Ethiopia Country Operational Plan
COP 2021
Strategic Direction Summary

Final May 26, 2021

Contents

PEPFAR Acronyms

MOH	Ministry of Health
ALHIV	Adolescents Living with HIV
ARV	Antiretroviral
ART	Antiretroviral Treatment
CoE	Center of Excellence
CxCa	Cervical Cancer
CSO	Civil Society Organization
CAG	Community ART refill Groups
CLM	Community Led Monitoring
COP	Country Operational Plan
DHS	Demographic Health Survey
DOD	Department of Defense
DSDM	Differentiated Service Delivery Models
DSD	Direct program support
DIC	Drop -in Center
EID	Early Infant Diagnosis
EAC	Enhanced Adherence Counselling
EPHIA	Ethiopia Population HIV Impact Assessment
ETB	Ethiopian Birr
EFDA	Ethiopian Food & Drug Administration
EPSA	Ethiopian Pharmaceutical & Supplies Agency
EPHIA	Ethiopian Public Health Institute
FBO	Faith based organization
FSW	Female Sex Worker
GBV	Gender Based Violence
GFATM	Global Fund for Tuberculosis, HIV/AIDS & Malaria
GoE	Government of Ethiopia
GDP	Gross Domestic Product
HCW	Health Care Worker
HIVDR	HIV Drug Resistance
HEI	HIV Exposed Infants
HIVST	HIV Self Testing
HTS	HIV Testing Service
FFHAPCO	Federal HIV/AIDS Prevention & Control Office
HIV	Human Immunodeficiency Virus
IBBS	Integrated Biological & Behavioral Survey
ICT	Index Case Testing
INGO	International Non-Governmental Organization
IPLS	Integrated Pharmaceutical Logistics System
IPV	Intimate Partner Violence
ITT	Interruption To Treatment
KP	Key Populations
LIP	Local Implementing Partner
MARPs	Most at risk populations

MOU	Memorandum of Understanding
MCH	Mother & Child Health
MMD	Multi-month dispensing
NHA	National Health Accounts
NNT	Number needed to test
NSP	National HIV Strategic Plan
NGO	Non-Governmental Organization
OTZ	Operation Triple Zero
OI	Opportunistic Infection
OVC	Orphans & Vulnerable Children
OPD	Outpatient Department
PNS	Partner Notification Strategy
PCAD	Peer led community based ART distribution
PLHIV	People Living with HIV
PWID	People with Injecting Drug Use
PEPFAR-E	PEPFAR Ethiopia
PMIS	Pharmaceutical Management Information System
POCT	Point of Care Testing
PCR	Polymerase Chain Reaction
PrEP	Pre-exposure Prophylaxis
PBFW	Pregnancy & Breast Feeding Women
PMTCT	Prevention of Mother to Child Transmission
PP	Priority Populations
PICT	Provider Initiated Testing
RTK	Rapid Test Kit
RHB	Regional Health Bureau
RoTA	Replication of Operation Triple A
SW	Sex worker
SNS	Social Network Testing
SNNPR	Southern Nations & Nationalities Region
SNU	Sub National Unit
SID	Sustainability & Index Dashboard
TA	Technical Assistance
TPT	Tuberculosis Preventative Therapy
USG	United States Government
VAC	Violence Against Children
VL	Viral Load
VLS	Viral Load Suppression
VMMC	Voluntary Male Medical Circumcision

1. Goal Statement

In COP21, PEPFAR-Ethiopia (PEPFAR-E) will continue to support the national HIV program as it confronts the challenges of the COVID-19 pandemic and major conflict across the country, both of which threaten Ethiopia's progress towards epidemic control. The program focuses its investments to achieve the 95-95-95 targets in five priority regions while strengthening critical systems nationally. There are no major policy barriers impeding achievement of these targets.

PEPFAR-E HIV services are primarily delivered and monitored through government and civil society organizations (CSOs), a successful outcome of targeted technical assistance and capacity building of these institutions. Leadership capacity of federal institutions, regional health bureaus, and CSOs will continue to be strengthened for effective coordination. PEPFAR-E will work closely with all partners to strengthen collaboration to find, treat, and virally suppress remaining cases. Interventions will focus on facilities and communities with the highest estimates of HIV burden and program performance as demonstrated through HTS _POS, TX_CURR, and TX_PVLS indicators. We will continue to provide vital support to orphans and vulnerable children.

PEPFAR-E will continue to adapt program support to mitigate COVID-19 risks through the expansion of e-platforms, virtual mentoring for health care providers, counselling for clients, and promoting expanded options for self-testing and multi-month ART dispensation. The accelerating COVID-19 pandemic will require ongoing efforts to maintain robust infection prevention and control precautions to protect both the health workforce and clients. In light of major conflict in the Tigray region, PEPFAR-E will provide targeted support of key facility and community implementing partners, and support key government institutions to revitalize HIV services in the region including an emphasis on continuity of treatment, and systems interventions that support treatment continuity.

Through the above approaches, PEPFAR-E will also support:

- Revising case finding strategies to further improve testing yield through optimized modalities;
- Strengthening continuity of treatment activities to minimize treatment interruption and expand return-to-treatment programs;
- Decreasing HIV-related mortality through increased attention to Advanced HIV Disease;
- Improving pediatric treatment coverage and viral load suppression in ages <10 years and mortality reduction in ages <5 years;
- Linking OVC and their HIV+ caregivers to high impact HIV services, with additional provision of primary prevention interventions for children age 9–14 years;
- Introducing tailored treatment models for those over 50 years to improve health-related quality of life; and,
- Supporting PMTCT interventions and increasing EID coverage.

Provision of technical assistance (TA) is focused on: (1) reinforcing sub-national capacity for

leadership and governance; (2) supporting ongoing national efforts for domestic resource mobilization and resource mapping; (3) improving laboratory systems; (4) strengthening case-based surveillance and response, including recency testing and related health information systems; (5) improving supply chain management and systems for improved HIV commodity availability and access; and (6) enhancing quality improvement for client-centered clinical services.

Critical stakeholder and partner engagement efforts continue to focus on stigma and discrimination reduction, enhanced and continuous community engagement, adoption of the latest evidence-based best practices, and careful targeting of program interventions to achieving and maintaining epidemic control in Ethiopia.

2. 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. The estimated population is around 103,389,414 (July 2020) divided among approximately 80 ethnic groups. Ethiopia's real gross domestic product growth slowed to 6.1% in 2019/20 due to the effects of COVID-19, with a per capita income of $850.[1] The median age is 19.6 years with a population growth rate of 2.56% (2020 est.) 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, now estimated at 24% (2015 World Bank); since 1990, the total fertility rate (TFR) has declined from 7.2 to 4.6; the infant mortality rate has declined from 120 per 1,000 live births to 41; and the adult literacy rate has increased from below 25% to 49%.

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

Table 2.1.0 Regional estimates of people living with HIV (PLHIV) and HIV prevalence[2]

Row Labels	Sum of Host Country Est. PLHIV (FY21)	Prevalence (Spectrum Regional Estimate-15+) %
Amhara	190,930	1.3
Oromia	150,866	0.6
Addis Ababa	104,743	3.4
Tigray	49,133	1.3
SNNPR	47,015	0.4
Sidama	20,579	0.7
Gambella	13,488	3.9
Afar	11,689	0.9
Dire Dawa	11,014	3.0
Benishangul-Gumuz	6,032	0.8
Somali	5,402	0.1
Harari	5,214	2.9
Grand Total	616,105	0.9

*SNNPR

[1] World Bank 2021
[2] SPECTRUM 2021 estimates

The current 2021 UNAIDS Ethiopia Spectrum national PLHIV estimate is 616,105. The conflict in Tigray, which started in November 2020, is threatening Ethiopia's continuing momentum to reach epidemic control and determining the national HIV cascade is hampered because of lack of reporting from Tigray. As of FY20 Q4, there were 42,172 (9.7% of the country total) people receiving ART in Tigray. It is estimated that 74.8% of HIV positive adults (ages 15-64 years) know their HIV status; among adults living with HIV who know their HIV status (excluding Tigray), 71% were receiving ART; and among adults receiving ART, 91% were virally suppressed. The viral load coverage has decreased because of the dual use of PCR Machines for COVID-19 identification. Therefore, viral load suppression estimates represent data only from viral load coverage of 73%, with the viral suppression status of an estimated 159,533 clients unknown. Of people who received HIV testing service in the past year, the overall yield was 0.5% ; of those testing positive, 73% were linked to treatment. (MOH Annual Review Table 2.1.2)

Apart from revised SPECTRUM estimates, there is sparse updated epidemiological information. KPs & PPs,[i.e. FSWs, widowed and divorced people, truck drivers, adolescent girls and young women (AGYW) engaged in transactional sex, male clients of sex workers (SWs)], people who inject drugs (PWID) and those who live along major transport corridors are all estimated to have significantly higher HIV prevalence rates than the general population, but recent size estimates are lacking. The Gambella region continues to have the highest HIV prevalence with little distinction between urban and rural residents; 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 20-39 years 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.

Table 2.1.1 Ethiopia Government Results															
	Total		<15				15-24				25+				*Source, Year*
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	103,389,414	100%	20,051,622	19.4	20,597,513	19.9	10,741,142	10.4	11,075,099	*10.7*	20,699,880	20	20,224,158	19.6	Central Statistical Authority(CSA) Projections
HIV Prevalence (%)		0.9		NA		NA		0.26		0.18		1.84		0.84	DHS 2016
AIDS Deaths (per year)	11,673		NA		NA		NA		NA		NA		NA		2021 Spectrum
# PLHIV	616,105		19,265		19,861		40,106		27,324		322,308		187,241		2021 Spectrum
Incidence Rate (Yr)		0.01		NA		NA		NA		NA		NA		NA	2021 Spectrum
New Infections (Yr)	10,943														2021 Spectrum
Annual births	3,149,003														Refers to Year 2020, CSA, and DHS 2016
% of Pregnant Women with at least one ANC visit		69	NA	NA			NA	NA			NA	NA			Health Sector Transformation Plan, Annual performance report 2019/2020. The indicator available is Pregnant women received four or more ANC visits
Pregnant women needing ARVs		17,635													2021 Spectrum
Orphans (maternal,															

paternal, double)															
Notified TB cases (Yr)	112,000														Global TB Control Report
% of TB cases that are HIV infected		6%													Global TB Control Report
% of Males Circumcised		91													DHS 2016
Estimated Population Size of MSM*	NA														Extrapolated from Size Estimation exercises by PEPFAR E interagency Team
MSM HIV Prevalence	NA														
Estimated Population Size of FSW	223,138														Extrapolated from Size Estimation exercises by PEPFAR E interagency Team
FSW HIV Prevalence		24													National MARPS Survey
Estimated Population Size of PWID															
PWID HIV Prevalence															
Estimated Size of Priority Populations (specify)	2,373,935	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
Estimated Size of Priority Populations Prevalence (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table. Cite sources*														

(maternal, paternal, double)															Spectrum from MOH
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	209,755	72%	NA		NA		NA		NA	136,896	75%		35,331	63%	Program data
Estimated Population Size of FSW	223,138														Extrapolated from Size estimation by PEPFAR-E interagency
FSW HIV Prevalence		23%	NA		NA		NA		NA		NA		NA		National MARPs survey, EPHI/CDC national MARPs survey report
Estimated Size of PPs	2,373,935	NA	NA	N A	NA		NA		NA		NA		NA	NA	UNAIDS
Estimated PPs Prevalence	NA	NA	NA		NA		NA		NA		NA	NA	NA	NA	

Table 2.1.2 95-95-95 cascade: HIV diagnosis, treatment and viral suppression*										
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
Total population	103,389,414	1%	616,105	491,036	479,618	78%	91%	7,838,039	39,974	*29,196*
Population <15 years	40,649,135	NA	39,126	25,091	17550	45%	75%	NA	NA	NA
Men 15-24 years	11,075,099	0%	27,324	18,084	13632	50%	100%	NA	NA	NA
Men 25+ years	20,224,158	1%	187,241	161,077	156750	84%	94%	NA	NA	NA
Women 15-24 years	10,741,142	0%	40,106	25,668	22737	57%	83%	NA	NA	NA
Women 25+ years	20,699,880	2%	322,308	261,116	268949	83%	93%	NA	NA	NA
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	223,138	23%	NA	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*Table represents National figures over the Ethiopian Fiscal Year (July 2019-June 2020)

Figure 2.1.3 National and PEPFAR-E Trend for Individuals currently on Treatment[1]

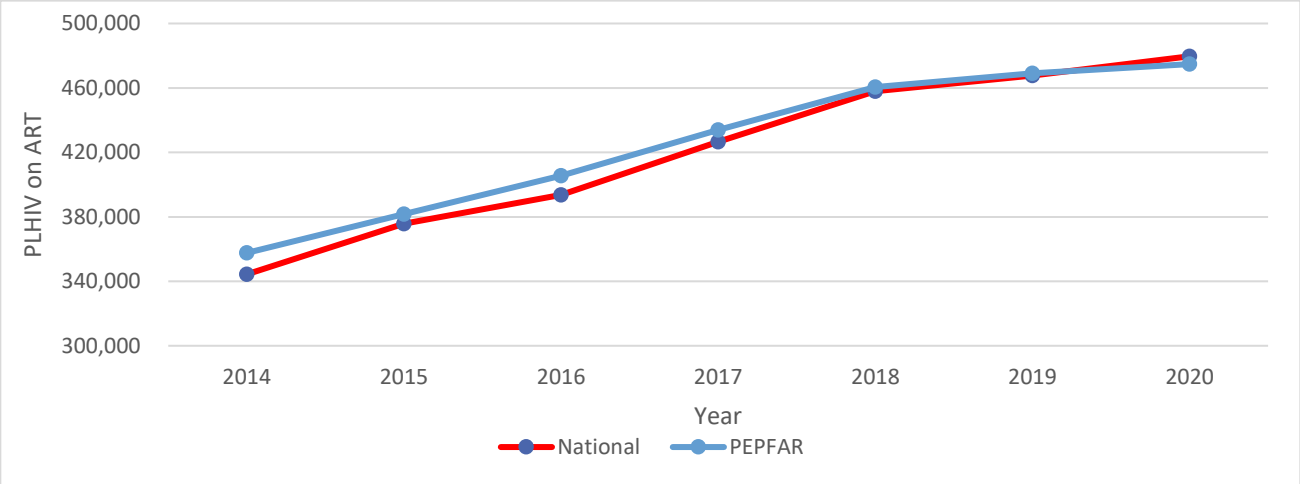
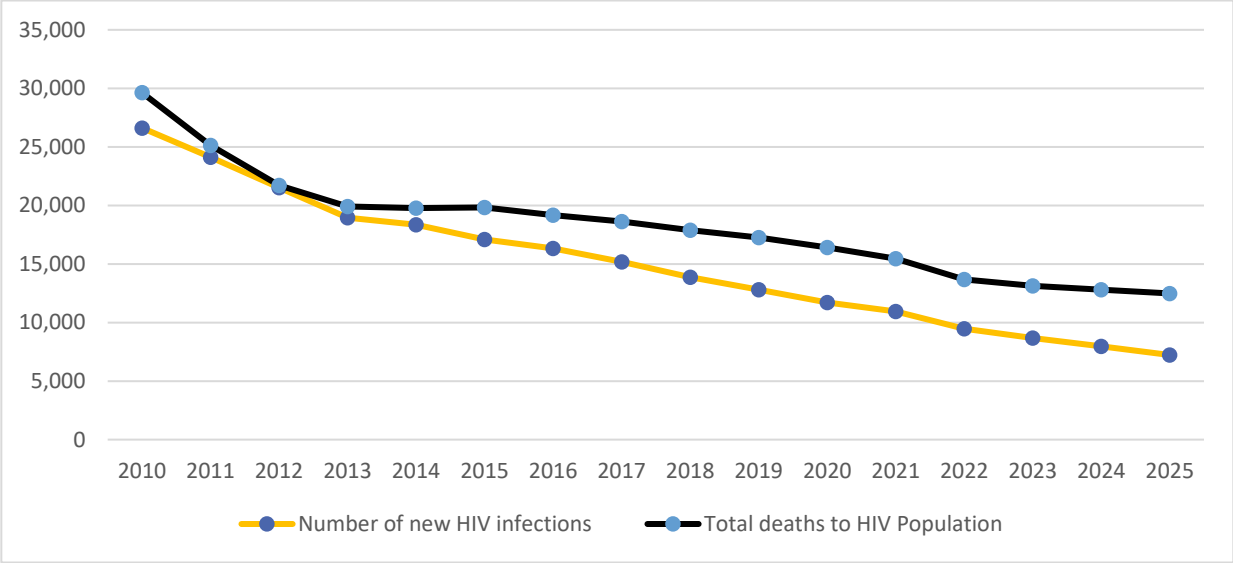


Figure 2.1.4 Trend of New Infections and All-Cause Mortality Among PLHIV[2]



[1] 2020 Spectrum Estimates

National Fiscal year is a quarter ahead of PEPFAR Fiscal year (June and September respectively). According to PEPFAR programmatic strategy, geographic prioritization, there have been transitions of Woredas/ districts but that is not visible here as we continue to count a large number of PLHIV receiving treatment services in centrally supported areas. The latter resulted in very small differences between the government and PEPFAR figures. Estimates of new HIV infections and deaths to HIV population for years 2021-2025 are projections provided by the Spectrum model.

