ENHAT- CS Annual Progress Report FY13

ENHAT-CS Team

October 2012 – September 2013

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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
FY13

(OCTOBER 2012 – SEPTEMBER 2013)

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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
PFSA	Pharmaceuticals fund and supply agency
PHCU	Primary Health Care Unit
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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1. Reporting period

From: 1October 2012	**To:** 30 September 2013

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
Oct – Dec'12		
Libona newspaper	Dawn of Hope Ethiopia Association	Monthly publication
The Voice of Women newsletter	National Network Positive Women Ethiopia (NNPWE)	Quarterly publication since November 2012
Jan – Mar'13		
Libona newspaper	Dawn of Hope Ethiopia Association	Monthly publication
The Voice of Women newsletter	National Network Positive Women Ethiopia (NNPWE)	Quarterly publication
ENHAT-CS Annual Brief, Issue 2	ENHAT-CS	January 2013
Apr-Jun'13		
Libona newspaper	Dawn of Hope Ethiopia Association	Monthly publication
The Voice of Women newsletter	National Network Positive Women Ethiopia (NNPWE)	Quarterly publication
ENHAT-CS Semi-Annual Brief, Issue 3	ENHAT-CS	Semi-annual publication, May 2013
ENHAT-CS Semi-Annual PMTCT Update	Dr. Lemma Ketema	USAID Partners Review Meeting on Semi-Annual PMTCT Program, 30 May 2013
Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia	Nelia Matinhure, Bedria Mohamed, Gebre Mekonnen, Demlie Belete and Zewdu Zegeye	7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Malaysia, 30 June – 3 July 2013 (oral poster discussion session)
Vertical transmission of HIV less than half among mothers belonging to mother-support groups (MSG) compared to non-member mothers at health centers in Tigray, Ethiopia	Mebrahtu Abraha, Tsegazeab Kahsu, Hagos Godefay, Elke Konings	7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Malaysia, 30 June – 3 July 2013 (poster presentation)

Jul-Sept'13

Title	Author	Date
Vertical transmission of HIV by age of infant testing and type of mother/infant prophylaxis in Tigray, Ethiopia	Tsegazeab Kahsu, Mebrahtu Abraha, Fentahun Tadesse, Bud Crandall, Hagos Godefay, Elke Konings	STI & AIDS World Congress 2013, Vienna, Austria, 14-17 July 2013 (poster presentation)
Vertical transmission of HIV less than half among mothers belonging to mother-support groups (MSG) compared to non-member mothers at health centers in Tigray, Ethiopia	Mebrahtu Abraha, Tsegazeab Kahsu, Hagos Godefay, Elke Konings	STI & AIDS World Congress 2013, Vienna, Austria, 14-17 July 2013 (poster presentation)
Abstracts of Research Sponsored by ENHAT-CS Part 1: Amhara Region Part 2: Tigray Region	Hussein Ismail (ed.)	Program publication, 1 September 2013

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

Oct – Dec'12

Dr. Fred Hartman	27 Nov'12	12 Dec'12	MSH	Technical support/program supervision
Dr. Elke Konings	13 Oct'12	26 Oct'12	MSH	M&E and OR
Ms. Ashley Marks	21 Oct'12	21 Nov'12	MSH	OR

Jan – Mar'13

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	7 Jan'12	29 Jan'12	MSH	Technical support/program supervision
Dr. Elke Konings	7 Jan'13	22 Jan'13	MSH	M&E and OR
Seleman Ally	10 Feb'13	17 Feb'13	MSH	DHIS-2

Apr-Jun'13

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	8 Apr'13	21 Apr'13	MSH	Technical support/program supervision
Dr. Elke Konings	10 Apr'13	26 Apr'13	MSH	M&E and OR

Jul-Sep'13

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	10 Jul'13	24 Jul'13	MSH	Technical support/program supervision
	4 Sep'13	12 Sep'13	MSH	Technical support to PY3 work plan
Dr. Elke Konings	25 Jul'13	2 Aug'13	MSH	M&E and OR
	4 Sep'13	12 Sep'13		

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	Return to Ethiopia	Host Organization	Purpose of the travel
Oct – Dec'12					
Genaye Eshetu	Thailand	8 Oct'12	1 Dec'12	Media Light Asia	Attended communications training program
Jan-Mar'13					
John Shin	USA	2 Mar'13	16 Mar'13	MSH	Attended Project and Center Financial Management Business Process Review Process, at MSH headquarters
Dr. Tsegazeab Kahsu	India	18 Mar'13	30 Mar'13	Public Health Foundation of India and USAID MEASURE Evaluation Project	Attended training on program evaluation
Elsa Gebregzi	Uganda	19 Mar'13	22 Mar'13	MSH	Attended regional training on MSH worldwide financial policy and procedures
Bud Crandall	Vietnam	23 Mar'13	1Apr'13	MSH	Attended Maximize Efficiency and Impact Workshop
Elsa Gebregzi	Vietnam	23 Mar'13	2 Apr'13		

Name	Destination	Departure from Ethiopia	Return to Ethiopia	Host Organization	Purpose of the travel

Apr-Jun'13

Dr. Solomon Sisay	South Africa	13 May'13	24 May'13	USAID MEASURE Evaluation Project	Attended regional workshop on Impact Evaluation of HIV and Health Programs
Tesfaye Arega	Uganda	3 Jun'13	14 Jun'13	DHIS 2 Academy	East Africa 2013 Advanced Level, Entebbe, June 4-13 2013
Nelia Matinure	Malaysia	2 Jun'13	8 Jun'13	7th IAS Conference on HIV Pathogenesis, treatment and prevention,	Oral presentation at poster discussion session: "Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia"
Dr. Mebrahtu Abraha	Malaysia	2 Jun'13	8 Jun'13	7th IAS Conference on HIV Pathogenesis, treatment and prevention,	Poster presentation: "Vertical transmission of HIV less than half among mothers belonging to mother-support groups (MSG) compared to non-member mothers at health centers in Tigray, Ethiopia"

Jul-Sep'13

Dr. Tsegazeab Kahsu	Austria	14 Jul'13	18 Jul'13	STI & AIDS World Congress 2013, Vienna, Austria	Poster presentations: Vertical transmission of HIV by age of infant testing and type of mother/infant prophylaxis in Tigray, Ethiopia "Vertical transmission of HIV less than half among mothers belonging to mother-support groups (MSG) compared to non-member mothers at health centers in Tigray, Ethiopia"

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

Jan – Mar'13

Pediatric HIV Program Assessment (USG interagency assessment team	18 Mar'13	26 Mar'13	Woreta and Gondar HCs, Amhara	Verbal debrief provided

Apr-Jun'13

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
PEPFAR/USAID site visit to HCs to assess PMTCT performance and issues (Yoseph Woldegebriel, Semunegus Mehrete, Jenna Kennold, Phounjjiang Neguyen)	17 Jun'13	21 Jun'13	Debreberhan HC, Kobo HC, Maichew HC	Pending

Jul-Sept'13

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
PEPFAR Prevention Visit (TDYs)	18 Jul'13	18 Jul'13	Bahirdar HC	Pending
HMIS Implementation and Site Level Support	23 Jul'13	25 Jul'13	Woldiya HC, Alamata HC	Pending
USG Regional Inspector General Audit field visit to HCs for data verification of key NGI indicators (Bradley Klingport, Bejamin Owusu)	16 Sept'13	20 Sept'13	Adet, Dangla, Injibara, Alember HCs	Verbal debrief with report pending
USAID Ethiopia SI &QA Team, office visit for conduction of a data quality assessment (led by Semunegus Mehrete)			ENHAT-CS central office, Addis	Pending

5. Activity

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

01-PMTCT (Prevention of Mother-to-Child Transmission)

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

Adoption and roll-out of option B+: Following the adoption of option B+ as the national PMTCT standard in August 2012, the GOE/FMOH prepared the necessary training materials, job aids, operational plan and a strategy document for the elimination for MTCT of HIV (eMTCT), which is the latest global effort toward an HIV-free generation. FMOH officially launched option B+ on Feb 20th 2013 in the presence of partners. Following a national training of trainers (TOT) and distribution of the national operational plan to the regional health bureaus (RHBs), training on option B+ was rolled out to health care providers in almost all health centers. However, there was a delay in finalizing the necessary monitoring tools, such as revised registers and reporting formats, to capture the implementation of option B+. Furthermore, the distribution of necessary ARVs was challenging. As a result, initiation of HAART at MCNH clinics at some health centers was delayed.

During FY13, the ENHAT-CS program provided technical support to the FMOH and the RHBs to prepare and implement the roll-out of option B+, including training, mentorship, technical assistance to update materials and support to print and distribute updated B+ HMIS registers to HCs in Amhara and Tigray. The program has also been a member of the national and regional technical working groups and continues to work closely with the FMOH, RHBs and other partners to implement option B+ in Tigray and Amhara.

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

- ✓ **217 health centers (HCs) are providing PMTCT services** (P1.3.D)

  Comment: ENHAT-CS reports PMTCT data from all 217 HCs that received ENHAT-CS mentorship and technical assistance during the reporting period *and* that are not supported for PMTCT by the USAID CPMTCT project. This reflects 100% of the PY13 target. Of note, by the end of FY13, all program-supported HCs were implementing option B+ at the HIV clinic, while integration of B+ at ANC is unfolding.

- ✓ **177,549 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 at labor and delivery by a skilled provider was 177,549 during the reporting period, i.e. 112% of the FY13 target. This number is 24% more than the 143,612 pregnant women seen at program-supported HCs in FY12. The increase is a direct result of the program's expansion into more HCs (217 in FY13, up from 191 in FY12). However, the average number of pregnant women seen per health center also increased by 9%. Higher ANC and L&D attendance can be attributed the program's continuous efforts to improve the quality of ANC/L&D care at supported health centers, as well as community mobilization on maternal and child health care through the women's health development army as part of the GOE's accelerated PMTCT plan.

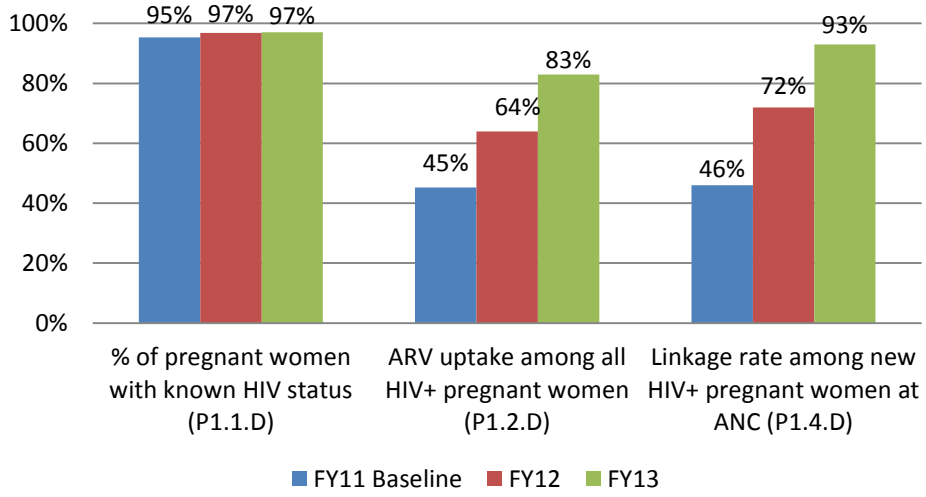
✓ **173,056 pregnant women had their HIV status known** (P1.1.D) **of whom 2.2% (3,825) were HIV positive** (P1.1D)

Among the **3,825**HIV-positives:

- **2,236 (58%) were known HIV-positive at entry**
- **1,589 (42%) were tested and found <u>newly</u> HIV-positive**

<u>Comment</u>: Continuing the FY12 trend, 97% of pregnant women seen at program-supported HCs during FY13 knew their HIV status (see Figure 1), which is well above the 2012 national rate of 37%. This achievement again represents 113% of the FY13 target.

Figure 1
PMTCT at ENHAT-CS-supported health centers, FY11-FY13



In FY13, 3,825 (2.2%) pregnant women seen at program-supported HCs were HIV+. Among the HIV positive pregnant women, 58% knew their HIV status at entry to ANC. As discussed in previous reports, this high proportion may reflect success of the PMTCT program, in that more HIV+ women want to fulfill their reproductive desires knowing they can prevent transmission to their baby or it may suggest a failure of FP services to reach HIV+ women who want to prevent pregnancy.

In FY13, the program supported OR efforts to better understand the reasons for the high proportion of known HIV-positives among pregnant women. In Tigray, an ENHAT-supported OR showed that among 964 HIV+ women seen at 12 health centers, 39 (3.5%) were pregnant and among them, 85% reported that the pregnancy was planned and wanted. Furthermore, 46% of all HIV+ women reported a desire to have at least one other child in the future. Also, 96% reported having heard of FP and 92% reported having received FP counseling. This study provided important information that our high proportion of known positives at ANC is a result of the success of PMTCT, rather than the failure of FP service provision. Another ENHAT-CS-supported study, conducted at 6 HCs in Amhara, found 14 (2.6%) of 530 women on ART to be pregnant and also among them, the majority (9 or 65%) reported that their pregnancy was planned and wanted.

Even though the samples of these studies were small, the results are consistent with the small study conducted in 2011 by HCSP at 4 HCs in Addis Ababa, which showed that the majority of pregnancies among HIV+ women were desired. To validate the results, ENHAT-CS now intends to conduct a larger scale study of HIV+ pregnant women seen through ANC at program-supported HCs.

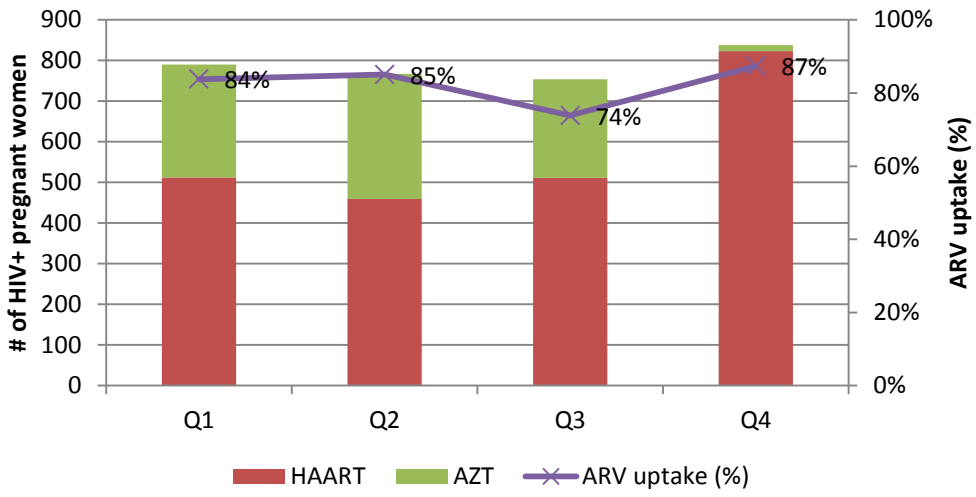
✓ **3,164 HIV-positive pregnant women received ARV for PMTCT at ANC** (P1.2.D).

844 received two ARVs
2,320 received ART at the ART clinic

Comment: Among the 3,825 HIV+ pregnant women seen at ANC during the reporting period, 3,164 (83%) received ARVS for PMTCT, which exceeds the program's FY12 rate of 64%, as well as both the FMOH national target of 80%, the 2012 national rate of 26%, and the program target of 70%, which was based on previous trends (see Figure 1 above).

The program's success may be attributed to the mentorship support, routine data quality assessments, the introduction of PMTCT follow-up charts, active involvement of MSGs, and improved services and tracing as a result of the program's priority focus on PMTCT. Furthermore, since Q3 of FY12, all program-supported HCs transitioned to offering option A, which, initiates HIV+ 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). In FY13, option B+, whereby all HIV+ pregnant women, regardless of gestational age and CD4 count, are offered ART, was rolled out in Q3 and completed by the end of Q4. The change to option B+ and then the completion of its roll-out is reflected in the data on ARV uptake in Q3 and Q4. Typical of transitions from an old to a new system, complete and accurate data recording and reporting lagged behind as evidenced by the apparent decline in ARV uptake in Q3 compared to Q2 and the increase in uptake between Q3 and Q4, with Q4 levels being – as expected- somewhat higher than Q2 (Figure 2). As expected, following the roll-out of option B+, by Q4, the majority (98%) of HIV+ pregnant women seen at program-supported HCs had been put on ART, suggesting that HCs are correctly implementing the new PMTCT strategy (Figure 2).

Figure 2
ARV uptake among HIV+ pregnant women, by type, FY13



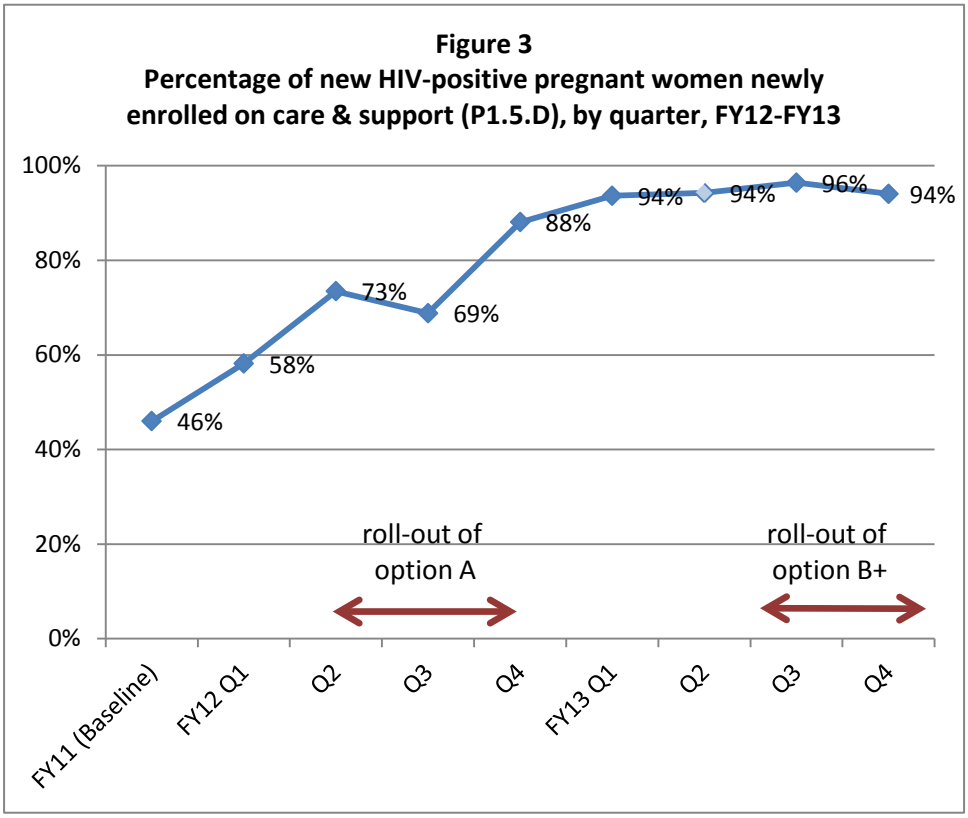
- ✓ **1,336 (95%) of newly tested HIV+ pregnant women at ANC were assessed for ART eligibility at ENHAT-CS supported HCs** (P1.4.D - data source: ART/ANC clinic)
- ✓ **1,336 (95%) of newly identified HIV+ pregnant women at ANC were newly enrolled into HIV/AIDS care and support in ENHAT-CS supported health center** (P1.5.D - data source: ART clinic).

  Comment: A total of 1,336 newly identified HIV+ ANC clients were assessed for ART eligibility and enrolled on care and support during the APR, representing 100% of the FY13 target and slightly below the FY12 total of 3,962. The number reflects a linkage rate among newly identified pregnant women at the ANC clinic of 95%. In previous years, the rate was 72% in FY12 and 46% in FY11 (see Figure 1). Of note, for calculating the linkage rate, the program excludes those tested and newly found HIV+ at L&D clinic, as the enrollment register at the HIV clinic only identifies pregnant women from the ANC clinic.

  As new HIV+ pregnant women directly start on HAART, more of them also enroll on care and support and thus the linkage rate improves. In part, this is explained by the fact that no initial CD4 test is needed and that enrollment takes place at the ANC clinic. This intervention removes the need for using an ART register at the HIV clinic to identify the number of HIV+ pregnant women who are assessed for eligibility and enrolled. By enrolling patients at the clinic where they are first diagnosed with HIV, integrated service delivery reduces under-reporting and the risk of losing patients during the referral process.

  However, improvement in the linkage rate started before option B+ was rolled out (Figure 3), and is therefore also due to the active involvement of mother mentors and the program's mentorship which continued to focus heavily on improved data recording and reporting and PMTCT as a top priority in support of the accelerated plan.

