United States Department of State

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UNCLASSIFIED January 13th, 2021

INFORMATION MEMO FOR AMBASSADOR MICHAEL RAYNOR, ETHIOPIA

FROM: S/GAC Chair, Catherine Godfrey and PPM, Chelsea Solmo

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

SUBJECT: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

Dear Ambassador Raynor,

I sincerely hope that this note finds you and your team well, safe, and healthy. We are grateful for your leadership protecting staff through this difficult time.

This year has brought unprecedented challenges with the COVID-19 pandemic impacting the entire global community. Despite obstacles faced, what has remained unwavering is the tireless commitment and incredible resiliency of our PEPFAR program, partners, and team across the over 50 countries in which we work. This includes rapid program adaptations, emerging innovations, and client-centered solutions to ensure continuity of HIV services. PEPFAR country teams and programs have proven to be focused and resilient in the face of dual pandemics of HIV and COVID-19.

PEPFAR programs have made enormous efforts to maintain clients on treatment, initiated and accelerated client centered service delivery adaptations, while doing what was possible in HIV prevention programs affected by COVID-19 shutdowns. The following themes have emerged across all PEPFAR-supported countries. The economic impact of COVID is profound at both national and community levels. Under these circumstances it is more important than ever to use granular data and expand what is working in specific SNUs. We saw differential progress in viral load coverage and suppression that were independent of the impact of COVID19. We need to focus on areas of recent treatment interruption to understand how COVID may have created or exacerbated barriers to access and treatment continuity. Understanding the new and persistent structural barriers to clients returning to care will ensure that we are addressing them appropriately. Across all countries we see persistent gaps in pediatric diagnosis, treatment and viral suppression. Particular attention should be paid to the pediatric cascade to identify challenges by district and country in order to create clear and actionable plans. OVC and other resources can be leveraged to improve early infant diagnosis by two months of age and strengthen resiliency among at-risk women and girls. Community-led monitoring must raise visibility and appropriate response to the needs of populations already vulnerable before COVID. The assessment of needs, and strategies that reinforce OVC caregivers and HIV-affected families in crisis should contribute to budget and activity planning for care and treatment, OVC and wraparound resources. Furthermore, analyzing expenditures at mechanism and program area will continue to build relationships with partner governments, the Global Fund, UN organizations and other donors. These relationships and planning efforts are critical to supply chain stability for key commodities and will help to understand other potential funding, including COVID-19 relief that is available in country to ensure most effective and efficient use of PEPFAR's contributions to the national HIV response in COP21.

We understand that specific programs will have carryover and others may not. These funds will be critical to ensure stabilization and expansion of critical prevention programming.

The COVID pandemic has also laid bare the depth and breadth of inequities across the globe. When constrained, Ministries of Health and governments make choices that differentially impact specific programming areas and specific populations. The pandemic revealed vulnerabilities in our non-public sector community efforts that we knew were present and are now fully exposed. In many cases these specific activities were the first to be dropped. Communities of women and children, and key populations including men who have sex with men, transgender individuals, sex workers, people who inject drugs, and people in prisons and other closed settings are not being adequately and sustainably supported by public-sector mechanisms. We have lost ground in all our prevention services for all populations and for our most vulnerable and marginalized populations and must make every effort to recover.

Despite the disruptions caused by the COVID-19 pandemic, several countries are achieving epidemic control of HIV, and others are on the brink of epidemic control. Indeed, most PEPFAR countries are on a path to achieving program coverage goals. With this in mind, PEPFAR programs should focus on four key themes as we approach Country Operational Plan 2021 planning and implementation: advancing client-centered services; engaging with communities; implementing resilient and adaptive approaches; and supporting capacities for sustainable epidemic control.

We commend you and your team for your attention to the adoption and implementation of the public health policies that have the greatest impact on HIV, particularly as these very policies are critical to ensuring sustained HIV services during COVID-19. Also, we appreciate your role in supporting PEPFAR teams through this challenging period and continuing to hold implementing partners accountable for their performance.

We are grateful to your incredible PEPFAR team in country, working together across agencies to ensure the most effective and efficient use of U.S. taxpayer dollars. We know there are strengths and weaknesses across the board and across the implementing agencies; and we look forward to working together to support those strengths and address those challenges.

We are very excited about your progress in:

- Linkage proxy, continuity of treatment and viral load suppression
- Completing more VMMC last year than in previous years
- Improving KP yield and linkage

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 18 years of PEPFAR implementation and we are deeply grateful for the ongoing deep coordination with the Global Fund and UNAIDS.

As you will see in COP guidance this year, there are no substantial changes in program direction. While assessing possible deficits in programming arising from COVID-19 our fundamental challenges continue, and we again highlight 5 overarching issues we see across PEPFAR.

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, (continuity of treatment surrogate)]
5. Ensuing all children are diagnosed and are on the best treatment regimens and virally suppressed

Moreover, we note the following specific key challenges in PEPFAR Ethiopia:

- Overtesting and low yield from testing is the greatest challenge right now in PEPFAR Ethiopia. Index case testing is not adequately scaled up.
- MoH policies have impacted testing and PrEP scale up.
- VLC dropped in Q3 and 4 due to COVID and it continues to be lower than desired

A fuller set of details, including funding earmarks and specific program direction are included in the accompanying COP/ROP 21 PEPFAR Planned Allocation and Strategic Direction Summary.

Consistent with the approach from last year, PEPFAR teams will once again be responsible for setting their targets in consultation with stakeholders. Teams should bear in mind that PEPFAR targets are not PEPFAR's but flow directly from the partner country government's commitment to the UNAIDS and SDG 3 goals. Since 2016 PEPFAR and the Global Fund 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 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 close to achieving the 2020 goals and with effort will be on track to achieve the 2030 goals. Sustaining the gains will need to be our constant focus.

S/GAC will not assign targets to countries, but only provide notional budget levels sufficient to achieve the full SDG goal and sustain gains made. **Teams will develop their own targets across PEPFAR program areas, with the treatment current target no less than the result that was to be achieved in COP 2020.** After the PEPFAR country team submits their COP 21 targets, the notional budget will then be adjusted to the presented level of ambition.

