UNCLASSIFIED January 14, 2020

INFORMATION MEMO FOR AMBASSADOR RAYNOR, Ethiopia

FROM: S/GAC – Ambassador Deborah L. Birx, MD

SUBJECT: FY 2020 PEPFAR Planned Country Allocation and Strategic Direction

Dear Ambassador Raynor:

First, I wanted to personally thank you and your Deputy Chief of Mission for your dedication to PEPFAR and working every day to achieve the most possible with the United States taxpayers' dollars. The ability to translate these resources into effective and impactful programming has and continues to be core to our collective progress. Your PEPFAR team in country is extraordinary and we are fortunate to witness their passion and compassion and the progress that has been achieved together.

We are very excited about your progress in:

- Improved facility to community linkage
- Consistent viral load suppression in all regions (with the sole exception of Tigray) at or above 90 percent.
- Improved service delivery for key populations

Together with the Government of Ethiopia and civil society leadership we have made tremendous progress together. Ethiopia should be proud of the progress made over the past 16 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

We did want to highlight both overarching issues we see across PEPFAR and a few specific to Ethiopia. Full details will follow in a more comprehensive letter from your S/GAC Chair and PPM.

Throughout the PEPFAR family of supported countries and communities, five gaps are shared across the globe holding us collectively back from achieving Sustainable Development Goal 3 related to controlling the HIV AIDS epidemic:

1. Continued new HIV infections in adolescents and young women
2. Supporting key populations with prevention and treatment services
3. Ensuring men are diagnosed and treated early (testing positive and new on treatment (linkage surrogate))

4. Ensuring 15-35-year-old asymptomatic clients are maintained on treatment and virally suppressed (net new on treatment and treatment current growth, (retention surrogate))
5. Ensuring all children are diagnosed and are on the best treatment regimens and virally suppressed

In addition, we expect PEPFAR Ethiopia to improve upon certain aspects of their program, in order to ensure we reach the last remaining milestones of our mission:

- Increase case-finding to reach UNAIDS' 95-95-95 goals
- Increase viral load coverage and improve suppression rates among children
- Increase retention among long-term patients

In a recent Office of Inspector General audit around PEPFAR coordination there were four draft preliminary recommendations based on their discussions with PEPFAR staff in the field from four countries, three of their recommendations are relevant to this Country Operational Plan planning cycle related to target setting, tool development, and timelines. Although we just received the draft report a few days ago we did not want to wait another COP cycle to make substantive changes related to the recommendations. The first was around targets and target-setting and the need for a clear and transparent understanding and dialogue in establishing targets. PEPFAR targets are not PEPFAR's, but flow directly from the UNAIDS Fast Track Strategy of 2016. Since 2016, both the PEPFAR strategy and targets were directly derived from the global communities of UNAIDS, WHO, and specifically Heads of State in their commitment to SDG 3 and are aligned to support the country's specific ambition towards those goals.

The global community in 2015 through their Heads of State committed to achieving SDG 3.3 by 2030 which for HIV is ending the HIV/AIDS epidemic as a public health threat. This was followed by a United Nations High Level Meeting on HIV/AIDS in June 2016, whereby these Heads of State committed to the 90/90/90 Fast Track Strategy. Essential to the strategy was 73% community viral load suppression (VLS) by 2020 and 86% community VLS by 2030 combined with increased prevention interventions and zero stigma and discrimination to ensure all ages, genders and risk groups have access to life saving prevention and treatment services. Also, in 2016, 22 PEPFAR-supported high HIV burden countries committed to the three Frees of Start Free, Stay Free, AIDS Free with 2020 targets of a decrease in new infections in children to 20,000, 85% of pregnant women on ART, AGYW new infections to < 100,000, 90% of children on ART and 25 million VMMCs. Since 2016 PEPFAR and the GF resources have been focused on achieving these global goals that have been translated to each country by UNAIDS and subsequently supported financially and technically by the PEPFAR family. Since 2016, PEPFAR has utilized these global commitment targets as PEPFAR targets with the commensurate increased funding to countries in 2016, 2017, and 2018 to achieve the goals set out by the Heads of State. Many countries have made tremendous progress towards these targets and others need to accelerate. Ethiopia is on track to achieve the 2020 and 2030 goals.