Figure 3
Percentage of new HIV-positive pregnant women newly enrolled on care & support (P1.5.D), by quarter, FY12-FY13



✓ **HEI cascade of services, APR'13**

Indicator	Number	%
Number of HEIs enrolled into care	3,639	
Number of HEIs enrolled at age 0-2 months	2,724	75%
Number of HEIs initiated on CPT within 2 months of birth	2,481	68%
Number of HEIs within 2 months of birth tested for HIV with PCR sample sent to regional lab	2,039	56%
Number of HEIs who received their PCR test results:		
• Total during the year (FY 13)	2,968	
• HEIs tested within 2 months	1,632	55%
• HEIs tested within 12 months	2,424	82%
Number HEIs who tested PCR positive	132	4.4%
Number of PCR positive HEIs linked to ART within facility	156	
Number of HEIs discharged from care	1,942	
Number of HEIs who died	154	
Number of HEIs lost to follow-up	544	
Number of HEIs under active follow-up at the end of APR' 13	5,526	
Infant Feeding Practice		
• Total reported by feeding type during the first 6 months of age	4,834	
• Number of HEIs on exclusive breast feeding	4,413	91%
• Number of HEIs on exclusive formula feeding	269	6%
• Number of HEIs on mixed feeding	152	3%

Comment: A total of 3,639 HIV-exposed infants (HEIs) were newly enrolled on HEI/EID follow-up during the reporting period, and at the end of FY13, a total of 5,526 HEIs were still on active follow-up. The proportion of HEIs who had a DBS sample taken within the first 2 months of birth age was 56%.

Among HEIs who had received a test result, 4.4% were HIV+, which is a significant drop from the 9.1% at the end of FY12. The total number of PCR-positive infants linked to ART within the facility during the reporting period exceeded the number who tested HIV+. This is because it includes a number of HEIs who received their test results in FY12. The program is working through ANECCA to improve HEI follow-up and linkage of HIV+ HEIs.

The results reflect successes in PMTCT. In FY13, the program conducted several ORs that offer further validation and insights in the program's achievements.

One OR addressed vertical transmission by maternal prophylaxis. Not surprisingly, this OR found that HEIs whose mother had taken prophylaxis were much less likely to be infected than those whose mothers had not taken prophylaxis (see below Table). However, of particular interest was the finding that HAART by the mother was the single most effective prevention strategy, with a positivity rate of 1.8% (RR=0.37; CI=0.19, 0.74; p=0.006) compared to 5.8% among babies whose mother had taken dual prophylaxis and 11.1% among mothers who had taken a single dose NVP. The rate among babies born to mothers who had not taken any prophylaxis was 23.2%. This finding underscored the importance not only of putting HIV+ pregnant mothers on PMTCT, but especially on HAART, and promoting institutional delivery and early infant testing. HAART was the most effective PMTCT regimen, regardless of the infant's regimen. This finding is particularly important in Ethiopia where most women give birth at home and may not be able to give the right medication to their baby at the right time. The data thus strongly supports the validity of option B+ as the national PMTCT standard in Ethiopia.

Vertical transmission rates by maternal prophylaxis, Tigray, 2012 (n=1,684 HEIs)

Mother's PMTCT regimen	Infant took prophylaxis	# (%) of HIV+ HEIs	n (1,684)	Relative Risk (RR) with Confidence Interval (CI)	Prevented fraction	p-value
HAART	Yes	10 (2%)	525	0.08, CI= 0.04, 0.15	92%	<0.0001
	No	0 (0%)	18	0.11, CI= (0.01, 1.73)	100%	0.115
Dual (AZT, 3TC+NVP)	Yes	35 (5%)	754	0.20, CI= (0.13, 0.25)	80%	<0.0001
	No	4 (14%)	29	0.67, CI= (0.27, 1.69)	33%	0.3978
Single dose NVP	Yes	2 (12%)	17	0.49, CI= (0.13, 1.85)	51%	0.2145
	No	0 (0%)	1	1.05, CI= (0.09, 11.64)	100%	0.9702
None	Yes	6 (10%)	58	0.31, CI= (0.08, 1.20)	69%	0.0898
	No	73 (26%)	282			

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

Comment: By age 6 months, the vast majority (91%) of HEI mothers reported that they had exclusively breastfed their baby, 6% reported to have given exclusive formula feeding and 3% reported to have practiced mixed feeding. In FY12, the proportions of HEIs on exclusive breastfeeding, exclusive formula and mixed feeding were similar, respectively, 93%, 4% and 3%.

✓ **2,424 of infants born to HIV-positive mothers were virologically tested for HIV within 12 months of birth. This represents 82% of the total infants who received their test results during the reporting period. Out of these, 1,632 infants (55% of the total) received virological testing within 2 months of age** (C.4.1.D)
Comment: A total of 2,424 HEIs were virologically tested and received their results within 12 months of age, considerably above the FY12 total of 1,805.

Of the HEIs who had received their test results within 12 months of birth, 1,632 infants (55% of the total number of HEIs who received their test results during the reporting period) received their test results within the first 2 months of birth, considerably above the FY12 total of 945..

✓ **65% 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 was 2,481, or 65% of the number of HIV+ pregnant women identified during the FY (P1.1.D). This is an excellent achievement in light of the frequent stock-outs of cotrimoxazole syrup and consistent with the FY12 achievement of 62%.

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

  Comment: The program technically and financially supported training of 406 health workers in PMTCT, using the national PMTCT/MNCH training curriculum. The total number trained far exceeds the target of 284 which was planned around the FY12 policy focused on option A. In FY13, the GOE swtiched to option B+ and the program hence supported its roll-out using the national updated option B+ training carriculum.

- ✓ **Additional Achievements**

  Adoption of option B+: Following the GOE adoption of option B+ in August 2012, the FMOH officially launched the new national PMTCT strategy on 20 February 2013. The program has been actively involved at national and regional levels to assist in the planning for the roll-out through active participation in the national and regional TWGs and being part of the national option B+ update TOT.

  Generic PMTCT Option B+ TOT: ENHAT-CS supported the national training of trainers (TOT) on the generic PMTCT option B+, which took place at Adama in August 2013. In addition to providing financial support, the program provided staff as master trainers. A total of 29 trainers successfully completed the training and joined the national PMTCT trainers' pool for rolling out option B+.

  Mother mentors with a mother support group (MSG): During the reporting period, ENHAT-CS provided support to 236 mother mentors of mother support groups (MSGs) in 59 high patient load HCs. In FY13, the program technically and financially supported the update training on option B+ for 219 mother mentors and 39 site coordinators. In these 59 HCs, the ANC/PMTCT, L&D, PNC and ART focal persons recommend all HIV+ pregnant and lactating mothers to join their health center MSG for support and counseling.

  In FY13, 1,608 mothers joined an MSG, which is estimated to be over 80% of eligible mothers in the 59 HCs. Of these mothers, 71% came from ANC clinics, 7% from L&D, 10% from PNC and 14% from community care and support services. As a result of advocacy by mother mentors for disclosure and partner testing at ART, ANC and OPD clinics, 57% of the 1,608 newly enrolled mothers had disclosed their HIV status to their partners, but only 24% of partners had been tested, indicating more effort needs to be directed to implement the family oriented approach.

  In FY13, 76% of 1,063 mothers delivered at health facilities (the EDHS 2011 reported 9.9% for institutional delivery in the general population). Of the 1, 336 mothers who were linked to various care and support services, 57% were linked to nutritional services, 36% to IGA support and 49% to other psychological, social, spiritual and legal community care and support services.

  The program continued to promote male involvement in MSG activities, with the result that partners of 1,280 women participated in MSG activities. On a pilot basis in 6 HCs, the program launched the mother–to-father initiative whereby MSG mentors encouraged members to bring in their partners for sessions addressing male involvement in MNCH and general child health. In FY13, at least 330 men attended mothers-to-father education sessions led by site coordinators.

  The health center-based efforts were complemented with activities by religious leaders, who conducted community conversations and mass education sessions that included promotion of male involvement in MNCH and PMTCT. In FY13, a total of 132,193 persons were reached through community conversations and another 617,089 through mass education at regular religious gatherings. Religious leaders successfully counseled 4,817men to accompany their wives to health center.

The program supported mother mentors to conduct group education and counseling sessions through coffee ceremonies, including psychosocial support, adherence counseling, promotion of facility delivery, encouragement of male involvement and family testing, group support, FP promotion, and appropriate infant and optimal infant feeding choices. In FY13, the number of women reached through coffee ceremonies each quarter increased from 3,646 in Q1 to 5,387 in Q2, 6,143 in Q3 and 6,561 in Q4.

A total of 5,470 (96% of planned) group sessions were conducted in FY13. These sessions included messages on infant and young child nutrition and discussions on group savings. The total number of MSG members who completed 52 sessions and thus "graduated" was 534 in FY13.

In this reporting period, MSG mentors also participated in 232 monthly, government-mandated primary health care unit meetings held at health centers to strengthen their linkages to community level support, including the tracing of mothers and children who missed clinic appointments, follow-up for adherence, and linkages to local care and support services. Through their networking with case managers, volunteers and religious leaders, MSG mother mentors traced 40% of the 277 HIV+ women who had missed their ANC appointments and subsequently convinced them to resume treatment.

Throughout the year, clinical mentors provided monthly mentorship and supportive supervision to all 59 MSG sites and their mother mentors. A more focused and in-depth mentorship was provided for all mother mentors using the program's MSG mentorship checklist. Supportive supervision focused on enhanced service delivery through mother mentors, proper documentation of activities and promotion of ownership of MSG activities at health center and woreda levels. The program completed the MSG guide for use by mother mentors as a reference tool for group education and individual counseling sessions.

Starting in Q3, the program expanded its support for mother mentors to an additional 26 MSGs, of which 17 were established by FHAPCO and 5 by the CPMTCT project. The remaining 4 were newly established at high patient load HCs with ENHAT-CS support. This increased the percentage of HCs covered from 21% to 31%. Of note, the current 59 HCs with MSGs are primarily located in high patient load facilities and represent 50% of all HIV+ women eligible for PMTCT in the two regions. The expansion increased this coverage to almost 70% of PMTCT eligible women in the two regions. In Q4, the program provided basic MSG training, including orientation on option B+ for 150 mother mentors (50% above target) and 64 site coordinators (146% above target) to support the new sites.

SOC assessment at MSG sites: In Q2 and Q4, the program conducted standards of care (SOC) assessments in 15 MSG sites in Tigray. The Q4 assessment showed that mother mentors are successfully tracing mothers who missed their appointments and bringing them back to treatment. Furthermore, the SOC assessments showed that almost all mothers registered and counseled by mother mentors deliver at heath facilities and that almost all infants below six months are exclusively breast-fed. Although, the Q4 SOC results showed improvements compared to Q2, areas that continue to need strengthening include: referral and linkages to RH services, economic strengthening, food support, promotion of partner testing and HIV testing of infants in the first two months. Results of the SOC were shared directly with the mother mentors and health center heads during supportive supervision.

OR on mother mentors and MSGs: The program conducted 4 ORs on the efficacy and role of mother mentors and the MSGs they support and shared the results with USAID. One of the ORs was conducted at the request of USAID in August 2013, and looked at service uptake and health outcomes among MSG and non-MSG members. This OR was conducted jointly with USAID and the USAID CPMTCT project and is being prepared for presentation at the upcoming national workshop on

launching the EMTCT strategy. All ORs consistently showed better service uptake, adherence and health outcomes among mothers and babies of mothers who belonged to an MSG compared to those that had not joined an MSG.

The ORs that specifically addressed vertical transmission among babies born to mothers belonging to an MSG and those not belonging to an MSG showed much lower transmission rates among the former than the latter. An OR conducted in Tigray showed that the positivity rate among infants born to mothers were followed at a health center with MSGs was 5.5%, and for those without an MSG, 11.4%, representing a 57% reduction in the rate of HEI positives for mothers active in an MSG (OR=0.43, 95% CI (0.20,0.92). A second OR, conducted at the request of USAID and in partnership with USAID and C-PMTCT at 44 HCs in 5 regions, showed that 2% of HEIs born to mothers belonging to an MSG were HIV+, compared to 3% among mothers not belonging to an MSG. A third data set, obtained from registers kept by mother mentors on MSG members at the 59 high patient load health centers that have mother mentors, showed that 2.3% of babies tested HIV+ at 2 months, compared to the 2012 national rate of 13% at 6 weeks.

Collaborative activities with other USG partners: ENHAT-CS continued its collaborations with MCHIP, CPMTCT, HEAL-TB and SCMS to coordinate and jointly plan TA and other support to the FMOH and RHBs.

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.

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)

✓ **8,976 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 the year, the program trained 350 NNPWE community volunteers who conducted community mobilization activities working in 59 target woredas and community sites and reached 8,976 (M 4,519 F 4,457) children aged 10 to 14 years with AB messages. They conducted house-to-house visits over four sessions and reported on the number of people reached with primarily AB messages, using the revised and updated NGI job aids and supportive BCC materials in accordance with the PEPFAR NGI guideline. The issues addressed during the four consecutive sessions focused on sexual abstinence, delay of sexual debut, mutual fidelity, and open discussion as stated in the job aids materials. The achievement represents 107% of the program's FY13 target and considerably above the 4,091 achieved in the program's startup period (FY12) when the volunteers had to be recruited, trained and deployed.

✓ **Additional Achievements**

3,225,269 people reached through mass education addressing HIV prevention services through FBO (EIFDDA) at community level: During the year, the program trained 344 religious leaders who mobilized their respective followers and conducted 1,757 mass education and community conversations using a faith-based mass education and community conversation guide. During the mass education and community conversation sessions, the religious leaders addressed issues and topics such as HIV prevention, reduction of sigma and discrimination, support for male involvement in PMTCT/MNCH, premarital counseling, use of holy water (tsevel) together with ART, and care & support for PLHIV including their family members. They also conducted mass education during church sermons and Friday prayers. In total, 3,225,269 people were reached with AB messages through mass education and community conversation interventions. The performance shows that the religious leaders, when properly trained, effectively mobilized their communities with HIV prevention messages using the mass education and community conversation guides with proper recording and reporting as well as continued follow-up.

59,981 copies of BCC, other educational materials and job aids addressing AB messaging customized and distributed: A key support to the facility and community level prevention activities is the provision of prevention materials. During the reporting period, ENHAT-CS customized and distributed 59,981 copies of BCC materials and job aids to the regions of Tigray and Amhara for use by clients, beneficiaries, MSG members and service providers. These materials were collected from FHAPCO/ARC, developed and produced by the program, and accordingly distributed through the clinical mentorship network. The materials were prepared in Amharic and Tigrigna following pretesting among participants during a targeted training in both regions. They are intended for use by the case managers and volunteers and include: MSG guides, faith-based mass education and community conversation guide, incoming and outgoing referral job aids and NGI job aid addressing AB messaging.

4,960 CDs of electronic educational materials distributed: Electronic educational materials focusing on AB messaging prepared by the program, collected from FHAPCO and other partners, were distributed to ENHAT –CS supported health centers through the clinical mentorship network. The content of the messaging mainly focused on roles of religious leaders on use of holy water (tsevel) together with ART, as well as on VCT and youth interventions. The focus was on reducing stigma and discrimination, and promoting behavior change to help mitigate HIV and AIDS. The materials produced on CDs are intended for use at health center OPD and MSG sites and other appropriate service sites where DVD players and TVs exist.

45 DVD players purchased by ENHAT- CS program distributed: One of the key supports to the health centers for prevention activities is the appropriate use of an inter-educative mechanism to disseminate messages to clients including MSG members and service providers. ENHAT – CS has been instrumental in the provision of print and electronic educational materials targeting clients and providers to be used in different service areas in a health center to address AB messaging. To identify the needs, an assessment was conducted in both regions. Of note, the CD educational materials collected from FHAPCO/ARC were intentionally distributed to the program-supported health centers already supplied with the DVDs and TVs. Based on the finding of the assessment, 45 DVD players (East Amhara 10 West Amhara 24 and Tigray 11) were purchased by ENHAT – CS program and accordingly distributed.

Support and participation in World AIDS Day (WAD) 2012: Every year, in December 1, World AIDS Day is commemorated with different events and activities. This year's 24th 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 with technical and financial support. The collaboration and involvement included advocacy and mobilization activities with AB messages commemorated in Addis Ababa, Axum (Tigray) and Metema (Amhara) through candlelight vigils, entertainment, sports show, religious ceremonies, panel discussions and other events led by religious and political leader in all sites. During the event an estimated 200,000 individuals were reached with behavior change abstinence and/or being faithful messages in which ENHAT–CS was visibly involved (for details see next session 03- OP).

A panel Discussion in Metema town (Amhara)

03-HVOP (HIV prevention through other [than AB] prevention)

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

✓ **23,792 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 the FY13 annual reporting period, 350 trained NNPWE community volunteers conducted community mobilization activities working in 59 grass root sites. They conducted house-to-house visits and reached 23,792 (M 12,818; F 10,974) individuals with OP messages, using the revised updated NGI job aids and supportive BCC materials implemented 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 home visiting sessions included psychosocial support, spiritual counseling, stigma reduction, mental health, PCP support, and other supportive materials.

The achievement represents 113% of the program's FY13 annual target and above the FY12 achievement of 22,310. The good result suggests that the trained volunteers have properly used the NGI guideline. It is also related to the reality that the NNPWE volunteers were engaged full-time to mobilize their intended target audiences while also prioritizing their routine support and home visits to the neediest of their PLHIV association members, who are often single, abandoned women, living alone or with small children.

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

Comment: Among the 422 persons who received PEP at ENHAT-CS supported HCs, 171 (41%) had had an occupational exposure, 105 (25%) had been sexually assaulted/raped and the remaining 146(34%) reported other non-occupational exposures. This distribution was similar in both regions. The achievement represents 95% of the program's FY13 target and is consistent with the FY12 performance of 416.

✓ **59,716 people living with HIV (PLHIV) reached with a minimum package of Positive Health Dignity and Prevention (PHDP) interventions** (P7.1.D)

Comment: During FY13, the program reached 59,716 PLHIV with a minimum package of services attaining 84% of the program's annual target. ENHAT-CS had been counting the number of PLHIV who received PHDP services as the total number of HIV+ clients seen at HIV clinics --the assumption being that every client seen at the HIV clinic is counseled on prevention. To provide a data source for documenting this service, ENHAT-CS, in FY13, introduced a program logbook at HIV clinics for the clinic HCPs to document non HMIS required data, which included specific PHDP services. As HCPs can be reluctant to consistently provide documentation using non HMIS forms, under-reporting is a factor in the above performance against target.

Additional Achievements

120,000 copies of the Libona newspaper distributed: The Libona newspaper is produced monthly in Amharic and Tigrigna languages (7,000 Amharic, 3,000 Tigrigna) with ENHAT-CS support to Dawn of Hope Ethiopia Associations (DHEA). The newspaper is produced monthly for distribution to the program supported health centers, PLHIV association members and served communities through the clinical mentorship network and PHCU. In FY13, 120,000 copies of Libona were distributed to the target audiences as stated above.

3,900 copies of the Voice of Women newsletter printed and distributed: Under a partnership and contract agreement, ENHAT-CS supported the National Network of Positive Women Ethiopia (NNPWE) to produce 3,900 copies of their quarterly newsletter "The Voice of Women" in Amharic and Tigrigna languages The newsletter was produced and printed twice during the year and distribution made through the same network as the Libona newspaper. The primary intention of the newsletter is for distribution to program-supported health centers, MSG sites, project partners, PLHIV association members and served communities.

45 DVD players distributed to the health centers supported by ENHAT – CS: As noted in the above section 02- HVAB, the program provided DVD players that allowed electronic presentation of OP messaging.

33,772 copies of printed BCC materials and job aids customized and produced: A key support to the facility and community level prevention activities is the provision of key messages addressing OP intervention. During the reporting period, ENHAT-CS distributed 33,772 copies of BCC materials and job aids to the regions of Tigray and Amhara for use by health center clients, beneficiaries, MSG members and service providers. These materials were collected from FHAPCO/ARC, customized and produced by ENHAT-CS and accordingly distributed through the clinical mentorship network. The materials were prepared in Amharic and Tigrigna and included:

- Mother Support Group (MSG) Guide
- Faith based mass education and community conversation guide
- Incoming referral job aid
- Outgoing referral job aid

Participation in TWG on IP/PS and other related activities: ENHAT-CS has been actively involved in the Advisory Technical Working Group (ATWG) on "Infection Prevention and Patient Safety" chaired by the Medical Services Directorate in the FMOH. The main aim of the task force is to ensure Infection Prevention and Patient Safety services and practices are institutionalized, owned by the system in a sustainable manner in order to mitigate all kinds of infections and health care wastes affecting patients, providers and the community. With ENHAT – CS involvement the following activities were accomplished::

- A national IP/PS training reference manual intended for health program managers was finalized, approved by the FMOH, printed and distributed through the regional health bureaus.
- Infection Prevention and Patient Safety health program managers training participant handouts, facilitators guide and power-point presentations documents were developed by the task force for use by all stakeholders to train health program managers and providers
- A national IP/PS commodities quantification assessment plan was finalized and submitted to the Medical Service Directorate (MSD) to be validated in a workshop organized by FMOH and PFSA
- Technical and resource materials were developed for training of managers to help institutionalize the practices and services at central and regional management and facility levels

344 health program managers and health center heads trained on infection prevention and patient safety(IP/PS): To support the FMOH initiative in strengthening IP/PS practices and services in the health care delivery system and ensure health program managers are involved fully, ENHAT trained 344(M 239; F 105) health program managers and service providers using the FMOH technical training packages and curriculum with intention to enable them to cascade the training to their facility staff and institutionalize the IP/PS according to national norms and standards.

Participation in Environmental Compliance and Environmentally Sound Design and Management training: The USAID/Ethiopia Mission organized a training on "Environmental Compliance and Environmentally Sound Design and Management" in Adama in December 2012 for participants and partners working with USAID projects that may impact the environment. The training was organized by USAID/Ethiopia Mission and conducted by the US-based Global Environmental Management Support Project (GEMS). The clinical and prevention advisors from ENHAT-CS attended this training. The training had the following objectives.

