

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

**Ethiopia Community Prevention of Mother-to-Child
Transmission Project (CPMTCT)
[IntraHealth International, Inc.](#)**

PROGRESS REPORT FOR

FY 2011

(OCTOBER 2010 TO SEPTEMBER 2011)

CONTACT INFO FOR THIS REPORT:

[ABEBE BOGALE](#)

[M&E MANAGER, CPMTCT PROJECT, INTRAHEALTH INTERNATIONAL](#)

[PATRICIA MCLAUGHLIN](#)

[PROJECT DIRECTOR, CPMTCT PROJECT, INTRAHEALTH INTERNATIONAL](#)

LIST OF ACRONYMS (Please fill in acronyms used in this report)

ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behavioral Change and Communication
BC/CM	Behavioral Change and Community Mobilization
BEmONC	Basic Emergency Obstetric and Newborn Care
CBO	Community-Based Organization
CHIS	Community Health Information System
CMSG	Community Mothers Support Group
COC	Certificate of Competency
CSO	Civil Society Organization
DBS	Dry Blood Sample
DCCM	Demand Creation Community Mobilization
EIFFDA	Ethiopian Inter Faith Dialogue and Development Action
EOC-DICAC	Ethiopian Orthodox Church Development and Inter Church Aid Commission
FMOH	Federal Ministry of Health
FP	Family Planning
GOE	Government of Ethiopia
HC	Health Center
HCT	HIV Counseling and Testing
HEI	HIV Exposed Infant
HEW	Health Extension Worker
HMIS	Health Management Information System
HO	Health Officer
HP	Health Post
IEC	Information, Education, and Communication
IOCC	International Orthodox Christian Charities
IP	Infection prevention
IRT	Integrated Refresher training for HEWs
IYCN	Infant and Young Child Nutrition
LDDP	Learning, Documenting, Disseminating Plan
MNCH	Maternal, Neonatal and Child Health
M&E	Monitoring and Evaluation
MSG	Mother Support Group
NVP	Nevirapine
PATH	Program for Appropriate Technology in Health
PFSA	Pharmaceutical Fund and Supply Agency
PHCU	Primary Health Care Unit
PI	Performance Improvement
PMP	Performance Monitoring Plan
PMTCT	Prevention of Mother-to-Child Transmission
PW	Pregnant Women
RHB	Regional Health Bureau
SBA	Skilled Birth Attendant
SCM	Supply Chain Management
SNNPR	Sothern Nations, Nationalities and Peoples' Regions
SS	Supportive Supervision
TA	Technical Assistance
TOT	Training of Trainers
TWG	Technical Working Group
VCHW	Volunteer Community Health Worker
VCT	Voluntary Counseling and Testing
UHEPs	Urban Health Extension Professional
WrHO	Woreda Health Office

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1. Reporting period

From: October 1,2010	September 30,2011
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2. Publications/reports

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

No/Not Applicable

Yes If yes, please list below:

Publications/Reports/Assessments/Curriculums

Title	Author	Date
National Comprehensive PMTCT/MNCH Training Package	FMOH	June 2011 – since under revision as FMOH decided to accept the 2010 WHO guidelines
National PMTCT/MNCH Training Package for Urban Health Extension Professional	IntraHealth (CPMTCT)	June 2011
BC/CM training in MNCH/PMTCT for HEW/VCHW	CPMTCT (Pathfinder)	January 2011

If Yes, Please attach an electronic copy of each document as part of your submission.

3. Technical assistance

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

No/Not Applicable

Yes Please list below:

Consultants/TDYers

Name	Arrival	Departure	Organization	Type of Technical assistance provided
Marsha Hamilton	09/20/2010	10/06/2010	IntraHealth International	To assist the project management team with the Yr 1 review and Yr 2 work planning and budgeting
Kate Stratten	09/27/2010	10/13/2010	IntraHealth International	To assist the project management team with the Yr 1 review and Yr 2 work planning and budgeting
Jospeh Petraglia	10/08/2010	10/20/2010	Pathfinder International	To assist the demand creation team with developing a pathways to change model and to revise community mobilization strategies for Yr 2 activities
Laura Gibney	11/12/2010	12/11/2010	IntraHealth International	To assist the M&E team to develop an M&E Operational Plan
Sharon Arscott Mills	02/17/2011	03/10/2011	IntraHealth International	To assist the QI team to develop a Quality of Care assessment tool and pilot it
Kate Stratten	2 April 2011	15 April 2011	IntraHealth	Management and technical support

			International	
Rae Galloway	May 22, 2011	May 27,2011	PATH	IFYN for HIV+ mothers and exposed infants (only 1.5 days dedicated to CPMTCT project)
Joseph Petraglia	19 April 2011	23 April 2011	Pathfinder International	Drafted SGD discussion guide and transition plan
Ruth Landry	June 23	July 25	PATH	Infant video production work
Karen Blyth	July 31, 2011	August 8' 2011	IntraHealth International	To assist the CPMTCT project in preparing for internal transition (also for non CPMTCT related agenda)
Ruth Landry	August 17	August 31	PATH	Finalize Infant Feeding Video production
Laura Gibney	August 11	September 18	IntraHealth International	COP targets, QoC assessment analysis, Data Quality Audit,Basleine follow-up assessment protocols

If Yes, Please attach an electronic copy of the TA report as part of your submission.

4. Travel and Visits

Did your organization support international travel during the reporting period?

No/Not Applicable

Yes

Please list below:

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

Name	Destination	Departure from Ethiopia	Arrival	Host Organization	Purpose of the travel

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

Description of Monitoring team	Start date	End date	Sites visited	Written recommendations provided
CDC-USAID Care and Treatment and PMTCT	June 28,2011	June 29,2011	Hashenge HC, Tigray	Oral recommendation by visiting team
USG MNCH/PMTCT integration team	Dec 2010	Dec. 2011	UHEP program and CMSG group in Hawassa; Saris HC and Saris CMSG, Addis Ababa	An overall trip report was produced
USAID PMTCT and Logistics team	August 10, 2011	August 10,2011	Saris and Dilfe health centers, Addis Ababa	Oral recommendations
USAID PMTCT and NEPI	July 13, 2011	July 13, 2011	Keta HC, Oromia	Oral recommendations
USAID HIV team lead and Deputy team lead	September 23, 2011	September 23, 2011	Hawassa CMSG and Millennium HC, SNNP	Informal, unplanned visit after FHAPCO ARM. Oral recommendations by visiting team

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	663-A-00-09-00429-00	Community PMTCT
<input type="checkbox"/> 02-HVAB		
<input type="checkbox"/> 03-HVOP		
<input type="checkbox"/> 04-HMBL		
<input type="checkbox"/> 05-HMIN		
<input type="checkbox"/> 07-CIRC		
<input type="checkbox"/> 08-HBHC		
<input type="checkbox"/> 09-HTXS		
<input type="checkbox"/> 10-HVTB		
<input type="checkbox"/> 11-HKID		
<input type="checkbox"/> 12-HVCT		
<input type="checkbox"/> 13-PDTX		
<input checked="" type="checkbox"/> 14-PDCS	663-A-00-09-00429-00	Support ARV prophylaxis and CTX provision for exposed infants, follow up of exposed infants
<input type="checkbox"/> 15-HTXD		
<input type="checkbox"/> 16-HLAB		
<input type="checkbox"/> 17-HVSI		
<input type="checkbox"/> 18-OHSS		

6. Accomplishments and successes during the reporting period

In this second year, the project aimed to consolidate successes and achievements of year one while strengthening approaches that promised to secure better performance, particularly with respect to increasing the uptake of MNCH/PMTCT services and improving follow-up of HIV+ mothers and HIV exposed infants. Of particular importance in Year Two was the project's expansion into additional health centers and increased outreach activities to increase PMTCT coverage; strengthening of the Primary Health Care Units (PHCU); establishment of new Mother Support Groups (MSG); development of sustainability and transition plans with RHBs; initiation of BEmONC training to improve the quality and uptake of labor and delivery services; implementation of several special assessments to increase the understanding of project results and inform decision-making; and development of M&E tools to improve results reporting.

Increased Service Uptake:

The project assisted the Government of Ethiopia to expand PMTCT services into 159 new health centers. The total number of HCs supported by CPMTCT with the full package of intervention was 207 HCs, with an additional 116 supported less intensively (no supportive supervision by CPMTCT staff).

CPMTCT supported the counseling and testing of **312, 443** pregnant women this year. This is a notable result considering that in EFY 2003 (July 2010 – June 2011), the FMOH reported that **976,847** pregnant women were counseled and tested for HIV *nationwide*.

