled out and reported as the highest yield in identifying children, and cohort monitoring for HEI was implemented in about 50% of sites and contributed to the improved EID for HEI. As of COP19, the PEPFAR OVC program was pivoted to provide enhanced support to the pediatric clinical program. As a result, the PEPFAR program has been strengthening the bi-directional referral of children and adolescents between the OVC and clinical programs through the implementation of the MOUs signed between the clinical program and OVC program. HTS has been offered free for children and adolescents since January 2010. VL testing is currently being scaled up for monitoring of patients, including children and adolescents on ART, but scale up remains a major challenge. Monitoring of children on ART was also reinforced with engagement of adolescent champions, peer navigators and the hiring of pediatric psychosocial support staff specifically for linking and retaining children in care.

Recency Testing

A recency infection surveillance program will identify hotspots of ongoing HIV transmission, target prevention efforts, and aim to interrupt further transmission to reduce overall new infection and HIV incidence. It will help in prioritization of resources and refocusing of case finding efforts including ICT, identify any issues of recycling known positives, identify barriers to early diagnosis for clients with latent infection, and limit diagnosis at advanced disease stages. The COP/ROP22 guidance articulates those countries near or at epidemic control should have recency testing for surveillance at scale across all sites and all HTS service delivery points within each site, whether supported by PEPFAR or by other entities. PEPFAR planned to for implementation of recency

testing in COP21 with protocol development and ethical clearance, lab sample characterization for PT by the National Public Health Laboratory, and cascaded trainings. The rollout of testing itself is scheduled to begin in July 2022. In accordance with PEPFAR guidance for surveillance in countries at or near epidemic control to have recency testing at scale across all sites, in COP22, PEPFAR Cameroon will continue with a stepwise scale-up of recency testing toto reach approximately 20 sites in two regions (North and West regions).) **Fig 4.1.11 Recency Testing Considerations**



4.1.3 Continuous Quality Improvement (CQI) and Quality Assurance (QA) in HIV testing

Improving the quality of laboratory and point of care HIV testing to reduce error and ensure efficient delivery of services is a critical, but often neglected aspect of global public health systems strengthening. Data from FY21 showed a proficiency testing concordance of 100%, which PEPFAR Cameroon intends to maintain in COP22 by intensifying mentorship and site supervision at all sites. The laboratory and clinic interface will be strengthened by reinforced collaboration between the lab partners and the clinical partners to ensure quality HIV testing.

The CQI process will be used to drive case finding performances, especially for low performing sites. For all target populations and geographical areas, PEPFAR Cameroon will continue tracking age- and sex-disaggregated performance at the site level by modality to identify high, medium, and low performing sites. Weekly data collection and reporting of program indicators will be strengthened, and IPs will work with high performing sites to identify and adapt best practices to mentor and to support low performing sites to improve performance.

In the context of COVID19, the program will continue to mitigate the impact by providing Personal Protective Equipment to testers, conducting virtual GSM and tele-mentoring, and taking ICT services to contacts who are unable to come to health facilities.

4.2 Ensuring viral suppression and ART continuity

4.2.1 Getting PLHIV on treatment

Based on National DHIS2 and 2021 Spectrum estimates, 388 354 (92%) of PLHIV in Cameroon were on treatment at the end of December 2021, leaving a gap of 33 827 (8%). At regional level, the initiation rate was highest in the Littoral (147%), West (102%), East (86%). This initiation rate

was low for the Far North, Adamawa, South-West, North-West, South, Centre, North and the Military varying respectively from 38% - 69%.

In FY21, our proxy linkage disaggregated by region and by sex shows overall good performance across all regions for both genders varying from 84% - 102%. However, males had slightly lower linkage rate compared to females. Looking at the disaggregation by age, PLHIV aged from 1-9, 30-50 and above have >80% linkage rates. We found sub-optimal linkage for the 10-14 (65%) and 15-29 years (76%) age groups, especially among males. The overall proxy linkage was 93% with 92% in Zone 1, 91% in Zone 2, 94% in Zone 3, 95% in Zone 4 and 96% in the Military Zone respectively.

PEPFAR data shows that of the 62,345 patients who tested positive in FY21, 58,126 were initiated on ART, reflecting an overall linkage rate of 93%. Age and sex disaggregation reveal that among the 58,126 patients linked to treatment, 63% (36,826) were female and 37% (21,300) were male. PEPFAR Cameroon assesses site level data for linkage with all the disaggregation and subpopulation for all supported sites across the 10 regions.

Outstanding gaps

Despite having great FY21 programmatic results for linkage (93%), there are still outstanding gaps in some Zones, regions, and among certain sub-populations. Our data shows sub-optimal ART coverage in Zone 4 (62%), specifically in the far north (56%) and the North (60%) regions. In addition, the South and the South-West Region are also areas of concern. Looking at ART coverage gap disaggregated by age and sex, more effort is needed to improve linkage of males aged 20-34 years (29-51%) and females 50+ (49%) as well as for both sexes across pediatric and adolescent groups (<20 years (figure 4.2.1 and 2).

Overall, suboptimal linkage to care and treatment remains an issue in Zone 4 and among the pediatric population and for males relative to females. Linking PLHIV to treatment is a key step in achieving epidemic control, therefore strategies and approaches are needed to address these gaps. DHIS2 2021 data indicates similar linkage gaps.

Figure 4.2.1. FY21 Initiation by age and sex

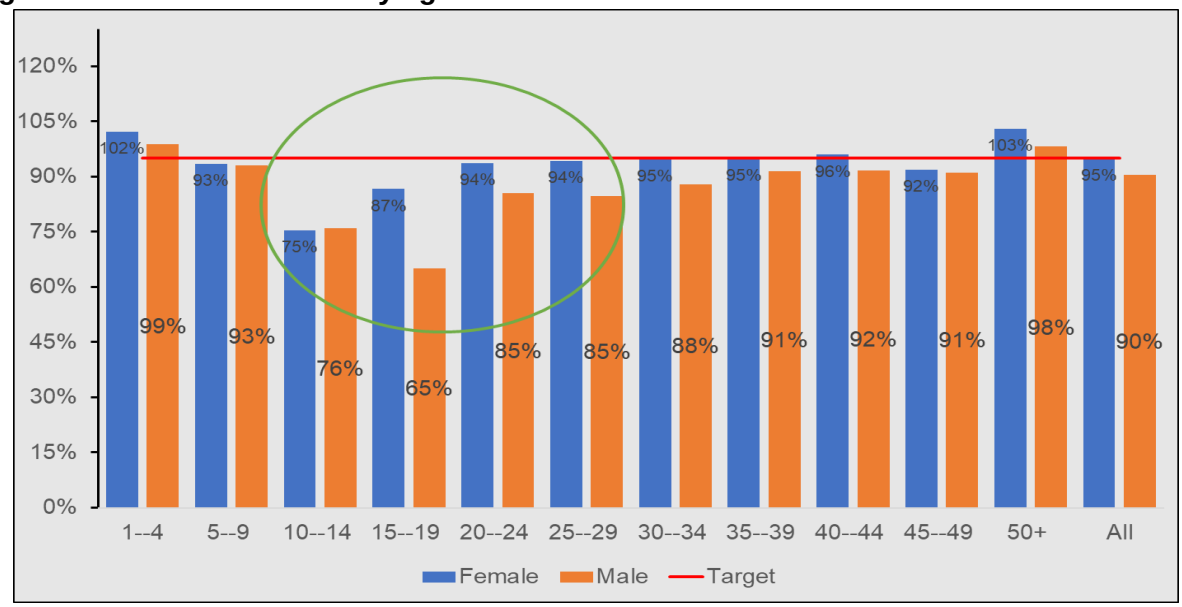


Figure 4.2.2. Who Are We Missing by Age, Sex, Region and Zone?

Zone	PLHIV		Current on ART		ART Coverage			ART Gap	
	Female	Male	Female	Male	Female	Male	Total	Female	Male
Zone 1	86,069	42,445	72,908	30,017	85%	71%	80%	13,161	12,428
Zone 2	72,513	35,227	59,085	25,129	81%	71%	78%	13,428	10,098
Zone 3	99,581	49,244	92,158	41,471	93%	84%	90%	7,423	7,773
Zone 4	69,282	36,606	44,613	21,372	64%	58%	62%	24,669	15,234
Grand Total	**327,445**	**163,522**	**268,764**	**117,989**	82%	72%	79%	**58,681**	**45,533**

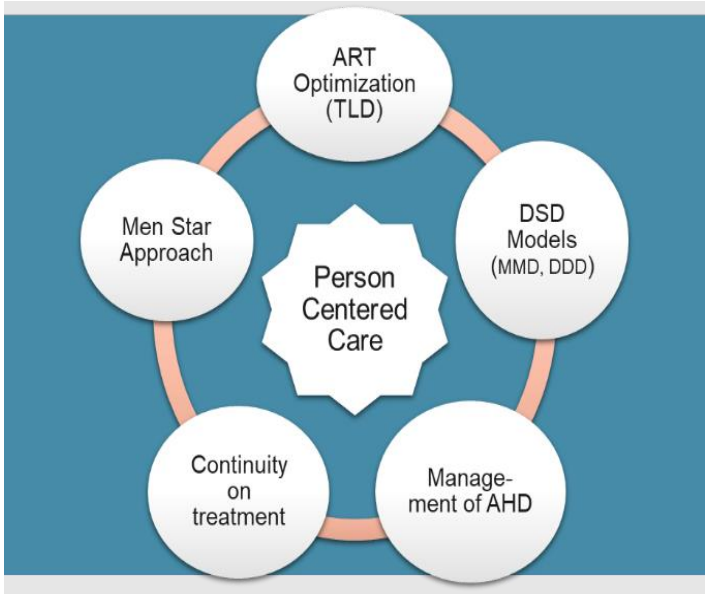
Region	PLHIV		Current on ART		ART Coverage			ART Gap	
	Female	Male	Female	Male	Female	Male	Total	Female	Male
Adamawa	16,896	8,800	13,148	6,448	78%	73%	76%	3,748	2,352
Centre	75,225	37,592	70,207	31,391	93%	84%	90%	5,018	6,201
East	24,356	11,652	21,951	10,080	90%	87%	89%	2,405	1,572
Far North	25,712	14,058	14,859	7,440	58%	53%	56%	10,853	6,618
Littoral	55,516	26,605	45,990	19,476	83%	73%	80%	9,526	7,129
North	26,674	13,748	16,606	7,484	62%	54%	60%	10,068	6,264
North West	33,525	15,480	29,338	11,968	88%	77%	84%	4,187	3,512
South	16,997	8,622	13,095	5,653	77%	66%	73%	3,902	2,969
South West	31,205	16,905	22,358	9,308	72%	55%	66%	8,847	7,597
West	21,339	10,060	21,212	8,741	99%	87%	95%	127	1,319
Grand Total	**327,445**	**163,522**	**268,764**	**117,989**	82%	72%	79%	**58,681**	**45,533**

Age	PLHIV		Current on ART		ART Coverage			ART Gap	
	Female	Male	Female	Male	Female	Male	Total	Female	Male
<01	629	505	112	103	18%	20%	19%	517	402
01-04	3,173	2,524	1043	1044	33%	41%	37%	2,130	1,480
05-09	4,613	4,954	2325	2093	50%	42%	46%	2,288	2,861
10-14	6,630	7,428	2552	2245	38%	30%	34%	4,078	5,183
15-19	9,982	10,929	4950	2063	50%	19%	34%	5,032	8,866
20-24	20,951	14,032	16048	4008	77%	29%	57%	4,903	10,024
25-29	31,236	19,374	24,936	6,631	80%	34%	62%	6,300	12,743
30-34	37,283	22,137	38,253	11,335	103%	51%	83%	(970)	10,802
35-39	39,339	22,448	44,747	16,265	114%	72%	99%	-5,408	6,183
40-44	34,168	19,358	42,165	18,894	123%	98%	114%	-7,997	464
45-49	22,577	12,374	34,520	18,951	153%	153%	153%	-11,943	-6,577
50+	116,864	27,459	57113	34358	49%	125%	63%	59,751	-6,899
Grand Total	**327,445**	**163,522**	**268,764**	**117,990**	82%	72%	79%	**58,681**	**45,532**

Strategies to improve on linkage and retention to Care and Treatment

PEPFAR Cameroon will continue to implement a person-centered care approach across the 10 Regions in COP222. This includes scale up of active linkage activities; scale up of TLD rollout; scale up of MMD of ART; extension of differentiated service delivery models; use of satellite sites to support the implementation of decentralized drug distribution; improved management of advanced HIV disease; and active patient tracking.

Figure 4.2.3. COP21 Person-centered care approach



As we advance to achieve epidemic control by attaining the 95-95-95 goals, it is important to adapt our program from the focus on rapid scaling of ART coverage and other services to the consistent and effective continuity of treatment and person-centered services for all PLHIV. This means to identify and specifically support populations where new transmission is occurring. Person-centered care recognizes that the cohort of PLHIV is aging and requires attention to improving quality and scope of care to lower mortality of those in treatment. In COP22, we will

continue to work through reaching epidemic control of HIV with an increased focus on populations experiencing gaps such as men, adolescent girls and young women/adolescent boys and young men (AGYW/ABYM), children and >50 years.

PEPFAR Cameroon will continue to scale up active linkage of clients from the various entry points using peer navigator programs based on an existing linkage agent model and with highly experienced expert client counselors and case managers. Patients not linked, especially TB diagnosed cases, will be monitored daily, up until final initiation on treatment. This initiative will involve training and mentoring healthcare workers (HCWs, e.g., doctors, nurses, psychosocial agents (PSA), case managers, index tracers, testing counselors) to develop competency in counseling, supporting HCWs to build a relationship of confidence with clients, accompanying patients to develop and implement personalized treatment plans, identifying and addressing key barriers to treatment adherence, issues of disclosure during counseling, and patient rights. As part of linkage strategy, HCWs will identify and link patients to their preferred facility for ART treatment initiation and management and closely monitor PSA at all entry points to ensure proper documentation of all patients identified as HIV positive who are linked to C&T services.

In COP22, all PEPFAR supported sites will continue to assess patient readiness and preparing them for treatment through proper therapeutic education and effective pre/posttest counseling before ART initiation; to implement same day ART initiation and to ensure all PLHIV identified are linked to C&T services. This facility-based linkage model will reinforce physical referrals through peer support agents who are expert client counselors to target young people, adolescents, and men. PEPFAR will continue to support GRC's decentralization of ART to PMTCT, TB, and HTS stand-alone sites to accommodate men and children through task shifting and to promote the family care model. The program will provide support to extend the community-based linkage model in association with CSOs in all 10 Regions. This will entail strong collaboration between the facility and the community to improve active linkage of patients identified at the community to the facility for treatment initiation through referral system.

In COP22, PEPFAR Cameroon will continue supporting MOH in the scale up of the fixed dose combination of TDF/3TC/DTG (TLD), which is the preferred 1st line ARV for all eligible PLHIV[1]. Clients enrolled on TLD based regimen increased from 35% in FY20 to 85% in FY21Q3 surpassing the 80% benchmark according to government policy. This trend slightly dropped to 74% in FY21Q4 due to limited stock availability in the country. In COP22, PEPFAR Cameroon will maintain focus on TLD scale-up across all 10 Regions, including women of childbearing age and PBFW through training and mentorship of HCWs, provision of Job Aids/SOPs, data collection tools for documentation and reporting, and will continue advocacy with GRC and all stakeholders to ensure availability of sufficient quantity of TLD at site level. Providing optimized ART regimens will be crucial for CALHIV, as pediatric DTG (pDTG) has been approved for use in children and adolescents as per the National Guidelines (2020)[2]; specifically, TLD (children >30kg), DTG 50mg-based regimen (children 20-30 kg), and DTG 10mg-based regimen (children >3kg and <20kg). Additionally, in collaboration with NACC, PEPFAR Cameroon will set up a free e-learning

[1] WHO guidelines July 2021
[2] Cameroon HIV national guidelines 2020

platform on HIV and TB care and treatment to ensure continuous capacity-building through training and mentoring. This tool will ensure the dissemination of up-to-date guidelines on patient case management (thus promoting the transition to TLD) and help to mitigate health care provider turnover, and its virtual format will ensure accessibility at any location and time.

Strategies to improve linkage among men 15+ years of age

PEPFAR Cameroon will continue to implement several strategies based on "Men Star approaches" throughout COP22. Men star core package include the following:

1. Demand creation using male peers either at soccer games or beer parlors
2. Testing experience with male testers
3. Treatment narrative with patient literacy
4. Better medication with the optimized treatment
5. Treatment navigation to orient men through the services at both clinical and community settings, and
6. Client support with a service referral and linkage system that seeks to identify and address patients' particular barriers and challenges, support for disclosure to partners and transport reimbursement when needed.

In addition to providing optimal ART regimens such as TLD, the program will promote universal entry points and holistic care for men, integrating men's health into HIV services with enhanced focus on confidentiality and privacy to allow for routine assessment and response to gender disparities in HIV services and HIV-related outcomes. A variety of patient support mechanisms will be implemented to help newly diagnosed men navigate the treatment experience, including the use of case managers and/or peer navigators.

Strategies to improve linkage of AGYW

PEPFAR Cameroon will continue to extend its tailored package of services to this population. The program will ensure that all identified positive AGYW are receiving services promoting treatment literacy. PEPFAR Cameroon will also strengthen bi-directional referrals between health facilities and community AGYW service providers to ensure effective linkage to treatment and a comprehensive follow-up of HIV-positive adolescents in need. The program will continue to identify and train at the facility level AGYW/ABYM focal points and teenage mother champions who are expert clients to ensure active linkage of newly identified HIV positive peers to C&T and adolescent-friendly services.

Strategies to improve linkage amongst adolescents and children

In addition to optimizing pediatric ART regimens in COP22, PEPFAR Cameroon will continue to scale up pediatric centers of excellence in all the 10 Regions, promote same day ART initiation for adolescents and youth, reinforce bi-directional coordination between health facilities and community OVC service providers to ensure effective linkage to treatment, and a close follow-up of CALHIV. PEPFAR Cameroon will also identify "adolescent champions" to mobilize peers and link them to adolescent-friendly services.

Over the past two implementation years, the OVC program pivoted to provide enhanced support to the HIV clinical cascade. The efforts to wrap around the clinical program have led the OVC program to enroll 10,161 CALHIV <18 years and 11,805 caregivers living with HIV into the OVC program-- about 60% of the country's ART cohort below 20 years of age. These results are due in part to an efficient wraparound and collocation of OVC and clinical programs, covering all large and midsize volume sites, except three facilities in zones with high levels of insecurity.

The Handshake Model

The clinical program plays a substantial role in ensuring continuity and complementarity of HIV services for key populations reached and tested positive by the community program. The clinical program ensures timely (same day) initiation to ART for these clients after an HIV test for verification, following national guidelines. A counter referral is done after initiation, but the clinical program continues providing other services to ensure the KP clients stay on treatment and achieve viral load suppression. When members of key populations test positive at the community -level, a peer navigator (PN) of the community program physically accompanies their clients to health facilities and presents them with a referral slip to the designated KP-friendly provider in what is known as the "handshake" between the community and facility provider. Once received at the facility for ART initiation, the facility KP focal person will navigate the referred client and ensure every other clinical service is provided prior to treatment initiation. These other services include confirmation of HIV status (as per national guidelines if not done at community level); screening, diagnosis and management of co-morbidities including TB, STIs, other OIs; SRH/FP services need assessment and provision (for FSW), GBV screening and management. Upon initiation at the facility, the KP client will be counter-referred to the community program (with a filled and signed counter referral slip). The newly initiated KP will continue clinic visits for ART dispensation and other clinical services as needed. ART dispensation will continue at the clinic until the newly initiated KP becomes virally suppressed and will be given options for differentiated ART dispensation, including dispensation at KP CBOs. Due to current policy limitations on where clients can be initiated on treatment, as part of the handshake model, KP clients identified in the community are oriented towards PEPFAR supported clinical sites but maintain the rights to choose where they want to continue with their care (initiation on ART). The community linkage agent has the obligation to ensure the client is linked to care and treatment and is receiving community-based adherence support as necessary.

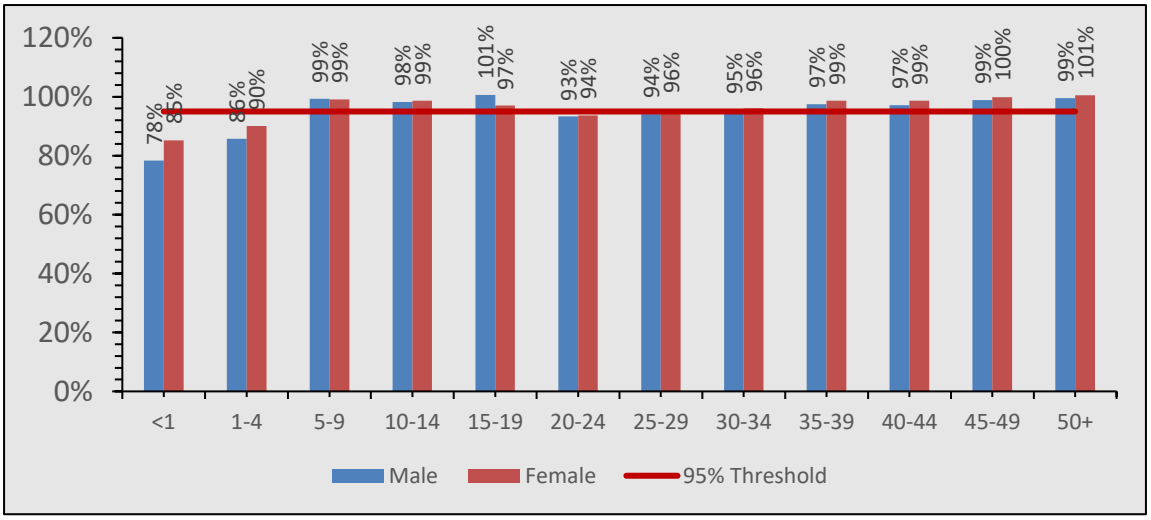
PEPFAR Cameroon will continue to strengthen the handshake model through improved collaboration between community and clinical partners. PEPFAR Cameroon will monitor the implementation of MOUs signed between the mechanisms and provide guidance for improving KP continuum of care services.

4.2.2 Ensuring PLHIV retention and Viral Load suppression

FY21 program data indicate that the overall retention rate of PLHIV on ART is 97%, with 341,090 PLHIV currently on treatment at PEPFAR-supported sites. These programmatic results demonstrate great performance in retention for both male and female patients aged greater than 5 years. Only children less than 5 years presented a suboptimal retention (<90%) (see Figure 4.2.4). The implementation of pediatric centers of excellence, the strengthening of mother baby

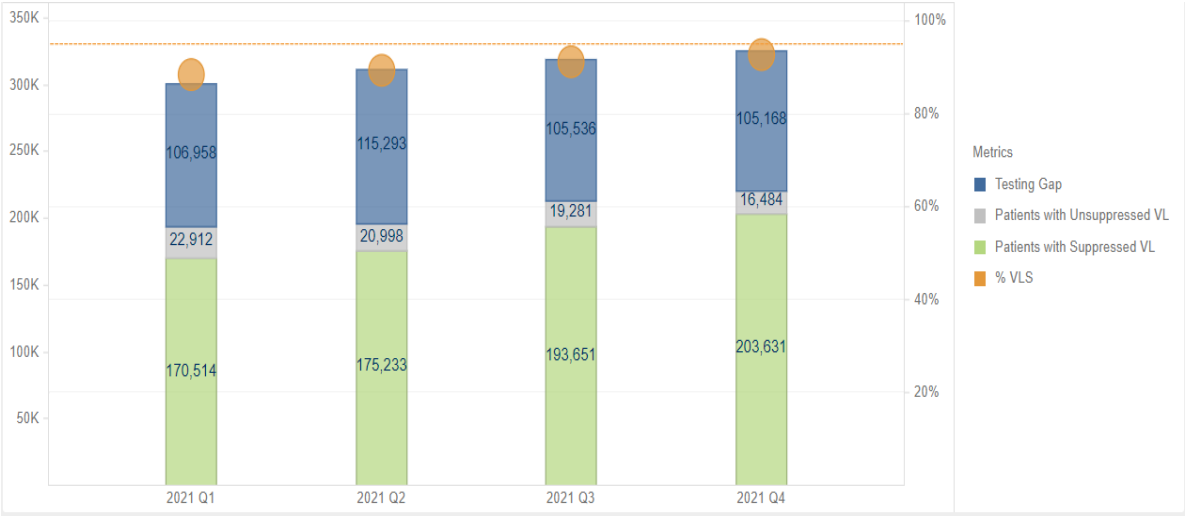
pair cohort monitoring and the availability of optimized pediatric ART regimen will be utilized to improve on this performance across PEPFAR supported sites in Cameroon.

Figure 4.2.4: FY21 Retention by age and sex



In FY21, viral load (VL) coverage was approximately 71% of 316, 980 PLHIV eligible for VL testing. The overall VL suppression rate increased from 88% to 93% (see Figure 4.2.5 for VL outcomes). VL suppression rates have increased throughout FY21 for both <15 (68% in FY21Q1 to 78% in Q4) and 15+ (89% in FY21Q1 to 93% in Q4) age groups, but greater focus is needed to accelerate VL suppression rates among the PLHIV <15 years. VL coverage ranged from 84% in the Center to 48% in the East Region while VL suppression varied from 96% in the West to 80% in the East. The West and North-West Regions had greater rates >95%.

Figure 4.2.5: Viral Load Outcomes, FY21

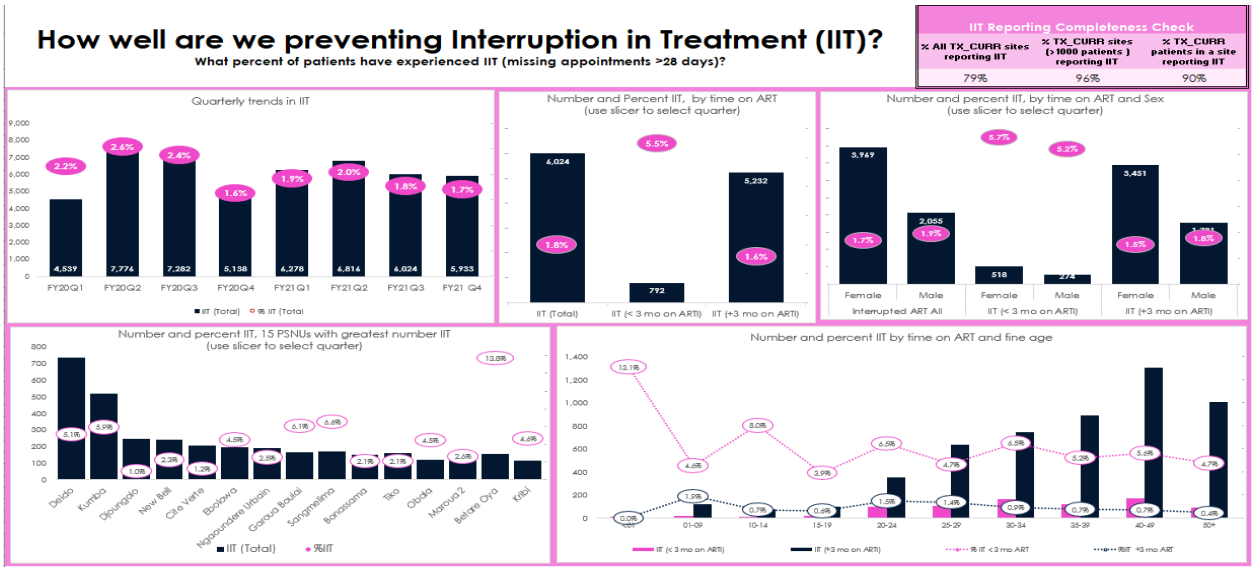


According to programmatic data, overall mortality rate among PLHIV was 0.54% out of 341, 090 patients in care at the end of FY21 with a range of 0.35% to 0.61% for adults (>15 years). This rate is slightly higher in male category compared to female.

Outstanding gaps

Despite significant gains during FY21, retention rates were suboptimal among children less than 5 years. FY21Q4 data indicates that PLHIV who are newly initiated on ART (<3 months) are more likely to experience interruption in treatment (IIT) than those who have been on ART 3+ months (5.5% vs. 1.6%) (figure 4.2.6). The percentage of IIT for those on ART <3 months is highest among <1;1–9 and 10-14-year-olds with respectively 13.1%; 4.6% and 8%) for those 15+ year-old the percentage is high and remains greater than 3.5% overall. Additionally, percent IIT for females on ART <3 months is slightly greater (5.7%) than for males (5.2%). Comparing trends in IIT and return to treatment (RTT), FY21Q4 data indicates that patients in all age categories have more treatment interruptions than are returned to care. In addition, patients transferred out (3,667) and those who died (1,714) represent the next highest proportion of our TX_ML modalities.

Figure 4.2.6: Number and % IIT by age and sex, Quarter FY21Q4



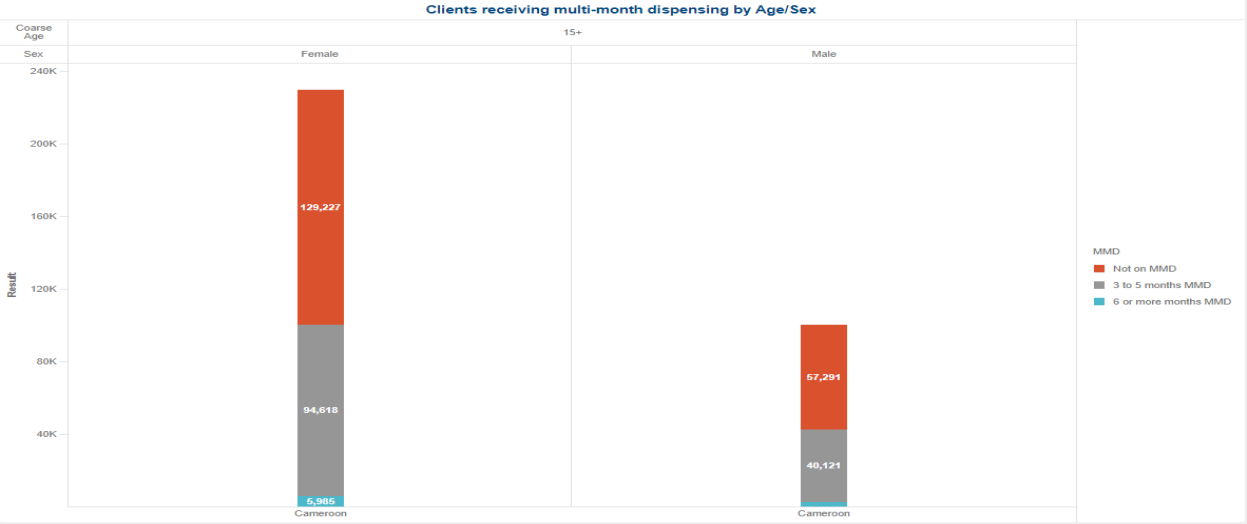
FY21 programmatic results also demonstrated a suboptimal VL suppression rate of 78% among children <15 years. In addition, looking at our high viral load (HVL) cascade for FY21, out of 22,596 clients with HVL, 68% (8,596) completed their three enhanced adherence and counseling (EAC) sessions, 56% (4,782) repeated their VL test, 51% (2,455) came back with an unsuppressed VL and only 58% (1,418) of them were switched to 2nd line ART.

Key gaps affecting VL coverage and suppression rates include frequent stockouts of VL reagents, inadequate systems for sample transport and return of results, weak systems to monitor patients with high VL, resistance of some HCW to use VL management tools, weak ART transition efforts for pediatric and adolescent due to limited stocks of optimized ARVs, and inadequate EAC cascade.

In FY21, our data shows that since FY21Q2 a reduction in MMD scale up due to limited stock of ARVs in country given an overall performance of 44% of all patients receiving 3+ month dispensation and 3% of patients receiving 6-month dispensation by the end of FY21. In addition, the figure below (fig. 4.2.7) shows the disaggregation by sex for patients aged >15 years old with

41.2% (143,638/341,090) of them receiving MMD (3+ months), with respectively 70% (100,603) and 30% (43,035) females and males.

Figure 4.2.7: Number Contribution of Clients Receiving MMD by Sex for >15 years, FY21



FY22 Q1 data highlight differentiated service delivery models are currently offered to 20% of our TX_CURR (70 976/348 723) with 54% for within the community and 46% at the facility. Fast tracking (26%) at the health facility followed by home dispensation (19%) and by dispensation through CBOs (14%) in the community represent the three most implemented models with the highest number of patients enrolled out of 9 models listed (family dispensation, SG, CAD, Extended clinic hours, 3rd party dispensation and ARVs shipped).

Concerning advanced HIV disease (AHD), FY21 data reported a total of 2,399 cases identified across our Zone 1 to 3 supported sites with a high mortality rate among patients with AHD (22%; 533/2,399). This rate varied from 52% in the South-West Region to 10% in the East Region.

Strategies to improve retention among all PLHIV

To reach the FY22 treatment targets and maintain 97% of PLHIV on treatment, PEPFAR Cameroon will ensure all PLHIV initiated on ART benefit from a person-centered care approach as described in the previous section. This will consist of a rapid initiation of ART and an intensified treatment adherence support. Our clinical IPs will continue assessing patient knowledge of the advantage of early treatment and the importance of lifelong ART and barriers to care through proper therapeutic education and effective counseling during follow up visit and calls. Expert clients will assist newly initiated patients with practical issues related to ARV medications during the first six months of ART, strengthening relationships with patients and therefore enhance retention in care. IPs will also continue to support health facilities to set up counseling space for therapeutic education and enhanced adherence counselling. The expert client/counselors/PSA will work closely with the community relay agent to undertake home visits and actively escort patients to the facility when needed. PEPFAR Cameroon will continue supporting health facility

retention committees to address issues related to retention and resistance and any others such as AHD based on the needs.

PEPFAR Cameroon will work with IPs to ensure oversight of patient management and quality service delivery following the national standard operating procedures (SOP). Support will be provided to GRC to update existing SOPs and other job aides to successfully implement and monitor care and treatment activities. The program will support revision of ART tools to ensure documentation of ART side effects. Site mentorship will be intensified to improve quality of service delivery. This mentorship model will consist of onsite training, mentoring provided by expert physicians, nurses, expert client counselors, linkage, and retention case managers from high performing ART sites to support low performing sites.

The program will continue to engage regional delegations of health and district health services to provide TA through mentorship and supervision to support adherence and retention interventions in all 10 Regions, including availability of commodities, documentation, and reporting to ensure quality HIV services to PLHIV. With IPs, the program will conduct regular focus group discussions among PLHIV with emphasis on clients newly initiated on ARV and harder to reach populations (such as men, AGYW, KP, youth and >50+ years) to continue to identify barriers to care, receive feedback on service quality, and continuously improve services that will increase access to HIV care and treatment.

PEPFAR Cameroon will maintain the assignment of clinical program staff to each clinical zone and specific sites to closely monitor site level performance on a weekly basis by tracking missed appointments and accounting for site level retention. IPs will support sites to develop systems in place for daily data triangulation and use. Data use will be enhanced at sites to improve quality of service delivery. IPs will work with facilities to track retention in care by service delivery model, sex, and age, and will improve strategies to track, document and report IIT, transfer out and died outcomes more accurately.

Since COP20, PEPFAR Cameroon planned to expand the implementation of MMD and other DSD models for patients who are stable with suppressed VL, and exceptionally for hard-to-reach patients who are unsuppressed, to enhance adherence and retention. Despite the difficulties of getting enough commodities to scale up this program, PEPFAR will continue to advocate with MOH and others stakeholders in other to really expand MMD for COP22 pending drug availability with 3-5 months dispensation for all eligible population including CALHIV, PBFW, AG/BYW and men and to increase 6-monthly MMD to 20% in selected sites by Region with specific patient selection criteria such as military-affiliated patients; IDPs; difficult to reach patients; long-distance travelers; and long-distance truck drivers. Poor adherence can lead to the development of HIVDR, hence compromising effectiveness of ARV treatment with low VL suppression. We plan to conduct an HIVDR survey beginning with a few Regions to identify reasons for this stagnation in suppression numbers among patients on treatment over 12 months. As we scale up MMD and transition to TLD regimen, we will continue monitoring trends in VL suppression and detect emergence of HIVDR.

Differentiated service delivery (DSD) models are implemented among facility and community levels which include*: i)* client managed group (One member of the group will visit the facility to pick up drugs for the group and distribute; this role is rotated among group members); *ii)* facility based individuals model (ART refills are separated from clinical visits, both of which are scheduled at longer intervals where the clients come to the facility for ARV refill (Fast tracking, Extended and Odd hours); *iii)* Out of facility, community and individual models (ART refills are provided to clients outside of the facilities with clinical consultations usually provided at longer intervals at the health facility (CAD through CBOs, Family/home models) and *iv)* health workers managed groups (Clients receive their ART refills in a group managed by a lay health worker. Both in and out of facility models, support clients with different types of needs such as: Newly initiated client, Client returning to care after an interruption, Patient not virally suppressed, Patient with AHD, Older patient, etc.)

Throughout FY23, PEPFAR Cameroon will continue to scale up the implementation of DSD models in all supported sites, focusing especially in Zone 4 and increasing the data collection and reporting of all the models. The country will continue to implement these models by leveraging on peer mentorship and champion/expert client/ mother mentors' programs who provide tailored support to patients. The use of trained expert clients in facilities and communities to follow newly identified, difficult patients such as IIT, HVL and to track those where PSA had limited access and polyvalent community relay agents to work with patients facing issues impacting retention, including mental health conditions and relationship problems will be expanded. PEPFAR Cameroon will also continue supporting PLHIV support groups and community adherence clubs including adapting group meetings at clinics to coincide with drug pickup and other clinical assessments.

Continuity of treatment is key and needs a strong patient tracking system to be effective. PEPFAR Cameroon will continue routine RTC efforts to ensure rapid tracking of defaulters and patients experiencing IIT through continuous patient tracking and ensuring they are brought back to care. PSA Monitoring (each PSA is accountable for their cohort) in collaboration with RTG provision of incentives based on performance showed great results in some zones and Region thus we will shift from facility to psychosocial support agent patient cohort monitoring. Cohorts of patients will continue to be assigned to linkage and retention case managers or PSA who will be responsible for monitoring patient appointments in harmonized logbooks, ensuring timely ART pick-up as scheduled, identifying defaulters, and encouraging their return through phone calls, short message services (SMS), home visits, etc. To address the gaps identified from IIT and RTT data, the program will focus on newly initiated patients (<3 months) and on younger patient using tailored strategies to retain them including dedicated peer navigators/expert clients, enhanced patient follows up, specific support group for them and adapted DSD models. In addition, the strengthening of patient education and literacy at each clinical visit, regular data triangulation at sites level, active involvement of community leaders and the scale up of Electronic Medical Record (EMR)/Unique ID system in other Regions and high-volume sites will reinforce patient tracking outcomes and reporting.

To improve on adherence and retention during COP22, PEPFAR Cameroon will continue to support the roll out of the decentralized drug distribution (DDD) using CBOs, private pharmacies,

and satellite sites (not currently supported by PEPFAR and not reporting in the DHIS2 which receive patients and were mentored by a PEPFAR-supported site to provide HIV screening and ARV dispensation) as well as other strategies such as family/home dispensation for disabled and/or bed-ridden patients. These models can help reduce patient travel times and waiting times while decongesting public facilities and reducing stigma.

To reduce morbidity and mortality associated with Advanced HIV disease (AHD), in COP22 PEPFAR Cameroon will improve on case identification and management through the review of national HIV treatment guidelines including opportunistic infections (OIs) and the provision of a comprehensive package of services to all people presenting with AHD, including those who are re-engaging with care after a period of ART interruption. This package will follow WHO guidelines which includes screening (CrAg, Toxoplasmosis serology, CD4), treatment (Tuberculosis, Cryptococcosis and Toxoplasmosis) and prophylaxis for major opportunistic infections (Cotrimoxazole, fluconazole, INH), rapid initiation of ART and intensified treatment adherence support. The program will also promote capacity-building of health care providers through training and mentorship; strong collaboration with MOH and other stakeholders to ensure the availability of commodities; close follow-up on user fee elimination for patients affected by AHD; implementation of express treatment triage programs (during consultation, and identify client with low CD4); close monitoring at the facility and frequent follow up home visits; and setting up a symptom checklist review and screening for OIs during clinic or home visits. In addition, the program will enhance AHD monitoring through enforcement on reporting and training and mentorship on data collection tools.

Strategies to improve retention among men

In COP22, PEPFAR Cameroon will continue to implement strategies to increase the convenience and responsiveness of health facilities to men's needs in order to improve retention among this group. Expedited services/fast-tracking for working men, extended clinic hours, transportation support when needed, facilitated access to tailored DSD models, and integrated HIV care and treatment services packaged with other services such as TB and STDs will be intensified and expanded to all PEPFAR-supported sites. Fostering welcoming environments at health facilities that are responsive to men's needs will involve the redesigning of clinics to include male-only spaces/corners, waiting areas, specific male-only hours, and more male imagery in clinics (e.g., posters). PEPFAR will continue to mentor HCW to ensure enhanced focus on confidentiality and privacy, as well as the provision of consistent, affirmative "Welcome Back" messaging that avoids the negative consequences of IIT and provide positive reinforcement for reengagement. Efforts to hire and train male nurses, counselors, peer outreach workers, case managers, and other staff remains a key strategy to facilitating a more responsive environment to men's needs and thus improving retention among this demographic.

Fast track mechanisms will be put in place to ensure men who attend clinics only for pickups are served in a timely manner. Improved documentation of MMD and CAD through DICs and other CBOs will be ensured to avoid misclassification of some patients as IIT. This includes military on deployment who sometimes receive 6-month ART packs or are served in the community and are misclassified as IIT. Health education and literacy materials tailored to men's health will be developed and made available to all men including KP and PP, with peer linkage and retention

agents available to address male, KP, and PP specific issues. Peer support groups and male-friendly clinics will be scaled up in all PEPFAR-supported sites.

Strategies to improve linkage of AGYW

As described in the AGYW Conceptual Model introduced in Section 4.3, PEPFAR Cameroon will continue to improve services in COP22 on linkage and retention among this subpopulation who are vulnerable and at high risk. All the services included under this conceptual model, such as treatment literacy, education on GBV and PrEP, and adherence support groups, will be offered across the entire HIV cascade. The program will also continue to support tailored DSD services for AGYW.

Strategies to improve retention among children and adolescents

PEPFAR Cameroon will continue to implement strategies to improve retention among younger cohorts through optimized pDTG for all eligible CALHIV, a client- and family-centered care approach, integrated TB/HIV activities, scale up DSD and MMD, and strengthen management of AHD. In addition, the program will leverage adolescent/youth multi-functional centers and associations as dispensation sites to improve adherence and retention amongst ALHIV.

PEPFAR Cameroon also leverages the OVC program to strengthen adherence for CALHIV in order to improve viral load suppression. Children in the OVC program with high viral loads receive enhanced adherence counseling during biweekly household visits by case workers, in collaboration with health facility staff. These children also benefit from case-conferencing, which brings together the clinical team, community health workers, caregivers, and the CALHIV to better understand the barriers to and enablers of viral load suppression. During case conferences, all stakeholders work together to develop a plan with clear roles and responsibilities from all the parties.

Strategies to improve retention of patients aged 50+

Based on FY21Q1 IIT and RTT programmatic data, retention among patients 50 years and older is suboptimal compared to younger age groups. PEPFAR Cameroon will carry out focus group discussions to understand the unique needs of this subpopulation and to guide the development of tailored strategies to improve retention. At the same time, the program will roll out a series of strategies, such as age-appropriate peer mentors/expert clients, DSD models adapted to their context (e.g., for retirees, home-bound patients, etc.), engagement of caregivers, support for transportation, additional psychosocial support, and an integrated package of services (BP, blood sugar, cancer screening, etc.).

Strategies to improve VL Suppression among PLHIV

In order to reach 95% VL coverage and suppression among PLHIV, PEPFAR Cameroon will continue implementing several strategies across all 10 Regions. These strategies will include the following: continued support for TLD transition, strengthening the sample transport system, ensuring availability of VL commodities, and increasing VL demand creation. The program will continue to emphasize the use of Undetectable = Untransmittable (U=U) messaging as a key component of adherence and counseling for patients. PEPFAR Cameroon will ensure improved management and enhanced monitoring of patients with high VL to increase number of patients

eligible for MMD and CAD once virally suppressed. For PLHIV with unsuppressed VL, the program will support the monitoring of VL outcomes following the implementation of U=U, the provision of tools for monitoring patients with high VL and low-level viremia and ensuring adequate documentation and reporting using a national EID/VL data system and dashboard. Furthermore, PEPFAR will support the systematic implementation and monitoring of all HVL patients to ensure the completion of three consecutive EAC sessions using VL registers and monitoring of EAC sessions through Excel tracking tools. The use of viral load champions and viremia/adherence clubs in health facilities to improve uptake of VL will be extended throughout the 10 Regions, and the creation and rollout of viremia clinics with multidisciplinary teams will be strengthened. Given the regional and zonal specificities of the country, the Government of Cameroon recently set up a decentralized transport system to meet the sample referral needs of the population. PEPFAR will continue to leverage this opportunity to optimize the sample referral system and improve turn-around-time for viral load and EID results. PEPFAR will also implement patient-centered approaches like positive parenting to improve VL coverage and retention for children and adolescents and will monitor the quality of testing services by ensuring all VL reference labs are enrolled in a quality assurance program towards accreditation.

PEPFAR Cameroon will ensure that HCW continue to receive coaching in VL literacy, VL results interpretation and use for clinical decision making, and adjustment/switching of ART regimen. Facilitative supervision will also be reinforced through the scale up of joint granular GSM/SIMS, ongoing supervision and continuous quality improvement initiatives to identify and address gaps in a timely manner.

PEPFAR Cameroon will support the continuous mentorship of HCW on the use of VL management tools such as unsuppressed VL registers and VL dashboards, especially in new Regions, as well as ensure the availability of such registers for EAC monitoring and tracking. Best practices reported at top performing sites will be promoted and adapted at low performing sites. IPs will closely monitor use and report on facility charges of HIV user fees to ensure elimination of financial barriers to HIV care and treatment.