The PEPFAR Country/Regional Operational Plan (COP/ROP 2021) notional budget for Ethiopia is **$100,400,000** inclusive of all new funding accounts and applied pipeline. All earmarks and program direction provided below must be met. 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 control.

We are hoping this 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.

PEPFAR, with partner governments, multilateral partners, and communities, continues to move rapidly toward control of the HIV pandemic and plan for sustainability of programs. Achieving epidemic control for HIV will be a remarkable accomplishment, saving millions of lives, significantly lowering the burden of HIV/AIDS in countries and communities, reducing the future costs required to sustain the HIV response, and building sustainable public health systems capacity in host countries.

Please note that within the next few days our PEPFAR Chairs and PEPFAR Program Managers (PPMs), working closely with our CAST teams, will plan to review this planning letter and details contained, herein, with your wider PEPFAR country team. Where PEPFAR successfully navigated disruption due to COVID-19 during 2020, it was a result of strong teams, local partners, communities, dedicated health and community workers, leveraging longstanding capacities and platforms established by PEPFAR. Our teams, partners, and communities worked together to adapt and further innovate program implementation and models of service delivery so that the adverse impacts of a dual pandemic threat on essential HIV services were mitigated. Stakeholder engagement is essential for a productive and impactful planning process. Included in this planning letter is an outline of the expectations for engaging key stakeholders and civil society, as we continue to finalize our approach to hosting a virtual 2021 COP planning and approval process.

I am so grateful to you and your entire team for your leadership and engagement in the planning, review and implementation of the President's Emergency Plan for AIDS Relief (PEPFAR) program, along with the community and Government to enhance PEPFAR's program impact.

Sincerely,

Deborah Birx

Attachment: **Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction Summary.**

CC: **S/GAC – Catherine Godfrey and Chelsea Solmo, Meron Seyoum**

Overview: Fiscal Year (FY) 2021 PEPFAR Planned Allocation and Strategic Direction

With input from the field teams through the quarterly POARTs, the agency self-assessments and from Headquarters Country Accountability and Support Teams (CAST), a thorough program review of your country over time has been conducted. This includes the end of year results of the Country Operational Plan (COP) 2019 and current COP 2020 implementation as we plan for COP 2021. We have noted the following key successes and challenges:

Successes:

1. Generally high continuity of care (retention)
2. High viral load suppression once individuals are in care
3. Improving KP testing yield and linkage to care

Challenges:

1. Index testing is not adequately scaled up
2. Treatment interruptions represent a threat to all programs, precision public health will identify groups at risk. There needs to be a differentiated strategy for conflict zones
3. Testing and treatment of pregnant and breast-feeding women
4. Viral load coverage and early infant diagnosis

Given Ethiopia's status of near achieving epidemic control, the following priority strategic and integrated changes are recommended:

1. Reducing mortality by focusing attention on those with advanced disease and children under 5
2. There is an increasing population of individuals over 50; this group represents 16% of TX_CURR. This group is especially vulnerable in the setting of COVID-19 and represents an important proportion of individuals who have interrupted treatment. Their needs may be different and treatment programs may need to tailor interventions to that population
3. Attention to PMTCT and the attendant need to increase early infant diagnosis
4. Attention to continuity of treatment with attention to early losses (those less than 3 months on treatment) and returning individuals to care

SECTION 1: COP/ROP 2021 PLANNING LEVEL

Based upon current analysis of spend levels, information submitted for the End-of-Fiscal Year 2020 (EOFY) tool, and performance data, the total COP/ROP 2021 planning level is comprised as follows: Note – all pipeline numbers were provided and confirmed by your agency. Due to increased costs in FY 2020, including those due to COVID, and correspondingly lower applied pipeline going into COP21, COP envelopes have been decreased in some OUs so that S/GAC has funds reserved to address program gaps identified by PHIAs that have yet to be completed and to address other potential future requirements as the impacts of COVID on the program are better known. These funds will be allocated to OUs at a later date as appropriate.

TABLE 1: All COP 2021 Funding by Appropriation Year

	Bilateral				Central				Total
	FY21	FY20	FY19	Unspecified	FY21	FY20	FY19	Unspecified	TOTAL
Total New Funding	**$93,489,774**	**$-**	**$-**	**$-**	**$400,000**	**$-**	**$-**	**$-**	**$93,889,774**
GHP-State	$90,702,274	$-	$-		$-	$-	$-		**$90,702,274**
GHP-USAID	$-				$400,000				**$400,000**
GAP	$2,787,500				$-				**$2,787,500**
Total Applied Pipeline	**$-**	**$-**	**$-**	**$6,510,226**	**$-**	**$-**	**$-**	**$-**	**$6,510,226**
DOD				$191,960				$-	**$191,960**
HHS/CDC				$2,798,829				$-	**$2,798,829**
HHS/HRSA				$136,324				$-	**$136,324**
PC				$-				$-	**$-**
USAID				$2,493,393				$-	**$2,493,393**
USAID/WCF				$638,951				$-	**$638,951**
State				$-				$-	**$-**
State/AF				$250,769				$-	**$250,769**
State/EAP				$-				$-	**$-**
State/EUR				$-				$-	**$-**
State/PRM				$-				$-	**$-**
State/SCA				$-				$-	**$-**
State/SGAC				$-				$-	**$-**
State/WHA				$-				$-	**$-**
TOTAL FUNDING	**$93,489,774**	**$-**	**$-**	**$6,510,226**	**$400,000**	**$-**	**$-**	**$-**	**$100,400,000**

SECTION 2: COP 2021 BUDGETARY REQUIREMENTS AND OTHER CONSIDERATIONS**

Ethiopia should plan for the full Care and Treatment (C&T) level of $58,000,000 and the full Orphans and Vulnerable Children (OVC) level of $9,700,000 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 2021 Earmarks by Appropriation Year*

	Appropriation Year			
	FY21	FY20	FY19	TOTAL
C&T	$58,000,000	$-	$-	**$58,000,000**
OVC	$9,700,000	$-	$-	**$9,700,000**
GBV	$1,000,000	$-	$-	**$1,000,000**
Water	$330,000	$-	$-	**$330,000**

**Only GHP-State and GHP-USAID will count towards the Care and Treatment and OVC earmarks. **Only GHP-State will count towards the GBV and Water earmarks.*

