



**Ethiopia**

**Country Operational Plan**

**(COP) 2022**

**Strategic Direction Summary**

**April 15, 2022**

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## **Acronyms**

ABC – Abacavir Antiretroviral  
AGYW – Adolescent girls and young women  
AHD - Advanced HIV Disease  
ANC – Antenatal clinic  
APR – Annual Program Results  
ART – Antiretroviral Therapy  
ARV – Antiretroviral  
ASLM – African Society for Laboratory  
CBO – Community-based organization  
CBS – Case-based surveillance  
CCM – Country coordinating mechanism  
CDC – Centers for Disease Control and Prevention (part of HHS)  
CEE – Core essential element  
CLM- Community Led Monitoring  
CODB – Costs of Doing Business  
COM – Chief of mission  
COP – Country Operational Plan  
CQI – Continuous Quality Improvement  
CQM – Continuous Quality Management  
CrAg – Cryptococcal Antigen  
CSO – Civil Society Organization  
CSW/SW – Commercial Sex Worker  
CXCA - Cervical Cancer  
CTX – Cotrimoxazole  
DATIM – Data for Accountability, Transparency, and Impact  
DOS – U.S. Department of State  
DP – Deputy Principal  
DRM – Domestic resource mobilization  
DSD – Direct Service delivery  
DTG – Dolutegravir  
EFV – Efavirenz  
EID – Early-infant diagnose  
EPSS – Ethiopian Pharmaceutical Supply Services  
EQA – External quality assessment  
FAST – Funding Allocation to Strategy Tool  
FBO – Faith-based organization  
FSW – Female sex workers  
FTE – Full-time equivalent  
FY – Fiscal year  
GBV – Gender-based violence  
GFATM – The Global Fund to Fight AIDS, Tuberculosis, and Malaria (also “Global Fund”)  
GHP – Global Health Programs  
GHSC-PSM – Global Health Supply Chain Program - Procurement and Supply Management  
HW – Health Workers  
HHS – U.S. Department of Health and Human Services  
Immunodeficiency Virus HIVDR – HIV Drug Resistant (surveys)  
HIVRTCQI – HIV Rapid Testing Continuous Quality Improvement  
HIVST – HIV self-testing  
HMIS – Health Management Information System  
HOP – Headquarters Operational Plan HPV – Human papilloma virus

HQ – headquarters  
HRH – Human Resources for Health  
HRIS – Human Resource Information Systems  
HRSA – Health Resources and Services Administration (part of HHS) HTS – HIV Testing  
IBBS – Integrated Bio-Behavioral Survey IC – Institutional Contractor  
IDP – Internally Displaced People  
KP – Key populations  
LAM – Lipoarabinomannan  
LCQI – Laboratory continuous quality improvement  
LEA – Legal Environment Assessment  
LIC – Low Income Country  
LOE – Level of effort  
LTFU – Lost to follow up  
LZN – Lamivudine/Zidovudine/Nevirapine  
M&E – Monitoring and evaluation  
M&O – Management and Operations  
MER – Monitoring, Evaluation, and Reporting  
MHPSS - Mental Health Psychosocial Support  
MMD – Multi-Month Dispensing  
MMS – Multi-Month Scripting  
MMT – Methadone Maintenance Treatment  
MOH – Ministries of Health  
MOU – Memorandum of Understanding  
MTCT – Mother-to-child-transmission  
NASA – National AIDS Spending Assessment  
NHA – National Health Accounts  
NIH – National Institutes of Health (part of HHS)  
NSP – National Strategic Plan  
NVP – Nevirapine  
OGA – Office of Global Affairs  
OR – Operations research  
OU – Operating Unit  
OVC – Orphans and vulnerable children  
PEP – Post-exposure prophylaxis  
PEPFAR – President’s Emergency Plan for AIDS Relief  
PITC – Provider-initiated testing and counseling  
PLHIV– People Living with HIV/AIDS or People Living with HIV  
POART – PEPFAR Oversight and Accountability Response Team  
POC – Point of care  
PPM – PEPFAR Program Manager  
PPP– Public-Private Partnership  
PrEP – Pre-exposure prophylaxis  
PSE – Private Sector Engagement  
PSNU – Priority sub-national unit  
QSC – Quality Score Card  
ROP – Regional Operational Plan  
RPM – Regional Planning Meeting  
RPSO – Regional Procurement Support Offices  
RT – Rapid testing  
RTK – Rapid test kit  
SAPR – Semi-Annual Program Results  
SCMS –Supply Chain Management System

SDS – Strategic Direction Summary  
S/GAC – Office of the U.S. Global AIDS Coordinator (part of State)  
SI – Strategic Information  
SID – Sustainability Index and Dashboard  
SIMS – Site Improvement through Monitoring System  
SNU – Sub-national unit  
STI – Sexually transmitted infection  
SW – Sex workers  
TA – Technical assistance  
TB – Tuberculosis  
TBD – To Be Determined  
TBT – TB preventive treatment  
TEE – Tenofovir/efavirenz/emtricitabine  
TLD – Tenofovir/lamivudine/dolutegravir  
TLE – Tenofovir/lamivudine/efavirenz  
TPT – TB preventive treatment  
TWG – Technical Working Group  
UNAIDS – Joint United Nations Program on HIV/AIDS  
UNDP – United Nations Development Program  
UNICEF – United Nations Children’s Fund  
UHEWs- Urban Health Extension Workers  
USAID – U.S. Agency for International Development  
US- United States  
VCT – Voluntary counseling and testing  
VL – Viral load  
VLS – Viral Load Suppression  
VMMC – Voluntary Medical Male Circumcision

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# 1.0 Vision and Goal Statement

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In close partnership with the Government of Federal Democratic Republic of Ethiopia (GFDRE), the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) program in Ethiopia (PEPFAR-E) has made great progress towards reaching HIV epidemic control targets. As of September 2021, Ethiopia has achieved over 78% treatment coverage among people living with HIV. The incidence has been reduced by 54%, and HIV-related mortality has been cut by 48% since 2010<sup>1</sup>. These gains, however, are threatened by challenges of the COVID-19 pandemic and major conflict across the country over the past two years. Furthermore, an emerging concern is severe drought, the worst in 40 years, that is anticipated to affect HIV programs especially in southern Ethiopia.

PEPFAR-E's COP22 vision is to reach and sustain epidemic control by preserving the enormous gains of the past decade, reaching the remaining PLHIV who do not yet know their HIV status, and restoring and strengthening the ART cohort in the regions most affected by the conflict. These goals support the priorities set out in the HIV/AIDS National Strategic Plan (NSP) for Ethiopia 2021–2025, including (1) geographic prioritization in woredas with the highest HIV incidence, (2) prioritization of key and priority populations, and (3) prioritization of high-impact, cost-effective interventions.

The COP22 strategy builds on the results of COP20 and COP21 while focusing on gaps in viral load (VL) suppression among children and geographic units that experienced significant treatment loss, largely due to the conflict of the past 2 years. The COP22 strategy emphasizes programs and initiatives that will help reach and maintain epidemic control while ensuring the accessibility, acceptability, uptake, equitable coverage, quality, effectiveness and efficiency of HIV services and systems.

As in prior COPs, critical stakeholder and partner engagement efforts will continue to focus on stigma and discrimination reduction, enhanced and continuous community engagement, adoption of the latest evidence-based best practices, and careful alignment of program interventions to achieve and maintain epidemic control in Ethiopia.

To implement these strategies, PEPFAR-E will support the following strategic objectives:

1. Build from the current emergency response activities to recover HIV and TB treatment services in regions most affected by conflict
  - Assuring commodities, supply chain, and information systems
  - Strengthening community-facility collaborations to track, trace, and reconnect clients with treatment interruption
  - Coordinating networked services and outreach to ensure health services are provided to internally displaced people (IDP)
  - Strengthening differentiated service delivery models (DSDM) (including multi-month ART dispensation) for treatment continuity
  - Addressing gaps in viral load services and results use
  - Reducing the highest risks for mortality – advanced HIV disease, TB screening and prevention

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<sup>1</sup> SPECTRUM 2022

- Mental health and psychosocial support (MHPSS) for PLHIV and health workers
  - Continuing technical assistance to the National Emergency Response and Recovery Task Force to ensure HIV and HIV/TB programs are emphasized
  - Monitoring and oversight of recovery and rehabilitation activities
  - Addressing the needs of survivors of violence (GBV and OVC services) by linking HIV testing, PEP, PrEP, and mental health services; and supporting referral networks and one stop shops
2. Ensure advancement towards sustainable epidemic control in regions less affected by conflict by building off COP21 priorities

**Maintaining the Gains and institutionalizing program innovations introduced in response to COVID-19**

- Closing sub-population gaps in VL coverage and high VL cascade
- Increasing treatment coverage through targeted testing, durable linkage, prevention of treatment interruption, and ensuring excellence in person-centered service delivery
- Strengthening the KP cascade through better data, coordinated community and facility services, and enhanced KP-led program monitoring
- Adopting and scaling up recent advances in TB screening and prevention, cervical cancer screening, infection prevention and control
- Reinvigorating community-facility collaborations to improve the uptake of partner services and the tracking, tracing, and reconnection of clients with treatment interruption

**Overcoming the most significant barriers to HIV epidemic control and 95-95-95**

- Identifying and overcoming gaps in the treatment cascade for children and adolescents living with HIV, with an emphasis on aligning OVC and pediatric treatment programs
- Supporting national elimination goals for mother to child transmission of HIV through better quality of services, data, and program support
- Optimizing the scale up of pre-exposure prophylaxis (PrEP) to further reduce HIV incidence

**Assuring HIV systems for sustainable, maintained epidemic control**

- HIV case surveillance will be expanded to all testing sites using a phase-by-phase approach. The following activities will be implemented besides the expansion: adoption of VL testing (RITA protocol), introduction of longitudinal surveillance, strengthened community collaboration, and improved monitoring of cluster-based public health response.
- Fortifying HIV information systems through scale up and improved interoperability of information systems that link clinical, pharmacy, laboratory, and supply chain data at the individual level
- Assuring commodities and supply chain systems to meet the complex needs of programs in the context of an unpredictable implementation environment
- Improving the health-span along with the lifespan through addressing the needs of the growing cohort of PLHIV over the age of 50 years

3. Building a self-reinforcing and sustainable HIV program by strengthening Community Led Monitoring (CLM) and Continuous Quality Improvement (CQI) activities

### **Building off current programs that promote Community Led Monitoring (CLM)**

In COP22, PEPFAR-E will support independent local CSOs to continue the community led monitoring activities in 7 regions and enhance PLHIV- and KP-focused CLM activities

- Mapping of stakeholders and beneficiary groups (KP, PLHIV)
- Assessing the capacity of existing community groups (KP, PLHIV)
- Enhancing the involvement of community level organizations and KPs in CLM implementation
- Introducing community-led design of metrics, tools, and monitoring systems
- Strengthening the capacity of CSOs and KP-led organizations to advocate for service delivery improvements and action planning
- Improving program monitoring and accountability through joint review, partnership, and collaboration

### **Integrating Continuous Quality Improvement into all HIV service delivery activities**

- Enhancing people -centered program design and monitoring
- Expanding the successful Quality Score Card (QSC) initiative beyond KP programs to more facility and community sites providing services to PLHIV
- Strengthening QI standards and capacity for all implementing partners

## **2.0 Epidemic, Response, and Program Context**

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### **2.1 Summary statistics, disease burden and country profile**

Ethiopia is Africa's second most populous nation and is classified as a Low-Income Country (LIC) by the World Bank. The estimated population is around 103,023,536, with representation from approximately 80 ethnic groups.<sup>2</sup> Ethiopia's real gross domestic product growth slowed to 6.1% in 2019/20 because of COVID-19, with a per capita income of \$850.<sup>3</sup> 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

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<sup>2</sup> Population Projections for Ethiopia 2007-2037, CSA 2012

<sup>3</sup> World Bank, 2021



Assessment (EPHIA) estimated an HIV prevalence in urban regions of 3.0% nationally with regional variation.

The 2021 HIV Spectrum model estimates the national PLHIV number to be 612,925. The conflict in North Ethiopia, which started in November 2020, is threatening Ethiopia's continuing momentum to reach epidemic control, and determining the national HIV cascade is limited by the lack of reporting from Tigray and parts of Amhara and Afar Regions. It is estimated that 84% of PLHIV adults and children know their HIV status; among people living with HIV who know their HIV status, 83% are confirmed to be receiving ART (however, treatment data is currently unavailable from conflict-affected areas in Tigray and parts of Amhara regions); and among adults receiving ART who have a documented viral load test, 96% were virally suppressed (VL <1,000 copies/mL). Viral load coverage has increased only modestly in the past year due to a combination of clinical, analytic, and data completeness factors, with unknown viral load status of an estimated 100,373 clients. Of people who received HIV testing service in the past year, an estimated 33,988 tested positive for HIV, and 91.4% of those testing positive 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. Gambella Region continues to have the highest HIV prevalence 3.56<sup>4</sup> with little distinction between urban and rural residents; some rural areas with high seasonal migrant populations have high HIV prevalence. HIV prevalence in the general population is 0.9% with the highest prevalence recorded among women in the age group 25+ years (1.84%), followed by males 25+ years (0.84%). The overall ART coverage is 70% with lower ART coverage of 33% among children below 15 years of age, but these estimates are affected by the lack of current reporting from conflict-affected areas in Tigray and parts of Amhara regions.

In FY21, despite 31,086 patients newly enrolled in antiretroviral therapy (ART), the reported number of patients currently on ART by the end of the year dropped by 48,287 due to incomplete reporting from conflict affected regions in northern Ethiopia. In sites that had consistent treatment reporting throughout FY21, the treatment cohort was modestly increased.

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<sup>4</sup> SPECTRUM 2022

## 2.1.1 Government of Federal Democratic Republic of Ethiopia Results



	Total		<15				15-24				25+				Source, Year
			Female		Male		Female		Male		Female		Male		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Population	103,023,536	100	20,428,602	19.8	20,929,220	20	10,779,771	10.5	10,951,472	10.6	20,172,397	19.6	19,762,072	19.2	CSA
HIV Prevalence (%)		0.90		NA		NA		0.26		0.18		1.84		0.84	DHS 2016
AIDS Deaths (Year)	11,627		930		962		649		606		5,083		3,398		Spectrum 2022
# PLHIV	612,925		20,572		21,216		41,578		28,177		319,247		182,135		
Incidence Rate (Yr)		0.02*		NA		NA		0.03		0.01		0.02*		0.01*	
New Infections (Yr)	11,967														
Annual births	3,092,394														
% of Pregnant Women with at least one ANC visit	2,303,562	70%	NA	NA			NA	NA			NA	NA			HSTP, Annual report 2020/2021 (2013 FFY)**.
Pregnant women needing ARVs	17,886	NA													Spectrum 2022
Orphans (maternal, paternal, double)	2,983,257		NA		NA		NA		NA		NA		NA		2022 Spectrum
Notified TB cases (Yr)	108193	100	5241	5	5346	5	12406	11	14305	13	30597	28	40658	38	Global TB Report 2021
% of TB cases that are HIV infected	5737	6.5													Global TB Report 2021
% of Males Circumcised	NA	91.0			NA	NA			NA	NA			NA	NA	DHS 2016
Estimated Population Size of MSM*	NA	NA													
MSM HIV Prevalence	NA	NA													
Estimated Population Size of FSW	241,617	NA													PEPFAR Eth Interagency team
FSW HIV Prevalence		18.7%					NA	NA			NA	NA			National MARPS Survey
Estimated Population Size of PWID	NA	NA													
PWID HIV Prevalence	NA	NA													
Estimated Size of Priority Populations (specify)	2,373,935	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	UNAIDS
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\*\*\* The indicator available is Pregnant women received four or more ANC visits

**Table 2.1.2 95-95-95 Cascade: HIV diagnosis, treatment, and viral suppression (FY21)**

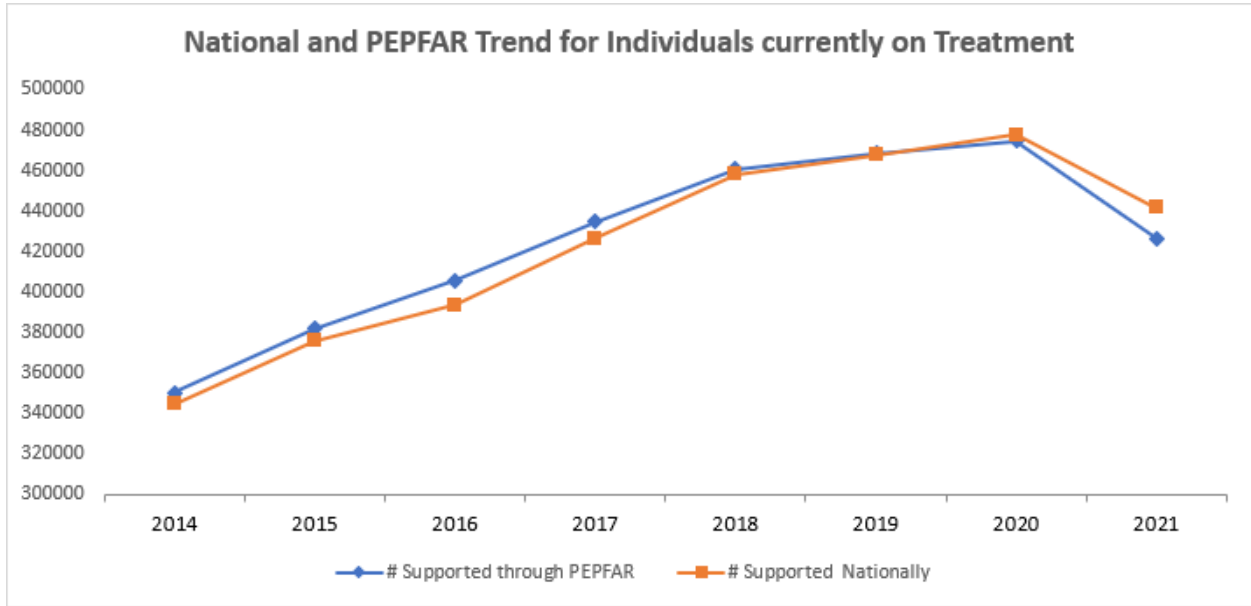
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	HIV Prevalence (%)	Estimated Total PLHIV (#)	PLHIV diagnosed (#)	On ART (#)	ART Coverage (%)	Viral Suppression (%)	Tested for HIV (#)	Diagnosed HIV Positive (#)	Initiated on ART (#)
2Data Source	Central Statistical Authority (CSA) Projections	DHS 2016, KP survey & Spectrum 2022	Spectrum 2022 KP Survey 2013&2020 & Literatures	Spectrum 2022	DHIS 2, MOH DATIM	DHIS 2, MOH/Spectrum 2022	DATIM	DHIS 2, MOH DATIM	DHIS 2, MOH DATIM	DHIS 2, DATIM
Total population	103,023,536	0.9	612,925	514,857	426,464	70%	96	7,237,175	33,988	31,081
Population <15 years	41,357,822	NA	41,788	15,183	13,727	33%	91	NA	NA	1,477
Men 15-24 years*	10,951,472	0.18	28,177	24,975	11,837	42%	92	NA	NA	1,068
Men 25+ years*	19,762,072	0.84	182,135	161,439	139,928	77%	96	NA	NA	9,525
Women 15-24 years*	10,779,771	0.26	41,578	35,979	19,458	47%	94	NA	NA	4,006
Women 25+ years*	20,172,397	1.84	319,247	276,259	241,524	76%	96	NA	NA	15,009
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	241,617	18.7	**24,374	13,161	11,787	***48%	95	90,737	6232	3841
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

*\*Age disaggregated #PLHIV diagnosed is calculated by taking the first 95 performance from spectrum for adult (15+) men and women*

*\*\* The data is for urban PEPFAR Supported woredas. PEPFAR Support KP Program in 277 woredas out of the 1100 total woredas.*

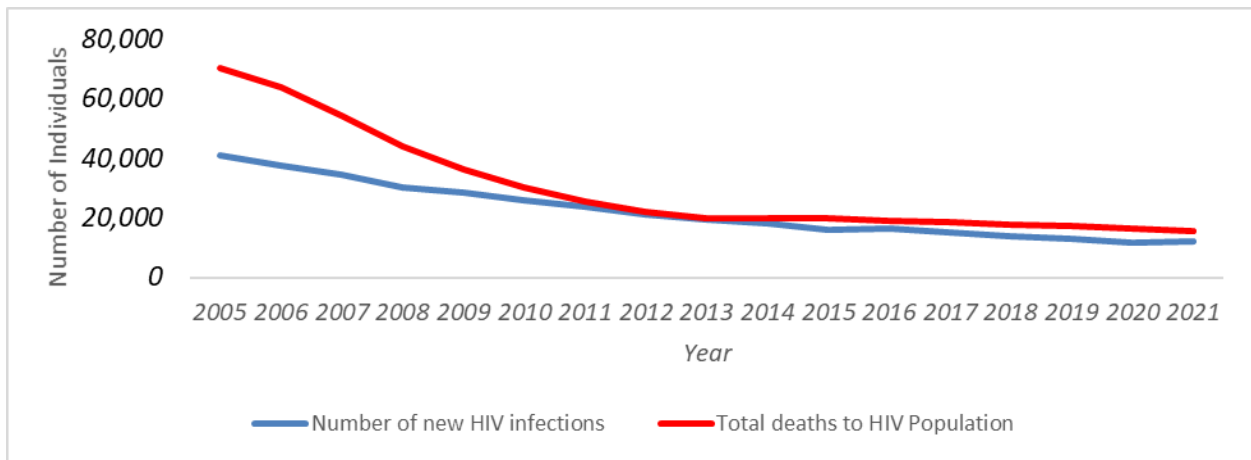
*\*\*\* Even though we had been collecting KP Cascade data separately; we anticipate that diagnosed FSW are still reported under the general population*

**Figure 2.1.3 Updated National and PEPFAR Trend for Individuals currently on Treatment**



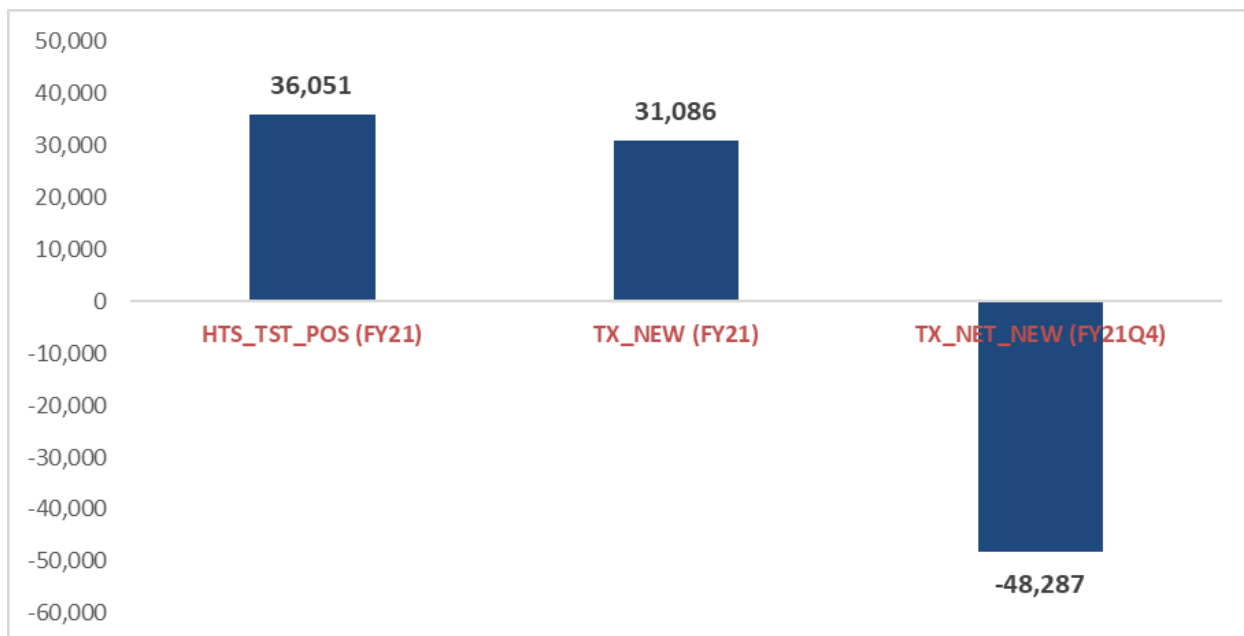
5

**Figure 2.1.4 Updated Trend of New Infections and All-Cause Mortality Among PLHIV**



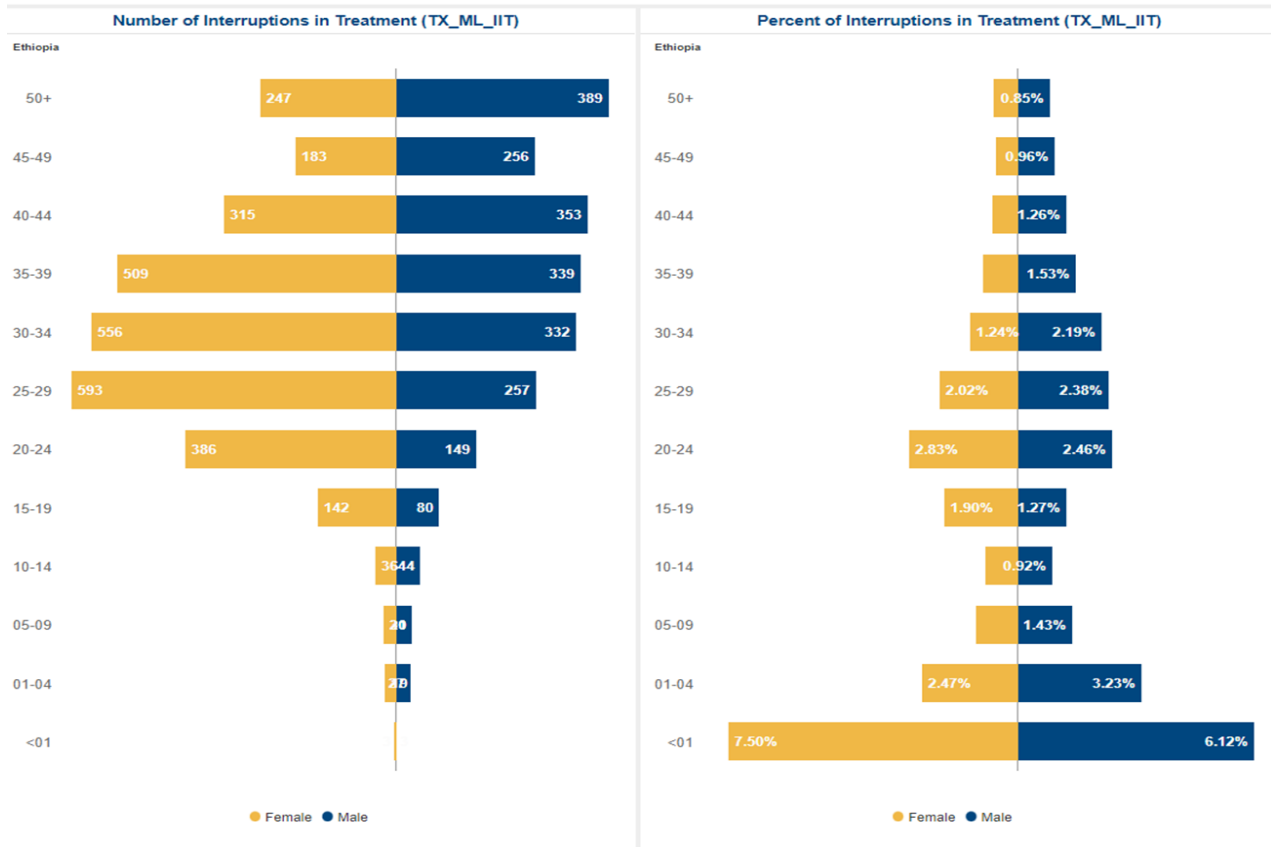
**Figure 2.1.5 Assessment of ART program growth in FY21\***

<sup>5</sup> PEPFAR supports 98% of the ART being offered nationally

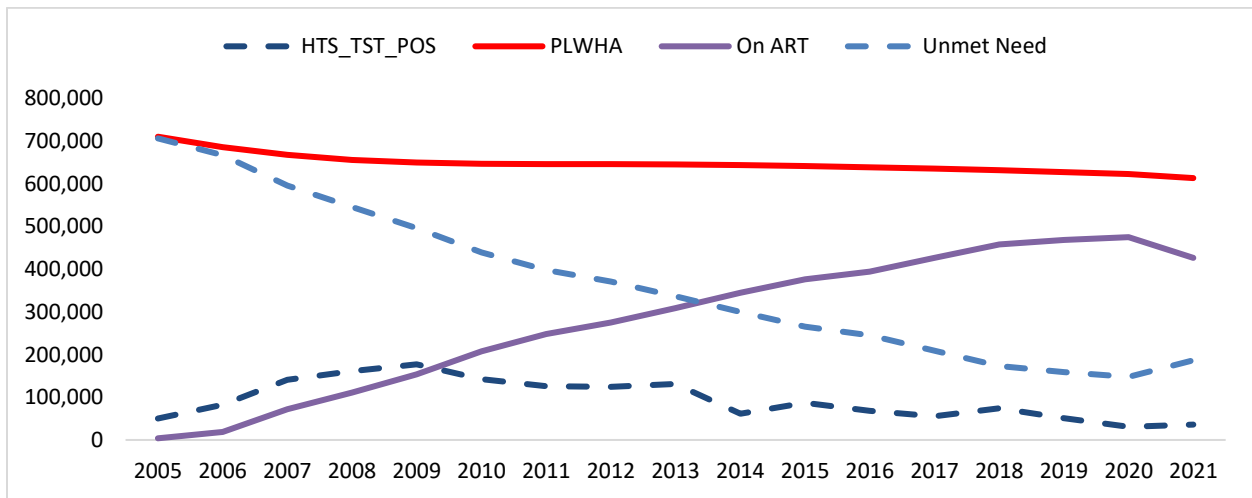


\* **Note:** HIV program data (HTS and TX indicators) in FY21 are incomplete due to lack of reporting from conflict-affected areas. In Tigray and parts of Amhara regions, 170 (14%) facilities did not report treatment data in FY21Q4.