4.3 Prevention, specifically detailing programs for priority programming

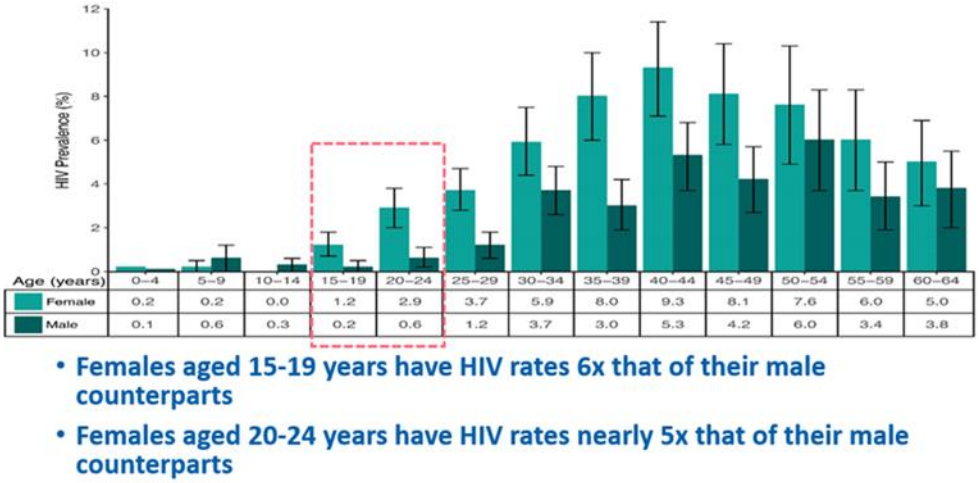
The PEPFAR program will continue to support the Government of the Republic of Cameroon in the implementation of its HIV prevention strategies for key populations (FSW, MSM, PWID, TG, and People in prisons and other closed settings) and vulnerable populations (children of female sex workers, clients of female sex workers, OVC, AGYW/ABYM, sero-discordant couples, pregnant and breastfeeding women and their partners, HEI, GBV survivors). PEPFAR will ensure that all beneficiaries reached with preventive services will be screened and tested for HIV. This will be done through the systematic HIV risk assessment and linkage to HIV testing services as part of the prevention services. The testing services will follow the national algorithm for HIV testing and HIV self-testing at the level of the health facility and/or at the level of the community. Section 4.1 above provides more details on the HTS program for PEPFAR Cameroon.

As with testing services, PEPFAR Cameroon tailors its prevention services to the various sub-populations.

4.3.1 Strategies to reach adolescents and youth

CAMPHIA 2018 data shows higher HIV prevalence rates among females in the 15-19 and 20-24 age groups compared to their male counterparts.

Figure 4.3.1 AGYW HIV Prevalence (CAMPHIA, 201)



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

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

Unfortunately, AGYW face significant barriers in accessing health services and protecting their own health. Limited access to comprehensive and accurate age and gender-appropriate information on SRH, as well as to HIV testing, modern contraception, and FP, means that they are not equipped to manage their sexual health or to reduce potential health risks. Gender disparities in power dynamics mean AGYW are less able to negotiate condom use and are more vulnerable to violence in the context of HIV. These factors lend to lower retention rates among AGYW on ART, and lower rates of viral suppression (52% VLS according to CAMPHIA 2018, and 54% according to FY21 program data). Sustained efforts to prevent and to diagnose HIV infection in AGYW as early as possible and to ensure subsequent rapid initiation of ART would improve the clinical cascade for AGYW and accelerate epidemic control in this sub-population.

Figure 4.3.2: Model for HIV Prevention among AGYW and ABYM

PEPFAR Cameroon will provide prevention programming for both AGYW and ABYM by offering, when relevant, a package of core interventions that conforms to PEPFAR minimum guidance, including:

- Behavior change communication, with a focus on risk avoidance
- Empowerment and life skills development
- Risk assessments and risk reduction counseling
- SRH/FP education and services, including condom and lubricant use promotion and distribution, and other contraception
- Positive parenting interventions
- HIV testing and counseling (see section 4.1 for more details on AGYW-targeted testing)
- Primary prevention of sexual violence and post-violence care, including PEP
- PrEP
- Prevention and management of comorbidities (TB, STIs and other OIs)
- Treatment literacy and adherence for ALHIV (see section 4.2 for more details on ART linkage and continuity for AGYW)
- Family strengthening
- Scaling up Community Mobilization for AGYW

The program will leverage on a gender/age-appropriate peer education scheme to promote and provide various services, often through individual or small group interventions, tailored to individual AGYW/ABYM needs through a person-centered approach. Service delivery will be adapted for AGYW in and out of school to include extended working hours and weekends. Depending on needs beyond the prevention package of services, AGYW/ABYM may be referred to health facilities, or to other legal and social services.

Entry points will include but are not limited to the OVC program (see details in following section), schools, apprenticeship workshops for out of school adolescents and youths, and adolescent and youth associations, including ALHIV CSOs. PEPFAR Cameroon will seek out out-of-school AGYW also through youth associations, among IDPs, support groups of ALHIV and PLHIV (their adolescent daughters), and social and print media. PEPFAR Cameroon will also identify “AGYW and teenage mother champions” through peer education to mobilize their peers and link them to adolescent-friendly services, facilitating access to prevention materials, reproductive health care and HIV services. PEPFAR’s KP program will be reaching AGYW in high HIV-burden areas such as around universities, within hotspots, at concessions around hotspots, and DICs. Three categories of AGYW will be targeted by the KP program: sexually active AGYW, those not sexually active, and those engaged in transactional sex, with a differentiated package of services for each category.

Although PrEP implementation is currently only authorized at clinical sites for MSM and FSW above the age of 18, PEPFAR is funding an evaluation of the program in COP21 that will include a feasibility assessment of PrEP among AGYW. It is expected that findings of this evaluation will pave the way to making PrEP available to other HIV negative high-risk groups such as AGYW, and an expansion of PrEP services across the national territory in COP22. This geographic and population expansion will follow a stepwise approach, prioritizing implementation sites with the largest number of PLHIV in their treatment cohorts and PBF AGYW. PEPFAR will also consider

PrEP implementation at clinics with smaller treatment cohorts but a significant client base of AGYW, or AGYW who recurrently seek PEP, especially health facilities in conflict areas. In COP22, PEPFAR Cameroon will continue assessing the gaps in PrEP implementation and working with NACC and other key stakeholders towards closing these gaps.

AGYW who are survivors of violence will benefit from a post-GBV clinical care package that includes as appropriate HTS, PEP, diagnosis and management of STIs, contraception, and referral to other support services.

A foundational aspect of the DREAMS approach is community engagement, to address environmental factors beyond the control of the individual or the AGYW subgroup. Through collaboration with key stakeholders such as the Ministry of Women's Empowerment and the Family, UNICEF, and NACC, PEPFAR plans on putting in place a community-driven approach, where community-members will have the opportunity to fully participate in designing, implementing, monitoring and evaluating activities. Community mobilization to secure community engagement in promoting positive gender norms also remains critical for programming and will be scaled up in COP22 where more community counterparts will be trained on implementing community mobilization for gender norms and social change. In COP21 implementation period, cross-training of clinical and community partners on adolescent-focused SGBV prevention was a key approach to strengthening the AGYW prevention portfolio. COP22 will see a continuation of this collaboration on various aspects of AGYW focused programming.

Through the peer-led prevention program, AGYW will serve as points of contact to reach and mobilize their sexual partners, ABYM as well as adult men, who are also priority population subgroups for the clinical program. These latter groups will be offered risk reduction counseling/activities alongside relevant HIV prevention, care and treatment services. ABYM benefit from the same prevention pack of services as AGYW, while the HIV prevention package of services for adult men is similar, conforming to PEPFAR minimum guidance, but reduced: behavior change communication including information, education, communication and life skills development through individual or small group talks; risk assessment and risk reduction counseling; condom and lubricant use promotion and distribution; prevention and management of comorbidities (TB, STIs and other OIs); PEP as applicable.

4.3.2. OVC programming

PEPFAR Cameroon is a comprehensive OVC program and includes a small scale OVC preventive package of services. Peace Corps volunteers, who will be returning to Cameroon in COP22, provide OVC preventive services implemented across the country, targeting AGYW/ABYM 10-14 years old. The program provides its beneficiaries with a comprehensive primary prevention service package comprised of evidence-based interventions, with the objective of increasing HIV risk avoidance practices and delaying sexual debut. The beneficiaries are recruited in schools and through communities.

Through child-centered, family-based case management, PEPFAR's OVC Comprehensive program supports children to be healthy, stable, safe, and schooled. The Comprehensive Program prioritizes the following subpopulations: CALHIV, children of PLHIV, HIV-infected PBFW and HEI, children of FSW, and survivors of violence against children. Children eligible for the program and their household receive an initial needs assessment, followed by a case

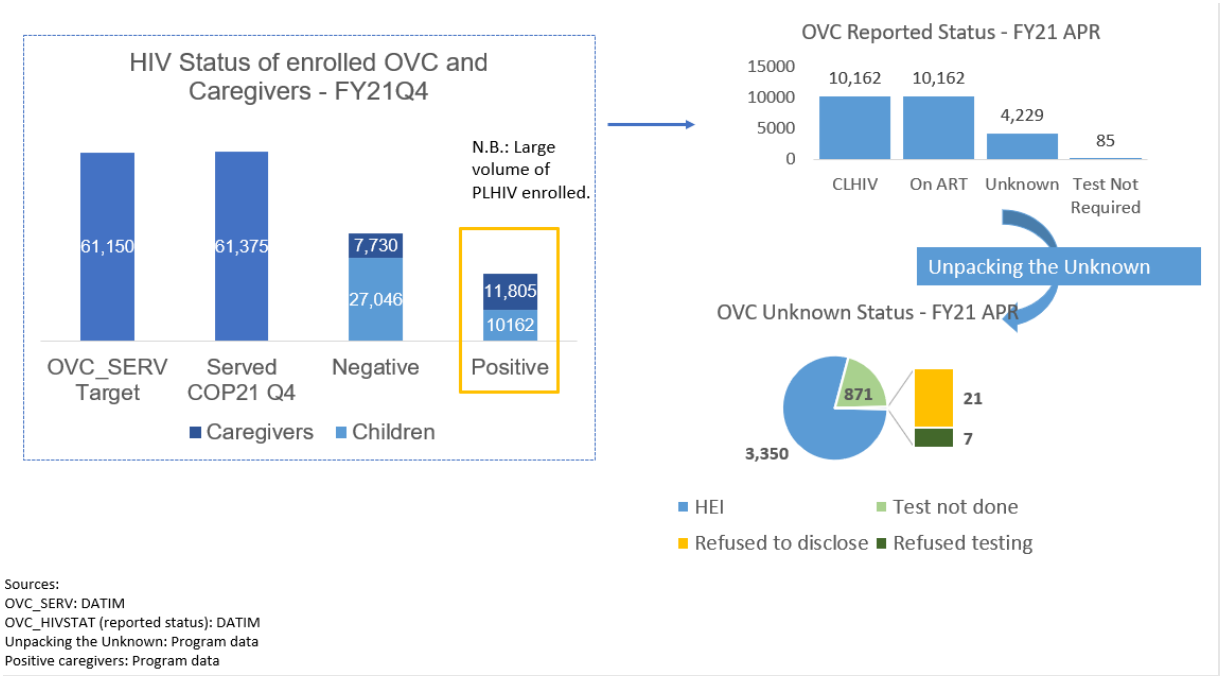
management plan specifying the health, legal, economic, and educational services that will be provided to the household.

In 2019, a year before the global trend, Cameroon OVC graduation rates peaked. As stable cases were graduating, the program pivoted to intensify support for CALHIV and their pediatric care outcomes. Following these efforts, the program now has about 90% of households containing at least one PLHIV. As a result of this pivot, PEPFAR expects to see the graduation rate decline over the coming years.

In FY2021, the OVC program continued to support the HIV clinical cascade by ensuring that about 90% of all beneficiaries knew their HIV status (HEI being the large majority with an unknown status), 100% of CALHIV were linked to ARVs, and the viral load suppression rate among OVC CALHIV was 85%. These results were achieved through a collaborative process among the clinical and community IP that led to MOUs signed in all PEPFAR zones. These MOUs reinforce the facility-community liaison process and delineate roles and responsibilities of each partner. In addition to signing these MOUs, the OVC partner has recruited, trained, and deployed community-facility liaison officers at the level of the health facilities to facilitate the enrollment of the CALHIV into the OVC program, as well as bi-directional referrals.

As part of the comprehensive package, the program conducts monthly household visits for all CALHIV to provide targeted, tailored interventions such as nutritional support, water sanitation and hygiene, early childhood development, positive parenting, household economic strengthening, pill box distribution, CALHIV and HEI appointment tracking, home-based ARV delivery, and TB screening. In addition to providing support to CALHIV, the OVC program also supports parents and caregivers living with HIV by facilitating ARV optimization, decentralized HIV service delivery, and MMD. Published studies and program records show that CALHIV are more likely to achieve viral load suppression when their parents or caregiver are equally virally suppressed.

Figure 4.3.3: OVC HIVSTAT cascade



Sources:
OVC_SERV: DATIM
OVC_HIVSTAT (reported status): DATIM
Unpacking the Unknown: Program data
Positive caregivers: Program data

In FY21Q4, the OVC Comprehensive Program served 61,375 beneficiaries, reaching its total annual target. In COP22, the OVC program will continue to serve approximately the same number of beneficiaries from the year prior, with a target of 65,321 beneficiaries, although there be a slight reduction in the OVC preventive component targets due to the slow return of the Peace Corps Volunteers who were not fully implementing in COP21, due to the COVID-19 pandemic. PEPFAR subsequently scaled up implementation from 44 districts in COP20 to 68 districts across the 10 regions in COP21.

The OVC Comprehensive Program will maintain its current footprint and will focus on improving the quality of services and the outcomes of the beneficiaries. This includes an increased effort to flexibly and innovatively integrate data to improve services on a continuous basis.

The OVC program will continue to offer a prevention package of services to adolescent girls and boys, aged 10-14 years, including HIV prevention education using S/GAC evidence-informed modules, such as the “Healthy and unhealthy relationships”, the “making decision about sex”, and the “obtaining sexual consent”. In addition, they will benefit from positive parenting and violence prevention using nationally adapted and validated modules, such as the “my changing body” and the “Wetti I go become when I grow”. Several interventions will be scaled up in COP22, including post-violence care, HIV prevention, SRH education, and joint positive parenting and violence prevention curriculum ("Parenting for Lifelong Health"). Adolescents will continue to be screened for HIV/STIs risks and referred for HTS, GBV, and other social services accordingly.

In COP22, the OVC program will continue its contribution to close the gap in pediatric HIV case finding through systematic HIV risk assessment, family centered disclosure support, and active referrals for HTS services (especially index testing) for eligible household members. In order to implement these activities with fidelity and in an efficient way, the OVC program will be rolling out the interagency pediatric index training module to strengthen clinical/OVC collaboration. The OVC program will continue to advocate for the expansion of the point-of-care molecular diagnosis network to improve monitoring of HEI final status and facilitate early linkage to ARVs for those diagnosed with HIV.

The OVC program will continue to work in collaboration with the clinical program to improve continuity in treatment for CALHIV and their caregivers. This will be done by offering and facilitating bidirectional referrals, appointment management, differentiated service delivery models such as MMD, home-based delivery of ARVs when necessary, facility and community-based support groups, family centered approaches, and continued use of pill boxes for ARVs and TPT. IIT tracking tool reviews will be conducted to optimize systems and support proper documentation of efforts and outputs. Also, the OVC program will be engaging a youth PLHIV network to provide mentoring and CAD to adolescents as they transition to adult care.

In FY23, the OVC program will strengthen its intervention to improve viral load uptake and suppression through the rollout of a joint training of case workers and psychosocial support agents, monitoring of ARV regimen optimization, as well as raising awareness of the U=U messaging. Interdisciplinary case-conferencing will continue to be prioritized and organized in a timely manner, taking advantage of the Pediatric Centers of Excellence and the mentorship program that is being set up by MOH through the support of PEPFAR. The OVC program will strengthen its tools and system to track and monitor VL uptake and suppression, as well as the uptake of home-based enhanced adherence counseling and VL sample recollection. To reduce

the turnaround time for VL testing, the OVC program will continue to advocate for the rollout of Point-of-care viral load testing for CALHIV, especially those with high viral load, to make sure appropriate decision could be taken by the clinicians to expedite clinical response to high VL. In addition to health services, OVCs and their household members will continue to benefit from nutritional counseling and economic strengthening, as well as prevention and management of gender-based violence and violence against children following the national guidelines.

The OVC program will work on program strengthening in COP22 in preparation to fully transition program implementation to a local partner. The OVC program will continue to take the necessary steps approved in the transition plan to ensure that all milestones are met for a successful transition. The local partner will benefit from the expertise of an international prime partner for organizational development, including the development of data management systems. Data management will furthermore be strengthened through the revision of tools and systems for data collection, analysis and usage, as well as the interoperability with the national health information system. Ensuring interoperability will provide the OVC program more visibility and ownership by the national health management information system.

4.3.3. Response to Gender Based Violence (GBV)

GBV is any form of violence that is directed at an individual based on their biological sex, gender identity or expression, or their perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life. GBV is often derived from unequal power relations between men and women. While anyone can experience violence, cisgender and transgender women experience higher rates of GBV than men.

GBV is a huge concern in Cameroon, exacerbated by a humanitarian crisis and is most often under-reported. Updates from DHIS 2018 survey reports that about 40% of women and men aged 15-49 have experienced physical violence since age 15 and 18% of women and 14% of men aged 15-49 experienced physical violence in the 12 months before the survey. Also, 13% of women and 6% of men aged 15-49 have experienced sexual violence. Women are three times as likely as men to experience physical spousal violence (34% versus 12%) but women and men are similarly likely to experience emotional violence (about 30%). The 2020 annual report on violence and violations towards sexual minorities in Cameroon also show increasing numbers of GBV towards sexual and gender minority groups.

In UNITY Platforms (PFU) 2020 report released in May 2021, more than 2000 cases of violence and violations of the rights of sexual and gender minorities affecting 930 people occurred in 2020, compared to just less than 1400 in 2019. More than half of the reported cases involved psychological violence, with the rest consisting of cases of physical, sexual, economic or legal violence and hate speech. Gay men were the most affected victims of violence (552), followed by lesbians (214) and transgender people (64), With the understanding that these numbers are under-reported, the increasing trend being 1134 in 2018, just under 1400 in 2019 and more than 2000 in 2020 presents a worrying situation. Following the OCHA Humanitarian report on GBV February 3, 2022, 1,668 GBV incidents were reported to GBV specialized service providers. Among the survivors, 96% were females, 41% children, 78% IDPs, 18% were host community members and 4% are returnees. Reported incidents included emotional abuse (31%), forced

marriage (28%), physical assault (16%), sexual assault (10%), denial of resources or opportunities (10%), and rape (5%).

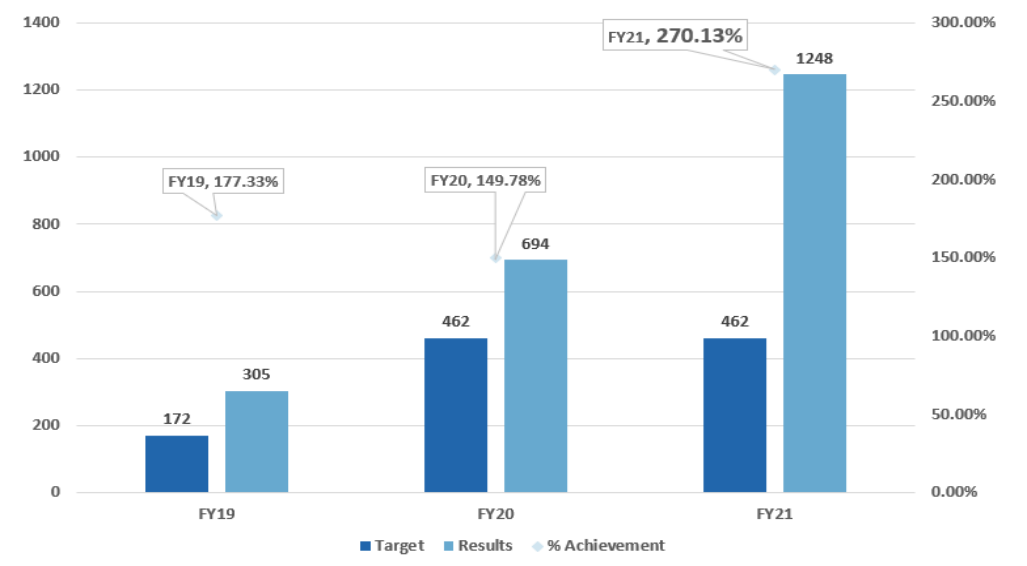
GBV and HIV/AIDS are mutually reinforcing epidemics. Experiencing GBV can contribute to HIV transmission in a variety of ways, including biological vulnerability, lack of communication and inability to access clinical services, and lack of condom use. Violence and harmful gender norms act as a barrier for HIV prevention, testing, and care and treatment of those at-risk or affected by HIV. Being HIV positive can also increase one's vulnerability and risk of experiencing GBV.

PEPFAR GBV Cameroon programs are designed to prevent GBV occurrence and provide post-GBV clinical care to survivors. The GEND_GBV indicator captures the number of individuals who receive PEPFAR-supported clinical post-GBV care based on the minimum package. PEPFAR Cameroon began implementing clinical post-GBV care in four PEPFAR-supported Regions in FY19 and is currently scaling up to cover the 10 Regions.

Results and Achievement

In FY21, PEPFAR Cameroon offered post-GBV clinical care to 1,248 survivors out of the 462 targeted with an achievement of 270% and a 309% increase from FY19, showing an increase year after year with FY21 being the highest achieving year.

Figure 4.3.4: Yearly Trends for GEND_GBV, FY19 – FY21



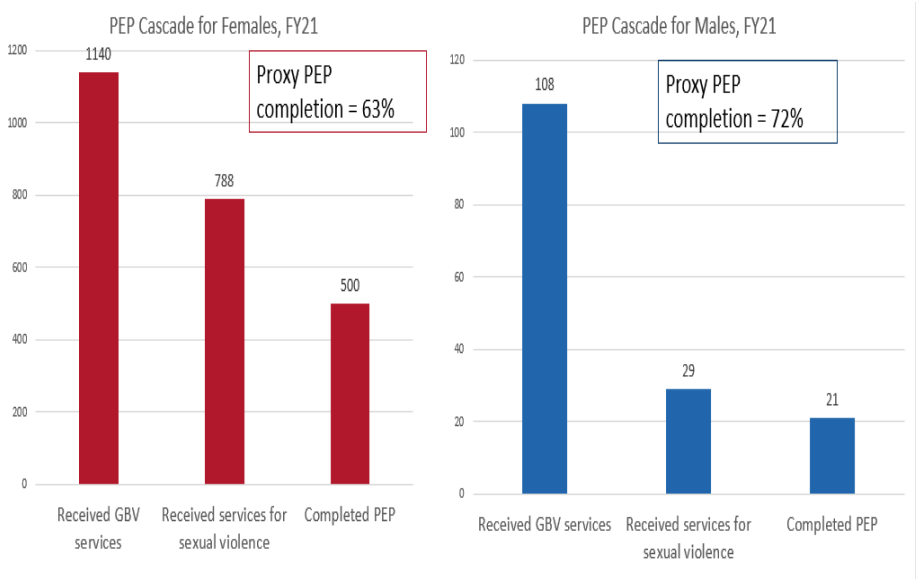
Among all survivors who received post-GBV Clinical Care, 35% (431) experienced either physical and/or emotional violence while the majority 65% experienced sexual violence.

Table 4.3.1: FY21 GEND_GBV Clinical Cascade by Type of Violence

SNU	Cumulative GEND_GBV FY21	Cumulative Survivors for Sexual Violence	Proportion of Survivors who suffered from Sexual violence	Cumulative Survivors for Physical and/or Emotional Violence	Proportion of Survivors who suffered Physical and/or Emotional Violence
Adamaoua	7	7	100%	0	0%
Centre	357	212	59%	145	41%
East	61	24	39%	37	61%
Far North	31	30	97%	1	3%
Littoral	110	75	68%	35	32%
North	23	16	70%	7	30%
Nord West	211	107	51%	104	49%
West	165	127	77%	38	23%
South	0	0	0%	0	0%
South West	283	219	77%	64	23%
Cameroon	1248	817	65%	31	35%

Among all survivors who experienced sexual violence, 65% received services for sexual violence. Among the 69% of all females who received services for sexual violence within the reporting period, 63% completed a course of PEP as did 72% of males among the 27% who of males who received services for sexual violence.

Figure 4.3.5: Post-Exposure Prophylaxis (PEP) Completion by Sex, FY21



The comprehensive package of services offered in PEPFAR supported sites includes provision of clinical services, such as counselling, rapid HIV testing with referral to care and treatment as appropriate, PEP for HIV (if sexual assault survivors are reached within 72 hours), STI screening/testing and treatment, counseling and referral for emergency contraception, and social and legal support services.

Outstanding gaps in GBV

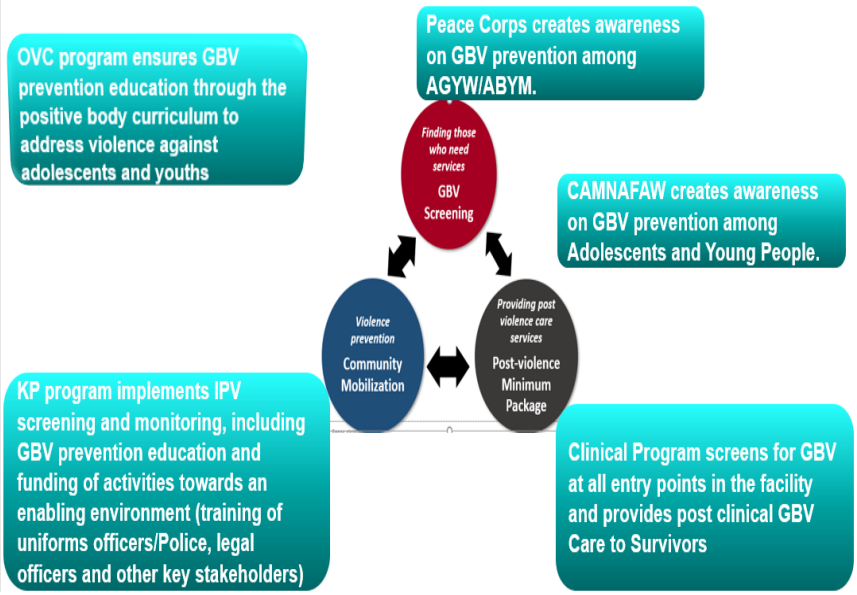
Absence of coordination and linkage between the prevention and post GBV Clinical programs. Scale up of the Post Clinical GBV clinical program remained nascent in the new PEPFAR

supported Regions due to limited resources. Non-availability of commodities and GBV Kits to offer the most comprehensive package of post GBV Clinical services.

Strategies to Improve Uptake of GBV Prevention and Post GBV clinical care within the PEPFAR Cameroon Program

In COP22, PEPFAR Cameroon plans to offer a comprehensive GBV prevention package to all young people including gender and sexual minority populations and Post GBV Clinical services to all GBV survivors in all PEPFAR supported sites with linkages between the GBV community and clinical programs.

Figure 4.3.6: Cameroon GBV Programs Consist of Preventing GBV Occurrence and Providing Post GBV Clinical Care to Survivors

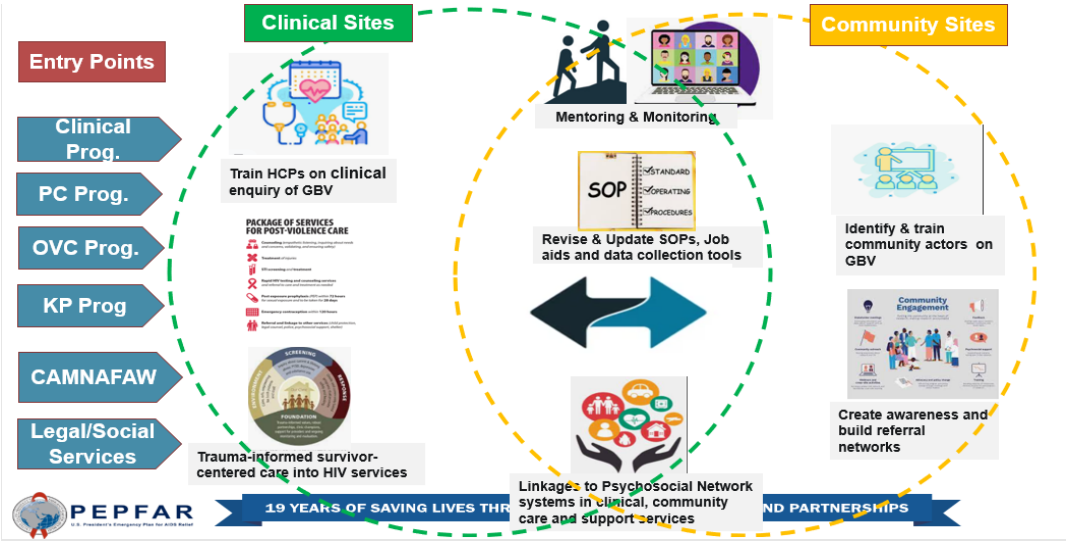


PEPFAR Cameroon plans to implement this model in collaboration with Directorate of Family Health at the Ministry of Health (DSFMOH), UNICEF, UNFPA, CAMNAFAW and Other CBOs supporting the minority populations to scale up GBV Prevention and Post GBV Clinical Services across PEPFAR Supported Health Districts in the 10 Regions. The community partners will identify and train community actors on GBV prevention and create awareness among young people and sexual minority populations while building referral networks with the Post GBV Clinical Program and other GBV support networks. All prevention programs within the PEPFAR program and other community programs including the legal /social services will serve as entry points to the Post GBV Clinical Program.

PEPFAR Cameroon will build capacity through training and mentorship of clinical partners and health care providers to enhance post clinical GBV service delivery uptake. The clinical IPs will work with the sites to build Post GBV Clinical care around a One-Stop shop Comprehensive Model and strengthen the continuum of response between GBV prevention and clinical post-violence response services and ensure its integration into the HIV cascade at key entry points, including HIV prevention interventions, HIV testing services (particularly index testing, and partner notification), HIV care and treatment, PMTCT, ANC, OVC services, and recency testing. PEPFAR Cameroon will ensure GBV case identification be conducted in alignment with PEPFAR guidance

in PrEP, index testing, and care and treatment service delivery, as well as within standard OVC case management. A comprehensive clinical response package which comprises of the clinical, legal, psychosocial, police services while ensure linkages to Psychosocial Network systems as needed including active referrals to other clinical and community care and support services will be offered to survivors. PEPFAR Cameroon will also ensure that all individuals conducting GBV case identification have been trained in providing first-line support (LIVES). Clinical IPs in collaboration with MOH and UNFPA to ensure availability of Post-GBV Clinical kits that will be offered to survivors. Trained expert advocates and case managers will be supported to organize and implement post-GBV clinical services in the facilities. Job aids, SOPs, registers, referral forms and other M&E tools will be produced and used at various entry points to ensure documentation and reporting following MER and other process indicators.

Figure 4.3.7: Post-GBV Clinical Care Package of Services for Survivors



4.3.4. PMTCT/Pediatrics

Over the years, the GRC and stakeholders have made significant efforts to ensure continued access to prenatal and postnatal care for PBFW, their partners, and their babies, toward the objective of an “AIDS-Free Generation by 2030”. The coverage and the quality of care offered to PBFW for PMTCT have advanced, with 73% of expected HIV+ pregnant women identified, 85% of those identified on ART, and Option B+ extended to nearly 83% of health facilities. The PEPFAR team will work to improve these results to expand Option B+ to additional health facilities.

Nevertheless, other data highlight the continuing need to improve on PMTCT coverage. Cameroon is one of the 22 priority countries worldwide in terms of unmet needs for the Prevention of Mother-to-Child Transmission of HIV (PMTCT) (UNAIDS, 2011). National HIV prevalence among pregnant women was 5.75%, according to the sentinel sero-surveillance survey conducted in 2016, with regional prevalence rising as high as 9.7% in East Region and 9.5% in Center Region. The NACC 2019 PMTCT Progress Report No.13 reports ANC coverage of 73.3%. During that same period, seropositivity among PBFW was 3.3%, with 84.5% of HIV-positive PBFW on

ARVs. Only 3.8% of the partners of PBVW were tested for HIV. Nevirapine was offered to 87.2% of children born to HIV-positive mothers, while 98.5% of HEI had a PCR done by 12 months, resulting in a positivity rate of 4.8%. 46.1% of children identified as HIV-positive were linked to treatment. Gaps and shortcomings persist, with some key challenges being the coordination and decentralization of interventions in all health facilities, task shifting to community actors, retention of the mother-baby pair in the continuum of care, early infant diagnosis, and linkage of positive children to care.

Recently, the MOH in collaboration with national experts, CSOs, and Technical and Financial Partners, developed the 2021-2023 Operational Plan for the elimination of Mother-to-Child Transmission of HIV (e-MTCT), in alignment with the overall strategic vision of an "AIDS-Free Generation by 2030". MOH is calling on the commitment of all national actors involved in the HIV response to take ownership and appropriation of this operational plan as an indispensable tool to accelerate e-MTCT to achieve the "3 FREEs": "Start Free, Stay Free, AIDS Free".

PEPFAR Cameroon aligns its PMTCT programming with this e-MTCT plan. In FY21, PEPFAR Cameroon scaled up its robust clinical program to cover 318 sites in the 10 Regions of Cameroon to implement optimized PMTCT strategies, leading to an improvement in the overall uptake of PMTCT service from 84% in FY19 to 90.7 % in FY20 and 98.1% in FY21. Some of the strategies that led to this achievement included the decentralization of PMTCT services through task shifting, the use of optimized ARVs including the implementation of an outreach catch-up strategy to reach pregnant women with PMTCT services in underserved and hard-to-reach populations. In addition, the implementation of the mother mentors strategy and the scale-up of cohort monitoring for PBFW on ART to cover the 10 Regions improved continuity of treatment and reduced MTCT of HIV. Index testing was also scaled up for partners and biological children of HIV-positive PBFW. Following the implementation of the new viral load testing algorithm for pregnant and breastfeeding women in the new national HIV management guidelines approved in FY19, viral load coverage and suppression rates for pregnant women also improved. The PEPFAR program will continue to support the GRC decision memo to decentralize ART to all PMTCT, HTS, and TB stand-alone sites for a more accessible and widespread approach and to achieve e-MTCT of HIV by 2023.

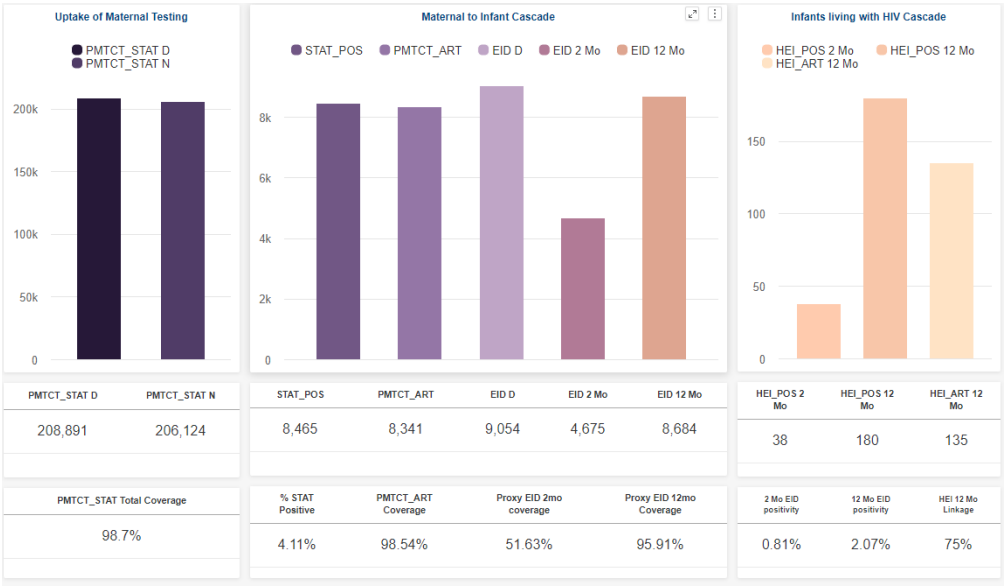
Results and achievements

In FY21, PEPFAR Cameroon received and offered HIV testing to 206,124 pregnant women at ANC1, out of a target of 208,891 (98.7% achievement). 8,465 women out of those tested were diagnosed HIV-positive, representing an achievement rate of only 27.5% of the annual target of 30,665. Of the 8,465 diagnosed as HIV-positive (known and new), 8,341 (98.5%) received ART, 74% (6,151) of whom were known positives and already on ART while 26% (2,176) were pregnant women newly identified as positives and newly linked to ART treatment. Pregnant and breastfeeding adolescent girls and young women (PBF AGYW) 10-24 years of age constituted 41.3% of the total number of pregnant women tested, and 20% of the total number of pregnant women receiving ART. Overall, a steady increase took place in the proportion of pregnant women received at PEPFAR-supported facilities who knew their status, from 78% in FY20 Q1 to 98.1% in FY21 Q4, as a result of improvement in the quality of PMTCT services offered to pregnant

women. The number of PBFW who were identified positive and linked to antiretroviral treatment also increased from 93.88% in FY20 to 98.54% in FY21. Viral load coverage for pregnant women increased from 7% in FY20 to 45% in FY21 Q4 and an increase in viral load suppression rate for both pregnant and breastfeeding women from 76% in FY20 Q1 to 90% in FY21 Q4.

PEPFAR Cameroon regularly analyzes the clinical cascade for pregnant women to inform program improvement strategies. Additionally, IPs continue to work with facilities to identify and address key barriers to PMTCT uptake such as decentralizing PMTCT services to informal health facilities that are providing limited HIV services to PBFW with no documentation or reporting.

Figure 4.3.8: PMTCT – HEI Cascade



Outstanding gaps

Despite progress made in the achievement of PMTCT indicators, gaps persist which delay e-MTCT. There is an approved national but no integrated e-MTCT implementation plan. HIV testing of pregnant women has not been optimized, for several reasons. First, ANC coverage remains limited, as about 16% of health facilities still do not offer PMTCT services and community interventions are not widespread. Secondly, national PMTCT data shows that 16% of pregnant women who attend ANC do not know their status because they are not tested for HIV. Third, when stockouts of HIV Rapid Test Kits occur, HTS for pregnant women is often deprioritized.

Furthermore, 15.5% of HIV+ women identified with known status at ANC and 26.6% identified at delivery room are not on ART. PMTCT coverage has been declining for pregnant women at ANC1, from 84% in FY19 to 82.6% in FY20 and down to 80.4% in FY21 at national level, demonstrating that substantial efforts still must be made to reach the 90% target for ANC1 coverage in the PEPFAR-supported sites. PEPFAR will focus especially on PBFW in underserved and hard to reach communities, such as IDPs in the conflict-affected Regions and AGYW, while also prioritizing the Regions that have the lowest coverage rates. Weak linkage of newly diagnosed pregnant women to treatment is particularly accentuated in rural areas; PEPFAR will be

prioritizing these efforts in Adamawa, East, and Far North Regions. Even though the transition to TLD for women of childbearing age living with HIV is gradually progressing, many providers are still not adhering to the transition. Implementation of Differentiated Service Delivery Models for PBFW has been limited; for instance, community ARV dispensation is not offered to this population. Additionally, stock outs of HIV test kits remain a challenge, which contributes to challenges with knowledge of status among PBFW, and VL coverage for PBFW is suboptimal (45%) with 90% suppression rate.

Post-natal services are often unable to track breastfeeding women for retesting, ART retention and EID testing for their babies. Cohort monitoring results, in concordance with findings during the NACC midterm review of the National Strategic Plan for the fight against HIV in 2019, showed that 25% of women who begin ART either before or during pregnancy stopped their treatment at one point, and approximately 20% started ART in the third trimester of pregnancy. Other areas of improvement include disclosure to partners, test kit and pediatric ARV availability, screening for syphilis (57% in 2016), Duo test usage, and VL coverage – although there is a 90% VL suppression rate among PBFW.

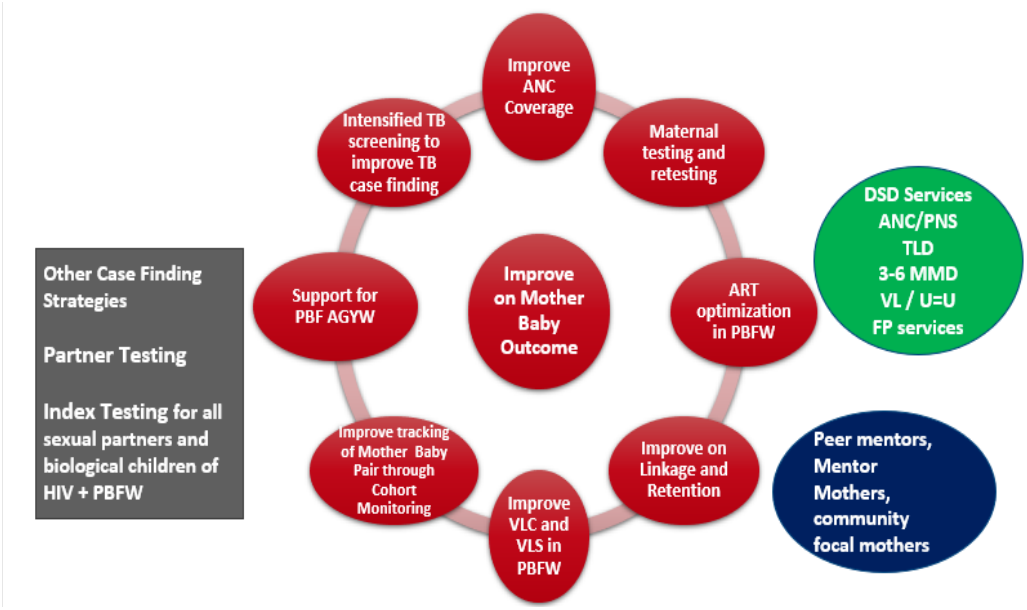
Strategies to improve PMTCT Uptake

PEPFAR Cameroon will support the implementation of the current national e-MTCT plan which has as objective to reduce morbidity and mortality in relation to HIV for PBFW and ensure the elimination of mother to child transmission of HIV.

Outputs will focus on ensuring that at least 95% of expected pregnant/breastfeeding women receive high-quality antenatal and post-natal care package of services, know their HIV and syphilis status together with their expected partners and receive effective treatment for HIV and/or syphilis (ARVs and/or ATBs). We expect at least 95% of HIV-positive pregnant/lactating women on ART to have suppressed viral loads through thorough monitoring of the HIV+ mother-exposed child pair until the end of the exposure period (24 months). The PEPFAR program plans to achieve these by ensuring appropriate program management: planning, coordination, monitoring and evaluation, supervision, training, and operations research.

To increase ANC coverage in COP22, PEPFAR Cameroon will Strengthen the provision and use of antenatal and postnatal care services among pregnant and breastfeeding women and their partners by improving their knowledge, attitudes and practices on ANC and PNC. The program has to ensure continuous capacity-building of health care providers, community health care workers, traditional birth attendants and community leaders on ANC and PNC and improve linkage and referral of pregnant women to health facilities for HIV/TB services while improving access to ANC and PNC. PEPFAR Cameroon will expand implementation of integrated Facility led community outreach interventions through the catch-up strategy by community health workers (CHWs) to find pregnant women in underserved and hard-to-reach populations who have difficulties accessing health care, with active linkage to health facilities using the dialogue structures in all PEPFAR supported sites in the 10 Regions. Clinical IPs will continue to work with regional and district health services to map out areas with low ANC uptake and provide targeted community outreach services.

Figure 4.3.9 COP22 PMTCT Strategies

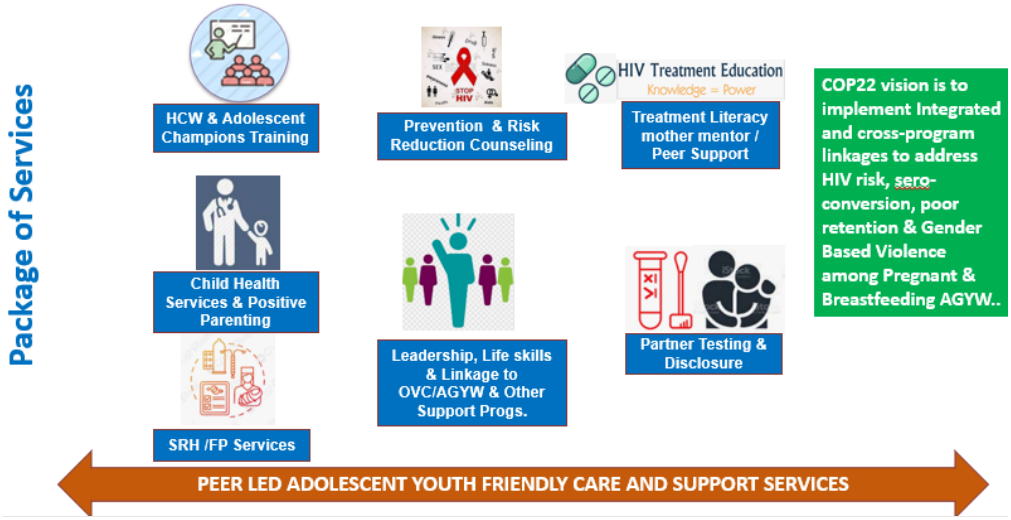


PEPFAR Cameroon will support health facilities to offer routine HTS and syphilis testing and counselling will be offered to all PBFW and their partners at ANC and PNC services. The Clinical IPs will improve the knowledge and practices of PBFW and their partners on HIV and Syphilis testing and build the capacity of health facility and community actors for PITC of PBFW and their partners at the health facility and in the community. The program will support the rollout of the Dual HIV/syphilis testing to enhance the dual elimination of HIV/Syphilis. All pregnant women who initially tested negative at first ANC visit will be retested and those who test positive will be retested by a second tester for verification within the context of the test and start strategy according to national guidelines. Maternal retesting in late pregnancy with option to test 14 weeks and retest at six or nine months and at post-partum at various service delivery areas, ANC, FP, EPI, MCH will be reinforced. Partner notification and index testing for all sexual partners and biological children of HIV-positive PBFW will be scaled up.

