Ethiopia

Country/Regional Operational Plan (COP/ROP) 2017

Strategic Direction Summary

April 21, 2017

Table of Contents

1.0 Goal Statement

In consultation with the Government of Ethiopia (GOE), implementing partners, multilateral representatives and civil society organizations (CSOs), PEPFAR Ethiopia (PEPFAR-E) is proud to present the 2017 Country Operational Plan (COP).

There has been considerable policy and programmatic progress over the past year to support the achievement of the 90-90-90 targets in Ethiopia. Ethiopia's Federal Ministry of Health (FMOH) launched its Catch-Up-Campaign in 2017 to implement targeted testing in geographic areas where evidence suggests there are large numbers of undiagnosed PLHIV, with the expectation that it will significantly "catch up" in reaching its treatment targets. Test and START was adopted nationally and begin implementation in FY17 Quarter 1. In addition, GOE is integrating differentiated models of care into its essential care and support package of services.

As a concentrated epidemic, WHO has clear guidelines and best practices for preventing the epidemic from spreading as well as ensuring cases from among key and priority populations are identified and positives are placed on treatment. Based on these guidelines and given the nature of the Ethiopia epidemic, PEPFAR-E goals include: supporting the Government of Ethiopia to achieve the UNAIDS 90-90-90 targets for sustained HIV epidemic control; supporting the national HIV response to target and focus its prevention, case detection as well as treatment care and support interventions towards those populations and hardest hit geographical areas; and building the capacity of the FMOH and community structures to ensure sustainable HIV/AIDS interventions and programs.

To achieve the 90:90:90 goals and sustain epidemic control in Ethiopia, PEPFAR-E identified three key programmatic gaps: insufficient identification of new HIV-positive persons; inadequate systems to assure virologic suppression of identified PLHIV; and inadequate domestic spending to support sustained HIV care and treatment.

This COP focuses on innovative solutions to address challenges in the country's HIV/AIDS response. Specifically, it identifies ways to improve case identification, the first "90" of the 90:90:90 cascade. Based on epidemiological evidence, the PEPFAR-E team will continue to implement a detailed package of interventions in scale-up woredas, and in strong support of the Government of Ethiopia's "Catch-Up Campaign".

Given the nature of Ethiopia's epidemic, PEPFAR-E strategic goals are primarily to (i) support GOE to achieve the UNAIDS Fast Track Strategy for sustained epidemic control; and (ii) support the national HIV/AIDS response to strengthen case detection, treatment, care and support interventions towards key and priority populations, and in high HIV burden geographic areas.

2.0 Epidemic, Response, and Program Context

2.1 Summary Statistics, Disease Burden and Epidemic Profile

With a projected population of over 94 million people by mid-2017, Ethiopia is the second most populous country in Sub-Saharan Africa. While registering impressive sustained economic growth, Ethiopia remains a low-income country with a real per capita income of US$550 and 33.5% of the population living below the international poverty line of $1.90/day. According to the UN Human Development Index (2015), Ethiopia ranks 174 out of 188 countries on both the overall index and the per capita Gross National Income, with a gross domestic product (GDP) of $1,428. It is also one of the least urbanized countries with 80% of the population living in rural areas.

The HIV/AIDS situation in Ethiopia continues to be characterized by a low-intensity, mixed epidemic with significant heterogeneity across geographic areas and defined by independent self-sustaining HIV transmission streams within KP, PP, and general populations. Per spectrum preliminary estimate by PEPFAR, January 2017, adult HIV prevalence in Ethiopia in 2016 was estimated to be 1.1%. There is substantial prevalence variation by region (6.6% in Gambella, 5.0% in Addis Ababa, and 0.7% in Southern Nations, Nationalities and Peoples' (SNNPR) region). The HIV epidemic in Ethiopia is primarily associated with areas of urban concentration (5.1% in cities above 50 thousand compared to 3.1% in smaller cities and 0.6% in rural areas) and proximity to major transport corridors. Those living within five kilometers of a major road have HIV prevalence rates that are four-times higher than those who live further away. The two exceptions to this general pattern include Gambella region, a small and sparsely populated region that has the highest regional prevalence in Ethiopia (6.4%) and little distinction between urban and rural prevalence, and development schemes and seasonal migrant destinations that show elevated HIV-related risk behaviors despite not being close to urban areas or major roads. Another defining feature of the Ethiopian HIV epidemic is the pattern of steep and steady declines in antenatal clinic (ANC) prevalence by as much as 60% since 2005 when PEPFAR and the Millennium AIDS Campaign signaled the start of a robust and successful national response.

Available data suggest that HIV transmission remains highest among KP and PP, while a high circumcision rate (92%), among other factors, continue to favor primary prevention among the general population. Among the general population, sources of new infection can be divided into sexual transmission from high-risk behavior before or outside marriage and sexual and vertical transmission occurring within marriage. The aging demographic profile of the epidemic combined with high rates of sero-discordant married couples (65%) imply that more HIV transmission occurs within marriage compared to other African epidemics; remarriage rates, however, exceed 40% regardless of gender or residence. Widowed and divorced men and women show substantially higher infection rates than other groups. Early arranged marriage, partner violence, and gender inequality are cited as causes of high divorce rates and significantly elevated rates of HIV prevalence associated with divorce and remarriage.

Significant gains in prevention of mother-to-child transmission (PMTCT) efforts and the rolling out of option B+ indicate that by the end of FY2015, using new SPECTRUM projections, 67% of Ethiopia's estimated HIV-positive pregnant women were already on ART or newly put on ART.

Table 2.1.1 Host Country Government Results															
	Total		**<15**				**15-24**				**25+**				***Source, Year***
			Female		**Male**		**Female**		**Male**		**Female**		**Male**		
	N	%	N	%	N	%	N	%	N	%	N	%	N	%	
Total Pop.	94,351,000	100	18,904,197	20	19,075,567	20	4,658,455	5	4,691,662	5	23,424,348	24.8	23,596,770	25	Adapted from Population Projections for Ethiopia 2007-2037, Addis Ababa; CSA. July 2013, for 2018
HIV Prev (%)		1		NA		NA		0.44		0.35		NA		NA	Prevalence for 15+ projected for 2018 from spectrum preliminary estimate, by PEPFAR, January 2017

AIDS Death (per Year)	9,336		745		702		637		673		3,861		2,719		Projected for 2018 from spectrum preliminary estimate by PEPFAR, January 2017
# PLHIV	659,735		21,488		22,413		46,636		37,889		335,790		195,517		Projected for 2018 from spectrum preliminary estimate by PEPFAR, January 2017
Inc. rate (Yr)															
New Infections (2018)	11,521														Projected for 2018 from spectrum preliminary estimate by PEPFAR, January 2017

Births/ yr	3,088,807														2015: Central Statistical Authority projections
% of Preg. Wom with at least one ANC visit	NA	98	NA	NA			98.4	NA							Health Sector Transformation Plan, Annual Performance Report 2015/16, FMOH
Preg. Wom. ARVs	24409														Projected for 2018 from spectrum preliminary estimate by PEPFAR, January 2017

OVC (both)	3,181,514		NA		NA		NA		NA		NA		NA		Projected for 2018 from spectrum preliminary estimate by PEPFAR, January 2017(OVCs are always below 18 years, disaggregation not available.)
Not, TB cases (2015/ 2016)	125,801														Health Sector Transformation Plan, Annual Performance Report 2015/16, FMOH
% of TB cases that are HIV+	NA	8%													2015: FMOH: HMIS report
% of Males circ.	NA	92.8%													2000 Ethiopia DHS data set analysis

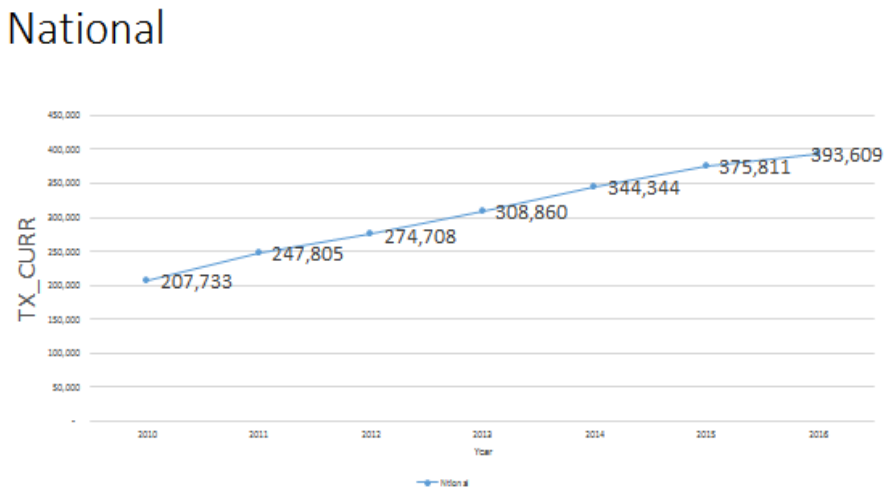
Estimated Population Size of MSM*	NA	NA													
MSM HIV Prevalence	N/A	24.4%													MSM survey Addis Ababa, 2013 (Unpublished)
Est. pop size of FSW	193,270	-													Extrapolated from Size estimation by PEPFAR interagency
FSW HIV Prevalence	NA	23 %													National MARPs survey, EPHA/ EPHI/CDC national MARPs survey report
Est. pop. size PWID	NA	NA													
PWID HIV Prevalence	NA	NA													

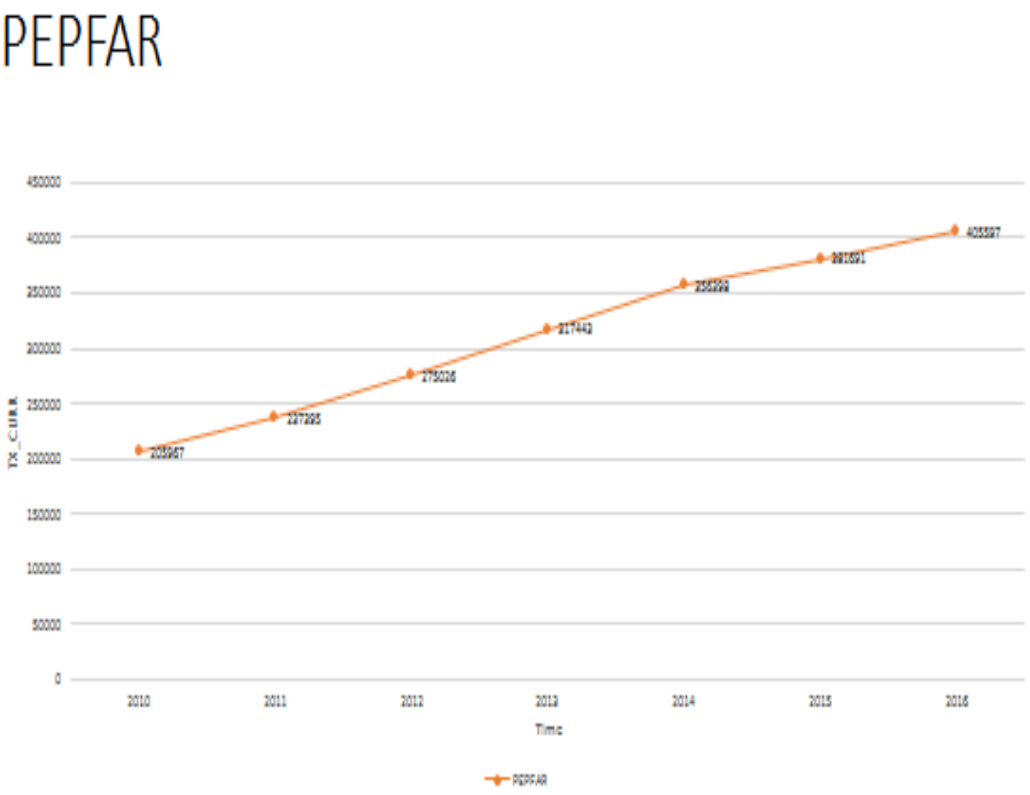
Est. size of priority Pop. (spec.)	2,373,935		NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	UNAIDS rule of thumb
	**If presenting size estimate data would compromise the safety of this population, please do not enter it in this table.*														

Table 2.1.2 90-90-90 cascade: HIV diagnosis, treatment and viral suppression* (2016 service data from APR)

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	94,351,001	1.09**	664,717	NA	405,404	61	76	3,564,489	42,391	35,051
Population less than 15 years	37,979,765	NA	66,517	NA	21,990	33	-	419,397	1,458	1,747
15-24 year olds	9,350,117	NA	81,437	NA	24,670	30		1,047,956	9,049	2,133
25+ year olds	47,021,118	NA	522,445	NA	359,048	69	-	1,737,136	31,524	31,171
MSM	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
FSW	193,970	23	41,803	NA	NA	NA	NA	NA	NA	NA
PWID	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Priority Pop (specify)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA

Figure 2.1.3 National and PEPFAR Trend for Individuals Currently on Treatment





2.2 Investment Profile

The Federal Ministry of Health recently completed the sixth round of the National Health Accounts (NHA). Once NHA findings are finalized, PEPFAR-E in collaboration with the Global Fund Results for Development (R4D), will analyze, map, and cross-walk government, PEPFAR, and Global Fund spending for HIV and TB to the agreed-upon, harmonized programmatic categories. In addition to helping understand the allocative efficiency of the combined spending on the relevant program areas, the cross-walk will also help align donor and domestic expenditure tracking system. Since the findings of the NHA are yet to be released, the only data available for official use is from 2011/2012.

Per the 2011/12, the total annual HIV/AIDS spending was $405 million. Of this total amount, 86% ($350 million) came from external donors, 13% came from public revenue ($55 million) and less than 1% ($680 thousand) came from the private sector (Table 2.2.1). It is important to note that the 13% of the public sector contribution was and remains an underestimate because it excludes significant costs for staffing and infrastructure among other areas. The AIDS Mainstreaming Fund, which every Ministry contributes 2% of their annual budget to, and the AIDS fund, which is based on voluntary contributions from public employees, contributed slightly under $4 million in the NASA study.

Table 2.2.1 Annual Investment Profile by Program Area (NASA 2011/12)[1]

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

PEPFAR funds are generally devoted to technical assistance (TA) and financial support, led by treatment and health system strengthening as indicated in tables 2.2.2 to 2.2.4. The Global Fund primarily supports diagnosis and treatment through provision of test kits and anti-retroviral (ARVs) for public and private sectors.

The private sector makes important contributions to HIV/AIDS activities in Ethiopia, particularly in urban scale-up areas where most private providers are found. The World Bank indicates that of the population served by private health sector in Ethiopia, 42% are from urban areas and 48% are from the highest income quintile, and service uptake for diseases of public health importance has significantly increased over the past years. This corresponds with an urban HIV prevalence of 4.2% and a prevalence of 4.9% among the highest income quintile, which is also mainly concentrated in urban

[1] The data for tables 2.2.1 and 2.2.2 is from the NASA 2011/2012, which is the most current data source for the national investment profile.

areas (SPECTRUM 2015).
The private health sector plays a significant role in HIV testing. HIV yields from private sector facilities are consistently above the national average, contributing more than 17% (7,173) of positive HIV tests while testing just 6.5% (231,278) of the total PEPFAR (APR16). This indicates that the private sector is able to reach a key portion of the target population living with HIV.

While the private sector's contribution to ART provision has been restricted by Ethiopian policy that limited ART provision only to private hospitals and selected nongovernmental organization (NGO)-owned facilities, through PEPFAR advocacy, the new health facility standards now permit higher clinics to be upgraded to provide ART services. This has allowed more private sector facilities that were providing only services such as HIV testing to provide treatment services as well, including the ability to initiate on ART those clients testing positive rather than just providing referral for treatment. This will contribute to improvements in linkage. Moreover, through PEPFAR's consistent dialogue and advocacy with FMOH, RHBs and FMHACA, the government has recently agreed to waive the requirement of having a pharmacy and pharmacist in order for ART services to be provided in private sector internal medicine and pediatric specialty clinics. This will result in a significant increase in the uptake of ART services in the private sector.
At the end of FY16, a total of 16,154 adults and children were regularly receiving ART from the 85 private health facilities supported by the program.

Table 2.2.2a Distribution of combined PEPFAR and Global Fund resources by program area, 2016

Program Area	Combined PEPFAR+GF expenditure	PEPFAR $	PEPFAR %	GF $	GF %
Clinical care, treatment and support	$143,556,809	$64,288,143	45%	$79,268,666	55%
Community-based care	$17,893,430	$17,893,430	100%	NA	NA
PMTCT	$6,969,598	$5,762,475	83%	$1,207,123	17%
HTS	$11,119,761	$5,594,756	50%	$5,525,005	$0
VMMC	$382	$302,976	100%	NA	NA
PP PREV	$10,999	$10,999	100%	NA	NA
KP PREV	$16,278,967	$13,264,810	81%	$3,014,157	19%
OVC	$14,585,053	$11,363,778	78%	$3,221,275	$0
Laboratory	$5,381,545	$3,011,957	54%	$2,369,588	44%
SI, Surveys, and Surveillance	$9,030,856	$8,230,856	91%	$800,000	$0
HSS	$14,218,462	$14,218,462	100%	$0	NA
Total	**$239,045,862**	**$143,942,642**	**60%**	**$95,405,814**	**$0**

Table 2.2.2b Procurement Profile for Key Commodities (2016)

Commodity Category	Total Expenditure	% PEPFAR	$ PEPFAR	% GF	$ GF	% Host Country	% Other
ARVs	$ 72,313,353	0%	$ -	100%	$ 2,313,353	$ -	$ -
Rapid test kits	$ 5,910,601	7%	$ 385,596	93%	$ 5,525,005	unknown	unknown
Other drugs	$ 3,092,305	10%	$ 320,294	90%	$ 2,772,011	unknown	unknown
Lab reagents	$ 8,885,398	73%	$6,515,810	27%	$2,369,588	unknown	unknown
Condoms	$ 774,328	0%	TBD	100%	$ 774,327	unknown	unknown
Viral Load commodities	$ 3,132,255	100%	$3,132,254	59%	$ -	unknown	unknown
VMMC kits	$ 40,000	100%	$ 40,000	0%	$ -	unknown	unknown
MAT	$ -	0%	$ -	0%	$ -	unknown	unknown
Other commodities	$ 3,202,094	100%	$ 3,202,094	0%	$ -	unknown	unknown
Total	$ 97,350,334		$ 3,596,048		$ 3,754,284		

Table 2.2.3 Annual USG Non-PEPFAR Funded Investments and Integration

Funding Source	Total USG Non-PEPFAR Resources	Non-PEPFAR Resources Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
USAID MCH	$39,815,000	$9,122,814	7	$18,810,000	Ending preventable child and maternal death
USAID TB	$13,000,000	$11,881,635	6	$13,260,000	MDR and TB Prevention, Treatment, and Elimination
USAID Malaria	$40,000,000	$1,000,000	3	$7,988,294	Malaria Prevention, Treatment, and Elimination
Family Planning	$31,550,000	$14,180,247	7	$29,438,294	Increasing access to and utilization of FP
NIH	$39,815,000	$9,122,814	7	$18,810,000	Ending preventable child and maternal death
CDC (Global Health Security)	$8,517,904				
Peace Corps	$0	$0	0	$0	
DOD Ebola	$0	$0	0	$0	
MCC	$0	$0	0	$0	
Total	**$172,697,904**	**$45,307,510**	**30**	**$88,306,588**	

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

Funding Source	Total PEPFAR Non-COP Resources	Total Non-PEPFAR Resources	Total Non-COP Co-Funding PEPFAR IMs	# Co-Funded IMs	PEPFAR COP Co-Funding Contribution	Objectives
VMMC	$747,790	$0	0	0	$0	Additive funding
Other Public-Private Partnerships		$1,200,000 (Over three years)	0	0	$0	
Total	$747,790	$1,200,000				

2.3 National Sustainability Profile

There were no changes in the national Sustainability profile for Ethiopia. As findings from COP16 indicate, Planning and Coordination, and Public Access to information are strengths. Given PEPFAR-E's increased efforts to support the Ethiopian government to attain the 90:90:90, and taking into consideration decreasing donor funding, the following SID categories remain priorities: service delivery; human resources for health; quality management; and domestic resource mobilization. PEPFAR-E is well positioned to improve service delivery and the National Health System by supporting the GoE in addressing relative weaknesses such as the distribution of resources at the sub-national level, linkage to care and treatment services, and generating demand for HIV services.

2.4 Alignment of PEPFAR Investments Geographically to Disease Burden

As depicted in Figure 1.4.1a, expenditure per PLHIV varied between $509 and $90 per person in all regions, with an average spend of $235 per PLHIV (average spend does not include the national and above national spend). The Harari regional health bureau has reported the highest expenditure per PLHIV, with reported spending of $509, followed by Benishangul Gumuz with $493 per PLHIV. The reason for the inflated (reported) expenditure in the Harari region is because beneficiary numbers are shared between the Harrari Region and Haramaya University. Since Haramaya University supports the highest load facility in Harari region, the beneficiaries in this facility are not accounted for in the region and hence the inflated spend. Usually, the emerging regional states of Benishangul Gumuz, Afar, Gambella, and Somali report a higher spend per PLHIV as these regions are hard to reach, have poor infrastructure and low human resource capacity for health, which increases costs of supporting the program in these regions. Additionally, unlike the other 7 administrative regions, in these four regions, the site level support for providing comprehensive HIV services is implemented by an international partner that adds to the spend per PLHIV. However, this past year we see the spend per PLHIV in some regions like Gambella and Somali to be lower. PEPFAR_E is still looking into the discrepancy in the spend per PLHIV as our partners supporting these regions are reporting a much higher expenditure in specific budget codes like Adult ART. There was no clear association of spend per PLHIV with total expenditure or regional HIV prevalence, although average unit costs also appears to be higher in city administrations such as Addis Ababa, Dire Dawa, and Harari. This probably reflects that unit cost is based on resident population rather than catchment area population size and

does not account for the additional cost of serving ART clients from surrounding regions. The other notable trend is the declining pattern of funding over time in all regions, even as coverage of testing and treatment has increased over the same period. This may have contributed to the increasing efficiency of PEPFAR support over time.

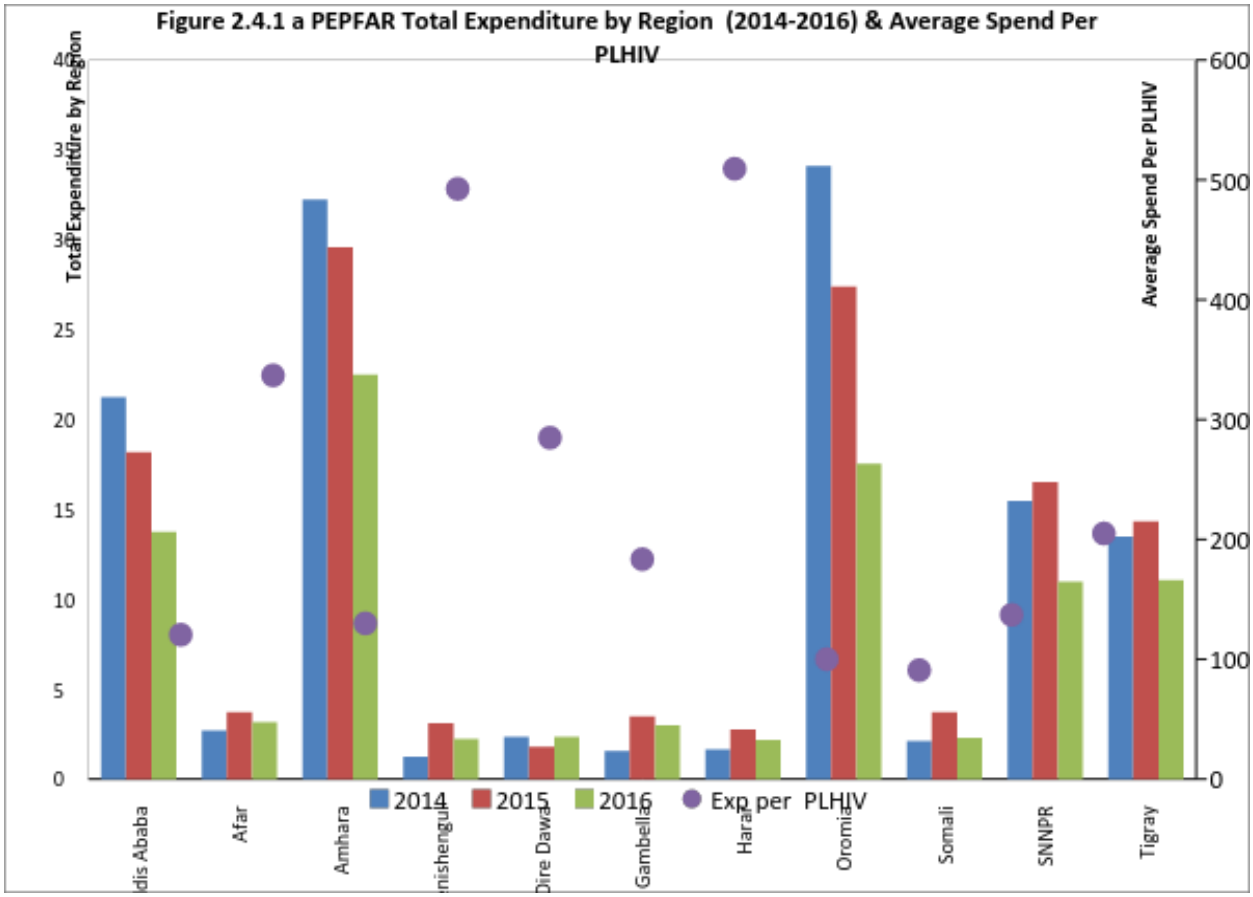


Figure 2.4.2: PLHWA by Region in 2016

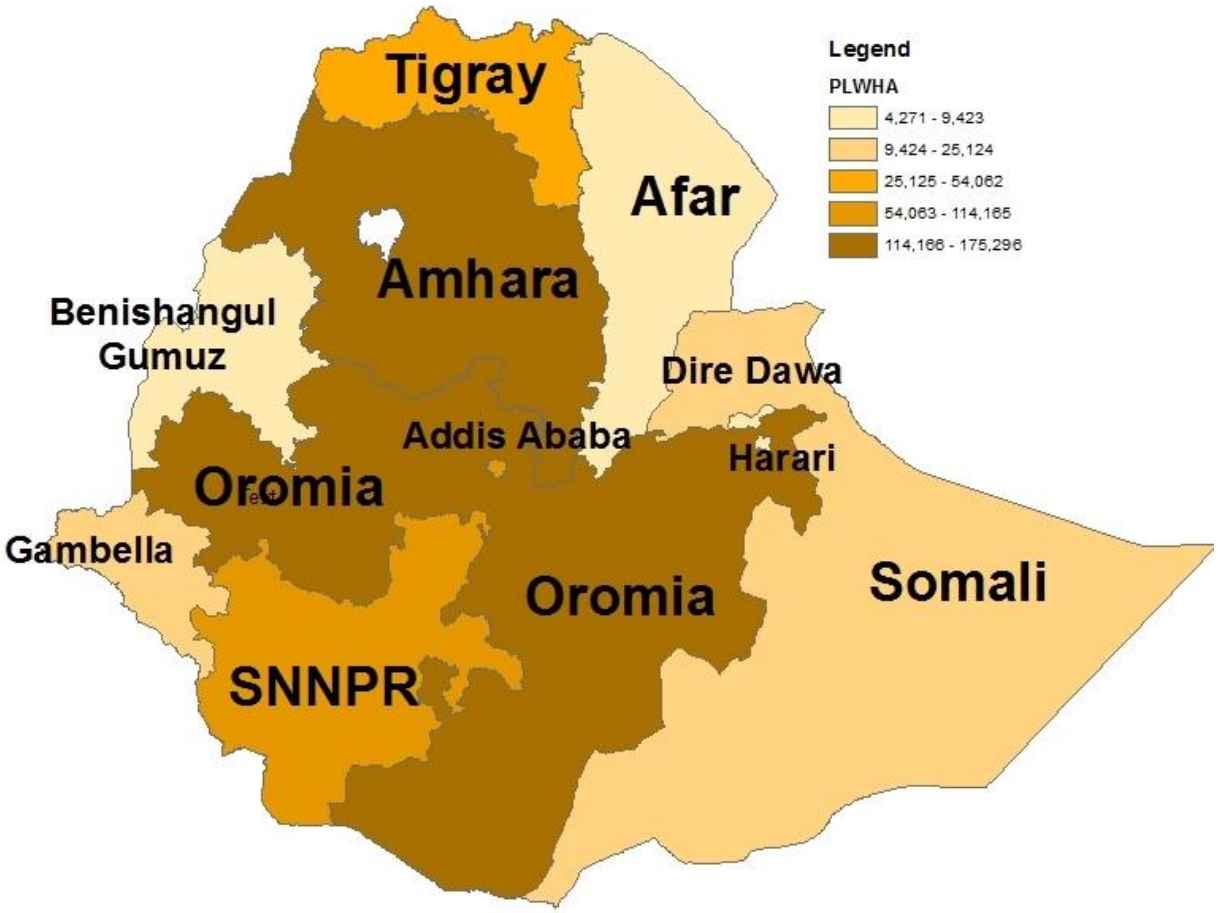


Figure 2.4.3 Ethiopia COP 17 SNU Prioritization

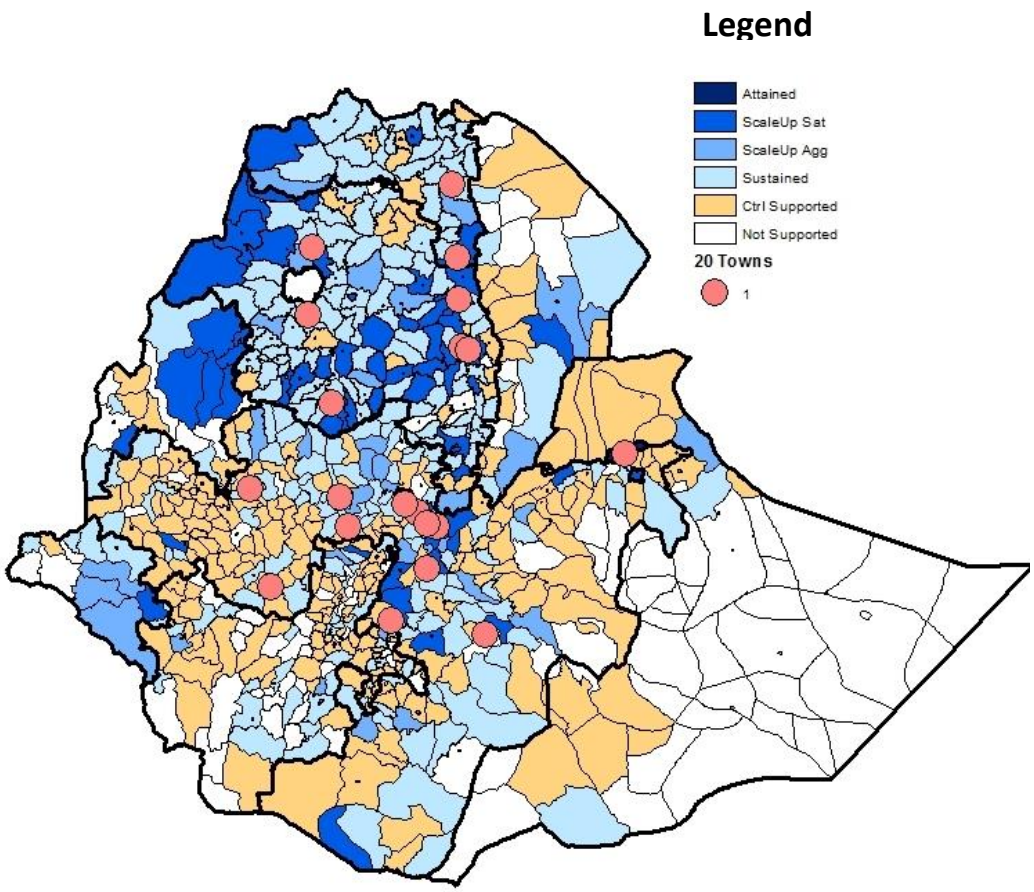
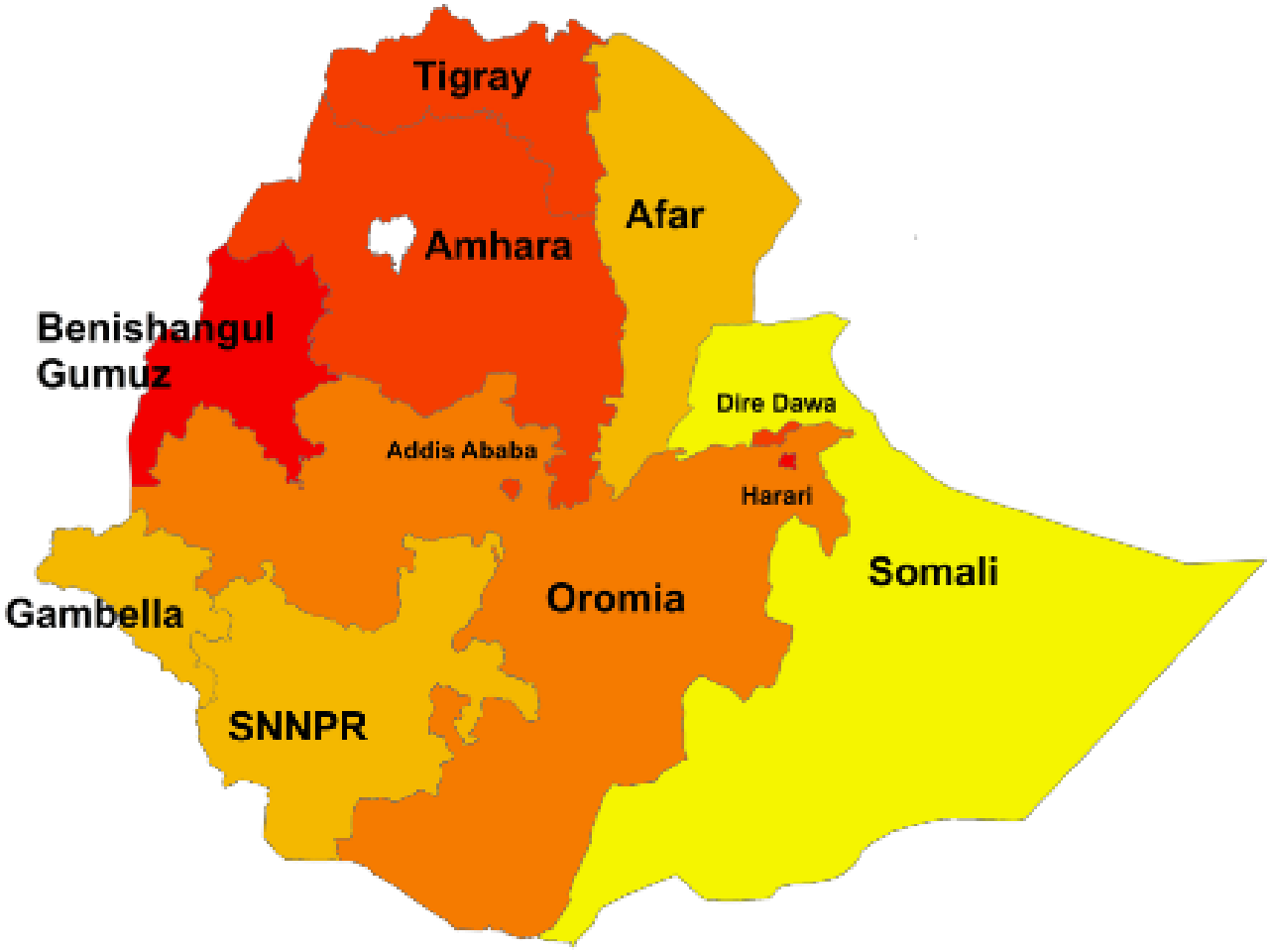


Figure : 2.4.4 2016 ART Coverage by Region



Legend: % of ART coverage by region

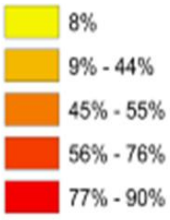
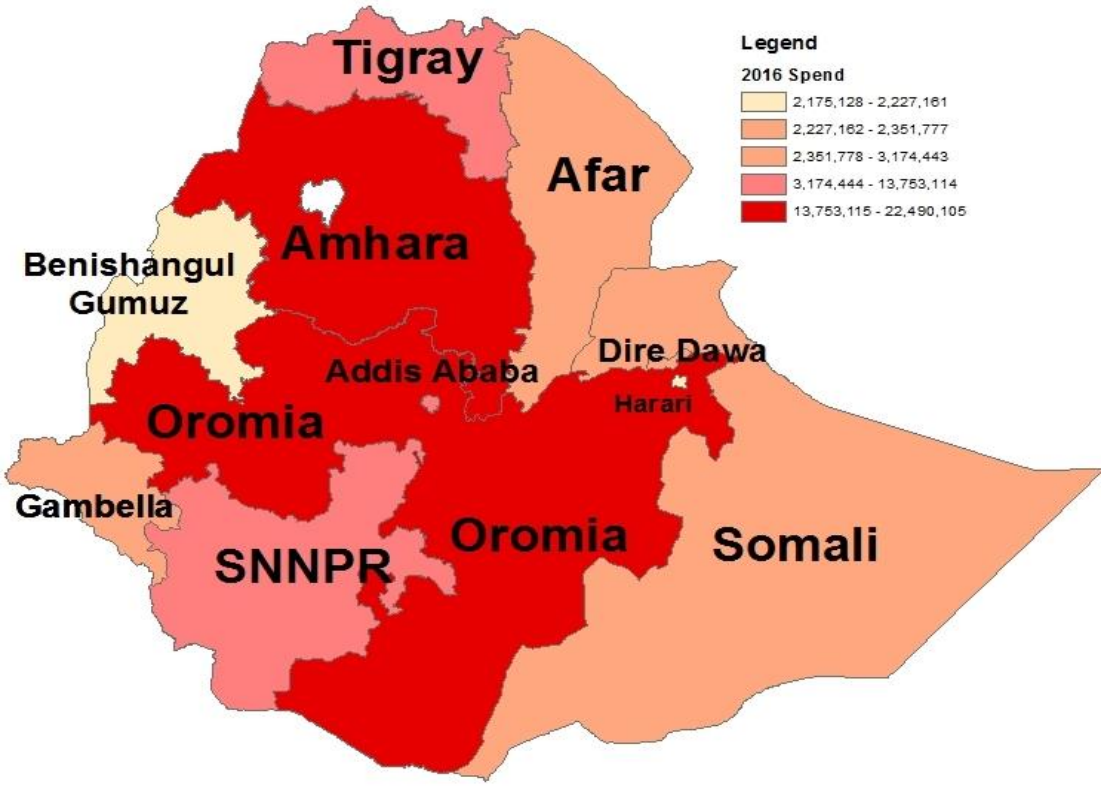


Figure 2.4.5 FY16 Expenditure by Region



2.5 Stakeholder Engagement

PEPFAR-E regularly collaborates with the GoE, the Global Fund, UNAIDS, other external donors, civil society organizations, and the private sector at both federal and regional levels. PEPFAR-E holds frequent meetings with the FMOH and Federal HIV/AIDS Prevention and Control Office (FHAPCO) to discuss new developments in PEPFAR, follow up on the Catch Up Campaign; and to also conduct quarterly program management reviews, including status updates on partner pipelines. The CDC team meets with Regional Health Bureaus (RHBs), local university partners, and local NGOs on a quarterly basis to discuss implementation, planning, and execution through their cooperative agreements. The USAID team meets with the Federal Ministries of Education, Labor and Social Affairs, and Women, Children, and Youth Affairs on a monthly basis to coordinate implementation of prevention among high-risk youth and migrant laborers, as well as social services for HIV/AIDS-affected orphans and vulnerable children. USAID also meets with Ethiopian professional and private sector associations to coordinate implementation and plan the transition of clinical care and treatment activities in the private sector.

