Ethiopia

Country/Regional Operational Plan

(COP/ROP) 2016

Strategic Direction Summary

April 21, 2016

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Goal Statement

In consultation with the Government of Ethiopia (GOE), implementing partners, multilateral representatives and civil society organizations (CSOs), PEPFAR Ethiopia (PEPFAR-E) is proud to present the 2016 Country Operational Plan (COP).

Ethiopia has come a long way in closing the gaps, but in FY15 the rate of growth of people living with HIV (PLHIV) on anti-retroviral therapy (ART) declined dramatically as a result of achieving only 50% of its target for PLHIV newly enrolled on ART despite exceeding by 50% the target for number of people tested for HIV. In part this is because the "easy to reach" PLHIV are already in care. It is the hard-to-reach PLHIV who still need to be identified; it requires zeroing in on high-risk populations to increase testing yield. The current broad, population-based testing strategy will not help us reach the first "90." Once PLHIV are identified, there is good linkage to care and retention on treatment. The key then to achieving the 90:90:90 is that first "90." In COP 16, PEPFAR-E will commit to targeting resources to understand who and where these PLHIV are and getting them identified, tested, and linked to treatment.

As a result of advocacy and discussions led by PEPFAR-E that followed the COP 16 DC Management Meeting (DCMM), Ethiopia's Federal Ministry of Health (FMOH) will launch a "Catch-Up Campaign" to implement targeted testing in geographic areas where evidence suggests there are large numbers of undiagnosed PLHIV, with the expectation that it can significantly "catch up" in reaching its own treatment targets. In combination with the "Catch-Up Campaign" the FMOH is working to revitalize the National AIDS Council (NAC), which is chaired by the President Teshome. This effort will also link in mayors of cities with high HIV burden to be involved in the "Catch-Up Campaign". Mayors are expected to lead, monitor, and be responsible for achieving targets. To further support this effort, the FMOH has recently announced its intention to adopt Test and START nationally. Adoption of the Test and START policy will drive demand from those most at risk of being infected, as it allows community leaders along with mayors to be able to broadcast the simple public health message that if you think you might be infected, get tested, as anyone infected with this virus is now eligible for life-saving treatment.

To achieve the 90:90:90 goals and sustain epidemic control in Ethiopia, PEPFAR-E identified three key programmatic gaps: insufficient identification of new HIV-positive persons; inadequate systems to assure linkage, retention, and virologic suppression of identified PLHIV; and inadequate domestic spending to support sustained HIV care & treatment.

The 2016 COP focuses on innovative solutions to address challenges in the country's HIV/AIDS response. Specifically, it identifies ways to improve case identification, the first "90" of the 90:90:90 cascade, and improve getting people into and retained on treatment. Based on epidemiological evidence, the PEPFAR-E team has identified 20 priority towns with high HIV burden and created a detailed package of interventions along with the "Catch-Up Campaign" to implement in these towns, focusing on improving HIV case finding and linkage to treatment. PEPFAR-E will be engaging with key local stakeholders in these towns to ensure that a focused, community-led effort to improve case identification will result in finding "hidden" key populations (KP) and priority populations (PP) and in bringing HIV-positive patients lost-to-follow-up (LTFU) back into the fold.

1.0 Epidemic, Response, and Program Context

With a projected population of over 94 million people by mid-2017, Ethiopia is the second most populous country in Sub-Saharan Africa. While registering impressive sustained economic growth, Ethiopia remains a low-income country with a real per capita income of US$550 and 33.5% of the population living below the international poverty line of $1.90/day.[1] According to the UN Human Development Index (2015), Ethiopia ranks 174 out of 188 countries on both the overall index and the per capita Gross National Income, with a gross domestic product (GDP) of $1,428. It is also one of the least urbanized countries with 82% of the population living in rural areas.

The HIV/AIDS situation in Ethiopia continues to be characterized by a low-intensity, mixed epidemic with significant heterogeneity across geographic areas and defined by independent self-sustaining HIV transmission streams within KP, PP, and general populations. Per 2015 SPECTRUM estimates, adult HIV prevalence in Ethiopia in 2015 was estimated to be 1.1%. There is substantial prevalence variation by region (6.4% in Gambella, 4.9% in Addis Ababa, and 0.7% in Southern Nations, Nationalities and Peoples' (SNNPR) region), residence (3.8% urban versus 0.6% rural), and gender (1.9% female versus 1.0 male during 2011). The HIV epidemic in Ethiopia is primarily associated with areas of urban concentration (5.1% in cities above 50 thousand compared to 3.1% in smaller cities and 0.6% in rural areas) and proximity to major transport corridors. Those living within five kilometers of a major road have HIV prevalence rates that are four-times higher than those who live further away. The two exceptions to this general pattern include Gambella region, a small and sparsely populated region that has the highest regional prevalence in Ethiopia (6.4%) and little distinction between urban and rural prevalence, and development schemes and seasonal migrant destinations that show elevated HIV-related risk behaviors despite not being close to urban areas or major roads. Another defining feature of the Ethiopian HIV epidemic is the pattern of steep and steady declines in antenatal clinic (ANC) prevalence by as much as 60% since 2005 when PEPFAR and the Millennium AIDS Campaign signaled the start of a robust and successful national response.

Available data suggest that HIV transmission remains highest among KP and PP, while a high circumcision rate (92%), among other factors, continue to favor primary prevention among the general population. Among the general population, sources of new infection can be divided into sexual transmission from high-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-discordant married couples (65%) imply that 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 groups. Early arranged marriage, partner violence, and gender inequality are cited as causes of high divorce rates and significantly elevated rates of HIV prevalence associated with divorce and remarriage.

Significant gains in prevention of mother-to-child transmission (PMTCT) efforts and the rolling out of option B+ indicate that by the end of FY2015, using new SPECTRUM projections, 67% of Ethiopia's estimated HIV-positive pregnant women were already on ART or newly put on ART.

[1] http://povertydata.worldbank.org/poverty/country/ETH

Table 1.1.1 Key National Demographic and Epidemiological Data											
	Total		**<15**				**15+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	
Total Population	89,958,011		230,678,47	25.6%	23,739,351	26.4%	21,704,166	24.1%	21,446,647	*23.8%*	2015: Central Statistical Authority Projections
HIV Prevalence (%)		1.11									SPECTRUM, 2015
AIDS Deaths (per year)	17,647		2,103		2,047		8,123		5,374		2015: HIV Related Estimates and Projections for Ethiopia–2015, FMOH
# PLHIV	729,517		46,793		48,301		392,801		241,622		2015: HIV Related Estimates and Projections for Ethiopia–2015, FMOH
Incidence Rate (Yr)											
New Infections (Yr)	18,806										2015: HIV Related Estimates and Projections for Ethiopia–2015, FMOH
Annual births	3,088,807										*2015: Central Statistical Authority Projections*
% of Pregnant Women with at least one ANC visit	96.1 (one visit) 67.9 (four visits)						96.1 (one visit) 67.9 (four visits)				2014: FMOH Annual Performance Report (2014/15)
Pregnant women needing ARVs	27,462										2015: HIV Related Estimates and Projections for Ethiopia–2015, FMOH (Mothers needing PMTCT)
Orphans (maternal, paternal, double)	3,417,279										2015: HIV Related Estimates and Projections for Ethiopia–2015, FMOH
Notified TB cases (Yr)	135951										2015: FMOH:HMIS report

% of TB cases that are HIV infected	10%										2015: FMOH:HMIS report
% of Males Circumcised	92.8%										2000 Ethiopia DHS Data set Analysis
Estimated Population Size of CSW	180,907 (Urban CSW)										Total Number extrapolated from combined EPHI/PSI 2014 size estimations and projections for FY17
CSW HIV Prevalence	24%										MARPS Survey, EPHI 2014 Unpublished Report & UNAIDS Country Progress Report, 2014
Estimated Population Size of PWID	NA										
PWID HIV Prevalence	NA										
Estimated size of all kinds of PP	2,373,935	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Military Population	138,000	NA	NA	NA	NA	NA	NA	NA	NA	NA	International Institute of Strategic Studies, The Military Balance, 2012. Information regarding gender is not publicly known and the military is confidential about this number. Eligible age for military is 16+. National population size of 73.8 million obtained from the Ethiopia Demographic and Health Survey, 2011
Military Prevalence (%)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*											

*Year refers to the data used for planning during COP preparation.

Table 1.1.2 90:90:90 cascade: HIV diagnosis, treatment and viral suppression (12 months)									
				HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Total PLHIV (#)**	**On ART (#)**	**Retained on ART 12 Months (#)**	**Viral Suppression 12 Months**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	89,957,619	1.1%	729,515	373,933			5,553,273	42,296	
Population less than 15 years	43,150,546		95,094	21,263			588,898	1,312	
Pregnant Women	3243247	2.0	27,462	18,471	86% (i.e.53477 divided by 62166)		1,516,982	18,580	7,427
[REDACTED]		*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*	*[REDACTED]*
CSW	180,907			NA	NA	NA			
PWID		NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)		NA	NA	NA	NA	NA	NA	NA	NA
Military Population	138,000	NA	NA	NA	NA	NA	NA	NA	NA

*Population data and that of pregnant women refer to 2015.

1.2 Investment Profile

According to the latest Ethiopian National AIDS Spending Assessment (NASA) report for 2011/12, total annual HIV/AIDS spending was $405 million. Of this total amount, 86% ($350 million) came from external donors, 13% came from public revenue ($55 million) and less than 1% ($680 thousand) came from the private sector (Table 1.2.1). It is important to note that the 13% of the public sector contribution was and remains an underestimate because it excludes significant costs for staffing and infrastructure among other areas. The AIDS Mainstreaming Fund, which every Ministry contributes 2% of their annual budget to, and the AIDS fund, which is based on voluntary contributions from public employees, contributed slightly under $4 million in the NASA study.

Table 1.2.1a Investment Profile by Program Areas (NASA 2011/12)[2]

Activities	Public (x 1000)	Private (x 1000)	External funds (x 1000)	Total (x 1000)	% Public
Prevention	$24,834	$189	$53,974	$78,997	31%
Treatment	$13,054	$15	$112,268	$125,336	10%
OVC	$459	$199	$26,861	$27,519	2%
Nat.Sys.Strength	$15,526	$173	$104,410	$120,109	13%
HR	$526	$41	$15,581	$16,148	3%
Social Services	$49	$58	$10,483	$10,590	0%
Enabling	$0	$5	$26,127	$26,132	0%
Research	$0	$0	$248	$248	0%
Totals	**$54,448**	**$680**	**$349,952**	**$405,080**	**59%**

[2] The data for tables 1.2.1a and 1.2.1b is from the NASA 2011/2012, which is the most current data source for the national investment profile.

Table 1.2.1.b Distribution of combined PEPFAR and Global Fund resources by program area, 2014 (in thousands)

Program Area	Combined PEPFAR+GF expenditure	PEPFAR $	PEPFAR %	GF $	GF %
Clinical care, treatment and support	$118,722	$38,072	(32%)	$80,649	(68%)
Community-based care	$17,675	$12,812	(72%)	$4,864	(28%)
PMTCT	$14,364	$14,364	(100%)	$0	(0%)
HTS	$23,409	$12,773	(55%)	$10,635	(45%)
VMMC	$382	$382	(100%)	$0	(0%)
PP prevention	$8,183	$3,885	(47%)	$4,298	(53%)
KP prevention	$9,204	$4,906	(53%)	$4,298	(47%)
OVC	$26,275	$21,195	(81%)	$5,081	(19%)
Laboratory	$24,785	$24,785	(100%)	$0	(0%)
SI, Surveys, and Surveillance	$3,246	$3,246	(100%)	$0	(0%)
HSS	$33,462	$26,723	(80%)	$6,739	(20%)
Total	**$279,706**	**$163,142**	**(58%)**	**$116,564**	**(42%)**

PEPFAR funds are generally devoted to technical assistance (TA) and financial support, led by treatment and health system strengthening at the time of the NASA study. Global Fund primarily supports diagnosis and treatment through provision of test kits and anti-retrovirals (ARVs) for public and private sectors. More recent 2014 data from PEPFAR and the Global Fund to Fights AIDS, Tuberculosis, and Malaria (GF) show a general shift toward testing and treatment from prevention and health systems strengthening for both major donors, while still continuing to support a broad range of other HIV-related programs.

While the public sector has remained the predominant player in the health sector in Ethiopia, the private sector makes an important contribution to HIV/AIDS activities, particularly in urban scale-up areas where private providers are concentrated. The World Bank/International Finance Corporation report, "International Finance Corporation Annual Report 2013: The Power of Partnerships: Main report (English)[3]," also indicated that of the population served by the private sector in Ethiopia, 42% are from urban areas and 48% are from the highest income quintile. The HIV prevalence among the urban population is 3.8% while it is 4.9% among the highest income quintile which is disproportionately higher than the national average of 1.1% (SPECTRUM 2015).

Many private health facilities are located in priority geographic locations and the service uptake for diseases of public health importance has significantly increased over the past years. Private sector also plays an important role in HIV testing. HIV yields from private sector facilities are

[3] http://documents.worldbank.org/curated/en/2013/01/18381978/international-finance-corporation-ifc-annual-report-2013-power-partnerships-vol-1-3-main-report

consistently above the national average (3.3% in the most recent APR) and contributed more than 12% of positive HIV tests reported in the last two years by PEPFAR Ethiopia.

Contribution of the private sector to ART provision has been more limited due to Ethiopia's restrictive regulatory system. Until recently, it was only private hospitals and selected nongovernmental organization (NGO)-owned facilities that were allowed to provide ART services. The new health facility standards published last year with the support of the PEPFAR-funded private health sector program now allows higher clinics to be upgraded to provide ART services. At the end of FY15, a total of 14,535 adults and children were regularly receiving ART from the 39 private health facilities supported by the program.

Table 1.2.2 Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GF	% Host Country	% Other
ARVs	$ 63,313,527	0%	100%	$ -	$ -
Rapid test kits	$ 9,243,320	4%	96%	unknown	unknown
Other drugs	$ 2,460,295	13%	87%	unknown	unknown
Lab reagents	$ 7,019,467	93%	7%	unknown	unknown
Condoms	$ 652,001	0%	100%	unknown	unknown
Viral Load commodities	$ 7,638,319	41%	59%	unknown	unknown
VMMC kits	$ 40,000	100%	0%	unknown	unknown
MAT					
Other commodities	$ 3,202,094	100%	0%	unknown	unknown
Total	$ 93,569,022				

Table 1.2.4 PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP

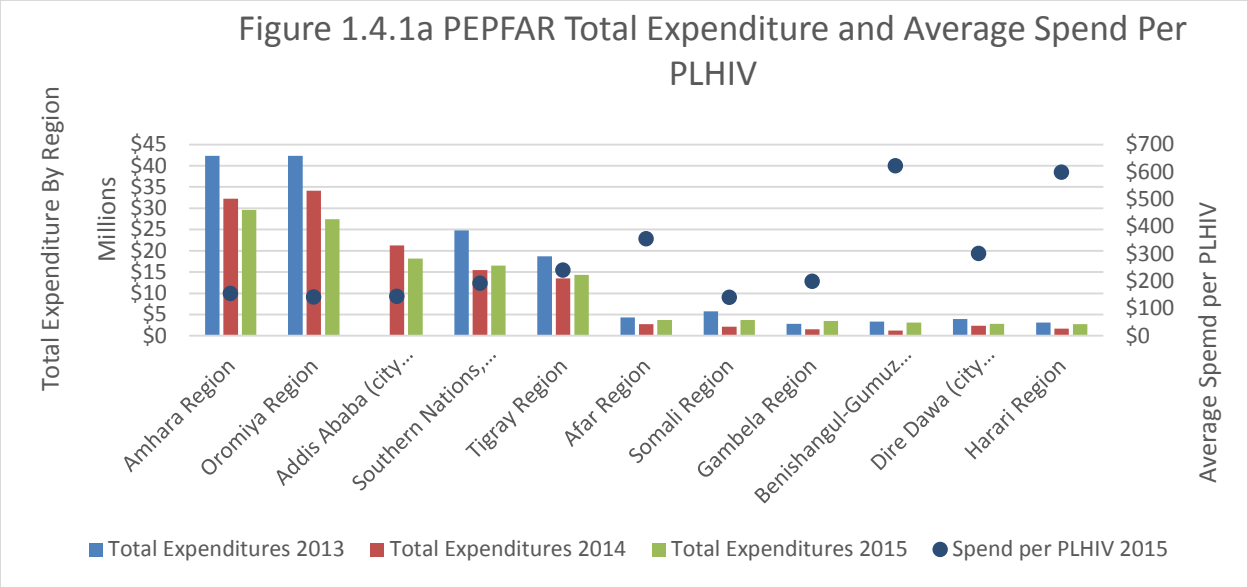
Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
VMMC	$150,000					Additive funding to meet gaps in VMMC programming.
Other Public-Private Partnerships		$1,200,000 (Over three years)			$200,000 (FY15)	General Electric Foundation. To focus on quality and availability of trained biomedical engineers and technicians in Ethiopia.
Total	$150,000	$1,200,000			$200,000	

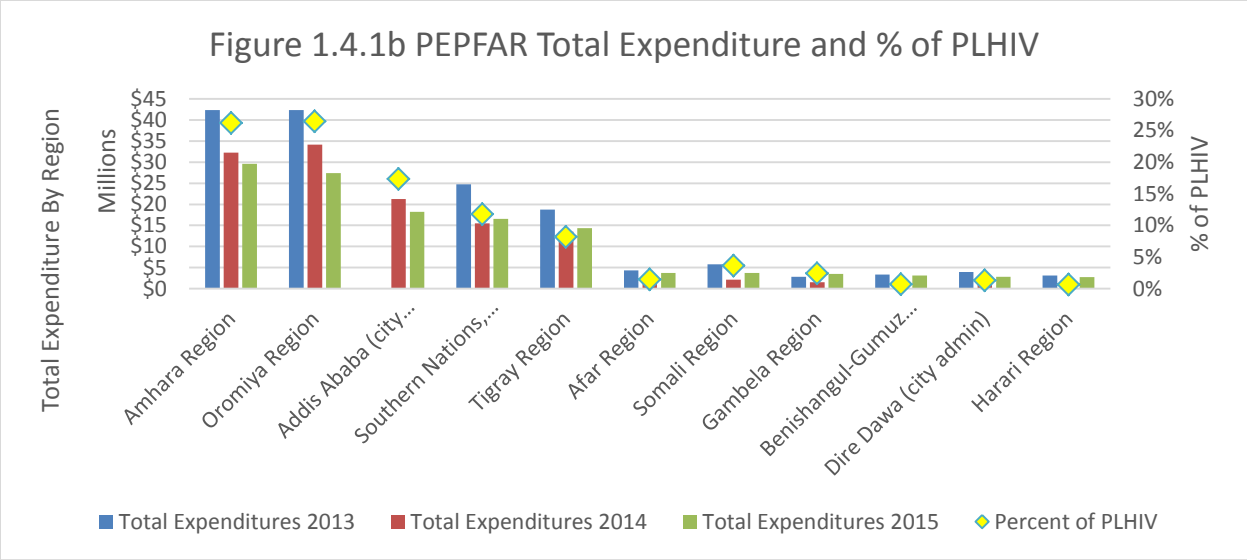
1.3 National Sustainability Profile

As a preliminary step for annual planning in COP16, PEPFAR-E convened a Sustainability Index and Dashboard (SID) workshop. Participants included representatives from the FMOH (national and regional representation), civil society (five organizations representing the largest civil society groups in the health sector and GF Country Coordinating Mechanism (CCM) members), the Joint United Nations Program on HIV/AIDS (UNAIDS), the World Health Organization (WHO), the United Nations High Commissioner for Refugees (UNHCR), the United Kingdom's Department for International DEvelopment)DfID), private sector, faith-based organizations (FBOs), and PEPFAR implementing partners. Participants were then divided into four groups to discuss and complete the SID domains. Then the entire group reconvened for a presentation of outcomes agreed upon during the small-group discussions. The group identified planning and coordination and public access to information as strengths. Given PEPFAR-E's increased efforts to support the Ethiopian government to attain the 90:90:90, and taking into consideration decreasing donor funding, the following SID categories are priorities for COP16: service delivery; human resources for health; quality management; and domestic resource mobilization. PEPFAR-E is well positioned to improve service delivery and the National Health System by supporting the GoE in addressing relative weaknesses such as the distribution of resources at the sub-national level, linkage to care and treatment services, and generating demand for HIV services. Please see the full SID narrative for an in-depth discussion of the COP16 plans for these domains.

1.4 Alignment of PEPFAR Investments Geographically to Disease Burden

As depicted in Figure 1.4.1a, spend per PLHIV varied between $140 and $621 per person in most regions, with an average spend of $172 per PLHIV (average spend does not include the national and above national spend). The notable exception was the Benishangul Gumuz region, which reported spending $621 per PLHIV. The developing regional states Benishangul Gumuz, Afar Gambella, and Somali report a higher spend per PLHIV as these regions have poor infrastructure, which increases costs. Additionally, unlike the other regions these four regions are still being supported by an international partner that adds to spend per PLHIV. There was no clear association of spend per PLHIV with total expenditure or regional HIV prevalence, although average unit costs also appears to be higher in city administrations such as Addis Ababa, Dire Dawa, and Harari. This probably reflects that unit cost is based on resident population rather than catchment area population size and does not account for the additional cost of serving ART clients from surrounding regions. The other notable trend is the declining pattern of funding over time in all regions, even as coverage of testing and treatment has increased over the same period. This shows the increasing efficiency of PEPFAR support over time.





Total PEPFAR expenditure aligns well with the general distribution of disease burden by region, as seen in Figure 1.4.1b. Total expenditure increases almost in parallel with increasing percentage of the total disease burden in each region. Urban centers such as Addis, Dire Dawa, and Harari report a slightly higher proportion of the total spend relative to their disease burden, but this may be explained by the tendency of urban centers to absorb treatment expenses from surrounding catchment areas as described in the previous figure.

Figure 1.4.2a: Map of the 20 prioritized towns and priority woredas in COP16.

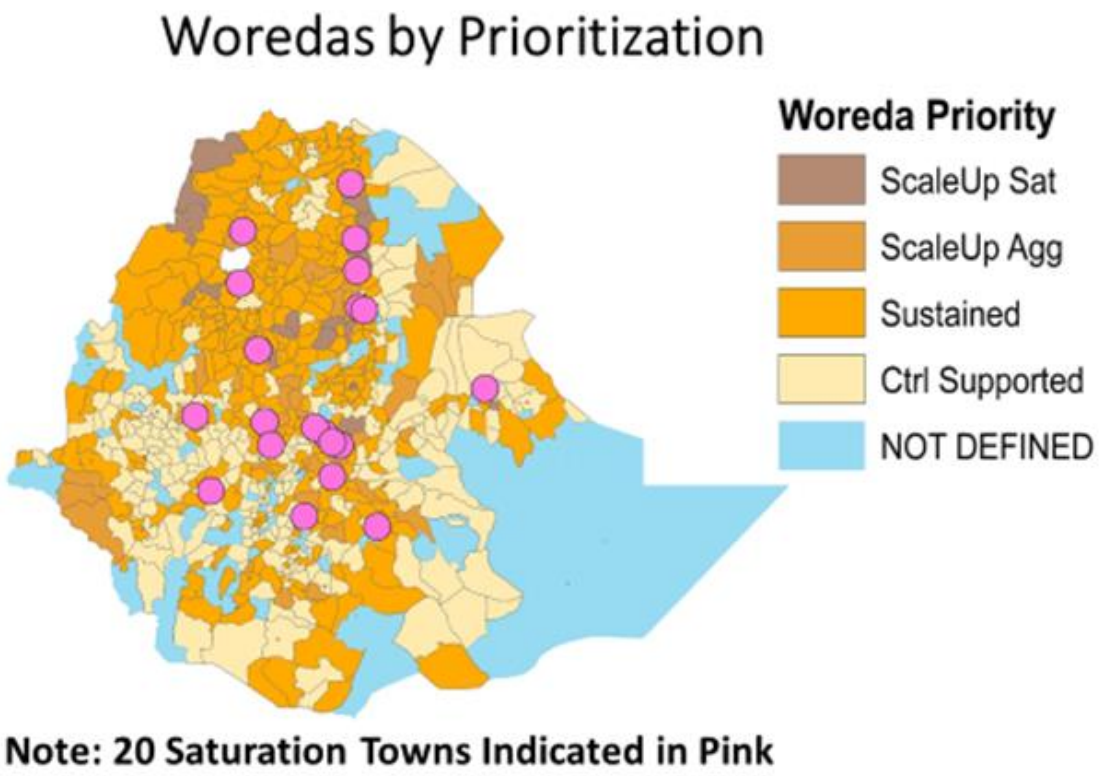


Figure 1.4.2b: Total PEPFAR expenditures in FY15.