To increase our understanding of the number of women receiving ART prophylaxis or HAART, the project implemented a retrospective individual client tracking system. A total of 946 HIV+ women were tracked. These were women identified as positive in ANC at project supported HCs or outreach in the catchment areas of CPMTCT-supported Expansion HCs mainly in Year Two but some in Year One. ***Of these women, 85% who were over 28 weeks gestation at the time of data collection were found to have received ARV prophylaxis or HAART:*** 431 received ARV prophylaxis (368 at expansion HCs and 63 at other facilities) and 237 were on HAART (33 at expansion HCs and 204 at other sites). In addition, HIV exposed infants who

were identified in delivery, PNC, Family Planning or other HC units were also tracked for services already received (prior to their identification in these departments) and afterward: 90% of these 437 HEI had received ARV prophylaxis/HAART at either CPMTCT supported HC or other facilities. However, DBS testing was confirmed for only 56% of these infants (175 of 437 HEI received DBS test in two months of birth, 70 received serology testing between 2-12 months of birth). A challenge for project in the future will be to track services received by HEI identified in ANC.

Comparing the initial three months performance of 47 year one HCs to their performance one year later, there was a 16% increase in new ANC clients; a 56% increase in ANC clients tested for HIV; a 42% increase in deliveries attend by SBA; and a whopping 254% in male partner testing. However, the massive increase in male partner testing and the large increase in deliveries by SBA were due to very low rate initially.

Overall for the 103 expansion HC that were supported by the project for this entire year, the estimated ANC coverage in the population (using 25,000 as the estimated population per HC catchment area) has risen to 51%, 20% of ANC clients are delivering in HC, and 20% of male partners are being tested (EDHS 2011 preliminary results show 33.5% of pregnant women in the country had at least one ANC visit and 10% deliveries by SBA).

Training:

In-service training: 5,635 health sector staff trained in MNCH/PMTCT, BEmONC PQI&SS, CD4/DBS, IPLS , HMIS, IYCN and BC/CM. 982 VCHW/para-social workers trained in behavior change and community mobilization for MNCH/PMTCT, MSG and infant and young child nutrition.

Pre-deployment training: 493 graduating nurses, midwives, and health officers were trained in PMTCT/MNCH and 164 graduating midwives were trained in BemONC & PMTCT. In addition, 21 teaching staff from the School of Midwifery and Nursing at Hawassa University were trained in BEmONC.

Graduating health officers (HO) in Amhara have been deployed to woreda health offices, with all project supported woredas receiving at least one health officer trained by the project. In Tigray the graduating midwives and nurses, all diploma level, will be deployed to HCs but settling transfer allowances, transportation fees, and other issues has delayed deployment to date. All but four graduating midwives from Gondar university B.Sc program who received training by the project were from project supported regions. Deployment information is not yet available, but is being monitored in conjunction with the RHBS.

Supplies:

Advocacy, resulting from project staff's observations in HCs, helped improve the supply and distribution of combined ARV prophylaxis at HCs across all regions. It ensured CPMTCT supported HC were included in national PFSA/SCM procurement and distribution lists. This led to most CPMTCT supported HC providing free MNCH services/supplies/drugs, even though the HC must pay for the drugs, labs and supplies.

Community referral and follow-up

As reported above, this year for the first time CPMTCT retrospectively tracked the PMTCT services received by some of the HIV+ ANC clients identified in project-supported expansion HC and in outreach in the catchment areas of expansion HCs (data sources included HMIS registers, HIV+ mother and HEI tracking wall charts, and HEW reports). It also tracked the services received by HEI who were identified in delivery, PNC, Family Planning and other departments. These clients were being tracked at HC/PHCU level, using PMTCT wall charts and PHCU meetings, but the project was not reporting the tracking. This element will be included in all project reports in year three.

Sustainability and Transition Workshops:

Sustainability and transition workshops were held in Tigray, Amhara and SNNP regions. Agreement was reached on transition criteria for reduction of project support to HC/PHCU. Issues affecting the long-term

capacity of the health sector and/or CSO to assume complete responsibility for training in MNCH/PMTCT and PQI&SS, for supporting MSGs and CMSG, and for conducting supportive supervision at HC and PHCU were discussed and action plans formulated for the coming year. In addition, IntraHealth discussed with regions on how best to assist the region in expanding/strengthening PMTCT in additional HC/PHCU without additional funding.)

Monitoring and Evaluation

Key achievements in project monitoring and evaluation included:

- Finalization of the detailed M&E Operational Plan. This document was key to developing the project's comprehensive M&E system and has been used for training staff and on an ongoing basis as a reference document. In the final quarter, the Demand Creation & Community Mobilization (DCCM) supervision checklist and the data collection strategy for DCCM activities were revised.
- Revision of the project's 'Learning, Documenting and Disseminating Plan' (a document which outlines and tracks proposed operations research in the project).
- Operations Research included (i) implementation in Tigray of a pilot project to provide free layette kits to mothers delivering at HC as an incentive for institutional delivery, and (ii) completing a cost effectiveness analysis of Mother Support Groups (MSG).
- Completion of a draft protocol for assessing the project's supportive supervision system and of a cost-effectiveness analysis design for the layette pilot project.
- Development and piloting of the project's Data Quality Assessment system for all components of the project.
- Submission of abstracts to ICASA (cost effectiveness of MSG analysis was accepted as poster presentation) and to the USG organized MNCH/PMTCT integration workshop planned for November.
- Completion of the baseline assessment and of the comparative baseline /follow-up assessments of key health service-use results in woredas supported by CPMTCT.

OBJECTIVE 1: To build the capacity of regional health bureaus, zonal and woreda health offices and community-based organizations to support and manage community-based PMTCT services.

During the reporting period, the project built the capacity of regional health bureaus, zonal and woreda health offices, PHCU and community-based organizations to support and manage PMTCT services. Of particular importance during the period have been efforts to address supply issues, insufficient DBS/CD4 testing and sustainability and transition concerns.

KEY ACHIEVEMENTS FOR OBJECTIVE 1

Improved supply availability at HC level:

CPMTCT used its ground-level observations of supply shortages (drugs, labs, IP materials etc), and observation of variable interpretations of several policies or proclamations (ARV prophylaxis, MNCH/PMTCT fee exempt service proclamation) to mobilize FMOH, USAID and the Supply Chain Management project to:

- Clarify guidance and ensure supply of regarding ARV combined prophylaxis rather than SdNVP at all PMTCT sites;

- Ensure that all CPMTCT supported health centers, as well as IFHP supported HC offering PMTCT services, were included on PFSA/SCM supply lists for relevant drugs and supplies.
- Address the issue of temporarily unaffordable/unavailable laboratory reagents and supplies. With the support of USAID, CPMTCT and IFHP supported HC will receive essential labs and Rapid Test Kits (RTK) as part of “program” drugs (free to HC).
- Work at ground level with WrHO and HC, has led to most of the CPMTCT supported HC providing free MNCH services, even though they currently purchase the drugs/lab reagents they provide for free.

In response to on-going supply issues, regular meetings between PFSA/SCM, IntraHealth and RHB are now taking place to ensure sites updated and included in procurement and distribution, and that HC level staff receive IPLS training. In collaboration with PFSA/SCM, CPMTCT supported **IPLS training** for 264 individuals mainly pharmacy professionals (i.e. 229 HC staff from 183 HCs, 28 staff from 27 WrHOs/Sub-city Health Offices, 6 staff from 6 zonal health departments, 1 staff from Amhara RHB). IP materials and lab reagents were purchased and distributed to project supported health centers.

Improved Access to CD4 and DBS Testing

Considerable effort was put into improving, client access to CD4 and DBS testing CPMTCT at supported HCs. This included: training of 151 staff from 106 HCs, holding stakeholders meetings in the regions, and raising issues at national and regional level regarding testing protocols for low incidence sites, PMTCT HC codes, kits for taking samples, and transportation boxes for samples. However, these issues are not yet resolved in any of the regions on a regional basis; it is still a HC by HC improvement. Work will continue in this area in 2012.

Technical working group activities

CPMTCT senior technical staff regularly participated in the following national level technical working groups: PMTCT/Safe Motherhood; Nutrition and HIV; and National Health Communications. It was through these TWGs that the project was able to participate in, influence and sometimes lead in the development of key PMTCT related guidelines, policies and curricula.

PMTCT/Safe Motherhood TWG: At the behest of this TWG and FMOH, the CPMTCT project contracted out oversaw the revision of the *National Comprehensive PMTCT/MNCH Training*. The revised curricula had been approved by the FMOH, however a recent decision by the FMOH to adopt the WHO 2010 recommendations on PMTCT, has meant the materials needed to be revised again, and also that the National PMTCT guidelines needed to be amended. CPMTCT project staff is leading a TWG sub-group responsible for the revision of the training manual and are active participants in designing both the *PMTCT Emergency Plan*, and the *Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality*.

Nutrition and HIV & National Nutrition TWG: CPMTCT staff supported the updating of the guideline on nutritional care for people living with HIV/AIDS and produced a radio spot on the importance of breastfeeding in the context of HIV/AIDS for national breastfeeding week. In addition CPMTCT project staff provided substantial input into the production of the IYCN counseling cards.

National Health Communications TWG: The project participated in this TWG's efforts to standardize MNCH/PMCT messages, sharing CPMTCT IEC materials and BC/CM training materials. The translated versions of the BC/CM training materials were shared with the FMOH for adaptation for training the health development army.

