Côte d'Ivoire

Country Operational Plan

(COP/ROP) 2020

Strategic Direction Summary

April 29, 2020

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The program is addressing Côte d'Ivoire's unacceptably high AIDS-related mortality by increasing opportunities for early HIV diagnosis with index-, self-, and targeted-testing, increasing access to early infant diagnosis (EID), ensuring continued same day ART initiation, addressing comorbidities by introducing testing and treatment for cryptococcal meningitis, TB (with urinary TB lipoarabinomannan (LAM) testing, and scale up of GeneXpert), and scaling up of TB preventive therapy. Moreover, facility and community-based interventions to increase case finding and retention among men will reduce HIV-related mortality given the late presentation and poor outcomes experienced by this sub-population. Among these interventions will be updating counseling messaging to reflect U=U messaging, the importance of early diagnosis, and the reality of a healthy, productive life on ART.

PEPFAR-CI is a working in close collaboration and partnership with GoCI leadership to improve monitoring and program performance through data-driven decision making, leveraging multi-level engagement with stakeholders and the Embassy Front Office.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Côte d'Ivoire has an estimated total population of 25,262,921 in 2019 (National Institute of Statistics - INS) of which males account for 50.4% (12,724,845) and females 49.6% (12,538,075). The estimated Ivoirian population under 15 years of age is 10,548,626, or 42%. The 2017/2018 population-based HIV Impact Assessment (PHIA) found an HIV prevalence of 2.9% for 15 to 64-year-olds. PHIA also found a prevalence of 2.5% among the 15 to 49-year-old population, which is much lower than the 3.7% reported in the 2011/2-12 DHS for the same age group. Much higher estimates exist among female sex workers (FSW) and men who have sex with men (MSM) (11.4%[1] and 12.33% respectively). The 2020 UNAIDS Spectrum estimates, using the PHIA results, noted a total PLHIV of 425,779, including 30,276 children living with HIV, and approximately 32,000 OVC and 19,000 pregnant women needing ARVs. An estimated 285,922 of PLHIV (67%) are on treatment, leaving a gap of 139,857 PLHIV not on treatment. Annually, there are approximately 13,000 new HIV infections (2,700 among children) and 13,000 AIDS-related deaths in Côte d'Ivoire.

Côte d'Ivoire has worked steadily towards reaching HIV epidemic control over the past sixteen years. With a total PEPFAR-CI investment of almost $1.7 billion from 2004 to date, an investment from the Global Fund to Fight AIDS, Tuberculosis and Malaria (GF) of $164.7 million from 2004-2017, and increasing GoCI financial contributions and efforts, the number of PLHIV on antiretroviral therapy (ART) has increased from 4,536 in 2004 to 285,922 in 2019. Of these, 235,888 patients (83%) are receiving care at the 913 facilities supported by PEFPAR, as of FY20Q1. The success of Option B+ is contributing to the achievement of the first 95 goal, specifically for women, of the Joint United Nations Program on HIV/AIDS (UNAIDS) 95:95:95 goals. While gaps remain in the first 95 and third 95, particularly among children (41% know HIV status; 60% viral suppression among PLHIV on ART) and men (65% know HIV status) – Cote d'Ivoire has achieved 94% for the second 95. Further, current FY20Q1 results demonstrate 99% linkage rates among PEPFAR-supported sites and catchment areas.

Despite these advances, the country still faces obstacles in achieving epidemic control. While retention has improved, gaps remain, particularly among sites not prioritized in COP19. Gaps still exist in identifying HIV-infected men, women and children, and linking them to treatment services. The ART gap among adult women also remains high and coverage among men and children remains low. Viral suppression among children 0-14 years old (59%) also remains low, with varying rates among fine age bands at PSNU level (ranging from 16 to 90%). Gaps along the clinical cascade are significantly greater for men, where most HIV-positive young and adolescent men remain unidentified and most men 25+ who are diagnosed are not on treatment; as a result, the community VLS rate for men >15 remains under 50%. Adolescent girls and young women face unique risks to

[1] Johns Hopkins University, Enda Sante, "Etude de la Prévalence, de la Prévention, et de la Prise en Charge du VIH Chez les Populations Clés en Côte d'Ivoire, 2014."

HIV infection and barriers to services, including unacceptably high rates of violence: one in five females (19.2%) experience sexual violence before age 18.

Recent measures by the GoCI and intensified PEPFAR-CI efforts are addressing these deficits. Beginning in January 2017, President Alassane Ouattara has focused more attention on the health sector, though this sector has historically seen less public investment than infrastructure, education, and other sectors contributing to strong economic growth. The national policy now aligns with PEPFAR-CI's strategy on focused testing to increase HIV-positivity yield, with written guidance distributed in October 2017. As of FY20Q1, facility-based provider-initiated testing and counseling (PITC) testing yields outside of ANC have increased by 41% across COP19's prioritized sites since COP18's testing pause (FY19Q3). Other PEPFAR-supported sites only increased yields by 17% over the same period. Challenges remain in the widespread implementation of targeted testing across all sites where lower volume, non-prioritized sites conducted over 60% of tests while supporting only 37% of total TX_CURR.

A February 2020 circular reiterated the importance of rapid transition to TLD, differentiated service delivery (e.g. 3-6 MMD for stable patients[2], community ART dispensation) and TB preventive treatment (TPT) for all ART patients). Weekly monitoring shows the proportion of patients on TLD continues to increase with 30% coverage among COP19's prioritized sites in February 2020 (up from 9% in October 2019). Non-prioritized sites, however, have 12% of patients on TLD (up from 4%). As of February 2020, eighty-nine percent of stable patients are also on multi-month dispensing (3MMD, 26%; 6MMD, 63%) according to weekly monitoring results. Unfortunately, barriers to these interventions remain for certain populations. For example, women of childbearing age may still be discouraged from TLD transition given the circular's disproportionate emphasis upon remote risks, rather than the undisputed benefits of long-term viral suppression. Stable ART patients may be denied TPT based on the mandate for chest x-ray or sputum investigation to rule out active TB disease. MMD requires a documented VLS result, when paradoxically, the distance and costs involved in monthly ART pickups impede attaining VLS. Conversely, the nationwide adoption of Test and Start, expansion of MMD, and implementation of the circular to abolish all user fees in public health facilities, are contributing to improved enrollment and retention in treatment services. A presentation on progress towards the elimination of user fees was highlighted in a February 2020 PEPFAR stakeholders' meeting on a situational analysis carried out by civil society organizations, where 91% of respondents reported that user fees had been eliminated with the new policy. As of March 2018, 100% of PEPFAR-supported ART sites were implementing Test and Start.

In order to achieve 95:95:95 goals in Côte d'Ivoire, PEPFAR programming in FY2021 will require further attention to address critical programmatic and systems gaps in: retention, particularly among young people (20-40); case identification across all populations, particularly men and children; linkage to services for children, KP, AGYW 15-24 years of age, and men; access to and uptake of VL testing; VLS rates, particularly among men who represent the highest risk for ongoing

[2] Cote d'Ivoire Ministère de la Santé et de l'Hygiene Publique, Note Circulaire 02160, 19 Mars 2019

transmission, young women and children who have the poorest rates of suppression; and data quality issues jeopardizing the ability to adequately interpret, plan, and appropriately manage program activities.

Tables 2.1.1 and 2.1.2 provide an overview of GoCI's health statistics, specific to HIV, PMTCT, OVC and KPs, showing a 2.9% HIV prevalence with 425,802 PLHIV.

Table 2.1.1 Cote d'Ivoire epidemiological context. This table provides a summary of HIV data for Cote d'Ivoire, with demographic data, HIV prevalence and Key population sizes.

Host Country Government Results															
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	25,262,521		5,248,750	20.8%	5,300,456	21.0%	2,610,098	10.3%	2,598,629	10.3%	4,679,807	18.5%	4,825,760	19.1%	Spectrum 2020
HIV Prevalence (%)		2.9		0.2%		0.2%		0.9%		0.3%		Data N/A		Data N/A	CIPHIA 2017-2018
AIDS Deaths (per year)	13,280		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Spectrum 2020
# PLHIV	425,802		14,891		15,385		27,483		11,825		233,052		113,167		Spectrum 2020
Incidence Rate (%)		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A	
New Infections (Yr)	13,560														Spectrum 2020
Annual births	1,221,805														National program
% of Pregnant Women with at least one ANC visit		85	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			MICS Survey 2016
Pregnant women needing ARVs	18,667														Spectrum 2020

Orphans (maternal, paternal, double)	230,000		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		UNAIDS report 2019
Notified TB cases (%)	25,299		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data
% of TB cases that are HIV infected.	5.5%		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		Data N/A		2014 National TB Program routine data
% of Males Circumcised	Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A			Data N/A	Data N/A	
Estimated Population Size of MSM*	32,289														Program Estimates 2020
MSM HIV Prevalence		11.6													IBBS 2015-2016
Estimated Population Size of FSW	52,590														Program Estimates 2020
FSW HIV Prevalence		11.4													IBBS 2014
Estimated Population Size of PWID	Data N/A	Data N/A													
PWID HIV Prevalence	Data N/A	Data N/A													
Estimated Size of Priority Populations (Military)	40,000	3.4	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	Data N/A	SABERS 2014

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression. This table provides a summary of the epidemiological context of Cote d'Ivoire, with demographic data, HIV prevalence and Key population sizes

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 (15-49) (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	25,262,921	2.9	425,802	304,874	285,928	67%	80%	2,548,586	62,294	55,768
Population <15 years	10,548,626		30,276		12,488	41%	59%	348,204	2,236	2,306
Men 15-24 years	2,598,629		11,825		5,086	43%	63%	126,547	1,066	822
Men 25+ years	4,825,760		123,167		76,048	62%	81%	438,398	18,647	16,348
Women 15-24 years	2,610,098		27,483		12,206	44%	72%	591,521	5,533	4,812
Women 25+ years	4,679,807		233,052		180,100	77%	82%	1,043,916	34,812	31,480
MSM	32,289	12.3	3971					11,184	885	810
FSW	52,590	11.4	5995					29,932	2,117	1,834

*Source: national data: National Institute of Statistics, National AIDS Control Program

Figures 2.1.1 – 2.1.4 show key indicators in epidemiological data related to HIV, including the number of people on ART and new HIV infections in comparison to mortality among PLHIV.

Figure 2.1.1 Updated National and PEPFAR Trend for Individuals currently on Treatment*

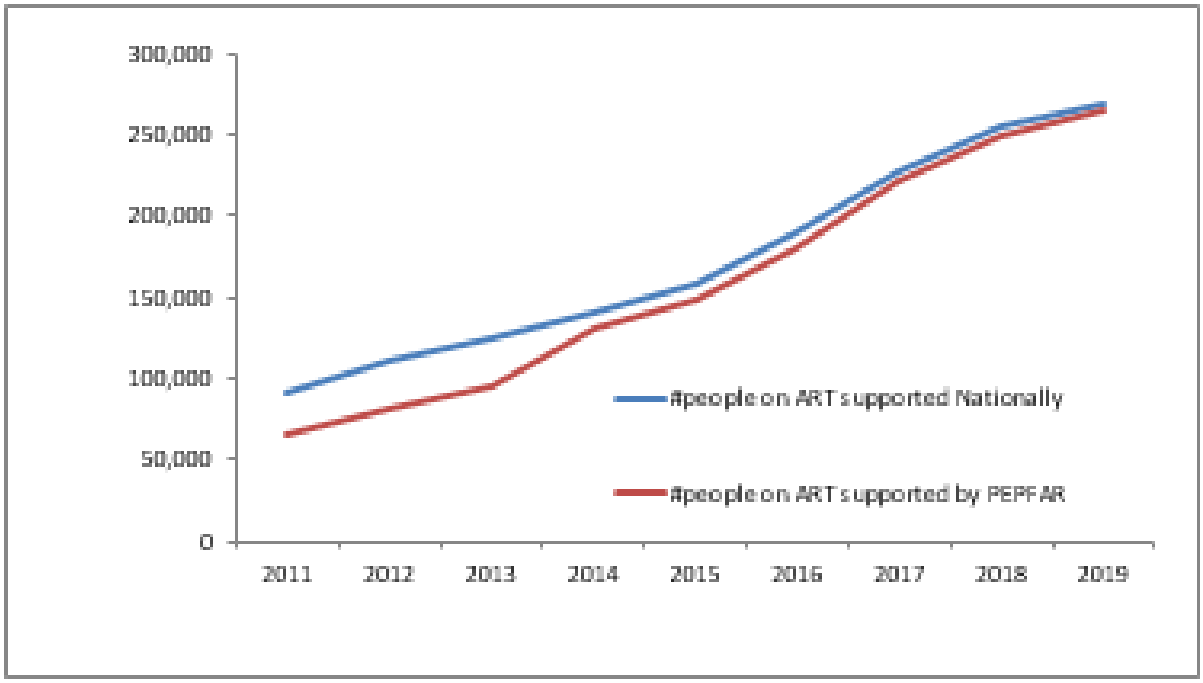


Figure 2.1.2 Updated Trend of New Infections and All-Cause Mortality Among PLHIV*

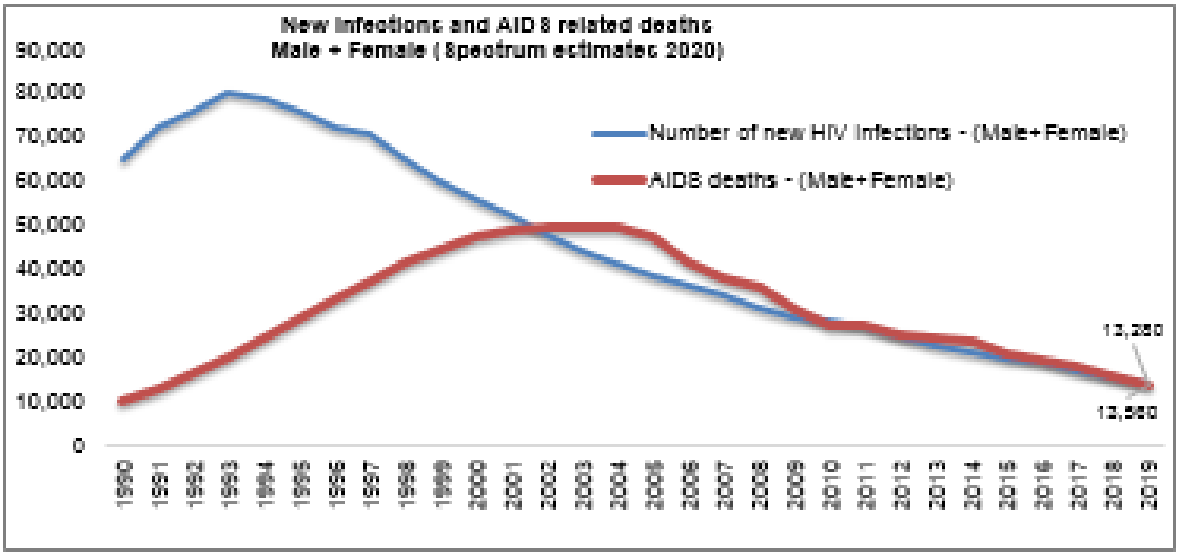


Figure 2.1.3 Updated Trend of New Infections and All-Cause Mortality Among Men*

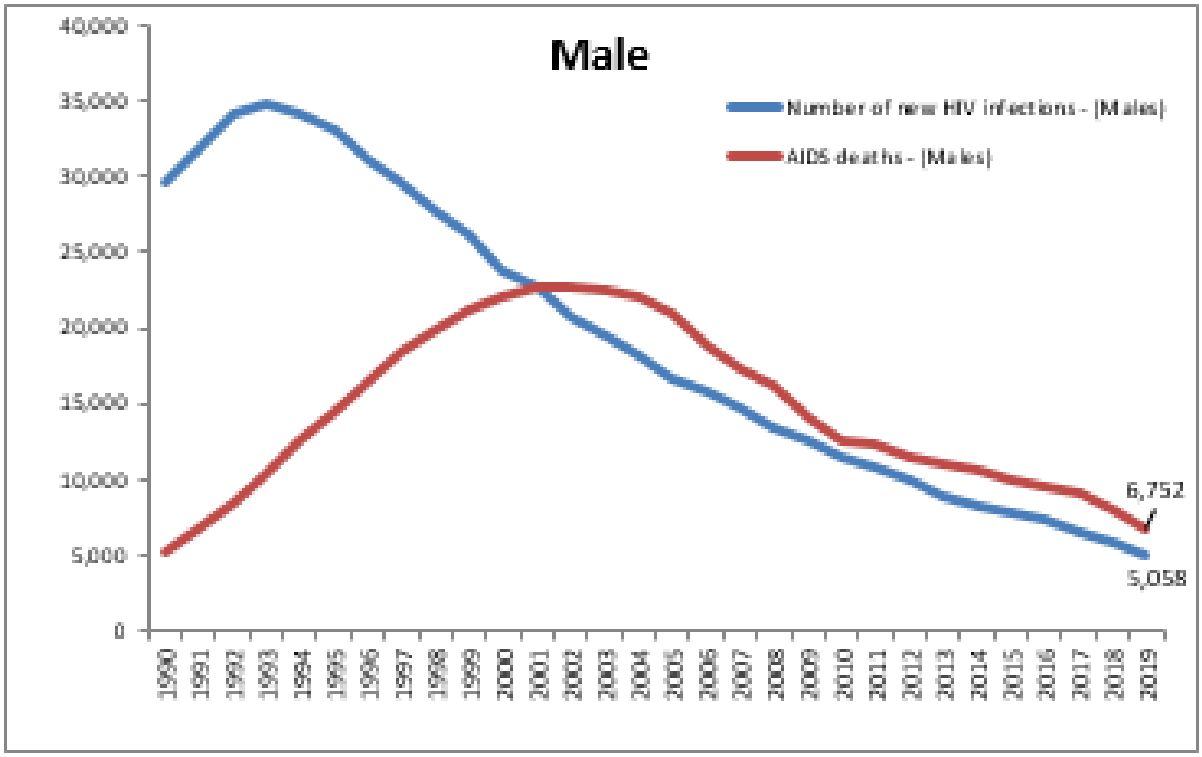
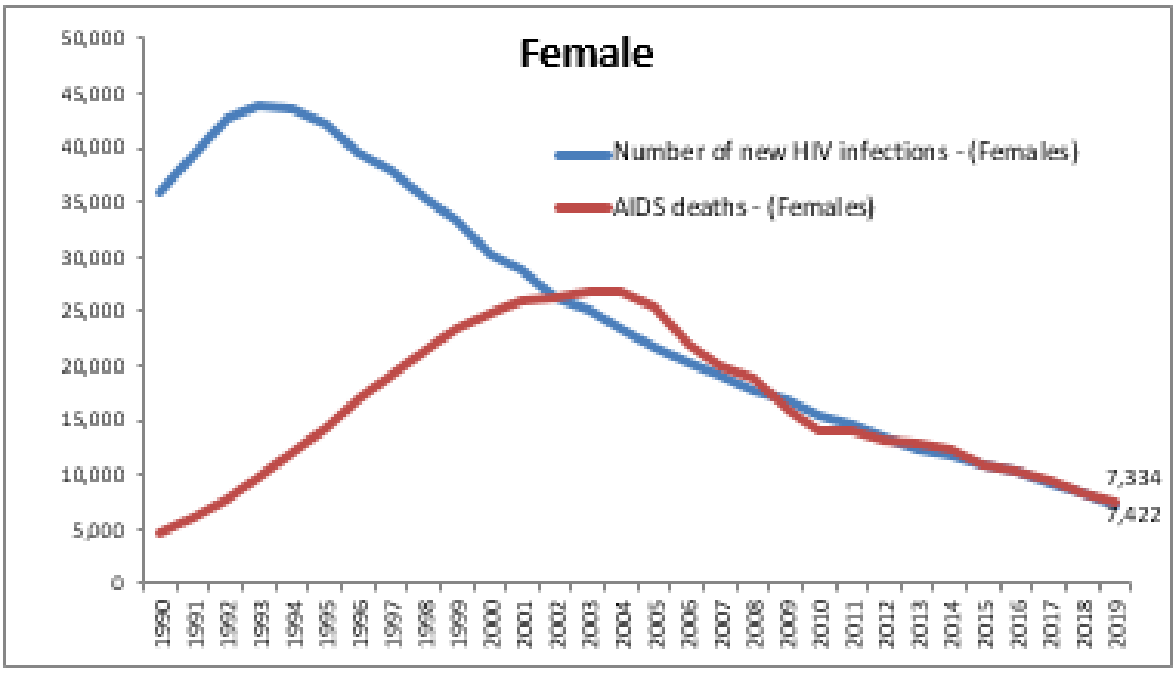


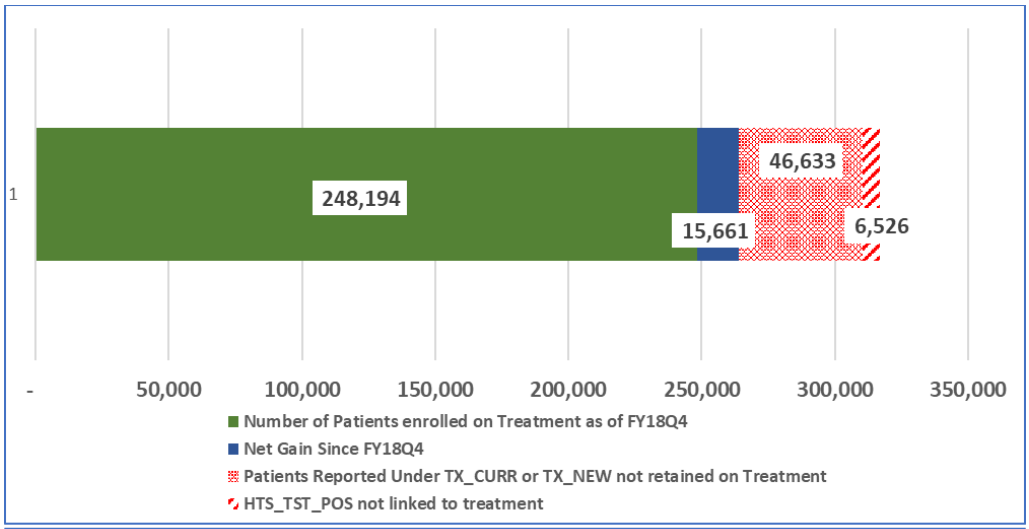
Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV*



*These data are pulled directly from most recent Spectrum Estimates for the period of 1990 to 2019.

Figures 2.1.5 and 2.1.6 illustrate an increase in the number of PEPFAR-supported patients retained on treatment in FY20 Q1 compared to FY19. Figure 2.1.7 provides the patient sex and age breakdown of patients not retained on treatment.

Figure 2.1.5 Retention of PLHIV on ART in FY19 (n = 1309 sites reporting TX_CURR at FY19Q4)



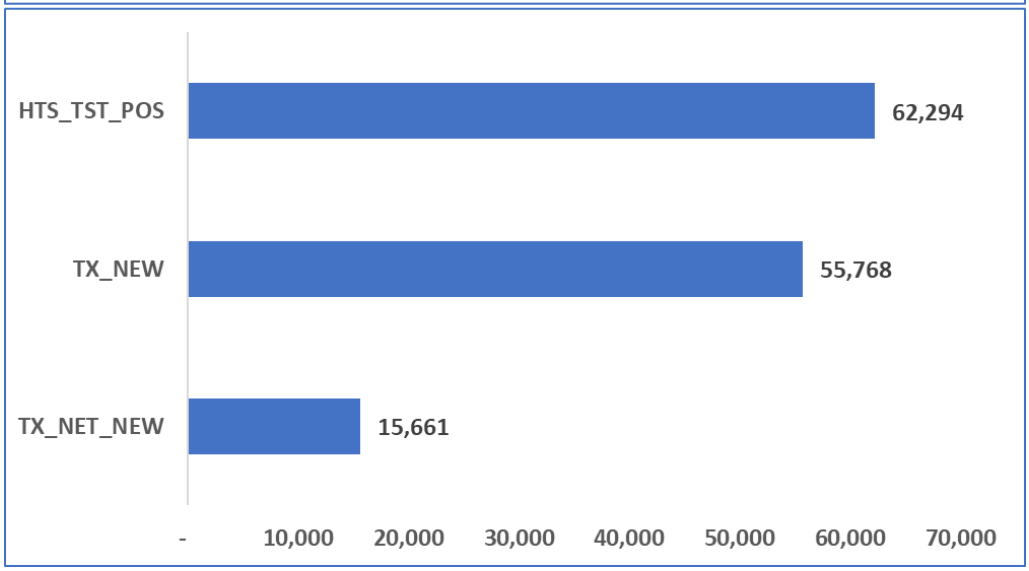


Figure 2.1.6 Progress retaining individuals in lifelong ART in FY20Q1 (n = 913 sites reporting TX_CURR at FY20Q1)

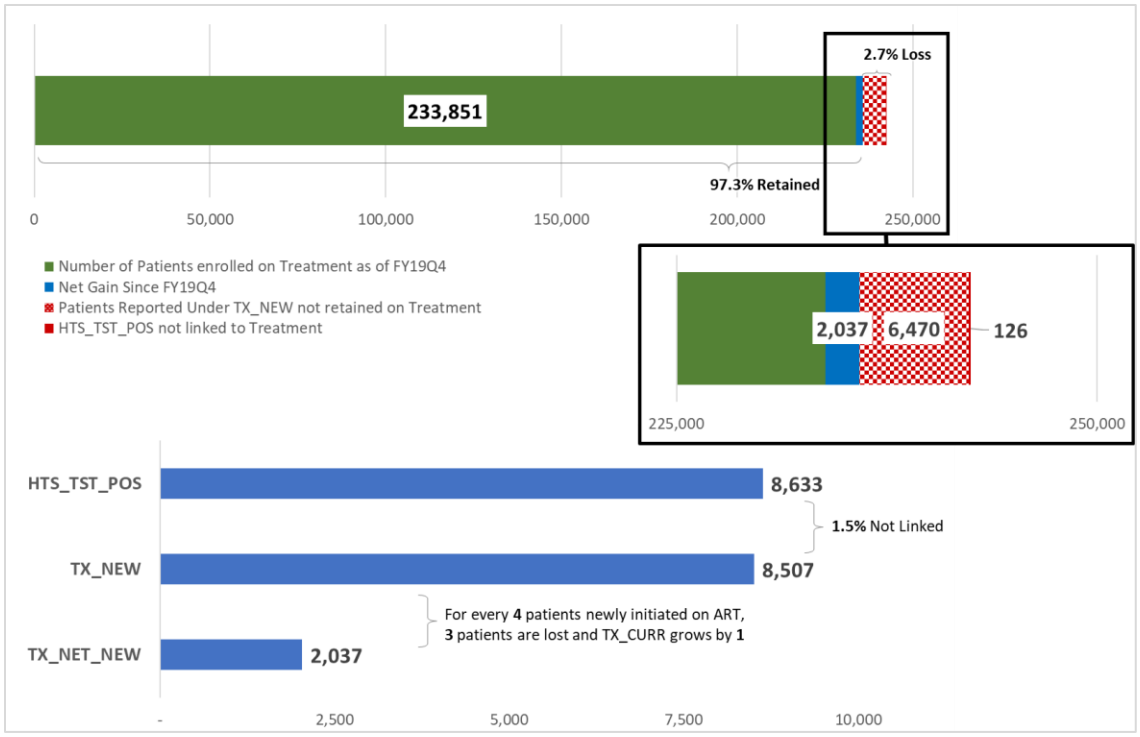


Figure 2.1.7 Proportion of clients lost from ART 2018 Q4 to 2019 Q4

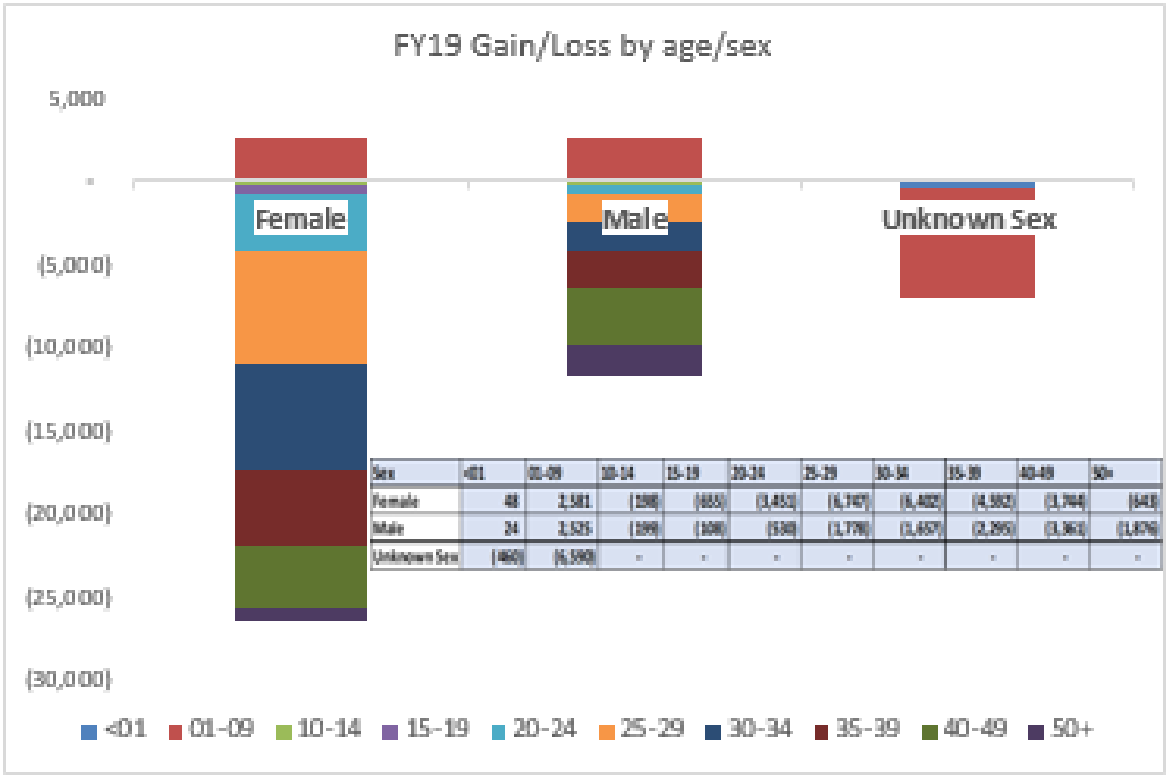


Figure 2.1.8 illustrates the 140,000-person treatment gap as well the gap in case finding.

Figure 2.1.8 Epidemiologic Trends and Program Response

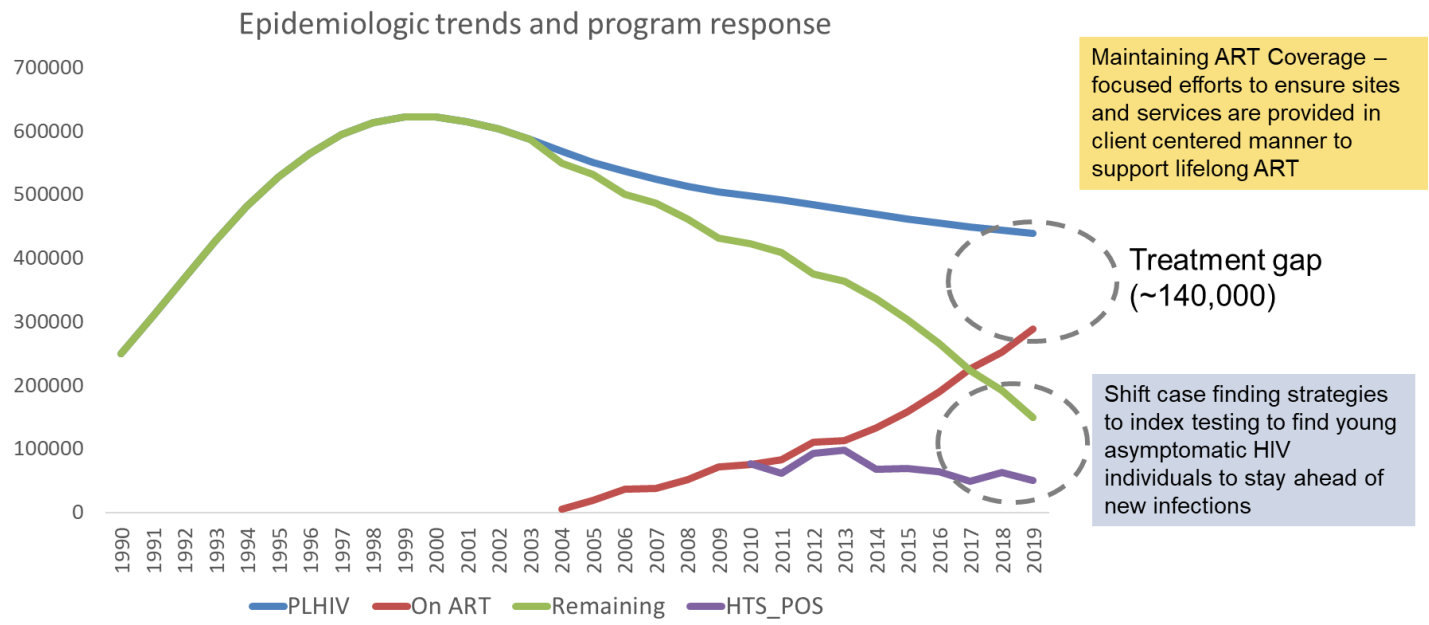
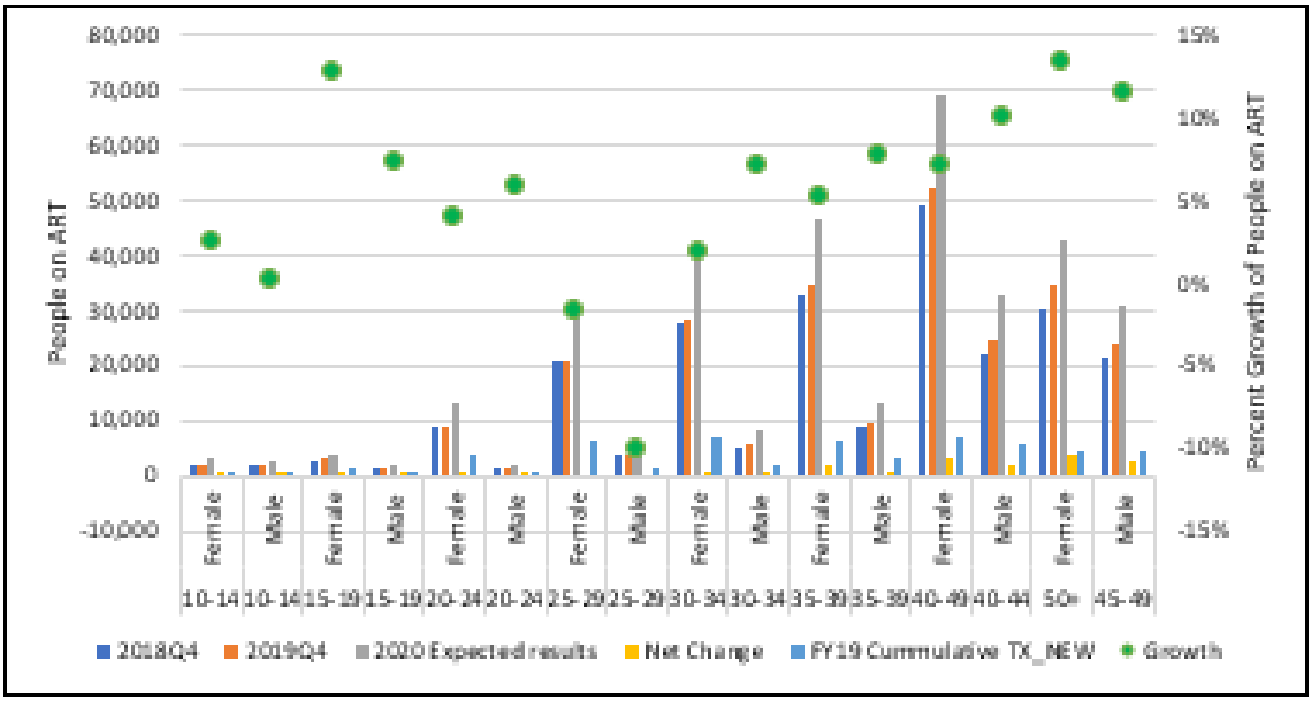


Figure 2.1.9 shows the HIV treatment growth by age/sex in order to pinpoint where there are specific areas of intervention needed to maintain and grow the HIV treatment population (Net change in HIV treatment by sex and age bands 2018 Q4 to 2019 Q4).

Figure 2.1.9 Côte d'Ivoire Treatment growth, FY18Q4 – FY19Q4, All Prioritized SNU



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

In the COP20 framework, PEPFAR investments will support clinical services primarily through the public sector health care system, working with the MSPH staff, including doctors, nurses, midwives, pharmacists, laboratory staff and data managers through an approach that integrates HIV services with other health programs.

Within that framework, PEPFAR-Côte d'Ivoire (PEPFAR-CI) is shifting resources toward site-level, service delivery support that has a more direct impact on quality HIV testing and treatment service provision for an increasing number of patients. The program will also focus on strengthening collaboration between clinical and community implementing partners to streamline services so that they are patient centered. Best practices and innovative strategies aimed at improving case finding, retention of HIV positive clients across all age bands on treatment, and viral load suppression will be disseminated and scaled across both community and facility partners. Site-level support includes the mentoring and coaching of service providers, quality improvement oversight of services, provision of supplies and equipment, staff salary support, provision of tools and standard operating procedures (SOPs), minor rehabilitation, and support for sample transportation. This package of services will be calibrated based upon the patient-needs of each site, and the limited resources available.

Specifically, COP20 will focus on the following new activities to improve client linkage and retention:

- Improving quality of care and delivering patient-centered services to meet the needs of prioritized populations who are historically hard to reach and/or underserved in Côte d'Ivoire:
    - Expanding male-friendly services to address ART gaps and reach men. Strategies will include extended hours of service and integration of HIV services into a wellness/multi-disease screening approach for men as well as outreach testing for hard to reach sub-populations. Experiences from other countries, such as Lesotho, show that with good counseling, men prefer minimal interaction with the health system, and are not necessarily interested in support groups, but high rates of treatment linkage and retention were demonstrated when services were tailored to men's convenience. Integrating HIV services with non-HIV services helps reduce fear of stigmatization among male clients.
    - Introducing key population (KP) community-facility integrated services across the entire HIV prevention, care and treatment cascade at 15 KP majority clinical sites. In response to the retention crisis and an opportunity to address KP specific needs, services will be provided including those addressing stigma and discrimination. The strategy will also include the provision of high-quality services for the general population served at these sites and will encompass case finding to reach men specifically through FSW clients and stable partners, as well as hard to reach MSM. Children of FSWs, having shown high testing yields in PEFPAR-CI, will also be reached through this approach and linked to relevant HIV services in an effort to strengthen pediatric reach and services.

- Implementation of peer-led facility-based adolescent adherence support groups, building on experiences from countries such as Kenya, Tanzania, and Zimbabwe, and using the December 2019 version of the WHO technical guidance on adolescent-friendly health services for HIV. In this model, facility-based adolescent adherence support groups have improved retention and long-term viral load suppression in that sub-population. Provision of community-level support will be delivered through other existing platforms, such as disclosure and adherence support for adolescents and caregivers through the OVC program.
- Scaling up home visits and caregiver support to overcome barriers to pediatric survival in Côte d'Ivoire and improve case finding, linkage to treatment and retention rates among HIV positive children. Under this strategy, implementing partners will provide focused mentorship to health care workers to guide parents/caregivers on ARV administration for infants, toddlers and young children. Additionally, home visits will improve linkage for children diagnosed through EID, and facilitate additional support to the family unit, for older children and adolescents struggling with adherence and retention. Strengthened collaboration and bi-directional referrals between clinical and OVC programs will further reinforce these efforts.
- Introducing community ARV distribution at scale in an effort to improve PLHIV retention in care and treatment and decongest health facilities. Aligned with the scale up of TLD, 6-MMD, and the differentiated support that will be provided to PLHIVs in COP20, is the roll out of community ARV distribution. Existing community structures, such as PLHIV support groups and other existing outreach platforms will be leveraged to facilitate patient access to ARVs while strengthening support for retention and adherence. Models most appropriate to the Ivoirian context will be formalized in consultation with MSPH and CSOs over the course of COP19 for rapid implementation in COP20, with an emphasis on cost-efficiency.
- Scaling up the implementation of CommCare, a tablet-based, patient-level case management system that allows facility and community health workers to track patients and identify among other things; missed appointments, loss to follow-up, transition to TLD and 6-MMD, and upcoming or missed viral load appointments. With the recent adoption of CommCare by MSHP, the system will be rolled out to 139 high impact sites and will be synchronized with the Ministry's SIGDEP facility-based electronic health record. Facility-level dashboards will also facilitate monthly coordination meetings with facility and community IPs, to identify success and challenges in collaboration for individual patient management.
- Partnering with faith communities to reduce stigma and strengthen HIV and treatment literacy for improved HIV outcomes across the clinical cascade. Through this strategy, PEPFAR-CI's implementing partners will work with the faith-based network to develop *Messages of Hope* to reduce HIV stigma and discrimination and strengthen demand for HIV services. Workshops and trainings with faith leaders will be held to identify opportunities for increased faith community involvement

and strengthen their capacity to support interventions for HIV prevention, case finding and care and support of PLHIV. Among the key issues addressed will be treatment cessation through "faith healing," HIV stigma and the need for strengthened HIV literacy.

