Ethiopia
Country Operational Plan
(COP/ROP) 2018
Strategic Direction Summary
May 17, 2018
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1.0 Goal Statement

Ethiopia is at a historic moment of the HIV/AIDS response, is positioned to reach sustained epidemic control by the end of the COP18 implementation period, Figure 1.1.

Figure 1.1: Ethiopia – Pathway to Reaching Epidemic Control

Progress, albeit slow, has been made in intensifying case detection and ART initiation in order to detect, initiate, and suppress the virus in the remaining people living with HIV (PLHIV). The national program has undertaken a rapid scale-up of viral load testing, but much more needs to be done to improve results turnaround and use. Still, gaps remain across age and sex groups (Table 1.1), especially among pediatrics, 15-24 year olds and 50+ year old women.

Table 1.1: Treatment Coverage by age and sex bands

<table>
<thead>
<tr>
<th>Age Distribution</th>
<th>Estimated PLHIV 2017</th>
<th>PLHIV on ART 2018Q1</th>
<th>ART Coverage 2018Q1</th>
<th>Remaining PLHIV that Need ART 2018Q1</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
<td>Female</td>
<td>Total</td>
<td>Male</td>
</tr>
<tr>
<td>0-4</td>
<td>8,189</td>
<td>7,872</td>
<td>16,061</td>
<td>1575</td>
</tr>
<tr>
<td>5-9</td>
<td>10,800</td>
<td>10,440</td>
<td>21,240</td>
<td>3,589</td>
</tr>
<tr>
<td>10-14</td>
<td>12,557</td>
<td>12,310</td>
<td>24,867</td>
<td>8,207</td>
</tr>
<tr>
<td>15-19</td>
<td>15,948</td>
<td>19,921</td>
<td>35,869</td>
<td>7,278</td>
</tr>
<tr>
<td>20-24</td>
<td>16,698</td>
<td>23,873</td>
<td>40,571</td>
<td>5,735</td>
</tr>
<tr>
<td>25-49</td>
<td>120,420</td>
<td>231,152</td>
<td>351,572</td>
<td>117,443</td>
</tr>
<tr>
<td>50+</td>
<td>45,005</td>
<td>75,618</td>
<td>120,623</td>
<td>36,629</td>
</tr>
<tr>
<td>Overall</td>
<td>229,617</td>
<td>381,186</td>
<td>610,803</td>
<td>180,456</td>
</tr>
</tbody>
</table>
There are 610,335 PLHIV in Ethiopia, a decrease of approximately 100,000 from the 2016 UNAIDS estimates; with about 70% receiving lifesaving treatment, and an estimated 88% virally suppressed among those tested. Better and more precise data is expected from the Ethiopia Population HIV Impact Assessment (EPHIA), preliminary results are due in September 2018. PEPFAR program data shows slight variations in progress toward attaining 95-95-95 in all regions, and in all age and sex bands. For example Amhara’s gap to 91% treatment coverage is 34,410; meanwhile the gap in Somali is 2,679. To respond to this variation, PEPFAR has restructured its geographic intervention categories. Among the 11 regions (2 of which are city administrations) 3 are characterized as COP17 Attained (Dire Dawa, Tigray and Harari), 4 are COP18 Attained (or Maintained) (Amhara, SNNP, Addis Ababa and Oromia), and 4 are Emerging (Afar, Benishangul-Gumuz, Gambella, and Somali). These distinctions are made based on the current (as of APR17) and anticipated (as of APR18) levels of ART coverage, with “Maintained” regions, having the largest gaps and the greatest need for intensified programming for epidemic control. The success of the COP18 strategy will depend significantly on the performance in COP17.

The majority of PEPFAR’s investments are in the COP18 Attained category. In this category, PEPFAR will support a comprehensive package of services along the clinical cascade, as well as interventions for Orphans and Vulnerable Children, and Female Sex Workers and high-risk priority populations (in Addis Ababa and Amhara only). In contrast, in the COP17 Attained regions, PEPFAR’s support will significantly reduce. The goal is for these regions to reach epidemic control by the end of COP18 implementation, after which PEPFAR will transition its site-level support. In these regions, PEPFAR will support the regional health bureaus to implement facility driven ICT to reach the remaining PLHIV, and to maintain epidemic control through strengthening adherence and retention. Similarly, all site-level PEPFAR support to the Emerging regions will end by September 2019; continuation of site-level support to Gambella will be informed by based on program performance and a USG desk review to be conducted during COP18.

PEPFAR set targets to support testing of 340,727 number of persons (15,204 estimated positive), and initiating 26,060 new persons on treatment; for a total of 516,832 persons receiving care and treatment services. These targets will be achieved through intense support of tailored activities at the national, regional, facility and community levels, as illustrated in Figure 1.2. PEPFAR will focus on improving service delivery models that will be scale-up with fidelity. In COP18, facility-initiated Index Case Testing (ICT) is the primary PEPFAR supported modality to case finding. Strong focus will be given to improving linkage, increasing viral load coverage, and ensuring adherence and retention by (1) strengthening accompanied referrals; (2) improving patient tracking across the clinical cascade through improved data capture, quality and use for action; and, (3) supporting the Government of Ethiopia (GoE) to scale up differentiated models of service delivery.

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1 City administration
2 Emerging region is GoE’s naming convention, not by PEPFAR

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Case-based surveillance, including incidence, together with a focus on data use for public health response, will be pivotal to this strategy for sustained epidemic control, starting with COP18. In order to sustain epidemic control by preventing new infections and reducing AIDS related deaths, Ethiopia will have to track, identify and respond in real time to changes in the epidemic. For that reason, at the national and regional levels, PEPFAR seeks to establish or strengthen case-based surveillance systems and activities such as HIV recency testing that are necessary to monitor the epidemic. Patient-level information systems must be able to provide continuous, de-identified patient records for supporting case-based surveillance and monitor performance of the program with greater fidelity across the clinical cascade. In addition to these systems level activities that are important for an appropriate and timely public health response, PEPFAR will continue to improve quality management processes, and technical assistance to ensure effective quantification, procurement, and distribution of commodities.

In addition to considerable policy changes in recent years, the Federal Ministry of Health (FMoH) revised the HIV consolidated guidelines to include adoption of HIV self-testing (HIVST), transition to tenofovir-lamivudine-dolutegavir (TLD) as the recommended first line ARV regimen for new and existing adult/adolescent patients, rapid and same day treatment initiation, partner services and index case testing, and scale up of differentiated models of service delivery. The policy and programmatic progress seen in Ethiopia is as a result of the Government of Ethiopia’s (GoE) commitment to an AIDS-free generation; as well strong collaboration with civil society organizations (CSOs), and key stakeholders such as UNAIDS, The Global Fund, and WHO. COP18 builds on these existing partnerships and will continuously address the critical need to align PEPFAR and Global Fund resources, particularly as resources become scarce and the country reaches epidemic control.
2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Epidemic Profile

With a projected population of over 98 million, 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$660 (World Bank 2016) and 33.5% of the population living below the international poverty line of $1.90/day (World Bank 2010). According to the UN Human Development Index (2016), Ethiopia ranks 174 out of 188 countries on both the overall index and the per capita Gross National Income ($1,523), with a gross domestic product (GDP) of $72.37 billion. It is also one of the least urbanized countries with 23% 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 Key and Priority Populations (KP and PP), and in pockets of the general population. Per 2016 DHS estimate, adult HIV prevalence in Ethiopia is estimated to be 0.9%. There is substantial prevalence variation by region (4.8% in Gambella, 3.4% in Addis Ababa, and 0.4% in SNNP). The overall PLHIV burden has decreased significantly. Based on 2017 SPECTRUM estimates, Ethiopia has 610,335 PLHIV and 13,556 AIDS deaths annually, as shown in table 2.1.1. Incidence is estimated at 0.13 per thousand or approximately 12,397 cases a year. Significant gains have been made in ensuring HIV positive pregnant women are placed on ART and that men are circumcised. Collectively, these data suggest that Ethiopia is close to reaching epidemic control but still has key pockets where HIV programming should be further addressed.

The HIV epidemic in Ethiopia is primarily associated with areas of urban concentration and proximity to major transport corridors. Those living close to major roads have HIV prevalence rates that are much 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 (4.8%) 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.

According to the 2014 National MARPS Survey conducted by Ethiopian Public Health Institute (EPHI), HIV transmission remains highest among KP and PP. High circumcision rate (91%), among other factors, continue to contribute to lower rates of HIV transmission among the general population. For KP, FSW HIV prevalence is estimated at 23% and MSM HIV prevalence is estimated at 24.4% (2013 MSM survey, Addis Ababa) although a robust size estimate and mapping study has not been conducted in recent years. There are currently no reliable estimates for PWID though they are noted as a key population that needs services in the most recent GFATM technical review panel (TRP) report. Priority include high risk AGYW involved in transactional sex, male clients of sex workers, daily/seasonal laborers, truck drivers, HIV negative partners in discordant couples, STI cases, prison inmates, and widowed and divorced women and are estimated to be at 2,373,935.

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.
<table>
<thead>
<tr>
<th>Source, Year</th>
<th>Total Population</th>
<th>HIV Prevalence (%)</th>
<th>AIDS Deaths (per year)</th>
<th># PLHIV</th>
<th>Incidence Rate (Yr)</th>
<th>New Infections (Yr)</th>
<th>Annual births</th>
<th>% of Pregnant Women with at least one ANC visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
<td>N</td>
</tr>
<tr>
<td>Total</td>
<td>98,640,990</td>
<td>100%</td>
<td>1,976,374</td>
<td>20%</td>
<td>19,942,903</td>
<td>20%</td>
<td>44,870,268</td>
<td>5%</td>
</tr>
<tr>
<td>Female</td>
<td>9,492,934</td>
<td>9.6%</td>
<td>1,710,798</td>
<td>17.3%</td>
<td>1,839,134</td>
<td>18.5%</td>
<td>4,013,232</td>
<td>4.4%</td>
</tr>
<tr>
<td>Male</td>
<td>89,148,056</td>
<td>90.4%</td>
<td>8,265,576</td>
<td>82.7%</td>
<td>18,103,769</td>
<td>18.5%</td>
<td>40,857,036</td>
<td>45.6%</td>
</tr>
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<td>Refers to Year 2019. Adapted from Population Projection of Ethiopia from CSA.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<tr>
<td>Refers to Year=2019. Spectrum from FMOH.</td>
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<tr>
<td>Refers to Year=2019. (All Ages) Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<tr>
<td>Refers to Year 2019. CSA and DHS2016.</td>
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<tr>
<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<tr>
<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<tr>
<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<td>Refers to Year 2019. Spectrum from FMOH.</td>
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<tr>
<td>Health Sector Transformation Plan, Annual.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Category</td>
<td>Number</td>
<td>Source</td>
<td></td>
<td></td>
<td></td>
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<td>------------------------------------------------------------------------</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Pregnant women needing ARVs</td>
<td>23,431</td>
<td>Refers to Spectrum from FMOH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orphans (maternal, paternal, double)</td>
<td>2,997,533</td>
<td>Refers to Spectrum from FMOH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Notified TB cases (Yr)</td>
<td>125,801</td>
<td>Health Sector Transformation Plan, Annual Performance Report 2015/16, FMOH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of TB cases that are HIV infected</td>
<td>8%</td>
<td>2015: FMOH: HMIS report</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>% of Males Circumcised</td>
<td>91%</td>
<td>DHS 2016</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Population Size of MSM*</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MSM HIV Prevalence</td>
<td>24.4%</td>
<td>MSM survey Addis Ababa, 2013 (Unpublished)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Population Size of FSW</td>
<td>199,511</td>
<td>Extrapolated from Size estimation by PEPFAR interagency</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FSW HIV Prevalence</td>
<td>23%</td>
<td>National MARPs survey, EPHI/EPHI/CDC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Population Size of PWID</td>
<td>NA</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>PWID HIV Prevalence</td>
<td>NA</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Size of Priority Populations (specify)</td>
<td>2,373,935</td>
<td>UNAIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Estimated Priority Populations Prevalence (specify)</td>
<td>NA</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

*If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*
Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*

<table>
<thead>
<tr>
<th>Epidemiologic Data</th>
<th>HIV Treatment and Viral Suppression</th>
<th>HIV Testing and Linkage to ART Within the Last Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total population</td>
<td>94,351,001</td>
<td>0.9%</td>
</tr>
<tr>
<td>Population &lt;15 years</td>
<td>37,979,765</td>
<td>NA</td>
</tr>
<tr>
<td>Men 15-24 years</td>
<td>4,691,661</td>
<td>0.18%</td>
</tr>
<tr>
<td>Women 15-24 years</td>
<td>23,596,771</td>
<td>0.84%</td>
</tr>
<tr>
<td>Women 25+ years</td>
<td>4,658,456</td>
<td>0.20%</td>
</tr>
<tr>
<td>MSM</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>FSW</td>
<td>193,970</td>
<td>23%</td>
</tr>
<tr>
<td>PWID</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Priority Pop (specify)</td>
<td>NA</td>
<td>NA</td>
</tr>
</tbody>
</table>

*Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression*
2.2 Investment Profile

The Federal Ministry of Health recently completed the sixth round of the National Health Accounts (NHA 2014). The 2014 NHA is the latest available data on health spending and was released in 2017. According to the 2014 NHA, the health expenditure in Ethiopia is estimated to be $1,788,676,523 (March 2018 exchange rate of one dollar to 27.73 Ethiopian Birr). The government of Ethiopia manages the largest proportion of health spending although its share declined slightly from 48.9 percent in 2010/11 to 44 percent in 2013/14. Donors, insurance entities, and the private sector play a lesser role, each managing only 2 percent of spending.³

The NHA survey also showed that a significant share of health spending (49 percent) goes to prevention, management, and treatment of infectious and parasitic diseases and of this amount, nearly 10 percent goes to HIV/AIDS (see figure 2.2.1).

Figure 2.2.1: Spending on major disease and health conditions, 2013/2014 NHA

³ NHA assessment conducted in 2013/14 and report is released in 2017.
The 2013 National AIDS Spending Assessment (NASA) further disaggregates the sources of spending for the HIV/AIDS program. Approximately 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 2.2.1). It is important to note that the 13% attributed to the public sector contribution continues to be 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 according to the NASA.

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

PEPFAR funds are devoted to providing technical assistance (TA), direct support to testing, care and treatment, and viral load activities, health system strengthening activities, and strengthening supply chain management as indicated in tables 2.2.2 and 2.2.3. The Global Fund primarily supports diagnosis and treatment through provision of test kits and anti-retroviral (ARVs) for public and private sectors. PEPFAR provides nearly 100% of the non-commoditized HIV donor assistance in Ethiopia.

<table>
<thead>
<tr>
<th>Program Area</th>
<th>Combined PEPFAR+GF expenditure</th>
<th>PEPFAR $</th>
<th>PEPFAR %</th>
<th>GF $</th>
<th>GF %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical care, treatment</td>
<td>$143,556,809</td>
<td>$64,288,143</td>
<td>45%</td>
<td>$79,268,666</td>
<td>55%</td>
</tr>
<tr>
<td>and support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-based care</td>
<td>$17,893,430</td>
<td>$17,893,430</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>PMTCT</td>
<td>$6,969,598</td>
<td>$5,762,475</td>
<td>83%</td>
<td>$1,207,123</td>
<td>17%</td>
</tr>
<tr>
<td>HTS</td>
<td>$11,119,761</td>
<td>$5,594,756</td>
<td>50%</td>
<td>$5,525,005</td>
<td>50%</td>
</tr>
<tr>
<td>VMMC</td>
<td>302,976</td>
<td>302,976</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>PP PREV</td>
<td>$10,999</td>
<td>$10,999</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>KP PREV</td>
<td>$16,278,967</td>
<td>$13,264,810</td>
<td>81%</td>
<td>$3,014,157</td>
<td>19%</td>
</tr>
<tr>
<td>OVC</td>
<td>$14,385,053</td>
<td>$11,363,778</td>
<td>78%</td>
<td>$3,221,275</td>
<td>22%</td>
</tr>
<tr>
<td>Laboratory</td>
<td>$5,381,545</td>
<td>$3,019,575</td>
<td>54%</td>
<td>$2,369,988</td>
<td>44%</td>
</tr>
<tr>
<td>SI, Surveys, and Surveillance</td>
<td>$9,030,856</td>
<td>$8,230,856</td>
<td>91%</td>
<td>$800,000</td>
<td>9%</td>
</tr>
<tr>
<td>HSS</td>
<td>$14,218,462</td>
<td>$14,218,462</td>
<td>100%</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Total</td>
<td>$239,045,862</td>
<td>$143,942,642</td>
<td>60%</td>
<td>$95,405,814</td>
<td>40%</td>
</tr>
</tbody>
</table>

---

4 The data for tables 2.2.1 and 2.2.2 (a and b) is from the NASA 2011/2012, which is the most current data source for the national investment profile.
### Table 2.2.2b Procurement Profile for Key Commodities (2017)

<table>
<thead>
<tr>
<th>Commodity Category</th>
<th>Total Expenditure</th>
<th>% PEPFAR</th>
<th>$ PEPFAR</th>
<th>% GF</th>
<th>$ GF</th>
<th>% Host Country</th>
<th>% Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>ARVs</td>
<td>38,231,372</td>
<td>0%</td>
<td>0</td>
<td>100</td>
<td>38,231,372</td>
<td>$ 12,989,456</td>
<td>-</td>
</tr>
<tr>
<td>Rapid test kits</td>
<td>21,999,308</td>
<td>1%</td>
<td>281,879</td>
<td>99%</td>
<td>21,717,429</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Other drugs</td>
<td>394,447</td>
<td>100%</td>
<td>394,447</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Lab reagents</td>
<td>4,799,282</td>
<td>100%</td>
<td>4,799,282</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Condoms</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Viral Load</td>
<td>3,367,890</td>
<td>100%</td>
<td>3,367,890</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>VMMC kits</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>MAT</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Other commodities</td>
<td>2,254,110</td>
<td>100%</td>
<td>2,254,110</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td>Another commodity2 condom testing machine</td>
<td>185,850</td>
<td>100</td>
<td>185,850</td>
<td>0</td>
<td>0</td>
<td>unknown</td>
<td>unknown</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>$71,232,259</strong></td>
<td><strong>16%</strong></td>
<td><strong>$11,283,458</strong></td>
<td><strong>84%</strong></td>
<td><strong>$59,948,801</strong></td>
<td><strong>$12,989,456</strong></td>
<td></td>
</tr>
</tbody>
</table>

### Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Total USG Non-PEPFAR Resources</th>
<th>Non-PEPFAR Resources Co-Funded IMs</th>
<th># Co-Funded IMs</th>
<th>PEPFAR COP Co-Funding Contribution</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>USAID MCH</td>
<td>42,000,000</td>
<td>6,200,000</td>
<td>4</td>
<td></td>
<td>Ending preventable child and maternal death</td>
</tr>
<tr>
<td>USAID TB</td>
<td>13,000,000</td>
<td>1,050,000</td>
<td>3</td>
<td></td>
<td>MDR and TB Prevention, Treatment, and Elimination</td>
</tr>
<tr>
<td>USAID Malaria</td>
<td>37,000,000</td>
<td>1,500,000</td>
<td>3</td>
<td></td>
<td>Malaria Prevention, Treatment, and Elimination</td>
</tr>
<tr>
<td>Family Planning</td>
<td>31,550,000</td>
<td>4,844,657</td>
<td>4</td>
<td></td>
<td>Increasing access to and utilization of FP</td>
</tr>
<tr>
<td>NIH</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Ending preventable child and maternal death</td>
</tr>
<tr>
<td>CDC (Global Health Security)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peace Corps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DOD Ebola</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MCC</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>123,550,000</strong></td>
<td><strong>13,594,657</strong></td>
<td></td>
<td></td>
<td>****</td>
</tr>
</tbody>
</table>

Page 13 of 55
Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP (2017)

<table>
<thead>
<tr>
<th>Funding Source</th>
<th>Total PEPFAR Non-COP Resources</th>
<th>Total Non-PEPFAR Resources</th>
<th>Total Non-COP Co-Funding PEPFAR IMs</th>
<th># Co-Funded IMs</th>
<th>PEPFAR COP Co-Funding Contribution</th>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>VMMC</td>
<td>$747,790</td>
<td>$0</td>
<td>0</td>
<td>o</td>
<td>0</td>
<td>Additive funding</td>
</tr>
<tr>
<td>Other Public-Private Partnerships</td>
<td>$1,200,000 (Over three years)</td>
<td>o</td>
<td>0</td>
<td>o</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>$747,790</td>
<td>$1,200,000</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2.3 National Sustainability Profile Update
PEPFAR co-convened a Sustainability Index Dashboard (SID) workshop with UNAIDS, on October 12, 2017. Participants included representatives from the Ministry of Health (national and regional), Ministry of Finance, Ethiopian Public Health Institute, Civil Society Organizations, WHO, UNHCR, UNFPA, private sector, faith-based organizations, PEPFAR implementing partners and USG agencies. Representatives from UNAIDS gave opening remarks followed by an overview of the PEPFAR SID3.0 process. Additionally and to provide program context, the PEPFAR Team presented the program’s FY17 Quarter 3 performance results. Lastly, participants were divided into four groups to discuss and complete the SID domains. Participants reconvened for one hour during which domain facilitators presented outcomes from the group discussions. Results are provided in table 2.3.1.