Over the past 4 years, PEPFAR resources were allocated based on need, performance, and specifically on the country's and communities' desire to achieve the SDG, Fast Track Strategy, and Three Free goals and country specific targets. Based on the OIG recommendation, S/GAC

will take a different approach this year to target-setting. Our collective hope is that together we use this moment of reflection on progress and challenges along with the realization that the end of 2020 is only 11 months away to address these overarching challenges this year through COP 2019 implementation and use COP 2020 to maintain our progress, address any ongoing challenges and finally fund ambition for greater impact. Thus, S/GAC will not assign targets to countries but only provide notional budget levels. After the PEPFAR country team submits their targets the notional budget will then be adjusted to the presented level of ambition. Additional funding is available as ambition funding for treatment.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2020) notional budget is **$100,050,000** inclusive of all new funding accounts and applied pipeline and reflects the following:

1. Sustaining the gains in treatment services based on your projected COP 2019 treatment result (FY2020 treatment current funded in COP19) $73,500,000
    a. The care and treatment budget is determined by all of your FY18 C/T expenditure services and commodities (no RTK commodities), including all aspects of the health system inclusive of human resources, laboratory and systems, commodities (exclusive of RTKs), an upward adjustment from FY19 treatment current to the FY2020 treatment current fully burdened cost of treatment services and commodities, and 100% of program management costs and data needs
    b. This Budget is broken down by
        i. Care and Treatment services including partner program management costs, FY2020 upward adjustment, EMR and data with surveillance, recency $57,000,000
        ii. TB preventive treatment $3,000,000
        iii. Cervical cancer $6,000,000
        iv. For earmark purposes 50% of M/O costs $7,500,000
        v. Care and Treatment qualifies for ambition funds if addresses gap #3-5
2. Continued orphans and vulnerable children funding: $11,200,000
    a. HKID $9,700,000 dollars for continued historical OVC services
    b. 10% of M/O or $1,500,000
3. Continued VMMC funding based on your percent of VMMC in the appropriate age band of >15 years old
    a. Total VMMC $540,000
4. Continued expansion of Key Populations prevention and expansion of PrEP depending on country submitted targets
    a. Key Population (with RTKs but not treatment) $7,000,000
    b. PrEP total: $1,400,000 dollars
5. RTK and service support to ANC HIV testing $410,000
6. Remaining 40% M/O based on COP19 $6,000,000

Total COP2020 notional budget of $100,050,000 (comprised of $90,445,795 new and $9,604,205 pipeline).

Teams will develop their own targets across PEPFAR program areas described above, with the treatment current target no less than the result that was to be achieved in COP 2019. Testing support outside of ANC and KP should be consistent with any targets above FY2020 treatment current and be submitted with any ambition funding. Targets reflecting continued and sustained OVC programming and KP programming. PrEP, cervical cancer and Preventive TB, increased targets consistent with the level of increased budgets.

Again, the team has received a notional budget as noted above and a final budget approval will be contingent on the team's desired targets. As always funding is associated with a performance target that will be achieved with those resources. Targets and the subsequent approved budget should reflect the level of ambition the PEPFAR team in collaboration with the Government of Ethiopia and civil society of Ethiopia believes is critical for the country's progress towards controlling the pandemic and maintaining controlling.

Additionally, country teams and specifically agencies independently can request additive ambition funds in the OU FAST to be submitted, based on their stated increased ambition in Treatment, with commensurate increased partner level targets. This funding is available to agency partners with the highest performance with evidence that they are addressing the one of the critical gaps outlined above. Budget requests must be consistent with the cost of expanded targets and address one of the gaps in programming #3-5 above. These requests should be discussed with the S/GAC chair and PPM during the January strategy retreat and tentatively approved and be submitted with the DataPack and FAST tool. The final budget and associated country level targets will be discussed and approved during the Johannesburg meeting.

We are hoping this new approach to target-setting and budget will establish an open dialogue on target-setting and empower teams to work with all stakeholders to plan a strategic and impactful COP. The expectation is for country teams and agencies to propose to S/GAC the targets they believe are achievable and feasible and hold their partner's accountable to that achievement. In addition, this new approach to target-setting gives high performing partners and agencies with additional aspirations the opportunity to do more to achieve even greater impact with additional ambition resources.

In the next 48 hours, more detailed descriptions of OU's programmatic successes and challenges will be conveyed to your wider PEPFAR team by the S/GAC Chair and PPM in a phone call, after which the detailed planning level letter will be immediately released.

Again, thank you for your work and we are looking forward to working with you to achieve your Fast Track Strategy and ultimately the SDG 3 goal.

Together we can.

