Ethiopia

Country Operational Plan

(COP/ROP) 2019

Strategic Direction Summary

March 29, 2019

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1.0 Goal Statement

In COP19, PEPFAR Ethiopia (PEPFAR-E) will support the national HIV control program of the Government of Ethiopia (GOE) to reach and sustain HIV epidemic control by focusing direct service delivery (DSD) support in five priority regions and strengthening critical systems nationally. With a focus on sustainability, as epidemic control is obtained, PEPFAR-E will continue to evolve programmatic focus, emphasize support to above-site technical assistance (TA) and increase partnerships with local entities. Government entities will be strengthened to better lead the HIV response, maintain gains made to date, and develop appropriate transition plans where needed. Regional health bureaus will have leadership capacity strengthened for coordination of regional responses and will work closely with civil society organizations (CSOs), urban health extension workers (UHEWs) and community partners to strengthen community-facility linkages, find remaining PLHIV not in care, and provide essential preventive services to orphans and vulnerable children (OVC).

No current policy barriers exist for exceeding the 90-90-90 targets, though considerable work remains to operationalize updated policies at regional and local levels. This will be facilitated by working groups at all levels, leveraging the GOE's renewed engagement and commitment to achieving and sustaining HIV epidemic control.

Programmatic approaches will strengthen national systems for:

1. **Detection of cases** to link them to treatment and care especially among female sex workers, men and children;
2. **Suppression of viral load** to lower transmission rates; and
3. **Response** to ensure thorough patient care and early identification and prevention of epidemic backsliding.

To accomplish this, PEPFAR-E will pursue the following objectives:

1. Strengthen support for core systems and government agencies at central level – namely, Federal Ministry of Health (FMOH), Federal HIV/AIDS Prevention and Control Office (FHAPCO), Ethiopia Public Health Institute (EPHI), Ethiopia Pharmaceutical and Supply Agency (EPSA), Ministry of Finance (MOF), Ministry of Women, Child and Youth Affair (MOWCYA) and Ministry of Labor and Societal Affairs (MOLSA).

2. Support FMOH to execute sound, unified program planning and quarterly performance monitoring, in conjunction with WHO, UNAIDS, GFATM and other stakeholders.

3. Focus DSD investments on identification of remaining cases and achieving population-level viral load suppression in 5 priority regions with largest gaps to treatment saturation – Addis Ababa, Oromia, Amhara, SNNPR, and Gambella - with a focus on pediatrics, adolescents and adult men. This requires adjusting targets for TX_CURR and TX_NEW (especially for Addis Ababa); accelerating HIV Self Testing (HIVST) and Pre-Exposure Prophylaxis (PrEP) implementation; increasing yields for index case testing (ICT) and provider initiated testing and counseling (PITC); intensifying TB Preventive Therapy (TPT); and eliminating Gambella's VMMC backlog.

4. Transition PEPFAR assistance to more above-site, non-DSD support in all 11 regions using a TA model which includes: (a) reinforcing (sub-)national leadership and governance capacity; (b) implementing sustainable financing strategy, adopting domestic resource mobilization legal framework, and mapping resources; (c) improving laboratory systems, (d) scaling up case-based surveillance (CBS) and response, including recency testing and health information systems (HIS); (e) improving supply chain management systems, HIV commodity availability and access; and (f) assuring quality clinical services.

Stakeholder, especially CSO, engagement is increasingly critical for the success of PEPFAR investments as the program evolves to sustain epidemic control. Stakeholder contributions span domestic resource mobilization, stigma and discrimination reduction, adoption of latest evidence-based best-practices, and mobilization of targeted populations to receive services.

2.0 Epidemic, Response, and Program Context

2.1 Summary statistics, disease burden and country profile

Ethiopia is sub-Saharan Africa's second most populous nation and one of its poorest. Population estimates vary between 100 and 110 million[1] divided among approximately 80 ethnic groups[2], with approximately 27%[3] living below the World Bank-defined poverty line of $1.90 per day. Approximately 65% of Ethiopia's population is under 25 years of age and about 79% of the population resides in rural areas[4]. These statistics belie Ethiopia's substantial economic and social progress over the last 30 years. In 1990, 40% of the population lived below the World Bank poverty line; since 1990, the total fertility rate (TFR) has declined from 7.2 to 4.6 [5]; the infant mortality rate has declined from 120 per 1,000 live births to 41[6]; and the adult literacy rate has gone from below 25% to 49%[7].

The HIV epidemic in Ethiopia is mixed, with wide regional variations and urban concentration in prevalence and some distinct transmission pockets among key and priority populations (KP & PP) and in some sectors of the general population[8]. The 2016 Demographic and Health Survey (DHS) estimated a national prevalence of 0.9%. The 2018 Ethiopian Population-based HIV Impact Assessment (EPHIA) estimated an urban HIV prevalence of 3.0% nationally with regional variations (see Table 2.0).

Table 2.0 Urban HIV Prevalence by Region, 2017-2018 EPHIA

[1] 2019 CIA World Factbook
[2] Wikipedia
[3] World Bank Poverty and Equity Data Portal, 2015
[4] 2019 CIA World Factbook
[5] DHS 2016
[6] World Bank, 2017
[7] World Bank World Data Atlas
[8] DHS 2016

Tigray	**2.7**
Afar	4.1
Amhara	4.1
Oromia	3.0
Somali	0.8
Benishangul-Gumuz	2.4
SNNPR	1.8
Gambella	5.7
Harari	4.6
Addis Ababa	3.1
Dire Dawa	4.6

The current working UNAIDS Spectrum estimate for PLHIV is 649,264 (with a confidence interval of 519,266 – 833,618) in Ethiopia. Of the estimated PLHIV, about 72% know their status and of those who know their status, 98.6% report current use of antiretroviral therapy (ART) and of those, 89.6% are virally suppressed.[9] Collectively, the data suggest that Ethiopia is close to reaching HIV epidemic control, but still has pockets which need to be appropriately addressed.

KPs & PPs (FSWs, widowed and divorced people, truck drivers, adolescent girls and young women (AGYW) engaged in transactional sex, male clients of sex workers (SWs), and those who live along major transport corridors are all estimated to have significantly higher HIV prevalence rates than the general population. Outside this trend, Gambella has little distinction between urban and rural residents with regard to HIV prevalence and some rural areas (with high seasonal migrant populations) away from transport corridors show elevated HIV risk behaviors despite their locales. Within the general population (in urban areas), women between the ages of 20 and 39 have significantly higher prevalence (6.1%-9.1%) than their male counterparts (0.9%-2.4%). Adult male prevalence peaks at 5.7% in the 40-44 age band[10].

Addis Ababa, despite its relative economic advantages and ease of access to health care, falls well below the rest of the country in key HIV indicators when non-residents are factored out. EPHIA data suggests that youth (15-24) have low VL suppression (48.2%) and therefore require special emphasis for engagement into care. Finding youth, getting and keeping them on treatment to achieve high rates of VL suppression must be a focus of any effort to achieve epidemic control. Similarly, ensuring that Addis Ababa residents across all age bands reach and maintain critical 90-90-90 goals must be a major focus for sustained epidemic control.

[9] 2018 EPHIA
[10] Ibid.

Table 2.1.1 Host Country Government Results

Table 2.1.1 Host Country Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	100,829,000	100%	20,202,131	20%	20,386,290	20%	4,978,298	5%	5,013,772	5%	25,032,629	25%	25,216,890	26%	Refers to Year 2020. Adapted from Population Projection of Ethiopia from CSA.
HIV Prevalence (%)		0.9%		NA		NA		0.26%		0.18%		1.84%		0.84%	DHS 2016
AIDS Deaths (per year)	11,843		1,086		1,143		859		907		5152		2,695		Refers to Year=2020. Spectrum from FMOH
# PLHIV	645,680		26,894		27757		45377		32223		329199		184224		Refers to Year=2020. Spectrum from FMOH
Incidence Rate (Yr)		0.07 /1,000													Refers to Year=2020 (All Ages) Spectrum from FMOH
New Infections (Yr)	12161														Refers to Year=2020. Spectrum from FMOH
Annual births	3,149,013														Refers to Year 2020.

															CSA and DHS 2016
% of Pregnant Women with at least one ANC visit		98%													Health Sector Transformation Plan, Annual Performance Report 2015/16 FMOH
Pregnant women needing ARVs	18,815														Refers to Year=2020. Spectrum from FMOH
Orphans (maternal, paternal, double)	2,960,527														Refers to Year=2019. Spectrum from FMOH
Notified TB cases (Yr)	117,705	100%	4,557	4%	2,350	2%	15,560	13%	17,857	15%	32,240	27%	45,140	38%	Global TB Control Report WHO 2018
% of TB cases that are HIV infected	8239	7%													Global TB Control Report WHO 2018
% of Males Circumcised		91%													DHS 2016
Estimated Populatio	223,138														Extrapolated from Size estimation by PEPFAR-

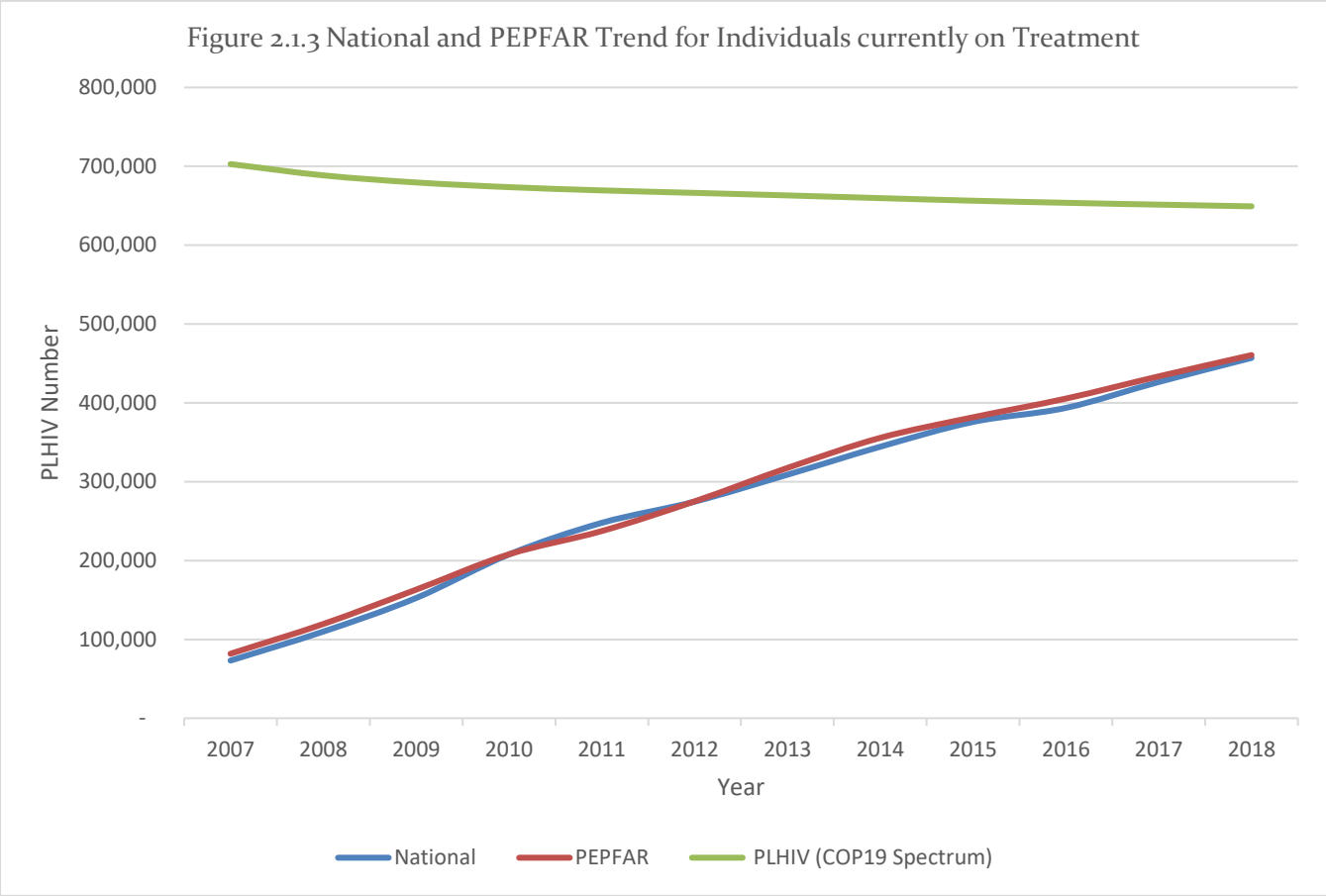
n Size of FSW															E interagency
FSW HIV Prevalence		23%													National MARPs survey, EPHI/CDC national MARPs survey report
Estimated Size of PPs	2,373,935														UNAIDS
Estimated PPs Prevalence	NA														

Table 2.1.2: 90-90-90 Cascade

Table 2.1.2 90-90-90 Cascade: HIV diagnosis, treatment and VL suppression										
Epidemiologic Data					HIV Treatment and VL Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#) YEAR=2018	HIV Prevalence (%) YEAR=2018	Estimated Total PLHIV (#) YEAR=2018	PLHIV diagnosed (#)	On ART (#) FY=2018	ART Coverage (%) FY=2018	VL Suppression (%)	Tested for HIV (#) FY=2018	Diagnosed HIV Positive (#) FY=2018	Initiated on ART (#) FY=2018
Total population	100,829,000	0.90%	649,264	511,620	460,565	71%	92%	5,799,961	60,428	42,862
Population <15 years	40,588,421	NA	59,101	NA	22,605	38%	75%	791,991	2,709	2,374
Men 15-24 years	5,013,772	0.18%	33,873	NA	14,339	42%	100%	686,438	3350	1,741

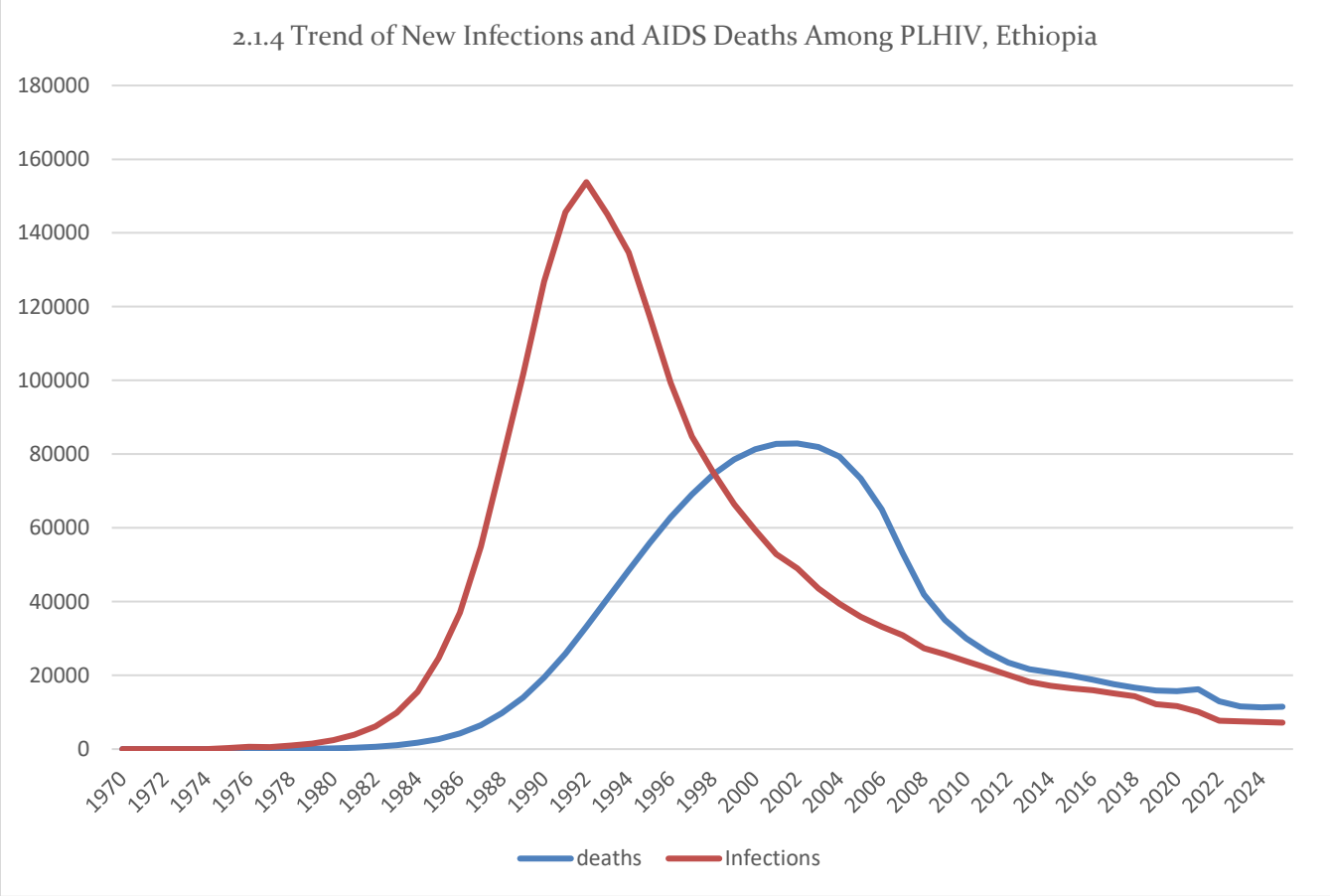
Men 25+ years	25,216,890	0.84%	182,338	NA	150,984	83%	94%	1,058,187	19175	14,166
Women 15-24 years	4,978,298	0.26%	47,758	NA	29,654	62%	83%	1,443,931	8627	5,439
Women 25+ years	25,032,629	1.84%	326,194	NA	243,022	75%	93%	1,818,220	26560	19,142
FSW	223,138	23%	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Figure 2.1.3 National and PEPFAR-E Trend for Individuals currently on Treatment[11]



[11] 2019 Spectrum Estimates
National Fiscal year is a quarter a head of PEPFAR Fiscal year (June and September respectively). According to PEPFAR programmatic strategy, Geographic prioritization, there have been transition of Woredas/ districts but that is not visible here as We continues to count huge number of PLHIV population on treatment receiving Treatment services in centrally supported areas. The latter resulted in very small difference in the government and PEPFAR figures

Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV[12]



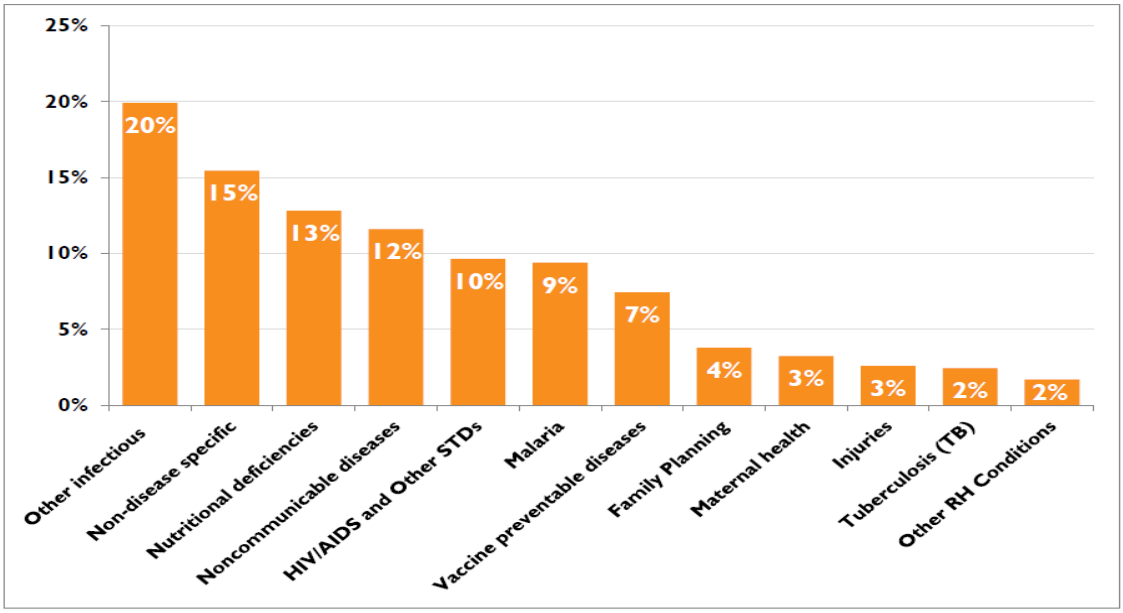
2.2 Investment Profile

The FMOH 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 GOE 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.[13]

[12] 2019 Spectrum Estimates
[13] NHA assessment conducted in 2013/14 and report is released in 2017.

The NHA survey also showed that a significant share of health spending (49%) 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 Diseases and Health Conditions[14]



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.

As the Health Account (HA) indicates, GOE is increasing commitment to fund health with an increase in domestic resources and donor resources decrease. Ethiopia is exercising new reform agenda across the board with renewed commitment for the HIV response as we evolve to sustain epidemic control.

[14] National Health Account 2013/14.