Table 2.3.1: Results of Sustainability Analysis for Epidemic Control in Ethiopia

<table>
<thead>
<tr>
<th>Governance, Leadership, and Accountability</th>
<th>2015 (SID 2.0)</th>
<th>2017 (SID 3.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Planning and Coordination</td>
<td>7.87</td>
<td>9.29</td>
</tr>
<tr>
<td>2. Policies and Governance</td>
<td>6.58</td>
<td>8.08</td>
</tr>
<tr>
<td>3. Civil Society Engagement</td>
<td>4.00</td>
<td>5.17</td>
</tr>
<tr>
<td>4. Private Sector Engagement</td>
<td>4.44</td>
<td>8.39</td>
</tr>
<tr>
<td>5. Public Access to Information</td>
<td>7.00</td>
<td>6.00</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>National Health System and Service Delivery</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>6. Service Delivery</td>
<td>4.40</td>
<td>5.32</td>
</tr>
<tr>
<td>7. Human Resources for Health</td>
<td>6.00</td>
<td>6.06</td>
</tr>
<tr>
<td>8. Commodity Security and Supply Chain</td>
<td>7.08</td>
<td>7.08</td>
</tr>
<tr>
<td>10. Laboratory</td>
<td>5.51</td>
<td>5.42</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Investments, Efficiency, and Sustainable Financing</th>
<th>2015 (SID 2.0)</th>
<th>2017 (SID 3.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11. Domestic Resource Mobilization</td>
<td>2.78</td>
<td>6.94</td>
</tr>
<tr>
<td>12. Technical and Allocative Efficiencies</td>
<td>1.11</td>
<td>5.56</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Strategic Information</th>
<th>2015 (SID 2.0)</th>
<th>2017 (SID 3.0)</th>
</tr>
</thead>
<tbody>
<tr>
<td>13. Epidemiological and Health Data</td>
<td>4.48</td>
<td>4.90</td>
</tr>
<tr>
<td>14. Financial/Expenditure Data</td>
<td>3.75</td>
<td>6.67</td>
</tr>
<tr>
<td>15. Performance Data</td>
<td>4.74</td>
<td>5.97</td>
</tr>
</tbody>
</table>
• Private sector engagement has shown significant improvement, a sharp increase from 4.44 (SID 2.0) to 8.39. This increase is partially attributed to active engagement of the private sector facilities in sector planning with FMOH, and the consistent work of the Pharmaceuticals Fund and Supply Agency (PFSA) to ensure that private facilities are included in the quantification and distribution process of HIV commodities, especially test kits.

• Public Access to Information shows a decrease from 7 (SID 2.0) to 6 (SID 3.0). Although surveillance, expenditure, and performance reports are shared with the public, dissemination is not timely. Therefore, Federal HIV/AIDS Prevention and Control Office (F/HAPCO) and other stakeholders risk using old data to inform funding and programmatic decisions. This creates a significant challenge in tailoring interventions to the locations and populations with the highest disease burden.

• Quality Management registered a low score in SID 2.0 but has improved greatly in SID 3.0. In 2016, the GoE established an HIV Quality Improvement (QI) Framework, which includes monitoring tools specific to HIV service delivery. Since then, they have consistently implemented the QI framework at clinical sites, and this may account for some of the improvement since the 2015 SID assessment.

• PEPFAR continues to be well positioned to improve service delivery by supporting the GoE to target resources that will increase case detection and improve linkage to care and treatment services. The program will also continue providing technical assistance to increase real time data availability, quality and use and public access at all levels.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden
As depicted in figures 2.4.1 and 2.4.2, expenditure per PLHIV varied between $369 and $115 per person per year across regions, with an average expenditure of $225 per PLHIV (average expenditure does not include the national and above national expenditure). Harari region reported the highest expenditure per PLHIV at $369, followed by Oromia with $115 per PLHIV. The emerging regional states of Benishangul Gumuz, Afar, Gambella, and Somali report relatively higher expenditure per PLHIV as these regions are hard to reach, have poor infrastructure and low human resource capacity for health, contributing to increased costs of supporting the program in these regions. Additionally, unlike the other regions where regional health bureaus capacities are greater, in these four regions comprehensive HIV services are implemented mainly by an international partner, thereby increasing the expense per PLHIV.

---

5 SID 2.0 and 3.0 is conducted after the NASA assessment. SID result s shows improvement in PHSP engagement.
2.5 Stakeholder Engagement
PEPFAR collaborates with the GoE, the Global Fund, UNAIDS, other external donors, civil society organizations, and the private sector at the federal and regional levels. More specifically, PEPFAR holds frequent meetings with the FMOH and F/HAPCO to discuss new developments in the PEPFAR program and to conduct quarterly program management reviews, including status updates on partner pipelines. Additionally, each agency engages national stakeholders directly. The team meets with Regional Health Bureaus (RHBs) and local NGOs on a quarterly basis to discuss planning, and implementation of activities. Regular meetings are held with the Federal Ministries of Health, Education, Labor and Social Affairs, and Women, Children, and Youth Affairs, as well F/HAPCO, civil society organizations and local NGOs to coordinate implementation of key activities such as prevention among high-risk populations and social services for HIV/AIDS-affected orphans and vulnerable children. Meetings are also held with the Ethiopian professional and private sector associations to coordinate implementation and plan the transition of clinical care and treatment, and community and social service activities in the private sector.
For COP 18, PEPFAR will continue to work very closely with FHAPCO, EPHI and RHBs in the implementation of ICT, self-testing, same day treatment initiation, viral load scale-up, and implementation of case-based surveillance and recency testing. In addition to government stakeholders, PEPFAR engages other donors and multilateral institutions including the Global Fund and UNAIDS, particularly to align and, where possible, complement fiscal resources and data (such as SPECTRUM estimates) used to inform program decisions. This collaboration will continue in an effort to maximize program impact and reduce inefficiencies. PEPFAR fully participated in the Global Fund grant preparations and budget discussions to identify areas/gaps that need to be addressed in COP18, maximize use of available resources and to reduce redundancies.

The COP18 guidance, tools and planning level letter were shared with external stakeholders. Key stakeholders including CSOs participated in the strategic retreat convened in January 2018, in collaboration with FMOH/FHAPCO. Participants provided input on PEPFAR proposed planning direction for COP18. Participants raised concerns regarding access to a timely surveillance, expenditure, and performance report so as to better tailor interventions to the locations and populations with the highest disease burden.

PEPFAR continues to work closely with CSOs to ensure their involvement in the HIV/AIDS national response. PEPFAR and UNAIDS established a consultative group of CSOs that includes the National Association of PLHIV (NEP+), faith based and professional groups, as well as PLHIV associations to collaborate to identify and understand the complex dynamics driving stigma, discrimination, and violence, and to implement innovative evidence based community led approaches to address the issue.

Stakeholder meetings are frequently convened, during which program performance is reviewed, barriers discussed, and best practices and lessons learned are shared. The goal is to hold a joint stakeholder and implementing partner meeting every quarter to ensure strong collaboration and exchange of best practices among partners. This will strengthen efforts to improve case identification, improve linkage to care and treatment, and reduce lost-to-follow-up (LTFU). Partner management and engagement is described in section 4.4.
3.0 Geographic and Population Prioritization

As of 2017, it was estimated that there were 610,335 PLHIV in Ethiopia, with 71% on ART (433,337/610,335). Based on COP17 targeting, by the end of APR18 (FY19), PEPFAR, will have supported the national program to have 519,295 PLHIV on life-saving ART, exceeding the 81% coverage (the 90-90-90 target), and thereby population-level saturation with this intervention; see Table 3.1 for expected gap to 90% ART coverage at the end of COP17 implementation.

### Table 3.1: 2017 PLHIV estimates, APR17 Coverage, APR18 Targeted Coverage, and Gaps to 95-95-95, by Region

<table>
<thead>
<tr>
<th>Regions</th>
<th>2018 Estimate</th>
<th>Current TX_CURR QII</th>
<th>TX_CURR When We Achieve COP2017 Target</th>
<th>Gap To 2nd 95 as of QII</th>
<th>COP18 Gap To 2nd 95 when we achieve COP17</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addis Ababa (1 of 20 towns)</td>
<td>107,917</td>
<td>94,690</td>
<td>100,680</td>
<td>2,705</td>
<td>(3,285)</td>
</tr>
<tr>
<td>Afar</td>
<td>12,994</td>
<td>4,307</td>
<td>6,420</td>
<td>7,420</td>
<td>5,307</td>
</tr>
<tr>
<td>Amhara (6 of 20 towns)</td>
<td>184,784</td>
<td>135,517</td>
<td>147,476</td>
<td>31,248</td>
<td>19,292</td>
</tr>
<tr>
<td>Benishangul Gumz</td>
<td>5,364</td>
<td>4,190</td>
<td>4,589</td>
<td>651</td>
<td>252</td>
</tr>
<tr>
<td>Dire Dawa (1 of 20 towns)</td>
<td>10,479</td>
<td>6,721</td>
<td>7,727</td>
<td>2,736</td>
<td>1,730</td>
</tr>
<tr>
<td>Gambella</td>
<td>12,636</td>
<td>8,024</td>
<td>10,152</td>
<td>3,380</td>
<td>1,252</td>
</tr>
<tr>
<td>Harari</td>
<td>4,350</td>
<td>4,457</td>
<td>4,494</td>
<td>-531</td>
<td>(568)</td>
</tr>
<tr>
<td>Oromiya (10 of 20 towns)</td>
<td>157,065</td>
<td>108,159</td>
<td>123,694</td>
<td>33,593</td>
<td>18,057</td>
</tr>
<tr>
<td>SNNP</td>
<td>57,231</td>
<td>34,050</td>
<td>38,947</td>
<td>17,601</td>
<td>12,704</td>
</tr>
<tr>
<td>Somali</td>
<td>5,883</td>
<td>2,076</td>
<td>2,679</td>
<td>3,233</td>
<td>2,630</td>
</tr>
<tr>
<td>Tigray (2 of 20 towns)</td>
<td>51,615</td>
<td>41,182</td>
<td>46,772</td>
<td>5,401</td>
<td>(189)</td>
</tr>
<tr>
<td>Total</td>
<td>610,318</td>
<td>451,454</td>
<td>502,889</td>
<td>107,437</td>
<td>57,182</td>
</tr>
</tbody>
</table>

*451,456 includes Military TX_Curr which 8,081
*502,889 includes Military TX_CURR which is 9,259

Moreover, updated Spectrum model estimates shows the gap between new infections and the number of estimated all-cause HIV-related deaths is narrowing. Encouragingly, the overall trend, since 2004-2006 and the scale-up of ART, is characterized by steady reductions in both new HIV infections and HIV-related deaths. As mentioned in the Goal Statement, Ethiopia is considered to have achieved epidemic control. As a result of progress toward attainment of ART coverage in age and sex bands, for planning purposes, PEPFAR designates the operational unit and Sub-National Units (SNUs) as either Attained or Centrally-Supported. (See Table 3.2)

---

6 Based on a refreshed Spectrum model using the 2016 Ethiopia Demographic Health Survey (EDHS2016) results for regional HIV prevalence.
Table 3.2 Current status of ART saturation and progress towards 95/95/95 across all SNU.

<table>
<thead>
<tr>
<th>Prioritization Area</th>
<th>Total PLHIV/% of all PLHIV for COP18</th>
<th># Current on ART (FY17)</th>
<th># of SNU COP17 (FY18)</th>
<th># of SNU COP18 (FY19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Attained</td>
<td>553,139 (91.1)</td>
<td>391,894</td>
<td>122</td>
<td>401</td>
</tr>
<tr>
<td>Central Support</td>
<td>47,177 (7.8%)</td>
<td>29,219</td>
<td>253</td>
<td>201</td>
</tr>
</tbody>
</table>

For COP17 Attained Regions, the objective is to sustain epidemic control through maintenance of the treatment cohort. This will entail, primarily, a technical assistance model, with very light service delivery support limited only to high-volume sites with special emphasis on adherence/retention. TA will focus predominantly on viral load support, adherence/retention, and quality management for epidemic control, supporting these regions to achieve 95-95-95 at the population-level, while focusing in on specific Woredas. For example, in Tigray, the focus will be to support a tailored package of interventions for reaching saturation. Efforts in these Attained Regions will focus on strengthening core systems for quality of care, ensuring comprehensive services for all populations, and strengthening capabilities for rapid detection, notification and response to new cases of PLHIV. Starting in FY19, PEPFAR will discontinue support to the following areas:

- Community level targeted HIV testing, adherence and retention, and comprehensive prevention and treatment services to key and priority population will be discontinued.
- HIV testing and ART services at private health facilities.
- Adherence services through NEP+ at public health facilities.

For "Maintained" (COP18 Attained) Regions, the objective is to reach aggregate population level saturation with ART during COP18. The package of support will reinforce active case finding and rapid initiation to treatment. Technical assistance will be provided for focused provider-initiated testing and counseling using special screening tools in select service outlets (STIs, TB, OIs, etc.). This will also support active case-finding among at-risk populations where there are critical gaps to ART coverage. Clinics at public facilities and community level service delivery points will achieve established minimum performance standards for comprehensive quality of care to all populations. GBV awareness and prevention activities will be integrated throughout the clinical cascade through training and mentorship. Regional and City Administration Health Bureaus will serve as the core platforms for HIV clinical services with complementary facility-based adherence and retention support, and community-level programming for the clinical cascade including OVC and FSW services. Under COP18, PEPFAR will continue the community level comprehensive prevention and treatment package of services for FSW to reach key and priority populations and provide services in Addis Ababa and Amhara region. PEPFAR support for these services in Oromia and SNNP regions will be discontinued. Support to PLHIV on ART and PMTCT through private sector, NGO and faith based organizations will no longer receive direct PEPFAR support, but may receive support through the Regional Health Bureaus. Community level care, treatment and support services including tracking and linkage of persons lost to follow-up, support for viral load literacy and suppression, and provision of differentiated care services to PLHIV will continue only in Addis Ababa City Administration.

The four (4) Emerging Regions are designated officially with this label by the Government of Ethiopia; they have unique characteristics of highly-mobile populations and lower levels of socio-economic development compared to the other seven (7) regions of the country. COP18 will be the last year of direct PEPFAR assistance in the Emerging Regions of Somali, Afar, and Benishangul-Gumuz. Comprehensive prevention and treatment services for key and priority populations at the community level and support to PLHIV receiving ART and PMTCT services in the private and non-governmental service outlets will be discontinued. In these regions, the primary platform for PEPFAR COP18 assistance to the clinical cascade will be an international TA partner (TBD) providing both TA and DSD assistance to public sites, together with facility-based and community adherence and retention support partners. Community level care, treatment and support services including tracking and linkage of persons lost to follow-up, support for viral load literacy and suppression, and provision of differentiated care services to PLHIV will continue only in
Gambella. Given the large refugee population in Gambella, State/PRM will continue supporting programming in the refugee camps. In addition, the only comprehensive, region-wide VMMC program will be continued in Gambella. Continued assistance to Gambella will be informed by findings of an assessment to be conducted during COP18.

In all regions, direct assistance for PMTCT testing will be withdrawn, but PEPFAR will still provide enhanced monitoring of the PMTCT cascade from priority sites/towns and supporting aggressive follow-up with HIV+ mothers who are not on ART, unsuppressed pregnant and lactating mothers, HEIs, and partners of HIV-infected mothers.

Throughout these classifications, it is critical to understand the interplay between populations in different geographies. For instance, facilities in metropolitan cities such as Dire Dawa and Addis Ababa, and others serve much larger population catchments, including clients from neighboring regions. A rapid assessment conducted in February 2018, showed significant inter-regional and intra-regional patient referrals to ART sites. Out of 2109 records pulled from 11 large ART hospitals in 10 towns, 24% (506/2109) were for clients coming from a different locality than the site being assessed (range: 2.9% to 53.7%). Efforts are underway to better quantify this interplay, to understand the major drivers for patients seeking services outside of their home town, and to strengthen information systems to better capture patient level data across the clinical cascade and for inter-facility tracking.

Figure 3.1: Ranked Gaps to Saturation, as of APR17, by Region

Within these 11 regions, there are PSNUs, called Woredas (equivalent to districts), which still have not achieved 90-90-90 coverage, in the aggregate and/or within specific age-sex bands. National level estimates for coverage among age-sex bands shows gaps to saturation among all of the age-sex bands, with the largest among females, age 25+. As the country maintains epidemic control, it will be critical to narrow the focus to the remaining PSNUs and relevant population groups to ensure adequate intervention coverage for attainment while still supporting the entire country to reach 95-95-95 targets.

Figure 3.2: Ranked Gaps to Saturation, as of APR17, by Age and Sex
Precision around geographic foci below the regional levels, and population-group foci within particular age-sex bands and key population groups, is undermined by lack of good prevalence and coverage data to effectively target programs to the town level. PEPFAR eagerly awaits the results of the EPHIA to further confirm prevalence, incidence, and viral suppression in urban PSNUs, across targeted age-and-sex bands. This will have significant implications on program planning and performance monitoring in urban PSNUs, going forward.

4.0 Program Activities for Epidemic Control in COP 18 Attained Locations and Populations (Amhara, Oromia, SNNP and Addis Ababa)

4.1 Finding the missing, getting them on treatment, and retaining them

4.1a Case Detection Strategies: In COP 18, innovative case detection strategies to attain and sustain epidemic control in supported regions will include:

- **Index Contact/Case Testing (ICT):** A major focus in COP 18 will be the scale up of ICT for all newly diagnosed HIV positives with enhanced partner notification services (PNS) for additional case detection and aggressively linking new PLHIV to treatment. Additionally, to guide the systematic and standardized implementation of ICT, the program has supported the preparation of a facility initiated ICT SOP that is being implemented by the RHBs. To scale up the current index contact elicitation and testing practice, which is conducted by ART health officers and nurses, dedicated personnel for PNS will be in place, particularly in high volume facilities. Programs will train PNS providers, ART providers, and adherence counselors in major urban areas, and also facilitate bidirectional linkage. Community level partners working with local CSOs will work closely with facility-based providers to support health facility-initiated ICT. This support includes disclosure support, counseling sexual contacts and high risk family members of index cases who did not report to the health facility for testing services with the goal of linking them to testing services in health facilities following one or more counseling sessions. To provide ongoing support
to the scale up using standardized implementation of ICT, RHB mentors will also be trained and capacitated on mentorship and supportive supervision for index testing.

- **HIV Self Testing (HIVST):** HIV Self Testing (HIVST) services will be integrated with assisted partner notification services to provide alternative testing options and improve testing uptake among partners of PLHIV. Community initiated HIVST will be scaled to all implementation towns targeting FSWs and their sexual partners. The HIVST pilot conducted in the community among FSWs has shown encouraging results with high acceptability and will continue to build on the pilot’s best practices and service delivery methods. FSW drop in centers in the community will provide assisted HIVST and will encourage FSW to self-test with them. The DICs will also ask the FSW to retest after 6 months (as per the national guidance) or test at any juncture in case of exposure to HIV. This testing service will also be offered to FSWs’ sexual partners and other highly vulnerable population groups reached in the community.

Facility-initiated approaches of HIVST will be implemented to allow index partners to self-test at home or in a private setting in a health facility. When applicable, assisted HIVST providers will also encourage individuals to take self-test kits home for themselves and/or to give to their spouses and/or other sexual partners. In addition to the facility initiated approach, distribution of self-test kits will be supported through trained HIVST providers at convenient locations to increase testing coverage and frequency of testing among the undiagnosed PLHIV in sexual networks. Self-testing will also be utilized to encourage social network testing through optimizing trained peer navigators, in selected facilities including, key population friendly facilities.

- **Risk Based Facility Testing:** To attain and maintain epidemic control, the program will also focus on risk based facility testing that targets patients or clients with STI, TB, or other opportunistic infections and key populations in the outpatient and inpatients departments. Screening and follow up of STI patients is essential and good practice as patients with STIs may have unprotected sex with members of their sexual networks. Alternatively, some individuals could be members of key or priority population groups including at risk AGYW, widowed or divorced women, and high risk men. Testing among STI patients will help detect new HIV infections and help break the HIV transmission cycle by enabling access to the contacts of HIV-positive STI patients. To increase pediatric HIV case detection, implementing partners will focus on ICT of the biological children of HIV positive women and risk based testing among children admitted to inpatient units. RHBs will intensify risk based facility testing at high case load public facilities through the strengthening of daily triage of patients for testing, weekly review of yield by service delivery points, utilization of RTK in outlets where new positives could be detected and successfully linking all positives to ART services. An HIV risk screening tool will also be adapted and utilized to implement a more targeted provider initiated testing and counseling (PITC) among men, adolescents and young adults.

4.1b Linkage to Treatment Services: PEPFAR will increase successful linkage of newly identified HIV positive clients to care and treatment services through accompanied referrals, ascertaining successful linkages for referred clients, use of customized tools to track linkages, and routine monitoring of performance on linkages by conducting referral audits. In all treatment facilities, PEPFAR supports rapid and same day ART initiation, where possible, for all newly identified HIV positive clients. Additionally, for individuals who present at facilities with advanced HIV disease, PEPFAR will ensure that facilities provide a full package of services including the screening and treatment of (or prophylaxis for) opportunistic infections and other concurrent illnesses. Post-test counseling will be strengthened to help the client understand the benefits of linkage to and early initiation of ART. To ensure linkage, HIV-positive clients, newly identified at facility testing sites will be escorted to ART through an accompanied referral. In settings where successful linkage can be tracked, the program will promote the use of referral slips with a feedback section that will be used to ensure linkage with the referring organization or facility tracking the linkage. In addition, regular linkage auditing will be conducted between referring and receiving facilities and corrective action will be taken on the on the gaps identified. Efforts will be made to improve quality of
participating in collaborative site level supportive supervision and mentoring. Services training is provided to site level adherence supporters and caregivers, timely identification of defaulters and tracking adherence support to those receiving ART. Lay personnel provide adherence preparation and education prior to initiation on ART, continued adherence support to those receiving ART (particularly for those with risk of poor adherence), disclosure support, timely identification of defaulters and tracking of lost clients, and facilitate referral linkages. In-service training is provided to the site level adherence supporters and case managers, and also provided for site level supportive supervision and mentoring. The CareComm/m-Health system is expected to be used to track more efficiently and address the current linkage gap and to thereby improve the rate of completed

### 4.1o Retention on Treatment Services:
PEPFAR will also work with national stakeholders to: (1) optimize ARV regimens including the introduction of Dolutegravir as part of the first line ARV regimens; (2) transition existing clients on the TLE regimen to TLD; and (3) strengthen the use of routine viral load testing for ART monitoring and identification of treatment failure. Viral load test results will be used for timely clinical decisions and to manage patients' treatment. In addition, PEPFAR will provide program support to strengthen appropriate and timely switching to second line ARV regimens for those patients who fail their first line regimens. The PEPFAR program will also use facility-based case management activities and community based adherence support initiatives to advance the scale up and strengthening of differentiated models of service delivery. Case managers, adherence supporters and community peer volunteers will provide routine peer-to-peer adherence support to newly initiated patients and to existing clients through: (1) counseling; (2) education; (3) regular monitoring of scheduled appointments; and (4) identifying clients who miss their scheduled appointments. Case managers, adherence supporters and community volunteers will: (1) trace defaulters; (2) reengage them to facility level ART services; and (3) facilitate linkage with community services, including community level adherence support.