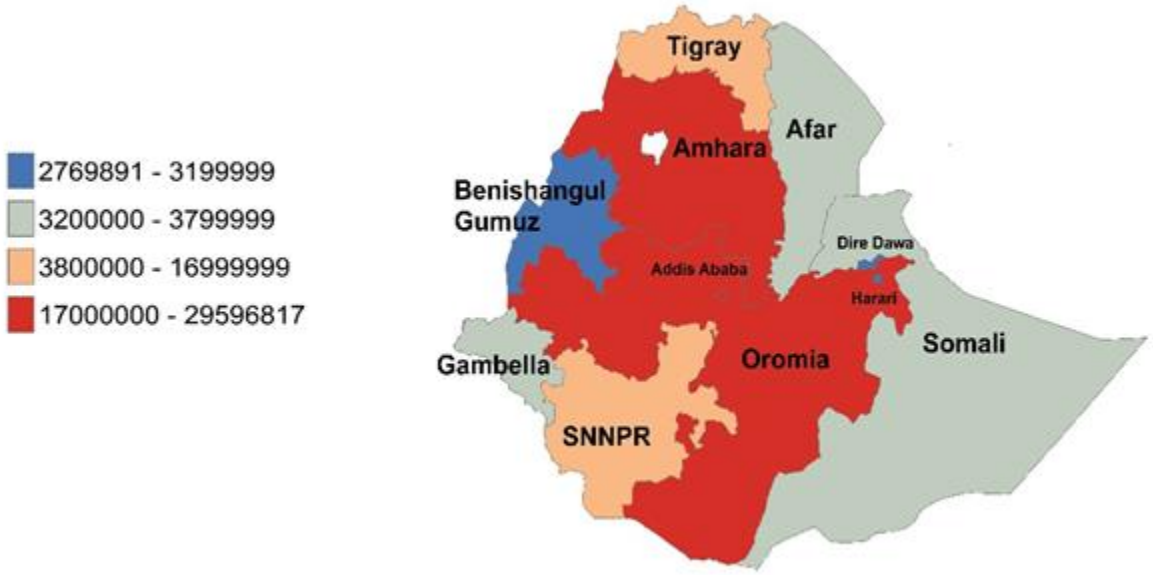


Figure 1.4.2c: Total PLHIV in Ethiopia FY15.

REGION	PLHIV FY 15
Addis Ababa	126,376
Afar	10,541
Amhara	191,067
Beneshangul Gumu	5,019
Dire Dawa	9,295
Gambela	17,473
Hareri	4,630
Oromia	192,800
SNNPR	86,021
Somali	26,570
Tigray	59,723

1.5 Stakeholder Engagement

The PEPFAR team regularly engages and works with the GoE, GF, other external donors, civil society, and the private sector at both federal and regional levels. PEPFAR holds a monthly meeting with the FMOH and Federal HIV/AIDS Prevention and Control Office (FHAPCO) to discuss new developments in PEPFAR and conducts quarterly program management reviews, including partner pipelines on the basis of a mutually agreed upon scale. The CDC team meets with Regional Health Bureaus (RHBs), local university partners, and local NGOs on a quarterly basis to discuss implementation, planning, and execution through their cooperative agreements supporting comprehensive clinical care and treatment. The USAID team meets with the Federal Ministries of Education, Labor and Social Affairs, and Women, Children, and Youth Affairs on a monthly basis to coordinate implementation of prevention among high-risk youth and migrant laborers, as well as social services for HIV/AIDS-affected orphans and vulnerable children. USAID also meets with Ethiopian professional and private sector associations to coordinate implementation and plan the transition of clinical care and treatment activities in the private sector. The PEPFAR-E team works closely with UNAIDS to engage CSOs. For COP16, the PEFPAR team will be working with UNAIDS to carry out the first Legal Environment Assessment (LEA) and an updated Stigma and Discrimination Assessment (SDA), which includes consulting with an array of stakeholders.

The PEPFAR team engaged CSOs and private sector firms throughout the COP15 and the COP16 development process to ensure that their input and expertise were used as constant feedback on programming, as well as ensuring that there is an agreed upon shared understanding of the direction for PEPFAR-supported programming. Meetings with CSOs and key stakeholders were held to develop the COP16 SID and in preparation for the LEA and SDA. Additionally, PEPFAR has undertaken a months-long process of engaging with CSOs and stakeholders to develop the Gender Analysis, which is being submitted for COP16. PEPFAR will also share the SDS with CSOs and stakeholders after COP submission, to ensure that their input is included prior to the final COP review and there is a shared understanding of PEPFAR-supported programming for COP 16.

2.0 Core, Near-Core, and Non-Core Activities

Ethiopia was the first PEPFAR country to carry out the core, near-core, and non–core classification to 'right-size' the program in 2013. The outcome of the exercise informed both COP14 implementation and COP15 planning. In December 2015, PEPFAR-E carried out the second round of this strategic discussion leveraging the UNAIDS 90:90:90 goals. As illustrated in the matrix in Appendix A, the outcomes are very similar to the categorization of COP14 and identify the key programs required to achieve epidemic control. In summary, core activities focus on the major components of clinical care and treatment, including combination prevention targeted to high- and medium-risk populations, with a strong focus on commercial sex workers (CSWs). Recognizing the heavy burden of highly vulnerable children, these programs also remain core in COP16. Near-core activities will receive reduced and short- term U.S. government funding with clearly articulated transition plans. These include blood safety programs both within civilian and military populations, as well as finalization of construction commitments. Finally, non-core activities for COP16 include provision of household supplies and micro credit, support of tertiary education (including university subsidies and scholarships), vocational training, and support to income generating activities without established market potential.

Two areas, private sector support for epidemic control and PEPFAR's support to Health Management Information System (HMIS), produced the most in-depth discussions. The PEPFAR-E team made the following decisions on how to integrate these key activities in COP16:

Private sector support: The PEPFAR-E team recognizes the important role the private health sector plays in delivering core HIV/AIDS services in Ethiopia. PEPFAR's support of the private sector is essential to achieving epidemic control. The language used in the COP14 and COP15 core activities framework around TA to private health sector for care and treatment is not illustrative of the current U.S. government support. Therefore, this language will be removed with the understanding that the activities described in the prevention, care, and treatment program areas includes support from both the public and private health sectors.

HMIS: PEPFAR needs to retain its influence on the HMIS environment in Ethiopia to ensure that we have access to high-quality data for planning and reporting purposes. PEPFAR-E has adopted the PEPFAR Health Information Systems (HIS) Technical Working Group's (TWG's) recommendations from October 2014, including moving towards using one open source HMIS for Ethiopia and introducing a Program Management Office (PMO). Given the FMOH's anticipated decision to move forward with a District Health Information Software (DHIS) II platform, PEPFAR is poised to support the government in the transition from the current platform to DHIS II.

3.0 Geographic and Population Prioritization

The COP15 SDS described the geographic heterogeneity of Ethiopia's HIV epidemic with PLHIV most concentrated in urban settings and within five kilometers of an asphalt road (transport corridors), which resulted in PEPFAR-E's decision to assess HIV disease burden at the district/woreda level. Use of a "catchment-area approach" to assess disease burden and unmet need at the district level was also described in that document. That approach relied on SPECTRUM's region-specific estimates for disease burden and assumed that the proportion of the region's PLHIV on treatment in each district reflected the care seeking pattern of all PLHIV in the region. This methodology took into account that PLHIV do not necessarily obtain services in the district where they live and assumed that those not yet on treatment have, or will have, the same service-seeking patterns as those currently on ART. On this basis districts were sorted from highest to lowest disease burden. Those districts accounting for 80% of Ethiopia's disease burden—273 including Addis Ababa's 116, of the country's 940—were classified as scale-up. Seven additional woredas were added because they included large numbers of female sex workers, and four more were added because they were sites of large development projects attracting large numbers of mobile workers.

At the end of FY 14, 56.3% of HIV-infected adults and 12.9% of HIV-infected children in scale-up woredas were on ART. PEPFAR-E set interim targets for COP15 of 71.6% coverage for adults and 20.3% coverage for children in scale-up woredas. In FY15, PEPFAR-E achieved only 54% of its TX_NEW target. As a result, coverage for adults in scale-up woredas actually dropped to 53.9%, but increased to 22.4% for children. These changes can largely be attributed to revised SPECTRUM estimates that shifted numbers of PLHIV upward for adults and downward for children. As a result, PEPFAR-E is not on a trajectory to achieve saturation in scale-up woredas by the end of FY17. In the March 2016 DCMM, the team concluded that a major reason for poor performance in reaching FY15 treatment targets was that PEPFAR-E was not sufficiently geographically focused. PEPFAR-E agreed to focus even further on the 20 highest-burden towns

and develop an intervention package that can achieve 80% coverage in these towns by end of FY17. Of the 20 towns with the highest HIV burden, six had <35% treatment coverage as of APR 15 and were considered too far from saturation for that to be achievable during COP16. The next six towns contributing to HIV burden that had adult coverage > 51% were selected for inclusion in the 20 focus towns. The selected 20 towns account for 41.2% of the country's PLHIV. Coverage by end of FY15 for the 20 towns was 61.4% for adults, 27.1% for children, and 57.5% overall. PEPFAR-E committed to focusing its efforts on reaching 80% ART coverage for adults and 58% for children < 15 yrs (range: 29 to 94%) in the selected towns. In 2015, the SPECTRUM estimate of number of HIV-infected children in Ethiopia declined by 40%. PEPFAR-E expects an additional downward estimate of the pediatric HIV population may be forthcoming.

Another 35 Woredas accounting for 66,716 PLHIV were also selected for scale-up saturation by end of FY17. The collective ART coverage in these woredas as of end of FY15 was 62% and projected to reach ART coverage of 71% by the end of FY16. As the average PLHIV in these woredas is 1906, and each of these woredas has an average of 1,183 clients on ART at end of the FY2015, the average net increment needed to reach 80% saturation is 341 clients. Given the performance level of these woredas, they should reach saturation with moderate effort from PEPFAR. The 20 towns and 35 woredas account for 50.3% of PLHIV in Ethiopia.

Analysis of FY15 program performance suggests that both linkage to care and patient retention are strong, and that the main obstacle to achieving saturation has been failure to identify previously undiagnosed PLHIV. A package of services has therefore been developed that is expected to maximize identification of the difficult-to-find PLHIV in each of the 20 communities and includes the following:

1. Focus on CSWs: Strengthen outreach by HIV-infected peers, extending ART access to CSW-friendly drop-in centers in the 20 towns, developing CSW-friendly services at 80 public facilities (the majority of which are in the 20 towns), and strengthen existing Confidential Clinics capacity to provide ART. At the drop-in and confidential clinics, extend testing and referral services to boyfriends of CSWs.
2. Targeted behavioral change and demand creation activities targeting key and priority populations.
3. Focus on clients of CSWs: Town leaders/Mayors will be encouraged to champion their town being a "stigma-free zone" and to actively promote testing for all who have engaged in risky behavior. PLHIV peer organization members will also be encouraged to conduct outreach for testing among high risk individuals they know.
4. Focus on sexually transmitted infection (STI) clients: Assure HIV testing is done for 100% of clients presenting to health facilities with STI symptoms.
5. Pilot Partner Notification for STI clients and newly diagnosed PLHIV in the 20 towns: While testing of family members has been implemented at a modest scale, little attention has been paid to identifying sexual contacts who are non-family members. Contacts of STI and PLHIV clients will be notified and encouraged to undergo HIV testing as well as treatment for STI.
6. Strengthen and further focus testing of family members of index cases.
7. Pilot HIV self-testing (HIVST) for KP and PP, including operations research: HIVST will be piloted to increase uptake of HIV testing among people not reached by other HIV services, many of whom are first-time testers.
8. Expand universal HIV testing of TB patients to include presumed TB patients and strengthen linkage of HIV co-infected TB and presumed TB patients to ART services.

9. Strengthen HIV testing in prisons.
10. Increase pediatric HIV case detection by systematically testing orphans, children of HIV-infected mothers, children accessing health services at TB clinics, malnutrition clinics, and in-patient units, as well as improving testing rates of HEIs at 6 weeks and following cessation of breast feeding.
11. Strengthen linkage to treatment services by assuring as often as possible that newly-diagnosed PLHIV are accompanied to ART clinic by an HIV-positive peer volunteer.

In addition to these measures, the recent agreement by the FMOH to adopt Test and START will help further accelerate these interventions to identify the hard-to-find PLHIV.

The funding required to implement these strategies and achieve the FY17 targets in the 20 towns is estimated to be $49,968,653, based on the unit expenditure (UE) for testing and treatment, plus a lump sum for each town averaging $50,400 that covers costs for use of telephone technology to track patients, piloting of self-testing, and implementation of partner notification, activities to be implemented in the 20 towns exclusively.

4.0 Program Activities for Epidemic Control in Scale-up Locations and Populations

4.1 Targets for Scale-Up Locations and Populations

Based on FY15's TX_NEW performance which fell significantly short of reaching its target, PEPFAR-E recognized that meeting FY16 targets established at time of COP15 submission will be very challenging. FY16 adult treatment scale-up targets, therefore, were revised pre-DCMM and set FY17 targets based on the following assumptions:

1. In FY16, 97% of cohort entering the year on ART will be retained.
2. TX_NEW will increase 10% over FY15.
3. 91% of TX_NEW will be retained by end of FY16.

This is reflected in the following formula: FY16 TX_CURR-Adult = (FY15 TX_CURR*0.97) + (FY15 TX_NEW*1.1*0.91). FY17 TX_CURR was calculated assuming 98% retention of cohort entering FY17 on ART and that TX_NEW will be 40% higher than in FY15 with 92% retention of those initiated on treatment in the course of the year, as reflected in the following formula: FY17_CURR-Adult = (FY16TX_CURR*0.98) + (FY15 TX_NEW*1.4*0.92).

Table 4.1.1 ART Targets in Scale-up Sub-national Units (SNUs) for Epidemic Control

SNU	Total PLHIV	Expected current on ART (APR FY16)	Additional patients required for 80% ART coverage	Target current on ART (APR FY17) *TX_CURR*	Newly initiated (APR FY17) *TX_NEW*	ART Coverage (APR 17)
Scale-up Saturation	367,060	252,124	41,524	297,034	57,006	81%
Scale Up Aggressive	217,624	104,946	69,153	116,529	16,350	54%
Total	584,684	357,070	110,677	413,356	73,356	71%

Based on these targets 55 woredas are expected to reach saturation by end of FY17. Inputs from the DCMM led to revisions of FY17 adult targets to achieve saturation for the 20 selected high burden towns. The FY17 "starting point" was determined using the same FY16 TX_Curr-Adult formula identified above. Then to determine TX_NEW-Adult, the following was calculated:

- TX_NETNEW = (FY17 EST PLHIV≥15*0.8)-FY16 TX_CURR; **TX_NEW** = ((TX_NET NEW/0.92) + (0.02*FY16 TX_CURR).

The remaining 86 scale-up woredas are classified aggressive scale-up. Their TX_CURR targets were based on the formulas based on FY15 performance previously cited.

Pediatric targets for scale-up woredas were revised based on FY15 performance utilizing the following formulas:

- FY16 TX_CURR-<15 = (FY15 TX_CURR*0.92) + (FY15 TX_NEW*1.1*0.89) reflecting 8% loss from the cohort entering FY16 on treatment, a 10% improvement in TX_NEW compared to FY15, and retention of those newly initiated on ART of 89% through the end of the FY.
- FY17 TX_CURR-<15 = (FY16 TX_CURR*0.93) + (1.25*(FY15 TX_NEW*0.90)).
- These formulas were applied across all scale-up woredas.

To determine testing targets, a cascade analysis was conducted. The target setting factored in HIV positives who will come from pre-ART care and PMTCT, HIV positive yield and the level of linkage to care and treatment services. By targeting the top 20 high-burden towns, focusing on KP and PP and targeted provider-initiated testing and counseling (PITC) at inpatient and outpatient wards, yield from FY15 APR adjusted upward by 25% (both adult and pediatric); region specific yield for tuberculosis- (TB) based on FY15APR and yield from STI sentinel surveillance were used for target calculation. Escorting and referral auditing linkage rates are 88% in the 20 towns, 86% in the remaining 35 scale-up saturation, and 84% in scale-up aggressive SNUs. Moreover, target calculation assumed the implementation of Test and START that 100% of those enrolled in care will be put on treatment.

Extra resources required to achieve saturation in the 20 towns are captured in the UE applied to increased numbers of newly started on ART required to achieve saturation, plus an additional lump sum averaging $50,400 per town to cover use of telephone SMS technology, self-testing, and partner notification activities targeted only for these towns.

The specific approaches to increasing TX_NEW are enumerated in Section 3 with details highlighted in 4.2–4.10. The contributions from each approach are captured in Table 4.1.2.

Table 4.1.2 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Districts

Entry Streams for ART Enrollment	Tested for HIV (APR FY17)	Identified Positive (APR FY17)	Newly initiated (APR FY17) *TX_NEW*
Adults			
Clinical care patients not on ART	-	-	**3,904**
HIV+ TB Patients not on ART	53,663	5,152	5,152
HIV-positive Pregnant Women	837,631	5,926	5,695
PITC, VCT, and priority & KP testing	2,772,504	49,990	58,148
Pediatrics			
Clinical care pediatrics not on ART	-	-	0
HIV Exposed Infants	14,215	867	824
Orphans and Vulnerable Children	23,342	934	934
Provider Initiated Testing	548,064	7,092	5,036
Total	4,249,419	78,118	67,631

The magnitude of the increases required in TX_NEW to achieve saturation poses significant challenges. However, PEPFAR-E will optimize enrollment in treatment by promoting a stigma free environment in the towns targeted for saturation, creating demand among high risk populations, supporting the FMOH's "Catch-Up Campaign" to make all health facilities beacons of compassionate and respectful care, and drawing on the reach of our implementing partners to identify and bring into care the hardest to reach high-risk population groups. The strategies developed for COP16 offer the greatest chance for meeting the challenges and achieving our ambitious treatment targets, especially with the initiation of Test and START. With this new policy shift, the FMOH will also need to consider guideline revisions that reflect further refining of a targeted testing policy. PEPFAR-E will work closely with the FMOH, providing TA that will enable it to make an informed decision regarding outcomes of such policy shifts.

One unanticipated challenge that has impacted achievements in Quarter 4 of FY15 and the first half of FY16 is a test kit stock out precipitated by decertification by WHO of the screening HIV test in use in Ethiopia for the last several years. A supply of a WHO approved screening test arrived in country only in May 2016, and an algorithm utilizing this test for screening been validated within country. The FMOH will be initiating its "Catch-Up Campaign" to regain the lost opportunities for diagnosing HIV resulting from this hiatus in testing. PEPFAR-E technical staff has been playing an important role in shaping that campaign to be geographically aligned with PEPFAR's geographic focus and prioritization of appropriate risk groups. PEPFAR has also provided TA in the validation of the new testing algorithm as well as TA to prevent this problem from occurring in the future.

4.2 Priority Populations

The primary recognized KP in Ethiopia is CSWs. Another KP of concern is people in prisons and other closed settings. PP include: divorced and widowed persons; AIDS orphans; HIV-negative partners in discordant couples; STI cases; long-distance truckers; clients of sex workers; uniformed services; people in transactional sex; waitresses; mobile/seasonal workers; and vulnerable adolescent girls and young women. PEPFAR prevention programs for KP and PP are already concentrated in scale-up woredas and SNUs. Prevention interventions have been prioritized in the 20 saturation towns, followed by the next level of 35 saturation towns, and then

the aggressive scale-up SNUs. Except for small-scale DOD and work site prevention programs, PEPFAR-E has already shifted all community prevention activities from the sustained SNUs. The new interventions and scale up of high-yield programs will focus on the 20 saturation towns. Density of CSW populations correlates closely with high PLHIV burden overlapping with urban woredas linked by major transport corridors. Prevention efforts aimed at KP and PP are all defined as core activities in COP16. Most programs adopt combination prevention linking standardized behavior change curricula with HIV testing services (HTS), STI treatment services, and care and treatment services. HIV testing yields, particularly for programs targeting mobile workers, have been much lower than anticipated. In response, PEPFAR-E will focus its testing and outreach efforts where yield has been high and further stratify KP and PP to target those most at risk.

Table 4.1.4a: Target Populations for Prevention Interventions to Facilitate Epidemic Control (PP_PREV)

Woreda Classification	Population Size Estimate (scale-up SNUs)*	Coverage Goal in FY17*	FY17 Target
Scale-up Saturation			305,801
Sclae-up Aggressive			134,070
Sustained			34,406
Total			474,277

*Since there is no size estimate for the heterogeneous PP, it is not possible to calculate the program coverage.

Table 4.1.4b Target Populations for Prevention Interventions to Facilitate Epidemic Control, KP_PREV_CSW

Woreda Classification	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY17 Target
Scale-up Saturation	67,957	109%	73,149
Sclae-up Aggressive	46,251	40%	19,420
Sustained	9,153	43%	210
Total	123,361	78%	92,779

Note: The coverage for the 20 saturation towns may seems exaggerated because IPs working in the community refers clients to IPs in the facility.
There will be a need for deduplication during the reporting.

Since PEPFAR-E's COP15 submission, there have been two major policy changes positively affecting PEPFAR's ability to control HIV among KP and PP. Very recently, the FMOH authorized Test and START for all. Secondly, the GoE has announced a Cities Fast Track initiative, which makes mayors accountable for achieving HIV epidemic control in their cities. These two initiatives will make it possible to initiate ART for CSW currently being seen at PEPFAR-supported confidential clinics and drop-in centers. Ten confidential clinics already provide ART, but the majority of the HIV-infected CSW at those facilities have CD4 counts that made them ineligible for treatment. The policy change will mean that all of them can be treated. The drop-in centers do not currently provide ART services, but CSW use those facilities for securing condom

supplies, STI treatment, HIV testing, and peer support in a stigma-free environment. With approval from the government, 20 drop-in centers will initiate ART in FY17. Scaling-up ART services in these facilities focused in the 20 priority will greatly enhance epidemic control and with the Cities Fast Track initiative. Children and partners of CSW will also be tested and if positive provides treatment at these sites. KP-friendly clinical services will be established at 80 public health facilities in scale-up woredas with PEPFAR support through Regional Health Bureaus. The private sector will receive PEPFAR support to strengthen their role in HIV care and treatment because there is evidence that CSW and PP prefer going to these sites. Stratification of PP to identify those at higher risk will be conducted to maximize yield from testing and to direct outreach efforts.

Besides supporting facilities providing KP friendly services, community leaders will lead demand creation campaigns, proclaiming their towns to be "stigma-free zones" and creating the enabling environment where KP and PP will be encouraged to seek HTS and care and treatment if positive. In addition to community leaders taking charge of these efforts, PEPFAR will support community-based peer organizations to provide outreach and education to the more difficult to find KP and PP. These activities will be focused in scale-up woredas, especially those targeted for saturation.

A policy bottleneck that has not improved since COP15 submission is the National Condom Strategy, which was drafted in 2013 but has not received formal approval. This results in lack of coordination in condom procurement and distribution. To mitigate this, PEPFAR-E procures and distributes free condoms for KP through community partners. Once the National Condom Strategy is approved and implemented, PEPFAR-E partners will be able to access condoms through the government distribution system.

Community involvement in PEPFAR programming is robust in spite of national restrictions placed on CSOs. Health work by community groups is generally more accepted than "advocacy" work, and PEPFAR-E works successfully with a wide range of local prime partners or sub-grant recipients to implement its programs. Existing community platforms and structures are being used to easily avail services to population groups. Bidirectional referrals to these community services are fully integrated into PEPFAR programming.

In FY17, PEPFAR-E will increase its HIV prevention, testing, and treatment services as well as TB screening in selected prisons. According to a survey by the United Nations Office on Drugs and Crime (UNODC) in 2013 (reported by FHAPCO to UNAIDS in 2014), prison populations in Ethiopia had a prevalence of 4.2%, higher than the general population, with limited access to HIV prevention services.

PEPFAR-E will support post-gender-based violence (GBV) care for all survivors in COP16. Healthcare providers will be trained on comprehensive GBV care and provided with national guidelines[4]. IPs will support awareness creation, screening for potential GBV survivors, and provide appropriate services. Monitoring of GBV services is integrated with other HIV programs

[4] Comprehensive GBV care includes HIV testing and administration of post-exposure prophylaxis for HIV within 72 hours of sexual assault; STI testing and post-exposure prophylaxis and treatment as needed; emergency contraception when appropriate; counseling and psychological support; collection and complete documentation of injuries, preferably with diagrams; collection of forensic specimens when appropriate; referral to police and legal services; and linkage to emergency shelter and protective services and support groups as needed.

and it will be direct service delivery (DSD) as the data clerks are used for compiling and reporting the GBV data.

4. 3 Voluntary Male Medical Circumcision (VMMC)

The VMMC program in Ethiopia has been implemented among adult men in Gambella region, military and refugee populations since 2009. Because of the nature of the program and the target population, it was not possible to calculate coverages by age group and fiscal years for DOD and State/PRM. The VMMC program in Ethiopia has been defined as a near-core program to be transitioned to the government once 80% VMMC saturation has been achieved among adult population 15–49. As per the recent population projection and MC unmet need estimation exercise done by the FMOH (2010-2019), the projected male population aged 10 years and above was estimated at 155,531 of whom 21,981 are in age group 10–14; 77,950 in the age group 15–29; and 55,600 in the age group 30 and above. Looking at current VMMC coverage including expected FY16 performance, among different age groups in Gambella, 11%, 67%, and 22% coverages have been achieved among age groups 10–14, 15–29, and 30 and above respectively, leading to the overall coverage of 43%. The program was expected to reach saturation levels in the primary target group of 15 to 29 year in the coming 2-3 years after which the prioritization of clients aged 10-14 years will increase (as per COP16 technical consideration guide page 38). The total VMMC target for COP16 is 12,116 VMMC procedures (CDC, 11,318; State/PRM, 798), which increases to 15,034 VMMC procedures if DOD targets (2918) are added. All woredas in Gambella (Scale up and Sustained) have background HIV prevalence well above the national average. Therefore all woredas/SNUs in Gambella are priority woredas for VMMC except for Jor and Akobo, which are physically inaccessible and have reported zero VMMC in previous COPs. All VMMC clients and partners are provided with HIV counseling and testing services and HIV positive clients are immediately linked to care and treatment facilities. All VMMC clients are provided with the standard WHO recommended services packages including post-operative wound care and distribution of condoms. VMMC commodities will be supplied by the Global Health Supply Chain (GHSC) program in COP 16 with PEPFAR funds, however procurement and on time delivery of commodities has been a challenge. In Ethiopia VMMC procedures are done using surgical methods (Forceps guided and dorsal slit) only. There is no use by the IP of devices like PrePex and Shang ring. Increased uptake of VMMC over the course of the program points to the development of positive social norms in favor of VMMC, although uptake still requires active promotion through social mobilization. The VMMC program in Ethiopia has been supplemented through additional central funding since COP15.

