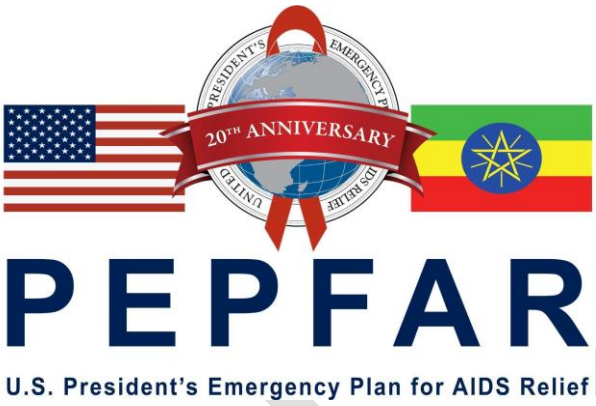

PEPFAR Ethiopia
Country Operational Plan (COP) 2023
Strategic Direction Summary
23 May 2023

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Acronym List

Acronym	Definition
AACAHB	Addis Ababa City Administration Health Bureau
ABYM	Adolescent Boys and Young Men
AGYW	Adolescent girls and young women
AHD	Advanced HIV Disease
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretrovirals

C/ALHIV	Children and Adolescents Living with HIV
CADRE	Cyclical Acquired HIV Drug Resistance
CBS	Case Based Surveillance
CDR	Central Data Repository
CLHIV	Children Living with HIV
CLM	Community-Led Monitoring
COP	Country Operational Plan
CQI	Continuous Quality Improvement
CRVS	Civil Registration and Vital Statistics
CSCS	Capital Security Cost Sharing
CSO	Civil Society Organization
CXCA	Cervical Cancer
DBS	Dried Blood Spot
DHIS2	District Health Information Software 2
DICs	Drop In Centers
DSD	Differentiated Service Delivery
DTG	Dolutegravir
eCHIS	Community Health Information System
EID	Early-infant diagnosis
EMRs	Electronic Medical Records
EOCs	Emergency Operation Centers
EPHI	Ethiopian Public Health Institute
ETORRS	Electronic Test Ordering and Result Reporting System
FETP	Field Epidemiology and Laboratory Training
FSWs	Female Sex Workers

GBV	Gender-Based Violence
GOE	Government of Ethiopia
HCWs	Healthcare workers
HEI	HIV Exposed Infants
HIS	Health Information System
HIVST	HIV Self Testing
HMIS	Health Management Information System
HRH	Human Resources for Health
HTS	HIV Testing Services
IBBS	Integrated HIV bio-behavioral survey
ICT	Index Case Testing
IP	Implementing Partner
IPV	Intimate Partner Violence
IRCE	Inter Religious Council of Ethiopia
KPs	Key Populations
LIPs	Local Implementing Partners
LMIS	Logistics Management Information System
M&E	Monitoring and Evaluation
MARPs	Most At Risk Populations
MHPSS	Mental Health Psychosocial Services
MMD	Multi-Month Dispensing
MOH	Ministry of Health
MTCT	Mother to Child Transmission
OOS-AGYW	Out of School and Vulnerable Adolescent Girls and Young Women
OTZ	Operation Triple Zero

OVC	Orphans and Vulnerable Children
PBFW	Pregnant and Breastfeeding Women
PEP	Post-Exposure Prophylaxis
PEPFAR-E	PEPFAR-Ethiopia
PITC	Provider-Initiated Testing and Counseling
PLHIV	People Living with HIV
PMIS	Pharmaceutical Management Information System
PMTCT	Prevention of Mother to Child Transmission
PPs	Priority Populations
PrEP	Pre-exposure prophylaxis
PWID	People Who Inject Drugs
REDCap	Research Electronic Data Capture
RHB	Regional Health Bureau
SDPs	Service Delivery Points
SGBV	Sexual and Gender Based Violence
SIMS	Site Improvement through Monitoring System
SRH	Sexual and Reproductive Health
TA	Technical Assistance
TB	Tuberculosis
TPT	Tuberculosis Preventive Therapy
TWG	Technical Working Group
UDS	Unified Data System
VIA	Visual Inspection with Acetic Acid
VL	Viral Load
VMMC	Voluntary Medical Male Circumcision

Vision, Goal Statement and Executive Summary

PEPFAR-Ethiopia (PEPFAR-E) has progressed well towards reaching 95-95-95 targets despite facing a COVID-19 epidemic, armed conflict, the worst drought in 40 years, multiple infectious disease outbreaks, widespread food insecurity, and other humanitarian crises across the country.

Country operational plan (COP) 23 provides an opportunity to anchor PEPFAR-E programming in the PEPFAR 5X3 strategy by collaborating with the MOH, civil society organizations (CSOs), and multilateral organizations to progress toward reaching the 95-95-95 targets by 2025. Built around the PEPFAR 5x3 strategy, PEPFAR-E's COP23 goals focus on Recovery of HIV services and the ART cohort in conflict affected areas, Attainment of 95-95-95 targets, and Sustaining the progress and advancing sustainability of PEPFAR programs (RAS). RAS is an important Ethiopian word that gives additional emphasis to this framework. In Ethiopian culture, *Ras* refers to the head of a council or program. The symbolism of RAS is strong: PEPFAR-E will assist the MOH in leading the HIV response as it moves into its next phase. Ensuring equity in access to quality HIV services underpins these focus areas. To achieve this equity, PEPFAR-E will meaningfully engage with the MOH, CSOs, PLHIV, and youth associations, at all levels to assure access for all.

Recovery:

Over the course of the last three years, armed conflict in the Tigray, Amhara, Afar, Oromia, and Benishangul-Gumuz regions has decimated much of the healthcare system infrastructure in these regions, interrupted HIV services for tens of thousands of people living with HIV (PLHIV), and increased HIV vulnerability through gender-based violence (GBV). In COP23, PEPFAR-E, in partnership with the MOH and community implementing partners (IPs), will work collaboratively to restore HIV services and bring back the HIV cohort to treatment in conflict affected areas in Afar, Amhara, Benishangul and Gumuz, Oromia, and Tigray. The cessation of hostilities agreement signed in October 2022 between the Government of Ethiopia (GOE) and the Tigrayan Peoples' Liberation Forces represents an opportunity to bring 42,000 PLHIV back into treatment in Tigray.

In country operational plans (COP) 21 and COP22, PEPFAR-E in collaboration with regional health bureaus (RHBs), the Ministry of Health (MOH), and other implementing partners (IPs)—together were able to bring most of the HIV treatment cohort back to care in Amhara and Afar - 25,968 PLHIV - 99% from Amhara and one percent from Afar. The lessons learned from implementing a joint community and facility model to bring PLHIV back to care in Amhara and Afar will be applied to other conflict affected areas to continue the restoration of HIV services in COP 23. This will contribute to both the first and second 95s, and restoration of the laboratory services and renewed viral load testing will contribute to the third 95. Additionally, services for GBV will be scaled up.

Service delivery in these areas will be difficult as many PLHIV have faced or continue to face an array of hardships; thus PEPFAR-E will work with the respective MOH facilities and community partners to reach PLHIV and those who have been impacted by GBV. The recovery effort aligns with PEPFAR 5x3 strategies, including reaching and sustaining epidemic control by restoring services in conflict-affected areas, providing services for HIV priority populations, and strengthening public health systems while leveraging community leadership. PEPFAR will

develop and maintain partnerships with local and international partners, including the private sector, to rehabilitate the healthcare system in these conflict-affected areas.

Attain:
In COP23, PEPFAR-E will focus on children, adolescents, youth, and key and priority populations (KPs/PPs), to improve equitable access to quality HIV services. PEPFAR-E will collaborate with MOH and community partners at national and regional levels to close the gaps in reaching 95-95-95 targets. There will be new initiatives at the national level to accelerate case finding and pediatric initiatives to identify CLHIV and link them to care.

Specific focus will be on the first 95 – case finding. Pediatric case finding is the most critical gap in the national program. According to the Spectrum model, which relies on imperfect ANC data, only 38% of children under 15 years old living with HIV know their status and are receiving ART. PEPFAR-E will expand its ANC sentinel sites to improve these estimates. The pediatric/adolescent program will continue to leverage the community/facility coordination, scale up pediatric case finding strategies, and strengthen referrals to and from the orphans and vulnerable children (OVC) program.

Focus will also be on case finding in key populations. In addition to intensified programming for FSWs and high-risk youth, developing programs for people who inject drugs (PWID) and prison populations will address gaps in case finding.

For the second 95, the focus will be on improved linkage between community and facility services, especially for children and KPs. For the third 95, the focus will be on improving viral load coverage for all age groups but especially for children where coverage is only 79% as well as improving viral load suppression (VLS) which is at 91%.

Sustain:
Effective implementation of the HIV program requires a continued focus on assuring quality services implemented through MoH facilities and community led programming as well as strengthening laboratory services, strategic information systems, supply chain management, and governance systems. Ethiopia is in a unique position of having a competent health workforce with the majority of PLHIV patients receiving services in MoH implemented programs that receive direct funding from PEPFAR.

To improve the quality of life for PLHIV on treatment, PEPFAR-E will support monitoring and documentation of antiretroviral therapy (ART) optimization, retention and sustaining viral load gains among clients on ART, strengthening treatment ART failure management, and provision of advanced HIV disease package trainings as well as introducing integration of care for non-communicable diseases (NCDs). Integration of services for HIV and NCD will enable the health system to expand coverage to improve Ethiopians' quality of life. The integration of HIV and NCD services including screening of hypertension and diabetes started as a pilot in COP22 in ten high case-load health facilities, and in COP23, the activities will be expanded to other facilities. Integration of NCD in service delivery has also been initiated in 50 selected community level service delivery points and will be scaled up in COP23. The program will emphasize equity for all

seeking services regardless of age, gender, or sexual orientation.

To end HIV/AIDS as a global public health threat by 2030, it is critical that PEPFAR supported HIV-response investments and activities are aligned with the unique situation in Ethiopia. The engagement of the MOH and CSOs at the Johannesburg meeting was encouraging and assures that together, we will chart a successful course for operationalizing the PEPFAR 5 x 3 Strategy that will help Ethiopia to achieve the 95-95-95 HIV treatment targets by 2025 as well as provide a strong public health infrastructure that can be leveraged to tackle current and emerging disease threats.

PEPFAR-E will align its activities with the new 5 x 3 strategy as follows:

Strategic Pillar 1: Health Equity for Priority Populations

- Focus on reducing persistent inequalities experienced by KPs, children, OVC, adolescent girls, young women, and gender-based violence (GBV) survivors. Closing the gap along the three 95s for key and priority populations through high quality population tailored services and approaches. According to 2022 spectrum estimates, PLHIV under 25 years in Ethiopia are falling below the second 95 target. Case finding, linking and retaining these priority populations to treatment, and viral load coverage remains low as well.

Strategic Pillar 2: Sustaining the Response

- Continue to support a transition to the MOH, local partners, and community-led integrated HIV programming aligned with MOH HIV strategies at all levels. This will include continued advocacy for the inclusion of local partners at national and regional levels in joint review and planning of the HIV response and continued capacity building of CSOs/local implementing partners (LIPs).

Strategic Pillar 3: Public Health Systems and Security

- Optimize supply chain and commodity security focusing on strengthening the pharmaceutical system at service delivery points that includes the logistics management information system (LMIS), pharmaceutical management information system (PMIS), and rational use of antiretrovirals (ARVs).
- Strengthen patient-level information systems via Electronic Medical Record (EMR) modules for enhanced use of patient level de-identified data at health facility, regional, and national levels, and establish data exchange between EMR and disparate information systems like Laboratory, Pharmacy, Surveillance, Master Patient Index (MPI) and aggregate reporting systems (DHIS2).
- Strengthen the implementation of health information system components, such as the District Health Information Software 2 (DHIS2), Community Health Information System (eCHIS), facility logistics management information system, and decision support systems, to ensure timely and complete HIV program reporting.

- Collaborate with EPHI in the implementation of HIV Case Based Surveillance (CBS) via strengthening and standardizing the HIV CBS information system including the real time HIV CBS data analytics using Power BI and automation of the record matching using Master patient Index (MPI)
- Expand the Central Data Repository (CDR) at Addis Ababa to a National Data Repository (NDR) at MOH to securely bring together individual-level, longitudinal HIV treatment cohort data in the form of a NDR for appropriate in-country programmatic use and curated de-identified data sets for advanced data analysis.
- Strengthen community case finding and healthcare worker capacity to support health security emergency preparedness, disease surveillance, and community engagement priorities.

Strategic Pillar 4: Transformative Partnerships

- PEPFAR-E will explore partnerships with private sector organizations to leverage existing platforms to increase access to HIV information, products, and services for the most vulnerable populations at the facility and community level.
- PEPFAR-Ethiopia intends to target both health related organizations, including but not limited to private health facilities as well as pharmaceutical and medical device companies, and organizations with corporate social responsibility or social business programming that aligns with PEPFAR programming (e.g. Mastercard Foundation).
- PEPFAR-E will also seek to leverage different business services and business collaborations such as Ethio Telecom/ Safaricom, the American Chamber of Commerce, and Rotary International. PEPFAR-E will engage with the Public Affairs Section to identify ways to leverage USG supported activities, e.g. music festivals, or to facilitate aligning with other major events in the country, like the annual Great Ethiopian Run.
- PEPFAR-E will look to increase collaboration with technical institutions by inviting them to participate in and lead dialogues that help set key priorities more actively for Ethiopia's HIV/AIDS response. PEPFAR-E will work with these agencies to align our efforts with overarching public health priorities.

Strategic Pillar 5: Follow the Science

- PEPFAR-E will collaborate closely with government counterparts and implementing partners to intentionally expand and scale up evidence-based interventions, such as differentiated service delivery models to increase HIV treatment uptake and adherence at the facility and community levels.
- PEPFAR-E will continue to strengthen the quality of HIV services through the implementation of data quality assurance and quality improvement methods for HIV testing, ARV treatment, viral load monitoring, PMTCT, and HIV case-based surveillance (CBS) programs at both facility and community levels.
- PEPFAR-E will work with government counterparts to expand and strengthen case surveillance.
- PEPFAR-E will use patient-level data and longitudinal case surveillance to assess outcomes.

Enabler 1: Community Leadership

- Continue to support local partner led community programming through capacity building of youth-led community-led monitoring programs.
- Strengthen community feedback loops for HIV programming by sharing data with community, MOH, and implementing agencies and advocating for change by community partners on a quarterly basis.
- Prioritize youth in the design, implementation, monitoring, and evaluation of community led monitoring activities for HIV programming.

Enabler 2: Innovation

- Leverage facility and community programs to identify HIV service delivery and product innovation opportunities.

Enabler 3: Leading with Data

- Prioritize improving HIV data quality through digitization of health information systems and strengthening interoperability among systems, particularly between community and facility levels.

Table 1.1 95-95-95 cascade: HIV diagnosis, treatment, and viral suppression*

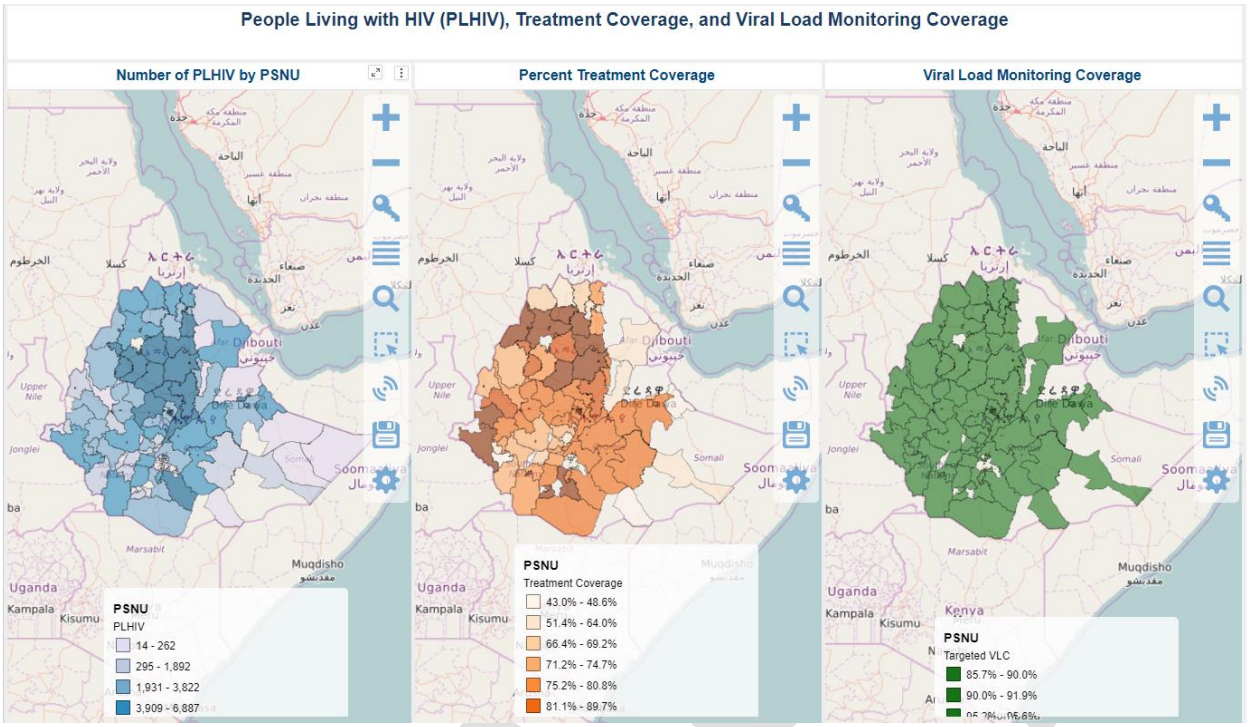
Epidemiologic Data					HIV Treatment and Viral Suppression			HIV Testing and Linkage to ART Within the Last Year		
	Total Population Size Estimate (#)	**HIV Prevalence (%)**	**Estimated Total PLHIV (#)**	**PLHIV Diagnosed (#)**	**On ART (#)**	**ART Coverage (%)**	**Viral Suppression (%)**	**Tested for HIV (#)**	**Diagnosed HIV Positive (#)**	**Initiated on ART (#)**
Total population	7107,799,336	NA	603,537	505,595	461,494	76.5	96	7,257,031	36,893	*31,254*
Population <15 years	42,472,378	NA	33,026	NA	12,916	39.1	91	527,834	1,793	*1,650*
Men 15-24 years	11,236,211	0.22	24,258	189,691**	12,550	51.7	94	749,086	1,988	*1,165*
Men 25+ years	21,285,746	0.67	193,592		149,410	77.2	97	1,084,455	11,314	*9,410*

Women 15-24 years	11,050,386		33,145	315,905**	20,559		93	2,419,102	5,530	*4,363*
Women 25+ years	21,754,616		319,517		263,029		96	2,476,554	16,268	*14,666*
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	*NA*
FSW	252,199	18.7	47,157	NA	9,919	NA	97	99,998	5,471	*4,012*
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	*NA*
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	*NA*

*These should be national data; if the data do not exist, PEPFAR data may be used if relevant.