Figure 2.2.2 Financing Source Trend[15]

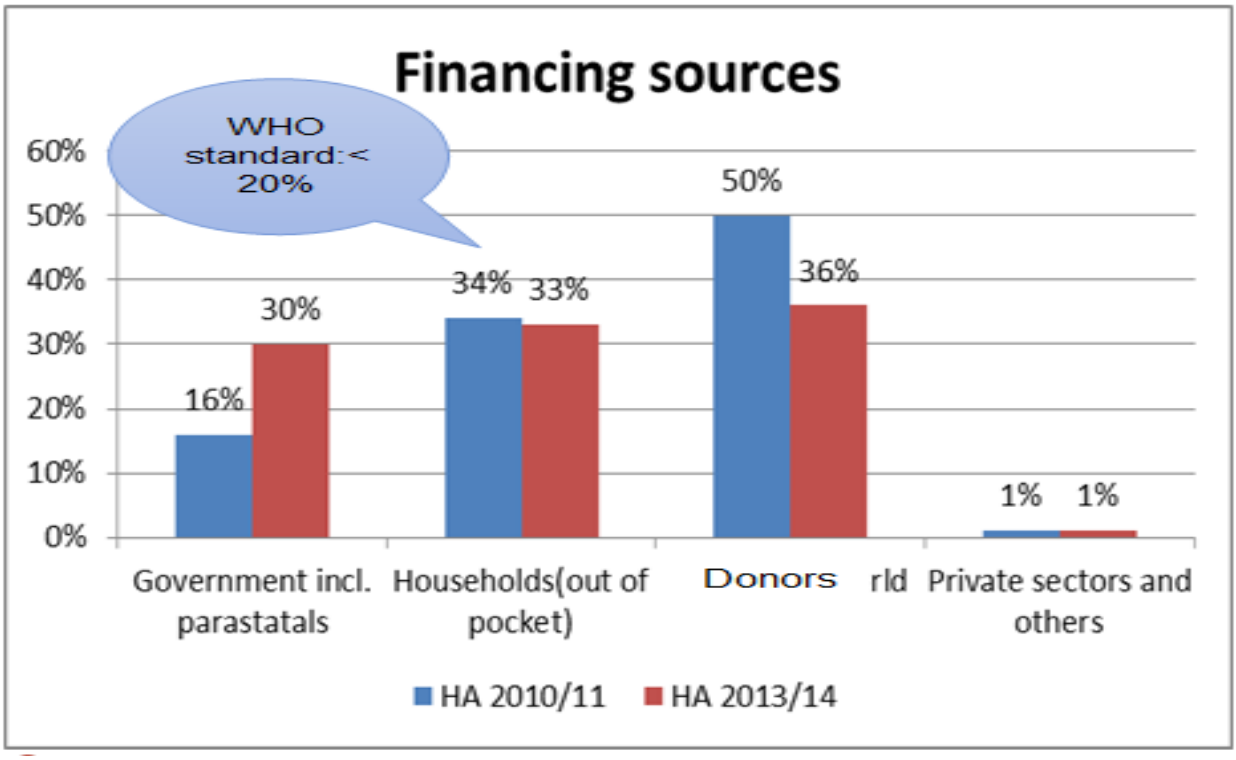


Table 2.2.1: Annual Investment Profile by Program Area

Table 2.2.1 Annual Investment Profile by Program Area (NASA 2011/12)[16]					
Activities	**Public (x 1000)**	**Private (x 1000)**	**External funds (x 1000)**	**Total (x 1000)**	**% Public**
Prevention	$24,834	$189	$53,974	$78,997	31%
Treatment	$13,054	$15	$112,268	$125,336	10%
OVC	$459	$199	$26,861	$27,519	2%
Nat. SYS .Strength	$15,526	$173	$104,410	$120,109	13%
HR	$526	$41	$15,581	$16,148	3%
Social Services	$49	$58	$10,483	$10,590	0%
Enabling	$0	$5	$26,127	$26,132	0%
Research	$0	$0	$248	$248	0%
Total	**$54,448**	**$680**	**$349,952**	**$405,080**	**59%**

[15] National Health Account 2010/11 and 2013/14

[16] 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 2.2.2. Annual Procurement Profile for Key Commodities

Commodity Category	Total Expenditure	% PEPFAR	% GFATM	% Host Country	% Other
ARVs	48,161,950.28	2.23	97.77	0	0
Rapid test kits	9,468,935.03	0	100	0	0
Other drugs (STI, INH for IPT)	1,030,238.77	0	68.6	0	31.4
OI	1,339,191	0	100	0	0
Lab reagents	985,120	100	0	0	0
Condoms	3,062,304.86	5	22	0	73
VL commodities	13,315,946.95	73.84	26.16	0	0
VMMC kits				0	0
MAT				0	0
Other commodities (CD4, EID)	1,136,375.23	0	100	0	0
Total	**78,500,062.12**				

The GOE application to the Global Fund to Fight AIDS, Tuberculosis, and Malaria (GFATM) indicates that funding needs continue to increase as reaching the last 10% of treatment coverage will be costly because the case finding strategies will focus in finding remaining positives in targeted geography and population group.

Figure 2.2.3: National HIV Resource Need and Gap (2018 – 2020)[17]

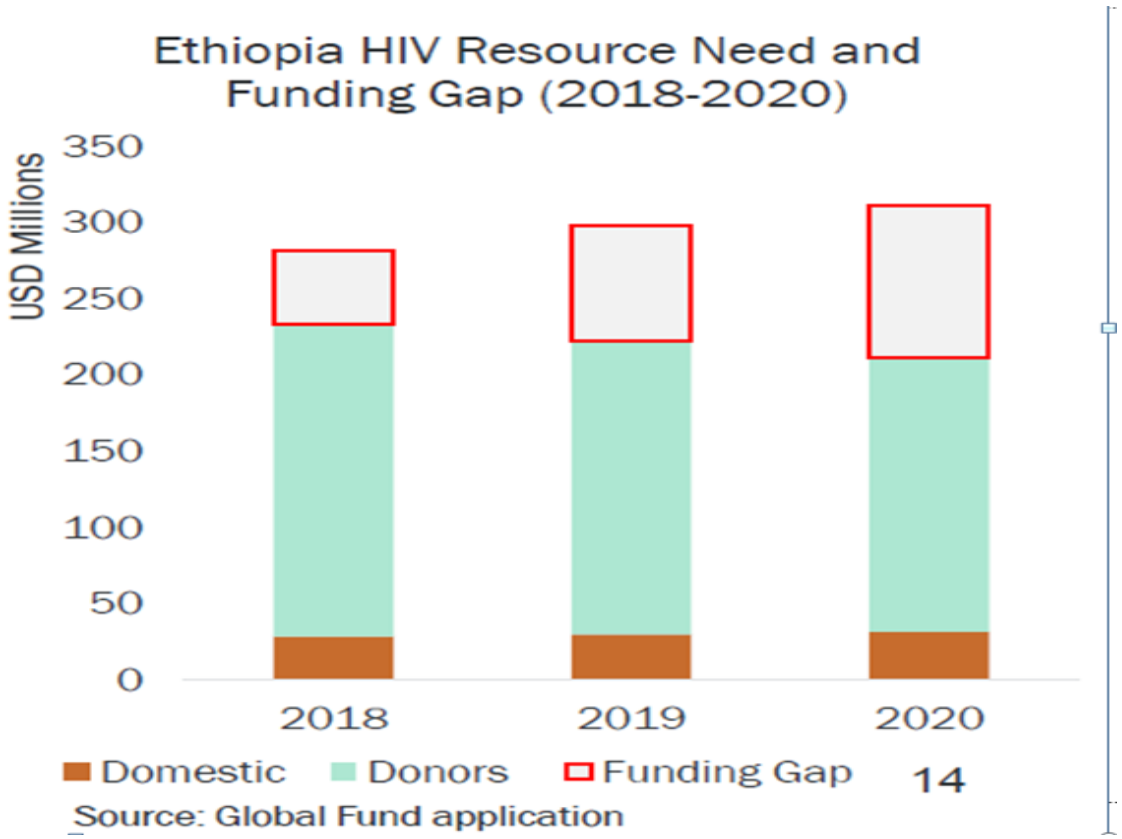


Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

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Funding Source	**Total USG Non-PEPFAR Resources**	**Non-PEPFAR Resources Co-Funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
USAID MCH	42,000,000	500,000	1	NA	
USAID TB	13,000,000	600,000	1	NA	
USAID Malaria	36,000,000	1,200,000	1	NA	
Family Planning	31,550,000	800,000	1	NA	
NIH				Na	

[17] GFATM Application 2018

CDC (Global Health Security)	1,335,000	$1,249,000	5	NA	
Peace Corps				NA	
DOD Ebola				NA	
MCC				NA	
Total	**123,850,000**	**4,349,000**	**1**		

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives

Table 2.2.4 Annual PEPFAR Non-COP Resources, Central Initiatives, PPP, HOP						
Funding Source	**Total PEPFAR Non-COP Resources**	**Total Non-PEPFAR Resources**	**Total Non-COP Co-funding PEPFAR IMs**	**# Co-Funded IMs**	**PEPFAR COP Co-Funding Contribution**	**Objectives**
VMMC – Central Funds	$ 784,831	$ 784,831	N/A	N/A	N/A	
Other PEPFAR Central Initiatives	N/A	N/A	N/A	N/A	N/A	
Other Public Private Partnership	N/A	N/A	N/A	N/A	N/A	
Total	**$ 784,831**	**$ 784,831**				

2.3 National Sustainability Profile Update

COP planning incorporates results from the Sustainability Index Dashboard (SID) into the assessment of systems investments that would help the program overcome barriers in order to achieve targets, and to define activities and budgets. The SID is completed every two years. PEPFAR-E convened the SID 3.0 workshop during the COP18 process with a wide range of stakeholders and in COP2020, the achievements and gaps outlined in SID 3.0 will be reviewed for progress. Table 2.3.1 outlines prior SID results.

Dark Green Score (8.50-10 points) (sustainable and requires no additional investment at this time)
Light Green Score (7.00-8.49 points) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 points) (emerging sustainability and needs some investment)
Red Score (<3.50 points) (unsustainable and requires significant investment)

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

Table 2.3.1: Results of Sustainability Analysis for Epidemic Control in Ethiopia		
	2015 (SID 2.0)	2017 (SID 3.0)
Governance, Leadership, and Accountability		
1. Planning and Coordination	7.87	9.29
2. Policies and Governance	6.58	8.08
3. Civil Society Engagement	4.00	5.17
4. Private Sector Engagement	4.44	8.39
5. Public Access to Information	7.00	6.00
National Health System and Service Delivery		
6. Service Delivery	4.40	5.32
7. Human Resources for Health (HRH)	6.00	6.06
8. Commodity Security and Supply Chain	7.08	7.08
9. Quality Management	1.62	6.67
10. Laboratory	5.51	5.42
Strategic Investments, Efficiency, and Sustainable Financing		
11. Domestic Resource Mobilization	2.78	6.94
12. Technical and Allocative Efficiencies	1.11	5.56
Strategic Information		
13. Epidemiological and Health Data	4.48	4.90
14. Financial/Expenditure Data	3.75	6.67
15. Performance Data	4.74	5.97

PEPFAR-E has made incredible strides towards achieving the UNAIDS 90-90-90 goals. PEPFAR-E 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 TA to increase real time data availability, quality and use and public access at all levels. The GOE has demonstrated strong leadership in coordinating the national response. Although, Ethiopia still remains highly dependent on donors to fund the HIV response. As donor contributions decline, the long-term sustainability of the national HIV program in Ethiopia could be at risk.

Sustainability strengths

The SID 3.0 domains were identified as sustainable, approaching, or emerging sustainability. Strengths were largely achieved in "Governance, Leadership and Accountability."

i. Private sector engagement (PSE) (8.39, light green) has shown significant improvement, a sharp increase from 4.44 (SID 2.0) to 8.39.[1] 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

[1] SID 2.0 and 3.0 is conducted after the NASA assessment. SID result s shows improvement in PHSP engagement.

that private facilities are included in the quantification and distribution process of HIV commodities, especially test kits.

ii. Quality Management (6.67, yellow) achieved significant gains 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.

Vulnerabilities

iii. Public Access to Information (6.0, yellow) has become a significant vulnerability to the sustainability of the national program. Although surveillance, expenditure, and performance reports are shared publicly, the dissemination of these results is delayed. Therefore, FHAPCO and other stakeholders must have available data that is up-to-date in order to inform funding and programmatic decisions. This creates a significant challenge in tailoring interventions to the locations and populations with the highest disease burden.

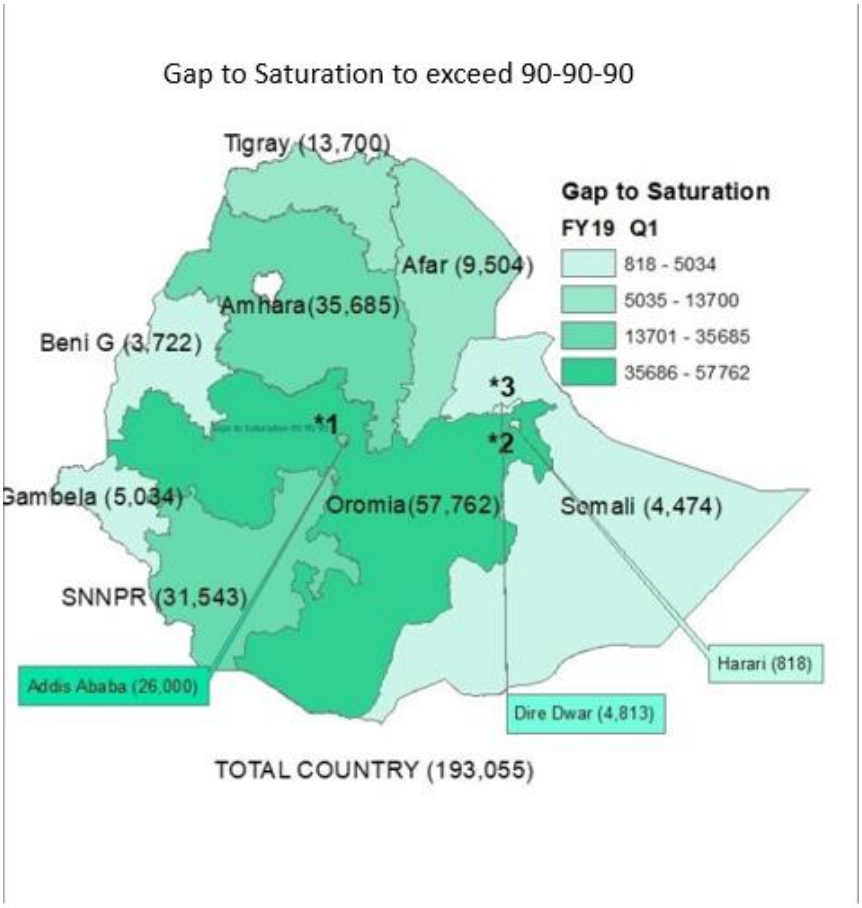
In COP19, PEPFAR-E and the GOE are committed to sustainable financing and the development of a framework for domestic resource mobilization (DRM). The COP19 funded activities to support sustainable financing include:

- Increased advocacy through information to encourage domestic financial participation.
- Develop legal frameworks at federal and select sub-national unit (SNU) levels for increased DRM for the HIV/AIDS program (for example: 2% HIV allocation)
- Develop national and regional implementation guidance for improved public financial management and tax administration
- Support implementation of the Sustainable financing/Increased Domestic Resource Mobilization Strategy for the HIV/AIDS Program by conducting a baseline assessment of domestic financing and through the development of sustainable financing roadmap of HIV/AIDS.
- Support FMOH Think Tank Group through technical support on tailored innovative financing strategies to increase domestic resource mobilization for priority public health programs at national and selected sub national level.

2.4 Alignment of PEPFAR investments geographically to disease burden

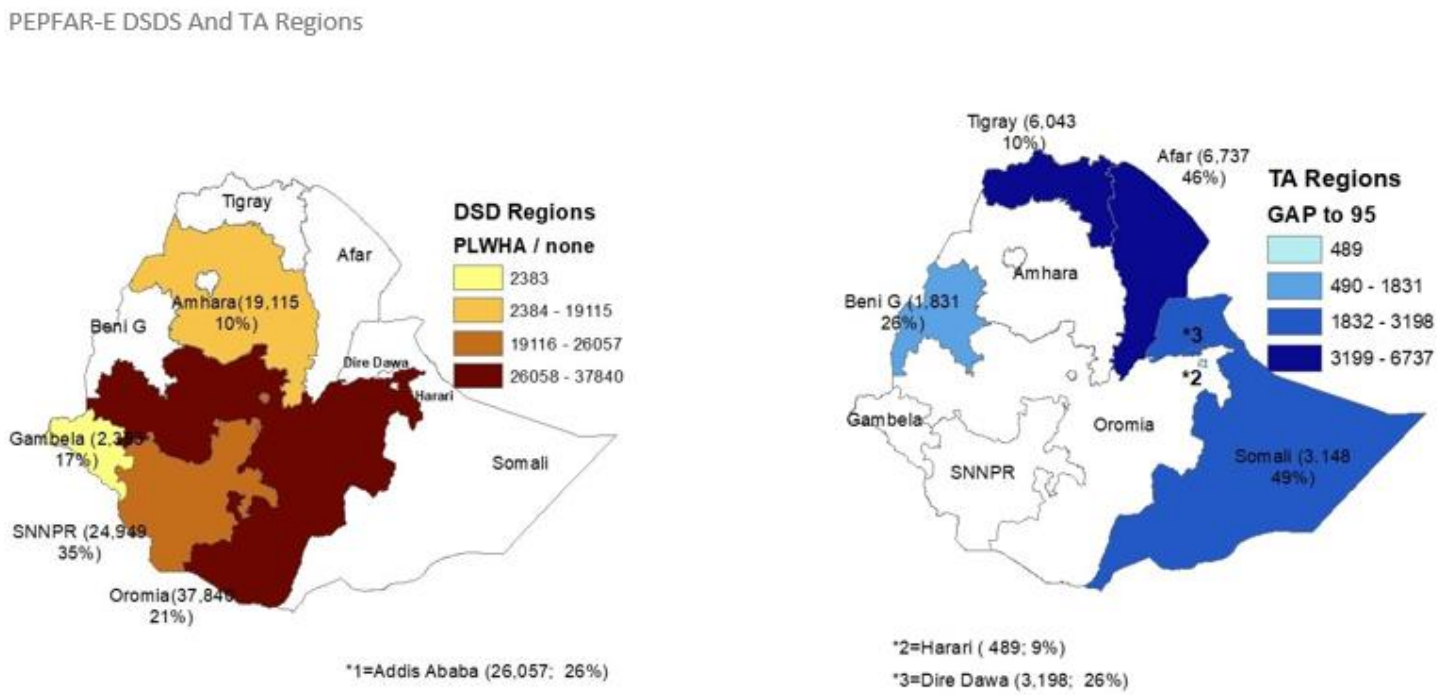
HIV care and treatment services are available across Ethiopia largely through public health facilities and community-based platforms. In FY18, 460,604 PLHIV received treatment at PEFPAR-supported sites as well as •310,597 OVC and 162,352 care givers. As Ethiopia approaches epidemic control, investments will be optimized to reach and sustain epidemic control in the highest burden regions. In the 5 regions with the greatest gap to saturation, DSD support will include intensified and targeted case finding, ensuring at least 92% of all diagnosed PLHIV are on optimal regimens ART, and patients on ART receive an initial 6 month and then annual VL test.

Figure 2.4.1 Gap to Saturation



The working 2019 SPECTUM estimate of PLHIV, the 2018 EPHIA and program data for PLHIV currently on ART (TX_CURR) were used to understand treatment gaps by geography. The SNUs/ geographic locations with greatest treatment gap are Oromia (57,762), Amhara (35,658) and, Addis Ababa (26,059). COP19 budget allocations for DSD combined with TA support are aligned to PEPFAR-supported geographic areas with the greatest gaps to treatment saturation: Addis Ababa, Oromia, Amhara, SNNPR and Gambella. In regions that have lower unmet needs and are approaching epidemic control, direct PEPFAR funding support will cease in COP19 and these regions will receive TA support through a national TA model, led by FHAPCO and the FMOH. Figure 2.4.2 outlines regions receiving direct PEPFAR assistant in COP19 and those regions that will receive TA support.

Figure 2.4.2 DSD and TA Regions

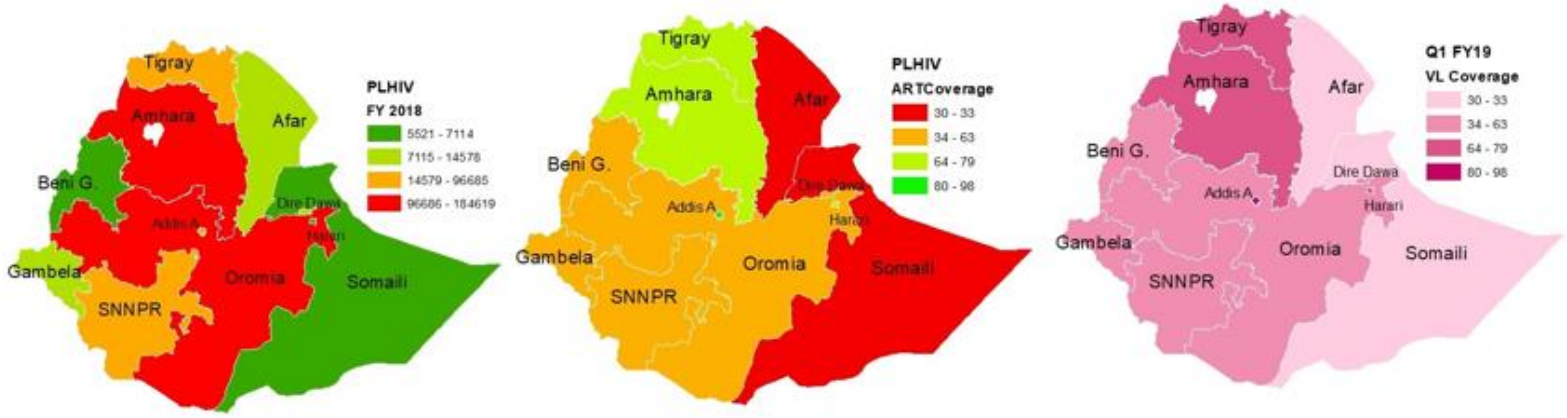


Accordingly Direct funding Cooperative agreements with RHBs (Oromia RHB, Amhara RHB, Addis Ababa City Administration as well as agreements with other implementing partners (IPs) like Population Service International (PSI), Project HOPE, and Family Health International (FHI 360) and others will direct their investments to these priority geographic areas. Figure 2.4.3 shows the PLHIV estimate and ART coverage by region.

As indicated in the COP18 SDS, expenditure (FY17) 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 (TA only in COP19) reported the highest expenditure per PLHIV at $369, followed while by Oromia region (DSD and TA in COP19) reported the lowest expenditure per PLHIV with $115 per PLHIV.