Table 4.1.3 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	*VMMC_CIRC* (in FY17)	Expected Coverage (in FY17)
Males 10-14	**21,981**	**11%**	**6,523**	**8,941 (41%)**
Males 15-29	**77,950**	**67%**	**1,465**	**53,692(69%)**
Males 30 and above	**55,600**	**22%**	**5,296**	**17,528 (32%)**
Military VMMC	**3,200**			-
State PRM (refugee community)	898			
Total/Average/for Gambella	**155,531**	**43%**	**13,284 (CDC only)**	**52%**

4.4 Prevention of Mother to Child Transmission (PMTCT)

Ethiopia has seen significant gains in PMTCT since the program inception. The adoption of PMTCT option B+ in 2013 helped to improve ART coverage among HIV positive mothers. The success in PMTCT has resulted in a decrease in new infections among children from 4,841 in 2014 to 2,689 in 2015 (SPECTRUM 2015 Estimation).

At PEPFAR supported PMTCT facilities, 93% of women attending ANC or labor and delivery services were tested for HIV; 18,490 HIV-infected women were identified, of whom 17,978 (97%) were initiated or were already receiving ART. Nationally, an additional 1,147,141 pregnant women were tested for a country-wide testing coverage rate of 92.6%, and an additional 1,262 women covered with ART (0.11% yield at non-PEPFAR supported facilities) for a total of 19,190 HIV infected pregnant women receiving ART. These data suggest: a) that PEPFAR is supporting sites that capture the large majority of HIV infected pregnant women, and b) with testing covering 92.6% of all pregnant women, SPECTRUM may have overestimated the number of women needing PMTCT services. Based on SPECTRUM estimate, PEPFAR-supported sites achieved 65.5% ART coverage of infected pregnant women with national achievement of 69.9%, but it is probable that the coverage is significantly higher. While these gains have been impressive, the result still falls below the target of reaching 90% of HIV positive mothers needing PMTCT to achieve mother to child elimination goals. The ability to accurately project the number of pregnant PLHIV expected in FY17 and reaching at least 90% of them with ART remains key to making further progress. In scale-up saturation woredas, PEPFAR-supported community organizations must work with health extension and health development army to further strengthen ANC service uptake and identify more HIV positive women through demand creation, linkage, and assuring HIV testing is done for those receiving most of their ANC services at a health post.

The PMTCT program has been less successful in documenting follow-up of mother and infant following birth. SIMS data show that 41% of visited facilities scored yellow or red for PMTCT Core Essential Element (CEE) 4.12 Tracking of Mothers and Infants for FY15Q1 – FY16Q1, suggesting problems with adherence and retention that are not adequately rectified through current patient tracking practices. The drop-off between pregnant women on ART and HIV-exposed infants (HEIs) tested for HIV DNA-PCR by 12 months is significant with only 10,908 tests performed in FY15. The causes of the poor early infant diagnosis (EID) performance are multifactorial, but all are being addressed. Generalized dried blood spot (DBS) test kit stock-outs were pervasive in early FY2015 but have since been resolved; prolonged turn-around time (TAT) for EID results, likely contributing to HEI LTFU, have been addressed through adoption of an EID implementation manual which includes standards for how long specimens can remain at the testing sites, time of transport to the appropriate regional lab, turnaround time within the lab, and time to reporting back to the facility. SMS printers have also been procured for selected sites, which will reduce TAT.

To improve mother and infant follow-up through the end of the infant's "at risk" period, a mother-baby pair cohort monitoring tool will be developed prior to COP16 and implemented in FY17, which is expected to facilitate post-partum follow-up of mother baby pairs, strengthen EID testing, help identify adherence issues, and improve final outcome tracking of HIV-exposed infants. Mentoring and supportive supervision will particularly focus on continuity of care post-delivery. Mother Support Groups will be expanded in scale-up woredas and utilized more effectively in addressing disclosure of status to partners, and in tracking patients who have missed appointments. Site level PMTCT continuous quality improvement (CQI) activities will be

supported to identify and correct program gaps, improve EID and final HEI outcome reporting, and decrease lost-to-follow up rates.

PEPFAR partners will implement family based approach using PMTCT as an entry point for the screening of partners and children of HIV infected women.

Targets in both scale-up and sustained woredas have been set with the goal of eliminating mother-to-child transmission (MTCT). Hence, in FY17, 95% of pregnant women will know their status and 95% of positive pregnant and lactating women will be on ART. Efforts will be more intensified in scale-up woredas as most of the HIV positive mothers are from these SNUs.

4.5 HIV Testing Services (HTS)

In FY15, PEPFAR-supported facilities exceeded testing targets by 50%, yet identified only 54% of the FY15 target. Key to achieving UNAIDS 90:90:90 milestones for epidemic control is finding the positives, which increasingly will be the harder to find people among more marginalized populations in the country. Current national testing policies are obstacles to achieving the targeted approach required to optimally utilize the country's supply of test kits. Despite stated intentions to endorse appropriately targeted testing, the 2014 National Guideline included broad, population-based testing recommendations that were untargeted. That combined with an rapid test kit (RTK) distribution algorithm designed to distribute kits equitably based on the broad target population's results in RTK shortages in districts with high background prevalence and excessive testing in geographic areas with very low prevalence. When RTK shortages at facilities occur, pregnant women are prioritized, while people presenting with symptoms likely due to HIV may not be tested.

Rectifying this problem requires above-site advocacy and TA with the FMOH. However, the FMOH is designing its "Catch-Up Campaign" using an appropriate targeted testing approach, and understands the need to be more strategic in its testing policy. While testing policy changes are being considered, PEPFAR is promoting targeted testing at facility level and outreach and demand creation in the community to reach the most high-risk populations.

Specific activities for COP16 include:

- **Strengthen community-based testing services to reach KP and PP:** Community-based testing programs can reach the right population in the right place. Community-based programs will intensify behavioral interventions in the 20 towns targeting CSWs, CSWs' partners and other high-risk PP groups to create demand for and linkage to HTS. Peer education sessions will target populations to reduce risky behavior and increase health seeking behavior. Existing community platforms supported by partners including drop-in centers, confidential CSW clinics, private sector, and CSW-friendly public facilities will be used to avail HTS service. Partners working with populations needing HTS outside of regular working hours will extend service hours. Motivated peers, who are themselves KP and have passed through the services, will be trained on referral and linkage of sex workers and other PP. A snowball approach will be used to identify and reach KP and PP who are known positive or have not been tested.
- **PITC in clinical settings:** In the 20 priority towns, targeted PITC will be implemented in public and private inpatient and outpatient wards. Those targeted will include patients with TB or suspected TB, STI, opportunistic infection, or other signs and symptoms suggestive of HIV/AIDS, clients with identified high-risk behavior and widowed or divorced women. Facility-based HTS contributed to 85% and 90% of the overall HIV

positives detected in FY15 APR and FY16 Q1, respectively. HTS programs will test 100% of TB patients and link all positives to care and treatment services. To increase pediatric HIV case detection, programs will, focus on testing orphans; children admitted to inpatient units, evaluated for malnutrition, or diagnosed with TB; children of CSW, at-risk adolescent girls, as well as children of positive women. PEPFAR's partners serving orphans and vulnerable children (OVC) will maximize their testing of PEPFAR-supported OVCs while strengthening capacity of RHBs to work with relevant regional government agencies to increase testing of OVCs and caregivers nationally.

- **Increasing HIV case detection among STI clients:** To assure all patients in scale up SNUs presenting with STI symptoms are tested for HIV, sensitization workshops will be conducted for providers and appropriate community workers, and demand for testing services targeting persons with behavioral risks will be created through local media. Post-test counseling will be strengthened, and HIV-positive clients newly identified either at community or facility testing sites will be escorted to HIV treatment facility. Percent of STI patients tested and percent of positives linked to ART clinic will be monitored and regularly reviewed.
- **Partner Notification for STI and HIV positives:** HIV testing of STI contacts, whether or not the index case is HIV positive, will increase HIV case detection and contribute to interrupting sexual transmission networks. To implement this activity in the 20 scale-up saturation towns, a cadre will be trained to obtain contact information, approach contacts in a safe and effective manner, link them to HIV testing and counseling, accompany positives to treatment services, and locate and motivate their partners to seek medical evaluation and treatment. In the United States, such cadres are called Disease Intervention Specialists. The existing health cadre that is appropriate to take on this role will be determined through discussion with the FMOH. An implementing partner will adapt US based training curricula, tools, and standard operating procedures (SOPs), to implement this activity.
- **Testing for families of index cases:** Index family testing will assure that the spouse or partner of every patient testing positive and children of all women testing positive are tested. Patients testing positive will be helped with disclosure, and service providers will be sensitized to understand that HIV counseling is not over until disclosure has been accomplished and appropriate family members have been tested. Appropriate trainings to enhance counselor capacity to assure family members are tested will be provided.
- **HIV Self-Testing (HIVST):** HIVST will give individuals the opportunity to test discreetly and conveniently. HIVST may increase uptake of HIV testing among KP not reached by other HIV testing services. PEPFAR-E will pilot HIVST in the 20 priority towns. This pilot is intended to not only increase the HIV testing uptake in COP16, but to also inform future HTS programming.
- **Utilizing peer organizations to encourage testing among their networks:** Programs will optimize partnerships with PLHIV associations, whose members know people engaged in risky behaviors that may be resistant to testing. PLHIV associations will be supported to host targeted outreach or home-based testing events, creating demand for HTS among high-risk groups and sending invitations to individuals known to engage in risky behavior.
- **Linkage to treatment services:** To minimize missed opportunities between HTS and ART services in the 20 priority towns, HIV positive clients will be linked to ART through accompanied referral or referral slips where a closed loop will be ensured. In addition,

regular linkage auditing will be made between referring and receiving facilities and corrective action taken depending on the gap identified.

- **Partner Monitoring:** PEPFAR E will be rigorously monitoring trends of HIV positivity among partners providing HTS services. Recent monitoring of selected partners has helped make strategic programmatic decisions including shifts in geographic focus. Trend analysis of yield will also enable partners to systematically change their HIV testing approaches, considering characteristic of population groups to be reached and other contextual factors their testing innovative and partners which were reporting on a bi-weekly basis have shown encouraging improvements in yield. Moving forward, PEPFAR-E will be strengthening partner notification for all partners providing HTS services.

PEPFAR-E will help assure the success of these efforts by supporting monthly supportive supervision/mentoring, conducting data workshops, conducting yield analyses, linkage auditing, engaging CSOs and town leadership in demand creation, utilizing local media, and providing ongoing appropriate guidance.

4.6 Facility- and Community-Based Care and Support

While only 10.46% of SIMS CEEs in the adult care and treatment domains scored yellow or red in Q1 of FY16, community/facility linkage was the most consistently raised issue. Historically, these linkages have been weak. To address this at the facility level in scale-up saturation woredas, peers will be utilized to escort and link newly diagnosed PLHIV from health facility and community-based testing points. The first point of contact at the facility is generally the case manager, who is also an HIV-positive peer, who will maintain an active directory of community-based services and track referrals with a standard referral log book. At the community level, PLHIV associations, caregivers, and health extension professionals will serve as patient navigators to provide enhanced pre- and post-test counseling, link patients into care and treatment services, assist facility-based case managers in tracking LTFU of pre-ART clients, and help assure treatment adherence and retention in care. Additionally, other community-based organizations including religious structures, other CBOs/NGOs, and post-test clubs for KP will receive PEPFAR support to augment services provided at health facilities. These organizations work closely with health facilities and other community service outlets (such as OVC partners) to improve bidirectional referral linkage, tracing of lost to follow-up clients and retention of patients to care and treatment. Introduction of mobile technology to improve adherence support, appointment reminder and tracking of LTFU; and assigning community focal persons to improve bilateral referral linkage will be implemented in scale-up woredas. These measures should significantly enhance facility and community linkages, contributing to improving both the referral of known positives into treatment and retaining patients in care.

With the introduction of Test and START policy for all PLHIV, case managers will actively retrieve pre-ART patients previously ineligible for treatment, many of whom have been LTFU. The strengthened linkages to the community are expected to improve the success of these efforts.

Disclosure has been a barrier that affects both the first and second 90. Failure to disclose to spouse and family members prevents other at-risk family members from being tested. Similarly, patients who do not disclose their status are highly likely to be LTFU, as they cannot explain their ongoing need for clinic visits. Trainings to strengthen capacity of case managers, community support providers and HIV peer volunteers to assist PLHIV in the difficult task of disclosure will

be enhanced. Additionally, as trust builds between PLHIV and case managers and community supporters, PLHIV who have disclosed their status will be encouraged to promote testing among high-risk individuals they know and to permit partner notification of non-family sexual contacts, further contributing to the first 90 and reaching the most difficult to reach populations.

Integration of mental health services was piloted in FY15 and will be brought to scale in FY17 with case managers being trained to identify common psychiatric conditions, HIV treatment providers trained in use of a limited number of psychotropic drugs, and referral mechanisms established to assure linkage to appropriate care for more complex psychiatric conditions. Bringing integrated mental health services to scale will increase patient well-being and contribute to retention.

Additional facility-based care and support activities that will be continued include: determination of eligibility for PCP prophylaxis and provision of Cotrimoxazole for those eligible; screening and management of opportunistic infections (OIs) including cryptococcal Ag screening and management for those with CD4 < 100; positive health dignity and prevention (PHDP) services; nutritional assessment, counseling and support (NACS); water sanitation and hygiene; pain and symptom management; and peer support. Cervical cancer screening has been taken over by the GoE; however, Ethiopia is receiving PEPFAR funding from Pink Ribbon Red Ribbon to enhance access to this screening and treatment. The activities are in line with the revised PEPFAR core/near-core/non-core framework.

In scale-up aggressive and scale-up saturation woredas, the community will be empowered to actively engage and work with the HIV-infected and HIV-affected individuals in facilitating the provision of prioritized community-based care and support services that include peer education (one-on-one and small group) and support, nutritional assessment and counseling and referral for nutritional support, promotion of safe water and hygiene practices, psychosocial counseling, identification and referral of victims of GBV, PHDP, and social services including economic strengthening activities to improve household food security status and sustainable livelihood programs as appropriate, and referrals for other services (e.g. family planning).

Regarding the core, near-core, and non-core exercise, many care and support services currently provided were prioritized using evidence for care and support program prioritization and a core package of care services are identified. PEPFAR-E is building the capacity of community structures (including federal, regional, and town level HAPCOs, town community coordination committee, community care coalition at kebele level, Urban Health Extension program, and PLHIV associations) with the expectation that those community-based care and support activities that are categorized as near-core will be transitioned in the coming years.

PEPFAR will procure essential commodities for treatment of severely malnourished PLHIV clients and laboratory monitoring (including CD4 and viral load (VL) reagents) for patients enrolled in care. While these procurements will benefit all PLHIV, their beneficiaries will be concentrated in scale-up aggressive and scale-up saturation SNUs, as this is where the demand will be greatest based on disease burden.

4.7 TB/HIV

Ethiopia is among the high TB, TB/HIV, and multi-drug resistant (MDR)-TB burden countries globally with estimated incidence and prevalence of TB 207 and 200 per 100,000 populations, respectively. Of registered TB cases, 93% and 95% have their HIV status documented at national and PEPFAR supported sites, respectively. HIV prevalence among TB patients is 10%. PLHIV in care are routinely screened for TB at every follow up visit. TB is one of the leading OIs among PLHIV in Ethiopia; approximately 4.5% (TB/HIV directly-observed treatment, short-course (DOTS) assessment 2014) of PLHIV enrolled in care are also receiving treatment for TB. The 2014 revised national TB diagnostic algorithm recommends GeneXpert® test as a primary diagnostic test for evaluating PLHIV with presumptive TB. The 2013/14 revised ART criteria of FMOH recommends provision of ART to all HIV positive TB patients within two months of TB treatment initiation, irrespective of CD4 or clinical status. ART coverage for HIV positive TB patients is 59% and 89% at national and PEPFAR-supported sites, respectively.

HIV positive TB patients receive TB and ART treatment at different clinics within the same facility and sometimes at different health facilities through intra- and inter-facility referral mechanism, respectively. TB screening services have been integrated with ANC and maternal, neo-natal and child health (MNCH) services. There has been an ongoing discussion with FMOH and stakeholders to pilot integrated ART service at the TB clinic (one-stop-shop model) using the option B+ platform at selected TB (DOTS) stand-alone sites in scale-up woredas to improve quality of TB/HIV care through timely initiation of ART, minimizing patient discomfort and cost, as well as improving adherence to treatment and retention. However, the implementation has been significantly delayed.

In FY17 PEPFAR-E will focus on the following core activities with the goal of identifying almost all HIV positives among presumed and diagnosed TB cases and achieving 100% ART coverage for HIV positive TB patients. Besides, PEPFAR-E will intensify support at the 20 towns selected for scale up to saturation to improve TB case finding, hence increasing newly identified HIV-positive individuals. In FY17 PEPFAR-E will implement the following program support activities:

- Integrate intensified TB case finding at each service delivery points at health facilities.
- Improve linkage between community- and facility-level TB services.
- Implement active TB case detection programs at prisons and urban slums.
- Ensure routine offering of PITC for all presumed and diagnosed TB cases and ensure 100% ART coverage for HIV positive TB patients (assuring that Presumed TB cases are tested for HIV rather than simply focusing on confirmed TB cases is a new activity, which is expected to increase overall detection of PLHIV).
- Implement family based approach for TB/HIV care including screening of partners of TB-HIV co-infected index cases, family members and household contacts for both TB and HIV at priority sites.
- Initiate CPT and ART for all HIV positive TB cases in a timely manner, and routinely screen all PLHIV in care for TB and provide IPT to at least 50% of newly enrolled PLHIV after excluding active TB.
- Evaluate all PLHIV with presumptive TB using GeneXpert® and initiate TB treatment for those diagnosed with active TB in a timely manner.
- Currently there are 106 GeneXpert® machines in the country procured by different stakeholders, and 23 more are in the pipeline with a long-term goal of covering all hospitals and high case load health centers with GeneXpert® placement. The FMOH has a plan to make these machines accessible to all facilities by networking them with the diagnostic centers

through sample referral mechanism (postal system). PEPFAR-E will support HR capacity building, procurement of supplies, EQA for the TB diagnostic services and support scale up of rapid diagnostic services such as GeneXpert® and sample transportation system.
- Strengthen referral linkage across the different TB/HIV service outlets and LTFU tracking system. Regional Health Bureaus will be tasked to utilize PEPFAR funds to assure that TB found to be co-infected with HIV at a site that does not provide ART are successfully linked to an ART site and are started on ART.
- Track and report TB/HIV activities using standardized tools.
- Pilot integrated ART service at the TB clinics at selected health facilities in scale-up woredas.

While these activities will be focused in scale-up SNUs, screening and prevention of TB, as well as TB and HIV treatment for co-infected patients will remain part of a basic package of services in all areas with ongoing PEPFAR support. Likewise, TB infection control will continue to be a priority focus that will be supported at all scale up and maintenance sites to prevent transmission of TB at the health facilities.

4.8 Adult treatment

As noted in Section 4.5, a country-wide test kit shortage in FY15 precipitated by WHO decertification of Ethiopia's HIV screening test highlighted testing strategies and policies which result in over-testing of low-risk populations and test kit shortages in settings where positive yield is likely to be high. In addition to the challenges of identifying the hard to reach PLHIV, these policies also significantly contributed to Ethiopia meeting only 54% of its TX_NEW 2015 targets. In FY16 PEPFAR-E technical staff is providing strong TA to FMOH to revise these testing policies. The initiation of Test and START is essential to achieving ambitious treatment targets for FY17, which will require an average of a 3.5 fold increase in TX_NEW in FY17 compared to FY15 in the 20 large towns targeted for saturation.

Through its "Catch-Up Campaign", the FMOH will allocate a major portion of recently procured test kits to PEPFAR scale-up SNUs with a primary focus on the 20 priority towns selected for saturation and incorporating more targeted testing strategies. PEPFAR-E will leverage two other FMOH initiatives to achieve its treatment targets. It will support the Ministry's Compassionate and Respectful Care initiative by funding sensitization trainings for providers reinforced through RHB mentors; and it will align its strategy of encouraging priority town leaders and mayors to actively champion local HIV epidemic control with the FMOH's Cities Initiative.

PEPFAR-E expects that improvements in achieving the first 90 will drive achievement of its treatment targets, as linkage and retention indicators are already strong. Additionally, adoption of Test and START is expected to bring back into care a large number of PLHIV previously LTFU due to being ineligible for treatment. Test and START is also expected to increase voluntary counseling and testing (VCT) yield as more truly at-risk people are motivated to seek testing, knowing treatment would be immediately available. PEPFAR-E already supports CSW-friendly clinics that provide ART for eligible clients. However, most of these clients' CD4 are > 500 so are not on ART. These women will now all be initiated on ART. In addition, PEPFAR supported drop-in centers that reach harder to reach CSWs will be authorized to provide ART in addition to the currently programmed condom provision, HTS, and STI treatment. Children and partners of CSW will be tested and treated at these sites. Services may also be expanded to include male clients of sex workers (seen during different service hours). Eighty public facilities in scale-up woredas are also developing KP friendly services.

To further strengthen retention PEPFAR-E is proposing alternative service delivery models in targeted towns for saturation. At the time of this writing, the FMOH is still in discussion with PEPFAR-E on how best to pilot the alternative service delivery models. Focus will be on facilities with more than 2,000 PLHIV enrolled on treatment. At these facilities standards of care will be differentiated for patients newly initiated on treatment, stable, and unstable patients (see table below).

Table 4.8.1 Table Comparing Current Service Delivery Models and Proposed Differentiated Service Delivery Models

	Current SDM	COP16 proposed SDM for stable patients (Facility Vs Community)	
Visits	6 to 8 clinical assessments/ ART refills (every 1.5 to 2 months)	2 clinical assessment visits (Q 6 months)	3 to 4 ART refills (Q 03 to 04 months)
Provider	ART Provider	ART Provider	Expert client, case managers, Adherence supporters, peer support groups
Eligibility for ART	CD4 count ≤ 500; all pediatrics HIV patients; all HIV co infected TB patients; discordant couples, all HIV positive pregnant and breast feeding women, all CSWs	All irrespective of CD4	
ART initiation	Multiple visit before initiating ART	Test and Start	
Services	• ARV, CTX, and FP refill • Nutrition monitoring • TB screening • Adherence support (enhanced) and tracking • M&E • PHDP • OI screening and treatment	• **ARV, CTX, and FP refill** • **Nutrition monitoring** • **TB screening** • Adherence support (enhanced) and tracking • M&E • OI screening and treatment • PHDP	• ARV, • TB screening • Adherence Support and tracking • M&E • PHDP (including partner services)
Laboratory testing	• CD4: baseline and then every 06 months • VL: Targeted Other laboratories: need based	• CD4 count: baseline (If possible) and to make decision on CPT discontinuation and initiation of NVP based regimen • VL: at 6 months following initiation of ART, then every 12 months • Other laboratory services: need based	
Stable patient definition	None	1. **Inclusion criteria** • On ART for at least 12 months • Most recent VL 1,000 or less • In the absence of VL, CD4 count should be >350 2. **Exclusion criteria** • Second line treatment • HIV positive pregnant and breast feeding women • Presence of current illnesses (including OI, severe malnutrition and co-morbidities)	

In these communities there will be increased reliance on community-based treatment, consistent with recent changes in Ethiopia's core/near-core/non-core framework, with frequency of facility visits reduced to every six months. Retention, patient satisfaction, and provider satisfaction will be monitored at these sites with the intent of bringing these models to scale. Additionally, mental health services within ART clinics will be expanded, as will resources for food. Adolescent-friendly services will be developed at facilities with large numbers of adolescent clients. These activities, combined with improvements in compassionate and respectful care and stronger community/facility linkages, will result in improvement in overall retention. Community/facility linkage was the most consistently raised issue noted during SIMS visits in Q1 FY16 (10.64% scored a yellow or red for an Adult Care and Treatment CEE with only 2.13% getting a red). RHBs and the Network of Networks of HIV Positives in Ethiopia (NEP+) will be coordinated to address the issue with standard referral log books and mapping of community-based organizations.

Overcrowded waiting areas and long waiting times as well as confidentiality concerns also contribute to loss to follow-up. This will be partially alleviated at sites adopting alternative service delivery models. Additionally, PEPFAR will support renovations to expand waiting areas and increase exam rooms in a limited number of high volume facilities in scale-up SNU. PEPFAR is leading Ethiopia's transition from CD4 monitoring of ART effectiveness to routine VL monitoring, providing a major portion of the reagents, funding for sample transport, training of laboratory staff and clinical providers, and TA in coordinating the transition. More timely and accurate identification of first line treatment failure will also improve retention in treatment and survival. Additionally, PEPFAR will continue to support comprehensive HIV training and refresher trainings, reinforced by mentoring, supportive supervision, review meetings and provision of guidelines and job aids to maintain an informed and skilled workforce. For FY 2017, PEPFAR-E's target for adult TX_NEW in scale-up SNUs is 73,356, which is 71% more than was achieved for both adults and children, countrywide in FY15. If achieved, 20 major towns (including Addis Ababa) and 35 additional woredas will have reached saturation.

4.9 Pediatric treatment

PEPFAR will build upon results achieved in previous years to ensure efficiency and delivery of quality pediatric HIV treatment services through an integrated, comprehensive and family-centered approach. In FY15, the number of children receiving ART was 21,926 and children less than 15 years account for approximately 6% of total number of people on ART. Pediatric ART is provided in over 75% of all PEPFAR-supported sites providing ART to adults.

