



# **Ethiopia Country Operational Plan COP2020/FY2021**

## **Strategic Direction Summary March 23, 2020**

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## 1.0 Goal Statement

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In COP20, PEPFAR Ethiopia (PEPFAR-E) will support the Government of Ethiopia (GoE)'s national HIV program to achieve and sustain epidemic control by focusing direct service delivery (DSD) and technical assistance (TA) investments to achieve 95-95-95 targets in five remaining priority geographies and strengthening critical systems nationally. PEPFAR-E will continue and expand more sustainable approaches, such as technical assistance and working within existing local structures. Government entities and local partners will be strengthened to lead the HIV response, monitor the epidemic, and develop sustainability plans for continued support to HIV programs, Orphans and Vulnerable Children (OVC) and Adolescent Girls and Young Women (AGYW). Leadership capacity of regional health bureaus and civil society will be strengthened for effective coordination of regional responses, and PEPFAR/E will work closely with all partners to strengthen community-facility linkages and to find and retain remaining cases. Finally, interventions will be focused on geographic locations (facilities and communities) with the highest numbers of HIV positive individuals as demonstrated through HIV Testing Services (HTS) \_POS and TX\_CUR indicators.

At this point in time, there are no remaining policy barriers to achieving 95-95-95 targets, though considerable work remains to operationalize policy at regional and local levels. This process will be facilitated by appropriate working groups at all levels, leveraging the GoE's renewed commitment to achieve and sustain epidemic control. Particular attention will be paid to efforts to expand PrEP and HIVST access to wider groups than has previously been possible.

Programmatic approaches and milestones will strengthen national systems for:

1. Detection of cases to link them to treatment and care, especially among certain target groups, such as men, children and female sex workers
2. Suppression of viral load to lower transmission rates; and
3. Response to ensure thorough patient-centered care, early identification of adherence issues, and prevention of epidemic backsliding.

To accomplish this, PEPFAR-E will pursue the following objectives:

1. Strengthen support for core GoE contributors to epidemic control at the central level.
2. Support the Ministry of Health (MoH) to execute strong program planning and quarterly performance monitoring, in conjunction with all stakeholders and partners.
3. Focus Direct Service Delivery (DSD) investments on detecting remaining cases and achieving population-level viral load suppression in targeted geographies in PEPFAR-E's five priority regions—Addis Ababa, Oromia, Amhara, SNNPR, and Gambella. Targeted geographies will be those with the highest rates of HIV infection as indicated by a combination of TX\_CURR (at Q1, FY20) and HTS\_POS (FY '19 APR).
4. Expansion of PrEP and HIVST targets.
5. Increased both yield for ICT, and percentage of positives identified through ICT.
6. Increased access to high impact HIV services for OVC and their HIV infected caregivers, and provision of primary prevention intervention to boys and girls age 9–14 years.
7. Continued efforts to eliminate the Gambella VMMC backlog

8. Provision of technical assistance in the six non-priority regions focused on: (1) reinforcing sub-national capacity for leadership and governance; (2) implementing a sustainable financing strategy, including adoption of a legal framework for domestic resource mobilization and resource mapping; (3) improving laboratory system; (4) strengthening case-based surveillance and response, including recency testing and related health information systems; (5) improving supply chain management and systems for improved HIV commodity availability and access; and (6) enhancing quality assurance for clinical services.

Stakeholder and partner engagement are critical to the success of PEPFAR investments, especially as the program evolves to sustain epidemic control. These efforts continue to focus on domestic resource mobilization, stigma and discrimination reduction, enhanced and continuous community engagement, adoption of the latest evidence-based best practices, and careful targeting of program interventions to bring Ethiopia across the line of epidemic control and ensure continued control.

## 2.0 Epidemic, Response, and Program Context

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### 2.1 Summary Statistics, Disease Burden, and Country Profile

Ethiopia is sub-Saharan Africa's second most populous nation and one of its poorest. Population estimates is around 108,113,150 (July 2020) divided among approximately 80 ethnic groups, with an approximate Growth Domestic Product, per capita, of \$2,200 (2017 est.). The median age is 19.6 years with a population growth rate of 2.56% (2020 est.) These statistics belie Ethiopia's substantial economic and social progress over the last 30 years. In 1990, 40% of the population lived below the World Bank poverty line; since 1990, the total fertility rate (TFR) has declined from 7.2 to 4.6; the infant mortality rate has declined from 120 per 1,000 live births to 41; and the adult literacy rate has gone from below 25% to 49% .

The HIV epidemic in Ethiopia is mixed, with wide regional variations and urban concentration in prevalence and some distinct transmission pockets among key and priority populations (KP & PP) and in some sectors of the general population. The 2016 Demographic and Health Survey (DHS) estimated a national prevalence of 0.9%. The 2018 Ethiopian Population-based HIV Impact Assessment (EPHIA) estimated an urban HIV prevalence of 3.0% nationally with regional variations (see Table 2.0).

Region	Prevalence	Disease Burden
Tigray	2.7	57,035
Afar	4.1	11,066
Amhara	4.1	207,872
Oromia	1	161,971
Somali	0.8	6,021
Benishangul-Gumuz	2.4	6,817
SNNPR	1.8	61,090
Gambella	1.7	11,986
Harari	4.6	1,618
Addis Ababa	1.1	111,611
Dire Dawa	4.6	11,917

The current working UNAIDS Spectrum estimate for PLHIV is 665,723 in Ethiopia. Of these, it is estimated that in Ethiopia, 79.0% of HIV positive adults (ages 15-64 years) know their HIV status and among adults living with HIV who know their HIV status, 97.1% were receiving ART and among adults living with HIV who reported ARV use or had detectable ARVs, 87.6% had suppressed viral loads. Collectively, the data suggest that Ethiopia is close to reaching HIV epidemic control, but still has pockets which need to be appropriately addressed.

KPs & PPs, i.e. FSWs, widowed and divorced people, truck drivers, adolescent girls and young women (AGYW) engaged in transactional sex, male clients of sex workers (SWs), and those who live along major transport corridors are all estimated to have significantly higher HIV prevalence rates than the general population. Outside this trend, Gambella region has little distinction between urban and rural residents HIV prevalence and some rural areas (with high seasonal migrant populations) away from transport corridors show elevated HIV risk behaviors despite their locales. Within the general population (in urban areas), women between the ages of 20 and 39 have significantly higher prevalence (6.1%-9.1%) than their male counterparts (0.9%- 2.4%). Adult male prevalence peaks at 5.7% in the 40-44 age band.

Addis Ababa, despite its relative economic advantages and ease of access to health care, falls well below the rest of the country in key HIV indicators when non-residents are factored out. EPHIA data suggests that youth (15-24) have low VL suppression (48.2%) and therefore require special emphasis for engagement into care. Finding youth, getting, and keeping them on treatment to achieve high rates of VL suppression must be a focus for sustained epidemic control.

**Table 2.1.1 Host Country Government Results**

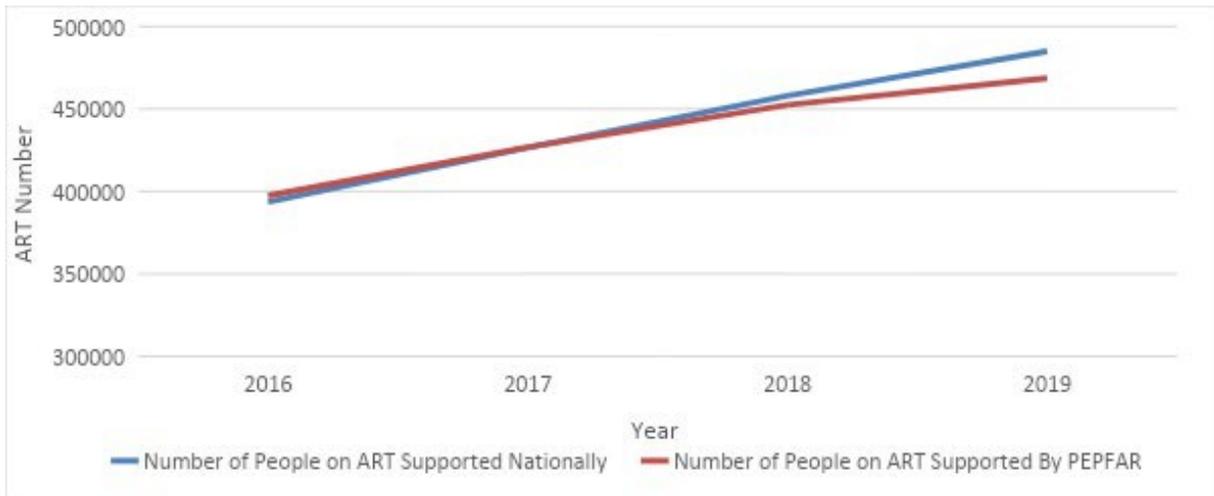
	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	100,829,000	100%	20,202,131	20%	20,386,290	20%	4,978,298	5%	5,013,772	5%	25,032,629	25%	25,216,890	26%	Refers to Year 2020. Adapted from Population Projection of Ethiopia from CSA.
HIV Prevalence (%)		0.9%	NA		NA		0.26%		0.18%		1.84%		0.84%	DHS 2016	
AIDS Deaths (per year)	11,843		1,086		1,143		850		907		5152		2,695	Refers to Year=2020. Spectrum from FMOH	
# PLHIV	645,680		26,894		27757		45377		32223		320190		18,4224	Refers to Year=2020. Spectrum from FMOH	
Incidence Rate (Yr)		0.07 /1,000												Refers to Year=2020 (All Ages) Spectrum from FMOH	
New Infections (Yr)	13,071	100%	1,188	9%	1,232	9%	3,071	23%	1,034	8%	3,577	27%	2,969	23%	Refers to Year=2020. Spectrum from FMOH
Annual births	3,149,013													Refers to Year 2020. CSA and DHS 2016	
% of Pregnant Women with at least one ANC visit		98%	NA		NA		NA		NA		NA		NA	Health Sector Transformation Plan, Annual Performance Report 2015/16 FMOH	
Pregnant women needing ARVs	18,815		NA		NA		NA		NA		NA		NA	Refers to Year=2020. Spectrum from FMOH	
Orphans	2,960,527		NA		NA		NA		NA		NA		NA	Refers to Year=2019.	

(maternal, paternal, double)															Spectrum from FMOH
Notified TB cases (Yr)	117,705	100%	4,557	4%	2,350	2%	15,560	13%	17,857	15%	32,240	27%	45,140	38%	Global TB Control Report WHO 2018
% of TB cases that are HIV infected	8239	7%													Global TB Control Report WHO 2018
% of Males Circumcised		91%	NA		NA		NA		NA		NA		NA		DHS 2016
Estimated Population Size of FSW	223,138														Extrapolated from Size estimation by PEPFAR-E interagency
FSW HIV Prevalence		23%	NA		NA		NA		NA		NA		NA		National MARPs survey, EPHI/CDC national MARPs survey report
Estimated Size of PPs	2,373,935	NA	NA	NA	NA		NA		NA		NA		NA	NA	UNAIDS
Estimated PPs Prevalence	NA	NA	NA		NA		NA		NA		NA	NA	NA	NA	

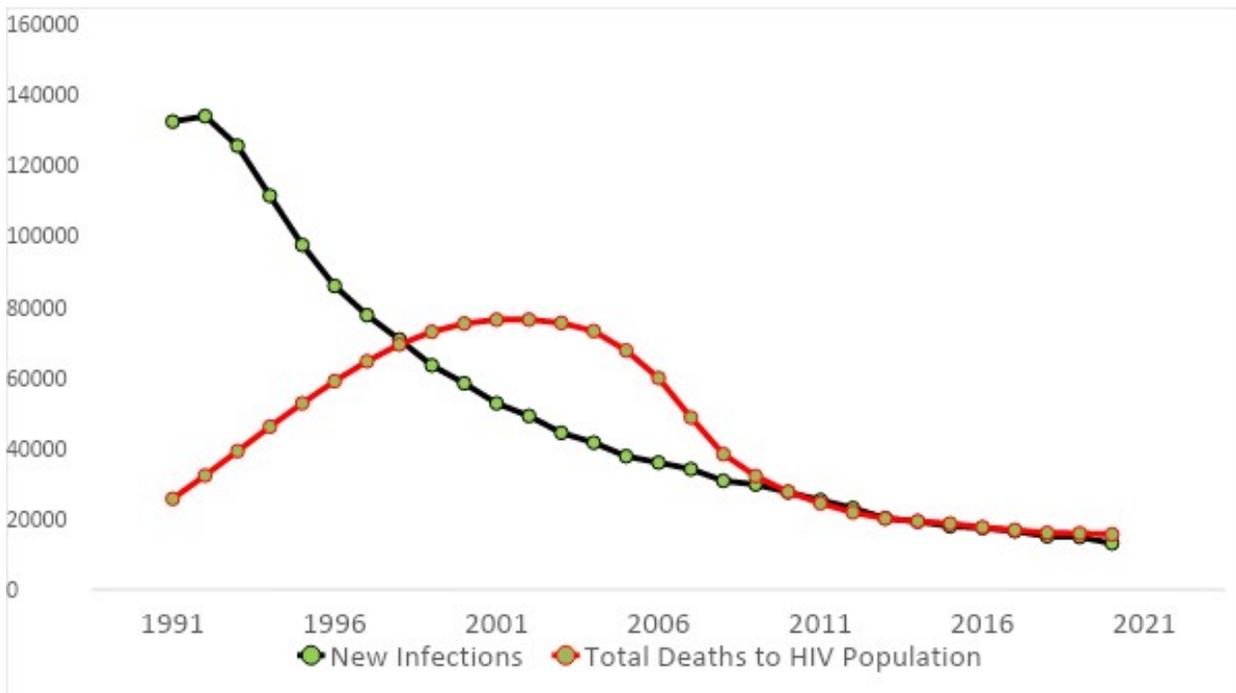
**Table 2.1.2 90-90-90 Cascade: HIV diagnosis, treatment and VL suppression**

Epidemiologic Data					HIV Treatment and VL Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#) YEAR=2019	HIV Prevalence (%) YEAR=2019	Estimated Total PLHIV (#) YEAR=2019	PLHIV diagnosed (#)	On ART (#) FY=2019	ART Coverage (%) FY=2019	VL Suppression (%)	Tested for HIV (#) FY=2019	Diagnosed HIV Positive (#) FY=2019	Initiated on ART (#) FY=2018
Total population	100,832,337	0.90%	665,723	530,351	468,705	70%	92%	8,158,286	51,093	33,800
Population <15 years	39,665,591	NA	39,792	24,974	20,576	52%	75%	NA	NA	NA
Men 15-24 years	10,464,355	0.18%	26,524	17,342	14,403	54%	100%	NA	NA	NA
Men 25+ years	20,194,220	0.84%	206,389	178,473	159,086	77%	94%	NA	NA	NA
Women 15-24 years	10,774,594	0.26%	40,747	25,226	27,741	68%	83%	NA	NA	NA
Women 25+ years	19,733,677	1.84%	352,271	284,336	263,849	75%	93%	NA	NA	NA
PSW	223,138	23%	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

**Figure 2.1.3 National and PEPFAR-E Trend for Individuals currently on Treatment<sup>1</sup>**



**Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV<sup>2</sup>**

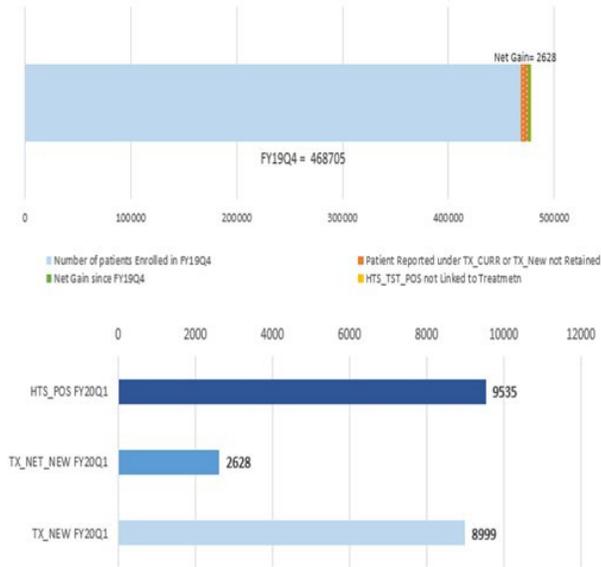


<sup>1</sup> 2020 Spectrum Estimates

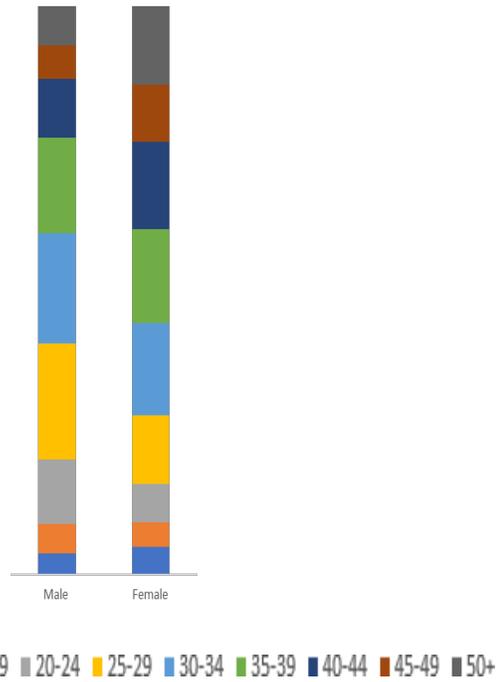
National Fiscal year is a quarter ahead of PEPFAR Fiscal year (June and September respectively). According to PEPFAR programmatic strategy, geographic prioritization, there have been transitions of Woredas/ districts but that is not visible here as we continue to count a large number of PLHIV receiving treatment services in centrally supported areas. The latter resulted in very small differences between the government and PEPFAR figures.