Overall, the proxy linkage rate (based on newly identified positive patients and newly enrolled ART patients) is 77% for FY18Q1; however this should be interpreted with caution as an assessment of 46 high volume facilities in Addis Ababa, showed higher linkage rates with evaluation of site level data. The proxy linkage rate is lowest for those aged 15-19 and 20-24 year olds. Generally, the proxy linkage rates for females is much higher than males in these age groups but the figures highlight a real gap vis-à-vis HIV burden. Among all regions/SNUs, Addis Ababa generally has a lower proxy linkage rate, especially for those aged 15 to 19 years old. In comparison to other regions, Tigray also has a lower linkage proxy rate for men 25-49 and 50+, and SNNP has a lower linkage rate for females 10-14. In summary, there is lower linkage in Addis Ababa among both men and women, but Tigray and SNPR have particularly lower linkage rates among men 25+ and 50+ as compared to women. PEPFAR will introduce HIV self-testing among clients of FSWs and PPs, as well as provide linkage to care and treatment services for FSW using peer demand creators and the provision of FSW friendly services at the facility and community levels.

Loss to follow-up (LTFU) is an ongoing challenge, which is being addressed through deployment of peer PLHIV case managers and adherence supporters at each supported high-load facility. These cadres of peer lay personnel provide adherence preparation and education prior to initiation on ART, continued adherence support to those receiving ART (particularly for those with risk of poor adherence), disclosure support, timely identification of defaulters and tracking of lost clients, and facilitate referral linkages. In-service training is provided to the site level adherence supporters and case managers, and also provided for site level supportive supervision and mentoring. The CareComm/m-Health system is expected to be used to track more efficiently and address the current linkage gap and to thereby improve the rate of completed
referrals and adherence to treatment. The CareComm/m-Health system utilizes a case management tool to ensure targeted adherence counseling for better VL suppression among PLHIV.

Disclosure is also still a persistent challenge affecting not just case finding among partners, but also retention. Significant numbers of stable PLHIV who were eligible to be enrolled in appointment spacing choose not to enroll because they have not yet disclosed their status to their immediate social support system and their family members. This situation increases the risk for PLHIV to default on ART, and the program needs to better understand how to support PLHIV to enroll in appointment spacing. As such, this challenge also underscores the need for strengthened assisted disclosure support for PLHIV. FHAPCO is conducting an operational research activity which will assess the reasons PLHIV engage in repeat testing with the goal to minimize unnecessary retesting among PLHIV as well as to better understand and address the causes for LTFU. Data collection will be completed in March 2019 and result will be available July 2019. The results from the operational research will be translated into more effective strategies, programmatic course corrections and, by extension, better results.

The OVC program, in collaboration with health facilities identify HIV-positive children who are lost to follow-up (LTFU) for pediatric ART. It will promote synergies and collaboration between Community Care Coalitions (CCCs), Local Implementing Partners (LIPs) and health facilities to facilitate the early identification and tracking of HIV-positive children that have been LTFU. Link Desk Volunteers will consult Clinical Case Managers weekly at health centers to review defaulter lists and report defaulters to CCCs/LIPs for tracing, as per existing confidentiality policies. Pregnant women or caregivers identified as LTFU for PMTCT services will also be included in these retention efforts in the HIV continuum of care.

4.2 Target Populations

4.2a HIV prevention and risk avoidance for AGYW and OVC: As of 2017, approximately 4 million children lost one or both of their parents. Of those children orphaned due to HIV/AIDS in urban areas, about 89% reside in six regions of the country where the PEPFAR OVC program operates. The regions are Oromia, Amhara, SNNP, Tigray, and the city administrations of Dire Dawa and Addis Ababa. In FY19, the OVC program will work in 126 SNUs of these six regions to serve 325,000 OVC and their caregivers. It will contribute to HIV prevention and treatment outcomes – the achievement of the “95-95-95” goals - as well as mitigate the impact of HIV on HIV-affected households and communities. This will support beneficiaries to transition from direct subsidies to an approach of empowering individuals, families, communities, and local governments to respond to the needs of vulnerable children. The OVC program will use the approach below in order to recruit and prioritize the OVC sub-populations or vulnerable children most affected by HIV from targeted SNU.
The OVC program has identified concrete ways to strengthen HIV prevention efforts among pre-adolescent and adolescent girls. Low awareness of HIV risk factors, poor transition from primary to secondary school, poor access to sexual and reproductive health services, gender-based and sexual violence, family poverty and lack of economic opportunities for young people (leading young people to engage in risky sexual practices) contribute to risk of HIV infection, particularly among adolescent girls and OVC. Implementing partners will focus on non-biomedical interventions that reduce the risk of HIV for children and adolescents/AGYW. The program will strengthen the skills and economic capacity of adolescent girls, their families, and communities in order to create better, safer economic opportunities. Mentoring groups for AGYW using the Adolescent Mentoring Approach through the Youth Power Action (YPA) model will offer economic empowerment as well as strengthen links to sexual and reproductive health, and improve access to school and community HIV prevention activities.

In December 2017, 70 Children of HIV+ FSW were tested at Drop in Center in Oromia and 3 were positive (4% yield).
The OVC program will work alongside key population, testing, and community partners to increase case finding among children at a high risk of HIV. Many older children living with HIV still need to be identified and linked to treatment. Index case testing among HIV affected families can still be improved. Family matrices are not completed consistently with new patients visiting ART clinics and matrices are not being revisited or revised upon return appointments. In addition, there continues to be high loss to follow up among HIV exposed infants (HEI). The OVC program will support efforts to scale up testing for children of HIV+ FSW in all drop-in centers (DICs) and enroll them in the OVC Program. The program will also support completion of the family matrix when enrolling families in the OVC program and return the matrices to clinics. The OVC program will continue to refine and roll out the OVC HIV risk assessment algorithm, working with the government to make the tool more sensitive and targeted and referring OVC and caregivers at high risk for testing. The OVC program will also strengthen mother-baby cohort monitoring by prioritizing HEI for enrollment in the OVC program and providing specialized case management to HIV positive mothers and their HEI. Finally, the OVC program will continue to work through local partners to identify and enroll hard-to-reach OVC populations at a high risk of HIV infection, such as children living and working on the street, children exposed to sexual violence, and child domestic workers, to ensure children are assessed for HIV risk and referred for testing.

The OVC program will also work closely with public health facilities, RHBs, relevant government agencies, and treatment partners to improve treatment linkage, retention, adherence and viral suppression. Treatment outcomes for children and adolescents continue to be compromised by inadequate adolescent focused psychosocial services concentrating on adherence and disclosure issues, insufficient skill among service providers to provide counselling on adherence issues tailored for older children and parents, and sub-optimal patient monitoring practices. In addition, poverty and poor nutrition among HIV+ children, inadequate supervision by adults caring for HIV+ children who are not their biological children compromise treatment success. This, combined with low viral load testing coverage has led to low viral suppression rates. The OVC program will continue to prioritize children and adolescents at a high risk of LTFU and poor viral suppression for enrollment in the OVC program. The program will cross train OVC case managers to use National tools (manual and job aids) and support health care workers for age appropriate disclosure process. The program will also support OVC and caregivers to advocate for viral load testing through demand creation to increase viral load testing coverage and to continue to engage in regular case management with HCWs to actively track children LTFU, support them to re-engage in care at the health facility, and provide swift referrals for those children found to be ill and non-adherent to ART including cases with suspected treatment failure. Finally, the program will provide community and home
based adherence support to HIV+ children and adolescents, including age-appropriate adherence counseling, nutrition counseling, and economic strengthening to generate funds for transport to clinic appointments, nutritious food, and education costs.

Savings and loan associations and other household economic strengthening (HES) activities are essential to the efforts of the OVC program to prevent HIV infection, improve treatment outcomes, and mitigate the impact of HIV on affected households. HES activities are also critical to supporting HIV affected households to achieve self-sufficiency and graduate them from direct project support. To promote the scale up of successful HES approaches, the OVC program will refine standardized ES tools and approaches; support the development and the roll-out of the National ES implementation manuals. This will be done with the leadership of FHAPCO to support the implementation of ES interventions in a standardized, cost-effective and sustainable way leading to improved HIV outcomes. In addition, the program will provide TA to the GOE and local implementing partners to lead and supervise the implementation of ES activities.

The social service infrastructures in Ethiopia are still developing and the shortage of qualified workers has the potential to limit the provision of social services to vulnerable populations including OVC, their caregivers, and adolescent girls. The program will assist the local systems to improve the availability of social service workers and provide adequate social services for highly vulnerable children, including adolescents, and their families. They will be deployed at the kebele level to work closely with communities through CCCs and LIPs in order to increase case-finding, strengthening the bi-directional referral linkage, enhance adherence and retention to achieve viral load suppression and expand high quality services through comprehensive case management.

The program will also support training institutions and community structures like CCCs to strengthen the social services system in a sustainable manner by preventing and responding to neglect, violence, and exploitation of at-risk children and adolescents. The program will also partner with relevant federal ministries and regional government offices to expand lessons learned from PEPFAR-supported woredas and scale up best practices to other woredas through training and deployment social service workers.

4.2b Children: In contrast to Ethiopia’s progress in reaching HIV epidemic control among adults, identification and treatment of children living with HIV (CLHIV) remains a challenge. With PEPFAR support, the GoE has expanded comprehensive HIV care and treatment services for children to a total of 945 health centers and hospitals. Even though access ART has increased considerably through PEPFAR support, only 36% of the estimated CLHIV are currently receiving ART. According to 2017 SPECTRUM estimates, there are an estimated 56,514 children under the age of 15 years living with HIV/AIDS. However, only 22,438 children were receiving ART as of October, 2017(APR). As such and in FY 19, the PEPFAR program will continue to prioritize activities to identify undiagnosed CLHIV and initiate them on treatment.

To improve pediatric ART coverage, PEPFAR will focus on optimizing high yield pediatric case finding strategies, including family ICT and PITC. Implementing partners will utilize standardized tools to identify all eligible children of adult index cases and ensure HIV testing and linkage to treatment. The program will also focus on increasing the utilization of risk screening tools to maximize yields at pediatric outpatient departments. Strategies to improve turnaround time for early infant diagnostic testing (EID) results, including point of care (POC) testing, will improve identification and early ART initiation in HIV-infected infants.

In COP18, PEPFAR will ensure delivery of quality pediatric HIV services for the existing cohort of children and adolescents on ART through an integrated, comprehensive, and family-centered approach. PEPFAR supports the provision of comprehensive services to the HIV exposed /infected children and adolescents including: (1) early infant HIV diagnosis (EID) using an age appropriate test (DNA PCR or Rapid Antibody test) and enrollment into care; (2) growth monitoring and developmental assessment; (3) counseling on infant feeding; (4) cotrimoxazole preventive therapy (CPT); (5) TB risk assessment; (6) early diagnosis and
treatment of common infections; (7) psychosocial support; and (8) adherence and retention in care and viral load monitoring. PEPFAR will boost interventions to improve, adherence and retention in care, and track cases that are lost to follow up. Case managers and mother support groups will play a more active role in assuring that children of all adult index cases are tested, linked and retained in care and treatment services. PEPFAR will also further strengthen test and start for all children < 15 years of age to ensure linkage to rapid/same day treatment for eligible children with confirmed HIV positive status.

PEPFAR will improve access to VL testing for children and adolescents and educate patients, clinicians, and laboratory workers on the importance of routine VL testing. The program will promote key interventions to improve current low viral suppression rates in children and adolescents including: (1) adoption and implementation of appropriate treatment regimens and dosage; (2) use of child friendly drug formulations; and (3) enhanced adherence and counselling services. This targeted approach will also include the use of lopinavir/ritonavir-based first line regimens in children <3 years old and include transition to dolutegravir-based regimens for adolescents ≥10 years old and ≥30 kg. In addition, the PEPFAR program will continue to support the government in sites with a high volume of adolescent clients to provide a standardized adolescent package of care, which includes peer support groups, provision of adolescent friendly health services on adherence, disclosure, stigma, transition to the adult treatment program, and sexual and reproductive health.

PEPFAR will also strengthen linkages between facilities providing paediatric ART and nearby local PEPFAR-funded OVC organizations by including them in regular catchment area meetings and implementing standardized bidirectional referral mechanisms. PEPFAR partners supporting health facilities will work with the OVC program to strengthen HIV testing of OVC, ensure linkage of those testing positive to treatment services, prioritize HIV exposed infants/infected children for community support, and support HIV-infected children and adolescents with elevated viral load. In addition, coordination with PEPFAR-supported and non-PEPFAR supported community social support and nutrition programs will be strengthened to ensure HIV-exposed/infected children and their families will be linked to appropriate services based on needs.

For COP 18 maintained regions (Amhara, Oromia, Addis Ababa and SNNP), PEPFAR will focus on improving case detection through: (1) risk-based PITC and ICT including testing children of HIV positive adults in care (including children of positive pregnant women enrolled in PMTCT ANC services); (2) routine testing of children at TB clinics, inpatient wards, and malnutrition treatment units; (3) screening and referral of high risk OVC for HIV testing; and (4) improving HIV-exposed infant services and diagnostic testing. In addition, activities in these regions will focus on improving the quality of services for children and adolescents currently receiving care to increase retention rates and improve viral load suppression.

The revision of guidelines by the MOH to adopt provision of TLD for children ≥10 years of age and ≥30 kg will impact the procurement and distribution needs for pediatric ARV. PEPFAR will actively participate in national quantification exercises to ensure proper estimation for TLD and pediatric LPV/r formulations. PEPFAR will also continue to be engaged with the FMOH as active participants in the pediatric national taskforce and relevant technical working groups (TWGs). The USG will continue to work with other international and bilateral organizations, including the GFATM, WHO, & UNICEF to advance the quality of services for children and, more specifically with GAVI, the Vaccine Alliance, to promote immunization services, particularly for HIV-exposed/infected children.

The program will monitor its performance and progress using PEPFAR MER indicators including: (1) number of children newly identified; (2) newly initiated on ART; (3) currently on ART; and (4) age-disaggregated data for retention and VL suppression. In addition, PEPFAR will generate, analyze and monitor program data through available reports, SIMS field visits, & partner performance reviews, as well as through non-PEPFAR data sources. Finally, the program will also conduct site level data reviews and
analysis to monitor performance indicators, understand the dynamics of patient attrition and transition to adulthood identify quality gaps, and inform quality improvement activities.

4.2c Key populations: In Ethiopia, the government only officially recognizes one KP group—FSWs. However, they recognize a number of priority populations and PEPFAR actively provides HIV services for priority populations through its current programming. Priority populations in Ethiopia include: (1) divorced and widowed persons; (2) OVC; (3) HIV-negative partners in discordant couples; (4) STI cases; (5) long-distance truckers; (6) clients of sex workers; (7) uniformed services; (8) prison inmates; (9) young women involved in transactional sex; (10) mobile/seasonal workers; and (11) vulnerable adolescent girls and young women. There are an estimated 199,511 FSWs in Ethiopia, as per the size estimate study conducted by Population Service International (PSI) and EPHI. In COP18 PEPFAR community KP/PP activities will now focus in urban areas/hotspots in Addis and Amhara. FSW and other PP population will also be addressed through facility-based services.

Implementing an FSW program in public health facilities is a challenge as conventional health facilities are designed for general population use. The location, opening hours, package of services, health care workers’ training and approach of services promotion, are tailored to the general public and not for specialized populations. PEPFAR is working to address these critical barriers affecting FSWs’ access to HIV services at health facilities. In order to make these facilities FSW-friendly, major activities are underway. These include: (i) providing FSW sensitivity training to health care workers, (ii) developing a standard minimum package of HIV services tailored to FSWs as per WHO standards for KP (biannual HIV testing, same day ART for those who are positive, quarterly STI screening and treatment, screening for TB and OI comorbidities, condom promotion demonstration and distribution, provision of short and long term family planning services, GBV services, harm reduction counselling for substance abuse). To increase access to health facilities, the integration of this FSW package of services is prioritized for locations that are close to hotspots. These facilities will keep operating hours that are convenient to FSWs, including lunch and early evening peak hours. Peer navigators attached to the facilities will escort and navigate FSWs through the minimum package of services. Data that shows the full clinical cascade for FSWs has been a major challenge as the HMIS does not yet capture data by population. However, the revised HMIS which is currently being rolled out captures FSW disaggregates.

The density of the FSW population correlates closely with high PLHIV burden overlapping with urban woredas linked by major transport corridors. 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 expected but have shown improvement with intensified targeted testing approaches. As a result of continuous data monitoring, PEPFAR-E will continue to refocus its testing and outreach efforts in locations with demonstrated high yield, along with further stratification of FSW and PP groups to target the highest risk sub groups among them.

In COP17 thirteen confidential clinics and 25 DICs in the 20 priority towns are providing ART for FSWs. Eleven of these confidential clinics reported 733 FSWs received ART at the end of FY18 Q1. DICs initiated community level ART service provision in November 2016 and, since then, DICs have shown promising results enrolling a total of 1,604 HIV positives. Of these 1,522 were new ART initiations and 1,494 from that cohort currently remaining on ART. Moving forward in COP18, the community-based key and priority population program will focus only in Amhara and Addis Ababa.

Children and partners of FSW will also be tested and, if found to be HIV positive, they will be linked and enrolled in treatment. The DICs will continue to provide testing and treatment services in COP17 to ensure treatment, adherence and viral load transportation and monitoring services for HIV positive FSWs and their children. Community ART service provision closer to clients and their homes has demonstrated reduced burdens for patients and resulted in increased use of testing services and adherence to treatment. Thus far, out of the clients whose blood samples were sent from DICs and results received, 91% have
achieved viral load suppression. Twenty-six DICs are also located in 26 towns providing behavioral interventions, HTS services and referral to private or public facilities for treatment. The DIC approach is one advocated by WHO as a differentiated model of care that works for FSW, to improve rates of testing and linkage to care. In COP17, the activity is being implemented in 79 SNUs out of which only 42 SNUs have DICs.

In COP18, the program will limit its intervention to Amhara and Addis Ababa regions, with only 16 SNUs with DICs. Services in 27 DICs located in regions outside Addis Ababa and Amhara will be discontinued. In COP17, KP-friendly clinical services are being introduced at 80 public health facilities in scale-up woredas and expected to reach 21,469 FSWs. RHB KP clinical cascade service utilization data (FSWs tested, on ART, virally suppressed) will be reported by public facility KP sites using the KP service utilization data capturing tool (see Appendix C). This approach includes high volume facilities in the 20 priority towns with associated KP targets for these sites.

Stratification of PP to identify those at higher risk will continue in order to maximize yield from testing and to direct outreach efforts. Priority populations such as the client of sex workers, truck drivers and young women involved in transactional sex will be reached with tailored interventions in the community to minimize their risk of infection and increase access to HTS services. Outreach testing services will continue to be provided in hotspots where priority populations require increased access to HTS services. Program data has shown that the HIV yield for priority populations is, on average, 3.5%. Additionally, national STI case surveillance showed the HIV positive yield from STI cases is 3-5 % (close to the yield for FSWs); hence, all STI cases will be targeted for HIV testing, and those individuals found to be positive linked to ART. In COP17, the program will carry out PrEP advocacy at the national level and ensure the readiness of selected KP sites to pilot PrEP in COP18. The results of an HIV self-test pilot will also be disseminated to all relevant stakeholders and to the GoE informing expansion in communities and facilities targeting KP and other vulnerable populations.

To address HIV related stigma, the program will engage community leaders to lead “stigma-free zone” campaigns and create an enabling environment where KP and PP will be encouraged to seek HTS and care and treatment, if HIV positive. In addition, PEPFAR will support community-based peer organizations to provide outreach and education to the more difficult to reach KP and PP. These activities will be focused in maintained woredas, especially those targeted for saturation.

**Condom policy:** Although the condom program has primarily underpinned the success of broader HIV prevention efforts in the country, there is an urgent need to ensure condoms are available to most-at-risk population groups. Though condoms are a pivotal part of the national HIV prevention program, the absence of a national comprehensive condom strategy that ensures efficient utilization of resources is a key gap in the country’s response to HIV/AIDS. One crucial challenge to developing an efficient approach to condom distribution is integrating the efforts of different actors involved in the distribution of condoms. More specifically, the two identified key gaps are: (i) the absence of efficient utilization of existing distribution mechanisms; and (ii) limited coordination of warehousing infrastructures. In addition, the country currently faces key coordination gaps and needs better tracking of condom distribution with all condoms distribution integrated in the national LMIS system. The goal of the draft, national condom strategy is to ensure access to quality condoms and promote correct and consistent condom use for prevention of HIV/STIs and unplanned pregnancies among the sexually active population, with a special emphasis on key, priority and vulnerable populations. After a two year delay in the review and finalization of the national condom policy, FHAPCO revitalized the efforts to finalize the national strategy and a viable national condom strategy is anticipated to be available and implemented by June 2018. In COP18, the strategy is expected to be fully disseminated and actively implemented by national stakeholders.

**Community involvement:** The role of CSOs, including community-based, non-governmental and faith-based organizations (FBOs) in HIV/AIDS prevention, care and support efforts in Ethiopia has become increasingly important as the country moves towards epidemic control and will need to consider strategies
to sustain the gains made over the last decade. Civil society plays a critical role in HIV/AIDS advocacy and service delivery, especially at the community level. Without CSOs, fewer services would be available to vulnerable populations. USG partners implementing HIV services at the community level for key and vulnerable populations have been building the technical, management and financial capacity of CSOs, including PLHIV associations, to support direct service delivery of HIV testing and treatment services for key and priority populations, and care and support for OVC. This support and involvement of CSO and community organizations to work across the spectrum of HIV/AIDS services and provision of direct service delivery at community level will continue in COP18. PEPFAR will also continue its support and collaboration with 32 local implementing partners and CSOs to further country ownership and sustainability. Decreases funding due to reduced HIV burden estimates have resulted in a decreased scope of community activities which limits CSO and LIPs sustainability activities. Additionally in COP18, PEPFAR will support gender-based violence (GBV) care for all survivors. Healthcare providers at both the community and facility levels will be trained on comprehensive GBV care and provided with national guidelines. Concomitantly, implementing partners will support GBV awareness creation, screen for potential GBV survivors, and provide appropriate services.