- Rolling out a package of services in order to reduce mortality among clients with advanced HIV disease. In COP20, PEPFAR-CI will scale up the following services at all high impact sites, targeting adults and children with advanced disease: rapid initiation of ART, TB diagnosis (including TB-LAM, Sputum GenXpert) and treatment, TB preventive therapy (TPT) for TB-negative PLHIV receiving ART, cryptococcal antigen screening and fluconazole pre-emptive therapy for CrAg positive clients without evidence of meningitis, cotrimoxazole preventive therapy (CPT), and tailored adherence counseling and support to ensure optimal adherence to the advanced disease package, including home visits.
- Implementing index testing with fidelity at scale as a key means of case finding in COP20. While the foundation has been laid for index testing in Côte d'Ivoire, greater follow-up is needed to ensure effective implementation of SOPs for improved effectiveness and reach while ensuring WHO standards are respected.
- Implementing a PEPFAR-CI task force with multidisciplinary background that matches the weaknesses observed, with a goal to oversee and fix the pediatric program regularly. The objective of the PEPFAR Pediatric and Adolescent Task Force is to review periodically (weekly, monthly and quarterly) specific indicators of the program and act appropriately.

2.3 Investment Profile

The government is committed to ensuring equitable access to quality health services for all Ivoirians. This commitment is outlined in the 2016-2020 National Health Development Plan (PNDS). The GoCI recently signed up for the Global Financing Facility (GFF), a country-led and innovative approach to financing, which will help significantly increase investments in health. As a catalyst for a health investment platform, the GFF supported the development of the investment case to prioritize high-impact interventions required to achieve the goals set in the health development plan. The PNDS was presented during the first ever 3-day, April 15-18, 2019, National Dialogue on Health Financing chaired by the Vice-President of the Republic of Côte d'Ivoire.

As stated in the 2020-2023 Investment Case for Health launched during the National Dialogue on Health Financing, the health budget represents 6% of the national total budget. This is very low despite the continuous economic growth that Côte d'Ivoire has experienced during the past seven years. Household payments and foreign investments cover 60% of the total health expenditures. This high dependency on external resources is a serious vulnerability for continuity of funding for health services.

An analysis of the investments in the health sector from 2016-2018 suggests that the U.S. government was the largest foreign contributor to health, accounting for 15% of heath investments, second to the GoCI with 62.05% (which also includes household and private sector expenses).

Although there has not been a National AIDS spending assessment in Côte d'Ivoire since 2012, Table 2.3.1 below illustrates the most recent financial information on health investments in Côte d'Ivoire.

Table 2.3.1: Health Investments in Côte d'Ivoire (2016-2018)

Funding Source	Total 2016-2018	%
MSHP	$1,456,828,886	61.6%
USG	$353,801,567	14.9%
The Global Fund	$283,009,328	11.9%
GAVI	$73,834,785	3.1%
WFP	$51,860,650	2.1%
World Bank	$47,258,734	1.9%
French Development Agency (AFD)	$26,114,742	1.1%
UNFPA, KOIKA, Muskoka	$23,181,236	0.98%
KFW	$21,381,619	0.9%
UNICEF	$8,619,123	0.36%
Others	$18,472,727	0.78%
Total	$2,347,974,372	100%

Source: Adapted from 2020-2023 Investment Case for Côte d'Ivoire, April 2019 (1$ to 550 CFA)

Table 2.3.2 Procurement Profile of Key Commodities (January - December 2019)

Commodity Category	Total Expenditures	PEPFAR	% PEPFAR	GF	%GF	GoCI	% GoCI	UNITAID	% UNITAID
ARVs	$40,277,657	$14,908,608	36.0%	$9,579,846	23.1%	$15,789,203	38.1%		0.0%
Rapid test kits	$3,299,069	$841,101	2.0%	$1,000,972	2.4%	$1,278,003	3.1%	$178,993	0.4%
Other drugs (CTx, STI kits)	$1,567,600	$268,047	0.6%	$0	0.0%	$1,299,553	3.1%		0.0%
Lab reagents	$6,383,594	$109,988	0.3%	$0	0.0%	$6,273,606	15.1%		0.0%
Viral Load/EID reagents	$4,982,844	$4,602,175	11.1%	$68,738	0.2%	$188,475	0.5%	$123,456	0.3%
TB (Genexpert) commodity	$400,383	$120,923	0.3%	$198,580	0.5%	$80,880	0.2%		0.0%
Condoms	$983,059	$983,059	2.4%	$0	0.0%	$0	0.0%		0.0%
Other supplies	$0		0.0%		0.0%		0.0%		0.0%
Total	$57,894,206	$21,833,901	37.7%	$10,848,135	18.7%	$24,909,720	43.0%	$302,449	0.5%

*Multiple data sources including the Central Medical Stores (NPSP), GF, RETRO-CI and USAID Global Supply Chain Program (GHSC-PSM)

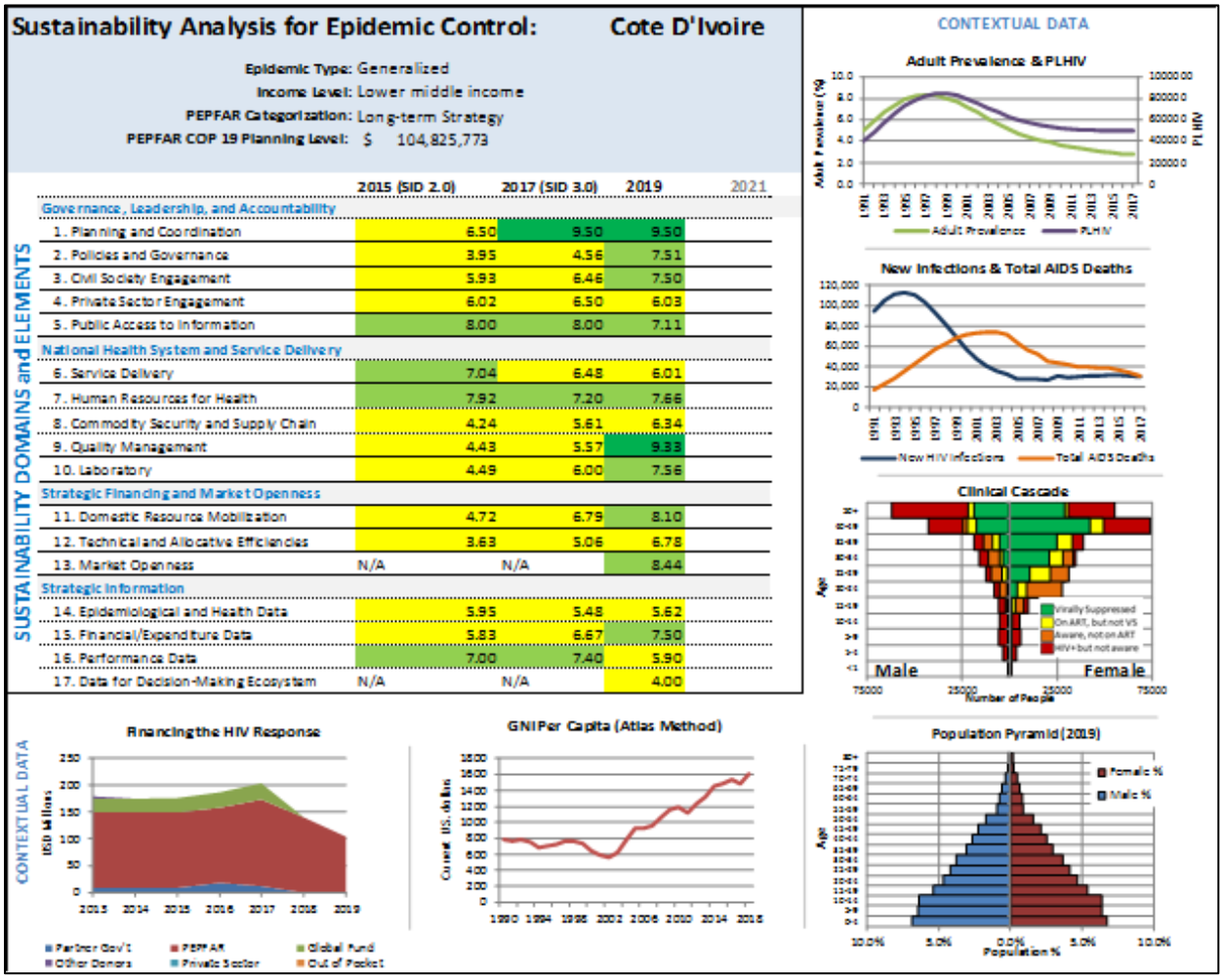
Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration

Annual USG Non-PEPFAR Funded Investments and Integration (FY20)				
Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**
USAID Maternal and Child Health	$2,000,000	$0	0	$0
USAID TB	$0	$0	0	$0
USAID Malaria	$25,000,000	$4,959,080	3	$29,959,080
USAID Family Planning	$2,000,000	$0	0	$0
NIH	$0	$0	0	$0
CDC (Global Health Security)	$605,773	$0	0	$0
Peace Corps	$0	$0	0	$0
DOD	$0	$0	0	$0
MCC	$0	$0	0	$0
Total	$30,527,680	**$4,959,080**	3	**$29,959,080**

2.4 National Sustainability Profile Update

In September 2019, PEPFAR, working in collaboration with UNAIDS and other key stakeholders, completed the 2019 Sustainability Index and Dashboard (SID) and Responsibility Matrix (RM) in collaboration with the MSHP through the DGS and PNLS. The participatory process of completing the SID included other partner governments and stakeholders including key GoCI ministries, civil society, private sector and other bilateral and multilateral donors (i.e., Global Fund, World Bank). In general, Côte d'Ivoire has made progress on the majority of the sustainability elements. Despite this notable progress, the program is still struggling in some areas with persistent vulnerabilities. As seen in Figure 2.4.1, these areas of vulnerability include private sector engagement, service delivery, commodity security and supply chain, technical and allocative efficiencies, epidemiological and health data, performance data, and data for decision making ecosystem. In COP20, PEPFAR-CI will focus on several above-site interventions aiming to improve the score for sustainability elements, prioritizing those with low scores. PEPFAR-CI is also collaborating with the MSHP and other health sector donors to continue oversight on sustainability elements with good scores.

Figure 2.4.1 Sustainability Index Dashboard



2.5 Alignment of PEPFAR investments geographically to disease burden

Beginning in COP19, PEPFAR investments transitioned from supporting 83 to 60 of the 86 health districts in Côte d'Ivoire where an estimated 90% of the PLHIV are located (Spectrum 2019 and 2020 estimates). In addition to 198 sites[3] in the 23 transitioned districts to MSHP, PEPFAR-CI also transitioned an additional 138 low-volume sites[4] to MSHP and ended support to 68 private sites. As of April 2020, PEPFAR investments support a total of 913 ART sites[5], including the military program as a single (1) site in the 60 health districts.

COP19 further directed most of the investment to a set of "140 prioritized sites". These sites included the military program as a "site" and 139 high-volume sites of which 1 later closed for renovation prior to FY20 (COP19) implementation. The remaining 138 non-military ART sites and 1 military PSNU account for 63% of people on HIV treatment, 47% of total patient loss, 62% of patients not virally suppressed, and where 53% of positive cases are being identified (as of December 2019). Further, community-based investments were also directed in COP19 to support these prioritized sites and their immediate catchment areas.

In COP20, PEPFAR investments will continue to support the same 60 health districts where a core package of services will be provided across PEPFAR-funded sites and catchment areas. Within the 60 health districts, PEPFAR investments will adjust COP19's "prioritized site" approach to further align with PLHIV on ART volume and coverage gaps; critical gaps in the case finding, retention, and achievement of pediatric viral load suppression; and where large numbers of KP are served. Direct service delivery and technical assistance approaches will be calibrated to the specific performance challenges, patient volume, and sub-population gaps at each facility and surrounding catchment area, within the constraints of available funding. A detailed articulation of the strategy is found in Section 3.0.

2.6 Stakeholder Engagement

From the beginning of the COP20 process, PEPFAR-CI has engaged many critical stakeholders including: the Government of Côte d'Ivoire (GoCI) - Minister of Health, Director General of Health (DGS), and the National AIDS Control Program (PNLS); Civil Society Organizations (CSOs); and bilateral and multilateral partners such as UNAIDS, WHO, and the GF. The PNLS and CSOs have been engaged in the review of COP implementation throughout the year, notably through the quarterly and day-long pre- or post-PEPFAR Oversight and Accountability Results Team (POART) meetings organized by the PEPFAR Coordination Office (PCO). Specifically, meetings were organized with CSOs to review recommendations from COP19 around ministry sites' adherence to

[3] Includes the 186 sites identified during COP19 planning and an additional 12 sites that were redistricted into the 23 transitioned districts prior to FY21 (COP19) implementation.
[4] Low volume sites were identified as those having <5 total HTS_TST_POS for FY18 or <10 TX_CURR as of FY19Q1 (December 2018); 138 sites were identified as low-volume during COP19 planning.
[5] During finalization of COP19 implementation, 9 sites consolidated with other ART sites or were closed for rehabilitation while an additional 9 sites were identified during partner transitions and implementation as missing from initial site counts, but meeting COP19 criteria and providing ART.

policy changes regarding their oversight of user fee elimination at PEPFAR supported health facilities. PCO facilitated other preparatory meetings to identify sharing of best practices for quality delivery of HIV services to PLHIV. In February 2020, continued advocacy for "TLD for all" was highlighted by an influential CSO member during his "Radio Synergie" interview where he urged the GOCI to revise its guidelines accordingly and fully align with WHO recommendations to aid in rapid distribution and uptake of TLD among PLHIV, especially among women of childbearing age. Documents outlining recommendations from these meetings have been shared with all partners on a regular basis.

Notable examples of Côte d'Ivoire's high-level engagement in the COP20 process include the following:

- In September 2019, PEPFAR, working in collaboration with UNAIDS and other key stakeholders, completed the 2019 Sustainability Index and Dashboard (SID) and Responsibility Matrix (RM) in collaboration with the MSHP through the DGS and PNLS. The participatory process of completing the SID included other partner governments and stakeholders including key GoCI ministries, civil society, private sector and other bilateral and multilateral donors (i.e., Global Fund, World Bank) (see Section 2.4). In addition, DOD completed the 2019 Military Sustainability Index and Dashboard (MILSID) in collaboration of the Ministry of Defense (MOD) through the Military Health Directorate (DSASA), the MOD's different departments (including Human Resources and Finances), the different military forces (Army, Navy, Air, Gendarmerie, Special forces) and the Army's HIV Sectoral Committee (CSLS), and with the active participation of key stakeholders including the PNLS and the Organization of Military PLHIV.

- In mid-January and early February 2020, PEPFAR-CI hosted two meetings with CSOs to solicit feedback and discuss progress and challenges with the implementation and oversight of the circular signed during the COP19 Regional Planning Meeting (RPM) removing all user fees in public health facilities. CSOs receive PEPFAR support to serve as "watchdogs" for ensuring that public facilities eliminated user fees in accordance with the circular. The meetings produced increased advocacy at MSHP level to continue monitoring all public facilities that were not applying the "no user fees" policy.

- In accordance with the directives of the GF and its missions, the Country Coordinating Mechanism (CCM)-Côte d'Ivoire organized a multisectoral dialogue in late January 2020 in order to bring together all the actors involved in the fight against AIDS, Tuberculosis and Malaria. This country dialogue builds on multi-sectoral, inclusive dialogue where partners come together develop solutions to maximize the impact achieved and to examine how all available resources can serve the country's objectives. In this context and to ensure the continuity of the efforts and the sustainability of the achievements, the GF announced on December 16, 2019 the amount allocated to Côte d'Ivoire for the 2021-2023 cycle. The dialogue aimed to orient all stakeholders on the funding request processes for the three (3) diseases from 2021 to 2023. CSOs and other multilateral partners took part in this dialogue and contributed their feedback on how resources will be maximized in the most efficient

way to consider the needs of PLHIV in Cote d'Ivoire. The table below highlights planned Global Fund Investments for 2021-2023.

Table 2.6.1: Summary of Global Fund Investments for 2020-2022

Diseases	Allocation	Allocation Utilization Period
HIV	$89,652,900	1 January 2021 to 31 December 2023
Tuberculosis	$18,449,500	1 January 2021 to 31 December 2023
Malaria	$143,440,000	1 January 2021 to 31 December 2023
Total		$251,542,000

Exchange Rate: April 2019 (€1 to $1.086651)

The GF will focus its investments on reducing incidence and scaling-up effective prevention efforts, and in strengthening both health and community systems. It will also prioritize its investments with key and vulnerable populations and ensure that human rights-related barriers to health and gender inequalities are addressed. Successes achieved will need to be sustained including working in collaboration with other stakeholders to mobilize increased national resources for health. It is expected that funding requests submitted be aligned with prioritized country needs and guided by relevant National Strategic Plans and program reviews. For the HIV funding request, government and all actors involved in the fight against HIV will need to intensify current efforts towards achieving epidemic control. To improve retention in care and address the challenge of loss to follow up, the GF strongly encourages policy and programmatic changes to facilitate community dispensation of antiretroviral (ARV) drugs, and to update and roll out the national guidelines on TLD. Investments will also support strengthening health and community systems that are essential to accelerating progress toward epidemic control, removing human rights and gender-related barriers in access to services, and increasing domestic resources for health -- specifically for HIV, tuberculosis and malaria, which are essential to ending the epidemics and strengthening the health systems that are the foundation of the disease response.

- The Minister of Health participated in the COP20 RPM held in Johannesburg, South Africa on February 21, 2020 and was accompanied by the DGS as well as the U.S. Ambassador to Côte d'Ivoire.

The stakeholder engagement calendar below provides a detailed overview of how PEPFAR-CI engaged these stakeholders and involved them in the development of COP20. Since March 2020, many activities have been carried out remotely via phone or email in light of the ongoing COVID-19 pandemic.

Table 2.6.2 PEPFAR-CI COP Activities

Date	Objective	Outcomes	Next steps	Comments
Before COP20 Submission				
01/14/2020	PEPFAR-CI shared with stakeholders: The COP19 development process, the PLL COP19 overview	Stakeholders understand the COP process Stakeholders understand the timeline for the next steps of the COP19.	Plan the next meeting. Share the documentation.	Meeting was held at UNAIDS and led by PCO
01/30/2020	Monthly Coordination Meetings (DGS) Q1 results shared by regional directors (RDs) Under MSHP /DGS leadership With participation of: CSO; WHO, IPs, UNAIDS, GF, PNLS and all DDs (district directors)	Opportunity for regional directors to share their achievement /challenges and way moving forward (from Q1) to improve performance and fix issues related to retention, TPT for all, TLD transition for all (incl. women of childbearing age), and other WHO recommendations in presence of all DRs, DDs to improve in-country ownership	Monthly monitoring meeting at the regional level under DR leadership to review all IPs achievement CSOs representatives to participate and report any issues found at the site/community level	
01/27-28/2020 In –Country retreat	Discuss COP20 guidance /orientation COP20 expectations from stakeholders, timelines for future steps Receive input from stakeholders on the COP20 strategy for CI.	Stakeholder feedback was shared	Continue discussion via phone and email to ensure stakeholder inputs are considered for, especially the need to support CSO watchdogs' activities and stigma/discrimination intervention	
04/02/2020	Phone call with stakeholders to discuss impact of COVID-19 on HIV patients, PNLS contingency plan for treatment and communication plan for disseminating information to PLHIV			The GF, UNAIDS, PEPFAR and PNLS participated in this remote meeting to ensure that revised treatment options were made available considering COVID-19 (MMD, TLD and VL)

Date	Objective	Outcomes	Next steps	Comments
04/06/2020	Summary of Draft revised COP20 proposal (Table 5, Datapack, Commodities, FAST and strategic vision) shared with stakeholders			Draft was shared via email with CSO and all stakeholders (Documents were in French and English). Feedback solicited via email given the COVID-19 situation
4/10/2020	Phone call with CSOs to answer/clarify any questions regarding the COP20 proposal	PEPFAR will advocate for CSO engagement and participation in the information disseminated to the public regarding COVID-19 in order to minimize misinformation circulating about the pandemic, as well as educating the public about the importance of protecting testing sites erected in their communities.		Focus of the meeting on COP20 footprint and services packages by types of sites COVID-19 response and HIV, as well as community-led monitoring activities planned for COP20
04/13/2020	Draft COP20 SDS shared with stakeholders			Draft SDS was shared via email with CSO and all stakeholders (English version)
04/30/2020	Final SDS to be shared with CSOs and other stakeholders			
After COP20 Submission				
05/05/2020	PEPFAR-CI to explain how stakeholder feedback was incorporated in COP20 planning and how PEPFAR will continue to engage them throughout the year	Stakeholders understand how PEPFAR will continue to engage with them throughout the year and what feedback was incorporated into COP20, what was not, and why these decisions were made.	Share the redacted COP20 when available and approved.	A redacted version of the approved COP20 will be shared by email. Hard copies will be available upon request.

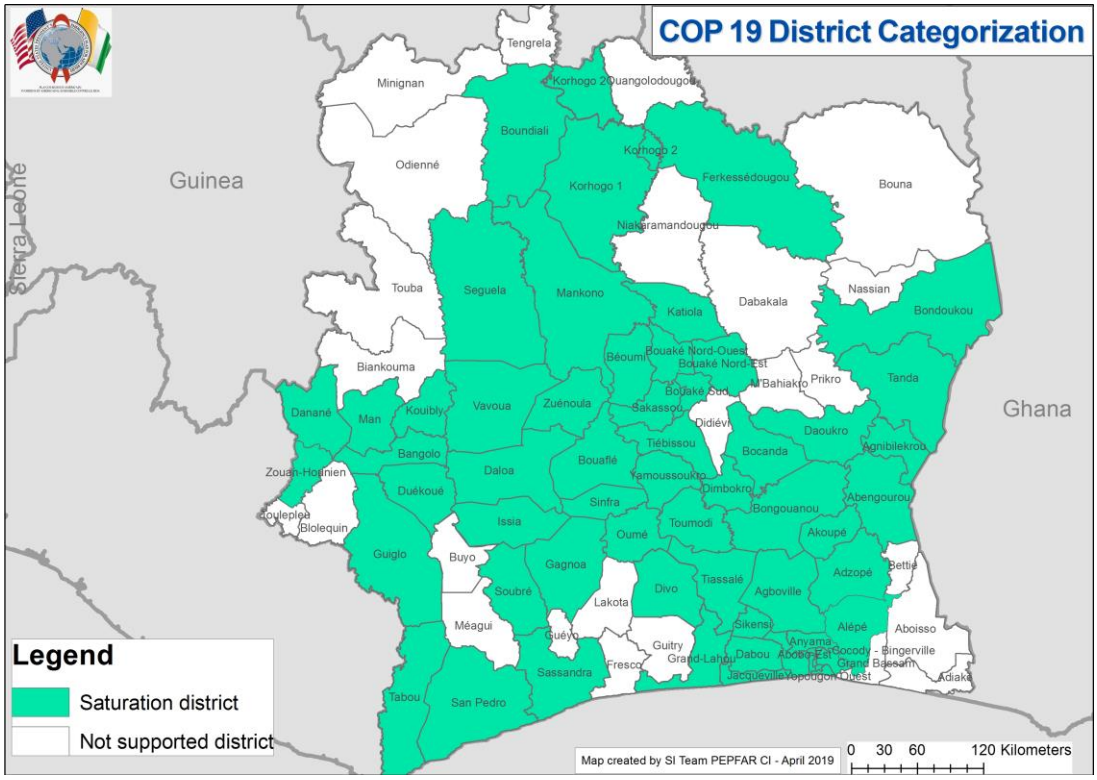
3.0 Geographic and Population Prioritization

PEPFAR-CI prioritizes investments, both geographically and demographically, to achieve 95:95:95 and reach epidemic control. In COP20, PEPFAR-CI will continue to support clinical service delivery and community services in 60 of 86 health districts in Côte d'Ivoire, as of COP19/FY20 (see Figure 3.1 for a map of the 60 districts. These 60 districts are prioritized for targeted programming to higher-risk populations with 90% of the PLHIV burden (see Table 3.1 for the current status of ART saturation in these districts).

According to recent UNAIDS PLHIV estimates (2020), Treichville-Marcory (81%) and Bouake-Nord-Ouest (81%) have met the second 90 target. Cocody-Bingerville and Divo are close with 80% ART coverage estimates. PEPFAR-CI anticipates achieving the second 90 treatment saturation (81% ART coverage) in 12 districts by the end of FY2020 and the second 95 (90% ART coverage) in 56 districts by the end of FY2021.

PEPFAR-CI used the updated UNAIDS PLHIV and small area estimates (2020), including input from the CIPHIA results (2018), to further assess ART coverage gaps by subpopulation at the district level. An additional four districts have achieved the second 90 among women (Adjame-Plateau-Attecoube, Bouake-Sud, Soubre, and Yopougon-Est). Only Bouake-Nord-Ouest has achieved more than 81% ART Coverage among children (<15), men and women; while Treichville-Marcory has achieved more than 81% coverage among just men and women.

Figure 3.1.1 COP19 & COP20 PEPFAR geographic presence



To achieve the 95:95:95 targets, the PEPFAR-CI program is continuing to intensify targeted case finding and rapid ART enrollment strategies for prioritized districts and populations. Implementing partners (IPs) will continue to adapt their technical assistance (TA) and coaching approaches to increase their site-level presence and direct support (including HRH), particularly at prioritized low-performing sites with the capacity for significantly higher volume. Site level and district-level data from FY20Q1 show improvement in linkage and retention and varying degrees of success in case identification. Consequently, PEPFAR-CI is directing its IPs on intensive oversight to continue to fix retention and linkage problems at remaining sites (mostly lower volume/non- prioritized) at the site level (see Section 4 for detailed description of activities). PEPFAR-CI also used site-level retention and VL/VLS data to further target COP20 investments and focus key interventions to address population-specific gaps in prioritized tiers of sites that represent those with the greatest need and opportunity for greatest impact (see below for an explanation of site-level prioritization and alignment of investments). Table 3.1.1. shows the current status of ART saturation and progress towards 95-95-95 across all 60 PEPFAR-supported health districts.

Table 3.1.1 Current Status of ART saturation -

Current Status of ART Saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP20**	**# Current on ART (FY19)**	**# of SNU COP19 (FY20)**	**# of SNU COP20 (FY21)**
Attained				
Scale-up Saturation	90% 381,288 / 425,779 national PLHIV est.	258,459	60	60
Scale-up Aggressive				
Sustained				
Central Support				
Not PEPFAR Supported	10% 44,491 / 425,779 national PLHIV est.	27,483	26	26

In order to reach ART saturation, as mentioned in Section 2.5 above, PEPFAR-CI will provide a different degree of packages by both clinical and community to different sites depending on the need.

Clinical-based Support

In COP20, a core package of services will be provided across all PEPFAR-funded sites. In addition, COP20 will align additional HRH investments at the facility level (ART site) based upon site-specific needs as follows:

- **High impact: 173 ART sites, including military PSNU, representing 67% of TX_CURR (FY20Q1)**

These sites comprise COP19's 139 prioritized sites, including the military program; 11 additional sites outside of Abidjan where largest contribution to district-level gaps can be addressed in case finding, ART coverage, retention and viral suppression; 11 additional sites in urgent need of closing the gap in pediatric VLC/VLS (95 total pediatric prioritized sites); and 12 additional sites identified for their large proportion of KP on treatment (of a total of 15 sites with a large proportion of KPs). Sites will receive PEPFAR's core package of services in addition to increased human resources for health (HRH) investments calibrated based on performance, needs, and gaps to strengthen targeted testing, scale-up of index testing, and adherence/retention support to prevent loss to follow up (LTFU) and achieve program goals and COP20 targets. Facility-based HRH investments will consider existing community-based cadres (and vice versa) to maximize efficiency in activities including defaulter tracing, adherence and retention support, and patient return to care. To ensure investments are as efficient as possible, there will be clearly defined and distinct roles and responsibilities for facility and community-based HRH staff. In the military program, HRH investments will continue supporting the military health system to address the gaps due to the proportion of military HRH, leaving the Ministry of Defense (MOD) under its early retirement policy, and the positions that are scarcely provided by the MOD such as social or community actors.

- **Moderate impact sites: 282 ART sites representing 24% of TX_CURR (FY20Q1)**
  Moderate impact sites include additional sites located primarily outside of Abidjan (234 of 282 sites are not in one of two Abidjan regions). Based on volume and gaps in case finding, retention and VLS, some moderate impact sites will receive additional HRH investments, including a lay worker at the site and a social worker, data clerk, and data manager based at the district level. As mentioned above, facility-based HRH investments will be calibrated based on community-based cadres and roles and responsibilities will be clearly defined and distinct. The remainder of moderate impact sites will receive support through a Technical Assistance-Service Delivery Improvement (TA-SDI) approach in coordination with MSHP support and supervision. Sites receiving the TA-SDI approach will receive PEPFAR's core package of services and be supported by IPs through quarterly mentorship and supervisory support for core services across clinical cascade, differentiated service delivery, and lab sample transportation. Sites will report results as a TA-SDI site as defined in the PEPFAR Monitoring, Evaluation, and Reporting (MER) guidance.

Together high and moderate impact sites include a total of 455 ART sites and the military PSNU, accounting for more than 90% of TX_CURR (FY20Q1 results)

- **Low impact: ART sites representing <10% of TX_CURR (FY20Q1)**
  The remaining ART sites will be reviewed further in consultation with MSHP and most will be transitioned to MSHP during COP20. A small number of sites may be identified as serving critical populations or geographic locations warranting continuing PEPFAR-support. This support will include the core package of services through a TA-SDI approach: sites will receive quarterly visits for mentorship and will report results as defined in the PEPFAR MER guidance. MSHP will provide transitioned sites with training, sharing of best practices, and oversight

through MSHP's monthly coordination meetings. Similar to sites and districts currently not supported by PEPFAR, these additional sites transitioned to MSHP will provide services in accordance to new national policy with technical support from the district health management team, which includes differentiated service delivery (to include community ART), TB preventive therapy, transition to TLD, etc.

Community-based Support

Community-based support for case finding, adherence/retention, and viral load suppression will be provided through differentiated packages of services at the community-level based on targets and population profiles at the district-level, demonstrating the greatest needs. Community support will be aligned with sites that have concentrated gaps in case finding, retention, and VLS among prioritized populations. Population profiles include age and sex disaggregation for case finding among hard to reach sub-populations and sub-groups of PLHIV (such as new on treatment, lost to follow up, and PLHIV with poor VLS) for tailored care and support. To ensure investments are as efficient as possible, there will be clearly defined and distinct roles and responsibilities for facility and community-based HRH staff.

As most of the low impact sites are expected to transition to MSHP, no additional PEPFAR investments in general community programming are expected in the low impact sites or their catchment areas. Since 2017, the MSHP has adopted differentiated service delivery model[6] (DSDM) policy as part of the standard care package for patients on ART that is being scale up at all sites. In February 2020, this package was expanded to include community ARV distribution. In COP19, the National AIDS Control Program (PNLS), the Direction of Community Health (DSCMP) in collaboration with donors and implementing partners are developing the models, procedures, monitoring tools and materials to the implementation of community ARV distribution at a small scale. The implementation will be expanded in COP20, to all ART sites, especially in remote hard-to-reach areas. As community ARV distribution is a national policy, its implementation will be national. In low HIV burden districts/low volume ART sites, including the majority of low impact sites that are transitioned to MSHP, they will use community health agents (ASC) who are traditionally engaged in health promotion/prevention activities, including bed-net distribution, immunization campaigns, maternal, neonatal and child health (MNCH), and directly observed of tuberculosis (DOT) treatment to also distribute ARVs as part of a comprehensive package. Community health agents are selected by their own community members with the approval of the health district director and are directly supervised by nurses and/or midwives of the heath care center they are attached to. This will be the way forward to sustain this activity with country ownership.

OVC programming will continue to work in 38 of the 60 PEPFAR-supported districts (selection made in COP18 based on volume of PLHIV), KP programming will focus on 42 districts plus the

[6] Cote d'Ivoire Ministère de la Santé et de l'Hygiene Publique, Note Circulaire, Fevrier 2017

military program based on KP population density and hot-spots, and DREAMS will remain in the same 4 districts as COP19. Population-specific programming materials will be shared with MSHP, who may pursue expansion of these programs, such as DREAMS programming, to other districts.

Additional details on the packages of services to be provided by all packages and at the community-level are provided in Section 4. See also Figure 3.1 for COP20 PEPFAR geographic presence.

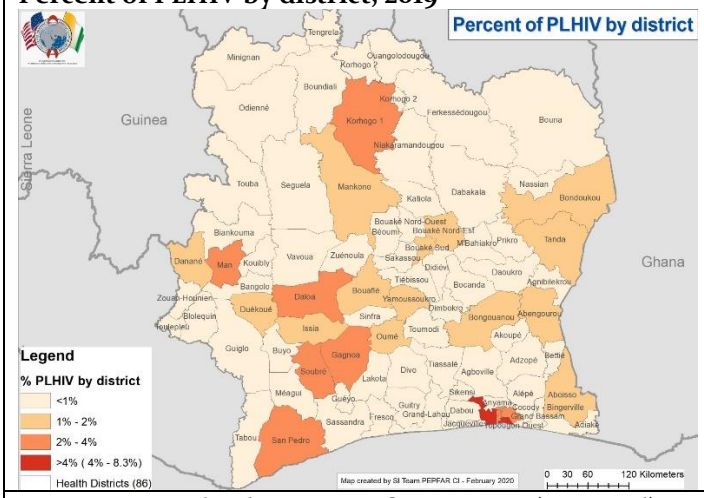
Table 3.1.2 Clinical/Community based Investments

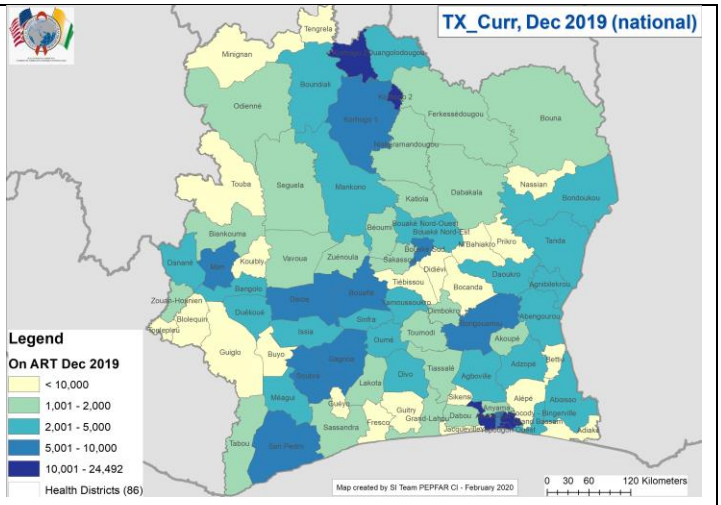
Types of Sites	Number of Sites	HRH	Supervisory Visits	Laboratory Sample Transport	Patient-centered Quality Care Support	Other Support (materials etc.)	Comments
High Impact	173 (includes military program)	Social workers, Facility lay workers, data clerks and data managers based at site	Monthly	Provided	Targeted case finding through community outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; Differentiated adherence/retention support; Community-level promotion of HIV literacy and stigma reduction	Training, supplies, equipment, etc.	
Moderate Impact: Direct Service Delivery (DSD)	282	Lay worker assigned to the site; social workers, data clerks and data manager assigned to the district	Monthly	Provided	Targeted case finding through community outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; adherence/ Differentiated retention/adherence support; Community-level promotion of HIV literacy and stigma reduction	Training, minimal supplies, and equipment	
Moderate Impact TA-SDI		No PEPFAR staff at sites and PEPFAR district-based staff are not assigned to these sites	Quarterly	Provided	Targeted case finding through community outreach; Community ART; Multi-month dispensing; continuous quality improvement (CQI) activities; Differentiated adherence/retention support; Community-level promotion of HIV literacy and stigma reduction	None	

Figure 3.1.2 below shows the current HIV prevalence, ART treatment coverage and viral load testing coverage by district.

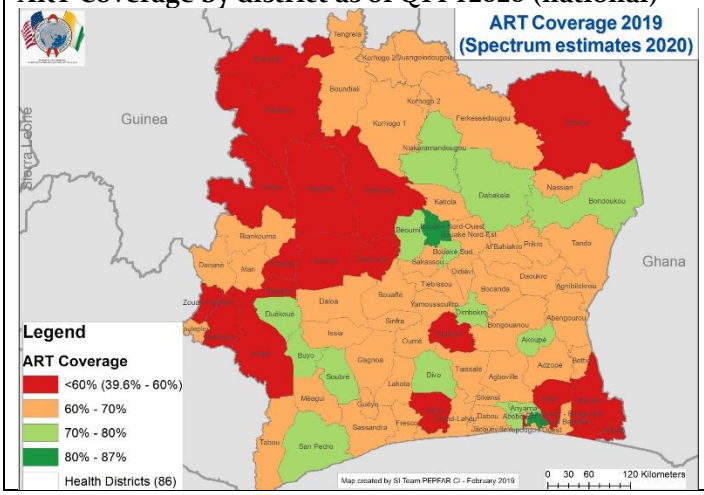
Figure 3.1.2 HIV Prevalence, Treatment Coverage and Viral Load Testing Coverage

Percent of PLHIV by district, 2019

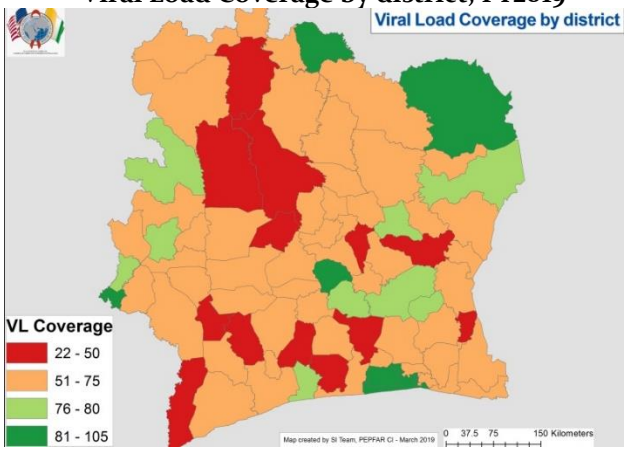




ART Coverage by district as of Q1 FY2020 (national)



Viral Load Coverage by district, FY2019



4.0 Client Centered Program Activities for Epidemic Control

4.1 Finding the missing and getting them on treatment

PEPFAR-CI aims to treat 357,466 PLHIV by the end of FY2021. In order to achieve epidemic control, PEPFAR-CI is centering its efforts in 173 ART sites, including military PSNU, representing 67% of TX_CURR (FY20Q1). Those prioritized sites constitute the high impact sites among the 922 ART sites supported by PEPFAR located in 60 districts covering ~70% of PLHIV in Côte d'Ivoire.

Table 4.1.1 below provides details on the core package of services that will be provided to all sites.

Table 4.1.1: COP20 Core Package of Services

Undiagnosed	Newly on Treatment	LTFU/Defaulters
▪ Facility and community index testing with fidelity ▪ Targeted facility-based PITC ▪ EID ▪ Targeted outreach testing ▪ OVC testing ▪ Prevention support/PrEP (HIV-ve)	▪ Treatment literacy (U=U) initiation support ▪ Appointment reminders ▪ Treatment initiation (TLD/DTG optimization) ▪ Preparation for MMD ▪ Pediatric and adolescent support package of services (disclosure support) ▪ VL monitoring/VL champions ▪ Mother-infant pair visits, OVC referrals ▪ TB Tx or TPT/Advanced disease package ▪ STI screening/treatment	▪ Appointment reminders ▪ Facility-community tracking/tracing and regular review of results ▪ Weekly data monitoring ▪ Treatment coaching/VL monitoring ▪ Addressing reasons for defaulting/stopping ART ▪ Documentation of transfer-out ▪ Mother-infant pair visits, OVC referrals ▪ TB Tx or TPT Advanced disease package
Not Linked	**Already on Treatment**	**Unsuppressed VL**
▪ Treatment literacy (U=U) ▪ Patient tracking and navigation ▪ ART readiness assessment ▪ Linkage facilitator ▪ Case management ▪ Psychosocial support ▪ Appointment management	▪ Treatment literacy (U=U)/adherence counseling and ongoing support ▪ VL monitoring/VL champions ▪ Differentiated service delivery models, including MMD, community ART refill/pickup ▪ TLD/DTG-based regimen optimization	▪ Enhanced adherence counselling and repeat VL monitoring ▪ Appointment reminders ▪ ART optimization ▪ Pediatric and adolescent support groups/package of services ▪ Appointment reminders ▪ TB Tx or TPT/Advanced disease package

	▪ TB Tx or TPT/Advanced disease package ▪ STI screening/treatment	

4.1.1. General approaches

***Direct Service Delivery approach and shifts in FY2020 to be continued in FY2021*:**

A key barrier in Côte d'Ivoire HIV/AIDS response is the limited capacity to consistently deliver core clinical services at an optimal standard of care. PEPFAR-CI-supported clinical services are implemented primarily in the public sector health facilities through an integration of HIV services with other diseases and delivery by the Ministry of Health (MSHP) clinicians, including doctors, nurses, midwives, pharmacists, laboratory staff, and data managers.