<sup>2</sup> 2020 Spectrum Estimates

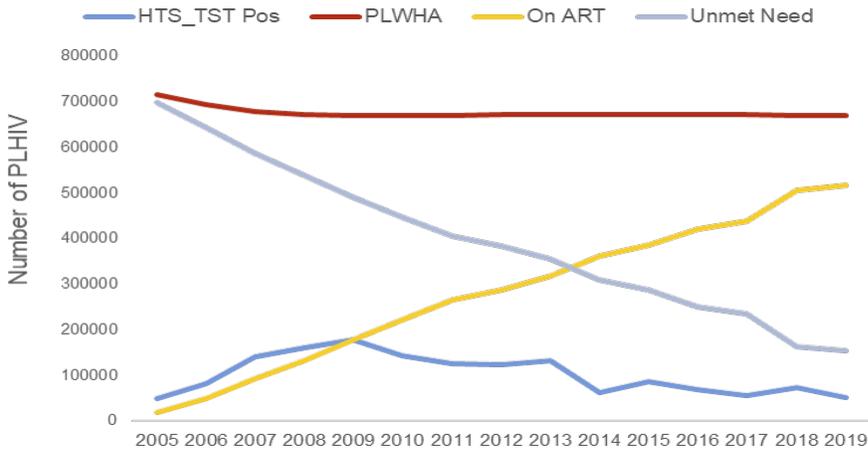
**Figure 2.1.5 Progress retaining individuals lost in lifelong ART in FY19**



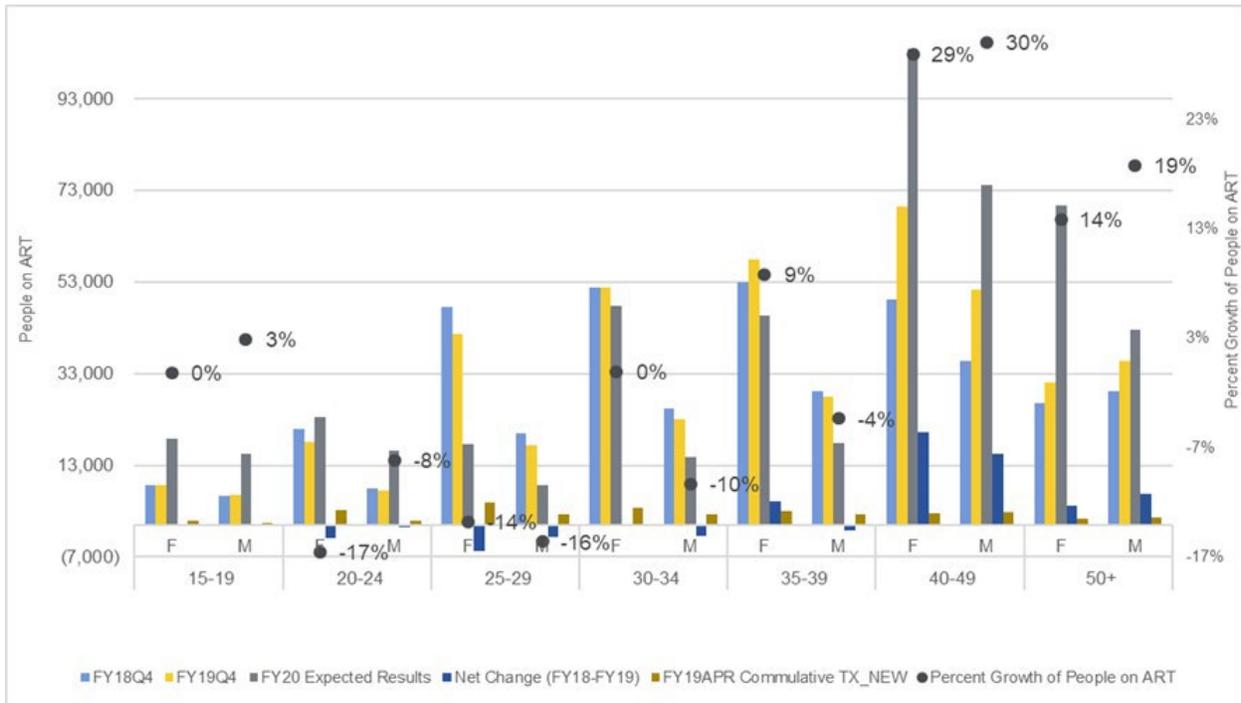
**Figure 2.1.6 Proportion of clients from ART 2018 Q4 to 2019 Q4**



**Figure 2.1.7 Epidemiologic Trends and Program Response**



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



## **2.1 New Activities and Areas of Focus for COP20, Including Focus on Client Retention**

As Ethiopia inches closer to attaining the 95-95-95 targets for treatment coverage and reaching epidemic control, major programmatic challenges appear to be retaining the clients already enrolled on ART, minimizing loss from the program and making progress towards growing the treatment cohort. This becomes increasingly difficult as the program moves out of geographic areas that used to receive direct program support (DSD) and as the number of PLHIV that do not know their status and/or not enrolled to the program become fewer.

Ethiopia will continue to implement and scale client centered services including differentiated models of service delivery, extended working hours to provide ART services during week-ends, holidays, after-hours etc., friendly services for adolescents, separate space and scheduling for clients with high viral load, facility-community collaboration for case identification, adherence support and tracing of lost clients. In addition to strengthening and expanding the implementation of the 6 months multi-month dispensing (MMD) and the health worker managed community ART refill groups (CAG), fast track pharmacy refill will be implemented and scaled. Based on identified gaps in retention or volume of reported lost clients, return to treatment initiatives will be undertaken to selected geographic areas and sites to identify, track, and support HIV-positive clients to re-enroll in ART. This will be done in close collaboration and coordination between facility and community stakeholders. There will be routine activities at site and community levels for early identification, reporting and follow-up to support clients who are lost, and document cases that are dead or have transferred out including silent transfers. In addition, due to ongoing and intermittent security issues in different parts of the country, it is expected that there will be interruptions in the provision of services and program activities at times. In affected areas, appropriate messaging on availability of services, providers, need for adherence to treatment (avoiding discontinuation of treatment), etc. will be provided. Health facilities and providers will be capacitated to address the demands and needs of those who might be displaced or self-transferred. The main driver of the increase in the treatment cohort is HIV case finding and the program will work to strengthen linkages and early ART initiation including same day initiation.

Based on lessons learned and implementation of Operation Triple Zero in AA, there will be expansion and scale-up of the activity to improve adherence/retention among adolescents. Reduction of stigma and discrimination at all levels, including facilities and communities and continued collaboration and engagement with community members will continue to be integral to all partners' efforts.

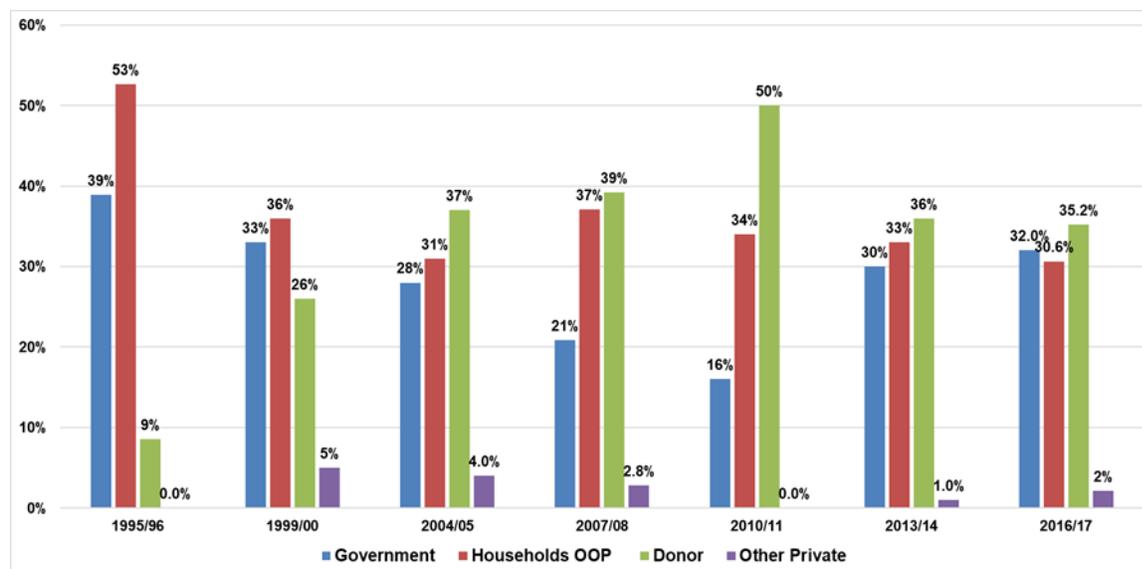
## **2.2 Investment Profile**

The FMOH recently completed the seventh round of the National Health Accounts (NHA 2016/17). The 2016/17 NHA is the latest available data on health spending that was released September 2019. According to the 2016/17 NHA, the health expenditure in Ethiopia is estimated to be ETB 72.1 billion (3.1 billion USD). The 2016/17 NHA report indicates that this is a 45 percent increase in nominal terms from ETB 49.6 (2.5 USD) in 2013/14.

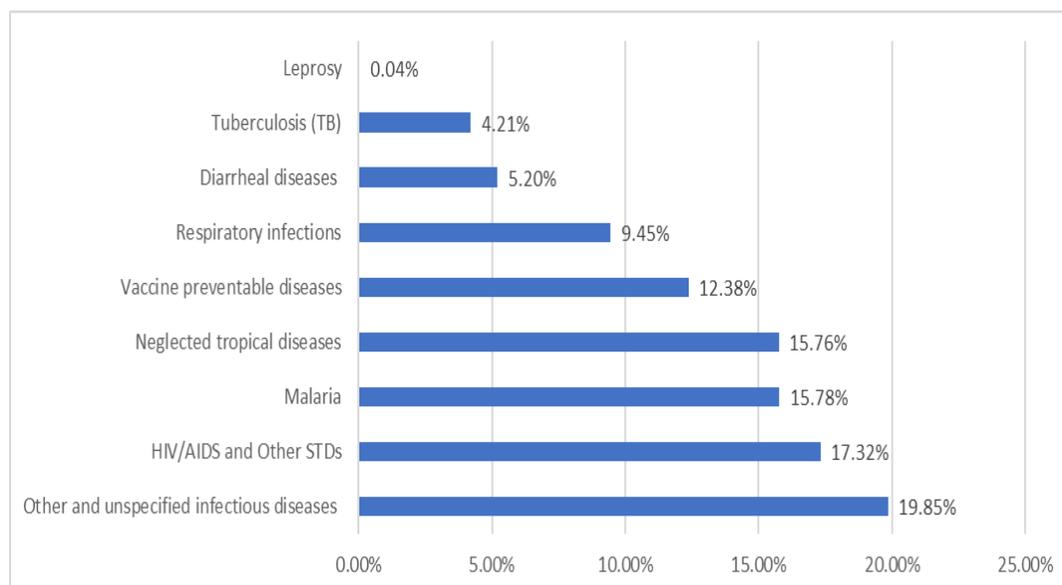
The NHA further indicates that the Government manages more than half of the total health resources 52 percent while it contributes only 32 percent. The GoE accounted for one third of health spending, with a remarkable increase in its nominal value of health spending from ETB

\$ 14.7 billion to \$23.7 billion between 2013/14 to 2016/17. External funding and out-of-pocket spending on health accounted for 66 percent of the total health expenditure (see figure 2.2.2).

**Figure 2.2.1 Total Health Expenditure by Source of Financing (%), 2016/17 NHA**



A significant share of health spending on infectious and parasitic diseases went to curative care (42 percent), while the prevention component was supported by around 37 percent. Of health spending on infectious and parasitic diseases, nearly 17.32 percent went to HIV/AIDS (see figure 2.2.2). Out of the total health expenditure on infectious and parasitic diseases, health spending on curative care reduced by seven percent since 2013/14.



Though health spending is steadily growing overall in volume, the GoE contribution is still low. The share of government health expenditure was found to be 1.4 percent of GDP in 2016/17, which is far below the global average of 5.3 percent. The host government covers the costs of personnel, office space and other operational expenses for the health facilities (Health posts, Health centers,

hospitals, regional laboratories) and above site structures such as FMOH, FHAPCO, EPSA, EPHI, regional Health offices, zonal health offices, woreda health offices

**Table 2.3.1 Annual Investment Profile for HIV by Program Area<sup>3</sup>**

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other (SDG)
Clinical care, treatment and support	64,105,565	39%	61%		
Community-based care, treatment, and support	6,449,538	100%			
PMTCT	1,754,323	68%*			32%
HTS	13,283,641	90%	10%		
VMMC	944,813	100%			
Priority population prevention	2,733,905	43%	14%	25%	17%
AGYW Prevention	-				
Key population prevention	3,778,793	72%		28%	1%
OVC	11,282,058	100%			
Laboratory	18,544,688	84%	16%		
SI, Surveys and Surveillance	7,685,675	100%			
HSS	8,605,986	99%	1%		
<b>Total</b>	<b>139,168,984</b>				

**Table 2.3.2 Annual Procurement Profile for Key Commodities**

Product Category	Forecast for July 2020 - June 2021	PEPFAR	GF	GOE	GAP
ARVs	57,632,377.00	706,441.60	57,632,377.00		
Medicines for opportunistic infections	2,874,665.00		2,874,665.00		
Medicines for sexually transmitted infections	878,242.00		878,242.00		
Condom requirements	4,246,548.00				4,246,548.00
HIV diagnostic rapid test kits	9,525,864.00	642,877.85	9,525,864.00		
EID and Viral load monitoring pharmaceuticals	11,638,050.00	7,571,191.52			
CD4 reagents	4,122,612.00				4,122,612.00
Hematology reagents	1,258,801.00				1,258,801.00
Chemistry reagents	764,678.00				764,678.00
Lab consumables	450,261.00				450,261.00

<sup>3</sup>\*Although PEPFAR has transitioned the testing part of the program, it still supports treatment an EID. 68% contribution is possible mainly due to MSG program cost is covered by PEPFAR

TPT		487,354.88			
TB Lab		728,396.31			
Hepatitis		26,951.40			
Cervical Cancer supplies		561,151.44			
<b>Total</b>	<b>93,392,099.00</b>	<b>10,724,364.99</b>	<b>70,911,148.00</b>	<b>0.00</b>	<b>10,842,900.00</b>

**Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration**

<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-Funding PEPFAR IMs</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	39,000,000				
USAID TB	13,000,000				
USAID Malaria	36,000,000				
Family Planning	27,050,000				
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
MCC					
Other (specify)	7,500,000		1	\$1,412,800	HSS/DRM
<b>Total</b>	<b>122,550,000</b>	<b>7,500,000</b>	<b>1</b>	<b>1,412,800</b>	

## 2.4 National Sustainability Profile Update

The regular PEPFAR monitoring of the national sustainability status helps inform planning and implementation to overcome barriers and use enabling opportunities.

The Sustainability and Index Dashboard (SID) tool is completed every two years by PEPFAR teams, partners, and stakeholders to assess the state of sustainability of the national HIV/AIDS response across countries and to monitor its progress over time. Table 2.3.1 outlines the FY19 SID results.

Table 1: Sustainability Element Score Criteria
Dark Green Score (8.50-10.00 pts) (sustainable and requires no additional investment currently)
Light Green Score (7.00-8.49 pts) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 pts) (emerging sustainability and needs some investment)
Red Score (<3.50 pts) (unsustainable and requires significant investment)

Table 2.3.1: Results of Sustainability Analysis for Epidemic Control in Ethiopia				
	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
<b>Governance, Leadership, and Accountability</b>				
1. Planning and Coordination	7.87	9.29	8.12	
2. Policies and Governance	6.58	8.08	6.08	
3. Civil Society Engagement	4.00	5.17	4.17	
4. Private Sector Engagement	4.44	8.39	1.94	
5. Public Access to Information	7.00	6.00	6.56	
<b>National Health System and Service Delivery</b>				
6. Service Delivery	4.40	5.32	4.01	
7. Human Resources for Health	6.00	6.06	5.71	
8. Commodity Security and Supply Chain	7.08	7.08	3.05	
9. Quality Management	1.62	6.67	4.62	
10. Laboratory	5.51	5.42	4.78	
<b>Strategic Financing and Market Openness</b>				
11. Domestic Resource Mobilization	1.78	6.94	5.36	
12. Technical and Allocative Efficiencies	1.11	5.56	4.44	
13. Market Openness	N/A	N/A	8.70	
<b>Strategic Information</b>				
14. Epidemiological and Health Data	4.48	4.90	4.12	
15. Financial/Expenditure Data	3.75	6.67	5.83	
16. Performance Data	4.74	5.97	6.83	
17. Data for Decision-Making Ecosystem	N/A	N/A	4.17	

Trends in progress from the 2017 SID are noted below with caveats: the small group discussions used to inform the scoring today may vary from those in 2017 as a result of new GoE leadership in place since 2018, and the fact that different people participated in the SID exercise. Additionally, new questions were added to several elements for assessment, thereby hindering a direct comparison of results over time.

## *Strengths*

The COP19 SID characterizes Ethiopia as having strong planning and coordination. The government has developed and oversees a cost multi-year national strategy, although it does not include detailed plans and activities to address the needs of all key populations. Per its mandate, the role of the Federal HIV/AIDS Prevention and Control Office (F/HAPCO) is to ensure implementation of policies and programming, and to coordinate the overall HIV/AIDS response; however, FHAPCO has had challenges with fulfilling its defined role. During the SID workshop, there were conflicting opinions in some responses across sections. In general, Domain A participants felt that while plans and coordination are well-defined, they are not well implemented.

Slight improvements were observed in the overall score for Planning and Coordination (“approaching sustainability and requires little or no investment”). The increase can be attributed to improved GoE tracking of HIV activities by CSOs. Three elements were assessed as “emerging sustainability and needs some investment”.

Policies and Governance decreased slightly from the 2017 SID (6.58 to 6.08), however, it is notable that the 2019 assessment of the element was measured by ten questions (an increase from six questions in 2017). Civil Society Engagement also shows slight improvement in SID 2019 (4.0 to 4.17) as a result of the new CSO proclamation that supports the oversight role of CSOs and their active engagement in HIV programming. Domestic Resource Mobilization, Technical Allocation Efficiencies and Market Openness are scored at 5.3, 4.44 and 8.7, respectively. The scores for the first elements of this section declined somewhat from SID 17, but remain in the “emerging sustainability and needs some investment” category.

The overall scores for Strategic Information are “emerging sustainability and needs some investment,” with scores ranging between 4.12–6.84. Compared to SID 2017, there was a slight decline in SID 2019 across Epidemiological and Health Data (4.90 to 4.12), and Financial/Expenditure Data (6.67 to 5.83), while Performance Data increased from 5.97 to 6.83.