Pregnant and breastfeeding AGYW living with HIV are a vulnerable group, as they are less likely to; know their HIV status before pregnancy, to be on ARVs when tested positive, to engage in ANC and PNC with poorer adherence to ART, have increased risk of MTCT of HIV, maternal mortality, and stillbirth and experience high levels of stigma and Gender Based Violence. “Age-appropriate risk and vulnerability screening interventions to address disparities” for Pregnant and breastfeeding (PBF) AGYW will be implemented and scaled up in all PEPFAR supported sites. Services offered for this target population will include active screening of young mothers for risk-factors and seroconversion at multiple care points (i.e., infant immunization visits, FP visits), adolescent-friendly PMTCT services that will include peer-led activities, flexible ANC schedules and trained health care providers. POCs and Adolescent champions will be identified among PBF AGYW at ANC and will have their capacities strengthened to provide adolescent and youth friendly services. Other services will include prevention and risk reduction counselling, treatment literacy through mother mentors and peer support, partner testing and disclosure, child well health services and positive parenting, SRH services including FP, capacity-building on leadership, life skills while ensuring referrals and linkages to other OVC/AGYW and other support services.

Services for Prevention and detection of incident infections in PBFW through provision of HTS and PrEP to vulnerable populations will be made available. Rollout on HIV prevention services, including PrEP, with a focus on reaching AGYW, in high HIV prevalence settings

Figure 4.3.10 PMTCT Services for Pregnant and Breastfeeding Women



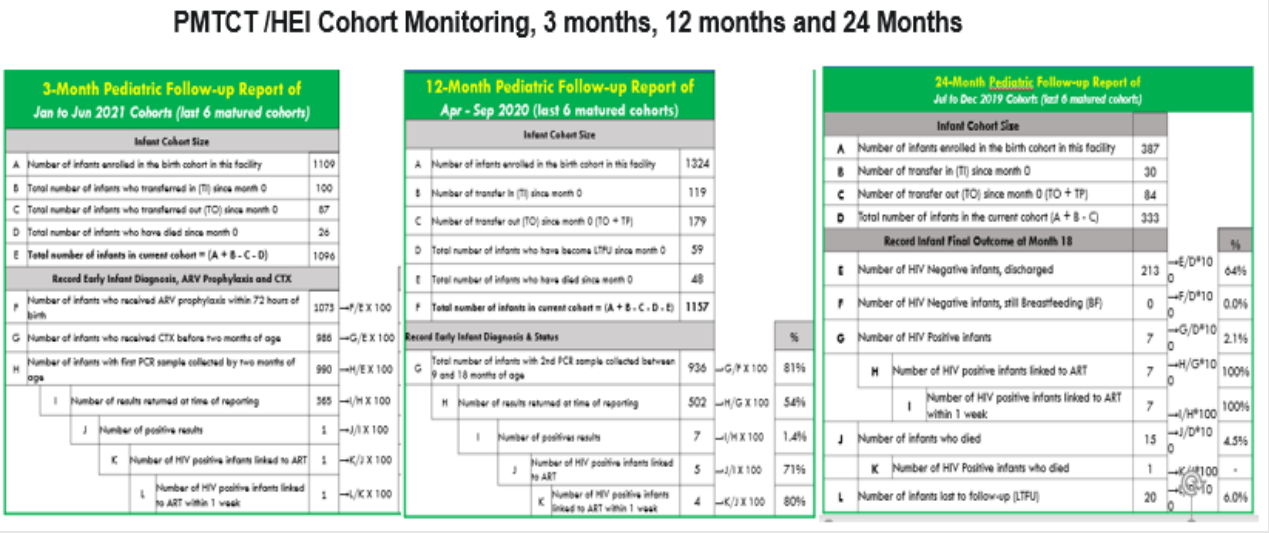
PEPFAR Cameroon will institutionalize comprehensive family HIV prevention, care and treatment programming by supporting decentralization of ART to PMTCT stand-alone sites and intensifying same day ART initiation for PBFW who test positive. Optimized ARVs and/or antibiotic (ATB) treatment for PBFW and their partners infected with HIV+ and/or syphilis will be provided while strengthening treatment literacy for PBFW and their partners on HIV/AIDS/syphilis treatment. The program will also strengthen the capacity of health care providers on ARV and ATB management of PBFW and their HIV+/syphilis+ partners and ensure linkage to quality care. PEPFAR Cameroon will continue to promote TLD Transitioning as the preferred 1st line regimen for all PLHIV ≥ 30 kg, including AGYW and all women in replacement of Efavirenz based regimen and ensure the complete removal of Nevirapine based regimens except in case of intolerance to dolutegravir, TLE (300/300/400 mg) may be offered as an alternative.

PEPFAR Cameroon will continue to advocate for the complete elimination of user fee for ANC 1 for all PBFW while supporting GRC to ensure effective implementation of the decision to eliminate user fees for HIV+ PBFW at ANC. PEPFAR Cameroon will continue to implement the catch-up strategy in priority districts with low coverage in the 10 Regions to find pregnant women in the community and link them to the facility. CHWs will empower women through home visits and community-based action groups to improve their awareness of ANC services and facilitate trust in health care workers. Mobile health technologies, SMS reminders and encouraging messages through social and print media will be used to increase community mobilization for ANC services. The mother-mentor program will be expanded to all PEPFAR-supported sites. Community-facility linkage through CHWs will be expanded across the 10 Regions.

Partner notification will be scaled up routinely in ANC when partner is eligible for testing. HIVST for mothers or male partners of ANC clients in combination with other strategies such as SMS, community follow-up, incentives to return the results for linkage to care will be scaled up in all

PEPFAR supported sites. Index case testing will be scaled up for all sexual partners and biological children of HIV-positive PBFW. Site level performance data across the clinical cascade for PMTCT will be monitored and used for performance improvement.

Figure 4.3.11: Monitoring Treatment Continuity in PMTCT: Longitudinal Cohort Monitoring and PMTCT_FO



PEPFAR Cameroon will engage regional delegations of health and district health services to support ANC and PMTCT interventions and reporting in informal health facilities to ensure provision of quality ANC and PMTCT interventions in line with national guidelines, access to PMTCT commodities, linkage of HIV-positive PBFW to established health facilities for continuum of care as needed, and documentation and reporting on PMTCT interventions. PEPFAR will work with IPs to ensure a continuum of care to IDPs by using multidisciplinary teams, case managers and CBOs to reach out to PBFW and their partners with HIV services.

In COP22, PEPFAR Cameroon will organize its third National Forum on the Prevention of Mother to Child HIV Transmission, Pediatric and Adolescent Care with a Call to all Stakeholders for Action. The forum will assess progress made after implementation of these strategies to address the gaps identified in the PLL which highlighted the fact that Pediatric outcomes lag behind adults in nearly all areas of the cascade: Case Finding, Treatment VLC/S; 2-month EID coverage was unacceptably low and must improve and the transition to DTG-10 still which is currently being implemented as a Pilot must be dramatically accelerated. The clinical program will also leverage the OVC program to identify PBFW and HEIs who fell off treatment continuity and link them back into care for HIV services.

Results and achievements in CALHIV

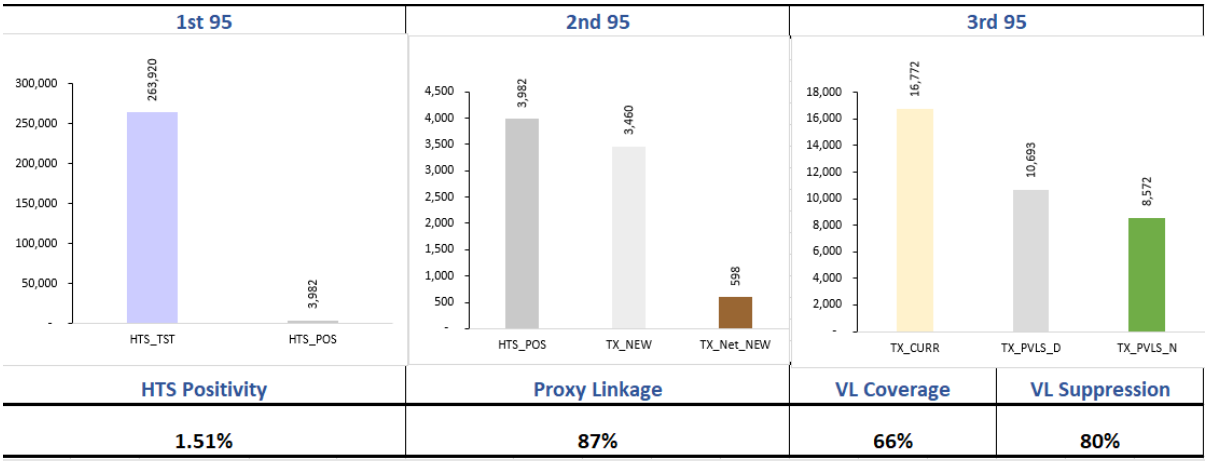
In 2019, Cameroon registered 14,970 HEI born to HIV-positive pregnant mothers who underwent PCR testing, among whom 724 tested positive, giving a positivity rate of 4.8%.

In FY21, PEPFAR Cameroon provided PMTCT EID to 8,684 HEI through PCR testing at twelve months, representing 95.9% of all children born to HIV positive pregnant women who delivered during the reporting period at PEPFAR supported sites (8,684/9,054) and 29.4% of the annual

coverage (8,684/29,509), with a positivity rate of 0.81% at 2 months and 2.07% at 2-12 months. Among all HIV Exposed Infants born to HIV positive mothers on ART 4,675 were tested at <2Months accounting for 18.8% of the planned number of children to be tested by two months and HIV Exposed infants 2-12 months accounted for 85.9%. Proxy EID coverage at 2 months was 52% and 95.9% at 2-12 months. In FY21, 21.9% of HEI (6,673) had an unknow Final Outcomes (FO). PEPFAR will continue to advocate for an expansion of the Point-Of-Care EID as strategy to reduce the turnaround time for the HEI as well as fast tracking the decision-making process of initiating infected children on ART.

Still in FY21, 180 children were identified as positive (38 HEIs at 2 months and 145 at 2-12 months) with 75% (135/180) of HIV-positive infants <1-year-old enrolled on ART, up from 72% in FY20.

Figure 4.3.12 FY21 Cascade for Children 0-14 years and Adolescents 15-19 years of age



At the end of FY21, PEPFAR Cameroon provided HTS to 263,920 children and adolescents and achieved 152% of the annual PEPFAR target of 173,503 and identified 4,008 CALHIV representing 44.4% of PEPFAR annual target of 9,037 with an overall positivity rate of 1.51%. Among all tested were children 120,324 achieving 110.8% of the annual PEPFAR target planned for children (108,618) and identified 1,900 children representing 36.2% of the annual PEPFAR target of 5,169 with a positivity rate of 1.51%. Adolescents tested were 146,766 achieving 226.2% of the annual PEPFAR target of 64,285 with a positivity of 1.47%.

From among the 4,008 CALHIV identified, 3,460 were initiated on ART accounting for 87% of our overall linkage rate and 35.3% of overall newly enrolled on ART compared to the annual target of 10,165 for FY21. The linkage rate for children <15 years of age was 97% (1850/1900) with an achievement of 31% for children newly initiated on ART compared to the annual FY21 target of 6,007 and for adolescents 15-19 years of age, the linkage rate was 83% (1743/2108) with an achievement of 42% of children newly initiated on ART compared to the annual FY21 target of 4,158.

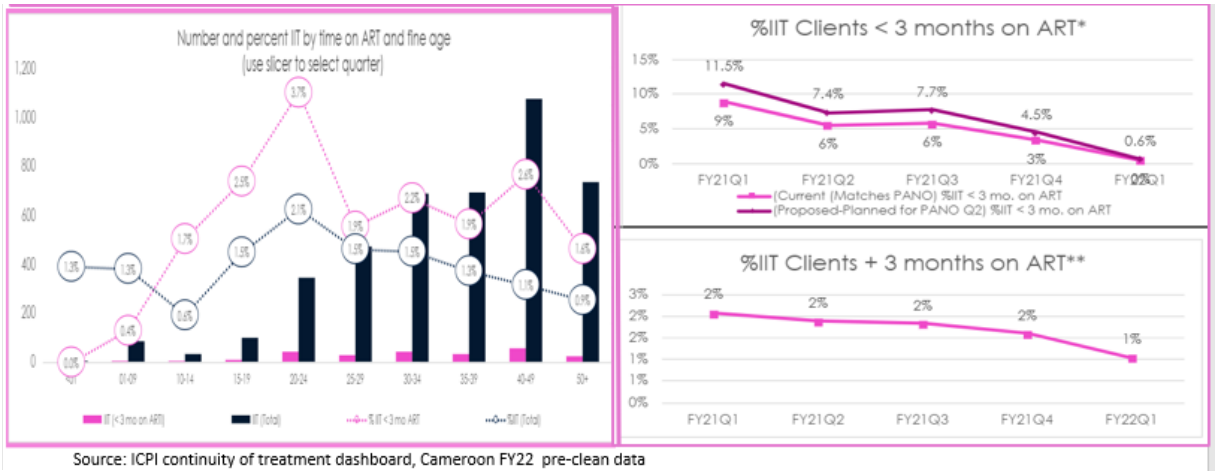
ART was provided to 16,772 CALHIV out of the 33,436-target planned for FY21 achieving 50% of the annual target, among whom 64% were children aged <15 (10,903) and 36% adolescents 15-19 (5,965). The CLHIV on ART accounted for 50.7% of PEPFAR FY21 pediatric target

(21,521), a decrease from 64% in FY20 with a TX_NEW of 44.7% (1,850/6,007). For ALHIV on ART we had an annual achievement of 50.1% of PEPFAR FY21 adolescent target (11,915) with a TX_NEW of 41% (1,743/4,158)

In FY21, PEPFAR Cameroon made progress in retaining children and adolescents in care, moving from 80% in FY20 to 84% in FY21 for children aged <15, and 85% for adolescents. Efforts are being made to improve on retention for adolescents in care in COP22. We also saw an increase in MMD for CALHIV of up to 38% in FY21Q1 when we began to see a decline to about 26% in FY21Q4 due to limited stocks of pediatric and adolescent commodities.

Looking at Continuity of Treatment – Net New Waterfall Analysis for children <15 years of age shows negative Net New of -39 with unattributed loss accounting for the largest proportion of TX_ML followed by TO due to decentralization of ART C&T and by IIT and Died. Transfer out was higher among the 1-4 and 20 – 24 age categories with the Highest Percentage deaths reported for the <5-year-old. Overall deaths were >20% for children <15 with more deaths reported among adolescent boys (13%) than for girls (8%). Older adolescents 15-19 year old and youths had the highest % Treatment interruption (IIT Total) (left graph) with a downward Trend in %IIT among children <15y/o (right graph).

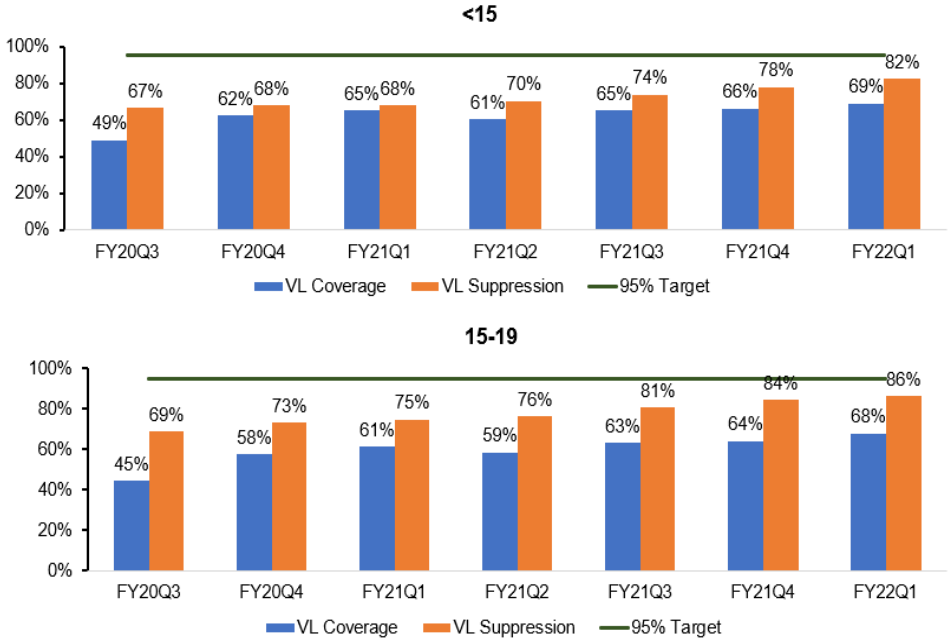
Figure 4.3.12: FY212Q1: %IIT for Peds and Adolescents on ART



Source: ICPI continuity of treatment dashboard, Cameroon FY22 pre-clean data

The overall viral load coverage among all children aged <15 and adolescents on treatment was 66% up from 57% in FY20 which is an improvement of 11 percent above FY20. This VL coverage is slightly higher for children 66%, than for the adolescents 64%. Among all CALHIV with a recorded viral load test result, 80% were virally suppressed (4,439/6,527) showing an increase of 10 percentage-points from FY20`s suppression rate of 70%. CLHIV aged <15 years showed a slightly lower viral load suppression rate of 78% of compared to 84% for adolescents aged 15-19 on treatment. Even though we are not yet where we want to be, overall, we see improving VLC and VLS rates for children and Adolescents across the quarters with Optimized pART, MMD improving DSD service delivery and support from the OVC program

Figure 4.3.13: OU FY22 Q1 Overall VL Coverage and suppression for Age

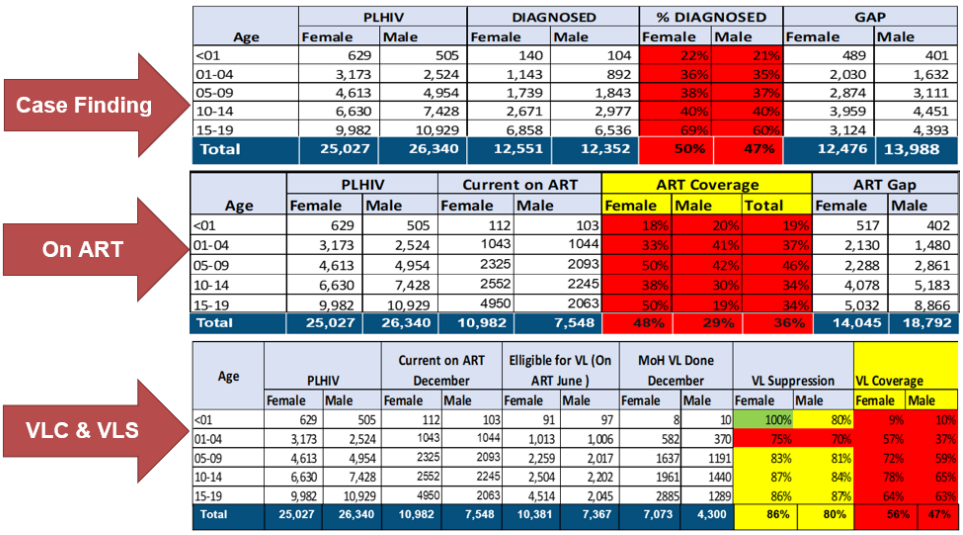


In FY21, 61% of children aged <15 (602/991) with TB infection knew their HIV status, up from only 46.4% (619/1,333) with TB/HIV coinfection reported among 133 children with 94% (125/133) linked to ART up from 85% (166/195) in FY20. Among adolescents 63% (589/936) with TB infection knew their HIV status up from 18.5% (587/3,178) reported in FY20 with 71 adolescents reported with coinfection of whom 96% (68/71) were linked to ART show great progress in FY21 up from 20% (103/516) in FY20. In FY21, we also observe good TB screening rates of above 97.4% among HIV+ children aged <15 years, (9794/10,051) with a positive TB screening rate of 2.6% (44/257), compared to 1.7% in the 15-year age group in FY20, however, the TB screened positive rate remains suboptimal compared to the expected 5%. In FY21, INH uptake for children <15 years was 21% even though still low it is up from 4% (451/11,120) reported in FY 20 with a TPT completion rate of 66.9% (1,362/2,035) up from 49% (221/451) completion rate in FY20

Outstanding gaps

Treatment and Care for children and adolescents remains the weakest domain in the HIV response despite innovative strategies adopted nationwide (free ARVs in 2005 and early infant diagnosis in 2007, user fee elimination etc.) Despite a ministerial circular of 2018 to decentralize pediatric care, implementation has been very slow with only 21% of sites offering quality services to children and only 28% of PMTCT sites offering DBS sample collection. In 2020, approximately 116 sites had at least 1 child and/or adolescent on treatment.

Figure 4.3.14: FY212Q1: Who Are We Missing by Sex and by Age?



Age	PLHIV		DIAGNOSED		% DIAGNOSED		GAP	
	Female	Male	Female	Male	Female	Male	Female	Male
<01	629	505	140	104	22%	21%	489	401
01-04	3,173	2,524	1,143	892	36%	35%	2,030	1,632
05-09	4,613	4,954	1,739	1,843	38%	37%	2,874	3,111
10-14	6,630	7,428	2,671	2,977	40%	40%	3,959	4,451
15-19	9,982	10,929	6,858	6,536	69%	60%	3,124	4,393
Total	**25,027**	**26,340**	**12,551**	**12,352**	**50%**	**47%**	**12,476**	**13,988**

Age	PLHIV		Current on ART		ART Coverage			ART Gap	
	Female	Male	Female	Male	Female	Male	Total	Female	Male
<01	629	505	112	103	18%	20%	19%	517	402
01-04	3,173	2,524	1043	1044	33%	41%	37%	2,130	1,480
05-09	4,613	4,954	2325	2093	50%	42%	46%	2,288	2,861
10-14	6,630	7,428	2552	2245	38%	30%	34%	4,078	5,183
15-19	9,982	10,929	4950	2063	50%	19%	34%	5,032	8,866
Total	**25,027**	**26,340**	**10,982**	**7,548**	**48%**	**29%**	**36%**	**14,045**	**18,792**

Age	PLHIV		Current on ART December		Elligible for VL (On ART June)		MoH VL Done December		VL Suppression		VL Coverage	
	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male
<01	629	505	112	103	91	97	8	10	100%	80%	9%	10%
01-04	3,173	2,524	1043	1044	1,013	1,006	582	370	75%	70%	57%	37%
05-09	4,613	4,954	2325	2093	2,259	2,017	1637	1191	83%	81%	72%	59%
10-14	6,630	7,428	2552	2245	2,504	2,202	1961	1440	87%	84%	78%	65%
15-19	9,982	10,929	4950	2063	4,514	2,045	2885	1289	86%	87%	64%	63%
Total	**25,027**	**26,340**	**10,982**	**7,548**	**10,381**	**7,367**	**7,073**	**4,300**	**86%**	**80%**	**56%**	**47%**

Despite progress made since FY19 in pediatric and adolescent HIV prevention, treatment and care, we are still missing the children and adolescents at all levels of the clinical cascade. The program still observes a number of challenges along the entire pediatric and adolescent clinical cascade.

For the first 95, suboptimal case finding is reported for children and adolescents. With regards to Early infant diagnosis, there is weak identification and enrollment of HEIs in the mother-baby cohort for monitoring, low EID testing coverage of 52% at 2 months (FY21) due to low access to EID POC, poor distribution of EID POC platforms, stockout of EID sample collection and Test kits, inadequate sample transport systems to transport EID/VL samples to the reference laboratories, and frequent stock outs of EID commodities.

Persistent closure of key pediatric entry points with centralization of HTS due to limited stocks of RTKs since the onset of COVID19 is yet to be resolved. Limited targeted testing due to suboptimal use of the pediatric screening tool has resulted in the excessive testing of children with very low yields. Index case testing is not fully scaled in all PEPFAR supported sites.

Despite a decline in the number of children living with HIV since 2010, ARV coverage remains low at 37% among children 0-14 years, and 39.5% among Adolescents 15 19 years compared to 84.4% for adults 25 years and older. This situation is worsened by the inconsistent availability of optimized pediatric ART regimens, poor adjustment of pediatric ART dosage with weight and age according to guidelines due to the mothers coming for ARV pickups for the children rather than the pair, suboptimal linkage rates for adolescents 10-19 years of age both males and females (65%-87%) with low uptake of TPT at 21% and limited implementation of DSD Models, MMD, disclosure and inadequate transitioning of adolescents into adult care. Approximately 11% of HEIs identified at birth did not receive ARV prophylaxis (NVP) in FY21.

We observed increased death rates of up to 17.9 for children <5 years due to suboptimal identification and management of children with advanced HIV disease (AHD) in pediatric services.

Tuberculosis and malnutrition were the most common causes of death reported among children and adolescents. Only 50 out of 298 PEPFAR supported sites have the capacity to manage C/A with AHD with limitations in prevention, diagnosis, and case management. Regarding TB/HIV coinfection, less than 50% of children and adolescents with TB infection knew their HIV status and only 20% of adolescents with coinfection were linked to ART. There was a low positive TB screening rate of 2.3% compared to the expected 5%. There was also a low pediatric TPT uptake of 4% and a low completion rate of 49% for children. The diagnosis of pediatric TB is a real challenge for national programs, either because of lack of appropriate materials or insufficient skills among staff. Cameroon's National TB Control Program (NTCP) has not been immune to this challenge. In 2019, pediatric cases in the under-15 age group represented only 5.5 percent of all cases (with about 2 % in the 0-4 age group), whereas the norm is around 12-15%. Children, especially those aged <5 years, are an important vulnerable group, hence the importance of this intervention.

Since the pivot of the OVC program to strengthen support of the pediatric HIV care and treatment cascade, the PEPFAR implementing partners have been working jointly to strengthen the bidirectional referral, leading to the enrollment of 60% of the CALHIV under 20 years old into the OVC program at the end of FY2021. The joint efforts of the clinical and OVC partners has resulted in some improvements in the pediatric HIV cascade indicators such as the VL coverage and suppression rates. The latter indicator rose from 70% to 80% from FY20 to FY21. In FY 2023, the OVC program will continue to provide the comprehensive package of services to CALHIV enrolled in the program a until they meet all the graduation benchmarks.

Retention across the pediatric cascade among HIV-positive children and adolescents on ART continues to be a challenge for CALHIV. In FY21 we see overall improvement in the retention rates for children and adolescents 5-19 years of age ranging from 90% for females 1-4 years of age to over 100% for the 15 -19-year age bracket, up from 39% in FY20 but with a slight decrease among children <1 years old 78% for males and 85% for males up from 36% for males and 33% for females in FY20 and 86% for boys in the 1-4 years age brackets.

Despite efforts in improving on retention for children and adolescents we reported a Net New of only 598 in FY21, with unattributed Loss accounting for the largest proportion of TX_ML followed by transfer out (TO) due to decentralization of ART C&T and by treatment interruption for children and adolescents >3 months on ART and those who Died. Older adolescents (15–19-years old) and youths had the highest % Treatment interruption (IIT Total) with a downward Trend in % IIT among children <15y/o

Supply chain tension persisted as an outstanding gap in FY21. We saw a decline in MMD for CALHIV from 36% in FY21 Q1 down to 26% in FY21 Q4, limited stocks of optimized pediatric ARVs continues to be an issue leaving some CALHIV on suboptimal regimens with gaps in communication around pediatric commodities that needs to be absolutely addressed.

Though our VLC and VLS for CALHIV remained suboptimal in FY21 we saw an improvement in VLC for CALHIV of 66% up from 56% in FY20 with a 10 percentage-points improvement in the viral load suppression rate of 80% in FY21 up from 70% in FY20. Some of the gaps included nonsystematic request for VL tests by service providers, VL reagent stock outs, VL samples not

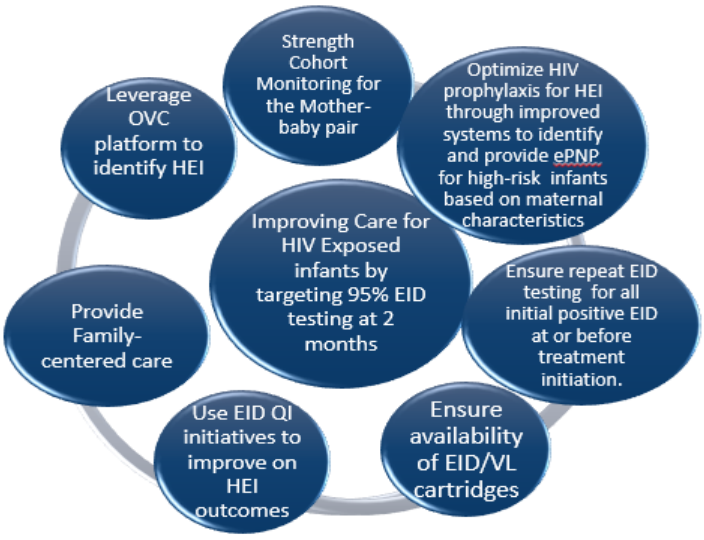
systematically collected, absence of an integrated national sample transport system, low retention rates across the pediatric cascade, parents versus the C/A attending clinics for ARV pickups rendering weight dosage adjustments impossible, inadequate EAC for pediatric and adolescent cascade. Additionally, we have suboptimal availability of optimized ARV formulations for children, socioeconomic factors that contribute to poor adherence and poor ART clinic attendance, resistance of some HCW to use VL management tools, and parent or caregiver reticence to disclose HIV status to children and adolescents.

Weak documentation of pediatric and adolescent ART transition efforts and poor communication of commodity issues between health facilities (HF) and the Regional Fund for Health Promotion (RFHP) also negatively impact VL outcomes for CALHIV.

Strategies to reach children and adolescents

In COP22, PEPFAR Cameroon will expand key strategies to improve pediatric and adolescent HIV prevention, care, and treatment to all 368 (347 clinical and 21 military) sites in the 10 Regions. PEPFAR Cameroon will support the decentralization of pediatric and adolescent HIV services to PMTCT standalone sites to improve on case finding and linkage of positive HIV children identified through PMTCT and the family centered care. PEPFAR Cameroon will expand its bi-directional referral strategy for CLHIV between clinical sites and the OVC program across the 10 Regions to continue enhancing uptake of HIV prevention care and treatment services and retention for children and adolescents in care. The clinical service providers will continue to receive OVC at health facilities and provide HIV prevention, treatment, and care services, while the OVC service providers will play a key role in ensuring community support for linkage to care, retention, and adherence among children and adolescents living with HIV and other wraparound services in core areas identified in individual case plans of HIV-positive children and adolescents.

Figure 4.3.15: Optimized Strategies for HIV Exposed Infants (HEI)



PEPFAR Cameroon will improve on care for HIV exposed infants by targeting 95% Early Infant Diagnosis at 2 months and strengthening the capacities of structures to provide care and

prophylactic services for HEIs. HIV prophylaxis for HEIs will be optimized through improved systems to identify and provide ARV prophylaxis for high-risk infants based on maternal characteristics.

PEPFAR Cameroon will continue to advocate and support the expansion of POC testing for EID as a strategy to reduce the turnaround time for test results as well as fast tracking the initiation of ART for HEI diagnosed with HIV. The program will also continue to ensure the creation of networks of HF around existing POC platforms to maximize use and enhance uptake of EID for HEI while ensuring the availability of EID test kits. Sample transport systems will be set up and/or strengthened to support EID and VL uptake and testing TAT through a hub and spoke model (e.g., use of bikers). Linkage and retention case managers assigned to postnatal services will capture all mothers on ART who deliver and will enroll the mother-baby pair in the cohort register for monitoring until 18 months postpartum, when the final HIV status of the HEI is known. Cohort monitoring for HEI will be expanded and strengthened for the mother-baby pair to enhance EID uptake for all HEI until final outcome is reported across all 10 Regions. Clinical IPs will work with health facilities to monitor EID uptake, track HEI and TAT. The IPs will also ensure a repeat EID testing for all initial positive EID at or before treatment initiation. PEPFAR Cameroon will work closely with the supply chain partner to ensure continuous availability of EID/VL cartridges for EID testing.

Community partners will be empowered to actively search for HEI in the community and link them to the facilities for EID services. PEPFAR Cameroon will leverage the OVC program to monitor HEI and ensure that they are referred to the health facilities for Early Infant Diagnosis until final HIV status is determined. The program will also facilitate access to testing sites (through payment of transportation costs as needed) and track HEI who have a positive PCR in the communities to fast-track and link them for treatment initiation. PEPFAR will support the linkage of EID services for HEI to a standard package of ANC and postpartum care for mothers and infants and will provide technical support to promote the use of EID Continuous Quality Improvement (CQI) initiatives to improve on HEI outcomes. Pediatric linkage and retention case managers will also ensure linkage of infants who test positive for HIV and provide comprehensive counseling and support to the mother or caregiver to ensure the infant stays in care. IPs will work with facilities to share best practices from high performing sites with low performing sites. Routine review of PMTCT status among HEI in EPI, maternity and outpatient departments will be ensured monitoring the child welfare card to identify the need for EID.

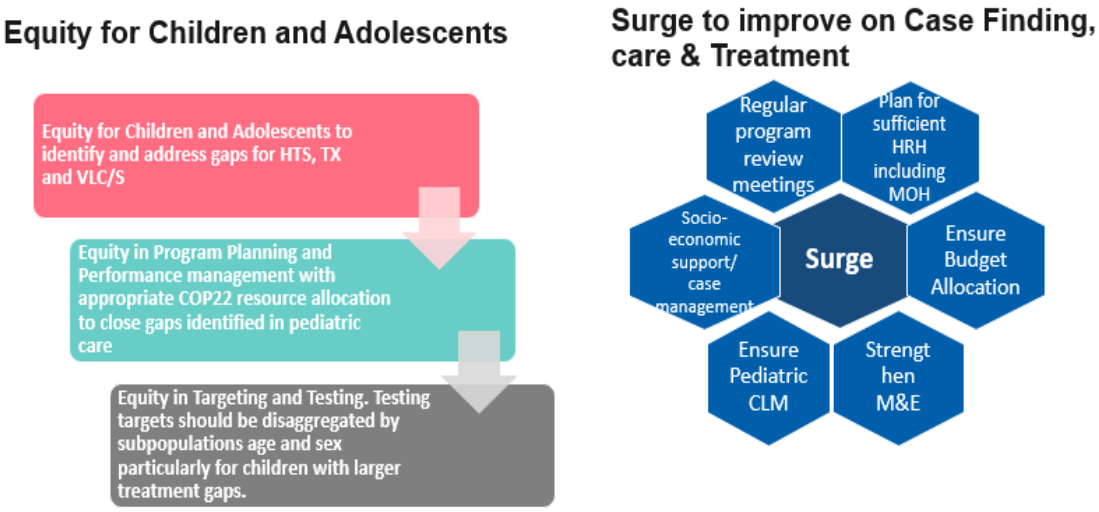
PEPFAR Cameroon COP22 Program will focus on all missed opportunities along the Care Continuum to improve on pediatric case finding through decentralization of pediatric and adolescent care, tracking of HEI without final outcome for EID, scale up index case testing, offer HTS services for hard-to-reach children in the communities and offer an optimal mix of testing approaches. The program will ensure an improvement in pediatric and adolescent care and treatment including viral load coverage and suppression.

COP22 Strategies to close the gaps will be focused on equity for children and adolescents to identify and address gaps for HTS, TX and VLC/S, equity in program planning and performance management with appropriate COP22 resource allocation to close gaps identified in pediatric care

and equity in targeting and testing. Testing targets will be disaggregated by subpopulations' age and sex particularly for children with larger treatment gaps.

A surge plan will be developed and implemented to address the gaps in pediatric and adolescent care including for the military facilities. PEPFAR Cameroon will plan for sufficient human resources, strengthen the M&E, ensure appropriate budget allocation, provide socio economic support to intensify case management,

Figure 4.3.16: Strategies to Optimize Pediatric and Adolescent HIV Testing Services

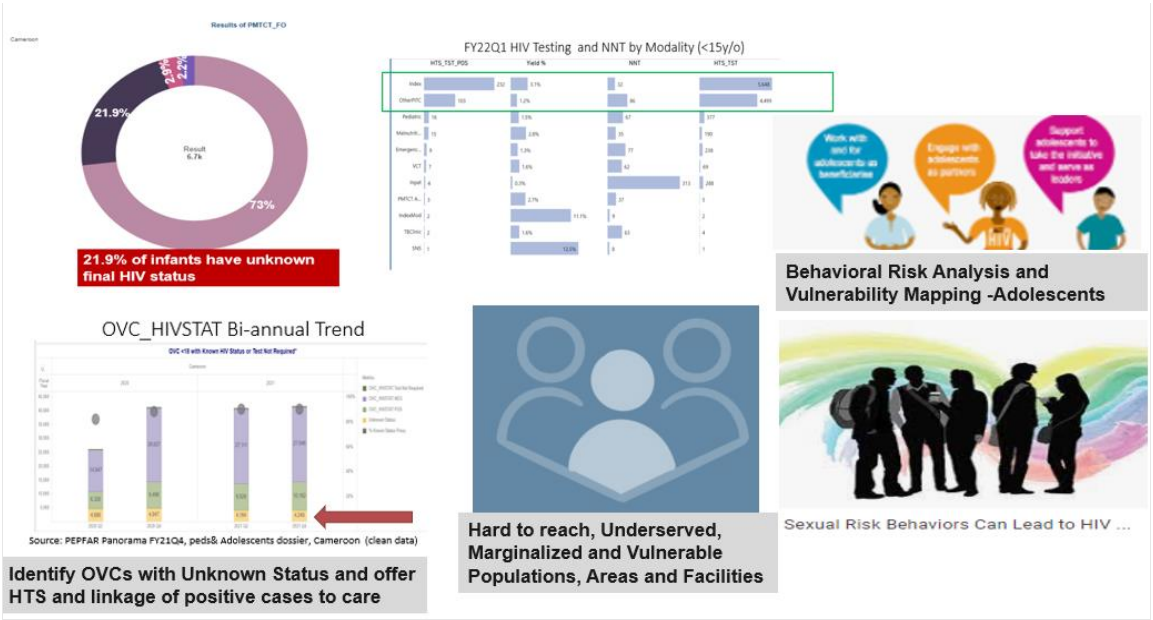


PEPFAR Cameroon plans to decentralize pediatric and adolescent care through the creation of pediatric training centers and a mentorship program to cover at least 50% of the sites up from the current 21% under the leadership of MOH/NACC. High Volume pediatric clinics will be identified following defined criteria and strengthened to offer high quality services to children and adolescents. PEPFAR Cameroon will conduct a baseline assessment for these sites to identified eventual gaps that will be addressed by the clinical IPs. Site Mentors will have their capacities strengthened to train and mentor spoke facilities to offer a minimum package of pediatric and adolescent services to CALHIV. A competency based harmonized training curricular developed by MOH in collaboration with its Partners will serve as the guidelines for the implementation of pediatric training centers of excellence. Additional tools, SOPs, job aids and registers will be developed to strengthen monitoring and evaluation of the project.

Figure 4.3.17: Decentralization of Pediatric and Adolescent HIV Management

PEPFAR Cameroon Plans to Scale-up Case Finding for children <15 years of age and adolescents. The Cameroon Pediatric Surge Program will exploit all missed opportunities such as identifying children whose final outcome is unknown, OVC with unknown status, underserved and vulnerable children including those in hard to reach communities and high risk/vulnerable adolescents who are the most likely to be positive and offer them with HIV Prevention, Care and Treatment Services, including offer of enrollment into the OVC program where possible.

Figure 4.3.18: Missed Opportunities to identify HIV+ Children <15 years of age



PEPFAR Cameroon will expand the pediatric package of services and support the GRC to complete the rollout of Test and Treat for pediatric and adolescents in the 10 Regions. Index case testing with the lowest Numbers needed to test (NNT) for childrem will be scaled up to ensure all

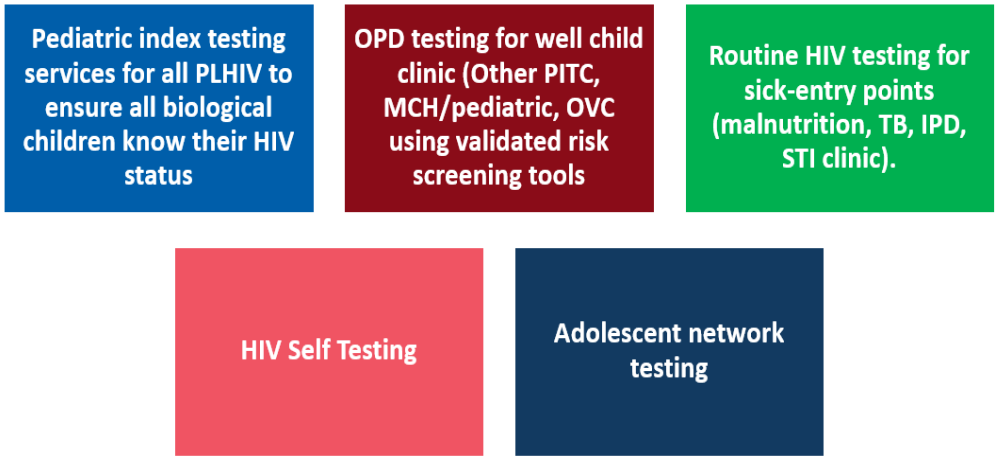
biological children and siblings of all PLHIV on ART know their HIV status. Index testing will be offered to biological children of newly tested HIV-positive women or to men who test positive, but the wife's status is unknown or died of an unknown cause, who are deemed to be at high risk for HIV. Through the bidirectional referral mechanism, the OVC program will support case workers of local partners under the guidance of the Care and Support Linkage Officers to conduct HIV risk assessment for household members (children and caregivers) of index cases with unknown status and refer them to health facilities for HIV testing.

Outpatient department testing for well children including PITC, MCH/pediatric, OVC, using validated risk screening tools will be strengthened to offer HTS to children and adolescents. PITC will be reestablished at all high yield pediatric and adolescent entry points in facilities with availability of rapid test kits. Targeted testing will be intensified using the screening tool to assess for risk and identify the most at-risk and vulnerable adolescents for testing at both facility and community levels.

Routine HIV testing will be offered for children and adolescents at sick-entry points. HIV testing will be offered to children with malnutrition, presumptive or confirmed TB, emergency patients, STI clinics and inpatients for those with unknown status at admission and are at high risk for HIV.

High risk and vulnerable adolescents will be offered HTS through their networks and or benefit from HIV Self Testing.

Figure 4.3.19: Strategic Mix of HIV Testing Services for Children and Adolescents



PEPFAR Cameroon will continue to strengthen Linkage and same day ART initiation for children and adolescents. Health care providers will be trained and mentored on pediatric HIV management including counseling and testing, pediatric ART optimization, therapeutic education, VL, treatment literacy, advanced HIV disease and enhanced adherence counseling and retention to provide quality HIV services to children and adolescents.

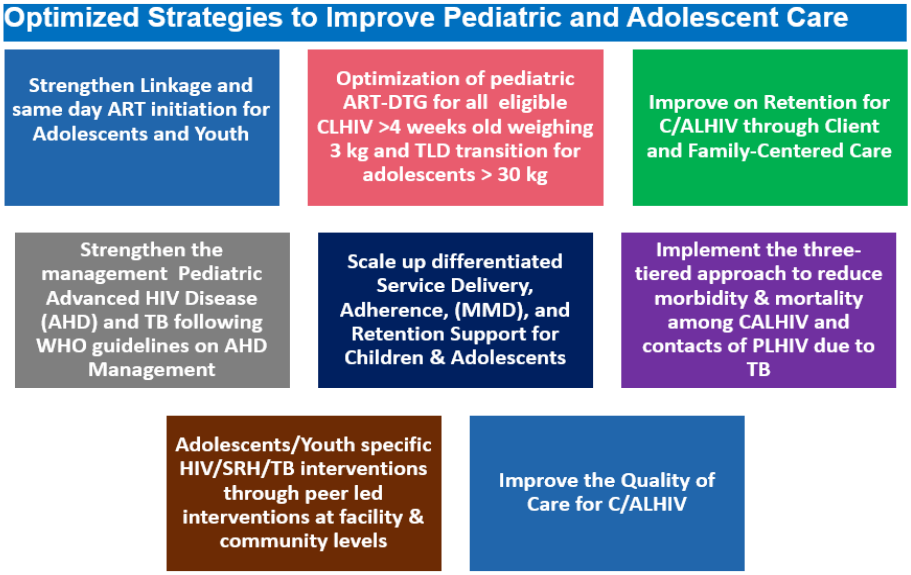
The program will continue to support health care providers to adhere to the national ART guidelines and ensure optimization regarding 1st, 2nd, and 3rd line ART and ensure Optimization of pediatric ART-DTG for all eligible CLHIV >4 weeks old weighing 3 kg and TLD transitioning for adolescents > 30 kg. PEPFAR will support GRC to pursue a progressive transitioning to pediatric

dolutegravir (pDTG or DTG10) for all children <20kg in COP22. The transition which began in August 2021(COP20), for all newly identified positive CLHIV in 20 selected sites (≥20 CALHIV in TX_CURR) for 6 months will take a phased approach while ensuring depletion of Lopinavir/Ritonavir. The second phase will take place from January to December 2022 for sites with 10-19 CALHIV in TX_CURR. The third phase will start in January 2023 for remaining sites (<10 CALHIV in TX_CURR). Nonetheless, the transition can be accelerate depending on the availability of pDTG in the country.

In COP22 PEPFAR programs will continue to line list all children currently on inappropriate regimens and switch them to optimized pediatric ART regimens. PEPFAR will continue supporting IPs to ensure the availability of updated dosing charts at sites, the appropriate prescription of optimized pediatric ARVs, removal of all NVP- EFV-based ART regimens, and ensure availability and timely request of pediatric DTG drugs. Appropriate weight and height scales will be provided to ensure weight appropriate ART prescriptions according to needs.

PEPFAR Cameroon will improve on retention of CALHIV through client and family-centered care such as use of pediatric linkage case management experts and adolescent champions to accompany children and adolescents who test positive at facility and community levels for ART initiation.

