

## **ENHAT- CS Annual Progress Report FY12**

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ENHAT-CS Team

October 2011 – September 2012

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**PEPFAR Ethiopia In-Country Reporting System (IRS)  
Reporting Template**

***Management Sciences for Health  
Ethiopian Network for HIV and AIDS Treatment, Care and  
Support Program  
(ENHAT-CS)***

**ANNUAL PROGRESS REPORT  
FY12**

*(OCTOBER 2011–SEPTEMBER 2012)*

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## LIST OF ACRONYMS

AA	Addis Ababa
AB	Abstinence, be faithful
AFB	Acid fast bacilli
AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal care
ANECCA	African Network for Care of Children Affected by HIV/AIDS
ARC	AIDS Resource Center
ART	Anti-retroviral therapy
ARV	Anti-retroviral
BCC	Behavior change communication
BCP	Basic care package
CAM	Catchment area meeting
C&S	Care and support
CBO	Community-based organization
CCG	Community core group
CD4	Cluster of differentiation 4 (better known as T cell)
CME	Continuous medical education
CPT	Cotrimoxazole therapy
CTX	Cotrimoxazole
DBS	Dry blood sample
DHS	Demographic and health survey
DNA-PCR	Deoxyribose nucleic acid-polymorphous chain reaction
DOHE	Dawn of Hope Ethiopia
DOTS	Directly observed treatment short-course
DQA	Data quality assurance
DTS	Dried serum sample
D4T	Stavudine
EDHS	Ethiopian Demographic and Health Survey
EHNRI	Ethiopian Health and Nutrition Research Institute
EID	Early infant diagnosis
EIFDDA	Ethiopian Interfaith Forum for Development Dialogue and Action
EPI	Expanded program for immunization
EQA	External quality assurance
ESR	Eritrocyte sedimentation rate
F	Female
FFC	Family focused care
FFSDP	Fully functional service delivery point
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FHI	Family Health International
FMOH	Federal Ministry of Health
FP	Family planning
FY	Financial year
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HAPSCO	HIV/AIDS Prevention, Care and Support Organization
HBC	Home-based care
HC	Health center
ENHAT-CS	HIV/AIDS Care and Support Program
HCT	HIV counseling and testing
HEI	HIV-exposed infants
HEW	Health extension worker
HgB	Hemoglobin

HIV	Human immune deficiency virus
HIV+	HIV positive
HMIS	Health management information system
IAS	International AIDS Society
IGA	Income generating activity
IP	Infection prevention
IPT	Isoniazid preventive therapy
JPM	Joint pediatrics mentorship
JSI	John Snow International
KOOW	Kebele-oriented outreach worker
L&D	Labor and delivery
LQAS	Lot quality assurance sampling
LTFU	Lost-to-follow-up
M	Male
M&E	Monitoring and evaluation
MDR	Multi-drug resistance
MDT	Multi-disciplinary team
MIS	Management information system
MNCH	Maternal, neonatal and child health
MOH	Ministry of Health
MOU	Memorandum of understanding
MSG	Mother support group
MSH	Management Sciences for Health
NACS	Nutritional assessment, care and support
NGI	Next generation indicator
NGO	Non-governmental organization
NNPWE	National network of Positive Women Ethiopians
NVP	Nevirapine
OI	Opportunistic infection
OP	Other prevention
OPD	Out-patient department
OR	Operations research
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief
PFA	Pharmaceuticals fund and supply agency
PITC	Provider initiated testing and counseling
PLHIV	People living with HIV
PMP	Performance monitoring plan
PSI	Population Services International
PwP	Prevention with positives
Q	Quarter
REQAS	Regional external quality assurance
REST	Relief Society of Tigray
RH	Reproductive health
RHB	Regional health bureau
RLTWG	Regional laboratory technical working group
RPR	Rapid plasma regain
SCMS	Supply chain management systems
SI	Strategic information
SNNPR	Southern Nations, Nationalities, and People's Region
SOC	Standard of care
SOP	Standard operating procedure
SPM	Strategic plan management
SPS	Strengthening pharmaceutical systems

STD	Sexually transmitted disease
STTA	Short term technical assistance
T&C	Testing and counseling
TB	Tuberculosis
TB-CAP	Tuberculosis Control Assistance Program
TBL	Tuberculosis and leprosy
TDF	Tenofovir
THPP	Targeted HIV Prevention Program
TOT	Training of trainers
TWG	Technical working group
USAID	United States Agency for International Development
VCAP	Voluntary community anti-AIDS promoters
VCT	Voluntary counseling and testing
WAD	World AIDS Day
WBC	White blood cells
WHO/AFRO	World Health Organization/ Africa Regional Office
WVI	World Vision International

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## I. Reporting period

<b>From</b> 1 October 2011	<b>To</b> 30 September 2012
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## 2. Publications/reports

**Did your organization support the production of publications, reports, guidelines or assessments during the reporting period?**

No/Not Applicable

Yes

If yes, please list below:

Publications/Reports/Assessments/Curriculums

Title	Author	Date
Gender mainstreaming in HIV/AIDS programs (poster presentation)	Belkis Giorgis, Cassandra Gallese, Bud Crandall, Fred Hartman, Elke Konings	16 <sup>th</sup> International Conference on AIDS and STIs in Africa (ICASA), Addis Ababa, December 2011
Towards an HIV-free generation: challenges and opportunities in Ethiopia (accepted for poster presentation)	Elke Konings, Lemma Ketema, Tsegazeab Kahsu, Biruhtesfa Bekele, Mulugeta Abuye, Fred Hartman, Bud Crandall	Children and HIV: Closing the Gap – Ending Vertical Transmission through Community Action Symposium, Washington D.C., July 2012
Successful national scale up of comprehensive HIV/AIDS services in Ethiopia (accepted for poster presentation)	Bud Crandall, Fred Hartman, Elke Konings, Tesfaye Arega	XIX International Aids Society Conference, Washington D.C., July 2012
ARV uptake and linkage to care services among HIV-positive pregnant women at health centers in Ethiopia (accepted paper for oral presentation)	Ketema Lemma, Alemayehu Legesse, Tesfaye Arega, Sisay Solomon, Fred Hartman, Bud Crandall, Elke Konings	Integration for Impact Conference, Nairobi, Kenya, September 2012
Implications of adopting new WHO guidelines for antiretroviral therapy initiation in Ethiopia (accepted paper)	Elke Konings, Yirga Ambaw, Katherine Dilley, Peter Gichangi, Tesfaye Arega, Bud Crandall	Bulletin (online) of the World Health Organization, September 2012 issue
ENHAT-CS semi-annual brief, issue I	ENHAT-CS	September, 2012
Baseline Assessment Report of Health Center Laboratories in Amhara and Tigray	Dr. Wubshet Mamo	Stakeholders/Partners Meeting, 14 September 2012, Addis Ababa
Situational Assessment in Integrating Mental Health into HIV/AIDS Treatment, Care and Support in Health Centers in Amhara and Tigray Regions, Challenges, Opportunities and Recommendations	Dr. Tedla Giorgis	Stakeholders Meeting, 20 September 2012, Addis Ababa

**3. Technical assistance:** Did your organization utilize short-term technical assistance during the reporting period?

No/Not Applicable

Yes

Please list below:

**Consultants/TDYers**

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	15 Sept '11	17 Oct '11	MSH	Technical support and program supervision
	9 Nov'11	20 Nov'11		
	6 Jan'12	18 Jan'12		
	4 Feb'12	12 Feb'12		
	16 Apr'12	24 Apr'12		
	5 May'12	12 May'12		
	12 Jul'12	24 Jul'12		
	3 Aug'12	10 Aug'12		
	3 Sept'12	12 Sept'12		
	21 Sept'12	26 Sept'12		
Dr. Elke Konings	10 Oct '11	10 Nov '11	MSH	M&E and OR
	3 Jan'12	10 Feb'12		
	15 Apr'12	4 May'12		
	8 Jul'12	31 Jul'12		
	4 Sept'12	18 Sept'12		
Yen Lim	9 Oct'11	15 Oct'11	MSH	Contractual assistance
Seleman Allie	25 Dec'11	12 Jan'12	Consultant	On-line database development
	3 May'12	20 May'12		
Ronnie Lovich	26 Mar'12	4 Apr'12	SCUS	TA for gender mainstreaming and MSG
Jemal Mohammed	14 Jun'12	15 Jun'12	MSH	TA for leadership development program component
Rose Nasaba	23 Jul'12	28 Jul'12	ANECCA	Psychosocial training
Zina Jarra	29 Jul'12	12 Aug'12	MSH	Costing study

**4. Travel and Visits** Did your organization support international travel during the reporting period?

No/Not Applicable

Yes

Please list below:

**International Travel (All international travel to conference, workshops, trainings, HQ or meetings).**

Name	Destination	Departure from Ethiopia	Arrival	Host Organization	Purpose of the travel
Tesfaye Arega, Strategic Information Director, ENHAT-CS	Mombasa, Kenya	10 Jun'12	20 Jun'12	ENHAT-CS	Attend the DHIS2 Training and Conference for East and Southern Africa
Hella Dawit, Data Officer, ENHAT-CS					
Ayeligne Mulualem, Head, RHB Amhara	Washington DC and Boston, MA	July	July	MSH	Study tour including participation in IAS'12
Hagos Godefay, Head, RHB Tigray	Washington DC and Boston, MA	July	July	MSH	Study tour, including participation in IAS'12
Lemma Ketema, MNCH/HIV integration advisor, ENHAT-CS	Nairobi, Kenya	11 Sept'12	16 Sept'12	MSH	Oral presentation at Integration for Impact Conference

**Have any Monitoring Visit/supervision been made to your program in during the reporting period?**

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
US Ambassador, Donald E. Booth	1 Nov'11	1 Nov'11	Wukro HC (Tigray)	None received
USAID Ethiopia DQA Team	Nov '11	Nov '11	Adigudom HC (Tigray) and Bahir Dar program office	“ “
USAID Ethiopia HIV/AIDS Team Leader, Sheri-Nouane Duncan-Jones	15 Nov'11	15 Nov'11	Adigudom HC (Tigray)	“ “
	21 Nov'11	21 Nov'11	Addis Zemen and Bahir Dar HCs (Amhara)	“ “
USAID Ethiopia, Shileshi Kassa, Dr. Mesfin Tilaye	23 Mar'12	23 Mar'23	Kasech Health Center	“ “
USAID Ethiopia, Dr. Helina Worku (AOTR), Shileshi Kassa, Dr. Mesfin Tilaye	23 Mar'12	23 Mar'23	Mekele Health Center	“ “
National PMTCT TWG, Sr. Etenesh Gebru (FMOH), Dr. Atnafu Getachew (WHO), Dr. Kurabacehw Abera (AIDSTAR-One), Dr. Lemma Ketema (ENHAT-CS)	23 Apr'12	27 Apr'12	Ambeame Health Center and Dera Woreda Health Office amongst other non-program sites.	Yes
Joint Interagency (CDC & USAID) Team, Dr. Afework Negash (USAID0 , Getahun Sisay (CDC), Semunegus Mehret (USAID)	7 May'12	11 May'12	Shire HC, Axum HC, Semein HC	Verbal report provided
Joint Interagency (CDC & USAID) Team, Dr. Edson Muhwezi (USADI), Dr. Abdulhamid Isehak (CDC), Tsegaye Tilahun (USAID), Mesfin Tilaye (USAID)	14 May'12	18 May'12	Kombolcha HC, Debretabor HC,	Verbal report provided
USAID HIV/AIDS team, Dr. Helina Worku, Dr. Padma Shetty, Dr. Mary Kabanyana	23 Sept'12	23 Sept'12	Marawi HC	Verbal report provided

## 5. Activity

Program Area (Tick all which apply)	Activity ID	Activity Title ( Please write the title of the activity)
<input checked="" type="checkbox"/> 01-PMTCT		
<input checked="" type="checkbox"/> 02-HVAB		
<input checked="" type="checkbox"/> 03-HVOP		
<input type="checkbox"/> 04-HMBL		
<input type="checkbox"/> 05-HMIN		
<input type="checkbox"/> 07-CIRC		
<input checked="" type="checkbox"/> 08-HBHC		
<input checked="" type="checkbox"/> 09-HTXS		
<input checked="" type="checkbox"/> 10-HVTB		
<input type="checkbox"/> 11-HKID		
<input checked="" type="checkbox"/> 12-HVCT		
<input checked="" type="checkbox"/> 13-PDTX		
<input checked="" type="checkbox"/> 14-PDCS		
<input type="checkbox"/> 15-HTXD		
<input checked="" type="checkbox"/> 16-HLAB		
<input checked="" type="checkbox"/> 17-HVSI		
<input checked="" type="checkbox"/> 18-OHSS		

## 01-PMTCT

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 01-PMTCT

**PMTCT accelerated plan, adoption of Option A of new WHO guidelines and Option B+:** At the beginning of FY12, Ethiopia published and began to roll out an accelerated plan for scaling up PMTCT services, aiming at rapidly increasing national coverage. In January, Ethiopia also adopted Option A of the new WHO guidelines for PMTCT, to increase the number of HIV-positive women taking ARVs for PMTCT. In August, Ethiopia switched to Option B+, which is expected to further increase PMTCT coverage. While Option A initiates ARV prophylaxis at 14 weeks of gestation (instead of the previous 28) and provides HAART to women with a CD4 count below 350 (instead of the previous 200), Option B+ recommends triple therapy for life for all pregnant women, irrespective of their gestational age or CD4 count, and initiates therapy under a preferred TDF/3TC/EFV regimen that can be taken as a once daily FDC pill.

The accelerated plan and the new Option A guidelines took effect during Q2. Accordingly, ENHAT-CS began to roll them out to program-supported health centers (HCs) using the national training plan and materials, and supported by on-site mentorship. The transition from the old to the new guidelines for Option A at program-supported health centers was completed in Q3, and currently almost all program-supported HCs have fully adopted the new guidelines. The latest national guidelines and Option A will continue to be part of the program's training and TA package at new ART health centers until the FMOH and RHBs launch the transition to Option B+.

During the APR'12 reporting period, ENHAT-CS achieved the following results in the area of PMTCT:

✓ **191 health centers (HCs) are providing PMTCT services (PI.3.D)**

Comment: ENHAT-CS reports PMTCT data from all HCs that received ENHAT-CS mentorship and technical assistance during the reporting period and that are not supported for PMTCT by another implementing partner, i.e. 191 of the 205 HCs that currently offer comprehensive HIV/AIDS services, including ART, or 100% of the FY12 target. The remaining 15 HCs were supported for PMTCT by the USAID CPMTCT project.

✓ **143,612 pregnant women were seen by a skilled provider (trained on MNCH/PMTCT)**  
(Non-NGI: PMP indicator # 4)

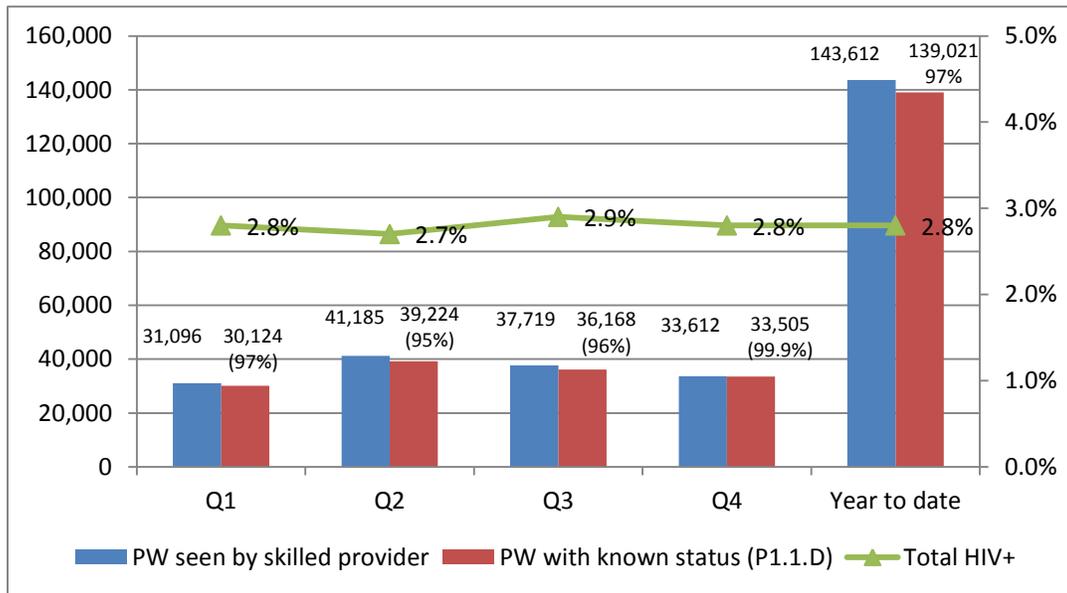
Comment: The number of pregnant women provided with ANC and the number of women seen for labor and delivery care by a skilled provider was 33,612 in Q4, slightly down from 37,719 in Q3 and 41,185 in Q2, but still up from the 31,096 seen in the first quarter. Other than expected seasonality in pregnancy, a probable factor for the decreasing numbers since Q2 is the increasing number of health centers that opened, making services more accessible to pregnant women and thus decreasing the load on existing health centers. As a result of the accelerated plan, it is also possible that the quality of ANC and L&D services at existing non-program supported non-ART HCs in more remote areas improved and thereby attracted more pregnant women who would previously have sought ANC services at HCs in urban and peri-urban areas. The cumulative total number of pregnant women seen by a skilled provider in FY12 was 143,612 representing 104% of the PY1 program target.