## *Vulnerabilities to Sustainability*

The decrease in Public Access to Information (7.0 to 6.56) can be attributed to expenditure transparency. While the participants this year concluded that some expenditure data exists, Ethiopia does not have complete annual overall expenditure data on HIV/AIDS. In contrast, SID 2017 indicated the existence of annual HIV expenditure data. This disparity in views led to the drop in score.

The overall scores for National Health System and Service Delivery are “emerging sustainability and need some investment” with scores ranging between 4.01 – 5.71. The Commodity Security and Supply Chain element was assessed as “unsustainable and requires significant investment” with a score of 3.05. In comparison to the SID 2017 assessment, the SID 2019 indicated declining scores across each element of the domain. This is mainly because the country continues to maintain donor driven supply of commodities such as Antiretroviral, Condom, HIV testing and OI drugs. In addition, lack of comprehensive supply chain study/survey and the need to have coordination in terms of capacity building to both administrative level and health care delivery points were identified as gaps. The current national draft strategic planning for HIV program has captured the

need to strengthen capacity building coordination at all level and commodity supply, which will enhance condom supply, and public and private sector engagement for RTK supply.

The 2019 SID identified emerging levels of sustainability requiring additional investment and the vulnerabilities outlined in the 2019 SID will be used to inform priorities for investment during the COP 20/21 planning processes. PEPFAR-E ensures PEPFAR investments leverage and compliment investments of GoE and other donors. PEPFAR-E will continue to support activities and areas of investment that will have a significant impact on reaching and sustaining epidemic control in Ethiopia.

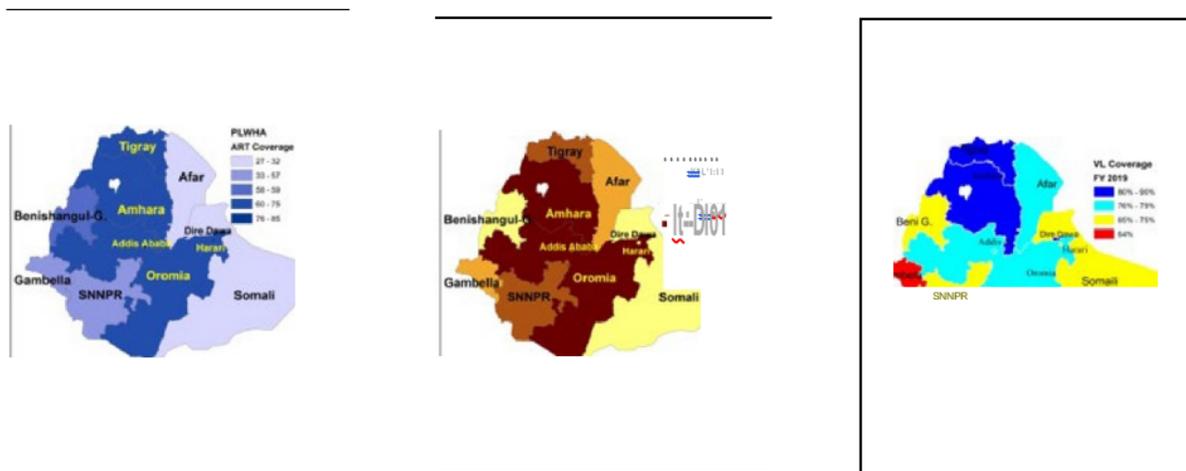
## 2.5 Alignment of PEPFAR Investments Geographically to Disease Burden

HIV care and treatment services are available across Ethiopia largely through public health facilities and community-based platforms. In FY19, 468,705 PLHIV received treatment at PEPFAR-supported sites as well as 497,893 OVC.

As Ethiopia approaches epidemic control, investments will be optimized to reach and sustain epidemic control in the highest burden regions. In the 5 regions with the greatest gap to saturation, DSD support will include intensified and targeted case finding, ensuring at least 92% of all diagnosed PLHIV are on optimal regimens ART, and patients on ART receive an initial 6 month and then annual VL test.

The working 2020 SPECTRUM estimate of PLHIV, the 2018 EPHIA and program data for PLHIV currently on ART (TX\_CURR) were used to understand treatment gaps by geography. The SNUs/ geographic locations with the greatest treatment gap are Oromia (41,887), Amhara (39,554) and Addis Ababa (5,347) and Oromia will be receiving Ambition funds in COP20. In regions that have lower unmet needs and are approaching epidemic control, direct PEPFAR funding support has ceased in COP19 and these regions will receive TA support through a national TA model, led by FHAPCO and the FMOH.

**Figure 2.5.1 PLHIV by SNU, Total PLHIV by SNU, and Coverage of total PLHIV with ART, and Viral Load Coverage by SNU.**



## 2.6 Stakeholder Engagement

The COP20 process has been open and consultative, and the plan reflects the strong engagement with and input from a range of stakeholders. Collaboration with stakeholders continued to be stronger this year throughout the planning process. In particular, the PEPFAR-E team received substantial input from FMOH, FHAPCO, EPHI, EPSA, GFATM, UNAIDS, WHO, civil society and faith-based organizations to prioritize investments included in COP20. PEPFAR-E also worked with implementing partners, local and international, to evaluate partner performance and progress towards goals in order to refine COP19 implementation and focus COP20 planning efforts. PEPFAR-E direct funding for the private sector was phased out in COP17. However, private sector collaboration will continue through multilateral stakeholder engagement platforms while private sector facilities also continue to benefit from government support and PEPFAR technical assistance.

PEPFAR-E created an opportunity for early engagement of the GoE and UNAIDS in December 2019. PEPFAR-E leadership met with Minister of Health, Dr. Lia Tadesse, to request strong collaboration and engagement by the FMOH in COP planning and implementation; Dr. Lia expressed FMOH's commitment to fully participate in the process.

The COP20 guidance, tools and planning level letter were shared with external stakeholders. Key GoE entities (FMOH, FHAPCO, EPHI, EPSA, MOF, MOWYCA) and external stakeholders (UNAIDS, GFATM, WHO, CSOs) participated in the stakeholder's strategic retreat convened in January 2020. The stakeholder meeting was interactive, and all stakeholders have participated in small group sessions to provide inputs on the PEPFAR-E strategic direction for COP20. Agency Headquarter personnel also joined the retreat, and all participants provided comments on the proposed PEPFAR-E planning direction for COP20.

PEPFAR-E conducted IP meetings, also attended by stakeholders, to evaluate performance and better understand implementation challenges and possibilities in order to refine plans to improve community-facility linkage and achieve epidemic control in COP20, including in non-priority regions. In COP 20, PEPFAR-E will continue to work very closely with the FMOH, FHAPCO, EPHI, EPSA, RHBs and community partners to carry out ICT, self-testing, same day treatment initiation, and scale up viral load, CBS and recency testing to find the remaining cases and get them virally suppressed.

Finally, in preparation for the COP20 Regional Planning Meeting in Johannesburg, PEPFAR-E held a final stakeholder meeting in Addis Ababa to review and discuss the final COP20 strategy, data analyses, and presentation. Many stakeholders and partners joined the Johannesburg meeting as part of the Ethiopia team delegation, including the State Minister of Health, the General Director of FHAPCO, Ethiopian Public Health Institute, Addis Ababa Regional Health Bureau, one representative from Ethiopian Consortium of Christian Relief & Development Associations (CCRDA), Network of People living with HIV (NEP+), Network of Positive Women

in Ethiopia (NPWE), UNAIDS, WHO and Global Fund. Robust participation of these external stakeholders and partners resulted in a stronger plan for COP20.

CSO and FBO representatives that participated in the regional planning meeting had the opportunity to present their proposals for community led monitoring, which is a new initiative for Ethiopia and will truly be independent, community-led and owned, thus building on the national strategic approaches that are delivering impact and ensuring robust advocacy and monitoring. Community-led monitoring will focus on quality of services, and reduction of stigma and discriminations to facilitate access to and retention in services amongst others to ensure effective client outcomes.

Building on this annual planning process, PEPFAR-E will continue to engage with external partners and stakeholders—including civil society—at all levels to support optimized implementation of COP20. Implementation will include ongoing consultations, including sharing of quarterly results at the national and regional levels, and quarterly program management reviews with the GoE and community representatives, including status updates on partner pipelines. COP20 implementation will also leverage current efforts to deepen engagement with RHBs and other indigenous organizations across program implementation areas.

### 3.0 Geographic and Population Prioritization

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Geographic and population prioritizations were determined using the 2017-2018 EPHIA survey, the current UNAIDS Spectrum model estimates, and program data. Geographic regional prioritization is based on prevalence and greatest unmet need towards treatment saturation, with distinctions made between DSD with TA, and TA-only regions in terms of PEPFAR support. PEPFAR will focus DSD assistance to the 4 regions of Addis Ababa, Oromia, Amhara, and SNNPR which have the largest gaps to saturation. In addition, DSD assistance will be maintained in Gambella region, which has the highest prevalence of HIV, hosts a large refugee population, and has limited capacity to deliver health services. The major focus will be on active case detection given this is the major barrier to achieving epidemic control. In the remaining regions where the gap to saturation is smaller, there will be a shift to a TA/NSD model. TA regions will be supported centrally through FMOH agencies including FHAPCO and EPHI.

**Table 3.1 ART Saturation and Progress Towards 95/95/95 Across all SNUs**

<b>Table 3.1 Current Status of ART saturation</b>				
<b>Prioritization Area</b>	<b>Total PLHIV/% of all PLHIV for COP20</b>	<b># Current on ART (FY19)</b>	<b># of SNU COP19 (FY20)</b>	<b># of SNU COP20 (FY21)</b>
Attained	85%	396237	867	867
Scale-up Saturation	N/A	N/A	N/A	N/A
Scale-up Aggressive	N/A	N/A	N/A	N/A
Sustained	N/A	N/A	N/A	N/A
TA Support	15%	64,531	209	209
Military	NA	7937	1	1

## 4.0 Client Centered Program Activities for Epidemic Control

### 4.1 Finding the Missing and Getting Them on Treatment

HIV case finding remains the critical gap to treatment cohort growth given Ethiopia’s strong retention. PEPFAR-E will continue to work with the national program to continue to focus national HIV testing guidelines (e.g. elimination of universal under-5 testing) for deployment of the most effective modalities, such as optimization of risk-screening tools with optimized provider-initiated testing and counseling, index-case testing, assisted and unassisted HIVST, and social-network strategy (SNS). Recently, the Government of Ethiopia has agreed to issue a circular to discontinue universal under-5 testing and mandate use of the HIV risk screening tool at all service delivery points. Further efforts will be made to revise HIV testing guidelines as part of the new 5-year National Strategic Plan and new 3-year GFATM grant to address the primary role of ICT, alignment of national and PEPFAR testing targets and yield assumptions, and ensure separate services for premarital and other low-risk testing needs.

#### 4.0.1 ICT Scale-up with Fidelity

Sites and providers will be supported to meet a set of minimum core standards established by the national HIV testing services technical working group (TWG), in alignment with international consensus. These standards will address aspects including, but not limited to: (1) Facilities will retrospectively record review of eligible biological children,

including adolescents ages 15-18, of adult TX\_CURR and ensure testing for all; (2) facility and community-based partners will provide disclosure support and conduct active ICT services (3) unassisted HIV self-testing (HIVST) through secondary distribution via index cases (and/or caregivers for children) will be used to reach partners who do not wish to see a facility provider; (4) community partners will provide unassisted HIVST services in the community and introduce social marketing strategy for HIVST to increase demand and access (5) client-centered counseling and testing services with focus on timing and accessibility for services convenient to adults and children, based on preferences, patient literacy, and ensuring high-quality, confidential counseling services; (6) use of recency testing data to identify geographic and demographic hot-spots and further target case-finding and prevention measures; (7) index patient and contact literacy; (8) service package to prevent and monitor intimate partner violence as well as link clients at risk and survivors of IPV/GBV to services; (9) ensuring competent staff provide ICT, using culturally-appropriate counseling and contact elicitation scripts, registers and job aids; and, (10) Town/Woreda health offices capable of monitoring ICT performance, providing mentorship for more challenging index cases and their contacts, managing cross-site and cross-jurisdiction contact tracing, and ensuring 100% linkage of newly diagnosed men to treatment services. To execute this minimum standards approach, PEPFAR-E will concentrate facility-based and community-based ICT in 181 DSD and 312 TA facilities and 114 Woredas for maximum impact. This process entails selection of priority urban and peri-urban foci within the relevant 74 zones to the sites and woredas, and further micro-plan development within each focal zone and to include associated health departments, facilities and community LIPs. These micro-plans will build capacity for, and optimize workforce at facilities and woreda health departments and among community actors to ensure the minimum standards (5Cs) for provision of ICT within these zones and at high volume, high-impact sites. Local health departments will lead efforts to use CBS/Recency testing results for accelerated ICT and linkage to services, including PrEP for HIV-negative individuals in sero-discordant relationships with partners with unsuppressed viral load as well as other HIV-negative individuals at significant risk. All these efforts will be underpinned by improving patient and provider literacy around ICT, retention and VLS within the Undetectable = Untransmittable (U=U) strategic communications framework strategy led by the Federal HIV/AIDS Prevention and Control Office (FHAPCO).

#### **4.0.2 PITC**

PEPFAR-E will further support optimization of PITC by ensuring (1) facility- customized design, fully integrating screening services into routine service provision by clinicians for adult, adolescent and pediatric cases; (2) dedicated and family- and client- centered counseling; (3) patient and provider literacy; and, (4) robust monitoring of the number of persons needed to test to find one positive (NNT). If coverage is >90% and NNT continues to increase, HIV risk screening will be refined through daily and weekly review and targeting of only those patient groups from whom PITC services are detecting the positives. High-risk, high-efficiency entry points such as STI clinics, TB and malnutrition (for children) will be monitored to ensure testing coverage of >90%.

### **4.0.3 Case Finding among Key and Priority Populations**

Key Populations (KPs) are among primary targets for new HIV case finding. Our COP 19 quarter 1 data shows the HIV positivity yield among tested female sex workers (FSW) and their sexual contacts was 22.2%. PEPFAR-E will continue its efforts of case finding among these populations by employing social network testing (SNS), ICT and PNS. Currently, 31 drop-in centers (DICs) in the community and 80 public health facilities are providing KP-friendly services which are confidential and tailored to their specific needs. New cases identified from both public sites and DICs will be counseled and asked for their consent to elicit their sexual contacts or supported to serve as “seeds” for SNS. Targeted community outreach testing will be used to reach KPs that prefer to access services in their vicinity and in towns where there are no DICs. This will include hard-to-reach key and priority populations: FSW, clients of FSWs, men and at-risk, out-of-school adolescent girls and young women. With the temporary halt of ICT among KP’s, PEPFAR-E in collaboration with MOH and implementing partners is developing minimum standards for safe implementation of ICT. PEPFAR -E will ensure the integration of intimate partner violence (IPV) screening and management with ICT implementation and the WHO’s 5 Cs (Consent, Confidentiality, Counseling, Correct test result and Connection/Linkage to prevention, care and treatment services) are in place for all HIV testing services and other case finding modalities.

### **4.0.4 HIV Self-Test (HIVST)**

PEPFAR-E supported the first HIVST pilot implementation in the country in collaboration with MOH/EPHI beginning in 2017. PEPFAR-E has used this opportunity to demonstrate feasibility of implementing HIVST in Ethiopia and advocated for implementation of unassisted HIVST at scale. Currently MOH has approved the implementation of unassisted HIV self-testing to create demand and close the gaps in case finding, currently the main barrier to the epi-control efforts. In FY20 Q1, a total of 3,008 individuals were tested through assisted HIVST, with 134 new HIV+ cases identified (4.5% yield). All the 134 new cases underwent confirmatory testing and 95% linked to ART. In the remaining COP19 periods and COP 20, PEPFAR-E in collaboration with MOH and implementing partners will implement unassisted self- testing at scale both in the community and facility to reach men, adolescent girls and young women (AGYW) and hard to reach key populations. In addition to these existing facility- and community-based initiatives to support unassisted HIVST, social marketing and distribution of HIV self-test kits will be one of the interventions to be piloted in COP20 in selected woredas in Addis Ababa. Pharmacy outlets, particularly private pharmacies, will be utilized to facilitate access to target population groups.

#### **4.0.5 Linkage**

Newly diagnosed adult PLHIV will be accompanied by HIV+ peers for linkage within and between facilities within a Town. Children will be supported to link to treatment services, including optimal regimens, OVC support, etc. by a skilled, dedicated nurse provider, competent in family-counseling and supporting parents/caregivers to design patient-specific treatment plans. These nurses, reinforced by local health offices, will work with community partners on case finding, rapid (same day) initiation, and linkage of newly identified PLHIV to community services. For linkage between facilities and outside of towns, local health offices will coordinate and conduct linkage audits.

### **4.2 Retaining Clients on Treatment and Ensuring Viral Suppression**

Ethiopia already has strong retention with >95% proxy retention. Still, given the maturity of the program, more needs to be done to make “good even better” and reach 98% overall retention. Improving treatment and viral load literacy, including the adaptation and scale-up of U=U, will contribute to more optimal rates of adherence to ART and retention in care and be an area for joint endeavor between the Government of Ethiopia and its partners. This initiative, reinforced by renewed collaborations with faith-based organizations, other civil society and Federal and Regional administrations, will augment all efforts to strengthen retention and viral load suppression in Ethiopia. While from a policy and guideline perspective, Ethiopia has met all minimum requirements, there is still additional work to be done with scaling up client-centered services, including introducing and scaling up fast-track pharmacy refills, scaling-up the health care managed community ART groups, strengthening the six month appointment spacing model (MMD), expanding implementation of extended or flexible working hour services as well as strengthening timely and appropriate use of viral load results to guide clinical decision for managing patients on ART.