TABLE 3: COP 2021 Initiative Controls

	Bilateral	Central	TOTAL	Comments/Notes
Total Funding	**$100,000,000**	**$400,000**	**$100,400,000**	
Core Program	$97,000,000	$-	**$97,000,000**	
Cervical Cancer	$2,000,000	$-	**$2,000,000**	
Community-Led Monitoring	$-	$-	**$-**	
Condoms (GHP-USAID Central Funding)	$-	$400,000	**$400,000**	
DREAMS	$-	$-	**$-**	
HBCU Tx	$-	$-	**$-**	
One-time Conditional Funding	$-	$-	**$-**	
Surveillance and Public Health Response	$-	$-	**$-**	
VMMC	$1,000,000	$-	**$1,000,000**	

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

TABLE 4: State ICASS Funding

	Appropriation Year			
	FY21	FY20	FY19	Unspecified
ICASS	$255,210	$-	$-	

SECTION 3: PAST PERFORMANCE – COP/ROP 2019 Review

Table 5. COP/ROP Ethiopia Level FY20 Program Results (COP19) against FY21 Targets (COP20)

Indicator	FY20 result (COP19)	FY21 target (COP20)
TX Current <15	**17,424**	**28,445**
TX Current >15	**457,224**	**554,184**
VMMC >15	**31,267**	**50,000**
Cervical Cancer Screening	**0**	**130,768**
TB Preventive Therapy	**46,031**	**119,442**

Table 6. COP/ROP 2019 | FY 2020 Agency-level Outlays versus Approved Budget

Agency	Sum of Approved COP/ROP 2019 Planning Level	Sum of Total FY 2020 Outlays	Sum of Over/Under Outlays
DOD	400,269	152,226	248,043
HHS/CDC	62,774,029	56,329,274	6,444,755
HHS/HRSA	400,000	213,658	186,342
State	4,099,534	1,746,349	2,353,185
USAID	49,745,360	44,616,835	5,128,525
Grand Total	**117,419,192**	**103,058,342**	**14,360,850**

Table 7. COP/ROP 2019 | FY 2020 Implementing Partner-level Significant Over-Outlays versus Approved Budget

The following IMs outlayed at least 110 percent in excess of their COP/ROP19 approved level.

Mechanism ID	Partner Name	Funding Agency	Total Planning Level	Total Outlays	Outlay Delta Check
18242	U.S. Agency for International Development	USAID	$40,000	$320,016	($280,016)
10559	National Alliance of State	HHS/CDC	$98,992	$311,291	($212,299)

Table 8. COP/ROP 2019 | FY 2020 Results & Expenditures

Agency	Indicator	FY20 Target	FY20 Result	% Achievement	Program Classification	FY20 Expenditure	% Service Delivery
HHS/CDC	HTS_TST	1,017,431	2,947,774	290%	HTS Program Area	$153,031,967	82%
	HTS_TST_POS	61,000	26,708	44%			
	TX_NEW	65,253	27,745	43%	C&T Program Area	$766,693,505	71%
	TX_CURR	563,574	472,339	84%			
	VMMC_CIRC	40,789	33,483	82%	VMMC Sub-Program Area	$100,009,382	87%
	OVC_SERV	N/A	N/A	N/A	OVC Beneficiary	$34,385,164	75%
DOD	HTS_TST	3,702	982	27%	HTS Program Area	$5,399,460	68%
	HTS_TST_POS	8	4	50%			
	TX_NEW	N/A	N/A	N/A	C&T Program Area	$41,017,489	74%
	TX_CURR						
	VMMC_CIRC	4,807	1,303	27%	VMMC Sub-Program Area	$14,155,555	95%
	OVC_SERV	N/A	N/A	N/A	OVC Beneficiary	$3,251,379	68%
USAID	HTS_TST	62,121	49,927	80%	HTS Program Area	$138,175,249	84%
	HTS_TST_POS	6,000	4,138	69%			
	TX_NEW	1,259	1,441	114%	C&T Program Area	$1,151,646,640	87%
	TX_CURR	3,373	2,258	67%			
	VMMC_CIRC	N/A	N/A	N/A	VMMC Sub-Program Area	$69,654,366	95%
	OVC_SERV	451,742	431,828	96%	OVC Beneficiary	$177,555,087	80%
				Above Site Programs			
				Program Management			

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 (90% of diagnosed PLHIV are on treatment) and VLS suppression (93% 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). The findings are similar if not identical (in the case of PLHIV identified) to the findings in COP 19. In COP21, we expect PEPFAR Ethiopia to improve 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 high yields in FSWs (over 9%) 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 VLS in children than in adults. Treatment interruptions among long-term patients must also be mitigated. While continuity is currently at 95% among long-term patients, this rate of continuity of treatment will not maintain the cohort and optimize long term outcomes for all clients.

PEPFAR Ethiopia should continue to program effectively for prevention activities.

Case Finding

OU/PSNU Levels

- PEPFAR Team needs to prioritize supporting the Government of Ethiopia to develop a national HIV testing strategy for achieving epidemic control, together with associated guidelines, SOPs, tools and training materials. This strategy should include optimized PITC and roll-out and use of adult and pediatric risk screening tools and regions should be nationally represented in the roll-out plan to ensure targeting of testing at the health facilities to reduce overtesting.
- Continue the roll-out of assisted and unassisted HIV Self-Testing under COVID across KP and other vulnerable groups. This should include index partners who do not want to access traditional testing, index clients who do not wish to participate in partner notification services but agree to provide self-tests for their partners and other KPs who face barriers accessing traditional testing.
    - Conduct virtual trainings on HIVST to include best practices on successful implementation of HIVST in other countries.
- Continue and complete the assessment of health facilities to determine if all PEPFAR-supported sites meet the minimum standards for the implementation of index case testing and ensure IPV screening in the provision of index case testing services.
    - Consider conducting virtual training for the FMOH and IPs on IPV screening based upon the successful experiences of other countries.
- Improve VLC and VLS, which have stagnated, by expanding access to POC testing, decreasing lab TAT, and increasing the proportion of eligible C/ALHIV enrolled in the OVC program to receive support to achieve viral suppression. Priority should be given to rapid adoption of pediatric DTG/other optimal regimens, with close monitoring of uptake of pediatric DTG. In the facility, clinical IPs should also improve/enhance mentoring of staff on management of pediatric treatment and on management of treatment failure in children and adolescents. Enhanced data reviews of viral load test results, EAC implementation for children and adolescents and parental education are additional measures that clinical IPs can take to improve treatment services for children.