CSO capacity building: 45 leaders from 20 CSOs participated in the 10-day *Basic Managerial and Leadership Skills* training and 47 senior officials from 22 CSOs (the 2 additional CSOs are members of EIFDDA) received the *Basic Finance for Non Finance Managers* training. The project also assisted two of the CSOs to submit a proposal to *Positive Action for Children* (Glaxco Foundation) to undertake PMTCT activities.

Sustainability and technical transition workshops: Under the Capacity Project in Ethiopia, IntraHealth assisted the government to expand PMTCT services into 228 health centers (expansion HCs and indirect HCs), supporting each health center for nine months to a year, before “transitioning” the health centers back to only government (or other GO) support. In many cases, the coverage and quality of PMTCT services declined after the transition. The CPMTCT project has, therefore, proposed a different approach of a gradual reduction of technical and financial support to health center services and primary health care units, including training, supportive supervision, demand creation activities and MSG,. It has also agreed that health authorities and CPMTCT would monitor health center/PHCU performance under reduced levels of support.

This year CPMTCT agreed with SNNP, Amhara and Tigray regions key project activities that need to be assumed by the public health sector in order to sustain the benefits from the CPMTCT project (higher utilization of more and better MNCH/PMTCT services). Criteria for reducing the level of technical support to HC/PHCU; and priority actions to address sustainability related issues were agreed in these workshops. All regions expressed a firm commitment to the MSG intervention and proposed very concrete steps, somewhat different in each region, to address expansion of the MSGs as well as health sector/woreda assumption of financial and technical support to MSGs. The regions' capacity to assume training responsibilities and performance-based supportive supervision is variable; further, the approaches for assuming responsibility for supportive supervision vary across regions, though each region clearly outlined a plan for assuming this responsibility.

PERFORMANCE INDICATOR RESULTS FOR OBJECTIVE 1:

Table 1 provides results for indicators in the project's Performance Monitoring Plan pertaining to Objective 1.

Table 1: Performance for Key Indicators (Objective 1)

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% achieved to date)	Remark
1.1 - 1	# of CBOs provided with technical assistance for CPMTCT program management	0	22	22	22	22	20 (110%)	20 PLHAs and women association, EOC-DICAC and EIFDDA
1.1- 2	# of RHBs & woredas provided with TA for CPMTCT mgt	RHB	5	5	5	5	5 (100%)	
		Woredas	142	171	171	171	171	160 (107%)
1.2 -1	# of national technical forums on MNCH/PMTCT	Reported annually _____				0	1 (0%)	Safe motherhood/PMTCT

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% achieved to date)	Remark	
	best or promising practices							month and meetings were canceled by FMOH at last minute	
1.2 -2	# of MNCH/PMTCT guidelines, job aides and other tools developed/ revised and implemented	Reported annually_____				4	3 (133%)	PMTCT/MNCH training; Wall chart, PHCU guideline, BC/CM flipchart	
1.3 -1	# of logistics management skills workshops for woreda, HC, HP and region	0	3	3	2	8	15 (53%)	Fewer workshops with more people	
1.3- 2	# of GOE personnel at logistics management skills workshop	0	122	56	86	264	225 (117%)	With the assistance of PFSA/SCM we were able to train more HC than assumed.	
1.4 -1	# of CBOs and woredas (provided with TA in financial management or financial procurement)	CBOs	0	22	0	0	22	20 (110%)	
		Woredas (or sub cities)	0	0	0	0	0	0	
1.4- 2	# of individuals trained in financial management	0	91	14	0	105	60 (175%)		
1.5 -1	# of MNCH/PMTCT recommendations that have been adopted by GOE	Reported annually_____				1	1 (100%)	WHO 2010 recommendation PMTCT	
1.5 -2	# of MNCH/PMTCT policies passed/amended that are consistent with CPMTCT advocacy	Reported annually_____				0	1		
1.5 -3	# of national public presentations highlighting service delivery successes or problems and proposing replication or change for solution	Reported Annually_____				0	2	FMOH cancelled workshops planned for Safe Motherhood month, and the project decided to hold the Sustainability and Transition Workshops at regional level rather than at national level.	
1.6 - 2	# of public health sector staff trained in HMIS and use of HMIS data for quality improvement and decision making	489	140	288	0	917	250 (367%)	This includes CHIS training provided to HEWs in Tigray, and planned HMIS training that began as 2010 year ended	

The capacity building results in Table 1 are laying the foundation for an effective transition of support for the PMTCT/MNCH services from the project to the government over the remaining project years.

OBJECTIVE 2: Increase access to MNCH/PMTCT services by providing facility and community services and improving bi-directional linkage/ referrals between PMTCT/MNCH services at the facility and community level.

Major accomplishments under this objective include the strengthening of PHCU to improve follow-up and referral of HIV+ mothers and HEI, expansion into 159 health centers and the provision of training in MNCH/PMTCT, job aids, supplies and lab reagents, to allow health centers to offer improved services. The project supported 207 expansion health centers and supported woredas in establishing and strengthening PMTCT services in another 116. The project also supported pre-deployment training of diploma nurses and BSc health officers in MNCH/PMTCT, as well as BEmONC and PMTCT training to graduating midwives. In addition, 85 CPMTCT supported HC labor and delivery staff in Tigray, Amhara and Oromia to begin BEmONC training and post-training mentoring.¹

Training:

MNCH/PMTCT training was provided to 970 staff (Basic for 866 and refresher for 104) at project supported health centers. Most of the MNCH/PMTCT training was facilitated by RHB/ZHD or woreda staff that had been trained as trainers by the CPMTCT project. Infant feeding training for 154 providers and 131 mentor mothers was provided by CPMTCT staff (MSG officers and the PATH-seconded Infant Feeding Advisor). As updated IYCN guidance is now being included in the PMTCT guidelines and MNCH/PMTCT being revised to comply with WHO 2010 Recommendations for PMTCT services, less provider training will be needed in future.

In addition, the project piloted an internet-based education methodology called SpacedEd on the topic of infant and young child nutrition. It was used to update project staff and a few colleagues from the Ethiopian Pediatric Society and FMOH on the topic. The report of the pilot is attached as an annex to the annual report.

Couples Counseling:

In addition to supporting the government's national couples counseling day, fifty five religious fathers, who were selected from 11 PMTCT intervention woredas of EOC-DICAC, have been provided with five day training on couple counseling & male involvement with a view to organizing encouraging couples counseling at church events and recommending that their spiritual children get tested, especially during pregnancy. Ten couple counseling and testing events were organized in eight intervention woredas. A total of 1992 mothers and partners received counseling and testing services from trained counselors.

Community referral and follow-up tools and mechanisms: PHCU and CMSG:

PMTCT tracking wall charts and PHCU meetings

The CPMTCT project modified past project HIV+ mothers and HEI wall charts and provided them to all supported HC. These wall charts document each positive mother/infant and staff can identify at a glance anyone who is due for delivery, HIV+ pregnant women/HEI who have or have not come for ARV, DBS, etc. This wall chart is used to help HC staff follow-up on defaulters, and for HEW to track referral up-take. The mechanism used to share this information, and attribute follow-up tasks is the Primary Health Care Unit (PHCU) review/planning meeting.

The CPMTCT project provides technical and minimal financial support for (PHCU) meetings, attended by HEW/UHEP and HC staff. These meetings focus on MNCH and specifically address follow-up and referral uptake for HIV+ mothers and HEI, as well as overall uptake of MNCH/PMTCT services. We believe the

¹ Oromia training for 36 staff ended first week of October but as the bulk of training took place in September it is included in the report.

PHCU meetings contributed to the project achieving 85% of eligible PW, tracked in individual follow-up, receiving ARV/HAART.

Demand creation and follow-up registers and CMSG groups

In coordination with the UHEPs, CMSG mentor mothers undertake household visits once a week where they identify and refer pregnant women for ANC, HCT, ARV and HEI follow-up. If a pregnant woman is identified and has not been to ANC, she is referred and then revisited within the month to verify referral uptake. If negative, the visits cease. If positive (and willing to share this information), she is invited to the CMSG group. If she decides not to join, CMSG mothers continue to visit on a monthly basis to encourage adherence to recommended practices. Facility MSG mentor mothers also contribute to tracking and follow-up of defaulters. HC staff using the PMTCT tracking wall charts for mothers who have chosen not to join the MSG.

This year the CMSG groups have been successfully using the demand creation and follow-up ledger developed in Year One. The ledger is used to refer pregnant women for ANC/PMTCT services, and, if the women are positive and choose to join the CMSGs, to follow-up the HIV+ mother on a monthly basis to ensure service uptake.

Pre-deployment Training:

Although skills based pre-service training is ideal pre-deployment training in priority subjects, like BEmONC and PMTCT is a temporary alternative that is cheaper than in-service training and does not require staff to leave their posts. It also has the added benefit, as mentioned above, in helping graduating students pass their COC exams, which are required for employment. The project trained 493 graduating nurses, midwives and health officers this year.

