

ENHAT- CS Annual Progress Report FY14

ENHAT-CS Team

October 2013 – September 2014

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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)*

**PROGRESS REPORT
APR'14**

(OCTOBER 2013 –SEPTEMBER 2014)

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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
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
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
DHEA	Dawn of Hope Ethiopia Association
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
FHAPCO	Federal HIV/AIDS Prevention and Control Office
FMOH	Federal Ministry of Health
FP	Family planning
FY	Financial year
GOE	Government of Ethiopia
HAPCO	HIV/AIDS Prevention and Control Office
HBC	Home-based care
HC	Health center
ENHAT-CS	HIV/AIDS Care and Support Program
HCP	Health Care Provider
HCT	HIV counseling and testing
HEI	HIV-exposed infants
HEW	Health extension worker
HgB	Hemoglobin
HIV	Human immune deficiency virus
HMIS	Health management information system
IAS	International AIDS Society
IGA	Income generating activity
IP	Infection prevention
IPT	Isoniazid preventive therapy
JPM	Joint pediatrics mentorship
L&D	Labor and delivery
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
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
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
TOT	Training of trainers
TWG	Technical working group
USAID	United States Agency for International Development
VCT	Voluntary counseling and testing
WAD	World AIDS Day
WBC	White blood cells
WHO/AFRO	World Health Organization/ Africa Regional Office
WVI	World Vision International

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I. Reporting period

From: 1 October 2013	To: 30 September 2014
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2. Publications/reports

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

No/Not Applicable

Yes If yes, please list below: XIX International Aids Society Conference,

Publications/Reports/Assessments/Curriculum

Oct – Dec'13

Title	Author	Date
Libona (newspaper)	Dawn of Hope Ethiopia Association	Monthly publication
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	American Public Health Association (APHA) Annual Meeting, Boston, USA, 2-6 November 2013 (poster presentation)
Rising pregnancy rates among known HIV-positive women in at health centers in Addis Ababa, Ethiopia	Solomon Sisay, Serkalem Girma, Tesfaye Arega, Legesse Alemayehu, Bud Crandall, Elke Konings	American Public Health Association (APHA) Annual Meeting, Boston, USA, 2-6 November 2013 (poster presentation) International Conference on Family Planning, Addis Ababa, Ethiopia, 12-15 Nov'13
Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia	Nelia Matinhure, Bedria Mohamed, Gebre Mekonnen, Demlie Belete and Zewdu Zegeye	17 th International Conference on AIDS and STIs in Africa (ICASA), Cape Town, South Africa, 7-11 Dec'13 (poster presentation)
Test and Treat is Feasible for Resource Poor Countries in Africa	Fred Hartman,	17 th International Conference on AIDS and STIs in Africa (ICASA), Cape Town, South Africa, 7-11 Dec'13 (poster presentation)

Jan – Mar'14

Title	Author	Date
Libona (newspaper)	Dawn of Hope Ethiopia Association	Monthly publication
ENHAT-CS Annual Performance Brief, Issue 4	ENHAT-CS	Annual program brief, Jan-14
Sexual behavior and vulnerability to HIV infection among seasonal migrant laborers in Metema District, Northwest Ethiopia	<u>Kassa Tiruneh</u>	EPHA 25 th Silver Jubilee Conference, Addis Ababa, 20-22 Feb-14 (oral presentation)
The case for a universal 'test and treat' approach for HIV in Ethiopia	<u>Tsegazeab Kahsu</u> ; Tesfaye Arega; Elke Konings; Bud Crandall; A. Frederick Hartman	EPHA 25 th Silver Jubilee Conference, Addis Ababa, 20-22 Feb-14 (oral presentation)
Pre-ART care retention in ENHAT-CS program supported HCs - secondary data analysis of pre-ART cohorts	Mulugeta Abuye, Jessica Liddell, Hussein Ismail, Elke Konings	EPHA 25 th Silver Jubilee Conference, Addis Ababa, 20-22 Feb-14 (poster presentation)
What happens to HIV-positive patients after they are screened for TB at public health centers in Ethiopia	<u>Hussein Ismail</u>	EPHA 25 th Silver Jubilee Conference, Addis Ababa, 20-22 Feb-14 (poster presentation)
Mother Mentor/Mother Support Group Strategy for Expansion of Peer Support for Mothers Living with HIV	ENHAT-CS	Program publication, 2014
Mother support groups improve uptake of HIV services among HIV-positive pregnant women	ENHAT-CS	Operations Research Brief, Mar-14

Apr-Jun'14

Title	Author	Date
Libona (newspaper)	Dawn of Hope Ethiopia Association	Monthly publication since June 2012

Jul-Sept'14

Universal "Test and Treat" for All HIV+ People in Ethiopia is Feasible	Harman F., Crandall B., Kahsu T., Konings E.,	142 American Public Health Association (APHA) Annual Meeting and Expo, New Orleans, USA, 15-19 November 2014 (poster presentation)
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3. Technical assistance

Did your organization utilize short-term technical assistance during the reporting period?

No/Not Applicable

Yes Please list below:

Consultants/TDYers

Oct – Dec'13

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	9 Oct-13	31 Oct-13	MSH	Technical support and program supervision
Dr. Elke Konings	12 Oct-13	21 Oct-13	MSH	M&E and OR

Apr-Jun'14

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Dr. Fred Hartman	11 Apr'14	24 Apr'14	MSH	Technical support and program supervision
Dr. Elke Konings	12 Apr'14	21 Apr'14	MSH	M&E and OR

Jul-Sep'14

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Maryanne O'brien	17 Jul-14	28 Jul-14	MSH	Communications support for development of program documentation
John Shin	14 Sep-14	28 Sep-14	MSH	PEPFAR Expenditure Analysis

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).

Oct-Dec'13

Name	Destination	Departure from Ethiopia	Return to Ethiopia	Host Organization	Purpose of the travel
Dr. Solomon Sisay	USA	29 Oct-13	10 Nov-13	APHA Annual Conference, MSH	Poster presentation and program presentation to MSH HQ
Tesfaye Arega	USA	29 Oct-13	10 Nov-13	APHA Annual Conference, MSH	Participation in conference and program presentation to MSH HQ
Nelia Matinure	South Africa	4 Dec-13	12 Dec-13	ICASA	Poster presentation: "Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia"

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

Oct -Dec'13

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
PMTCT TDY Team Visit to Ethiopia	2 Dec-13	13 Dec-13	ENHAT-CS Addis Central Office visit by Dr. B. Ryan Phelps	Pending

Jan-Mar'14

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
Adult Care and Treatment TDY from OGAC (Kerry Dierbert-OGAC, Tedd Ellerbrock-CDC, Tom Minor-USAID, Ahmet Saadani-CDC, Carol Langley-OGAC, Llana Lapido-Salaiz-USAID, Melissa Briggs-CDC)	17 Mar-14	24 Mar-14	Woleta, Bahir Dar and Han HCs of west Amhara (visited by Tedd Ellerbrock and Ilana Lapidis-Salaiz)	Pending

Jul-Sept'14

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
Field visit by US deputy ambassador for Ethiopia, accompanied by Dr Han Kang (USAID HIV and AIDS Team Leader), Dr Mesfin Tilaye (Health Network Program Advisor) deputy ambassador	14 Aug-14	15 Aug-14	Amhara RHB and Han HC	N/A
Field visit by USAID Ethiopia team to review partners' continuum of care services	17 Aug-14	26 Aug-14	Amhara RHB, Bahir Dar HC, Gondar HC, Tigray RHB, Kassech HC	Pending
Implementation of Site Improvement through Monitoring System (SIMS) tool	2 Sep-14	3 Sep-14	Debre Berhane HC, North Shoa, Amhara	Formal report provided
HC visit by HIV core team from Washington to meet and discuss with facility and community level service providers and their stakeholders as part of their development of 'HIV Care and Support Pathways' algorithm for program managers in Ethiopia	17 Sep-14	17 Sep-14	Debre Berhane HC, North Shoa, Amhara	

5. Activity

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

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

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

Development of national strategic plan for eMTCT of HIV (2013-2015): Ethiopia adopted a new strategic plan 2013-2015 for the elimination of mother-to-child transmission of HIV (eMTCT) in September 2013. The strategic plan takes into consideration the national HIV epidemiology, the latest global scientific evidence in HIV treatment and care, as well as a national MNCH/PMTCT bottleneck analysis. It builds on Ethiopia's accelerated plan for PMTCT, which was developed in 2012, and includes an aggressive expansion of ANC/PMTCT service coverage, as well as the adoption of option B+ for PMTCT, whereby all HIV-positive pregnant women receive ART for life, regardless of gestational age or clinical stage. ENHAT-CS has been a key Government partner in the development and launch of the national eMTCT strategy and Early Infant Diagnosis (EID) manual, and in rolling out option B+ at program-supported health centers (HCs) through training and on-site health center (HC) mentorship. By the end of this reporting period, all 276 program-supported HCs (including the HCs supported for PMTCT by the CPMTCT project) were implementing option B+.

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

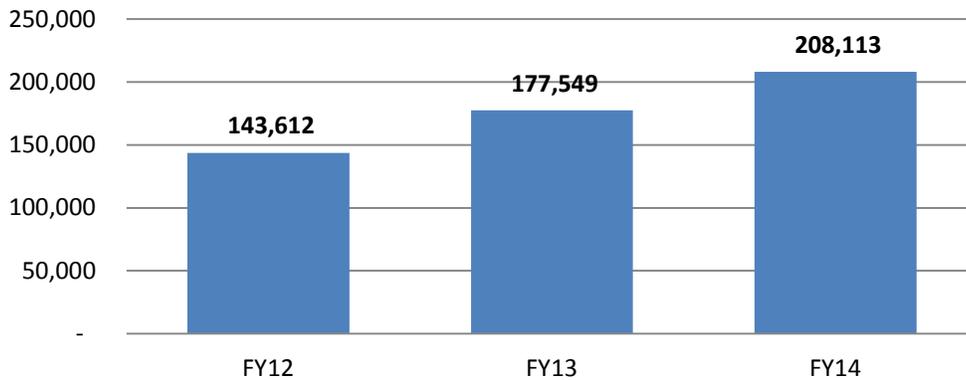
✓ **217 health centers (HCs) are providing PMTCT services (PI.3.D)**

Comment: ENHAT-CS reports PMTCT data from 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 (59 HCs). The FY14 result reflects 100% of the year's target.

✓ **208,113 pregnant women were seen by a skilled provider (trained on MNCH/PMTCT) (Non-MERs: 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 208,113 during the reporting period. This result exceeds the number of pregnant women seen at the same 217 program-supported HCs in FY13 by 17%. The average number seen per health center also rose to 959, up from 818 in FY13 and 697 in FY12. This 38% increase since FY12 is most likely a direct result of both the Government's and the program's strong emphasis on demand creation for and strengthened quality of maternal and child health services.

Number of pregnant women seen by a skilled ANC provider



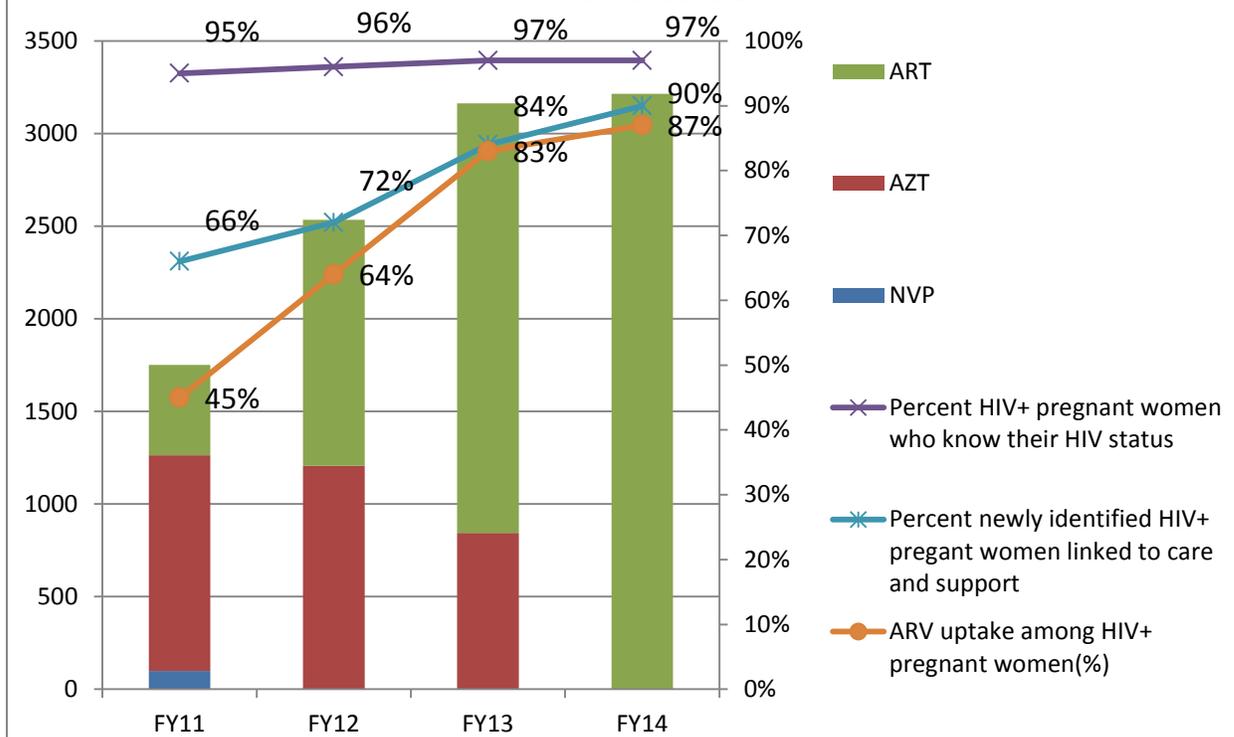
✓ **201,484 pregnant women had their HIV status known (P.I.D) of whom 1.8% (3,706) were HIV positive (P.I.D)**

Among the **3,706** HIV-positives:

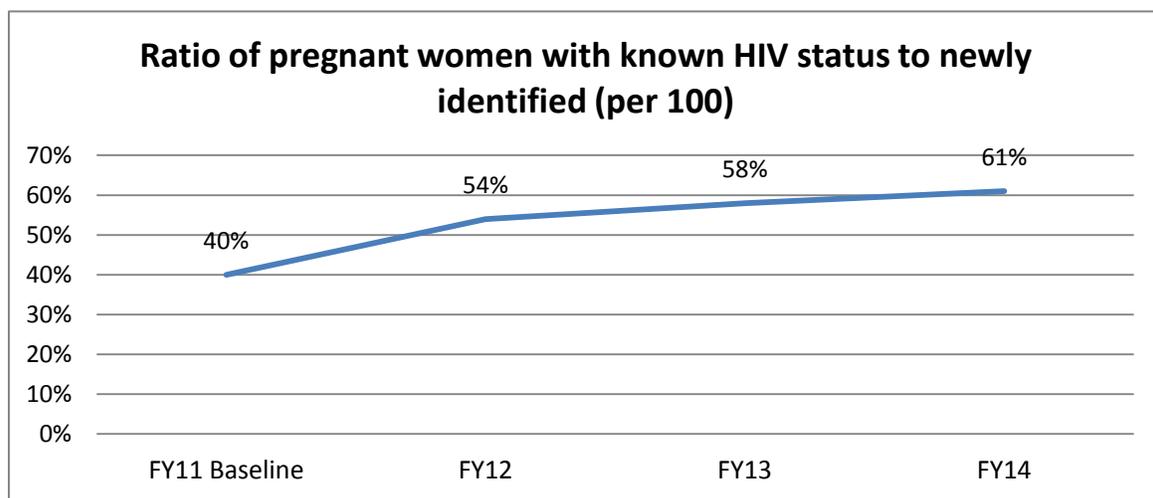
- **2,271 (61%) were known HIV-positive at entry**
- **1,435 (39%) were tested and found newly HIV-positive**

Comment: Continuing the FY12 and FY13 trend, 97% of pregnant women seen at program supported HCs during the reporting period knew their HIV status, which is well above the 2012 national rate of 67%.

PMTCT cascade



Among all HIV-positive pregnant women, 61% knew their HIV status at entry to ANC. This compares to only 40% of HIV-positive pregnant women who knew their status at baseline in 2011. Program-supported Operations Research (OR), from a small sample of known HIV-positive pregnant women in FY13, showed that many HIV-positive pregnant women want to fulfill their reproductive desires knowing that they can prevent transmission to their baby and protect their own health status as well. In addition, as data from ENHAT-CS' Mother Support Group (MSG) registers show (see below), almost all HIV-positive mothers delivered at a health facility. The trend toward higher proportions of HIV-positive pregnant women who knew they were HIV positive reflects the success of the PMTCT program and of keeping HIV-positive women in the health system, combined with effective community outreach that has educated women and their families on the benefits of ANC and the effectiveness of PMTCT programs in preventing HIV transmission.. The role of mother mentors and their MSGs in this process is significant, since a high percentage of HIV-positive pregnant women belonging to an MSG deliver at a health facility and the percentage of HIV-positive infants among women who attend MSGs is half that of women who do not.



✓ **3,214 (87%) HIV-positive pregnant women received ARV for PMTCT at ANC (PI.2.D)**



I received two ARVs

3,213 received ART either at ANC or the ART clinic

Comment: Among the HIV-positive pregnant women seen at ANC during the reporting period, 3,214 (87%) received ARVs for PMTCT, which is even higher than the 84% achieved in FY13.

The program's success may be attributed to the program's mentorship support, routine data quality assessments, introduction of PMTCT follow-up charts, active involvement of mother mentors with MSGs, and improved services and tracing as a result of the program's priority focus on PMTCT. Furthermore, since Q3 of FY13, all supported HCs transitioned to offering option B+, whereby all HIV-positive pregnant women, regardless of gestational age and CD4 count, are offered ART. The roll-out was completed by end of Q4 of FY13, and the success of the completed roll-out is reflected in this reporting period, when ART was the standard PMTCT strategy.

✓ **0 newly tested HIV+ pregnant women at ANC were assessed through clinical staging or CD4 determination at ENHAT-CS supported HCs (PI.4.D)**

Comment: With the adoption and roll-out of option B+ at all program supported HCs, pregnant women are no longer assessed for eligibility for ART.

✓ **1,298 of newly identified HIV-positive pregnant women at ANC were newly enrolled into HIV/AIDS care and support in ENHAT-CS supported health center (PI.5.D)**

Comment: A total of 1,298 newly identified HIV-positive ANC clients were newly enrolled in care and support during the reporting period. However, with the adoption of option B+, which initiates all HIV-positive pregnant women on ART for life, they were no longer assessed clinically and via CD4 determination at enrollment. With option B+, ART is now initiated at the ANC clinic at all program supported HCs, and the ANC health care provider then records the patients in the HIV clinic enrollment and ART register to obtain a unique ART number for each. However, the patients are only transferred to the HIV clinic for management after the baby is 18 months of age. The difference between PI.2D, whose data source is the ANC, and PI.5D, whose data source is the HIV clinic, is most probably due to the Government's late introduction of appropriate MNE tools for PMTCT option B+ at the ANC clinic, which resulted in initial disruptions in cross documentation between the clinics (all HIV-positive ANC clients must be registered at the HIV clinic).

✓ **HIV Exposed Infants (HEI) cascade of services, FY14**

HIV Exposed Infants (HEI) cascade of services (FY14 results)

Indicator		Number	%	
Number HEIs enrolled into care during FY14		3,664		
Number HEIs enrolled at age 0-2 months		3,009	83%	
Number HEIs enrolled at age 0-2 months initiated on CPT within 2 months of birth		2,623	87%	
Number enrolled HEIs who were tested for HIV with PCR sample sent to regional lab		2,926	80%	
Tested within 2 months		2,286	77%	
Tested between 2 and 12 months		585	20%	
Tested between 13 and 24 months		100	3%	
Number HEIs who received their PCR test results		2,516		
Of total enrolled		69%		
Of total tested		86%		
Number HEIs who received their PCR test result who were HIV-positive		120	4.8%	
Those who tested positive	Age	No. tested	No. positive	% positive
	0-2 months	1,716	29	1.7%
	3-12 months	692	60	8.7%
	13-24 months	108	31	28.7%
Number PCR positive HEIs linked to ART within facility		113	94%	

Number HEIs discharged from care	1,900	9.2%
Number HEIs who died	89	0.4%
Number HEIs lost to follow-up	367	1.8%
Number HEIs under active follow-up at the end of FY14	18,394	88.6%

Comment: A total of 3,644 HIV-Exposed Infants (HEIs) were newly enrolled on HEI/EID follow-up during the reporting period, and at the end of the reporting period, a total of 18,394 HEIs were still on active follow-up. Among all newly enrolled infants, 80% had their DBS sample taken, among whom, 77% at age 0-2 months. This result is encouraging in light of widespread reports of DBS and DNA-PCR reagent stock-outs during the reporting period. The result likely reflects the efforts of program mentors in redistributing commodities from overstocked facilities to facilities with stock-outs.

Among HEIs who had received a test result, 4.7% were HIV positive, slightly up from the 4.4% observed during FY13. Of note, the younger the infant is when tested, the lower the HIV infection risk seems to be, with 1.7% positive among those PCR tested at below 2 months, 8.7% among those tested between 2 and 12 months, and 28.7% among those tested between 13 and 24 months. This could reflect either the effect of ARV intervention or the effect of breast-feeding on the rate of MTCT of HIV. Almost all infants who are PCR tested at an early age have mothers who took PMTCT services and almost all these infants were put on prophylaxis immediately when they entered the system. The result underscores the importance of PMTCT and the need to initiate HEI follow-up shortly following birth.

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

Comment: By age 6 months, the vast majority (93.8%) of HEI mothers reported that they had exclusively breastfed their baby, 4.5% reported to have given exclusive formula feeding and 1.7% reported to have practiced mixed feeding. This is similar to the distribution noted in FY13.