Deborah Birx

UNCLASSIFIED January 16, 2020

COP 2020 Planning Level Letter | PART 2

INFORMATION MEMO FOR AMBASSADOR MICHAEL A. RAYNOR, ETHIOPIA

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

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

Since 2004, PEPFAR has partnered with the Government of the Federal Democratic Republic of Ethiopia (GOE) to advance progress toward HIV epidemic control. PEPFAR's bilateral investment has supported scale up of treatment and as of September 30, 2019, 468,705 HIV positive Ethiopians are currently receiving ART through PEPFAR-supported facilities in the public sector. This comprises 91 percent of the diagnosed PLHIV in Ethiopia, putting the country on the verge of hitting UNAIDS' 95-95-95 goals.

In COP 2018, the PEPFAR Ethiopia team continued to advance progress toward epidemic control by scaling effective HIV service delivery interventions for key populations. The team worked with the Federal Ministry of Health (FMOH) to agree to expanding pre-exposure prophylaxis (PrEP) targets. Additionally, innovative social network strategy (SNS) testing doubled the yield of newly identified positives in female sex workers (FSWs) from five to ten percent. PEPFAR also strengthened its facility to community linkage, to increase case-finding and ensure those identified as positive received lifesaving treatment. Viral load suppression (VLS) among people stably on treatment remained high at or around 90 percent in most regions. In addition, the team is rapidly scaling case-based surveillance activities and recency testing.

Throughout these efforts, the team has built strong working relationships with the government, multilateral partners, civil society, and other stakeholders, leading to increased coordination of the HIV/AIDS response in Ethiopia. This continued coordination will be instrumental as Ethiopia moves forward to be among the first countries in Sub-Saharan Africa to reach epidemic control.

In COP 2020, we expect PEPFAR Ethiopia to continue case-finding to reach 95% of those living with HIV to know their status. Case finding will require continued scale up of index testing,

especially increased efforts to reach non-marital partners, and social network testing in key population groups. The team will also need to increase case finding, treatment, and VLS in children with intensive index testing of children of adults living with HIV. Viral load coverage (VLC) must be increased while also continuing to scale case-based surveillance and recency testing. Retention among long-term patients must be improved to at least 98% to maintain high coverage. The team should continue Addis Ababa acceleration activities and take lessons learned on increasing quality of care to other regions.

SECTION 1: COP 2020 PLANNING LEVEL

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

Table 1. COP 2020 Total Budget including Applied Pipeline

OU Total	Bilateral				Central	TOTAL
	FY20	FY19	FY17	Unspecified	Unspecified	TOTAL
Total New Funding	$ 90,445,795	$ -	$ -			$ 90,445,795
GHP-State	$ 87,658,295	$ -	$ -			$ 87,658,295
GHP-USAID	$ -	$ -	$ -			$ -
GAP	$ 2,787,500	$ -	$ -			$ 2,787,500
Total Applied Pipeline				$ 9,604,205	$ -	$ 9,604,205
DOD				$ -	$ -	$ -
HHS/CDC				$ 2,202,513	$ -	$ 2,202,513
HHS/HRSA				$ -	$ -	$ -
PC				$ -	$ -	$ -
State				$ -	$ -	$ -
USAID				$ 7,401,692	$ -	$ 7,401,692
TOTAL FUNDING	$ 90,445,795	$ -	$ -	$ 9,604,205	$ -	$ 100,050,000

*** Based on agency reported available pipeline from EOFY 2019.*

SECTION 2: COP 2020 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Ethiopia should plan for the full Care and Treatment (C&T) level of $73,500,000 and the full Orphans and Vulnerable Children (OVC) level of $11,200,000 from Part 1 of the PLL across all funding sources. These earmark levels on new funding are subsets of those amounts that must be programmed with specific types of funding due to Congressional requirements. The full amount programmed across all sources will be visible in the FAST.

Table 2. COP 2020 Earmarks

Earmarks	COP 2020 Planning Level			
	FY20	FY19	FY17	Total
C&T	$ 60,000,000	$ -	$ -	$ 60,000,000
OVC	$ 9,700,000	$ -	$ -	$ 9,700,000
GBV	$ 687,504	$ -	$ -	$ 687,504
Water	$ 305,131	$ -	$ -	$ 305,131

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

Table 3. Total COP 20 Initiative Funding

	COP 20 Total
Total Funding	**$ 26,240,000**
VMMC	$ 540,000
Cervical Cancer	$ 6,000,000
DREAMS	$ -
HBCU Tx	$ -
COP 19 Performance	$ 10,000,000
HKID Requirement	$ 9,700,000

*** See Appendix 1 for detailed budgetary requirements and other budgetary considerations.*

SECTION 3: PAST PERFORMANCE – COP 2018 REVIEW

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

Indicator	FY19 result (COP18)	FY20 target (COP19)
TX Current Adults	**447,995**	**517,084**
TX Current Pediatrics	**20,710**	**49,862**
VMMC among males 15 years or older	**15,071**	**36,403**
DREAMS	**N/A**	**N/A**
Cervical Cancer	**15**	**N/A**
TB Preventive Therapy	**22,378**	**197,181**
PrEP	**314**	**2,601**