Among graduating health officers (233) trained on Comprehensive MNCH/PMTCT in Amhara, all are assigned in Amhara region, especially at woreda level. CPMTCT-supported woredas all got at least one of these health officers. In Tigray, CPMTCT supported deployment training for 222 Nurses (PMTCT/MNCH) and 74 Diploma Midwives (BEmONC+PMTCT/MNCH), who are expected to be deployed to health centers,, with CPMTCT health centers given priority. However, their deployment has been delayed due to transfer settlement processing, and confusion about which health centers need staff in light of recent promotions and transfers. These staff graduated in June and already passed CoC exams but unless they are deployed within the next few months, the benefits of the training may be diminished as they will not have had an opportunity to use the skills and knowledge learned. A similar delay also occurred with respect to graduating midwives and nurses who received pre-deployment MNCH/PMTCT training in Amhara.

It seems pre-deployment training could provide real and consistent benefit to the health sector while pre-service training is being improved (and used for updates as science changes more quickly than curriculum); however, much better HR planning is needed to avoid a long gap between graduation and deployment.

Basic Emergency Obstetric and New Born Car (BEmONC):

Sixty four BSc graduating midwives from Gondar University and 76 graduating diploma midwives from Dr. Tewolde Legesse Health Sciences College in Tigray received the 21 day BEmONC training provided by CPMTCT using the FMOH BEmONC curriculum, before they graduated. Ninety percent of the students in Tewold Legesse passed the Certificate of Competency (COC) exam (needed for employment). The previous year's performance was 24% and the national average was 66%. While the CoC exams are not applied to degree level students, the BEmONC training course theoretical post test average was 92.6% (minimum 87% and maximum 100%) and in the practical evaluation 93.8% of participants passed the skill exam. Additionally, 21 Hawassa University School of Nursing and Midwifery instructors completed the BEmONC course. Eighty five in-service labor and delivery staff at 50 HC in Oromiya, Tigray and Amhara also completed the BEmONC training and are currently receiving post-training mentoring.

Outreach:

Woredas are responsible for achieving targets for ANC, HCT and other health indicators but face immense challenges in some regions due to dispersed populations, mountainous terrain, and areas where health centers have not begun offering PMTCT services (1445 of 2660 HC in the country provide PMTCT). Where these challenges exist, well-organized outreach is a reasonable way to provide integrated services, not only for ANC/PMTCT but also for family planning, weight/height monitoring for children, immunizations and other services. Through outreach, woredas, zones and regions meet their targets for ANC and HCT, and some regions like Tigray and SNNP also report meeting their cascade targets for ARV uptake among HIV+ pregnant women identified. Outreach is very popular with woredas and regions. However, on a project level, it has proven difficult to reliably track what happens to HIV+ pregnant women identified in outreach outside of project-supported health centers. Given the move towards a PHCU rather than woreda structuring of health services, and after discussion with USAID and regions, the project has decided to expand into additional health centers but to only do outreach within the catchment areas of HCs supported by the project.

PERFORMANCE INDICATOR RESULTS FOR OBJECTIVE 2

The above activities contributed to the results demonstrated in Table 2. Data for the PEPFAR results in the table come from the monthly reports from health facilities. However, it is important to also consider the individual tracking results presented above as they provide a clearer perspective on follow-up services received by the HIV+ ANC clients and their infants.

(a) MNCH/PMTCT RESULTS

Table 2: Performance for Key Indicators (Objective 2)*

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% Achieved to date)	Remark
2.0 - 7	# of new ANC clients	56,818	101,297	97,258	86,727	345,162	359,443 (96%)	
2.0- 1 (P1.1.D)	# of pregnant women with known HIV status (includes women who were tested for HIV and received their results)	41,429	97,108	88,822	85,084	312,443	291720 (107%)	
2.0- 2 (P1.1.D)	# of HIV+ pregnant women identified in the reporting period	315	361	443	429	1548	4,263 (36%)	Lower HIV prevalence than planned
2.0 -3 (P1.2.D)	# of HIV+ pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission	69	118	125	142	453	3,198 (14%)	Apart from low prevalence, CPMTCT <u>only</u> reports ARVs provided at CPMTCT supported HC, not for those receiving service at other facilities. See the discussion above regarding ARV uptake at HC level.

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% Achieved to date)	Remark
2.0 - 4	# of newborns born to HIV+ mothers who received ARV prophylaxis	56	56	81	104	297	2,132 (14%)	Similar to indicator 2.0-2
2.0 - 5 (C4.2D)	# of infants receiving Cotrimoxizole (CTX) prophylaxis	30	38	52	83	203	2,132 (10%)	Similar to above
2.0-6.1 (C4.1.D)	# of infants born to HIV+ mothers who received HIV test in 2 months of birth	20	19	30	49	192	2,132 (9%)	Similar to above.
2.0 -6.2 (C4.1.D)	# of infants born to HIV+ mothers who received HIV test between 2-12 months	13	8	25	28			
2.0 - 8	# of deliveries by skilled birth attendant	3,075	3,361	4,135	4355	14,926	35,018 (43%)	The roll out of BEmONC training, and the distribution of new born corner supplies that are project strategies to improve L&D quality and thus uptake were delayed to ensure proper coordination with other partners.
	# of clean deliveries by HEWs	2,844	2,729	4,582	3,200	13,355	NA	
2.0 - 9	# of deliveries for HIV+ women by skilled birth attendant	54	48	68	107	277	3198 (9%)	Lower than expected prevalence
2.0 -10 (P1.4.D)	# of HIV+ pregnant women assessed for ART eligibility through WHO clinical staging or CD4 testing	155	211	230	331	927	4263 (22%)	Lower than expected prevalence. Also, many HIV+ were identified outside catchment areas of CPMTCT supported HCs.
2.0 -11 (P1.5.D)	# of HIV+ pregnant women newly enrolled in care and support services	343	555	652	686	2,236	1000 (223%)	This reflects increased access to CD4 testing as well as increased enrollment in MSG.
2.0 -12	% of infants by feeding type							
	Exclusive Breast Feeding	93%	96%	94%	98%	95%	90% (95%)	
	Exclusive Formula Feeding	7%	2%	4%	1%	4%	10% (4%)	

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% Achieved to date)	Remark
	Mixed Feeding	0	2%	1%	1%	1%	0% (1%)	
3.5 -1	# of male partners of pregnant women who are counseled and received their results	6,421	14,718	15,970	14,555	51,664	87, 516 (59%)	Measurement of this indicator is difficult when partners come in after their wife's first ANC visit. See explanation in data quality challenges.
2.5 - 2	# of HIV-positive women counseled on family planning	136	202	257	269	864	4263 (20%)	Similar to 2.0-2. 864/927 HIV+ women at CPMTCT HC were counseled and tested on family planning
2.1 -1 (P1.3.D)	# of health facilities providing ANC services that provide both HIV testing and ARVs for PMTCT on site	99	183	196	207	207	200 (104%)	
2.1 - 2	# of health posts providing PMTCT/MNCH services	167	1870	1236	282	1870	630 (297%)	Due to shift in strategy towards outreach
2.2 - 3	# of MSG sites supported	41	73	91	96	96	100 (96%)	
2.1 -3 (H2.3.D)	# of health care workers who successfully completed an in-service training program within the reporting period	1,070	1,396	3,098	749	6,313	13,240 (48%)	The Project agreed with USAID to cease HMIS and financial management training in order not to overlap with others.
2.1 -4	# of PMTCT service providers trained in effective referral/follow-up mother-baby pairs	309	333	1,662	0	2,304	1200 (192%)	This includes HEWs trained in BC/CM for MNCH/PMTCT and UHEPs trained on MNCH/PMTCT (effective referral/follow-up is part of the training module). This result is a double count with other trainings
1.2 - 5	# of midwives who received training on BEmOC	0	0	140	130	270	300 (90%)	
2.2 -1	# of completed pilot MNCH/PMTCT service delivery innovations	Reported annually: _____				0	1	Layette pilot will end Jan 2012