Some key retention challenges recognized in FY19-to-date include: (1) difficulties with confirming transfer outs and associated documentation (including silent transfers); (2) basic demographic details on patients that is key to follow-up (e.g. phone numbers); (3) specific challenges with retention among adolescents and young adults, , including losses within the first 12 months of treatment initiation; (4) seeking traditional healing activities that may undermine adherence – e.g. holy water use and discontinuing treatment; and, (5) ongoing insecurity situation in many parts of the country, which will likely persist in the run-up to the 2020 elections (and beyond). Innovations to address these challenges, all underpinned by the U=U initiative, include: (1) One-to-one peer support for newly-initiated patients and those with high viral load, including reinforcing interface between community and facility-based actors; (2) optimizing regimens; (3) reinforcing client centered services and DSDM; (4) improving documentation of patient demographics; (5) engaging FBOs as program advocates and ensuring messaging that is consistent and aligned with evidence based approaches for HIV case identification, treatment of HIV and co-morbidities, and at the same time respecting and adhering to social and religious values among the community ; and, (6) an ongoing bring back-to-treatment periodic campaigns.

### 4.3 Prevention for Priority Programming

Ethiopia's National HIV Prevention Road Map 2018–2020 is aligned with the national HIV/AIDS Strategic Plan 2015–2020 and with global recommendations. In this Road Map, Ethiopia has defined its KP and PP groups taking local epidemiology into consideration. The KPs are FSWs and prisoners. PPs are widowed, separated or divorced women. PLHIV and their partners; mobile and resident workers in hotspot areas; young women involved in transactional sex; and vulnerable AGYW. As per the EPHI national MARPs study conducted in 2013, the prevalence among distance drive is also high (4.9%). These population groups are at a high risk of HIV infection, have limited access to services, and some face stigma and discrimination. There are an estimated 220,623 FSWs in Ethiopia as per the size estimates conducted by PSI and EPHI in 2011.

Currently, the National HIV Strategic Plan (NSP) is under revision and the PEPFAR team is supporting MoH in the development of the NSP for 2021–2025. Likewise, an IBBS for FSW is being conducted by EPHI through support from Global Fund. The National PrEP guideline is updated and an IBBS among AGYW has been completed recently. PEPFAR team has used information to inform COP20 strategies; it will continue to refine and align its intervention with NSP and utilize the findings of the IBBS to inform KP programming in the remaining quarters of COP19 as well as COP20.

In order to reduce the spread of HIV and to reach sustained epidemic control in Ethiopia, improving access to, and friendliness of HIV services for KP and PP remain crucial. However, reaching target populations such as non-self-identified SWs, part-time SWs, young girls who are new entrants to sex work, and men, is complex.

In COP20, PEPFAR-E will support HIV services for KP in the community hot spots, Drop-In-Centers (DICs) and selected friendly public health facilities. In order to increase case identification and improve yield among FSWs and their partners, evidence-based testing approaches, including ICT/PNS, SNS, HIVST and recency testing will be implemented. Results of recency testing will be used for the rapid response to the recent infection through ICT/PNS and SNS.

Children and partners of FSW will also be offered testing and, if diagnosed HIV-positive, they will be linked to and enrolled in treatment. Adult men with higher risk of HIV infection, at-risk out-of-school AGYW, and women who engage in transactional sex will also be reached through ICT/PNS, SNS, and targeted outreach services.

DICs are located in Addis Ababa and Amhara, providing comprehensive HIV prevention, care and treatment services, including family planning, GBV services, and harm reduction counseling for substance use on-site or through referral. In FY 21, the program will continue providing comprehensive HIV services in the community in SNU with high impact and high yield interventions in Amhara and Addis Ababa; out of which only 31 SNU have a DIC, with 20 of these also providing ART services for FSWs. Moreover, Cervical Cancer Screening, treatment and referral services for all HIV positive FSWs will be integrated in the 20 ART DICs. Facility based

HIV services will be provided to FSWs, sex partners and eligible children in selected public health facilities within major towns of Amhara, Addis Ababa, Oromia, SNNPR and Gambella and will track the full clinical cascade from detection to VL suppression.

Stratification of PP to identify those at higher risk will continue in order to maximize yield from testing. PPs such as the clients of FSWs, truck drivers and young women involved in transactional sex will be reached with tailored interventions to minimize risk of infection and increase access to HTS. Community mobilizers will reach FSWs and PPs with the minimum package of prevention services in the community and link PPs and high risk FSWs to HTS. To increase demand for HIV testing among key populations, unassisted HIV self-testing will be employed at scale. Community based providers will accompany HIV positive clients to ART services provided at DICs and health facilities.

Linkage and initiation on ART for HIV-positive clients will be a key strategy under COP20. Regular linkage audits using facility-community collaboration SOPs will be strengthened and institutionalized. Same day ART initiation, disclosure, adherence support, and tracking of LTFU clients will be conducted. VL testing will be done for HIV positive clients in care as per the national guideline and will work to achieve optimum VL suppression.

#### **4.3a. PrEP for Key and Priority Populations**

Counseling services will be provided for HIV negative clients to remain negative and provision of PrEP will be used as one strategy to reduce new infections and HIV acquisition. The 2018 national comprehensive HIV care guideline recommends PrEP for clients at substantial risk of HIV infection or incidence rate of three or more. Eligible clients for the PrEP services include FSWs and The GOE has shown interest in expanding PrEP to FSW and other high-risk population groups. Currently, the PrEP services have been provided in 31 public health facilities and ten DICs for FSWs and HIV negative sero-discordant partners. In COP20, PrEP will be implemented in 20 DICs and 117 public health facilities. The PrEP\_CURR targets in COP20 significantly increased from 2,600 in COP19 to 15,350.

The Ethiopia PEPFAR team has successfully improved targeted HIV case finding among FSWs, increasing yields from approximately five percent through outreach to a yield of 22.4 percent through ICT and partner services in FY20 Q1. These strategies, now being rolled out, have allowed the program to reach higher risk FSW and their sexual partners who are eligible for PrEP, and has led to enrollment of newly diagnosed FSW into ART, and reengagement of HIV-positive FSW who have fallen out of care. The team is also planning to offer PrEP and enroll HIV negative clients in sero-discordant relationships with HIV-positive partners that are not virally suppressed or with partners of unknown status. Services will include offering PrEP to pregnant and breastfeeding women with overlapping risk behaviors such as engagement in sex work and/or in HIV negative sero-discordant partners. PrEP scale up will also be linked to scale of HIV self testing

PEPFAR-supported IBBS among AGYW conducted in 2019 in Addis Ababa and Gambella has shown high HIV prevalence (2.7%) and risk behavior among AGYW in Ethiopia, particularly among out-of-school AGYW 15-24 years old. At risk AGYWs will be reached with HTS services and targets have been set in the PP\_PREV indicator in COP20. Prevention interventions will support identification of high AGYW who are engaged in sex work or transactional sex that would benefit from enrollment in PrEP services. Risk screening will be performed among AGYW with standardized questionnaires and linkage to and provision of appropriate services will be affected.

**a) HIV prevention and Risk Avoidance for AGYW and OVC**

PEPFAR Ethiopia program for Orphan and Vulnerable Children (OVC) works to improve access to HIV service for OVC beneficiaries and their care providers. It supports health and well-being outcomes of orphans and vulnerable children (OVC) and enables them utilize services for improving HIV and AIDS care, health, nutrition, economic security, education, protection, and psychosocial wellbeing. Starting COP19 the OVC program aligning its approach with the HIV epidemic status in the country including geographic refocusing. By the end of COP19 the program will transition out of Tigray and Dire Dawa; and it will focus its COP 20 intervention in five PEPFAR maintained regions such as Amhara, Oromia, SNNPR, Addis Ababa and Gambella. In COP20 the OVC program plans to serve 298,496 OVC with comprehensive and primary prevention interventions, and 50,000 caregivers.

In COP20, the program will focus on supporting new HIV case identification among OVC and linking them to ART; reducing the pediatric and adolescent treatment and retention gaps; improving access to viral load testing and viral suppression among enrolled beneficiaries; and providing training to 9-14 year old boys and girls on primary prevention including sexual violence prevention and prevention of HIV risks.

To enhance that, the program will focus on enrolling more HIV positive children and adolescents, and children of PLHIV who are with low viral suppression and retention problems to enhance their treatment outcomes. It will work to mitigate the impact of HIV by empowering individuals, families, communities, and local governments to respond to the needs of at high risk children mainly C/ALHIV.

In COP 20 the program will employ two models of interventions: Comprehensive and preventive interventions. The priority sub-populations for COP20 for OVC Comprehensive intervention will be: HIV infected children and adolescents <18 years of age, children of PLHIV, Children with HIV infected sibling, HIV exposed infants, children of female sex workers, survivors of sexual violence, and HIV infected pregnant and breast-feeding Women (PBFW) aged 10-24 years. Similarly, the OVC primary prevention intervention will focus on implementing time-limited, curriculum-based training. PEPFAR approved curriculums such as IMPOWER (for girls) and Parenting Lifelong Health (for both boys and girls) will be the curriculum used to train target boys and girls. The training will be provided at school and community venues by closely working with schools, community groups, faith-based organizations, etc.

In accordance with the COP20 priority interventions for OVC program beneficiaries to improve their retention and VLS, it will:

- Offer at least 90% of TX\_Curr (< 18-year of age), in the geographies where the OVC program operate, to enroll in the OVC program (prioritizing those with poor VLS and new on treatment),
- Ensure that at least 95% of OVC\_SERV know HIV status,
- Ensure 100% of HIV+ OVC\_SERV are on ART,
- Support those on ART remain adherent to their treatment and retained in care, and
- Support HIV+ access viral load testing and achieve viral suppression

To achieve these, the OVC program will closely work with public and private health facilities which provide HIV services to facilitate access to services and information exchange. To strengthen the community-facility links, there will be MOUs between facility and community partners that outlines: bi-directional referral protocols, shared confidentiality agreements, training for OVC staff, case conferencing, and joint case identification by working through multi-disciplinary team approaches. It will also work with partners working with key populations to assess/enroll HIV+ children of FSWs into the OVC program. In addition, in coordination with PEPFAR-supported and other community social and nutrition support programs will be strengthened to ensure HIV-exposed/infected children and their families will be linked to appropriate services based on their needs.

In addition, the program will strengthen caregiver treatment literacy and provide psychosocial support during OVC home visits by case managers and social workers provide social services (psychosocial support, socioeconomic interventions, education support, and parenting) for those priority sub-populations.

To improve new HIV case identification, the program will facilitate index testing access for biological children of HIV+ mothers and conduct home visits to facilitate testing uptake for children. It will also support access to treatment and retention in care services for HIV infected children and HIV+ women in adult care.

To reduce lost to follow-up (LTFU) and find LTFU cases (especially HEI) it will: support contact tracing and follow-up children < 2 years lost from in PMTCT by tracking the PMTCT cascade; find, assess and refer HIV exposed LTFU infants; find, assess and refer infants of HIV+ mothers to ensure EID testing (with a focus on 10-24-year-old females); conduct tracing to help return to EID services; provide follow up support for mothers of HIV+ infants to improve retention and VLS; and conduct GBV screening and provide referral and linkage to comprehensive post-violence care services. It will also provide document reasons for refusal and LTFU to inform future strategies, continue to provide case management and socioeconomic support to mitigate barriers affecting retention.

COP19 Q4 data shows that the community level OTZ strategy in Addis Ababa is successful in engaging CLHIV to provide adherence support for ART services, and ensuring viral load test results monitoring. Children enrolled in the community OTZ were shown to have better viral suppression rates compared to other CLHIV. Thus, in COP20, the OVC program will scale up community OTZ implementation in Oromia region, SNNPR, Amhara regions, and in Addis Ababa.

In COP20, the OVC program will enhance the capacity of community case workers, social service workers, and/or para-social service workers to identify and address risk factors for poor adherence, especially early non-adherence (first three months) and poor retention in care. They will support monitoring ART adherence and VL status during household visits (or during clinics visit for families living in distant communities by layering the service with clinics) and provide quality adherence counseling and support in the community, or refer for enhanced adherence counseling (EAC) when needed. Stable adolescents will be linked to ART refill groups and other community-based mechanisms to facilitate their access to medications. Community VL champions will be identified to support increased demand for and timely use of VL testing. Youth will be identified and trained to equip them with necessary skills to become peer youth counselors and treatment champions. Regular meetings will be held for community case workers/social workers and health providers to review performance results of case management, identify gaps and modify interventions to increase effectiveness and efficiency.

Regarding AGYW, the program will use evidence-based approaches to address the structural drivers that increase HIV risk. Comprehensive HIV services as well as HIV and gender-based violence (GBV) prevention services will be provided for high risk AGYW. The OVC program will work on a comprehensive package of social, economic and biomedical interventions to reduce vulnerability to HIV. The program will implement multi-faceted and integrated response approaches by collaborating and closely working with the health, education, psychosocial, economic and civil society/community sectors.

The program will also work to build social assets of vulnerable AGYW who generally lack social networks of empowerment. Hence, adolescents will be linked to community and facility-based services to address their needs. To change risky sexual behavior among youth through delayed sexual debut or condom use, and prevent violence and abuse, the program will increase caregivers' knowledge, skills, and confidence to talk to their children about sexual health. As gender disparities and GBV increase AGYW vulnerability to HIV due to multiple factors, including limited ability to negotiate safer sex, engaging in transactional sex, disclosure and access to HIV treatment because of fear of violence and abandonment, the program will work on primary prevention strategies based on curriculum that incorporates healthy and unhealthy relationships, and healthy choices around sex.

The facility-based HIV prevention for AGYW and children program mainly focus on risk screening for HIV and GBV; provision of HIV and GBV prevention services; post violence services for GBV survivors; adherence; disclosure support and continuum of care services for PLHIV adolescent and youth in PEPFAR supported health facilities.

The capacity of government, CSOs, FBOs at national, regional, and community-based levels will be built to facilitate access to quality services for comprehensive and preventive OVCs by strengthening social services systems to support smooth transition of OVC programs to LIPs. Local implementing partners (LIPs) and FBOs will be supported to institutionalize HIV and violence prevention training and support for community case managers and social service cadres; and strengthening MOLSA, MOWCYA and HAPCO in rolling out the National plan of Action for children and Child policy will be continued.

To provide the GOE, PEPFAR and other stakeholders with critical data on violence against children and youth and to inform implementation of programs to prevent violence and respond to the needs of its survivor's, PEPFAR is conducting Violence against Children Survey (VACS) in COP19 and its result is expected to be available at the beginning of COP20. Thus, the finding of the survey will be utilized to further refine our approach on addressing challenges identified through this assessment and inform policy considerations. It is expected that the survey will elucidate on childhood marriage, teen pregnancy, gender attitude, violence victimization, HIV, etc.

#### **b) Children/PMTCT**

The 2019 updated national comprehensive and integrated PMTCT guideline endorses DTG based regimen and EFV400mg as preferred first line ARVs for PBFW and women of childbearing potential. The country has also adopted provision of enhanced postnatal prophylaxis (NVP+AZT for the first 6weeks and NVP alone for the following 6 weeks) for all HIV Exposed Infants. The guideline emphasizes the importance of retaining mothers on treatment and follow up care, recommends frequent routine viral load monitoring (after three months of ART initiation and then every six months). It also gives a clear direction to improve EID coverage and to shorten the turnaround time (TAT) to less than three weeks and scaling up EID point of care testing (POC). Ethiopia has also adopted current WHO guidance for optimal pediatric ART regimens and started implementation in FY19. Although there were shortages of certain pediatric formulations early in transition, significant progress has been made recently with over 70 % of children<15 transitioned to optimal regimens and many sites completely transitioned off NVP based regimens. FMOH is currently working with stakeholders to ensure adequate supply of Pediatric ARV formulations, improve health care provider's capacity and monitor the progress of the transition. A pilot of Operation Triple Zero (OTZ) at 6 sites in Addis has shown promising improvements in improving adherence, retention, and viral suppression. Based on lessons from the pilot, the national package of adolescent pediatric psychosocial support (APPSS) is currently being revised to incorporate elements of OTZ service package for provision of tailored services for adolescents.

In COP 20, the main case finding strategy to detect HIV positive children will be index case testing (ICT) and optimized PICT. Facilities will retrospectively record eligible biological children of adult ART clients, ensure 100% testing and initiation on optimal treatment regimen. Innovative

strategies to realize this target may include improving messaging to caregivers, transport reimbursements for testing, weekend hours to minimize children missing school and use of self-test kits for caregivers unable to bring children in for testing. High-risk, high-efficiency entry points such as TB and malnutrition will be monitored to ensure testing coverage of >90%. To optimize PITC in children <15, risk-based testing services in <5 clinics and OPD settings will be done through appropriate counseling. PEPFAR will work with FMOH to ensure adoption and validation of pediatric screening tools in pediatric OPD, pediatric inpatient, and entry points.

Interventions to Improve viral suppression and retention in care among children will be priority activities. Upcoming new pediatric ARV formulations will be incorporated in national guidelines as available and progress of Pediatric ART optimization will be closely monitored. OTZ will be scaled up to additional high case load facilities in maintained regions. In addition PEPFAR will work to establish a pediatric center of excellence in high caseload facilities that will serve as a regional learning hub for increasing in-country expertise on pediatric HIV by hosting and precepting multidisciplinary teams (MDT) teams' onsite, and making available pediatric experts who will provide assessment, training and support to local and regional ART sites.

The country will also continue ensuring provision of optimized ART for HIV positive pregnant and lactating women and supporting and monitoring the implementation of TLD for all women of childbearing potential including Adolescent girls and young women (AGYW). Reaching 95% EID testing coverage within 12 month of age and 80% coverage within 2 months of age by increasing access to EID diagnostic services and facilitating efficient use of Point of Care (POC) testing will be the main activity. The country will also introduce and support the implementation of new initiatives like PrEP and cervical screening in the PMTCT program. Overall conducting real-time PMTCT program monitoring (cohort monitoring) and quality improvement activities at the site level and supporting implementation eMTCT strategies of the country will remain the cornerstone of the program.