✓ **139,021 pregnant women had their HIV status known (P1.1.D) of whom 2.8% (3,962) were positive (P1.ID)**

Among the **3,962** HIV-positives:

- **2,129 (1.5%) were known HIV-positive at entry**
- **1,833 (1.3%) were tested and found newly HIV-positive**

Comment: Consistent with the above indicator, the number of pregnant women with known HIV status at program-supported health centers slightly declined from Q2 to Q3 to Q4.



The annual achievement only reached 74% of the FY12 target. Per USAID instruction, the FY12 target was increased based on the assumption that the national accelerated plan for PMTCT would roll out rapidly and increase demand at community level for MNCH/PMTCT services. However, the plan was only partially rolled out in FY12 and the demand creation activities were not fully operationalized in the regions where ENHAT-CS operates. This resulted in less than expected ANC attendance at program supported HCs.

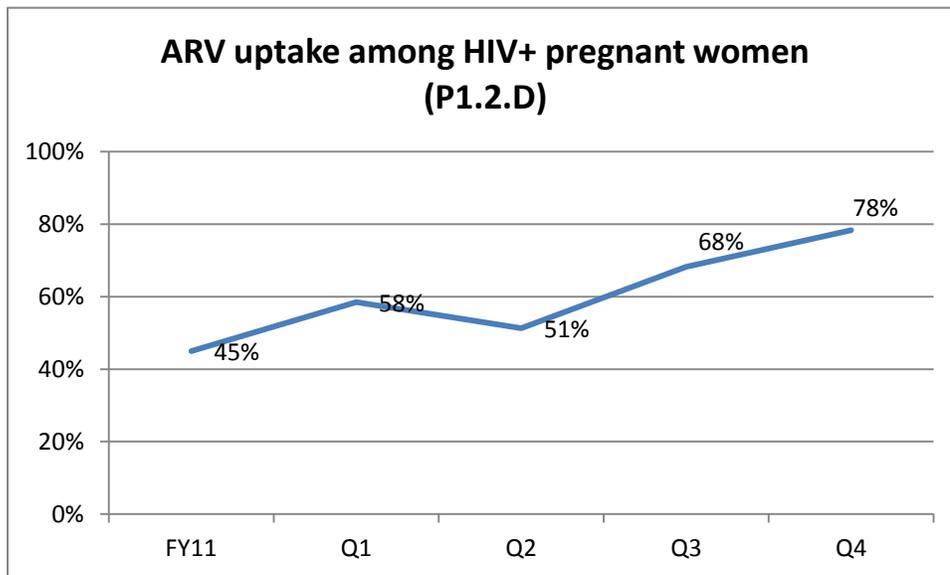
Among all pregnant women seen at program-supported HCs, 1.5% was known HIV-positive at entry and 1.3% was found to be HIV-positive through PITC at ANC or L&D.

Among all HIV-positives, the proportion known HIV-positive at entry was 54% in FY12. The rate was relatively stable across the four quarters, from 46% in Q1, 55% in Q2, 57% in Q3, and 53% in Q4.

✓ **2,535 HIV-positive pregnant women received ARV for PMTCT (P1.2.D).**

2 received a single dose nevirapine prophylaxis  
1,204 received two ARVs  
1,329 received ART at the ART clinic

Comment: Among the 3,962 HIV-positive pregnant women seen during FY12, 64% received ARVs for PMTCT, compared to 45% in FY11. Uptake increased over the year from one quarter to the next and by the end of FY12, program-supported HCs reported an uptake of 78%, approaching the national target of 80%.

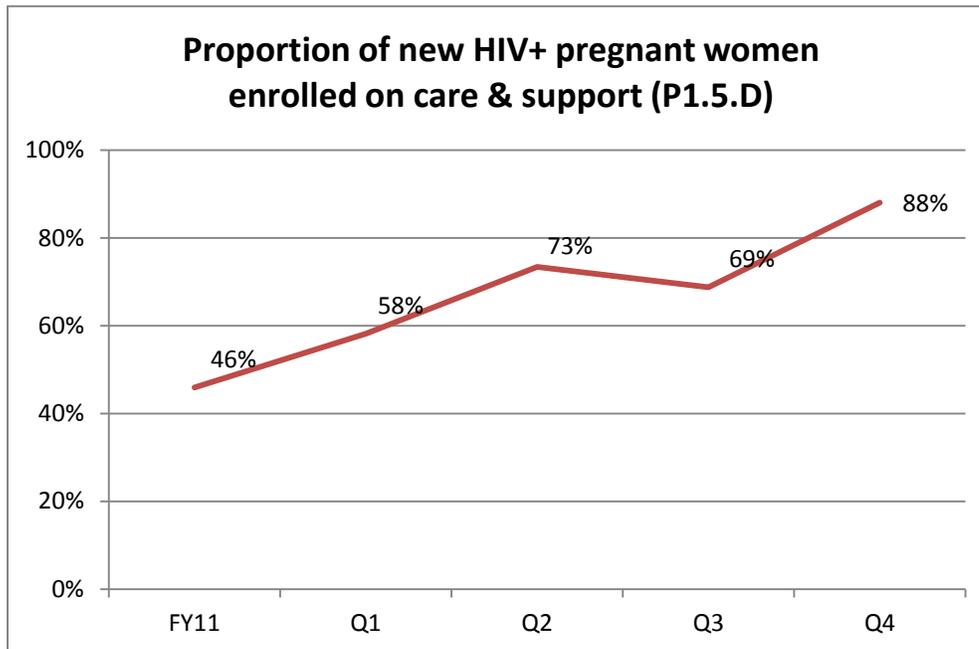


The above improvement is likely due to better recording and reporting, intensive mentorship provided, and improved services. Furthermore, by Q3, all program-supported HCs had transitioned to offering Option A, which, as mentioned above, initiates HIV-positive pregnant women on ARVs at 14 weeks of gestational age (instead of the previous 28 weeks) and on ART when their CD4 count is below 350 (instead of the previous 200).

Now that the Government of Ethiopia (GOE) adopted Option B+, the FMOH is considering to introduce a one stop shop approach at the ANC clinic, so that HIV-positive pregnant women seen at ANC will no longer need to be referred to the ART clinic for the duration of the pregnancy. The program intends to conduct operations research to determine if the “one stop shop” approach at ANC clinics, once adopted, will indeed increase uptake of PMTCT services.

- ✓ **1,318 (72%) of the 1,833 newly tested HIV+ pregnant women were assessed for ART eligibility at ENHAT-CS supported HCs (PI.4.D - data source: ART clinic)**
- ✓ **1,318 (72%) of the 1,833 newly tested HIV+ pregnant women were newly enrolled into HIV/AIDS care and support in ENHAT-CS supported HC (PI.5.D - data source: ART clinic).**

Comment: The proportion of newly identified HIV-positive pregnant women who were assessed for ART eligibility and enrolled on care and support increased steadily from one quarter to the next and achieved 88% in Q4, with an overall 72% for the entire year FY12 compared to 45% in FY11.



The above improvement over the course of the year is likely related to the resumption of monthly mentorship and TA, the program's focus on accurate data recording and reporting during the mentorship process, and improved skills of the data clerks following the program's refresher trainings during program start-up.

Of note, the reported data in Q4 is consistent with findings from assessments of the standards of care (SOC) that the program conducted in June of this year at 80 of the 190 HCs supported by the program for PMTCT. The SOC assessments include a physical verification and review of the registers and patient cards at the HCs and showed that 292 of 318 (92%) newly identified HIV-positive pregnant women were linked to care and support services.

- ✓ **284 health workers were trained on integrated PMTCT/MNCH according to national guidelines (see H2.3D)**

Comment: Based on the program's expansion plan, attrition rates and national HR standards, the program trained 123 health workers in Q2 using national PMTCT/MNCH training curriculum. This accounted for 92% of the the program's first year's training plan. In Q4, the program trained an additional 161 health workers, including 156 providers at HCs not supported by the program. The latter were trained in response to RHB requests to assist with the PMTCT site expansion under the accelerated plan. The total achievement hence represents 212% of the FY12 target.

✓ **Additional Achievements**

**HEI data base:** In Tigray, the program has been supporting the RHB to collect data on the HIV infection rates in HEIs by PMTCT regimen of both mother and infant. To date, information on 1,543 HEIs shows that, with a vertical transmission rate of 2%, HAART is the most effective PMTCT regimen, regardless of whether the infant takes ARVs, followed by dual therapy but only when both mother and infant receive it (4%). This data strongly supports B+.

Mother/Infant PMTCT regimen	% of HEIs who test HIV-positive (n=1,543)
Dual/Dual	4%
Dual/None	16%
HAART/Dual	2%
HAART/None	0%
SdNVP/SdNVP	18%
None/None	26%

**Capacity Building for program staff:** Technical training and updates on all program components was provided to all ENHAT-CS technical staff in Addis Ababa, from April 30–May 12. The PMTCT component emphasized the update on Option A, PMTCT drug regimens and improving maternal, newborn and child health care in facilities through integrated mentorship approaches.

**Support to the national PMTCT accelerated plan initiative:** Program staff actively participated as members of the national and regional PMTCT technical teams and worked closely with FMOH and regional implementers in supportive supervision for the accelerated PMTCT service provision. During Q3, the program supported, both technically and financially, the piloting of the new FMOH PMTCT continuous quality improvement (CQI) tool in Amhara as requested by the FMOH.

**Adoption of Option B+:** At the PEPFAR technical working group on PMTCT and pediatric HIV/AIDS in January, the program presented data in support of promoting Option B+. The presentation included data on vertical transmission rates by PMTCT regimen at program-supported HCs in Tigray and on MSH’s work in Malawi, including the publication in a Lancet article that resulted in WHO updating its PMTCT guidelines to include consideration of B+ and in the adoption of B+ by several countries across Africa. Following the TWG meeting, PEPFAR/Ethiopia formally adopted the position to promote B+ with the FMOH. In Q3, the FMOH convened a technical advisory team for the national adoption of Option B+. ENHAT-CS’s RH/MNCH integration advisor has been a key member of this team and chaired the development of a concept paper on the programmatic implications of adopting Option B+, which was submitted to the state minister for health. Following the GOE adoption of Option B+ in August, the program has been actively involved at national and regional levels to assist in planning for the roll-out.

**Extended PEPFAR POP TWG 2012 meeting:** ENHAT-CS actively participated in both TWGs convened by PEPFAR/Ethiopia in FY12. The program hosted the second PEPFAR POP TWG meeting, which was conducted at Siyonat Hotel on June 13, 2012. Both the January and the June meetings placed great emphasis on PMTCT. A number of presentations, updates and PEPFAR program achievements and gaps were discussed and consensus reached on how to go forward. In addition to PEPFAR’s implementing partners in Ethiopia, the TWGs were also attended by UN organizations.

**Mother support groups:** During the reporting period, ENHAT-CS provided support to 236 mother mentors of mother support groups (MSGs) in 59 primarily high patient load HCs, all of which had previously been supported by HIV/AIDS Care and Support Program (HCSP). In these HCs, the ANC, L&D and ART focal persons recommend all HIV-positive pregnant and lactating mothers to join their HC MSG for support and counseling. The package of services provided by MSG mother mentors includes psycho-social support, adherence counseling, promotion of facility delivery, encouragement of male involvement and family testing, group support, FP promotion, and appropriate infant feeding

options. In this reporting period, the program enhanced its focus on prevention of unintended pregnancies in HIV-positive women through improved provision of FP services. Through use of personal testimonials, the MSG mother mentors continued to promote uptake of FP by HIV-positive lactating mothers.

During Q3, the program began tracking the number of newly enrolled mothers and at least 453 mothers were newly enrolled in MSG activities. As expected, the number of newly enrolled mothers increased in the fourth quarter as mother mentors expanded MSG activities beyond ANC and PMTCT to the OPD and ART waiting rooms. With another 482 mothers newly enrolled in MSG activities in Q4, the FY12 total reached 2,171.

During the reporting period, a total of 236 mother mentors and 57 site coordinators/PMTCT nurses received refresher training. This training used an adapted 5 day training curriculum for MSGs, which incorporates 2 extra days for involvement of men in PMTCT, savings club skills training and infant and young child feeding and nutrition for pregnant and lactating mothers. In addition, the program trained 350 female community volunteers based in NNPWE woreda associations to strengthen community support for PMTCT/MNCH through NGO partners and their affiliate woreda level community based organizations. Among other tasks, they promote FP counseling, dual protection and access to services for HIV-positive women and their spouses/partners during home visits and association meetings.

Through NNPWE, the program continued to address gaps through mentorship for MSGs; promotion of ownership of MSG activities at woreda and HC level; strengthening MSG linkages with case managers and volunteers; and expanding their network for tracing pregnant mothers and HEIs through the community network of PLHIV associations affiliated to NNPWE.

Monthly mentorship and supportive supervision was provided for all 59 MSG sites by clinical mentors. A more focused and in-depth mentorship was provided for all the 59 MSG sites using the program's new MSG mentorship checklist. During the monthly and quarterly mentorship, the program staff worked with the HC heads to resolve issues of inadequate and inappropriate space (a factor compromising confidentiality of MSG clients). Mentorship visits also addressed gaps in recording and reporting and appropriate record keeping of MSG daily activities using government approved reporting formats as well as creating more effective and formal linkages among MSG mentors, case managers and community outreach workers.

The program also conducted in-depth assessments of compliance with the national standard of care (SOC) for MSGs at 8 of the 59 program-supported HCs with MSGs. The overall compliance rate was 81%, but masked great variations. For instance, while close to 100% of MSG members received counseling on assisted delivery, only 18% had their partners tested for HIV. During the SOC assessment, it became clear that some areas with poorer compliance were those that MSG mentors did not accurately document. The program therefore provided tools and on-site orientation on how to properly document in their registers. The program will also initiate MSG sessions for couples to include and reach more partners for counseling and testing.

To strengthen HC – community (primary health unit) linkages through the kebele-based HEWs and their support network (women leaders, women team members and CBOs for linking HIV-positive mothers to community PMTCT and other support services), MSG mentors participated in 125 primary health care unit meetings held monthly at health centers. Their continued participation in these meetings will strengthen their linkages to community level support, including tracing of mothers and children who miss clinic appointments, follow-up for adherence, and linkages to local care and support services.

In FY12, MSG mother mentors traced 95 HIV-positive women who had missed their appointments and convinced them to resume treatment. MSG mother mentors also linked an additional 935 HIV-positive mothers to their MSGs. Another 1,230 HIV-positive women were provided with family planning counseling. The mother mentors also advocated for partner testing at ART, ANC and OPD clinics, resulting in 286 partners of MSG members being tested in FY12. Furthermore, 61 grass roots PLHIV associations were provided with technical support to conduct association meetings focused on PHDP/positive living at least once a month.

As MSG mother mentors continue to expand their activities beyond the HC walls and work closely with PLHIV associations, case managers, outreach workers and religious leaders, the program anticipates a rise in the number of mothers traced and linked back to care and support.



MSGs discuss issues during coffee ceremony session (East Amhara)

#### Collaborative activities with other USG partners

- The program collaborated with the SCI implemented USAID **ENGINE** and **TransACTION** projects to develop a training curriculum and train the aforementioned 236 MSG mother mentors and 57 site coordinators on infant and young child feeding, nutrition for pregnant and lactating mothers and savings club skills. These collaborative activities were expanded to train 10 ENHAT-CS staff, who is working with the MSGs and volunteer outreach workers, on infant and young child nutrition (IYCN). The trained staff began conducting intensive on-site mentorship of MSGs mother mentors and community volunteers to increase knowledge and promote appropriate infant and young child feeding/nutrition practices for PLHIV in the target woredas. Fifty-seven (57) mother mentors were trained on-site on IYCN counseling skills. Based on savings skills imparted during the refresher training in Q2 and Q3, savings clubs were started with 574 MSG mothers and mentors saving at least 46,500 Birr by the end of FY12, with saving amounts ranging from 500 to 22,300 Birr per site.
- At program start-up, ENHAT-CS staff met with key partners working in MNCH/PMTCT. They included **MCHIP**, **CPMTCT**, **HEAL TB** and **SCMS**. With each partner, ENHAT-CS reviewed opportunities for collaboration and gaining efficiencies, and agreed on ways to collaborate.

**Standards of care (SOC) assessment:** ENHAT-CS conducted standard of care assessments at 80 HCs. The objective was to assess the quality of care by determining the compliance of MNCH/PMTCT/FP services with the national standards. The results of the assessments were shared with respective health centers staff and action points were taken. Detailed results of the assessment will be communicated to the RHBs, woreda health offices, and health centers to improve service quality.

**Sharing ENHAT-CS program achievements with RHBs:** ENHAT-CS shared its program achievements to date, including its challenges, with the two RHBs. The achievements in the area of PMTCT were discussed at length. Both in Amhara and Tigray, the RHBs expressed their appreciation for the program's work and requested support for expanded activities in MNCH to address issues beyond PMTCT.

**Executive Committee of Ethiopian Pediatric Society:** Two ENHAT-CS pediatricians participated in the monthly executive committee meetings of the national pediatric society to promote the society's collaboration with Ethiopian professional associations to promote PMTCT for mother-baby pairs and appropriate HEI and EID management.

**Participation in “Integration for impact conference 2012”** held in Nairobi from Sept 12-14, 2012. The program's RH/MNCH and HIV integration advisor presented an abstract entitled “ARV uptake and linkage to care services among HIV-positive pregnant women at health centers in Ethiopia”. The abstract reported the results of a study conducted by program staff under its predecessor project HCSP and was presented at a plenary session.

## 02- HVAB (HIV prevention through abstinence and be faithful)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 2-HVAB (Sexual Prevention: AB)

**Note:** In FY12, ENHAT-CS phased out the KOOWs, previously supported by the USAID HIV/AIDS, Care and Support Program (2007-2011), and began prioritizing its support to AB and OP, at community level, on strengthening HCs to link with HEWs and their support network of community volunteers and community-based organizations. ENHAT-CS therefore limited its direct assistance for community-based prevention activities to NNPWE and EIFFDA, both ENHAT-CS partners, through training, advocacy, and support. The program trained and deployed 350 NNPWE community volunteers during Q3. ENHAT-CS only began reporting on AB and OP NGIs after the NNPWE volunteers initiated AB and OP activities during household visits according to the NGI guideline definitions. Reporting on the prevention NGIs (P8.1.D and P8.2.D) therefore primarily started in Q4.