Partner Performance

- The Beza Posterity Development Organization expended 89% of their testing budget and exceeded their HTS_POS target. The rest of the implementing partners failed to achieve at least 75% of their target with the Federal Police Commission, Oromia Regional Health Bureau and Southern Nations & Peoples Regional State HB reaching less than 50% of their HTS_POS target.
    - Oromia Regional Health Bureau spent 157% of their testing budget and only achieved 24% of their target for HTS_TST_POS and Southern Nations & Peoples Regional State HB spent 92% of their testing budget and only achieved 44% of their target for HTS_TST_POS.
- 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.

Continuity of treatment

OU/PSNU Levels

- Systems need to be in place to optimize pediatric index testing and ensure 100% of biological children <19 years of age are offered testing. Additionally, IPs need to support the use of validated risk screening tools for targeted testing in high volume settings, such as Under 5 clinics and outpatient departments.
- The program should conduct a root cause analysis to better understand losses and interruption in treatment (ITT), including better understanding of the contribution of aging out. Linking HIV exposed infants, positive children/adolescents to OVC programs and other support services/programs (teen clubs, etc.) at the facilities or in the community need to be implemented as soon as possible.
- For those on MMD, especially those newly eligible for MMD under expanded eligibility criteria in 2020 (e.g., newly initiated, not virally suppressed, etc.), closely monitor missed appointments and IIT and provide targeted continuity of treatment interventions/services to those who have interruptions in treatment or are at high risk for viral non-suppression.
    - Early losses (<3 months on treatment) appear to be a critical gap, tracing individuals who have missed their first expected clinical contact will be important in improving continuity of treatment
- The program should investigate community-based distribution to MMD patients and a decentralized drug distribution of ARVs to MMD patients focusing on 6MMD and the removal of policy barriers.
- Supply and distribution systems should continue to expand community interventions to support treatment and should be recalibrated to support SNUs and/or populations with weaker continuity of treatment, newly initiated clients, and virally unsuppressed clients. For stable, virally suppressed clients, Ethiopia should carefully weigh the costs of community interventions and potential risks of ART disruption given the success of MMD.
- Interventions to improve continuity of treatment in conflict zones will need to be tailored to that environment and include continued expansion of MMD.
- Strengthen focus on patient literacy and demand creation among the population for these critical services, including VL literacy, U=U, ART, MMD, and ICT/HIVST.

Partner Performance

- Oromia Regional Health Bureau, Addis Ababa City Administration Health Bureau and Amhara Regional Health Bureau in Quarter 4 all enrolled greater than 55,000 clients into ARV dispensing for 6 or more months. All partners showed a rapid scale up of MMD in the context of COVID-19.

    - The Oromia Health Bureau expended 62% of their Care & Treatment budget and Addis Ababa City Administration Health Bureau expended 97%.
- All partners had patients with interruption to care. Hiwot Integrated development organization had a 3.66% patient loss (31 patients) and Amhara Regional Health Bureau had the most patients with an interruption to treatment (1,898 patients, 1.34% patient loss).
- 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 & Treatment

OU/PSNU Levels

- Attention should be paid to region and age groups with low VLC and low VLS. SNUs, IPs or sites with sub-optimal or declining VLC or VLS should be targeted for focused TA/intervention.
    - VLC needs improvement in all geographies/ages/sexes, with particular attention to Dire Dawa, Benishangul-Gumuz, Afar and Tigray. Men also demonstrate lower VLC in many age groups.
    - There is a need to expand VLC in Amhara, Oromia and SNNPR which have high volume NSU with low coverage. Additionally, VLC must be expanded to high volume facilities with VLC <85%.
    - DBS rollout should continue for all facilities with TX_CURR <500 and optimization should continue for facilities with TX_CURR <100.
    - Consideration should be given for prioritizing TLD for young men and women with lower rates of VLC and VLS, focused tracking of clients, and meeting the needs of these clients through clinic/services with EAC and other interventions specifically designed for young patients with high viral loads.
- VLS is high in all regions, with a need for improvement in the Tigray Region. All regions should strive for 95% VLS and particularly attention should be paid to low performing SNUs like Tigray where the VLC is less than 50%.
    - VLS needs to be improved in adolescent and children.
    - Treatment coverage must be improved in children to match program-wide achievement.

Partner Performance

- Beza Posterity Development Organization and Hiwot Integrated Development Organization met at least 90% of their TX_NEW target and are performing well.
    - Federal Police Commission HIV/AIDS Prevention and Control Office, Oromia Regional Health Bureau, Addis Ababa City Administration Health Bureau, Southern Nations Nationalities & Peoples Regional State HB, PSI, Columbia University, Amhara Regional Health Bureau, and Federal HIV/AIDS Prevention and Control Office failed to achieve at least 90% of their TX_NEW target.
    - Oromia Regional Health Bureau expended 62% of their Care and Treatment but only reached 29% of their TX_NEW target
- Federal Police Commission HIV/AIDS Prevention and Control Office and Hiwot Integrated Development Organization met at least 95% of their TX_CURR target and are performing well.
    - Oromia Regional Health Bureau, Addis Ababa Administration City Health Bureau, Southern Nations Nationalities & Peoples Regional State HB, PSI, Columbia University, Amhara Regional Health Bureau, Federal HIV/AIDS Prevention and Control Office, and Beza Posterity Development Organization failed to achieve at least 95% 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.