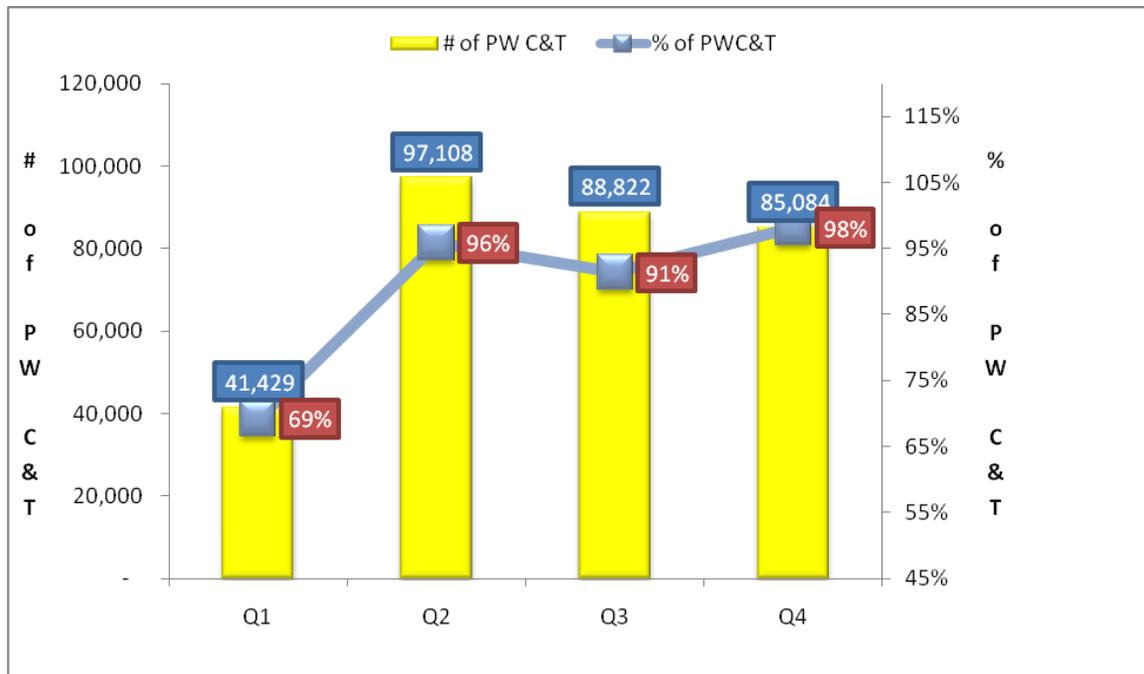
PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% Achieved to date)	Remark
2.2 - 2	# of MSG site coordinators/ mentor mothers who have received MSG training	64	291	204	108	667	250 (267%)	Though the figure corresponds to completed TIMS forms, it is an over count of individuals trained as some mothers received infant feeding training and basic or refresher training on separate occasions.
2.3 - 1	# of woredas with service mapping completed of referral sites in the community	60	0	0	0	60	75 (80%)	Other partners had supported so no need to replicate
2.4 - 1	# of tools/systems introduced for confirming client follow-up of referrals	Reported annually: _____				2	1 (200%)	Wall charts updated,/PHCU review meetings
1.2 - 3	# of trainings in integrated MNCH/PMTCT for health providers and their supervisors	15	16	13	8	52	25 (208%)	Due to the need to update staff on the new HBB and LTFP modules, addition trainings held
1.2 - 4	# of health providers/ supervisors who successfully completed training or refresher training in integrated MNCH/PMTCT	219	656	679	285	1,839	625 (294%)	HBB and LTFP methods were included as a module in all basic and refresher MNCH/PMTCT trainings conducted in this year
2.6 - 1	# of community-facility MNCH oversight committees established (WAC committees not Health boards)	Reported annually: _____				63	50	Health center boards are one mechanism for community-facility oversight and are representative of different interests. Woreda Advisory Committees are more involved in uptake of service and HEP issues.

* Of the 207 HCs expected to provide monthly service delivery data for the 4th quarter, one month of data from 13 HCs in SNNPR were missed.

The 312,443 pregnant women reported in Table 2 as knowing their HIV status were counseled and tested at the following service sites: health centers (92,329); outreach (163,223); HEWs (52,906) and UHEPs (3,985). This result, which is greater than the annual target for this indicator, was the result of a

significant improvement in performance from the first quarter to the final quarter, as illustrated below in Figure 1.

Figure 1. Number and percentage of pregnant women with HIV known status by quarter



Amongst the ANC clients tested, HIV+ prevalence was low. The average HIV + prevalence in CPMTCT project sites was 0.5%, far lower than the HIV + prevalence rate assumed when targeting, which was 1.4%. Prevalence at the different service outlets was as follows:

- Expansion HCs (1.00%)
- Outreach (0.18%)
- UHEPs (2.22%)
- HEWs t (0.42%)

Of these ANC clients who tested positive, the results in Table 2 do not illustrate the number who actually received ARV prophylaxis because many of the women received ARV prophylaxis or HAART at health facilities not supported by CPMTCT. In part this was because much of the project's counseling and testing was conducted in outreach activities at health posts (HPs) outside the catchment areas of CPMTCT-supported health centers. Further, because CPMTCT-supported health centers refer positive women to ART sites, many of the women receive HAART at those locations rather than at CPMTCT supported HCs.

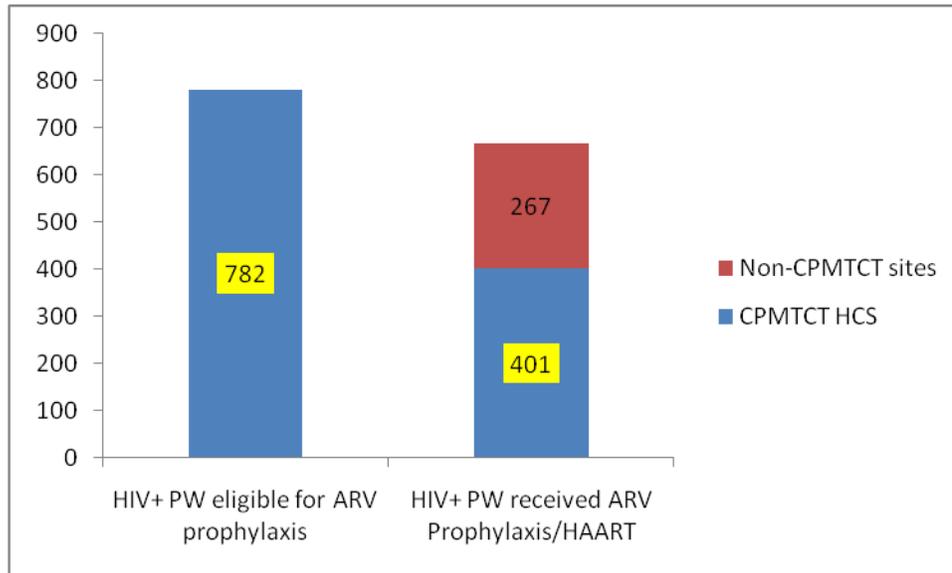
To obtain information on the proportion of HIV+ women and their infants who received the follow-up services (services needed after receiving a positive test result), CPMTCT implemented a tracking system for individual clients. These results are presented below. This tracking was retrospective; in future a prospective tracking system will be used.

Results Tracking for Individual Clients

HC staffs are tracking ANC clients who tested positive at HCs or in outreach in a HP within the catchment areas. Most of these clients tested positive in FY 2011 though some from the previous year were also included. Data sources included registers, wall charts, witness observations and personal accounts.

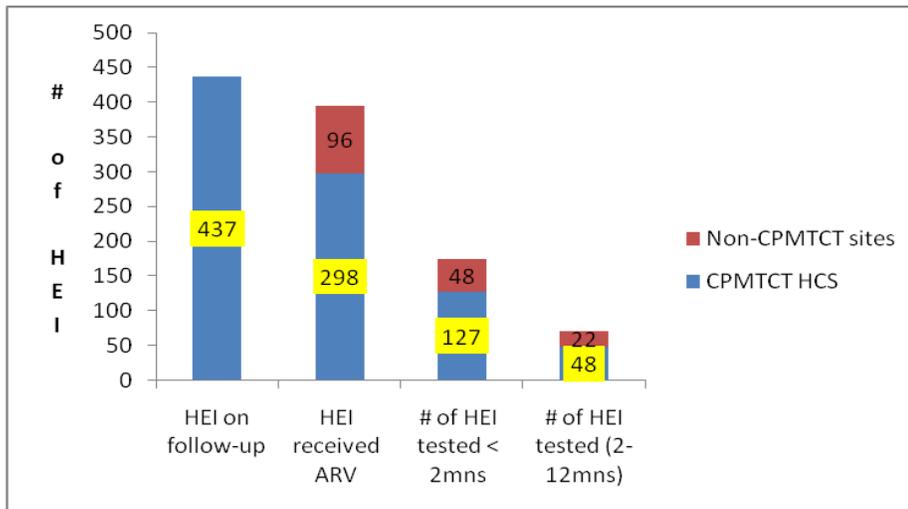
Of the 946 HIV+ women who were tracked for use of follow-up services, 431 received ARV prophylaxis (368 at expansion HCs and 63 at facilities other than expansion HCs) and 237 had started ART (33 at expansion HCs and 204 elsewhere). Of these women, only 782 were eligible for ARV (>28weeks gestational age). Of the eligible women, 85% received ARV or on HAART.

Figure 2. ARV/HAART uptake of eligible HIV+ pregnant women tracked in follow-up



The project also tracked individual results for HIV-exposed infants who had been identified during delivery, post-natal care, family planning or in other services (i.e. in services other than ANC) at a CPMTCT supported Health Center. Of these 437 HEI, 394 had received ARV prophylaxis (298 at expansion HCs, and 96 in other facilities) as per the HEI follow-up tracking information. Moreover, 245 HEI received DBS or serology testing.

