

Approved



Ethiopia

Country Operational Plan

FY 2014

Note: *Italicized sections of narrative text indicate that the content was not submitted in the Lite COP year, but was derived from the previous Full COP year. This includes data in Technical Area Narratives, and Mechanism Overview and Budget Code narratives from continued mechanisms.*



Operating Unit Overview

OU Executive Summary

Country context

With over 90 million people, Ethiopia is the 2nd most populous country in Sub-Saharan Africa. Despite impressive economic growth, it remains a low-income country with a real per capita income of US\$471 and 39% of the population living below the international poverty line of \$1.25/day. The 2013 UN Human Development Index ranks Ethiopia 173 out of 187 countries on both the overall index and the per capita GNI (Gross National Income). It is also one of the least urbanized countries with 82% of the population living in rural areas. In 2010, Ethiopia launched a five-year Growth & Transformation Plan (GTP) which envisages an annual Gross Domestic Product (GDP) base growth case scenario of 11% and a high growth case scenario of 14.9%. Improving the quality of social services and infrastructure, ensuring macroeconomic stability, and enhancing productivity in agriculture and manufacturing are major objectives of the GTP. The Government of Ethiopia's (GOE) Health Sector Development Plan IV (HSDPIV) and the Strategic Plan for Intensifying Multisectoral HIV & AIDS Response (SPMII) outline health contributions to GTP goals.

The HIV/AIDS situation in Ethiopia continues to be characterized by a low intensity mixed epidemic defined by independent self sustaining HIV transmission streams within key populations. There is significant heterogeneity across geographic areas, urban vs. rural, and population groups. Adult HIV prevalence is 1.5% nationally with substantial variation by region (from 6.5% in Gambella to 0.9% in SNNP), residence (4.2% urban vs. 0.6% rural) and gender (1.9% female vs. 1.0% male). Comparison with 2005 DHS data suggests stable low HIV prevalence of 0.6% in rural areas but substantial declines from 5.5% to 4.2% in urban areas. All of the urban decline was registered in medium and small size towns, while Addis and larger cities remained relatively stable, probably as a result of selective in-migration and better access to ART. Results from 2012 adjusted antenatal surveillance indicate sustained declines in general population prevalence at the national level (3.7% in 2005 to 2.3% in 2012) and for urban (9.6% in 2005 to 4.4% in 2012) and rural areas (3.7% in 2005 to 1.8% in 2012); urban ANC prevalence in 2012 ranged from 8.8% in Harar to 3.2% in Oromiya. Peak ANC prevalence seen among 25-34 year olds in urban areas (5.7%) and 35-49 year olds (2.5%) in rural areas suggests the main burden of infection is moving towards older age groups in line with more mature epidemic patterns. SPECTRUM projections combining DHS and ANC data estimate a rapidly declining mixed epidemic where incidence has fallen to 0.03%, a 60% reduction since the introduction of PEPFAR in Ethiopia in 2005. The main exceptions were seen in Harar and the Somali region, where urban ANC prevalence increased between 2005 and 2012. The consistent exception to the rule for the Ethiopian epidemic is Gambella region in southwestern Ethiopia, with less than 0.5% of the population and 2% of the total HIV burden, but the highest overall prevalence at 6.5% and a worrying



9% prevalence among women aged 15-24 years . National incidence rates were estimated at 19,670 new cases in 2013 and projected to fall over time, but there is a substantial burden of 791,723 people currently living with HIV need secondary prevention and treatment.

. Available data suggest that HIV transmission remains highest among most-at-risk populations (MARPs), while dominant social norms and a high circumcision rate (92%) continue to favor primary prevention among the general population. Among the general population, sources of new infection can be divided into sexual transmission from risk behavior before or outside marriage and sexual and vertical transmission occurring within marriage. The aging demographic profile of the epidemic combined with high rates of sero-discordance among married couples (68%) and conservative sexual norms that limit extramarital risk behavior also mean more HIV transmission occurs within marriage compared to other African epidemics; remarriage rates, however, exceed 40% regardless of gender or residence. Widowed and divorced men and women show substantially higher infection rates than other groups⁶. Early arranged marriage, partner violence and gender inequality are cited as causes of high divorce rates. Despite the high prevalence of marital dissolution, divorced women still face significant stigma at home and often migrate to urban areas where lack of training and employment opportunities increase the chance they will turn to transactional sex or other risky relationships to support themselves and their families.