### **c. Key Populations**

Ethiopia's National HIV Prevention Road Map 2018-2020 is aligned with the national HIV/AIDS Strategic Plan 2015-2020 and with global recommendations. In this road map, Ethiopia has defined its KP and PP groups taking local epidemiology into consideration. The KPs are FSWs and prisoners. PPs are widowed, separated or divorced women; distance drivers; PLHIV and their partners; mobile and resident workers in hotspot areas, young women involved in transactional sex, and vulnerable AGYW. These population groups have high risk of HIV infection, limited access to services, and some face stigma and discrimination. There are an estimated 220,623 FSWs in Ethiopia as per the size estimates conducted by PSI and EPHI. Currently, the national HIV strategic plan (NSP) is under revision and PEPFAR team is supporting MoH in the development of the NSP from 2021-2025. Likewise, IBBS for FSW is being conducted by EPHI through support from Global Fund. National PrEP guideline is updated and IBBS among AGYW completed recently. PEPFAR team has used information to inform COP20 strategies and will continue to refine and align its intervention with NSP and utilize the findings of the IBBS to inform the KP

programming in the remaining quarters of COP 19 as well as COP20. In order to reduce the spread of HIV and to reach sustained epidemic control in Ethiopia, improving access and friendliness of HIV services for KP and PP remain crucial. However, reaching target populations such as non-self-identified SWs, part-time SWs, young girls who are new entrants to commercial sex work and men is complex. The needs of key populations in Ethiopia continue to be addressed through multiple approaches, used by clients based on their preferences. In COP20, PEPFAR will support HIV services for KP in the community hot spots, Drop-In-Centers (DICs) and selected friendly public health facilities.

In-order to increase case identification and improve yield among FSWs and their partners, evidence-based testing approaches including ICT/PNS, SNS, HIVST and recency testing will be implemented. Results of recency testing will be used for the rapid response to the recent infection through ICT/PNS and SNS. Children and partners of FSW will also be tested and, if found to be HIV positive, they will be linked and enrolled in treatment. Adult men with higher risk of HIV infection, at-risk out-of-school AGYW, and women who engage in transactional sex will also be reached through ICT/PNS, SNS and targeted outreach services. DICs are in Addis Ababa and Amhara providing comprehensive HIV prevention, care and treatment services including family planning, GBV services, and harm reduction counseling for substance abuse on site or through referral. In FY 21, the activity will continue providing comprehensive HIV services in the community in SNU with high impact and high yield interventions in Amhara and Addis Ababa; out of which only 31 SNU have a DIC, in which 20 of them provide ART services for FSWs. Moreover, Cervical Cancer Screening, treatment and referral services to all HIV positive FSWs will be integrated to the 20 ART DICs. Facility based HIV services will be provided to FSWs, sex partners and eligible children in selected public health facilities within major towns of Amhara, Addis Ababa, Oromia, SNNPR and Gambella and will track the full clinical cascade from detection to VL suppression. Stratification of PP to identify those at higher risk will continue in order to maximize yield from testing. PPs such as the clients of FSWs, truck drivers and young women involved in transactional sex will be reached with tailored interventions to minimize risk of infection and increase access to HIV testing services (HTS). Community mobilizers will reach FSWs and PPs with the minimum package of prevention services in the community and link PPs and high risk FSWs to HTS. To increase demand for HIV testing among key populations, unassisted HIV self-testing intervention will be employed at scale. Community based providers will accompany HIV positive clients to ART service providing DICs and health facilities. Linkage and initiation on ART services for HIV positives will be a key part of COP20 activity. Regular linkage auditing using facility-community collaboration SOP will be strengthened and institutionalized. Same day ART initiation, disclosure, adherence support and tracking of LTFU up clients will be conducted. VL testing will be done for HIV positive clients in care as per the national guideline and will work to achieve optimum VL suppression.

Counseling services will be provided for HIV negative clients to remain negative and provision of PrEP will be used as one strategy to reduce new infection and HIV transmission. The 2018 national comprehensive HIV care guideline recommends PrEP for clients as substantial risk of

HIV infection or incidence rate of three or more, and eligible clients for the PrEP services include FSWs and HIV negative sero-discordant partners. The GOE has shown interest in expanding PrEP to FSW and other high-risk population groups. Currently the PrEP services have been provided in 31 public health facilities and 10 DICs for FSWs and HIV negative sero-discordant partners. In COP20, PEPFAR-E will support the national program to scale-up PrEP services based on recent guideline changes to include both KP and sero-discordant partners, with a combined PrEP\_Total target of 14,000 (compared to 2,600 in COP19). These services will be provided at 20 DICs and 117 public health facilities. The PrEP targets in COP 20 significantly increased from 2,600 to 14,000. Retrospective and ongoing analysis of ICT results to enumerate and actively follow-up on negative partners of index clients will be key to addressing the latter. Sero discordant HIV negative pregnant and breast-feeding women are included to access PrEP in the PMTCT setting. For case-finding, ICT and SNS among female sex workers remain the most effective approaches and recent guidelines produced by FHAPCO have endorsed scale-up of SNS for this population.

HIV self-testing will be scaled up to high risk key population and partners to maximize HIV case finding. The efforts by the Government of Ethiopia, under FHAPCO leadership, to adapt and scale-up U=U will also have a significant impact on addressing needs of key populations. This advocacy and communications strategy will seek to (1) Boost demand for HIV testing among at-risk; (2) Improve initiation and retention on ART; (3) Increase the demand for viral load testing; (4) Decrease HIV stigma & discrimination; (5) Increase community engagement; and, (6) Galvanize leadership at all levels around a unifying theme for achieving and sustaining epidemic control. The Ethiopia PEPFAR team has successfully improved targeted HIV case finding among FSWs, increasing yields from approximately 5% through outreach to a yield of 22.4% through ICT and partner services in FY 20 Q1. These strategies, now being rolled out, have allowed the program to reach higher risk FSW and their sexual partners who are eligible for PrEP, and have led to enrollment of newly diagnosed FSW into ART, and reengagement of HIV-positive FSW who have fallen out of care. The team is also planning to offer PrEP and enroll HIV-negative partners in sero-discordant relationships where the HIV+ partner has not yet achieved VL suppression.

PEPFAR supported IBBS among AGYW conducted in 2019 has shown high HIV prevalence and risk behavior among AGYW in Ethiopia, particularly among out-of-school AGYW. At risk AGYWs will be reached with HTS services and targets have been set in the PP\_PREV indicator in COP20. Prevention interventions will support identification of high AGYW who are engaged in sex work or transactional sex that would benefit from enrollment in PrEP services. Risk screening will be performed among AGYW with standardized questionnaires and linkage to and provision of appropriate services will be affected.

#### d) VMMC

The prevalence of male circumcision (MC) among adult males aged 15-49 years in Gambella, ranges from 10-40% among the refugee population (MC studies by United Nations High Commission for Refugees (UNHCR), 72% among urban residents (EPHIA, 2018) to 72% among the total Gambella population (EDHS 2016). The region has the highest regional HIV prevalence of 4.8% (EDHS 2016) and 5.7% (EPHIA, 2018). The prevalence of HIV among military population is 1.2% (SABERS 2018). The rate of HIV among uncircumcised males is 1.5 times as high as among circumcised males (5.3% vs 3.5%; EPHIA 2018). The current unmet need for VMMC in Gambella region is 56,073. This gap is estimated among the combined host and refugee populations of men 15 years of age and older.

The VMMC program in Ethiopia has provided services to adult males from the host & military and refugee population since 2009 and 2013, respectively. The recent population projections and MC coverage estimates from the national VMMC TWG and FMOH (2020-2021), projected a VMMC eligible male population aged 15 years and above at 158,637 for the Gambella indigenous/host population. Looking at current MC coverage including expected FY20 VMMC target achievement (10,500), 101,586 clients aged 15+ will have received VMMC services resulting in an overall coverage for this age group of 64%. By end of FY20, the remaining gap will be at 41,187 VMMCs to reach 90% coverage among the male host population in Gambella.

As reported by UNHCR in December 2019, there are 308,980 refugees in Gambella residing in 7 camps. Men constitute approximately 50% of the total population, of which approximate 40,000 are aged 15+ and eligible for VMMC (out of which 36,000 circumcisions are needed to reach 90% population coverage). Accounting for the 1,144 VMMC already performed among refugees aged 15 years and above (data extracted from DATIM) since COP15, combined with FY20 VMMC targets for refugees (20,000 men 15+), the remaining gap is estimated at 14,886 procedures to achieve 90% of VMMC coverage among male refugees.

The total 15+ new male military recruits that need VMMC services were estimated at 44,244. Out of which around 40,000 male recruits needed to be circumcised to reach 90% MC population coverage. By the end of COP 19 about 31,734 military recruits will have received MC services making the overall VMMC population coverage 60% among new military recruits. This will leave a gap of about 8,266 MCs to reach 90% coverage which can feasibly be accomplished in COP21.

The total VMMC unmet need in Gambella (both refugee and host population) among men 15 years of age and older is estimated to be approximately 56,073 VMMC procedures. In line with a three-year plan developed in COP19 to achieve 90% VMMC coverage, and if FY20 targets are met, achieving a COP20 target of 45,000 positions the program well to achieve 90% coverage by the end of COP21. At the end of COP20 a gap of only 11,037 circumcisions will be left among the host community to reach 90% coverage which can feasibly be accomplished in COP21. Of the proposed COP20 target, 70% of circumcisions are expected to be conducted among men aged 15-29 and the remaining 30% among men 30+.

The total COP20 VMMC target will be 50,000; 37,750 will be done using the ambition fund and 12,250 through the core COP20 fund. Achieving this ambitious COP20 VMMC target would enable the program to achieve 90% coverage among refugees by the end of COP20. Leaving a gap of only 11,037 and 8,266 circumcisions among host community and military population respectively,

To accomplish COP20 targets, PEPFAR-Ethiopia will accelerate service delivery among men 15 years of age and older to support a 3-year plan developed under COP19 aiming for 90% coverage to be achieved by the end of COP21. The program made significant shifts in Quarters 3 and 4 of FY19, increasing the proportion of men over 15 circumcised to 70% and 80%, respectively. In COP20, PEPFAR-E will support increased demand creation for VMMC services, among men 30+ and among male refugees. Additionally, PEPFAR-E will support mentorship and training of providers to account for staff turn-over and the need for training of new s and refresher training for existing staff, continuation of quality control and program improvements as needed. All VMMC clients who test HIV positive will be linked to care and treatment and offered same day ART initiation. RTKs are supplied by the Federal MOH and distributed to the health facilities by the Gambella Regional Health Bureau.

Mopping up the VMMC backlog for men +15 years will be achieved through a combination of VMMC service delivery in 15 VMMC facilities and coupled with intensive back-to-back VMMC campaigns. The program uses a human centered design for its communications, and demand-creation approaches. Health Extension Workers, community and religious leaders, teachers and community mobilizers are actively engaged in mobilizing men during the campaigns to target and reach men aged 15 and older with VMMC services in Gambella.

<b>Table 4.1.3 a VMMC Coverage and Targets by Age Bracket in Scale-up Districts</b>				
<b>Target Populations</b>	<b>Population Size Estimate (SNU<sub>s</sub>)</b>	<b>Current Coverage (End of COP19)</b>	<b>VMMC_CIRC (COP20)</b>	<b>Expected Coverage (end of COP20)</b>
Gambella 15+ Male Population, including refugees	108,637	62%	45,000	84%
Military 15+ Male population	44,244	60%	5000	72%
Total/Average/for Gambella	242,881	62%	50,000	80%

#### **4.4 Additional Country Specific Activities Listed in the Planning Level Letter**

##### *Assuring Partner and Programmatic Performance*

Across all three programmatic priorities (case-finding and linkage, retention and VLS, and prevention), PEPFAR Ethiopia continues to support robust quality programming through partner management approaches that include partner performance reviews, joint supportive supervisory visits, weekly monitoring of HMIS indicators via the Priority Towns Quality Improvement Tool

(PTQIT) and community unified data system dashboards, SIMS, and integrated PEPFAR Regional Support Teams for Maintained Regions. Externally, partner management and program performance are reinforced through close collaboration with the GOE. Joint performance reviews with GoE and PEPFAR. This takes the form of (1) supporting FMOH-led establishment of minimum standards for programmatic efforts (e.g. ICT for key and general population); (2) developing centers of excellence for pediatrics, viremia clinics for unsuppressed patients, and special initiatives for improving retention, adherence and viral load suppression among adolescents; (3) institutionalizing data quality improvement by standardizing workflows, SOPs, and fostering communities of practice; (4) promoting use of VL results for individual patient case management and improving quality of clinical program; and, (5) reinforcing catchment-area and health bureau-level meetings to improve case finding, retention, OVC-Peds programming across the facility-community interface.

The benefits of ART at individual and community level are dependent on adequate levels of adherence and retention. PEPFAR-E will concentrate efforts to improve adherence and retention among newly initiated PLHIV, particularly among those clients for whom the reported data shows low coverage and retention (age 15 and above, 15–24 males and females). Further strengthening and maintaining the adherence level for those aged 50 and above and increasing the ART coverage will be emphasized. Coupled with optimization of ART regimens, PEPFAR-E will ensure adherence, retention and VL suppression by improving: (1) patient monitoring, (2) lab-clinic interface, (3) patient-centered approaches for enhanced adherence support, (4) collaborations between facility-community actors to trace clients LTFU, and (5) expansion of differentiated service delivery approaches.

#### *Patient Monitoring*

There are significant challenges in ascertaining whether clients who have been started on life-long ART are optimally adhere to their prescribed ARV regimens and the level of attrition from the program (from death or LTFU). As CBS moves to phase II, tracking longitudinal events across a patient's life-course, the quality of information on patient adherence and retention will improve.

#### *Lab-Clinic Interface*

Strengthening the use of routine VL testing for monitoring clients on ART is vital to ensuring adequate viral suppression rates among the treatment cohort. Demand creation among parents and caregivers will be especially critical for improving VL coverage and literacy for pediatrics and adolescents, as with all other age/sex bands. Prompt communication and action by clinicians for those clients who have a detectable or high VL will be enhanced. This will be enabled by

improved information exchange between VL databases and electronic medical records through PEPFAR HIS investments to move to CBS. Improved placement of test-orders and rapid return of results will enhance clinical case management and monitoring of population-level VL suppression. Viremia clinic days will be established in high volume facilities to improve management of clients with high VL.

#### *Facility-Community Interface*

Through standardized operating procedures that strengthen data sharing and use across facility- and community-based actors, PEPFAR-E will improve LTFU tracking and return to care and treatment. Facilities will generate line-lists of patients LTFU and follow-up by phone, while also sharing these line-lists with community-based partners, which will follow-up with these clients in the community. Through routine performance reviews and information sharing, line-lists on patients LTFU will be updated and new lists will be shared for tracing-up. This interface and collaboration will include the return to treatment initiatives for tracing and returning lost clients.

#### *Differentiated Service Delivery*

Strengthening and expanding the implementation of the 6 months Multi-Month Dispensing (MMD) and the health worker managed community ART refill groups (CAG), fast track pharmacy refill (FTR) will be implemented and scaled-up. To enable successful implementation and client uptake, PEPFAR-E will support the availability of 90 day and 180-day ARV drug packs to alleviate the challenges encountered on the volume of medicines clients must take to their home.

Both the facility and the community will implement peer-to-peer support for awareness creation, providing literacy on HIV treatment and healthy living, and early identification and tracking of defaulters. One-to-one peer support at initiation on ART will be provided particularly to newly identified clients and to those with high viral load results. In order to combat false beliefs and negative messaging around HIV and the use of ART, faith-based organizations (FBO) will be engaged. FBOs have a key role to play in disseminating messages of hope. Where HIV was once a death sentence, now with treatment, there is new hope as undetectable is untransmittable. People on HIV treatment who are virally suppressed can live long, healthy lives. FBOs and religious leaders will provide spiritual and psychosocial support to PLHIVs, encourage partner testing, promote positive living with HIV, and provide regular standardized messaging to their followers on remaining adherents to ART, even while seeking faith-based curative services. FBOs will identify clients who discontinue ART to attend religious cure services and work closely with other community partners to re-engage them on ART. They will also use the faith-based media outlets and holy water sites to properly and adequately inform their followers on the importance of remaining adherent to ART, as well as mitigate stigma (both self-imposed and external) pertaining to HIV infection and ART. This activity will be implemented by Interfaith Religious Council of Ethiopia (IRCE), with technical assistance from IPs. IRCE has membership from the Ethiopia Orthodox, Protestant and Muslim faith groups.

## 4.5 Commodities

Overall, HIV-related program commodities are on stock greater than 95 percent of the time based on survey and site level data reported to the regions. ARVs are available >99 percent of the time. The country has faced some challenges around lab commodity supply availability and RTK availability at sites. This is in part due to delayed receipt of shipments from manufacturers, as well as continued challenges with fully integrating RTKs into the supply chain system. A key challenge for the supply chain system is the lack of end to product visibility down to sites, which impacts the quality of supply chain decisions. Further, it was found that data quality of the reporting forms was poor, resulting in a high rate of false stock out reporting.

In COP20, PEPFAR-E will continue providing above site supply chain technical assistance to EPSA and its regional hubs, HAPCO, FMOH, and Regional Health Bureaus to strengthen supply chain performance, implement innovations to ensure sustainability, and to support procurement of HIV related health commodities. The above-site TA will include: (1) forecasting and quantifications; (2) distribution and warehouse management; (3) fleet management; and, (4) procurement strengthening and pipeline monitoring. TA under COP20 will be more focused around strengthening and expanding the Center of Excellence (CoE) supply chain maturity model across high volume and high throughput EPSA hubs and Central EPSA warehouses. This model focuses on building the quality management system (QMS) within the supply chain, implementing EPSA's M&E system to monitor supply chain and service related KPIs, and optimizing route and distribution networks down to health facilities, including frequency of distribution. TA providers are placed in all regional EPSA hubs to support EPSA staff and branch managers to supply health facilities on time with needed HIV commodities.

PEPFAR-E will continue a critical intervention initiated under COP19 to implement ARV dispensing tools and data collection in all PEPFAR priority sites and regions. This is a critical intervention to allow the host government and PEPFAR to triangulate clinical data with dispensing data, track patients who missed their ARV pick up appointment in a timely manner for meeting retention targets, and to have accurate regimen data for pediatric and adult ART for HIV quantification and procurement.

PEPFAR-E will also shift its TA focus to greater site level and sub national support to ensure sites are complying with procedures for resupply and providing enhanced pharmacy services to its clients. PEPFAR-E will work in collaboration with EPSA, EFDA, and clinical IPs to provide training to Regional Health Bureau and district level (woreda) pharmacy staff in pharmacovigilance, Integrated Pharmaceuticals Logistics System (IPLS) for resupply of commodities, monitor use of the pharmacy dispensing tools and data use and triangulation, and in monitoring ARV regimen prescriptions and regimen changes to ensure rational use. PEPFAR TA will conduct regular joint supervision visits with RHBs and woredas to ART sites for mentoring and monitoring ARV dispensing, data collection and data for decision-making, rational use and improved dispensing to ART clients, pharmacovigilance tracking and reporting, and overall inventory management and compliance with stock reporting and resupply procedures in

line with the IPLS. PEPFAR-E will also support the mentoring and supportive supervision of ART sites to monitor stock levels/status and avoid stock out of ARVs, RTKs and viral load/EID. This support will build the capacity of host country institutions and the supply chain system.