**Prevalence data available for 15+ age groups.

Source: Target Setting tool



Source: PEPFAR Panorama Workspace

Figure 1.1; Total PLHIV by SNU, coverage of total PLHIV with ART, and viral load coverage by SNU

Table 1.2 Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP23	# Current on ART (FY22)	# of SNU COP22 (FY23)	# of SNU COP23 (FY24)
Attained	557,855	429,150	794	141
Scale-up: Saturation	NA	NA	NA	NA
Scale-up: Aggressive	NA	NA	NA	NA
Sustained	39,727	21,370	36	23
Central Support	NA	NA	NA	Na
No Prioritization (Military)	NA	7,796	1	1
Total National	597,582	458,316	831	165*

*Target setting level in COP23 (FY24) changed from woreda to zone and the PSNU number reduced from 831 to 165 including military

Pillar 1: Health Equity for Priority Populations

Plan to Close Gaps in the Pediatric Cascade

Though Ethiopia has made significant progress in provision of ART services for adults, there is still a significant gap in treatment coverage and viral suppression among children and adolescents living with HIV (C/ALHIV). The COP23 PEPFAR 5X3 strategy stipulates that this population group requires special attention to address existing equity gaps and achieve the 95-95-95 targets. The COP23 PEPFAR-E plan will focus on closing the performance gaps across the pediatric and adolescent cascade particularly with regard to enhancing case finding.

In COP23, PEPFAR-E will work with the MOH and partners to support the pediatric acceleration initiative which began in COP22. This initiative seeks to prioritize pediatric HIV issues and implement tailored approaches to maximize support to high impact facilities. The surge effort will emphasize conducting pediatric specific review meetings, mentoring, utilization and monitoring of site level data, messaging for demand creation, and experience sharing among implementing partners.

To enhance case finding, PEPFAR-E will strengthen a mix of strategies at both facility and community levels. In addition to index case testing (ICT), which is the primary case finding strategy, optimized provider-initiated testing and counseling (PITC) and routine testing at high-risk entry points, such as TB clinics, malnutrition clinics, and inpatient wards, will be enhanced. Facilities will be supported to continuously review their records to identify eligible biological children of adult ART clients and ensure one hundred percent testing and initiation on optimal treatment regimens for newly diagnosed C/ALHIV. Strategies to realize this target may include improving messaging to caregivers, increasing transport reimbursements for testing, expanding weekend hours to minimize children missing school, and using self-test kits for caregivers unable to bring children in for testing. To optimize PITC among children <15 years and OVC, risk-based testing services in under five clinics and outpatient department (OPD) settings will be done through appropriate counseling.

Currently, the majority of children and adolescents on ART are receiving dolutegravir (DTG) based regimens, including children weighing <20 kg to whom DTG 10 mg was widely rolled out in COP21-22. In COP23, PEPFAR-E will continue to ensure that all C/ALHIV are receiving optimized regimens with a particular focus on children in conflict affected areas. Technical assistance (TA) provision to ensure adherence to treatment and timely detection and management of high viral load cases will be strengthened. Supply chain partners will maximize efforts to ensure the continuous supply of pediatric ARV formulations including introduction of new formulations as available. Moreover, provision of AHD packages of services for C/ALHIV including Cotrimoxazole preventive therapy (CPT) and tuberculosis (TB) Preventive Therapy (TPT) prophylaxis, diagnosis, management of OIs, nutritional assessment, and integration of immunization services will be strengthened.

Capacity building through provision of regular training using national guidelines and mentoring support for pediatric HIV health cadres will be strengthened to boost provider skills and confidence in pediatric case management. PEPFAR-E will also expand pediatric demonstration

centers in high volume facilities that will serve as regional learning hubs for increasing expertise in pediatric HIV care and treatment by hosting and precepting multidisciplinary teams and using pediatric experts at referral hospitals.

Facility based Operation Triple Zero (OTZ) programs have shown promising outcomes in terms of viral suppression and retention among adolescents enrolled in the program. The OTZ package of services includes provision of optimized ART, weekday, and weekend clinical services, high VL clinics, peer support group activities led by adolescent champions, planned transition to adult services, sexual and reproductive health (SRH) services, motivational group activities, caregiver involvement and counseling, and disclosure support. In COP23, OTZ will expand to more high case load facilities, and existing service packages will be optimized. PEPFAR-E will support establishment of more transition clinics at health facilities building upon existing experience in the country.

PEPFAR-E will also focus on interventions to reduce treatment interruption and reconstitution of the pediatric treatment cohort in conflict affected areas, particularly in Tigray. 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.

Through memorandums of understanding (MoU) in most Woredas, collaboration between community OVC programs and facilities will be strengthened so that C/ALHIV on treatment are enrolled in the OVC program and receive an optimized OVC service package. The PEPFAR-E team will also engage with the Global Fund, under MOH leadership, to ensure appropriate forecasting and quantification for pediatric formulations of ARVs and opportunistic infection drugs. PEPFAR-E will strengthen partnerships with multilateral stakeholders, such as WHO and UNICEF, to align TA and resources with existing maternal and child health programs.

Regular compilation, reporting, analysis, and data use for pediatric program improvement at the site level will be strengthened. Moreover, available program data including electronic medical records (EMRs) will be reviewed and analyzed to triangulate outputs from modeled CLHIV estimation.

Plan for Services for Pregnant and Breastfeeding Women

An effective prevention of mother to child transmission (PMTCT) program is vital for the achievement of the 95-95-95 UNAIDS targets. National PMTCT program data from the last six months performance (July - December 2022, DHIS2) showed PMTCT_ART coverage of 69% and an increase in the absolute number of HIV infected infants (n=168). Moreover, the estimated annual mother to child transmission of HIV (MTCT) rate has declined only slightly despite the significant effort put into the program over the past many years (16.9% in 2021 to 12% in 2022).

Since COP18, PEPFAR-E has not monitored testing indicators (PMTCT_STAT and PMTCT_STAT_POS) due to partial transition and support of antenatal (ANC) testing aspects of the PMTCT program. Due to this transition, the PEPFAR program was not able to monitor the

data quality across the PMTCT cascade and this resulted in data quality problems in ANC data. Thus, ensuring comprehensive support, resuming proper reporting, and monitoring systems need to be in place. To achieve the stated goals and reduce the MTCT rate in Ethiopia as well as improve the Spectrum estimates for PMTCT and estimates of CLHIV, coordinated efforts are needed, and the following activities will be accomplished at PEPFAR supported sites:

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- Strengthening facility-community collaboration is important to improve the contribution of community partners to eMTCT. Community programming can educate mothers on breastfeeding, family planning, and supporting their children. At the same time, community health workers will receive training to support linking mothers to ANC care to improve the PMTCT continuum of care. To further strengthen this partnership, community resource persons will receive lists of clients on PMTCT who interrupted treatment, trace them in the community, provide counseling, and re-engage them in treatment. Newborns that may not have their early infant diagnosis (EID) will also be tracked in the community and linked to undertake EID.
- Improve mother support group programs (MSG) which is a peer support program that aims to provide psychosocial support to HIV positive women in order to access medical care for themselves and their families.
    - The program is facilitated by trained HIV positive mothers (mentor mothers) who have benefited from PMTCT/ART services during their pregnancy and postnatal period. PMTCT clients will have the opportunity to discuss their personal circumstances in a safer environment with someone who relates to their situation, receive enhanced adherence support to care and treatment and contribute to the improvement of overall quality and effectiveness of the PMTCT program. Mother mentors also will do a telephone call to mothers who missed their appointments.
    - For those mothers who are not accessible to the telephone call, they will share the line lists to community resource persons who will also do community-based tracing of mothers/children and re-engage/link them back to facility and link them to community-based care and support services. MSG also prepare and conduct group sessions with coffee ceremony, a social gathering platform that is used to sharing of their life testimony
- Preventing unintended pregnancies among women living with HIV by ensuring access to voluntary family planning counseling and services, including integration into ART services and in the postpartum setting and provision of safer conception counseling for women living with HIV who wish to become pregnant.
- Safer conception counseling services are services that respect the rights of families to conceive while minimizing HIV transmission risks between partners as well vertical transmission.
- Identifying all pregnant and breastfeeding women (PBFW) living with HIV as early as possible, including through HTS at ANC1, and intensifying maternal retesting during pregnancy and breastfeeding based on risk exposure and assessment findings.
- Supporting implementation of the dual HIV/syphilis rapid tests during ANC, which is a new nationally endorsed initiative.

- Providing comprehensive services to support continuity of treatment for PBFW to help achieve and maintain viral suppression through the end of breastfeeding and beyond.
- Ensuring access to viral load (VL) testing and timely results in pregnancy and during breastfeeding.
- Scaling up longitudinal tracking and retention support for women living with HIV and HIV-exposed infants (HEI).
- Optimizing comprehensive care of HEI, including HIV prophylaxis for HEI, increasing timely infant virological testing/early infant diagnosis of infants living with HIV, ensuring rapid linkage to treatment and continuity of care, and testing for HEI until final HIV status is ascertained.

To combat low continuity of treatment among PBFW and HEI, priority responses will also include:

- Integration of PMTCT services into all antenatal, postpartum, neonatal, and child health services, to provide one-stop services for mothers and infants. The community care and treatment and OVC activities also contribute to improved continuity of treatment among PBFW and HIE.
- Full access to better tolerated and more robust treatment (e.g., TLD).
- Use of differentiated service delivery models to facilitate access to treatment or continuation of pre-pregnancy care, including assessing eligibility for 3-multi-month dispensing (MMD) for the mother.
- Mother-to-mother mentoring, counseling, case management (including psychosocial support and active tracing of mother-infant pairs who miss appointments), and other community-based and evidence-based interventions to support PBFW, including discussion and planning for the estimated 18-month to 2-year follow up period for mother-infant pairs.
- Facilitate processes for medical record sharing between PMTCT service delivery points and ART clinics to ensure continuity of care.
- Support activities to meet WHO's validation criteria for elimination of vertical transmission of HIV, syphilis, and hepatitis as well as the Path to Elimination to ultimately decrease HIV MTCT rates to less than five percent, <50/100,000 new pediatric HIV infections.
- Implementing and continuing to scale up pre-exposure prophylaxis (PrEP) in maternal newborn and child health and family planning settings.
- Ensure continuity of treatment and viral suppression to undetectable levels.
- Focused support to ANC sentinel sites and increasing capacity of healthcare workers (HCWs) and monitoring and evaluation (M&E) officers.
- Introduce the use of electronic medical records in ANC/PMTCT settings and in selected high load sites.

Plan for AGYW Services

Out-of-school and vulnerable adolescent girls and young women (AGYW) (OOS-AGYW) continue to have increased risk of HIV and other STI acquisition but are underserved with tailored and comprehensive HIV prevention, care, and treatment services. Nationally, 34% of new infections occur among AGYW 15-24 years in 2021 (EPHI 2022). A 2020 integrated HIV bio-behavioral survey (IBBS) conducted in Addis Ababa and Gambella among AGYW indicated that HIV prevalence among this population is five times higher than the general population national average. The study also noted that only 69.2% of them had been tested for HIV in Addis Ababa, indicating a potentially lower achievement outside of Addis Ababa. Additionally, the survey indicated an overall HIV prevalence of 2.7% contributed to by various risk factors of OOS-AGYW, including early sexual debut of >70%, inconsistent or absent use of condoms of >80%, and experience of sexual abuse (ever) of 13.8% among other factors. Additionally, there are high risk AGYW in many urban areas that are engaged in transactional sex (FHAPCO 2020).

PEPFAR-E will work to increase accessibility of HIV combination prevention and testing services to adolescents and youth. Interventions will include youth-tailored messages on HIV and sexual and reproductive health in person and through social media. Activities will focus on counseling and testing services; risk reduction counseling; GBV screening at appropriate service delivery points and the provision of first-line support; post-violence care and referral services; post exposure prophylaxis (PEP); awareness creation about services and HIV risk; STI screening and referral; and linkage to treatment at public or other ART facilities. PEPFAR-E will also support prevention related activities to empower adolescents and youth that will include life skills education and mental health counseling. Finally, PEPFAR-E will support sexual and reproductive health programming for these populations, including counseling on sexual relations and safe sex, pregnancy testing, and services across the pregnancy continuum (e.g., antenatal care, safe deliveries, postnatal care, postpartum family planning, and postabortion care).

Youth and adolescents face unique challenges when it comes to accessing care as there are limited youth-friendly services at hours that do not conflict with school or extracurricular activities. PEPFAR-E will improve upon these accessibility and utilization issues by capacitating providers to provide youth-friendly services; extending hours and weekend services at clinics; and providing service fee exemptions for youth. These youth will also be linked to peer support groups and one-stop SRH services at youth friendly public health facilities and KP and OVC sites.

PEPFAR-E will strengthen the adolescent/youth support groups to increase their involvement in HIV prevention, testing, and linkage to ART services. These programs will link closely with other youth-centered programs to cross-refer clients for HIV, SRH, economic strengthening, and other relevant services. In addition to trained health workers, adolescent peer service providers will play a key role in providing adherence support, promoting positive living, and identifying and reaching adolescent KPs in their communities.

PEPFAR-E will use the COP23 approved LIFT UP Equity fund to support and complement on the AGYW HIV services and to close the gaps for adolescents and children by strengthening and

enhancing services across the continuum of care via support to both community and facility programming in high burden urban areas and their community woredas.

Although PrEP is highly effective, its uptake has been slow in Ethiopia due in part to low awareness of PrEP among young people at risk of HIV and a national policy environment that has not expanded access to adolescents and youth. PEPFAR- E is committed to closing the PrEP access gap by improving PrEP awareness and advocating for expanding the eligible population in collaboration with the GOE.

To narrow the case finding gap and increase risk awareness and HIV prevention, PEPFAR-E will work to make HTS services accessible and friendly to adolescents and youth with sexual HIV exposure. Adolescent and youth friendly clinics as well as KP drop-in centers (DICs), OVC, and community sites will offer index testing, social network testing, tailored and targeted community testing, PITC for youth presenting for sexual and reproductive services, and HIV self-testing (HIVST). A menu of these HIV testing modalities will be offered to adolescents and youth at youth-friendly clinics, so that they choose their preferred mode of testing. Adolescents and youth engaging in sex work and injecting drugs will be prioritized for testing.

Plan for KP Services

The National HIV/AIDS Strategic Plan 2021–2025 defines KPs as including female sex workers (FSWs), prisoners, and PWIDs. PPs 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. These population groups are at high risk of HIV infection, have limited access to services, and face stigma and discrimination.

According to the size estimates conducted by PSI and the Ethiopian Public Health Institute (EPHI) in 2011, there were an estimated 222,550 FSWs in Ethiopia, and the projected FSW size estimate for COP23 is 252,196. The HIV prevalence among FSWs varies from 14.0% in Shashemene to 28.2% in Bahir Dar, and according to EPHI-led size estimates, HIV prevalence was 18.7% among FSWs in Ethiopia in 2020. Per the EPHI national most at-risk populations (MARPs) study conducted in 2013, the prevalence of HIV among long-distance drivers was also high at 4.9%.

The HIV prevalence among other KPs remains high, including 4.2% among prisoners (UNODC & Federal Prison Administration 2014) and six percent among people who inject drugs (five percent among men PWID and 31% among women PWID) in Addis Ababa (EPHI & UNODC 2015). HIV prevalence among other PPs ranges from 1.3-11%. The EDHS 2016 reported HIV prevalence of 11.5% among widowed women and 3.5% among divorced women (CSA and ICF 2018) as well as a 1.3% routine HIV test positivity rate among mobile workers (MOH 2021). HIV prevalence is low (2.7%) among AGYW in Ethiopia (2019).

These data clearly show the high HIV prevalence among KPs and PPs and demonstrate how critical it is to ensure access to and utilization of HIV testing, care, and treatment services for these populations to reach the 95-95-95 targets. Reaching these target populations, especially

non-self-identified SWs, part-time SWs, and young women who are new entrants to sex work, is complex and requires a mix of complementary community and facility-based programs to provide client-centered services.

In COP23, PEPFAR-E will undertake an IBBS of FSWs to better understand this population size and their behaviors. This data will help inform programming in COP23 year two and beyond.

COP23 KP HIV programming will employ a combination of HIV prevention approaches supporting immediate access to treatment and care and tailoring a package of services to specific the needs and context of the target communities and sub-populations in alignment with the WHO Consolidated HIV Guidelines for KPs. Combination HIV prevention activities will blend behavioral, biomedical, and structural approaches to reduce the number of new HIV infections.

Specifically, PEPFAR-E will continue to support HIV services for KPs in community hot spots, DICs, and select KP-friendly public health facilities. DICs located in Addis Ababa, Amhara, Oromia, SNNPR, Sidama, Tigray, and Gambella will provide comprehensive HIV prevention, care, and treatment services, including family planning, GBV services, mental health, STI screening and management, TB screening and prevention, and harm reduction services on-site or through referral. In COP23, the program will continue providing comprehensive HIV services in these regions, in which 40 SNUs have a DIC, with 33 of these also providing ART services for FSWs. Moreover, cervical cancer screening, treatment, and referral services for all FSWs with HIV will be integrated into these 33 ART DICs, and all DICs will integrate NCD screening and referral services. Facility-based comprehensive HIV prevention, care, and treatment services will be provided to FSWs, sex partners, and eligible children in selected RHB facilities with KP friendly clinics in the major cities of Amhara, Addis Ababa, Oromia, SNNPR, SWR, Sidama, Tigray, and Gambella with monitoring throughout the clinical cascade from detection to VL suppression.

In COP23, PEPFAR-E will work to strengthen KP programs by prioritizing: (1) behavioral interventions, with comprehensive prevention packages including targeted demand creation, condom and lubricant distribution, comprehensive reproductive health services, GBV/IPV (intimate partner violence) screening, first-line support, clinical post-violence care, referral, linkage, and psychological and legal support; (2) biomedical interventions that include a people-centered, high-yield, and differentiated mix of testing modalities, pre- and post-exposure prophylaxis (PrEP and PEP), and 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 include mental health and psychosocial support, substance abuse, and ongoing harm reduction counseling services.

Scaling up of targeted testing strategies to increase case finding has allowed the program to reach higher-risk FSWs and their sexual partners who are eligible for PrEP, supported the enrollment of newly diagnosed FSW into ART (test and start), and improved re-engagement of

FSWs with treatment interruption into ART services. Children and partners of FSW will also be offered self-testing, and, if diagnosed HIV-positive, will be linked to and enrolled in treatment. PWID, at-risk out-of-school AGYW, women who engage in transactional sex, and adolescent boys and young men (ABYM) will also be reached through ICT/partner notification strategies, social network strategies, and targeted outreach services. Moreover, KP clinical cascade activities to reach PWID will be supported as demonstration project in few selected sites in Addis Ababa. Through the demonstration project an estimated 200-300 PWID will be reached.

In COP23, PEPFAR-E will also continue strengthening the MOH and RHBs' quality scorecard activities to improve the quality of KP services at national and regional levels. Moreover, the program will work closely with the PEPFAR coordination office to advocate for the establishment of a KP consortium and expand KP-focused community-led monitoring (CLM) activities to bolster KP community leadership, collaboration, and empowerment.

Additionally, KP programs will enhance the current 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; establishing a KP data security system; 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. PEPFAR-E will also support including KP program indicators in EMR with unique identifiers using biometrics. The GOE is embarking on a plan to have electronic, biometric-based IDs, and PEPFAR-E will explore ways to collaborate.

In COP23 PEFAR-E will continue procuring condoms for the KP program. These condoms are procured for at the community DICs and facility public KP friendly clinic levels. The condoms will be procured and distributed through the supply chain mechanism equally to the 31 community DICs and 115 government KP friendly clinics. The PEPFAR-E technical working groups (TWGs) work in collaboration to monitor the distribution and consumption of these PEPFAR commodities on a quarterly basis during the COP23 implementation period.