- Strengthen the capacity of USAID staff and implementing partners to incorporate environmentally sound design and management practices into existing and upcoming development and relief program planning and budgets
- Improve the ability of USAID staff and implementing partners to consistently apply and comply with USAID procedures
- Enhance collaboration, networking, exchange of new strategies and technical solutions for development efforts between USAID, implementing partners and the government of Ethiopia entities.

Participation in World AIDS Day 2012: Every year in December 1, World AIDS Day is commemorated with different events and activities under an announced theme from UNAIDS. This year's 24th anniversary theme, "Getting to Zero"- Zero New HIV Infections, Zero Discrimination and Zero AIDS Related Deaths, a campaign intended to run every year until 2015 building on previous years successful World AIDS Day which focused on Universal Access and Human Right was colorfully celebrated at national and regional levels The national level 2012 WAD was commemorated in December 1, 2012 in Addis Ababa held at the national convention hall. In addition to the national level celebration in which ENHAT CS was actively involved similar events also took place in Tigray and Amhara regions. The timing of 2012 WAD celebration was an added opportunity to attract attention at a time when Ethiopia officially adopted option B+ to the accelerated PMTCT plan.

The program was requested by FHAPCO to collaborate and support this year's event as it has done in the previous years. ENHAT CS as a partner, agreed to collaborate and support the activities relevant to its mandate at central and regional levels. At central level ENHAT CS participated as active member of a technical task force chaired by the Director for Multi - Sectorial Response Directorate responsible for logistics and resource mobilization activities. In the regions of Tigray and Amhara where ENHAT CS is operating the regional offices actively participated with technical and financial supports.

The 2012 World AIDS Day was colorfully celebrated both at national and regional levels. ENHAT-CS actively participated and provided technical and financial support to central and regional events In both regions an estimated 500,000 people were reached with key messages.

ENHAT CS was actively involved through collaboration with government counterparts and partners and was highly visible. The national level event was commemorated in the presence of:

- The Minister of Health
- The Deputy Mayor of Addis Ababa
- United States Ambassador to Ethiopia
- PEPFAR Coordinator
- UNAIDS representative
- Chief of Party, ENHAT CS and
- Invited guests

The Minister of Health in his key note address reiterated the Ethiopian government's commitment to ensure all citizens have access and equal opportunity to information and services. He acknowledged and commended the role of partners as pivotal and urged them to continue supporting the government efforts. He also underscored the timing of option B+ and the reported reduction of HIV prevalence in Ethiopia. In addition to the Minister's address, other speakers who addressed the meeting included:

- The Deputy Mayor of Addis Ababa
- Mr. Donald E. Booth, US Ambassador to Ethiopia
- Federal FHAPCO Director General
- Representative of NEP+
- UNAIDS Coordinator

Address by US Ambassador Donald E. Booth

ENHAT-CS was represented by its senior staff including Mr. Bud Crandall, the COP of ENHAT-CS at the national level events. ENHAT-CS was also actively involved with technical and financial support for activities relevant to its mandate at regional levels. The program-supported activities and events included the following.

Central level collaboration and involvement:

- ENHAT represented by the prevention advisor as member of the national committee chaired by FHAPCO
- Supported the production costs of 3,000 T shirts with appropriate MSH branding and logos and the given theme Getting to Zero and PMTCT
- The COP and DCOP together with the Prevention Advisor participated in the national level celebration

Regional level collaboration and involvement:

- Member of the regional task force
- Supported panel discussions in Metema,Axum and Mehony towns
- Supported production costs of 13 banners
- Supported production costs of 17, 392 posters
- Supported production costs of 20,000 brochures
- Supported media coverage through regional Fana and Mekelle FM

Leadership role and commitment (Tigray)

08-HBHC (Adult 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)

✓ **124,255 eligible adults and children provided with a minimum of one care service** (C1.1.D)

Comment: During FY13, 124,255 people (M 47,838; F 76,417) were provided a minimum of one care service (129% of the annual target and well above the FY12 achievement of 85,284). Of the total, 26,139 (21%) were younger than 18 years. Service provision under C2.1.D includes both clinical care services and community level services. To avoid double counting, only the HIV-affected are counted at community level.

Community services at the household level include home-based care (HBC), referral to health center 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 assistance, protection, screening/assessment/referral for TB and STI, IGA support, adherence support and bereavement counseling. Community volunteers continued to promote social inclusion of PLHIV by linking them to various community support groups including PLHIV associations. In this reporting period:

- 21,102 new HIV-infected clients were identified and registered for community care and support. Out of this number, 11% were children less than 18 years and 70% were females.
- 28,221 new HIV-affected members of households were identified and registered for community care and support. At least 70% of them were children under 18 years and 51% were females.
- 46,056 HIV-infected clients and HIV-affected family members were provided with care and support services. They were provided with messaging on appropriate nutrition for PLHIV and HIV, WASH, stigma reduction, HIV, VCT and TB/HIV through home visits by the volunteer outreach workers. Of these 42% were children below 18 years, 59% were females and 45% were HIV infected.
- 463 lost clients were traced and brought back to treatment through outreach volunteer workers and HEWS. Of these, 17% were on TB treatment, 54% on ART, 19% PMTCT clients and 11% HEIs. This highly effect client tracing system contributes to the progam's overall low lost-to-follow up rate of 7.2%.
- 4,805 HIV-infected and -affected clients were referred to other community care and support services through community volunteers. Of these, 25% were referred for food, 10% for IGA, 47% for psychological, spiritual and legal support, 5% for OVC support, and 13% to PLHIV associations, with many clients being referred for multiple services.
- 20,818 adults were provided with HBC and adherence counseling using updated job aids during home visits by outreach volunteer workers in FY13. Of these 70% were females.
- 15,074 new households were reached with messages on stigma reduction, WASH, TB DOTs and PCP through home visits.
- 778,882 people received messages on VCT, stigma reduction, male involvement in PMTCT, and reduction of gender-based violence and TB DOTS through mass education and community conversations conducted by religious leaders.
- 38,869 PLHIV were provided with community mental health support, including spiritual and psychosocial support through religious leaders.

- 704 PLHIV were referred to PLHIV associations and other support groups with confirmation of receipt of services.
- 3,995 couples were provided with premarital counseling and referred to health center for HIV testing through 605 religious leaders in FY13.
- 3,803 couples were referred through religious leaders, for HIV testing at health center.
- 17,900 HIV+ women were reached through 358 meetings focusing on PHDP held at four NNPWE PLHIV affiliate associations.

ENHAT-CS continued to strengthen the bi-directional, closed loop referral system that facilitates referrals between the health center case manager and HEWs and improves their documentation. The program continued to provide support to 172 woredas to strengthen the implementation of the referral system through re-mapping of available community care and support services and updating referral directories for use by all stakeholders in the primary health care network. In FY13, the program trained an additional 147 (85% of target) woreda HIV officers, PMTCT and MNCH focal persons to bring to two the number of woreda health office staff trained in each woreda to manage the woreda health network. In FY13, the program assisted 259 (99% of target) health centers to map available resources, create services directories, set up and maintain functional bi-directional, closed loop referral systems. To enhance the capacity of health center heads to coordinate the referral system, the program trained 55 health center heads as part of the FY13 expansion.

Through supportive supervision, the program worked with individual health center heads, community referral network mobilizers and case managers to strengthen health center-community linkages and document completed referrals. The program supported the woreda health offices in its target zones to coordinate activities of local CBO/FBOs activities and facilitate their active participation in woreda and health center meetings. Refresher training and ongoing support was provided to 350 volunteer outreach workers focusing on proper use of job aids, HBC and PCP kits and use of reporting formats. The program also trained 633 religious leaders to strengthen their role in the woreda heath network focusing on linkages and provision of faith based initiatives.

Finally, the program also engaged with NEP+ to establish a viable referral system linking case managers at HCs with those at hospitals. NEP+ began to support this effort in the program's target areas with program support through a grant, which USAID approved during the reporting period.

✓ **78,202 HIV-positive adults and children receiving a minimum of one clinical service** (C2.1.D)

Comment: The number of HIV+ patients who received at least one clinical service (limited to the HIV clinic to avoid double counting) during the reporting period included 29,172 (38%) male and 49,030 (62%) female clients. The program has achieved 109% of its FY13 target and is well above the FY12 achievement of 64,313.

✓ **56% HIV-positive persons receiving cotrimoxazole prophylaxis** (C2.2.D)

Comment: Among all patients seen during the program year, 43,405 (56%) received cotrimoxazole prophylaxis. This achievement is 100% of the annual target and consistent with the FY12 performance of 56% as well. According to the national guideline, HIV patients with a CD4 count below 350 are put on CTZ. Patients with two consecutive CD4 tests above 350 are to be discontinued. There is a concern that patients who should be discontinued are not, as many do not receive appropriately

scheduled CD4 testing (every six months) due to restricted access to such testing. We do not know what the appropriate percentage of ART patients should be on CTZ prophylaxis, but it should definitely not be 100% given the guidelines above. The level we report may be appropriate for a mature program where the average HIV+ patient, who has been on ART for 3 or more years, has a CD4 count of >350.

- ✓ **6,235 eligible clients received for food and/or other nutrition services** (C5.1.D)

  Comment: During the reporting period, 6,235 eligible clients received food and/or other nutrition services, of which 1,569 were pregnant and lactating women. This result represents 109% of the FY13 target and well above the FY12 achievement of 5,134.

  In order to meet the needs of HIV-infected persons and HIV-affected family members for nutritional services, ENHAT-CS collaborates with and refers patients to implementing partners that provide and/or support such nutritional service delivery including the USAID Food by Prescription project. The number of clients reported under C5.1.D only includes clients who received NACS at ENHAT-CS supported health facilities.

  Of note, nutritional assessment is considered to be part of the standard clinical package provided by HCPs to all HIV clinic patients. However, there is no data source to verify such.

  As NACS involves nutrition assessment, counseling and support, the program does not assume that the above standard clinical practice of the HIV clinic's HCP providing nutrition assessment meets the NACS criteria. The program only counts those patients who receive nutritional assessment by the HCP and who are then determined to be in need of and receives nutritional counseling (which is provided by the case manager and documented in a verified data source, a program logbook).

- ✓ **27% Contraceptive acceptance rate among HIV-positive women** (Non-NGI; PMP Indicator # 31)

  Comment: Comparable to the 2011 EDHS finding and FY12 program achievement that 27% of women use modern contraceptives, 27% of HIV+ women seen at program-supported HCs received FP services in FY13. Among them, 18.5% were new acceptors while 8.5% were repeat users.

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

  Comment: 11 (M 8; F 3) HIV+ Visceral Leishmaniasis (VL) patients were referred to a nearby hospital. The small number, lower than the PY12 result of 20, reflect FY13 shortages of laboratory tests for VL. WHO has reported that the test procured by SCMS for emergency gap filling was the Fast (or Direct) Agglutination Test, which had never been used in Ethiopia before. Following reports of problems using the test, the WHO program officer for Neglected Tropical Diseases (NTDs) analyzed the test in the field and found it to have high sensitivity (proportion of positives who are actually identified as such) but very poor specificity (proportion of healthy people who are correctly identified as not having the condition). As such, the test was producing excessive false positives. Of note, the WHO had been procuring and utilizing the InBios Kalazar Detect rapid test for the last six to seven years testing without problem. They have now procured an initial supply for distribution.

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

  Comment: ENHAT-CS promotes integrated diagnosis and management of onchocerciasis and HIV at HIV clinics. In FY13, none of the program-supported HCs reported a case. The Carter Center is supporting the GoE to carry out community level mass prevention initiatives in the endemic areas. As only a small number of HCs are in these areas, with Metema health center in North Gondar being the main one, this campaign has resulted in no demand for services at HIV clinics.

- ✓ **965 HIV-positive patients diagnosed with STI and treated for STI** (Non-NGI; PMP Indicator # 35)

  Comment: A total of 965 STI patients were diagnosed and treated for STI. Two-thirds of these patients were female. ENHAT-CS is working with partners supporting free STI treatment to make the service available to HIV+ patients. The reported number of patients treated for STIs through program-support has almost doubled compared to the reported number in FY12 (509), as the program expands coverage and better documents services provided at supported HIV clinics through the program logbook.

- ✓ **2,255 HIV-positive patients diagnosed with malaria who were treated for malaria** (Non-NGI; PMP Indicator # 44)

  Comment: Routine malaria diagnosis and screening is being promoted in malaria endemic areas by HIV clinics for all patients. During the reporting period, 2,255 HIV positive patients were diagnosed and treated for malaria. Females accounted for 1,404 (62%) and 202 (9%) were children under 15 years of age. The reported number of HIV+ patients treated for malaria has increased from 118 in FY12 due to the program expansion and especially due to better documentation through the program logbook.

- ✓ **6,141 referrals made and documented for HIV/AIDS related services** (non-NGI; PMP indicator #32

  - ***1633*** *referrals were made by HC health providers inter-facility for HIV/AIDS related services*
  - ***3,281*** *referrals were made by HC health providers to community (HEWs) for HIV/AIDS related services*
  - ***1,227*** *referrals were made by community to HCs*

  Comment: The above data captures referrals with documented linkages, and demonstrated improved results from the FY12 total of 4,814. Of note, 259 program-supported HCs are now using the bi-directional closed loop referral system developed with program support. As more health centers conduct health center-based PHCU meetings, the program anticipates a sustained increase in the number of health centers and health posts documenting completed referrals.

- ✓ **Additional Achievements**

  Support to quarterly woreda health network meetings. The program's goal is to support 172 higher HIV prevalence woredas, which contain 261 supported health centers (206 FY12 and 55 FY13), to hold quarterly woreda health network meetings. By Q4, 95% of the supported 172 woredas conducted and documented quarterly review meetings. The review meetings provide woreda health offices with GOE-mandated platforms to coordinate activities and interact with local NGOs and other partners providing community care and support services. They 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 respective woredas; 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.

In addition, in FY13, 161 (94% of target) woreda HIV officers developed, with program support, woreda action plans to follow up on issues normally discussed during the quarterly meetings. They were trained to further strengthen their coordination and management of the woreda health network.

Support to monthly health center-based PHCU review meetings. In FY13, the program supported 261 HCs to conduct 2,078 (74% of target) monthly health center-based PHCU meetings, with a special focus on integrating a review of the referral system into this GOE mandated platform. These monthly government-mandated health center review meetings, which involve woreda health officers, HEWs, HEW supervisors, health center heads, volunteers and FBO/CBO representatives, are intended to promote collaboration, share information, enhance community tracking of adherence defaulters, and strengthen the primary health care unit (PHCU) from health center to HP and kebele.

Care and support focused mentorship and supportive supervision was provided to all 261 current program-support HCs through 518 visits. This included assistance in updating their service directory, supporting the health center staff to strengthen the bidirectional closed loop referrals system.

Collaborative activities: The program collaborated with World Vision's PCP program to enhance delivery of PCP messages to HIV pregnant and lactating mothers through mother support groups. To this effect, the program received and provided safe water containers from PCP to all 59 MSGs to be used by mother mentors to access clean water for use during coffee ceremonies at HCs. At least 20,414 MSG members benefited from the use of these jerry cans during the coffee ceremonies held this reporting period.

NTDs: During the reporting period, the program supported the Tigray RHB in the establishment of a treatment center for VL at Sheraro health center. The program also partnered with WHO and the MSH-implemented SCMS project for emergency procurement of VL medication and kits. In FY13, ENHAT- CS also provided technical support the Amhara RHB VL treatment center at Addiszemen HC through program mentorship.

Mental health service integration: See section 18-OHSS

9-HTXS (Adult Treatment)

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

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

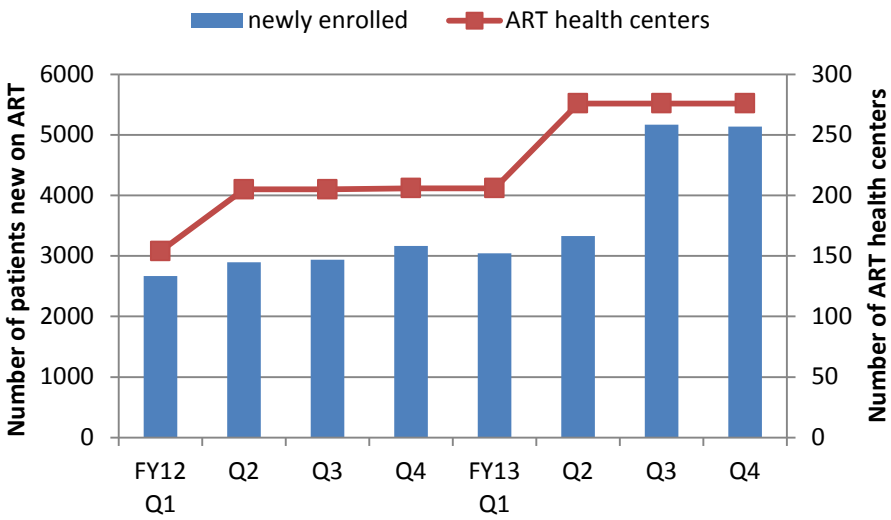
Comment: During FY13, ENHAT-CS provided technical assistance to 276 HCs to provide comprehensive HIV/AIDS services, including ART, i.e. an expansion from 206 in FY12. The results represent 100% of the FY13 target.

The program provided team-based clinical and system mentorship to all clinics in the HCs as well as the pharmacy units, at least once a month. In most woredas, both the RHB and the woreda health offices' HIV experts participated in conducting the monthly mentorship.

✓ **16,678 new individuals were enrolled on ART** (T1.1.D)

Comment: A total of 16,678 HIV+ patients were newly enrolled on ART at program-supported HCs during the reporting period. The achievement accounts for 128% of the annual target. This over-achievement relative to the target and against the FY12 achievement of 11,668 can certainly be attributed to the change in guidelines for ART initiation. Under the old guidelines, patients were started on ART when their CD4 count dropped below 200. In FY13, Ethiopia switched to the 2010 WHO guidelines which recommend ART initiation at a CD4 count of 350. Following the implementation of the new guidelines in March 2013, the number of patients newly enrolled on ART increased by 55%, as compared to previous quarters (Figure 4).

Figure 4
Number of ART patients and ART health centers supported by ENHAT-CS, by quarter, FY12-FY13



Female patients accounted for 11,166 or 67% of all newly enrolled ART patients. Among the newly enrolled patients, 1,107 (6.6%) were children under 15 years old, including 56 infants (see section 13-PDTX).

✓ **2,155 ART clients were transferred into ENHAT-CS supported health centers** (Non-NGI; PMP indicator # 23)

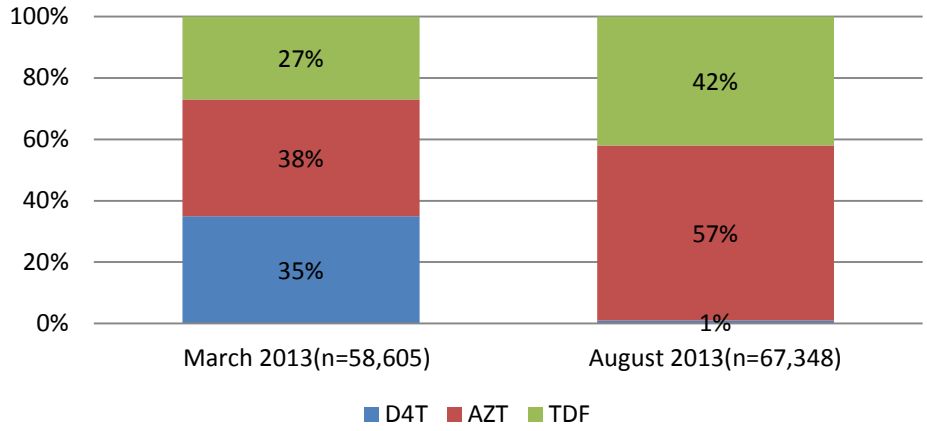
Comment: A total of 6,484 ART patients were transferred into ENHAT-CS supported HCs during the reporting period, well above the FY12 achievement of 4,394. This indicator shows that hospitals and HCs continued to successfully off-load ART patients to existing and new ART HCs during the reporting period.

✓ **71,007 HIV patients are currently receiving ART** (T1.2.D)
Comment: By the end this reporting period, a total of 71,007 HIV+ patients (102% of the program's FY13 target) were receiving ART at ENHAT-CS supported HCs.

Female patients accounted for 45,427 (64%) and children under 15 years of age, including 80 infants, for 3,656 (5.1%) of all current ART patients.

The phasing out of Stavudine (D4T) from the first line antiretroviral drug list and shift other drugs is completed. By the end of FY13, only 0.9% of adult patients were on D4T. These patients are suspected of treatment failure during transition to another regimen and under further investigation. Assuming that all newly initiated patients were started on TDF, 88% of patients on D4T were shifted to AZT, which is consistent with the assumptions used for national ARV drug quantification. Figure 5 compares the proportion of patients currently on ART by regimen at the start of the phase-out process (March 2013) and at the end of August 2013.

Figure 5
Proportion of current adult ART patients, by regimen



✓ **86% of adults and children known to be alive and on treatment 12 months after initiation of ART** (T1.3.D)

Comment: Throughout FY13, the percentage of patients still alive and on treatment at program supported HCs one year after starting ART was 86%. This achievement was essentially on target and slightly above theFY12 achievement of 83%.