Lab

OU/PSNU Levels

- EID testing achievement in Q1-2 was low (47-54%) due to stock outs of EID testing supplies such as DBS. Better integration between supply chain partners and federal MOH will allow for appropriate purchasing and consistent stock.
- EID data is incomplete and missing for several past quarters. There are data quality issues with 2mo and 12mo EID coverage. The percent of HIV positive infants linked to treatment is too low (ranging between 59% - 81%) and may be a documentation issue. Implementing Partners should identify the few low-performing sites and create site-specific action plans to ensure and document that all HIV positive infants are linked to treatment.
- Ethiopia's high MTCT rate (17% per 2019 SPECTRUM estimates) is likely related to insufficient national ART coverage among pregnant women (74% in 2019), disengagement from treatment, and incident maternal HIV infections during pregnancy or lactation. Given the regional variance of ART coverage among pregnant women, above-site support to national and sub-national government and non-government stakeholders and platforms (e.g., PMTCT TWG and national validation committee) must be strengthened to improve accuracy of reporting and increase ART coverage among PW in low performing regions.
- Ethiopia is lagging in lab CQI across all lab testing areas. Efforts need to be made to improve lab CQI of all labs to ensure the quality of testing. Proficiency testing should be implemented for both conventional and point of care testing sites.
    - Closely monitor/balance VL demand across quarters, backlog development/ status, commodity-related (reagents, consumables) or issues that may lead to interruptions or backlogs.

PREP

OU/PSNU Levels

- Expand PrEP access to align with WHO guidance to implement PrEP among all high incidence populations.
    - Allow PrEP access to anyone requesting PrEP and prepare for introduction of new biomedical prevention products such as long acting injectables.
- Expand the types of sites which are providing PrEP to include community-based implementation outside of health facilities.

Partner Performance

- Oromia Regional Health Facility, Southern Nations Nationalities & Peoples Regional State HB, PSI, Columbia University, Beza Posterity Development Organization and Hiwot Integrated Development Organization all exceeded their target for PREP_CURR.
- Addis Ababa City Administration Health Bureau expended 74% of their Prevention budget and only 61% of their target for PREP_CURR, and Amhara Regional Health Bureau expended 95% of their Prevention budget and met only 9% of their target for PREP_CURR.

Commodities

OU/PSNU Levels

SECTION 4: COP/ROP 2021 DIRECTIVES

The following section has specific directives for COP 2021 based on program performance noted above. Please review each section carefully including the minimum program requirements and specific country directives.

Minimum Program Requirements (MPR)
All PEPFAR programs – bilateral and regional– were expected to have the following minimum program requirements in place by the beginning of COP20 implementation (FY2021). Adherence to these policies and practices is essential to the success of all PEPFAR programs at the national, subnational, and service delivery levels (e.g. facility, school, community). 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.

All PEPFAR programs are expected to meet all the requirements below, and the COP21 Planning Meeting will include a review of the status of each requirement, including assessment of implementation (including barriers) at the point of client services. To the extent that any requirement(s) have not been met by the time of the COP21 Planning Meeting, the PEPFAR Ethiopia team will need to present a detailed description of existing barriers and the remediation plans proposed that will allow them to meet the requirement(s) prior to the beginning of FY2021. The list will be included in the Strategic Direction Summary (SDS), as well.

Failure to meet any of these requirements by the beginning of FY2022 may affect the Ethiopia budget. The minimum requirements for continued PEPFAR support include the table on the following page.

Table 9. COP/ROP 2021 (FY 2022) Minimum Program Requirements

Minimum Program Requirement	Status and issues hindering Implementation
Care and Treatment	
1. Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to treatment across age, sex, and risk groups.	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 who are ≥4 weeks of age and weigh ≥3 kg, and removal of all NVP- and EFV-based ART regimens.	Need to continue to switch from EFV and DTG based regimens and rapidly plan for DTG 10mg for children.
3. Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	Differentiated service delivery models adopted and implemented. Must expand MMD to include individuals not previously eligible for DSD such as those recently initiated, those who have not yet achieved virological suppression, and migrants. Older adults represent a population that

	may have other health needs, attention to integration of other services may be helpful.
4. All eligible PLHIV, including children, should complete TB preventive treatment (TPT) by the end of COP21, and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	TPT and TB treatment for PLHIV is available. Cotrimoxazole is available in PEPFAR sites. Team should continue their work on identifying patients eligible for TPT and assuring TB screening at every visit for PLHIV
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.	Must continue to work to scale up VL and EID coverage and to improve network optimization, including putting underperforming partners on performance improvement plans. Need to assure results are returned and used in patient care.
Testing	
1. Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.	Revising the testing strategy in Ethiopia must be a high priority. The PEPFAR team needs to prioritize supporting the Government of Ethiopia to develop a national HIV testing strategy for achieving epidemic control. This strategy should include optimized PITC and roll-out and use of adult and pediatric risk screening tools, and regions should be nationally represented in the roll-out plan to ensure targeting of testing at the health facilities to reduce over testing.
Prevention and OVC	
1. 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*)*	Policies need to be changed to expand PREP access to all high-risk populations.
2. Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 9-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV	The OVC package was reviewed and is aligned. Team needs to concentrate on linking CLHIV to OVC programs and supporting families with parents living with HIV through the OVC program to maintain VLS. Need to develop programs for supporting CLHIV through TA in transition regions.

Policy & Systems	
1. 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.	All user fees have been eliminated.
2. 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.	Various quality assurance and quality improvement activities are being implemented. Team should continue current activities including the expansion of CLM. Site safety including infection prevention and control is an important area for quality management activities.
3. 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 there are barriers to reducing stigma and discrimination in some groups. Returning viral load results to clients is a key innovation first proposed in COP20. Attention to this goal will improve treatment literacy. Continue current activities and work with faith communities to amplify messages.
4. Clear evidence of agency progress toward local, indigenous partner direct funding.	Continue to increase proportion of awards to local partners.
5. Evidence of host government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	Need to work with MoH and MoF to advance their domestic resource mobilization strategy.
6. Monitoring and reporting of mortality developing robust information about populations at risk.	Monitoring and reporting are in place. Data completeness for the TX_ML indicator and attention to the mortality component of this indicator with age, sex and regional analyses will be very helpful. Continue to scale case-based surveillance rapidly to provide more complete data.
7. Scale-up of case surveillance and unique identifiers for patients across all sites.	Must continue to scale unique identifiers 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 consider all the following technical directives and priorities:

Table 10. COP/ROP 2021 (FY 2022) Technical Directives

OU –Specific Directives
HIV Treatment
1. Continue scaling VLC in all geographies/ages/sexes. Particular attention should be given to Afar, Tigray, Dire Dawa, and Benishangul-Gumuz. This should include demand creation for VL testing and scaling dried blood spot tests for remote areas and for pediatrics.
2. Increase VLS in children and adolescents, and in Tigray Region. Team should strive for 95% VLS in all regions and adaptions may need to be made for conflict areas. Viral loads should be returned to clients to aid in demand creation.
3. Improve treatment coverage, particularly for children 0-9, increasing to at least 95%.
4. Continuity of treatment must be increased to at least 98% to address the current epidemic in Ethiopia.
5. Address mortality by addressing advanced disease and treatment coverage in children under 5.
HIV Prevention
1. Increase PrEP uptake in FSWs and serodiscordant couples, including those testing negative in index testing and rapidly scale in KP program.
2. Continue with DoD and Gambella programs to reach saturation.
3. Support POCT-VL for pregnant and breastfeeding women.
Other Government Policy or Programming Changes Needed
Need to work with the FMOH to revise the testing strategy in the National Strategic Plan to reduce overtesting. Need to focus on high yield modalities: Index testing for adults and all children of PLHIV, social network testing in high yield networks, risk assessment to limit PITC, TB, STI and inpatient testing. Need to focus on geographies and facilities with high yields and intensify performance monitoring and supportive supervision for focus sites.

Supply Chain COP 21 Recommendations:

- Ethiopia continues to experience localized stock outs due to weak site-level supply management and overall pharmaceutical services. USG/PEPFAR continues its strategy to shift its focus to subnational system strengthening for the supply chain to focus on building capacity of regions and selected woredas to strengthen site level supply management and quality of services. This will be implemented through a local partner and USAID is in the process of designing its activities. USG/PEPFAR will seek options for cost-sharing these activities with other bilateral and donor partners including GFATM, Gavi and Gates Foundation.
- End to end supply chain and commodities data is seen as a gap by all partners. A key challenge for the supply chain system is the poor end-end logistics management information (LMIS) at SDPs, including ART dispensing information. USAID Ethiopia should use PEPFAR funding to support USAID's existing Digital health activities through the expansion of the automated LMIS (Dagu 2.0) and the ART dispensing tool (PMIS) to PEPFAR-supported sites, and to support PEPFAR in improving data collection and use of supply chain data for PEPFAR commodities and sites. In addition, as USAID/Ethiopia expands its effort to bring pharmaceutical ART services down to the clients through implementation and expansion of differentiated service delivery models including private sector retail outlets and other community-based outlets, USAID/Ethiopia should support the integration of data collection and ARV distribution tracking systems into the pharmaceutical management system.

- In the interest of supporting the government of Ethiopia develop in maturity and adopt more responsibilities related to their HIV Public Health Program, PEPFAR should support a multi-year G2G agreement, started in COP20, with the ultimate goal of transferring the PSM-managed lab and RTK procurement to EPSA. This multi-year G2G supports EPSA to
    - support to USG/PEPFAR's goals to increase client-centered care and treatment services for PLHIV through differentiated service delivery models
    - reach a high supply chain maturity that focuses on supporting procurement accreditation
    - ensure high level of procurement performance for HIV commodities funded by Global Fund and managed by EPSA,
    - increase use of private sector and other private-sector partners for optimizing its warehouse and distribution services, including maintaining technical assistance for its center of excellence activities,
    - support for the strategy to reduce stock outs of HIV-related commodities with a focus on ARVs and RTKs.
        - The stock out reduction strategy and roadmap is an activity that will be integrated into the PMI-led playbook for identifying systemic root causes and strategies for addressing these at site level.
        - USAID should eventually transfer PSM-managed lab and RTK procurement to EPSA by Year 3 to reduce costs and achieve economies of scale.

Shift the focus of supply chain technical assistance to the subnational level to increase pharmaceutical management at the hubs and the PEPFAR facilities in collaboration with existing TGF, GAVI and the Gates Foundation.

COP/ROP 2021 Technical Priorities

Client Centered Treatment Services

COP21 planning must ensure treatment continuity for all current and new clients. To do this, programs must specifically and thoroughly address the challenge of interrupted antiretroviral treatment, especially after initiating ARVs and through young adulthood. Maintaining epidemic control, as measured by the proportion of PLHIV with viral suppression, will require long-term, continuous adherence to ART for an adult population that is 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 free, fit the lives of the clients, and empower clients to on ART to stay the course. PEPFAR requires development and full implementation of key client-centered policies and practices at the site-level, including client education on the benefits of lifelong treatment, optimized treatment (dolutegravir-based therapy) and multi-month dispensing, convenient and safe ARV access arrangements, and community and client participation in design and evaluation of services.

Pediatric- and Adolescent-Centered Services

In COP21, PEPFAR programs are required to demonstrate improvement in pediatric case finding, including safe and ethical index testing, to close HIV treatment gaps across age and sex bands. Programs must move forward with the introduction and broad use of pediatric DTG formulations in FY21 (COP20), with full implementation expected to occur during the first quarters of FY22 (COP21). Programs need to further advance pediatric- and adolescent-specific continuity of treatment programming, including age-appropriate differentiated models of care and leveraging bidirectional synergies with clinical and OVC implementing partners. OUs must develop a comprehensive plan to achieve ≥ 90% viral load coverage and viral load suppression across all age and sex bands. To further reduce morbidity and mortality,

clinical programs should include an evidence-based advanced HIV disease package of care for children and adolescents.

TB/HIV

TB/HIV services must be integrated, including DSD and MMD models for both TB and TB preventive treatment (TPT). All PLHIV must be screened for TB at every clinical encounter and have access to molecular diagnostic testing and/or point of care tests such as LF-LAM. TPT is considered routine HIV care, and all country programs must have offered TPT to all PLHIV on treatment by the end of COP21; targets have been set accordingly. Countries should budget for full coverage, and plan to use optimal regimens (3-HP) as supply allows.

Advanced HIV disease

The advanced disease package of care should be fully integrated into clinical care and includes diagnostics and therapeutics for tuberculosis and cryptococcal meningitis as well as cotrimoxazole. Countries should budget adequately for commodities including urinary LAM, CrAg, amphotericin B and flucytosine. Please see section 6.5.2 of the COP guidance.