In FY15, while 58% of adult PLHIV received ART (368,140 currently on ART out of 634,423 PLHIV), only 23% of children less than 15 years old were on ART (21,926 currently on ART out of 95,094 PLHIV). Major barriers to scaling up pediatric care and treatment in Ethiopia include: the test kit distribution and testing prioritization guideline previously described, which has resulted in high volume hospitals in high prevalence towns (Addis, for instance) where pediatric inpatient units are without capacity to test for months at a time; inability to systematically test orphans in part due to legal restraints requiring policy changes; inadequate testing of children of known HIV-positive mothers; weak reporting system to know percentage of HIV exposed infants are tested post-cessation of breast feeding, sample transport challenges with decentralization of EID services, prolonged turn-around-time for getting DNA-PCR results, and insufficient advocacy and limited understanding among the general population about pediatric HIV. Additionally, there

have been no surveillance activities to corroborate SPECTRUM estimates for the number of PLHIV < 15 years of age. The fact that pediatric HIV case detection has lagged so far behind adult HIV case detection has led many to question the SPECTRUM estimates.

Because the baseline performance of pediatric patients currently on ART is so far from 80%, the PEPFAR Family Care and Treatment TWG has come to a consensus to develop region specific targets based on their baseline performance from previous national reports. Key areas of focus will be to contribute towards the three 90s. To achieve the first 90 the following activities will be undertaken: aggressive targeted testing at high yield entry points, testing children of HIV positive adults in care (including children of positive pregnant women enrolled in PMTCT ANC services); improving HIV exposed infant services, testing OVC by strengthening community linkage and the linkage of those testing positive to treatment services. Case managers, Mother Support Groups, and community-based testing implementing partners will play a more active role in assuring that children of adult index cases are tested. There will be also focused testing of children of PLHIV CSWs in PEPFAR supported confidential clinics and drop-in centers.

To achieve the second 90, the PEPFAR program will also support the government and regions to roll out a standardized adolescent package of care, which includes provision of adolescent friendly health services covering issues related to school, adherence, disclosure, sexuality/reproductive health and stigma in sites with high load of adolescent clients. Moreover Test and START of all children (under 15 years of age) will be further strengthened by assuring that it is implemented uniformly in all PEPFAR supported sites. To achieve the third "90", PEPFAR-E will ensure access to VL testing, improve retention rate and decrease LTFU through adherence support activities; and educate patients, clinicians and laboratorians on the importance of routine VL testing. In COP2016, PEPFAR support via the RHBs will also reach health managers at district level to improve their capacity in developing and implementing pediatric HIV work plans and budgets.

4.10 OVC

The OVC portfolio will continue to concentrate on community-based socioeconomic supports in areas served by pediatric care and treatment programs, which are scale-up SNUs. In FY 2017, as funding allows, new enrollments and transition/graduation will be implemented as per the PEPFAR OVC guidelines. Meanwhile, HIV-positive children, the children of HIV-positive parents and caregivers, and HIV-exposed children will also be prioritized for enrollment. The new OVC service delivery program (Yekokeb Birhan follow-on) will continue efforts to contribute to pediatric case finding by focusing both on community and facility-based referral linkages. Furthermore, it will work on specifically targeted young children and adolescents (and specifically adolescent girls) with age-appropriate OVC programming intended to enhance health, HIV education and protection services for these sub-populations. The program will also reinforce home to home counselling using the trained para social workers, and community volunteers in collaboration with urban health extension workers to refer children and caregivers for testing and treatment. The economic strengthening platform like saving and credit groups and local Community Care Coalitions (CCCs) will also be used to enhance both testing and adherence. The testing approach will focus on OVC groups that have had higher testing yields in previous years including street children, children of sex workers, adolescent girls, double orphans, OVC who lost their parents with suspected AIDS, and children with clinical symptoms. Regarding caregivers, the program will give due attention to testing for HIV. Those testing positive will be linked to ART services and will receive all the necessary care and support services as per the PEPFAR OVC guideline.

In Ethiopia, HIV/AIDS, poverty, and poor access to healthcare and education and other factors contribute to child and household vulnerability. According to the FMOH (2015), the HIV related estimates and projections, there are 3,330,549 orphans among whom 336,271 are due to HIV/AIDS.

The OVC program will promote HIV testing and facilitate linkages to prevention services among OVC who test negative (to keep them HIV-free) and to care and treatment services among those who test positive. PEPFAR's OVC program in FY17 will be entirely located in scale-up woredas and reach 50% of its target from the 20 scale-up saturation towns and the remaining from scale up aggressive woredas; and therefore, will be well-positioned to access PEPFAR-supported health services in community and facility settings.

While Ethiopia will not receive resources from central initiatives, the current program will pivot by improving targeting to address the most vulnerable children and adolescents. Integrating Childhood Development (ECD) services and Positive Parenting skills training (including discipline, communication on adolescent risk and HIV disclosure) into care and treatment services of OVC is also planned and will contribute to positive outcomes.

PEPFAR will provide technical assistance to CCCs to promote HIV testing for at risk orphans who are not getting direct PEPFAR support but are living in the community and receive services through the CCCs. Para-social workers, a cadre trained with PEPFAR support, will also contribute to strengthening the bi-directional referral linkage, HIV disclosure, retention and adherence. They also play a significant role in the implementation of OVC transition plans to assure that those transitions go smoothly.

Adolescent prevention services for high risk adolescent OVCs and adolescent support groups for HIV positive OVCs in scale-up saturation towns will also be implemented. In addition, HIV testing and linkage services will be supported at orphanages in scale up OVC program implementation woredas.

PEPFAR will continue to support the training of social service workers. PEPFAR will engage the relevant federal ministries and regional bureaus to recommend deployment of some workers to woredas not covered by the OVC program. These workers should serve as case managers for the OVC in these woredas, assess their needs and link them to health and social services provided by their communities and/or local authorities. Accordingly, community facilitators, para-social workers, and volunteers under each implementing partner conduct regular assessments using Child Support Index (CSI) and individual care plan to detect any improvements of children/families to determine case closure. Ten percent of the targeted children are expected to be graduated from the OVC program and achieved a degree of self-sufficiency while 0.6% will age out of the program.

The Ethiopian social service system and institutions are underdeveloped resulting in shortage of qualified workers and impeding the provision of social services to vulnerable populations including OVCs, families, and adolescent girls. Focusing on local capacity building and workforce development is a cost efficient strategy for transitioning OVC and other HIV/AIDS related social service provision programs and sustaining PEPFAR investments. PEPFAR has actively contributed to improving the availability of social service workers for provision of adequate social services for highly vulnerable children, their families and adolescent girls, and thus has supported GoE rollout of its Social Protection Strategy. The government will deploy this workforce at kebele level and work closely at the community level/e.g. Community Care Coalition). Building the capacity of the Ministry of Labor and Social Affairs, Ministry of Women and Children Affairs, training institutions, and community structures like the CCC will contribute to strengthening the

social services system to prevent and respond to neglect, violence and exploitation of children and adolescents.

Social service workers should serve as case managers for OVC in the scale-up SNUs and assess their needs and link them to health and social services providers (communities and/or local authorities). These cadres have been playing a crucial role in strengthening the bi-directional referral linkage, in assisting with HIV disclosure and adherence counseling, and in implementing a smooth OVC transition plan.

Hence, for FY 2017, PEPFAR will continue to support the training of social service workers and build the capacity of government and the community structure to strengthen the social services system to prevent and respond to neglect, violence, and exploitation of children and adolescents as part of a sustainability strategy for the OVC program.

Table 4.1.5 Targets for OVC and Linkages to HIV Services

District	Estimated # of OVC	Target # of active OVC (FY17 Target)	OVC_KNOWNSTAT*
Adama Town	66,088	7,420	573
Bahir Dar Liyu	67,237	7,549	583
Hawassa Town	57,155	6,417	495
Dese Town	77,961	8,753	676
Gondar Town	79,457	8,921	689
Jimma Town	57,778	6,487	501
Bishoftu Town	78,721	8,838	682
Woldiya Town	45,825	5,145	397
Mizan Aman Town	34,576	3,882	300
Debre Markos Town	55,258	6,204	479
Sodo Town	38,792	4,355	336
Arbaminch Town	37,783	4,242	327
Ambo Town	60,602	6,804	525
Nekemte Town	50,786	5,702	440
Yirga Alem Town	34,362	3,858	298
Kombolcha Town	51,659	5,800	448
Shashemene Town	40,490	4,546	351
Dila Town	35,856	4,026	311
Woliso Town	44,846	5,035	389
Mojo Town	47,927	5,381	415
Goba Town	50,279	5,645	436
Metema	28,796	3,233	250
Debre Tabor Town	43,429	4,876	376
Adigrat Town	41,374	4,645	359
Debre Birhan Town	79,333	8,907	688
Finote Selam Town	37,845	4,249	328

Butajira Town	35,013	3,931	303
Kobo Town	39,457	4,430	342
Sebeta Town	34,362	3,858	298
Adwa Town	24,826	2,787	215
Bichena Town	27,860	3,128	241
Dugda	41,606	4,671	361
Shewa Robit Town	41,374	4,645	359
Lalibela Town	40,410	4,537	350
Bure Town	45,620	5,122	395
Debark Town	31,770	3,567	275
Kalu	31,432	3,529	272
Kemisie Town	38,504	4,323	334
Dengila Town	35,966	4,038	312
Dembia	29,749	3,340	258
Adet Town	45,122	5,066	391
Nifas Mewcha Town	27,032	3,035	234
Dukem Town	23,487	2,637	204
Burayu	34,362	3,858	298
Welkite Town	28,190	3,165	244
Bati Town	29,401	3,301	255
Mekaneyesus Town	35,623	4,000	309
Yirgachefe Town	31,218	3,505	271
Dejen Town	30,470	3,421	264
Becho	9,416	1,057	82
Alaba	20,111	2,258	174
Batu (Ziway) Town	49,308	5,536	427
Bako Tibe	42,779	4,803	371
Boditi Town	9,929	1,115	86
Hosaena Town	15,177	1,704	132
Areka Town	20,689	2,323	179
Addis Ketema Woreda 4	16,965	1,905	147
Addis Ketema Woreda 5	12,828	1,440	111
Addis Ketema Woreda 9	18,621	2,091	161
Adi Haki	7,798	875	68
Akaki Kality Woreda 2	5,592	628	48
Akaki Kality Woreda 3	7,036	790	61
Akaki Kality Woreda 4	4,549	511	39
Akaki Kality Woreda 5	3,518	395	30
Akaki Kality Woreda 6	4,756	534	41
Akaki Kality Woreda 7	4,343	488	38

Akaki Kality Woreda 8	5,174	581	45
Akaki Kality Woreda 9	3,724	418	32
Arada Woreda 1	6,158	691	53
Arada Woreda 2	7,348	825	64
Arada Woreda 3	6,967	782	60
Arada Woreda 4	6,687	751	58
Arada Woreda 5	5,290	594	46
Arada Woreda 6	3,275	368	28
Arada Woreda 7	6,951	780	60
Arada Woreda 8	910	102	8
Arada Woreda 9	1,455	163	13
Arada Woreda 10	6,618	743	57
Ayder	10,268	1,153	89
Gulele Woreda 1	6,655	747	58
Gulele Woreda 2	6,824	766	59
Gulele Woreda 3	6,824	766	59
Gulele Woreda 4	6,427	722	56
Gulele Woreda 5	6,824	766	59
Gulele Woreda 6	6,824	766	59
Gulele Woreda 7	15,658	1,758	136
Gulele Woreda 8	4,756	534	41
Gulele Woreda 9	9,787	1,099	85
Gulele Woreda 10	7,655	859	66
Hawilti	6,438	723	56
Kedamay Weyane	5,893	662	51
Kirkos Woreda 1	3,111	349	27
Kirkos Woreda 2	2,830	318	25
Kirkos Woreda 3	2,931	329	25
Kirkos Woreda 10	2,714	305	24
Kirkos Woreda 11	2,714	305	24
Kolfe Keraniyo Woreda 1	16,907	1,898	147
Kolfe Keraniyo Woreda 4	4,925	553	43
Kolfe Keraniyo Woreda 5	12,638	1,419	110
Kolfe Keraniyo Woreda 6	8,898	999	77
Kolfe Keraniyo Woreda 7	2,481	279	22
Kolfe Keraniyo Woreda 8	7,893	886	68
Kolfe Keraniyo Woreda 9	3,253	365	28
Kolfe Keraniyo Woreda 10	8,898	999	77
Kolfe Keraniyo Woreda 11	8,612	967	75
Kolfe Keraniyo Woreda 12	9,226	1,036	80
Kolfe Keraniyo Woreda 13	8,231	924	71

Kolfe Keraniyo Woreda 14	4,327	486	38
Kolfe Keraniyo Woreda 15	4,782	537	41
Quiha	10,400	1,168	90
Semen	8,871	996	77
Yeka Woreda 1	1,333	150	12
Yeka Woreda 2	1,206	135	10
Yeka Woreda 3	1,301	146	11
Yeka Woreda 4	1,280	144	11
Yeka Woreda 5	1,439	162	12
Yeka Woreda 6	1,280	144	11
Yeka Woreda 7	1,074	121	9
Yeka Woreda 8	1,227	138	11
Yeka Woreda 9	1,375	154	12
Yeka Woreda 10	1,412	159	12
Yeka Woreda 11	1,069	120	9
Yeka Woreda 12	1,423	160	12
Yeka Woreda 13	1,037	116	9
Total	**2,692,976**	**302,352**	**23,342**

*This total is OVC only and does not include caregivers. The total in the data pack includes both OVC and caregivers.

Please see the OVC Phased Transition Plan Narrative and Worksheet, which were submitted separately from the SDS for COP16.

5.0 Program Activities in Sustained Support Locations and Populations

5.1 Package of Services in Sustained Support Locations and Populations

PEPFAR will continue to provide technical support to assure quality of prevention, care, and treatment services in sustained woredas. This technical support will include quarterly HIV - focused mentoring at ART and PMTCT sites that have identified at least five PLHIV in the prior year, supportive supervision, provision of in-service trainings, availing all current guidelines to all sites, and provision of job aids. Additionally, laboratories at facilities in these woredas will be the same sample transport system as exists in scale-up woredas to transport VL tests to regional labs. These labs will be provided with reagents and other supplies required for CD4 testing and monitoring for ART toxicity, sample transport services to regional laboratories for test such as VL not available locally, and a limited list of commodities, including some drugs used for treatment of opportunistic infections.

The package of services offered to patients at these sites is as described in the Comprehensive HIV Guideline (2014) and modified in FY16 (re: VL monitoring) includes the following:

- Targeted HIV testing and counseling service to pregnant women, patients with suspected OI including TB, partner and children of known HIV positive clients, STI clients, victims of rape, children at high-yield entry points, as well as orphans with unknown HIV status.
- PITC services (VCT will continue to be provided but will not be supported with PEPFAR funds).
- Care and treatment activities including WHO clinical staging, TB screening, screening and management of opportunistic infections, psychosocial services, peer support groups and adherence counseling, provision of co-trimoxazole prophylaxis, components of PHDP service, nutritional assessment and counseling, baseline CD4 test and subsequently if needed to cease co-trimoxazole preventive therapy (CPT) or if a switch to a Neverapine (NVP) containing regimen is being considered, ART to eligible patients, and VL monitoring, as it is scaled up nationally.
- Option B+ PMTCT services (detailed below).
- Case management for purposes of providing adherence support and retrieval of patients who have missed appointments will also be sustained. However, the additional support to enhance their capacity including financing of mobile phone access will be confined to scale-up woredas.

PMTCT services at sustained support areas and populations will include:

- Testing of all partners and children of known HIV-positive PMTCT clients using the family matrix.
- Providing quarterly mentoring and supportive supervision visits. In contrast, scale up sites will have more frequent (monthly) mentoring visits.
- Providing in-service PMTCT trainings as needed.
- Availing all current guidelines to all sites promptly.
- Providing PMTCT job aids.
- Providing Option B+ PMTCT services as per national guidelines.
- Providing EID to all HEIs at 6-8 weeks of age.

- Linking HIV infected children promptly to ART.
- Tracking and monitoring all HEIs according to national guidelines including regular growth monitoring and developmental checks, TB screening, NVP and cotrimoxazole prophylaxis. Tracking of HEIs will continue until their final HIV outcome status is known after cessation of breastfeeding.
- Tracking and monitoring all HIV-positive pregnant and lactating women enrolled in PMTCT according to national guidelines including regular WHO clinical staging, CD4 and VL levels, TB screening, adherence counseling, cotrimoxazole, and isoniazid prophylaxis, integrated reproductive health services, STI screening, nutritional assessment and counseling and support, ART at labor and delivery.
- Supporting follow-up and tracking defaulted PMTCT mothers and HEIs by mentor mothers and mother support groups (MSG). However, scale-up woredas will have intensified MSG support.
- Providing training on CQI and quality assurance as part of the new PMTCT training modules.
- Implementing the new mother baby pair cohort monitoring tool when it becomes available.

Quality Assurance and Quality Improvement (QI/QM)

PEPFAR-E will support FMOH and RHBs to further institutionalize QI/QM for HIV/AIDS services at sustained support locations. Here, PEPFAR-E will support: rolling out the recently launched national healthcare quality improvement strategy; developing HIV QI framework; and coordinating/harmonizing QI/QM initiatives at health facilities. Approaches will include: integrating patient feedback into quality improvement; use of structured learning and mentoring on improvement science for health leaders and healthcare workers; stocktaking of current HIV QI/QM implementation; and supporting health facilities to identify specific areas for improvement from HMIS, SIMS, and patient feedbacks.

Moving from COP15 to COP16, considering the major strategic shift and need to focus on the scale-up woredas, we have increased TX_CURR by 4% from 73,018 to 7,596. This is translated into treatment new, testing, and TB targets.

We have no targets in centrally-supported areas, so no target based budgeting. Only facility-based activities have target-based budgeting for sustained with lower UEs than the scale-up aggressive and scale-up saturation woredas (e.g. UE for adult ART in sustained woredas is $95.68 compared to $109.26 in sustained). PP and KP related prevention activities have no targets in sustained woredas and no budget for sustained. VCT is also not being funded in Sustained woredas, nor are community-based outreach services or demand creation.

In general, a lump sum one time budget $2,706,903 in the PBAC under HTXS is meant for system-level investment to ensure high-quality ART services in centrally-supported SNUs are maintained post-transition of those SNUs from PEPFAR to the FMOH and RHBs. The mechanisms credited with this lump sum are Columbia University – International Center for AIDS Care and Treatment Programs (CU-ICAP), SNNPR HB, Amhara RHB, Oromia RHB, and Tigray RHB. The CU-ICAP mechanism includes its TA support at FMOH and RHB levels, as well as the four emerging regions where it is also providing site-level support at facilities in scale-up and sustained woredas.

Table 5.1.1 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts				
Sustained Support Volume by Group	**Expected result APR 16**		**Expected result APR 17**	**Percent increase (decrease)**
HIV testing in PMTCT sites	PMTCT_STAT	547,589	567,285	3.6%
HTS (only maintenance ART sites in FY17)	HTS_TST	1,458,759	1,489,898	2.1%
Current on ART	TX_CURR	73,018	75,961	4%
OVC	OVC_SERV	93,959	0	(100%)

HTS

In sustained SNUs, testing targets assume passive testing based on the provider's judgment. Targets also assume lower linkage to care (80%), but HIV yields have been adjusted upward by 25% compared to FY15 performance assuming the national roll out and advocacy on targeted testing will have effect on HTS services in sustained SNUs. VCT targets in these SNUs were shifted to PITC, which saved $700,000. This savings will be allocated to strengthen partner notification and linkage to HTS in the 20 priority towns. HTS service packages in sustained SNUs include support to maintain high-quality HTS, and national level targeted testing advocacy support, which will have effect on all SNUs. To ensure the quality of HTS at sustained SNUs, programs will do need-based counselor training on HTS and quarterly supportive supervision. There will also be national level targeted testing advocacy support through Federal FMOH using local media with reinforcement through supportive supervision to the respective Regional Health Bureaus. Taking these factors into consideration, the required resources for these activities were calculated using the lowest UE for PITC.

Other Prevention

There will not be community-based prevention activities except for a small amount of activities supported by DOD and work sites. Healthcare providers in public health facilities will be encouraged to provide HTS services to STI patients and provide the appropriate care to the survivors of the GBV.

VMMC

PEPFAR-E supports VMMC programs in few of the sustained SNUs, with a total budget of $387,125. The VMMC programs are located in remote parts of the country where HIV prevalence is high, but sparsely populated with a lower HIV burden compared to the densely populated major urban areas.

Resource for Sustained SNUs	Budget
Adult Tx	$ 6,060,542
Adult Pr-ART	$ 75,193
Ped ART	$ 533,243
Ped Pre_ART	$ 140.78
CBCTS (Pregnant women tested and receiving results)	$ 1,114,986
Women receiving ARV prophylaxis	$ 433,531
PMTCT (infants tested)	$ 223,153
PICT	$ 931,985
VMMC	$ 387,125
Total	$ 9,759,898

5.2 Transition plans for redirecting PEPFAR support to scale-up locations and populations

As our RHB implementing partners demonstrate proficiency in providing services at the facility level without PEPFAR support in centrally-supported woredas, they will be gradually charged with increasing their geographic coverage to include sustained woredas. This will require additional domestic investment. PEPFAR will be negotiating with GoE to increase their financial footprint to enable the transition to continue without jeopardizing patient care. PEPFAR is no longer funding implementing partners to work at the community level in sustained woredas to create demand or conduct outreach services to KP. Those activities were transitioned to local CSOs and government agencies. Meanwhile, as saturation is achieved in scale-up saturation woredas, PEPFAR resources will be directed toward meeting saturation targets in scale-up aggressive woredas, while also continuing limited financial support in sustained woredas while government takes on greater ownership.

For OVC, teams should describe a phased transition plan based on careful planning and using evidence informed graduation models to ensure continuity of services for children who will shift to non-PEPFAR funded service providers. To assist in planning, teams should leverage the OVC section in the Summary & Targets tab of the Data Pack.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

To achieve the 90-90-90 goals and sustain the epidemic control in Ethiopia, PEPFAR Ethiopia identified three key programmatic gaps:

1) **Insufficient identification of new HIV-positive persons:**
    - Persistent stigma is a barrier to accessing HTS, especially for the highest-risk, most-marginalized populations. Enabling environments must be created at both the community and facility level. PEPFAR is addressing this through its efforts in the 20 target towns to involve mayors in proclaiming the town to be "stigma-free" and promoting testing for anyone exposed to HIV risk. PEPFAR is also supporting community outreach activities targeting the most at risk populations. At the facility level, PEPFAR is supporting the Ministry's Compassionate and Respectful Care initiative, that is intended both to promote community perception of and actual experience at public health facilities. Additionally, PEPFAR is supporting testing at "KP-friendly" service delivery points including confidential clinics and drop-in centers located in urban "hot spots" where KP work.
    - Test kit shortages at site level have significantly contributed to insufficient identification of new HIV-positive persons. The system level causes for this include: an inappropriate algorithm for test kit distribution, which results in an over-supply in areas with low background HIV prevalence and shortages in geographic areas with high HIV prevalence; national testing guidelines, which recommend testing broad population groups (e.g. 15-24, all children seen at Under-5 clinics); not utilizing MCH funding for testing of pregnant women, resulting in prioritizing pregnant women for testing with PEPFAR-funded test kits when test kits supplies are limited, resulting in missed opportunities to diagnose HIV in sick PLHIV accessing health services; and woreda-level planning that focuses on meeting testing targets rather than targets established for PLHIV identified. PEPFAR is championing changes in national policy to address these issues.
    - There are no national systems in place to actively identify PLHIV who are not accessing testing facilities by their own initiative. PEPFAR is addressing this by having implementing partners develop STI and HIV partner-notification systems, testing of family members of identified PLHIV, testing orphans, and making testing services available in prisons and at worksites that attract mobile workers.
    - There is limited epidemiological data to target HTS on the high-yield SNUs. PEPFAR-E will work with FMOH and the Ethiopia Public Health Institute (EPHI) to quantify and mapping KP and PP in selected geographic location.

2) **Inadequate systems to assure linkage, retention, and virologic suppression of identified PLHIV:**
    - Absence of unique identification numbers assigned to every individual in the country contributes to difficulty assuring that patients identified at a testing site are linked to care and treatment. PEPFAR-supported facilities for KP are utilizing finger print technology to address this gap, but GoE does not have a similar plan, so this will continue to be a challenge. Accompanied referral and strengthening referral mechanisms are being

funded, as are multi-disciplinary team meetings within facilities, and catchment area meetings that connect referring sites to referral facilities.

- Community-based government health cadres (Health Extension Workers) in some communities assist facilities in tracking patients who have missed appointments, thereby contributing to patient retention. However, this is a cadre with many responsibilities. This, as well as the need to assure patient confidentiality, limits their involvement in assuring patient retention. PEPFAR-E supports case managers and adherence supporters at facility level and community level care and support services as well as community level tracking and linkage services for patients who have missed appointments or been LTFU.
- Pre-ART patients are at greatest risk of being LTFU. This retention problem will be solved once the GoE adopts Test and START. PEPFAR-E is providing TA that is intended to overcome current government concerns about adopting this policy.
- PEPFAR-E will pilot alternative service delivery models for stable patients. This is expected to lead to system-level guideline revisions that will alleviate the burden of frequent facility visits for stable patients and is expected to improve retention.
- Long-term retention is dependent on assuring that patients are virologically suppressed. In FY16 the FMOH adopted a routine VL monitoring policy. Successful implementation of this policy will improve retention by decreasing time patients are exposed to a failing treatment regimen. The FMOH is currently cascading the new policy across the country. PEPFAR-E will be monitoring the success of this implementation plan and assist GoE in overcoming any bottlenecks. PEPFAR-E is also building system-level capacity by implementing laboratory quality management systems, including regional External Quality Assessments (EQA) in SNUs supported by respective implementing mechanisms; supporting national leadership, coordination, and capacity-building of laboratory systems; and supporting the implementation of laboratory information systems.