- ✓ **76,567 individuals with advanced HIV infection who ever started on ART** (T1.4.D)

  Comment: By the end of the reporting period, a total of 76,567 HIV+ patients had ever started on ART at ENHAT-CS supported HCs. Female patients accounted for 48,015 (63%) of all patients ever started on ART. Among ever started on ART, 3,957(5.2%) were children under 15 years old.

- ✓ **(*Outcomes among ART patients*)** (Non-NGI; PMP Indicator #29)

	Number of ART clients who died	Number of ART clients who stopped therapy	Number of ART clients transferred out	Number of ART clients lost to follow-up
Overall	10.3%	0.2%	17.4%	7.2%
at 6 months	5.1%	0.4%	6.6%	4.3%
at 12 months	6.7%	0.9%	10.5%	5.8%
at 24 months	8.9%	1.0%	18.0%	8.2%

  Comment: The data reported in the above table show that overall, 10.3% of ART patients following their treatment at program-supported HCs had died and 7.2% were lost to follow-up by the end of the reporting period. Also, 18% of patients started on ART at program-supported health centers had been transferred out. Consistent with data on disease progression among HIV+ patients, more than 50% of overall deaths and lost to follow-up to date occurred in the first six months after initiation of treatment. These results sustain the excellent patient outcomes noted in FY12.

  The overall patient retention rate is 82.5% (10.3% dead and 7.2% LTFU), which is better than the 72% national retention rate and that of Amhara (72%) and Tigray (76%) reported by FPHACO (Multisectoral HIV/AIDS Response M&E Report for 2004 EFY, July 2011-June 2012). This confirms the success of HIV and AIDS services expansion to HCs, where an increasing number of ART patients are being followed and the LTFU rates are typically lower, for a variety of reasons: 1) HCs are located closer to people's homes; 2) case managers and mother mentors in HCs maintain community linkages and improve adherence; 3) sicker ART patients are referred to hospitals and healthier patients are downloaded to HCs; and 4) HCs manage generally healthy and stable patients, including children.

- ✓ **81% of patients enrolled in care are in care and/or on ART at 12 months** (Non-NGI; PMP Indicator # 30)

  Comment: The program's FY13 result of 81% is consistent with its FY12 achievement of 83%. Of note, the GOE is currently undertaking an assessment on the retention of pre-ART patients. ENHAT-CS is monitoring compliance with care among pre-ART patients by measuring the proportion still in care after 12 months of being enrolled at the health center. 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 acquire this information from a combination of the program pre-ART logbook and the health center's pre-ART register.

✓ **Additional Achievements**

Assessment of health center service quality: As part of the preparation for expanding ART sites, a joint ENHAT-CS accreditation assessment for ART service provision readiness was conducted with the Amhara and Tigray RHBs at the beginning of the program year. A total of 80 HCs in Amhara and 34 in Tigray were considered to start ART services, of which, respectively, 45 and 25 HCs were selected for expansion and support by the program.

The assessment showed that most health centers only partially complied with national standards, with variable availability and, at times, a significant lack of essential medical equipment, including otoscope, reflex hammer, microscope and other equipment. The assessment also showed that most new health centers had a low HIV case detection, in spite of good HCT rates. As the program expanded into more rural HCs, the HIV prevalence proved lower, and hence a lower case detection rate.

Mentorship: ENHAT-CS conducted monthly team-based clinical and system mentorship at all 276 ART HCs using the ENHAT-CS mentorship checklist. 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.

During the year, the program revised the mentorship strategy to take the health center's caseload of HIV patients into account. Every health center with more than 500 patients currently on ART received at least two 4 person-days mentorship since May 2012 while other HCs continued to receive around one mentorship visit per month.

Standard of Care Assessment (SOC): ENHAT-CS conducted SOC assessments and provided feedback at 35 randomly selected HCs. Results of the assessment were shared and discussed with the respective health centers.

HIV/AIDS TWGs: ENHAT-CS has been 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 attended all meetings held during the reporting period.

10-HVTB (TB/HIV Services)

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

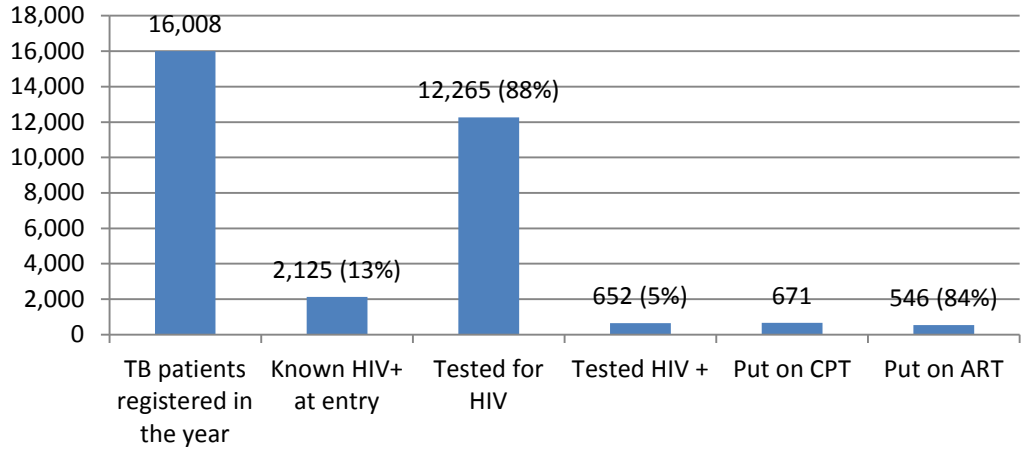
✓ **276 health facilities providing TB treatment of HIV-infected individuals** (Non-NGI; PMP indicator #38)

Comment: All 276 ART HCs supported by ENHAT-CS provided TB treatment for HIV+ individuals.

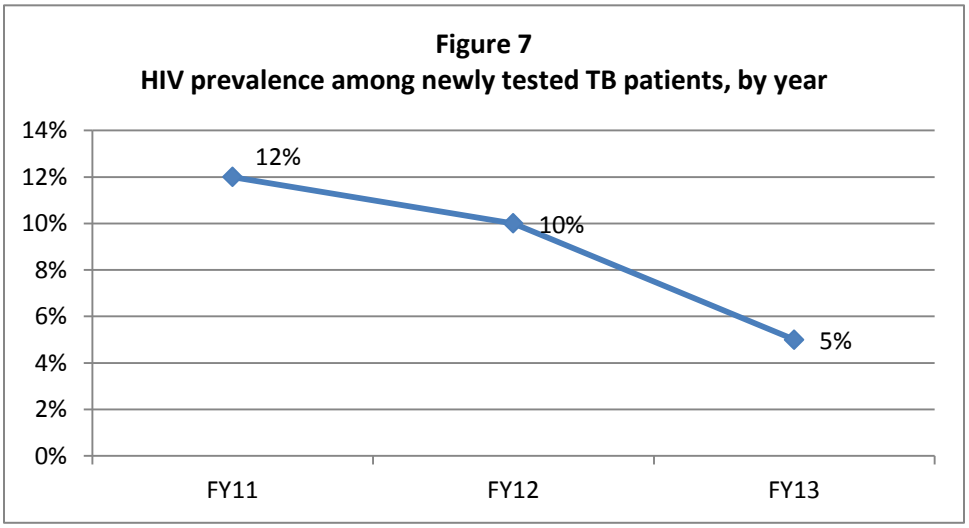
✓ **14,468 (90%) TB patients had an HIV test result recorded in the TB register** (C3.1.D)

Comment: Out of the 16,008 TB patients who had been registered during the reporting period, 2,125 (13%) knew their HIV status at entry into the TB clinic Figure 6). Among the remaining TB patients, 12,265 (88%) were tested for HIV. Because many providers were incorrectly reporting the number of patients with unknown status, the program changed the reporting format in Q3. As is always the case with changing recording and reporting forms, the change resulted in an under-estimate of the true proportion tested for HIV during Q3, and this reduced the overall figure for FY13. The true proportion is most likely to have remained around 95%, based on our knowledge of actual practice at the TB clinics and as evidenced by the standard of care assessment which showed that 97% of TB patients with unknown status were tested for HIV. Program mentors are paying special attention to this indicator, which will also be included in the upcoming data quality assurance (DQA).

Figure 6
TB/HIV co-infection at program-supported TB clinics



Overall 14,465 (90%) TB patients registered during the reporting period knew their HIV status, well above the FY12 achievement of 12,603. Among the newly tested TB patients, 652 (5%) were found HIV+. Of note, the proportion of new TB patients testing HIV+ has dramatically declined over the past couple of years (Figure 7). This trend certainly shows the success and beneficial effect of expanded ART services.



✓ **81% (63,205) of HIV+ patients visiting the ART clinic during the period were screened for TB in HIV care and treatment settings** (C2.4.D)

Of whom:

- ✓ **3,262 (5%) were screened positive**
- ✓ **Of these, 75% (2,439) were examined for AFB in the sputum**
- ✓ **Of these, 15% (378) tested sputum-positive for TB**

Comment: The number of HIV patients reported to have been screened for TB in the year was 63,205 or 81% of all HIV patients, down from 96% in FY12. We believe that, based on experience and SOC assessment results, almost all HIV patients are regularly screened for TB. However, the program discovered that many HCs compiled the data for the NGI incorrectly, and counted all HIV patients screened at least once during the reporting period instead of at their last visit only, as directed by the NGI guideline. Hence, in FY13, the program introduced a new TB logbook at all HCs. Unfortunately, unlike the data compilation in FY12, this new logbook requires additional work by TB health care providers to record routine data, as the HMIS does not use this definition and indicator. As a result, many providers complained to the mentors of a lack of time to fill in both the government required HMIS tools and the logbook. The program will work closely with data clerks and ART providers to ensure they have the capacity to accurately capture and report all patients screened for TB.

Because of these challenges, the 81% achieved during FY13 may underrepresent the true proportion of HIV patients routinely screened for TB. Indeed, during FY13, a total of 237,818 screenings, or on average, 3 screenings per patient, took place at program-supported HCs, of which 11% were repeats from the previous year. The proportion screened at least once (95%) is very close to the program target of 96%, which was based on the FY12 approach.

Among the patients screened for TB, 3,262 (5%) screened positive and 75% of those were referred and assessed for AFB sputum smear. Of all HIV+ patients referred for sputum smears, 15% were positive for TB.

However, HCs have limited capacity to diagnose TB in HIV+ 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+ patients may be extra-pulmonary. In both instances, diagnosis can be very difficult without X-rays at the health center 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 significant proportion of their screened positive TB patients to another facility for further assessment. The low number of reported HIV/TB patients may also be the result of declining incidence of TB cases in Ethiopia or high death rates in HIV/TB co-infected patients.

In FY13, ENHAT-CS conducted an OR to better understand what happens to HIV patients who are screened positive for TB. During a three month period, the study collected data on 12,260 HIV+ clients' screening for tuberculosis (TB) at 12 health centers in the Amhara and Tigray regions. The review identified 250 (2.0%) patients who screened positive. Among them, 195 (78%) got an AFB sputum test at the health center and a result was obtained for 170 (87%), of whom 7 (4.1%) tested positive for TB. Among the 163 who tested negative, 21 were referred for further investigation. Of the patients for whom the health center did not do an AFB, 19 were referred elsewhere. Of the 40 referred patients, 16 (40%) turned out to be positive for tuberculosis,. The study showed that in total, only 0.2% of all screened patients seen at program-supported health centers were TB positive.

✓ **1.5% (1,196) 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: A total of 1,196 (50% male and 50% female) HIV+ patients were started on anti-TB drugs. This represents 0.7% of all HIV patients seen at program-supported health centers. The result for C2.5.D accounts for 73% of the program's FY13 target of 2.1%, which was the FY12 achievement as well. While certainly related to the continuing fall in the rate of TB in Ethiopia (FMOH reduced its estimated TB of prevalence rate by 59% in FY12) the likely under-achievement may also be due to a lower incidence of TB among patients once they are on HAART, a hypothesis that was confirmed by the above mentioned OR which showed that only 0.2% of all HIV patients screened at the program-supported HCs had TB.

Of note, the program's key data quality audit, conducted in Q1, showed a perfect match between recorded and reported data. ENHAT-CS will conduct an OR to determine why the performance is lower than anticipated.

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

Comment: The number of patients who started on IPT was significantly lower than anticipated, and probably related to both the critical shortages of IPT at many health centers during the reporting period and the questionable efficacy of IPT making providers reluctant to offer it. Of note, IPT has been used in Amhara HCs only, while the Tigray RHB had decided to limit IPT to hospitals.

Following discussions with USAID on the low uptake of IPT in patients at program-supported HCs, the program conducted a global literature review of IPT use in HIV patients. The review showed that globally only 0.1% of those PLHIV's who are eligible currently receive a course of IPT. The main reasons for the low uptake of IPT center around fears of isoniazid resistance, the subsequent development of multi-drug resistant TB, conflicting evidence regarding the length of time needed for effective prevention of TB, and provider and policy-maker concerns about the effectiveness of IPT in preventing active TB, especially in cases of re-infection. In addition, health care providers may be

hesitant to start patients on IPT due to concerns about their ability to exclude active TB, patient adherence, drug safety, and drug availability. Though there is evidence to suggest that IPT is useful in preventing the development of TB, modeling studies have found that IPT is most likely to be effective when entire clusters of individuals can be treated completely and simultaneously and that the benefits of IPT may be more limited if infection is not cleared from the entire cluster, which may be especially difficult to do in resource-limited settings such as Ethiopia. This suggests that the benefits of IPT may be limited if high prevalence rates of TB facilitate re-infection even after IPT treatment. Furthermore. the research indicates that early and continued ART treatment is one of the most important factors in reducing future TB development and transmission. The review thus suggests that while IPT may be useful in reducing TB incidence, the focus should be on maintaining good ART treatment, and on starting ART earlier, perhaps even implementing a test and treat protocol, in order to reduce TB infection.

✓ **Additional Achievements**

Participation in TWG: ENHAT-CS has continued to participate in regional technical working groups addressing HIV/TB co-infection.

Assessment of health center 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.

Training: See HSS section

Program area 12- HVCT (Counseling and Testing)

Accomplishments and successes during reporting period with explanations for under and over achievements:

✓ **276 service outlets (HCs) providing counseling and testing according to national or international standards** (P9.1.D)

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

✓ **1,589,812 individuals received Testing and Counseling (T&C) services for HIV and received their test results** (P11.1.D)

- **510,475 (32%) were tested through VCT** (PMP indicator #13)
- **1,079,337 (68%) were tested through PITC** (PMP indicator #13)
- **1,450,060(91%) were individually tested** (PMP indicator #13)
- **139,752 (9%) were couple tested** (PMP indicator #13)

Comment**:** The number tested for HIV during the reporting period represents 102% of the program's FY13 target, and well above the program's FY12 achievement of 1,362,250. Of the total, female clients account 915,238 (58%) and the proportion is consistent throughout the four quarters. The number of children under 15 years old who were tested was 134,925 (9%).

The majority of clients tested for HIV (68%) were tested through PITC, underscoring the continued value of the PITC strategy. When disaggregated by type of counseling, 91% were individually tested and 9% was tested as a couple.

Among the individuals who were tested for HIV during the reporting period, 16,210 (1%) were HIV+, which is somewhat lower than the overall national prevalence of 1.5%.

During mentorship visits, several HCs reported a shortage of test kits and supplies. Some also reported reduced motivation among health providers to offer HIV testing and the high work load was also reported as a challenge.

✓ **Additional Achievements**

Assessment of health center service quality: See section 09-HTXS above.

HTC SOC assessment: Based on feedback from program mentors (who conduct a standard of care (SOC) assessment of PITC and VCT services in their monthly mentorship activities that assess availability of testing and counseling at every service area, testing rate among clients seen at each service area and linkage of HIV positive individuals to ART clinic) PITC continues to be offered to between 95% and 100% of ANC, L&D, and TB clients. However, the proportions continue to be much lower at OPD and other clinics.

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

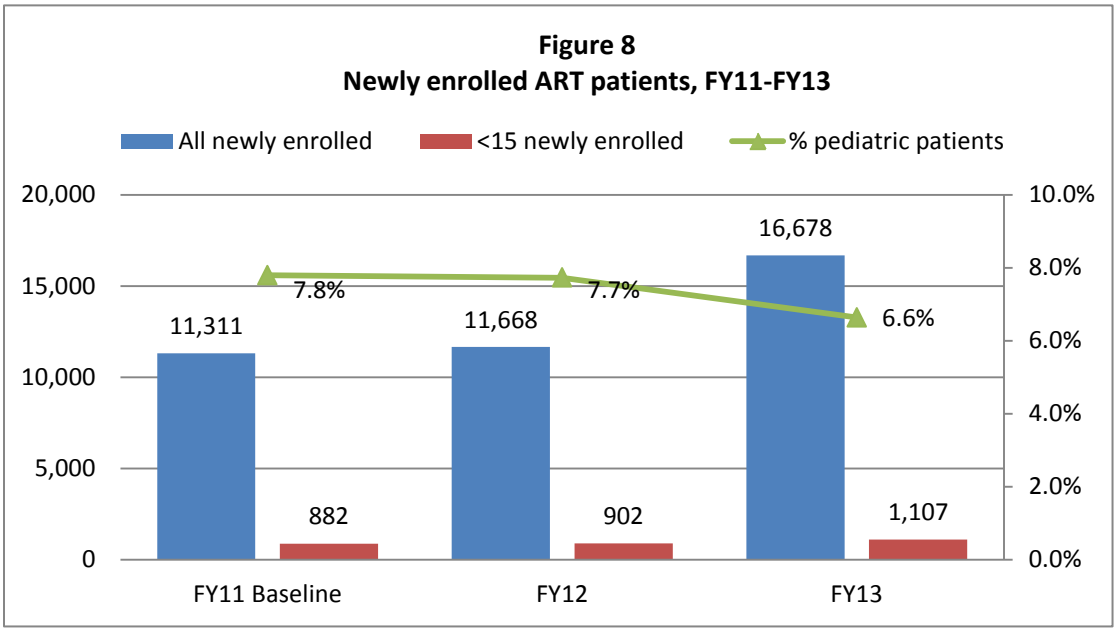
13-PDTX (Pediatric Treatment)

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

✓ **1,107 children (including 56 infants) with advanced HIV infection were newly enrolled on ART** (T.1.1.D)

Comment: Among the newly enrolled ART patients, 1,107 (6.6%) were children under 15 years old, including 56 infants. Although the proportion of pediatric clients newly started on ART showed a slight decline over the quarters, the actual number progressively increased (Figure 8). The proportion declined as a result of the policy change which now puts people on ART when they reach a CD4 count of 350 instead of the previous 200. This policy change affected primarily the adults. The increase in absolute number of pediatric patients newly enrolled at program-supported health center is not only the result of the expansion to other HCs but also testifies to the program's success, through ANECCA, in strengthening HCs and their providers to be more confident in managing pediatric patients.

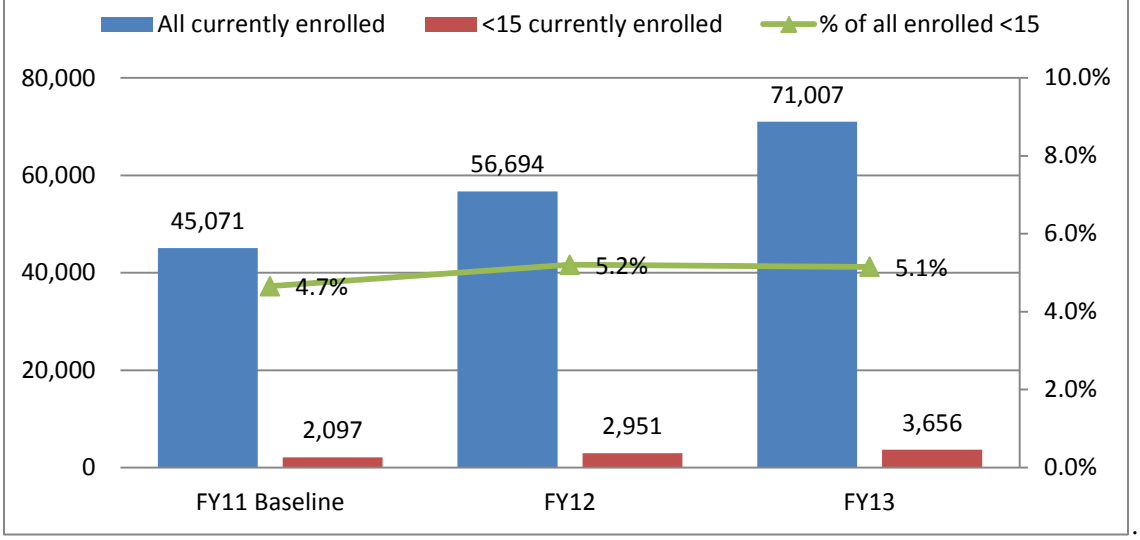
Figure 8
Newly enrolled ART patients, FY11-FY13



✓ **3,656 children (including 80 infants) are currently receiving ART** (T1.2.D)

Comment: Among patients currently on ART, 3,656 (5.1%) were children under 15 years old (Figure 9). Though a majority of pediatric ART patients continue to be seen by hospitals, most hospitals are increasingly off-loading pediatric cases to the HCs located closer to the clients' homes.