For COP 17, PEPFAR-E will continue to work very closely with external stakeholders especially with FMOH/FHAPCO and Regional Health Bureaus in implementing the Catch up Campaign. During the planning process and current implementation of the Catch up Campaign, PEPFAR-E along with the FMOH/FHAPCO engaged all stakeholders for feedback on implementation of the campaign; ensure campaign is progressing toward attaining its objectives and targets.

In addition, PEPFAR- E engages the Global Fund and UNAIDS, particularly around resource alignment and use of data (such as SPECTRUM estimates) to inform program decisions. This collaboration will continue in an effort to maximize resources and reduce inefficiencies. PEPFAR-E will participate in the steering and writing committees for development of the upcoming Global Fund Concept Note

The COP17 guidance, tools and planning level letter were shared with external stakeholders including CSOs. CSOs participated in the strategic retreat convened in January 2017, in collaboration with FMOH/FHAPCO. Participants provided input on PEPFAR-ET proposed planning direction for COP17 towards accelerating the move to reach the 90-90-90 targets. Some of the barriers identified include lack of ownership at all levels of the health sector, unavailability of required commodities/timely stock refill, declining budget climate even though demand for quality services has increased, lack of standard platform for laboratory machine procurement and lack of capacity to maintain equipment. Participants recommended regular revisions of geographic prioritization; evidence based targeting and also adequate emphasis on resource allocation. The PEPFAR-E team works closely with CSOs to ensure their involvement in the HIV/AIDS national response. PEPFAR and UNAIDS established a consultative group of CSOs which includes NEP+, FGAE, faith based and professional groups, as well as PLHIV associations. The consultative body developed a work-plan which details their contribution toward attaining 90-90-90. However the plan has not been implemented because there are no resources available.

Stakeholder meetings are frequently convened, during which program performance is reviewed, barriers discussed, and best practices and lessons learned are shared. An Implementing Partner meeting was held in November 2016 and will be continued every quarter to ensure strong collaboration and exchange of best practices among partners working in the 20 focus towns. This will strengthen efforts to improve case identification which will result in finding “hidden” key populations (KP) and priority populations (PP), improve linkage to care and treatment, and reduce lost-to-follow-

up (LTFU).

3.0 Geographic and Population Prioritization

Ethiopia's HIV epidemic remains geographically heterogeneous and concentrated in urban settings with PLHIV most concentrated in urban settings and within five kilometers of an asphalt road (transport corridors). PEPFAR-E monitors HIV disease burden at the district/woreda level and continues to use a "catchment-area approach" to assess disease burden and unmet need at the district level. This approach relies on SPECTRUM's region-specific estimates for disease burden and assumes that the proportion of the region's PLHIV on treatment in each district reflects the care seeking pattern of all PLHIV in the region. This methodology took into account that PLHIV do not necessarily obtain services in the district where they live and assumed that those not yet on treatment have, or will have, the same service-seeking patterns as those currently on ART. On this basis districts are sorted from highest to lowest disease burden. Those districts accounting for over 54.6%% of Ethiopia's disease burden— including Addis Ababa's 116, of the country's 940—are classified as scale-up saturation. Subset of the scale up saturation woredas, including Addis Ababa, accounting for 40.4% of the PLHIV population are designated for PEPFAR twenty town strategy. Of the twenty towns, 7 towns are selected to reach "attained" status by September 30, 2018.

At the end of FY 16, 71.8% of HIV-infected adults and 36.8% of HIV-infected children in scale-up saturation woredas were on ART. PEPFAR-E set treatment targets for COP2017 to reach 92.5% coverage for adults and 72.2% coverage for children in scale-up saturation woredas. For the twenty towns, the treatment coverage target for adults is 90.7% and 72.3% for children and 79% overall. In FY16, PEPFAR-E achieved only 48% of its TX_NEW target. All 20 towns with the highest HIV burden had greater than 50% treatment coverage in APR 16. In 2015, the SPECTRUM estimate of number of HIV-infected children in Ethiopia declined by 40%. PEPFAR-E expects an additional downward estimate of the pediatric HIV population may be forthcoming.

Nationally, the greatest unmet need remains in the <25 age bands; this is also reflected in the unmet need for the 20 Towns that PEPFAR is focusing on in its support to the Government of Ethiopia's larger Catch-Up Campaign that targets 178 towns. Among these twenty towns, PEPFAR E anticipates supporting GOE to achieve overall saturation in all twenty towns, but none of these will have ART saturation across all age/sex disaggregates, or attainment, due to the challenges for reaching both males and females in the <25 age bands. This picture will refine further in mid-2017 when the DHS+ results which provide long-overdue national and regional prevalence estimates for age/sex disaggregates, will be available. There will be further clarity after the EPHIA targeting the urban centers completes in 2017. A total of 190 Woredas are targeted for scale-up in COP17, with an estimated 398,418 PLHIV. 83/312 scale-up Woredas are scale-up aggressive and the program has targeted 107/312 scale-up saturation Woredas to achieve 81% ART coverage for COP17. In addition, 122/312 woredas will be attained in COP 17 out of which a total of 116 woredas in Addis are considered part of the 122 to be attained woredas.

Analysis of COP15 (FY16) program performance suggests that both linkage to care and patient retention are strong, and that the main obstacle to achieving saturation has been failure to identify previously undiagnosed PLHIV and provide access to rapid ART initiation, including same-day initiation for clients who are ready. A package of services has therefore been developed that is expected to maximize identification of the difficult-to-find PLHIV in each of the 20 towns and other

scale-up woredas and includes the following, which is described further in Section 4.5:

1. Strengthen community and facility-based testing services to reach KP and PP
2. Consolidate HTS at the 80 key population friendly public facilities
3. Intensify targeted provider-initiated testing (PITC) in clinical settings
4. Increasing HIV case detection among STI clients
5. Accelerate expansion of Partner Notification Services for STI and HIV positives
6. Intensify systematic active disclosure support to index PLHIV to link their partners and children of HIV positive mothers to HTS
7. HIV Self-Testing (HIVST)
8. Use peer organizations to encourage testing among their networks
9. Enhance targeted demand creation for HTS
10. Linkage to treatment services that accelerates "Test and Start"
11. Adapt and pilot HIV risk screening tool to implement a more targeted PITC
12. RTK procurement , targeting, use, and systems strengthening
13. Maintain and mainstream momentum from the CUC

In addition to these measures, PEPFAR-E technical staff and leadership will continue to reinforce implementation of rapid initiation on ART, and advocate for national testing guidelines that are focused on optimizing yield, and advocate for policy change for the integration of rapid test kits into the national Integrated Pharmaceutical Logistics System together with an updated nationally validated testing algorithm.

Table 3.1: Current Status of ART Saturation

Prioritization Area	Total PLHIV/% of all PLHIV for COP17	# Current on ART (FY16)	# of SNU COP16 (FY17)	# of SNU COP17 (FY18)
Attained	**145,039 (22 %)**	**106,346**		**122**
Scale-up Saturation	**215,270 (33 %)**	145,755	176	107
Scale-up Aggressive	**183,148 (28 %)**	79,993	86	83
Sustained	**96,847 (15 %)**	56,680	295	250
Other	**19427 (3 %)**	16,630	388	383

Table 3.2 ART Targets in Scale-up Sub-national Units for Epidemic Control						
SNU	Total PLHIV - 2018	Expected current on ART (APR FY17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18)	Newly initiated (APR FY18) TX_NEW	ART Coverage (APR 17)
Scale-up saturation	**215,270**	170,432	1,784	196,933	31,605	91%
Scale Up Aggressive	183,148	92,106	54,412	105,370	16,651	57.5%
Total	398,418	262,538	55,133	302,303	48,256	75.9%

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

4.1 Targets for Scale-Up Locations and Populations

Based on FY16's TX_NEW performance which fell significantly short of reaching its target, PEPFAR-E recognized that meeting FY17 targets established at time of COP16 submission will be very challenging. FY16 adult treatment scale-up targets, therefore, were revised pre-DCMM and set FY17 targets based on the following assumptions:

1. In FY16, 97% of cohort entering the year on ART will be retained.
2. TX_NEW will increase 10% over FY15.
3. 91% of TX_NEW will be retained by end of FY16.

This is reflected in the following formula: FY16 TX_CURR-Adult = (FY15 TX_CURR*0.97) + (FY15 TX_NEW*1.1*0.91). FY17 TX_CURR was calculated assuming 98% retention of cohort entering FY17 on ART and that TX_NEW will be 40% higher than in FY15 with 92% retention of those initiated on treatment in the course of the year, as reflected in the following formula: FY17_CURR-Adult = (FY16TX_CURR*0.98) + (FY15 TX_NEW*1.4*0.92).

Table 4.1.1 Entry Streams for Adults and Pediatrics Newly Initiating ART Patients in Scale-up Woredas

Entry Streams for ART Enrollment	**Tested for HIV (APR FY18) HTS TST**	**Newly Identified Positive (APR FY18) HTS TST POS**	**Newly initiated on ART (APR FY 18) TX_NEW**
Adults			
Clinical Care Patients not on ART	**1,232**	**1,232**	**1,232**
HIV+ TB Patients not on ART	**27,559**	**4,448**	**1,334**
HIV+ Pregnant Women	**707,234**	**4,631**	**4,441**
Other testing	**3,371,178**	**56,753**	**59,080**
Total Adults			
Pediatrics (<15)			
Clinical Care Pediatric Patients not on ART	**84**	**84**	**84**
***HIV Exposed Infants**	**13,905**	**695**	**660**
Other Pediatric Testing	**787,098**	**4,628**	**4,221**
Total Pediatrics			
TOTAL			

***HIV Exposed Infant (HEI) in this case refers to HEI<12mo of age, where testing is PMTCT_EID and PMTCT_EID_POS and treatment is TX_NEW<1**

The FY17 "starting point" was determined using the same FY16 TX_CURR-Adult formula identified above. Then to determine TX_NEW-Adult, the following was calculated:

- TX_NETNEW = (FY17 EST PLHIV≥15*0.8)-FY16 TX_CURR; **TX_NEW** = ((TX_NET NEW/0.92) + (0.02*FY16 TX_CURR).

The remaining 86 scale-up woredas are classified aggressive scale-up. Their TX_CURR targets were based on the formulas based on FY15 performance previously cited.

Pediatric targets were calculated based on FY15 performance because FY16 performance was particularly low:

- For the 20 focus towns: FY18 TX_CURR <15 = (FY17 TX_CURR*0.96) + (FY15 TX_NEW*1.25*0.93), considering 4% loss from the cohort enrolled in treatment in FY17, and a 25% increment in TX_NEW compared to FY15, and 93% retention of those newly initiated on ART through the end of the FY18.
- For scale up woredas outside of the 20 towns: FY18 TX_CURR-<15 = (FY17 TX_CURR*0.96) + 1.15*FY15TX_NEW*0.93, considering 4% loss from the cohort enrolled in treatment in FY17, and a 15% increment in TX_NEW compared to FY15, and 93% retention of those newly initiated on ART through the end of the FY18.
- For sustained woredas: FY18 TX_CURR-<15 = (FY17 TX_CURR*0.96) + 1.05*(FY15 TX_NEW*0.93, considering 4% loss from the cohort enrolled in treatment in FY17, and a 5% increment in TX_NEW compared to FY15, and 93% retention of those newly initiated on ART

through the end of the FY18.

To determine testing targets, a cascade analysis was conducted. The target setting factored in HIV positives that will come from pre-ART care and PMTCT, HIV positive yield and the level of linkage to care and treatment services. Moreover, target calculation assumed the implementation of Test and START that 100% of those enrolled in care will be put on treatment.

The specific approaches to increasing TX_NEW are enumerated in Section 3 with details highlighted in 4.2–4.10.

Table 4.1.2 VMMC Coverage and Targets by Age Bracket in Scale-up Districts

Target Populations	**Population Size Estimate (SNUs)**	**Current Coverage (date)**	***VMMC_CIRC* (in FY18)**	**Expected Coverage (in FY18)**
Males 10-14	**21,981**	**52%**	**7,085**	**18,428 (84%)**
Males 15-29	**77,950**	**61%**	**7,576**	**54,994(71%)**
Males 30 and above	**55,600**	**19%**	**4,723**	**21,695 (39 %)**
Military VMMC			**4,937**	-
State PRM (refugee community)			**1,760**	
Total/Average/for Gambella	**155,531 (CDC only)**	**49% (CDC only)**	**26,081 All Agencies**	**61%(CDC only)**

Table 4.1.3a Target Populations for Prevention Interventions to Facilitate Epidemic Control (PP_Prev)

Woreda Classification	Population Size Estimate (scale-up SNUs)*	Coverage Goal in FY17*	FY18 Target
Scale-up Saturation	-	-	241,504
Scale-up Aggressive	-	-	90,166
Sustained	-	-	34,255
Total	-	-	365,925

Table 4.1.3b Target Populations for Prevention Interventions to Facilitate Epidemic Control, KP_PREV_CSW

Woreda Classification	Population Size Estimate (scale-up SNUs)	Coverage Goal (in FY17)	FY18 Target
Scale-up Saturation	44,449	90%	40,011
Sclae-up Aggressive	37,979	59%	22,718
Sustained	35,311	0	0
Total	117,739	53%	62,729

The increases required in TX_NEW in younger age/sex disaggregates to achieve attainment poses significant challenges. Some of this could be due to lack of precision of the current prevalence estimates, a dynamic which will be clarified with the new DHS+ results to be availed in summer 2017, and refined further with PHIA results anticipated for early 2018. Saturation in the ages 25+ categories for both males and females will be achieved across all 20 towns by the end of FY18. PEPFAR-E will support the FMOH to optimize enrollment in treatment by first, and foremost, deploying aggressive case detection measures and institutionalizing the best practices and momentum of the FMOH's "Catch-Up Campaign" (CUC) to focus testing practices for maximum yield. The program will continue to promote a stigma free environment in the towns targeted for saturation, create demand among high risk populations, and promote quality of compassionate and respectful care at all sites. The Government of Ethiopia's commitment to "mainstream" the CUC strategies is a powerful indication of the country's pivot to achieve the ambitious targets in the 90-90-90 strategy developed for COP17, and an effort to shift even from further "Test and Start" to "Test and Same-Day Initiation," as a recognition of some of the deficiencies still seen with initiation on ART.

Supply chain resilience for RTKs remains a severe threat to achieving COP17 targets. These challenges are due to a combination of inter-related factors:

1. Delays in establishing a new, nationally-validated testing algorithm (as per WHO requirements), which is also the condition precedent for GFATM procurement.
2. Allocations of test kits that are not set to evidence-based targets, but rather on the basis of quota.
3. Lack of targeted testing modalities at the site level
4. Because RTKs are the only tracer commodity not fully incorporated into the Integrated Pharmaceutical Logistics System, which supports the remaining 24 out of the 25 priority tracer commodities of the FMOH, it is unknown which tests are where, in what quantities, how they are allocated, distributed, tracked, consumed, where they get them from, how they are requisitioned, etc.

4.2 Priority Populations

The recognized KP group in Ethiopia is the commercial sex worker (CSW). Priority populations include: divorced and widowed persons; OVC; HIV-negative partners in discordant couples; STI cases; long-distance truckers; clients of sex workers; uniformed services; prison inmates; people in transactional sex; waitresses; mobile/seasonal workers; and vulnerable adolescent girls and young women. PEPFAR prevention programs for KP and PP will concentrate in attained and scale-up woredas and SNUs. Introduction of new interventions and scale up of high-yield programs will focus on the 20 saturation towns.

The density of CSW populations correlates closely with high PLHIV burden overlapping with urban woredas linked by major transport corridors. Prevention efforts aimed at KP and PP are all defined as core activities in COP17. Programs adopt combination prevention, linking standardized behavior change curricula with HIV testing services (HTS), STI treatment services, and care and treatment services. HIV testing yields, particularly for programs targeting mobile workers, have been much lower than expected but have shown improvement with intensified targeted testing approaches. As a result of continuous monitoring of data, PEPFAR-E will continue to refocus its testing and outreach efforts in locations with demonstrated high yield, along with further stratification of KP and PP groups to target the highest risk sub groups among them.

Since PEPFAR-E's COP16 submission, there have been several major policy changes positively affecting PEPFAR's ability to reach HIV epidemic control among KP and PP. The FMOH adopted Test and START and began implementation of a catch up campaign in 178 selected towns, including the 20 PEPFAR priority towns. The aim of the CUC is to identify 70,527 new HIV positive cases and enroll them in treatment, of which 16.8% (11,872/70,527) is estimated to be key or priority populations (per PEPFAR-E's definition)[2]. Another development was the approval of community ART services in drop-in centers for CSWs. Thirteen confidential clinics and 25 drop in centers in the 20 priority towns are now providing ART for CSWs; of which 11 confidential clinics reported 470 CSWs received ART at the end of FY17 Q1. Drop in centers initiated ART service provision in November 2016, and since then have shown promising results enrolling a total of 422 CSWs on ART. Children and partners of CSW will also be tested, and if positive will be enrolled in treatment. KP-friendly clinical services will be provided at 80 public health facilities in scale-up woredas. This sustainable approaches includes high load facilities in the 20 priority towns with associated KP targets for these sites.

The private sector will receive PEPFAR support to strengthen their role in HIV care and treatment based on evidence that KP and PP are accessing these sites. Stratification of PP to identify those at higher risk will continue in order to maximize yield from testing and to direct outreach efforts. In COP 17 PrEP will be piloted at the KP sites for CSWs and self-testing will be scaled up at PP and KP, based on recommendations for the HIV Self Testing (HIV-ST) pilot.

To address HIV related stigma, community leaders will be engaged to lead "stigma-free zone" campaigns and create an enabling environment where KP and PP will be encouraged to seek HTS and care and treatment if positive. In addition to community leaders taking charge of these efforts, PEPFAR will support community-based peer organizations to provide outreach and education to the more difficult to find KP and PP. These activities will be focused in scale-up woredas, especially those targeted for saturation.

A continuing policy bottleneck is the lack of a National Condom Strategy, which has been in draft form since 2013. Without this framework, condom procurement and distribution lacks the required and critical coordination. Once the National Condom Strategy is approved and implemented, all PEPFAR-E partners will be able to access condoms through the government distribution system. PEPFAR-E will push this as a priority agenda in National HIV Prevention Advisory Group (NaHPAG).

[2] Government of Ethiopia's Catch Up Campaign Strategy

Community involvement in PEPFAR programming is robust in spite of national restrictions placed on CSOs. Health work by community groups is generally more accepted than "advocacy" work, and PEPFAR-E works successfully with a wide range of local partners to implement programs. New and existing patient-centered community HIV models are being utilized to link priority population groups with available services. Bidirectional referrals between community and facility services are fully integrated into PEPFAR programming.

PEPFAR-E will support post-gender-based violence (GBV) care for all survivors in COP17. Healthcare providers at both the community and facility levels will be trained on comprehensive GBV care and provided with national guidelines[3]. IPs will support awareness creation, screening for potential GBV survivors, and provide appropriate services. Monitoring of GBV services is integrated with other HIV programs and it will be direct service delivery (DSD) as the data clerks are used for compiling and reporting the GBV data.

4. 3 Voluntary Male Medical Circumcision (VMMC)

The VMMC program in Ethiopia has been implemented among adult men in Gambella region, military and refugee populations since 2009. Because of the nature of the program and the target population, it was not possible to calculate coverage by age group and fiscal year for DOD and State/PRM. However, 15% new military recruits are estimated to be uncircumcised each year.

The VMMC program in Ethiopia has been defined as a near-core program to be transitioned to the government once 80% MC saturation has been achieved among adult population 15–49yrs old. As per the recent population projection and MC unmet need estimation exercise done by the FMOH (2010-2019), the projected male population aged 10 years and above was estimated at 155,531 of whom 21,981 are in age group 10–14; 77,950 in the age group 15–29; and 55,600 in the age group 30 and above. Looking at current MC coverage including expected FY17 performance, among different age groups in Gambella, 52%, 61%, and 19% coverages have been achieved among age groups 10–14, 15–29, and 30 and above respectively. By the end of FY 17, it is anticipated that more than 92,980 cumulative VMMC procedures will have been provided among Gambella adult male (75,733), military (17,247) and refugee population. The program is expected to reach saturation levels in the primary target group of 15 to 29 year in the coming 2-3 years after which prioritization of clients aged 10-14 years will increase. The total VMMC target for COP17 is 26,082 MC procedures (CDC, 19,385; State/PRM, 1,760; DOD, 4,937); out of which 13,271 targets are attributed to COP17 central funds.

All VMMC clients and partners are provided with HIV counseling and testing services and HIV positive clients are immediately linked to care and treatment facilities. All VMMC clients are provided with the standard WHO recommended services packages including post-operative wound care and distribution of condoms. In Ethiopia, MC procedures are done using surgical methods (Forceps guided and dorsal slit) only. The following service packages will be implemented in COP17 for Gambella military and refugee population:

- Supporting provision of key clinical and prevention service including circumcision using a medical method recognized by WHO (Forceps guided and dorsal slit surgical methods)

[3]Comprehensive GBV care includes HIV testing and administration of post-exposure prophylaxis for HIV within 72 hours of sexual assault; STI testing and post-exposure prophylaxis and treatment as needed; emergency contraception when appropriate; counseling and psychological support; collection and complete documentation of injuries, preferably with diagrams; collection of forensic specimens when appropriate; referral to police and legal services; and linkage to emergency shelter and protective services and support groups as needed.

- Providing counseling on abstinence during the healing process and age appropriate sexual risk reduction
- HIV testing prior to Circumcision for all men aged 15 and above and their sexual partners
- Condom distribution
- Post-surgery follow up including assessment of adverse events
- Conducting limited VMMC services demand creation
- Linkage to treatment/care services for men who test HIV positive will be implemented in sustained SNUs
- Providing key VMMC surgical kits and supplies

Increased uptake of VMMC over the course of the program points to the development of positive social norms in favor of VMMC, although uptake still requires active promotion through social mobilization. The VMMC program in Ethiopia has been supplemented through additional central funding since COP15, with $747,790 provided in COP17.

4.4 Prevention of Mother to Child Transmission (PMTCT)

Ethiopia has seen significant gains in PMTCT since the program's inception. The adoption of PMTCT Option B+ in Ethiopia in 2013 helped to spur HIV testing in antenatal clinics (ANC), and ART administration to HIV positive pregnant and breastfeeding mothers. Consequently, new pediatric HIV infections decreased by 22.5% from 2,689 in 2015 to 2,083 in 2016 (SPECTRUM 2015 Estimates).

First 90: At PEPFAR-supported PMTCT facilities, the number of pregnant/lactating women tested for HIV decreased from 1,165,753 (93%) of 1,792,919 women in FY15 to 992,193 (87%) of 1,139,789 women in FY16 (Source: APR 16). FMOH continued to prioritize HIV testing in PMTCT sites in FY16. RTKs are allocated differently that other HIV commodities and, though there was adequate stock of RTKs in the country, allocation planning for RTKs down to site level and a slow roll out of training on the new RTK being used in country, likely contributed to a drop in HIV testing of pregnant/breastfeeding mothers.

This combination of factors the RTK shortage, likely caused the drop in HIV testing of pregnant/breastfeeding mothers. In FY16, the 952 PEPFAR-supported PMTCT sites tested 988,938 mothers for HIV; of these, 15,172 (1.5%) were identified as HIV positive (Source: Panorama). The estimated number of mothers needing PMTCT in 2016 was 27,434 (Spectrum 2015), of which PEPFAR-supported PMTCT sites identified 55.3%. These data indicate that PEPFAR-supported sites identified the majority of HIV positive pregnant/breastfeeding women. From FY15 to FY16, the percent of HIV+ mothers enrolled in PMTCT that were previously known to be HIV positive increased from 60% in FY15 to 65% in FY16 (Source: DATIM).

Second 90: At PEPFAR-supported ANC or labor and delivery sites in FY16, 14,636 (97%) of 15,263 HIV+ mothers identified were administered ART. Linkage to ART for PEPFAR-supported PMTCT sites remains excellent. Spectrum 2015 estimated that 27,434 mothers would need PMTCT in 2016. If this estimate is accurate, then PEPFAR would have provided ART to 53% of mothers needing PMTCT in FY2016. However, since the HIV testing yield from PEPFAR-supported sites in FY16 remained low (1.5%) nationally (Source: COP17 Datapack), it is possible that Spectrum 2015 over-estimated the number of mothers needing PMTCT in 2016.

Third 90: Viral load testing of pregnant/lactating HIV positive mothers began implementation in

FY2016; data on viral load suppression among HIV-positive mothers will be available by the end of September 2017 as it is currently, an annually reportable indicator. Efforts will be made in COP17 to report on a quarterly frequency on viral load suppression

While the PMTCT program performance has been steadily improving, results still fall below the target of achieving the elimination of mother-to-child transmission (eMTCT), <1% transmission. Administering ART to at least 90% of HIV infected pregnant and lactating mothers is the key to achieving eMTCT. The first step is increasing the number of pregnant women seeking ANC.

The 2016 Ethiopian DHS survey reported that among women aged 15-49 years who had a live birth in the preceding 5 years, 62% received antenatal care from a skilled provider for the last live birth (range 51.3% in Afar region to 96.8% in Addis Ababa, and 90.1% in urban versus 58% rural residence). To identify a larger percentage of the HIV+ pregnant/lactating mothers, it will be critical to increase ANC and postnatal care (PNC) demand and coverage nationwide. In scale-up saturation, aggressive and attained woredas, PEPFAR-supported community organizations must work with health extension workers and the health development army to further increase demand for ANC services, and assure HIV testing for all pregnant women including those receiving ANC services at health posts.

To date, the Ethiopian PMTCT program has focused mostly on providing ARV to HIV+ pregnant women. Consequently, the PMTCT program performance during the second half of the PMTCT cascade, after birth of HEI, has been less successful and needs strengthening. Since 2015, PEPFAR and the FMOH have been developing a mother baby cohort monitoring tool for Ethiopia with technical assistance PEPFAR. The tool is being pilot tested in March 2017. In April 2017, and a training of the trainers (TOT) workshop will be held for FMOH and RHB PMTCT staff. Tool implementation is expected to refocus PMTCT sites on tracking maternal ART retention, and HEI EID and final outcome performance. This is essential for moving Ethiopia towards eMTCT certification.

In FY16, the number of HEIs tested for EID by 12 months of age at PEPFAR-supported PMTCT sites was 12,559 (80%) of the expected 15,575 HEIs; this met the EID testing target of 80% for the first time. The EID positivity rate was 1.5% (Source: Panorama). This indicates that at PEPFAR-supported PMTCT sites, MTCT has been nearly eliminated in FY2016. The PMTCT program plans to obtain EID testing on 80% of HEIs by 2 months of age, and to ensure EID TAT of less than 1 month. Current barriers include: improperly collected and packaged DBS specimens at PMTCT sites, slow mail delivery of DBS specimens to regional labs, protracted delays in EID testing at the regional labs due to machine failure and reagent stock outs, and slow mail delivery of DBS test results to facilities. These barriers are being addressed by implementing expanded training of DBS collection for PMTCT providers as part of the revised PMTCT training modules introduced in January 2016. In addition, continuous quality improvement (CQI), quality assurance (CQA), and monitoring and evaluation activities training were included in the expanded 2016 PMTCT training program. The CQI and CQA training will enable PMTCT site providers to identify and address site program gaps including low EID rates, prolonged TAT, and low final HEI outcome rates.

Although the FMOH signed a memorandum of understanding (MOU) with the postal service to provide couriers to expedite the transportation of DBS EID specimens to regional labs, this has been only partially successful in reducing EID TAT. The introduction of postal couriers hasn't helped remote locations with limited numbers of post offices, nor has it reduced TAT in areas with lab machine failure and reagent stock outs. Consequently, partners have procured SMS printers for some

sites to expedite EID result reporting. However, these SMS printers have limited effectiveness in reducing TAT due to gaps in internet and telephone service in some areas. Accordingly, the Clinton Health Initiative (CHI) plans to pilot Point of Care (POC) HIV testing at birth. PEPFAR will monitor the pilot results to determine whether it would be feasible and cost-effective to expand POC testing at birth in Ethiopia. In addition, PEPFAR has provided TA to EPHI and regional labs to mitigate machine failure and reagent stock-outs as a means of reducing EID TAT.

In 2016, DATIM began requiring sites to report rates of HEI final outcome testing. HEI final outcome status was determined for 7,190 (46%) of the estimated 15,575 HEIs in FY 2016 (Panorama). However, the HEI final outcome results (HIV positive or negative) were not reported (Panorama).

In FY17-FY18, RHB mentoring and supportive supervision to PMTCT sites will emphasize continuity of care from pregnancy, labor & delivery, through lactation. Mother Support Groups in scale-up woredas will support mothers in disclosing HIV status to partners, providing adherence counseling, and improving retention by actively tracking patients who have missed appointments and returning them to care.

PEPFAR partners will implement family-based HIV testing in the PMTCT setting and will use PMTCT clinic as a venue for screening partners and children of HIV infected women. Targets in both scale-up and sustained woredas have been set towards the direction of eliminating MTCT. Based on proposed FY17 targets assuming 1.8% maternal prevalence and 5% MTCT, there would be 90 MTCT per 100,000 live births (above the 50 per 100,000 threshold for EMTCT, but moving in the right direction). Hence, in FY18, 95% of pregnant women will know their status and 95% of positive pregnant and lactating women will be on ART. Efforts will be more intensified in scale-up woredas as most of the HIV positive mothers are from these SNUs.

4.5 HIV Testing and Counseling Services (HTS)

In FY16, PEPFAR-supported facilities achieved only 65% of testing targets, and only 41% of the FY16 positive target. Key to achieving UNAIDS 90:90:90 milestones for epidemic control is aggressively diagnosing PLHIV among more marginalized populations in the country. Current national testing policies are obstacles to achieving the targeted approach required to optimally utilize the country's supply of test kits. Despite stated intentions to endorse appropriately target testing modalities to optimize detection, the 2014 National Guideline included broad, population-based testing recommendations, including repeated testing of pregnant mothers for eMTCT.

Combined with an RTK distribution based on quota, rather than targets based on empirically estimated yields, Ethiopia continues to experience RTK shortages in districts with high background prevalence of undiagnosed PLHIV and excessive testing in geographic areas with very low prevalence. When RTK shortages at facilities occur, pregnant women are prioritized, while people presenting with symptoms likely due to HIV may not be tested. These practices are compounded by the situation whereby RTKs are allocated, delivered and tracked outside of the Integrated Pharmaceutical Logistics System, thereby undermining the HIV program's ability to effectively monitor allocations, deliveries, and consumption vis-à-vis performance.

With the Catch-Up Campaign, the FY17 Q1 performance is promising and demonstrates the progress that can be made when (1) testing modalities are focused for yield, and (2) RTKs are consistently available at priority sites. PEPFAR continues to support the Government of Ethiopia to mainstream

these dynamics into routine HIV services and in COP17 continues to promote targeted testing at facility level and outreach and demand creation in the community to reach the most difficult to reach high risk populations.

These specific activities for COP17 include an array of more aggressive approaches to detect new cases:

1. **Strengthen community and facility-based testing services to reach KP and PP**: Community and facility-based programs will intensify behavioral interventions in the 20 towns targeting commercial sex workers (CSWs), partners of CSWs, and other high-risk PP groups to create demand for and linkage to HTS. Peer education sessions will target populations to reduce risky behavior and increase health seeking behavior. Existing platforms supported by partners including drop-in centers, confidential CSW clinics, private sector facilities, and CSW-friendly public facilities will be used to provide HTS services. Populations, including such as daily and seasonal laborers, truck drivers, and clients of CSW who need HTS outside of regular working hours will be offered extended service hours, including evening, lunch hour and weekend testing in drop in centers, confidential clinics, and targeted outreach sites. Motivated peers will be trained on referral and linkage of sex workers and other PP. A snowball approach will be used to identify and reach KP and PP who have not been tested. Dynamic micro planning in priority SNUs to map KP will continue and a snowballing approach will also be used to identify KP and PP.
2. **Enhance targeted demand creation for HTS:** Demand creation activities among index partners and HIV exposed children will be implemented through motivated, committed and respected PLHIV peers identified through PLHIV associations. FSW peers who have passed through HIV behavioral and biomedical interventions and volunteer to be involved will be trained and coached on demand creation and utilized to reach out and test unreached FSWs and their partners. Providing male friendly services in confidential clinics, training and utilizing the FSWs to be educators to the men who come to them and extending self-testing to contacts/clients of FSWs will also be implemented to attract and test contacts/clients of FSWs. To maintain momentum of effective demand creation activities, programs will conduct regular review, recognize model demand creators and incentivize per new HIV infection identified and successfully linked to treatment services.
3. **Increase HIV case detection among STI clients:** To ensure that all patients in scale up SNUs who present with STI symptoms are tested for HIV, sensitization workshops will be conducted for providers in facility and community settings. Post-test counseling will be strengthened, and HIV-positive clients, newly identified either at community or facility testing sites, will be escorted to HIV treatment facility.
4. **Intensify targeted provider-initiated testing (PITC) in community and facility clinical settings:** In the 20 priority towns and scale up SNUs, targeted PITC will be implemented in public and private inpatient and outpatient wards. Those targeted will include patients with TB or suspected TB, STI, opportunistic infection, or other signs and symptoms suggestive of HIV/AIDS, clients with identified high-risk behavior and widowed or divorced women. Facility-based HTC contributed to 85% and 90% of the overall HIV positives detected in FY16 APR and FY17 Q1, respectively. Programs will intensify facility based targeted PITC in high case load public facilities through strengthening daily triage of patients for testing, weekly monitoring of yield by service outlet, and use of RTKs in outlets where new positives could be detected and linking all positives to ART services.
5. **Enhance HIV case detection among OVC:** To increase pediatric HIV case detection, programs will focus on testing OVC; children admitted to inpatient units, evaluated for malnutrition, or diagnosed with TB; children of CSW, at-risk adolescent girls, and children of positive women.

PEPFAR's OVC Program will prioritize the identification of HIV positive children and those at greatest risks of HIV infection using vulnerability criteria and thresholds to identify the most vulnerable children and families and refer to public and private health service providers for HIV testing and counseling. PEPFAR's OVC partners will maximize their testing of PEPFAR –supported OVC and their care providers by strengthening the capacity of RHBs to work with relevant regional government agencies. .