Standard modeling assumptions applied to unique features of the Ethiopia epidemic, however, may alter the balance between vertical and sexual transmission. Given sharp contrasts in urban-rural prevalence, it is likely that much of rural incidence originates from contact with urban sexual networks as a result of growing population mobility in Ethiopia. Consequently the focus of sexual prevention efforts is on urban areas and MARPs.

HIV/AIDS awareness is extensive. Although comprehensive knowledge about HIV prevention methods is more limited, it has increased from 35% to 43% among women and from 57% to 64% among men (DHS 2005; DHS 2011). Almost three-quarters of never-married men (72%) and nearly half of women (47%) who have had two or more partners in the past 12 months reported using a condom during the last sexual intercourse. HIV testing is high among urban populations at 59% lifetime and 34% in the last year. A bio-behavioral study of secondary schools located in urban and transport corridor locations with elevated HIV prevalence (i.e., 'hotspots') in Amhara found only 1 case of HIV (0.08%) and 13 cases of sexually transmitted herpes among 1,317 secondary students .

Urban commercial sex-workers (CSW) are assumed to be the most important key population in terms of population size (estimated size between 60,000 & 160,000) and HIV prevalence (estimated at 25%). Key risk groups include mobile populations such as distance drivers, daily laborers, migrant workers in remote infrastructure development projects, uniformed services, sexually active unmarried urban youth, divorced



or widowed adults, and those engaging in transactional sex where sexual networks overlap with sex-workers or their clients. A national bio-behavioral survey of CSW in 7 regional capitals and 4 transport corridors will be released mid 2014 and will provide a size estimation for CSW. Additional information will also be available from a PEPFAR supported comprehensive mapping and size estimation exercise of CSW in 178 major cities and hotspot towns. Condom use at last sex with a non-marital partner was reported by 76% of urban men but only 40% of urban women (DHS 2011), with both levels and gender discrepancies unchanged since 2005. [REDACTED] There is no evidence to suggest intravenous drug use contributes to HIV transmission in Ethiopia.

Significant gains in PMTCT efforts and the rolling out of option B+ indicate that by the end of FY2013, using new SPECTRUM projections, 75% of Ethiopia's estimated HIV+ pregnant women were identified and 89% of those were placed on lifelong ART. PMTCT programs will be addressed under the care and treatment section.

Of Ethiopia's approximately 4.4 million orphans, 770,000 are estimated to be orphaned due to AIDS. This number is projected to decline from 897,034 in 2011 to 610,796 by 2016, a decline of 32% presumably due to success in keeping parents alive with ART (SPECTRUM). According to a 2010 Ministry of Labor and Social Affairs (MOLSA) report, approximately 150,000 children live on the streets, with 60,000 of these children living in the capital city.

There have been significant gains in maternal and child mortality. The 2011 DHS showed a decrease of 28% in child mortality from 128 to 99 per 1,000 births, a decrease in infant mortality from 77 to 59 deaths per 1,000 (with recent modeling indicating a further decline to 68/1000), a decline in total fertility rate (TFR) from 5.4 to 4.8 births per woman and an increase in modern contraceptive use among married women from 15% to 29%, although 25% of married women still had unmet needs for family planning. The maternal mortality ratio remains unchanged at 676/100,000 births, with also no change in neonatal mortality rate. This is not surprising when only 34% of women accessed antenatal care and only 10% of deliveries were attended by a health professional. However, encouraging women to attend antenatal care and delivery in health facilities is receiving high level political commitment and is a major focus of GOE efforts through the health extension worker (HEW) program and health development army. Anecdotal evidence indicates changing behaviors. The roll out of the B+ option for HIV infected pregnant women is also likely to impact vertical transmission.

There remain a number of pervasive gender-based problems although there are improvements: domestic violence, harmful traditional practices which include Female Genital Mutilation (FGM), early marriage and marriage by abduction (both are illegal), and food and work prohibitions for girls and women. FGM remains widespread, with areas in eastern Ethiopia reporting 60-80% of women underwent infibulations, although a



2008 review reported a 24% national reduction in FGM cases over the previous 10 years due in part to a strong anti-FGM campaign and legislation . More recent information shows an overall decline in FGM among girls 21-24 years and among girls 15-17 years. Afar, Oromiya and SNNP still report female circumcision rates between 75-90%; Afar figures however, still indicate that of those girls who have been circumcised, one third are infibulated. .