Figure 9
Currently enrolled ART patients, FY11-FY13



✓ **88% of children under 15 years old were known to be alive and on treatment 12 months after initiating ART** (T1.3.D)

Comment: The proportion of pediatric patients still on ART at the same health center where they started ART 12 months earlier was 88%. The overall retention rate of pediatric clients continues to be better than that of adult clients, suggesting that HIV+ children are relatively more stable than adult ART patients at health center.

✓ **3,957 children under 15 years old is the cumulative number of children ever started on ART** (T1.4.D)

Comment: Among the total ever started on ART, 3,957 (5.2%) were children <15 years, which is an improvement over the FY12 achievement of 2,850 (4.8%), which suggests that more and more children are being initiated on ART in HCs.

Additional Achievements

Mentoring Activities: 479 intensive mentoring activities focused on pediatric HIV/AIDS were conducted at all program-supported HCs by senior pediatricians from ENHAT-CS partner, ANECCA.

Training activities: The ANECCA pediatric advisors have participated as trainers in the following HIV care and treatment training activities organized by the respective regional health bureaus and ENHAT-CS program: Pediatric ART/IMNCI, PMTCT/MNCH, adult ART/IMAI, GoE mentors' training, and training in pediatric psychosocial care and counseling. They have also participated in stavudine phase-out, PMTCT option B+ and TB screening orientations in the two regions.

Standards of Care (SOC) Assessment: ENHAT-CS conducted standards of care (SOC) assessment at selected HCs in Amhara and Tigray on Feb 25- Mar 05, 2013. The assessment at ANC/PMTCT clinic, delivery room, U5 clinic, EPI clinic, and pediatric ART and HEI clinic was done by the pediatric advisors. The results showed that, over the previous 12 months, 98% of eligible pediatric patients received CPT (the result in FY12 was 96%), 97% were appropriately staged based on WHO clinical guidelines (75% in FY12); 100% were on appropriate drug regimens (97% in FY12). However, only 71% were screened for TB (87% in FY12), 53% had their weight and length plotted (28% in FY12) and 35% of pediatric HIV patients under 3 years of age, had their head circumference measured (32% in FY12). The results show an overall improvement with the exception of TB screening. All results were discussed with the health care providers at the respective units during the assessment; areas of strength are being reinforced and areas of weakness are being addressed through monthly mentorship as well as intensive pediatric mentorship by ANECCA.

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

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

- ✓ **4,004 children received a minimum of one clinical service (C2.1.D)**

  Comment: The number of children <15 years who received at least one clinical care service represents 5.1% of the total. They included 2,114 boys and 1,890 girls. The FY13 result is slightly below the FY12 achievement of 5.5%, which may be due to the earlier noted policy change that now puts people on ART when they reach a CD4 count of 350 instead of the previous 200, which primarily affected adults

- ✓ **3,369 children under 15 years of age received cotrimoxazole (CTX) prophylaxis (CPT)** (C.2.2.D)

  Comment: A total of 3,369 children received CPT during the year. This represents 84% of all pediatric patients receiving a minimum of one clinical care service.

- ✓ **655 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, at 655, is consistent with the FY12 total of 649, and represents 9.8% of all patients referred for this service during the reporting period.

Additional Achievements

Age distribution of pediatric HIV patients. During a presentation to the FMOH in May 2013, UNAIDS raised the issue of 'missing children'. The issue concerns a large group of children between 5 and 14 years of age, who live with HIV but may be missed by the system. However, the evidence is limited. UNAIDS requested partners and stakeholders for collaboration to obtain data on the age distribution of pediatric AIDS patients. ENHAT-CS therefore collected age and sex distribution data from the households that the program supports through NNPWE.

The data showed a high proportion (74%) of HIV+ children found in HIV-infected and affected households are between 5 and 14 years of age. Overall, there were about the same number of girls and boys in each age group. However, among the HIV+ children, there were more boys infected than girls, suggesting that survival among HIV+ girls is lower than among HIV+ boys, which is a finding that is similar to other studies. The data also showed the effect of PMTCT which became properly available in Ethiopia about 3-4 years ago. Hence, the data showed that fewer of the youngest children were born HIV+ and that survival was strongest among the older children (5-9 and 10-14 years) probably due to treatment and other factors. However, among children 15-18 year olds, the numbers were smaller, either because the HIV+ children had died or because more children of that age had moved away.

The program communicated with UNAIDS and is following up on the collaboration.

16-HLAB (Laboratory infrastructure)

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

- ✓ **276 laboratories with capacity to perform clinical laboratory tests** (H1.1.D)
- ✓ **2,968 DBS/DNA-PCR tests performed or referred for EID of HEIs** (Non-NGI; PMP indicator # 28)

  Comment: During the reporting period, 2,969 blood samples of HEIs were received by the regional laboratories for DBS testing, somewhat above the FY12 achievement of 2,656. This performance represents 96% of the program target. This performance was met despite a significant shortage of reagents for the test encountered during the second quarter. The program addressed the issue by re-distributing reagents from Tigray to Amhara HCs.

- ✓ **242 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**

  Laboratory mentorship: All 276 program supported health centers received a laboratory mentorship visit at least quarterly using a structured checklist, which addressed the following areas: 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). In addition focused support was provided following EQA assessment findings and feedback. Finally, oral and written feedback at the end of the mentoring day will be provided and documented in the mentoring folder.

  Over the course of FY13, ENHAT-CS-supported health center laboratories have improved their adherence to SOPs for reliable, accurate and quality testing, proper documentation and data management, preventive maintenance practices, internal quality control practices and readiness for EQA participation, waste management, inventory and supply chain management, conducive laboratory arrangement and work flow as shown by the standard of care assessment.

  Color atlas printed and distributed: To assist laboratory personnel in their day-to-day activities, ENHAT CS prepared and distributed different color atlases covering topics on intestinal parasites, hemoparasites and urine sediments (casts) for all 276 program-supported health facilities during the reporting period. All supported facilities were also provided with an IQC log book for HIV, TB and malaria, and CD4 sample transport log books to improve documentation.

Decentralization workshop for EQA: ENHAT-CS supported the decentralization of the EQA program to hospitals and selected health centers in Amhara region through its collaboration with the regional labs and HEAL-TB. ENHAT-CS supported a one day orientation workshop for five zones.

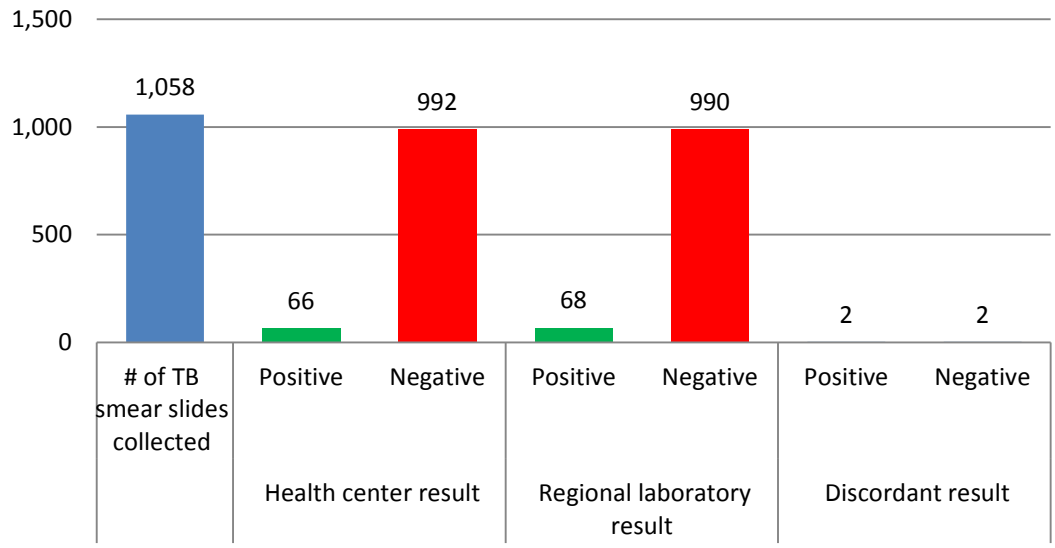
Support strengthening and expansion of EQA centers: All health centers in Amhara were covered in the EQA scheme and assigned to the 56 EQA centers; all ENHAT CS supported facilities were also linked to one of this EQA centers. In addition to expansion of EQA centers ENHAT CS supported the strengthening EQA sites by fulfilling different equipment and furniture for 24 EQA centers and potential health center hub testing sites. Desktop computers, printers with toners, office tables, swivel chairs and standard laboratory tables were supplied.

Regional External Quality Assessments (REQAs) have been conducted: REQAS was conducted in collaboration with regional lab and other partners, in both regions. The number of REQAS conducted in Amhara was on target for TB and HIV during the year; with quarterly REQAS for TB and biannual panel testing for HIV. However, the Amhara decentralized EQA system is still to address malaria, as no EQA was conducted for malaria during FY13. In Amhara, the EQA program was conducted jointly with HEAL-TB to strengthen lab services.

In Tigray, two rounds of REQAS were conducted in collaboration with the regional lab. The assessments included TB, HIV and malaria. The activities conducted during REQAS included onsite assessment of tuberculosis, slide collection for blind rechecking, onsite assessments of HIV for point of care (POC) testing at the health centers. ENHAT-CS laboratory teams provided assistance to the Regional Laboratory by reading slides collected from the health centers for blind rechecking.

Overall, our EQA program shows an overall concordance rate for all TB smears read at HCs of 99.6% compared to reviewer's readings, corresponding to 97.1% sensitivity (i.e. the % of positive results that are truly positive) and 99.8% specificity (i.e. the % of negatives that are truly negative) (Figure 10). These EQA results suggest a strong overall quality of laboratory TB smears at health centers, thus supporting more effective case detection and treatment.

Figure 10
Concordance between health center and regional laboratory TB test results, EQA, Tigray, FY13



Laboratory SOC assessment was piloted: Laboratory SOC assessments consisting of 13 indicators were developed and piloted. The SOC indicators that encompass the major lab activities at health center level, such as specimen ejection rate, proper requisition, TAT, and EQA performance. The mentoring checklist has been applied widely and addresses all comprehensive laboratory services. Laboratory SOC assessment was conducted in nearly 50% of program supported health centers.

Hub testing and spoke referral health center based testing system: In FY13, the program had planned to procure 39 PIMA POC machines for establishing 37 health center hub testing sites in Amhara and Tigray, which would serve both their CD4 testing needs and those of satellite referring health centers. However, USAID did not approve the procurement after they determined that the GOE did not have funding in place to procure the required and expensive reagents.

Subsequently, ENHRI decided to procure PIMA machines, with the assistance of UNICEF and CHAI. However, these PIMAs are to be placed in mid patient load HCs and are not to be utilized for serving CD4 testing needs of their satellite HCs. Due to the different selection criteria, only 6 of the 27 HCs selected in Amhara and Tigray to receive PIMAS are those the program planned to be health center hub testing sites.

However, the GOE is still planning to develop health center hub testing sites, but will do so by providing them with higher capacity BD FACSCount type CD4 machines, along with chemistry and hematology analyzers.

Among the likely 15 health center hub testing sites for West Amhara, 2 already have CD4 machines and are serving as hub testing sites for 20 referral HCs. The hub sites were supported intensively by the program lab advisor and lab mentors, who participated in a pre-installation assessment and readied the sites for installation of instruments, equipment and/or machines. ENHAT-CS collaborated in this effort with the SCMS project staff located in MSH's regional office in Bahirdar. Health center

laboratories that received this support, had already secured hematology instruments before the installation team arrived from Addis Ababa. The type of work conducted were changing power cables, old sockets, search for lost or misplaced hematology and clinical chemistry instruments spare parts and accessories arrived with instruments. Finally, everything was collected and stored in a suitable room selected for the instruments to facilitate ease of access. ENHAT-CS continues to support the regional labs by coordinating and following up of the installation of hematology and chemistry machines.

23 different Internal Quality Control recording and monitoring logs and formats were distributed the program supported facilities. Based on the observed gaps during the assessment and TA, a total of 23 logs and formats were distributed to all HCs for use in internal quality control, equipment preventive maintenance, occurrence management and turnaround time (TAT) monitoring HCs. The HCs also received an orientation on their use.

LED-based Fluorescence Microscope and EQA training has been organized from April 01-April 07/2013. The program organized and supported a seven-day training on a new TB diagnostic technology called LED-based fluorescence microscope. The training took place from April 1 to 7, 2013 and was implemented in collaboration with Dessie Regional Health Research Laboratory Center. A total of 28 lab professionals including 3 regional lab staff, 2 ENHAT-CS mentors, 4 hospital staff, and 19 health centers lab professional attended the training. EQA implementation methods were also briefly discussed during the training. This was conducted jointly with HEAL-TB which procured the LED microscopes.

17-HVSI (Strategic Information)

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

- ✓ **115 (29M, 86F) data clerks were trained on SI for HIV/AIDS services** (H2.2.D)
- ✓ **254 data clerks received refresher training on SI** for HIV/AIDs services (H2.3.D 'other').
- ✓ **79 NNPWE volunteers were trained on community component of NGI data collection and handling** (H2.2.D)
- ✓ **348 NNPWE volunteers received refresher training on community component of NGI data collection and handling** (H2.3.D 'other')

Comment: The program conducted data clerk pre-service and refresher training, which lasted for three days. During the training, data clerks were also oriented on the new updates and on the existing indicators for further clarification and understanding. The training was for newly opened ART health center sites and also for gap filling at existing ART HCs. The program also conducted pre-service and refresher training for the NNPWE community volunteers that included 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. EPHA will integrate ENHAT-CS data and information onto their website and is currently planning to post all the program-supported ORs completed by the universities through their partnership with the RHBs.

- ✓ **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 the University of Bahir Dar –in OR 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, began a process of identifying thematic areas for research.

Operations Research: EPHA's M&E and OR manager joined the ENHAT-CS team at the beginning of Q1 to assist with coordination and management of the OR activities directly implemented by program staff with those implemented through the collaborating university partners.

As per the agreement with the regions and universities on OR partnership, the program coordinated the selection of 23 proposals out of the 104 OR proposals submitted by the Regional Health bureau staff, university staff and university students for grant support. In Q3, a total of 23 (7 from Tigray and 16 from Amhara region) proposals were accepted for support by ENHAT-CS. The program provided supervision to the implementation of appropriate data collection procedures under the leadership of

the embedded OR partnerships, using a checklist. All studies were finalized and prepared for OR results dissemination workshops. Abstracts of all 23 research initiatives were published in a folder, with two parts, each reporting the research conducted in one of the two regions (see Annex 2).

Besides the above mentioned workshop and booklet, the program has started pulling all research papers together for publication in a booklet which will be distributed to regional health bureaus and different institutions for program consumption as part of results dissemination. The results are also to be released on EPHA and other regional websites for the users.

In addition to the above collaborative OR activities with the regions and universities, the program also implements OR activities through its own program staff. The ORs conducted in FY13 include the following.

- ✓ ***The role of MSGs in uptake of HIV services among HIV-positive pregnant women and their babies at health centers*** – This OR includes 4 studies that have been written up and shared with USAID. The program will publish the ORs in one booklet in early FY14.

  All ORs consistently showed better service uptake, adherence and health outcomes among mothers and babies of mothers who belonged to an MSG compared to those that had not joined an MSG.

  The ORs that specifically addressed vertical transmission among babies born to mothers belonging to an MSG and those not belonging to an MSG showed much lower transmission rates among the former than the latter. An OR conducted in Tigray showed that the positivity rate among infants born to mothers were followed at a health center with MSGs was 5.5%, and for those without an MSG, 11.4%, representing a 57% reduction in the rate of HEI positives for mothers active in an MSG (OR=0.43, 95% CI (0.20,0.92).

  A second OR, conducted at the request of USAID and in partnership with USAID and C-PMTCT at 44 HCs in 5 regions, showed that 2% of HEIs born to mothers belonging to an MSG were HIV+, compared to 3% among mothers not belonging to an MSG.

  A third data set, obtained from registers kept by mother mentors on MSG members at the 59 high patient load health centers that have mother mentors, showed that 2.3% of babies tested HIV+ at 2 months, compared to the 2012 national rate of 13% at 6 weeks.

- ✓ ***Vertical transmission of HIV by age of infant testing and type of mother/infant prophylaxis in Tigray*** - published as abstracts at IAS'13 and being prepared as a paper to be published either by peer reviewed journal or ENHAT-CS.

  Not surprisingly, this OR found that HEIs whose mother had taken prophylaxis were much less likely to be infected than those whose mothers had not taken prophylaxis. However, of particular interest was the finding that HAART by the mother was the single most effective prevention strategy, with a positivity rate of 1.8% (RR=0.37; CI=0.19, 0.74; p=0.006) compared to 5.8% among babies whose mother had taken dual prophylaxis and 11.1% among mothers who had taken a single dose NVP. The rate among babies born to mothers who had not taken any prophylaxis was 23.2%. This finding underscored the importance not only of putting HIV+ pregnant mothers on PMTCT, but especially on HAART, and promoting institutional delivery and early infant testing. HAART was the most effective PMTCT regimen, regardless of the infant's regimen. This finding is particularly important in Ethiopia where most women give birth at home

and may not be able to give the right medication to their baby at the right time. The data thus strongly supports the validity of option B+ as the national PMTCT standard in Ethiopia.

- ✓ ***Strengthening the gender focus to improve ANC/PMTCT service quality: comparing the perceptions of service quality and priorities among clients and providers***- published as abstract presented at IAS'13 and ICASA'13; will also be prepared as ENHAT-CS OR brief or report.

  Through qualitative focus group discussions, this OR highlighted four main issues. First, because they were counseled not to get pregnant without consulting their HIV provider, HIV+ women felt stigmatized and chided when they got pregnant. Second, participants felt that mother mentors and their support group (MSG) equipped them with skills for positive living. Third, participants reported that ANC/PMTCT services were not male-friendly, as men were not allowed to witness the birth of their children. Finally, participants preferred to link their ART appointments to market days, religious holidays, or other convenient times, which did not always coincide with health center hours. Health center management teams ranked these four issues as the lowest priority for making changes. As such, health center client and provider perceptions of gender-related issues were directly opposed, underscoring the importance of educating providers about client needs and equipping them with tools to improve services. Better integration of providers with MSGs should be explored.

- ✓ ***Follow-up, DBS testing, turn-around time and results among HEIs born at health centers*** – the program designed this OR by supporting ANECCA, who will lead the implementation beginning in Q1 of FY14.

- ✓ ***Pediatric HIV status disclosure at South Gondar health center*** - This study is ongoing as part of a ENHAT-CS staff member's MPH thesis

- ✓ ***The efficacy of using the family matrix for identifying new HIV patients*** – completed; a report will be completed in FY14.

  This analysis confirmed that the index case method was significantly better at identifying new positive patients compared to PITC (11.1% vs. 0.9%, p, .000), compared to VCT (11.1% vs. 2%, p, .000), or compared to VCT and PITC combined (11.1% vs. 1.2%, p, .000). When the VCT and PITC method were compared, the VCT method was significantly better at identifying new HIV positive patients than the PITC method (2% vs. 0.9%, p, .000). The OR thus highlights the importance of creating and using a family matrix for HIV patients to reach family members for early HIV detection and linkage to care.

- ✓ ***Health outcomes of pre-ART patients at health centers*** - – completed; a report will be completed in FY14.

  This OR reviewed 10,028 pre-ART patients over a 6 month period (October to March 2013) seen at 205 health centers. Out of the 8,118 (81%) who were retained in care, 3,932 (48%) patients initiated ART within 12 months of their enrolment into care and 4,186, or 52%, of patients remained on pre-ART care. Out of the 10,028 initial pre-ART patients, 1,249 (13%) were lost to follow-up within the 12 month period after they started pre-ART, 440 (4%) patients transferred out, and 221 (2%) died. The analysis results show that overall there was no significant difference in retention between male and female pre-ART clients (male 80% and female 81%, p-

value .104). Similarly, there was no difference regarding retention of patients attending health centers in rural areas with that of urban ones (urban, 81%, rural, 81%, p-value .366). Retention was found to be significantly better among children under 15 years of age compared to adults (87% vs. 80%, p-value, .000) and among patients seen at higher patient load health centers compared to lower patient load health centers (82% vs. 76%, p-value .000). This OR showed that retention rates among pre-ART patients are good and similar to retention rates among ART patients.

- ✓ ***Are pregnancies among known HIV+ women intended, and are their FP and RH needs appropriately met by health providers?*** – This topic was earlier addressed by HCSP and subsequently in other small studies under the partnership agreements between the RHBs and universities. The program developed a protocol for a large scale OR to confirm the results that the majority of pregnancies among HIV+ women are intended and wanted.

- ✓ ***Sexual behavior and vulnerability to HIV infection among migrant laborers in Metema district: a cross-sectional study*** – this PhD study has been completed; the data are being in analyzed and a report is being prepared and will be ready in early FY14.

- ✓ ***Client satisfaction of HIV-related services at public health centers*** – data collection started in FY13 and will be completed in early FY14.

- ✓ ***What happens to HIV patients who screen positive for TB at the HIV clinic?*** – completed with report being finalized in early FY14.

  During a three month period, the study collected data on 12,260 HIV+ clients' screening for tuberculosis (TB) at 12 health centers in the Amhara and Tigray regions. The review identified 250 (2.0%) patients who screened positive. Among them, 195 (78%) got an AFB sputum test at the health center and a result was obtained for 170 (87%), of whom 7 (4.1%) tested positive for TB. Among the 163 who tested negative, 21 were referred for further investigation. Of the patients for whom the health center did not do an AFB, 19 were referred elsewhere. Of the 40 referred patients, 16 (40%) turned out to be positive for tuberculosis. The study showed that in total, only 0.2% of all screened patients seen at program-supported health centers were TB positive.