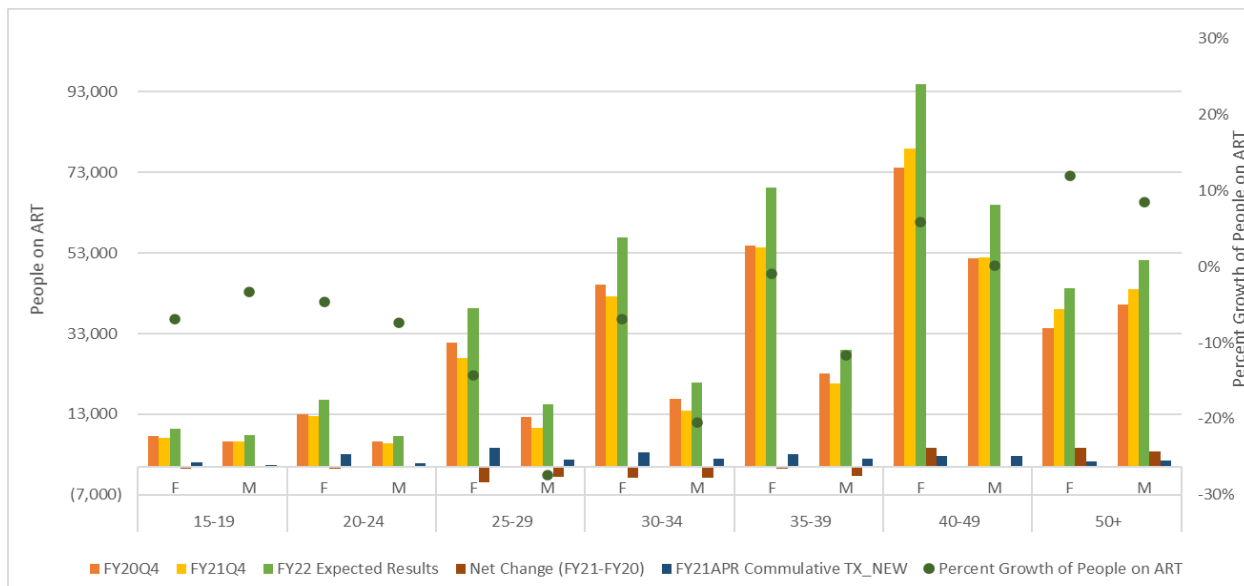
**Figure 2.1.6 Number and percent of clients experiencing interruption in treatment by Age/Sex, FY21 Q4**



**Figure 2.1.7 Epidemiologic Trends and Program Response, Ethiopia**



**Figure 2.1.8 Net change in HIV treatment by sex and age bands 2020 Q4 to 2021 Q4**



\* Due to lack of reporting, data from Tigray region is excluded from this analysis. Above results should be interpreted with caution, as data is incomplete from Amhara region in FY21Q4, but has not been excluded from this analysis

## 2.2 New Activities and Areas of Focus for COP22, Including Focus on Client ART

### Continuity

COP20 and COP21 (FY21–22) represent a particularly challenging time for the Ethiopian HIV program, with widespread conflict and disruption of health services and program support resulting in the absence of routine program reporting and monitoring from conflict-affected areas. The effects of conflict and instability extended beyond areas most directly affected by active armed conflict and has affected program performance in almost all regions and program activities. Overall, the ART cohort as measured by TX\_CURR decreased in FY21, primarily due to non-reporting sites in two of the regions with larger ART cohorts (Tigray and Amhara regions). In conflict-affected areas, there was widespread damage to infrastructure (Electricity, Telecom, others), loss of information systems, basic equipment and furniture, and displacement of clients and health workers. These unprecedented challenges over a prolonged period pose continuing constraints on program implementation and support. The priority activity in conflict-affected areas is reconnecting clients to treatment who have experienced interruption due to the conflict. Successful reconnection of clients to treatment requires re-starting essential HIV testing and treatment services, rehabilitation of health facilities to provide essential services, community-facility linkages to identify and return clients to treatment, retraining of health workers, and recovery of supply chain, information, and laboratory services. There are ongoing efforts to resume services and most facilities in now accessible conflict-affected areas have started providing HIV care and treatment services. Further strengthening and maximizing the implementation of DSD models in all regions and optimizing the collaboration between facility and community services is necessary to continue progress to epidemic control.

In regions less affected by conflict, there has been moderate growth of the ART cohort, but not sufficient to achieve 95/95/95 treatment goals. Based on identified gaps in treatment continuity and interruptions, return to treatment initiatives will be undertaken in selected geographic areas and sites to identify, track, and support PLHIV to re-engage in ART services. Additional focus will be made to enhance people-centered services for virally unsuppressed clients and clients newly initiated on treatment, address advanced HIV disease (AHD), and services aimed at the

growing cohort of PLHIV greater than 50 years, ensuring that healthy aging is promoted through management of co-morbidities and coordination of other age-specific health and wellness needs. This will be done in adherence with MOH policies for DSD models and close collaboration and coordination between facility and community stakeholders. Standardized procedures for the early identification, reporting, and follow-up to support PLHIV experiencing treatment interruption at facility and community levels will be strengthened and scaled up. The main driver in increasing the treatment cohort is HIV case finding and the program will work to strengthen case finding through mixed, targeted modalities, linkage to rapid ART initiation, treatment continuity, and partner services.

The implementation of the Replication of Addis Ababa Acceleration (RoTA) initiative is led by the MOH and currently implemented in all regions to accelerate case finding, new client enrollment, treatment continuity, and increasing viral load coverage and suppression. The multisectoral U=U initiative will be further scaled-up and will engage and empower clients for improved adherence and optimal viral load suppression for improved individual outcomes and preventing transmission of HIV. Integration of messaging around U=U into HIV prevention, care, and treatment programs, including those serving key populations, will be strengthened. 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.

To strengthen the treatment cascade for children and adolescents living with HIV (C/ALHIV), 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 a package of care for children with advanced HIV disease to reduce mortality in children <5 years.

In COP22, HIV testing coverage for TB will continue to be maintained at recent high levels, with greater focus provided to strengthening the testing coverage for presumptive TB and TB contact cases. Linkage tracking will be strengthened for people with TB diagnosed with HIV and referred to ART services. Priority client-centered care interventions for TB/HIV programs include the scale up of MMD for TB treatment and TPT, coordinated treatment interruption tracking, and alignment with ART DSD services. Community–facility collaboration to tracking of clients with interruptions in TB treatment and TPT will be strengthened. Targeted intervention strategies at high volume sites with low TPT coverage and completion will continue to be strengthened, with particular focus for groups with higher coverage gaps, including PLHIV newly enrolled to ART and C/ALHIV.

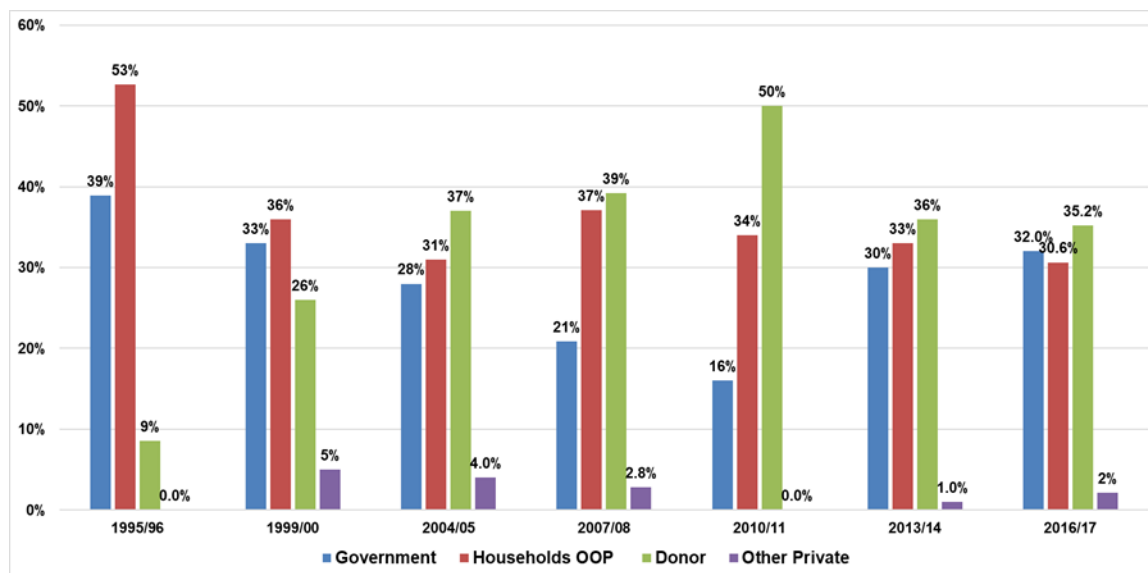
### **2.3 Investment Profile**

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 and 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). According to the NHA report for 2016/17, this is a 45% increase in nominal terms from ETB 49.6 billion (2.5 billion USD) in 2013/14.

The NHA further indicates that the government manages more than half of the total health resources (52%), while it contributes 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 and 2016/17. External funding and out-of-pocket health spending accounted for 66% of total health expenditure (see Figure 2.3.1).



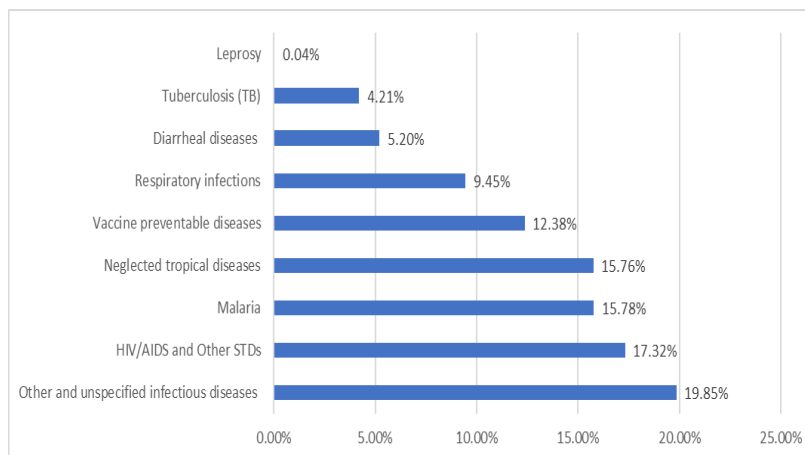
**Figure 2.3.1 Total Health Expenditure by source of Financing (percentage), 2016/17 NHA**



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 all health spending on infectious and parasitic diseases, nearly 17.3% went to HIV/AIDS (see Figure 2.3.2). Of the total health expenditure on infectious and parasitic diseases, health spending on curative care has reduced by 7% since 2013/14.

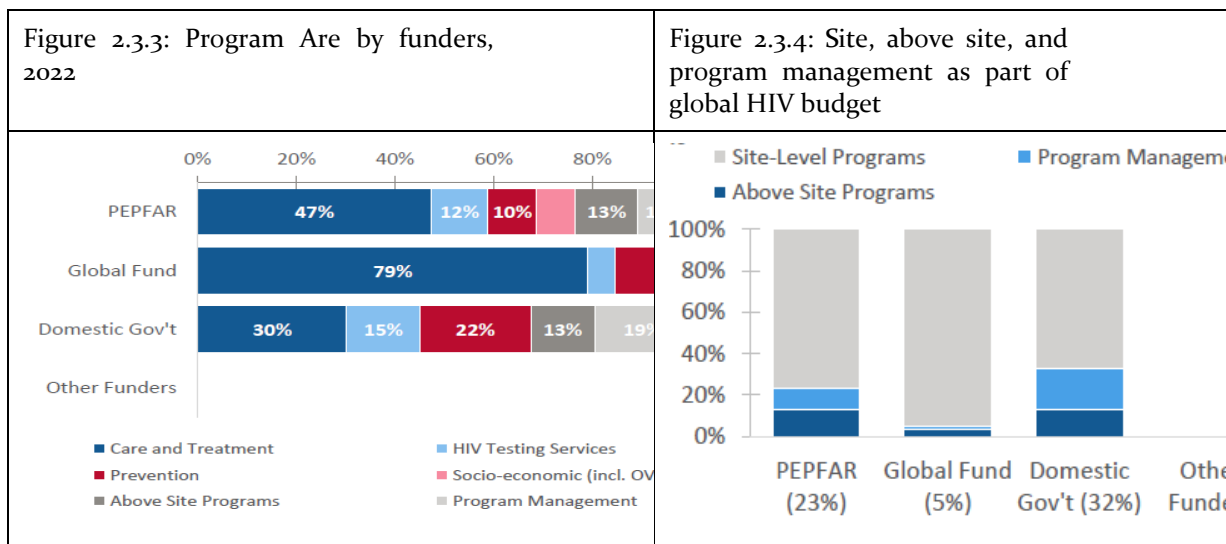
Though health spending is steadily growing overall in volume, the GoE contribution is still low. The share of government health expenditure was found to be 1.4% of GDP in 2016/17, which is far below the global average of 5.3%. The host government covers the costs of personnel, office space, and other operational expenses for the health facilities (health posts, health centers, hospitals, and regional laboratories) and above-site structures such as MOH, Ethiopian Pharmaceutical and Supplies Services (EPSS), Ethiopian Public Health Institute (EPHI), Regional Health Bureaus, Zonal health offices, and 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 public, private, and international stakeholders, was completed. 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 because of a decrease in international donor funding from 85.9% to 82.4%.

The 2022 HIV resource alignment exercise led by the United States President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis, and Malaria (the Global Fund) provides a harmonized, routine, and detailed financing landscape across all sources of funding for HIV/AIDS. According to the report, all funders are investing more in HIV care and treatment programs, as illustrated in Figure 2.3.3. On the other hand, as shown in Figure 2.3.4, more funding went to HIV programs at the site level. Public health facilities and local community implementing partners are the primary actors at site level.



Government of Ethiopia 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<sup>6</sup>.

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<sup>6</sup> Ethiopia National AIDS Spending Assessment (NASA) Report (2017/18 and 2018/18) FHAPCO, 2021

Table S1. Investment Profile (Budget Allocation) for HIV Programs, 2022

	Total	Domestic Gov't	Global Fund	PEPFAR	Other Funders	Trend
	\$	%	%	%	%	2018-2022
Care and Treatment	\$163,104,635	8%	59%	33%	0%	
HIV Care and Clinical Services	\$139,793,750	7%	69%	24%	0%	
Laboratory Services incl. Treatment Monitoring	\$13,399,753	0%	0%	100%	0%	
Care and Treatment (Not Disaggregated)	\$9,911,132	32%	1%	67%	0%	
HIV Testing Services	\$26,292,595	24%	26%	50%	0%	
Facility-Based Testing	\$14,193,773	0%	41%	59%	0%	
Community-Based Testing	\$2,654,733	0%	38%	62%	0%	
HIV Testing Services (Not Disaggregated)	\$9,444,089	67%	0%	33%	0%	
Prevention	\$32,386,244	30%	35%	35%	0%	
Community mobilization, behavior and norms change	\$11,130,133	0%	61%	39%	0%	
Voluntary Medical Male Circumcision	\$1,079,534	0%	0%	100%	0%	
Pre-Exposure Prophylaxis	\$589,026	0%	21%	79%	0%	
Condom and Lubricant Programming	\$2,831,397	0%	84%	16%	0%	
Opioid Substitution Therapy	\$533,139	0%	100%	0%	0%	
Primary Prevention of HIV & Sexual Violence	\$1,583,659	0%	100%	0%	0%	
Prevention (Not Disaggregated)	\$14,639,356	65%	1%	34%	0%	
Socio-economic (incl. OVC)	\$9,646,303	0%	9%	91%	0%	
Case Management	\$1,555,084	0%	0%	100%	0%	
Economic Strengthening	\$2,264,602	0%	0%	100%	0%	
Education Assistance	\$1,104,303	0%	0%	100%	0%	
Psychosocial Support	\$791,921	0%	0%	100%	0%	
Legal, Human Rights, and Protection	\$0					
Socio-economic (Not Disaggregated)	\$3,930,393	0%	23%	77%	0%	
Above Site Programs	\$24,636,271	22%	18%	59%	0%	
HRH Systems	\$0					
Institutional Prevention	\$0					
Procurement and Supply Chain Management	\$427,860	0%	0%	100%	0%	
Health Mgmt Info Systems, Surveillance, and Research	\$15,547,386	25%	14%	61%	0%	
Laboratory Systems Strengthening	\$2,657,586	0%	0%	100%	0%	
Public Financial Management Strengthening	\$650,316	43%	57%	0%	0%	
Policy, Planning, Coordination and Management of Disease Ctrl Programs	\$2,750,940	0%	68%	32%	0%	
Laws, Regulations and Policy Environment	\$0					
Above Site Programs (Not Disaggregated)	\$2,602,183	53%	0%	47%	0%	
Program Management	\$13,741,013	0%	12%	88%	0%	
Implementation Level	\$13,741,013	0%	12%	88%	0%	
Total (incl. Commodities)	\$278,099,635	15%	44%	41%	0%	
Commodities Only	\$112,073,868	0%	91%	9%	0%	
% of Total Budget	40%					

Source: HIV Resource Alignment. Domestic Gov't and Other Funders data included where available. PEPFAR regional program data were not available disaggregated by country for 2018-2019.

Table 2.3.2 Investment Profile (Funding Landscape) for HIV Commodities

Table 2.3.3 Investment Profile (Funding Landscape) for HIV Commodities						
Product Category	Forecast for July 2021 - June 2022	PEPFAR	GF*	GOE	GAP [1]	Remark
ARVs	\$41,051,181	\$98,784	\$40,555,116		\$397,281	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	\$2,735,382		\$1,749,485	\$700,000	\$985,897	
Condom requirements	\$1,339,200	\$400,000	\$1,078,686		\$0	
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	\$10,442,768	\$8,900,802			\$1,541,966	The Gap will be covered by the stock on hand and the pipeline order

monitoring pharmaceuticals						
CD4 reagents	\$2,324,662		\$1,476,704	\$3,388,294		There is a risk that the Government co-financing commitment may not materialize for timely procurement
Hematology reagents	\$1,190,927			\$1,970,598		
Chemistry reagents	\$6,367,896			\$1,198,764		
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	
<b>Total</b>	<b>\$76,651,137</b>	<b>\$11,318,683</b>	<b>\$52,219,893</b>	<b>\$3,388,294</b>		

**Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration**

<b>Table 2.3.3 Annual USG Non-PEPFAR Funded Investments and Integration</b>					
<b>Funding Source</b>	<b>Total USG Non-PEPFAR Resources</b>	<b>Non-PEPFAR Resources Co-funding PEPFAR IM</b>	<b># Co-Funded IMs</b>	<b>PEPFAR COP Co-Funding Contribution</b>	<b>Objectives</b>
USAID MCH	\$38,650,000	\$5,300,000	2	\$ 3,300,000	Support the digital health and supply chain interventions
USAID TB	\$14,000,000	\$1,300,000	2		Same as above
USAID Malaria	\$36,000,000	\$2,590,166	2		Same as above
Family Planning	\$31,000,000	\$2,500,000	2		Same as above
NIH					
CDC-CARES Act DGHP Funds	\$300,000	\$300,000	1	\$8,125,000	IPC for COVID 19 and other infectious diseases
GID funds	\$200,000	\$200,000	1	\$8,125,000	Support for planning and implementation of comprehensive vaccine preventable disease surveillance in Ethiopia
CDC- (DHQP)	\$450,000	\$450,000	2	\$12,185,000	Investments for continued IPC capacity building efforts
Peace Corps	NA				
DOD Ebola	NA				

MCC	NA				
Other (specify)	NA				
<b>Total</b>	<b>\$119,650,000</b>	<b>\$11,690,166</b>	<b>2</b>	<b>\$3,300,000</b>	

## 2.4 National Sustainability Profile Update

The HIV/AIDS Sustainability Index and Dashboard (SID) is a tool 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. Scores for these elements are displayed on a color-coded dashboard, together with contextual charts and information. The SID allows stakeholders to track progress and gaps across these key components of sustainability. Consistent with PEPFAR's commitment to transparency, the SID 2019 dashboards and narrative were made publicly available in fiscal year (FY) 2020.

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
<b>Governance, Leadership, and Accountability</b>				
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	
<b>National Health System and Service Delivery</b>				
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	
<b>Strategic Financing and Market Openness</b>				
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
<b>Strategic Information</b>			
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

According to the 2017/18 -2018/19 NASA, the international entities remained at the forefront of funding activities in Ethiopia. The most significant contribution to HIV spending for both years came from international entities. In 2018/19 international entities contributed 82.4%, a decrease from 85.9% in 2017/18. The public entity contributed 13.7% in 2017/18 and 17% in 2018/19 while the private sector contributed less than 1% in both years.

The substantial external contribution was from the Government of the United States (PEPFAR) followed by multilateral organizations. PEPFAR contributed US\$ 140.4 million in 2017/18, decreasing substantially to US\$ 92.7 million in 2018/19. Other bilateral pooled showed an 8% increase between the two years.

The Global Fund was the most significant contribution 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).

The private sector was the least contributor with less than 1% of total funds in both years. However, the sector had a 19% increase from US\$ 1.2 million to US\$ 1.5 million in 2018/19.

**2.5 Alignment of PEPFAR investments geographically to disease burden**

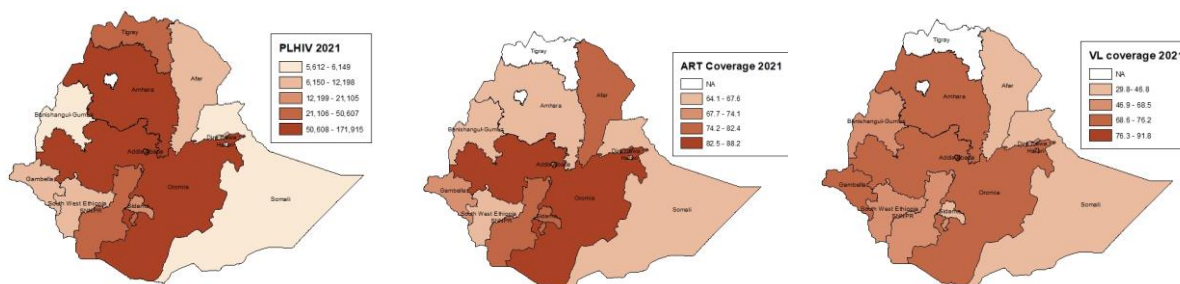
HIV care and treatment services are available across Ethiopia largely through public health facilities and community-based platforms. In FY21, 426,361 PLHIV received treatment at PEPFAR-supported sites with an overall 76% viral coverage and 96% viral suppression rate. These estimates are limited by the continued conflict in northern part of Ethiopia including Tigray, Amhara and Afar regions, as the status of the 62,498 (42,172 Tigray, 20,326 Amhara, there was no significant impact on treatment continuity in Afar) PLHIV who were receiving treatment at sites currently not reporting is unknown. Targeted support will be provided to find individuals and reinitiate treatment, including support of the essential systems that are required to ensure quality care for PLHIV in Tigray and Amhara regions.

As Ethiopia approaches epidemic control, investments will be optimized to reach and sustain epidemic control in the highest burden regions. In the 6 regions including Tigray 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 draft 2022 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 Amhara

(28,556) and Oromia (21,559). 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 model led by MOH.

**Figure 2.5.1** PLHIV, ART coverage, and viral load coverage by Region, Ethiopia, 2021.



## 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 COP22. As such, a virtual stakeholders meeting was held on February 9-10, 2022, early in the COP22 development process, with broad participation from the GoE, multilateral organizations, and civil society. The COP22 guidance, tools, and planning level letter were shared with external stakeholders. A further virtual in-country stakeholder consultation to share and elicit feedback for COP22 plans was attended by H.E. Dr. Lia Tadesse, the Minister of Health, and had wide participation from MOH, RHBs, implementing partners, PLHIV networks, civil society, and multilateral institutions (GFATM, UNAIDS). During COP Planning Meetings held on March 15-17, 2022, opportunities for further consultation and feedback from the GOE, multilateral organizations, and civil society organizations including community-led monitoring partners were also provided. All COP22 presentations, PEPFAR draft tools and visuals have been made available on a public share drive.

## 2.7 Stigma and Discrimination

Despite increased access to information about the benefits of HIV prevention, testing, and treatment, stigma, and discrimination among PLHIV has been a prevailing challenge for the HIV program in Ethiopia. It is an important barrier to HIV prevention, partner services, early diagnosis and treatment initiation, and the lifelong treatment continuity and adherence necessary for viral load suppression to achieve population-based HIV epidemic control. In collaboration with key stakeholders, the Network of Networks of HIV Positives in Ethiopia (NEP+) in collaboration with Federal HIV/AIDS Prevention and Control Office (FHAPCO) and UNAIDS conducted a stigma index survey in 2021. Despite the observed reduction in the stigma index compared to prior years, a considerable proportion of respondents reported facing some



form of stigma from their social environment because of their HIV status (38%). The survey revealed that stigma and discrimination against PLHIV have contributed to delays in HIV testing, treatment initiation, and treatment interruptions (NEP+, 2021).

A strategic focus area in COP22 is to address HIV-related stigma and discrimination to increase access to HIV testing and treatment services and improve treatment continuity and viral load suppression. Reduction of stigma and discrimination at all levels, including facilities, communities, and institutions, through continued collaboration and community engagement, will continue to be integral to all partners' efforts. Partners will continue to focus on integrating stigma and discrimination reduction efforts along the HIV care continuum, including peer support through case management, enhanced and continuous community engagement, adoption of evidence-based best practices (e.g., U = U), availing written and posted policies on patient rights, person-centered services based on clients' preferences and choices, and careful alignment of program interventions to achieve epidemic control. Partners will collaborate with other stakeholders to end stigma and discrimination and to foster an enabling environment that will increase access to, and uptake of, HIV prevention, treatment, and care services at health facilities and community settings for all PLHIV, especially adolescents, young people, women, and key populations (KP). Adolescent differentiated service delivery (DSD) models will be expanded in COP22 to empower adolescents to disclose their HIV status, improve treatment adherence and continuity, and achieve and maintain viral suppression. As part of addressing stigma and discrimination towards female sex workers and their clients, KP-friendly sites will continue capacity-building training (respectful and compassionate care and KP sensitivity training) and scale up the use of the Quality Scorecard to inform program implementation. In addition, through mentoring and supportive supervision, technical assistance will be provided to institutional and community HIV care providers.