The 2011 DHS reported that 27% of children aged 5-14 are involved in child labor. There is ongoing concern regarding the trafficking of young women; reports from projects addressing female sex workers indicate that 34% are <18 years. In urban areas, women have fewer employment opportunities than men, and the jobs available do not provide equal pay for equal work. Women's access to gainful employment, credit, and the opportunity to own and/or manage a business is further limited by their low level of education & training, and by traditional attitudes. Although there has been a marked increase in the number of girls attending school, dropout rates among girls are higher than among boys, and fewer girls than boys reach tertiary educational facilities. For those reaching higher education institutions, there is a 44% average dropout rate for women and 19% for men in the 1st & 2nd years .

There is sustained GOE political commitment to addressing the national HIV epidemic although, as the epidemic matures, there is also a need to strategically focus limited resources. Ethiopia has expanded HIV/AIDS services to over 3,000 HCT, 2,150 PMTCT, and 913 ART sites across the country. Government counseling and testing remains high with over 12 million people tested in 2013 but efforts need to be focused . Over 1.3 million pregnant women were tested for HIV in 2013, of which 21,546 were HIV+, but 59% of these were known positives, leaving a new detection rate of 0.6% pregnant HIV+ women identified through ANC . From a baseline of 8,226 persons ever started on ART in 2005, 317,443 remained on ART by end of FY13 with PEPFAR support (69% of estimated need at CD4<350) and an estimated 82% of adults and children were known to be alive and on treatment 12 months after initiation of ART11.

Significant challenges remain in addressing PMTCT and the high maternal mortality. Over 90% of women in need of a caesarian section cannot access one; approximately 19,000 women die from childbirth-related causes every year and an estimated 3,500 women annually develop obstetric fistula. Using modelling, there are about 375,000 women with fistula and 161,000 with urinary incontinence. The revised SPECTRUM estimate for the number of HIV positive pregnant women is 25,722 in 2014. Significant progress has also been noted over the past year. Of the estimated 3 million pregnant women per year, 1,390,801 women attending antenatal care were tested for HIV, an increase of 23% from 2012. Of the 21,546 who tested HIV positive, 85% reportedly received antiretrovirals to decrease mother to child transmission, a significant improvement over the previous year (69%) due to quality improvement efforts. The GOE has made addressing maternal mortality and PMTCT a top priority, evidenced by funding and political support for strong outreach using the health extension worker program and the "health development army," plus a



focus on increasing capacity for obstetric care at health centers and hospitals. The 2013 APR results show considerable improvement over results from 2012, which are expected to improve further with the high-energy roll out of Option B+; obstacles within the HMIs to better report on PMTCT indicators also have been addressed.

Ethiopia is one of 25 countries in Africa that has shown at least a 50% decrease in both new infections and the number of deaths due to HIV/AIDS since 2005. It is also one of 13 countries that has passed the “tipping point (0.34)” where the number starting on ART (59,137 in 2013) exceeds the number of new infections (19,670). With further effort and perseverance, Ethiopia will remain on a path towards an AIDS-free generation. These encouraging results, grounded in dominant social norms and a high circumcision rate, reflect the combined efforts of high-level GOE political commitment and a supportive donor community, including support from PEPFAR and the Global Fund for AIDS, Tuberculosis & Malaria (GF), whom together contribute almost 90% of total donor funding to address HIV. Recently, the GOE also adopted the new WHO 2013 revised guidelines for initiation of ART at CD4<500 mm³ and treatment for all HIV/TB co-infected patients.

SPECTRUM estimates indicate that 26% of new infections in 2013 were in children, which is relatively high compared to 10-15% in other African countries. In 2014 this decreases to 16% of estimated new infections with a further decrease to 10% in 2015, as PMTCT programs become more effective. However, SPECTRUM also estimates that there are over 140,000 HIV+ children in 2014. This troubling figure calls for further analysis. Pediatric case detection and enrollment on treatment continues to lag with only 3,826 children initiated on treatment, and 18,931 currently on treatment, in 2013. Recently GOE officials declared they will treat all HIV infected children under 15 years of age regardless of CD4 count.