Table 5. COP 2018 | FY 2019 Agency-Level Outlays versus Approved Budget

OU/Agency	Sum of Approved COP 2018 Planning Level	Sum of Total FY 2019 Outlays	Sum of Over/Under Outlays
Ethiopia			
DOD	$363,265	$864,213	($500,948)
HHS/CDC	$59,005,102	$60,646,077	($1,640,975)
HHS/HRSA	$400,000	$289,851	$110,149
PC	$0	$530,756	($530,756)
State	$692,252	$303,614	$388,638
State/AF	$3,700,000	$3,700,000	$0
State/SGAC	$0	$0	$0
USAID	$46,090,255	$43,350,693	$2,739,562
Grand Total	**$111,020,946**	$110,455,276	$565,670

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 6. COP 2018 | FY 2019 Implementing Partner-level Outlays versus Approved Budget

Mech ID	Prime Partner	Funding Agency	COP/ROP18/FY19 Budget (New funding + Pipeline + Central)	Actual FY19 Outlays ($)	Over/Under FY19 Outlays (Actual $ - Total COP/ROP18 Budget $)
18340	NETWORK OF NETWORKS OF HIV	HHS/ CDC	3,240,641	3,603,938	(363,297)

	POSITIVES IN ETHIOPIA				
16738	ETHIOPIAN PUBLIC HEALTH ASSOC IATION	HHS/ CDC	193,736	237,450	(43,714)
80088	Beza Posterity Development Organization	USAID	210,986	308,000	(97,014)
18519	Population Services International	USAID	4,215,889	6,733,155	(2,517,266)
18241	Tera Tech EM, INC	USAID	350,000	1,339,451	(989,451)
17856	UNIVERSAL CONSTRUCTION	USAID	283,605	1,745,761	(1,462,156)

**Outlays reported in this letter represent a snapshot in time. With respect to outlays reported as "central" (if/applicable), note those numbers are being included in this format for the first time this year and any reported under/over-outlays may be subject to further adjustments as the process for such funds is refined.*

Table 7. COP 2018 | FY 2019 Results and Expenditures

Agency	Indicator	FY19 Target	FY19 Result	% Achievement	Program Classification	FY19 Expenditure	% Service Delivery
HHS/ CDC	HTS_TST	306,506	**455,370**	149%	HTS Program Area	$5,861,472	12%
	HTS_TST POS	13,755	**7,856**	57%			
	TX_NEW	25,946	**33,947**	131%	C&T Program Area	$19,421,123	25%
	TX_ CURR	514,636	**466,814**	94%			
VMMC_ CIRC		24,196	**23,776**	98%	VMMC Subprogram of PREV	$765,557	14%
	OVC_ SERV	N/A	**N/A**	N/A	OVC Major Beneficiary	$0	N/A
DOD	HTS_TST	3,831	**1,018**	27%	HTS Program Area	$0	N/A
	HTS_TST POS	N/A	**4**	N/A			
	TX_NEW	N/A	**N/A**	N/A	C&T Program Area	$0	N/A
	TX_ CURR	N/A	**N/A**	N/A			
	VMMC_ CIRC	5,000	**2,446**	49%	VMMC Subprogram of PREV	$63,270	24%
	OVC_ SERV	N/A	**N/A**	N/A	OVC Major Beneficiary	$0	N/A
HTS_TST		30,390	**42,719**	141%	HTS Program Area	$3,823,925	87%
	HTS_TST POS	1,449	**1,938**	134%			
TX_NEW		N/A	**N/A**	N/A	C&T Program		

USAID	TX_CURR	N/A	N/A	N/A	Area	$17,922,322	94%
	VMMC_CIRC	N/A	N/A	N/A	VMMC Subprogram of PREV	$115,986	100%
	OVC_SERV	497,893	496,370	99%	OVC Major Beneficiary	$9,488,273	94%
					Above SitePrograms	$19,390,836	0%
					Program Management	$13,158,195	0%