### 4.2d Reaching Men through VMMC

VMMC program activities are implemented in Gambella among host, refugee and military communities. Since 2009, a cumulative total of approximately 121,700 VMMC procedures have been undertaken among these communities (CDC, 96,000; DOD, 17,000 and PRM, 8700). As per the 2016 VMMC unmet need estimation exercise conducted by the FMOH, the projected male population aged 10 years and above who are eligible for VMMC among Gambella host population was 155,531. PEPFAR estimates that it would need to complete 124,425 procedures of the total eligible population of 155,531 to reach 86% VMMC population coverage. In addition, there are about 110,000 South Sudanese refugee males aged 10 years and above who may be eligible for VMMC, out of which only 8,700 (8%) have received VMMC services in public health facilities in Gambella during 2014-2016 (as reported by JHPIEGO) and from refugees’ health program in camps. At the end of COP17, a total of 96,000 procedures would have been conducted, leaving a backlog of 28,425 among Gambella host national population and 79,300 among refugees. There is a significant VMMC backlog (107, 725), especially in the age group 30 and above, with 51% saturation in age group 15-29. In COP18, PEPFAR will focus on clearing backlogs among the host community in Gambella across all age groups, through static, outreach and regular VMMC campaigns and conducting awareness and demand creation activities, where needed. The program in Gambella will increase the COP18 VMMC target to 24,194 VMMC procedures with provision of technical assistance to facilities to integrate and implement Early Infant Male Circumcision (EIMC). Concomitantly, another PEPFAR partner, UNHCR, will mainly implement awareness and demand creation strategies among the refugee community in Gambella as low awareness is the main barrier for VMMC services up-take among refugees. UNHCR will also implement routine VMMC activities in the camps with atarget of 2788. Similarly, the Ethiopian National Defense Force (ENDF) will increase its COP18 VMMC target to 5,000 VMMC procedures, targeting new military recruits, and male children above 10 years of age of active duty military personnel and older active male military personnel who may have missed previous VMMC opportunities. The military VMMC program has backlogs of about 4,000 uncircumcised men who missed the VMMC service opportunities during the new military recruit training center campaigns. In addition, approximately 10% of incoming new recruits are uncircumcised resulting in an estimate of 2,000 uncircumcised men every year. The primary goal of the Military VMMC program is to prevent a growing pool of uncircumcised individuals within the Military.

The total VMMC target for COP18 will be 31,982 VMMC procedures across the Gambella host, military population and refugee community. The VMMC activities will be implemented through a budget of $1.3 million including the budget for procurement of VMMC surgical kits. All implementing partners will provide the minimum package of VMMC services as indicated in COP18 guidelines, carefully monitoring adverse reactions and preventing tetanus infection. Implementing partners will also provide training on surgical procedures and monitoring of adverse events for health care workers implementing VMMC, particularly on VMMC surgical methods for children aged 10-14 and early infants less than 61 days. To
ensure program sustainability and prevent VMMC backlogs, all VMMC implementing partners will also provide technical assistance to the respective health facilities they are supporting on integration of EIMC.

4.3. Additional country-specific priorities listed in the planning level letter

Although targets are still not being reached, HTS_TST_POS performance has improved over the last three fiscal years (FY 15-17). In COP16, only 66% of the HTS_TST_POS targets were achieved. To improve program results in testing and achieve the UNAIDS 95:95:95 milestones, it is essential to enhance active case finding through sexual networks and partner notification services for linkage to treatment services as well as focused community-based testing that targets key and priority populations. As the estimated pool of new HIV cases decreases, it will become more challenging to find undiagnosed positives and the program will need to consider implementation of innovative case detection approaches including index case contact testing and targeted testing in the community using social network community testing platforms. Following successful advocacy, the FMOH has revised the national HIV guidelines to include important case detection strategies such as index case testing, PNS and HIVST as important case detection strategies. With the change in national guidelines, the PEPFAR program will more effectively and efficiently identify new positives recognizing that there are additional testing approaches and non-testing strategies that will be needed to identify and reach difficult to reach populations, particularly as the numbers of the new HIV+ decline significantly in coming years.

The HTS target setting assumptions were done based on the updated regional categorization (COP 17 attained, COP 18 attained and emerging regions). In COP 18, for attained and emerging regions, direct service delivery support in the areas of testing will include: index case testing and risk based testing targeting KP and PP in the community with innovative testing approaches; patients with STI in the outpatient departments and inpatients with identified risk of HIV. In COP 17, all regions (Tigray, Dire Dawa and Harari) offered community-based and facility based HTS support. As the country is close to epidemic control, in COP18 there is a greater focus on addressing LTFU and scaling up treatment. In the current context, testing will focus on index case testing, limited PITC and targeted outreach services and STI patient testing. TB patient testing in these regions has already been factored in through TB_STAT. Implementing partners will not provide direct support for PMTCT testing and no testing support to sites that detected <5 positives in COP17.

Community-based partners: As the HIV prevalence decreases and identifying new HIV positive becomes challenging, the role of community based partners in identifying hard to reach new PLHIV and providing adherence and retention services to PLHIV who are enrolled in differentiated care and treatment services and those struggling with their treatment adherence, is paramount. However, capacity gaps to provide quality services are observed among LIP and CSO working in the community, emphasizing the need for increased capacity building. PEPFAR will provide ongoing guidance and support to improve performance in case identification and linkage to treatment as has been highlighted through established processes such as monthly follow-up, reporting and monitoring systems. PEPFAR-funded IPs monitor their performance on a monthly and biweekly basis and conduct quarterly performance review meetings with local implementing partners that are responsible for direct service delivery improvements as well as with the GoE and national stakeholders. These program oversight efforts are also supplemented with weekly phone calls between USG staff (e.g. AORs/CORs) and implementing partners to discuss on achievement and implementing any needed programmatic or strategic changes. The OVC program ensures alignment with PEPFAR program strategy by reaching and empowering adolescents, children, and households to address HIV through high-quality, a high-impact service, which is aligned with the programming principles in PEPFAR’s OVC Guidance for Vulnerable Children Programming and the USG’s Action Plan on Children in Adversity.

Facility-based partners: The PEPFAR-E epidemic control teams (ECTs) will provide ongoing guidance and support to the RHBs to align with the PEPFAR strategy and focus on efforts to implement innovative approaches in case detection and linkage. ECTs will also support the documentation of programmatic successes and provide technical assistance to RHBs and their partners through joint planning, training, service and data quality assessments, and routine performance monitoring. The ECTs will also utilize the
meetings to conduct remediation planning to address case detection and linkage performance gaps, including monthly financial utilization status vis-a-vis target performance. The IPs will also conduct weekly site level and monthly town level case detection and linkage performance reviews by SDP and by town respectively. Based on results, they will take immediate corrective actions to improve any performance gaps.

The IPs will also report ICT results every month so that the ECTs can review and provide feedback, as needed, to address program gaps. The monthly ICT performance review feedback will also be supplemented by telephone conference discussion with the RHBs so that the RHBs will take timely and appropriate action on the feedback provided by the ECT teams. Based on quarterly reported results in DATIM, the ECT will conduct joint quarterly review meetings with partners and facilitate the scale up of best practices.

SIMS: Both community and facility partners also conduct regular SIMS visits to ensure that PLHIV have access to high quality services. In COP18, SIMS visits will be conducted with a focus on high volume health facilities and community sites. Results and feedback from the SIMS visits will underpin the program’s Continuous Quality Improvement (CQI) initiatives and efforts to improve data quality and HIV services. Besides the routine SIMS visits, high volume sites will be selected for targeted SIMS visits to initially determine which areas experience program quality challenges. The targeted SIMS process entails implementation of a streamlined and tailored SIMS visit using existing tools. These sites will be supported to develop CQM (Continuous Quality Management) plans based on QI methodologies that will address identified performance gaps. SIMS visits will also be integrated with program monitoring visits by A/CORs where specific program areas will be monitored in great detail and joint follow up plans developed and tracked, as needed. Moreover, PEPFAR agencies hold regular partners’ meetings annually where they discuss performance, lessons learned, and share best practices among partners.

4.4 Collaboration, Integration and Monitoring

Partner forums are in place at regional levels and very useful to harmonize the planning and implementation of programmatic activities among funding sources, stakeholders and implementing partners. PEPFAR will continue to support and optimize the partner forums to effectively coordinate the activities of the different national stakeholders that support program implementation, achieve efficiencies and maximize impact.

Based on quarterly reported results in DATIM, the PEPFAR-E ECTs will conduct joint quarterly review meetings with partners and facilitate the scale up of best practices. The ECTs will also utilize the meetings to conduct remediation planning to address case detection and linkage performance gaps, including monthly financial utilization status vis-a-vis target performance. The IPs will also conduct weekly site level and monthly town level case detection and linkage performance reviews by SDP and by town respectively. Based on results, they will take immediate corrective actions to improve any performance gaps. The IPs will also report ICT results every month so that the ECTs can review and provide feedback, as needed, to address program gaps. The monthly ICT performance review feedback will also be supplemented by telephone conference discussion with the RHBs so that the RHBs will take timely and appropriate action on the feedback provided by the ECT teams.

Partners continuously collect and review site-level data and submit biweekly reports on HIV testing, case identification, and treatment initiation by population type. The data is reviewed by the activity managers and analyzed on a biweekly and monthly basis for data driven action planning, course correction (including any adjustments to work plans), and quality improvement. Weekly update calls and monthly partner management meetings are held with partners to discuss the review of site level data, progress on performance, and other programmatic issues including SIMS results, findings from supportive supervision visits and corrective actions that have been taken to improve program performance.

In COP17, PEPFAR supported the recruitment of surge staff at the RHB, town and facility, to deliver critical HIV services and improve case detection, linkage, retention and viral suppression in PEPFAR priority sites.
Moving forward, PEPFAR needs to place greater emphasis on improving the efficient use of existing resources for the health workforce, different LIPs, CSOs, PLHIV networks, FBO and religious institutes. Additionally, the program must maximize the value of the existing health workforce investments at the RHBs, town, facility and community levels in collaboration with the GoE and national stakeholders. The health workforce and the cadres of peer volunteers at the community and facility are currently responsible for the following activities: (1) improving targeted testing; (2) improving ART coverage through identifying and linking HIV-infected patients to care; (3) encouraging same day ART initiation for newly identified PLHIV; (4) and tracing LTFU clients. They are also responsible for routine viral load testing, effective sample referral, use of data/results for decision making, and reporting on performance, and encouraging communities and individuals to take an active role in demanding and seeking out HIV services. Given the scope of their responsibilities, the PEPFAR supported community and facility health care workers are critical to the national response.

To guide systematic and standardized implementation, PEPFAR has supported the development of a facility initiated ICT SOP that is being implemented by the RHBs. The RHBs will coordinate with and strengthen bidirectional referral linkage and feedback between the facility and community. Depending on index cases or their contacts’ preference, implementers will work to minimize missed opportunities in ICT service uptake through offering alternative testing sites and linking them to these venues. Providers will also be trained about the importance of client referrals based on their testing preference and about client tracking to facilitate greater adherence, retention and additional case detection among index contacts.

In COP 18, above service delivery activities including clinical and system mentoring as well as capacity building of HCWs through training will be conducted with the goal of addressing barriers and gaps to achieving current targets and to reaching epidemic control. Above site activities will support the FMOH in adapting innovative case detection implementation SOPs for HIVST and recency testing in addition to the development of training materials and other job aids. The above site TA partners will also build the capacity of the RHBs in implementing and rolling out these approaches through training providers and building a pool of a regional TOT that will roll out implementation in the regions. Moreover, TA will be provided to strengthen above site structures and systems for strategic planning, implementation and monitoring, and data use for continuous quality improvement. The goal of this approach is to address gaps in epidemic control with a focus on the scale up of index case testing. The above site TA partner will support the RHBs in collecting and reporting ICT results, and submitting their data to their respective ECTs for review, feedback and program support.

### 4.5 Targets for COP18 Attained/Maintained Locations and Populations

<table>
<thead>
<tr>
<th>Attained Support Volume by Group</th>
<th>Expected result APR 18</th>
<th>Expected result APR 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing (all populations)</td>
<td>HTS_TST</td>
<td>4,079,803</td>
</tr>
<tr>
<td>HIV positives (all populations)</td>
<td>HTS_TST_POS</td>
<td>60,705</td>
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<tr>
<td>Treatment new</td>
<td>TX_NEW</td>
<td>54,532</td>
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<tr>
<td>Current on ART</td>
<td>TX_CURR</td>
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<tr>
<td>OVC</td>
<td>OVC_SERV</td>
<td>439,753</td>
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<tr>
<td>Key populations</td>
<td>KP_PREV</td>
<td>68,520</td>
</tr>
</tbody>
</table>

Footnote: Includes targets from centrally supported SNUs
5.0 Program Activities for Epidemic Control in COP17 Attained Locations and Populations – (Tigray, Dire Dawa and Harari)

5.1 COP17 Programmatic Priorities
This section describes PEPFAR’s approach to three regions achieving epidemic control by the end of COP17. PEPFAR will transition away from supporting all FSW community prevention activities in these attained regions by the end of COP17. PEPFAR will not support active demand creation activities. Passive support at facility level will be provided to STI cases to ensure they receive HIV testing services and linkage to care and treatment. OVC programs will continue providing the full package of services in all attained regions however there will not be active new enrolments.

In COP 18, PEPFAR –E will not support active demand creation for case finding and HIV testing and counseling services will be done passively for those presenting in health facility requesting to be tested and risk based PITC will be provided for those presenting with AIDS defining illnesses in these attained regions. COP18 testing targets for the attained SNUs are 126,124, a significant shift from approximately 629,699 in COP17. In COP 18, in attained SNUs, routine testing of pregnant women for HIV will not be supported, however the minimum package of services for PMTCT will be provided for all positive pregnant women and their exposed infants. The level of effort will be reduced for some activities such as reduced frequency of mentorship and supervisory visits, no expansion of mother support groups, and no additional trainings.

In COP 18 attained regions, PEPFAR –E support will focus on the provision of quality ART services ensuring adherence and retention as well as provision of quality viral load services for those PLHIV newly enrolled on ART and those already enrolled on ART for the past 13 years. In attained SNUs, PEPFAR will ensure that quality standards of care and treatment services are accessible and sustained for patients already enrolled in treatment through provision of technical assistance. The package of services are aligned with Ethiopia’s minimum standard package of services for PLHIV as outlined in the 2018 National Comprehensive HIV/AIDS Testing, Care and Treatment Guidelines. Rapid initiation of ART for all newly identified HIV positive clients including same day ART will be strengthened in all treatment facilities. For those who present with advanced disease, the full package of services including screening and treatment of opportunistic and other concurrent illnesses will be provided. Optimizing the ARV regimens, more specifically introduction of Dolutegravir as part of the first line ARV regimen and transitioning of existing clients on TLE regimen to TLD will be undertaken. The basic care and support services including clinical staging, measurement of CD4 count to determine eligibility for OI prophylaxis (for those newly enrolling on ART) and subsequently if needed to cease CPT or if patients are suspected to be failing first line or second line regimen, screening and management of OIs, PHDP services, nutritional assessment and counseling, linkage to PLHIV support groups. In addition, HIV services will proactively identify and manage patients with co-morbidity, mental health problems, pain and symptom management. Adherence and psychosocial support will be provided in attained SNUs. In addition, TA will be provided to ensure delivery of the basic care package for those with advanced illness based on the revised Comprehensive National Guideline for Testing, Care and Treatment.

The use of routine viral load testing for ART monitoring and early identification of treatment failure will be strengthened. The results of the viral load tests will be used for individual patients’ management and timely clinical decision making. Appropriate and timely switching to second line ARV regimens for those patients who fail their first line regimens will be strengthened. PEPFAR will continue delivery of quality care and treatment services for HIV infected children through an integrated, comprehensive, and family-centered approach. The program will support pediatric case finding, implementation of test and treat policy,
provision of a comprehensive care package and ensure availability of essential laboratory services including viral load monitoring. PEPFAR support will capitalize on improving quality of services to improve adherence to treatment, retention in care and viral suppression for the existing cohort of children and adolescents on treatment while implementing family ICT and risk based PITC to promote pediatric HIV case detection. Peer case managers and adherence supporters at the facility provide routine peer-to-peer adherence support to newly initiated patients and to existing clients through counseling, education, regular monitoring of scheduled appointments, identifying clients who miss their scheduled appointments, tracing of defaulters and engaging them back to care, and facilitating linkage with community services, including community level adherence support. Discussions are ongoing to transition this PEPFAR supported case management program to GoE and Global Fund. Continuous quality improvement will be supported in order to maintain the standard of care provided to patients.

5.2 Targets for COP17 Attained Locations and Populations

<table>
<thead>
<tr>
<th>Attained Support Volume by Group</th>
<th>Expected result APR 18</th>
<th>Expected result APR 19</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV testing (all populations)</td>
<td>HTS_TST</td>
<td>629,699</td>
</tr>
<tr>
<td>HIV positives (all populations)</td>
<td>HTS_TST_POS</td>
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<td>Treatment new</td>
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<td>OVC</td>
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<tr>
<td>Key populations</td>
<td>KP_PREV</td>
<td>11,350</td>
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</tbody>
</table>

5.3 Establishing service packages to meet targets in COP17 Attained Regions

Three regions - Tigray, Dire Dawa and Harari are projected to reach attained by the end of COP17. In COP 18 attained regions, PEPFAR –E support will focus on the provision of quality ART services, ensuring adherence as well as provision of quality viral load services for those PLHIV newly enrolled on ART and those already enrolled on ART for the past many years. PEPFAR will continue delivery of quality care and treatment services for HIV infected children through an integrated, comprehensive, and family-centered approach. PEPFAR will support provision of comprehensive services to the HIV exposed /infected children and adolescents receiving ART such as growth monitoring and developmental assessment, counseling on infant feeding, cotrimoxazole preventive therapy (CPT), TB risk assessment, and early diagnosis and treatment of common infections, adolescent focused services psycho-social support, adherence and retention in care, tracking loss to follow up cases, and viral load monitoring. Test and Start for all children < 15 years of age will be further strengthened with a particular focus on rapid initiation of ART, adoption and implementation of appropriate treatment regimens and dosage, use of child friendly drug formulations and enhanced adherence and counselling services. Facility based programs will also improve pediatric case detection through testing of biological children of HIV positive mothers, biological siblings of under 15 index cases and enhanced EID. Risk based testing will also be conducted among children diagnosed with tuberculosis, admitted in the inpatient wards, OVC and those receiving services in the malnutrition clinics.

Weekly site level reviews and monthly town level review of performance will be conducted and data will be used for performance improvement. Mentoring and supportive supervision activities will be conducted regularly to coach and build the capacity of providers, review site level data, identify best practices and replicate, detect missed opportunities and help sites address any remaining gaps.
6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Surveillance activities such as HIV incidence surveillance with recency testing and case-based surveillance (CBS) are critical to sustaining epidemic control. These and other table 6 investment activities noted in Appendix C are aligned with prioritized site level activities such as improvement in case detection through innovative approaches, strengthening site level information systems, sample referral, supply chain, and coordination and management. All activities augment site level effort to reach sustained epidemic control. Activities listed in table 6 will address key issues and gaps identified through SID 3.0 (epidemiological and health data, HRH, supply chain), low case detection and LTFU, and linkage. Additionally, the reduction in investments is a result of consolidated successes and gains in creating an enabling environment with increased country ownership and greater sustainability of the HIV/AIDS program.

GoE and other donors including PEPFAR are investing in system level development to address key barriers at sites and above site. GoE invests in HRH development and filling the gaps in clinical services and infrastructure development. Global Fund focuses its resources on securing HIV commodities (i.e. RTKs, ARVs) and on some health system strengthening activities.

PEPFAR has established benchmarks and outcomes to monitor progress and to effectively address key issues and barriers. Some of the benchmarks and outcomes have been rolled over from COP17. However, the benchmarks and outcomes are clearly defined quantitatively and qualitatively to address the barriers and gaps.

6.1 Case-based and Incidence Surveillance

The hallmark of COP18 (and beyond) is to shift the program toward a focus on CBS and incidence surveillance with recency testing and sustaining community viral load suppression. Routine individual-level reporting of new HIV infections (i.e., HIV case reporting [CR]) and longitudinal surveillance of reported HIV cases through the progression of the disease (i.e. CBS) provide ongoing national and sub-national data to prevent, detect, and more effectively respond to any changes in the HIV epidemic. As most SNUs in Ethiopia move closer to reaching attainment of HIV treatment targets, HIV incidence surveillance on newly identified PLHIV using rapid HIV recency tests as part of routine program implementation will be essential to provide real-time description of the epidemiology of recent infections. Recency testing will be utilized for newly diagnosed PLHIV to augment case detection through a focus on sexual networks with recent or ongoing HIV transmissions. HIV recency testing will be integrated with the HIV case based surveillance system to be implemented among newly identified PLHIV. This allows the country program to rapidly focus the public health response to “hot-spots” of sub-populations and SNUs with on-going HIV transmission.

In 2016, as part of an HIV case surveillance feasibility assessment, PEPFAR Ethiopia piloted a facility-based prospective case reporting in 10 health facilities in Addis Ababa. This assessment demonstrated that surveillance data can be collected and transferred through the health administrative hierarchy. The findings also demonstrate that opportunities do exist in Ethiopia to use existing patient-level data to identify patients most in need and areas where gaps in service delivery exist, and use this information to drive response to the HIV epidemic.