Over the past few years, conflicts in Somalia, Eritrea and Southern Sudan have resulted in an increase in the refugee population within Ethiopia, currently at almost half a million refugees in camps situated in the peripheries of the country. Eastern, northern and western camps house different populations. ANC 2012 surveillance information from Dima refugee camp in Gambella showed a rate of 12.9%, and that of Funido at 6.4%, both several fold greater than the national average although within the range of the surrounding population. The camps in the north are mainly populated by young men and a significant number of unaccompanied minors; the eastern camps house refugees from Somalia, where HIV prevalence is low but there are high risk behaviors.

The U.S. government (USG) is the largest bilateral donor to the Ethiopian health sector. Ethiopia to date has also been the largest recipient of GF resources; most other donors contribute through pooled funding. PEPFAR provides significant support for health systems strengthening (HSS), including efforts to expand the health workforce through support to pre-service training, implementation of Ethiopia's Pharmaceutical



Logistics Master Plan, the Laboratory Master Plan, the Health Management Information System Scale-up, Health Sector Financing Reform and Health Insurance, Hospital Reform Implementation Guidelines, and the Human Resources for Health (HRH) strategy. The private healthcare sector is nascent but growing and could be an important complement to the public arena, particularly as the public sector allows private practice as a workforce retention strategy.

PEPFAR focus in COP 2014

The Ethiopia plan for COP14 reflects GOE priorities and is aligned with the principles of the Global Health Initiative. The GHI strategic framework is based on three pillars: 1) improve access to health care services; 2) increase demand for services; and 3) strengthen the health systems. Progress in these three areas will increase utilization of quality health services, decrease maternal, neonatal and child mortality, and reduce incidence of communicable diseases.

Given the encouraging results in combating the epidemic and declining resources, COP 2014 is different from past submissions, however. The Ethiopia PEPFAR team has developed a collective vision on the future of USG support to the effort to combat the HIV/AIDS epidemic which maximizes reduced resources and focuses on the unique aspects of the epidemic in Ethiopia. COP 2014 captures this vision by focusing on 1) saving lives and 2) preventing new infections. These two goals will be pursued by consolidating gains achieved to date, continuing program realignment, furthering of country ownership, and incorporating directives from the Deputy Principals and PEPFAR guidance. This process of "right-sizing" the program identified what activities will no longer be funded (or, non-core); identified activities which will transition to other funders including the GOE (or, near core); and specified ways to increase the efficiency of USG partner implementation for an identified set of core activities. As a long-term strategy country, core activities will continue to be funded for the foreseeable future. For near core activities, COP 2014 includes a transition plan with a downward trajectory of funding over the next 2-3 years. Identified non-core activities will receive limited, if any, additional resources in COP 2014 and will be transitioned within a period of 12-18 months (i.e., not later than September 2015).

Core activities focus on the major components of clinical care and treatment within the public sector, including implementation of the WHO 2013 revised guidelines, support for adherence and laboratory systems and ongoing quality improvement measures. Combination prevention is targeted to high and medium risk populations which include CSW and to key populations including uniformed services, migrant workers, clients of sex workers and focused programs in refugee camps. Underpinning these two core sets of activities is ongoing technical assistance (TA) to strengthen supply chain and health management information systems and support to the health workforce through pre-service training for key professionals with more limited and targeted in-service training. Recognizing the heavy burden of highly vulnerable children, these programs also remain core. To move towards a sustainable health sector we will provide



ongoing support to implement health care financing reforms, including health insurance. Program implementation will be guided by the evidence base, with ongoing efforts to fill information gaps and maximize efficiencies based on evidence. For example, support to health facilities will be limited to those that identified a minimum number of HIV positive cases in the last year. In negotiations with GF a reduced basket of targeted commodities will be purchased and the USG will look for increases in the use of other funds available to GOE to complement essential HIV commodities needs.

A number of near core activities which directly support USG core programs were identified. These will receive reduced and shorter term USG funding with a clearly articulated transition plan. These include blood safety programs both within civilian and military populations, finalization of construction commitments, community and peer support activities, programs aimed at targeted strengthening of government leadership and governance and TA to the private sector. The high level of male circumcision in Ethiopia and the success of the targeted USG supported program in Gambella, means that the USG will be able to transition VMMC by the end of COP 2015 implementation.

Through extensive interagency discussions, five additional areas were selected to receive reduced and shorter-term funding (these areas are considered non-core): a) in school youth programs in which a one year set of activities will be completed that institutionalize in-school HIV prevention curricula and services with transition to direct funding by the Ministry of Education; b) prevention activities focused on the general population which will utilize previously re-programmed funding and cease within 2 years; c) economic strengthening(ES) activities to standardize intervention modalities will end with COP 2014; ongoing ES interventions for targeted PLHIVs will be transitioned to the GF supported revolving fund not later than September 2016; d) one year of limited TA support for cervical cancer screening and treatment so that the Federal Ministry of Health (MOH) is well placed to continue scale up of these services.