6. **Accelerate partner notification for STI and HIV positives (Assisted Partner Notification):** HIV testing of STI contacts through active sexual network referral, will increase HIV case detection and contribute to interrupting sexual transmission networks. To implement this activity in the 20 focus towns, a cadre, mandated and capacitated similarly to the Disease Intervention Specialists in the United States, will serve as the "shoe-leather" epidemiologists in active HIV case detection. They will be trained to obtain contact information, approach contacts in a safe and effective manner, link them to HIV testing and counseling, accompany positives to treatment services, and locate and motivate their partners to seek medical evaluation and treatment. TA is being provided to the GOE for the development of SOP, training curriculum and tools to implement partner notification services. To assure all patients in scale up SNUs presenting with STI symptoms are tested for HIV, sensitization workshops will be conducted for providers and appropriate community workers, and demand for testing services targeting persons with behavioral risks will be created through local media. Post-test counseling will be strengthened, and HIV-positive clients, newly identified either at community or facility testing sites will be escorted to HIV treatment facility.
7. **Enhance testing for families of index cases:** Index family testing will assure that the spouse of every patient testing positive and children of all women testing positive are tested. Patients testing positive will be helped with disclosure, and service providers will be sensitized to understand that HIV counseling is not over until disclosure has been accomplished and appropriate family members have been tested. Appropriate training to build the capacity of community-level care providers and counselors will be provided to ensure disclosure and testing of family members. Systematic disclosure support and demand creation among partners and children of HIV positive mothers will be implemented by a network of trained Case Managers (CM) and Adherence Supporters (AS) working in ART sites in priority SNUs. Counselors and CMs work with index PLHIV to identify and arrange best time and location for testing of PLHIV contacts in facility or community sites based on their choice. Programs will systematically elicit the names of current or previous partners of index clients, actively follow-up with clients and their partners to ensure that partners receive HTS. Moreover, facility based programs will coordinate and track bidirectional linkage to and from community based HTS.
8. **HIV Self-Testing**: HIVST will give individuals the opportunity to test discreetly and conveniently and will complement existing HTS services. HIVST will be expanded to all 20 priority towns as an additional testing approach to increase uptake of HIV testing among KP, including clients and boyfriends of CSW. Whenever possible, HIVST will also be extended to the partners of sex workers through FSW who are trained to be educators of men who come to them. Assisted HIV testing, which is a combination of HIVST and testing performed by FSW peers. All FSW peers who will participate in assisted self-testing will be trained and monitored by counselors working in confidential clinics to ensure their proficiency in assisting clients and linking those who tested positive for confirmatory testing.
9. **Utilize peer organizations to encourage testing among their networks:** Programs will optimize partnership with PLHIV associations, whose members know people engaged in risky

behaviors who may be resistant to testing. PLHIV associations will be engaged and supported to host targeted outreach or home-based testing events, creating demand for HTC among high-risk groups and sending invitations to individuals known to engage in risky behavior.

10. **Linkage to treatment services:** To minimize missed opportunities between HTC and ART services in the 20 top priority towns, HIV positive clients will be linked to ART on the same day of diagnosis through accompanied referral together with referral slips for tracking. In addition, regular linkage auditing will be made between referring and receiving facilities and corrective action taken depending on the gap identified.
11. **Pilot HIV risk screening tool for targeted PITC in public and private facilities:** Utilizing lessons learned in direct service delivery (DSD) community HTS, an HIV risk screening tool for use in pediatric OPD will be adapted for more consistent "targeted testing" services in sites in priority towns.
12. **Maintain momentum from the CUC:** There have been encouraging signs that Catch-Up Campaign has gained momentum with its catchment area meetings, community to facility linkage monitoring, regular site level performance review and facility and town level leadership engagement. PEPFAR-E will support the national program to build on these efforts by supporting monthly supportive supervision/mentoring, conducting data workshops, doing yield analyses, linkage auditing, engaging civil society and town mayors in demand creation, utilizing local media, and providing ongoing appropriate guidance.
13. **Intensified monitoring of programs**: Programs will continue to frequently monitor performance, conduct regular review of results, recognize better performers and share best practices.
14. **RTK procurement, targeting, use, and systems strengthening:** The achievement of the first 90 in these priority SNUs/Towns, is dependent on sustainable availability of RTKs and PEPFAR-E will procure RTK for direct delivery to community HTS implementing partners. Additionally, PEPFAR will reinvigorate efforts to monitor RTK consumption in relation to performance at sites, while advocating for national testing guidelines that promote targeted testing modalities, for RTK allocations based on targets, and for integrating RTKs into the Integrated Pharmaceutical Logistics System to streamline the supply chain and improve commodity security.

4.6 Facility- and Community-Based Care and Support

Despite the significant success in scaling up ART services in Ethiopia, linkage after HIV diagnosis, engagement into care, adherence and retention in care and treatment remains an area of focus. FY 16 APR result indicated that the linkage rate between HIV diagnosis and enrollment into care and the 12 month retention on treatment is 75% and 86% respectively, for PEPFAR supported sites in Ethiopia. With the recent introduction of "test and start" in Ethiopia, further strengthening of referral linkage, adherence and retention through provision of evidence-informed facility and community-based care and support services is very critical to attain the 2nd and 3rd 90 PEPFAR goals. To engender improved adherence to treatment and retention and reduce morbidity and mortality in scale-up aggressive and scale-up saturation woredas, PEPFAR-Ethiopia will continue to support the provision of the following standard package of care and support services in line with the FY 17's care and support program prioritization and the core, near-core, and non-core exercise: clinical staging; measurement of CD4 count to determine eligibility for OI prophylaxis and subsequently if needed to cease CPT or if a switch to a NVP containing regimen is being considered; viral load testing; screening and management of OIs; cotrimoxazole prophylaxis therapy (CPT); positive health dignity and prevention (PHDP) services; nutritional assessment, counseling and support (NACS); psychosocial services; water sanitation and hygiene; pain and symptom management; PLHIV support groups; cryptococcal Ag

screening and management for those with CD4 < 100; and screening and management of mental health problems. In line with the national mental health strategy, the Ministry has a plan to expand the integration of mental health services into HIV care through task sharing by using case managers to screen PLHIV and link them for further diagnosis and management. The national training curriculum for case managers and standard operating procedures were developed by the Ministry through PEPFAR technical support and is ready for national use. Care and support program implementing partners will continue to cascade training for case managers and Peer Community volunteers to identify common psychiatric conditions and link to ART prescribers, trained in the use of a limited number of psychotropic drugs, or nearby psychiatric clinics. . In addition, trained Community volunteers will provide community based screening and referral for access to facility based services for mental health and substance abuse. For more complex psychiatric conditions, referral mechanisms have been established to assure linkage to appropriate care. In addition, monthly supportive supervision and mentoring support, in-service trainings, and continuous quality improvement initiatives will be supported in these SNUs.

In scale-up aggressive and scale-up saturation woredas, the community will be empowered to actively engage and work with the HIV-infected and HIV-affected individuals in facilitating the provision of prioritized community-based care and support services. These support services include: peer, both one-on-one and small group, education and support; nutritional assessment, counseling, and referral to nutritional support; promotion of safe water and hygiene practices; psychosocial counseling; identification and referral of victims of gender based violence (GBV); PHDP and social services including economic strengthening activities to improve household food security status and sustainable livelihood programs as appropriate; and referrals to other services like family planning. PEPFAR is building the capacity of community structures, including: federal, regional, and town level HAPCOs; town community coordination committees; community care coalitions at the kebele level; Urban Health Extension programs; and PLHIV associations.

To strengthen the referral linkage between community and health facilities in scale-up aggressive and saturation woredas, peers will be utilized to escort and link newly diagnosed PLHIV from community-based testing points to HIV/AIDS care & treatment facilities. The first point of contact at the facility is generally the case manager, who is also an HIV-positive peer, who will maintain an active directory of community-based services and track referrals with a standard referral log book. At the community level, peer members of PLHIV associations, caregivers, and health extension professionals will serve as patient navigators to provide enhanced pre- and post-test counseling, link patients into care and treatment services, assist facility-based case managers in tracking LTFU of pre-ART clients, and help assure treatment adherence and retention in care. For those patients who failed to be linked, the focal person together with the community volunteers will navigate to identify them and bring back to care and support. Additionally, other community-based organizations including religious structures, other CBOs/NGOs, and post-test clubs for KP will receive PEPFAR support to augment services provided at health facilities. These organizations work closely with health facilities and other community service outlets (such as OVC partners) to improve bidirectional referral linkage, tracing of LTFU clients, and retention of patients to care and treatment. Peer community volunteers will perform screenings for TB and STI and provide referral linkages to services including HTC. PEPFAR will implement the differentiated care model for PLHIV which aims to determine the intensity and frequency of community based services based on individual needs to create more flexible, convenient, and acceptable models of service delivery for clients. Accordingly, there will be continuous assessment of the needs of the client and varying intensity of service and frequency of visits. Intensive case

management will be provided to unstable PLHIVs, pediatric cases and pregnant women while the needs of other stable PLHIVs will be addressed through the Community-based Adherence support Groups (CAG). Community Health Workers will use mobile application to record and track information about clients they serve through electronic case management forms. Introduction of mobile technology to improve adherence support, appointment reminder and tracking of LTFU by sending reminders to patients through short message service (SMS) ; and assigning community focal persons to improve bilateral referral linkage will be implemented in scale-up woredas. These measures should significantly enhance facility and community linkages, contributing to improving both the referral of known positives into treatment and retaining patients in care.

Disclosure has been a barrier that affects both the first and second 90. Failure to disclose to spouse and family members prevents other at-risk family members from being tested. Similarly, patients who do not disclose their status are highly likely to be LTFU, as they cannot explain their ongoing need for clinic visits. Trainings to strengthen capacity of case managers, community support providers and HIV peer volunteers to assist PLHIV in the difficult task of disclosure will be enhanced. Additionally, as trust builds between PLHIV and case managers and community supporters, PLHIV who have disclosed their status will be encouraged to promote testing among high-risk individuals they know and to permit partner notification of non-family sexual contacts, further contributing to the first 90 and reaching the most difficult to reach populations.

Targeted, enhanced adherence counseling will be given to adolescents and young adults age under 30 years old as well as other populations in which treatment gaps often remain, such as children, pregnant women, and key populations using case managers, mother support groups and peer-supporters in the facility and community settings to improve retention and viral suppression. In addition, adolescent friendly services to provide comprehensive HIV prevention, care and treatment services including sexual and reproductive health services will be expanded in HIV clinics and community service outlets to prevent HIV transmission, improve adherence and retention in scale up SNUs. Adolescent peer support groups will be organized in HIV clinics and different community service outlets to share their experience and also promote disclosure. In addition, intensified counseling, follow-up, and involvement of caregivers will be used to facilitate age-appropriate disclosure and strengthen household monitoring of patients.

PEPFAR will procure Co-trimoxazole for prevention of opportunistic infections and therapeutic and supplemental food commodities for management of severely malnourished PLHIV clients., While these procurements will benefit all PLHIV, their beneficiaries will be concentrated in scale-up aggressive and scale-up saturation SNUs, as this is where the demand will be greatest based on disease burden.

4.7 TB/HIV

Ethiopia is among the high TB, TB/HIV, and MDR-TB burden countries globally with an estimated TB incidence of 192 per 100,000 population. Among registered TB cases 83% and 86% have their HIV status documented at national and PEPFAR supported sites, respectively. HIV prevalence among TB patients is 8% with wide regional variation ranging from 4.7% in SNNPR to 25% in Addis Ababa. PLHIV in care are routinely screened for TB at every follow up visit. TB is one of the leading opportunistic infections (OIs) among PLHIV in Ethiopia; approximately 1.6% (HMIS 2015/16) of PLHIV enrolled in care are also receiving treatment for TB. TB program activities as part of the collaborative TB/HIV activities are critical components of achieving the 90-90-90 HIV targets. The 2014 revised

national TB diagnostic algorithm recommends GeneXpert® as the primary diagnostic test for evaluating PLHIV with presumptive TB. The National Consolidated HIV Prevention, Care and Treatment Guidelines also recommend provision of ART to all HIV positive TB patients, irrespective of CD4 or clinical status. ART coverage for HIV positive TB patients is 79% and 92% at national and PEPFAR-supported sites, respectively. The additional HIV case finding and referral after testing of TB patients also contributes to the enhanced ART coverage.
HIV positive TB patients receive TB and ART treatment at different clinics within the same facility and sometimes at different health facilities through intra- and inter-facility referral mechanism, respectively. TB screening & IPT services have been integrated with ANC and MNCH services. There has been an ongoing discussion with FMOH and stakeholders to pilot integrated ART service at the TB clinic (one-stop-shop model) using the option B+ experience at selected TB (DOTS) stand-alone sites in scale-up woredas to improve quality of TB/HIV care through timely initiation of ART, minimizing patient discomfort and cost, as well as improving adherence to treatment and retention. In FY17 PEPFAR-E will focus on the following core activities with the goal of identifying almost all HIV positives among presumed and diagnosed TB cases and achieving 100% ART coverage for HIV positive TB patients. This core activity is a critical aspect of TB program contribution to HIV case finding and referral to scale up ART coverage. Besides, PEPFAR-E will intensify support at the 20 towns selected for scale up to saturation to improve TB case finding through TB screening of 100% PLHIV and using GeneXpert as the primary diagnostic test and increasing newly identified HIV-positive individuals.

In FY17 PEPFAR-E will support and implement the following TB/HIV program activities:

- Integrate intensified TB case finding at facility and community level service delivery points through strong linkages with TB program activities.
- Improve linkage between community- and facility-level TB services.
- Implement active TB case detection and infection control programs at prisons and other key populations in collaboration with TB program activities.
- Ensure routine offering of PITC for all presumed and diagnosed TB cases and ensure 100% ART coverage for HIV positive TB patients (assuring that Presumed TB cases are tested for HIV rather than simply focusing on confirmed TB cases, which is expected to increase overall detection of PLHIV).
- Implement family based approach for TB/HIV care including screening of partners of TB-HIV co-infected index cases, family members and household contacts for both TB and HIV at priority sites.
- Timely initiate CPT and ART for all HIV positive TB cases, routinely screen all PLHIV in care for TB and provide IPT to at least 80% of newly enrolled PLHIV after excluding active TB.
- Evaluate all PLHIV with presumptive TB using GeneXpert® and initiate TB treatment for those diagnosed with active TB in a timely manner.
- Currently there are 146 GeneXpert® machines in the country, which are mainly procured by USAID and Global Fund, 42 more are in the pipeline, and 100 additional machines are planned to be ordered with a long-term goal of covering all hospitals and high caseload public and private health centers with GeneXpert® placement. The FMOH has a plan to make these machines accessible to all facilities by networking them with the diagnostic centers through sample referral mechanism (postal system) and additional strategy to re-enforce sample transport by leveraging TB program support in integrated sample transport for sputum as well as viral load samples which has shown to cover for the current major sample transport gap. PEPFAR-E will collaborate with stakeholders working on TB program and support HR capacity building, procurement of supplies, EQA for the TB diagnostic services and support scale up of

rapid diagnostic services such as GeneXpert® and sample transportation system.
- Strengthen referral linkage across the different TB/HIV service outlets and LTFU tracking system. Track and report TB/HIV activities using standardized tools.
- Pilot integrated ART service at the TB clinics at selected ART service providing health facilities in scale-up woredas.

While these activities will be focused in scale-up SNUs, screening and prevention of TB, as well as TB and HIV treatment for co-infected patients will remain part of a basic package of services in all areas with ongoing PEPFAR support. Likewise, TB infection control will continue to be a priority focus that will be supported at all scale up and maintenance sites to prevent transmission of TB at the health facilities. Scaling up of all these activities to meet the critical gaps in case finding of both TB and HIV, require strong collaboration between TB and HIV services and PEPFAR investments in both programs.

4.8 Adult treatment

Partner performance data in the first quarter of FY 17 has already shown significant improvements compared to that of FY16. The launching and implementation of the Catch-Up Campaign at the end of FY16 and the adoption and roll-out of 'test-and-start' during the first quarter of FY 17, have contributed to this improvement.

The FMOH, acknowledging that it is nearly 90,000 behind its own TX_CURR targets, has initiated the "Catch-Up Campaign," to allocate a major portion of recently procured test kits to PEPFAR scale-up SNUs with a primary focus on the 20 priority towns selected for saturation and incorporating more targeted testing strategies. PEPFAR-E will leverage two other FMOH initiatives to achieve its treatment targets. It will support the Ministry's Compassionate and Respectful Care initiative by funding sensitization trainings for providers reinforced through the Regional Health Bureaus', private health sector' facilities, and drop-in center mentors. PEPFAR-E will also align its strategy of encouraging priority town leaders to actively champion local HIV epidemic control with the FMOH's Cities Initiative. Improvements in achieving the first 90 targets will drive the performance in attaining the second 90 treatment coverage targets. The linkage to care which is 75% and 12 month ART retention in treatment 86% has showed improvement from the previous reporting period Additionally, roll-out of Test & Start and improved adherence counseling of clients are expected to bring back into care a large number of PLHIV previously LTFU due to being ineligible for treatment. Test & Start is also expected to increase VCT yield as more at-risk people are motivated to seek testing, knowing treatment would be immediately available.

PEPFAR-E supports KP friendly clinics that provide ART for eligible clients. PEPFAR supported drop-in centers that reach harder to reach CSWs, have been authorized to provide ART in addition to condom provision, HTS, and STI treatment. Children and partners of CSW will also be tested and treated at these sites. Services may also be expanded to include male clients of sex workers who may be seen during different service hours. Further, eighty public facilities in scale-up woredas are developing KP friendly services.

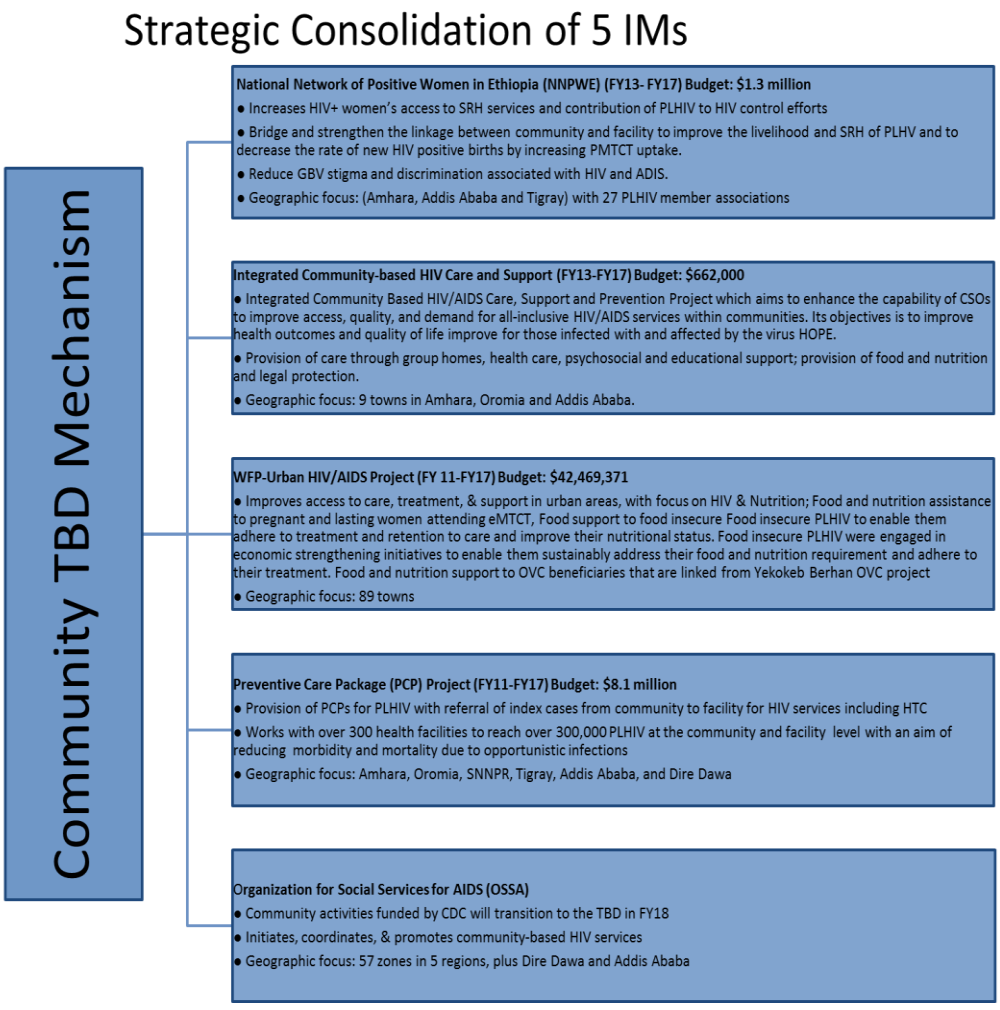
To further strengthen retention, PEPFAR-E supports the implementation of differentiated ART service delivery models in selected high load health facilities among the 20 towns targeted for saturation. This approach has been endorsed by the FMOH and six high load facilities that are located in different regions have been selected for piloting in FY 17. After completing the piloting of this approach it is expected to be scaled-up in FY 18 and forward. At these facilities standards of care will be

differentiated for patients newly initiated on treatment, stable, and unstable patients (see table below). Besides the appointment spacing model, PEPFAR-E will work with the FMoH to introduce other models such as community ART initiatives.

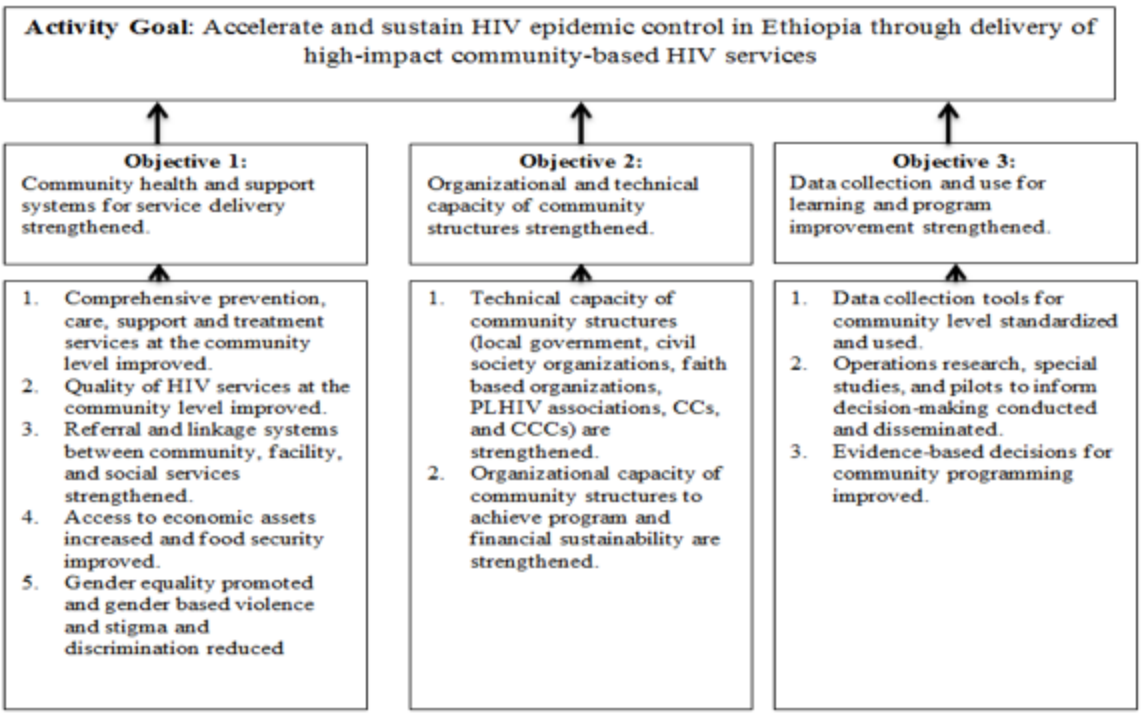
SERVICE DELIVERY APPROACH	CURRENT STATUS	COP17 PROPOSED APPROACH
Eligibility for ART	**Test & Start**	**Test & Start**
ART initiation	Test and Start with initiation of ART as soon as the patient is ready	Same day ART initiation for those who are ready
Service delivery approach: PEPFAR Ethiopia is planning to start the implementation of new service delivery models for stable patients in high volume ART sites (defined as those sites with high client volume)	Clinic visit with drug pick for stable patients: every 01 to 03 months Appointment spacing every 6 months for stable patients is being piloted in 6 high case-load health facilities	Roll-out appointment spacing (every 6 months) for stable patients to other high case load facilities in 20 towns and other scale-up SNU. Pilot other community ART models
Definition of Stable Patients	**Inclusion criteria** 1. On ART for at least 12 months 2. Most recent VL < 1,000 or 3. In the absence of VL, CD4 count should be > 200 **Exclusion criteria** 1. Second line treatment 2. HIV positive pregnant and breastfeeding women 3. Children < 15 years of age. 4. Presence of current illness (including OI, severe malnutrition and comorbidities)	**Inclusion criteria** 1. On ART for at least 12 months 2. Most recent VL < 1,000 or 3. In the absence of VL, CD4 count should be > 200 **Exclusion criteria** 1. Second line treatment 2. HIV positive pregnant and breastfeeding women 3. Presence of current illness (including OI, severe malnutrition and comorbidities)
Laboratory testing	**CD4 count**: baseline (If possible) and to make decision on CPT discontinuation and initiation of NVP based regimen **VL**: at 6 months following initiation of ART, 12 months and then yearly **Other laboratory services**: need based (including pregnancy testing and RFT)	**CD4 count**: baseline (If possible) and to make decision on CPT discontinuation and initiation of NVP based regimen **VL**: at 6 months following initiation of ART, 12 months and then yearly **Other laboratory services**: need based (including pregnancy testing and RFT)

Community-based Service Delivery: PEPFAR-E will continue to support community-level testing and care activities, while integrating community-level treatment models. A Community TBD mechanism responds to country-specific guidance in the FY 2017 PEPFAR Planned Country Allocation and Strategic Direction memo to "consider evidence-based community based models in supporting adherence and retention in care" and engage in "continued advocacy for GOE to pilot other community treatment models." This activity consolidates the best practices of five PEPFAR-E community activities, including that referenced in COP17 technical guidance (Appendix J.3.4.2, page 384). The budget of this IM is a reduction when compared to the total combined budget of the five IMs it consolidates, demonstrating efficiency of cost while at the same time increasing the scope to accommodate new innovative approaches.

In March 2017, the PEPFAR-E and the International AIDS Society co-convened a national consultative meeting on DSM with stakeholders from national and regional government offices, UNAIDS, PLHIV groups, and civil society organizations. In February 2016, FMOH agreed to implement the health care worker managed group model, which is one of the differentiated service delivery models; this is in addition to the appointment spacing model which was approved in June 2016. Additional stakeholder consultations will take place in COP17 with PLHIV groups, supply chain stakeholders, and local government actors to further engage in discussion on DSM in Ethiopia.



Community-based index testing will also focus on widowed and divorced women. The mechanism's goal and objectives are defined in the figure below.



With a growing number of PLHIV on ART in Ethiopia, PEPFAR-E will provide essential community-based support to PLHIV to achieve high adherence and retention and reach viral load suppression through comprehensive direct service delivery at the community level, providing strong referral and linkage to facility-based services as needed. In these communities, there will be increased reliance on community-based treatment, consistent with recent changes in Ethiopia's core/near-core/non-core framework, with frequency of facility visits reduced to every six months. Retention, patient satisfaction, and provider satisfaction will be monitored at these sites with the intent of bringing these models to scale.

Laboratory Support to Ensure Viral Load Suppression: PEPFAR-E suppots Ethiopia's transition from CD4 monitoring of ART effectiveness to routine VL monitoring, providing a major portion of the reagents, funding for sample transport, training of laboratory staff and clinical providers, and TA in coordinating the transition. More timely and accurate identification of first line treatment failure will also improve retention in treatment and survival. Additionally, PEPFAR will continue to support comprehensive HIV training and refresher trainings, reinforced by mentoring, supportive supervision, review meetings and provision of guidelines and job aids to maintain an informed and skilled workforce. For FY 2018, PEPFAR-E's target for adult TX_NEW in scale-up SNUs is 48,256 and 17,609 in the attained, with the intention of aggregate saturation across all age groups, driven by attainment in the +25 age group, in the 20 priority towns (including Addis Ababa) and in 171 additional SNUs.

One of the challenges with viral load scale-up has been the frequent breakdown and lack of a rapid process for providing routing preventive maintenance and repairs. To address this challenge, PEPFAR-E is supporting maintenance of viral load machines by integrating this support into the negotiated reagent cost such that all machines have maintenance agreement for five years. Frequent machine breakdown is observed specially at the beginning of the scale-up plan implementation because the

system is new to the laboratory personnel and even the company engineers. To address this, PEPFAR-E has agreed on the following interventions and these recommendations are being implemented:
1. More training will be provided to the laboratory personnel on the equipment handling and preventive maintenance. This will be company-led training. Manuals will be distributed to all testing sites and commonly encountered errors and their troubleshooting procedures will be included in the training package.
2. The company will assign at least three certified engineers in country. The engineers, in addition to providing curative maintenance services, will regularly visit viral load testing sites for preventive maintenance and training of site level staff.
3. The company will establish stock of critical spare parts in country. This facilitates immediate curative maintenance services reducing waiting time for equipment repair significantly
4. EPHI (national lead institute for laboratory services) will closely monitor the implementation of the agreement

Finally, PEPFAR-E will continue to focus its laboratory technical assistance on achieving the UNAIDS 90-90-90 goals and this support will align with PEPFAR site prioritization. The specific core laboratory technical assistance activities include the following:

1. Strengthen the quality of HIV rapid testing by supporting establishment of national HIV rapid testing algorithm, capacity development on rapid test kit lot testing and post market surveillance, implementation of standardized HIV rapid test logbook, enrollment of all testing points in PEPFAR priority sites in proficiency testing program (external quality assessment), training and certification of testers, promote implementation of internal quality control, supportive supervision of sites and use of CDC-WHO quality handbook for assessment of sites.
2. Scale-up implementation of viral load testing as a core component of routine ART monitoring. Sub-activities include: (1) Strengthening capacity of viral load testing sites through infrastructure support, training of staff, equipment maintenance, continuous power supply and arrangement of back-up testing services; (2)Reinforcing specimen referral system with close monitoring of turnaround time for results delivery, implement DBS for viral load testing and use of electronic test requisition and result reporting system; (3) Implementing the viral load and EID database in all viral load testing sites, generate data and use data to improve program performance; and, (4)Strengthening the laboratory-clinical interface for effective use of viral load test results for clinical decision making
3. Support the implementation of continuous laboratory quality improvement to improve workflow, processes and procedures and promote international accreditation of viral load testing laboratories. This will help improve the quality of viral load testing.
4. While PEPFAR only requires annual monitoring of viral load suppression, PEPFAR will intensify efforts, through the Surge Strategy, to monitor viral load suppression across the Twenty Towns on a quarterly basis.

4.9 Pediatric Treatment

PEPFAR will build upon results achieved in previous years to ensure efficiency and delivery of quality pediatric HIV treatment services through an integrated, comprehensive, and family-centered approach. Children less than 15 years accounted for less than 6% of the total number of people on ART in FY16, and the number of children receiving ART was 21,990. Pediatric ART is provided in over 75% of all PEPFAR-supported sites providing ART to adults.

In FY16, while 63.3% of adult PLHIV received ART (383,501 currently on ART out of 606,053 PLHIV),

only 33% of children less than 15 years old were on ART (21,990 currently on ART out of 66,517 PLHIV). Major barriers to scaling up pediatric care and treatment in Ethiopia include: sub-optimal use of data to implement active detection approaches, test kit allocations that are not based on targets, lack of RTK integration into the rest of the Integrated Pharmaceutical Logistics System, and testing modalities that remain unfocused. These circumstances have resulted in high volume hospitals in high prevalence towns, including Addis Ababa, where pediatric inpatient units are without capacity to test for months at a time, an inability to systematically test OVC and inadequate testing of children of known HIV+ mothers. Detection of pediatric cases is further complicated by the weak reporting system to calculate the percentage of HIV exposed infants that are tested post-cessation of breastfeeding; sample transport challenges with decentralization of EID services; prolonged turnaround-time for getting DNA-PCR results; inadequate capacity for service providers on pediatric treatment and a limited understanding among the general population about pediatric HIV. Like other age/sex disaggregates, the actual gap to unmet need among pediatrics remains questionable; there have been no recent surveillance activities to corroborate SPECTRUM estimates for the number of PLHIV < 15 years of age; it is anticipated that this situation will be addressed with the upcoming DHS+ results for Ethiopia in summer, 2017.

The PEPFAR Family Care & Treatment TWG used the FY16 performance as a baseline to set ambitious targets and improve coverage with an assumption that active case finding interventions will be maximized, particularly in scale up woredas. Key areas of focus will all contribute to the three 90s. To achieve the first 90, the following activities will be undertaken: aggressive, targeted testing at high yield entry points; testing children of HIV positive adults in care (including children of positive pregnant women enrolled in PMTCT ANC services); routine testing of children at TB clinics, malnutrition treatment units; improving HIV exposed infant services; and, testing of OVC by strengthening community linkage of those testing positive to treatment services. Moreover, targeted testing using standard screening tools will be used to maximize yields at pediatric outpatient departments. Case managers, Mother Support Groups, and community-based testing will play a more active role in assuring that children of adult index cases are tested. There will also be focused testing of children of PLHIV CSWs in PEPFAR-supported confidential clinics and drop-in centers.

To achieve the second 90, the PEPFAR program will also support the government to roll-out in sites with a high load of adolescent clients a standardized adolescent package of care, which includes provision of adolescent friendly health services on adherence, disclosure, stigma, transition to the adult treatment program, and sexuality/reproductive health. Test and Start for all children < 15 years of age will be further strengthened with a particular focus on ensuring provision of same day treatment for children with confirmed HIV positive status. To achieve the third 90, the PEPFAR program will ensure access to VL testing, improve retention rates, and decrease LTFU through adherence support activities and will educate patients, clinicians, and laboratorians on the importance of routine VL testing and the use of age disaggregated data on VL suppression. Community Health Workers will use mobile application to record and track information about clients they serve through electronic case management forms. Introduction of mobile technology will help to improve adherence support, appointment reminder and tracking of LTFU by sending reminders to patients through short message service (SMS). PEPFAR will advocate for implementation the differentiated care model for children and adolescent. In COP 17, PEPFAR support will also reach health managers at the district level to improve their capacity to develop and implement pediatric HIV work plans and budgets.

4.10 OVC

In Ethiopia, poverty, HIV/AIDS, and poor access to health care and education contribute to child and household vulnerability. In 2017, there are estimated 3,266,333 orphans and vulnerable children (OVC) in the country, of which 345,700 are either infected or affected by HIV/AIDS. Among orphans and adults tested through the OVC program, 6% (802/13,004) of OVC and 19% (1715/9243) of adults tested positive. To effectively target higher yielding populations, the Ministry of Health has added OVC and their caregivers to the list of priority populations for HIV testing.

The OVC program implements in woredas prioritized for the scale-up of prevention activities and care and treatment services. It is well-positioned to provide greater access to health services in both community and facility settings. The OVC program in scale-up to saturation woredas emphasizes expanded HIV testing of OVC and their caregivers. Additionally, the program emphasizes adolescent prevention services for high risk adolescent OVC and adolescent support groups for HIV positive OVC. PEPFAR provides technical assistance to promote more extensive requirements for testing among OVC who get assistance from local Community Care Coalitions (CCC). Para social worker cadre contributes to strengthening the multi-directional referral linkage, HIV disclosure, retention and adherence. They play a significant role in the implementation of the OVC transition plan and the new OVC testing screening tool.

The Ethiopian social service infrastructure is still developing and the shortage of qualified workers has the potential to limit the provision of social services to vulnerable populations including OVC, families of OVC, and adolescent girls. Focusing on local capacity building and workforce development is a cost efficient strategy for transitioning OVC and other HIV/AIDS related social service provision programs and sustaining PEPFAR investments. The PEPFAR program assists these local systems to improve the availability of social service workers and to provide adequate social services for highly vulnerable children, including adolescents, and their families.

PEPFAR will support GOE to rollout the Social Protection Strategy through a workforce that includes professionals and para-professionals equipped to provide social services to these prioritized vulnerable populations. They will be deployed at the kebele level to work closely with communities through CCCs. Training institutions and community structures like CCCs will be supported to: strengthen the social services system; prevent and respond to neglect, violence, and exploitation of at-risk children and adolescents. PEPFAR will partner relevant federal ministries and regional government offices to expand lessons learned from PEPFAR woredas and scale up this experience to other woredas by training and deploying social service workers.

Social service workers will implement a case management approach so OVC will receive customized support based on vulnerability assessments. The social service workers serve as OVC case managers to assess their needs and link them to health and social services provided by their communities and/or local authorities. This cadre is playing a crucial role in strengthening the bi-directional referral linkage, supporting HIV disclosure and adherence, and implementing the OVC transition plan.

The OVC program has transitioned from direct subsidies to an approach of empowering individuals, families, communities, and local governments to respond to the needs of vulnerable children. Implementing partners now focus on strengthening the skills and economic capacity of communities and families in order to improve the self-sufficiency of OVC households and graduate them from direct project support. Savings and loan associations and other household economic strengthening

activities generate enormous benefits for members and vulnerable populations in the community. Historically, children under 5 and youth ages 15 and over have been underserved by the OVC program, as programming has been focused on primary-school aged children and children in families. OVC support will focus on providing children living outside of families and children of vulnerable adults, such as children living on the streets and children sex workers, with comprehensive services.

In COP17 474,010 beneficiaries (325,000 OVC and 149,010 caregivers) living in selected high priority SNUs will be reached with a plan to gradually reduce the overall number of beneficiaries over the course of COP17 implementation to a number that can be supported robustly with the new programmatic model. This will be monitored vigorously through the quarterly POART process. The proposed approach focuses programming in high-prevalence regions, as well as a chance to leverage resources through other PEPFAR activities operating in the same regions.

The program conducts progress review meetings quarterly to review program performance, share learning, identify gaps and challenges, and prepare action plans to address issues. Most importantly, the review meetings provide opportunities for consultations and feedback with implementing partners, local government partners, and other actors. Issues that are raised through program monitoring and supportive supervision visits are thoroughly discussed and additional guidance is provided. This allows for further strengthening of program performance to ensure contribution to PEPFAR's testing, care and treatment goals.