3) **Inadequate domestic spending to support sustained HIV care & treatment**
   - PEPFAR will invest in capacity-building for CSOs to mobilize and utilize domestic resources for the implementation of community-based services to PLHIV; providing technical assistance for the Ethiopia Health Insurance Agency (EHIA), RHBs, and woreda administrations in implementing social health insurance and community-based health insurance initiatives; providing technical assistance to the Pharmaceuticals Fund and Supply Agency (PFSA) and RHBs to link private facilities to the national supply chain system; and providing supply chain management and commodity security TA.
   - To ensure that a secure, reliable and adequate supply of high-quality products are available in Ethiopia, including: drugs, lab and medical supplies; health items, and equipment required for effective and efficient HIV/AIDS prevention, care and treatment; developing capacity and capability for pharmaceutical logistics management at region and lower levels to utilize resources and to coordinate the efforts of various stakeholders.
   - Strengthening the health commodity management information system; and strengthening supply chain management, leadership, and partner collaboration.

Table 6.1.1 Key Programmatic Gap #1: Table 1 INSUFFICIENT IDENTIFICATION OF NEW HIV-POSITIVE PERSONS						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Testing in low prevalence populations; exhausting HIV RTK; GoE allocation of RTK by non-epi criteria	Govt. Policy changed to allocate HIV RTK according to epi needs (ASAP! But definitely <3yrs)	Activity 1: Strengthening the implementation of targeted HIV testing with particular focus to scale up SNUs	HVCT	$77,056	17908 (FMOH)	
	Evidence based estimates of PLHIV at scale-up woredas for RTK quantification and distribution	Activity 2: Provide training to Urban Health Extension Workers to implement targeted testing in urban settings for high risk groups and pregnant women; Develop, distribute and train on tools (referral slips and registers) for urban health extension workers to track referrals for HTC services; Strengthen the communication and referral linkage between HCs and Urban Health Extension Professionals (UHE-Ps) for HTC or ART services	HVCT (66%) MTCT (17%)	$450,000	14210	
	Identification of 90% of all PLHIV in Ethiopia in scale-up and aggressive scale-up <3yrs		HBHC (17%)			

		Activity 3:Conduct operational research and situational analysis to inform project strategies	HVCT, (10%) MTCT, (10%) HTXS, (10%) HBHC, (10%), PDTX, (10%), PDCS, (10%), HVTB, (20%), HLAB, (10%), HVOP (10%),	$196,170	ET_17824	Light Green
		Activity 4: Support the distribution and supply of HIV test kits and STI kits for most at risk populations, as well as free condoms for HIV prevention as part of the combination prevention package.	HVOP	$150,000	14228	Commodity Security and Supply Chain, performance data, access and demand, technical efficiency. YELLOW
		Activity 5: Support the supply and targeted distribution of free condoms for HIV prevention as part of the combination prevention package, in collaboration with government.	HVOP	$50,000	14228	Commodity Security and Supply Chain technical efficiency, access and demand. YELLOW
		Activity 6: Support External quality assurance at each implementation site; networked health facility in the community providing clinical service to MARPs.	HVCT	$60,000	14228	Quality Management, Technical Efficiency. RED

Insufficient innovative methods to identify HIV-positives, HIV transmission networks, etc.	Identification of 90% of all PLHIV in Ethiopia in scale-up and aggressive scale-up <3yrs*	Activity 1 Strengthening the Health Management Information System through printing distribution and Supportive supervision, as well as providing training on HMIS for its own staff and emerging regions of Afar, Benishangul, Somali and Gambella	HVSI	**$544,957**	**17908 (FMOH)**	15. Performance Data
	Report published with strong evaluation of effectiveness of innovative methods for detecting new PLHIV in Ethiopia	Strengthening the FMOH implementation of HIMS/HIS and provide technical support by international partner		$1,362,724	(TBD (Tulane follow-on	
		Activity 2 :Health Facility site level HIV service data management support	HVSI	$98,690	13934(AACHB)	
				$205,211	16752 (ARHB),	
				$19,837	13929 (DDRHB),	
				$19,837	13770 (HRHB),	
				$279,722	13794 ((ORHB),	
				$180,079	16901(SNNPRHB)	
				$86,294	17000 (TRHB)	
				$40,969	12319(FPC)	
				$112,635	16742 (NDFE)	
				$155,969	16749 (ICAP)	
		Activity 3: Community site level data support by updating and standardizing client monitoring system and implementation	HVSI	$19,264	12301 (OSSA)	
		Activity 4: Coordination and implementation of TB/HIV, STI/HIV and PMTCT Surveillance	HVSI	$435,366	16751 (EPHI),	13. Epidemiological and Health Data
				$24,672	13934(AACHB)	
				$51,303	16752 (ARHB),	
				$4,959	13929 (DDRHB),	
				$4,959	13770 (HRHB),	
				$69,930	13794 ((ORHB),	
				$45,020	16901(SNNPRHB)	

				$21,573	17000 (TRHB)	
		Activity 5: Adapt and support the implementation of evidence based STI and PLHIV partner notification and linkage to HTS system in Scale up SNUs	HVCT	191,812	10559 (NASTAD)	
		Activity 6: Strengthening index family testing through disclosure support, Partner notification and linkage to HTS in Scale up SNUs,	HVCT	191,812	TBD (NEP+ follow on)	
		Activity 7: Review of the progress at mid -term to see the extent to which the MULU/MARPs project fulfilled its intended objectives focusing on the three main expected intermediate results	HVOP	250,000	14228	Performance data. YELLOW
		Activity 8: Facilitate and support the establishment of Bio-behavioral information centers by the taskforce and Support worksites with a mini-media equipment [This activity will continue under a different mechanism as of COP16]	HVOP	$16,672	14230	Yellow
		Activity9: Operational researches and situational analysis to inform project strategies	HVOP	120,000	14228	Performance data. YELLOW
			HBHC	$44,787.60 $678.60		Light Green 17825

		Activity 10: To conduct baseline assessment and get critical baseline information on the capacities of host government, civil society organizations, communities and families to effectively plan, deliver and optimize comprehensive continuum of HIV care services.	HTXS PDCS MTCT OHSS HVOP HVSI	$1,357.20 $7,464.60 $6,107.40 $2,714.40 $4,750.20		
Insufficient, reliable, subnational and local HIV epi data to target HIV testing and allow setting of proper targets	Avail comprehensive map of key population for targeted HIV testing in Ethiopia in <3yrs	Activity 1: Quantification and mapping of Key population and priority population in selected geographic locations. Information generation and dissemination on HIV/AIDS, STI and TB	HVSI	$600,006 $100,000	16738 (EPHA) 16751 (EPHI)	13. Epidemiological and Health Data
		Activity 2: Support the size estimation study to build on and expand to new towns within prioritized SNUs.	HVOP	$200,000	14228	Epidemiological and Health Data, Allocative Efficiency, Technical Efficiency, performance data, Access and Demand, Planning and Coordination. YELLOW

		Activity 3: Support to conduct qualitative and quantitative research on underlying factors for vulnerable adolescent girls that put them at high risk of HIV infection and characterize the path ways of these girls that lead them to sex work and transactional sex practices. Conduct biomarker survey among high risk adolescents [This activity will continue under a different mechanism as of COP16]	HVSI	$150,000	10564	Yellow
		Activity 4: Integrated biological & behavioral survey among Adolescents. The IBBS will collect information on many key parameters of programmatic importance.	HVSI	$500,000	TBD	Epidemiological and Health Data. YELLOW
Persisting stigma regarding HIV infection inhibiting testing, disclosing, and 100% linkage to services	Catalyze a powerful coalition to address stigma leading to a 50% reduction in the HIV Stigma Index by 3 yrs.	Activity 1: Use national platform to advocate for reduction of stigma and partner disclosure promotion. Adapt evidence based stigma reduction strategies. Documentation of best practices of stigma reduction activities that contribute to meet the 90-90-90 goals	HVOP	$55,358	13931 (FHAPCO)	

		Activity 2: create public awareness, educate the community and strengthen PLHIV associations' capacity and engagement	HTXS	$150,000	TBD (NEP+ follow on)	
		Activity3: The project will continue to support law enforcement bodies on gender mainstreaming and development of a joint action plan among various stakeholders in priority SNUs	MTCT (66%), HBHC (34%),	$10,020	14351	
		Activity 4: Support to conduct Stigma and discrimination index survey	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$29,858 $452 $905 $4,976.40 $4,071.60 $1,809.60 $3,166.80	17825	Yellow
Inadequate partnerships and coordination at community level and between community & clinics to assure identification and linkage of every PLHIV	Improve by at least one point on a 5-point scale the measurement on a Scorecard for Partnerships and Coordination of HIV-engaged Organizations at the Community Level within 3 yrs. [NOTE: One activity under this Outcome will be to either find or develop the tool.]	Activity 1: Develop and implement regional HIV Strategic plan that includes major stakeholder	OHSS	$79,362	13931 (FHAPCO)	Planning and Coordination (Score 7.87, light Green)
		Activity 2: Coordination of national regional, zonal and woreda or town level prevention activities to meet the first 90 of 90-90-90 UNAIDS goal.	HVOP	$40,000	13931 (FHAPCO)	Planning and Coordination (Score 7.87, light Green)
		Activity 3: Advocate the implementation of Test & START strategy and coordinate efforts at all level using different forums	HVOP	$40,000	13931 (FHAPCO)	Planning and Coordination (Score 7.87, light Green)

		Activity 4: Establish and Strengthen national and regional prevention working groups and provide need based support for the technical working group.	HVOP	$20,000	13931 (FHAPCO)	Planning and Coordination (Score 7.87, light Green)
		Activity 5: support for coordination and leadership of town level activities where organizations such as PLWHA association, woreda health office, woreda HAPCO are summoned to discuss on town level MAPRs interventions	HVOP	$100,000	14228	Oversight and Stewardship, access and demand, Performance data. RED
		Activity 6: Build the organizational and technical capacity of local organizations (including local non-government orgs') by providing grant to implement high impact community level interventions for PLHIV	HVOP	$350,000	14228	YELLOW
		Activity 7: Organize national conference involving key national and regional stakeholders and follow up the implementation of conference recommendations	HVOP	$13,884	14230	Light green

		Activity 8: Strengthen Woreda level multi-sectoral HIV prevention structure in development clusters and other high risk sites [This activity will continue under a different mechanism as of COP16]	HVOP	$11,000	14230	Dark Green
		Activity 9: Build the organizational and technical capacity of local organizations (including PLHIV associations and faith based organizations') by providing grant to implement high-impact, community-level interventions for PLHIV [This activity will continue under a different mechanism as of COP16	HBHC PDCS MTCT HVSI	$375,000.00 $10,000.00 $80,000.00 $35,000.00	14217	Yellow
		Activity 10: Provide technical and financial support to strengthen the system for coordination and collaboration among community level major stakeholders	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$29,858.40 $452.40 $905 $4,976.40 $4,071.60 $1,809.60 $3,166.80	17825	Dark Green
		Activity 11: Quality of community based interventions improved"	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$223,938 $3,393 $6,786.00 $37,323.00 $30,537.00 $13,572.00 $23,751.00	17825	Yellow
TOTAL						

Table 6.1.2 Key Programmatic Gap #2: INADEQUATE RETENTION AND ADHERENCE IN ART & ACCESS TO LAB, ESP. VL						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Lack of innovative, streamlined, patient-centered ART services	Streamlined, patient-centered ART service model implemented for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs.	Activity 1: Improved case detection and early initiation of treatment through contact tracing and linkage program using disease intervention specialists	HTXS	$119,911	10559 (NASTAD)	
		Activity 2: HIV-positive peers are linked to newly identified patients and provide ongoing, routine, in-person practical and emotional support to patients at their homes, and address patient-specific barriers as they present, and enhance linkage	HTXS	$243,454	10559 (NASTAD)	
		Activity 3: Provide TA support to RHBs on Data-driven HIV/AIDS QI/QM implementation at health facilities to address gaps in the implementation of patient centered ART services	OHSS	$300,000	TBD (CHAI follow-on)	Quality Management (Score 1.62, *Red*
		Activity 4: Implement CQI at health facilities to improve quality of ART service delivery. Strengthen Multi-Disciplinary Team (MDT) at health facilities and support Catchment Area Meetings (CAM) to deliberate and review site level performance and development improvement plan	HTXS HBHC	$1,635,000	13934(AACHB) 16752 (ARHB) 13929 (DDRHB) 13770 (HRHB) 13794 ((ORHB) 16901 (SNNPRHB)	Quality Management (Score 1.62, Red

					17000 (TRHB)	
					12319 (FPC)	
					16742 (NDFE) 16749 (ICAP)	
					12319 (FPA)	
					TBD (FGAE)	
					10601 (AAU)	
					12321 (UoG)	
					13932 (HrU)	
					10548 (JU)	
					10517 (HaU)	
					10557 (MU)	
		Provide technical assistance to FMOH & RHBs in monitoring the implementation of consolidated national HIV prevention, treatment, care and support guidelines	HTXS MTCT PDTX OHSS	$37,685.95 $15,206.61 $9,256.20 $3,966.94	14309	Light Green
		Support the FMOH to conduct TOT training on comprehensive HIV care/ART (adult & pediatrics) & PMTCT	HTXS MTCT PDTX OHSS	$9,421.49 $3,801.65 $2,314.05 $991.74	14309	Yellow
		Initiate test and start services in DICs in 20 towns to avail treatment services for KP in these community. Adherence clubs will also be established to provided adherence and retention services in the community for KP	HTXS HVOP HBHC HVCT	$862,000 $200,000 $400,000 $100,000	14228	

		Support FHAPCO to review existing community based HIV prevention, care and treatment guideline for PLHIV based on international standards	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$59,716.80 $904.80 $904.80 $1,809.60 $9,952.60 $8,143.20 $3,619	17825	Light Green
Weak referral and tracking of HIV-positive persons	Monitor and assure effective referral of HIV-positive persons and linkage to ART, including rollout in all saturation and scale-up areas in 3 years	Activity 1: The establishment of HIV case surveillance	HVSI	$329,298	10559 (NASTAD)	13. Epidemiological and Health Data
	95% of HIV+ people linked and referred to Art services in 3 years	Activity 2: strengthening the site level data management support at FGAE CSW clinics	HVSI	$28,896	TBD(FGAE follow-on)	15. Performance Data
		Activity 3: Increase demand creation and referral of CSWs to CSWs clinic and strengthen partner notification for STI patients and linkage to HCT	HVOP	$ 150,000	TBD(FGAE follow-on)	
		Activity 4: Develop mother baby pair cohort monitoring and reporting tool to improve retention of HIV positive pregnant/lactating women and their HIV exposed infants on care.	MTCT	$50,000	17908 (FMOH)	
		Activity 5: Provision of community level care and support services complementary to health facility; and support community level tracking and linkage of LTFU PLHIV to health facility services	HBHC (34%), MTCT (66%)	$ 100,000	12306 (OSSA)	
		Activity 6: The project will continue to support identification and referral of pregnant women at community level, linkage for ART services, and adherence and counseling in priority SNUs		$53,993	14351	

		Activity 7: Support activities to strengthen referral-linkage and feedback mechanisms	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$125,405.28 $1,900.08 $3,800.16 $20,900.88 $17,100.72 $7,600.32 $13,300.56	17825	Light Green
		Activity 8: Community level activities are well coordinated and referral and linkage strengthened	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$131,762.80 $2,035.80 $4,071.60 $22,393.80 $18,322.20 $8,143.20 $14,250.60	17825	Light Green
Inadequate access to high quality HIV laboratory services, esp. VL	Quality-controlled VL testing with >98% provision of timely results for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs.'	Activity 1 Implement laboratory quality management system including regional EQA in SNU supported by respective implementing mechanisms	HLAB	$96,320	13934(AACHB)	10. Laboratory (Yellow)
				$298,592	16752 (ARHB)	
	100% of ART sites having access to GeneXpert and TB culture and DST diagnostic test through sample referral network			$43,344	13929 (DDRHB)	
				$43,344	13770 (HRHB)	
				$313,040	13794 (ORHB)	
				$178,192	16901 (SNNPRHB)	
				$115,584	17000 (TRHB)	
				$19,264	12319 (FPC)	
				$48,160	16742 (NDFE)	
				$ 192,640	16749 (ICAP)	
				$ 9,632	12319 (FPA)	
				$28,896	TBD (FGAE follow on)	

Activity 2: National leadership, coordination and capacity building of laboratory systems (laboratory continuous quality improvement, National EQA, strengthening specialized testing services like EID and viral load, HIV rapid test kit validation, equipment management, laboratory information system, laboratory monitoring and evaluation)	HLAB	$740,281 $96,320	16751 (EPHI 13530 (CDC as prime)	10. Laboratory (Yellow)
Activity 3: Support transportation of EID, Viral load, CD4 and MDR TB specimens through Ethiopian Postal Services Enterprise to increase access to quality laboratory services.	HTXS	$1,438,587	16751 (EPHI)	10. Laboratory (Yellow)
Activity 4: Support the implementation of laboratory information system and provide TA to EPHI to build local capacity for Equipment maintenance	HLAB	$143,859	10604(APHL)	10. Laboratory (Yellow)
Activity 5: Technical support on evaluation and implementation of Point-of-care tests including Viral load and EID; certification of laboratories and training of laboratory auditors	HLAB	$85,503	16779 (ASLM)	10. Laboratory (Yellow)
Activity 6: Technical assistance to Ethiopian Public Health Institute and Regional laboratories for implementation of laboratory quality management system	HLAB	$96,320	10515 (CLSI)	10. Laboratory (Yellow)

		Activity 7: Technical Assistance for HR capacity building and QA for regional lab and Health facility labs in TB diagnostic services such as TB culture, GeneXpert, DST, etc.	HVTB	$53,000	16751 (EPHI)	10. Laboratory (Yellow)
		Activity 8: technical assistance for development of implementation guidelines, SOPs, tools for monitoring diagnostic test service utilization and impact		$ 44,000	16750 (WHO)	10. Laboratory (Yellow)
		Support scale up of routine viral load and EID testing in the private health sector.	HLAB	$8,000	ET_17824	Light Green
		Enroll the private health sector laboratories in the national and regional external quality assessment programs for HIV rapid testing and TB. microscopy	HLAB	$11,280	ET_17824	Light Green
Inadequate follow up for patients delayed or lost to follow up, including in community	Greater than 90% retention at 24 months for all adults and children on ART by 3 yrs. from implementation of COP16	Activity 1: Strengthen site level capacity for patient tracing and linkage between facility and community	HTXS	$200,000	TBD (NEP+ follow on)	6. Service Delivery (4.4 score)
		Activity 2: Strengthen case management services to proactively identify and manage patients at-risk for LTFU	HTXS	$800,000	TBD (NEP+ follow on)	6. Service Delivery (4.4 score)
		Activity 3: Strengthen patients follow-up during pretreatment time through provision of peer support and tracking of patients who missed their appointment	HTXS	$300,000	TBD (NEP+ follow on)	6. Service Delivery (4.4 score)

		Activity 4: Implement community level care and support interventions such as psychosocial support, use of telephone reminders, and home to home visit to ensure the wellbeing clients and other high impact care and treatment interventions.	HBHC	$119,294	12306 (OSSA)	6. Service Delivery (4.4 score)
		Activity 5: Support FMOH in developing training material and guidelines to strengthen mental health integration into HIV/AIDS services	HBHC	$40,000	16749 (ICAP)	6. Service Delivery (4.4 score)
		In 2017, the partner will strengthen the supervision and mentoring of volunteers (Women PLHIV, Religious leaders, and other volunteers) at community level.	HBHC (34%), MTCT (66)	$53,993	14351	
		Build the capacity of community health care workers (Members of PLHIV associations and religious leaders) through mentoring and supportive supervision for the proper delivery of high impact community based interventions	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	$116,733.60 $1,809.60 $3,619.20 $19,905.60 $16,286.40 $7,238 $12,667	17825	Light Green
TOTAL						

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Finance				$91,528			
	Provide technical assistance on business development and access-to-finance to private health facility owners and banks to leverage the loan guarantee through the DCA to build their capacity in identifying TB and HIV cases and enroll them in HIV and TB services.	Sustained epidemic control	Hundred (100) private health facilities will accesses financial resources from DCA and will have more capacity to diagnose and provide service to TB and HIV clients.	$91,528.272	OHSS	17824	Light Green
Governance				$ 1,085,806.22			
	Provide technical assistance to relevant public and private health institutions to conduct analysis of health policies and laws impacting the ability of the private sector to engage in delivery of critical health services.	Sustained epidemic control	Policies & legal frameworks will be revised and put in place and there by the number of private health facilities providing HIV services will increase by 50%	$177,170.094	OHSS (100%)	17824	Light Green
	Support the development of public private mix guideline for HIV and constant review of national guidelines and quality management tools as	Sustained epidemic control	Guidelines & operational manuals on public private Partnership for HIV will be	1854 1854 1854 1854	HVCT MTCT HTXS HBHC	17824	Light Green

	per international standards		operationalized in 100 % of the supported private health facilities.	1854 1854 1854 1854 1854 1854	PDTX PDCS HVTB HLAB HVOP OHSS		
	Promote household resiliency among OVC, caregivers and PLHIV in priority SNUS through /by supporting the GOE to develop a national Economic Strengthening (ES) guideline and Standardize ES approaches	Second 90; Sustained Epi Control.	The national Economic Strengthening (ES) Guidelines made available for use by all PEPFAR ES beneficiaries	$ 139,050	HKID	16930	
	Conceive, pilot, evaluate and advance learning for innovative approaches that increase the effectiveness of ES approaches for PEPFAR related outcomes.	Sustained Epi Control.	Relevant economic Strengthening data/information generated in all OVC intervention SNUs (73 woredas) and evidence based decision making enhanced.	$324,450	HKID	16930	
	Provide technical assistance to FMOH to revise the National Guidelines for HIV/AIDS and Nutrition based on available evidence	3rd 90 & sustained epidemic control	100% stakeholders will use the revised National HIV/nutrition Guideline revised to provide standardized HIV/Nutrition service.	$3,244.5 $18,540 $3,708 $20,394	OHSS HBHC PDCS MTCT	14215	Light Green
	Support networking and partnership with National level Advisory and Steering Committees on work place HIV prevention interventions	First 90	Regular meetings will be held and partnership strengthened with the national level advisory and steering committee to oversee HIV prevention workplace	$3,708	HVOP	14230	Light Green

	Provide support for worksites/enterprises to develop gender responsive workplace HIV/AIDS policies	First and second 90	A gender responsive workplace HIV/AIDS policy will be developed and in place for all supported worksites. All worksites will be familiarized with the policy and all worksites will develop and implementation plan to mainstream gender in the worksites	$2,539.98	HVOP	14230	Light Green
	Provide TA to the government for the development of policies, strategies, legal frameworks, and implementation guidelines pertaining to health care financing initiatives including exempted health services and fee waiver systems addressing indigents and PLHIV	Addresses all the triple 90 goals and contributes to the epidemic control	In <3 yrs, increase in GoE budget allocation for categorical HIV programs by 15%, plus commitment to ongoing 5% annual rise	$324,450	OHSS	16912	Yellow
	Provide TA for the FMoH to revise and update the TB, TB/HIV and MDR TB guidelines	1st , 2nd and 3rd 90's	TB, TB/HIV, Leprosy and MDR TB guidelines updated	$50,011.65	HVTB		Light Green
HRH - Systems/Institutional Investments				$ 5,366,428.03			
HRH-Pre service	Build institutional capacity of the universities to deliver quality Medical education : Faculty development, Review curriculum ensure that the HIV section updated, establishing e learning system, skill lab, establishment of networking	#s 1 , 2 and 3	At least one newly graduated physician deployed at 100% of PEPFAR supported high load facilities to deliver quality HIV services, lead and conduct mentorship.	$46,350	OHSS	10601 (AAU)	7. Human Resource for Health (Score 6.0, *Yellow*)
				$92,700		12321 (UoG)	
				$46,350		13932 (HrU)	
				$92,700		10548 (JU)	
				$46,350		10517 (HaU)	
				$92,700		10557 (MU)	

	to facilitate exchange of faculty and supporting educational materials procurement-including books			$46,350 $40,179.888		16742 (NDFE) 12319 (FPC)	
HRH pre- service OHSS	Build the capacity of FMOH to coordinate medical education and facilitate exchange of resource through networking of medical schools. Conduct supportive supervision in collaboration with partners and Ministry of education.	#2,3	27 medical schools produce competent physicians through regular monitoring of quality education in 3 years	$92,700	OHSS	10534 (FMOH)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre- service OHSS	Provide technical (faculty development and curriculum review), material (books and skill lab materials and etc.) and financial support to 20 universities and hospital medical colleges to produce competent physician to deliver quality HIV clinical services. This activity doesn't include 7 universities which have direct CoAg.	# 2, 3	At least one newly graduated physician deployed at 100% of PEPFAR supported high load facilities to deliver quality HIV services, lead and conduct mentorship through TA support to 20 medical schools	$785,740.032	OHSS	16749 (ICAP)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre- service OHSS	Provide technical support through twining partnership between Rice University and Ethiopian higher institutions (Jimma and Addis Ababa universities and Tegbarid Polytechnic colleges) to produce Biomedical engineers technicians; support transition/graduation from twinning partnership - St. Paul hospital Medical College OB/GYN and Addis Ababa University Emergency Medicine residency programs to the respective institutions.	#4	At least one newly graduated biomedical engineer/technician deployed to high HIV burden sites to maintain biomedical equipment.	$ 834,300	OHSS	10599 (AIHA)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre- service	Support the pre-service	#4	In 3 years, 95% of	$ 92,700	OHSS	TBD (CHAI	. Human Resource for