PEPFAR/E agreed to regularly reassess programmatic activities based on geographic prevalence. For example, recent analysis of health facilities providing HTC, PMTCT and ART services showed that on average 25% of PEPFAR supported sites, across all regions, were contributing approximately 75% of results. A significant number of sites identified none or <13 HIV+ clients in the last year. PEPFAR/E will therefore no longer provide support for sites where there were no HIV positive patients identified in the last year. For low volume sites (client load threshold to be defined), PEPFAR will work with the GOE to identify alternate ways to deliver service (e.g., outreach, transport vouchers, etc.). PEPFAR support will continue for all other sites. Review of site level information will take place on a regular basis in order to identify emerging patient trends as the new treatment initiatives roll out. We will apply the same approach of geographic focusing to non-facility based interventions.

Special consideration will be given to the four emerging regions (Afar, Somali, Gambella and



Benishangul-Gumuz). These peripheral regions have a weak health infrastructure and poor human resource capacity. Data shows that Gambella has the highest regional HIV prevalence in the country and hosts expanding refugee camps with very high positivity rates according to the recent high ANC surveillance survey. The Somali region has a rising ANC positivity rate. All these regions are transected by major transport corridors and large scale development projects with resultant higher risk migrant populations. Based on this evidence, the USG will continue to provide both geographically and programmatically focused support there in the medium term.

Within the USG, USAID leads behavioral and structural prevention, nutrition, the overall TB program, OVC and other community-based activities. HHS/CDC will lead in biomedical prevention efforts, clinical care and treatment, and implementation science.

Progress & Future

COP 2014 builds upon key GOE strategic plans: the GTP, HSDP IV & SPM II. These foundational documents provide a strong platform for the USG program. The HSPD IV, SPM II, and GHI Implementation Plan will end in 2014. For COP 2015, the USG will prepare a Sustainability Plan with the GOE to advance country ownership of the national HIV response as per PEPFAR guidance.

Strong country leadership and ownership continue to characterize Ethiopia's HIV/AIDS program. GF remains the principal donor for ARV drugs and commodities, but the USG and GF are discussing how to leverage our resources to maximize our support within Ethiopia's Investment Case (IC). USG, UNAIDS and GF are supporting the GOE's efforts to develop the IC, including TA. We envisage extending this collaborative model to support Ethiopia's development of a concept note for the GF's New Funding Mechanism. Additionally the USG and GF are sharing information on support to the HIV essential commodities basket. PEPFAR and GF are working with the GOE to address supply chain issues and reach consensus on guidance for the laboratory platform. PEPFAR also shared with GF key elements of COP 14. With the public sector providing almost all service delivery, the government leads the HIV/AIDS response. USG funding to transition care and treatment services to regional health bureaus also promotes country ownership. The USG is engaging the GOE to create a greater space for civil society and private sector as partners in the HIV response.

Efforts to promote greater transparency and accountability are moving forward. In 2013, a NASA and a NHA were conducted, results of which are pending. [REDACTED] by sharing the results of the 2013 PEPFAR expenditure analysis with the MOH, the USG is providing the tools to encourage an environment that promotes accountability and transparency and evidence-based decision making. In COP 2013, USAID proposed three new G2G mechanisms and the required assessments are underway. CDC has been providing direct funding to government entities since 2001. CDC also transitioned the clinical care and



treatment program to the MOH and regional health bureaus (RHB), with additional support for local universities for training.

Program overview

Over the next 2 years, PEPFAR/E will: a) identify the optimal balance of programs, policies and research to save the most lives and prevent the most new HIV infections in Ethiopia within existing budget constraints; b) identify and prioritize those program areas where PEPFAR resources can make the greatest impact. In light of declining budget trajectories, the third principle is to ensure good coordination with the GOE and local partners to build capacity in managerial, technical, and financial ownership to enable successful transition of the full range of HIV/AIDS activities.