#### **a) New Initiatives**

Under COP20, USG PEPFAR will engage the private sector to support modernizing the Ethiopian supply chain. Building on a pilot to be implemented by GF in one region for outsourcing last mile distribution, PEPFAR-E will draw lessons learned and look to support the pilot and possible expansion. In addition, the private sector can play an important role in delivering a client-centered supply chain, which brings our commodities to the client rather than our clients to the commodities. PEPFAR will support decentralized drug distribution through private and semi-private pharmacy retail outlets in Addis Ababa. Finally, USG through PEPFAR will support institutional capacity building of EPSA through a direct G2G. This activity will provide EPSA with the resources to support the private sector engagement in last mile distribution, differentiated delivery models for ARV distribution, and to ensure HIV-related commodities are available on time and in sufficient quantities.

#### **b) Supply Chain Donor Coordination**

In the area of supply chain, there are an increasing number of players supporting EPSA central, in the area of leadership, management and governance, warehouse management and supply chain optimization, distribution and route optimization, procurement TA support, and private sector engagement. In addition, UNICEF may be funded to provide warehouse system strengthening support to EPSA and EPSA hubs. Ethiopia has established a supply chain donor's forum whereby the major donors including PEPFAR and Global Fund. The donor group coordinates the support to the GoE to leverage resources for different supply chain and commodity security activities. Due to turnover in donor supply chain focal points, the group has only recently started meeting again. The shift towards greater sub-national and site level support is in part due to the increased focus and support from other partners and donors at central EPSA level. There is also an active HIV/AIDS specific procurement and supply management technical working group that focuses on the HIV/AIDS commodity funding, forecasting and quantification, pipeline monitoring, stock status monitoring, capacity building and any initiatives such as ARV optimization, RTK integration. The USG strategy is therefore to strengthen these instruments for the overall supply chain TA and support.

### **4.6 Collaboration, Integration and Monitoring**

PEPFAR-E is collaborating with GoE, and multilateral and bilateral organizations on all aspects of HIV program implementation. PEPFAR-E and GFTAM are closely working in harmonizing program support to the host government alignments include HIV commodity support, such as HIV test kits; and ARVs and VL testing reagents. All HIV rapid test kits and ARVs supported through GFTAM and PEPFAR=E procure VL testing reagents, and some TB diagnostic supplies. USG is represented on the GFATM CCM.

CDC and USAID technical staff are collaborating with FHAPCO/FMOH in joint performance review meetings and are supporting supervision of public facilities and community sites. PEPFAR-E technical team participates in the national technical working groups and plays a key role in the development of technical guidance. They are working closely with FHAPCO/FMOH in the development of the National Strategic Plan 2021–2025.

PEPFAR-E agencies have prioritized partner management for achieving results. All partners report data on key 95-95-95 indicators on a quarterly basis and these are jointly reviewed by PEPFAR E to identify gaps and areas where an improvement plan is needed. PEPFAR E conducts a monthly intensive IP performance monitoring and improvement plan that involves frequent analysis of health facility and community site data. PEPFAR E also conducts monthly meetings with implementing partners to address low performance and scaling up of best practices. A tremendous amount of work has been done with the implementation of OTA; enhanced interagency collaboration with ACAHB and IPs, developed OTA M&E framework, sites were reporting weekly and biweekly reports were submitted to OGAC. OTA data was reviewed by the team, and feedback was provided to sites with recommendations to improve performance. Best practices of this campaign include collaborative HF-Community performance review and feedback mechanism, ownership of OTA M&E by the health managers and health workers at all levels, enhanced data analysis, and use at all levels. This good practice will be scaled up in COP19 and 20 to other regions' city administrations.

To achieve 95-95-95 targets, health facilities and community-based HIV service delivery points will need to provide efficient, effective, and high-quality services to ensure that people living with HIV know their status, receive and sustain antiretroviral therapy, and achieve viral suppression. A key resource in this process, among other system factors, is the health workforce. COP20 PEPFAR-E will focus on improving the efficient use of existing human resources in the public health facilities to enhance HIV cohort growth. Various elements of the health workforce are currently responsible for the following activities: (1) strengthening and intensifying case-finding through index case testing and optimized testing approach; (2) improving ART coverage through increased identification and efficient linkage of HIV-infected patients to care and treatment services; (3) implementation of rapid ART initiation including same day ART initiation for newly identified PLHIV; and (4) early identification and tracking LTFU clients. They are also responsible for monitoring clients on ART using routine VL testing, ensuring effective sample referral, use of data/results for clinical decision making and patient management, and regular reporting of performance, and encouraging communities and individuals to take an active role in demanding and seeking out HIV services. In response to these, PEPFAR-E will provide technical assistance to sustain robust HRH workforce planning according to quality data to improve HIV and other health outcomes. Accurate data is still needed on the number of available health care workers and the gap. PEPFAR-E will also provide technical support to monitor site level resource utilization to assess how sites and implementing partners allocate their resources and whether those resources are optimally allocated. In order to allocate resources efficiently, it is critical to

understand how the resources are used and how much they cost, for example, how health workers spend their time and what tasks they perform.

During the COP20 planning process, the PEPFAR-E team reviewed above-site activities to ensure they are mapped directly to key barriers and measurable outcomes. Thus, PEPFAR-E updated key system barriers and expected outcomes to prioritize systems investments that will have the greatest impact on the epidemic. PEPFAR-E system investments are focused on enhancing local capacity building, coordination, case-based surveillance on all regions, improving supply chain, lab quality, and sustaining health financing.

Ethiopia is challenged with low case findings and maintaining the existing cohort on ART. Different strategies have been in place to help grow the cohort at facility and community sites. In COP20, PEPFAR-E reinforces the capacity of FMOH, RHBs and facilities to enhance the implementation of innovative approaches such as ICT, SNS, use of risk screening in all testing modalities, and back to treatment campaigns to grow the cohort. The above site support includes training, mentorship and supervision. TA will be provided to strengthen above site structures and systems for strategic planning, implementation and monitoring, and data use for continuous QI. The goal of this approach is to address gaps in epidemic control with a focus on the scale up of ICT. The above site TA partner will support the RHBs in collecting and reporting ICT results and submitting their data to their respective RSTs for review, feedback and program support. CBS and recency testing will be expanded to all regions both at the facility and community settings to inform HIV program response.

**Table 4.7.1 ART Targets by Prioritization for Epidemic Control**

<b>Table 4.7.1 ART Targets by Prioritization for Epidemic Control</b>						
<b>Prioritization Area</b>	<b>Total PLHIV</b>	<b>Expected current on ART (APR FY20)</b>	<b>Additional patients required for 80% ART coverage</b>	<b>Target current on ART (APR FY21) TX_CURR</b>	<b>Newly initiated (APR FY21) TX_NEW</b>	<b>ART Coverage (APR 21)</b>
Attained	565,575	432,577	19,883	497,731	74,377	88.0%
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained						
PEPFAR Supported	100,148	70,474	9,644	75,609	6,588	75.5%
Commodities (if not included in previous categories)	NA	8675	NA	9,250	761	NA
<b>Total</b>	<b>665,723</b>	<b>511,726</b>	<b>20,852</b>	<b>582,590</b>	<b>81,726</b>	<b>87.5%</b>

**Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts**

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIR C (in FY21)	Expected Coverage (in FY21)
Total	15+	NA		50,000	NA
Military	15+	NA	60% (Oct 2019 – Sept 2020)	5,000	NA
Ahobo	15+	24,646	62% (Oct 2019 – Sept 2020)	2,364	100%
Dima (Gambella)	15+	23,689	62% (Oct 2019 – Sept 2020)	2,760	100%
Etang	15+	244,608	62% (Oct 2019 – Sept 2020)	8,656	100%
Gambella	15+	116,340	62% (Oct 2019 – Sept 2020)	4,534	100%
Gambella Zurya	15+	43,387	62% (Oct 2019 – Sept 2020)	1,001	100%
Gog	15+	78,554	62% (Oct 2019 – Sept 2020)	703	100%
Jikawo	15+	24,051	62% (Oct 2019 – Sept 2020)	3,030	100%
Jor	15+	12,971	62% (Oct 2019 – Sept 2020)	2,906	100%
Lare	15+	47,663	62% (Oct 2019 – Sept 2020)	5,773	100%
Makuey	15+	25,070	62% (Oct 2019 – Sept 2020)	3,577	100%
Mengesh	15+	27,081	62% (Oct 2019 – Sept 2020)	4,245	100%
Wantawo	15+	30,396	62% (Oct 2019 – Sept 2020)	5,451	100%

**Table 4.7.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate (SNUs) and disease burden	Coverage Goal (in FY21)	FY21 Target
[Specify target populations for focus, e.g. AGYW] <i>Indicator Codes include PP_PREV and KP_PREV</i>			
<b>KP_PREV (Total)</b>	<b>220,614</b>	<b>29%</b>	<b>64,326</b>
<b>SNU/Region/ Woreda</b>			
SNNPR	12,743	65%	8,283
Oromia	28,014	65%	18,210
Gambella	1685	65%	1095
Amhara	33433	85%	28000
Addis Ababa	11,013	79%	8739
<b>PP_PREV</b>			
Clients of Sex workers	NA		55,845

**Table 4.7.4 Targets for OVC and Linkages to HIV Services**

SNU	Target # of active OVC (FY21Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY21 Target) OVC*
Addis Ababa	67,312	57,989
Amhara	125,581	107,258
Gambella	5,583	5,002
Oromia	106,652	91,095
SNNPR	43,530	37,179
<b>TOTAL</b>	<b>348,658</b>	<b>298,523</b>

## 4.8 Cervical Cancer Program Plans

In 2009, PEPFAR-E, through CDC introduced cervical cancer (CxCa) screening visual inspection of cervix with acetic acid (VIA) and treatment of pre-cancerous lesions with cryotherapy, using a single visit approach at 16 health facilities, of which five were centers of excellence (CoE). Loop electrosurgical procedure (LEEP) services were also implemented at the five referral CoE sites for women with extensive lesions which cannot be treated with cryotherapy. Based on the success of this pilot project and the burden of CxCa in the country (13.4 percent), the MoH has adopted this strategy and scaled-up at national level for all women aged between 30–49 years irrespective of their HIV status since 2015. Furthermore, CDC has supported FMOH to expand LEEP service to additional 10 sites in Addis Ababa, Harari, Oromia, and SNNP from 2016–2019. Currently, with no-cost extension period, this support will continue for additional six months in FY20 with modified scope to support the Ministry's effort to speed-up the national scale-up of CxCa screening and treatment in the country.

Though the FMOH has an aggressive plan to expand VIA screening and treatment service to 1,000 sites in the country, it has faced challenges that hinder the ambitious Government plan. Since 2015, the Government has managed to scale-up VIA to about 25 percent of the sites. Because of this, the most affected portion of the population (WLHIV) is not getting the expected quality of services which contributes to the national HIV epidemic control effort. For instance, EPHIA (2018) data showed that only 16 percent of women living with HIV (30–49 years) received screening for CxCa. Currently, VIA/cryotherapy service is not available in about half of the ART sites >300 TX\_CURR in maintained regions. Some of the key programmatic challenges encountered in the national scale-up of CxCa screening and treatment services are related to lack of up-to-date national guidelines and job aids; weak demand creation at community and HCWs level; stigma; lack of capacity to maintain trained HRH at different level of the health system; lack of capacity for preventive maintenance and troubleshooting resulting in frequent equipment failure; frequent shortage of medical supplies and accessories; lack of capacity to introduce new technologies; poor referral networking; and, lack of system for mentorship, coaching and quality improvement.

In order to address these challenges, PEPFAR-E will support the FMOH to speed-up CxCa secondary prevention efforts in COP20. Both technical and site level support will be provided at different levels of the health system in the five maintained regions. ICAP will provide above-site support to the ministry and RHBs to strengthen the existing VIA and cryotherapy services to reach WLHIV between ages 25–49 years; to introduce new technologies (thermal ablation and HPV DNA testing) and the revision and development of guidelines and training manuals in addition to the site level support in Gambella region.

HPV DNA testing will be availed through viral load testing using COBAS and Abbott platforms to support high caseload sites with >1000 WLHIV ages 25–49 years as a triage before VIA screening. In addition, thermal ablation will be expanded to sites with >150 WLHIV and in sites where there is no cryotherapy. The partner will support regions to establish nine additional CoEs that will serve both as sites for training and LEEP services.

The CoE sites will be equipped with necessary teaching aids including video colposcopy; and will support HFs through training, coaching and mentorship. ICAP will also support data capturing and monitoring systems at different levels along the health care system. The RHBs in the five maintained regions will establish a regional system to ensure all eligible WLHIV have access to the service and provide site level support to sites that provide VIA and cryotherapy/LEEP treatment services. There will be regional and zonal level HRH to provide mentoring and program oversight to ensure quality of services and to build local capacity on preventive maintenance and troubleshooting as well as routine monitoring and evaluation. Referral networking will be established for LEEP and cancerous lesions treatment by conducting service mapping to develop a referral directory of services in each region. Minimal logistical planning and support will be provided for women referred for LEEP and suspected cancer diagnostic and treatment services; and a system will be developed to ensure patients reached to referred sites and receivable of feedback. The FMoH will have a role in providing technical assistance to transitioned regions to ensure eligible WLHIV received CxCa screening and treatment services through the government's effort to scale-up the service, in addition to the overall program oversight through supervision and reporting.

In addition, awareness about cervical cancer screening services and limited access are barriers affecting the implementation of the services at scale to effect impact. To address those issues, community partners will implement demand creation interventions and CxCa screening, treatment and referral services by integrating the services with the community-based comprehensive HIV services of key populations (female sex workers). This intervention will be implemented by population services international (PSI) at the Drop-in-Centers (DIC) situated at hotspot areas. The DIC have created access to ART, HIV testing, STI screening and treatment, condom, pre-exposure and post-exposure prophylaxis, and contraceptive services, in addition to KP tailored prevention bio-behavioral interventions. These service integrations and improved access have positively impacted PLHIV who otherwise would not get any HIV services due to fear and stigma. Female sex workers accessing services at DICs will be educated about cervical cancer. Eligible clients will be asked for consent and will be offered a screen with VIA at DICs, or through referral to other service outlets of their preference. Education materials and guidelines will be adopted.

At community level, Project HOPE will work with Network of Women Living with HIV and PLHIV association to create awareness and demand for the services. Project HOPE is a PEPFAR-E partner currently working at community level to improve access to HIV testing, including self-testing, community ART distribution, and adherence and retention support. It works closely with the PLHIV association and is currently supporting the Network of Women Living with HIV on prevention of gender-based violence and stigma mitigation. Thus, the PEPFAR-E community partners and community platforms will be ideal to create demand and mobilize for CxCa service uptake. Community partners will work closely with MoH, regional health bureaus and health facilities on messaging, development and distribution of IEC materials, and referral of clients.

Building the capacity of care providers on their awareness risks factor, screening for, and management of cervical cancer will be focus areas. Healthcare providers including ART clinicians, case managers, peer educators, and program managers will be trained and mentored to accurately and effectively provide the services at public health facilities and DICs. In order to ensure quality of screening and treatment services, national guidelines, tools and SOPs will be availed and utilized properly; service assessment to identify gaps and develop and implement CQI plans will be implemented; and routine quality assurance checks through coaching, mentoring and supervision will be conducted to ensure women are being accurately screened and treated. Furthermore, evidence-based innovative technologies to improve the quality of VIA screening (e.g. mHealth initiatives to allow supervisors to provide remote consultation on specific cases) will be introduced at selected high caseload sites. On the other hand, documentation of lessons learned and outcome of new initiatives (HPV DNA and thermal ablation) will be strengthened to generate evidence that will inform the program for future scale-up. Monitoring and evaluation tools will be integrated into ART clinics both at public sites and DICs to ensure an appropriate recording and reporting system is established. With all these efforts, PEPFAR-E plans to reach 50 percent of eligible WLHIV age between 25–49 years of age that are on treatment.

#### **4.9 Viral load and Early Infant Diagnosis Optimization**

Viral load coverage increased from 61 percent in FY19Q1 to 76 percent FY20Q1, with 80 percent coverage in Oromia and 84 percent coverage in Addis Ababa. Tigray reported suboptimal viral suppression of 81 percent among 61 percent of those tested. PEPFAR supported demand creation activities, specimen collection, transportation, reagents and supplies for testing, and the result return system. PEPFAR will continue supporting optimization of VL testing through expansion of VL testing operation hours in high load testing facilities, training of testing personnel, quality assurance, and enforcing the reagent leasing arrangements where placement of machines and maintenance is the responsibility of the vendors. The supply chain activity will strengthen stock monitoring and provide biweekly reporting for VL and EID reagents and supplies. An emphasis will be placed on treatment provider awareness of VL monitoring requirements to increase demand and ensure timely VL monitoring of all PLHIV. In seven conventional VL testing facilities where 79 percent of VL analyzed in FY19, extended working hours to address the

demand from their catchment area were arranged. Three of the labs, EPHI, Adama, and Addis Ababa also have backup machines.

Specimen referral networks will be revised in all sub-national units to enhance the efficiency of VL testing and results reporting. Testing laboratories will be assigned according to geographic proximity rather than by administrative boundaries. Specimen referral and testing will be integrated into both POC and conventional platforms. GeneXpert machines are being used for TB, EID and VL, whereas conventional platforms for VL, EID, HBV and HPV testing.

POC-VL will be implemented for PBFW in facilities with access to GeneXpert machines and remotely located from conventional platforms; 10% of PBFW will be covered with this approach.

PEPFAR-E will also support the scale-up of POC-EID tests from the current 17% contribution from all EID tests to 50% in FY21. POC-EID uses GeneXpert machines. In FY20, 119 facilities are providing POC-EID, and this will be expanded to all 280 GeneXpert sites in FY21. GoE is negotiating an all-inclusive agreement for the GeneXpert system with Cepheid Company and it is expected to be signed by July 2020.