In 2017, PEPFAR is working with the Public Health Emergency Unit of Amhara regional health bureau, to implement panic alert reporting for high HIV viral load results and ensure quality specimens reach testing laboratories (see Flow Diagram, below)
Building from the encouraging experiences with the 2016 feasibility assessment and the ongoing monitoring of patients with unsuppressed viral load as public health emergency in Amhara, PEPFAR is establishing a case reporting system to generate the first HIV surveillance report in the current fiscal year. A case reporting protocol is being developed and data system and reporting standard operating procedures are being established. As HIV is not mandated as a notifiable condition currently; there is no policy imperative to drive reporting of new cases from providers. Therefore, advocacy efforts are under way to include HIV as reportable disease in the Ethiopian Public Health Emergency System (PHEM). Moreover, Ethiopia’s CR and CBS will be built integrated into PHEM, this will in turn enable leveraging PHEM personnel and system and make the system sustainable.

In COP18, the establishment of HIV CR and CBS are priority activities for PEPFAR. The main goal of the PEPFAR supported HIV case surveillance system in Ethiopia is to monitor the epidemic and inform the public health response. Specifically, CBS enables monitoring of epidemiologic trends in newly identified HIV cases by demographics, behavior, mode of transmission, and recency of HIV infection. It also enables monitoring of clinical status (WHO Stage, initial CD4, and other opportunistic infections) and linkage to services (e.g., same-day ART) at the point of diagnosis. Hence, in COP18, Ethiopia will implement HIV case reporting and recency testing for new cases, at-scale.

Activities considered as building blocks for CBS will also be prioritized. These include:

1. Improving the quality and use of patient-level data across the clinical cascade through revamped investment in health information for HIV epidemic control (details below)
2. Enhancing capture of high-quality demographic data from facility medical record units and using an algorithm for record-matching, under a de-identification protocol for exporting existing patient-level data.
3. Supporting FMOH to implement data warehousing/repository based on decisions made by the TWG, and in alignment with the national FMOH enterprise architecture
4. Conducting information exchanges
5. Supporting the visualization and use of case surveillance data, especially incident cases and unsuppressed PLHIV (as per the flow diagram below already implemented in Amhara Region), at functional Emergency Operation Centers located at regional health bureaus and the Ethiopia Public Health Institute.
6.2 Health Information Systems for HIV Epidemic Control

Efforts to improve quality and use of patient data across the clinical cascade for case surveillance, QMEC, and for rapid public health response are core to the success of the strategy for COP18 and beyond. Activities will be implemented to reinforce people, processes, software and hardware – all of which are critical to the information systems for HIV epidemic control.

2018-2019: Improving Quality and Use of Patient Data Across the Clinical Cascade for Case Surveillance and QMEC

<table>
<thead>
<tr>
<th>Task Category</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient-level Data</td>
<td>Electronic Medical Record – ART Module</td>
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field of information technology and the understanding of what PEPFAR can and should support in health system strengthening has also changed. Investment in SmartCare began in 2008; it has been, and still is, first and foremost, an investment in the strategic information needs of the PEPFAR program. Still, all data collected about SmartCare indicates that, problems notwithstanding, the tool clearly adds value in PEPFAR data collection and result reporting. Accordingly, PEPFAR will support a government-led strategy for a transition of legacy health information systems to newer alternatives; in the meantime, the HIV program will need a working solution that is good enough to meet its needs in the interim.

**Patient-Level Data: Laboratory.** Currently, the electronic standalone VL/EID databases at 19 referral labs, support reporting on VL/EID MER indicators. Reports are aggregated from these databases by exporting results into Excel files and sending them to EPHI for compilation into one database and descriptive analyses. Regional health bureaus do not have access to this database of aggregated results across laboratories within their catchment. Submission of test-orders and return of results is not automated and is not captured within the SmartCare EMR module. These deficiencies undermine turnaround time, quality of patient management and program performance towards population-level viral load suppression.

**Key Activities:** For the next 18 months there will be an acceleration of efforts to reinforce information for HIV epidemic control, involving people processes, software, and hardware.

- Improve linkage between testing (community/facility) and the EMR by assessing existing processes, work streams, and information flows and implementing improvements
- DQA/DQI activities – special focus on improving completeness/accuracy of demographic data for matching/tracking
- Incorporate data capture of newly diagnosed PLHIV into EMR
- Fix EMR bugs with updates and strengthen the enabling infrastructure/environment in high-volume sites (antivirus, connections, UPS, etc.)
- Initiate data exchange between referral labs and high-volume sites
- Support ART Module improvement, deployment and end-user training
- Provide mentoring and supportive supervision
- Support FMOH to develop national requirements and standards for their next generation EMR solution and creation of a detailed implementation plan for introducing next generation solution, with focused support on adaptations for HIV-related modules
- Establish helpdesk system for the operational system support
- Complete EMR stabilization, including enabling environment in remaining ART sites
- Enhance tracking systems for the 1st and 2nd 90, including contact tracing tools for partner services and use of CommCare tool to improve linkages to treatment
- Automate data flows between service outlets and ART module
- Expand data exchange between referral labs and referring sites
- Conduct ongoing DQA/DQI activities across the clinical cascade
- Conduct indicator mapping between EMR and DHIS2 and pursue data exchange/interoperability between both the EMR and DHIS2, and between DHIS2 and DATIM
- Interface standalone VL/EID databases to a central repository (EPHI), and ensure RHB access
- Improve turnaround time of results for virally-unsuppressed patients through new SOPs
- Establish electronic test order and results (ETOR) transmission between high-volume sites and referral laboratories
- Reinforce enabling environment for referral laboratories and high-volume referring sites
- Expand weekly monitoring and response measures for unsuppressed patients to all “Maintained” Regions
- Reinforce enabling environment for remaining ART sites in “Maintained” Regions
- Expand ETOR into remaining ART sits in “Maintained” Regions
- Establish health information exchange between VL/EID database and EMR
6.3 **Summary of Activities that address Key Program Barriers**

**Social Services System Strengthening including workforce development:** PEPFAR has been providing support to GoE to establish and strengthen social service systems through: (i) the creation of a new cadre of front line workers (Para social workers) and (2) building the capacity of the institutions that train the para social workers (PSW) and bolster the capacity of community structures like community care coalitions (CCCs). The goal of this targeted capacity building approach is to strengthen the social services system so that it is better prepared to prevent and respond to neglect, violence and exploitation of children and adolescents at risk.

This capacity building support will also result in better quality of services. More specifically, the para social workers serve as case managers and will provide OVCs with standardized and customized support based on vulnerability assessments. They will also provide case management for OVC in their woredas, and then link the OVC to health and social services provided by their communities and/or local authorities.

In COP18, PEPFAR will continue to provide technical and material support to Technical and Vocational Education Training (TVET) centers to enhance their capacity for high quality trainings and to ensure PEPFAR priorities are incorporated into the PSW training curriculum. PEPFAR’s focus 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 program investments.

The PEPFAR program assists these local systems to improve the availability of social service workers and to provide adequate social services for highly vulnerable children, including adolescents, and their families. They will be deployed at the kebele level (a sub-unit under woredas or district) to work closely with communities through CCCs and LIPs. TVET centers will also revise their curriculum and training modules to: (1) incorporate current and up to date case management, referral, supportive supervision and case conferencing approaches and mechanisms; and (2) support and track the deployment of para-social workers as well as ensure coverage and sustainability of OVC services.

The PEPFAR program support for Ministry of Labor and Social Affairs (MOLSA), regional Bureaus of Labor and Social Affairs (BoLSA) and TVETs will accomplish the following:

- Provide pre-service training and deployment of parasocial workers.
- Provide training on case management, referral linkages and adherence to TVET trainers to cascade to PSW.
- Strengthen systems for parasocial service workers to provide technical support to volunteers at CCCs for case management and to mobilize local resources which will ensure a smooth transition of OVCs to the community and GoE in the future.

These cadres will play a crucial role by supporting the training of para social workers to expand high quality services through comprehensive case management. More specifically, they will improve case-finding and linkage as well as support HIV disclosure, adherence to treatment, and retention to achieve viral load suppression for OVC, their caregivers, and AGYW. They will also play a significant role in the implementation of the OVC transition plan and the new OVC testing screening tool.

This support will also help to address quality management gaps identified in the SID 3.0 through building GoE capacity and engaging existing community structures to promote sustainability of the OVC program. While the government continues to cover certain costs associated with the training (running cost of training facilities/colleges, instructors salaries and deployment and salary of the graduated social workers), PEPFAR will cover other training costs and technical assistance until the GoE’s and its training institutions are ready to take over the full cost on their own.

PEPFAR will also support standardization and roll-out of ES support for OVC beneficiaries through development of ES implementation manuals and tools, and provide TA to improve technical capacity of
GoE relevant ministries and directorates, IPs and CCC in the ES activity to transition leadership and ownership of ES activities. These will improve coordination, referral, and joint activity design/planning/implementation among implementing partners and other ES service providers (especially from GoE) as well as rolling-out of the “National ES Implementation” with the leadership of FHAPCO for the implementation of ES interventions in a standardized, cost-effective and sustainable way for improved HIV outcomes.

Other system gaps to assure linkage, retention, and viral suppression of identified PLHIV:
Although the SID 3.0 assessment for laboratory shows improvement, there are still significant challenges. The PEPFAR team is continuing to address key program challenges including sub-optimal transportation and laboratory networking for viral load service and prolonged viral load test result turnaround time. As part of efforts to differentiate HIV services and tailor it to vulnerable groups, PEPFAR has provided Test and Start services for FSW in DICs since COP16. Even though DICs are currently not yet linked to the national VL sample transport system, viral load samples are sent to regional labs for viral load testing and monitoring. Results are received in a timely fashion and are immediately communicated to clients. In COP18 the program will aim to ensure that DICs are linked to the national sample transport system. As such, the program is will continue to work with EPHI to include DICs in the national VL sample transport system. Samples will be collected at DICs, transported to RHB viral load testing laboratories, and the VL results will be actively tracked. In sum, the activity will facilitate the transportation and referral of viral load samples to the testing facilities and actively collect viral load results. However, the main goal of this activity is to ensure that VL results are used in a timely manner for clinical decision making, better health outcomes and as a measure of performance.

PEPFAR in collaboration with GoE and other relevant stakeholders are working to address key challenges including ineffective bi-directional linkage among different service delivery points and the lack of a standardized system to facilitate and track referral and effective linkages at the community level. In COP18, PEPFAR will focus on improving community health information systems by scaling up utilization of CommCare and integration of this application with the electronic Multi-sectoral Response Information System (eMRIS) and electronic Community Health Information System (eCHIS). As already stated, PEPFAR will also support the implementation of CommCare technology or applications (e-HIS) to ensure that community-facility linkage is both trackable and effective and to improve the rate of completed referrals. The CommCare application will also be used as a case management tool to provide targeted case management and counseling to address the specific reasons for non-adherence.

In Addis Ababa and Gambella, a community-focused implementing partner will support mHealth tool and eCHIS integration. More specifically, the partner will: (1) provide technical assistance in determining community based care and support intervention packages and improve workflow with relevant MOH staff and teams; and (2) roll out use of the mHealth (Commcare) tool for the provision of case management services and referral of clients from communities to facilities. The PEPFAR team will advocate to the MoH to adopt and implement the m-Health (Commcare) for the provision of case management service and referral of clients from community to facility at those attained and maintained regions where the PEPFAR community care and treatment activity will phase out.

Supply Chain Management Systems: In COP18, PEPFAR will continue providing supply chain technical assistance (TA) to FMOH, PFSA, RHB and priority health facilities to strengthen enabling environments to improve supply chain performance, implement innovations to ensure sustainability, and support procurement of HIV related health commodities. The TA will include: (1) forecasting and quantifications; (2) distribution and warehouse management; (3) fleet management; (4) procurement and pipeline monitoring; and. The TA will also include training of health care providers in PEPFAR-supported ART sites on the Integrated Pharmaceuticals Logistics System (IPLS); support to the federal, regional, district and service delivery points (SDPs) to develop, apply best practices, innovative solution, and use of data for decision making; provide training, mentoring to ensure commodities are appropriately ordered, managed in warehouse, inventory, distribution; support for improved dispensing to clients for ART outcomes; and TA
to enhance the pharmacy services provided at SDPs to increase transparency, accountability and reduce wastage. The number of automated logistics management information sites, which will cover over 85% of the ART patients in care, will increase to 800. PEPFAR will also support the mentoring and supportive supervision of priority towns and PEPFAR supported ART sites to monitor stock levels/status and avoid stock out of ARVs, RTKs and viral load/EID. This support will build the capacity of host country institutions and the supply chain system; and work to address gaps identified during the SID 3.0 assessment under “Commodity Security and Supply Chain”.

**TLE to TLD transition:** To support the national ART program to effectively transition TLE to TLD and improve pharmacy services to enhance treatment outcomes, supply chain efficiency and effectiveness and financial monitoring, PEPFAR will provide support to improve strategic planning for the supply chain and pharmacy services, resulting in increased availability of medicines, rational use, and compliance for clients. This support will include the following activities: (1) provide training to ensure seamless transition from TLE to of TLD, and (2) conduct supportive supervision and mentoring to supply chain in ART sites with a specific focus on PEPFAR priority sites. This support will improve commodity security and supply chain gaps identified during the SID 3.0 assessment and its implementation will be monitored to ensure TLE to TLD transition is completed without stock interruption and TLE wastage is minimized.

### 7.0 Staffing Plan

Overall, the staffing footprint for PEPFAR will decrease in COP18. This is in part in response to the downward trend of COP funding for COP18 and out years as well as the changing epidemiology in Ethiopia (moving from a “scale-up” to an “attained” program). Future technical staffing needs will evolve as the strategic direction changes over time. The PEPFAR Country Coordinator position continues to be vacant after nearly four years.

For CDC, this reduction in staff footprint will be accomplished through retirement and attrition and by recruiting and promoting internally. Seven long-term vacancies will also be eliminated from CDC’s overall staffing footprint: two USDH positions, four operations positions and one Health Systems position. Of CDC’s 78 positions, all employees have current FTE status with the USG. There are 53 technical positions that are 100% dedicated to PEPFAR and each of these 53 staff participate in SIMS visits to meet the annual monitoring requirement. The staff is organized around technical area of expertise (laboratory, prevention, etc.) as well as in newly established epidemic control teams (ECTs). The ECTs combine staff working across technical disciplines to focus on epidemic control at the region level including how to ensure coordinated partner activities for maximum efficiency. The remaining 25 positions are mostly operations and admin focused and are 90% dedicated to PEPFAR, sharing 10% of these support staffs’ time and level of effort with CDC’s Global Health Security program. CDC will also repurpose on Operations Branch position to a Public Health Specialist M&E technical position. CDC has reduced its CODB in line with the PEPFAR budget decreases and evolving programmatic priorities. From COP16 to COP17, CDC’s CODB was reduced by $1.5M and COP18 will see a further $1.1M decrease.

USAID has a limited, targeted staffing footprint, which has steadily reduced by 65% since COP12 to align with programmatic pivots and funding declines. Of USAID’s 29 positions, 23 are technical staff that are 100% dedicated to PEPFAR. Similar to CDC, each staff participate in SIMS visits to meet the monitoring requirement. The remaining 7 positions are not dedicated to PEPFAR at 100%, and these are primarily leadership and administrative roles. Of USAID’s five vacant positions, two are currently in the recruitment and hiring phase to include the Deputy PEPFAR Coordinator and an administrative assistant; staffs are anticipated to begin duties in 2018.

Neither USAID nor CDC will add positions in COP18. The staffing change is among the major contributors for the decrease in COBD for COP18 although other efficiencies and reductions in COBD were also made through strategic analysis and planning. The staffing and COBD footprint maximizes efficiencies across the
program while still maintaining the ability to provide substantial technical assistance to GoE and our implementing partners without compromising on scientific rigor or sound business practices.
# APPENDIX A - PRIORITIZATION

## Table A.1: SNU Prioritization

<table>
<thead>
<tr>
<th>Region</th>
<th># of SNU</th>
<th>COP</th>
<th>Prioritization</th>
<th>Results reported</th>
<th>Attained</th>
<th>SD-TH dissemination by each age and sex band, and gender (SD-TH-TH-SD-TH)</th>
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</thead>
<tbody>
<tr>
<td>Addis Ababa</td>
<td>1</td>
<td>COP15</td>
<td>Take-up, Seclusion</td>
<td>APR 18</td>
<td>62%</td>
<td>79% 79% 79% 118% 130% 69% 91% 65% 134% 100% 94% 50% 72% 77%</td>
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<td>70% 70% 70% 110% 124% 104% 103% 61% 121% 117% 103% 93% 21% 67%</td>
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<tr>
<td></td>
<td>3</td>
<td>COP17</td>
<td>Take-up, Seclusion</td>
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<td>94% 93% 93% 120% 120% 100% 100% 100% 120% 112% 100% 20% 25% 69%</td>
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<tr>
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<td>Take-up, Seclusion</td>
<td>APR 15</td>
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<td>72% 72% 72% 86% 86% 86% 86% 86% 86% 86% 86% 86% 86% 86%</td>
</tr>
<tr>
<td>Amhara</td>
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<td>COP15</td>
<td>Take-up, Seclusion</td>
<td>APR 18</td>
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<td>10% 10% 10% 38% 47% 56% 56% 56% 56% 56% 56% 56% 56% 56%</td>
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<tr>
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<td>17% 17% 17% 47% 47% 47% 47% 47% 47% 47% 47% 47% 47% 47%</td>
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<td>11% 11% 11% 43% 43% 43% 43% 43% 43% 43% 43% 43% 43% 43%</td>
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<tr>
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<td>62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62% 62%</td>
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<td>45% 45% 45% 45% 45% 45% 45% 45% 45% 45% 45% 45% 45% 45%</td>
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<tr>
<td></td>
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<td>Take-up, Seclusion</td>
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<td>30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30%</td>
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<tr>
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<td>30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30%</td>
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<tr>
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<td>30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30% 30%</td>
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<tr>
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<tr>
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<td>APR 16</td>
<td>21%</td>
<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<tr>
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<td>21%</td>
<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<tr>
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<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<tr>
<td></td>
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<td>APR 12</td>
<td>21%</td>
<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<tr>
<td></td>
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<td>21%</td>
<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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<tr>
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<td>21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21% 21%</td>
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</tbody>
</table>

Notes:
- Coverage among males is higher than females in the reproductive age group (15-49).
- COP 18 maintained
- COP 17 Attained
- Emerging Regions
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<thead>
<tr>
<th>Prioritization Area</th>
<th>Total PLHIV (PLHIV 17)</th>
<th>Expected current on ART (APR FY 18)</th>
<th>Additional patients required for 80% ART coverage (APR FY 19)</th>
<th>Target current on ART (APR FY19)</th>
<th>Newly initiated (APR FY 19) TX_NEW</th>
<th>ART Coverage (APR 19) TX_CURR</th>
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<tr>
<td>Attained</td>
<td>559,620</td>
<td>470,046</td>
<td>-22,350</td>
<td>485,972</td>
<td>25,094</td>
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<tr>
<td>Central Support</td>
<td>47,498</td>
<td>22,226</td>
<td>15,772</td>
<td>22,120</td>
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<td>47%</td>
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<tr>
<td>Military</td>
<td>9,259</td>
<td></td>
<td></td>
<td>9,859</td>
<td>853</td>
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<tr>
<td>Total</td>
<td>607,118</td>
<td>501,531</td>
<td>-6,578</td>
<td>505,763</td>
<td>25,947</td>
<td>83.3%</td>
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</table>
Table B.1.1 COP18 Budget by Approach and Program Area (generated from the FAST)

Table B.1.2 COP 18 Total Planning Level

<table>
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<th>Applied Pipeline</th>
<th>New Funding</th>
<th>Total Spend</th>
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<td>$ 29,420,356</td>
<td>$ 71,600,590</td>
<td>$ 101,805,777</td>
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Data for tables B.1.2 and 1.3 are from the FAST submitted May 8, 2018; all figures are from the Strategic Objectives-E tab
### Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

<table>
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<tr>
<th>PEPFAR Budget Code</th>
<th>Budget Code Description</th>
<th>Amount Allocated</th>
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</thead>
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<tr>
<td>MTCT</td>
<td>Mother to Child Transmission</td>
<td>$ 0.00</td>
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<tr>
<td>HVAB/Y</td>
<td>Abstinence/Be Faithful Prevention/Youth</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>HVOP</td>
<td>Other Sexual Prevention</td>
<td>$ 605,530</td>
</tr>
<tr>
<td>IDUP</td>
<td>Injecting and Non-Injecting Drug Use</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>HMBL</td>
<td>Blood Safety</td>
<td>$ 0.00</td>
</tr>
<tr>
<td>HMIN</td>
<td>Injection Safety</td>
<td>$ 0.00</td>
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<tr>
<td>CIRC</td>
<td>Male Circumcision</td>
<td>$ 313,054</td>
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<tr>
<td>HVCT</td>
<td>Counseling and Testing</td>
<td>$ 4,936,751</td>
</tr>
<tr>
<td>HBHC</td>
<td>Adult Care and Support</td>
<td>$ 4,378,931</td>
</tr>
<tr>
<td>PDCS</td>
<td>Pediatric Care and Support</td>
<td>$ 1,619,630</td>
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<tr>
<td>HKID</td>
<td>Orphans and Vulnerable Children</td>
<td>$ 13,229,711</td>
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<tr>
<td>HTXS</td>
<td>Adult Treatment</td>
<td>$ 29,527,487</td>
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<tr>
<td>HTXD</td>
<td>ARV Drugs</td>
<td>$ 10,000</td>
</tr>
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<td>PDTX</td>
<td>Pediatric Treatment</td>
<td>$ 3,275,879</td>
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<td>HVTB</td>
<td>TB/HIV Care</td>
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<td>Lab</td>
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</tr>
<tr>
<td>HVSI</td>
<td>Strategic Information</td>
<td>$ 2,673,413</td>
</tr>
<tr>
<td>OHSS</td>
<td>Health Systems Strengthening</td>
<td>$ 1,066,731</td>
</tr>
<tr>
<td>HVMS</td>
<td>Management and Operations</td>
<td>$ 5,222,320</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$ 71,600,590</strong></td>
</tr>
</tbody>
</table>