Figure 2.4.3 PLHIV and ART Coverage by Region

PEPFAR Ethiopia: People Living with HIV (PLHIV), Treatment Coverage and Viral Load Monitoring Coverage by Region



Source: PEPFAR data, March 2019

2.5 Stakeholder Engagement

The COP19 process has been open and consultative, and the plan reflects the strong engagement with and input from a range of stakeholders. Collaboration with stakeholders has been much greater in this year than in previous years. In particular, the PEPFAR-E team received substantial input from FMOH, FHAPCO, EPHI, EPSA, MOF, MOWYCA, GFATM, UNAIDS, WHO, civil society and faith-based organizations to prioritize investments included in COP19. PEPFAR-E also worked with implementing partners, local and international, to evaluate partner performance and progress towards goals in order to refine COP18 implementation and focus COP19 planning efforts. PEPFAR-E work with private sector was phased out in COP17.

PEPFAR-E collaborated with American International Health Alliance (AIHA) and the National Association of State and Territorial Apprenticeship Directors (NASTAD) to facilitate two workshops (in October and January) funded by HRSA's Headquarters' Operational (HOP) Fund to engage CSOs in building their organizational capacity to allow them to become direct local implementing partners (per PEPFAR's mandate to reach 70% LIPs) and to improve their understanding of PEPFAR and their ability to contribute to the COP planning process. Most of these CSOs are PLHIV organizations, and some of them were USAID's proposed LIPs for COP19.

This early CSO engagement was followed by early engagement of the GOE and UNAIDS in December. PEPFAR-E leadership met with the relatively new Minister of Health, Dr. Amir Aman, to request strong collaboration and engagement by the FMOH in COP planning and implementation. Dr. Amir expressed the FMOH's commitment to fully participate in the COP planning process and assigned Ministry leadership to meet weekly with PEPFAR-E leadership, and Ministry technical experts to take part in the PEPFAR-E technical working group discussions. He also stated the new Prime Minister Abiy was committed to being an HIV Champion for Africa. FHAPCO reconstituted the National AIDS Council (NAC) in March 2019 and PEPFAR-E is participating. PEPFAR-E also met with UNAIDS to reinvigorate the Donor & Development Partners HIV Coordination Group (DPG). Since then UNAIDS has convened a monthly meeting to share information on vision and strategies, share data, align support and ensure complementarity.

In addition to almost weekly meetings with leadership of FMOH, FHAPCO, EPHI and EPSA, PEPFAR-E regularly engaged with the Ministry at the technical level through participation in the new FHAPCO-led Sustained Epidemic Control TWG, Operation Addis Ababa Acceleration TWG which is recently formed to help expedite the COP18 plus up implementation, the National Information Revolution Advisory Group for the Ethiopian Health Information Systems, and in other routine Ministry-led TWGs such as the National HIV/AIDS Technical Advisory Group (TAG), and the Survey and Surveillance TWG. PEPFAR-E will also participate in the newly formed Electronic Medical Record (EMR) TWG. PEPFAR-E engaged with GFATM through quarterly visit update meetings and through Country Coordinating Mechanism (CCM) participation. In addition, PEPFAR-E participated, along with several other stakeholders, in the Spectrum estimate workshops and meetings convened by UNAIDS and the FMOH.

The COP19 guidance, tools and planning level letter were shared with external stakeholders. Key GoE entities (FMOH, FHAPCO, EPHI, EPSA, MOF, MOWYCA) and external stakeholders (UNAIDS, GFATM, WHO, CSOs) participated in the stakeholder's strategic retreat convened in January. Agency Headquarter personnel also joined the retreat, and all participants provided comments on the proposed PEPFAR-E planning direction for COP19.

PEPFAR-E conducted quarterly IP meetings, also attended by stakeholders, to evaluate performance and better understand implementation challenges and possibilities in order to refine plans to improve community-facility linkage, achieve saturation in Addis by end of COP18, and sustain epidemic control in COP19, including in non-priority regions. In COP 19, PEPFAR-E will continue to work very closely with the FMOH, FHAPCO, EPHI, EPSA, RHBs and community partners to carry out ICT, self-testing, same day treatment initiation, and scale up viral load, CBS and recency testing to find the remaining cases and get them virally suppressed.

Finally, in preparation for the COP19 Regional Planning Meeting in Johannesburg, PEPFAR-E held a final stakeholder meeting in Addis Ababa to review and discuss the final COP19 strategy, data analyses, and presentation. Many stakeholders and partners joined the Johannesburg meeting as part of the Ethiopia team delegation, including the State Minister of Health, the General Director of FHAPCO, two Regional Health Bureau Heads, one representative from Ethiopian Consortium of Christian Relief & Development Associations (CCRDA), UNAIDS, WHO and Global Fund. Additionally, two LIPs and several international NGOs had representation in Johannesburg. Robust participation of these external stakeholders and partners resulted in a stronger investment plan for COP19.

Building on this annual planning process, PEPFAR Ethiopia will continue to engage with external partners and stakeholders, including civil society, at all levels to support optimized implementation of COP19. Implementation will include ongoing consultations, including sharing of quarterly results at the national and regional levels, and quarterly program management reviews with the GOE, including status updates on partner pipelines. COP19 implementation will also leverage current efforts to deepen engagement with RHBs and other indigenous organizations across program implementation areas.

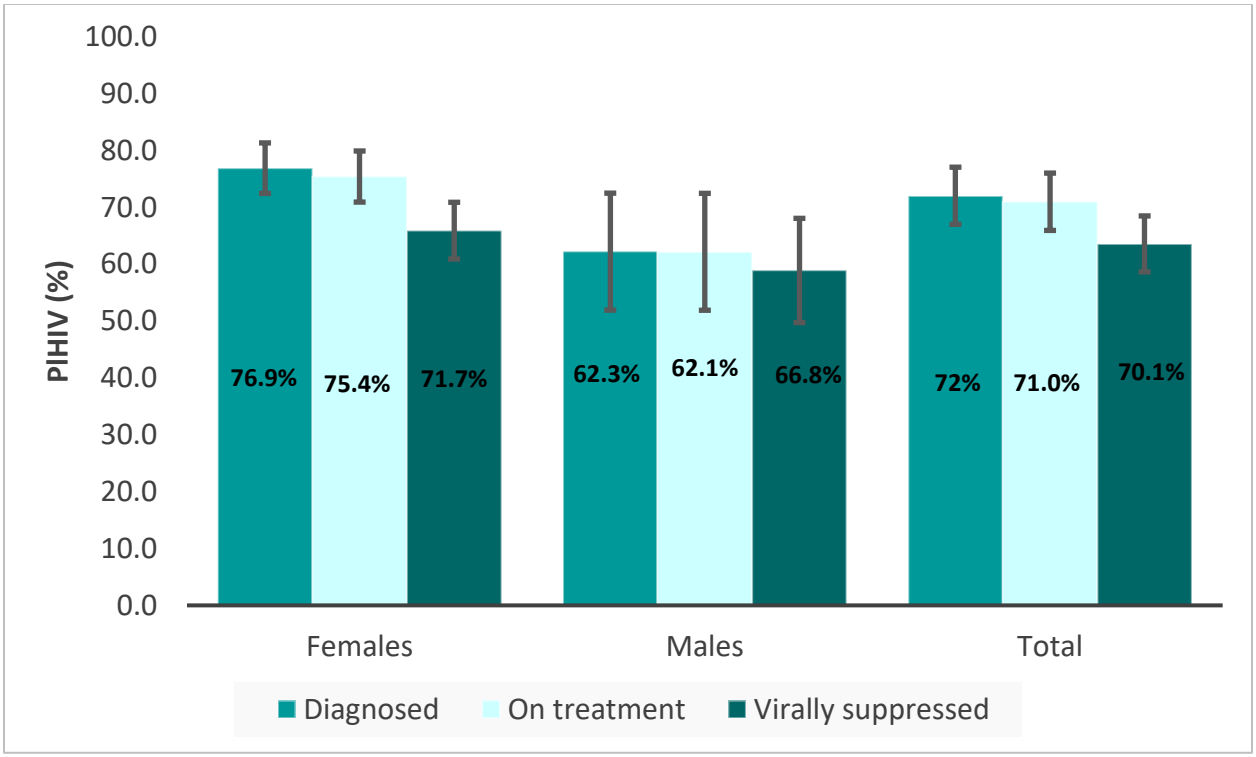
3.0 Geographic and Population Prioritization

Geographic and population prioritizations were determined using the 2017-2018 EPHIA survey, the current UNAIDS Spectrum model estimates, and program data. Geographic regional prioritization is based on prevalence and greatest unmet need towards treatment saturation, with distinctions made between DSD with TA, and TA-only regions in terms of PEPFAR support. PEPFAR will focus DSD assistance to the 4 regions of Addis Ababa, Oromia, Amhara, and SNNPR which have the largest gaps to saturation. In addition, DSD assistance will be maintained in Gambella region, which has the highest prevalence of HIV, hosts a large refugee population, and has limited capacity to deliver health services. The major focus will be on active case detection given this is the major barrier to achieving epidemic control. In the remaining regions where the gap to saturation is smaller, there will be a shift to a TA/NSD model.

3.1 Geographic Saturation and Population-Based VL Suppression

EPHIA results affirmed that Ethiopia has a strong HIV control program; once people know their status, there is a high prevalence of VL suppression (see figure 3.1.1).

Figure 3.1.1. Overall EPHIA Cascade



Although, comparing EPHIA with program data demonstrates how the latter actually obscures the true picture on performance in Addis Ababa. The EPHIA found the lowest prevalence of VL suppression in the capital city of Addis Ababa (Table 3.1) although by program data, Addis, appears to have reached treatment saturation.

Table 3.1 ART Coverage Against Exceeding 90-90-90 Targets, Q1FY19, by Region and AGE/SEX

Region	0-14 Male	0-14 Female	15-24 Male	15-24 Female	25-49 Male	25-49 Female	50+ Male	50+ Female	Total
Addis Ababa	1392 (118%)	1465 (129%)	2503 (96%)	3885 (119%)	22804 (156%)	45760 (131%)	9179 (60%)	7705 (33%)	94693 (98%)
Afar	61 (7%)	49 (5%)	95 (13%)	245 (20%)	1216 (45%)	2161 (41%)	294 (20%)	224 (17%)	4345 (30%)
Amhara	3273 (40%)	3011 (38%)	5004 (45%)	8049 (56%)	37961 (115%)	66173 (93%)	8444 (50%)	7788 (35%)	139703 (76%)
Benishangul-Gumuz	73 (19%)	69 (18%)	62 (18%)	153 (26%)	798 (56%)	1523 (55%)	223 (40%)	135 (20%)	3036 (43%)
Dire Dawa	135 (30%)	112 (26%)	121 (26%)	237 (30%)	1556 (62%)	3434 (73%)	562 (46%)	528 (34%)	6685 (55%)
Gambella	230 (35%)	284 (44%)	409 (69%)	1355 (110%)	2226 (69%)	3330 (60%)	174 (18%)	153 (15%)	8161 (59%)
Harari	123 (49%)	108 (45%)	83 (49%)	229 (69%)	980 (84%)	2328 (103%)	304 (61%)	272 (45%)	4427 (80%)
Oromia	3421 (30%)	3156 (29%)	4086 (37%)	7393 (49%)	28237 (88%)	52135 (82%)	7275 (46%)	6572 (35%)	112275 (63%)
SNNPR	1329 (35%)	1276 (35%)	1123 (34%)	3629 (61%)	10284 (71%)	16000 (59%)	1197 (21%)	878 (13%)	35716 (50%)
Somali	44 (8%)	29 (6%)	102 (37%)	150 (29%)	374 (32%)	747 (33%)	74 (12%)	139 (25%)	1659 (26%)
Tigray	984 (40%)	917 (38%)	1211 (38%)	2791 (63%)	10292 (93%)	20927 (95%)	2492 (43%)	2281 (32%)	41895 (72%)
Total	**11218 (37%)**	**10629 (37%)**	**15007 (44%)**	**28472 (60%)**	**120922 (103%)**	**216665 (90%)**	**30991 (48%)**	**26884 (32%)**	**460788 (71%)**

Evaluation of program data for Addis Ababa is complicated by challenges of accurately capturing residency, including both daytime and nighttime dynamics, and population healthcare seeking behavior. Accordingly, for the remainder of COP18 and COP19, the EPHIA results will be used to guiding target setting for Addis Ababa as a region.

Table 3.2 EPHIA Population Level VL Suppression, by Region

Region	Prevalence in %	95% CI
Tigray	(70.2)	56.2- 84.1
Afar	(68.2)	53.1- 83.2
Amhara	79.6	69.2- 89.9
Oromia	70.0	61.2- 78.8
Somali	*	*
Benishangul Gumuz	*	*
SNNPR	(67.2)	52.4- 81.9
Gambella	(56.7)	38.3- 75.1
Harari	(64.6)	50.3- 78.9
Addis Ababa	58.2	46.4- 70.1
Dire Dawa	(71.7)	49.3- 94.1
Total	70.1	65.4-74.8

*Estimates suppressed due to inadequate sample size

VMMC Coverage

The VMMC program in Ethiopia has been implemented among adult men in Gambella region, military and refugee populations since 2009. The prevalence of male circumcision (MC) among the adult population aged 15-49 in Gambella, ranges from 40% among refugee population (MC studies by United Nations High Commissioner for Refugees (UNHCR), 72% among urban residents (EPHIA) to 72% among the total Gambella population (DHS 2016).The total unmet need among the

adult male population in Gambella is estimated at 290,514 (155,531 indigenous; 134,983 refugees). To reach 90% VMMC saturation about 272,000 MC procedures are needed. So far, including about 24,000 VMMCs planned for COP 2018/FY19, about 176,673, (118,042 indigenous; 58,637, refugees) have been circumcised in Gambella region, or 65% of the target.

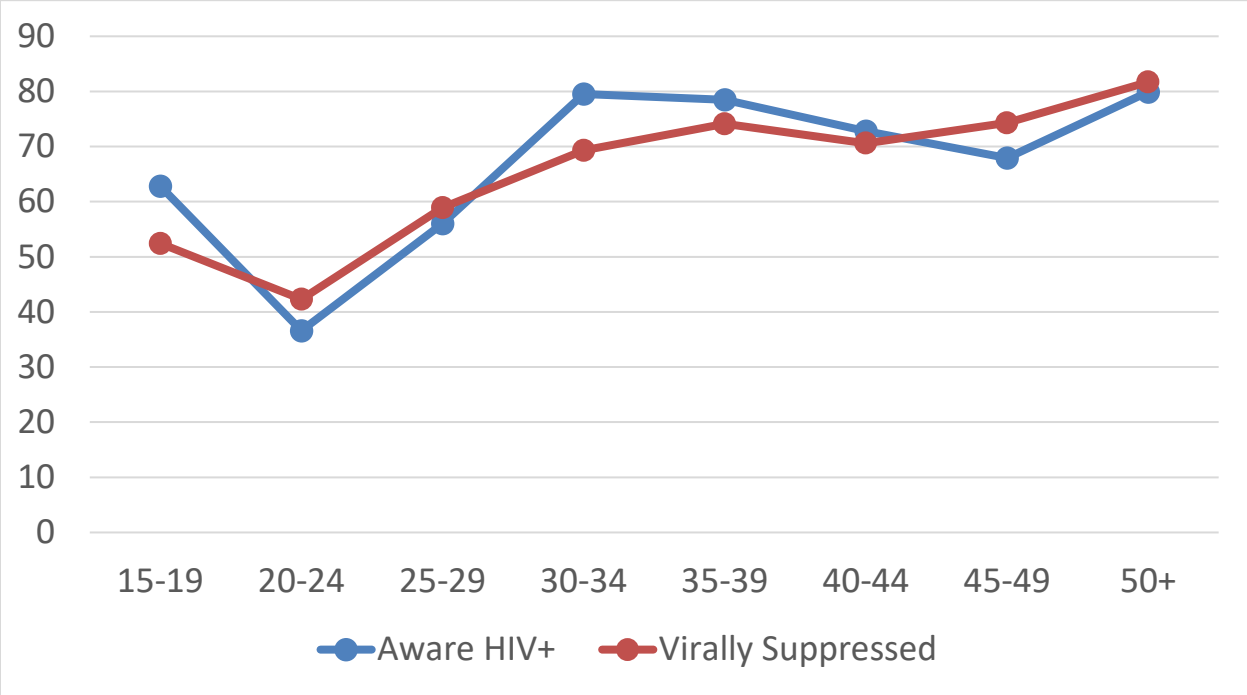
PEPFAR-E focus on 15-29 year olds and older age groups who are sexually active and will benefit from preventive effect of VMMC. The total VMMC eligible male population aged 15-29 in Gambella, including both host and refugee community is estimated at 126,186. This accounts for 42% of male population aged 10-49 eligible for VMMC in the region. Out of the total population aged 15-29 who needs VMMC services, 86,742 has already been circumcised which is 69% average VMMC saturation in the region. Therefore, to reach 90% saturation PEPFAR-E will need to support circumcisions for an additional 30,000 men in the age group 15-29, alone.

3.2 Geographic and Population Saturation, COP19

Table 3.3, depict regional prioritization for COP19 for DSD and TA with focus on the five regions of Oromia, Addis Ababa, SNNPR, Amhara and Gambella. All other regions will receive TA for maintaining the cohort and strengthening systems to sustain epidemic control. TA regions will receive targets across the clinical cascade and will be supported by the central institutions and agencies of the FMOH. Within the prioritized geographies, there are significant gaps in finding pediatric, adolescent/young adult, and adult male cases. Programmatic data of ART coverage by age and sex reveals significant gaps among pediatrics, adolescents and adults >50 years. (Figure 3.1). The EPHIA survey highlights the significant challenge with status awareness and VL suppression are in the younger age groups (Figure 3.1). While the epidemic is largely concentrated among PLHIV ages 35+, there is a rapidly expanding youth bulge in Ethiopia with low rates of detection and suppression, indicating that the program needs to prioritize these younger age groups. EPHIA found a low HIV prevalence of 0.3% among children 0-14 years old and an estimated 19,000 children living with HIV in urban areas. Despite the low burden among this age group, programmatic performance data suggests a critical need to improve the clinical cascade with an intensified focus on pediatric case finding.

EPHIA results also refocus the program on men, ages 15-64, as there are significant differences across the cascade between males and females with 59% unconditional VL suppression among males as compared to nearly 66% among females (See Figure 3.2, Overall EPHIA Cascade)

Figure 3.1. EPHIA: Awareness of HIV Status and VL Suppression, by 5-Year Age Bands



Therefore, finding and linking men to treatment will be a major area of focus in Addis Ababa and the other four service-delivery regions. The KP program targets FSWs and their clients and will remain a focus for DSD regions but will use refined active case finding approaches such as ICT and SNS for greater efficiency. There will also be a focus on expanding access to PrEP in sub-populations of FSW with high risk of HIV acquisition.

Among women, program data indicates significant gaps and among widowed, divorced (or separated) females at the higher end of the age spectrum, together with AGYW involved in transactional sex. Special attention will be given to the 9-14 year age groups for both girls and boys.

In addition to these areas of emphasis, PEPFAR/E will continue implementation of "Operation AAA" (Addis Ababa Acceleration) in order to ensure and sustain attainment in Addis Ababa, which has significantly lagged behind the rest of the country in exceeding 90-90-90 targets. Operation AAA focuses on case finding, strengthening the links between facilities and community programs and capitalizing on the work of UHEWs to facilitate those linkages. The involvement of the UHEWs, a relatively new cadre under the FMOH, is a critical element in ensuring sustainability of epidemic control in Addis Ababa and in other urban areas. They assist in tracking index case contacts, provide assisted HIVST and counseling services, facilitate linkage to community care groups and help in tracking and returning lost to follow-up (LTFU) patients to treatment.

3.3 Expected Impact of Prioritization for Reaching Sustained Epidemic Control

Efforts to maximize focus on optimized case-finding geographically and within population groups will support nationwide achievement of 85% population level coverage with ART by the end of COP19 implementation (555,916/649,271), and situate the program to reach well above the 90-90-90 target in COP20. Reaching targets in Addis and its environs outside of the city limits in greater

Oromia will make a significant impact on dent in HIV transmission, with benefits to the resident population and beyond.