✓ **64% (2,390) of infants born to HIV-positive mothers had virology tests for HIV within 12 months of birth. Out of these, 1,698 infants (71% of the total) received virology testing within 2 months of age (C.4.1.D)**

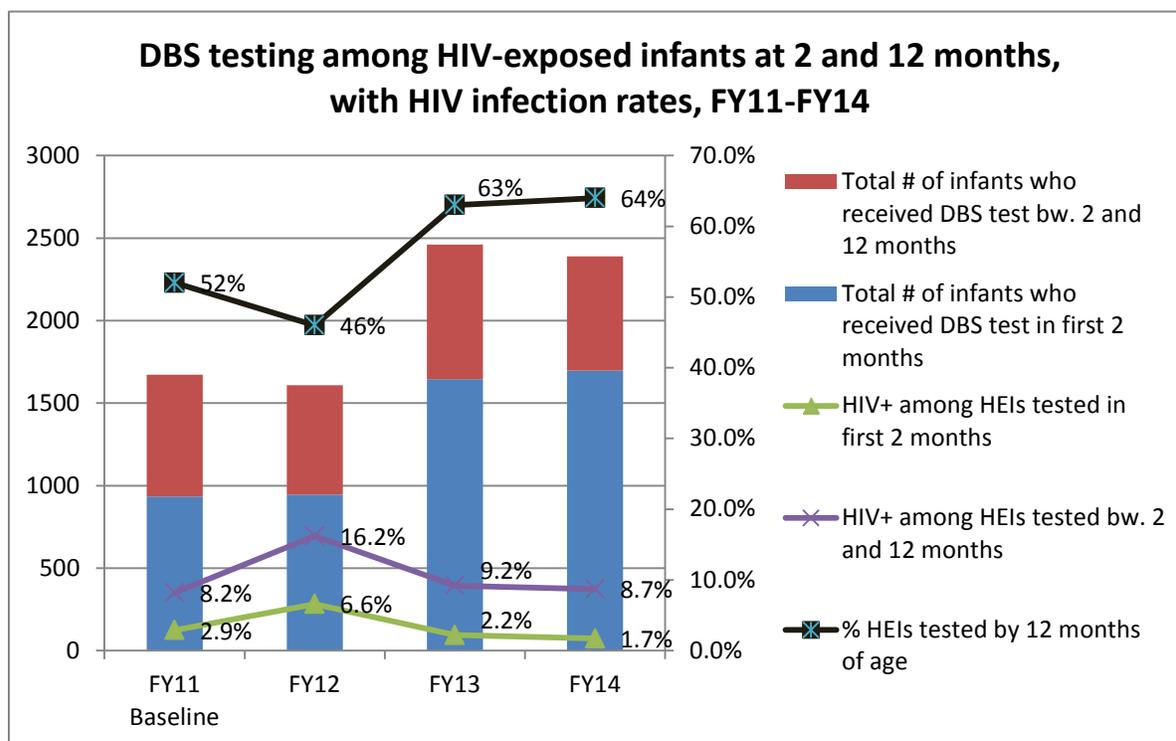
Comment: A total of 2,390 HEIs had a virology test and received their results within 12 months of age.

Of the HEIs who had received their test results within 12 months of birth, 71% (1,698) received their test results within the first 2 months of birth, considerably above 56% at baseline in FY11. As shown in the Figure below, over time, the proportion of HEIs that are virologically tested by 12 months of age increased from 52% at baseline in FY11 to 64% today. At the same time, among all HEIs tested by 12 months, the proportion tested within the first 2 months went up from 56% to 71%.

Of note, the drop in performance between the baseline in FY11 and FY12 likely reflects the reality that the baseline only encompassed 152 ART providing HCs that were supported by the MSH-implemented USAID HIV/AIDS Care and Support Program (HCSP) through mid-FY11. In FY12, the program expanded support to an additional 54 HCs, of which 29 had recently initiated ART under government support (with no follow-up on-site mentorship support), and 25 HCs that were only providing PMTCT services. Furthermore, there was a 6 month hiatus in mentorship activities between the end of HCSP and the start of ENHAT-CS and this affected all HIV services at the health centers but more so those for which providers were least comfortable and least skilled. These services included managing HEIs and pediatric HIV patients. Lastly, for most of FY12, Dessie Regional Laboratory was not fully functional and could not perform DBS tests. Managing HEIs continued to be a challenge in the first project year at existing ART HCs but also at the new ones. As Dessie Regional laboratory became functional again, and as all HCs over time began to receive ENHAT-CS' routine and regular mentorship as well as pediatric focused mentorship, training and other support activities targeting PMTCT, major improvements were noted especially in the second half of 2012. In part, this was the result of the 2012 accelerated plan which was accompanied by a manual introduced by the Federal Ministry of Health to guide program managers on the planning, implementation, coordination, monitoring, and evaluation of early infant diagnosis and treatment services. ENHAT-CS was involved in the implementation of this manual and the

initiation of HEI care programs at HCs. The accelerated improvements that began in the second half of FY12 have been sustained throughout the project since then, with currently 64% of HEIs being tested within the first year of life, of which 71% are being tested within the first 2 months of birth.

In the current reporting period, the HIV positivity rate was markedly lower among HEIs tested by 2 months compared to HEIs tested after 2 months. HEIs tested within the first 2 months are probably those who were born at the HC, and whose mother had stayed in the system. These results underscore the importance of PMTCT, as well as early enrollment on HEI follow-up and of DBS testing early in life. The improvements over time are the direct result of the program's intensified focus on PMTCT and HEI follow-up.



✓ **70% of HEIs 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 2,583, or 70% of the HIV-positive pregnant women identified during the FY (P.I.I.D). This is an excellent achievement in light of the frequent stock-outs of co-trimoxazole syrup and represents 107% of the FY14 target of 65%.

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

Comment: The program technically and financially supported the training of 167 health workers in PMTCT, using the national PMTCT/MNCH training curriculum. This was a gap filling training conducted to replace previously trained HC staff who left the facility.

✓ **Additional Achievements**

Supporting National eMTCT of HIV launching and implementation of option B+: During this FY, the program provided technical support to the FMOH to finalize needed M&E tools, update PMTCT guideline, and develop an implementation manual. Program technical staff also served as members of national and regional technical working groups that oversee and coordinate implementation of the eMTCT strategy.

During the reporting period, the program also continued its mentorship support, gap filling training, and monitoring of implementation of option B+ and provision of quality MNCH services, in collaboration with the Regional Health Bureaus (RHBs) of Tigray and Amhara.

Financial and technical support to the national launch of the eMTCT of HIV Strategy, and EID implementation manual workshop. The program supported the national launch of the strategy for the eMTCT and the EID Implementation Manual. The event was organized by the FMOH and took place in Addis Ababa on November 29-30, 2013. The program provided financial support and shared program evidence on the role of mother mentors with a mother support group (MSG) on PMTCT outcomes. Program staff worked as part of the workshop organizing committee as well as the core team that developed the EID implementation manual.

The program also supported the distribution of the National eMTCT of HIV Strategic Plan document, EID implementation manual, DBS collection job aid, DNA PCR reporting format to the Tigray RHB per request from the FMOH.

Distribution of Mama Kits: In order to facilitate clean and safe delivery in program supported HCs, the program distributed 8,964 USAID-donated Mama Kits to 183 HCs.

Mother mentors with a mother support group (MSG): During this reporting period, ENHAT-CS provided support to 340 mother mentors with an MSG at 85 typically high patient load HCs. In these HCs, the ANC/PMTCT, L&D, PNC and ART focal persons recommend all HIV-positive pregnant and lactating mothers to join their mother mentor led MSG for support and counseling.

In FY14, 1,772 mothers joined an MSG, estimated to be over 80% of eligible mothers in the 85 HCs. Of these, 61% came from ANC/PMTCT clinics, 6% from L&D, 9% from the postnatal clinic, and 24% 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, 61% of the 1,772 newly enrolled mothers in the reporting period had disclosed their HIV status to their partner, of whom 33% had been tested, indicating the challenges of partner testing.

In FY14, 96% of 779 MSG mother members delivered at health facilities (the EDHS 2011 reported 9.9% for institutional delivery in the general population). Of the 889 mothers who were linked to various community level care and support services during the reporting period, 20% were linked to nutritional services, 30% to IGA support and 50% to other psychological, social, spiritual and legal community care and support services.

The program promoted male involvement in MSG activities, with partners of 619 women participating in MSG activities. At 6 pilot HCs, the program launched a mother-to-father initiative whereby mother mentors encouraged their MSG members to bring their partners to sessions on male involvement in MNCH and general child health. In FY14, Q1, 565 men attended mothers-to-father education sessions led by site coordinators, typically an ANC/PMTCT nurse. In Q3, the number of men who attended these sessions had increased to 637.

The HC based efforts for increased male involvement were complemented with activities by 633 religious leaders (trained by the program in partnership with the Ethiopia Interfaith Forum for Development Dialogue-EIFDDA), who conducted community conversations and mass education sessions that included promotion of male involvement in MNCH and PMTCT. During the FY, 127,704 persons were reached through their community conversations and another 449,023 through their mass education at regular religious gatherings. In Q3, for example, religious leaders successfully counseled 4,202 men to accompany their wives to their HC.

The program also continued to support 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. During Q3, for example, a total of 7,461 women were reached through coffee ceremonies, and of this number, 38% attended coffee ceremonies that focused on infant and young child nutrition.

During this reporting period, 2,051 (100.5%) planned group sessions were conducted. These program-supported sessions included messages on infant and young child nutrition and discussions on group savings. As well, 351 MSG members completed all 52 sessions and thus “graduated” during the semi-annual period.

MSG mentors also participated in 143 monthly government mandated primary health care unit (PHCU) meetings held at HCs 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, mother mentors and their MSG members successfully traced 86% of the 30 HIV-positive women who had missed their ANC appointments, convincing them to resume treatment.

Throughout this reporting period, clinical mentors provided monthly mentorship and supportive supervision to all 85 MSG sites and their mother mentors. A more focused and in-depth mentorship was provided by members of the program care and support team for 54 (64%) of the 85 sites with 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 mother mentor and MSG strategy, which outlines program approaches, and strategies guidelines for use by mother mentors as a reference tool for group education and individual counseling sessions.

During Q1, the program began preparations to transition 29 MSGs to NNPWE (who were to receive USAID funding to support their assumption of this responsibility). This included end-of-program assessments using the MSG mentorship checklist and creation of site profiles for 22 MSGs in Amhara. Additionally, the program worked on training curricula to build the capacity of NNPWE association leaders to provide oversight and coordinate mother mentor activities at these MSG sites. In Q2, the program provided capacity building training to 61 NNPWE association leaders and prepared site profiles for the remaining seven sites.

No transition activities were carried out in Q3 and Q4 as USAID and NNPW renegotiated the terms of their agreement to exclude the taking of over of MSG mentor sites. This was because the RHBs agreed to support the MSG sites under CDC agreements and funding, which ENHAT-CS supported them to take on this role.

SOC assessment at MSG sites: in Q2, the program assessed compliance with national standards of care (SOC) in 15 randomly selected mother mentor sites. The assessment showed that mother mentors were successfully and consistently tracing all mothers who missed their appointments and bringing them back to treatment. The SOC survey also showed that 95% of all mothers who were counseled and registered at MSGs delivered at a health facility, and that 99% of all sampled infants below six months were exclusively breast-fed.

The FY14 SOC results showed marked improvements compared to an FY13 SOC survey. Notably, the proportion of mothers registered at an MSG in the last six months whose partner was tested for HIV increased from 39% to 65%. Referral linkages to nutritional support increased from 53% to 71%. Additionally, HIV testing of infants in the first two months of birth increased from 53% to 70%. SOC results were shared directly with the mother mentors and HC heads during supportive supervision.

Operations research: An assessment looking into the reasons for pregnancies among known HIV-positive mothers was conducted following ethical clearance from EPHA and the RHBs in Amhara and Tigray regions. This study built on an earlier study conducted by HCSP at 4 HCs in Addis Ababa and showed that the significant increase in the number pregnant women who knew they were HIV positive before getting pregnant was the result of women knowing the efficacy of PMTCT and wanting another baby. The OR in Amhara and Tigray was much larger, covering 20 HCs and 392 pregnant and recently delivered HIV-positive mothers. The study found that 71% of the women desired their recent pregnancy or birth, with 219 (56%) wanting their current pregnancy or recent birth, and 60 (15%) wanting them, but later. Only 25% never wanted the pregnancy or child. Currently, 18% were not using family planning, primarily because they wanted to have another baby while 82% reported past contraceptive use. The study found that all HC provided short term FP services at the HIV clinic and referred women elsewhere for long and permanent methods. The findings suggest that HIV-positive mothers seen at health centers in Amhara and Tigray have excellent access to FP services. Overall, the study confirmed the success PMTCT services enabling HIV-positive women to fulfill their reproductive desires.

Collaborative activities with other USG partners: ENHAT-CS continued its collaborations with other implementing partners, including 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.

2-HVAB

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 02-HVAB (Sexual Prevention: AB)

- ✓ **7,352 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: In FY14, the program-trained NNPWE community volunteers conducted community mobilization activities working in 59 target woredas and 46 community sites and reached 7,352 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 program's NGI job aids with 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, sexual abstinence, gender-based violence, stigma, open discussions and other issues as stated in the NGI job aids.

The achievement during the reporting period represents 88% of the program's FY14 annual target. The program likely did not fully achieve its target as the sub-grant to Save the Children, which led the program's community component, ended before the end of the FY, leading to its cessation of field activities at month six. In addition, the sub-grant to NNPWE, which directly implemented the community outreach program, also ended before the end of the FY, leading to its cessation of field activities in month nine.

Additional Achievements

6,439,303 people reached through mass education and community conversation sessions addressing HIV prevention services through FBO (EIFDDA) services at community level: 633 religious leaders (trained and supported in partnership with EIFDDA) mobilized their respective followers in the areas where ENHAT-CS is operating. They conducted 13,288 mass education and community conversation sessions using a program faith-based mass education and community conversation guide. During the mass education and community conversation sessions, the religious leaders addressed issues such as HIV prevention and testing, reduction of stigma and discrimination, support for male involvement in PMTCT/MNCH, premarital counseling, reduction of GBV, importance of continuing ART while using holy water (tsevel), referrals for HIV testing and related services, joint couple visits to health care facility for HIV related services, and care & support for PLHIV including their family members. They also conducted mass education during sermons and Friday prayers. In total, **6,439,303** people were reached with AB messages through mass education and community conversation interventions, showing that trained religious leaders effectively mobilized their congregation communities with HIV prevention, and with proper recording and reporting, using program mass education and community conversation guides.

52,155 copies of BCC and other educational materials addressing AB messaging distributed: A key support to program prevention activities is the provision of preventive educational materials. During the reporting period, ENHAT-CS collected and distributed, through its clinical mentorship network, copies of BCC and other educational materials to the regions of Amhara and Tigray. Prepared in the Amharic and Tigrigna languages, they were used by clients, case managers, religious leaders and volunteers for communicating AB messaging.

Support and participation in World AIDS Day (WAD) 2013. ENHATCS supported WAD'13 events through multiple events and activities, including advocacy and mobilization activities with AB messages in Metehara (central level), Axum (Tigray) and Jawi town (Amhara) through candlelight vigils, entertainment, sports shows, religious ceremonies, panel discussions and other events led by religious and political leader in all sites. An estimated 350,000 people were reached with AB messages (for further details, see next session 03- OP).

03- HVOP

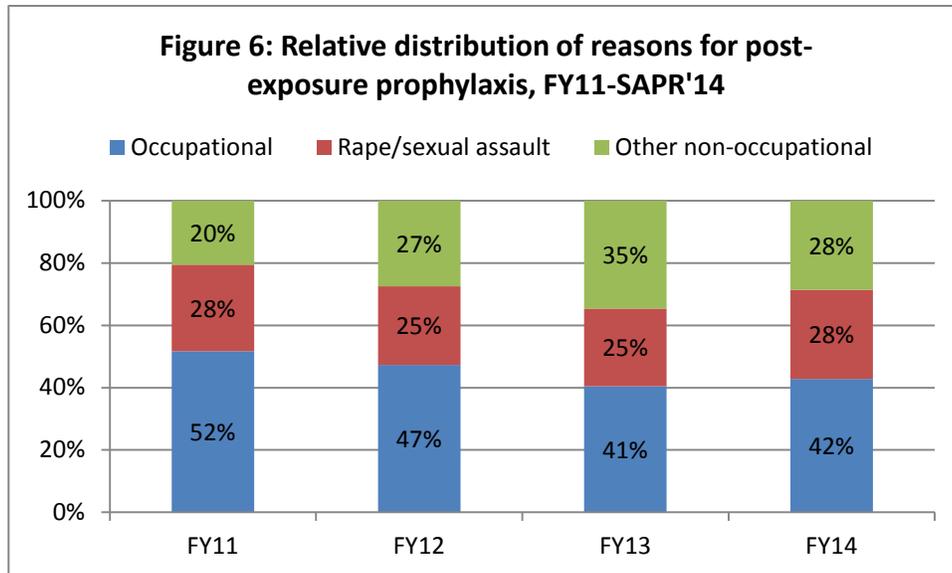
Accomplishments and successes during reporting period with explanations for under and over achievements:
Program area 3-HVOP (Sexual Prevention: OP)

- ✓ **17,883 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.I.D)**

Comment: During the first nine months of FY14, the trained 350 NNPWE community volunteers conducted community mobilization activities working in 59 grass root sites. They conducted house-to-house visits and reached 17,883 individuals with OP messages, using the program's NGI job aids and supportive BCC materials, and 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, all supported with BCC and other educational materials.

The performance result represents 85% of the program's FY14 annual target. As with the above AB component, the program likely did not fully achieve its target as the sub-grant to Save the Children, which led the program's community component, ended before the end of the FY, leading to its cessation of field activities at month six. As well, the sub-grant to NNPWE, which directly implemented the community outreach program, also ended before end of FY14, leading to its cessation of field activities in month nine.

- ✓ **457 persons were provided with post-exposure prophylaxis (PEP) services (P6.I.D)**
- ✓ Comment: Among the 457 persons who received PEP services at ENHAT-CS supported HCs, 201 (44%) had had an occupational exposure, 127 (28%) had been sexually assaulted/raped and the remaining 129 (28%) reported other non-occupational exposures (Figure 6). Over time, both this distribution and the absolute numbers show a decline in PEP for-occupational exposure of health providers, which is likely the result of the program's successful infection prevention efforts which accelerated in FY13. The achievement at 108% of the program's FY14 target.



- ✓ **66,434 people living with HIV (PLHIV) reached with a minimum package of Positive Health Dignity and Prevention (PHDP) intervention services (P7.I.D)**

Comment: During the reporting period, the program reached 5,372 PLHIV with a minimum package of services captured during clinical services. This report does not include community interventions to avoid double counting. ENHAT-CS initially counted the number of PLHIV who received PHDP services as the total number of HIV-positive clients seen at HIV clinics, with 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. This indicator has achieved 111% of the program's FY14 target.

- ✓ **Additional Achievements**

100,000 copies of the Libona newspaper printed and distributed: For the first 10 months of the FY, ENHAT-CS supported Dawn of Hope Ethiopia Association (DHEA) to monthly produce 10,000 copies of the Libona newspaper monthly (7,000 copies in Amharic and 3,000 in Tigrigna languages) for distribution to program supported HCs, PLHIV association members and served community through the clinical mentorship network, NNPWE community outreach volunteers and DHEA association members in both regions.

12,019 copies of job aids and other educational materials distributed (see Table): A key support to the facility and community level prevention activities is the provision of key messages addressing OP interventions. During the reporting period, ENHAT-CS distributed 12,019 copies of job aids and BCC materials to the regions of Amhara and Tigray intended for use by service providers at OPD, ART, ANC, labor and delivery and laboratory service areas.

In addition, 3,920 copies of job aids were printed and distributed in collaboration with the Ethiopian Public Health Association, encompassing seven kinds of job aids for use by service providers at OPD, ART, ANC, labor and delivery, and laboratory. The job aids were adopted upon approval to print from FMOH.

Job Aids and other Educational Materials distributed

Topic	Regional Distribution			Total
	East Amhara	West Amhara	Tigray	
TB screening and IPT algorithm	173	402	265	840
Testing and counseling of PMTCT protocol for ANC	173	402	265	840
Focused Ante Natal Care (FANC)	173	402	265	840
PEP after Occupational Exposure to infectious materials	173	402	265	840
WHO Pediatric HIV Clinical Staging	173	402	265	840
Testing and Counseling for PMTCT Protocol for Lab and Delivery settings	173	402	265	840
WHO Adult and Adolescent HIV Clinical Staging	173	402	265	840
ATV/r drug leaflet	449	589	310	1348
Second line patient communication tool	1000	1313	691	3004
Treatment failure Wall chart	200	261	138	599
Desk top job aids	396	519	273	1188
Total				12,019

53,376 copies of printed BCC and other educational materials distributed: 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 53,376 copies of BCC and other educational materials to the regions of Tigray and Amhara for use by HC clients through the clinical mentorship network.

24 kinds of job aids, brochure and KAP study reports delivered to the Federal Ministry of Health/Health Education Team: With the intention to strengthen the newly re-established FMOH health education team, the Ministry requested partners, including ENHAT-CS, to provide samples of IEC/BCC materials, job aids and other prevention-related KAP study reports produced in the supported regions. The program delivered 24 kinds of IEC/BCC materials, job aids and other related documents produced during both HCSP and ENHAT-CS, in both hard and soft copy.

Participation in TWG on IP/PS and other related activities at national and regional levels: ENHAT-CS was actively involved as a member of the national Advisory Technical Working Group (ATWG) on Infection Prevention and Patient Safety (IP/PS) chaired by the Medical Services Directorate of the FMOH. The main aim of the task force is to support the Ministry to ensure IP/PS services and practices are institutionalized and owned by the system in a sustainable manner in order to mitigate all kinds of infections and health care wastes affecting patients, health care providers, and the surrounding community and ecosystem. One of the key tasks of the national ATWG is to support and ensure RHBs have an established regional ATWG. During this reporting period, the following activities were accomplished with regard to IP/PS:

- ENHAT-CS initiated and supported the RHBs of Amhara and Tigray to establish and operationalize IP/PS Technical Working Groups (TWGs), including supporting them to develop and finalize terms of reference for the TWGs, along with identification of potential members.
- Relevant technical documents developed by the national TWG were distributed to the RHBs.

- IP/PS training resource packages intended for training of health program managers, service providers and support staff were collected from the FMOH for distribution to each ENHAT-CS supported HC.

Participation in World AIDS Day 2013: Every year World AIDS Day is commemorated in December 1 with different events and activities under a given theme from UNAIDS. This year's 25th anniversary theme, "Getting to Zero"- Zero New HIV Infections, Zero Discrimination and Zero AIDS Related Deaths, a campaign intended to run every year up to the end of 2015 by building on previous years successful World AIDS Day accomplishments.

This year's event was colorfully commemorated at central and regional levels and accordingly the focus of emphasis was as follows:

- HIV prevention campaign for large scale development workers
- Getting HIV free child through accelerated PMTCT and delivery in a health facility
- HIV preventive intervention for Commercial Sex Workers



Billboard on PMTCT Inaugurated, Amhara

At national level the event was celebrated in December 1, 2013 in one of the large scale development areas at Metehara Sugar Estate. Metehara is a semi urban industrial zone located in the center of large scale development areas along the Addis Ababa - Djibouti road and railway corridor. In addition to the national level celebration, in which ENHAT C-S was actively involved, similar events also took place in Tigray and Amhara regions. The main message promoted during the celebration at central and regional levels was as stated by the president was: "Let us protect ourselves from HIV and care for others to realize the Ethiopian Renaissance".

The WAD 2013 was celebrated in the presence of President Dr. Mulatu Teshome, Ministers, Oromia regional government officials, PEPFAR country coordinator, UN agency representatives, partners, invited guests and the residents of Metehara and surroundings. The president in his key note address reaffirmed the government's continued commitment to ensure all citizens have access and equal opportunity to information, treatment and care & support services targeting for AIDS Free Generation. He reminded all citizens to protect themselves and care for others in order to realize the Ethiopian renaissance. He reiterated his

government commitment to protect skilled workers against HIV/AIDS in and around large scale development areas to accelerate ongoing economic growth. He acknowledged and commended the role of partners as pivotal and urged them to continue supporting the government efforts.