- ✓ ***The use of telephone consultations to compliment on-site mentorship for HIV services at health centers*** – completed

  This study analyzed a total of 451 calls from health care providers from 137 health centers made to program mentors in a 6 month period. The average number of calls per mentor per month was 2.9. The average duration per call was 10.4 minutes (SD=8.0), ranging from 2 to 58 minutes. Only 9% lasted more than 20 minutes and 55% of them concerned ART management. Most calls were made by ART providers (58%), followed by data clerks (17%), health center heads (11%). There was no difference in telephone consultation use between old and new ART HCs. This study showed that consultations by telephone met an important need of health providers and were manageable for the mentors and should be incorporating especially as on-site mentorship is reduced from once a month to once a quarter.

- ✓ ***Implications of adopting a 'test and treat' strategy for ART initiation in Ethiopia*** – completed and being prepared for publication.

  Previously published 2010 data on the distribution of HIV patients by CD4+ count at 19 high-patient-load health centers in Ethiopia were used to estimate the additional cost to adopt a test-and-treat policy versus the current guidelines of a CD4 count < 350 and new WHO guidelines to start patients at a CD4 count of 500. The study found that providing ART to all HIV+ patients and limiting routine CD4 testing for stable patients to once every two years would result in a 14% increase ($13,464,614 per year) over the costs associated with the current policy in Ethiopia of limiting treatment to HIV+ patients with a CD4 count < 350. Considering the safety of ART and the right of all HIV+ patients to receive the best available care, the study concluded that test and treat is the most ethical as well as economically rational approach and a reasonable next step for resource-poor countries like Ethiopia.

- ✓ ***Pediatric HIV infection by age: a case of missed children?*** – on-going.

  ENHAT-CS collected age and sex distribution data from the households that the program supports through NNPWE.

  The data showed a high proportion (74%) of HIV+ children aged between 5 and 14 years of age found in the HIV-affected households. Overall, there were about the same number of girls and boys in each age group. However, among the HIV+ children, there were more boys infected than girls, suggesting that survival among HIV+ girls is lower than among HIV+ boys, which is a finding that is similar to other studies. The data also showed the effect of PMTCT which became properly available in Ethiopia about 3-4 years ago. Hence, the data showed that fewer of the youngest children were born HIV+ and that survival was strongest among the older children (5-9 and 10-14 years) probably due to treatment and other factors. However, among children 15-18 year olds, the numbers were smaller, either because the HIV+ children had died or because more children of that age had moved away.

- ✓ ***Predictors of mortality among HIV infected patients taking ART in public health facilities*** – started in FY13 and will be completed in FY14 as part of a program's Master's thesis.

- ✓ ***Use of IPT in HIV patients for TB prevention*** – completed and shared with USAID.

  The program conducted a literature review of IPT use in HIV patients. The review showed that globally only 0.1% of those who are eligible currently receive a course of IPT. The review also showed that ART is highly effective in TB prevention among HIV patients. Thus, while IPT may be useful in reducing TB incidence, its use is negligible and the focus should be on maintaining good ART treatment, and on starting ART earlier, perhaps even implementing a test and treat protocol, in order to reduce TB infection.

- ✓ **Additional Achievements**

  Institutional support to EPHA: In the FY13, the program has provided support to develop and finalize an EPHA project called "*Information Generation and Capacity Building Efforts on Climate and Health in Ethiopia"* which has a threefold purpose: (1) to identify climate-sensitive health risks and their distribution in Ethiopia, and develop a national research agenda, (2) to develop appropriate

training materials for health professionals to improve the capacity of health sector institutions to respond to climate sensitive health risks, and (3) to produce advocacy tools for communication specialists from mass media to raise awareness of the community (general public) and policy makers (politicians) that climate change is a fundamental threat to human health and thus mitigate the effects of climate change on the public health. ENHAT-CS also assisted EPHA in the development and submission of a proposal entitled '*Review and synthesis of researches and research related documents on tuberculosis in Ethiopia over the past 20 years to produce strong evidence for the evidence-informed policy and practice movement*'.

Finally, the program has also assisted EPHA to support FHAPCO to strengthen its capacity to generate evidence-based information by developing survey protocols to conduct the following surveys: (1) determination of mobile phone text-messaging effectiveness in enhancing adherence to ART in patients with HIV infection in Ethiopia, and (2) an assessment of the community conversation program evaluation which is a program that started in different corners of Ethiopia over 10 years ago.

Printing and Distribution of HMIS forms: Different HMIS materials were requested by each region during the reporting period and ENHAT-CS reprinted and distributed the materials to the regions and health centers based on their demand. The HMIS materials reprinted and distributed included: TB register-120 pcs, ANC register-258 pcs, ART register-520 pcs, HEI register-178 pcs, the revised screening logbook-405 pcs, adult intake forms-25,000 sets, pediatric intake forms-2,250 sets, family matrix monthly progress chart-pcs 340, cohort analysis reporting form-130 pcs, cohort wall chart-266 pcs, ART lab test request form/CD4 -940 pads, HIV care/ART follow-up card -25,700 pcs, ART apppointment card (two languages) -30,000 pcs, appointment card ANC (two languages)- 65,000 pcs, ANC partner invitation cards-127,000 pcs, HIV care/ART transfer and referral forms- 411 pads.

Online database: ENHAT-CS is using on-line DHIS-2 database software and this on-line data captures both routine health service data and information collected by mentors during their monthly visits using the environmental compliance checklist as well as data from the SOC assessments that are conducted during supportive supervision visits by the program advisors using standardized SOC assessment tools.

Data Quality Assessment: ENHAT-CS has made an effort to assure the quality of the program data. To ensure that the data collected is accurate so that they can be effectively used for evidence-based decision-making and program management, ENHAT-CS integrated data quality assessment into its overall strategic information strengthening and management plan. The program uses routine data quality assessment (RDQA) to assess the quality of the data for all program indicators on a routine and ongoing basis with the aim to strengthen the data management and reporting system of the program. The program also uses a key data quality assessment tool (KDQA) to assess, once a year, the quality of data for ten key program-level indicators.

During the reporting period, KDQA was conducted and looked at data reported in Q4 of FY12 (July-September 2012). A total of 31 randomly selected program-supported health centers were included in the assessment. The overall assessment results indicated that out of the ten verified key program indicators, eight had a minimal data error i.e., less than 10% error of margin set for the program. To address the identified data quality issues, action plans were developed following the data verification on site, and discussed with the health center head and management teams. Follow-up of the action plan implementation has assured through the program's regional staff especially the mentors.

Moreover, routine data verifications were done by regional M&E teams and clinical mentors during their routine mentorship services. Monthly staff meetings were conducted at each sub-regional office

and issues related to data quality were discussed. During this discussion, ENHAT-CS identified the need to use a modified TB-HIV reporting format to better capture TB-HIV patients from different sources at the TB clinic.

Data audit by the regional United States Government Inspector General Office. The program hosted a team from the regional USG Inspector General Office to conduct an independent data audit in the Amhara region. The audit involved comparing the data that the program reported to PEPFAR in 2012 with their observations at the data source (health center registers) at 5 randomly selected health centers. The audit focused on two core NGIs, patients newly enrolled in pre-ART and ART at five health centers around Bahirdar (Adet, Dangla, Injibara, Debretabor, Alember). The program's west Amhara regional technical manager, Dr. Fentahun, and the program's strategic information director, Tesfaye Arega, hosted the two auditors during their one week visit from 16 to 20 Sept.

The following week, the auditors provided a preliminary debrief to the program's COP and SI director. They stated that they were impressed with our team in west Amhara and reported that they found a less than a 2% overall difference between the data reported by the program and what they found in the registers at the five health centers. They were also impressed with the program's mentorship logbook, as it both provides a data source for each visit and documents key information to inform follow-up mentorship visits. This audit confirmed to USAID and the USG that what ENHAT-CS is reporting is consistent with the program's actual performance.

NGI C2.1.D. Disaggregation by age group: Following new OGAC instructions, the program updated its reporting formats to allow disaggregation by age for the following age groups: <15, 15-17, 18+, for NGIs C2.1.D. This change took effect in Q4 of FY12 and, for FY12, the age distribution data was derived as follows: In Q4, the program collected data on the new and repeat HIV patients visiting the HIV clinic. The data was obtained from all program-supported HCs. The age distribution found during Q4 of FY12 was then applied to the FY12 data. In FY13, the program applied this derivation only to the Q1 report. In following quarters, the program used the new screening logbook for direct capturing of the information. Based on information from the screening logbook, 4.1% and 2.8% of the patients in the 15+ age category are respectively male and female in the 15-17 age category.

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)

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

Comment: The program has recruited and deployed new case managers at all 70 expansion ART HCs in collaboration with the RHBs as well as mother mentors with an MSG at the highest patient load HCs. The program also trained data clerks, case managers, NNPWE volunteers, religious leaders and community referral network mobilizers as well.

✓ **3,859 health care workers who successfully completed an in-service training program** (H2.3.D)

Comment: During the reporting period, the program trained 3,859 health care workers, which is well above the program target (216%). A portion of this over-achievement was due to the requirement of the new PMTCT guideline for implementation of Option B+, which requires 3 day training for all health care workers involved in PMTCT. The shift from D4T-based regimens to TDF- or AZT-based regimens also required short workshops and on-site mentorship. All trainings used national curricula, and included adult ART treatment, pediatric ART, and TB/HIV guidelines. Finally, the program trained 289 religious leaders, upon request from EIFDDA to significantly expand the scope of their initiative.

Trainings conducted Oct 2012 - August 2013

Type of training	Number of trainees
Pediatric treatment	442
ANC/PMTCT	406
CT	144
Adult ART treatment	442
TB/HIV co-infection management	93
Laboratory related activities	309
Other	2,023

✓ **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 and Bahirdar. With 11 local organizations currently supported, the program has achieved 100% of its FY13 target.

- ✓ **Additional Achievements**

  New ART facility assessment and accreditation. 125 health center proposed by the RHB as potential ART expansion sites were assessed jointly with the RHBs using the government's standard facility accreditation checklist. The checklist mainly focuses on the availability of adequate human resources, the health center's HCT performance, the availability of rooms and transportation. A total of 70 HCs were selected for accreditation to provide ART services, 45 in Amhara and 25 in Tigray. ENHAT-CS provided technical and financial support to integrate these HCs.

  Joint GOE mentorship: ENHAT-CS has been working with the RHBs to develop and support woreda-level government mentorship. To date, the program has trained 116 staff selected from ART HCs and woreda health offices from three zones and 42 woredas. Of note, the zonal health department staff met the selection criteria, which prioritizes a clinical health training background. In addition, during training, it became evident that the woreda health office staff did not possess adequate expertise to provide clinical mentorship. As such, their role has been shifted to providing program support.

  However, the program did find that the HIV clinic focal persons (nurses and health officers) possessed strong expertise to provide clinical mentorship. While all have received training, their expertise has been greatly enhanced by being practicing clinicians who provide services daily to HIV+ patients. This finding strongly supports the FMOH guideline that mentors need to be practicing clinicians.

  Following the training, the program's mentors and technical advisors conducted an intensive 3-5 day joint mentorship with the government clinical mentors. This intensive joint mentorship was intended to capacitate the government mentors to conduct clinical mentorship and program support (on the part of the woreda health officers). The joint mentorship visits included gap identification (through charts and records review, observation, report analysis and interpretation, and asking the mentee about the difficult cases he/she ever came across). Following the intensive joint mentorship, a monthly joint mentorship was provided for 6 rounds during the reporting period. In addition, a pediatric focused joint mentorship was started through ANNECA.

  23 government mentors graduated: Among the 34 trained government mentors in West Amhara, West Gojam zone, 68% (23) were graduated after completing the six rounds of joint mentorship and achieving good results through mentorship skill assessment, 3(9%) government mentors failed the assessment, 5(15%) changed workplaces, and 3 (9%) government mentors were not assessed because of the busy schedule of RHB staff precluding them to visit health centers at the time of assessment. Mentors who scored 75 and above were certified. Government mentors who scored below 75 were not certified, and will receive continuous intensive mentorship for another 3 months after which they will be assessed and re-assessed.

Graduation of government mentors according to similar criteria will be done in the remaining two zones at the beginning of FY14. Criteria for certifying government mentors were the following.

	Criteria	**Weight**
1	Skill & knowledge assessment (average score***)	50
2	Independent mentoring done	20
3	Joint mentoring days attended	10
4	Health center head comment for commitment	10
5	Woreda head comment for commitment	10
	Total	**100**

Government mentorship site expansion: ENHAT CS in collaboration with the Amhara and Tigray RHBs will be expanding government mentorship sites to six more zones in FY14. For Amhara, based on the agreed expansion plan, ENHAT-CS conducted an orientation meeting with four zonal health offices and their catchment woredas and health center heads. Zones selected by the regional health bureau for a second round of government mentorship program implementation were Gondar town administration, North Gondar, East Gojam, North Shoa and North Wollo zones. Training of selected government mentors will be conducted in the first quarter of FY14. For Tigray, orientation meetings and trainings for government mentors will be also conducted for zonal health office, woreda health office and health center heads from Eastern Zone, Mekele city Administration and Southeastern Zone.

Development of regional comprehensive HIV/AIDS Treatment, Care and Support Implementation Guideline in Tigray: ENHAT-CS took the initiative to develop this standard operating procedure and actively participated in the TWG and subcommittees with which the program will finalize and print the documents.

Participation in TWG: At federal level, ENHAT-CS is a member of the national umbrella HIV/AIDs care and treatment TWG, as well as the TWGs for PMTCT/MNCH, Pediatric HIV and AIDS, IP/PS, and Laboratory Services, as well as the Option B+ task force for implementation.

At regional level, ENHAT-CS also plays a major role in all regional technical working groups (RTWGs), including the umbrella RTWG for HIV and AIDS/STI/TB as well as RTWGs for RH, PMTCT (including implementation of option B+), MNCH, MDR TB, and health system strengthening.

Equipment support: During this reporting period, ENHAT-CS has supplied Amhara and Tigray RHBs with furniture, computers and printers for 52 program-supported HCs.

Integrated Supportive Supervision (ISS): ENHAT-CS supported technically and financially Tigray RHB ISS during this reporting period. ENHAT-CS actively utilized the ISS findings by reviewing and discussing them with all technical staff during regional program meetings and developing action plans accordingly.

Catchment area meeting: Both regions have conducted catchment area meetings in the presence of RHB representatives, zonal health department heads and officers, woreda health office heads and officers, woreda HAPCO heads, health center heads, ART and PMTCT focal persons at least ones in the program year. The major objective the CAMs was to monitor progress of HIV/AIDS prevention, treatment and care and support services, to share best experiences among health facilities and improve the quality of services and referral linkages among the different level of the health care system working in HIV/AIDS treatment.

Gender mainstreaming activities: To ensure a systematic approach to gender mainstreaming, ENHAT-CS, in PY1, began implementing gender mainstreaming formative activities focusing on analysis and planning and initial design activities. A gender assessment and analysis was conducted with staff, MSG mentors and religious leaders. Based on the findings from the gender analysis and planning, the program developed and pilot tested data collection tools and conducted in this reporting period, a validation exercise targeting religious leaders, MSG clients, members of the health center multidisciplinary team and community members. Based on the findings (reported during SAPR'13), the program has developed gender mainstreaming checklist based guide use by MDT teams, which was piloted and finalized in Q4. The program will support use of the checklist in 261 HCs in FY14. As a member of the gender and HIV TWG, the program will lobby the adoption of this checklist at the national level. The results of the gender analysis also informed the revision of the refresher-training curriculum of 289 religious leaders and creations of a job aid for their use during community conversations and mass education events. As a result, 289 religious leaders were provided with refresher training focus on their gender biases and how to deal with gender issues during mass education and community conversations.

Mental Health integration: Following the baseline assessment on the feasibility of mental health HIV service integration in selected HCs, an implementation plan was developed and the program work with the RHBs to pilot the initiative. A thorough evaluation of the first year's achievements from the situational assessment, the workshop of stakeholders was held to review of the literatures. The two regions have assigned a focal person for mental health. Orientation workshops on mental health integration to HIV and AIDS were conducted in Debretabor, West Amhara, and in Axum, Tigray. The program selected 27 health centers supported by five hospitals as pilot sites of in the Tigray region. In Amhara, the service integration will be piloted in 10 health centers.

Following the two orientation workshops and agreement reached in both regions, trainings have been conducted successfully for facility-based ART nurse prescribers, case managers and mentors. Mental health-related indicators were developed, discussed with all the mentors in the training. These indicators will be incorporated into the mentorship checklist for data collection and reporting.

The program's mental health consultant, Dr. Tedla, also started to develop a screening log book, reporting format, and referral papers and they began working with the FMOH non-communicable disease unit to further the program. Implementation will start in FY14.

Operations research partnership: Both regions, with program-support, are working on establishing a research body under the regional health bureaus. The program's OR partnership advisors are working with the universities in the regions (University of Gondar, Bahir Dar University, Mekele University) to support the research units and the institutional ethical review boards and link them to the RHBs. For more details, please see section 17 on strategic information above.

Annual ENHAT-CS review meeting: In FY13, ENHAT-CS presented the program's FY12 annual and then FY13 semi-annual results to both regional health bureaus. All HIV team members, core process owners, and head and deputy bureau heads attended. After the meeting, the RHB staff noted that they found the meetings 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.

Leadership and Management Development (LMD) component: The program has an LMD component focusing on strengthening the leadership and management capacity of woreda health offices to manager their woreda health network. During this reporting period, the program continued its partnership with the Ethiopia team of the USAID Leadership, Management and Governance (LMG) global initiative. During the quarter, the main LMD activities included the following.

- Following the Master Trainer/Program Manager training last quarter, the program worked with the RHBs to ensure follow-up support for LDP training of their woreda health office leaders. The program initiated LDP workshops in the 2 Amahara zones that already initiated woreda-based government mentorship under the program's support.
- A six day long TOT was conducted by the MSH implemented USAID Leadership, Management and Governance (LMG) initiative at Adama from May 16 to 21/2013 targeting regional health bureaus and universities. A team with 6 members consisting of ENHAT-CS LDP Master Trainer/Program Manager, the two ENHAT CS Regional Health Service Strengthening Coordinators and three zonal LDP Focal Persons attended the training with the objective of facilitating future trainings of ENHAT-CS LDP.
- As part of the planned ENHAT-CS LDP initiative, a one-day senior alignment meeting (SAM) took place at Dangla, Amhara Region on 14 June 2013. The SAM targeted stakeholders who will be involved in supporting woreda-wide LDP in West Gojam Zone. The main purpose of the SAM was to introduce participants to the contents and process of ENHAT-CS's LDP and to build the necessary commitment among key stakeholders at all levels.
- The first of three leadership workshops, the scanning and planning workshop, was held in West Gojam in Q4, with South Wollo to start in early FY14. The West Gojam workshop had a total of 47 participants, comprised of a team with 3 members from each woreda and 2 participants from West Gojam Zonal Health Department, which was 100 % of the plan. The main objectives of the workshop was to introduce the impact of workgroup climate on improving health outcomes and enable the teams to use the Challenge Model, which helps them to move from vision to action by making a careful diagnosis of where they want to go, analyze their current situation and develop evidence based plan of action. The following two workshops, 1) aligning, mobilizing and inspiring and 2) reviewing of results with recommendations, will be conducted in FY14.

Tigray Health Festival: The program provided support to the preparations of the Tigray Health Festival which was carried out in April'13.

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

01-PMTCT (Prevention of Mother to Child Transmission)

Challenges and constraints for each program area:

Program area 01-PMTCT

1. Unavailability of national M&E tools and forms for option B+
2. Shortage of test kits; other laboratory supplies used for routine ANC and L&D services, such as hemoglobin-meter and VDRL; and ARV drugs, particularly NVP and recently AZT
3. Long time national stock-out of DNA-PCR reagent compromising the EID services.

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

Program area 01-PMTCT

1. Program provided the draft option B+ M&E register to supported health centers and will upgrade to the national standards when finalized.
2. Program mentors continue to monitor key shortages for informing RHBs and PFSA and continue to support facility health workers to monitor and properly request re-supply.
3. Program arranged inter-laboratory DNA-PCR reagent exchange till the national stock is procured.

02-AB (Abstinence and Be Faithful)

Challenges and constraints for each program area

Program area 2-HVAB

NNPWE community volunteers carrying out home visits that include AB messaging for children between the ages of 10-14 in highly vulnerable infected and affected households, often presented low literacy rates that negatively impacted on proper use of job aids and documentation of program activities.

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

Program area 2-HVAB

The program replaced non-literate volunteers and carried out refresher training for the NNPWE volunteers, complemented by continued support by NNPWE.

03-HVOP (Other Prevention)

Challenges and constraints for each program area Program area 3-HVOP NNPWE community volunteers carrying out home visits that include OP messaging for children between the ages of 10-14 in highly vulnerable infected and affected households, often presented low literacy rates that negatively impacted on proper use of job aids and documentation of program activities. EIFDDA religious leaders were found to possess gender biases that can undermine their understanding and support for HIV initiative e.g. women receiving an HIV test is a sign of infidelity.
Plans to overcome challenges and constraints in each of your program areas Program area 3-HVOP (Other Prevention) The program replaced non-literate volunteers and carried out refresher training for the NNPWE volunteers, complemented by continued support by NNPWE. Program provided refresher training for all religious leaders.