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 AGYW involved in transactional sex, ABYM, and mobile workers in hotspot areas (workers in bars, massage houses, and shisha houses; daily laborers; waitresses; petty traders; taxi drivers; etc.) 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 HIV prevention services in the community and link PPs and high-risk FSWs to HTS. Both assisted and unassisted HIVST will be expanded to increase demand for HIV testing among KPs. Policy advocacy will be performed to use HIVST for PrEP continuation (PrEP_CT). Community-based providers will

accompany KP and PP with HIV to ART services provided at DICs and public 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 standard operating procedures will be strengthened and institutionalized.

Plan to Address Stigma, Discrimination, Human Rights, and Structural Barriers

Fear of stigma and discrimination deter most-at-risk populations (MARPs)/KPs from using general HIV services. The Network of Networks of HIV Positives in Ethiopia (NEP+), in collaboration with the Federal HIV/AIDS Prevention and Control Office 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 and treatment initiation and to treatment interruptions (NEP+, 2021).

Despite increased access to information about the benefits of HIV prevention, testing, and treatment, stigma, and discrimination among PLHIV has been a persistent 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. The 2016 EDHS shows 48% of women and 35% of men thought that C/ALHIV should not be able to attend school with children who are HIV negative, and 55% of women and 47% of men would not buy fresh vegetables from a shopkeeper with HIV, indicating stigma and discrimination is an important factor in the transmission of HIV across communities. Disclosing HIV status even among family members is not easy. CLHIV do not openly talk about their status until their late adolescent ages for fear of stigma and discrimination at school and in the community; they take ARVs without fully understanding why they are taking the drugs and lack adequate psychosocial support. Peer support groups are few.

A strategic focus area in COP23 and beyond will be 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 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 KPs. Adolescent differentiated service delivery (DSD) models will be expanded in COP23 to empower adolescent girls and boys to disclose their HIV status, improve treatment adherence and continuity, and achieve and maintain viral suppression.

As part of addressing stigma and discrimination towards FSWs 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, TA 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 undetectable=untransmittable (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 among patients, the public, and institutions will help to eventually break the cycle of HIV-related stigma and discrimination. Communication strategies, including messages tailored to tackle HIV-related stigma and discrimination at 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 KPs, will: (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 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.

Faith-based organization activities in collaboration with the facility and community level service providers will conduct various sub-national advocacy conferences targeted to stigma reduction.

There will also be sensitization events for interfaith leaders and their constituents to encourage HIV testing, treatment, and stigma reduction, primarily for youth and older age groups.

Community-led organizations are also the most effective way of reaching PLHIV and KPs and will monitor HIV service quality, barriers, ARV procurement, human rights, and decriminalization initiatives.

Some of the human rights-based approaches to the HIV response will include training of health care providers, including facility and non-facility based, health care administrators, and health care regulators on non-discrimination, duty to treat, informed consent and confidentiality, and violence prevention and treatment.

At the above site level, PEPFAR-E will support an assessment of policy and regulatory challenges to address human rights in HIV services. PEPFAR-E will also support training and sensitization programming on health and human rights through mass media, social media, and digital platforms as well as integrated in the peer learning standards for key religious, political, and legal leaders.

HIV Testing Plan that Closes Gaps, Promotes Equity, Prioritizes Public Health Approaches, and Assures Appropriate Linkage to Treatment and Prevention Services

To reach and maintain the first 95, PEPFAR-E will support a strategic mix of person-centered and high impact case finding strategies supported by community and facility implementing partners. Capacity strengthening activities will be supported at all levels to increase HTS capabilities and align efforts with the longer-term vision of sustaining HTS services. The following will be major priority areas for case finding with a focus on KPs/PPs, which have the highest gaps in first 95 achievement (five percent):

1. Increase the availability of safe and ethical ICT to newly diagnosed, virally unsuppressed and other PLHIV on ART, with the goal of offering index testing services to 100% of eligible clients;
2. Strengthen the combination of healthcare integrated, people centered PITC optimization strategies to enhance case finding without compromising the volume of PLHIV detected. This includes conducting diagnostic testing of individuals who present to adult and pediatric inpatient wards with signs or symptoms suggestive of HIV, including signs or symptoms of TB; universal testing of all people presenting for medical attention at TB clinics, STI clinics, viral hepatitis clinics, and malnutrition clinics focusing on children with moderate and severe malnutrition; and conducting targeted testing at adult and pediatric outpatient departments, and at adolescent and youth friendly clinics through HIV Risk Screening and testing those eligible;
3. Scale up targeted community-based testing for populations, including KPs/PPs, with gaps in the first 95;
4. Expand the promotion and access to HIVST, both assisted and unassisted, to reach more high-risk populations who otherwise will not be reached through conventional testing modalities using the national HIV testing algorithm. HIVST will be leveraged and used by

integrating with ART, PMTCT, ANC, KP, STI, and TB management and other OPD PITC services so that hard to reach sexual partners of patients presenting for care at these units can get access through secondary distribution. Kit distribution with healthcare services in different service delivery points, Caregiver assisted HIVST to reach 2-15 year old children of PLHIV, social marketing, and vending machines, through discussion with MOH, will also be used to increase availability and access to HIVST.

5. Empower FSWs with HIV and those at high risk for HIV to serve as conduits for social network testing at facility and community levels;
6. Increase targeted demand creation for harder-to-access populations, such as KPs, through a combination of HIVST, ICT, and social network strategy testing modalities and;
7. Continue supporting the full implementation of the new HIV testing algorithm and its implementation in health facilities and community settings. PEPFAR-Es will work to ensure IQC and EQC for HTS at both community sites and facilities.

To strengthen pediatric HIV case finding, testing strategies will include:

1. Identifying and addressing ICT barriers for testing all eligible biological children of index cases. Programs will strengthen routine chart review for all PLHIV coming for a clinic visit and/or ART refill to ensure all sex partners and biological children <19 years of age have been elicited and tested and have documented status. For pediatric index clients, chart reviews will ensure all biologic parents and siblings <19 years of age have been elicited and tested. Disclosure support, elicitation, and provision of safe and ethical ICT service to sexual partners of adolescents living with HIV (ALHIV), will be supported. IPs will also support ICT learning sites (selected health facilities of excellence for ICT) through ensuring activities such as person-centered friendly services at flexible hours.
2. Providing caregiver assisted HIVST among 2-15 years old children of index cases and assisted or unassisted HIVST among 15–18-year-old children of PLHIV who otherwise will not be reached through ICT.
3. Routine HIV testing of children visiting healthcare entry points, including malnutrition clinics (TB clinics, and inpatient (targeting children with recurrent infections, OIs, and signs and symptoms suggestive of HIV) departments.
4. Case finding among OVC through collaboration between RHBs providing clinical service with organizations supporting OVC programs.
5. Risk screening and risk-based testing (PITC) in pediatric service delivery points (SDPs). Risk based testing will be strengthened at under five pediatric OPD and adolescent/youth friendly clinics using risk screening tools, without compromising the number of positives detected.
6. Strengthen collaboration between clinical partners and other community implementing partners (KP, OVC, and community care and treatment) to maximize case finding efforts among biological children of index cases identified in the existing community platforms.

Community-Facility collaboration will also aim to ensure linkage and initiation on ART for the identified HIV positive cases. Activities such as data sharing, joint performance review, and linkage audits among community and facility-based partners will be conducted regularly.

In COP23, implementing partners will continue supporting the MOH''s Pediatric Acceleration Initiative launched in the COP22 implementation period, and efforts to re-establish HTS in conflict-affected zones, and support 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.

Programs will support training and mentorship of health cadres, including facility/site managers, counselors, case managers, and peer volunteers, to build their capacity on sustainable implementation and monitoring of quality person centered HTS. Moreover, the capacity of providers on high-risk screening tool utilization, catchment area meetings, and supportive supervision activities will also be strengthened to build the capacity of RHBs, IPs, and woreda and town health offices on regularly reviewing HTS and linkage data and monitoring progress toward achieving the targets.

Strategies to reduce unnecessary PITC will include alignment of counseling messages on retesting to include retesting based on exposure and not a one-size fits-all approach and counseling to avoid retesting those on ART or previously diagnosed PLHIV with a documented HIV status. At the same time, IPs and RHBs will coordinate with responsible stakeholders to ensure sustainable availability of RTK and relevant commodities at sites and SDPs.

While working to minimize repeat testers among positives, HTS will also be used as an opportunity to re-engage known positive KP contacts, who are not currently enrolled on ART or those who have interrupted ART, back into treatment.

In war or security affected areas, HTS catch up activities will be implemented to mitigate service disruption. The catch-up will focus on clearing the ICT backlog at health facility and community sites through universal offering of ICT, strengthening use of HIVST, providing PITC at to all patients at TB and STI Clinics, strengthening testing at KP sites, and strengthening scale up of risk-based testing PITC in other service delivery points.

Testing for prevention

To attain and maintain treatment saturation programs will provide support for testing for prevention. Testing for prevention services will include ANC testing, Post ANC 1 testing, PrEP follow up testing, and VMMC testing.

Prevention Plan that Promotes Equity, Especially Advancing Access to PrEP

The 2021-2025 National Strategic Plan focuses on reaching 90% of KPs/PPs 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 breastfeeding 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 FSWs, HIV-negative partners in sero-discordant relationships where the HIV+ partner has not yet achieved VL suppression, HIV-negative pregnant and breastfeeding women who have HIV-positive partners and who attend ANC/PMTCT clinics, PWIDs, AGYWs, and other high-risk population groups. PEPFAR-E continues to advocate to the MOH to expand the PrEP eligibility guidelines to cover AGYW (who are not eligible as FSW or as part of a discordant couple). PrEP services are currently available for FSWs and HIV-negative sero-discordant partners in 182 public health facilities in 141 Woredas and forty DICs through the Hub-Spoke models to reach the surrounding communities in the catchment areas of the 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 FSWs and their sexual partners who are eligible for PrEP. In COP23, HIVST services will be integrated with PrEP services, consistent with current WHO guidance, to improve PrEP uptake, distribution, and monitoring. PrEP services will continue in 40 DICs and 182 public health facilities with a target of a ten percent increase from the COP22 targets resulting in 23,750 of PrEP_NEW and 11,175 of PrEP_CT. People on PrEP should have access to HIV testing during their follow up visits, and if found positive, will discontinue PrEP and be linked to the ART clinic to initiate treatment. Between FY22Q1-FY23Q1 a total of 17 PrEP test result positives with a positivity rate of 0.06%.

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 and distribution models for PrEP provision based on the recently released WHO guidance for simplified and differentiated PrEP services.

The PEPFAR-supported IBBS among AGYW conducted in 2019 showed a 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 COP23. Prevention interventions will support the identification of high-risk AGYW who are engaged in sex work or transactional sex and who 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 provided to those affected. AGYWs will be reached at the community level via community outreach workers, community mobilizers, and peer educators.

Pillar 2: Sustaining the Response

The new PEPFAR strategy underlines the importance of sustaining the program's success in reaching epidemic control so as to ultimately eliminate HIV as a public health threat by 2030.

Over time, the GOE, communities, and other stakeholders have built momentum to consistently incorporate sustainability into PEPFAR's planning process. Key activities include: (1) accelerating integration of HIV services and systems into local public health systems; (2) increasing capabilities and capacities for partner-country governments, local partners, and communities to lead and manage all aspects of the HIV response; and (3) aligning U.S. Government (USG) and other donor investments with national government planning and priorities. As per the PEPFAR guidance, COP planning shifted from a one year to a two-year cycle to allow partners more time to implement programs. The COP23 planning process is built on broad stakeholder participation and inputs, including robust participation from the MOH, CSOs, multilateral organizations (Global Fund, UNAIDS, and WHO), and other stakeholders.

The plan is to continue to shift the PEPFAR program towards sustaining HIV impact and ensure long-term sustainability by strengthening the capabilities of government, civil society, and local partners to lead and manage the program.

The new PEPFAR Strategy will support the international community's efforts to put countries on track to reach the Sustainable Development Goal three target of ending the global AIDS epidemic as a public health threat by 2030, through the attainment of key milestones by 2025. The PEPFAR Strategy will be closely coordinated with the Global AIDS Strategy 2021-2026, recently released by UNAIDS and adopted by the countries, and the post-2022 Global Fund Strategy to optimize complementarity, value for money, and impact.

The vision for COP23 implementation focuses on reaching and sustaining HIV epidemic control and planning for long term sustainability towards PEPFAR investments in HIV in Ethiopia.

Sustainability

Over the years, PEPFAR-E's implementing agencies have strengthened the capacity of government entities and community organizations to implement PEPFAR supported HIV programs and activities. Starting in 2014, PEPFAR-E transitioned some comprehensive prevention, care and treatment programs from international partners to the MOH and RHBs. In COP18, six regions and the uniformed services were transitioned to a TA model under the MOH. All facilities, except those in Gambella, have been transitioned to the MOH. Gambella's facilities will be transitioned in COP23.

Moreover, the community-based HIV programs, including OVC, KP/PP, and care and treatment, have been transitioned to LIPs. Overall, more than 65% of PEPFAR funding goes to local entities that will contribute to maintaining and sustaining a high level of performance and quality of HIV services at facility and community levels.

In the past few years, Ethiopia has faced consecutive challenges to public health service delivery and overall health security from COVID-19, armed conflict in different parts of the country, and drought. All these factors adversely affected access, availability, and provision of quality HIV services and threatened the gains in reaching the 95-95-95 targets. The country is also experiencing a high inflation rate (more than 30%) and higher cost of living. For PLHIV, the

higher cost of living includes more expensive non-ARV drugs, such as opportunistic infection drugs that are not covered by donors, and vitamin supplements.

There is a growing concern from donors about the country's own ability to sustain and to even expand its HIV response to meet and manage the trajectory of growth needed for prevention and treatment programs. To achieve the 95-95-95 targets, PEPFAR-E and partners, including MOH, CSOs and other in-country stakeholders, have to work together to develop a sustainability roadmap to maintain the gains made and move forward to full technical, managerial and financial country ownership of the program.

PEPFAR and the Global Fund are the major contributors to HIV programming in Ethiopia. The Global Fund supports the bulk of commodities and drugs. Both UNAIDS and WHO give TA to support the HIV program.

The GOE provides a smaller proportion of direct HIV-specific financial inputs to the national HIV/AIDS response. However, they play a crucial, primary role in the implementation of direct and indirect delivery of services and overall strategic leadership. Specifically, while the budget does not not accurately quantify the amount 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, program management, and disease surveillance and response.

Furthermore, the MOH oversees most human resources for health (HRH) at site and above-site levels. PEPFAR-E support fills in program gaps that have been identified and meets needs in case identification, linkage to care, treatment continuation, and viral load suppression. PEPFAR-E HRH support also focuses on enhancing community-facility collaboration and program data quality, and it is allocated to sites and above site levels that will have the greatest impact on controlling the HIV epidemic.

Although there is still much work to be done for Ethiopia to move toward sustaining its HIV response, the MOH's strong engagement in the COP23 planning process demonstrated its commitment to align its strategy with PEPFAR and the global HIV program, strengthen local capacity, and involve CSOs and other stakeholders.

In COP23, PEPFAR-E will continue to support the sustainability of the HIV response in Ethiopia via localization, integration, and alignment:

Localization:

- Strengthening the capacity of local implementing partners/ CSOs to lead, manage, plan and monitor HIV programming for vulnerable population groups.
- Strengthening the capacity of the health system to independently manage and implement HIV programs at national, regional, and community levels
- Strengthening M&E, mentorship, and quality improvement systems with the leadership of the MOH and RHBs to institutionalize an evidence-based decision-making culture.

- Continuing to provide TA to EPHI for epidemiologic and laboratory support.
- Improving coordination and the leadership role of the GOE and communities, including CSOs in the implementation of sustainable HIV programs.
- Using the National Supply Chain Assessment as a guide, PEPFAR-E will strengthen the capacity of national and regional supply chain systems is key for sustaining uninterrupted delivery of quality of HIV services at facility and community levels.
- Investing in workforce capacity building on HIV program management, clinical services, laboratory, supply chain, M&E at all levels
- Engaging local universities as centers of excellence and managing satellite health facilities. The RHBs have an agreement with local universities within their regions to provide in-service training for HIV service providers. Local universities in collaboration with RHBs plan to establish a network of communities of practice in clinical services including extension of clinical mentorship services to catchment facilities, and e-learning hub-and-spoke platforms. These teaching hospitals can become centers of excellence for HIV, TB, cervical cancer (CXCA), other priority infectious and non-infectious diseases, and infection prevention and control.
- Advocating for a progressive increase in government HIV budget allocations.
- Transitioning emerging regions from SNNPR (Sidama,Southwest and an additional two in the process of forming new regions) to MOH for above and site level support.

Integration:

- Scaling up information digitization at sites and moving to open web based EMRs. Expansion of the data repository systems at regional levels will be key for programmatic decision making at national and regional level.
- Improving laboratory systems at national and regional levels to provide quality diagnostic services for all HIV programs and other emerging public health threats. Leverage resources in sample transportation from HIV service sites and diagnostic facilities. Going forward, COP23 will explore opportunities for private sector involvement with subsidized costs for future sustainability.

Alignment:

- Aligning with the MOH on one plan, one budget, and one M&E plan for the HIV response.
- Improving ANC sentinel sites to get quality data and conduct another IBBS survey for KPs

Pillar 3: Public Health Systems and Security

Ethiopia is a both a global health security (GHS) and global health security agenda (GHSA) country. PEPFAR-E investments support health security improvements in several joint external evaluation (JEE) technical areas, including emergency preparedness and response, workforce development, laboratory systems, biosafety and biosecurity, disease surveillance, and risk communication and community engagement.

PEPFAR-E programming supports workforce development. PEPFAR-E continues to support the Advance Field Epidemiology and Laboratory Training (FETP) track for HIV/AIDS, which provides opportunities for FETP residents to focus on Ethiopia's HIV/AIDS program—ultimately yielding a

well-trained HIV/AIDS workforce. PEPFAR-E also continues to support laboratory strengthening as it relates to biosafety/biosecurity in Ethiopia at both the national and regional laboratories. PEPFAR-E developed a specimen transport system, which was utilized to transport COVID-19 specimens—demonstrating PEPFAR- E's investments support not only HIV/AIDS but also the public health system, including an effective way to transport emerging or re-emerging infectious disease specimens from the rural areas to a referral laboratory.

Additional CARES Act funds helped PEPFAR-E establish emergency operation centers (EOCs) in Oromia, Amhara, Addis Ababa, SNNP and Gambella regions of Ethiopia. These EOCs provided the foundation for emergency preparedness and response, which has been used for outbreaks of COVID-19, cholera, anthrax, Ebola preparedness, and other public health emergencies of international concern. PEPFAR-E also supports emergency preparedness through strengthening RHB management. Additionally, PEPFAR-E's investments have improved supply chain and health information systems, which are important for ensuring a robust response to public health emergencies.

PEPFAR-E also helps improve national laboratory systems. Activities have strengthened the referral lab for microbiology at EPHI and regional labs. Support has included training staff and providing equipment and supplies. Through this TA and financial assistance, these labs are well-positioned to test and detect infectious diseases which affect public health in Ethiopia.

PEPFAR-E has contributed to strengthening biosafety and biosecurity in Ethiopia through its support to establish a biosafety program at EPHI. With ongoing funding, EPHI now has three sets of certification equipment and six National Sanitation Foundation certified biosafety cabinet certifiers who are responsible for certifying over 180 biosafety cabinets throughout Ethiopia.