Figure 3. ARV uptake and testing by HEI Identified in HC Departments (other than ANC)



(b) MOTHER SUPPORT GROUPS RESULTS

HIV positive mother to mother support groups (MSG) are an evidenced based intervention that empower positive women to improve their adherence to recommended PMTCT practices and behaviors, as measured by key PMTCT indicators including ARV uptake, DBS testing, and infant feeding practices.

From October 2010 to September 2011, 1568 HIV+ women were members of IntraHealth International supported facility and community-based MSG groups. Using the assumptions of 25,000 people per HC catchment area and a pregnancy rate of 3.8%:

- Of an estimated 725 HIV+ pregnant women in the CMSG kebeles catchment population 330 (46%) joined CMSGs in addition to 325 HIV+ lactating mothers. Given that CMSGs are located in towns that are also served by hospital and health center MSGs; this represents a substantial number of HIV+ pregnant women.
- Of an estimated 455 HIV+ pregnant women in the facility-based MSGs catchment population (based on population estimates of 25,000 per catchment area and a pregnancy rate of 3.8%), 414 joined MSGs, in addition to 241 HIV+ lactating mothers. However, while this suggests a 91% result that would likely be a significant overestimate as some of the women joining MSGs live outside the catchment areas of the HCs. Further, it should be noted that there are different accounts of the size of catchment area populations.

In 2010/2011, 37 new MSG sites were begun in 5 regions, 67 mentors and 60 site coordinators received basic training, and in the 41 previously established sites, site coordinators and mentor mothers received refresher training. All mentor mothers were trained in updated Infant and young child feeding practices in the context of HIV, using materials produced by JHU-Tsehai with CPMTCT input. *As 40% of positive children are estimated to have become positive through breastfeeding, and mentor mothers had vocally expressed their concern over confusing guidance relating to feeding, this is a key project achievement.*

We anticipate that the project will continue to succeed in delivering effective Infant and Young Child Nutrition (IYCN) messages using the educational video drama on Infant and young child feeding practices in N HIV context produced by the project in September of this year.

Table 3: Performances of key MSG indicators (Objective 2)

Selected MSG Indicators		Q1	Q2	Q3	Q4	Total to Date (FY 2011)
Current members of MSGs by end of each quarter		486	790	1,199	1,568	1,568
# newly enrolled in MSG	HIV-positive pregnant women	116	188	237	203	744
	HIV-positive non-pregnant women	72	156	186	152	566
# newly enrolled MSG members on pre-ART or ART	Pre-ART	38	90	126	106	360
	ART	95	109	176	113	493
# MSG members who delivered	At HC/hospital	76	77	105	134	392
	At home	2	5	4	7	18
	<i>Total</i>	<i>78</i>	<i>82</i>	<i>109</i>	<i>141</i>	<i>410</i>
# MSG members who received antiretroviral (ART or ARV prophylaxis (%))	sdNVP/combined	26	55	52	63	196
	on ART	52	27	57	77	213
	<i>Total</i>	<i>78</i>	<i>82</i>	<i>109</i>	<i>140</i>	<i>409 (99.8%)</i>
# infants born to MSG members who received ARV prophylaxis (%)		77	77	107	138	399 (97%)
% MSG mothers with babies < 6 months practicing exclusive breast feeding		97%	96%	96%	97%	96%
% infants of MSG members 45 days to 2 months who started Cotrimoxazole		90%	98%	99%	94%	96%
# MSG members disclosed status to partners		61	89	136	146	432
# infants born to MSG mothers who received DBS testing (within 6 months of age)	Positive	3	2	5	4	14
	Negative	47	70	108	101	326
<i>Total</i>		<i>50</i>	<i>72</i>	<i>113</i>	<i>105</i>	<i>340</i>
# infants born to MSG mothers who received confirmatory HIV testing (within 9 to 18 months)	Positive	2	5	0	2	9
	Negative	20	43	54	42	159

As illustrated in Table 3, MSG members have very high uptake of MNCH/PMTCT services for themselves and their children. Overall, 99.8% of MSG members who delivered in the past year (i.e. 392 at a health facility and 18 at home) received ARV prophylaxis or ART: 213 were on ART and 196 received ARV prophylaxis. Further, 97% of infants (399) born to MSG members received ARV prophylaxis, 96% of MSG members with babies less than 6 months were exclusively breast feeding and 96% of infants 45 days to 2 months of age had started cotrimoxazole prophylaxis. In addition to these service use benefits, MSG members reported that the support, encouragement and friendship gained from the other mother support group members motivated them to live positively.

Objective 3: To increase demand for MNCH/PMTCT services through community mobilization/demand creation

Project partners Pathfinder and IOCC lead the DCCM activities in the project and this year made tremendous strides in rolling out the DCCM approach/activities. There is five-pronged strategy: i) raise awareness through mass media and distribution of IEC materials; ii) provide training, supervision and job aids to improve HEW understanding and skills in educating and persuading women and their partners to seek MNCH/PMTCT services, iii) train religious leaders, religious women's groups, women's association and PLHA to be role models and train their own members in PMTCT, iv) support a sub-set of CSO volunteers in undertaking education and referral activities at community level, and v) support review/meeting led by the WrHO to address uptake issues with the aforementioned groups.

Training:

- 2385 HEWs/UHEP/VCHW trained in community mobilization and behavior change skills in MNCH/PMTCT and their existing responsibilities in increasing community awareness of the importance of ANC/SBA/FP-PNC/PMTCT, and to encourage and refer pregnant women and partners for testing. This included 187 fathers and religious women group members from EOC-DICAC and 114 volunteers from EIFDDA, of whom 40 were religious leaders.
- 204 WrHO and CSO trainers trained in our five implementing regions.

Production and Distribution of IEC/BCC materials

BC/CM for MNCH/PMTCT training materials were translated into Amharic, Tigrigna and Afan-Oromo; IEC materials and job aids developed and distributed. These include:

- Four 45min DVD dramas on MNCH/PMTCT, translated into three languages
- T-shirts, bags, umbrellas and caps with MNCH/PMTCT messages distributed to HEW/VCHW in recognition of their work in mobilizing and referring communities for outreach and HC service uptake
- 5 posters (25,000 copies each) promoting ANC, couples HCT, institutional delivery, adherence to treatment (prophylaxis), post-natal care/ family planning
- Leaflets and stickers with key messages and
- 5000 flip charts for HEW to use a job aids when teaching about the importance of MNCH/PMTCT services.

Yetesfa mit' Radio serial drama was translated in to Tigrigna and Oromigna languages and broadcasted on five regional FM radio stations (originally produced by the Capacity Project in Amharic). Incentives were introduced to attract as wide an audience as possible, for example listeners who SMSs, mailed or e-mailed the correct response to questions at the end of the show received a small prize. . The drama is intended to increase knowledge and awareness of the community in general, and pregnant women in particular, on the need for ANC follow up, HIV testing during pregnancy and institutional delivery.

CSO capacity building included training in project and financial management, training in MNCH/PMTCT. Support provided to the Network of HIV Positive Associations (NAP+) to organize a workshop on how to improve uptake of ANC/PMTCT and ARV prophylaxis by pregnant women and the role of associations of HIV positive people in CPMTCT.

The project organized sensitization workshops with community leaders to introduce them to the project and to gain local support in woredas where the project expanded its reach. After initial sensitization meetings, the project supported periodic woreda/town advisory committee meetings (WACs) to secure and then review/plan woreda support in creating an enabling environment for pregnant women to seek ANC/PMTCT services. In addition, demand creation and community mobilization review/planning

meetings were supported and attended by HEWs and their supervisors and woreda level stakeholders to review progress, identify performance gaps and successes, and develop action plans to address gaps and replicate successes. While appropriate in the year two context, before the widespread establishment of the PHCU, the CPMTCT project believes that as PHCU meetings become more common, the need for quarterly review/planning meetings at woreda level will naturally decrease.

One key challenge the project faced was that HEW Supervisors, who began the year based at woreda level, were moved to health center level as HEWs became attached to PHCU rather than the woreda, then disappeared altogether as the HC manager became the supervisor of the PHCU and the HEWs. This thwarted project strategies for collecting referral cards from non-CPMTCT supported health centers, and is one of the many reasons for the Year 3 move to focus DCCM activities only on CPMTCT-supported health centers rather than at woreda/town level.

Performance Indicator Results for Objective 3

Table 4: Performance for Key Demand Creation Activities (Objective 3)

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% achieved to date)	Remark
3.1 - 2	# of evidence-based best practices recognized by expert body in country	Reported annually: _____				0	1	PHCU identified as a promising practice for documentation
3.2 - 1	# of the targeted population reached	87,138	83,819	83,331	112,493	366,781	390,000 (94%)	Includes only people reached through Small Group Discussion
3.2 - 2	# of IEC/BCC materials produced or adopted which primarily focus on PMTCT	Reported annually: _____				11	2 (550%)	Radio drama, flip chart, 5 posters, 4 videos
3.2 - 3	# of IEC/BCC materials distributed at community level	3,929	3,838	9213	16,263	33,243	10,000 (332%)	
3.2 - 4	# of referrals acted on by clients attending ANC/PMTCT services at HCs	7,823	7,712	7,981	12,244	198,983	54,698 (364%)	Through outreach significant # of pregnant women were referred by HEWs/VCHWs and received MNCH/PMTCT service at the time of outreach.
	# of referrals acted up on clients attending ANC/PMTCT services at Outreach	8,424	58,417	48,527	47,855			
3.2 - 5	# of community volunteers trained in PMTCT	132	206	204	47	589	800 (74%)	Cascade training was cancelled after the government requested that all partners cease training of HEW and support on IRT.