The focus of PEPFAR's facility-based service delivery support will be to complement MSHP clinicians with lay workers dedicated to addressing critical programmatic gaps. This will include dedicated personnel to ensure high-quality, patient-centered index testing, monitoring and case management of the pediatric ART cohort, support to caregivers for pediatric ART administration, viral load monitoring, and integrated services to improve case-finding among men.

PEPFAR-CI, with mutual agreement from the MSHP in FY20Q1, has paused generalized HIV testing and has limited this service at the facility level for asymptomatic clients and at the community level, except for index testing and the prevention of mother to child transmission (PMTCT), orphans and vulnerable children (OVC), DREAMS, and key populations (KP) programs. PITC will be targeted to improve case finding, to include patients presenting with STIs, TB, and those on inpatient or malnutrition services. In addition, PEPFAR will work closely with MSHP and CSOs to monitor the full implementation of the new national guidelines on the implementation of TLD, monitor the ban on user fees, and the implementation of differentiated models of service delivery including multi-month dispensing of ARVs. Following preliminary discussions, PEPFAR-CI will benefit from HQ-based technical support to operationalize a community ARV distribution model agreed upon with the MSHP with a more detailed strategy that outlines: i) service packages, ii) roles and responsibilities of facility-based versus community care providers, iii) human and financial resource allocations to address the needs of specific sites and sub-populations, and iv) a monitoring plan.

Strong collaboration and consultation with GoCI, international stakeholders, and professional associations will be critical in continuously reassessing the most efficient model for PEPFAR support, and to design an appropriate transition plan for sustainability and build on successes to achieve and maintain epidemic control. PEPFAR-CI will achieve this through monthly and

quarterly meetings, under DGS leadership, with all stakeholders involved in the HIV response and through joint monitoring of the COP process.

***Quality management*:**

Continuous quality improvement (CQI) and quality management (QM) are critical for improving service quality at underperforming sites with real time course correction. QM will be extended to all the 914 sites in 60 districts in FY2021 though with different degrees of interventions to ensure that HIV services are being offered with a goal of achieving increasingly higher quality and consistent standards of care. Quality Management/Quality Improvement (QM/QI) activities will be improved though the capacity building of National and Regional Level CQI Teams; technical assistance for CQI policy, guidelines, training/supervision materials review and District and Site Level Intensive Support for CQI interventions including regular data monitoring, Site Improvement Through Monitoring System (SIMS), "non-SIMS" granular site management (GSM) visits, SOPs, Training/Coaching will be provided. Targeted SIMS visits will be conducted at all 173 high impact sites to improve service delivery and above site level visits will ensure that implementing partners, district health management teams and other central and decentralized entities have the capacity to provide effective support to sites. Facility and community site level data will be collected and aggregated to produce regional and national benchmarking reports. Selected GSM visits will also be conducted by PEPFAR-CI to ensure that new guidelines and technical recommendations are implemented appropriately.

As such, all stakeholders will perform joint site visits at high impact sites at least twice during the year in addition to monthly monitoring of key indicators by PEPFAR-CI staff. IPs staff will conduct monthly coaching visits (including data reviews and site assessments), weekly remote check-ins and send weekly reports on key indicators to PEPFAR-CI team.

The 282 moderate impact sites will be monitored by PEPFAR-CI team in collaboration with MSHP through quarterly monitoring of key indicators and will receive GSM and SIMs visits if needed based on performance needs and gaps. At sites prioritized for DSD support, IP staff will conduct periodic coaching visits and site assessments and send monthly reports on key indicators to PEPFAR-CI team.

The 467 low impact sites will be further analyzed together with MSHP; those continuing to receive PEPFAR-CI support will be monitored in accordance with MER guidance for sites receiving TA-SDI support. IP staff will conduct quarterly coaching visits and send quarterly reports on MER indicators to PEPFAR-CI team.

PEPFAR-CI partner management is done at three levels:: (i) Activity Managers (AM) will conduct weekly and monthly progress reviews and course correction of deficiencies, in addition to monthly and quarterly partner meetings and financial reviews; (ii) the Interagency team will conduct site visits (frequency to be determined based upon site-specific needs) and data review of key indicators on a monthly basis; and (iii) the National Program will conduct quarterly program results reviews led by the PNLS with the participation of PEPFAR-CI, IPs, and stakeholders. In accordance with

COP 20 guidance, any partner with either: (1) <15% of target achievement at 3 months or (2) less than 40% of target achievement at 6 months will have a complete review of performance data and expenditures to date by program area, followed by remediation and intensive follow-up. These elements will be incorporated into the existing IP work plans. A second quarter of consistently poor performance by the IP will result in implementation of a corrective action plan (CAP). If after three quarters performance continues to be suboptimal, S/GAC will be notified.

Community-Facility Linkage:

Strengthening community and facility collaboration is a critical component of PEPFAR-CI's strategy to increase case finding and linkage to ART and retain patients on treatment. Starting in COP19, PEPFAR-CI rationalized the geographic distribution of clinical and community partners, limiting the number of partners intervening in one region and pairing each clinical IP with a community IP [7] to increase efficiency. Memoranda of understandings (MOUs) were created to formalize this collaboration, delineating roles and responsibilities of each partner in upholding services across the clinical cascade starting in Q4 of FY2019 and into FY2020. PEPFAR-CI will continue to review existing MOUs and monitors benchmarks of success in addressing coverage gaps across populations and age bands on a quarterly basis. Each IP will have a clear scope of work and standard operating procedures (SOP)s for monthly tracking of referrals/counter-referrals and patients lost to follow-up who have been found in the community and returned to a health facility to continue treatment. During COP 19, and continuing into COP 20, this data will be analyzed by the interagency PEPFAR-CI team, in order to quickly identify areas where coordination and data sharing among IPs need improvement. The newly distributed MSHP national referral and counter-referral tool will facilitate consistent tracking of patients.

Community IPs are responsible for the following community interventions based on the clinical MOU operationalized algorithm:

(1) targeted case finding in the community including index testing (2) provision of self-test kits (assisted or home-based), (3) active referral for ART initiation for those identified in the community to increase treatment coverage and reduce mortality, (4) Reinforced adherence counseling for ART patients (5) Community ART distribution, (6) implementation of differentiated care models, (7) establishing and implementing support groups including "patient buddy systems" (8) screening for opportunistic infections such as TB and active referral for treatment, and (9) home visit tracking of PLHIV who are lost to follow-up, and identifying barriers to seeking treatment and reasons for lost to follow-up. This community-to-facility bidirectional referral is important both for IPs to achieve their targets as well as to keep clients engaged across the continuum of care. Clinical IPs will provide intensified support to specific sub-populations to prevent LTFU, thereby reducing the need for community-based defaulter tracking. For the ART patients demonstrating challenges, facility- and

[7] For USAID the main community partner is Breakthrough-ACTION (BA) that serves as the interface with the facility representing the consortium of USAID specialized partners (including OVC/DREAMS and KP as well as the general population covered through BA).

community-based models of care and support will be offered as options for optimal patient-centered care. Clinical IPs will make referrals to community IPs for support services to improve adherence and VLS, as appropriate. Community and clinical IP work plans will reflect their synergistic roles in client care. Use of the community-facility matrix, introduced in COP19 and used at scale in COP20, will further strengthen monitoring of the community-facility collaboration and the dyad's shared results.

The clinical-community collaboration will ensure a smooth continuum of care for patients and support full implementation of differentiated service delivery models, including 6-MMD and/or community ART for stable patients; through this differentiation, stable patients will receive an increasingly "lighter touch" from the health system overall. PLHIV identified in the community are referred and escorted by community counselors or peers to the facility for same day ART initiation. In the context of index case testing and partner notification, counselors and providers ensure that a gender-based violence risk assessment is completed, and that contact elicitation is carried out in an ethical and patient-centered manner. Also, HIV-infected children and exposed infants are linked with OVC platforms as priority beneficiaries.

Lay worker counselors from the facility and the community will hold weekly coordination meetings to ensure that referred patients received same day or prompt ART initiation, patients lost to follow-up are tracked and traced, transfers out are documented, and patients' social needs are addressed promptly. Monthly multidisciplinary team meetings at sites and quarterly district coordination meetings will be reinforced to ensure effective partnership and outcomes as well as good linkage between community and clinical settings. The CommCare tool will facilitate patient-level tracking across both facility and clinical IPs.

Human Resources for Health (HRH):

HRH shortages are a significant barrier to high-quality service delivery required for HIV epidemic control. Specific challenges include: (i) lack of an accurate assessment of the total number of health providers required to provide HIV/AIDS services and other basic health services; (ii) MSHP and Ministry of Defense (MoD) budgetary constraints limiting the recruitment of sufficient staff; (iii) the imbalanced distribution of health care workers across the country; (iv) demotivated MSHP and MoD health care providers overwhelmed by HIV service delivery and data collection; (v) outdated attitudes promoting blanket (rather than targeted) provider-initiated testing and counseling (PITC); and (vi) the recent significant reduction in military health providers because of an early retirement policy implemented in 2020, (vii) the persistent problem of health care workers leaving public facilities during working hours to treat private patients off-site.

Currently, significant efforts are being made to use a data driven approach in determining and monitoring HRH requirements, allocation, performance, and productivity to support HIV targets achievements and the roll-out of key policies. Steps have been taken to ascertain the number of health care workers required at sites and the distribution of health care workers across the country. In COP20, a human resource information system (HRIS) will be developed to track PEPFAR staff

down to the facility and community level to ensure budget allocations for HRH align with expenditures. District level HRH investments working at the facility will consider existing community-based cadres to maximize efficiency in activities including defaulter tracing, adherence and retention support, and patient return to care. To ensure investments are as efficient as possible, there will be clearly defined and distinct roles and responsibilities for facility and community-based HRH staff.

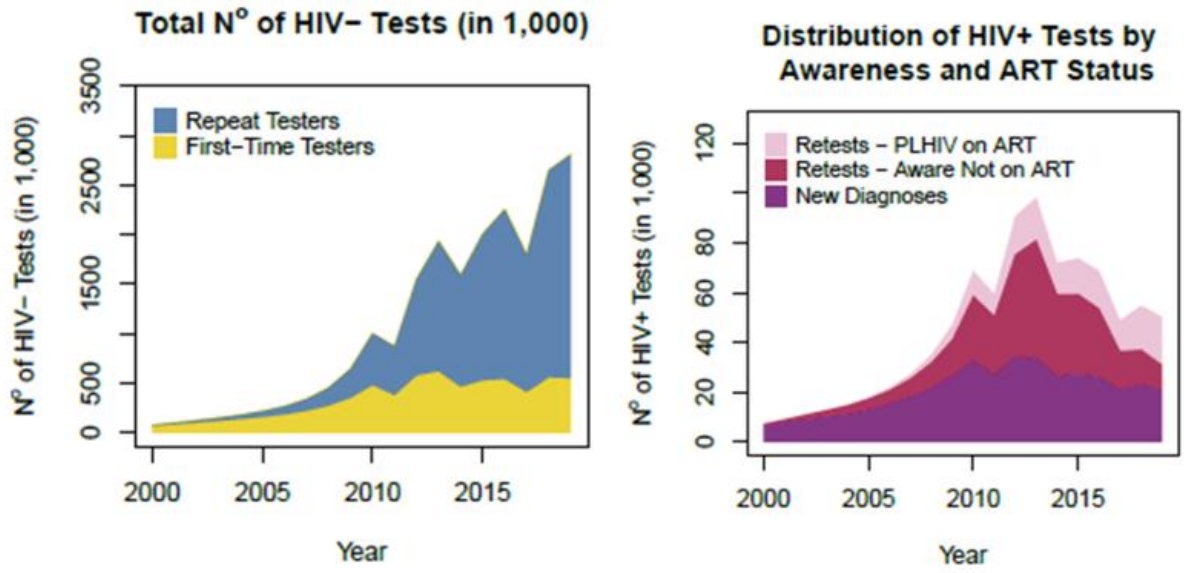
In COP20, emphasis will continue to be placed on improvements in quality of clinical services, effective and efficient counseling, and coordinated case management at high impact and moderate impact sites to promote retention, increase TLD transition, improve VLS, and enrollment of PLHIV in community ARV or MMD, and increase client engagement across the continuum of care.

The program will also engage with the MSHP for a broader national HRH strategy. The USG team will work with the district government for effective targeted supervision/mentoring and coaching of care providers on targeted testing and other policies, HRH performance review, providers motivational strategies, service quality management, data quality management and use of data for decision making on a monthly (high impact) or quarterly basis (moderate impact sites).

Case Finding Strategies

Key challenges mentioned in Côte d'Ivoire's COP20 letter were the lack of progress in a) finding new HIV-infected persons through targeted index testing as demonstrated in findings presented by UNAIDS using 2020 Spectrum estimates (see Figure 4.1.1 below), and b) linkage from testing into care, especially among men, adolescents, and children.

Figure 4.1.1.1 National Data Demonstrating Many Repeat Testers



Based on the mandate set by OGAC in the COP19 planning level letter (PLL) in an effort to focus on critical issues related to retention, community-based testing was paused effective immediately

in COP18, except for index testing and active case finding in the PMTCT, OVC, DREAMS, and KP programs. Implementation of the testing pause was mixed, as many facilities continued with generalized testing strategies and/or did not scale index testing. In addition, community-based index testing outside of the prespecified groups (PMTCT, OVC, DREAMS, and KP programs) was limited with room for improvement. The reduced numbers in case finding had a detrimental effect on the clinical cascade and treatment outcomes. While policy guidance at the central level was consistent with PEPFAR strategies, site-level implementation strayed from this guidance, after years of blanket HIV testing on demand. MSHP has recognized the need to reinforce messages on optimizing PITC and prioritizing index testing; these will be among the key objectives of the monthly and quarterly multi-stakeholder data reviews. In addition to developments in COP18 and 19 to strengthen community-facility collaboration are advances in collaboration and referrals between community partners with specific emphasis on vulnerable and hard to reach populations. SOPs and MOUs were developed between KP, OVC, and general population community partners to ensure effective case finding, active linkage, and appropriate prevention and care services for: vulnerable children including children of FSWs; stable and regular partners of FSWs; vulnerable AGYW; and PLHIV and vulnerable non-KP individuals identified through KP network testing.

In the remainder of COP 19 and continuing into COP 20, PEPFAR-CI will increase and improve case finding through strengthened index testing practices with fidelity, expanded implementation of the screening tool and testing algorithms at facilities, and improved community-based case finding strategies including partnership with faith leaders and groups to reach men, children, and women who do not present to ANC.

Index Case Testing

Côte d'Ivoire adopted index case testing in FY2019 as its main approach to address its most critical gap of case identification observed across all populations and age groups and is ensuring fidelity and scaling up this approach urgently now and into FY2021 with the goal of reaching epidemic control by 2022. The program anticipates increasing the proportion of positives coming from index case testing from 23% of, as of FY2020 Q1, to up to 60% for some settings in FY2021, for those identified within the facility. While this represents an increased focus upon implementation fidelity for index HTS, it also reflects an anticipated reduction in the volume of positives coming from non-index PITC given the emphasis upon targeting/risk stratification.

All positive cases newly identified in facility and community settings will systematically serve as index cases with active tracking of all sexual network partners for testing. Adhering to WHO's 5Cs and best practices for partner elicitation interviews, a routine listing of the sexual partners of all newly identified PLHIV, those currently on ART with unsuppressed VL, and those currently on ART who have not yet received index testing services will be done. Once they agree to index testing, this listing will be updated each time the patient comes to the health center or receives care and support at the community-level. Once they agree to index testing, the index client will be given the option for an assisted or unassisted disclosure to their sexual contacts, and HIV self-testing will be offered for selected target groups for COP20 (partners of female sex workers (FSW) and men who have sex

with men (MSM), military personnel aged 35+ and sexual partners of HIV positive women, and male partners of HIV positive pregnant women who do not accept testing through standard testing platforms). A standardized tracking system will ensure follow-up with index case clients to strengthen case identification and linkage to treatment. Furthermore, case conferencing meetings will be set up among providers involved in index case testing to share updates with active tracking of contacts.

Providers will be trained in brief motivation interviewing, to improve communication with the index cases and understand each index cases' unique risk situation. In addition, collaboration will be strengthened with providers across districts so that contacts identified outside of the immediate catchment can be reached. A risk assessment of intimate-partner violence will be conducted prior to partner notification, provision of first-line support (LIVES) per WHO requirement, with referral and linkage to the appropriate services for those screening positive. In the context of self-testing, counselors will be available to accompany patients tested positive in the community for confirmatory testing and ART initiation at the facility, and support will be provided for HIV status disclosure at both the community and facility levels.

Overall, this level of scale up will require rigorous monitoring of partner performance in FY2021. PEPFAR-CI will continue to conduct weekly partner monitoring for the large volume sites to monitor the implementation of index case testing with fidelity. Based on PEPFAR-CI partner level analysis of best practices in index testing, successful strategies are being replicated at prioritized sites. Full-scale implementation of index testing will be a major focus of the facility-based HRH strategy for COP 20.

An analysis of testing modalities shows that high positive volumes are expected in PITC, which will all be feeding index case testing. Facilities will offer multiple approaches within PITC and ANC:

- Options for index client to return with partner or refer for PITC
- Community-based index testing for those partners/contacts not coming into the facility. Currently, community contact tracing occurs after a two-week period but in some cases more or less time may be necessary, in order to ensure patient-centered, non-coercive contact elicitation while providing testing services to at risk partners in a timely manner. This is particularly relevant for the partners of newly diagnosed individuals. Strong coordinating platforms between clinical and community partners will be critical to accelerate this process.
- Establish both anonymous and facilitated disclosure options for partner notification. For those not willing to disclose, the former could be leveraged. These may include non-specific targeted messaging around risk and testing, etc.

In addition, female PLHIV on treatment at facilities and those attending ANC will be prioritized as index cases in order to reach their male partners for HIV testing.

Family testing of the biological children of HIV-infected women and FSW will be scaled up while clearly differentiating from sexual partner testing. If they have not been previously tested, children

of male-index clients (fathers) will be included when the biological mother is HIV-positive, deceased, or her HIV status is not known or not documented. HIV-infected children will be linked to OVC services as appropriate. Training will also be provided for index testing with fidelity in the pediatric context in addition to training on correct reporting and monitoring to track progress and implement real time corrective action.

The OVC program will contribute to case finding through a family-based approach. Specifically, OVC implementing partners will fully roll out a risk assessment tool for OVCs with unknown HIV status and provide testing services as needed. Partner elicitation for all HIV positive adults and sexually active adolescents in an OVC households will be updated monthly. The program will provide HIV testing services to sexual partners with unknown or undisclosed HIV status. All partners who test positive will be actively referred for immediate ART initiation.

4.1.2. Case finding and retention strategies oriented to Men

In terms of volume, FY19 annual results showed that PEPFAR-CI identified 19,713 men (out of 564,945 tested) through other provider-initiated testing and counseling (PITC) for HIV with a yield of 3.5% compared to 5% in FY18. Through FY20Q1, most of the 2,433 HIV-positive men continue to be found through PITC (1,593 representing 65.5%) followed by health facility-based index testing (474 representing 19.5%).

To improve this result, case finding for men will involve making facilities more friendly, as well as community-based strategies to find men who are less likely to present to the facility until late in the course of disease. PEPFAR will: ensure the existing screening tool is used and implemented with fidelity at scale across clinical and community sites; extend hours and scale up men-friendly clinics and; continue to rapidly, but safely scale index testing starting in FY2020. In addition, the program will evaluate the "other" PITC entry point data at the district and site/community level to identify the specific testing modalities representing the highest yield and volume (by age) for men, and to assess their capacity for greater expansion. In order to optimize PITC, a screening tool used in high yield sites, which includes sexual risk factors, STIs and other symptomatology, will be scaled-up with fidelity in FY 2021 to improve HIV case identification in low yield sites.

The TB symptom screening tool/algorithm will be used in all supported TB clinics to ensure 100% HIV testing among TB presumptive and TB confirmed clients during FY2020 and will be scaled-up to non-TB clinics in FY2021.

Moreover, the program will couple index case testing with targeted testing optimization. Positive cases identified through clinical and community services will systematically serve as index cases with tracking of all (primary or casual) sexual network partners for HTS. Psychosocial support for partner notification and/or partner testing (any modality) including self-testing will be provided.

For adolescent and young men (aged 15-24), IPs will reinforce age-appropriate sexual risk reduction counseling and linkage to care and treatment services. Additionally, men will be reached through other existing platforms like DREAMS where the male partners of adolescent girls and young

women (AGYW) will be identified and targeted and linked to prevention, testing, and care and treatment services as appropriate.

Experience in Côte d'Ivoire demonstrates that men are more likely to access testing services as part of a wellness package, which is the approach within which PEPFAR-CI embeds HIV services such as HTS for hard to reach populations.

PEPFAR-CI will work in coordination with Alliance Côte d'Ivoire (Global Fund PR) to increase the community outreach to non-PEPFAR sites within certain prioritized districts to ensure maximum complementarity.

ART Initiation, Linkage and Retention

FY20Q1 results saw that 25 districts have <100% linkage rates. To address this issue, the following interventions are beginning in COP19, and will continue into COP20.

Interventions at facilities:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Patient navigation to ART initiation
    - Weekly monitoring of linkage as QI measure at 173 high impact ART sites
- ART adherence support through:
    - Enrollment in age-appropriate support groups (or 1:1 support, per patient interest)
    - Fast track med dispensation at facility
    - Multi-month scripting for stable patients (6 months)
    - Facility-based community ART distribution (hybrid model)
- Better monitoring through roll-out of electronic ART registers and extended hours (after hours, weekend refills, workplace etc.)

Interventions in the community:

- Active linkage to ART through:
    - Enhanced post-test counseling
    - Accompaniment to ART initiation
    - Weekly monitoring of linkage as QI measure
- ART Adherence support through:
    - Age-appropriate treatment literacy materials and approaches
    - Enrollment in age-appropriate support groups (or 1:1 support, per patient interest)
    - Community based ART distribution
    - Engagement of community leaders

In addition to the above-mentioned interventions, PEPFAR-CI interagency team will strengthen implementing partner management through:

- Weekly and monthly review of results
- Weekly IP calls
- Weekly calls with non-performing sites by USG staff and IPs
- Prioritize visits at non-performing sites
- Pair high performing sites and low-performing sites for coaching and sharing of best practices

Table 4.1.1 Case finding and ART Initiation and Retention Strategies to Reach Men by age band

Age	Case Finding	ART Initiation and Retention
15-19	**Interventions at facilities:** • Intensified index HTS • Improved counseling messages **Interventions in community:** -Index HTS Linkage through youth prevention platforms: prevention, OVC/DREAMS programs. - School health programs	**Interventions at facilities:** • TLD uptake • Patient navigation • MMD **Interventions in community:** - ART Adherence support through: o Home visits for patients in need • Psychosocial support for caregivers • Disclosure and adherence support through the OVC program - Dedicated hours with school/student program
20-24	**Interventions at facilities:** - Provider initiated Self-testing -HIV testing at STI clinics-Intensified index HTS **Interventions in community:** - Embedded testing as part of a wellness/multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at workplaces, unions, male oriented gatherings Grins - Self-testing - Targeted mobile testing --Interventions to reduce HIV stigma and strengthen HIV literacy	**Interventions at facilities:** - TLD uptake - MMD Improved linkage to ART through - Expansion of ART services in universities and workplace health centers with high yield HIV testing - Extended hours - Scale up Men friendly clinics (with male providers) **Interventions in community:** - Differentiated care and treatment support - ART through Drop in centers (KP) - Community-based ARV distribution - Interventions to reduce HIV stigma and strengthen HIV literacy

25*	**Interventions at facilities:** - Other PITC reporting modality unpacked to optimize high yield entry points - Systematic index testing through facility-based testing entry points (Internal medicine, TB and STI) and referral to preventive health services and counselors - Replication of best practices found at high volume and high yield sites - Self-testing - Involvement of the workplace medical center **Interventions in community:** - Index testing - embedded testing as part of a multi-disease integrated package (malaria, TB, hypertension, diabetes and smoking cessation) at workplaces, unions, male oriented gatherings - Self-testing - -Interventions to reduce HIV stigma and strengthen HIV literacy	**Interventions at facilities:** -TLD uptake -MMD - Active linkage to ART through: o Expand ART services in workplace health centers with high testing yield o Focus on districts with high volume of positive cases identified low adult men ART coverage and tailor DSD services accordingly by age - ART Adherence support through expand multi-month prescriptions for stable patients - Extended hours - Scale up Men friendly clinics with male provider champions **Interventions in community:** - Differentiated care and treatment support - ART through Drop-in Centers (KP) - Community-based ARV distribution - -Interventions to reduce HIV stigma and strengthen HIV literacy

4.1.3. Children and adolescents' strategies

Case Finding

The number of children receiving ART nationwide increased by 18% between 2014 and 2018, with children under 15 accounting for approximately 5% of the treatment cohort. National data show that pediatric ART coverage is proportionately lower at 40%, compared to 59% adult coverage in Côte d'Ivoire. As a result, PEPFAR-CI is working closely with the GoCI and other stakeholders to fast track the pediatric HIV response and rapidly scale up pediatric case finding and ART coverage. The program aims to achieve 90% ART coverage among children by the end of FY2021, with a 50% reduction in mortality rates.

FY2021 goals are to (1) ensure that the majority of high-yield HTS and PMTCT sites offer testing for children and adolescents, with risk assessments conducted for 100% of OVCs to identify those in need of HTS, through strong collaboration between facilities and community settings, and (2) to start and retain on ART all infected children regardless of age. Key priorities for pediatric and adolescent care and treatment in FY2021 include increasing ART and VL testing coverage and suppression rates, TB prevention through TPT, expanding nutritional assessment counseling and support (NACS), and increasing systematic and routine HTS of all children, through a family-centered approach in the index testing context, and same day initiation of ART for those positive, especially:

- Index testing in family context:
    - If child is the family HIV index, then all his/her biological siblings and mother would be tested. The father would be tested if there is no information about the mother's status. The father would be an index contact if the mother is positive
    - If mother is the family HIV index, then all her biological children would be tested.
    - If they have not been previously tested, children of male-index clients (fathers) should be included when the biological mother is HIV-positive, deceased, or her HIV status is not known or not documented.
- HIV testing of:
    - Children in in-patient settings and malnutrition clinics
    - Children in outpatient settings, identified through the dedicated high-risk screening tool (suggestive signs and symptoms associated to immune deficiency or other related risk factors)
    - OVC identified through HIV risk screening tool
    - Biological children of FSW
- Increase PMTCT early infant diagnosis (PMTCT_EID) 2-month coverage and PMTCT final outcome (PMTCT_FO) to ≥ 80%
- Improve mother-infant pair retention throughout pregnancy and breastfeeding by using the cohort registry
- Enhanced tracking of HIV exposed infants (HEIs) not enrolled in care after birth, systematic screening of HEI at routine MCH visits, and optimized ANC counselling messages
- Enroll HEIs in OVC programs and provide peer support for mothers during pregnancy
- Ensure availability and use of postnatal infant prophylaxis
- Implement POC for viral load monitoring to identify exposed infants who may need intensified postnatal prophylaxis
- Leverage OVC program to provide treatment education and adherence counseling to improve retention and achieve viral load suppression among children and adolescents

ART Initiation and Linkage:

For FY2021, the program will focus effort on select acceleration sites that will scale with fidelity practices such as the provision of dedicated pediatric staff (healthcare workers and lay counselors), Lopinavir/ritonavir formulation (pellets for children <3 years), TLD for PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other dolutegravir (DTG)-)-based regimens for children weighing >20-29.9 kg through the Pediatric ART Optimization Plan, to reach epidemic control among HIV infected children and adolescents.

Aligning with the task-shifting policy, PEPFAR-CI, through monthly site visits and IP monitoring, will continue to build the capacity of general practitioners, nurses, and midwives to effectively initiate pediatric HIV care and treatment, and ensure that training of staff on the most recent ART guidelines and administration of ARVs. Additionally, the program will support the Ivorian Society

of Pediatricians (SIP) that will go hand in hand with the establishment of a mentoring system implemented at prioritized sites.

PEPFAR-CI will also support differentiated service delivery models for children and adolescents meeting the definition of "stable" patients. This includes three-month ARV dispensing and clinical consultation visits for children, or six-month dispensing and clinical consultation visits for adolescents, as well as community ART distribution or fast-track facility pick-up for stable patients/families.

PEPFAR-CI is now monitoring site level achievement monthly and working to collect and analyze testing yield and linkage to ART data from identified pediatric testing entry points on a weekly basis. The generation of a monthly listing of newly tested positive children has led to increased pediatric case finding and treatment coverage; the program will scale up this practice across all IPs to facilitate the monitoring of pediatric enrollment in and adherence to treatment. PEPFAR-CI will strengthen collaboration and cross-referral between clinical HIV programs, social welfare/community-based support systems, and OVC services to support clinic-based linkage and retention efforts.

The program has the objective of ensuring 95% suppression among all children on ART by COP21. To facilitate early identification of treatment failure in infants, PEPFAR-CI will use VL testing as the only routine biological monitoring test in all supported sites. Each of the pediatric sites will have a focal point for follow-up of children with unsuppressed VL who will link to the laboratory focal point. Each laboratory generates a weekly list of unsuppressed VL which will highlight children with unsuppressed VL to provide to facilities, which in turn will conduct active follow-up for supplementary patient and caregiver education, and enhanced adherence counseling support on a monthly basis. As per national guidelines, children receive a VL test every six months; but those with unsuppressed VL will receive a second test after three months. Testing for infants in remote sites with no available VL testing services will use Dried Blood Spot (DBS) samples.

Tables 4.1.3.1 and 4.1.3.2 outline comprehensive care and support models by age groups for children and adolescents.

Table 4.1.3.1 Comprehensive Care and Support Models for Pediatrics

Age	Facility	Community
	First 90 (Case Finding Strategies)	
	• Systematic EID (both conventional and POC) for HIV-exposed infants to improve 2-month EID coverage.	• Sensitize parents of infants with no EID performed in order to test them through DBS or POC machine for increasing 2-month EID coverage
	• Expand use of EID/POC to increase 2-month EID coverage (POC will be placed in ANC and vaccination service to reach maximum number of babies less than 2 months old)	• Increase enrolment of mother-baby pairs in OVC programs
	• Increase enrolment of mother-baby pairs in OVC programs	

Age	Facility	Community
< 1 year old	• Improve referral/linkage to KP program for children of KP	• Educate HIV-positive pregnant couples on attending ANC care and to delivery at a health facility
	• Educate HIV-positive pregnant women on the importance of attending ANC care and to delivery at a health facility	• Use lay workers to review mother and child booklets to ensure that HIV-exposed infants receive EID
	• Conduct and scale index testing with fidelity	• Implement community Index testing champion to coordinate community-based index testing service delivery
		• Index testing of children of HIV-positive women regardless of VLS
		• Conduct and scale index testing with fidelity
		• Conduct weekly review of pediatric case finding (EID, screening tool, index testing) results at all sites with CLHIV
1-10 years	• Monitor sites for consistent use of screening tool to improve targeted testing at OPD (malnutrition, inpatient)	• Increase enrollment of mother-baby pairs in OVC programs
	• Systematic testing of pediatric TB cases and TB suspects	• Educate HIV-positive pregnant couples on ANC care and delivery at a health facility.
	• Train and put in place facility index testing champion	• Lay workers to review mother and child records to ensure all HIV-exposed infants receive EID
	• Index testing of children of all HIV-positive women men if mother's status is unknown or dead	• Identify community Index testing champion to coordinate community-based index testing service delivery
	• Systematic Referral/linkage to OVC and KP programs	• Index testing of children of HIV-positive women regardless of VLS
	• Conduct weekly review of facility pediatric case finding results	• Index testing of children of HIV-infected men if mother's status is unknown or dead
	• Uninterrupted supply chain for testing commodities	• Conduct weekly of pediatric case finding (EID, screening tool, index testing) results
	• Consistent use of screening tool to improve targeting testing at OPD (malnutrition, inpatient)	• Ensure uninterrupted supply chain for testing commodities
	2nd 90 (Treatment and Retention Strategies)	

Scope of Work for PEPFAR Pediatric and Adolescents Task Force

National data show that pediatric ART coverage is proportionately lower at 40%, compared to 59% adult coverage in Côte d'Ivoire and that viral load suppression remains low among children 0-14 years old (54%), with varying rates among finer age bands (approximately 50-90%).
Weaknesses of the PEPFAR-CI pediatric program include low linkage to OVC services, supply chain challenges with pediatric formulations, inaccurate prescribing, and caregiver challenges with drug administration. Most of the children have a very low viral suppression rate primarily due to poor access to VL testing for those less than 4 years of age, and to an inappropriate drug regimen. In FY20, the PEPFAR-CI team put in place a task force with multidisciplinary background that matches the weaknesses observed, with a goal to oversee and fix the pediatric program regularly. The objective of the PEPFAR Pediatric and Adolescent Task Force is to review periodically (weekly, monthly and quarterly) specific indicators of the program and act appropriately.

The team is composed of key technical advisors from CDC, DOD and USAID;

- Pediatric Technical Advisor
- OVC Technical Advisor
- Viral Load/EID Technical Advisor
- Youth/Adolescent Advisor
- PMTCT Technical Advisor
- Supply Chain Technical Advisor
- SI Technical Advisor

Below are the specific activities conducted by the PEPFAR-CI Pediatric and Adolescent Task Force:

1. Define monitoring Indicators (Ped CM tool, supply chain, clinic, community, lab)
2. Assign partners/sites to each member of the PEPFAR-CI task force
3. Weekly monitoring of the prioritized sites' performance on the third 95by using the PCM tool
4. Monitor Clinical/Community/OVC meetings at site on index testing and PITC optimization, ART optimization regimen and Viral Load coverage and suppression,
5. Monthly meeting of PEPFAR task group to review clinical, OVC, community and supply chain data
6. Monthly meeting with partners to review the pediatric program (optimized PITC, Index, LPV/r, DTG, and TLD, etc.) performance
7. PEPFAR to create a Ped share drive or link to collect site visit and partners' monitoring documents
8. Follow up with IPs on mentorship plans to consider pediatric case identification, ART optimization, VL strategies and supportive supervision outcomes
9. Weekly monitoring on DTG/TLD for adolescents 20kgs and above (specific for adolescent)
10. Support PNLS/MSHP to develop adolescents' package of care and implement adolescent SQA assessment (specific for adolescent), in line with existing WHO standards
11. Monthly call with HQ to share progress on pediatric case identification, optimized ART and Viral Load issues
12. Monthly call with HQ to share progress (specific for adolescent)

The Pediatric Case Management Tool will be used to monitor approaches centered on children and adolescents at monthly basis

Table 4.1.3.2 Comprehensive Care and Support Models for Adolescents

Age	Facility	Community
	First 90 (Case Finding Strategies)	
10-19 years	• Targeted testing using the screening tool at all facility-based entry points, including sexual reproductive health services	• Index testing
	• Scale up index testing with fidelity	• Implement youth social networking testing
	• Expand HIV self-testing among high risk youth	• Expand self-testing among high risk youth (HIVST)
	• Coach providers, parent/guardians on HIV status disclosure, including to family/care givers	• Testing for high risk adolescents (DREAMS)
	• Expand HIV testing in school health program targeting high risk youth (STI, pregnant)	• Link youth with community-based prevention programs (OVC/DREAMS/AGYW)
	• Implement flexible hours and youth friendly clinics	• Coach providers, parent/guardians on HIV status disclosure
	• Collaborate with school health care centers to identify at risk children in need of HTS	
	2nd 90 (Treatment and Retention Activities)	
10-19 years	• Establish adolescent support groups in high volume sites and use adolescent peer counselors	• Strengthen community-based adherence and retention counseling
	• Identify adolescent champions and establish multi-disciplinary facility switching team (clinician, pharmacist, counsellors, phycologists if available) to ensure adolescents receive treatment and are retained	• Link youth with community-based prevention program to improve retention (OVC/DREAMS/AGYW)
	• Support caregivers to teach adolescents how to adhere to their medication	• Coach providers, parent/guardians on HIV status disclosure
	• Enhanced partner management to ensure supportive supervision (SS), mentorship or coaching on peds and adolescent ART provision and VL management	
	• Conduct weekly review of adolescent clinical cascade indicators	
	• Coach providers, parent/guardians on HIV status disclosure	

Age	Facility	Community
	• Track and monitor adolescent in TLD transition and MMD interventions	
	3rd 90 (Viral Load Coverage/Suppression)	
10-19 years	• Scale-up treatment and VL literacy for children and caregivers	• Scale-up treatment and VL literacy for patients and caregivers to include U=U messages
	• Incorporate U=U messaging into all clinical review visits	• Establish community-based adolescent friendly services and peer support groups around high-volume sites
	• Transition all adolescents to optimum ARV regimen and formulations	• Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for adolescents with unsuppressed VL
	• Scale adolescent friendly services and peer support groups in high volume sites	• Strengthen linkage with OVC and nutrition programs to ensure that adolescents receiving ART have additional retention and viral load counselling services in the community
	• Assess reasons for unsuppressed VL and provide EAC support	• Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration
	• Provide age-appropriate disclosure and psychosocial support, addressing stigma/discrimination among other barriers to adherence	
	• Implement an electronic early warning system from the laboratory to the clinic with the goal of reaching adolescents with unsuppressed VL	
	• Scale-up adolescent advanced disease package (TB, CrAg, CTX) in prioritized sites	
	• Weekly review of VL coverage and suppression data	

4.1.4. Tuberculosis/HIV strategies

TB is the leading cause of death among PLHIV in Côte d'Ivoire. In 2017, the mortality rate for TB/HIV co-infected patients was 21%. In Cote d'Ivoire, PEPFAR and its implementing partners support PNLS/PNLT with integrated TB/HIV care and treatment services at the national, regional and district levels in the 60 Districts. During FY19 HIV services were integrated in 100% TB clinics, 93% of new and relapsed TB cases knew their HIV status and 97% of the 3,423 HIV positive TB cases received ART. TB screening diagnostic and treatment among PLHIV: (include graph see example below). Integration of TB screening, diagnosis and TB prevention in ART clinics remains inadequate. During FY19, 92.4% of PLHIV on ART were screened for TB but only 0.5% were positive for TB symptoms – a lower achievement than the expected target ranging from 5% to 10%.

The MSHP adopted Tuberculosis Preventive Therapy (TPT) as part of the routine HIV care package in October 2018 with the development of guidelines, SOPs, training materials and monitoring tools. However, eligibility was limited to those newly enrolled on ART with CD4 >200, and required C-Xray to rule out TB prior to initiation of TPT, thus excluding pregnant women. In FY19, PEPFAR-CI began implementation of TPT at 6 ART sites and uptake was limited due to those policy barriers. In addition, FY19 results noted a suboptimal TPT completion rate; 201 (69%) of the 292 clients started on TPT completed treatment as of Q4. In February 2020, the MSHP revised its TPT policy to include patients already on ART and removed CD4 requirements. The circular also reiterated the 6-month duration of TPT prophylaxis, for adults and children, with-concurrent administration of Vitamin B6, without any associated fees for all HIV-infected persons. However, the requirement for Cxray to rule out active TB beyond the TB-symptom screen still remains.

Since FY19, GeneXpert has been integrated in the TB diagnostic algorithm for HIV-infected patients, but its use is very limited because sputum microscopy is the first diagnostic test in the TB national algorithm. Of the samples sent for TB diagnosis in FY19, 54% had positive results returned; TB test types comprised of 82.2% by smear microscopy, 9.8% Xpert, and 8% reported as other. In COP19, PEPFAR-CI is working with the National TB Control Program (PNLT) to rapidly increase access to GeneXpert for PLHIV as part of the TPT scale up plan and advocating for updating the National guidelines to include GeneXpert as the first-line for diagnostic test for TB in PLHIV according to the WHO guidelines. PEPFAR is also supporting PNLT to implement TB-LAM testing in 10 sites in Abidjan for PLHIV with advanced disease; however, TB-LAM is not currently included in the TB national algorithm.

In COP 19, PEPFAR will scale-up TPT with the goal of achieving 100% coverage among eligible patients in 70 high volume sites. This will be achieved through mentorship of health workers on the importance of TPT and ensuring that they are involved in implementing the scale-up plan; conducting chart reviews to ascertain TPT eligibility and flagging TPT-eligible clients to ensure they are offered TPT during their next clinic visit; making TPT available through all DSD models; including TPT performance review as part of site-support and monthly/quarterly data reviews with MSHP; routine reporting of progress towards OU-level TPT targets; procurement of isoniazid to prevent stock-outs and monitoring of treatment completion and adverse events. PEPFAR will work with the GF on TPT commodity procurement to ensure adequate supplies to accommodate the

scale-up. In addition, we will continue to support the existing GeneXpert network of 27 labs, to improve GeneXpert. IPs will mentor staff (laboratory and clinical) to improve access to TB diagnosis among PLHIV in all supported clinical sites. Human resources, test kits, sputum transportation, and results return through the laboratory information system (eLIS) will be provided through the lab program.