Prevention

PEPFAR/E will focus its prevention programs primarily on MARPs, other key populations and discordant couples as the main drivers of this epidemic. The standard approach of targeting occupational groups based on mobility or sexual risk behaviors does not always yield highest risk of infection, as demonstrated by the example of university students, a minority (15%) of whom engage in risky behavior but still show very low HIV prevalence rates. The focus for combination prevention programs is on CSW, clients of sex workers, uniformed services, migrant workers and daily laborers, sexually active unmarried urban youth, divorced or widowed adults, and those engaging in transactional sex where sexual networks overlap with sex-workers or their clients. Targeted programs within refugee camps also are part of the portfolio. Efforts will be made to encourage CSW to increase condom use with non-paying clients (65%) or spouses (39%). Raised CD4 thresholds for ART broaden the scope for using treatment as prevention among key populations, providing strong linkages from behavioral outreach through clinical care. PEPFAR supports the development of a national condom strategy, which will include efforts to rationalize free and socially marketed condoms using a total market approach.

Significant gains in PMTCT and the rolling out of option B+ indicate that by the end of FY2013, using new SPECTRUM projections, 65% of pregnant women were placed on lifelong ART. (PMTCT programs will be addressed under the care and treatment section.)

MC efforts in Ethiopia have been targeting new military recruits and refugees in Gambella (population c. 340,000) where the 2011 DHS found HIV prevalence among uncircumcised males exceeded 8% compared to 4% among circumcised males. Over 16,000 men were circumcised in Gambella in FY13. The Ethiopian National Defense Forces (ENDF) are now carrying out their own circumcisions. At the current pace, it will be possible to complete the catch-up phase targeting adult males before the end of FY15, at which time the program will be transitioned to the GOE.



WHO estimates that 5-10% of global new HIV infections arise from receiving contaminated blood. The MOH has taken initiatives to strengthen the managerial and governance structures of the national blood transfusion system and to improve the quality of blood services. All RHBs except Addis Ababa have taken full responsibility for managing and coordinating blood transfusion programs, paying staff salaries and creating blood services coordination units. The number of volunteer blood donors, however, still remains small with a collection in FY13 equivalent to 0.8 units of blood/1,000 persons, compared to the 10-20 units recommended by WHO. GOE commitment to address these issues is demonstrated by Tigray, which achieved 100% voluntary non-remunerated blood donation in 2013.

PEPFAR support for the ENDF and MOH in safe blood supply is yielding good systemic results. Remaining efforts to ensure a safe blood supply will focus on encouraging blood donors and improving the procurement capacity of PFSA to obtain reagent test kits and other equipment. A total of 24 blood banks (11 existing, 13 new) have been equipped, staffed and trained under the NBTS and RHBs with mobile blood collection teams assigned to each; 119 private and public hospitals (99%) received 80% of transfused blood units from the NBTS network, compared to only 73% in FY12. PEPFAR will construct a national referral blood bank estimated to be completed in mid-2016. RHBs have been given the authority and budgets to manage and coordinate their own blood safety programs through direct cooperative agreements under PEPFAR with additional technical support from the MOH and WHO. Further training will also be provided on the appropriate use of blood components as opposed to whole blood transfusion. The ENDF has a national referral blood center and 4 other centers. A joint expert visit from CDC and DOD in May 2014 will guide PEPFAR/E in the development of a national blood safety strategy that builds upon investments in the military and civilian blood safety systems and of a transition plan for both MOH and ENDF. As a near core activity, this effort will be transitioned over to the GOE with a 2-3 year timeframe. COP 2014 will be the last year of PEPFAR support to general population activities for in-school youth prevention programs. These will be fully transitioned to the GOE.

Ethiopia has high counseling and testing rates but with a more focused and mature epidemic the positivity yield on un-targeted testing has been declining. Target populations should be prioritized based on HIV prevalence, with fewer HTC investments in populations with very low prevalence, e.g., farm workers and university students. In regions with low prevalence PEPFAR support for provider-initiated counseling and testing (PICT) will be through selected clinics with potential for higher prevalence, e.g., Tuberculosis (TB), Sexually Transmitted Infections (STI), ANC clinics and through index case testing. The USG will also promote decreasing the frequency of repeat testing to every 6 months in high risk groups. PEPFAR is addressing recurrent systemic challenges in the distribution of rapid test kits (RTKs). RTKs should be re-validated in line with WHO guidelines in low-prevalence settings (2012), and back-up tests should be validated in case of manufacturer-level stock-out. Once HCT has identified an HIV+ person, every effort will be made to link that person into clinical services, as PEPFAR/E increases focus on PLERS.