Previously, POC-EID implementation was supported by the Clinton Health Access Initiative (CHAI), but that is now fully transitioned to the GOE. The PEPFAR COP20 budget includes funding for procurement of all GeneXpert cartridges needed for EID.

PEPFAR allocated \$6.94 million USD for VL reagent and consumables for COP20 with a savings of \$2.67 million USD from COP19 due to a price reduction in the framework agreement reached with manufacturers.

## 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

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Reaching 90-90-90 and 95-95-95 will transform the epidemiology in many settings leading to a shift in HIV control strategy. Last mile efforts include active case finding in hot spot areas. Therefore, efforts to grow the cohort requires building systems level capacity of the GoE and CSOs to address the critical problems of case finding and retention of PLHIV in care. As described in section 2.4, PEPFAR-E convened a SID workshop in 2019 and scored the elements necessary to achieve epidemic control. The GoE routinely tracks HIV activities and coordinates HIV responses at federal and regional level.

Almost all required policies have been addressed. To improve the decreasing score noted in private sector engagement and commodity security and supply chain, the GoE must strengthen the engagement of diverse private sector actors in the HIV response. The private sector is critical to resource mobilization and supporting sustainability. HIV commodities procurement is fully dependent on donor support.

Overall, the SID analysis revealed weakness in the majority of the domains and elements prioritized to support in COP20, specifically improving private sector involvement, scaling up case based surveillance, resource mobilization support to sustain the program, TA support to improve supply chain, and local capacity building to enhance indigenous organizations.

#### Identified systems barriers:

- Lack of strategy and legal framework for sustained domestic HIV program financing
- Inadequate access to high quality HIV laboratory services, especially VL and EID
- Lack of strong social systems to coordinate and sustainably implement quality services for OVC Program beneficiaries
- Insufficient system to capture/monitor HIV epi data at national, sub national and individual level
- Weak supply chain security
- Limited local capacity for efficient health program management successful implementation of transition to local organization

Systems level investments planned for COP20 are focused on addressing these key barriers and priorities to propel Ethiopia to achieve sustained epidemic control. Planned activities are described below.

#### *Support local institutions for locally led public health response for sustained HIV Epidemic Control*

In COP20, PEPFAR-E will work with relevant partners to strengthen GoE and CSO capacity on policy, planning, coordination, and efficient program implementation. These interventions will enable PEPFAR-E to realize its successful transition to local prime partner initiatives, and local organizations to successfully execute their programmatic and fiduciary responsibilities.

#### *Governance, policy, planning, and coordination*

FHAPCO/FMOH addressed most of major policy gaps; there is a need to strengthen planning and coordination for the sustainability of the HIV response, particularly the transition of PEPFAR direct service delivery support. Finalization and operationalization of the National Strategic plan 2021–2025 is the key focus of PEPFAR-E in FY 20–21.

#### *Support sustainable HIV financing*

In COP19, a domestic resource mobilization strategy and its advocacy plan was drafted. The domestic resource mobilization strategy has been reviewed and accepted by FMOH and FHAPCO. Sensitization workshops have been held with members of parliament. Currently, the document is pending a legal framework for its implementation. Thus, supporting the implementation of the domestic resource mobilization strategy and the legal framework will be priority tasks of COP20.

## *Monitoring Epidemiological Data*

The community level unified data system initiated in COP19 for community-based activities will be used for easy data capture, tracking, analysis and reporting. The data will be visualized through a dashboard to facilitate individual level monitoring and informed decision making. In COP19, digitization of the existing paper-based case management and data capturing systems has started. Activities in COP20 will include unified data system (UDS) maintenance, server subscription fees, UDS mentorship and supportive supervision, UDS quarterly review meeting all USAID partners, technical backstop services for Comm-Care, quality assurance training, UDS refresher/gap filling training support, training on data use (dashboard utilization); and integration of UDS to eCHIS.

In COP20, FMOH will be supported to improve the national level MTCT elimination goals through the review of key programmatic data to identify and document best practices, support analysis and interpretation of HMIS data for program use, support national level gap filling TOT trainings, and to provide TA during program review meetings and supportive supervisions. TA will be provided to FMOH to strengthen the oversight of PMTCT program implementation in the country with special focus on optimizing ART, ensuring adherence, retention, viral load monitoring, and ensuring comprehensive HEI care including EID.

## *HIV Surveillance*

PEPFAR-E has implemented HIV CBS and is recency testing in 402 health facilities and 9 community DIC centers from all 11 Regions of the country, reaching 72% of the total treatment cohort reporting facilities. To facilitate data use, a data visualization platform has been established at EPHI, and information is being generated and reviewed regularly to inform individual level response at facility level for enhanced patient intervention, and at above site level for programmatic response. Efforts are underway to build the capacity of RHBs and woreda offices to use the same data visualization solutions, and to facilitate data use at lower sub national units. To initiate the longitudinal CBS, the smart care-EMR system will be enhanced and interoperability solution introduced. Longitudinal surveillance will be introduced in selected facilities in FY20. In COP20, the HIV case reporting and recency testing will be further scaled-up across all regions at facility and community settings, until all newly diagnosed individuals are reached with recency testing. In addition, longitudinal HIV CBS (with longitudinal reporting of sentinel events) will be scaled up to selected high load HFs in the country. Capacity building efforts will be further strengthened to support data visualization and data use for enhanced targeted individual interventions and for informing HIV cluster response.

## *Violence Against Children Survey (VACS)*

PEPFAR-E, in collaboration with GOE (CSA, FMOH, MOYCA, FHAPCO and EPHI) and IPs will implement a national household survey to retrospectively assess violence against children and youth 13-24 years of age. VACS will be used to inform the national HIV program and PEPFAR's assistance with mitigating violence and associated risk of HIV acquisition. Accurate and timely data on violence against children and youth are critical for the development and implementation of programs to prevent violence and respond to the needs of survivors, as well as for the development of a coordinated multi-sectoral approach. The survey will provide stakeholders with an evidence base for policy and programming to prevent violence against children. The GOE has committed to conducting VACS, dissemination of findings, and using the information for programmatic and policy decisions. The GOE has also recently committed to and developed a roadmap to eliminate child marriage and female genital mutilation. The

Ethiopia VACS will provide baseline data that will be used to inform the components of the roadmap that support elimination of child marriage.

#### *HIV Drug resistance (HIVDR) Monitoring*

PEPFAR Ethiopia will implement laboratory-based HIVDR patient monitoring to detect emerging drug resistance and to construct the appropriate first, second, and third-line ARV regimens in Ethiopia. The durability and effectiveness of the dolutegravir (DTG) based regimen needs to be preserved with regular information on patterns of HIVDR. Laboratory based HIVDR patient monitoring has higher yields of genotyped specimens in contrast to clinic-based HIVDR patient monitoring, which allows for precise age-based and sub-populations HIV drug resistance estimates. Laboratory based HIVDR will utilize residual specimens from routinely collected viral load testing and does not require special collection of specimens for patient monitoring purposes nor consent for resistance testing.

#### *Supply Chain Systems*

A reliable supply chain system is a critical system requirement to sustain HIV epidemic control and ensure ART clients are retained on treatment with appropriate clinical monitoring. In COP20, the PEPFAR-E supply chain TA partner will support the chain system on supply forecasting, procurement, pharmacy data triangulation, last mile distribution to ensure adequate HIV commodity availability and accessibility, pharmacovigilance, warehousing and introduction of differentiated drug distribution services at pharmacies.

#### *Laboratory*

VL coverage increased from 61% in FY19 Q1 to 76% in FY20 Q1. PEPFAR-E will continue supporting optimization of VL testing through expansion of VL testing operation hours in high load testing facilities, training of testing personnel, quality assurance, and enforcing the reagent leasing arrangements where placement of machines and maintenance is the responsibility of the vendors. An emphasis will be placed on treatment provider awareness of VL monitoring requirements to increase demand and ensure timely VL monitoring of all PLHIV and timely return of test results. All viral load, EID and TB laboratories will be enrolled in international accreditation schemes. Chemical waste generated from the laboratories will be handled appropriately to prevent human, animal and environmental exposures.

#### *OVC*

Technical assistance will be provided to GOE and local prime CSOs to strengthen implementation of the new OVC strategies and direction. TA will be provided to community case workers/social workers to implement quality comprehensive OVC services and primary prevention training. GoE and CSOs will be supported to develop protocols/SOPs on how and where to refer child survivors/sexual violence survivors for appropriate services and reporting in SNU with high rates of HIV and sexual violence, include primary prevention in their micro-planning and mobilize resources to support sexual violence survivors.

In addition to the above-mentioned investments, PEPFAR-E will also continue to support the completion of current construction activities as well workforce development investments. No new construction or HRH investments will be made in COP20. (Attach the Table 6-E tab and SRE workbook in Appendix C).

## 5.1 Community-Led Monitoring

Community-Led Monitoring (CLM) is key to ensuring availability, access to, and delivery of quality HIV care and services. CLM will empower patients and communities to seek out this information, increase health literacy, expand engagement with health service delivery, support demand creation, and demand accountability from the health system to improve and deliver these services. CLM can also help diagnose and pinpoint to both acute and persistent problems, challenges and barriers to effective services and client outcomes at site level. Historically PEPFAR-E has involved and engaged CSOs in various activities—including COP meetings and stakeholders’ retreats—to have their voices represented in PEPFAR planning and programming, and in capacity-building of CSOs on data analysis. In COP20, the PEPFAR-E program will support and fund CLM activities through the PEPFAR-E Coordination Office (PECO), in close collaboration with independent, local CSOs and the GoE.

The PEPFAR-E team has assessed existing community monitoring frameworks in Ethiopia to understand what and how information is currently monitored. The PEPFAR-E CLM initiative will primarily focus on routinely monitoring critical gaps to availability, accessibility, and delivery of quality HIV prevention and treatment services. Quantitative and qualitative data will be collected using standardized tools and synthesized through a variety of methods that reveal insights from communities about problems and solutions to health and HIV services delivery problems at the facility, community, sub-national and national levels. The process includes direct observation of the conditions of services by service monitors (who are patients representing the community), through interviewing or surveying clients, as well as service providers. The services received by clients are observed and scored by survey, score card, and other similar tools. Results will be presented and analyzed in collaboration between community representatives, providers and facility managers to ensure dialogue and help all sides in participating with identification and subsequent implementation and monitoring of solutions and action items. PEPFAR-E will ensure that this will not duplicate efforts; rather, it will be an added value to the PEPFAR MER by actively participating during tools development and providing feedback during the reporting. This effort will generate important information that is focused on the goal of improving service quality, continuity and retention.

CLM will be implemented in a phased approach initially in certain geographic areas, focusing on some of the critical challenges what the communities at the sites identify as their most important problem(s). Beyond COP20, based on the lesson and experiences during COP20, we will scale up to include additional geographic areas and communities will be able to monitor the critical challenges across the full clinical cascades of service deliveries and the community will guide about what needs to be addressed first.

PEPFA-E will involve key stakeholders, including GoE, UNAIDS, FBOs, and multiple CSOs to ensure meaningful engagement in the project design, planning and implementation periods through consultative engagement by inviting to participate in the CSO meetings, workshops, and by sharing quarterly reports and PEPFAR-E will support this initiative by creating a platform for CSOs to share this information—either through quarterly reports, or semi or annual CSO meetings. These meetings will be a platform for the CSO community to present findings to MOH, RHBs, Facility leadership, etc. and people within Government with decision-making powers so that they can effectively advocate for changes if/where needed.

This process will capacitate CSOs on fund management and information/reporting on CLM and will also empower the community and the facility to take full and joint ownership on the quality and provision of services to patients. Through technical support and training on CLM, the initiative will train, support, and equip individuals and communities directly affected by HIV to themselves carry out routine, ongoing monitoring of the quality and accessibility of HIV treatment and prevention services with CSO oversight. CLM Framework, standards and tools for Ethiopia will be created by CSOs in coordination and collaboration with key-stakeholders. PEPFAR-E will share best practices and lessons learned with SGAC which will contribute to the existing PEPFAR studies on CLM.

## 6.o US Government Management, Operations and Staffing Plan to Achieve Stated Goals

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Overall, the staffing footprint for PEPFAR-E is in a decreasing trend. This is in part in response to the downward trend of COP funding for COP18 and out years as well as the changing epidemiology in Ethiopia moving to epidemic control. Future technical staffing needs will evolve as the strategic direction changes over time. The PEPFAR-E Country Coordinator position has been vacant since January 2020 and will be advertised in COP19. The Senior Technical Advisor Position which was approved in COP18 is vacant and will be filled by the end of COP19.

PEPFAR-E has not made significant changes to its staff footprint. In the interagency, as per the experience with the acceleration of programming in Addis Ababa, USAID and CDC continue to reinforce programming by jointly participating on regional support teams, reinforcing joint programming across the community and facility interface for case finding, retention, OVC-Pediatrics. Technical staffs are assigned supportive supervision, including SIMS and other performance monitoring and improvement visits, as part of their participation on those regional support teams. These routine site visits are also designed to monitor site-level requirements for linkage and retention and client-centered services. Schedules are drawn for site visits, prioritizing high-volume sites and/or sites with performance challenges documented through MER indicator reporting and/or previous site visits.

The PEPFAR-E coordination office will support rapid implementation of the community led monitoring. PEPFAR-E does not have any vacancies of more than six months and is not proposing

a new position on the organizational structure. PEPFAR-E will not have new missing skill sets or competencies identified in the assessment of CODB.

Factors that will increase CODB are raising costs of the CSCS charges and ICASS costs for each employee. The tradeoffs of not fully approving the CODB request will be impaired technical assistance, oversight, and performance of partners supported under PEPFAR.

# APPENDIX A -- SNU Prioritization to Reach Epidemic

Region	# of SNU's	COP	Prioritization	Results reported	Attained - 90-90-90 (15) by Each Agent sex Band to reach 95-95-95 (20) over 11														Overall TX Coverage	
					Male<1	Female<1	Male(1-9)	Female(1-9)	Male(10-14)	Female(10-14)	Male(15-19)	Female(15-19)	Male(20-24)	Female(20-24)	Male(25-49)	Female(25-49)	Male50+	Female50+		
Addis Ababa	116	COP15	Scale-up:Saturation	APR.16	82%	79%	76%	77%	128%	138%	138%	89%	91%	89%	128%	106%	94%	56%	22%	77%
	116	COP16	Scale-up:Saturation	APR.17	69%	70%	75%	76%	130%	140%	104%	103%	65%	121%	117%	108%	55%	29%	82%	
	116	COP17	Atta ined	APR.18	94%	96%	105%	103%	190%	205%	132%	128%	71%	131%	139%	122%	58%	25%	94%	
	116	COP18	Atta ined	APR.19	71%	72%	102%	103%	183%	186%	155%	148%	72%	132%	149%	131%	56%	24%	96%	
	118	COP19	Atta ined	APR.20	100%	100%	175%	188%	194%	177%	343%	369%	233%	248%	175%	144%	67%	72%	138%	
Amhara	118	COP20	160	APR.21	293%	239%	66%	65%	118%	123%	123%	120%	62%	82%	142%	154%	64%	62%	106%	
	86	COP15	Scale-up:Sat	APR.16	16%	16%	20%	23%	39%	42%	34%	35%	31%	57%	90%	77%	82%	41%	69%	
	86	COP16	Scale-up:Sat	APR.17	13%	13%	21%	21%	42%	45%	38%	38%	29%	50%	97%	83%	80%	40%	70%	
	71	COP17	Scale-up:Sat	APR.18	42%	46%	33%	33%	67%	71%	49%	48%	32%	59%	116%	100%	88%	43%	83%	
	110	COP18	Atta ined	APR.19	45%	46%	41%	41%	82%	88%	54%	51%	32%	57%	119%	104%	83%	40%	83%	
	118	COP19	Atta ined	APR.20	54%	54%	58%	60%	142%	134%	103%	116%	85%	91%	113%	108%	71%	105%	99%	
	80	COP19	CentrallySupported	APR.20	12%	12%	27%	28%	39%	39%	22%	23%	17%	16%	20%	29%	21%	18%	23%	
	181	COP20	160	APR.21	59%	46%	66%	62%	80%	83%	70%	64%	64%	71%	95%	98%	56%	66%	84%	
Oromia	86	COP15	Scale-up:Sat/Agg	APR.16	9%	9%	16%	15%	37%	40%	31%	30%	29%	47%	80%	72%	37%	43%	60%	
	86	COP16	Scale-up:Sat/Agg	APR.17	11%	10%	17%	17%	49%	47%	35%	33%	28%	47%	89%	80%	85%	43%	69%	
	55	COP17	Scale-up:Sat/Agg	APR.18	38%	37%	27%	27%	67%	72%	45%	48%	35%	56%	121%	108%	102%	53%	83%	
	87	COP18	Atta ined	APR.19	39%	39%	29%	29%	89%	79%	49%	39%	28%	47%	108%	92%	78%	40%	74%	
	97	COP19	Atta ined	APR.20	29%	29%	153%	159%	112%	116%	133%	136%	104%	104%	137%	132%	104%	145%	130%	
	108	COP19	CentrallySupported	APR.20	2%	2%	31%	30%	18%	15%	15%	18%	14%	14%	14%	20%	21%	21%	15%	19%
	337	COP20	160	APR.21	51%	49%	56%	57%	82%	81%	68%	67%	71%	66%	121%	96%	74%	72%	89%	
SNNPR	16	COP15	Scale-up:Sat/Agg	APR.16	12%	12%	20%	22%	54%	58%	40%	34%	31%	37%	62%	58%	33%	36%	53%	
	16	COP16	Scale-up:Sat/Agg	APR.17	11%	12%	22%	22%	61%	66%	49%	39%	31%	36%	67%	63%	40%	36%	56%	
	20	COP17	Scale-up:Sat/Agg	APR.18	21%	21%	37%	37%	82%	89%	49%	49%	30%	60%	102%	91%	80%	38%	72%	
	31	COP18	Atta ined	APR.19	47%	42%	38%	38%	99%	105%	63%	52%	40%	59%	98%	91%	94%	44%	80%	
	34	COP19	Atta ined	APR.20	50%	50%	238%	237%	132%	118%	202%	148%	157%	99%	134%	134%	128%	178%	142%	
	27	COP20	160	APR.21	79%	176%	82%	82%	59%	50%	40%	61%	53%	66%	83%	81%	30%	26%	69%	
Gambella	4	COP15	Scale-up:Agg	APR.16	15%	13%	20%	23%	50%	54%	29%	17%	17%	17%	46%	48%	78%	32%	41%	
	4	COP16	Scale-up:Agg	APR.17	24%	28%	22%	22%	59%	60%	41%	29%	22%	23%	63%	66%	66%	42%	53%	
	5	COP17	Scale-up:Sat/Agg	APR.18	43%	36%	34%	33%	84%	91%	53%	33%	29%	28%	75%	80%	111%	49%	68%	
	8	COP18	Atta ined	APR.19	50%	50%	53%	54%	131%	141%	71%	49%	34%	36%	92%	97%	126%	57%	84%	