PEPFAR-E continues to strengthen disease surveillance in Ethiopia at EPHI as well as facility and community levels by improving the capacity of healthcare providers to test and detect diseases. Ethiopia is one of the founding countries of the Resolve 7-1-7 Alliance, a country-led initiative to achieve the 7-1-7 target for outbreak detection and control (seven days to detect a suspected disease outbreak, one day to notify relevant public health authorities, and seven days to complete early response actions). With continued PEPFAR support in COP23 to surveillance systems, laboratory, and workforce development, EPHI will demonstrate increased public health response capacity.

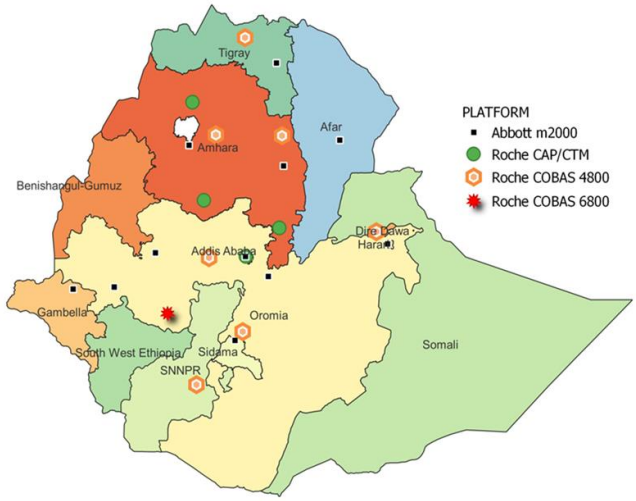
PEPFAR-E supports risk communication and community engagement through both its wide range of behavior change communication activities as well as its community programming that focuses on preventing, testing, and treating HIV/AIDS.

Laboratory Systems

PEPFAR-E supports conventional real-time PCR platforms placed for multiplex testing of HIV-VL, EID, HPV, and Hepatitis B (Fig 3.1). These platforms have been used for the COVID-19 response as well. The transition of Roche CAP/CTM platform is going on and all the six sites received

Roche COBAS 6800 or 8800. Two testing laboratories in Tigray region have been closed due to conflict. Both are expected to resume service in COP22, and the recovery will continue in COP23.

Point of Care (POC) EID and VL have been integrated with TB testing at GeneXpert sites. EID is at 149 sites and will be expanded to an additional 30. POC-VL is offered at 34 sites for pregnant/breastfeeding women, the pediatric age group, and people with unsuppressed VL follow up and will be expanded to an additional 16 sites in COP23.



Source: PEPFAR Ethiopia

Figure 3.1 Placement of Multiplex RT-PCR platforms for HIV-VL, EID, HPV test, and Other Diseases of Public Health Importance.

In COP22, national VL coverage reached 83%. The widespread instability in many regions affected access to facility, logistics for specimen transportation, and the return of results.

COP23 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, dried blood spot (DBS) VL will be strengthened, which will address phlebotomy and cold chain infrastructure challenges. To improve VL suppression in PBFW, children, and clients with unsuppressed VL despite enhanced adherence counseling, POCT-VL will be expanded from 34 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 laboratory platform. Diagnostic network optimization is reassessed on an average of every two years. Backup laboratories have also been identified to support primary referral laboratories when they are either non-functional or unable to meet the testing demand.

One hundred and ten health facilities are currently implementing electronic VL test requests and results 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 the last quarter of COP22.

Optimization of EID is also ongoing. In Addis Ababa, centralization of testing in two conventional laboratories enabled health technicians to run the minimum number of specimens required for a single run with a short turnaround time. Clinic lab interface and expansion of POC in other regions will be a priority in COP23.

HRH

To meet the 95-95-95 targets, it is crucial that health facilities and community-based HIV service delivery points provide efficient, effective, and high-quality services. This will ensure that individuals living with HIV are aware of their status, receive and maintain antiretroviral therapy, and achieve viral suppression. The health workforce plays a critical role in achieving these goals, and as such, COP23 is focused on increasing HIV cohort growth through the efficient use of existing human resources in public health facilities and community sites.

PEPFAR-E is dedicated to improving HIV prevention, case detection, care, and treatment, increasing ART coverage, and monitoring clients on ART with routine VL testing. The program will provide TA to maintain strong HRH workforce planning and monitor site-level resource utilization. Furthermore, PEPFAR-E will continue to build the capacity of healthcare providers through on-the-job and off-the-job in-service training to provide quality HIV services at both the facility and community levels. PEPFAR-E will align HRH staffing investments with regional and country-specific financing and health system priorities; integrate HIV services into broader health services; build stronger institutional capacity for robust health workforce planning, management, and financing; support regional and national preparedness capacity; and provide support for health worker protection.

These efforts will ensure that PEPFAR-E's investments in HRH are strategic, sustainable, and impactful in improving health outcomes for all.

Mental Health Integration

Screening PLHIV for mental health disorders is particularly important at the time of diagnosis and during ART initiation to ensure early detection and treatment. However, due to the limited number of trained mental health personnel in the Ethiopian health system, access to mental health services has been a challenge for PLHIV. In response to this problem, PEPFAR-E has been supporting the integration of mental health and substance use disorder screening and referral into HIV services through a task-sharing approach among ART clinicians and case managers at the facility level. In this approach, case managers proactively screen PLHIV for mental health and substance abuse disorders and link potential clients to ART clinicians or psychiatrists for further diagnosis and treatment. To this end, PEPFAR-E supported the MOH in the development of national training manuals, standard operating procedures, and recording and

reporting tools. The initiative has been scaled up to all PEPFAR-E supported ART sites. However, lack of psychotropic medication and limited services for substance abuse problems have been ongoing challenges.

At the community level, the PEPFAR-E- supported HIV prevention care and support activity has been implementing community-based HIV case management services, including, Mental Health Psychosocial Services (MHPSS), substance/alcohol screening, psychosocial support, and referral services as needed. This ensures that clients receive appropriate care for any MHPSS and/or alcohol or substance abuse problems and subsequently improves adherence and retention by differentiating services based on the needs of the individual client.

In COP23, PEPFAR-E will continue to strengthen the integration of mental health including alcohol and substance abuse disorders services into HIV services through a task-sharing approach. Patients who are newly initiated on ART and return to treatment and patients with high viral load and adherence problems will be prioritized for mental health and substance abuse problems screening. Additionally, patients who refuse to start ART and delay initiating ART for greater than two weeks for different reasons and patients with AHD will be given priority for screening. Both technical and site level support will be provided at different levels of the health system through direct cooperative agreements with RHBs in target regions.

PEPFAR-E will support the MOH to provide TA to transitioned regions to ensure the integration of the services in addition to overall national level program oversight through supervision and reporting. Capacity building through training, mentoring, and supportive supervision will be a key area to ensure continuity of services at the site level. Additionally, partners will be supported to build their regional level trainers' capacity through training of trainers and integrated supportive supervision. To address the gaps in access to psychotropic medication, PEPFAR will support the MOH to quantify psychotropic medication needs during national commodity quantification planning, and PEPFAR-E will collaborate with partners including the Global Fund to ensure timely availability of the drugs. Furthermore, PEPFAR-E will continue to provide technical support to the MOH through the national mental health technical working group.

As part of strengthening the service integration, national guidelines, tools, and standard operating procedures will be utilized properly; service assessment to identify gaps and develop performance improvement plans; and routine quality assurance checks through coaching, mentoring, and supervision will be conducted to ensure PLHIV are being accurately screened and managed. Furthermore, partners will use custom indicators to monitor and evaluate their programs on a quarterly basis. Performance reports will be presented during review meetings.

In COP23, PEPFAR-E will continue to strengthen the integration of services for mental health and substance and alcohol abuse to improve the clients' well-being as well as improve key outcomes, including treatment adherence and retention in care through a differentiated approach at community level. Local implementing partners will implement MHPSS and alcohol/substance abuse disorder services in compliance with the PEPFAR guidance to ensure

comprehensive and integrated MHPSS services to PLHIV at the community level. Community healthcare providers will be trained to proactively screen clients during recruitment and during treatment reengagement for mental health and alcohol or substance abuse disorders using a nationally approved and validated mental health screening tool and provide community level interpersonal psychotherapy services in an individual or group settings for those who screened positive for mild depression in selected sites. Patients who screen positive for more severe symptoms will be provided with psychosocial support and actively linked to a health facility in the network for further diagnosis and treatment as needed. Activities will sensitize the community, community health workers, and other community volunteers to prevent stigma and discrimination.

Cognizant of the MHPSS needs of providers who operate under stressful conflict, displacement, and other disaster situations, PEPFAR-E will support a "caring for the community caregivers" mental health and resilience approach to ensure improved coping skills of providers. This will be targeted at providers in some of the conflict affected project sites. The community-based LIPs will also include MHPSS screening into the GBV-LIVES services and ensure referral and linkage of survivors to the MHPSS services.

Cervical Cancer (CXCA) Prevention

In COP22, PEPFAR-E has been working to develop integrated mentorship guidelines for prevention of cervical cancer and breast cancer along with training materials and other tools. In COP22, PEPFAR-E has tried to reinstitute HPV DNA testing, and reagent purchase is currently under process with expected delivery in May 2023. In COP23, PEPFAR-E plans to train both healthcare providers and lab personnel and will reinstitute sample transportation from health facilities to labs. PEPFAR-E will continue to provide TA to the MOH and to RHBs including training of health care providers and mentorship as well as supportive supervision. PEPFAR-E will work to ensure quality of visual inspection with acetic acid (VIA) and treatment interventions as well. PEPFAR-E is also working to develop a protocol for evaluation of the experience of implementing HPV DNA testing in 75 health facilities and 15 labs.

In COP22, the major challenge has been the widespread unrest which has led to disruption of cervical cancer prevention services with loss of equipment and infrastructure. Additional challenges include gaps in awareness about CXCA prevention both for healthcare providers and clients which include missed opportunities at facilities and community level service delivery points, client refusal, and low follow up screening. Women living with HIV will come to the health facility, and providers may not provide necessary information about CXCA counseling and offer a screening.

In COP23, PEPFAR-E will continue to work on awareness creation both for healthcare providers and clients through media and peer support groups. We will continue to support sites to do line listing of eligible women to do screening and strengthen follow up screening again through line listing. We will continue to strengthen HPV DNA screening with a focus on shortening TAT and prioritizing testing of women living with HIV who are above the age of 50 and are being screened for the first time. In addition, PEPFAR-E will continue to provide training, mentorship,

and supportive supervision through implementing partners. PEPFAR-E will work to improve the quality of VIA and treatment interventions as well as access by expanding COE and LEEP sites. Furthermore, in COP23, we will continue to provide TA to the MOH and RHBs through the cervical cancer prevention TWG, support the expansion of the cervical cancer registry, strengthen histopathology services in referral hospitals, strengthen the ECHO platform for CXCA, support machine troubleshooting and maintenance, and strengthen EMR. We will also do an evaluation to understand why women refuse gynecologic exams or CXCA screening which could be due to both cultural and clinical reasons.

At the community level, PEPFAR-E will support cervical cancer awareness, education, and demand creation through mass media and public gatherings targeting women living with HIV aged 25-49 and those above 50 who have never been screened before. Eligible clients will be referred to health facilities for VIA screening. Patients who miss appointments for initial or follow-up VIA screening, including those who screen positive for HPV, will be tracked by the HFs using telephone calls. However, if clients, after repeated calls, are not returning to care, the line lists will be provided by facilities, so that community partners can trace the lost clients and counsel and actively link them to the facility. Within the KP DICs, PEPFAR-E will continue to strengthen screening with VIA and same day treatment services of precancerous lesions for all eligible clients presenting for services. Patients suspected of invasive lesions will be referred to health facilities in the network for further evaluation. PEPFAR-E will explore the opportunity to expand HPV screening services at the community level, and to HIV+ women.

TB/HIV

The Ethiopian guideline adapted globally recommended, updated TB/HIV programmatic approaches including enhanced TB case finding and TB preventive interventions among PLHIV on ART. Key program challenges which will be prioritized to be addressed in COP23 include low TB screening quality and yield in PLHIV; inadequate TB/HIV targeted interventions in TB hot spot geographies, sub-optimal TB/HIV service coverage performance in selected high volume hospitals, inadequate TPT coverage and completion in C/ALHIV, sub-optimal TB/HIV service integration in KP friendly services, and low attention to patient centered services for persons coinfected with TB and HIV. Though HIV testing coverage among TB cases is maintained at a high level, there has been some decline in the past few years due to COVID-19 and conflict.

TB/HIV service restoration activities in conflict affected areas will also focus on enhancing HIV case detection among TB and presumptive TB cases as well as linkage of HIV positive TB cases with comprehensive ART services. Best practices from successful implementation of TPT targeted interventions in high volume low coverage performance sites will be continued through identification of priority sites based on analysis of site level performance data. The introduction of the new short course TPT regimen (3HP TPT) has contributed to improved TPT adherence and completion. In COP23, PEPFAR TA support will continue towards universal scale up of 3HP including in conflict affected areas not yet included in the earlier scale up activities. In line with the national strategy, PEPFAR programs will strengthen facility – community

collaboration to improve community level TPT provision both for PLHIV and household TB contacts. The findings from the FY23 pilot project implementation involving bidirectional TB-COVID19 screening, MMD approaches for TPT and TB treatment, and virtual adherence support for patients on MMD TB/HIV care will determine further scale up of these innovative and patient centered approaches at national level in COP23.

PEPFAR TB/HIV programs will also focus on strengthening program management capacity at all levels of the health system for sustaining the program. Support will also be provided for strengthening TB lab infrastructure capacity and quality assurance as well as optimizing integrated specimen referral systems. TA will be provided for efficient utilization of resources including prioritization of diagnostic tests with multiplex testing to improve access. PEPFAR agencies and partners will continue to be actively engaged and contribute to the national TB/HIV TWG activities for updating national policy/strategy documents & guideline, SOP and training materials as well as TB/HIV program indicators in line with updated program needs.

Plan for Older Populations of PLHIV

The updated 2023 estimates for disaggregated clinical cascade performance for the OU show that there are significant gaps in linkage among diagnosed PLHIV in the 50+ age group. This has been consistently observed in previous estimates and COP planning exercises although results from the EPHIA study are markedly different from these estimates. There is a need to address this apparent gap among this population and, in COP23, efforts will be targeted to:

- Understanding the actual gap in attaining the 2nd 95 among in the 50+ age group with particular focus to females, through the EDHS HIV module
- Identifying any barriers to access HIV care and treatment services for this population
- Devise context specific strategies to track, link and retain them in HIV care and treatment services, including the use of adherence groups
- Develop plans and implement activities to attain the required coverage among this population
- Engage CSO, notably associations of PLHIV and peer-to-peer support in engaging the individuals, families, and community to address the identified barriers in accessing HIV services
- Provide person-centered comprehensive, integrated, quality HIV services for this population
- Assess the magnitude of recent infections among this population
- Monitor performance through program reviews and routine reports at different levels
- Involve and coordinate both facility and community stakeholders and activities for creating awareness, collaboration and aligning efforts
- Strengthen leadership engagement in these activities for guidance, oversight, and monitoring

Pillar 4: Transformative Partnerships

PEPFAR-E will support some of the human rights-based approaches to HIV and will address structural barriers through economic empowerment, including supporting government job creation, micro-financing, private sector, and community level initiatives. PEPFAR-E will implement interventions that address the underlying structural (social, cultural, and economic) causes of gender inequality, including addressing harmful traditional practices and social norms and empowering women and girls through inter-sector collaboration.

PEPFAR-E continued close partnership and coordination with key HIV/AIDS development partner counterparts, including the Global Fund and UNAIDS, will ensure that strategies, programs, and resources are aligned to support the Ministry of Health's HIV/AIDS programming.

PEPFAR-E has limited, previous experience engaging with the private sector. The most notable examples are short-term partnerships with Government of Ethiopia commercial entities, including with the national cellular phone company, Ethio Telecom, to set up an HIV/AIDS hotline and with the national airline, Ethiopian Airlines, to transport HIV commodities. In COP23, PEPFAR-E will focus on exploring and developing relationships with a range of private sector companies. PEPFAR-E intends to target both health related organizations, including but not limited to private health facilities as well as pharmaceutical and medical device companies, and organizations with corporate social responsibility or social business programming that aligns with PEPFAR programming (e.g. Mastercard Foundation).

PEPFAR-E will also seek to leverage different business services that can support programming, like working through Ethio Telecom or Safaricom, the newest cellular service provider in Ethiopia, to provide HIV/AIDS messaging or seeing if Coca-Cola's extensive distribution network can be utilized to support last mile delivery of HIV commodities. PEPFAR-E will also seek to collaborate with different business associations, including the American Chamber of Commerce, Rotary International, and other similar entities, to identify and facilitate partnerships. Additionally, PEPFAR-E will explore partnering with microfinance organizations to strengthen economic opportunities for PLHIV, particularly for KPs/PPs, OVCs, and other vulnerable Ethiopians. Finally, recognizing that there is a large and influential Ethiopian American diaspora, PEPFAR-E will seek to identify partnership and collaboration opportunities.

PEPFAR-E will also explore partnerships within CDC and USAID as well as other Embassy sections. USAID works in multiple sectors, and there seem to be opportunities to integrate PEPFAR programming into existing programs and relationships. For example, USAID's OVC program has signed a Memorandum of Understanding with its Integrated Youth Activity (IYA) to explore ways to link IYA beneficiaries with OVC programming. USAID's Education Office recently started a partnership with the LEGO Foundation, and PEPFAR-E will see where there may be opportunities to collaborate. PEPFAR-E will engage with the Public Affairs Section to identify ways to leverage USG supported activities, e.g., music festivals, or to facilitate aligning with other major events in the country, like the annual Great Ethiopian Run.

Pillar 5: Follow the Science

PEPFAR-E will continue to provide TA to the MOH and its agencies, including EPHI, for the generation, analysis, dissemination, and use of HIV related epidemiological data from the general population and among sub-population groups to estimate the prevalence, incidence, and burden/determinants of the disease and look at disease patterns over time and across geographic areas in all regions in a way that informs the efforts towards epidemic control. In this regard, PEPFAR-E is planning to support an IBBS among FSWs, while the Global Fund, with TA and in collaboration with PEPFAR, will support the Government of Ethiopia to conduct IBBSs targeting PWID and other KP groups, including AGYW, daily laborers, and widowed and divorced people. Data generated from these surveys will be used to guide targeting HIV programs towards the specified population groups.

Currently, HIV case-based reporting and recency surveillance are being implemented across over 900 selected health facilities and 29 community DICs nationally with a plan to initiate longitudinal case surveillance in these sites in COP23. HIV case reporting will be expanded to include all sites with at least one new HIV positive case or one PLHIV on treatment with capacity building of regions and systems support. Data generated from this activity is being used to provide optimum response at both individual client and hotspot levels. The data generated through longitudinal collection will support program management as well as be used for surveillance purposes targeting sub-population groups. Data from the recent Violence Against Children and Young Adults Survey will be used along with the HIV CBS and IBBS results to inform HIV programing and target relevant priority populations and geographies.

PEPFAR-E will support the design and expansion of HIV specific and all-cause mortality surveillance systems in selected urban areas where the HIV burden is high to look at the impact of HIV and HIV programs among PLHIV and the general population. A one-time HIV Mortality survey will be implemented by EPHI through funding support from the Global Fund and TA from PEPFAR.

The ANC/PMTCT-based sentinel site HIV surveillance system, which currently is being implemented in 122 health facilities, will be strengthened to improve the quality of data generated, reported, and being used as an input to the yearly SPECTRUM exercise to produce different HIV related estimates and projections used for country and regional HIV Program planning purposes.