Table 3.3 Current Status and projected gap for ART saturation, by service delivery and non-service delivery regions

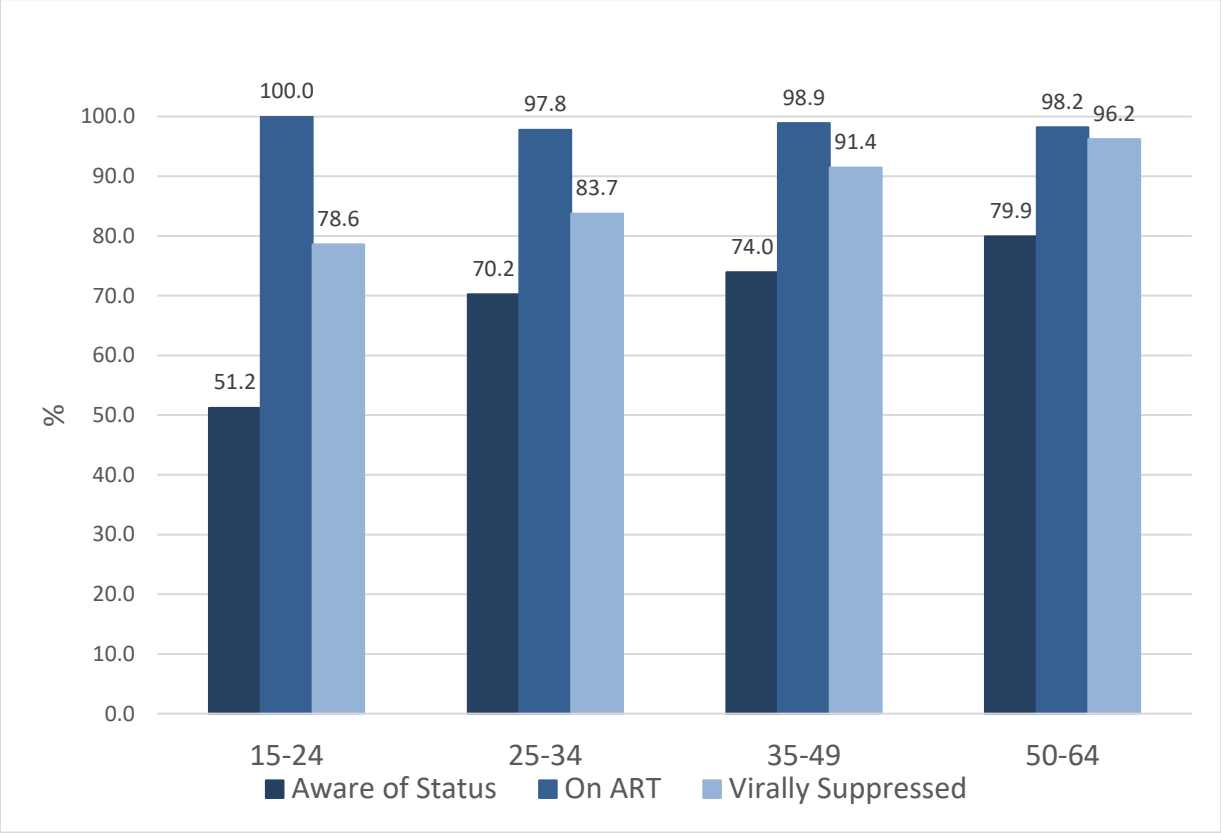
Region	PLHIV Est.			TXCURR		% of PLHIV Est on ART by APR19	95-95-95 target	COP19 Gap to 95-95-95	COP19 Target
	COP18	EPHIA*	Spectrum 2019	2018 APR	COP18 Target				
Service Delivery and TA									
Addis Ababa	109,201	68,586	96,685	95,063	100,699	104%	87,258	26,057	123875
Amhara	186,298	104,221	184,619	138,691	147,504	80%	166,619	19,115	159022
Gambella	12,401	5,754	13,889	8,390	10,152	73%	12,535	2,383	11513
Oromia	157,820	113,507	178,986	111,576	123,695	69%	161,535	37,840	131623
SNNPR	57,208	41,688	70,799	35,047	38,947	55%	63,896	24,949	43807
Military Ethiopia				8,318	10,714				9924
Non-Service Delivery, TA only									
Somali	5,842	5,475	6,456	2,103	2,679	41%	5,827	3,148	2671
Afar	13,109	10,077	14,578	4,364	6,420	44%	13,157	6,737	8037
Harari	4,310	4,245	5,521	4,373	4,494	81%	4,983	489	4598
Benishangul-Gumuz	5,362	4,086	7,114	4,494	4,589	65%	6,420	1,831	4729
Dire Dawa	10,481	9,081	12,103	6,680	7,725	64%	10,923	3,198	8547
Tigray	51,771	26,278	58,521	41,638	46,772	80%	52,815	6,043	47570
National Total	**613,803**	**392,998**	**649,271**	**460,737**	**504,390**	**78%**	**585,967**	**131,789**	**555,916**

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

4.1 Finding the missing, getting them on treatment, and retaining them ensuring VL suppression

The EPHIA demonstrates that case finding is the major barrier to epidemic control and once patients are diagnosed, nearly all are initiated on ART and prevalence of VL suppression is high. Within the 15-24 and 25-34 age-bands, there are challenges with VL suppression.

Fig. Figure 4.1 Conditional Cascade (90-90-90) by Age Band, EPHIA



As per Table 3.3, PEPFAR-E will support targeting across both service-delivery and non-service delivery (TA-only) regions.

Table 4.1 : Cascade Targets by Region, COP19

Region	HTS_TST (Number of individuals tested)	HTS_TST_POS (Number of Positives identified)	TX_NEW	TX_CURR	TX_PVLS N	TX_PVLS D
Addis Ababa	167,036	14,439	14,659	123,664	99,675	109,826
Amhara	192,322	11,851	12,774	159,228	129,128	143,308
Oromia	498,697	28,439	26689	142,825	109831	121,583
SNNPR	92,293	5,650	5,600	44,002	34865	38,617
Gambella	48,277	1,348	1,382	11,512	9,191	10,196

Military Ethiopia	12,330	607	535	9,450	8,196	9,877
Tigray	44,252	2,696	2,933	47,575	39,026	43,294
Dire Dawa	8,750	547	566	8,634	6,961	7,744
Harari	4,562	303	292	4,606	3,763	4,176
Afar	7,650	608	644	8,034	6,551	7,263
Benishangul-Gumuz	3,937	306	246	4,729	3,867	4,255
Somali	3,148	280	192	2,686	2,217	2,433
Total	**1,083,254**	**67,074**	**66,512**	**566,945**	**453,271**	**502,572**

Case Finding

Given that case finding is the critical barrier to reaching epidemic control, a major component of service delivery efforts in COP19 will focus on active case finding using ICT (minimum 20% yields), optimizing PITC (minimum 10% yield), and assisted HIVST. Other approaches, such as provider-initiated partner notification services (PNS), unassisted HIVST and social network testing (SNT) using recently identified PLHIV as "seeds" will be among some of the innovations pursued in COP19, together with the already FMOH-adopted initiatives for active case finding.

ICT and PNS

Historically, the HIV program has supported passive approaches to index case partner elicitation through a family-based approach, targeting married spouses and biological children. With a new active approach implemented in COP17, yields are now at 7.5% from ICT, with assisted partner services realizing yields above 20%, including non-spousal partners. Among children, ICT is the highest yielding modality at 2.3% as of FY19Q1. In COP19, PEPFAR-E will fully implement ICT & PNS across facilities and with more intensity, using line-lists generated from EMRs to achieve a +20% yield among adults and +2% yield among children. ICT will contribute 50% to the total HTS_TST detected in COP19 and will be the primary modality for PEPFAR support.

ICT/PNS prioritization for the following PLHIV

(1.) Current and past partners of all newly identified positives not initiated on treatment, (2.) biological children of all new identified positives, (3.) parent(s) of index children (if the index case is child), (4.) current and past partners of all TX_CURR with high VL, (5.) current and past partners of all TX_CURR LTFU who are tracked and brought back into care and treatment.

Geographically, Addis Ababa and the other four service-delivery supported regions remain the top priority for investment in case-finding, especially scaling ICT with fidelity.

Facility-initiated ICT, at scale, depends heavily on a reinforced interface between facility and community-based partners. This will be aided by clear workflows (see example, Figure XX), standard operating procedures (SOPs), partner mapping, and weekly performance reviews and information sharing within and across catchment areas, all of which are under development during COP18 implementation.

KPs

Among KPs, where FY19Q1 yield was 12.2% among FSWs, PPs and their contacts, PEPFAR-E will continue to scale-up ICT and PNS for FSWs, partners, and clients. Currently, in addition to 80 public sites providing KP-friendly services, 14 drop in centers (DICs) provide FSWs with confidential and friendly-services which are tailored to their specific needs. New cases identified from both public sites and DICs will be counseled to elicit additional sexual contacts, or supported to serve as "seeds" for SNT (see below). Targeted community outreach testing will be used to reach KPs that prefer to get services in their vicinity and in towns where there are no DICs. This will include hard-to-reach KPs & PPs i.e. the clients of SWs, men, and at-risk out-of- school adolescent girls.

Other PITC

While historically producing a high volume of positives with low yield and at a low cost per positive, optimizing PITC will be another priority in COP19. With an Annual Progress Report (APR) PITC yield of 0.8%, rigorous deployment of the recently FMOH-approved adult risk screening tool, together with workflow engineering and staffing considerations at high volume sites, will be critical factors for successful achievement of >10% yield through this modality. Validation of the HIV risk screening tools in outpatient department (OPD) settings to improve testing efficiency will be another priority activity in COP18/19.

SNT

With yields of +20% from initial pilot sites engaged in COP18 implementation, SNT is proving to be an efficient approach for breaking into networks among FSWs, and will be expanded into multiple target groups starting in COP18 and into COP19 for reaching adolescents/young adults and men. This will be implemented in all five priority regions and deployed from both public facilities and DICs.

HIVST

Starting with COP18, assisted HIVST will be scaled-up in COP19 to reinforce ICT across the community-facility interface with HIVST as a screening test and confirmatory testing at facilities. Accordingly, assisted HIVST will be expanded across all 5 priority service delivery regions, targeting FSWs, sero-discordant couples, and men. While not part of the FMOH guidelines, to-date, it is anticipated that unassisted HIVST may increase access even further, and a pilot will be pursued in COP19.

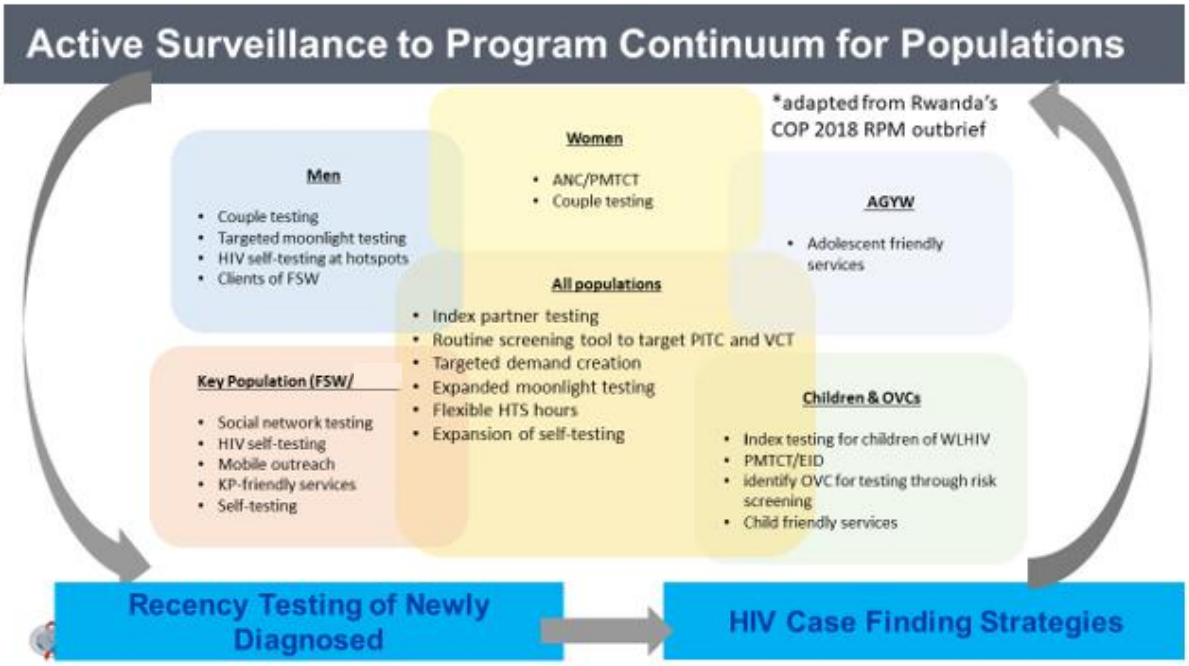
In addition to expansion of modalities for active case finding, operationally, there are several new initiatives to improve case finding and the entire clinical cascade in COP18/COP19. These include:

1. FMOH's endorsement of use of the UHEWs/family health team platform in Addis Ababa and other urban settings for accelerating case finding.

2. Expanded use of electronic medical record (EMR) databases from site level to generate line-lists for ICT, LTFU, high VL, that are shared within and between facilities, and across community-facility partnerships on a weekly basis to ensure strong collaboration and timely use of patient-level data for active case-finding.

3. Demand creation and service customization for population groups with gaps in ART saturation. Specifically, this will target adolescents/young adults, adult men, and adults ages 50+. Interventions will include flexible working hours on evenings and weekends, stigma reduction, sensitization of service providers, optimizing risk-based screening and ICT from dedicated sexually transmitted infection (STI) and TB clinics, information, education, ad communication (IEC) in adult ART settings to generate awareness and demand for pediatric and adolescent testing, and enhanced use of risk screening and testing among OVC.

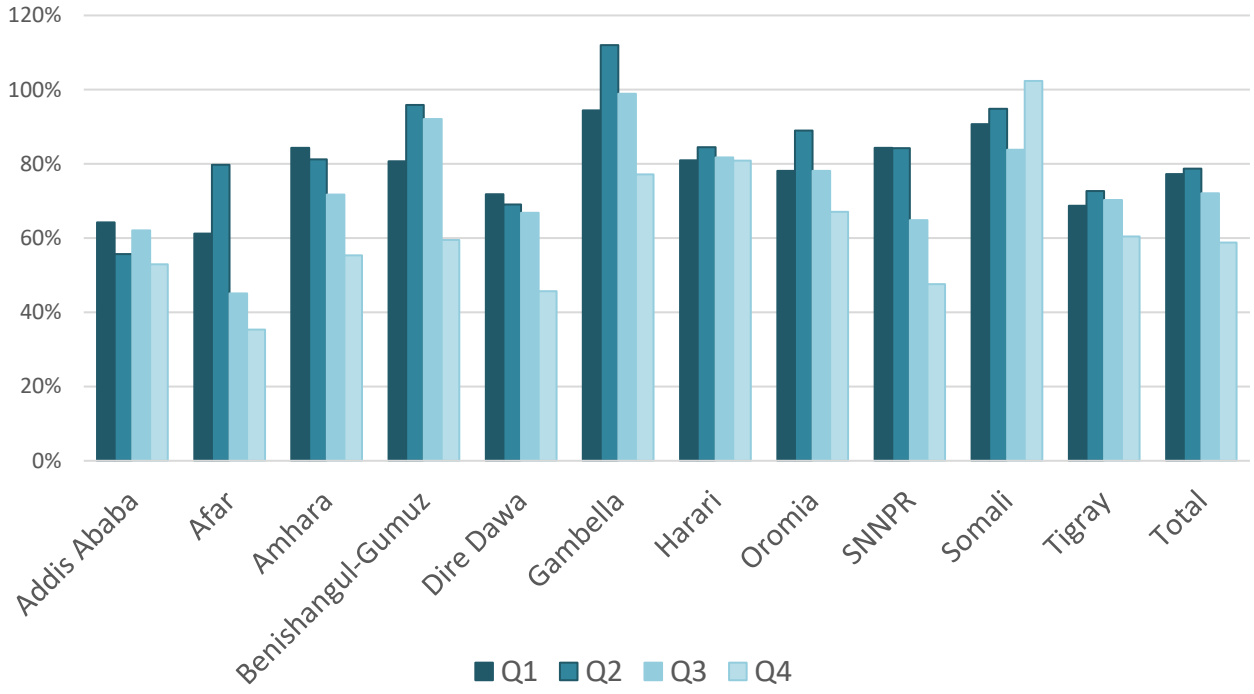
4. Case-based reporting (CBR) and using the Recency Assay to determine recent chains of transmission will empower the national program with more information for programmatic and public health action (see figure below). In COP19, PEPFAR-E will continue building on the national scale-up of CBR and ultimately implement CBS for monitoring of sentinel events of the cohort on treatment. This will reinforce active case finding approaches deployed from facilities, public, private and NGO, including (DICs). With the planned endorsement of the new national guideline for HIV CBS and response, all sites will be enrolled into public health emergency management (PHEM) system for reporting on new cases of HIV as a nationally-notifiable condition.



Initiation

Test and start with same-day initiation (where clinically indicated) is fully embraced in FMOH guidelines (2018) and is scaled across all facilities; linkage audits indicate strong programmatic performance with linking patients to treatment, further validated by EPHIA results across all regions. (Figure 4.2) Optimization of ART is underway and includes the introduction of dolutegravir, lower dose Efavirenz (EFV), and phase out of Nevirapine (NVP).

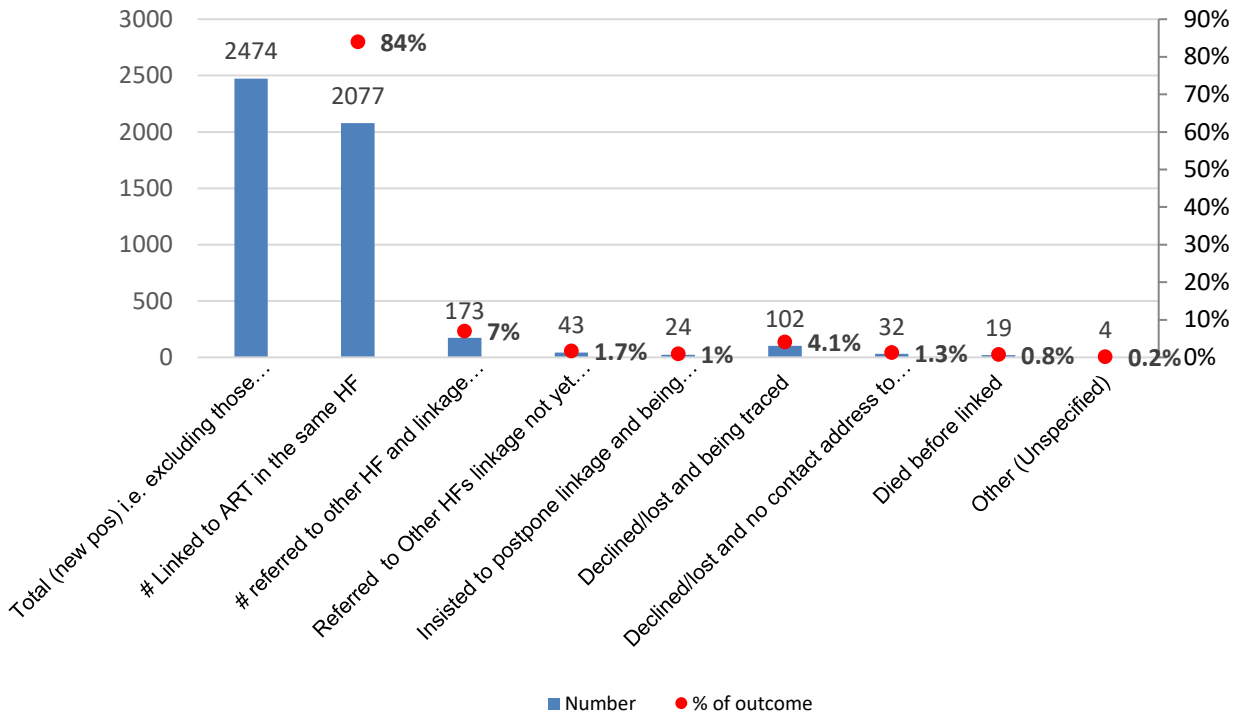
Figure 4.2. Proxy Linkage, by Region, by Quarter, FY18



For APR18, proxy linkage was at 71% (vs. target of 89%) but this is in stark contrast to EPHIA findings. For COP19, the linkage target is 95.5% and to achieve this the program will be shifting to measuring patient-level linkage as EMR deployment and use expands across ART sites.

Linkage and retention performance is especially of concern in Addis Ababa where VL suppression at the population level is low and younger age groups that are sexually active have lower rates of VL suppression.

Fig 4.3: Linkage Audit and Tracking of Newly-Identified HIV Cases at 25 Sites of Oromia Regional Health Bureau, FY18



In COP19, real-time use of patient-data for tracking from positive tracking registers will be accompanied with innovations like 1-to-1 accompanied referrals and enhanced counseling by facility- and community-based peers. Routine site-level and woreda/sub-city level performance reviews will create enabling environment for rigorous data use and information sharing across facility-community interface.

With relatively strong performance initiating patients on ART, renewed efforts are still required to improve initiation on treatment in COP19, especially to meet gaps in saturation among pediatrics, adolescents, young adults and adult men:

1. Customization of friendly, accessible services based on population preferences and needs, ranging from facility operations to demand generation targeting parents and current PLHIV and their partners.

2. Improved SOPs for tracking patients all the way to initiation within and across facilities providing ART. Positive tracking registers were deployed in FY18 and expanded deployment across facilities and joint use by community partners will reinforce tracking of patients across the community-facility interface. An SOP for the referral of clients will be used to standardize and strengthen the flow of clients among service delivery points.

3. Children and OVC: Provision of comprehensive services to the HIV exposed /infected children and adolescents including: (1) early infant HIV diagnosis (EID) and enrollment into care; (2) growth monitoring and developmental assessment; (3) counseling on infant feeding; (4) co-trimoxazole preventive therapy (CPT); (5) TB risk assessment; (6) early

diagnosis and treatment of opportunistic infections (OIs). Transition of all infants and children to optimized pediatric antiretroviral (ARV) case regimen and child friendly formulations as well as transitioning to TLD for adolescents >10 year. Strengthen linkages and bidirectional referrals between local OVC program & facilities providing Pediatric HIV services. Building health care worker (HCW) capacity and regular mentoring to improve quality of Pediatric care and treatment services.

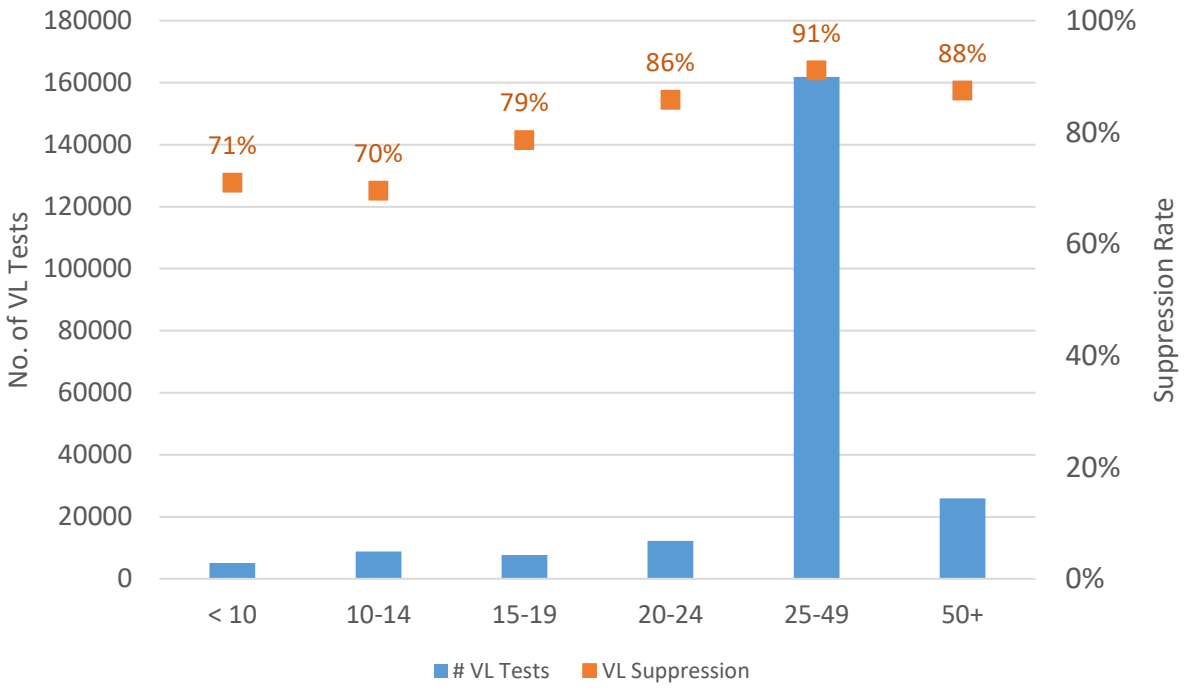
4. Expansion of differentiated service delivery models (DSDM) for stable patients will reduce waiting times and improve access for PLHIV newly initiating on treatment

Retention

The benefits of ART at individual and community levels is dependent on adequate levels of adherence and retention. Based on EPHIA results (Fig. 4.1 Conditional Cascade by Age-Band), PEPFAR Ethiopia will concentrate efforts to improve adherence and retention among newly initiated PLHIV, particularly men and 50+ age group. Coupled with optimization of ART regimens, PEPFAR-E will ensure adherence, retention and VL suppression by improving (1) patient monitoring, (2) lab-clinic interface, (3) patient- centered approaches for enhanced adherence support, (4) collaborations between facility-community actors to trace clients LTFU and (5) expansion of differentiated service delivery approaches.