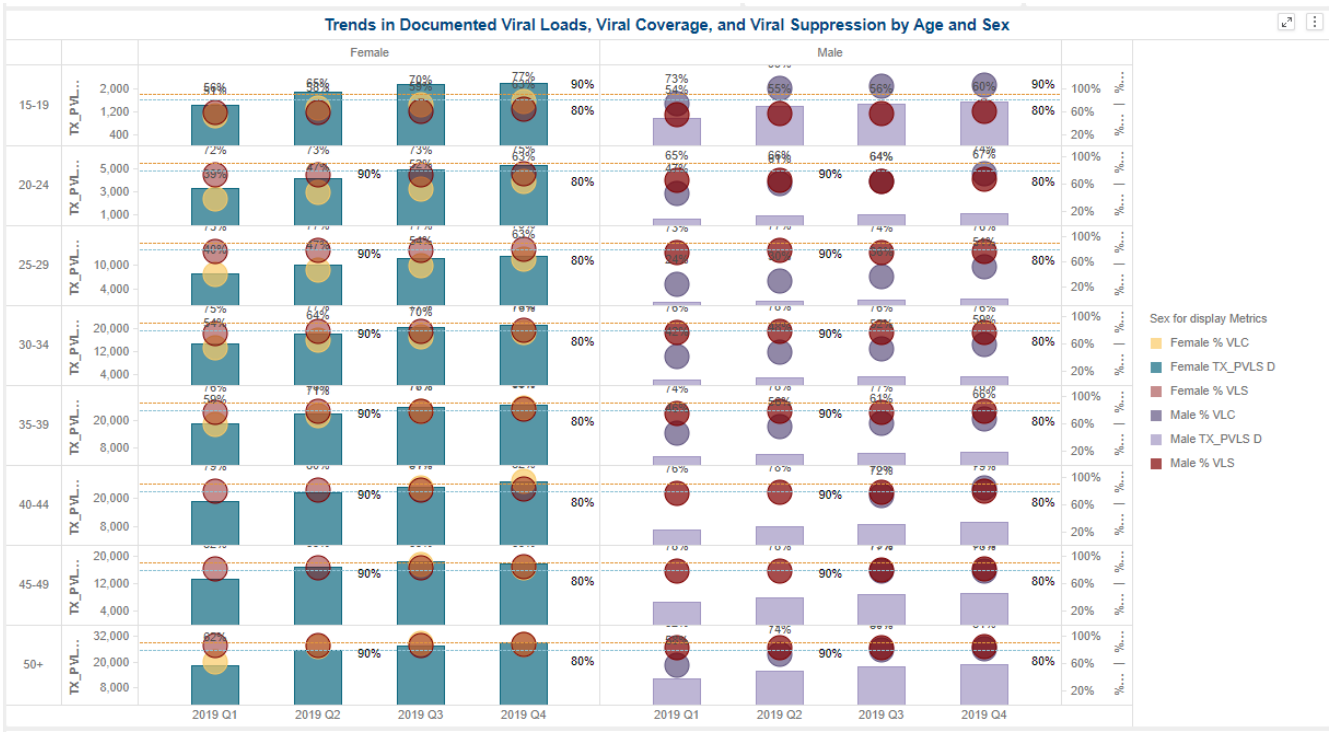
In COP 20, PEPFAR-CI will continue working with PNLS/PNLT and GF to develop an integrated policy that aligns with PEPFAR priorities for TB/HIV as outlined in COP20 guidance. Specific strategies will include: 1) HIV testing for all presumptive and confirmed TB patients in TB clinics and hospitals, with the goal of achieving 100% testing for these groups; additionally, the program will continue to implement the "Engage TB Strategy" using a family approach to reach the missing TB/HIV cases; 2) tracing and screening contacts of patients with TB; 3) rapid ART initiation for PLHIV who screen negative for TB and TB/HIV co-infected patients according to national guidance, 4) systematic symptom TB screening for all PLHIV at all routine encounters 5) prioritizing GeneXpert testing and immediate TB treatment for all ART clients screening positive for TB symptoms in the absence of contraindications 6) expanding availability and use of a point of care TB test, urine lipoarabinomannan (TB LAM) and CrAg tests for PLHIV presenting with advanced disease in 30 high impact sites, for selected patients with Advanced HIV disease according to the COP20 guidance; 7) initiate TPT for all eligible PLHIV who screen negative for active TB ; 8) ART provision for TB/HIV co-infected patients in all TB clinics;, according to the COP 20 guidance, in 30 high volume ART sites.

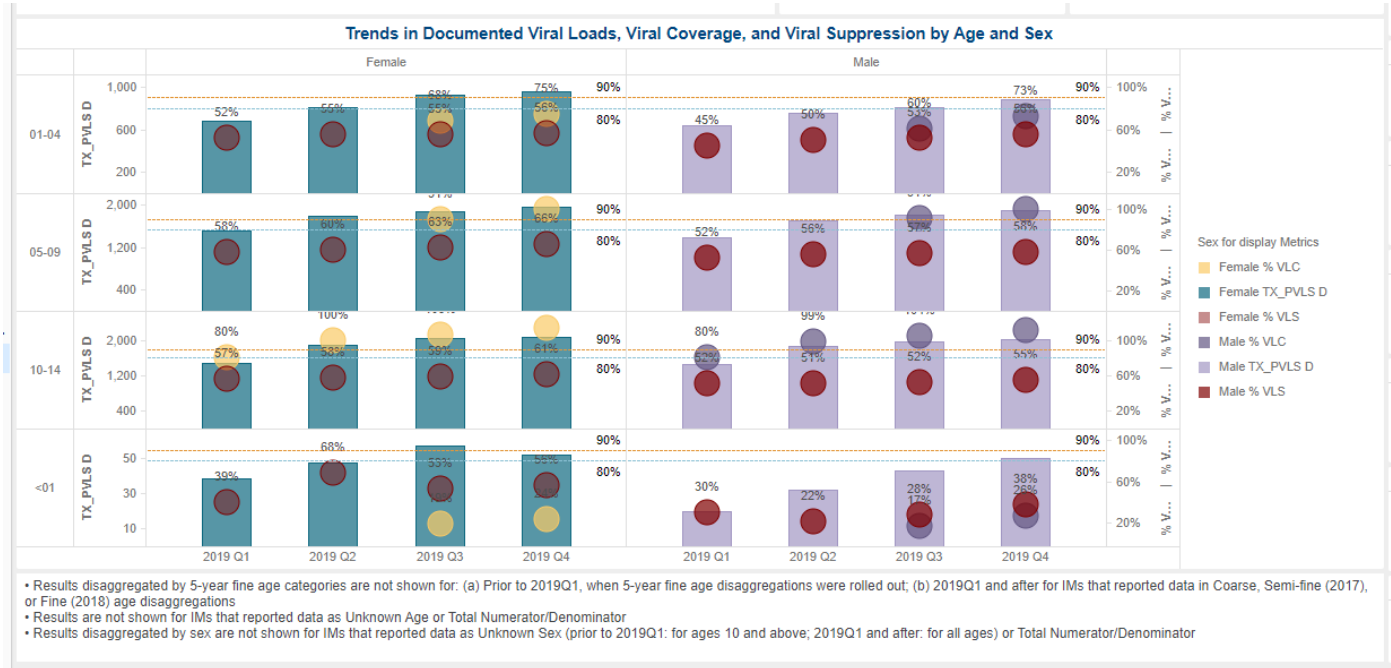
To address policy barriers to TB/HIV services, PEPFAR-CI will continue advocacy with PNLS/PNLT for (1)removal of Chest X-ray as a requirement for ruling out active TB before TPT initiation; (2) updating the national TB diagnostic algorithm to make GeneXpert the initial diagnostic test for PLHIV with TB symptoms according to WHO guidelines; (3) incorporating TB LAM into the national diagnostic algorithm for TB, for seriously ill patients and those with advanced HIV disease, in addition to developing national tools and training materials; (4)inclusion of shorter-course TPT regimen into the TB National guidelines.

4.2 Retaining clients on treatment and ensuring viral suppression

Retention of patients receiving antiretroviral treatment (ART) has been a major challenge for PEPFAR-CI over the past two years, including high LTFU among both men and women between ages 15 to 35. In FY19 APR, the overall VLS rate was 80% and 59% among children. Table 4.2.1 illustrates the trends in viral load coverage and suppression by sex and age bands.

Table 4.2.1 Trends in documented VL, VLC and VLS by sex and age-bands, FY19 Q1–Q4





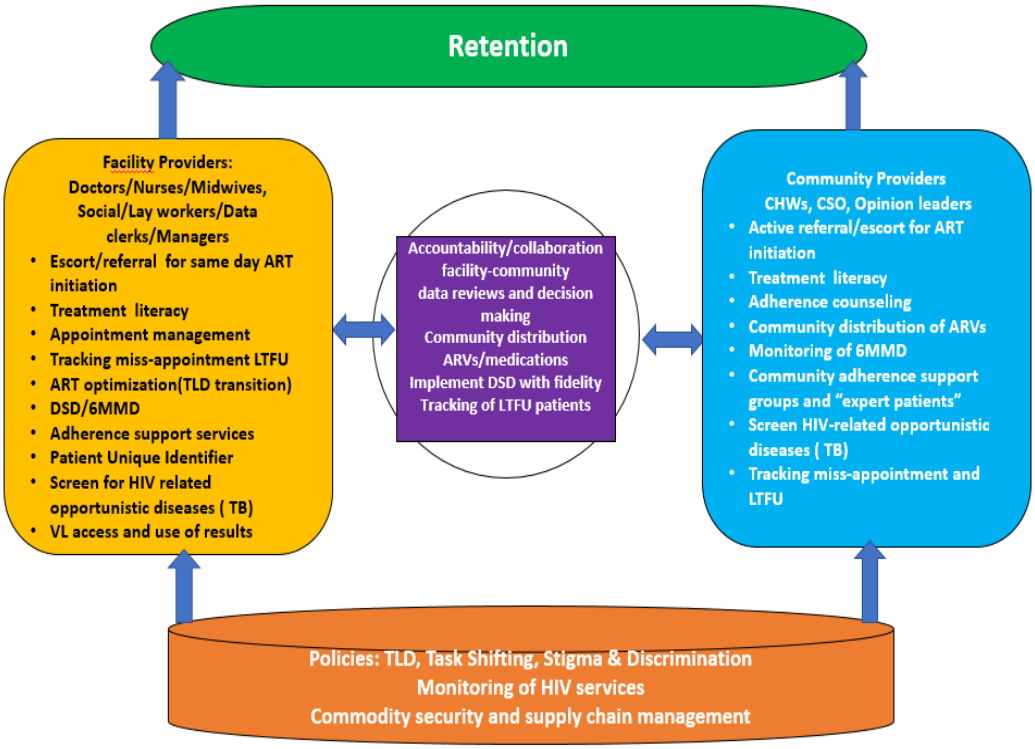
In COP18, PEPFAR-CI conducted a return-to-care campaign (RTCC) at 140 sites prioritized during COP19 planning, which included and in-depth review of data on "unexplained losses" at 86 sites. Outreach was conducted to 5,158PLHIV who were identified as LTFU, 3,413(66%) were reached for a survey and among those, 39% of those who were reached, the reasons for LTFU were personal barriers (denial, feel well, side effect, stigma, being "healed"); 29% related to logistical barriers (travel, transport cost, distance from home); and 10% due to clinic barriers (long waiting times, user fees, stigma). Another assessment conducted by AIDSFree project in 22 sites in Abidjan found that the top reason of LTFU was logistical barriers (38%), personal barriers (36%), incomplete documentation of patient transfer (19%) and structural barriers (7%).

At the policy level, the MOH issued a policy in April 2019 eliminating all HIV-related user fees at all public sites along with the removal of user fees for health care services for pregnant women and children under 5 years old. The policy included the adoption of TLD as the preferred first line therapy for newly initiated ART patients and the transition of patients already on TLE or other regimen on TLD, and availability of multi-month dispensing (MMD) of ARVs for 3 or 6 months to stable patients, and the transition of children to optimal ART regimen. An MSHP circular released in February 2020 reinforced the primacy of TLD for all, including women of childbearing potential. This circular also removed folic acid and double contraception as requirements for TLD initiation in women of childbearing age.

PEPFAR-CI, in collaboration with MSHP and implementing partners, has developed a set of standard operating procedures (SOPs), guidelines, tools and materials on ART adherence counseling, tracking and managing of routine patient appointments, and return to care for LTFU patients. Implementing partners and PEPFAR staff trained and coached providers, community lay workers and other relevant stakeholders to ensure implementation with fidelity of those tools and materials. As part of these efforts, PEPFAR-CI developed an algorithm to improve and monitor the collaboration between clinical and community partners which is critical in addressing the gaps across the clinical cascade. COP20 planning is based upon optimal HRH: patient ratios and intensified partner management such that sites have adequate and qualified HRH to deliver quality services.

Building off these successful strategies from COP18 and COP19, PEPFAR-CI will expand and support a patient-centered comprehensive facility and community-based retention and viral load suppression service package in COP20. This package will be tailored to meet the needs of specific sub-populations such as men, children and adolescents and districts with the largest gaps. Retention and viral load suppression service package will encompass a core set of interventions aiming at 1) preventing loss and drop out, 2) improve tracking and documentation of patient records and appointments, and 3) interventions targeting miss-appointment, LTFU and special populations.

Figure 4.2.1: Key changes to address areas of underperformance: COP 19 & 20



Tables 4.2.1 – 4.2.4 and figures 4.2.2 and 4.2.3 illustrate COP20 retention and viral load suppression packages for specific populations.

Table 4.2.1

Facility	Community
Identify linkage and retention agents to ensure that all HIV-infected children are linked to ART and OVC program	Effective follow-up of patients/families referred from facilities
Scale-up task shifting to non-pediatricians to ensure timely ART initiation and follow-up	Train and coach lay-workers and caregivers of infected children on the correct use of pediatric formulations, including LPV/r pellets
Monitor critical interventions, including Enhanced Adherence Counseling (EAC) and transition to optimized ART regimens	Ensure OVC enrollment of children living with HIV and leverage OVC to improve adherence
Conduct a pediatric surge at high volume sites to improve clinical cascade	Increase enrolment of mother-baby pairs in OVC programs
Support tracking and search of miss appointment and LTFU	Implement community-based adherence support groups for both children and caregivers Strengthen community based EAC
Implement multidisciplinary pediatric case management that will include intensified support (via text messages and home visits) for caregivers of children, and directly to adolescents with unsuppressed VL	Support adherence to treatment for children during home visit Support tracking and search for clients who miss appointments and are LTFU
Train and coach lay-workers, clinicians, pharmacists, caregivers of infected children on the correct use of pediatric formulations, including LPV/r pellets	Follow the correct use of pediatric formulation during home visit
Increase reference of mother-baby pairs in OVC programs	Offer the reenrollment into OVC program to mother baby pairs
Ensure uninterrupted supply chain system for ARV drugs	

Table 4.2.2 Viral load package for children

Facility	Community
Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for children with unsuppressed VL	Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration
Provide age-appropriate disclosure and psychosocial support, addressing stigma/discrimination among other barriers to adherence	Scale-up treatment and VL literacy for children and caregivers to include U=U messages
Implement an electronic early warning system from the laboratory to the clinic with the goal of reaching children with unsuppressed VL within one week of clinics receiving the result	Scale pediatric community-based friendly services and peer support groups around high-volume sites
Increase reference of mother-baby pairs to OVC programs	Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for children with unsuppressed VL
Scale-up pediatric Advanced Disease Package (TB, CrAg, CTX) in prioritized sites	Prioritize enrollment of unsuppressed children in OVC and nutrition programs to ensure that children receiving ART have additional retention and viral load counselling services in the community
Weekly review of VL coverage and suppression data	Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration

Figure 4.2.2: Adolescent-Centered Services

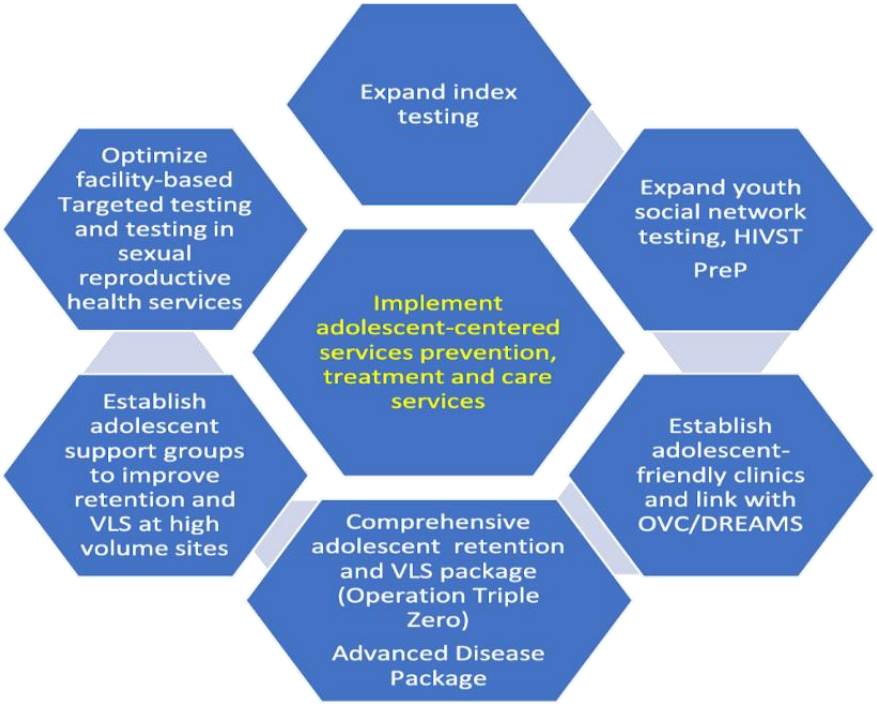


Table 4.2.3: Retention package for adolescents

Facility	Community
Establish adolescent-friendly services at facility level	Offer enrollment into OVC or/and DREAMS program for community follow-up

Facility	Community
Identify linkage and retention agents to ensure that all HIV-infected adolescents are linked to ART, OVC programs	Implement community-based adherence support groups for adolescent Strengthen community based EAC
Organize multidisciplinary adherence support for adolescents	Support tracking and search of miss appointment and LTFU
Referred adolescent girls and young women from PMTCT to OVC program	Increase enrolment of pregnant adolescents and young mothers from PMTCT in OVC programs to improve adherence and retention to treatment for them and their newborn

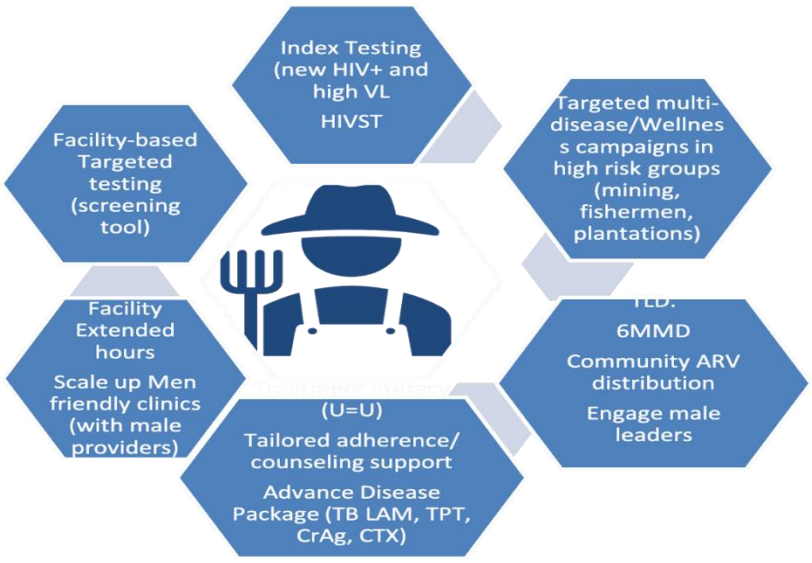
Table 4.2.4: Viral load package for adolescents

Facility	Community
Comprehensive adolescents' retention and VLS package for adolescents	Scale-up treatment and VL literacy for adolescents to include U=U messages
Referred unsuppressed adolescent to OVC/Community programs	Prioritized enrollment of unsuppressed adolescents in OVC or other community programs
Assess reasons for unsuppressed VL and provide EAC support (via text messages and home visits) for Adolescents with unsuppressed VL	
Provide age-appropriate disclosure and psychosocial support, addressing stigma/discrimination among other barriers to adherence	Reinforce psychosocial support for age appropriate status disclosure and addressed barriers for adherence
Weekly review of VL coverage and suppression data for adolescents	Weekly review of VL coverage and suppression data with facility providers as part of the clinical/community collaboration

Retention among men:

Given the disproportionately worse VLS rates and clinical outcomes among men, retention strategies need to be patient-centered and implemented immediately. As illustrated in the graphic below, extending hours, differentiating care for stable patients, integrating HIV services into broader wellness approaches, and designating men's champions will render services more accessible and attractive. Counseling messages must be updated and improved, to emphasize accurate risk perception and HTS, early ART initiation, and U=U.

Figure 4.2.3: The Guiding principles of the strategy



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

Continuous Quality Improvement (CQI)

Using data to improve service delivery requires appropriate analysis as well as an effective implementation plan for targeted responses to curb the HIV epidemic in CDI. In an effort to bolster epidemic control, the above-described service package will be complemented by the implementation of a MSHP-led continuous quality improvement (CQI) at the three levels of the health pyramid with support from a technical assistance partner. At the central level, the MSHP and the National AIDS Control Program (PNLS) will be responsible of developing, disseminating, and implementing CQI policies, guidelines, SOPs, training materials, indicators and tools. Under the leadership of the Director General of Health (DGS) and PNLS, a central level CQI committee will be created and will meet monthly, as part of the coordination meetings to review progress in achieving quantitative and qualitative service quality benchmarks and address any challenges. This committee will comprise representatives of MSHP central divisions/programs, regional health offices, implementing partners, PEPFAR and UN system agencies, the GF and Civil Society Organizations. This committee will also conduct site visits to assess the quality of services using a standard evaluation matrix.

Through a customized approach, specific to the needs of Côte d'Ivoire, QI technical assistance will include:

- A complementary approach to current USG partners and in collaboration with MSHP and implementing partners
- Activities to strengthen the clinical quality management structure by assessing the current QI infrastructure
- An assessment and update of the QI National Plan
- The extension of QI coaching participants in the scaling of current QI implementation, or the development of new, innovative quality activities
- Linking country QI teams to U.S. experts well-versed in the identified gap areas (on-site and through virtual connections), and
- The facilitation of support for QI champions across the country

The second level of CQI intervention will be established at the district level and will include representatives from the regional and district health offices, supporting sites from the district, implementing partners and CSOs. The district-level CQI committee will meet on bi-monthly basis to review progress in achieving quantitative and qualitative service quality benchmarks and address challenges as necessary. The committee will conduct routine site visits to assess the quality of services using a standard evaluation matrix.

Finally, the third CQI level of intervention is at the supported sites where services are delivered. Site-level CQI committees will be established and will meet on a monthly basis to review all the indicators across the clinical cascade, and especially those related to retention and viral load suppression. The committee will include representatives of different services, implementing partners, and CSOs. The committee will use various quantitative and qualitative data from different

sources (WETMOT, SIMS, GSM, MER, Community-led monitoring etc.) to assess progress in meeting the different benchmarks and to address any challenges across the clinical cascade.

4.3 Prevention, specifically detailing programs for priority programming:

HIV prevention AGYW and OVC

The OVC program is implemented in 38 of 60 PEPFAR prioritized districts. Three implementing partners (Save the Children, IRC, and SEV-CI) will deliver OVC services in COP20. The OVC program will continue to provide a robust community platform to link HIV-positive patients to ART and PMTCT services, while supporting retention and adherence via case management and socio-economic support. In COP20 an emphasis will continue to be placed on primary prevention of sexual violence and HIV infection for boys and girls (9-14 years old) enrolled in the OVC program, and for girls aged 10-19 enrolled in the DREAMS program.

In Q4 of FY 21, two local partners will be introduced to implement Save The Children's OVC portfolio. The early start-up of these local partners is scheduled to avoid interruption in service delivery in COP21.

A ratio of four children to one caregiver is reflected in the target to ensure that children under 18 are the focus of the program. The primary caregiver in the OVC household will be served by the program, in addition to all vulnerable children under 18 living in that household. The OVC program will continue to deliver parenting programs, including the primary prevention of sexual violence and HIV for boys' and girls' modules in intensification sites. Parenting for Lifelong Health will continue to implement and routinely monitor the OVC case management plan, as well as assess the achievement of graduation benchmarks for OVC households in order to graduate those reaching the self-sufficient stage.

HIV risk assessments will be done for all children with unknown HIV status to ensure that those in need of HIV testing are referred and are linked to ART if positive. Those found to be HIV negative or ineligible for testing will receive the primary prevention of sexual violence and HIV intervention. In COP20 the OVC program aims to enroll at least 90% of children and adolescents living with HIV (C/ALHIV) on ART. The OVC program will also be used as a means to provide age appropriate disclosure to children/adolescents living with HIV.

In close collaboration with clinical facilities, OVC IPs will monitor viral load data of C/ALHIV on ART to ensure adherence supports and viral suppression. Existing MOUs between clinical and OVC IPs, health facility staff, and NGOs will be updated and strengthened where necessary to improve bi-directional referrals, joint case management, and ensure complementary clinical and community-based service delivery for improved pediatric HIV outcomes.

The linkage with PMTCT services will be strengthened to ensure that HIV positive pregnant women are linked with OVC programs to support ART adherence and retention post-delivery and ensure

that HIV-exposed infants are enrolled to assist with EID follow-up. Adolescents and young HIV-positive mothers will be prioritized in enrollment, because they are at higher risk for missed appointments and post-partum LTFU.

The PEPFAR-CI OVC program will continue to leverage the DREAMS program when possible. Across the four DREAMS districts, in alignment with SGAC guidance, IPs will make referrals and counter referrals of AGYW aged 9-17 from the OVC program to complement DREAMS services based on their specific needs .

In COP20, DREAMS implementation will continue in the same four districts, Cocody-Bingerville, Abobo-Est, Man, and Daloa, with the addition of primary and secondary packages of services for the 20- 24-year-old age band. The approach for preventing sexual violence and HIV risk among girls 9-14 years of age will include: reinforcement of community awareness, case identification and reporting by community and school GBV committees; improving violence risk screening through active and early detection of girls facing GBV in their family or community; improving access to post-GBV care by widely spreading information on available post-exposure care services among OVC and DREAMS beneficiaries; and ensuring systematic referral from community to health facility and assistance to victims for non-medical support such as police, judicial, psychosocial support with family involvement. Mentor-led clubs and community mobilization for norms change will continue in DREAMS districts.

Besides the OVC program, DREAMS interventions will leverage existing platforms such as HTS, sexual and reproductive health, ANC, and other prevention programs. Through a mentoring system for AGYW and family and community interventions, DREAMS activities will increase awareness and skills to prevent and respond to GBV for girls. These interventions will reinforce the creation of a safe environment for girls in their families and communities. In addition, in COP20, PEPFAR-CI will scale-up PrEP for the most vulnerable young women, and economic strengthening activities with a link to entrepreneurship and employment. The implementing partners will increase recruitment of qualified DREAMS AGYW for paid positions in PEPFAR program, following COP20 guidance. AGYW who meet the recruitment profile will be prioritized. In addition, three DREAMS graduates will be employed as facility-based Ambassadors in Man district, assisting on the clinical side by sensitizing clients about the DREAMS program, ensuring bidirectional linkages to DREAMS/OVC at sites and participating in community outreach. Caregivers will participate in training on positive parenting specific for adolescents which will promote norms changes, especially around violence prevention, through the evidence-based curriculum Parenting for Lifelong Health.

PEPFAR-CI team will continue to conduct routine technical visits to community and clinical sites (at least monthly) to improve the quality of services related to OVC and AGYW. PEPFAR-CI also plans to build upon best practices and lessons learned from the COP19 internal quality assessment of services provided by the OVC/DREAMS IPs. Best practices include sharing promising experiences across IPs; conducting joint sites visits; frequent coaching of mentors and facilitators;

active participation of community leaders in service delivery; and involvement of beneficiaries in service provision, etc.

PEPFAR-CI's OVC and DREAMS approaches align with government guidelines for child protection and complement activities from other actors or donors, including the Global Fund and UNICEF. The National Program for OVC, the GoCI coordination body for DREAMS and OVC, will strengthen collaboration with the MSHP through active participation in all coordination meetings and joint engagement in material development to ensure sharing of lessons learned and scaling up best practices nationwide.

Children/PMTCT

Côte d'Ivoire's PMTCT program continues to be strong with 98% coverage and 100% of HIV positive women receiving treatment. The COP20 PMTCT package will be implemented in prioritized districts to scale up access of HIV services to pregnant and breastfeeding women (PBFW) in high burden and underserved settings. The strategies for PBFW will include support for demand creation activities and PITC at all mother and child entry points. The PMTCT package will provide HIV testing with same day ART initiation, friendly PMTCT services for adolescents, VL testing among pregnant women, EID among HIV-exposed infants (HEI), and linkage into pediatric care and treatment when necessary. To ensure high HTS coverage among ANC, all PMTCT sites will offer index testing with fidelity targeting partners and sexual networks of HIV-positive, biological children and adolescents. Self- test kits will be provided for hard to reach sexual contacts.

To increase 2-month EID coverage and ART linkage, the COP20 program will expand the following strategies: (1) Active tracking of mother & baby pairs; (2) Monitoring of clinical/community collaboration through weekly meeting between clinical and community actors to verify whether HEI that community actors has to relaunch for EID has effectively been tested, (3) Strengthening referral of children to the OVC program and (4). Daily monitoring of the mother and infant pair registers to create a weekly listing of HEI needing EID and follow up of EID appointment by phone calls/home visits.

To increase access of pregnant and breastfeeding HIV+ women to viral load testing, PEPFAR-CI - will provide HRH support (e.g. VL champions) to follow this cohort at site level, as described above for children. Chart review, follow up, and improved documentation will ensure that prenatal and post-partum visits are leveraged for VL sample collection. Dedicated VL champions will also follow up on VL results, ensure results are available to providers and patients, and support treatment literacy. Counseling and support messages will be reinforced to include U=U strategy. Best practices for retention and VLC/VLS will be shared among providers and across sites and IPs through the ECHO platform. Finally, expanding access to TLD will be critical to improving VLS rates.

At present, PBFW are not included in national guideline for PrEP. PEPFAR-CI'sstrategy is to advocate, through coordination meetings with MSHP and multilateral stakeholders and regular interactions with civil society organizations, for including PBFW into the national guideline.

Key Populations

In COP20, the KP program will undergo several strategic, programmatic and geographical level changes based on COP20 PEPFAR guidance. KP interventions will continue targeting MSM, FSW, and transgender individuals (TG), focusing on 42 districts to target high volume KP populations and underserved areas with integration of community-clinical services at 15 clinical sites. Outside of the 15 designated high proportion KP clinics, KP services will continue to be supported and improved in traditional public sector facilities, to continue providing sustainable, high-quality and stigma-free services.

The goal of integration of KP services at the community-clinical level is to ensure a holistic response with tailored KP-friendly services across the entire prevention, care and treatment cascade including addressing stigma and discrimination. The strategy will also include general population case-finding to reach men, clients, stable partners and children of FSWs. Thus, the strategy will include development and implementation of psycho-social services for KPs at existing KP-friendly and KP-competent sites and drop-in centers. The PEPFAR-CI KP Program will provide a mix of direct service delivery and targeted technical assistance at 15 selected facilities that focus on achieving the 95:95:95 within key populations.

KP program site selection is based on the epidemiology of HIV in Côte d'Ivoire. The three KP implementing partners cover the districts with the highest burden of disease. The 15 clinical sites were selected based on estimates of KP beneficiaries and all clinical sites are CBO run. This KP COP20 strategy will provide the full cascade of prevention, care and treatment to KPs and other PLHIV who access the 11 KP friendly clinical sites and 4 Drop-in centers (DICs). This strategy aims to reinforce KP friendly training & oversight among service providers to ensure KP friendly services across the full cascade, oversee existing DICs in Cocody, Attecoube, Bouake – (started in COP19) and in COP20 open a new DIC in another high KP prevalence community.

In COP20, Key Population Investment Fund (KPIF) will complement COP20 funding to allow USAID's KP partners to more closely consult communities on improved strategies for self-testing and index testing; better motivate PrEP adoption across KP sub-populations; provide organizational support to PLHIV and KP networks and KP-led groups; provide care and treatment services at one DIC; and support KP-led and competent organizations to fund initiatives to prevent and respond to incidents of violence, address stigma and discrimination, and provide legal literacy training across KP communities. KPIF activities will be concentrated for maximum impact by local partner and geography. The PEPFAR-CI team will inform the KP local partners about the scope of COP20 in terms of geographies, activities and targets for COP20 so the local CSOs can assess the new gaps in PEPFAR programming that they feel are important to address and the KPIF plans will be revised accordingly with them.

The KP program includes an overall package of services for KP across the cascade with overarching approaches tailored to the needs of MSM and FSW beneficiaries. The KP program is comprehensive and managed in a way to adapt to ensure that previously underserved populations receive client-centered care in line with WHO Normative Guidance on the provision of services for key populations. For FSW and MSM who are more active in hotspots, a package that is similar may be required, whereas hidden MSM or FSW who are not open about selling sex will require a similar package, differentiating by how they access services. The options for differentiated care include prevention and case finding modalities such as social network testing and referrals, index testing, HIV self-testing, and PrEP screening and enrollment; linkage referrals and treatment initiation; and case management, including viral load tracking and follow-up. The KP program will continue to work closely with KP community organizations to adapt these approaches to meet the unique needs of MSM and FSW beneficiaries. Adaptations include the creation of DICs specifically for MSM or FSW with providers and staff specifically trained to meet individual and community health needs; recruiting peer educators and navigators with ties to MSM and FSW community networks; creating online outreach strategies with specific approaches to reach hidden high-risk individuals and social networks, especially for MSM; and incorporating human rights and GBV response activities appropriate to the specific needs of MSM and FSW communities. In COP20, the KP program furthermore will continue to engage in routine analysis of KP data disaggregated by KP type and engages in continuous quality improvement to refine programming to meet specific targets for MSM and FSW beneficiaries. In Table 4.3.1, a KP Layering Table is provided to further illustrate how the KP program will target services to MSM and FSW beneficiaries.

Table 4.3.1 Côte d'Ivoire KP Layering Table: Comprehensive KP services across the HIV continuum

	Sex Workers	MSM
Primary Individual Interventions	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • SGBV screening	• Peer education • Condoms • Targeted HIV testing services • Routine STI screening • SGBV screening
Secondary Individual Interventions	• PrEP • Alcohol/drug harm reduction • Partner testing for sexual partners • ART adherence support • STI treatment • Viral load and other monitoring and investigative tests • TB screening and treatment • Disclosure of status to steady sexual partners/spouses • Post-violence care • Lubricants • OVC referrals for children of sex workers • Stigma and discrimination reduction	• PrEP • Post-violence care • ART adherence support • STI treatment • Alcohol/drug harm reduction • TB screening and treatment • Partner testing for sexual partners • Viral load and other monitoring and investigative tests • Disclosure of status to steady sexual partners/spouses • Lubricants • Online outreach to reach hidden beneficiaries • Stigma and discrimination reduction

The program will also leverage MSHP's updated policy on community ARV distribution to support KP retention and adherence. The KP program will continue to ensure that young KPs and children of KPs are appropriately referred and linked to other appropriate services by closely collaborating, through MOUs, with OVC and DREAMS community programs to provide support to OVC/Peds/AGYW. Close coordination among IPs will ensure that children of FSW access OVC and pediatric ART services, as needed. Likewise, the KP Program will collaborate with the DREAMS program to ensure young FSW aged 18 and older are screened and referred for relevant AGYW services, such as economic strengthening activities and post-GBV care. To mitigate stigma and discrimination, all IPs supporting clinical management of KP populations will offer comprehensive KP-focused health services, including sexually transmitted infections (STI) treatment, and psycho-social and GBV services.

The community led monitoring system will be leveraged to ensure the delivery of quality services along the community and HIV clinical cascade continuum. This model will also ensure that index testing is implemented without coercion, including GBV prevention and response and addressing stigma and discrimination within the community. CSOs participating in community led monitoring will report any concerns on quality of services and adverse experiences related to HIV care and treatment.

A capacity building component to the KP program was begun in COP19 and EpiC will continue working with two local NGOs and empower KP CSOs to build their capacity, including in strategic information/monitoring & evaluation, finance and human resource systems, selection of local sub-partners and support in sub-agreement monitoring.

In COP20, the expansion of PrEP will continue across 28 clinical sites, including the 11 KP integrated sites with a focus on FSWs with large number of clients, KPs with repetitive STI, KPs with high risk sexual behavior such as irregular use of condoms, and sero-discordant couples when the HIV seropositive partner is not virally suppressed and/or in non-monogamous partnerships. The PEPFAR-CI program will also intensify distribution of condoms and lubricants to KPs and their sexual partners through prevention and case finding platforms.

PEPFAR-CI used KP size estimation results of the Integrated Behavioral and Biological Survey (IBBS) funded by Global fund/ ENDA Santé in 2014, which shows an HIV prevalence of 11.4% among FSW. Programmatic mapping and size estimation using PLACE methodology was also done in April 2017, which found HIV prevalence of 12.33% among MSM. FY2019 (COP 18) PEPFAR program data analysis showed the following key challenges to achieving epidemic control among these populations: low case finding yield (7.1% for FSW and 7.9% for MSM); low linkage to ART for MSM (90.3%), FSW (87.3%), and even lower linkage for FSW between 20-24 years of age (55%); limited access to viral load services among KPs on ART.

In FY19, the prevention program for Key Populations (KP) reached 51,443 individuals with evidence-based prevention interventions, which represents 75.7% of the target of 67,967. Among those reached, 36,766 were FSWs, representing 85.8% of the 42,844target for FSWs and 12,677 MSM/TG

representing 50.5% of the target of 25,123. According to FY2019 results, 80% (41,313) of KP reached have been tested, which did not reach the program target of 95%. In COP20, PEPFAR will implement targeted testing interventions for KPs by reinforcing social network strategies to reach the most at-risk and most hidden KPs, including intensifying peer education. Self-testing will be scaled up among MSM, FSW, TG and their stable partners. Index testing will continue to be implemented with fidelity and in line with SGAC index testing guidance to conform to minimum ethical and safety standards for all community members, including implementing IPV risk assessment and service provision. The overall expected testing yield for KPs is 11.5 %.

In COP 20 the PEPFAR-CI KP program will target FSW who are difficult to reach and underserved in previous implementation periods, particularly those who work in remote areas around urban centers. The KP program will also continue to increase the engagement of 'maquis' (local restaurants) and hotel managers, pimps and 'queen mothers' of FSW by involving them in the program by sensitizing them and providing condoms and lubricants to promote contraceptive use by FSW.

The program will couple index testing with self-testing to reach the hard to find FSW, MSM, as well as their sexual partners, through peer navigators. Low self-test achievement (FY19 result of 20%) will be improved by training more peer navigators on the national guidelines on self-testing and on key messages about the availability and accessibility of KP-friendly services to overcome access-related barriers and strengthen demand for services. Demand for self-testing will be created through standard outreach/SBCC messaging, online outreach, support groups, and home visits to KP living with HIV by peer educators and navigators.

Some KP continue to decline HIV testing, for several key reasons: they know their status and did not want to disclose it to the community tester (peer educator), others prefer to be tested in health facilities, or some fear a positive HIV test result. The KP program will improve counselling through training and ongoing mentoring to reduce the HIV testing refusal rate. Training and mentoring will include WHO HIV testing standards to ensure the "5Cs" are observed (consent, confidentiality, counselling, correct test results and connection to HIV prevention, treatment and care) and IPV screening and referrals are implemented as standard practice. Additionally, counselling will include routine use by peer educators of risk assessments that identify KP with high-risk factors for HIV exposure and provide education on the benefits of testing and treatment, including U=U messaging. Finally, this underscores the importance of ongoing efforts towards stigma reduction at facilities.

During COP20, PEPFAR-CI will continue to support the GoCI in addressing human rights issues and institutional barriers in KP programming by extending training on stigma free service provision to health care workers and social workers in public health facilities. The KP sensitivity training will reinforce the capacity of health care workers in public health facilities and social workers to better provide KP-friendly and competent services. The LINK tool combined with ORA (online registration) will offer new options for KP to be tested.

The KP program will improve accessibility of viral load testing services to KPs through health care worker training in facilities, support sample transportation, and peer navigators to assist in patient follow-up. Community workers will reinforce U=U messaging and viral load literacy to improve KP awareness in the community. Post counselling, PLHIV support groups to treatment and community ART distribution strategy will be developed to improve adherence to treatment and retention.

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

Côte d'Ivoire specific priorities listed in the letter were addressed with the renewed and demonstrated commitment of the MSHP. The Test and Start implementation across all geographies, age, sex and risk groups is being fully implemented. The six-month MMD began in April 2019 in some sites and is now rolled out across all sites. As of February 2020, 72% of PLHIV were on 3 and 6-month MMD (each at 36%). On March 19, 2019, the MSHP signed the first circular note aligned with COP19 planning directing all public health facilities to eliminate all user fees for HIV and other services including MCH. It also included TLD transition and 6-month MMD. These policies took effect in COP19 and are being implemented in all PEPFAR service delivery sites.