[2] 2020 Spectrum Estimate

Figure 2.1.5. Epidemiological trends and Program Response

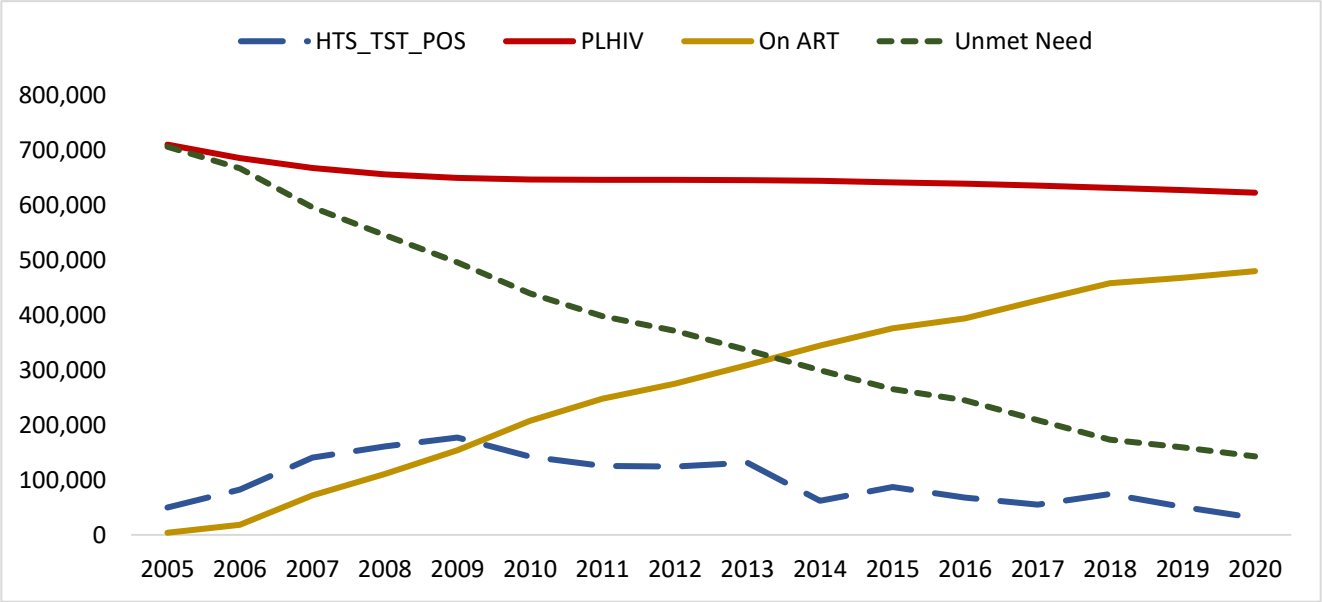
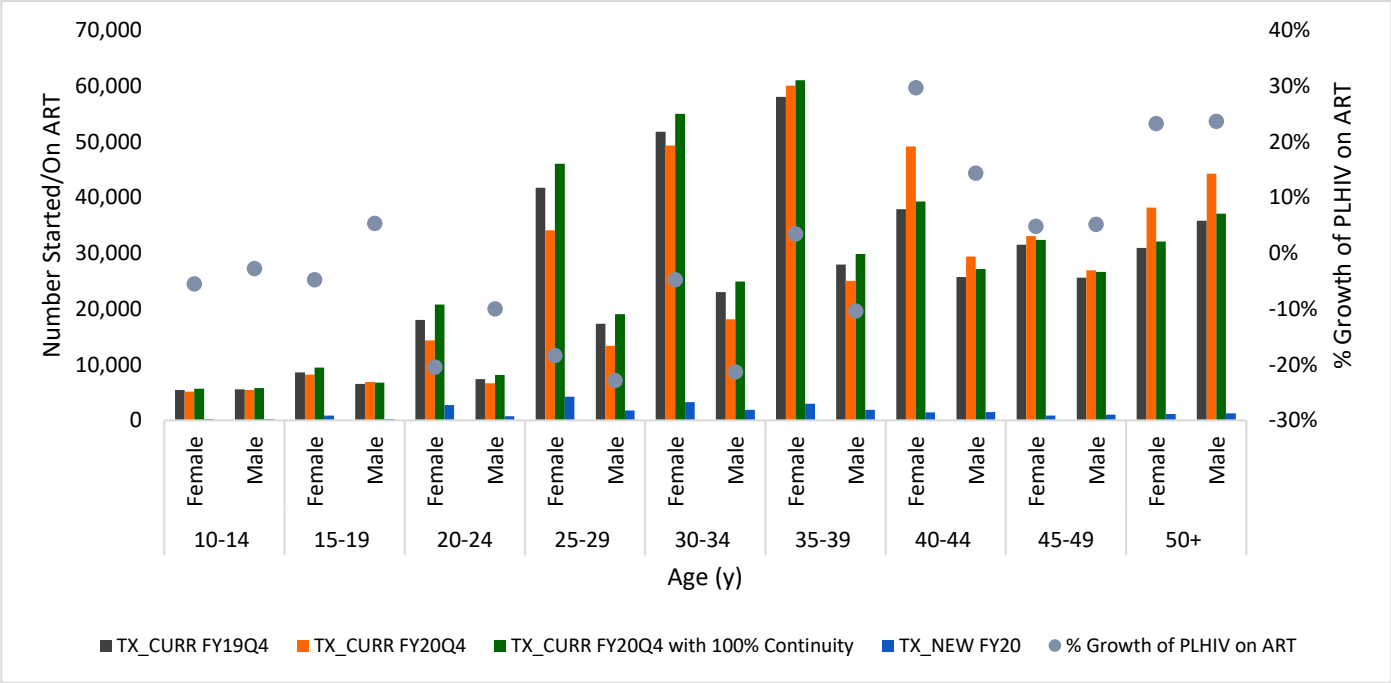


Figure 2.1.6 Net change in HIV treatment by sex and age bands FY19Q4-FY20Q4



2.2. New Activities and Areas of Focus for COP21

As Ethiopia inches closer to attaining the 95-95-95 targets for treatment coverage and reaching epidemic control, major programmatic challenges appear to be scaling up high-yield testing strategies to grow the treatment cohort, maintaining continuity of treatment for clients newly initiating ART, and increasing viral load testing coverage. These challenges become increasingly difficult to overcome as the program moves out of geographic areas that previously received direct program support (DSD) and as the number of PLHIV that do not know their status and/or are not in the program receiving treatment become fewer. Despite COVID-19, the program has managed to maintain progress in addressing these challenges.

Ethiopia will continue to implement and scale client centered services including differentiated models of service delivery, extended working hours to provide ART services during weekends, holidays, after-hours, etc., adolescent-friendly services, separate space and scheduling for clients with high viral load, facility-community collaboration for case identification, adherence support, implementation of DSD and tracing and return to treatment of clients. with treatment interruption. To further strengthen treatment continuity, PEPFAR Ethiopia will focus on strengthening and expanding the implementation of 6 months multi-month dispensing (MMD) and health worker managed community ART refill groups (CAG), Peer led community based ART distribution (PCAD) and while also introducing fast track pharmacy refills.

Based on identified gaps in treatment continuity and interruption, return to treatment initiatives will be undertaken in selected geographic areas and sites to identify, track, and support PLHIV to re-enroll in ART. Additional focus will be made to implement DSD for virally unsuppressed clients and clients newly initiated on treatment, address advanced HIV disease and services aimed at the over 50 years cohort, ensuring that co-morbidities are managed and age-specific peer support is provided. This will be done in close collaboration and coordination between facility and community stakeholders. There will be routine activities at site and community levels for early identification, reporting, and follow-up to support clients with treatment interruption and strengthen documentation of mortality and facility transfers among PLHIV receiving treatment. In addition, due to ongoing and intermittent security issues in different parts of the country, it is expected that there will be intermittent, localized interruptions in the provision of services and program activities. In affected areas, appropriate messaging on the availability of services providers, the importance of treatment continuity and the benefits of viral suppression will be provided. Health facilities and providers will be capacitated to address the demands and needs of those PLHIV who may be displaced or self-transferred to another treatment site The main driver in increasing the treatment cohort is HIV case finding and the program will work to strengthen case finding, linkage to rapid ART initiation, and treatment continuity.

Based on lessons learned and the successful implementation of Operation Triple Zero (OTZ) in Addis Ababa, there will be expansion and scale-up of OTZ and other adolescent-centered programs to improve treatment continuity and viral suppression among adolescents living with HIV (ALHIV). While these programs have produced encouraging results among adolescents, viral suppression in children <10 years remains sub-optimal. Interventions that focus on a family centered approach, pediatric regimen optimization, support for improved medication dispensation and adherence, and recruitment into the OVC program will be made. Furthermore, PEPFAR Ethiopia will support implementation of package of care for

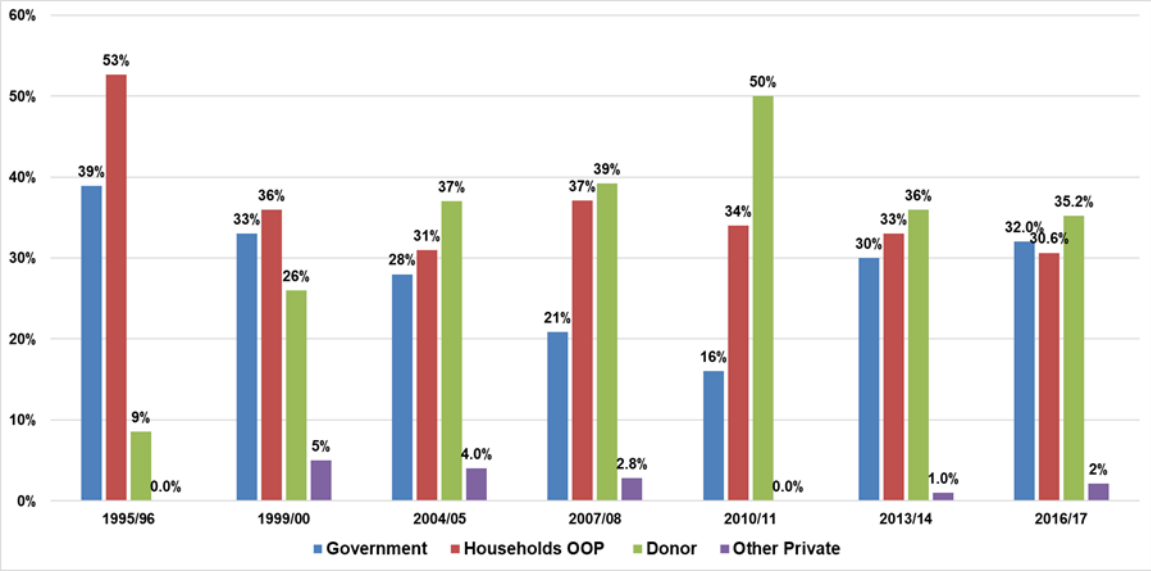
children with advanced HIV disease to reduce mortality in children <5 years. Reduction of stigma and discrimination at all levels, including facilities and communities and continued collaboration and engagement with community members, will continue to be integral to all partners' efforts.

2.3. Investment Profile

The MOH recently completed the seventh round of the National Health Accounts (NHA 2016/17). The 2016/17 NHA is the latest available data on health spending that was released in September 2019. According to the 2016/17 NHA, the health expenditure in Ethiopia is estimated to be ETB 72.1 billion (3.1 billion USD). The 2016/17 NHA report indicates that this is a 45 percent increase in nominal terms from ETB 49.6 billion(2.5billion USD) in 2013/14.

The NHA further indicates that the Government manages more than half of the total health resources (52%), while it contributes only 32%. The GoE accounted for one third of health spending, with a remarkable increase in its nominal value of health spending from ETB 4.7 billion to 23.7 billion between 2013/14 to 2016/17. External funding and out-of-pocket spending on health accounted for 66 percent of the total health expenditure (see figure 2.3.1).

Figure 2.3.1 Total Health Expenditure by source of Financing (percentage), 2016/17 NHA

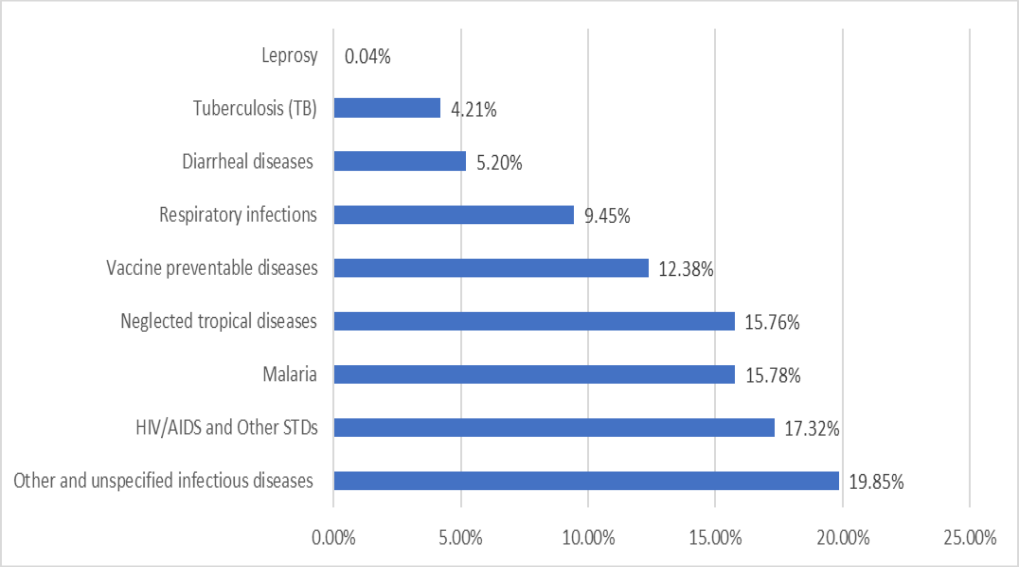


A significant share of health spending on infectious and parasitic diseases went to curative care (42%), while the prevention component was supported by around 37%. Of health spending on infectious and parasitic diseases, nearly 17.32% went to HIV/AIDS (see figure 2.3.2). Out of the total health expenditure on infectious and parasitic diseases, health spending on curative care reduced by 7% since 2013/14.

Though health spending is steadily growing overall in volume, the GoE contribution is still low. The share of government health expenditure was found to be 1.4% of GDP in 2016/17, which is far below the global average of 5.3%. The host government covers the costs of personnel, office space and other operational expenses for the health facilities (health posts, health centers,

hospitals, and regional laboratories) and above site structures such as MOH, HIV/AIDS Control and Prevention Office (FHAPCO), Ethiopian Pharmaceutical and Supplies Agency (EPSA), Ethiopian Public Health Institute (EPHI), Regional Health Bureaus, Zonal health offices, woreda health offices.