Program data from APR18 further illustrates the performance deficits in VL suppression among these younger age groups.

Fig 4.5: Viral Load Suppression by Age, FY18



Patient Monitoring

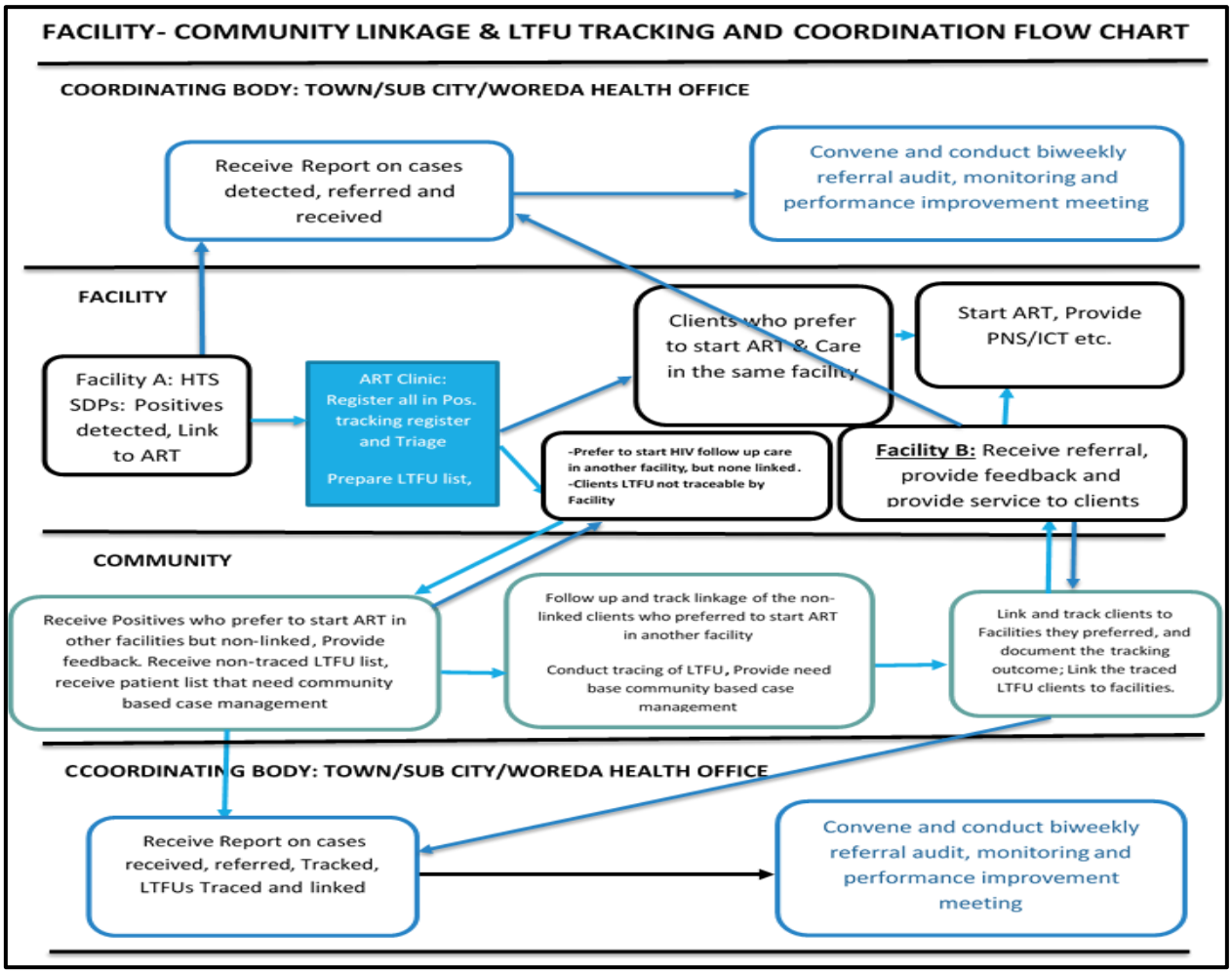
There are significant challenges in ascertaining whether clients who have been started on life-long ART are optimally adherent to their prescribed ARV regimens, and the level of attrition from the program (from death or LTFU). As CBS moves to phase II, tracking longitudinal events across a patient's life-course, the quality of information on patient adherence and retention will improve.

Lab-Clinic Interface

Strengthening the use of routine VL testing for monitoring clients on ART is vital to ensuring adequate viral suppression rates among the treatment cohort. Demand creation among parents and providers will be especially critical for improving VL coverage for pediatrics and adolescents, as with all other age/sex bands. Prompt communication and action by clinicians for those clients who have a detectable or high VL will be enhanced. This will be enabled by improved information exchange between VL databases and electronic medical records through PEPFAR HIS investments to move to CBS. Improved placement of test-orders and rapid return of results will enhance clinical case management and monitoring of population-level VL suppression. Viremia clinic days will be established in high volume facilities to improve management of clients with high VL.

Enhanced Adherence Support

Both the facility and the community will implement peer-to-peer support for awareness creation, providing literacy on HIV treatment and healthy living, and early identification and tracking of defaulters. One-to-one peer support at the initiation on ART will be provided, particularly among newly identified men. In order to combat false beliefs and negative messaging around HIV and the use of ART for HIV treatment, FBOs will be engaged. They will provide spiritual and psychosocial support to PLHIVs, encourage partner testing, promote positive living with HIV, and reinforcing messaging on adherence ART. Among adolescents, efforts will be made through the adaptation of Kenya's Operation Triple Zero to improve adherence/retention. Finally, stigma and discrimination reduction will continue to be integral to all partners' efforts.



Facility-Community Interface

Through standardized operating procedure that strengthens data sharing and use across facility- and community-based actors, PEPFAR-E will improve LTFU tracking and return to care and treatment. Facilities will generate line-lists of patients LTFU and conduct follow-up by phone while also sharing these line-lists with community-based partners which will follow-up with these clients in the community. Through routine performance reviews and information sharing, line-lists on patients LTFU will be updated and new lists shared for tracing up.

Differentiated Service Delivery

Reinforcing DSDM for stable patients is critical for relieving pressures on facility-based personnel so that they can provide quality enhanced adherence support and client monitoring for unstable patients. Appointment spacing model (ASM) will be strengthened and additional models including fast-track pharmacy refill and health worker managed community ART refill groups will be scaled-up. The activity will also be supported through community ART adherence groups.

4.2 Prevention, specifically detailing programs for priority programming

4.2a Orphans and Vulnerable Children

PEPFAR's support for OVC in has the goal of improving the health and well-being outcomes for OVC and enable OVCs to utilize services for improving HIV and AIDS care, health, nutrition, economic security, education, protection, and psychosocial wellbeing. In FY20, OVC program will work in 122 woredas/towns, 812 Kebeles in Amhara, Oromia, SNNPR, Tigray, Addis Ababa and Dire Dawa to serve 298,484 OVC and their caregivers. It will contribute to HIV prevention and treatment outcomes as well as mitigate the impact of HIV by supporting 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.

To control the epidemic among AGYW and children, the program will use evidence-based approaches to address the structural drivers that increase HIV risk. Hence comprehensive HIV services including HIV prevention and gender based violence (GBV) will be provided for high risk AGYW and children of 9-14 year old boys and girls.

Accordingly, the OVC program will work on a comprehensive package of social, economic and biomedical interventions to reduce vulnerability to HIV. The program will use a multi-faceted, integrated response from the health, education, psychosocial, economic and civil society/community sectors.

The OVC program will work to build the social asset of vulnerable AGYW who usually lack social networks to empower them. Hence, adolescents will be linked to community and facility based services to address their needs. To change risky sexual behavior among youth through delayed sexual debut or condom use, and prevent violence and abuse, the program will increase caregivers' knowledge, skills, and confidence to talk to their children about sexual health. As gender disparities and GBV increase women's and girls' vulnerability to HIV due to multiple factors, including limited ability to negotiate safer sex, engaging in transactional sex, disclose and access HIV treatment because of fear of violence and abandonment, the program will work on primary prevention strategies based on curriculum to be adopted on healthy and unhealthy relationships, healthy choice about sex, and understanding non-commercial sex.

OVC program will work with RHBs to strengthen HIV testing of OVC and caregivers, ensure linkage of positives to treatment services, prioritize HIV exposed infants/infected children for community support, and support HIV-infected children and adolescents with high VL. In addition, coordination with PEPFAR-supported and other community social and nutrition support programs will be strengthened to ensure HIV-exposed/infected children and their families will be linked to appropriate services based on their needs. In addition, the program will promote key interventions to improve current low VL suppression rates in children and adolescents.

The capacity of government, CSOs, FBOs at national, regional, and community-based levels will be built to facilitate access to quality services for OVCs by strengthening social services system including workforce development and support smooth transition of OVC program to LIPs. Technical and Vocational Education Training (TVET) will be supported to complete training and deployment of social workers to support OVC program, and sustainably institutionalize the training; LIPs and FBOs will be supported to institutionalize HIV and violence prevention training

and support for community case managers and social service cadres; and strengthening MOLSA, MOWCYA and HAPCO in rolling out the National/regional CCC Guideline, National plan of Action for children and Child policy, Social protection implementation strategy to regions, Woredas & Kebele/CCCs will be continued.

The facility-based HIV prevention for AGYW and children program mainly focus on risk screening for HIV and GBV; provision of HIV and GBV prevention services; post violence services for GBV survivors; adherence; disclosure support and continuum of care services for PLHIV adolescent and youth in PEPFAR supported health facilities.

To provide the GOE, PEPFAR and other stakeholders with critical data on violence against children and youth and to inform implementation of programs to prevent violence and respond to the needs of its survivor's, survey on Violence against Children Survey (VACS) will be conducted in COP19. Cross-sectional household survey of 13 to 24 year old females and males, designed to produce national-level estimates of experiences of physical, sexual, and emotional violence in childhood and in the past 12 months. VACs will address a range of issues including childhood marriage, teen pregnancy, gender attitude, violence victimization, HIV, etc. VACS data will be used to inform policy and programmatic efforts in Ethiopia. GOE, PEPFAR and its IPs are committed to working together to ensure the highest quality survey and use of VACS data to support policy and program changes to reduce incidence of violence and HIV in Ethiopia. VACs data will be used across programs including OVC, youth and gender program activities and HIV clinical platform for improved screening, linkage and service provision of survivors of violence.

4.2b Key Populations

Ethiopia's National HIV Prevention Road Map 2018-2020 is aligned with the national HIV/AIDS Strategic Plan 2015-2020 and with global recommendations. In this road map, Ethiopia has defined its KP and PP groups taking local epidemiology into consideration. The KPs are FSWs. PPs are prisoners, widowed, separated or divorced women; distance drivers; PLHIV and their partners; mobile and resident workers in hotspot areas, young women involved in transactional sex, and vulnerable AGYW. These population groups have high risk of HIV infection, limited access to services, and some face stigma and discrimination. There are an estimated 210, 967 FSWs in Ethiopia as per the size estimates conducted by PSI and EPHI.

In order to reduce the spread of HIV and to reach sustained epidemic control in Ethiopia, improving access and friendliness of HIV services for KP and PP remain crucial. However, reaching target populations such as non-self-identified SWs, part-time SWs, young girls who are new entrants to commercial sex work and men is complex.

In COP19, PEPFAR will support HIV services for KP in selected friendly public health facilities in the service delivery regions. This approach is one of the sustainable models aimed at promoting GOE ownership. Hence, we will strengthen HIV services for FSWs at the KP friendly public health facilities. In-order to increase case identification and improve yield among FSWs and their partners, new testing approaches including SNT, HIVST, ICT/PNS, and recency testing will be implemented.

Children and partners of FSW will also be tested and, if found to be HIV positive, they will be linked and enrolled in treatment. Adult men with higher risk of HIV infection will also be reached through ICT/PNS, and SNT services.

In addition to the KP friendly public health facilities, DICs are located in Addis Ababa and Amhara providing HIV prevention, care and treatment services including family planning, GBV services, harm reduction counselling for substance abuse on site or through referral. The DIC approach is also advocated by WHO as a differentiated model of care that works for FSWs, to improve rates of testing and linkage to care. In FY 20, the activity will continue providing comprehensive HIV services in the community in 116 SNUs in Amhara and Addis Ababa; out of which only 14 SNUs have a DIC. Facility based HIV services will be provided to FSWs, sex partners and eligible children in selected public health facilities with in major towns of Amhara, Addis Ababa, Oromia, SNNPR and Gambella and will track the full clinical cascade from detection to VL suppression.

Stratification of PP to identify those at higher risk will continue in order to maximize yield from testing. PPs such as the clients of FSWs, truck drivers and young women involved in transactional sex will be reached with tailored interventions to minimize risk of infection and increase access to HIV testing services (HTS). Community mobilizers will reach FSWs and PPs with the minimum package of prevention services in the community and link PPs and high risk FSWs to HTS. Community based providers will accompany HIV positive clients to ART services.

Linkage to ART services for HIV positives using patient level tracking will be a key part of COP19. Regular linkage auditing using facility-community collaboration SOP will be implemented. Same day ART initiation, disclosure, adherence support and tracking of LTFU up clients will be conducted. VL testing will be done for HIV positive clients in care as per the national guideline and will work to achieve optimum VL suppression.

Counselling services will be provided for HIV negative clients to remain negative and provision of PrEP will be used as one strategy to reduce HIV transmission. The 2018 national comprehensive HIV care guideline recommends PrEP for clients as substantial risk of HIV infection or incidence rate of three or more, and eligible clients for the PrEP services include FSWs and discordant couples. The GOE has shown interest in expanding PrEP to FSW and other high risk population groups. Currently the PrEP services have started in 9 public health facilities and 5 DICs for FSWs. In COP 19 PrEP will be rolled out to additional sites.

The Ethiopia PEPFAR team has successfully improved targeted HIV case finding among FSWs, increasing yields from approximately 3% through traditional outreach to a yield of 12.2% through ICT and partner services, and approximately 20% through SNT through Q1, FY19. These strategies, now being rolled out, have allowed the program to reach higher risk FSW who are eligible for PrEP, and have led to enrollment of newly diagnosed FSW into ART, and reengagement of HIV-positive FSW who have fallen out of care. The team is also planning to offer PrEP and enroll HIV-negative partners in sero-discordant relationships where the HIV+ partner has not yet achieved VL suppression. At risk AGYWs will be reached with HTS services and targets have been set in PP_PREV indicator in COP19, which will support identification of high AGYW that may be engaged in sex work or transactional sex that would benefit from potential enrollment in PrEP. Risk screening will be performed among AGYW with standardized questions (e.g. number of sex partners, unprotected sex, STIs, etc.), including transactional sex.

4.2c VMMC

Starting in COP 2019, Centers for Disease Control (CDC) will expand services to refugee communities and intensify routine VMMC activities among the native Gambella and refugee population focusing on age group 15-29 and older. The total COP 2019 VMMC target is 40,000 MC procedures (nearly twice COP 2018 target) which will be implemented in 15 static, 28 outreach sites and all refugee camps in the region. PEPFAR-E will support direct implementation of VMMC activities for the first time in Gambella, without sub-granting as was done in previous COPs, thereby ensuring program efficiency and effectiveness. To meet COP2019 VMMC targets, the prime partner will organize and conduct year round back to back VMMC campaigns in 28 outreach sites and all refugee camps. Additional VMMC staff will be hired, trained and deployed by the partner to address the VMMC backlog in the refugee camps. New recruits are screened for MC upon entry using basic military training center registers. Due to the intense military training program and overlap of activities, approximately 15,000 trainees were graduated without being circumcised. The military provides free medical service to its members and dependents, thus the backlog also includes children of active duty military personnel with age band of 10-14.All needed VMMC supplies including reusable VMMC kits, consumables and equipment for emergency management of adverse events will be procured and distributed. As demand for VMMC among refugee is relatively low, there will be efforts to increase awareness level and services uptake. Community mobilizers, local government, community and religious leaders will be involved in awareness creation and VMMC client mobilization activities.

The military VMMC program conducts VMMC among new recruits every year, among which 15% are uncircumcised. This accounts for 2,500 uncircumcised men every year. Until end of FY'18, Military VMMC program has conducted 19, 228 VMMC procedures. For COP'19, the Military VMMC program will have a total target of 4,803 VMMC procedures. The target is categorized with age bands of 10-14, 15-29 & 30+ with specific age band target of 1151, 3540 & 12 men within the military, respectively.

The military VMMC program data shows backlogs of about 15,000 uncircumcised men who missed the VMMC service opportunities. The targeted military populations are new military recruits, male children of active duty military personnel who are eligible for VMMC and older active duty male military personnel who may have missed pervious VMMC opportunities.

The Military VMMC program will be implemented in two Military training centers and six referral hospitals across different geographic areas in military bases. The strategy of using the new recruit training centers prevents accumulation of uncircumcised military male personnel over the years, which in turn contributes to the epidemic control by averting new infections.

To achieve the above target and prevent the growing pool of uncircumcised individuals within the military, the IP in collaboration with Ethiopian National Defense Force (ENDF) will provide comprehensive and quality VMMC services through 12 VMMC campaigns & 29 mini-campaigns. For the sustainability of the program, the IP will provide basic VMMC trainings, technical supports, mentoring, & supportive supervisions to ENDF health workers. In collaboration with ENDF, the IP will also conduct data quality assessment (DQA).VMMC commodities and supplies such as reusable VMMC kits will be centrally procured & distributed.

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

The following provides details on country specific priorities in the planning level letter that are not addressed in the previous sections.

Post-epidemic control activities

CBS and Recency

In support of nationwide scale-up of CBS, PEFPAR-E will support the national surveillance task force, including RHBs, and will also invest in strengthening open health information exchange between disparate patient-level information systems (EMR and VL databases at reference laboratories) and registries to support unique identification of clients for records matching/patient de-duplication. Testing for recent infections will be scaled nationally as a supplemental test for surveillance purposes conducted after confirmatory testing. Commodities and testing targets for recency have been allocated, accordingly. These efforts parallel the national scale-up of CBS for newly diagnosed HIV as a nationally notifiable condition in the FMOH surveillance guidelines. These efforts are described in more detail in later sections.

Financing

Described in more detail in subsequent sections, PEPFAR-E will expand its support for above-site activities with a dedicated focus on sustainable financing, particularly the strategy for domestic resource mobilization and the legal framework essential for executing this strategy.

Activities to Scale

TPT

PEPFAR Ethiopia will execute aggressive TB preventive therapy scale-up for 197,181 PLHIV. This includes the introduction of 3HP treatment for 10% of the TPT target. The remainder will be provided with isonicotinylhydrazide (INH). Achievement of this target will depend on aggressive record review, optimizing the EMR information, and conducting active, monthly patient follow-up to ensure provision of TPT for existing patients until completion of therapy. For new patients, there will be efforts to improve sensitization of providers and patients, while conducting monthly tracking of TPT uptake and completion among newly initiated clients on a routine basis. Furthermore, PEPFAR-E will work with the national program to integrate adherence support, TB screening and pharmacovigilance activities with TPT interventions while also pursuing harmonization of TPT provision and monitoring with the ASM, and with facilities' individual quality management/improvement activities.

TLD/Dolutegravir (DTG) transition

The FMOH has recognized the necessity of transitioning patients off of an inferior regimen and is leading efforts to accelerate NVP phase-out to TLD with United States Government (USG) and GFATM support. This timeline has been accelerated by 8 months and only 6% of cohort will be remaining on NVP as of September 2019. Also, transition for all patients on TLE to TLD will be

completed during COP19 implementation. This effort requires close coordination between FMOH, GFATM and PEPFAR to ensure adequate availability of the new regimens, in-country, for support of the accelerated treatment coverage towards exceeding 90-90-90.

Gambella

In addition to an aggressive effort to clear the VMMC backlog in Gambella Region, PEPFAR-E will follow the lead of government policy established in 2018 whereby refugee populations are mainstreamed with host-community populations for service delivery. Accordingly, PEPFAR-E will be consolidating to one service-delivery partner for comprehensive facility-initiated testing, care and treatment services in both host and refugee communities. Simultaneously, this partner will also provide TA to RHBs with above-site support for systems strengthening and capacity-building to lead the epidemic response.

Activities to Discontinue or Reduce in Funding

OVC
Targets for OVC will decrease overall due to reduction in deaths. New targets will be established for AGYW, and increased focus on OVC ages 9-14 years. PEPFAR-E will continue to plan with the government to transition the OVC program. Specifically, this first entails directing 40 percent of the PEPFAR funding to "indigenous" organizations. In COP19, 50% of OVC funding will go to local organizations; seven LIPs will transfer from sub-grantees to direct recipients of PEPFAR assistance. Also, the OVC program will transition out of non-service delivery regions of Tigray and Dire Dawa by the end of COP19.