PEPFAR-E will continue supporting data quality assurance and data quality improvement for HIV testing, ARV treatment, viral load monitoring, PMTCT, and HIV case-based surveillance (CBS) programs at both facility and community levels. The data will be used for program monitoring, and HIV CBS data will serve as an input for SPECTRUM estimation. PEPFAR-E is also working with the MOH on data alignment between DHIS2 and DATIM reports. Workforce capacity building on HIV data quality and information use will be a focus for both pre-service and in-service training programs via training of HIV track FELTP residents leveraging GHS programming as well as training all relevant cadres from MOH, RHBs, zonal health offices, and Woreda health facilities. We have developed guidelines and standard operating procedures aimed at

enhancing HIV data quality and information use to support data driven decision making in HIV program planning and epidemic control.

Strategic Enablers

Community Leadership

PEPFAR has engaged relevant stakeholders at the local level to sensitize them with the CLM concept, empowering clients to obtain information about services and participate in monitoring service quality. Both qualitative and quantitative data have been collected, analyzed, and reported to relevant stakeholders. Interface or advocacy meetings have been conducted with concerned decision-makers, and action plans have been developed to address identified gaps. Interventions have been taken to address these gaps, and implementers have continuously followed up to ensure that promised action plans are in place. Some enhancements have been documented based on the CLM findings and action plans.

CLM activities have been implemented in close collaboration with local government offices, health facilities, and local implementers at both facility and community levels. Ongoing feedback to health facilities and community sites being monitored is taking place. CLM findings are officially reported to respective offices in charge of coordinating the HIV response, and findings are disseminated to key stakeholders to inform the HIV program.

Community-based organizations representing PLHIV, youth, and faith-based organizations have participated in in-country strategic discussions prior to the co-planning meeting in Johannesburg and provided written feedback on key strategic priorities.

In COP23, PEPFAR-E will continue to actively engage community-based organizations through the implementation and program review process throughout the COP year. PEPFAR-E will increase the number of partners engaged in CLM to focus on pillar one populations that have been left behind in the HIV response. PEPFAR-E will also engage with the Global Fund to advocate for the adoption and scale up of CLM approaches for HIV programming in Ethiopia. These partners will join quarterly program meetings to present their findings to keep PEPFAR-E on track and ensure that we are meeting the needs of beneficiaries.

Innovation

As Ethiopia approaches epidemic control, much needs to be done to increase and maintain treatment coverage while finding and serving the most vulnerable and difficult to reach population groups and to sustainably transition HIV programming to the government.

PEPFAR-E will take a bold approach in COP23 to introduce new approaches to reach KPs that have not been equitably served in previous years due to stigma and discrimination, appropriate targeted programming, and policy gaps. Evidence will be generated to inform high level decision-makers for enhanced programming. PEPFAR-E programs will ensure that people-centered approaches are implemented by creating a conducive platform through which clients'

voices are heard so that innovative local solutions to existing challenges are created. This will ensure that they can be quickly adopted, and sustainability of effective programming ensured.

PEPFAR-E will strengthen its existing partnerships and form new partnerships with civil society organizations and local implementing partners that have complementary capabilities to the PEPFAR program and enable a different way of working to advance strategic priorities in the efforts to address health issues of young and adolescent girls, KPs, PLHIV, and orphans and vulnerable children.

HIV Self-test for children 2-15 years old, which was piloted in COP22, will be scaled-up and expected to boost the case finding effort among children. Those caregivers that particularly have difficulty bringing children of index cases to facilities for various reasons will benefit from this approach. PEPFAR-E will continuously engage with MOH to make sure that newly approved child friendly ARV formulations are introduced to the program as available in the market.
To ensure the sustainability of HIV treatment, the private sector should play a bigger role by increasing access to ART. Decentralized Drug Distribution (DDD) is one of the innovative approaches that increase access to medicines and improve service quality for ARVs provision. The DDD model will reduce long queues for patients, improve quality of care for the sickest, improve access and reduce travel costs, and lead to better patient follow-up and client satisfaction resulting in reduced loss to follow up and improved treatment outcomes. PEPFAR-E has started supporting the Ministry of Health, EPSS, RHBs, and private and community pharmacies to pilot and implement the DDD. In COP23, it will continue to be a priority of supply chain technical assistance, and a pilot of the DDD initiative in selected public and private pharmacies, including Kenema Pharmacies (special pharmacies that provide low-cost ARV dispensing), will be supported.

Leading with Data

Data driven planning, monitoring, and resource allocation must occur at the subnational, community, and site levels to achieve the greatest impact. Collection and use of disaggregated data that characterizes the populations (e.g. age, sex, KPs or PPs, etc.) served in the lowest geographic level (i.e. Woreda/district) where HIV services are being provided is critical for understanding current program performance, analyzing the progress towards HIV epidemic control, and identifying gaps to be filled and areas to be improved. As Ethiopia reaches HIV epidemic control, using accurate, de-duplicated, and de-identified patient level information at health facility and community levels is critical for monitoring the performance of the clinical cascade. It is important to ensure that critical patient level and aggregate data are available for programs at all levels, while privacy and confidentiality continue to be protected and maintained.

Health Information System (HIS) and data management investments are essential to sustain the HIV response. These investments advance country-level data systems and expand stakeholders' capacity to manage, analyze, and use data to facilitate appropriate patient management, inform public health response, and guide programmatic decisions for HIV and other public health concerns. They also help monitor PEPFAR investment impacts.

PEPFAR-E's strategy and plan for health data systems and data use are guided by the national eHealth architecture and the information revolution agenda in the health sector transformation plan. The national strategic direction aims to strengthen the country's health information system and improve data quality, analysis, and use. PEPFAR data system and information use align with the national plan by providing TA and funding for the development and maintenance of national HIV-related data systems and data use activities at national, regional, and health facility levels.

Patient monitoring is essential for ensuring the quality and continuity of care. It generates data that enables programs to monitor the treatment and health status of patients over time as well as to measure program performance across health facilities and geographical settings. To this end, there is a strong need for smart data systems that can integrate multiple data types and facilitate data crosswalks to verify or complement findings. Because patient monitoring systems inform program monitoring, it is essential to establish a central data management system that provides information for decision-making and optimizes program and patient outcomes. The central data repository will bring together longitudinal person-level data across service delivery points and types of data (e.g., clinical, laboratory, logistics, community, CBS, etc.) nationally. The national data system serves as a common source via integrating information systems to ensure data points are recorded once and available for all needs.

There have been efforts to centralize relevant patient level and aggregate data, like the central data repository from EMR ART patient record, unified data system from community HIV records, data exchange for viral load data, and logistics system central data with the associated data analytics to monitor the performance of the program and enhance evidence-based decision making. In COP23, PEPFAR-E will continue collaborating with MOH to lead with data via collecting and using smart data, accelerating data integration with national person-centric data repositories, supporting interoperability, and aligning with the national health management information system. PEPFAR will support training and TA to strengthen the capacity of Ethiopian health workers to collect, manage, and analyze HIV-related data. This includes supporting the development of standardized data collection tools, data quality assessments, and data use for program planning, monitoring, and evaluation. PEPFAR and MOH’s strategy for data systems and data use in relation to HIV is focused on strengthening the country's health information system to improve the quality of HIV-related data and using this data to inform program planning, monitoring, and evaluation.

In COP23, PEPFAR-E will work with the MOH to ensure that an HIV module is included in the EDHS. PEPFAR-E will provide direct TA to EPHI to support the DHS.

Target Tables

Target Table 1 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV (FY23)	New Infections (FY23)	Expected Current on ART (FY23)	Current on ART Target (FY24) *TX_CURR*	Newly Initiated Target (FY24) *TX_NEW*	ART Coverage (FY24)*	ART Coverage (FY25)
Attained	564,474	6,347	475,894	494,457	30,275	89%	NA
Scale-Up Saturation	NA	NA	NA	NA	NA	NA	NA
Scale-Up Aggressive	NA	NA	NA	NA	NA	NA	NA
Sustained	40,497	846	24,308	25,237	1,512	64%	NA
Central Support	NA	NA	NA	NA	NA	NA	NA
Commodities (if not included in previous categories)	NA	NA	NA	NA	NA	NA	NA
No Prioritization	NA	-	7,992	8,306	504	NA	NA
Total	**604,971**	**7,193**	**508,194**	**528,000**	**32,291**	**88%**	**91%**

***FY24 ART coverage calculated from PLHIV estimated used for FY 2024 target setting (597,582: Sustained - 39,727 & Attained - 557,855)**

Table 2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

SNU	Target Populations	Population Size Estimate (SNUs)	Current Coverage (FY23) %	VMMC_CIRC (in FY24)	Expected Coverage (in FY24)	VMMC_CIRC (in FY25)	Expected Coverage (in FY25)

Anguwak	Male 15+	51,734	74	3,407	80	-	-
Etang Spec Woreda	Male 15+	59,563	74	5,182	84	-	-
Gambella Town	Male 15+	36,082	73	3,087	81	-	-
Mejenger	Male 15+	23,007	80	947	85	-	-
Nuwer	Male 15+	53,352	78	2,630	86	-	-
-	**Total (Average)**	**235,010**	**76**	**15,253**	**83**	**NA***	**NA***

*No VMMC_CIRC target for year 2 in the Target setting tool

Target Table 3 Target Populations for Prevention Interventions to Facilitate Epidemic Control

Target Populations	Population Size Estimate* (SNUs)	Disease Burden*	FY24 Target	FY25 Target
KP_PREV				
Addis Ababa	20,020	18.70%	16,316	-
Amhara	74,649	18.70%	36,183	-
Gambella	4,556	18.70%	1,808	-
Oromia	106,344	18.70%	28,968	-
Sidama	9,194	18.70%	4,288	-
SNNPR	27,463	18.70%	8,299	-
Southwest Ethiopia	6,168	18.70%	1,465	-
Tigray	27,535	18.70%	11,377	-
Afar	11,617	18.70%	0	-

Benishangul-Gumuz	4,103	18.70%	0	-
Dire Dawa	3,308	18.70%	0	-
Harari	1,040	18.70%	0	-
Somali	3,385	18.70%	0	-
TOTAL	**299,382**	**18.70%**	**108,704**	**108,688****
PP_PREV				
Addis Ababa	NA	-	16,307	-
Amhara	NA	-	43,303	-
Gambella	NA	-	1,461	-
Oromia	NA	-	10,539	-
Sidama	NA	-	2,900	-
SNNPR		-	2,772	-
Southwest Ethiopia	NA	-	625	-
Tigray	NA	-	12,528	-
TOTAL	NA	-	**90,435**	**90,435****

**Include data sources in the text (i.e., not in the table itself)*
***OU level target for year 2 (FY25)*

Target Table 4 Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC OVC_SERV Comprehensive	Target # of OVC OVC_SERV Preventative	Target # of active OVC OVC_SERV DREAMS	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files OVC_HIVSTAT
Addis Ababa	54,855	42,552	12,444	-	34,850
Afar	74,739	-	-	-	-
Amhara	658,711	78,892	22,796	-	63,800
B/Gumuz	46,884	-	-	-	-
Dire Dawa	18,661	-	-	-	-

Gambella	22,283	3,614	1,118	-	,125
Harari	6,871	-	-	-	-
Oromia	1,177,482	66,173	19,800	-	55,449
Sidama	141,538	7,952	2,323	-	6,497
SNNPR	491,374	16,900	5,195	-	13,948
South West Ethiopia	-	3,366	989	-	2,772
Somali	219,427	-	-	-	-
Tigray	133,758	21,350	6,542	-	18,275
FY24 TOTAL	**3,046,583**	**240,799**	**71,207**	-	**198,716**
FY25 TOTAL	**-**	**240,799**	**71,207**	-	**198,716**

Core Standards

PEPFAR Ethiopia COP 23 core standards include:

Offer safe and ethical index testing to all eligible people and expand access to self-testing. The minimum standards for safe and ethical index testing were introduced in 2020, and assessments of the standards were completed in 2022. ICT and all other HIV testing modalities will adhere to the WHO's rights-based five core principles (consent, confidentiality, counseling, correct test results, and connection to treatment or other services). Moreover, sites and providers will be supported to meet a set of minimum core standards established by the National HIV Testing Services TWG. 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, and 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 HIVST through secondary distribution via index cases will be used to reach partners who prefer to self-test;
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. Tailored staff recognition strategies, such as posting "Best Counselor of the Month," providing certificates of recognition, granting a few hours leave, etc., will be used to maintain staff motivation. Moreover, programs will be guided to actively solicit feedback from persons receiving service and use it to improve services through tailoring person-centered ICT to the specific needs of each subpopulation, and;
9. Town/Woreda health offices will strengthen their 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 to treatment services. The support will build capacity for and optimize workforce at facilities, woreda health departments, local implementing partners, CSOs, and other community actors to ensure the minimum standards for safe and ethical ICT are provided within these zones and at high volume, high-impact sites. On top of achieving the targets, the capacity building support to the extended arms of MOH/RHBs will play a key role for sustainability.

PEPFAR-E has been pioneering, advocating, and supporting activities to demonstrate the feasibility of implementing HIVST in Ethiopia. The MOH has adapted the implementation of assisted and unassisted HIVST to the 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, the MOH has approved the scale up of caregiver assisted HIVST among children 2-15 years old.

In COP23, PEPFAR-E will strengthen caregiver assisted HIVST to increase access for children of index cases who are not reached through conventional ICT services. In COP23, PEPFAR-E 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); social marketing home-to-home distribution through peer, sexual, and social networks; distribution to KP and clients of FSWs and high-risk PBFW; distribution from STI patients to their sexual partners; and targeted use in OPD settings. To provide person-centered distribution services, PEPFAR-E will expand HIVST availability in SDPs, such as ART/PMTCT clinics, STI/virology 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, AGYW, and hard to reach key and priority populations. PEPFAR-E will utilize selected health facilities co-located with pharmacy outlets to make the HIVST kits available and facilitate access to high-risk target population groups who prefer to self-test rather than being tested through the national testing program. Moreover,

the distribution of HIVST kits will be integrated with the Decentralized Drug Distribution (DDD) platform in selected pharmacies to increase access to the eligible population groups.

Fully implement "test-and-start" policies.
Adoption of a test and start strategy and policy was included in national guidelines and endorsed in 2016 with successful implementation, demonstrable access, and direct and immediate (>95%) linkage of clients from testing to uninterrupted treatment across all age, sex, and risk groups, including KP/PP getting comprehensive HIV services in community DICs and public KP friendly clinics. All HIV-positive individuals are offered the option of rapid or same-day ART according to guidelines. In COP23 and beyond, the test and start strategy will be further strengthened and expanded.

Directly and immediately offer HIV-prevention services to people at higher risk
PEPFAR-E will continue offering HIV prevention services to people at high risk of acquiring HIV, including KP and PP. Prevention services will be offered directly and immediately to people at high risk; such services include provision of condoms and lubricant, risk/harm reduction counseling, STI screening, and PrEP for those eligible who are HIV negative to keep them HIV-free.

The inclusion of AGYW, PWID, and other high risk population groups as eligible population groups for PrEP is still in process. Thus, advocacy on some policy issues for expanding population groups for PrEP beyond FSWs and discordant couples (e.g., AGYW, ABYM, PWID, other high risk population groups) and on other PrEP options (e.g., CAB-LA) and models of PrEP delivery to address distance barriers and improve accessibility are priorities in COP23. PEP is being provided for occupational exposure and sexual gender-based violence (SGBV) survivors, but the uptake among the SGBV survivors has been low due to the late presentation of survivors to the service and due to the requirement of HIV testing to get PEP.

In COP23, PEPFAR-E will strengthen its support for GBV management with particular focus in conflict affected areas of the country. This includes the provision of comprehensive and age appropriate post-GBV care that meets the expressed needs of survivors and provides identification and first-line support for GBV within HIV/AIDS prevention, case finding, care, and treatment programs. PEPFAR-E will strengthen referrals from HIV/AIDS services to GBV services and vice-versa; provide violence informed HIV service delivery at supported sites to mitigate the impact of GBV which will include integrating routine enquiry of intimate partner violence as part of safe and ethical index testing, partner notification and PrEP services and clinical enquiry within care and treatment settings; and strengthen post-rape care services, including the provision of HIV PEP.

GBV prevention interventions will target both community and policy level changes. At the community level, these will include trainings on interpersonal communication; community mobilization and mass media activities; and programs that address societal and community norms that perpetuate violence against women and girls and other marginalized populations, that promote gender equality, and that build conflict resolution skills.

PEPFAR-E will strengthen linkages between health, legal, law enforcement, and judicial services and programs to prevent and mitigate gender-based violence, support for review, revision, and enforcement of laws and for legal services relating to GBV, including strategies to more effectively protect young victims and punish perpetrators. PEPFAR-E will also focus on policy advocacy with GOE on the provision of PEP for SGBV survivors, at both clinical and community sites, irrespective of their HIV testing.

The prevalence of male circumcision among adult males aged 15-49 years in Gambella is 72% compared to a 92% national male circumcision prevalence (EDHS 2016). The region has the highest HIV prevalence of 4.8% (EDHS 2016) and 5.7% (EPHIA, 2018). The rate of HIV among uncircumcised males is 1.5 times as high as among circumcised males (5.3% vs 3.5%: EPHIA 2018). The voluntary male medical circumcision (VMMC) program in Ethiopia has been providing services to Gambella host, refugee, and military adult male populations since 2009. A total of more than 230,000 VMMC procedures have been performed in Gambella up to the end of COP21/FY22, since then.

However, the program lacks robust data to make realistic estimation of VMMC needs in Gambella region. In 2016, the Federal Ministry of Health in collaboration with the national VMMC TWG estimated the VMMC eligible male population aged 15 years and above to be 158,637 for the Gambella host population. However, because of high population dynamics, especially a high refugee influx, and outdated data, this estimate is not valid for current use to monitor program performance, provide a male circumcision coverage estimation, or inform program planning and decisions. There are many South Sudanese in the region, who are not officially registered as refugees, living mixed with the local community in addition to the 378,075 officially registered refugee population currently residing in camps (UNHCR, January 2023). Ethiopia and South Sudan share a more than 500 kilometers long border along the Gambella Regional State, which is porous and allows population movement in both directions.

The main goal of the VMMC program in Gambella is to achieve 90% VMMC population coverage among 15+ year old Indigenous and refugee men as per WHO and UNAIDS' recommendations. Currently, the COP planning process is largely guided by the existing high demand for VMMC services among both communities in the region. In COP 23 the Gambella RHB will support implementation of comprehensive HIV prevention, care, and treatment activities among refugee sites. The RHB will collaborate with Agency for Administrations of Refugees and Returnees Affairs (ARRA) and the Bureau of Population, Refugees, and Migration at the Department of State through UNHCR to address immediate HIV prevention, care, and treatment needs of refugees on Gambella..

Moreover, in COP23, the VMMC program will focus on using VMMC service outlets as entry points for uncircumcised men, especially ABYM, to a comprehensive set of prevention services, including HIV testing, condoms, Prep, PEP, risk reduction counseling, and promotion of healthy gender norms. Prioritization of adolescent boys and young men aged 15-29 years, accounting for 70-80% of program volume, will be a key program focus in COP23, since the program will

also have an indirect contribution in preventing HIV infections among sexual partners and decreasing risk of cervical cancer. To address the awareness gap among refugee communities, communication activities will be enhanced for demand creation to link clients to HIV prevention services, improve adolescent men's access to HIV testing including self-testing, and connect those who are positive to treatment besides guiding those who are negative to additional prevention services. The program will also collaborate with other HIV prevention and SRH services to increase education on and referral to VMMC services and improve access to comprehensive HIV prevention and SRH services.