OHSS	masters on hospital care and health administration (MHA) training programs at Jimma, Addis Ababa, Mekelle and Gondar University through TA support from Yale university. Yale university provides faculty development, curriculum review and field work supervision		PEPFAR supported public hospitals services managed by Masters in Hospital Administration (MHA) graduates to spearhead QI/QM activities			follow on)	Health (Score 6.0, Yellow)
HRH pre-service - SI	Support the pre-service education for field epidemiology training program and leadership for strategic information program. The support include faculty development, field work for residents and supervisors and education materials	#4	25 field Epidemiologists graduated annually and deployed to RHBs to lead HIV surveillance activities by 2018	$137,258.109	HVSI	16738 (EPHA)	7. Human Resource for Health (Score 6.0, *Yellow*)
HRH pre-service - SI	Support the diploma training for HIT (Health Information technicians), through faculty development, curriculum review and material support	$4	1000 Health Information Technicians will be trained and deployed in health facilities supported by PEPFAR	$278,100	HVSI	TBD (Tulane follow-on)	7. Human Resource for Health (Score 6.0, *Yellow*)

Pre-service HMBL	7 universities having medical education programs will develop blood safety and transfusion education materials, integrate the material in to the education curriculum of different health cadres (medical, nursing, laboratory and pharmacy students) and provide training to medical education instructors in the university. These activities will enable medical colleges to train all cadres of health professionals to produce adequate & competent health professionals on blood safety and also address the issue of providing basic trainings to new staff, every year.	#s 1 , 2 and 3	7 universities of medical education program use blood safety integrated curriculum to train all cadres of health professionals to produce adequate & competent health professionals on blood safety.	$46,350	HMBL	(FMOH)	7. Human Resource for Health (Score 6.0, Yellow)
	Strengthening pre-service health care workers education for midwives at 48 institutions (26 universities and 22 regional health science colleges) through faculty development, curriculum review, and provision of resource materials and skills lab equipment. This intervention will enhance the knowledge of midwives to manage HIV /AIDS services.	First 90 and Second 90	In 48 teaching institutions HIV core competencies integrated into nursing and midwifery course	$463,500	OHSS	14209	7. Human Resource for Health (Score 6.0, Yellow)

	Strengthening pre-service education for health extension workers at 23 institutions through faculty development, curriculum review, provision of resource materials and skills lab equipment. This intervention will enhance the knowledge of health extension workers to prompt HIV /AIDS prevention.	First 90	In 23 teaching institutions health extension curricula customized and utilized to improve quality of education in 3 years	$370,800	OHSS	14209	7. Human Resource for Health (Score 6.0, Yellow)
	Establishing and/or strengthening in-service training at 35 in-service training institutions including the standardization and institutionalization of IST through increased capacity for planning, implementing, monitoring and mobilizing resources. Assistance includes improving IST trainer capacity, standardizing national training packages, coaching, mentoring, supportive supervision, financial management tools, standard operating procedures. IST is mainly on HIV/AIDS prevention and control.	First 90 and Second 90	In-service training institutionalized in 35 training centers to deliver hands on health and HIV/AIDS training in 3 years	$556,200	OHSS	14209	Yellow
Pre service	Increase the quality and sustainability of social services and case management for OVC and caregivers by building social service workforce development & system strengthening	Contributes for the 1st and 2nd 90 and sustained Epi control)	3000 social service workers/para social workers/ trained and deployed in community and government structures to prevent and respond for neglect, violence and exploitation of	$ 927,000	HKID	17271	

			children & adolescents at risk 3000 para social workers will contributed strengthened referral mechanisms and other systems to ensure cross referrals between clinic and social services (cross-referrals) 10 % OVC and Care givers adherence, HIV disclosure , retention among OVC and caregivers improved 200,000 OVC received quality of social services including case management 20,000 OVC transitioned from the program smoothly with the support of social services workers				

			20,000 OVC transitioned from the program smoothly with the support of social services workers				
Pre service	Improve workforce development and the social services system through TA and capacity development of MOWCA), community platforms (e.g. Community care Coalition(CCC) and training institutions like TVET and School of Social Work	This activity contributes significantly contributes for the 1st and 2nd 90 and sustained Epi control	Built the capacity of the government and community platform (like CCC) to strengthening the child-sensitive social service system in 30 priority SNUs(Woredas)	$278,100	HKID	17271	
			10 Training institutions capacity built to provide quality training on social services workforce development				
			Community and national-level child protection/ GBV prevention and response activities, and referrals to other services improved by 10 %				
			Standardized the social workforce development curriculum and competencies to provide quality training for Social services workers				
Inst & Org Development				$ 8,534,655.20			

HIV/AIDS quality improvement/quality management (QI/QM)	Support FMOH and 11 RHBs to strengthen HIV quality improvement systems at the scale-up and sustained sub-national units/health facilities (including the 20 priority towns); support health facilities to plan, implement, and monitor HIV quality improvement activities.	#s 1 , 2 and 3	FMOH and 11 RHBs able to monitor QI performance of 90% of PEPFAR supported hospitals and produce quarterly and annual data through minimal external TA support	$ 411,561	OHSS	TBD(CHAI follow-on)	Quality Management (Score 1.62, *Red*)
Capacity Building	Provide technical and financial support to woreda-based health sector planning for MOH and RHB; and coordinate response to the HIV epidemic at federal and regional levels	# 4	FMOH and 11 RHBs able to coordinate plan and monitor HIV/AIDS services without external TA support for sustained epidemic control by the end of 3 years.	$ 116,075	OHSS	10559 (NASTAD)	Planning and Coordination (Score 7.87, Light *Green*)
capacity building of professional association	Build the capacity within the nursing and midwifery workforce through training, support in the development of nursing and midwifery standard and SOP to improve quality of nursing care in HIV prevention, care, and treatment.	#s 1 , 2 and 3	Nursing and midwifery care practices for HIV positives improved by 90% at aggressive and sustained health facilities in 3 years	$125,145	OHSS	13948 (ICAP)	3. Civil Society Engagement (Score 4.0)
Capacity building of blood banks and facilities	RHBs of the 7 big regions will provide trainings to blood bank and hospital staff on blood safety, conduct quarterly review meetings and supportive supervisions. These activities will increase the technical capacities of the staff to increase annual blood collection by 10-15% yearly,	#4	25 blood and all transfusion facilities take over the management and coordination role in 3 years' time. All blood banks increased collection, testing and distribution of safe	$29,754.846 $70,384.329 $11,730.258 $11,888.775 $82,114.587 $35,191.701 $23,461.443	HMBL	13934(AACHB) 16752 (ARHB), 13929 (DDRHB), 12319 (HRHB), 16749 ((ORHB), 12306 (SNNPRHB), 17000 (TRHB)	

	conduct donor recruitment & screening to decrease prevalence of HIV among blood donors to less than the current level of 0.78% and provide safe and appropriate blood transfusion services in transfusion hospitals.		units of blood by 15% in 3 years' time (taking COP2015 collection performance as base line) by maintaining 5% annual rise of blood collection each year.	$892,88.64		13948 (ICAP)	
Capacity building FMOH and RHB	The FMOH (NBBS) through technical assistance from WHO will provide blood safety management and coordination trainings to blood program management staff drawn from NBBS and RHBs, conduct semiannual review meetings and supportive supervisions, procure and distribute essential equipment and test kits to blood banks & hospitals, developed blood safety policies, strategic plans and develop or revise SOPS.	#4	The FMOH (NBBS) and RHBs take over the management and coordination role in 3 years' time, increase GoE budget contribution to blood safety by 20% each year and facilitate program transition and local ownership.	$132,6742.794	HMBL	13158 (FMOH)	
	TA support to the national blood safety program management and coordination. Contribute to the development blood policies, guidelines and SOPs. Also provide TOTs			$304,879.176		16750(WHO)	
TA and capacity building	TA to national and regional TB control program management; human resource (secondement), TA to policy and guideline and training material development/revision, program monitoring and strategic information, TOTs, global fund proposal writing	#1, 2 and 3	FMOH and 11 RHBs able to coordinate and monitor HIV/TB program at national regional level respectively through secondment of experts.	$176,130	HVTB	16750 (WHO)	

TA and capacity building	Build the capacity of FMOH and RHB in program coordination and management, ensuring quality of comprehensive care and support interventions; and in development of guidelines, job aids and training materials	#s 1 , 2 and 3	11 RHBSs use updated guidelines and SOPs to improve quality of comprehensive care and support service at PEPFAR supported health facilities. FMOH & eleven RHB coordinated care and support program in their respective regions without external TA	$370,800	HBHC	16749 (ICAP)	
TA and capacity building	Build the capacity of FMOH and RHB in program planning and management, improved retention of HIV positive pregnant/lactating mother and their HIV exposed infants through the development of guidelines, monitoring tools, SOPs and training materials	#1,2,3,4	11 RHBs use updated guidelines, SOP and monitoring tool in all PEPFAR supported sites to monitor MTCT program activities through TA support	$88,065	MTCT	16749 (ICAP)	
Program leadership and management	Policy and guidance, program leadership, management and coordination, planning & program monitoring and review Public awareness	#1, 2, and 3	11 RHBs and their respective HIV/TB service providing facilities used updated guideline to improve quality of services	$129,780	HVTB	17908 (FMOH)	

Organizational capacity building	Build capacity of Ethiopian Medical Laboratory Association as an exit strategy for the international laboratory partners.	#4	EMLA will have managerial and technical capacity to completely takeover the technical assistance currently provided by international partners in laboratory-clinical interface, laboratory policy implementation and continuing laboratory education for quality HIV testing and treatment monitoring.	$62,502.048	HLAB	13934 (EMA)	Laboratory (Yellow)
Organizational capacity building	Build capacity of Ethiopian Public Health laboratory association as an exit strategy for the international laboratory partners.	#4	EPHLA will have managerial and technical capacity to completely takeover the technical assistance currently being provided by international partners in national laboratory strategic planning, laboratory strategic leadership and laboratory monitoring and evaluation for quality HIV testing and ART monitoring.	$89,288.64	HLAB	16738 (EPHA)	Laboratory (Yellow)
Capacity Building	Twenty professional will be trained each year to assist Ministry of Science and Technology (MOST) in ensuring the ethical and scientific integrity of HIV	#4	Improved capacity of MOST in overseeing of health and health related studies. Reduce turnaround time for ethical clearance of study protocols by 90%.	$24,102	HVSI	16738(EPHA)	

Capacity building	Building capacity of regional health bureaus to ensure quality of ART services in centrally supported SNUs	#4	100% transition of site level support in all centrally supported SNU to the respective RHB	$1,258,965.189		16749 CU-ICAP)	6. Service Delivery 4.40
			8 RHBs received TA for implementing CQI in 95% HIV care and treatment sites in centrally supported SNU to maintain quality of clinical services	$250,066.593	HTXS	16752 (ARHB)	
				$125,033.76		17000 (TRHB)	
				$500,133.186		13794 (ORHB)	
				$375,100.353		16901 (SNNPR)	
	Build capacity on oversight of private sector HIV service provision through TA and training to FMOH, Pharmaceuticals Fund and Supply Agency (PFSA), regional/ city administration health bureaus and regional referral laboratories	Sustained epidemic control	FMOH, PFSA, and other government entities will have strengthened capacity to provide supervision and oversight for 80% of private sector in the provision of HIV/AIDS services.	$38,470.5	HVCT	17824	Red
				$38,470.5	MTCT		
				$115,411.5	HTXS		
				$38,470.5	HBHC		
				$38,470.5	PDTX		
				$38,470.5	HLAB		
				$38,470.5	HVOP		
				$38,470.5	OHSS		
	Provide technical assistance and grants (institutional as well as performance based grants) to private health facility associations and private practitioners' professional in advocacy, policy dialogue; and professional ethics and standards of quality (Self-regulation)	Sustained epidemic control	7 regional, 1 national PHFAs and 2 professionals associations will have an Improved organizational systems, tools and processes in the coming two years.	$178,447.5	HVCT	17824	Red
				$50,985	MTCT		
				$50,985	PDTX		
				$50,985	$50,985		
				$50,985	HLAB		
				$50,985	HVOP		
				$76,477.5	OHSS		

	Support the Public Private Partnership in Health (PPPH) case team with in FMoH in identify its needs for human resource and capacity building; operationalization and dissemination of the PPPH Framework; and building the capacity of government staff within the PPPH case team on how to identify good candidates for private sector partnerships and how to design and broker successful partnership for services on disease of public health importance.	Sustained epidemic control	100% implementation of the national public private partnership framework in all region	$ 78,909	OHSS	17824	Light Green
	Provide TA and training to strengthen the inspection capacity of the regulatory body, development of implementation guidelines, and develop supervisory tools and job aids.	Sustained epidemic control	100% of regions will be able to regulate based on standard manuals & guidelines for the private health sectors in the country.	$44,054.748	OHSS	17824	Red
	Strengthen the capacity of FMOH and 6 Regional Health Bureaus (RHBs) to further strengthen the integration of NACS into routine HIV Care and Treatment services	3d 90 & sustained epidemic control	The six Regional health bureaus will have capacity to implement standardized NACS service in all priority PEPFAR supported ART sites.	$11,031.3 $110,313 $126,072 $69,339.6	OHSS HBHC PDCS MTCT	14215	Dark Green
	Provide capacity building support to FMOH, RHB, WoHO and HC staff to improve their technical competency on planning, managing, monitoring and evaluation of the HIV and Urban Health Program.	Address Sustained Epi Control	Capacity of FMOH, RHB, WoHO improved for better HIV and Urban Health Programming	$440,650.377	OHSS	14210	Red

	Provide technical assistance to host government institutions (Town level HAPCOs') for more effectively planning, delivery and optimization of community level prevention, care and treatment for PLHIV.	1st , 2nd and 3rd 90's	80% of government institutions (Town level HAPCOs and community care coalitions) where the project operates will have improved capacity for planning, delivering and optimizing community based prevention, care and treatment services for PLHIV.	$248,303.439 $6,621.43122 $52,971.43122 $23,175	HBHC PDCS MTCT HVSI	14217	Yellow
	Provide technical assistance to host government institutions (Town level HAPCOs') for more effectively planning, delivery and optimization of community level prevention, care and treatment for PLHIV.	1st , 2nd and 3rd 90's	80% of government institutions (Town level HAPCOs and community care coalitions) where the project operates will have improved capacity for planning, delivering and optimizing community based prevention, care and treatment services for PLHIV.	$72,354.98268 $1,096.28874 $2,192.355 $12,059.343 $9,866.988 $4,384.71 $7,673.706	HBHC HTXS PDCS MTCT OHSS HVOP HVSI		
	Provide technical assistance to strengthen the Global Fund Country Coordinating Mechanisms (CCM) secretariat	1st , 2nd and 3rd 90's	The Global Fund CCM secretariat strengthened	$21,834.29844 $8,810.32851 $5,362.80624 $2,298.34818	HTXS MTCT PDTX OHSS	14309	Yellow

Inadequate partnerships and coordination between Civilian community and the military Population at Military hotspot areas	Capacity building through training and material supply to selected Military hotspots. Establishing Civil Military task forces. Facilitate KP friendly testing and STI services.	Contribute to the 1st and 2nd 90's	Civil Military alliance program in 5 hot spots sites in Benishangul Gumz, Afar and Tigray regions established to provide KP friendly testing and STI services. 6 existing hotspot sites in Amhara, Tigray, Oromia and SNNPR will be graduated by the end of FY 2017.	$21,148.30	HVOP	16798 (fhi360)	
Capacity Building of Blood Banks and Transfusion services at Military Hospitals	Capacity building of blood banks through training, technical support in Blood banking and blood transfusion and material and reagent supply. Networking of satellite Command Blood banks to the central blood bank through Internet and data link	Contribute to the 1st and 3rd 90's	Increase blood transfusion service coverage by 5% annually in the coming two years in Eastern Command, Diredawa/ Harare and Western Command, Bahirdar through establishment of two sites Increased coverage of blood transfusion services through networking of satellite transfusion sites with the central Military blood bank through TA support to monitor blood safety management.	$171,392.103	HMBL	7515 (Ethiopia National Defense Force)	

			All Military blood transfusion service site managed, and monitored by NDEF without external TA in the coming 3 years				
Laboratory				$ 304,492.62			
Capacity building and quality assurance	Provide technical and capacity building support to regional labs to strengthen TB diagnostic support, lab biosafety and quality assurance. Lab sample transportation and networking; local validation scale up of new TB diagnostic technics and TB drug resistance surveillance activities.	#1,2, and 3	10 TB diagnostic centers in 6 regions continue providing quality assured TB diagnostic services.	$185,400	HVTB	16751 (EPHI)	Laboratory (Yellow)
	Enroll laboratories in the private health sector in continuous quality improvement process including WHO/AFRO step-wise laboratory accreditation with prioritization of scale up sites	Sustained epidemic control	35 Private health facilities supported by the project will be accredited based on WHO/AFRO step-wise laboratory accreditation	$13,905	HLAB	17824	Light Green
	TA and support to specimen transportation and laboratory networking in the private health sector	Sustained epidemic control & 3rd 90	100% of Private health facilities are linked with the public specimen transportation system to send specimen to regional laboratories for EID, viral load, TB & MDR TB and ART monitoring. Sputum sample transportation strengthened	$19,467	HLAB	17824	Light Green

	Support Ethiopian public health institute (EPHI) to strengthen the sputum sample transportation using the Ethiopian Postal Services Enterprise as specimen courier. The support includes provision of technical assistance and introduction of mobile phone SMS to track sputum samples and hasten result feedback system	1st , 2nd and 3rd 90's	Sputum sample transportation strengthened	$39,370.617	HVTB	17635	Light Green
	Support the introduction of subsidized Gene Xpert services in the private facilities	1st 90 & Sustained epidemic control.	Gene X-Pert implemented in3 private facilities with high TB case load.	$46,350	HVTB	17824	
Strategic Information				$ 1,045,890.13			
Surveillance	HIV/AIDS, TB mortality tracking in 6 University-based DHS Sites will be supported to collect and analyze HIV attributable death in their respective area, and 1 urban burial site surveillance	# 4	6 DHS local university sites collect and analyze HIV attributable death quantified to monitor the impact of HIV care and treatment program	$268,830	HVSI	16738(EPHA)	13. Epidemiological and Health Data
Surveillance	72 health facilities collect and use site level data to monitor (as an early warning indicator) the level of ARV drug resistance in selected facilities and nationally	# 3, 4	72 health facilities use site level data to monitor ARV drug resistance	$72,604	HVSI	16750 (WHO)	13. Epidemiological and Health Data
Monitoring and evaluation	HIV services and program data from all partners collected and analyzed timely at FHAPCO to monitor coverage and performance of HIV/AIDS programs nationally	# 4	HIV data timely collected and analyzed at FHAPCO from HIV providing services	$44,644	HVSI	13931(FHAPCO)	15. Performance Data

	Provide training and technical assistance and avail required tools to strengthen the implementation of HMIS in the private health sector	Sustained epidemic control	100% of private facilities supported by the project will implement standardized paper based HMIS	$12,762 $12,762 $12,762 $12,762 $12,762 $12,762 $12,762 $12,762 $12,762	HVCT MTCT HTXS HBHC PDTX PDCS HVTB HLAB HVOP OHSS	17824	Light Green
	Support RHBs to conduct standard of care assessment on NACS to selected high volume facilities.	3rd 90 & sustained epidemic control	Standard of care assessment check list developed & assessment done on 100% of high volume ART sites with NACS service.	$3,245 $18,540 $37,080 $20,394	OHSS HBHC PDCS MTCT	14215	
	Provide technical assistance for FMOH & RHBs on data collection, recording and reporting of NACS indicators..	3d 90 & sustained epidemic control	Technical assistance provided to all six regional health bureau & FMOH on strategic information resulted in improved data management & use for NACS indicators.	$3,244.5 $18,540 $37,080 $20,394	OHSS (7%) HBHC (40%) PDCS (8%) MTCT (44%)	14215	Light Green

	Support will focus on: • The transition from the existing eHMIS and other e-application into the DHIS II • TA on scaling up of paper based multi-sectoral response information system (MRIS) and on full functionality of the developed system at national level Federal HAPCO • Data use and TA in full implementation of both paper based and electronic MRIS in prioritized PEPFAR-supported sites of SNNPR and Oromia	These activities will support the utilization of service data for program decision making across the clinical cascade	•Smooth data migration will be in effect •Enhanced monitoring functions of Federal Ministry and the two regional Health Bureaus through the nationally owned MRIS •MRIS scaled up in prioritized PEPFAR-supported sites of Oromia and SNNPR.	$278,100	HVSI	17641	Light Green
	Organize a joint performance improvement review meeting with task forces/AIDS board in development clusters and other high risk sites	1st 90	Performance review meeting conducted every quarter in each region in the aim to strategies how to improve quality of the overall project performance improved in the supported worksites	$5,885	HVOP	14230	Light Green
	Provide technical support to worksites to develop standardized gender responsive HIV/AIDS workplace policy familiarization and developing implementation plan	1st, 2nd, 3rd	A gender responsive workplace HIV/AIDS policy will be developed and in place for all supported worksites. All worksites will be familiarized with the policy and all worksites will develop and implementation plan to mainstream gender in worksites	$13,442	HVOP	14230	Red

	Support activities to strengthen planning, monitoring, evaluating and assuring the quality of data for community based programs to PLHIV	1st , 2nd and 3rd 90's	80% of community structures supported by the program will have strengthened M&E capacity to support evidence-based decision-making.	$41,518 $629.433 $1,258 $6,920 $5,661 $2,516 $4,403	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	17825	Light Green
	Support the routine HIV & nutrition related data collection, analysis & reporting.	1st , 2nd and 3rd 90's	Relevant programmatic qualitative and quantitative data are collected, analyzed used and shared.	$10,007.13 $266,86 $2134.85 $934.00	HBHC PDCS MTCT HVSI	14217	Light Green
Systems Development				$ 1,201,070.70			
	Build the capacity through mentoring and training of private providers on rational drug use	Sustained epidemic control, 3rd 90	100% of private health facilities supported by the project will implement rational pharmaceutical practices.	$8,343	OHSS	17824	Light Green
	Strengthen the FMHACA performance of product registration and licensing system of FMHACA	Contributed to the tripe 90	Increase availability of quality assured medicines and health products at affordable price	$231,750	OHSS	14212	Red
	Strengthen the post marketing surveillance system (PMS) of ARVs and OIs	Contribute to the second and third 90	Post market quality control and assurance system built	$185,400	OHSS	14212	Red

	Strengthen product Quality Assurance Laboratory of EFMHACA and EFMHACA branch labs, to expedites the dossier evaluation and market authorization	Quality assurance is key milestone for products that used for triple 90's	WHO prequalification and ISO accreditation of the lab	$185,400	OHSS	14212	Red
	Support the Regional Bioequivalence Centre (RBEC) to make it technically competent to conduct bioavailability/bioequivalence studies for local as well as regional pharmaceutical industries	Ensure the availability of OIs and other essential medicines for HIV/AIDS that contribute the second and third 90	Help to provide training on dosser and dosser evaluations and to	$185,400	OHSS	14212	Red
			Local capacity on dosser data requirements, local quality assured products and improvement in local production				
	Establish the quality testing laboratory of Pharmaceuticals Fund and Supply Agency	Contribute to the third 90	Quality assured product procurement systems	$185,400	OHSS	14212	Yellow
	Support FMOH, RHBs (SNNP and Oromia), and C/THOs to further strengthen the implementation and use of the data management system for the Urban Health Extension Program	Address Sustain ed Epi Control	A well capacitated program managers will be available at all levels to use the data management system to monitor Urban Health Extension Program	$46,350	OHSS	14210	Light green
	Supporting the transition from paper-based MRIS to e-MRIS: The collection of reliable HIV data to tracking the status of HIV/AIDS in communities. Supports	1st , 2nd and 3rd 90's	100% PEPFAR priority sites will transition from paper-based MRIS to e-MRIS.	$109,037.00	HVSI	17825	Light Green

	FHAPCO's initiative to transition from a paper-based MRIS to a (e-MRIS), which will allow for the collection and administration of HIV/AIDS related information within the local context and enable access to reliable MRIS data from a number of stakeholders.						
	Supporting the transition from paper-based MRIS to e-MRIS: to collect reliable HIV data this is a critical step in tracking the status of HIV/AIDS in communities. This activity supports FHAPCO's initiative to transition from a paper-based MRIS to a e-MRIS, which will allow for the collection and administration of HIV/AIDS related information within the local context and enable access to reliable MRIS data from a number of stakeholders.	1st , 2nd and 3rd 90's	100% PEPFAR priority sites will transition from paper-based MRIS to e-MRIS.	$36,401.436 $2,207.14065 $17,657.1252 $7,724.99691	HBHC PDCS MTCT HVSI	14217	Light Green
TOTAL				$ 17,538,342.91			

6.2 Critical Systems Investments for Achieving Priority Policies

The FMOH has expressed an eagerness to implement Test & Start; yet, they fear the funding for ART from external donors will be inadequate for the demand. Meetings are planned with GF, which is Ethiopia's prime provider of ART. These meetings should help to convince the GoE that there is adequate funding to implement Test & Start. In addition, PEPFAR's TA includes familiarizing the FMOH with the A-DOT tool that can demonstrate the government cost savings of implementing Test & START, along with alternative service delivery models for stable patients. Once the policy is adopted, it will be easy to cascade the implementation to the facility level through use of a "Circular" and informing the Regional Health Bureaus, which will then sensitize healthcare workers through Regional Review meetings, circulating the Circular, and site-level mentoring. Meanwhile, guidelines will be revised and disseminated. PEPFAR plans to support trainings on the new guidelines, ensure adequate HRH and commodities are available at high-load sites, regular use of data at to ensure that guidelines changes are implemented as expected, and that high-quality care and patient outcomes are not compromised. The FMOH has also expressed willingness to support piloting of alternative service delivery models for stable patients, and will eagerly await assessment of pilot projects PEPFAR will implement in communities served by facilities that currently provide ART for more than 2,000 PLHIV.