PEPFAR-E will continue to support the Government of Ethiopia's efforts to scale-up the U=U initiative that has the power to dismantle HIV stigma and discrimination by giving life with HIV a new face. U=U will continue to promote treatment adherence and continuity to attain durable viral suppression so that PLHIV can live long, healthy lives while also ensuring they cannot sexually transmit HIV to their loved ones. Greater understanding of U=U amongst patients, the public, and institutions helps to eventually break the cycle of HIV-related stigma and discrimination. U=U communication strategies, including messages tailored to tackle HIV-related stigma and discrimination on personal, community, and facility levels, will be further revised and streamlined through health education sessions and various print and electronic media platforms. Furthermore, ensuring the integration of U=U messaging into facility and community HIV prevention, care, and treatment programs, including those serving key populations, is a key priority area. In general, the U=U messaging and communications strategy will seek to: (1) boost demand for HIV testing among populations not currently seeking services; (2) improve initiation, adherence, and continuity of ART; (3) increase the demand for viral load testing; (4) support interventions to achieve and maintain viral load suppression; (5) decrease HIV stigma and discrimination; (6) increase community engagement; and (7) galvanize leadership at all levels around a unifying theme for achieving and sustaining epidemic control.

The peer-to-peer support being provided through the case management program will continue to play an important role in addressing stigma and discrimination through the greater involvement of PLHIV in HIV services. Case managers, adherence supporters, and community engagement facilitators (CEF are peer supporters) are expert clients who have been significantly involved in providing person-centered education and counseling to PLHIV about HIV testing, disclosure, treatment initiation and continuity, viral load monitoring, and screening of other comorbidities, including cervical cancer and mental health. Facility and community service providers will closely work in reducing stigma and discrimination, promoting treatment

continuity, and prompt identification of treatment interruptions with coordinated return to treatment activities.

The faith-based organization activities implemented by the Inter Religious Council of Ethiopia (IRCE), together with national and regional leadership of member faith organizations, in collaboration with the facility and community level service provisions, will conduct various sub-national advocacy conferences targeted to stigma reduction. The IRCE will also conduct sensitization events for interfaith leaders and their constituents to encourage HIV testing, treatment, and stigma reduction, primarily for youth and older age groups.

### 3.0 Geographic and Population Prioritization

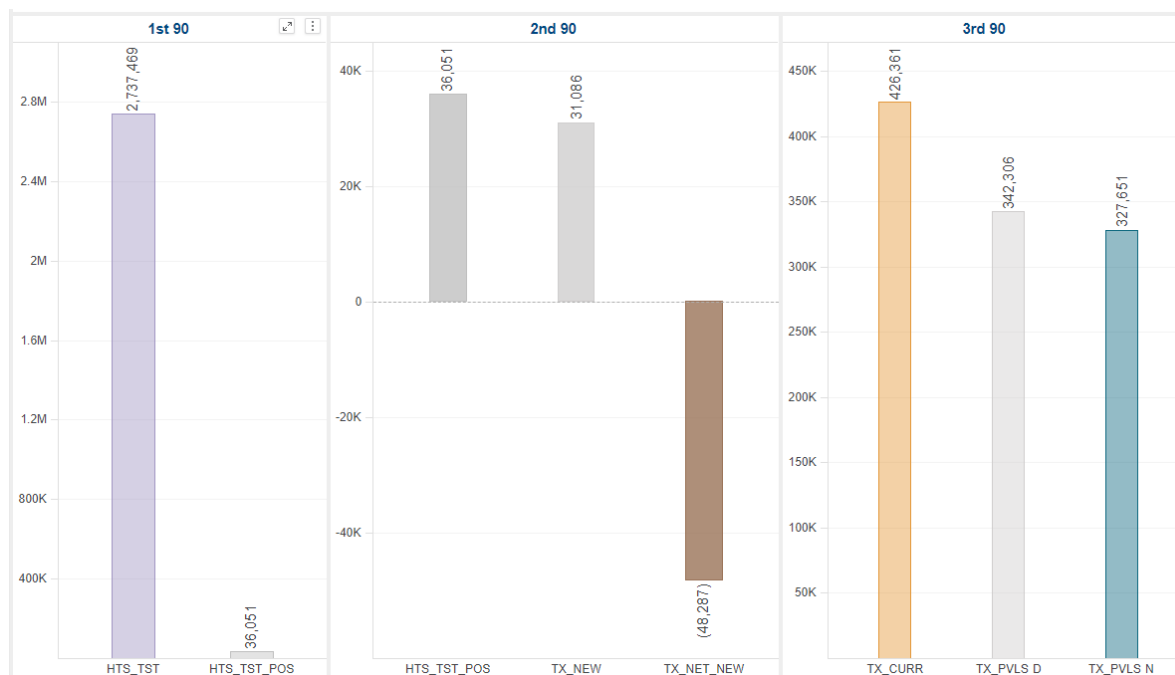
PEPFAR-E’s geographic and population prioritization aligns with the GoE’s 2021–2025 National Strategic Plan. Updates to the National Strategic Plan include definitions of key and priority populations in Ethiopia that align with PEPFAR’s prioritization. Geographic prioritization includes adjustments for newly formed regions in recent years, Sidama and South-west Ethiopia.

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

<b>Table 3.1 Current Status of ART saturation</b>				
<b>Prioritization Area</b>	<b>Total PLHIV/% of all PLHIV for COP22</b>	<b># Current on ART (FY21)</b>	<b># of SNU COP21 (FY22)</b>	<b># of SNU COP22 (FY23)</b>
Attained	556,132 / 91.4%	397,481	795	794
Scale-up Saturation				
Scale-up Aggressive				
Sustained	322,46 / 5.3%	21,104	36	36
Central Support				

## 4.0 Client-Centered Program Activities for Epidemic Control

Figure 4.0.1 Overview of 95/95/95 Cascade, FY21



### 4.1 Finding people with undiagnosed HIV and ensuring durable linkage to treatment

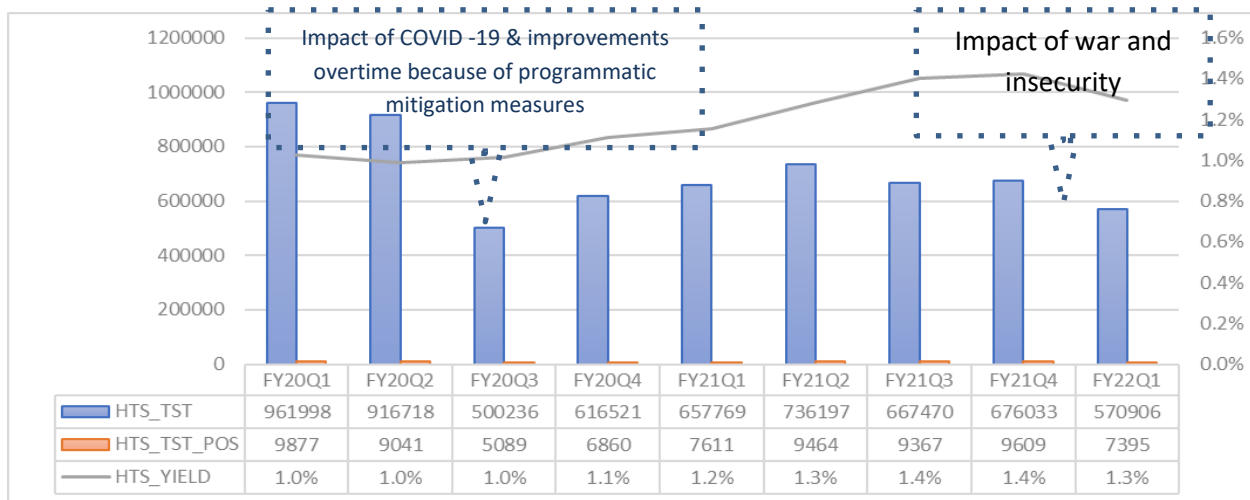
To reach and maintain the first 95, PEPFAR Ethiopia will support a strategic mix of person-centered case finding strategies implemented by community and facility implementing partners. Capacity strengthening activities will be supported to increase HTS capabilities and align efforts with the longer-term vision of sustaining HTS services. The following will be major focus areas: (1) Increase the availability of safe and ethical index case testing (ICT) among newly diagnosed and virally unsuppressed index cases, with the goal of offering index testing services to 100% of eligible clients; (2) Improve risk screening and risk-based testing to advance provider-initiated testing and counseling (PITC); (3) Scale up targeted community-based testing for populations with gaps in the first 95% and/or high HIV incidence, including KP and other priority populations in geographic regions with high incidence; (4) Expand the promotion of and access to HIV self-testing (HIVST), both assisted and unassisted, to reach more populations that would benefit from this service; (5) Empower FSWs with HIV and those at high risk for HIV to serve as seeds for Social Network Testing (SNT) at facility and community levels; (6) Increase targeted demand creation to harder-to-access populations such as KP through a combination HIVST, ICT, and SNS testing modalities; and (7) Support the implementation of the new HIV testing algorithm and its implementation in health facilities and community settings.

To close the pediatric case finding gap, efforts will be enhanced to increase C/LHIV case finding with a focus on universal ICT for all biological children less than 19 years old, risk based PITC in pediatric service delivery points (SDPs), and HIVST. Clinical partners will also coordinate with OVC implementing partners to maximize case finding efforts among children and adolescents served by OVC programs. Regions experiencing conflict have had significant disruption to HTS and other public health services. In COP22, implementing partners will support efforts to re-

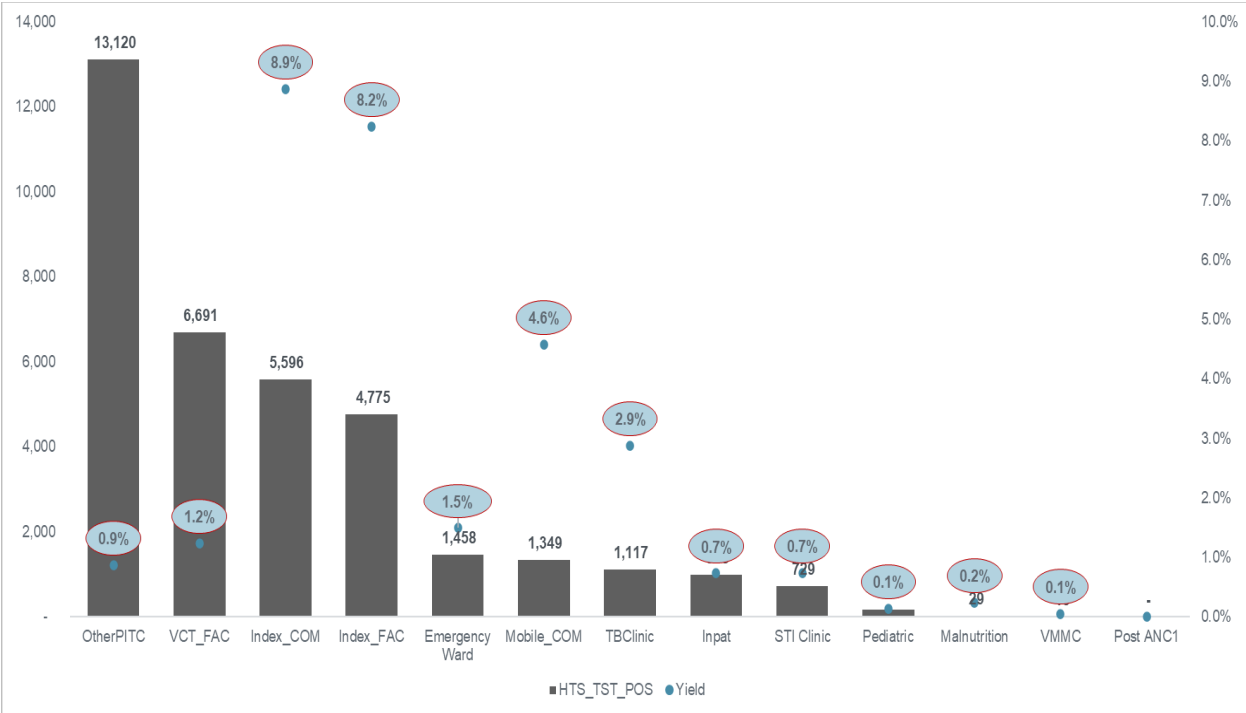
establish HTS in conflict-affected zones and support sites to find innovative solutions to continue providing case-finding services. Moreover, implementing partners will conduct regular reviews of index testing cascades to improve the quality and scale of index testing and to ensure all eligible clients are offered safe and ethical ICT services. To increase HTS service uptake, implementing partners will strengthen provider capacity to improve counseling and partner elicitation messaging through training, case-based learning, shadowing of experienced counselors, and counseling and coaching sessions.

In addition to strengthening safe and ethical ICT for pediatric case finding, programs will enhance risk-based testing in outpatient and other pediatric entry points. Testing strategies will include: (1) Providing all PLHIV with safe and ethical pediatric index testing services to confirm the HIV status of all biological children; (2) Assessing the completion of the family tree documented in medical records for all PLHIV on treatment (i.e., documented HIV status for all biological children, biological parents, and biological pediatric and adolescent siblings) at each clinical visit; (3) Improve OPD testing for children <5 years of age with screen-in risk screening tools to identify the large number of undiagnosed CLHIV patients presenting to OPD; (4) Ensure universal HIV testing at points of entry for people presenting with illness (moderate and severe malnutrition, tuberculosis, and Invasive pneumococcal Disease (IPD)); and (5) Strengthen collaboration between RHB clinical partners and community OVC partners to maximize case finding among OVC who are not being cared for by their biological parents.

**Figure 4.0.1 Testing Volume and Yield by Modality and Age/Sex, FY21**



**Figure 4.0.2. HTS\_ POS and Yield by Modality, FY21 APR, Ethiopia**



**4.1.1. ICT Scale-up with Fidelity**

The minimum standards for safe and ethical index testing were introduced in 2020, and assessments of the standards have been completed in 2022. Moreover, sites and providers will be supported to meet a set of minimum core standards established by the national HIV testing services technical working group (TWG), in alignment with international consensus. These standards will include, but not be limited to, the following specific activities: (1) Facilities/sites will retrospectively review records of eligible biological children, including adolescents ages 15-18 years, of adult clients on treatment to ensure testing for all eligible contacts; (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 will be used to reach partners who do not wish to see a facility provider; (4) Community partners will provide unassisted HIVST services in communities and introduce social marketing strategies and vending machines for HIVST to increase demand and access; (5) Person-centered counseling and testing services will focus on timing and accessibility for services convenient to adults and children, based on preferences, patient literacy, and assurance of high-quality, confidential counseling services; (6) Index patient and contact literacy; (7) Person-centered safe and ethical implementation of ICT will be included as part of a package of services to prevent and monitor intimate partner violence (IPV) as well as link clients at risk and survivors of IPV/GBV to services; (8) Partners will ensure competent staff provide ICT, using culturally-appropriate counseling and contact elicitation scripts, registers and job aids, case-based learning, coaching by experienced counselors, and mentorship to build provider capacity; and

(9) Town/Woreda health offices will strengthen capacity to monitor ICT performance, providing mentorship for more challenging index cases and their contacts, managing cross-site and cross-jurisdiction contact tracing, and ensuring linkage of newly diagnosed men to treatment services. The support will build capacity for and optimize workforce at facilities, Woreda health departments, and community actors to ensure the minimum standards for safe and ethical ICT (i.e., WHO 5Cs - consent, confidentiality, counseling, correct test results, and connections to treatment and prevention services) are provided within these zones and at high volume, high-impact sites.

#### **4.1.2. Provider-initiated Testing and Counseling (PITC)**

PEPFAR-E will support PITC optimization by improving risk screening and risk-based testing (increased risk identified by behavioral, clinical, or demographic characteristics, or a combination of these), testing of people with opportunistic infections and AIDS-defining illnesses, and testing of all patients with TB, STI, and children with moderate to severe malnutrition. Programs will support facilities to fully integrate HIV risk screening services into routine patient management by clinicians for adults, adolescents, and children. Key areas of support will focus on strengthening provider capacity for counseling and use of HIV risk screening tools in a family-and person-centered setting. Furthermore, IPs will support regular monitoring of testing records to optimize PITC for effective case finding. MOH, with support from PEPFAR, has revised the HIV risk screening tool to make it concise and user-friendly. In COP22, implementing partners will support the implementation of HIV risk screening tools at both adult and pediatric OPDs. Programs will support the HIV testing system at all levels to monitor the proportional contributions and testing positivity data with a focus on new cases being identified (recognizing the need to balance case finding volume and testing positivity) by different case finding modalities disaggregated by age, sex, and population group, and use the results to inform program improvement.

#### **4.1.3. Case Finding among Key and Priority Populations**

Key and Priority Populations (KPs) are among the primary targets for new HIV case finding. FY21APR data shows the HIV positivity rate among tested female sex workers (FSW) and their sexual contacts was 17%. PEPFAR-E will continue efforts to accelerate case finding among these populations by focusing on proven testing modalities, including social network testing (SNS), safe and ethical ICT, and HIVST. Currently, 40 community Drop-in Centers (DICs) and 113 public health facilities are providing KP-friendly services that are confidential and tailored to the specific needs of the population. New cases identified from both public sites, DICs, and communities will be counseled and asked for their consent to elicit their sexual contacts and supported to serve as "seeds" for SNS. Targeted community outreach testing and other community testing services 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 such as FSWs, clients of FSWs, long-distance drivers, widowed and divorced women and men, and at-risk, out-of-school adolescent girls and young women. To ensure the safe and ethical implementation of ICT among KPs, PEPFAR-E, in collaboration with MOH and implementing partners, has developed, and implemented minimum standards for the safe

implementation of ICT and will continue to enhance the implementation of these standards in COP22. PEPFAR-E will ensure the integration of comprehensive Gender-Based Violence (GBV) services, which includes intimate partner violence (IPV) screening and management with ICT implementation, put in place site level adverse event monitoring and reporting mechanism, and ensure the WHO's 5 Cs (Consent, Confidentiality, Counseling, Correct test result, and Connection/Linkage to prevention, care, and treatment services) are in place for all HIV testing services and other case finding modalities.

#### **4.1.4. HIV Self-Testing (HIVST)**

PEPFAR-E has been pioneering, advocating, and supporting activities to demonstrate the feasibility of implementing HIVST in Ethiopia. MOH has adapted the implementation of assisted and unassisted HIVST to local context, and programs have shown encouraging results in scaling up the strategy over the last several quarters. With the intention of closing the case finding gap among children, MOH has approved a pilot of caregiver assisted HIVST among children >2 years old of index cases in selected health facilities. Implementation progress is being monitored and results will inform the potential scale up of caregiver assisted HIVST. In COP22, programs will scale up both assisted and unassisted HIVST through multiple approaches, including secondary distribution of HIVST kits distribution to index cases for their partner(s), through a social marketing approach, home to home distribution, distribution to KP and clients of FSW, high-risk PBFW, STI patients to distribute to sexual partners, and targeted use in OPD settings. To provide person- centered distribution service, IPs will expand HIVST through availing HIVST kits in service delivery points (SDPs) such as ART/PMTCT clinic, STI/venereology clinics, OPD, KP friendly clinics, DICs, facility co-located pharmacies, and communities. To narrow the case finding gap, implementing partners will implement unassisted self-testing at scale both in communities and facilities to reach men, adolescent girls, and young women (AGYW) and hard to reach key and priority populations. Pharmacy outlets will be utilized to facilitate access to target population groups.

#### **4.1.5. Voluntary Counseling and Testing (VCT)**

Clients seek HIV testing services through VCT SDPs for a variety of reasons, including those who learn about their risk through SNS, ICT, HIVST, and other demand creation activities. As a result, VCT was the third highest contributor to case finding reported in FY21 APR. To improve the efficiency of VCT, PEPFAR-E will focus on provider training to improve counseling capacity to minimize testing among people with known HIV positive status (while ensuring linkage to treatment for these clients) and to minimize unnecessary repeat testing. Program support will also focus on the provision of adequate counseling, including clarifying the benefits of ART and linkage to an ART clinic for treatment initiation and case management.

#### **4.1.6 HTS quality, monitoring, and site level support**

In COP22, programs will conduct regular review and use performance data to improve the quality and scale of index testing to ensure all index cases are offered safe and ethical ICT, the monitoring of safe and ethical ICT, and the monitoring of the number of sexual partners and

biological children elicited and offered HTS. PEPFAR-E will collaborate with implementing partners to monitor performance and use results to prioritize specific age and sex populations to address unmet needs through tailored ICT, HIVST, targeted PITC, SNS, and targeted community testing. Regular mentorship, coaching, and supportive supervision activities will be strengthened to ensure the implementation of safe and ethical ICT, SNS, and optimized PITC. Regular review of site level results will inform quality improvement activities, including the development of performance improvement plans (PIPs), job aides (counseling scripts), SOPs, and guidelines.

#### **4.1.7 Community Facility Linkage and Coordination**

To avoid missed opportunities for HIV case identification and ART initiation and continuity, PEPFAR implementing partners in facility and community settings will collaborate to ensure that all newly diagnosed adult PLHIV will be accompanied by counselors and peers living with HIV for linkage to treatment within and between facilities within a town. Programs will support health care workers and support parents/caregivers to link children living with HIV to treatment services. Local health offices will coordinate and conduct linkage audits to connect facilities and towns and ensure documentation of referrals is complete. Active linkage strategies will be strengthened, especially the use of accompanied referrals by counselors, facility case managers, or peer cadres. PEPFAR-E will support the adoption of innovative approaches using information technology (e.g., eHealth/mHealth) to improve referral linkage and reminders.

#### **4.2 Ensuring viral suppression and ART continuity**

In COP22, PEPFAR-E will support efforts to maximize treatment continuity with tailored activities for specific populations (newly enrolled, adolescents, 50+ age groups) and geographies (conflict affected) to prevent treatment interruptions, rapidly identify and return clients who have experienced interruption, and ensure viral load testing and viral suppression.

PEPFAR-E will collaborate with GoE and partners to improve treatment and viral load literacy, including the adaptation and scale-up of U=U, to strengthen adherence to ART and treatment continuity. This initiative, reinforced by renewed collaboration with faith-based organizations, civil society organizations, and federal and regional health administrations, will augment efforts to strengthen treatment continuity and viral load suppression. While Ethiopia has met all minimum policy and guideline requirements, there is 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 (CAG), peer-led community based ART distribution (PCAD), and extended and flexible working hour services. PEPFAR team is exploring other client-centered service options i.e., decentralized drug distribution through community pharmacies.



Beyond strengthening treatment continuity, the program will build on existing efforts to improve the timely and appropriate use of viral load results to guide clinical decision-making for optimal quality HIV treatment. This includes the scale up of clinics dedicated to the management of clients with high VL, close monitoring of the high VL cascade, and facility-community linkages to provide multidisciplinary support to clients with high VL. Efforts will be strengthened to shorten the Turnaround Time (TAT) of VL test results return and improve the use of VL results for clinical management.

The management of AHD will be strengthened through implementation of activities described in the national AHD DSD manual, which includes the rapid diagnosis of opportunistic infections (OIs), coordination with Global Fund and FMOH for the availability of diagnostic tests and prophylaxis/treatments, technical assistance, and mentorship to improve provider recognition of AHD, and improved monitoring and evaluation of AHD services. PEPFAR-E will support MOH and RHBs to develop an AHD implementation manual, standard operating procedures, and patient education materials to strengthen AHD service delivery. PEPFAR-E will support the implementation of optimal AHD services in ART facilities with close linkages with community partners and peer volunteers.

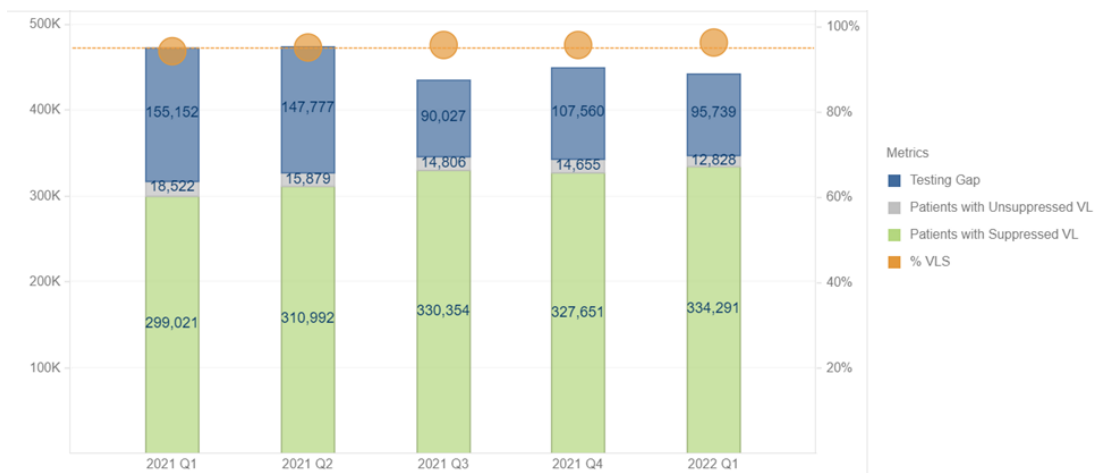
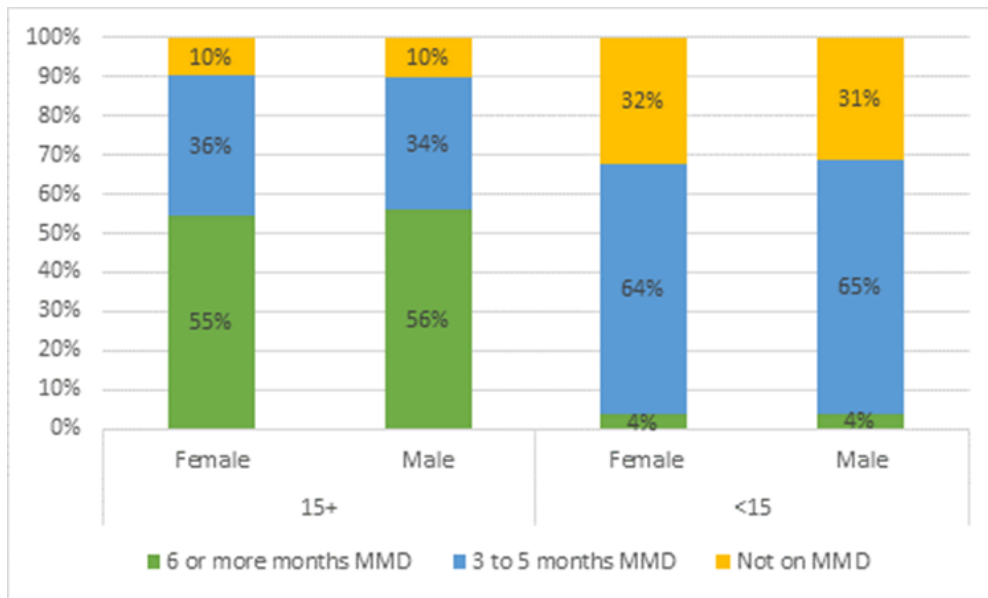
CD4 testing is done to diagnose advanced HIV disease (AHD), and is recommended to be done at initial diagnosis, return to treatment after a period of interruption for >28 days, and at identification of virological failure. As an alternative or in addition to CD4 testing, a clinical diagnosis of stage 3 or 4 can also be used to diagnose AHD, but clinical staging has been found to lack sensitivity.

The CD4referral network has been updated in all regions, focused on the availability of a CD4 testing platform either on-site or in a referral laboratory (Table 4.0). The Global Fund is procuring CD4 reagents and consumables as part of commodities for AHD or will continue the support in FY23.