Regarding PEPFAR-CI's testing strategy, IPs have resumed testing at the community-level after being instructed to pause testing in COP19. Community IPs have resumed index and targeted testing in the community, in addition to testing the sexual partners and children of newly identified positives identified at facilities. PEPFAR-CI, with mutual agreement from MSHP, had halted HIV index testing among key populations limiting this service at the facility and the community levels, except for the PMTCT, OVC, and DREAMS programs. Given the recent (March 25, 2020) PEPFAR COVID-19 update, PEPFAR-CI is working to reinstate index testing among key populations while also ensuring standards are met using validated tools. For the general population as well, IPs will provide focused mentorship and training on high-quality, ethical partner notification and index testing. A plan for scale-up of TPT at all treatment sites will be developed and implemented as part of a quality treatment strategy in FY2021.

The user fees impact continues to be assessed through the leadership of the MSHP and active participation of CSOs with PEPFAR support. Based on the most recent survey conducted by the Network of PLHIV's Organizations (RIP+) in January 2020, it was revealed that 91 percent of PLHIV interviewed did not pay any user fees. They reported a persistence of user fees among nine percent of patients who had to pay to have access to ANC and HIV services. Specifically, some payments were made for ANC consultations and consumables such as gloves and syringes. The PEPFAR-CI team will continue to advocate for MSHP to address these issues, and continue monitoring implementation at every level through regular, unannounced site visits, specifically at PEPFAR-CI supported facilities, to ensure that PLHIV do not pay any fees for treatment or other services relative to their status and also through civil society watchdog network that will continue to be funded in COP20.

An intensive interagency and interdisciplinary site visit effort started in March 2019 to address high "lost to follow-up" among PLHIV and to help bring these patients back to care and reinstate ART. Begun in COP 19, a focused strategy to promote accountability and improve collaboration between clinical and community partners will continue in COP 20. This strategy is the basis for finding lost to follow-up patients, bringing them back to care, and ensuring that at least 90% of PLHIV are retained in care and ensure viral suppression. The innovative, evidence-based solutions that will be identified through the implementation of these strategies will be adopted and scaled up in COP20 to reach epidemic control. Site visit monitoring will continue to include the timely return of viral load results to patients through a strong laboratory information system.

PEPFAR-CI's OVC program refocused investments on prevention for 9-17-year olds. Additionally, the program will ensure that all OVC know their HIV status and that all HIV+ OVC are on ART. The COP19 implementation is aligning with the updated OVC_SERV indicator, including minimum graduation benchmark requirements. A national graduation tool is used by IPs and the graduation rate expected for COP20 is 10% of OVC households. Improving pediatric HIV care is a major focus of COP 20 programming, PEPFAR implementing partners will ensure that OVC services are leveraged to support at least 90 percent of children and adolescents living with HIV and are effectively contributing to achieving viral load suppression among those children.

Based on the assessment of program performance reflected in COP18 Q1-Q4 POART findings and discussions and COP19 Q1 performance to date, several IPs were put on performance improvement plans in Q2 of FY2020. This method of close partner management, coupled with rigorous site visits and weekly data reviews which will continue into COP20, will enable and support IPs to be innovative and share best practices in their program approaches and improve accountability for achieving 95:95:95 among all PLHIV subgroups. Another aspect of this intensified partner management will be a demonstrable shift in financial and human resources towards site-level service delivery. Furthermore, increased emphasis will be placed on monitoring and performance of the community-facility dyads to ensure effective community-facility collaboration for improved results across the HIV prevention and care continuum. A novel community-facility matrix will be used to facilitate joint monitoring by PEPFAR-CI, the GoCI, and CSOs with increased emphasis on shared accountability by community and facility partners. The role and capacity of CSOs will be further strengthened in COP20 to ensure continuous monitoring of service quality by building a platform for open and ongoing exchange and reinforced partnership with PEPFAR and the GoCI.

All agencies are continuing to make efforts to increase the level of PEPFAR funding to local partners. In COP20, a total of $15,899,946 is allocated to local partners which constitutes 15 percent of the total COP20 budget.

4.5 Commodities

Amidst the COVID-19 epidemic, which is also disrupting the global supply chain system, a number of Côte d'Ivoire HIV commodity shipments have been delayed. As a risk mitigation strategy, the National Aids Control Program (PNLS) has decided to suspend implementing the 6-MMD until there is more visibility on the delivery schedule of pending orders. In the meantime, patients eligible for MMD will receive ARVs refills for three months. Patient's eligibility for MMD is regardless of their status (new patients on ART, stable or non-stable ART patients). This situation will significantly improve the implementation of MMD.

Regarding the FY2021 HIV commodity funding landscape, PEPFAR-CI and the GF will continue to be the main external donors, and the GoCI will continue to increase its contribution. In order to avoid any duplication in resource allocation, GoCI, GF, and PEPFAR-CI, WHO, and UNAIDS are committed to fully coordinate their planning processes, including the annual quantification and quarterly supply planning exercises, and monthly stock analysis. PEPFAR-CI's COP20 total of $14.85M budget for commodities t has been developed under a number of assumptions: the GF contribution for HIV commodities will be around $11M based on GF's New Funding Model (NFM) under development for HIV program in Côte d'Ivoire; and the GoCI will contribute approximately $19M for procurement of HIV commodities based on its 2021 HIV commodities supply plan. PEPFAR investments in COP2020 will cover 28% of HIV commodities needs, while GF contribution will cover 34% and the GoCI will fund the remaining 38%. If all these pledges are met, the 2021 supply for HIV commodities will be totally funded. S/GAC anticipates $2M cost savings due to unmet ART targets during COP18 and COP19 that would serve as a safeguard if these assumptions are not met.

The COP20 budget for commodities was developed to complement the national needs for commodities, contributing to the common basket for supplies. Table 4.5.1below summarizes the proposed an approximate percentage of allocations of items by category and by funding sources.

Table 4.5.1 Proposed Distribution of Communities by Funding Source

Proposed distribution by Funding Source			
	PEPFAR	GF	GoCI
ARVs Adults (1st line)*	**40%**	**20%**	**40%**
ARVs Adults (2nd line)	0%	50%	**50%**
ARVs Ped (1st line)	**40%**	**50%**	**10%**
ARVs Ped (2nd line)	0%	70%	**30%**
Lab supplies (hemato and bioch	0%	0%	**100%**
EID	**40%**	40%	**20%**
VL reagents	**40%**	**35%**	**25%**
CD4 reagents	0%	0	**100%**
Other Lab Supplies	**0%**	20%	**80%**
OI Drugs	**40%**	30%	**30%**
Rapid test kits	**50%**	10%	**40%**
(*) no order of TLD 30 through PEPFAR			

The majority of COP20 commodities have been budgeted for procurement through the GHSC-Procurement Programs, except for a very small amount attributed to very specific lab items which have been budgeted under the CDC-RETROCI procurement mechanism.

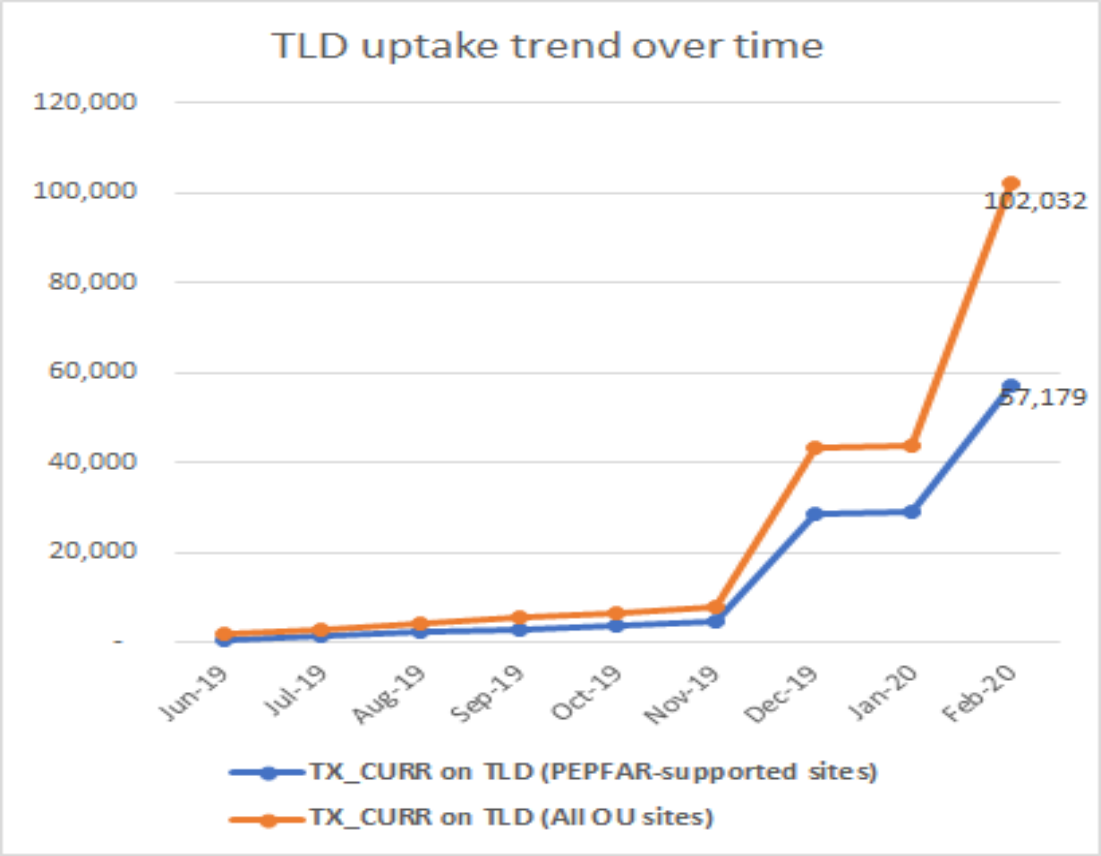
Procurement of Tenofovir+Lamivudine+Dolutegravir (TLD) as the preferred first-line drug for ART

On a programmatic level, PEPFAR-CI's budget for commodities will be used primarily to partially fund the procurement of first line ARV drugs for adults (TLD). The National AIDS Control Program has expressed concerns regarding dispensing/using TLD packs of 180 count, therefore COP20 funds will be used to support procurement of TLD bottles of 90 count. Procurement of Tenofovir+Lamivudine+Efavirenz (TLE) will be funded by GF and the GoCI and no quantity of TLE is budgeted under COP20.

The TLD transition which started in July 2019 was initially slow because of concerns regarding neural tube defects which restricted TLD availability to PLHIVPLHIV of child-bearing age. The same circular of April 2019 also recommends that all non-TLD eligible patients be switched from TLE600 to TLE400, in line with the latest WHO recommendation; all new orders of TLE have therefore been adjusted to reflect that change. PEPFAR-CI, along with other stakeholders, including GF, have worked with the MSHP to develop and implement an acceleration plan, which resulted in switching 102,032 patients to TLD as of February 29th, 2020 (see Figure 4.5.1 TLD uptake trend over time). On April 14th, 2020 the MSHP issued a new circular to update the current policy to extend Tenofovir+Lamivudine+Dolutegravir (TLD) treatment to all HIV-positive adults, including women of childbearing potential, and children >=20 kg. The MSHP policy has an additional requirement that women of childbearing potential will receive information about the benefits and associated risks before being enrolled on TLD, but it no longer requires that they be on two forms of contraception prior to transition. The PEPFAR Côte d'Ivoire Team has expressed its' concern to the Ministry of Health that this selective counseling for women of child-bearing age will discourage them from transitioning to TLD. The country team will continue to engage with CSOs to ensure that information is accurately presented and allows women living with HIV to make informed decisions. PEPFAR-CI continues to support the MSHP in developing and implementing a TLD supply plan that ensures continuous availability of adequate quantities of TLD at service delivery points. The COVID-19 pandemic outbreak has created growing disruptions to the supply chain for commodities in general. Air freight capacity is being challenged both at origin and destination. There have been increasing restrictions on movement including closing borders, airports and ports. These challenges have created delays in shipments of commodities. The supply chain country team will continue to monitor the situation and mitigate supply chain risks, to mitigate the impact on TLD transition. The goal is to ensure that 100% of eligible PLHIV are transitioned to TLD by December 31st, 2020.

Figure 4.5.1 below shows the TLD uptake in Côte d'Ivoire from June 2019 to February 2020.

Figure 4.5.1 TLD uptake trend over time



The PEPFAR-CI program is currently implementing MMD with dispensation of 6-month equivalent refills of drugs to eligible patients. Implementation began slowly, but there has been significant progress in FY20. As of February 29th, 2020, 75% of eligible PLHIV on ART were on MMD: 1% on 2-month; 36% on 3-month; 1% on 4 or 5-month and 36% on 6-month or more MMD. Eligibility for MMD is defined as patients who are stable and virally suppressed. Only 26% of eligible PLHIV are still on 1-month dispensing. It is expected that by the end of FY2020, all eligible patients will be receiving a 3- or 6-month MMD.

Optimization of Pediatric ART

All new patients weighing 20-29.9kg will be transitioned to dolutegravir (DTG). For protease inhibitor-based regimens for all eligible patients, PEPFAR-CI will begin a more aggressive transition ensuring all new and existing eligible patients are on LPV/r syrup, pellets, or tablets. Côte d'Ivoire will procure 27,105 doses of 4-in-1 to support pediatric care and treatment programs.

All the formulations/products that are needed for the optimization including DTG 50mg and LPV/r pellets, have already been registered in the country. Côte d'Ivoire started administration of LPV/r pellets in FY20. An implementation plan and roll out of a protease inhibitors (PI) based regimen is expected to begin with 5,479 patients in the 5-14kg weight band.

Procurement of Tenofovir/Lamivudine for PrEP

During FY21 PEPFAR-CI will support procurement of ARVs for PrEP. PEPFAR-CI will procure 108,000 doses of Tenofovir/Lamivudine 300/150 mg. These quantities will serve 9,000 eligible beneficiaries to reduce pre exposure risks to HIV infections.

Procurement of drugs for treatment of cryptococcal meningitis

In COP20, PEPFAR-CI investments will also support the procurement of treatment for cryptococcal meningitis for approximately 634 patients (10% of TX_NEW, then 5% CrAg positive). The treatment will be made available at regional hospitals. The proposed treatment algorithm includes the following: oral fluconazole 1,200 mg/day and flucytosine 100 mg/kg/day for two weeks or amphotericin/fluconazole as below if flucytosine not available followed by fluconazole 800 mg/day for 8 weeks, then 200 mg/day maintenance.

Procurement of diagnostics and TPT

As part of improvements in the advanced disease care package, PEPFAR-CI will improve early diagnosis and detection of TB among PLHIV by procurement of Xpert Ultra cartridges to perform 47,000 TB tests on GeneXpert and 72,000 TB Lam test kits. PEPFAR-CI will also procure INH and vitamin B6 for TPT.

Procurement of condoms and lubricants

In COP20, PEPFAR-CI investments will be used to fund procurement and the distribution of 20 million male condoms, 500,000 female condoms, and 500,000 units of lubricants, with support from the COP20 Condom Procurement Fund. Condoms will be stored at central medical stores (NPSP) and distributed through local NGOs.

4.6 Collaboration, Integration and Monitoring

4.6.1 Strengthening cross-technical collaborations and implementation across agencies and with external stakeholders, including the GF and MSHP

PEPFAR-CI remains committed to maintaining and strengthening effective collaboration with all key stakeholders, including the Ministry of Health and Public Hygiene (MSHP), the Ministry of Defense (MOD), the GF, WHO, UNAIDS, and CSOs on all aspects of program implementation and results achievement. This ongoing active collaboration has resulted in broad participation of these major players in the COP20 planning process. PEPFAR-CI intends to continue this close and effective collaboration through quarterly sharing and review of performance data, including best practices and programmatic challenges, joint planning and sites visits, and joint monitoring of policy implementation.

In view of a sustained epidemic control, the DGS will maintain a Joint Monitoring Plan coordination mechanism to improve the overall performance of the national AIDS program (PNLS). This approach illustrates the MSHP overall vision to ensure the sustainability of the national HIV/AIDS response. One of the ways to achieve long-term sustainability is to in increase the accountability of

decentralized authorities (elected or appointed) in the implementation and monitoring of HIV/AIDS activities at regional and district levels.

The goal of the Joint Monitoring Plan, under the leadership of the DGS and technical oversight of the PNLS, is to bring together all key holders including donors, CSOs, Region Presidents, Prefets, Sous-Prefets, regional and district health officials under a joint framework for planning and reviewing the performance of the program.

PEPFAR-CI will continue to support this Joint Monitoring Plan in the following ways:

- National level, under the leadership of the DGS, in COP20, PEPFAR-CI will focus on data utilization for decision making and continue to participate in weekly monitoring, monthly performance data reviews led by the DGS, quarterly performance reviews led by minister, regular field supervision, and semi-annual review of performance with other stakeholders. The PEPFAR-CI team will also support the MSHP in the development of policy documents, guidelines, ministerial orders or other types of formalized agreements to reach the 95-95-95 goals.
- Decentralized level, through active oversight of Regional Health Directors and Health District Directors as well as collaboration with decentralized authorities (regions and autonomous districts) to ensure participation of communities.

Site level- through collegial accountability of health facilities and community actors, with CSO playing active role in monitoring implementations of policies. The performance of community-facility collaboration will be further strengthened with the introduction of the "Collaborative Monitoring Matrix" that will assess both the effectiveness and impact of community-facility collaboration. The matrix includes intermediary indicators that show the level of community and facility collaboration as well as outcomes indicators that demonstrate HIV outcomes. With COP 19 funding, the MSHP is currently developing tools to monitor the impact of the joint plan on program performance, based on systematic review and triangulation of patient level care and treatment outcome with key monitoring strategies such as supervision and coaching provided by regional and district health teams, decentralized authorities response to specific challenges, community mobilization actions for LTFU tracking, etc. PEPFAR-CI will continue to support the systematic utilization of these tools and help improve them as necessary.

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

Based on the performance gaps identified during the COP19 implementation period, PEPFAR-CI has developed and enforced monitoring plans by IP, based on specific gaps by district, to improve case finding, reduce LTFU and improve linkage and retention.

In COP20, all USG agencies will prioritize partner management for achieving results. There will be – at a minimum -- monthly monitoring of prioritized sites by USG, IPs, and MSHP, focusing on

critical gaps in achieving improvements in quality and patient-centered services including retention, lost to follow-up, data quality, as well as monitoring of policy roll out (TLD, MMD, TPT, and elimination of user fees) to ensure effective implementation. The USG team will ensure weekly data collection of site level data and monthly reviews to identify high performing sites where best practices can be rapidly identified and scaled as well as rapidly identifying and addressing any issues related to the quality of services or IP performance identified. Continued use of the interagency technical working groups (TWG) as a platform for data-driven decision making; the TWG will facilitate rapid and standardized review of key indicators (both MER and custom indicators) across the cascade as well as IP expenditures to ensure that PEPFAR investments are achieving targets and their impact on PLHIV.

PEPFAR-CI will support appropriate increase of human resources within the GoCI to implement joint monitoring, including Performance-Based Funding (PBF) to help address critical gaps at district level through site-level recognition and also improve oversight and quality of HIV service delivery with a special focus on TA sites.

As a result of granular site management (GSM) and other data-driven initiatives, PEPFAR-CI has more clarity on the specific gaps at sites and has moved into the next phase of closing those gaps by working closely with the IPs to address the different issues along with developing plans to roll out differentiated approaches and solutions depending on need and in collaboration with the MSHP. Consistently underperforming sites will be subject to focused monitoring by the site management team (MSHP, CSO and USG staff), to rapidly address performance gaps.

As part of civil society engagement in the HIV response and in accordance with COP20 Guidance, in COP20, PEPFAR-CI will start a small grants program to support and fund a community monitoring platform with civil society organizations/ network and the GoCI. Local community groups will be engaged in the planning, implementation, and refinement of these community monitoring platforms. Community monitoring mechanisms must be action-oriented and routine. Specific metrics will be tailored to a given context, including specific needs and concerns of community members. That mechanism will provide routinely information back to PEPFAR and GoCI.

The innovation of this mechanism will be:

- To obtain granular and local data for local use and problem-solving. This data can then be reported up for advocacy.
- To obtain better information as you get people to own their health, you get people who are proud of their own health management; you get people who are proud to participate.
- To get the essential voice in creating the dynamic between what the states must deliver, what providers must give, and what communities must contribute.

PEPFAR-CI will also use the Community Monitoring Mechanism “CSO-CI HEALTH TRACKER”, through access by the Civil Society, MSHP and other strategic partners; that database will mix

qualitative and quantitative information on the same database to allow a better understanding on what happening on the field to lead us for better data for decision making

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

The PEPFAR-CI HRH strategy in COP20 aims to continue to provide support for human resources for health to ensure implementation along the clinical cascade, particularly with resources allocated to improved clinical service delivery package, outreach and support in the community to ensure high client retention, and implementation of task-shifting for care and treatment. Currently, over 10,000 persons are working on HIV-related activities at PEPFAR-supported sites in Côte d'Ivoire, 51% of whom are supported directly by PEPFAR. In COP20, PEPFAR-CI will continue to provide support to staff at high impact and direct service delivery moderate impact facilities and high impact and moderate impact communities as needed to ensure services are provided with a patient-centered approach.

PEPFAR-CI site visits will incorporate HRH reviews into routine site (both clinical and community) monitoring to allow sites that need increased HRH support or optimized HRH to be identified and supported promptly. In addition, PEPFAR-CI will monitor the allocation, productivity and impact of HRH by linking staffing changes to relevant facility and community performance.

Community cadres will be responsible for community-based case finding, ensuring all patients found positive are properly counseled and linked to treatment, tracing all defaulters, supporting patients who are at risk of missing an appointment, and making sure patients who are eligible for viral load testing return to the clinic for their tests. PEPFAR-CI is constantly analyzing workforce requirements for the maintenance of HIV services in consultation with implementing partners. The serves as the basis for formal dialogue with the MSHP and other stakeholders on greater shared responsibility of HRH requirements and as part of domestic resource mobilization efforts for HIV. In addition, PEPFAR-CI continues to work assiduously with the MSHP on the definition and standardization of responsibilities and remuneration for community health workers within the framework of the National HIV response and the National Health Development Plan (PNDS 2016-2020). Finally, this analysis underpins the design and implementation of effective strategies to accelerate programmatic progress.

To address challenges with the third 90 of the clinical cascade, PEPFAR-CI is introducing numerous measures to drastically improve VL uptake and increase viral suppression rates. These changes/interventions include training health care and community health workers, with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based financing to improve lab staff retention; effective utilization of VL testing dashboards to fast track unsuppressed VL with emphasis on children, adolescents and men and to document clinical site and laboratory performance; improving the laboratory information system to collect data on VL uptake and real time data analysis. Programs and district health teams will be

responsible for developing and implementing effective policies, planning, HRH and real time monitoring of patient data. Packages of activities are defined for IPs to support the district heath teams, provide resources for registers, training materials, transportation and improve turnaround time for VL results. Lab mapping to optimize VL lab network and improve laboratory clinical interface will continue. Facility and community IPs will receive adequate resources and staff for optimal management of patients to improve VL suppression, reduce mortality, and reduce lost to follow-up.

4.6.4 Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites;

Strengthening community and facility linkages is a critical component of PEPFAR-CI's strategy to increase case finding and linkage to ART and retain patients on treatment. Starting in COP19, PEPFAR-CI rationalized the geographic distribution of clinical and community partners, pairing each clinical IP with a community IP to increase efficiency. MOUs were created to formalize this collaboration, delineating roles and responsibilities of each partner in upholding services across the clinical cascade. In FY19, PEPFAR-CI reviewed existing MOUs and performed monthly oversight to monitor benchmarks of success in addressing coverage gaps across populations and age bands at 140 prioritized sites. Each IP had a clear scope of work and standard operating procedures (SOP)s for monthly tracking of referrals/counter-referrals and PLHIV LTFU who have been found in the community and returned to a health facility to continue treatment. Key indicators were defined to monitor the collaboration. This collaboration will be strengthened and scaled up in 445 sites representing 90% of PLHIV on ART in COP20.

According to the interagency community-clinical MOU operationalized Algorithm, community IPs are responsible, after patient handover from clinical IPs, for the following community interventions: (1) index testing of sexual partners and children of PLHIV, provided that these contacts have not come into facilities for HTS, (2) support for self-testing, (3) active referral for ART initiation for those identified in the community to increase treatment coverage and reduce mortality, (4) Reinforcing adherence counseling for ART (5) Community ART distribution, (6) implementation of differentiated care models, (7) establishing and implementing support groups including "patient buddy systems", (8) screening for opportunistic infections such as TB and active referral for treatment, and (9) home visit tracking of PLHIV who are LTFU and identify barriers to seeking treatment and reasons for loss to follow-up. This community-to-facility bidirectional referral is important for both IPs to achieve their targets as well as keep clients engaged across the continuum of care. Clinical IPs will also be responsible for referring clients in need to community IPs for appropriate, relevant community-based interventions, such as supportive services that increase retention (including adherence support) and improve viral suppression. Community and clinical IP work plans will reflect their integrated roles in client care.

The clinical-community collaboration will strengthen the continuum of care for patients and support full implementation of differentiated service delivery models. HIV-infected individuals

identified in a clinical facility will receive care and treatment services in the facility and additional community-based support as needed. Stable patients will be transitioned immediately to differentiated models of care, with decreasing "touch" by the health system. PLHIV identified in the community are referred and escorted by community counselors or peers to the facility for same day ART initiation. In the context of index case testing and partner notification, counselors and providers ensure that gender-based violence risk assessments and referrals are completed. Also, C/ALHIV and exposed infants are linked with OVC platforms as prioritized beneficiaries.

Clinical and community lay workers hold weekly coordination meetings to ensure that: referred patients receive same day or prompt ART initiation, patients lost to follow-up are tracked and traced, transfers out are documented, and patients' social needs are addressed promptly. Monthly multidisciplinary team meetings at sites and quarterly district coordination meetings will be reinforced to ensure effective collaboration and coordination between community and clinical settings.

4.6.5 Ensuring above service activities are mapped to key barriers and measurable outcomes related to reaching epidemic control

Based on the joint review of MER indicator results, the Sustainability Index and Dashboard (SID 3.0), SIMS visit findings for the last three fiscal years, and review of other trend analyses from granular site-level data, PEPFAR-CI consulted with the MSHP and other stakeholders to identify key system barriers to determine above service delivery interventions that can help improve and sustain retention on ART.

In COP20, PEPFAR-CI will spend $5.2 Million on above service delivery interventions. Table 4.6.5.1 below provides a mapping identified key barriers to measurable outcomes related to above service delivery interventions. Please refer to Table 6 (Appendix C) for more details.

Table 4.6.5.1 Key Barriers and Measurable Outcomes for Above-Site Delivery Interventions

Key Systems Barrier	Expected Outcome
1.Persistence of stigma and discrimination against people infected and affected by HIV/AIDS; limited HIV literacy across general population, among PLHIV and HCWs.	Decrease in denial of HIV status among PLHIV Increased retention & adherence Improved monitoring/reporting of stigma and discrimination, GBV among KPs by health care workers and community health workers at 15 facilities. Reduced HIV morbidity and stigma/discrimination
2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential); transition to	Transition to TLD for 100% of eligible PLHIV by 12/2020

Key Systems Barrier	Expected Outcome
other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.	Increase in VL suppression rates across all age, gender, and subgroups Decrease in HIV transmission Decrease in HIV morbidity and mortality
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 annual testing and results delivered to caregiver within 4 weeks.	Improved access to VL/EID and increased VL suppression rate Decrease in TB/HIV morbidity and mortality Decrease in overall morbidity and mortality among PLHIV
10. QI Assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; CSOs…)	Improved capacity of MSHP/DCS to coordinate the national HIV/AIDS response. Increased accountability of health care providers Increased quality of HIV services and improvements in retention, adherence
11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDs Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce and encourage HIV treatment and prevention.	At least 90% of PLHIV are retained in care and are virally suppressed.
14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	Improved data quality and timeliness for better programmatic decisions and allocations Decrease in morbidity and mortality
15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	Improved disease case surveillance and site level reporting Increased capacity of district leadership and care providers to manage programs Decrease LTFU and improvements in retention and adherence

4.6.6 Use of unique identifiers across sites and programs in clinical settings

In COP18 (FY19), PEPFAR-CI collaborated with MSHP to develop an HIV-program level unique identifier solution (UID, using a pseudo-code) to address Côte d'Ivoire's systemic program linkage, retention, and data quality issues. In late COP18, MSHP approved the concept to use securely encrypted biometric code (based on fingerprint) to constitute a UID. Finally, a combination of pseudo-code and biometric code will be used for all PLHIVs and TB patients across all programs (e.g., HTC, ART, PMTCT, Lab). This UID, once fully integrated into Côte d'Ivoire's HIS architecture,

will improve linkage and deduplication. COP19 activities will deploy the biometric solution to an initial 10 sites and integrate it with the site-level EMR (SIGDEP2) to assess acceptability and effectiveness of the solution before scaling to all of COP19's prioritized sites.

In COP20, the goal is to upgrade SIGDEP2 to modern architecture (OpenMRS 2.2) in order to prepare interoperability between this system and OpenELIS and integrate the UID solution into SIGDEP2 and OpenELIS. Given resource constraints, further scale up of the UID solution will not be addressed in COP20 to expand to remaining ART sites in PEPFAR-supported districts. In addition, COP20 will not support the development of a master patient index (MPI; client register), which is a required component to implement deduplication of patients across programs and sites. These additional activities – expansion of UID solution to remaining ART sites and development of an MPI – can be prioritized and funded in the future to eventually allow for achievement of the following:

Expected Outcomes

- Use unique patient-level data for HIV program monitoring, evidence-based decision-making, disease surveillance and public health response
- Use interoperable health information systems to exchange information between OpenELIS (lab results, including VL) and EMR, to improve turn-around time, data quality and use for clinical decision-making
- Use combined longitudinal ART patient data coming from various sources, such as HTC, ART, Lab, and case notification, for improved service quality at facility level, for more comprehensive and accurate data analysis.

4.7 Targets by population

Table 4.7.1. ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) TX_CURR	Newly initiated (APR FY21) TX_NEW	ART Coverage (APR 21)
Attained						
Scale-Up Saturation	381,288	289,324	15,706	352,049	69,892	92%
Scale-Up Aggressive						
Sustained						
Military		4,788		5,795	1,126	
Not PEPFAR Supported	44,491	27,483	35,593	0	0	0%
Central Support						

Prioritization Area	Total PLHIV	Expected current on ART (APR FY20)	Additional patients required for 80% ART coverage	Target current on ART (APR FY21) TX_CURR	Newly initiated (APR FY21) TX_NEW	ART Coverage (APR 21)
Commodities (if not included in previous categories)						
TOTAL	425,779	294,112	46,511	357,844	71,018	84%

Table 4.7.2. Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate (SNUs) and disease burden	FY21 Target (%)
AGYW	159,705	42,761 (27%)
PP_PREV	231,078	149,210 (65%)
KP_PREV	84,879	34,321 (40%)
TOTAL	475,662	226,292

Table 4.7.3. Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21Target) OVC_SERV(<18)	Target # of active OVC (FY21Target) OVC_SERV(<18, 18+)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Abengourou	8,173	2,254	2,742	2,506
Abobo-Est	13,585	13,656	17,124	14,404
Abobo-Ouest	15,807	3,859	4,649	4,289
Adjame-Plateau-Attecoube	14,993	9,061	11,204	10,068
Adzope	4,719	1,795	2,198	1,994
Agboville	5,016	2,845	3,511	3,161
Akoupe	1,914	1,567	1,939	1,743
Anyama	3,036	2,065	2,552	2,296
Bangolo	4,092	2,033	2,504	2,261
Bondoukou	6,985	4,603	5,683	5,115
Bongouanou	9,515	4,353	5,349	4,838
Bouafle	8,646	2,451	2,976	2,725
Bouake-Nord-Est	5,951	3,056	3,753	3,397
Bouake-Nord-Ouest	5,214	4,953	6,145	5,502
Bouake-Sud	9,449	3,098	3,784	3,443
Cocody-Bingerville	16,962	15,147	18,127	15,999
Daloa	3,597	1,897	2,333	2,108
Daloa	11,209	15,317	17,826	15,998
Divo	5,159	6,718	8,360	7,465
Duekoue	6,072	4,114	5,098	4,572
Gagnoa	12,078	4,249	5,193	4,722
Guiglo	4,917	2,971	3,699	3,302
Issia	6,083	1,754	2,132	1,948
Korhogo 1	10,527	6,797	8,354	7,552
Koumassi-Port Bouet-Vridi	21,428	8,783	10,751	9,759
Man	10,989	8,733	10,299	9,145
Mankono	6,798	699	795	778
Ourne	5,489	2,092	2,560	2,325
San-Pedro	13,574	3,962	4,826	4,402
Sinfra	4,664	2,522	3,105	2,803
Soubre	12,111	3,308	4,042	3,677
Tabou	2,805	499	592	556
Tanda	5,830	4,558	5,642	5,066

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY21Target) OVC_SERV(<18)	Target # of active OVC (FY21Target) OVC_SERV(<18, 18+)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Tiassale	3,146	2,756	3,414	3,062
Treichville-Marcory	42,350	4,738	5,619	5,266
Yamoussoukro	7,502	2,619	3,195	2,911
Yopougon-Est	26,279	4,449	5,324	4,944
Yopougon-Ouest-Songon	19,448	3,807	4,533	4,232
TOTAL	376,112	174,138	211,932	196,334

4.9 Viral Load and Early Infant Diagnosis Optimization

FY19 has seen an expansion of VL coverage (VLC) from 67% in Fy17 to 84%, and similar improvement of VL suppression (VLS) from 70% to 80% among PLHIV in Côte d'Ivoire's PEPFAR supported 60 districts. Despite this overall improvement, the program still has weakness in coverage and low VLS rates in 39 over the 60- prioritized covered districts. Detailed analysis of VLC and VLS suppression have shown gaps in key populations such has pregnant and breastfeeding women, young adult women 20-39 years and children aged 0-4 years old. Indeed, deep analysis of FY19Q1 data and results have shown that about 20,000 women aged 20-39 eligible for VL did not have access to the test, and about 1,048 children aged 1-4 years are still waiting to have at least one VL test done. To mitigate these weaknesses the team has developed an innovative approach for program and clinical IP management.

In order to achieve epidemic control by reaching 95% coverage and 95% suppression by September 2021, PEPFAR-CI will focus on the 455 high impact and moderate impact clinical sites, including about 96 pediatric sites with CLHIV cohorts of > 20 patients, for improvement. The low impact sites receiving PEPFAR support will have a technical assistance model with no additional human resource support; these sites will, however, be linked to nearby high impact and moderate impact sites, thereby benefiting from those investments. The FY19 surge plan defined the path by identifying key and innovative strategies, such as home blood collection, after hours services, blood collection and laboratory shift hours and weekend testing, and partner management solutions for closing the gap. The PEPFAR in-country team defined indicators across the clinical cascade, and lay worker to patient ratio. Weekly targets for VL coverage and suppression were set by partners for the previous 139 clinical prioritized sites, such as the number of blood samples to collect and the number of patients to enroll into the enhanced adherence counseling (EAC). This has resulted to 91% coverage and 83% suppression at the 139 priority sites. Since Q2 COP18, CDC through I-Tech developed and implemented an electronic tool to monitor VL appointments and follow-up with unsuppressed patients and enroll them in enhanced adherence counseling. The electronic tool is

being used by clinical IPs to generate weekly reports for CDC to review and have shown results in COP18's 139 prioritized sites with higher coverage and suppression rate at 91% and 83% respectively, compared to 72% and 79% at non- prioritized sites.

During COP20, IPs will continue to implement and expand strategies and practices that have been demonstrated to improve VLC and VLS during COP19. These strategies include extended operating hours at clinical sites for consultation and blood draws during weekends and evenings after work; home blood draws and transportation for patients with physical disabilities; reduced time spent at the clinic by combining appointments for ARV pick up with VL testing; and prioritization of children and PBFW by maximizing opportunities for VL testing at routine visits, and by proactively tracking these cohorts, alerting patients and providers when tests are due, and following up on results for decision-making. Additional strategies for improving VLC include dedicated VL testing days with fast track patient circuits at the facility or nearest satellite lab, and additional HRH for VL collection. Dedicated clinical and community lay counselors will be recruited and strategically placed at key sites. Their roles are to remind patients of their appointment, collect any relevant information that will help improve patients' adherence to treatment and reduce loss to follow-up, and share the list of non-reachable patients with community IPs to initiate home visits. These strategies will be implemented at all PEPFAR-supported sites, calibrated to their specific needs and within existing budget constraints. Progress will be monitored every week using the VL/EAC electronic tools. IPs will be monitored on a weekly basis with coaching and visits to sites with the poorest performance by PNLS and district health teams, and close monitoring to improve indicators. IPs with poor performance after 3 months of implementation of the surge plan will be put on performance improvement plans. The goal for PEPFAR-supported sites will be to reach 95% coverage and 95% suppression by September 2021.

1) strategies for TB/HIV integration and optimization of existing POC and conventional instrument capacities

The country has two well organized TB GeneXpert and VL/EID HIV laboratory networks that need to be integrated and optimized in order to improve access to laboratory services for PLHIV. In COP20, Table 6 investments will include extending the existing Laboratory Information System (OpenELIS) to TB and improve it to reduce sample TAT, as well as investments to build the laboratory-clinical interface. The system will have the required annual security upgrade to comply with international guidelines to enable secure access to the system and protect patient records. The Lab information System will also be upgraded for interoperability with patient EMR SIGDEP2. All these upgrades aim to reduce laboratory turnaround time by introducing electronic VL/EID and TB demand and result return to clinical and community sites.

2) projected new sites or geographic areas in FY20 for EID and VL among PBFW only

Project UNITAID and MSHP has implemented POC EID testing at 27 PMTCT sites. PEPFAR has worked closely with MSHP to develop a national VL/EID POC testing policy and will extend the project to 60 high volume PMTCT sites. The goal is to reach 50% of EID and PBFW with POC

testing, using the spoke and hub model. Additional strategies such as community EID testing and testing at other entry points such as vaccination and nutrition centers will help improve VL and EID coverage for the mother and children pair. In FY21, optimization of the network will be done through community VL/EID testing with the goal to reduce TAT to a maximum of 24 hours.

3) Funds allocated in the FAST (including commodity procurement, trainings or TA etc.)

COP20 funds allocation to improve VL access and suppression, TB testing:

175,000 VL tests and 191,900 sample collection tubes will be procured through the GHSC-PSM Mechanism, at $17.92 and $ 2.05 per unit for a total of $3,136,473 and $393,337 respectively.

Funds were also allocated to procure WHO Approved TB LAM assay for about 72,000 units at $371,059 for the provision of CrAg testing.

The 6 clinical implementing partners (ARIEL, EGPAF, ICAP, HAI, SEVCI, ACONDA) unit cost per patients on ART includes costs associated with laboratory service that include, sample transportation, training and coaching /supervision.

I-Tech University of Washington received $768,750 to maintain the existing laboratory information system, OPENLIS. Because of the reduced budget under COP20, new development to improve OPENLIS such as interoperability, to reduce results turn-around time will be challenging to implement.

No funds have been allocated to implement a national referral system for sample transportation, due to budget constraints. Clinical implementing partners will be funded to ensure patient's access to VL/EID.

4) Transition arrangements for existing POC platforms owned by other stakeholders and located within PEPFAR

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

To address challenges with the third 90 of the clinical cascades, PEPFAR-CI is introducing numerous measures to drastically improve access, uptake and increase VLS rates. Focus will be on children, adolescents, pregnant and breastfeeding women where gaps have been observed. These changes/interventions include training health care and community health workers, with on-site coaching, supervision, and competency assessments for lab professionals; provision of performance-based financing to improve lab staff retention; effective utilization of VL testing dashboards to fast track unsuppressed VL with emphasis on pregnant women, young adult women aged 20-39 years, children and adolescents, and to document clinical site and laboratory performance; improving the laboratory information system to collect data on VL uptake and real time data analysis. Programs and district health teams will be in charge of developing and implementing effective policies, planning, HRH and real time monitoring of patient data. Packages

of activities are defined for implementing partners to support the district heath teams, provide resources for registers, training materials, transportation and improve turnaround time for results. Lab mapping to optimize VL lab network and improve laboratory clinical interface will continue. Facility and community IPs will receive adequate resources and staff for optimal management of patients to improve VL suppression, reduce mortality, and reduce loss to follow-up.

5.0 Program Support Necessary to Achieve Sustained Epidemic Control

Through SID 3.0, MER, SIMS and Granular Site Management visits, PEPFAR-CI has identified seven (7) key system barriers that prevent it from fully achieving its objectives. To address these barriers, most of the systems level investments in Table 6 support activities to strengthen and enable an environment for quality service delivery.