Fig 2.3.2 Infectious disease share of government expenditures



More recently, the National AIDS Spending Assessment covering the total spending and flow of HIV/AIDS funds during the period 2017/18 to 2018/19 from the public, private, and international stakeholders was completed. The overall HIV spending in Ethiopia was US $280.2 million in 2017/18, with a 14% decrease in 2018/19 to US $241.9 million, largely as a result of a decrease in international donor funding from 85.9% to 82.4%. Government contributed 13.7% in 2017/18 and 17% in 2018/19 while the private sector contributed less than 1% in both years. This emphasizes the critical reliance of the HIV/AIDS program on international donors, with 96% of the funding for care and treatment programs coming from external sources. PEPFAR contributed US $140.4 million in 2017/18, decreasing substantially to US $92.7 million in 2018/19. The Global Fund was the most significant contributor in the multilateral category with an increase from US $91.5 million in 2017/18 to US $95.8 million in 2018/19, followed by International Non-Governmental Organizations (INGOs). Fifty-seven percent of all HIV funding went through public agents/purchasers (in 2018/19), which implies important leadership/ownership by the government. There is no doubt that the GoE is making significant contributions to the HIV response, principally to human resources, infrastructure, and other health systems costs, but there is a need for the GoE to explore domestic resource mobilization options for long term sustainability[3].

[3] Ethiopia National AIDS Spending Assessment (NASA) Report (2017/18 and 2018/18) FHAPCO, 2021

Table 2.3.3 Annual Investment Profile for HIV by Program Area[3]

Program Area	Total Expenditure	% PEPFAR	% GF	% Host Country	% other SDG
Clinical care, treatment and support	21,791,430	95%	5%		
Community-based care, treatment, and support	5,079,924	100%			
PMTCT	-				
HTS	12,777,269	100%	0%		
VMMC	1,199,451	100%			
Priority population prevention	1,245,827	100%	0%	0%	0%
AGYW Prevention	-				
Key population prevention	7,997,979	91%	9.6%	0%	0%
OVC	10,127,177	100%			
Laboratory	13,095,924	100%	0%		
SI, Surveys and Surveillance	10,741,115	100%			
HSS	36,303,402	76%	24%	0.05%	0.01%
Total	**120,359,498**	91%	9%	0.02%	0.00%

Table 2.3.4 Annual Procumbent Profile for Key Commodities						
Product Category	**Forecast for July 2021 - June 2022**	**PEPFAR**	**GF***	**GOE**	GAP[1]	**Remark**
ARVs	$49,158,789	$98,784	$40,555,116		$8,504,889	This is the new GF grant that starts July 2021. The figures here do not include pipeline deliveries under the current grant. This gap thus will be covered by the stock on hand and the pipeline order
Medicines for opportunistic infections and sexually transmitted infections	$2,848,112		$1,749,485	$700,000	$1,098,627	
Condom requirements	$1,603,692	$400,000	$1,078,686		$125,006	

HIV diagnostic rapid test kits	$7,666,905	$1,243,745	$6,713,846		$0	Includes RTKs for community, as well as Covid-supplemental funding and to cover delays in EPSA procured RTKs
HIV recency test	$284,086	$284,086			$0	
EID and Viral load monitoring pharmaceuticals	$10,449,430	$8,900,802			$1,548,628	The Gap will be covered by the stock on hand and the pipeline order
CD4 reagents	$2,109,577		$1,476,704	$3,388,294,294		There is a risk that the Government co-financing commitment may not materialize for timely procurement.
Hematology reagents	$584,952			$ 970,598		
Chemistry reagents	$400,534.35			$1,198764		
Lab consumables	$665,346		$665,346			
Other lab reagents and consumables (EQA)	$391,266	$391,266.00			$0	
TPT	$2,191,518		$646,056		$1,545,463	It is expected that TPT needs will be further covered by INH as well as pipeline 3HP supplies from COP20.
TB Lab	$630,515				$0	
Hepatitis	$3,899,910				$0	
Cervical Cancer supplies	$541,286				$0	
Total	$83,425,507.24	$10,391,476	$52,219,893	$4,008,294		

[1] The gap for some commodities is not a real gap as only takes into account the financial year funding and does not reflect current Stock on hand and shipments in pipeline. USG does not expect a gap in VL/EID, ARVs, and potentially TPT.

Table 2.3.5 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-funding PEPFAR IM	# Co-Funded IMs	PEPFARCOP Co-Funding Contribution	Objectives
USAID MCH	38,650,000	1,000,000	1	302,224	Health Care financing including HIV sustainable financing support
USAID TB	14,000,000				
USAID Malaria	36,000,000				
Family Planning	31,000,000	1,000,000			Same as above
NIH					
CDC (Global Health Security)					
Peace Corps					
DOD Ebola					
MCC					
Other (specify)					
Total	**119,650,000**	**2,000,000.00**	**1**	**302,224**	

2.4. National Sustainability Profile Update

The Sustainability and Index Dashboard (SID) tool is completed every two years by PEPFAR teams, partners, and stakeholders to assess the state of sustainability of the national HIV/AIDS response across countries and to monitor its progress over time. Table 2.4.1 outlines prior FY19 SID results. There are no further updates for COP 21. Based on Table 1, there remain two areas of concern: Commodity security and supply chain and private sector involvement. The majority of the other areas covered by the SID (shown in yellow) suggest the need for continued investment.

Table 1: Sustainability Element Score Criteria
Dark Green Score (8.50-10.00 pts) (sustainable and requires no additional investment currently)

Light Green Score (7.00-8.49 pts) (approaching sustainability and requires little or no investment)
Yellow Score (3.50-6.99 pts) (emerging sustainability and needs some investment)
Red Score (<3.50 pts) (unsustainable and requires significant investment)

Table 2.4.1: Results of Sustainability Analysis for Epidemic Control in Ethiopia

	2015 (SID 2.0)	2017 (SID 3.0)	2019	2021
Governance, Leadership, and Accountability				
1. Planning and Coordination	7.87	9.29	8.12	
2. Policies and Governance	6.58	8.08	6.08	
3. Civil Society Engagement	4.00	5.17	4.17	
4. Private Sector Engagement	4.44	8.39	1.94	
5. Public Access to Information	7.00	6.00	6.56	
National Health System and Service Delivery				
6. Service Delivery	4.40	5.32	4.01	
7. Human Resources for Health	6.00	6.06	5.71	
8. Commodity Security and Supply Chain	7.08	7.08	3.05	
9. Quality Management	1.62	6.67	4.62	
10. Laboratory	5.51	5.42	4.78	
Strategic Financing and Market Openness				
11. Domestic Resource Mobilization	2.78	6.94	5.36	
12. Technical and Allocative Efficiencies	1.11	5.56	4.44	
13. Market Openness	N/A	N/A	8.70	
Strategic Information				
14. Epidemiological and Health Data	4.48	4.90	4.12	
15. Financial/Expenditure Data	3.75	6.67	5.83	
16. Performance Data	4.74	5.97	6.83	
17. Data for Decision-Making Ecosystem	N/A	N/A	4.17	

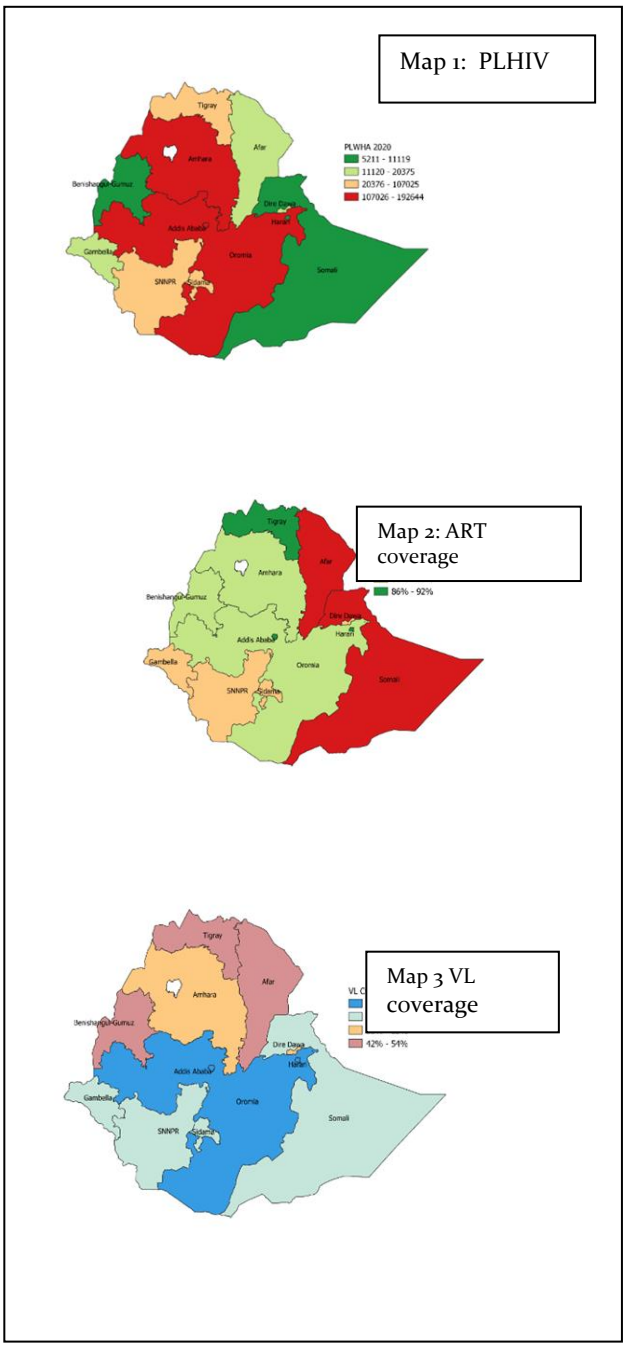
2.5. Alignment of PEPFAR investments geographically to disease burden

HIV care and treatment services are available across Ethiopia largely through public health facilities and community-based platforms. In FY20, 474,597 PLHIV received treatment at PEPFAR-supported sites with an overall 71% viral coverage and 93% viral suppression rate. However, following the eruption of conflict in Tigray region, the exact status of the 42,172 PLHIV who were receiving treatment is unknown. Targeted support will be provided to find and restore these individuals in care including support of the essential systems that are required to ensure quality care of PLHIV in that region.

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 ART regimens, and patients on ART receive an initial 6 month and then annual VL test, consistent with national HIV guidelines.

The working 2021 SPECTRUM estimate of PLHIV, the 2018 EPHIA and program data for PLHIV currently on ART (TX_CURR) were used to understand treatment gaps by geography to achieve 95-95-95. The SNUs/geographic locations with the greatest treatment gap are Oromia (20,947) and Amhara (28,952), with Addis Ababa having achieved 95-95 treatment coverage. In regions that have lower unmet needs and are approaching epidemic control, direct PEPFAR funding support ceased in COP19 and these regions receive TA support through a national TA model, led by FHAPCO and the MOH.

Figure 2.5.1 PLHIV, ART coverage, and VL coverage, by SNU



2.6 Stakeholder Engagement

In support of COVID mitigation measures for large in-person meetings, the PEPFAR-E team has made every attempt to provide an open and consultative process in the development of COP21. As such, a virtual stakeholders meeting was held on January 28th 2021, early in the COP21 development process, with broad participation from the GoE, multilateral organizations, and civil society. The COP21 guidance, tools, and planning level letter were shared with external stakeholders. Presentations from the FY20Q4 and FY21 Q1 POART calls were also shared. A further virtual in-country stakeholder consultation to share and elicit feedback for COP21 plans was attended by Dr. Lia Taddesse, the Minister of Health, and had wide participation from MOH FFHAPCO, EPHI, implementing partners, PLHIV networks, civil society, and multilateral institutions (GFATM, UNAIDS, WHO). During COP Planning Meetings held on April 15th and 16th 2021, opportunities for further consultation and feedback from the GOE, multilateral organizations, and civil society were also provided. All COP21 presentations and PEPFAR draft tools have been made available on a public share drive.

3. 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 in the 4 regions: Amhara, Oromia and SNNPR[4] and Addis Ababa which, have the largest gaps in treatment coverage[5]. 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. Furthermore, in light of the breakdown of essential services in Tigray, significant efforts will be made to return individuals to care and to keep them in care both at the facility and community levels. In the remaining regions with smaller gaps in treatment coverage, there will be continued strengthening of TA models. TA regions will be supported centrally through MOH agencies including FHAPCO and EPHI.

[4] In 2020, Sidama zone in SNNPR became a separated region. In this document this change is as yet to be reflected in the statistics.
[5] Program data from Addis Ababa over estimates ART coverage likely due to PLHIV from Oromia seeking treatment.

Table 3.1 ART saturation and progress towards 95/95/95 across all SNUs

Table 3.1 Current Status of ART saturation				
Prioritization Area	**Total PLHIV/% of all PLHIV for COP21**	**# Current on ART (FY20)**	**# of SNU COP20 (FY21)**	**# of SNU COP21 (FY22)**
Attained	559,214 (91%)	445,422 (94%)	743	795
Scale-up Saturation				
Scale-up Aggressive				
Sustained	33578, (5.5%)	21,443 (5%)	88	36
Central Support				

4. Client Centered Program Activities for Epidemic Control

4.1 Finding and Treating the Remaining PLHIV not Receiving Treatment

HIV case finding remains the critical gap to treatment cohort growth given Ethiopia's strong treatment continuity. Advocacy to emphasize high-yield testing modalities and alignment of national and PEPFAR testing targets was successful for inclusion in the new 5-year National Strategic Plan and new 3-year GFATM grant. PEPFAR-E will continue to work with the national program to revise national HIV testing strategy and guidelines to emphasize high-yield modalities (e.g., index-case testing, risk-based provider-initiated testing , social network strategy, use of recency testing for enhanced case finding, and elimination of universal under-5 testing). Building on the success from Operation Addis Ababa Acceleration (OTA), the Government of Ethiopia in collaboration with PEPFAR-E and other stakeholders, recently launched the Replication of Operation Triple A (RoTA) as a national campaign to enhance case finding by streamlining case finding strategies and strengthening community-facility collaboration. To reduce unnecessary testing, MOH has adapted the use of HIV risk screening tools at all service delivery points. A national Performance Improvement Plan (PIP) to improve case finding was also developed with clear and action-oriented recommendations at different levels. The PEPFAR-E team is a major stakeholder in this effort and is providing technical assistance for and regular monitoring of RoTA implementation.

Case finding strategies have adopted robust infection prevention measures to prevent COVID-19 transmission, and are tailored to the needs of prioritized geographical areas and sub-population levels.

4.1.1. Scale up of Safe and Ethical Index Case Testing

The minimum standards for safe and ethical implementation of index case testing (ICT) services were introduced and an assessment of the standards was done. Sites and providers will be supported to meet this set of minimum core standards established by the national HIV Testing Services Technical Working Group, in alignment with international consensus. These standards will address aspects including, but not limited to:

(1) Facilities will retrospectively review records to identify all eligible biological children, including adolescents ages 15-18, of adult TX_CURR and ensure testing;
(2) Facility and community-based partners will provide disclosure support and conduct active ICT services;
(3) Unassisted HIV self-testing (HIVST) through secondary distribution via index cases (and/or caregivers for children) will be used to reach partners who do not wish to see a provider. Unassisted HIVST will also be used to create testing access to clients receiving STI services and their sexual partners through secondary distribution via index clients;
(4) Community partners will provide unassisted HIVST services in the community and introduce a social marketing strategy for HIVST to increase demand and access;
(5) Client-centered counseling and testing services will be expanded, with focus on timing and accessibility for services convenient to adults and children, based on preferences, patient literacy, and ensuring high-quality, confidential counseling services;
(6) Testing data will be used to identify geographic and demographic hot-spots and further prioritize case-finding and prevention measures, in accordance with national guidelines;
(7) Index HIV and treatment literacy will be strengthened for clients and contacts;
(8) Client centered safe and ethical implementation of ICT with service package to prevent and monitor intimate partner violence and link clients at risk and survivors of IPV/GBV to appropriate services will be scaled up;
(9) Ensuring Health worker competency to provide safe and ethical ICT services will be strengthened, using culturally-appropriate counseling and contact elicitation scripts, registers, job aids, case discussions, coaching by experienced counselors, and mentoring; and,
(10) Town/Woreda health offices will be capacitated to monitor ICT performance, provide mentorship for more challenging partner services scenarios, manage cross-site and cross-jurisdiction contact tracing, and ensure linkage to treatment services.