4.11 Addressing COP17 Technical Considerations

PEPFAR-E's goal with COP17 is to support the national program to maximize HIV case detection through focused testing in order to achieve 80% ART treatment coverage (from 57.5% in 2015) in the 20 priority towns by September 2018. To reach this goal, PEPFAR-E, by September 30, 2018 would have identified 66,000 PLHIV (50% from the 20 priority towns) and provided care and treatment services for 500,000 PLHIV; total from all PEPFAR supported woredas, not just the 20 priority towns. To accomplish this, PEPFAR-E will have to increase focus on prevention and treatment services for persons under 30 years, increase testing yield and improve testing modalities, reinforce retention and viral load suppression, all while supporting a sustainable quality service delivery model. Through the Ethiopia Surge Strategy for human resource, Appendix D, PEPFAR-E will ensure that there are competent human resources at all levels site, SNU and regional health bureau who are optimizing Test and Same-Day Initiation and ensuring viral load suppression.

Focus on prevention and care services for persons under 30 years. Based on spectrum modelling estimates, the greatest proportionate bulge in unmet need for Attainment is in the younger (<25 years) age and sex disaggregates. While these gaps may be revised after the DHS+ results are available in mid-2017, PEPFAR-E will continue to support the national program to target pediatrics, adolescents and young adults with interventions to improve detection and same-day ART initiation. This will involve refining the understanding preferences of these populations for receiving prevention messaging, barriers to changing risky behaviors, and matching service delivery models to their preferences – e.g. students having access to clinics that are open in the evenings so as not to conflict with classes. The PEPFAR program will also support the government to implement, at sites with a high load of adolescent clients, a standardized adolescent package of care, which includes provision of adolescent friendly health services on adherence, disclosure, stigma, transition to the adult treatment program, and sexuality/reproductive health. High levels of HIV related morbidity and mortality are increasingly being recognized in this adolescent group, in particular, due to low access to ART, poor

linkages to and retention in care, and ART coverage rates for this age group is lower than for other age groups. Addressing these challenges and adapting systems to deliver good quality, effective health care and social support for adolescents living with HIV is critical for reaching attainment. PEPFAR-E will maintain support for, and scale-up, this process that was initiated in COP16 to adopt policy and then implement facility-based adolescent focused psychosocial support interventions including rollout of guidelines and job aids, training of health care providers, improving disclosure counselling for HIV infected adolescents in care at all health facilities and establishment of adolescent peer support programs in high case load facilities. This effort will improve disclosure practices, treatment adherence and retention in care, and viral suppression and ultimately reduce morbidity and mortality among this age group.

Increased testing yield and improving testing modalities. Detection of new PLHIV is the greatest obstacle to achieving the 90-90-90 targets in Ethiopia. Accordingly, PEPFAR-E will support the national program with the following approaches to increase testing yield and improve testing modalities. First, this involves ensuring that the key inputs (test kits) are available at all service delivery points. This entails supporting implementation of national testing guidelines that are focused on yield and especially optimizing PITC in facilities; ensuring allocations to facilities based on targets; and, advocating for the integration of RTKs into national supply chain management system. Second, PEPFAR-E will support the national program with scaling-up successful models for index case testing, including family/partners, and self-testing for KPs, PPs and their partners. Third, PEPFAR-E will support the national program to implement partner notification services for active contact tracing and linkage to services for PLHIV and their partners. (Refer to Section 4.5 for more on specific approaches to improve case detection.)

Improved retention and viral suppression. While retention for CURRENT_ART is strong at 86%, there is still room for improvement and significant work that needs to be done to reach population viral suppression. Accordingly, PEPFAR-E will support the national program with the follow approaches. To achieve the third 90, the PEPFAR program will ensure access to VL testing, improve retention rates, and decrease LTFU through adherence support activities and will educate patients, clinicians, and laboratorians on the importance of routine VL testing, use of patient-level results to guide clinical care, and the use of age-disaggregated data on VL suppression to guide the program. PEPFAR-E will support strengthening of linkages of PLHIV between communities and facility to prevent loss-to-follow-up by developing, implementing and monitoring, standard operating procedures for the linkages. It will also strengthening site-level capacity for case management, including longitudinal monitoring of patients across the clinical cascade, adherence preparation, peer support, disclosure, education and proactive identification/management of patients at-risk for loss-to follow-up. Adolescent psycho-social support services and mental health service integration will be reinforced, together with more aggressive client tracking using registers and mobile phone applications. PEPFAR-E will support site level CQI at health facilities to improve quality of ART service delivery. This includes planning, training of ART providers and the MDT, setting standards and implementing sites level activities with monitoring of performance at site level. It will work to strengthen the functioning of the site Multi-Disciplinary Team (MDT) at health facilities, support networking of services and catchment facilities and support Catchment Area Meetings (CAM) for a coordinated and linked program implementation and full continuum of care service provision for improved outcomes and impact. Printing and distribution of job aids, reference materials, guidelines and other tools contributes to improving quality of services, and standardizing the program and service provision.

Support a sustainable, quality service delivery model. PEPFAR-E's program has been built primarily around the bulk of services being provided through the regional health bureaus which support direct service delivery and TA to sites, together with private sector and NGO providers that reach key and priority populations and are able to generate innovations that can be shared and scaled through the public sector. This combination has well-situated PEPFAR-E's assistance to be supportive of the national program of the Government of Ethiopia and for eventual transition of PEPFAR assistance from direct service delivery to a technical assistance model. Still, there is a need to further find efficiencies in the program by exploring the effectiveness and efficiency (including costing) of differentiated service delivery models (DSDM) and strengthening core laboratory, supply chain and information systems. In terms of DSDM, Ethiopia started piloting appointment spacing only for Adult patients at selected facilities. However, a family-centric approach is important for offering comprehensive support for children and adolescents. With COP17, PEPFAR-E will support the FMOH to adopt policy and initiate implementation of appointment spacing for stable pediatric and adolescent patients to ensure, as far as possible, family-aligned ART delivery (same date, venue and provider) for caregivers, children and siblings. It is expected that this activity will significantly contribute to the 2nd, and 3rd 90's by Improving quality and retention in care, and viral suppression resulting in favorable treatment outcome.

4.12 Commodities

Ethiopia has established supply chain donors forum whereby the major donors including USAID, WHO, UNICEF, UNFPA, DFID, GFATM, People That Deliver and IRISH AID are members. The donor group coordinates the support to the GOE in an organized fashion to leverage resources for different supply chain and commodity security activities. There is also an active HIV/AIDS specific procurement and supply management technical working group that focuses on the HIV/AIDS commodity funding, forecasting and quantification, pipeline monitoring, stock status monitoring and capacity building. The USG strategies is therefore to strengthen these instruments for the overall supply chain TA and support. Moreover, through the PEPFAR support, Programs dashboard is developed of which HIV/AIDS program dashboard is one of it. USG will support to ensure access to this dashboard for HIV/AIDS program managers and supply chain professionals to increase supply chain and product data visibility at different levels.

To proactively address challenges on RTK supply, the supply chain TA partner will conduct assessment to PFSA central and regional branches for availability of RTKs. PEPFAR priority sites especially in twenty towns will be assessed bimonthly for the availability and consumption of RTK in relation to assigned targets. The partner and USG prevention TWG will work with MOH, PFSA and RHBs to promote distribution of RTKs based on HIV testing targets and expected HIV positives assigned to each facility. In addition, the supply chain TA partner will assign focal person at different levels to closely monitor RTK supply status and facilitate communication and coordination among PFSA, RHBs and facilities. The partner will work with MOH and PFSA to integrate the RTK supply with the main supply chain system for the other commodities to create more transparent and accountable supply system for RTKs. In addition, USG through its supply chain TA will work with the Ethiopian health insurance agency and health care financing projects to increase availability and access to tracer OI medicines and alleviate possible shortages. PEPFAR will collaborate with partners working on supply chain to adequately and continuously avail VL and EID commodities. Ongoing PEPFAR support to the GOE will ensure that all PMTCT sites provide DBS sample collection services. Improvements in the supply chain to all health faclites need more emphasis to avoid missed opportunities and unnecessary

delays in infant testing. The supply chain TA partner will visit the viral load and EID testing sites frequently to monitor the stock status of viral load and EID reagents. The viral load implementation team composed of EPHI, PFSA, CDC and PSM (supply chain TA partner) will coordinate the quantification, procurement and distribution of viral load and EID reagents regularly.

4.13 Collaboration Integration and Monitoring

There are both challenges and solutions across the entire clinical cascade with respect to Collaboration, Integration and Performance Monitoring.

Strengthening cross technical collaborations and implementation across agencies and with external stakeholders, including the GFATM and MOH. Across external stakeholders, PEFPAR is supporting the transition to open-source, GOE-managed aggregate HMIS (DHIS2) and an HIS architecture that supports interoperability between HMIS (and DATIM), HRIS, EMR and eLIS. It also works closely with the MOH and GFATM on commodities security for HIV Response, including technical assistance to GF CCM and joint planning around COP and the Global Fund Concept Note.

- Within the targeted 20 Towns, as part of the HRH Surge Strategy in support of the Ministry of Health's Catch-Up Campaign, PEPFAR will conduct interagency rapid assessments to identify the human resources and interventions necessary to improve efficiency and service quality to reach attainment. Assessments will be conducted at RHB, facility, and community levels to inform tailored plans to address gaps and improve case detection, linkage, retention and viral suppression. The strategy will further enable: Attainment Micro-plans and monitoring Town and catchment SNUs to achieve attainment
- Implementation of partner notification services
- Monitoring performance of targeted testing and same-day initiation
- Strengthened programmatic and service linkages, both within and between facilities, and between facilities and communities
- Same-day ART initiation for newly identified PLHIV and retention in care and treatment
- Enhanced TB/HIV collaborative activities for increased yield and linkage
- Routine viral load testing, effective sample referral, use of results for decision making, and reporting of performance
- Compiling, ascertaining data quality and reporting of the monthly performance data according to PEPFAR requirements
- Coordination and collaboration with activities of other HIV epidemic control implementers and stakeholders
- Social mobilization and demand creation activities
- Monthly deployment of site monitoring and rapid assessment tools to improve site-level and above-site level program performance
- Monitoring the frequency and quality of weekly and monthly reports from sites; these reports will guide technical assistance and quality improvement measures
- Strengthened performance of laboratories and related systems for EID and VL monitoring, including a focus on laboratory quality systems and improving turnaround time for results, and the effective use of results for clinical case management
- Routine RTK consumption and testing performance monitoring and de-conflict ART clinic and pharmacy reports
- Improved communication between RHBs and PFSA hubs to ensure 100%, 24/7 availability of

rapid test kit stocks at the 99 priority sites

- Monthly reports on town, SNU performance for the CUC command center steering committee, RHBs, Regional administrations and the national program

Partner Management and Performance Monitoring. PEPFAR E will reinforce partner management and monitoring across the cascade to improve impact in a shorter amount of time by focusing on the following efforts at Site- and Above-Site levels:

1. Site Level: PEPFAR will work with priority sites in the 20 towns to generate weekly site level inventory for HIV resources and commodities, support reliable site-level forecasting of need and timely request for resources and commodities, and ensure data consistency between ART clinic and the pharmacy/dispensing unit. On a monthly basis, these sites will be supported to report on: (1) Test-and-Start implementation; (2) Analysis of HTS and ART data, including testing by modality, age/sex dis-aggregated data for ART, and linkage analysis etc. (3) Comparison of HTS performance, with RTK consumption, and RTK inventory reports, with specific attention on ensuring targeted testing, appropriate and focused use of RTKs that maximizes yields minimizes wastage, and prevents stock-outs; (4) Performance towards targets, including through facility catchment area meetings, and engaging community-level implementing partners within the catchment area to monitor bi-directional community-facility linkages, improving initiation and reducing loss-to-follow-up; and, (5) Quarterly viral load monitoring coverage among ART patients. On a more ad hoc basis, PEPFAR E and MOH will support data-quality assessments and quality improvement TA, including SIMS at the site and above-site level.
2. Town/SNU levels: PEPFAR-E will support development micro-plans for each of the twenty-towns and conduct monthly performance reviews against the micro-plans in the 20 Towns from the aforementioned Command Center personnel. This will involve all partners within their catchment areas. Regional health bureaus will be supported to conduct quarterly performance reviews at the involving all partners within catchment areas; and the FMOH will be supported to conduct semi-annual national performance reviews. PEPFAR-E will support all above-site levels to conduct routine monitoring visits of priority sites for service and data quality, and performance to targets.

PEPFAR-E will continue to reinforce referral lab capacities for quality VL testing and reinforce the specimen referral network to reduce turnaround time of EID and VL results from referral labs to sites. The national integrated specimen referral system will be reinforced increase access to quality of laboratory services to effectively support the national ART program. Specimen referral network is key for implementation of viral load and EID scale-up plan. This will include transportation of DBS specimens for viral load and EID. An agreement is in place between Ethiopian Public Health Institute (EPHI) and Ethiopian Postal Services Enterprise (EPSE) to transport specimen and return of results back to the facilities in timely manner. EPHI will train the postal workers and laboratory personnel on collection, packaging, transportation and safety during handling of specimens. Sites will be supplied with standard specimen transportation containers equipped with cold chain system. EPHI will collaborate with Regional Health Bureaus and other implementing partners to monitor the implementation of the specimen referral network. EPSE will use standardized logbook for tracking of specimen including time of pick-up and delivery of specimens. The specimen referral network will be optimized based on geographic proximity rather than regional boundary to bring efficiency and effectiveness in to the system. Emphasis will be given to monitoring the turnaround time and quality of specimen during transportation. The frequency of specimen transportation will be adjusted based

on the number of patients on ART in a facility. Optimal utilization of the specimen referral network will significantly increase access to quality viral load and EID testing services across the country.

Improving efficiencies of service delivery through improved models of care delivery across community and facility sites. To reinforce linkages across the cascade, especially with adherence, PEPFAR Ethiopia will support implementation of a case management program in all the 11 regions of Ethiopia in more than 650 sites and deploying close to 2000 trained case managers and adherence supporters of which 431 are in the twenty priority towns who are themselves PLHIV enrolled in care and treatment services. Through this effort, support is provided at high volume sites (in scale-up and sustained SNU) to new and existing ART patients for adherence preparation and education, disclosure, family enrollment, PHDP, and continued counseling for appropriate and un-interrupted compliance to prescribed ARV regimens. ART patients receive early and follow-up peer to peer support that is focused on the needs of each individual patient. To ensure that ART patients receive all available care services, case managers and adherence supporters support linkage of patients to facility level and community level services. For those patients who miss their scheduled clinical appointments, tracing through telephone, peers, associations and physical tracing is conducted. Educational materials, job aids (including telephone apparatuses and airtime) and M&E tools are distributed to the sites, and monitoring and reporting performed using customized tools as the activities are not captured in the routine HMIS. The activity is implemented through the regional networks in the 11 administrative regions which provide above site support and management of the program at regional level. Patients in the more than 650 sites will be supported to remain adherent to program, the ARV drugs and remain virally suppressed.

5.0 Program Activities for Epidemic Control in Attained and Sustained Locations and Populations

Table 5.1.1., "Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts", is not included because no woredas have achieved Attained status.

Table 5.1.2 Expected Beneficiary Volume Receiving Minimum Package of Services in Sustained Support Districts

Sustained Support Volume by Group		**Expected result APR 17**	**Expected result APR 18**
HIV testing in PMTCT sites	*PMTCT_STAT*	516,579	242,858
HTS (only sustained ART sites in FY 17)	*HTC_TST/HTS_POS*	1,666,143/9522	319,528/1,153
Current on ART	*TX_CURR*	57,208	57,455
OVC	*OVC_SERV*	**19,646**	**0**

5.2 Priority population prevention

PEPFAR-E has transitioned all community prevention activities out of sustained SNUs. There are a few military supported sites and work site prevention programs which continue to receive comprehensive HIV prevention services as detailed in 4.2. In addition, passive support is provided to STI cases to ensure they receive HIV testing services and linkage to treatment.

5.3 Voluntary medical male circumcision (VMMC)

The target population is uniformly distributed in all SNU categories, therefore the package of services as detailed in section 4.3 will be implemented at all sites.

5.4 Preventing mother-to-child transmission (PMTCT)

The minimum package of services as detailed in section 4.4 will be implemented at all sites, although the level of effort will be reduced for some activities such as - reduced frequency of mentorship and supervisory visits, no expansion of mother support groups, and no additional trainings.

5.5 HIV testing and counseling (HTS)

In sustained SNUs, testing targets assume passive PITC, there are no demand creation activities. Based on APR16 results, FY18 targets are 319,000, a significant shift from approximately 1.5 million in FY16.

5.6 Facility- and community-based care and support

In attained SNUs, PEPFAR is obligated to ensure that quality standards of care and support services are accessible and sustained for patients already enrolled in treatment. The package of services are aligned with Ethiopia's minimum standard package of services for PLHIV as outlined in the 2014 national comprehensive HIV/AIDS guidelines and the 2015 national community level care and support services delivery guideline for PLHIV and affected families. The basic services include: clinical staging; measurement of CD4 count to determine eligibility for OI prophylaxis and subsequently if needed to cease CPT or if a switch to a NVP containing regimen is being considered; screening and management of OIs; CPT; PHDP services; nutritional assessment and counseling (NAC); PLHIV support groups; in-service trainings; quarterly mentoring and supportive supervision; and VL monitoring and scale-up. In addition, mental health integration into HIV services to proactively identify and manage patients with

co-morbidity; water sanitation and hygiene; pain and symptom management; adherence support; and food and psychosocial support, including economic strengthening for food security, will be supported in attained SNUs.

To facilitate these services, case managers and clinicians will ensure linkage to appropriate facility and community resources. Continuous quality improvement activities will be supported in order to maintain the standard of care provided to patients.

5.7 TB/HIV

In attained and sustained SNUS, screening and prevention of TB, as well as TB and HIV treatment for co-infected patients will remain part of a basic package of services. Likewise, TB infection control will continue to be a priority focus that will be supported at all PEPFAR supported SNUs including sustained sites to prevent transmission of TB at the health facilities.

5.8 Adult treatment

Most facilities in sustained SNUs have low patient volume and therefore differentiated service delivery model will not be implemented. PEPFAR-E will continue to support a minimum package of services to ensure persons on treatment receive the care needed to improved patient outcomes, prevent HIV transmission and achieve epidemic control.

5.9 Pediatric Treatment

In sustained woredas, PEPFAR-E will continue delivery of quality care and treatment services for HIV infected children through an integrated, comprehensive, and family-centered approach. The program will support pediatric case finding, implementation of test and treat policy, provision of comprehensive care package and ensure availability of essential laboratory services including viral load monitoring.

5.10 OVC

There are no interventions in sustained and attained locations.

5.11 Establishing service packages to meet targets in attained and sustained woredas

As a result of poor performance in FY16 and other contextual factors, woredas that would have reached attained status by FY18 are now projected to reach attained. Further disaggregation by age and sex confirms this gap in reaching attained by the end of FY18.

In the sustained woredas, quality clinical services will be continued to ensure that those on treatment are maintained on treatment, and receive needed care. New sites will not be added to this category, and there will be no demand creation related to prevention services. Health providers will continue to receive support through supervision, mentoring, and training. There will be peer support for adherence and retention in care including tracing for defaulters both in the community and facility settings. Tailored services will be available in KP friendly clinics to address the preventive and medical needs of these populations including ART. PEPFAR will continue to provide technical support to assure quality of prevention, care, and treatment services. Technical support will include quarterly HIV -focused mentoring at ART and PMTCT sites, supportive supervision, provision of in-service trainings, availing all current guidelines to all sites, and provision of job aids.

Package of services for Sustained SNUs:

- *Care and treatment, including essential laboratory services for PLHIV:* For sustained SNU, there will support at facility level for routine clinical services, ARV, WHO clinical staging, TB screening, psychosocial services, peer support groups and adherence counseling, provision of co-trimoxazole prophylaxis, components of PHDP service, nutritional assessment and counseling, OI management and adherence. Case management for purposes of providing adherence support and reducing the number of missed appointments. Laboratories in these woredas will be included in the sample transport system used in scale-up woredas to transport VL tests to regional labs. These labs will be provided with reagents and other supplies required for CD_4 testing and monitoring; sample transport services to regional laboratories, especially for VL.

- *Prevention services* will include:
    - Targeted HIV testing and counseling service to pregnant women, patients with suspected OI including TB, partner and children of known HIV positive clients, STI clients, victims of rape, children at high-yield entry points, as well as orphans with unknown HIV status.
    - PITC services.
    - Sexually Transmitted Infection (STI) screening and treatment
    - STI/HIV Risk reduction counseling
    - Condom promotion and distribution
    - Need based training of HCWs on risk reduction counseling, STI and GBV care
    - Comprehensive post gender based violence care
    - Referral & linkage to care & treatment services
    - M & E activities as per the requirement

- *HIV Testing and Counseling services will include:*
    - Passive HTS based on HIV risk assessment of client by the provider or targeted PITC
    - Referral and linkage to treatment HIV positive cases
    - Support to maintain HTS quality
    - Minimal need based HCW training on all SNUs
    - Supportive supervision as per PEPFAR requirement
    - M & E activities as per the requirement

Partner performance monitoring will continue but with reduced frequency. The program will conduct progress review meetings quarterly with the primary objective of reviewing results and progress toward targets, identifying gaps and challenges and preparation of action plans to address issues. Most importantly, the review meetings provide opportunities for consultations and feedback with implementing partners, local government partners, CSOs, and other actors.

5.12 Commodities

Please refer to 4.12. Similar support will be provided in sustained and attained woredas, except that intensive monitoring of supply status of RTKs will focus mainly at PEPFAR priority SNUs.

5.13 Collaboration, Integration and Monitoring

In the area of collaboration and integration to address challenges across the clinical cascade, support will be provided to strengthen linkage to care and treatment services. PLHIV currently receiving ART

will be provided with peer based adherence support both at the health facility and at community platforms. Alignment of the financial and technical support to the national program between PEPFAR and other stakeholders like GFATM will be strengthened for improving the procurement and distribution of ARV drugs, lab reagents, other supplies and commodities. There will be continued effort and collaboration between ART clinical services and testing sites for strengthening the laboratory monitoring of ART patients so that routine viral load testing will be fully implemented, samples are timely transported and resulted returned, clinicians use VL test results for effective clinical decision making, and performance is reported consistently and accurately. There will be increased use of data for evidence based planning and site level performance monitoring and improvement. PEPFAR E will support the FMOH effort in the catch-up campaign and other similar initiatives to foster collaboration and leverage resources and efforts for improved program performance.

6.0 Program Support Necessary to Achieve Sustained Epidemic Control

To achieve the 90-90-90 goals and sustain the epidemic control in Ethiopia, PEPFAR Ethiopia identified three key programmatic gaps:

6.1.1. Insufficient identification of new HIV-positive persons:

- Persistent stigma is a barrier to accessing HTS, especially for the highest-risk, most-marginalized populations. Enabling environments must be created at both the community and facility levels. PEPFAR is addressing this through its efforts in the 20 target towns to involve mayors in these towns to create "stigma-free zones" and promote targeted testing approaches. Peer HIV Case Managers (CMs) and adherence supporters (ASs), who are themselves PLHIV, will be trained to implement facility based targeted demand creation activates through addressing the persisting stigma regarding HIV infection and facilitating disclosure and linkage to HTS. PEPFAR will continue to support targeted community outreach with most at risk populations. PEPFAR is supporting the MOH's Compassionate and Respectful Care initiative that is intended to improve client experience at health facilities. Additionally, PEPFAR is supporting testing at "KP-friendly" service delivery points including drop-in centers and confidential clinics and located in urban "hot spots".
- Inconsistent availability of test kits at site level in both the public and private sector contributes to challenges in identification of new HIV-positive persons. The system level causes for this include: lack of approved national algorithm for HIV testing; national testing guidelines which recommend testing broad population groups (e.g., 15-24 year olds, all children seen at Under-5 clinics); a quota system for distribution by regions which is not based on targets or testing yield; and woreda-level planning that focuses on meeting testing targets rather than targets established for PLHIV identified. PEPFAR is championing changes in national policy to address these issues.
- There are no national system in place to actively identify PLHIV who are not accessing testing facilities by their own initiative. PEPFAR is addressing this by providing targeted outreach among KP, supporting the development of STI and HIV partner-notification systems, testing of family members of identified PLHIV, testing OVC, and making testing services available in prisons and at worksites that attract mobile workers.
- There is limited epidemiological data to target HTS on the high-yield SNUs. PEPFAR-E will work with FMOH and the Ethiopia Public Health Institute (EPHI) to quantify and map KP and PP in selected geographic locations.
- PEPFAR will continue working with community-based partners and FMOH and RHBs to build the technical capacity of RHBs on planning, implementing and monitoring innovative and targeted HTS with particular focus to the twenty priority towns. TA will enhance program implementation and monitoring through capacity building on the use of age/sex disaggregated data for decision making, performance monitoring, ensure data quality, linkage to treatment services as well as working toward attainment.

6.1.2. Inadequate systems to assure linkage, retention, and virologic suppression of identified PLHIV:

- Absence of unique identification numbers assigned to every individual in the country contributes to difficulty in ensuring that patients identified at a testing site are linked to care and treatment. Though PEPFAR-supported KP sites are utilizing fingerprint and piloting iris scan technologies to address this gap, at this time the GoE does not have a plan to address this challenge nationally. Accompanied referral and strengthening referral mechanisms are being

supported, as are multi-disciplinary team meetings within facilities and catchment area meetings that connect referring sites to referral facilities.

- Though community-based government health cadres (Health Extension Workers) assist facilities in tracking patients who have missed appointments and thereby contribute to patient retention, HEWs have many responsibilities outside of HIV-related services that can limit their involvement in assuring patient retention. PEPFAR-E, therefore, supports case managers and adherence supporters at facility and community level care and support services as well as community level tracking and linkage services for patients who have missed appointments or been LTFU.
- Pre-ART patients are at greatest risk of being LTFU. This retention problem will be addressed now that the GoE has adopted Test and START. PEPFAR-E will continue to provide TA to FMOH, RHBs, and private sector facilities to ensure optimal implementation of test and start policy in all PEPFAR-supported health facilities.
- Among the reasons for inadequate access to quality HIV laboratory services, especially for VL and EID testing was poorly performing specimen referral system (SRS) with vast regional boundaries and inadequate number of lab facilities performing VL and EID testing which has contributed for long TAT as well. This problem has been acknowledged and through PEPFAR support is being addressed systematically. Through PEPFAR support and EPHI coordination involving RHBs, the national integrated SRS is implemented for increasing access to quality laboratory services in timely manner for effectively supporting the national ART program based on the geographic proximity to strategically located testing sites irrespective of regional boundaries. Specimen referral network is key for implementation of viral load and EID scale-up plan which includes transportation of DBS specimen for viral load and EID. A formal binding agreement is in place between EPHI and Ethiopian Postal Services Enterprise (EPSE) to transport specimen and return of results back to the facilities in timely manner via trained EPSE staff and proper packaging.
- In FY16, the FMOH has adopted a routine VL monitoring policy for PLHIV who have been on ART at least six months. The adoption and implementation of this policy continues to improve and the utilization of routine VL testing for ART monitoring and proper utilization of the right regimen for PLHIV. PEPFAR-E support is enabling public and private facility partners to effectively implement the policy, including strengthening of viral load testing capacity of the laboratories (human resource, laboratory infrastructure, optimal working schedule, arrangement of back-up system, coordination of specimen referral) and above site technical support (for effective coordination and oversight), implementation of viral load and EID database and support laboratory-clinical interface. Emphasis has been given to reducing TAT for viral load test result delivery and monitoring and evaluation of the program. Maintaining the quality of HIV rapid testing through implementation of a standardized HIV rapid testing logbook, enrollment of HIV testing points in dried tube specimen (DTS)-based external quality assessment (EQA) and supportive supervision, internal quality control, training and certification of testers and use of quality manual for point of care testing are among the key activities. Enrolling and mentoring selected high case load facility laboratories under a continuous quality improvement (CQI) scheme is also being supported.

6.1.3. Inadequate domestic spending to support sustained HIV care and treatment services and commodities

- PEPFAR will invest in capacity-building for CSOs to mobilize and utilize domestic resources for the implementation of community-based services for PLHIV; providing technical assistance

for the Ethiopia Health Insurance Agency (EHIA), RHBs, and woreda administrations to implement community-based health insurance initiatives; providing technical assistance to the Pharmaceuticals Fund and Supply Agency (PFSA) and RHBs to link private facilities to the national supply chain system; and providing supply chain management and commodity security TA.
- Strengthening the health commodity management information system; and strengthening supply chain management, leadership, and partner collaboration.

6.2.1 Test and Start

- Among programs targeting CSWs, Test and Start is being rolled out at confidential sex worker clinics, drop-in centers for CSWs, and KP sites at public facilities. PEPFAR's integration of ART services for CSWs in these supported sites will be expanded in COP2017, based on HIV burden. PEPFAR will also support the introduction of accompanied referrals by lay counselors (from community to facility) and partner notification system. All these activities require support for strengthened and expanded community health system that are able to provide responsive treatment services to KP/PP in prioritized SNUs.

6.2.2. New and Efficient Service Delivery Models

- PEPFAR-E will pilot alternative service delivery models for stable patients. Piloting of appointment spacing and community ART models in COP16 will be scaled up in COP17. This is expected to lead to system-level guideline revisions that will alleviate the burden of frequent facility visits for stable patients and is expected to improve retention.
- In 2015 WHO recommended the use of oral antiretroviral drugs for, pre-exposure prophylaxis, to people at substantial risk of HIV infection. Oral PrEP-containing TDF should be offered as part of combination HIV prevention approaches and marks an additional prevention choice for people at continuing risk of HIV. In Ethiopia the national MARPs survey (EPHI 2013/14) showed that commercial sex workers are disproportionally at high risk of HIV infection (CSWs HIV prevalence 24%) compared to the general population (1.2%). Inclusion of PrEP at KP sites in Ethiopia will encourage national level efforts in scaling-up HIV prevention efforts, particularly in line with the WHO Global Health Sector Strategy for HIV 2016-2021. In COP 17 PEPFAR will pilot PreP among commercial sex workers in Addis Ababa. Rapid scale up of this program is expected in 2018 after evaluation of the feasibility of the pilot.

6.3 Proposed system investments outside of programmatic gaps and priority policies.
Human Resources for Health Support

In COP 2017, PEPFAR will significantly scale-down its support on HRH following the decline in PEPFAR resources. PEPFAR has been supporting pre-service education of priority health cadres involved in the provision of HIV/AIDS prevention, care and treatment services with the objective of improving the quality of education and increasing the number of providers involved in the provision of HIV/AIDS-related services for vulnerable population and PLHIVs. There also have been investments in the area of strengthening in-service training (IST) activities to ensure full institutionalization of IST.

In COP 2017, we will be consolidating the gains made to date in the areas of pre-service education and in-service training through targeted support for HRH in the 35 IST units and 48 universities to enable them to provide quality education on HIV/AIDS. Activities targeted towards the ISTUs will include improving IST trainer capacity through coaching, mentoring and supportive supervision and standardizing national training packages, financial management tools, and standard operating

procedures. Activities in the pre-service education area include: faculty development, curriculum review, provision of resource materials, and skills lab equipment. Support for pre-service education and in-service training will directly impact the 90:90:90 targets by increasing the availability of trained and qualified HCWs (Health Extension Workers, midwives and Health Officers) who will provide HIV prevention, care and treatment services at facility and community levels, with a focus on high-case load facilities.

As a result of the reduction in funding, PEPFAR will no longer provide technical support to FMOH to implement National Health Workforce Account – a tool that is envisioned to produce comprehensive information and data on HCW needs and status in the country.

Social Services system strengthening including the workforce development: PEPFAR supports para-social worker training institutions and community structures, including Community Coordinating Committee (CCCs), in order to strengthen the social services system and prevent and respond to neglect, violence and exploitation of children and adolescents at risk. Through case management by social service workers, OVC will receive customized support based on vulnerability assessments. These social service workers serve as case managers for the OVC in woredas and at the community level to assess their needs and link them to health and social services provided by their communities and/or local authorities. These cadres have been playing a crucial role in strengthening the bi-directional referral linkage, supporting HIV disclosure and adherence, and implementing the OVC transition plan.

In COP17, PEPFAR will continue to support the training of social service workers and build the capacity of the federal and local government and community structures to strengthen the social service system for the sustainability of the OVC program. While the government continues to cover some training costs, including the running cost of training facilities/colleges, instructor salaries, and salaries of graduated social workers, PEPFAR will focus its support on training costs, technical assistance and capacity building as the capacity of the GoE to take over the full cost of these activities increases.

Strengthening the social services system, including workforce development, is one of the key strategies for a successful transition of OVC support while also strengthening referral linkages, case management, and disclosure and adherence of HIV positive OVCs and caregivers.

Health Care Financing Support: Similarly, investments in the area of health care financing will be significantly reduced in COP2017. In COP2017, PEPFAR resources will be used to focus investment in the area of increasing domestic resource mobilization through advocacy work at federal and regional levels. This is expected to play role in availing more domestic resources to support priority HIV/AIDS prevention, care and treatment services in priority locations. PEPFAR resources will also be used to support expansion of community-based health insurance to additional high HIV-burden districts to minimize cost barrier to PLHIVs in accessing HIV care services that are not covered through the free HIV program (e.g., in-patient treatment cost, certain lab investigations and procurement of drugs that are not covered through the free HIV program).

Supply Chain Management Systems: PEPFAR will continue providing supply chain technical assistance (TA) to FMOH, PFSA, RHB and priority health facilities. The TA will include forecasting and quantifications, distribution and warehouse management, fleet management, procurement and pipeline monitoring, and supply chain information systems and automation. The TA will also include

training of health care providers in PEPFAR-supported ART sites on Integrated Pharmaceuticals Logistics System (IPLS) and Health Commodities Management Information System (HCMIS).

IPLS is a national system used to manage inventories and stock refill request and report at national, regional hub at facility level, whereas HCMIS is an automation of IPLS used at all levels to manage inventories at facility level, aggregate national requirements, conduct stock analysis and use for national quantification. Training will also be given on logistics management and refresher training on stock management, support on reordering and reporting procedures to enable staff to request commodities though the national logistics systems. The TA will be provided at above site and all PEPFAR supported ART sites, including the twenty priority towns and all PFSA branches and 11 regional health bureaus. In COP 17, the number of automated logistics management information sites will increase to 700 which will cover over 85% of ART patients in care. Other ART and PMTCT facilities will be supported to improve paper-based logistics management information systems. PEPFAR will also support the mentoring and supportive supervision of priority towns and PEPFAR-supported ART sites to monitor stock levels/status and avoid stock out of ARVs, RTKs, viral Load/EID, other lab commodities, and STI, OI medicines.

Through the improvement of pharmacy services, patient centered pharmaceutical care, drug information centers, rational medicine use, and containment and prevention of antimicrobial resistance, PEPFAR will enhance ART adherence, reduce drug resistance, and reduce medication errors that will help to achieve the third 90. Establishment and strengthening of drug and therapeutic committees and multi-disciplinary team will help to prevent loss and theft of key commodities like ARVs, RTKs, RUTF/RUSF and OI medicines.

7.0 Staffing Plan

PEPFAR-E's COP16 SDS reported that the team had 22 vacancies. For COP 17, there are 12 PEPFAR funded and five partially PEPFAR funded positions (13%) that are not filled. The team has reassessed and made a measurable change on staffing status by shifting the funding source for some positions and filling vacant positions. However, a key leadership position, the PEPFAR Country Coordinator, continues to be vacant after nearly three years. The team is not planning to request new staffing and focuses on filling current vacancies and repurposing positions to support the programmatic pivots.

All 123 employees have full-time employee (FTE) status with the U.S. Government. Of that total, 86 are 100% dedicated to PEPFAR and approximately 93% fully PEPFAR funded staff have 100% of their time devoted to PEPFAR. Ethiopian (host country) nationals constitute 85% of PEPFAR funded staff, and there is no plan to shift citizenship type for any position in COP 17. Technical and programmatic leadership, management and support make 70% of the overall footprint. As part of its phase out strategy from PEPFAR, Peace Corps has made a significant reduction in the number of staff who are partially dedicated to PEPFAR (from 22 in COP 16 to four in COP 17). Hiring of a Senior Technical Advisor position within the PEPFAR Coordination Office was in the final stage but could not be completed due to the federal hiring freeze.