PEPFAR-E will continue engaging with UNAIDS, WHO, FMOH, local CSOs (e.g., the Ethiopian Surgical Society), and communities to advocate for and support integration of VMMC program components into local, regional, and national health systems (e.g., task shifting to non-physician providers, sharing use of national healthcare staff and facilities, and providing oversight and training). The program will also focus on strengthening healthcare systems by training and capacitating RHB and MOH staff and local providers in quality control, program management, IPC, and safe service delivery and support establishment and maintenance of basic surgical skills and improved IPC efforts besides full transition to using reusable surgical instruments and providing guidance in managing surgical instrument reprocessing and sterilization.

Provide orphans and vulnerable children (OVC) and their families with case management and access to socioeconomic interventions in support of HIV prevention and treatment outcomes. The PEPFAR-E OVC initiative seeks to enhance the standard of HIV services provided to OVC and their caregivers. OVC can improve their health and well-being by taking advantage of programs that support HIV care, health, nutrition, economic security, education, protection, and psychosocial wellbeing.

PEPFAR-E's OVC program will continue to work on two distinct but complementary OVC program strategies in the eight PEPFAR-supported regions of the country: Amhara; Oromia; the Southern Nations, Nationalities, and Peoples' Region (SNNPR); Sidama; Southwest Ethiopia; Addis Ababa; Gambella; and Tigray. The initiatives are known as OVC Comprehensive for children and families with known high-risk traits and OVC Preventive for adolescent girls in high HIV burden areas, 10-14-year-old girls and boys for primary prevention of sexual violence and HIV, and children and adolescents living with HIV.

In COP23, 270,000 OVC under the age of 18 and 42,000 caregivers will be targeted for services. The comprehensive services will be delivered to 198,707 priority subpopulations, which include children and adolescents living with HIV, children of adults living with HIV at risk treatment interruption; children who have lost parents to AIDS, HEI at high risk of treatment interruption (i.e., pregnant, and adolescent mothers and their infants), children of female sex workers (especially FSWLHIV), and survivors of sexual violence. The graduation benchmark achievements will be monitored throughout the year. Children of FSWs with HIV will be assessed and enrolled in the OVC program in collaboration with partners working on KPs.

The OVC program will continue to train 71,292 10–14-year-old adolescents in COP23 using PEPFAR-approved curricula, such as Sinovuyo Teen, which promotes caring and trusting relationships between caregivers and their teenagers; coaching boys into men, which develops healthy relationship skills among young males; and that improves self-defense, physical, mental, and verbal skills. In addition, the OVC program will work closely with the health, educational, psychological, economic, civil society, and community sectors to provide a comprehensive package of social, economic, and biological interventions to reduce adolescent susceptibility.

Given the increased risk of HIV infection among children affected by and vulnerable to HIV, the program will track HIV status among OVC beneficiaries under the age of 18 (OVC_HIVSTAT) in the comprehensive program, assess their risk of HIV infection, and facilitate access and retention in ART treatment for those who are HIV positive.

The program will focus on assisting in the identification of new C/ALHIV, linking individuals to ART, reducing treatment interruption, expanding access to viral load testing, and providing services to increase their viral suppression rates. Priority interventions in this regard will include enrolling at least 95% of children under the age of 18 who are currently receiving ART into the OVC program, prioritizing those with poor viral load suppression and those new to treatment, ensuring that at least 95% of beneficiaries served by PEPFAR-E OVC programs know their HIV status, and ensuring that 100% of OVC beneficiaries with HIV are receiving ART.

The OVC program will track the PMTCT cascade to assist with contact tracing and follow-up for children under the age of two who have had PMTCT services interrupted to improve treatment continuity, particularly for HEI. Community-facility linkage will be strengthened through partnership-building and data-sharing between both service areas. To ensure the continuity of HIV care and treatment for C/ALHIV, the social service and child protection systems will be improved, and the enrollment of CLHIV at risk of treatment interruption into OVC activities will be prioritized. Furthermore, by focusing on conflict-affected areas, monitoring of missed appointments and return-to-care activities will be reinforced.

To improve the comprehensive services provided to targeted beneficiaries, survivors of violence will be assisted in a timely and effective manner. Violence screening as part of OVC case management, as well as referral and linkage to comprehensive post-violence treatment services as part of first-line support, will be carried out. Caregivers and child/adolescent survivors of sexual and physical/emotional violence will also receive first-line care and be referred for clinical and non-clinical services. The link with providers of post-violence care will be enhanced, and referral protocols will be updated.

Survivors of sexual violence will be provided with prompt and efficient assistance to strengthen the comprehensive services provided to targeted beneficiaries. Domestic violence victims will be referred for clinical and non-clinical assistance in addition to receiving initial care. Referral protocols will be improved, and the connection with post-violence care providers will be strengthened.

For children and adolescents living with HIV and associated vulnerabilities, case management in facilities and the community will continue, and community based MHPSS initiatives will be launched. Referral services will be provided for children who require additional services such as SRH, emergency care, immunization, and nutrition.

HIV-affected and infected children and their families will be linked to additional relevant social services based on their needs through collaboration with PEPFAR-supported and other community-based programs. During OVC home visits by community caseworkers and social service workers, the program will improve caregivers' treatment literacy and provide psychosocial support, socioeconomic interventions, education support, and parenting skill instruction, among other activities. To fulfill the program's objectives, the OVC program will collaborate closely with public and private health facilities that provide HIV care and support to improve access to services and information exchange.

In COP23, the program will advance community case workers' and social service providers' capacity to recognize and handle risk factors for poor treatment continuity and adherence, particularly in the first three months of treatment. Linkage coordinators will give quality adherence counseling and assistance in the community during home visits, support monitoring of children's ART adherence and VL status, and recommend enhanced adherence counseling when necessary.

The OVC program will increase caregivers' knowledge, abilities, and confidence in discussing sexual and reproductive health issues with their children to increase behaviors that reduce the risk of HIV transmission, such as delaying sexual activity and using condoms, as well as prevent abuse and violence. Gender inequities, a lack of capacity to negotiate safer sex, transactional sex, barriers to HIV disclosure and treatment due to fear of violence and abandonment, and GBV all increase women and girls' vulnerability to HIV. Therefore, services for teenagers and young adults will include HIV and GBV risk screening as appropriate depending on the service delivery site, HIV and GBV prevention programs, post-violence services for GBV survivors, adherence and disclosure support, and continuity of treatment.

Ensure HIV services at PEPFAR-supported sites are free to the public.
Screening and management of OIs, including cotrimoxazole preventive therapy (CPT) and TB preventive therapy (TPT), have been provided free of charge at PEPFAR supported ART sites although there have been challenges especially with regards to commodities for the diagnosis and management of advanced HIV disease. In COP23, PEPFAR-E will continue to work in collaboration with the Ministry of Health and Global Fund, to avail OI drugs including drugs needed for prevention and treatment of advanced HIV diseases such as fluconazole, amphotericin B, and flucytosine. In addition, cervical cancer prevention services will be provided free of charge at PEPFAR supported sites, and these include HPV testing, VIA screening, and treatment of precancerous cervical lesions. Furthermore, PEPFAR will work with MOH and GF to avail medications for PLHIV presenting with common mental health disorders.

PEPFAR-E will engage in both policy and service delivery work to ensure the availability of free services including post-GBV care for survivors. On top of advocating that the GOE support free services, PEPFAR-E will allocate adequate budget and procure some essential drugs and supplies; conduct joint planning with other relevant stakeholders, such as the Global Fund; and monitor and report on AHD program implementation to support timely decision making.

Eliminate harmful laws, policies, and practices that fuel stigma and discrimination and make consistent progress toward equity.

Programs must consistently advance equity, repudiate stigma and discrimination, and promote human rights to improve HIV prevention and treatment outcomes for KPs, AGYW, children, and other vulnerable groups. This progress must be evidence-based, documented, and included in program evaluation reports.

PEPFAR-E will continue to support the Government of Ethiopia's efforts to reduce HIV stigma and discrimination by giving life with HIV a new face (e.g., "HIV is no longer a death sentence") and scaling-up the U=U initiative. 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. PEFAR-E will also work closely with CSOs and FBOs on integrating messaging to increase awareness about HIV in the community and to reduce stigma and discrimination among PLHIV.

Optimize and standardize ART regimens.

Programming will focus on offering DTG-based regimens to all PLHIV including adolescents, women of childbearing potential, and children four weeks of age and older.

All PLHIV, including adolescents, women of childbearing potential, and children four weeks of age and older, will be offered optimized DTG-based ARV regimens according to the updated national consolidated guidelines. All newly enrolled clients and existing clients on ART are eligible for DTG regimens including those receiving treatment for active TB disease or TPT. DTG is a component of ARV regimens for clients in first-, second-, and third-line regimens. All clients will receive clinical and laboratory monitoring while receiving DTG regimens to monitor response, identify adverse events, and further optimize their regimens (e.g., substitution or switching).

PEPFAR-E will support this initiative through provider training, provider job-aids, mentoring, supervision, and performance reviews. Support will be provided for the appropriate forecasting of the need for optimized ARV regimens for all clients that are tailored to their age, comorbidity status, and DSD model. Additional support will include strengthening collaboration between the supply chain system, logistics management, pharmacy services, and the health facility HIV care and treatment services; supporting regular inventory reviews and distribution and use of ARV drugs; strengthening adherence to prescribed ARV regimens through provision of

simplified dosing schedules, appropriate packs of drugs, reminders, and adherence support; strengthening recording, data quality, data use, and reporting of client level regimen information; and strengthening pharmacovigilance. The community partners will provide intensive adherence counseling and support to clients offered optimized DTG-based ARV regimens.

Offer differentiated service delivery models

The country has had notable successes in implementing 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 armed conflict. Successful DSD model implementation and scale-up have also been 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.

DSD, as a provision of people-centered services to all clients, will be strengthened. Activity monitoring and the performance of the existing DSD models will be strengthened besides facilitating the implementation and roll-out of new DSD models through capacity building, provision of manuals and tools, mentoring, supervision, and performance reviews. Strengthening and maximizing the implementation of DSD models in all regions and optimizing the collaboration between facility and community services are necessary to continue progress toward epidemic control. Expanding new models includes DSD for advanced HIV disease, older adults, and family-centered services and DDD.

In COP23, the MOH in partnership with PEPFAR-E and implementing partners will evaluate current DSD models in Ethiopia to provide evidence of program impact and health outcomes, identify gaps in the existing framework, and inform future directions for DSD models.

Through the assessments of the status of the implementation of the current DSD models, identified gaps and challenges will be addressed, and experiences and lessons from best performing sites, partners, and programs will be shared. Ensuring the commodity needs for each model is accounted for in the quantification of the program needs. To this end, all stakeholders will work collaboratively to integrate the provision of services in the DSD models with other program services, health systems, and existing structures.

In COP23, in alignment with the PEPFAR 5X3 strategy and as part of improving equity of health services to address the needs of adolescents, children, and youth, the Adolescent and Youth Differentiated Service delivery (AY DSD) models both at facilities and in communities will be expanded. This will help to empower adolescents to disclose their HIV status, improve treatment adherence and continuity, achieve and maintain viral suppression, and decrease new HIV infection through access to integrated HIV services, including HIV testing, condom promotion, SRH, and appropriate messaging.

In regions less affected by conflict, there has been moderate growth of the ART cohort but not sufficient to achieve the 95-95-95 targets. Based on identified gaps in treatment continuity and interruptions, return to treatment initiatives will be strengthened in selected geographic areas and sites. PLHIV who interrupted treatment will be tracked, identified, and supported to re-engage them in ART services.

Additional focus will be on enhancing people-centered services for virally unsuppressed clients, clients newly initiated on treatment, and clients with AHD. Services aimed at the growing cohort of PLHIV greater than 50 years old will help ensure 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 led by the MOH, currently implemented in all regions to accelerate new client enrollment, treatment continuity, and increased viral load coverage and suppression will be strengthened further in COP23.

Integrate tuberculosis (TB) care

Program data shows that the yield of TB symptom screening has been low over the past few years. The new WHO TB screening algorithm has been adapted to the national TB/HIV guideline since 2021 and new screening tools such as Chest X-Ray (CXR) and C-reactive protein (CRP). TA has been provided to the MOH to develop detailed operational guidance for the use of the new screening tools for prioritized high risk TB groups based on the national context. The MOH is also working to find means to reimburse costs associated with the use of new screening tools to avoid catastrophic, out-of-pocket expenses to the patient. Moreover, the use of CRP for TB screening will be evaluated in a pilot project to assess its contribution to TB case detection and cost effectiveness in the local context where the TB incidence rate is less than one percent among the PLHIV cohort.

The contribution of other newly introduced diagnostic tools such as the Urine LAM test will also be evaluated to inform further scaling up planning. A program evaluation will be conducted for the TB Innovations project, which is a pilot project involving TB - COVID19 bi-directional screening and DSD models for TPT and TB treatment together with virtual patient support, to inform the further scale up and national guideline adaptation of optimal patient centered care. With intensified site level support and surge interventions, TPT uptake among PLHIV receiving treatment has improved. In COP23, high volume sites with low TPT coverage and CLHIV will be targeted for focused intervention and improved TPT uptake. Due to its convenience and

improved adherence, 3HP has been accepted well by HCWs and PLHIV. This service will be strengthened and available in all PEPFAR supported sites in COP23.

All PLHIV are screened for TB routinely at every encounter during clinical care and while accessing services at community-based SDPs. The community engagement facilitators and community resource persons will scale up TB screening services for PLHIV who are enrolled in community case management services, using standardized symptom screening tools for TB symptoms. They will refer symptomatic clients suspected of TB infection to health facilities for further TB screening with more-sensitive, WHO-recommended screening tools. When HIV clients are diagnosed with TB coinfection and enrolled in community case management, the community care providers will provide intensified adherence support to ensure TB treatment completion. Community providers will also provide adherence support for eligible clients on TPT to ensure completion.

All eligible PLHIV, including children and adolescents, should complete TPT and cotrimoxazole, where indicated, and these services must be fully integrated into the HIV clinical care package at no cost to the patient.

In COP23, HIV testing coverage for TB will continue to be maintained at high levels with greater focus on 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 will 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 track 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 a particular focus for groups with higher coverage gaps including PLHIV newly enrolled to ART and C/ALHIV. Strengthening the collaboration with the community partners will be important to enhance tracking of clients with TPT interruption and improve TPT uptake and completion.

Diagnose and treat people with advanced HIV disease (AHD)

In COP22, PEPFAR-E has been supporting the MOH in the development of AHD policy and guidelines. The WHO AHD package has been adopted and detailed in the national guidelines for comprehensive prevention, care, and treatment. A separate AHD DSD implementation manual has also been developed along with AHD DSD recording and reporting tools. Additionally, CD4 reagents for the available PIMA and Facs Presto equipment have been acquired. Site selection in a hub and spoke model was done for the first round of implementation, and training has been provided. Furthermore, ART registers have been revised to include AHD parameters, and an assessment was conducted in 15 high case load hospitals in inpatient units to understand the gaps. The main challenge in COP22 is the lack of

key AHD commodities, including CrAg tests, Flucytosine, Liposomal Amphotericin B, and Fluconazole.
In COP23, PEPFAR-E will expand AHD management services to all PEPFAR supported ART sites through a hub and spoke strategy, a model which arranges HIV service delivery assets into a network of an anchor establishment (hub), such as a hospital, which offers a full range of services. The hub is complemented by secondary establishments (spokes), such as health centers, which offer limited services. This strategy is used for patient referral and capacity building of service providers.

In COP23, PEPFAR-E plans to prioritize patients newly initiating ART, those with treatment failure, and those returning to treatment after a period of discontinuation for prompt CD4 testing and evaluation for AHD and its management. In addition, all children under five years old who are not stable on effective ART and who are considered to have advanced HIV disease will be prioritized for CD4 testing and evaluation to provide the WHO-recommended and MOH/PEPFAR-adopted package of AHD services. In addition, PEPFAR-E will strengthen inpatient services for diagnosis and management of AHD services and the linkage and referral between these services and the outpatient ART follow up units. Furthermore, CD4 testing will be strengthened through prompt identification of CD4 machine issues and troubleshooting. Training, mentorships, and supervision will continue to be provided through partners to improve health care workers' capacity to diagnose and manage patients with AHD.

In COP23, PEPFAR-E will also consider gap-filling purchases of key commodities through partners for the diagnosis and management of clients with AHD. In addition, PEPFAR-E will continue to provide TA to the MOH to expand the Hub and Spoke sites, CQI activities, documentation, and reporting as well as support ECHO platforms to provide WHO-recommended and MOH adopted packages.

Optimize diagnostic networks for VL/EID, TB, and other coinfections.
In coordination with other donors and the National TB Program, PEPFAR-E will support complete diagnostic network optimization and transition to integrated diagnostics and multiplex testing to address multiple diseases to ensure 100% EID and VL testing coverage and return of results within the stipulated turn-around time.

Integrate effective quality assurance (QA) and continuous quality improvement (CQI) practices into site and program management
PEPFAR-E has been collaborating with the MOH to develop national guidelines and standards to ensure the delivery of quality of HIV related services at health facility and community levels. There are standardized approaches for HIV program planning, implementation, monitoring, and evaluation with up-to-date health management information systems. Data quality assurance has been given due attention in both health facilities and communities to ensure that the program is governed by sound evidence. MOH, PEPFAR-E, and other partners have been engaged in regular joint and HIV program supportive supervision visits aimed at improving the quality of HIV programming, health service delivery, and patient outcomes. Site Improvement through Monitoring System (SIMS) visits have been implemented across health facilities and

community sites, which have enabled the program to monitor service quality, identify gaps, and devise performance improvement plans to address the gaps. The RHBs have dedicated quality teams to follow CQI initiatives across HIV program areas implemented in the health facilities and community sites in their catchment areas. There have been several program specific quality improvement initiatives in community activities, HIV testing, laboratory, KPs, ARV treatment, recency surveillance, data quality, infection prevention, and the HIV logistics system, which have contributed to the improvement of program performance at all levels.

The MOH has a national HIV strategic plan and national guidelines, which include elements about HIV program quality, quality assurance, and quality improvement for specific technical areas like HIV testing, laboratory, data quality, etc. In COP23, PEPFAR-supported activities, including implementing partner agreements and work plans, will align with the national strategy in support of QA/CQI. We will continue providing quality HIV services following national guidelines, using standardized approaches, continued data-based monitoring, building the capacity of the health workforce, and active engagement of health workers and patients in quality assurance and quality improvement initiatives. The program will ensure that best practices are documented and adapted across different programs and in different geographic areas. Global CQI experiences, like laboratory accreditation, TB program initiatives, IPC tools, VMMC quality assurance, standard operating procedures, mentorship tools, and others, will be adapted for local use.

Following are the program areas and activities where quality assurance and CQI activities will be focused in COP23:

- **Program management:** introducing a standardized approach for site standards assessment, including the consistent evaluation of HIV prevention, testing, care, and treatment activities at health facility and community levels; ensuring PEPFAR-supported activities alignment with national policy in support of QA/CQI; working with the MOH to establish quality assurance and improvement systems that include ongoing monitoring of program performance; conducting supportive visits, community score card, and community-led monitoring; supporting policy and technical support for strengthening governance, public policy, and enhancing partnerships; integrating HIV into national health systems and insurance schemes; and strengthening infection prevention and control programs using multimodal prevention strategies and standard operating procedures.
- **Ensuring HIV service quality through implementation of QI and DQA**: providing training and regular mentorship activities for managers and quality improvement teams to implement CQI activities, including doing structured gap and root cause analysis, developing change ideas, identifying, and testing local solutions; using a “plan, do, study, act” approach; conducting small-scale tests of change to respond to identified gaps; and using quality data to measure progress; this will also include conducting regular DQAs to PEPFAR supported sites.
- **HIV prevention:** condoms; quality PrEP program implementation; appropriate provider education and consistent messaging and information; PMTCT; and VMMC.