Figure 4.3.20: Strategies to Improve on Pediatric and Adolescent Care

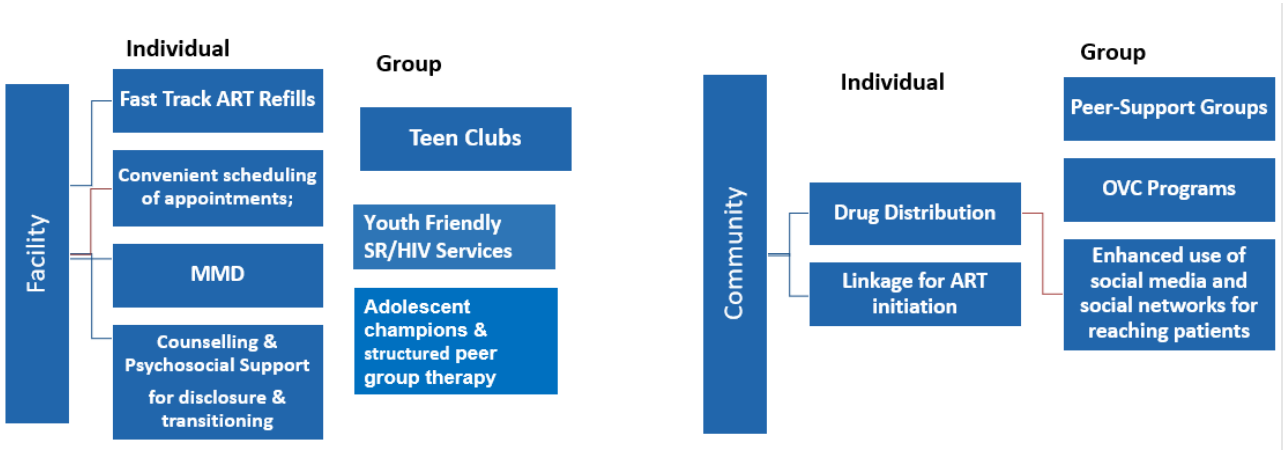


Pediatric-specific WHO AHD STOP AIDS packages of intervention will be incorporated into pediatric and adolescent HIV programs to strengthen management of pediatric advanced HIV disease. The AHD package for CALHIV includes thorough screening and treatment for TB, cryptococcus and malnutrition, ensure early treatment within seven days using Optimized rapid ART initiation and for children who screen negative, ensure availability of Cotrimoxazole to prevent bacterial infection, TPT and fluconazole while ensuring routine vaccine.

The diagnosis of pediatric TB is a real challenge for the national program, either because of a lack of materials or insufficient skills among staff. Cameroon's NTCP has not been immune to this

challenge. In 2019, pediatric cases in the under-15 age group represent only 5.5% of all cases (with about 2% in the 0-4 age group), whereas the norm is around 12-15%. Children, especially those aged 0-4 years, are an important vulnerable group, hence the importance of this intervention. Under reporting also contributes to these low coverage rates and in order to address this under-reporting, it will be necessary to train staff, strengthen the diagnostic capacities of health care facilities, develop partnership with MCH services, Integrated Management of Childhood Illness (IMCI) programs, nutrition centers and pediatric learned societies. The three-tiered approach to reduce morbidity and mortality among CALHIV due to TB will be implemented through intensify TB case finding for all ages, optimized TB HIV C&T and provision of TB prevention while ensuring TPT completion. Other key interventions or activities will include: defining pediatric targets for expected TB suspects at treatment centers, train staff on the management (diagnosis prevention, and treatment) of pediatric TB, Intensify the diagnosis of pediatric TB through the acquisition of equipment to facilitate diagnosis, such as nebulizers, nasopharyngeal tubes and provision of appropriate algorithms, use multi-skilled community health workers and community-based active research workers to step up the search for contacts of index cases <5 years of age for referrals to health facilities, Develop SOPs for sample collection procedures and for the provision of preventive therapy (TPT) and support the completion of TPT. Acquire and provide TPT to eligible children and adolescents. Improve sample transportation systems for the Xpert machines and the return of test results in the shortest possible time. Organize annual collaboration/partnership meetings with MCH services and other pediatric programs (IMCI, Nutrition centers etc) and link each of these services to the diagnostic and treatment network through the sample transportation network and reference-counter-reference.

Figure 4.3.21: Improving Retention and the Quality of Care for CALHIV Through DSD Models



High quality of care through expanded facility and community DSD models will be implemented to prevent treatment interruptions and if not successful, will rapidly identify, locate, and support CALHIV who do not initiate ART, who miss appointments early in treatment (< 3 months), or who disengage from services (3 months or more) and document outcomes. To improve retention among children and adolescents, family-centered care will be promoted to include child friendly clinicians offering DSD to children, convenient appointment times in consideration of school hours, fast tracking of ART refills, age-appropriate disclosure support, parental skills and caregiver support, and regular screenings. MMD will be scaled up with optimized pediatric and

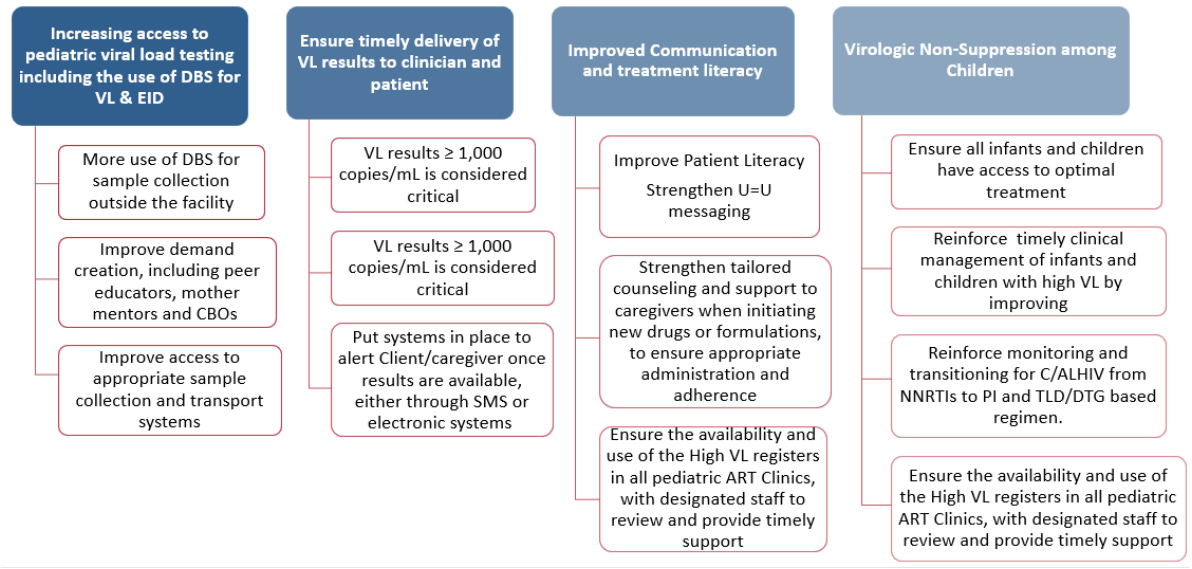
adolescent ART regimens based on the availability. PEPFAR Cameroon will support IPs to reinforce the alignment of drug pick-ups for children with appointments for vaccination, mother's drug pick-up or support group activities. However, children will have to be brought to the facility at least once in a quarter for anthropometric measurement in order to adjust ART dosage whenever necessary. Adolescents will be targeted through support groups, convenient service hours, and use of non-clinical safe space for information, screening, and counseling. Facility and Community-level adolescent/youth peer led interventions will implement specific HIV/SRH/TB interventions through capacity-building of youths multifunctional center and associations to provide a comprehensive package of HIV/STI/SRH/TB services including decentralized drug distribution (DDD) for eligible ALHIV. Providers and case managers will also be trained to provide parenting caregiver support.

PEPFAR Cameroon will continue to strengthen coordination and collaboration between the clinical and OVC partners following the signing of MOUs to ensure support for all CALHIV with AHD, linkage/retention issues and other psychosocial challenges to achieve better outcomes for children and adolescents. According to needs identified, PEPFAR Cameroon will leverage its OVC platform to provide transportation support and/or accompaniment to treatment centers for ART initiation of CALHIV who are not on ART and follow-up clinical visits as well as facility and community-based support groups, trained case workers will conduct at monthly home visits (bi-weekly home visits to CALHIV with high VL) to CALHIV to provide early childhood development (ECD) activities for children below 8 years of age focused on positive parenting and early stimulation, adherence counseling, monitoring and support or accompanied referrals to health facilities to ensure confirmatory testing among HEI including age and stage appropriate disclosure support, education progress monitoring; nutritional assessment and counselling; violence screening;; and other services as needs arise. Together with health facility Psychosocial Agents, the OVC program will track absent and defaulting children and adolescents and link them back to car and support the organization of and participate in case conferencing on cases for adherence support and continuity on ART. The OVC program will also support the establishment and/or strengthening of existing adolescent peer HIV support groups in the communities. Coordination will be strengthened with Psychosocial Agents/Case Workers including other health care providers to ensure participation in clinical reviews, case conferences (monthly, or as mutually agreed), review of needs of CALHIV enrolled in OVC services for TB screening, due for VL testing, tracking VL results and viral suppression rates, drug refills, support MMD and provide reminders to caregivers on attendance. Monthly meetings will also be held with community partners to review progress in referral for OVC beneficiaries with unknown HIV status for testing in health facilities and participate in Clinical IP led monthly meetings with health facilities to review HIV testing for referred OVCs, ART initiation and Viral suppression for CALHIV enrolled in OVC services, adherence barriers and agree on the way forward, as well as progress on MMD for CALHIV and optimized ART regimens. Additional services for adolescents living with HIV will include screening for drug, alcohol, and sexual risk behavior and providing counseling to reduce identified risk behaviors. The program will strengthen bidirectional referral between community-based organizations and health facilities including organizing case conferencing, and monthly coordination meetings.

VL testing will be scaled up for children and adolescents living with HIV. In FY21 to improve on viral load coverage, health care providers were mentored to line-list all children eligible for viral

load testing and ensure VL prescriptions are provided with samples collected and referred to the reference laboratories for VL testing. The results once available are presented for interpretation and decision making according to national guidelines. These efforts will continue in COP22 including reinforcement of demand creation with involvement of peer educators, adolescent champions, mother mentors and CBOs on one hand and on the other improve access to appropriate sample collection and transport systems. Family-centered testing will be promoted by integrating POC VL in infants and children since POC VL is already being used for PBFW. Additionally, PEPFAR will put systems in place in FY23 to alert client/caregivers once VL results are available, either through SMS or electronic systems for timely information and decision making. PEPFAR Cameroon will improve on communication and treatment literacy through strengthening of the Undetectable = Untransmissible (U=U) messaging and tailored counseling and support to caregivers when initiating new drugs or formulations and ensure appropriate administration and adherence. Pediatric viral load testing in all Regions will be increased through advocacy for more use of DBS for sample collection outside the facility, and access to appropriate sample collection and transport systems.

Figure 4.3.22: Optimized Strategies to Scale up VLC and VLS for Children and Adolescents



To improve on viral load suppression in COP22, PEPFAR Cameroon will ensure all infants and children have access to optimized treatment. Enhanced transition of stable children to pediatric Dolutegravir and adolescents to TLD must be ensured. Timely clinical management of infants and children with high VL must be reinforced through enhanced adherence and counselling by improving the availability and use of EAC job aids, SOPs, High VL registers, and other decision-making tools required for client management and documentation in all pediatric clinics. Enhanced adherence counseling will be intensified through training and mentorship for children and adolescents with high viral load to improve on viral suppression. The EAC program will be implemented in clinical settings, which includes provision of tailored messaging to caregivers of children and adolescents and establishing a system for timely return and management of high VL results in pediatric clinics.

Child friendly corners and support groups for children will also be implemented. The capacity of HCWs will also be strengthened to facilitate disclosure and documentation for transitioning of adolescents to adult ART services and for the adult health care providers to receive adolescents transitioned from other pediatric services. Tools adapted for pediatric counselling and disclosure in use since FY18 will be produced and made available at all PEPFAR-supported sites. Support group activities for children, adolescents and their parents will be intensified, and sites will be strengthened to use these sessions to provide treatment literacy/age-appropriate therapeutic education and integrated services. PEPFAR Cameroon will continue to support the identification of "adolescent champions" to lead age-appropriate therapeutic education and foster retention.

A network for pediatric C&T including adolescents, caregivers, and their health care providers will be created using WhatsApp groups, adolescent U-Reporting platform, adolescent magazines *(100% Jeune/Amongst us Youths)* and the ECHO platform to facilitate sharing of information and support.

OVC partners will continue to work with Clinical partners to review a list of eligible children and adolescents for viral load testing and ensure follow-up for referral for sample collection at the facility and community by the competent staff as per the national recommendation. They will document VL result of project participants as provided by the Clinical IP appropriately using the case management tools; collaborate with the Clinical Partners to conduct a joint assessment and develop a joint case management plan for each child with HVL. These plans would include plans for OVC program caseworkers to conduct home visits to strengthen adherence and retention, as well as provide the additional package of services geared towards addressing the challenges faced by the children in efforts to improve VL suppression. The OVC program will immediately call project participants with high viral load and facilitate referral (through payment or reimbursement of transportation to the health facility for enrollment into EAC). The OVC program will collaborated with Clinical IPs to provide a continuum for family-centered disclosure counseling to CALHIV and provide transportation support and/or accompaniment to health facility for repeat VL testing for participants with HVL who completed their EAC. The OVC program will organize/strengthen ALHIV support groups in the communities and facilitate access to support group activities, counsel children and adolescents on the importance of VL testing when due and support with transport and/or transportation reimbursement to children and adolescents going for VL sample collection. The OVC program will provide wrap-around services such as household economic strengthening activities and education support for formal schooling and vocational training to help mitigate the negative impact of HIV on households. Finally, the program will seek to leverage other existing programs such as USAID's Food for Peace program (targeting refugees and IDPs), the President's Malaria Initiative (in health districts in the North and Far North Regions), and the World Bank's Social Safety Net program to improve the living conditions of OVC and their families.

Key Populations

Based on existing epidemiologic studies (IBBS 2016), HIV prevalence remains high among KP (24.3% in FSW and 20.7% in MSM, IBBS 2016) with the burden of the epidemic concentrated in urban cities. Therefore, KP prevention efforts will remain a key strategy in COP22 and in the community, will be focused in the current implementation areas of Yaoundé, Douala, Bamenda, Kribi, Ngaoundere, Bafoussam and Bertoua. These cities were selected in coordination with the

Global Fund community principal recipient (PR) and civil society, and the choice was based on HIV burden. Together, the seven urban centers covered are those with the highest burden of KPLHIV based on the best available size estimates. In addition, the cities cover the major national and international transport corridors, major university towns, and communities hosting large concentrations of internally displaced persons and refugees. In these cities, PEPFAR will continue to scale up targeted community interventions focused on preventing new HIV infections, strengthening case finding, linkage to treatment, ART adherence and retention support. In addition, differentiated models of service delivery like community-based dispensing will be reinforced. In the Clinical program, where the focus is on prisoners, there will be programming to identify and serve other KP walk-ins in both current community SNUs and where the community program is not present.

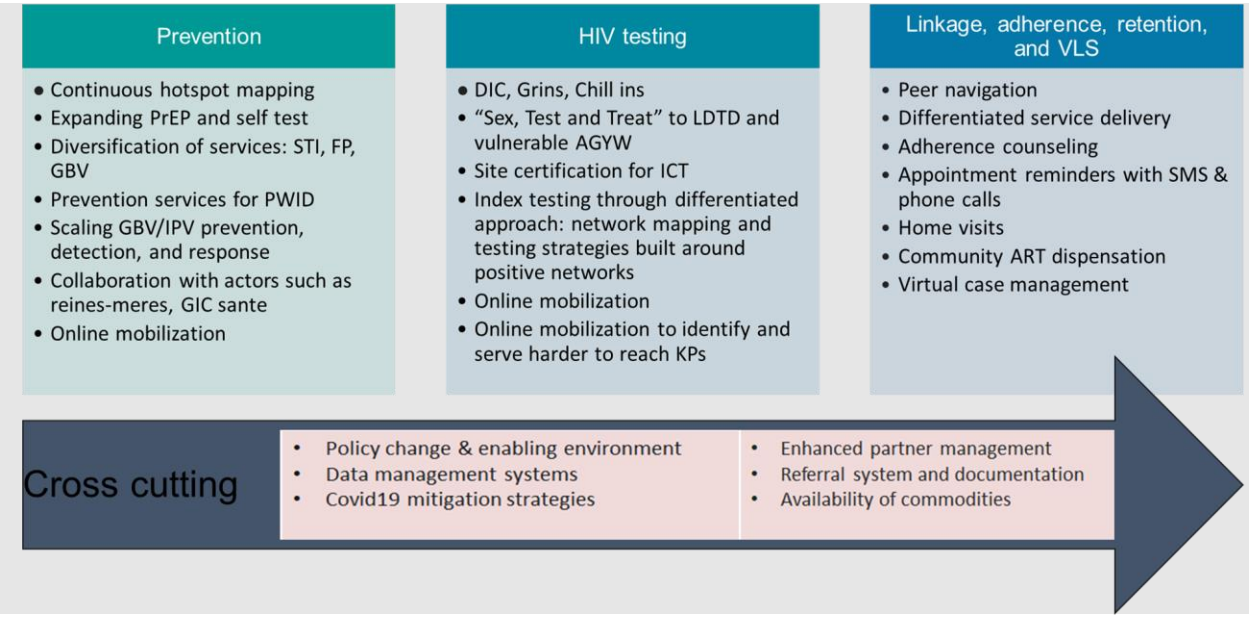
PEPFAR Cameroon's KP program will target MSM, FSW, TG, PWID and People in prisons and other closed settings. The program is designed to also identify other priority and vulnerable populations, including partners and spouses of KPs, children of KPs, and clients of sex workers. PEPFAR Cameroon implements a comprehensive KP program that includes prevention, case finding and continuum of care and treatment. The KP clinical program, whilst continuing to ensure KPs have access to HIV prevention, HIV testing and HIV care and treatment services, made huge strides in FY21.

KPs FY21 results and achievement

Overall, the program reached 95,938 KPs with prevention interventions including offering of testing services. Of the KPs reached, 54,447 were tested being an uptake of 63% when a total number of 9825 known positives are considered. In FY21, PEPFAR found 3,805 new positive KPs and linked more than 92% of them to treatment. In FY21, PEPFAR also initiated 3,240 new KPs on PrEP and distributed more than 18,500 self-test kits.

FY21 performance was principally achieved by implementing comprehensive community-facility KP programming that focused on new and old strategies including: reinforcing community and clinical collaboration through the development of MOU frameworks, OD and capacity development to CBOs and drop in centers in the reinforcement of one-stop-shop model, identifying and collaborating with non-traditional health actors (GIC Santé, roadside drug vendors and traditional healers/herbalists etc.), strengthening health facility-prisons collaboration for systems strengthening (provision of tools, guidelines, SOPs, trainings), prison community engagement (peer educators, expert clients, prison health care providers and administrative staff) quality care, supportive supervision, and minor repairs at prison ART clinics to make the clinic conducive for both service providers and clients. Figure 4.3.12 below highlights key interventions prioritized by PEPFAR Cameroon KP program.

Figure 4.3.23: COP20/21 KP program strategies and activities:



In order to better target and test beneficiaries most likely to be HIV-positive, index testing will continue to be prioritized in FY23. In addition, innovative approaches to differentiated index testing through social events and social network strategies formally introduced in FY22 will be scaled up by CBOs in FY23.

The KP programs will remain a key route to target other priority populations including clients of sex workers, KP partners and children. Regarding clients of FSW, the program will continue to implement the Sex, Test and Treat approach where FSW counsel their clients and provide them with a coupon for free testing at DICs or participating health centers. Under that strategy, the program has seen encouraging yields at up to four times the national prevalence for adult men.

In addition, PEPFAR Cameroon has been working with GRC, Global Fund, UNAIDS, and other partners to update national policies, tools, and standardized approaches for KP programming to include new prevention activities like PrEP and HIV self-testing. In 2020, we successfully advocated for the introduction of Self testing and a pilot of PrEP in the KP program. In FY22, while PEPFAR Cameroon starts PrEP implementation for key populations at clinical settings, it is also supporting an evaluation of PrEP activities that were implemented as a pilot. The outcome of this evaluation will hopefully inform a policy review and expansion of PrEP implementation to other high-risk populations and geographic locations. In FY23, PEPFAR Cameroon will continue PrEP expansion, and this is subject to policy update. In addition, PEPFAR Cameroon will continue to engage stakeholders beyond the health sector such as local authorities, law enforcement, and the judiciary to create an enabling environment for FSW and MSM free from stigma, discrimination, or fear of violence which have been identified as barriers to uptake of some innovative strategies including PrEP.

KP Targeted Subgroups and Strategies

The KP program will target all KP groups as stipulated in MER 2.6. In the community program, the focus will be on MSM, FSW, TG and PWID while the clinical KP program has as principal KP targets, persons in prison and other closed settings. Through a facility-led outreach approach and close collaboration with prison administrators and health staff under the supervision of the Regional Technical Group Coordinator, clinical IPs will continue to support HIV service delivery at prisons in PEPFAR-supported health districts. Clinical IPs will expand support to build a sustainable HIV/TB program in prisons that will provide quality HIV services across the cascade. In addition to strengthening provision of HIV prevention, testing, care and treatment for prisons, PEPFAR Cameroon through its clinical IPs will continue to work with prison administrators and health staff for prison systems strengthening including continuous staff capacity-building; provision and training on use of various tools, registers, guidelines, SOPs etc.; establish prison support group(s), recruit and train inmates LWHIV and successful on their treatment as expert clients to run support group activities, supportive supervision, provision of working material, renovation and minor repairs of the prison ART clinics to make the environment conducive for both staff and clients.

Apart from prisoners, the clinical program will provide services to FSW who will opt to seek services directly at the health facilities. With the use of the risk assessment and KP categorization tools, FSW and other KP population sub groups who access various services at different entry points of the facility will be reached with tailored risk reduction messages, counseling, HIV testing and other prevention messages and services as applicable including STI diagnosis and treatment, TB prevention, screening and management (INH or TB treatment), SRH/FP services, condom/lubricant provision, GBV screening and management, PEP, and PrEP.

From above, the clinical program is directly targeting prisoners and FSW, however, other KP groups that are not targeted such as MSM, TG and PWID who opt to receive services at clinical sites will be offered services. It is also important to highlight that in the context where a PEPFAR-supported health facility is found in a health district that is not covered or reached with services for KPs by the KP community program, the health facilities in such context through a facility-led outreach approach will meet the prevention and testing needs of KPs in such underserved communities.

It is also important to highlight that in the context where a PEPFAR-supported health facility is found in a health district that is not covered or reached with services for KPs by the KP community program, the health facilities in such context through a facility-led outreach approach will meet the prevention and testing needs of KPs in such underserved communities.

In COP22, PEPFAR Cameroon will continue to implement activities and provide quality services to KPs as described in figure 4.3.12 above. The KP program will build on mobilization efforts in both community and online to identify and reach new KPs. Investing in the information system through the provision of TA to both the KP partner and sub-partners in addition improving collaboration with other stakeholders including clinical partners should allow for quality management and reporting of results across the cascade. Investing in demand creating activities, enabling environment interventions including livelihood activities and activities to prevent GBV,

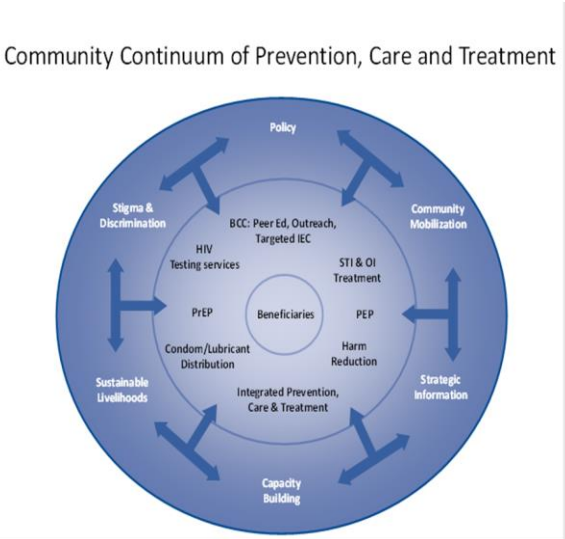
stigma and discrimination will continue to promote equitable access to services by KPs. In COP22, PEPFAR will continue to advocate for policy changes that will allow for a comprehensive one-stop-shop model of community KP programming, allow for PrEP service expansion, allow for self-testing expansion, and promote equitable access to health services by all.

In prevention specifically, the PEPFAR program will focus on expanding PrEP to other population groups if policy expansion is approved by GRC. The program will increase PEPFAR contribution to activities that seek to improve the KP programmatic environment and that reduce stigma and discrimination against KPs. The program will expand on GBV prevention and post GBV care services and will seek to expand testing for prevention including the strategic use of self-testing to both find hard to reach positive KPs and to ensure KPs know their status. There will be an increased effort to strengthen online mobilization efforts with a goal to find new KPs. These efforts will be complemented by regular hotspot mapping that will allow the KP program to identify and serve most at-risk KPs.

One significant new strategy that PEPFAR Cameroon will implement in COP22 is providing TA to the Global Fund KP program to ensure that KPs in the places where PEPFAR community program is not present receive similar level and quality of KP services. The Global Fund program has requested this TA support to ensure they can adequately set up and implement a continuum of care program that will not only provide prevention (including PrEP) services but will find positives, ensure delivery of test results, link all positives to treatment and then ensure community adherence and retention support. Figure 4.3.13 below captures key new strategies in PEPFAR Cameroon's KP program.

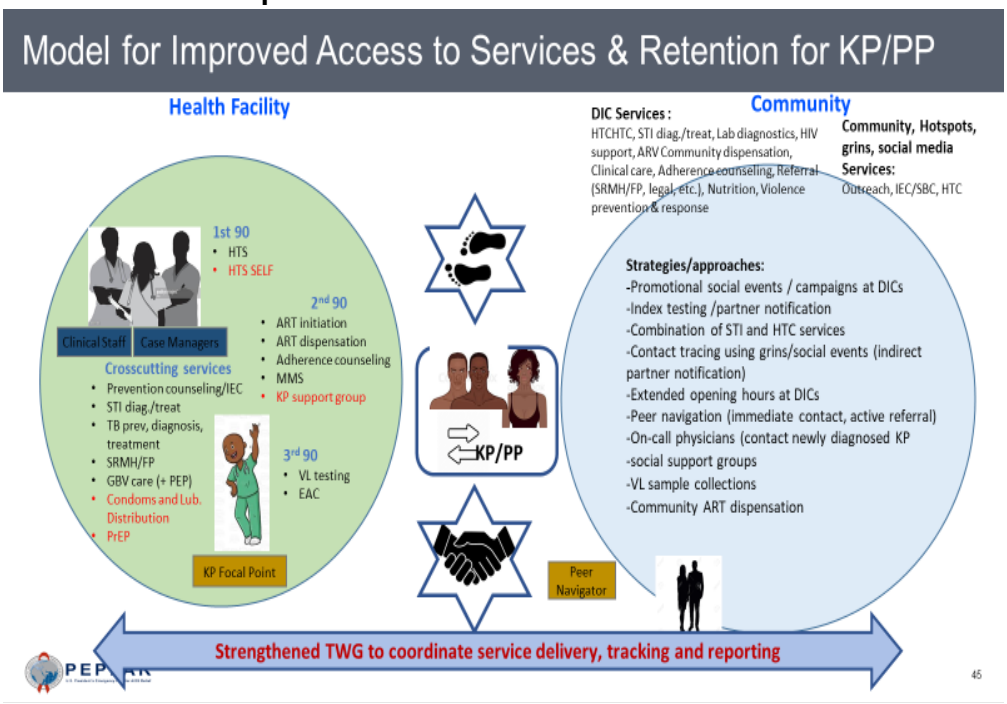
Finally, Community led monitoring targeting the KP population will amongst other issues seek to determine the availability of prevention services, commodities, and the quality of services KP report receiving at both community Drop-in-Centers (DIC) and health facilities.

Figure 4.3.24: Key New Strategies in PEPFAR Cameroon KP Program



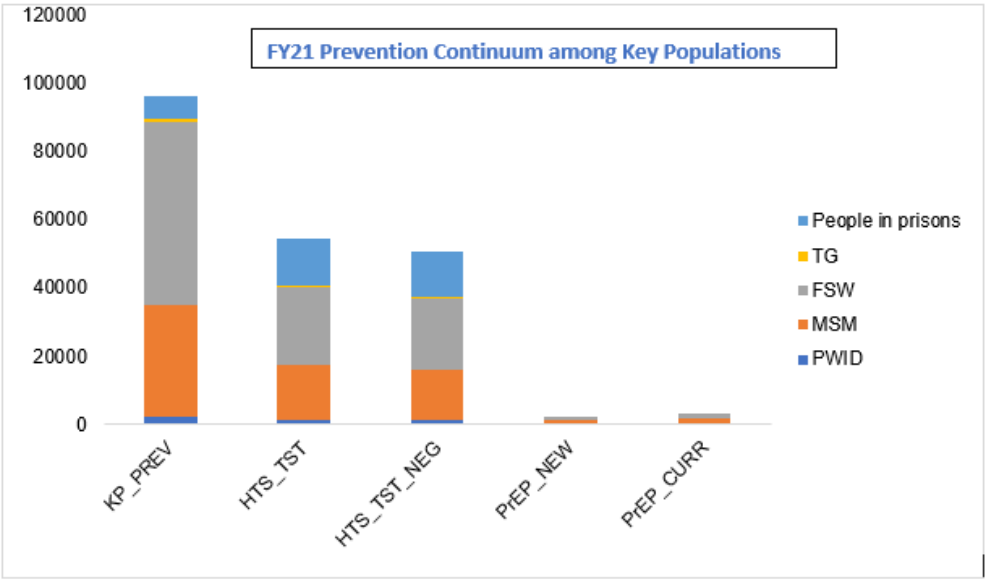
1. Setup and rollout TA support on continuum of prevention, care and treatment in the Global Fund program
2. Improve the use of HIVST kits to reach more beneficiaries
3. Improve enabling environment activities (HRGP like) geared towards provision of safe space and other human right support activities
4. Livelihood – finance group income-generating activities
5. Expand PrEP to other KP groups and AGYW
6. OD to KP led organizations and local primes

Figure 4.3.25: Model for improved access to services and retention for KP



Pre-Exposure Prophylaxis (PrEP)

Figure 4.3.26: Prevention Continuum by Key Population Group



The PEPFAR program has been working alongside the Government of Cameroon to develop systems and tools for the implementation of PrEP for key populations in Cameroon. With the close monitoring of the NACC and PrEP Task Force, the program has recorded an important growth of the PrEP uptake among key populations, moving from 208 newly initiated on PrEP in FY19 to 940 in FY20, and 1,075 at SAPR of FY21. PrEP implementations have been currently approved in the

four large cities of Douala, Yaoundé, Bafoussam, and Bertoua, among which two were added in COP20. Event-driven PrEP was also launched in COP19 but still does not have the expected impact on the uptake of PrEP services. Given the satisfactory results obtained, the PEPFAR program will continue to advocate towards NACC for an increased footprint to two additional cities of Ngaoundere and Kribi. The program will continue to advocate for the reduction of the age barrier that restricts eligibility for KPs that are below 21 years old. The program will also continue to provide quality training and mentorship to the providers at community-level, improve the quality of SOPs and job aids, as well as M&E systems around PrEP service delivery. PrEP services will continue to be coupled with an evaluation of GBV and IPV risk among beneficiaries in order to provide an appropriate response. The demand-creation for PrEP services is currently limited by the inability of the program to widely communicate on PrEP services, except in networks of beneficiaries, which has an impact on the credibility of the information provided. This will be mitigated through a large-scale implementation of PrEP services to HIV sero-discordant couples and partners of pregnant and breastfeeding women.

While PrEP implementation at clinical sites starts during FY22, PEPFAR Cameroon will continue working with the Government of Cameroon and other PrEP stakeholders to support PrEP pilot evaluation which is expected will bring PrEP to scale to cover more geographic zones and make it available to other high-risk key populations such as TG, PWID and high-risk members of priority and general populations including AGYW, PBF and negative partners of sero-discordant couples.

It is worth noting that PrEP as a prevention option, just as condoms and lubricants will not be offered to prisoners – as per the government of Cameroon's (Ministry of Justice) policy on prohibition of these categories of interventions in the prison milieu.

TB/HIV

Cameroon is one of 30 countries with the highest burden of TB/HIV co-infection with a rate of 24% (NTCP, 2020). In 2021, the estimated number of TB cases expected was 30,042 of which 22,740 (76%) cases were notified (NTCP, 2021), representing a 1% increase from 22,540 in 2020. The estimated incidence of drug susceptible TB in 2020 was 174 cases per 100,000 inhabitants (WHO, 2020) while the incidence of multi-drug resistant TB (MDR-TB) was estimated at 3.6 per 100,000 inhabitants with a TB mortality rate of 29 per 100,000 inhabitants. On average, about 46,000 new TB cases are expected each year (WHO, 2020), of which 10 to 12% are children. The incidence of TB decreased by 18% (212 to174 per 100,000 inhabitants) from 2015 to 2020. In 2021, 22,740 drug susceptible TB cases and 140 MDR-TB cases were notified in the 306 Diagnostic and Treatment Centers (DTC) in the country with a therapeutic success rate for new and relapsed TB cases of 85%. The cities of Yaoundé and Douala and the Far North Region reported 47% of all TB cases. Among all TB cases infected with HIV, 98% were on ART. To reduce the burden of TB, the NTCP is implementing the National Strategic Plan for the Fight against Tuberculosis 2020-2024, as part of the WHO "End Tuberculosis" strategy.

Despite being preventable and curable, TB remains the leading cause of infectious disease morbidity and mortality for PLHIV, with the urban cities of Yaoundé (15%) and Douala (17%) accounting for one third (32%) of all TB patients in Cameroon (NTCP, 2021). To support GRC in the scale up of TB prevention and treatment, CDC has been implementing a Cooperative Agreement with Cameroon NTCP since FY18 to 'Decrease the TB/HIV Burden and Develop Systems to Achieve and Sustain TB/HIV Epidemic Control in Cameroon under the President's

Emergency Plan for AIDS Relief (PEPFAR). This award has contributed to strengthening prevention, diagnosis, and treatment of TB in PLHIV through screening and case identification; TB infection prevention and control; HIV testing, monitoring and clinical care for TB clients; and health system strengthening.

TB/HIV prevention: results and achievements

In FY22 Q1, 98% of new and relapsed TB cases in PEPFAR supported sites knew their HIV status, 20% of TB patients were co-infected with HIV, and 93% of HIV positive TB cases were on ART. In FY21 Q4, 92% of all PLHIV were screened for TB, and 1.3% had a positive TB symptom screen – lower than the 5% expected target and a drop from 2% in the previous year. Among those screened positive, 26% were confirmed with TB, of which 79% were initiated on TB treatment. PEPFAR continues to support the integration of TB and HIV services at facility level with focus on in-service capacity-building for service providers to provide quality HIV/TB services to co-infected patients. Among 92% of PLHIV screened for TB in FY22 Q4, 99% had a negative TB symptom screen, of which 35% were initiated on TB preventive therapy and 69% completed their 6 months treatment.

Some notable progress was made in TB/HIV prevention and care in 2021. For the first time, shorter TPT regimens were adopted by MOH including 3HP (weekly dose of isoniazid + rifapentine for 3 months) for eligible PLHIV and 3RH (daily Rifampicin + Isoniazid for 3 months) for under-five household contacts of positive sputum smear TB cases. In addition, the one-stop-shop model of TB/HIV service delivery was introduced for the management of TB presumptive cases and HIV/TB co-infected patients at the TB units. Following the introduction of this policy, health care providers from high volume TB units were trained on HIV prevention, care, and treatment. Also, doctors, nurses, and psychosocial agents were trained on IPT and TB/HIV care. To improve documentation of TB screening at all facility entry points, over 6000 National TB screening registers and other M&E tools were produced by the NTCP and distributed to sites in all 10 Regions.

TB/HIV prevention: outstanding gaps

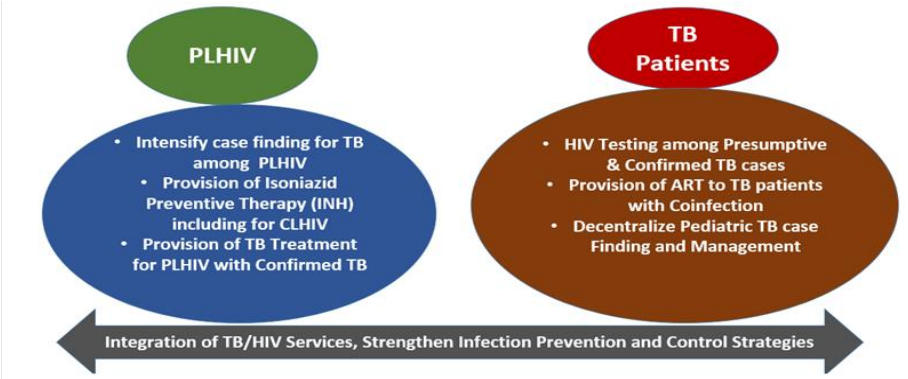
Despite implementation of TB/HIV integrated activities in Cameroon, TB/HIV prevalence remains high at 24% (NTCP, 2020) and TB remains a leading cause of death among PLHIV and a major opportunistic infection in AHD. TB case finding, diagnosis and treatment remains suboptimal, especially among children. TB diagnosis continues to rely on microscopy for most diagnosed cases despite increased roll out of molecular platforms (55 GeneXpert, 28 TB Lamp) due to frequent stockout of cartridges in the country. The number of Diagnosis and Treatment Centers (DTCs) increased from 256 in 2018 to 306 in 2021, but not all DTCs offer microscopy. The diagnosis of TB patients remains a challenge especially in the two big cities of Yaoundé (15%) and Douala (17%), with only about 32% of all TB patients notified. Several DTCs do not offer TB diagnostic tests to patients onsite and instead refer them to other facilities for testing due to unavailability of personnel, inappropriate space, and unavailability of microscopes, which has resulted to patients being lost to follow up between the referral and the testing sites. The TB diagnostic capacity for PLHIV, prisoners, children, contacts of confirmed Pulmonary TB and other at-risk populations remain suboptimal. The COVID-19 pandemic negatively impacted TB/HIV service delivery as the fear of the pandemic led to significant reduction in hospital attendance

across all Regions. In addition, the unstable socio-political context in the Far North, North-West and South-West Regions have caused the displacement of many clients within and out of the country and has greatly limited community interventions.

Strategies to expand uptake of TB/HIV services

In COP22, PEPFAR Cameroon will continue expanded TB/HIV service provision in all PEPFAR supported sites.

Figure 4.3.26: Strategies to Improve Management of TB/HIV Coinfection



To reach the COP22 targets and decrease the burden of TB among PLHIV, PEPFAR Cameroon will continue to support collaboration between NACC and the NTCP to scale up integrated TB/HIV services in facilities through the one-stop-shop model. In 2021, TB diagnostic and treatment Centers were upgraded by MOH to implement the one-stop-shop model of HIV and TB service delivery. This policy requires that all TB units provide a full package of HIV and TB services to all TB presumptive cases and HIV/TB co-infected patients. Co-infected clients are provided with both HIV and TB treatment with aligned refills, both treatment outcomes are monitored, and patients are provided with comprehensive care and adherence support through reminder phone calls, peer support, and home-based adherence support especially during the active phase of TB treatment. In addition, the TB unit staff manage patient data, registers, and reporting tools. After 6 months, if the patient is cured from TB, they will be transferred to the HIV unit to continue with HIV care and treatment. PEPFAR Cameroon will also continue to strengthen the decentralization of TB case finding and management in Pediatric, PMTCT clinics and in prisons.

Active TB case finding will be implemented by using the National TB screening tool for adults and children at various facility entry points and in the community through various DSD models. PEPFAR Cameroon will continue to support the National TB program and health districts to strengthen active TB case finding in the community-by-community health workers and ensure that all presumptive cases identified are referred for HIV and TB testing services. To ensure that all clients receiving ART through community ART dispensation are screened, PEPFAR will continue to train CBOs to carry out routine TB screening. Prisoners will be systematically screened for TB at entry, annually and on exit. Thanks to the ongoing Diagnostic Network Optimization (DNO), 100% of sites will be linked for TB molecular testing of PLHIV with TB symptoms and the specimen transport system for VL/EID/TB will be strengthened. To significantly reduce turnaround time for results, the integrated Lab information management system (LIMS) will be strengthened and scaled up to cover all 10 Regions. PEPFAR will also continue to advocate for novel diagnostics

like Urine TB LAM to improve the diagnosis of TB among children and patients with advanced HIV disease (AHD).

In addition, PEPFAR Cameroon through its clinical IPs will continue to strengthen the sample transport system for TB/HIV(VL/EID) to ensure that the samples of all eligible clients are collected and sent to the Lab. To improve TB testing of presumptive children, Pediatric focal persons will be trained in alternative sample collection techniques including gastric and nasopharyngeal aspiration in the pediatric Centers of excellence currently being set up across all Regions. Child household contacts of PLHIV confirmed with TB will be systematically screened for TB and children enrolled in the OVC program will also be offered routine TB screening.

TPT will be provided to PLHIV who screen negative for TB in all PEPFAR-supported sites. PEPFAR will be working closely with the National TB program to introduce and progressively scale up the 3-HP regimen among eligible PLHIV to significantly increase adherence and completion rates. MOH plans to introduce 3-HP in 6 high volume sites from November 2022 and progressively scale up to other sites after 6 months.

Table 4.3.1: Pilot sites for introduction of 3-HP regimen among eligible PLHIV

Region	Sites
Center	Hopital Jamot Yaounde
	Hopital Central Yaounde
Littoral	Hopital Laquintinie Douala
	Mboppi Baptist Hospital
North-West	Bamenda Regional Hospital
	Nkwen Baptist Hospital

Support will be provided to the NTCP to organize webinars and conduct on-site supervisions to train health care providers and build capacity on TPT and TB/HIV care and treatment. The national guidelines will be revised to include the shorter and more optimized 3HP regimen (weekly dose of Isoniazid + Rifapentine for 3 months) for eligible PLHIV. To significantly scale up TPT, MOH will be supported to organize TPT catchup campaigns when stocks permit.

Differentiated service delivery models (CBOs and home-based services) will be scaled up for dispensation of TPT and adherence support for TB/HIV co-infected patients. PEPFAR Cameroon will continue to work with MOH and all stakeholders in ensuring availability, timely and enough quantities of TPT drugs. GRC will also be supported to produce and make available data collection tools for TPT and train/mentor service providers (Doctors, nurses, and Psychosocial agents) to provide TPT to PLHIV without active TB and document services offered in the registers.

To strengthen TB infection prevention and control (TBIC) procedures in health facilities, PEPFAR Cameroon will continue to support the National TB Program to develop SOPs and IPC tools, build

the capacity of HCWs and auxiliary staff on basic infection prevention and control strategies and biosafety. Systematic TB screening of health and related staff in all the sites will also be implemented according to national guidelines. In the current COVID-19 context, clinical IPs will scale up integrated COVID-19/TB screening to ensure that all suspected cases of COVID-19 are systematically screened for TB and those presenting with TB-like symptoms will be provided with TB and HIV testing.

PEPFAR Cameroon will strengthen the health system by building monitoring and evaluation capacity through implementation of an online data service for the management of network communications, reinforce the capacity of NTCP central and regional level staff to get real time data on TB and TB/HIV, and digitalize data collection, transmission, and analysis by integration and harmonization in the District Health Information System (DHIS2). In COP22, PEPFAR Cameroon will continue to support TB/HIV data review meetings, TB/HIV Technical Working Group (TWG) meetings and coordination meetings at all levels of the health system. Mentorship, supervision, monitoring and evaluation will be strengthened through TA, site visits, partner management and monitoring. Clinical sites will receive continuous coaching through weekly virtual GSMs and CQI activities with the full participation of the National AIDS Control Committee and the National TB Control Program to foster collaboration and provide timely solutions to challenges on the ground.

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

Cameroon had country-specific priorities from the COP22 planning level letter, shown in the table below. Strategies to address these directives are described in detail throughout the relevant sections of the SDS document.

Cameroon – Specific Directives
HIV Clinical Services
1. Stakeholders must achieve an alignment of targets in COP22 and must develop an optimized and fully funded procurement plan to support common targets. This may result in a reduction of PEPFAR targets across the cascade, but this is reflected in the COP22 budget level. TLD must be made available to all adult and pediatric patients >30kg. All pediatric patients <30kg but greater than 4kg must be transitions to DTG10. Procurement plans must reflect this and reversals in TLD adoption in favor of TLE must stop. MMD must be made available to all patients, regardless of viral load suppression status, including pediatrics. 2. Pending final Spectrum estimates, case-finding must be prioritized in COP22 such that 90% of HIV positive individuals in Cameroon known their status by the end of COP22. To support 1st 90 goal, index testing must continue to scale up. Clinical partners must continue to ensure the screening tool is implemented properly and that index testing continues to scale in a way that emphasizes confidentiality, consent, and index testing best practices at all facilities. 3. Viral load coverage must continue to scale up in COP22, and pending Spectrum estimates, should target 90% in COP22. 4. All eligible PLHIV, including children and adolescents, should complete a course of TB preventive treatment in COP22.
HIV Prevention Services
1. PrEP for KP and AGYW – In COP 2022, PrEP should continue to be scaled up with a focus on ensuring policy and programmatic access to PrEP for higher incidence populations. Populations prioritized for PrEP should be tailored to the OU's epidemic context with a focus on Key

Populations (including sex workers, men who have sex with men, transgender people, people in prisons and other closed settings, people who inject drugs), adolescent girls and young women including pregnant and breastfeeding AGYW, and other identified higher-incidence populations. A formal review of the initial PrEP rollout must be conducted prior to COP22 and expansion of access to PrEP must be in place prior to COP22 start in order for the team to be able to access the PrEP funding outlined in this letter. 2. TPT must be scaled and made available to all ART patients. This will require additional funding to ensure proper procurements are made to make these available to all 3. U=U messaging prioritized in all clinical partners, ensuring patients understand the importance of viral load suppression.
Other Government Policy, Systems, or Programming Changes Needed
1. Structural barriers for KP – COP/ROP 22 plans should prioritize and take specific steps to address the structural barriers that impede scale up of KP-led and KP-competent differentiated HIV services, as well as the lack of robust data to guide key populations programming. To strengthen strategic information to guide KP responses, plans may include efforts to strengthen individual level data systems and analyses and address gaps in subnational data. Addressing structural barriers should entail improving the enabling environment for HIV service delivery; mitigating harmful policy and social norms that fuel stigma, discrimination and violence faced by key populations; strengthening the capacity of key populations organizations; and strengthening the KP competency of HIV service providers. PEPFAR teams should ensure they are coordinating strategically with relevant State and U.S. government units (e.g., DRL), partner government, multilateral, and other donor funding streams and institutions. As part of the new COP22 MPR, PEPFAR teams will be expected to describe and present their approach to improving KP data and addressing barriers to accelerated KP-centered HIV services during COP/ROP 22 planning meetings. 2. A formal review of government policy regarding PrEP access must be conducted prior to the start of COP22, and access for AGYW and other high-risk group including those under 21 years of age must be allowed. 3. The Government of Cameroon must meet their co-financing commitments and ensure on time and optimized procurements of all HIV commodities. 4. Government circular instructing clinics to halt transition of patients to TLD, restricting MMD, and initiating new patients on TLE must be recalled following adequate ARV stock in country.