- ✓ **4,091 targeted individuals reached with individual and/or small group level preventive interventions that are primarily focused on abstinence and/or being faithful and are based on evidence and/or meet the minimum standards required through behavior change abstinence and/or being faithful messaging (AB) approaches (P8.2.D)**

Comment: During FY12, 350 trained NNPWE community volunteers undertook community mobilization activities working in 59 grass roots sites and reached 4,091 individuals 10 to 14 years old with AB messages. They conducted house-to-house visits and reported on the number of people reached with primarily AB messages, using the revised NGI job aids and BCC materials in accordance with the PEPFAR NGI guideline. The target group included young children aged 10-14 years. The issues addressed during the four consecutive sessions focused on sexual abstinence, delay of sexual debut, mutual fidelity, and open discussion supported by the provision of IEC/BCC materials.

The achievement represents 52% of the program's FY12 target. The reason for under-achievement on this indicator is related to the delays in training the NNPWE volunteers. As a result, most individuals who were reached according to the NGI guideline were counted only in Q4. Of note, the program's FY12 target assumed that the NNPWE volunteers would support an average of 30 HHS each, containing an average of 0.78 children between the ages of 10-14. The volunteers actually exceeded the average number of HHs, reached 32 on average (totaling 11,334 HH). And a sample of 101 NNPWE supported HHs did find an almost exact same average (0.8). However, the volunteers tend to schedule their HH visits on when the adult caretaker(s) is home. It is likely that the volunteers were unable, in their shortened home visit timeframe of one quarter, to present the required four AB sessions to all the children, who are often outside of the HH e.g. attending school etc.

- ✓ **Additional Achievements**

**Customization of 630 NGI job aids on AB:** A key support to the community level prevention activities is the delivery and appropriate use of key AB messages. During the reporting period, 630 NGI job aids were developed in Amharic and then printed and distributed to program-supported HCs for use by the 350 trained NNPWE community outreach during home visit sessions.

**Customization of 2,858 copies of 10 different kinds of BCC materials and job aids** focusing AB messaging were collected from FHAPCO/ARC and distributed to the health facilities through the clinical mentors. The materials' AB messaging aims to reduce stigma and discrimination, and promote sustainable behavior change to help mitigate HIV and AIDS. The materials are intended for distribution by the case managers through the program's community referral network mobilizers (CRNM) to the community, MSGs, and PLHIV associations, as well as for clients visiting the health facilities.

**Support to and participation in World AIDS Day (WAD) 201:** Every year, on December 1, World AIDS Day is commemorated with different events and activities. This year's 23<sup>rd</sup> anniversary theme, "Getting to Zero - Zero New HIV Infections, Zero Discrimination and Zero AIDS Related Deaths" represented a global campaign intended to run until 2015. ENHAT-CS was actively involved at central and regional levels rendering technical and financial support. The support included advocacy and mobilization activities with AB messages in Addis Ababa, Axum (Tigray) and Bahir Dar (Amhara) through candlelight vigils, entertainment, a sports show, religious ceremonies, panel discussions and other events led by religious and political leaders. An estimated 200,000 individuals were reached with behavior change abstinence and/or being faithful messages (AB). Please see the section on OP for a complete account of ENHAT-CS support and participation in WAD'11.



**Faith-Based Organizations (FBO) Pledge – Amhara Region**

**35,000 youth were reached** through behavior change communication addressing abstinence and/or being faithful messaging (AB) approaches. At the request of the Ethiopian Higher Education Institute and FHAPCO, ENHAT CS collaborated and supported a public universities' sport festival, organized for public university students and hosted by Ambo University on February 4-19, 2012 under the theme "Sport for Health and Quality Education". ENHAT-CS participated on the event's technical task force and financial support to procure and distribute 161 T-shirts and BCC materials during the sports festival.

### 03- HVOP (HIV prevention through other prevention)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 3-HVOP (Sexual Prevention: OP)

**Note:** In FY12, ENHAT-CS phased out the KOOWs, HIV-positive community volunteer outreach workers previously supported by the HCSP, and began prioritizing its support to AB and OP, at community level, on strengthening HCs to link with HEWs and their support network of community volunteers and community-based organizations. ENHAT-CS therefore limited its direct assistance for community-based prevention activities to NNPWE and EIFFDA, both ENHAT-CS partners, through training, advocacy, and support. The program trained and deployed 350 NNPWE community volunteers during Q3. ENHAT-CS only began reporting on AB and OP NGIs after the NNPWE volunteers initiated AB and OP activities during household visits according to the NGI guideline definitions. Reporting on the prevention NGIs (P8.1.D and P8.2.D) therefore primarily started in Q4.

- ✓ **22,310 targeted individuals reached with individual and/or small group level preventive intervention that are based on evidence and/or meet the minimum standards through activities that promote HIV/AIDS prevention through other behavior change beyond abstinence and/or being faithful OP approaches (P8.1.D)**

Comment: During FY12, 350 trained NNPWE community volunteers undertook community mobilization activities working in 59 grass roots sites. They conducted house-to-house visits and reported on 22,310 people reached with OP messages, using the revised NGI job aids and BCC materials in accordance with the PEPFAR NGI guideline. The target group included adolescents and adults 15 years and older. The issues covered during the four consecutive sessions included psychosocial support, spiritual counseling, stigma reduction, mental health, PCP support, and others, and were supported by IEC/BCC materials.

The achievement represents 45% of the program's FY12 target. The reason for under-achievement on this indicator is related to the reality that the NNPWE volunteers prioritize their support and home visits to the most needy of their PLHIV association members. These are often single, abandoned women, living alone or with small children. The assumptions underlying the FY12 target included an average household size of 4 adults. The actual average number of people 15 years and older found in 101 sampled HHs was only 1.9 adults. So while the volunteers exceeded their target of supporting 30 HHs, by reaching an average of 32, the average number of adult members in each proved significantly lower.

- ✓ **416 persons were provided with post-exposure prophylaxis (P6.1.D)**

Comment: Among the 416 persons who received PEP at ENHAT-CS supported HCs, 197 (48%) had had an occupational exposure, 105 (25%) had been sexually assaulted/raped and the remaining 114 (27%) reported other non-occupational exposures. This distribution was similar between Amhara and Tigray. The total for FY12 to date was 305 and represents 121% of the program's FY12 target. The slight over-achievement relative to the FY12 target is also likely due to improved record keeping and reporting.

- ✓ **60,749 PLHIV reached with a minimum package of PwP interventions (P7.1.D)**

Comment: During FY12, the program reached 60,749 PLHIV with a minimum package of services attaining 118% of the program's annual target. ENHAT-CS has been counting the number of PLHIV who received PwP services as the total number of HIV-positive clients seen at HIV clinics --the assumption being that every client seen at the HIV clinic is counseled on prevention. To document this service more accurately, ENHAT-CS will include specific PwP services in the logbook that the program has updated and produced for use by HIV clinics. This logbook has been printed and was distributed for use by HIV clinics.

✓ **Additional achievements**

**Strengthened community support for PHDP services through NGO partners and their affiliate woreda level community-based organizations:** 350 NNPWE community outreach volunteers were trained to support PLHIV with services that include delivery of the minimum package of services and referral for different services (see HBHC section below).

**40,000 copies of the Libona newspaper were printed and distributed** with ENHAT-CS support to Dawn of Hope Ethiopia (DHEA), which resumed production of their Libona newspaper every month, starting in June 2012 when a total of 10,000 copies were produced and distributed (3,000 in Tigrigna and 7,000 in Amharic) to program-supported health centers and served community, through the clinical mentorship network. During FY12, DHEA published and distributed a total of 40,000 copies to program-supported health centers, PLHIV association members and served community, through the clinical mentorship network, NNPWE community outreach volunteers and DHEA association members in both regions.

**Publication of Voice of Women newsletter and distribution to Amhara and Tigray:** Under a partnership and contract agreement, ENHAT-CS supported the National Network of Positive Women Ethiopia (NNPWE) to produce 1,500 copies of their quarterly newsletter “The Voice of Women” in Amharic and Tigrigna languages. The first issue is currently in production and will be distributed to program-supported health centers, MG sites, project partners, PLHIV association members and served community, through the clinical mentorship network and NNPWE community outreach volunteers.

**Customization of 190,391 copies of BCC materials and job aids on OP:** A key support to the facility and community level prevention activities is the delivery and appropriate use of key OP messages. During the reporting period, ENHAT-CS distributed a total of 190,391 copies of brochures, posters, job aids and other reference materials in the regions of Tigray and Amhara for use by clients, beneficiaries and service providers out of which 30,389 copies of promotional materials were also produced for WAD 2011 and Ambo public Universities sports festival. The materials and total copies is included the following:

- 46,000 copies of a booklet on opportunistic infection and positive living
- 6,000 copies of a poster on ART
- 47,858 copies of a brochure on prevention and care and support
- 30,000 copies of ART drug information booklet
- 30,144 copies of reference materials for service providers
- 30,228 copies of promotional materials for WAD 2011
- 161 copies of promotional materials for Ambo public universities sports festival

The materials were delivered and distributed through the case managers who are responsible to facilitate further distribution through the CRNM to the beneficiaries, the MSGs, PLHIV associations and health center clients.

**Customization of 630 NGI job aids on OP:** One of the key supports to the community level prevention activities is the delivery and appropriate use of key OP messages. During the reporting period, 630 NGI job aids were developed, printed and distributed to ENHAT CS supported health centers MSG sites for use by NNPWE community outreach volunteers to address affected individuals and household members aged 15 and older during a home visit in the 59 MSG sites.

**Customization of 630 NGI job aids on PHDP:** A key support to the community level prevention activities is the delivery and appropriate use of key PHDP messages. During the reporting period, 630 NGI job aids were developed, printed and distributed to ENHAT CS supported health centers for use by NNPWE community outreach volunteers to address individuals aged 15 and above years old during a home visit in the 59 MSG sites.

**Distribution of 1,265 infant and young child nutrition flip chart on OP:** The program reprinted and distributed 1,265 flip charts to health centers for use by service providers at ART, U5, PMTCT, FP, ANC, OPD and MSG service sites as reference and educational materials.

**Training of 195 health center heads on infection prevention and patient safety(IP/PS):** To support the FMOH initiative to strengthen the IP/PS practices and processes in the health care setting, ENHAT trained 195 (M 132, F 63) health centers heads using the FMOH training packages and curriculum with intention to enable them to cascade the training to the other health facility staff and institutionalize the IP/PS according to national norms and standards.

Region	Target	Trained		Achievement
		Male	Female	
East Amhara	63	48	13	97%
West Amhara	82	68	10	95%
Tigray	60	16	40	93%
Total	205	132	63	95%

**Participation in TWG on IP/PS and other related activities:** ENHAT-CS has been actively involved in the Technical Working Group (TWG) on Infection Prevention and Patient Safety chaired by the Medical Services Directorate in the FMOH. With program-support, the TWG accomplished the following:

- A national IP/PS training reference manual was finalized, approved by the FMOH, printed and distributed to the regions and partners
- The IP/PS training participant handouts, facilitators guide and power-point presentations documents were developed, printed and distributed to the regions for use as training guides by all stakeholders
- A training of trainers (TOT) on IPPS organized by the FMOH in collaboration with TWG members was conducted for participants from all regions to validate the documents as standardized training documents
- Using the standardized training documents, TWG members in collaboration with the FMOH conducted TOT for regional trainers so that each regions will have its own pool of trainers
- Through involvement of TWG a Health Care Waste Management (HCWM) five year strategic action plan was finalized and approved by the Agrarian Health Service Directorate
- A national IP/PS commodities quantification assessment plan was finalized and submitted to the Medical Service Directorate (MSD)
- Technical and resource materials were developed for training managers and administrators to help institutionalize the practices and services at central and regional management and facility levels

### **2011 World AIDS Day Commemoration:**



### **Presidential address during the World AIDS Day 2011, Addis Ababa**

The national level 2011 WAD was commemorated in December 1, 2011 with different events and activities in Addis Ababa held at the national convention hall. In addition to the national level celebration in which ENHAT-CS was actively involved, similar activities were also undertaken in the regions of Tigray and Amhara. The timing of 2011 WAD also provided an opportunity to attract attention for solidarity at a time when Ethiopia was hosting the 16<sup>th</sup> International Conference on AIDS and STI in Africa (ICASA), which took place in Addis Ababa from December 4-8, 2011.

During WAD'11, an estimated 400,000 individuals were mobilized and reached with OP messages implemented through public meetings and entertainments.

Upon request by FHAPCO, ENHAT-CS collaborated and supported WAD'11 activities relevant to its mandate at central and regional levels. At central level, ENHAT-CS worked as an active member of the national steering committee, chaired by the Director of the Multi-sectoral Response Directorate to look after logistics and resource mobilization issues. In the regions of Tigray and Amhara, ENHAT-CS provided both technical and financial support and participated actively in the regional WAD events.

The national level event was commemorated in the presence of His Excellency, the President of Ethiopia, Girma Woldegiorgis; the Mayor of Addis Ababa, Kuma Demeksa; the US Ambassador, Donald E. Booth; the Federal Minister of Health, Dr. Tedros; and invited guests.

In his keynote address, the President reiterated the GOE's continued commitment to ensure all citizens have access and an equal opportunity to obtain information and services. He acknowledged and commended the role of partners as pivotal and urged them to continue supporting the government's efforts. He also underscored the timing and venue of the 16<sup>th</sup> ICASA being hosted in Addis Ababa as an opportune moment for reinforcing commitment. The president's keynote address as well as the speeches by the mayor of Addis Ababa, the US ambassador to Ethiopia, and the federal minister of health, focused heavily on the continued commitment to universal access to treatment, prevention and care & support services, moving towards the attainment of this year's motto "Getting to Zero". Accelerating PMTCT was also a much emphasized theme. The speeches were accompanied by poems, songs and music presented by youth groups and several testimonials given by HIV/AIDS service beneficiaries.

In the regions of Tigray and Amhara, World AIDS Day 2011 was colorfully commemorated in the historic cities of Axum and Bahir Dar. Key activities implemented in both regions included panel discussions, sport shows and candle light vigils, and a parade accompanied by police marching bands. The events received live media coverage. ENHAT-CS was actively involved and rendered technical as well as financial support for activities relevant to its mandate. All ENHAT-CS support was clearly branded with the USAID and MSH logos and included:

- ENHAT-CS staff active involvement as task force members with RHAPCO/RHB
- Financial support to commemorative panel discussions
- Production costs for 1,250 T-shirts
- Production costs for 5 banners
- Production cost for 1 billboard



**Participation of people with disabilities in the World AIDS Day parade  
Bahir Dar, Amhara, 1 December 2011**

## 08-HBHC (Home based HIV care and support)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 8-HBHC (Care: Adult Care and Support)

✓ **85,284 eligible adults and children provided with a minimum of one care service (C1.I.D)**

Comment: During this reporting period, 85,284 adults and children were provided a minimum of one care service (100% of the annual target).

Of note, during the first two quarters, ENHAT-CS only reported the number of eligible adults and children who received services at ART HCs and not in the community, because the program-supported activities conducted by KOOWs were designed only to be a short term transition to community linkages primarily through the Government's PHU, and therefore did not conform to the NGI reporting guidelines. Hence, during the semiannual period, the above NGI (C1.I.D) was the same as C2.I.D - number of eligible adults and children receiving a minimum of one clinical service. However, starting in Q3, ENHAT-CS, consistent with the FMOH's discouragement of externally supported volunteers, phased out its support to the 2,832 KOOWS (1,982 in Amhara and 850 in Tigray) and integrated its community-level support into the FMOH referral mechanisms through HEWs and the GOE's health development army (HDA), supported by a small cadre of 350 NNPWE community volunteers. In Q3, the program began adding to the number reported for C2.I.D the HIV-affected supported during community-level household visits by the NNPWE volunteers, who were trained by ENHAT-CS to report according to the NGI guidelines.

Thus, in addition to the 64,313 HIV-positive clients who received at least one clinical care service (see C2.I.D), 20,971 HIV-affected and eligible adults and children were provided with a minimum of one care service. Of these 13% were children below 18 years.

The services provided at household level include HBC, referral to HC and other community care and support services, FP counseling, HIV prevention for infected or affected family members, WASH, psychosocial and spiritual support, food support, shelter, protection, screening/ assessment/referral for TB and STI, IGA support, adherence support and bereavement counseling. Community volunteers have also been involved in promoting social inclusion of PLHIV by linking them to various community support groups including PLHIV associations. In FY12:

- 281 clients were identified and traced through outreach volunteer workers and HEWS
- 8,747 HIV positive adults were referred and linked to the HC and community
- 13,037 adults were provided with HBC and adherence using updated job aids support during home visits by outreach volunteer workers
- 4,949 infected and affected household members were referred to other community care and support services (food, IGA, legal aid, psychosocial and spiritual support)
- 11,334 households were reached with messages on, stigma reduction messages, WASH, TB DOTs and PCP through home visits
- 291 religious leaders trained in Q4 began to conduct mass education and community conversations targeting stigma reduction. They reached an estimated 127,000 people through 122 mass education events and another 8,993 people through 199 community conversations
- 1,403 PLHIV were referred to PLHIV associations for various services
- 1,892 PLHIV were provided with community mental health support, including spiritual and psycho-social support through religious leaders and PLHIV associations
- A total of 3,359 PLHIV were referred to PLHIV associations and other support groups
- 11,816 infected and affected people were provided with messaging on appropriate nutrition for PLHIV and HIV, HVCT, and TB/HIV through home visits by the volunteer outreach workers. Of this number, 46% were PLHIV
- About 21,634 infected and affected people were reached of which 60% are PLHIV
- 214 couples were provided with premarital counseling through religious leaders
- 4,106 PLHIV including 150 OVC were provided with financial support ; at least 16,532 Birr was raised from community resources for this purpose.