Table 6.2.1 Test and Start						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Only preliminary GoE political commitment, policy, and guidelines for Test & S	Govt Policy changed and to Test & Start and fully implemented in <3 yrs.	Activity 1				
		Activity 2				
		Activity 3				
Insufficient facilities and HRH for ART for a sudden, large increase in number of persons on ART	In 3 yrs., 90% of stable ART patient seen only 2 facility visits/year	Activity 1. Strengthening of in-service training unit at local universities to institutionalize and provide HIV/AIDS related trainings in collaboration with the respective RHBs to improve quality clinical services.	OHSS	$31,872	10601 (AAU)	7. Human Resources for Health (score 6.0)
				$34,848	12321 (UoG)	
				$31,872	13932 (HrU)	
				$ 34,848	10548 (JU)	
				$ 31,872	10517 (HaU)	
				$ 34,848	10557 (MU)	
				$ 31,872	16742 (NDFE)	
		Activity 2: Create/strengthen a national platform for online CME program in collaboration with partners & FMOH and publish and disseminate HIV/AIDS updates through the Ethiopian Medical Journal. Build the capacity of health professional associations to implement CME for HIV/AIDS Activity 3	OHSS	$120,400	13933 (EMA)	7. Human Resources for Health (score 6.0)
Inadequate resources (and FEAR of thereof) including ARVs downstream after initiating Test & Start	Adequate supplies of ARVs and other inputs, including HRH and ART facilities has been consistently assured for 3 yrs.'	Activity 1. Strengthen the availability of workforce data at the facility through HRIS for planning and decision making at Regional level. Conduct HRH data analysis at the regional level to ensure adequate & competent HCW deployed or received adequate training	OHSS	$ 111,154	16752 (Amhara)	7. Human Resources for Health (score 6.0)
				$ 111,154	13794 (Oromia)	
				$ 81,872	16901 (SNNPR)	

		to implement test and start and meet 90-90-90 target		$ 77,056	17000 (Tigray)	
				$ 51,302	13934 (A.A.)	
				$ 38, 528	13770 (Harari)	
				$ 38, 528	13939 (Dire Dawa	
		Activity 2: Strengthening the implementation of HRIS at national level. Build the capacity of MOH to enter backlog data and run the system; compile and produce up-to-date national HR data report. Conduct annual HRH assessment to ensure adequate allocation of competent HCW		$ 70,000	10534 (FMOH)	Human Resources for Health (score 6.
		Activity 3: Provide TA to Institutionalize HRIS implementation: Software upgrading, TOT at the national level, implementation follow-up support to the national and regional level. Support regions and FMOH to generate HR information from HRIS and HRH assessment.	OHSS	$ 577, 920	TBD (Tulane follow on)	Human Resources for Health (score 6.
		Organize workshop on Cost sharing and analyze worksites' contribution (including cost sharing) to HIV Combination prevention and sustainability [This activity will continue under a different mechanism as of COP16]	HVOP	$15,400	14230	Yellow

		Provide TA to worksites to allocate financial resources for HIV and AIDS-related activities (a minimum of one HIV prevention activity for a long term at least for a year and on regular basis, covering salaries of staff, opportunity costs, direct budget support, employees contribution, service and drug related costs, etc.)	HVOP	$4,500	14230	Light Green
TOTAL						

Table 6.2.2 New and efficient service delivery models						
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Proposed COP/ROP16**	**Budget Code(s)**	**Activity Budget Amount**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Lack of policy change to allow new differentiated, patient-centered models of care	Govt Policy changed and to support a broad range of differentiated care models for ART and fully implemented in <3 yr	Activity 1: Adolescent focused policy (10-14) adopted and implemented by RHBs	PDTX	$40,000	13934 (AACHB)	
				$40,000	16752 (ARHB)	
				$15,000	13929 (DDRHB)	
				$15,000	13770 (HRHB)	
				$40,000	13794 (ORHB)	
				$40,000	16901 (SNNPRHB)	
				$15,000	17000 (TRHB)	
				$10,000	12319 (FPC)	
				$20,000	16742 (NDFE)	
				$15,000	16749 (ICAP)	
		Activity 2 Support MOH and RHBs to develop and adopt a policy on less frequent follow up visits of stable Pediatric patients	PDTX	$50,000	16749 (ICAP)	

		Activity 3 Support MOH and RHBs to develop and adopt a policy on less frequent follow up visits of stable Pediatric patients	PDCS	$50,000	16749 (ICAP)	
		Activity 4: support to FMOH in policy formulation, development and/or updating, and dissemination	HTXS	$100,000	10534 (FMOH)	
		Activity 5: support FMOH and RHB in program review, identifying programmatic gaps and challenges, and devising new strategies and actions	HTXS	$450,0000	16749 (ICAP)	
		Activity 6: Technical assistance to implement and monitor targeted HIV testing of presumed TB cases in addition to confirmed TB cases as well as investigation of hous77old contacts of TB patients for both TB and HIV in a family based approach	HVTB	$26,500 $67,500 $15,000	17908 (FMOH) 16750 (WHO) 16749 (ICAP)	
		Activity 7 Technical assistance for development revision of TB/HIV strategic plans, guidelines training materials, job aids and diagnostic algorithms		$55,000 $112,500 $15,000	17908 (FMOH) 16750 (WHO) 16749 (ICAP)	
		Provide technical assistance to FMOH for the country's adoption & revision of national HIV normative guidance based on the global standards	HTXS MTCT PDTX OHSS	$89,720.66 $51,140.78 $20,635.75 $12,560.89 $5,383.24	14309	Light Green
		Provide technical assistance to FMOH for the country's adoption & revision of national HIV normative guidance based on the global standards	HTXS MTCT PDTX OHSS	$89,720.66 $51,140.78 $20,635.75 $12,560.89 $5,383.24	14309	Light Green
Inadequate supply and quantification for procurement and supply chain of appropriate regimens persons on	Adequate supplies of ARVs and other inputs has been accurately quantified, consistently procured, and reliably delivered for 3 yrs.	Activity 1: TA for quantification and forecasting of TB commodities including diagnostic test supplies such as GeneXpert cartridges	HVTB	$15,000 $5,000 $10,000	17908 (FMOH) 16750 (WHO) 16751 (EPHI)	
		Activity 2				
		Activity 3				

Lack of sufficient capacity at community level for promoting retention and adherence initiating Test & Start	Strong community-level models for supporting retention and adherence have been demonstrated in 90% of saturation and aggressive scale-up areas by 3 yrs.'	Activity 1: Strengthen standardizing community level peer-support group to strengthen members coping mechanism in a highly stigmatizing environment and remain adherent to their care and treatment services	HBHC	$450,000	12306 (OSSA)	
		Activity 1: TA for strengthening and tracking linkage of community TB	HVTB	$15,000	16750 (WHO)	
				$5,000	16749 (ICAP)	
		Activity 3				
Danger of perception that this policy is being driven by cost saving at the expense of quality care	>90% patients convinced (e.g., in patient satisfaction surveys) that ART is being provided at high quality and in patient-focused manner in 3 yrs.	Activity 1				
		Activity 2				
		Activity 3				
Lack of widespread and standardized models for patient peer-support group including community-delivered ART	>75% of all ART patients are participating actively in some community-supported adherence and mutual support activities in saturation and aggressive scale-up areas by 3 yrs	Activity 1 Collaborate with health facilities and RHB to pilot and implement community-based antiretroviral distribution and adherence monitoring model through Community ART Groups (**CAG**) in selected scale-up saturation SNU.	HBHC	$50,000	12306 (OSSA)	
		Activity 2: TA for strengthening partnership and engagement of civil society organizations in, TB suspect identification and referral, TB/HIV treatment adherence support, linkage to community level care and support services as well as treatment absentee and lost to follow up tracking	HVTB	$30,000	17908 (FMOH)	
				$10,000	16750 (WHO)	
				$5,000	16749 (ICAP)	
		Activity 3				
TOTAL						

6.3 Proposed System Investments Outside of Programmatic Gaps and Priority Policies

Table 6.3 Other Proposed Systems Investments							
Systems Category* (only complete for categories relevant to country context)	**Activity**	**For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control.**	**Outcomes expected after 3 years of investment**	**Budget Amount**	**Budget Code(s)**	**Associated Implementing Mechanism ID**	**Relevant SID Element and Score (if applicable)**
Finance							
	Provide technical assistance on business development and access-to-finance to private health facility owners and banks to leverage the loan guarantee through the DCA.	Sustained epidemic control	Increase the private health sectors access to financial resources	$98,736	OHSS	17824	Light Green
Governance							
	Provide technical assistance to relevant public and private health institutions to conduct analysis of health policies and laws impacting the ability of the private sector to engage in delivery of critical health services.	Sustained epidemic control	Improved supportive policy and legal frameworks for the private health sector	$191,122	OHSS (100%)	17824	Light Green

	Support the development of public private mix guideline for HIV and constant review of national guidelines and quality management tools as per international standards	Sustained epidemic control	Guidelines reviewed and updated on public private mix for HIV.	$20,000	HVCT (10%) MTCT (10%) HTXS (10%) HBHC (10%) PDTX (10%) PDCS (10%) HVTB (10%) HLAB (10%) HVOP (10%) OHSS (10%)	17824	Light Green
	Promote household resiliency among OVC, caregivers and PLHIV in priority SNUS through /by supporting the GOE to develop a national Economic Strengthening (ES) guideline and Standardize ES approaches	Second 90; Sustained Epi Control.	• Develop the National Economic Strengthening (ES) Guideline; Standardize ES tools and approaches developed • Roll out the national ES guideline and tools	$150,000	HKID	16930	
	Conceive, pilot, evaluate and advance learning for innovative approaches that increase the effectiveness of ES approaches for PEPFAR related outcomes.	Sustained Epi Control.	Expanded evidence base for economic strengthening	$ 350,000	HKID	16930	
	Provide technical assistance to FMOH to revise the National Guidelines for HIV/AIDS and Nutrition based on available evidence	3d 90 & sustained epidemic control	Technical assistance provided & National HIV/nutrition Guideline revised	$50,000	OHSS (7%), HBHC (40%) PDCS (8%) MTCT (44%)	14215	Light Green
	Support networking and	First 90	Strengthened	$4,000	HVOP	14230	Light Green

	partnership with National level Advisory and Steering Committees [This activity will continue under a different mechanism as of COP16]		and functional networking and partnerships among enterprises put in place				
	Provide support for worksites/enterprises to develop gender responsive workplace HIV/AIDS policies [This activity will continue under a different mechanism as of COP16]	First and second 90	Gender and Work place HIV Policy in work places developed	$2,740	HVOP	14230	Light Green
	Provide TA to the government for the development of policies, strategies, legal frameworks, and implementation guidelines pertaining to health care financing initiatives including exempted health services and fee waiver systems addressing indigents and PLHIV	Addresses all the triple 90 goals and contributes to the epidemic control	In <3 yrs, increase in GoE budget allocation for categorical HIV programs by 15%, plus commitment to ongoing 5% annual rise	$350,000	OHSS	14207	Yellow
	Provide TA for the FMoH to revise and update the TB, TB/HIV and MDR TB guidelines	1st , 2nd and 3rd 90's	TB, TB/HIV, Leprosy and MDR TB guidelines updated	$53,950.00	HVTB		Light Green
HRH - Systems/Institutional Investments							
HRH-Pre service	Build institutional capacity of local medical schools and health science colleges through technical assistance, material and financial support to provide quality pre-service trainings.	#s 1 , 2 and 3	Adequate supply of Health work force assured to deliver HIV clinical services manage & administer facilities and programs.	$ 50,000 $100,000 $50,000 $100,000 $50,000 $100,000 $50,000 $43,344	OHSS	10601 (AAU) 12321 (UoG) 13932 (HrU) 10548 (JU) 10517 (HaU) 10557 (MU) 16742 (NDFE) 12319 (FPC)	7. Human Resource for Health (Score 6.0, *Yellow*)

HRH pre- service OHSS	Build the capacity of FMOH to coordinate medical education and facilitate exchange of resource through networking of medical schools.	#2,3	Improve the sustainability, availability and quality of health professionals needed to achieve improved health outcomes.	$100,000	OHSS	10534 (FMOH)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre- service OHSS	Provide technical , material and financial support to 20 universities and hospital medical colleges to produce competent physician to deliver quality HIV clinical services	# 2, 3	Improved quality of medical education and retention of students.	$847,616	OHSS	16749 (ICAP)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre- service OHSS	Provide technical and material support to Biomedical engineers technicians training program; support the post-graduate OB/GYN education; Providing quality	#4	Improved quality of biomedical engineering and technicians training; Improved quality of OB/GYN residence training program and retention of residents; Improved quality of Emergency training program: and improve the quality of medical education.	$900,000	OHSS	10599 (AIHA)	. Human Resource for Health (Score 6.0, Yellow)

HRH pre- service OHSS	Support the pre-service masters on hospital care and health administration (MHA)training programs at Jimma, Addis Ababa, Mekelle and Gondar University	#4	Train hospital CEOs who are committed to improving the delivery of quality health services	$100,000	OHSS	TBD (CHAI follow on)	. Human Resource for Health (Score 6.0, Yellow)
HRH pre-service -SI	Support the pre-service education for field epidemiology training program and leadership for strategic information program	# 4	Improve the capacity of public health professionals in the public health sector on data generation and use	$148,067	HVSI	16738 (EPHA)	7. Human Resource for Health (Score 6.0, *Yellow*)
HRH pre-service -SI	Support the diploma training for HIT (Health Information technicians)	# 4	Improved capacity of the public health sector in health information system and data management	$300,000	HVSI	TBD(Tulane follow-on)	7. Human Resource for Health (Score 6.0, *Yellow*)
Pre-service HMBL	Build institutional capacity of local medical schools and health science colleges through technical assistance, material and financial support to provide quality pre-service trainings on blood safety.	#s 1 , 2 and 3	Ensure adequate & Competent health professionals on blood safety through integration of safe blood transfusion in pre-service education curriculum	$50,000	HMBL	(FMOH)	. Human Resource for Health (Score 6.0, Yellow)

	Strengthening pre-service health care workers education for midwives at 48 institutions (26 universities and 22 regional health science colleges) through faculty development, curriculum review, and provision of resource materials and skills lab equipment.	First 90 and Second 90	Existing curricula reviewed and updated including strengthening of HIV/AIDS related content; clinical skills materials and skills lab equipment provided to strengthen student clinical skills; clinical skills education reviewed and improved. Midwives provided pre-service training on PMTCT and other HIV curricula; Pre-service training institutions supported with various inputs	$500,000	OHSS	14209	Yellow

	Strengthening pre-service education for health extension workers at 23 institutions through faculty development, curriculum review, provision of resource materials and skills lab equipment.	First 90	Essential HIV related content integrated into the curriculum to address HIV/AIDS related issues and care and treatment in line with scope of practice; HEWs provided pre-service training using updated HIV and Health curricula; training institutions supported with various inputs	$400,000	OHSS	14209	Yellow
	Establishing and/or strengthening in-service training at 35 in-service training institutions including the standardization and institutionalization of IST through increased capacity for planning, implementing, monitoring and mobilizing resources. Assistance includes improving IST trainer capacity, standardizing national training packages, coaching, mentoring, supportive supervision, financial management tools, standard operating procedures.	First 90 and Second 90	Increased number of trained health care workers in all regions to provide quality HIV/AIDS care; in-service training units supported with various inputs	$600,000	OHSS	14209	Yellow

	Increase the quality and sustainability of social services and case management for OVC and caregivers by building social service workforce development & system strengthening	Contributes for the 1st and 2nd 90 and sustained Epi control)	• Social service workers/para social workers/ trained • Prevented and responded to neglect, violence and exploitation of at-risk children & adolescents • Established and strengthened referral mechanisms and other systems to ensure cross referrals between clinic and social services (cross-referrals) • Adherence, HIV disclosure , retention among OVC and caregivers improved • Adherence, HIV disclosure , retention among OVC	$1,000,000	HKID	17271	

	Improve workforce development and the social services system through TA and capacity development of MOWCA), community platforms (e.g. Community care Coalition(CCC)) and training institutions like TVET and School of Social Work	This activity contributes significantly contributes for the 1st and 2nd 90 and sustained Epi control	• Capacity of the government and training institutions built in order to strengthening the child-sensitive social service system • Built the community platform (like CCC) who work on OVC issues • Quality of training monitoring and supervision improved • OVC services jointly planned and provided by government and community entities • Training institutions provide training on social services workforce development • Social services	$300,000	HKID	17271	

			system for OVC and caregivers strengthened. • Community and national-level child protection/ GBV prevention and response activities, and referrals to other services improved • National guiding Principles, revise curriculum Functions and Competencies to train the para professionals in social services workforce revised				
Inst & Org Development							

HIV/AIDS quality improvement/quality management (QI/QM)	Support FMOH and RHBs to strengthen HIV QI/QM systems at the scale-up and sustained sub-national units/health facilities; support health facilities to plan, implement, and monitor HIV QI/QM activities; and enhance HIV QI/QM leadership and governance capacity of high HIV burden public health institutions through deployment of MHA graduates	#s 1 , 2 and 3	• Improved capacity of FMOH, RHBs, and health facilities to plan, implement and monitor HIV QI/QM. • Improved quality of HIV services at health facilities to attain the 90:90:90 goal	$ 443,971	OHSS	TBD(CHAI follow-on)	Quality Management (Score 1.62, *Red*)
Capacity Building	Provide technical and financial support to woreda-based health sector planning for MOH and RHB; and coordinate response to the HIV epidemic at federal and regional levels	# 4	Improved capacity of host government to coordinate, plan and monitor HIV/AIDS services for sustained epidemic control.	$ 125,216	OHSS	10559 (NASTAD)	Planning and Coordination (Score 7.87, Light *Green*)
capacity building of professional association	Build the capacity within the nursing and midwifery workforce; strengthen and expand the delivery of HIV prevention, care, and treatment; and support integration with other basic health services.	#s 1 , 2 and 3	Improved the quality of nursing and midwifery care practices, including those for HIV positive people	$135,000	OHSS	13948 (ICAP)	3. Civil Society Engagement (Score 4.0)
Capacity building of blood banks and facilities	Support FMOH and RHBs to improve blood banks program management of blood collection, testing and	#4	Improved availability of safe and adequate blood	$32,098 $75,927 $12,654 $12,825	HMBL	13934(AACHB) 16752 (ARHB) 13929 (DDRHB) 12319 (HRHB)	

	distribution of safe blood to transfusion health facilities.		in transfusion facilities and improved quality of services.	$88,581 $37,963 $25,309 $96,320		16749 (ORHB) 12306 (SNNPRHB) 17000 (TRHB) 13948 (ICAP	
Capacity building FMOH and RHB	Support the national blood safety program management and procurement of commodities TA support to the national blood safety program management	#4	Improved planning, and management of blood safety program	$1,431,222 $328,888	HMBL	13158 (FMOH) 16750(WHO)	
TA and capacity building	TA to national and regional TB control program management; human resource (secondement), TA to policy and guideline and training material development/revision, program monitoring and strategic information, TOTs, global fund proposal writing	#1, 2 and 3	Improved HIV/TB program management capacity at national and regional levels; Improved availability of updated normative guidelines and SOPs;	$190,000	HVTB	16750 (WHO)	
TA and capacity building	Build the capacity of FMOH and RHB in program coordination and management, ensuring quality of comprehensive care and support interventions; and in development of guidelines, job aids and training materials	#s 1 , 2 and 3	Improved capacity of FMOH in coordination and management of care and support program	$400,000	HBHC	16749 (ICAP)	

TA and capacity building	Build the capacity of FMOH and RHB in program planning and management, improved retention of HIV positive pregnant/lactating mother and their HIV exposed infants through the development of guidelines, monitoring tools, SOPs and training materials	# 1,2,3,4	Improved the capacity of FMOH/7 RHB in monitoring PMTCT Program activities.	$95,000	MTCT	16749 (ICAP)	
Program leadership and management	Policy and guidance, program leadership, management and coordination, planning & resource mobilization, program monitoring and review Public awareness	#1, 2, and 3	Improved program management and leadership at national level, improved resource mobilization, coordination; Improved program performance, Increased public awareness and health seeking behavior	$140,000	HVTB	17908 (FMOH)	
Organizational capacity building	Build capacity of Ethiopian Medical Laboratory Association as an exit strategy for the international laboratory partners.	# 4	EMLA will have organizational and technical capacity to contribute to strengthening of national laboratory systems (laboratory-clinical interface, laboratory policy and continuing	$67,424	HLAB	13934 (EMA)	Laboratory (Yellow)

			laboratory education) for quality HIV testing and treatment monitoring.				
Organizational capacity building	Build capacity of Ethiopian Public Health laboratory association as an exit strategy for the international laboratory partners.	#4	EPHLA will have organizational and technical capacity to contribute to strengthening of the national laboratory systems (strategic planning, laboratory strategic leadership and laboratory monitoring and evaluation) for quality HIV testing and ART monitoring.	$96,320	HLAB	16738 (EPHA)	Laboratory (Yellow)
Capacity Building	Improved capacity of MOST in over siting of health and health related studies	#4	Strengthen the capacity of the Ministry of Science and Technology (MOST) which oversight all Health and health related studies supported by bilateral agencies	$26,000	HVSI	16738 (EPHA)	

Capacity building	Building capacity of regional heal bureaus to ensure quality of ART services in centrally supported SNUs	#4	• Successful transition of centrally supported SNU • Quality of HIV clinical service maintained	$1,358,107 $269,759 $134,880 $539,518 $404,639	HTXS	16749 (CU-ICAP) 16752 (ARHB) 17000 (TRHB) 13794 (ORHB) 16901 (SNNPR)	6. Service Delivery 4.40
	Build capacity through TA and training to FMOH, Pharmaceuticals Fund and Supply Agency (PFSA), regional/ city administration health bureaus and regional referral laboratories	Sustained epidemic control	FMOH, PFSA, and other govt. entities have strengthened capacity to provide TA and oversight to the private sector in the provision of HIV/AIDS services.	$415,000	HVCT (10%) MTCT (10%) HTXS (30%) HBHC (10%) PDTX (10%) HLAB (10%) HVOP (10%) OHSS (10%)	17824	Red
	Provide technical assistance and grants (institutional as well as performance based grants) to private health facility associations and private practitioners' professional in advocacy, policy dialogue; and professional ethics and standards of quality (Self-regulation)	Sustained epidemic control	Improved organizational systems, tools and processes of private health facility associations and private practitioners' professional associations	$550,000	HVCT (35%) MTCT (10%) PDTX (10%) HVTB (10%) HLAB (10%) HVOP (10%) OHSS (15%)	17824	Red

	Support the Public Private Partnership in Health (PPPH) case team with in FMoH in identify its needs for human resource and capacity building; operationalization and dissemination of the PPPH Framework; and building the capacity of government staff within the PPPH case team on how to identify good candidates for private sector partnerships and how to design and broker successful partnership for services on disease of public health importance.	Sustained epidemic control	Robust public private partnerships in Health implemented	$ 85,123	OHSS	17824	Light Green
	Provide TA and training to strengthen the inspection capacity of the regulatory body, development of implementation guidelines, and develop supervisory tools and job aids.	Sustained epidemic control	Inspections capacity/ supervisory skills of regulatory body improved	$ 47,542	OHSS	17824	Red
	Strengthen the capacity of FMOH and 6 Regional Health Bureaus (RHBs) to further strengthen the integration of NACS into routine HIV Care and Treatment services	3d 90 & sustained epidemic control	The Regional health bureau will have capacity to implement standardized NACS service.	$ 170,000	OHSS (7%) HBHC (40%) PDCS (8%) MTCT (44%)	14215	Dark Green

	Provide capacity building support to FMOH, RHB, WoHO and HC staff to improve their technical competency on planning, managing, monitoring and evaluation of the HIV and Urban Health Program.	Address Sustained Epi Control	Capacity of FMOH, RHB, WoHO improved for better HIV and Urban Health Programming	**$475,351**	OHSS	14210	Red
	Provide technical assistance to host government institutions (Town level HAPCOs') for more effectively planning, delivery and optimization of community level prevention, care and treatment for PLHIV.	1st , 2nd and 3rd 90's	Improved capacity of host government for planning, delivering and optimizing community based prevention, care and treatment services for PLHIV	$267,857.14 $7,142.86 $57,142.86 $25,000.00	HBHC PDCS MTCT HVSI	14217	Yellow
	Provide technical assistance to host government institutions (Town level HAPCO and community care coalitions) by providing grant for more effectively planning, delivery and optimization of community level prevention, care and treatment for PLHIV	1st , 2nd and 3rd 90's	Improved capacity of host government for planning, delivering and optimizing community based prevention, care and treatment services for PLHIV	$78,052.84 $1,182.62 $2,365 $13,009 $10,644 $4,730 $8,278	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	17825	Yellow
	Provide technical assistance to strengthen the Global Fund Country Coordinating Mechanisms (CCM) secretariat	1st , 2nd and 3rd 90's	The Global Fund CCM secretariat strengthened	$23,553.72 $9,504.13 $5,785.12 $2,479.34	HTXS MTCT PDTX OHSS	14309	Yellow