4.5 Additional Program Priorities

Policy/guideline changes that impact the program implementation, Policy barriers to prevention programming

The PrEP services have been implemented as a pilot in a limited group of KPs (MSM and FSW aged 21 years and above) and in a limited community settings (cities of Douala, Yaoundé, Bafoussam, Bertoua, Bamenda) with the program being restricted for demand generation that should only take place within KP networks. PrEP programming was recently expanded into clinical settings of the cities mentioned above, to which NACC added two additional cities of Kribi and Ngaoundere (for PrEP clinical model only). However, even with this clinical expansion, PrEP implementation remains restricted to the same key populations (MSM and FSW) and the same age group. In COP21, PEPFAR Cameroon is supporting the GOC to design and conduct an evaluation of the current PrEP implementation pilot. This evaluation is meant to inform further deliberations and consideration of PrEP service expansion beyond the current geographic locations, population, and age groups. PEPFAR will work jointly with other key stakeholders to

support NACC in the design and implementation of this evaluation as well as the framing of the updated PrEP policy. PEPFAR Cameroon hopes to take advantage of any future PrEP policy updates to introduce other innovative approaches including the vaginal ring as well as the injectable ARVs as soon as they are WHO-prequalified. PEPFAR Cameroon also intends to influence a change in PrEP policy that will see a drop of the age limit to 18 years, increased ability to conduct broad communication and demand creation for PrEP and ability to reach other KP groups (PWID and TG) and other vulnerable and priority population groups such as AGYW, sero-discordant couples and PBF women. This policy change will ensure PEPFAR Cameroon meets its PLL minimum requirement and allow for a successful expansion of PrEP interventions.

Antenatal care (ANC) services were harmonized a couple of years ago including fees. However, the access and utilization of antenatal care (ANC) services is not yet optimal in Cameroon as the country is still far from meeting the 95% of ANC coverage due to several barriers including cultural and cost barriers to antenatal services. The Government enacted the user fees elimination policy in 2020 and this policy was updated to target the access to ANC services including the first antenatal consultation that is meant to be provided for free, as well as other services for pregnant women living with HIV. The aim of this policy is to increase the access and utilization of services for pregnant women, as well as ensure the timely detection of those who are living with HIV to prevent the vertical transmission. The PEPFAR program will continue to work with the Civil Society organizations, the Government, and other key stakeholders to monitor and advocate for the full implementation of this policy for the benefit of the mothers and their babies. More specifically, PEPFAR will continue to support the implementation of the user fees elimination policy as well as the rollout of the Universal Health Coverage for the key and priority populations, including the PBFW.

Policy barriers affecting HIV case finding, linkage and retention

HIVST services in Cameroon are still limited to people aged 18 years and above. This is limiting the possibility of the program to utilize this testing approach to optimize HIV pediatric case finding.

The PEPFAR program will continue to support the design and implementation of the decentralized service delivery approach for HIV testing in Cameroon whilst advocating for the expansion of HIVST to at-risk adolescents in community settings. In addition, the PEPFAR program will work with the other key stakeholders such as the Global Fund, WHO, UNAIDS and UNICEF to build the capacity of the civil society to implement some clinical services in the one-stop-shop format as well as ensuring that this approach is designed and structured in the differentiated service delivery policy.

Policy barriers for ART regimen optimization

The Cameroon HIV program has integrated and scaled up the uptake of TLD as the preferred first line regimen, reaching the peak of 75% coverage at the end of COP20. Program data and research studies have shown that patients on the optimized DTG regimen are having a higher viral load suppression rate. However, further progress is limited for the general population, the children, as well as the pregnant and breastfeeding women. The country is planning to maintain the coverage rate of adults with DTG-based regimen at 75% versus 24% on EFV-based regimen, probably because the guidelines still refer to EFV-based regimen as the preferred alternative option to the first preferred first line regimen for pregnant and breastfeeding women. For the

children below three years of age, the plan is to ensure a complete transition at the end of January 2023. PEPFAR will support GRC to pursue a progressive transitioning to pediatric dolutegravir (pDTG or DTG10) for all children <20kg in COP22. The transition which began in August 2021(COP20), for all newly identified positive CLHIV in 20 selected sites (≥20 CALHIV in TX_CURR) for 6 months will take a phased approach while ensuring depletion of Lopinavir/Ritonavir. The second phase will take place from January to December 2022 for sites with 10-19 CALHIV in TX_CURR. The third phase will start in January 2023 for remaining sites (<10 CALHIV in TX_CURR). Nonetheless, the transition can be accelerate depending on the availability of pDTG in the country.

The PEPFAR program will be working with NACC to update the ART guidelines in order to complete the optimization of the ART regimen in all the population subgroups. Also, PEPFAR will continue to support the country program in the monitoring of adverse effects of DTG-based regimen.

Ensuring scale up of index testing in alignment with the PEPFAR Guidance on Implementing Safe and Ethical Index Testing, ongoing monitoring, action, and accountability

Index testing (ICT) has been an important entry point/modality for case finding in the PEPFAR Cameroon program. PEPFAR Cameroon will continue to implement ICT at all community and facility sites. Programming that allows for ethical sharing of data between community and facility sites to boost ICT will be promoted. MOUs between clinical and community partners and between PEPFAR partners and the Regional Technical Groups that highlight the need for targeted approaches to case finding including index case finding. PEPFAR Cameroon will continue to train program staff to ensure ICT implementation adheres to WHO's 5 "Cs" and scale up ICT in new sites while ensuring refresher training is carried out at old sites. PEPFAR Cameroon will ensure 30% of all case finding/newly identified positives in COP22 are found through ICT. The program intends to use a mix of strategies anchored around ICT and social network strategies (SNS) to find hard to reach PLHIV in order to close the first 95 gap. Implementing ICT in accordance with WHO guidelines means PEPFAR Cameroon will continue to prioritize assessment of IPV risk, follow up with index cases and monitoring for IPV, adverse event monitoring and community engagement.

Program direction in COP22 based on the assessment of program performance reflected in COP20 Q1-Q4 POART findings and discussions and COP21 performance to date

While not directly related to performance, PEPFAR program will be completing transitioning of programs to local partners for both the Community KP and the OVC programs. These transitions will increase local ownership and ensure both OVC and KP programs can maximize efficiencies. A key programmatic change in COP22 is the introduction of a TA/NSD mechanism to provide TA to Global Fund KP grant principal recipient in areas where the current KP community partner is not operating. This approach will ensure case finding and linkage to care is optimized. In fact, the Global Fund program approached PEPFAR for TA support to understand and design a continuum of care package since this has not been a priority in the program for years. The TA will allow for regular tracking of all positives, ensuring that those tested receive their results, ensure 95% of all

positives are linked to treatment and ensure community base adherence and retention services are adequately implemented.

Implementing Partners management ensure alignment with PEPFAR program strategy and to improve partner performance in an ongoing and timely manner

PEPFAR program will optimize partner management through interdisciplinary site visits, intensified partner management, and QA/QI activities, to ensure fidelity with the approved work plan, strategies, and compliance with standards. The interdisciplinary site visits could take place during SIMS visits and outside of SIMS visits with a team comprising of SI, technical, and finance staff. These visits are meant to not only ascertain those interventions are implemented in line with PEPFAR standards but also that implementation, data management, financial controls and management are acceptable to the PEPFAR program, as well as the identification of success stories and root cause analysis of issues identified. In addition to the site visits, PEPFAR program utilizes intensified partner management with weekly, biweekly, and monthly meetings with IP which will include award management, program management, monitoring of progress towards key performance indicators. These high frequency deep dive sessions will also be cascaded to the sites by the IP to the sub-partners and the supported sites. Furthermore, PEPFAR program will implement DQAs once a year to ascertain the data quality while the IP will do RDQAs every quarter with feedback provided to the agency. Microplanning workshops are held at the beginning of the fiscal year following the COP kickoff meeting, to develop clear workplans for each implementing partner, ensuring that all program priorities are covered. These workplans become part of the framework for monitoring the progress and performance

Community-led monitoring plans and program, including focus on key populations, and ensuring findings are utilized to drive program improvement.

Community-Led Monitoring is a key PEPFAR intervention aimed at engaging with the communities to design and implement person-centered HIV programs that meet the needs and the perspectives of the communities in terms of access, utilization, and quality of HIV services provided through community-led evidence-based advocacy. The CLM program will add to already existing initiatives such as the facility-driven monitoring of patient satisfaction surveys to provide equity in service delivery as well as supporting program quality improvement.

In COP21, the Cameroon PEPFAR program launched its first Community-Led Monitoring (CLM) initiative, with the focus on the monitoring of the implementation of the user fees elimination. This program covers 400 sites in 147 districts across the ten regions of Cameroon, including all the PEPFAR supported sites and a few non-PEPFAR supported sites. This program is led by ReCAP+, a network of more than 80 associations of people living with HIV. ReCAP+ worked with several key stakeholders including its member CSOs, health facilities, regional funds for health promotion, NACC, and the various levels of MOH to identify the indicators, the data management and validation process, as well as the dashboard that is utilized for disseminating the results obtained and conduct advocacy. The ReCAP+ network received a cascading training from Global Fund consultants for the use of CLM in the data driven advocacy. Following that training, the partner has been intensifying their advocacy campaigns at site level, district, regional and central level.

Following PEPFAR guidance, the PEPFAR program will broaden the scope of the CLM program in COP 22 with the coverage of additional populations such as the key populations and the youth living with HIV. The CLM will also be expanded towards the monitoring of the quality of HIV services by the community organizations.

The CLM for the general population will continue to be implemented in its current geographical footprints through the network of associations of PLHIV with the objective of strengthening the organizational development and systems of CSOs for the provision of evidence-based advocacy. While the monitoring of implementation of the user fees elimination policy will still remain at the heart of the CLM program as a key strategy to achieve epidemic control, the CLM program will be expanded towards the monitoring of indicators related to the access, utilization and quality of HIV services as well as the implementation of the user fees elimination policy at PEPFAR and non-PEPFAR supported sites. The process for defining the indicators to be monitored will include a wide consultation of the civil society organizations beyond the current network of PLHIV associations. This same consultation will also be utilized for the optimization of the data collection, validation and usage process, as well as for the revision of the current model to allow for the improvement of the incentives of the site monitors. The PEPFAR program will continue to empower the CSOs involved in the CLM mechanism with organizational development and the building of robust systems for data driven advocacy that could be transposed to the monitoring of other communicable and noncommunicable diseases as well as program areas such as Universal Health Coverage.

The KP-led CLM will be implemented through the US Embassy smalls grants program with the objective of developing a shared understanding of the enablers and barriers for KPs access to regular HIV services including HIV prevention, testing, linkage, treatment retention, VL, social and legal services. Following the PEPFAR CLM principles, the KP-led CLM program will be addressing the KP needs in a productive, collaborative, respectful, and solutions-oriented manner. This program will be implemented through a network or networks of KP associations whose membership include all the KP subcategories (MSM, FSW, PWID, TG, and persons in enclosed settings) and that is able to cover all the sites selected for the implementation of this program. The geographic scope of the KP-led CLM will be aligned with the current footprints of the PEPFAR KP program in the cities of Bamenda, Bafoussam, Bertoua, Douala, Yaounde, Kribi, Ngaoundere, Buea, Limbe, Dschang and Foumbot. The program design and indicators will be led by the implementing KP-partner with the participation of all the relevant constituencies including the Global Fund implementing partners, the Government and the multilateral and bilateral agencies and partners intervening in KP programing. These indicators will cover mainly the KP services provided to the KPs at the facility and the community settings (CBOs, hot spots, drop-in-centers, and health facilities). The services to be monitored include but are not limited to HIV testing and linkage, antiretroviral treatment, and viral load services, differentiated models of services, medicated assisted treatments for KPs, STIs prevention and treatment, mental health, and gender affirmative hormone therapy, as well as stigma and discrimination, cost barriers, referral to health/legal/social services, and end user satisfaction.

Following the COP 22 directives, the PEPFAR program will also implement the Youth-led CLM program. This program will be implemented by a network of associations of AYLHIV. This organization will serve as a subrecipient of the general population CLM implementing partner and will be responsible for the monitoring of the accessibility, utilization and quality of adolescents and

youth friendly services. This program will also monitor the involvement of the adolescents and youth in the design, implementation, and monitoring of HIV strategies and policies. This Youth-led CLM will be implemented in 50-80 sites across the four PEPFAR zones for an average of 12-20 sites per zone. The selected sites will be a representative sample of sites that implement pediatric and adolescents HIV care and treatment services in urban and rural settings, public, private and faith-based settings, as well as local and national hospitals. monthly feedback will be provided to the health facilities as well as quarterly feedback to MOH, PEPFAR and other donors involved in the HIV services. This result dissemination will be coupled with data-driven advocacy, even though standalone advocacy will be implemented outside of the meetings.

In addition to these interventions, the PEPFAR program will work alongside other donors to reinforce the CLM institutional framework at all levels of the health pyramid (national, regional and district level), in alignment with the Community Health Strategic Plan. This will include the building of a CSO-LED coalition on CLM at national level. PEPFAR will collaborate with other donors to assess and build the capacity of local partners to assess and build institutional and technical capacity of CSOs. In this line, the PEPFAR program will explore the possibility of tapping into Global Fund TA funds for additional capacity development or targeted CLM TA through one of the CLM TA providers working with UNAIDS. Some support could include reviewing and finalizing dashboards, guidance, and other useful tools or manuals being developed. A review of potential COI within the proposed structure may be a helpful activity as well. PEPFAR will also see in the CLM an opportunity to work with civil society organizations in the development of a “People's COP” utilizing CLM data. This could help tie in PEPFAR as one of the recipients of evidence-based advocacy efforts, strengthening the feedback loops across stakeholders.

4.6 Commodities

Since COP20, the Cameroon supply chain has made significant progress to support the availability of commodities at all levels of the system including central, regional and health facilities. PEPFAR investments have helped to improve national supply planning, inventory data visibility at central and regional levels, and last mile delivery of commodities. The key challenge to commodity security is the existence of national stock tensions and funding gaps. Stretched government budgets have been strained further by the impacts of COVID-19 and prevented the government from meeting key commodity funding commitments, while at the same time some laboratory commodities needed to meet PEPFAR program targets have been diverted for COVID-19 testing.

The COVID-19 outbreak also delayed the deliveries of Global fund shipments of TLE in COP20, which led to an increased transition for patients on TLE-based regimens to TLD-based regimens. Accordingly, the percentage of patients on TLD increased to 85% in FY21Q3 and surpassed national targets of 75% which put additional strain on TLD commodities. To mitigate stock tension, NACC issued a circular in September 2021, recommending the reduction in the MMD and initiation of all new adults’ patients on TLE. By FY21Q1 the percentage of patients receiving MMD had risen to 59%, but since has fallen to 36% in FY22Q1. Similarly, the percentage of patients on TLD decreased from 85% in FY21Q3 to 77% in FY22Q1. As soon as the availability of ARVs is guaranteed, PEPFAR will advocate for the cancellation of this circular.

The PEPFAR Cameroon program has further experienced stock tension of rapid diagnostic tests which has impacted the ability to find new HIV cases leading to suboptimal achievements in the 1st 95 targets. The arrival of COP21 Global Fund shipments will alleviate RTK stock tensions. EID/VL labs have been under stocked for multiple months as some laboratory commodities have been diverted for COVID-19 testing. In 2017 PEPFAR collaborated with GRC, Global Fund and other partners to lead the effort on conventional and POC EID and VL platform mapping and instrument capacity utilization which is being used to identify appropriate networks for platform integration based on geographical location, type of platforms and volume of tests required. This collaboration continues to be strengthened over the years and as a result, the country now benefits from a significant reduction in the cost of VL test kits from $56 to $16 including equipment maintenance applicable to GRC, Global Fund, all other stakeholders in country and negotiations are ongoing for further reductions. PEPFAR Cameroon will continue to coordinate with Global Fund, GRC, and other partners to define efficient strategies to monitor and address supply chain challenges such as harmonizing the cost of EID and VL testing commodities and improving quantification systems to prevent frequent stock outs and ensure systems in place for DNO. Cameroon has experiences stock tension impacting programs across the spectrum of HIV care, and filling commodities gaps will be a key element to achieving epidemic control.

In COP21, PEPFAR trained USG agencies and Government counterparts on the use of the Quantification Analytics Tool (QAT) to increase visibility on supply planning data and facilitate consensus building across needs. In COP22, PEPFAR will further support the transition of the forecasting exercise from the currently used CHAI tool to QAT to improve forecast accuracy and streamline the development of procurement plans.

The total quantification of national needs for COP22 across PEPFAR-supported commodity categories is $41,972,404 excluding freight and insurance costs, or $52,885,229 including all costs. After accounting for donors (Global Fund and UNICEF) and government commitments, the remaining projected gap of unfunded need is $3,329,486. PEPFAR will close this gap and support agreed upon program targets with a contribution of $3,503,188 plus an additional $500,000 for male and female condoms. The quantification of needs and the funding gap presumes fulfillment of a GRC commitment to procure $8,232,270 of ARVs in 2023. Given historical difficulties for GRC to meet its ARV funding commitments, PEPFAR will work closely with The Global Fund to advocate through to the country grant management coordination unit for the fulfillment of GRC commitment.

The COVID-19 pandemic has caused extreme shortages of shipping containers and constrained the labor force, which has both driven up freight costs and caused some transporters to limit or cancel shipping routes to Africa. The result has been greater competition in the marketplace and rising freight costs. PEPFAR utilized recent pricing estimates for freight costs in the COP22 planning cycle.

A secondary result of limited shipping lanes and labor has been to severely constrain the production and movement of active pharmaceutical ingredients necessary for the manufacture of HIV commodities, leading to increased lead times from order placement to delivery. PEPFAR will request access of OU pipeline funds to place COP22 orders before the release of COP22 funding to ensure reception of shipments of key commodities by December 2022, to anticipate potential

long lead time due to the COVID-19 pandemic. PEPFAR through its implementing agencies will subcontract with the Center for Supply of Essential Drugs and Medical Consumables (CENAME) and the Regional Funds for Health Promotion (RFHP) for storage of PEPFAR-procured commodities.

In COP20, PEPFAR leveraged private sector services subcontracted through USAID/GHSC-PSM to conduct last mile deliveries for PEPFAR-procured and Global Fund-procured commodities. This strategy helped to mitigate the effects of COVID-19 on delivery timelines, as evidenced through the improvement of LMD indicators from the beginning of COP21. To uphold SGAC and USAID goals for transition to local partners, USAID will implement and execute a FAA (Fix Amount Award) with one local parastatal provider for LMD activities. Lessons learned from this bilateral partnership will inform further transitions.

For cold chain and ambient laboratory commodities, PEPFAR supported the last mile delivery to reference laboratories through GHSC-PSM, in addition to support provided to NACC for distribution planning. USAID has finalized a bilateral contract with a local partner to distribute laboratory commodities from the central level to Reference Laboratories. Transition planning is underway. This support will continue in COP22. In COP22, Last Mile Delivery will be conducted by a combination of local private sector and parastatal providers.

To improve order submission rate and order on-time submission, PEPFAR supported the country's effort to develop an online ordering tool for HIV commodities, which can be used at both PEPFAR-supported and non-PEPFAR-supported sites to streamline the order collection and validation process. This is an interim solution owned and managed by NACC staff while waiting for the finalization of the Electronic Logistics Management Information System (eLMIS). PEPFAR supported the use of the tool in Littoral and Centre Regions in COP21 and will support the extension of the tool in all the Regions of the country in COP22. PEPFAR will also continue supporting the improvement of visibility on laboratories commodities stock status and consumption data through DHIS-2 and any other tool validated by the country.

At site level, PEPFAR through CDC implementing partners supported health facilities to elaborate and submit monthly orders and reports. In COP22, PEPFAR will support Supply Chain Data Quality Assessments in all PEPFAR Zones, providing refresher training for site-level staff and strengthening coordination between clinical and pharmacy activities. In COP22, CDC will strengthen reporting of health facility-level commodities. Increased quality of site-level reporting will allow PEPFAR programs to respond quickly to commodities issues.

In COP22 agencies within PEPFAR will improve coordination and data sharing to ensure gaps may be addressed by the full team at all levels of the supply chain. It is important that partners at the national and regional level know commodities levels within the health facilities to better facilitate quantification, and likewise it is important for site-level partners to know the availability of commodities at the national and regional level to inform their monthly commodities requests. An interagency group will meet monthly to share supply chain updates and discuss issues as they may arise.

PEPFAR continues to pursue transparent, all-inclusive global pricing for viral load commodities. All-inclusive pricing has already been negotiated and shown positive results regarding

consistency and service levels in Nigeria, Zambia, Uganda, Kenya, Mozambique, and Tanzania. PEPFAR will continue work to expand pricing access to all PEPFAR-supported countries including Cameroon.

All supply chain support activities for FY23 will be aligned with the National Supply Chain Strategic Plan. PEPFAR will support the development of a yearly supply chain operational plan in coordination with other donors including the PMI, Global Fund, UNFPA, UNICEF. Key priorities will be integrated in the annual work plan of supply chain IPs.

MOH has created a National Condoms Technical Working Group (TWG) that is chaired by NACC Permanent secretary to improve the stakeholder coordination, ensure the regular supply of condoms, and enhance innovative condom-related communication strategies. Participants in this meeting include Government and private sector stakeholders involved in the supply chain management of condoms at national and regional level. During the different sessions, participants share condom distribution data, stock on hand, and expected supplies. Activities from this TWG successfully achieved no condoms shortage in 2021. This TWG also served as a meeting point to ensure condom availability during key national events such as the 20222 African Cup of Nations, World AIDS Day and the launching of new types of condoms. In COP22, PEPFAR will continue to contribute to this working group, PEPFAR will also participate in the national quantification of condoms and support the development of supply plans for condoms to ensure that all donors' contributions are captured, and any eventual shortage is anticipated and mitigated.

4.7 Collaboration, Integration and Monitoring

In COP22, PEPFAR Cameroon will improve collaboration and leverage technical strengths and competencies across all agencies to ensure efficiencies in addressing gaps identified in COP20/21 and development of COP22 to meet the program goals of achieving epidemic control by sex and across different age groups and populations by Sept 2023. To address these gaps, the team through a collaborative effort, will build on their technical strengths and expertise to guide implementation of innovative strategies for achieving epidemic control among children, OVC, AGYW, KP, adolescents, adult women, and men in all four zones across the national territory. Agencies will continue to collaborate with MOH in conducting GSM/SIMS/DQA/SQA to drive CQI activities at site and above site levels for overall improvement of program performance and the quality of patient-centered services across the clinical cascade. Regular supportive site and above site visits including CoAg teams will be conducted to strengthen IP management for accountability and impact. Weekly IP data review meetings, program area specific review calls with IPs and HQ Subject Matter Experts (SMEs), Quarterly Mini-POART will be done to monitor progress made and ensure that implementation of strategies across the cascade is done with fidelity and at scale. PEPFAR Cameroon agencies will improve collaboration with and support CSOs to implement Community-Led Monitoring and other community outreach programs to ensure the provision of quality patient-centered HIV/TB services and provide feedback for improvement. PEPFAR Cameroon agencies will collaborate in implementing a single model of self-testing as an innovative strategy for finding men, HIV recency testing to strengthen HIV disease surveillance efforts to enable prioritization of prevention and case finding efforts and will also leverage on this collaborative effort and their different clinical, pharmaceutical and supply chain expertise to support the GRC to complete the TLD transition process which started during

COP19 implementation. PEPFAR Cameroon agencies will continue to advocate at the level of MOH for policy change on PrEP to include AGYW and will scale up PrEP implementation for key populations, including priority populations and sero-discordant couples.

To address specific gaps identified in COP20/COP21, PEPFAR Cameroon's key interventions in COP22 towards achieving epidemic control in all four zones across the ten regions of the country will focus on knowing who to target, where and how to find PLHIV, finding those we are missing (men, children, young adults and adolescents), reinforcing efforts to identify the drivers of the epidemic and improving on strategies to link positives to rapid ART initiation, retain patients on ART treatment, improve viral load coverage and keep them virally suppressed. To ensure success and sustainability, PEPFAR Cameroon will continue to leverage and strengthen existing collaboration with the GRC, CSOs and other key stakeholders such as Global Fund, UNAIDS, Unitaid, GIZ and UNICEF. In COP22, PEPFAR Cameroon will continue to fund UNAIDS to support the GRC in coordinating efforts towards ensuring the availability of HIV data at district, regional and national levels for decision making and fund UNICEFUNICEF to organize the PMTCT Workshop.

PEPFAR Cameroon has intensified partner management by investing in innovative CQI approaches like the weekly virtual GSM in the context of COVID-19 to ensure staff safety while continuing to provide TA to sustain the gains of the program and ensure improved performance and quality of services during the period when community transmission was high and, in a context, where the uptake of vaccination is low. In addition to this, PEPFAR Cameroon plans to conduct targeted integrated GSM/SIMS site visits based on site performance followed by feedback using the remediation tracker and the implementation of the remediation tracker to drive CQI activities at site level and will continue to implement these activities to improve efficiencies in partner/site performance in COP22. PEPFAR Cameroon agencies will carry out Non-Service Delivery activities at sites namely trainings, TA, and Mentoring of Site Level Staff.

For COP22 PEPFAR Cameroon agencies will continue to conduct routine DQA and corrective actions by agency and by IP at site and community level, trainings on the most recent version of PEPFAR's Monitoring, Evaluation and Reporting (MER) guidance and indicators.

The PEPFAR Cameroon program conducts quarterly mini-POART with the IPs to review data for oversight, accountability, performance, and corrective actions for overall improvements in program quality and performance. Additionally, annual microplanning meetings are held to review partner work plans to ensure that COP strategies are accurately captured with activities that are appropriately aligned with allocated budget and PEPFAR objectives. The program also plans to implement peer review meetings which will serve as a CQI collaborative forum where the different sites/zones meet to share their CQI experience, discuss their challenges and share best practices for replication.

The Minister of Health signed a service note on March 2, 2020, on activation of the EOC and implementation of the Cameroon surge activities in COP19 in collaboration with MOH-NACC, DGHP and the implementing partners to accelerate progress towards epidemic control by Sept 2021. Surge tools and systems put in place at the facility level will be used to fast-track activities in COP22 to achieve and sustain epidemic control in 2023

A TWG within the PEPFAR inter-agency will be instituted concerning KP activities, and meetings held at least every month to discuss site implementation, structural barriers, and areas of improvement. In addition, monthly meetings will be conducted between PEPFAR community and clinical IPs to share Facility ART UIC and community UIC of clients reached to avoid double counting when reporting in DATIM. Ongoing collaboration between PEPFAR KP community partners and the Global Fund community Principal Recipient (CAMNAFAW) will continue with each partner leveraging another's resources, ad hoc and monthly meetings held at central and regional levels.

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

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

4.8 Targets by population

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	468,155	403,864	-	391,512	40,008	83.6%
Scale-Up Aggressive	1,032	-	-	-	-	-
Sustained	-	-	-	-	-	-
Central Support	18,925	-	-	-	-	-
Not PEPFAR Supported	6,364	-	-	-	-	-
Commodities (if not included in previous categories)	-	-	-	-	-	-
Total	**494,476**	**403,864**	**-**	**391,512**	**40,008**	**83.6%**

Table 4.8.2 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	**Population Size Estimate***	**Disease Burden***	**FY23 Target**
PP_PREV	**-**	**-**	**32,433**
AGYW	**-**	**-**	**14,049**
ABYM	**-**	**-**	**3,281**
CFSW	**-**	**-**	**7,785**
Other Priority Populations	**-**	**-**	**7,318**
KP_PREV	**-**	**-**	**96,786**
FSW	**-**	**-**	**42,246**
MSM	**-**	**-**	**40,709**
People in prisons and other enclosed settings	**-**	**-**	**10,001**
PWID	**-**	**-**	**3,383**
TG	**-**	**-**	**447**
TOTAL	**-**	**-**	**129,219**

Table 4.8.4 Targets for OVC and Linkages to HIV Services						
Zone	**Region**	**Estimated # of OVC**	**Target # of active OVC (FY23) OVC_SERV Comprehensive**	**Target # of OVC (FY23) OVC_SERV Preventive**	**Target # of active OVC (FY23Target) OVC_SERV DREAMS**	**Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23)**
Zone 1	Nord Ouest	-	5,014	-	-	3,481
	Ouest	-	5,018	-	-	3,645
	Sud Ouest	-	2,653	-	-	1,606
Zone 2	Littoral	-	14,597	200	-	10,086
	Sud	-	861	300	-	621
Zone 3	Centre	-	21,921	300	-	14,933
	Est	-	4,292	100	-	2,855
Zone 4	Adamaoua	-	2,825	-	-	1,701
	Extreme Nord	-	3,171	-	-	2.064
	Nord	-	2,760	-	-	1,791
Total		**-**	63,112	**900**	**-**	42,783

4.9 Cervical Cancer Program Plans

N/A for Cameroon

4.10 Viral Load and Early Infant Diagnosis Optimization

To ensure the availability of efficient and impactful best practices to close remaining gaps in low VL testing coverage among PBFW, non-suppressed population, low VL testing coverage and suppression among infants, children, adolescents, and low EID at two months, describe how innovative strategies to include: 1) all-inclusive pricing, 2) complementary use of POC and centralized instruments, 3) TB/HIV diagnostic integration, 4) multiplexing, and 5) use of data systems to include SMS to alert patients of the availability of their test results, will fit into the country's national DNO.

At the end of 2021 a total of 31,868 children and adolescents were on ART, and the national ART coverage was as follows; 48.3 % for children age <10 years, 54.3%for children aged <15 years, 50.1% in adolescents aged 15-19 years and 61% in young adults aged 20-24 years however, identification and management of HIV infection among this population remains weak, often compounded by other challenges such as frequent stock out of ARVs, ART related-commodities and prolonged turnaround times for return of DNA/RNA PCR results to caregiver of over 30-60 days, well above the WHO recommended standard of a maximum of 5 days. In FY21, viral suppression among pregnant women in the PEPFAR-supported sites was low at 88.5 compared to the adult population

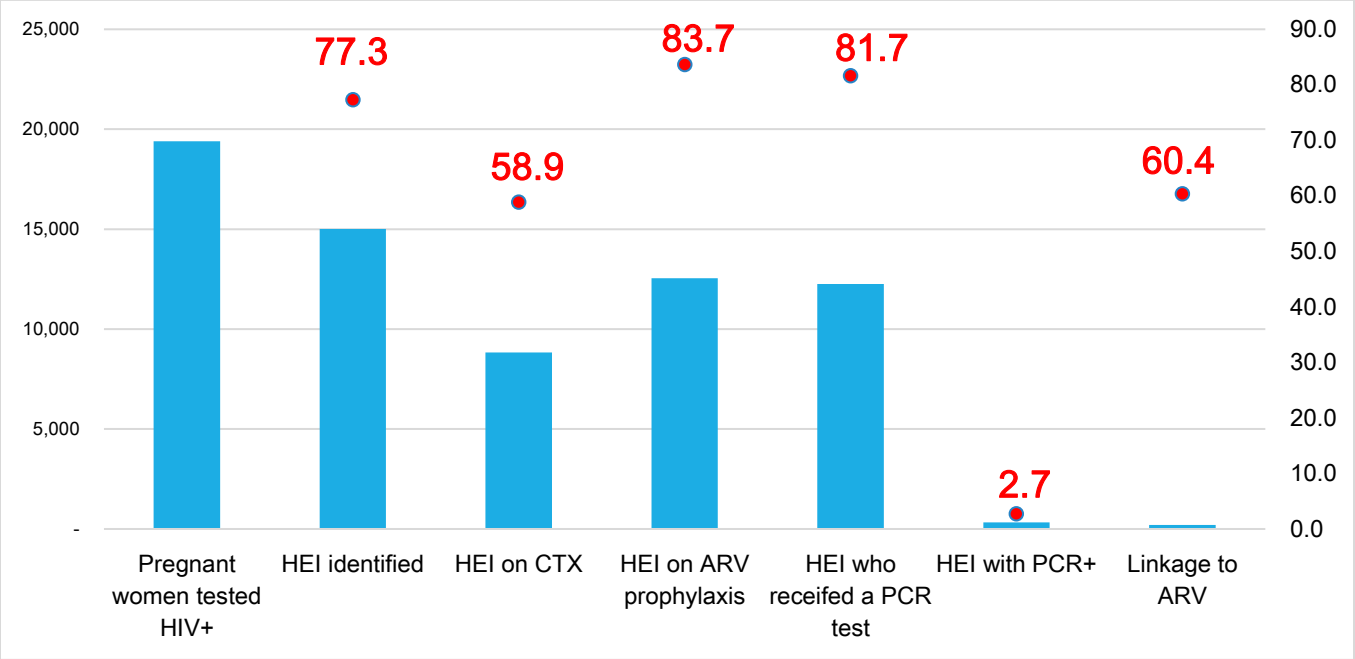
however, there was a slight increase along the quarters from 88% to 90%. VL coverage for PBFW was suboptimal (46%) Frequent stock out of VL reagents and samples backlog in the Reference Labs, Low hospital attendance due to fear of contracting COVID-19. Supply chain challenges associated with border closures and global flight restrictions further led to reagent stock outs and sample backlogs. The repurposing of instruments and staff originally procured for HIV (VL/EID) and TB testing to support COVID-19 has also impacted the program. VL sample collection supplies, long distances, high transport cost for clients to come to the facility, poor patient tracking systems, pick up of ARVs by other family members, displaced clients, are key challenges contributing to this gap, resulting in missed opportunities to offer quality PMTCT/EID and VL monitoring services as well as low retention on ART for pregnant and breastfeeding women (especially for breastfeeding women who have interrupted treatment post-partum). Although user fees elimination for HIV services which started in January 2020 following the Ministerial circular of April 2019 has led to improved demand creation, service uptake and scale up of VL for HIV positive PBFW, children, and adolescents, there are still some challenges as mentioned above to be addressed.

Cameroon has a high burden of TB/HIV co-infection and TB remains the leading cause of infectious disease morbidity and mortality for PLHIV (National TB Control Program, 2017). The 2018-2022 National Strategic Plan midterm review from NACC indicates an ART active file of 386,345 at the end of December 2021, 2019, among whom were 10,903 children aged <15 years and 330187 aged >15 years. The National TB Control program's 2020 report indicated that of the 22,540 TB cases diagnosed in the country, 92% (20,737) knew their HIV status with a TB/HIV co-infection rate of 24% (5,410/22,540) among whom 98% (5,301) were on ART. Achieving 100% TB screening remains a challenge because of clients who don't come in-person at the facility but send relatives to pick up their medication. TB diagnosis remains a challenge, due in part to a lack of well-established and appropriate sample referral and transport systems, easy access to efficient diagnostic capacity and inadequate infrastructure to support quality processes in TB diagnosis. Some facilities resort to referring patients to other sites for testing, resulting in patients being lost along the TB/HIV testing cascade. There is also the need to strengthen systems in place for the follow-up of presumptive TB cases through the TB evaluation cascade to determine and document outcome.

In FY16, Cameroon initiated a decentralized phased approach for introducing and integrating near-POC and POC testing to improve efficiencies in EID for HEI and VL testing for HIV positive PBFW and CALHIV into HIV and/or TB laboratory-clinical facility network. These POCs include the two WHO prequalified platforms for decentralized HIV infant testing and VL testing: the m-PIMA POC (previously Alere q) and the GeneXpert near POC, which were introduced in country by Clinton Health Access Initiative, EGPAF, and United Nations Children's Fund in a UNITAID-supported project. Initial introduction was in a few reference, regional, and district hospitals, but has since been expanded to support 162 sites across all 10 regions and the number of platforms has also increased from 8 in 2017 to about 109 in 2021 and include 25 m-PIMAs and 60 GeneXperts. The use of POC platforms under the UNITAID project improved turnaround time for return of results which reduced from >30days to same day (within 2hours). However, this quickly changed when the project came to an end in 2017 until 2020 when additional platforms were procured under the Islamic bank funded UNICEF project. More children living with HIV can be quickly identified and immediately put on treatment by clinicians.

EID POC testing faced some challenges with stock outs of cartridges because the UNITAID-supported project was completed in July 2019. However, in 2020, UNICEF received some POC devices and cartridges which have boosted both EID and VL uptake although issues of coordination and mapping of these platforms to health facilities remains inefficient impacting overall coverage numbers. POC testing has proven to be an impactful intervention to achieve the first and third 95 for HEIs and the 2019 NACC national annual report indicates as shown below that, in 2021 8,684 HEIs were documented born of HIV positive pregnant women, of these HEIs were given nevirapine for prophylaxis given a coverage rate of 76.8% (6,673/8,684) were tested for HIV amongst which 180 (2.7%) of them tested HIV positive and 75% (135/180) were initiated on ART.

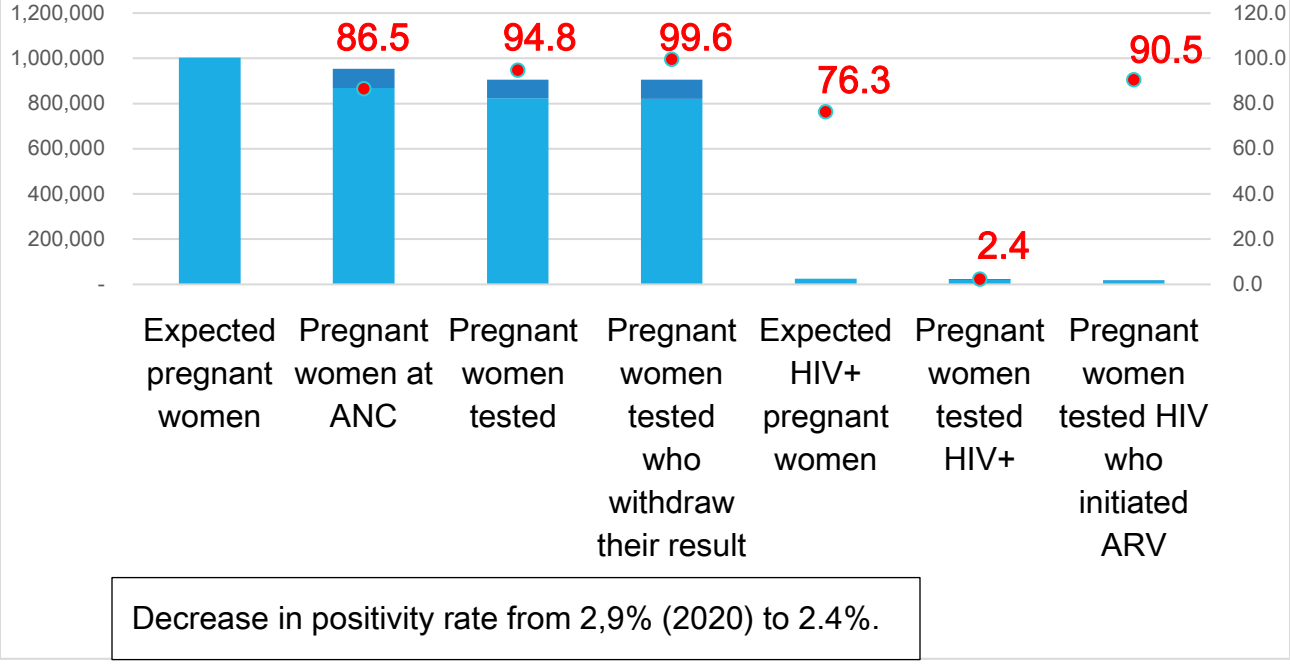
Figure 4.10.1: HIV cascade among HIV exposed infant in Cameroon, FY21



Improvement on HEI identification compared to 2020 (77.3 vs 67.8%)

The program experienced a decrease in ARV prophylaxis coverage from 87.2% (2020) to 83.7% in 2021. A significant drop in DNA PCR coverage between 2020 (97.5%) to 2021 (81.7%). Linkage to ART treatment among HEI tested HIV+ was stable between 2020 and 2021 (62.5% and 60.4%) respectively. Also shown below is the PMTCT and EID cascades for 2021 presented by NACC during the COP22 planning meeting in April 2021.

Figure 4.10.2: HIV cascade among pregnant women in Cameroon, FY21



As a country, we noticed an overall improvement in 2021 compared to 2020; the ANC attendance was HIV testing and ART coverage Among the pregnant women identified HIV+, were already and of pregnant women were retested in CPN or in the delivery room.

Of the 109 POC platforms distributed across the 10 regions, only about a third of these platforms are currently being used for integrated TB/HIV (EID) testing.

In COP22, PEPFAR Cameroon will leverage existing conventional and POC platforms for VL, EID and TB to strategically scale up and expand POC VL testing for PBFW in hard-to-reach sites and populations in all PEPFAR-supported zones. UNICEF has placed 40 POC machines especially in the North, West, South and East regions, and the PEPFAR program is leveraging on these platforms. This will ensure availability of commodities, efficient and impactful use of POC instruments to support VL testing among PBFW and EID testing for HEIs. As part of the strategy to enhance TB/HIV integration and optimization of both conventional and POC instrument capacities, PEPFAR Cameroon will invest in strengthening coordination of the network of health facilities around existing point of care hubs to optimize use and enhance uptake of EID and POC VL for PBFW. In 2021. PEPFAR collaborated with GRC, Global Fund and other partners to lead the effort on conventional and POC EID and VL platform mapping and instrument capacity utilization which is being used to identify appropriate networks for platform integration based on geographical location, type of platforms and volume of tests required. This mapping will be reviewed in FY 22 and 23 for optimal integration of programs, gain efficiencies and cost savings. PEPFAR Cameroon will continue to coordinate with Global Fund, GRC, and other partners to define efficient strategies to monitor and address supply chain challenges such as harmonizing the cost of EID and VL testing commodities and improving quantification systems to prevent frequent stock outs and ensure systems in place for DNO, this collaboration continues to be strengthened over the years to include all other stakeholders in country and benefit from the advantage of bulk procurement and other advantages.

PEPFAR Cameroon will continue to work with GRC to strengthen implementation of MOH directives on the elimination of user fees for HIV services (e.g., VL testing) and against unauthorized ANC service fees and other malpractices which serve as a barrier to accessing other care and treatment services. PEPFAR Cameroon will scale up strategies to take these services to meet clients in the community who can't come to the facility to scale up service uptake and improve person-centered services. PEPFAR Cameroon will leverage on existing POC platforms from the UNITAID project and the recent additions from the Islamic Bank sponsored UNICEF project and will support efforts to strengthen sample transportation within the network of facilities to continue to improve access to EID and POC VL for PBFW and CALHIV. In the same light, PEPFAR Cameroon will collaborate with and leverage Global Fund-funded TB program to facilitate network optimization of polyvalent platforms at all levels using existing and new platforms. PEPFAR will also provide TA to encourage coordination of platform mapping and continuous networking through the existing EID and VL technical working group.

As the COVID-19 situation improves, PEPFAR Cameroon will work with the MOH and other stakeholders to ensure routine and uninterrupted VL, EID and TB testing. In doing this, COVID-19 mitigation options will be deployed within the facilities that allow for social distancing. These include reduction in waiting times for sample collection, avoiding crowded waiting rooms, scheduling, and staggering appointments, streamlining clinic flow so that patients for sample collection do not interact with multiple clinic providers, and reactivating safe sample transport systems. These will be implemented to ensure improved sample collection and testing. More use of DBS for sample collection outside of the facilities to avoid many patients coming to the facility for sample collection will be encouraged. The use of point of care platforms in the interim to test and deliver quick results to avoid patient or sample movement will be considered as well.

To avoid supply chain issues, orders for laboratory test kits and consumables will be placed at least one month earlier than baseline to account for potential shipping delays. There will be routine review and update of stock levels at national and subnational levels and forecast for additional consumable needs. PEPFAR Cameroon will provide technical support to MOH and develop standard operating procedures (SOPs) to ensure laboratories running COVID-19 and HIV-related tests on the same instrument provide testing concomitantly. Issues to be considered and agreed upon will include consumable use, sample transport, data systems, space and time allocation, and HRH.

Projected new sites or geographic areas in FY22 for EID and VL among PBFW only and funds allocated in the FAST; (including commodity procurement, trainings, or TA etc.)

PEPFAR will leverage on existing platforms to expand POC EID and VL for PBFW in hard-to-reach regions within Zone 4 (Northern Zone) as well as well as conflict-affected regions within Zone 1 (Western Zone). Although the unmet need within Zone 4 (Northern Zone) is significantly lower than within Zones 1 (Western), 2 (Southern) and 3 (Eastern), HEIs and PBFW remain a vulnerable population in these regions, added to the challenges with access to facilities and sample transport. PEPFAR funding has been allocated in the FAST to support External Quality Assessment for the different assays and testers, trainings required to support near POC implementation, strengthening sample transport, and TA to support waste management especially for the GeneXpert platforms. PEPFAR funds will also support implementation of CQI which has been successfully implemented in Cameroon and will be used to enhance POC EID and POC VL for PBFW uptake through improved

sample collection and reduced turnaround time for getting results back to patients. CQI will focus on EID and linkage of HIV positive infants to ART treatment services, VL testing for PBFW and CALHIV, and increasing ANC attendance for pregnant women through mobile ANC, active finding of PW/HEIs in the community and linking them to ANC/EID services at the facility

Review of Diagnostic Network Optimization (DNO) Activity
The minimum requirements for diagnostic network optimization should not be a one-time activity but diagnostic networks should be continuously monitored using a stakeholder approach and improved as needed.

Lessons learnt from the response of PEPFAR-supported countries to SARS-CoV-2 demonstrates the feasibility of diagnostic network integration and provides an example to build upon for future integration. Lessons learned from cross-disease resource sharing between TB, HIV and COVID-19 will inform decisions for optimal integration and patient-centered service delivery models in the future.