To execute this minimum standards approach, PEPFAR-E will concentrate facility-based and community-based ICT in 181 DSD and 312 TA facilities in 114 Woredas for maximum impact. This process entails selection of priority urban and peri-urban foci within the relevant 74 zones to the sites and woredas, and further micro-plan development within each focal zone to include associated health departments, facilities, and community LIPs. These micro-plans will build capacity for the workforce at facilities and woreda health departments and among community actors to ensure the implementation of minimum standards (5Cs - consent, confidentiality, counseling, correct test results, and connections to treatment and prevention services) for provision of ICT within these zones and at high-impact sites. Local health departments will lead efforts to use Recency case surveillance and data for accelerated ICT and linkage to services, including PrEP for HIV-negative contacts in sero-discordant relationships and/or significant risk, and ensuring treatment for contacts newly-diagnosed or with known HIV infection. All these efforts will be underpinned by improving patient and provider literacy around ICT, treatment continuity, and viral suppression within the Undetectable = Untransmittable (U=U) campaign and strategic communications framework strategy led by the Federal HIV/AIDS Prevention and Control Office (FHAPCO).

4.1.2. Provider Initiated Testing and Counseling (PITC)

PEPFAR-E will further support optimization of PITC by ensuring the following standards:

(1) Facility-customized design, fully integrating HIV risk screening into routine service provision by clinicians for adult, adolescents, and children;
(2) Dedicated and family-and client-centered counseling;
(3) Increasing patient and provider literacy;

(4) Robust monitoring of the number of persons needed to test to find one positive (NNT). If utilization of HIV risk screening is >90% and NNT continues to increase, HIV risk screening strategies and tools will be refined to ensure testing is directed to service delivery points that continue to identify new cases; and
(5) High-risk, high-efficiency entry points such as STI clinics, TB, and malnutrition (for children) will be monitored to ensure testing coverage of >90%.

4.1.3. HIV Self-Testing (HIVST)

In 2017, PEPFAR-E supported the first HIVST pilot in the country in collaboration with MOH/EPHI. PEPFAR-E used this opportunity to demonstrate the feasibility of implementing HIVST in Ethiopia and advocated for implementation of unassisted HIVST at scale. This strategy has become increasingly important in the context of the COVID-19 epidemic. Currently MOH has approved the implementation of unassisted HIV self-testing to create demand and close gaps in case finding. In FY21Q1, 12,257 individuals (more than 4-fold increase compared to FY20Q1) were tested through assisted HIVST, with 315 new HIV+ cases identified (3% yield). All 315 new cases received confirmatory testing, and 94% were linked to ART. In the remaining COP20 period and in COP21, PEPFAR-E, in collaboration with MOH and implementing partners, will implement unassisted self-testing at scale both in community and facility settings to reach men, adolescent girls and young women (AGYW), and harder to reach key populations. In addition to these existing facility- and community-based initiatives to support unassisted HIVST, social marketing and distribution of HIV self-test kits will be piloted in COP20 in selected woredas in Addis Ababa. Pharmacy outlets, particularly private pharmacies, will be utilized to facilitate access to target population groups. Lessons will be drawn in COP20 on willingness to pay for HIVST kits among key and priority populations in Addis Ababa. PEPFAR seeks to launch and scale up an effective HIVST social marketing approach in COP21 in Addis Ababa City Administration, Amhara Region, and potentially other PEPFAR priority regions. PEPFAR will also work to widen the reach among target populations including clients receiving STI services and their sexual partners, who may prefer to self-test. Moreover, HIVST among children >2 years of adult index cases will be piloted in selected facilities and communities in COP20, with lessons learned used to scale up this service in COP21.

4.2. Case Finding among Key and Priority Populations

Key Populations (KPs) are among primary targets for new HIV case finding. PEPFAR FY21Q1 data show the HIV index case testing yield among tested female sex workers (FSW) and their sexual contacts was 22.2%. PEPFAR-E will continue its efforts for case finding among these populations by employing social network testing (SNS), ICT, and PNS. Currently, 40 community drop-in centers (DICs) and 80 public health facilities are providing confidential KP-friendly services tailored to their specific needs. New cases identified from public sites and DICs will be counseled and asked for their consent to elicit their sexual contacts or to serve as "seeds" for SNS. Targeted community outreach testing will be used to reach KPs that prefer to access services in their vicinity and in towns where there are no DICs. This will include hard-to-reach key and priority populations: FSW, clients of FSWs, men, and out-of-school adolescent girls and young women. To ensure safe and ethical implementation of ICT among KP's, PEPFAR-E in collaboration with MOH and implementing partners has developed and will monitor minimum standards as noted in Section 4.1.1 PEPFAR-E will ensure the integration of comprehensive Gender Based Violence (GBV) services which includes intimate partner violence (IPV) screening and management and the WHO 5 Cs (Consent, Confidentiality, Counseling, Correct test result and Connection/Linkage to prevention and care and treatment services) are in place for all HIV testing services and other case finding modalities.

4.3. Key Populations and Prevention for Priority Programming

The recently endorsed National HIV/AIDS Strategic Plan 2021–2025 defines key populations to include FSWs, prisoners, and people who inject drugs (PWID). Priority populations include widowed, separated or divorced men and women, discordant couples, mobile and resident workers in hotspot areas, young women involved in transactional sex and high risk AGYW. As per the EPHI national MARPs study conducted in 2013, the prevalence among long distance drivers is also high (4.9%). These population groups are at a high risk of HIV infection, have limited access to services, and face stigma and discrimination. There were an estimated 220,623 FSWs in Ethiopia as per the size estimates conducted by PSI and EPHI in 2011.

The PEPFAR team technically contributed and supported FHAPCO in the development of the 2021-2025 NSP. To update currently available population size estimates, an IBBS for FSW is currently being conducted by EPHI through support from Global Fund, and an IBBS among AGYW was recently completed. The PEPFAR team has used this information to inform COP21 strategies and will continue to refine and align its intervention with the NSP, utilizing the findings of the IBBS to inform KP programming in the remaining quarters of COP20 and COP21.

The needs of key populations in Ethiopia continue to be addressed through multiple approaches. In order to reduce the spread of HIV and reach sustained epidemic control in Ethiopia, improving access and quality of KP and PP client-centered HIV services remains crucial. However, reaching target populations, such as non-self-identified SWs, part-time SWs, young women who are new entrants to sex work, and men, is complex. In COP21, PEPFAR-E will support HIV services for KPs in community hot spots, Drop-In-Centers (DICs) and selected KP-friendly public health facilities. Scaling up targeted strategies to increase case findings (described under 4.2) have allowed the program to reach higher-risk FSW and their sexual partners who are also eligible for PrEP, and have led to enrollment of newly diagnosed FSW into ART, and reengagement of HIV-positive FSW with treatment interruption. The team is planning to offer PrEP and enroll HIV-negative partners in sero-discordant relationships where the HIV+ partner has not yet achieved VL suppression. In COP21, PEPFAR will also continue strengthening the MOH, and RHBs quality scorecard card (QSC) activities to ensure the quality of KP services at national and regional levels.

The efforts by the Government of Ethiopia, under FHAPCO leadership, to adapt and scale-up U=U will also have a significant impact on addressing needs of key populations. This advocacy and communications strategy will seek to: (1) Boost demand for HIV testing among at-risk populations; (2) Improve initiation and retention on ART; (3) Increase the demand for viral load testing; (4) Decrease HIV stigma & discrimination; (5) Increase community engagement; and, (6) Galvanize leadership at all levels around a unifying theme for achieving and sustaining epidemic control.

Children and partners of FSW will also be offered testing and, if diagnosed HIV-positive, will be linked to and enrolled in treatment. Adult men with higher risk of HIV infection, people who inject drugs (PWID), at-risk out of-school AGYW, and women who engage in transactional sex will also be reached through ICT/PNS, SNS, and targeted outreach services.

DICs located in Addis Ababa, Amhara, Oromia, SNNPR, Sidama, and Gambella provide comprehensive HIV prevention, care, and treatment services, including family planning, GBV services, and harm reduction services on-site or through referral. In COP21, the program will continue providing comprehensive HIV services in these regions, in which 40 SNUs have a DIC, with 33 of these also providing ART services for

FSWs. Moreover, cervical cancer screening, treatment, and referral services for all HIV-positive FSWs will be integrated into these 33 ART DICs. Facility based HIV services will be provided to FSWs, sex partners and eligible children in selected public health facilities within major towns of Amhara, Addis Ababa, Oromia, SNNPR, and Gambella, with monitoring throughout the clinical cascade from detection to VL suppression. In COP21 PEPFAR will continue supporting the RHB's KP friendly clinics integrated at public facilities and ensure sustainability and efficiency of the KP program.

Stratification of PPs 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 high-risk adolescent girls and young women involved in transactional sex will be reached with tailored interventions to minimize risks of infection and increase access to 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. To increase demand for HIV testing among key populations, unassisted HIV self-testing will also be expanded. Linkage and initiation on ART for HIV-positive clients will continue to be a key strategy under COP21. Community based providers will accompany HIV positive clients to ART services provided at DICs and health facilities. Rapid (including same day) ART initiation, disclosure, adherence support, prevention of treatment interruptions, return to treatment activities, and viral load services in accordance with national guidelines will be conducted. Regular linkage audits using facility-community collaboration SOPs will be strengthened and institutionalized.

Table 4.4.1 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate*	Disease Burden	FY22 Target
	(SNUs)	Est. HIV Prevalence (%)	
KP_FSW	**230,866**	**24**	**77,761**
Addis Ababa	15,374	24	13,941
Afar	8,962	24	
Amhara	57,585	24	27,136
Benishangul-Gumuz	3,164	24	
Dire Dawa	2,552	24	
Gambella	3,513	24	2,212
Harari	802	24	
Oromia	82,034	24	19,298
Sidama	7,093	24	4,072
SNNPR	25,938	24	7,383
Somali	2,607	24	
Tigray	21,242	24	3,719
PP_PREV			**75,238**
Military Ethiopia	NA		5,000
Addis Ababa	NA		11,476
Amhara	NA		39,344

Gambella	NA		1,583
Oromia	NA		11,010
Sidama	NA		3,142
SNNPR	NA		3,683

4.4. PrEP

The 2021 National Strategic Plan (NSP) focuses on reaching 90% of key and priority populations with targeted combination HIV prevention interventions by 2025. In addition to counselling to maintain their negative HIV status, the 2018 National Comprehensive HIV care guidelines (currently in the process of being updated) recommends PrEP for clients at substantial risk of HIV infection. Eligible populations groups for PrEP services include FSWs and sero-negative discordant couples. Currently, PrEP services are being provided in 31 public health facilities and 20 community Drop-in-Centers (DICs) for FSWs and HIV negative sero-discordant partners.

The PEPFAR-E team has successfully improved targeted HIV case finding through ICT and partner services, providing opportunities for the program to reach higher risk FSW and their sexual partners who are eligible for PrEP. In COP21, PrEP services will be expanded in 33 DICs and 117 public health facilities with a target of PrEP_NEW KP 19,626 and PrEP_CURR KP 24,511 , significantly increased from the target of 2,600 in 2019. PEPFAR-E is also planning to offer PrEP to HIV-negative clients in sero-discordant relationships with HIV-positive partners that are not virally suppressed or with partners of unknown status, and to pregnant and breastfeeding women with risks such as engagement in sex work and/or in HIV-negative sero-discordant partners. Considering the NSP strategic objective and the complaints of pill burden of oral PrEP by some clients, in COP21 PEPFAR will pilot the recently introduced biomedical prevention (long acting PrEP Injectables and Vaginal ring) at selected community Drop-in-Centers (DICs). Moreover, PEPFAR in collaboration with MOH and partners will advocate on the expansion of eligible population groups for PrEP based on the available data.

The PEPFAR-supported IBBS among AGYW conducted in 2019 showed high HIV prevalence and risk behaviors among AGYW in Ethiopia, particularly among out-of-school AGYW. At risk AGYWs will be reached with HTS services and targets have been set in the PP_PREV indicator in COP21. Prevention interventions will support identification of high AGYW who are engaged in sex work or transactional sex that would benefit from enrollment in PrEP services. Risk screening will be performed among AGYW with standardized questionnaires and linkage to and provision of appropriate services will be affected.

4.5. HIV prevention and risk avoidance for AGYW and OVC

PEPFAR Ethiopia program for Orphan and Vulnerable Children (OVC) works to improve access to HIV services for OVC beneficiaries and their care providers. It supports health and well-being outcomes of OVCs and enables services for improving HIV care, health, nutrition, economic security, education, protection, and psychosocial wellbeing. In COP19 the OVC program re-aligned its approach to focus on geographic areas with highest unmet need and transitioned out of Tigray and Dire Dawa. Based on the situation in Tigray precipitated by the recent conflict, emergency interventions for OVCs through LIPs will take place in the last half of COP20. Within the COP21 planning amount dedicated for OVCs, 299,934 OVCs and 49,904 caregivers will be reached with comprehensive and primary prevention interventions, in five PEPFAR maintained regions: Amhara, Oromia, SNNPR, Addis Ababa, and Gambella as well as in Tigray. The program will focus on supporting new HIV case identification among OVC and linkage to ART, reducing the pediatric and adolescent treatment continuity gaps, improving access to viral load testing and viral suppression among enrolled beneficiaries, and providing training to 9-14 year old boys and girls on

primary prevention including sexual violence and HIV prevention. Results from FY21Q1 showed a viral suppression rate of 91% for those <18 years who were enrolled in the program. In COP21 the program will continue to employ comprehensive and preventive interventions focusing on children and adolescents <18 years living with HIV, children of PLHIV, siblings of Children/Adolescents Living with HIV (C/ALHIV), HIV-exposed infants, children of female sex workers, survivors of sexual violence, and HIV-infected pregnant and breast-feeding women (PBFW) aged 10-24 years. The OVC primary prevention intervention will focus on implementing time-limited, curriculum-based training using PEPFAR-approved curricula such as IMPOWER (for girls) and Parenting Lifelong Health (for both boys and girls). The training will be provided at school and community venues by closely working with schools, community groups, faith-based organizations, etc.

In COP21 priority interventions for OVC program beneficiaries to improve treatment continuity and VLS will:

- Offer at least 90% of TX_Curr (< 18-years) the opportunity to enroll in the OVC program (prioritizing those with poor VLS and new on treatment), in the areas where the OVC program operates;
- Ensure that at least 95% of OVC_SERV know their HIV status;
- Ensure 100% of HIV+ OVC_SERV are on ART;
- Support adherence and treatment continuity for those on ART; and
- Support access to viral load testing for C/ALHIV to achieve and maintain viral suppression.

To achieve these objectives, the OVC program will closely work with public and private health facilities which provide HIV services to facilitate access to services and information exchange. To strengthen the community-facility links, MOUs between facility and community partners will be signed that outline bi-directional referral protocols, shared confidentiality agreements, training for OVC staff, case conferencing, and joint case identification by working through multi-disciplinary team approaches. The OVC program will also work with partners working with key populations to assess and enroll CLHIV of FSWs into the OVC program. In addition, in coordination with PEPFAR-supported and other community social and nutrition support programs, HIV-exposed and infected children and their families will be linked to appropriate other services based on their needs.

In addition, the program will strengthen caregiver treatment literacy and provide psychosocial support during OVC home visits by case managers and social workers and provide social services (e.g., psychosocial support, socioeconomic interventions, education support, parenting) for those priority sub-populations.