Before the formal opening of the ceremony the event was preceded and honored with blessings given by traditional elders from Oromia region. The other entertaining activities that attracted attention of the audience included reading poems, songs, circus and other shows presented by youth coming from Metehara and Adama towns. During the occasion remarks made by the president and other guests urged all stakeholders to work for AIDS Free Generation by focusing large scale development workers and aim for HIV free child through promotion of accelerated PMTCT and facility based delivery services. Mr. Bud Crandall, COP of ENHAT-CS and the prevention advisor participated in the national level commemoration at Metehara.

In Tigray and Amhara, the occasion was commemorated in December 1, 2013 in the historic city of Axum and Jawi town respectively in the presence of the regional states guest of honors and invited guests. In Amhara, it is significant to note that the event was commemorated in Jawi town located close to the Sudanese border and center of another industrial sugar complex. Please also note that in Tigray the venue and timing of the World AIDS Day 2013 was an opportunity to reach a large population as December 1 was also an annual St. Mary Tsion religious festival in which an estimated 300,000 pilgrims assembled from all over the country.

As noted in the above narration report, the key activities supported by the program and implemented at central and regional levels during the event included panel discussions, a sports show, and a candle light vigilance parade accompanied by police band and with continuous live media coverage. The program also supported the procurement and production of promotional materials such as banners, posters, brochures T. shirts and candles. The central and regional level of ENHAT - CS involvement and support was highly visible and major accomplishments included the following.

- ENHAT-CS, represented by its prevention advisor, was a member of the national task force and resource mobilization committee, chaired by FHAPCO
- Regional ENHAT-CS staff were members of resource and social mobilization task forces chaired by their RHBs
- 2,259 T-shirts were procured and produced with MSH branding and, with key messaging promoting accelerated PMTCT service and getting an HIV free child
- 40,085 copies of banners, posters and other promotional materials procured and printed
- Two billboards erected in Bahir Dar and Jawi with key messages
- Two panel discussions conducted targeting migrant workers, higher education students and other vulnerable population groups
- Follow up made to ensure MSH/ENHAT-CS branding was included in all print materials, banners and other activities produced for the event

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)

✓ **131,494 eligible adults and children provided with a minimum of one care service (C.I.I.D)**

Comment: During this reporting period, 131,494 people (M 51,348; F 80,146) were provided with a minimum of one care service (107% of the FY14 target). Of the total, 23,702 (18%) were younger than 18 years. Service provision under C.I.I.D includes both facility-based clinical care services (documented under C2.I.D) and community level services.

Community services at household level, provided by the NNPWE community outreach volunteers, who were trained and supported by the program in partnership with NNPWE and its regional associations, included home-based care (HBC), referral to HC and 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.

Ongoing support was provided to the 350 program-trained NNPWE volunteers focusing on proper use of their job aids, HBC and PCP kits and use of reporting formats. The volunteers were provided with HBC kit refills through collaborative activities with SCMS.

In this reporting period, the volunteers provided a minimum of one care service through home visits to over 31,550 clients, who 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 clients, 31% were children below 15 years and 11% were children aged 15-17, while 60% were female.

As well, 13,893 HIV-positive women and 3,812 males were reached by the NNPWE volunteers through 268 PLHIV association meetings focusing on PHDP held by four NNPWE PLHIV affiliate associations. In addition, 302 lost clients were traced and brought back to treatment through outreach volunteer workers. Of these, 51% were on ART, 21% were on PMTCT and TB treatment respectively, and 7% were HEIs.

The program's regional care and support teams provided focused mentorship to 172 (100% of target) woreda health offices and 222 HCs (85% of target) in its targeted zones to strengthen the bi-directional, closed loop referral system that facilitates referrals between the HC based case manager and community based HEWs and PLHIV associations to improve their documentation of effective linkages.

The program provided support to 633 religious leaders to strengthen their role in the woreda health network focusing on linkages and provision of faith based initiatives. This included formally introducing them to the woreda health office, HC heads, HEWs and other PHCU stakeholders to further strengthen their role in strengthening the woreda health network.

- ✓ **87,328 HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)**

Comment: The number of HIV-positive patients who received at least one clinical service (limited to the HIV clinic to avoid double counting) during the reporting period included 31,650 (36%) male and 55,678 (64%) female clients. The program achieved 101% of its FY14 target.
- ✓ **53% HIV-positive persons receiving cotrimoxazole prophylaxis (C2.2.D)**

Comment: Among all patients seen during the reporting period, 46,450 (53%) received cotrimoxazole prophylaxis. This achievement met the FY14 target and was consistent with the FY13 performance of 56%. As the ART coverage continues to expand and HIV-positive people successfully remain on ART over time, the need for CTX prophylaxis declines as individual CD4 counts remain high (FMOH policy requires patients to have a CD4 count <350 to be eligible for CTX).
- ✓ **4,890 eligible clients received for food and/or other nutrition services (C5.1.D)**

Comment: During the reporting period, 4,890 eligible clients received food and/or other nutrition services, of which 1,084 were pregnant, and lactating women, representing 78% of the FY14 target.

Of note, the number of clients that the program reports under C5.1.D only includes clients who received nutritional assessment, counseling and support (NACS), from the case manager, not screening by the HIV clinic nurse or health officer. As such, the program only counts patients who were referred by the HIV clinic health care provider to the case manager for provision of NACS.

Of note, 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 (FBP) project.

One possible reason for the achievement being somewhat below target is that the FBP project is ending and has already handed over activities to the Government in many HCs. Continued provision of service may have been affected by this transition.
- ✓ **21% Contraceptive acceptance rate among HIV-positive women (Non-NGI; PMP # 31)**

Comment: During this reporting period, the program reported 5.2% new and 15.4% repeat users at the HIV clinic. Of note, the performance for repeat users is related to the HMIS guideline, which only counts repeat users once per year, during the GOE's first quarter (Jul-Sep).
- ✓ **5 HIV-positive patients referred for visceral leishmaniasis treatment in endemic areas (Non-NGI; PMP Indicator # 33)**

Comment: Three adult male HIV-positive Visceral Leishmaniasis (VL) patients were referred to a nearby hospital. There still was a shortage of WHO provided rK39 test kits at the HC, which likely explains the low number. A mid-FY'14 communication from the WHO officer overseeing their support to the national program reported that the FMOH was still trying to clear 20,000 test kits procured by WHO, which had already stayed in customs for a long time.

✓ **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. During this period, none of the program-supported HCs reported a case. The Carter Center is supporting the GOE to carry out community level mass medication administration as prevention initiatives in endemic areas. As only a small number of program-supported HCs are in these areas, with Metema HC in North Gondar Zone of Amhara being the main one, this campaign has resulted in zero demand for the service at HC HIV clinics. The program's investment in detecting and managing this NTD in HIV patients has led to a low yield, calling into question the cost-effectiveness of integrating this NTD service among HIV patients at health centers in Amhara and Tigray.

✓ **1,372 HIV-positive patients diagnosed with STI and treated for STI** (Non-NGI; PMP # 35)

Comment: A total of 1,372 HIV clinic patients were diagnosed and treated for STI, of whom 75% (1,040) were female. ENHAT-CS collaborated with PSI to make free STI services available to HIV-positive patients.

✓ **2,058 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 program supported HC HIV clinics for all their patients. During this reporting period, 2,058 HIV-positive patients were diagnosed and treated for malaria. Females accounted for 1,211 (59%) and 140 (7%) were children under 15 years of age.

✓ **4,301 referrals made and documented for HIV/AIDS related services** (non-NGI; PMP indicator #32).

- **975** referrals were made by HC health providers inter-facility for HIV related services
- **2,402** referrals were made by HC health providers to community e.g. HEWs and PLHIV associations, for HIV/AIDS related services
- **924** referrals were made by community to HCs

Comment: The above data captures referrals with documented linkages. Of note, 261 program-supported HCs were using the program-developed bi-directional closed loop referral system.

Additional Achievements

Support to quarterly woreda health network meetings. The program's goal was to support 172 higher HIV prevalence woredas, which contain 261 supported HCs to hold quarterly woreda health network 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 Q1, 44% of the supported 172 woredas conducted and documented network meetings. From Q2, the program no longer continued to fund these meetings due to budget constraints and the realization that the PHCU monthly meeting at HC plays a more sustainable and key role in linking HC and community services.

Support to monthly HC-based PHCU review meetings. During this reporting period, the targeted 261 HCs conducted a total of 1,228 monthly HC-based PHCU meetings, which is 78% of the targeted number of one per month per HC. These monthly government-mandated HC review meetings, which involve woreda health officers, HEWs, HEW supervisors, HC 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 HC to health post to served kebeles.

To sustain gains achieved through the PHCU monthly meetings, the program developed a checklist to be used by woreda health officials and RHBs during their routine supportive supervision visits to HCs. This is further detailed in the later discussion on transition under the HSS section.

Care and support focused mentorship and supportive supervision was provided to 261 current program-support HCs During this reporting period, the program's Save the Children led regional care and support teams visited all the 261 HCs at least once during the first six months of the FY (afterwards Save the Children's field activities ended, as noted earlier). This support, provided by the program's regional care and support teams, included assistance in updating their service directory, supporting the health center staff to strengthen the bi-directional closed loop referrals system.

Collaborative activities: The program collaborated with World Vision's PCP program to enhance delivery of PCP messages to HIV-positive pregnant and lactating mothers through mother mentors and their MSGs. To this effect, the program-supported HCs with mother mentors and an MSG continued to benefit from safe water containers, supplied by PCP in FY13 to 59 MSGs to ensure the mother mentors and MSG members, at the HC, have access to safe water. An estimated 4,987 MSG members benefited from the use of these jerry cans during the coffee ceremonies held during this reporting period.

Mental health service integration: The program successfully supported 37 HCs to provide mental health services integrated within the HIV clinic. This included screening and referral by the case manager and diagnosis and treatment or referral by the HIV clinic nurse or health officer. During the FY, the following results were achieved:

Case Management:

24,809 patients were screened by the case managers

Of the screened patients:

- 4.6% (1,138) were identified with suspected mental health problems

Of the 1,138 patients with suspected mental health programs

- 82% (938) were referred to the HIV clinic HCP for further assessment

HIV clinical services:

The HIV clinic HCPs identified and diagnosed 757 patients with mental health problems, encompassing:

- Anxiety: 33%
- Depression: 32%
- Psychosis: 12%
- Memory loss/dementia: 12%
- Epilepsy/seizure: 8%
- Substance abuse: 3%

644 patients (of the above 757) were eligible for treatment by psychotropic medications (for treating Anxiety, Depression, Psychosis, and Epilepsy).

- Memory loss/dementia is typically treated with ARVs
- Substance abuse is typically addressed through counseling.

498 (77%) of the above 644 were either treated at the HC or referred to another health facility i.e. hospital

450 (90%) of the above 498 were treated at the HC

For drug availability, surveys in Q3 and Q4 encompassing 24 HCs found the below percent of HCs with at least one psychotropic medication available for treatment:

- 98% for Epilepsy/Seizure (Anti-convulsant: (Phenobarbital (tab); Phenytoin (tab); Carbamazepine (tab))
- 74% for Anxiety (Anxiolytic: Diazepam (tab, inj); Bromazepam (tab))
- 68% for Psychosis (Anti-psychotic: Haloperidol (tab, inj); Chlorpromazine (tab))
- 60% for Depression (Anti-depressant: Amitriptyline (tab); (Fluoxetine (tab))

09-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)**

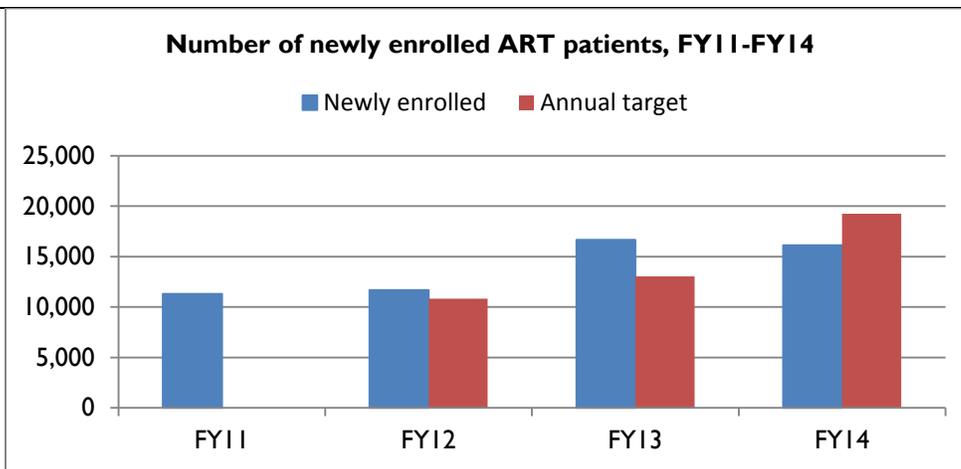
Comment: During this reporting period, ENHAT-CS provided technical assistance to 276 HCs to provide comprehensive HIV services, including ART. As the program is transitioning to the Government, ENHAT-CS did not expand ART sites in FY14. The result is 100% of the FY14 target.

The program provided team-based, routine clinical and health systems mentorship to all clinics in the HCs, as well as the pharmacy units. The focus of mentorship support was on: integration of mental health services at the HIV clinic; consolidating PMTCT option B+ services; implementation of the FMOH's newly adopted guidelines for initiation of ART (CD4 count threshold of 350, then 500 for initiating treatment); and supporting government mentors. In most woredas, both the RHB and the woreda health offices' HIV focal persons participated in mentorship visits. Graduated government mentors in Amhara have also conducted separate mentorships using a structured mentorship checklist--see transition discussion in the later HSS section for further details on government mentorship.

✓ **16,129 new individuals were enrolled on ART (T1.1.D)**

Comment: A total of 16,129 HIV-positive patients were newly enrolled on ART at program supported HCs during the reporting period. Female patients accounted for 10,762 or 67% of all newly enrolled ART patients. Among the newly enrolled patients, 1,086 (7%) were children under 15 years old, including 63 infants (see section 13-PDTX).

The achievement accounts for 84% of the annual target. Of note, the FY14 target was based on USAID's assumption of a 22% increase in quarters 3 and 4 above the trend in the first two quarters, when the GOE adoption of a CD4 cut-off point of <500 was expected to have its greatest impact on increased enrollment. This appears to have been over-optimistic, as the increase in enrollment proved to be less than assumed. An ENHAT-CS program analysis of CD4 data from supported HCs, estimated only a 10% increase due to the increase CD4 cut-off point of <500, which proved to be more accurate. In reality, the program's performance for FY14, at 16,129, was very consistent with its FY13 performance of 16,678, as the below table demonstrates:

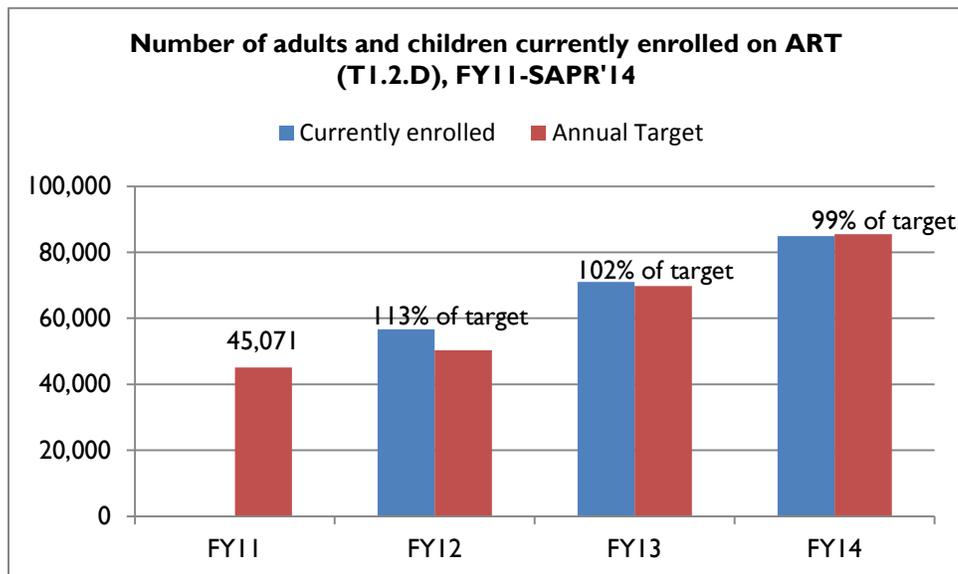


5,971 ART clients were transferred into ENHAT-CS supported health centers (Non-NGI; PMP indicator # 23)

Comment: A total of 5,971 ART patients were transferred into ENHAT-CS supported HCs during the reporting period. This indicator shows that hospitals and HCs continued to off-load its ART patients to ART providing HCs during the reporting period.

✓ **84,910 HIV patients are currently receiving ART (T1.2.D)**

Comment: By the end of this reporting period, 84,910 HIV-positive patients (99% of the program's FY14 target) were currently receiving ART at ENHAT-CS supported HCs. Female patients accounted for 54,639 (64%) and children under 15 years of age, including 167 infants, accounted for 4,580 (5.4%) of all current ART patients.



✓ **89% of adults and children known to be alive and on treatment 12 months after initiation of ART (T1.3.D)**

Comment: During the reporting period, the percentage of patients still alive and on treatment at program supported HCs, one year after starting ART, was 89%. This achievement is 104% of the program's FY14 target.

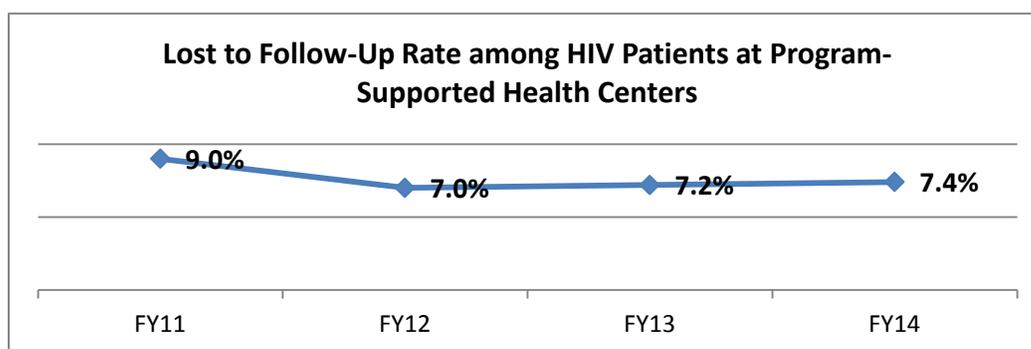
✓ **91,456 individuals with advanced HIV infection who ever started on ART (T1.4.D)**

Comment: By the end of the reporting period, a total of 91,456 HIV-positive patients had ever started on ART at ENHAT-CS supported HCs. Female patients accounted for 57,853 (63%) of all patients ever started on ART, and 5,031 (5.5%) 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	10.6%	0.3%	18.2%	7.4%
at 6 months	3.0%	0.2%	5.1%	4.5%
at 12 months	5.0%	0.4%	8.9%	6.1%
at 24 months	8.0%	0.5%	16.0%	7.5%

Comment: The above table shows that overall, 10.6% of ART patients following their treatment at program supported HCs had died and 7.4% were lost to follow-up by the end of the reporting period. The overall lost to follow-up rate during this reporting period, as the below table shows, has remained relatively stable, and which is well below estimated national levels.



Among patients who started on ART at program supported HCs, 18% had been transferred out. Consistent with data on disease progression among HIV-positive patients, more than 50% of all deaths and lost to follow-up occurred in the first year after initiation of treatment.

The overall patient retention rate is 82% (10.6% dead and 7.4% LTFU), which is better than the reported 72% national retention rate and better than the reported regional rates of Amhara (72%)

and Tigray (76%) in the FPHACO Multi-sectoral HIV/AIDS Response M&E Report for 2004 EFY (July 2011-June 2012). This confirms the success of HIV service 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, which improves adherence; 3) sicker ART patients are referred to hospitals and healthier patients are transferred to HCs; and 4) HCs manage generally healthier and more stable patients, including children.

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

Comment: The program's FY14 result of 83% is consistent with its FY13 achievement. 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 HC. The indicator includes both patients who continue to be on pre-ART status and patients who started ART since being enrolled. During ENHAT-CS, the FMOH failed to develop a pre-ART register that documents the number of active pre-ART patients. As such, ENHAT-CS acquired its information from a combination of the program pre-ART logbook and the HC's pre-ART enrollment register.

- ✓ **Additional Achievements**

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.

Government mentorship follow-up: see HSS section

Government mentorship expansion: see HSS section

Mental health integration: see HBC section

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 technical advisory group (TAG) and attended all meetings held during the reporting period. The program supported the change to a CD4 count of 500 for initiating ART treatment, while advocating for a further move to a Test and Treat policy. Program studies show that 'Test and Treat', where all HIV-positive patients are put on ART for life, will only increase overall costs by 15% by placing all HIV-positive patients essentially on option B+. As WHO is not currently supporting this recommendation, it is unlikely this change will occur in Ethiopia until WHO recommends it.

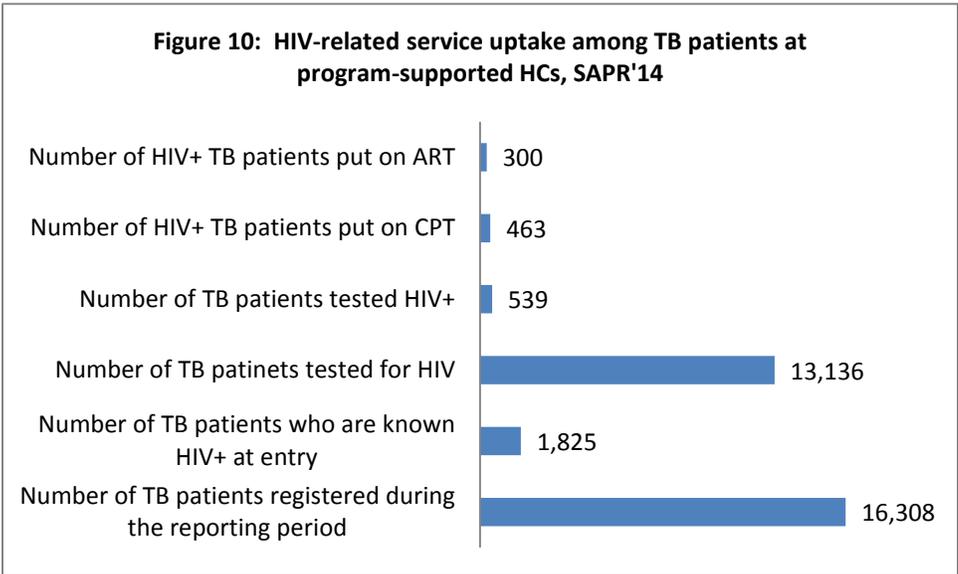
10-HVTB

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.

- ✓ **14,670 TB patients had an HIV test result recorded in the TB register** (C3.I.D)



Comment:

A total 16,308 TB clinic patients were registered during the reporting period.