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

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

The systems barriers were taken from the mechanisms in Table 6 that started either in COP19, COP20, COP22 and ended in COP22. This means priority is given to the mechanism activities that are scheduled to terminate in COP22 so they can be evaluated. Those that are scheduled to end post COP22 are not included. The next factor to be considered was the level of achievement of the benchmark. Activities that attained more than 50% of the benchmark were considered. In addition, the feasibility of addressing the barrier is also considered. The sustainability of the mechanism was also considered using the SID score. The frequency of the barrier was also considered.

The system gaps identified through SID include suboptimal availability of electronic registers and data systems, insufficient HRH, suboptimal technical capacity in some areas. Table 6 investments are on epidemiological and health data, policies and governance, laboratory, and service delivery. In terms of epidemiological and health data, Table 6 investments will help in improving Strategic Information. SI is critical in determining the effect of health systems strengthening interventions on service delivery targets and overall system goals. Updating regional and district HIV estimates will provide an accurate picture of Cameroon's progress toward HIV Epidemic control. Health information systems (HIS) such as DAMA, EMR, and DHIS2 are critical to program monitoring and performance improvement planning. Despite progress made, there is still a need for high-level involvement, coordination and utilization of data generated by different stakeholders. During data review meetings, the SIMS, MER, DHIS2 and other data sources have revealed discrepancies that need to be addressed. PEPFAR Cameroon is working with NACC under an

existing cooperative agreement with CDC to reinforce MOH's HIS by developing and strengthening SI system tools, establishing systems, and intensifying coordination, mentorship, and supervision to ensure implementation and quality service delivery in accordance with national guidelines and policies. PEPFAR Cameroon is also working with the government around issues of data governance, confidentiality, access, and use. PEPFAR Cameroon will also organize national conferences to share best practices, challenges and lessons learnt to come up with recommendations to be adopted nationally. Through NACC, PEPFAR will continue to support GRC in training, coordination, and harmonization of data to ensure the scale up of new prevention, treatment, and care strategies.

The timelines, benchmarks and outcomes take into account an update of the activities and the previous benchmarks. PEPFAR Cameroon has made significant progress towards addressing some of the systems barriers identified, but PEPFAR reporting system (DATIM) and MOH reporting systems (DAMA, DHIS2, EMR) show that there are still challenges particularly with the collection and use of data, standards, and governance. In COP22, PEPFAR Cameroon will continue to make critical systems investment to close gaps and support activities to meet the well-defined benchmarks. Each benchmark will be monitored over a set timeline with measurement and outcome indicators clearly defined; however, progress made will be reported during the quarterly POART calls. PEPFAR will support the GRC to conduct DQA and/or service quality assessments at both regional and district levels with the involvement of high-level MOH staff. The policies, tools, SOPs, and guidelines developed will also be used to monitor progress made. The impact of these activities will lead to better-harmonized data with fewer discrepancies and optimal program implementation.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

The PEPFAR Cameroon team maintains a vacancy in the PEPFAR Country Coordinator position and is exploring options to fill the requirements of this position until a permanent direct hire is found. In summary, DOD and Peace Corps maintain their staffing needs from COP21; USAID will be adding an additional three staff members pending the Chief of Mission's approval; CDC is currently looking to fill five vacancies. Specific details on staffing and cost of doing business in the interagency is detailed below:

CDC

CDC continues to experience insufficient staffing and heavy workload since the clinical program expansion in COP19 from four to ten regions without a commensurate increase in staffing. As a result of the staffing gaps, CDC continues to stretch its staffing footprint to ensure quality service delivery, conduct oversight and monitoring, and meet program goals. Two technical LES positions funded in COP21 are currently in the classification process and CDC is repurposing the previously PEPFAR-funded GHSA position to support staffing for PEPFAR program in COP22. These actions will partially address the current gaps in staffing needs for increased oversight and monitoring of partners in the ten regions of Cameroon. Staff will meet SIMS requirements by combining partner management site visits and SIMS to optimize staff time on the field especially for hard-to-reach zones due to long distances and/or insecurity.

CDC will see an increase in the Cost of Doing Business (CODB) as it has been directed to relocate from current office location by March 2023 because of Cameroon's designation as a High Threat High Risk post. This move requires a major increase in budget of about $6M for one-time reconstruction, $700K recurring cost of Capital Security Cost Share (CSCS), and $50K one-time transportation cost.

DOD

DOD program will maintain its footprint in the ten regions and in 21 sites from COP21 to COP22. The staffing will remain the same as COP21 levels, that is two LES.

Peace Corps

Peace Corps staffing will remain the same as COP22 levels, that is three LES. CODB allocated for COP22 will cover volunteer return to country in September 2022 (Q4 FY22). However, with an expected growth in volunteer numbers and activities over the next few years, CODB allocation is expected to change accordingly with the progressive growth in volunteer numbers and activities over time.

State

The PEPFAR Coordination Office under the Department of State currently maintains a vacancy for the PEPFAR Coordinator, with the hiring process ongoing. The office maintains two LES positions: one Global Fund Liaison and one Strategic Information Advisor. CODB remains the same as COP21.

USAID

USAID's overall staffing budget has increased 19%, due to the approval of three additional FSN positions to support local partner transitions justified by a periodic staffing analysis. In April 2018, PEPFAR announced a goal to direct 70 percent of USAID/PEPFAR funds to local partners through direct prime awards 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. Cameroon received approval to add three new local employee positions in COP22 as part of this agreement: a program management specialist (technical), a local solutions specialist, and a contracting specialist. The Cameroon Health Office and the West Africa Regional Mission both provided significant technical input into the request for these specific roles. The newly arrived U.S. Ambassador to Cameroon is currently reviewing position descriptions for these roles; the Cameroon Health Office will recruit accordingly after his review. These positions will help PEPFAR Cameroon continue to transition successfully to local partners.

APPENDIX A – Prioritization

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

NU	COP	Prioritization	Results Reported	Attained 90 – 90 – 90 (81%) by Each Age and Sex Band to Reach 95 – 95 -95 (90%) Overall																								Overall TX Coverage
				Treatment Coverage by APR by Age and Sex																								
				<1		01-04		05-09		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+		
				F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	
Abong Mbang	COP19	Scale-up Saturation	APR20	60%	60%	70%	67%	62%	59%	45%	43%	42%	34%	57%	42%	90%	114%	73%	82%	65%	68%	72%	68%	100%	81%	78%	98%	75%
Abong Mbang	COP20	Scale-up Saturation	APR21	80%	80%	90%	86%	86%	82%	82%	76%	77%	74%	80%	73%	90%	114%	86%	88%	86%	84%	90%	85%	100%	91%	91%	98%	89%
Abong Mbang	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	94%	88%	95%	88%	96%	90%	97%	92%	97%	92%	95%	92%	91%
Abong Mbang	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	100%	96%	98%	92%
Akonolinga	COP18	Sustained	APR19			33%	40%	35%	29%	17%	27%	30%	13%	54%	17%	51%	26%	44%	23%	55%	44%	55%	58%	70%	63%	83%	73%	54%
Akonolinga	COP19	Scale-up Saturation	APR20	67%	50%	53%	53%	54%	50%	39%	38%	36%	33%	49%	38%	71%	92%	57%	67%	56%	62%	69%	67%	93%	78%	54%	73%	63%
Akonolinga	COP20	Scale-up Saturation	APR21	100%	75%	73%	73%	77%	75%	69%	68%	63%	64%	69%	63%	82%	92%	75%	78%	76%	77%	84%	81%	93%	87%	76%	85%	79%
Akonolinga	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	90%	88%	88%	88%	88%
Akonolinga	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	92%	95%	91%
Ambam	COP19	Scale-up Saturation	APR20	33%	25%	79%	73%	71%	63%	50%	45%	60%	42%	82%	54%	110%	130%	77%	83%	66%	67%	76%	69%	106%	82%	71%	85%	79%
Ambam	COP20	Scale-up Saturation	APR21	100%	75%	93%	87%	88%	85%	82%	82%	83%	79%	89%	80%	110%	130%	88%	89%	86%	84%	91%	87%	106%	93%	89%	94%	92%
Ambam	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Ambam	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Ayos	COP18	Sustained	APR19		33%	110%	73%	32%	60%	15%	33%	39%	21%	62%	17%	54%	39%	48%	36%	56%	48%	73%	48%	94%	55%	87%	69%	59%
Ayos	COP19	Scale-up Saturation	APR20	100%	67%	80%	73%	74%	70%	54%	52%	51%	39%	68%	50%	99%	125%	81%	92%	80%	85%	99%	94%	134%	108%	78%	101%	88%
Ayos	COP20	Scale-up Saturation	APR21	100%	67%	80%	73%	74%	70%	54%	52%	51%	39%	68%	50%	99%	125%	81%	92%	80%	85%	99%	94%	134%	108%	78%	101%	88%
Ayos	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	91%	88%	88%	88%	89%
Ayos	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	90%	90%	90%	90%	90%	90%	95%	90%	100%	96%	100%	96%	92%
Bafang	COP19	Scale-up Saturation	APR20	100%	100%	89%	89%	65%	68%	50%	54%	53%	50%	68%	60%	101%	152%	93%	129%	111%	142%	147%	167%	185%	179%	99%	150%	112%
Bafang	COP20	Scale-up Saturation	APR21	100%	100%	89%	89%	65%	68%	50%	54%	53%	50%	68%	60%	101%	152%	93%	129%	111%	142%	147%	167%	185%	179%	99%	150%	112%
Bafang	COP21	Scale-up Saturation	ARP22	200%	200%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	94%	94%	103%
Bafang	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	100%	92%	91%	100%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	96%
Bafia	COP18	Sustained	APR19			76%	61%	74%	30%	24%	32%	37%	11%	48%	11%	62%	25%	66%	38%	66%	47%	77%	63%	85%	65%	121%	85%	69%
Bafia	COP19	Scale-up Saturation	APR20	50%	50%	65%	61%	55%	52%	40%	39%	39%	33%	52%	39%	73%	95%	58%	69%	57%	62%	68%	68%	91%	78%	56%	73%	64%
Bafia	COP20	Scale-up Saturation	APR21	75%	75%	82%	78%	77%	73%	71%	68%	65%	64%	71%	64%	82%	95%	75%	79%	76%	76%	83%	81%	91%	88%	76%	85%	79%
Bafia	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	94%	88%	90%	88%	89%
Bafia	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	99%	90%	100%	100%	100%	100%	100%	100%	100%	100%	94%
Bafut	COP18	Sustained	APR19			36%	18%	50%	56%	33%	26%	17%	17%	14%	9%	23%	5%	41%	14%	43%	41%	51%	65%	57%	95%	66%	79%	44%
Bafut	COP19	Scale-up Saturation	APR20	100%	67%	55%	55%	56%	56%	42%	43%	39%	35%	48%	38%	65%	91%	54%	66%	53%	60%	65%	66%	93%	82%	70%	100%	65%
Bafut	COP20	Scale-up Saturation	APR21	100%	67%	64%	64%	67%	61%	58%	52%	54%	43%	59%	44%	72%	91%	64%	69%	64%	64%	73%	69%	93%	83%	77%	100%	71%
Bafut	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	89%
Bafut	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	97%	100%	98%	100%	92%
Bali	COP18	Sustained	APR19			50%	29%	45%	36%	20%	57%	15%	36%	26%	5%	36%	6%	51%	20%	77%	40%	79%	69%	92%	79%	132%	119%	65%
Bali	COP19	Scale-up Saturation	APR20			67%	57%	64%	64%	47%	50%	48%	43%	52%	40%	74%	106%	59%	78%	58%	72%	72%	78%	103%	97%	78%	110%	73%
Bali	COP20	Scale-up Saturation	APR21			83%	71%	73%	73%	60%	57%	63%	50%	64%	45%	79%	106%	67%	80%	67%	74%	78%	80%	103%	97%	83%	110%	78%
Bali	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	88%	88%	88%
Bali	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	98%	98%	91%
Bamenda	COP18	Sustained	APR19	13%	18%	49%	45%	93%	92%	109%	97%	60%	85%	47%	35%	67%	30%	95%	44%	123%	72%	160%	121%	174%	170%	166%	216%	115%
Bamenda	COP19	Scale-up Saturation	APR20	69%	65%	132%	128%	118%	122%	89%	94%	94%	84%	111%	90%	152%	219%	124%	158%	121%	143%	148%	156%	212%	192%	159%	225%	149%
Bamenda	COP20	Scale-up Saturation	APR21	69%	65%	132%	128%	118%	122%	89%	94%	94%	84%	111%	90%	152%	219%	124%	158%	121%	143%	148%	156%	212%	192%	159%	225%	149%
Bamenda	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	93%	88%	94%	88%	95%	88%	95%	88%	92%	88%	90%
Bamenda	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	92%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	98%	100%	93%
Bamenda3	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	98%	100%	93%
Bandjoun	COP19	Scale-up Saturation	APR20	50%	50%	43%	43%	25%	27%	19%	21%	19%	17%	27%	24%	39%	53%	35%	48%	42%	52%	56%	62%	70%	68%	36%	54%	42%
Bandjoun	COP20	Scale-up Saturation	APR21	100%	50%	86%	43%	69%	27%	67%	21%	64%	17%	64%	24%	68%	53%	66%	48%	71%	52%	80%	62%	87%	68%	70%	54%	64%
Bandjoun	COP21	Scale-up Saturation	ARP22	100%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%
Bandjoun	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	95%	98%	92%
Bangangte	COP19	Scale-up Saturation	APR20	100%	100%	89%	89%	65%	68%	50%	54%	51%	48%	65%	55%	97%	144%	90%	122%	108%	135%	143%	159%	179%	174%	96%	145%	108%
Bangangte	COP20	Scale-up Saturation	APR21	100%	100%	89%	89%	65%	68%	50%	54%	51%	48%	65%	55%	97%	144%	90%	122%	108%	135%	143%	159%	179%	174%	96%	145%	108%
Bangangte	COP21	Scale-up Saturation	ARP22	94%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	94%	94%	95%
Bangangte	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	93%	92%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	94%

Bangem	COP18	Sustained	APR19									33%		58%	20%	49%	24%	49%	12%	34%	18%	31%	38%	56%	43%	60%	37%	38%
Bangem	COP19	Scale-up Saturation	APR20			33%	33%	75%	60%	60%	50%	33%	17%	42%	30%	61%	76%	49%	50%	40%	39%	42%	38%	60%	46%	56%	71%	49%
Bangem	COP20	Scale-up Saturation	APR21			100%	100%	100%	100%	120%	100%	83%	100%	85%	80%	88%	88%	89%	88%	90%	85%	92%	91%	96%	93%	94%	97%	91%
Bangem	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	93%	88%	89%	88%	89%
Bangem	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	100%	100%	100%	100%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Bangourain	COP19	Scale-up Saturation	APR20	100%	100%	33%	33%	14%	17%	11%	13%	25%	13%	30%	27%	42%	65%	39%	52%	47%	58%	62%	69%	75%	73%	44%	66%	47%
Bangourain	COP20	Scale-up Saturation	APR21	100%	100%	100%	33%	71%	17%	67%	13%	69%	13%	67%	27%	72%	65%	70%	52%	76%	58%	85%	69%	93%	73%	76%	66%	69%
Bangourain	COP21	Scale-up Saturation	ARP22	200%	200%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	103%
Bangourain	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	90%	100%	95%	98%	93%
Bankim	COP19	Scale-up Saturation	APR20	33%	33%	25%	25%	19%	19%	15%	15%	13%	10%	18%	15%	27%	38%	22%	27%	20%	23%	23%	24%	33%	30%	27%	38%	25%
Bankim	COP20	Scale-up Saturation	APR21	67%	67%	75%	67%	71%	71%	74%	67%	66%	66%	67%	63%	70%	70%	70%	66%	72%	66%	75%	69%	78%	71%	75%	75%	71%
Bankim	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Bankim	COP22	Scale-up Saturation	ARP22	90%	90%	100%	90%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%
Banyo	COP19	Scale-up Saturation	APR20	100%	100%	46%	46%	45%	43%	34%	34%	30%	26%	40%	33%	60%	79%	49%	59%	45%	50%	51%	52%	74%	65%	63%	87%	55%
Banyo	COP20	Scale-up Saturation	APR21	100%	100%	85%	85%	86%	78%	79%	76%	74%	74%	76%	72%	83%	87%	81%	80%	81%	78%	86%	81%	93%	87%	88%	96%	83%
Banyo	COP21	Scale-up Saturation	ARP22	150%	150%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	93%
Banyo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	94%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	96%	90%	100%	93%	100%	92%
Batibo	COP18	Sustained	APR19			30%	10%		19%	9%		15%	10%	15%		17%	6%	14%	3%	22%	14%	28%	18%	21%	32%	26%	20%	18%
Batibo	COP19	Scale-up Saturation	APR20	100%	100%	70%	70%	76%	81%	59%	62%	58%	52%	67%	57%	93%	131%	76%	96%	74%	86%	89%	95%	128%	117%	96%	136%	91%
Batibo	COP20	Scale-up Saturation	APR21	100%	100%	80%	70%	82%	81%	73%	62%	70%	52%	75%	57%	93%	131%	81%	96%	80%	86%	92%	95%	128%	117%	96%	136%	93%
Batibo	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Batibo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	97%	90%	90%	100%	93%	98%	91%
Batouri	COP19	Scale-up Saturation	APR20	67%	50%	71%	67%	56%	52%	41%	39%	38%	33%	51%	38%	82%	106%	66%	76%	58%	63%	64%	63%	88%	74%	71%	92%	68%
Batouri	COP20	Scale-up Saturation	APR21	100%	75%	93%	87%	88%	85%	85%	83%	74%	80%	78%	75%	89%	106%	85%	87%	85%	85%	88%	87%	97%	93%	90%	92%	88%
Batouri	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	89%	94%	90%	90%	89%	90%
Batouri	COP22	Scale-up Saturation	ARP22	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	96%	100%	100%	90%	100%	90%	100%	90%	96%	94%
Belabo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	90%
Bertoua	COP19	Scale-up Saturation	APR20	60%	55%	89%	83%	76%	72%	55%	52%	52%	43%	73%	53%	116%	144%	93%	103%	82%	85%	91%	85%	125%	100%	100%	123%	94%
Bertoua	COP20	Scale-up Saturation	APR21	60%	55%	89%	83%	76%	72%	55%	52%	52%	43%	73%	53%	116%	144%	93%	103%	82%	85%	91%	85%	125%	100%	100%	123%	94%
Bertoua	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	92%	88%	94%	89%	95%	91%	96%	92%	96%	93%	94%	92%	91%
Bertoua	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%
Betare Oya	COP19	Scale-up Saturation	APR20	33%	25%	29%	27%	28%	26%	21%	19%	17%	15%	22%	15%	36%	46%	29%	33%	26%	27%	28%	27%	39%	32%	31%	39%	30%
Betare Oya	COP20	Scale-up Saturation	APR21	100%	75%	71%	73%	76%	74%	76%	72%	64%	68%	66%	63%	71%	73%	71%	69%	72%	69%	74%	71%	78%	75%	75%	77%	72%
Betare Oya	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Betare Oya	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Bibemi	COP19	Scale-up Saturation	APR20	100%	100%	13%	13%	20%	19%	16%	15%	16%	14%	20%	15%	31%	38%	26%	26%	22%	22%	24%	21%	34%	26%	31%	36%	26%
Bibemi	COP20	Scale-up Saturation	APR21	100%	100%	63%	63%	67%	56%	63%	55%	55%	57%	56%	52%	62%	60%	60%	56%	61%	55%	63%	56%	67%	59%	65%	65%	61%
Bibemi	COP21	Scale-up Saturation	ARP22	200%	200%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	98%
Bibemi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Biyem Assi	COP18	Scale-up Saturation	APR19	30%		56%	42%	90%	77%	71%	65%	55%	60%	67%	45%	122%	54%	135%	60%	120%	69%	110%	93%	111%	103%	132%	147%	106%
Biyem Assi	COP19	Scale-up Saturation	APR20	90%	82%	133%	127%	153%	144%	115%	107%	116%	92%	155%	110%	207%	251%	130%	138%	93%	95%	98%	91%	146%	115%	147%	177%	129%
Biyem Assi	COP20	Scale-up Saturation	APR21	90%	82%	133%	127%	153%	144%	115%	107%	116%	92%	155%	110%	207%	251%	130%	138%	93%	95%	98%	91%	146%	115%	147%	177%	129%
Biyem Assi	COP21	Scale-up Saturation	ARP22	88%	140%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	93%	88%	94%	88%	94%	88%	91%	88%	91%
Biyem Assi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	99%	90%	100%	100%	98%	100%	93%
Bogo	COP19	Scale-up Saturation	APR20	100%	100%	80%	80%	60%	60%	46%	46%	42%	43%	63%	44%	103%	131%	92%	109%	89%	97%	99%	97%	140%	121%	115%	143%	97%
Bogo	COP20	Scale-up Saturation	APR21	100%	100%	80%	80%	60%	60%	46%	46%	42%	43%	63%	44%	103%	131%	92%	109%	89%	97%	99%	97%	140%	121%	115%	143%	97%
Bogo	COP21	Scale-up Saturation	ARP22	87%	200%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	92%
Bogo	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	100%	90%	100%	90%	95%	93%
Boko	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Bonassama	COP18	Scale-up Saturation	APR19	27%	9%	39%	27%	41%	44%	61%	39%	43%	30%	51%	29%	81%	41%	85%	38%	73%	49%	70%	54%	65%	60%	73%	80%	65%
Bonassama	COP19	Scale-up Saturation	APR20	55%	55%	89%	84%	102%	94%	76%	71%	82%	62%	106%	76%	139%	173%	87%	94%	62%	64%	62%	59%	88%	71%	83%	103%	82%
Bonassama	COP20	Scale-up Saturation	APR21	64%	64%	89%	84%	102%	94%	80%	73%	84%	66%	106%	78%	139%	173%	87%	94%	65%	66%	66%	61%	89%	73%	85%	103%	84%
Bonassama	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	94%	88%	95%	88%	95%	88%	92%	88%	90%
Bonassama	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	90%	90%	93%	90%	90%	100%	93%	98%	91%

Bourha	COP19	Scale-up Saturation	APR20			400%	400%	300%	300%	200%	200%	183%	200%	273%	200%	420%	533%	406%	425%	382%	378%	433%	378%	591%	486%	483%	545%	408%
Bourha	COP20	Scale-up Saturation	APR21			400%	400%	300%	300%	200%	200%	183%	200%	273%	200%	420%	533%	406%	425%	382%	378%	433%	378%	591%	486%	483%	545%	408%
Bourha	COP21	Scale-up Saturation	ARP22	100%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%
Bourha	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	99%
Buea	COP18	Sustained	APR19	13%	22%	25%	26%	30%	32%	28%	38%	26%	22%	34%	16%	51%	33%	58%	24%	53%	29%	49%	44%	54%	51%	63%	61%	47%
Buea	COP19	Scale-up Saturation	APR20	38%	33%	50%	47%	57%	53%	44%	41%	39%	35%	49%	35%	67%	84%	50%	55%	41%	43%	44%	41%	63%	50%	60%	75%	52%
Buea	COP20	Scale-up Saturation	APR21	88%	89%	86%	87%	91%	89%	91%	90%	88%	91%	87%	88%	89%	84%	88%	87%	89%	86%	91%	88%	94%	90%	92%	94%	90%
Buea	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	94%	88%	90%	88%	89%
Buea	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	95%	90%	90%	100%	98%	98%	92%
Cité Des Palmiers	COP18	Scale-up Saturation	APR19	10%		34%	32%	43%	36%	39%	37%	30%	37%	37%	21%	60%	27%	65%	27%	47%	33%	53%	44%	57%	49%	67%	86%	52%
Cité Des Palmiers	COP19	Scale-up Saturation	APR20	50%	50%	78%	73%	91%	84%	67%	63%	72%	56%	94%	69%	122%	153%	76%	84%	54%	57%	55%	53%	77%	63%	74%	93%	73%
Cité Des Palmiers	COP20	Scale-up Saturation	APR21	60%	60%	80%	75%	91%	85%	71%	67%	75%	59%	94%	72%	122%	153%	78%	84%	59%	60%	60%	56%	80%	66%	76%	93%	76%
Cité Des Palmiers	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	88%
Cité Des Palmiers	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	95%	98%	91%
Cité Verte	COP18	Scale-up Saturation	APR19	31%	57%	187%	136%	258%	233%	242%	179%	116%	165%	92%	73%	135%	63%	148%	78%	130%	88%	132%	109%	151%	132%	233%	263%	147%
Cité Verte	COP19	Scale-up Saturation	APR20	108%	100%	189%	176%	224%	208%	168%	155%	159%	133%	210%	155%	281%	357%	176%	198%	127%	137%	134%	131%	200%	167%	200%	257%	180%
Cité Verte	COP20	Scale-up Saturation	APR21	108%	100%	189%	176%	224%	208%	168%	155%	159%	133%	210%	155%	281%	357%	176%	198%	127%	137%	134%	131%	200%	167%	200%	257%	180%
Cité Verte	COP21	Scale-up Saturation	ARP22	88%	88%	96%	96%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	92%	88%	93%	88%	94%	88%	95%	88%	91%	88%	90%
Cité Verte	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	92%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%	100%	98%	100%	93%
Dang	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	91%
Deido	COP18	Scale-up Saturation	APR19	28%	25%	63%	65%	134%	108%	158%	105%	105%	127%	84%	113%	135%	101%	132%	87%	123%	75%	127%	92%	128%	113%	164%	194%	126%
Deido	COP19	Scale-up Saturation	APR20	100%	92%	182%	172%	214%	197%	159%	149%	167%	133%	220%	159%	288%	356%	178%	195%	126%	133%	127%	121%	179%	146%	171%	212%	170%
Deido	COP20	Scale-up Saturation	APR21	100%	92%	182%	172%	214%	197%	159%	149%	167%	133%	220%	159%	288%	356%	178%	195%	126%	133%	127%	121%	179%	146%	171%	212%	170%
Deido	COP21	Scale-up Saturation	ARP22	0%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	95%	88%	95%	88%	96%	88%	93%	88%	86%
Deido	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	99%	100%	98%	98%	92%
Djohong	COP19	Scale-up Saturation	APR20	100%	100%	50%	50%	55%	55%	43%	43%	34%	27%	43%	33%	65%	88%	54%	67%	49%	58%	30%	112%	82%	75%	71%	93%	61%
Djohong	COP20	Scale-up Saturation	APR21	100%	100%	100%	83%	91%	82%	86%	79%	76%	73%	76%	71%	85%	88%	82%	82%	82%	81%	79%	112%	96%	90%	91%	93%	85%
Djohong	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Djohong	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%
Djoum	COP19	Scale-up Saturation	APR20	50%	50%	38%	33%	31%	27%	21%	19%	20%	14%	30%	23%	40%	50%	28%	32%	24%	26%	28%	27%	39%	32%	26%	34%	30%
Djoum	COP20	Scale-up Saturation	APR21	100%	100%	75%	78%	77%	80%	79%	81%	71%	76%	75%	73%	79%	78%	76%	74%	78%	74%	80%	76%	84%	80%	79%	80%	78%
Djoum	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Djoum	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Djoungolo	COP18	Scale-up Saturation	APR19	18%	17%	29%	40%	57%	38%	40%	33%	43%	40%	67%	75%	92%	65%	88%	53%	75%	55%	77%	66%	90%	76%	127%	142%	82%
Djoungolo	COP19	Scale-up Saturation	APR20	58%	54%	106%	100%	123%	114%	92%	85%	92%	73%	121%	88%	162%	200%	101%	110%	73%	76%	78%	73%	115%	92%	115%	142%	102%
Djoungolo	COP20	Scale-up Saturation	APR21	58%	54%	106%	100%	123%	114%	92%	85%	92%	73%	121%	88%	162%	200%	101%	110%	73%	76%	78%	73%	115%	92%	115%	142%	102%
Djoungolo	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	92%	88%	94%	88%	95%	88%	96%	89%	96%	89%	93%	89%	90%
Djoungolo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	90%	100%	94%	100%	100%	98%	100%	94%
Doume	COP19	Scale-up Saturation	APR20	50%	33%	27%	27%	21%	20%	15%	15%	15%	13%	20%	16%	31%	41%	25%	30%	22%	25%	25%	25%	34%	29%	26%	36%	26%
Doume	COP20	Scale-up Saturation	APR21	100%	67%	73%	73%	74%	70%	73%	74%	65%	70%	66%	66%	71%	72%	70%	69%	71%	70%	74%	71%	78%	74%	73%	77%	72%
Doume	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Doume	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Dschang	COP19	Scale-up Saturation	APR20	100%	100%	111%	111%	82%	89%	63%	69%	66%	64%	86%	74%	125%	187%	115%	157%	137%	171%	181%	202%	224%	218%	122%	185%	138%
Dschang	COP20	Scale-up Saturation	APR21	100%	100%	111%	111%	82%	89%	63%	69%	66%	64%	86%	74%	125%	187%	115%	157%	137%	171%	181%	202%	224%	218%	122%	185%	138%
Dschang	COP21	Scale-up Saturation	ARP22	133%	133%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	96%	94%	96%	94%	96%	94%	94%	94%	98%
Dschang	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	100%	100%	100%	100%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	97%
Ebolowa	COP19	Scale-up Saturation	APR20	56%	50%	63%	58%	61%	54%	42%	38%	45%	33%	63%	43%	85%	101%	61%	64%	53%	52%	60%	54%	84%	65%	56%	68%	62%
Ebolowa	COP20	Scale-up Saturation	APR21	89%	80%	85%	81%	89%	86%	86%	83%	79%	79%	83%	78%	85%	101%	85%	83%	85%	81%	89%	84%	96%	89%	87%	90%	87%
Ebolowa	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	88%	88%	88%
Ebolowa	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	95%	91%
Edea	COP18	Sustained	APR19	52%	23%	39%	59%	57%	44%	28%	17%	23%	12%	47%	11%	61%	23%	67%	36%	69%	53%	77%	59%	71%	68%	72%	73%	61%
Edea	COP19	Scale-up Saturation	APR20	50%	40%	83%	79%	77%	72%	58%	55%	52%	43%	66%	48%	89%	112%	69%	79%	67%	71%	75%	72%	96%	79%	59%	76%	73%
Edea	COP20	Scale-up Saturation	APR21	75%	60%	89%	84%	80%	75%	65%	60%	58%	50%	70%	52%	89%	112%	73%	80%	71%	73%	79%	74%	96%	81%	64%	78%	76%
Edea	COP21	Scale-up Saturation	ARP22	150%	200%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	92%	88%	93%	88%	88%	88%	96%
Edea	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	98%	100%	100%	95%	98%	93%

Efoulan	COP18	Scale-up Saturation	APR19		15%	46%	26%	27%	21%	16%	8%	16%	5%	49%	14%	66%	30%	56%	31%	40%	28%	30%	25%	29%	24%	38%	33%	35%
Efoulan	COP19	Scale-up Saturation	APR20	23%	23%	44%	42%	50%	46%	37%	35%	39%	31%	50%	36%	67%	83%	42%	46%	30%	31%	32%	30%	47%	38%	47%	59%	42%
Efoulan	COP20	Scale-up Saturation	APR21	54%	54%	67%	65%	73%	69%	68%	64%	66%	63%	71%	64%	80%	89%	67%	67%	62%	60%	63%	60%	72%	65%	71%	76%	67%
Efoulan	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	95%	88%	96%	89%	96%	89%	93%	89%	90%
Efoulan	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Ekondo Titi	COP18	Sustained	APR19			30%	9%	25%	18%	10%	19%	21%	17%	14%	3%	15%	10%	23%	12%	23%	14%	26%	23%	37%	34%	74%	47%	29%
Ekondo Titi	COP19	Scale-up Saturation	APR20	50%	33%	30%	27%	38%	35%	30%	29%	24%	17%	30%	19%	41%	52%	31%	34%	25%	26%	27%	25%	38%	31%	38%	47%	32%
Ekondo Titi	COP20	Scale-up Saturation	APR21	100%	67%	90%	82%	88%	88%	90%	95%	83%	87%	83%	83%	85%	83%	85%	84%	87%	83%	89%	86%	91%	89%	90%	91%	87%
Ekondo Titi	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	90%	88%	88%	88%	88%
Ekondo Titi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	98%	96%	91%
Eseka	COP18	Sustained	APR19			23%	7%	13%		22%	3%	11%	9%	18%	2%	16%	10%	25%	11%	24%	18%	29%	35%	32%	17%	28%	26%	22%
Eseka	COP19	Scale-up Saturation	APR20	33%	33%	23%	21%	25%	24%	19%	18%	16%	11%	20%	15%	27%	36%	23%	26%	22%	24%	27%	26%	36%	30%	22%	28%	25%
Eseka	COP20	Scale-up Saturation	APR21	67%	67%	62%	57%	63%	60%	59%	56%	53%	51%	53%	51%	57%	60%	56%	55%	57%	55%	61%	57%	67%	61%	58%	60%	58%
Eseka	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Eseka	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Figuil	COP19	Scale-up Saturation	APR20	100%	100%	100%	100%	86%	75%	67%	67%	58%	60%	80%	62%	129%	168%	103%	126%	89%	103%	95%	100%	134%	121%	126%	167%	109%
Figuil	COP20	Scale-up Saturation	APR21	100%	100%	100%	100%	86%	75%	67%	67%	58%	60%	80%	62%	129%	168%	103%	126%	89%	103%	95%	100%	134%	121%	126%	167%	109%
Figuil	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	90%	88%	88%	88%	88%
Figuil	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Fontem	COP18	Sustained	APR19						20%	9%	8%	8%	8%	6%	10%	6%	3%	7%	4%	10%	10%	12%	10%	14%	32%	13%	20%	11%
Fontem	COP19	Scale-up Saturation	APR20	100%	50%	17%	14%	33%	30%	27%	25%	17%	23%	24%	14%	33%	40%	24%	26%	19%	20%	20%	19%	28%	23%	28%	36%	25%
Fontem	COP20	Scale-up Saturation	APR21	100%	50%	100%	86%	89%	80%	91%	92%	83%	92%	81%	81%	83%	83%	82%	81%	84%	83%	87%	84%	88%	85%	87%	88%	85%
Fontem	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Foumban	COP19	Scale-up Saturation	APR20	80%	80%	77%	77%	58%	62%	45%	49%	46%	44%	61%	51%	89%	132%	82%	112%	98%	124%	130%	147%	162%	158%	88%	133%	99%
Foumban	COP20	Scale-up Saturation	APR21	80%	80%	77%	77%	58%	62%	45%	49%	46%	44%	61%	51%	89%	132%	82%	112%	98%	124%	130%	147%	162%	158%	88%	133%	99%
Foumban	COP21	Scale-up Saturation	ARP22	94%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	94%	94%	95%
Foumban	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%	100%	100%	100%	100%	100%	100%	98%	100%	93%
Foumbot	COP19	Scale-up Saturation	APR20	67%	67%	108%	108%	74%	80%	57%	63%	60%	57%	77%	66%	114%	164%	106%	141%	127%	157%	168%	188%	211%	202%	113%	167%	127%
Foumbot	COP20	Scale-up Saturation	APR21	67%	67%	108%	108%	74%	80%	57%	63%	60%	57%	77%	66%	114%	164%	106%	141%	127%	157%	168%	188%	211%	202%	113%	167%	127%
Foumbot	COP21	Scale-up Saturation	ARP22	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	94%	94%	95%
Foumbot	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	90%	95%	92%
Fundong	COP18	Sustained	APR19			72%	42%	105%	79%	78%	78%	37%	30%	21%	11%	35%	13%	56%	24%	82%	46%	114%	79%	115%	108%	110%	140%	74%
Fundong	COP19	Scale-up Saturation	APR20	67%	67%	92%	88%	86%	88%	64%	67%	61%	57%	73%	60%	101%	145%	83%	107%	82%	99%	100%	108%	144%	134%	109%	158%	101%
Fundong	COP20	Scale-up Saturation	APR21	67%	67%	92%	88%	86%	88%	64%	67%	61%	57%	73%	60%	101%	145%	83%	107%	82%	99%	100%	108%	144%	134%	109%	158%	101%
Fundong	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	92%	88%	88%	88%	89%
Fundong	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	90%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	96%	90%	100%	100%	100%	100%	98%	100%	94%
Galim	COP19	Scale-up Saturation	APR20	100%	100%	17%	17%	23%	25%	18%	20%	13%	7%	18%	15%	27%	41%	25%	34%	30%	37%	40%	45%	50%	48%	27%	41%	30%
Galim	COP20	Scale-up Saturation	APR21	100%	100%	67%	17%	69%	25%	65%	20%	57%	7%	59%	15%	63%	41%	62%	34%	66%	37%	73%	45%	78%	48%	67%	41%	56%
Galim	COP21	Scale-up Saturation	ARP22	100%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%
Galim	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	96%	95%	93%
Garoua Boulai	COP19	Scale-up Saturation	APR20	150%	150%	140%	127%	128%	121%	92%	88%	81%	69%	114%	84%	182%	223%	147%	162%	130%	135%	144%	133%	198%	158%	156%	194%	149%
Garoua Boulai	COP20	Scale-up Saturation	APR21	150%	150%	140%	127%	128%	121%	92%	88%	81%	69%	114%	84%	182%	223%	147%	162%	130%	135%	144%	133%	198%	158%	156%	194%	149%
Garoua Boulai	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Garoua Boulai	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	96%	90%	90%	90%	90%	100%	90%	100%	99%	100%	100%	100%	100%	93%	100%	90%	100%	91%	95%	95%
Garoua I	COP19	Scale-up Saturation	APR20	100%	100%	128%	121%	107%	103%	84%	82%	84%	69%	114%	87%	182%	244%	146%	172%	126%	140%	136%	137%	194%	168%	178%	233%	152%
Garoua I	COP20	Scale-up Saturation	APR21	100%	100%	128%	121%	107%	103%	84%	82%	84%	69%	114%	87%	182%	244%	146%	172%	126%	140%	136%	137%	194%	168%	178%	233%	152%
Garoua I	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Garoua I	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	98%	100%	95%
Garoua II	COP19	Scale-up Saturation	APR20	38%	38%	9%	9%	10%	9%	8%	7%	7%	6%	11%	7%	17%	22%	14%	16%	12%	13%	13%	13%	18%	16%	17%	21%	14%
Garoua II	COP20	Scale-up Saturation	APR21	75%	63%	55%	46%	54%	49%	56%	49%	50%	49%	51%	46%	55%	52%	54%	50%	55%	49%	57%	51%	60%	53%	58%	56%	54%
Garoua II	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	93%	88%	94%	89%	94%	89%	91%	89%	89%
Garoua II	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Gaschiga	COP19	Scale-up Saturation	APR20	100%	50%	17%	17%	25%	25%	21%	20%	21%	20%	25%	20%	41%	52%	32%	36%	28%	29%	30%	28%	42%	34%	39%	52%	33%
Gaschiga	COP20	Scale-up Saturation	APR21	100%	50%	67%	67%	67%	67%	64%	60%	59%	60%	60%	55%	67%	72%	64%	62%	63%	60%	65%	59%	71%	64%	70%	74%	65%
Gaschiga	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Gaschiga	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Guere	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Guider	COP19	Scale-up Saturation	APR20	150%	150%	80%	73%	74%	74%	61%	58%	59%	52%	81%	63%	127%	170%	101%	121%	86%	98%	92%	94%	132%	115%	122%	162%	105%
Guider	COP20	Scale-up Saturation	APR21	150%	150%	80%	73%	74%	74%	61%	58%	59%	52%	81%	63%	127%	170%	101%	121%	86%	98%	92%	94%	132%	115%	122%	162%	105%
Guider	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	92%	88%	93%	88%	93%	88%	89%	88%	90%
Guider	COP22	Scale-up Saturation	ARP22	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	90%	100%	98%	98%	95%
Guidiguis	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Hina	COP19	Scale-up Saturation	APR20	200%	200%	133%	133%	100%	100%	75%	75%	73%	75%	107%	73%	178%	227%	157%	175%	153%	159%	169%	159%	244%	194%	196%	233%	164%
Hina	COP20	Scale-up Saturation	APR21	200%	200%	133%	133%	100%	100%	75%	75%	73%	75%	107%	73%	178%	227%	157%	175%	153%	159%	169%	159%	244%	194%	196%	233%	164%
Hina	COP21	Scale-up Saturation	ARP22	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	89%	87%	91%	87%	93%	87%	93%	87%	89%	87%	88%
Hina	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	100%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	97%
Japoma	COP19	Scale-up Saturation	APR20	25%	20%	16%	15%	12%	11%	9%	8%	11%	8%	13%	8%	18%	22%	11%	12%	8%	8%	8%	8%	11%	9%	11%	14%	11%
Japoma	COP20	Scale-up Saturation	APR21	50%	40%	26%	25%	23%	21%	21%	16%	22%	16%	23%	16%	27%	29%	21%	20%	19%	16%	19%	16%	22%	17%	21%	21%	20%
Japoma	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Japoma	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Kaele	COP19	Scale-up Saturation	APR20	200%	100%	100%	86%	62%	62%	50%	47%	52%	44%	71%	54%	120%	155%	108%	124%	103%	113%	115%	113%	164%	141%	130%	168%	112%
Kaele	COP20	Scale-up Saturation	APR21	200%	100%	100%	86%	62%	62%	50%	47%	52%	44%	71%	54%	120%	155%	108%	124%	103%	113%	115%	113%	164%	141%	130%	168%	112%
Kaele	COP21	Scale-up Saturation	ARP22	100%	200%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	92%
Kaele	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	100%	100%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	96%	98%	96%
Kar Hay	COP19	Scale-up Saturation	APR20	100%	100%	25%	20%	33%	30%	25%	25%	17%	8%	25%	18%	46%	54%	41%	47%	40%	41%	44%	42%	63%	52%	48%	61%	42%
Kar Hay	COP20	Scale-up Saturation	APR21	100%	100%	100%	80%	89%	90%	92%	83%	78%	85%	80%	76%	83%	83%	83%	83%	87%	82%	90%	88%	95%	89%	90%	93%	86%
Kar Hay	COP21	Scale-up Saturation	ARP22	100%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	89%	87%	90%	87%	91%	87%	87%	87%	89%
Kar Hay	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Kette	COP19	Scale-up Saturation	APR20	100%	100%	20%	20%	38%	33%	27%	25%	25%	23%	33%	24%	58%	69%	46%	49%	40%	41%	44%	40%	60%	47%	47%	60%	45%
Kette	COP20	Scale-up Saturation	APR21	100%	100%	60%	80%	88%	78%	82%	75%	71%	77%	70%	71%	81%	85%	78%	78%	77%	77%	81%	78%	87%	82%	81%	86%	79%
Kette	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	90%	88%	88%	88%	89%
Kette	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%
Kolofata	COP19	Scale-up Saturation	APR20	50%	50%	43%	43%	29%	27%	22%	21%	19%	16%	26%	15%	43%	56%	41%	46%	39%	41%	44%	42%	62%	51%	48%	61%	42%
Kolofata	COP20	Scale-up Saturation	APR21	100%	50%	100%	100%	93%	87%	89%	84%	81%	84%	81%	77%	84%	83%	85%	80%	88%	82%	91%	86%	94%	90%	92%	92%	87%
Kolofata	COP21	Scale-up Saturation	ARP22	100%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%
Kolofata	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	90%	100%	90%	100%	90%	98%	93%
Kouoptamo	COP19	Scale-up Saturation	APR20	50%	50%	11%	11%	16%	17%	12%	13%	9%	5%	12%	10%	19%	27%	18%	25%	22%	27%	29%	33%	36%	36%	19%	29%	22%
Kouoptamo	COP20	Scale-up Saturation	APR21	100%	50%	56%	11%	63%	17%	60%	13%	58%	5%	57%	10%	60%	27%	59%	25%	62%	27%	69%	33%	72%	36%	63%	29%	51%
Kouoptamo	COP21	Scale-up Saturation	ARP22	200%	200%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	103%
Kouoptamo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	96%	90%	90%	90%	91%	91%
Kousseri	COP19	Scale-up Saturation	APR20	83%	71%	27%	25%	21%	20%	16%	16%	17%	14%	22%	17%	38%	48%	34%	39%	33%	36%	37%	36%	53%	44%	41%	54%	36%
Kousseri	COP20	Scale-up Saturation	APR21	100%	86%	85%	79%	87%	82%	87%	83%	78%	82%	78%	76%	82%	80%	83%	79%	85%	81%	89%	84%	91%	86%	89%	90%	84%
Kousseri	COP21	Scale-up Saturation	ARP22	87%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%
Kousseri	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	91%
Koza	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Kribi	COP19	Scale-up Saturation	APR20	60%	60%	81%	74%	77%	69%	54%	49%	58%	42%	80%	55%	106%	126%	74%	80%	64%	65%	73%	67%	101%	80%	68%	82%	76%
Kribi	COP20	Scale-up Saturation	APR21	80%	100%	95%	87%	94%	90%	90%	87%	85%	84%	90%	84%	106%	126%	89%	89%	88%	86%	93%	88%	101%	94%	91%	95%	93%
Kribi	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	92%	88%	92%	88%	88%	88%	89%
Kribi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	96%	90%	100%	90%	90%	100%	99%	100%	95%	95%	93%
Kumba	COP18	Sustained	APR19	11%	10%	46%	41%	70%	74%	62%	70%	44%	39%	53%	33%	93%	34%	119%	56%	110%	73%	110%	94%	110%	96%	136%	134%	98%
Kumba	COP19	Scale-up Saturation	APR20	67%	60%	115%	110%	126%	118%	99%	94%	94%	72%	110%	78%	150%	190%	110%	123%	89%	94%	93%	89%	133%	109%	129%	162%	114%
Kumba	COP20	Scale-up Saturation	APR21	67%	60%	115%	110%	126%	118%	99%	94%	94%	72%	110%	78%	150%	190%	110%	123%	89%	94%	93%	89%	133%	109%	129%	162%	114%
Kumba	COP21	Scale-up Saturation	ARP22	88%	120%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	95%	88%	95%	88%	92%	88%	91%
Kumba-north	COP22	Scale-up Saturation	ARP22	90%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%
Kumba-south	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	100%	100%	100%	100%	90%	100%	95%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	98%