- **HIV testing:** HIV rapid testing CQI; EID; community engagement; and ensuring quality of HIV testing services.
- **KPs:** quality, person-centered HIV services in prevention, diagnosis, treatment, and care and partnering with community and civil society groups to improve the quality of KP programs and services.
- **Laboratory:** laboratory CQI and accreditation; patient access to POC and conventional VL testing; and lab quality management systems (LQMS)
- **HIV care:** fewer orphans due to AIDS deaths; adolescent and youth PLHIV peer-led service delivery models; adolescent friendly-health services; gender-based violence; the "One-Stop Shop" service delivery model for TB/HIV, KP, etc; quality FP information and services; clinical post-GBV care; and addressing stigma.
- **HIV Treatment:** linkage and differentiated service delivery; a quality score measurement system; accessible, person-centered quality treatment at HF, communities, and households; address IIT; counsel clients to address priority clinical needs; manage co-morbidity conditions including cervical cancer; TB prevention; and STI management and treatment.
- **HIV drug and logistics support:** safe storage conditions and logistics management system.
- **HIV data quality and use:** data quality assessment (DQA), Root Cause Analysis (RCA), and site support; periodic revision of data collection/reporting tools; development of standard operating procedures, job aids, and routine data quality checks; quality data inputs; KP surveys; and implementation science.
- **Monitoring and Evaluation:** routine review of program data, utilization of standardized monitoring and supportive supervision tools such as SIMS, use of quality score card, and KP led and community-led monitoring; the database or above-site repository with a dashboard to retrieve real-time data; and the use of a granular, data-driven approach.

Offer treatment and viral-load literacy

Offering treatment and strengthening VL literacy will improve continuity of ARV treatment and viral load suppression. Evidence based interventions (e.g., U=U) that focus on promoting treatment adherence and viral load suppression and reducing stigma and discrimination, will encourage clients to access and use HIV prevention, treatment, and care services that will improve continuity of treatment and thereby attain viral load suppression.

So far, U=U has been implemented throughout the county; U=U communication strategies have been developed; 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 and community level patient education; U=U concept was integrated into the national consolidated ART guideline and training manuals; and capacity building trainings have been provided to HCWs and media personnel. Additional job aids, including U=U counseling and patient education guide, are being developed to ensure integration of U=U messaging into facility level HIV prevention and care services.

A strategic focus area in COP23 is to strengthen treatment and viral load literacy and continue to address HIV-related stigma and discrimination through adoption of evidence-based best practices including U = U.

Partners will continue to focus on integrating patient education on early initiation, treatment adherence, viral suppression, and 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, 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.

The GoE will continue to collaborate with PEPFAR-E and implementing partners to scale-up the U=U initiative. U=U communication strategies, including messages tailored to tackle non-adherence and HIV-related stigma and discrimination on personal, community, and facility levels, will be streamlined through health education sessions and various print and electronic media platforms. Additionally, as part of strengthening the integration of U=U initiative into HIV prevention, care, and treatment services, partners will continue to provide tailored capacity building training for healthcare providers, clinicians, and people working in the media to ensure appropriate and quality patient education services. U=U initiative integration into the joint HIV service supportive supervision and integrated mentorship will be ensured.

The multisectoral U=U initiative will be further scaled-up and strengthened and will engage and empower clients for improved adherence and optimal viral load suppression for improved individual outcomes and preventing transmission of HIV. Ensuring the integration of U=U messaging into facility and community HIV prevention, care, and treatment programs, including those serving KPs, 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.

Continued efforts need to be exerted to increase knowledge of PLHIV about HIV infection, the need for life-long treatment and follow-up, maximize ART literacy, its effectiveness, and the potential to prevent HIV transmission with optimal adherence attaining viral suppression.

There is a need to reinforce the importance of routine viral load testing and its use in client care management, emphasize positive living, promote healthy behaviors, and engage peer PLHIV in adherence support and reinforce messaging. Addressing barriers to ART adherence and retention in services, with particular attention to Interruption in Treatment (IIT) and return to treatment (RTT) is critical. The importance of focused media activities to access different population groups through accurate messaging and address specific gaps in awareness is critical.

The peer-to-peer support being provided through the case management program both at the facility and community 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, mother mentors, and community engagement facilitators (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 promptly identifying treatment interruptions with coordinated return to treatment activities.

It is also important to strengthen the engagement of CSOs, including PLHIV associations and faith-based organizations, in awareness creation, mobilizing the community, enhancing peer-to-peer approaches to optimize the provision of U=U messaging, and reducing stigma and discrimination. The faith-based organization activities implemented by the IRCE, together with national and regional leadership of member faith organizations, in collaboration with the facility and community level service provisions, will continue to conduct various sub-national advocacy works targeted to stigma reduction.

The IRCE will also continue to conduct sensitization events for interfaith leaders and their constituents to encourage HIV testing, treatment, and stigma reduction, primarily for youth and older age groups. Regional branches of IRCE, in collaboration with LIPs, will assign trained community focal persons at religious healing and prayer sites that will identify clients that interrupt treatment, provide counseling, and link treatment interrupters to health facilities to re-initiate treatment.

Enhance local capacity for a sustainable HIV response.

In COP23, the GOE continues to be an active partner in the HIV response in Ethiopia and will continue to work with PEPFAR-E and relevant partners to strengthen GOE and CSO capacity on policy, planning, coordination, and efficient program implementation. These initiatives will enable the GOE to successfully transition the HIV program to a host government and local organization led initiative.

Government entities will continue to be strengthened to lead the HIV response, maintain gains made to date, and develop appropriate transition plans where needed. RHBs will have their leadership capacity strengthened for coordination of regional responses and will work closely with CSOs, urban health extension workers, and community partners to strengthen community-facility linkages, find remaining PLHIV not in care, and provide essential prevention services.

PEPFAR-E will continue to work with partners to strengthen the capacity of the MOH and RHBs in strategic planning, micro planning and monitoring, program implementation, coordination, and performance reviews.

PEPFAR-E will also work to strengthen Indigenous organizations and LIPs' ability to effectively carry out programming. PEPFAR-E will advocate for the MOH and RHBs to engage CSOs and LIPs at both the community and above site level in the planning, coordination, implementation, and monitoring and review of programs. PEPFAR-E will work with LIPs to strengthen their human resource capacity to support the HIV response. On top of that, PEPFAR will continue its intensified TA support model, which includes site visits and partner performance monitoring, especially for LIPs. Finally, expanding and strengthening CLM through engagement of multiple local partners will help to build the capacity of LIPs and increase accountability.

Increase partner government leadership

The need to increase leadership engagement of the MOH and RHBs at all levels of the HIV program in strategic planning, resource allocation, priority setting, coordination, implementation, monitoring, and review is critical for supporting sustainability of the HIV response. The GOE's capacity should be strengthened in forecasting needs, planning, and procurement of program commodities, distribution, and monitoring. There is a need to strengthen the health systems, services for provision of people centered integrated comprehensive services and networking of services, facilities, and facility-community level activities. The government should fully engage and involve CSOs including PLHIVs and community-based organizations in the planning, implementation, and monitoring and review of programs.

Monitor morbidity and mortality outcome

Through Global Fund financial support and PEPFAR technical support, EPHI will be doing mortality surveys in selected high burden hospitals and health centers to produce data on patterns of mortality and cause of death among PLHIV by retrospective record review of seven years data (2016-2022) in FY23. This will be compared to the previous similar survey done between 2000-2015 to look at trends.

- Plan and conduct focused assessment on causes of illness and death among PLHIV, ex. Among 50+ age groups
- Collect evidence on prevalent illnesses among PLHIV, their management, and patient outcomes
- Assess access to integrated services for infectious and non-infectious illnesses among PLHIV
- MOH and PEPFAR will work on the health management information system towards integrating the M&E of HIV and the associated infectious and non-communicable disease in the ART clinics. Attempts will be made to integrate both the services and the M&E in the paper-based health management information system (HMIS) as well as digital health interventions (EMR and HMIS reports). The paper-based and digital systems at health facility and health administration levels will be used in generating data on infectious and non-infectious causes of morbidity and mortality among PLHIV, to improve national HIV programs and public health response.
- As part of the HIV CBS, mortality surveillance among PLHIV (including adults, children, and infants) will be initiated in select high load health facilities in COP22 and currently,

protocol is being finalized by EPHI. In addition, the longitudinal CBS to be initiated in COP22 will be incorporating selected morbidity and mortality related sentinel events. In COP23, the mortality and longitudinal HIV CBS will be scaled-up to additional high-load facilities so that more quality data to monitor the morbidity and mortality among PLHIV is available and be used to inform the program.

- In addition, PEPFAR-E has started allocating small amount of fund to MOH in COP22 to enhance death registration in selected high HIV burden geographic areas as a pilot, with verbal autopsies to look for cause of death ascertainment as part of strengthening the national Civil Registration and Vital Statistics (CRVS) system to complement mortality surveillance among PLHIV. This support will continue in COP23 to scale-up to few additional high HIV burden geographic areas.
- The annual modeling estimate from spectrum also provides all-cause and AIDS related death among PLHIV and closely working and supporting the national HIV estimation and projection exercise will be needed, including ensuring the use of quality programmatic and locally available other input data

Adopt and institutionalize best practices for public health case-based surveillance (CBS)
CBS is foundational to public health practice. It helps us to understand diseases and their spread and determine appropriate actions to control outbreaks. Case based surveillance occurs each time public health agencies at the local or national levels collect information about a case or person diagnosed with a disease or condition that poses a serious health threat.

HIV CBS refers to an approach to surveillance that involves the reporting of individual-level information from each person diagnosed with HIV to the public health agency responsible for monitoring and controlling the HIV epidemic. As information along the course of disease from diagnosis to entry into care, initiation of ART, viral suppression, comorbidity, and death are needed to measure progress towards epidemic control, data on each of these events is collected and maintained longitudinally. This is a distinctive characteristic of CBS systems and distinguishes it from aggregate reporting. To accurately add new information pertaining to an existing case record, and to also distinguish duplicate case reports (i.e., two or more reports for the same individual), a CBS system must be designed to permit matching to identify information relating to the same individual from information concerning a new, previously unreported individual.

Ethiopia began implementing HIV CBS in June 2019. The MOH, EPHI, and RHBs established a governance structure including a National Steering Committee, National and Regional Technical Working Groups to coordinate the planning, implementation, and monitoring of the CBS program across the country. A phased approach is employed in the development and implementation of HIV CBS across selected high-load health facilities, currently reaching in more than 750 facilities and 29 community DICs. The HIV case-based reporting system is where individual-level information of newly diagnosed HIV-positive individuals from multiple service delivery points is systematically collected in a granular manner.

Digital health interventions are required at different stages of the implementation starting from data entry up to analytics. Data is collected using paper-based case report form at HIV testing points and entered to a web-based electronic data entry form developed using the Research Electronic Data Capture (REDCap) system hosted at EPHI data server. Data is transmitted to EPHI through a secure internet connection. The data is exported and transferred to another software to de-duplicate and match records using algorithms derived from multiple client identifiers before conducting data analysis and visualization for enhanced public health response. Currently, a semiautomated matching algorithm is being finalized with a plan for full automation and MPI development in the coming years. In addition to the intended purpose, the HIV CBS information system platform has been utilized to support other disease surveillance/surveys like COVID-19 and this will enhance the capacity of the public health system by leveraging such a platform for other priority public health disease/conditions.

USG Operations and Staffing Plan to Achieve Stated Goals

PEPFAR-E's staffing footprint is designed to be proportionate to Ethiopia's progress 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-E coordinating office is not proposing any new positions in COP23. 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 Deputy Coordinator position was filled in January 2023. The Senior Technical Advisor position, which was approved in COP19, is vacant, and the coordination office will remove the position and reprogram the funding since the office is now fully staffed. 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 position and no proposed new positions.

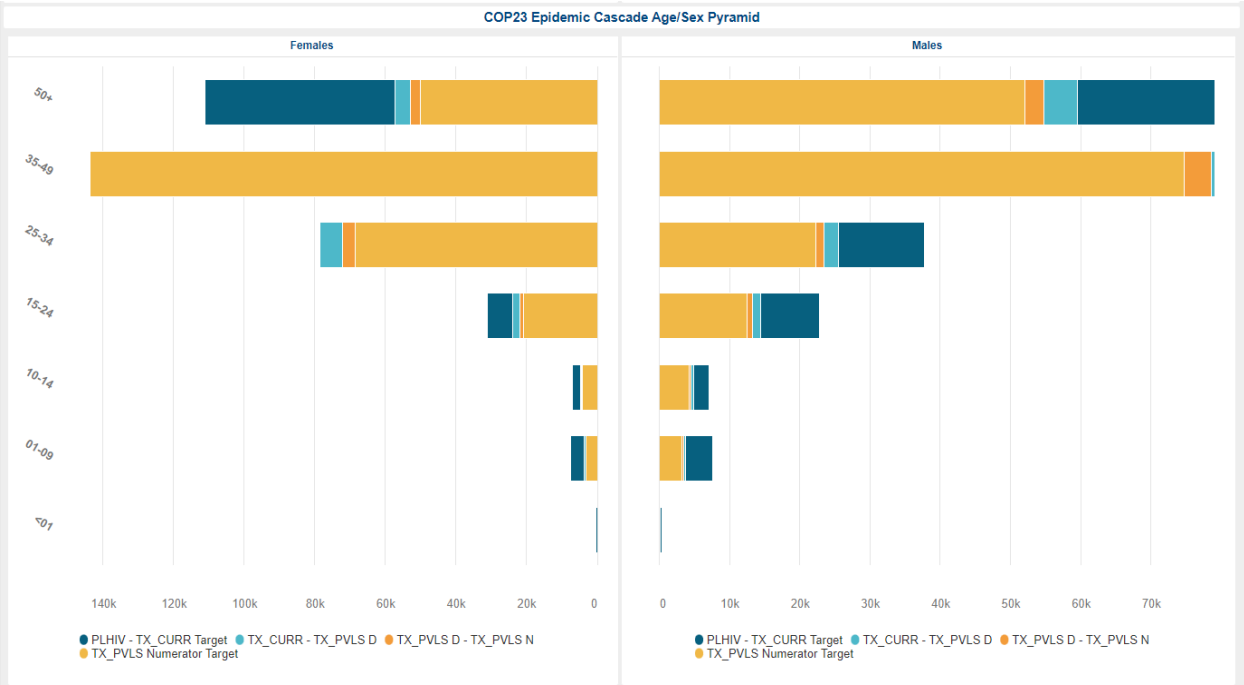
The management and operations budget of CDC has experienced a slight increase. This is primarily due to the rise in residence rent for direct hire positions, as well as the annual Within Grade Increases (WGI) and the five percent increment on Locally Employed Staff (LES) salaries. Additionally, there have been adjustments made to the US Direct Hire (USDH) Cost of Living Allowance (COLA).

Furthermore, there has been an increase in program travel expenses, which has also contributed to the rise in the CDC's management and operations budget. Additionally, there has been an increase in the cost of Capital Security Cost Sharing (CSCS).

USAID/Ethiopia will do an assessment of its HIV team organizational structure to ensure alignment with the new PEPFAR 5x3 strategy. Based on a preliminary review, USAID/Ethiopia anticipates maintaining the same HIV team size and keeping the same division of work by thematic area, including KP, OVC, supply chain, HIS, and SI, but will likely do some task shifting among staff to address 5x3 priorities, particularly to ensure the continued focus on increased local partner led community programming.

USAID/Ethiopia identified a need to strengthen the project and financial management skills of its HIV team, especially with respect to managing locally implementing partners. Before the end of FY 2023, both internal and external training will be provided to staff to improve their skills. The recruitment for USAID/Ethiopia's Senior Supply Chain Advisor position has taken longer than anticipated primarily due to the relatively small pool of experts available for this role, the negative impact of the conflict on living conditions in Addis Ababa, and some unexpected delays in the recruitment process. With the cessation of hostilities, the environment in Addis Ababa is slowly improving, and the Health Office has prioritized the recruitment process. The Pharmaceutical Logistics Advisor has been doing an exemplary job covering the vacant position, and USAID/Ethiopia does not expect any gaps, while the recruitment is being completed. USAID/Ethiopia expects a similar CODB for COP23.