✓ **64,313 HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)**

Comment: The number of HIV-positive patients who received at least one clinical service (limited to the ART clinic to avoid double counting) during the reporting period included 24,068 (37%) male and 40,245 (63%) female clients. The result represents 111% of the program's FY12 target. Reflecting age- and sex-specific HIV prevalence data, 48% of <15 years and 63% of ≥15 years were female.

Patients receiving at least 1 clinical service	Q1	Q2	Q3	Q4	Year to date
<15 years old	2,421	400	389	354	3,564
Male	1,297	208	193	170	1,868
Female	1,124	192	196	184	1,696
≥15 years old	46,699	4,901	4,687	4,462	60,749
Male	17,254	1,711	1,673	1,562	22,200
Female	29,445	3,190	3,014	2,900	38,549

✓ **36,038 HIV-positive persons receiving cotrimoxazole prophylaxis (C2.2.D)**

Comment: The number of HIV-positive patients who received cotrimoxazole prophylaxis during the reporting period included 3,939 (21%) children under 15 years of age. The achievement to date represents 89% of the program's FY12 target.

According to national guideline, HIV patients with a CD4 count below 350 are put on CTZ. Therefore, a significant number of HIV patients are expected to not qualify for CTZ. The current result of 36,038, or 56% of the 64,313 patients, who received at least one clinical service (C2.1.D), is consistent with this expectation.

✓ **5,134 eligible clients received for food and/or other nutrition services (C5.1.D)**

Comment: In FY12, 5,134 eligible clients received food and/or other nutrition services, i.e. 102% of the program's FY12 target. In order to meet the needs of HIV/AIDS infected persons and affected family members for nutritional services, ENHAT-CS collaborates with and refers patients to partners providing and/or supporting such nutritional service delivery. The number of clients reported under C5.1.D only includes number of clients who received NACS at ENHAT-CS supported health facilities.

✓ **Contraceptive acceptance rate among HIV-positive women was 27%, including 7% of new acceptors and 20% repeats (Non-NGI; PMP Indicator # 31)**

Comment: The program developed and printed a logbook for the HIV clinic to include non-NGI indicators. Data on this indicator were reported in Q4, following the distribution of the logbook to the HCs in Q3.

✓ **20 (9 male and 11 female) HIV-positive patients referred for visceral leishmaniasis treatment in endemic areas (Non-NGI; PMP Indicator # 33)**

Comment: The program developed and printed a logbook for the HIV clinic to include non-NGI indicators. Data on this indicator were reported in Q4, following the distribution of the log book to the HCs in Q3.

✓ **1 HIV-positive patient diagnosed with onchocerciasis who started treatment for onchocerciasis in endemic areas (Non-NGI; PMP Indicator # 34)**

Comment: The program developed and printed a logbook for the HIV clinic to include non-NGI indicators. Data on this indicator were reported in Q4, following the distribution of the logbook to the HCs in Q3.

- ✓ **509 (162 male and 371 female) HIV-positive patients diagnosed with STI who were treated for STI** (Non-NGI; PMP Indicator # 35)

Comment: The program developed and printed a logbook for the HIV clinic to include non-NGI indicators. Data on this indicator were reported in Q4, following the distribution of the log book to the HCs in Q3.

- ✓ **118 (67 male and 51 female) HIV-positive patients diagnosed with malaria who were treated for malaria** (Non-NGI; PMP Indicator # 44)

Comment: The program developed and printed a logbook for the HIV clinic to include non-NGI indicators. Data on this indicator were reported in Q4, following the distribution of the log book to the HCs in Q3.

- ✓ **4,814 referrals made and documented for HIV/AIDS related services** (non-NGI; PMP indicator #32)

- **1,463** referrals were made by HC health providers inter-facility for HIV/AIDS related services
- **2,117** referrals were made by HC health providers to community (HEWs) for HIV/AIDS related services
- **1,234** referrals were made by community to HCs

Comment: A key component of ENHAT-CS is to better link PLHIV to the HC and hospital HIV clinics (through the case manager), and to the HEWs and their support network and do so in a sustainable manner. To this end, ENHAT-CS has been developing a bi-directional, closed loop referral system that facilitates referrals between the HC case manager and HEWs and improves their documentation. Working through health posts and HEWs, i.e. the government's formal structure at community level that links HCs and communities, the bi-directional, closed-loop referral system is intended to be sustainable when ENHAT-CS support ends.

Following initial assessments and consultations with health centers, woredas and case managers, as reported in the SAPR'12, the program developed a draft model of the bi-directional, closed-loop referral system through a consultative process with the program's 22 care and support staff. The draft model was then refined and endorsed by participants during the program's Q2 training of woreda HIV/AIDS officers, CRNMs and health center heads/HEW supervisors.

The program provided support to 172 woredas to strengthen the implementation of the bi-directional, closed-loop referral system through support to the GOE-mandated quarterly woreda level review meetings and monthly health center based PHU meetings (see below). The program also supported the 172 woredas and 206 HCs to map available community care and support services and create a referral directory for use by all stakeholders in the primary health care network. Furthermore, the program worked with individual HC heads, community referral network mobilizers (CRNMs) and case managers to strengthen HC-community linkages and document completed referrals. Of particular note, the program completed discussion with the RHB to harmonize the numerous referral slips currently in use by different programs and came up with one common, government owned referral slip. As such, the program worked with RHBs in Amhara and Tigray to come up with and distribute harmonized referral logbooks and referral slips for use by the case managers and HEWs to refer and document completed referrals.

By the end of the reporting period, 206 HC were using the bi-directional closed loop referral system. As more health centers conduct subsequent HC based PHU meetings, the program anticipates an increase in the number of health centers and health posts documenting completed referrals.

✓ **Additional achievements**

**Recruitment of community referral network mobilizers (CRNMs) and re-deployment of KOOWS previously supported by HCSP:** the program continued to work with 172 woredas and zonal administrations to support the 206 CRNMs as well as 2,832 KOOWs supporting previously HCSP-supported facilities. As previously noted, the program phased out its support to KOOWs during Q3 in order to align the program with the government primary health unit's network system.

In Tigray, by the end of the semiannual reporting period, the program had already linked 355 female KOOWs to the PHU network as members of the GOE mobilized, women-centered health development army (HAD). In this reporting period, the program continued to work with woreda health offices to assist more KOOWs to join the HDA. As a result, an additional 132 joined the HDA to bring the total number of transitioned KOOWs in Tigray to 487. In East Amhara, 117 KOOWs have either joined the HDA or been absorbed by HAPCO and other NGOs in the regions.

**Care and support mentorship checklist developed:** In this reporting period, local NGOs and program staff began using the ENHAT-CS care and support checklist which was developed during Q1 and Q2, for their quarterly mentorship and supportive supervision activities.

**Strengthened linkages with GOE HEWs:** The program trained a total of 169 woreda HIV officers to strengthen their capacity to manage and coordinate woreda health network activities. Additionally, 201 health center heads were trained on the management, use and coordination of the bi-directional closed loop referral system. As noted above, the program worked with the RHBS in Amhara and Tigray to harmonize the numerous referrals systems and slips. Through its partner, IMPACT, the program developed a referral guide/SOP that further clarifies the organization, management and use of the bi-directional, closed loop referral system at different levels. Additionally, the program worked with IMPACT to develop flow charts to assist the case managers in referring and documenting completed referrals.

**Support to quarterly woreda health network meetings.** In FY12, the program supported 172 woredas to conduct and document quarterly review meetings. This was the first set of meetings, and, as such, assisted the woreda health offices to make an inventory of woreda health network partner activities. The program directly supported 161 woredas HIV officers to develop woreda action plans to follow up on issues normally discussed during the quarterly meetings. These action plans were officially endorsed by the woreda health office, thereby showing government commitment to strengthen the woreda health network.

For background, at the request of woreda health offices, ENHAT-CS started supporting the government-mandated quarterly woreda health network review meetings in the last reporting period. By supporting these quarterly meetings, the program is resuscitating GOE mandated woreda platforms to coordinate activities and interact with local NGOs and other partners providing community care and support services. These meetings are intended to integrate and coordinate woreda health network partners, including harmonization of woreda and FBO/CBO work plans and activities; receive and review quarterly reports to track and monitor HIV/AIDS treatment, care and support activities in their woreda; strengthen management and use of a bi-directional closed loop referral system; promote government ownership of woreda level programs and recognition of work done by woreda health network partners. Together with the woreda health offices, ENHAT-CS developed supportive guidelines for conducting these meetings.

**Support to monthly HC based PHU review meetings.** In this reporting period, the program supported 206 HC to conduct 292 GOE-mandated monthly HC-based PHU meetings with a special focus on integrating a review of the referral system into this GOE mandated platform. The meetings also serve as a platform to establish and strengthen linkages and networks between the community-based care and support providers and the respective PHU service delivery providers at health post, and HC levels, strengthening integrated service provision, referrals, linkages and tracing mechanisms for lost to follow-up patients. Together with the woreda health office, ENHAT-CS developed guidelines for conducting these meetings. The meetings are proving to be crucial in tracing clients who have missed their ART appointment.

For background, these monthly government-mandated HC review meetings involve woreda health officers, HEWs, HEW supervisors and HC heads and are intended to promote collaboration, share information and strengthen the primary health unit (PHU) from HC to HP, kebele and communities. Of note, a key ENHAT-CS program focus is the management and use of a documented bi-directional, closed loop referral system that draws on the FMOH Guideline for Implementation of a Patient Referral System (FMOH 2010).

**Collaborative activities:** In this reporting period, the USAID ENGINE and TransACTION programs collaborated with ENHAT-CS on the refresher training of community care and support program officers, MSG mother mentors and MSG site coordinators to enhance their nutritional assessment and counseling support (NACS) skills when they counsel mothers on nutrition and feeding options for HEIs. This collaboration has also enabled the MSG mother mentors to resuscitate saving clubs and small IGA activities and expand membership to other MSG members.

**Mental health:** During Q3, ENHAT-CS continued to work through I-TECH and sensitized regional stakeholders of both Amhara and Tigray in the area of mental health and its integration into HIV/AIDS care and treatment and support services. The sensitization workshops took place at Mekele, Ayder Referral, Felege Hiwot and Gondar University Hospitals.

**Mental Health integration assessment and result dissemination and stakeholder meeting conducted:** In Q4, the program conducted an assessment was conducted in selected health centers, woreda health offices and Regional health Bureau to determine the level of mental health service provision at facility as well as program levels and the feasibility of mental health integration in to ART clinic for PLHIV. The results of the assessment were shared with different stakeholders including health facilities and woreda offices, RHB, PFSA, WHO and other NGOs working on mental health during a one-day result dissemination stakeholder meeting held in Addis Ababa. The next step is to prepare and provide training, to produce job aid, to start integrating mental health in selected facilities, to avail job aids that support health care providers and to incorporate mental health activity in routine mentorship activity at select pilot health facilities.

**NTDs:** During this quarter, the program continued discussions with the Tigray RHB on supporting their establishment of a treatment center for visceral leishmaniasis (VL) at Sheraro HC, including a site visit with the deputy RHB head. In addition, lab SOPs have been developed for VL and schistosomiasis.

**Participation in the international conference on the status of schistosomiasis organized by Gondar University:** ENHAT-CS participated and financially supported an international conference on the status and future directions of research on schistosomiasis control in Ethiopia organized by Gondar University from March 23-25, 2012.

## 09-HTXS (Adult Treatment)

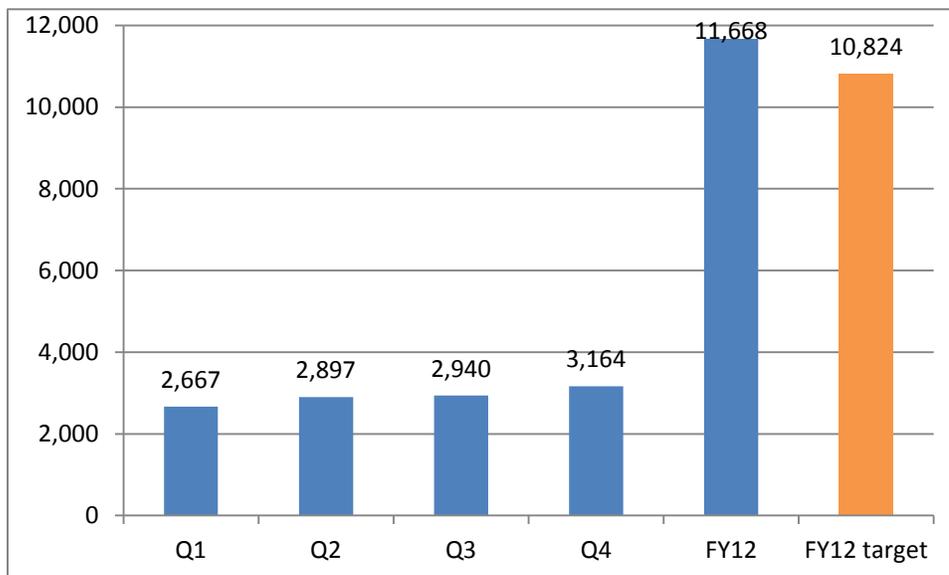
Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 9-HTXS

### ✓ 206 ENHAT-CS supported HCs offer comprehensive HIV/AIDS services (T1.5.D)

Comment: During this reporting period, ENHAT-CS provided technical assistance to 206 ART HCs, of which 52 are newly supported PYI HCs. Of note, as MSF revised its departure plan and continued to support Abderafi HC, one of the original 52 newly selected HCs for ENHAT-CS support, the RHB requested that the program support Dilbza HC of Beyeda Woreda of North Gondar Zone. The program will start supporting this HC in Q4.

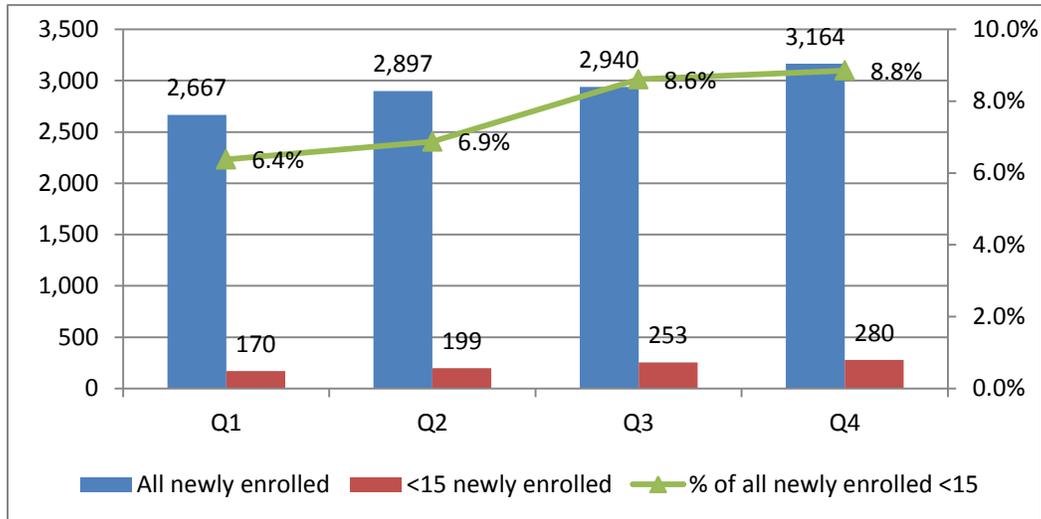
At least once a month, the program provided team-based clinical mentorship to all clinics in each of the 206 HCs, including pharmacy units. The program invites and encourages RHB and woreda health office HIV experts to participate in these monthly mentorship activities in most of the woredas.

### ✓ 11,668 new individuals were enrolled on ART (T1.1.D)



Comment: A total of 11,668 HIV-positive patients were newly enrolled on ART at program-supported HCs during the reporting period. The trend shows a slight increase over the quarters. Female patients accounted for 7,213 or 62% of all newly enrolled ART patients.

Among the above FY12 11,668 newly enrolled patients on ART, 902 (8%) were children under 15 years old, including 51 infants. The pediatric enrollment increased from 6.4% in Q1 to 8.8% in Q4 (see later section on pediatric treatment).



- ✓ **4,394 ART clients were transferred into ENHAT-CS supported health centers (Non-NGI; PMP indicator # 23)**

Comment: A total of 1,478 ART patients were transferred into ENHAT-CS supported HCs during the reporting period. This indicator shows that hospitals and HCs continued to successfully off-load ART patients to existing and new ART HCs during the reporting period.

- ✓ **56,694 HIV patients are currently receiving ART (T1.2.D)**

Comment: By the end of August 2012, a total of 56,694 HIV-positive patients (113% of the program's FY12 target) were receiving ART at ENHAT-CS supported HCs. Female patients accounted for 35,370 (62%) and children under 15 years of age, including 58 infants, for 2,951 (5.2%) of all current ART patients (see later section on pediatric treatment).

- ✓ **83% of adults and children known to be alive and on treatment 12 months after initiation of ART (T1.3.D)**

Comment: Exceeding the program's FY12 target of by 3 percentage points, 83% of patients started on ART during the period March-May, 2011, were alive and still on treatment at the health center where they started one year later. Females (85%) and children (88%) showed a higher rate of retention than males (80%).

- ✓ **59,738 individuals with advanced HIV infection who ever started on ART (T1.4.D)**

Comment: By the end of PY 1, a total of 59,738 HIV-positive patients had been ever started on ART at ENHAT-CS supported HCs. Female patients accounted for 36,129(60%) of all patients ever started on ART.