COP 2018 | FY 2019 Analysis of Performance

We commend PEPFAR Ethiopia for their continued efforts in advancing Ethiopia's progress towards meeting UNAIDS' 95-95-95 goals. Ethiopia's national level numbers illustrate high levels of ART coverage (91% of diagnosed PLHIV are on treatment) and VLS suppression (90% of PLHIV on treatment who have had a viral load test are virally suppressed), while highlighting the need for increased HIV case finding (79% PLHIV identified). In COP20, we expect PEPFAR Ethiopia to continue case-finding to reach 95 percent. This case-finding should include scaled index testing to account for at least 75% of newly identified positives coming from index testing. Index testing should include testing of non-marital partners and be increased in children. SNS testing in key populations has also shown to be effective, as evidenced by the increase of testing yield in FSWs from 5% generally to 10% in those reached by SNS services. Additionally, improvements in facility-community linkage should continue to be scaled program-wide to support increased case-finding and to ensure newly identified PLHIV are immediately linked to treatment. The team will also need to continue Addis Ababa acceleration activities, and expand lessons learned from these activities on increasing case-finding and quality of care to other regions, including the model of increased collaboration with regional health authorities.

While treatment coverage remains high generally, the program should focus on increased treatment in children, as program results underline lower treatment coverage in children than in adults (roughly 58% treatment coverage in children compared to roughly 74% in adults). Retention among long-term patients must also be improved. While retention currently is 95% among long-term patients, this rate of retention will not maintain the cohort and optimize long term outcomes for all clients.

And though viral suppression rates are high across the program, challenges remain in children (74% VLS in under 15 compared to 91% VLS in over 15). Shifting pediatric patients from nevirapine-based regimens needs to be accelerated during COP19. VLC, currently at 73% for the entire country program, must be increased in all geographic areas, ages, and sexes, while also scaling case- based surveillance and recency testing.

PEPFAR Ethiopia should continue to program effectively for prevention activities. We are pleased the FMOH has agreed to expanding PrEP targets from 2,600 to 19,000 for COP19 and look forward to more ambitious targets for COP20.

Case Finding

OU/PSNU Levels

- Drastic improvements have been seen in facility-community linkage, but this should continue to be scaled program-wide to benefit all clients.
- Addis Ababa acceleration activities led to increased case finding, but team must ensure these gains in case finding also translate to gains in newly initiated clients on treatment, as linkage to treatment was lower than expected.
- Low contact elicitation rate in index testing, at about 1.3 contacts per index client. Work to increase identification of non-marital partners and to reach networks of men with high risk practices.
- Increase index testing of children to reach all children of adults living with HIV.

Partner Performance

- Oromia Regional Health Bureau, Addis Ababa Administration City Health Bureau, and PSI met at least 90% of their HTS_POS target and are performing well.
  - Addis Ababa Administration City Health Bureau expended 200% of their testing budget, with 110% HTS_POS target achievement.
  - Oromia Regional Health Bureau expended 250% of their testing budget, with 160% HTS_POS target achievement.
- Federal Police Commission HIV/AIDS Prevention and Control Office, SNNPR Regional State Health Bureau, Columbia University, and Amhara Regional Health Bureau failed to achieve at least 90% of their HTS_POS target.
  - Amhara Regional Health Bureau expended close to 200% of their testing budget, with 20% HTS_POS target achievement.
  - Columbia University expended over 300% of their testing budget, with just under 80% HTS_POS target achievement.
- Partners that continue to underperform will be further evaluated. Consequences may include a performance improvement plan, and, if improvement is not demonstrated within the designated timeframe, funding may be decreased.

Care and Treatment

OU/PSNU Levels

- VLS is high in most regions. All regions should strive for 95% VLS. VLS also needs to be improved in adolescent and children.
- VLC needs improvement in all geographies/ages/sexes, with particular attention to Amhara, Gambella, and SNNPR. Men also demonstrate lower VLC in many age groups.
- Treatment coverage must be improved in children to match program-wide achievement.
- Retention must be increased to support a maturing epidemic. Rapid implementation of dolutegravir-based regimens and 6-month dispensing should improve retention further.

Partner Performance

- Oromia Regional Health Bureau, Addis Ababa Administration City Health Bureau, and Amhara Regional Health Bureau met at least 90% of their TX_NEW target and are performing well.
- Federal Police Commission HIV/AIDS Prevention and Control Office, SNNPR Regional

State Health Bureau, and Columbia University failed to achieve at least 90% of their TX_NEW target.
- Columbia University met at least 98% of their TX_CURR target and is performing well.
- Federal Police Commission HIV/AIDS Prevention and Control Office, Oromia Regional Health Bureau, Addis Ababa Administration City Health Bureau, SNNPR Regional State Health Bureau, and Amhara Regional Health Bureau failed to achieve at least 98% of their TX_CURR target.
- Partners that continue to underperform will be further evaluated. Consequences may include a performance improvement plan, and, if improvement is not demonstrated within the designated timeframe, funding may be decreased.