	14	COP 20	060	APR.21	63%	1.2%	64%	92%	53%	43%	53%	12%	11%	15%	7%	2%	3%	2%	
Tgray	18	COP 15	Si c le s p Se t / Agg	APR.16	15%	1%	21%	22%	41%	44%	37%	38%	33%	6%	94%	83%	8%	7%	
	18	COP 15	Si c le s p Se t / Agg	APR.17	14%	1%	22%	21%	40%	46%	43%	43%	33%	6%	10%	93%	85%	4%	7%
	21	COP 17	Si c le s p Se t / Agg	APR.18	41%	4%	32%	32%	70%	76%	57%	58%	37%	70%	18%	11%	9%	7%	9%
	34	COP 19	Ata ined	APR.19	39%	4%	41%	41%	82%	88%	62%	59%	35%	65%	15%	11%	80%	4%	9%
	47	COP 19	CentrallySupported	APR.20	57%	5%	52%	55%	10%	10%	100%	90%	75%	73%	91%	87%	65%	33%	84%
52	COP 20	TA	APR.21	45%	7%	83%	81%	75%	69%	75%	89%	62%	90%	95%	11%	5%	44%	87%	
B0	1	COP 15	Si c le s p Se t	APR.16	15%	1%	16%	16%	39%	44%	45%	42%	34%	50%	73%	70%	70%	31%	5%
	1	COP 19	Si c le s p Se t	APR.17	11%	1%	16%	16%	39%	43%	45%	49%	34%	50%	73%	74%	68%	30%	6%
	1	COP 17	Ata ined	APR.18	40%	4%	36%	37%	78%	86%	58%	51%	37%	55%	9%	8%	7%	2%	7%
	1	COP 19	Ata ined	APR.19	33%	3%	42%	42%	88%	97%	77%	67%	46%	66%	11%	11%	85%	20%	9%
	1	COP 19	CentrallySupported	APR.20	16%	1%	66%	70%	60%	84%	11%	10%	88%	70%	6%	71%	53%	73%	7%
1	COP 20	TA	APR.21	0%	0%	81%	80%	87%	94%	65%	62%	32%	45%	87%	92%	66%	33%	6%	
H0	1	COP 15	Si c le s p Se t	APR.16	17%	1%	32%	32%	100%	10%	6%	5%	4%	6%	11%	10%	4%	4%	9%
	1	COP 15	Si c le s p Se t	APR.17	20%	2%	35%	36%	12%	12%	8%	9%	50%	6%	10%	10%	10%	10%	
	1	COP 17	Si c le s p Se t	APR.18	60%	6%	48%	49%	18%	19%	61%	75%	4%	6%	13%	12%	67%	6%	10%
	1	COP 19	Ata ined	APR.19	30%	3%	54%	55%	19%	20%	100%	51%	4%	6%	13%	12%	90%	4%	10%
	1	COP 19	CentrallySupported	APR.20	29%	2%	40%	41%	19%	18%	16%	13%	13%	8%	7%	7%	6%	9%	8%
1	COP 20	TA	APR.21	80%	4%	73%	52%	30%	20%	11%	8%	5%	4%	9%	17%	5%	6%	9%	
Banking & Gums	2	COP 15	Si c le s p Se t	APR.16	29%	2%	19%	19%	40%	44%	41%	37%	35%	55%	94%	85%	10%	50%	7%
	2	COP 15	Si c le s p Se t	APR.17	25%	2%	20%	19%	43%	46%	45%	39%	35%	53%	10%	63%	10%	4%	7%
	6	COP 17	Si c le s p Se t	APR.18	33%	3%	34%	33%	71%	76%	52%	47%	39%	56%	12%	10%	10%	52%	8%
	3	COP 19	Ata ined	APR.19	50%	5%	38%	38%	77%	80%	58%	52%	37%	56%	12%	11%	6%	4%	9%
	12	COP 19	CentrallySupported	APR.20	23%	2%	57%	59%	77%	77%	10%	8%	8%	6%	80%	7%	7%	11%	8%
21	COP 20	TA	APR.21	14%	0%	37%	2%	63%	74%	52%	41%	35%	48%	8%	8%	53%	2%	70%	
A0	6	COP 15	Si c le s p Agg	APR.16	0%	0%	5%	5%	12%	13%	22%	18%	17%	24%	43%	40%	34%	2%	3%
	6	COP 15	Si c le s p Agg	APR.17	0%	0%	6%	7%	15%	17%	29%	19%	17%	25%	50%	46%	37%	2%	3%
	6	COP 17	Si c le s p Se t / Agg	APR.18	5%	5%	10%	10%	2%	2%	34%	28%	2%	34%	75%	69%	5%	3%	5%
	6	COP 19	Ata ined	APR.19	6%	6%	12%	11%	2%	2%	4%	37%	30%	42%	96%	86%	61%	40%	6%
	12	COP 19	CentrallySupported	APR.20	50%	50%	2%	2%	38%	37%	117%	100%	9%	70%	101%	9%	66%	130%	8%
34	COP 20	TA	APR.21	5%	10%	13%	8%	20%	17%	8%	19%	16%	39%	58%	61%	21%	19%	42%	
Small	2	COP 15	Si c le s p Agg	APR.16	3%	3%	6%	6%	22%	23%	2%	20%	17%	20%	48%	4%	6%	2%	3%
	2	COP 19	Si c le s p Agg	APR.17	5%	5%	7%	7%	17%	18%	2%	24%	18%	3%	54%	4%	4%	2%	3%
	3	COP 17	Si c le s p Agg	APR.18	5%	5%	11%	10%	24%	26%	31%	29%	29%	39%	66%	5%	5%	2%	4%
	2	COP 19	Ata ined	APR.19	6%	6%	12%	12%	2%	2%	32%	30%	2%	40%	9%	61%	5%	2%	4%
	10	COP 19	CentrallySupported	APR.20	60%	60%	4%	4%	7%	9%	15%	15%	12%	90%	12%	12%	9%	16%	11%
100	COP 20	TA	APR.21	0%	0%	17%	13%	2%	2%	51%	48%	56%	44%	60%	4%	16%	2%	40%	

## APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter 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	\$2,079,411
HVAB/Y	Abstinence/Be Faithful Prevention/Youth	\$ 0.00
HVOP	Other Sexual Prevention	\$4,277,817
IDUP	Injecting and Non-Injecting Drug Use	\$ 0.00
HMBL	Blood Safety	\$ 0.00
HMIN	Injection Safety	\$ 0.00
CIRC	Male Circumcision	\$2,124,130
HVCT	Counseling and Testing	\$12,519,713
HBHC	Adult Care and Support	\$7,691,913
PDCS	Pediatric Care and Support	\$4,916,586
HKID	Orphans and Vulnerable Children	\$7,761,704
HTXS	Adult Treatment	\$41,685,945
HTXD	ARV Drugs	\$ 0.00
PDTX	Pediatric Treatment	\$961,018
HVTB	TB/HIV Care	\$3,000,000
HLAB	Lab	\$662,050
HVSI	Strategic Information	\$1,843,152
OHSS	Health Systems Strengthening	\$1,222,554
HVMS	Management and Operations	\$6,714,817
<b>TOTAL</b>		<b>\$97,460,810</b>

Table B.1.1 COP20 Budget by Program Area

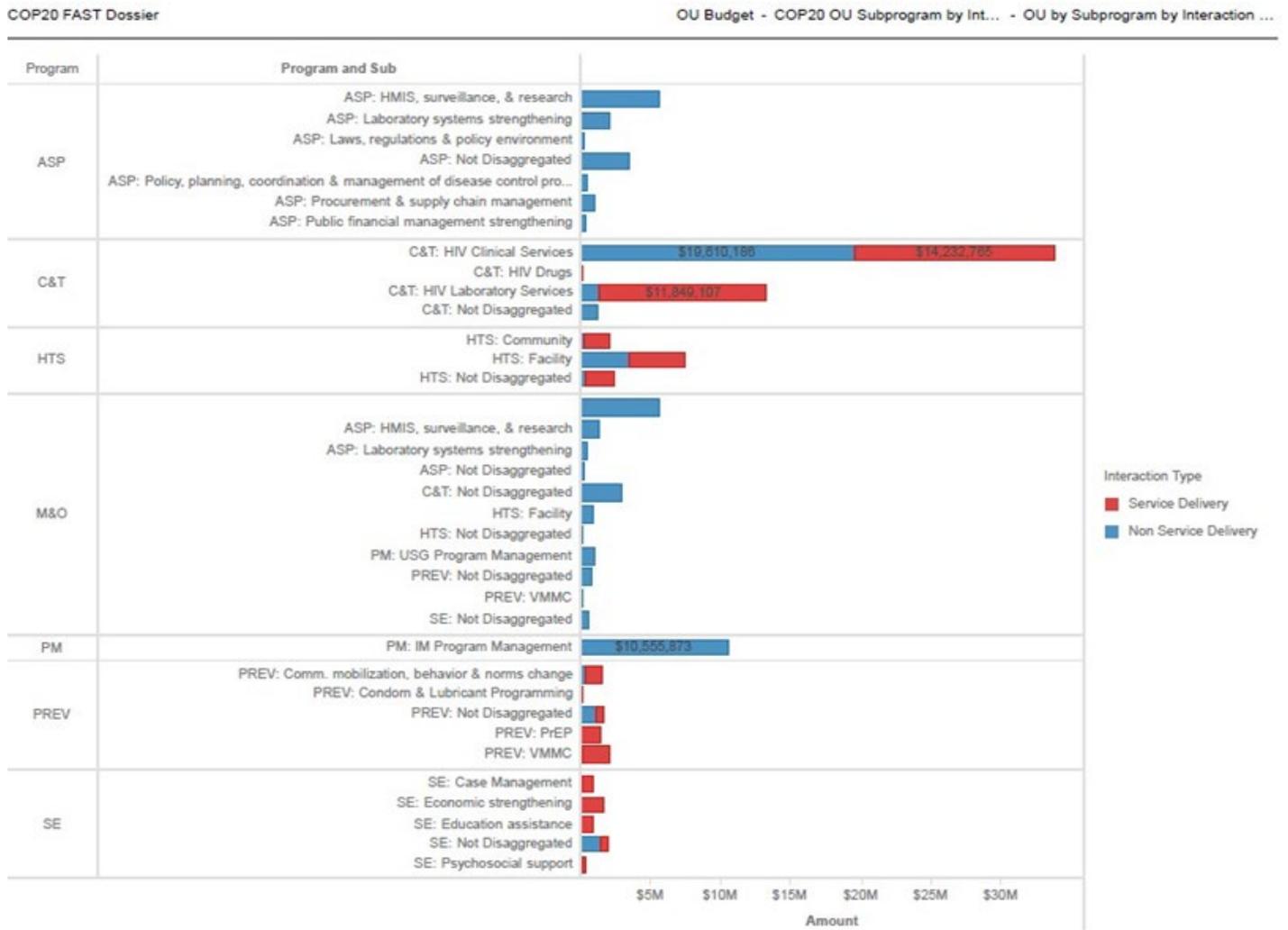


Table B.1.2 COP20 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
\$US 12,204,205	\$US 97,460,810	\$US 109,665,015

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

### B.2 Resource Projections

The budget calculation is done based on the four budget categories: intervention, program area and beneficiary, commodity-based budgeting, management and operation, and cross-cutting attributions. Budget for system level activities is calculated in the Funding and Allocation to Strategy (FAST) and Table 6.o tools. Initially, strategic directions and priority areas were set to complete implementing mechanism (IM) level allocations. We have used the 2018 Expenditure

Reporting and incremental based budgeting grounded on program needs as well as availability of pipelines to determine COP 19 budget. The next step is allocating commodities and the M&O budgets ensuring that required earmarks are met.

# 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	Project Hope-The People-To-People Health Foundation, Inc.	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not di	Program and data quality management	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP19	COP21	Update data capturing tools and support rollout of unified data system to community partners.
USAID	Reputation Services International	ASP: HMIS, surveillance, & research-NSD	Key Pop: Not disaggrega	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP19	COP21	Establishing additional sites in Addis Ababa reporting Case Based Surveillance and conduct rapid response to cases of recent infection among key population in the community. This will have paradigmatic impact in reducing the incidence and contribute for controlling and sustaining the epidemic control.
USAID	BEZA POSTERITY DEVELOPMENT ORGANIZATION	ASP: HMIS, surveillance, & research-NSD	Key Pop: Not disaggrega	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP20	COP21	Drop-In-Centers in Amhara region reporting Case Based Surveillance and conducting rapid response to cases of recent infection among key population in the community. This will have paradigmatic impact in reducing the incidence and contribute for controlling and sustaining the epidemic control.
USAID	ETHIOPIAN SOCIETY OF SOCIOLOGISTS, SOCIAL WORKERS AND ANTHR	ASP: Policy, planning, coordination & management-NSD	OVC: Orphans & vulnerab	Overnight, technical assistance, and supervision to subnational levels	Lack of strong social systems, and Government, Local CSO/NGOs and community structures capability to provide support services	COP19	COP21	Local partners implementing OVC program including services to survivors of sexual violence and HIV-caregivers achieve their targets.
USAID	Chamanix International, Inc.	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not di	Training in laboratory systems strengthening	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP19	COP21	Reduce wastage to 2% and sustain continued availability
USAID	Chamanix International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not di	Forecasting, supply chain plan, budget, and implementation	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP18	COP21	Forecasting accuracy 75%, Ensure 100% of PEPFAR priority site reporting using standard RRF
USAID	Chamanix International, Inc.	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not di	Forecasting, supply chain plan, budget, and implementation	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP19	COP21	ARV stockout 2%; Stock according to plan 50%
USAID	Chamanix International, Inc.	ASP: Procurement & supply chain management-NSD	Non-Targeted Pop: Not di	Forecasting, supply chain plan, budget, and implementation	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP19	COP21	ARV stockout 2%; Stock according to plan 50%
HHS/CDC	OROMIA REGIONAL HEALTH BUREAU	ASP: HMIS, surveillance, & research-NSD	Non-Targeted Pop: Not di	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case based surveillance system, up and running under the national public health emergency management system of the country, and information used for targeted public health response
HHS/CDC	OROMIA REGIONAL HEALTH BUREAU	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not di	Lab quality Improvement and assurance	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service interruption due to machine failure by 95%
HHS/CDC	ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU	ASP: HMIS, surveillance, & rese	Non-Targeted Pop: Not di	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case based surveillance system, up and running under the national public health emergency management system of the country, and information used for targeted public health response
HHS/CDC	ADDIS ABABA CITY ADMINISTRATION HEALTH BUREAU	ASP: Laboratory systems strengthening-NSD	Non-Targeted Pop: Not di	Lab quality Improvement and assurance	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service interruption due to machine failure by 95%
State/AF	DEPARTMENT OF STATE	ASP: Not Disaggregated-NSD	Non-Targeted Pop: Not disaggregated			COP16	COP22	Reach 90% completion of all construction by the end of COP 20
HHS/CDC	SOUTHERN NATIONS NATIONALITIES & PEOPLES REGIONAL STATE HB	ASP: HMIS, surveillance, & rese	Non-Targeted Pop: Not di	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case based surveillance system, up and running under the national public health emergency management system of the country, and information used for targeted public health response
HHS/CDC	SOUTHERN NATIONS NATIONALITIES & PEOPLES REGIONAL STATE HB	ASP: Laboratory systems stren	Non-Targeted Pop: Not di	Lab quality Improvement and assurance	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service interruption due to machine failure by 95%
HHS/CDC	Trustees of Columbia University in the City of New York	ASP: HMIS, surveillance, & rese	Non-Targeted Pop: Not di	Surveillance	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP19	COP19	Report on survey findings and use for programmatic improvement
HHS/CDC	World Health Organization	ASP: Policy, planning, coordina	Non-Targeted Pop: Not di	Assessing Impact of policies and regulations on HIV	Slow progress in policy adaptation and implementation of globally recommended new strategies and approaches	COP17	COP20	Policy adaptation of globally recommended new priority HIV comprehensive care and control interventions and strategies.

## APPENDIX D– Minimum Program Requirements

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Area	Policy	Status	Remark
Care and Treatment	1. Test and Start	Completed	Adopted and implemented Nationwide
	2. TLD transition	Completed	TLD rolled out for new clients and transition ongoing for existing clients.
	3. DSD & MMD	Completed	DSDM models adopted and implemented
	4. TPT	Completed	TPT and TB treatment for PLHIV is available.
	5. VL/EID optimization	Completed	Some laboratory optimization has occurred, but challenges remain. VL coverage not at 90%
Case Finding	1. Index testing and HIVST	Completed	Index testing being scaled, and IPV prevention and monitoring incorporated into COP19 implementation
Prevention and OVC	1. PrEP	Completed	PrEP currently offered for FSWs and sero-discordant couples
	1. Evolve OVC Services & packages	Completed	OVC package reviewed and is aligned
Policy & Public Health Systems Support	1. Elimination of all User Fees	Completed	All user fees are eliminated
	2. CQI Integration	Completed	Various quality assurance and quality improvement activities are being implemented
	3. Tx & VL Literacy, U=U	Completed	Strong host country leadership on health literacy, but barriers to reducing stigma and discrimination in some groups
	4. Increase Funding to Indigenous Partners	Completed	
	5. Increased Government Resources	Completed	Host country HIV spending remains relatively flat with heavy reliance on donor funding
	6. Monitoring Morbidity & Mortality	Completed	Monitoring and reporting in place
	7. Scale-up CBS and Unique Identifier	Completed	CBS is being scaled; GOE is developing unique ID system more broadly