Table 4.2.: Distribution of CD4 testing platforms by sub national units

Region	PIMA	FACS Presto	FACS Calibur
Addis Ababa	9	31	5
Afar	9	7	
Amhara	45	35	1
Benishangul-Gumuz	5	3	
Dire Dawa	3	4	
Gambella	7	6	
Harari	4	6	
Oromia	50	64	2
SNNPR, Sidama, Southwest Ethiopia	33	37	
Somali	6	7	

**Figure 4.2.1 Number and Percent Contribution of Clients Receiving MMD by Age/Sex, FY22 Q1**



**Figure 4.2.2 Viral Load Outcomes, Fy22 Q1**

### 4.3 Prevention, specifically detailing programs for priority programming:

a) **HTS:** Incorporating HIV Testing Services into Prevention Programming and Prevention Monitoring

In COP22, PEPFAR-E will work with partners to better understand the role of HIV testing as it relates to prevention programs, including settings offering PrEP, voluntary medical male circumcision (VMMC), and ANC PMTCT services. In these settings, HIV testing is not primarily focused on case finding, and only a limited number of new cases are expected to be identified in these settings. In Ethiopia, HTS is used for prevention in the following programs:

- **VMMC:** VMMC programs implemented in Gambella region require HIV testing to all individuals eligible for circumcision. In the rare event when new HIV cases are identified through VMMC clinics, linkage to ART sites is supported to ensure prompt access to treatment. The programs will link HIV-negative men who are at high risk of contracting the virus with other HIV preventive services.
- **PrEP:** HIV testing is also required for all eligible clients prior to PrEP enrollment and as part of PrEP continuation to identify breakthrough infections while taking PrEP. Once enrolled in PrEP, clients are tested every three months. To introduce more person-centered options for clients taking PrEP, HIV self-testing will also be offered for follow-up testing.
- **ANC PMTCT:** ANC testing is a critical service to prevent MTCT through early identification of mothers with HIV and ensuring continuous ART. Sex partners of pregnant and breastfeeding women are also recommended for testing, including HIV self-testing. However, as PEPFAR implementing partners do not report ANC testing through DATIM, PEPFAR-E is currently unable to monitor ANC HTS data and is investigating opportunities to better analyze these data.

b) **OVC:** The Ethiopian Orphan and Vulnerable Children (OVC) program aims to improve the quality of HIV services for OVC and their caregivers. It supports services to improve HIV care, health, nutrition, economic security, education, protection, and psychosocial status, helping OVC to attain greater health and well-being. In COP22, PEPFAR-E will continue working on two distinct but complementary OVC program strategies: OVC Comprehensive (for children and their families with known high-risk characteristics) and OVC Preventive (for at-risk girls and boys) in six PEPFAR-maintained regions: Amhara, Oromia, Southern Nations, Nationalities, and Peoples' Region (SNNPR), Addis Ababa, Gambella, and Tigray. In the COP22 fund designated for OVC, in those regions, a total of 333,727 OVC and 51,180 caregivers will be targeted with comprehensive and primary prevention interventions. Using an OVC/Pediatric Treatment Co-Location Analysis, the program will add 44 new Sub National Units (SNUs) in existing operating regions with a high number of children currently receiving antiretroviral therapy (measured by TX\_CURR ), a high number of children with low viral load suppression (measured by TX\_PVLS), and a high number of HIV-exposed infants, bringing the total number of CLHIV enrolled in OVC programs to 20,031 and the total number of SNUs implementing OVC to 213. As a result, the OVC program will be able to reach around 65% of the national CLHIV on treatment estimate. Despite having been scaled back from Tigray a few years ago, the program returned to this region in FY20 to

address HIV-related issues exacerbated by recent conflict and re-aligned its strategy with the greatest unmet need. The supplemental fund released in COP21 was utilized to support emergency interventions for Tigray's OVC; in COP22, the support will continue using earmarked funding to ensure the continuity of life-saving HIV prevention, care, and treatment services. In COP22, the program will focus on assisting in identifying new CLHIV, linkage to ART, reducing treatment interruption in children and adolescents, increasing access to viral load testing, and supporting viral suppression among enrolled beneficiaries, and providing HIV and sexual violence prevention training to 10–14-year-old boys and girls. In the fourth quarter of FY21, the viral suppression rate for 18-year-old OVC enrolled in the program was 94 percent (this data is from health facilities). To improve treatment continuity and viral load suppression, priority interventions for OVC program beneficiaries will include enrolling at least 95% of children under 18 years who are currently receiving ART in the OVC program, prioritizing those with poor viral load suppression and those who are new to treatment, ensuring that at least 95% of beneficiaries served by PEPFAR OVC programs for children and families affected by HIV (OVC\_SERV) know their HIV status, and ensuring that 100% of OVC beneficiaries with HIV are receiving ART. The program will ease access to index testing for biological children of PLHIV and undertake home visits to facilitate testing uptake for children to improve new HIV case identification. To improve treatment continuity, particularly for HIV-exposed infants (HEI), the OVC program will track the prevention of mother-to-child transmission (PMTCT) cascade to support contact tracing and follow-up for children under the age of two with interruptions from PMTCT services; find, assess, and refer HIV-exposed infants with interrupted treatment; find, assess, and refer infants of mothers with HIV to ensure EID testing (with a focus on 10–24-year-old females); provide follow-up support for mothers of infants with HIV to improve treatment continuity and VLS; and conduct gender-based violence (GBV) screening and provide referral and linkage to comprehensive post-violence care services. The program will also continue to provide case management and socioeconomic support to lessen barriers to treatment continuity, as well as document reasons for treatment interruption and refusal to guide future strategies. The comprehensive interventions will target C/ALHIV age 10 to 24 years, children of PLHIV, siblings of C/ALHIV, HIV-exposed infants, children of female sex workers, sexual violence survivors, and pregnant and breast-feeding women (PBFW) with HIV age 10 to 24 years. Children of FSWs with HIV will be assessed and enrolled in the OVC program in collaboration with partners working on key populations (KP). In addition, HIV-affected and infected children and their families will also be linked to other relevant social services depending on their needs, in cooperation with PEPFAR-supported and other community-based programs. During OVC home visits by community caseworkers and social service workers, the program will also improve caregivers' treatment literacy and provide psychosocial support, socioeconomic interventions, education assistance, and parenting skill instruction, among other activities, for those prioritized sub-populations. To achieve the program's goals, the OVC program will work closely with public and private health facilities that provide HIV care and support to enhance access to services and information exchange. To strengthen community-facility linkages, a memorandum of understanding (MOUs) between facility and community partners will be signed to outline bi-directional referral protocols, share confidentiality agreements, train OVC staff on clinical skills, conduct case conferencing, and identify cases jointly through multi-disciplinary team approaches. The

community case workers will assist in screening CLHIV and caregivers for TB symptoms and provide mental health and psychosocial support. In COP22, the program will continue to improve community case workers' and social service workers' abilities to identify and manage risk factors for poor adherence and treatment continuity, especially in the first three months of treatment. During household visits, linkage coordinators will support monitoring children's ART adherence and VL status, provide quality adherence counseling and support in the community, and refer for enhanced adherence counseling (EAC) when needed. To ensure continuous access to medication, stable children and adolescents with viral suppression will be linked to multi-month dispensing (MMD) services, ART refill groups, and other community-based mechanisms. Community caseworkers, social service workers, and health care providers will meet on a regular basis to assess case management performance results, identify gaps, and change interventions to improve effectiveness and efficiency. The program will strengthen caregivers' knowledge, skills, and confidence to talk to their children about sexual and reproductive health to limit behaviors that raise the risk of HIV transmission (e.g., delayed sexual debut and condom use) and prevent violence and abuse. Gender inequities, limited ability to negotiate safer sex, transactional sex, challenges in disclosure and access to HIV treatment due to fear of violence and abandonment, and GBV all enhance the vulnerability of women and girls to HIV. Risk screening for HIV and GBV, HIV and GBV prevention programs, post-violence services for GBV survivors, adherence and disclosure support, and continuity of care services are among the other services available to adolescents and young people. To improve access to quality services by strengthening social service systems, the program will continue to collaborate with the government, non-governmental organizations, and faith-based organizations to, and faith-based organizations to institutionalize HIV and violence prevention training and support community case managers and social service cadres at the national, regional, and community levels.

The OVC program will train 92,223 adolescents (10–14-year-olds) using PEPFAR-approved curricula such as Sinovuyo Teen (caring and trusting relationships between caregivers and their teenagers), Coaching Boys into Men (healthy relationship skills among young males), and Impower (A Self-Defense physical, mental, and vocal skills) by collaborating closely with schools, community groups, faith-based organizations, and other organizations. In addition, the OVC program will coordinate and closely engage with the health, educational, psychological, economic, and civil society/community sectors to deliver a complete combination of social, economic, and biological interventions to minimize adolescent vulnerability. The national services training manual will be used to train community cadres on violence against children and GBV, as well as develop guidelines, standard operating procedures, and job aids to help organizations better identify and report cases of GBV, as well as provide timely and effective support to sexual violence survivors. First-line care to domestic abuse victims will be provided, as well as how to refer them for clinical and non-clinical support. Links with post-violence care providers will be strengthened and referral protocols revised. In COP22, the Violence Against Children Survey (VACS) report will be completed and become available to be both part of a multi-sectoral planning process (i.e., Data4Action) to prevent and address violence against children as well as to refine violence prevention and response activities.

**Children/PMTCT:** The 2021 National Guideline for Prevention of Mother-to-Child Transmission of HIV, Syphilis, and Hepatitis B Virus endorses optimization of PMTCT\_ART and HEI ARV prophylaxis. The first-line regimen for pregnant and breast-feeding women is TDF+3TC+DTG. Ethiopia has also adopted 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 treatment continuity for mothers, timely follow-up care, and routine viral load monitoring on a regular basis. 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 will also support the implementation of new initiatives like PrEP and cervical cancer screening in the PMTCT program. Case finding through ICT will be strengthened further by utilizing PMTCT as a point of entry to enroll all partners and eligible biological children at all PEPFAR-supported sites.

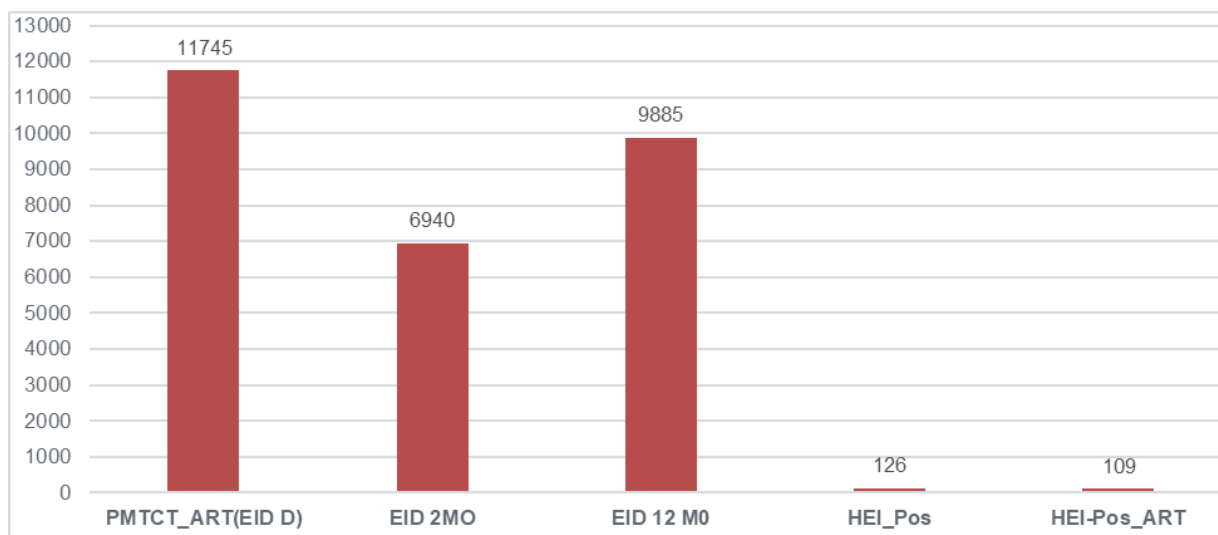
PEPFAR-E will also continue to ensure provision of optimized ART for pregnant and breastfeeding women (PBFW) with HIV and to support and monitor optimized ART (i.e., TLD) for all women of childbearing potential, including AGYW. PEPFAR-E will also support the targets of 95% EID testing coverage within 2 months of age by increasing access to EID diagnostic services and facilitating efficient use of POCT. 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. In COP 22, the primary case-finding strategies to detect C/ALHIV will be index case testing (ICT) and optimized PICT. Health facilities will retrospectively record eligible biological children of adult ART clients, ensure 100% testing, and initiate an optimal treatment regimen for newly diagnosed C/ALHIV. Innovative strategies to achieve this target may include improved messaging to caregivers, transport reimbursements for testing, weekend hours to minimize children missing school, and use of HIV self-test 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. Ethiopia has adopted current WHO guidance for optimal pediatric ART regimens and started implementation since FY19. Although there were shortages of certain pediatric formulations early in the transition, significant progress has been made in FY21 with most children >20 kg transitioned to DTG-based regimens. In FY22, the roll out of pediatric DTG 10 mg formulation for children weighing <20 kg was initiated and will continue through FY23 to reach C/ALHIV residing in conflict-affected areas.

Results from November 2020 of 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 counseling and disclosure support. In FY22, OTZ is being expanded to Oromia, SNNPR, and Amhara regions, in addition to existing programs in Addis Ababa. The healthcare worker managed Adolescent DSD model (OTZ) will be incorporated into the national guidelines and expanded further to enhance the provision of a tailored package of services for adolescents living with HIV. PEPFAR will also focus on interventions to reduce treatment interruption and reconstitute the pediatric treatment cohort in conflict-affected areas. Multi-month dispensing

for C/ALHIV will be strengthened per the national guidelines, including alignment of clinic visit dates to ensure provision of family-centered care.

Reducing mortality among those with CLHIV will also be a key area of intervention at COP22. In addition to ART optimization, the provision of an Advanced HIV Diseases (AHD) package of services for C/ALHIV, including CPT and TPT prophylaxis, diagnosis, and management of OIs, nutritional assessment, and integration of immunization services will be strengthened. In addition, PEPFAR will expand Pediatric Demonstration Centers 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. In COP22, technical assistance will be provided to FMOH to initiate an accelerated plan to strengthen the pediatric cascade by involving RHBs in high-burden regions and other relevant stakeholders.

**Figure 4.3.1 PMTCT Cascade**



### c) Key Populations

The National HIV/AIDS Strategic Plan (NSP) 2021–2025 defines key populations as including 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. According to the size estimates conducted by PSI and EPHI in 2011, there were an estimated 222,550 FSWs in Ethiopia. The HIV prevalence among FSWs varies from 14.0% in Shashemene to 28.2% in Bahir Dar. According to EPHI-led size estimates, HIV prevalence is 18.7% in FSWs in Ethiopia in 2020.

The needs of key populations in Ethiopia continue to be addressed through multiple approaches. Improving access and quality of KP and PP client-centered HIV services remains crucial to improve health outcomes for KP and PP, and for achieving sustained epidemic control in Ethiopia. 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, and requires a mix of complimentary community and facility-based programs to provide client-centered services for KP. In COP22, PEPFAR-E will continue to support HIV services for KPs in community hot spots, Drop-In Centers (DICs), and selected KP-friendly public health facilities. DICs located in Addis Ababa, Amhara, Oromia, SNNPR, Sidama, and Gambella provide comprehensive HIV prevention, care, and treatment services, including family planning, GBV services, STI screening and management, TB screening and prevention, and harm reduction services on-site or through referral. In COP22, the program will continue providing comprehensive HIV services in these regions, in which 40 SNU have a DIC, with 33 of these also providing ART services for FSWs. Moreover, cervical cancer screening, treatment, and referral services for all FSWs with HIV 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 the major towns of Amhara, Addis Ababa, Oromia, SNNPR, and Gambella, with monitoring throughout the clinical cascade from detection to VL suppression. In COP22, PEPFAR will continue supporting the RHB's KP-friendly clinics integrated into public facilities and ensure the sustainability and efficiency of the KP program.

PEPFAR-E will work to strengthen KP programs by prioritizing: (1) Behavioral interventions, with comprehensive prevention packages including targeted demand generation, condom and lubricant distribution, comprehensive reproductive health services, GBV/IPV screening, clinical post-violence care, referral, linkage, and psychological and legal support; (2) Biomedical interventions that include people-centered, high-yield, differentiated mix of testing modalities, pre- and post-exposure prophylaxis, other care, treatment, and viral load services; and (3) Structural interventions that address critical policy issues and enabling environments that impede the scaling up of KP services. Moreover, programs will provide support to identify and address mental health services, substance abuse, and ongoing harm reduction counseling.

Scaling up targeted strategies to increase case finding (described under Section 4.1) has allowed the program to reach higher-risk FSW and their sexual partners who are eligible for PrEP, supported the enrollment of newly diagnosed FSW into ART, and the re-engagement of FSWs with treatment interruption into ART services. Children and partners of FSW will also be offered testing and, if diagnosed HIV-positive, will be linked to, and enrolled in treatment. 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.

In COP22, PEPFAR-E will also continue strengthening the MOH and RHBs' Quality Score Card (QSC) activities to improve the quality of KP services at national and regional levels. Moreover, the program will work closely with the PEPFAR-E Coordination Office (PECO) to advocate for the establishment of a KP consortium and KP-led CLM activities. In addition, KP programs will establish a robust data system to better understand the treatment cascade for KP, and to guide the programs to address barriers in the cascade. Key activities for improved data quality and



use include regular auditing, mentoring, and supportive supervision; strengthening data collection, analysis, reporting, and utilization, developing KP data-specific dashboards and utilization of data for decision making at all levels, periodic bio-behavioral surveillance, KP size estimates, KP program indicators inclusion in electronic medical records (EMR) with unique identifiers using biometrics, establishing a system of KP data security, and working with Strategic Information experts to produce a KP data tracking system, including establishing harmonized M&E tools and systems to monitor and track clients across both facility- and community-based KP services.

Stratification of PPs to identify those at higher risk will continue to maximize case finding with higher efficiency. PPs such as the clients of FSWs, long-distance drivers, widowed and divorced women and men, high-risk adolescent girls and young women involved in transactional sex, and mobile workers in hot spot areas (workers in bars, massage houses, shisha houses, daily labor, waitresses, petty traders, taxi drivers) 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. Unassisted HIV self-testing will be expanded to increase demand for HIV testing among key populations. Community-based providers will accompany KP and PP with HIV to ART services provided at DICs and health facilities to strengthen linkage and treatment initiation. 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 prioritized. Regular linkage audits using facility-community collaboration SOPs will be strengthened and institutionalized.

### **Pre-exposure prophylaxis (PrEP)**

The 2021-2025 National Strategic Plan (NSP) focuses on reaching 90% of key and priority populations with targeted and combination HIV prevention interventions by 2025. In addition to counseling to maintain their negative HIV status, the 2021 National Comprehensive HIV Care Guideline recommends PrEP for clients at substantial risk for HIV infection. Eligible population groups for PrEP services include HIV-negative FSWs, HIV-negative partners of sero-discordant couples, and HIV-negative pregnant and breast-feeding women who have HIV-positive partners for those who attend ANC/PMTCT clinics. The PEPFAR-E 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 PWIDs, AGYWs, and other high-risk population groups. PrEP services are currently available for FSWs and HIV-negative sero-discordant partners in 225 public health facilities in 19 Woredas and 33 community Drop-in-Centers (DICs).

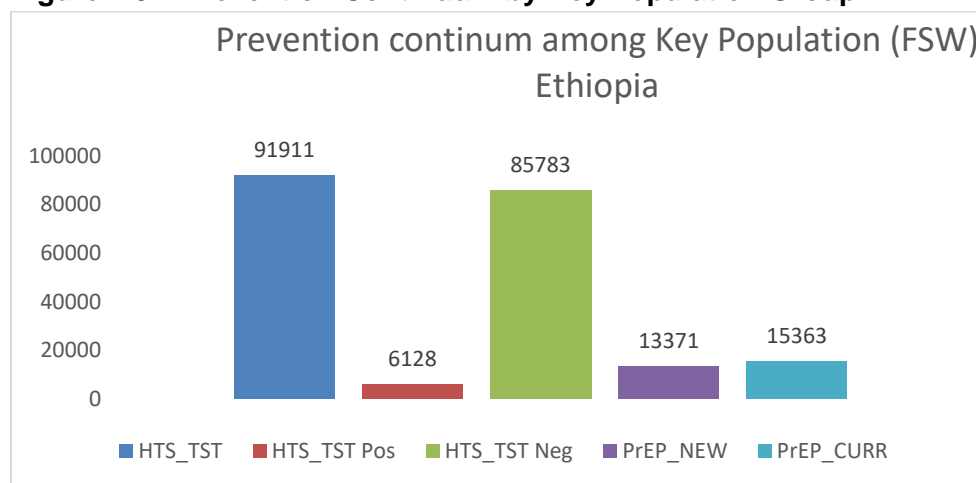
The PEPFAR-E team has successfully improved targeted HIV case finding through ICT and partner services, providing opportunities for the program to reach higher risk FSW and their sexual partners who are eligible for PrEP. In COP22, HIVST services will be integrated with PrEP services, in accordance with current WHO guidance, to improve PrEP uptake, distribution, and monitoring. PrEP services will continue in 33 DICs and 117 public health facilities with a target of doubling the number of PrEP\_NEW KP to 15,230 and PrEP\_CT to 5,894.

Considering the NSP 2021-2025 strategic goals and client hesitancy about the pill burden of oral PrEP, PEPFAR will pilot recently introduced biomedical prevention products for PrEP such as long-acting injectable cabotegravir and Dapivirine vaginal ring at selected community Drop-in-Centers (DICs) and KP-friendly public facilities during COP22. Moreover, PEPFAR-E, in collaboration with MOH and partners, will advocate for the expansion of eligible population groups for PrEP based on the available data.

PEPFAR-E will continue maximizing our efforts to address the programmatic gaps to ensure that all eligible clients are offered PrEP in a client-centered approach. PEPFAR-E will also work with MOH to scale up the PrEP in PMTCT settings and address any programmatic gaps in this population.

PEPFAR team will work with MOH to better understand the HIV incidence among AGYW. Meanwhile, considering the risk they have, we recommend and will continue to work with MOH to expand PrEP eligibility to include AGYW. The PEPFAR-supported IBBS among AGYW conducted in 2019 showed 2.7% HIV prevalence and high-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 COP22. Prevention interventions will support the identification of high-risk 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.

**Figure 4.3.2 Prevention Continuum by Key Population Group**



Key populations have a range of needs to be addressed by facility and community packages of services. PEPFAR key population programs will work to make facility and community-based services more KP-friendly by strengthening the coordination and relationships between facility and community actors. To this effect, maximizing the complementarity of KP services, enhancement of referral and linkage tracking will be among the key focus areas for COP22 program implementation. Programs will work to ensure that KP clients' service needs are met wherever they choose to access the needed services. PEPFAR-E and implementing partners will monitor the implementation of the KP facility-community collaboration SOP so that facility

and community sites maximize complementarity with one another and avoid duplication of efforts. Orientation will be provided to IPs on the facility-community collaboration SOP, which provides detailed guidance for successful implementation.

#### **d) 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 the United Nations High Commission for Refugees (UNHCR), 72% among urban residents (EPHIA, 2018), and 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 the military population is 1.2% (SABERS 2018). The prevalence of HIV among uncircumcised males is 1.5 times as high as among circumcised males (5.3% vs 3.5%: EPHIA 2018). The VMMC program in Ethiopia has been providing services to the Gambella host and refugee and military adult male population since 2009.

#### **Indigenous/host population of Gambella**

In 2016, under the guidance of the Federal Ministry of Health, the national VMMC TWG estimated the VMMC eligible male population aged 15 years and above to be 158,637 for the Gambella indigenous/host population. However, this size estimate is now outdated and not valid for use to monitor the progress of program performance, MC coverage estimation, and to inform program decisions. Furthermore, the estimated data excludes many South Sudanese who are not officially registered as refugees and living in the Gambella region, mixed with the local community and migrant population seeking jobs in the region, all accessing public facilities for VMMC services. Ethiopia and South Sudan share a more than 500-mile-long border along the Gambella Regional State, which is porous, allowing population movement in both directions. In addition to this, there are highlanders who were settled in the region long ago and have changed circumcision norms. They used to circumcise their children when they were infants, but now they bring their children for VMMC to facilities when they are old enough, around 15 years old, because VMMC services at public facilities are safe and free of charge. To address the need for more accurate and current population and VMMC coverage data, PEPFAR-E and implementing partners plan to conduct a community-based sample survey involving all PEPFAR-supported Woredas in Gambella in COP22. It is believed that this survey data will generate male circumcision coverage estimates for men aged 15+ years in the Gambella region. The VMMC program in Gambella has been implemented since 2008 with the objective of reaching 90% population coverage as per WHO and UNAIDS recommendations. The survey results will provide information on progress towards this objective and will assist in making informed decisions about the trajectory of VMMC program support in the future. In the absence of this data, for COP22, to estimate the need for VMMC services in Gambella region, PEPFAR-E has projected the base 15+ male population used in COP21 planning (198,000) and multiplying it by 4.1% birth rate, resulting in an estimate of 206,118 men aged 15+ years.

## **Refugee community in Gambella**

As reported by UNHCR, there are currently 340,246 refugees in Gambella residing in 7 camps. Men constitute approximately 50% of the total population, of which approximately 65,641 are aged 15+ and eligible for VMMC services. Using this denominator, an estimated 59,000 circumcisions are needed to reach 90% population coverage. As of FY 21 APR, 22,546 (38%) of the 15+ refugee male population residing in 7 camps in the region had received VMMC services.

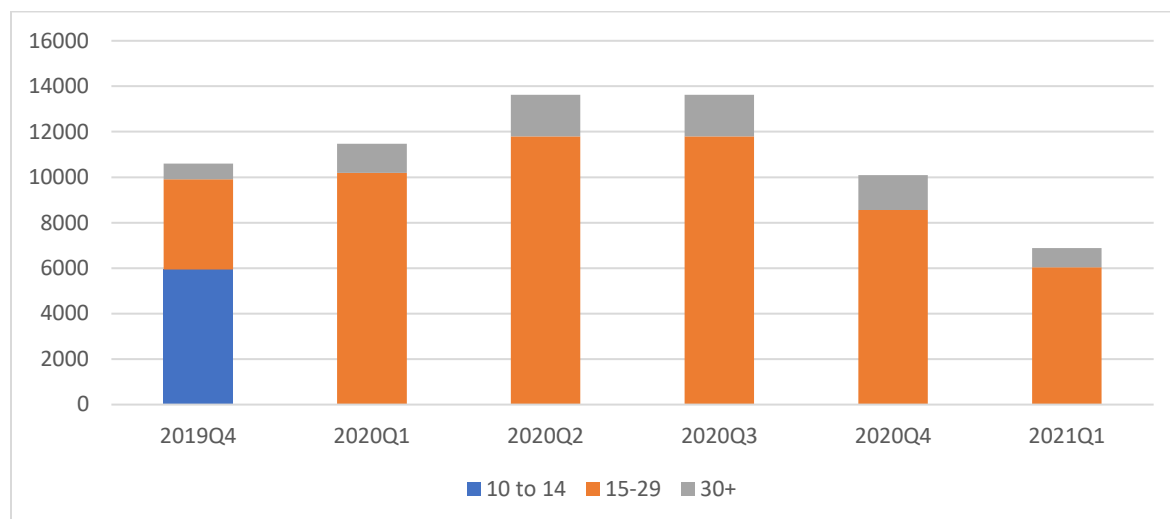
## **COP22 VMMC Goal**

The total COP22 VMMC target has been set at 30,000 MC procedures, which will be performed by PEPFAR-E implementing partners among the host and refugee population in the Gambella region. 70% of the total target will be implemented in the host population, while the remaining 30% will be implemented in the refugee community. The PEPFAR priority age group for VMMC, which is 15–29, will account for 80% of the total target.

## **e) Implementation approach and strategies**

In COP22, PEPFAR-E will continue implementing VMMC activities at all supported facilities by exercising maximal IPC and safety precautions to protect health care providers and VMMC clients against healthcare-associated infections and COVID-19. VMMC programs will continue providing services through static and outreach sites. To avoid the risk of COVID-19 transmission in health care settings, all VMMC clients are pre-registered and given staggered appointments to avoid mass gathering around the facilities. Standard safety procedures like social distancing, wearing masks, hand washing, temperature checks, hand sanitizers, and symptom screening will be reinforced by health workers on arrival at health facilities. An SOP on the provision of VMMC services in the context of COVID-19 has been developed by PEPFAR-E and implementing partners and has been distributed to all VMMC facilities. In collaboration with implementing partners and FMOH, PEPFAR-E has developed and distributed COVID-19 related job aides in the form of a quick desktop reference manual to guide health workers providing VMMC services. In COP22, PEPFAR-E will continue supporting targeted demand creation activities to increase the uptake of VMMC services among refugee men age 15+ living in refugee camps. Additionally, PEPFAR-E will support mentorship and training of providers to account for staff turnover and provide basic and refresher training for newly hired and existing HCWs. VMMC services and data quality improvement activities will be implemented at all supported facilities to ensure the quality of services continuously. All VMMC clients are screened for the presence of high-risk factors for HIV infection and will be tested for HIV voluntarily. All clients who test HIV positive will be linked to care and treatment and offered same-day ART initiation.

**Figure 4.3.3 VMMC Quarterly Trends by Age is required**



#### **4.4 Additional country-specific priorities listed in the planning level letter**

In COP22, PEPFAR E will focus on four key themes. 1) Achieve and maintain epidemic control through evidence-based, equitable, and people-centered HIV prevention and treatment services. 2) support resilient and capacitated countries' health systems, communities, enabling environments, and local partners to build enduring capabilities. 3) Improve cooperation and coordination for greater impact, budget sharing, and long-term viability. 4) employ an equity lens with a present focus on reducing persistent inequalities experienced by children, key populations, and adolescent girls and young women.