Appendices

Table A.1: SNU Prioritization

SNU	COP15 Prioritization	APR 16 Achieve-ment	COP16 Prioritization	Expected Achieve-ment By APR17	COP17 Prioritization	COP17 Target (APR18)
Addis Ababa	Scale-up	74%	ScaleUp Sat	82%	Attained	91%
Dire Dawa Town	Scale-up	76%	ScaleUp Sat	85%	Attained	97%
Shashemene Town	Scale-up	55%	ScaleUp Sat	67%	Attained	90%
Debre Markos Town	Scale-up	72%	ScaleUp Sat	80%	Attained	91%
Ambo Town	Scale-up	55%	ScaleUp Sat	68%	Attained	83%
Woliso Town	Scale-up	54%	ScaleUp Sat	67%	Attained	81%
Goba Town	Scale-up	55%	ScaleUp Sat	59%	Attained	89%
Adama Town	Scale-up	53%	ScaleUp Sat	69%	ScaleUp Sat	80%
Bahir Dar Liyu	Scale-up	73%	ScaleUp Sat	90%	ScaleUp Sat	96%
Dese Town	Scale-up	70%	ScaleUp Sat	80%	ScaleUp Sat	86%
Mekelle Town	Scale-up	70%	ScaleUp Sat	80%	ScaleUp Sat	91%
Gondar Town	Scale-up	71%	ScaleUp Sat	80%	ScaleUp Sat	91%
Woldiya Town	Scale-up	71%	ScaleUp Sat	80%	ScaleUp Sat	91%
Jimma Town	Scale-up	55%	ScaleUp Sat	70%	ScaleUp Sat	83%
Asela Town	Scale-up	55%	ScaleUp Sat	67%	ScaleUp Sat	88%
Bishoftu Town	Scale-up	54%	ScaleUp Sat	67%	ScaleUp Sat	92%
Kombolcha Town	Scale-up	72%	ScaleUp Sat	80%	ScaleUp Sat	91%
Nekemte Town	Scale-up	53%	ScaleUp Sat	66%	ScaleUp Sat	89%
Alamata Town	Scale-up	64%	ScaleUp Sat	73%	ScaleUp Sat	90%
Mojo Town	Scale-up	57%	ScaleUp Sat	70%	ScaleUp Sat	90%
Harar	Scale-up	90%	ScaleUp Sat	97%	ScaleUp Sat	103%
Debre Birhan Town	Scale-up	69%	ScaleUp Sat	84%	ScaleUp Sat	100%
Metema	Scale-up	73%	ScaleUp Sat	95%	ScaleUp Sat	118%
Debre Tabor Town	Scale-up	70%	ScaleUp Agg	78%	ScaleUp Sat	87%
Humera Town	Scale-up	66%	ScaleUp Agg	83%	ScaleUp Sat	102%
Raya Azebo	Scale-up	73%	ScaleUp Sat	83%	ScaleUp Sat	94%
Shire Endasilasie Town	Scale-up	51%	ScaleUp Sat	68%	ScaleUp Sat	87%
Finote Selam Town	Scale-up	71%	ScaleUp Agg	79%	ScaleUp Sat	90%
Kobo Town	Scale-up	68%	ScaleUp Sat	82%	ScaleUp Sat	98%
Mersa Town	Scale-up	72%	ScaleUp Agg	79%	ScaleUp Sat	87%
Mota Town	Scale-up	71%	ScaleUp Agg	77%	ScaleUp Sat	85%
Maychew Town	Scale-up	68%	ScaleUp Sat	78%	ScaleUp Sat	89%
Legambo	Scale-up	73%	ScaleUp Sat	81%	ScaleUp Sat	90%
Axum Town	Scale-up	70%	ScaleUp Agg	76%	ScaleUp Sat	84%
Bichena Town	Scale-up	73%	ScaleUp Sat	81%	ScaleUp Sat	90%
Adwa Town	Scale-up	70%	ScaleUp Agg	82%	ScaleUp Sat	96%
Metehara Town	Scale-up	50%	ScaleUp Agg	70%	ScaleUp Sat	97%
Boset	Scale-up	60%	ScaleUp Agg	72%	ScaleUp Sat	90%
Shewa Robit Town	Scale-up	73%	ScaleUp Sat	83%	ScaleUp Sat	93%

Lalibela Town	Scale-up	71%	ScaleUp Agg	81%	ScaleUp Sat	92%
Robe Town	Maintenance	55%	ScaleUp Agg	70%	ScaleUp Sat	86%
Semera Logia Town	Scale-up	45%	ScaleUp Agg	67%	ScaleUp Sat	92%
Kalu	Scale-up	73%	ScaleUp Agg	79%	ScaleUp Sat	87%
Assosa Town	Scale-up	85%	ScaleUp Sat	96%	ScaleUp Sat	108%
Kemisie Town	Scale-up	73%	ScaleUp Sat	81%	ScaleUp Sat	90%
Holeta Town	Scale-up	62%	ScaleUp Agg	76%	ScaleUp Sat	98%
Were Ilu	Scale-up	69%	ScaleUp Sat	77%	ScaleUp Sat	85%
Tenta	Scale-up	71%	ScaleUp Agg	78%	ScaleUp Sat	87%
Adama	Scale-up	54%	ScaleUp Agg	69%	ScaleUp Sat	89%
SekotaTown	Scale-up	69%	ScaleUp Sat	78%	ScaleUp Sat	87%
Debark Town	Scale-up	75%	ScaleUp Sat	89%	ScaleUp Sat	105%
Enjibara Town	Scale-up	75%	ScaleUp Sat	82%	ScaleUp Sat	91%
Kafta Humera	Scale-up	71%	ScaleUp Sat	119%	ScaleUp Sat	170%
Shambu Town	Scale-up	58%	ScaleUp Agg	68%	ScaleUp Sat	82%
Dodola	Scale-up	53%	ScaleUp Agg	64%	ScaleUp Sat	77%
Merab Armacho	Scale-up	73%	ScaleUp Sat	87%	ScaleUp Sat	103%
Pawe	Scale-up	86%	ScaleUp Sat	101%	ScaleUp Sat	118%
Dejen Town	Scale-up	72%	ScaleUp Sat	78%	ScaleUp Sat	86%
Kelela	Maintenance	73%	ScaleUp Sat	79%	ScaleUp Sat	86%
Raya Kobo	Maintenance	73%	ScaleUp Sat	83%	ScaleUp Sat	95%
Ambasel	Maintenance	68%	ScaleUp Sat	71%	ScaleUp Sat	75%
Enebse Sar Midir	Maintenance	68%	ScaleUp Sat	73%	ScaleUp Sat	78%
Awabel	Maintenance	74%	ScaleUp Sat	83%	ScaleUp Sat	94%
Ataye Town	Scale-up	70%	ScaleUp Sat	80%	ScaleUp Sat	91%
Simada	Scale-up	73%	Sustained	75%	ScaleUp Sat	81%
Baso Liben	Maintenance	72%	Sustained	81%	ScaleUp Sat	89%
Delanta	Scale-up	75%	Sustained	78%	ScaleUp Sat	85%
Shebel Berenta	Maintenance	78%	Sustained	0%	ScaleUp Sat	93%
Dembecha Town	Maintenance	74%	Sustained	83%	ScaleUp Sat	91%
Gondar Zuria	Maintenance	75%	Sustained	78%	ScaleUp Sat	85%
Antsokiya Gemza	Maintenance	74%	Sustained	82%	ScaleUp Sat	90%
Raya Alamata	Maintenance	75%	Sustained	87%	ScaleUp Sat	96%
Gubalafto	Maintenance	102%	Sustained	113%	ScaleUp Sat	123%
Bure (Amhara)	Maintenance	52%	Sustained	110%	ScaleUp Sat	120%
Mile	Scale-up	48%	ScaleUp Agg	76%	ScaleUp Sat	109%
Dese Zuria	Maintenance	75%	Sustained	84%	ScaleUp Sat	92%
Jabi Tehnan	Maintenance	83%	Sustained	90%	ScaleUp Sat	99%
Dega Damot	Maintenance	79%	Sustained	76%	ScaleUp Sat	83%
Bambasi	Maintenance	82%	Sustained	84%	ScaleUp Sat	92%
Borena	Transition	97%	Sustained	108%	ScaleUp Sat	118%
Quara	Maintenance	65%	Sustained	124%	ScaleUp Sat	135%
Aneded	Maintenance	85%	Sustained	94%	ScaleUp Sat	103%
Dangur	Maintenance	91%	Sustained	97%	ScaleUp Sat	106%
Muhor Na Aklil	Maintenance	60%	Sustained	137%	ScaleUp Sat	142%

Lasta	No PEPFAR Support	73%	Sustained	95%	ScaleUp Sat	103%
Genida Wuha Town	Maintenance	80%	Sustained	156%	ScaleUp Sat	171%
Mandura	Maintenance	91%	Sustained	100%	ScaleUp Sat	110%
Dibate	Maintenance	86%	Sustained	86%	ScaleUp Sat	94%
Bulen	Maintenance	91%	Sustained	91%	ScaleUp Sat	98%
Adami Tulu Jido Kombolcha	Scale-up	59%	Sustained	79%	ScaleUp Sat	86%
Chilga	Maintenance	77%	Sustained	86%	ScaleUp Sat	94%
Hitosa	Maintenance	58%	Sustained	106%	ScaleUp Sat	115%
Dawnt	Maintenance	73%	Sustained	86%	ScaleUp Sat	95%
Wenbera	Maintenance	91%	Sustained	88%	ScaleUp Sat	96%
Tegede	Maintenance	77%	Sustained	85%	ScaleUp Sat	94%
Arsi Negele	Scale-up	55%	ScaleUp Agg	103%	ScaleUp Sat	155%
Hulet Ej Enese	Maintenance	87%	Sustained	0%	ScaleUp Sat	112%
Ada'a	Maintenance	57%	Sustained	86%	ScaleUp Sat	93%
Basona Werana	Maintenance	83%	Sustained	91%	ScaleUp Sat	100%
Mengesh	Maintenance	74%	Sustained	246%	ScaleUp Sat	250%
Asagirt	Transition	80%	Sustained	93%	ScaleUp Sat	103%
Gelan Town	Transition	72%	Sustained	96%	ScaleUp Sat	106%
Sire	Transition	135%	Sustained	152%	ScaleUp Sat	163%
Doba	Maintenance	53%	Sustained	111%	ScaleUp Sat	119%
Adwa	Transition	70%	Sustained	99%	ScaleUp Sat	105%
Metu Zuria	No PEPFAR Support	104%	Sustained	0%	ScaleUp Sat	168%
Dillo	Transition	88%	Sustained	125%	ScaleUp Sat	134%
Sinana	Transition	136%	Sustained	195%	ScaleUp Sat	243%
Jijiga Town	Scale-up	8%	ScaleUp Agg	9%	ScaleUp Agg	10%
Hawassa Town	Scale-up	39%	ScaleUp Agg	51%	ScaleUp Agg	62%
Gambella	Scale-up	31%	ScaleUp Agg	40%	ScaleUp Agg	50%
Sodo Town	Scale-up	38%	ScaleUp Agg	49%	ScaleUp Agg	61%
Mizan Aman Town	Scale-up	36%	ScaleUp Agg	44%	ScaleUp Agg	52%
Arbaminch Town	Scale-up	37%	ScaleUp Agg	40%	ScaleUp Agg	42%
Dila Town	Scale-up	39%	ScaleUp Agg	50%	ScaleUp Agg	66%
Yirga Alem Town	Scale-up	36%	ScaleUp Agg	38%	ScaleUp Agg	41%
Gog	Scale-up	32%	ScaleUp Agg	37%	ScaleUp Agg	41%
Jinka Town	Scale-up	32%	ScaleUp Agg	37%	ScaleUp Agg	42%
Fiche Town	Scale-up	54%	ScaleUp Agg	59%	ScaleUp Agg	64%
Hosaena Town	Scale-up	38%	ScaleUp Agg	47%	ScaleUp Agg	55%
Tepi Town	Scale-up	39%	ScaleUp Agg	42%	ScaleUp Agg	45%
Dima (Gambella)	Scale-up	27%	ScaleUp Agg	42%	ScaleUp Agg	55%
Adigrat Town	Scale-up	68%	ScaleUp Sat	74%	ScaleUp Agg	83%
Dubti	Scale-up	47%	ScaleUp Agg	57%	ScaleUp Agg	70%
Odo Shakiso	Scale-up	58%	ScaleUp Agg	65%	ScaleUp Agg	74%
Metu Town	Scale-up	52%	ScaleUp Agg	60%	ScaleUp Agg	69%
Batu (Ziway) Town	Scale-up	53%	ScaleUp Agg	59%	ScaleUp Agg	67%

Gimbi Town	Scale-up	55%	ScaleUp Agg	62%	ScaleUp Agg	69%
Woreta Town	Scale-up	72%	ScaleUp Agg	77%	ScaleUp Agg	85%
Wukro Town	Scale-up	69%	ScaleUp Agg	75%	ScaleUp Agg	83%
Kuyu	Scale-up	53%	ScaleUp Agg	57%	ScaleUp Agg	62%
Sebeta Town	Scale-up	57%	ScaleUp Agg	70%	ScaleUp Agg	84%
Hayik Town	Scale-up	71%	ScaleUp Agg	74%	ScaleUp Agg	78%
Gode Town	Scale-up	9%	ScaleUp Agg	9%	ScaleUp Agg	11%
Butajira Town	Scale-up	43%	ScaleUp Agg	52%	ScaleUp Agg	60%
Adola Town	Scale-up	61%	ScaleUp Agg	67%	ScaleUp Agg	74%
Ada Berga	Scale-up	53%	ScaleUp Agg	56%	ScaleUp Agg	59%
Meket	Maintenance	74%	ScaleUp Agg	80%	ScaleUp Agg	88%
Denbi Dollo Town	Scale-up	55%	ScaleUp Agg	57%	ScaleUp Agg	60%
Mekane Selam Town	Scale-up	68%	ScaleUp Agg	70%	ScaleUp Agg	74%
Chiro Town	Scale-up	56%	ScaleUp Agg	67%	ScaleUp Agg	87%
Abey Chomen	Scale-up	52%	ScaleUp Agg	55%	ScaleUp Agg	59%
Bonga Town	Scale-up	37%	ScaleUp Agg	38%	ScaleUp Agg	38%
Bule Hora Town	New	0%	ScaleUp Agg	0%	ScaleUp Agg	4%
Asayita	Scale-up	46%	ScaleUp Agg	53%	ScaleUp Agg	61%
Bure Town	Scale-up	77%	ScaleUp Agg	81%	ScaleUp Agg	87%
NegeleTown	Scale-up	54%	ScaleUp Agg	63%	ScaleUp Agg	73%
Dengila Town	Scale-up	72%	ScaleUp Agg	77%	ScaleUp Agg	84%
Gida Ayana	Scale-up	54%	ScaleUp Sat	60%	ScaleUp Agg	67%
Agaro Town	Scale-up	59%	ScaleUp Agg	67%	ScaleUp Agg	76%
Bedele Town	Scale-up	56%	ScaleUp Agg	70%	ScaleUp Agg	86%
Adet Town	Scale-up	71%	ScaleUp Agg	78%	ScaleUp Agg	87%
Dembia	Scale-up	67%	ScaleUp Agg	72%	ScaleUp Agg	77%
Cheha	Scale-up	36%	ScaleUp Agg	38%	ScaleUp Agg	41%
Chagni Town	Scale-up	65%	ScaleUp Agg	72%	ScaleUp Agg	79%
Burayu Town	Scale-up	60%	ScaleUp Agg	67%	ScaleUp Agg	75%
Enarj Enawga	Maintenance	71%	ScaleUp Sat	80%	ScaleUp Agg	90%
Dendi	Scale-up	52%	ScaleUp Agg	62%	ScaleUp Agg	73%
Sululta Town	Scale-up	54%	ScaleUp Agg	64%	ScaleUp Agg	76%
Nifas Mewcha Town	Scale-up	72%	ScaleUp Agg	76%	ScaleUp Agg	81%
Minjar Shenkora	Maintenance	72%	ScaleUp Sat	77%	ScaleUp Agg	83%
Ebinat	Maintenance	67%	ScaleUp Agg	74%	ScaleUp Agg	82%
Hintalo Wajirat	Maintenance	69%	ScaleUp Sat	74%	ScaleUp Agg	80%
Addis Zemen Town	Scale-up	70%	ScaleUp Agg	74%	ScaleUp Agg	79%
Bati Town	Scale-up	70%	ScaleUp Sat	77%	ScaleUp Agg	85%
Awash Town	Scale-up	44%	ScaleUp Agg	58%	ScaleUp Agg	74%
Dukem Town	Scale-up	52%	ScaleUp Agg	59%	ScaleUp Agg	68%
Abobo	Scale-up	33%	ScaleUp Agg	41%	ScaleUp Agg	53%
Nejo Town	Scale-up	54%	ScaleUp Agg	65%	ScaleUp Agg	77%
Habro	Scale-up	50%	ScaleUp Agg	60%	ScaleUp Agg	71%
Debub Achefer	Maintenance	69%	ScaleUp Sat	77%	ScaleUp Agg	87%
Ginir	Scale-up	52%	ScaleUp Agg	54%	ScaleUp Agg	57%

Mekaneyesus Town	Scale-up	69%	ScaleUp Agg	68%	ScaleUp Agg	69%
Yirgachefe Town	Scale-up	40%	ScaleUp Agg	41%	ScaleUp Agg	41%
Robe	Scale-up	51%	ScaleUp Agg	67%	ScaleUp Agg	84%
Dugda	Scale-up	56%	ScaleUp Sat	66%	ScaleUp Agg	77%
Durame Town	Scale-up	37%	ScaleUp Agg	41%	ScaleUp Agg	44%
Meta Robi	Maintenance	52%	ScaleUp Agg	58%	ScaleUp Agg	65%
Yabelo Town	Scale-up	60%	ScaleUp Sat	70%	ScaleUp Agg	82%
Chencha	Scale-up	38%	ScaleUp Agg	40%	ScaleUp Agg	42%
Dodota	Scale-up	48%	ScaleUp Agg	53%	ScaleUp Agg	59%
Welkite Town	Scale-up	40%	Sustained	44%	ScaleUp Agg	46%
Awubere	Scale-up	10%	Sustained	12%	ScaleUp Agg	12%
Tsegede	Scale-up	68%	Sustained	92%	ScaleUp Agg	101%
Arsi Negele Town	New	55%	ScaleUp Agg	64%	ScaleUp Agg	74%
Amibara	Scale-up	37%	ScaleUp Agg	59%	ScaleUp Agg	84%
Sawla Town	Maintenance	38%	Sustained	48%	ScaleUp Agg	50%
Areka Town	Scale-up	35%	ScaleUp Agg	55%	ScaleUp Agg	84%
Debub Bench	Scale-up	39%	Sustained	59%	ScaleUp Agg	62%
Debay Tilatgen	Maintenance	70%	Sustained	74%	Sustained	75%
Marawi Town	Maintenance	67%	Sustained	70%	Sustained	71%
Aykel Town	Scale-up	73%	Sustained	74%	Sustained	75%
Limu Kosa	Scale-up	54%	Sustained	59%	Sustained	60%
Cheliya	Maintenance	51%	Sustained	57%	Sustained	57%
Jeldu	Scale-up	59%	Sustained	58%	Sustained	59%
Adaba	Maintenance	56%	Sustained	65%	Sustained	66%
Jama	Maintenance	74%	Sustained	77%	Sustained	79%
Merti	Scale-up	53%	Sustained	63%	Sustained	64%
Moyale (Oromia)	Maintenance	55%	Sustained	67%	Sustained	68%
Saesi Tsadamba	Maintenance	67%	Sustained	68%	Sustained	70%
Boloso Sore	Scale-up	40%	Sustained	41%	Sustained	40%
Godere	Scale-up	38%	Sustained	58%	Sustained	56%
Becho	Scale-up	59%	Sustained	71%	Sustained	71%
Korem Town	Scale-up	63%	Sustained	66%	Sustained	67%
Alaba	Scale-up	40%	Sustained	40%	Sustained	40%
Alem Ketema Town	Maintenance	68%	Sustained	70%	Sustained	71%
Mekdela	Transition	71%	Sustained	71%	Sustained	72%
Kebri Beyah	Scale-up	8%	Sustained	9%	Sustained	8%
Dera (Oromia)	Maintenance	57%	Sustained	57%	Sustained	58%
Emba Alage	Maintenance	70%	Sustained	70%	Sustained	72%
Denibu Gofa	Scale-up	38%	Sustained	38%	Sustained	38%
Sendafa Town	Maintenance	52%	Sustained	57%	Sustained	57%
Gidan	Maintenance	73%	Sustained	71%	Sustained	72%
Ginde Beret	Maintenance	55%	Sustained	59%	Sustained	59%
Bako Tibe	Scale-up	54%	Sustained	59%	Sustained	60%
Aleta Wondo Town	Maintenance	38%	Sustained	39%	Sustained	39%
Bokoji Town	Scale-up	59%	Sustained	58%	Sustained	59%

Abi Adi Town	Maintenance	68%	Sustained	70%	Sustained	71%
Habru	Maintenance	77%	Sustained	83%	Sustained	84%
Albuko	Maintenance	73%	Sustained	73%	Sustained	74%
Werebabu	Maintenance	73%	Sustained	76%	Sustained	77%
Atsbi Wonberta	Maintenance	73%	Sustained	74%	Sustained	76%
Mareka	Maintenance	36%	Sustained	36%	Sustained	35%
Wegidi	Maintenance	72%	Sustained	75%	Sustained	76%
Dabat	Maintenance	72%	Sustained	78%	Sustained	79%
Kochere	Maintenance	42%	Sustained	49%	Sustained	48%
Kimbibit	Maintenance	55%	Sustained	54%	Sustained	55%
Goncha Siso Enese	Maintenance	76%	Sustained	0%	Sustained	0%
Gumer	Maintenance	39%	Sustained	38%	Sustained	37%
Merab Azernet	Maintenance	37%	Sustained	35%	Sustained	35%
Takusa	Maintenance	71%	Sustained	75%	Sustained	76%
Bora	Transition	52%	Sustained	51%	Sustained	52%
Lude Hitosa	Maintenance	52%	Sustained	53%	Sustained	54%
Degua Temben	Maintenance	70%	Sustained	67%	Sustained	68%
Boditi Town	Scale-up	38%	Sustained	35%	Sustained	35%
Wondo Genet	Maintenance	44%	Sustained	51%	Sustained	50%
Dolo Odo	Scale-up	7%	Sustained	8%	Sustained	8%
Wadla	Maintenance	71%	Sustained	72%	Sustained	73%
Dawa Chefa	Maintenance	65%	Sustained	72%	Sustained	73%
Dejen	Maintenance		Sustained		Sustained	
Wonberima	Maintenance	70%	Sustained	73%	Sustained	74%
Deder Town	Maintenance	55%	Sustained	58%	Sustained	59%
Guagusa Shikudad	Maintenance	72%	Sustained	74%	Sustained	75%
Babile (Oromia)	Scale-up	56%	Sustained	62%	Sustained	63%
Dehena	Maintenance	77%	Sustained	79%	Sustained	80%
Ezha	Maintenance	38%	Sustained	37%	Sustained	36%
Tulo (Oromia)	Maintenance	56%	Sustained	59%	Sustained	59%
Shebedino	Maintenance	41%	Sustained	48%	Sustained	48%
Mehal Meda Town	Maintenance	73%	Sustained	77%	Sustained	78%
Ankasha Guagusa	Maintenance	72%	Sustained	75%	Sustained	77%
Etang	Maintenance	47%	Sustained	51%	Sustained	50%
Legahida	Maintenance	75%	Sustained	81%	Sustained	82%
Were Jarso	Maintenance	55%	Sustained	57%	Sustained	57%
Gedeb Asasa	Maintenance	56%	Sustained	56%	Sustained	56%
Werabe Town	Maintenance	41%	Sustained	39%	Sustained	39%
Shiraro Town	Maintenance	74%	Sustained	77%	Sustained	79%
Lega Tafo Town	Maintenance	58%	Sustained	67%	Sustained	68%
Ahiferom	Scale-up	70%	Sustained	78%	Sustained	79%
Kacha Bira	Maintenance	39%	Sustained	37%	Sustained	37%
Hawzen	Maintenance	67%	Sustained	69%	Sustained	70%
Digluna Tijo	Maintenance	55%	Sustained	54%	Sustained	55%
Munesa	Transition	59%	Sustained	58%	Sustained	58%

Sayint	Maintenance	72%	Sustained	76%	Sustained	77%
Tselemti	Maintenance	69%	Sustained	71%	Sustained	72%
Konso	Maintenance	42%	Sustained	44%	Sustained	43%
Ayira	Maintenance	51%	Sustained	51%	Sustained	51%
Merab Belsa	Maintenance	74%	Sustained	76%	Sustained	77%
Wegera	Maintenance	69%	Sustained	74%	Sustained	75%
Chena	Scale-up	36%	Sustained	40%	Sustained	39%
Dereashe	Maintenance	36%	Sustained	35%	Sustained	34%
Haro Maya Town	Maintenance	56%	Sustained	65%	Sustained	66%
Shirka	Maintenance	51%	Sustained	49%	Sustained	49%
Dale Wabera	Maintenance	53%	Sustained	53%	Sustained	54%
Tarma Ber	Maintenance	69%	Sustained	70%	Sustained	70%
Tach Gayint	No PEPFAR Support	69%	Sustained	0%	Sustained	0%
Dera (Amhara)	Maintenance	75%	Sustained	79%	Sustained	80%
Bedesa Town	Maintenance	56%	Sustained	59%	Sustained	59%
Ale (Oromia)	Maintenance	50%	Sustained	51%	Sustained	51%
Debre Elias	Maintenance	70%	Sustained	74%	Sustained	76%
Fagita Lekoma	Maintenance	73%	Sustained	75%	Sustained	76%
Wuchale	Maintenance	50%	Sustained	53%	Sustained	53%
Enemor Ener	Maintenance	45%	Sustained	42%	Sustained	42%
Ilu	Maintenance	49%	Sustained	51%	Sustained	52%
Ejere	Maintenance	51%	Sustained	55%	Sustained	56%
Semen Achefer	Maintenance	70%	Sustained	71%	Sustained	71%
Jima Rare	No PEPFAR Support	54%	Sustained	0%	Sustained	0%
Tach Armacho	Maintenance	71%	Sustained	80%	Sustained	81%
Bugna	Maintenance	72%	Sustained	78%	Sustained	79%
Toke Kutayu	Maintenance	66%	Sustained	69%	Sustained	69%
Gudru	Maintenance	52%	Sustained	54%	Sustained	54%
Menesibu	Maintenance		Sustained		Sustained	
Adi Arkay	Maintenance	65%	Sustained	72%	Sustained	74%
Masha Town	Scale-up	34%	Sustained	36%	Sustained	35%
Sodo	Maintenance	35%	Sustained	34%	Sustained	33%
Humbo	Maintenance	43%	Sustained	42%	Sustained	42%
Laelay Adyabo	Maintenance	58%	Sustained	61%	Sustained	62%
Hidabu Abote	Maintenance	54%	Sustained	52%	Sustained	53%
Enemay	Maintenance	78%	Sustained	88%	Sustained	89%
Jile Timuga	Maintenance	68%	Sustained	72%	Sustained	73%
Jawi	Maintenance	70%	Sustained	86%	Sustained	88%
Liben (East Shewa)	Maintenance	58%	Sustained	62%	Sustained	63%
Lay Armcho	Maintenance	67%	Sustained	71%	Sustained	72%
Merab Badwacho	Maintenance	40%	Sustained	39%	Sustained	39%
Mendi Town	New	52%	Sustained	52%	Sustained	53%
Gulo Meheda	Maintenance	68%	Sustained	74%	Sustained	74%

Debub Ari	Maintenance	48%	Sustained	49%	Sustained	48%
Sinan	Maintenance	66%	Sustained	0%	Sustained	0%
Alefa	Maintenance	74%	Sustained	82%	Sustained	83%
Kutaber	Maintenance	73%	Sustained	78%	Sustained	79%
Machakel	Maintenance	71%	Sustained	0%	Sustained	0%
Illu Gelan	Maintenance	51%	Sustained	51%	Sustained	51%
Gazgibla	Maintenance	74%	Sustained	77%	Sustained	78%
Mida Woremo	Maintenance	78%	Sustained	79%	Sustained	79%
Gewane	Maintenance	50%	Sustained	63%	Sustained	66%
Welkayit	Maintenance	69%	Sustained	84%	Sustained	85%
Merab Este	Maintenance	70%	Sustained	71%	Sustained	72%
Gimbichu	Maintenance	59%	Sustained	62%	Sustained	63%
Bensa	Maintenance	40%	Sustained	40%	Sustained	39%
Misrak Belesa	Maintenance	72%	Sustained	74%	Sustained	75%
Basketo	Maintenance	40%	Sustained	41%	Sustained	40%
Dolo Mena	Maintenance	53%	Sustained	60%	Sustained	61%
Asegede Tsimbila	Maintenance	74%	Sustained	77%	Sustained	78%
Dire	Maintenance	58%	Sustained	59%	Sustained	60%
Kofele	Maintenance	51%	Sustained	53%	Sustained	53%
Merab Abaya	Maintenance	39%	Sustained	41%	Sustained	40%
Sekela	Maintenance	73%	Sustained	74%	Sustained	75%
Kemba	Maintenance	43%	Sustained	46%	Sustained	45%
Were Lehe	Maintenance	24%	Sustained	33%	Sustained	33%
Bibugn	Maintenance	74%	Sustained	76%	Sustained	77%
Cheko	Maintenance	40%	Sustained	47%	Sustained	46%
Kewet	Maintenance	70%	Sustained	75%	Sustained	77%
Sibu Sire	Maintenance	53%	Sustained	51%	Sustained	51%
Gasera	Maintenance	59%	Sustained	62%	Sustained	63%
Abichu Gnaa	Maintenance	54%	Sustained	52%	Sustained	52%
Sheko	Maintenance	40%	Sustained	42%	Sustained	41%
Diga	Maintenance	57%	Sustained	59%	Sustained	60%
Sokoru	Maintenance	54%	Sustained	53%	Sustained	54%
Degem	Maintenance	53%	Sustained	52%	Sustained	53%
Tikur Enchini	Maintenance	61%	Sustained	60%	Sustained	61%
Goro (Bale)	Transition	53%	Sustained	53%	Sustained	53%
Sekota Zuria	Transition	77%	Sustained	80%	Sustained	81%
Anfilo	Maintenance	59%	Sustained	59%	Sustained	59%
Guba	Maintenance	68%	Sustained	75%	Sustained	76%
Seharti Samre	Maintenance	71%	Sustained	72%	Sustained	74%
Jima Arjo	Maintenance	52%	Sustained	48%	Sustained	49%
Wonchi	Maintenance	56%	Sustained	54%	Sustained	54%
Begi	Maintenance	58%	Sustained	55%	Sustained	55%
Jerdga Jerte	Maintenance	53%	Sustained	53%	Sustained	53%
Ofla	Maintenance	84%	Sustained	82%	Sustained	83%
Agarfa	Maintenance	52%	Sustained	49%	Sustained	50%

Wenago	Maintenance	61%	Sustained	62%	Sustained	61%
Goncha Kolola	Maintenance	73%	Sustained	73%	Sustained	74%
Ameya	Maintenance	51%	Sustained	52%	Sustained	52%
Moretna Jiru	Maintenance	78%	Sustained	78%	Sustained	79%
Woliso	Maintenance	55%	Sustained	55%	Sustained	56%
Daro Lebu	Transition	45%	Sustained	43%	Sustained	43%
Farta	Transition	75%	Sustained	74%	Sustained	75%
Omonada	Maintenance	55%	Sustained	53%	Sustained	53%
Gozamin	Maintenance	76%	Sustained	0%	Sustained	0%
Endamehoni	Maintenance	75%	Sustained	74%	Sustained	76%
Kilte Awlalo	Maintenance	63%	Sustained	66%	Sustained	67%
Quarit	Maintenance	74%	Sustained	72%	Sustained	73%
Wolmera	Maintenance	61%	Sustained	68%	Sustained	68%
Abala	Maintenance	48%	Sustained	56%	Sustained	59%
Chole	Maintenance	57%	Sustained	59%	Sustained	59%
Medebay Zana	Maintenance	70%	Sustained	67%	Sustained	68%
Tahtay Maychew	Maintenance	71%	Sustained	74%	Sustained	75%
Bore	Maintenance	56%	Sustained	58%	Sustained	59%
Fogera	Maintenance	74%	Sustained	0%	Sustained	0%
Bena Tsemay	Maintenance	42%	Sustained	71%	Sustained	70%
Dawo	Maintenance	55%	Sustained	52%	Sustained	52%
Ganta Afeshum	Maintenance	74%	Sustained	75%	Sustained	77%
Gimbo	Maintenance	45%	Sustained	50%	Sustained	50%
Kiremu	Maintenance	58%	Sustained	62%	Sustained	63%
Meta	Maintenance	51%	Sustained	49%	Sustained	50%
Mulo	Maintenance	47%	Sustained	51%	Sustained	52%
Ankober	Maintenance	72%	Sustained	76%	Sustained	76%
Saya Debirna Wayu	Maintenance	65%	Sustained	63%	Sustained	64%
Girawa	Maintenance	51%	Sustained	52%	Sustained	53%
Abe Dongoro	Maintenance	52%	Sustained	54%	Sustained	54%
Amuru	Maintenance	58%	Sustained	61%	Sustained	62%
Dembecha	Maintenance	73%	Sustained	78%	Sustained	79%
Shebe Senbo	Maintenance	52%	Sustained	53%	Sustained	53%
Lay Gayint	Maintenance	83%	Sustained	0%	Sustained	0%
Angolala Tera	Maintenance	73%	Sustained	75%	Sustained	76%
Gomma	Maintenance	56%	Sustained	69%	Sustained	70%
Goro Gutu	Maintenance	55%	Sustained	55%	Sustained	56%
Gambella Zurya	Maintenance	58%	Sustained	60%	Sustained	58%
Janamora	Maintenance	74%	Sustained	73%	Sustained	74%
Kercha	Maintenance	55%	Sustained	55%	Sustained	55%
Sebeta Hawas	Maintenance	59%	Sustained	60%	Sustained	61%
Lome	Scale-up	54%	Sustained	61%	Sustained	62%
Arero	Maintenance	58%	Sustained	63%	Sustained	64%
Mojana Waderea	Maintenance	72%	Sustained	73%	Sustained	74%
Tahtay Adyabo	Maintenance	66%	Sustained	74%	Sustained	75%

Berbere	Maintenance	55%	Sustained	58%	Sustained	59%
Menz Mama Midir	Maintenance	74%	Sustained	75%	Sustained	77%
Deberelibanos	Maintenance	51%	Sustained	59%	Sustained	59%
Mereb Lehe	Maintenance	75%	Sustained	77%	Sustained	79%
Beyeda	Transition	78%	Sustained	92%	Sustained	95%
Goro Dola	Transition	74%	Sustained	71%	Sustained	72%
Hababo Gudru	Maintenance	62%	Sustained	66%	Sustained	67%
Kore	Scale-up	51%	Sustained	53%	Sustained	53%
Dengila	Maintenance	66%	Sustained	70%	Sustained	71%
Tena	Maintenance	56%	Sustained	67%	Sustained	68%
Bele Gasegar	Maintenance	76%	Sustained	79%	Sustained	80%
Gishe	Maintenance	70%	Sustained	71%	Sustained	72%
Kamashi	Maintenance	86%	Sustained	82%	Sustained	83%
Limu	Transition	45%	Sustained	44%	Sustained	44%
Elidar	Transition	0%	Sustained	23%	Sustained	24%
Gelana	Maintenance	49%	Sustained	51%	Sustained	52%
Homosha	Transition	74%	Sustained	76%	Sustained	77%
Libokemkem	Maintenance	76%	Sustained	0%	Sustained	0%
Bahir Dar Zuria	Maintenance	66%	Sustained	77%	Sustained	79%
Banja Shekudad	Maintenance	66%	Sustained	71%	Sustained	71%
Lare	Scale-up	40%	Sustained	63%	Sustained	61%
Saba Boru	Maintenance	48%	Sustained	57%	Sustained	58%
Arbaminch Zuriya	Transition	0%	Sustained	26%	Sustained	26%
Enderta	Transition	50%	Sustained	79%	Sustained	79%
Yalo	Transition	0%	Sustained	11%	Sustained	11%
Misrak Este	Transition	73%	Sustained	102%	Sustained	102%
Hambela Wamena	Transition	52%	Sustained	80%	Sustained	80%
Dali Fage	Transition	0%	Sustained	12%	Sustained	12%
Girja	Transition	53%	Sustained	80%	Sustained	80%
Kola Temben	Transition	58%	Sustained	82%	Sustained	82%
Meda Welabu	Maintenance	51%	Sustained	115%	Sustained	120%
Huka (Halu)	No PEPFAR Support	78%	Sustained	105%	Sustained	105%
Mao Komo Sp. Woreda	Transition	25%	Sustained	42%	Sustained	42%
Wantawo	Maintenance	0%	Sustained	14%	Sustained	14%

Table A.2 ART Targets by Prioritization for Epidemic Control

Prioritization Area	Total PLHIV	Expected current on ART (APR17)	Additional patients required for 80% ART coverage	Target current on ART (APR FY18) TX_CURR	Newly initiated (APR FY 18) TX_NEW	ART Coverage (APR 18)
Attained	145,039	117,095	**387**	131,364	17,609	**91%**
Scale-Up Saturation	215,270	170,432	**3,937**	196,933	31,605	**91%**
Scale-Up Aggressive	**181,934**	**92,106**	**55,260**	**105,370**	**16,651**	**58%**
Sustained	**97,110**	**57,208**	**21,451**	**57,455**	**1,296**	**59%**
Central Support	**19,206**	**0**	**NA**	**0**	**0**	**NA**
Military	**NA**	**8,435**	**NA**	**8,933**	**717**	**NA**
Total	**661,716**	**445,276**	**83,392**	**500,054**	**67,878**	**75%**

Table A.3: Targets for OVC and Linkages to HIV Services

SNU	Estimated # of Orphans and Vulnerable Children	Target # of active OVC (FY18Target)	Target # of active beneficiaries receiving support from PEPFAR OVC programs whose HIV status is known in program files (FY18 Target)
Adama Town	84,019	11,547	1,244
Bahir Dar Liyu	78,173	10,744	1,157
Dese Town	83,384	11,460	1,234
Hawassa Town	70,011	9,622	1,036
Gondar Town	89,597	12,314	1,326
Dire Dawa Town	36,381	5,000	538
Woldiya Town	37,436	5,145	554
Jimma Town	81,473	11,197	1,206
Asela Town	16,430	2,258	243
Shashemene Town	36,584	5,028	541
Bishoftu Town	64,306	8,838	952
Debre Markos Town	72,429	9,954	1,072
Kombolcha Town	42,202	5,800	625
Ambo Town	49,507	6,804	733
Nekemte Town	81,530	11,205	1,207
Sodo Town	56,454	7,759	836
Mizan Aman Town	28,246	3,882	418
Arbaminch Town	30,865	4,242	457
Dila Town	55,862	7,677	827
Yirga Alem Town	15,738	2,163	233
Mojo Town	39,153	5,381	579
Woliso Town	19,253	2,646	285
Debre Birhan Town	53,036	7,289	785
Metema	11,351	1,560	168
Goba Town	38,032	5,227	563
Debre Tabor Town	23,269	3,198	344
Hosaena Town	13,599	1,869	201
Adigrat Town	33,798	4,645	500
Finote Selam Town	19,027	2,615	282
Kobo Town	23,436	3,221	347
Batu (Ziway) Town	40,295	5,538	596
Sebeta Town	15,513	2,132	230
Bichena Town	16,182	2,224	240
Adwa Town	22,549	3,099	334
Butajira Town	16,553	2,275	245