Among the ever enrolled in to ART, 2,850 (5%) were children under 15 years old. The number of children ever enrolled is smaller than the number currently enrolled on ART (2,952), suggesting that a significant number of current pediatric ART patients were transferred into the HC. Since HCs have begun offering pediatric treatment only 2 or 3 years ago, many pediatric patients were initiated on ART at hospitals, which began off-loading these patients to HCs that started offering pediatric ART services.

✓ **(Outcomes among ART patients who are no longer on ART)** (Non-NGI; PMP Indicator #29)

	% of ART clients who died	% of ART clients who stopped therapy	% of ART clients transferred out	% of ART clients lost to follow-up
Overall	10%	0.2%	15%	7%
at 6 months	6%	0.3%	6%	4%
at 12 months	7%	0.9%	10%	7%
at 24 months	8%	0.9%	12%	8%

Comment: The outcome data reported in above Table show that 10% of patients following their treatment at program-supported HCs had died and 7% were lost to follow-up by the end of FY12. Also, 15% of patients started on ART in the facilities had been transferred out.

At the FY12 annual FPHAPCO meeting, the FMOH reported a national lost-to-follow up rate of 11%, down from 17% in 2007-9. An improvement was also noted at program-supported HCs compared to FY11 when the LTFU rate was 9%, suggesting programmatic improvements in retaining and tracing patients. The decrease in the national rate not only suggests improved patient retention and tracing at all health facilities but also confirms the success of HIV and AIDS services expansion to HCs, where an increasing number of patients are being followed and the LTFU rates are typically lower because HCs are located closer to people's homes and manage generally healthy and stable patients

Consistent with data on disease progression among HIV-positive patients, more than 50% of overall deaths and lost to follow-up to date occurred in the first six months after initiation of treatment

✓ **83% of patients enrolled in care are in care and/or on ART at 12 months** (Non-NGI; PMP Indicator # 30)

Comment: In FY11, the GOE decided to monitor adherence to care among patients not yet enrolled on ART. ENHAT-CS will also monitor compliance with care among pre-ART patients by measuring the proportion still in care after 12 months of being enrolled at the HC. The indicator includes both patients who continue to be on pre-ART status and patients who started ART since being enrolled. Until the FMOH updates and rolls out new pre-ART registers, which will capture this data, ENHAT-CS will derive this information from a combination of the program pre-ART log book and the HC's pre-ART register.

✓ **Additional achievements:**

**Assessment of HC service quality:** As part of its start-up activities, ENHAT-CS conducted an assessment of the service quality at the 154 existing ART HCs and at 52 HCs where the program planned on integrating ART during its first year. The assessments were conducted by the program's mentors in collaboration with RHB and woreda health office staff, using elements of HCSP's FFSDP tool and the national health center accreditation tool. The assessments focused on the quality of service provision, availability of supplies and IEC/BCC materials, gaps in capacity building, reporting and M&E.

Overall, the assessment showed that most health centers only partially complied with national standards, with variable availability and, at times, a complete lack of essential medical equipment, including otoscope, reflex hammer, microscope and others and (b) low HIV case detection at the new HCs, in spite of good HCT rates. The quality of laboratories and pharmacies was of particular concern, with 48% of laboratories having only one trained lab technician and 37% of pharmacies having a private counseling room. The results of the assessments were shared at MDT meetings and during onsite service area feedback, and are currently used in ENHAT-CS' procurement plans.

**Mentorship:** ENHAT-CS conducted monthly team-based clinical mentorship at all 206 ART HCs using the revised ENHAT-CS mentorship checklist, developed and piloted in Q1. Mentorship included one-to-one mentorship at each clinic, chart reviews, clinical case discussions and participation in MDT

meetings and, as needed, additional consultation by telephone. The mentorship strategy of ENHAT-CS has been revised to take into account the case load of HCs. Accordingly, since May, 2012, every HC with more than 500 patients currently on ART receives at least a 4 person-day mentorship support visit.

**Mentorship checklist and guide:** Early in PY1, ENHAT-CS reviewed and discussed the efficacy of the mentorship checklist with its clinical mentors and technical advisors based in its three field offices. Based on the feedback and on the program needs, ENHAT-CS revised the tool, pilot-tested and finalized in Q2.

**Refresher training for mentors and advisors:** ENHAT-CS provided a 12 day intensive refresher training with practical sessions, from April 30 - May 12, 2012 in Addis Ababa, for all program senior and clinical care mentors and advisors. The training was focused on providing clinical updates and mentorship approaches.

**Standards of care (SOC) assessment:** Early in PY1, the program revised its standards of care assessment tool and carried out an assessment at 80 HCs, including the HIV clinic.

**Actively participating in HIV/AIDS TWGs:** ENHAT-CS is actively participating in the national advisory and technical working groups related to HIV. ENHAT-CS is a member of the national HIV/AIDS care, treatment and prevention advisory group and actively participating in the adherence, pre ART, Stavudine phase-out, and pediatrics TWGs.

## 10-HVTB

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 10-HVTB

- ✓ **206 health facilities providing TB treatment of HIV-infected individuals** (Non-NGI; PMP indicator #38)

Comment: All 206 ART HCs supported by ENHAT-CS provided TB treatment for HIV-infected individuals.

During the reporting period, ENHAT-CS initiated discussions with the RHBs, I-TECH and HEAL-TB about piloting the “one stop shop” approach whereby HIV-positive TB patients would receive both ART and TB treatment at the TB clinic. During the next fiscal year, the program will, in collaboration with the RHBs, define selection criteria and identify HCs where the approach may be piloted.

- ✓ **12,603 TB patients had an HIV test result recorded in the TB register** (C3.1.D).

Indicator	M	F	Total	Percentage
No of TB patients registered	7,857	6,702	14,559	
No of TB patients counseled for HIV testing	7,047	5,953	13,000	89%
No of TB patients tested for HIV	6,541	5,537	12,078	93%
No of TB patients tested HIV+	616	576	1,192	10%
No of HIV+ TB patients put on CPT	481	477	958	80%
No of HIV+ TB patients (linked) put on ART	240	254	494	41%

Comment: Out of the 12,603 TB patients who had an HIV test result recorded on the TB register, 525 were known HIV-positive patients at entry into the TB clinic (i.e. referred to the TB clinic from the HIV clinic). The remaining 12,078 TB patients were newly tested for HIV and had a result recorded in the TB register, i.e. 93% of the 13,000 TB patients counseled for HIV testing in FY12. The number included 6,724 (54%) male and 5,772 (46%) female patients.

Among the 12,078 newly HIV tested, 10% (1,192) were found HIV-positive. The relatively low co-infection rate could be explained partly by the exclusion of known HIV-positives at entry. The proportion put on CPT is a good proxy for linkage rate and was 80%, which is consistent with SOC assessment finding which was also 80%.

- ✓ **61,881 HIV+ patients visiting the ART clinic during the period were screened for TB in HIV care and treatment settings** (C2.4.D)

Of whom:

- **5,454** were assessed with AFB (9% of those screened)
  - **525** were TB-positive

Comment: With 61,881 HIV-positive patients screened in FY12, the program has achieved 111% of its annual target. Consistent with the male/female ratio among ART patients, the number of female patients (37,816) screened for TB accounted for 61% of the total screened.

Among the screened, 9% were referred and assessed with AFB sputum smear and 9.6% of these referred turned positive for the bacilli. However, HCs have limited capacity to diagnose TB in HIV-positive patients, especially those with AIDS, who have a very weak immune response, and even active pulmonary TB cases may have negative sputum smears. Furthermore, many TB cases in HIV-positive patients may be extra-pulmonary. In both instances, diagnosis can be very difficult without X-rays at the HC level, and FMOH guidelines do not permit syndromic TB treatment at HCs based on a clinical diagnosis.

Recognizing this, it is possible that HCs may refer a large proportion of their positive TB patients to another facility, or because of high death rates in HIV/TB co-infected patients. ENHAT-CS will conduct a special data review to determine why the proportion is lower than anticipated and consult with USAID on how to address this.

✓ **1,360 of HIV-positive patients in HIV care or treatment (pre-ART or ART) have started TB treatment during the reporting period (C2.5.D)**

Comment: 1,360 (48% (664) male and 52% (696) female) HIV-positive patients were started or are on anti-TB drugs. The program has achieved 101% of its target for FY12.

✓ **6,076 of eligible HIV-positive patients were started on Isoniazid Preventative Therapy (IPT) (C2.6D)**

Comment: The program started 6,076 patients on IPT in PY I, which accounts 83% of the baseline. Of note, the Tigray RHB has decided to limit IPT to hospitals. Considering the known benefits of IPT for decreasing morbidity and mortality of HIV patients, ENHAT-CS will advocate with the RHB for the introduction of IPT at health centers, using national and international evidence.

✓ **Additional achievements**

**Assessment of HC service quality:** See section 09-HXST above. The TB clinic was included in the assessment.

**Mentorship:** See section 09-HTXS above. The TB clinic was included in all mentorship.

**Mentorship checklist and guide:** See section 09-HTXS above. ENHAT-CS consulted with HEAL-TB to develop and harmonize standardized mentorship tools and continues to collaborate to maximize efficiencies and coordination especially at HCs supported by both ENHAT-CS and HEAL-TB.

**Standards of care (SOC) assessment:** See section 09-HTXS above. ENHAT-CS consulted with HEAL-TB to develop and harmonize standardized SOC tools and continues to collaborate to maximize efficiencies.

**Monitoring & Evaluation:** For rapid start-up, ENHAT-CS used existing data collection tools and methods developed under HCSP for collecting, reporting and analyzing QI data. During QI, ENHAT-CS revised the reporting formats to align them with ENHAT-CS indicators. This effort included TB data recording and reporting tools.

**Collaborative activities:** Early on, the program met with HEAL TB and TB-Care to coordinate, rationalize and harmonize work plans, tools and program implementation at HCs where the programs overlap. TB-Care works primarily at the national level and HEAL TB at the facility level. Most collaboration will thus take place with HEAL TB.

The program subsequently met with HEAL TB at regional level to coordinate, rationalize and collaborate on activities in the Amhara region, where HEAL TB is supporting 88 of the 146 ENHAT-CS-supported HCs. Areas of collaboration were identified as part of HEAL TB's preparation for a USAID visit and were then shared with the team's technical staff.

ENHAT-CS and HEAL TB agreed on the coordination and collaboration activities details of which were documented in the QI report. The key activities include the following:

- *Rationalize training and coordination meetings*
- *Coordinate and rationalize mentorship*
- *Harmonize referral approaches*
- *Coordinate support to HC laboratories including EQA, DST and sample transport*
- *Share and align program resources to maximize efficiencies*
- *Partner in operations research and other special studies*

**Collaboration and partnership to conduct OR and other special studies on HIV/TB co-infection related areas:** In Q4, the program met with HEAL-TB and TB CARE and initiated an action plan to support the Amhara RHB/RLs to expand the decentralized EQA from the current 5 HEAL TB zones to all 11 zones, with inclusion of malaria as well as TB slide assessment.

**Participation in the 7th National TB conference and world TB day** which was held from March 21-24, 2012. The Conference was held at Axum Hotel in Mekele, Tigray, under the theme: **Effective partnership to combat TB: rallying the forces in Ethiopia** and included the national TB research conference (TRAC) hosted by Mekele University. Over 50 research papers on TB, TB/HIV and MDR TB were presented. This conference created a good opportunity for regions to present the achievements and challenges of the regional TB programs, and discuss the way forward. The three days sessions focused on a wide range of topics including: TB in Ethiopia; challenges of TB in Ethiopia; challenges of MDR TB and zoonotic TB in Ethiopia; case studies, TB diagnostics, laboratory-based research and TB/HIV co infection.

**Development of MDRTB SOP for Tigray :** ENHAT CS being member of the RHB TWG, actively participated in the development of Regional MDRTB SOP based on the national implementation plan. ENHAT CS supported technically throughout the activity and financially for the MDRTB treatment site assessment.

**Participation in TWG, West Amhara.** ENHAT-CS participated in the technical working group in the RHB.

**Training:** See HSS section

**Improving TB diagnosis capacity.** see 16 HLAB

## I2-HVCT

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area I2- HVCT (Counseling and Testing)

- ✓ **206 service outlets (HCs) providing counseling and testing according to national or international standards** (P9.I.D)

Comment: Through mentorship, the program's support to HCs in T&C during the quarter included onsite coaching of health workers on the national opt-out approach of PITC at every unit of the HC, including outpatient, family planning, ANC, labor & delivery, TB/HIV, and EPI as well as VCT in the VCT clinic.

- ✓ **1,362,250 individuals received Testing and Counseling (T&C) services for HIV and received their test results** (P11.I.D)

- **482,276 (35%) were tested through VCT** (PMP indicator #13)
- **879,794 (65%) were tested through PITC** (PMP indicator #13)
- **90% were individually tested** (PMP indicator #13; based on Q2, Q3 and Q4 data only)
- **10% were couple tested** (PMP indicator #13; based on Q2,Q3 and Q4 data only)

Comment: The number tested for HIV during the year represents 107% of the program's FY12 target, and includes 765,101 (56%) female clients. The number of children under 15 years old who were tested was 94,580 (7%).

The majority (65%) was tested through PITC, underscoring the continued value of the PITC strategy. Based on the data from the Q2-Q4 of the program year, when disaggregated by type of counseling, 90% were individually tested and 10% was couple testing.

Among the **1,362,250** individuals who were tested for HIV during the reporting period, **19,493** (1.4%) were HIV-positive.

During mentorship visits, several HCs, particularly in the Tigray region, reported a shortage of test kits and supplies. Some also reported reduced motivation among health providers to offer HIV testing and work load has been reported as a challenge.

- ✓ **Additional achievements**

**Assessment of HC service quality:** See section 09-HTXS above.

**Mentorship:** See section 09-HTXS above. PITC and VCT were included in all mentorship.

**Mentorship checklist and guide:** See section 09-HTXS above.

**Standards of care (SOC) assessment:** Based on feed-back from program mentors, mentors will conduct standard of care (SOC) assessments of PITC and VCT services in their mentorship activities.

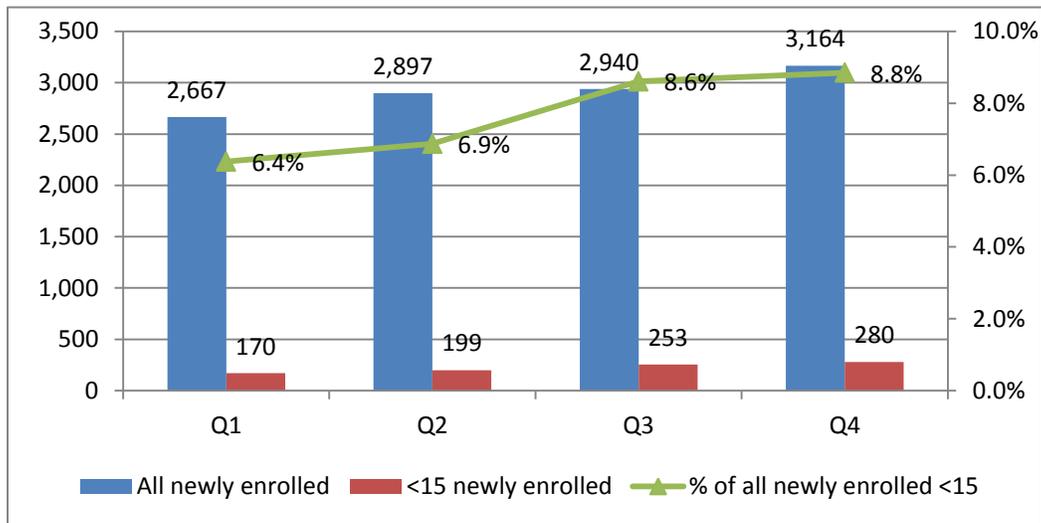
**Monitoring & Evaluation:** For rapid start-up, ENHAT-CS used existing data collection tools and methods developed under HCSP for collecting, reporting and analyzing QI data. During Q1, ENHAT-CS revised the reporting formats to align them with ENHAT-CS indicators. This effort included PITC and VCT data recording and reporting tools, which then were rolled out.

### 13-PDTX (Pediatric Treatment)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 13-PDTX

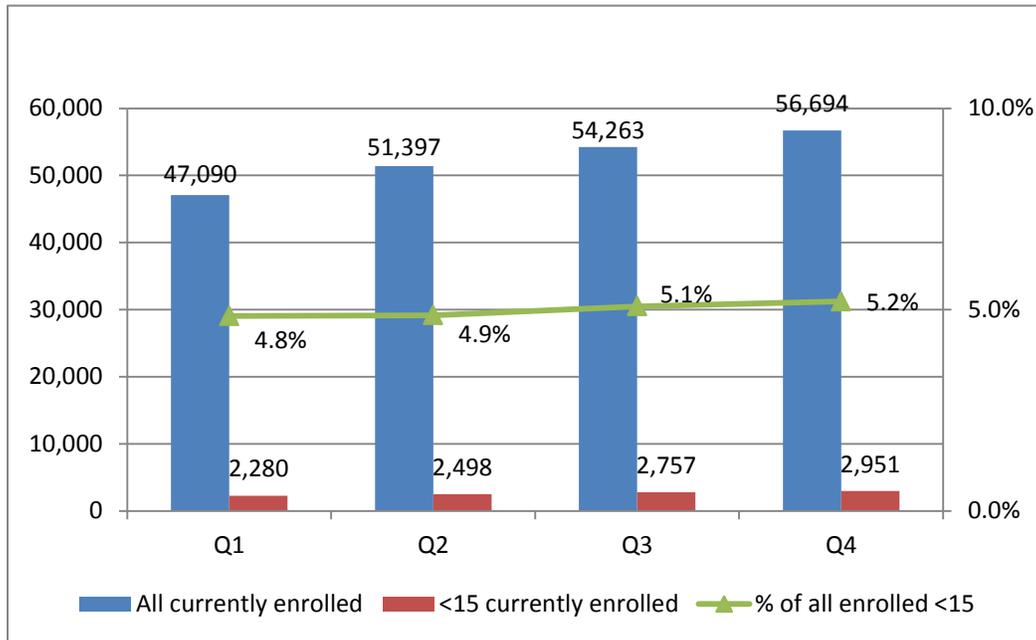
- ✓ **902 children (including 51 infants) with advanced HIV infection were newly enrolled on ART (T.I.I.D)**

Comment: Among the newly enrolled patients, 902 (8%) were children under 15 years old, including 51 infants. The proportion of all newly enrolled that is under 15 years of age has been steadily increasing since Q1 and by Q4, had reached 8.8% thus approximating the national target of 10%.