#### **4.5 Additional Program Priorities**

The Ethiopia FMOH is currently revising national consolidated HIV prevention, testing, treatment, and service delivery guidelines to align with program priorities outlined in the 2021–2025 National Strategic Plan, the 2021 updated WHO guidelines, and PEPFAR guidance. In addition, many client-centered and infection prevention and control policies introduced by MOH in response to COVID-19 are being institutionalized in the updated guidelines. Updates in the new guidelines include policies on prioritized testing modalities, expanded eligibility criteria for multi-month ART dispensation, refreshed regimens for ART optimization for adults and children, expanded eligibility criteria and service delivery options for PrEP, new diagnostic and preventive treatment options for TB, and management of advanced HIV disease and frequent co-illnesses.

The minimum standards for safe and ethical index testing were introduced in 2020, and assessments of the standards have been completed in 2022. In COP22, implementing partners will be expected to monitor sites and providers to meet a set of minimum core standards established by the national HIV testing services technical working group (TWG), in alignment with international consensus (outlined in Section 4.1.1).

COP20 and COP21 performance review was central to informing COP22 direction and strategic priorities. Performance measures showed a clear difference in program results based on the presence of active conflict in a geography. These results informed the strategy of differentiated program priorities, expectations, and resources to support treatment recovery efforts in areas most affected by conflict. COP20 and COP21 performance review also highlighted specific program gaps in the pediatric treatment cascade, treatment interruptions in the first 3 months of treatment, geographies and sub-populations with sub-optimal viral load coverage, and missed opportunities for scaling up case finding, PrEP, TB preventive therapy, and cervical cancer services. Detailed investigations of the contributing factors for program results were used to inform technical priorities outlined in this document.

PEPFAR-E agencies closely monitor implementing partner program results and expenditures to ensure alignment with PEPFAR program strategy and improve partner performance. Partner management and regional support teams meet bi-weekly to review program results, and parallel reporting systems have been implemented to identify program gaps before quarterly reports to PEPFAR are submitted. Joint site supervision, cascaded training, and combined program review are used to collectively identify program successes and barriers and build consensus on corrective actions and program pivots.

Community-led monitoring is another program priorities and will focus on Key Populations programs including engaging the KP groups and PLHIV in the monitoring process, advocacy to address the challenges and continuous quality improvement activities. Key interventions in CLM include mapping of stakeholders and community-based organization, capacity building for CLM implementers, KP groups, PLHIV and stakeholders who engage in CLM, organizing continued performance review and sharing findings with stakeholders through review meetings and reporting.

#### **4.6 Commodities**

PEPFAR commodity support has been limited to the provision of VL/EID lab reagents, limited numbers of rapid test kits (RTKs), community testing, recency tests for case-based surveillance, male and female condoms, and proficiency test panels. In addition, in COP22, PEPFAR/Ethiopia will procure approximately 34,500 tests for human papillomavirus PCR testing for cervical cancer diagnosis. Commodity funding in COP22 is estimated to be around \$10 million. Other HIV commodities have been purchased through the GFATM grant to Ethiopia, with close coordination between PEPFAR-E, Global Fund, and MOH to quantify program commodity needs, ensure commodities to support new and/or scaled-up initiatives are planned for, and avoid duplication of efforts. These initiatives include diagnostics for TB and diagnostics and treatments for opportunistic infections. The Government of Ethiopia will provide funding for the procurement of hematology and chemistry reagents and supplies.

Despite these challenges, PEPFAR-E does not anticipate stockouts of necessary commodities due to the funding gap. The coordination platforms are in place and continue to be strengthened by PEPFAR-E and implementing partners for efficient procurement and distribution of HIV related commodities. The COVID-19 pandemic has impacted procurement of some HIV/AIDS commodities. To help mitigate these effects, PEPFAR-E has provided technical assistance to

the procuring agency, EPSS, to strengthen stock monitoring practices, improve supplier relationships, and expand the implementation of a framework agreement with suppliers, which has resulted in improved on-time delivery of commodities.

#### **4.7 Collaboration, Integration and Monitoring**

Cross-technical collaboration and implementation across agencies is ensured through collaborative activities via PEPFAR-E and national MOH-led Technical Working Groups (TWGs).

The two decades of PEPFAR laboratory investment in Ethiopia has been leveraged for response to emerging and re-emerging health conditions, most notably during the response to COVID-19. Most PEPFAR-supported laboratories, platforms, and personnel supported COVID-19 testing, as well as investigations of other diseases of public health importance, including cholera and measles.

To achieve the 95-95-95 targets, health facilities and community-based HIV service delivery points need to provide efficient, effective, and high-quality services to ensure that people living with HIV are aware of their status, receive and maintain antiretroviral therapy, and achieve viral suppression. The health workforce, among other system factors, is a critical resource in this process. PEPFAR-E will focus at COP22 on improving the efficient use of existing human resources in public health facilities to increase HIV cohort growth. The health workforce is expected to carry out the following activities: (1) increasing ART coverage through increased identification and efficient linkage of People infected with HIV to care and treatment services; (2) rapid ART initiation, including same-day ART initiation for newly identified PLHIV; and (3) early identification and tracking of LTFU clients. They are also in charge of monitoring clients on ART with routine VL testing, ensuring effective sample referral, using data/results for clinical decision making and patient management, and reporting performance on a regular basis, as well as encouraging communities and individuals to take an active role in demanding and seeking HIV services. In response, PEPFAR-E will provide technical assistance to maintain strong HRH workforce planning based on quality data to improve HIV and other health outcomes. Accurate data on the number of available health care workers and the gap are still required. PEPFAR-E will also provide technical assistance to monitor site-level resource utilization to determine how sites and implementing partners allocate their resources and whether those resources are optimally allocated. For example, it is critical to understand how resources are used and how much they cost to allocate resources efficiently in terms of the level of effort and tasks performed.

The country has had notable successes in implementing differentiated service delivery (DSD) models at both facility and community levels. These efforts were instrumental in ensuring treatment continuity and avoiding treatment interruptions in the face of the COVID-19 pandemic and the ongoing armed conflict. Successful DSD model implementation and scale-up has been also associated with high viral suppression rates among clients despite fewer clinical visits. Further efforts will continue to strengthen existing models and newly introduced models to ensure the delivery of person-centered quality services and promote sustainability of HIV treatment programs. In COP22, PEPFAR-E will coordinate with MOH and implementing

partners to evaluate current DSD models in Ethiopia to provide evidence of program impact and health outcomes, identify gaps in the existing framework, and to inform future directions for DSD models.

PEPFAR-E supports community-led monitoring through independent local civil society organizations in seven regions (Amhara, Oromia, Addis Ababa, Gambella, SNNP, Afar and Dire Dawa), focusing to ensure treatment service quality with involvement of clients in monitoring and advocacy processes. Some challenges identified with community-led monitoring include the sustained engagement of stakeholders in program review, regular joint supervision, and prioritization of activities.

Therefore, in COP22 focus will be given to KP programs, integration with Quality Improvement and facility-community collaboration initiatives, and continuous collaboration of stakeholders including GOE and bilateral and multilateral partners. Specific activities include capacity strengthening for civil society organizations, KP groups, and stakeholders to strengthen CLM activities and advocacy for program implementation.

The Ethiopian Government has started a national ID system, which is in its early stage of piloting. Until the government establishes a fully developed Unique ID system, we will continue using a matching algorithm for HIV case surveillance led by EPHI. Matching is performed through a combination of automated and manual processes to identify unique patients and deduplicate records in the data system. We will work towards improved coverage of patient-level data across the RHBs through linked systems with storage of de-duplicated HIV and CBS data covering the 997 HIV CBS participating sites in COP22. PEPFAR-E has been supporting the development of a Master Patient Index (MPI) platform via CDC headquarters led Technical Assistance Platform (TAP) partners. We will automate the matching exercise for HIV CBS data using the PEPFAR-recommended MPI solution developed by TAP partners.

## 4.8 Targets by population

Table 4.8.1 ART Targets by Prioritization for Epidemic Control						
Prioritization Area	Total PLHIV	Expected current on ART (APR FY22)	Additional patients required for 90% ART coverage	Target current on ART (APR FY23) - TX_CURR	Newly initiated (APR FY23) - TX_NEW	ART Coverage (APR 23)
Attained	556,132	467,404	33,115	510,328	51752	92%
Scale-Up Saturation						
Scale-Up Aggressive						
Sustained	32,246	21,977	7,044	26,510	5004	82%
Central Support						
Commodities (if not included in previous categories)	NA	8066**	NA	8196**	295**	
<b>Total</b>	<b>608,150*</b>	<b>497,447</b>	<b>49,888***</b>	<b>545,034</b>	<b>57,051***</b>	<b>90%</b>



\* Includes Non PEPFAR supported, and the total number affected (reduced) while converted from spectrum to Zonal level estimates using Naomi modeling, \*\*Military, \*\*\* Includes Military

**Standard Table 4.8.2**

Table 4.8.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts					
SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (date)	VMMC_CIRC (in FY23)	Expected Coverage (in FY23)
Abobo	Male 15+ Age	1,497	75%	59	80%
Dima	Male 15+ Age	2,576	76%	88	80%
Etang	Male 15+ Age	56,584	68%	5228	80%
Gambella	Male 15+ Age	30,272	45%	8149	80%
Gambella Zurya	Male 15+ Age	11,824	67%	1173	80%
Godere	Male 15+ Age	13,409	25%	5797	80%
Gog	Male 15+ Age	20,445	58%	3491	80%
Jikawo	Male 15+ Age	1,602	76%	56	80%
Makuey	Male 15+ Age	5,318	74%	244	80%
Wantawo	Male 15+ Age	6,203	66%	672	80%
<b>Total/Average</b>		<b>246,410*</b>	<b>70%**</b>	<b>24957</b>	<b>80%</b>

The VMMC program in Ethiopia is implemented in high HIV burden and low circumcision practice SNUs in Gambella region (Figure 4.8.2). The VMMC program has previously been supported by CDC in the Gambella region and by DOD in military settings. The DOD mechanism will no longer continue in COP22.

**Table 4.8.3 Target Populations for Prevention Interventions to Facilitate Epidemic Control**

Target Populations	Population Size Estimate*	Disease Burden	FY22 Target
	(SNUs)	Est. HIV Prevalence (%)	
<b>KP_FSW</b>	<b>241,617</b>	<b>18.70%</b>	<b>96,047</b>
Addis Ababa	16,429	18.70%	14,548
Afar	9,370	18.70%	0
Amhara	60,173	18.70%	29,544
Benishangul-Gumuz	3,307	18.66%	0
Dire Dawa	2,667	18.71%	0
Gambella	3,672	18.71%	3,444
Harari	838	18.74%	0
Oromia	85,720	18.70%	26,882
Sidama	7,413	18.70%	3,347

SNNPR	22,139	18.69%	6,586
Somali	2,727	18.81%	0
South -West Ethiopia	4,967	18.68%	2,153
Tigray	22,195	18.71%	9,543
<b>PP_PREV</b>			<b>77,146</b>
Addis Ababa	NA		13,333
Amhara	NA		42,043
Gambella	NA		1,749
Oromia	NA		12,489
Sidama	NA		3,468
SNNPR	NA		3,315
South-West Ethiopia	NA		749

\*Include data sources in the text (i.e., not in the table itself)

Table 4.8.4 Targets for OVC and Linkages to HIV Services					
	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY23 Target) OVC_SERV Comprehensive	Target # of OVC (FY23 Target) OVC_SERV Preventative	Target # of active OVC (FY23 Target) OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY23 Target) OVC*
Addis Ababa	54,855	67,991	16,909	NA	41,692
Affar	74,739			NA	
Amhara	658,711	125,444	30,063	NA	77,003
B/Gumuz	46,884			NA	
Dire Dawa	18,661			NA	
Gambella	22,283	5,834	1,246	NA	3,995
Harari	6,871			NA	
Oromia	1,177,482	105,946	24,178	NA	68,775
Sidama	141,538	12,671	3,233	NA	7,666
SNNPR	491,374	27,243	6,918	NA	16,733
SW Eth		5,352	1,068		3,571
Somali	219,427			NA	
Tigray	133,758	34,426	8,608	NA	22,069
<b>TOTAL</b>	<b>3,046,583</b>	<b>384,907</b>	<b>92,223</b>	<b>NA</b>	<b>241,504</b>

#### 4.9 Cervical Cancer Program Plans

Beginning in COP20, Ethiopia has been included in the Go Further initiative to accelerate cervical cancer (CxCa) prevention programs. In COP20 and COP21, PEPFAR-E has been providing FMOH and RHBs both above-site technical and site-level support to accelerate CxCA

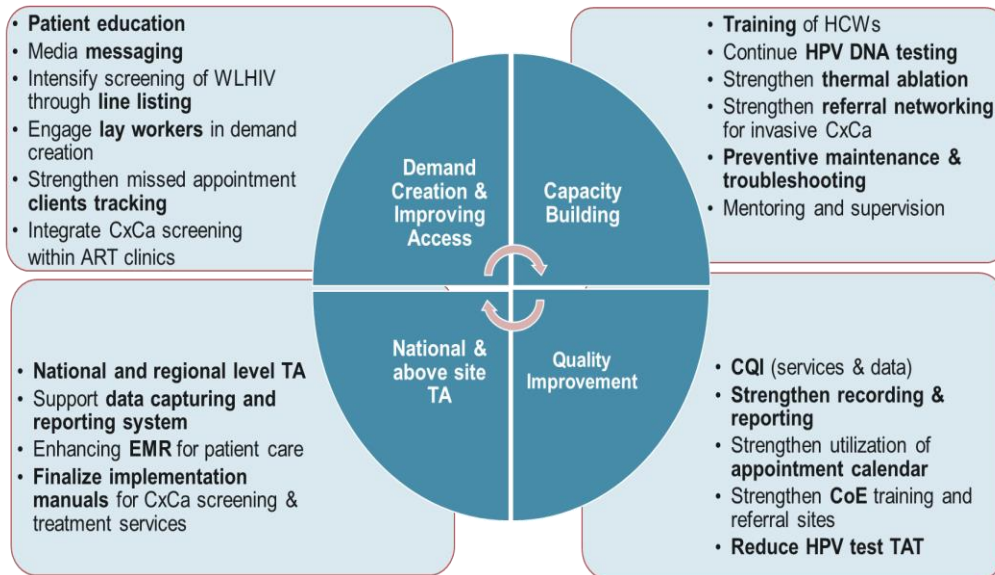
prevention efforts among PLHIV on treatment. In FY21, cervical cancer screening services were strengthened and expanded from 158 (31%) to 497 (98%) of priority ART sites and 10 community DICs. Furthermore, PEPFAR-E supported the introduction of new diagnostic and therapeutic technologies, including HPV DNA testing and thermal ablation therapy. In addition, PEPFAR-E has provided technical support to the FMOH CxCa TWG in the revision of the National Cervical Cancer Prevention Guideline, training manuals, and recording and reporting tools, which have been printed and distributed to ART sites. PEPFAR-E implementing partners have also supported data capturing and monitoring systems, including in the EMR, at different levels of the health care system. Treatment with thermal ablative instruments was expanded to 348 high volume ART sites, supported by the necessary onsite mentorship and coaching. HPV DNA testing service has been introduced at 69 selected HFs using Roche and Abbott VL/EID platforms in 15 laboratories. Necessary HPV DNA testing SOPs and training were developed and deployed.

At the community level, ten cryotherapy machines were made available for the corresponding ten DICs in Amhara and Addis Ababa regions. PEPFAR-E has also provided capacity strengthening for healthcare providers through training, coaching, and mentoring. With regards to quality improvement and strengthening referrals, PEPFAR-E has helped establish ten Centers of Excellence (CoE) sites that will serve as training and referral sites in a “hub and spoke” model. These sites are equipped with teaching aids, including video colposcopy and LEEP instruments, and will support HFs by training, coaching, and mentoring health workers. As of FY 21 APR, despite the challenges of COVID-19 and widespread insecurity, 70,259 WLHIV have received cervical cancer screening services, with 84% treatment coverage. In COP20, the overall screening coverage of eligible WLHIV between the ages of 25-49 reached 35%. The major barrier to wider scale up of the CxCa prevention program is reduced clinical visits associated with the expansion of DSD models including MMD, COVID-19 mitigation measures, and insecurity, with 72 sites in Amhara and Afar regions experiencing service interruption. In addition, there are challenges related to client and provider awareness, missed opportunities during clinical visits, lack of capacity at different levels, and service delivery quality.

In COP22, PEPFAR-E will continue to strengthen demand creation efforts using various messaging platforms at community and health facility levels, including generating line lists of eligible clients who have not yet received screening services and improve scheduling of clinical and CxCA screening appointments in addition to the line listing of eligible clients. These efforts will be further strengthened by community partners who support the creation and provision of integrated CxCa prevention services in DICs serving key and priority populations (KP/PP). Likewise, community partners will integrate demand creation activities for cervical cancer screening and treatment in communities and provide accompanied referral of eligible clients to health facilities.

In COP21 and COP22, PEPFAR-E will continue to provide technical assistance to the FMOH in finalizing the CxCA mentorship guidelines, referral implementation manual, SOPs, and any other policy-related documents and updates. RHBs will be supported through various capacity-strengthening initiatives, including availing technical experts at the regional level, strengthening HPV DNA testing services in selected HFs, and community DICs, expanded training and supervision. Referral linkage for LEEP and for suspected cancer cases will be strengthened

through the implementation of the CxCa referral implementation manual, referral directory, and online registration system to oncology specialty centers. Continuous quality improvement through a variety of initiatives will be integral to improve screening and treatment services and data quality. Figure 4.9 summarizes the key strategic areas that will be implemented to strengthen cervical cancer screening and treatment services in Ethiopia in COP22.

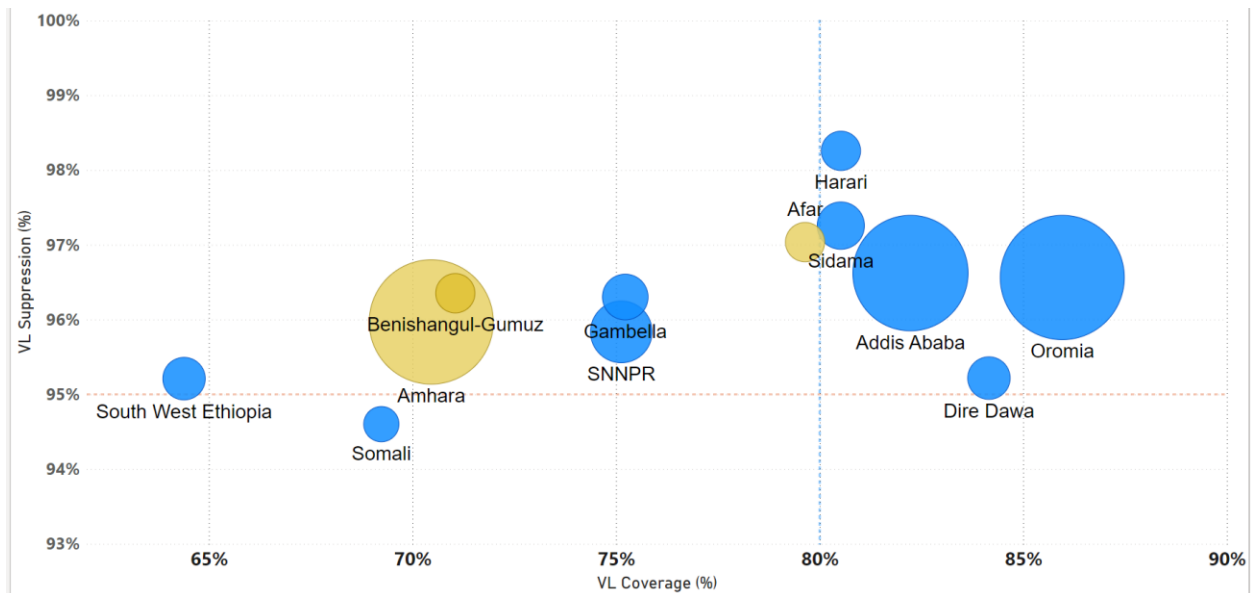


#### 4.10 Viral Load and Early Infant Diagnosis Optimization

In FY22Q1, VL coverage remains below 80%, with suboptimal coverage in most regions (Figure 4.10.1). In Amhara, disruptions to health facilities and specimen referral networks due to insecurity negatively affected VL coverage. The impact of insecurity was less apparent in Afar region, where high-volume ART facilities are closer to the testing lab and farther from the epicenter of conflict. The newly established Southwest region, which includes areas formerly part of SNNPR, Somali, SNNPR, and Gambella regions, is less affected by conflict, but has low uptake of routine viral load services.

Figure 4.10.1 shows VL coverage in conflict-affected (yellow circles) and less-affected regions (blue regions), FY22 Q1. The Amhara region, which has the largest treatment cohort, has been most negatively affected.

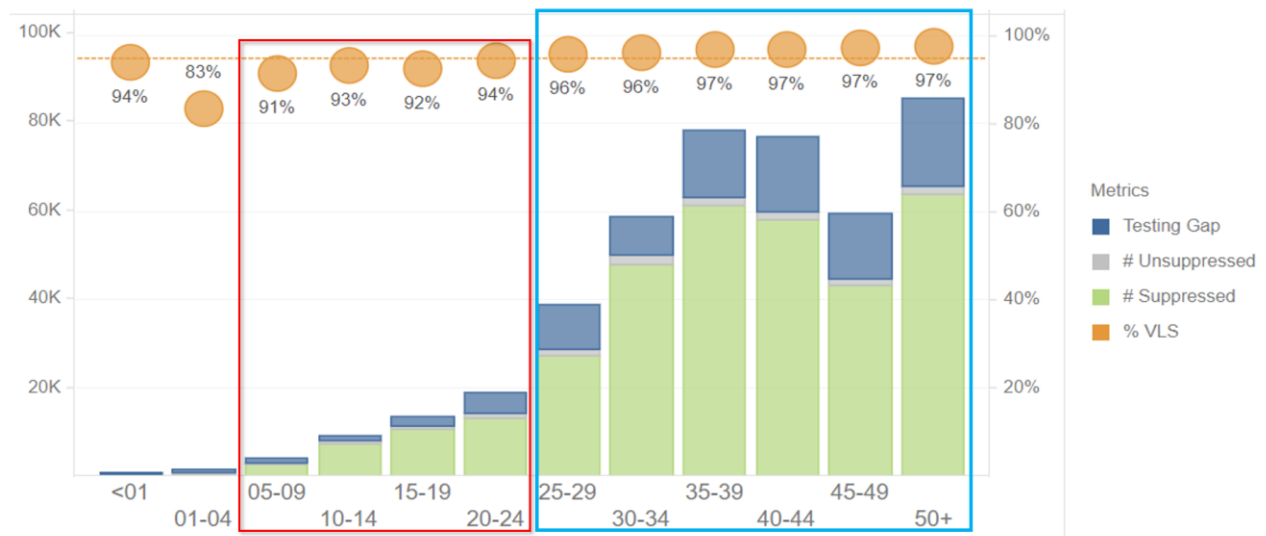
**Figure 4.10.1 VL coverage in conflict-affected and less-affected regions, FY22 Q1**



Impressively, viral load suppression has been maintained at 96% nationally for the past three quarters, with notable improvements in regions and sub-populations with suppression historically <90%.

All age groups between 5 and 24 years now have >90% suppression (Figure 4.10.2), a substantial improvement from prior quarters driven by several factors, including pediatric and ART optimization, expansion of adolescent-focused services, and improved treatment continuity. Among adults aged 25 and above, all age groups have >95% VL suppression, driven by ART optimization, improved DSD models, and the expansion of high VL clinics.

**Figure 4.10.2 VL coverage in age bands, FY22 Q1.**

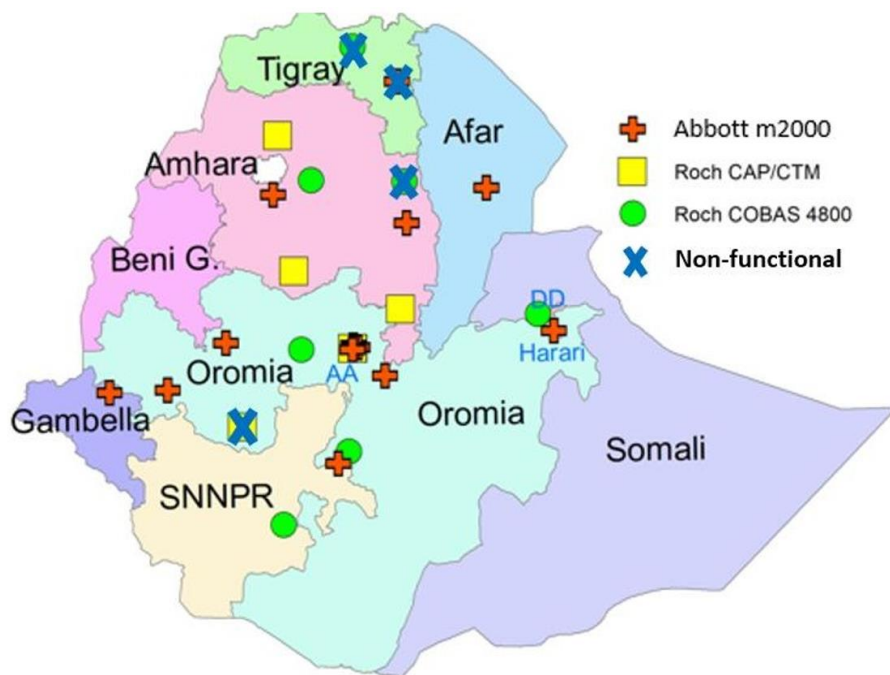


COP22 VL scale-up strategies include continuation of recovery activities in conflict-affected regions and a focus on populations and regions with lower VL coverage. To address the gap in VL coverage in children and in remote facilities, DBS VL will be scaled up, which will help address barriers due to limited phlebotomy services and cold chain infrastructure. To improve VL suppression in PFBW, children, and clients with unsuppressed VL despite enhanced adherence counseling, POCT-VL will be expanded from 36 to 50 facilities. Expansion plans for DBS and POCT VL are based on current results, facility burden of HIV, and distance from conventional VL laboratories. The integrated specimen referral network mapped out all the testing platforms and considered multiple pathogens testing on one piece of equipment. Diagnostic network optimization is reassessed on average every two years, with the most recent one completed in December 2021. Backup laboratories have also been identified to support primary referral laboratories when they are either non-functional or unable to meet the testing demand.

Sixty health facilities are currently implementing electronic VL test request and result return, which connects Smart-Care ART, the VL-EID database, and web-API. An added feature of SMS use for patient notification is under development with planned introduction in COP22.

**Figure 4.10.3** shows the all-inclusive placement of conventional real-time PCR platforms that are being used for multiplex testing of HIV-VL, EID, HPV testing, and COVID-19. The transition of Roche CAP/CTM platform has begun, and Jimma and the National Reference Lab have already been replaced. The remaining four platforms are scheduled for transition in FY23. Three testing labs in North Ethiopia are closed due to the conflict, and one in the Oromia region is closed due to equipment replacement.

**Figure 4.10.3 Placement of multiplex RT-PCR platforms for HIV-VL, EID and HPV test.**



## 5.0 Program Support Necessary to Achieve Sustained Epidemic Control

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To strengthen health systems in Ethiopia to achieve and sustain epidemic control, PEPFAR-E has prioritized systems-level investments in COP22 based on gaps identified through various mechanisms, including quarterly POART/MER results and a consultative process with the Ministry of Health, Regional Health Bureaus, CSOs, and FBOs. During COP22 development, there was also extensive stakeholder engagement and consultation with the Ministry of Health, Regional Health Bureaus, Global Fund, the Bill & Melinda Gates Foundation, UNAIDS, UNFPA, and other donors, as well as the private sector.

The rationale and process used for narrowing the focus in relation to SID scores included prioritizing and selecting the SID elements with low SID scores, in relative terms. SID scoring was not done last year, so we used the SID score from COP19.

Overall, the SID analysis revealed weaknesses in most of the domains and elements prioritized for support at COP22, specifically improving private sector participation, scaling up case-based surveillance, resource mobilization support to sustain the program, TA support to improve the supply chain, and local capacity building to strengthen indigenous organizations. Key system barriers have been identified as policies and governance, civil society engagement, service delivery, commodity security and supply chain, laboratory, epidemiological and health data, and data for decision-making ecosystems.