Of these, 14,961 (92%) either knew their status at entry or were tested:

- 1,825 (12.2%) were known positive at entry
- 539 (3.6%) tested HIV positive

In summary: of the 14,961 TB clinic patients who knew their status

- 2,364 (15.8%) were HIV positive

- ✓ **72% of HIV-positive patients visiting the ART clinic during the period were screened for TB in HIV care and treatment settings (C2.4.D)**

Of whom:

- **2% were screened positive in the past two quarters**
 - **Of these, 64% were examined for AFB in the sputum**
 - **Of these, 14% tested sputum-positive for TB**

Comment: The NGI guideline states that the result is the last screening of the reporting period. Taking the average TB screening at the end of each quarter's reporting period, 72% of HIV-positive patients were screened during the FY, which is close to the program's target of 80%. However, the PEPFAR reporting spreadsheets do not allow an average across the four quarters, as the denominator is the final total for C2.I.D. To approximate the actual average that the program achieved across all four quarters, the Q3 totals for patients screened was used for the total, resulting in the same 72% performance.

Of note, there is no HMIS register that captures TB screening. As such, the program introduced a program TB logbook at all supported HCs. Since the logbook is a reporting tool only for the program, some HCPs exhibit reduced motivation to consistently use it, complaining that they lack the time to fill in both Government-required HMIS registers and program introduced logbooks. While the program works with its deployed data clerks and ART HCPs to better ensure that they accurately capture and report on all patients screened for TB, under-reporting is likely. The program's standards of care (SOC) surveys support this. Of 1,220 individual patient folders assessed, 1,631 (90%) showed that the patients were screened for TB at their last HIV clinic visit.

As noted above, 2% of HIV clinic patients were screened positive in the past two quarters. Of these, 64% were examined for AFB in the sputum, with 14% tested sputum-positive for TB. However, HCs continue to have limited capacity to diagnose TB in HIV-positive patients, especially those with AIDS, who have a very weak immune response, and even active pulmonary TB cases may have negative sputum smears. Furthermore, many TB cases in HIV-positive patients may be extra-pulmonary. In both instances, diagnosis can be very difficult without X-rays at the HC level, and FMOH guidelines do not permit syndromic TB treatment at HCs based on a clinical diagnosis.

Recognizing this, it is possible that HCs may refer a significant proportion of their screened positive TB patients to another facility. The low number of reported HIV/TB patients may also be the result of high death rates in HIV/TB co-infected patients.

To better understand what happens to HIV patients once they screen positive for TB, the program conducted a HC-based cross-sectional survey at 12 randomly selected high patient load HCs. The study found that out of 12,260 patients screened, only 23 (0.19%) were found TB positive. This is highly consistent with the program's routinely collected data, which presented a 0.18% rate for CY'13. As such, this OR offers further support that TB-HIV co-infection amongst patients screened for TB at the HIV clinics of program supported HCs is very low. This low incidence is likely because approximately 65% of

the patients visiting program supported HCs are receiving ART, and have been doing so for over three years on average. ART is known to effectively prevent TB and other opportunistic infections.

The above noted program's standards of care surveys, also found that over 90% of reviewed ART patients and nearly 70% of pre-ART patients had a CD4 count above 350, where vulnerability to TB infection decreases. But as many also had a CD4 count below 500 as well, this supports the validity of the recent WHO recommendation and Ethiopian acceptance to raise the CD4 cut-off point for ART initiation from 350 to 500, which also moves closer to a universal 'test and treat' strategy that will further decrease vulnerability to TB.

- ✓ **1.4% (1,224) 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 1,224 (49% male; 51% female) HIV-positive patients were started on anti-TB drugs. This represents 1.4% of all HIV patients seen at program-supported health centers. The result accounts for 92% of the program's FY14 target of 1.5%. Of note, the program's DQA, conducted in Q1, showed a perfect match between recorded and reported data for this indicator.

- ✓ **3,225 of eligible HIV-positive patients were started on Isoniazid Preventive Therapy (IPT) (C2.6D)**

Comment: The number of patients who started on IPT continued to be low but increased significantly in Amhara where IPT became available again during the reporting period. As shown by a previous literature review conducted by ENHAT-CS, the efficacy of IPT is extremely low and globally, its coverage is less than 10%. Furthermore, ART acts as an infinitely more effective prevention for TB in HIV-positive patients. Many HCPs continue to be reluctant to offer IPT, as they are unsure of its supply and are concerned of isoniazid resistance. Of note, IPT has been used in Amhara HCs only, while the Tigray RHB had decided to limit IPT to hospitals.

- ✓ **Additional Achievements**

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

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

Training: See HSS section

12- HVCT

Accomplishments and successes during reporting period with explanations for under and over achievements: Program area 12- HVCT (Counseling and Testing)

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

Comment: Through mentorship, the program's support to HCs in Testing and Counseling (T&C) continued to include on-site coaching of HCPs on national opt-out approach of PITC at every HC clinic, including OPD, FP, ANC, labor & delivery, TB/HIV, and EPI, as well as VCT in the VCT clinic.

- ✓ **1,205,673 individuals received Testing and Counseling (T&C) services for HIV and received their test results (P11.I.D)**

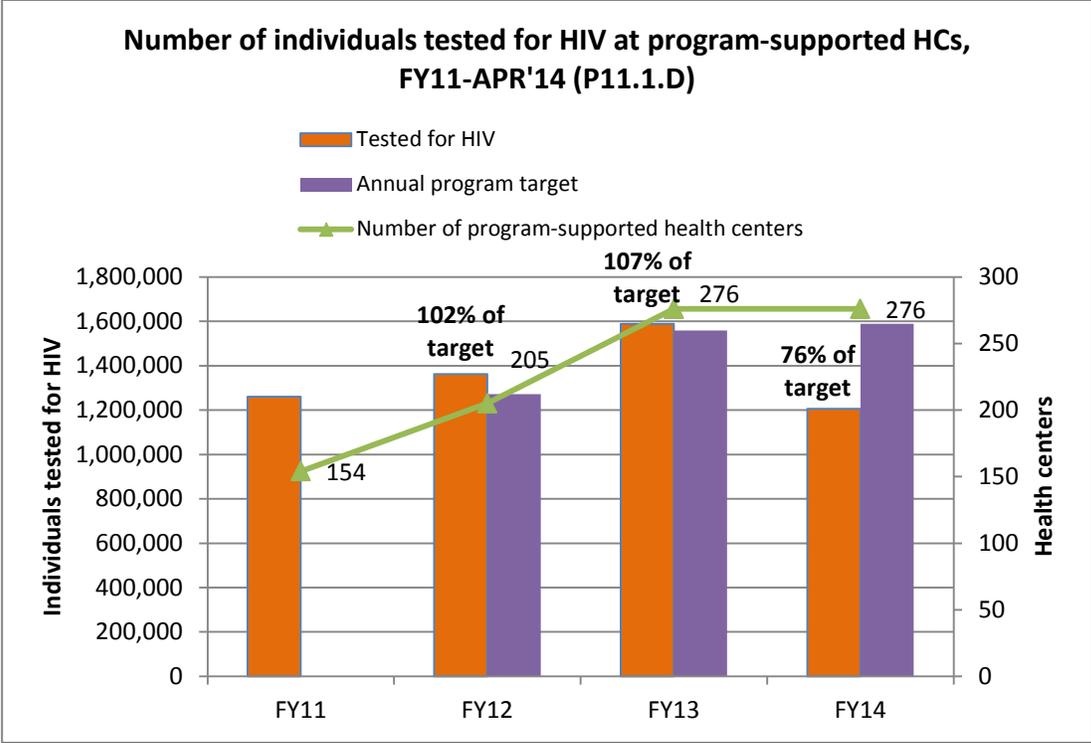
- **496,236 (41%) were tested through VCT (PMP indicator #13)**
- **709,437 (59%) were tested through PITC (PMP indicator #13)**
- **1,025,374 (85%) were individually tested (PMP indicator #13)**
- **180,299 (15%) were couple tested (PMP indicator #13)**

Comment: The number tested for HIV during the reporting period represents 76% of the program's FY14 target, and female clients accounted for 60% of the total. The number of children under 15 years old who were tested was 7%.

The majority of clients tested for HIV (59%) were tested through PITC, underscoring the continued value of the PITC strategy. When disaggregated by type of counseling, 85% were individually tested and 15% was tested as a couple.

The number of people tested for HIV during the reporting period reflects 76% of the program's FY14 target (see the below Figure). This below target result was certainly affected by a FMOH policy change during the FY that started promoting a more focused approach for HIV testing, based on potential yield. This approach recommends testing key populations, including truck drivers, sex workers, military and migrant populations as well as prioritizing VCT to couples and limiting PITC to the ANC, L&D and TB clinics unless patients present with symptoms that warrant a test.

The impact on this policy change is consistent with feedback from program mentors from their monthly HC mentorship activities. They report that while PITC is continued to be offered to 95%-100% of ANC, L&D, and TB clients, the proportion is much lower at OPD and other clinics. In addition, they report chronic shortages of HIV test kits in many of their HCs, further reducing testing.



✓ **Additional Achievements**

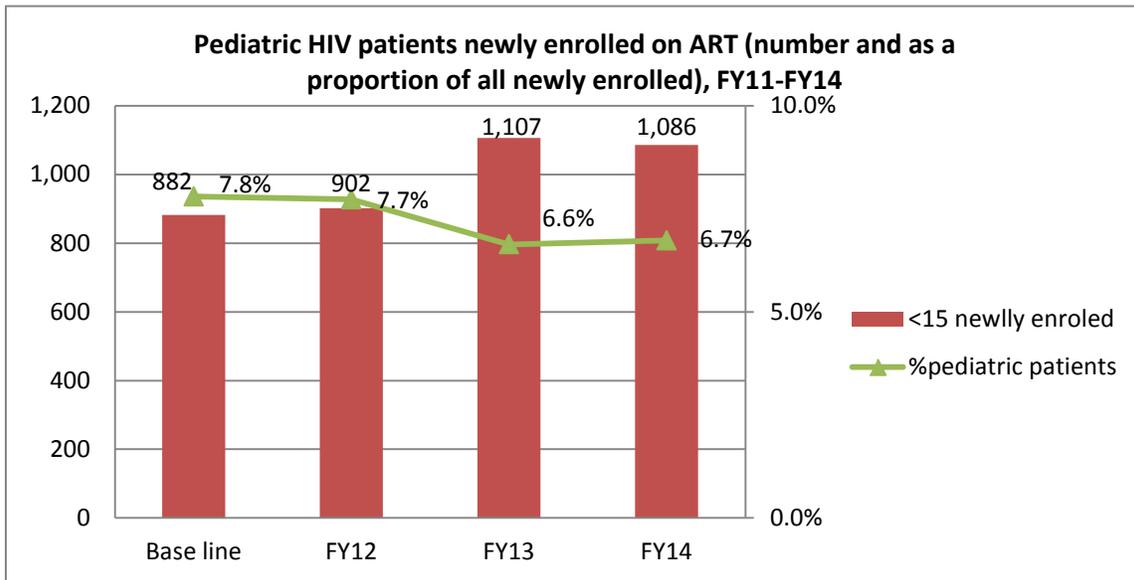
Mentorship: See earlier section 09-HTXS above. Of note, PITC and VCT are included in all mentorship.

13-PDIX (Pediatric Treatment)

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

- ✓ **1,086 children (including 63 infants) with advanced HIV infection were newly enrolled on ART (T.1.1.D)**

Comment: Among the newly enrolled ART patients, 1,086 (6.7%) were children under 15 years old, including 63 infants. The actual number of children newly started on ART during the reporting period is approximately the same as in the previous year, showing that HCs continue to enroll pediatric patients (see below Figure). The proportion of children enrolled on ART has declined as increasing numbers of adults are placed on ART when the threshold for initiating adult treatment was increased to a CD4 count of 350, and recently to 500, with no corresponding change for pediatric eligibility. The increase in absolute number of pediatric patients newly enrolled at program supported HCs testifies to the program's success, through ANECCA, in strengthening HCs and their providers to be more confident in managing pediatric patients.

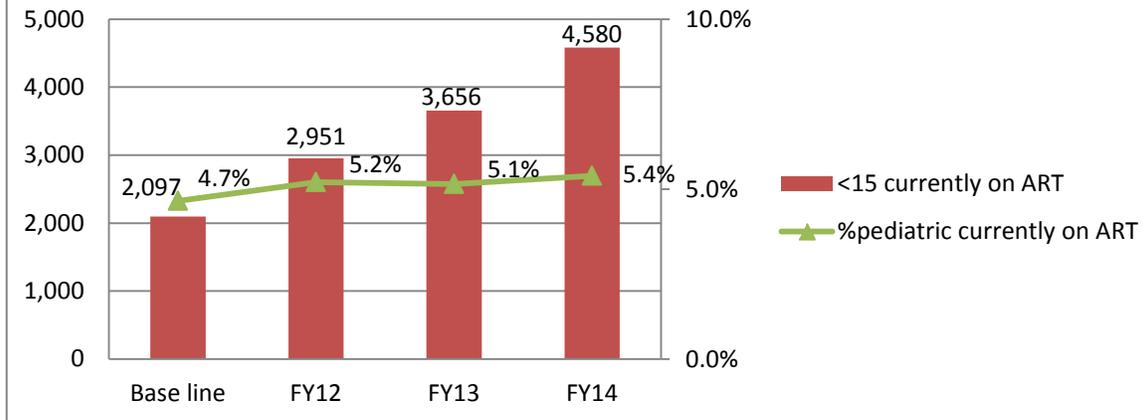


- ✓ **4,580 children (including 167 infants) are currently receiving ART (T1.2.D)**

Comment: Among patients currently on ART, 4,580 (5.4%) are children under 15 years old (see below Figure 13). As Figure 13 shows, the proportion of children among all patients currently on ART went down in FY13 and then stabilized during this reporting period, even with a significant increase in actual numbers of pediatric patients on ART. Again, this is the effect of the changes in the cut-off point for adult ART initiation, which took effect in FY13 but did not apply to children, hence the denominator (total currently on ART) rose.

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.

Pediatric HIV patients currently on ART (number and as a proportion of all current ART patients), FY11-FY14



- ✓ **89% 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 HC where they started ART 12 months earlier was 89%. The overall retention rate of pediatric clients continues to be better than that of adult clients, suggesting that HIV-positive children are relatively more stable than adult ART patients at HCs.

- ✓ **5,031 children under 15 years old is the cumulative number of children ever started on ART (T1.4.D)**

Comment: Among ever started on ART, 5,051 (5.5%) were children <15 years. The increasing trend amongst children (5.5% ever started vs. 6.7% newly enrolled) suggests that more and more children are being initiated on ART in HCs.

Additional Achievements

Mentoring activities: During FY14, a total of 212 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 participated as trainers in HIV care and treatment training activities organized by the respective RHBs with ENHAT-CS assistance and supported other training activities, including: GOE mentors’ training; comprehensive pediatric ART training; PMTCT; and gestational diabetes training; and Gestational Diabetes training (conducted only in the Tigray region).

SOC Assessment: The pediatric advisors conducted SOC surveys in ANC, L&D, U5, EPI, pediatric ART and HEI clinics at 30 HCs in Amhara and Tigray regions during this reporting period (March 2014), with data analysis currently being finalized.

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

✓ **4,925 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 5.6% of the total. They included 2,605 boys and 2,320 girls.

✓ **3,264 children under 15 years of age received co-trimoxazole (CTX) prophylaxis (CPT) (C.2.2.D)**

Comment: A total of 3,264 children received CPT during the year. This represents 7% of all clients receiving co-trimoxazole and 66% of all pediatric clients receiving a minimum of one clinical care service.

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

Comment: 564 children under the age of 18 years were referred for food or other nutritional services, representing 11.5% 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 and were probably infected vertically at or shortly after birth. However, these children do not appear in the system. UNAIDS showed that the empirical evidence is very limited. ENHAT-CS therefore agreed to collaborate with UNAIDS and collected age and sex distribution data from the over 10,000 households that the program supported through NNPWE and its community volunteers.

The data showed a high proportion (74%) of HIV-positive children found in HIV-infected and affected households are between the ages of 5 and 14 years. Overall, there were about the same number of girls and boys in each age group. However, among the HIV-positive children, there were more boys infected than girls, suggesting that survival among HIV-positive girls is lower than among HIV-positive boys, which is a finding that is similar to other studies.

The data also showed the effect of PMTCT, which became generally available in Ethiopia about 3-4 years ago. Hence, fewer of the younger children (0-4 years) were found to be HIV positive, with considerably higher numbers amongst older children (5-9 and 10-14 years). But among children 15-18 years old, the numbers again were smaller, which is consistent with data on mature epidemics that one third of infants are estimated to be slow progressors with a median survival of about 16 years.

The study concludes that children living in affected households and other OVCs represent a reachable group that could account for a substantial proportion of the HIV-infected older children and recommends that HIV programs urgently synergize with social protection sectors to address these high vulnerable children with HIV testing and related services. ENHAT-CS and UNAIDS have prepared a joint paper and have submitted it for publication.

16-HLAB

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** (HI.I.D)
 - ✓ **2,971 DBS/DNA-PCR tests performed or referred for EID of HEIs** (Non-NGI; PMP # 28)
- 214 health facilities with capacity for malaria parasite diagnosis that performed diagnosis in the past 3 months** (Non-NGI; PMP indicator # 43)

Comment: During the reporting period, 2,971 blood samples of HEIs were received by the regional laboratories for DBS testing. This performance was met despite a significant shortage of DBS test kits encountered during the reporting period at some facilities.

Comment: The lab assessment identified the number of HCs with capability to perform 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: At least once in a quarter during the first six months of the program, all 276 (100%) program-supported HCs received a focused laboratory mentorship visit by program lab mentors, using a structured checklist (lab mentors were under the program sub, I-TECH, whose ceased field activities mid-year as their contract ended before the end of the FY).

The checklist 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 was provided and documented in the mentoring folder.

Over the course of program implementation, ENHAT-CS supported HC 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; and conducive laboratory arrangement and work flow--as shown by the program's lab standard of care survey.

23 senior lab professionals who were from Dessie Regional laboratory, new hospitals and ART HCs was trained on the use of lab ART auto machines: MSH/ENHAT-CS successfully organized Laboratory ART Auto machine training in collaboration with EHNRI and the Dessie Health and Research Lab Center in Oct'14. A total of 23 senior lab professionals from various ART health centers, hospitals and RL attended both theoretical (5 days) and practical sessions (6 days).

ENHAT-CS lab program technically supported a PIMA CD4 regional roll out training.

The program collaborated with EHNRI, CDC-Ethiopia, regional laboratories, and CHAI to have 58 health professionals from 27 selected HCs and ENHAT-CS mentors to receive a 3 day theoretical and practical training. ENHAT-CS technically contributed by assigning a lab advisor to support the RL in facilitating the training and covered the 3 days training module. The training focused on key areas: clinical system strengthening and clinical laboratory diagnostics; PIMA analyzer product overview; sample collection and preparation; reagents; internal quality control; test runs and connectivity.

Instruments/machines/equipment installation support: Through the program's lab advisor, ENHAT-CS collaborated with the regional lab and PFSA to improve the continuous supply of lab reagents, including hematology and chemistry machine reagents, to program supported HCs. The program was also involved in supporting facilities through trouble shooting of machines for easy problems, preventive maintenance and reporting and curative maintenance for failed machines. While improvements occurred, this will remain a daunting challenge for the country's health system that is beyond the capacity of the program to significantly address.

Technical support was provided to the regional review meeting organized by the Amhara Regional Laboratory on comprehensive EQA implementation success and challenges in the presence of all governmental and non-governmental partners: A two day annual review meeting was organized by the Amhara RL to evaluate the success and challenges of its decentralized regional EQA approach. Representatives of governmental partners; zonal, hospital, woreda and EQA centers delegates; and other partners attended. Based on the annual regional EQA activity report, the program has been implemented very well in many health facilities. And zonal and woreda health offices were found to have given increased attention to quality laboratory work. As a result, the number of participating laboratories increased significantly. EQA centers were found to be maximizing their capacities and their performance increased over time. To strengthen laboratory quality, 24 EQA center lab professionals were trained on HIV panel sample preparation techniques.

Decentralization for EQA: ENHAT-CS provided technical support for decentralization of EQA in Tigray and Amhara through its collaboration with the regional labs. Of note, Amhara uses a decentralized system, within which decentralized EQA centers provide EQA to its area facilities. Of its 16 decentralized EQA centers, 7 are program supported HC labs. Tigray is currently using a centralized system, where EQA is carried out by its RL, but is planning to decentralize with hospitals established as EQA centers. A summary of recent results are as follows:

TB EQA

In Tigray, the second of two EQA assessments for TB was completed during this reporting period, with the first completed in FY13. Both rounds encompassed 60 ENHAT-CS supported HCs. Overall, 2,621 AFB slides were collected and assessed, with a discordant rate of 0.8%.

In Amhara, no EQA assessments for TB were carried out in FY14. However, two rounds were carried out in FY13, where the EQA centers collected and assessed AFB slides on a quarterly basis from an average of 231 health facilities, including program supported HCs. Overall, 39,248 AFB slides were collected and assessed, with a 0.5% discordance rate reported.

The overall quality of TB smear quality in both Amhara and Tigray was found to be excellent based on the low discordant rates.

HIV EQA

For each HIV panel test, 6 panels are assessed (2 positive, 2 negative, 2 weak positive). In Amhara, only one test (of 6 panels) is carried out per facility, targeting the highest testing clinic. In Tigray, four clinics are targeted: PMTCT, VCT, MCH and laboratory.

In Amhara, no HIV panel assessments were conducted during this period. However, in FY13, two rounds were carried out. The first round involved 98 program supported HCs. The second round involved 132 health facilities, which included 63 program supported HCs, 61 other HCs and 8 hospitals. Overall results for Amhara's 1,346 assessed HIV panels were:

- ENHAT-CS HCs: 934 panels tested, with 45 (4.8%) discordant
- Non-ENHAT-CS HCs: 358 panels tested, with 32 (8.9%) discordant
- Hospitals: 54 panels tested, with 8 (14.8%) discordant

In Tigray, a first round of HIV panel testing, which was started in late FY13, was completed during this reporting period, as well as a second round. For the two rounds, 27 and 26 health facilities were assessed, of which 18 were program supported HCs and 9 regional hospitals. Overall, 1,792 panels were assessed, with 83 (3.5%) panels found discordant.

While there is not a national standard on acceptable discordance rates for HIV panel testing, the regional labs have adopted <5% as acceptable. The overall rates for ENHAT supported HCs in both Amhara and Tigray met this level. In Amhara, the non-ENHAT-CS supported HCs and hospitals did not.

17-HVSI

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

- ✓ **580 Health Information/Information Technicians, woreda HMIS supervisors and data clerks were trained on SI** (part of H2.3.D)

Comment: During the reporting period 304 Government HIT/ITs and their supervisors as well as 276 data clerks were trained on PEPFAR-NGI data management and reporting for 3 days. The objective of the training was to capacitate Government data clerks (health information technicians or HITs) and program data clerks to capture data, summarize it and report on NGI indicators. The training of Government staff is similar to the basic data clerk training in content but is tailored to the PEPFAR reporting process that the Government will use. To make the training effective, woreda HMIS personnel and HIT supervisors also participated in the training. Following the training, the HITs were assigned to work together with ENHAT-CS data clerks and received program on-site mentorship.

As HIT/ITs are assigned to every health facility, they will eventually take on the work currently carried out by program-supported data clerks. However, the RHBs will utilize CDC funding to continue program data clerks, at least for an additional year after program cessation. Tigray intends to keep 55 data clerks at high HIV patient load HCs, while Amhara intends to retain all 276.