08-HBHC (Adult Care and Support)

Challenges and constraints for each program area Program area 8-HBHC (Adult Care and Support) The above noted above issues with NNPWE volunteers and religious leaders Shortage of HBC kits for use by new volunteers
Plans to overcome challenges and constraints in each of your program areas Program area 8-HBHC (Care and Support) The above noted responses to address issues with NNPWE volunteers and EIFDDA religious leaders Program worked with SCMS to acquire adequate HBC kits

09-HTXS (Adult Treatment)

Challenges and Constraints for each program area

Program area 9-HTXS

1. Declining uptake of ART in Tigray
2. CD4 sample transport problem due to:
   - Frequent non-functionality of CD4 machines affecting most hospitals
   - Vacutair test tube shortage
   - No or irregular per diem/transport allowance payment for sample transport by laboratory technicians
3. Turnover of trained staff, especially ART providers and data clerks
4. A lack of hemoglobin testing capacity at many HCs has impeded the transition from D4T to the recommended AZT regimen.

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

Program area 9-HTXS

1. Kept strengthening and renew emphasis on regular assessments of patients who are on pre-ART service for restaging and early initiation of ART for those eligible through ongoing mentorship and SOC activities.
2. Continued working with regional laboratories, PFSA and RHBs, while hastening the procurement of PIMA machines
3. Contineud to provide gap filling trainings
4. Mentors continued to encourage HCs and woredas to utilize health care financing to produce the necessary equipment and supplies for Hgb testing. When not available, mentors recommended prescription of a non AZT regimen, as per the national guideline.

10-HVTB (TB/HIV)

Challenges and constraints for each program area

Program area 10

1. INH drug shortage in all health centers (available INH expired on 30 Nov'12)
2. IPT not well accepted (Tigray RHB does not allow its use in health centers), concerns about developing INH resistance and relative ineffectiveness of IPT.

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

Program area 10

1. Discuss with MSH/SCMS & PFSA how to resupply of INH & pyridoxine
2. Literature review indicates that continued expansion of ART more effective in preventing TB than IPT; therefore, will promote the finding that this aspect of HIV-TB programming is not as effective.

12-HVCT (Voluntary Counseling and Testing)

Challenges and Constraints for each program area

Program area 12: HVCT

1. Country cannot provide adequate RTKs to meet national demand, leading to provision to health centers on a quota rather than need basis.
2. Low pediatric uptake of PITC

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

Program area 12: HVCT

1. Mentors support health centers rational use of available RTKs, with a focus on near universal testing at ANC, L&D and TB clinics, coupled with working with RHBs, PFSA, and SCMS, to help address noted shortages
2. Program's clinical care mentors continue to focus on mentoring health center clinics on pediatric PITC

13-PDTX (Pediatric Treatment)

Challenges and Constraints for each program area

Program area 13: PDTX

Expected FMOH acceptance and roll out of revised national guidelines for pediatric care and treatment postponed after FMOH has requested a review of the guidelines.

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

Program area 13: PDTX

Program, under ANECCA lead, will continue to actively participate in the TWG that is advising the FMOH on pediatric guidelines.

14-PDCS (Pediatric Care and Support)

Quarterly challenges and Constraints for each program area

Program area 14: PDCS

As above, expected FMOH acceptance and roll out of revised national guidelines for pediatric care and treatment postponed after FMOH has requested a review of the guidelines.

A shortage of cotrimoxizole syrup and tablets at some HCs.

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

Program area 14: PDCS

As above, program, under ANECCA lead, will continue to actively participate in the TWG that is advising the FMOH on pediatric guidelines.

Program continues to work with the RHBs and PFSA to ensure adequate supply.

16-HLab (Laboratory Infrastructure)

Quarterly challenges and Constraints for each program area

Program area 16: HLAB

1. ART monitoring test interruption due to frequent automation failure at referral site or ART specimen transport interrupted due to delayed payment of transport per diem issues (in some areas not paid for nearly one year). Basic laboratory test service interruption in some health centers due to stock out of reagents and failure of timely supply by PFSA.
2. No standard general lab registration and lab request and reporting form used in almost all health centers
3. Poor lab infrastructure (inadequate room, no sink, electric power and water supply) and shortage of lab equipment and furniture at some health centers observed
4. Shortage of laboratory personnel in some health centers which have only one laboratory technician

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

Program area 16: HLAB

1. ENHAT-CS will work with health centers, woreda health offices and the RHBs as well as partners to address the interruption in tests, reagents and other supplies.
2. The program will work with partners to develop and customize standard laboratory forms, duplicate and distribute for health centers and conduct mentorship
3. The program will work with the woreda health office and RHBs and partners to provide technical and material support besides regular supportive supervision and mentorship
4. The program will work with the RHBs to ensure they can assign adequate number of lab staff according to the national standard of health centers

17-HVSI (Strategic Information)

Quarterly challenges and Constraints for each program area

Program area 17-HV

1. Ongoing turn-over of data clerks
2. HCPs at times unwilling or unable due to time constraints to fill out program logbook data which are required for NGIs that are not part of the national HMIS
3. Oromia RHB requested ICAP to increase data clerk salaries to around 2,200 ETB per month, to be consistent with their facility based HIT/ITs. JHU followed suit in the regions they support. However, the RHBs of Amhara and Tigray have not increased the salaries of their HIT/ITs, which remain at around 1,500 ETB per month. Program data clerks have become angry over their lower salaries versus their colleagues in Oromia.

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

Program area 17-HVSI

1. Continued gap filling training
2. Mentors continued to encourage HCPs to fill out the logbook, emphasizing the importance of continued support
3. The program consulted with the Amhara and Tigray RHBs, as it cannot increase the salary of program data clerks significantly above these RHB's level of salaries without their consent. Both regions agree to the salary increase, allowing the program to implement it.

18-OHSS (Health Systems Strengthening)

Quarterly challenges and Constraints for each program area

Program area 18-OHSS

1. Quarterly woreda health network meetings and monthly health center based PHU meeting were not held as planned
2. Expansion of activities to strengthen the referral network in the 55 new sites was a bit slow as the program awaited permission from respective RHB to train health center heads.
3. Lack of capacity and program ownership by some woreda health offices
4. Irregularity of MDT meeting due to overlapping commitments of the health center staff
5. Supportive supervision not given for most facilities
6. Low capacity of CRNMs to coordinate the primary health network
7. The GoE is increasingly resistant to trainings that take health workers away from assigned duty posts

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

Program area 18-OHSS

1. Follow-up of this activity by program teams and discussion with health center heads and woredas were carried out to explore how they can conduct the meetings timely.
2. In Tigray, the program has requested and obtained permission to train the officers during weekend
3. Program continued to provide capacity building of woreda health offices in leadership and management, technical oversight of health facilities and on-site mentorship
4. Encouraged woreda health offices experts, together with woreda HAPCO, to visit their ART HCs and participate in the MDT team meeting regularly.
5. Collaborate with regional health bureaus for better coverage of health centers in supportive supervision
6. Provided quarterly TA to CRNM's through supportive supervision
7. The program has reduced the length of training workshops to allow them to be held over weekends.

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. Due to high turnover among data clerks, some HCs struggled with appropriate data recording and reporting

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

1. The program continued gap filling and refresher training for data clerks and on the job mentorship coupled with continuous monthly review of data quality at field office level with the involvement of all ENHAT-CS staff, including mentors

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

1. Through mentorship, ensure proper reporting by age group
2. Continue to recruit and train data clerks for gap filling to fill vacancies and continue carrying out internal data validation checks
3. Continue to carry out DQA assessment

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. Continue active participation in the roll-out of PMTCT option B+
2. Provide ongoing and more intensive quarterly mentorship to strengthen MSG activities

Program area 02-HVAB (Abstinence and Be Faithful)

1. Provision of appropriate print and electronic BCC materials and job aids produced by the program and collected from partners
2. Ongoing regional and onsite support to care & support and NNPWE volunteers

Program area 03-HVOP (Other Prevention)

1. Follow up training on IPPS at health center managerial level

Program area 08-HBHC (Adult Care and Support)

1. Provide gap filling training for volunteers
2. NNPWE communities volunteers continue to provide HH visits in accordance with NGI requirements
3. Continue to work with woreda health offices and health centers, including ongoing support to monthly PHU meetings with expanded community representation for monitoring and strengthening the bidirectional closed loop referral system

Program area 09-HTXS (Adult Treatment)

1. Provide regular team-based mentorship to all ART sites
2. Conduct activity reporting meeting and case presentations at the end of each month at each field office
3. Continue partnership with regional associations of the National Network of Networks of HIV Positives in Ethiopia, to strengthen referral linkage between heath centers and their area hospital.

Program area 10-HVTB (TB/HIV)

1. Provide formal TB and TB/ HIV training to health care workers
2. Collaborate with HEAL TB, who will upgrade program mentors on MDR TB, to strengthen their support to HCs for its diagnosis and referral.

Program area 12-HVCT (Voluntary Counseling and Testing)

1. Continue to have mentors support PITC at key health center clinics, and monitor and report stock outs of RTKs

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
3. Actively support the FMOH to roll out an expected national pediatric HIV accelerated plan.

Program area 14-PDCS (Pediatric Care & Support)

1. Same as above

Program area 16-HLAB (Laboratory Infrastructure)

1. Provide laboratory mentorship focusing on filling identified technical and logistics gaps
2. Identify and provide focused mentorship to potential hub testing HC laboratories

Program area 17-HVSI (Strategic Information)

1. Train and refresher train program staff on M&E and SI system
2. Conduct RDQA and KDQA
3. Conduct and analyze SOC assessment
4. Provision of gap filling printing of HMIS tools to HCs

Program area 18-OHSS (Health Systems Strengthening)

1. Support RHBs to conduct regional and zonal catchment area review meetings
2. Support RHBs to conduct joint supportive supervision
3. Graduate government mentors in collaboration with the RHBs
4. Expand government mentorship at selected woredas
5. New and gap filling trainings
6. Support health center led monthly PHU review meetings, including a focus on health center and community referral and linkages
7. Complete the analysis of gender validation exercise data and initiate implementation of a health center MDT gender mainstreaming checklist guide.
8. Continue to support health centers participating in piloted integration of mental health services within the HIV clinic
9. Support the RHBs to meet the deliverables in their cooperative agreements with CDC, in such areas as mentorship, HIV centered training, and reporting on the PEPFAR NGIs,
10. Support NNPWE to assume responsibility for mother mentors with an MSG at program supported health centers
11. Support regional NEP+ associations to assume responsibility of case management at program supported health centers

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

ENHAT-CS environmental compliance focuses on infection preventions (IP), patient safety and health care waste disposal management. As noted in the above narrative in section 03-HVOP, the program is actively participating in the TWG on IP/PS, chaired by the Medical Services Directorate (FMOH). Infection Prevention and Patient Safety (IP/PS) as well as Environmental Compliance activities during the quarter included:

Participation in national Advisory Technical Working Group (ATWG) on IP/PS and other related activities: ENHAT-CS chaired by Director of Medical Service (FMOH). ENHAT – CS was actively involved, with the following achievements supported:

- A national IP/PS training reference manual for health program managers was circulated to ENHAT–CS program and technical managers
- The IP/PS management training timeline discussed with RHBs in both regions and agreed a schedule for August 2013
- A national IP/PS commodities quantification assessment finalized and submitted to MSD and PFSA for approval in a validation workshop

Participation in Environmental Compliance and Environmentally Sound Design and Management training: The USAID/Ethiopia Mission sponsored training on Environmental Compliance and Environmentally Sound Design and Management, which was conducted in Adama, in December 2012. The training conducted by the US-based Global Environmental Management Support Project (GEMS). The workshop targeted participants from USAID implementing partners working in environment-related projects. ENHAT-CS clinical and prevention advisors participated in the training.

Waste management and disposal: 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 environmental data is to be entered on a quarterly basis into an online database, allowing the program to report on health center's compliance with these environmental safety procedures and in Q4, the tool was updated and used at health centerss in all the clinics including HIV, TB, ANC/PMTCT, L&D, Lab, VCT, OPD, Emergency OPD, FP,EPI and under 5 clnics. The following compliance was reported:

- 98% of health centers routinely oriented their staff on risks and hazards of health care waste and on appropriate waste management procedures including waste minimization, segregation, handling, collecting and storage, transportation, disposal and treatment of waste products
- Storage/disposal of sharps
    - 90% of clinics used sharps boxes, with the remaining using waste bins
    - 72% of health centers incinerated, and 15% burned them
- Storage/disposal of non-infected solid waste
    - 76% of clinics used open waste bins, of which 18% were covered but only 7% labeled for safe differentiation
    - 64% of health centers burned and 16% incinerated it
- Storage/disposal of stored contaminated solid waste (gloves, gauze, etc.)
    - 68% of clinics used open waste bins,of which 23% were covered but only 9% labeled for safe differentiation
    - 53% of health centers burned and 28% incinerated it

- Disposal of highly infectious (anatomical and pathological waste
  - 72% of health centers buried, 3% burned, and 4% incinerated it
- Disposal of liquid waste
  - 46% of health centers used a septic tank, 22% buried it in a pit,16% put it in open pit and 6% used an open field
- Staff IP
  - 95% of L&D wards and 82% of emergency OPD used surgical gloves during delivery and treatment
  - 89% of cleaners used utility gloves, 45% aprons, 54% plastic boots, 39% masks and 15% caps

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

1. The GOE has expressed reluctance to allow mother mentors to receive a stipend, incorrectly labeling them as community based volunteers, similar to their health development army women volunteers. USAID needs to facilitate a better understanding of the role of health center based MSG mother mentors, which is actually similar to the health center based case manager.
2. Procurement of reagent for DNA-PCR may need intervention at the higher level

11. Financial accomplishment (in USD)

Life of Project budget (a)	Obligated to date (b)	Expenditure (Accrual and actual disbursement) to date (c)	Remaining balance (d) = (b) – (c)	Remarks
$40,992,055	$24,801,141	$16,672,969	$8,128,172	MSH has been informally notified that the LOP budget will be reduced to the currently obligated amount of $24,801,141

Annexes

Trip reports (see section 3. Technical Assistance, for list of reports)

Publications (see section 2. Publications and reports, for list of publications)

ENHAT-CS PERFORMANCE INDICATOR TABLE (FY13) APR (submitted 21 Oct'13)

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)						COMMENTS
					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
1	P1.1.D	Number of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	125,484	188,232	139,021	74%	152,923	39,198	45,116	47,738	41,004	173,056	113%	Cumulative result fully on target.
		Known positives at entry	1,564		2,129	NA	2,187	572	525	548	591	2,236		**Note**: results are from 217 of 276 supported HCs, as have excluded 59 HCs joiintly supported with the USAID CPMTCT project
		No. of new positives identified	2,382		1,833	NA	1,789	371	377	473	368	1,589		
2	P1.2.D	Percent of HIV-infected pregnant women who received antiretrovirals to reduce risk of mother-to-child-transmission	45%	See below	64%		70%	84%	85%	74%	89%	83%	118%	Non-cumulative (variable percent) result fully on target.
		Numerator: Number of HIV-infected pregnant women who received antiretrovirals to reduce risk of mother-to-child transmission	1,787	1,671	2,535	152%	2,783	790	767	754	853	3,164		
		By regimen type: Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	487		1,329	NA	1,670	512	459	511	838	2,320		
		By regimen type: Maternal AZT	1,166		1,204	NA	1,113	278	308	243	15	844		
		By regimen type: Single Dose Nevirapine (SD-NVP)	98		2	NA	0	0	0	0	0	0		
		Denominator: Number of HIV-infected pregnant women identified in the reporting period (including known HIV-positive at entry)	3,946		3,962	0	3,976	943	902	1,021	959	3,825		
3	P1.3.D	Number of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	154	206	191	93%	217	191	217	217	217	217	100%	Cumulative result fully on target
4	Non-NGI	Number of pregnant women who were seen by skilled provider (trained on MNCH/PMTCT)	131,575	137,897	143,612	104%	157,973	39,939	45,898	48,983	42,729	177,549	112%	Cumulative result fully on target
5	P1.4.D	Number of HIV positive pregnant women assessed for ART eligibility through clinical staging (using WHO clinical staging criteria) or CD4 testing	1,095	1,148	1,318	115%	1,342	294	344	350	348	1,336	100%	Cumulative result fully on target
6	P1.5.D	Number of HIV positive pregnant women newly enrolled into HIV care and support services	1,095	1,148	1,318	115%	1,342	294	344	350	348	1,336	100%	Cumulative result fully on target
7	P1.6.D	Percentage of HIV/AIDS exposed infants by feeding type		No targets specified for indicator			No targets specified for indicator						No targets specified for indicator	
		Exclusive breastfeeding	Not available		93%	NA		88%	94%	94%	91%	91%		
		Exclusive formula feeding	" "		4%	NA		8%	3%	4%	6%	6%		
		Mixed feeding	" "		3%	NA		4%	3%	2%	3%	3%		
8	H2.3.D	Number of health care workers who successfully completed an in-service training program	Not applicable	2,500	2,653	106%	1,790	514	338	1,243	1,764	3,859	216%	Cumulative result fully on target
	Non-NGI	Pediatric treatment	" "	181	255	141%	322	134	84	107	117	442		
		ANC/PMTCT	" "	134	284	212%	0	27	0	247	132	406		Includes unplanned training of HCPs on B+
		CT	" "	108	102	94%	181	0	44	61	39	144		
		Adult ART treatment	" "	273	255	93%	321	134	84	107	117	442		
		TB/HIV co-infection management	" "	81	91	112%	111	36	37	20	0	93		
		Laboratory related activities	" "	98	230	235%	235	37	89	71	112	309		
		Other	" "	1,625	1,436	88%	620	146	0	630	1,247	2,023		Data clerks (254), GOE mentorship (172), pediatric psycho-social care (29), IP/PEP (344), NNPWE volunteers (348), religious leaders (289), MSG site coordinators (64), mental health (96), woreda/zonal officers (380), leadership and management dev. (47)
9	P8.1.D	Number of the targeted population reached with individual and/or small group level preventive interventions that are based on evidence and/or meet the minimum standards required	Not applicable	50,000	22,310	45%	21,000	6,654	9,007	4,798	3,333	23,792	113%	Cumulative result fully on target.
		By sex: Male	" "		8,582	NA		3,361	5,509	2,314	1,634	12,818		**Note**: while determination of the target for P8.1.D did not include P8.2.D, its results have been included to ensure consistency with the NGI guideline.
		By sex: Female	" "		13,728	NA		3,293	3,498	2,484	1,699	10,974		
		By Age: 10-14,			7,350			2,739	3,015	1,896	1,326	8,976		
		By Age: <15			14,960			3,915	5,992	2,902	2,007	14,816		
10	P8.2.D	Number of the targeted population 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	Not applicable	7,875	4,091	52%	8,400	2,739	3,015	1,896	1,326	8,976	107%	Cumulative result fully on target
11	P9.1.D	Number of service outlets providing counseling and testing according to national and international standards.	154	206	205	100%	276	206	276	276	276	276	100%	Cumulative result fully on target