The systems-level investments planned for COP22 are aimed at addressing these key barriers and priorities to propel Ethiopia toward long-term epidemic control. The activities that are planned are listed below.

*Support a locally led public health response to the HIV epidemic:* In COP22, PEPFAR-E will continue to work with relevant partners to strengthen GoE and CSO capacity on policy, planning, coordination, and efficient program implementation. These interventions will enable PEPFAR-E to realize its successful transition to local prime partner initiatives and local organizations to successfully execute their programmatic and fiduciary responsibilities.

*Governance, policy, planning, and coordination:* GoE agencies, including FMOH have addressed most major policy gaps. There remains a need for strengthened planning and coordination for the HIV response's sustainability, particularly the gradual transition of PEPFAR direct service delivery support for regions with higher HIV burden to government agencies.

*HIV Case Surveillance:* PEPFAR-E has implemented HIV case surveillance across Ethiopia, in coordination with the introduction of recent infection surveillance using recency testing, with a phased approach to eventually reach all HIV testing sites. Currently, about 600 health facilities and 33 community DICs from all regions are providing services to close to 90% of the total treatment cohort, with a plan to reach 757 sites in COP21 and 997 sites in COP22. To facilitate data use, a data visualization platform has been established at EPHI, and information is being generated and reviewed regularly to identify clusters and inform public health responses. The visualization platform is the National CBS Power BI Dashboard and is accessible to program and management staff working in MoH, EPHI, regions, and partners. All other HIS-related assistance to facilitate surveillance data capture, transmission, storage, analytics, and visualization is progressing as planned and will continue in COP22. A site-level response guideline has been developed and launched, and training has been given to regions to initiate monitoring of site-level response, cluster identification, investigation, and above-site response. Efforts are underway to build the capacity of RHBs, zones, and woreda offices to use the same data visualization solutions and facilitate data use at sub-national levels. Longitudinal CBS (reporting of sentinel events), using the EMR ART as the data source, is being introduced as part of an amended CBS protocol. The EMR system is being enhanced to capture all relevant data elements, and an interoperability solution is being introduced to facilitate data transmission across the systems. Longitudinal CBS will be introduced in selected facilities in FY21 and scaled-up to include additional high-volume sites in COP22. The Recent Infection Testing Algorithm (RITA), which includes VL testing for more accurate classification, is being introduced in selected health facilities in COP21, with a plan for expansion to all CBS participating sites.



*Mortality Surveillance:* Currently, preparatory activities are underway to initiate mortality surveillance among PLHIV (including adults, children, and infants) in select urban areas with high HIV burden, with further expansion planned in COP22. In addition, PEPFAR-E will support MoH to enhance death registration, contemplate verbal autopsies to look cause of death ascertainment as part of strengthening the national Civil Registration and Vital Statistics (CRVS) system to complement mortality surveillance among PLHIV.

*HIV Estimates:* Beginning in COP22, the annual HIV estimation and projection exercise will be supported to improve the quality of input data from PMTCT and care and treatment programs for producing epidemiologic data, helping with better epidemic monitoring, and informing the annual HIV program plan.

*HIV Drug Resistance Surveillance:* PEPFAR-E will monitor cyclical acquired HIV drug resistance (CADRE) in people on dolutegravir-based regimens who are not virally suppressed (VL >1,000 copies/mL), with the objective of producing precise age- and sub-population-based HIV drug resistance estimates. Laboratory-based HIV drug resistance monitoring 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. The protocol for data collection was approved by EPHI and the CDC Center for Global Health. The eligibility criteria for adults 15 years and older is receipt of DTG-based regimens for at least 9 months and VL >1,000 viral copies/mL. The eligibility criteria for children aged 15 years is slightly different, as there are many children currently on a protease inhibitor-based regimen, and DTG 10 mg was only recently introduced in January 2022. Thus, the first round of CADRE will include children with VL >1,000 copies/mL and receiving both DTG and non-DTG-based regimens. Data collection for the first round of CADRE is expected to be completed in FY22. COP22 activities for CADRE include data analysis, report writing, and results dissemination, along with preparation for the next cycle. CADRE is the only nationally representative HIV drug resistance monitoring of existing or emerging mutations, and specifically for mutations associated with virologic failure of DTG-based regimens, in Ethiopia.

*Supply chain and commodities:* A reliable supply chain system is a critical requirement to sustain the progress towards HIV epidemic control, maintain the national program's successes, and ensure continuity of treatment for clients on ART. In COP22, the PEPFAR-E supply chain TA partner will support the system with supply forecasting, supply planning, procurement, pharmacy data triangulation through the implementation of the Pharmacy Management Information System (PMIS) and Logistic Management Information System (LMIS) at ART dispensaries and medical stores, last mile distribution to ensure adequate HIV commodity availability and accessibility, pharmacovigilance, warehousing distribution, and pilot a Decentralized Drug Distribution (DDD) service model at private and government-owned pharmacies to bring services closer to the beneficiaries. In addition, the TA will support the restoration and rebuilding of supply chain systems and pharmacy services of health facilities in conflict-affected areas.

*Laboratory:* PEPFAR-E will continue supporting optimization of VL testing through specimen referral network optimization, training of testing personnel, quality assurance, and enforcing the reagent rental agreement where placement of machines and maintenance is the responsibility

of vendors. Old VL/EID platforms will be replaced with new platforms to avoid frequent service disruptions due to breakdowns. Alternate specimen collection modalities will be used to reach the pediatric age group and facilities less accessible and damaged by the armed conflict in northern Ethiopia. COP22 lab support will focus on resuming tier-lab network and system recovery in conflict-affected regions. Timely return of emergency test results such as unsuppressed VL will be ensured with immediate communication through electronic modalities or phone calls. All viral load, EID, and TB culture laboratories will be enrolled in an international accreditation scheme and provided with the necessary support for external quality assessment. Chemical waste management will also be a priority for the lab system to prevent human, animal, and environmental exposures.

*Management Information Systems (MIS):* MIS and the integration of PMIS into the Dagu system, with planned scale up of Dagu to 1,200 ART facilities. The management of patient-related information on the utilization of antiretroviral (ARV) medications in Ethiopian health facilities has seen improvements since the introduction of the Standard Operating Procedures for Antiretroviral Drugs Management at Health Facilities. Accordingly, the system has allowed the effective and efficient documentation and reporting that is important in the management and monitoring of patient uptake and regimen profiles at national, regional, and health facility levels; (4) Promoting data quality and information use at health facilities, as well as DQA on HIV-related data at PEPFAR community sites using the Digital Tool; (5) Health information exchanges at EPHI, as well as unique identifiers for HIV CBS support; and (6) Supporting the Unified Data System (UDS) based on the CommCare digital platform in community HIV programs. The UDS harmonizes the data collection and case management systems of community HIV activities. It aids in the tracking of performance and monitoring of service quality across programs; and (7) supports data and health information system recovery in conflict-affected areas for patient level, community, aggregate, and surveillance systems.

The government has made significant investments in the public health sector that have led to improvements in health outcomes. Nevertheless, communicable diseases like HIV/AIDS, TB, and malaria remain a serious challenge in Ethiopia. Therefore, the goal of the systems investment is to ensure the most efficient and effective systems that support identifying and remediating key above-site gaps in the clinical cascade and developing and implementing national policies necessary to achieve the 95-95-95 targets.

No assessment was carried out to draw indications that the system is adequately functioning at a country level, but the fact that existing infrastructure, human resources, and systems were repurposed and appropriately used for COVID-19 response, and the country's health system is maintaining health services during the internal conflict are indications of a well-functioning system.

## 6.0 USG Operations and Staffing Plan to Achieve Stated Goals

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PEPFAR Ethiopia's staffing footprint is designed to be proportionate to the progress of Ethiopia towards HIV epidemic control, the urgent needs around program recovery efforts in conflict-affected regions, and the continued progress towards sustainable, government-led, maintenance of the HIV program.

The PEPFAR Ethiopia Coordinating Office is not proposing any new positions in COP22. In addition to its coordination role, the PEPFAR Ethiopia Coordination Office oversees the rapid roll-out of small grants for community-led monitoring. The PEPFAR Coordinator position was filled in October 2021, and the Deputy Coordinator position is currently being recruited. The Senior Technical Advisor position, which was approved in COP19, is vacant and will be filled by October 2022.

PEPFAR-supported agencies (USAID and CDC) continue to reinforce PEPFAR program requirements and priority activities in a complimentary and coordinated approach.

CDC's staffing footprint includes technical officers for HIV service delivery, laboratory, strategic information, monitoring and evaluation, partner management, management and operations, and science and communications. Senior technical advisors provide cross-branch and strategic support to identify and overcome barriers to sustainable epidemic control. Regional and partner management support teams composed of interdisciplinary technical experts have been created to provide comprehensive technical assistance, program monitoring, and accountability to implementing partners. All staff participate in quality improvement efforts, including SIMS and other quality improvement initiatives, in collaboration and coordination with implementing partners. Quality improvement efforts are prioritized for sites identified as high volume and/or low performance by reviewing key metrics for HIV epidemic control, including case finding, linkage to treatment, treatment continuity, and viral load, with an overarching focus on providing client-centered services. In recent years, CDC has altered staffing to meet identified needs for specific skills and competencies, including client-centered services and infection prevention and control. Currently, CDC has no long-term vacant positions and no proposed new positions. In COP22, CDC is reducing CODB by \$500,000 from COP21.

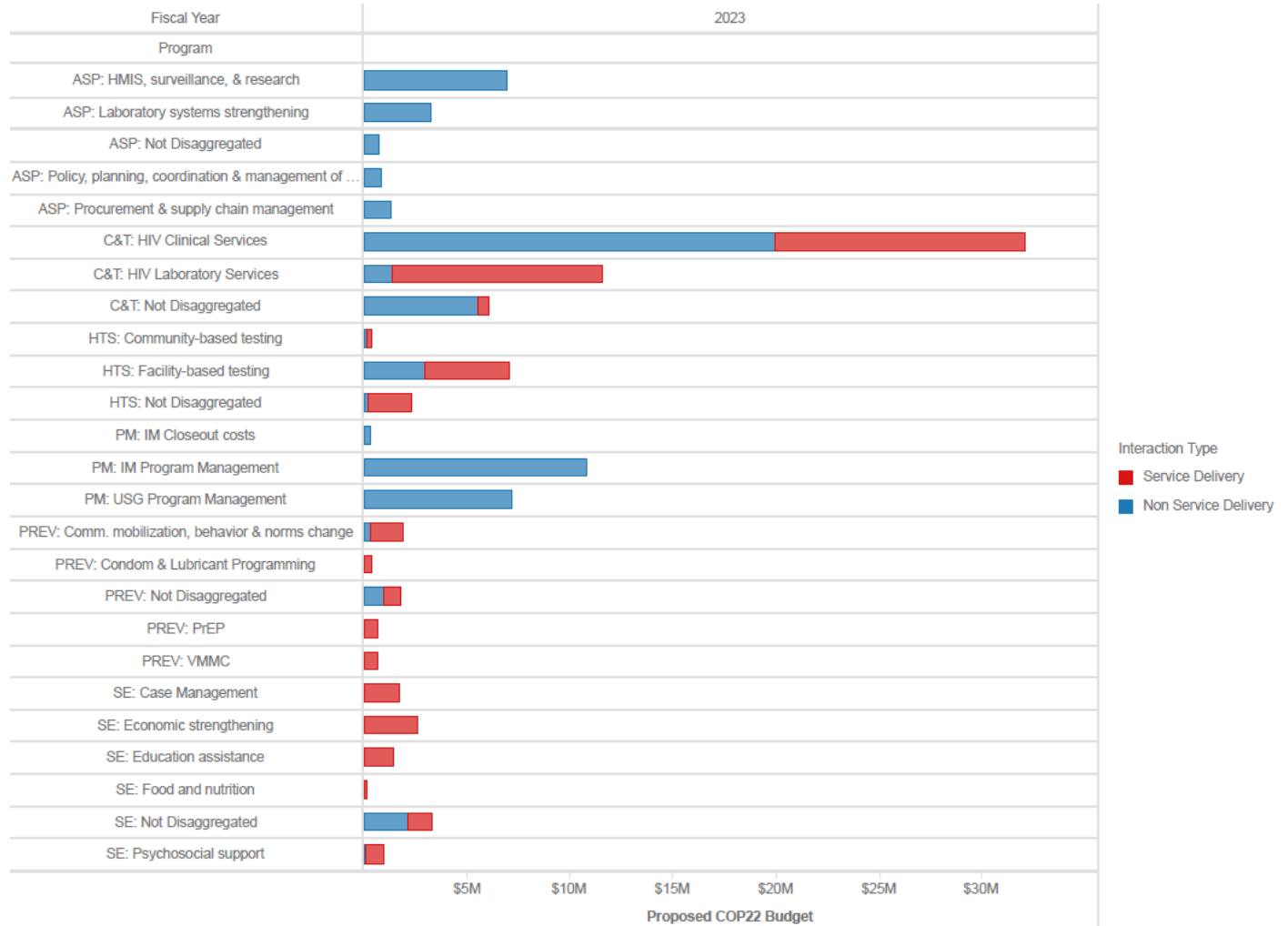
USAID's staffing footprint includes thematic area experts and specialists as well as program management support staff for HIV prevention and control activities. USAID has two vacant positions (HIV/Infectious Team Lead and Senior Supply Chain/Logistic Officer) that are in the recruitment process. USAID has been analyzing its staffing footprint to support programmatic pivots and has adjusted over the last several COPs. For example, the total number of staff in COP12 was 83, in COP17 it was 29, and 18 positions in COP22. USAID will continue to have the use of institutional contractors related to the oversight and management of the transition to local prime partnerships. There is a need to have an intensified site visit approach and oversight of partners that reflects close monitoring of partner performance (specifically of local partners).



# APPENDIX B – Budget Profile and Resource Projections

## B1. COP22 Planned Spending in alignment with planning level letter guidance

Table B.1.1 COP22 Budget by Program Area



**Table B.1.2 COP22 Budget by Program Area**

Program	Metrics	Proposed COP22 Budget			Percent of Proposed COP 22 Budget		
		Sub-Program	Non-Service Delivery	Service Delivery	Total	Non-Service Delivery	Service Delivery
<b>Total</b>		<b>\$64,824,572</b>	<b>\$41,225,428</b>	<b>\$106,050,000</b>	<b>61%</b>	<b>39%</b>	<b>100%</b>
C&T	<b>Total</b>	<b>\$26,818,386</b>	<b>\$22,813,854</b>	<b>\$49,632,240</b>	<b>54%</b>	<b>46%</b>	<b>100%</b>
	HIV Clinical Services	\$19,932,223	\$12,147,306	<b>\$32,079,529</b>	62%	38%	<b>100%</b>
	HIV Laboratory Services	\$1,331,026	\$10,216,548	<b>\$11,547,574</b>	12%	88%	<b>100%</b>
	Not Disaggregated	\$5,555,137	\$450,000	<b>\$6,005,137</b>	93%	7%	<b>100%</b>
HTS	<b>Total</b>	<b>\$3,246,307</b>	<b>\$6,448,511</b>	<b>\$9,694,818</b>	<b>33%</b>	<b>67%</b>	<b>100%</b>
	Community-based testing	\$136,769	\$212,763	<b>\$349,532</b>	39%	61%	<b>100%</b>
	Facility-based testing	\$2,890,770	\$4,153,307	<b>\$7,044,077</b>	41%	59%	<b>100%</b>
	Not Disaggregated	\$218,768	\$2,082,441	<b>\$2,301,209</b>	10%	90%	<b>100%</b>
PREV	<b>Total</b>	<b>\$1,271,030</b>	<b>\$4,006,651</b>	<b>\$5,277,681</b>	<b>24%</b>	<b>76%</b>	<b>100%</b>
	Comm. mobilization, behavior & norms change	\$293,881	\$1,580,563	<b>\$1,874,444</b>	16%	84%	<b>100%</b>
	Condom & Lubricant Programming		\$400,000	<b>\$400,000</b>		100%	<b>100%</b>
	Not Disaggregated	\$977,149	\$780,767	<b>\$1,757,916</b>	56%	44%	<b>100%</b>
	PrEP		\$625,321	<b>\$625,321</b>		100%	<b>100%</b>
	VMMC		\$620,000	<b>\$620,000</b>		100%	<b>100%</b>
SE	<b>Total</b>	<b>\$2,159,586</b>	<b>\$7,956,412</b>	<b>\$10,115,998</b>	<b>21%</b>	<b>79%</b>	<b>100%</b>
	Case Management		\$1,712,157	<b>\$1,712,157</b>		100%	<b>100%</b>
	Economic strengthening		\$2,622,814	<b>\$2,622,814</b>		100%	<b>100%</b>
	Education assistance		\$1,417,680	<b>\$1,417,680</b>		100%	<b>100%</b>
	Food and nutrition		\$118,661	<b>\$118,661</b>		100%	<b>100%</b>
	Not Disaggregated	\$2,090,711	\$1,214,304	<b>\$3,305,015</b>	63%	37%	<b>100%</b>
	Psychosocial support	\$68,875	\$870,796	<b>\$939,671</b>	7%	93%	<b>100%</b>
ASP	<b>Total</b>	<b>\$12,977,435</b>		<b>\$12,977,435</b>	<b>100%</b>		<b>100%</b>

	HMIS, surveillance, & research	\$6,944,198		<b>\$6,944,198</b>	100%		<b>100%</b>
	Laboratory systems strengthening	\$3,217,146		<b>\$3,217,146</b>	100%		<b>100%</b>
	Not Disaggregated	\$708,773		<b>\$708,773</b>	100%		<b>100%</b>
	Policy, planning, coordination & management of disease control programs	\$831,200		<b>\$831,200</b>	100%		<b>100%</b>
	Procurement & supply chain management	\$1,276,118		<b>\$1,276,118</b>	100%		<b>100%</b>
PM	<b>Total</b>	<b>\$18,351,828</b>		<b>\$18,351,828</b>	<b>100%</b>		<b>100%</b>
	IM Closeout costs	\$340,000		<b>\$340,000</b>	100%		<b>100%</b>
	IM Program Management	\$10,812,820		<b>\$10,812,820</b>	100%		<b>100%</b>
	USG Program Management	\$7,199,008		<b>\$7,199,008</b>	100%		<b>100%</b>

**Table B.1.3 COP22 Total Planning Level**

Operating Unit	Proposed COP22 Budget	Proposed COP22 Budget	Proposed COP22 Budget
	Applied Pipeline	New	Total
<b>Total</b>	<b>\$6,838,330</b>	<b>\$99,211,670</b>	<b>\$106,050,000</b>
<i>Ethiopia</i>	\$6,838,330	\$99,211,670	\$106,050,000

**Table B.1.4 COP22 Resource Allocation by Program and Beneficiary**

Operating Unit	Beneficiary	Proposed COP22 Budget						Percent to Total								
		C&T	HTS	PREV	SE	ASP	PM	Total	C&T	HTS	PREV	SE	ASP	PM	Total	
Ethiopia	<b>Total</b>	<b>\$49,632,240</b>	<b>\$9,694,818</b>	<b>\$5,277,681</b>	<b>\$10,115,998</b>	<b>\$12,977,435</b>	<b>\$18,351,828</b>	<b>\$106,050,000</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
	Non-Targeted Pop	\$42,523,258	\$7,476,948	\$1,972,871	\$18,829	\$12,350,213	\$18,240,255	\$82,582,374	86%	77%	37%	0%	95%	99%	78%	
	OVC	\$539,080		\$718,023	\$10,097,169			\$11,354,272	1%		14%	100%			11%	
	Priority Pops		\$514,118	\$300,534			\$111,573	\$926,225		5%	6%			1%	1%	

## B.2 Resource Projections

Resource allocation is based on an incremental approach and on the expected activities and priorities stated in the PLL and COP22 guidance. Referred data sources include pipeline reports, financial performance, and expenditure, as well as triangulation of spending and results.



# APPENDIX C – Tables and Systems Investments for Section 6.0

Complete key system barriers, Table-6 and SRE tables and information can also be accessed here: [{SharePoint & public shared drive link to final tools}](#)

Key System Barriers (Entry of Objectives, Related SD Elements, Barriers to Local Responsibility)						Risks/ops	
Step 1: Select SD element	SD score (retrospective)	Step 2 - What is the outcome expected from investing in this element? (any duplicate outcome to more than one row to allow capture of all barriers)	Step 3: What are the barriers to local responsibility for this outcome?	Step 4: Describe the barrier	Step 5: Timeline to Barrier Addressed	Comments	
3. Civil Society Engagement	5.8	Strengthen Local Partners as they transition to receive HIV/AIDS funding as a stand-alone Partner to comply with regulations	Lack of managerial capacity	Limited local capacity CSOs / local implementing partners on health/HIV/AIDS program management and efficient use of resources	4-5 years		
6. Commodity Security and Supply Chain	4.8	Increased availability of and accessibility to life saving HIV commodities such as ARV, OI, KITS, ICDs and VCs reagents	Lack of technical capacity	Weak supply chain system due to inadequate supply chain workforce in terms of capacity, professional mix, lack of standardized workflow, poor infrastructure, poor coordination among supply chain parties	4-5 years		
17. Data for Decision-Making Ecosystem	7.2	Establish fully functional real-time data entry performance tracking metrics on Contraception/ UDS to all service delivery sites; support data-driven decision making towards patient-centered continuity in care	Lack of technical capacity	Weak community/health information system to collect and report data timely	3-3 years		
17. Data for Decision-Making Ecosystem	7.2	Improved Last Mile Viability of HIV/AIDS Supply Chain Commodities, Reduced HIV/AIDS Commodity stock-out and Improved Data Quality and use	Lack of technical capacity	Sub-optimal implementation of Electronic MMS (Steps 1.1 and PMS) (Pharmaceutical Management Information System) to support HIV commodities last mile viability and reduce stock-out, issues related with use of standardized DQA tool and limited practice of data analysis and use at site level	3-3 years		
6. Service Delivery	5.1	Improved KPP programming in the implementation of comprehensive HIV prevention, care and treatment services including new and innovative interventions by the local capacity. Moreover, high risk men, PWIDs, AGYW case finding approaches, linkages to care and treatment will be standardized and appropriate tools revised or developed	Lack of technical capacity	Limited local capacity for KPP programming including strategies for finding high risk men, PWIDs implementing new and innovative approaches	4-5 years		
6. Service Delivery	5.1	Service uptake improved, Client retention on PrEP improved, Policy adopted and included in the MOH PrEP Implementation guide and protocol approved	Legal, policy or regulatory constraint	Demand creation, stigma, service uptake, maintaining clients on PrEP and policies are critical challenges. Thus, working on factors limiting the uptake and introducing the new biomedical products such as long acting (Cabotegravir) and Dolutegravir (DTG) for PrEP among PWIDs will increase uptake and contribute to maintain clients on PrEP	4-5 years		
14. Epidemiological and Health Data	5.5	Systems to capture/monitor HIV epi data at national, subnational and individual level improved	Legal, policy or regulatory constraint	Insufficient system to capture/monitor HIV epi data at national, subnational and individual level	4-5 years		
14. Epidemiological and Health Data	5.5	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in <b>aidetic control</b>	Lack of Financial Resources	The government does not have required finance to cover the cost for the necessary infrastructure related to the implementation of relevant survey /surveillance activities	6-9 years		
14. Epidemiological and Health Data	5.5	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in <b>aidetic control</b>	Lack of managerial capacity	The government does not have adequate managerial and governance capacity across the structure (facility to national level) for the implementation of relevant survey /surveillance activities	4-5 years		
14. Epidemiological and Health Data	5.5	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in <b>aidetic control</b>	Lack of sufficient HRH	The government does not have the required number and quality of trained staff for implementing the relevant survey/surveillance activities across the health structure	6-9 years		
2. Policies and Governance	7.4	Revision of the national HIV policy and working in validation of eMCTC process until eMCTC realized	Other	Some key aspects of the HIV policy have been hindering index testing to be implemented in its full capacity due to lack of provider protection. Regarding eMCTC validation process, there has been lack of capacity from the PMON side	3-3 years	This is not a type error. Implementing safe and ethical ICT is a critical strategy for preventing HIV. The provider aspect of it is also important. There have been reports of providers being concerned about index contacts questioning and intimidating them about who gave them their address and why they are calling. Although the index cases may consent, it is sometimes difficult to predict the contact's reaction or actions. As a result, this was brought up at the National HIV TWG level, and policy support for provider protection was proposed.	
14. Epidemiological and Health Data	5.5	Evaluating HPV DNA testing, strengths and gaps and using the evidence for future expansion	Lack of technical capacity	There is both lack of technical and financial capacity at government to do risk stratification	3-3 years		
17. Data for Decision-Making Ecosystem	7.2	Population wide VMMC coverage data that can influence decision making will be generated	Lack of Financial Resources	The implementing partner needs financial resources to conduct the survey. The government cannot allocate this amount of budget	3-3 years		
6. Service Delivery	5.1	Improved PMCT_ART & ICD coverage; reduced mother to child transmission be on the right path towards eMCTC goal	Lack of Financial Resources	Inadequate resources due to reduced or withdrawal of support previously provided by different partners	3-3 years		
6. Service Delivery	5.1	Improved PMCT_ART & ICD coverage; reduced mother to child transmission be on the right path towards eMCTC goal	Lack of sufficient HRH	Repeat demand to hire staff by the government was not possible due to the existing financial and HR policies	3-3 years		
6. Service Delivery	5.1	Improved PMCT_ART & ICD coverage; reduced mother to child transmission be on the right path towards eMCTC goal	Lack of technical capacity	The program unit works with limited staff as hiring of expertise with higher caliber has been a consistent challenge. This gap was previously addressed by different partners who provided technical assistance through TWG and secondment of staff	3-3 years		
10. Laboratory	4.2	Continuous laboratory quality Management system in public	Other	Inadequate access to high quality HIV laboratory services, eq. VI and ICD	4-5 years		
2. Policies and Governance	7.4	Quality score card is fully implemented at all KP sites. HIV Services will be provided for free for KPs / PSWs at all government KP sites.	Legal, policy or regulatory constraint	Inadequate quality of KP services at government public facilities. No user fee exemption for HIV services and treatment for KPs as public health intervention.	3-3 years	<ul style="list-style-type: none"> <li>•KIPs are provided comprehensive HIV package of services at the KP facility clinics in government facilities, these services include HIV risk reduction counseling, condom promotion demonstration, STI screening and treatment, HIV testing care and treatment, Family planning, GAV and PrEP services.</li> <li>•CCP 22 PL recommends for countries to advocate and work on policy changes for all these comprehensive KP package of services be provided for free at government facilities.</li> <li>•In Ethiopia, we have started to work on this activity of providing free comprehensive KP package of services.</li> <li>•However, some of the regions and facilities are providing free comprehensive KP package of services while other regions and facilities are charging some fees like consultation fee, lab services and some STI drugs (these are finding of our quality score card findings).</li> <li>•Inance for CCP 22 we have a plan to work with government to nationally certify (make national policy) that all government KP sites provide all the comprehensive KP services which include HIV risk reduction counseling, condom promotion demonstration, STI screening and treatment, HIV testing care and treatment, Family planning, GAV and PrEP service for free including consultation fee, lab services and some STI drugs fee.</li> </ul>	