*Data matches FACTS Info records (Summary of Planned Funding by Agency)*

### B.2 Resource Projections

The COP18 Planning Level Memo, COP18 guidance, and the COP18 Strategic Vision for Ethiopia were inputs to determining allocations by implementing mechanism and budget code. Pre-populated COP17 strategic objectives and approaches formed the basis for the IM budgeting process and activities for each IM. These were based on the strategic objectives aimed at moving the program towards epidemic control. Budgeting for each IM was applied by assessing activities to be scaled-up or down or completely dropped based on COP18 priorities and strategic direction.
### APPENDIX C – Data Capturing Tools for FSW Service Provision in the Facility

#### Key Population Friendly Service Provision Register

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>STI/SCM</th>
<th>GOV Services</th>
<th>STI/SCM</th>
<th>TB/HIV Services</th>
<th>Comodities</th>
<th>Pregnants</th>
<th>PMCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Facility</td>
<td>Date of Entry</td>
<td>Age</td>
<td>Gender</td>
<td>Occupation</td>
<td>STI/SCM</td>
<td>GOV Services</td>
<td>STI/SCM</td>
</tr>
<tr>
<td>Location Code</td>
<td>Date of Entry</td>
<td>Age</td>
<td>Gender</td>
<td>Occupation</td>
<td>STI/SCM</td>
<td>GOV Services</td>
<td>STI/SCM</td>
</tr>
<tr>
<td>Referral Source</td>
<td>Date of Entry</td>
<td>Age</td>
<td>Gender</td>
<td>Occupation</td>
<td>STI/SCM</td>
<td>GOV Services</td>
<td>STI/SCM</td>
</tr>
<tr>
<td>Name of Facility</td>
<td>Date of Entry</td>
<td>Age</td>
<td>Gender</td>
<td>Occupation</td>
<td>STI/SCM</td>
<td>GOV Services</td>
<td>STI/SCM</td>
</tr>
</tbody>
</table>

**Code of Test Result**
1. VDRL
2. TPPHA
3. RPR
4. HIV-1
5. HIV-2
6. Other

### HIV Negative Follow-up Form for FSWs and Their Partners

<table>
<thead>
<tr>
<th>Facility Name:</th>
<th>Client Name:</th>
<th>Address: Region</th>
<th>Age:</th>
<th>Woreda/Sub City:</th>
<th>Sex:</th>
<th>Date of First HIV Test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>House No:</td>
<td>Date Referred to Other HF:</td>
<td>HTS Follow-up Status</td>
<td>STI Screening &amp; SCM</td>
<td>Family Planning Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Follow-up Date (EC)</th>
<th>Date HIV Test Repeated</th>
<th>HIV Test Result (R/NR)</th>
<th>Screened/Managed for STI</th>
<th>Counselling for FP (Y/N)</th>
<th>Received Condoms (Y/N)</th>
<th>Received FP Method</th>
<th>Next Follow-up Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Legend for HTS Follow-up Status:*
- No sign & symptoms
- Uterine Blockage
- Vaginal Blockage
- Genital Ulcer
- Genital Itching
- Genital Bump
- Sexual violence
- Lower Abdominal Pain
- Other STI

*Legend for STI Screening & SCM:*
- Yes
- No

*Legend for Family Planning Services:*
- Yes
- No
### Key Population Program Level Support Reporting Template

**Reporting ICAPRO:_______, Reporting Month:_______, Reporting Date:____/____/_____

<table>
<thead>
<tr>
<th>Indicators</th>
<th>Monthly Target</th>
<th>Monthly Achievement</th>
<th>Gaps/Collisions</th>
<th>Action Taken</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Objective 1: To support RHBs in planning monitoring and evaluation of the KP friendly services in their selected facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1 # of TRHBs supported</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.2 # of TRHBs with Mapping of KP clients and sites</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3 # of TRHBs assigned focal person</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1.4 # of training manuals printed and distributed to TRHBs</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Objective 2: To support RHBs to ensure training of HCWs in provision of standards of care and peer navigators who can link their peers to facility-based HIV prevention, care, and treatment and referral linkage to community support organizations for economic support</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.1 # RHBs staff trained in KP TOT</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.2 # of HCWs trained</td>
<td>160</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.3 # of peer navigators trained</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.4 # HBMs trained</td>
<td>20</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.5 # supportive supervision conducted</td>
<td>14</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.6 # RHBs collected, analyzed, report and provided feedback to sites</td>
<td>84</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.7 # facilities with KP focal person</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Objective 3: To support RHBs ensuring integrated confidentiality HIV services for KP through provision of HIV prevention, harm reduction, and screening and management of comorbidities and ensuring HIV cascade: HTC → Linkage → Enrollment → ART → Adherence → VL suppression in 80 KP friendly facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.1 # IEC/RF material distributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.2 # PSTs distributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.3 # of facilities with equipment, FP commodities, STI kits &amp; supplies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.4 # of HPs supervised</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.5 # fractional peer navigator assigned to the facility</td>
<td>80</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.6 # of HPs mentorship &amp; Supportive supervision conducted</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Objective 4: To support RHBs to ensure availability of monitoring &amp; evaluation system in the 80 KP friendly facilities</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4.1 # of facilities with Logbook and reporting forms</td>
<td>80</td>
<td></td>
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<tr>
<td>4.2 # of KP facilities submitted the monthly activity reports</td>
<td>80</td>
<td></td>
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<tr>
<td>4.3 # DQA conducted</td>
<td>160</td>
<td></td>
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<tr>
<td>5. Objective 5: Support ICAP’s CO &amp; ROs team in planning and monitoring of the KP friendly services in their respective regions</td>
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<td></td>
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</tr>
<tr>
<td>5.1 # ICAP staff trained</td>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2 # of monthly meetings conducted</td>
<td>Monthly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3 # ICAP’s central ROs clinical &amp; MME team trained</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4 # of ICAP’s monthly review meetings conducted</td>
<td></td>
<td></td>
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<tr>
<td>6. Objective 6: To collaborate with CDC to support RHBs in the implementation of KP friendly sites</td>
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<td></td>
<td></td>
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<tr>
<td>6.1 # meetings conducted</td>
<td>Monthly</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>6.2 # ISS conducted</td>
<td>Quarterly</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.3 # of best practices documented</td>
<td>Annually</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SN</td>
<td>Indicators</td>
<td>Monthly Target</td>
<td>Monthly Achievement</td>
<td>Gaps/Causes</td>
<td>Action Taken</td>
</tr>
<tr>
<td>----</td>
<td>----------------------------------------------------------------------------</td>
<td>----------------</td>
<td>---------------------</td>
<td>-------------</td>
<td>--------------</td>
</tr>
<tr>
<td></td>
<td>HIV cascade</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.1</td>
<td># of FSWs identified and linked to HPs for HTC</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1.2</td>
<td># of FSWs counseled and tested for HIV</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1.3</td>
<td># of FSWs tested HIV positives</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>1.4</td>
<td># of HIV positive FSWs linked to care</td>
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<td></td>
<td></td>
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<tr>
<td>1.5</td>
<td># of HIV positive FSWs started ART</td>
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<td></td>
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</tr>
<tr>
<td>1.6</td>
<td># of FSWs on ART with baseline VL =&lt;1000 c/ml</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>1.7</td>
<td># of FSWs on ART with follow-up VL =&lt;1000 c/ml</td>
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<tr>
<td>1.8</td>
<td># of partners identified and linked to HPs for HTC</td>
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<td></td>
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<tr>
<td>1.9</td>
<td># of partners counseled and tested for HIV</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.10</td>
<td># of partners tested HIV positives</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.11</td>
<td># of HIV positive partners linked to care</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>1.12</td>
<td># of HIV positive partners initiated ART</td>
<td></td>
<td></td>
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<tr>
<td>1.13</td>
<td># of partners on ART with baseline VL =&lt;1000 c/ml</td>
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<tr>
<td>1.14</td>
<td># of partners on ART with follow-up VL =&lt;1000 c/ml</td>
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<tr>
<td>2</td>
<td>GBV Services</td>
<td></td>
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<tr>
<td>2.1</td>
<td># of GBV survivors received PEP</td>
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<tr>
<td>2.2</td>
<td># of GBV survivors received service packages</td>
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<tr>
<td>3</td>
<td>STI screening and SCM</td>
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<tr>
<td>3.1</td>
<td># HIV+ FSWs screened/managed for STI</td>
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<td></td>
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<td></td>
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<tr>
<td>3.2</td>
<td># HIV+ partners screened/managed for STI</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>4</td>
<td>TB Screening for HIV Positive</td>
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</tr>
<tr>
<td>4.1</td>
<td># of HIV+ FSWs screened for TB</td>
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<td></td>
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</tr>
<tr>
<td>4.2</td>
<td># of HIV+ FSWs completed IPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.3</td>
<td># of HIV+ FSWs diagnosed and treated for TB</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>4.4</td>
<td># of HIV+ partners screened for TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.5</td>
<td># of HIV+ partners completed IPT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.6</td>
<td># of HIV+ partners diagnosed/trated for TB</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>FP/condoms provisions</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td># of FSWs counseled for FPs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.2</td>
<td># of FSWs received condoms and lubricants</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.3</td>
<td># of FSWs received FP service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.4</td>
<td># of FSWs received FP service</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.5</td>
<td># of FSWs received pregnancy test</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6</td>
<td># of partners received condoms</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
APPENDIX E – Glossary Terms