To improve new HIV case identification, the program will facilitate access to index testing for biological children of PLHIV and conduct home visits to facilitate testing uptake for children. The program will also support access to treatment continuity and adherence services for C/ALHIV and their parents.

To improve treatment continuity, especially for HEI, the OVC program will: (i) support contact tracing and follow-up for children <2 years with interruption from PMTCT services by tracking the PMTCT cascade; (ii) find, assess, and refer HIV-exposed infants with interrupted treatment; (iii) find, assess, and refer infants of HIV-positive mothers to ensure EID testing (with a focus on 10-24-year-old females); (iv) conduct tracing to help return to EID services; (v) provide follow up support for mothers of HIV-positive infants to improve treatment continuity and VLS; and (vi) conduct GBV screening and provide referral and linkage to comprehensive post-violence care services. The program will also document reasons for treatment interruption and refusal to inform future strategies and continue to provide case management and socioeconomic support to mitigate barriers affecting treatment continuity.

There has been progressive improvement in VLS among children <15 years due to regimen optimization, the implementation of adolescent-friendly services e.g., Operation Triple Zero) in Addis Ababa, and the

enrollment of children on ART into the OVC program. In FY21Q1, overall viral suppression for children <15 years was 86%, with even better results for those enrolled in the OVC program, which includes those <18 years (91%).

In COP21, the OVC program will enhance the capacity of community case workers, social service workers, and/or para-social service workers to identify and address risk factors for poor adherence and treatment continuity, especially in the first three months of treatment initiation. Health workers will support monitoring youths' ART adherence and VL status during household visits (or during clinics visit for families living in distant communities by layering the service with clinics), provide quality adherence counselling and support in the community, and refer for enhanced adherence counseling (EAC) when needed. Stable adolescents with viral suppression will be linked to MMD services, ART refill groups, and other community-based mechanisms to facilitate continued access to treatment. Community Viral Load champions will be identified and supported to act as an additional mechanism to increase demand for and timely use of VL testing. Youth will be identified and trained with necessary skills to become peer youth counselors and treatment champions. Regular meetings will be held for community case workers, social workers, and health providers to review performance results of case management, identify gaps, and modify interventions to increase effectiveness and efficiency.

To address ongoing challenges among AGYW, the program will use evidence-based approaches to address the structural drivers for HIV transmission Comprehensive HIV services as well as HIV and gender-based violence (GBV) prevention services which will be provided for high risk AGYW. The OVC program will work on a comprehensive package of social, economic, and biomedical interventions to reduce vulnerability to HIV. The program will implement multi-faceted and integrated response approaches by collaborating and closely working with the health, education, psychosocial, economic, and civil society/community sectors. The program will also work to build the social assets of vulnerable AGYW who usually lack social networks by linkage to community and facility-based services to address their needs.

To reduce behaviors that increase the risk of HIV transmission (e.g, through delayed sexual debut and condom use,) and prevent violence and abuse, the program will increase caregivers' knowledge, skills, and confidence to talk to their children about sexual health. Gender disparities, limited ability to negotiate safer sex, engaging in transactional sex, difficulties in disclosure and access to HIV treatment because of fear of violence and abandonment, and GBV all increase women's and girls' vulnerability to HIV. The program will work on primary prevention strategies based on a curriculum focused on healthy and unhealthy relationships and healthy choices about sex. Other services for adolescents and youth include risk screening for HIV and GBV, provision of HIV and GBV prevention services, post violence services for GBV survivors, adherence and disclosure support, and continuum of care services.

In order to provide the GoE with more information on the status of violence against children, PEPFAR and other stakeholders will conduct a Violence against Children Survey (VACS), hopefully to be started in COP20 and completed in COP 21, depending on the feasibility of carrying out such a survey in the context of COVID-19 and civil insecurity. This is a standardized 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. Results from the VACS will be used to inform policy and programmatic efforts in Ethiopia. The GOE and PEPFAR are committed to working together to ensure the highest quality survey implementation and extensive use of VACS data to support policy and program changes to reduce the incidence of violence and HIV in Ethiopia

The OVC program will provide training on violence against children and GBV to community cadres using the Basic Services Training manual as well as develop guidelines, SOPs, and job aids to strengthen the capacity of organizations to identify and report cases of VAC and GBV and provide prompt and effective

support to survivors of sexual violence. In addition, they will be trained on how to provide first-line support when violence is disclosed, and how and where to refer beneficiaries for clinical and non-clinical GBV and VACS services. Linkages and referral mechanisms with providers of post-violence care will also be enhanced. To facilitate access to services and support for survivors of sexual violence, the OVC program will assist community cadres to enhance linkages and referrals with clinical and community-based providers of post-violence care services, including any existing emergency shelters for survivors. In Ethiopia due to the COVID-19 pandemic and ongoing conflict in various parts of the country, there are reports of increased Gender Based Violence (GBV). In COP21 the PEPFAR-E program will implement GBV case identification and post-violence care activities in both public facilities and community DICs, serving different sub--population groups highly affected and impacted by GBV. The program will strengthen GBV prevention, response systems and service delivery, and will provide comprehensive and age-appropriate clinical post-GBV care that meets the expressed needs of survivors at both public health facilities and community DICs.

The capacity of government, CSOs, and FBOs at national, regional, and community-based levels will be built to facilitate access to quality services for comprehensive and preventive OVCs by strengthening social services systems to support smooth transition of OVC programs to local implementing partners (LIPs)() LIPs and FBOs will be supported to institutionalize HIV and violence prevention training and support for community case managers and social service cadres. Continued strengthening of the Ministry of Labor and Social Affairs (MOLSA), Ministry of Women, Children and Youth Affairs (MOWCYA) and FHAPCO in rolling out the National Plan of Action for Children and Child Policy will be continued.

Table 4.6.1 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of OVC (FY22Target)					
		OVC_SERV (Total All Ages)	OVC_SERV Comprehensive		OVC_SERV Preventative (9-14 age)	OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY22 Target)
		Total	18+	<18	9-14		<18
Addis Ababa	54,855	67,321	9,323	34,874	23,124	NA	34,874
Affar	74,739	-	-			NA	
Amhara	658,711	125,582	18,323	64,505	42,754	NA	64,505
Benis Gumz	46,884	-	-			NA	
Dire Dawa	18,661	-	-			NA	
Gambela	22,283	5,584	581	3,009	1,994	NA	3,009
Harari	6,871	-	-			NA	
Oromia	1,177,482	106,655	15,557	54,785	36,313	NA	54,785
Sidama	141,538	13,090	1,912	6,722	4,456	NA	6,722
SNNP	491,374	30,441	4,439	15,637	10,365	NA	15,637
Somali	219,427	-	-			NA	
Tigray	133,758	-	-			NA	
TOTAL	**3,046,583**	**348,673**	**50,135**	**179,532**	**119,006**	**NA**	**179,532**

4.6. Voluntary Medical Male Circumcision (VMMC)

The prevalence of male circumcision (MC) among adult males aged 15-49 years in Gambella, ranges from

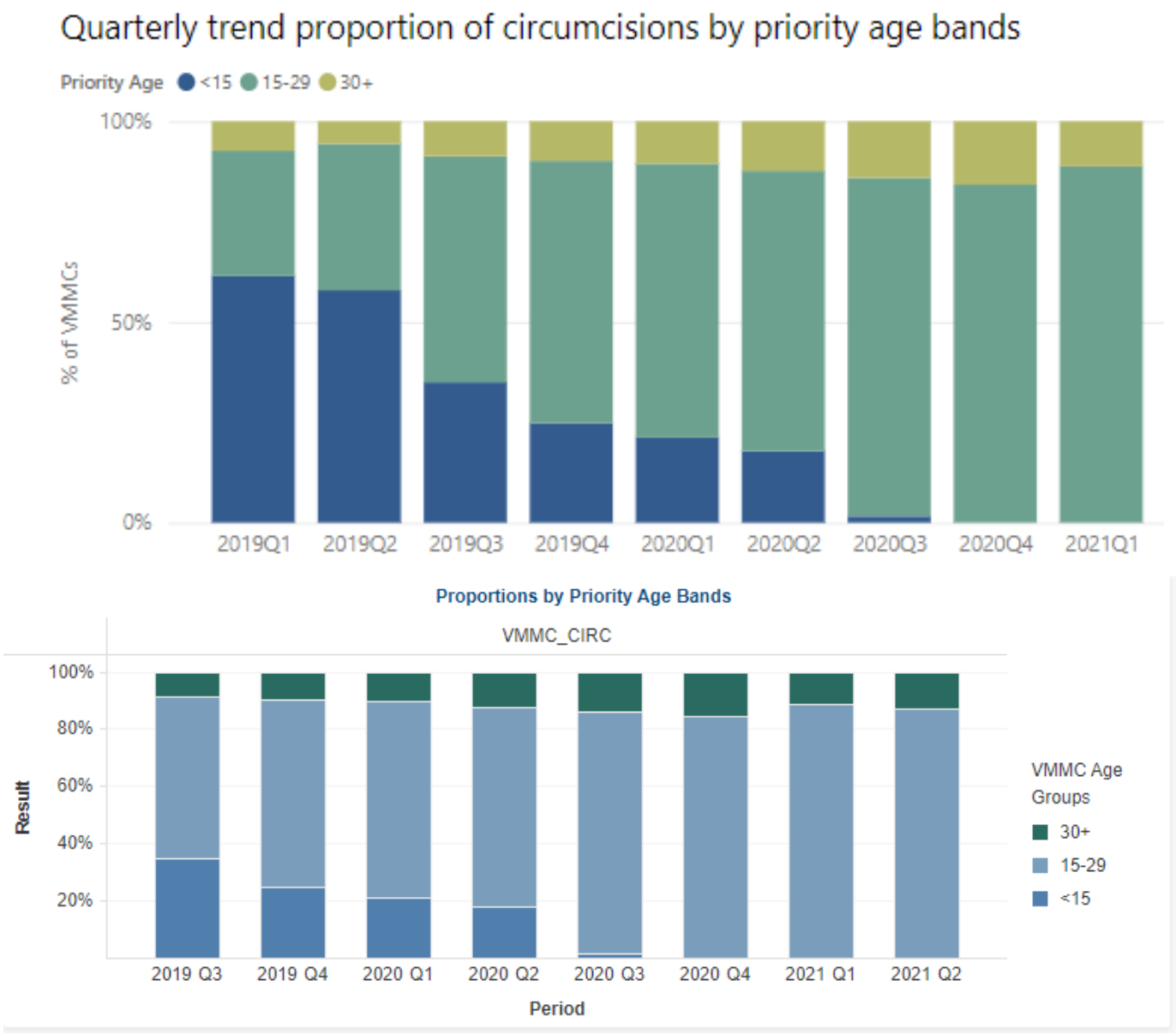
10-40% among the refugee population (MC studies by United Nations High Commission for Refugees (UNHCR)), 72% among urban residents (EPHIA, 2018) to 72% among the total Gambella population (EDHS 2016). The region has the highest regional HIV prevalence of 4.8% (EDHS 2016) and 5.7% (EPHIA, 2018).The prevalence of HIV among military population is 1.2% (SABERS 2018).The rate of HIV among uncircumcised males is 1.5 times as high as among circumcised males (5.3% vs 3.5%; EPHIA 2018). The current unmet need to reach 90% population coverage for VMMC in Gambella region, is 42,000. This gap is estimated among the combined host and refugee populations of men 15 years and older. The VMMC program in Ethiopia has been providing services to Gambella host & refugee and military adult men population since 2009.

Implementation approach

To accomplish COP21 targets, PEPFAR-Ethiopia will continue implementing VMMC activities at all supported facilities by exercising maximal safety precaution to protect health care providers and VMMC clients against COVID-19. Programs will continue pausing all VMMC campaigns, clients will be preregistered and given staggered appointments to avoid mass gathering around the facilities. enhanced infection prevention and control (IPC) and safety strategies including universal masking, safer triage and patient flow, temperature and symptom screening, and WASH procedures will be reinforced by the facility on arrival of VMMC clients. An SOP on provision of VMMC services in the context of COVID-19 has been developed by CDC and the IP and distributed to all VMMC facilities to guide HCW on implementation of VMMC services in the context of COVID-19. CDC in collaboration with ICAP and MOH has been also developing COVID-19 related job aids in the form of quick desktop or wall chart reference material to guide health workers who are providing VMMC services. In COP20, PEPFAR-E will support targeted demand creation activities to increase VMMC services uptake among refugee men 15+ in the refugee camps. Additionally, PEPFAR-E will support mentorship and training of providers to account for staff turn-over and provide basic and refresher training for newly hired HCW and existing staff, respectively. VMMC services and data quality monitoring activities will be implemented at all supported facilities to ensure quality of services continuously. All VMMC clients who test HIV positive will be linked to care and treatment and offered same day ART initiation. RTKs are supplied by the Federal MOH and distributed to the health facilities through the regional EPSA hubs.

Gambella Indigenous/Host population; The 2016 population projections and MC coverage estimates by the national VMMC TWG and MOH (2020-2021), projected a VMMC eligible male population aged 15 years and above at 158,637 for the Gambella indigenous/host population. However, this figure may be inaccurate due to changing population dynamics and service utilization. Some refugees are living with the local community and accessing services from public facilities. South Sudanese also cross the more than 500 mile porous border and seeking services from nearby facilities. VMMC facilities in Gambella are only about 5-15 miles away from the border. In addition there are highlanders who were settled in the region long ago. They had traditionally circumcised their boys at infancy but now they bring the children when they are approximately 15 years of age to get VMMC services at public facilities which is safe and free of charge. Migrant laborers from SNNPR and other places are also using VMMC services. The VMMC needs assessment done in 2016 did not include these population groups. Therefore, for COP21 VMMC planning and target setting purpose we have adjusted the total VMMC need among Gambella 15+ host population to 198,000, and used this figure to calculate the COP21 VMMC target and coverage. Therefore, assuming 100% achievement of the COP20 VMMC target of 32,451 for the host community, the cumulative VMMC performance among the host Gambella population will be 153,822 men aged 15+ (72%). By the end of FY21, the remaining gap to reach 90% VMMC coverage among 15+ males will be 24, 500.

Fig 4.7 VMMC Quarterly trends by age



Gambella Refugee Community: The refugee population in Gambella fluctuates, but according to UNHCR is currently around 336,692 people residing in 7 camps. Men constitute approximately 50% of the total

population, of which approximate 40,000 are >15 years and eligible for VMMC (out of which 36,000 circumcisions are needed to reach 90% population coverage). Accounting for the 8,480 VMMC services already performed among refugees >15 years since 2016 (DATIM), combined with FY21 VMMC targets for refugees (12,549), and assuming 80% (10,0000) would be achieved at the current pace of performance, the remaining gap is estimated at 17,481 procedures to achieve 90% of VMMC coverage among male refugees.

Military population: In COP20, eligible new male military recruits that needed VMMC services were estimated at 46,744, out of which around 42,000 need to be circumcised to reach 90% MC population coverage. By the end of COP20 about 35,484 military recruits will have received MC services, making the overall VMMC population coverage 76% among new military recruits. This will leave a gap of about 6,516 VMMC to reach 90% coverage which can feasibly be accomplished in COP21.

COP21 VMMC target

The estimated total VMMC unmet need in Gambella (both refugee and host population) among men 15 years of age and older is approximately 42,000 VMMC procedures at the end of COP20/FY21. The total COP21 VMMC target has been set at 25,110 MC procedures out of which 20,110 will be performed by CDC among host and refugee population and the remaining 5000 by DoD among military community.