Shewa Robit Town	33,798	4,645	500
Lalibela Town	21,777	2,993	322
Bure Town	24,084	3,310	356
Kalu	12,784	1,757	189
Dengila Town	17,295	2,377	256
Kemisie Town	22,294	3,064	330
Agaro Town	23,029	3,165	341
Adet Town	18,372	2,525	272
Dembia	11,766	1,617	174
Burayu Town	29,393	4,040	435
Debark Town	13,686	1,881	203
Nifas Mewcha Town	9,139	1,256	135
Bati Town	11,867	1,631	176
Dukem Town	12,537	1,723	186
Mekaneyesus Town	31,578	4,340	467
Dejen Town	12,158	1,671	180
Yirgachefe Town	11,409	1,568	169
Dugda	36,606	5,031	542
Durame Town	7,691	1,057	114
Chencha	14,552	2,000	215
Areka Town	18,241	2,507	270
Adi Haki	7,291	1,002	108
Addis Ketema Woreda 4	14,712	2,022	218
Addis Ketema Woreda 5	10,740	1,476	159
Addis Ketema Woreda 9	18,219	2,504	270
Akaki Kality Woreda 2	34,034	4,677	504
Akaki Kality Woreda 3	6,243	858	92
Akaki Kality Woreda 4	4,082	561	60
Akaki Kality Woreda 5	4,388	603	65
Akaki Kality Woreda 6	3,107	427	46
Akaki Kality Woreda 7	4,002	550	59
Akaki Kality Woreda 8	4,679	643	69

Akaki Kality Woreda 9	3,274	450	48
Arada Woreda 1	34,538	4,747	511
Arada Woreda 10	5,152	708	76
Arada Woreda 2	6,636	912	98
Arada Woreda 3	5,515	758	82
Arada Woreda 4	5,959	819	88
Arada Woreda 5	4,751	653	70
Arada Woreda 6	2,146	295	32
Arada Woreda 7	6,076	835	90
Arada Woreda 8	1,106	152	16
Arada Woreda 9	1,288	177	19
Ayder	9,866	1,356	146
Gulele Woreda 1	5,952	818	88
Gulele Woreda 10	6,701	921	99
Gulele Woreda 2	5,959	819	88
Gulele Woreda 3	5,959	819	88
Gulele Woreda 4	5,588	768	83
Gulele Woreda 5	6,236	857	92
Gulele Woreda 6	6,221	855	92
Gulele Woreda 7	13,017	1,789	193
Gulele Woreda 8	4,278	588	63
Gulele Woreda 9	8,622	1,185	128
Hawilti	6,017	827	89
Kedamay Weyane	5,566	765	82
Kirkos Woreda 1	2,772	381	41
Kirkos Woreda 10	2,481	341	37
Kirkos Woreda 11	2,423	333	36
Kirkos Woreda 2	2,576	354	38
Kirkos Woreda 3	2,598	357	38
Kolfe Keraniyo Woreda 1	15,331	2,107	227
Kolfe Keraniyo Woreda 10	7,924	1,089	117
Kolfe Keraniyo Woreda 11	7,902	1,086	117
Kolfe Keraniyo Woreda 12	7,844	1,078	116
Kolfe Keraniyo Woreda 13	7,138	981	106
Kolfe Keraniyo Woreda 14	3,878	533	57

Kolfe Keraniyo Woreda 15	4,358	599	65
Kolfe Keraniyo Woreda 4	4,329	595	64
Kolfe Keraniyo Woreda 5	11,758	1,616	174
Kolfe Keraniyo Woreda 6	8,062	1,108	119
Kolfe Keraniyo Woreda 7	2,590	356	38
Kolfe Keraniyo Woreda 8	6,738	926	100
Kolfe Keraniyo Woreda 9	2,954	406	44
Quiha	10,470	1,439	155
Semen	10,165	1,397	150
Yeka Woreda 1	1,179	162	17
Yeka Woreda 10	1,310	180	19
Yeka Woreda 11	953	131	14
Yeka Woreda 12	1,288	177	19
Yeka Woreda 13	902	124	13
Yeka Woreda 2	1,113	153	16
Yeka Woreda 3	1,135	156	17
Yeka Woreda 4	1,106	152	16
Yeka Woreda 5	1,244	171	18
Yeka Woreda 6	1,128	155	17
Yeka Woreda 7	946	130	14
Yeka Woreda 8	1,077	148	16
Yeka Woreda 9	1,490	167	18
Hadinet	38,728	4,000	431
Alamata Town	38,728	4,000	431
Total	**2,384,267**	**325,000**	**34,996**

APPENDIX B

B.1 Planned Spending in 2017

Table B.1.1 Total Funding Level

Applied Pipeline	New Funding	Total Spend
$US12,729,590	$US144,599,160	$US157,328,750

Table B.1.2 Resource Allocation by PEPFAR Budget Code (new funds only)

PEPFAR Budget Code	Budget Code Description	Amount Allocated
MTCT	Mother to Child Transmission	$3,554,493
HVAB	Abstinence/Be Faithful Prevention	$6,952
HVOP	Other Sexual Prevention	$15,487,575
IDUP	Injecting and Non-Injecting Drug Use	$0
HMBL	Blood Safety	$697,693
HMIN	Injection Safety	$33,450
CIRC	Male Circumcision	$954,737
HVCT	Counseling and Testing	$13,269,550
HBHC	Adult Care and Support	$16,980,726
PDCS	Pediatric Care and Support	$3,830,973
HKID	Orphans and Vulnerable Children	$13,229,711
HTXS	Adult Treatment	$49,749,684
HTXD	ARV Drugs	$32,109
PDTX	Pediatric Treatment	$4,151,810
HVTB	TB/HIV Care	$4,181,052
HLAB	Lab	$3,351,955
HVSI	Strategic Information	$3,234,432
OHSS	Health Systems Strengthening	$3,088,220
HVMS	Management and Operations	$8,764,038
TOTAL		**$144,599,165**

B.2 Resource Projections

Resource needs for program activities in the coming implementation year were identified in an iterative process during COP preparation.

The budget calculation followed the four budget categories, namely, Target Based Budgeting, Activity based Budgeting, commodity based budgeting and M&O. We used IM TBB and PBAC tools to calculate the budget based on the above categories. As an initial step, targets were set by SNU categorization. Once SNU targeting was complete, IM allocations were set. To determine the TBB, the team defined Unit Budgets (UBs) based on the 2016 Expenditure Analysis and changes to service packages. Once this process was complete, the commodity and the Management and Operations

budgets were added; and finally the activity based budget. The process took into consideration the required earmarks for OVC, and care and treatment.

Adjustments to Adult ART budget mapping tables were made qualitatively, as designed, with interagency agreement. Once preliminary budget codes were derived from PBAC, final iterations were completed at senior interagency level to rationalize the final budget.

Appendix C: Section 6.0 Tables: Program Support Necessary to Achieve Sustained Epidemic Control - Please refer to the attached document submitted in both Excel and PDF formats.

Appendix D: HRH Surge Strategy for Regional Health Bureaus - Please refer to the attached document submitted in PDF format.

Appendix E: PEPFAR Ethiopia HMIS Summary and Way Forward - Please refer to the attached document submitted in PDF format.

CONSTRUCTION ACTIVITY (USAID)					**Ethiopian Health Infrastracture program for water**		**3,899,800**	**17856**	
					Ethiopian Health Infrastracture program for Engineering services		**1,460,000**	**18241**	
					Ethiopian Health Infrastracture program for construction		**2,849,750**	**18242**	
CONSTRUCTION ACTIVITY (CDC - STATE/AF)					**Infrastructure Development for Health System Strengthening: ongoing construction projects**		**4,000,000**	**14267**	
Table 6.1.1 Key Programmatic Gap #1: Insufficient identification of new HIV+									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Limited capacity, inadequate partnerships and poor coordination at community level and between community and clinics to assure identification and linkage of every PLHIV	Improved effectiveness of identifying PLHIV in the community and linking to facility services, including treatment in priority SNUs	1. MOUs established between major facility/community/GOE stakeholders, including RHBs, town FHAPCO, PLHIV Associations, CSOs on common standards and strategies to identify/test/link high risk groups in communities 2. Baseline assessment of availability and distribution of community testing sites using geospatial methods 3. Community HIV testing protocols developed and service providers trained	1. Results from rapid assessment of service delivery implementation inform program improvements 2. Expand and improve quality of community testing sites based on demand and results from baseline assessment 3. TA provided based on QI/QA findings to address quality gaps in community services	1. # of high risk clients who are tested at established community level testing sites 2. % of identified positive cases that are linked in the community to the facilities for treatment 3. # of MOUs and formal agreements put in place between community/facility/government stakeholders	1. Develop MOUs between major facility/community/GOE stakeholders, including RHBs, town FHAPCO, PLHIV Associations, CSOs on common standards and strategies to identify/test/link high risk groups in communities 2. Initial activities related to increasing knowledge/capacity of high risk population groups in communities to seek testing and other HIV services 3. Develop training protocol and build capacity of community level service providers 4. Use geo-spatial methods to identify high load facilities and high risk groups to locate and establish community level testing sites 5. Roll out community level testing of high risk groups in priority SNUs	HBHC PDCS HTXS PMTCT HVOP OHSS HVSI	71,054 5,183 2,591 0 12,215 27,483 21,376	17825 (Community TBD)	Service Delivery, 4.4
GoE allocation of RTK by non-epi criteria and not in the community for KP and PP	Increased availabiilty of community testing sites as an integral component of the GOE's health care system	Increased availablity and targeted distribution of test kit and condoms in prioritized community settings for KP and PP	Increased availablity and targeted distribution of test kit and condoms in prioritized community settings for KP and PP	1. Program monitoring data on number of KP/PP tested and number of positives identified 2. Number of condoms distributed; number of condom outlets put in place	1. Procure, manage supply of, and distribute condoms and other HIV test kits 2. Train community level providers to provide targeted services	HVOP	100,000	18519 (PSI)	Commodity Security, 6.88
Testing in low prevalence populations exhausting HIV RTKs	Reduced risk behaviour among KP/PP and increased access to HTC and treatment services in the community	Innovative service delivery and BCC approaches tailored to KP/PP scaled up in priority SNUs	Innovative service delivery and BCC approaches tailored to KP/PP expanded to additional scale up SNUs	Program monitoring data on number of KP and PP reached with behavioural and biomedical services	Conduct bench mark anlysis risk taking behaviors among KP/PP to inform program design and implementation	HVOP	90,000		Quality management, 1.62
Insufficient innovative methods to identify HIV-positives	Enhanced external quality assurance system in HTC service delivery outlets in the community providing clinical service to MARPs	Greater than 50 % of communtiy testing sites receive quarterly EQA	Greater than 80 % of community testing sites received EQA quarterly	1. Program data 2. Number of HTS sites in which EQA was conducted by RHB and received results 3. Number of HTS sites providing testing services per national guidelines	1. Provide TA to RHBs to include community level service outlets in their quarterly EQA planning and supervision 2. Train lab technicians on HIV testing per national guidelines	HVCT	64,000		Quality management, 1.62
Insufficient innovative methods to identify HIV-positives	Improved community health system to expand and provide innovative testing approach mix, such as, but not limited to HIVST	Greater than 75% of KP/PP in prioritized SNUs reached recieve HIV testing services	Greater than 95% of KP/PP in prioritized SNUs reached recieve HIV testing services	1. Program data 2. number of KP/PP tested through different testing approaches	1. Expand HIV ST service for KP /PP in DIC, thorugh outreach in priority SNUs 2. Train community based health care providers to provide testing services 3. Establish supportive supervision and monitoring protocols for new approaches	HVCT HVOP	81,000 162,000	18519 (PSI)	Service delivery, 4.4
Inadequate partnerships and coordination among/between CSO, law enforcement bodies, and clinical services to GBV victims, including HIV services	Law enforcement/CSOs are aware and responsive to GBV services, policies, and appropriately link victims to HIV services after screening	1. IEC materials developed, adopted, and disseminated 2. Gender-sensitive forums created in priority SNUs 3. Creation of referral system for GBV	1. Robust referral system in place linking GBV victims to aprropriate clinical and social services 2. Law enforcement/CSOs to have mainstreamed GBV standards in their provision of services and referrals	Program monitoring data	1. Develop IEC materials on GBV to sensitize target populations 2. Create forums to link target groups with stakeholder groups working on GBV and gender/health issues 3. Referral system put in place between CSO/law enforcement and clinical	HBHC	3,158	17825 (Community TBD)	Civil Society engagement, 4.0 Service delivery, 4.4
Capacity building of ENDF blood banks and Transfusion centers through training, technical support in Blood banking and blood transfusion and equipment and reagent supply.	#4	ENDF will have self sustained two blood banks and 5 transfusion centers	Two blood banks and three transfusion centers established and functional. Signed Transition plan will be in place.	The remaining two transfusion centers will be established where by ENDF will have complete and fully networked blood banks and transfusion centers who can remotly reading eachother in blood component processing and testing ENDF will take over some of the program costs, like IT support, Equipment maintenance support, Blood sample transfer	1. Equipment,supplies and reagent support 2. Blood processing software support 3. Technical support by HQ blood experts from U.S. Navy blood peogram 4.Trainings; 5. Internet and data link support to network all blood banks and transfusion centers to enable them exchange data and manage data at the central bllod bank.There are also activities droped from PEPFAR support 1. IT support and maintenance 2. Medical equipment maintenance 3. Blood sample transfer	HMBL	$ 207,429	16798	Yellow

Testing in low prevalence populations; exhausting HIV RTK; GoE allocation of RTK by non-epi criteria	1. Changed government policy to allocate HIV RTK according to epi needs (Immediate! But definitely <3yrs). 2. Evidence based estimates of PLHIV at scale-up woredas for RTK quantification and distribution. 3. Identification of 90% of all PLHIV in Ethiopia in scale-up and aggressive scale-up <3yrs	95% of public facilities in Scale up SNUs have RTK for implementing targeted testing	100% of public facilities in Scale up SNUs have sustainable RTK and implemented targeted HTS	Proportion of supported facilities in scale up SNUs with sustainable availability of RTK and targeted HTS	Accelerate the implementation of targeted HIV testing with particular focus to scale up SNUs/20 Towns through sustaining, guiding, and monitor the CUC activities; advocacy to address stigma regarding HIV infection and advocacy and policy support to implement innovative testing approaches. Federal Ministry of Health (FMOH) has shown positive steps to prioritize kits to the twenty towns for the catch up campaign (CUC). However, the amount of kit and speed of change toward implementing targeted testing with the aim of detecting and linking new HIV infection to treatment is not to the required level. There is still need to provide policy guidance and enforcement on the implementation targeted testing; guide and support target based RTK quantification, distribution and site level utilization with the aim of detecting new infection. Moreover, addressing stigma and creating favorable policy environment, advocacy and support through FMOH is key for the implementation of evidence based innovative testing approaches in priority SNUs and in the country as a whole.	HVCT	61,644	17908 (FMOH)	NA
		71% of RHB have capacity to implement and monitor innovative and targeted testing in scale up SNUs	85% of RHB have capacity to implement and monitor innovative and targeted testing in scale up SNUs	Proportion of RHBs with technical capacity to implement and monitor innovative and targeted HTS	Build the technical capacity of all 11 RHBs and scale-up Woreda/Town personnel (with primary focus on the 20 Towns) to implement and regularly monitor targeted HTS in scale up SNUs, to achieve the first 90. Targeted testing program planning, implementation and monitoring technical capacity is critical to achieve the 1st 90%, which is an important entry point to the 2nd and 3rd 90% goals of UNAIDs. ICAP has been providing above site TA to the RHBs on this regard. However, from SIMS visits, partner monitoring meetings and periodic performance reviews, there are still capacity gaps in terms of: 1. using data for decision making; 2. using available evidences for geographic & population prioritization; 3. planning based on evidence and executing focused support to SNUs which could impact the overall effort to achieve epidemic control; and 4. regular review of results and taking corrective actions including ensuring sustainable availability of critical supplies (E.G. RTK). This activity will build the capacity of RHBs on planning, implementing and monitoring innovative and targeted HTS with particular focus to priority SNUs to help RHBs achieve PEPFAR targets and ultimately the UNAIDS 90, 90, 90 goals. Moreover, the activity will enhance program implementation and monitoring through capacity building on the use of age/sex disaggregation, monitoring performance and address unmet need; ensure data quality, linkage to treatment services as well as working toward attainment.	HVCT	394,635	16749 (CU_ICAP)	NA
Insufficient innovative methods to identify HIV-positives, HIV transmission networks, etc.	Identification of 90% of all PLHIV in Ethiopia in scale-up and aggressive scale-up <3yrs* Report published with strong evaluation of effectiveness of innovative methods for detecting new PLHIV in Ethiopia	Partner services endorsed and implemented in scale up SNUs by 5 RHBs	1. Number of RHBs implementing PNS 2. Number of PLHIV/STI partners elicited, notified and tested	1. Number of RHBs implementing PNS 2. Number of PLHIV/STI partners elicited, notified and tested	Provide TA to FMOH, RHBs and other stakeholders to implement a scalable partner notification services model in selected urban areas with large unmet need for case detection; establish active contact tracing and linkages to prevention and treatment services. HIV testing of STI and PLHIV partners through PN and referral, will increase HIV case detection and contribute to interrupting sexual transmission. Implementation of active PNS requires developing country specific PNS guidelines, SOPs, training packages/manuals and crafting implementation strategy that works to country specific context. Partner services in Ethiopia has been passive and any of the above tools are not in place to facilitate active PNS and linkage to HTS. Establishing the PNS system and having a network of trained cadres on PN, such as Disease Intervention Specialist (DIS) in US, will help facilitates systematic disclosure support to index cases and create demand for HTS among partners of PLHIV/STI patients and link them to testing. These cadre of trained providers will work with index cases to elicit the names of current or previous partners, actively follow-up with clients and their partners, notify and arrange best time and location for testing. This activity, as one of the innovative demand creation and linkage to testing services, has been started as pilot in COP 16. In addition to working with FMOH and RHBs to create conducive policy environment, Selected high case load facilities in Addis Ababa and Oromia regions will be used to pilot the program through the respective RHBs. In COP 17, the activity will be expanded to the rest of the facilities in 20 Priority Towns and standard implementation guidelines and tools will be developed.	HVCT	172,630	10559 (NASTAD)	NA

		75% of PLHIV in treatment and new detected positives provided with systematic disclosure support and 75% of them get their partners and HIV exposed children tested	85% of PLHIV on TX and new detected positives provided with systematic disclosure support and 85% of them get their partners and HIV exposed children (HEC) tested	Number of PLHIV on TX provided with assisted disclosure support, partners and HEC linked to and tested for HTS	Provide direct service to strengthen index case testing through disclosure support, stigma reduction, partner notification and linkage to HTS in all Scale up SNUs. This is a facility based targeted demand creation activity through systematically addressing the persisting stigma regarding HIV infection and facilitating disclosure, linkage to testing, and "Start" services. Systematic disclosure support and demand creation to HTS is one of the key activities to enhance testing uptake among index partners and HIV exposed children. This will be facilitated through building a site level system of proactive assisted disclosure support to all PLHIV on treatment, elicit the names of contacts and HIV exposed children (HEC) and link those who do not know their HIV status (or those with ongoing risk of acquiring HIV) to HTS. This targeted site level demand creation among high yield population groups will feed the catalytic innovative testing strategies; help to improve identification of previously undiagnosed PLHIV and augment facility based targeted PITC services. The implementation of the activity requires building skills on eliciting names and contact information of partners of index cases, providing disclosure support, linking partners and HIV exposed children to HTS and linking the positives to "Start" services. Peer HIV Case Managers (CMs) and adherence supporters (ASs), who are themselves PLHIV, and who know the needs of PLHIV more than anybody will be trained and supported to implement these activities at site level.	HVCT	100,000	18340 TBD (NEP+ follow on)	NA
Insufficient, reliable, subnational and local HIV epi data to target HIV testing and allow setting of proper targets	Avail comprehensive map of key population for targeted HIV testing in Ethiopia in <3yrs	Protocol developed, cleared, Data collection started	Data collection, write up and dissemination completed	Implementation status of the study	Undertake a study to understand the magnitude of repeat testers among HIV positive clients; to understand the yield difference b/n private and public facilities and to learn who are being tested in private vs public facilities. This study will help to better understand the existing HTS and inform HIV strategies relevant to identify previously undiagnosed PLHIV. This will help generate subnational and local HIV data to target HIV testing services and allow setting of proper targets in a setting where new HIV infections could be detected and linked to treatment. Evaluation questions expected to be answered by this evaluation include: 1. What is the magnitude of repeat testers among HIV positive clients in public vs private facilities? 2. Is there HIV testing yield difference between private and public facilities? 3. Who are being tested in private vs public facilities (by population group and residence)?	HVCT	77,056	13931 (FHAPCO)	NA
Persisting stigma regarding HIV infection inhibiting testing, disclosing, and 100% linkage to services	Catalyze a powerful coalition to address stigma leading to a 50% reduction in the HIV Stigma Index by 3 yrs.	Stigma reduction startegy guideline is developed/Adpted	Guideline distributed to all relevant stakeholders	Stigma reduction strategy gudeline	Use national platform to advocate for reduction of stigma and partner disclosure promotion. Adapt evidence based stigma reduction strategies. Documentation of best practices of stigma reduction activities that contribute to meet the 90-90-90 goals	HVOP	47,054	13931 (FHAPCO)	NA
Inadequate partnerships and coordination at community level and between community & clinics to assure identification and linkage of every PLHIV	Improve by at least one point on a 5-point scale the measurement on a Scorecard for Partnerships and Coordination of HIV-engaged Organizations at the Community Level within 3 yrs. [NOTE: One activity under this Outcome will be to either find or develop the tool.]	• Active coordination at 20 towns for implementation of HIV programs • Annual HIV prevention data summit • Revision of HIV package of services for KP & PP • Increased engagement of CSOs and PLHIV associations	• Effective coordination at 20 towns for implementation of HIV programs • Annual HIV prevention data summit • Revised HIV package of services for KP & PP is implemented • Effective engagement of CSOs and PLHIV associations	• Number of town level coordination meetings • Prevention data summit conducted • Revised HIV package of services for KP & PP • Number of meetings with CSOs & PLHIV associations	• Support to FHAPCO is a continuing activity. Coordination at national and subnational Wereda/ town levels with emphasis for the twenty towns is important to achieve the first 90. The focus will be on HIV prevention activities including CUP campaign to support the 90-90-90 strategy. The current coordination activities are weak & are not aligned with evolving PEPFAR geographic priorities. The coordination activities will be supported by national & subnational prevention TWGs. • Update the package of services for key and priority populations with introduction of new and innovative approaches such as partner services to improve HIV case detection. The existing HIV package of services for KP & PP/MARPs is outdated (2011) & lack new & innovative approaches that will help to improve HIV case detection. • Strengthen engagement of CSOs and PLHIV associations in planning, implementation and performance review. The current engagement of CSOs and PLHIV associations is inadequate. • Conduct annual prevention summit where local data are analyzed & best practices are shared. Previously the prevention summits were not aligned with PEPFAR geographic priorities & also didn't focus on data.	HVOP	85,000	13931 (FHAPCO)	NA
TOTAL for 6.1.1.							**1,785,508**		

Table 6.1.2 Key Programmatic Gap #2: Inadequate systems to assure linkage, retention, and virologial suppression for PLHIV

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Inadequate partnerships and coordination at community level and between community & clinics to assure identification and linkage of every PLHIV	1. FMOH/FHAPCO and community stakeholders owns and sustains well coordinated community/facility system 2. FMOH establishes or strengthens regional coordination mechanisms and regularly convenes review meetings and forums engaging community level HIV service implementers community and other stakeholders	1. TWG or other coordinating mechanism established; TOR drafted 2. TWG conducts at minimum quarterly supportive supervision at site level and provides on site feedback	1. TWG or other coordinating mechanism evaluates the effectiveness of referral system and provides recommendations for corrective action 2.FMOH expands coordinating partnership based on evaluation findings and needs in the community	Number of Community level major stakeholders (CCC, CC, Local NGOs, PLHIV networks, CSOs HEWs etc) whose capacity for coordination and collaboration of major HIV activities icreased	1. FMOH/FHAPCO establishes TWG or other coordinating mechanism 2. TOR developed 3. Forum created to bring together community/facility stakeholder groups and make aware, utilize, and monitor linkages to services	HBHC HTXS MTCT OHSS PDCS	106,728 1,649 0 14,841 3,298	17825 (Community TBD)	Planning and Coordination, 8.38
Insufficient innovative methods to identify HIV+ and HIV transmission networks	90% of KP/PP who are retained in treatment and adhere to treatment are virally suppressed	Retention and adherance rate among KP/PP living with HIV increased to 95% in DIC which provide treatment	Retention and adherance rate among KP/PP living with HIV increased to 95% in DIC which provide treatment	Program data (% of KP who adhere to treatment; % of KP LHIV virally suppresse; # ART adherence clubs established)	1. Establish KP/PP adherence clubs 2. Lay counsellors training to provide services in DICs in adherence clubs	HBHC	296,640	18519 (PSI)	Service Delivery, 4.4 Technical efficiency, 1.1
Insufficient innovative methods in private sector to identify & monitor PLHIV & exposed infants.	All PHSP-support PMTCT & ART service provider will have an acess to viral load for ART monitoring & Early infant Digonosis (EID) service through referals to networked sites.	80% of PHSP-supported PMTCT & ART service providers will have AN acess to viral load for ART monitoring & Early infant Digonosis (EID) service through referals to networked sites.	90% PMTCT & ART service provider Private facilites suppourted by PHSP will have AN acess to viral load for ART monitoring & Early infant Digonosis (EID) service through referals to networked sites.	1. Number of private health facilites with an improved acess for viral load & EID service. 2. Number of laboratories enrolled in PT & TB Microscopy EQA	1. Link private facilites for EID & viral load testing 2. Enroll selcted laboratories into EQA	HLAB	13,881	17824 (Abt)	Quality Management, 1.62
Lack of policy change to allow new differentiated, patient-centered models of care	1. FHAPCO leads implementation of the new WHO-adopted innovative community servcie delivery models in all priority SNUs 2. All community stakeholders implement the new community service guidelines as service of care	1. Support FHAPCO's efforts to reconvene the TWG members 2. Revised TOR includes collection, revision, and adoption of community service guidelines to align with updated WHO standards	1. Develop, publish, and disseminate training materials, guidelines to all RHBs in priority SNUs 2. Reconvened TWG provides will monitor availability and implementation of guidelines	Number of Community service outlest that have the revised community service deliver guidelines available on site for use. Number of Regions and SNU implementing and reporting interventions in line with the new service delivery models as a standard of care	1. Provide technical assistance to FHAPCO to review existing community based HIV prevention, care and treatment guideline for PLHIV based on international standards 2. Support publication and distribution of updated guidelines 3. Strengthen coordination and collaboration among community level major stakeholders	HBHC HTXS MTCT OHSS PDCS	65,570 1,140 0 10,260 2,281	17825 (Community TBD)	Policy and governance, 6.58
Weak referral and tracking of HIV-positive persons; Inadequate follow up for patients delayed or lost to follow up, including in community	1. Multi-directional referral system between facility and community and among various intervention points within communities (including social services) is functional, efficent, and available in 50% of major SNUs. 2. Community level referal tracking system digitalized and expanded nationally.	1. SOPs, guidelines, and service directory developed in priorty SNUs 2. Protocol and standards for multi-directional referral system developed 3. Electronic referral platform initiated	1. Service directory updated regularly 2. Effective and efficient multi-directional referral system in place, functioning, and routinely monitored 3. Implementation of Electornic (SMS) referral in at least 50% of prioritized SNUs	% of referred beneficiaries who access the continuum of HIV services	1. Create community/social and facility service directories utilizing GIS methods in priority SNUs 2. Forum created to bring together community/facility stakeholder groups and make aware, utilize, and monitor linkages to services	HBHC HTXS MTCT OHSS PDCS	101,578 1,539 0 13,852 3,078	17825 (Community TBD)	Service delivery, 4.4
Inadequate follow up for patients delayed or lost to follow up, including in community	A majority of community health care workers, PLHIV associations and religious leaders in priority SNUs play a leadership role in the national HIV response, including delivery of targeted HIV services	1. Baseline assessment of the type and mix of the community health services delivered through community health care workers/PLHIV associations/religious leaders conducted 2. Workplan developed in consultation with community associations focused on providing targeted TA and supportive supervision for comprehensive HIV service delivery 3. Targeted community based HIV services delivered in accordance with workplan and national standards	1. Quality of comprehensive HIV services provided by CHWs, PLHIV associations/religious leaders improved and regularly monitored 2. Scale up of high impact HIV services provided by CHWs, PLHIV, religious leaders in priority SNUs.	1. Number of functional community adherence support groups established 2. Number of PLHIV receiving ART through community service delivery models 3. Number of PLHIV supported with community based ART adherence support groups	1. Provide regularly mentoring and supportive supervision to peer PLHIV associations, religious organizations, and other community stakeholders to provide effective, high impact HIV services in the community 2. Tailor SOPs, job aids to community health workers, PLHIV associations, etc. in support of effective service delivery	HBHC HTXS MTCT OHSS PDCS	105,060 1,629 0 14,658 3,257	17825 (Community TBD)	Service delivery, 4.4

Lack of innovative, streamlined, patient-centered ART services	Streamlined, patient-centered ART service model implemented for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs	About 80 health facilities started APTS which is an innovative patient center phrmacy service. The plan is to increase this to other ART sites. About 90 hospital establish medicine resource centers and we want to increase to the remaining hospitals	1. 50 ART sites implement APTS 2. 10 hospitals establish DIS	1. APTS implementation report 2. DIS center establishement report	New: Scale up the implementation of Auditable Pharmaceuticals Transactions and Services (APTS) and Drug information services (DIS) to high volume ART sites and support ART pharmacies to implement patient centered pharmaceutical care	HTXS	750,000	18375 (PSM)	Technical efficiency, 1.11
Lack of innovative, streamlined, patient-centered ART services	Streamlined, patient-centered ART service model implemented for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs	LTF in quarter that were identified by Pharmacy management ranges from 2500 to 3000 per quarter. Most of these communicated to the clinics and adherenace support team on time to improve adherenace abd also retain on care	Reduced LTF by 80% from FY2015 bench mark	LTF report	New: Enhance ART adherence , reconsider innovative approach for increase period dispensing of ARVs for stable patients	HTXS	200,000	18375 (PSM)	Technical efficiency, 1.11
Lack of innovative, streamlined, patient-centered ART services	Streamlined, patient-centered ART service model implemented for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs	Improved quality of care and sustained viral suppression through real time dispensing. December 2015 to February 2016, reports collected from five hospitals (Debre Tabor, Debre Markos, Adare, Butajira and Felege Hiwor hospitals) indicates that a total of 127 medication errors were identified by pharmacists, all of which were corrected in consultation with prescribers - contributing towards improved quality of care and sustained viral suppression during real time dispensing	Improved quality of care and sustained viral suppression through real time dispensing	Adherence report	New: Provide support to reduce medication errors, strengthen rational medicine use and pharmacovigilance	HTXS	100,000	18375 (PSM)	quality Management, 1.62
Lack of innovative, streamlined, patient-centered ART services	Streamlined, patient-centered ART service model implemented for >90% of stable ART patients in saturation and aggressive scale-up sites in <3 yrs	50% of stable ART patients receive streamlined ART services	>90% of stable ART patients receive streamlined ART services	Program evaluation	Improved case detection and early initiation of treatment through contact tracing and linkage program using disease intervention specialists	HTXS	86,336	10559 (NASTAD)	NA
					HIV-positive peers are linked to newly identified patients and provide ongoing, routine, in-person practical and emotional support to patients at their homes, and address patient-specific barriers as they present, and enhance linkage		175,287	10559 (NASTAD)	
		At least 70 % of implementing sites deliver full continuum of quality care service provision and patients remain adherent	At least 85 % of implementing sites deliver full continuum of quality care service provision and patients remain adherent	SIMS findings, SQA	This mechanism will support and Implement site level CQI at health facilities to improve quality of ART service delivery. This includes planning, training of ART providers and the MDT, setting standards and implementing sites level activities with monitoring of performance at site level. It will work to strengthen the functioning of the site Multi-Disciplinary Team (MDT) at health facilities, support networking of services and catchment facilities and support Catchment Area Meetings (CAM) for a coordinated and linked program implementation and full continuum of care service provision for improved outcomes and impact. Printing and distribution of job aids, reference materials, guidelines and other tools contributes to improving quality of services, and standardizing the program and service provision.		30,000	13934(AACHB)	Quality Management
							30,000	16752 (ARHB)	
							30,000	13929 (DDRHB)	
							30,000	13770 (HRHB)	
							30,000	13794 ((ORHB)	
							30,000	16901 (SNNPRHB)	
							30,000	17000 (TRHB)	
							30,000	12319 (FPC)	
							30,000	16742 (NDFE)	
							30,000	18337(FPA)	
							30,000	18339 (FGAE)	
							30,000	10601 (AAU)	
							30,000	12321 (UoG)	
							30,000	10548 (JU)	
							30,000	10557 (MU)	
							30,000	16749 (ICAP)	
		80% of HIV+ people tested in the community referred and linked to ART services.	90% of HIV+ people tested in the community linked and referred to ART services.	% of people tested positive in the community referred and linked to ART services in the health facilities.	Provision of community level care and support services complementary to health facility; and support community level tracking and linkage of LTFU PLHIV to health facility services	HBHC	46,800	12306 (OSSHD)	Service Delivery (4.4 score)
Inadequate access to high quality HIV laboratory services, esp. VL	Quality-controlled VL testing with >98% provision of timely results for >90% of ART patients 6 months and above on ART in saturation and aggressive scale-up sites in <3 yrs	• 65% of PLHIV on ART for six months and above will receive at least one viral load result per year and will access other core HIV laboratory services (HIV rapid test, EID) • 85% of HIV testing points in PEPFAR priority sites will be enrolled in external quality assessment and 90% score acceptable results	• 75% of PLHIV on ART for six months and above will receive at least one viral load test per year and will access other core HIV laboratory services provided • 95% of HIV testing points in PEPFAR priority sites will be enrolled in external quality assessment and 95% score acceptable results	• Number of HIV patients on ART with at least one viral load test result per year as documented in patient chart/laboratory database • Number of sited enrolled in EQA their achievement	Regional Health Bureaus (RHBs), FGAE and Uniformed Services (Armed Forces, Federal Police and Federal Prison Administration) will continue to support the implementation of the scale-up of viral load testing as routine ART monitoring. The main activities include strengthening of viral load testing capacity of the laboratories (human resource including data clerks, laboratory infrastructure, optimal working schedule, arrangement of back-up system, coordination of specimen referral), address quality of viral load testing and EID, implementation of viral load and EID database and support laboratory-clinical interface for optimal use of viral load testing. Emphasis will be given to reducing turnaround time (TAT) for viral load test result delivery and monitoring and evaluation of the program. Maintaining quality of HIV rapid testing through implementation of standardized HIV rapid testing logbook, enrollment of HIV testing points in dried tube	HLAB	77,056	13934(AACHB)	Laboratory (Yellow)
							216,000	16752 (ARHB)	
							32,000	13929 (DDRHB)	
							28,000	13770 (HRHB)	
							200,000	13794 ((ORHB)	