- ✓ **2 Data centers/delivery points were established** (Non-NGI indicator # 46)

Comment: One of ENHAT-CS's deliverables is to have results of program operations research (OR) placed in an Ethiopian website for public access. During the reporting period, the program collaborated with the RHBs in Amhara and Tigray, each of which have posted program-supported ORs conducted in their respective regions on the RHB websites. In collaboration with the authors, program staff have been reviewing and editing the ORs for publication on the websites. Six extracts were reviewed, edited and formatted, and put on the websites of the regional health bureaus. The same extracts were also submitted to EPHA for uploading to its website for public use.

The Amhara RHB posted them in both Amharic and English

- <http://www.amhara.gov.et/web/health-bureau/research-and-training>

The Tigray RHB posted them in Tigrinya only

- <http://www.trhb.gov.et/>

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

Comment: ENHAT-CS supported the RHBs to engage with 3 regional university schools of public health for OR and M&E activities, involving the University of Mekele in Tigray and the University of Gondar and University of Bahir Dar in Amhara. These universities have been actively working with the RHB since the start of FY13, in part facilitated by the program OR partnership advisors embedded in the RHBs – they finalized a total of 23 OR studies. Through these efforts, the program promoted the RHBs, in partnership with their regional universities, to understand the power of low cost operations research, and carry out such, which is often based on analysis of routine data, to answer key questions and inform evidence based decision making.

In FY14, the program continued to partner with the RHB and regional universities and supported them to hold a one day dissemination workshop in each region on the results of 23 OR initiatives (16 from Amhara region and 7 from

Tigray region) conducted in the two regions. These were attended by regional and federal GOE representatives as well as partnering organizations. The results of the 23 OR studies are available on request; a select number was published on the RHB websites (see above). The program also assisted in reviewing and editing the ORs and supported the RHBs to upload them on their websites and/or publish them in an extract booklet.

Additional Achievements

Data Quality Assessment: 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 integrates 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 this reporting period, the program conducted its second KDQA, reviewing data reported in Q4 of FY13 (July-September 2013). A total of 32 randomly selected program-supported HCs in east and west Amhara and Tigray were included in the assessment. A total of 19 program indicators were assessed and the summary results suggest continued good data accuracy and at times even an improvement over the first round KDQA.

The accuracy of ENHAT-CS' routine program data was also confirmed independently by an audit by the USAID Office of the Inspector General (OIG) which reviewed two key indicators (newly enrolled and current ART patients) at 5 HCs of west Amhara and found a below 2% margin of error.

The program's KDQA provided further evidence for the findings by the OIG audit, with respective margins of error of 0.9% and 1.6% acquired from a larger sample of 32 HCs on the same indicators. These excellent results testify to the rigor with which data are recorded and reported. From its start, ENHAT-CS has placed great emphasis on data recording, reporting and use for decision making, both at the HC and program levels. The program invested key resources in selecting, training and re-training data clerks and ensuring that every program supported HC has a program deployed data clerk. Furthermore, the program's monthly mentorship, as well as quarterly supportive supervision, dedicates a significant portion of time and effort to supporting health care providers and data clerks in data management and use.

To maintain data accuracy, continuous vigilance will be needed through continuous mentoring support and checking data consistency at HC level and proper and ongoing orientation of Government mentors who need to place emphasis on encouraging health care providers to update the registers on a timely basis. As the program was transitioning to the Government, ENHAT-CS worked with the RHBs and other MOH staff at both management and facility levels, including the HITs who will replace the data clerks to train them on these aspects.

Routine DQA. In addition to the KDQA, the program continued to carry out routine data verifications through 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.

13 ENHAT-CS M&E staff were trained on program data management. A total of 13 ENHAT-CS program staff (10 male and 3 female), including the regional M&E Advisors, Quality Assurance Officers and Data Officers, received refresher training on the program's online database management, using the DHIS-2, and internal data quality assurance techniques. They also reviewed overall M&E activities of the program. The training was held from October 24 to October 26, 2013.

Operations research: In addition to the above collaborative OR activities with the RHBs and universities, the program also implemented OR activities through its own program staff. In FY14, the program completed the following studies at program-supported HC (unless otherwise noted).

1. **Predictors of mortality among HIV-infected patients taking ART in public health facilities in Bahir Dar, Ethiopia.** Among 1,901 ART patients studied at 4 program-supported HCs, 79% were on active follow-up, 12% were transferred out, 4% were lost to follow-up, 2% had stopped treatment and 2% had died. There were 44 deaths in 4,476.4 person-years of retrospective follow-up resulting in an incidence density of 9.8 per 1,000 person-year observations (95% CI 7.3 to 13.2). In multivariate analysis, independent predictors of mortality were being bedridden, WHO Stage IV, CD4 cell count less than 100 cells/mm³, history of CNS toxoplasmosis, year of ART initiation and interruption of ART. *Implication:* prevention, early detection and management of these predictor conditions may improve the quality and longevity and reduce mortality among HIV patients.
2. **What happens to HIV-positive patients after they are screened for TB?** Among 12,260 HIV clinic patients seen at a random sample of 12 HCs between June and August 2013, 12,010 (98%) screened negative and 250 (2%) screened positive for TB. Among patients who were screen-negative and eligible for IPT (n=11,031), 12% were put on IPT. Among patients who screened positive, 78% were given an AFB test at the HC and 8% were referred for further investigations like chest X-ray. However, 15% of the lab results were not returned to the HC, and another 14% patients did not undergo any type of lab investigation. Overall, 0.2% of all HIV-positive patients were confirmed with active TB. They were all put on anti-TB treatment. HIV patients' age, sex or frequency of visits to the HC did not show any association with the occurrence of TB. *Implication:* the incidence of TB in HIV patients at HCs in Amhara and Tigray was very low, probably due to a majority already being on ART. The finding supports earlier initiation of ART and universal 'test and treat' as a TB prevention strategy.
3. **Client satisfaction with ART clinic services.** A random sample of 1,924 clients was interviewed at 152 HCs. Among them, 91% were on ART and 9% on pre-ART. Overall, 89% of clients reported being satisfied with the services received on the survey day, 83% during the previous two visits at the HIV clinics, and 66% would recommend their respective health centers to a friend who has HIV. A high proportion of clients reported satisfaction with confidentiality (88%); privacy (79%); respect (89%); comfort (91%); availability of ARV drugs (99%) and lab services (89%); waiting time to see a health provider (85%); and receiving lab results during their visit at the clinic (70%). Relatively lower proportions reported being satisfied with the availability of non-ARV drugs (68%), provision of a choice in health service (57%), and availability of case managers for consultation on demand (66%). *Implication:* health providers and managers should continue to be supported in providing good service to HIV clients while they also need to address the shortages of non-ARV drugs and case managers.
4. **The case for a universal 'test-and-treat' approach for HIV in Ethiopia.** Providing ART to all HIV-positive patients and limiting routine CD4 testing for stable patients to once every two years would result in a 9% increase in the number of patients on ART and a 13% increase in the costs associated with the current policy in Ethiopia of limiting treatment to HIV-positive patients with a CD4 count < 500. If routine CD4 testing were limited to once a year and to ARV-resistant cases, the reduced need for CD4 testing would offset the shown increase in funds needed for ARVs. *Implication:* The results showed that adopting universal 'test and treat' is only marginally more expensive than the current cost of ART in Ethiopia and therefore, 'test and treat' should be considered as the standard.
5. **Pre-ART care retention: secondary data analysis of pre-ART cohorts.** Of 10,028 pre-ART patients, 8,118 were still on pre-ART care or on ART at the HC where they were initially enrolled after 12 months of enrollment. Among retained pre-ART clients, 64% (5,205) were female, 65% (5,268) were from urban HCs, 92% (7,460) were adults and 56% (4,513) were from MSG-supported sites. Overall, there was no significant difference in retention of male and female patients, or of patients attending HCs in rural or urban areas. There

was a significant difference between pre-ART patient retention in MSG sites compared to non-MSG sites (MSG-83% (4,513/5,427), Non-MSG 78% (3605/4601), p-value .000, OR=1.364) with better retention at MSG sites regardless of gender, age, or health center location. The majority of retained patients 82% (6,657/8,102) were in high load HCs (p-value 0.000). *Implication:* HCs with lower numbers of HIV patients need to be supported to develop better strategies to retain new HIV patients.

- 6. Use of telephone consultations to compliment on-site mentorship for HIV services.** Over a six month period, program mentors reported receiving 451 calls from 137 HCs. The average number of calls per mentor per month was 2.9. The average duration was 10.4 minutes (SD=8.0), ranging from 2 to 60 minutes. Only 9% lasted more than 20 minutes. Most calls were made by ART providers (58%), followed by data clerks (17%), HC heads (11%) and PMTCT providers (4%). Adult and pediatric ART management was the most common reason for consultation (39%), followed by M&E (16%), HIV-exposed infant management (15%), program management (15%), PMTCT (8%) and post exposure prophylaxis (3%). There was no association between the frequency of consultations with HC or the year in which ART services were initiated. *Implication:* making consultations with mentors by telephone available to health providers appears to be a low cost approach that meets an important need of health providers.
- 7. Strengthening the gender focus to improve ANC/PMTCT service quality.** Focus group discussions highlighted four main issues. First, while being counseled not to get pregnant without consulting their HIV provider, HIV-positive women felt stigmatized and chided when they got pregnant, resulting in guilt and depression. Second, participants felt that information received from mother support groups (MSG) equipped them with good 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 despite health center invitation letters to men to accompany their spouses. 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 opening hours. The survey showed that all HC management teams ranked these four issues as a 3, i.e. the lowest priority for making changes. *Implication:* providers and clients have different, often opposing perceptions of the quality of HIV services. Providers need to be educated and sensitized on clients' perceptions and be supported to address the quality issues expressed by them.
- 8. Reasons for pregnancies among known HIV positive women.** Among women who were on chronic HIV care and support at 20 program supported HCs from April to June 2014, three quarters had at least one birth since knowing their HIV status. Being in chronic HIV care and support for more than 12 months was positively associated with current pregnancy ($p < 0.031$). Just over half (56%) women reported that the last or current pregnancy was desired (planned). Another 15% wanted a pregnancy or child but later. Ever use of any contraceptive methods among the HIV-positive mothers was 82%, with hormonal injectable being the preferred method. However, condom use was only at 17%, indicating low dual protection. All HIV clinics offer condoms, pills and injectable and refer for long acting and permanent methods and according to program data, current contraceptive use remains low though comparable to that in the general population. *Implication:* 71% of the known HIV-positive women reported their last or current pregnancy was planned or desired (but later). Despite widespread availability of family planning at the HIV clinic, 25% of the women never wanted the pregnancy or child, suggesting that more education and attitude change interventions are needed.
- 9. Magnitude and Associated Factors of Pediatric and Adolescent Human Immunodeficiency Virus Infection Status Disclosure in South Gondar, ETHIOPIA.** Of a total of 239 children/caretakers included in the analysis, 44.4% knew their infection status explicitly. The mean age of disclosure was 10.71 years (± 2.83). Older age (14-17 years), external support, initial CD4 count of 200-349 cells/mm³, being started on ART at a hospital, and self-medication were associated with disclosure of HIV infection status. Young children given medication by parents, those who have no external support and those who were started on ART at HCs should be targeted for disclosure.

10. **Assessment of follow-up and care for HEIs born at health centers.** This review of HEI records at program-supported HCs between October 2011 and September 2013 showed high enrollment (96%) in HEI follow-up and EID services, high uptake of DBS within the first two months (93%), high uptake of CPT (95%), high uptake of infant prophylaxis (89%) and a low HIV infection rate of 1.4% among HEIs born at the HCs. However, registration of growth monitoring (60%) was poor, as were immunization rates appropriate for age (76%). *Implication:* the study points to the importance of retaining HIV-positive pregnant mothers in the health system and promoting facility-based delivery, to ensure HEIs receive appropriate services. However, it is equally important that HEI service providers equally address routine infant care services.
11. **The role of mother mentors in supporting HIV-positive women.** This booklet presents four studies that compared health service uptake and health outcomes between HIV-positive mothers who received mother mentor services and those who did not. The data point very strongly to the positive impact of mother mentors on follow-up/retention; adherence to treatment, care and support; HEI care and on vertical transmission rates. *Implication:* in the absence of negative effects, the studies strongly support the promotion of integrating mother mentor services into standard care and support services for HIV-positive mothers.
12. **GDM in ANC clients in Tigray.** This study, co-funded by the MSH INCH fund, showed that 11% of ANC clients seen at three high patient load HCs in Tigray had GDM, - higher than 9% prevalence of GDM in the USA. However, 80% of them responded well to simple behavioral interventions. HIV-positive patients had higher rates of GDM and did not respond as well to interventions. The OR also showed successful adaptation of international guidelines to the Ethiopian context and demonstrated a low-cost approach to integrating GDM services at ANC clinics in public health centers. *Implication:* GDM is a big health issue among women seen at health centers in Tigray. These results should be verified through larger studies and if confirmed, the adoption and implementation of Ethiopia-specific guidelines for screening for and managing GDM should be made an explicit, high priority in standard ANC services.
13. **The missed HIV-positive children of Ethiopia.** Carried out in collaboration with UNAIDS, this study highlights the presence of a large population of children between 5 and 15 years old living with HIV in Ethiopia, the magnitude of which has not previously been recognized. The majority were vertically infected and never identified nor linked into treatment and care. The paper uses ENHAT-CS data collected through NNPWE volunteers on children living in affected households. *Implication:* children living in affected households and other OVCs represent a reachable group which could account for a substantial proportion of the HIV-infected older children. HIV programs should urgently synergize with social protection sectors to reach and address these children with HIV testing and related services.

The following program-led ORs were published and or presented on local and international scientific conference during the reporting period.

1. *Test and treat is feasible for resource poor countries in Africa* ,
 - a. 142nd American Public Health Association (APHA) Annual Meeting and Expo, New Orleans, USA, 15-19 November 2014
 - b. 17th ICASA Conference, South Africa, 7-11 Dec'13
2. *Sexual behavior and vulnerability to HIV infection among season migrant laborers in Metema District, Northwest Ethiopia: A cross-sectional study*, 25th EPHA Annual Conference, Ethiopia, 20-22 Feb'14
3. *The case for a universal 'test-and-treat' approach for HIV in Ethiopia*, 25th EPHA Annual Conference, Ethiopia, 20-22 Feb'14
4. *Pre-ART care retention in ENHAT-CS program supported health centers: secondary data analysis of pre-ART cohorts*, 25th EPHA Annual Conference, Ethiopia, 20-22 Feb'14

5. *What Happens to HIV-positive patients after they are screened for TB at public health centers in Ethiopia?*, 25th EPHA Annual Conference, Ethiopia, 20-22 Feb'14
6. *Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia*, 17th ICASA Conference, Malaysia, 7-11 Dec'13
7. *Rising pregnancy rates among known HIV-positive women in at health centers in Addis Ababa, Ethiopia*, American Public Health Association (APHA) Annual Meeting, Boston, USA, 2-6 Nov 2013
8. *Vertical transmission of HIV by age of infant testing and type of mother/infant prophylaxis in Tigray, Ethiopia*, STI & AIDS World Congress 2013, Vienna, Austria, Jul'13
9. *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*,
 - a. American Public Health Association (APHA) Annual Meeting, Boston, USA, 2-6 November 2013
 - b. 7th International AIDS Society Conference on HIV Pathogenesis, Treatment and Prevention, Malaysia, 30 June – 3 July'13
10. *The Role of Mother Mentors in Supporting HIV-Positive Mothers*, ENHAT-CS publication, February 2014

Support to EPHA: The program provided support to EPHA to strengthen its overall institutional development. In the reporting period, the program developed a project idea for tobacco control, which was selected by the Review Committee of the Bloomberg Initiative to Reduce Tobacco Use Grants Program, to go forward to a full proposal for the grant. Additionally, the program has taken part in a consultative meeting of EPHA's planning, monitoring and evaluation guideline development.

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)

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

Comment: During this reporting period, the program trained 13 new data clerks to replace those who had left. In addition, the program trained 61 staff of the central and regional offices of NNPWE.

As noted earlier, for the NNPWE training, the program's original plan was to strengthen the capacity of the NNPWE national and Amhara and Tigray regional associations to assume management of the mother mentorship program at HCs, with USAID funding. During this reporting period, the program provided capacity building training to 61 (51 M; 10F) association leaders. The training fostered a common understanding of the mother mentor national curriculum, while focusing on strategies currently used in the 85 program supported mother mentor sites. The training also focused on strategies to strengthen HC - community linkages through association activities and follow-up mechanisms, as well as their role in providing technical support through mentorship and reporting.

- ✓ **1,612 health care workers who successfully completed an in-service training program (H2.3.D)**

Comment: During the reporting period, the program trained 1,612 health care workers, as follows:

Type of Training	M	F	Total
Comprehensive ART/IMA1 (adult)	125	54	179
Comprehensive ART/IMA1 (pediatric)	125	54	179
PMTCT option B+ training (gap filling)	66	101	167
Laboratory related services: lab automation	34	20	54
Other	1,033(304 HITs, 282 LMG and 447 Gov. mentors: clinical and program)		
1,069	543	1,612	

Note: Training courses on adult and pediatric ART, which includes ART/IMA1 as well as pharmacy, is separated and reported under two separate course categories, adult and pediatric.

- ✓ **11 local organizations provided with TA for HIV-related capacity building (Non-NGI; PMP # 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 RHBs of Amhara and Tigray; the program's implementing partners, IMPACT, EIFDDA, NNPWE, EPHA, DOHE, HST; and the program's collaborating universities of Bahir Dar, Gondar and Mekele. With 11 local organizations currently supported, the program has achieved 100% of its FY13 target.

Additional Achievements

✓ **PEPFAR standards**

PEPFAR is increasingly requiring and utilizing comprehensive and objective standards for assessing partner performance. For HSS, this involves the PEPFAR Strategic Information Management System (SIMS) comprehensive evaluation of service delivery. For strategic information, this involves rigorous strategic information reporting requirements in accordance with the PEPFAR Monitoring, Evaluation and Reporting Systems (MERS), and its detailed Partners Site Inventory report, under the guidance of the detailed PEPFAR NGI data collection guidelines. Audits by the Office of the Inspector General Office confirm the accuracy of reported data on key indicators.

ENHAT-CS has performed well on these measures, as the following presents:

Data audit by the regional United States Government Inspector General Office.

As reported in the FY13 APR, ENHAT-CS hosted a team from the regional USG Inspector General Office from 16-20 Sep-14 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 (HC registers) at 5 randomly selected health centers. The audit focused on two core NGIs, patients newly enrolled in pre-ART and ART at five HCs around Bahirdar (Adet, Dangla, Injibara, Debreabor, Alember).

The audit report was published during this FY (23 May-14), and is titled: AUDIT OF USAID/ ETHIOPIA'S HIV CARE AND TREATMENT ACTIVITIES AUDIT REPORT NO. 4-663-14-006-P

The audit found the data in the assessed HCs to be within 2% of that reported by the program to PEPFAR. Following is the reports positive summary of their findings:

“ENHAT-CS generally was achieving its goals. The project’s overall goal is to “mitigate the impacts of HIV/AIDS and improve quality of life of [people living with HIV] their families and the community.” As part of this goal, the project aims to expand both adult and pediatric care and treatment. These activities address the second objective in the partnership framework. In FY 2012 ENHAT-CS reported helping the Ethiopian Government provide clinical care to 64,313 patients compared to a target of 58,007, and helped treat 56,694 compared to a target of 50,344, exceeding their targets by 11 and 13 percent, respectively. We tested both of these clinical indicators at five health centers in Amhara, without exception.”

“Beyond the reported results, ENHAT-CS had helped the Ethiopian Government expand its treatment services. For example, the government had expanded the number of health centers that provided HIV treatment from 110 in FY 2011 to 192 in FY 2013 with assistance from ENHAT-CS. Additionally, the project implemented innovative tools that made its activities more effective. For example, ENHAT-CS kept a register at each health center it supported to document each visit, including items for follow-up—a valuable tool to improve the usefulness of site visits.”

HSS evaluation by the PEPFAR Strategic Information Management System (SIMS) evaluation tool:

From 2-3 Sep-14, a team of four technical staff, three from USAID Ethiopia and one from Health Resources and Services Administration (HRSA) Washington, visited a program supported HC, Debre Berhane, to conduct an evaluation of the HC's quality of HIV service delivery and health system, using the new PEPFAR SIMS (Strategic Information Management System) tool.

The SIMS is a comprehensive tool that provides a detailed and comprehensive evaluation of a HC's health system, and includes review of the HCs quality of provision of HIV services in accordance with

approved standards of care, availability of reference materials (e.g. guidelines, guides, job aids, etc.) and systems utilized (e.g. tracing patients who miss ART appointments etc.).

The tool measures 24 specific programming domains, with over 400 queries leading to a total of 105 scored assessment areas. For Debre Berhane HC, 76 assessment areas were appropriate. For example, the HC does not provide blood transfusions, so blood safety was not assessed.

The assessment demonstrated that, with program support, Debre Berhane presented a strong health system for providing quality HIV services. A total score of 88% was achieved, involving an average score of 3.5, which fell halfway between a dark green (surpasses expectations) and light green (meets expectations). Following is a summary of performance on the 76 assessed areas:

- 54 dark greens (surpasses expectations)
- 11 light greens (meets expectations)
- 5 yellows (needs improvement)
- 5 reds (needs urgent improvement)

Three red scores were because the HC's case manager was not actively tracking community referrals. She was documenting referrals to the community using a program logbook, and was filing referral slips received from the community, but she wasn't putting the information in the logbook for active trading. Another red score was pediatric growth monitoring. All the required equipment was present but the health care providers weren't consistently using them to track and document growth. These four areas noted for urgent improvement can be easily rectified almost immediately.

The fifth red was an unreliable supply chain for ARVs, which is beyond our or the HC's control.

Of note, the HRSA evaluator noted that the HC's lab was very impressive, stating that it was one of the best HC labs that she had ever seen in Africa.

- ✓ **Fax machine support to selected ART health centers:** To facilitate HCs' communication capacity, including the timely receipt of hard copy DBS test results, especially DNA PCR positive ones, and thus to improve their timely initiation of treatment, fax machines were distributed to all HCs with landline telephone and 24 hour electric supply. After a survey, it was determined that 192 HCs did not have access to a fax machine but did have electrical power, so 192 fax machines were procured and distributed during the reporting period. A survey in Q3 found that 167 (87%) were installed and operational, but the communication system between RL and HCs was not fully actualized.
- ✓ **Participation in TWG:** During the reporting period, ENHAT-CS staff actively participated in different national TWGs, namely:
 - HIV and AIDS care, treatment and prevention advisory group (national umbrella TWG)
 - PMTCT/MNCH TWG
 - Option B+ task force for implementation
 - Pediatric HIV and AIDS
 - IP/PS
 - Laboratory services
 - Gender and HIV

ENHAT-CS, at regional level, is also a member of the regions' umbrella TWG for HIV and AIDS/STI/TB, as well as task forces and sub-committees formed to address key issues, such as the development of the 5-year costed HIV strategic plan and annual work plan for their cooperative agreements with CDC.

✓ **Support Amhara RHB's Health Festival:** During this reporting period, the program supported the first ever Amhara regional health festival and was actively involved in different committees during the groundwork.