APR – Annual Performance Report
ANC – Antenatal Care
AGYW – Adolescent Girls and Yong Women
ART – Anti-retroviral Therapy
BoLSA – Bureau of Labor and Social Affairs
CBS – Case Based Surveillance
CCCs – Community Care Coalitions
CDC – Center for Disease Control
CLHIV- Children Living with HIV
CPT- Co-trimoxazole preventive therapy
COP – Country Operational Planning
CODB – Cost of Doing Business
CQM- Continuous Quality Management
CSA – Ethiopian Statistics Agency
CSO – Civil Society Organization
DATIM – Data for Accountability, Transparency and Impact
DIC- Drop in Centers
DoD – Department of Defense
DHS- Demographic Health Survey
DSD- Direct Service Delivery
ECT – Epidemic Control Team
EID- Early Infant HIV Diagnosis
e-CHI – Electronic Community Health Information
EIMC- Early Infant Male Circumcision
EPHIA – Ethiopia Population HIV Impact Assessment
EPHI – Ethiopian Public Health Institutes
FBO – Faith Based Organizations
FHAPCO – Federal HIV/AIDS Prevention and Control Office
FMOH- Federal Ministry of Health
FSW – Female Sex Worker
GBV- Gender Based Violence
GDP – Gross Domestic Product
GF – Global Fund
GFATM TRP – Global Fund to Fight AIDS, Tuberculosis and Malaria- Technical Review Panel
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>GoE</td>
<td>Government of Ethiopia</td>
</tr>
<tr>
<td>HCW</td>
<td>Health Care Workers</td>
</tr>
<tr>
<td>HIVST</td>
<td>HIV Self-Test</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management</td>
</tr>
<tr>
<td>HRH</td>
<td>Human Resource for Health</td>
</tr>
<tr>
<td>HSS</td>
<td>Health System Strengthening</td>
</tr>
<tr>
<td>ICT</td>
<td>Index Case Testing</td>
</tr>
<tr>
<td>IPLS</td>
<td>Integrated Pharmaceuticals Logistics System</td>
</tr>
<tr>
<td>IM</td>
<td>Implementing Mechanism</td>
</tr>
<tr>
<td>KP</td>
<td>Key Population</td>
</tr>
<tr>
<td>LFTU</td>
<td>Lost to Follow-Up</td>
</tr>
<tr>
<td>LiPs</td>
<td>Local Implementing Partners</td>
</tr>
<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
</tr>
<tr>
<td>MOLSA</td>
<td>Ministry of Labor and Social Affairs</td>
</tr>
<tr>
<td>MSM</td>
<td>Men Having Sex with Men</td>
</tr>
<tr>
<td>NACS</td>
<td>Nutritional Assessment and Counseling Service</td>
</tr>
<tr>
<td>NASA</td>
<td>National AIDS Spending Assessment</td>
</tr>
<tr>
<td>NGOs</td>
<td>Non Governmental Organizations</td>
</tr>
<tr>
<td>NHA</td>
<td>National Health Account</td>
</tr>
<tr>
<td>OVC</td>
<td>Orphans and Vulnerable Children</td>
</tr>
<tr>
<td>PEPFAR</td>
<td>President’s Emergency Plan for AIDS Relief</td>
</tr>
<tr>
<td>PFSA</td>
<td>Pharmaceutical Fund and Supply Agency</td>
</tr>
<tr>
<td>PHEM</td>
<td>Public Health Emergency System</td>
</tr>
<tr>
<td>PICT</td>
<td>Provider Initiated HIV Counseling and Testing</td>
</tr>
<tr>
<td>PLHIV</td>
<td>People Living with HIV</td>
</tr>
<tr>
<td>POC</td>
<td>Point of Care</td>
</tr>
<tr>
<td>PP</td>
<td>Priority Population</td>
</tr>
<tr>
<td>PPP</td>
<td>Public Private Partnership</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention Mother to Child Transmission</td>
</tr>
<tr>
<td>PRM</td>
<td>Population Refugee and Migration (under U.S. Department of State)</td>
</tr>
<tr>
<td>PSNU</td>
<td>Priority Sub National Units</td>
</tr>
<tr>
<td>PWID</td>
<td>People who Inject Drugs</td>
</tr>
<tr>
<td>QI</td>
<td>Quality Improvement</td>
</tr>
<tr>
<td>RHBs</td>
<td>Regional Health Bureaus</td>
</tr>
<tr>
<td>RTKs</td>
<td>Rapid Test Kits</td>
</tr>
</tbody>
</table>
SDP – Service Delivery Point
SI – Strategic Information
SID- Sustainability and Index Dashboard
SIMS- Site Improvement Monitoring System
SNU – Sub-National Units
STDs- Sexually Transmitted Diseases
TA – Technical Assistance
TB- Tuberculosis
TLE - Tenofovir-Efavirenz-Dolutegavir
TLD - Tenofovir-Lamivudine-Dolutegavir
TWGs – Technical Working Groups
TVET – Technical Vocational Education and Training
UNAIDS – United Nation Joint AIDS Program
UNFPA – United Nation Population Fund
UNHCR – United Nation for Higher Commission for Refugees
USAID – United States Agency for International Development
USG – United State Government
VL- Viral Load
VMMC – Voluntary Medical Male Circumcision
WHO- World Health Organizations
Table 6 Attachment
<table>
<thead>
<tr>
<th>Funding Agency</th>
<th>Implementing Mechanism Name</th>
<th>Prime Partner</th>
<th>Mechanism ID</th>
<th>Program Area</th>
<th>COP17 Strategic Objective</th>
<th>COP18 Strategic Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 HHS/CDC</td>
<td>Peer-to-Peer Capacity Building of Ministries of Health in Public Sector HIV Program Management</td>
<td>National Alliance of State and Territorial AIDS Directors</td>
<td>10559</td>
<td>C&amp;T</td>
<td>Support the implementation of evidence-based interventions including PNS to improve case detection and linkage to ART.</td>
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<tr>
<td>2 HHS/CDC</td>
<td>Peer-to-Peer Capacity Building of Ministries of Health in Public Sector HIV Program Management</td>
<td>National Alliance of State and Territorial AIDS Directors</td>
<td>10559</td>
<td>C&amp;T</td>
<td>Support the implementation of evidence-based interventions including PNS to improve case detection and linkage to ART.</td>
<td>Support deployment of 1-to-1 peer counseling monitor for improved facility-community adherence (Same-day ART, adherence and retention)</td>
</tr>
<tr>
<td>3 HHS/HRSA</td>
<td>Twinning Initiative</td>
<td>American International Health Alliance Twinning Center</td>
<td>10599</td>
<td>HSS</td>
<td>Unallocated</td>
<td>Strengthen laboratory equipment maintenance to reduce equipment down time for viral load machines from the current level by 80% by end of FY19</td>
</tr>
<tr>
<td>4 HHS/CDC</td>
<td>Oromia Regional Health Bureau HIV/AIDS program</td>
<td>Oromia Health Bureau, Ethiopia</td>
<td>13794</td>
<td>HSS</td>
<td>To improve the laboratory service provision and SI for quality and optimal implementation of program activities</td>
<td>To strengthen quality HIV diagnostic (including EID) and VL testing services for improved case detection and viral load suppression, and reinforce the quality and use of data for epidemic control (HIV case-based surveillance, recency testing, active case detection)</td>
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<td>6 HHS/CDC</td>
<td>Strengthening local ownership for sustainable provision of HIV/AIDS services</td>
<td>Addis Ababa Health Bureau</td>
<td>13994</td>
<td>HSS</td>
<td>To improve the laboratory service provision and SI for quality and optimal implementation of program activities</td>
<td>To strengthen quality HIV diagnostic (including EID) and VL testing services for improved case detection and viral load suppression, and reinforce the quality and use of data for epidemic control (HIV case-based surveillance, recency testing, active case detection)</td>
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<td>8 State/AF</td>
<td>Infrastructure development for health systems strengthening</td>
<td>Regional Procurement Support Office/Frankfurt</td>
<td>14267</td>
<td>HSS</td>
<td>Construction and renovation of Laboratory and OPD to improve qualified diagnostic and clinical services</td>
<td>Improve health services infrastructure through construction/renovation of outpatient comprehensive HIV service clinics and regional labs to enhance the quality of diagnosis</td>
</tr>
<tr>
<td>9 HHS/CDC</td>
<td>Strengthening local ownership for sustainable provision of HIV/AIDS services</td>
<td>UNNPR</td>
<td>16001</td>
<td>HSS</td>
<td>To improve the laboratory service provision and SI for quality and optimal implementation of program activities</td>
<td>To strengthen quality HIV diagnostic (including EID) and VL testing services for improved case detection and viral load suppression, and reinforce the quality and use of data for epidemic control (HIV case-based surveillance, recency testing, active case detection)</td>
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<tr>
<td>2 Technical area guidelines and tools</td>
<td>To enhance the national system and strategies for notification of partners of newly diagnosed with HIV through implementation of partner notification services (PNS), and integrating HIV self-testing &amp; recency testing into PNS guidelines and training curriculums. Collaborate with MOH and RHs in identifying unidentified people living with HIV and facilitating their access to HIV services in high-load health facilities</td>
<td>Insufficient innovative methods to identify HIV-positives, HIV Transmission networks,</td>
<td>NA</td>
<td>N/A</td>
<td>National guidelines and healthcare worker training curriculum that integrates HIV self-testing and recency testing to partner services developed. Improved uptake of HIV testing among partners of PLHIV. Improved identification of HIV-infected persons among index partners, increased linkage to care through referral of newly identified HIV-infected partners to ART services.</td>
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</tr>
<tr>
<td>2 Technical area guidelines and tools</td>
<td>NASDA will work in collaboration with RHs and health facilities to ensure optimum adherence to antiretroviral therapy. To this end, peer counselors based at facilities will help ensure patients' adherence to treatment by creating confidence in treatment, dispel myths about illness and ART, and share experience as a peer PCHV. These peer counselors will be trained to act as role models, raising awareness to improve adherence to treatment.</td>
<td>Lack of innovative, streamlined, patient-centered ART services</td>
<td>NA</td>
<td>N/A</td>
<td>Improved adherence and retention in treatment</td>
<td></td>
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<tr>
<td>3 Laboratory quality improvement and accreditation</td>
<td>APM will collaborate with viral load equipment manufacturers and local agents to strengthen the equipment maintenance practices and train laboratory personnel and local engineers on preventive equipment maintenance and equipment handling. To enable viral load testing, APM will also focus on maintenance training and mentorship on ancillary equipment like freezers, AC and biosafety cabinets, pipettes and other equipment directly linked to viral load testing.</td>
<td>Frequent lab machine breakdown (VL)</td>
<td>Human Resources for Health</td>
<td>2.95</td>
<td>Laboratory personnel and local engineers will be trained in all 18 viral load testing laboratories. Maintenance capacity established for ancillary laboratory equipment directly linked to viral load testing and equipment downtime reduced from the baseline to 80%. Laboratories function with no interruption of services to achieve viral load testing coverage of 90% by end of FY19.</td>
<td></td>
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<td>4 Laboratory quality improvement and accreditation</td>
<td>Implement laboratory CAI activities in PSNU conducting VL/EID, HIV recency, HIVST and core tests with EQA, supportive supervision, mentorship and need based trainings such as LQMS, SLMTA. Provision of uninterrupted VL/EID, CD4 and TB diagnostics service with monitoring and updating of specimen referral networks. Lab equipment maintenance, including ancillaries, back-up power, air conditioning, and negative pressure system. Maintain LIS and strengthen data management capacity for core HIV tests</td>
<td>Inadequate access to high quality HIV laboratory services, exp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Uninterrupted service of VL, EID and core HIV tests service with established backup system. 90% of PUVH on ART for six months and beyond will have routine viral load monitoring. VL/EID testing facilities applied for ISO accreditation, hospital laboratories in supported PSNU enrolled in SLIPTA scheme, and health center laboratories participate in LQMS. 90% of supported laboratories enrolled in EQA and score acceptable result.</td>
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<td>5 Surveys and surveillance</td>
<td>Conduct HIV case and incidence surveillance in collaboration with EPH and ICAP. Ensures implementation is integrated in the health system and provides continuous technical support in ensuring availability of necessary tools, SOPs at HFs. Creates a regional data repository system with high-level data confidentiality and security. Provides quality assurance procedures for HIV recency assay at implementing facilities and use incidence results to guide case-finding and linkage to treatment</td>
<td>Insufficient, reliable, subnational and local HIV epi data</td>
<td>Epidemiological and Health Data</td>
<td>4.9</td>
<td>Describe the HIV epidemic in terms of people, place and time, and detect outbreaks or clusters of infection in the Region from a uniquely identifiable patient level data. Recent HIV infections among newly diagnosed PLHIV identified through HIV-case based surveillance and routine HTs service and used for targeted prevention and interrupt chain of transmission through partner notification service</td>
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<td>Insufficient, reliable, subnational and local HIV epi data</td>
<td>Epidemiological and Health Data</td>
<td>4.9</td>
<td>Describe the HIV epidemic in terms of people, place and time, and detect outbreaks or clusters of infection in the Addis Ababa municipality from a uniquely identifiable patient level data. Recent HIV infections among newly diagnosed PLHIV identified through HIV-case based surveillance and routine HTs service and used for targeted prevention and interrupt chain of transmission through partner notification service</td>
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<td>8 Construction and renovation</td>
<td>CDC, Ethiopia’s renovation and construction projects have been prioritized to improve sites that are outdated or simply lack the space to serve their current volume of clients seeking HIV clinical and laboratory services.</td>
<td>Weak infrastructure to deliver comprehensive HIV clinical and lab services and lack of safety protection.</td>
<td>NA</td>
<td>N/A</td>
<td>Improved access &amp; quality HIV clinical and lab services; Create a safe and conducive environment</td>
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<td>9 Laboratory quality improvement and accreditation</td>
<td>Implement laboratory CAI activities in PSNU conducting VL/EID, HIV recency, HIVST and core tests with EQA, supportive supervision, mentorship and need based trainings such as LQMS, SLMTA. Provision of uninterrupted VL/EID, CD4 and TB diagnostics service with monitoring and updating of specimen referral networks. Lab equipment maintenance, including ancillaries, back-up power, air conditioning, and negative pressure system. Maintain LIS and strengthen data management capacity for core HIV tests</td>
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<tr>
<td>1. 2 years</td>
<td>Partner performance report on PNS</td>
<td>COP18 baseline data</td>
<td>Partner services endorsed and implemented in scale up SNUs by 5 RHBs</td>
<td>FOR REFERENCE ONLY. THESE COLUMNS WILL BE COMPLETED FOR MONITORING AT FY19 PART CALLS</td>
<td></td>
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<tr>
<td>2. 2 years</td>
<td>Partner performance report on adherence and retention support</td>
<td>COP18 baseline data</td>
<td>90% of stable ART patients receive streamlined ART services</td>
<td></td>
<td></td>
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<tr>
<td>3. 2 years</td>
<td>Partner progress report</td>
<td>COP18 baseline data</td>
<td>Reduce viral load service interruption due to machine failure by 50%</td>
<td></td>
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<tr>
<td>4. 2 years</td>
<td>MER indicator</td>
<td>FY18Q1 data indicated 21.5% national VL coverage</td>
<td>90% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
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<td>5. 2 years</td>
<td>HIV case reports</td>
<td>HIV case report system established to avail data from facilities in 20 towns at least in paper base flow to a central data repository and used for program decision making</td>
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<tr>
<td>8. 3 years</td>
<td>Renovation/construction report</td>
<td>Reached 60% of completion of construction</td>
<td>Reach 75% completion of all construction by the end of COP 18</td>
<td></td>
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<td>MER indicator</td>
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<tr>
<td>HHS/CDC</td>
<td>Strengthening local ownership for sustainable provision of HIV/AIDS services</td>
<td>SNPR</td>
<td>16301</td>
<td>HSS 0</td>
<td>To strengthen quality HIV diagnostic (including EID) and VL testing services for improved case detection and viral load suppression, and reinforce the quality and use of data for epidemic control (HIV case-based surveillance, recency testing, active case detection)</td>
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<tr>
<td>HHS/CDC</td>
<td>Technical Assistance to National Health Information Systems and Health Workforce Development</td>
<td>TBD</td>
<td>18341</td>
<td>C&amp;T 0</td>
<td>Improve the linkage, continuous tracking and retention of HIV positives patients through defining a minimum data set across the clinical cascade and deploying tools and approaches for collecting, using and reporting on this minimum data set (HIV Case Based surveillance TA, quality management, HIV Surveillance and recency testing, VL suppression and Same day ART initiation;)</td>
<td></td>
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<td>HHS/CDC</td>
<td>Technical Assistance to National Health Information Systems and Health Workforce Development</td>
<td>TBD</td>
<td>18341</td>
<td>HSS TA to the national program to strengthen quality and use of site-level information through electronic medical records, data quality improvement, visualization platforms and lab information systems Monitor performance and quality of core epidemic control indicators and support HIV surveillance and response, including field investigations, from national and regional public health institutes</td>
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<tr>
<td>State/AF</td>
<td>Strengthening PEPFAR Visibility</td>
<td>U.S. Department of State</td>
<td>112033</td>
<td>C&amp;T 0</td>
<td>Improve access to care and treatment services through the identification of barriers at local health facilities. Address faith related misconceptions related to seeking care and treatment services.</td>
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<tr>
<td>HHS/CDC</td>
<td>&lt;Placeholder - 70075 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>72075</td>
<td>C&amp;T 0</td>
<td>To support quality laboratory services</td>
<td></td>
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<tr>
<td>HHS/CDC</td>
<td>&lt;Placeholder - 70076 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>72076</td>
<td>HSS 0</td>
<td>Strengthen quality lab services to improve HIV detection, treatment and suppression capacities</td>
<td></td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>&lt;Placeholder - 70078 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>72078</td>
<td>C&amp;T 0</td>
<td>Support policy revision and guideline adaptation to address key policy level bottlenecks and facilitate timely implementation of globally recommended HIV prevention and control strategies (public health response)</td>
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<td>10</td>
<td>Surveys and surveillance</td>
<td>Conduct HIV case and incidence surveillance in collaboration with EPH and IAP. Ensures implementation is integrated in the health system and provides continuous technical support in ensuring availability of necessary tools, SOPs at HFs. Creates a regional data repository system with high-level data confidentiality and security. Provides quality assurance procedures for HIV recency assay at implementing facilities and use incidence results to guide case-finding and linkage to treatment</td>
<td>Insufficient, reliable, substandard and local HIV_epi_data</td>
<td>Epidemiological and Health Data</td>
<td>4.9</td>
<td>Describe the HIV epidemic in terms of people, place and time, and detect outbreaks or clusters of infection in the Region from a uniquely identifiable patient level data. Recent HIV infections among newly diagnosed PLHIV identified through HIV case-based surveillance and routine HTS service and used for targeted prevention and interrupt chain of transmission through partner notification service</td>
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<td>Information systems</td>
<td>Reinforce patient level health information systems for monitoring case detection, linkage to ART, retention in care and viral suppression, and to serve as the foundation for case surveillance. Facilitate ART data sharing within, and between facilities and regional laboratories through health information exchange. Focus on COP2018 attained regions (Oromia, Amhara, SNNP, and Addis Ababa), as well as tailored support to high case load facilities within COP2017 attained regions (Tigray, Harar, and Dire Dawa)</td>
<td>Weak quality of patient level data</td>
<td>Performance Data</td>
<td>5.07</td>
<td>Improved linkage of HIV+ patients to care, 12-months retention form 85% to 92%, VL turn-around-time reduced to &lt;3hws through record matching/case de-duplication. Data quality and data use will all be strengthened. Establishes a patient centered data exchange platform and building blocks for case-based surveillance toward routine reports and dissemination of public health events like new infection, unsuppressed viral load for program M&amp;E, disease surveillance and public health action.</td>
</tr>
<tr>
<td>12</td>
<td>Information systems</td>
<td>Strengthen public health response by aggressively monitoring incident cases, and unsuppressed cases already initiated on ART, in coordination with laboratory recency testing and HTS_Pois results from facilities to initiate aggressive case contact tracing and viral suppression interventions. This will involve real-time monitoring out of functional HHM command posts and field investigations of incident cases mounted by trained field epidemiologists.</td>
<td>Weak quality of patient level data</td>
<td>Performance Data</td>
<td>5.07</td>
<td>Enhanced systems for incident case finding and linkage of new HIV+ patients to treatment, thereby enhancing patient level and population-level viral load suppression. Public health response to HIV reinforced within Ethiopian health system and field investigation capabilities reinforced.</td>
</tr>
<tr>
<td>13</td>
<td>IEC and/or demand creation</td>
<td>HIV messaging on religious media channels to address issues relating to stigma and to reach PLHIV who either do not know their status or are noncompliant with treatment</td>
<td>Decreasing engagement of religious institutions in HIV prevention and retention activities.</td>
<td>NA</td>
<td>Increased awareness of ART adherence issues by religious media users and religious leaders themselves combined with their active engagement supporting continued use of ARTs in faith based teachings.</td>
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<tr>
<td>14</td>
<td>Laboratory quality improvement and accreditation</td>
<td>To provide site level technical support to the emerging regions in the implementation of continuous laboratory quality improvement in VL, EID and HIV testing. This activity will improve laboratory work flow efficiency, timely result reporting, routine VL testing coverage and ensures the quality of testing results</td>
<td>Inadequate access to high quality HIV laboratory services, esp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Laboratory efficiency maximized. Optimum and uninterrupted VL and EID testing in all testing facilities, improved the quality of laboratory services, enhanced routine VL testing coverage and suppression rate.</td>
</tr>
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<td>15</td>
<td>Laboratory quality improvement and accreditation</td>
<td>Implement laboratory CQI activities in PSNU conducting VL/EID, HIV recency, HIVST and core tests with EQA, supportive supervision, mentorship and need based trainings such as IQM5, SLMTA. Provision of uninterrupted VL/EID, CO2 and TB diagnostics service with monitoring and updating of specimen referral networks. Lab equipment maintenance, including ancillaries, back-up power, air conditioning, and negative pressure system. Maintain LIS and strengthen data management capacity for core HIV tests</td>
<td>Inadequate access to high quality HIV laboratory services, esp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Optimum VL &amp; EID testing, HIV testing facilities in priority sites enrolled in EQA &amp; 90% score acceptable results; all labs participate in IQM5; high load facility labs &amp; all RAs participate in SLIPTA; 60% of labs enrolled for accreditation</td>
</tr>
<tr>
<td>16</td>
<td>Host country institutional development</td>
<td>WHO will provide TA support to FMoH HIV and TB/HIV programs to improve implementation and monitoring capacity and facilitate timely adaptation and implementation of globally recommended approaches and strategies including KP, HIV self-testing, Partner service, PEP, DSDM, new drug introduction and others. WHO will also support the FMoH in their engagement with the RBs related to their roles in line with COP18 vision direction to ensure sustainability of epidemic control.</td>
<td>Slow progress in policy adaptation and implementation of globally recommended new strategies and approaches</td>
<td>NA</td>
<td>Improved program management capacity, mid-term program review conducted; HIV and TB/HIV strategic plans revised incorporating the new approaches leading to successful transition of activities for epidemic control sustainability.</td>
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<tr>
<td>10</td>
<td>2 years</td>
<td>HIV case reports</td>
<td>HIV case reporting system established to allow data from facilities in 20 towns at least in paper base flow to a central data repository and used for program decision making</td>
<td></td>
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<tr>
<td>11</td>
<td>3 years</td>
<td>Progress reports</td>
<td>Current patients on care and treatment and to be updated progressively</td>
<td>Functional patient level information system with capacity to capture HIV care continuum indicators</td>
<td></td>
<td></td>
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<tr>
<td>12</td>
<td>3 years</td>
<td>Progress reports</td>
<td>Current patients on care and treatment and to be updated progressively</td>
<td>• PMCHI supported the eHMIS transition to DHIS2 • HIV/AIDS related patient level information systems made interoperable with DHIS2</td>
<td></td>
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<tr>
<td>13</td>
<td>1 year</td>
<td># of RL participating in HIV adherence related messaging</td>
<td>USG/UNAIDS Joint Community Consultation (February 2018)</td>
<td>Religious leaders from the 3 major religious institutions aired message on HIV treatment and adherence to their PLHIV associations participated in service quality issues identification and improvement in 15 health facilities</td>
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<td>14</td>
<td>2 years</td>
<td>MER indicator</td>
<td>FY1RQ1 data indicated 21.5% national VL coverage</td>
<td>90% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
<td></td>
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<tr>
<td>15</td>
<td>2 years</td>
<td>MER indicator</td>
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<td>90% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
<td></td>
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<tr>
<td>16</td>
<td>3 years</td>
<td>Partner progress report</td>
<td>New innovative approaches such as PNS, DSDM and other emerging recommendation fully adapted</td>
<td></td>
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<tr>
<td>Funding Agency</td>
<td>Implementing Mechanism Name</td>
<td>Prime Partner</td>
<td>Mechanism ID</td>
<td>Program Area</td>
<td>COP17 Strategic Objective</td>
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<tr>
<td>17 HHS/CDC</td>
<td>&lt;Placeholder - 70078 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70078</td>
<td>C&amp;T</td>
<td>0</td>
<td>Support policy revision and guideline adaptation to address key policy level bottlenecks and facilitate timely implementation of globally recommended HIV prevention and control strategies (public health response)</td>
</tr>
<tr>
<td>18 HHS/CDC</td>
<td>&lt;Placeholder - 70079 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70079</td>
<td>HSS</td>
<td>0</td>
<td>To provide technical support for implementation of continuous laboratory quality improvement, accreditation of viral load and EID laboratories, support HIV recency testing and strengthen quality of HIV rapid testing</td>
</tr>
<tr>
<td>19 HHS/CDC</td>
<td>&lt;Placeholder - 70080 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70080</td>
<td>PREV</td>
<td>0</td>
<td>Strengthen Public Health Response to maintain epidemic control – coordination, policy, guidelines, performance reviews, and strategic direction</td>
</tr>
<tr>
<td>20 HHS/CDC</td>
<td>&lt;Placeholder - 70080 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70080</td>
<td>PREV</td>
<td>0</td>
<td>Strengthen Public Health Response to maintain epidemic control – coordination, policy, guidelines, performance reviews, and strategic direction</td>
</tr>
<tr>
<td>21 HHS/CDC</td>
<td>&lt;Placeholder - 70081 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70081</td>
<td>HSS</td>
<td>0</td>
<td>Strengthen specimen referral network to provide quality viral load testing services for 90% of eligible PLHIV receiving antiretroviral treatment and increase access to quality EID and MDR TB diagnosis by the end of FY19</td>
</tr>
<tr>
<td>22 HHS/CDC</td>
<td>&lt;Placeholder - 70081 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
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<td>C&amp;T</td>
<td>0</td>
<td>Strengthen specimen referral network to provide quality viral load testing services for 90% of eligible PLHIV receiving antiretroviral treatment and increase access to quality EID and MDR TB diagnosis by the end of FY19</td>
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<tr>
<td>23 HHS/CDC</td>
<td>&lt;Placeholder - 70081 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70081</td>
<td>HSS</td>
<td>0</td>
<td>Lead and coordinate the design, development and implementation of national HIV/AIDS survey and surveillance programs to generate, utilize and disseminate surveillance data for informed decision (HIV surveillance, CBS, recency testing, public health response)</td>
</tr>
<tr>
<td>Approach</td>
<td>COP18 Activity (above-site, above-service delivery)</td>
<td>Key Systems Barrier</td>
<td>Related SID 3.0 Element</td>
<td>SID 3.0 Element Score</td>
<td>Expected Outcome</td>
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<tr>
<td>27</td>
<td>Technical area guidelines and tools</td>
<td>WHO will provide TA and guidance, organize consultative meetings, lead and coordinate TWG to revise HIV and TB/HIV guidelines, diagnostic algorithms, in-service training manuals, SOPs and job aids incorporating new updates and new approaches; assist in national TB/HIV TOTs. Provide TA for revision of TB/HIV recording and reporting tools to capture key program indicators</td>
<td>Slow progress in policy adaptation of globally recommended new strategies and approaches</td>
<td>NA</td>
<td>National guidelines, training manuals, diagnostic algorithms updated in a timely manner; national TOTs conducted using updated manuals. M&amp;E tools updated to meet the program need.</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Laboratory quality improvement and accreditation</td>
<td>ASLM will support preparation of viral load and EID labs for international accreditation. Provide training on laboratory standards, mentor and conduct assessment and provide laboratory auditor, method validation and verification training. ASLM will support regulatory body to have systems for lot verification and post market surveillance for HIV rapid test kits. It will provide technical assistance for EPHI on the implementation of point of care testing for EID and HIV recency testing.</td>
<td>Inadequate access to high quality HIV laboratory services, esp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Mentornship and external audit will be done for 10 viral load and EID labs; it will achieve full or limited scope accreditation. Twenty-two individuals will be trained on laboratory auditing and 30 laboratory personnel will receive training on method validation and verification. System for HIV recency testing and lot verification and post market surveillance will be deployed. Point of care testing implementation will be supported</td>
</tr>
<tr>
<td>29</td>
<td>Policy and governance</td>