Kumbo East	COP18	Sustained	APR19			33%	29%	50%	54%	63%	50%	33%	43%	17%	15%	25%	7%	36%	22%	54%	30%	91%	65%	96%	99%	78%	104%	55%
Kumbo East	COP19	Scale-up Saturation	APR20	60%	60%	71%	71%	67%	69%	50%	52%	51%	46%	60%	52%	82%	120%	67%	87%	65%	79%	79%	87%	114%	106%	86%	125%	81%
Kumbo East	COP20	Scale-up Saturation	APR21	80%	60%	81%	71%	75%	69%	63%	52%	63%	46%	69%	52%	85%	120%	73%	87%	73%	79%	84%	87%	114%	106%	89%	125%	85%
Kumbo East	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	93%	88%	90%	88%	89%
Kumbo East	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%	100%	100%	95%	98%	92%
Kumbo West	COP18	Sustained	APR19	33%	67%	136%	67%	124%	79%	109%	100%	44%	100%	20%	20%	28%	28%	56%	39%	100%	80%	126%	141%	159%	174%	95%	165%	89%
Kumbo West	COP19	Scale-up Saturation	APR20	100%	100%	121%	113%	108%	113%	82%	87%	82%	75%	99%	80%	134%	192%	109%	142%	106%	129%	129%	141%	186%	174%	141%	201%	132%
Kumbo West	COP20	Scale-up Saturation	APR21	100%	100%	121%	113%	108%	113%	82%	87%	82%	75%	99%	80%	134%	192%	109%	142%	106%	129%	129%	141%	186%	174%	141%	201%	132%
Kumbo West	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	95%	88%	95%	89%	96%	89%	93%	89%	90%
Kumbo West	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	98%	100%	95%
Lagdo	COP19	Scale-up Saturation	APR20	150%	150%	67%	60%	59%	59%	48%	45%	42%	35%	62%	47%	97%	125%	78%	90%	68%	74%	72%	71%	103%	88%	95%	127%	81%
Lagdo	COP20	Scale-up Saturation	APR21	150%	150%	89%	70%	82%	76%	81%	64%	70%	57%	78%	63%	97%	125%	88%	90%	83%	82%	87%	80%	103%	92%	95%	127%	90%
Lagdo	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Lagdo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	98%	90%	94%	91%
Limbe	COP18	Sustained	APR19		22%	20%	51%	54%	38%	58%	54%	33%	53%	39%	20%	68%	37%	83%	41%	77%	53%	85%	63%	81%	74%	106%	113%	73%
Limbe	COP19	Scale-up Saturation	APR20	63%	56%	89%	84%	92%	87%	73%	68%	68%	56%	82%	58%	113%	141%	84%	92%	69%	71%	73%	68%	105%	84%	100%	124%	88%
Limbe	COP20	Scale-up Saturation	APR21	88%	56%	89%	84%	92%	87%	94%	68%	90%	56%	92%	58%	113%	141%	93%	92%	91%	71%	94%	68%	105%	84%	100%	124%	94%
Limbe	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	91%	88%	92%	88%	88%	88%	89%
Limbe	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	100%	100%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	95%
Logbaba	COP18	Scale-up Saturation	APR19	68%		50%	42%	28%	37%	12%	15%	20%	9%	64%	13%	103%	24%	91%	43%	58%	28%	39%	32%	28%	22%	36%	38%	45%
Logbaba	COP19	Scale-up Saturation	APR20	33%	33%	58%	54%	66%	60%	49%	45%	51%	39%	67%	48%	87%	110%	54%	60%	39%	41%	39%	37%	55%	45%	52%	66%	52%
Logbaba	COP20	Scale-up Saturation	APR21	50%	50%	63%	58%	72%	66%	56%	51%	58%	46%	71%	52%	87%	110%	59%	63%	46%	46%	46%	43%	60%	50%	58%	69%	57%
Logbaba	COP21	Scale-up Saturation	ARP22	100%	150%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	94%	88%	91%	88%	92%
Logbaba	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Lolodorf	COP19	Scale-up Saturation	APR20			20%	20%	38%	33%	25%	23%	29%	23%	34%	25%	47%	59%	33%	37%	28%	30%	32%	31%	44%	37%	31%	38%	34%
Lolodorf	COP20	Scale-up Saturation	APR21			80%	80%	88%	89%	83%	85%	76%	85%	76%	75%	79%	83%	77%	78%	78%	75%	81%	78%	85%	83%	81%	84%	80%
Lolodorf	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Lolodorf	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	95%	91%
Lomie	COP19	Scale-up Saturation	APR20			67%	67%	60%	60%	46%	43%	38%	40%	55%	40%	82%	107%	66%	79%	58%	67%	64%	67%	88%	79%	72%	92%	69%
Lomie	COP20	Scale-up Saturation	APR21			83%	83%	80%	90%	85%	79%	72%	80%	78%	75%	88%	107%	83%	88%	83%	84%	86%	86%	94%	93%	88%	92%	86%
Lomie	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Lomie	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	90%	100%	90%	100%	93%	94%	94%
Loum	COP19	Scale-up Saturation	APR20	100%	100%	75%	60%	43%	38%	33%	30%	39%	30%	45%	29%	60%	77%	46%	53%	44%	47%	49%	48%	62%	53%	39%	50%	48%
Loum	COP20	Scale-up Saturation	APR21	100%	100%	100%	80%	57%	50%	44%	40%	50%	40%	53%	36%	65%	81%	52%	58%	51%	51%	55%	52%	67%	58%	46%	55%	55%
Loum	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	94%	88%	95%	88%	95%	88%	91%	88%	90%
Loum	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mada	COP19	Scale-up Saturation	APR20	67%	67%	23%	23%	24%	22%	19%	18%	15%	11%	19%	15%	33%	46%	29%	37%	28%	33%	31%	33%	45%	41%	36%	48%	32%
Mada	COP20	Scale-up Saturation	APR21	100%	100%	85%	85%	88%	81%	88%	85%	79%	83%	79%	77%	82%	80%	83%	79%	85%	81%	89%	83%	91%	86%	89%	88%	85%
Mada	COP21	Scale-up Saturation	ARP22	100%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%
Mada	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	90%	100%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	97%	100%	90%	100%	96%
Maga	COP19	Scale-up Saturation	APR20	100%	100%	11%	11%	17%	16%	14%	13%	13%	12%	15%	12%	27%	33%	24%	26%	23%	23%	26%	23%	37%	29%	28%	36%	25%
Maga	COP20	Scale-up Saturation	APR21	100%	100%	78%	78%	83%	79%	91%	83%	74%	80%	76%	73%	79%	76%	80%	76%	83%	78%	86%	80%	88%	83%	86%	86%	81%
Maga	COP21	Scale-up Saturation	ARP22	150%	800%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	119%
Maga	COP22	Scale-up Saturation	ARP22	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	91%
Malantouen	COP19	Scale-up Saturation	APR20	100%	100%	36%	36%	30%	33%	23%	26%	26%	27%	35%	28%	51%	72%	48%	64%	57%	71%	75%	85%	95%	90%	51%	75%	57%
Malantouen	COP20	Scale-up Saturation	APR21	100%	100%	73%	36%	70%	33%	67%	26%	63%	27%	66%	28%	73%	72%	72%	64%	78%	71%	89%	85%	95%	90%	77%	75%	73%
Malantouen	COP21	Scale-up Saturation	ARP22	150%	150%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	96%	94%	94%	94%	99%
Malantouen	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	90%	90%	90%	90%	100%	95%	100%	100%	100%	100%	95%	98%	93%
Mamfe	COP18	Sustained	APR19			33%	40%	69%	29%	19%	35%	23%	32%	40%	37%	51%	24%	69%	25%	61%	48%	85%	74%	97%	89%	190%	178%	82%
Mamfe	COP19	Scale-up Saturation	APR20	50%	50%	122%	110%	131%	121%	106%	100%	91%	79%	110%	80%	151%	194%	113%	129%	91%	99%	97%	95%	138%	117%	132%	172%	119%
Mamfe	COP20	Scale-up Saturation	APR21	50%	50%	122%	110%	131%	121%	106%	100%	91%	79%	110%	80%	151%	194%	113%	129%	91%	99%	97%	95%	138%	117%	132%	172%	119%
Mamfe	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Mamfe	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	100%	90%	100%	100%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	100%	100%	97%

Manjo	COP19	Scale-up Saturation	APR20			33%	33%	20%	20%	14%	14%	23%	14%	25%	27%	37%	42%	28%	30%	27%	27%	30%	27%	38%	30%	24%	33%	29%
Manjo	COP20	Scale-up Saturation	APR21			67%	67%	40%	40%	29%	29%	38%	29%	36%	36%	46%	47%	36%	37%	36%	33%	39%	33%	47%	37%	33%	40%	38%
Manjo	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	88%
Manjo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	93%	91%
Maroua 1	COP19	Scale-up Saturation	APR20	60%	60%	30%	29%	24%	23%	19%	19%	17%	14%	24%	17%	42%	50%	38%	42%	37%	38%	41%	38%	59%	47%	46%	58%	39%
Maroua 1	COP20	Scale-up Saturation	APR21	80%	80%	80%	76%	85%	81%	88%	83%	77%	82%	77%	75%	81%	80%	82%	79%	85%	81%	88%	84%	91%	87%	88%	90%	84%
Maroua 1	COP21	Scale-up Saturation	ARP22	87%	100%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%	87%	87%	87%	88%
Maroua 1	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Maroua 2	COP19	Scale-up Saturation	APR20	167%	167%	207%	193%	157%	147%	122%	119%	112%	100%	153%	111%	258%	339%	235%	277%	227%	250%	253%	252%	361%	311%	284%	377%	247%
Maroua 2	COP20	Scale-up Saturation	APR21	167%	167%	207%	193%	157%	147%	122%	119%	112%	100%	153%	111%	258%	339%	235%	277%	227%	250%	253%	252%	361%	311%	284%	377%	247%
Maroua 2	COP21	Scale-up Saturation	ARP22	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	89%	87%	91%	87%	92%	87%	93%	87%	89%	87%	88%
Maroua 2	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	96%	98%	90%	100%	90%	100%	90%	95%	92%
Maroua 3	COP19	Scale-up Saturation	APR20	100%	67%			5%	4%	4%	4%	2%	3%	6%	3%	9%	11%	8%	9%	8%	8%	9%	8%	13%	10%	10%	12%	8%
Maroua 3	COP20	Scale-up Saturation	APR21	100%	67%			86%	74%	85%	82%	74%	77%	74%	73%	76%	70%	77%	71%	80%	73%	83%	78%	83%	77%	83%	79%	77%
Maroua 3	COP21	Scale-up Saturation	ARP22	500%	500%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	122%
Maroua 3	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Massangam	COP19	Scale-up Saturation	APR20			50%	50%	75%	75%	50%	60%	60%	60%	70%	57%	100%	136%	94%	115%	111%	125%	148%	150%	182%	167%	98%	150%	110%
Massangam	COP20	Scale-up Saturation	APR21			50%	50%	75%	75%	50%	60%	60%	60%	70%	57%	100%	136%	94%	115%	111%	125%	148%	150%	182%	167%	98%	150%	110%
Massangam	COP21	Scale-up Saturation	ARP22	100%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%
Massangam	COP22	Scale-up Saturation	ARP22	90%	90%	90%	100%	90%	100%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	100%	100%	98%	100%	95%
Mayo Oulo	COP19	Scale-up Saturation	APR20	100%	100%	25%	25%	38%	38%	33%	30%	30%	30%	45%	29%	71%	90%	58%	69%	51%	57%	54%	56%	78%	69%	72%	92%	60%
Mayo Oulo	COP20	Scale-up Saturation	APR21	100%	100%	75%	75%	75%	75%	89%	70%	70%	80%	74%	64%	87%	95%	82%	86%	80%	80%	83%	81%	96%	90%	92%	103%	84%
Mayo Oulo	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Mayo Oulo	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	90%	90%	90%	90%	100%	90%	100%	90%	100%	91%	100%	100%	90%	94%	90%	90%	90%	100%	90%	95%	94%
Mbalmayo	COP18	Sustained	APR19	50%	50%	54%	46%	33%	33%	18%	16%	28%	10%	59%	12%	59%	34%	71%	42%	73%	50%	75%	67%	76%	63%	82%	79%	63%
Mbalmayo	COP19	Scale-up Saturation	APR20	50%	50%	54%	50%	48%	45%	35%	34%	34%	29%	46%	34%	66%	83%	54%	61%	53%	56%	65%	61%	87%	71%	51%	66%	58%
Mbalmayo	COP20	Scale-up Saturation	APR21	67%	83%	73%	68%	73%	69%	66%	63%	62%	61%	67%	61%	78%	83%	72%	74%	73%	72%	81%	77%	93%	83%	73%	81%	75%
Mbalmayo	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	91%	89%	93%	93%	94%	95%	95%	96%	96%	96%	97%	97%	97%	94%	97%	93%
Mbalmayo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	100%	100%	95%	95%	92%
Mbandjock	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mbang	COP19	Scale-up Saturation	APR20			17%	14%	27%	25%	19%	18%	12%	17%	21%	13%	32%	39%	26%	28%	23%	23%	26%	23%	35%	27%	29%	36%	26%
Mbang	COP20	Scale-up Saturation	APR21			83%	71%	82%	75%	75%	71%	64%	72%	65%	67%	71%	69%	69%	70%	71%	68%	73%	70%	77%	73%	75%	76%	72%
Mbang	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Mbang	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	93%	91%
Mbanga	COP19	Scale-up Saturation	APR20	50%	33%	30%	27%	18%	17%	14%	13%	16%	12%	18%	11%	25%	31%	20%	22%	19%	20%	21%	20%	27%	22%	17%	21%	21%
Mbanga	COP20	Scale-up Saturation	APR21	100%	67%	40%	36%	29%	28%	27%	21%	27%	20%	28%	19%	33%	38%	29%	29%	28%	27%	31%	27%	37%	29%	27%	28%	29%
Mbanga	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	94%	88%	90%	88%	90%
Mbanga	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mbangue	COP18	Scale-up Saturation	APR19	1%	15%	15%	17%	16%	25%	24%	11%	18%	11%	41%	29%	70%	28%	58%	23%	42%	32%	28%	33%	35%	25%	36%	37%	37%
Mbangue	COP19	Scale-up Saturation	APR20	57%	57%	75%	70%	82%	76%	61%	57%	59%	50%	79%	60%	104%	131%	64%	72%	46%	49%	46%	45%	64%	54%	62%	80%	62%
Mbangue	COP20	Scale-up Saturation	APR21	71%	71%	79%	73%	84%	78%	67%	61%	63%	56%	80%	64%	104%	131%	68%	74%	52%	53%	52%	49%	69%	58%	66%	81%	66%
Mbangue	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Mbangue	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	99%	90%	96%	90%	90%	90%	90%	96%	93%	98%	92%
Mbengwi	COP18	Sustained	APR19			25%		54%	92%	44%	35%	16%	29%	20%		24%	27%	37%	22%	56%	25%	50%	37%	77%	71%	93%	89%	49%
Mbengwi	COP19	Scale-up Saturation	APR20	50%	50%	38%	38%	46%	46%	33%	35%	32%	24%	38%	29%	50%	76%	40%	53%	39%	48%	48%	53%	69%	65%	54%	74%	50%
Mbengwi	COP20	Scale-up Saturation	APR21	100%	100%	50%	50%	62%	54%	50%	41%	52%	35%	54%	38%	61%	78%	54%	57%	53%	53%	60%	58%	77%	69%	65%	76%	60%
Mbengwi	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	95%	88%	96%	88%	97%	89%	97%	91%	98%	91%	96%	91%	92%
Mbengwi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	98%	100%	92%
Mbouda	COP19	Scale-up Saturation	APR20	80%	80%	74%	74%	55%	58%	42%	46%	46%	43%	58%	48%	85%	125%	78%	106%	94%	117%	125%	139%	155%	148%	83%	126%	94%
Mbouda	COP20	Scale-up Saturation	APR21	80%	80%	84%	74%	74%	58%	65%	46%	66%	43%	72%	48%	89%	125%	85%	106%	94%	117%	125%	139%	155%	148%	90%	126%	98%
Mbouda	COP21	Scale-up Saturation	ARP22	94%	100%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	96%	94%	96%	94%	94%	94%	95%
Mbouda	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	100%	100%	98%	98%	93%
Meiganga	COP19	Scale-up Saturation	APR20	43%	43%	34%	32%	31%	30%	24%	24%	21%	18%	28%	21%	44%	56%	36%	41%	33%	36%	39%	38%	56%	47%	48%	61%	40%
Meiganga	COP20	Scale-up Saturation	APR21	86%	71%	76%	68%	78%	71%	76%	70%	66%	67%	68%	63%	75%	74%	73%	70%	75%	70%	78%	72%	84%	77%	81%	84%	75%
Meiganga	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Meiganga	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Melong	COP19	Scale-up Saturation	APR20	100%	100%	20%	20%	38%	38%	30%	27%	30%	27%	33%	25%	43%	54%	33%	37%	31%	32%	35%	33%	44%	36%	28%	37%	35%
Melong	COP20	Scale-up Saturation	APR21	100%	100%	40%	40%	50%	50%	40%	36%	40%	36%	42%	38%	50%	61%	41%	44%	40%	38%	44%	39%	51%	43%	37%	43%	43%
Melong	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	91%	88%	88%	88%	89%
Melong	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Meri	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Messamena	COP19	Scale-up Saturation	APR20			50%	50%	36%	36%	27%	27%	25%	24%	39%	32%	60%	82%	49%	59%	44%	49%	49%	49%	68%	57%	53%	70%	51%
Messamena	COP20	Scale-up Saturation	APR21			83%	83%	82%	82%	80%	80%	69%	76%	74%	73%	83%	88%	79%	83%	80%	80%	82%	82%	90%	85%	84%	90%	82%
Messamena	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Messamena	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	98%	100%	92%
Meyomessala	COP19	Scale-up Saturation	APR20			45%	42%	42%	38%	30%	27%	28%	17%	40%	28%	53%	63%	39%	39%	33%	32%	38%	33%	53%	40%	36%	43%	39%
Meyomessala	COP20	Scale-up Saturation	APR21			82%	83%	84%	81%	81%	80%	76%	80%	77%	78%	82%	83%	79%	77%	80%	78%	83%	79%	87%	83%	82%	84%	81%
Meyomessala	COP21	Scale-up Saturation	ARP22		88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Meyomessala	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mfou	COP18	Sustained	APR19					14%	10%	10%	4%	10%	4%	19%	11%	26%	14%	38%	24%	41%	29%	48%	38%	54%	42%	55%	39%	35%
Mfou	COP19	Scale-up Saturation	APR20	40%	40%	40%	38%	35%	33%	27%	25%	26%	21%	32%	24%	47%	59%	38%	44%	38%	40%	46%	44%	62%	51%	36%	47%	41%
Mfou	COP20	Scale-up Saturation	APR21	60%	60%	65%	62%	65%	62%	61%	58%	56%	57%	59%	54%	67%	73%	63%	64%	64%	63%	70%	66%	79%	71%	65%	69%	66%
Mfou	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	94%	88%	90%	88%	89%
Mfou	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%
Mifi	COP19	Scale-up Saturation	APR20	113%	113%	133%	133%	103%	111%	79%	87%	85%	78%	110%	93%	158%	238%	146%	201%	174%	221%	230%	263%	287%	280%	156%	236%	176%
Mifi	COP20	Scale-up Saturation	APR21	113%	113%	133%	133%	103%	111%	79%	87%	85%	78%	110%	93%	158%	238%	146%	201%	174%	221%	230%	263%	287%	280%	156%	236%	176%
Mifi	COP21	Scale-up Saturation	ARP22	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	96%	94%	97%	94%	97%	94%	95%	94%	95%
Mifi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	97%	90%	100%	100%	100%	100%	98%	98%	93%
Mokolo	COP19	Scale-up Saturation	APR20	200%	200%	138%	138%	113%	113%	90%	86%	88%	81%	122%	89%	204%	263%	183%	212%	176%	193%	194%	193%	278%	235%	219%	287%	191%
Mokolo	COP20	Scale-up Saturation	APR21	200%	200%	138%	138%	113%	113%	90%	86%	88%	81%	122%	89%	204%	263%	183%	212%	176%	193%	194%	193%	278%	235%	219%	287%	191%
Mokolo	COP21	Scale-up Saturation	ARP22	133%	133%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%	87%	88%	87%	87%	87%	91%
Mokolo	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	100%	100%	95%	100%	90%	90%	100%	90%	100%	90%	100%	96%	100%	100%	100%	100%	100%	100%	98%	100%	97%
Moloundou	COP19	Scale-up Saturation	APR20	50%	50%	14%	14%	25%	23%	18%	17%	11%	16%	19%	12%	29%	37%	23%	26%	20%	22%	22%	22%	31%	25%	25%	33%	24%
Moloundou	COP20	Scale-up Saturation	APR21	100%	50%	71%	71%	75%	77%	76%	72%	64%	74%	67%	64%	70%	71%	69%	69%	70%	68%	73%	71%	76%	73%	73%	76%	71%
Moloundou	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Moloundou	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Monatele	COP18	Sustained	APR19		100%		100%		10%	50%	31%	9%		33%	24%	37%	14%	37%	29%	69%	29%	49%	44%	49%	50%	102%	65%	50%
Monatele	COP19	Scale-up Saturation	APR20	100%	100%	60%	60%	44%	40%	33%	31%	35%	31%	50%	35%	70%	86%	55%	66%	54%	60%	65%	66%	86%	75%	50%	67%	60%
Monatele	COP20	Scale-up Saturation	APR21	100%	100%	80%	80%	78%	70%	67%	62%	65%	62%	70%	65%	81%	86%	73%	78%	74%	76%	81%	80%	93%	86%	73%	82%	77%
Monatele	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	89%	88%	88%	88%	89%
Monatele	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	95%	91%
Mora	COP19	Scale-up Saturation	APR20	133%	100%	27%	25%	23%	22%	18%	18%	18%	15%	25%	18%	41%	53%	37%	43%	36%	39%	40%	39%	57%	48%	45%	58%	39%
Mora	COP20	Scale-up Saturation	APR21	133%	100%	87%	81%	87%	81%	89%	83%	78%	83%	78%	76%	83%	81%	84%	82%	86%	82%	90%	86%	92%	89%	90%	91%	85%
Mora	COP21	Scale-up Saturation	ARP22	125%	167%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	92%
Mora	COP22	Scale-up Saturation	ARP22	90%	90%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Moulvoudaye	COP19	Scale-up Saturation	APR20	200%	200%	25%	20%	11%	10%	8%	8%	13%	8%	16%	6%	29%	33%	26%	27%	25%	24%	28%	24%	40%	30%	32%	37%	26%
Moulvoudaye	COP20	Scale-up Saturation	APR21	200%	200%	100%	80%	89%	80%	83%	83%	75%	85%	73%	71%	78%	75%	80%	77%	82%	76%	85%	82%	86%	81%	85%	85%	81%
Moulvoudaye	COP21	Scale-up Saturation	ARP22	300%	300%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	105%
Moulvoudaye	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mozogo	COP22	Scale-up Saturation	ARP22	90%	90%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	91%
Muyuka	COP18	Sustained	APR19	25%		13%	6%	21%	31%	23%	12%	14%	17%	21%	6%	26%	12%	34%	17%	33%	22%	39%	25%	34%	30%	62%	40%	32%
Muyuka	COP19	Scale-up Saturation	APR20	50%	50%	38%	35%	42%	38%	32%	30%	27%	23%	33%	24%	46%	58%	34%	38%	28%	29%	29%	28%	42%	34%	41%	52%	36%
Muyuka	COP20	Scale-up Saturation	APR21	75%	100%	88%	88%	88%	88%	90%	88%	84%	89%	84%	83%	85%	86%	85%	82%	87%	83%	89%	85%	90%	86%	89%	90%	87%
Muyuka	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	91%	88%	88%	88%	89%
Muyuka	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	93%	90%
Mvangan	COP19	Scale-up Saturation	APR20					13%	11%	8%	8%	5%	8%	15%	6%	20%	21%	14%	13%	6%	23%	14%	11%	19%	13%	13%	14%	13%
Mvangan	COP20	Scale-up Saturation	APR21					88%	78%	75%	77%	75%	77%	72%	75%	75%	71%	73%	71%	72%	75%	76%	74%	78%	78%	76%	76%	74%
Mvangan	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	88%	88%	88%
Mvangan	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Mvog-Ada	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	90%	100%	91%	100%	100%	98%	100%	93%

Nanga Eboko	COP18	Sustained	APR19			63%	78%	67%	88%	25%	33%	33%	33%	53%	24%	67%	31%	63%	42%	59%	47%	89%	43%	86%	71%	102%	103%	69%
Nanga Eboko	COP19	Scale-up Saturation	APR20	100%	100%	88%	78%	67%	63%	50%	48%	51%	48%	66%	48%	94%	121%	75%	88%	73%	81%	89%	88%	119%	102%	71%	97%	82%
Nanga Eboko	COP20	Scale-up Saturation	APR21	100%	100%	100%	89%	80%	75%	75%	71%	72%	71%	77%	66%	94%	121%	83%	88%	83%	86%	89%	93%	119%	102%	84%	97%	89%
Nanga Eboko	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	95%	88%	95%	88%	96%	88%	93%	88%	91%
Nanga Eboko	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%	90%	90%	100%	100%	98%	98%	92%
Ndelele	COP19	Scale-up Saturation	APR20	50%	50%	38%	38%	29%	27%	20%	19%	19%	17%	29%	20%	45%	56%	36%	39%	32%	32%	35%	32%	48%	38%	38%	47%	36%
Ndelele	COP20	Scale-up Saturation	APR21	100%	100%	88%	88%	79%	73%	80%	76%	67%	74%	70%	67%	75%	80%	74%	73%	75%	73%	78%	75%	83%	78%	78%	82%	76%
Ndelele	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	90%	88%	88%	88%	89%
Ndelele	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Ndikinimeki	COP18	Sustained	APR19			14%		50%	50%	22%	21%	17%	10%	30%		32%	7%	41%	27%	48%	60%	49%	44%	71%	55%	65%	48%	44%
Ndikinimeki	COP19	Scale-up Saturation	APR20	50%	50%	57%	50%	43%	43%	33%	32%	31%	30%	42%	30%	59%	76%	48%	55%	47%	51%	57%	56%	78%	64%	47%	59%	52%
Ndikinimeki	COP20	Scale-up Saturation	APR21	100%	100%	86%	75%	71%	71%	67%	63%	58%	65%	65%	56%	74%	82%	69%	71%	70%	70%	77%	74%	88%	79%	71%	77%	73%
Ndikinimeki	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	95%	88%	95%	88%	93%	88%	91%
Ndikinimeki	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	90%	93%	100%	100%	100%	98%	98%	92%
Ndop	COP18	Sustained	APR19	11%	11%	53%	38%	51%	52%	38%	54%	28%	25%	32%	8%	36%	20%	51%	26%	57%	34%	52%	48%	54%	46%	62%	48%	46%
Ndop	COP19	Scale-up Saturation	APR20	33%	33%	53%	51%	46%	48%	35%	37%	37%	34%	46%	36%	62%	88%	50%	63%	49%	57%	59%	62%	85%	76%	64%	89%	60%
Ndop	COP20	Scale-up Saturation	APR21	56%	44%	63%	56%	60%	52%	52%	43%	54%	41%	59%	42%	70%	88%	61%	66%	61%	60%	69%	65%	89%	78%	73%	90%	68%
Ndop	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	93%	88%	94%	88%	95%	88%	95%	88%	92%	88%	90%
Ndop	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	97%	98%	92%
Ndu	COP18	Sustained	APR19	25%	25%	42%	58%	100%	50%	44%	41%	24%	29%	12%	8%	26%	15%	48%	20%	56%	39%	63%	60%	71%	62%	56%	69%	47%
Ndu	COP19	Scale-up Saturation	APR20	50%	50%	53%	53%	45%	47%	35%	37%	35%	32%	42%	35%	57%	82%	46%	61%	46%	55%	56%	61%	81%	75%	61%	88%	57%
Ndu	COP20	Scale-up Saturation	APR21	75%	75%	63%	58%	61%	53%	53%	44%	51%	39%	55%	42%	66%	84%	59%	63%	59%	59%	67%	65%	86%	78%	71%	89%	66%
Ndu	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	93%	88%	95%	88%	96%	88%	96%	90%	97%	90%	94%	90%	91%
Ndu	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	98%	100%	95%
New Bell	COP18	Scale-up Saturation	APR19	9%	17%	49%	28%	74%	55%	55%	58%	63%	51%	79%	52%	150%	57%	145%	73%	116%	85%	90%	91%	93%	78%	97%	100%	98%
New Bell	COP19	Scale-up Saturation	APR20	91%	83%	140%	132%	169%	157%	127%	118%	128%	106%	164%	125%	215%	282%	134%	156%	96%	107%	97%	98%	137%	118%	129%	173%	131%
New Bell	COP20	Scale-up Saturation	APR21	91%	83%	140%	132%	169%	157%	127%	118%	128%	106%	164%	125%	215%	282%	134%	156%	96%	107%	97%	98%	137%	118%	129%	173%	131%
New Bell	COP21	Scale-up Saturation	ARP22	88%	0%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	92%	88%	93%	88%	93%	88%	89%	88%	85%
New Bell	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	97%	100%	100%	100%	100%	98%	100%	94%
Ngaoundal	COP19	Scale-up Saturation	APR20	50%	50%	35%	33%	26%	25%	20%	20%	18%	16%	25%	19%	39%	53%	33%	39%	30%	33%	35%	35%	51%	44%	43%	57%	36%
Ngaoundal	COP20	Scale-up Saturation	APR21	100%	100%	76%	72%	74%	69%	75%	70%	69%	67%	69%	64%	75%	76%	73%	71%	75%	69%	78%	72%	83%	77%	80%	83%	75%
Ngaoundal	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	92%	88%	93%	88%	88%	88%	90%
Ngaoundal	COP22	Scale-up Saturation	ARP22	90%	90%	90%	100%	100%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	90%	90%	100%	90%	90%	90%	100%	90%	95%	93%
Ngaoundere Rural	COP19	Scale-up Saturation	APR20	75%	75%	18%	17%	13%	13%	10%	10%	9%	9%	14%	11%	22%	29%	18%	21%	16%	18%	18%	19%	27%	23%	23%	31%	20%
Ngaoundere Rural	COP20	Scale-up Saturation	APR21	100%	100%	71%	67%	74%	66%	73%	66%	63%	66%	65%	60%	69%	66%	68%	63%	70%	64%	73%	66%	75%	69%	74%	73%	69%
Ngaoundere Rural	COP21	Scale-up Saturation	ARP22	100%	150%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%
Ngaoundere Rural	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	90%	90%
Ngaoundere Urbain	COP19	Scale-up Saturation	APR20	67%	67%	98%	94%	89%	87%	70%	69%	62%	55%	81%	64%	125%	169%	102%	123%	94%	106%	108%	110%	158%	138%	132%	181%	114%
Ngaoundere Urbain	COP20	Scale-up Saturation	APR21	67%	67%	98%	94%	89%	87%	70%	69%	62%	55%	81%	64%	125%	169%	102%	123%	94%	106%	108%	110%	158%	138%	132%	181%	114%
Ngaoundere Urbain	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	93%	88%	94%	88%	95%	90%	95%	90%	92%	90%	91%
Ngaoundere Urbain	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	90%	100%	90%	100%	90%	99%	100%	90%	100%	90%	100%	90%	98%	93%
Ngog Mapubi	COP18	Sustained	APR19			20%	20%	6%	6%		4%	4%		22%	3%	15%	11%	15%	6%	19%	21%	21%	19%	27%	15%	24%	19%	17%
Ngog Mapubi	COP19	Scale-up Saturation	APR20	50%	50%	10%	10%	18%	17%	13%	12%	13%	12%	15%	12%	22%	27%	18%	22%	18%	20%	21%	22%	29%	25%	17%	22%	20%
Ngog Mapubi	COP20	Scale-up Saturation	APR21	100%	100%	50%	50%	59%	56%	54%	52%	53%	52%	52%	52%	55%	55%	54%	53%	55%	53%	58%	55%	62%	58%	55%	57%	55%
Ngog Mapubi	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Ngog Mapubi	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%	95%	90%
Ngong	COP19	Scale-up Saturation	APR20	100%	100%	50%	46%	43%	42%	34%	34%	31%	26%	44%	35%	72%	93%	57%	67%	49%	54%	52%	53%	74%	64%	69%	92%	59%
Ngong	COP20	Scale-up Saturation	APR21	100%	100%	83%	69%	74%	71%	69%	69%	64%	65%	68%	65%	83%	93%	76%	80%	74%	73%	77%	75%	87%	82%	84%	92%	78%
Ngong	COP21	Scale-up Saturation	ARP22	133%	200%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	90%	88%	88%	88%	95%
Ngong	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Ngoumou	COP18	Sustained	APR19			22%	33%	63%	56%	52%	32%	20%	13%	30%	27%	49%	22%	63%	24%	54%	50%	84%	72%	89%	63%	112%	86%	64%
Ngoumou	COP19	Scale-up Saturation	APR20	100%	100%	89%	89%	81%	81%	62%	59%	59%	48%	77%	60%	114%	143%	92%	107%	91%	99%	111%	109%	151%	125%	87%	116%	100%
Ngoumou	COP20	Scale-up Saturation	APR21	100%	100%	89%	89%	81%	81%	62%	59%	59%	48%	77%	60%	114%	143%	92%	107%	91%	99%	111%	109%	151%	125%	87%	116%	100%
Ngoumou	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	90%	88%	88%	88%	89%
Ngoumou	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	100%	100%	98%	98%	93%

Nguelemendouka	COP19	Scale-up Saturation	APR20			27%	25%	19%	18%	14%	13%	14%	12%	21%	14%	33%	40%	27%	28%	24%	24%	27%	24%	38%	29%	29%	36%	27%
Nguelemendouka	COP20	Scale-up Saturation	APR21			73%	75%	76%	73%	72%	71%	66%	70%	67%	64%	72%	73%	70%	69%	72%	69%	75%	71%	79%	74%	74%	77%	72%
Nguelemendouka	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Nguelemendouka	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Nguti	COP18	Sustained	APR19			60%	20%	83%	43%	63%	33%	17%	10%	10%	7%	19%	4%	35%	15%	30%	18%	38%	31%	58%	50%	74%	57%	37%
Nguti	COP19	Scale-up Saturation	APR20			60%	60%	67%	57%	50%	44%	39%	30%	50%	40%	70%	92%	52%	59%	42%	46%	44%	44%	64%	55%	58%	77%	54%
Nguti	COP20	Scale-up Saturation	APR21			80%	80%	100%	100%	100%	100%	83%	90%	85%	87%	89%	92%	88%	85%	89%	84%	91%	88%	96%	90%	92%	94%	90%
Nguti	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	88%
Nguti	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	98%	98%	92%
Njombe Penja	COP18	Sustained	APR19	100%		200%	150%	133%	50%	113%	163%	73%	125%	47%	58%	106%	29%	183%	103%	258%	166%	287%	206%	353%	472%	297%	248%	220%
Njombe Penja	COP19	Scale-up Saturation	APR20	200%	200%	275%	275%	300%	300%	225%	225%	227%	188%	278%	200%	361%	476%	274%	326%	259%	289%	290%	289%	372%	316%	232%	300%	290%
Njombe Penja	COP20	Scale-up Saturation	APR21	200%	200%	275%	275%	300%	300%	225%	225%	227%	188%	278%	200%	361%	476%	274%	326%	259%	289%	290%	289%	372%	316%	232%	300%	290%
Njombe Penja	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	95%	88%	95%	88%	93%	88%	91%
Njombe Penja	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	95%	90%	91%
Nkambe	COP18	Sustained	APR19		17%	75%	64%	79%	68%	61%	57%	38%	26%	33%	11%	43%	24%	58%	26%	60%	40%	64%	62%	74%	64%	66%	61%	54%
Nkambe	COP19	Scale-up Saturation	APR20	33%	33%	54%	52%	48%	49%	36%	38%	35%	33%	42%	35%	59%	85%	49%	63%	48%	58%	59%	64%	84%	79%	63%	92%	59%
Nkambe	COP20	Scale-up Saturation	APR21	50%	50%	67%	56%	62%	54%	52%	43%	51%	41%	55%	41%	68%	85%	60%	66%	60%	61%	69%	67%	88%	81%	72%	92%	67%
Nkambe	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	94%	88%	94%	88%	91%	88%	89%
Nkambe	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	97%	90%	97%	100%	100%	100%	98%	98%	93%
Nkolbisson	COP19	Scale-up Saturation	APR20	20%	17%	13%	13%	13%	12%	10%	9%	8%	7%	11%	6%	14%	18%	9%	10%	7%	7%	7%	7%	11%	9%	10%	13%	9%
Nkolbisson	COP20	Scale-up Saturation	APR21	60%	50%	52%	50%	55%	53%	55%	51%	48%	50%	49%	46%	51%	51%	50%	48%	50%	47%	51%	48%	53%	49%	52%	52%	50%
Nkolbisson	COP21	Scale-up Saturation	ARP22	100%	200%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	93%
Nkolbisson	COP22	Scale-up Saturation	ARP22	100%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	91%
Nkolndongo	COP18	Scale-up Saturation	APR19		7%	21%	17%	22%	14%	13%	9%	18%	7%	39%	19%	56%	25%	45%	24%	28%	20%	21%	19%	19%	16%	20%	23%	26%
Nkolndongo	COP19	Scale-up Saturation	APR20	30%	28%	30%	29%	34%	32%	25%	24%	24%	20%	32%	23%	43%	54%	27%	30%	20%	21%	21%	20%	31%	25%	31%	39%	28%
Nkolndongo	COP20	Scale-up Saturation	APR21	59%	55%	59%	57%	64%	61%	61%	58%	56%	56%	60%	55%	66%	70%	58%	58%	56%	53%	57%	54%	62%	57%	62%	65%	59%
Nkolndongo	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	92%	88%	88%	88%	89%
Nkolndongo	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	96%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%
Nkongsamba	COP18	Sustained	APR19		100%	133%	50%	80%	50%	70%	43%	25%	55%	42%	13%	48%	23%	47%	17%	100%	44%	120%	76%	146%	94%	149%	121%	88%
Nkongsamba	COP19	Scale-up Saturation	APR20	100%	100%	122%	110%	120%	113%	90%	86%	85%	73%	110%	81%	144%	184%	111%	130%	106%	117%	119%	118%	152%	130%	94%	123%	117%
Nkongsamba	COP20	Scale-up Saturation	APR21	100%	100%	122%	110%	120%	113%	90%	86%	85%	73%	110%	81%	144%	184%	111%	130%	106%	117%	119%	118%	152%	130%	94%	123%	117%
Nkongsamba	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	92%	88%	93%	88%	95%	88%	96%	88%	96%	88%	93%	88%	91%
Nkongsamba	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	91%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%	100%	100%	100%	100%	98%	100%	93%
Ntui	COP18	Sustained	APR19		25%	39%	16%		24%	2%	9%	21%	4%	33%	9%	33%	20%	24%	26%	27%	19%	25%	25%	30%	25%	23%	23%	24%
Ntui	COP19	Scale-up Saturation	APR20	25%	25%	17%	16%	13%	12%	9%	9%	9%	9%	14%	9%	18%	24%	15%	17%	14%	16%	18%	17%	24%	20%	14%	19%	16%
Ntui	COP20	Scale-up Saturation	APR21	75%	75%	50%	53%	53%	52%	51%	49%	47%	49%	49%	45%	52%	52%	51%	49%	52%	50%	55%	52%	59%	54%	53%	54%	52%
Ntui	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	91%	88%	92%	88%	88%	88%	90%
Ntui	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Nylon	COP18	Scale-up Saturation	APR19	45%	42%	51%	44%	76%	58%	67%	44%	35%	49%	66%	33%	96%	38%	108%	44%	94%	52%	93%	66%	93%	77%	101%	102%	84%
Nylon	COP19	Scale-up Saturation	APR20	91%	83%	114%	108%	142%	131%	106%	99%	109%	84%	142%	104%	184%	231%	114%	127%	81%	87%	82%	79%	115%	95%	110%	139%	110%
Nylon	COP20	Scale-up Saturation	APR21	91%	83%	114%	108%	142%	131%	106%	99%	109%	84%	142%	104%	184%	231%	114%	127%	81%	87%	82%	79%	115%	95%	110%	139%	110%
Nylon	COP21	Scale-up Saturation	ARP22	390%	257%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	92%	88%	92%	88%	88%	88%	108%
Nylon	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	100%	90%	92%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	90%	100%	100%	100%	100%	98%	100%	94%
Obala	COP18	Sustained	APR19	25%	25%	50%	68%	41%	18%	21%	27%	31%	11%	36%	10%	62%	25%	67%	45%	73%	54%	87%	77%	92%	80%	103%	100%	70%
Obala	COP19	Scale-up Saturation	APR20	75%	75%	78%	74%	75%	71%	56%	53%	52%	46%	70%	52%	99%	127%	79%	92%	77%	84%	93%	92%	125%	106%	75%	100%	86%
Obala	COP20	Scale-up Saturation	APR21	100%	75%	89%	74%	88%	71%	77%	53%	71%	46%	80%	52%	99%	127%	86%	92%	86%	84%	93%	92%	125%	106%	86%	100%	91%
Obala	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	90%	88%	88%	88%	89%
Obala	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	97%	90%	100%	100%	100%	100%	98%	98%	93%
Odza	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%
Okola	COP18	Sustained	APR19					33%		6%		13%	6%	42%	8%	39%	10%	41%	27%	26%	31%	42%	41%	49%	35%	41%	31%	33%
Okola	COP19	Scale-up Saturation	APR20	50%	50%	14%	14%	25%	23%	18%	18%	19%	17%	23%	17%	34%	43%	27%	30%	26%	28%	32%	30%	43%	35%	25%	32%	29%
Okola	COP20	Scale-up Saturation	APR21	50%	50%	57%	57%	67%	62%	59%	59%	56%	56%	56%	54%	62%	65%	57%	57%	58%	57%	64%	61%	70%	63%	60%	62%	60%
Okola	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	91%	88%	92%	88%	88%	88%	90%
Okola	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%	90%	90%
Oku	COP19	Scale-up Saturation	APR20	33%	33%	23%	23%	18%	19%	14%	15%	13%	15%	18%	15%	23%	34%	19%	25%	18%	23%	22%	25%	32%	31%	24%	36%	23%
Oku	COP20	Scale-up Saturation	APR21	67%	67%	46%	31%	41%	29%	36%	22%	35%	26%	38%	23%	41%	40%	38%	32%	38%	30%	42%	31%	49%	37%	42%	41%	38%
Oku	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	94%	88%	90%	88%	90%
Oku	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	91%	98%	91%

Pette	COP19	Scale-up Saturation	APR20	200%	200%	500%	333%	300%	300%	250%	214%	250%	200%	321%	233%	531%	669%	478%	556%	465%	494%	506%	494%	748%	636%	578%	736%	499%
Pette	COP20	Scale-up Saturation	APR21	200%	200%	500%	333%	300%	300%	250%	214%	250%	200%	321%	233%	531%	669%	478%	556%	465%	494%	506%	494%	748%	636%	578%	736%	499%
Pette	COP21	Scale-up Saturation	ARP22	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%
Pette	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	100%	90%	100%	92%	100%	100%	100%	100%	98%	100%	94%
Pitoa	COP19	Scale-up Saturation	APR20	200%	200%	67%	67%	70%	64%	54%	54%	46%	43%	62%	42%	101%	136%	83%	97%	72%	79%	77%	78%	110%	95%	99%	132%	86%
Pitoa	COP20	Scale-up Saturation	APR21	200%	200%	83%	67%	90%	64%	85%	54%	68%	43%	77%	42%	101%	136%	89%	97%	85%	79%	89%	78%	110%	95%	99%	132%	92%
Pitoa	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%
Pitoa	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Poli	COP19	Scale-up Saturation	APR20	100%	100%	60%	60%	44%	40%	33%	33%	33%	33%	53%	44%	84%	113%	67%	82%	58%	67%	62%	65%	87%	80%	82%	111%	70%
Poli	COP20	Scale-up Saturation	APR21	100%	100%	100%	80%	78%	70%	75%	67%	67%	67%	76%	69%	90%	113%	84%	91%	80%	81%	84%	81%	95%	91%	93%	111%	86%
Poli	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	89%	88%	88%	88%	89%
Poli	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	91%
Pouma	COP18	Sustained	APR19			150%	50%	75%	125%	20%	40%	20%		73%		61%	33%	126%	33%	128%	65%	140%	127%	138%	130%	182%	136%	111%
Pouma	COP19	Scale-up Saturation	APR20			150%	150%	150%	150%	120%	120%	100%	67%	32%	313%	156%	200%	122%	143%	64%	243%	133%	136%	175%	150%	108%	136%	131%
Pouma	COP20	Scale-up Saturation	APR21			150%	150%	150%	150%	120%	120%	100%	67%	32%	313%	156%	200%	122%	143%	64%	243%	133%	136%	175%	150%	108%	136%	131%
Pouma	COP21	Scale-up Saturation	ARP22			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Pouma	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	95%	95%	91%
Rey Bouba	COP19	Scale-up Saturation	APR20	67%	67%	27%	25%	19%	18%	15%	15%	13%	11%	20%	17%	32%	43%	25%	30%	22%	24%	24%	23%	34%	29%	29%	39%	26%
Rey Bouba	COP20	Scale-up Saturation	APR21	67%	67%	73%	58%	62%	59%	62%	56%	56%	54%	58%	53%	63%	67%	61%	60%	61%	57%	63%	58%	68%	61%	65%	68%	62%
Rey Bouba	COP21	Scale-up Saturation	ARP22	150%	150%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	93%
Rey Bouba	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	92%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Saa	COP18	Sustained	APR19		50%	44%	33%	25%	12%	10%	23%	15%	4%	22%	7%	23%	6%	37%	18%	46%	24%	56%	51%	65%	60%	54%	67%	41%
Saa	COP19	Scale-up Saturation	APR20	100%	100%	67%	67%	50%	47%	38%	36%	43%	30%	54%	43%	77%	98%	61%	72%	59%	65%	72%	71%	96%	82%	58%	76%	66%
Saa	COP20	Scale-up Saturation	APR21	100%	100%	78%	78%	75%	71%	71%	64%	68%	61%	72%	67%	84%	98%	76%	80%	77%	78%	85%	82%	96%	90%	77%	86%	80%
Saa	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	91%	88%	91%	88%	88%	88%	89%
Saa	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	95%	91%
Sangmelima	COP19	Scale-up Saturation	APR20	50%	50%	100%	94%	104%	93%	71%	64%	73%	62%	104%	71%	139%	167%	98%	108%	84%	88%	97%	91%	135%	109%	91%	114%	102%
Sangmelima	COP20	Scale-up Saturation	APR21	50%	50%	100%	94%	104%	93%	71%	64%	73%	62%	104%	71%	139%	167%	98%	108%	84%	88%	97%	91%	135%	109%	91%	114%	102%
Sangmelima	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	89%	88%	88%	88%	88%
Sangmelima	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	95%	95%	91%
Santa	COP19	Scale-up Saturation	APR20	67%	67%	50%	50%	46%	48%	34%	37%	40%	33%	45%	34%	62%	87%	50%	63%	49%	57%	59%	63%	85%	77%	64%	92%	60%
Santa	COP20	Scale-up Saturation	APR21	100%	100%	64%	57%	58%	52%	53%	43%	55%	40%	57%	41%	70%	87%	60%	66%	60%	61%	69%	67%	88%	79%	72%	92%	68%
Santa	COP21	Scale-up Saturation	ARP22	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	93%	88%	95%	88%	96%	88%	96%	88%	93%	88%	90%
Santa	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	98%	100%	92%
Santchou	COP19	Scale-up Saturation	APR20			50%	50%	20%	20%	14%	17%	33%	17%	42%	38%	62%	85%	60%	73%	71%	79%	92%	92%	114%	100%	62%	96%	67%
Santchou	COP20	Scale-up Saturation	APR21			100%	50%	80%	20%	71%	17%	67%	17%	71%	38%	78%	85%	78%	73%	85%	79%	92%	92%	114%	100%	82%	96%	80%
Santchou	COP21	Scale-up Saturation	ARP22			94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	94%	95%	94%	95%	94%	94%	94%	94%
Santchou	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	92%	100%	100%	100%	100%	98%	100%	93%
Soa	COP18	Sustained	APR19	100%		33%	17%		18%		7%	42%		69%	25%	75%	52%	66%	39%	55%	50%	50%	52%	43%	38%	44%	47%	49%
Soa	COP19	Scale-up Saturation	APR20	100%	100%	50%	50%	40%	36%	29%	29%	31%	27%	40%	30%	59%	73%	47%	52%	46%	48%	56%	52%	74%	60%	44%	57%	50%
Soa	COP20	Scale-up Saturation	APR21	100%	100%	67%	67%	70%	64%	64%	64%	62%	60%	65%	60%	75%	82%	70%	70%	70%	70%	77%	74%	86%	78%	70%	77%	72%
Soa	COP21	Scale-up Saturation	ARP22	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	94%	88%	95%	88%	95%	88%	92%	88%	90%
Soa	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	94%	91%
Tchollire	COP19	Scale-up Saturation	APR20	133%	133%	55%	55%	35%	33%	27%	27%	32%	25%	45%	36%	72%	96%	59%	68%	51%	56%	55%	55%	78%	67%	71%	95%	61%
Tchollire	COP20	Scale-up Saturation	APR21	133%	133%	82%	82%	75%	67%	69%	65%	64%	61%	70%	64%	83%	96%	77%	82%	76%	75%	79%	76%	90%	83%	86%	95%	80%
Tchollire	COP21	Scale-up Saturation	ARP22	133%	200%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	95%
Tchollire	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	96%	90%	92%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%
Tibati	COP19	Scale-up Saturation	APR20	50%	50%	33%	32%	30%	30%	24%	24%	21%	18%	28%	22%	44%	55%	36%	41%	33%	35%	38%	37%	56%	46%	47%	62%	40%
Tibati	COP20	Scale-up Saturation	APR21	100%	100%	78%	68%	76%	73%	76%	71%	69%	69%	71%	65%	76%	76%	75%	71%	76%	70%	80%	73%	85%	77%	82%	84%	76%
Tibati	COP21	Scale-up Saturation	ARP22	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	88%	88%	88%
Tibati	COP22	Scale-up Saturation	ARP22	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