Integrated Supportive Supervision (ISS): During this reporting period, the program supported, technically and financially, the Amhara and Tigray RHBs to conduct ISS. The ISS is a standard Government oversight activity of its health facilities, which is carried out by RHB management and technical staff and partners, using RHB developed guides and detailed checklist. ENHAT-CS regional management actively utilized the Tigray ISS findings by reviewing and discussing them with the program's regional technical staff and during regional program meetings and developing action plans accordingly to address gaps that were uncovered.

✓ **Technical support to Catchment Area Meeting:** During this reporting period, the program supported the RHBs to conduct catchment area meetings involving ART providing hospitals and HCs, regional government (PFSA, regional lab) and PEPFAR implementing partners.

The Amhara RHB catchment area meetings included reviews of the status of the Government mentorship initiative, as well as major issues affecting the ART program, including: commodity and medication supply shortages (DBS test kit, HIV test kit, reagents for CD4 and chemistry testing, pediatric ARVs); and delay in installing hematology machines distributed by PFSA.

The Tigray RHB catchment area meetings also focused on the transition process, including governmental mentorship, data management and PEPFAR reporting, as well as other issues affecting the ART program, including: referral linkage and feedback; defaulter tracing; and supply issues like shortage of IP materials, and DBS test kits.

Transition achievements

In its third and final year, and with PEPFAR transition HIV care and treatment from implementing partners to in-country government and non-governmental organizations, ENHAT-CS focused on supporting counterparts, especially the Amhara and Tigray RHBs, to assume responsibilities for key program supported areas. The key transition areas that the program focused was on:

- Mentorship of HCs (including clinical HIV service delivery and laboratory)
- Reporting on PEPFAR NGIs

In addition, the program focused on supporting the RHBs to assume responsibility for additional program areas, as follows:

- Training HCPs in HIV areas
- Case management services
- Task shifting of mental health services
- Leadership and Management Development training
- Mother mentors and MSGs
- Approaches for gender mainstreaming
- Approaches for sustaining a continuum of HIV care between HCs and their area hospitals and their served communities
- Approaches for sustainable evidence-based decision making

✓ **Transition of clinical mentorship of HCs**

The program's woreda based approach was to:

- Train HC based HIV clinic focal persons to provide clinical mentorship (prioritizing the HIV, and ANC/PMTCT and L&D clinics) both within their facility and to 3-4 satellite HCs within their woreda (which generally only provide option B+ PMTCT services)
- Train zonal health department and woreda health officers to provide program/system support to the clinical mentors
- Have RHBs, zonal health department and woreda health officers participate in joint mentorship of government clinical mentors
- Implement government mentorship in all zones of Amhara and Tigray
- Provide ongoing program mentorship of government clinical mentors
- Facilitate woreda health officers to support govt. clinical mentorship visits to satellite HCs
- Work with RHB mentorship units to oversee and sustain

As such, following the training of government clinical mentors, joint mentorship was conducted with the trainees by program mentors and regional advisors. The program mentors conducted joint mentorship with the government clinical mentor within their HC for the first four to six months post-training, guided by a structured checklist that includes: demonstration of history taking and physical examination; observations of chart and review of record; provision of case management, data use for decision making and monitoring; participation in the MDT meeting; and giving reading assignments in between practical trainings.

After the joint mentorship period, the government clinical mentors were assessed, and those determined to be able to carry out independent mentorship, were graduated. Those requiring further support received additional joint mentorship.

After graduation, the graduated government clinical mentors are to provide mentorship support of HIV and ANC/PMTCT and L&D clinics sites within their own HC and 3-4 woreda satellite HCs, using a structured checklist. The program recommends they provide, per month, one-day of internal clinical mentorship and one-day clinical mentorship of one to two satellite HCs.

Government mentorship site expansion: In FY13 and 14, the program supported, in collaboration with the RHBs, its government clinical mentorship initiative in the following locales:

Region	Zone		Woreda	HCs	GOE clinical mentors
Amhara (east)	5	Wollo (South), Gojam (East), Gondar (North), Gondar (South), Awi, Bahir Dar	78	98	98
Amhara (west)	5	Gojam (West), Shoa (North), Wollo (North), Oromia, Waghirma	51	63	63
Tigray	7	Southern, Central, North Western, Southeastern Mekele city, Eastern and Western	49	44	95
Total	17		188	217	238

As can be seen from the above table, the program has supported 17 zones of the two regions, 188 of their woredas and trained a total of 238 clinical mentors from the same number of HCs, as well as a program/system mentor from each woreda health office and zonal and RHB representatives.

Joint government mentorship: Following the training of government mentors, joint mentorship was conducted during this period, with the program mentors and regional advisors.

Graduated government mentors provide support beyond their own HCs: In Amhara region, all the trained government clinical mentors graduated from joint mentorship and started conducting independent mentorship, using a structured checklist, and prioritizing the HIV and PMTCT providing clinics. General observations indicate that the independent activities conducted by the mentors are satisfactory, but mentorship of satellite HCs has been limited, which indicates that woreda health office organization and planning requires strengthening.

The program also supported the Amhara RHB to conduct gap filling training of an additional 137 government mentors, selected from all zones and woredas. As this training was funded by RHB funding, it shows that the RHB is taking ownership of the government mentorship initiative and plans to sustain it after ENHAT-CS cessation.

Transition of mentorship of HC laboratories

Health facility laboratories are not under the authority of the RHBs, but are under the RLs, who are under the EHNRI, not the FMOH. EHNRI has also received CDC funding to support PEPFAR transitioning. The program advocated for a simple, almost cost free HC lab mentorship approach that embeds it into the evolving decentralized EQA system. Technical specialists from the decentralized regional EQA centers are expected to carry out semi-annual visits to HCs for HIV panel testing. The program advocated that their role be expanded to include general mentorship of the HC lab, complemented by ongoing provision of telephone consultation support. This was advocated by the program to the regional laboratories and the National Laboratory Services TWG.

As part of Tigray's transition support, during this reporting period, the program supported reestablishment of the Tigray Laboratory Service TWG to support the transition of lab support from implementing partners, as well as to address quality service issues. The program's Tigray regional laboratory advisor was appointed the TWG secretary, with two meetings conducted. A plan of action was developed on how to transition laboratory mentorship, as well as for decentralization of EQA, status of sample referral linkages, supply shortages, status of auto machines, and improved turnaround time. Within the TWG, the HC mentorship transition focus on integrating lab mentorship into the existing EQA program's facility outreach was discussed. It was noted that regional laboratory staff have already received mentorship training supported by ITECH and orientation by ENHAT-CS on the program's lab mentorship checklist and forms.

In addition to external mentorship, the program has built the capacity of and advocated for HC laboratory personal to assess their PITC testing sites (OPD, PMTCT, VCT, TB clinics), evaluate performance and provide mentorship for corrective action.

The Tigray RL advisor attended meetings and discussions held between the RL and ICAP on the development of their transition strategic plan and implementation action plan for Mar to Sep'14. Of note, the RHB is planning a mentorship strategy that deploys RL and hospital based mentors for

providing laboratory quality management mentorship focusing on strengthening a lab quality officer for conducting internal/onsite mentorship as well.

✓ **Transition of reporting on PEPFAR NGIs**

Given the complexity of the PEPFAR NGI guidelines, RHB assumption of this responsibility will be a key transition challenge. Of note, considerable sustainability exists, as nearly all of the NGI data sources are from the FMOH HMIS, and the FMOH has reportedly revised its HMIS to better meet the disaggregation and reporting required of the PEPFAR NGI indicators. In addition, an estimated 91% of program supported HCs have a RHB employed health data technician, with around 42% being a health information technician (HITs) and 58% an information technician (IT).

However, the NGI guidelines are detailed and strict on how data is to be collected, with considerable disaggregation, and how to avoid double counting. To help the transition of this difficult challenge, the program held consultations with ICAP, who is the key PEPFAR partner for providing technical assistance to the Government for the five year transition period. As part of the consultations, the program shared its data collection system with them, including its data clerk manual, data collection guide and data collection/reporting formats.

During this reporting period, the program's regional staff also held consultations with each RHB leadership on how they can assume responsibility of this function. Both regions stated that they prefer to have PEPFAR reporting responsibility, at facility level, be primarily assumed by their deployed HIT/ITs. However, the Tigray RHB is utilizing funding from CDC to continue program data clerks at 55 HCs (ART HCs with an HIV case load >100 patients). The Amhara RHB is utilizing funds from CDC to continue all program data clerks for an additional year.

During this reporting period, the program provided 3-day trainings to 304 government counterparts, including the IT/ITs deployed at program supported HCs, woreda health officers and RHB HMIS unit staff. The objective of the trainings were to capacitate the HIT/ITs to capture data, summarize it and report on NGI indicators. This training was similar to the basic data clerk training in content but was tailored to the PEPFAR reporting process that the Government will use. The training specifically focused on:

- Overview of the transition process from program data clerks to government HIT/IT
- Practical review of data sources and tools currently used by the program data clerks, including the HIV clinic intake form, ART and pre-ART registers, ANC/LD/PMTCT registers, HEI tools (HEI follow-up form, register, DBS request form), logbooks (including the appointment, screening, PEP, cohort, family matrix, and referral log books), and registers utilized in PITC entry points e.g. VCT, FP, TB, OPD, etc.
- All PEPFAR NGI monthly reporting formats by program areas 1-10 (definition, data source and utilization for decision making)

The training was conducted by the program's regional M&E team, clinical mentors and best performing data clerks, with support by the program's regional technical and program managers. It emphasized the importance of data management and the importance of the HIT/ITs to be in their office on a daily bases to ensure every aspect of HIV clinic services provided by the HCPs are fully documented, as immediate updating of registers and logbooks is essential to ensure each NGI has a complete, accurate data source at the end of every month.

Following the training, program clinical care mentors carried out focused mentorship of the HIT/ITs to ensure they have the necessary knowledge and skill for PEPFAR reporting, including utilization of ENHAT CS tools.

✓ **Transition of training of HCPs on HIV areas**

The ENHAT-CS transition plan was for the program to work with the RHB HIV core process team to support their assumption of HIV related trainings, including:

- Identifying staff that requires training, including gap filling training
- Arranging trainings in collaboration with the RHB training unit
- Leading logistical arrangements (jointly identify training venues)

ENHAT-CS does not anticipate that the RHBs will have difficulty assuming responsibility for training HCPs on HIV related topics. RHBs already carry out considerable training on other health service areas. A key gap has been the funding of HIV focused trainings, which CDC cooperative agreements should address.

For Amhara, during this reporting period, the program worked closely with the Amhara RHB staff in identifying and organizing gap filling trainings in partnership with RHB officers involved in ART training for HCPs, pharmacists and PMTCT. As part of this transition of responsibility, the program supported the RHB to organize, lead and finance a one-day orientation workshop to update ART service providers on the new CD4 cut off point of <500. Overall, 109 HCPs participated in 4 rounds of the orientation workshop, where ENHAT-CS role was limited to having its advisors be trainers. This RHB led initiative showed the Amhara RHB's commitment to take the leading role in HIV focused trainings.

The Tigray RHB's TWG for HIV/TB/STI, which ENHAT-CS was the secretary of, focused on transitioning activities. On HCP training, the RHB team ensured that their HIV experts are assigned to assess specific HIV service training, and that a comprehensive HIV training profile assessment is integrated into their joint supportive supervisions. In addition, the RHB assumed selected leadership of HCP trainings during the reporting period, including:

- Identifying training gaps within the program's areas of ART/IMAI, and PMTCT and selecting trainers and inviting the HCP trainees. Training gaps are being identified from the supportive supervision checklist results, and health facility reports
- Participating in preparation of training materials, and arranging training venues
- Conducting daily training evaluations

✓ **Transition of case management services**

ENHAT-CS established a partnership with the regional NEP+ associations, with the focus on establishing a platform for the transition of program case managers to these associations, under expanded CDC funding, upon program cessation. The regional associations are the Network of Charitable Societies of HIV Positives Association in Amhara (NAP+) and the Network of Charitable Societies of HIV Positives in Tigray (TNEP+). Key achievements during this reporting period to strengthen their capacity to assume transitioned responsibility included:

NAP+

- Held two rounds, totaling 22 catchment area meetings, in all zones of Amhara. The meetings brought together each catchment area's case managers and adherence supporters from hospitals and case managers from HCs, along with representatives of the RHB, respective zonal health department (head and ART focal person), HC ART focal persons and PLHIV association heads of the zonal towns. A total of 1,206 participants attended the two rounds, with an average of over 340 case managers and adherence supporters and 156 ART focal persons attending each, as well as attendees from the RHB, zonal health department and woreda health offices. The catchments area meetings focused on discussing on the last six months performance, sharing experiences between NAP+ and ENHAT-CS case managers and adherence supporters, and addressing challenges.
- Carried out mentorship visits at 27 HCs where both NAP+ and ENHAT-CS case managers are jointly deployed, as well as at 13 hospitals.
- Management and technical staff carried out two rounds of supportive supervision at 58 HCs. In addition, for the NAP+ management and technical team to develop capacity on program technical oversight, technical staff from NAP+ actively participated the monthly ENHAT-CS regional meetings, and ENHAT-CS West Amhara regional managers also periodically visited the NAP+ offices to share experiences and discuss common issues with the NAP+ managers.

TNEP+

- Held 10 catchment area meetings involving 85 HCs and 14 hospitals from all regional zones of Tigray. The meetings brought together each catchment area's case managers and adherence supporters from hospitals and case managers from HCs, along with HC ART focal persons and representatives of the RHB. Overall, 173 case managers and adherence supports and 99 ART focal persons attended. As above, the catchments area meetings focused on discussing on the last six months performance, sharing experiences between NAP+ and ENHAT-CS case managers and adherence supporters, and addressing challenges.
- Mentors provided on-sites mentorship to case managers at 81 HCs, of which 71 were mentored twice. Nine of these HCs with untrained case managers were provided with a half day on-the-job training by the TNEP+ mentors on the basics of ART adherence case management service. The 10 health centers that were mentored only once were found to be too distant to do frequent mentorship visits. One HC was not able to be mentored as it was not accessible by public transport and the remaining did not have a present case manager.

✓ **Transition of task shifting of mental health service provision to HCs**

The program's transition plan was to support the GOE's decision to greatly expand provision of mental health services by task shifting service delivery to HCs. The key element of the program's transition plan was to pilot mental health service delivery at HCs level to provide lessons learned to support the program's initiative, including:

- Demonstrate that HCPs can provide basic mental health service provision
- Demonstrate that HCs can obtain and maintain a regular supply of psychotropic drugs
- Sharing the program's tools, simplified for HCs, as models for the FMOH's national program

The program's pilot initiative integrated mental health services into HIV clinic service delivery at 37 HCs. The program developed a training curriculum and trained HCPs from both HIV and OPD clinics, a guideline, job aids, M&E tools and a mentorship checklist to support this pilot. In the earlier section on mental health, the success of the pilot is highlighted, which the program shared with the RHBs.

Of note, Dr. Kisetse, the current Minister of Health of Ethiopia, was previously the head of Amanuel Hospital, which was, at the time, the only psychiatric hospital in the country. He is strongly committed to expanding HC provision of mental health services to additional HCs. Using the country's MDG pool fund, the FMOH is planning to expand provision of mental health service delivery to an additional 100 HCs in the second half of FY14 and over 350 in FY15.

Through the program's consultant, Dr. Tedla, who is also an advisor to Dr. Kisetse, program materials and lessons learned were shared with the FMOH to support development of national implementation guidelines and materials for the national expansion. In support of this expansion, the program also held workshops in each region in Mar'14 to facilitate RHB assumption of responsibilities for MH service delivery and sharing of lessons learned and challenges. Key lessons learned include:

- The program's success indicates that the existing Ethiopian primary health care system has the capacity to effectively treat patients with mental illness, which can significantly increase treatment coverage for people with mental disorders by introducing integrated outpatient mental health services at health centers that are accessible and affordable.
- Integration of mental health into primary care at health centers, which the development of a National Mental Health Strategy (2013/14-2015/16) has contributed significantly to, will pay dividends, socially and economically, resulting in patients relapsing less often and hence needing less hospital care; in addition they remain integrated with families and friends and are able to start income-generating projects. Many health care professionals who were interviewed supported this by highlighting the importance of primary care for mental health and were enthusiastic about the overall reform.
- With training and ongoing support and supervision, health professionals working in health centers, such as nurses and health officers, can be trained to provide effective mental health care, including prescription of psychotropic medications. While some patients require referral to psychiatrists, the vast majority can be successfully managed by health care professionals (nurses and health officers) trained in mental health.
- Involving case managers in mental health provision was found to be effective, with 82% of suspected cases referred to the HIV clinic nurse or health officer for diagnosis. In addition, it is likely that the involvement of case managers, who are HIV-positive peer counselors, helps HIV clinic patients better cope with stress, stigma, drug side effects, etc., thus preventing development of more serious mental health issues.

- Psychotropic medications were able to be made generally available in clinics in the same way as other medicines, but making them free would significantly increase access amongst health center patients.
- Ongoing support and supervision of the nurses and health officers by trained mental health professionals in area hospitals is essential to ensure quality treatment. As there is currently no system to support this, the roles of mental health professionals in regional, zonal and district hospitals need to include supervision and training.
- HMIS indicators were found to be insufficient to monitor adequate implementation, so priority mental disorders need to be added (e.g. psychosis, depression, alcohol use disorders, with epilepsy is already included), which will also facilitate drug forecasting
- There is a low awareness about mental illness in the community and amongst primary health care workers, which means that many people with mental illness do not seek help. The simultaneous increase in public awareness by integrating mental health services in primary care capacity is pivotal to reduce stigma and encouraged people to seek care. However, in addition to training health center case managers to screen for mental health problems and professional health care providers to provide treatment or referral, the engagement of community based health extension workers is essential to ensure the detection of mental health problems and referral of persons with mental illness to health centers.

✓ **Transition of Leadership and Management Development (LMD) training for achieving sustainable improvements in woreda health offices' capacity to manage their woreda health network**

The program's LMD component focused on strengthening the leadership and management capacity of woreda health offices to manage their woreda health network. This is generally considered to be a priority level of the Ethiopian health system that requires significant strengthening. Thus, a key focus of the program was to collaborate with the MSH implemented USAID Ethiopia Leadership, Management and Governance (LMG) project to demonstrate and provide evidence to RHBs and woreda health offices on the efficacy of the LMG methodology with the intention of having the RHBs adopt and implement it as a sustainable means of improving woreda health office performance.

During the reporting period, the program successfully introduced LMD in the three planned demonstration zones. As indicated in the Table below, the program trained a total of 129 health care professionals with a core team consisting of three members from 42 woreda health offices. Participants attended the three consecutive team-based LMD workshops referred as 1) Scanning; 2) Focusing and Planning; and 3) Aligning, Mobilizing and Inspiring. The workshops were primarily organized and imparted through participation based on the MSH's LDP workshop module.

Number of healthcare providers who attended the 3 consecutive LMD workshops by woreda and gender

Region	Zone	# of Woredas	Number of Participants		
			Male	Female	Total
Amhara	West Gojam	15	43	4	47
Amhara	South Wollo	19	54	3	57
Tigray	Southern Tigray	8	21	4	25
Total		42	118	11	129

Between the three workshops, the respective woreda health offices' core teams worked with their larger health office team to face their identified priority health challenge. Furthermore, as the teams proceeded from one implementation level to the next, they received support and feedback from trained local facilitators from the zonal health departments, with technical guidance from the program's LMD Training Advisor/Master Trainer. Overall, the teams completed their projects over a period of 8 to 10 months and presented their results in final workshops attended by senior officials from their RHB and zonal health departments. As depicted in the below table, the teams reported significant improvements in terms of achieving their desirable results within this short period of time.

Summary of reported improvements on priority health challenges identified for this project period

Health Challenge	# woreda teams working on challenge	Average performance over baseline
Increase # of deliveries conducted by trained HCPs/ number deliveries conducted in HC	17	200% increase
Increased # of pregnant women attending 4 or more ANC visits.	1	107% Increase
Increase # of pregnant women tested for HIV	5	37% increase
Increase VCT uptake among daily laborers	1	493% increase
Increase number of fully vaccinated children	3	17% increase
Increase household latrine utilization coverage	2	53% increase
Increase households implementing the full health package of practices promoted by the Urban Health Extension Program	1	24% increase
Improve community sanitation/increased declared open defecation free environment areas	7	37% increase
Improve adherence to activity report submission date	1	50% increase
Improve TB case detection status	2	22% increase
Improve weaning practice	1	30% increase
Minimize percentage of ART lost-to-follow-up and dropout cases	1	10% decrease

On top of introducing the methodology to the demonstration woredas, the program trained and utilized local facilitators from the health departments of the three involved zones in order to further demonstrate its sustainability. Similarly, the program documented the entire process and provided

reports with key quantitative data to the MSH LMG program and the RHBs on the methodology's efficacy at woreda health office level to provide evidence based advocacy for its adoption by the RHBs to strengthen their woreda health offices' capacity and performance.

✓ **Transition of support for services provided by mother mentors with MSGs**

As noted earlier, the program's transition plan was to strengthen the capacity of NNPWE and its regional associations to assume management of HC based mother mentorship. However, in Q2, USAID informed the program that the government had decided to assume responsibility of the mother mentors. Currently, both RHBs have allocated some of their CDC funding to continue the initiative at both HC and hospital levels.

This decision can be partially attributed to successful advocacy conducted by the program in collaboration with USAID and the CPMTCT project, including documentation and sharing with the FMOH the findings from ENHAT-CS and CPMTCT studies on the impact of mother mentors and their MSGs on improving service uptake and health outcomes among HIV-positive pregnant women and their infants. This included presentation of the results at the national launch of the national "elimination of MTCT" initiative held by the FMOH in November 2013. The results, which strongly supported the value of mother mentors and MSGs, likely helped the FMOH to recognize the important role of mother mentors with MSGs for PMTCT and implementation of option B+.

✓ **Transition of approaches for sustainable gender mainstreaming**

The program's transition plan was to advocate to the Government to adopt similar tools to what the program developed and used, which included a simple checklist based guide to facilitate increased awareness and monitoring of some basic HC appropriate indicators.

For background, to ensure a practical approach to gender mainstreaming that HCs could utilize, 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, religious leaders and HCPs.

Based on the findings, the program developed and pilot tested data collection tools and conducted a validation exercise targeting religious leaders, MSG clients, members of the HC multidisciplinary staff team and community members. From this, the program developed a checklist based gender mainstreaming guide for use by HC MDT staff teams, which was piloted and finalized in late FY13. This gender mainstreaming guide provides HC management with simple, practical ways of assessing and integrating basic gender issues into routine HC activities. During this reporting period, 261 HCs began using the checklist on a quarterly basis.

In Amhara, 142 (74%) program supported HCs discussed gender issues in their MDT meetings guided by the program's structured checklist and developed action plans based on identified gaps in gender issues. The HCs reported that the checklist was simple, usable and provided a practical approach for assessing and integrating basic gender issues into routine HC activities and services. The HCs agreed to integrate the guide into routine activities to sustain after program closure.

In Tigray, 79 HC directors and 38 woreda health office officers were oriented on gender issues and to consider gender based violence as an agenda in their monthly MDT meetings. In addition, 4 copies of the checklist guide were sent to all 85 HCs during Q2 of this reporting period.