ENDF
Direct support to ENDF will end during COP19 with support for TA targets provided through agreements with FHAPCO/FMOH and EPHI. Limited assistance for VMMC among military personnel will continue in COP19.

Federal Prisons
Like ENDF, PEPFAR direct to Federal Prisons will end during COP19 with support for TA targets provided through agreements with FHAPCO/FMOH and EPHI.
Above Site Activities

In COP19, PEPFAR-E will not be supporting new construction, evaluations, operational research, workforce development or pre-service training.

Management and Operations (M&O)
Agencies have reduced their M&O budgets in COP19 in accordance with COP19 planning level guidance and are assessing current workforce compositions to ensure adequate support for LIPs and for a post-epidemic control program.

4.4 Commodities

PEPFAR commodity support has been limited to provision of VL lab reagents, EID, limited numbers of rapid test kits (RTKs) and HIVST kits and condoms (through the USAID-managed "condom fund"). In COP 19, PEPFAR will procure recency tests sufficient to cover HTS_POS targets. All

other HIV commodities have been purchased through the GFATM grant to Ethiopia. Two issues have arisen which will change that in COP 19 and the out years. In discussions with the GFATM this year, it has become clear that there is a mismatch between GFATM planning and PEPFAR treatment targets. The GFATM has planned to provide sufficient ARV stocks to treat 480,000 people (lately updated to 500,000), while PEPFAR treatment targets for COP 19 are set at 555,000. In addition, PEPFAR requirements for an accelerated phase out of NVP-containing ARVs has created an additional gap as about 130,000 people will move from NVP-based regimens to TLD or TLE400 about six months ahead of what had originally been planned. The GFATM has agreed to forward fund additional purchases of TLD and other required ARVs to cover the short-term gap created by the accelerated NVP phase out with the understanding that if there are not additional GFATM resources made available for ARV procurement, PEPFAR will provide funding to cover the gap. The total estimated gap is about $10M. The Ethiopia team has budgeted $1.1M for TLD purchases in its COP 18 plus-up proposal, and an additional $1.1M in its COP 19 plan to begin covering the gap. For the balance not funded by the GFATM, resources will need to be identified in COP 20.

In addition, in COP 19, PEPFAR/E will procure approximately 12,000 doses of 3HP to facilitate its introduction into Ethiopia as the preferred TB Preventive Therapy (TPT), replacing INH. A condition for this purchase is that the cost of 3HP must drop to $15 or less per course of treatment. Reviewing the current INH stock situation and planned GFATM procurements of INH through COP 19, it has been determined that there are sufficient stocks of INH either on hand or in the pipeline to allow achievement of both PEPFAR-E and National TB Program (NTP) targets for TPT.

4.5 Collaboration, Integration and Monitoring

4.5a Strengthening cross technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH

The PEPFAR Ethiopia team is committed to strengthening interagency relationships and collaboration across program areas among all stakeholders. Internal TWGs have been reorganized to better reflect Ethiopia's movement toward epidemic control and the consequent evolution of the PEPFAR program away from DSD and toward a strong TA program. In addition, the PEPFAR/E team has recommitted to revitalization of and full participation in standing national TWGs and ad hoc working groups that have formed or will form around such specific issues as HIVST, PrEP and sustained epidemic control.

Enhanced and strengthened community/facility linkage is a key area for enhanced collaboration across the national HIV response. Beginning in Addis Ababa, which is a major focus of both COP 18 and COP 19, collaboration and cooperation are being formalized through the development of a set SOPs and flowcharts which will clearly define the roles of various players and set the parameters for interaction and collaboration among them. With a focus on ICT as the primary case identification modality, it is expected that as the SOPs are developed and refined, they will provide the basis for similar arrangements across PEPFAR-supported geographies and for the national HIV response.

COP 19 will also see the development of leadership and coordination functions at RHBs and nationally through HAPCO. The RHBs will convene and lead quarterly performance review

meetings for all participants in the HIV response. In PEPFAR-supported SNUs, these reviews will reflect PEPFAR's commitment to shared responsibility, accountability, and results. Success will be determined at the SNU level and where partner performance falls short, responsibilities may be redistributed.

4.5b Strengthening IP management and monitoring and the implementation of innovative strategies across the cascade, with fidelity and at scale, to improve impact within shorter time periods.

The PEPFAR/E team is closely examining IP management practices and refining these to ensure stronger and timelier IP performance, achieve efficiencies and maximize impact.

In addition to the measures described in Section 4.5a, IPs in PEPFAR-supported regions partner fora have been established to facilitate closer communication, early resolution of implementation issues and enhanced collaboration. PEPFAR/E has established interagency Regional Support Teams (RSTs) with broad technical and management representation. These teams will regularly review partner data and will participate in regional performance management meetings convened by the RHBs. The RSTs will conduct remediation planning to address performance gaps and through their regular data reviews will recommend corrective actions necessary to close performance gaps. IPs will be required to report testing, case identification and treatment initiation data by population group on a bi-weekly basis and this data will be closely reviewed by the RSTs to ensure timely action.

4.5C Improving integration of key health system interventions, including HRH and laboratory (VL) activities across the cascade

A number of actions are being taken to enhance the efficiency of VL testing and results reporting, including integration of specimen referral systems for VL, EID, and TB diagnostics; assigning testing labs on a geographic basis rather than by administrative boundaries; formalization of arrangements between labs for the provision of back-up services in cases of equipment down-time; bi-weekly stock reporting for VL commodities; and implementation of electronic test ordering and results delivery in high volume facilities through an EMR/VL database interface.

PEPFAR/E has made significant investments in HRH and efforts in COP 19 will focus on improving the efficient use of existing human resources in the public sector and among HIV response stakeholders to enhance the value of existing cadres within the health workforce. Various elements of the health workforce are currently responsible for the following activities: (1) strengthening and scaling-up high yield HTS with particular focus on ICT, PNS and SNT; (2) improving ART coverage through increased identification and efficient linkage of HIV-infected patients to care and treatment services; (3) implementation of rapid ART initiation including same day ART initiation for newly identified PLHIV; (4) and early identification and tracking LTFU clients. They are also responsible for monitoring clients on ART using routine VL testing, ensuring effective sample referral, use of data/results for clinical decision making and patient management, and regular

reporting of performance, and encouraging communities and individuals to take an active role in demanding and seeking out HIV services.

During the course of COP 19 in the 6 transitioning regions, NDFE and federal prison administration, site level PEPFAR salaried staff will be transitioned to RHB and uniform services management. As this transition is implemented, PEPFAR will continue its HR support at above service delivery areas such as Woreda/Zonal and regional levels to maintain program management and monitoring capacity before transitioning these responsibilities as well.

4.5d Improving quality and efficiencies of service delivery through improved models of care delivery across community and facility sites

To minimize the frequency of clinical visits by clients on ART and decrease the work load for ART providers, new models of service delivery have been introduced and implemented. These models will improve both quality of service and efficiency of service delivery at the ART providing sites. The ASM has been adopted, rolled-out and is being implemented in all SNU in Ethiopia. All stable clients on ART are eligible for a six monthly schedule for clinical visits and pharmacy refill. There are defined eligibility criteria and an algorithm to categorize clients as 'stable'.

In addition to being 'stable', clients' willingness to be enrolled in ASM is a determining factor in successful enrollment. Client reluctance to participate in ASM are largely related to fears around unintended disclosure of status and challenges for secure and safe storage of ARV drugs in the home. In an effort to overcome these issues, additional options for ART refill are being planned and/or piloted. Fast-track pharmacy refills are planned where clients collect their ART refills at three months directly from the pharmacy (without a clinical visit to the ART providers). Another model utilizes the UHEWs and brings clients into community ART refill groups that will be led by the clients. The UHEW supervises and manages the groups. There will be a six monthly clinical visit and ARV refill at the facility by all members of the group. This will be supplemented by a three monthly ART refill at the community by the UHEW. Any client may opt to be enrolled in ASM or the UHEW managed model if the alternative model is available at the facility. The eligibility criteria for enrollment is similar for both ASM and the alternative UHEW managed community ART refill group model. In addition, Community Adherence Groups (CAG) at the community provide peer-based adherence support. These CAG are vital for clients supporting in ASM and also other clients who are not enrolled in ASM.

4.5e Ensuring above service delivery activities are mapped to key barriers and measurable outcomes related to reaching epidemic control

During the COP19 planning process, the PEPFAR team, reviewed above-site activities to ensure they are mapped directly to key barriers and measurable outcomes. Thus, the PEPFAR/E above site TWG revised key system barriers and expected outcomes to prioritize systems investments that will have the greatest impact on the epidemic. PEPFAR/E systems investments are focused to enhance local capacity building, coordination, case based surveillance to all regions, improving supply chain, lab quality and sustaining health financing.

Above-site 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 the targets and to reaching epidemic control. These 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. 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 who 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 QI. The goal of this approach is to address gaps in epidemic control with a focus on the scale up of ICT. The above site TA partner will support the RHBs in collecting and reporting ICT results, and submitting their data to their respective RSTs for review, feedback and program support.

4.5f Use of unique identifiers across sites and programs in clinical settings

As Ethiopia reaches HIV Epidemic Control, using accurate, de-duplicated, and de-identified patient level information becomes paramount for monitoring the performance of the clinical cascade, and supporting CBS. It is recommended that CBS should be scaled rapidly with the development of better patient tracking tools, including unique identifiers. Furthermore, for improving performance across clinical cascade, there is a clear need for patient de-duplication and matching capacity.

Linking records on the individuals from testing, care and treatment, laboratory services and pharmacy will generate the data set for granular site management across the entire clinical cascade – within and between facilities. To accomplish this, using data drawn from disparate systems, a unique patient identifier is critical. De-duplicated patient data can be stored in a single registry from where matching of patient happens for future clinic visits based on matching algorithms or biometrics. The clean and de-duplicated client registry forms the basis for a Master Patient Index (MPI), which is foundational for health information exchange at individual patient level.

However, developing a master patient index is virtually impossible without a system to uniquely identify patients. This requires that the Ethiopia HIV control program access civil registration identifiers, demographic data linkages for constructing pseudoID through algorithm, and/or biometrics (gold-standard). To date, the efforts to establish CBR involve the deployment of a single technique – pseudoID through algorithm supported through demographic data linkages – because a national civil registration system is not in place, and biometrics have only been piloted at a very small-scale. In 2016, a proof of concept on patient-matching was conducted to ascertain whether conditions were ripe to support implementation of HIV case based surveillance. This assessment of existing paper-based and electronic health record data quality found the quality of key variables sufficient to not only inform case matching algorithms, but also to identify opportunities to improve clinical data collection. By operationalizing available electronic data, four case matching algorithms were developed, and applied to identify unique patients with clinical records across participating health facilities. While some of the components for enabling a master patient index for known PLHIV are in place – e.g. EMR (SmartCare) upgrade – others are lacking.

The objective of this activity is to establish effective, standardized health information exchanges in support of CBS and for achieving UNAIDS 90-90-90 targets. Successful establishment of the MPI with health information exchanges is critical for sustaining epidemic control, and can be leveraged for other disease priorities.

While acknowledging the GOE's efforts to establish a national/global unique identifier (GUID) covering all sectors (including health) for all Ethiopians, an MPI will address immediate PEPFAR and FMOH priorities of supporting continuity of care, de-duplication and linkage of patient records for program monitoring and CBS. Accordingly, PEPFAR-E will support in accelerating the establishment of a master patient index, using cleaned patient demographic data and a combination of PseudoID, biometrics and newly-introduced civil registration identifiers, to improve data quality and use for epidemic control and for surveillance. Efforts in the remainder of COP18 will focus on Addis Ababa, where telecommunications and internet coverage is highest, and impact of these efforts on epidemic control will be most significant. The PEPFAR Ethiopia approach aims for substantial and ongoing improvement of client identification through a multi-pronged approach over the course of COP18-COP19, starting in Addis Ababa.

The use of unique ID and the associated activities will contribute in the generation of evidence for decision making and facilitating the HIV continuum of care as follows:

1. Use of de-duplicated, de-identified, and high-quality patient level data for HIV program monitoring, evidence-based decision-making, disease surveillance and public health response
2. Accelerated support for realizing longitudinal tracking of all PLHIV for CBS
3. Enhanced continuity of care and improved resource utilization by reducing LTFU Establishment of health information exchange between VL database and EMR to improve turn-around time, data quality and use for clinical decision-making and
4. Development of interoperability layer that is agnostic to software – e.g. transition of SmartCare to next generation solutions(s) as identified by national EMR TWG

4.6 Targets for scale-up locations and populations

Standard Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in DSD Regions (Addis Ababa, Amhara, Oromia, SNNP and Gambella Regions)

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in DSD Regions (Addis Ababa, Amhara, Oromia, SNNP and Gambella Regions)			
Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly Initiated on ART (APR FY 20)
	(APR FY20)	(APR FY20) HTS_TST_POS	*TX_NEW*
	HTS_TST		
Total Men	206,534	12,663	13,319
Total Women	290,438	21,197	23,166
Total Children (<15)	501,653	27,867	24,619
Total from Index Testing	228,426	34,041	32,339
Adults			
TB Patients	23,751	1144	1144
Pregnant Women	0	0	933
VMMC clients	28,705	0	0
FSWs	102,641	4,277	4,063
Other Testing	444,516	32,716	31,080
Previously diagnosed and/or in care			
Pediatrics (<15)			
HIV Exposed Infants	7209	139	132
Other pediatric testing	494,444	27,728	24,487
Previously diagnosed and/or in care			

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Military Ethiopia DSD (Federal Police Commission and FHI 360)			
Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly Initiated on ART (APR FY 20)
	(APR FY20)	(APR FY20) HTS_TST_POS	*TX_NEW*
	HTS_TST		
Total Men	1,274	96	80
Total Women	502	37	60
Total Children (<15)	53	4	4
Total from Index Testing	126	36	34
Adults			
TB Patients	206	24	24
Pregnant Women	0	0	27
VMMC clients			
KPs	0	0	0
Other Testing	1,570	109	118
Previously diagnosed and/or in care			
Pediatrics (<15)			
HIV Exposed Infants	28	4	4
Other pediatric testing	25	0	0
Previously diagnosed and/or in care			

Table 4.6.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Military Ethiopia TA (Federal HAPCO)			
Entry Streams for ART Enrollment	Tested for HIV	Newly Identified Positive	Newly Initiated on ART (APR FY 20)
	(APR FY20)	(APR FY20) HTS_TST_POS	*TX_NEW*

	HTS_TST		
Total Men	19,554	1461	1,212
Total Women	28,031	2,137	2,133
Total Children (<15)	31,513	1,604	1528
Total from Index Testing	24,076	2,820	2679
Adults			
TB Patients	7,935	376	376
Pregnant Women	0	0	0
VMMC clients			
KPs	0	0	0
Other Testing	39,650	3,222	2,969
Previously diagnosed and/or in care	0	0	0
Pediatrics (<15)			
HIV Exposed Infants	1,494	0	0
Other pediatric testing	30,019	1,604	1528
Previously diagnosed and/or in care			

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Table 4.6.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	**Target Populations**	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY20)**	**Expected Coverage (in FY20)**
Gambella Region	10-14	61,541	35,749 (58%)	9,193	65%
	15-29	126,186	74,752(59%)	17,184	73%
	30+	102,788	66,136(64%)	14,415	78%
	Total/Average	**290,514**	**176,637 (61%)**	**40,792**	**75%**

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Table 4.6.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control			
Target Populations	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY20)	FY20 Target
[Specify target populations for focus, e.g. AGYW] *Indicator Codes include PP_PREV and KP_PREV*	KP Estimation= 223,138	85%	KP_ PREV=54,550 PP_PREV= 141,118

Table 4.6.4 Targets for OVC and Linkages to HIV Services

Table 4.6.4 Targets for OVC and Linkages to HIV Services			
SNU	Estimated # of OVC	Target # of active OVC (FY20Target) OVC_SERV	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY20 Target) OVC*
Addis Ababa (62 SNUs)	379,408	47,426	47,426
Amhara (25 SNUs)	811,768	101,471	101,471
Dire Dawa (1 SNU)	37,480	4,685	4,685
Oromia (16 SNUs)	690,088	86,261	86,261
SNNPR (8 SNUs)	297,408	37,176	37,176
Tigray (10 SNUs)	171,720	21,465	21,465

4.7 Cervical Cancer Program Plans

PEPFAR Ethiopia transitioned the cervical cancer screening and treatment of pre-cancerous lesions program in FY15 after building local government capacity including the development of a national cervical cancer prevention and control implementation plan. Following the transition, the ministry had scaled-up the service at national level for all women 30-49 years of age, irrespective of HIV status. For HIV-infected women, the national guideline recommends screening at HIV diagnosis, regardless of age for sexually active women.

As of COP19, PEPFAR Ethiopia will provide above-site TA to the MOH and the 5 RHBs through the ICAP mechanism with a limited budget ($200,000). The purpose of this support is to strengthen and accelerate the implementation of a national plan to scale-up the cervical cancer screening program. From the ministry side, there is an intention and ongoing technical level discussion to introduce HPV-DNA screening, which can be used as an opportunity to augment the existing effort of cervical cancer screening among HIV-infected women.

4.8 VL and EID Optimization

VL testing scale-up is already underway in Ethiopia, and PEPFAR-supported actions in support of the scale-up are described in Section 4.5C. In addition, PEPFAR/E will continue to work with the Ministry of Health to ensure optimization of VL testing through expansion of VL testing operation hours, recruitment and retention of qualified testing personnel, expanding QA activities, and shifting from GOE ownership of VL testing equipment to reagent leasing arrangements. The supply chain activity will strengthen stock monitoring and provide biweekly or monthly stock reporting for VL, EID, RTK, HIVST, and recency tests. An emphasis will be placed on treatment provider awareness of VL monitoring requirements to increase demand and ensure timely VL monitoring of all PLHIV.

Presently, point of care (POC)-EID is being supported in 68 facilities across the country and 60 are sharing the instrument for both TB and EID. Previously, POC-EID implementation was supported by the Clinton Health Access Initiative (CHAI), but that is now being transitioned to the GOE, with commodity procurements funded by the GFATM. The COP19 budget includes funding for limited procurement of GeneXpert cartridges for EID.

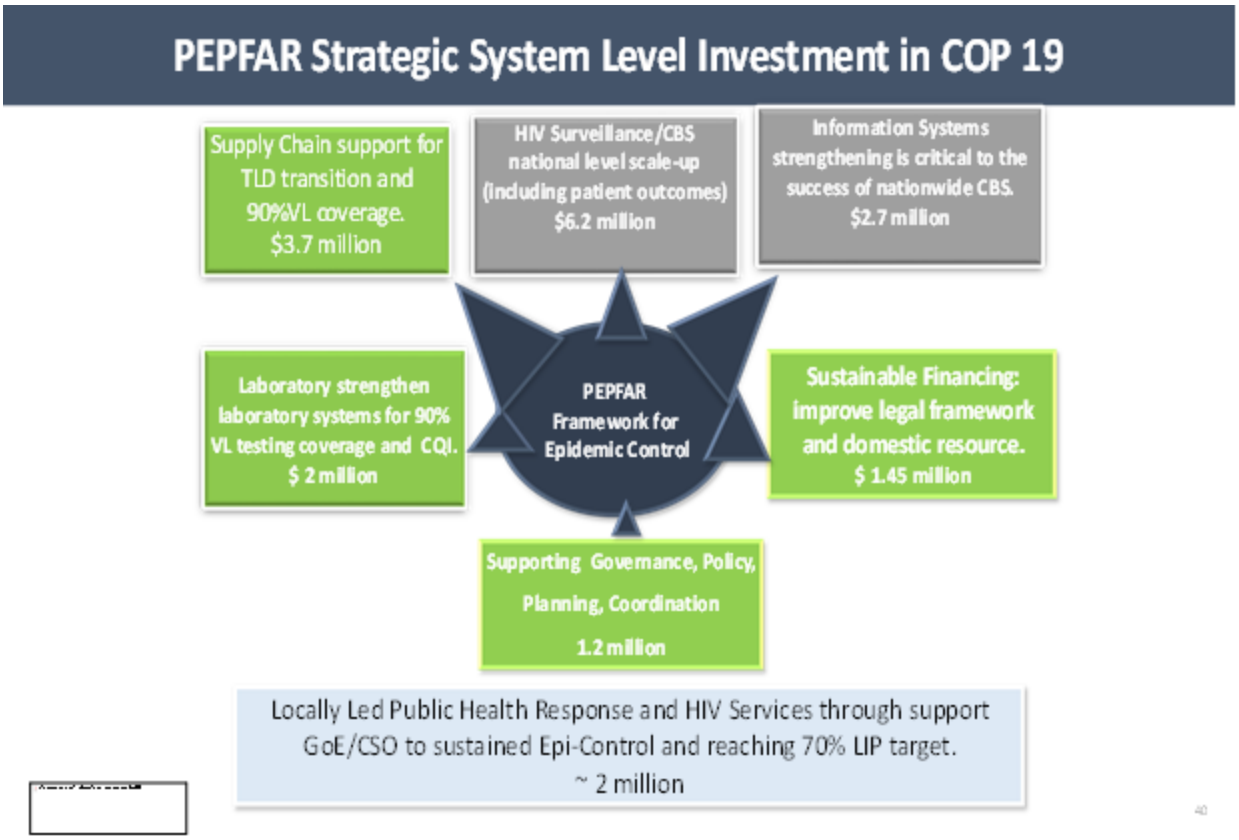
5.0 Program Activities for Epidemic Control in Attained Locations and Populations

In COP19, PEPFAR will focus its program activities in the Addis Ababa, Oromia, Amhara, SNNPR, and Gambella, and implement activities as described in Section 4 of the SDS, above. PEFPAR will reinforce existing HIV case finding strategies that continue to have yields while also scaling up case finding by including– ICT, PNS, SNS and intensification of assisted HIVST.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

Ethiopia is on the verge of reaching HIV epidemic control. PEPFAR and GOE are working together to accelerate and achieve HIV epidemic control by the end of COP19 as well as sustain the gains thereafter. To reach this ambitious goal, PEPFAR Ethiopia must apply systems thinking to the current epidemic status. To assist PEPFAR countries in developing a program to support epidemic control, the OGAC ECT1 team has developed a framework for sustained epidemic control. GOE, under the leadership of FHAPCO, has established an epidemic control TWG to define HIV epidemic control in Ethiopia. This TWG is also charged with adapting the OGAC provided framework for Ethiopia's context, noting areas of support necessary to achieve and sustain epidemic control in the country. The PEPFAR Ethiopia team is closely working with both ECT1 and EC TWG to define Ethiopia's epidemic control and devise strategies.