There are no new procurements planned.

Care & Treatment

In FY13 PEPFAR/E provided a minimum of one care service to 1,307,895 PLHIV, HIV affected individuals and OVC; of the 365,300 PLHIV who received a minimum of one clinical service, 23,204 were children < 15 years old. Co-trimoxazole Prophylactic Therapy (CPT) was given to 242,022 eligible pre-ART and ART patients, 66% of patients in clinical care; 50,031 (81%) HIV+ clinically malnourished clients received therapeutic or supplementary food; 307,805 individuals (94% of APR target) were reached with a minimum package of PHDP interventions; 139,020 vulnerable households of PLHIV, PMTCT clients and OVC who are food insecure were linked to economic strengthening activities.

PEPFAR also supported the national TB program in a programmatic review and revision of guidelines. TB/HIV activities were supported at 880 public and 247 private/NGO health facilities; close to 90% of PLHIV in care were screened for TB at their last follow up visit and 1.9% started TB treatment. The recent national TB/HIV surveillance survey report indicates a 93% testing rate for HIV among TB patients registered for DOTS & a co-infection rate of 17%; PEPFAR will continue to provide support to strengthen TB laboratory diagnosis. Currently, there are 8 laboratories with capacity to carry out liquid and solid TB culture as well as Line Probe Assay test for rapid drug susceptibility testing. PEPFAR also supported the decentralization of external quality assurance (EQA) for AFB microscopy, the validation study on GeneXpert, procurement of five 4-module GeneXpert machines with their accessories and the development of implementation guideline on GeneXpert. MDR-TB treatment has been scaled-up significantly over the past few years in PEPFAR supported sites and more than 1260 patients received treatment since the program was launched in 2010. Currently, there are 21 treatment initiating centers and over 200 treatment follow up centers in four major regions (Oromia, Amhara, Tigray & SNNPR) and Addis Ababa and Dire Dawa. Program focus will be to consolidate these gains.

To ensure continuum of care for PLHIV and OVCs, PEPFAR supports community level interventions, implemented through associations and networks of PLHIVs for peer support and adherence counseling. Over the next 2-3 years, PEPFAR is preparing to finalize capacity building efforts and transition these important community programs to local partners.

By the end of FY 2013, 317,443 adult HIV patients were receiving ART at 932 PEPFAR supported HIV treatment sites in all 11 regions of Ethiopia, including public hospitals and health centers, private hospitals, non-governmental and ENDF health facilities. A total of 525,625 adults were in need of ART in 2013 (by CD4 <350 eligibility criterion) (SPECTRUM), a coverage rate of 60%. In the same reporting period, 59,137 adults were newly initiated on ART. The estimate for the number of new HIV infections in adults in 2014 is



15,345. As of January 2014, Ethiopia adopted the new 2013 WHO ART guideline recommendations and will initiate ART for all adult HIV patients with $CD4 < 500/mm^3$, all TB/HIV co-infected patients, and all pregnant/breast feeding HIV+ women on ART. This policy decision increases the estimates of the total need for ART to 632,323 in 2014 and 642,945 in 2015. Priority will be given to the sickest patients. While the Tipping Point Ratio is met for Ethiopia, much needs to be done to meet ART coverage of 80%, the milestone to achieve an AIDS-free generation.

With the proportion of patients on second line ART regimens at $<2\%$, early and appropriate detection of treatment failure remains a challenge for the treatment program. Strengthening sample transport systems will be prioritized to increase access to Viral Load (VL). In tandem with monitoring of clinical and immunologic criteria, we expect improved identification of patients failing a first line regimen. PEPFAR team and ART partners will continue to work with the TWG and task force led by FMOH to develop an updated algorithm for the early detection of treatment failure. Surveys conducted regularly for HIV drug resistance and Early Warning Indicators (EWI) by EHNRI, including the HIV drug resistance threshold (transmitted resistance) survey will provide evidence that will be fed into quality improvement measures.. The last EWI survey was carried out in 2013 but results are pending.

COP 2014 will consolidate the transition of the comprehensive clinical care and treatment program to RHBs with a single TA transition partner (ICAP). Previous clinical care partners will stop activities in September 2014. ICAP and the RHBs will work with the MOH to develop or revise policies, plans and guidelines for implementation of quality Improvement activities at HIV treatment facilities. A few international implementation partners focus on transition of nutrition services and TB/HIV. An evaluation of the readiness of RHBs to take over the nutrition programs will be undertaken in FY 15; site level support will be transitioned to the RHBs with oversight from ICAP.