Also during this reporting period, the program promoted, during its participation in the national TWG on Gender and HIV, inclusion of this or similar practical approaches into FMOH approaches for gender mainstreaming.

✓ **Transition of approaches for sustaining a continuum of HIV care between HCs and their area hospitals and their served communities**

The program's transition plan prioritized woredas and HCs to continue their HIV focused MDT (PHCU) meeting, preferably with expanded representation e.g. religious leaders, PLHIV association representatives. For linkages between HCs and their served communities, the program recognized that the key forum for sustaining strong linkages is the PHCU meeting. As HIV focused MDT meetings i.e. PHCU meetings, is believed to be a funded component of the RHBs cooperative agreements with CDC, the program focused on strengthening the PHCU meeting as the transition platform for this transition target.

These monthly government-mandated HC review meetings, which involve woreda health officers, HEWs, HEW supervisors, HC heads, expanded by the program to include community volunteers such as representative of PLHIV associations and religious leaders, promote collaboration, share information, enhance community tracking of adherence defaulters, and strengthen the primary PHCU, from HC to health post and bekele.

To better sustain the effectiveness of the PHCU monthly meeting, the program developed a supportive supervision checklist to be used by woreda health officials to guide their routine support visits to HCs, including oversight of the PHCU. The program also developed a checklist to guide a referral focal person to be assigned from members of the MDT to better ensure linkages, including the functionality of the bi-directional closed loop referral system, beyond program phase-out.

During this reporting period, the program-developed referral checklist was discussed with 166 woreda health officers and 222 HC heads, leading to 222 HCs and 166 woredas agreeing to support sustained PHCU meetings.

The checklist was also presented to the RHBs of Amhara and Tigray and was well received by both RHBs, who stated that they are ready to implement it through the woreda health network at program supported HCs.

The Tigray RHB, during a meeting that brought together all woreda HIV and health officers and NGOs in Mar'14, officially announced to all woredas to incorporate the checklist and appoint a referral focal person at all their HCs.

The Amhara RHB incorporated the checklist in their own checklist and will orient the woreda health offices on its use as part of their revised supportive supervision checklist and has agreed to instruct HC heads, during their normal supportive supervision, to appoint a referral system focal person.

The program believes the HIV focused PHCU meetings have a good chance of continuing post program cessation given the commitment expressed by woredas, actions taken by the RHBs and the fact that it may be a funded component of the RHBs' cooperative agreements with CDC.

✓ **Transition of approaches for sustainable evidence-based decision making**

The program's transition plan was to strengthening sustainable RHB capacity to carry out operations

research (OR), in partnership with regional universities, to enhance their capacity for evidence based decision making

In FY13, the program established an effective partnership between RHBs and their regional universities for carrying out OR to enhance their evidence based decision making. A key focus was to demonstrate to the RHBs the effectiveness of focused, inexpensive OR for providing critical evidence on key questions for enhancing their decision making. Previous to this, they tended to emphasize large scale, expensive population surveys. In FY14, the program is continuing to support their sustainable carrying out of ORs (through learning by doing) by supporting the RHBs to independently carry out, as previously noted, the following OR:

- HIV Prevention, risk perception and sexual practices among developmental corridors (hotspots) in Amhara region (data analysis and write up is on progress)
- Assessment of cause of maternal and child death and the contributions of HIV/AIDS using verbal autopsy in Tigray region.

For Amhara, during this reporting period, the program continue to support the OR partnership with its regional universities of Bahir Dar and Gondar, including:

- In October, the program partnered with the RHB and universities to hold a one day dissemination workshop on the results of the 23 ORs, which were attended by regional and federal Government representatives as well as partner organizations.
- Identified key research areas printed in booklet form and distributed to regional stakeholders
- Research extracts compiled, printed and distributed to stakeholders
- Uploading of program supported ORs into the RHB website for enhanced public access

For Tigray, the program has supported the RHB to engage with Mekele University's College for Health Services for OR activities. During this reporting period, in October, the program partnered with the RHB and university to hold a one day dissemination workshop on the results of the 7 ORs, which were attended by regional and federal Government representatives as well as partner organizations.

During Q2 of this reporting period, the program's OR partnership advisor supported the investigators to finalize their OR extracts for publication and all have submitted a final OR extract.

In addition, as noted above, program collaborated with the RHB to support their OR, titled "Assessment of cause of maternal and child death and the contributions of HIV/AIDS using verbal autopsy in Tigray. The Tigray OR partnership advisory committee monitored the OR process to ensure agreed upon research protocols were followed correctly, using an OR progress monitoring checklist.

These above efforts have initiated a sustainable partnership between the RHB and regional university, as well as recognition within the RHB that OR is an effective and low cost approach for answering key questions leading to enhanced evidence based decision making.

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

N/A, as the program's field activities ceased as of the end of FY14 (30 Sep-14), and all program operations will end on 31 December 2014

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:

- I. The program reports under the GOE system, which allows its data to both feed into the HMIS and PEPFAR reporting requirements. The GOE has recently extended its monthly end period to around the 21st of each month. With field operations, program mentors and data clerks scheduled to end on 30 Sept, this extended end date posed a challenge for collection of Sep-14 data for this APR-14.

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

- I. The program extended the contracts of its mentors and deployed data clerks to 15 Oct-14, allowing Sept-14 data to be collected and inputted into the program's database for the APR-14 report.

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

- I. Throughout the FY, a key component of the program's monthly on-site mentorship is for the mentors to review the data quality compiled by the data clerks for each area of program reporting.

8. Major Activities planned in the next reporting period

As noted above, all program field activities ended as of 30 Sep-14. For the next quarter, the program will focus on the following main activities:

- Close all program offices
- Downsize all program staff
- Dispose of all program assets in accordance to the USAID Ethiopia approved disposition plan. The key component will be the transfer of program vehicles to the RHBs (11 to Amhara, 7 to Tigray).
- Submit this PEPFAR APR-14
- Submit the PEPFAR Expenditure Analysis
- Produce an end of program report
- Conduct an end of program review meeting in Addis Ababa for major stakeholders: PEPFAR, USAID, Government counterparts, UN and donor organizations, implementing partners, MSH staff etc.
- Produce end of program reports for the Amhara and Tigray regions
- Conduct regional end of program review meetings

9. Environmental compliance

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

ENHAT-CS environmental compliance focuses on IP/PS and waste disposal, with a core focus on promoting environmental compliance at HC level. In FY13, the program developed an environmental compliance checklist for use by its mentors during HC visits. Periodically conducted e.g. quarterly basis, it promotes HCs to practice both best and acceptable practices for handling waste that are aligned with national standards. The program mentors promote these practices at the following clinics: HIV, TB, ANC/PMTCT, L&D, Lab, VCT, OPD, Emergency OPD, FP, EPI, and U5. The checklist addresses the following: non-infectious waste (e.g. paper etc.), contaminated solid waste (e.g. gloves, gauze, etc.), sharps waste (e.g. needles, in pricks, slides etc.), liquid waste, and highly infectious anatomical and pathological waste (e.g. placenta, retained placental material, tissue, etc.). The checklist also reviews how the HCs temporarily store and dispose of waste, as well as how cleaners protect themselves during disposal.

In addition, the program's Prevention Advisor actively participated in the national TWG on IP/PS, chaired by the Medical Services Directorate (FMOH). A key focus of the national TWG on IP/PS during the FY has been to have regional TWGs established, as per national guideline.

During this reporting period, the program continued to support the Tigray RHB to establish a regional IP/PS TWG. Program senior regional staff sensitized the core process owner by sharing and discussing the results of the program's environmental health assessment checklist, for informing the RHB on the status of environmental compliance at program supported HCs as well as to demonstrated that the checklist is a practical tool for better institutionalizing IP/PS at health facility level and monitoring progress.

In Tigray, HCs have Government deployed environmental health technicians (EHTs). The program mentors, when carrying out the checklist, partnered with and ensured that the EHTs can utilize the environmental compliance checklist, as well as monitoring their cascading of IP training to all HC staff.

In Amhara, the program distributed the national IPPS training resource package and training aid flip charts to selected HCs to facilitated cascading of IPPS training to health center staffs.

In both Tigray and Amhara, the checklist was completed four times, at the end of FY13 (Q4), and Q1, Q2 and Q3 of FY14, at 249, 234 and 268 and 229 HCs respectively. Between the first round and fourth round:

- Practices that are not expensive and do not require infrastructure improvements showed the greatest improvement (covered waste bins with labels, protective gloves and clothing)
- Some practices were already highly practiced but did show small improvement (sharps boxes, HCPs using protective 'clean' gloves).
- Practices that require significant infrastructure improvements showed the least change (incineration, utility sinks with running water, septic tank)

Changes in use of specific best practices were as follows:

The use of sharps boxes was high throughout, but showed a small improvement

- First round: 96%
- Fourth round: 97%

Use of covered waste bins with labels improved significantly (with use of open containers reduced by 9%)

- First round: 10%
- Fourth round: 24%

Lab disinfection showed a small improvement, but was essentially unchanged

- First round: 32%
- Fourth round: 33%

Incineration showed a small improvement, but was essentially unchanged

- First round: 42%
- Fourth round: 44%

Handling of liquid waste with utility sink with running water showed a small decrease, but was relatively unchanged

- First round: 28%
- Fourth round: 26%

Disposal of liquid waste with septic tank showed some improvement

- First round: 51%
- Fourth round: 56%

Health care providers handling waste with gloves was high throughout but showed improvement

- First round: 91%
- Fourth round: 98%

Cleaners using protective clothing (5 key items) showed improvement

- First round: 52%
- Fourth round: 56%

Specifics by waste type are presented in the following table:

Waste Handling and Disposal			Sep'13	Dec'13	Mar'14	Jun'14	Perce nt chang e in best practi ce	
Sharps waste	Clinic handling	Best Practice	Sharps box	96%	97%	97%	97%	+1%
		Acceptable	Covered waste bins with labels	1.4%	0.6%	1.2%	0.9%	
		Not acceptable	Covered waste bins with no labels	0.6%	0.2%	0.2%	0.3%	
		Not acceptable	Open waste bins	1.7%	1.9%	1.4%	2.3%	
		Best Practice	Lab: lab technicians disinfect	35%	34%	40%	41%	
	HC disposal	Best Practice	Incinerate	79%	85%	84%	88%	+9%
		Acceptable	Burn in pit	17%	13%	14%	8%	
		Acceptable	Bury in pit	2.5%	1.8%	1.6%	1%	
		Not acceptable	Put in open pit	1.7%	0%	0.4%	1.9%	
		Not acceptable	Put in open field	0.4%	0%	0%	1.4%	

Non-infectious solid waste	Clinic handling	Best Practice	Covered waste bins with labels	8%	13%	14%	17%	+9%
		Acceptable	Covered waste bins with no labels	11%	7%	8%	11%	
		Not acceptable	Open waste bins	81%	80%	78%	72%	
	HC disposal	Best Practice	Incinerate	17%	24%	19%	21%	+4%
		Acceptable	Burn in pit	70%	73%	71%	61%	
		Acceptable	Bury in pit	7.4%	1.8%	4.8%	6%	
		Not acceptable	Put in open pit	4.5%	1.4%	5.2%	6%	
		Not acceptable	Put in open field	0.4%	0%	0.4%	5%	
	Contaminated solid waste (gloves, gauze etc.)	Clinic handling	Best Practice	Covered waste bins with labels	10%	22%	23%	26%
Acceptable			Covered waste bins (with no labels)	0%	11%	14%	16%	
Not acceptable			Open waste bins	75%	67%	63%	58%	
Best			Lab: lab technicians disinfect	19%	9%	11%	22%	+3%
HC disposal		Best Practice	Incinerate	29%	31%	29%	26%	-3%
		Acceptable	Burn in pit	56%	58%	61%	54%	
		Acceptable	Bury in pit	8%	9%	7%	9%	
		Not acceptable	Put in open pit	6%	2%	3%	6%	
		Not acceptable	Put in open field	0.4%	0%	0%	6%	
Highly infectious (anatomical and pathological) waste	Clinic handling	Best Practice	Covered waste bins with labels	13%	37%	31%	46%	+33%
		Not acceptable	Covered waste bins with no labels	17%	15%	14%	12%	
		Not acceptable	Open waste bins	70%	48%	55%	42%	
	HC disposal	Not acceptable	Incinerate	5%	3%	0%	4%	
		Not acceptable	Burn in pit	3%	1.8%	5%	4%	
		Best Practice	Bury in pit	85%	89%	91%	85%	0%
		Not acceptable	Put in open pit	6.6%	6.0%	2.9%	2%	
		Not acceptable	Put in open field	0.4%	0%	0.4%	5%	

Liquid waste	Clinic handling	Not acceptable	Covered waste bins with labels	1%	0.7%	0.5%	1.7%		
		Not acceptable	Covered waste bins with no labels	1%	3%	1%	1.6%		
		Not acceptable	Open waste bins	45%	33%	35%	44%		
		Best Practice	Utility sink with running water	28%	33%	32%	26%	-2%	
		Acceptable	Utility sink with NO running water	25%	30%	31%	27%		
		Best Practice	Lab: lab technicians disinfect	42%	48%	54%	37%	-5%	
	HC disposal	Best Practice	Septic tank	51%	60%	50%	56%	+4%	
		Acceptable	Bury in pit	24%	24%	35%	23%		
		Not acceptable	Put in open pit	18%	12%	12%	10%		
		Not acceptable	Put in open field	7%	4%	2%	11%		
Health care providers handle waste with clean gloves				91%	95%	97%	98%	+7%	
Cleaners	Temporary storage before disposal	Best Practice	Covered waste bins with labels	23%	31%	30%	23%	0%	
		Not acceptable	Covered waste bins with no labels	77%	69%	70%	77%		
	Protection during HC disposals	Best Practice	Mask		43%	47%	35%	48%	+5
			Utility gloves		93%	93%	87%	90%	-3
			Caps		16%	19%	10%	24%	+8
			Apron		49%	51%	52%	58%	+9
			Plastic boots		58%	62%	56%	62%	+4
Average for all items		52%	54%	48%	56%	+4			

10. Issues requiring the attention of USAID Management

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

All Program Areas

The program has been carrying out a staged downsizing, as follows:

ENHAT-CS downsizing plan

End date	Activities	Lead organization
31-Mar-14	Focused mentorship to HCs on pediatric HIV care and treatment	ANECCA
	Focused technical support to RHBs for OR	ANECCA
	Focused mentorship to HC laboratories	I-TECH
	Embedded support to regional laboratories	I-TECH
	Technical support to woreda health offices' health network	IMPACT
	Focused support of HCs for continuum of care	Save the Children
30-Jun-14	Support for community outreach volunteers	NNPWE
	Focused mentorship to mother mentors	NNPWE
	Support to religious leaders	EIFDDA
	Publication of national PLHIV newspaper, Libona	DHEA
31 Jul-14	Training of government HIT/ITs	MSH
	Training of health care providers	MSH
	Training of government mentors	MSH
31-Aug-14	Technical support to woreda health offices for LMD	MSH
	Technical support to RHBs for OR	EPHA
30-Sep-14	Mentorship to HCs	MSH
	Case management services by HC case managers	HST
	Financial support for mother mentors	MSH
	Data collection/compilation at HC by data clerks	HST
	PEPFAR NCI reporting	MSH
	Technical support to RHBs and FMOH	MSH
	Support for government mentorship and other transition areas	MSH
31 Nov-14	Closure of program field offices	
31-Dec-14	End of program	MSH

End date	Staff	Lead organization
31-Jan-14	Deputy director for special programs	MSH
31-Mar-14	Pediatric HIV/AIDS advisor (6)	ANECCA
	Community mobilization and NGO capacity building advisor	Save the Children
	Regional laboratory advisor embedded in RL (3)	I-TECH
	Regional lab mentors (8)	I-TECH
	Regional OR partnership advisors	I-TECH
	Project Engineer	MSH
15-Apr-14	Regional NGO capacity building officer (3)	IMPACT
	Program officer (for woreda health office capacity building)	IMPACT
	Senior pediatric advisor	ANECCA
	Program director for I-Tech component	I-TECH
	Regional care and support coordinator (3)	Save the Children
	Driver (5)	MSH
31-May-14	Regional care and support cashier (3)	Save the Children
30-Jun-14	Program advisor/team leader for care & support	Save the Children
	Regional HSS/coordination advisor (2)	EPHA
15-Jul-14	Regional MSG capacity building officer (3)	NNPWE
	Regional care and support mentor (7)	NNPWE
30-Jul-14	M&E/OR manager	EPHA
	Program coordinator (FBO partnership)	EIFDDA
	Program coordinator (care and support mentors)	NNPWE
	Regional FBO partnership officer (3)	EIFDDA
31-Aug-14	Clinical care advisor	MSH
	Prevention advisor	MSH
	Regional MNCH/PMTCT/RH advisor (2)	MSH
	Regional ART/TB-HIV advisor (2)	MSH
	Regional clinical care advisor	MSH
	Regional program/training officer	MSH
	Driver (3)	MSH
31 Sep-14	Case managers (deployed at HCs)	HST
	Mother mentors (deployed at HCs)	MSH

15 Oct-14	Program mentors (26)	MSH
	Data clerks (deployed at HCs)	HST
31-Oct-14	LMD master trainer/manager	MSH
	Regional mentorship coordinator (3)	MSH
	Regional quality assurance officer (3)	MSH
	Driver (13)	MSH
31 Nov-14	Regional technical manager (2)	MSH
	Data officer	MSH
	Regional data officer	MSH
31-Dec-14	Chief of party	MSH
	Deputy chief of party	MSH
	Technical director for field operations	MSH
	Program director for M&E and QA	MSH
	Senior manager for finance, contracts, compliance	MSH
	Finance, contracts and compliance officer (2)	MSH
	Finance, contracts and compliance assistant (2)	MSH
	Communications specialist	MSH
	Regional program manager (2)	MSH
	Driver (6)	MSH

11. Data Sharing with Host Government

Have you shared this report with the host government?

Yes
No

If yes, to which governmental office/s?

If No, why not?

ENHAT-CS prepares separate reports to each RHB that provides detailed information specific to each region.

12. Appendices

(Include any relevant documents, data etc. as appendices)

MSH short term assistance (STTA) reports

1. Annex 1 (Reports) STTA report (Dr. Fred Hartman) 9-31 Oct'13
2. Annex 2 (Reports) STTA report (Dr. Elke Konings) 12-21 Oct'13
3. Annex 4 (Reports) STTA report (Dr. Fred Hartman) 11-24 Apr'14
4. Annex 5 (Reports) STTA report (Dr. Elke Konings) 11-21Apr'14
5. Annex 6 (Reports) STTA report (Maryanne O'Brien) 17-28 Jul'14

Publications

7. Annex 7 (Publications) Libona (newspaper) Oct'13 - Jun'14
8. Annex 8 (Publications) 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 (APHA'13 poster)
9. Annex 9 (Publications) Rising pregnancy rates among known HIV-positive women in at health centers in Addis Ababa, Ethiopia (APHA'13 poster)
10. Annex 10 (Publications) Strengthening the gender focus to improve ANC/PMTCT service quality in Ethiopia (ICASA'13 poster)
11. Annex 11 (Publications) Test and treat is feasible for resource poor countries in Africa (ICASA'13 poster)
12. Annex 12 (Publications) Sexual behavior and vulnerability to HIV infection among seasonal migrant laborers in Metema District, NE Ethiopia (EPA'14 oral presentation)
13. Annex 13 (Publications) The case for a universal 'test and treat' approach for HIV in Ethiopia (EPA'14 oral presentation)
14. Annex 14 (Publications) Pre-ART care retention in ENHAT-CS program supported HCs - secondary data analysis of pre-ART cohorts (EPA'14 poster presentation)
15. Annex 15 (Publications) What happens to HIV-positive patients after they are screened for TB at public health centers in Ethiopia (EPA'14 poster presentation)
16. Annex 16 (Program Brief) Mother mentor-MSG strategy (Oct'14)
17. Annex 17 (Program Brief) The role of mother mentors in supporting HIV-positive mothers (Feb'14)
18. Annex 18 (Success Story) Tracing HIV patients who stopped treatment (Jan'14)
19. Annex 19 (Success Story) Religious leaders intervention for ART adherence Mayichew (Jan'14)
20. Annex 20 (Success Story) Religious leaders impact a small town Mehoni (Jan'14)
21. Annex 21 (Success Story) One teaching can save thousands of lives Mayichew (Jan'14)

ENHAT-CS PERFORMANCE INDICATOR TABLE model (APR-14) submitted to USAID 22 Oct-14

#	NGI No.	INDICATOR	ENHAT - CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)		ENHAT-CS TARGET (FY14)	ENHAT-CS PERFORMANCE (FY14)						
					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved	
1	PMTCT_STAT_TA (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	173,056	113%	178,248	43,485	49,805	44,583	63,611	201,484	113%	Cumulative result on target
		Known positives at entry	1,564		2,129	NA	2,187	2,236		2,407	545	516	514	696	2,271		Note: results are from 217 of 276 supported HCs, as have excluded 59 HCs jointly supported with the USAID CPMTCT project
		No. of new positives identified	2,382		1,833	NA	1,789	1,589		1,743	371	344	316	404	1,435		
2	PMTCT_ARV_TA (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%	83%	118%	85%	86%	84%	88%	88%	87%	102%	
		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	3,164		3,528	788	723	734	969	3,214		
		By regimen type: Antiretroviral therapy for HIV-infected pregnant women eligible for treatment	487		1,329	NA	1,670	2,300		3,528	787	723	734	969	3,213		
		By regimen type: Maternal AZT	1,166		1,204	NA	1,113	844		0	1	-	-	-	1		
		By regimen type: Single Dose Nevirapine (SD-NVP)	98		2	NA	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	3,825		4,150	916	860	830	1,100	3,706				
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	217	100%	217	217	217	217	217	217	100%	Cumulative result on target
4	(Non-MERS)	Number of pregnant women who were seen by skilled provider (trained on MNCH/PMTCT)	131,575	137,897	143,612	104%	157,973	177,549	112%		45,880	51,313	45,540	65,380	208,113	No target specified for indicator	
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	1,336	100%	1,466	365	280	290	363	1,298	N/A	Indicator no longer relevant due to Option B+
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	1,336	100%	1,466	365	280	290	363	1,298	89%	Cumulative result moderately 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							No target specified for indicator	
		Exclusive breastfeeding	Not available		93%	NA		91%			93%	93%	95%	94%	94%		
		Exclusive formula feeding	-		4%	NA		6%			5%	5%	3%	5%	5%		
		Mixed feeding	-		3%	NA		3%			2%	1%	2%	2%	2%		
8	(H2.3.D) (Non-MERS)	Number of health care workers who successfully completed an in-service training program	Not applicable	2,500	2,653	106%	1,790	3,859	216%	935	347	712	371	182	1,612	172%	Cumulative result on target
		Pediatric treatment	-	181	255	141%	322	442		162	0	155	24		179	110%	
		ANC/PMTCT	-	134	284	212%	0	406		84	83	62	22		167	199%	
		CT	-	108	102	94%	181	144			0						
		Adult ART treatment	-	273	255	93%	321	442		162	0	155	24		179	110%	
		TB/HIV co-infection management	-	81	91	112%	111	93			0						
		Laboratory related activities	-	98	230	235%	235	309		49	54	0	0		54	110%	
		Other	-	1,625	1,436	88%	620	2,023		478	210	340	301	182	1,033	216%	
															Other includes: HIT/IT (304); LMD (282); GOE mentors (447)		
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	23,792	113%	21,000	6,291	5,936	4,056	137	17,883	85%	Cumulative result moderately below target, as partners leading community initiatives ended earlier (Save the Children at end of Mar-14 and NNWPE at end of Jun-14)
		By sex: Male	-		8,582			12,818			3,115	2,960	1,983	706	8,764		
		By sex: Female	-		13,728			10,974			3,176	2,976	2,073	894	9,119		
		By Age: 10-14	-		7,350			8,976			2,679	2,406	1,698	569	7,352		
		By Age: 15+	-		14,960			14,816			3,612	3,530	2,358	1,031	10,531		
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	8,976	107%	8,400	2,679	2,406	1,698	569	7,352	88%	Same as above
11	(P9.1.D)	Number of service outlets providing counseling and testing according to national and international standards.	154	206	205	100%	276	276	100%	276	276	276	276	276	276	100%	