				Implementation of standardized HIV rapid testing logbook, enrollment of HIV testing points in dried tube specimen (DTS)-based external quality assessment (EQA), supportive supervision, internal quality control, training and certification of testers and use of WHO quality manual for point of care testing is key activity. EQA for HIV rapid testing considers public, private and community testing sites. RHBs, FGAE and Uniformed Services		136,000	16901 (SNNPRHB)
						84,000	17000 (TRHB)
						15,200	12319 (FPC)
						30,000	16742 (NDFE)
						7,704	18337 (FPA)
						23,117	18339 TBD (FGAE follow on)
						104,831	16749(ICAP)
	• 65% of PLHIV on ART for six months and above will receive at least one viral load result per year and will access other core HIV laboratory services (HIV rapid test, EID) • 85% of EID test results will be returned back to facilities within acceptable TAT	• 75% of PLHIV on ART for six months and above will receive at least one viral load test per year and will access other core HIV laboratory services • 95% of EID test results returned to facilities within acceptable TAT	• Number of HIV patients on ART with at least one viral load test result per year as documented in patient chart/laboratory database • EID test results returned to sites in acceptable TAT	Ethiopian Public Health Institute (EPHI) will lead and coordinate the national laboratory program to improve access to quality laboratory services for viral load, EID and HIV rapid testing. EPHI will continue to enroll laboratories in international and national external quality assessment, provide national leadership role in implementing quality assurance for HIV rapid testing and strengthen capacity of viral load and EID testing through training and mentorship of testers and preventive and curative maintenance of equipment. EPHI will also support implementation of viral load and EID database in Federal Hospitals and sites of Uniformed Services and maintains national database for viral load and EID. EPHI will pilot and expand point of care (POC) test for viral load and EID. It will implement comprehensive laboratory quality tool to monitor quality of viral load and EID testing. The tool helps to assess the laboratory process, procedures, work flow and functionality of equipment and other parameters that directly affect quality of viral load test results.	HLAB	400,000	16751 (EPHI)
	• Integrated specimen referral network strengthened with 80% of all PEPFAR supported sites included in the network • 85% of results from referral testing will reach facilities in acceptable TAT 65% of ART sites having access to quality VL, EID, CD4, GeneXpert, TB culture and DST test onsite or through sample referral network	• Integrated specimen referral network strengthened with 95% of PEPFAR supported sites included in the network • 95% of test results from referral testing will reach facilities in acceptable TAT 90% of ART sites having access to quality VL, EID, CD4, GeneXpert, TB culture and DST test onsite or through sample referral network	• Number of HIV patients on ART with at least one viral load test result per year as documented in patient chart/laboratory database • Percentage of test results returned to facilities in acceptable TAT • Percentage of PEPFAR supported sites reached through specimen referral system	EPHI will coordinate the national integrated specimen referral system to increase access to quality of laboratory services to effectively support the national ART program. Specimen referral network is key for implementation of viral load and EID scale-up plan. This will include transportation of DBS specimens for viral load and EID. Formal agreement is in place between EPHI and Ethiopian Postal Services Enterprise (EPSE) to transport specimen and return of results back to the facilities in timely manner. EPHI will train the postal workers and laboratory personnel on collection, packaging, transportation and safety during handling of specimens. Sites will be supplied with standard specimen transportation containers equipped with cold chain system. EPHI will collaborate with RHBs and other implementing partners to monitor the implementation of the specimen referral network. EPSE will use standardized logbook for tracking of specimen including time of pick-up and delivery of specimens. The specimen referral network will be optimized based on geographic proximity rather than regional boundary to bring efficiency and effectiveness in to the system. Emphasis will be given to monitoring the turnaround time and quality of specimen during transportation. The frequency of specimen transportation will be adjusted based on the number of patients on ART in a facility. Optimal utilization of the specimen referral network will significantly increase access to quality viral load and EID testing services across the country.	HTX	2,100,000	16751 (EPHI)
	• 65% of PLHIV on ART for six months and above will receive at least one viral load result per year and will access other core HIV laboratory services (HIV rapid test, EID) • 85% of PEPFAR priority sites directly supported by ICAP will be enrolled in HIV rapid test EQA and 90% achieve acceptable result	• 75% of PLHIV on ART for six months and above will receive at least one viral load test per year and will access other core HIV laboratory services provided • 95% of PEPFAR priority sites directly supported by ICAP will be enrolled in HIV rapid test EQA and 95% achieve acceptable results	• Number of HIV patients on ART with at least one viral load test result per year as documented in patient chart/laboratory database • Number of sites enrolled in EQA for HIV rapid test and the score	ICAP will provide above site technical support to seven Regional Health Bureaus (RHBs). ICAP's focus in seven RHBs will be building capacity of the RHBs to lead regional laboratory program on viral load testing and EID, quality assurance of HIV rapid testing and continuous laboratory quality improvement and monitoring and evaluation of the laboratory program. These includes establishing systems, skill transfer for the regional program managers, developing laboratory quality monitoring tools and support laboratory program data collection and use of data for improving quality of laboratory services. ICAP will also provide technical support for development of national guidelines and will play critical role in national and regional technical working groups. In addition, ICAP will strengthen the implementation of viral load and EID database for real time data collection and reporting. ICAP will continue to support optimal utilization of viral load testing capacity through proper training of staff, creating network of viral load testers, provision of power stabilizers and back-up power with automatic switch capacity. ICAP will also support establishment of cold storage capacity at testing laboratories and support air conditioning systems for optimal operation of viral load machines. In four emerging regions, ICAP will provide site level technical support to strengthen and establish capacity for the implementation of the scale-up of viral load testing as routine ART monitoring. ICAP will continue site level support to increase access to quality viral load testing and EID. It will work to address quality of HIV rapid test through implementation of HIV rapid test logbook, enroll all testing points in priority SNUs in external quality assessment program, and facilitate implementation of internal quality control procedures and site supervision. In addition, ICAP will strengthen specimen referral system working with EPHI, RHB and EPSE and the implementation of viral load and EID database at Gambella viral load testing site.	HLAB	124,831	16749 (CU ICAP)

		• Pilot implementation of POCs completed and plan for expansion of POC test finalized • Twenty laboratory assessors trained and certified and 16 laboratories receive external auditing	• POC for viral load and EID expanded to 15 high case load facilities • Forty laboratory assessors from national and regional reference laboratories trained on laboratory auditing and 40 laboratories receive external audit. • Lot testing capacity established at FMHACA	Quarterly progress report by the partner on key achievements	African Society of Laboratory Medicine (ASLM) will support EPHI in piloting and expansion of point of care technologies for viral load and EID. ASLM will provide laboratory auditor training and do external assessment of laboratories to support continuous laboratory quality improvement with focus on viral load and EID testing sites. It will also provide support to strengthen implementation of laboratory information system (LIS) in high case load facilities to improve quality of laboratory services and for real time data reporting. To reduce TAT for viral load test result return, ASLM will support the national implementation of electronic test requisition and result reporting system at high HIV case load facilities. This requires use of the existing LIS and installation of simplified LIS at testing sites and connecting the specimen referring sites based on assigned network of specimen referral. Verification of quality of HIV rapid test kits before the kits get distributed to sites and randomly checking quality of test kits after distribution at a regular interval are very important components of addressing quality of HIV rapid testing. Such systems are not currently in place and the regulatory authority has no such capacity. ASLM will work with the national regulatory agency (Ethiopian Food, Medicine and Health Administration and Control Authority-FMHACA) to establish lot testing and post market surveillance for HIV rapid test kits.	HLAB	200,000	16779 (ASLM)	
		• Two viral load testing laboratories will receive international accreditation	• Four laboratories will receive international accreditation and at least 10 EPHI and regional laboratory are trained and mentored on the use and interpretation of laboratory standards	Number of laboratories accredited from national program data	Clinical Laboratory Standards Institute (CLSI) will provide technical assistance to EPHI and Regional laboratories for implementation of laboratory quality management system (mentoring national and selected regional reference laboratories for ISO accreditation, training of laboratory personnel on the use and interpretation of laboratory standards). The focus is to move viral load and EID testing laboratories towards international (ISO) accreditation. The activity has a spillover effect for the other high case load laboratories. The standards, SOPs and job aids developed and skill transferred to EPHI and regional laboratories can easily support laboratories in priority sites.	HLAB	64,000	10515 (CLSI)	
		• 50% of ART sites have access to GeneXpert test through sample transportation mechanism • All GeneXpert sites have trained lab staff	• 100% of ART sites in the prioritized SNUs have access to GeneXpert and TB culture and DST test through sample transportation mechanism	# lab staff received TOT training; # of sites networked with GeneXpert test service. # of service interruption events at the GeneXpert/TB Culture sites, QA coverage, Average turnaround time for TB diagnostic tests.	TB is one of the leading causes of morbidity and mortality among PLHIV in Ethiopia. TB contribute to HIV disease progression among PLHIV if not addressed in a timely manner. Timely diagnosis of TB and drug resistant TB among PLHIV and linkage to TB treatment is crucial TB/HIV intervention to reduce TB associated morbidity and mortality among PLHIV and ensure viral suppression among HIV positive TB cases who are on ART contributing to the third 90 goal. EPHI's TB lab capacity building and TA support to the regional labs is key for improving access to quality assured TB diagnostic tests. EPHI will also support scale up of more sensitive and rapid diagnostic services such as GeneXpert to improve TB case finding among PLHIV. EPHI will maintain quality of TB culture and DST service at the regional labs to strengthen TB and Drug resistance TB diagnosis and treatment monitoring. The lab capacity building support also help to exclude active TB among PLHIV with presumptive TB cases there by improving uptake of TB prevention Treatment (TPT). The lab capacity building activities supported by EPHI include training, Technical assistance and mentorship to the regional labs, equipment and supply procurement/maintenance, lab biosafety interventions, quality assurance, sample transportation system, program management (supportive supervision and review meetings); development/revision of lab test guidelines/SOPs/job aids; revision of training manuals, Lab panel preparation. Short term outcome: improved capacity and access to quality assured TB lab diagnostic service; Reduced time for diagnosing TB among PLHIV. Long term outcome: reduced TB associated morbidity and mortality among PLHIV.	HVTB	250,000	16751 (EPHI)	
Inadequate follow up for patients delayed or lost to follow up, including in community	Greater than 90% retention at 24 months for all adults and children on ART by 3 yrs from implementation of COP16	85% retention at 24 months.	88% retention at 24 months.	program reports (HMIS)	Strengthen site level capacity for patient tracing and linkage between facility and community	HTXS	1,085,295	TBD (NEP+ follow on)	6. Service Delivery (4.4 score)
					Strengthen case management services to proactively identify and manage patients at-risk for LTFU	HTXS	1,373,514	TBD (NEP+ follow on)	
					Strengthen patients follow-up during pretreatment time through provision of peer support and tracking of patients who missed their appointment	HTXS	723,530	TBD (NEP+ follow on)	

		HIV/AIDS related patient level information systems maintained by Facilities and used to inform the performance of HIV/AIDS programs	• HIV/AIDS related patient level information systems maintained and made interoperable with DHIS2	• Partner progress report • Site level data report	The budget will be used to build the capacity of the RHBs and uniformed services in the implementation of HIV patient level information system (EMR, MRU, ART module) at selected high load health facilities supported by PEPFAR under the respective RHBs. This system is critical for HIV/AIDS patient monitoring and reporting of PEPFAR indicators including disaggregation of HIV testing data by outlets and modalities at health facilities. The system will also reduce patient waiting time, improve data quality and quality of service and will also serve as a platform for HIV Case- Based surveillance in selected facilities. Through this mechanism of RHBs and uniformed service facilities, PEPFAR-Ethiopia will support the smooth transition of the existing electronic health information systems (eHMIS) core to the HIV response to new DHIS2 supported through the Data Use Partnership to ensure the reporting of HIV/AIDS data to PEPFAR. This mechanism will strengthen the paper based Health Management Information System (HMIS) at the RHBs through, hiring and deployment of HMIS staff to ensure integration of HIV data into the HMIS reporting system. This will also support the provision by the respective regional health bureaus of supportive supervision, review meeting, trainings and gap filling printing of HIV/AIDS related registers and formats for facilities. Since these systems capture patient level data, they directly affect the information on the levels of the three 90s	HVSI	39,584 50,000 7,935 7,935 50,000 40,000 34,518 16,388 45,054	13934(AACHB) 16752 (ARHB), 13929 (DDRHB), 13770 (HRHB), 13794 ((ORHB), 16901(SNNPRHB) 17000 (TRHB) 12319 (FPC) 16742 (NDFE)	
TOTAL for 6.1.2.								**10,165,853**	

Table 6.1.3 Key Programmatic Gap #3: Inadequate domestic spending to support sustained HIV care and treatment

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Limted capacity & coordination of regional helath bureaus & PFSA to link private facilites to national supply chain management system	Improved capacity of PFSA & RHBs to suppourt private facilites enrollment in to national supply chain management system	Regional helath bureaus & PFSA will be able to suppourt 80 % of PHSP suppourted facilites through onsite mentoring & inservice training for on product quantification & forecast , proper requesting & reporting of medicines/ Supplies data & proper disposal of expired commodites.	Regional helath bureaus & PFSA will be able to suppourt 90 % of PHSP suppourted facilites through onsite mentoring & inservice training for on product quantification & forecast , proper requesting & reporting of medicines/ Supplies data & proper disposal of expired commodites.	Proportion of private health facilites enrolled in to national supply management system	Provide TA to PFSA & RHBs to link private facilites to the national supply chain system & build the capacity of private providers through training & onsite mentoring on product quantification & forecast , proper requesting & reporting of medicines/ Supplies data & proper disposal of expired commodites.	OHSS	23,400	17824 (Abt)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	All PEPFAR supported HFs in the priority towns able to generate information on stock level at any time	75% of HFs able to generate information on stock level at any time	90% of the HFs in PEPFAR supported priority towns able to generate information on stock level at any time	Number of HFs able to generate stock status at any point	To provide TA and strengthen HIV/AIDS commodity information management through HCMIS FE and generate a bimonthly stock level information in PEPFAR supported ART sites (for about 600 facilities-site level support to improve inventroy management, to give practical on job training, and generate bimontly logistics reports)	OHSS	200,000	18265 (AIDSFree)	Techinal efficiency, 1.11
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	Number of PEPFAR-supported facilities using the IPLS increased by 90% from the baseline of FY17	Number of PEPFAR-supported facilities using the IPLS increased by 50% from the baseline of FY17	Number of PEPFAR-supported facilities using the IPLS increased by 90% from the baseline of FY17	Number of PEPFAR-supported facilities using the IPLS	Support the implementation of Integrated Pharmaceutical Logistics System (IPLS) in the PEPFAR supported sites (training and joint supportive supervision)	OHSS	150,000	18265 (AIDSFree)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	Warehouse and distribution operation activities standardized and implemented	1. 300 PFSA staff trained in storage and distribution SOPs, 2. 25 in pharmaceutical warehouse management, and 3. 25 PFSA staff trained in distribution management	1. 250 PFSA staff trained in storage and distribution SOPs 2. 30 in pharmaceutical warehouse management, and 3. 30 PFSA staff trained in distribution management	PFSA staff trained in storage and distribution SOPs, pharmaceutical warehouse management, and distribution management	Strengthen the PFSA physical warehousing & distribution system at 17 PFSA primary and secondary warehouses to maximize efficiency distributions and warehousing of HIV/AIDS commodities and PEPFAR procured commodities	OHSS	150,000	18375 (PSM)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	No stock outs of ARVs and HIV RTK and VL reagents for >12 consecutive months, good buffer stocks at all times, and commodities management system recognized as among top 10% in Africa within 3 years	1. Sustain HCMIS at PFSA central and branches; and MRIS at FMHACA 2. Develop roadmap for the implementation of GS1 standard track and trace 3. Draft policy framework and stakeholder analysis for GS1	1. Sustain HCMIS at PFSA central and branches and MRIS at FMHACA 2. Pilot the implementation of GS1 standard track and trace 3. Develop policy framework and stakeholder analysis for GS1	1. Functionality of HCMIS at PFSA central and branches 2. Functionality of MRIS at FMHACA 3. Report on the implementation status of GS1 standard track and trace	Enhance decision making through improving logistics data visibility, quality and access at national and subnational levels (PFSA, FMHACA, RHB and FMOH): 1. Continue the HCMIS support to PFSA central and branches 2. Support FMHACA in Medicine registration information system(MRIS) 3. Develop roadmap and policy framework for piloting and implementation of global standard (GS1) for track and trace of commodities from manufacturer to patient level 4. Support pharmacy data management	OHSS	125,000	18265 (AIDSFree)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	1. Improved availability of tracer HIV/AIDS commodities in PEPFAR supported facilities 2. Reduced wastage and expiration of HIV/AIDS commodities in the PEPFAR supported facilities	1. Availability of ARV during the day of visit is over 98% 2. Reduced wastage rate from 8% to 2% or less	1. To increase availability to 99% 2. Reduced wastage rate from 8% to 2%	1. Stock status of PEPFAR procured health commodities at all levels 2. HIV/AIDS program commodities delivered to ART site/ last miles on time, 3. Wasteage and expiration of rate of HIV//AIDS commodities 4. Availability of tracer HIV/AIDS commodities in PEPFAR supported sites	Provide HIV/AIDS commodity management technical assistance to ensure commodity security (adequate supply of quality products are available in PEPFAR supported sites, including ARV, VL, CD4 nutritional supplies, OIs and medical supplies required for effective and efficient HIV/AIDS prevention, care and treatment)	OHSS	250,000	18375 (PSM)	Commodity security and supply chain, 6.88

Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	All PEPFAR supported health facilities able to do trouble shooting on HCMIS	About 50% of the PEPFAR supported health facilities able to do trouble shooting on HCMIS	Over 85% of the PEPFAR supported health facilities able to do trouble shooting on HCMIS	Number of health information technologist (HIT) trained on HCMIS; 2. number of health facilities with HCMIS; 3) Pilot for track and trace of selected HIV commodities	Provide a training and TA on HCMIS management to PEPFAR supported ART sites (HCMIS user trainings and providing maintenance and troubleshooting technical support at the site level using a hotline call services)	HLAB	160,000	18265 (AIDSFree)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	Quality and timely logistics data are available for decision making at the all PEPFAR supported health facilities	1. Increase number of dashboard users 2. Increase number of individuals trained in dashboard usage 3. Increase number of facilities with improved RRF generation and quality	1. Increase number of dashboard users 2. Increase number of individuals trained in dashboard usage 3. Increase number of facilities with improved RRF generation and quality	1. Number of dashboard users 2. Number of individuals trained in dashboard usage 3. Number of facilities with improved RRF generation and quality	To provide TA and strengthen HIV/AIDS commodity information management through HCMIS centaral and Hub editions to generate a bimonthly stock levels in all PFSA hubs (17 branches and the central medical store) and improve utilization of dashboard (data for decision making) at FMOH, RHB & PFSA program managers	OHSS	100,000	18265 (AIDSFree)	Quality management, 1.62
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	1) Improved the quantification capacity of PFSA and health facilities; 2) Annual quantification report	Annual quantification report; 2) Training reports	1) Revised quantification report; 2) Training reports	Quantification report; 2) Training reports	Provide TA and Support to the country counterparts (PFSA / FMOH / EPHI / HAPCO) in conducting HIV/AIDS quantification of health commodities for Ethiopian public health programs (Training and conducting annual quantification)	OHSS	100,000	18375 (PSM)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	1. Improved the quantification capacity of PFSA and health facilities 2. Annual quantification report	1. Annual quantification report 2. Training reports	1. Revised quantification report; 2.Training reports	1. Quantification report 2. Training reports	Support PFSA for quantification of Nutrition Assessment Counseling & support(NACS), provide support for regional key stakeholders to avoid misuse of RUTF at PEPFAR supported sites	OHSS	25,000	18375 (PSM)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	1. Improved warehouse management 2. Reduce the wastage of health commodities	Improved warehouse management to reduce the wastage of health commodities	Improved warehouse management to reduce the wastage of health commodities	1. Performance report on the implementation of SOPs 2. Reduction of health commodity wastage at warehouse level	Support the rollout of supply chain related tools (i.e. the implementation of existing SOPs on waste management, warehousing management, fleet management, quantification and forecasting)	OHSS	25,000	18375 (PSM)	Commodity security and supply chain, 6.88
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	All HFs able to do trouble shooting on HCMIS	50% of HFs able to do trouble shooting on HCMIS	All HFs able to do trouble shooting on HCMIS	Functional HCMIS	Provide training and TA on HCMIS management to PEPFAR supported ART sites (HCMIS user trainings and providing maintenance and troubleshooting technical support at the site level using a hotline call services)	OHSS	75,000	18265 (AIDSFree)	Quality management, 1.62
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	All PEPFAR supported health facilities are able to generate information on stock level at any time	75% of HFs able to generate information on stock level at any time	All HFs able to generate information on stock level at any time	Number of HFs able to generate stock status at ny point	To provide TA and strengthen HIV/AIDS commodity information management through HCMIS FE and generate a bimonthly stock level information in PEPFAR supported ART sites (for about 600 facilities-site level support to improve inventroy management, to give practical on job training, and generate bimontly logistics reports)	HTXS	250,000	18265 (AIDSFree)	Commodity security and supply chain, 6.88
Inadequate domestic budget allocation for HIV categorical services	In <3 yrs, increase in GoE budget allocation for categorical HIV programs by 15%, plus commitment to ongoing 5% annual rise	5% increase in GOE budget allocation	10% increase in GOE budget allocation	GOE share of budget out of the total HIV/AIDS budget from all sources	Continous advocacy at National level (FMOH Management) to expand domestic resource mobilization for HIV/AIDS activities to reduce the looming resource gap in finance and commodities	OHSS	50,000	16912 (Abt Associates/HFG)	Domestic resource mobilization, 2.78
Cost barriers to HIV services beyond free ARVs: inpatient care, lab, transport, XRay, other out-of-pocket (OOP) costs	A standard fee-waiver system will be in place benefiting more number of PLHIVs to have access to comprehensive HIV care and treatment services	OOP reduced for PLHIVs by 25%	OOP reduced for PLHIVs by 50%	Annual OOP expenditure by PLHIV	TA to the host government in strengthening protection mechanism for the poor through waiver, CBHI and other mechanisms.	OHSS	150,000	16912 (Abt Associates/HFG)	Domestic resource mobilization, 2.78
3. Cost barriers to HIV services beyond free ARVs: inpatient care, lab, transport, XRay, other out-of-pocket (OOP) costs	CBHI coverage increased to 50% of the districts	CBHI coverage increased to 25% of the districts	CBHI coverage increased to 50% of the districts	CBHI Coverage report of FOH	Provide TA for the EHIA, RHBs and the woreda administrations in the implementation of Community Based Health Insurance Initiatives.	OHSS	60,000	16912 (Abt Associates/HFG)	Domestic resource mobilization, 2.78
Non-secure commodity procurement (ARVs and HIV lab reagents) and supply chain logistics	1. Improve partnership and collaborations between USAID and PFSA 2. Strengthen the regular procurement and supply management for HIV/AIDS	1. Regular updates on pipeline 2. Share SOH reports between PFSA and PEPFAR partners	1. Regular updates on pipeline 2. Share SOH reports between PFSA and PEPFAR partners	1. Meeting minutes 2. Pipeline and SOH reports for HIV programs	Strengthen the supply chain management leadership & partner collaboration through the PSM TWG and commodity security training	OHSS	50,000	18375 (PSM)	Commodity security and supply chain, 6.88
TOTAL for 6.1.3.							**1,943,400**		

Table 6.2.1: Test and START									
Key Systems Barrier	**Outcomes expected after 3 years of investment**	**Year One (COP/ ROP16) Annual Benchmark**	**Year Two (COP/ ROP17) Annual Benchmark**	**Relevant Indicator or Measurement Tool**	**Proposed COP/ROP 2017 Activities**	**Budget Code(s)**	**Activity Budget Amount**	**Implementing Mechanism**	**Relevant SID Element and Score (if applicable)**
Weak community health systems unable to provide comprehensive servcies to KP/PP	Strengthened and expanded community health system able to provide responsive treatment services to KP/PP in prioritized SNUs	1. Linkages between community services and facility services improved for KP/PP 2. Expanded treatment services in DICs for KP 3. Minimum of 25 DICs in 20 prioriy towns provide comprehensive services, including treatment	1. Improved linkage to treatment services for KP/PP 2. Scale up of comprehensive services, including treatment in additional DICs in priority SNUs	Program data	1. Initiation of treatment in DICs 2. Introduction of accompanied referrals by lay counselors (from community to facility)	HTXS	444,972	18519 (PSI)	Service delivery, 4.4
TOTAL for 6.2.1.							**444,972**		

Table 6.2.2: New and efficient service delivery models

Key Systems Barrier	Outcomes expected after 3 years of investment	Year One (COP/ ROP16) Annual Benchmark	Year Two (COP/ ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Proposed COP/ROP 2017 Activities	Budget Code(s)	Activity Budget Amount	Implementing Mechanism	Relevant SID Element and Score (if applicable)
Lack of policy change to allow new differentiated, patient-centered models of care	Govt Policy changed and to support a broad range of differentiated care models for ART and fully implemented in <3 yr	40% high load facilities supported by RHBs will have adolescent focused services	60% high load facilities supported by RHBs will have adolescent focused services	Implementing partner progress and SIMS report	High levels of HIV related morbidity and mortality are increasingly being recognized in the adolescent group due to low access to ART, poor linkages to and retention in care, and ART coverage rates for this age group is lower than for other age groups. Addressing these challenges and adapting systems to deliver good quality, effective health care and social support for adolescents living with HIV is acritical component of care highly contributing for the epidemic control. This activity is planned to maintain a process initiated in COP16 to adopt policy and enhance implementation of facility based adolescent focused psychosocial support Interventions including rollout of guidelines and job aids, training of health care providers, improving disclosure counselling for HIV infected adolescents in care at all health facilities and establishment of Adolescent peer support programs in high case load facilities. This activity is expected to significantly contribute to achieve the 2nd and 3rd 90 of UNAIDS goals by improving disclosure practices, treatment adherence and retention in care, and viral suppression and ultimately reduce morbidity and mortality among this age group. This activity is currently progressing satisfactorily and needs to be maintained and further scaled up.	PDTX	18,540	13934 (AACHB)	NA
							18,540	16752 (ARHB)	
							6,953	13929 (DDRHB)	
							6,953	13770 (HRHB)	
							18,540	13794 (ORHB)	
							18,540	16901 (SNNPRHB)	
							6,953	17000 (TRHB)	
							4,635	12319 (FPC)	
							9,270	16742 (NDFE)	
							6,953	16749 (ICAP)	
		Advocacy with GOE to consider Adoptions and initiation of DSDM for children & adolescents Pilot at six sites completed	Scale up implementation of Family centered Differentiated service delivery model based on lessons from pilot and agreed upon recommendations	Proportion of ART patients provided with differentiated care Number of sites implementing DMSD	Evidences from where Differentiated Service Delivery Model (DSDM) for ART delivery has been piloted indicate that such interventions contribute to improving retention and adherence, and achieving UNAIDS global targets. A review by WHO experts indicated that, DSDM for children and Adolescents as a component of family centered care and its impact for this population group is evidenced by data from different African countries. Ethiopia has already started piloting appointment spacing only for Adult patients at selected facilities. However, A family approach is considered important for offering comprehensive support for children and adolescents. This activity aims at supporting the FMOH to adopt policy and initiate implementation of differentiated service delivery model, particularly appointment spacing for stable pediatric and adolescent patients to ensure, as far as possible, family-aligned ART delivery (same date, venue and provider) for caregivers, children and siblings. It is expected that this activity will significantly contribute to the 2nd, and 3rd 90's by Improving quality and retention in care, and viral suppression resulting in favorable treatment outcome.	PDTX	32,445	16749 (ICAP)	
						PDCS	32,445	16749 (ICAP)	
		85% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs. All RHBs and FMOH have designated focal persons to coordinate the programs.	90% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs.	Capacity assessment tools utilized Number of sites with updated national guidelines and SOPs. Number of RHBs and FMOH with designated focal person to coordinated care and support program.	This mechanism will work to provide above site technical assistance and build the capacity of FMOH and the 11 RHB (including the four emerging regions) in developing strategic evidence based plan and annual program work plan, program management, coordination of the various levels and program activities, core capacity to ensuring the implementation of quality comprehensive HIV treatment services. To meet the planned/targeted ART coverage in priority locations and population/age groups, it will support the SNU level planning, above site coordination, regular monitoring and maintaining skilled work force at each SNU with primary focus on the twenty towns. This support at these priority SNU locations requires SNU level presence by the partner with a team of highly skilled staff with the ultimate goal of strengthening local ownership and attaining the three 90s. This mechanism also supports the adoption, development or revision of guidelines, tools, job aids and training materials. CU-ICAP will build the capacity of FMOH and RHBs in program coordination and management of adult care and support, PMTCT and pediatric treatment and care and support program areas to fully implement and sustain the delivery of quality of services along the continuum of HIV care. The partner will provide above site level technical support to seven RHBs (Addis Ababa, SNNPR, Oromia, Dire Dawa, Harar, Amhara and Tigray) to improve linkage, retention and viral suppression. The partner will support RHBs to monitor the performance of PEPFAR twenty towns. In addition, CU-ICAP will build the capacity of FMOH at national level in coordination and management of care and support, PMTCT and pediatric treatment and care and support program areas. The partner will support the ministry in developing or standardizing or revising guidelines, job aids and training curriculums through participating in technical working groups (TWGs). CU-ICAP will provide technical assistance and support the Ministry to effectively integrate mental health services into chronic HIV/AIDS care services.	HTXS	1,307,200	16749 (ICAP	
		TA to improve HIV testing among TB patients as well as presumed TB cases in all PEPFAR supported sites	TA to improve HIV testing among TB patients as well as presumed TB cases in all PEPFAR supported sites	Number of PEPFAR supported sites in attained, scale up and sustained SNUs.	Technical assistance to implement and monitor targeted HIV testing of presumed TB cases in addition to confirmed TB cases as well as investigation of houshold contacts of TB patients for both TB and HIV in a family based approach	HVTB	230,000	16749 (ICAP)	
		Policy on PreP developed and adopted for HIV negative CSWs	one-time activity: COP18 and beyond efforts will focus on scale-up	Partner performance report	NEW:Support MOH and RHBs to develop and adopt a policy on PreP for HIV negative commercial sex workers	HVOP	12,150	17908 (FMOH)	

Lack of sufficient capacity at community level for promoting retention and adherence initiating Test & Start	Strong community-level models for supporting retention and adherence have been demonstrated in 90% of saturation and aggressive scale-up areas by 3 yrs	70% of scale up saturation & aggressive SNUs supported by the partner have strong community-level models for supporting retention and adherence	80% of scale up saturation & aggressive SNUs supported by the partner have strong community-level models for supporting retention and adherence	% of scle up saturation & aggressive SNUs supported by the partner with strong community-level models for supporting retention and adherence	Strengthen standardizing community level peer-support group to strengthen members coping mechanism in a highly stigmatizing environment and remain adherent to their care and treatment services	HBHC	196,200	12306 (OSSHD)	6. Service Delivery (4.4 score)
Danger of perception that this policy is being driven by cost saving at the expense of quality care	>90% patients convinced (eg, in patient satisfaction surveys) that ART is being provided at high quality and in patient-focused manner in 3 yrs	70% of scale up saturation & aggressive SNUs supported by the partner have strong community-level models for supporting retention and adherence	80% of scale up saturation & aggressive SNUs supported by the partner have strong community-level models for supporting retention and adherence	% of scle up saturation & aggressive SNUs supported by the partner with strong community-level models for supporting retention and adherence	NEW: Conduct program evaluation on the contribution of community level care and support services implemented bu OSSHD	HBHC	52,200	12306 (OSSHD)	6. Service Delivery (4.4 score)
TOTAL for 6.2.2.							**1,978,515**		

Table 6.3 Other Proposed Systems Investments

Activity	For each activity, indicate which of the following the activity addresses: 1) First 90; 2) Second 90; 3) Third 90; or 4) Sustained Epi Control. (Teams may select more than one.)	Outcomes expected after 3 years of investment	Year One (COP/ROP16) Annual Benchmark	Year Two (COP/ROP17) Annual Benchmark	Relevant Indicator or Measurement Tool	Budget Code(s)	Activity Budget Amount	Associated Implementing Mechanism ID	Relevant SID Element and Score (if applicable)
Finance									
Provide TA and training to private health facility owners/banks on business development planning and access-to-finance to leverage the loan guarantee through the DCA.	90/90/90	Private health sector infrastructure and services are expanded through increased access to financial resources	At least 25 private health acilites will receive DCA funds to renovate their infratsructure & expand their HIV/AIDS & TB service	At least 50 private health facilites will receive DCA funds to renovate their infratsructure & expand their HIV/AIDS & TB service	1. Number of private health facilites that secure funds through DCA 2. Number of private facilities with DCA loans that have successfully renovated their infrastructure	OHSS	84,358	17824 (Abt)	Private sector engagement, 4.44
Build the capacity of CSOs to mobilize and utilize domestic resources for the implementation of community based services to PLHIV	90/90/90	50% of participating CSOs in priority SNUs have business/resource mobilization plans in place, and are able to successfully moblize resources delivery of community based HIV services	1. Develop resource mobilizate/business planning tools and aids for CSOs 2. Collect baseline information on capacity of CSOs to mobilize resources and develop business plans 3. Start capacity builiding activities informed by #1 and #2	30% of participating CSOs in priority SNUs have business/resource mobilization plans in place, and are able to successfully moblize resources delivery of community based HIV services	Number of CSOs whose capacity for DRM is improved. Number of CSOs that started to utilize the mobilized domestic resources to implement community HIV services. [Note: one of the activities will be to develop a composite indicator to measure the CSOs' capacity of mobilize DRM]	HBHC HTXS MTCT OHSS PDCS	94,401 1,466 0 13,192 2,932	17825 (Community TBD)	Civil society engagement, 4.0 Domestic resource mobilization, 2.78
Provide TA to FMOH to conduct a situational analysis that will inform policy change that enable the private health sector to engage in delivery of comphrehensive HIV service alighned with 90-90-90.	90/90/90	Number of favorable policies updated or passed that support robust private sector engagement in HIV national response	1. Assessment of health/HIV policy and regulatory environment for private sector engagement completed 2. Dissemination of findings to stakeholders	1. Private health sector advocacy events based on policy assessments and outcomes 2. Marked improvements in private sector policy and regulation environment	Improvement/Increase in the proportion of policy & regulatory framework which affect the private health sector's engagement in the delivery of critical health services	OHSS	75,000	17824 (Abt)	Private sector engagment, 4.44
Provide technical assistance to FMOH to revise the National Guidelines & SOPs for HIV/AIDS and Nutrition based on available evidence	90/90/90	National HIV/nutrition Guideline updated and disseminated; SOPs for nutrition mainstreamed in HIV programming	1. NACS guidelines and related SOPs updated 2. Consultative workshops implemented; SOPs disseminated and used at facility level	1. Nutrition SOPs adopted at national & regional level in coordination with stakeholders 2. Job aids, assessment tools & guideline on NACS disseminated	Program monitoring data	OHSS HBHC PDCS	3,150 18,000 3,600	14215 (FHI360)	Service Delivery, 4.4
HRH - Systems/Institutional Investments									
Support GOE in strengthening systems and national training of para social workers to increase the quality and sustainability of OVC/caregivers social services/case management	90/90/90	1. About 1,000 Social service workers/parasocial workers/ and supervisors trained and deployed at OVC priorty SNU 2. Improved national strategy for training and deployment of parasocial workers 3. Parasocial workers in full compliance of national social service standards for OVC/caregivers 4. Identification of positive OVC and caregivers increased and linked to treatment	1. Identify and develop MOUs with parasocial training colleges in priority SNUs 2. Revise and develop social work curriculm	1.Support GOE with initiating training of parasocial workers based on revised curriculum 2.Case management tools and resources developed, piloted and scaled up 3. Improved national strategy to support the training and deployment of parasocial workers and supervisors	1. Number of parasocial workers trained and deployed to OVC priority SNUs 2. Number of parasocial workers training to use tools to support referral 3. % of clients with case plans reporting improved well-being after 6-12 months (according to well-being indicators)	HKID	630,000	17271 (ESSWA)	Technical efficiency, 1.11
Support recruitment, salaries, benefits, training, supplies and equipment for key town (SNU) and regional level clinical and public health specalists who will be seconded to RHBs and Town Catch-Up Campaign Command Posts to achieve attainment in the 20 towns. These personnel will be responsible for the following activities: (1) Micro-plans and monitoring Town and catchment SNUs to achieve attainment; (2) Monitor performance of targeted testing approaches by modality and age/sex disaggregates; (3) Monitor linkages, both within and between facilities, and between facilities and communities; (4) Promote and monitor same-day ART initiation for newly identified PLHIV; (5) Strengthening routine viral load testing, effective sample referral, use of results for decision making, and reporting of performance; (6) Promote data quality, analysis and use of the monthly performance data according to PEPFAR requirements; (7) Coordinate activities of other HIV epidemic control implementers and stakeholders, including social mobilization and demand creation; (8) Deploy site monitoring tools to improve site-level and above-site level program performance - minimum of one site visit, per month, to every facility within the team's jurisdiction; (9) Monitor frequency and quality of weekly and monthly reports from sites; uses them to guide technical assistance and quality improvement measures; (10) Strengthen performance of EID and VL monitoring; improved turnaround time and use of results for clinical decision=making; (11)	90/90/90	Attainment in the 20 towns	N/A	Attainment in 7/20 Towns	20 Towns M&E Framework	HTXS	2,182,028	16749 (ICAP)	Human resource for health, 6.0