✓ **2,757 children (including 44 infants) are currently receiving ART (TI.2.D)**

Comment: Among patients currently on ART, 5.2% were children under 15 years old, which is close to the national data showing 6%. However, the estimated national target of 9% is not yet met in the program supported health centers. In Amhara and Tigray, the majority of HIV-infected children are still receiving ART at hospitals, although most hospitals are increasingly off-loading pediatric cases to the HCs located closer to the clients' homes. Another possibility is the success of PMTCT in encouraging participating HIV-positive women to increasingly enroll their newborns in HEI follow-up care. Conversely, it is possible that many HEIs, especially those whose mothers did not use PMTCT, die shortly after birth and never make it into the health system.



✓ **88% of children under 15 years old were known to be alive and on treatment 12 months after initiating ART (TI.3.D)**

Comment: in FY12, 88% of pediatric patients were still on ART at the same HC 12 months earlier. The proportion among pediatric patients is higher than the 82% reported for patients >14 years. This suggests that HIV-positive children are very stable ART patients at HC.

✓ **2,850 children under 15 years old is the cumulative number of children ever started on ART (TI.4.D)**

Comment: Among the total ever started on ART, 4.8% (2,850) were children <15 years. This number is smaller than those currently enrolled on ART, suggesting that a significant number of pediatric ART patients were transferred into the HCs. Since HCs have begun offering pediatric treatment as recent as 2 to 3 years ago, many pediatric patients initiated ART at hospitals, which have begun off-loading these patients to HCs as they begin offering pediatric ART services.

✓ **Additional Achievements**

**Mentoring Activities:** 309 intensive mentoring activities focused on pediatric HIV/AIDS were conducted at 162 HCs in the Amhara and Tigray regions by senior pediatricians from ENHAT-CS partner, ANECCA, during the reporting period.

**Training Activities:** In FY12, the program's regional pediatric advisors actively participated in comprehensive pediatric ART and PMTCT trainings using the national in-service training curriculum. A total of 255 and 284 health care workers have successfully completed a comprehensive training on pediatric HIV treatment and PMTCT, respectively (see HSS section for details). In addition, training on pediatric psychosocial care was given to 19 ENHAT-CS program mentors, advisors and care and support officers at west Amhara.

**SOC Assessment:** The standard of care assessment was conducted at 80 HCs in Amhara and Tigray regions during Q3. Feedback was provided to HC staff and heads based on the findings in each health center. Data at the program level were analyzed in Q4 and will be shared and discussed with RHBs, zonal, woreda and health center managers.

**Executive Committee of Ethiopian Pediatric Society:** Two ENHAT-CS pediatricians participated in the monthly executive committee meetings of the national pediatric society to promote collaborating with Ethiopian professional associations to promote PMTCT for mother-baby pairs and appropriate HEI, EID, and pediatric HIV case management.

**The National Pediatric ART/HIV Task Force:** ENHAT-CS actively participated at meetings and workshops organized by the FMOH. ENHAT-CS senior pediatric HIV advisor is a member of the national pediatric HIV treatment, care and support task force which promotes country ownership of the HIV program including pediatric HIV care and treatment.

#### 14-PDCS (Pediatric Care and Support)

Accomplishments and successes during reporting period with explanations for under and over achievements:  
Program area 14-Pediatric Care and Support

✓ **HEI cascade of services**

On active HEI follow-up at beginning of FY12	3,798	
	<b>FY12</b>	<b>%</b>
Newly enrolled in HEI follow-up/EID	3,091	
PCR sample collected within 2 months of birth	1,259	41%
Received result	945	75%
PCR tested within 12 months of birth	1,805	58%
Tested PCR positive	165	9.1%
Enrolled in care and support	*187	**72%
Referred to other facility	24	15%
For active HEIs at beginning of FY12 + newly enrolled during FY12	6,889	
	LTFU	654 9.5%
	Died	128 1.9%
<b>Tested PCR negative and discharged</b>	1,603	
<b>Currently on active HEI follow-up at the end of FY12</b>	4,729	

\* Includes HEIs enrolled in FY11; \*\*data source: SOC assessment, June 2012

Comment: A total of 3,091 HIV-exposed infants (HEIs) were newly enrolled on HEI/EID follow-up during FY12, and at the end of FY12, 4,729 were still on active HEI follow-up. The proportion of HEIs who had a DBS sample taken within 2 months of birth was 41% and within 12 months of birth was 58%. Overall, 75% of HEIs who were tested in the first two months received a test result in FY12. Among HEIs tested in FY12 testing, 9.5% were HIV-positive, which may reflect success in PMTCT as it is substantially lower than the 17%-30% national level for Ethiopia reported by the FMOH in Jun'12.

Among those testing HIV-positive, 15% were transferred to another facility. The total number enrolled on care and support exceeded the number who tested HIV-positive, because it includes a number of HEIs who received their test results in FY11. From the SOC assessments, it appeared that 72% of all DBS positive HEIs were enrolled on care and support. The program is working through ANECCA to improve HEI follow-up and linkage of HIV-positive HEIs.

✓ **% of HEIs by feeding type (P1.6.D)**

Comment: By age 6 months, the vast majority (93%) of HEIs were reported by their mothers that they had been exclusively breastfed while 4% were reported to have received exclusive formula feeding and 3% mixed feeding.

✓ **3,564 children received a minimum of one clinical care service (C2.1.D)**

Comment: The number of children who received at least one clinical care service represents 6% of the total number who received at least one clinical care service.

✓ **3,939 HIV positive children under 15 years of age received cotrimoxazole (CTX) prophylaxis (CPT) (C.2.2.D)**

Comment: The number of children who received CPT represented 11% of all patients who received CPT.

- ✓ **1,805 infants were virologically tested for HIV within 12 months of birth and, of those, 945 infants (52%) received virological testing within 2 months of age (C.4.1.D)**

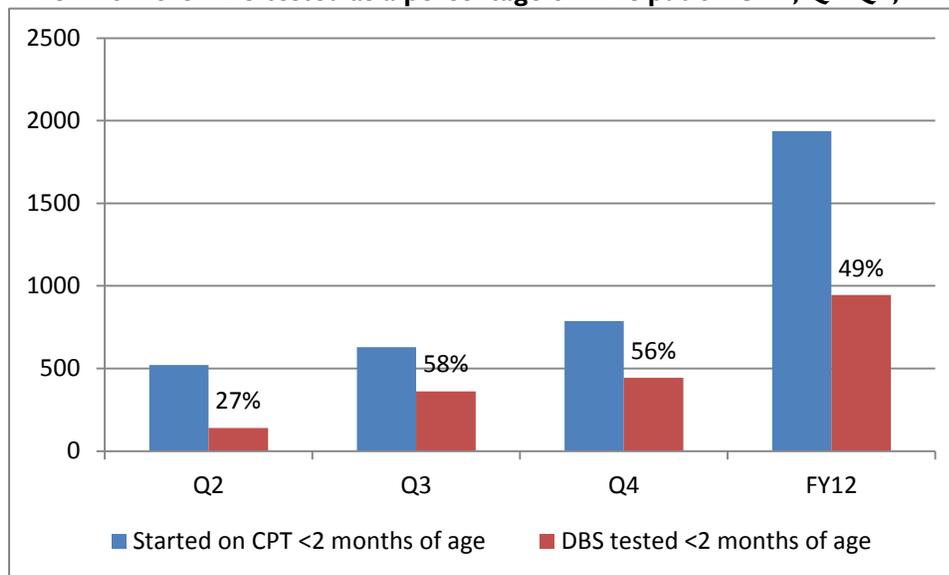
Comment: A total of 945 HEIs were virologically tested within 12 months of age. Among them, the proportion being tested in the first 2 months increased from 29% in Q2 to 59% in Q3 and 62% in Q4. This can be explained by the fact that the Dessie regional laboratory is now fully functional. Continued mentoring support is also a likely contributor to the result.

The total number of HEIs tested within 12 months of birth was 188% of the program’s FY12 target. The over-achievement is related to the higher-than-expected number of infants tested within 2 months, and probably also to the program’s focused mentorship resulting in improved provider confidence and ability to manage and test HEIs at HCs according to the SOC rather than referring them to hospitals. Indeed, the SOC assessments conducted at 80 HCs in June showed that 60% of HEIs were tested within 2 months of birth. Despite improved DBS testing in the youngest HEIs, there are still many infants who are tested after 2 months of age. This late testing may be due to late enrollment of the HEIs, inadequate supplies of the DBS kit and, in some cases, the assignment of untrained health care providers to care for HEIs in some health centers.

- ✓ **2,465 infants born to HIV-positive women are started on CTZ prophylaxis within two months of birth (C.4.2.D)**

Comment: The number of HEIs who were started on cotrimoxazole within 2 months of birth progressively increased over the quarters. Data collection on the proportion of infants virologically tested within 2 months of age began in Q2. The proportion represents only 49% of those started on CPT within 2 months. This suggests that many more HEIs under 2 months of age are seen at HCs than were tested and, therefore, suggests missed opportunities.

**Number of HEIs put on CPT and DBS tested for HIV within the first 2 months of age, with HEIs who were DBS tested as a percentage of HEIs put on CPT, Q2-Q4, FY12**



- ✓ **649 children under 18 years of age received food and/or other nutrition services (C5.1.D)**

Comment: the number of children under 18 years who were referred for food or other nutritional services represents 12.6% of all patients referred for this service during the reporting period. The number has decreased during the last 2 quarters, for unknown reasons.

## **16-HLAB (Laboratory infrastructure)**

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 16- HLAB (Laboratory Infrastructure)

- ✓ **206 laboratories with capacity to perform clinical laboratory tests** (HI.I.D)
- ✓ **2,656 DBS/DNA-PCR tests performed or referred for EID of HEIs** (Non-NGI; PMP indicator # 28)

Comment: During the reporting period, 2,656 blood samples of HEIs were received by the regional laboratories for DBS testing.

- ✓ **149 (72%) of health facilities with capacity for malaria parasite diagnosis and has performed diagnosis in the past 3 months** (Non-NGI; PMP indicator # 43)

Comment: The lab assessment included efforts to identify the number of HCs with malaria parasite diagnosis and the number among them that performed a diagnosis in the past 3 months. This indicator is based on the number reported through HMIS.

- ✓ **Additional achievements:**

**Baseline assessment of HCs conducted:** A detailed baseline assessment of 204 program supported HCs was conducted in the months of March and April 2012. The finding of the assessment was shared to relevant stakeholders in a one day dissemination workshop in Q4.

**Laboratory mentorship:** Technical support to all HC laboratories through mentorship was provided by the program's laboratory mentors using a standard checklist as a guide. The overall focus of laboratory mentorship was to fill the gaps that were identified during the baseline assessment and External Quality Assurance Laboratory Supervision (EQA).

The activities done during mentorship include: laboratory work station and design revision; distribution of different lab logs and formats; onsite orientation on record keeping; carrying out preventive maintenance for common lab equipment; internal quality control for rapid HIV screening at each testing point using panel sera, onsite orientation on DBS sample collection; revision of CD4 sample transportation path flow system; DBS sample collection; distribution of HIV kits to the new ART sites; technical support on CD4, hematology and chemistry sample collection (preparation, transportation, and storage was provided based on the national laboratory quality policy); introduction of essential quality assurance components; and provision of technical support for laboratory supplies and logistics management (e.g. bin card).

**Standard laboratory operating procedures (SOPs) customized:** 28 standard lab SOPs for various lab test menus and safety practices were customized from documents prepared nationally by EHNRI. Below is the list of SOPs customized and distributed to HCs.

<b>List of Laboratory SOPs Customized for ENHAT-CS supported HC Laboratories</b>	
1	SOP 1 - Ziehl-Neelsens staining technique SOP
2	SOP 2 - AFB sputum collection SOP
3	SOP 3 - Widal test SOP
4	SOP 4 - Weil felix SOP
5	SOP 5 - Waste management SOP
6	SOP 6 - Urine microscopy SOP
7	SOP 7 - Urine chemical strip SOP
8	SOP 8 - Unigold SOP
9	SOP 9 - STOOL EXAM SOP
10	SOP 10 - STAT-PAK SOP Customized
11	SOP 11 - SOP for sample collection and handling for Hematology analyte SOP
12	SOP 12 - SOP for Hgb. estimation using sahli's method
13	SOP 13 - Skin slit SOP
14	SOP 14 - RPR SOP
15	SOP 15 - rk-39 (leishmaniasis) SOP
16	SOP 16 - Preventive microscope maintenance SOP
17	SOP 17 - Pregnancy test SOP
18	SOP 18 - KOH SOP
19	SOP 19 - KHB SOP
20	SOP 20 - H.Pylori SOP
21	SOP 21 - Gram stain SOP
22	SOP 22 - ESR SOP
23	SOP 23 - Disinfectant SOP
24	SOP 24 - Blood grouping (direct method) SOP
25	SOP 25 - Preparation and examination of blood films SOP
26	SOP 26 - Manual differential leukocyte count SOP
27	SOP 27 - Micro hematocrit SOP
28	SOP 28 - PEP SOP

**Regional External Quality Assessments (REQAs) have been conducted for all ART health centers:** Two rounds of REQAs have been conducted by the Bahir Dar, Dessie and Mekele regional labs in collaboration with ENHAT-CS. All program supported facilities were included in the assessment. The REQAs included: onsite assessment of tuberculosis; slide collection for blind rechecking; onsite assessments of HIV on the respective testing point of the health centers; and collection of malaria baseline microscopy capacity (as malaria was not included during this assessment). ENHAT-CS laboratory teams provided assistance for one week to the regional laboratory by reading slides that were collected from the health centers for blind rechecking. AFB slide blind rechecking was completed and feedback started to all assessed facilities.

**Logistics and technical support was given for the national laboratory sentinel**

**surveillance:** Dessie health and research laboratory has 10 sentinel and 15 satellite sites. All surveillance materials and supplies for the 25 sites were distributed with ENHAT-CS logistics support. Each site received overall technical assistance for sentinel surveillance procedures and sample quality control.

**National workshop on TB EQA:** ENHAT-CS participated in the TB EQA guideline review workshop conducted in Adama from 12 to 15 June, 2012. The workshop was organized by EHNRI in collaboration with USAID/TBCARE and PHSP, and included participants from all regional laboratories and selected private health sectors, armed force hospitals, universities and partners. Discussion points included the national TB EQA updates, updates on AFB EQA performance (coverage, challenges and way forward), general discussion on future directions (strategies to improve) to enhance AFB microscopy EQA, and current national AFB EQA guidelines.

**Hub testing and spoke referral HC based testing system:** In Q4, the program completed an assessment of the Amhara and Tigray regional labs proposed HC based hub and spoke testing system. Once SCMS (see below note on collaboration) completes a review of the equipment needs that have been recommended, the program will finalize its agreement with the regional labs and then initiate procurement of point of care PIMA CD4 machines and hematology and chemistry analyzers (if required) after importation of the PIMA is fully approved by the GOE.

**Collaborative activities:**

- **Meeting with Alere on PIMA CD4 machine.** The program met with East Africa regional director and Africa business development director of Alere, the agent for the PIMA CD4 machine, who provided a technical review of the machine.
- **Collaboration with SCMS for procurement of the PIMA.** ENHAT-CS has initiated collaboration with SCMS to procure the hematology and chemistry analyzers, as well as the PIMA CD4 machines when fully approved, for its hub HC testing sites. The collaboration with SCMS will ensure that the procured equipment is standardized models for Ethiopia as per USAID requirement, will be brought through customs without undue delay and distributed through the national PFSA system and in accordance with their distribution plan. The collaboration plans to have actual procurement carried out by Partnership for Supply Chain Management (PFSCM), a legal entity established by JSI and MSH, providing such services.

## 17-HVSI (Strategic Information)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 17- HVSI (Strategic Information)

- ✓ **243 (108M, 135F) data clerks were trained on SI for HIV/AIDS services** (under H2.3.D 'other') and **350 NNPWE volunteers were trained on community component of NGI data collection and handling** (under H2.2.D)

Comment: The program conducted data clerk refresher training for 141 data clerks, which lasted for three days. During the training, data clerks were also oriented on the new ENHAT-CS indicators. The training was also for data clerks deployed to newly opened ART HC sites and also for gap filling at existing ART HCs. Of these, 26 (7M, 19F) were trained for gap filling during Q4. The program also conducted training for the NNPWE community volunteers on NGI data registration and compilation. The training focused on proper documentation of the services that the volunteers provide to the community, including prevention with positives, small group prevention on AB and OP, and general population prevention. An orientation on program SI activities was also provided as part of the ENHAT-CS team orientation workshop held in October. ENHAT-CS local partners, EIFFDA, EPHA, IMPACT and NNPWE.

- ✓ **Number of data centers/delivery points established** (Non-NGI; PMP indicator # 46)

Comment: ENHAT-CS has been working through its partner, EPHA to identify and select at least one public access data center/delivery point for sharing program results.