Table 5-6 (Entry of Above Site Programs Activated) Please note that for this tab to function properly, sets														
Activity Budget	COPI2 Program Area	COPI2 Beneficiary	COPI2 Activity Category	SD Element	SD Score 2019	SD Score 2021	SD component the activity is expected to boost	Expected Outcome	Primary Barrier to Local Responsibility: this activity	Barrier to Local Responsibility this activity addresses (optional)	Barrier to Local Responsibility this activity addresses (optional)	COPI2 Activity Description	Intervention Start	Intervention End
\$33,456	ASP: Not Disaggregated-ND	Non-Targeted Pop: Not disaggregated	Civil society engagement	3. Civil Society Engagement	4.17	-	N/A	Strengthen local partners' capacity to directly manage, implement, and monitor PEPFAR programs, and maintain consistent PEPFAR program achievement	Lack of managerial capacity			Strengthening local partners' (LPP) financial management capacity and compliance with USAID regulations as well as strengthening award management and program performance management capacity. Provision of embedded and virtual technical assistance, coaching, mentoring and trainings to the LPP. Cascade technical support to the subgrantees operating under the local primes so that a reclassification and maturity levels are ensured between the prime and their respective subgrantees.	COPI9	Not COPI2
\$361,038	ASP: HMIS, surveillance, & research-ND	Non-Targeted Pop: Not disaggregated	HMIS systems	34. Epidemiological and Health Data	4.12	-	N/A	Fully digitized, real time data collection, analysis and visualization tool that is fully integrated with the national eCHS system and will be used for reporting, performance monitoring and case management	Lack of technical capacity			Strengthen case management, referral tracking and data capturing and analysis for community based HIV programs implemented by local implementing partners and other (P). The Unified Data System (UDS) initiated in COPI9 for all USAID community-based HIV activities will be continued to be used for every data capture, tracking, analysis, visualization, reporting, performance monitoring and for decision making. Case management and monitoring of beneficiary outcome will be strengthened. Integration of the UDS to PEPFAR's national eCHS that was started in COPI2 will be finalized. Activities in COPI2 include: - Full integration of UDS/CommCare with eCHS; the partner will continue to work closely with the Government; capacity building for government staff will be conducted to HIV modules. All Community based HIV modules will be fully integrated into the national system. - Ensure real-time data entry and data use for decision making by all local implementing partners through expanding real-time data entry to all service delivery sites establishing fully functional real-time data entry performance tracking metrics on CommCare/UDS supporting service providers to enter data at time-of-service provision (same day data entry whenever and wherever feasible) providing at-level support to facilitate real-time data entry; supporting data-driven decision making towards patient-centered continuity in care, ART, treatment adherence, viral suppression - Ensure electronic case management at all service delivery sites (all providers capturing service information as they provide services to beneficiaries). UDS case management functionality of UDS, in a way to proactively manage interruption to treatment (IT), HIV, CAS, CCM, etc. will be achieved. Full establishment of a bi-directional (closed loop) referral system to all PEPFAR supported sites and maximum utilization of the SMS functionality within COGSM, ITT, HIV, DDC, etc. will be done. - A dashboard of Key Performance Indicators (KPI) will be updated given the development of new MEI or other custom indicators that help monitor implementation across all community based activities.	COPI9	COPI2
\$400,000	ASP: Not Disaggregated-ND	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	1.05	-	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Improved supply chain system which reduced stock out of HIV/AIDS commodities by implementing the Pharmaceutical transaction systems	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	Frequent stock monitoring will be continued as a priority support to government which will ensure commodity flow in the pipeline from national level to hubs and to sites. This includes reviewing reporting rates, providing feedback to health facilities and ensuring timely delivery of HIV/AIDS commodities through integrating with other program activities. Expanding the Pharmaceutical Management Information System to district ART sites. Support the decentralized service delivery model as this is key system to collect ARV client pharmacy level product and client information for supply chain decision making. Provide technical support to the integrated pharmaceutical logistics system that will track information and product flow in the system. Provide result oriented supportive supervision to improve quality of supply chain operations and enhance data quality and coordination platform. Continue supporting implementation of decentralized drug distribution (DD).	COPI0	COPI2
\$1,046,320	ASP: Procurement & supply chain management-ND	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	1.05	-	8.8 Management and Monitoring of Supply Chain: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage, plan, monitor, and provide guidance - supply chain activities including forecasting, stock monitoring, logistics and warehousing support, and other forms of information monitoring across all levels? (Select only ONE -----)	Timely procurement of HIV/AIDS commodities for both preposed through PEPFAR and other donors.	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	Continue providing support on the forecasting preparation, assumption building, support the quarterly supply planning activities strategic support such as framework of contracting, supplier qualification. Procurement of PEPFAR commodities, supporting contract and supplier relationship management. Regular monitoring of the HIV commodity supply and provide TA for timely clearance of commodities from ports, warehousing and distribution TA to all HIV program commodities.	COPI0	COPI2
\$609,115	ASP: Laboratory systems strengthening-ND	Non-Targeted Pop: Not disaggregated	Forecasting, supply chain plan, budget, and implementation	8. Commodity Security and Supply Chain	1.05	-	8.6 Stock: Does the host country government manage processes and systems that ensure appropriate ARV stock in all levels of the system?	Laboratory commodities management system strengthened and increased availability of VL, ED and RUC	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	Technical Assistance to ensure continuous availability of VL, ED commodities. During COPI2 the new HIV RUC algorithm will be implemented that requires significant effort at site level interventions which includes reviving the RUC tools, provide mentoring training, monthly monitoring of RUC supply and utilization, redistribution in case needed to ensure sustainable supply.	COPI0	COPI2
\$880,000	ASP: HMIS, surveillance, & research-ND	Non-Targeted Pop: Not disaggregated	HMIS systems	34. Epidemiological and Health Data	4.12	-	N/A	Improved test re-visitability of HIV/AIDS commodities and reduced stock out, and improved Data Quality and use for Community HIV/AIDS activities	Lack of technical capacity			*Technical Assistance to Improve Supply Chain Viability and reducing HIV/AIDS Commodity stock-out by Scale up of Dago 2.0 to PEPFAR supported facilities by installation of the system and making available required computers and printers. Capacity building and hardware expansion to PEPFAR ART sites with Dago system for online reporting of RUC to VITAL. Automation of PMS (Pharmaceutical Management Information System) for PEPFAR sites to enable the Pharmaceutical Care provider to follow up adherence, treatment outcomes, prevent adverse drug reactions, drug interactions and other medication related issues. - Technical Assistance to HIV/AIDS Community Program DQ (Data Quality Improvement ) by Conducting data analysis and generate insights and evidence that will inform HIV program design and implementation at community level. Conduct DQ on HIV related data at PEPFAR community sites using Digital Tool. Capacity building to service providers to improve reporting rates, data completeness and timeliness at PEPFAR supported Community Sites.	COPI1	COPI9

500,000	ASP: Policy, planning, coordination & management of disease control programs-NGO	Non-Targeted Pop: Not disaggregated	HIMS systems	34. Epidemiological and Health Data	4.12	N/A	Improved accessibility and use of HIV data through the national HIMS	Lack of technical capacity				• Technical Assistance to HIV/AIDS Community Program (COJ Data Quality Improvement ) by Conducting data analysis and generate insights and evidence that will inform HIV program design and implementation at community level. Conduct DQA on HIV related data at PEPFAR community sites using Digital Tool. Capacity building to service providers to improve reporting rate, data completeness and timeliness at PEPFAR community sites.	COF01	COF03
\$43,860	ASP: HIMS, surveillance, & research-NGO	Key Pop: Not disaggregated	Surveillance	34. Epidemiological and Health Data	4.13	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau(s), exist with specific authority to manage- plan, monitor, and provide guidance- for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Systems to capture/monitor HIV epi data at national, subnational and individual level improved	Legal, policy or regulatory constraint			Implementation of HIV case-based surveillance and recent infection surveillance including the expansion of V1 testing to 22 Drop In Centers (DIC) through viral load sample referrals to the V1 testing centers that provide the comprehensive HIV prevention, care and treatment services for key populations.	COF19	COF25
500,000	ASP: Policy, planning, coordination & management of disease control programs-NGO	Non-Targeted Pop: Not disaggregated	Overnight, technical assistance, and supervision to subnational levels	6. Service Delivery	4.01	-	6.9 Sub-national Service Delivery Capacity: Do subnational health authorities (i.e., district, provincial) have the capacity to effectively plan and manage HIV services sufficiently to achieve sustainable epidemic control?	Improved IPP programming in the implementation of comprehensive HIV prevention, care and treatment services including new and innovative interventions by the local capacity. Moreover, high risk men, PWID, and/or sex trading approaches, linkages to care and treatment will be standardized and appropriate tools needed or developed	Lack of technical capacity			Provide Technical Assistance to directly funded IPPs for the provision of comprehensive HIV prevention, testing and care and treatment services for low and priority populations including high risk men and out-of-school adolescent girls. The TA will include enhancing ICT/PIIS in the community and other appropriate testing approaches for the target including provision of HIVCT and PIIS. As the activity is one of the pioneers in key and priority population programming, in this area of epidemic control it will provide TA to government agencies and Town HCs in these areas. The activity will support the government in development and revision of guidelines, protocols, policy and advocacy on issue related to HIV prevention and care and treatment for key and priority populations.	COF19	COF03
500,000	ASP: HIMS, surveillance, & research-NGO	Key Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	2. Policies and Governance	4.08	-	2.2 Enabling Policies and Legislation: Are there policies or legislation that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery? Note: If one of the listed policies differentiate policy for specific groups, please note in the Notes/Comments column	Service uptake improved. Client retention on PEP improved. Policy adopted and included in the GCE PEP implementation guide and protocol approved.	Legal, policy or regulatory constraint			Plating Deproline Vaginal Ring (DPR) as PEP among Female Sex Workers in the community Drop In Centers (DIC)	COF01	COF04
\$47,152	ASP: HIMS, surveillance, & research-NGO	Key Pop: Not disaggregated	Surveillance	34. Epidemiological and Health Data	4.13	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau(s), exist with specific authority to manage- plan, monitor, and provide guidance- for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Systems to capture/monitor HIV epi data at national, subnational and individual level improved	Legal, policy or regulatory constraint			Implementation of HIV case-based surveillance and recent infection surveillance including the expansion of V1 testing to 18 Drop In Centers (DIC) through viral load sample referrals to the V1 testing centers that provide the comprehensive HIV prevention, care and treatment services for key populations.	COF19	COF25
510,800	ASP: Policy, planning, coordination & management of disease control programs-NGO	Key Pop: Sex workers	Clinical guideline, policies for service delivery	6. Service Delivery	4.01	N/A	Quality score card is fully implemented at all IP sites. HIV services will be provided for free for 80% /7500 at all government IP sites.	It is not included in local HIV response plans	Physical infrastructure not complete/further investment needed by donors	Lack of sufficient HRH		Quality Scorecard implementation to improve client satisfaction and IP program. Policy/advocacy for free comprehensive HIV and STI services at public facilities	COF22	Part COF25
500,000	ASP: HIMS, surveillance, & research-NGO	Female: Adult women	Evaluation	34. Epidemiological and Health Data	4.13	-	14.6 Comprehensiveness of Prevalence and Incidence Data: To what extent does the host country government collect HIV prevalence and incidence data according to relevant disaggregations, populations and geographic context? (Note: Full score possible without selecting all disaggregates.)	Prevalence of HPV DNA among WGSW in Ethiopia known	Lack of technical capacity	Lack of Financial Resources	Lack of managerial capacity	1.Determine the prevalence of HPV infection among WGSW in Ethiopia. 2.Describe the genotypes of HPV infection among WGSW in Ethiopia. 3.Describe the determinants of HPV infection among WGSW in Ethiopia. 4.Determine the magnitude of VIA positivity among HPV positive WGSW in Ethiopia. 5.Determine the average TCT time for HPV DNA test results for clinical decision in GB IFA that have implemented the screening test. 6.Describe HPV DNA screening implementation strategies, feasibility and lessons learned in Ethiopia. 7. to determine treatment rates among VIA positive) using cryo(TA or LEEP)	COF22	COF04
540,000	ASP: Policy, planning, coordination & management of disease control programs-NGO	Non-Targeted Pop: Not disaggregated	Clinical guideline, policies for service delivery	6. Service Delivery	4.01	-	6.8 National Service Delivery Capacity: Do national health authorities have the capacity to effectively plan and manage HIV services?	Achieved Path to DMCT; reduced MTCT to less than 5%	Lack of technical capacity	Lack of sufficient HRH	Lack of Financial Resources	Support the national and regional PMTCT program through Planning and overseeing the overall PMTCT program implementation & leading PMTCT validation process, follow up, monitor process impact indicators and assess the status.	COF22	COF04

26,000	ASR: HIMS, surveillance, & research-ND	Non-Targeted Pop Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	N/A	Prevalence of Male Circumcision among 15+ men in Gambella region	Lack of Financial Resources	Lack of Financial Resources	Lack of Financial Resources	The survey would generate male circumcision coverage information among 15+ men in Gambella region. The VMNC program in Gambella has been implemented since 2008 to achieve 90% population coverage as per WHO and UNAIDS's recommendation. So the survey result will provide data on how closer we are to achieving the above mentioned goal and also assist in making informed decision about continuity of VMNC program support in the future. Partner and other program planners must identify methods for capturing need for VMNC among South Sudanese refugees living in the Gambella community, Highlander men, and other migratory men, all of whom access VMNC services but are not captured in the documentation of VMNC coverage estimates. Existing population data are outdated for use in VMNC coverage estimation because they include mostly Ethiopian men living in Gambella and exclude many migratory and refugee men who live in the community. Even though the VMNC performance data indicate high coverage, the demand for VMNC service—according to implementing partners—continue to remain steady. Anecdotal reports indicate that there is higher need and demand for VMNC in Gambella than what the high coverage estimates might predict. The goal of this community survey is to capture more accurate estimate of coverage by better understanding of the need for VMNC among all eligible men in Gambella. Accurately estimating this documentation will help VMNC programs develop better targets to meet actual demand in the population.	COP22	COP22
578,000	ASR: Laboratory systems strengthening-ND	Non-Targeted Pop Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.76	-	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (If exact or approximate percentage known, please note in Comments)	VU/ED testing facilities mentioned, supported and applied for ISO accreditation in Gambella and PEFAR maintained four regions enrolled in IQMS.	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	Continuous quality improvement (CQI) activities for VU/ED and TB diagnostics with EQA, Mentorship, supportive supervision; enrollment and maintaining of ISO accreditation.	Prior to COP 18	COP23
550,000	ASR: HIMS, surveillance, & research-ND	Non-Targeted Pop Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage—plan, monitor, and provide guidance—for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in epidemic control	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Scale-up and maintenance of HIV case-based surveillance and recent infection surveillance using recently testing as part of CSE with partner RHG. The recent infection surveillance includes scaling-up of baseline viral load testing indicator as part of recent infection testing algorithm (RITA).	COP18	Past COP25
590,000	ASR: Laboratory systems strengthening-ND	Non-Targeted Pop Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.76	-	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (If exact or approximate percentage known, please note in Comments)	VU/ED testing facilities mentioned and applied for ISO accreditation, enrolled in SPTA, subzone and/or CQI, participated in ...	Lack of technical capacity	Lack of sufficient HRH	Lack of managerial capacity	Continuous quality improvement (CQI) activities for VU/ED and TB diagnostics with EQA, Mentorship, supportive supervision; enrollment and maintaining of ISO accreditation.	Prior to COP 18	Past COP25
530,000	ASR: HIMS, surveillance, & research-ND	Non-Targeted Pop Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage—plan, monitor, and provide guidance—for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in epidemic control	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Scale-up and maintenance of HIV case-based surveillance and recent infection surveillance using recently testing as part of CSE with partner RHG. The recent infection surveillance includes scaling-up of baseline viral load testing indicator as part of recent infection testing algorithm (RITA).	COP18	Past COP25
585,000	ASR: Laboratory systems strengthening-ND	Non-Targeted Pop Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.76	-	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (If exact or approximate percentage known, please note in Comments)	VU/ED testing facilities mentioned, and applied for ISO accreditation, enrolled in SPTA scheme, participated in IQMS;	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	Continuous quality improvement (CQI) activities for VU/ED and TB diagnostics with EQA, Mentorship, supportive supervision; enrollment and maintaining of ISO accreditation.	Prior to COP 18	Past COP25
550,000	ASR: HIMS, surveillance, & research-ND	Non-Targeted Pop Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage—plan, monitor, and provide guidance—for HIV/AIDS epidemiological surveys and/or surveillance activities including, data collection, analysis and interpretation, and quality assurance across all sectors. Select only ONE answer.	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in epidemic control	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Scale-up and maintenance of HIV case-based surveillance and recent infection surveillance using recently testing as part of CSE with partner RHG. The recent infection surveillance includes scaling-up of baseline viral load testing indicator as part of recent infection testing algorithm (RITA).	COP18	Past COP25
530,000	ASR: Laboratory systems strengthening-ND	Non-Targeted Pop Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.76	-	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (If exact or approximate percentage known, please note in Comments)	VU/ED testing facilities mentioned, and applied for ISO accreditation, enrolled in SPTA scheme, participated in IQMS;	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	Continuous quality improvement (CQI) activities for VU/ED and TB diagnostics with EQA, Mentorship, supportive supervision; enrollment and maintaining of ISO accreditation.	Prior to COP 18	Past COP25

\$300,000	ASP: Policy, planning, coordination & management of disease control programs/MSD	Non-Targeted Pop: Not disaggregated	Assessing impact of policies and regulations on HIV	3. Policies and Governance	4.08	-	2.3 Enabling Policies and Legislation: Are there policies or legislations that govern HIV/AIDS service delivery or policies and legislation on health care which is inclusive of HIV service delivery? Note: If one of the listed policies/legislation policy for specific groups, please refer to the Note/Comments column	Revised HIV policy, validate eMCTC, update HIV policy and guidelines	Legal, policy or regulatory constraint	Lack of technical capacity	Other	The partner will continue to provide technical assistance to the national HIV team and disease prevention directorate as well as different HIV and TB TWGs to revise the national HIV policy, to include provider protection as a possible referral from one partner or index case while providing partner notification service. The partner will technically support revision of HIV/AIDS policy to include Client Centered prevention against IPV (intimate partner violence) particularly for female index cases during disclosure of HIV status or partner notification. Advocate for IPV definition alignment. In addition, the partner will continue to support the national eMCTC validation effort by providing TA to government directly and through the TWG and implementation of the triple (MCTC) strategies. Support the government through the national PMCTC TWG in overall PMCTC program planning, coordination and monitoring. The IP will also continue to provide TA to GDE in the overall revision of HIV/TB guidelines, and provide TA to incorporate indicators for UrvuSAM test implementation monitoring. Provide TA for transition to universal implementation of 3AP as preferred-TRT regimen for eligible PLUW in all regions.	Prior to COP 18	COP23
\$1,938,947	ASP: HMIS, surveillance, & research/MSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	14.1 Management and Monitoring of Surveillance Activities: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage - plan, monitor, and provide guidance - for HIV/AIDS epidemiological surveys and/or surveillance activities including: data collection, analysis	Improved individual level HIV client tracking and quality data to generate evidence for informed decision making and program improvement so as to result in epidemic control	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Coordinate the scale-up and maintenance of HIV case-based surveillance and recent infection surveillance using reagent testing at national level as part of GDE. The recent infection surveillance includes scaling-up of baseline viral load testing, inclusion as part of recent infection testing algorithm (RITA). Support the scale-up and maintenance of HIV GDE in seven sites providing facilities through the IP, coordinate the lab and data quality assurance process for the surveillance. As part of the longitudinal GDE, it is expected to establish mortality surveillance among PLUW for both age groups, including adults, children, and infants. Annual HIV estimation and projection related activities will also be coordinated. It will also work on building the national human resource capacity	COP18	Post COP25
\$300,000	ASP: HMIS, surveillance, & research/MSD	Non-Targeted Pop: Not disaggregated	Surveillance	14. Epidemiological and Health Data	4.12	-	14.9 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy for a national surveillance and survey strategy with specific for HIV?	HIV CR surveillance will be established and integrated with other disease surveillance under the IP and generate evidence to monitor treatment and emergence of HIVCR	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	Since data collection for CADRE is expected to be completed in COP21, the IP is expected to undertake key activities including surveillance data analysis, report writing, and result dissemination along with preparation for the next cycle of lab based drug resistance surveillance for monitoring HIV drug resistance in context of TDR transition. Workshops for data analysis, report writing and result dissemination will be conducted. The final report will also be printed in a hard copy for dissemination. The preparations for the next cycle include protocol amendments, start requesting IRB approval, secure budget in the next year planning, etc.	COP20	Post COP25
\$1,105,000	ASP: Laboratory systems strengthening/MSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.78	-	10.2 Management and Monitoring of Laboratory Services: Does an administrative entity, such as a national office or Bureau, exist with specific authority to manage - plan, monitor, purchase, and provide guidance - laboratory services at the regional and district level across all sectors? (Select only ONE answer)	VU/EID testing facilities mentioned, and applied for ISO accreditation, included in SIPTA scheme, anticipated in IGMS;	Lack of managerial capacity	Lack of technical capacity	Lack of sufficient HRH	IP will provide national leadership and coordination support for the implementation of continuous laboratory quality improvement in priority sites and international accreditation of viral load labs. It will implement quality assurance tools for HIV rapid test and enroll more labs in external quality assessment for TB, viral load and EID and implement the WHO viral load standard. It will provide national leadership and coordination for HIV reagent testing.	Prior to COP 18	Post COP25
\$120,000	ASP: Laboratory systems strengthening/MSD	Non-Targeted Pop: Not disaggregated	Lab quality improvement and assurance	10. Laboratory	4.78	-	10.3 Regulations to Monitor Quality of Laboratories and Point of Care Testing (POCT) Sites: To what extent does the host country have regulations in place to monitor the quality of its laboratories and POCT sites? (If exact or approximate percentage known, please refer to Comments)	VU/EID testing facilities mentioned, and applied for ISO accreditation, included in SIPTA scheme, anticipated in IGMS;	Lack of technical capacity	Lack of managerial capacity	Lack of sufficient HRH	IP will support preparation of VU and EID labs for ISO accreditation. Provide training on laboratory standards, mentor and conduct assessment and provide laboratory auditor, method validation and verification training. IP will support regulatory body to have systems for lab verification and peer monitor surveillance for HIV rapid test kits and reagent test kits. It will provide technical assistance for GDE on the implementation of point of care testing for EID and HIV reagent testing.	COP19	COP23
\$300,000	ASP: HMIS, surveillance, & research/MSD	Non-Targeted Pop: Not disaggregated	Vital registration systems	17. Data for Decision-Making Ecosystem	4.17	-	14.2 Who Leads General Population Surveys & Surveillance: To what extent does the host country government lead and manage planning and implementation of the HIV/AIDS portfolio of general population epidemiological surveys and/or surveillance activities. (population-based household surveys, case reporting/critical surveillance, drug resistance surveillance, etc)?	Generation of evidence for cause and patterns of death among the general population with emphasis on HIV related mortality using VA as part of the national effort to enhance national level OHS implementation	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	As part of the OHS system improvement strategic plan, support the GDE effort to improve death registration including engagement of cause of death for adults, children and infants by using verbal autopsy as guided by the national VA implementation guideline with a focus on geographic areas where there are larger HIV treatment cohorts, priority/Micro planning wards and areas covered under the HIV GDE	COP22	Post COP25
\$50,000	ASP: HMIS, surveillance, & research/MSD	Non-Targeted Pop: Not disaggregated	Evaluation	14. Epidemiological and Health Data	4.12	-	14.8 Timeliness of Epi and Surveillance Data: To what extent is a timeline for the collection of epidemiologic and surveillance data outlined in a national HIV/AIDS surveillance and survey strategy for a national surveillance and survey strategy with specific for HIV?	Generation of local evidence on key PMCTC program outcomes to inform the annual HIV estimation and projection mainly on the MTCT rate and pediatric infection	Lack of Financial Resources	Lack of sufficient HRH	Lack of managerial capacity	GDE PMCTC program team will conduct PMCTC program outcome evaluation and produce information on key PMCTC outcome indicators which will be used as an input to the annual spectrum model based HIV estimation and projection. The activity includes the design, protocol development, data collection, analysis and report writing with a plan to disseminate the result	COP22	COP22
\$50,000	ASP: Policy, planning, coordination & management of disease control programs/MSD	Key Pop: Sex workers	Clinical guideline, policies for service delivery	6. Service Delivery	4.01	-	N/A	Quality score card is fully implemented at all IP sites. HIV services will be provided for free for STN / FOWs at all government ST sites.	Lack of technical capacity	Lack of managerial capacity	Lack of Financial Resources	Quality Scorecard Implementation to improve client satisfaction and IP program. Policy/Advocacy for free comprehensive HIV and STI services in public facilities	COP22	Post COP25

These tables contain information on the status of the research grants and the corresponding research projects. The status of the grants is based on the information provided by the researchers. The status of the research projects is based on the information provided by the researchers.

Proj. No.	Proj. Title	Proj. Status	Start Date	End Date	Funding Source	Proj. Type	Phase	Phase No.	Phase Name	Phase Start	Phase End	Phase Duration	Phase Description	Phase Lead	Phase Co-Lead	Phase Contact	Phase Status	Phase Progress	Phase Budget	Phase Actual	Phase Variance	Phase Comments	Proj. Status	Proj. Type	Proj. Phase	Proj. Start	Proj. End	Proj. Duration	Proj. Description	Proj. Lead	Proj. Co-Lead	Proj. Contact	Proj. Status	Proj. Progress	Proj. Budget	Proj. Actual	Proj. Variance	Proj. Comments
001	Project 1	Active	2023-01-01	2023-12-31	Funding Source 1	Research	Phase 1	1	Phase 1 Name	2023-01-01	2023-06-30	6 Months	Phase 1 Description	Lead 1	Co-Lead 1	Contact 1	Phase 1 Status	Phase 1 Progress	Phase 1 Budget	Phase 1 Actual	Phase 1 Variance	Phase 1 Comments	Proj. 1 Status	Proj. 1 Type	Proj. 1 Phase	Proj. 1 Start	Proj. 1 End	Proj. 1 Duration	Proj. 1 Description	Proj. 1 Lead	Proj. 1 Co-Lead	Proj. 1 Contact	Proj. 1 Status	Proj. 1 Progress	Proj. 1 Budget	Proj. 1 Actual	Proj. 1 Variance	Proj. 1 Comments
002	Project 2	Completed	2022-01-01	2022-12-31	Funding Source 2	Research	Phase 2	2	Phase 2 Name	2022-01-01	2022-12-31	12 Months	Phase 2 Description	Lead 2	Co-Lead 2	Contact 2	Phase 2 Status	Phase 2 Progress	Phase 2 Budget	Phase 2 Actual	Phase 2 Variance	Phase 2 Comments	Proj. 2 Status	Proj. 2 Type	Proj. 2 Phase	Proj. 2 Start	Proj. 2 End	Proj. 2 Duration	Proj. 2 Description	Proj. 2 Lead	Proj. 2 Co-Lead	Proj. 2 Contact	Proj. 2 Status	Proj. 2 Progress	Proj. 2 Budget	Proj. 2 Actual	Proj. 2 Variance	Proj. 2 Comments

## APPENDIX D– Minimum Program Requirements

<b>Care and Treatment</b>	
1) Adoption and implementation of Test and Start, with demonstrable access across all age, sex, and risk groups, and with direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across age, sex, and risk groups.	<b>Completed</b>
2) Rapid optimization of ART by offering TLD to all PLHIV weighing $\geq 30$ kg (including adolescents and women of childbearing potential), transition to other DTG-based regimens for children who are $\geq 4$ weeks of age and weigh $\geq 3$ kg, and removal of all NVP- and EFV-based ART regimens.	<b>Completed</b>
3) Adoption and implementation of differentiated service delivery models for all clients with HIV, including six-month multi-month dispensing (MMD), decentralized drug distribution (DDD), and services designed to improve identification and ART coverage and continuity for different demographic and risk groups.	<b>In-Process-</b> Ongoing activities will include greater focus on specific population
4) All eligible PLHIV, including children and adolescents, - should complete TB preventive treatment (TPT), and cotrimoxazole, where indicated, must be fully integrated into the HIV clinical care package at no cost to the patient.	<b>Completed</b>
5) Completion of Diagnostic Network Optimization activities for VL/EID, TB, and other coinfections, and ongoing monitoring to ensure reductions in morbidity and mortality across age, sex, and risk groups, including 100% access to EID and annual viral load testing and results delivered to caregiver within 4 weeks.	<b>In- process-</b> Diagnostic network optimization activities are a regular process with the Ethiopian Public Health Institute and other GoE entities. However, there are significant implementation challenges: -Supplies: Ensuring consistent, uninterrupted supplies for VL and EID testing -Maintenance: Ensuring regular maintenance of PCR and Gene XPert machines. This is being addressed by moving to an all-inclusive maintenance agreement with manufactures -Specimen referral network: This has largely been successful using the Ethiopian Postal Service. However, some areas remain difficult to reach. This is being addressed through the introduction of POC VL in select areas. -Specific populations: VL coverage lags for children, and in some areas, PBFW, especially. This is being addressed by introducing DBS and POC VL for those populations.
<b>Case Finding</b>	
6) Scale-up of index testing and self-testing, ensuring consent procedures and confidentiality are protected and assessment of intimate partner violence (IPV) is	<b>Completed</b>

<p>established. All children under age 19 with an HIV positive biological parent should be offered testing for HIV.</p>	
<p><b>Prevention and OVC</b></p>	
<p>7) Direct and immediate assessment for and offer of prevention services, including pre-exposure prophylaxis (PrEP), to HIV-negative clients found through testing in populations at elevated risk of HIV acquisition (PBFW and AGYW in high HIV-burden areas, high-risk HIV-negative partners of index cases, key populations and adult men engaged in high-risk sex practices)</p>	<p><b>In process-</b> The inclusion of AGYW, PWID, other high risk population groups as eligible population groups for PrEP is still in process, thus advocacy on some policy issues in expanding population groups for PrEP beyond FSW and DC (e.g., AGYW, PWID, other high risk population groups) and advocacy for models of PrEP delivery to address distance barriers/improve accessibility are priorities in COP22</p>
<p>8) Alignment of OVC packages of services and enrollment to provide comprehensive prevention and treatment services to OVC ages 0-17, with particular focus on 1) actively facilitating testing for all children at risk of HIV infection, 2) facilitating linkage to treatment and providing support and case management for vulnerable children and adolescents living with HIV, 3) reducing risk for adolescent girls in high HIV-burden areas and for 10-14 year-old girls and boys in regard to primary prevention of sexual violence and HIV.</p>	<p><b>In process-</b> Alignment done; testing, linkage to treatment, case management, and primary prevention of sexual violence and HIV are in progress. In conflict zones, plan for accelerated implementation if security access improves</p>
<p><b>Policy &amp; Public Health Systems Support</b></p>	
<p>9) In support of the targets set forth in the Global AIDS strategy and the commitments expressed in the 2021 political declaration, OUs demonstrate evidence of progress toward advancement of equity, reduction of stigma and discrimination, and promotion of human rights to improve HIV prevention and treatment outcomes for key populations, adolescent girls and young women, and other vulnerable groups.</p>	<p><b>In process</b> - U=U communication strategy and training manual were developed; U=U initiative was launched and being implemented throughout the county; regional level U=U messaging adaptation using local languages was done and the U=U messaging is being transmitted through different media platforms including facility level patient education; U=U concept was integrated into the national consolidated ART guideline; and capacity building trainings have been provided to HCWs and media personnel. Currently, additional job aid is under development to ensure integration of U=U messaging into facility level HIV prevention and care services.</p>
<p>10) Elimination of all formal and informal user fees in the public sector for access to all direct HIV services and medications, and related services, such as ANC, TB, cervical cancer, PrEP, and routine clinical services affecting access to HIV testing and treatment and prevention.</p>	<p><b>Completed</b></p>
<p>11) OUs assure program and site standards, including infection prevention &amp; control interventions and site safety standards, are met by integrating effective Quality Assurance (QA) and Continuous Quality Improvement (CQI) practices into site and program management. QA/CQI is supported by IP work plans, Agency agreements, and national policy.</p>	<p><b>In process:</b> CQI included in National IPC policy and strategy, for health facilities to conduct IPC QI projects and ensure CQI in IPC practice. QI training on IPC program provided, baseline assessment conducted, results analyzed regularly and used for facility quality improvement operational plan. Then IPC projects' implementation status is monitored by facility and regional IPC and QI focal persons using color coded standard IPC monitoring tools. Scaling up of these CQI experiences to additional 101 facilities (in 5 regions) through ARPA funding is ongoing. In FY 23, there is a plan to execute QA and CQI for IPC</p>

program support using the updated SIMS tool (incorporating CEEs for IPC activities).