The ECT 1 framework for sustained epidemic control (as shown in the figure below) served as a reference point for additional input and deliberation with the EC TWG. Through the EC TWG and in consultation with ECT1, the program has identified potential barriers to epidemic control as well as crafting solutions/identifying program areas for investment. This process included the development and prioritization of outcomes requiring systemic and programmatic interventions to address barriers where the outcomes are linked to specific activities addressing the barriers over the coming years. Three-year outcomes were validated during this review process and yearly benchmarks developed. System level investments planned for COP 19 are focused to address these key barriers and priorities and propel Ethiopia to sustainably achieve its epidemic control vision. The key barriers to reaching epidemic control and the associated planned activities to remove those barriers are described in the following paragraphs.



1. **Investing in sustainable solutions and supporting sustainable financing**: At this stage of the epidemic finding sustainable solutions to maintaining HIV epidemic control becomes paramount. Financial sustainability through DRM is a key pillar to ensuring sustainable epidemic control in Ethiopia. HIV/AIDS programs in Ethiopia are highly external donor dependent for commodities and programmatic implementation. As external donor funding continuously reduces, the country needs to develop its capacity to mobilize domestic resources to sustainably finance its program. The last sustainable index dashboard (SID) exercise, recent programmatic observations through Site Improvement through Monitoring System (SIMS) and, discussions with PEPFAR IPs show weak coordination and limitations in local capacity as some of the remaining barriers affecting progress towards HIV epidemic control.. Thus, PEPFAR system level investment in COP 19 will continue to focus on:

    a. *Supporting local institutions for locally led public health response for sustained HIV Epidemic Control*. The last SID score for CSO engagement (5.17) and technical and allocative efficiency (5.56) indicate more support is needed to strengthen local institutions to take leadership and responsibility for the HIV program in Ethiopia. As PEPFAR support evolves from a DSD to TA model, it will ensure LIPs have the capacity to lead the HIV response, continue to provide quality assured key HIV program interventions and, use resources efficiently. To build LIP capacity, PEPFAR/E will provide TA to LIPs working on PEPFAR programming in the facility and community level (CSO, FBO, and GOE). This TA will focus on building adequate institutional capacity to mobilize and efficiently manage resources. This support for LIPS in COP19

is crucial to meet PEPFAR's target of ~ 70% direct LIP funding by 2020 and ensure long term sustainability of the program.

b. *Support sustainable HIV financing***:** FHAPCO has identified sustainable HIV financing through the mobilization of domestic resources as a flagship strategy for maintaining HIV epidemic control in Ethiopia. Currently, Ethiopia lacks a sufficient legal framework and strategy to ensure sustainable financing. PEPFAR/E and GOE have prioritized support for developing sustainable financing strategy and policies as key activities for COP19. Activities to support sustainable financing and a domestic resource mobilization strategy will include capacity building, establishing a "think tank" working group, developing a sustainable financing implementation plan This work will be done at the federal and select SNU levels in collaboration with FHAPCO, FMOH, MOF and other pertinent ministries and agencies.

c. *Enhancing Coordination and collaboration among stakeholders implementing HIV program in Ethiopia***:** As PEPFAR/E already began transitioning out of some regions for DSD support in COP18, coordination and collaboration among all IPs is critical to ensure sustained epidemic control. COP 19 support will include strengthening GOE and CSO capacity to plan and coordinate activities for above site TA support. In COP19, 6 regions will move to a TA support models led by a national TA provider, FHAPCO. FHAPCO will develop, with input from other GOE institutions and PEPFAR/E, SOPs and guidance on activity coordination and reporting Monitoring, Evaluation and Reporting (MER) guidance and performance indicators. FMOH, FHAPCO, EPHI, MOWCYA, MOLSA, and MOF are GOE institutions identified to be supported (directly and through TA) in COP19. Planned activities will enable the institutions to strengthen their capacity to exercise leadership and coordination roles as well as prepare themselves to takeover and sustain PEPFAR activities.

IN COP 18, PEPFAR/E is already working to strengthen coordination among USG agencies as well as PEPFAR IPs for shared responsibility and results. PEPFAR IPs are revitalizing coordination platforms at regional and sub-regional level and are in the process of developing SOPs and terms of reference for conducting regular meetings. In COP19, PEPFAR/E will continue to reinforce collaboration and coordination amongst partners during all phases of the HIV response to attain and sustain HIV epidemic control.

2. HIV Surveillance/CBS: IN COP19, PEFPAR/E will continue investments to strategic information (SI) in order to supply the data and information needed to inform provide services needed to achieve epidemic control.

a. *HIV case based surveillance and HIV recency testing:* Routine assessment and monitoring of the HIV epidemic through ongoing surveillance of newly diagnosed PLHIV remains essential. As Ethiopia makes progress to reaching epidemic control, systems to capture/monitor individual patient data that includes information on HIV recency, risk factors and longitudinal/sentinel events provides valuable data for decision making. Data generated by CBS for individual and cluster identification is then linked with investigation/response measures, including patient management and programmatic adjustments.

PEPFAR/E is implementing the first phase of HIV CBS and HIV recency testing in selected high HIV load health facilities in four regions (Addis Ababa, Oromia, Amhara and SNNPR) as part of the national PHEM system. HIV case reporting and recency testing is linked to case detection strategies by monitoring each newly identified individual has received the appropriate HIV response measures at facility level. PEPFAR is working with EPHI and RHBs to create a weekly data visualization and response-monitoring platform at woreda level. In COP19, the HIV case reporting will be scaled-up at national level both at facility and community settings, with the target of achieving enrollment of facilities covering at least 90% of the HIV treatment cohort. In COP 19, PEPFAR/E will support deployment of systems needed for the 2nd phase of case based surveillance (with longitudinal reporting of sentinel events) and for data QI and information use across the clinical cascade. In Phase II, health facilities complete paper based CRF and also enter data in to EMR which is transmitted to the central CBS Redcap database via the data exchange platform. The Woreda HO, zonal HO and RHB will have access to the central database to undertake reviews, approve the electronic CBS data in their jurisdiction, use analytics and decision making.

b. *VACS:* PEPFAR, in collaboration with GOE (FMOH, MOYCA, FHAPCO and EPHI) and IPs will implement an urban-focused, VACS including biomarkers, to inform the national HIV program and PEPFAR's assistance with mitigating violence and associated risk of HIV acquisition. Accurate and timely data on violence against children and youth are critical for the development and implementation of programs to prevent violence and respond to the needs of its survivors, as well as for the development of a coordinated multi-sectoral approach. The GOE has committed to conducting VACS, disseminate findings, and use the information for programmatic and policy decisions.

3. Information systems: Robust HIS at all levels are a cornerstone of nationwide CBS and are also core to clinical case management across the cascade, monitoring program performance, and ensuring reliable information for policy-making and strategy.

a. PEPFAR/E has been supporting **patient-level HIS (SmartCare-EMR)** in high HIV caseload health facilities. The SmartCare upgrade supports CBR, clinical care, reporting on all MER indicators with all disaggregates, as well as line-lists and reports to reinforce ICT, tracking patients for LTFU, appointment spacing, and high VL monitoring. However, once deployed in FY19Q1 and de-identified data was analyzed, it became evident that there were serious deficiencies in the completeness and quality of data captured not just in the EMR, but also in the source paper patient records, especially on demographics. In COP19, the program will shift to analysis and use of quality patient data at the site level for active case finding, management and improved patient outcome.

b. Am **MPI** will address immediate PEPFAR/E and FMOH priorities of supporting continuity of care, de-duplication and linkage of patient records for program monitoring and CBS. As per OGAC guidance, PEPFAR/E will leverage CBS system and triangulate demographic variables to uniquely identify cases and clients. In COP19, PEPFAR/E will support the establishment of a master patient index, using cleaned patient demographic data and a combination of PseudoID, biometrics and newly-introduced civil registration identifiers, to improve data quality and use for epidemic control and for surveillance. These include support for design, testing, deployment, IT infrastructure and equipment, and performance

monitoring. Deduplication, demographic matching, pseudo unique identification, data analytics and decision-making are amongst the activities to be led by EPHI.

4. Improvements to supply chain management systems (SCMS), capacity and availability of commodities:

Finding PLHIV and putting them on treatment is dependent on the availability of commodities and requires a reliable SCM and distribution system. Assessment conducted in February 2019 on HIV RTK availability showed a significant gap in stock availability among public and private health facilities that ranges from 50% availability for second test in the private while it is 93% in the public health facilities. FY 19 Q1 ARV supply has stock out rate of 6.5% and Abbot Machine plate form reagent wastage is about 9.6%. These stock outs and inefficiencies are caused due to gaps in procurement, quantification, inventory management, logistics management information system, poor quality & delayed reports by health facilities, mal-distribution to health facilities and inadequate coordination at different SCM levels.

Introduction of newer products like TLD and DTG 50 mg require engagement of all administrative level and services deliveries for successful implementation of the initiatives. In COP 19, PEPFAR supply chain TA partner Global Health Supply Chain Procurement and supply management project will strengthen its support to the system through mentorship, supportive supervision, training, provision of warehouse safety appliances and facilitating coordination at PSA, RHB, FMOH, laboratory monitoring sites, Woreda, Zonal Health units and health delivery points. It will intensify SCM to seamlessly roll-out TLD transition, NVP phase-out, pediatric regimen optimization, and reach 90% VL testing coverage. It will also strengthen routine site-level pharmacy data use for supply and patient-level monitoring and reduce stock-outs of all commodities including RTKs and VL EID commodity wastage. In COP19, unlike in previous years, PEPFAR/E will procure ARVs (TLD) to cover the commodity gap created by accelerated NVP phase out and additional targets for COP18 and 19. PEPFAR/E will also support procurement of other HIV commodities such as VL reagents, HIV RTK, HIVST kit, VMMC kits, and HIV recency testing kits and 3HP for TPT in support of COP19 initiatives. It will also work on institutional capacity building on SCM, quantification in support of multi-month scripting, and warehousing for accountable supply chain system.

5. Laboratory: VL testing coverage has increased from just 3% in COP16 to current coverage of 58%. COP19 will build on the results achieved in COP 18 implementation to strengthen laboratory systems to reach 90% VL testing coverage by the end of COP19. PEPFAR/E support will continue to focus on quality of laboratory tests and ensure timely reporting of VL results for clinical decision making and program monitoring. Building institutional capacity is also a priority for creating a sustainable quality-assured laboratory system, including support for TB/HIV, VL/EID, and HIV rapid and recency testing.

Through EPHI, PEPFAR/E will support need based in-service trainings for VL, EID, TB diagnostics, high yield HIV rapid testing modalities, HIV rapid test for recent infection as well as laboratory quality management system. PEPFAR has been and will continue to support gap-filling health worker hiring for VL testing laboratories as well as regional lab program coordination. PEPFAR/E will not implement any new construction or HRH investment in COP 19 however, PEPFAR/E will support completion of currently underway (nearly completed) laboratory construction activities.

7.0 Staffing Plan

The PEPFAR team is comprised of staff from the PEPFAR Coordination Office through the State Department, CDC, USAID and Department of Defense (DOD). The PEPFAR team reviewed and assessed staff alignment within the context of sustained epidemic control. Overall, the staffing footprint for PEPFAR will decrease in COP19. This is partly in response to the downward trend of COP funding in out years as well as the changing epidemiology in Ethiopia moving to epidemic control. Future technical staffing needs will evolve as the strategic direction changes over time.

The PEPFAR Country Coordinator position is filled after nearly four years of and Senior Technical Advisor (Eligible Family Member Position) which was approved in COP18 is vacant and process is delayed due to the hiring freeze and PEPFAR leadership transition.

CDC Ethiopia will continue to reduce the overall USG staffing footprint and revise the organizational structure in accordance with PEPFAR program priorities. The COP19 budget will include 6 U.S. Direct Hire (USDH) positions, with 1 lab advisor vacancy to be filled in Q3. There are no long-term vacancies expected. In COP18, CDC eliminated one USDH position and five locally employed staff (LES) positions. Of the 5 positions to be retired during COP18, 3 of these positions will be replaced in COP19. In general CDC's cost of doing business is in a decreasing trend in response to the changes in the overall funding. CDC will continue to adjust its current staffing profile to align with PEPFAR program priorities and maximize efficiencies.

USAID has been analyzing staffing footprint in order to support programmatic pivots and made continual annual adjustments. USAID will add four new positions in COP19. Positions will be centrally funded and roles are focused to oversight and management of program transition to local prime partnerships. USAID will have additions of 10 new LIPs during the next fiscal year which requires an intensified oversight to partners that reflects close monitoring of partners performance (specifically to LIPs).

APPENDIX A -- PRIORITIZATION

Table A.1 Continuous Nature of SNU Prioritization to Reach Epidemic Control

Region	# of SNUs	COP	Prioritization	Results reported	Attained : 90-90-90(81%) by Each Age and sex Band to reach 95-95-95(90%) overall													
					Male <1	Female<1	Male (1-9)	Female (1-9)	Male(10-14)	Female(10-14)	Male(15-19)	Female(15-19)	Male(20-24)	Female(20-24)	Male(25-49)	Female(25-49)	Male50+	Female 50+
Addis Ababa	116	COP 15	Scale-up: Saturation	APR 16	82 %	79%	76 %	77%	128 %	138%	89%	91%	65%	124%	106 %	94%	56%	22%
	116	COP 16	Scale-up: Saturation	APR 17	69 %	70%	75 %	76%	130 %	140%	104 %	103%	65%	121%	117 %	103%	55%	23%
	116	COP 17	Attained	APR 18	94 %	93%	105 %	108 %	190 %	205%	132 %	128%	71%	131%	139 %	122%	58%	25%
	116	COP 18	Attained	APR 19	71 %	72%	102 %	103 %	183 %	198%	155 %	148%	72%	132%	149 %	131%	56%	24%
	118	COP 19	Attained	APR 20	100 %	100 %	175 %	186 %	194 %	177%	343 %	369%	220 %	244%	175 %	144%	67%	72%
Amhara	49	COP 15	Scale-up Sat	APR 16	16 %	16%	20 %	20%	39%	42%	34%	35%	31%	57%	90%	77%	82%	41%
	49	COP 16	Scale-up Sat	APR 17	13 %	13%	21 %	21%	42%	45%	38%	38%	29%	54%	97%	83%	80%	40%
	71	COP 17	Scale-up Sat	APR 18	42 %	43%	33 %	33%	67%	71%	49%	46%	32%	59%	116 %	100%	88%	43%
	110	COP 18	Attained	APR 19	45 %	46%	41 %	41%	82%	88%	54%	51%	32%	57%	119 %	104%	83%	40%
	118	COP 19	Attained	APR 20	54 %	54%	58 %	60%	142 %	134%	109 %	116%	85%	91%	113 %	101%	71%	106%

	40	COP 19	Centrally Supported	APR 20	12 %	12%	27 %	26%	33%	36%	22%	20%	17%	16%	20%	24%	21%	16%
oromia	46	COP 15	Scale-up Sat/Agg	APR 16	9%	9%	16 %	15%	37%	40%	31%	30%	29%	47%	80%	72%	87%	43%
	46	COP 16	Scale-up Sat/Agg	APR 17	11 %	10%	17 %	17%	43%	47%	35%	33%	28%	47%	89%	80%	85%	43%
	55	COP 17	Scale-up Sat/Agg	APR 18	36 %	37%	27 %	27%	67%	72%	48%	45%	35%	59%	121 %	108%	102 %	53%
	87	COP 18	Attained	APR 19	36 %	36%	29 %	29%	69%	74%	43%	39%	28%	47%	103 %	92%	78%	40%
	97	COP 19	Attained	APR 20	26 %	26%	153 %	159 %	112 %	116%	133 %	136%	104 %	104%	137 %	132%	104 %	145%
	108	COP 19	Centrally Supported	APR 20	2%	2%	31 %	30%	18%	15%	18%	18%	14%	14%	20%	21%	21%	15%
SNNPR	16	COP 15	Scale-up Sat/Agg	APR 16	12 %	12%	20 %	20%	54%	58%	40%	34%	31%	37%	62%	58%	83%	36%
	16	COP 16	Scale-up Sat/Agg	APR 17	11 %	12%	22 %	22%	61%	66%	43%	36%	31%	39%	67%	63%	80%	36%
	20	COP 17	Scale-up Sat/Agg	APR 18	21 %	21%	37 %	37%	82%	89%	48%	45%	36%	60%	102 %	91%	80%	38%
	31	COP 18	Attained	APR 19	47 %	42%	38 %	38%	98%	105%	63%	52%	40%	55%	98%	91%	94%	44%
	34	COP 19	Attained	APR 20	50 %	50%	228 %	237 %	132 %	118%	202 %	148%	153 %	99%	134 %	134%	128 %	178%
	45	COP 19	Centrally Supported	APR 20	2%	2%	50 %	48%	22%	22%	25%	31%	17%	23%	23%	23%	30%	22%
Gambella	4	COP 15	Scale-up Sat/Agg	APR 16	15 %	13%	20 %	20%	50%	54%	29%	17%	17%	17%	46%	48%	78%	32%
	4	COP 16	Scale-up Sat/Agg	APR 17	24 %	24%	22 %	22%	55%	60%	41%	25%	22%	23%	63%	66%	99%	42%

	5	COP 17	Scale-up Sat/Agg	APR 18	43 %	36%	34 %	33%	84%	91%	53%	33%	27%	28%	75%	80%	111 %	49%
	8	COP 18	Attained	APR 19	50 %	50%	53 %	54%	131 %	141%	71%	46%	34%	36%	92%	97%	126 %	57%
	8	COP 19	Attained	APR 20	152 %	152 %	104 %	107 %	93%	87%	141 %	102%	107 %	63%	83%	93%	109 %	172%
Tigray	18	COP 15	Scale-up Sat/Agg	APR 16	15 %	14%	21 %	20%	41%	44%	37%	38%	33%	62%	94%	83%	89%	43%
	18	COP 16	Scale-up Sat/Agg	APR 17	14 %	15%	22 %	21%	46%	49%	43%	43%	33%	61%	107 %	93%	85%	43%
	21	COP 17	Scale-up Sat/Agg	APR 18	41 %	41%	33 %	33%	70%	76%	57%	56%	37%	70%	136 %	117%	92%	47%
	34	COP 18	Attained	APR 19	39 %	41%	41 %	41%	82%	88%	62%	59%	35%	65%	136 %	117%	80%	41%
	47	COP 19	Centrally Supported	APR 20	57 %	57%	52 %	55%	101 %	104%	100 %	99%	75%	73%	91%	87%	65%	88%
DD	1	COP 15	Scale-up Sat/Agg	APR 16	15 %	16%	19 %	19%	39%	44%	45%	41%	34%	50%	73%	70%	70%	31%
	1	COP 16	Scale-up Sat/Agg	APR 17	11 %	11%	19 %	19%	39%	43%	48%	43%	34%	50%	78%	74%	68%	30%
	1	COP 17	Attained	APR 18	40 %	44%	36 %	37%	78%	86%	58%	51%	37%	55%	92%	86%	72%	33%
	1	COP 18	Attained	APR 19	33 %	33%	42 %	43%	88%	97%	77%	67%	46%	69%	119 %	112%	85%	39%
	1	COP 19	Centrally Supported	APR 20	16 %	16%	66 %	70%	60%	84%	119 %	107%	88%	70%	69%	71%	53%	73%
Harari	1	COP 15	Scale-up Sat/Agg	APR 16	17 %	18%	32 %	32%	100 %	107%	68%	58%	46%	63%	118 %	105%	99%	46%
	1	COP 16	Scale-up Sat/Agg	APR 17	20 %	22%	35 %	36%	123 %	132%	83%	69%	50%	68%	134 %	119%	103 %	48%
	1	COP 17	Scale-up Sat/Agg	APR 18	60 %	60%	48 %	49%	181 %	193%	91%	75%	49%	69%	137 %	121%	97%	46%

	1	COP 18	Attained	APR 19	80 %	60%	54 %	55%	193 %	207%	100 %	81%	49%	68%	138 %	121%	90%	43%
	1	COP 19	Centrally Supported	APR 20	29 %	29%	40 %	41%	193 %	198%	169 %	136%	128 %	82%	78%	78%	68%	96%
Benishangul Gumuz	2	COP 15	Scale-up Sat/Agg	APR 16	29 %	29%	19 %	18%	40%	44%	41%	37%	35%	55%	94%	85%	106 %	50%
	2	COP 16	Scale-up Sat/Agg	APR 17	25 %	29%	20 %	19%	43%	46%	45%	39%	35%	53%	103 %	93%	103 %	49%
	6	COP 17	Scale-up Sat/Agg	APR 18	33 %	50%	34 %	33%	71%	76%	52%	47%	39%	56%	120 %	107%	105 %	52%
	3	COP 18	Attained	APR 19	50 %	50%	38 %	38%	77%	80%	58%	52%	37%	56%	126 %	112%	99%	49%
	12	COP 19	Centrally Supported	APR 20	282 %	282 %	57 %	59%	77%	77%	102 %	89%	84%	62%	80%	79%	77%	111%
Afar	6	COP 15	Scale-up Sat/Agg	APR 16	0%	0%	5%	5%	12%	13%	20%	18%	17%	24%	43%	40%	34%	23%
	6	COP 16	Scale-up Sat/Agg	APR 17	0%	0%	6%	7%	15%	17%	23%	19%	17%	25%	50%	46%	37%	25%
	6	COP 17	Scale-up Sat/Agg	APR 18	5%	5%	10 %	10%	23%	25%	34%	28%	24%	34%	75%	69%	52%	35%
	6	COP 18	Attained	APR 19	6%	6%	12 %	11%	26%	28%	43%	37%	30%	42%	96%	86%	61%	40%
	12	COP 19	Centrally Supported	APR 20	50 %	50%	24 %	25%	38%	37%	117 %	100%	94%	70%	101 %	99%	69%	130%
Somali	2	COP 15	Scale-up Sat/Agg	APR 16	3%	3%	6%	6%	22%	23%	26%	20%	17%	20%	48%	47%	46%	28%
	2	COP 16	Scale-up Sat/Agg	APR 17	5%	5%	7%	7%	17%	18%	25%	24%	18%	32%	54%	48%	42%	20%
	3	COP 17	Scale-up Sat/Agg	APR 18	5%	5%	11 %	10%	24%	26%	31%	29%	24%	39%	66%	59%	52%	24%