Site safety and infection prevention and control

PEPFAR is committed to providing prevention and treatment services safely, and the COVID-19 pandemic has highlighted the need to focus attention on site safety. COP 21 guidance emphasizes the importance of and need for robust implementation of infection prevention and control at health facilities. All PEPFAR programs should incorporate the implementation and monitoring of infection prevention and control interventions as an integral component of quality HIV care services at all PEPFAR supported facilities.

Community-led Monitoring

In COP 21, 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)

In COP 2021, PrEP should continue to be made widely available with a focus on getting PrEP, (including possible new PrEP options) to the people that need it. Groups to be prioritized for PrEP include HIV negative partners of index cases key populations including sex workers, men who have sex with men, transgender persons, people in prisons and other closed settings, people who inject drugs, adolescent girls and young women and, pregnant and breastfeeding women, in areas with high HIV incidence or with higher risk partners, and other identified serodifferent couples. Groups should be tailored to the OU's epidemic context.

OVC

To support the Minimum Program Requirement described above, in COP 21 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, pediatric case finding, case conferencing, shared confidentiality, joint case identification, and data sharing. In high volume clinics within high burden SNUs, at least 90% of children (<age 19) in PEPFAR-supported treatment sites

should be offered enrollment in OVC programs. OVC staff placed in clinics (e.g., as linkage coordinators, case managers, etc.) should have the capacity to assess child and family needs (including food and economic security) and to offer appropriate referrals. 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 for those 15 or older. While Shang ring may be considered for those below age 15 with headquarters approval, it should be limited to those age 13 or above who are able to understand the procedure and provide informed consent, along with parental consent as dictated by local laws. 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. 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 and report into the cervical cancer MER indicators. 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.

Condoms and Lubricants
Condoms are key to a successful combination HIV prevention approach and are a cost-effective tool for preventing other sexually transmitted infections and unintended pregnancies. PEPFAR's goal is to ensure high levels of use, equitable access to, and sustained demand for condoms and lubricants among key and priority populations and low-income groups. In COP21, through the Condom Fund, GHP-USAID will provide $20.3 million in assistance to PEPFAR-supported countries to procure and deliver condoms and lubricants to address key condom supply and demand issues This funding is in addition to funds allocated for condom programming and additional condom/lubricant procurement in each country from COP21 country funding as determined during the COP planning process.

Ethiopia will have access to $400,000 million from the Condom Fund in COP21/FY22, contingent upon adequate justification of need. Coordination with other donors that provide commodities, including the Global Fund, is also critical and expected. The process for estimating your country's total condom and lubricant need is outlined in the COP21 guidance. Among other items, this justification should include an outline of how Ethiopia will support condom programming in FY22 with funds from your base COP21, the Condom Fund, the GF and/or other donors, and the host-country government. Please note that in FY22 there will also be limited funding available to cover unexpected or emergency condom and/or lubricant requests from PEPFAR-supported countries. Access to these funds will be provided on a first come, first served basis, and OUs will be required to provide a justification for why their special request is being made.

PLHIV Stigma Index 2.0
PEPFAR teams are required to either fund host country PLHIV network-led implementation of the revised PLHIV Stigma Index 2.0 utilizing the standard methodology, or complement Global Fund or other donors financing implementation of the PLHIV Stigma Index 2.0, if it has not already been implemented in the OU. If the revised PLHIV Stigma Index 2.0 has not been previously conducted in the OU, then PEPFAR teams must work with UNAIDS, Global Fund or other donors to ensure its

implementation during COP 21, whether supported by PEPFAR or other resources. Completion of the PLHIV Stigma Index 2.0 should be accompanied by a response and action plan discussed and agreed upon by all stakeholders that will address findings. Where the PLHIV Stigma Index 2.0 has already been conducted, COP/ROP 21 focus should be on concerted action to address findings.

Human Resources for Health (HRH) and Sustainability

Using data from the HRH Inventory completed in COP20 Q4, OUs are expected to complete a comprehensive HRH analysis to optimize staffing at the site- and above-site-levels. PEPFAR programs in countries that will be near to or reach 95/95/95 in the COP20 implementation cycle are required to develop and implement plans to sustain their progress and effectively retain clients in quality HIV treatment programs. Results from the Sustainability Index and Dashboard (SID) 2019 should inform the OUs on their progress and gaps related to the policies and technical areas for inclusion in the sustainability plans. Resource alignment data should be used to understand the HIV funding landscape--especially with a more granular understanding of PEPFAR and GFATM investments-- who is paying for what services in order to enhance strategic collaboration and coordination and avoid duplication during the program planning cycle.

Cross-HIS Data interoperability - Use and Analysis

Improved data visibility, and analysis are essential for better understanding the HIV epidemic and reaching epidemic control.

PEPFAR Ethiopia should 1) consistently and continuously use and analyze data at the individual patient level with aim of program improvement (e.g. use patient level data to understand retention differences across patient cohorts and create more tailored risk models and intervention). 2) utilize available data interoperability solutions to harmonize and triangulate data across EMRs, commodities, pharmacy dispensation, laboratory data, HRH and other data.

Systems Investments

PEPFAR teams are expected to align systems investments with key systems barriers to achieving epidemic control. System investments should also be aligned to achieving and maintaining minimum program requirements for COP including adoption and use of unique identifiers, building country capacity in disease surveillance and other core competencies to achieve and maintain epidemic control including country ability to perform continuous quality improvement. Systems investments that have achieved their goals should be candidates for countries to assume responsibility to achieve the minimum program requirement for increased responsibility and increased government expenditures.

Faith and Community Initiative (FCI)

Building upon PEPFAR's standing principle to ensure "every dollar is optimally focused for impact", OUs with continuing FCI investments should continue implementing best practices in accordance with FCI and COP21 Guidance. Priorities for COP21 FCI implementation for addressing gaps in reaching men and children include: coordination through an Inter-Faith Steering Committee to advance treatment literacy; and decentralized, continuing care through faith-engaged community posts, faith-engaged highly targeted HIV self-testing, and/or community adolescent treatment programs for youth living with HIV.

Innovative solutions and adaptive practices

There are extraordinary examples of innovation by our field teams and partners during COVID. These include adaptations and lessons learned that span across many of our technical and program areas as well as all countries we work in. Teams should look at ways to strengthen and improve our capacity to innovate, design, and create within the communities we serve. This includes systematically looking at the evidence base and how to learn from these examples as well as strengthen our methods to help scale proven strategies and interventions.