- ✓ **3 local universities involved in the generation and communication of M&E/OR evidence** (Non-NGI; PMP indicator # 47)

Comment: Through its partner, I-TECH, ENHAT-CS has supported the RHBs to engage regional public health schools of three local universities – the University of Mekele in Tigray and the University of Gondar in Amhara, and also University of Bahir Dar –in OR and M&E activities. These universities have agreed to work with the RHB. The program hired two OR partnership coordinators, one for each region. In both regions, the OR partnership advisors are embedded in the RHBs. Each region has held meetings to review the roles of the universities in the regional public health program and began a process of identifying thematic areas for research which will form the basis for 10 small OR initiatives per region, supported by the program's OR partnership coordinators and the collaborating universities.

- ✓ **Additional achievements:**

**Gap filling printing of HMIS forms:** HMIS registers were collected from the central office based on gaps identified during baseline assessments. New reporting formats, sufficient for a 6 month period, were duplicated, bound and distributed to 60 HCs. Duplication and binding was done in program field offices, which provided cost savings. The case managers' registration logbook, referral logbook, family matrix registration logbook (regionally made), reporting format, and lost-to-follow-up tracking sheet were duplicated and distributed.

The program has printed and distributed different HMIS materials during this quarter including intake forms, ART registers, cohort analysis wall charts, screening logbooks, family planning registers, ANC/PMTCT registers, family matrix wall charts, PMTCT wall charts, appointment cards for ART & PMTCT and partner invitation cards.

**Online database:** To gain greater efficiencies in data reporting and quality control, ENHAT-CS began customizing the free on-line DHIS-2 database software for use by the program, with the assistance of a DHIS-2/HISP consultant. This on-line data base replaces the program's initial reporting system that used MS office excel software. The database captures both routine health service data and information collected by mentors during their monthly visits using the mentorship checklist as well as data from the SOC assessments that will be conducted during supportive supervision visits by the program advisors using standardized SOC assessment tools.

During Q3, ENHAT-CS pilot-tested and finalized the database for roll-out to the program's three field offices, and staff were trained in the use of the new database. Q4 data was reported through the DHIS-s.

During the quarter, two ENHAT-CS staff from the central offices participated in the East Africa DHIS2 workshop conducted in Mombasa.

**Data Quality Assessment:** ENHAT-CS has made an effort to assure the quality of the program data. As part of this effort the program has developed a data quality assessment guide & tools for its own internal data quality assessment. The data quality assessment tool has been pilot tested and they are ready for utilization.

**Program Quality Assessment –through SOC:** During this year the program quality has been assessed using SOC tools. The main focus of the assessment was on the clinical aspect of the program. Data collected through SOC were entered into the online database analysis was carried out by the central M&E team. The result of the analysis was discussed and it was shared to regional program offices as feedback. Most of substandard achievement was communicated to mentors for follow up and improvement.

**DQA manual:** during the quarter, ENHAT-CS finalized and began to pilot test the program's data quality assessment tools and manual. Based on the pilot result the tools will be refined and will be ready for use in Q1 of PY2.

**Reference manual for data clerks and mentors:** Based on the USAID-approved PMP and data collection tools that the program updated and put in place, the program developed and printed a reference manual for data clerks and mentors. The manual will serve as a job aid to ensure standardized data collection, recording and reporting.

**Operations Research:** ENHAT-CS has employed an M&E and OR manager through its partner, EPHA, to coordinate and manage the OR activities directly implemented by program staff with those implemented through the collaborating university partners.

The program has also been working with EPHA to ensure full compliance with ethical review committee requirements for all OR that the program intends to conduct. During FY12, the program developed draft study protocols on the "One stop shop" service delivery at TB clinics and will seek clearance from the ethical review board. All other OR-type activities do not require ERB clearance because they involve routine M&E data analysis and verification.

## 18- OHSS (Other Health Systems Strengthening)

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 18-(OHSS (Health Systems Strengthening)

- ✓ **973 community health and para-social workers who successfully completed a pre-service training program (H2.2.D)**

Comment: The number of community health and para-social workers trained represents 90% of the FY12 target.

- ✓ **2,653 health care workers who successfully completed an in-service training program (H2.3.D)**

Comment: During FY12, the program trained 2,653 health care workers. The trainings used national curricula and guidelines, and included adult ART treatment, pediatric ART, infection prevention, laboratory activities, mother support group coordination, and community work.

- ✓ **11 local organizations provided with TA for HIV-related capacity building (Non-NGI; PMP indicator # 45)**

Comment: In this reporting period, the program continued to work with and strengthen the capacity of local partners, including the program's main counterparts, the RHB of Tigray and the RHB of Amhara; the program's implementing partners, IMPACT, EIFDDA, NNPWE, EPHA, DOHE, HST; and the program's collaborating universities of Gondar and Mekele (with Bahir Dar to follow). They received the following capacity building assistance:

RHBs	<ul style="list-style-type: none"> <li>- ENHAT-CS HSS advisor seconded to the RHBs participated in RHB activities on a daily basis</li> <li>- ENHAT-CS hired 2 OR partnership advisors seconded to the RHBs to link OR with the Universities of Mekele, Bahir Dar and Gondar</li> <li>- RHB staff were involved in training and mentorship</li> <li>- RHBs received technical and financial support for HSS activities including review meetings, supportive supervision, EQA activities</li> </ul>
IMPACT, EIFDDA, NNPWE, DOHE	<ul style="list-style-type: none"> <li>- Staff were included among training participants in ENHAT-CS trainings</li> <li>- Received TA and support for BCC activities</li> <li>- Received support to produce newsletters</li> <li>- Staff participated in care &amp; support mentorship activities</li> </ul>
HST	<ul style="list-style-type: none"> <li>- Continued to receive support to deploy and manage data clerks and case managers</li> </ul>
EPHA	<ul style="list-style-type: none"> <li>- Received support for the 13<sup>th</sup> World Congress on Public Health</li> <li>- Program SOW was expanded to include operations research</li> </ul>
Universities	<ul style="list-style-type: none"> <li>- Received orientation to the program</li> <li>- ENHAT-CS hired 2 faculty advisors to be linked to the Universities of Mekele, Bahir Dar and Gondar</li> </ul>

✓ **Additional achievements:**

**Program launching workshop:** ENHAT-CS carried out one-day program launch workshops with the RHBs in both Mekele and Bahir Dar, each involving a wide range of partners and stakeholders, in November 2012. The workshops were organized to create a strong partnership among stakeholders and to familiarize them with ENHAT-CS strategies and technical approaches.

**HSS/coordination advisors embedded:** The program embedded an HSS/coordination advisor in each RHB to support the RHB by participating and organizing TWG meeting and supportive supervision. The advisors are also fully engaged in revision of supportive supervision checklist, catchment area TOR and reporting template. Their support enhances close collaboration between ENHAT CS and the RHB supporting the regions in comprehensive HIV and AIDS treatment care and support services.

**Gender mainstreaming activities:** To ensure a systematic approach to gender mainstreaming, ENHAT has adopted the “Process for Gender Integration” through the Program Cycle,<sup>1</sup> originally adapted from the approach used by the Measure Evaluation project.

ENHAT-CS implemented gender mainstreaming formative activities focusing on analysis and planning and initial design activities. Analysis focused on specific behaviors and actions associated with care seeking, treatment follow-up and adherence, and protective practices, exploring barriers and issues for each program component for service delivery and community engagement. Specific activities included the following.

- ✓ **A gender assessment and analysis was conducted with staff, MSG mentors and religious leaders:** As part of the overall gender mainstreaming activities in the ENHAT- CS program, a series of discussions were conducted to identify key gender related issues likely to arise in the provision of care, support and prevention with PLHIV. These discussions inform the development of materials to support the work of health extension workers (HEWs), mother support group (MSG) facilitators, case managers and local NGO partners and others involved in the care and support of PLHIV. They will also inform the development of material to support community conversations that aim to create a more supportive environment.
- ✓ **Preparations for the validation exercise based on gender analysis series:** Based on the findings from the above gender analysis and planning, the program developed data collection tools for the validation exercise, targeting religious leaders, MSG clients, members of the health center multidisciplinary team and community members. The validation exercise will be carried out in 9 high patient load health centers supported by MSG and linked to faith-based initiatives at the community level. The following tools were developed:
  1. The MDT gender mainstreaming planning tool/ check list
  2. Religious leaders’ tool
  3. Focus Group Discussion (FGD) tools for MSG clients
  4. FGD for community members (men, women, girls and boys)
- ✓ **Pilot testing of tools:** The tools were pilot tested in the last quarter of the program year. One of the tools, the religious leaders’ tool, was administered to 291 religious leaders as pre- and post-test questions to judge their knowledge and self-efficacy to mainstream gender in their daily religious duties. Results of the analysis will inform the development of job aids religious leaders will use during community conversations

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<sup>1</sup> Caro, D. for IGWG, *A Manual for Integrating Gender into Reproductive Health and HIV Programs: From Commitment to Action (2<sup>nd</sup> Ed)*. Interagency Gender Working Group and USAID, August 2009.

**Integrated Joint supportive supervision (JISS) in Amhara and Tigray:** In accordance with the RHBs plan to conduct integrated supportive supervision biannually, two JISS were organized and conducted during this reporting period. Technical staff from ENHAT-CS, the RHB and other partners participated in the supervision. The JISS helped the RHBs to cover all hospitals and all program-supported HCs, and selected health posts, including women-centered health development army (HDA) groups. ENHAT-CS participated fully, providing technical, financial and logistic support to each RHB. After completing the assessment, the team provided feedback to the health facility staff, woreda health offices and zonal health departments.

In Tigray, 8 teams of different technical staff from the RHB and other partners participated in the 28 day supervision. This second ISS helped the RHB to cover all hospitals and HCs, and 179 health posts, including 172 HDA groups. ENHAT-CS participated fully, including provision to the RHB of technical, financial and logistic support. After completing the assessment, the team provided feedback to the health facility staff, woreda health offices and zonal health departments. Among the gaps identified were shortage of test kits, absence of IPT services in many HCs, and delays in DBS results. It was found that EQA was done for AFB, malaria, and HIV in all HCs during this quarter. The ISS findings were used as a major input for development of the RHB's 2005 EFY annual plans. The major findings were discussed in a partners' forum and RHB heads strongly advised all partners to harmonize their next year's plans. **Catchment area meetings (Amhara):** In Q2, the program provided material and technical support for 10 catchment area meetings (CAMs). The meetings were also attended by other partners including I-TECH-Ethiopia, regional PFSA, Food by Prescription, HEAL-TB, SCMS, regional laboratory, RHAPCO, and HC and hospital focal persons. At these catchment area meetings, issues related to MNCH/PMTCT, prevention, C&S, ART treatment, TB/HIV, SI, laboratory capacity and health systems were covered.

**Zonal review meetings (Tigray):** During Q3, the Tigray RHB carried out zonal review meetings with woreda and health center staff for two days in 6 zonal towns. ENHAT-CS supported these meetings and attended 2 of them (Southern and Westerns Zones). The review meetings were also attended by other partners, including ITECH Ethiopia, regional PFSA, Food by Prescription, SCMS, regional laboratory, RHAPCO, and HC and hospital focal persons. During the meetings, the RHB discussed bottlenecks to achieve results, and presented a video on best practices by HCP/facilities. Participants agreed on creating strong health development army groups and utilizing all resources to achieve the MDGs/GTP health aspects, under the theme "No mother should die giving life" and "Zero new HIV infections and death".

**Semiannual ENHAT-CS review meeting:** ENHAT-CS presented the program's semiannual results to both regional health bureaus and published its first semi-annual brief with notable program results. All HIV team members, core process owners, bureau heads and deputy heads attended. After the meeting, the RHB staff noted that they found the meeting to be very useful as it provided them with a good understanding of the program and current health center performance while providing them with a forum for frank discussion. They stated that they wished to continue these on a semi-annual basis.

**Participation at ICASA:** ENHAT-CS supported the participation in ICASA for 17 of its staff, including 7 senior program and clinical staff from its three field offices. ENHAT-CS staff presented a poster on gender mainstreaming when scaling up HIV/AIDS services, which was developed and submitted to the conference by HCSP.

**Participation at the 13<sup>th</sup> World Congress on Public Health, April 2012:** ENHAT-CS supported the participation of 10 program and 2 RHB staff in the 13<sup>th</sup> World Congress on Public Health, which was hosted by ENHAT-CS partner, EPHA, in Addis Ababa in April 2012. ENHAT-CS also had a booth at the Congress, where it shared its brochure as well as HCSP's end of program report and OR briefs with the attendees.

**Visceral Leishmaniasis (VL) treatment site assessment (Sheraro):** The current treatment sites for VL in Tigray region are hospitals. Considering the inaccessibility of these treatment facilities to a significant number of affected people, the RHB has proposed to open an additional treatment center at Sheraro HC. The regional HIV version coordinator and ENHAT-CS regional program manager conducted an assessment at the Sheraro Woreda Health Office and Sheraro HC to review their readiness. The woreda health office and HC staff expressed their commitment to this initiative, realizing that VL treatment is a top priority of the community, noting that it has been raised in the town and regional parliaments. ENHAT-CS will continue to work with the RHB to realize this initiative.

**Supporting HCs to monitor their drug and supply stock:** In an effort to strengthen and improve the supply chain management system, ENHAT-CS provided training on the integrated pharmaceutical logistic system management in collaboration with regional PFSAs and SCMS. This training was intended to capacitate the mentors to better monitor the availability of ARV and PMTCT drugs, RTKs, DBS and other supplies. ENHAT-CS conducted stock assessment of RTKs and DBS kits in June. All facilities in Tigray have DBS and RTK kits, but the RTKs have been limited to PMTCT and selected services. As a result, PITC has not been routinely offered in the region's HCs. Most of the new ART HCs in Amhara do not have DBS kits, and only 70% had RTKs. ENHAT-CS has discussed the issue with the RHBs and PFSAs, and one of the reasons mentioned for the shortage is inappropriate resupply requests by the health centers. The program will continue to work with the respective facilities to support them to make more accurate resupply requests.

**Distance Learning:** ENHAT-CS held discussions on distance learning (DL) with Dr. Ann Downer, Executive Director, I-TECH and Associate Professor at the Department of Global Health of the University of Washington. Ann described recent University of Washington DL initiatives, including development of 12 CDROM short courses on clinical areas such as ART and lab. She shared with ENHAT-CS three completed courses, which the program will have program mentors take. The program intends to then have the mentors roll out the short courses to their supported health center HCPs. A longer term collaboration could involve adaptation of a FMOH training curriculum into a DL format.

**Leadership Development Program (LDP) component:** Mr. Jemal Mohammed provided technical assistance for development of the program's LDP component. Mr. Mohammed recently was appointed as project director of the USAID funded LMG project and previously led the MSH Ethiopia implemented USAID LDP in 2010. He led workshops with ENHAT-CS program management and its implementing partners that described the conceptual framework of LDP that led to discussions on implementation by ENHAT-CS.

**GOE mentorship sensitization workshop:** As a means of ensuring ownership and sustainability ENHAT CS involved woreda HIV and family health officers in routine mentorship activities throughout the year to build capacity of the woreda to plan, implement and monitor HIV programs. ENHAT CS continues to work strongly and closely with RHB to realize ownership and sustainability. In order to realize this ENHAT-CS committed to train GOE mentors and build their capacity through joint mentorship with program mentors.

The GOE mentorship strategy was prepared jointly by RHB and ENHAT-CS, and will be piloted in two zones in Amahra and one zone in Tigray. The Amhara RHB and ENHAT-CS selected West Gojam and South Wollo zones for the first phase of GOE mentorship training and implementation. The draft strategy was shared and enriched at orientation meetings conducted in Fenotselam and Dessie. Participants included the RHB head and deputy head, disease prevention health promotion and planning core process owners, regional HIV officers, zonal health higher officials of woreda health offices, woreda health office heads and health center heads. The meetings resulted in the identification of selection criteria for GOE mentors, training and joint mentorship activities. An action plan was developed to select, train and implement GOE mentorship in PY II first quarter. A similar program will also be conducted in Tigray.

**ART accreditation assessment of HCs:** The Tigray Health Bureau and ENHAT-CS conducted a joint assessment of 33 HCs that had been pre-identified by the regional HIV version team for accreditation to ART sites. The assessment was based on the national accreditation criteria and additional recommended indicators including the catchment area HIV prevalence rates, presence of PLHIV associations, and distance from ART site to hospitals. Two teams comprised of physicians, lab and pharmacy technologists were assigned. Both teams had a pre-assessment meeting to standardize the checklist. The findings were presented in a post-assessment meeting conducted at the RHB and 25 HCs were selected for the accreditation. ENHAT-CS will begin supporting these 25 HCs in PY2.

## 6. Challenges and Constraints and plans to overcome them during the reporting period

### 01- PMTCT

#### Challenges and constraints for each program area:

##### Program area 01-PMTCT

1. Demand creation component for accelerated PMTCT plan through health development army (HDA) not fully realized due to structural and coordination related constraints
2. Huge need for PMTCT/MNCH trained health professionals to meet the demand for accelerated plan.
3. Upcoming changes to PMTCT under Option B+ will require huge need for update training
4. Shortage of test kits and supplies used for routine ANC and L & D services to initiate and roll out implementation of new guideline
5. FMOH/RHBs and ENHAT-CS use different data sources and indicator to count linkage resulting in significantly different percentages of linkage

#### Plans to overcome challenges and constraints in each of your program areas:

##### Program area 01-PMTCT

1. Continue to support the roll out of the accelerated PMTCT plan both at national and regional level
2. Support health worker training for the accelerated plan
3. Support on-site training for Option B+ and work with other partners
4. Work with RHBs, PFSA, as well as SCMS, to identify and address the shortages of test kits and supplies
5. Work with RHB, including M&E units, to explain differences and conduct OR on linkage of HIV+ pregnant women to better determine realistic understanding of actual linkage.