Support recruitment, salaries, benefits for key clinical and public health specialists at the federal level to achieve attainment in the 20 towns. These personnel will be responsible for supporting the regional health bureaus to implement the following activities: (1) Develop operational and monitoring plans for the 20 towns; (2) monitor quality of performance of dedicated teams at the SNU/town level; (3) Facilitate recruitment and deployment of proposed staff at the site levels; (4) Conduct regular monitoring and review progress of SNU and site-level implementation in the 20 Towns and their respective cluster of SNUs; (5) Increase oversight of target-based allocations for HIV commodities, especially RTKs, and monitor distribution, consumption, and HTS performance through a dedicated supply chain focal person; (6) Strengthen coordination and performance monitoring, working between PFSA hubs, RHBs, SNU and sites; (7) Conduct monthly reviews within each of the twenty towns, and host quarterly reviews for all scale-up SNUs; and (8) Support intensified analyses of dis-aggregated data and routinely monitor for data quality and use in supported priority locations and sites. At the national level, these officers will (1) Generate national level reports on a monthly basis, coordinate planning and performance monitoring; (2) Hold semi-annual performance reviews; (3) Provide oversight of implementation; and, (4) Advocate for, and develop, revised guidelines, updated policies, etc.	90/90/90	Attainment in the 20 towns	N/A	Attainment in 7/20 Towns	20 Towns M&E Framework	HTXS	81,648	17908 (FMOH)	Human resource for health, 6.0
Establishing and/or strengthening in-service training at 35 in-service training institutions including the standardization and institutionalization of IST through increased capacity for planning, implementing, monitoring and mobilizing resources. Assistance includes improving IST trainer capacity, standardizing national training packages, coaching, mentoring, supportive supervision, financial management tools, standard operating procedures.	90/90/90	Number of in-service training units capacitated to provide HIV prevention, care and treatment using updated training guidelines	20 in-service training units will be capacitated to ensure delivery of training on HIV Prevention care and treatment using updated guidelines and training materials.	35 in-service training units will be capacitated to ensure delivery of training on HIV Prevention care and treatment using updated guidelines and training materials.	Number of in-service training units that are able to provide HIV/AIDS training with minimum support from PEPFAR	OHSS	150,000	14209 (JHPIEGO)	Human resource for health, 6.0
Strengthening pre-service health care workers education for midwives at 48 institutions (26 universities and 22 regional health science colleges) through faculty development, curriculum review, and provision of resource materials and skills lab equipment.	90/90/90	48 institutions will be able to provide quality education for midwives on HIV prevention, care and treatment with minimal support from PEPFAR	50% of the universities and regional health science colleges will be able to provide quality education on HIV prevention, care and treatment with minimal support from PEPFAR	75% of the universities and regional health science colleges will be able to provide quality education on HIV prevention, care and treatment with minimal support from PEPFAR	Number of the universities and regional health science colleges that are able to provide quality education for midwives on HIV prevention, care and treatment with minimal support from PEPFAR	OHSS	60,000	14209 (JHPIEGO)	Human resource for health, 6.0
Strengthening pre-service education for health extension workers at 23 institutions through faculty development, curriculum review, provision of resource materials and skills lab equipment.	3rd 90	23 institutions will be able to provide quality education for health extention workers on HIV prevention, care and treatment with minimal support from PEPFAR	50% of the universities and regional health science colleges will be able to provide quality education on HIV prevention, care and treatment with minimal support from PEPFAR	75% of the universities and regional health science colleges will be able to provide quality education on HIV prevention, care and treatment with minimal support from PEPFAR	Number of the universities and regional health science colleges that are able to provide quality education for health extention workers on HIV prevention, care and treatment with minimal support from PEPFAR	OHSS	50,000	14209 (JHPIEGO)	Human resource for health, 6.0
Activity 4: Provide technical and material support to Biomedical engineers technicians training program;	Sustained Epi Control	Improved quality of biomedical engineering and technicians training;	Ensure an adequate supply of biomedical engineers and equipment technicians to ensure ongoing equipment maintenance at the healthcare facility level.	Ensure an adequate supply of biomedical engineers and equipment technicians to ensure ongoing equipment maintenance at the healthcare facility level.	Number of new biomedical engineers and equipment technicians who graduated from a pre-service training institution (Other HRH category).	OHSS	650,000	10599 (AIHA)	Human Resource for Health (Score 6.0, Yellow)
Inst & Org Development									
Provide technical assistance and support to MOLSA, BOLSA, Minsitry of Women and Children Affairs at Federal & regional levels, and social work training institutions to improve the quality of community HIV services for OVCs and care givers	90/90/90	Government, academic and other OVC stakeholder groups in PEPFAR priority SNUs are capacitated to identify OVC and caregivers, and link to care/treatment services	1. Case management tools developed and piloted 2. National strategy updated reflecting strengthened capacity of para social workers and supervisors	1. Establishment of national startegic plan that inlcudes child-sensitive social protection of vulnerable groups 2. Fully capacitated para social workers trained to use standardized case management tools to support referrals	1. Case management monitoring tools 2. National strategic plan on child-sensitive social protection in place 3. Number and % of SNUs with strategic plans on child-sensitive social protection	HKID	270,000	17271 (ESSWA)	Quality Management, 1.62
Build capacity of FMOH, Pharmaceuticals Fund and Supply Agency (PFSA), and RHBs to provide oversight and monitor HIV service provision in private helath facilites	90/90/90	FMOH, PFSA, and other govt entities have strengthened capacity to provide TA and oversight to the private sector to increase the contribution in provision of HIV/AIDS services.	Improved contribution of private health sector to provide comphrensive HIV/AIDS service	Improved contribution of private health sector to provide comphrehensive HIV/AIDS service	Program Evaluation Program monitoring data	HBHC HVCT HVOP HTXS HLAB PMTCT PDTX OHSS	29,880 61,000 42,000 89,640 5,976 23,940 29,880 37,350	17824 (Abt)	Private sector engagment, 4.44
Support the FMOH to strengthen Public Private Partnership in Health (PPPH) by operationalizing and disseminating the PPPH Framework for HIV services	90/90/90	PPPH has capacity to solicit and award PPPH projects which improve HIV/AIDS services in private sector	PPPH models designed, solicited & awarded to suppourt Public private partnership for HIV/AIDS services	Implementation of innovative PPPH models to enahnce quality & acess to HIV/AIDS service through PPPH model	Number of PPPH models implemented	HVOP HVCT	45,496 42,000	17824 (Abt)	Private sector engagment, 4.44
Provide TA, training, and develop supervisory tools/job aids to FMHACA to strengthen inspection capacity of the regulatory bodies of private health sector at national & regional levels	90/90/90	Inspections capacity/ supervisory skills of regulatory body improved	Private health sector will support FMHACA in development of 3 new helath facility standards & finalization of 6 new standards & provide trainings for regulatory experts in all regions & suppourt in procurement of inspection tools	Enhanced implementation of inspection to private sector by regulatory body to ensure quality of service delivery with score of 75% & above in the green zone of the scoring system	Program Evaluation	OHSS	42,771	17824 (Abt)	Private sector engagment, 4.44
Strengthen the capacity of FMOH and 6 Regional Health Bureaus (RHBs) to integrate NACS services into routine HIV Care and Treatment services	90/90/90	Six regional health bureaus will be fully capacitated to implement standardized and integrated NACS & HIV/AIDS services	1. Seconded nutritional expert staff at FMOH and 6 RHBs will guide integration of NACS into HIV/AIDS services 2. QI activites for NACS are regulated	1. Seconded staff have institutionalized QI and monitoring activities 2. FMOH has standardized NACS strategy of nutrition integration into HIV services	Program Evaluation	HBHC OHSS	107,000 10,710	14215 (FHI360)	Quality Management, 1.62

			2. QI activites for NACS are regulated implemented and feedback loops are created for programming	nutrition integration into HIV services		PDCS	122,400		
Provide technical assistance and performance based grants to private health facility associations to engage in advocacy, policy dialogue, and improvement in quality of HIV/AIDS service provision in the private health sector	90/90/90	Improved institutional capacity in all 300 private health facilities and professional associations to deliver high quality HIV services in priority SNUs	On site mentoring/TA to at least 25% of private sector-supported facilities	On site mentoring/TA to at least 50% of private sector-supported facilities	Performance report	OHSS HVOP HLAB HVCT PMTCT HVTB PDTX	74,250 47,400 9,600 53,000 39,600 39,600 39,600	17824 (Abt)	quality Management, 1.62
Provide technical and financial support to GOE's efforts to develop and standardize national Economic Strengthening (ES) guidelines for OVC /caregivers resiliency	90/90/90	1. All PEPFAR partners use national ES guidelines 2. ES activities standardized across all implementers	1. National working group SOW developed; MOUs put in place 2. Start development of ES guidelines	National ES guideline finalized and implementation supported	National ES guideline developed and rolled out	HKID	75,000	16930	Policy and governance, 6.58 Service delivery, 4.4
Provide TA to town level HAPCOs to effectively plan, deliver and optimize community level prevention, care and treatment services for PLHIV in priority SNUs	90/90/90	A majority of town HAPCOs in priority SNUs are successfully implementing targeted prevention, care and treatment services through community based interventions	1. Baseline information on the range of community interventions in line with 90/90/90 strategy collected 2. Develop standards of care in line with community needs and international standards 3. Implement and scale up community interventions based on #1 and #2	50% of town HAPCOs implement community based prevention, care, and treatment in line with standards of care and 90/90/90	1. Number of functional community adherence support groups established 2. Number of clients supported with community based ART adherence support services 3. Number of PLHIV receiving ART through community service delivery models 4. Numbe or successful referrals for PLHIV 5. Number of PLHVLTFU who are linked to care and started treatment again	HBHC PMTCT HTXS OHSS PDCS	241,071 0 1,064 9,580 6,429	17825 (Community TBD)	Service Delivery, 4.4
Blood safety program in Ethiopia will contribute to sustained HIV epidemic control through prevention of HIV transmission, in health facilities, as a result of blood transfusion. As per World Health Organization (WHO's) estimation, 5-10% of new HIV infection globally arise from transfusing HIV contaminated units of blood. To ensure sustained supply of safe units of blood (free from all pathogens including HIV), to transfusion hospitals adequately, all blood banks in the country (25 in number) will engage in Internal (IQ) and External Quality (EQ) Improvement activities, for step wise accreditation by African Society of Blood Transfusion(AfSBT). To achieve this goal the National Blood Bank services Agency (NBBS) and Regional Health Bureaus (RHBs) will implement the following activities; 1) Build technical and management capacity of blood safety team in the NBBS and RHBs; 2) Provide training on quality improvement and blood bank accreditation process to NBBs and RHB staff; 3) Procure and supply key blood bank equipment and supplies; 4) support blood collection, testing, storage and distribution activities by blood banks; 5) Monitor appropriate clinical use of blood in Hospitals; 6) support blood banks in IQ ,EQ and accreditation processes both technically and financially; 7) Support establishment and strengthening of Blood Safety Information (BSIS).	Sustained Epi Control	Improved planning, and management of blood safety program	1. 5 blood banks will get accreditation by AfSBT 2. 150,000 units of blood will be collected tested and distributed	Collect, Test for TTIs including HIV, and distribute 200,000 unit of blood to 90% of transfusion hospitals nationwide.	BS_COLL; Number of whole blood collections each year by the NBTS network.	HMBL	420,000	13158 (FMOH)	NA
Build the capacity of FMOH and RHB in program coordination and management, ensuring quality of comprehensive care and support ,PMTCT and pediatric treatment and care & support interventions; and in development of guidelines, job aids and training materials	90/90/90	Improved capacity of FMOH in coordination and management of care and support program	85% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs. All RHBs and FMOH have designated focal person to coordinate the program areas	90% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support and PMTCT anational guidelines and SOPs.	Number of sites with updated national guidelines and SOPs. Number of RHBs and FMOH with designated focal person to coordinated care and support and PMTCT programs.	PDCS	30,000	16749 (ICAP)	
Build the capacity of FMOH and RHB in program coordination and management, ensuring quality of comprehensive care and support ,PMTCT and pediatric treatment and care & support interventions; and in development of guidelines, job aids and training materials	90/90/90	Improved capacity of FMOH in coordination and management of care and support program	85% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs. All RHBs and FMOH have designated focal person to coordinate the program areas	90% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support and PMTCT anational guidelines and SOPs.	Number of sites with updated national guidelines and SOPs. Number of RHBs and FMOH with designated focal person to coordinated care and support and PMTCT programs.	PDTX	70,000	16749 (ICAP)	

WHO is key partner of the FMOH and provides TA for adaptation of key policies and updated global recommendations. WHO also provides TA for the FMOH and regional TB/HIV program management to improve program performance through joint planning, monitoring and evaluation of key TB/HIV program support activities. WHO will continue to provide technical assistance for revision of TB/HIV strategic plans, normative guidelines, training materials, job aids and diagnostic algorithms. WHO will also assist the national TB program in Printing & distribution of the revised (2017) national TB/HIV guideline. This support by WHO will promote provision of standardized and quality TB/HIV service and help to improve program performance. The activities include organizing international TA support, direct technical support by country office, staff secondement to the national and regional programs; TA to national and regional TOTs, TA to national and regional review meetings, national TB program review and national level TB program assessment; Strengthening TB/HIV strategic information (including analysis and interpretation of HMIS data as well as dissemination through annual bulletins for program use; TA for GeneXpert scale up and TB infection control and MDR-TB service expansion; orientation of technical working group experts on new policies and recommendation in TB/HIV programs, supporting consultative meetings, contributing for printing and distribution of guidelines and job aids in times of shortages.	90/90/90	Improved HIV/TB program management capacity at national and regional levels; Improved availability of updated normative guidelines and SOPs;	Improved HIV/TB program management capacity at national and regional levels; Improved availability of updated normative guidelines and SOPs;	Number of national & regional TB/HIV partners supported.	Improved HIV/TB program management capacity at national and regional levels; Improved availability of updated normative guidelines and SOPs;	HVTB	370000 0	16750 (WHO)	
Build the capacity of FMOH and RHB in program coordination and management, ensuring quality of comprehensive care and support interventions; and in development of guidelines, job aids and training materials	90/90/90	Improved capacity of FMOH in coordination and management of care and support program	85% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs. All RHBs and FMOH have designated focal person to coordinate care and support services.	90% of PEPFAR supported sites under 11 RHBs used updated comprehensive care, treatment and support national guidelines and SOPs.	Number of sites with updated national guidelines and SOPs. Number of RHBs and FMOH with designated focal person to coordinated care and support program.	HBHC	288,000	16749 (ICAP)	Planning and Coordination (Score 7.87)
The Federal Ministry of Health (FMOH) plays key role in TB/HIV program leadership and management. It is also responsible government entity for technical and financial resource mobilization and coordination. The FMOH also leads policy adaptations, guideline and training manual revisions in close collaboration with stakeholders. It also oversees TB and HIV control program coordination at central level. National level public health education activities are conducted by the FMOH through electronic and print media to improve public awareness in TB prevention and control as well as create demand for TB/HIV services. Capacity building support to the FMOH TB/HIV program management staff will help to address capacity related gaps especially during staff turnover. This support will also strengthen the capacity of program management to conduct regular program monitoring and review meetings and their skill in interpretation and use of data for evidence based planning to improve program performance. The FMOH through its program leadership, guidance and supportive supervision support will promote targeted testing of high risk groups e.g. Presumed TB cases and TB contacts for HIV; strengthen HTC coverage for TB patients, ART coverage and intensified TB case finding and TB prevention activities in line with the 90-90-90 goal. The FMOH in collaboration with stakeholders will update TB/HIV monitoring tools to incorporate targeted testing activities to monitor performance. Interruption and stock out of key TB commodities such as INH, reagents and GeneXpert cartridge has been a challenge affecting quality of TB case finding and TB prevention activities among PLHIV as well as target achievement in TB/HIV programs. FMOH will provide technical assistance for the national level stock assessment, support consultative workshops with stakeholders for drug quantification and forecasting exercise. This support will help to ensure smooth supply of key TB/HIV program commodities and avoid stock outs and service interruptions there by contributing to improvement in quality of TB/HIV care.	90/90/90	• Improved staffing and capacity at the national TB program management level • Improved availability of updated national guidelines and job aids at the TB/HIV sites. • Improved public awareness on TB/HIV prevention and control • Increased demand for TB/HIV services • Improved program monitoring • Improved quantification and forecasting for TB/HIV commodities • Improved availability of key TB/HIV commodities • Reduced national and site level stock out of key TB/HIV commodities	• Adequate # of staff assigned for TB/HIV program management • 5o% of program staff received TOT training in program management • Improved program performance: TB/ART >90%; IPT uptake > 40% • Supportive supervision and review meetings conducted as per the schedule • Public awareness messages transmitted as per the annual plan. • National level quantification done for TB drugs, reagents and supplies • Stock out event's for key TB commodities reduced by half	>95%; TB_ART: >95%; IPT coverage >60%) • No major stock out for key TB/HIV commodities •	• # of stock outs for key TB/HIV commodities	HVTB	245,000	17908 (FMOH)	
PEPFAR Small Grants - Support local partners to Increase knowledge of HIV prevention methods, the importance of understanding one's serostatus and how to reduce disease transmission among high risk groups in their communities.	First 90	NA	1. 1500 people reached with basic HIV prevention messages. 2. 500 people in high risk groups received condoms	90% of IP have enhanced capacity to implement an effective prevention program for at- risk groups.	# people reached with Basic HIV/AIDS prevention messaging and # people received condoms	HVOP	40,000	11033 (PEPFAR Visibility)	NA
PEPFAR Small Grants - Work with local partner to Support in/out of school peer education and access to and utilization of youth friendly HTC services in their communities.	First 90	NA	1. 10 school supported groups created access to youth friendly services 2. 500 youth reached with lifeskills education through a peer education approach.	90% of IP have enhanced capacity to implement an effective prevention program for at- risk groups.	# school supported groups that are striving to create youth friendly services and # people receiving lifeskills education through peer support				
PEPFAR Small Grants - Strengthen referral linkages between community based structures and health facilities for HTC and care and support services.	First 90/Second 90	NA	500 cases referred for testing and HIV services	Referral between community based sturctures and health facilities for HTC and services becomes the norm in 30% of target communities	# cases referred for counseling and testing				
PEPFAR Small Grants - Support local partners to Increase awareness of GBV and promote girls/women's empowerment to reduce vulnerability to HIV risk in their communities.	First 90	NA	1. 175 people reached with GBV messages 2. 15 organizations received GBV information and incorporated GBV issues into their activities.	Evidence of continued open community discussions on GBV (among both men and women)	# people reached with GBV messages # organizations receiving GBV information and incorporating GBV issues into their activities				

PEPFAR Small Grants - Work with local partners to Support sustainble economic strengthening through microenterprise development, promotion of self-help groups and other savings and credit options for PLHIV, in their communities.	Second 90/Third 90	NA	400 people received support and self report a new or increased income	40% of supported beneficiaries are able to meet their basic needs	# people infected or affected by HIVAIDs who received support and self report a new or increased income	HBHC	100,000		
PEPFAR Small Grants - Assist local partners in the provision of Food and nutritional support for PLHIV or OVC households in their communities.	Second 90/Third 90	NA	200 people received food/nutritional support	Improved health conditions for 80% of the target group	# people infected or affected by HIVAIDs who receive food and/or nutritional support.				
PEPFAR Small Grants - Through local partners, support caregivers/parents to increase the number of OVC who receive HTC services.	Second 90/Third 90	NA	100 OVC received HTC services	More OVCs know their serostatus.	# OVC receiving HTC services	HKID	60,000		
PEPFAR Small Grants - Assist local partners in the provision of developmentally appropriate eduational, psychosocial support to OVC in their communities.	Second 90/Third 90	NA	600 OVC received support and attend school during grant period	80% OVC who received support continue their education	# OVC receiving support and attending school				
PEPFAR Small Grants - Work with local partners to Support sustainble economic strengthening through microenterprise development, promotion of self-help groups and other savings and credit options for OVC or their caregivers in their communities.	Second 90/Third 90	NA	230 OVC or their caregivers received support and self report a new or increased income	40% of supported beneficiaries are able to meet their basic needs	# people infected or affected by HIVAIDs who received support and self report a new or increased income				
Laboratory									
Enroll laboratories in the private health sector in continuous quality improvement process including SLIPTA (WHO/AFRO step-wise laboratory accreditation) with prioritization of scale up sites	90/90/90	All Private health sector project suppourted laboratories enrolled in to laboratory accreditation program will be accredited according to international standards	The project will suppout 14 laboatories of facilites engged in ART, PMTCT & TB/HIV service for laboartory accreditation	Expand enrollment of additional 10 private facilites in to accreditation process.	Proportion of laboratories accrediated	HLAB	10,800	17824 (Abt)	Laboratory, 5.51
Provision of TA and support to specimen transportation and laboratory networking in the private health sector	90/90/90	Private health facilities are linked with the public specimen transportation system to send specimen to regional laboratories for EID, viral load, TB & MDR TB and ART monitoring	95% of private helath sector suppourted facilites linked for sample transport.	100 % of private helath sector suppourted facilites linked for sample transport.	Proportion of Private Health facilites linked for sample transport.	HLAB	15,120	17824 (Abt)	Laboratory, 5.51
Strategic Information									
Conduct required OVC Impact Indicator Survey	90/90/90	Availability of high quality and accurate OVC data to inform development, programming, and resource allocation decisions	Develop and finalize survey tool, pilot survey, and begin implementation	Complete survey implementaiton, disseminate findings, adapt OVC programming	The nine MER OV Essential Survey Indicators collected and analayized over a two-year period	HKID	0	18659 (MEASURE Evaluation)	NA
Conduct operational research to generate evidence on effecitveness of ES outcomes for improved OVC programming	90/90/90	Having robust local evidence for ES activities for the contribution of HIV intervention, mainly for OVC	Research protocol developed and get approval from the goverment and start the data collection	Survey instrument piloted; data collection complete	ES indicators	HKID	100,000	16930 (FHI360)	NA
Provide training and technical assistance and avail required tools to strengthen the implementation of HMIS in the private health sector	90/90/90	HMIS in private sector strengthened	All ART sites & 80 % of TB, VCT & PMTCT sites suppourted by PHSP will get with regular technical assitance & capacity building.	All ART, TB, VCT & PMTCT sites suppourted by PHSP will get with regular technical assitance & capacity building.	Number Pivate facilites implementing HMIS provided with technical assistance & capacity building.	HBHC HTXS HLAB OHSS HVTB PDCS PDTX	12,390 12,390 9,912 12,390 12,390 12,390 12,390	17824 (Abt)	Performance data, 4.7
Technical support and joint implementation with RHBs to conduct standard of care assessment on NACS to selected high volume facilities	90/90/90	Standardized quality of NACS services implemented in all high volume HIV/ART sites	1. SOC assessmnet done jointly with RHB for 50% of high ART case load facilites 2. Follow up QI activites planned & implemented in cordination with stakeholders	1. SOC assessmnet done jointly with RHB for 50% of high ART case load facilites 2. Follow up QI activites planned & implemented in cordination with stakeholders	Number of high case load ART facilites with SOC assessmnet	HBHC OHSS PDCS	36,000 3,150 18,000	14215 (FHI360)	Service Delivery, 4.4
Provide technical assistance for FMOH & RHBs on data collection, recording and reporting of NACS indicators	90/90/90	Improved data quality of NACS indicators	1.FMOH & 6 RHBs receive TA on NACS indicators and data use methods 2. Implementation of RDQA & performance	NACS data reviews for decision making regularly implemented	Program monitoring and evaluation data	OHSS PDCS	3,150 36,000	14215 (FHI360)	Quality Management, 1.62

			review of NACS service			HBHC	18,000		
Conduct CSW size estimation study to build on and expand to new towns within prioritized SNUs for improved KP programming .	90/90/90	Responsive programs will be designed utilizing CSW size estimation results and KP/PP will be identified and reached with behavioural and biomedical services	Data collection completed and report finalized	Implementation of program for KP/PP based on results from the size estimate	# of towns size estimation conducted	HVOP	135,000	18519 (PSI)	Epidemiologic and health data, 4.48
Quantification and mapping of Key population and priority population in selected geographic locations and dissemination of strategic information on HIV/AIDS, STI and TB. It has been five years since the first round of key population (MARPS) survey was conducted. In COP 2017, PEPFAR Ethiopia needs to update the bio-behavioral information on the previously identified MARPS and additional bridging populations and newly identified locally relevant key pops. This survey will show the current status of the epidemic in the previously included towns and additional ones from the PEFAR focused towns. While EPHI leads the survey (protocol development, clearance, training and supervisions) and handles the laboratory and data management activities, EPHA will handle the logistics for preparatory works and implementation and dissemination of the survey results. Since this is a national scale survey requiring more staff deployments to field, EPHA is strategically suited for this due to better efficiency , flexibility and timely delivery on this task. . In addition to enabling measurement of all the three 90 among the KPs, the biological component has returns test results to participants, supporting the first 90, referral to care and treatments supports the second 90, measurement of viral load for the survey participants supports the thirds 90. The behavioral risk measurement, and size estimations components clarify the targets/denominator enriches the context to the epidemic control. Large scale, logistic mobilization skills, limited capacity. EPHA will also use part of this budget for the dissemination of strategic information related to HIV/AIDS, STI and TB/HIV through standing publications and workshops supported by PEPFAR programs	Measures the level of the three 90s in this specific population groups. 90/90/90	Prevalence, incidence and cascade of HIV care & treatment, and viral suppression rates among Key pops FSWs, truck drivers and other locally relevant KPs available D109	Consultative workshop conducted - Survey Protocol developed - Lab logistics ordered	Data collection; analysis and dissemination	Partner progress and final survey report	HVSI	72,000	16751 (EPHI)	NA
Strengthening the management of HIV/AIDS related paper and electronic based Health Management Information Systems at the federal ministry of health (FMOH) and in the emerging regions (Afar, Benshanguel, Somali and Gambella) through, hiring and deployment of HMIS staff to ensure integration of HIV data into the HMIS reporting system, Supportive supervision, conduct of review meetings, trainings and gap filling printing of HIV/AIDS related registers and formats for facilities. This budget will also support the FMOH in coordinating the transition of the existing e HMIS system in to the new adopted DHIS2 system to ensure a smooth HIV/AIDS data migration, reporting and data use as per the data use partnership platform. FMOH will also use this budget to ensure the continuity of existing patient level HIV/AIDS information system (EMR HIV/AIDS module, EMR-MRU, full-fledged EMR system) through supportive supervision and monitoring including to make sure that these systems are interoperable with the DHIS2.As the information system captures data on all entries of HIV/AIDS Programs in relates to all the three 90s	Measures the level of the three 90's	• Quality HIV/AIDS data from health facilities supported with paper based HMIS in emerging regions • Streamlined electronic HIV/AIDS data reporting through DHIS2	• Improved capacity to do DQA and data use in emerging regions • Coordinated transition of eHMIS in to DHIS 2 • Assessment and customization of the new platform • Coordinate the training of health workers and deployment of DHIS2	• Integrated data quality and use into their facilities in emerging regions • Complete technology platform transition to DHIS2 in the regions	• Partner progress report	HVSI	175,000	FMOH(17908)	NA
Strengthen implementation of existing electronic health information systems (e -HMIS) core to the HIV response and support transition to new DHIS2 supported through the Data Use Partnership. The budget will also provide technical support (software upgrade, trouble shooting, training/capacity building, ensuring system interoperability) to FMOH and RHB in the implementation of HIV patient level information system (EMR, MRU, ART module) at selected high load health facilities including 20 towns supported by PEPFAR. These systems are critical for HIV/AIDS patient data management in high load facilities including for the capture, analysis and reporting of disaggregated HIV testing data by outlets and modalities at health facilities. The patient level data system will also serve as a platform for HIV Case- Based surveillance. Since these systems capture patient level data, they directly affect the information on the levels of the three 90s	Measures the level of the three 90's	FMOH and RHBs ensure the sustenance of HIV/AIDS patient level information systems with full ownership, integration into DHIS 2 and capacity to manage them through the TA provided to them	• FMOH supported the e HMIS transition to DHIS2 • HIV/AIDS related patient level information systems made interoperable with DHIS2	• RHBs will have the capacity to manage the HIV AIDS information systems effectively	• Progress reports	HVSI	300,000	TBD (Tulane follow on)	NA
Coordination and implementation of TB/HIV, STI and PMTCT Surveillance. The TB/HIV and STI surveillances will inform programs in the burden of co-morbidities and monitor the collaborative program performance, using core indicators which are not reported through the routine HMIS. The TB/HIV surveillance provides information on 7 core TB/HIV service quality indicators including TB mortality among TB/HIV patients, timely initiation of ART among TB/HIV patients from 79 selected health facilities. This information is used for monitoring the Tb/HIV program quality. The STI surveillance generates data on the HIV yield from STI patients along with other behavioral indicators at 25 selected health facilities. This information is used at PEPFAR for HTC target setting. The PMTCT surveillance is replacing the ANC sentinel surveillance which is the basis for generation of the national HIV prevalence and other estimates. This will be undertaken in 122 selected facilities in all part of the country. EPHI will play the overall coordination role, standardization, TOT training provision, quality assurance and conduct of review meetings for all these surveillance programs. The RHBs will do surveillance cascaded trainings, specimen transportation and monitoring of the surveillance systems. The estimates generated from the PMTCT based surveillance activities will be used as denominator for the first 90 while those generated from the other surveillance activities inform about the qualities of HIV/AIDS services and HIV yield analysis	Measures the level of the first and second 90's	The level and trends of HIV infection tracked and related estimates regularly generated and used	• PMTCT surveillance initiated and data collection completed • TB/HIV and STI surveillance conduced and report produced.	• Annual report from TB/HIV, STI and PMTCT based surveillance programs	• Annual TB/HIV, PMTCT and STI surveillance report • Partners progress reports	HVSI	188,000 17,764 36,938 3,570 3,570 50,350 32,414 15,533	16751 (EPHI), 13934(AACHB) 16752 (ARHB), 13929 (DDRHB), 13770 (HRHB), 13794 ((ORHB) 16901(SNNPRHB) 17000 (TRHB)	NA

Coordination and implementation of HIV Case Based Surveillance. As per COP 17 guidance, the HIV case surveillance system is the best method to obtain individually identified data on the three 90s to effectively monitor the PEPFAR programs. This surveillance system will provide real time HIV case reports generated from surveillance sites starting in AA and special zone of Oromia to inform PEPFAR programs on cascade of HIV care on all the sentinel events along the continuum of care. The activity will be scaled up to the high load HIV sites including the PEPFAR focused 20 towns. The data generated from Addis Ababa on the proof of concept has indicated that about 8% of clients in Addis Ababa are from surrounding Zones of Oromia are duplicated. A strengthened case based surveillance system will generated accurate information on de-duplicated cases of HIV through generation of Unique identifies, using pre-tested standard algorithms there by enabling the generation of dynamic data set with all the sentinel events depicting progression along the continuum of HIV care and treatment. NASTAD will provide TA to EPHI and RHB for the strengthening the system as well as capacity building while EPHI plays the overall coordination role and standardization.	Measures the level of the three 90's	Real time individual level information on HIV-positive persons by testing out lets, sex, age and linkage to ART and viral load suppression level in supported facilities in priority PEPFAR focused areas	System development and implementation in Addis Ababa and Oromia special Zone	• Expansion to include health facilities in the PEPFAR prioritized towns • HIV case real time reports generated from surveillance sites in AA and special zone of Oromia	Partner Progress report on case based surveillance	HVSI	200,000	10559 (NASTAD)	NA
In adequate data for program planning and decision making in ENDF HIV/AIDS Prevention Program.	Data for program planning and decision making.	Protocol Development, IRB aaproval, questionier development and translation, data collection and HIV testing training, pilot testing of the tool data collection	Data entry and analysisis training, Data entry,data analysis, report writing, dta desimination	SABERS result	HIV Surveilance Survey on all ENDF active duty miltary perssonel. Some of the sub activities under this are;Protocol development, IRB approval, dta tool development.	HVSI	100,000	16798 (ENDF)	NA
HIV/AIDS, TB mortality tracking in 79 urban cemetery sites in Addis Ababa and 6 University-based DHS Sites: This support will generate data for tracking the urban and rural HIV and related diseases mortality and to monitor the impact of the HIV /AIDS response in the country using verbal autopsy. This system is the only community based source of data for tracking the HIV/AIDS and TB mortality to evaluate the impact of PEPFAR programs. This information generated from this surveillance is used to define the epidemic knowing the HIV/AIDs and TB mortality pattern in both urban and rural Ethiopia. Though the focus is mainly in urban sites, the inclusion of rural sites provides a unique opportunity to track the HIV/AIDS mortality pattern in the rural population through a longitudinal population based data. The data from this surveillance is currently used by FMOH, EPHI and other global partners to assess the burden of mortality from HIV, TB and malaria for planning resource allocation.	Sustained Epi Control	HIV attributable death disaggregated by age and sex quantified to monitor the impact of HIV care and treatment program	Annual HIV and related mortality surveillance report generated and used to inform PEPFAR programs	Trend on HIV and related mortality surveillance available	Annual surveillance report	HVSI	158,000	16738 (EPHA)	NA
Technical support for implementation of drug resistance surveillance. This surveillance generates information for individual facilities to assess factors leading to the risk of emergence of HIV drug resistance: including Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion rates at selected nationally representative sites. The measurement and detection of these EWI levels ensures the early detection and institution of early corrective actions at facility, region and national level before treatment failure manifested by unsuppressed viral load level happens. In the advent of scale up of viral load testing, the actual viral load testing will improve for the last two indicators among the EWI. However, viral load testing has very recently started rolling out and will not be able to generate national level information at the moment. Until routine reporting systems is able to generate the data on the level of EWI with immediate remedial actions prevent HVDR, EWI surveys from representative sites are the key to avail this information. According to the WHO Global report on early warning indicators (EWI), July 2016, in order to eliminate AIDS as a public health threat during a time of limited global financial resources, efforts to identify gaps in ART programme functioning and to improve the quality of ART service delivery very critical. The identification and correction of gaps in the quality of service delivery, as detected through the monitoring of early warning indicators (EWIs) maximizes the long-term durability and effectiveness of current and future recommended regimens to ensure that the WHO/UNAIDS targets to eliminate AIDS as a public health threat are achieved. http://apps.who.int/iris/bitstream/10665/246219/1/9789241511179-eng.pdf?ua=1. With this activity WHO will provide technical assistance to EPHI and regional RHB to assess and provide regular annual surveillance data from EWI on Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion at selected nationally representative 79 health facility throughout Ethiopia on annual basis as per the global HIV drug resistance guideline	Second 90/Third 90; Sustained Epi Control	Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion generated and utilized from the routine reporting system.	Risk of emergence of ARV drug resistance monitored	HIV Early warning drug resistance survey integration in the routine system initiated	Progress and annual surveillance report	HVSI	56,391	16750 (WHO)	NA

Technical support for implementation of drug resistance surveillance. This surveillance generates information for individual facilities to assess factors leading to the risk of emergence of HIV drug resistance: including Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion rates at selected nationally representative sites. The measurement and detection of these EWI levels ensures the early detection and institution of early corrective actions at facility, region and national level before treatment failure manifested by unsuppressed viral load level happens. In the advent of scale up of viral load testing, the actual viral load testing will improve for the last two indicators among the EWI. However, viral load testing has very recently started rolling out and will not be able to generate national level information at the moment. Until routine reporting systems is able to generate the data on the level of EWI with immediate remedial actions prevent HVDR, EWI surveys from representative sites are the key to avail this information. According to the WHO Global report on early warning indicators (EWI), July 2016, in order to eliminate AIDS as a public health threat during a time of limited global financial resources, efforts to identify gaps in ART programme functioning and to improve the quality of ART service delivery very critical. The identification and correction of gaps in the quality of service delivery, as detected through the monitoring of early warning indicators (EWIs) maximizes the long-term durability and effectiveness of current and future recommended regimens to ensure that the WHO/UNAIDS targets to eliminate AIDS as a public health threat are achieved. http://apps.who.int/iris/bitstream/10665/246219/1/9789241511179-eng.pdf?ua=1. With this activity WHO will provide technical assistance to EPHI and regional RHB to assess and provide regular annual surveillance data from EWI on Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion at selected nationally representative 79 health facility throughout Ethiopia on annual basis as per the global HIV drug resistance guidelines.	Second 90/Third 90; Sustained Epi Control	Prescribing practices, retention on ART at 12 at months, Lost To Follow up at 12 months, On-time pill pick-up, On-time appointment keeping, drug stock outs, viral load suppression and viral load completion generated and utilized from the routine reporting system.	Risk of emergence of ARV drug resistance monitored	HIV Early warning drug resistance survey integration in the routine system initiated	Progress and annual surveillance report	HVSI	150,000	16751 (EPHI)	NA
Support Field Epidemiologists to provide technical support to active surveillance approaches and monitor program performance at the top 20 scale-up Woreda's, RHB, and FMOH. FLTP graduates/students will be assigned at PEPFAR focused 20 Towns and will assist facilities for the analysis of data by gender, sex, testing modality, treatment and other outcomes to strengthen data use to inform programs properly. At RHB and FMOH, they will support region and federal level data analysis for coordination of the 20 towns monitoring. They will also provide site level support to establish/ strengthen the system for monitoring partner notification services and distributions of commodities	90/90/90	Capacity built at site level to analyses date for proper decision making		EFTP graduates deployed on the 20 PEPFAR towns		HVSI	50,000	16738 (EPHA)	NA
Systems Development									
Provide technical and other support to FHAPCO's initiative to transition from a paper-based MRIS to e-MRIS.	90/90/90	Targeted community outlets are able to use e-MRIS for program onitoring and decision making	50% of targeted communities have transitioned from paper based MRIS to e-MRIS	80% of targeted communities have transitioned from paper based MRIS to e-MRIS	Program data on # of community service outlets that are using e-MRIS	HVSI	105,862	17825 (Community TBD)	Performance data, 4.48
Provide mentoring, training of private health care workers and SOP development on rational drug use	90/90/90	Strengthened rational pharmaceutical practices in private health facilities	Private health facilites will implement standardized practice of rational drug use and will be able to use all SOP based on the national guideline	All Private health sector supported facilites will implement automated information system for rational pharmaceutical practice	Number of facilites implementing rational pharamaceutical practice	OHSS	8,101	17824 (Abt)	Quality Management, 1.62 Private sector engagement, 4.44
Provide TA to community based groups (PLHIV associations, CSOs, CCC) to strengthen their capacity to plan, monitor, and evaluate their programs	90/90/90	1. Community based groups are routinely using program and other data to make program decisions 2. 80% of supported community service outlets score light green or better on SIMS	1. Routine data quality reviews and protocols are put in place 2. At least 50% of supported community service outlets score light green or better on SIMS	1. Quarterly data reviews implemented 2. 70% of supported community service outlets score light greena or better on SIMS	Program monitoring data	HBHC HTXS MTCT OHSS PDCS	40,309 612 0 5,496 1,221	17825 (Community TBD)	Performance data, 4.48 Civil society engagement, 4.0
TOTAL for 6.3.							**9,179,616**		

*Reference Appendix C for a list of activity types that fit in each category.

GRAND TOTAL for Construction Only	**12,209,550**
GRAND TOTAL (without construction)	**25,497,863**
GRAND TOTAL (with construction)	**37,707,413**