Tignere	*COP19*	*Scale-up Saturation*	*APR20*	33%	33%	45%	42%	30%	29%	23%	23%	22%	21%	27%	20%	40%	51%	33%	41%	30%	35%	35%	36%	50%	45%	43%	56%	37%
Tignere	*COP20*	*Scale-up Saturation*	*APR21*	67%	100%	91%	75%	80%	71%	81%	73%	71%	71%	71%	65%	76%	75%	76%	72%	76%	71%	80%	74%	85%	79%	82%	83%	77%
Tignere	*COP21*	*Scale-up Saturation*	*ARP22*	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Tignere	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	94%	90%
Tiko	*COP18*	*Sustained*	*APR19*		17%	56%	48%	124%	95%	155%	138%	59%	42%	49%	33%	100%	40%	173%	67%	184%	109%	153%	138%	155%	162%	138%	172%	133%
Tiko	*COP19*	*Scale-up Saturation*	*APR20*	100%	100%	164%	152%	170%	158%	134%	126%	129%	102%	152%	111%	210%	271%	156%	177%	126%	135%	134%	129%	192%	159%	184%	234%	163%
Tiko	*COP20*	*Scale-up Saturation*	*APR21*	100%	100%	164%	152%	170%	158%	134%	126%	129%	102%	152%	111%	210%	271%	156%	177%	126%	135%	134%	129%	192%	159%	184%	234%	163%
Tiko	*COP21*	*Scale-up Saturation*	*ARP22*	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	90%	88%	92%	88%	93%	88%	94%	88%	90%	88%	89%
Tiko	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	100%	90%	100%	100%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	100%	100%	100%	100%	98%	100%	95%
Tokombere	*COP19*	*Scale-up Saturation*	*APR20*	300%	300%	80%	67%	64%	58%	50%	47%	46%	40%	66%	50%	111%	139%	101%	114%	96%	103%	107%	103%	154%	124%	122%	152%	104%
Tokombere	*COP20*	*Scale-up Saturation*	*APR21*	300%	300%	80%	67%	64%	58%	50%	47%	46%	40%	66%	50%	111%	139%	101%	114%	96%	103%	107%	103%	154%	124%	122%	152%	104%
Tokombere	*COP21*	*Scale-up Saturation*	*ARP22*	300%	300%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	88%	87%	90%	87%	90%	87%	87%	87%	105%
Tokombere	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	100%	100%	100%	100%	100%	98%	100%	94%
Tombel	*COP18*	*Sustained*	*APR19*			25%	17%	53%	39%	18%	13%	23%	20%	13%	3%	18%	12%	22%	13%	27%	23%	30%	17%	42%	27%	76%	63%	32%
Tombel	*COP19*	*Scale-up Saturation*	*APR20*	67%	67%	50%	50%	47%	44%	36%	35%	32%	28%	41%	28%	56%	73%	42%	48%	35%	37%	37%	36%	53%	44%	50%	64%	45%
Tombel	*COP20*	*Scale-up Saturation*	*APR21*	100%	67%	92%	92%	88%	94%	91%	91%	83%	88%	83%	83%	87%	88%	86%	84%	88%	85%	90%	87%	92%	89%	91%	93%	88%
Tombel	*COP21*	*Scale-up Saturation*	*ARP22*	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Tombel	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	93%	90%
Touboro	*COP19*	*Scale-up Saturation*	*APR20*	100%	100%	63%	59%	53%	52%	43%	42%	38%	33%	52%	40%	81%	112%	66%	79%	57%	65%	61%	63%	87%	77%	80%	108%	69%
Touboro	*COP20*	*Scale-up Saturation*	*APR21*	100%	100%	81%	76%	77%	71%	76%	68%	68%	63%	72%	63%	87%	112%	81%	85%	78%	78%	81%	78%	93%	87%	89%	108%	83%
Touboro	*COP21*	*Scale-up Saturation*	*ARP22*	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Touboro	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	91%
Tubah	*COP19*	*Scale-up Saturation*	*APR20*	50%	50%	43%	43%	25%	25%	19%	20%	25%	20%	27%	19%	37%	54%	30%	38%	29%	34%	35%	38%	50%	47%	38%	54%	36%
Tubah	*COP20*	*Scale-up Saturation*	*APR21*	50%	50%	57%	57%	50%	33%	44%	33%	46%	33%	45%	29%	52%	59%	47%	44%	47%	41%	52%	43%	63%	53%	54%	59%	50%
Tubah	*COP21*	*Scale-up Saturation*	*ARP22*	100%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	91%	88%	92%	88%	92%	88%	88%	88%	90%
Tubah	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	95%	98%	91%
Wum	*COP18*	*Sustained*	*APR19*	20%	20%	29%	29%	51%	79%	38%	23%	11%	18%	16%	6%	27%	12%	40%	18%	51%	33%	46%	35%	55%	48%	50%	62%	39%
Wum	*COP19*	*Scale-up Saturation*	*APR20*	40%	40%	38%	38%	40%	41%	30%	32%	31%	29%	35%	31%	48%	71%	39%	52%	39%	47%	47%	52%	68%	63%	50%	75%	48%
Wum	*COP20*	*Scale-up Saturation*	*APR21*	60%	60%	52%	48%	57%	47%	49%	39%	49%	36%	51%	37%	60%	74%	53%	56%	54%	51%	60%	56%	76%	67%	63%	78%	59%
Wum	*COP21*	*Scale-up Saturation*	*ARP22*	88%	100%	88%	88%	88%	88%	88%	88%	89%	88%	92%	88%	95%	88%	96%	88%	97%	89%	97%	91%	97%	91%	96%	91%	91%
Wum	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	100%	100%	95%	100%	98%	98%	92%
Yabassi	*COP18*	*Sustained*	*APR19*				33%	75%		20%		10%	33%	14%		14%	7%	11%	19%	22%	4%	23%	26%	24%	24%	38%	25%	21%
Yabassi	*COP19*	*Scale-up Saturation*	*APR20*			50%	33%	25%	25%	20%	17%	30%	17%	27%	13%	36%	50%	28%	33%	27%	30%	30%	30%	38%	33%	23%	33%	30%
Yabassi	*COP20*	*Scale-up Saturation*	*APR21*			100%	67%	50%	50%	40%	33%	40%	33%	36%	25%	44%	57%	36%	43%	37%	39%	39%	39%	47%	43%	34%	40%	40%
Yabassi	*COP21*	*Scale-up Saturation*	*ARP22*			88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Yabassi	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Yagoua	*COP19*	*Scale-up Saturation*	*APR20*	75%	75%	69%	65%	61%	59%	49%	47%	42%	39%	60%	46%	99%	129%	90%	105%	86%	95%	96%	96%	137%	117%	108%	140%	94%
Yagoua	*COP20*	*Scale-up Saturation*	*APR21*	75%	75%	69%	65%	61%	59%	49%	47%	42%	39%	60%	46%	99%	129%	90%	105%	86%	95%	96%	96%	137%	117%	108%	140%	94%
Yagoua	*COP21*	*Scale-up Saturation*	*ARP22*	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	87%	89%	87%	91%	87%	91%	87%	87%	87%	88%
Yagoua	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	94%	90%	100%	90%	90%	90%	90%	90%	90%	90%	100%	90%	100%	95%	100%	100%	100%	100%	100%	100%	98%	100%	95%
Yokadouma	*COP19*	*Scale-up Saturation*	*APR20*	67%	67%	54%	50%	48%	46%	35%	33%	31%	27%	44%	31%	72%	88%	58%	64%	51%	53%	56%	53%	77%	63%	61%	79%	58%
Yokadouma	*COP20*	*Scale-up Saturation*	*APR21*	100%	100%	85%	79%	83%	83%	81%	79%	70%	76%	75%	71%	85%	88%	82%	82%	81%	80%	85%	82%	92%	87%	86%	94%	84%
Yokadouma	*COP21*	*Scale-up Saturation*	*ARP22*	88%	100%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	89%	88%	89%	88%	88%	88%	89%
Yokadouma	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Zoetele	*COP19*	*Scale-up Saturation*	*APR20*	100%	100%	67%	67%	78%	70%	54%	47%	54%	40%	72%	42%	97%	115%	68%	72%	58%	58%	66%	60%	93%	73%	62%	76%	70%
Zoetele	*COP20*	*Scale-up Saturation*	*APR21*	100%	100%	83%	83%	100%	90%	92%	80%	79%	80%	85%	74%	97%	115%	84%	83%	84%	80%	88%	83%	93%	88%	86%	89%	87%
Zoetele	*COP21*	*Scale-up Saturation*	*ARP22*	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%	88%
Zoetele	*COP22*	*Scale-up Saturation*	*ARP22*	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP22 Budget by Program Area

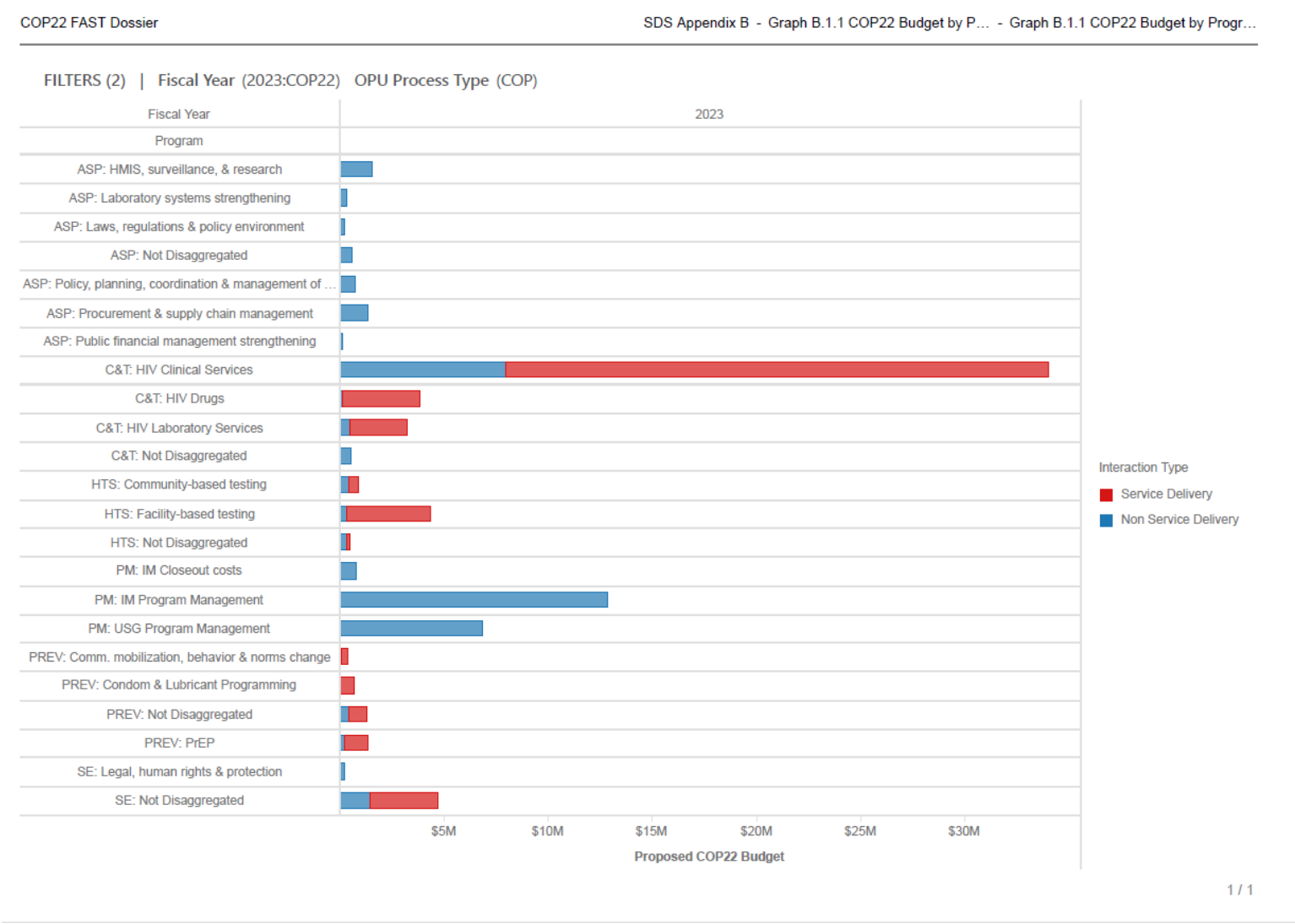


Table B.1.2 COP22 Budget by Program Area

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

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		$37,175,236	$43,265,764	$80,441,000	46%	54%	100%
C&T	Total	$8,997,795	$32,478,754	$41,476,549	22%	78%	100%
	HIV Clinical Services	$7,931,593	$26,076,610	$34,008,203	23%	77%	100%
	HIV Drugs	$97,957	$3,710,708	$3,808,665	3%	97%	100%
	HIV Laboratory Services	$464,411	$2,691,436	$3,155,847	15%	85%	100%
	Not Disaggregated	$503,834		$503,834	100%		100%
HTS	Total	$990,136	$4,574,354	$5,564,490	18%	82%	100%
	Community-based testing	$408,186	$418,060	$826,246	49%	51%	100%
	Facility-based testing	$272,157	$4,020,536	$4,292,693	6%	94%	100%
	Not Disaggregated	$309,793	$135,758	$445,551	70%	30%	100%
PREV	Total	$579,943	$2,950,083	$3,530,026	16%	84%	100%
	Comm. mobilization, behavior & norms change	$30,000	$287,398	$317,398	9%	91%	100%
	Condom & Lubricant Programming		$638,480	$638,480		100%	100%
	Not Disaggregated	$390,918	$861,566	$1,252,484	31%	69%	100%
	PrEP	$159,025	$1,162,639	$1,321,664	12%	88%	100%
SE	Total	$1,595,541	$3,262,573	$4,858,114	33%	67%	100%
	Legal, human rights & protection	$193,501		$193,501	100%		100%
	Not Disaggregated	$1,402,040	$3,262,573	$4,664,613	30%	70%	100%
ASP	Total	$4,627,198		$4,627,198	100%		100%
	HMIS, surveillance, & research	$1,540,174		$1,540,174	100%		100%
	Laboratory systems strengthening	$256,790		$256,790	100%		100%
	Laws, regulations & policy environment	$182,303		$182,303	100%		100%
	Not Disaggregated	$557,108		$557,108	100%		100%

Table B.1.3 COP22 Total Planning Level

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

Metrics	Proposed COP22 Budget		
Operating Unit	Applied Pipeline	New	Total
Total	**$1,156,807**	**$79,284,193**	**$80,441,000**
Cameroon	$1,156,807	$79,284,193	**$80,441,000**

Table B.1.4 COP22 Resource Allocation by Program and Beneficiary

FILTERS (2) | Fiscal Year (2023:COP22) OPU Process Type (COP)

Operating Unit	Metrics	Proposed COP22 Budget							Percent to Total						
	Beneficiary	C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total
Cameroon	**Total**	**$41,476,549**	**$5,564,490**	**$3,530,026**	**$4,858,114**	**$4,627,198**	**$20,384,623**	**$80,441,000**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
	Females	$1,040,404		$364,398				**$1,404,802**	3%		10%				2%
	Key Pops	$3,095,704	$721,246	$1,651,727	$78,984	$137,500		**$5,685,161**	7%	13%	47%	2%	3%		7%
	Males	$2,669,624						**$2,669,624**	6%						3%
	Non-Targeted Pop	$31,083,356	$4,751,941	$842,329	$183,903	$4,427,998	$20,347,771	**$61,637,298**	75%	85%	24%	4%	96%	100%	77%
	OVC			$287,398	$4,595,227	$37,500		**$4,920,125**			8%	95%	1%		6%
	Pregnant & Breastfeeding Women	$2,082,353						**$2,082,353**	5%						3%
	Priority Pops	$1,505,108	$91,303	$384,174		$24,200	$36,852	**$2,041,637**	4%	2%	11%		1%	0%	3%

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APPENDIX C – Key Systems Barriers and Above Site Investments

Key Systems Barriers

Key Systems Barriers-E (Entry of Objectives, Related SID Elements, Barriers to Local Responsibility)					
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
14. Epidemiological and Health Data	7.3	Electronic register in health facility	Lack of Financial Resources	Slow implementation of electronic register in all facilities in some zones related to insufficient resources	2-3 years
2. Policies and Governance	7.2	Functional and harmonized data systems	Other	Suboptimal resources for data systems	2-3 years
10. Laboratory	6.7	Platforms available in country	Lack of sufficient HRH	Insufficient number of staff for DNO	4-5 years
6. Service Delivery	6.3	Six (6) Pilot sites trained on TPT short regimen	Lack of technical capacity	Suboptimal awareness in new guidelines	1 year
8. Commodity Security and Supply Chain	4.8	Improved HIV supply chain visibility, productivity, and responsiveness through rationalization and fast replenishment of inventory	Lack of technical capacity	Insufficient warehouse and inventory level optimization	4-5 years
8. Commodity Security and Supply Chain	4.8	Improved timeliness and accuracy of data to react quickly to avoid impending stock outs or expiries	Lack of technical capacity	Challenges in logistics data quality leads to inaccurate distribution, inaccurate forecasts, and chronic under/overstocks at SDPs.	4-5 years
11. Domestic Resource Mobilization	5.1	Universal access to quality HIV treatment and care	Legal, policy or regulatory constraint	Out of pocket expenses for medical services puts families and communities at risk. User fees charged at service delivery points impede uptake of health/clinical services	4-5 years
1. Planning and Coordination	8.6	Resilient CSO/Local Partner primes delivery successful PEPFAR programs	Lack of technical capacity	Weak and inadequate structures at local partner organizations to ensure risk free transition	4-5 years
14. Epidemiological and Health Data	7.3	Improve capacity for CSOs to manage community HMIS: to collect and report on quality KP and OVC (community) data	Lack of technical capacity	Weak national health system and service delivery	2-3 years
2. Policies and Governance	7.2	Availability of Legal Environment Assessment for use by all stakeholders	Legal, policy or regulatory constraint	User fees charged at service delivery points impede ART uptake and retention	4-5 years

Above Site Investments- Laboratory

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$112,500	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.56	5.71	Platforms in country	Lack of sufficient HRH	Review of laboratory Diagnostic Network Optimization (DNO)	COP22	Post COP25
$112,500	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	6.56	5.71	Platforms in country	Lack of sufficient HRH	Review of laboratory Diagnostic Network Optimization (DNO)	COP22	Post COP25

Above Site Investments-Domestic Resource Mobilization

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$ 37,500	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	6.31	6.31	Implementation of UHC	Legal, policy or regulatory constraint	Provide technical assistance to the Government of Cameroon to support development and implementation of a sustainable health financing strategy including financial management systems to ensure timely and accurate reimbursements to health facilities.	COP19	COP22
$ 37,500	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Domestic resource mobilization	11. Domestic Resource Mobilization	6.31	6.31	Implementation of UHC	Legal, policy or regulatory constraint	Support the Ministry of Health to successfully advocate to other Government of Cameroon stakeholders (Ministry of Finance, Ministry of Planning, Head of State) for increased domestic revenue allocation to the health sector.	COP19	COP23

Above Site Investments-Systems and Health Data

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Catego	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$171,230	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Electronic register in 90 PEPFAR-supported sites in zone 1	Lack of Financial Resources	Optimise the use of electronic register (DAMA) in all 80 PEPFAR supported sites in zone 1	COP19	COP22
$143,003	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Electronic register in all PEPFAR-supported sites in zone 2	Other	Optimise the use of electronic register (DAMA) in all 72 PEPFAR supported sites in zone 2	COP19	COP22
$239,593	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Electronic register in all PEPFAR-supported sites in zone 3	Other	Optimise the use of electronic register (DAMA) in all 73 PEPFAR supported sites in zone 3	COP19	COP22
$22,727	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	availability of regional and district estimates	Other	Improve the quality of data system to make available regional and district HIV data estimates in 10 regions	COP20	COP22
$405,436	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Availability of EMR in facilities	Lack of Financial Resources	Advocacy for electronic medical record EMR	COP22	Post COP25
$60,000	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Electronic register in all 74 PEPFAR-supported sites in zone 4	Lack of Financial Resources	Optimise the use of electronic register (DAMA) in 83 PEPFAR supported sites in zone 4	COP19	COP22
$230,085	ASP: HMIS, surveillance,	Non-Targeted Pop: Not	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Integrated data systems for HIV related data available	Physical infrastructure not complete/further investment needed by donors	Improve quality and optimization of integrated data system	COP19	COP22
$40,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	regional and district estimates	Legal, policy or regulatory constraint	Coordinate activities geared towards updating regional and district HIV estimates	COP20	COP22
$ 37,500	ASP: HMIS, surveillance, & research-NSD	Key Pops: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	New Local Partner primes collect, manage and report quality data	Lack of technical capacity	Strengthen capacity of new prime KP and CLM local partners to collect, maintain, report on, and use quality data for decision-making	COP22	COP24
$ 37,500	ASP: HMIS, surveillance, & research-NSD	OVC: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	New Local Partner primes collect, manage and report quality data	Lack of technical capacity	Strengthen capacity of new prime local OVC partners to collect, maintain, report on, and use quality data for decision-making	COP22	COP24
$ 100,000	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	14. Epidemiological and Health Data	6.22	6.18	Online HIV ordering tool used at the regional level for order collection and validation, distribution planning in 10 regions.	It is not included in local HIV response plans	Supply chain partner will build on the development and initial rollout phases of the online HIV ordering tool in Centre and Littoral regions through scaling to all remaining regions of Cameroon as an interim order collation and validation solution while awaiting full scale implementation of eLMIS.	COP21	COP23

Above Site Investments-Policies and Governance

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Catego	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$18,182	ASP: Policy, planning, co	Non-Targeted Pop: Not d	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Advocacy meetings conducted between IP and MOH	Lack of Financial Resources	Advocacy to improve quality of data system to make available regional and district HIV data estimates in 10 regions	COP22	COP22
$74,038	ASP: Policy, planning, co	Non-Targeted Pop: Not d	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Guidelines and plans	Lack of sufficient HRH	Provide support to Department of drug and lab in the development of National guidelines and policies	COP22	COP23
$74,038	ASP: Policy, planning, co	Non-Targeted Pop: Not d	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Guidelines and plans	Lack of sufficient HRH	Provide support to Department of drug and lab in the development of National guidelines and policies	COP22	COP23
$50,000	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	regional and district estimates	Legal, policy or regulatory constraint	Advocacy for activities geared towards updating regional and district HIV estimates	COP20	COP22
$ 82,303	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Availability of free HIV services to all PLHIV	Legal, policy or regulatory constraint	Put in place a strong system to monitor user fees elimination in health facilities and share findings with all stakeholders	COP19	COP25
$ 82,304	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Universal access to quality HIV treatment and care	Legal, policy or regulatory constraint	Support efforts to sensitize local health authorities and health care workers on the new HIV user fee policy and strengthen coordination with central and regional level government structures to ensure timely reaction to reported violations based on accurate data provided	COP19	COP25
$ 82,304	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Universal access to quality HIV treatment and care	Legal, policy or regulatory constraint	Empower PLHIV and communities to leverage evidence gathered to demand improved access to services	COP19	COP25
$100,000	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	6.18	7.11	Improved access to quality HIV services for KPs at Community and Facility sites	Legal, policy or regulatory constraint	State departments small grants will monitor and assess the enablers and barriers to access regular HIV services including testing, linkage, treatment and viral load, as well as legal and social services, KP specific services including access to health commodities such as condoms and lubricants by KP individuals in community and facility sites	COP22	COP25

Above Site Investments-Service Delivery

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Catego	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description	Intervention Start	Intervention End
$31,790	ASP: Laboratory systems	Non-Targeted Pop: Not	Clinical guidelines, policies for service delivery	6. Service Delivery	6.17	6.17	Standard training modules	Lack of technical capacity	Build capacity of staff on Tuberculosis Preventive Therapy (TPT): short regimens in pilot facilities in 3 out of 10 regions from October 2022-September 2023	COP22	COP22
$100,000	ASP: Policy, planning, co	Non-Targeted Pop: Not	Clinical guidelines, policies for service delivery	6. Service Delivery	6.17	6.17	TLD regimens prescribed	Lack of sufficient HRH	Conduct supervision to review implementation of TLD transition	COP19	COP22
$ 82,303	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.17	6.17	Improved quality of HIV services	Lack of information on costs and program requirements	Ensure CLM carries out monitoring of quality of services at all PEPFAR supported sites and some non PEPFAR sites to a total of more than 400 sites. Using site monitors and interviews with PLHIV, others who access HIV service and service providers to assess the quality of HIV services offered and delivered in the country	COP21	Post COP25
$ 37,500	ASP: Public financial management strengthening-NSD	Non-Targeted Pop: Not disaggregated	Clinical guidelines, policies for service delivery	6. Service Delivery	6.17	6.17	Implementation of UHC	Legal, policy or regulatory constraint	Support the Government of Cameroon in the development of its Universal Health Coverage System, ensuring that HIV/AIDS care and treatment remain an essential part of the service delivery package.	COP19	COP23
$ 70,802	ASP: Policy, planning, coordination & management of disease control programs-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	6. Service Delivery	6.17	6.17	Community based organizations have resilient systems to manage USG funds	Lack of managerial capacity	Provide institutional capacity building to the community-based organizations in the areas of administrative and financial management and overall federal grant compliance	COP21	COP24

Above Site Investments-Supply Chain

Activity Budget	COP22 Program Area	COP22 Beneficiary	COP22 Activity Category	SID Element	SID Score 2019	SID Score 2021	Expected Outcome	Primary Barrier to Local Responsibility this activity addresses	COP22 Activity Description
$ 400,529	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.57	6.18	National quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT, EID, and VL commodity supply completed biannually. Stockouts mitigated or averted where possible.	Lack of technical capacity	Supply chain partner will provide continuous support for the monitoring and management of adult and pediatric ARVs, HIV testing kits, PrEP, EID, and VL commodity supply while including considerations for ARV optimization and Multi-Month Dispensing (MMD). Activities include: (i) Generate, capture, use and transmit data on how medicines and other commodities are being used at the regional level to ensure accurate and timely counting and reporting the total number of usable and unusable commodity items available in the warehouse (ii) Collaborate with DPML/NACC/CENAME and key stakeholders to prevent and address commodities shortages and stock outs and improve supply chain coordination among key actors, especially in the area of supply chain transformation. (iii) Support for the planning and execution of national quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT, EID, and VL commodity supply.
$ 400,528	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.57	6.18	Stockouts mitigated or averted where possible. Stockout of key commodities at facility level <5% where stock is available in country.	Lack of Financial Resources	Improve commodity security at the regional and site levels through efficient and effective Long Haul and Last Mile Distribution strategy. Activities include: (i) Support to CENAME for the elaboration of distribution plans from central to Regional Levels. (ii) Support to RFHPs in the areas of: -order requisition -inventory management -facility order review -pick and pack procedures and commodity dispatch -route optimization -monthly physical inventory counts (iii) Coordination with Regional Technical Groups for monthly order review and validation meetings. (iv) Subcontract management with private sector Logistics Service Providers for the execution of Last Mile Deliveries in accordance with RTG approved distribution plans. (v) Transitional support to RFHPs (or other local partners) where LMD is transitioned from the supply chain partner.
$ 400,529	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	5.57	6.18	Laboratory reagent stockouts at the site level <5% where stock is available in country.	Lack of Financial Resources	Support improved laboratory equipment utilization rates through continuous supply of laboratory reagents and samle collection materials. Activities include: (i) Coordinate with the Laboratory TWG and other stakeholders to collect and analyze data and monitor stock levels. (ii) Make recommendations for redistributions as needed to avoid expiries and optimize lab equipment usage. (iii) Transitional support to local partner to conduct cold chain distributions bimonthly or as cold chain shipments arrive.

APPENDIX D – Minimum Program Requirements

The minimum requirements for continued PEPFAR support include:

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.	Status: Completed Issues/Barriers: Though test and start has been formally implemented throughout Cameroon, problems with direct and immediate linkage continue to exist for certain subpopulations. Specifically, linkage for HEI to ART has been suboptimal, and some problems with the KP referral process have been identified and continue to require attention and active partner management.
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.	Status: In progress, but not on track to meet COP21 goals. COP22 will target 100% of adults and children weighing >30kg offered TLD, and 100% of pediatrics >3kg and >4 weeks of age offered DTG-10. Optimized procurement plan must support this strategy. Issues/Barriers: TLD Stock tensions and procurements of sub-optimal regimens for both adult and pediatric treatment continue to inhibit the success of this essential program requirement in COP21.
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.	Status: In process-target completion date is end of COP22 Issues/Barriers: TLD procurement delays caused stock tensions that resulted in the formal prohibition via an MOH circular of MMD towards the end of COP20 and into COP21. Prior to this directive, six-month MMD lagged behind 3 months. DDD has been implemented in some places, but needs to scale up to all regions, especially in rural and conflict areas. Exploration of DDD through selected private pharmacies will be explored in the two major cities of the country.
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.	Status: In process though progress has fallen far short of targets Issues/Barriers: Low availability of INH commodities as well as other policy and staff training barriers made achievement of this requirement impossible in Cameroon in COP20 and COP21. Improved commitments to INH procurements and required supporting supply chain infrastructure by all stakeholders must support this requirement and clinical partners must support rollout with training and sensitization of staff to ensure that there is no reluctance to prescribe TPT.
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	Status: In process, target completion date is end of COP21 Issues/Barriers: DNO is being completed as part of COP21 activities. EID access, especially at 2 months has been especially suboptimal in Cameroon, with long backlogs due to stockout of EID POC testing cartridges and sample collection kits. Stockouts are

viral load testing and results delivered to caregiver within 4 weeks.	due to a substantial funding gap for Cameroon. This must be addressed in COP22.
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.	Status: Fully implemented and ongoing Issues/Barriers: Index testing continues to scale effectively, and progress in index contributions to overall case finding should be applauded. Ongoing training to ensure confidential and consent-driven index testing must continue at all facilities. Self-testing roll out has been successful but limited. Self-testing should continue to scale up in COP22 and be incorporated into the optimized procurement plan.
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)	Status: In process -target completion date of COP21 Issues/Barriers: Currently PrEP access is limited to only key populations over the age of 21. To expand PrEP access and meet PEPFAR COP22 funding requirements for PrEP, the PrEP TWG must convene prior to COP22 and agree to expand access, with a specific focus on access to adolescent girls and young women, pregnant and breastfeeding women, and HIV negative partners in sero-discordant couples.
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.	Status: Full completion date in COP22 Issues/Barriers: While OVC prevention programming has exceeded targets, OVC graduation rates have peaked over the last two fiscal years and will start to decline over time. Program will continue to strengthen pediatric cascade results, including in case finding, linkage, viral load retention and coverage, 2-month EID coverage, and TB screening and TPT coverage. AGYW risk reduction programming has been affected by the absence of the Peace Corps in Cameroon, and critically, by the inability of AGYW to access PrEP in Cameroon. The HIV status of each OVC beneficiary will be tracked and documented as well as that of the household members.
Policy and 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.	Status: In process Issues/Barriers: Increased enforcement in 2021 of the law criminalizing same-sex relations posed a grave threat to the human rights and dignity of some key populations in Cameroon. The soon-to-be released IBBS will provide better estimates of stigma and discrimination faced by key populations in Cameroon. The findings of this survey must be incorporated into COP22 programming in a way that implements specific and measurable activities to reduce stigma and discrimination.
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,	Status: In process Issues/Barriers: The government has taken huge steps forward to eliminate all formal and informal user fees for HIV and other clinical services. By January

such as ANC, TB, cervical cancer, PrEP and routine clinical services affecting access to HIV testing and treatment and prevention.	2022, 73% of public facilities have adhered to the user elimination policy. While implementation has been mixed, trends have been positive, especially in eliminating fees related to viral load testing, often the most expensive HIV service.
11) OUs assure program and site standards, including infection prevention and 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.	Status: In process Issues/Barriers: QA and CQI practices are routinely incorporated into PEPFAR programming and supported by SIMS and other agency-led site visits, however oversight was limited due to constraints from COVID. Generally, QA and CQI are routinely and effectively incorporated into programming and these efforts should continue.
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.	Status: In process Issues/Barriers: There are no structural barriers to this work. Implementation at clinical sites and other stigma reduction activities are ongoing and will continue to be sustained while identifying and addressing any gaps.
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	Status: Started/limited progress Issues/Barriers: Two CDC partners are already local (1 clinical and 1 Lab). The international partners effectively started only in COP20 after a process of establishing the program. They started by building the government capacity by engaging them for greater country ownership and sustainability and putting in place systems to build local capacity and facilitate efficient transition to local partners within 5 years. USAID has made two local awards (CLM and VL Cold Chain) in COP21 representing 8 percent of funding. In COP22, with the full local transition of the KP and partial OVC, USAID expects to reach 42 percent of its resources allocated to LP. The transition of LMD in the first Region is the final design phase with award projected during COP22. These awards will consider KP-owned and/or women-led local partners.
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Status: Not completed Issues/Barriers: Partner government co-financing has continued to pose a challenge to program performance and were one of the main drivers of stock outs in COP20 and COP21. The GRC has not met all funding commitments which are necessary to unlock Global Fund procurements. As of January 2022, interim report, actual GRC funding commitments for HIV response for the period 2021-2023 is 5.6 million euros of which close to 800,000 have materialized. Additionally, domestic spending on HIV in 2019, the most recent year for which there was verified data, constituted a very small proportion of overall HIV

	response expenditure in Cameroon, around 10%, which was a decline from the prior year. The World Bank reports that domestic government expenditure on health in Cameroon has declined over the past 15 years and was about 0.2% of GDP in 2019.
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Status: In process Issues/Barriers: Cameroon has made great progress in reducing HIV-related mortality over the past 5 years, and in FY 21, deaths decreased as a proportion of all interruptions in treatment. Monitoring of morbidity and mortality outcomes that began in COP18 should continue to scale, with morbidity and mortality monitoring systems prioritized.
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	Status: Started/limited roll out or progress Issues/Barriers: While there have been some efforts, especially in partnership with the WHO to promote unique IDs and case-based surveillance in Cameroon, currently unique IDs are not being used and case-based surveillance has been launched but in a very limited capacity The main barriers are funding for the information systems to support these efforts and scale-up EMR use to streamline the system and support case-based surveillance.

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

The Government of the Republic of Cameroon (GRC), in partnership with PEPFAR Cameroon, other multilateral donors, civil society and the private sector, has made significant progress towards the goal of reaching epidemic control of HIV. From national programmatic data from June 30, 2021, Cameroon's estimated status is 82/95/91, showing positive trends for incidence and mortality. Estimated HIV prevalence stands at 2.7% among adults aged 15 - 49. However, the continuous and sustained inability of the GRC to meet its co-financing commitments for FY 21/22 towards the Global Fund produces gaps in commodities including ARVs mainly on TLD90, RTKs and VL and EID consumables which affects the gains made by the country and imparts its ability to reach epidermic control.

Historically, the GRC has been very efficient in constructing and equipping health structures, including hospitals, health districts and centers as well as ensuring the structures have human resources to run them. However, the maintenance of these structures and ensuring they have adequate commodities have always been inadequate and constitute a weakening force which affects even the HIV response. Moreover, the health systems in-country doesn't systematically make provision for the staff running these health structures to undergo on-the-job training or any other form of training which can reinforce their capacities to adapt to global alterations in health. This is an area where the GRC can take greater responsibility in guaranteeing high quality and regular training of staff for the smooth running of these structures including the HIV treatment units therein.

Another area where the GRC can take greater responsibility would be integrating the support staff of HIV treatment units including the Psychosocial workers, the data clerk, the site coordinators, the testers etc. into the public service. These staff are the backbone of the HIV response and ensuring that they are integrated into the public service with monthly and regular salaries, social and medical insurance and enrolled into pension schemes will greatly improve their efficiency and productivity at the work they do which is vital for the survival of people living with and affected by HIV. In so doing, donor funds which are used in recruiting these staff will be focused on programs implementation, supplementing trainings and commodities and this will help to increase the country's trajectory to reaching epidermic control.

Furthermore, the GRC has made enormous strides in creating the "Basket Fund" which is a financial mechanism at the central bank to pull funds from its commercial banks and meet its co-financing commitments in all domains including the health sector. Unfortunately, the regulations and processes around this mechanism are drawn-out and cumbersome and thus reduce the effectiveness of the mechanism. Here again, the GRC can work to improve on the regulations governing this mechanism to have access to funds that will enable it to meet its co-financing commitment by the Global Fund and ensure the availability of the health commodities under its responsibility.

Adhering to international conventions and policies in health is another area where the GRC can and should take greater responsibility. Taking-up greater responsibility in the coordination of the National Aids Control Committee and the technical ministerial department with policy governing mandates will equally advance some of the policy shift agenda PEPFAR is advocating for to support the country's ability to reach epidermic control.

One of the most important core elements of the HIV response is the availability of commodities to cover the entire HIV cascade, including RTKs for testing, ARVs for adult and pediatric treatment and VL to verify viral load suppression. These commodities are, in most part, procured by the Global Fund and the GRC through a 20% co-financing, and to a very lesser extent by PEPFAR. Over the years, the GRC has not been able to meet its co-financing commitment and this reality is still true through FY21/22. In COP22, PEPFAR will continue to advocate for these commitments to be met. In collaboration with the Global Fund team in Geneva, PEPFAR will draft a joint petition to the GRC inciting it to concretely commit to co-financing agreement with the Global Fund.

PEPFAR's support to the country's Universal Health Coverage through resources mobilization, if successful, will allow the GRC to assemble resources to pay its bills. In COP22, it will continue to support the country's supply chain through technical assistance to strengthen its capacity to procure, manage and distribute health commodities to last mile. Through PEPFAR's local partner transition plans, it will ensure sustainability by building organizational capacities and partner expertise on HIV programming for PLHIV, OVCs and KPs. PEPFAR will put in place a strong system to monitor user fees elimination in health facilities. It will continue to provide support to the Department of drug and lab in the development of National guidelines and policies and train health care providers on treatment guidelines. Building capacity on TPT: short regimens will equally be an area of focus in COP22.

Table E.1: Interagency programs above site investment in COP22 in support of the SID elements with low ratings.

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
6.18	N/A	Electronic register in all PEPFAR- supported sites in Zone 1	Other	-	-	Optimize the use of electronic register (DAMA) in PEPFAR supported sites in Zone 1
6.17	N/A	Standard training modules	Lack of technical capacity	-	-	Build capacity on TPT: short regimens
6.18	N/A	Electronic register in all PEPFAR- supported sites in Zone 2	Other	-	-	Optimize the use of electronic register (DAMA) in PEPFAR supported sites in Zone 2
6.18	N/A	Electronic register in all PEPFAR- supported sites in Zone 3	Other	-	-	Optimize the use of electronic register (DAMA) in PEPFAR supported sites in Zone 3
6.18	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?	availability of regional and district estimates	Other	-	-	Improve the quality of data system
7.11	N/A	Availability of regional and district estimates	Other	-	-	Advocacy to improve quality of data system
6.18	-	-	-	-	-	Advocacy for EMR
6.18	N/A	Electronic register in all PEPFAR- supported sites in Zone 4	Other	-	-	Optimize the use of electronic register (DAMA) in PEPFAR supported sites in Zone 4
6.18	8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain	National quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT,	Lack of technical capacity	Lack of sufficient HRH	-	Supply chain partner will provide continuous support for the monitoring and management of adult and pediatric ARVs,

	plan that guides investments in the supply chain?	EID, and VL commodity supply completed biannually. Stockouts mitigated or averted where possible.				HIV testing kits, PrEP, EID, and VL commodity supply while including considerations for ARV optimization and MMD. Activities include: (i) Generate, capture, use and transmit data on how medicines and other commodities are being used at the regional level to ensure accurate and timely counting and reporting the total number of usable and unusable commodity items available in the warehouse (ii) Collaborate with DPML/NACC/CENAME and key stakeholders to prevent and address commodities shortages and stock outs and improve supply chain coordination among key actors, especially in the area of supply chain transformation. (iii) Support for the planning and execution of national quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT, EID, and VL commodity supply.
6.18	8.4 Supply Chain Plan: Does the country have an agreed-upon national supply chain plan that guides investments in the supply chain?	National quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT, EID, and VL commodity supply completed biannually. Stockouts mitigated or averted where possible.	Lack of technical capacity	Lack of sufficient HRH	-	Supply chain partner will provide continuous support for the monitoring and management of adult and pediatric ARVs, HIV testing kits, PrEP, EID, and VL commodity supply while including considerations for ARV optimization and Multi-Month Dispensing (MMD). Activities include: (i) Generate, capture, use and transmit data on how medicines and other

						commodities are being used at the regional level to ensure accurate and timely counting and reporting the total number of usable and unusable commodity items available in the warehouse (ii) Collaborate with DPML/NACC/CENAME and key stakeholders to prevent and address commodities shortages and stock outs and improve supply chain coordination among key actors, especially in the area of supply chain transformation. (iii) Support for the planning and execution of national quantifications for adult ARV, pediatric ARV, HIV testing kits, PrEP, TPT, EID, and VL commodity supply.
6.18	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Stockouts mitigated or averted where possible. Stockout of key commodities at facility level <5% where stock is available in country.	Lack of Financial Resources	Underdeveloped private market	-	Improve commodity security at the regional and site levels through efficient and effective Long Haul and Last Mile Distribution strategy. Activities include: (i) Support to CENAME for the elaboration of distribution plans from central to Regional Levels. (ii) Support to RFHPs in the areas of: -order requisition -inventory management -facility order review -pick and pack procedures and commodity dispatch -route optimization -monthly physical inventory counts (iii) Coordination with Regional Technical Groups for monthly order review and validation meetings.

						(iv) Subcontract management with private sector Logistics Service Providers for the execution of Last Mile Deliveries in accordance with RTG approved distribution plans. (v) Transitional support to RFHPs (or other local partners) where LMD is transitioned from the supply chain partner.
6.18	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Laboratory reagent stockouts at the site level <5% where stock is available in country.	Lack of Financial Resources			Support improved laboratory equipment utilization rates through continuous supply of laboratory reagents and sample collection materials. Activities include: (i) Coordinate with the Laboratory TWG and other stakeholders to collect and analyze data and monitor stock levels. (ii) Make recommendations for redistributions as needed to avoid expiries and optimize lab equipment usage. (iii) Transitional support to local partner to conduct cold chain distributions bimonthly or as cold chain shipments arrive.
6.18	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Online HIV ordering tool used at the regional level for order collection and validation, distribution planning in 10 regions	It is not included in local HIV response plans	Lack of technical capacity		Supply chain partner will build on the development and initial rollout phases of the online HIV ordering tool in Centre and Littoral regions through scaling to all remaining regions of Cameroon as an interim order collation and validation solution while awaiting full scale implementation of eLMIS.