### 02-AB (Abstinence and Be Faithful)

#### Challenges and constraints for each program area

##### Program area 2-HVAB

1. NNPWE volunteers require additional support in documentation

#### Plans to overcome challenges and constraints in each of your program areas

##### Program area 2-HVAB

1. Provide on-site orientation and mentorship to volunteers

### 03-HVOP (Other Prevention)

#### Challenges and constraints for each program area

##### Program area 3-HVOP

1. Need to revise OP target based on lower average number of adults per supported HH

#### Plans to overcome challenges and constraints in each of your program areas

##### Program area 3-HVOP (Other Prevention)

1. Same as above

### 08-HBHC (Adult Care and Support)

#### Challenges and constraints for each program area

##### Program area 8-HBHC (Adult Care and Support)

1. Poor documentation of completed referrals

#### Plans to overcome challenges and constraints in each of your program areas

##### Program area 8-HBHC (Care and Support)

1. Strengthen linkages and partnership between program's case managers and community referral network advisors with woreda health offices, HEW supervisors and HEWs to strengthen the bi-directional closed loop referral system, including continuing to work with the RHBs for use of a harmonized referral slip
2. Provide all supported HCs with standardized referral slips, log books and provide mentorship to case managers on proper recording keeping of referrals
3. Support monthly HC based PHU meeting to strengthen the referral and tracing mechanisms

### 09-HTXS (Adult Treatment)

#### Challenges and Constraints for each program area

##### Program area 9-HTXS

1. CD4 sample transport problem due to:
  - Frequent non-functionality of CD4 machines affecting most hospitals
  - Vacutainer test tube shortage
  - No or irregular per diem/transport allowance payment for sample transport by laboratory technicians
2. Turnover of trained staff specially ART providers and some data clerks
3. Shortage of supplies like OI drugs and INH
4. Significant number of pre-ART patients status not well known
5. Almost all patients started on Stavudine (D4T) two years back are still on the regimen

#### Plans to overcome challenges and constraints in each of your program areas

##### Program area 9-HTXS

1. Work closely with the regional laboratories and health bureaus to address the problems related to sample transport. Routinely communicate with all stakeholders on gaps identified.
2. Provide IMAI training based on gap filling
3. Collaborate with SCMS/PFSA on supply issues
4. ENHAT CS will continue to advocate and support the FMOH HIV Care and Treatment TWG to approve a pre-ART patient register that allows tracking of pre-ART patient health center visits coupled with ongoing mentorship that emphasizes regular assessments of patients who are on pre-ART service for ART eligibility
5. Actively participate in the national taskforce for transitioning from Stavudine to other regimens

## 10-HVTB (TB/HIV)

### Challenges and constraints for each program area

#### Program area 10

1. Shortage of RTKs
2. Low TB case detection rate
3. Low household contact screening for smear positive pulmonary TB patients and no data source
4. Poor linkage and low rate of ART initiation for TB/HIV co infected patients
5. Health workers lack confidence to initiate IPT in children

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 10

1. Mentors continue to monitor availability at health centers coupled with working with RHBs, PFSA, and SCMS, to help address the noted shortages
2. Embedded regional lab advisors continue to facilitate improved external and internal quality assurance support to HCs coupled with HC mentorship by program clinical and laboratory mentors. In Amhara, collaborate with HEAL TB to support the RHB/RL's decentralized EQA system
3. Introduce the family matrix form for contact screening and provide support through mentorship
4. Revise data collection procedures to better capture linkage, coupled with ongoing support to health worker training on management of TB/HIV co-infection supported by ongoing on-site mentorship
5. Ongoing mentorship focuses on improving understanding and confidence of HCPs

## 12-HVCT (Voluntary Counseling and Testing)

### Challenges and Constraints for each program area

#### Program area 12: HVCT

1. Shortage of RTKs
2. Low motivation of health care providers for conducting PITC

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 12: HVCT

1. Mentors continue to monitor availability at HCs coupled with working with RHBs, PFSA, and SCMS, to help address the noted shortages
2. Program's clinical care mentors continue to focus on mentoring HC clinics on PITC

## 13-PDTX (Pediatric Treatment)

### Challenges and Constraints for each program area

#### Program area 13: PDTX

1. Provision of complex pediatric treatment challenging to HCPs, including a lack of skill for pediatric phlebotomy for CD4/chemistry sample collection
2. Frequent CD4 and chemistry machine failure
- 3.

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 13: PDTX

1. Partnership with ANECCA, with pediatric advisors supplementing ongoing mentorship with more focused mentorship on HIV/AIDS pediatric treatment
2. Monitor and communicate CD4 and chemistry machine failures with government counterparts

## 14-PDCS (Pediatric Care and Support)

### Quarterly challenges and Constraints for each program area

#### Program area 14: PDCS

1. Low PITC performance in U5 and EPI clinics
2. Shortage of key supplies:
  - a. OI and prophylactic drugs (cotrimoxazole suspension, INH 100 mg preparation and NVP syrup for PMTCT)
  - b. RTKs for HIV testing
3. Poor growth monitoring and interpretation
4. Long turn-around time of DBS
5. Lack of skill of health care providers in providing counseling and psychological support to children e.g. pediatric disclosure

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 14: PDCS

1. Mentors focus on motivate staff at U5 and EPI clinics for PITC activity and follow-up on progress. Identify champions for PITC (nurses, counselors) and encourage them.
2. Mentors monitor and program works with RHBs, PFSA and SCMS to identify and address shortage of drugs and RTKs
3. Mentors and ANECCA pediatric advisors place more emphasis and focus on growth monitoring and interpretation during health center visits by doing actual measurements, plotting on charts and interpreting during case discussion at facility level
4. Program's regional lab advisors continue to support more rapid testing and communication of results
5. Incorporate psychosocial care training into comprehensive pediatric ART training and build the skill of HCPs on psychosocial care during regular mentoring activities

## 16-HLab (Laboratory Infrastructure)

### Quarterly challenges and Constraints for each program area

#### Program area 16: HLAB

1. Erratic lab supply distribution system and shortage of reagents for DBS sample processing (and AFB reagent in Tigray HCs)

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 16: HLAB

1. Provide lab support, through lab mentors visiting HCs to support lab services and recognize difficulties and through a regional lab advisor embedded in each regional lab to facilitate assistance to HC labs

## 17-HVSI (Strategic Information)

### Quarterly challenges and Constraints for each program area

#### Program area 17-HVSI

1. Shortage of HMIS tools specifically ART register, HEI register and HEI follow up chart, L & D register and FP register

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 17-HVSI

1. Support RHBs through gap filling printing of HMIS tools, including distribution to program supported HCS

## 18-OHSS (Health Systems Strengthening)

### Quarterly challenges and Constraints for each program area

#### Program area 18-OHSS

1. Low capacity of CRNMs to coordinate the primary health network
2. Knowledge gap of woreda HIV officers on clinical mentoring

### Plans to overcome challenges and constraints in each of your program areas

#### Program area 18-OHSS

1. Provide TA to CRNM's through ongoing quarterly mentorship/supportive supervision
2. Provide training to and involve qualified WorHO staff in mentoring

## 7. Data Quality issues during the reporting period

### Specific concerns you have with the quality of the data for program areas reported in this report

#### All Program areas:

1. Incomplete documentation of linkages between newly tested HIV-positive individuals to HIV clinic
2. Casual data check is indicating some degree of under-reporting

### What you are doing on a routine basis to ensure that your data is high quality for each program area

1. Mentors to continue promoting health workers to physically escort patients testing HIV-positive to the ART clinic for enrollment and then document the linkage at their clinic
2. Continuous monthly review of data quality at field office level with the involvement of all ENHAT-CS staffs including mentors

### How you planned to address those concerns / improve the quality of your data for each program area

1. Recruit and train data clerks for gap filling to fill vacancies
2. Internal data validation checks

## 8. Major Activities planned in the next reporting period

Major activities planned in the next reporting period should high planned activities and solutions to identified constraints.

### Program area 01-PMTCT (Prevention of Mother to Child Transmission)

1. Explore with RHB the possibility of piloting one stop shopping service of ART for HIV-positive pregnant women in ANC clinic.
2. Continue to actively participate in the accelerated PMTCT plan at national and regional level, including continuing orientation of HCPs on the new guidelines
3. Provide ongoing with quarterly and more intensive mentorship to strengthen MSG activities

### Program area 02-HVAB (Abstinence and Be Faithful)

1. Provide training for religious leaders on HIV messaging during their community conversations

### Program area 03-HVOP (Other Prevention)

1. Provide focused mentorship on PEP
2. Follow the cascade of infection prevention trainings to HC staff

### Program area 08-HBHC (Adult Care and Support)

1. NNPWE communities volunteers continue to provide HH visits in accordance with NGI requirements
2. Continue to work with woreda health offices, including during quarterly woreda and monthly PHU meetings to monitor and strengthen the bidirectional closed loop referral system

### Program area 09-HTXS (Adult Treatment)

1. Provide gap filling training for replacement HCPs
2. Initiate mentorship training for selected GOE health staff
3. Provide regular team based mentorship to all ART sites at least once a month
4. Conduct activity reporting meeting and case presentations at the end of each month at each field office

### Program area 10-HVTB (TB/HIV)

1. Provide formal TB and TB/ HIV training to health workers
2. Initiate discussions with RHBs for piloting one stop shopping service of ART for TB/HIV co-infected patients at TB clinic

### Program area 12-HVCT (Voluntary Counseling and Testing)

1. Continue SOC assessment of VCT performance and feedback through monthly mentorship

### Program area 13-PDTX (Pediatric Treatment)

1. Continue provision of focused mentorship of high patient load HCs on pediatric care and treatment
2. Upgrade skills of ENHAT-CS mentors in pediatric HIV treatment by organizing joint mentorship program with pediatric HIV advisors and TA from ANECCA consultant on psychosocial support

#### Program area 14-PDCS (Pediatric Care & Support)

1. Upgrade skills of ENHAT-CS mentors in pediatric HIV care and support by organizing joint mentorship program with pediatric HIV advisors and TA from ANECCA on psychosocial support

#### Program area 16-HLAB (Laboratory Infrastructure)

1. Provide laboratory mentorship focusing on filling the technical and logistics gaps identified from the base line assessment
2. Identify and provide focused mentorship to potential hub laboratories

#### Program area 17-HVSI (Strategic Information)

1. Distribute ENHAT-CS data reference manual to data clerks and mentors
2. Conduct RDQA
3. Analyze SOC data
4. Provision of gap filling printing of HMIS tools to HCs

#### Program area 18-OHSS (Health Systems Strengthening)

1. In collaboration with regional PFSA, improve capacity of mentors through training on IPLS so they can better support HC reporting and resupply requests
2. Support RHBs to conduct catchment area meetings
3. Support RHBs to conduct regional or zonal review meetings
4. Support RHBs to conduct joint supportive supervision
5. Support woreda health offices to conduct quarterly woreda health network review meetings with their staff and community representatives
6. Support HC led monthly PHU review meetings, including a focus on HC and community referral and linkages
7. Conduct orientation training of 198 religious leaders to carry out HIV messaging during their community conversations mass education events
8. Complete the gender validation exercise and initiate development of a HC job aid and MDT gender mainstreaming

## 9. Environmental compliance

#### Describe any issues related to environmental compliance (if there are any)

ENHAT-CS environmental compliance focuses on infection preventions (IP) and waste disposal. The program is actively participating in the TWG on IP/PS, chaired by the Medical Services Directorate (FMOH). As noted in the above narrative in section 03-HVOP:

- National IP/PS training reference manual was finalized, approved by the FMOH, and made ready for printing.
- IP/PS training participant handouts, facilitators guide and a power-point presentation were developed, finalized and made ready for printing.
- First round of IP/PS training of trainers (TOT), organized by the FMOH, took place in collaboration with the TWG members for trainees from the regions of Amhara and four other regions. Participation by trainees from Tigray is planned for the second round.
- Draft Health Care Waste Management (HCWM) Strategic Action Plan was reviewed and finalized during a three day workshop and submitted to the Agrarian Health Service Directorate for review and approval.
- National IP/PS commodities quantification assessment plan was reviewed.

In addition, the program’s mentorship checklist includes monitoring of supported health centers’ storage of and disposal of sharp materials, contaminated supplies and liquid and solid waste. The checklist data is inputted into an online database, allowing the program to report on HCs’ ongoing compliance with these environmental safety procedures. Data on storage and disposal of sharps, contaminated materials and liquid waste were collected and analyzed on a sub-set of 49 health centers.

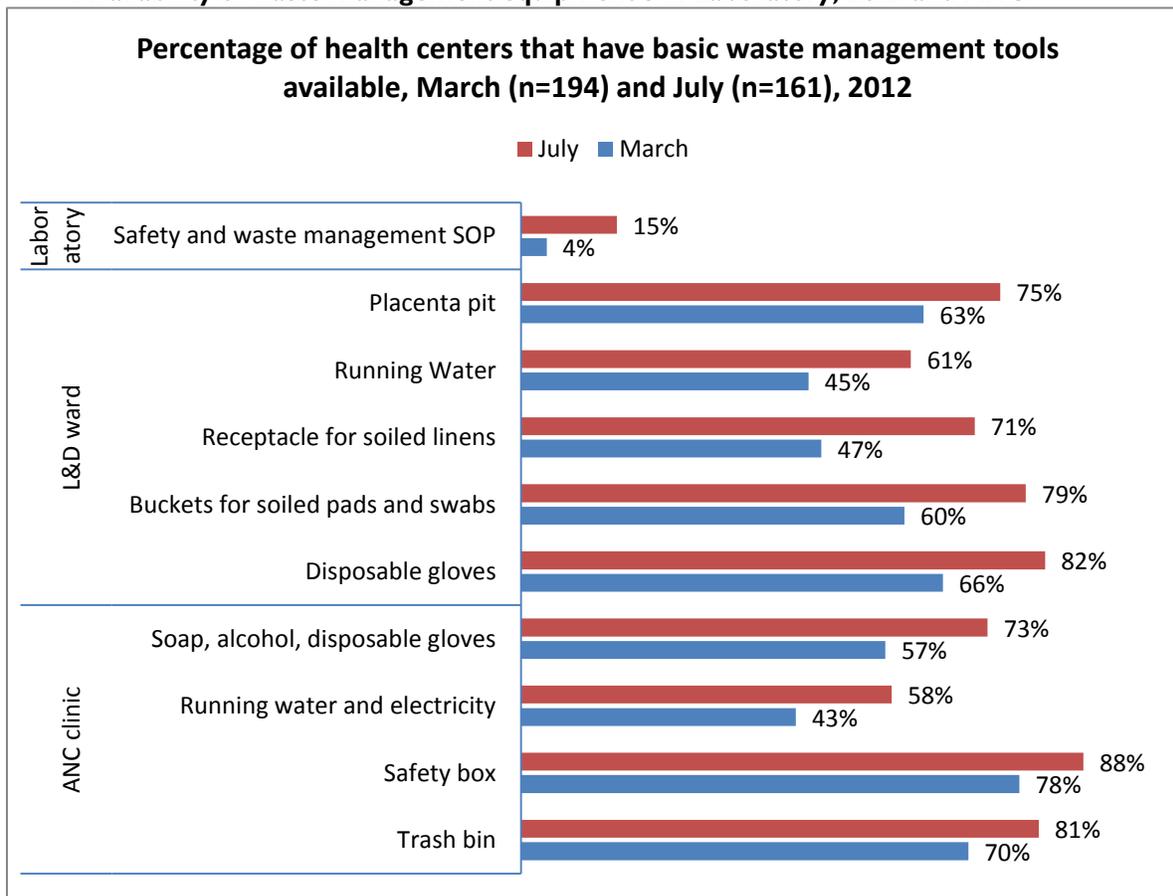
**Sharps:** In March, 61% of HCs stored sharps materials in a sharp box, 30% in a biohazard bag, and 9% used a waste bin. In July, 100% of HCs used a sharp box for storing of sharps materials. Disposal of sharps by incinerator increased from 89% to 93% of HCs between March and July, while the remaining HCs burned their sharps.

**Contaminated materials:** In March, 73% of HCs stored contaminated materials using a waste bin, 18% used a biohazard bag and 7% a sharp box. In July, the proportion of HCs using a waste bin had dropped to 50% while 47% were using biohazard bags. However, 3% still reported using a sharp box. In March, 35% destroyed contaminated materials using an incinerator, 52% burned them, and 13% buried them. In July, 41% used an incinerator and 59% burned them.

**Liquid waste:** In March, 6% of HCs disposed of liquid waste by burning it, 31% buried it, and the remaining 63% used other methods. In July, 11% burned their liquid waste, 33% buried it, and 56% used other methods.

The mentors also collected information on the availability of waste management tools. The table below shows improvements in all areas between March and July 2012.

**Availability of waste management equipment’s in Laboratory, L&D and ANC**



## 10. Issues requiring the attention of USAID Management

Identify and state issues that USAID needs to look at and address for each program area

### All Program Areas

The FMOH is actively discouraging organizations to maintain community volunteers, including prohibition of payments (even minimal travel stipends), with the assumption that such community support will be assumed by the government mobilized women-centered health development army (HDA). This is problematic when applied to HIV-positive people, who, under this procedure, would need to disclose their status to their neighborhood women development team members to get HIV specific support. This contravenes international ethical standards that mandates that disclosure of status be fully volunteer and unpressured e.g. not related to provision of assistance.

Currently, the program continues to support the NNPWE volunteers, all of whom are HIV-positive and active members of grass roots PLHIV associations. Of note, they have received approval from the Charities and Societies Agency to continue supporting their PLHIV volunteer activities at community level.