<td>Strengthen the national and regional HIV/AIDS coordination activities and alignment of PEPFAR and GFATM assistance by holding a strategic review after the EPHIA. Strengthen the engagement of regional and city administration health boards and Civil Society Organizations (CSOs) and PLHIV associations in program planning, implementation and in performance review. Advocate for stigma reduction and promotion of partner disclosure.</td>
<td>Inadequate partnerships and coordination at the national and regional level; Persisting stigma regarding HIV infection inhibiting testing, disclosing, and 100% linkage to services</td>
<td>Policies and Governance</td>
<td>8.08</td>
<td>Health year country programs including partner coordination framework to respond to priority geographies and populations. Improved Partnerships and Coordination of HIV-engaged Organizations. 50% reduction in the HIV Stigma Index over 3 yrs.</td>
</tr>
<tr>
<td>20</td>
<td>Technical area guidelines and tools</td>
<td>Update guidelines and training materials, job aids, etc. on service delivery for key &amp; priority populations with introduction of new &amp; innovative approaches such as partner services to improve HIV case detection. Finalize repeat testers’ assessment. Adapt evidence-based SOPs and guidelines on stigma reduction. Conduct annual prevention summit where local data are analyzed &amp; best practices are shared. Stigma reduction &amp; partner disclosure are the key activities that will facilitate HTS uptake</td>
<td>Lack of updated guidelines and tools for KP services and stigma reduction</td>
<td>NA</td>
<td>Enhanced capacity in coordination &amp; M&amp;E; Improved quality of HIV prevention services for MARPs and vulnerable population groups. Strengthen annual HIV prevention data summit. Lessons learned from various level platforms will be shared among prevention stakeholders. Guidelines and tools updated, disseminated and implemented</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Laboratory quality improvement and accreditation</td>
<td>EPHI will provide national leadership and coordination support for the implementation of continuous laboratory quality improvement in priority sites and international accreditation of viral load labs. It will implement quality assurance tools for HIV rapid test and enroll more labs in external quality assessment for TB, viral load and EID and implement the WHO viral load scorecard. It will provide national leadership and coordination for HIV self and recency testing.</td>
<td>Inadequate access to high quality HIV laboratory services, esp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Viral load and EID testing labs will implement quality assurance to provide quality services. Labs in priority sites will implement continuous laboratory quality improvement and 8 labs will achieve international accreditation. Regions will expand EQA on HIV rapid testing to 50% of sites and 80% achieve acceptable performance. Ninety percent of all viral load-testing results delivered within defined turnaround time. System is in place for quality HIV recency testing and HIV self-testing.</td>
</tr>
<tr>
<td>22</td>
<td>Laboratory sample referral/transportation systems</td>
<td>EPHI will provide national leadership on the implementation of specimen transportation for provision of quality viral load, EID and TB diagnostic services. EPHI will monitor performance of Postal Services in transporting specimen and results. EPHI will provide training on specimen collection, packaging, safety and transportation. EPHI will procure standard specimen transportation containers. EPHI will support capacity development at testing labs for viral load, EID and MDR TB diagnostics.</td>
<td>Inadequate access to high quality HIV laboratory services, esp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>All PEPFAR priority sites are reached through specimen referral network, 200 laboratory personnel and 120 postal workers will be trained, 300 standard specimen transportation containers will be procured and distributed to sites, Viral load testing coverage will increase from the current status to 90%, turnaround time for the viral load result delivery decreased by 50% from baseline. 65% of ART sites having access to quality VL, EID, CD4, GeneXpert, TB culture and DST test onsite or through sample referral network</td>
</tr>
<tr>
<td>23</td>
<td>Surveys and surveillance</td>
<td>EPHI will lead strategy, policy and protocol development for the implementation of Case surveillance system, HIV recency testing and the bio-behavioural key population survey, as well as the lab quality assurance relevant to all three endeavors. EPHI will coordinate the participation of Regional Health Bureaus, participating health facilities, and other relevant stakeholders to ensure seamless implementation, monitoring and evaluation, and continuous quality improvement of surveillance.</td>
<td>Insufficient, reliable, subnational and local HIV epidemiological data</td>
<td>Epidemiological and Health Data</td>
<td>4.9</td>
<td>Avail surveillance data from uniquely identifiable patients and determining from where, and which population groups are new HIV infections coming from to inform targeted prevention and treatment strategy; estimate the HIV(1)/HIV(2) prevalence, incidence and size of key population in major urban settings and determine the level of the three 90s among key pop groups.</td>
</tr>
<tr>
<td>Expected Timeline for Achievement of Outcome (1, 2, or 3 years)</td>
<td>Relevant Indicator or Measurement Tool</td>
<td>COP18 Baseline Data</td>
<td>Year One (COP18) Annual Benchmark (Planned)</td>
<td>FY19 Q2 Results</td>
<td>FY19 Q4 Results</td>
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<tr>
<td>17 3 years</td>
<td>Partners progress report</td>
<td>Existing strategic plan</td>
<td>Strategic plan review and consultative meetings</td>
<td></td>
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<tr>
<td>18 3 years</td>
<td>MER indicator</td>
<td>FYQ1 data indicated 21.5% coverage</td>
<td>75% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
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<tr>
<td>19 3 years</td>
<td>Partner Progress report</td>
<td>Achieve coordination at national, subnational and 20 towns for implementation of HIV programs increased engagement of CSOs and PLHIV associations improved stakeholder engagement in stigma reduction intervention</td>
<td></td>
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<tr>
<td>20 3 years</td>
<td>Partner Progress report</td>
<td>Annual HIV prevention data summit revision of HIV package of services for KP &amp; PP Stigma reduction strategy guideline is developed/Adapted</td>
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<tr>
<td>21 3 years</td>
<td>MER indicator</td>
<td>FYQ1 data indicated 21.5% coverage</td>
<td>75% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
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<tr>
<td>22 3 years</td>
<td>MER indicator</td>
<td>FYQ1 data indicated 21.5% coverage</td>
<td>Integrated specimen referral network strengthened with 80% of all PEPFAR supported sites included in the network 80% of results from referral testing will reach facilities in acceptable TAT</td>
<td></td>
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<tr>
<td>23 2 years</td>
<td>Partners progress report</td>
<td>HIV case reporting system established HIV biobehavioural indicators and status of three 90s estimated among key population groups and used to inform PEPFAR programs</td>
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<tr>
<td>HHS/CDC</td>
<td>&lt;Placeholder - 70077 Ethiopia HHS/CDC&gt;</td>
<td>&lt;Placeholder&gt;</td>
<td>70077</td>
<td>HSS</td>
<td>0</td>
<td>To strengthen quality HIV diagnostic (including EID) and VL testing services for improved case detection and viral load suppression, and reinforce the quality and use of data for epidemic control HIV case-based surveillance, recency testing, active case</td>
</tr>
<tr>
<td>HHS/CDC</td>
<td>&lt;Placeholder - 70077 Ethiopia HHS/CDC&gt;</td>
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<tr>
<td>USAID</td>
<td>Household Economic Strengthening</td>
<td>PHI 360</td>
<td>16990</td>
<td>OVC</td>
<td>(1) Develop implementation manuals for the National Economic strengthening guidelines as well as translate the guidelines into local languages; (2) Increase the technical capacity of local IPs Standardize and operationalize the economic strengthening approach and interventions through roll-out of the National Economic Strengthening Guidelines and development of ES Implementation Manuals. Support for improved information management systems and data utilization by MOLSA, BOLSA &amp; CCC to improve information management systems and data utilization for improved comprehensive case management.</td>
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<tr>
<td>USAID</td>
<td>Capacity Building of Local Organizations</td>
<td>Ethiopian Society of Sociologists, Social Workers and Anthropologists</td>
<td>17271</td>
<td>OVC</td>
<td>Support the workforce development/the training of parasocial workers providing social services to OVC &amp; caregivers</td>
<td>Increase case-finding, linkage, adherence, and retention to achieve viral load suppression for OVC, their caregivers, and AGYW by supporting the training of para social workers to expand high quality services through comprehensive case management.</td>
</tr>
<tr>
<td>USAID</td>
<td>Capacity Building of Local Organizations</td>
<td>Ethiopian Society of Sociologists, Social Workers and Anthropologists</td>
<td>17271</td>
<td>OVC</td>
<td>Increase viral load suppression through sample transport and results tracking from community service delivery points to viral load testing sites.</td>
<td></td>
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<tr>
<td>USAID</td>
<td>USAID Prevention Follow On</td>
<td>PSI</td>
<td>18519</td>
<td>C&amp;T</td>
<td>0</td>
<td>Facilitate blood safety in Ethiopia via construction of national blood transfusion center</td>
</tr>
<tr>
<td>USAID</td>
<td>Ethiopia Health Infrastructure Program</td>
<td>Universal Construction</td>
<td>17856</td>
<td>HSS</td>
<td>0</td>
<td>Strengthen enabling environments to improve supply chain performance, innovations and research conducted, shared, and implemented, sustainability</td>
</tr>
<tr>
<td>USAID</td>
<td>Global Health Supply Chain Program</td>
<td>Global Health Supply Chain Program</td>
<td>18375</td>
<td>HSS</td>
<td>0</td>
<td></td>
</tr>
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<td>Approach</td>
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<tr>
<td>24</td>
<td>Laboratory quality improvement and accreditation</td>
<td>Inadequate access to high quality HIV laboratory services, exp. VL and EID</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Uninterrupted service of VL, EID and care HIV tests service with established backup system. 96% of PUVI on ART for six months and beyond will have routine viral load monitoring. VL/EID testing facilities applied for ISO accreditation, hospital laboratories in supported PSNU enrolled in SLIPTA scheme, and health center laboratories participate in EOMS. 90% of supported laboratories enrolled in EQA and score acceptable result.</td>
<td></td>
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<tr>
<td>25</td>
<td>Surveys and surveillance</td>
<td>Insufficient, reliable, subnational and local HIV_epi_data</td>
<td>Epidemiological and Health Data</td>
<td>4.9</td>
<td>Describe the HIV epidemic in terms of people, Place and time, and detect outbreaks or clusters of infection in the Region from a uniquely identifiable patient level data. Recent HIV infections among newly diagnosed PLHIV identified through HIV-case based surveillance and routine HTS service and used for targeted prevention and interrupt chain of transmission through partner notification service</td>
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<tr>
<td>26</td>
<td>Technical area guidelines and tools</td>
<td>Lack of standardization of approaches and tools</td>
<td>Policy and Governance</td>
<td>6.58</td>
<td>ES tools refined and standardized with participation of GO and IPs, harmonized ES activities for better outcomes. GO and local partners design, implement, monitor, and evaluate their ES interventions in ways that permit comparisons and promote collaborative learning, as well as identify and scale up cost-effective and sustainable practices.</td>
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</tr>
<tr>
<td>27</td>
<td>Information systems</td>
<td>Absence of web based, functional and comprehensive workforce database for the social service sector</td>
<td>Quality management</td>
<td>6.67</td>
<td>Evidence informed decision on social service workforce development (selection, training, deployment, and status tracking). Improved information management and data utilization by MOLSA, BiLSA, and CCs</td>
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<tr>
<td>28</td>
<td>Workforce development, pre-service training</td>
<td>Suboptimal workforce development opportunities for social service</td>
<td>Technical efficiency</td>
<td>5.56</td>
<td>Improved coordination of care for non-biomedical/sustainable quality social services and reduced vulnerability among OVC and their families;</td>
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<td>Increased number of OVC and their caregivers, including AGYW, referred for testing and started on treatment through a strengthened bi-directional linkage in between the community and facilities;</td>
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<td></td>
<td>Increased number of HIV positive OVC and their caregivers who regularly receive adherence support and follow up for VL suppression;</td>
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<td></td>
<td>Increased resiliency of OVC and their caregivers by providing quality, comprehensive OVC services through a family and community - centered care and support approach</td>
<td></td>
</tr>
<tr>
<td>29</td>
<td>Laboratory sample referral/ transportation systems</td>
<td>Sub-optimal transportation and laboratory networking for viral load service. DCs are not linked to the national sample transport system, yet.</td>
<td>Laboratory</td>
<td>7.08</td>
<td>Increase number of FSWs receiving their viral load test results timely and constantly to ensure their adherence to treatment and viral load suppression</td>
<td></td>
</tr>
<tr>
<td>30</td>
<td>Construction and renovation</td>
<td>No dedicated facility for collection, storage and processing of blood and blood products</td>
<td>NA</td>
<td>6.88</td>
<td>A fully functioning National Blood Transfusion Service Center that supports a nationally coordinated blood safety program to provide safe and adequate blood and blood products for transfusion.</td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>Host country institutional development</td>
<td>Lack of trained supply chain professionals. Regulatory proclamation and policy are not aligned to meet the requirements of pharmaceutical procurements. Poor infrastructure (facilities, roads, power)</td>
<td>Commodity security and supply chain</td>
<td>6.88</td>
<td>Availability of high quality ARVs improve adherence and treatment outcomes. SDP wastage rates are reduced reducing cost to the HIV program. Data quality is increased allowing more informed decision making.</td>
<td></td>
</tr>
<tr>
<td>Expected Timeline for Achievement of Outcome (1, 2, or 3 years)</td>
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<tr>
<td>24</td>
<td>2 years</td>
<td>MER indicator</td>
<td>FY1LQ1 data indicated 21.5% national VL coverage</td>
<td>50% PLHIV on ART for minimum of six months have at least one viral load result per year</td>
<td></td>
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<tr>
<td>25</td>
<td>2 yrs</td>
<td>HIV case reports</td>
<td>HIV case reporting system established to avail data from facilities in 20 towns at least in paper base flow to a central data repository and used for program decision making</td>
<td></td>
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</tr>
<tr>
<td>26</td>
<td>1 year</td>
<td>Number of refined and standardized ES tools and used by local IPs and GOE. Number of ES Implementation Manuals and ES tools developed.</td>
<td>National ES Guidline developed, but not yet rolled out.</td>
<td>Roll-out and disseminate the National ES Guidline Implementation Manual and tools for implementation of ES activities by four GOE agencies and 44 IPs.</td>
<td></td>
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<tr>
<td>27</td>
<td>2 years</td>
<td>User friendly database for workforce system established and utilized for decision making. % improvement in capacity according to evidence based index. % of social service workers tracked using the MOLSA database</td>
<td>10% of social service workers tracked using the MOLSA database. 15% of MOLSA/ROLSA staff trained in utilization of data for decision making</td>
<td>Continue updating database to be more user friendly. 50% of social service workers tracked using the MOLSA database</td>
<td></td>
<td></td>
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<tr>
<td>28</td>
<td>3 years</td>
<td>The number of new PSWs graduated from pre-service training institutions; the number of PSW employed by government and/or private organizations; the number of PSW received regular supportive supervision; and the number of PSW supervisors trained. This will result in sustainable quality services by increasing referral linkage for OVC beneficiaries and their caregivers, providing comprehensive case management (including counseling for testing, encouraging HIV status disclosure, supporting adherence, and tracing LTIFU, in collaboration with Health Care Workers), supporting the CCC to mobilize local resources for OVC and care givers, and providing technical assistance for community volunteers.</td>
<td>1,329 PSW graduated from TVETs training program. Additional 309 PSW are currently enrolled for training. Deployed PSW are implementing case management practices and improving bi-directional referral linkage, retention and case finding.</td>
<td>Additional 860 PSW trained and graduated from TVETs center. 60% of trained PSW employed by government/by private employer (disaggregated) (IN MAINTAINED geography)</td>
<td></td>
<td></td>
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<tr>
<td>29</td>
<td>3 years</td>
<td>Number of FSWs tested in DIC who have received their viral load results. Number of FSWs with viral load suppressed results.</td>
<td>80% of current and all newly identified positive FSWs eligible for VL testing in DIC receive their results within a month</td>
<td>100% of eligible FSWs on ART access viral load testing services, and 90% of viral load test results received within 1 month time frame and used for clinical decision making.</td>
<td></td>
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<tr>
<td>30</td>
<td>1 year</td>
<td># of health facilities constructed or renovated meeting provisional acceptance as per USAID standards, disaggregated by type of facility and region</td>
<td>75% complete</td>
<td>Completion of a Blood Center</td>
<td></td>
<td></td>
</tr>
<tr>
<td>31</td>
<td>3 years</td>
<td>% stock out rate of tracer commodities</td>
<td>Current ARV stockout is 2%. Current wastage is 2-8%.</td>
<td>ARV less than or maintained at 2%; Wastage 2-5%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Funding Agency</td>
<td>Implementing Mechanism Name</td>
<td>Prime Partner</td>
<td>Mechanism ID</td>
<td>Program Area</td>
<td>COP17 Strategic Objective</td>
<td>COP18 Strategic Objective</td>
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</tr>
<tr>
<td>USAID</td>
<td>Global Health Supply Chain Program</td>
<td>Global Health Supply Chain Program</td>
<td>18375</td>
<td>C&amp;T</td>
<td>0</td>
<td>Improve pharmacy services to enhance treatment outcomes, supply chain efficiency and effectiveness and financial monitoring.</td>
</tr>
<tr>
<td>USAID</td>
<td>Global Health Supply Chain Program</td>
<td>Global Health Supply Chain Program</td>
<td>18375</td>
<td>HSS</td>
<td>0</td>
<td>Procure HIV related health commodities</td>
</tr>
<tr>
<td>USAID</td>
<td>Capacity Building of Local Organizations</td>
<td>Ethiopian Society of Sociologists, Social Workers and Anthropologists</td>
<td>17271</td>
<td>OVC</td>
<td>Support the workforce development/the training of parasocial workers providing social services to OVC &amp; caregivers</td>
<td>Prevent and protect OVC, their caregivers and AGYW against violence and strengthen case management by building the social service system and capacitating and improving the responsiveness of Community Care Coalitions and the GOE (MOLSA, BOLSA, TVET).</td>
</tr>
<tr>
<td>USAID</td>
<td>Capacity Building of Local Organizations</td>
<td>Ethiopian Society of Sociologists, Social Workers and Anthropologists</td>
<td>17271</td>
<td>OVC</td>
<td>Support the workforce development/the training of parasocial workers providing social services to OVC &amp; caregivers</td>
<td>Strengthen referrals to improve case management of OVC through development of mentoring and supportive supervision tools and resources for para social workers.</td>
</tr>
<tr>
<td>USAID</td>
<td>Infrastructure Program - Engineering</td>
<td>Tera Tech EM, INC</td>
<td>18241</td>
<td>HSS</td>
<td></td>
<td>Provide engineering and construction oversight for health infrastructure activities under 17856 and 18242 in order to provide quality facilities that achieve their intended results.</td>
</tr>
<tr>
<td>USAID</td>
<td>Infrastructure Program - Construction</td>
<td>TBD: Multiple</td>
<td>18242</td>
<td>HSS</td>
<td></td>
<td>Health infrastructure constructed throughout Ethiopia to support HIV/AIDS Care and Prevention, as well as maternal and child health, and chronic disease treatment.</td>
</tr>
<tr>
<td>USAID</td>
<td>Population Council/Project SOAR</td>
<td>Population Council/Project</td>
<td>Placeholder - 70087 Ethiopia USA</td>
<td>HSS</td>
<td></td>
<td>Improved HIV programming for out-of-school adolescent girls based on evidence generated on their knowledge, characteristics and vulnerabilities, risk behaviors and HIV prevalence</td>
</tr>
<tr>
<td>Approach</td>
<td>COP18 Activity (above-site, above-service delivery)</td>
<td>Key Systems Barrier</td>
<td>Related SID 3.0 Element</td>
<td>SID 3.0 Element Score</td>
<td>Expected Outcome</td>
<td></td>
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<tr>
<td>32 Host country institutional development</td>
<td>PSM will identifying best practice, gaps in the three essential logistics data and triangulate with service data for improved efficiency in supply chain. The innovative thinking and improved strategic planning into the supply chain and pharmacy services, resulting in increased availability of medicines, rational use, compliance for clients and reduce resistance in clients. Training to ensure seamless transition from TLE to TLD, conducting supportive supervision and mentoring to supply chain in ART sites and specific focus on PEPFAR priority sites. Reviewing SCM technical guidelines for VL EID SCM, HIV RTK and developing SOP</td>
<td>Shortage of human resource capacity within the public health system. High turn-over of staff at all levels of the health systems especially in the pharmacy and supply chain sector. Continual change in treatment and testing protocol, and changes in required HIV medicines and supplies.</td>
<td>Commodity security and supply chain</td>
<td>6.88</td>
<td>Best practice SOP are developed and distributed for VL EID SCM, HIV RTK. Transition from TLE to TLD is completed without stock interruption and wastage of TLE is minimized. Increased use of innovation and strategic planning approaches improve HIV medicine availability, improved dispensing practice and contribute to reduced resistance in clients.</td>
<td></td>
</tr>
<tr>
<td>33 Supply chain systems</td>
<td>The objective is to procure reagent and supplies of VL, EID, CD4, and Haematology testing, VMMC &amp; RTK for HIV program</td>
<td>Lack of funding for reagent and supplies of VL, EID, CD4, Haematology, VMMC kits and RTK</td>
<td>Commodity Security and Supply Chain</td>
<td>7.06</td>
<td>Increased access to VL, EID, CD4, Haematology, VMMC and RTK</td>
<td></td>
</tr>
<tr>
<td>34 Workforce development, pre-service training</td>
<td>Provide technical and material supports to TVET's centers to enhance their capacity and ensure the quality of training EPFAR priorities are incorporated into the PSW training curriculum. Support TVET centers to revise their curriculum and training modules to incorporate current and up to date case management, referral, supportive supervision and case conferencing approaches and mechanisms. Support the development of teaching aids to ensure quality and sustainability of PSW/SSWs training. Support the tracking of the deployment of para-social workers and ensure coverage, sustainability of the OVC services. Support regional Boils, BoWMCAs and TVETs to provide pre-service training and deployment of para-social workers. Provide training on case management, referral linkages and adherence to TVET trainers to cascade to PSW. Strengthening of systems for para-social service workers to provide technical support to volunteers at CCGs for case management and to mobilize local resources which will ensure a smooth transition of OVCs to the community and GOE in the future.</td>
<td>Suboptimal workforce development opportunities for social service</td>
<td>Technical efficiency</td>
<td>5.56</td>
<td>Improved coordination of care for non-biomedical/sustainable quality social services and reduced vulnerability among OVC and their families; Increased number of OVC and their caregivers, including AGYW, referred for testing and started on treatment through a strengthened bi-directional linkage in between the community and facilities; Increased number of HIV positive OVC and their caregivers who regularly receive adherence support and follow up for VL suppression; Increase resiliency of OVC and their caregivers by providing quality, comprehensive OVC services through a family and community- centered care and support approach</td>
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</tbody>
</table>
| 35 Technical area guidelines and tools | • Provide supportive supervision, coaching, mentoring, and case conferencing PSW and Case Workers/Community workers.  
• Develop case management, referral and supportive supervision tools and resources for PSW in collaboration with GOE & Local implementing partners.  
• Develop national level supervision (supportive supervision, mentoring, coaching, and case conferencing) tools, guidelines and resources.  
• Support target regions and areas to contextualise the case management, referral and supervision tools, guidelines and resources reviewed/developed at national level.  
• Cascade trainings of case management, referral and supervision based on the revised/newly developed tools to frontline workers (PSWs, OVCs, CCC members).  
• Use resiliency focused and strengths-based case management approach for social service provision to OVC, AGYW and their families. | Lack of of standardised and contextualised casemanagement, mentoring and supervision tools and guidelines | Policy and Governance | 6.58       | Number of cases managed (cases reached) as per newly developed/revised case management tools  
Availed standardized national case management tools to provide services for OVC, their caregivers and AGYW by PSW and community volunteers |
<p>| 36 Construction and renovation   | Provide engineering and construction oversight for the final activities under 17856 and 18242. | Poor quality facilities | NA | Completion of facilities which meet intended quality standards |
| 37 Construction and renovation   | Safe and sustainable water supply (wells) will be provided to 11 previously completed health centers to support quality HIV and health services | Limited access to critical WASH services at health center | NA | Completed health centers support HIV treatment, prevention, and testing as well as maternal and child health, and chronic disease treatment. |
| 38 Assessments, evaluation, operation research | Conduct data collection to identify risks and vulnerabilities faced by out-of-school AGYW in Ethiopia, to assess HIV knowledge and risk behaviors, as well as individual, interpersonal and structural level factors creating environments of risk for AGYW and estimate the HIV prevalence of out-of-school AGYW | Insufficient, reliable, subnational and local HIV epidemiological data on out-of-school AGYW | Epidemiological and Health Data | 4.90 | Evidence generated to identify characteristics risks and vulnerabilities faced by out-of-school AGYW in Ethiopia, to inform HIV prevention programming. Data to be collected will assess HIV knowledge and risk behaviors, as well as individual, interpersonal and structural level factors creating environments of risk for AGYW. HIV prevalence of out-of-school AGYW will be estimated and where to find and how to recruit out-of-school AGYW will be understood. |</p>
<table>
<thead>
<tr>
<th>Expected Timeline for Achievement of Outcome (1, 2, or 3 years)</th>
<th>Relevant Indicator or Measurement Tool</th>
<th>COP18 Baseline Data</th>
<th>Year One (COP18) Annual Benchmark (Planned)</th>
<th>FY19 Q2 Results</th>
<th>FY19 Q4 Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>32 3 years</td>
<td>number of SOP's introduced TLE to TLD transition milestones met reduction in medication dispensing errors</td>
<td>TBD (baseline capacity assessment)</td>
<td>TLD transition plan and SOP finalized and implemented; Dispensing errors mitigated 5 year supply chain strategic plan developed. Will include innovative and best practices to improve HIV medicine availability, as well as strengthen commodity security and supply chain.</td>
<td></td>
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<tr>
<td>33 1 year</td>
<td>Percentage availability of each category of commodity</td>
<td>COP 17 has showed test of 54% test performance towards 3rd 90</td>
<td>EPHI and VL testing sites will provide 100% testing of the eligible patient on ART</td>
<td></td>
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</tr>
<tr>
<td>34 3 years</td>
<td>Number of new PSWs graduated from pre-service training institutions; the number PSW employed by government and/or private organizations; the number of PSW received regular supportive supervision; Number of PSW supervisors trained. This will result in sustainable quality services by increasing referral linkage for OVC beneficiaries and their caregivers, providing comprehensive case management (including counselling for testing, encouraging HIV status disclosure, supporting adherence, and tracing LTFU, in collaboration with Health Care Workers), supporting the CCC to mobilize local resources for OVC and care givers, and providing technical assistance for community volunteers.</td>
<td>140 PSW currently under training in TVETs training program; Some of these PSW will begin to implement case management practices and improving bi-directional referral linkage, retention and case finding.</td>
<td>Additional 140 PSW trained and graduated from TVETs center. 60% of trained PSW employed by government/private employer (disaggregated) (in ATTAINED geography)</td>
<td></td>
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<tr>
<td>35 2 years</td>
<td>Case management, mentoring and supportive supervision tools developed and rolled out to implementation sites for PSW and community volunteers Improved quality of services and service providers' efficiency for the service that they provide to OVC, care giver and AGYW</td>
<td>National task force established to start development of the tools; and the tool development process is in its preliminary phase.</td>
<td>Case management and monitoring tools developed and rolled out to OVC program implementing partners and to all level government stakeholders (Ministry of Labor and Social Affairs (MOLSA), Bureau of Labor and Social Affairs (BoLSA), Bureau of Women and Children Affairs (BoWCAs), Ministry of Women and Children Affairs (MOWCA), and HAPCO/ MoH).</td>
<td></td>
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<tr>
<td>36 1 year</td>
<td>Engineering and construction oversight report</td>
<td>Report on the quality of construction received.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>37 1 year</td>
<td># of health facilities constructed or renovated meeting provisional acceptance as per USAID standards, disaggregated by type of facility and region</td>
<td>11 out of 22 health facilities</td>
<td>22 health facilities have access to water services.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>38 1 year</td>
<td>number of survey completed</td>
<td>No data available on out-of-school Adolescent girls in relation to their risk and vulnerabilities, knowledge of HIV, risk behaviours, interpersonal and structural level factors and HIV prevalence.</td>
<td>Survey completed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>