PEPFAR/E analysis of results/facility indicated that, especially in PMTCT sites, many did not have any HIV+ patients. In general, across all regions, 25% of the sites yielded 75% of the HIV+ patients. Based on this data, PEPFAR will redirect its support to the higher volume facilities and provide tools to the RHBs to enable them to oversee HIV/AIDS programs in the lower yielding facilities as part of integrated primary health care supportive supervision. PEPFAR/E will regularly share this information with MOH, especially given new WHO guidelines, in order to address changing evidence should there be an increase in patients attending health facilities. PEPFAR/E will seek to identify alternate modalities for reaching those patients in low yield sites.

As the roll-out of option B+ continues with the full support of GOE, PEPFAR, GF and other health partners, it is expected that the lost to follow-up rate for pregnant women will decrease, leading to a decrease in vertical transmission rates. Additionally, PEPFAR-supported efforts to improve follow up in the MCH setting



are intended to increase the number of HIV exposed infants that will receive EID. These two key sets of information will be monitored as part of quality improvement efforts.

Across many PEPFAR supported sites, pediatric results have been disappointing. To identify children at risk of HIV infection through better EID, we will use a family matrix, index case testing, and expanded outreach to OVC populations and improved linkages to HTC and care and treatment. The PEPFAR/E OVC TWG has enlarged its membership to include members from the care, treatment and prevention TWGs in order to improve these linkages. The GOE's approach to treat all HIV+ children <15 years should also help identify more children. However, support will also be needed to improve health worker skills in treating HIV+ children.

In an effort to address the treatment needs of Female Sex Workers (FSW), confidential clinics have been established in select urban areas to provide prevention, care and treatment services. These clinics are designed to provide FSW with anonymous and confidential access and/or linkage to comprehensive HIV and related services. Additionally, PEPFAR partners continue to link FSW with a network of private clinics and MARPS friendly public clinics to expand their treatment options.

All procurements are follow-on awards supporting core components of the program. The majority of these are to government entities.

Health systems strengthening

Ethiopia has one of the most ambitious decentralization programs in Africa. It has a federal system of governance where powers and mandates are devolved first to regional states and then to woreda (district) authorities and subsequently kebele (village) authorities. The decentralized levels receive block grants from the federal level based on an appropriation formula. The majority of health services are delivered by the public sector with per capita expenditures in health quadrupling since 1995, now estimated at \$16 which still falls well below the recommended sub-Saharan per capita budget. Results from the latest National Health Account have yet to be released.

The Ethiopian health sector is a three-tier health care delivery system. The lowest level is the woreda, comprising a primary hospital (serving 60,000-100,000 people), overseeing up to 5 health centers (1/15,000-25,000 population) which, in turn, supervise 5 satellite Health Posts (1/3,000-5,000 population). A Primary Hospital, health center and health posts form a Primary Health Care Unit (PHCU). The second tier is a General Hospital with population coverage of 1-1.5 million people; the third is a Specialized Hospital that covers a population of 3.5-5 million. Government offices, including the MOH, RHBs, and woreda Health Offices share decision making and oversight authority, duties and responsibilities. The MOH and the RHBs focus on policy matters and technical support while Woreda Health Offices manage and coordinate the



district health system. The HIV/AIDS multisectoral response follows a similar same pattern.

Over the next two years, PEPFAR will strategically support health system strengthening activities which contribute towards the overall goal of saving lives and preventing new infections. Within the six building blocks of the health system, ongoing commitments to infrastructure (integrated OPD wings, regional labs, national blood referral center, health centers) are scheduled to be concluded by COP 2015. Support for the health and social service workforce will work at national level on policies and guidelines and licensing; support for pre-service training of a wide array of health and social service workers including physicians, nurses, midwives, health extension and social workers, biomedical engineers, epidemiologists and health administrators. In line with MOH guidance on in-service training, support will be provided to develop training units within local universities and referral hospitals. Only targeted in-service training (e.g., for CSW, OVCs) will be carried out by international implementing partners. Significant support will continue to develop effective supply chain and laboratory systems and a functioning health management information system to provide the necessary data for decision making. Support for increase in domestic financing will also continue through targeted TA to roll out health care financing reforms, which also leverages USAID's health sector resources.