Table 4.7.1 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Target Populations	Population Size Estimate (SNUs)	Current Coverage (End of COP20)	VMMC_CIRC (COP21)	Expected Coverage (end of COP21)
Gambella 15+ Male Population, including refugees	**238,000**	**72%**	**20,000**	**80%**
Military 15+ Male population	**46,744**	**65%**	**5000**	**87%**
Total/Average/for Gambella and military	**284,000**	**73%**	**25,000**	**82%**

Table 4.7.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

		Population Size Estimate	Current Coverage (End of COP20 Oct 2021-Sept 2021)	*VMMC_CIR C*	Expected Coverage (in FY22)
SNU	**Target Populations**	**(SNUs)**		**(in FY22)**	
Total	**15+**	**NA**	**NA**	**25,000**	**NA**
Military	15+	46,744	75%	5,000	86%
Abobo	15+	24,646	72%	1,050	86%
Dima (Gambella)	15+	23,689	72%	1,200	80%

Etang	15+	244,608	72%	3,800	80%
Gambella	15+	116,340	72%	2,000	80%
Gambella Zurya	15+	43,387	72%	440	80%
Gog	15+	78,554	72%	320	80%
Jikawo	15+	24,051	72%	1,340	80%
Jor	15+	12,971	72%	1,300	
Lare	15+	47,663	72%	2,565	80%
Makuey	15+	25,070	72%	1,580	80%
Mengesh	15+	27,081	72%	1,885	80%
Wantawo	15+	30,396	72%	2,520	80%

4.7. Linkage to Treatment

Newly diagnosed adult PLHIV will be accompanied and escorted by PLHIV peers for linkage within and between facilities within towns. Children will be supported to link to treatment services, including optimal regimens, OVC support, etc. by a skilled, dedicated nurse provider, competent in family-counseling and supporting parents/caregivers to design patient-specific treatment plans. These nurses, reinforced by local health offices, will also work with community partners on case finding, rapid (including same-day)ART initiation, and linkage of newly identified PLHIV to community services. For linkage between facilities and outside of towns, local health offices will coordinate and conduct linkage audits.

4.8. Ensuring treatment continuity and viral suppression

Despite the unprecedented risk to treatment continuity posed by the COVID-19 pandemic, Ethiopia strengthened treatment continuity with >98% overall continuity in the last 5 quarters (FY20Q1–FY21Q1). In COP21, Ethiopia plans to further strengthen treatment continuity by focusing on populations and geographies with lower continuity, and by reducing treatment interruptions in the first 3 months after ART initiation, when the highest proportion of treatment interruptions occur. Clear facility-based packages of services have been identified for those initiating ART and on treatment for <6 months, those stable and virally suppressed, and those that are unstable and not virally suppressed, with mirror packages of community support. Improving treatment and viral load literacy, including the adaptation and scale-up of U=U, will contribute to more optimal rates of adherence to ART and treatment continuity, and be an area for joint endeavor between the GoE and its partners. This initiative, reinforced by renewed collaboration with faith-based organizations, other civil society organizations, and Federal and Regional administrations, will augment efforts to strengthen continuity and viral load suppression in Ethiopia. While Ethiopia has met all minimum policy and guideline requirements, there is still additional work to be done with scaling up client-centered services, including strengthening the six-month appointment spacing model (6-MMD) and 3-MMD for eligible clients, and introducing and scaling up other differentiated service delivery models such as fast-track pharmacy refills, health care worker managed community ART groups, peer-led community based ART distribution (PCAD) extended and flexible working hour services. To enable successful implementation and client uptake, PEPFAR-E will support the availability of 90-day and 180-day ARV drug packs to alleviate the challenges encountered on the volume of medicines clients must take to their home.

Beyond strengthening treatment continuity, COP21 will build on existing efforts to improve the timely and

appropriate use of viral load results to guide clinical decision making for high quality HIV treatment. This includes the scale up of clinics dedicated to the management of clients with high VL results, close monitoring of the high VL cascade, and facility-community linkages to provide multidisciplinary support to clients with high VL.

COP21 will have greater focus on addressing advanced HIV disease through the rapid diagnosis of co-morbidities, coordination with Global Fund for the availability of diagnostic tests and treatments for opportunistic infections (OIs), TA and mentorship to improve provider recognition of advanced HIV disease, and close linkages with community partners and peer volunteers to provide additional support.

Table 4.8.1 ART Targets by Prioritization for Epidemic Control

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	**Total PLHIV**	**Expected current on ART**	**Additional patients required for 80% ART coverage**	**Target current on ART (APR FY22)** ***TX_CURR***	**Newly initiated (APR FY22)** ***TX_NEW***	**ART Coverage (APR 22)**
Attained	559,214	470,865	(23,494)	521,903	60,386	93%
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	33,578	22,865	3,997	25,481	3,089	76%
Commodities (if not included in previous categories)	NA	8,299	NA	9,049	938	NA
Total	616,105	502,029	(9,145)	556,433	64,413	90%

4.8.1.Children, Adolescents, and Prevention of Mother to Child Transmission (PMTCT)

The 2019 updated national comprehensive and integrated PMTCT guideline endorses DTG or EFV400mg-based regimens as preferred first line ARVs for PBFW and women of childbearing potential. Ethiopia has also adopted provision of enhanced postnatal prophylaxis (NVP+AZT for the first 6 weeks and NVP alone for the following 6 weeks) for all HIV Exposed Infants. The guideline emphasizes the importance of continuing mothers on treatment and follow up care, and recommends routine viral load monitoring after three months of ART initiation and then every six months. It also gives clear direction to improve EID coverage and to shorten the turnaround time (TAT) to less than three weeks by scaling up EID point of care testing (POCT). Ethiopia has also adopted current WHO guidance for optimal pediatric ART regimens and started implementation in FY19. Although there were shortages of certain pediatric formulations early in transition, significant progress has been made recently, with almost complete ART optimization for children <15 years. Introduction of pediatric DTG 10 mg formulation is planned for the last quarter of COP20. Results from November 2020 from adolescents enrolled in Operation Triple Zero (OTZ) showed a viral suppression rate of 93%. The OTZ package of services includes optimized ART, weekday and weekend clinical services, high VL clinics, peer support group activities, planned transition to adult services, SRH, motivational group activities, and counselling and disclosure support. In COP20 and COP21, OTZ is being expanded to Oromia, SNNPR, and Amhara regions, in addition to Addis Ababa. Based on lessons from the pilot, the national package of adolescent pediatric psychosocial support (APPSS) is currently being revised to incorporate elements of OTZ service package for provision of tailored services for adolescents.

In COP21, the primary case finding strategies to detect C/ALHIV will be index case testing (ICT) and optimized PICT. Facilities will retrospectively record eligible biological children of adult ART clients, ensure 100% testing, and initiation on optimal treatment regimen for newly-diagnosed C/ALHIV. Innovative strategies to realize this target may include improving messaging to caregivers, transport reimbursements for testing, weekend hours to minimize children missing school, and use of self- test kits for caregivers unable to bring children in for testing. High-risk, high-efficiency entry points such as TB and malnutrition will be monitored to ensure testing coverage of >90%. To optimize PITC in children <15 years, risk-based testing services in <5 years clinics and OPD settings will be done through appropriate counseling. PEPFAR will work with MOH to ensure adoption and validation of pediatric HIV risk screening tools in pediatric OPD and pediatric inpatient service delivery points. In addition, PEPFAR will work to establish Pediatric Centers of Excellence (PCOE) in high volume facilities that will serve as regional learning hubs for increasing in-country expertise in pediatric HIV care and treatment by hosting and precepting multidisciplinary teams (MDT) teams, and using pediatric experts to support local and regional ART facilities with assessment, training, and clinical support..

PEPFAR-E will also continue to ensure provision of optimized ART for HIV-positive pregnant and breastfeeding women (PBFW), and to support and monitor optimized ART (i.e. TLD) for all women of childbearing potential, including AGYW. PEPFAR-E will support the targets of 95% EID testing coverage within 12 month of age and 80% coverage within 2 months of age by increasing access to EID diagnostic services and facilitating efficient use of POCT. Ethiopia will also introduce and support the implementation of new initiatives like PrEP and cervical cancer screening in the PMTCT program. PEPFAR-E will further support the national PMTCT program by conducting real-time cohort program monitoring, quality improvement activities at the site level, and implementation of eMTCT strategies.

4.9. Cervical Cancer Program

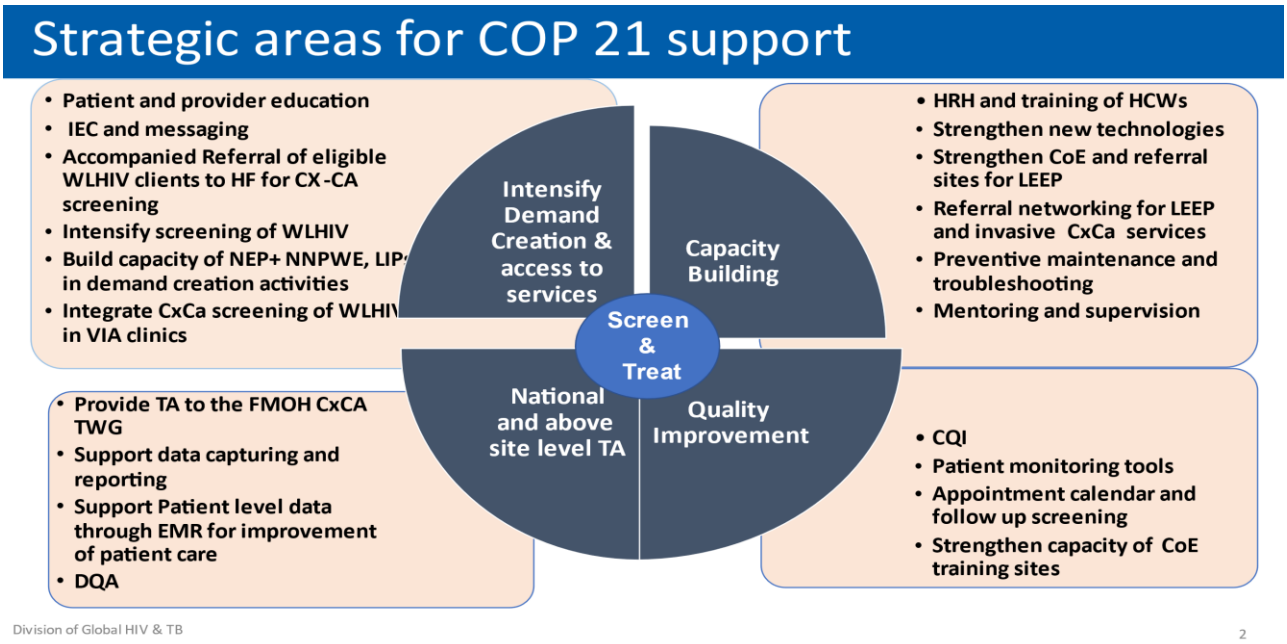
In 2009, PEPFAR-E introduced cervical cancer (CxCa) screening with visual inspection of cervix with acetic acid (VIA) and treatment of pre-cancerous lesions with cryotherapy, using a single visit approach at 16 health facilities, of which five were centers of excellence (CoE). Loop electrosurgical procedure (LEEP) services were also implemented at the five referral CoE sites for women with extensive lesions which cannot be treated with cryotherapy. Based on the success of this pilot and the burden of CxCa in the country (13.4% in 2015) the MOH adopted this strategy and scaled-up services at a national level for all women ages 30–49 years irrespective of HIV status. However, only 16% of women 30-49 years living with HIV have received screening for CxCa. (EPHIA 2018) Furthermore, VIA/cryotherapy service was never available in about half of ART facilities with Tx_Curr >300 in regions with PEPFAR direct service delivery support. Key programmatic challenges encountered in the national scale up of CxCa screening and treatment services include lack of up-to-date national guidelines and job aids, weak demand creation at community and HCW levels, stigma, lack of capacity to maintain trained HRH at multiple levels of the health system, lack of capacity for preventive maintenance and repair resulting in frequent equipment failure, frequent shortage of medical supplies and accessories, lack of capacity to introduce new technologies, poor referral networking, and lack of systems for mentorship, coaching, and quality improvement.

In COP20, PEPFAR-E is supporting MOH to accelerate CxCa secondary prevention efforts by providing both technical and site level support with above site support to the MOH and RHBs to strengthen the existing VIA/cryotherapy services, introduce new technologies (thermal ablation and HPV DNA testing), and revise guidelines and training manuals. The previously established CoE sites were equipped with necessary teaching aids including video colposcopy and will support HFs through training, coaching, and mentorship. PEPFAR-E implementing partners also supported data capturing and monitoring systems at different levels of the health care system. The program was also strengthened through the RHBs in Addis

Ababa, Oromia, Amhara, SNNPR, Sidama, and Gambella regions. The MOH will provide technical assistance to all other regions. These efforts are further strengthened by community partners, who support demand creation and integrated CxCa services in DICs serving key populations. Community level LIPS provide demand creation for cervical cancer screening and treatment, do accompanied referral of eligible clients to HF and follow up referred clients access to the cervical cancer screening services at the HFs.

Fig 4.9 outlines the COP21 strategy for ongoing support for cervical cancer programs.

Fig 4.9 COP21 Cervical cancer interventions



4.10. Additional Country Specific Activities Listed in the Planning Level Letter

4.10.1. Reducing mortality by focusing attention on those with advanced disease and children under 5 years

COP21 will strengthen existing treatment programs through greater focus on addressing advanced HIV disease through the rapid diagnosis of co-morbidities, coordination with Global Fund for the availability of diagnostic tests and treatments for opportunistic infections (OIs), TA and mentorship to improve provider recognition of advanced HIV disease, and close linkages with community partners and peer volunteers to provide additional support.

To address reducing mortality among children under 5 years, efforts will be strengthened to integrate HIV care and treatment services with MCH (immunization services e.g., s, nutrition assessment and support, prevention and treatment of malaria, deworming) and provision of a preventive care package. PEPFAR will coordinate with Global Fund and the GoE for the quantification and procurement of pediatric formulations of OI drugs and for monitoring age-disaggregated treatment outcomes.

4.10.2. Strategies for PLHIV over 50 years

With increasing longevity, this group currently represents 16% of TX_CURR, and is expected to grow substantially in coming years. PLHIV over 50 years are more likely to have other medical co-morbidities and are at increased risk for severe outcomes of COVID-19 infection. COP21 will address case finding among this age group by integrating HIV risk screening tools in chronic care (eg., cardiac diabetes and cardiovascular disease) clinics. For women over 50 years, engaging female social support groups will be utilized to increase the demand for HIV testing. and treatment. Care and treatment strategies for PLHIV over 50 years will be adapted to prioritize optimized ARV regimens, user-friendly screening and management of other chronic diseases and facilitated referrals when appropriate, triaging and fast track services for those with co-morbidities, and age-appropriate peer support for adherence and treatment continuity.

4.10.3. Attention to continuity of treatment with focus on reducing interruptions in the first 3 months after ART initiation and return to treatment activities

PEPFAR-E will concentrate efforts to improve adherence and retention among PLHIV newly initiating ART, particularly among populations and geographies with lower treatment coverage and continuity. Through standardized operating procedures and signing of MOU among facility and community implementing partners that strengthen data sharing and use across facility- and community-based actors, PEPFAR-E will improve interruption of treatment tracking and return to care and treatment. Through routine performance reviews and information sharing, facilities will generate line-lists of patients with interrupted treatment, initiate follow-up by phone, to be followed up by community partners, who will trace these clients in the community.

COP20 programs which engage both facility and community partners in peer-to-peer support for increasing literacy on HIV treatment and healthy living, supporting adherence and treatment continuity, and tracking and tracing of clients with treatment interruptions, will be further strengthened in COP21. One-to-one peer support will be provided particularly to clients newly initiating ART and to those with high viral load. In order to combat myths and negative messaging around HIV and ART, faith-based organizations (FBOs) and religious leaders will provide spiritual and psychosocial support to PLHIV, encourage partner testing, promote positive living with HIV, and provide regular standardized messaging to their followers on remaining adherent to ART, even while seeking faith-based curative services. FBOs will help identify clients who discontinue ART to attend religious cure services and work closely with other community partners to re-engage them in ART. They will also use faith-based media outlets and holy water sites to properly and adequately inform their followers on the importance of remaining adherent to ART, as well as mitigate stigma (both self-imposed and external) pertaining to HIV and ART. This activity will be implemented by the Interfaith Religious Council of Ethiopia (IRCE), with technical assistance from other implementing partners. IRCE has membership from Ethiopian Orthodox, Protestant, and Muslim faith groups.