The proposed activities are related to SID 3.0 elements with the objectives to: i) improve availability of quality and timely OVC and DREAMS including increasing demand for PrEP among AGYW, ii) increase demand for HIV services and coverage among men including self-testing, iii) effect rapid ART distribution of TLD for all PLHIV, v) decrease HIV morbidity and mortality, and improve VL coverage and availability of results, vi) improve data quality to better assess and improve linkage and retention, vi) reduce HIV-related stigma and discrimination against KP and PLHIV, vi) work with existing platforms to assess, establish a national QI plan, and strengthen clinical quality management structures and implement CQI approaches to improve the quality of service delivery at supported sites. In addition, PEPFAR-CI will collaborate with the MSHP to leverage multi-stakeholder data reviews to focus interventions on sites and program areas lagging behind; performance-based financing will be implemented at selected prioritized sites to accelerate

progress in critical areas such as case finding, retention and viral load suppression for adolescents and children; case finding for men and women; and retention of young adults.

These objectives and their corresponding above-site activities provide the foundation for the site-level, service delivery interventions supported through PEPFAR-CI. All planned activities work together toward sustained epidemic control.

1) Stigma and Discrimination

- During FY2021, PEPFAR-CI will design and implement a program to reduce stigma and improve HIV and treatment literacy through the local network of faith and community leaders, following the Faith in Communities Initiatives (FCI) model. Starting in high burden areas in Abidjan, this activity will use materials and successful interventions from other FCI countries and adapt them to the Ivorian context. The intervention will include: mapping of faith and community structures; workshops and trainings with faith and community leaders; material production; and supervision and ongoing support for roll out in select, high-burden districts.

The benchmarks and outcomes identified by the PEPFAR-CI team are measurable and reasonable, with the intention of monitoring progress on a quarterly basis.

2) Laboratory

During FY2021, PEPFAR-CI will focus on addressing the challenges and weaknesses identified during FY2019:

- Insufficient laboratory and clinical interface for HIV, TB and OIs results utilization for better patient management
- Weak maintenance of laboratory equipment for advance disease monitoring
- Delays in sample processing to weak human resources and infrastructure
- VL/EID results long turnaround time

In FY21, PEPFAR-CI will extend the existing Lab Information System (LIS) to TB diagnostic laboratory network. This should result in reducing laboratory results TAT and improve laboratory-clinical interface. Required annual security upgrades of the Laboratory Information System (OpenELIS) will also be implemented to comply with international guidelines to enable a secure access to the system and protect patient records. In addition, the LIS will be upgraded to improve the interface between patients' medical results and the VL, EID and TB lab, these upgrades will be made to the LIS for interoperability with the patients' electronic medical record (EMR) SIGDEP2

3) Supply chain

Supply chain strengthening interventions in FY2021 will continue to contribute to bolstering health systems for quality control, monitoring and real-time response. It's worth mentioning that, unlike

previous years, the funding for supply chain technical assistance has been significantly reduced. Consequently, PEPFAR footprints in this area will decrease significantly.

Building on the prior year achievements in this area, PEPFAR-CI investments focus on support to: implement commodity data collection plan (in compliance with SGAC's new data requirement, PPMR-HIV, TLD and MMD indicators); development of logistics management and reporting tools (inventory, reporting, tools) to hep ARVs distribution by CHWs; implement ARVs distribution by CHWs (inventory, reporting, tools) management and reporting; update SOPs and LMIS to include community ARVs distribution; production and use of logistics data to inform decision making for increased availability of communities at service delivery points; and expand implementation and maintain electronic logistics management information system for health to 26 new health districts. Table 6 includes detailed interventions. Concurrently, these activities will assure improved coordination among stakeholders and increased ownership by local institutions of supply chain processes.

4) OVC/DREAMS
    - In COP20, PEPFAR will develop and disseminate OVC/DREAMS tools (case management, report templates, screening tools, etc.); Revise and adapt OVC/DREAMS database to include new requirements (age band, eligibility criteria, unique identifier for beneficiaries, improved needs analysis); Strengthen and ensure full functionality of OVC/DREAMS database for fast-tracking of OVC services and accurate reporting of DREAMS layering; and complete full transition of the OVC/DREAMS database to PNOEV.

5) PEPFAR CI will also support PrEP demand creation for AGYW to preemptively address challenges in AGYW uptake of PrEP seen in other countries. Materials will be developed and tailored to the Ivoirian context, following successful examples from other DREAMS countries, and disseminated with the support of DREAMS implementing partners. Collaboration with MSHP:

Through the cooperative agreement with the MSHP, PEPFAR above-site investments will achieve the following:

- Monthly and quarterly multi-stakeholder data reviews. These will include the PEPFAR team, implementing partners, MSHP, multilateral stakeholders, and CSO representatives. The focus will be to review site-level data on critical program areas (e.g. case finding among men, VLC/VLS among children and young people, case-finding and retention among adult women, etc.) and target interventions to the sites in need of assistance. Performance-based financing will also be included among these interventions, to incentivize high-performing sites.
- Data quality will be maintained and improved through the updating and dissemination of data collection tools aligned with PEFPAR indicators. Moreover, the SIGDEP 2 HMIS system will be upgraded to permit interoperability with

OPENLIS and other electronic data sources. In future COP years, the PEPFAR team anticipates being able to implement patient-level case-based surveillance systems, for which these SIGDEP upgrades would constitute a first step.

- All laboratory QMS activities will be entirely transferred to the MSHP; the national public health laboratory and PEPFAR team will ensure that this is effective and that the lab activities and results are monitored adequately to provide quality laboratory services to patients. The MSHP will be in charge of the distribution of HIV RT proficiency testing panels, supervision and coaching of laboratory units in addition to performance evaluation of HIV rapid testing services both at clinic and within the community. The DIEM will continue to receive support through the MSHP CoAg to ensure all equipment are maintained properly.

Table 6-E tab of the Excel workbook and SRE-Tool E worksheet can be found in Appendix C.

6.0 USG Operations and Staffing Plan to Achieve Stated Goals

Staffing analysis

The PEPFAR Côte d'Ivoire team reevaluated its staffing footprint to improve human resources programmatic alignment in order to facilitate and sustain HIV epidemic control, and successfully implement the national program. With the implementation of key care and treatment activities, this will increase the focus of staff time on specific program components such as intensified programmatic management and strategic information analysis. For COP20, the PEPFAR Coordination Office (PCO) is proposing some changes to improve staffing programmatic alignment, with the addition of a DREAMS Coordinator, to be funded by CDC.

CDC

In COP19 CDC Côte d'Ivoire went through a reduction in force (RIF) as of October 1, 2019 due to sharp budget cuts. To better align remaining staff with programmatic needs, CDC is requesting to repurpose the locally engaged (LE) staff Executive Assistant position to a Deputy Prevention, Care and Treatment Branch Chief, to better align with PEPFAR programmatic investments in care and treatment management and oversight, and to better support the current staffing structure. Hiring for this position will happen once CDC is able to submit the position for reclassification through the State HR position classification process.

During COP19 planning, CDC Côte d'Ivoire received guidance from S/GAC to align the clinical program with the investments in the 60 highest disease burdened districts across the country. Consequently, CDC is realigning the Prevention, Care and Treatment branch to provide enhanced technical partner management over the CDC partners implementing clinical activities in these high burden districts. CDC plans to fill all vacant positions and realign its staffing to meet current program priorities by the end of FY2021. When all vacant positions are filled, CDC Côte d'Ivoire will be operating at a full staffing level, but will still be stretching its staffing capacity with the increased demands for site level monitoring and weekly and closer partner management (until IPs' performance improves) to assure improved program results and epidemic control.

For the COP20 budget, CDC is approved $605,773 for a Global Health Security Agenda (GHSA) position. This position will function as the GHSA Program Director, allowing the CDC Country Director and Deputy Director to focus solely on PEPFAR.

USAID

USAID conducted an analysis to ensure adequate staffing levels to provide intensive partner management and execute the required number of increased site visits. USAID's staffing levels enable sufficient oversight of PEPFAR-funded, USAID programs to successfully implement

community prevention activities across all populations, as well as improve the collaboration between community implementing partners and their clinical counterparts.

USAID currently has three vacancies. USAID has completed the recruitment process for the two Côte d'Ivoire based Local Capacity Development and Gender Advisors that were approved and created in COP19. The two positions are expected to start in May 2020.

USAID has received approval to hire one additional local staff to support staffing needs around HIV Prevention. The individual will be based in the USAID office and will spend between 50%-75% of his/her time providing oversight and technical guidance to DREAMS implementing partners. This position will also play a key role representing USAID in the interagency space on DREAMS programming.

DOD

For COP20, DOD has two local positions to cover program performance needs and will continue to use ICASS to limit the number of staff and to optimize administrative and other support cost sharing. DOD has one vacant local hire position, the Strategic Information Specialist. All documentation was approved by the Embassy's Management section and the Regional Classifier for position classification. The candidates have been preselected and it is expected that the recruitment will be completed by the end of September 2020. DOD has no new positions proposed for COP20 and no major changes to CODB.

PCO

During COP19, PCO reduced its staffing by two positions (Administrative Assistant and Media and Community Outreach Coordinator) and shared administration responsibilities with CDC, USAID and PAS.

Proposed New Positions for COP20

PCO

For COP20, the PEPFAR Coordination Office (PCO) is proposing some changes to improve staffing programmatic alignment, with the addition of a DREAMS Coordinator (who will be funded through a CDC mechanism). PCO also received approval from SGAC to add an Administrative Assistant. Since the elimination of this position at the end of COP18, there has been an increased need for clerical and administrative support that cannot be covered by CDC and USAID despite multiple coordination efforts. This new staff will be local hire based at PCO and will also spend at least 20% of his/her time to support community outreach activities on behalf of PCO.

APPENDIX A – Prioritization

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

District	CDP	prioritisation	Results Reported	*Attained: 90-90-90 (81%) by Age and Sex Based to Reach 95-95-95 (90%) Overall*																							
				Treatment Coverage at APR by Age and Sex																							
				<1		1-4		5-9		10-14		15-19		20-24		25-29		30-34		35-39		40-44		45-49		50+	
				M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
Abengourou	CDP15	Agg	APR16	8%	6%	11 %	11 %	18 %	19 %	21 %	21 %	5%	3%	18 %	4%	58 %	15 %	79 %	21 %	10 %	37 %	15 %	87 %	15 %	87 %	49 %	47%
	CDP16	Agg	APR17	13%	13%	21 %	24 %	29 %	34 %	35 %	38 %	6%	4%	23 %	4%	68 %	18 %	93 %	25 %	12 %	44 %	18 %	50 %	18 %	50 %	57 %	55%
	CDP17	Satur	APR18	26%	37%	26 %	37 %	26 %	37 %	26 %	37 %	93 %	47 %	93 %	47 %	93 %	47 %	93 %	47 %	93 %	47 %	93 %	47 %	93 %	47 %	93 %	47%
	CDP18	Satur	APR19	8%	17%	20 %	36 %	27 %	34 %	83 %	72 %	35 %	38 %	25 %	54 %	38 %	87 %	47 %	10 %	55 %	10 %	65 %	20 %	85 %	21 %	58 %	57%
	CDP19	Satur	APR20	72%	77%	51 %	14 %	53 %	53 %	67 %	59 %	33 %	68 %	60 %	94 %	10 %	25 %	98 %	13 %	10 %	12 %	83 %	99 %	60 %	94 %	44 %	78%
	CDP20	Satur	APR21	77%	83%	90 %	90 %	90 %	90 %	92 %	93 %	89 %	93 %	90 %	78 %	93 %	93 %	93 %	90 %	94 %	92 %	94 %	89 %	93 %	93 %	94 %	92%
Aboisso-Est	CDP15	Satur	APR16	14%	14%	21 %	30 %	32 %	43 %	38 %	48 %	7%	3%	26 %	4%	84 %	15 %	11 %	21 %	15 %	37 %	22 %	89 %	22 %	89 %	71 %	47%
	CDP16	Satur	APR17	17%	15%	29 %	31 %	40 %	44 %	47 %	50 %	0%	4%	30 %	4%	97 %	18 %	13 %	25 %	17 %	44 %	25 %	50 %	25 %	50 %	82 %	50%
	CDP17	Satur	APR18	100 %	107 %	10 %	13 %	10 %	13 %	10 %	13 %	13 %	57 %	13 %	57 %	13 %	57 %	13 %	57 %	13 %	57 %	13 %	57 %	13 %	57 %	13 %	57%
	CDP18	Satur	APR19	5%	5%	22 %	29 %	29 %	35 %	74 %	88 %	43 %	20 %	23 %	36 %	23 %	60 %	22 %	89 %	39 %	93 %	56 %	94 %	77 %	94 %	42 %	36%
	CDP19	Satur	APR20	177 %	220 %	23 %	31 %	97 %	10 %	48 %	50 %	15 %	55 %	26 %	13 %	49 %	23 %	82 %	24 %	94 %	14 %	83 %	77 %	50 %	46 %	28 %	36%
	CDP20	Satur	APR21	70%	83%	95 %	95 %	95 %	95 %	95 %	95 %	88 %	93 %	89 %	78 %	90 %	93 %	93 %	89 %	92 %	93 %	93 %	89 %	93 %	93 %	92 %	93%
Aboisso-Ouest	CDP15	Satur	APR16	20%	18%	33 %	38 %	48 %	56 %	55 %	62 %	8%	4%	28 %	5%	92 %	23 %	12 %	28 %	16 %	50 %	24 %	11 %	24 %	11 %	78 %	64%
	CDP16	Satur	APR17	20%	16%	34 %	33 %	47 %	48 %	55 %	53 %	0%	4%	32 %	5%	10 %	23 %	14 %	29 %	19 %	52 %	27 %	12 %	27 %	12 %	89 %	65%
	CDP17	Satur	APR18	13%	22%	28 %	32 %	48 %	38 %	99 %	90 %	49 %	31 %	22 %	39 %	23 %	65 %	27 %	94 %	34 %	98 %	63 %	93 %	77 %	95 %	48 %	37%

	COP18	Satur	APR20	116%	108%	13 6%	16 8%	13 6%	16 8%	13 6%	16 8%	92 %	94 %	92 %	94 %	92 %	94 %	92 %	94 %	92 %	94 %	92 %	94 %	92 %	94 %	92 %	94%
	COP19	Satur	APR20	289%	224%	41 3%	31 6%	33 9%	27 5%	21 1%	23 6%	15 5%	15 0%	12 8%	21 9%	14 3%	40 0%	16 9%	54 3%	19 8%	40 7%	26 2%	27 8%	16 4%	21 2%	13 4%	178%
	COP20	Satur	APR21	83%	82%	96 %	96 %	96 %	96 %	96 %	96 %	89 %	92 %	90 %	79 %	91 %	92 %	93 %	93 %	94 %	92 %	94 %	90 %	94 %	92 %	94 %	92%
Adjame-Plateau-Attecoube	COP15	Agg	APR16	5%	4%	8%	9%	11 %	12 %	13 %	14 %	5%	3%	10 %	4%	51 %	15 %	70 %	21 %	93 %	37 %	13 5%	87 %	13 5%	87 %	43 %	47%
	COP16	Agg	APR17	4%	5%	10 %	10 %	15 %	15 %	17 %	17 %	5%	4%	10 %	4%	62 %	18 %	84 %	24 %	11 1%	43 %	16 3%	10 1%	16 3%	10 1%	52 %	54%
	COP17	Agg	APR18	45%	35%	45 %	35 %	45 %	35 %	45 %	35 %	72 %	58 %	72 %	58 %	72 %	58 %	72 %	58 %	72 %	58 %	72 %	58 %	72 %	58 %	72 %	58%
	COP18	Agg	APR19	13%	5%	16 %	16 %	21 %	27 %	30 %	41 %	15 %	17 %	14 %	33 %	20 %	67 %	35 %	99 %	34 %	10 2%	78 %	10 2%	86 %	91 %	49 %	41%
	COP19	Satur	APR20	57%	35%	77 %	84 %	49 %	58 %	29 %	39 %	14 %	40 %	22 %	61 %	33 %	12 1%	66 %	15 0%	75 %	14 3%	92 %	90 %	75 %	61 %	54 %	53%
	COP20	Satur	APR21	83%	77%	86 %	86 %	86 %	86 %	87 %	87 %	93 %	94 %	93 %	80 %	95 %	96 %	95 %	93 %	96 %	94 %	96 %	92 %	96 %	94 %	96 %	94%
Adzope	COP15	Agg	APR16	4%	4%	10 %	8%	13 %	13 %	16 %	12 %	2%	1%	0%	1%	10 %	0%	26 %	8%	34 %	13 %	50 %	32 %	50 %	32 %	16 %	17%
	COP16	Agg	APR17	10%	6%	16 %	13 %	23 %	19 %	27 %	22 %	2%	1%	0%	2%	20 %	7%	28 %	9%	36 %	17 %	53 %	39 %	53 %	39 %	17 %	21%
	COP17	Agg	APR18	32%	22%	32 %	22 %	32 %	22 %	32 %	22 %	56 %	32 %	56 %	32 %	56 %	32 %	56 %	32 %	56 %	32 %	56 %	32 %	56 %	32 %	56 %	32%
	COP18	Agg	APR19	40%	41%	45 %	48 %	20 %	32 %	22 %	59 %	11 %	37 %	20 %	71 %	30 %	10 1%	47 %	11 0%	48 %	80 %	72 %	58 %	69 %	71 %	33 %	25%
	COP19	Satur	APR20	52%	22%	75 %	81 %	54 %	56 %	24 %	36 %	10 %	42 %	27 %	73 %	34 %	95 %	34 %	89 %	77 %	10 6%	71 %	67 %	67 %	55 %	55 %	59%
	COP20	Satur	APR21	80%	86%	94 %	94 %	93 %	96 %	95 %	95 %	91 %	92 %	91 %	79 %	92 %	93 %	93 %	91 %	94 %	93 %	95 %	91 %	95 %	93 %	95 %	93%
Agboville	COP15	Agg	APR16	9%	7%	15 %	15 %	21 %	21 %	24 %	24 %	3%	2%	10 %	2%	34 %	0%	46 %	13 %	61 %	23 %	80 %	53 %	80 %	53 %	28 %	20%
	COP16	Agg	APR17	12%	8%	19 %	17 %	27 %	25 %	32 %	28 %	3%	2%	11 %	2%	35 %	9%	48 %	12 %	63 %	22 %	93 %	52 %	93 %	52 %	30 %	28%
	COP17	Agg	APR18	30%	27%	30 %	27 %	30 %	27 %	30 %	27 %	57 %	30 %	57 %	30 %	57 %	30 %	57 %	30 %	57 %	30 %	57 %	30 %	57 %	30 %	57 %	30%
	COP18	Agg	APR19	89%	162 %	42 %	57 %	31 %	35 %	35 %	43 %	10 %	25 %	34 %	75 %	37 %	11 5%	44 %	11 0%	71 %	10 0%	67 %	66 %	62 %	60 %	34 %	26%
	COP19	Satur	APR20	47%	68%	44 %	60 %	31 %	34 %	28 %	37 %	11 %	22 %	14 %	39 %	19 %	59 %	25 %	56 %	42 %	68 %	43 %	43 %	43 %	44 %	32 %	38%
	COP20	Satur	APR21	76%	81%	96 %	95 %	95 %	95 %	96 %	95 %	90 %	93 %	91 %	78 %	92 %	92 %	93 %	91 %	94 %	92 %	95 %	90 %	95 %	92 %	95 %	92%
Agnibilekro u	COP15	Sunt	APR16	11%	9%	18 %	18 %	26 %	26 %	30 %	29 %	5%	3%	18 %	4%	60 %	17 %	82 %	23 %	10 0%	40 %	15 0%	95 %	15 0%	95 %	51 %	51%

	COP16	Sust	APR17	9%	7%	24%	15%	20%	22%	24%	25%	6%	3%	20%	4%	65%	16%	88%	22%	11%	39%	17%	92%	17%	92%	55%	50%
	COP17	Sust	APR18	20%	27%	29%	27%	29%	27%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%	85%	44%
	COP18	Sust	APR19	0%	0%	22%	32%	18%	21%	64%	34%	20%	20%	20%	35%	27%	59%	24%	84%	44%	71%	53%	71%	93%	92%	44%	46%
	COP19	Satur	APR20	90%	98%	77%	11%	53%	29%	31%	22%	15%	41%	9%	46%	61%	84%	48%	93%	71%	88%	55%	66%	63%	93%	59%	44%
	COP20	Satur	APR21	78%	83%	90%	90%	90%	89%	89%	90%	88%	92%	90%	78%	91%	92%	92%	90%	94%	92%	94%	90%	94%	91%	94%	92%
Akaapa	COP15	Agg	APR16	9%	5%	15%	10%	20%	15%	24%	17%	2%	2%	7%	2%	24%	9%	32%	13%	48%	23%	63%	54%	63%	54%	20%	20%
	COP16	Agg	APR17	12%	8%	29%	16%	27%	24%	32%	26%	4%	3%	13%	3%	43%	13%	59%	17%	78%	33%	11%	73%	11%	73%	37%	30%
	COP17	Agg	APR18	33%	17%	33%	17%	33%	17%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%	48%	36%
	COP18	Agg	APR19	167%	248%	15%	13%	43%	75%	62%	81%	5%	44%	48%	15%	83%	21%	10%	23%	12%	24%	12%	12%	13%	11%	73%	47%
	COP19	Satur	APR20	107%	111%	11%	87%	42%	61%	20%	33%	7%	30%	11%	77%	20%	82%	45%	93%	67%	14%	67%	67%	88%	97%	46%	57%
	COP20	Satur	APR21	97%	73%	94%	94%	94%	94%	93%	97%	93%	93%	92%	79%	94%	93%	94%	92%	95%	93%	96%	92%	95%	93%	96%	93%
Alepe	COP15	Sust	APR16	10%	4%	16%	9%	22%	13%	28%	15%	2%	1%	7%	2%	25%	7%	34%	10%	45%	17%	65%	41%	65%	41%	23%	22%
	COP16	Sust	APR17	13%	6%	22%	13%	31%	19%	37%	21%	2%	2%	7%	2%	23%	10%	32%	14%	42%	24%	62%	57%	62%	57%	30%	33%
	COP17	Sust	APR18	35%	21%	35%	21%	35%	21%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%	30%	16%
	COP18	Sust	APR19	162%	177%	57%	12%	35%	21%	28%	61%	6%	24%	21%	71%	50%	11%	61%	12%	74%	57%	81%	10%	96%	12%	50%	47%
	COP19	Satur	APR20	77%	241%	87%	24%	87%	61%	39%	40%	25%	18%	8%	72%	46%	11%	50%	14%	12%	19%	13%	15%	12%	16%	98%	150%
	COP20	Satur	APR21	83%	88%	93%	86%	88%	89%	94%	91%	85%	91%	87%	77%	89%	91%	91%	89%	92%	93%	93%	89%	94%	90%	92%	93%
Anyama	COP15	Agg	APR16	6%	4%	11%	8%	15%	12%	17%	13%	3%	1%	10%	2%	33%	7%	45%	10%	60%	18%	87%	42%	87%	42%	28%	22%
	COP16	Agg	APR17	7%	6%	11%	12%	15%	17%	18%	19%	4%	2%	11%	2%	44%	9%	60%	12%	79%	22%	11%	52%	11%	52%	37%	28%
	COP17	Agg	APR18	33%	27%	33%	27%	33%	27%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%	73%	30%
	COP18	Agg	APR19	21%	44%	49%	31%	58%	61%	75%	13%	33%	59%	21%	40%	38%	80%	35%	11%	45%	93%	55%	11%	80%	10%	54%	48%
	COP19	Satur	APR20	324%	234%	28%	14%	11%	16%	79%	12%	58%	64%	65%	11%	75%	19%	94%	24%	11%	20%	11%	12%	11%	15%	78%	111%

	COP20	Satur	APR21	86%	89%	95%	94%	93%	94%	95%	96%	90%	93%	92%	80%	93%	93%	94%	92%	95%	93%	96%	91%	96%	93%	95%	93%
Bangolo	COP15	Agg	APR16	2%	3%	3%	2%	5%	3%	6%	3%	1%	1%	5%	1%	15%	4%	21%	5%	28%	9%	41%	22%	41%	22%	33%	12%
	COP16	Agg	APR17	2%	3%	3%	3%	4%	4%	4%	4%	2%	1%	0%	1%	21%	6%	29%	8%	38%	14%	56%	32%	56%	32%	18%	17%
	COP17	Agg	APR18	75%	65%	75%	65%	75%	65%	75%	65%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%	48%	20%
	COP18	Agg	APR19	0%	0%	8%	6%	3%	11%	10%	59%	4%	7%	4%	34%	17%	50%	19%	51%	26%	41%	42%	41%	38%	33%	15%	21%
	COP19	Satur	APR20	6%	6%	2%	2%	3%	5%	3%	4%	0%	5%	14%	7%	12%	12%	7%	11%	11%	17%	17%	18%	12%	10%	6%	22%
	COP20	Satur	APR21	73%	87%	85%	86%	86%	85%	86%	86%	90%	91%	91%	78%	92%	93%	93%	90%	94%	91%	95%	89%	94%	91%	94%	91%
Beoumi	COP15	Sunt	APR16	4%	3%	7%	7%	9%	10%	11%	13%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	19%	20%
	COP16	Sunt	APR17	6%	3%	9%	7%	13%	10%	15%	12%	3%	2%	10%	2%	33%	9%	45%	12%	59%	22%	86%	51%	86%	51%	27%	27%
	COP17	Sunt	APR18	20%	22%	20%	22%	20%	22%	20%	22%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%	39%	23%
	COP18	Sunt	APR19	63%	85%	63%	85%	63%	85%	63%	85%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	120%
	COP19	Satur	APR20	115%	121%	10%	81%	39%	24%	20%	34%	19%	57%	26%	70%	27%	13%	66%	10%	69%	86%	57%	79%	79%	10%	82%	125%
	COP20	Satur	APR21	77%	78%	93%	93%	88%	89%	89%	88%	93%	93%	92%	79%	94%	93%	94%	91%	95%	93%	96%	91%	96%	93%	95%	93%
Bettie	COP15	Sunt	APR16	3%	6%	6%	13%	8%	18%	9%	20%	2%	1%	7%	2%	21%	6%	29%	9%	39%	15%	57%	36%	57%	36%	18%	19%
	COP16	Sunt	APR17	5%	5%	8%	10%	11%	15%	11%	17%	2%	1%	7%	1%	22%	6%	31%	8%	40%	15%	59%	35%	59%	35%	19%	19%
	COP17	Sunt	APR18	10%	20%	10%	20%	10%	20%	10%	20%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%	37%	21%
	COP18	Sunt	APR19	63%	83%	63%	83%	63%	83%	63%	83%	11%	13%	11%	13%	11%	13%	11%	13%	11%	13%	11%	13%	11%	13%	11%	134%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Blankouma	COP15	Sunt	APR16	3%	3%	1%	1%	2%	2%	2%	2%	3%	2%	9%	2%	30%	8%	42%	11%	55%	19%	80%	44%	80%	44%	28%	24%
	COP16	Sunt	APR17	3%	2%	2%	4%	3%	6%	4%	6%	4%	2%	13%	3%	43%	10%	59%	14%	78%	25%	11.5%	60%	11.5%	60%	37%	32%
	COP17	Sunt	APR18	13%	13%	11%	11%	11%	11%	11%	11%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%	49%	24%

	COP18	Sust	APR19	35%	48%	35 %	48 %	35 %	48 %	35 %	48 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	88%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Bicklequin	COP15	Sust	APR16	2%	2%	4%	5%	5%	7%	6%	7%	1%	1%	5%	1%	16 %	3%	21 %	4%	28 %	6%	43 %	15 %	41 %	15 %	13 %	8%	
	COP16	Sust	APR17	3%	2%	5%	5%	6%	7%	7%	7%	2%	1%	0%	1%	20 %	4%	27 %	6%	35 %	11 %	53 %	25 %	52 %	25 %	16 %	14%	
	COP17	Sust	APR18	9%	11%	9%	11 %	9%	11 %	9%	11 %	34 %	11 %	34 %	11 %	34 %	11 %	34 %	11 %	34 %	11 %	34 %	11 %	34 %	11 %	34 %	11%	
	COP18	Sust	APR19	35%	48%	35 %	48 %	35 %	48 %	35 %	48 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	88%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Bocanda	COP15	Sust	APR16	7%	8%	11 %	16 %	16 %	23 %	19 %	26 %	3%	2%	12 %	2%	39 %	10 %	53 %	13 %	70 %	23 %	10 %	55 %	10 %	55 %	33 %	20%	
	COP16	Sust	APR17	7%	5%	11 %	11 %	16 %	16 %	19 %	19 %	4%	2%	12 %	2%	41 %	10 %	56 %	14 %	74 %	25 %	10 %	58 %	10 %	58 %	35 %	33%	
	COP17	Sust	APR18	12%	16%	12 %	16 %	12 %	16 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28 %	60 %	28%	
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Bondoukou	COP15	Agg	APR16	10%	9%	17 %	20 %	24 %	28 %	29 %	32 %	5%	2%	17 %	3%	56 %	12 %	76 %	16 %	10 %	29 %	14 %	68 %	14 %	68 %	47 %	30%	
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	COP18	Agg	APR19	78%	108 %	78 %	10 %	78 %	10 %	78 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	100 %
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Bouaflé	COP15	Satur	APR16	12%	10%	20 %	20 %	28 %	29 %	33 %	33 %	4%	2%	14 %	3%	47 %	12 %	64 %	16 %	85 %	28 %	12 %	67 %	12 %	67 %	40 %	38%
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	COP17	Satur	APR18	164 %	161 %	16 %	16 %	16 %	16 %	16 %	16 %	58 %	42 %	58 %	42 %	58 %	42 %	58 %	42 %	58 %	42 %	58 %	42 %	58 %	42 %	58 %	42 %	42%
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Bouaké-Nord-Est	COP15	Agg	APR16	6%	4%	10 %	8%	14 %	11 %	17 %	13 %	4%	2%	12 %	2%	40 %	8%	58 %	11 %	72 %	20 %	10 %	48 %	10 %	48 %	34 %	26%
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Bouaké-Nord-Ouest	COP15	Satur	APR16	21%	20%	35 %	42 %	49 %	61 %	58 %	68 %	7%	4%	24 %	5%	78 %	23 %	10 %	29 %	14 %	51 %	20 %	12 %	20 %	12 %	66 %	64%
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	COP20	Satur	APR21	89%	86%	30 5%	28 1%	24 3%	22 4%	29 2%	27 0%	94 %	94 %	95 %	81 %	96 %	94 %	97 %	93 %	97 %	94 %	97 %	93 %	97 %	94 %	97 %	94%
Bouake-Sud	COP15	Satur	APR16	10%	7%	17 %	15 %	24 %	22 %	28 %	25 %	6%	3%	20 %	4%	67 %	16 %	92 %	22 %	12 %	38 %	17 %	91 %	17 %	91 %	56 %	49%
	COP16	Satur	APR17	13%	8%	22 %	18 %	31 %	25 %	36 %	29 %	7%	4%	25 %	4%	82 %	18 %	11 %	25 %	14 %	44 %	21 %	10 %	21 %	10 %	69 %	58%
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	COP18	Satur	APR19	83%	115 %	83 %	11 5%	83 %	11 5%	83 %	11 5%	85 %	97 %	85 %	97 %	85 %	97 %	85 %	97 %	85 %	97 %	85 %	97 %	85 %	97 %	85 %	97%
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Bouna	COP15	Sunt	APR16	5%	5%	8%	10 %	12 %	15 %	14 %	16 %	2%	1%	7%	2%	25 %	7%	34 %	10 %	44 %	17 %	65 %	40 %	65 %	40 %	21 %	23%
	COP16	Sunt	APR17	6%	5%	9%	10 %	13 %	15 %	15 %	17 %	3%	2%	9%	2%	30 %	9%	42 %	12 %	55 %	21 %	80 %	50 %	80 %	50 %	26 %	27%
	COP17	Sunt	APR18	14%	17%	14 %	17 %	14 %	17 %	14 %	17 %	37 %	20 %	37 %	20 %	37 %	20 %	37 %	20 %	37 %	20 %	37 %	20 %	37 %	20 %	37 %	20%
	COP18	Sunt	APR19	55%	80%	55 %	80 %	55 %	80 %	55 %	80 %	70 %	87 %	70 %	87 %	70 %	87 %	70 %	87 %	70 %	87 %	70 %	87 %	70 %	87 %	70 %	87%
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	COP18	Sunt	APR19	69%	89%	69 %	89 %	69 %	89 %	69 %	89 %	87 %	69 %	87 %	69 %	87 %	69 %	87 %	69 %	87 %	69 %	87 %	69 %	87 %	69 %	87 %	87%
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Cocody-Bingerville	COP15	Satur	APR16	34%	26%	56 %	55 %	78 %	79 %	92 %	89 %	8%	5%	27 %	5%	89 %	22 %	12 1%	31 %	16 0%	54 %	23 4%	12 8%	23 4%	12 8%	75 %	69%
	COP16	Satur	APR17	38%	29%	60 %	62 %	83 %	89 %	99 %	10 0%	10 %	6%	34 %	7%	11 2%	28 %	15 4%	39 %	20 3%	69 %	29 7%	16 4%	29 7%	16 4%	95 %	88%
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	COP18	Satur	APR19	109%	115%	10 9%	11 5%	10 9%	11 5%	10 9%	11 5%	88 %	90 %	88 %	90 %	88 %	90 %	88 %	90 %	88 %	90 %	88 %	90 %	88 %	90 %	88 %	90%
	COP19	Satur	APR20	384%	504%	34 9%	36 7%	13 0%	97 %	57 %	53 %	35 %	74 %	48 %	17 0%	92 %	26 7%	13 1%	27 5%	10 2%	10 1%	12 5%	95 %	80 %	66 %	52 %	44%
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Dabakala	COP15	Sunt	APR16	7%	5%	12 %	11 %	17 %	16 %	21 %	18 %	2%	1%	7%	1%	22 %	5%	30 %	7%	40 %	12 %	59 %	29 %	59 %	29 %	59 %	38%
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	COP18	Sunt	APR19	66%	54%	66 %	54 %	66 %	54 %	66 %	54 %	90 %	63 %	90 %	63 %	90 %	63 %	90 %	63 %	90 %	63 %	90 %	63 %	90 %	63 %	90 %	63%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Daboa	COP15	Satur	APR16	13%	9%	21 %	19 %	29 %	27 %	35 %	30 %	5%	3%	18 %	3%	60 %	14 %	82 %	19 %	10 0%	33 %	15 9%	78 %	15 9%	78 %	51 %	42%
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	COP17	Satur	APR18	109%	97%	10 9%	97 %	10 9%	97 %	10 9%	97 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	10 3%	44 %	44%
	COP18	Satur	APR19	85%	112%	85 %	11 2%	85 %	11 2%	85 %	11 2%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	10 4%	11 4%	114%
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	COP20	Satur	APR21	72%	75%	95 %	92 %	94 %	94 %	95 %	93 %	90 %	92 %	92 %	79 %	92 %	92 %	93 %	90 %	95 %	92 %	95 %	90 %	95 %	92 %	95 %	92%
Daloa	COP15	Satur	APR16	12%	7%	19 %	14 %	27 %	21 %	32 %	24 %	6%	4%	21 %	5%	68 %	19 %	93 %	25 %	12 3%	45 0%	18 7%	10 0%	18 7%	10 0%	58 %	57%
	COP16	Satur	APR17	10%	15%	31 %	31 %	44 %	45 %	52 %	50 %	9%	0%	32 %	7%	10 4%	28 %	14 3%	38 %	18 9%	68 %	27 6%	16 1%	27 6%	16 1%	88 %	86%
	COP17	Satur	APR18	155%	70%	15 5%	70 %	15 5%	70 %	15 5%	70 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	12 2%	64 %	64%
	COP18	Satur	APR19	89%	100%	89 %	10 6%	89 %	10 6%	89 %	10 6%	93 %	89 %	93 %	89 %	93 %	89 %	93 %	89 %	93 %	89 %	93 %	89 %	93 %	89 %	93 %	89%
	COP19	Satur	APR20	60%	82%	60 %	42 %	43 %	80 %	35 %	54 %	25 %	65 %	35 %	10 4%	57 %	13 8%	77 %	13 7%	87 %	14 2%	73 %	10 0%	70 %	98 %	29 %	77%
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Danana	COP15	Sunt	APR16	3%	3%	5%	7%	6%	10 %	8%	12 %	4%	2%	12 %	2%	41 %	10 %	56 %	13 %	74 %	24 %	10 8%	56 %	10 8%	56 %	35 %	30%

	COP16	Sust	APR17	5%	4%	8%	8%	11%	11%	11%	11%	4%	3%	15%	3%	50%	13%	69%	17%	91%	31%	13%	71%	13%	71%	42%	39%
	COP17	Sust	APR18	16%	25%	16%	25%	16%	25%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%	82%	37%
	COP18	Sust	APR19	35%	48%	35%	48%	35%	48%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%	75%	88%
	COP19	Satur	APR20	8%	14%	11%	8%	13%	10%	6%	19%	5%	33%	14%	32%	19%	41%	29%	41%	27%	51%	28%	84%	19%	71%	110	73%
	COP20	Satur	APR21	76%	86%	87%	88%	87%	87%	88%	89%	88%	91%	89%	78%	91%	91%	92%	90%	93%	91%	94%	89%	94%	91%	93%	92%
Daoukro	COP15	Sust	APR16	9%	6%	15%	13%	21%	19%	25%	23%	4%	3%	15%	3%	49%	12%	67%	17%	88%	30%	12%	71%	12%	71%	41%	38%
	COP16	Sust	APR17	7%	6%	13%	13%	16%	18%	18%	21%	5%	3%	16%	3%	52%	13%	72%	18%	95%	32%	13%	76%	13%	76%	44%	41%
	COP17	Sust	APR18	33%	22%	33%	22%	33%	22%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%	72%	35%
	COP18	Sust	APR19	61%	85%	61%	85%	61%	85%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	12%	10%	120 %
	COP19	Satur	APR20	50%	59%	70%	81%	65%	77%	51%	92%	19%	29%	28%	65%	16%	29%	30%	81%	54%	94%	70%	89%	88%	11%	13%	101 %
	COP20	Satur	APR21	87%	73%	92%	93%	92%	92%	92%	95%	90%	93%	91%	79%	93%	93%	94%	91%	94%	93%	95%	91%	95%	93%	95%	93%
Didievi	COP15	Sust	APR16	3%	3%	4%	7%	6%	10%	7%	12%	1%	1%	5%	1%	15%	5%	21%	7%	27%	12%	40%	28%	40%	28%	13%	15%
	COP16	Sust	APR17	2%	2%	4%	5%	5%	7%	6%	8%	2%	1%	6%	1%	20%	5%	28%	7%	38%	12%	53%	29%	53%	29%	17%	15%
	COP17	Sust	APR18	13%	20%	13%	20%	13%	20%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%	27%	16%
	COP18	Sust	APR19	30%	42%	30%	42%	30%	42%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%	63%	75%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Dimbokro	COP15	Sust	APR16	15%	12%	25%	25%	34%	37%	40%	41%	7%	4%	26%	5%	84%	19%	11%	25%	15%	45%	22%	10%	22%	10%	71%	57%
	COP16	Sust	APR17	15%	9%	25%	19%	35%	27%	41%	30%	8%	4%	28%	5%	92%	19%	12%	26%	16%	47%	24%	11%	24%	11%	78%	59%
	COP17	Sust	APR18	46%	40%	46%	40%	46%	40%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%	92%	39%
	COP18	Sust	APR19	65%	90%	65%	90%	65%	90%	85%	10%	85%	10%	85%	10%	85%	10%	85%	10%	85%	10%	85%	10%	85%	10%	85%	101 %
	COP19	Satur	APR20	40%	42%	79%	31%	76%	75%	76%	10%	31%	41%	30%	74%	46%	13%	37%	12%	81%	15%	88%	15%	93%	17%	13%	110 %