3.4 - 1	# of VCHWs, CBHRAs, HEWs, UHEPs trained in methods of educating the community about early warning signs	441	494	1,683	0	2,618	1000 (262%)	All CBC/CM training includes this
3.5 - 2	# of clergy and other volunteers trained in how to promote positive male engagement in MNCH/PMTCT	0	206	204	0	410	200 (205%)	A carry over from under-achievement of last year

While the results in Table 4 for numbers of referrals to health services acted on are very impressive (364% of the target), they are still an undercount due to problems in collecting referral cards. HEW Supervisors, who began the year based at woreda level, were first moved to the health center level (as HEWs became attached to PHCU rather than the woreda) and then had their post eliminated as HC managers became the supervisor of the PHCU and the HEWs. This thwarted project strategies for collecting referral cards from non-CPMTCT supported health centers, and is one of the many reasons for Year 3 move to focus DCCM activities only on CPMTCT-supported health centers rather than at woreda/town level.

To gain insights into the specific contributions of the project's woreda-based DCCM activities, CPMTCT conducted a baseline- follow up assessment of 40 randomly selected woredas. Twenty woredas were in areas where the project had been implementing demand creation and community mobilization activities more intensively and 20 were in areas where it had not been active (no project training of HEW in BC/CM due to recent FMOH decision to forbid HEW training other than IRT).

Service delivery data on ANC visits and deliveries with skilled birth attendants (two services CPMTCT expects to increase through DCCM activities) were collected from the randomly selected woredas for the months January-June 2009, at baseline and two years later (2011). Table 5 shows preliminary data from this assessment.

Table 5. Key Performance Indicators in DCCM and non-DCCM Woredas

Outcome Indicators	DCCM Woredas			Non-DCCM Woredas		
	Baseline	Follow-Up	% Change	Baseline	Follow-Up	% Change
# ANC visits	18,115	26,538	+46%	25,704	28,841	+12%
# deliveries with a skilled birth attendant	2,890	5,369	+86%	7,999	9,433	+18%

Additional analysis from this assessment is being undertaken and will be disseminated shortly.

OBJECTIVE 4: Improve the quality of community and facility-based MNCH/PMTCT Services

The CPMTCT project improves the quality of MNCH/PMTCT services at health centers through a performance improvement approach, which involves a cycle of training, supportive supervision (SS), developing action plans to improve performance and new or refresher training as needed. To build sustainability into this approach, the project has trained ZHD/WrHO trainers in the approach and they have trained other ZHD/WrHO supervisors as well as HC managers and HC providers. The project also technically and financially supported joint supportive supervision, which involves the WrHO/ZHD performing SS with the project's Service Delivery Officers (SDO), and follow-up supervision and mentoring by SDOs.. A similar approach is applied to improving MSG quality and in DCCM activities.

The project's approach to strengthening the quality of BEmONC services is different in that after facility staffs are trained, the project hires BEmONC mentors to visit each HC for up to three days to observe deliveries. In addition to mentoring staff in labor and delivery practices, mentor other maternal health services, like FANC, FP and PNC, and, as needed, provide additional coaching and on-the-job training to health center staff. These mentors have been trained in performance improvement methods and action plans are agreed before departing for another health center. These plans and mentoring findings are also shared with CPMTCT service delivery officer responsible for providing supervision/mentoring to the site.

Some key achievements this year included:

- Revision of PMTCT HIV+ mother and HEI tracking wall charts, productions of a draft guideline on how to facilitate PHCU review/planning meetings, and revision of the DCCM supervision checklist.
- Transition of responsibility for PQI&SS training to TOT staff, who trained 525 health center providers, HC managers and health sector supervisory staff in PQI&SS.
- CPMTCT project staff undertook monthly supervision/mentoring visit to all of MSG sites, and have drafted criteria for the reduction of technical support to both community and facility MSG. Likewise, the CPMTCT project agreed criteria to reduce the level of support to HC/PHCU with RHB/ZHD/WrHO/HC as part of the sustainability and transition workshops, and RHB and Intrahealth will assess older health centers to reduction on support in quarter one of FY2012. Project provided 489 FSS to health centers in addition to coaching HC managers to hold 504 PHCU meetings.
- BEMoNC mentoring began after training of health center labor and delivery staff from 16 health centers in Tigray and 16 in AMhara completed the BEmONC training.

Piloting a Rapid Quality of Care Assessment

In addition to the above, a key project achievement was the development and piloting of a rapid quality of care assessment (QoC) at HCs for PMTCT and some other aspects of FANC using observations, simulations and record reviews. After developing and pre-testing the instrument, the QoC assessment was carried out in Spring of this year in 42 randomly selected HCs across the regions supported: (i) 22 HCs that the project had been supporting for 9 months or more and (ii) 20 HCs where CPMTCT support had begun \leq 3 months before the QoC assessment. The 22 HCs were assessed to determine the quality of care at HC

that had received the PMTCT training and had had at least 9 months to practice delivering PMTCT services with project support. The assessment of the 20 HCs supported for ≤ 3 months was conducted to provide baseline data for future quality of care assessments.

The data from the rapid QoC is still being analyzed; however, initial results from the PMTCT component indicate that there were too few HIV+ clients in both type of site (supported for ≤ 3 months or >9 months) to really assess the quality of services such as counseling delivered to HIV positive clients, and there were too few deliveries to be able to assess the quality of care in delivery, particularly for HIV+ clients. Table 6 depicts overall quality of PMTCT care for HCs supported for ≤ 3 months and 9 months

Table 6: Summary of Quality of PMTCT Care

S.No	Quality of Care in PMTCT index score	HCs supported for 3 months (N=20)	HCs supported for 9 months (N=22)
		# (%) HCs	# (%) HCs
1	Score $\geq 80\%$		10(45%)
2	Score = 60% - <79%	13(65%)	10(45%)
3	Score = 40%-59%	6(30%)	2(9%)
4	Below 40%	1(5%)	

Overall, 45% of HC supported >9 months achieved the requisite standard for quality of care in PMTCT services score (the standard being a score of $\geq 80\%$); none of the HCs supported ≤ 3 months did. One reason that many did not achieve the requisite score was because drug/test kit availability was included in the score and was not necessarily something the HCs could control; however, there was improved supply availability relative to the HCs supported for ≤ 3 months.

However, another important factor was the quality of counseling. The assessment illustrated a problem with the quality of counseling (unfortunately, only pre-test counseling and post-test counseling for negatives could be assessed given that there were no newly identified positive clients at the time of the assessment and the simulations for positives were so poorly conducted that there were eliminated from the score). It may be that with opt-out C&T, providers do not put much weight on pre-test counseling and that with clients testing negative they are less careful in their counseling. Counseling with clients testing positive might be better; however, it could not be assessed.

The Rapid Quality of Care assessment illustrated the difficulties of assessing quality of PMTCT care in facilities with very low prevalence (particularly when PMTCT services had not been offered a long time and the number of positives was negligible or null). The system for assessing quality of care will be modified in future in order to incorporate more 'expert patient' simulations. Further, the project will use the results from this QoC assessment to improve aspects of quality of care, particularly counseling, at service sites.

Both the BEmONC mentoring and QoC assessment finding show some shortcomings in the current supervision/mentoring system, which largely uses checklists that look at HMIS performance, record review, interviews and observation of supplies. We have decided that each quarter, the SDO will apply a section of the QoC as assessment to the FANC service and/or post-test counseling and assist the team to develop actions plans to improve quality until standards are met. The problem in the Quality of Care assessment of insufficient clients taking positive and few deliveries will also make direct observations of some services difficult in SS visits, where that is the case, other methods will be used to gauge the quality of care.