4.10.4. Attention to PMTCT and the attendant need to increase early infant diagnosis

While the MTCT rate at 18 months is estimated at 14.96% (Spectrum 2020), this estimate is based on model input data that relies on a limited number of publications, that may not be generalizable to the national PMTCT cohort. In contrast, PEPFAR program data indicates a much lower MTCT rate. COP21 will support efforts at a national level to improve PMTCT data quality and advocate for greater high-level leadership involvement in the e-MTCT validation process. In order to improve EID coverage, PEPFAR will support

expansion of EID POC sites and the procurement of EID supplies working towards 80% coverage at 2 months and 95% coverage at 12 months.

5. Program support necessary to achieve sustained epidemic control

5.1. Laboratory Support

COP21 will continue to support the laboratory system through the Ethiopian Public Health Institute. This will include: a) scaling up of Core HIV tests and support for the multiplex use of both POC and conventional diagnostic testing platforms (HIV-VL, EID, TB, HPV); b) strengthening of the integrated specimen referral network; c) VL/EID lab ancillary equipment maintenance; d) lab support to diagnose opportunistic infections (e.g Urine LF-LAM for TB); e) supports for lab-based HPV screening; e) quality assurance of Core HIV tests (HIV RTK, Recency, EID, VL, TB Diagnostics); e) accreditation of VL, EID, and TB culture laboratories; f) preparation for lab-based drug resistance (HIVDR) monitoring; and g) reactivation of HIV recency testing after the pause due to COVID-19.

5.2. Health Information System and Surveillance

COP21 support to health information systems comprises: 1) Supporting the accessibility and use of HIV data through the national development and scale up of Standardized Electronic Medical Records (EMR); 2) Maintaining patient-level information systems for patient-level data including EMR ART, Clinician and Pharmacy modules, and transitioning to PEPFAR-recommended and MOH-endorsed open-source EMR; 3) Implementing Dagu maturity work and ongoing maintenance support through Automation of PMIS and Integration of PMIS to Dagu and scaling up to 1500, facilities; 4) Promoting data quality and information use at health facilities; 5) Health information exchanges across disparate information systems (clinical, laboratory and surveillance) at EPHI and unique identifiers for HIV CBS support and information use; and 6) UDS based on the CommCare digital platform in community HIV programs.

HIV Drug Resistance (HIVDR) monitoring: PEPFAR Ethiopia will implement laboratory-based HIVDR patient monitoring following the CADRE protocol to detect emerging drug resistance and to construct appropriate first, second, and third-line ARV regimens in Ethiopia. The durability and effectiveness dolutegravir (DTG)-based regimens need to be preserved with regular information on patterns of HIVDR. Laboratory based HIVDR patient monitoring has higher yield of genotyped specimens in contrast to clinic-based HIVDR patient monitoring, which will allow for precise age- and sub-populations-based HIV drug resistance estimates. Laboratory based HIVDR will utilize residual specimens from routinely collected viral load testing and does not require special collection of specimens for patient monitoring purposes nor consent for resistance testing.

HIV Case Based Surveillance (CBS:) PEPFAR-E has implemented HIV CBS with recency testing in 402 health facilities and 9 community DIC centers from all regions of the country, reaching approximately 72% of the treatment cohort. To facilitate data use, a data visualization platform has been established at EPHI, and information is being generated regularly and reviewed to inform individual level response at

the facility level for enhanced patient intervention and at above site level for programmatic response. Efforts are underway to build the capacity of RHBs and woreda health offices with the same data visualization platform to facilitate data use at subnational units. In COP21, HIV case reporting and recency testing will be further scaled up across regions both at facility and community settings, with the ultimate objective of reaching all newly diagnosed individuals. In addition, longitudinal CBS, with reporting of sentinel events utilizing an enhanced EMR system with greater interoperability, to be introduced in selected facilities in COP20, will be expanded in COP21. Capacity building efforts will be further strengthened to support the data visualization and data use for enhanced targeted individual intervention and for informing HIV cluster response.

5.3. Commodities and Supply Chain

Overall, HIV-related program commodities are in stock greater than 95% of the time based on survey and site level data reported to the regions. Although ARVs are available >99% of the time, Ethiopia has faced serious challenges around lab commodity supply availability and RTK availability at sites. Site-level stockouts are due to multiple factors, including delayed receipt of shipments from manufacturers for supplies procured through EPSA and challenges with fully integrating RTKs into the supply chain system. Lab commodity supply availability, in particular EID and VL, were also hampered during 2020 by the dual use with Covid PCR testing. A key challenge for the supply chain system is the lack of end to product visibility down to sites, which impacts the quality of supply chain decisions. Further, it was found that data quality of reporting and resupply request forms was poor, resulting in a high rate of false stock out reporting, as well as delayed of submission of forms resulting in delayed resupply to some sites.

In COP21, PEPFAR-E will continue providing above site supply chain technical assistance to EPSA and its regional hubs, FHAPCO, MOH, and Regional Health Bureaus to strengthen supply chain performance, implement innovations to ensure sustainability, and to support procurement of HIV-related health commodities. The above-site TA will include: (1) forecasting, quantification, and supply planning; (2) distribution and warehouse management; (3) fleet management; and (4) procurement strengthening and pipeline monitoring. Under COP20, PEPFAR-E supported the development of EPSA's risk management strategy. TA under COP21 will be more focused around strengthening and expanding the Center of Excellence (CoE) supply chain maturity model across high volume and high throughput EPSA hubs and Central EPSA warehouses. This model focuses on building the quality management system (QMS) within the supply chain, implementing EPSA's M&E system to monitor supply chain and service related KPIs, and optimizing route and distribution networks down to health facilities, including frequency of distribution. TA providers are placed in all regional EPSA hubs to support EPSA staff and branch managers to supply health facilities on time with needed HIV commodities.

PEPFAR-E will continue to support implementation of ARV dispensing tools and data collection in all PEPFAR priority sites and regions. This is a critical intervention to allow the GOE and PEPFAR to triangulate clinical data with dispensing data, track patients who missed their ARV pick up appointment in a timely manner for strengthening treatment continuity, and to have accurate regimen data for pediatric and adult ART for HIV quantification and procurement.

PEPFAR-E will also shift its TA focus to greater site level and sub national support to ensure sites are adhering to procedures for resupply and providing enhanced pharmacy services to their clients. PEPFAR-E will work in collaboration with EPSA, EFDA, and clinical IPs to provide training to Regional Health Bureau and district level (woreda) pharmacy staff in pharmacovigilance, Integrated Pharmaceuticals Logistics System (IPLS) for resupply of commodities, monitor use of the pharmacy dispensing tools and data use and triangulation, and in monitoring ARVT regimen prescriptions and regimen changes to ensure rational use. PEFPAR TA will conduct regular joint supervision visits with RHBs and woredas to ART sites for mentoring

and monitoring ARV dispensing, data collection and data for decision-making, rational use and improved dispensing to ART clients, pharmacovigilance tracking and reporting, and overall inventory management and compliance with stock reporting and resupply procedures in line with the IPLS. PEPFAR-E will also support the mentoring and supportive supervision of ART sites to monitor stock levels/status and avoid stock out of ARVs, RTKs and viral load/EID commodities. This support will build the capacity of host country institutions and the supply chain system. Under COP21, PEPFAR will support decentralized drug distribution through private and semi-private pharmacy retail outlets in Addis Ababa.

Supply Chain Donor Coordination: To ensure donor coordination among the various players supporting the supply chain, Ethiopia has established a supply chain donor's forum. There is also an active HIV/AIDS specific procurement and supply management technical working group that focuses on the HIV/AIDS commodity funding, forecasting and quantification, pipeline monitoring, stock status monitoring, capacity building and any initiatives such as ARV optimization and RTK integration.

5.4. Community-Led Monitoring

Through COP20 funding, 12 CSOs were awarded grants to carry out Community-Led Monitoring (CLM) activities; however, delays resulted in activities starting only in April 2021. The CLM initiative will primarily focus on routine monitoring of critical gaps to the availability, accessibility, and delivery of quality HIV prevention and treatment services. Quantitative and qualitative data will be collected using standardized tools and synthesized through a variety of methods that reveal insights from communities about problems and solutions to health and HIV services delivery at facility, community, sub-national, and national levels. The process includes direct observation of the conditions of services by service monitors (who are patients representing the community), through interviewing or surveying clients and service providers. The services received by clients are observed and scored by survey, score card, and other similar tools. Results will be presented and analyzed in collaboration between community representatives, providers and facility managers to ensure dialogue and help all sides in participating with identification and subsequent implementation and monitoring of solutions and action items. PEPFAR-E will ensure that this will not duplicate efforts; rather, it will provide added value to the PEPFAR MER by actively participating during tools development and providing feedback during the reporting. This effort will generate important information that is focused on the goal of improving service quality and continuity.

PEPFAR-E will involve key stakeholders, including GoE, UNAIDS, FBOs, and multiple CSOs to ensure meaningful engagement in the project design, planning and implementation periods through consultative engagement by inviting to participate in CSO meetings and workshops, and by creating a platform for CSOs to share this information—either through quarterly reports, or semi or annual CSO meetings. These meetings will be a platform for the CSO community to present findings to MOH, RHBs, facility leadership, etc. and people within GoE with decision-making powers so that they can effectively advocate for changes if/where needed.

6. US Government Management, Operations and Staffing Plan to Achieve Stated Goals

Overall, PEPFAR-E's staffing footprint is decreasing over time. This is in part in response to the downward trend of COP funding for COP21 as well as the changing epidemiology in Ethiopia as it moves towards epidemic control. The PEPFAR-E Country Coordinator position has been vacant since January 2020 but the recruitment process is completed and the position will be filled before the end of FY20. The Senior

Technical Advisor Position which was approved in COP18 is vacant and will be filled by the end of COP20.

PEPFAR-E has not made significant changes to its staff footprint since COP20. USAID and CDC continue to reinforce programming by jointly participating in regional support teams, reinforcing joint programming across the community and facility interface. Technical staff are assigned to supportive supervision, including SIMS and other performance monitoring and improvement visits, as part of their participation on those regional support teams. These routine site visits are also designed to monitor site-level requirements for linkage and retention and client-centered services. Schedules are drawn for site visits, prioritizing high-volume sites and/or sites with performance challenges documented through MER indicator reporting and/or previous site visits. The PEPFAR-E coordination office will support rapid implementation of the community led monitoring and PEPFAR-E is not proposing positions in COP21.

APPENDIX A -- SNU Prioritization to Reach Epidemic

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+	Female50+	Overall TX Coverage
Addis Ababa	116	COP15	Scale-up:Saturatio	APR16	82%	79%	76%	77%	128%	138%	89%	94%	65%	126%	106%	94%	56%	22%	77%
	116	COP16	Scale-up:Saturatio	APR17	69%	70%	75%	76%	130%	140%	104%	103%	65%	121%	117%	103%	55%	23%	82%
	116	COP17	Attained	APR18	94%	98%	105%	103%	190%	205%	132%	128%	71%	131%	139%	122%	58%	25%	94%
	116	COP18	Attained	APR19	71%	72%	102%	103%	183%	198%	155%	148%	72%	132%	148%	131%	56%	24%	96%
	118	COP19	Attained	APR20	100%	100%	175%	186%	194%	177%	343%	369%	220%	244%	175%	144%	67%	72%	128%
	118	COP20	DSD	APR21	233%	238%	66%	65%	116%	123%	120%	120%	62%	82%	142%	154%	64%	62%	106%
Amhara	69	COP15	Scale-upSat	APR16	16%	16%	20%	21%	39%	42%	34%	35%	31%	57%	90%	77%	82%	41%	66%
	69	COP16	Scale-upSat	APR17	13%	13%	21%	21%	42%	45%	38%	38%	29%	50%	97%	83%	80%	40%	70%
	71	COP17	Scale-upSat	APR18	42%	43%	33%	33%	67%	71%	49%	49%	32%	59%	116%	100%	88%	43%	83%
	110	COP18	Attained	APR19	45%	46%	41%	41%	82%	88%	54%	51%	32%	57%	119%	104%	83%	40%	85%
	118	COP19	Attained	APR20	54%	54%	58%	60%	142%	134%	109%	116%	85%	91%	113%	101%	71%	105%	99%
	40	COP19	CentrallySupported	APR20	12%	12%	27%	28%	33%	36%	22%	20%	17%	16%	20%	24%	21%	16%	21%
	181	COP20	DSD	APR21	59%	46%	69%	62%	80%	83%	70%	64%	64%	71%	95%	98%	56%	66%	84%
Oromia	46	COP15	Scale-upSat/Acc	APR16	9%	9%	16%	15%	37%	40%	31%	30%	29%	47%	80%	72%	87%	43%	60%
	46	COP16	Scale-upSat/Acc	APR17	11%	10%	17%	17%	43%	47%	35%	33%	28%	47%	89%	80%	85%	43%	65%
	55	COP17	Scale-upSat/Acc	APR18	36%	37%	27%	27%	67%	72%	48%	48%	35%	59%	121%	108%	102%	53%	88%
	87	COP18	Attained	APR19	38%	38%	29%	29%	69%	74%	48%	49%	28%	47%	108%	92%	78%	40%	74%
	97	COP19	Attained	APR20	28%	28%	153%	159%	112%	116%	133%	136%	104%	104%	137%	132%	104%	145%	130%
	108	COP19	CentrallySupported	APR20	2%	2%	31%	30%	18%	15%	18%	18%	14%	14%	20%	21%	21%	15%	19%
	337	COP20	DSD	APR21	51%	47%	58%	57%	82%	81%	68%	65%	71%	66%	121%	96%	76%	72%	89%
SNNPR	16	COP15	Scale-upSat/Acc	APR16	12%	12%	20%	20%	54%	58%	40%	34%	31%	37%	82%	88%	83%	38%	59%
	16	COP16	Scale-upSat/Acc	APR17	11%	12%	22%	22%	61%	66%	43%	38%	31%	39%	87%	93%	80%	36%	56%
	20	COP17	Scale-upSat/Acc	APR18	21%	21%	37%	37%	82%	88%	48%	45%	36%	60%	102%	91%	80%	38%	77%
	31	COP18	Attained	APR19	47%	47%	38%	38%	98%	105%	63%	52%	40%	55%	98%	91%	94%	44%	80%
	34	COP19	Attained	APR20	50%	50%	228%	237%	132%	118%	202%	148%	153%	99%	134%	134%	128%	178%	145%
	95	COP19	CentrallySupported	APR20	2%	2%	50%	48%	22%	22%	25%	31%	17%	23%	23%	29%	30%	22%	25%
	217	COP20	DSD	APR21	79%	179%	82%	82%	59%	50%	40%	61%	53%	99%	93%	81%	50%	28%	69%
Gambella	4	COP15	Scale-upAcc	APR16	15%	13%	20%	20%	50%	54%	29%	17%	17%	17%	46%	48%	78%	32%	44%
	4	COP16	Scale-upAcc	APR17	24%	28%	22%	22%	59%	60%	41%	25%	22%	23%	63%	66%	99%	42%	59%
	5	COP17	Scale-upSat/Acc	APR18	43%	36%	34%	33%	84%	91%	53%	33%	29%	28%	75%	80%	111%	49%	68%
	8	COP18	Attained	APR19	50%	50%	53%	54%	131%	141%	71%	46%	38%	36%	92%	97%	126%	57%	84%
	8	COP19	Attained	APR20	152%	152%	104%	107%	93%	87%	141%	102%	109%	63%	83%	93%	106%	172%	98%
	14	COP20	DSD	APR21	63%	126%	64%	92%	58%	43%	53%	121%	117%	159%	78%	75%	21%	31%	72%
Tigray	18	COP15	Scale-upSat/Acc	APR16	15%	14%	21%	20%	41%	44%	37%	38%	33%	62%	94%	85%	86%	43%	71%
	18	COP16	Scale-upSat/Acc	APR17	14%	15%	22%	21%	46%	49%	43%	43%	33%	61%	107%	93%	85%	43%	77%
	21	COP17	Scale-upSat/Acc	APR18	41%	41%	33%	33%	70%	76%	57%	58%	37%	70%	136%	117%	92%	47%	95%
	34	COP18	Attained	APR19	39%	41%	41%	41%	82%	88%	62%	59%	35%	65%	136%	117%	80%	41%	93%
	47	COP19	CentrallySupported	APR20	57%	57%	52%	55%	101%	104%	100%	99%	75%	73%	91%	87%	65%	88%	84%
	52	COP20	TA	APR21	45%	71%	83%	81%	79%	89%	78%	85%	62%	90%	95%	110%	51%	44%	87%
DD	1	COP15	Scale-upSat	APR16	15%	16%	19%	19%	39%	44%	45%	41%	34%	50%	73%	70%	70%	31%	59%
	1	COP16	Scale-upSat	APR17	11%	11%	19%	19%	39%	43%	48%	43%	34%	50%	78%	74%	68%	30%	62%
	1	COP17	Attained	APR18	40%	44%	36%	37%	78%	86%	58%	51%	37%	55%	92%	86%	72%	33%	77%
	1	COP18	Attained	APR19	38%	38%	42%	43%	88%	97%	77%	67%	46%	69%	119%	112%	88%	39%	92%
	1	COP19	CentrallySupported	APR20	16%	16%	66%	70%	60%	84%	119%	107%	88%	70%	69%	71%	52%	73%	71%
	1	COP20	TA	APR21	0%	0%	51%	30%	87%	94%	65%	62%	32%	45%	67%	92%	46%	38%	67%
Harari	1	COP15	Scale-upSat	APR16	17%	18%	32%	32%	100%	107%	69%	58%	46%	63%	118%	105%	96%	45%	90%
	1	COP16	Scale-upSat	APR17	20%	22%	35%	36%	122%	132%	83%	69%	50%	68%	134%	119%	103%	48%	100%
	1	COP17	Scale-upSat	APR18	60%	60%	48%	49%	181%	193%	91%	79%	49%	69%	137%	121%	97%	45%	109%
	1	COP18	Attained	APR19	60%	60%	54%	55%	193%	207%	100%	81%	49%	68%	138%	121%	90%	43%	107%
	1	COP19	CentrallySupported	APR20	29%	29%	40%	41%	193%	198%	169%	136%	138%	82%	78%	78%	68%	96%	87%
	1	COP20	TA	APR21	80%	40%	73%	52%	200%	202%	110%	83%	56%	90%	97%	117%	57%	47%	95%
Benishangul Gumu	2	COP15	Scale-upSat	APR16	29%	29%	19%	18%	40%	44%	41%	37%	35%	55%	94%	85%	106%	50%	72%
	2	COP16	Scale-upSat	APR17	25%	29%	20%	19%	43%	46%	45%	39%	35%	53%	103%	93%	103%	49%	77%
	6	COP17	Scale-upSat	APR18	33%	50%	34%	33%	71%	76%	52%	47%	39%	56%	120%	109%	105%	52%	89%
	3	COP18	Attained	APR19	50%	50%	38%	38%	77%	80%	58%	52%	37%	56%	126%	112%	99%	49%	92%
	12	COP19	CentrallySupported	APR20	282%	282%	57%	59%	77%	77%	102%	89%	84%	62%	80%	79%	77%	111%	82%
	21	COP20	TA	APR21	14%	0%	37%	27%	63%	74%	52%	41%	35%	48%	86%	89%	53%	29%	70%
Afar	6	COP15	Scale-upAcc	APR16	0%	0%	5%	5%	12%	13%	10%	18%	17%	29%	43%	40%	30%	25%	32%
	6	COP16	Scale-upAcc	APR17	0%	0%	6%	7%	15%	17%	23%	19%	17%	25%	50%	46%	37%	25%	36%
	6	COP17	Scale-upSat/Acc	APR18	5%	5%	10%	10%	29%	25%	34%	28%	28%	32%	75%	69%	52%	35%	53%
	6	COP18	Attained	APR19	6%	6%	12%	11%	29%	28%	43%	37%	30%	42%	96%	86%	61%	40%	66%
	12	COP19	CentrallySupported	APR20	50%	50%	24%	25%	58%	57%	117%	100%	94%	70%	101%	99%	69%	130%	89%
	34	COP20	TA	APR21	5%	10%	13%	8%	20%	17%	8%	19%	19%	39%	56%	61%	21%	19%	42%
Somali	2	COP15	Scale-upAcc	APR16	3%	3%	6%	6%	22%	23%	25%	20%	17%	20%	48%	47%	46%	25%	38%
	2	COP16	Scale-upAcc	APR17	5%	5%	7%	7%	17%	18%	25%	24%	18%	32%	54%	48%	42%	20%	37%
	3	COP17	Scale-upAcc	APR18	5%	5%	11%	10%	24%	26%	31%	29%	29%	39%	66%	59%	52%	24%	48%
	2	COP18	Attained	APR19	6%	6%	12%	12%	28%	30%	32%	30%	25%	40%	69%	61%	54%	25%	48%
	10	COP19	CentrallySupported	APR20	60%	60%	43%	45%	79%	98%	157%	131%	128%	90%	126%	125%	92%	167%	114%
	100	COP20	TA	APR21	0%	0%	17%	18%	29%	22%	51%	49%	56%	44%	60%	48%	16%	25%	40%