Prevention

OU/PSNU Levels
- The team has increased focus on the 10 to 14 year old age band in OVC services.
- VMMC services are moving away from the 10 to 14 year old age band to the 15-49 year old age band.
- PrEP must be expanded. Of 46,565 that tested negative in index testing, only 181 were initiated on PrEP. Only about 120 new on PrEP in COP18 Q4. Many of those testing negative in index testing remain at high risk of HIV acquisition; all should be evaluated for risk and offered PrEP if high risk.
- PrEP should be expanded for key populations so that all those at high risk are offered PrEP.

Above-Site

OU/PSNU Levels
- RTK availability and distribution across sites has been a historic issue in ensuring adequate supplies.
- The team has accomplished a rapid uptake in recency testing and case-based surveillance, with 85% of facilities activated to collect data as of October 2019.
- Data quality improvement activities are in place, but vary, and should be institutionalized for increased standardization.
- Supply chain planning has been an ongoing issue for Ethiopia. The team should focus supply chain support to the subnational level and last mile to manage HIV-related pharmacy services, and continue support to national quantification and forecasting of HIV commodities.
- Viral load coverage remains below 90%. The team should support the GoE in laboratory optimization to provide full VL coverage to all PLHIV on treatment.

SECTION 4: COP 2020 DIRECTIVES

The following section has specific directives for COP 2020 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.
All PEPFAR programs – bilateral, regional, and country pairs – are expected to have the following minimum program requirements in place no later than the beginning of COP 2019 implementation (FY 2020). Adherence to these policies and practices are essential to the success of all PEPFAR programs at the national, subnational, community, and service delivery levels. Evidence demonstrates that lack of any one of these policies/practices significantly undermines progress to reaching epidemic control and results in inefficient and ineffective programs.

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

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

	Minimum Program Requirement	Status	Outstanding Issues Hindering Implementation
Care and Treatment	1. Adoption and implementation of Test and Start with demonstrable access across all age, sex, and risk groups, with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.[1]	Test and Start adopted and implemented.	Must ensure over 95% immediate linkage to treatment for all age, sex, and risk groups.
	2. Rapid optimization of ART by offering TLD to all PLHIV weighing >30 kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children weighing ≥20kg, and removal of all nevirapine-based regimens.[2]	TLD rolled out for new clients, and transition ongoing for existing clients to be complete by end of January.	Must continue to rapidly remove nevirapine-based regimens, including in children.
	3. Adoption and implementation of differentiated service delivery models, including six-month multi- month dispensing (MMD) and delivery models to improve identification and ARV coverage of men and adolescents.[3]	Differentiated service delivery models adopted and implemented.	Must expand MMD beyond current 79% of sites and roll out of multi-month packs (as opposed to providing multiple 30-day packs).

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

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

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

	4. All eligible PLHIV, including children, should have been offered TB preventive treatment (TPT) by end of COP20; cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.[4]	TPT and TB treatment for PLHIV is available. Cotrimoxazole is available in PEPFAR sites.	Continue to scale TPT and TB treatment to ensure all receive these services by end of COP20.
	5. Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	Some laboratory optimization has occurred, but challenges remain. Viral load coverage not at 90%.	Must continue to work on network optimization, including putting underperforming partners on performance improvement plans; assure results are returned and used in patient care.
Case Finding	6. Scale up of index testing and self- testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent must be tested for HIV.[5]	Index testing being scaled, and IPV screening is included in the COP19 plan.	Must ensure intensified index testing to account for at least 75% of new positives. Assure voluntary participation in index testing and assessment for IPV.

[4] Latent Tuberculosis infection: Updated and consolidated guidelines for programmatic management. Geneva: World Health Organization, 2018

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

Prevention and OVC	7. Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV- negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high- risk sex practices)[6]	PrEP currently offered for female sex workers and serodiscordant couples.	Must continue to advocate for expansion of eligible groups for PrEP and offer PrEP to those testing negative in index testing, and work as widely as possible within current scope.
	8. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) providing support and case management for vulnerable children and adolescents living with HIV 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.	OVC package was reviewed and is aligned.	Must continue to increase proportion of OVC being served in the 10-14 year old age band.

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

Policy & Public Health Systems Support	9. Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP and routine clinical services, affecting access to HIV testing and treatment and prevention.[7]	All user fees for access to all direct HIV services and medications, and related services eliminated.	N/A.
	10. OUs assure program and site standards are met by integrating effective quality assurance and Continuous Quality Improvement (CQI) practices into site and program management. CQI is supported by IP work plans, Agency agreements, and national policy.[8]	Various quality assurance and quality improvement activities are being implemented.	Must ensure quality assurance and quality improvement activities are implemented as planned, and continued and expanded in COP20 to ensure adequate site and program management and increased long term retention.
	11. Evidence of treatment and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U = U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	Strong host country leadership on health literacy, but barriers to reducing stigma and discrimination in some groups.	Must ensure U=U and other updated HIV messaging is rolled out by end of COP20 to reduce stigma and discrimination. Work with faith communities to amplify messaging.