	2	COP 18	Attained	APR 19	6%	6%	12 %	12%	28%	30%	32%	30%	25%	40%	69%	61%	54%	25%
	10	COP 19	Centrally Supported	APR 20	60 %	60%	43 %	45%	79%	99%	157 %	131%	126 %	90%	126 %	125%	92%	167%

COP 19 Attained

COP 19 Centrally Supported

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected Current on ART (APR19)	Additional Patients Required for 80% ART Coverage	Target Current ART(APR20 TX_CURR)	Newly Initiated(APRFY201 TX_NEW)	ART Coverage APR 20
Attained	380,612	420,127	(115,637)	458,239	57,854	120%
Centrally Supported	197,193	94,743	63,011	99,256	8,123	50%
Not PEPFAR Supported	71,467	-	57,174	-	-	0%
Military Ethiopia	-	9,859	(9,859)	9,450	535	'NA'
Grand Total	649,271	524,729	(5,311)	566,945	66,512	87%

Table A.3 Projected ART Coverage

	FY19 Projected Coverage				FY20 Projected Coverage			
	<15		**15+**		**<15**		**15+**	
	Female	**Male**	**Female**	**Male**	**Female**	**Male**	**Female**	**Male**
Addis Ababa	147%	153%	120%	117%	177%	183%	128%	124%
Amhara	51%	53%	86%	85%	81%	83%	87%	86%
Gambella	49%	50%	80%	78%	85%	85%	83%	82%
Oromia	40%	39%	73%	71%	79%	75%	74%	72%
SNNPR	45%	46%	58%	58%	80%	80%	59%	60%

APPENDIX B – Budget Profile and Resource Projections

Table B.1.1 COP19 Budget by Program Area

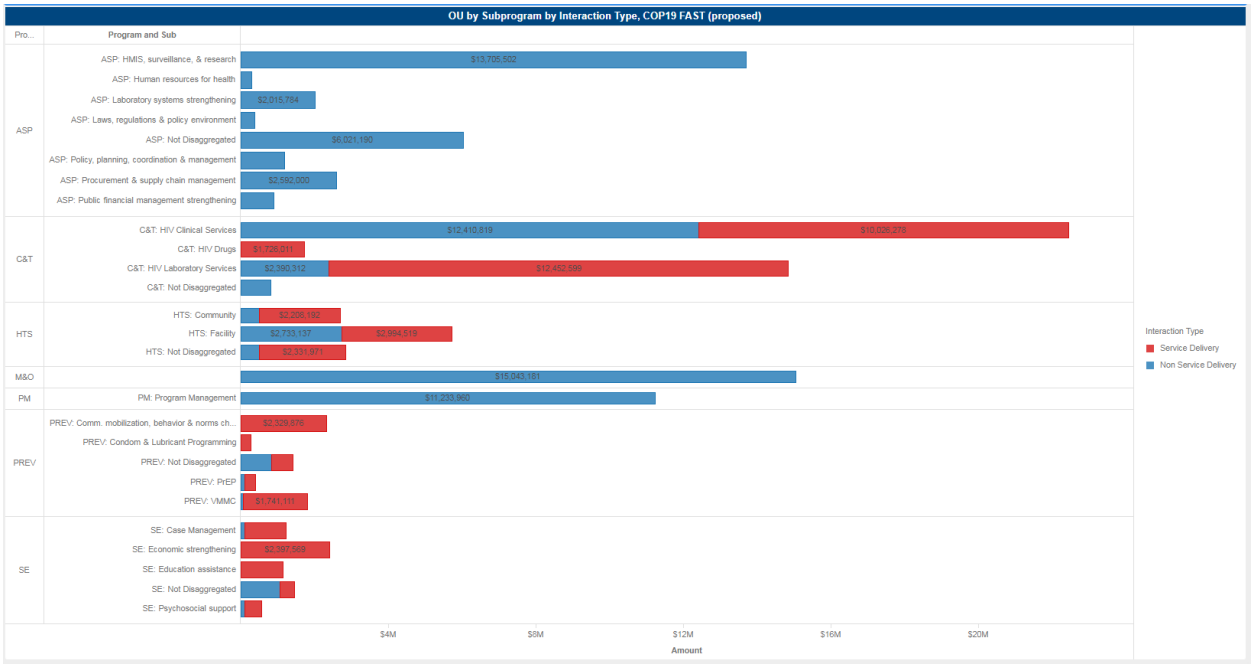


Table B.1.2 COP19 Total Planning Level

Table B.1.2 COP19 Total Planning Level		
Applied Pipeline	New Funding	Total Spend
$US	$US	$US
$ 55,038,050	$ 62,381,142	$ 117,419,192

Table B.1.3 Resource Allocation by PEPFAR Budget Code (new funds only)

Initiative Type	Fiscal Year	2020
	Budget Code	Amount
Planning Level	APPLIED PIPELINE	$55,038,049
	CIRC	$880,241
	HBHC	$1,793,938
	HKID	$9,751,374
	HLAB	$2,891,694
	HMIN	$25,755
	HTXD	$11,944,737
	HTXS	$11,416,453
	HVAB	$29,361
	HVCT	$10,272,393
	HVMS	$1,947,835
	HVOP	$486,043
	HVSI	$3,730,578
	HVTB	$2,027,442
	MTCT	$282,288
	OHSS	$409,561
	PDCS	$1,894,421
	PDTX	$2,597,023

Table B.1.4 OU Budget

Initiative Type	Fiscal Year	2020
	Funding Agency	Amount
Planning Level	DOD	$400,269
	HHS/CDC	$62,774,029
	HHS/HRSA	$400,000
	State	$906,197
	State/AF	$3,193,333
	USAID	$49,745,358

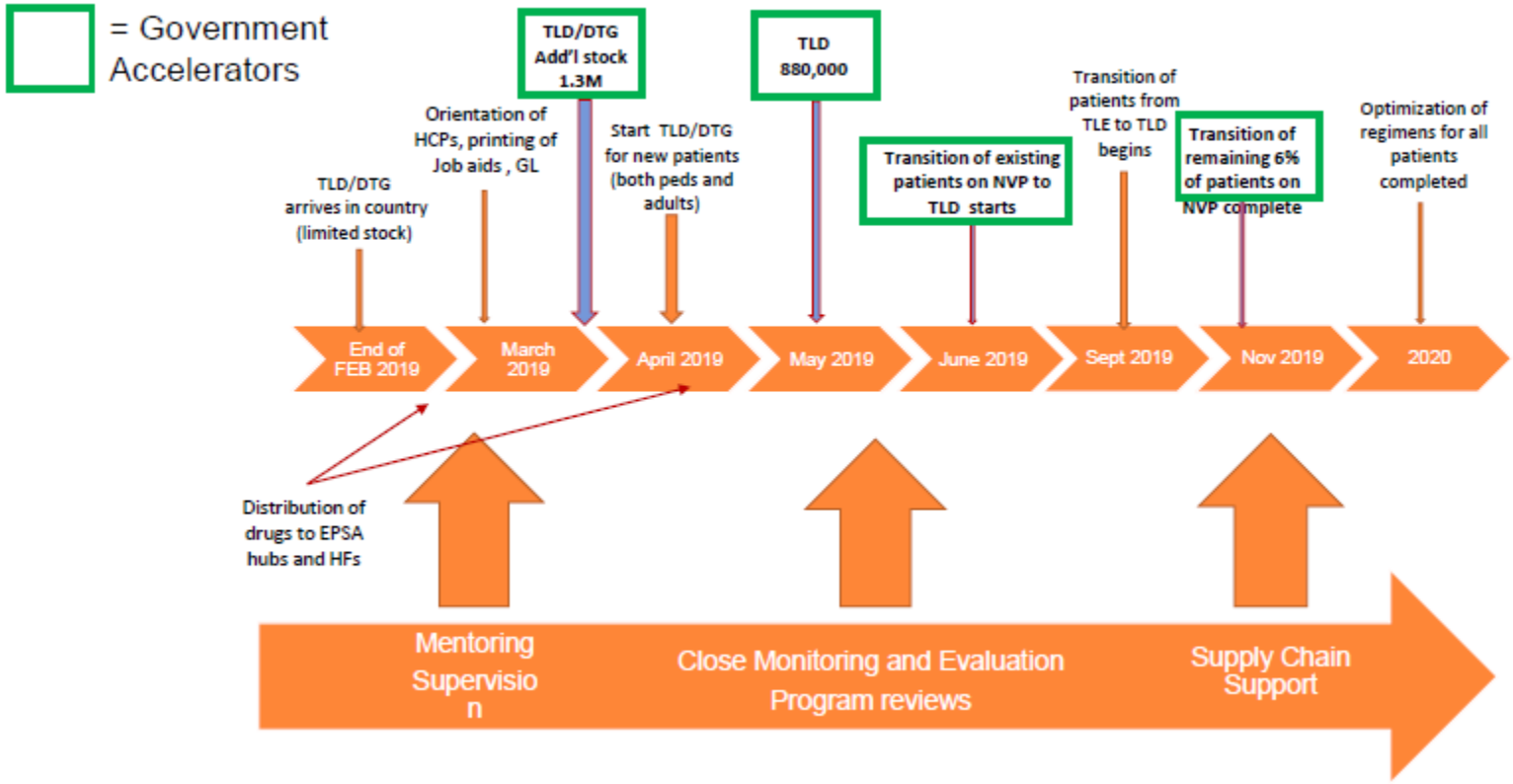
B.2 Resource Projections

The budget calculation is done based on the four budget categories; intervention, (Program area and beneficiary), commodity-based budgeting, Management and Operation and Cross Cutting Attributions. Budget for system level activities is calculated in the Funding and Allocation to Strategy (FAST) and Table 6.0 tools. Initially strategic directions and priority areas were set to complete implementing mechanism (IM) level allocations. We have used the 2018 Expenditure Reporting and incremental based budgeting grounded on program needs as well as availability of pipelines to determine COP 19 budget. The next step is allocating commodity and the M&O budgets ensuring that required earmarks are met.

APPENDIX D– Minimum Program Requirements

Policy	Status	Remark
NVP phased out Sept 2019	In progress	• To be completed by Nov 2019 (previously June 2020)
	Complete	• Adopted TLD for children +20kg in policy • ARV and TLD supply plan tools, adjust for accelerated DTG rollout and NVP phase out • Adopted TLD for all women of child-bearing age on effective contraception
Test and Start	Complete	
Differentiated service delivery and MMS	Complete	
TLD transition	Complete	
Index testing and HIVST	Complete	
TPT	Complete	
>95% Linkage	Complete	
Elimination of all user fees	Complete	
VL/EID optimization	Complete	
Monitoring morbidity and mortality	Complete	
Evolve OVC services	Complete	
Increased host-government resources	Complete	
Increase funding to indigenous partners	Complete	
Unique patient identifiers	Complete	

Figure D. Accelerated Timeline for NVP Phase-Out



Tables and Systems Investments for Section 6.0

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	TBD	ASP: Public financial management strengthening	Non-Targeted Pop: Not disaggregated	$ 882,500.00	Lack of strategy and legal framework for sustained domestic HIV program financing	COP19	COP21	Implemented capacity building and action planning activities at national and select sub-national levels toward Sustainable HIV Financing through increased DRM. • Regular HIV resource tracking ongoing, led by government and integrated into health resource tracking (SHA/NHA) • Analyses undertaken to diagnose inefficiencies in HIV system
USAID	TBD	ASP: Laws, regulations & policy environment	Non-Targeted Pop: Not disaggregated	$ 380,300.00	Lack of strategy and legal framework for sustained domestic HIV program financing	COP19	COP20	Supported activities on advocacy and legal framework at national and select sub-national levels for Sustainable HIV Financing through increased Domestic Resource Mobilization (DRM)
USAID	ETHIOPIAN SOCIETY OF SOCIOLOG ISTS, SOCIAL WORKERS AND ANTHR	ASP: Human resources for health	OVC & care givers: Not disaggregated	$ 300,000.00	Lack of strong social systems, and Government, Local CSO/FBOs and community structures capacity to provide quality services for OVC and facilitate transition of OVC Program	COP17	COP20	Complete training and deployment of PSW to support the LIP transition and quality OVC programming. Continue to expand use of CBOs/FBOs and the social service workforce for HIV and for viloence prevention and care.
USAID	ETHIOPIAN SOCIETY OF SOCIOLOG ISTS, SOCIAL WORKERS AND ANTHR	ASP: Policy, planning, coordination & management	OVC: Orphans & vulnerable children	$ 180,000.00	Lack of strong social systems, and Government, Local CSO/FBOs and community structures capacity to provide quality services for OVC and transition OVC Program	COP19	COP21	Identified opportunities to expand use of GOE (MOLSA and MOWCYA), CBOs/ for HIV and for violence prevention and care and involving in the transition plan of the OVC program.
USAID	Population Services International	ASP: Not Disaggregated	Key Pops: Not disaggregated	$ 700,000.00	Limited local capacity for KPP programming including strategies for finding highrisk men	COP19	COP20	National guidelines, training manuals for prevention and key and priority population will be updated in a timely manner. Improved uptake of HIV testing services among KPPs, high risk men and out of school adolescents, partners of HIV postive key populations. Improved identification of HIV-infected persons among FSWs and index cases and partner. Increased linkage to care through referral of newly identified HIV-infected key populations and their contacts to ART services.
USAID	Project Hope-The People-To-People Health Foundation, Inc.	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 197,552.00	Limited capacity of LIP to implement new and innovative approaches of HIV services such as client centered differentiated HIV testing and care services	COP17	COP19	MOU signged between facility and communtiy stakeholders and effective seameless coordination ensured thereby increasing the access to services Stable patients will be enrolled and receive ARV servcies through multiple models of DSDM Major LIPs, COBs and FBOs / religious organizations will be engaged and significantly contribute to the provision of high impact HIV services including targeted HIV testing, viral load litracy, support TLD transition and adherence to ART. Improved quality of servcies provided for PLHIVs through the CBOs, peer PLHIV associations, religious organizations (FBO), and other community stakeholders.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
USAID	Project Hope-The People-To-People Health Foundation, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 175,602.00	Lack of CSO/LIP capacity to advocate for, coordinate, mobilize resources and efficiently use it to implement innovative service approaches and meet PEPFAR target and to sustain HIV epidemic control	COP18	COP20	Community service outlets make use of the revised community service deliverY guidelines as a standard of care. LIPs implement and report interventions in line with the new service delivery models as a standard of care. LIPs will have developed their own resource mobilization ramework LIPs that will raise local resources and use the resource to support community based HIV Care and support activities
USAID	Project Hope-The People-To-People Health Foundation, Inc.	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,400,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP19	COP21	Standardization of tools and digitizing of tools. Roll-out to community sites in Addis Ababa
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 700,000.00	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP18	COP21	Forecasting accuracy 70%, 85% reporting using standard RRF
USAID	Chemonics International, Inc.	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 864,000.00	Weak supply chain system due to In adquate of Supply chain work force, lack of standardize work flow, poor infrastructure	COP18	COP21	Complete TLD Transition and pediatric ART optimization in all ART sites, NVP phase out and HIV RTK supply opimization, increase MMD /ASM to 605 of ART patient and support quanitification of HIV commodity need
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 500,000.00	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP19	COP21	tracking patient level drug information in high case load helth facilities
USAID	U.S. Agency for International Development	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 40,000.00		COP18	COP19	The retention amount paid to the contractor per the agreement
USAID	Chemonics International, Inc.	ASP: Procurement & supply chain management	Non-Targeted Pop: Not disaggregated	$ 1,392,000.00	Weak supply chain system due to In adquate of Supply chain work force, lack of standardize work flow, poor infrastructure	COP18	COP20	ARV stockout less than 5%, Stock according to plan 40%.
USAID	TBD	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 991,588.00	Limited local capacity (CSO and governmental) on health program management and efficient use of resources	COP19	COP21	Conduct local implementing partners landscape and organizational capacity assessment and develop plan to address deficiencies. This is critical to ensure sustainable transition to country led HIV epidemic control programming.
USAID	Chemonics International, Inc.	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 384,000.00	Weak supply chain system due to inadequate supply chain workforce, lack of standardized work flow, poor infrastructure	COP19	COP20	Reduce wastage to 3%, Stockout 3%, increase availability to 99%
USAID	UNIVERSAL CONSTRUCTION	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 250,000.00		COP18	COP19	The retention amount paid to the contractor per the agreement
HHS/CDC	FEDRAL POLICE COMMISSION HIV /AIDS PREVENTION AND CONTROL O	ASP: HMIS, surveillance, & research	Priority Pops: Military & other uniformed services	$ 50,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	FEDRAL POLICE COMMISSION HIV /AIDS PREVENTION AND CONTROL O	ASP: Laboratory systems strengthening	Priority Pops: Military & other uniformed services	$ 30,000.00	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service inttruption due to machine failure by 90%
HHS/CDC	OROMIA REGIONAL HEALTH BUREAU	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,144,105.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response
HHS/CDC	OROMIA REGIONAL HEALTH BUREAU	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 317,152	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service inttruption due to machine failure by 90%
HHS/CDC	ADDIS ABABA CITY ADMINISTRATI ON HEALTH BUREAU	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 720,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response
HHS/CDC	ADDIS ABABA CITY ADMINISTRATI ON HEALTH BUREAU	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 60,000	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service inttruption due to machine failure by 90%
HHS/CDC	SOUTHERN NATIONS NATIONALITIE S & PEOPLES REGIONAL STATE HB	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 250,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response
HHS/CDC	SOUTHERN NATIONS NATIONALITIE S & PEOPLES REGIONAL STATE HB	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 54,050.00	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	Reduce viral load service inttruption due to machine failure by 90%
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 3,019,159.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	.HIV case reporting system established to avail data from 435 facilites in all regions to a central data repository and used for program decision making. -.112 health facilities using next generation ART smart care/EMR. .Health information exchanges across disparate information systems (lab, clinical and surveillance), establishment of unique client identfication through master client registries in all regions
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 400,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP20	Implementation of data quality and information use support in all regions and provide TA to the National DQA Program
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 400,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP17	COP21	Functional patient level information system with capacity to capture HIV care continuum indicators
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 2,979,743.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP19	COP21	Protocol developed, cleared and survey conducted.

Table 6-E (Entry of Above Site Programs Activities)

Funding Agency	PrimePartner	COP19 Program Area	COP19 Beneficiary	Activity Budget	Key Systems Barrier	Intervention Start	Intervention End	COP19 Benchmark
HHS/CDC	Trustees Of Columbia University In The City Of New York	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 500,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP17	COP21	TA support to nation and regional comprehensive HIV clinical and programmtic monitoring; use and expand best practice to improve quality od patient care
HHS/CDC	AMHARA REGIONAL HEALTH BUREAU	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,000,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response
HHS/CDC	AMHARA REGIONAL HEALTH BUREAU	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 239,482.00	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	90% VL Coverage
HHS/CDC	World Health Organization	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 175,000.00	Slow progress in policy adaptation and implmentation of globally recommended new stratgies and approaches	COP17	COP20	Full transition to TLD; 3HP roll out atleast to 50% of eligible client coverage; Policy guidance and national guideline in place for SNS and services for men.
HHS/CDC	World Health Organization	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 50,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP17	COP21	All TPT data report regularly reported by service coverage and kind of regimen.Annual HIV and TB program report analyzed and dissiminated.
HHS/CDC	UNIVERSITE CHEIKH ANTA DIOP	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 331,100.00	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	8 VL labs accrediated
HHS/CDC	FEDERAL HIV/AIDS PREVENTION A ND CONTROL OFFICE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 200,000.00	Slow progress in policy adaptation and implementation of globally recommended new strategies and approaches	COP19	COP21	Improved capacity to manage transition of case finding, linkage, initiation and retention and viral suppression in the transition region and partners. Increased engagment of stakeholders
HHS/CDC	ETHIOPIAN PUBLIC HEALTH INSTI TUTE	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 1,957,495.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP21	HIV case reporting will be fully integrated with the Ethiopian national PHEM (public health emergency management) system and HIV case report will be generated from all HIV service providing health facilities in the country and used for public health response
HHS/CDC	ETHIOPIAN PUBLIC HEALTH INSTI TUTE	ASP: Laboratory systems strengthening	Non-Targeted Pop: Not disaggregated	$ 600,000.00	Inadequate access to high quality HIV laboratory services, esp. VL and EID	COP17	COP21	90% National VL coverage
HHS/CDC	ETHIOPIAN PUBLIC HEALTH INSTI TUTE	ASP: Policy, planning, coordination & management	Non-Targeted Pop: Not disaggregated	$ 20,000.00	Slow progress in policy adaptation and implementation of globally recommended new strategies and approaches	COP18	COP21	Guideline for Recnecy assay devloped and distributed
HHS/CDC	ETHIOPIAN PUBLIC HEALTH ASSOC IATION	ASP: HMIS, surveillance, & research	Non-Targeted Pop: Not disaggregated	$ 85,000.00	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	COP18	COP19	Draft report produced ands used to inform programs
State/AF	DEPARTMENT OF STATE	ASP: Not Disaggregated	Non-Targeted Pop: Not disaggregated	$ 3,000,000.00		COP16	COP21	Reach 90% completion of all construction by the end of COP 19
USAID	Population Services International	ASP: HMIS, surveillance, & research	Key Pops: Not disaggregated	$ 150,000.00	Insufficient system to capture/monitor	COP19	COP21	Integration of CBS and recency testing into DIC