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)						COMMENTS
					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
12	P11.1.D	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results	1,260,829	1,271,927	1,362,250	107%	1,558,877	323,428	424,100	474,319	367,965	1,589,812	102%	Cumulative result fully on target
		By sex: Male	535,023		597,149			137,573	181,664	205,013	150,324	674,574		
		By sex: Female	725,806		765,101			185,855	242,436	269,306	217,641	915,238		
		By age/sex: <15 (Male)	Not available		49,218	NA		15,711	18,180	19,208	17,746	70,845		
		By age/sex: <15 (Female)	" "		45,362	NA		14,091	16,122	17,717	16,154	64,084		
		By age/sex: 15+ (Male)	Not available		547,931	NA		121,862	163,484	185,805	132,578	603,729		
		By age/sex: 15+ (Female)			719,739			171,764	226,314	251,589	201,487	851,154		
		By age: <15	97,584		94,580			29,802	34,302	36,925	33,900	134,929		
		By age: 15+	1,163,245		1,267,670			293,626	389,798	437,394	334,065	1,454,883		
		Negative	1,207,560		1,342,792			319,637	419,814	469,794	364,357	1,573,602		
		Positive	22,902		19,458	NA		3,791	4,286	4,525	3,608	16,210		
13	Non-NGI	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their test results (by type of counseling/test)	1,260,829	1,271,927	1,362,250	107%	1,558,877	323,428	424,100	474,319	367,965	1,589,812	102%	Cumulative result fully on target
		Individual	Not available		976,834	NA		302,836	378,125	426,383	342,716	1,450,060		
		Couple	" "		96,501	NA		20,592	45,975	47,936	25,249	139,752		
		VCT	535,024		482,276	NA		94,120	150,746	168,300	97,309	510,475		
		PITC	725,805		879,974	NA		229,308	273,354	306,019	270,656	1,079,337		
14	P6.1.D	Number of Persons provided with post-exposure prophylaxis (PEP)	596	345	416	121%	444	130	82	108	102	422	95%	Cumulative result on target
		By exposure type: Occupational	177		197	NA		64	27	43	37	171		
		By exposure type: Rape/Sexual Assault Victims	95		105	NA		34	29	21	21	105		
		By exposure type: Other Non-Occupational	70		114	NA		32	26	44	44	146		
15	C1.1.D	Number of eligible adults and children provided with a minimum of one care service	55,895	85,457	85,284	100%	96,344	75,511	97,045	81,967	114,554	124,255	129%	Cumulative result fully on target
		By sex: Male	20,852		32,033			29,015	37,239	31,697	44,028	47,838		**Note**: each quarter's data presents total number of patients who visited in the quarter. However, the total only calculates the patients first annual visit, with repeat visits not
		By sex: Female	35,043		53,251			46,496	59,806	50,270	70,526	76,417		
		By age/sex: <18 (Male)	Not available		5,341	NA		5,852	9,345	5,913	11,940	12,994		
		By age/sex: <18 (Female)	" "		5,441	NA		5,587	9,397	6,248	12,064	13,145		
		By age/sex: 18+ (Male)	Not available		26,692	NA		23,163	27,894	25,784	32,088	34,844		
		By age/sex: 18+ (Female)	" "		47,810			40,909	50,409	44,022	58,462	63,272		
		By age: <18	2,695		10,782			11,439	18,742	12,161	24,004	26,139		
		By age: 18+	53,200		74,502	NA		64,072	78,303	69,806	90,550	98,116		
16	C5.1.D	Number of eligible clients who received food and/or other nutrition services	4,724	5,043	5,134	102%	5,740	1,276	1,380	1,471	2,108	6,235	109%	Cumulative result fully on target
		By age: <18	581		649	NA		133	119	216	183	651		Note: of the total of 4,172 patients receiving services, 1,991(including 439 pregnant/ lactating women) are from 112 HCs supported by the USAID FBP project. In Q3, a total of 1,049 (including 121 pregnant/ lactating women) were from these HCs.
		By age: 18+	4,143		4,485	NA		1,143	1,261	1,255	1,925	5,584		
		Pregnant/lactating women	1,652		1,665	NA		368	455	289	457	1,569		
17	C2.1.D	Number of HIV-positive adults and children receiving a minimum of one clinical service	55,895	58,007	64,313	111%	71,899	60,466	66,079	71,068	80,329	78,202	109%	Cumulative result fully on target.
		By sex: Male	20,852		24,068			22,631	24,634	27,344	28,731	29,172		**Note**: each quarter's data presents total number of patients who visited in the quarter. However, the yearly total only calculates the patients first annual visit, with their repeat
		By sex: Female	35,043		40,245			37,835	41,445	43,724	51,598	49,030		
		By age/sex: <15 (Male)	Not available		1,868	NA		1,713	1,857	2,525	2,791	2,114		
		By age/sex: <15 (Female)	" "		1,696	NA		1,487	1,647	2,551	3,132	1,890		
		By age/sex: 15+ (Male)	" "		22,200			20,918	22,777	24,819	25,940	27,058		
		By age/sex: 15+ (Female)	" "		38,549			36,348	39,798	41,173	48,466	47,140		
		By age: <15	2,695		3,564			3,200	3,504	5,076	5,923	4,004		
		By age: 15+	53,200		60,749			57,266	62,575	65,992	74,406	74,198		
		By age/sex: 15-17 (Male)	Not available		933			1,041	1,086	1,071	1,217	1,313		
		By age/sex: 15-17 (Female)	" "		1,543			1,059	1,124	1,295	1,609	1,365		
		By age/sex: 18+ (Male)	" "		21,267	NA		19,877	21,691	23,748	24,723	25,745		
		By age/sex: 18+ (Female)	" "		37,006	NA		35,289	38,674	39,878	46,857	45,775		
18	C2.2.D	Percent of HIV-positive persons receiving cotrimoxazole prophylaxis (program coverage)	51%	See below	56%	80%	56%	56%	56%	57%	54%	56%	100%	Non-cumulative (variable percent) result fully on target
		Numerator: Number of HIV-positive persons receiving cotrimoxazole prophylaxis	28,292	40,604	36,038	89%	39,500	34,052	37,287	40,652	43,405	43,405		
		By age: <15			3,939			2,630	2,858	3,151	3,369	3,369		
		By age: 15+			32,099			31,422	34,429	37,501	40,036	40,036		
		Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)	55,895	58,007	64,313	1	71,899	60,466	66,079	71,068	80,329	78,202		
		By age: <15	2,891		3,564	NA		3,200	3,504	5,076	5,923	4,004		
		By age: 15+	25,401		60,749	NA		57,266	62,575	65,992	74,406	74,198		

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)						COMMENTS
					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
19	C4.1.D	Percent of infants born to HIV-positive women who received an HIV test within 12 months of birth	52%	See below	46%	46%	70%	70%	63%	42%	80%	63%	90%	Non-cumulative (variable percent) result moderately on target
		Numerator: Number of infants who received an HIV test within 12 months of birth during the reporting period	2,039	960	1,805		2,800	658	565	433	768	2,424		Shortage of DBS reagents a contributing factor
		Infants who received virological test in the first 2 months	993		945		1,500	434	380	290	542	1,646		
		Infants who were tested virologically for the first time between 2 and 12 months or who had an antibody test between 9 and 12 months	1,046		860		1,300	224	185	143	226	778		
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry) [P1.1.D)	3,946		3,962		3,976	943	902	1,021	959	3,825		
20	C4.2.D	Percent of infants born to HIV-positive women who are started on CTZ prophylaxis within two months of birth	1,905	No target specified for indicator	62%	NA	No target specified for indicator	74%	61%	57%	68%	65%	No target specified for indicator	
		Numerator: Number of infants to HIV-positive women who are started on CTZ prophylaxis within two months of birth			2,465			698	548	584	651	2,481		
		Denominator: Number of HIV-positive pregnant women identified in the reporting period (including known HIV-positive at entry) [P1.1.D)			3,962		3,976	943	902	1,021	959	3,825		
21	T1.1.D	Number of adults and children with advanced HIV infection newly enrolled on ART	11,311	10,824	11,668	108%	13,044	3,044	3,330	5,168	5,136	16,678	128%	Cumulative result fully on target
		By sex: Male	4,333		4,455	NA	4,971	1,128	1,174	1,692	1,518	5,512		
		By sex: Female	6,978		7,213	NA	8,073	1,916	2,156	3,476	3,618	11,166		
		By age/sex: <15 (Male)	459		478		533	114	105	155	181	555		
		By age/sex: <15 (Female)	423		424		496	130	120	160	142	552		
		By age/sex: 15+ (Male)	3,888		3,977		4,438	1,014	1,069	1,537	1,337	4,957		
		By age/sex: 15+ (Female)	6,621		6,789		7,577	1,786	2,036	3,316	3,476	10,614		
		By age: <1	53		51	NA	57	9	14	18	15	56		
		Pregnant Women	375		424		474	114	135	193	621	1,063		
22	T1.2.D	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	45,071	50,344	56,694	113%	69,738	59,079	61,896	66,238	71,007	71,007	102%	Non-cumulative (current) result fully on target
		By sex: Total Male	17,107		21,324	NA	26,292	22,071	22,960	24,239	25,580	25,580		
		By sex: Total Female	27,964		35,370	NA	43,446	37,008	38,936	41,999	45,427	45,427		
		By age/sex: <15 (Male)	1,141		1,610		2,142	1,656	1,770	1,856	1,979	1,979		
		By age/sex: <15 (Female)	956		1,341		1,843	1,430	1,521	1,621	1,677	1,677		
		By age/sex: 15+ (Male)	15,966		19,714		24,150	20,415	21,190	22,383	23,601	23,601		
		By age/sex: 15+ (Female)	27,008		34,029		41,603	35,578	37,415	40,378	43,750	43,750		
		By age: <1	42		58	NA	71	66	96	90	80	80		
		Pregnant Women	240		440	NA	484	423	533	639	967	967		
		Percent children with advanced HIV infection receiving antiretroviral therapy (ART) [Current]	5%		5.2%	NA	5.7%	5.2%	5.3%	5.2%	5.1%	5.1%	90%	Non-cumulative (variable percent) result moderately on target
		Percent women and girls with advanced HIV infection receiving antiretroviral therapy (ART) [Current]	62%		62%	NA	62%	63%	63%	63%	64%	64%	103%	Non-cumulative (variable percent) result fully on target
23	Non-NGI	Number of ART clients transferred into the health center	2,434	No targets specified for indicator	4,394	NA	No targets specified for indicator	1,185	992	2,153	2,154	6,484	No targets specified for indicator	
24	T1.3.D	Percent of adults and children known to be alive and on treatment 12months after initiation of ART	82%	80%	83%	103%	85%	85%	87%	87%	86%	86%	101%	Non-cumulative (variable percent) result fully on target
		Numerator: Number of adults and children who are still alive and on treatment at 12 months after initiating ART			9,860		9,934	2,432	2,576	2,548	2,628	10,184		
		By sex: Male	78%		3,701	NA	3,974	906	910	925	986	3,727		
		By sex: Female	84%		6,159	NA	5,960	1,526	1,666	1,623	1,642	6,457		
		By age: <15	85%		792	NA	795	195	187	213	224	819		
		By age: 15+	82%		9,068	NA	9,139	2,237	2,389	2,335	2,404	9,365		
		Denominator: Total number of adults and children who initiated ART in the 12 months prior to the beginning of the reporting period, including those who have died, those who have stopped ART, and those lost to follow-up.			11,924		11,688	2,846	2,978	2,924	3,059	11,807		
25	T1.4.D	Number of adults and children with advanced HIV infection who ever started on ART (EVER STARTED)	48,221		59,889	NA	No targets specified for indicator	62,933	66,263	71,431	76,567	76,567	No targets specified for indicator	
		By sex: Male	18,585		23,040	NA		24,168	25,342	27,034	28,552	28,552		
		By sex: Female	29,636		36,849	NA		38,765	40,921	44,397	48,015	48,015		
		By age: <15	1,948		2,850	NA		3,094	3,319	3,634	3,957	3,957		
		By age: 15+	46,273		57,039	NA		59,839	62,944	67,797	72,610	72,610		
26	T1.5.D	Number of health facilities that offer ART	154	206	206	100.0%	276	206	276	276	276	276	100%	Cumulative result fully on target
27	H1.1.D	Number of testing facilities (laboratories) with capacity to perform laboratory tests	206	206	206	100.0%	276	206	276	276	276	276	100%	Cumulative result fully on target
28	Non-NGI	Number of DBS/DNA-PCR tests performed (samples taken at HC) or referred for EID of HEIs	2,039	2,177	2,656	122%	3,102	814	644	705	805	2,968	96%	Cumulative result on target
	Non-NGI	Of those who are enrolled in ART but are not currently on ART, what proportion:		No target specified for indicator			No targets specified for indicator						No targets specified for indicator	
		Number of ART clients who died	Cumulative measure											

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					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
29		*overall*	5,351 (11.6%)		10.2%	NA		10.6%	10.6%	10.5%	10.3%	10.3%		
		at 6 months	Not available		5.6%	NA		5.2%	5.6%	4.6%	4.2%	5.1%		
		at 12 months	" "		7.4%	NA		7.4%	6.1%	6.9%	6.5%	6.7%		
		at 24 months	" "		8.3%	NA		8.2%	8.7%	9.2%	9.3%	8.9%		
		Number of ART clients who stopped therapy	Current measure											
		overall	84 (0.2%)		0.2%	NA		0.2%	0.0%	0.3%	0.2%	0.2%		
		at 6 months	Not available		3.0%	NA		0.4%	0.8%	0.1%	0.1%	0.4%		
		at 12 months	" "		0.9%	NA		0.6%	1.3%	0.5%	1.2%	0.9%		
		at 24 months	" "		0.9%	NA		0.8%	1.3%	0.9%	1.1%	1.0%		
		Number of ART clients transferred out												
		overall	7,952 (19%)		15.0%	NA		15.7%	16.0%	16.7%	17.4%	17.4%		
		at 6 months	Not available		6.3%	NA		4.7%	5.6%	5.9%	5.9%	6.6%		
		at 12 months	" "		9.9%	NA		10.8%	9.8%	9.6%	11.9%	10.5%		
		at 24 months	" "		12.1%	NA		12.4%	17.0%	18.2%	20.0%	18.0%		
		Number of ART clients lost to follow-up	Current measure											
		overall	9%		7.0%	NA		7.4%	7.4%	7.6%	7.2%	7.2%		
		at 6 months	Not available		4.2%	NA		4.4%	3.9%	4.7%	4.2%	4.3%		
		at 12 months	" "		7.4%	NA		6.6%	6.0%	5.4%	5.2%	5.8%		
		at 24 months	" "		7.6%	NA		8.1%	7.8%	8.7%	8.1%	8.2%		
30	**Non-NGI**	Of persons enrolled in care (i.e. both those receiving and not receiving ART), what proportion are in care and on ART at 12 months?	Not available	No target specified for indicator	83%	NA	No target specified for indicator	80%	82%	81%	82%	81%	No target specified for indicator	
31	**Non-NGI**	Contraceptive acceptance rate among eligible HIV+ women	Not available	No target specified for indicator	27%	NA	No target specified for indicator	27%	23%	24%	27%	27%	No target specified for indicator	
		New	" "		7%	NA		7%	6%	7%	8%	8%		
		Repeat	" "		20%	NA		20%	17%	17%	18%	18%		
32	**Non-NGI**	Number of all referrals made and documented for HIV/AIDS related services	Not applicable	No target specified for indicator	4,814	NA	No target specified for indicator	1,317	1,262	1,632	1,930	6,141	No target specified for indicator	
		Number of referrals made by health providers inter-facility for HIV/AIDS related services	" "		1,463	NA		402	368	425	438	1,633		
		Number of referrals made by health providers to health posts/HEW for HIV/AIDS-related services	" "		2,117	NA		715	616	890	1,060	3,281		
		Number of individuals referred to health center from community	" "		1,234	NA		200	278	317	432	1,227		
33	**Non-NGI**	Number of HIV-positive patients referred for visceral leishmaniasis treatment (in endemic areas only)	Not available	No target specified for indicator	20	NA	No target specified for indicator	5	3	3	0	11	No target specified for indicator	
		By sex: Male	" "		9	NA		4	2	2	0	8		
		By sex: Female	" "		11			1	1	1	0	3		
		By age/sex: <15 (Male)	" "		0	NA		0	1		0	1		
		By age/sex: <15 (Female)	" "		0			0	0		0	0		
		By age/sex: 15+ (Male)	" "		9	NA		4	1	2	0	7		
		By age/sex: 15+ (Female)	" "		11	NA		1	1	1	0	3		
34	**Non-NGI**	Number of HIV-positive patients diagnosed with onchocerciasis who started treatment for onchocerciasis (in endemic areas only)	Not available	No target specified for indicator	1	NA	No target specified for indicator	0	0	0	0	0	No target specified for indicator	Carter Center is supporting Government to carry out community mass treatment exercises in endemic areas, resulting in no demand at HCs
		By sex: Male	" "		1	NA		0	0	0	0	0		
		By sex: Female	" "		0			0	0	0	0	0		
		By age/sex: <15 (Male)	" "		0	NA		0	0	0	0	0		
		By age/sex: <15 (Female)	" "		0			0	0	0	0	0		
		By age/sex: 15+ (Male)	" "		1	NA		0	0	0	0	0		
		By age/sex: 15+ (Female)	" "		0	NA		0	0	0	0	0		

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)						COMMENTS
					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
35	Non-NGI	Number of HIV-positive patients diagnosed with STI who were treated for STI	Not available	No target specified for indicator	509	NA	No target specified for indicator	385	342	362	261	965	No target specified for indicator	
		By sex: Male	" "		162	NA		100	99	91	53	243		
		By sex: Female	" "		347			285	243	271	208	722		
		By age/sex: <15 (Male)	" "		3	NA		0	4	0	0	4		
		By age/sex: <15 (Female)	" "		6	NA		2	5	1	3	9		
		By age/sex: 15+ (Male)	" "		159	NA		100	95	91	53	239		
		By age/sex: 15+ (Female)	" "		341	NA		283	238	270	205	713		
36	H2.2.D	Number of community health and para-social workers who successfully completed a **pre-service** training program within the reporting period	Not applicable	1,076	973	90%	253	53	236	188	419	896	354%	Cumulative result fully on target
		By sex: Male	" "		431	NA	112	21	99	71	266	457		Data clerks (115), case managers (93), NNPWE volunteers (79), communithy referrral network mobilizers (115), mother mentors (150), religious leaders (344)
		By sex: Female	" "		542	NA	141	32	137	117	153	439		
37	P7.1.D	Number of People Living with HIV/AIDS (PLHIV) reached with a minimum package of Prevention with PLHIV (PwP) interventions (HC total only)	53,200	51,661	60,749	118%	70,952	41,513	5,309	6,209	6,685	59,716	84%	Cumulative result moderately below target
		By facility: Clinic/Facility-based		Same as above	60,749		70,952	41,513	5,309	6,209	6,685	59,716		
		By facility: Community/Home-based		Not applicable										
38	Non-NGI	Number of health facilities providing TB treatment for HIV infected individuals	154	206	206	100%	276	206	276	276	276	276	100%	Non-cumulative (current) result fully on target
39	C2.4.D	Percent of HIV-positive patients who were screened for TB in HIV care or treatment settings	99%	96%	96%	100%	92%	82%	95%	79%	72%	80%	87%	Non-cumulative (variable percent) result moderately below target
		Numerator: Number of HIV-positive patients who were screened for TB in HIV care or treatment settings (subset of C2.1.D)	55,386	55,686	61,881	1	66,147	49,748	62,691	56,304	57,475	62,687		
		By sex: Male			24,065		No target specified for indicator	18,247	22,600	20,007	19,915	22,764		
		By sex: Female			37,816		No target specified for indicator	31,501	40,091	36,297	37,560	39,923		
		Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)	55,895	58,007	64,313	1	71,899	60,466	66,079	71,068	80,329	78,202		
		By sex: Male	20,726		24,068	NA		22,631	24,634	27,344	28,731	29,172		
		By sex: Female	34,660		40,245	NA		37,835	41,445	43,724	51,598	49,030		
40	C2.5.D	TB/HIV: Number (percent) of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	1.7%	2.3%	2.1%	90.7%	2.1%	0.4%	0.3%	0.5%	0.5%	1.5%	73%	Non-cumulative (variable percent) result moderately below target
		Numerator: Number of HIV-positive patients in HIV care or treatment (pre-ART or ART) who started TB treatment	933	1,352	1,360	101%	1,510	242	221	356	378	1,196		**Note**: starting in Q3, the result is the sum of: 1) at HIV clinic, those sceened for TB at HIV clinic and found AFB postive and those found AFB negative but then diagnosed TB positve through referral, 2) at TB clinic, 80% of TB clinic known HIV+ patients at entry referred from different service outlets within the HC, and those testing HIV+
		By sex: Male	423		664			110	110	175	208	602		
		By sex: Female	510		696			132	111	181	170	594		
		Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)	55,895	58,007	64,313	1	71,899	60,466	66,079	71,068	80,329	78,202		
		By sex: Male	423		24,068			22,631	24,634	27,344	28,731	29,172		
		By sex: Female	510		40,245			37,835	41,445	43,724	51,598	49,030		
41	C3.1.D	TB/HIV: Number TB patients who had an HIV test result recorded in the TB register	15,832	No target specified for indicator	12,603	NA	No target specified for indicator	3,225	3,597	3,944	3,702	14,468	No target specified for indicator	
		By sex: Male	8,314		6,774	NA		1,738	1,964	2,098	2,023	7,823		
		By sex: Female	7,518		5,829	NA		1,487	1,633	1,846	1,679	6,645		
42	C2.6.D	TB/HIV: Number of eligible HIV-positive patients starting Isoniazid Preventative Therapy (IPT)	7,336	No target specified for indicator	6,076	NA	No target specified for indicator	774	18	6	88	886	No target specified for indicator	
		By sex: Male	2,677		2,236	NA		295	7	3	36	341		
		By sex: Female	4,659		3,840	NA		479	11	3	52	545		
43	Non-NGI	Number of health facilities with capacity for malaria parasite diagnosis and has performed diagnosis in past 3 months	Not available	No target specified for indicator	149	NA	No target specified for indicator	185	185	242	242	242	No target specified for indicator	

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)						COMMENTS
					Total (FY12)	% Target Achieved		Q1 (Oct-Dec'12)	Q2 (Jan-Mar'13)	Q3 (Apr-Jun'13)	Q 4 (Jul-Sept13)	Total (FY13)	% Target Achieved	
44	Non-NGI	Number of HIV-positive patients diagnosed with malaria who were treated for malaria	Not available	No target specified for indicator	118	NA	No target specified for indicator	749	650	440	416	2,255	No target specified for indicator	
		By sex: Male	" "		67	NA		278	245	172	156	851		
		By sex: Female	" "		51			471	405	268	260	1,404		
		By age/sex: <15 (Male)	" "		23	NA		30	33	23	23	109		
		By age/sex: <15 (Female)	" "		5			32	28	24	9	93		
		By age/sex: 15+ (Male)	" "		44	NA		248	212	149	133	742		
		By age/sex: 15+ (Female)	" "		46	NA		439	377	244	251	1,311		
45	Non-NGI	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Not applicable	11	11	100%	11	11	11	11	11	11	100%	Cumulative result fully on target
46	Non-NGI	Number of data centers/delivery points established	Not applicable	Not included in PY1 work plan	0	Not included in PY	1	0	0	0	0	0	N/A	Establishment of data center planned after completion of RHB/regional university OR dissemination workshops in early FY14
47	Non-NGI	Number of local universities involved in the generation and communication of M&E/OR evidence	Not applicable	2	3	150%	3	3	3	3	3	3	100%	Cumulative result fully on target