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

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

	12. Clear evidence of agency progress toward local, indigenous partner prime funding.	Increased number of awards have been given to local partners.	Continue to increase proportion of awards to local partners.
	13. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended.	Host country HIV spending remains relatively flat, with heavy reliance on donor funding.	Must ensure domestic resource mobilization strategy is finalized and adopted in COP20. Planned secundment of advisor from Treasury Dept to MoH in COP19 should assist in this area.
	14. Monitoring and reporting of morbidity and mortality outcomes including infectious and non- infectious morbidity.	Monitoring and reporting in place.	Continue to scale case- based surveillance rapidly to provide more complete data.
	15. Scale-up of case- based surveillance and unique identifiers for patients across all sites.	Case-based surveillance is being scaled. GoE is investing in deduplication more broadly.	Must continue to scale unique identification and case- based surveillance to ensure all sites are equipped and all patients are covered.

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

Table 9. COP 2020 (FY 2021) Technical Directives

Ethiopia-Specific Directives
Case Finding
1. Intensify index testing, including in children, and other optimized testing strategies. This should include training for providers on non-spousal partner elicitation, and revised risk screening tools as needed.
2. Use lessons learned during Addis Ababa acceleration in other regions.
3. Scale SNS testing services, especially for key populations including high risk men.
4. Adopt and scale unassisted HIV self testing.

5. Institute strong surveillance and rapid response to clusters of recent infections.
Care and Treatment
1. Increase VLS in children and adolescents. Team should strive for 95% VLS in all regions.
2. Continue scaling VLC in all geographies/ages/sexes. Particular attention should be given to men, and to Amhara, Gambella, and SNNPR. This should include demand creation for VL testing, and scaling dried blood spot tests for remote areas and for pediatrics.
3. Improve treatment coverage in children, increasing to at least 95%.
4. Retention must be increased to at least 98% to address the current epidemic in Ethiopia.
5. Strengthen client-centered approach for delivering ART pharmacy services through differentiated care models and dispensing locations (private pharmacies, community dispensing, and other differentiated care models).
6. Continue to build on community-facility collaboration to address retention and LTFU and return those lost to care.
7. Complete ART optimization: continue TLD roll-out and NVP phase out per timeline, strengthen provision of second line ART in health facilities, and complete pediatric ART optimization.
8. Scale up 3HP for TPT.
9. Conduct lab-based HIV drug resistance surveillance.
Prevention
1. Increase PrEP uptake in FSWs and serodiscordant couples, including those testing negative in index testing.
2. Continue expanded VMMC in Gambella.
3. In COP20, OVC and clinical implementing partners in Ethiopia must work together to ensure that 90% or more of children and adolescents on ART with PEPFAR support in OVC SNUs are offered the opportunity to enroll in the comprehensive OVC program.
Above Site
1. Continue scaling recency testing and case-based surveillance.
2. Institutionalize data quality improvements.
3. Support FHAPCO, FMOH, EPHI and EPSA to maintain quality programming in transition regions.
4. Increase private sector engagement for supply chain.
5. Adopt undetectable=untransmittable (U=U) messaging to increase adherence, and decrease stigma and discrimination.
6. Support the scale up of implementation of the HIV domestic resource mobilization strategy.
7. Strengthen pharmacovigilance system at regional, facility and national level for TLD and other ARV and HIV commodities.
8. Reinforce implementation of reagent rental including lab equipment maintenance.
9. Redirect focus on Ethiopia's supply chain support to the subnational level and last mile to manage HIV-related pharmacy services, including strengthening the capacity of regional health bureaus, districts and health facilities to manage their supply chain and pharmaceutical services and activities. Key activities will include working with subnational level in M&E of the supply chain system, data for decision-making, close follow up and monitoring of patient pharmacy data for ART services, and improved governance/ planning/budgeting and coordination of needs between RHB and facilities will be critical activities. At national level, continued support to national quantification and forecasting of HIV commodities, with goal to transition capacity and ownership of tools and processes to FMOH.