Inadequate partnerships and coordination between Civilian community and the military Population at Military hotspot areas	Capacity building through training and material supply to selected Military hotspots. Establishing Civil Military task forces. Facilitate KP friendly testing and STI services.	Contribute to the 1st and 2nd 90's	Civil Military alliance task Force will be established in 5 hotspot sites. 6 existing hotspot site will be graduated	$300,000	HVOP	16798 (fhi360)	
Capacity Building of Blood Banks and Transfusion services at Military Hospitals	Capacity building of blood banks through training, technical support in Blood banking and blood transfusion and material and reagent supply. Networking of satellite Command Blood banks to the central blood bank through Internet and data link	Contribute to the 1st and 3rd 90's	• Two more transfusion centers will be established. • Three satellite transfusion centers will be networked with the central Military blood bank • Final transition plan will be in place and actual transition will commence.	$184,889	HMBL	7515 (Ethiopia National Defense Force	
Laboratory							
Capacity building and quality assurance	Provide technical and capacity building support to regional labs to strengthen TB diagnostic support, lab biosafety and quality assurance. Lab sample transportation and networking; local validation scale up of new TB diagnostic	#1,2, and 3	Improved access and capacity to quality assured TB diagnostic services.	$200,000	HVTB	16751 (EPHI)	Laboratory (Yellow)

	technics and TB drug resistance surveillance activities.						
	Enroll laboratories in the private health sector in continuous quality improvement process including WHO/AFRO step-wise laboratory accreditation with prioritization of scale up sites	Sustained epidemic control	Private health facilities accredited	$15,000	HLAB	17824	Light Green
	TA and support to specimen transportation and laboratory networking in the private health sector	Sustained epidemic control & 3rd 90	Private health facilities are linked with the public specimen transportation system to send specimen to regional laboratories for EID, viral load, TB & MDR TB and ART monitoring	$21,000	HLAB	17824	Light Green
	Support Ethiopian public health institute (EPHI) to strengthen the sputum sample transportation using the Ethiopian Postal Services Enterprise as specimen courier. The support includes provision of technical assistance and introduction of mobile phone SMS to track sputum samples and hasten result feedback system	1st , 2nd and 3rd 90's	Sputum sample transportation strengthened	$42,471.00	HVTB	17635	Light Green
	Support the introduction of subsidized Gene Xpert services in the private facilities	1st 90 & Sustained epidemic control.	Gene XPert implemented in private facilities	$50,000	HVTB	17824	

Strategic Information							
Surveillance	HIV/AIDS, TB mortality tracking in 6 University-based DHS Sites and 1 urban burial site surveillance	# 4	HIV attributable death quantified to monitor the impact of HIV care and treatment program	$290,000	HVSI	16738(EPHA)	13. Epidemiological and Health Data
Surveillance	Technical support for implementation of drug resistance surveillance	# 3, 4	ARV drug resistance monitored	$78,321	HVSI	16750 (WHO)	13. Epidemiological and Health Data
Monitoring and evaluation	Support the monitoring and evaluation of HIV/AIDS programs	# 4	Well-functioning M & E system in place at FHAPCO	$48,160	HVSI	13931(FHAPCO)	15. Performance Data
	Provide training and technical assistance and avail required tools to strengthen the implementation of HMIS in the private health sector	Sustained epidemic control	HMIS in private sector strengthened	$137,674	HVCT (10%) MTCT (10%) HTXS (10%) HBHC (10%) PDTX (10%) PDCS (10%) HVTB (10%) HLAB (10%) HVOP (10%) OHSS (10%)	17824	Light Green
	Support RHBs to conduct standard of care assessment on NACS to selected high volume facilities.	3d 90 & sustained epidemic control	Standard of care assessment check list developed & assessment done on NACS service	$50,000	OHSS (7%) HBHC (40%) PDCS (8%) MTCT (44%)	14215	Light Green

	Provide technical assistance for FMOH & RHBs on data collection, recording and reporting of NACS indicators.	3d 90 & sustained epidemic control	Technical assistance provided on strategic information resulted in improved data management & use.	$5,000	OHSS (7%) HBHC (40%) PDCS (8%) MTCT (44%)	ET_14215	Light Green
	Support will focus on: • The transition from the existing eHMIS and other e-application into the DHIS II • TA on scaling up of paper based multi-sectoral response information system (MRIS) and on full functionality of the developed system at national level Federal HAPCO • Data use and TA in full implementation of both paper based and electronic MRIS in prioritized PEPFAR-supported sites of SNNPR and Oromia	These activities will support the utilization of service data for program decision making across the clinical cascade	• Smooth data migration will be in effect • Enhanced monitoring functions of Federal Ministry and the two regional Health Bureaus through the nationally owned MRIS • MRIS scaled up in prioritized PEPFAR-supported sites of Oromia and SNNPR.	$ 300,000	HVSI	17641	Light Green
	Organize a joint performance improvement review meeting with task forces/AIDS board in development clusters and other high risk sites	1st 90	Quality of the overall project performance improved	$ 6,348	HVOP	14230	Light Green
	Provide technical support to	1st 90	A gender	$ 14,500	HVOP	14230	Red

	worksites to develop standardized gender responsive HIV/AIDS workplace policy , carryout policy familiarization and developing implementation plan [This activity will continue under a different mechanism as of COP16]		responsive HIV/AIDS policy in a work place setting be availed for use & Improved planning skill of project worksites				
	Support activities to strengthen planning, monitoring, evaluating and assuring the quality of data for community based programs to PLHIV	1st , 2nd and 3rd 90's	Relevant programmatic qualitative and quantitative data are collected, analyzed used and shared.	$44,788 $679 $1,357 $7,465 $6,107 $2,714 $4,750	HBHC HTXS PDCS MTCT OHSS HVOP HVSI	17825	Light Green
	Support the routine HIV & nutrition related data collection, analysis & reporting.	1st , 2nd and 3rd 90's	Relevant programmatic qualitative and quantitative data are collected, analyzed used to improve quality of HIV & Nutrition services.	$10,795.18 $287.87 $2,302.97 $1,007.55	HBHC PDCS MTCT HVSI	14217	Light Green
Systems Development							
	Build the capacity through mentoring and training of private providers on rational drug use	Sustained epidemic control, 3rd 90	Strengthened rational pharmaceutical practices in private health facilities	$9,000	OHSS	17824	Light Green

	Strengthen the FMHACA performance of product registration and licensing system of FMHACA	Contributed to the triple 90	Increase availability of quality assured medicines and health products at affordable price	$250,000	OHSS	14212	Red
	Strengthen the post marketing surveillance system (PMS) of ARVs and OIs	Contribute to the second and third 90	Post market quality control and assurance system built	$200,000	OHSS	14212	Red
	Strengthen product Quality Assurance Laboratory of EFMHACA and EFMHACA branch labs, to expedites the dossier evaluation and market authorization	Quality assurance is key milestone for products that used for triple 90's	WHO prequalification and ISO accreditation of the lab	$200,000	OHSS	14212	Red
	Support the Regional Bioequivalence Centre (RBEC) to make it technically competent to conduct bioavailability/bioequivalence studies for local as well as regional pharmaceutical industries	Ensure the availability of OIs and other essential medicines for HIV/AIDS that contribute the second and third 90	• Help to provide training on dosser and dosser evaluations • Local capacity on dosser data requirement, local quality assured products and improvement in local production	$200,000	OHSS	14212	Red
	Establish the quality testing laboratory of Pharmaceuticals Fund and Supply Agency	Contribute to the third 90	Quality assured product procurement systems	$200,000	OHSS	14212	Yellow

	Support FMOH, RHBs (SNNP and Oromia), and C/THOs to further strengthen the implementation and use of the data management system for the Urban Health Extension Program	Address Sustained Epi Control	A well capacitated program managers will be available at all levels to use the data management system to monitor Urban Health Extension Program	$50,000	OHSS	14210	Light green

	Supporting the transition from paper-based MRIS to e-MRIS: The collection of reliable HIV data to tracking the status of HIV/AIDS in communities. Supports FHAPCO's initiative to transition from a paper-based MRIS to a (e-MRIS), which will allow for the collection and administration of HIV/AIDS related information within the local context and enable access to reliable MRIS data from a number of stakeholders.	1st , 2nd and 3rd 90's	FHAPCO provides leadership, management and coordination of e-MRIS activities to achieve results that support HIV/AIDS and health sector - eMRIS strategic planning is undertaken, including coordination of inputs, Systems analysis, documenting use cases, functional requirements, monitoring development of eMRIS.	$117,624	HVSI	17825	Light Green

	Supporting the transition from paper-based MRIS to e-MRIS: to collect reliable HIV data this is a critical step in tracking the status of HIV/AIDS in communities. This activity supports FHAPCO's initiative to transition from a paper-based MRIS to a e-MRIS, which will allow for the collection and administration of HIV/AIDS related information within the local context and enable access to reliable MRIS data from a number of stakeholders.	1st , 2nd and 3rd 90's	• FHAPCO provides leadership, management and coordination of e-MRIS activities to achieve results that support HIV/AIDS and health sector • eMRIS strategic planning is undertaken, including coordination of inputs, Systems analysis, documenting use cases, functional requirements , monitoring development of eMRIS.	$39,285.63 $2,380.95 $19,047.60 $8,333.33	HBHC PDCS MTCT HVSI	14217	Light Green
TOTAL							

7.0 Staffing Plan

PEPFAR-E's COP15 SDS reported that the team had 19 vacancies. For COP16, there are currently 22 positions (14%) that are not yet filled. Key leadership vacancies include the PEPFAR Country Coordinator and USAID Deputy HIV Team Lead. The PEPFAR Country Coordinator position has been vacant from July 2014, and the new coordinator is anticipated to be onboard in June 2016. To date there is one new planned staffing request in the coordination office. PEPFAR-E is focused on filling current vacancies and re-purposing positions (if needed) to support the programmatic pivots.

All 151 employees have full-time employee (FTE) status with the U.S. Government. Of that total, 127 are 100% dedicated to PEPFAR and approximately 87% of the total numbers of positions are fully PEPFAR funded. Ethiopian (host country) nationals constitute 85% of PEPFAR funded staff and there is no plan to shift citizenship type for any position in COP16.

Technical and Programmatic Leadership and Support makes 64% of the overall footprint, after deducting non-program PC staff, and the team feels there is enough staff to manage programs. PEPFAR-E does not see the need to repurpose current vacant positions in administrative and finance (nine).

A Senior Technical Advisor position was added after COP15 submission and approval is pending. The Public-Private Partnerships (PPPs) Advisor left post in December 2014; the position has since been repositioned to a Strategic Advisor. In addition to managing PPPs, the Strategic Advisor will also serve as the Global Fund Liaison, including some SI responsibilities.

The only anticipated change to PEPFAR Cost of Doing Business (CODB) will be the addition of the Senior Technical Advisor. This position was authorized by the U.S. Embassy Front Office as the PEPFAR office did not have a Coordinator, which created a challenging work load for the remaining staff. Additionally, this position was created to fill the need required for a more data-driven approach to PEPFAR programming. This expense can be covered from COP14 CODB pipeline including COP15.

APPENDIX A

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
Totals						

Table A.1 Program Core, Near-core, and Non-core Activities for COP16

Level of Implementation	**Core Activities**	**Near-core Activities**	**Non-core Activities**
Site level			
Sub-national level			
National level			

Table A.2 Program Area Specific Core, Near-core, and Non-core Activities for COP16

Prevention	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Training in provision of HCT services	Printing and distribution of national HCT guidelines	
	Procurement of HIV RTKs and related supplies for HCT programs	Promotion /advocacy on targeted testing (more of a central type of activity)	
	Support referral and tracking of HIV positive to create demand and do partner and family testing		
	Targeted testing for KP and PP		
	Index case testing		
	Targeted demand creation to increase HCT uptake		
	KP and PP Partner and families of PLHIV		
	QA and QI of HCT services		
	Data analysis and use		
	Targeted HIV testing in high yield service delivery outlets		
	Targeted HIV testing for high yield sites for patients with TB, STI, OI and other symptoms of HIV		
	Targeted pediatric PICT at health facility entry points		
	Printing and distribution of job aids on quality HCT service		
Blood Safety	Strengthen the managerial and coordination capacity of the FMOH/NBTS.		

	Support IEC/BCC activities for voluntary and non-remunerated donor education and recruitment		
	Support activities improving blood safety total quality system (Accreditation and EQA)		
	Revised blood safety guidelines, s standards, SOPs, strategic plans and policies		
	Improving quality of blood collection and blood testing (transfusion-transmissible infections)		
	Providing TOT training on appropriate clinical use of blood for clinicians working in hospitals	Cascading of training to service providers	Cascading of training of ACUB (appropriate clinical use of blood) to service providers at the sub-national level
	Equipment for blood storage and distribution		
	Training on blood banking and lab procedures blood bank staff		
	Establish/strengthen transfusion committees in transfusion hospitals and provide training on t transfusion on procedures and haemovigilance		
	Procure and distribute key blood bank equipment, test kits and supplies		
	Strengthen/improve data capturing and reporting system with IT system and training for improved program management		
HMIN			Targeted infection prevention commodity procurement
HVOP	STI screening, diagnosis and treatment or syndromic management based on updated national guideline	Support to MOE to curriculum development	
	Training for STI		
	Targeted behavioral intervention for KP		
	Targeted behavioral interventions for PP		
	Refugee in Gambella		
	Uniformed service and inmates		
	Mobile/seasonal workers		
	Vulnerable adolescent girls		
	People in transactional sex		
	Discordant couples		
	Divorced and widowed		
	STI kit procurement and distribution		
	Targeted condom procurement, supply and distribution		

	Gender based interventions targeting KP and PP		
	Support on data generation, analysis and use among KP and PP		
VMMC		Provide the minimum package of VMMC services	
		Procure and distribute VMMC kits, supplies and relevant commodities	
		Linkage to treatment/Care services for men who test HIV+	
		Training on MC procedure, adverse event and safety	
		Targeted demand creation for comprehensive VMMC service provision in Gambella	
Care and Treatment	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Test & START : Provision of ART for adults and pediatric population irrespective of CD_4 count and clinical status		
	Adherence Support/Case Management (Adult plus pediatrics) – improves retention of ART (pre-ART) patients in care and treatment services, and optimize adherence. Case management activities contribute to fighting stigma and discrimination and further strengthen activities in preventing HIV transmission to other uninfected individuals through enhancing disclosure, achieving virology suppression by optimizing adherence, and promoting responsible healthy living		
	NACS and Food – Includes nutritional assessment and counseling services, and provision of nutritional support to those malnourished PLHIV		
	OI drugs (Cotrimoxazole) – CPT		
	PHDP (both facility and community) : The packages of PHDP services include adherence counseling : disclosure and partner testing, provision of family planning and safe pregnancy counseling		

	services: risk reduction counseling and condom provision; and STI assessment and treatment		
	Mentoring supportive supervision and training (Adult plus pediatrics)		
	TB/HIV collaborative interventions: (Adult plus pediatrics) : provision of INH prophylactic therapy for TB, TB screening and TB infection control		
	Wash and hygiene (Adult plus pediatrics) : Support for point of use water treatment and hygiene		
		Provision of Albendazole, multivitamin and Zinc as part of preventative care package (Adult plus pediatrics)	
		Pain assessment and management (Adult plus pediatrics)	
	Mental health and substance abuse (Adult plus pediatrics): Integration of mental health services at ART service delivery points and screening and referral of mental health and substance abuse disorders using community health workers to mitigate the impact of mental health illnesses and substance abuse problem on patient's adherence to treatment and medication and risk of HIV transmission. Development of guideline and training material at FMOH level and provision of training, mentoring and supportive supervision at site level.		
	PMTCT : Option B+ with its comprehensive care services , EID		
		Economic Strengthening and social protection support	
	VL and CD4 : Includes procurement of reagents, equipment, maintenance services, and training and mentoring of laboratory professionals		
	Sample transportation (Adults plus pediatrics) : Support EPHI and the postal system for sample transportation		

	EQA: VL, TB, CD4, Chemistry and hematology. GeneXpert)		
	Laboratory monitoring : hematology and chemistry		
	TA to private health sector using international partner		
	GeneXpert		
		Laboratory monitoring: hematology and chemistry	
	TA to private health sector	SIT agreement: The language in the COP15 Core, Near-core, Non-Core framework that refers to TA to the private health sector in the Care and Treatment area is not fully descriptive of the current USG support to the private health sector nor is it descriptive of the idea of expanding the TA support to include provision of ART; a. This language will be removed from the Framework for COP16 with the understanding that the activities described in the Prevention, Care and Treatment program areas include both supports to the public and private health sectors. b. The Prevention, Care and Treatment TWGs will continue their work to unpack activities that are currently being supported by PEPFAR in both the public and private health sectors. c. As the PEPFAR Ethiopia team moves through the next modular planning steps to develop COP16 (i.e. reviewing site level data, EA, partner performance, pipeline via the data pack, PBAC and other COP16 tools provided by S/GAC) decisions will be made that determine PEPFAR Ethiopia's investment approach. d. As usual during COP development, new activities proposed	

		would require interagency review alongside continuing programs.	
OVC	**Core Activities**	**Near-core Activities**	**Non-core Activities**
	Case management and identification of children and adolescent sub population made vulnerable by or to HIV and AIDS	Mapping services within targeted communities and developing service directories	
	Assessing child, adolescent and family socio-economic status and risk (across all areas; healthy ,safe, stable, schooled)	supporting the development of national MIS	
	Developing strengths base case management plans for children and families with monitoring of referral completion and stated case closure goals	Training in case management for CHV and voluntary children's officers (including tracing of children LTFU) within PEPFAR catchment areas	
	Implementing special studies to identify gaps in programming impact		
	Health (access o health/HIV services and promotion of HIV testing of OVC program participants, including EID and confirmatory HIV testing		
	Referral to interventions focused on keeping adolescents HIV free for those who test HIV negative especially adolescent girls		
	Establish and strengthening referral mechanisms and other systems to ensure cross referral between clinic and social services (cross referrals)		Providing HH supplies as blankets and mattresses
	Coordination with commodity and counseling providers to ensure that dual protection is accessible to adolescent OVC		
	Integrating ART adherence assessment, counseling and support into routine household support for family members with HIV		
	Provision of food support through referral linkage and ES		
	Coordination with NACS (e.g. referral of suspected malnutrition, education)		
	Facilitating update of and monitoring completion of referrals for: Nutrition and food security programs, TB/HIV testing; treatment and care services for all children and partners of		

	index cases, child survival services, age specific healthcare needs adolescents for SRH and FP services, especially adolescent girls and immunization for under 5's		
	Safe protection & psychological support at community and national level, child protection/GBV prevention and response activities and referral to other services	Strengthening government managed and case management system to prevent and respond to child abuse and support family placement and permanency for children	Strengthening birth registration systems
	supporting clinic based child abuse and GBV response services (including emergency medical services/PRC)	Strengthening structures for community-based mediation of child abuse cases	supporting placement in long-term residential care facilities
	Addressing psycho-social , health among children and their caregivers through individual, group based and relationship based activities	M&E system for National child protection/ social welfare efforts	Carrying out large scale child rights awareness campaigns
	Succession planning and permanency support	Supporting advocacy and policy efforts to improve safety of children from violence	Dissemination of child protection laws
	Positive parenting skills (including discipline, communication on adolescent risk, HIV disclosure)		
	Support to "safe space" approach for adolescents at high risk especially girls (i.e. street children , domestic workers)		
	Stable (Economic Strengthening and social protection support) Social service system strengthening : professional development for social and para social workers in child protection, GBV and permanency, build the capacity of the government to strengthening the social		
	Facilitating group based household economic strengthening (HES) activities, such as saving groups		
	Carrying out market assessments for income generating Activities (IGAs)		
	Supporting market linkage, occupational training and other individual HES activities		
	Supporting access to and uptake of social protection		

	efforts (such as social grants, cash transfer, programs, bursaries. etc.)		
	Limited and temporary emergency cash generally required for <10% of cases) N/A	Linkage business/agricultural projects to market/value chain development	Providing micro credit
		Targeted food security initiatives	Providing housing
			Covering vocational training and/or IGA's without established market potential
	School (education) based on analysis of gender disparities in completion rates (primary and secondary levels) identify key at risk groups for education support	Facilitating access to primary (and secondary education for girls) through long-term or open ended subsidies	Supporting tertiary education (including university subsidies and scholarship)
	Facilitating access to primary and secondary education through temporary and targeted support	Support to ECD centers, improving education quality, especially making classroom environments gender and HIV sensitive	
	School based psychosocial support and safety from violence	Supporting community education councils and PTAs to provide support to OVC	
	Supporting early childhood development (ECD) in coordination with PMTCT and Pediatric HIV)		
	Integrating ECD into HIV care and treatment for children under five		
HSS and SI	Core	Near-core	Non-Core
	Pre-service education under graduate programs- MD, Nurse, Midwife, Anesthetics, HEWs , health Information Technician, Biomedical Engineers		
	Post-Graduation Programs : Biostatics and Health, Masters in hospital Administration	Field epidemiology and laboratory training program, Emergency Medicine, Gynecology and obstetrics training, M&E, Integrated surgical officers	
	In service training (IST unit establishment, National level support) - curriculum development, database system, standardization		
	HRIS (system development, training)		
	HIV Service Quality Improvement - system development at all levels of the healthcare system		
	Health Sector Financing Reform (Domestic Resource Mobilization,		

	Revenue Retention and Utilization ; TA ; training, developments of manual)		
	Leadership and Governance		Moved from near-core because there is consistent gap in leadership and management skills
	Monitoring and Evaluation		
	HMIS		Team could not reach in to consensus to categorize this program area and have escalated it to SIT

Table A.3 Transition Plans for Non-core Activities

Transitioning Activities	Type of Transition	Funding in COP16	Estimated Funding in COP 17	# of IMs	Transition End date	Notes
Support to new blood banks	Financial	$0	$0	7	As of now	PEPFAR is not currently supporting new blood banks
Support cascading of training on ACUB to sub national level.		$65,264	$57,071	7	As of end of COP16	
Targeted IP commodity procurement	Technical, Financial, commodity supply	0	$0	1	As of end of COP15	Infection prevention materials among other commodities are funded by Global Fund
Totals						

APPENDIX B

B.1 Planned Spending in 2016

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US 18,943,069	**$US 155,556,931**	**$US 174,500,000**

Table B.1.2 Resource Allocation by PEPFAR Budget Code (New Funding Only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	5,762,475
HVAB	Abstinence/Be Faithful Prevention	10,999
HVOP	Other Sexual Prevention	13,264,810
IDUP	Injecting and Non-Injecting Drug Use	0
HMBL	Blood Safety	2,011,951
HMIN	Injection Safety	22,362
CIRC	Male Circumcision	302,976
HVCT	Counseling and Testing	5,594,756
HBHC	Adult Care and Support	17,593,430
PDCS	Pediatric Care and Support	1,447,998
HKID	Orphans and Vulnerable Children	11,363,778
HTXS	Adult Treatment	52,438,036
HTXD	ARV Drugs	0
PDTX	Pediatric Treatment	4,916,900
HVTB	TB/HIV Care	5,485,210
HLAB	Lab	3,011,957
HVSI	Strategic Information	8,230,856
OHSS	Health Systems Strengthening	14,218,461
HVMS	Management and Operations	9,879,976
TOTAL		**155,556,931**

B.2 Resource Projections

Resource needs for program activities in the coming implementation year were identified in an iterative process during COP preparation. As an initial step, budget codes dominated by above-site level activities (e.g. Blood, health systems strengthening, strategic information) were separated from those with MER targets and assigned a preliminary budget placeholder based on COP15 allocations minus a proportional reduction based on overall budget reductions in COP16.

For budget codes having MER indicators, preliminary budget code levels were determined by PBAC output. These were based on inputs for unit expenditure, target size, both adjusted for sustained and scale-up woredas, and manual adjustment of distributions within the budget mapping sheet. By interagency agreement, unit expenditures were taken directly from FY15 data available in the national unit expenditures sheet of the EA NAV tool (March 27, 2016 version). UE data was complete and PEPFAR-E used the UE adjustment tool provided by OGAC. The UE adjustment tool was used to factor-in the strategic shifts and program pivots. Given the uncertainties of PBAC estimation and the danger of underfunding critical treatment programs, however, the decision was made to err on the higher side as inputs to PBAC. A challenge was with the SBOR lump sum amount in the PBAC.

Adjustments to budget mapping tables were made qualitatively with interagency agreement. Targets, by contrast, were submitted to the PEPFAR Ethiopia Coordination Office by individual agencies, and were sometimes but not always had interagency consensus. Once preliminary budget codes were derived from the PBAC, final iterations were done at the senior-inter-agency level to rationalize budget code levels with overall agency budget ceilings and specific budget code earmarks.

APPENDIX C

Systems Investments for Section 6.0

Included Activities	Excluded Activities
Human Resources for Health (HRH): Systems/Institutional Investments	
Pre-service training; in-service training systems support and institutionalization; HRH performance support/quality; HRH policy planning and management; HR assessments and information systems; other HRH activities not classified as above	N/A
Human Resources for Health (HRH): Personnel Costs for Service Delivery	
In-service training; all HRH support at sites and community across all program areas	Other site-level investments such as purchase of vehicles, equipment and furniture, construction and renovation, and site-level recurrent categories such as ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, building rental and utilities
Governance	
Technical area-specific guidelines, tools, and policy; general policy and other governance; other governance activities not classified as above	N/A
Finance	
Expenditure tracking; efficiency analysis and measurement; health financing; costing/cost modeling; other health financing activities not classified as above	N/A
Systems Development	
Supply chain systems; health information systems (HIS); laboratory strengthening; other systems development activities not classified above	ARVs, non-ARVs drugs and reagents, HIV test kits, condoms, travel and transport, freight for transport of commodities to sites and other supply chain costs incurred at the site-level
Institutional and Organizational Development	
Civil society and non-governmental organizations (NGOs); government institutions; social welfare systems strengthening; other institutional and organizational activities not classified above	N/A
Strategic Information	
Monitoring and evaluation; surveys; operations research; geographic mapping, spatial data, and geospatial tools; surveillance; other strategic information activities not classified above	N/A
Laboratory	
Quality management and biosafety systems; implementation and evaluation of diagnostics (POC and VL monitoring); laboratory information and data management systems; laboratory workforce; quality management system; sample referral systems; accreditations; technical assistance to assure or improve quality of laboratory services	Vehicles, equipment and furniture, construction and renovation for site labs, and recurrent categories from site labs such as lab reagents an supplies, travel and transport, building rental and utilities will not be included