#	NGI No.	INDICATOR	ENHAT - CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)		ENHAT-CS TARGET (FY14)	ENHAT-CS PERFORMANCE (FY14)						
					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved	
16		By age: <18	581		649	NA		651		796	182	108	117	157	564		
		By age: 18+	4,143		4,485	NA		5,584		5,501	1,384	1,037	801	1,104	4,326		
		Pregnant/lactating women	1,652		1,665	NA		1,569		2,042	417	134	374	159	1,084		
17	C2.1.D_TA (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	78,202	109%	87,869	76,555	79,904	84,024	87,328	87,328	99%	Cumulative result on target.
		By sex: Male	20,852		24,068			29,172		32,512	27,913	29,159	30,516	31,650	31,650		
		By sex: Female	35,043		40,245			49,030		55,357	48,642	50,745	53,508	55,678	55,678		
		By age/sex: <15 (Male)	Not available		1,868	NA		2,114		2,636	2,216	2,330	2,480	2,605	2,605		
		By age/sex: <15 (Female)	* *		1,696	NA		1,890		2,636	1,939	2,066	2,203	2,320	2,320		
		By age/sex: 15+ (Male)	* *		22,200			27,050		29,875	25,697	26,829	28,036	29,045	29,045		
		By age/sex: 15+ (Female)	* *		38,549			47,140		52,721	46,703	48,679	51,305	53,358	53,358		
		By age: <15	2,695		3,564			4,004		5,272	4,155	4,396	4,683	4,925	4,925		
		By age: 15+	53,200		60,749			74,198		82,597	72,400	75,508	79,341	82,403	82,403		
		By age/sex: 15-17 (Male)	Not available		933			1,313		1,494	659	688	711	725.71	726		
		By age/sex: 15-17 (Female)	* *		1,543			1,365		1,494	675	722	808	881.83	882		
		By age/sex: 18+ (Male)	* *		21,267			25,745		28,997	25,038	26,134	27,325	28,319	28,319		
		By age/sex: 18+ (Female)	* *		37,006			45,775		51,403	46,028	47,959	50,497	52,476	52,476		
18	C2.2.D	Percent of HIV-positive persons receiving cotrimoxazole prophylaxis (program coverage)	51%	See below	56%	80%	56%	56%	100%	56%	51%	53%	53%	53%	53%	95%	Non-cumulative (variable percent) result on target
		Numerator: Number of HIV-positive persons receiving cotrimoxazole prophylaxis	28,292	40,604	36,038	89%	39,500	43,405		49,206	39,322	42,115	44,433	46,450	46,450		
		By age: <15			3,939			3,369			2,914	3,021	3,127	3,264	3,264		
		By age: 15+			32,099			40,036			36,408	39,094	41,306	43,186	43,186		
		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	78,202		87,869	76,555	79,904	84,024	87,328	87,328		
		By age: <15	2,891		3,564	NA		4,004			4,155	4,396	4,683	4,925	4,925		
By age: 15+	25,401		60,749	NA		74,198			72,400	75,508	79,341	82,403	82,403				
19	PMTCT_EID_Total (NGI) (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%	63%	90%	70%	66%	61%	58%	71%	64%	92%	Non-cumulative (variable percent) result 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	2,424		2,905	603	523	485	779	2,390		
		Infants who received virological test in the first 2 months	993		945		1,500	1,646		1,525	428	367	353	550	1,698		
		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	778		1,380	175	156	132	229	692		
		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	3,825		4,150	916	860	830	1,100	3,706		
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	65%	No target specified for indicator	65%	74%	66%	67%	71%	70%	107%	Non-cumulative (variable percent) result on target
		Numerator: Number of infants to HIV-positive women who are started on CTZ prophylaxis within two months of birth			2,465			2,481		2,698	679	568	556	780	2,583		
		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	3,825		4,150	916	860	830	1,100	3,706		

#	NGI No.	INDICATOR	ENHAT - CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)		ENHAT-CS TARGET (FY14)	ENHAT-CS PERFORMANCE (FY14)							
					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved		
21	TX_NEW_Total (NGI) (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	16,678	128%	19,263	3,897	3,761	4,120	4,351	16,129	84%	Cumulative result moderately below target	
		<15	882		902		1,029	1,107		1,541	244	245	287	310	1,086	-	FY14 target based on USAID assumption of a 22% increase above trend in Q3 and Q4, when the GOE adoption of a CD4 cut off point of <500 was expected to increase enrollment. However, the increase in enrollment was less than assumed. However, the result is consistent with an ENHAT-CS estimate of a 10% increase, based on analysis of CD4 data from supported HCs.	
		15+	10,509		10,766		12,015	15,571		17,722	3,653	3,516	3,833	4,041	15,043			
		<15 male	459		478		533	555		771	146	113	150	156	565			
		<15 female	423		424		496	552		771	98	132	137	154	521			
		15+ male	3,888		3,977		4,438	4,957		6,549	1,126	1,127	1,207	1,342	4,802			
		15+ female	6,621		6,789		7,577	10,614		11,173	2,527	2,389	2,626	2,699	10,241			
		Less than 1 year Male									37	15	9	5	10	39		
		Less than 1 year Female									25	3	3	5	13	24		
		1 to 4 years Male										47	28	45	28	148		
		1 to 4 years Female										31	34	26	33	124		
		5 to 9 years Male										44	47	58	66	215		
		5 to 9 years Female										41	57	57	61	216		
		10 to 14 years Male										40	29	42	52	163		
		10 to 14 years Female										23	38	49	47	157		
		15 to 19 years Male										18	22	23	18	81		
		15 to 19 years Female										93	72	87	101	353		
		20 to 24 years Male										50	61	70	84	265		
		20 to 24 years Female										470	414	436	439	1,759		
		25 to 49 years Male										937	902	987	1,084	3,910		
		25 to 49 years Female										1,847	1,817	1,952	1,998	7,614		
50+ years Male										121	142	127	156	546				
50+ years Female										117	87	151	160	515				
Male	4,333		4,455		4,971	5,512		7,320		1,272	1,240	1,357	1,498	5,367				
Female	6,978		7,213		8,073	11,166		11,943		2,625	2,521	2,763	2,853	10,762				
Sex total	11,311		11,668		13,044	16,678		19,263		3,897	3,761	4,120	4,351	16,129				
Pregnant Women	375		424		474	1,063		1,616		475	413	369	432	1,689				
Breastfeeding Women																		

#	NGI No.	INDICATOR	ENHAT - CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)		ENHAT-CS TARGET (FY14)	ENHAT-CS PERFORMANCE (FY14)						
					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved	
22	TX_CURR_TA	Number of adults and children with advanced HIV infection receiving antiretroviral therapy (ART) [CURRENT]	45,071	50,344	56,694	113%	69,738	71,007	102%	85,480	74,138	77,914	81,366	84,910	84,910	99%	Non-cumulative (current) result on target
	(T1.2.D)																
		<15	2,097		2,951		3,985	3,656		4,701	3,873	4,140	4,446	4,580	4,580		
		15+	42,974		53,743		65,753	67,351		80,779	70,265	73,774	76,920	80,330	80,330		
		<15 male	1,141		1,610		2,142	1,979		2,564	2,087	2,199	2,350	2,414	2,414		
		<15 female	956		1,341		1,843	1,677		2,137	1,787	1,941	2,096	2,166	2,166		
		15+ male	15,966		19,714		24,150	23,601		29,491	24,581	25,610	26,669	27,857	27,857		
		15+ female	27,008		34,029		41,603	43,750		51,288	45,684	48,164	50,251	52,473	52,473		
		Less than 1 year Male									86	89	85	91	91		
		Less than 1 year Female									71	74	66	76	76		
		1 to 4 years Male									591	623	644	647	647		
		1 to 4 years Female									480	522	533	542	542		
		5 to 9 years Male									778	816	892	931	931		
		5 to 9 years Female									665	724	804	835	835		
		10 to 14 years Male									632	671	729	745	745		
		10 to 14 years Female									571	621	693	713	713		
		15 to 19 years Male									572	615	650	704	704		
		15 to 19 years Female									1,094	1,138	1,285	1,388	1,388		
		20 to 24 years Male									1,377	1,444	1,542	1,599	1,599		
		20 to 24 years Female									5,283	6,094	6,241	6,612	6,612		
		25 to 49 years Male									19,713	20,454	21,165	21,881	21,881		
		25 to 49 years Female									36,183	37,697	39,345	40,832	40,832		
	50+ years Male									2,918	3,097	3,312	3,673	3,673			
	50+ years Female									3,125	3,235	3,380	3,640	3,640			
	Male	17,107		21,324		26,292	25,580		32,055	26,668	27,809	29,019	30,271	30,271			
	Female	27,964		35,370		43,446	45,427		53,425	47,471	50,105	52,347	54,639	54,639			
	Sex total	45,071		56,694		69,738	71,007		85,480	74,138	77,914	81,366	84,910	84,910			
	Pregnant Women	240		440		484	967			2,086	1,220	1,185	1,254	1,254			
	Breastfeeding Women	Not available														Data source not available	
	Percent children with advanced HIV infection receiving antiretroviral therapy (ART) [Current]	5%		5.2%	NA	5.7%	5.1%	90%	5.7%	5.2%	5.3%	5.5%	5.4%	5.4%	95%	Non-cumulative (variable percent) result on target	
	Percent women and girls with advanced HIV infection receiving antiretroviral therapy (ART) [Current]	62%		62%	NA	62%	64%	103%	62%	64%	64%	64%	64%	64%	104%	Non-cumulative (variable percent) result on target	
23	(Non-MERS)	Number of ART clients transferred into the health center	2,434	No targets specified for indicator	4,394	NA	No targets specified for indicator	6,484	No targets specified for indicator		1,704	1,331	1,268	1,668	5,971	No target 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%	86%	101%	85%	86%	87%	90%	89%	89%	104%	Non-cumulative (variable percent) result 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	10,184		11,087	2,657	2,948	4,653	5,745	16,003		
		By sex: Male	78%		3,701	NA	3,974	3,727		4,435	956	1,017	1,476	1,746	5,195		
		By sex: Female	84%		6,159	NA	5,960	6,457		6,652	1,701	1,931	3,177	3,999	10,808		
		By age: <15	85%		792	NA	795	819		887	232	231	301	384	1,148		
		By age: 15+	82%		9,068	NA	9,139	9,365		10,200	2,425	2,717	4,352	5,361	14,855		
		New PEPFAR FY14 reporting requirements															
		Less than 4 years Male									39	38	36	66	179		
		Less than 4 years Female									35	44	43	51	173		
		5 to 14 years Male									68	60	103	140	371		
		5 to 14 years Female									90	89	119	127	425		
		15 + years Male									849	919	1,337	1,540	4,645		
	15 + years Female									1,576	1,798	3,015	3,821	10,210			
	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	11,807		13,044	3,074	3,375	5,191	6,422	18,062			

#	NGI No.	INDICATOR	ENHAT- CS BASELINE (FY11)	ENHAT-CS TARGET (FY12)	ENHAT-CS PERFORMANCE (FY12)		ENHAT-CS TARGET (FY13)	ENHAT-CS PERFORMANCE (FY13)		ENHAT-CS TARGET (FY14)	ENHAT-CS PERFORMANCE (FY14)							
					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved		
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	76,567	No targets specified for indicator	95,380	79,224	82,985	87,105	91,456	91,456	96%	Cumulative result on target	
		By sex: Male	18,585		23,040	NA		28,552			29,508	30,748	32,105	33,603	33,603			
		By sex: Female	29,636		36,849	NA		48,015			49,716	52,237	55,000	57,853	57,853			
		By age: <15	1,948		2,850	NA		3,957			4,189	4,434	4,721	5,031	5,031			
		By age: 15+	46,273		57,039	NA	72,610			75,035	78,551	82,384	86,425	86,425				
26	(T1.5.D)	Number of health facilities that offer ART	154	206	206	100%	276	276	100%	276	276	276	276	276	276	100%	Cumulative result on target	
27	LAB_CAP	Number of testing facilities (laboratories) with capacity to perform laboratory tests	206	206	206	100%	276	276	100%	276	276	276	276	276	276	100%	Cumulative result on target	
28	(Non-MERS)	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	2,988	96%		846	650	607	868	2,971	No target set for FY14		
29	(Non-MERS)	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							No target specified for indicator		
		Number of ART clients who died	Cumulative measure															
		overall	5,351 (11.6%)		10.2%	NA		10.3%			10.6%	10.6%	10.5%	10.7%	10.6%			
		at 6 months	Not available		5.6%	NA		5.1%			3.2%	2.9%	2.9%	3.1%	3.0%			
		at 12 months	* *		7.4%	NA		6.7%			7.1%	5.8%	4.0%	4.2%	5.0%			
		at 24 months	* *		8.3%	NA		8.9%			8.0%	8.1%	8.2%	7.8%	8.0%			
		Number of ART clients who stopped therapy	Current measure															
		overall	84 (0.2%)		0.2%	NA		0.2%			0.3%	0.3%	0.3%	0.3%	0.3%			
		at 6 months	Not available		3.0%	NA		0.4%			0.2%	0.3%	0.3%	0.2%	0.2%			
		at 12 months	* *		0.9%	NA		0.9%			0.5%	0.5%	0.3%	0.3%	0.4%			
		at 24 months	* *		0.9%	NA		1.0%			0.3%	0.7%	0.3%	0.5%	0.5%			
		Number of ART clients transferred out																
		overall	7,952 (19%)		15.0%	NA		17.4%			17.8%	18.1%	18.4%	18.7%	18.2%			
		at 6 months	Not available		6.3%	NA		6.6%			5.6%	4.8%	5.3%	4.6%	5.1%			
		at 12 months	* *		9.9%	NA		10.5%			11.1%	9.7%	8.2%	7.6%	8.9%			
		at 24 months	* *		12.1%	NA		18.0%			17.4%	15.4%	15.8%	15.7%	16.0%			
Number of ART clients lost to follow-up	Current measure																	
overall	9%		7.0%	NA		7.2%			7.6%	7.5%	7.4%	7.3%	7.4%					
at 6 months	Not available		4.2%	NA		4.3%			4.2%	4.6%	4.5%	4.8%	4.5%					
at 12 months	* *		7.4%	NA		5.8%			6.3%	6.3%	6.1%	5.9%	6.1%					
at 24 months	* *		7.6%	NA		8.2%			8.6%	8.2%	7.2%	6.2%	7.5%					
30	(Non-MERS)	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	81%	No target specified for indicator		80%	81%	85%	87%	83%	No target specified for indicator		
31	(Non-MERS)	Contraceptive acceptance rate among eligible HIV+ women	Not available	No target specified for indicator	27%	NA	No target specified for indicator	27%	No target specified for indicator		9%	13%	16%	21%	21%	No target specified for indicator		
		New	* *		7%	NA		8%			1.5%	2.7%	3.6%	5.2%	5.2%			
		Repeat	* *		20%	NA		18%			7.3%	10.3%	12.8%	15.4%	15.4%			
32	(Non-MERS)	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	6,141	No target specified for indicator		1,416	874	818	1,193	4,301	No target specified for indicator		
		Number of referrals made by health providers inter-facility for HIV/AIDS related services	* *		1,463	NA		1,633			277	201	264	233	975			
		Number of referrals made by health providers to health posts/HEW for HIV/AIDS-related services	* *		2,117	NA		3,281			795	499	378	730	2402			
		Number of individuals referred to health center from community	* *		1,234	NA		1,227			344	174	176	230	924			
33	(Non-MERS)	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	11	No target specified for indicator		2	1	-	2	5	No target specified for indicator		
		By sex: Male	* *		9	NA		8			2	1	0	2	5			
		By sex: Female	* *		11	NA		3			0	0	0	0	0			
		By age/sex: <15 (Male)	* *		0	NA		1			0	0	0	0	0			
		By age/sex: <15 (Female)	* *		0	NA		0			0	0	0	0	0			
		By age/sex: 15+ (Male)	* *		9	NA		7			2	1	0	2	5			
		By age/sex: 15+ (Female)	* *		11	NA		3			0	0	0	0	0			

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					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved	
34	(Non-MERS)	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	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	0		
		By sex: Female	*	*	0			0			0	0	0	0	0		
		By age/sex: <15 (Male)	*	*	0	NA		0			0	0	0	0	0		
		By age/sex: <15 (Female)	*	*	0			0			0	0	0	0	0		
		By age/sex: 15+ (Male)	*	*	1	NA		0			0	0	0	0	0		
		By age/sex: 15+ (Female)	*	*	0	NA		0			0	0	0	0	0		
35	(Non-MERS)	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	965	No target specified for indicator		394	269	248	461	1,372	No target specified for indicator	
		By sex: Male	*	*	162	NA		243			94	67	54	117	332		
		By sex: Female	*	*	347			722			300	202	194	344	1040		
		By age/sex: <15 (Male)	*	*	3	NA		4			0	0	0	2	2		
		By age/sex: <15 (Female)	*	*	6	NA		9			1	0	0	1	2		
		By age/sex: 15+ (Male)	*	*	159	NA		239			94	67	54	115	330		
		By age/sex: 15+ (Female)	*	*	341	NA		713			299	202	194	343	1038		
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	896	354%	27	0	74	0	0	74	274%	61 NNPE association leaders and 13 data clerks
		By sex: Male	*	*	431	NA	112	457			0	14	0	0	14		
		By sex: Female	*	*	542	NA	141	439			0	60	0	0	60		
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	59,716	84%	59,716	52,862	3,735	5,354	4,483	66,434	111%	Cumulative result on target
		By facility: Clinic/Facility-based		Same as above	60,749		70,952	59,716		59,716	52,862	3,735	5,354	4,483	66,434		
		By facility: Community/Home-based		Not applicable													
38	(Non-MERS)	Number of health facilities providing TB treatment for HIV infected individuals	154	206	206	100%	276	276	100%	276	276	276	276	276	276	100%	Non-cumulative (current) result 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%	80%	87%	80%	72%	74%	74%	68%	72%	89.4%	Non-cumulative (variable percent) moderately on target Note: the NGI guideline requires this indicator to be measured at the last clinic visit of the reporting period. As the program reports quarterly, an accurate measure of performance for the FY would be the averaged performance across the FY's 4 quarters. For FY14, this was 72%. However, the denominator is C2.1.D, which cannot be averaged across the 4 quarters of the FY in the PEPFAR MERS and PSIR reporting spreadsheets. As such, the program presented the results from Q3 in the total as a proxy of the 4 quarter average, as this allows the same 72% result as the average across all 4 quarters of the FY.
		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		66,147	62,687		70,295	55,448	59,470	62,448	59,020	62,448		
		By sex: Male			24,065		No target specified for indicator	22,764			18,974	21,245	23,064	20,533	23,064		
		By sex: Female			37,816		No target specified for indicator	39,923			36,474	38,225	39,384	38,487	39,384		
		Denominator: Number of HIV-positive adults and children receiving a minimum of one clinical service (C2.1.D)	55,895	58,007	64,313		71,899	78,202		87,869	76,555	79,904	84,024	87,328	87,328		
		By sex: Male	20,726		24,068			29,172			27,913	29,159	30,516	31,650	31,650		
By sex: Female	34,660		40,245			49,030			48,642	50,745	53,508	55,678	55,678				
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%	1.5%	73%	1.5%	0.4%	0.4%	0.4%	0.3%	1.4%	93%	Non-cumulative (variable percent) result on target Note: starting in Q3 of FY13, the result for this indicator is the sum of: (1) at HIV clinic; those screened for TB at HIV clinic and found AFB positive and those found AFB negative but then diagnosed TB positive through referral for external testing (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+ at clinic
		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	1,196		1,318	292	340	308	284	1,224		
		By sex: Male	423		664			602			143	147	151	163	604		
		By sex: Female	510		696			594			149	193	157	121	620		
		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	78,202		87,869	76,555	79,904	84,024	87,328	87,328		
		By sex: Male	423		24,068			29,172			27,913	29,159	30,516	31,650	31,650		
By sex: Female	510		40,245			49,030			48,642	50,745	53,508	55,678	55,678				
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	14,468	No target specified for indicator	14,468	3,191	3,960	4,023	3,496	14,670	101%	Cumulative result on target
		By sex: Male	8,314		6,774	NA		7,823			1,780	2,239	2,166	1,931	8,116		
		By sex: Female	7,518		5,829	NA		6,645			1,411	1,721	1,857	1,565	6,554		
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	886	No target specified for indicator	886	519	1,123	727	856	3,225	No target specified for indicator	
		By sex: Male	2,677		2,236	NA		341			89	400	249	300	1,038		
		By sex: Female	4,659		3,840	NA		545			430	723	478	556	2,187		

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					Total (FY12)	% Target Achieved		Total (FY13)	% Target Achieved		Q1 (Oct-Dec'13)	Q2 (Jan-Mar'14)	Q3 (Apr-Jun'14)	Q4 (Jul-Sep'14)	Total (FY14)	% Target Achieved
43	(Non-MERS)	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	242	No target specified for indicator		245	214	214	214	214	No target specified for indicator
44	(Non-MERS)	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	2,255	No target specified for indicator		542	503	319	695	2,059	No target specified for indicator
		By sex: Male	*	*	67	NA		851			241	199	132	276	848	
		By sex: Female	*	*	51			1,404			301	304	187	419	1,211	
		By age/sex: <15 (Male)	*	*	23	NA		109			18	26	11	19	74	
		By age/sex: <15 (Female)	*	*	5			93			17	16	11	22	66	
		By age/sex: 15+ (Male)	*	*	44	NA		742			223	173	121	257	774	
		By age/sex: 15+ (Female)	*	*	46	NA		1,311			284	288	176	397	1,145	
45	(Non-MERS)	Number of local organizations provided with technical assistance for HIV-related institutional capacity building	Not applicable	11	11	100%	11	11	100%	11	11	11	11	11	100%	Cumulative result on target
46	(Non-MERS)	Number of data centers/delivery points established	Not applicable	Not included in PY1 work plan	0	Not included in PY1 work plan	1	0	N/A	1	0	2	2	2	200%	Cumulative result on target with ORs downloaded into the two regional state's websites
47	(Non-MERS)	Number of local universities involved in the generation and communication of M&E/OR evidence	Not applicable	2	3	150%	3	3	100%	3	3	3	3	3	100%	Cumulative result on target