	COP20	Satur	AFR21	70%	71%	92%	94%	95%	94%	98%	97%	89%	93%	92%	79%	98%	93%	94%	91%	95%	93%	96%	91%	96%	93%	95%	93%
Divo	COP15	Agg	AFR16	8%	8%	13%	17%	18%	24%	21%	27%	3%	2%	12%	3%	39%	13%	53%	14%	70%	26%	10%	60%	10%	60%	33%	32%
	COP16	Agg	AFR17	10%	9%	17%	18%	23%	26%	27%	29%	4%	3%	15%	3%	49%	13%	67%	18%	89%	32%	13%	76%	13%	76%	41%	41%
	COP17	Agg	AFR18	10%	33%	19%	31%	19%	31%	19%	31%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%	65%	33%
	COP18	Agg	AFR19	70%	105%	79%	10%	79%	10%	79%	10%	99%	11%	99%	11%	99%	11%	99%	11%	99%	11%	99%	11%	99%	11%	99%	112%
	COP19	Satur	AFR20	67%	80%	52%	52%	29%	33%	22%	21%	16%	23%	7%	42%	28%	64%	28%	76%	42%	80%	61%	66%	58%	53%	45%	45%
	COP20	Satur	AFR21	85%	78%	94%	94%	93%	93%	94%	96%	95%	95%	94%	81%	95%	95%	96%	94%	97%	95%	97%	94%	96%	95%	97%	95%
Duekoue	COP15	Agg	AFR16	3%	3%	5%	0%	8%	9%	9%	10%	2%	2%	7%	2%	22%	9%	30%	12%	39%	21%	57%	50%	57%	50%	18%	27%
	COP16	Agg	AFR17	4%	4%	10%	8%	14%	11%	16%	13%	3%	2%	10%	3%	32%	12%	44%	16%	58%	29%	85%	69%	85%	69%	27%	37%
	COP17	Agg	AFR18	20%	34%	26%	34%	26%	34%	26%	34%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%	48%	37%
	COP18	Agg	AFR19	78%	107%	78%	10%	78%	10%	78%	10%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%	85%	99%
	COP19	Satur	AFR20	5%	5%	0%	11%	15%	21%	9%	8%	11%	20%	7%	30%	18%	27%	18%	35%	20%	38%	29%	39%	28%	45%	15%	44%
	COP20	Satur	AFR21	80%	78%	93%	92%	92%	93%	95%	94%	93%	94%	94%	79%	95%	93%	95%	92%	96%	94%	97%	92%	97%	93%	96%	94%
Ferkessedougou	COP15	Sunt	AFR16	8%	8%	13%	17%	18%	25%	22%	28%	5%	5%	17%	5%	56%	22%	78%	31%	10%	54%	14%	12%	14%	12%	47%	69%
	COP16	Sunt	AFR17	13%	9%	21%	19%	29%	28%	34%	31%	6%	5%	22%	6%	72%	28%	98%	35%	13%	61%	18%	14%	18%	14%	61%	70%
	COP17	Sunt	AFR18	10%	33%	19%	31%	19%	31%	19%	31%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%	69%	47%
	COP18	Sunt	AFR19	60%	89%	60%	89%	60%	89%	60%	89%	10%	13%	10%	13%	10%	13%	10%	13%	10%	13%	10%	13%	10%	13%	10%	132%
	COP19	Satur	AFR20	10%	29%	33%	41%	50%	40%	50%	25%	23%	38%	18%	87%	53%	13%	61%	10%	67%	21%	62%	55%	78%	89%	34%	53%
	COP20	Satur	AFR21	88%	93%	89%	88%	89%	90%	91%	92%	88%	92%	90%	78%	92%	90%	92%	90%	93%	91%	94%	89%	94%	91%	94%	93%
Presco	COP15	Sunt	AFR16	7%	6%	12%	13%	17%	19%	20%	21%	3%	2%	10%	3%	38%	12%	45%	16%	59%	28%	87%	67%	87%	67%	28%	38%
	COP16	Sunt	AFR17	7%	7%	12%	15%	17%	22%	20%	25%	3%	3%	11%	3%	38%	12%	50%	17%	65%	30%	98%	70%	98%	70%	31%	38%
	COP17	Sunt	AFR18	10%	12%	16%	12%	16%	12%	16%	12%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%	35%	26%

	COP18	Sust	APR20	63%	83%	63 %	83 %	63 %	83 %	63 %	83 %	82 %	93 %	82 %	93 %	82 %	93 %	82 %	93 %	82 %	93 %	82 %	93 %	82 %	93 %	82 %	93 %	93%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Gagnoa	COP15	Satur	APR16	11%	9%	21 %	19 %	30 %	28 %	35 %	31 %	5%	3%	16 %	4%	52 %	14 %	71 %	20 %	94 %	35 %	13 8%	83 %	13 8%	83 %	44 %	44%
	COP16	Satur	APR17	18%	14%	30 %	29 %	42 %	42 %	50 %	48 %	7%	5%	24 %	6%	80 %	21 %	11 0%	32 %	14 5%	56 %	23 2%	13 3%	23 2%	13 3%	68 %	71%
	COP17	Satur	APR18	98%	110 %	98 %	11 0%	98 %	11 0%	98 %	11 0%	10 3%	55 %	10 3%	55 %	10 3%	55 %	10 3%	55 %	10 3%	55 %	10 3%	55 %	10 3%	55 %	10 3%	55 %	55%
	COP18	Satur	APR19	89%	106 %	89 %	10 6%	89 %	10 6%	89 %	10 6%	98 %	95 %	98 %	95 %	98 %	95 %	98 %	95 %	98 %	95 %	98 %	95 %	98 %	95 %	98 %	95 %	95%
	COP19	Satur	APR20	43%	28%	34 %	36 %	37 %	37 %	25 %	24 %	15 %	20 %	18 %	50 %	35 %	75 %	40 %	90 %	50 %	88 %	49 %	68 %	55 %	69 %	26 %	57%
	COP20	Satur	APR21	82%	83%	96 %	96 %	96 %	96 %	97 %	96 %	91 %	92 %	92 %	78 %	93 %	92 %	94 %	91 %	95 %	92 %	95 %	90 %	96 %	92 %	95 %	92%
Grand-Lahou	COP15	Sust	APR16	5%	7%	8%	14 %	11 %	21 %	13 %	21 %	3%	2%	9%	2%	20 %	9%	40 %	13 %	53 %	23 %	78 %	54 %	78 %	54 %	25 %	20%
	COP16	Sust	APR17	9%	8%	15 %	17 %	21 %	24 %	24 %	27 %	4%	3%	13 %	3%	42 %	12 %	57 %	27 %	75 %	30 %	11 0%	71 %	11 0%	71 %	35 %	38%
	COP17	Sust	APR18	16%	28%	16 %	28 %	16 %	28 %	16 %	28 %	44 %	27 %	44 %	27 %	44 %	27 %	44 %	27 %	44 %	27 %	44 %	27 %	44 %	27 %	44 %	27 %	27%
	COP18	Sust	APR19	57%	76%	57 %	76 %	57 %	76 %	57 %	76 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	88%
	COP19	Satur	APR20	93%	111 %	23 %	40 %	50 %	19 %	25 %	18 %	15 %	24 %	9%	31 %	9%	36 %	27 %	51 %	36 %	67 %	58 %	64 %	51 %	51 %	50 %	51%
	COP20	Satur	APR21	69%	77%	89 %	91 %	90 %	91 %	94 %	93 %	88 %	92 %	89 %	77 %	90 %	91 %	92 %	90 %	93 %	92 %	94 %	89 %	94 %	91 %	93 %	93%
Gueyo	COP15	Sust	APR16	6%	3%	10 %	7%	14 %	10 %	16 %	11 %	1%	1%	5%	1%	16 %	4%	22 %	5%	29 %	9%	43 %	20 %	43 %	20 %	14 %	11%
	COP16	Sust	APR17	6%	4%	9%	9%	13 %	13 %	15 %	14 %	2%	1%	6%	1%	18 %	4%	25 %	6%	33 %	11 %	49 %	25 %	49 %	25 %	16 %	13%
	COP17	Sust	APR18	5%	5%	5%	5%	5%	5%	5%	5%	30 %	12 %	30 %	12 %	30 %	12 %	30 %	12 %	30 %	12 %	30 %	12 %	30 %	12 %	30 %	12 %	12%
	COP18	Sust	APR19	39%	41%	39 %	41 %	39 %	41 %	39 %	41 %	54 %	48 %	54 %	48 %	54 %	48 %	54 %	48 %	54 %	48 %	54 %	48 %	54 %	48 %	54 %	48 %	48%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Guiglo	COP15	Agri	APR16	5%	4%	8%	9%	11 %	12 %	13 %	14 %	3%	2%	11 %	3%	36 %	11 %	50 %	15 %	66 %	27 %	96 %	64 %	96 %	64 %	31 %	34%

	COP16	Agg	APR17	6%	4%	10 %	9%	14 %	13 %	16 %	15 %	3%	2%	11 %	3%	37 %	12 %	51 %	16 %	67 %	28 %	99 %	67 %	99 %	67 %	32 %	38%
	COP17	Agg	APR18	35%	29%	35 %	29 %	35 %	29 %	35 %	29 %	57 %	33 %	57 %	33 %	57 %	33 %	57 %	33 %	57 %	33 %	57 %	33 %	57 %	33 %	57 %	33%
	COP18	Agg	APR19	78%	107 %	78 %	10 7%	78 %	10 7%	78 %	10 7%	85 %	99 %	85 %	99 %	85 %	99 %	85 %	99 %	85 %	99 %	85 %	99 %	85 %	99 %	85 %	99%
	COP19	Satur	APR20	4%	4%	17 %	14 %	16 %	17 %	23 %	20 %	4%	21 %	15 %	30 %	25 %	46 %	30 %	66 %	24 %	61 %	41 %	61 %	37 %	52 %	24 %	85%
	COP20	Satur	APR21	74%	73%	87 %	87 %	87 %	86 %	87 %	89 %	85 %	89 %	86 %	77 %	87 %	89 %	89 %	87 %	90 %	89 %	91 %	87 %	91 %	89 %	90 %	89%
Gulfoy	COP15		APR16																								
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	COP17		APR18																								
	COP18	Agg	APR19	70%	105 %	70 %	10 5%	70 %	10 5%	70 %	10 5%	75 %	85 %	75 %	85 %	75 %	85 %	75 %	85 %	75 %	85 %	75 %	85 %	75 %	85 %	75 %	85%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Isola	COP15	Satur	APR16	7%	7%	12 %	16 %	16 %	23 %	19 %	26 %	5%	3%	16 %	3%	52 %	14 %	72 %	19 %	93 %	34 %	13 8%	81 %	13 8%	81 %	44 %	43%
	COP16	Satur	APR17	14%	10%	23 %	21 %	33 %	31 %	39 %	35 %	7%	4%	24 %	5%	80 %	21 %	10 9%	28 %	14 5%	50 %	21 1%	11 9%	21 1%	11 9%	68 %	64%
	COP17	Satur	APR18	95%	123 %	95 %	12 3%	95 %	12 3%	95 %	12 3%	97 %	52 %	97 %	52 %	97 %	52 %	97 %	52 %	97 %	52 %	97 %	52 %	97 %	52 %	97 %	52%
	COP18	Satur	APR19	103 %	132 %	10 3%	13 2%	10 3%	13 2%	10 3%	13 2%	11 3%	12 0%	11 3%	12 0%	11 3%	12 0%	11 3%	12 0%	11 3%	12 0%	11 3%	12 0%	11 3%	12 0%	11 3%	120 %
	COP19	Satur	APR20	82%	86%	30 %	36 %	66 %	48 %	16 %	32 %	36 %	40 %	27 %	94 %	43 %	11 5%	62 %	13 7%	83 %	12 8%	72 %	10 8%	83 %	10 5%	38 %	75%
	COP20	Satur	APR21	83%	83%	88 %	89 %	88 %	89 %	89 %	89 %	90 %	92 %	91 %	78 %	92 %	92 %	93 %	91 %	95 %	92 %	95 %	90 %	95 %	92 %	95 %	93%
Jacquevill e	COP15	Sust	APR16	7%	4%	11 %	8%	16 %	12 %	19 %	13 %	2%	1%	6%	1%	20 %	5%	27 %	7%	36 %	12 %	53 %	29 %	53 %	29 %	17 %	16%
	COP16	Sust	APR17	10%	6%	16 %	12 %	22 %	17 %	26 %	19 %	3%	2%	10 %	2%	33 %	9%	45 %	13 %	60 %	23 %	88 %	54 %	88 %	54 %	28 %	29%
	COP17	Sust	APR18	20%	11%	20 %	11 %	20 %	11 %	20 %	11 %	32 %	16 %	32 %	16 %	32 %	16 %	32 %	16 %	32 %	16 %	32 %	16 %	32 %	16 %	32 %	16%
	COP18	Sust	APR19	57%	78%	57 %	78 %	57 %	78 %	57 %	78 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88 %	77 %	88%
	COP19	Satur	APR20	24%	25%	12 %	12 %	45 %	26 %	24 %	20 %	4%	15 %	5%	30 %	13 %	41 %	22 %	48 %	34 %	56 %	45 %	55 %	37 %	39 %	41 %	47%
	COP20	Satur	APR21	67%	70%	94 %	86 %	92 %	88 %	92 %	95 %	92 %	93 %	95 %	80 %	94 %	93 %	93 %	90 %	96 %	92 %	97 %	90 %	96 %	93 %	95 %	92%

Katiola	COP15	Sunt	APR16	12%	6%	20 %	12 %	28 %	18 %	33 %	20 %	4%	2%	12 %	2%	40 %	8%	55 %	11 %	73 %	20 %	10 7%	47 %	10 7%	47 %	34 %	25%
	COP16	Sunt	APR17	14%	7%	23 %	15 %	32 %	21 %	38 %	24 %	4%	2%	15 %	3%	48 %	11 %	65 %	14 %	87 %	26 %	12 7%	61 %	12 7%	61 %	40 %	32%
	COP17	Sunt	APR18	23%	17%	23 %	17 %	23 %	17 %	23 %	17 %	49 %	19 %	49 %	19 %	49 %	19 %	49 %	19 %	49 %	19 %	49 %	19 %	49 %	19 %	49 %	19%
	COP18	Sunt	APR19	72%	59%	72 %	59 %	72 %	59 %	72 %	59 %	83 %	59 %	83 %	59 %	83 %	59 %	83 %	59 %	83 %	59 %	83 %	59 %	83 %	59 %	83 %	59%
	COP19	Satur	APR20	117 %	126 %	68 %	57 %	92 %	64 %	63 %	18 1%	44 %	55 %	25 %	66 %	34 %	58 %	82 %	59 %	38 %	85 %	73 %	12 6%	73 %	19 5%	26 %	103 %
	COP20	Satur	APR21	78%	84%	93 %	89 %	90 %	91 %	91 %	95 %	91 %	93 %	90 %	79 %	93 %	92 %	94 %	91 %	95 %	93 %	95 %	91 %	95 %	92 %	95 %	93%
Korhogo	COP15	Satur	APR16	18%	10%	23 %	22 %	30 %	32 %	35 %	35 %	6%	4%	22 %	4%	71 %	18 %	10 0%	24 %	13 2%	43 %	19 2%	10 3%	19 2%	10 3%	61 %	55%
	COP16	Satur	APR17	10%	13%	26 %	27 %	36 %	40 %	43 %	45 %	8%	5%	27 %	5%	89 %	22 %	12 2%	30 %	16 1%	56 %	23 6%	12 8%	23 6%	12 8%	75 %	68%
	COP17	Satur	APR18	120 %	111 %	12 6%	11 1%	12 6%	11 1%	12 6%	11 1%	12 2%	58 %	12 2%	58 %	12 2%	58 %	12 2%	58 %	12 2%	58 %	12 2%	58 %	12 2%	58 %	12 2%	58%
	COP18	Satur	APR19	89%	101 %	89 %	13 1%	89 %	13 1%	89 %	13 1%	13 6%	14 1%	13 6%	14 1%	13 6%	14 1%	13 6%	14 1%	13 6%	14 1%	13 6%	14 1%	13 6%	14 1%	13 6%	141 %
Korhogo 1	COP19	Satur	APR20	132 %	113 %	10 5%	10 8%	78 %	86 %	83 %	71 %	61 %	11 6%	44 %	28 3%	19 7%	30 6%	18 6%	28 6%	15 9%	20 9%	13 8%	12 3%	11 4%	97 %	40 %	70%
	COP20	Satur	APR21	82%	82%	94 %	94 %	94 %	94 %	96 %	95 %					94 %		95 %		95 %	92 %	96 %	90 %	96 %	92 %	95 %	
Kouibly	COP15	Sunt	APR16	2%	1%	3%	2%	5%	3%	5%	4%	2%	1%	6%	1%	10 %	5%	26 %	7%	34 %	12 %	50 %	28 %	50 %	28 %	10 %	15%
	COP16	Sunt	APR17	3%	2%	5%	5%	7%	7%	8%	8%	2%	1%	8%	2%	25 %	7%	34 %	9%	45 %	17 %	66 %	40 %	66 %	40 %	21 %	21%
	COP17	Sunt	APR18	8%	6%	8%	6%	8%	6%	8%	6%	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18 %	18%
	COP18	Sunt	APR19	35%	48%	35 %	48 %	35 %	48 %	35 %	48 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94 %	81 %	94%
	COP19	Satur	APR20	8%	9%	6%	6%	19 %	11 %	12 %	12 %	3%	13 %	2%	14 %	6%	26 %	17 %	31 %	24 %	40 %	30 %	40 %	30 %	51 %	21 %	68%
	COP20	Satur	APR21	95%	76%	84 %	87 %	87 %	87 %	87 %	85 %	87 %	91 %	88 %	78 %	89 %	91 %	91 %	88 %	92 %	91 %	91 %	89 %	94 %	90 %	93 %	91%
Koumassi-Port Bouet-Vridi	COP15	Agg	APR16	13%	7%	18 %	15 %	25 %	22 %	29 %	24 %	5%	3%	18 %	3%	60 %	12 %	82 %	17 %	50 9%	30 %	15 9%	71 %	15 9%	71 %	51 %	38%
	COP16	Agg	APR17	12%	9%	23 %	20 %	29 %	28 %	34 %	32 %	7%	3%	23 %	4%	74 %	16 %	10 2%	22 %	13 5%	39 %	19 7%	91 %	19 7%	91 %	63 %	49%
	COP17	Agg	APR18	48%	38%	48 %	38 %	48 %	38 %	48 %	38 %	10 4%	46 %	10 4%	46 %	10 4%	46 %	10 4%	46 %	10 4%	46 %	10 4%	46 %	10 4%	46 %	10 4%	46%
	COP18	Agg	APR19	82%	101 %	82 %	10 1%	82 %	10 1%	82 %	10 1%	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82 %	77 %	82%

	COP19	Satur	AFR20	135%	98%	18 4%	24 5%	11 4%	15 5%	86 %	10 5%	43 %	57 %	47 %	11 6%	48 %	22 4%	91 %	28 9%	12 1%	22 7%	18 4%	24 4%	10 2%	10 3%	68 %	82%
	COP20	Satur	AFR21	83%	80%	93 %	93 %	93 %	93 %	94 %	94 %	90 %	92 %	90 %	78 %	93 %	92 %	93 %	90 %	94 %	92 %	94 %	90 %	95 %	92 %	94 %	92%
Lakota	COP15	Sust	AFR16	13%	9%	18 %	20 %	25 %	28 %	29 %	32 %	4%	3%	14 %	3%	46 %	14 %	62 %	19 %	82 %	35 %	12 1%	82 %	12 1%	82 %	39 %	44%
	COP16	Sust	AFR17	14%	11%	24 %	22 %	33 %	32 %	39 %	36 %	5%	4%	37 %	5%	57 %	18 %	78 %	25 %	10 3%	45 %	15 0%	10 6%	15 0%	10 6%	48 %	57%
	COP17	Sust	AFR18	21%	20%	21 %	26 %	21 %	26 %	21 %	26 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37 %	61 %	37%
	COP18	Sust	AFR19	83%	83%	83 %	83 %	83 %	83 %	83 %	83 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81 %	72 %	81%
	COP19	Not Supp	AFR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	AFR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Man	COP15	Satur	AFR16	7%	4%	12 %	9%	16 %	13 %	19 %	14 %	5%	3%	16 %	3%	52 %	14 %	71 %	19 %	94 %	33 %	13 7%	79 %	13 7%	79 %	44 %	42%
	COP16	Satur	AFR17	9%	6%	15 %	11 %	21 %	18 %	25 %	21 %	6%	4%	21 %	5%	70 %	20 %	97 %	27 %	12 7%	48 %	18 7%	11 5%	18 7%	11 5%	60 %	62%
	COP17	Satur	AFR18	140 %	73%	14 9%	73 %	14 9%	73 %	14 9%	73 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51 %	97 %	51%
	COP18	Satur	AFR19	84%	114 %	84 %	11 4%	84 %	11 4%	84 %	11 4%	10 3%	11 5%	10 3%	11 5%	10 3%	11 5%	10 3%	11 5%	10 3%	11 5%	10 3%	11 5%	10 3%	11 5%	10 3%	115 %
	COP19	Satur	AFR20	6%	5%	5%	14 %	12 %	18 %	16 %	12 %	9%	17 %	7%	31 %	15 %	30 %	21 %	41 %	28 %	46 %	33 %	47 %	31 %	58 %	18 %	70%
	COP20	Satur	AFR21	80%	82%	88 %	87 %	88 %	88 %	89 %	88 %	91 %	92 %	92 %	78 %	93 %	92 %	94 %	90 %	95 %	92 %	96 %	90 %	96 %	92 %	95 %	92%
Mankono	COP15	Agg	AFR16	6%	6%	11 %	13 %	15 %	19 %	17 %	21 %	2%	1%	7%	2%	24 %	7%	33 %	10 %	44 %	17 %	64 %	40 %	64 %	40 %	20 %	22%
	COP16	Agg	AFR17	8%	7%	13 %	14 %	18 %	20 %	21 %	22 %	3%	2%	11 %	3%	38 %	11 %	52 %	15 %	68 %	27 %	10 0%	61 %	10 0%	61 %	32 %	34%
	COP17	Agg	AFR18	33%	27%	33 %	27 %	33 %	27 %	33 %	27 %	59 %	34 %	59 %	34 %	59 %	34 %	59 %	34 %	59 %	34 %	59 %	34 %	59 %	34 %	59 %	34%
	COP18	Agg	AFR19	85%	98%	85 %	98 %	85 %	98 %	85 %	98 %	86 %	83 %	86 %	83 %	86 %	83 %	86 %	83 %	86 %	83 %	86 %	83 %	86 %	83 %	86 %	83%
	COP19	Satur	AFR20	8%	12%	20 %	24 %	14 %	18 %	23 %	16 %	7%	25 %	7%	61 %	41 %	75 %	45 %	10 0%	58 %	99 %	54 %	68 %	67 %	64 %	29 %	47%
	COP20	Satur	AFR21	83%	79%	90 %	89 %	90 %	90 %	91 %	92 %	88 %	91 %	89 %	78 %	90 %	90 %	92 %	89 %	93 %	91 %	94 %	88 %	94 %	90 %	93 %	91%
M'bahiakro	COP15	Sust	AFR16	4%	0%	7%	0%	10 %	0%	12 %	0%	2%	1%	6%	1%	20 %	6%	28 %	8%	37 %	14 %	54 %	34 %	54 %	34 %	17 %	18%
	COP16	Sust	AFR17	4%	3%	7%	5%	10 %	7%	11 %	8%	2%	2%	7%	2%	24 %	7%	33 %	10 %	43 %	18 %	68 %	42 %	68 %	42 %	20 %	23%

	COP17	Sust	APR18	18%	15%	18 %	15 %	18 %	15 %	18 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15 %	27 %	15%
	COP18	Sust	APR19	52%	72%	52 %	72 %	52 %	72 %	52 %	72 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Miriigwan	COP15	Sust	APR16	1%	1%	2%	3%	2%	4%	3%	5%	1%	1%	3%	1%	11 %	3%	16 %	4%	21 %	7%	30 %	18 %	30 %	18 %	30 %	18 %	30 %	9%
	COP16	Sust	APR17	2%	4%	3%	8%	4%	11 %	5%	12 %	2%	1%	5%	2%	18 %	7%	24 %	9%	32 %	16 %	46 %	38 %	46 %	38 %	46 %	38 %	15 %	20%
	COP17	Sust	APR18	0%	0%	0%	0%	0%	0%	0%	0%	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11 %	21 %	11%
	COP18	Sust	APR19	71%	80%	71 %	80 %	71 %	80 %	71 %	80 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73 %	76 %	73%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nauulan	COP15	Sust	APR16	0%	3%	0%	7%	0%	10 %	0%	13 %	3%	2%	9%	2%	28 %	7%	39 %	10 %	51 %	18 %	75 %	42 %	75 %	42 %	75 %	42 %	24 %	23%
	COP16	Sust	APR17	5%	4%	9%	9%	12 %	13 %	15 %	14 %	3%	1%	11 %	2%	34 %	7%	50 %	9%	66 %	16 %	96 %	38 %	96 %	38 %	31 %	38 %	31 %	21%
	COP17	Sust	APR18	33%	6%	33 %	6%	33 %	6%	33 %	6%	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22 %	43 %	22%
	COP18	Sust	APR19	52%	75%	52 %	75 %	52 %	75 %	52 %	75 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	11 %	91 %	112 %
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Nlakaram adougou	COP15	Sust	APR16	8%	5%	13 %	10 %	18 %	15 %	21 %	17 %	2%	1%	7%	1%	22 %	6%	30 %	8%	40 %	14 %	59 %	33 %	59 %	33 %	19 %	33 %	19 %	18%
	COP16	Sust	APR17	7%	6%	12 %	13 %	17 %	19 %	20 %	21 %	2%	1%	8%	1%	26 %	6%	36 %	8%	47 %	14 %	69 %	34 %	69 %	34 %	22 %	34 %	22 %	18%
	COP17	Sust	APR18	32%	25%	32 %	25 %	32 %	25 %	32 %	25 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14 %	28 %	14%
	COP18	Sust	APR19	44%	36%	44 %	36 %	44 %	36 %	44 %	36 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51 %	73 %	51%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%

Odienne	COP15	Sunt	APR16	9%	9%	15 %	20 %	21 %	28 %	25 %	32 %	3%	2%	0%	2%	29 %	8%	40 %	11 %	53 %	19 %	78 %	45 %	78 %	45 %	25 %	24%
	COP16	Sunt	APR17	13%	10%	21 %	22 %	29 %	31 %	35 %	35 %	4%	2%	13 %	3%	44 %	11 %	60 %	15 %	79 %	26 %	11 5%	61 %	11 5%	61 %	37 %	33%
	COP17	Sunt	APR18	17%	20%	17 %	20 %	17 %	20 %	17 %	20 %	57 %	28 %	57 %	28 %	57 %	28 %	57 %	28 %	57 %	28 %	57 %	28 %	57 %	28 %	57 %	28%
	COP18	Sunt	APR19	47%	53%	47 %	53 %	47 %	53 %	47 %	53 %	73 %	70 %	73 %	70 %	73 %	70 %	73 %	70 %	73 %	70 %	73 %	70 %	73 %	70 %	73 %	70%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Ouangolo dougou	COP15	Sunt	APR16	5%	9%	9%	19 %	12 %	27 %	15 %	30 %	3%	3%	12 %	3%	39 %	13 %	54 %	18 %	71 %	32 %	10 4%	75 %	10 4%	75 %	33 %	40%
	COP16	Sunt	APR17	9%	9%	16 %	19 %	22 %	28 %	26 %	32 %	5%	3%	15 %	4%	51 %	16 %	70 %	22 %	92 %	39 %	13 5%	93 %	13 5%	93 %	43 %	50%
	COP17	Sunt	APR18	8%	10%	8%	19 %	8%	19 %	8%	19 %	43 %	27 %	43 %	27 %	43 %	27 %	43 %	27 %	43 %	27 %	43 %	27 %	43 %	27 %	43 %	27%
	COP18	Sunt	APR19	60%	80%	60 %	80 %	60 %	80 %	60 %	80 %	70 %	10 0%	70 %	10 0%	70 %	10 0%	70 %	10 0%	70 %	10 0%	70 %	10 0%	70 %	10 0%	70 %	100 %
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Oume	COP15	Agg	APR16	5%	4%	9%	9%	12 %	13 %	15 %	14 %	3%	2%	10 %	3%	34 %	11 %	47 %	14 %	62 %	26 %	90 %	60 %	90 %	60 %	29 %	32%
	COP16	Agg	APR17	8%	7%	13 %	14 %	17 %	21 %	21 %	23 %	4%	3%	15 %	3%	51 %	13 %	70 %	18 %	92 %	32 %	13 4%	76 %	13 4%	76 %	43 %	43%
	COP17	Agg	APR18	34%	28%	34 %	26 %	34 %	26 %	34 %	26 %	75 %	43 %	75 %	43 %	75 %	43 %	75 %	43 %	75 %	43 %	75 %	43 %	75 %	43 %	75 %	43%
	COP18	Agg	APR19	80%	104 %	80 %	10 4%	80 %	10 4%	80 %	10 4%	86 %	95 %	86 %	95 %	86 %	95 %	86 %	95 %	86 %	95 %	86 %	95 %	86 %	95 %	86 %	95%
	COP19	Satur	APR20	83%	70%	50 %	48 %	20 %	48 %	29 %	58 %	19 %	58 %	12 %	85 %	15 %	96 %	34 %	11 3%	61 %	86 %	53 %	68 %	60 %	66 %	27 %	59%
	COP20	Satur	APR21	83%	75%	92 %	92 %	92 %	92 %	93 %	93 %	90 %	91 %	90 %	78 %	92 %	91 %	93 %	90 %	94 %	91 %	94 %	89 %	94 %	91 %	94 %	92%
Prikro	COP15	Sunt	APR16	5%	4%	8%	9%	11 %	14 %	13 %	15 %	3%	2%	12 %	2%	39 %	10 %	53 %	14 %	70 %	25 %	10 2%	58 %	10 2%	58 %	33 %	31%
	COP16	Sunt	APR17	6%	8%	11 %	17 %	15 %	25 %	18 %	28 %	4%	2%	15 %	3%	49 %	11 %	67 %	15 %	88 %	26 %	12 8%	62 %	12 8%	62 %	41 %	33%
	COP17	Sunt	APR18	14%	23%	14 %	23 %	14 %	23 %	14 %	23 %	71 %	36 %	71 %	36 %	71 %	36 %	71 %	36 %	71 %	36 %	71 %	36 %	71 %	36 %	71 %	36%
	COP18	Sunt	APR19	52%	72%	52 %	72 %	52 %	72 %	52 %	72 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79 %	66 %	79%

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	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Sakassou	COP15	Sust	APR16	14%	12%	21 %	25 %	32 %	36 %	37 %	41 %	4%	3%	13 %	3%	44 %	13 %	60 %	17 %	79 %	31 %	11 6%	72 %	11 6%	72 %	37 %	39%	
	COP16	Sust	APR17	16%	16%	16 %	13 %	27 %	28 %	38 %	43 %	45 %	46 %	6%	3%	20 %	4%	65 %	16 %	89 %	22 %	11 7%	38 %	17 1%	93 %	55 %	49%	
	COP17	Sust	APR18	69%	69%	69 %	58 %	69 %	58 %	69 %	58 %	69 %	58 %	96 %	46 %	96 %	46 %	96 %	46 %	96 %	46 %	96 %	46 %	96 %	46 %	96 %	46%	
	COP18	Sust	APR19	52%	52%	52 %	11 2%	52 %	11 2%	52 %	11 2%	52 %	11 2%	5%	11 %	5%	11 %	5%	11 %	5%	11 %	5%	11 %	5%	11 %	5%	11%	
	COP19	Satur	APR20	217 %	114 %	14 9%	43 %	77 %	51 %	92 %	11 3%	59 %	53 %	33 %	76 %	20 %	12 7%	54 %	14 4%	80 %	13 4%	10 1%	13 9%	13 5%	15 6%	14 6%	258 %	
	COP20	Satur	APR21	75%	78%	93 %	90 %	90 %	92 %	97 %	90 %	90 %	94 %	90 %	79 %	93 %	92 %	93 %	92 %	95 %	93 %	96 %	91 %	95 %	93 %	95 %	93%	
San-Pedro	COP15	Satur	APR16	8%	7%	14 %	14 %	19 %	20 %	23 %	23 %	4%	3%	15 %	4%	49 %	15 %	67 %	20 %	88 %	36 %	12 9%	85 %	12 9%	85 %	41 %	46%	
	COP16	Satur	APR17	10%	8%	16 %	16 %	22 %	23 %	27 %	26 %	6%	4%	19 %	5%	64 %	18 %	87 %	25 %	11 5%	45 %	16 8%	10 6%	16 8%	10 6%	54 %	57%	
	COP17	Satur	APR18	28%	28%	28 %	29 %	28 %	29 %	28 %	29 %	66 %	38 %	66 %	38 %	66 %	38 %	66 %	38 %	66 %	38 %	66 %	38 %	66 %	38 %	66 %	38%	
	COP18	Satur	APR19	14%	14%	14 %	15 %	14 %	15 %	14 %	15 %	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	1%	
	COP19	Satur	APR20	37%	50%	39 %	41 %	50 %	58 %	38 %	40 %	23 %	44 %	18 %	49 %	51 %	12 1%	49 %	12 1%	64 %	12 8%	77 %	10 4%	83 %	87 %	94 %	79%	
	COP20	Satur	APR21	83%	82%	93 %	90 %	90 %	90 %	93 %	93 %	92 %	93 %	92 %	79 %	94 %	93 %	95 %	92 %	95 %	93 %	96 %	93 %	96 %	93 %	95 %	93%	
Sassandra	COP15	Agg	APR16	6%	4%	9%	8%	11 %	12 %	16 %	18 %	2%	2%	8%	2%	28 %	10 %	38 %	11 %	50 %	23 %	73 %	55 %	73 %	55 %	23 %	30%	
	COP16	Agg	APR17	7%	6%	12 %	12 %	17 %	17 %	20 %	19 %	3%	2%	12 %	3%	39 %	11 %	54 %	15 %	71 %	26 %	10 4%	62 %	10 4%	62 %	33 %	33%	
	COP17	Agg	APR18	21%	21%	21 %	21 %	21 %	21 %	21 %	21 %	45 %	29 %	45 %	29 %	45 %	29 %	45 %	29 %	45 %	29 %	45 %	29 %	45 %	29 %	45 %	29%	
	COP18	Agg	APR19	88%	92%	88 %	92 %	88 %	92 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69 %	78 %	69%	
	COP19	Satur	APR20	62%	66%	94 %	76 %	41 %	74 %	42 %	41 %	17 %	58 %	20 %	59 %	36 %	90 %	54 %	11 5%	89 %	12 1%	10 4%	10 4%	10 3%	98 %	97 %	111 %	
	COP20	Satur	APR21	80%	70%	92 %	94 %	92 %	92 %	92 %	95 %	92 %	93 %	92 %	79 %	94 %	93 %	94 %	93 %	96 %	93 %	96 %	93 %	96 %	92 %	96 %	93%	
uguela	COP15	Sust	APR16	3%	4%	4%	8%	6%	11 %	7%	12 %	2%	1%	8%	2%	26 %	7%	38 %	10 %	47 %	18 %	69 %	42 %	69 %	42 %	22 %	22%	
	COP16	Sust	APR17	7%	7%	12 %	16 %	17 %	23 %	20 %	25 %	4%	3%	14 %	3%	45 %	13 %	61 %	18 %	81 %	32 %	11 8%	76 %	11 8%	76 %	38 %	41%	

	COP17	Sunt	APR18	10%	18%	10 %	18 %	10 %	18 %	10 %	18 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34 %	64 %	34%
	COP18	Sunt	APR19	62%	69%	62 %	69 %	62 %	69 %	62 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69 %	72 %	69%
	COP19	Satur	APR20	33%	53%	25 %	24 %	14 %	11 %	9%	4%	11 %	29 %	15 %	79 %	87 %	13 %	85 %	16 %	78 %	12 %	58 %	75 %	59 %	74 %	46 %	74 %	46 %	54%
	COP20	Satur	APR21	77%	86%	89 %	93 %	89 %	89 %	93 %	92 %	88 %	90 %	89 %	78 %	93 %	90 %	92 %	88 %	93 %	90 %	94 %	88 %	94 %	90 %	93 %	90 %	93 %	90%
Sikensi	COP15	Sunt	APR16	5%	3%	8%	7%	11 %	10 %	13 %	11 %	2%	1%	6%	1%	19 %	4%	25 %	5%	34 %	9%	49 %	22 %	49 %	22 %	36 %	22 %	36 %	12%
	COP16	Sunt	APR17	9%	7%	14 %	14 %	20 %	21 %	24 %	21 %	3%	2%	10 %	2%	34 %	8%	46 %	11 %	61 %	20 %	89 %	47 %	89 %	47 %	28 %	47 %	28 %	25%
	COP17	Sunt	APR18	8%	3%	8%	3%	8%	3%	8%	3%	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13 %	34 %	13%
	COP18	Sunt	APR19	57%	76%	57 %	76 %	57 %	76 %	57 %	76 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64 %	56 %	64%
	COP19	Satur	APR20	84%	87%	47 %	22 %	33 %	42 %	17 %	15 %	3%	19 %	2%	22 %	7%	33 %	23 %	52 %	40 %	55 %	48 %	49 %	40 %	37 %	28 %	37 %	28 %	28%
	COP20	Satur	APR21	81%	87%	92 %	92 %	94 %	91 %	92 %	98 %	89 %	91 %	90 %	78 %	92 %	92 %	94 %	89 %	95 %	92 %	95 %	90 %	96 %	91 %	94 %	91 %	94 %	91%
Sinfra	COP15	Agg	APR16	10%	12%	16 %	26 %	22 %	37 %	26 %	42 %	4%	2%	12 %	3%	40 %	11 %	54 %	15 %	72 %	26 %	10 %	62 %	10 %	62 %	34 %	62 %	34 %	33%
	COP16	Agg	APR17	16%	12%	27 %	26 %	37 %	37 %	44 %	42 %	5%	3%	16 %	4%	54 %	15 %	74 %	20 %	98 %	36 %	14 %	85 %	14 %	85 %	46 %	85 %	46 %	40%
	COP17	Agg	APR18	50%	61%	50 %	61 %	50 %	61 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67 %	12 %	67%
	COP18	Agg	APR19	80%	104 %	80 %	10 4%	80 %	10 4%	80 %	10 4%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	22 2%	20 1%	222 %
	COP19	Satur	APR20	47%	78%	37 %	32 %	79 %	54 %	62 %	42 %	24 %	34 %	16 %	51 %	16 %	72 %	25 %	93 %	53 %	10 %	52 %	73 %	60 %	72 %	29 %	72 %	29 %	72%
	COP20	Satur	APR21	81%	88%	95 %	96 %	95 %	94 %	97 %	97 %	90 %	92 %	92 %	79 %	92 %	92 %	93 %	91 %	95 %	92 %	95 %	90 %	95 %	92 %	94 %	92 %	94 %	92%
Soubre	COP15	Agg	APR16	5%	4%	8%	8%	11 %	12 %	13 %	13 %	2%	2%	8%	2%	26 %	7%	36 %	10 %	47 %	18 %	69 %	42 %	69 %	42 %	22 %	42 %	22 %	23%
	COP16	Agg	APR17	6%	5%	9%	10 %	13 %	14 %	16 %	16 %	3%	2%	11 %	2%	35 %	10 %	48 %	13 %	63 %	24 %	92 %	58 %	92 %	58 %	30 %	58 %	30 %	30%
	COP17	Agg	APR18	29%	33%	29 %	31 %	29 %	31 %	29 %	31 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38 %	69 %	38%
	COP18	Agg	APR19	88%	92%	88 %	92 %	88 %	92 %	88 %	92 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55 %	62 %	55%
	COP19	Satur	APR20	11%	28%	33 %	39 %	29 %	32 %	20 %	28 %	14 %	31 %	14 %	45 %	33 %	76 %	42 %	90 %	67 %	98 %	87 %	68 %	94 %	60 %	88 %	60 %	88 %	50%
	COP20	Satur	APR21	80%	78%	86 %	87 %	86 %	86 %	88 %	87 %	94 %	95 %	95 %	82 %	96 %	95 %	96 %	94 %	97 %	95 %	97 %	94 %	97 %	95 %	97 %	95 %	97 %	95%

Tabou	COP15	Agg	APR16	3%	2%	5%	4%	7%	6%	8%	6%	1%	1%	5%	1%	17%	5%	21%	7%	30%	13%	45%	31%	45%	31%	14%	16%		
	COP16	Agg	APR17	4%	2%	6%	4%	8%	6%	10%	7%	2%	2%	8%	2%	26%	8%	35%	11%	46%	20%	68%	47%	68%	47%	22%	25%		
	COP17	Agg	APR18	33%	24%	33%	24%	33%	24%	33%	24%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%	56%	34%		
	COP18	Agg	APR19	88%	92%	88%	92%	88%	92%	88%	92%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%	80%	71%		
	COP19	Satur	APR20	43%	43%	41%	27%	46%	60%	28%	35%	2%	38%	8%	63%	18%	11%	46%	10%	73%	11%	98%	10%	15%	10%	94%	103%		
	COP20	Satur	APR21	85%	78%	90%	90%	89%	90%	91%	91%	89%	92%	91%	78%	92%	92%	93%	90%	95%	92%	95%	90%	95%	92%	95%	92%		
Tanda	COP15	Agg	APR16	12%	9%	20%	19%	28%	28%	31%	32%	5%	3%	17%	3%	55%	13%	75%	18%	99%	31%	14%	74%	14%	74%	46%	40%		
	COP16	Agg	APR17	16%	13%	26%	24%	36%	34%	43%	39%	6%	3%	20%	4%	67%	16%	92%	22%	12%	39%	17%	93%	17%	93%	57%	49%		
	COP17	Satur	APR18	163%	68%	16%	66%	16%	66%	16%	66%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%	93%	44%		
	COP18	Satur	APR19	77%	111%	77%	1%	77%	1%	77%	1%	1%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%	2%		
	COP19	Satur	APR20	35%	73%	58%	66%	70%	71%	56%	51%	43%	36%	11%	68%	23%	99%	49%	14%	98%	17%	12%	16%	12%	16%	87%	167%		
	COP20	Satur	APR21	70%	80%	93%	90%	90%	90%	92%	91%	90%	92%	91%	79%	92%	92%	94%	93%	95%	92%	95%	90%	95%	92%	95%	92%		
Tongrela	COP15	Sust	APR16	21%	2%	36%	4%	49%	6%	59%	7%	5%	3%	59%	4%	62%	14%	84%	20%	11%	35%	16%	83%	16%	83%	52%	45%		
	COP16	Sust	APR17	27%	18%	44%	27%	62%	38%	73%	43%	8%	5%	27%	5%	88%	22%	12%	30%	15%	53%	23%	12%	23%	12%	74%	68%		
	COP17	Sust	APR18	30%	8%	39%	8%	39%	8%	39%	8%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%	66%	30%		
	COP18	Sust	APR19	55%	81%	55%	81%	55%	81%	55%	81%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%	59%	75%		
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%		
Tiassale	COP15	Agg	APR16	7%	6%	11%	12%	15%	18%	18%	20%	2%	1%	7%	2%	24%	6%	32%	9%	43%	15%	62%	37%	62%	37%	20%	20%		
	COP16	Agg	APR17	11%	8%	18%	17%	25%	24%	30%	27%	3%	2%	12%	2%	39%	10%	54%	14%	71%	25%	10%	58%	10%	58%	33%	33%		
	COP17	Agg	APR18	34%	38%	34%	38%	34%	38%	34%	38%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%	55%	28%		
	COP18	Agg	APR19	70%	105%	79%	10%	79%	10%	79%	10%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%	80%	91%		