Performance Indicator Results for Objective 4

Table 7: Performance for Key Quality Improvement Indicators (Objective 4)

PMP Ref. No.	Performance indicator	Q1	Q2	Q3	Q4	Total to date (FY2011)	Annual Target & (% achieved to date)	Remark
4.0 -1	% of service delivery sites (HCs, community provider sites) with acceptable data quality standards	Reported annually: _____				n/a	80%	To be conducted as of November 2011
4.0 -2	Project's data quality control system implemented in project-supported sites	Reported annually: _____				n/a	2	To be conducted as of November 2011
4.0 -3	% of clients satisfied with the service that the health cadres are providing	Reported annually: _____				53%	80%	53% of clients in QoC assessment indicated a high level of satisfaction with ANC services in their visit and 29% a medium level of satisfaction
4.0 -4	% of health facilities meeting the requisite standard of care for PMTCT	Reported annually: _____				45%	80%	Score was from QoC assessment in HC supported <u>≥ 9 months</u> and included drug/test kit availability which may have been beyond the control of the HCs.
4.2 - 1	# of HC Managers and Providers trained in PMTCT QI/PI	0	114	143	136	393	295 (133%)	Strategic change to focus on HC level
4.3 - 1	# of GOE personnel trained in PI/SS (<u>not HC managers</u>)	38	66	17	31	152	230 (66%)	As above
4.3 - 2	# of service sites receiving joint supportive supervision regularly	29	97	125	147	147	200 (74%)	Joint supportive supervision to HCs only
4.3 - 3	# of MSGs receiving supportive supervision regularly	23	73	91	96	96	100 (96%)	
4.4 -1	# of follow-up visits for mentoring PMTCT service providers (HC only)	48	103	90	248	486	560 (87%)	In addition to follow-up supervision visits, coach managers to hold over 400 PHCU meetings.
4.5 -1	# of new quality improvement related resource materials (guidelines, job aids, and MNCH/PMTCT integration tools) approve/ implemented for the first time	Reported annually: _____				2	2 (100%)	PMTCT wall chart; PHCU meeting guide
4.6 - 1	# of WrHOs using HMIS data to assess performance during review meetings	68	42	18	59	187	160 (117%)	

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

Supply issues: Challenge: a) ARV combined prophylaxis not being provided to all PMTCT sites. b) Stock outs of key HIV labs and OI drugs; c) MNCH supplies like sheets and IP materials, drugs and laboratory supply stock outs (inability to purchase in start-up phases).

Solutions: a) With support from the FMOH and USAID, the project informed regions about the current policy on combined ARV prophylaxis, worked with RHB to update sites lists through government channels and with USAID and the Supply Chain Management project to do this update through USG channels. In Amhara, PFSA designed a strategy to redistribute stocks from nearby ART/PMTCT centers with supplies to other nearby HC.. The woredas manages the consumption report of all the PMTCT sites. b) Monthly meetings with PFSA, Intrahealth and RHB to address supply chain issues are held; c) While working with the health center to persuade woredas to provide an increased budget to allow free MNCH services, worked with USAID to include basic labs for PMTCT sites in future procurements. These will be part of the “program” drugs and supplies and free of charge to health centers.

Basic furniture and utilities shortage: Challenge: Many health centers lack basic office furniture and seating for clients. **Solution:** Provision of furniture to some sites in Addis Ababa after confirmation that the sub-city budget was insufficient. Other regions have allotted a small amount of money per HC to support procurement of basic supplies/furniture in year three (budgeted at \$400/HC for all job aids, wall charts, furniture, sheets, IP materials etc).

DCCM context: Challenge: As one mechanism to monitor the effectiveness of the project's DCCM activities, Woreda-based HEW supervisor were trained to collect referral cards from health centers in the woreda quarterly. However, the supervisor post was eliminated, making it impossible to collect referral cards from all health centers in the woreda in a consistent and timely fashion. **Solution:** In future the project will focus demand creation activities only in catchment areas of HC supported by the CPMTCT project; referral cards will be collected and reviewed at PHCU meetings.

Project reporting cannot capture project successes: Challenge: The goal of the CPMTCT project is to improve the uptake of MNCH/PMTCT services. As many of the sites that CPMTCT supports are new and just initiating PMTCT, sometimes they are initially unable to provide complete ARV prophylaxis, DBS or CD4 testing and usually they are not ART sites. This means that a significant number of HIV+ clients and HIV exposed infants need to be attended at other health facilities. Further, much of the DCCM work and outreach has been in catchment areas of HCs supported by other organizations. Hence, the CPMTCT reported uptake of services, and cascade of service use, as measured by PEPFAR, has looked insufficient. **Solution:** To combat this problem, the project has reached an agreement with USAID to expand services into addition HCs, to work on improving the availability of more complete services at HC level, and to focus DCCM activities only in the catchment areas of HCs supported by the project.

DBS/CD4 testing at PMTCT sites: Challenge: Although the Health Promotion and Disease Prevention sections of both FMOH and RHB have policies stating that this testing should be provided at PMTCT sites, regional laboratories and PFSA only had plans to provide reagents/test kits to and accept samples from ART sites and refused to accept samples from staff who had not been trained by the regional laboratory staff in sample taking and transport. **Partial Solution:** Training provided to laboratory staff at CPMTCT-supported health centers by Regional Laboratory technicians. Rather than allotting a specific day per week to accept samples from CPMTCT-supported health centers outside of Addis Ababa, regional laboratories agreed to accept samples from sites at any time as the number of HEI infants is very small. **Additional challenges:** Distribution of sample transport boxes and test kits/reagents are still lagging and agreement with the main regional laboratory regarding accepting samples from non-ART sites, has not always been communicated appropriately to all sub-regional laboratories. These two factors mean that HIV+ women and HIV-exposed infants from project supported health centers are still referred to the ART for CD4 and

DBS testing. **Proposed Solutions:** In addition to ensuring the inclusion of sites on PFSA/SCM procurement/distribution lists, and request for a letter signed by the RHB and main regional laboratory instructing other laboratories to accept samples from project sites, CPMTCT plans to schedule a meeting at national level of EHNRI/Regional Labs, PFSA at national and regional level and FMOH/RHB staff to resolve these issues as part of the Emergency PMTCT plan.

8. Data Quality issues during the reporting period

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

The frequent change in HMIS reporting timeline by RHBs, the continued use of old and new HMIS, shortages of HMIS registers and forms, and lack of trained staff at HC adversely affects the accuracy, consistency and completeness of data reported from HCs.

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

The project performs data quality checks during regular joint supportive supervision visits; these checks are a part of the checklist that is used in the visits. In addition, country office M&E team and regional M&E officers periodically visit expansion health centers, health posts and woreda health offices to examine HMIS and project registers and the quality of data collection and reporting.

Actions taken:

The project, in consultation with RHBs and partners, supported HMIS trainings for health care providers and community health workers. In addition, Pre-ART registers were distributed to most CPMTCT HCs.

At the end of the year, project M&E staff developed a comprehensive data quality assessment tool to assess all types of project data, from various sources. They piloted the tool at the end of FY 2011 and will conduct the assessment early in FY 2012.

9. Major Activities planned in the next reporting period

- With RHB identify additional health centers which require CPMTCT support to improve or initiate MNCH/PMTCT services within existing project towns/woredas.
- Hold sustainability and transition workshops in Oromiya and Addis Ababa regions include workshop identified priority actions in annual work plans and implement agreed priority actions identified in sustainability and transition workshops.
- Complete and submit to the Mission, the annual CPMTCT work plan; finalize regional level work plans and budgets
- Update staff on FMOH priorities including the roadmap for reducing maternal and neo-natal morbidity and mortality and the PMTCT emergency plan, as well as the new WHO guidelines, and pre-ART related TB screening, adult OI and other issues..
- Work with RHB to ensure that additional project-supported health centers have needed MNCH/PMTCT related job aids, registers, drugs and supplies, including pre-ART and HEI registers
- Distribute new born corner materials to 196 HC
- With PATH and FMOH, launch the IYCN videos and the finalized nutritional counseling cue cards.
- Training of SNNP women's association in BC/CM for MNCH/PMTCT. With C-Change finalize the adaption of the 4 episode audio drama and begin using with EOC-DICAC religious women's' groups.
- In cooperation with FMOH/RHB and as part of the PMTCT emergency Plan, support regions to train health center staff in MNCH/PMTCT.
- BEmONC in-service training and post-training mentoring
- Supportive supervision to MSG and PHCU and improved system of supportive supervision/mentoring to HC sites.
- Complete analysis of baseline follow-up and QoC assessments; finalize protocol for internal mid-term review of project.

10. Environmental compliance

IntraHealth Service Delivery Officers (SDOs) used supportive supervision visits to orient health care providers on the importance of Environmental Mitigation and Management (EMM) issues which includes proper and safe disposal system at health facilities (using incinerators, disposal pits, etc). The SDOs were working to ensure that all the existing and new PMTCT expansion sites have IP materials such as gloves, buckets, towels, alcohol, soap, etc. Furthermore, the project in consultation with the Mission and PFSA provides IP materials for expansion HCs.

11. Financial accomplishment

(... in USD)

Life of Project budget (a)	Obligated to date (b)	Expenditure (Accrual and actual disbursement) to date (c)	Remaining balance (d) = (b) – (c)	Remarks
\$30,000,000	\$16,144,796	12,783,405	3,361,391	

12. Issues requiring the attention of USAID Management

Continued support in resolving on-going DBS/CD4 issues at PMTCT health centers will be greatly appreciated.

13. Data Sharing with Host Government:

Have you shared this report with the host government?

Yes

No

If yes, to which governmental office/s?

FMOH, Urban and Rural Health Promotion Disease Prevention Directorates

If No, why not?

14. Appendices

Ruth Landry Trip Report

Karen Blyth Trip Report

Laura Gibney Trip Report (annexes not attached as this large file already submitted)

SpacedEd evaluation