The COVID-19 pandemic in Ethiopia presents multiple challenges to maintaining and strengthening HIV care and treatment services. The initial response to COVID-19 was difficult to coordinate for a variety of factors, including the absence of a dedicated infection prevention and control (IPC) unit at national (MoH) and regional health bureaus, non-functional IPC committees in most health facilities, fear of transmission in health facilities both by providers and clients, and government-imposed restrictions in public transportation. Key program support activities including training, mentorship and supportive supervision have also been significantly affected. Additional major threats to the continuity of HIV services include shortage of health care workers (absence from work and assignment in other COVID-19 specific activities), reduced patient flow, disruptions in supply chain of key commodities, and shortage of IPC commodities (PPEs, disinfectants, etc.). In addressing the above challenges, HIV program resources have been redirected to strengthen national and regional level IPC program management, prevent facility level transmission of COVID-19, and promote health worker screening and safety. IPC program support activities have helped to revitalize the national IPC technical working group, re-establish and invigorate health facility IPC committees, fill procurement gaps of key IPC commodities (e.g., gloves, masks, and disinfectants), and introduce screening and triage activities to reduce the risk of transmission of respiratory infections. Technical assistance has been provided to establish a dedicated IPC unit at the MOH and to define and implement a comprehensive package of IPC interventions in the context of COVID-19- at selected high-volume facilities.

Subsequent resource mobilization efforts have generated funding from a variety of sources, including the CDC COVID-19 International Task Force, CDC Foundation, and the U.S. CARES and ARPA legislation. These diverse funding sources have been coordinated to support a wide range of IPC program capacity strengthening activities, including IPC policy, strategy and roadmap development, personnel support for the MoH IPC program unit, capacity strengthening training, and implementation of a standardized IPC package at health facilities. The most robust IPC activities, including source control and triage, inpatient isolation and quarantining, health care worker screening for COVID-19, bidirectional TB/COVID-19 screening, and robust M&E and CQI efforts, have been implemented at 27 high volume facilities in FY21 and FY22, with plans to scale up to an additional 100+ facilities in the rest of FY22. In total, these facilities provide treatment to over half of the HIV treatment cohort

COP22 planning to continue strengthening IPC programs and activities include a focus on supporting IPC program management leadership at MoH, developing a national IPC M&E system, and establishing an IPC certification program to generate IPC professionals. These activities are designed to improve the sustainability of IPC activities, which will require attention to continue to be strengthened regardless of the trajectory of the COVID-19 pandemic. PEPFAR resources will support Regional Health Bureau program management, maintain facility IPC committee functions and facility preparedness, and broaden the focus of IPC activities to include the prevention of transmission and containment of health care associated Infections



	(HAIs), including influenza, TB, and other emerging infectious diseases.
12) Evidence of treatment literacy and viral load literacy activities supported by Ministries of Health, National AIDS Councils and other host country leadership offices with the general population and health care providers regarding U=U and other updated HIV messaging to reduce stigma and encourage HIV treatment and prevention.	<b>In process-</b> U=U communication strategy and training manual were developed; U=U initiative was launched and being implemented throughout the county; regional level U=U messaging adaptation using local languages was done and the U=U messaging is being transmitted through different media platforms including facility level patient education; U=U concept was integrated into the national consolidated ART guideline; and capacity building trainings have been provided to HCWs and media personnel. Currently, additional job aid is under development to ensure integration of U=U messaging into facility level HIV prevention and care services.
13) Clear evidence of agency progress toward local partner direct funding, including increased funding to key populations-led and women-led organizations in support of Global AIDS Strategy targets related to community-, KP- and women-led responses	<b>Not started</b> - There is no formal KP association in Ethiopia to design KP led community activities and involve KP leaders due to legal and policy barriers. But KP are actively involved in KP programs as peer educators, navigators, and ambassadors
14) Evidence of partner government assuming greater responsibility of the HIV response including demonstrable evidence of year after year increased resources expended	<b>In process:</b> The HIV DRM strategy is reviewed by House of People's representatives and awaiting Parliament approval
15) Monitoring and reporting of morbidity and mortality outcomes including infectious and non-infectious morbidity.	<b>In process:</b> Concept note developed for mortality surveillance (MS) among PLHIV. Consultative workshop, protocol development, initiation in selected facilities, death, and CoD (using VA) improvement support for CRVS in MoH in COP22 in selected urban areas
16) Scale-up of case surveillance and unique identifiers for patients across all sites.	<b>In process:</b> Expansion to reach more than 997 facilities including community sites in COP22 with goal to reach all testing sites; scale-up longitudinal CBS; RITA expansion, strengthen public health response; support HIV FETP track

# APPENDIX E – Assessing Progress towards Sustainable Control of the HIV/AIDS Epidemic

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## 1. Misalignments between Investments and Outcomes

PEPFAR-E funds prevention, care, and treatment activities implemented at facility and community sites, as well as cross-cutting activities in the laboratory, strategic information, supply chain management and other above site activities. Historically, support for health systems strengthening (HSS) has included efforts to expand the health workforce through pre-service training, the implementation of Ethiopia's Pharmaceutical Logistics Master Plan, the Laboratory Master Plan, the Health Management Information System Scale-up, Health Sector Financing Reform and Health Insurance, Hospital Reform Implementation Guidelines, and the Human Resources for Health (HRH) strategy. The private healthcare sector is nascent, but it has the potential to be a valuable supplement to the public sector, especially when the public sector looks to private practice as a means of retaining employees.

Starting in 2014, PEPFAR began transitioning the full care and treatment portfolio [OS(A)1] to the Ethiopian government, providing funding to eight of the 11 Regional Health Bureaus (RHBs) and one international NGO to provide technical assistance. Moreover, the community-based HIV programs including OVC, KP and care and treatment programs are being transitioned to local implementing partners / LIPs by having direct funding and putting in place technical assistance provision to these LIPs starting in 2018.

At COP22, PEPFAR-E will continue to support the national HIV control program of the Government of Ethiopia (GOE) to reach and sustain HIV epidemic control by focusing on direct service delivery (DSD) support in six priority regions, including Tigray recovery interventions and strengthening critical systems nationally. With a focus on sustainability, as epidemic control is obtained, PEPFAR-E will continue to evolve its programmatic focus, emphasize support for above-site technical assistance (TA), and increase partnerships with local entities. Government entities will be strengthened to better lead the HIV response, maintain gains made to date, and develop appropriate transition plans where needed. Regional health bureaus will have their leadership capacity strengthened for coordination of regional responses and will work closely with civil society organizations (CSOs), urban health extension workers (UHEWs), and community partners to strengthen community-facility linkages, find remaining PLHIV not in care, and provide essential preventive services to orphans and vulnerable children (OVC).

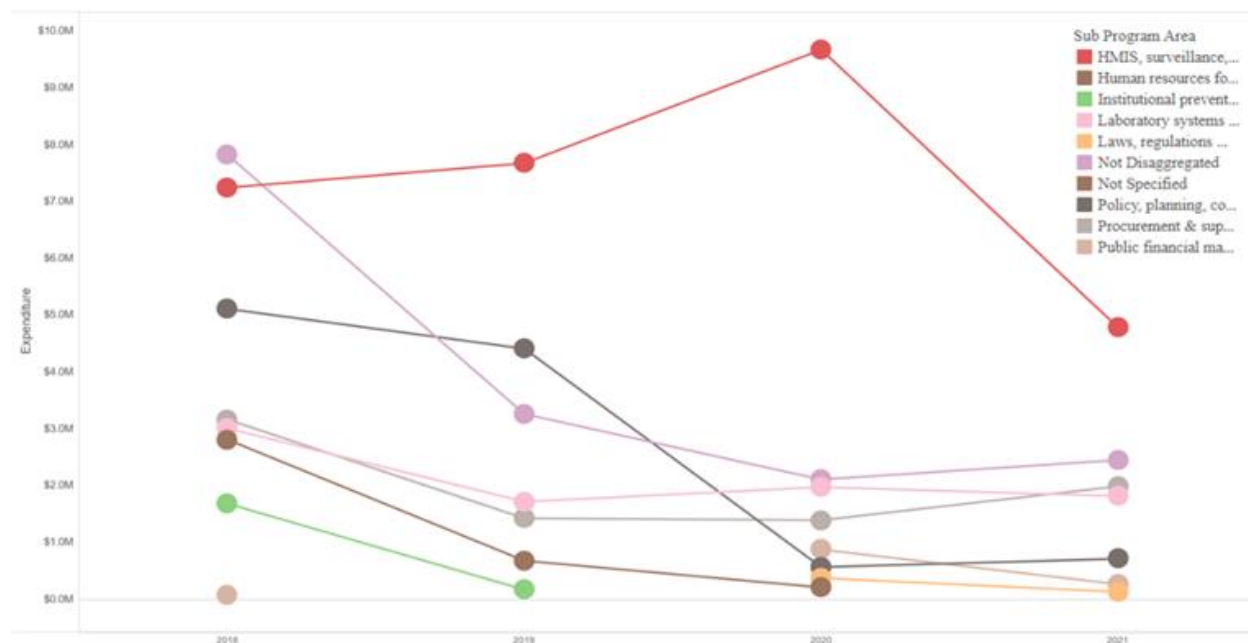
- ***Program Expenditures vs. SID Score Trends and Responsibility Ratings:***

SID2021 was not conducted because of the COVID influence for in person exercise, and the host government was also focused on the mitigation and responses to the conflict happening in the country. Currently, comparison of systems-related (above site programs) expenditures and changes in relevant SID scores including 2021 over time might not be possible.

However, commodities and above site activities [OS(A)2] are two areas where there is significant resource mismatch or gaps, and these program areas are critical for epidemic management. Continuous sustainability assessments involving key stakeholders will be crucial, and PEPFAR-

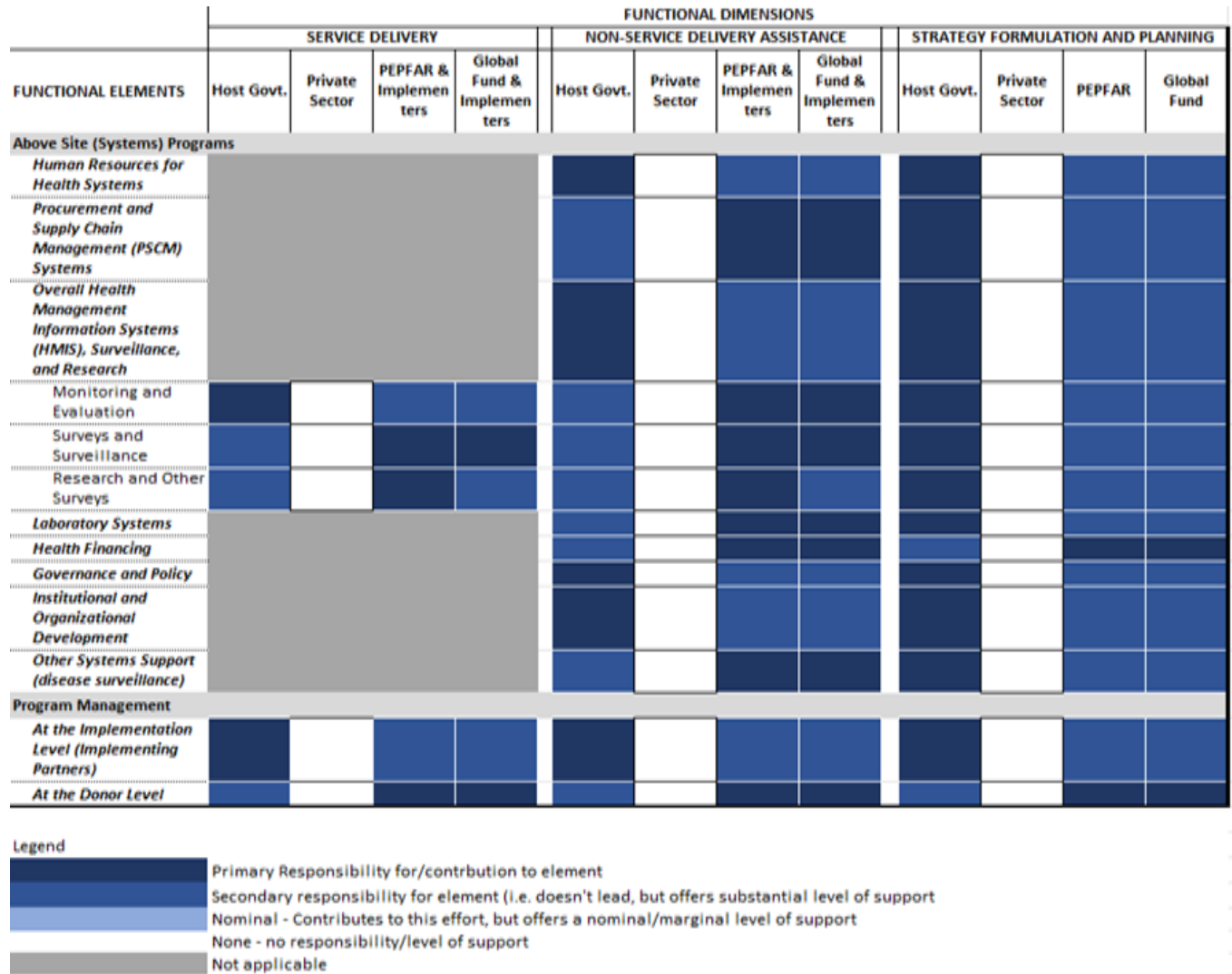
E will continue to work with the Government of Ethiopia and other stakeholders to align and use available resources optimally, as well as mobilize domestic resources. Trends in systems-related (above site programs) expenditures are stabilized but further assessment is required to understand the current sustainability situation.

**Figure E.1.1. Trends in Investments and SID Scores for System-Related Elements**



The Government of Ethiopia (GOE) has been assigned primary responsibility for most functional elements of the RM. In comparison to PEPFAR and the Global Fund, the GOE provides a smaller proportion of direct HIV-specific financial contributions to the national HIV/AIDS response, but they play a crucial role in the implementation of direct and non-direct delivery of services and overall strategic leadership. Specifically, while the USD amount is not accurately quantified on-budget for HIV control, the GOE provides the bulk of the service-delivery and non-service-delivery workforce and all the physical infrastructure for facility-based clinical services across the cascade, laboratory systems and services, and disease surveillance and response. This fact automatically situates GOE in a primary role in service delivery and many non-service delivery aspects of the RM. PEPFAR and the Global Fund share primary and secondary responsibility with GOE across all elements, with few observed as having nominal or no role. A few elements were assessed as having a nominal or no role. In general, the HIV/AIDS response in Ethiopia remains highly reliant on PEPFAR and Global Fund presence and contributions.

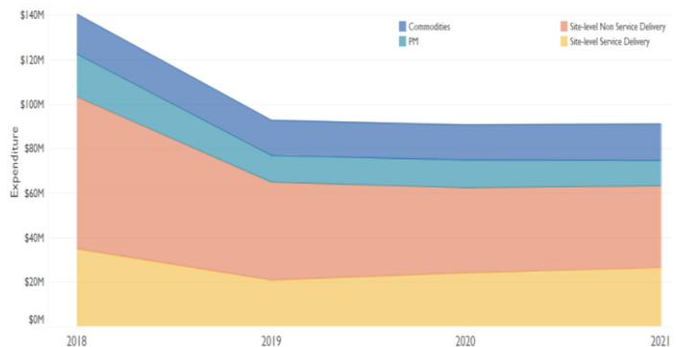
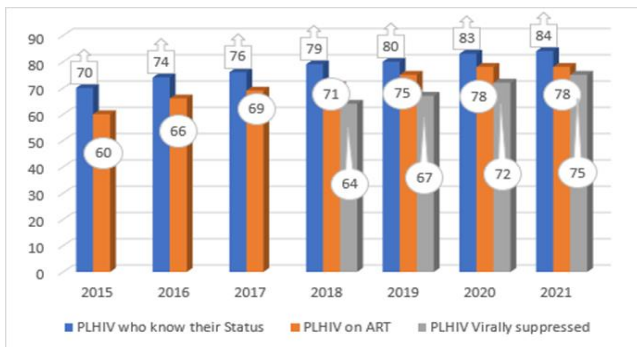
**Figure E.1.2. Percent Primary Responsibility Ratings from Responsibility Matrix**



- **Trajectory of Service Delivery, Commodities, Non-Service Delivery, Above Site Program, and Program Management Expenditures and Country’s Status of Achieving HIV/AIDS Epidemic Control:**

Trends in service delivery, commodities, non-service delivery, above-site programs, and program management spending have stabilized in FY21. This is expected to continue in COP22 while the program is geared towards maintaining gains nationally with a focus on the recovery of conflict-affected areas. The program data indicates that the OU is progressing well towards the second two 90’s/95’s.

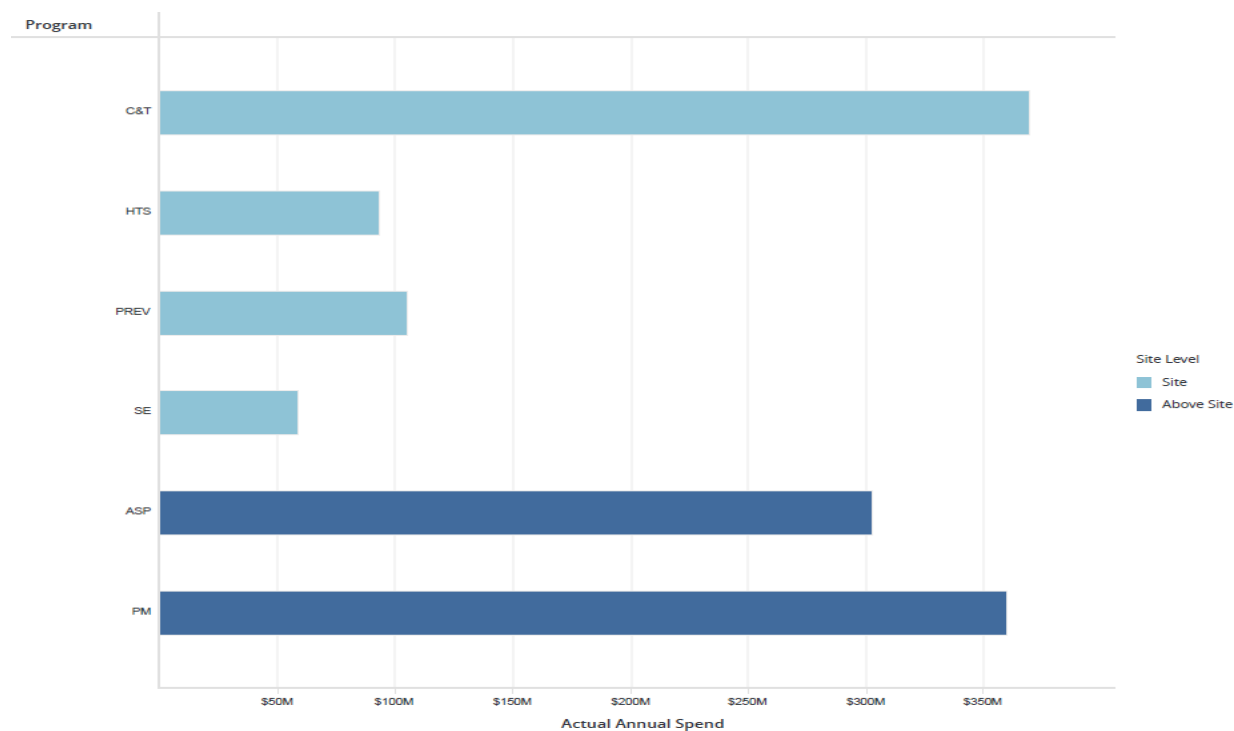
**Figure E .1.3. Assessing PEPFAR Ethiopia Expenditure Trends by Interaction Type and Epidemic Control status**



- ***HRH Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery:***

To strengthen the sustainability of HIV services, MOH is responsible for most human resources for health (HRH) at site and above-site levels. PEPFAR-E’s support for HRH is designed to supplement identified program gaps and to support specific needs in case finding, linkage to treatment, treatment continuity, and viral load suppression. PEPFAR-E’s support for HRH is focused on strengthening the community-facility collaboration and program data quality and is placed in sites and SNUs which will have the greatest impact on HIV epidemic control. The remuneration analysis shown in Figure E.1.4 shows that the majority of site level support is dedicated to supporting Care & Treatment activities. Data on MOH expenditures for HRH is limited. PEPFAR-E will work to support HRH at direct service delivery levels where the need is greatest in delivering HIV services, mainly to strengthen continuity of care. Most of the investment in staff at the site level support went toward care and treatment.

**Figure E.1.4. Remuneration by Site/Above Site & Service Delivery/Non-Service Delivery**



**2. Areas for Transition**

Starting in 2014, PEPFAR-E began transitioning the full care and treatment portfolio to the Ethiopian government, providing funding to eight of the 11 Regional Health Bureaus (RHBs) and one international NGO to provide technical assistance.

The HIV program in Ethiopia is already largely directed and implemented by the government of Ethiopia and its health agencies. The implementation model for site-level services, above-site monitoring, and multiple levels, and coordinated planning and program review has been designed with sustainability as a guiding principle. GoE agencies at federal and regional levels are the primary implementing partners for HIV clinical services, laboratory, and information systems. Local implementing partners are the primary implementing partners for community-based activities and work closely with local governments i.e. regional health bureaus. MOH-led national technical working groups and regional support teams reinforce the collaborative approach to the HIV program and strengthen the capacity of the host government to take on increasing responsibility for the program.

This approach will continue in COP22, with a notable transition in response to the emergence of two new regions in recent years, the Sidama and South-West Ethiopia

regions. These regions were previously supported through a cooperative agreement with the region they were previously included in. This support will now be provided by FMOH and other federal agencies in a similar model as for other regions that do not receive direct support from PEPFAR.

### **3. Engagement with Partner Country Governments in COP22 to Ensure Sustainability of Core Elements of the HIV Response**

As described in Section 2, the HIV program implementation model has been designed for sustainability, with GoE and its health agencies already responsible for most HIV clinical services. Similarly, the GoE has a central and increasing role in the necessary systems to sustain HIV epidemic control.

Surveillance systems, including HIV case surveillance, HIV drug resistance surveillance, and planned mortality surveillance, are all the responsibility of the Ethiopian Public Health Institute, with PEPFAR-E providing technical and resource assistance.

Laboratory systems at the federal, regional, sub-regional, and site level are similarly structured under the Ethiopian Public Health Institute and regional public health institutes.

Supply chain systems including quantification, procurement, warehousing, and distribution fall under the mandate of the Ethiopian Pharmaceutical Supply Service (EPSS). Pharmaceutical service provision to ensure uninterrupted supply of quality, affordable, and accessible pharmaceutical products to improve the health care service is overseen by the Ministry of health and regional health bureaus. PEPFAR-E provides technical assistance to MOH, EPSS, including its nineteen branches throughout the country, regional health bureaus and health facilities to ensure uninterrupted supply of commodities.

Information systems are being transitioned to greater responsibility and management under the GoE. The patient-level electronic medical record (EMR) is planned for transition to an openMRS model that will be managed by the GoE. This transition will improve interoperability of different modules across the health information systems.

### **4. Agreements and plans on Data Use and Sharing and Quality control (including Central Support reporting).**

PEPFAR-supported HIV/AIDS program implementation, monitoring, and evaluation are achieved in collaboration with the government and community counterparts. MER and DHIS2 data will be used for the purpose of the HIV/AIDS country's operational plan and, subsequently, for performance review and quality improvement. There is a regular review by the interagency team on the performance of the different HIV program components based on the reports received from the respective health facilities, communities, and other partners. The PEPFAR country team ensures that there is a data-driven quarterly HIV/AIDS program review by all stakeholders with a focus on the progress towards the 95-95-95 targets. The regular data-driven

review as interagency and among diverse stakeholders ensures that there is a regular data sharing mechanism and transparency in HIV/AIDS program review. Similarly, the government organizes annual and semi-annual review meetings to gather and discuss overall national performance and policy issues. Surveillance data is also collected through different systems, is also de-identified and is used for program response at an aggregate level. Surveys that are supported by USG are implemented by the respective protocol data sharing agreements.

The interagency team also conducts need-based quality control visits at health facilities and community sites to explore issues that cannot be articulated with the routine reports that include reviewing data quality, program quality, and quality of care. During the COVID-19 outbreak and conflict situations, minimum service quality guidance, such as a minimum service package, and implementation monitoring support were provided. Every SIMS assessor is required to sign a confidentiality agreement. An agreement should be given to the assessed health facility or the facility head. This result data is also presented at an aggregate level by de-identifying the health facilities. Efforts are underway by PEPFAR PMDAT with the MOH team on indicator mapping, facility reconciliation (MOH-MFL), MOH data import and data review with the objective of deriving PEPFAR data directly from the MOH system and reducing duplicative data entry and parallel reporting structures, thereby strengthening MoH systems to effectively monitor and maintain epidemic control and facilitate systems interoperability. Data from the health facility is imported only using the unique IDs of the health facility and indicator codes. Annual HIV estimations and projections are other platforms being used to bring available data together, review the quality, and produce results for planning and resource allocation. Demographic and program data that are used for the estimation are always endorsed by the National Technical Working Group at every stage.

However, a standardized approach to data use, sharing, and quality control with government structures and other key stakeholders is lacking. There are also significant data quality problems and limitations in continuous data quality control practices. There are also limitations to accessing aggregate-level data from government systems.

PEPFAR-E will work with the government to institute plans and procedures to ensure timely data use, share data between PEPFAR and the government as well as other concerned stakeholders, and strengthen data quality control systems.