APPENDIX B – Budget Profile and Resource Projections

B1. COP20 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP21 Budget by Program Area

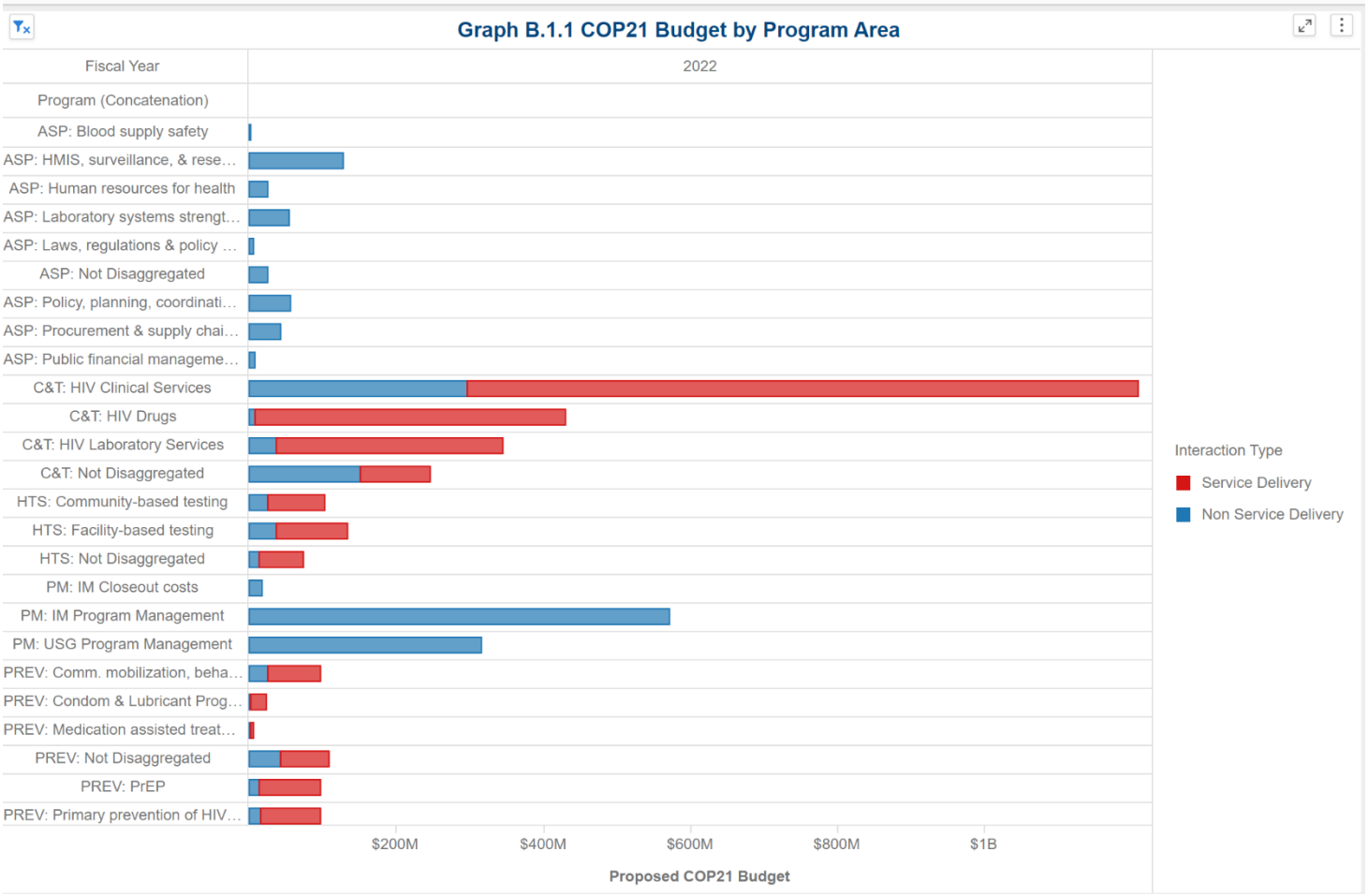


Table B.1.2 COP21 Budget by Program Area							
Program	**Fiscal Year**	**2022**					
	Metrics	**Proposed COP21 Budget**			**Percent of COP 21 Proposed Budget**		
	Subprogram	**Non Service Delivery**	**Service Delivery**	**Total**	**Non Service Delivery**	**Service Delivery**	**Total**
Total		**$39,510,212**	**$49,474,823**	**$88,985,035**	**44.40%**	**55.60%**	**100.00%**
C&T	**Total**	**$9,603,816**	**$37,920,905**	**$47,524,721**	**20.21%**	**79.79%**	**100.00%**
	HIV Clinical Services	$8,425,419	$29,982,902	**$38,408,321**	21.94%	78.06%	**100.00%**
	HIV Drugs	$74,348	$2,575,489	**$2,649,837**	2.81%	97.19%	**100.00%**
	HIV Laboratory Services	$1,001,276	$5,362,514	**$6,363,790**	15.73%	84.27%	**100.00%**
	Not Disaggregated	$102,773		**$102,773**	100.00%		**100.00%**
HTS	**Total**	**$923,020**	**$5,486,897**	**$6,409,917**	**14.40%**	**85.60%**	**100.00%**
	Community-based testing	$385,078	$583,154	**$968,232**	39.77%	60.23%	**100.00%**
	Facility-based testing	$355,613	$4,763,695	**$5,119,308**	6.95%	93.05%	**100.00%**
	Not Disaggregated	$182,329	$140,048	**$322,377**	56.56%	43.44%	**100.00%**
PREV	**Total**	**$397,284**	**$2,868,566**	**$3,265,850**	**12.16%**	**87.84%**	**100.00%**
	Comm. mobilization, behavior & norms change		$201,773	**$201,773**		100.00%	**100.00%**
	Condom & Lubricant Programming		$588,000	**$588,000**		100.00%	**100.00%**
	Not Disaggregated	$304,944	$1,105,459	**$1,410,403**	21.62%	78.38%	**100.00%**
	PrEP	$92,340	$973,334	**$1,065,674**	8.66%	91.34%	**100.00%**
SE	**Total**	**$1,662,857**	**$3,198,455**	**$4,861,312**	**34.21%**	**65.79%**	**100.00%**
	Legal, human rights & protection	$204,333		**$204,333**	100.00%		**100.00%**
	Not Disaggregated	$1,458,524	$3,198,455	**$4,656,979**	31.32%	68.68%	**100.00%**
ASP	**Total**	**$5,553,946**		**$5,553,946**	**100.00%**		**100.00%**

	HMIS, surveillance, & research	$1,446,031		**$1,446,031**	100.00%		**100.00%**
	Human resources for health	$43,615		**$43,615**	100.00%		**100.00%**
	Laboratory systems strengthening	$327,500		**$327,500**	100.00%		**100.00%**
	Laws, regulations & policy environment	$746,500		**$746,500**	100.00%		**100.00%**
	Not Disaggregated	$82,536		**$82,536**	100.00%		**100.00%**
	Policy, planning, coordination & management of disease control programs	$1,018,094		**$1,018,094**	100.00%		**100.00%**
	Procurement & supply chain management	$1,889,670		**$1,889,670**	100.00%		**100.00%**
PM	**Total**	**$21,369,289**		**$21,369,289**	**100.00%**		**100.00%**
	IM Closeout costs	$5,000		**$5,000**	100.00%		**100.00%**
	IM Program Management	$14,890,363		**$14,890,363**	100.00%		**100.00%**
	USG Program Management	$6,473,926		**$6,473,926**	100.00%		**100.00%**

Table B.1.3 COP21 Total Planning Level			
Fiscal Year	2022	2022	2022
Metrics	Proposed COP21 Budget	Proposed COP21 Budget	Proposed COP21 Budget
Operating Unit	Applied Pipeline	New	Total
Total	**$10,010,226**	**$93,889,774**	**$103,900,000**
Ethiopia	$10,010,226	$93,889,774	**$103,900,000**

Table B.1.4: COP21 Resource Allocation by Program and Beneficiary														
Fiscal Year	**2022**													
Program	**C&T**		**HTS**		**PREV**		**SE**		**ASP**		**PM**		**Total**	
Beneficiary	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**	**Proposed COP21 Budget**	**Percent to Total**
Total	**$49,029,868**	**100%**	**$12,163,818**	**100%**	**$5,779,968**	**100%**	**$7,045,773**	**100%**	**$12,971,689**	**100%**	**$16,908,884**	**100%**	**$103,900,000**	**100%**
Females	$3,260,000	7%											**$3,260,000**	**3%**
Key Pops	$2,987,074	6%	$1,906,094	16%	$1,060,125	18%			$118,260	1%			**$6,071,553**	**6%**
Males					$775,583	13%							**$775,583**	**1%**
Non-Targeted Pop	$41,168,791	84%	$8,688,248	71%	$2,574,827	45%			$12,265,832	95%	$16,908,884	100%	**$81,606,582**	**79%**
OVC	$1,014,003	2%	$1,013,931	8%	$655,557	11%	$7,045,773	100%	$587,597	5%			**$10,316,861**	**10%**
Pregnant & Breastfeeding Women	$500,000	1%											**$500,000**	**0%**
Priority Pops	$100,000	0%	$555,545	5%	$713,876	12%							**$1,369,421**	**1%**

APPENDIX C– Minimum Program Requirements

Area	Policy	Status	Remark
Care and Treatment	1. Test and Start	Completed	Adopted and implemented Nationwide
	2. TLD transition	Completed	TLD rolled out for new clients and transition ongoing for existing clients.
	3. DSD & MMD	Completed	DSDM models adopted and implemented
	4. TPT	Completed	TPT and TB treatment for PLHIV is available.
	5. VL/EID optimization	Completed	Some laboratory optimization has occurred, but challenges remain. VL coverage not at 90%
Case Finding	1. Index testing and HIVST	Completed	Index testing being scaled, and IPV prevention and monitoring incorporated into COP19 implementation
Prevention and OVC	1. PrEP	Completed	PrEP currently offered for FSWs and sero-discordant couples
	1. Evolve OVC Services & packages	Completed	OVC package reviewed and is aligned
Policy & Public Health Systems Support	1. Elimination of all User Fees	Completed	All user fees are eliminated
	2. CQI Integration	Completed	Various quality assurance and quality improvement activities are being implemented
	3. Tx & VL Literacy, U=U	Completed	Strong host country leadership on health literacy, but barriers to reducing stigma and discrimination in some groups
	4. Increase Funding to Indigenous Partners	Completed	
	5. Increased Government Resources	Completed	Host country HIV spending remains relatively flat with heavy reliance on donor funding
	6. Monitoring Morbidity & Mortality	Completed	Monitoring and reporting in place
	7. Scale-up CBS and Unique Identifier	Completed	CBS is being scaled; GOE is developing unique ID system more broadly