COP 2020 Technical Priorities

Client and Family Centered Treatment Services

COP 2020 planning must specifically and thoroughly address the challenge of interrupted antiretroviral treatment and client loss, especially among young adults. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous ART for a population that is often young and asymptomatic— and for whom HIV treatment is easily interrupted by drug side effects, inconvenience, lack of time, poor customer service, stigma and discrimination, or life circumstances. Maintaining long-term viral suppression necessitates planning and implementing services that are convenient and fit the lives of the clients, and make it easy for patients on ART to continue treatment. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient ARV pick-up arrangements, and community and client participation in design and evaluation of services. Ethiopia must ensure 100% "known HIV status" for biological children of TX_CURR clients (15+), including chart review and retrospective elicitation of eligible biological children.

Community-led Monitoring

In COP20, all PEPFAR programs are required to develop and support and fund a community-led monitoring activity through State Department Ambassador's small grants in close collaboration with independent, local civil society organizations and host country governments. Collaboration with community groups, civil society organizations and patients/beneficiaries can help PEPFAR programs and health institutions diagnose and pinpoint persistent problems, challenges, and barriers to effective service and client outcomes at the site level.

Pre-Exposure Prophylaxis (PrEP)

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

TB Preventive Treatment (TPT)

TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP20; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

OVC

To support the Minimum Program Requirement described above, in COP20 clinical sites and OVC implementing partners should jointly develop formal relationships, such as a memoranda of understanding (MOU), outlining the roles and responsibilities of each member of the multi-disciplinary care team and addressing key issues such as bi-directional referral protocols, case conferencing, shared confidentiality, and joint case identification. PEPFAR-supported treatment clinicians should play a key role in training OVC community case workers to build their knowledge in areas such as adherence, retention, and disclosure.

VMMC
Funds have been provided to conduct VMMC for males 15 years or older. The team is reminded of the revised guidance which allows surgical VMMC under the age of 15 only by the dorsal slit method and only for those who have attained Tanner stage 3 or higher of development and are able to provide full informed consent for the procedure. While Shang ring may be considered for those below age 15 regardless of Tanner stage, the same informed consent issues apply. All VMMC providers must adhere to the requirements for reporting of Notifiable Adverse Events.

Cervical Cancer Screening and Treatment:
Funding for cervical cancer screening and treatment of pre-invasive lesions in women living with HIV. The target for screening must be equal to half of the TX_CURR for women age 25-49. All teams performing cervical cancer screening must adhere to the PEPFAR screening guidance. Basic treatment should be available for pre-cancerous lesions at the site of screening except under exceptional circumstances. All sites performing screening should establish clear referral mechanisms for patients needing treatment not available on site such as LEEP or evaluation for potential invasive cancer. Patient referral between sites should be facilitated and outcomes of the referral tracked to assure appropriate treatment and to allow reporting of results.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised Stigma Index 2.0, or complement Global Fund or other donors financing implementation of the Stigma Index 2.0, if it has not already been implemented in the OU. This revised U.S. government compliant version can begin the process of baseline data collection for evaluating the future impact of interventions on reducing stigma, and can inform future HIV program planning. If the revised Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its implementation during COP20, whether supported by PEPFAR or other resources.

COP 2020 Stakeholder Engagement (see section 2.5.3 of COP Guidance)

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

PEPFAR field team. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund New Funding requests with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

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

APPENDIX 1: Detailed Budgetary Requirements

Table 10. COP 2020 New Funding Detailed Controls by Initiative

	COP 2020 Planning Level			
	FY20			COP 20 Total
	GHP-State	GHP-USAID	GAP	
Total New Funding	**$ 87,658,295**	**$ -**	**$ 2,787,500**	**$ 90,445,795**
Core Program	$ 67,958,295	$ -	$ 2,787,500	**$ 70,745,795**
COP 19 Performance	$ 10,000,000			**$ 10,000,000**
HKID Requirement ++	$ 9,700,000			**$ 9,700,000**

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

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

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

HKID Requirement: Ethiopia's COP 2020 minimum requirement for the HKID budget code is reflected in Table 3 and is a subset of the OVC earmark. Your COP 2020 HKID requirement is derived based upon the approved COP 2019 HKID level inclusive of OVC and prevention intervention for children under 19 budget codes. The COP 2020 planned level of new funds for HKID can be above this amount; however, it cannot fall below it.

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

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

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

COP 2020 Applied Pipeline (See Section 9.1.2 Applied Pipeline of COP Guidance)

All agencies in Ethiopia should hold a 4 month pipeline at the end of COP 2020 implementation in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. Any agency that anticipates ending COP 2019 implementation (end of FY 2020) with a pipeline in excess of 4 months is required to apply this excessive pipeline to COP 2020, decreasing the new funding amount to stay within the planning level.