APPENDIX A -- Prioritization



Source: PEPFAR PANORAMA

Figure A.1 Epidemic Cascade Age/Sex Pyramid

APPENDIX B -- Budget Profile and Resource Projections

Table B.1.1 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Intervention

Intervention	2023	2024	2025
ASP>HMIS, surveillance, & research>Non Service Delivery>Key Populations	$141,022	$0	$0
ASP>HMIS, surveillance, & research>Non Service Delivery>Non-Targeted Populations	$6,303,176	$0	$0
ASP>Health Management Information Systems (HMIS)>Non Service Delivery>Non-Targeted Populations	$0	$2,926,441	$2,873,662
ASP>Human resources for health>Non Service Delivery>Non-Targeted Populations	$0	$4,642	$28,848
ASP>Laboratory systems strengthening>Non Service Delivery>Non-Targeted Populations	$3,267,147	$3,514,080	$4,831,937
ASP>Laws, regulations & policy environment>Non Service Delivery>Key Populations	$0	$50,000	$0
ASP>Management of Disease Control Programs>Non Service Delivery>Non-Targeted Populations	$0	$380,000	$442,488
ASP>Management of Disease Control Programs>Non Service Delivery>Pregnant & Breastfeeding Women	$0	$300,000	$300,000
ASP>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$608,773	$0	$0
ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Key Populations	$156,200	$0	$0
ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Non-Targeted Populations	$475,000	$0	$0
ASP>Policy, planning, coordination & management of disease control programs>Non Service Delivery>Pregnant & Breastfeeding Women	$200,000	$0	$0
ASP>Procurement & supply chain management>Non Service Delivery>Non-Targeted Populations	$1,226,118	$1,000,000	$902,659

ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Key Populations	$0	$891,022	$0
ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Non-Targeted Populations	$0	$4,294,044	$4,294,044
ASP>Surveys, Surveillance, Research, and Evaluation (SRE)>Non Service Delivery>Pregnant & Breastfeeding Women	$0	$200,000	$200,000
C&T>HIV Clinical Services>Non Service Delivery>Children	$1,947,000	$1,997,000	$1,797,000
C&T>HIV Clinical Services>Non Service Delivery>Key Populations	$727,078	$763,041	$594,823
C&T>HIV Clinical Services>Non Service Delivery>Non-Targeted Populations	$17,649,652	$20,120,196	$18,532,551
C&T>HIV Clinical Services>Non Service Delivery>Pregnant & Breastfeeding Women	$0	$1,220,766	$1,220,766
C&T>HIV Clinical Services>Service Delivery>Children	$1,671,000	$1,971,000	$1,671,000
C&T>HIV Clinical Services>Service Delivery>Key Populations	$2,636,008	$3,247,795	$2,537,407
C&T>HIV Clinical Services>Service Delivery>Non-Targeted Populations	$7,371,218	$7,113,324	$6,824,002
C&T>HIV Clinical Services>Service Delivery>OVC	$539,080	$0	$0
C&T>HIV Drugs>Service Delivery>Children	$0	$95,849	$0
C&T>HIV Drugs>Service Delivery>Non-Targeted Populations	$0	$766,269	$1,822,742
C&T>HIV Laboratory Services>Non Service Delivery>Non-Targeted Populations	$1,454,932	$1,251,026	$1,251,026
C&T>HIV Laboratory Services>Service Delivery>Children	$460,266	$650,215	$404,888
C&T>HIV Laboratory Services>Service Delivery>Key Populations	$47,578	$398,707	$38,598
C&T>HIV Laboratory Services>Service Delivery>Non-Targeted Populations	$10,090,133	$8,512,181	$9,780,160
C&T>HIV/TB>Non Service Delivery>Non-Targeted Populations	$0	$2,370,000	$2,370,000
C&T>HIV/TB>Service Delivery>Non-Targeted Populations	$0	$25,000	$25,000
C&T>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$5,455,137	$0	$0
HTS>Community-based testing>Non Service Delivery>Non-Targeted Populations	$236,769	$275,020	$258,021
HTS>Community-based testing>Service Delivery>Key Populations	$0	$1,990,871	$554,155
HTS>Community-based testing>Service Delivery>Non-Targeted Populations	$212,763	$933,611	$1,368,917

HTS>Facility-based testing>Non Service Delivery>Key Populations	$350,000	$65,000	$65,000
HTS>Facility-based testing>Non Service Delivery>Non-Targeted Populations	$2,540,770	$3,510,148	$3,510,148
HTS>Facility-based testing>Service Delivery>Key Populations	$456,200	$917,200	$917,200
HTS>Facility-based testing>Service Delivery>Non-Targeted Populations	$3,697,107	$3,270,447	$3,270,447
HTS>Not Disaggregated>Non Service Delivery>Key Populations	$44,785	$0	$0
HTS>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$154,296	$0	$0
HTS>Not Disaggregated>Service Delivery>Key Populations	$852,767	$0	$0
HTS>Not Disaggregated>Service Delivery>Non-Targeted Populations	$1,308,324	$0	$0
PM>IM Closeout costs>Non Service Delivery>Non-Targeted Populations	$340,000	$0	$0
PM>IM Program Management>Non Service Delivery>Non-Targeted Populations	$10,912,820	$10,478,167	$11,405,117
PM>IM Program Management>Non Service Delivery>OVC	$0	$674,453	$722,283
PM>USG Program Management>Non Service Delivery>Military	$65,074	$0	$60,074
PM>USG Program Management>Non Service Delivery>Non-Targeted Populations	$7,133,934	$9,082,640	$9,022,566
PM>USG Program Management>Non Service Delivery>OVC	$0	$381,531	$381,531
PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>Non-Targeted Populations	$273,029	$0	$0
PREV>Comm. mobilization, behavior & norms change>Non Service Delivery>OVC	$50,852	$0	$0
PREV>Comm. mobilization, behavior & norms change>Service Delivery>Key Populations	$125,407	$0	$0
PREV>Comm. mobilization, behavior & norms change>Service Delivery>Non-Targeted Populations	$757,985	$0	$0
PREV>Comm. mobilization, behavior & norms change>Service Delivery>OVC	$667,171	$0	$0
PREV>Condom & Lubricant Programming>Service Delivery>Key Populations	$0	$392,000	$0
PREV>Condom & Lubricant Programming>Service Delivery>Non-Targeted Populations	$418,100	$8,000	$15,922
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Key Populations	$0	$125,407	$0

PREV>Non-Biomedical HIV Prevention>Non Service Delivery>Non-Targeted Populations	$0	$727,014	$2,103,882
PREV>Non-Biomedical HIV Prevention>Non Service Delivery>OVC	$0	$880,179	$0
PREV>Non-Biomedical HIV Prevention>Service Delivery>Key Populations	$0	$3,592	$113,791
PREV>Non-Biomedical HIV Prevention>Service Delivery>Non-Targeted Populations	$0	$23,474	$124,620
PREV>Non-Biomedical HIV Prevention>Service Delivery>OVC	$0	$23,459	$45,782
PREV>Not Disaggregated>Non Service Delivery>Key Populations	$173,680	$278,465	$278,465
PREV>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$803,469	$641,616	$641,616
PREV>Not Disaggregated>Service Delivery>Key Populations	$776,845	$1,093,445	$855,053
PREV>Not Disaggregated>Service Delivery>Non-Targeted Populations	$3,922	$1,217,312	$15,872
PREV>PrEP>Non Service Delivery>Key Populations	$0	$100,000	$100,000
PREV>PrEP>Service Delivery>Key Populations	$590,321	$512,985	$524,206
PREV>PrEP>Service Delivery>Non-Targeted Populations	$35,000	$281,197	$272,234
PREV>VMMC>Service Delivery>Non-Targeted Populations	$620,000	$480,000	$480,000
PREV>Violence Prevention and Response>Non Service Delivery>Non-Targeted Populations	$0	$68,000	$68,000
SE>Case Management>Service Delivery>OVC	$1,712,157	$2,327,670	$2,025,053
SE>Economic strengthening>Service Delivery>OVC	$2,622,814	$4,005,282	$4,355,548
SE>Education assistance>Service Delivery>OVC	$1,417,680	$2,226,758	$3,309,121
SE>Food and nutrition>Service Delivery>OVC	$118,661	$319,415	$81,020
SE>Not Disaggregated>Non Service Delivery>Non-Targeted Populations	$18,829	$0	$0
SE>Not Disaggregated>Non Service Delivery>OVC	$2,071,882	$0	$0
SE>Not Disaggregated>Service Delivery>OVC	$1,214,304	$0	$0
SE>Psychosocial support>Non Service Delivery>OVC	$68,875	$105,590	$295,270
SE>Psychosocial support>Service Delivery>OVC	$870,796	$1,367,454	$1,065,485
TOTAL	**$106,143,906**	**$112,850,000**	**$111,050,000**

Table B.1.2 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Program Area

Program	2023	2024	2025
C&T	$50,049,082	$50,502,369	$48,869,963
HTS	$9,853,781	$10,962,297	$9,943,888
PREV	$5,295,781	$6,856,145	$5,639,443
SE	$10,115,998	$10,352,169	$11,131,497
ASP	$12,377,436	$13,560,229	$13,873,638
PM	$18,451,828	$20,616,791	$21,591,571
TOTAL	**$106,143,906**	**$112,850,000**	**$111,050,000**

Table B.1.3 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Beneficiary

Targeted Beneficiary	2023	2024	2025
Children	$4,078,266	$4,714,064	$3,872,888
Key Populations	$7,077,891	$10,829,530	$6,578,698
Military	$65,074	-	$60,074
Non-Targeted Populations	$83,368,403	$83,273,849	$86,536,481
OVC	$11,354,272	$12,311,791	$12,281,093
Pregnant & Breastfeeding Women	$200,000	$1,720,766	$1,720,766
TOTAL	**$106,143,906**	**$112,850,000**	**$111,050,000**

Table B.1.4 COP22, COP 23/FY 24, COP 23/FY 25 Budget by Initiative

Initiative Name	2023	2024	2025
Cervical Cancer	$4,127,443	$4,229,270	$5,934,402
Community-Led Monitoring	$300,000	$600,000	$600,000
Condoms (GHP-USAID Central Funding)	$400,000	$400,000	$0
core Program	$0	$0	$92,858,319
Core Program	$90,301,463	$94,122,535	
KP Survey	$0	$800,000	$0
LIFT UP Equity Initiative	$0	$1,000,000	$0
OVC (Non-DREAMS)	$10,315,000	$11,218,195	$11,177,279

VMMC	$700,000	$480,000	$480,000
TOTAL	**$106,143,906**	**$112,850,000**	**$111,050,000**

B.2 Resource Projections

To plan for COP23, PEPFAR-E adopted an incremental funding approach that considers expected activities and key priorities aligned with strategic pillars and enablers. This ensures that resources are allocated in a way that maximizes their impact and supports our overarching goals.

Partner performance and expenditure reporting were also considered to inform the budget allocation decision for effective and efficient resource utilization. In COP23, PEPFAR-E is committed to transparency and accountability in all aspects of implementation. PEPFAR-E aims to make the most of our resources and deliver meaningful impact towards achieving sustained epidemic control.

APPENDIX C – Above site and Systems Investments from PASIT and SRE

To strengthen health systems in Ethiopia to achieve and sustain epidemic control, PEPFAR-E will prioritize systems-level investments in COP23 based on gaps identified through various mechanisms, including quarterly POART/MER results reviews and a consultative process with the MOH, RHBs, CSOs, and FBOs. During COP23 development, there was extensive stakeholder engagement and consultations with the Ministry of Health, RHBs, Global Fund, UNAIDS, UNFPA, and other donors, as well as the private sector.

The SID analysis revealed weaknesses in most of the domains and elements prioritized for support in COP22, specifically improving private sector participation, scaling up case-based surveillance, improving resource mobilization to sustain the program, increasing TA support to improve the supply chain, and improving 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 COP23 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 COP23, 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. In COP23, PEPFAR-E plans to provide approximately 65% of its budget to local

partners, which is in line with global PEPFAR guidance to provide 70% of programming funds through locally owned, led, and operated organizations (e.g., partner government; faith based institutions; KP-led, women led, youth led organizations; and private-sector entities.)

Governance, policy, planning, and coordination

GOE agencies, including the MOH, have been addressing 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 Based 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 753 health facilities and 29 community DICs from all regions are providing services to close to 94% Tx_Curr and 92% HTS Positive with a plan to reach 997 sites in COP22 and 1,195 sites in COP23. To facilitate data use, a data visualization platform has been established at EPHI, and information is being generated and reviewed regularly to identify hot spot geographic areas 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 COP23. A site-level and above-site level response guideline has been developed and launched, and training has been provided to regions to initiate monitoring of site-level response, hotspot 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 after case reporting, using the EMR ART as the data source for sentinel events, is being introduced with an amendment to the CBS protocol, and for this purpose, an interoperability solution is being introduced to facilitate data transmission between the EMR-Smart care and RedCap systems. Longitudinal CBS will be introduced in selected facilities in FY23 and scaled-up to include additional high-volume sites in COP23. The Recent Infection Testing Algorithm (RITA), which includes VL testing for more accurate classification, is being introduced in selected health facilities in COP22, at small scale with a plan for expansion to additional CBS participating sites in COP23.

Mortality Surveillance

There has been no active and systematic surveillance of HIV-associated mortality among PLHIV in Ethiopia. The aim of the mortality surveillance activity is to routinely monitor the cause of death (CoD) among people diagnosed HIV positive and determine the distribution, trends, and patterns of leading causes of death among PLHIV. This will tremendously help to identify the unmet needs of various care and treatment program interventions and drive program planning and allocations at national and sub-national levels. This activity will be a key component of

PEPFAR's pillar five, and it aims to develop and advance an applied epidemiology and surveillance approach to end HIV/AIDS as a public health threat, strengthen the national health systems, and enable holistic public health surveillance and detection approaches.

Currently, protocol development is underway to initiate mortality surveillance among PLHIV, including adults, children, and infants, in 25 select health facilities with high HIV burden with further expansion planned to 50 health facilities in COP23. Additionally, PEPFAR-E is supporting MOH to enhance death registration and use of verbal autopsies to ascertain cause of death to strengthen the national civil registration and vital statistics (CRVS) system to complement mortality surveillance among PLHIV. Verbal autopsies are planned to assign a cause of death for all community deaths. The evidence from this implementation will fill in information gaps on cause of death, particularly among PLHIV who are not diagnosed, diagnosed but not on treatment, and those on treatment but with unknown outcome after interruption in treatment. In COP22, the support is limited to 50% of the geographic areas in Addis Ababa. In COP23, this will be scaled up to all geographic areas in Addis Ababa and to an additional two towns in the country with high HIV burdens.

ANC Sentinel Surveillance for improved PLHIV estimation and projection

Beginning in COP22, the annual HIV estimation and projection exercise has been supported to improve the quality of input data from PMTCT and care and treatment programs, and beginning in COP23, ANC sentinel surveillance sites will have targeted support to improve the type and quality of routine ANC program data for surveillance and enable generation of evidence for better epidemic monitoring and informing the annual HIV estimation and projection exercise and program planning.

I***BBS and PSE for FSWs***

PEPFAR recommends all countries, regardless of their epidemic setting, should conduct biobehavioral surveys of relevant KPs/PPs and regularly update population size estimates. Ethiopia conducted an IBBS among FSWs in 2019 without PEPFAR support, and in COP23, an IBBS among FSWs will be supported by PEPFAR-E to provide data to inform the status of KP programs in the country for these population groups. A formative assessment will be done first to inform survey design and feasibility.

The objectives of the survey will be to estimate the achievements towards the 95-95-95 targets, viral suppression, prevalence of HIV, population size, HIV service uptake, prevalence of STIs (syphilis, gonorrhea, chlamydia), and risk factors associated with HIV. The survey will include approximately 13 cities and towns where the previous surveys were conducted with the aim of generating information on epidemiological trends. Currently, a concept note is being prepared with a plan to submit for final approval by May 15, 2023. EPHI will lead the implementation of the survey in COP23 with TA from other partners. The implementation will be a collaborative effort involving all stakeholders working on this KP group.

HIV Drug Resistance Surveillance

PEPFAR-E will monitor cyclical acquired HIV drug resistance (CADRE) in people on DTG-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 requires neither 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 nine months and VL >1,000 viral copies/mL. The eligibility criteria for children under 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 eligibility for children is with VL >1,000 copies/mL and receiving both DTG and non-DTG-based regimens. Data collection for the first round of CADRE, data analysis, report writing, and results dissemination, along with preparation for the next cycle, is expected to be completed in FY23. In COP23, the second round of the survey/evaluation data collection will be started as per the protocol. 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 system and pharmaceutical services

A reliable supply chain management system and pharmaceutical services are critical requirements to sustain the progress towards HIV epidemic control, maintain the national program's successes, and ensure continuity of treatment for clients on ART. In COP23, 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 PMIS and LMIS at ART dispensaries and medical stores, last mile distribution to ensure adequate HIV commodity availability and accessibility, pharmacovigilance, and warehousing distribution. This will also diagnose the challenge with sustainable supply of rapid test kits and recommend mitigation measures through engaging relevant stakeholders. Furthermore, the TA will support the Ministry of Health to pilot a decentralized drug distribution service model at private and government-owned pharmacies to bring services closer to the beneficiaries. Additionally, the TA will support the restoration and rebuilding of supply chain systems and pharmacy services of health facilities and EPSS branches in conflict-affected areas.

Laboratory

Support for core HIV and TB tests will continue in COP23. The urine lateral flow lipoarabinomannan test (LF-LAM), which is adopted in the Ethiopia guideline, will be expanded to strengthen TB case identification among PLHIV. HPV testing will be also supported in selected high volume ART facilities for cervical cancer prevention programs in women living with HIV. Routine VL testing using wave two all-inclusive price will be scaled up through diagnostic network optimization, training of testing personnel, reducing turnaround time, quality assurance, and enforcing the reagent rental agreement where placement of machines and maintenance is the responsibility of vendors. Old VL/EID platforms are being 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 in facilities less accessible and damaged by the armed conflict in Northern Ethiopia.

COP23 lab support will focus on resuming laboratory network system recovery in conflict-affected regions. Regions with low performance and newly emerged administrative issues will be addressed by targeted interventions. 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. The middle tier lab network will continue to enroll in Strengthening Laboratory management towards Accreditation (SLMTA). Waste management will also be a priority for the lab system to prevent human, animal, and environmental exposures.

Health Information Systems

PEPFAR-E has collaborated directly or indirectly with the MOH, EPHI, RHBs, and others in deploying and supporting EMRs for patients on antiretroviral therapy, supply chain information systems, eCHIS, laboratory systems, and HIV and CBS systems as well as data stores and analytical platforms. PEPFAR's support to the MOH includes development of EMR solutions, introduction of interoperability standards, and DQA capacity building.

PEPFAR-E supported digital health investments contributed to the national eHealth architecture as follows:

- Point of care systems, including EMR-ART, CommCare, Dagu, PIMS, a digitized tool for antiretroviral dispensing, and REDCap for HIV CBS.
- Interoperability, including support for an Electronic Test Ordering and Result Reporting System (ETORRS) and the Addis Ababa City Administration Health Bureau (AACAHB) Central Data Repository (CDR).
- Client registry, including matching algorithms for record deduplication and Master Patient Index (MPI).
- Institution based HIS and data sources, including EMR-ART and CommCare to autogenerate HMIS reports to be reported via DHIS2.
- Analytics and business intelligence, including analytics available from EMR-ART, CommCare, Logistics, and HIV CBS data at national and sub-national levels and the AACAHB CDR and HIV CBS database (REDCap) at EPHI serving as the data warehouse for EMR-ART and HIV CBS patient level data respectively.

The EMR-ART system is deployed in 750 health facilities across different regions, which covers over 414,000 ART patient records. This EMR software is specifically designed for HIV/ART services, providing a comprehensive and efficient way to manage HIV patient care and use the data for program monitoring. The EMR ART system has been helpful in data recovery and restoration of HIV treatment services in Amhara Region, and HIV data recovery efforts are underway in Tigray. PEPFAR-E has worked to develop and expand the National Supply Chain

System. As a result, highly automated, end-to-end data transfer exists from facility, pharmacy, and warehouse to hubs and then to the Nation Supply Chain Data Repository in the cloud. By September 2022, 864 health facilities deployed Dagu, which is a facility level LMIS, and 50 facilities implemented PMIS.

Data is entered and used at different levels in the value chain, from order submission to commodities receipt. The Community Unified Data System (UDS) has supported the delivery of standardized HIV services to more than 1.3 million beneficiaries by frontline community health workers, and 798 trained mobile workers have been deployed. There has been notable progress in the interoperability between laboratory systems and the EMR-ART system - ETORR. As of COP21, ETORRS has been deployed in 110 health facilities and 18 associated viral load testing labs in six regions. Health facilities have submitted 74,388 electronic viral load requests, and of these, 44,859 (60.3%) results were returned by testing labs using ETORRS. From October 1, 2022 to March 31, 2023, a total of 32,747 samples were sent from 110 referring health facilities to testing laboratories, of which 23,503 (71.8%) results were returned by the laboratories.

As Ethiopia continues to work towards controlling epidemics, PEPFAR is evolving its digital health strategies to align with the principles of "store once and use multiple times" to create sustainable solutions through country ownership. Major HIS interventions in COP23 will be increased deployment of PMIS and the integration of PMIS into the Dagu system with planned scale up of Dagu to 1,200 ART facilities. PEPFAR is shifting its focus from aggregate data to patient-level data to support clinical management, such as monitoring interruption in treatment, loss to follow up, and viral load suppression. To achieve this, PEPFAR-E will continue to use EMR in HIV Clinics and enable the secure centralization of patient-level data in shareable central data repositories. We will continue supporting health information exchanges at EPHI, unique identifiers for HIV CBS support, and the 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 supports data and health information system recovery in conflict-affected areas for patient level, community, aggregate, and surveillance systems. Promoting data quality and information use at health facilities as well as DQA on HIV-related data at PEPFAR community sites using these digital tools are focus areas towards enhancing evidence-based planning and decision making as per the PEPFAR 5X3 strategic direction and the national information revolution agenda.

There have been attempts to recover HIV data and health information systems in conflict affected regions, and the recovery and maintenance of health information systems will continue in terms of supporting the IT infrastructure, office furniture, data recovery, refresher training, and strengthening the performance monitoring team to work on data quality and use.