COP/ROP 2021 Active Engagement with Community and Civil Society (see section 2.5.3 of COP Guidance)

The full participation of community stakeholders and civil society in every stage of PEPFAR programming, planning, and monitoring as appropriate and consistent with applicable law, regulations and policy, from advocacy to service delivery, is critical to the success and sustainability of PEPFAR and the global effort to combat HIV. 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.

As in years past, civil society organizations are considered essential and invited to participate both in the virtual COP21 strategic planning meetings, as well as virtual approval meetings.

This engagement, of both civil society, and of faith-based organizations/faith communities, specifically includes the sharing of FY 2020 Q4 and FY 2020 APR results and analyses and the convening of an in-country planning retreat with local stakeholders during the last two weeks of January 2021 in order to introduce and discuss all COP/ROP 2021 tools, guidance, results and targets as well as the proposed trajectory and strategy for COP/ROP 2021. The PEPFAR investments to support the national response must be planned intentionally with the Global Fund with teams demonstrating how complementarity was achieved to ensure maximal impact on the HIV/AIDS epidemic is achieved.

In February and March 2021, PEPFAR will convene virtual meetings 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, faith-based organizations/faith communities, and multilateral partners. Specific guidance for the 2021 virtual meeting delegations will be provided separately.

Engagement with all stakeholders is required beyond the meetings and throughout COP/ROP 2021 development, finalization, and implementation. As in COP/ROP 2020, the draft Strategic Direction Summary (SDS) and Data Pack are required to be shared with both CSO and FBO stakeholders for their input and comments at least 48 hours prior to submission of these materials to the Embassy Front Office. Please refer to the COP/ROP 2021 Guidance for a full list of requirements and engagement timelines.

APPENDIX 1: Detailed Budgetary Requirements

Care and Treatment (C&T): OU's COP/ROP 2021 minimum requirement for the C&T earmark is reflected in Table 2. If there is no adjustment to the COP/ROP 2021 new funding level due to an adjustment in applied pipeline, countries must program to the full Care and Treatment earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The Care and Treatment earmark will be calculated as the sum of the following:

- 100% Care and Treatment (C&T) Program Areas
- 50% Testing (HTS) Program Areas
- 100% Above Site Program: Laboratory System Strengthening
- 70% Pregnant and Breastfeeding Women Beneficiary Group
- Proportional % Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the C&T earmark)

Orphans and Vulnerable Children (OVC): OU's COP/ROP 2021 minimum requirement for the OVC earmark is reflected in Table 2. Countries must program to the full OVC earmark amount across new FY 2021 GHP-State and GHP-USAID funding. The OVC earmark will be calculated as the sum of the following:

- 85% (DREAMS initiative funding — commodities planned under DREAMS initiative — Any HTS interventions planned under DREAMS initiative — Any C&T intervention planned under DREAMS initiative)
- 100% (OVC Beneficiary group funding — commodities planned under any intervention with OVC beneficiaries — Any HTS planned under interventions with OVC beneficiaries
- Proportional Program Management (Proportional Program Management will vary by mechanism and will be determined by the amount of other interventions at the mechanism that count towards the OVC earmark)

Abstinence, Be Faithful/Youth (AB/Y) Reporting Requirement: If AB/Y-programmed activities do not reach a 50 percent threshold of all sexual prevention funding, as calculated by the formula below, in any country with a generalized epidemic, S/GAC is required to report to the appropriate Congressional committees on the justification for the decision. In such cases, teams should provide brief justifications and explain the rationale for prevention programming decisions given the epidemiologic context, contributions of other donors, and other relevant factors. The written justifications should be uploaded as 'Budgetary Requirements Justification' to the document library of FACTS Info.

Abstinence, Be Faithful/Youth (AB/Y) programming, formerly captured in the HVAB budget code, will now be captured by using a combination of prevention program areas and beneficiaries, which are identified in the formula below. The numerator captures those interventions that are Abstinence, Be Faithful/Youth (AB/Y) programming, and the denominator approximates all sexual prevention activities. The proportion of Abstinence, Be Faithful/Youth (AB/Y) programming as a proportion of all sexual prevention activities is calculated by dividing the numerator by the denominator:

Numerator

Prevention: primary prevention of HIV and sexual violence

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, and boys)

+

Prevention: community mobilization, behavior, and norms change

(For OVC, OVC caregivers, young people and adolescents, children, young women and adolescent females, girls, young men and adolescent boys, boys, adults, not disaggregated)

Denominator

Prevention: primary prevention of HIV and sexual violence (all populations)

+

Prevention: community mobilization, behavior, and norms change (all populations)

+

50 % Prevention: Not disaggregated (all populations)

Gender Based Violence (GBV): OU's COP/ROP 2021 minimum requirement for the GBV earmark is reflected in Table 2. Your GBV earmark requirement is calculated as the total **new FY 2021** funding programmed to the GBV cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2020 GBV earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 funds for GBV can be above this amount; however, it cannot fall below it.

Water: OU's COP/ROP 2021 minimum requirement for the water earmark is reflected in Table 2. Your water earmark requirement is calculated as the total **new FY 2021 funding** programmed to the water cross-cutting code. Your COP/ROP 2021 earmark is derived by using the final COP/ROP 2019 water earmark allocation as a baseline. The COP/ROP 2021 planned level of new FY 2021 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 FY21 and must meet 40% by FY20. 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 FY21 as appropriate through their COP/ROP 2020 submission.

State ICASS: Table 3 shows the amount that the OU must program under State for ICASS Costs.

COP/ROP 2021 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/ROP 2021 implementation whenever possible in order to ensure sufficient funds and prevent disruptions in service delivery in the event of funding delays. If an agency/OU combination has a history of over-outlays, or in cases where an agency/OU COP envelope has increased in recent years, there may not be sufficient funding to maintain a 4-month buffer. Any agency that anticipates ending COP/ROP 2020 implementation (end of FY 2021) with a pipeline in excess of 4 months is required to apply this excessive pipeline to COP/ROP 2021, decreasing the new funding amount to stay within the planning level.