	COP19	Satur	APR20	98%	63%	46%	57%	38%	33%	23%	23%	10%	25%	10%	39%	16%	49%	28%	78%	51%	65%	52%	53%	58%	41%	34%	38%
	COP20	Satur	APR21	77%	93%	95%	92%	92%	93%	92%	93%	90%	92%	90%	78%	93%	91%	92%	89%	93%	93%	94%	89%	95%	91%	94%	93%
Tiebissou	COP15	Sunt	APR16	8%	7%	13%	16%	19%	22%	22%	25%	3%	1%	9%	2%	20%	6%	30%	9%	52%	16%	76%	37%	76%	37%	24%	20%
	COP16	Sunt	APR17	7%	7%	12%	14%	17%	21%	20%	23%	3%	2%	10%	2%	34%	8%	47%	11%	62%	19%	91%	45%	91%	45%	29%	24%
	COP17	Sunt	APR18	25%	20%	25%	20%	25%	20%	25%	20%	51%	23%	51%	23%	51%	23%	51%	23%	51%	23%	51%	23%	51%	23%	51%	23%
	COP18	Sunt	APR19	61%	85%	61%	85%	61%	85%	61%	85%	91%	10%	91%	10%	91%	10%	91%	10%	91%	10%	91%	10%	91%	10%	91%	108%
	COP19	Satur	APR20	116%	122%	29%	10%	41%	61%	11%	76%	28%	49%	9%	24%	55%	12%	20%	71%	28%	10%	61%	10%	76%	10%	93%	201%
	COP20	Satur	APR21	77%	79%	95%	98%	96%	96%	98%	99%	86%	91%	91%	78%	93%	90%	92%	89%	93%	93%	94%	88%	94%	90%	93%	93%
Touba	COP15	Sunt	APR16	2%	2%	3%	5%	4%	7%	5%	7%	1%	1%	4%	1%	14%	5%	20%	6%	26%	11%	38%	27%	38%	27%	12%	14%
	COP16	Sunt	APR17	4%	3%	6%	6%	8%	9%	10%	10%	2%	1%	7%	2%	22%	7%	30%	9%	40%	16%	58%	38%	58%	38%	18%	20%
	COP17	Sunt	APR18	3%	4%	3%	4%	3%	4%	3%	4%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%	26%	16%
	COP18	Sunt	APR19	43%	48%	43%	48%	43%	48%	43%	48%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%	68%	65%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Toulepleu	COP15	Sunt	APR16	5%	3%	9%	2%	12%	2%	14%	3%	1%	1%	3%	1%	11%	4%	15%	5%	20%	9%	29%	20%	29%	20%	9%	11%
	COP16	Sunt	APR17	5%	3%	8%	6%	11%	9%	13%	10%	1%	1%	4%	1%	15%	4%	20%	6%	27%	10%	39%	23%	39%	23%	12%	12%
	COP17	Sunt	APR18	0%	0%	0%	0%	0%	0%	0%	0%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%	20%	12%
	COP18	Sunt	APR19	57%	77%	57%	77%	57%	77%	57%	77%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%	61%	71%
	COP19	Not Supp	APR20	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	COP20	Not Supp	APR21	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Toumodi	COP15	Sunt	APR16	6%	9%	10%	19%	14%	28%	16%	31%	4%	2%	13%	3%	44%	11%	61%	15%	80%	26%	11%	61%	11%	61%	37%	33%
	COP16	Sunt	APR17	7%	7%	11%	15%	15%	22%	18%	25%	4%	3%	15%	3%	49%	13%	67%	18%	89%	31%	13%	74%	13%	74%	41%	40%

	COP17	Sust	APR18	22%	28%	22 %	28 %	22 %	28 %	22 %	28 %	80 %	36 %	80 %	36 %	80 %	36 %	80 %	36 %	80 %	36 %	80 %	36 %	80 %	36 %	80 %	36 %	36%
	COP18	Sust	APR19	56%	78%	56 %	78 %	56 %	78 %	56 %	78 %	93 %	11 %	93 %	11 %	93 %	11 %	93 %	11 %	93 %	11 %	93 %	11 %	93 %	11 %	93 %	11 %	111 %
	COP19	Satur	APR20	57%	60%	35 %	7%	52 %	27 %	75 %	48 %	22 %	38 %	13 %	50 %	23 %	85 %	41 %	97 %	78 %	12 %	89 %	23 %	87 %	23 %	12 %	100 %	
	COP20	Satur	APR21	84%	87%	89 %	88 %	89 %	87 %	88 %	89 %	88 %	93 %	91 %	78 %	91 %	91 %	92 %	89 %	94 %	91 %	94 %	89 %	94 %	91 %	93 %	91%	
Traichville -Marcory	COP15	Satur	APR16	42%	34%	70 %	72 %	97 %	10 %	11 %	11 %	20 %	17 %	67 %	20 %	22 %	84 %	30 %	11 %	39 %	20 %	58 %	48 %	58 %	48 %	18 %	258 %	
	COP16	Satur	APR17	44%	34%	74 %	71 %	10 %	10 %	12 %	11 %	21 %	18 %	74 %	22 %	24 %	90 %	33 %	12 %	43 %	21 %	64 %	51 %	64 %	51 %	20 %	276 %	
	COP17	Satur	APR18	103 %	105 %	10 %	10 %	10 %	10 %	10 %	10 %	23 %	18 %	23 %	18 %	23 %	18 %	23 %	18 %	23 %	18 %	23 %	18 %	23 %	18 %	23 %	180 %	
	COP18	Satur	APR19	115 %	142 %	11 %	14 %	11 %	14 %	11 %	14 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	12 %	127 %	
	COP19	Satur	APR20	165 %	210 %	24 %	33 %	26 %	38 %	33 %	48 %	22 %	18 %	19 %	13 %	25 %	29 %	28 %	48 %	27 %	48 %	37 %	38 %	39 %	33 %	38 %	311 %	
	COP20	Satur	APR21	80%	79%	90 %	89 %	89 %	89 %	91 %	90 %	95 %	95 %	96 %	82 %	96 %	95 %	97 %	94 %	97 %	95 %	97 %	94 %	97 %	95 %	97 %	95%	
Vavoua	COP15	Sust	APR16	5%	5%	9%	10 %	13 %	14 %	15 %	16 %	2%	1%	7%	2%	22 %	7%	31 %	10 %	40 %	17 %	59 %	41 %	59 %	41 %	59 %	22%	
	COP16	Sust	APR17	10%	9%	17 %	19 %	23 %	27 %	27 %	33 %	4%	3%	13 %	3%	44 %	13 %	61 %	18 %	80 %	32 %	11 %	76 %	11 %	76 %	37 %	41%	
	COP17	Sust	APR18	13%	15%	13 %	15 %	13 %	15 %	13 %	15 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29 %	48 %	29%	
	COP18	Sust	APR19	58%	75%	58 %	75 %	58 %	75 %	58 %	75 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86 %	78 %	86%	
	COP19	Satur	APR20	35%	110 %	58 %	24 %	52 %	55 %	23 %	24 %	20 %	47 %	22 %	10 %	48 %	92 %	55 %	13 %	87 %	11 %	48 %	57 %	57 %	53 %	22 %	46%	
	COP20	Satur	APR21	73%	84%	90 %	89 %	90 %	89 %	91 %	92 %	87 %	90 %	89 %	77 %	89 %	90 %	91 %	88 %	92 %	90 %	93 %	87 %	93 %	90 %	92 %	90%	
Yamoussoukro	COP15	Agg	APR16	8%	8%	14 %	16 %	20 %	23 %	23 %	28 %	5%	3%	17 %	4%	57 %	15 %	78 %	21 %	10 %	37 %	15 %	87 %	15 %	87 %	48 %	47%	
	COP16	Agg	APR17	10%	9%	17 %	18 %	24 %	26 %	29 %	29 %	6%	3%	22 %	4%	71 %	17 %	97 %	23 %	12 %	41 %	18 %	96 %	18 %	96 %	60 %	52%	
	COP17	Agg	APR18	39%	53%	39 %	53 %	39 %	53 %	39 %	53 %	86 %	45 %	86 %	45 %	86 %	45 %	86 %	45 %	86 %	45 %	86 %	45 %	86 %	45 %	86 %	45%	
	COP18	Agg	APR19	78%	100 %	78 %	10 %	78 %	10 %	78 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	10 %	84 %	100 %	
	COP19	Satur	APR20	26%	37%	39 %	55 %	35 %	49 %	83 %	82 %	60 %	35 %	33 %	71 %	83 %	17 %	40 %	12 %	59 %	14 %	77 %	13 %	88 %	13 %	12 %	185 %	
	COP20	Satur	APR21	78%	83%	87 %	88 %	87 %	86 %	89 %	89 %	90 %	92 %	91 %	78 %	93 %	92 %	94 %	91 %	95 %	92 %	95 %	90 %	96 %	92 %	95 %	92%	

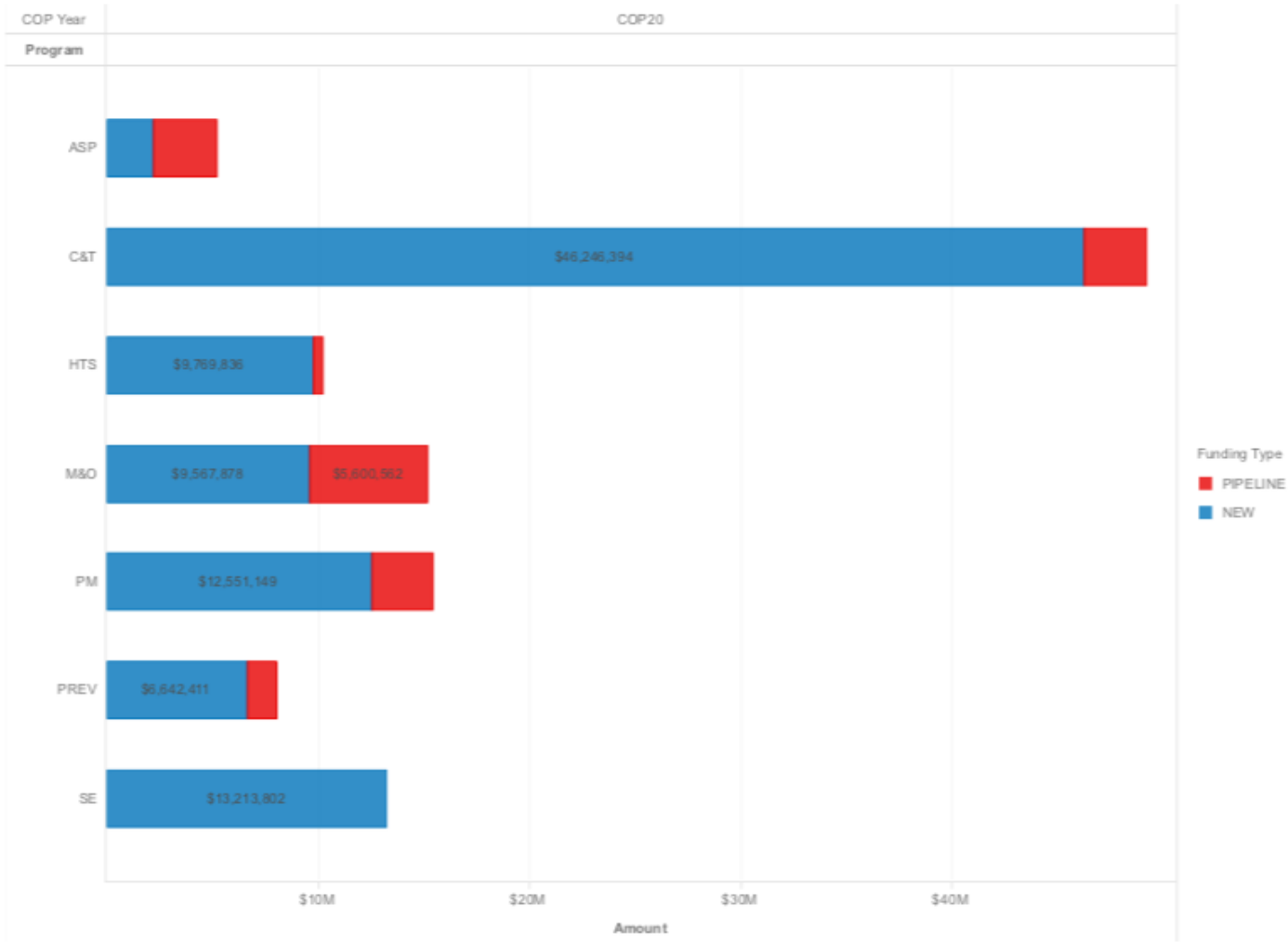
Yopougon -Est	COP15	Satur	APR16	6%	6%	10 %	12 %	14 %	17 %	16 %	19 %	5%	3%	17 %	4%	58 %	16 %	79 %	21 %	10 %	38 %	15 %	90 %	15 %	90 %	49 %	48%
	COP16	Satur	APR17	7%	5%	11 %	11 %	16 %	15 %	18 %	17 %	6%	3%	21 %	4%	68 %	16 %	93 %	22 %	12 %	39 %	18 %	93 %	18 %	93 %	57 %	49%
	COP17	Satur	APR18	107 %	114 %	10 7%	11 4%	10 7%	11 4%	10 7%	11 4%	10 0%	48 %	10 0%	48 %	10 0%	48 %	10 0%	48 %	10 0%	48 %	10 0%	48 %	10 0%	48 %	10 0%	48%
	COP18	Satur	APR19	89%	110 %	89 %	11 0%	89 %	11 0%	89 %	11 0%	90 %	92 %	90 %	92 %	90 %	92 %	90 %	92 %	90 %	92 %	90 %	92 %	90 %	92 %	90 %	92%
	COP19	Satur	APR20	78%	74%	11 9%	10 3%	44 %	57 %	39 %	34 %	34 %	36 %	27 %	93 %	47 %	13 5%	72 %	19 0%	83 %	15 9%	79 %	95 %	67 %	68 %	41 %	53%
	COP20	Satur	APR21	80%	80%	94 %	94 %	94 %	93 %	95 %	95 %	92 %	94 %	93 %	80 %	94 %	94 %	95 %	93 %	96 %	94 %	96 %	93 %	96 %	94 %	96 %	94%
Yopougon -Ouest-Songon	COP15	Satur	APR16	28%	22%	46 %	47 %	64 %	68 %	76 %	76 %	10 %	5%	34 %	6%	11 1%	25 %	15 2%	34 %	20 1%	60 %	29 4%	34 2%	29 4%	34 2%	94 %	76%
	COP16	Satur	APR17	28%	22%	47 %	47 %	65 %	68 %	77 %	76 %	11 %	6%	39 %	7%	12 7%	28 %	17 5%	38 %	23 1%	68 %	33 7%	38 1%	33 7%	38 1%	10 8%	80%
	COP17	Satur	APR18	358 %	141 %	15 8%	14 1%	15 8%	14 1%	15 8%	14 1%	14 8%	62 %	14 8%	62 %	14 8%	62 %	14 8%	62 %	14 8%	62 %	14 8%	62 %	14 8%	62 %	14 8%	62%
	COP18	Satur	APR19	105 %	123 %	10 5%	12 9%	10 5%	12 9%	10 5%	12 9%	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98 %	98%
	COP19	Satur	APR20	140 %	168 %	19 9%	19 2%	14 0%	14 9%	16 1%	18 0%	13 0%	15 1%	78 %	15 5%	94 %	27 2%	10 4%	26 7%	13 8%	29 1%	24 6%	27 7%	66 %	66 %	74 %	87%
	COP20	Satur	APR21	78%	80%	87 %	86 %	86 %	86 %	87 %	87 %	87 %	90 %	88 %	77 %	89 %	89 %	90 %	88 %	92 %	90 %	92 %	87 %	92 %	89 %	92 %	90%
Zouhan Hounien	COP15	Sunt	APR16	3%	3%	5%	6%	8%	9%	9%	10 %	2%	2%	8%	2%	28 %	8%	38 %	11 %	50 %	20 %	73 %	47 %	73 %	47 %	23 %	25%
	COP16	Sunt	APR17	4%	4%	6%	7%	8%	11 %	10 %	12 %	3%	2%	10 %	2%	38 %	10 %	45 %	13 %	60 %	23 %	87 %	55 %	87 %	55 %	28 %	30%
	COP17	Sunt	APR18	8%	6%	8%	6%	8%	6%	8%	6%	50 %	29 %	50 %	29 %	50 %	29 %	50 %	29 %	50 %	29 %	50 %	29 %	50 %	29 %	50 %	29%
	COP18	Sunt	APR19	35%	48%	35 %	48 %	35 %	48 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88 %	75 %	88%
	COP19	Satur	APR20	5%	5%	3%	9%	7%	7%	9%	5%	5%	12 %	4%	19 %	8%	24 %	12 %	26 %	13 %	22 %	17 %	30 %	18 %	37 %	12 %	34%
	COP20	Satur	APR21	82%	86%	86 %	83 %	85 %	85 %	84 %	87 %	87 %	89 %	88 %	77 %	88 %	89 %	90 %	87 %	91 %	89 %	91 %	86 %	91 %	89 %	91 %	89%
Zuenoula	COP15	Sunt	APR16	8%	8%	12 %	17 %	17 %	24 %	21 %	27 %	4%	3%	14 %	4%	46 %	15 %	64 %	20 %	84 %	35 %	12 %	84 %	12 %	84 %	39 %	45%
	COP16	Sunt	APR17	18%	16%	30 %	34 %	42 %	50 %	50 %	58 %	6%	4%	22 %	5%	72 %	22 %	99 %	30 %	13 1%	53 %	19 1%	12 5%	19 1%	12 5%	61 %	67%
	COP17	Sunt	APR18	33%	38%	33 %	38 %	33 %	38 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50 %	83 %	50%
	COP18	Sunt	APR19	58%	75%	58 %	75 %	58 %	75 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80 %	73 %	80%

	COP19	Satur	APR20	115%	75%	41%	41%	7%	31%	25%	27%	36%	78%	12%	63%	35%	67%	43%	89%	38%	78%	54%	66%	59%	70%	28%	65%
	COP20	Satur	APR21	77%	84%	90%	88%	87%	88%	88%	89%	85%	89%	87%	77%	89%	89%	89%	88%	93%	89%	93%	87%	92%	89%	93%	89%

APPENDIX B – Budget Profile and Resource Projections

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

Table B.1.1 COP20 Budget by Program Area



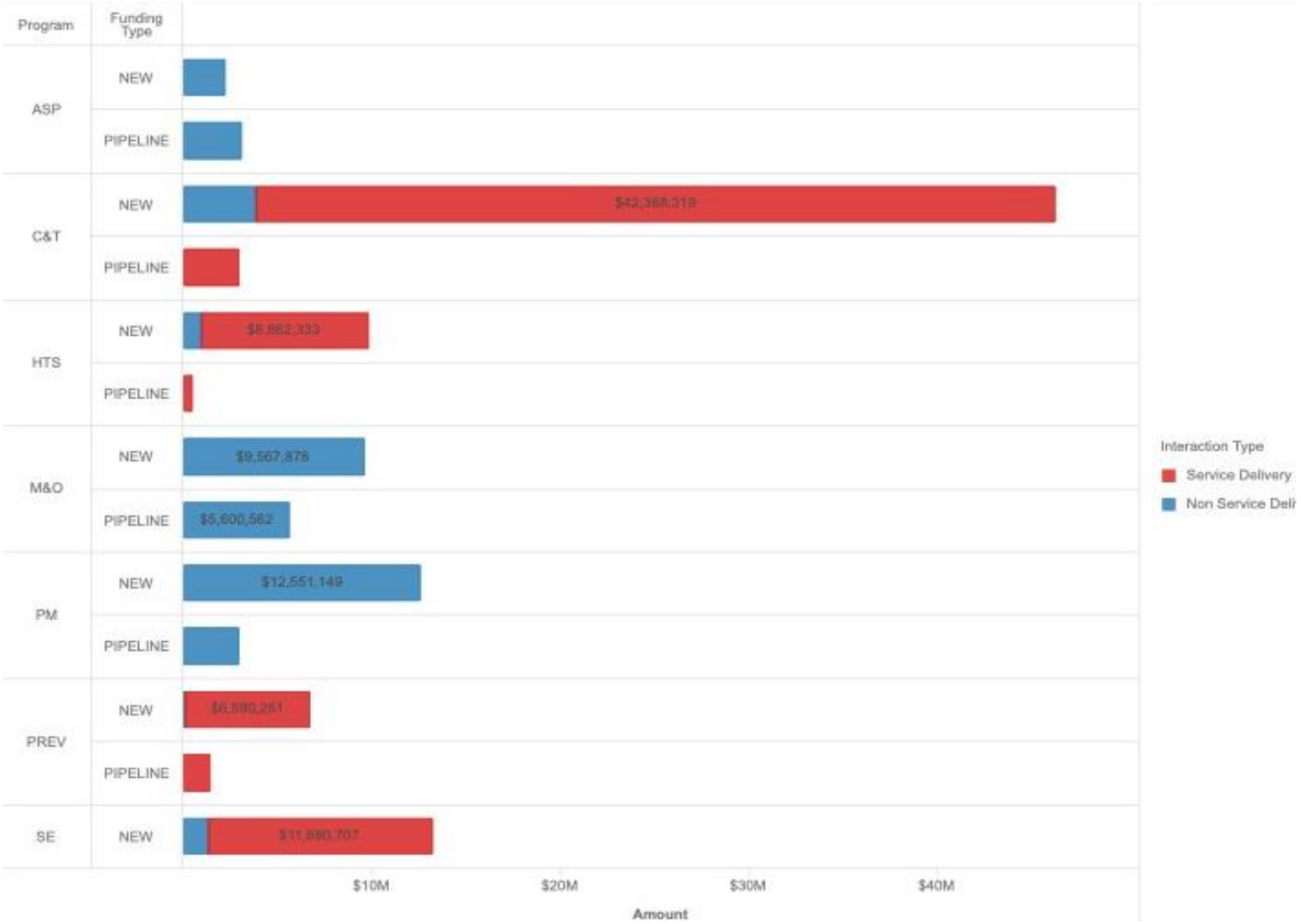

Program
Funding Type
ASP
NEW
PIPELINE
C&T
NEW
$42,368,319
PIPELINE
HTS
NEW
$6,982,333
PIPELINE
M&O
NEW
$9,567,878
PIPELINE
$5,600,562
PM
NEW
$12,551,149
PIPELINE
PREV
NEW
$6,580,251
PIPELINE
SE
NEW
$11,880,707
$10M
$20M
$30M
$40M
Amount
Interaction Type
Service Delivery
Non Service Deli

Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	**New Funding**	**Total Spend**
$16,264,124	$100,172,855	$116,436,979
Table B.1.2 COP20 Total Planning Level		

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

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)		
PEPFAR Budget Code	**Budget Code Description**	**Amount Allocated**
MTCT	Mother to Child Transmission	$1,718,829
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	$0
HVOP	Other Sexual Prevention	$6,969,453
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$0
HMIN	Injection Safety	$0
CIRC	Male Circumcision	$0
HVCT	Counseling and Testing	$9,710,023
HBHC	Adult Care and Support	$0
PDCS	Pediatric Care and Support	$5,886,473
HKID	Orphans and Vulnerable Children	$16,640,225
HTXS	Adult Treatment	$41,810,220
HTXD	ARV Drugs	$5,264,391
PDTX	Pediatric Treatment	$1,903,833
HVTB	TB/HIV Care	$896,081
HLAB	Lab	$332,154
HVSI	Strategic Information	$771,312
OHSS	Health Systems Strengthening	$1,692,234
HVMS	Management and Operations	$6,577,627
TOTAL		**$100,172,855**

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

B.2 Resource Projections

For COP20 resource projections, PEPFAR-CI used an incremental budget methodology using COP18 expenditures as a basis for continuing IMs, consistent with S/GAC guidance and the FAST process.

Prior to allocating COP20 resources, PEPFAR-CI conducted multiple in-depth reviews of the country program's performance by geography and by population, as of FY2020 Q2. In addition, the USG team conducted a district level review to understand the gaps in coverage by age and sex for case finding, care and treatment, viral load coverage and suppression. Based on the findings, the USG team engaged in robust dialogue with key stakeholders, including MSHP, PNLS, UN System Agencies, and CSOs to identify key programmatic gaps and agree on technical priorities to address these gaps and support the country program.

In an effort to invest COP20 funding in the most efficient way and to ensure that these investments would lead toward epidemic control, the USG team will maintain the geographic prioritization established in COP19 by focusing PEPFAR investments on 60 health districts (out of 86), but with a readjustment of site-level prioritization based on PLHIV on ART volume and critical gaps in pediatric viral load. In COP20, ART sites will be classified into three types, with varying degrees of PEPFAR support and investments (see Section 3.0). Community-based support will be concentrated at the 449 sites that make up high impact and moderate impact sites.

Final COP20 budget adjustments were made at the IM level, based on programmatic shifts from case finding to retention, geographic redistribution to implement the site prioritization, and rebuilding program costs with a focus on site-level service delivery interventions. Budget decisions were made by first allocating for M&O, closing costs, commodities, DREAMS, OVC, KP programming, and above-site activities. DREAMS and OVC funding allocation first removed country-wide activities and the remaining funding was split by IM-based on DREAMS targets. HKID allocation for OVC IMs was based on <18 OVC_SERV targets. Only funding for DREAMS and OVC activities in the community were included.

For the remaining budget envelope, each agency independently presented its technical direction (including required resources) to the SGAC Country Chair. Given that the resources required exceeded the COP ceiling budget, agencies were asked to stay closer to budgets initially submitted during the Regional Planning Meeting in Johannesburg, which were based on maintaining agency-level envelopes set during COP19. The COP19 budget, however, was not developed with the new type of site approach, and did not account for the strategies and scale up of certain program activities outlined for COP 20 (e.g., full scale-up of facility-based index testing, adherence groups, community ARV distribution, extended hours of service, etc.). Within their final COP20 envelopes, each agency has allocated funding to clinical and community IMs based on program areas and district-level targets articulated within each group of sites to provide a level of either DSD or TA support to a number of sites.

For all IMs, "Program Management" costs were reduced and capped at 20% of total IM funding to ensure most of the funding goes to field program interventions.

Commodities were estimated to account for patients to be tested and expected to be put on ART with respect to the on-going TLD transition and 6-month MMS. As for Table 6 interventions, they were identified to address key policy barriers and funded accordingly.

APPENDIX C – Tables and Systems Investments for Section 6.0

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

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
USAID	Family Health International	ASP: Laws, regulations & policy environment-NSD	Key Pops: Not disaggregated	Information and sensitization for public and government officials	1.Persistence of stigma and discrimination against people infected and affected by HIV/AIDS; limited HIV literacy across general population, among PLHIV and HCWs.	COP20	COP22	Development and Implementation of National Tool - Provide support for Monitoring/Reporting stigma and discrimination, GBV among KPs. Implemented by 110 health care workers and community health workers on the GBV system report at 14 facilities.
USAID	AIMAS	ASP: Laws, regulations & policy environment-NSD	Non-Targeted Pop: Not disaggregated	Information and sensitization for public and government officials	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDs Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce and encourage HIV treatment and prevention.	COP20	COP22	Messages and materials developed for an improved image and understanding of HIV in 2020; messages developed for men and AGYW; U=U and treatment literacy messages developed for service providers; scripts, and tools drafted.
USAID	NOUVELLE PHARMACIE DE LA SANTE PUBLIQUE DE COTE D'IVOIRE	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	2. Rapid optimization of ART by offering TLD to all PLHIV weighing>30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg, and removal of all nevirapine-based regimens.	COP19	COP22	Country counterpart ownership increased to 100%
USAID	AIMAS	ASP: Laws, regulations & policy environment-NSD	Females: Young women & adolescent females	Information and sensitization for public and government officials	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDs Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce and encourage HIV treatment and prevention.	COP20	COP22	Achieve 70% for the 1st 95 among AGYW
HHS/CDC	Elizabeth Glaser Pediatric Aids Foundation	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	COP20	COP21	Report disseminated on HIV associated morbidity and mortality across all sites with SIGDEP capability
HHS/CDC	UNAIDS JOINT UNITED NATIONS PROGRAMME ON HIV/AIDS	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	COP16	COP21	Third situation room report disseminated; 2020 National and small area HIV estimates available

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

Funding Agency	PrimePartner	COP20 Program Area	COP20 Beneficiary	COP20 Activity Category	Key Systems Barrier	Intervention Start	Intervention End	COP20 Benchmark
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	Oversight, technical assistance, and supervision to subnational levels	10. OU Assure program and site standards are met by integrating effectives quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; CSOs…)	COP19	COP21	Monthly meetings organized with minutes and attendance list, 1 policy development to address emerging program gaps, 1 annual operational plan development workshop , 2 semi-annual data review meetings with PEPFAR clinical and community partners
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Policy, planning, coordination & management-NSD	Non-Targeted Pop: Not disaggregated	National strategic plans, operational plans and budgets	10. OU Assure program and site standards are met by integrating effectives quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; CSOs…)	COP19	COP21	3 workshops organized
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	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 annual testing and results delivered to caregiver within 4 weeks.	COP18	COP22	Implementation of QMS activities by MOH and coordination of laboratory activities
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: Human resources for health-NSD	Non-Targeted Pop: Not disaggregated	HRH recruitment and retention	10. OU Assure program and site standards are met by integrating effectives quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy. Weak local capacity empowerment and HRH sub-optimized (e.g. Coordination at subnational levels of health system; CSOs…); Clear evidence of agency progress towards, indigenous partner prime funding.	COP19	COP22	20 districts receiving PBF
HHS/CDC	MINISTERE DE LA SANTE ET DE LA LUTTE CONTRE LE SIDA.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not disaggregated	Program and data quality management	15. Scale-up of case-based surveillance and unique identifiers for patients across all sites.	COP17	COP21	Migration of SIGDEP to v2.2, Routine DQA conducted; M&E tools aligned and uptodate
HHS/CDC	UNIVERSITY OF WASHINGTON	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not disaggregated	HMIS systems	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 annual testing and results delivered to caregiver within 4 weeks.	COP19	COP20	The OpenElis Modules is fully operational in 27 TB labs and optimize by information sharing with openelis.

APPENDIX D – Minimum Program Requirements

Thanks to PEPFAR advocacy, Côte d'Ivoire has made some progress in meeting the program minimum requirements, but significant work remains to meet COP20 MPRs.

Care and Treatment

1. **Test and Start:** Côte d'Ivoire adopted the Test and Start policy along with Differentiated Service Delivery Models (DSDM) for stable patients in February 2017. Currently, Test and Start is implemented in all PEPFAR-supported sites across all age, sex and risk groups. DSDM is adopted and being implemented. Continue implementation at 100% of supported sites across all age, sex and risk groups in 936 sites, 60 districts. Ensure >95 linkage across all age, sex and risk groups in 914 sites, 60 districts
2. **Rapid ART Optimization:** The MSHP adopted the transition to TLD on February 2019 with 2-phased implementation approach. The policy was emphasized by a circular note on April 19, 2019 providing additional guidance for the implementation. The initial phase targeting adults and children (>35 kg or 10+ years old) newly initiated on ART started in April 2019 with training of providers at more than 100 high volume ART sites along with dispensation of the drug. The second phase targeted patients already on treatment and women without childbearing potential begun in July 2019 and was scaled up in December 2019 and January 2020 when the MSHP conducted a series of trainings/coaching of providers at 139 prioritized sites. Nevirapine-based regimen has been phased out in treatment protocols. The policy was revised on Feb 14, 2020 to allow transitioning of all adults and adolescents, and women with childbearing potential on TLD by removing the requirements of double contraception, and folic acid for women with childbearing potential. However, those women should be offered comprehensive counseling on the benefits and risks of TLD for informed consent. During COP20, PEPFAR CI will work with MSHP and implementing partners to increase uptake of TLD among all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing >20kg.
3. **6MMD:** On February 2019, the MSHP adopted 6 multi-month scripting for stable patients on ART and this policy is currently being scale-up at all sites. Community ART distribution adopted Feb 14, 2020. As of January 2020, 50% (**62,003/122,857**) eligible patients received 6MMD at 917 sites. PEPFAR will support MSHP to implement a phased scale community ARV distribution which will start in 10 districts in COP19. In COP20, PEPFAR will continue to expand the implementation of 6 multi-months dispensing in 100% of ART-supported sites for adults and children with a goal to reach at least 75% of eligible patients on 6MMD and expand community ARV distribution model to 30 districts.
4. **TPT:** The MSHP adopted Tuberculosis Preventive Therapy (TPT) as part of the routine HIV care package in October 2018 with a phased scale-up approach. The policy initially targeted patients newly enrolled on ART. TPT uptake is very limited though services are offered to patients at no fee. In FY20-Q1, only 6 sites were implementing TPT targeting patient newly on ART and only 33% (109/335) of patients newly enrolled were eligible for

TPT due to the requirement of chest X-ray and CD4 <200/mm3. In February 2020, the MSHP revised TPT policy to include patients already on ART and removed CD4 requirements. The policy, however, is unclear about chest X-ray requirement to rule out active TB. The plan for COP19 is to scale-up TPT in 70 sites, targeting 81,180 patients on ART. In COP20, all eligible PLHIV, including children will receive TPT and cotrimoxazole, where indicated and must be fully integrated into the HIV clinical care package at no cost to the patient.

5. **Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections**: In 2018 the MSHP adopted a National VL/EID scale-up plan which is being implemented. National VL/EID optimization exercise was completed in January 2020. Thanks to PEPFAR, Côte d'Ivoire supports a network of 17 VL/EID laboratory with capacity of 525,467 tests/year. All PEPFAR-supported 60 districts have access to VL/EID services. As of FY20-Q1, viral load coverage was 84% and viral load suppression (82%) with 20% of VL sample collected on DBS samples for rural sites. The current capacity of VL/EID platform is used at 53%. Some population such as pregnant women and young adults 20-39 have a low coverage. COP19 will focus on pregnant women and children by increasing access to VL/EID POC and improve TB diagnosis using Xpert. In COP20, PEPFAR CI will complete the Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ensure ongoing monitoring to reduce morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 2 weeks.

Case Finding

6. **Index Testing:** Since FY2018, PEPFAR CI is scaling up index testing at supported sites through clinical and community partners as a major case finding strategy. COP19 index testing was implemented at all PEPFAR supported districts and 936 clinical sites for all age, sex and risk population. Self-testing is occurring for high risk clients or to partners as part of index testing services. During COP20, PEPFAR CI will ensure that index testing is implemented with fidelity at all supported sites for different populations, focusing on patients newly initiated on ART, those with unsuppressed viral load, and those currently on ART who have not yet received index testing services. PEPFAR will ensure that consent procedures and confidentiality are protected, and assessment of intimate partner violence is promoted and established with referral to gender-based violence (GBV) services. All children under 10 years old with an HIV-positive biological parent will be targeted for index testing.

Prevention and OVC

7. **PrEP:** In 20018 the MSHP adopted guidelines for PrEP implementation. In August 2019, training of a pool of national trainers started, and additional training sessions of providers occurred in Feb-March 2020 by MSHP and IPs. Current policy allows PrEP for KPs, HIV-negative person in sero-discordant couples and vulnerable AGYW. IPs are scaling-up PrEP

to reach COP19 target of 8,894. There are enough stock of ARV drugs (TDF+3TC) to support the implementation. In COP20, PEPFAR will continue to scale up access to PrEP as part of comprehensive prevention service package for 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).

8. **OVC:** COP19 OVC interventions align with highest burden areas. PEPFAR is aligning OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on adolescent girls in high HIV-burden areas, 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV, and children and adolescents living with HIV who require socioeconomic support, including integrated case management. COP20 PEPFAR will particularly 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 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV. PEPFAR will continue to increase the ratio OVC: care givers.

Policy & Public Health Systems Support

9. **Elimination of all formal and informal user fees in the public sector:** The MSHP has taken a firm stand on eliminating user fees. In March 2019, the MSHP issued a circular note removing all formal and informal user fees for HIV patients, pregnant women attending facilities, and children under 5 years old. This policy was reinstated in the new circular issued on Feb 14, 2020PEPFAR-CI. MSHP, PEPFAR and Civil Society Organizations (CSO) are monitoring the implementation during site visits. Overall, there have been fewer reports of user fees. PEPFAR staff doing SIMS/GSM site visits have reported a few cases of user fees at a couple of sites. These findings are corroborated by that of the community-led monitoring observatory which reported that 9% (91/1040) patients paid user fees at 12 sites, 85% of which are health booklets and 15% commodities. Those reports have been shared with MSHP for corrective action. In response, the MSHP Office of Inspector General visited sites to monitor and enforce the implementation of the policy. In COP20, PEPFAR will continue monitoring through ongoing site visits (SIMS/GSM/ others), collaborate with CSOs through the observatory and report to MSHP, and support MSHP to enforce the implementation of the policy. PEPFAR will advocate for free CxCa screening and treatment of pre-cancerous lesion for HIV-infected women supported by MSHP and Donors.
10. **Continuous Quality Improvement (CQI):** Currently the PEPFAR team is working with the MSHP for the adoption of a national CQI policy document. PEPFAR ensures program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is

supported by IP work plans, Agency agreements, and national policy. CQI practices are integrated into site and program management by routine data reviews, site visits (SIMS, GSM, Drop by) for quality improvement at 140 prioritized sites in 60 districts. In COP20, PEPFAR will provide specific technical assistance to the MSHP through HRSA to establish and operationalize comprehensive CQI activities at the three levels of the health pyramid by involving key stakeholders. The different phases of implementation are: 1) needs assessment and development of action plan, 2) establish virtual platform, 3) assessment of CQI work), and 4) evaluation and transition of CQI activities. Quality Improvement Collaboratives will be implemented in select sites to review data for decision making around improvement of low performing key indicators (i.e., retention, viral load suppression, case finding, EID, etc.)

11. **Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils:** PEPFAR is working with MSHP leadership to develop and disseminate new HIV messaging considering the latest evidence on prevention, treatment and care for the general population, including the concept U=U. In COP20, PEPFAR will continue to provide TA to the MSHP for development of a strategic marketing approach to reposition living with HIV as a management condition (thereby addressing other Key System Barrier of Stigma), treatment literacy and demand creation for HIV services.
12. **Evidence of agency progress toward local, indigenous partner direct funding:** Country ownership of the response is the vision of the GoCI. In FY2019 26% of PEPFAR budget was allocated to local indigenous organizations. Each agency is working with its headquarters to reach the global program requirement. Currently, 3/6 clinical and 2/3 KP partners are local. Each agency is monitoring the benchmark.
13. **Evidence of host government assuming greater responsibility of the HIV response:** The GoCI has increased its contribution to the response to HIV over these past years. Its contribution to the purchase of HIV commodities increased to 54% of total needs: $11.3M in CY2018 to $17.5 M in CY2019. GoCI planned investments for commodities during COP19 implementation period is $19.68M. This represents 11% decrease from prior year investments ($22.3M committed in COP18). The health sector was allocated only 6% of the 2019 budget. In COP20, PEPFAR CI will continue to press the government to purchase more HIV commodities.
14. **Monitoring and reporting of morbidity and mortality:** Monitoring of morbidity and mortality among patients receiving care and treatment services is critical in the context of low retention. Since FY2019, PEPFAR is implementing the mortality and morbidity (TX_ML) required indicator at all supported sites and across all populations. Data will continue to be analyzed on a quarterly basis to inform the program. In COP19, PEPFAR has begun the implementation of LAM assay to diagnose co-morbidities for patients with advanced disease at 2 reference sites. COP20 will extend the LAM and CrAg assay and improve reporting on TX_ML as part of the implementation of an advanced disease package at the prioritized sites.

15. **Scale-up of case-based surveillance and unique identifiers for patients across all sites:** The MSHP approved the concept of implementing a unique patient identifier using securely encrypted biometric code in late COP18 and created a technical working group, which developed the concept note and the tools/software and systems. Currently there is a small-scale implementation at 10 sites in Abidjan. COP19 activities include scaling to all of COP19's prioritized sites. COP20 will not support the development of a master patient index (MPI; client register), which is a required component to implement deduplication of patients across programs and sites. These additional activities – expansion of UID solution to remaining ART sites and development of an MPI – can be prioritized and funded in the future to allow for deduplication of patients across sites and case-based surveillance.